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WOKINGHAM
BOROUGH COUNCIL

A Meeting of the **HEALTH OVERVIEW AND SCRUTINY COMMITTEE** will be held at the Civic Offices, Shute End, Wokingham, RG40 1BN on **MONDAY 30 NOVEMBER 2015** AT **7.00 PM**

Andy Couldrick
Chief Executive
Published on 20 November 2015

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The Health Overview and Scrutiny Committee aims to focus on:

- The promotion of public health and patient care
- The needs and interests of Wokingham Borough
- The performance of local NHS Trusts

MEMBERSHIP OF THE HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Councillors

Ken Miall (Chairman)	Kate Haines (Vice-Chairman)	Laura Blumenthal
UllaKarin Clark	Philip Houldsworth	Malcolm Richards
Rachelle Shepherd-DuBey	David Sleight	Alison Swaddle
Bob Wyatt		

Substitutes

Lindsay Ferris	Abdul Loyes	Tom McCann
Bill Soane		

ITEM NO.	WARD	SUBJECT	PAGE NO.
33.		**APOLOGIES** To receive any apologies for absence	
34.		**MINUTES OF PREVIOUS MEETING** To confirm the Minutes of the Meeting held on 29 September 2015.	**5 - 10**
35.		**DECLARATION OF INTEREST** To receive any declarations of interest	
36.		**PUBLIC QUESTION TIME** To answer any public questions A period of 30 minutes will be allowed for members of the public to ask questions submitted under notice. The Council welcomes questions from members of the public about the work of this committee. Subject to meeting certain timescales, questions can relate to general issues concerned with the work of the Committee or an item which is on the Agenda for this meeting. For full details of the procedure for submitting questions please contact the Democratic Services Section on the numbers given below or go to www.wokingham.gov.uk/publicquestions	
37.		**MEMBER QUESTION TIME** To answer any member questions	
38.	None Specific	**SOUTH CENTRAL AMBULANCE SERVICE** To receive an update on South Central Ambulance Service. *(30 mins)*	**11 - 74**

39.	None Specific	**FRAIL ELDERLY PATHWAY** To receive an update on the Frail Elderly Pathway and its implications for residents. *(20 mins)*	**Verbal Report**
40.	None Specific	**JOINT STRATEGIC NEEDS ASSESSMENT UPDATE** To receive an update on the Joint Strategic Needs Assessment. *(20 mins)*	**75 - 78**
41.	None Specific	**HEALTHWATCH UPDATE** To receive an update on the work of Healthwatch Wokingham Borough. *(15 mins)*	**79 - 82**
42.	None Specific	**WOKINGHAM CLINICAL COMMISSIONING GROUP PERFORMANCE OUTCOMES REPORT NOVEMBER 2015** To receive the Wokingham Clinical Commissioning Group Performance Outcomes Report November 2015. *(15 mins)*	**83 - 88**
43.	None Specific	**WORK PROGRAMME 2015/16** To discuss the Work Programme for the remainder of 2015/16. *(5 mins)*	**89 - 102**
44.		**ANY OTHER ITEMS WHICH THE CHAIRMAN DECIDES ARE URGENT** A Supplementary Agenda will be issued by the Chief Executive if there are any other items to consider under this heading.	

CONTACT OFFICER

Madeleine Shopland, Principal Democratic Services Officer	Tel 0118 974 6319, Email madeleine.shopland@wokingham.gov.uk
Tel	0118 974 6319
Email	madeleine.shopland@wokingham.gov.uk
Postal Address	Civic Offices, Shute End, Wokingham, RG40 1BN

MINUTES OF A MEETING OF THE
HEALTH OVERVIEW AND SCRUTINY COMMITTEE
HELD ON 29 SEPTEMBER 2015 FROM 7.00 PM TO 8.25 PM

Committee Members Present
Councillors: Ken Miall (Chairman), Kate Haines (Vice-Chairman), Laura Blumenthal, UllaKarin Clark, Philip Houldsworth, Malcolm Richards, Rachelle Shepherd-DuBey, David Sleight, Alison Swaddle and Bob Wyatt

Others Present
Nicola Strudley, Healthwatch Wokingham
Julian McGhee-Sumner
Jim Stockley, Healthwatch Wokingham
Tim Holton
Madeleine Shopland, Principal Democratic Services Officer
Stuart Rowbotham, Director of Health and Wellbeing

21. APOLOGIES
There were no apologies for absence.

22. MINUTES OF PREVIOUS MEETING
The Minutes of the meeting of the Committee held on 28 July 2015 were confirmed as a correct record and signed by the Chairman.

23. DECLARATION OF INTEREST
There were no declarations of interest made.

24. PUBLIC QUESTION TIME
There were no public questions.

25. MEMBER QUESTION TIME
There were no Member questions.

26. UPDATE ON HEALTH AND WELLBEING BOARD
Councillor McGhee-Sumner, Chairman of the Health and Wellbeing Board provided an update on the work of the Health and Wellbeing Board.

During the discussion of this item the following points were made:

- Members were informed that the Health and Wellbeing Board was likely to undergo a Local Government Association (LGA) Peer Challenge early next year. It was intended for the review to comprise three Health and Wellbeing Boards: Wokingham, Reading and West Berkshire.
- Individual reports and recommendations would be produced for the three Boards and also recommendations for common areas for improvements and possible opportunities for collective working.
- The review would enable the Board to reflect on and improve the way it worked and made an impact by identifying areas for improvement.
- Councillor McGhee-Sumner commented that he wanted the Board to be benchmarked against the three best performing Boards in the country. Councillor Clark asked which were the best Health and Wellbeing Boards. The Director of Health and Wellbeing indicated that the LGA reviews gave some indication of

performance but that Plymouth and North Lincolnshire Boards had been identified as examples of good practice. Councillor Clark questioned whether less well performing Boards should also be looked at to ensure that the Health and Wellbeing Board avoided pitfalls.

- Councillor Houldsworth asked Councillor McGhee-Sumner what he felt was the biggest single problem in health and social care and was informed that integration of health and social care was a challenge. In addition some areas such as Hospital @ Home had not had the take up that had been hoped for.
- The Committee discussed admissions and residential care. Councillor McGhee-Sumner commented that the Council had a good record of keeping people in their homes when appropriate.
- The Committee was informed of the Frail Elderly Pathway which looked to track individuals through the health and social care system. The Director of Health and Wellbeing offered to bring the data sets for the Frail Elderly Pathway to the Committee's November meeting.
- Councillor Richards commented that NICE guidelines stated that home care visits should last at least half an hour. However, sometimes visits did not require that amount of time, for example if the individual simply required help taking medication. Nicola Strudley emphasised that there were 15 minute med calls for those who needed assistance with their medication but that these were not considered care calls. The Director of Health and Wellbeing commented that some areas allocated 15 minute visits for intimate tasks such as bathing, potentially leading to issues of dignity in care. He assured the Committee that it was the Council's policy not to do this. The policy took a more personalised approach.
- Councillor Shepherd-DuBey queried how the Council could be sure that carers' visits lasted as long as recorded and whether carers were paid for travelling between appointments and was informed that discussions regarding telecare systems were taking place. Staff were paid for travel.
- Councillor Haines asked whether language barriers between carers and customers were an issue. The Director of Health and Wellbeing emphasised that there was a contract standard in place and that he had not received complaints on this matter.
- Recruiting and retaining front line care workers was an acute problem, particularly in South East England. Councillor Miall asked how Wokingham was addressing this. The Director of Health and Wellbeing indicated that Optalis currently met the National Living Wage but as this escalated the situation may become less sustainable. Councillor McGhee-Sumner added that care home fees had been held for the last 4-5 years but this too was becoming unsustainable as the National Living Wage increased. Councillor Miall requested that the Committee be kept updated on the matter.

RESOLVED: That Councillor McGhee-Sumner be thanked for his presentation.

27. EXECUTIVE MEMBER FOR HEALTH AND WELLBEING

The Committee received an update on the Health and Wellbeing portfolio from the Executive Member for Health and Wellbeing.

During the discussion of this item the following points were made:

- Members were updated on the Berkshire West Joint Commissioning Function. The Chief Executive Officers would be meeting to discuss if a review was needed.
- In response to a question regarding if there was sufficient variety of residential care providers to give people the best choice, Councillor McGhee-Sumner emphasised

that there was at least 20 providers in the Borough, not including extra care providers. The Council had contracts in place with various providers for extra care housing.

- Members questioned if the Council aimed to develop a market that delivered a wide range of sustainable high quality care and support services which were available to residents and were advised that the Council endeavoured to drive down prices without undermining the market.
- Councillor Houldsworth asked about needs assessments to determine the type of support required and waiting times. The Director of Health and Wellbeing commented that waiting time performance was not as good as was hoped for. However, those in urgent need received an urgent response and there was no one who required urgent care currently on the waiting list.
- It was confirmed that internal procedures and policies reflected the requirements of the Care Act 2014.
- Written information was provided about charging for residential placements before people began to look for placements. Leaflets were available on charging and financial assessments and people were signposted to advice and guidance. Councillor Miall questioned whether the independent people providing advice were truly independent and was advised that they were.
- Councillor Haines queried whether there had been any resistance from those looking for residential placements when the Council identified homes which it considered to be affordable and appropriate for the individual. Councillor McGhee-Sumner indicated that Officers tried to make clear the issue of affordability at an early stage. If a person had been resident in a home for some time and the placement began to become unaffordable the Council tried to come to an agreement with the provider. People were only moved to another home as a last resort. The Independent Care Brokerage Service helped people to understand what the most appropriate solutions would be for their personal circumstances and advised people to plan ahead in case their placement should became unaffordable. If people preferred a more expensive care home to the one the Council had offered they could still move there, if a relative paid the difference.

RESOLVED: That Councillor McGhee-Sumner be thanked for his presentation.

28. INDEPENDENT LIVING FUND UPDATE

The Director of Health and Wellbeing provided an update on the impact of the closure of the Independent Living Fund (ILF).

During the discussion of this item the following points were made:

- The Independent Living Fund was established in 1988 to make direct payments to enable disabled people and (where appropriate) their carers to purchase support that could not be obtained from local authorities.
- Following changes to the way in which care was delivered by local authorities, the ILF was closed to new claimants from December 2010. In 2012 the closure of the fund for existing beneficiaries from 31 March 2015 was announced. Judicial Review meant this was delayed until 30 June 2015. Since 1 July 2015 the Council had had full responsibility to fund eligible care needs (defined in accordance with the Care Act 2014) for current ILF beneficiaries in its area.
- Regular information updates were provided to the Council by ILF and these had initially confirmed that 19 cases were likely to transfer to the Council upon the fund's closure.

- All affected customers had been advised in writing in April of the transfer date, that the Council intended to carry out a full re-assessment of their needs and that, in the meantime, funding at the appropriate ILF level would be paid by the Council for July and August where appropriate. They had also been advised that should the re-assessment process not be completed by the end of August, further funding at the ILF level would be made available for September.
- 18 cases were transferred on 1 July. The Council had been informed that it would receive £230,456 in ILF grant funding for the remainder of the financial year.
- The Committee was advised of progress on the transferred cases as at 8 September. 2 recipients had moved outside of the Borough and ongoing care arrangements had been passed to their new local authority. The ILF grant did not move with the recipients; in another case a customer was now fully funded under S117 arrangements with Health partners; in another instance the review process had been completed and the customer now jointly funded by the Council and the CCG on a 50/50 basis; the re-assessment and Personal Budget review process had been completed in 7 cases; in 5 cases, the re-assessment process had been completed and reviews of the outcomes and possible impact on the Council defined Personal Budgets were ongoing; the re-assessment process was still ongoing in one case; and the Council had been unable to gain access to undertake the reassessment in another case.
- Councillor Swaddle asked what the situation was of the 19th individual of the cases identified pre transfer. The Director of Health and Wellbeing agreed to look into this and to feed back to the Principal Democratic Services Officer.
- The Director of Health and Wellbeing commented that it was difficult to understand the implications of the ILF transfer next year as it would no longer be separate ring fenced money.
- In response to a question from Councillor Haines it was clarified that the ILF was entirely separate to Disability Living Allowance.
- Members requested that a further report be provided to the Committee once all reviews had been completed.

RESOLVED: That

1) the report and update on the transfer of Independent Living Fund cases to the Council be noted.

2) a further report be provided to the Committee once all reviews have been completed.

29. HEALTHWATCH UPDATE

Nicola Strudley presented an update on the work of Healthwatch Wokingham Borough.

During the discussion of this item the following points were made:

- It was noted that as a result of a deaf blind champion walkabout at Wokingham Medical Centre a number of changes had been made to make it more accessible. A video would be put up on You Tube and the Healthwatch website.
- Healthwatch Wokingham Borough had helped to keep the spotlight on CAMHS and had influenced the joint strategy produced by the Council and CCG. They were pleased that the 18 month action plan included named individuals and dates against actions. The Healthwatch Board would be meeting with Berkshire Healthcare Foundation Trust to discuss the government document 'Future in Mind' and the

implications of this. Healthwatch Wokingham Borough had produced a FAQ about CAMHS.

- Healthwatch Wokingham Borough had introduced Twyford Village Partnership to the CCG Better Care Fund "Neighbourhood Cluster" Project Manager and they were willing to be a pilot site.
- With regards to Healthwatch Wokingham Borough's report 'Totes Emosh', Nicola Strudley informed the Committee that as a result of the work undertaken, St Crispin's School had changed its curriculum. Personal Health and Social Education now took place during registration period. Work was being undertaken with several students to develop an app on pathways and coping strategies in particular. The Council's Young Carer Project had been reinvigorated. Councillor Swaddle asked if Healthwatch Wokingham Borough would be working with others schools. Nicola Strudley indicated that whilst other schools had expressed an interest, Healthwatch was staffed by 1.5FTE so capacity was limited. Nevertheless, discussions about how Healthwatch's funding could be best utilised, would be taking place. She would be putting forward a proposal for a Young Person Worker.
- Healthwatch Wokingham Borough had been attending flu clinics at the Wokingham Medical Centre, which had been a good means of engaging with more people. Councillor Haines questioned whether they would be attending flu clinics at other surgeries and was informed that arrangements had been made to attend a forthcoming flu clinic in Woodley.
- Councillor Blumenthal commented that there had been stories in the media recently regarding NHS 111 and asked whether Healthwatch Wokingham Borough had received many comments on the service. Nicola Strudley indicated that the service was being recommissioned at present and that the Thames Valley Healthwatches were pulling together data to contribute to the recommissioning process. However, this was not a high volume topic.
- In response to a Member question, Nicola Strudley explained how Healthwatch Wokingham Borough handled calls from those outside the area.

RESOLVED: That Healthwatch Wokingham Borough be thanked for their report.

30. WORK PROGRAMME 2015/16

The Committee considered the Work Programme 2015/16.

During the discussion of this item the following points were made:

- It was noted that the November meeting had a heavy agenda. It was therefore proposed that the items on the Report of the Possible Implications for Scrutiny of the Francis Report Working Group – follow up of recommendations and Update from Council's representative on Berkshire Healthcare NHS Foundation Trust and Royal Berkshire Foundation Trust – Board of Governors, be deferred to the Committee's January meeting to ensure a more manageable agenda.
- Members were requested to email the Principal Democratic Services Officer with any questions they had or areas that they wished to focus on regarding the Joint Strategic Needs Assessment and the South Central Ambulance Service.
- Councillor Haines raised an issue regarding community responders and the provision of defibrillator equipment. The Principal Democratic Services Officer agreed to follow this up.
- A member of the public informed the Committee of NHS Wokingham CCG's consultation on its vision for the future of GP and primary care services and the

public event on 20 October. It was suggested that Committee members may wish to attend.

RESOLVED: That the Work Programme 2015/16 be noted.

TITLE	**South Central Ambulance Service**
FOR CONSIDERATION BY	Health Overview and Scrutiny Committee on 30 November 2015
WARD	None Specific
DIRECTOR	Andrew Moulton, Head of Governance and Improvement Services

OUTCOME / BENEFITS TO THE COMMUNITY

Members scrutinise the performance and operation of the local ambulance service provider.

RECOMMENDATION

That the Health Overview and Scrutiny Committee scrutinises the performance and operation of the local ambulance service provider, South Central Ambulance Service (SCAS) and is updated on its future plans.

SUMMARY OF REPORT

SCAS serves Berkshire, Buckinghamshire, Hampshire and Oxfordshire; approximately 3,554 sq. miles with a residential population of over four million.

Its three main functions are:

- the accident and emergency service to respond to 999 calls;
- the NHS 111 service for when medical help is needed fast but it is not a 999 emergency;
- Patient Transport Service

SCAS also offers:

- First Aid training to the public and to organisations;
- The Commercial Logistics collection and delivery service for NHS partners;
- Resilience and Specialist Operations (medical care in hostile environments e.g natural disasters and industrial accidents):
- Community First Responders.

Monitor
Monitor, the sector regulator for health services in England, publishes two ratings for each NHS foundation trust.

The continuity of services rating is Monitor's view of the risk that the Trust will fail to carry on as a going concern. A rating of 1 indicates the most serious risk and 4 the least. A rating of 2* means the trust has a risk rating of 2 but its financial position is unlikely to get worse.

The governance rating is Monitor's degree of concern about how the Trust is run, any

steps it is taking to investigate this and/or any action being taken. It will either highlight that Monitor has no evident concerns, that they have begun enforcement action, or that the foundation trust's rating is 'under review.'

SCAS is currently rated '3' for continuity of service and 'Green' for governance with 'No evident concerns.'

The Health Overview and Scrutiny Committee have not met with SCAS since November 2013 (Minutes of meeting of 25 November 2013 attached as Appendix 1).

Representatives from SCAS have been invited to provide Members with an update on aspects of the ambulance service provider's performance and operation. (presentation attached).

To inform discussions, attached at Appendix 2 is the SCAS Operational Plan 2015-16 and attached at Appendix 3 is the Care Quality Commission inspection report, published January 2015, following an inspection carried out in September and October 2014.

FINANCIAL IMPLICATIONS OF THE RECOMMENDATION

The Council faces severe financial challenges over the coming years as a result of the austerity measures implemented by the Government and subsequent reductions to public sector funding. It is estimated that Wokingham Borough Council will be required to make budget reductions in excess of £20m over the next three years and all Executive decisions should be made in this context.

	How much will it Cost/ (Save)	Is there sufficient funding – if not quantify the Shortfall	Revenue or Capital?
Current Financial Year (Year 1)	N/A	N/A	N/A
Next Financial Year (Year 2)	N/A	N/A	N/A
Following Financial Year (Year 3)	N/A	N/A	N/A

Other financial information relevant to the Recommendation/Decision
N/A

Cross-Council Implications
N/A

List of Background Papers
N/A

Contact Madeleine Shopland	**Service** Governance and Improvement Services
Telephone No 0118 974 6319	**Email** madeleine.shopland@wokingham.gov.uk
Date 03.11.15	**Version No.** 1

Appendix 1: Minutes of the meeting of the Health Overview and Scrutiny Committee 25 November 2013

34. SOUTH CENTRAL AMBULANCE SERVICE (SCAS)

At its September meeting the Committee had expressed concern that the 'Ambulance handover and crew clear delays' and the 'Ambulance Response Times' targets were not being achieved and invited the South Central Ambulance Service NHS Foundation Trust to the November meeting to explain why and what action was being taken to improve matters. Sue Byrne, Chief Operating Officer, SCAS and Keith Boyes, Area Manager, SCAS provided an update.

During the discussion of this item the following points were made:

- Between October 2012 and October 2013 there had been an increase in demand in the Wokingham Borough on a scale not seen elsewhere within the region.
- Across the region as a whole, SCAS was performing well. In Quarter 2 the unseasonably hot weather had proved challenging. Demand had spiked between July and August and then decreased in September.
- Discussions were underway regarding lessons learnt and preparation should there be very hot weather again next year.
- Whilst SCAS had achieved targets across its whole area between September and October, demand in the Wokingham Borough had also spiked in October. The reasons behind this were not entirely clear.
- As demand had increased, SCAS had increased resources to the area, non urgent activity had been cancelled and clinically trained managers had been escalated to help maximise efficiency.
- Increased demand was anticipated between December and January. No training was planned during this period to maximise staff availability. Work would take place with partner organisations such as the hospitals, to manage queuing.
- With regards to rotas SCAS planned to work differently. Demand could be forecasted by hour, by day. There was movement away from flat planning of resources.
- NHS 111 was providing additional demand. Currently 999 calls were taken via the AMPD system and NHS 111 calls were taken via NHS Pathways. From March/April all calls would be dealt with via the NHS Pathways system. This would provide more opportunities to clinically interact with patients before or if an ambulance was dispatched. The opportunity for more 'Hear & Treat' over the telephone would also increase.
- Andrew Bradley asked whether calls were broken down by type to provide a better indication of the reasons behind the spike in demand in the Wokingham area. Sue Byrne commented that calls were broken down into categories. The unusually hot weather in summer had increased the acuity of conditions including asthma and breathing difficulties, leading to more calls.
- Malcolm Richards asked whether peaks in activity coincided with outside normal GP surgery hours. Mondays were often very busy. Calls from GPs on behalf of patients peaked between 4-6pm. Discussions were being held with the commissioners regarding different ways of working to ensure that where possible patients were transported earlier in the day. Often those whose GP had called SCAS were those most in need of the ambulance service, yet it could be more difficult to reach patients if the call was made during the rush hour. This was particularly challenging when acuity increased.

- In response to a Member question regarding NHS 111 and at what point in a call an ambulance was dispatched if required, Sue Byrne indicated that on average it was 30-40 seconds after the call was answered. Even if an ambulance was not immediately dispatched the nearest resource was located and put on standby and could be advised to proceed on lights should it become necessary.
- Ken Miall asked about the benefits of the NHS Pathways system. Members were informed that it would give call handlers greater opportunity to understand callers' problems and to select the appropriate pathway. The AMPD system was designed to dispatch an ambulance not to ascertain whether one was required. The Committee was assured that there was little difference in the point of the call that an ambulance was dispatched when using the NHS Pathways system.
- Ian Pittock asked about overlapping shifts during peak times and new equipment. Sue Byrne stated that overlapping shifts were used and that SCAS would be getting 26 new ambulances and 56 cars in the new year. Some older equipment would then be retired.
- In response to Members queries regarding incidents when call handlers had wished to speak to patients who were under 16 or who were unable to get to the telephone Sue Byrne asked that she be provided with details of the calls. The calls could be audited to determine if the response had been appropriate. SCAS routinely audited a high level of calls.
- Kate Haines commented that there had been reports in the media about the standards of private ambulance services. Sue Byrne emphasised that SCAS used a very detailed procurement process for the private providers that it used and had reduced the number it used to 4 or 5. These were audited to ensure they met clinical and facilities quality standards and monthly clinical meetings were held with the providers. Clinical colleagues had judged their equipment fit for use. Keith Boyes reminded the Committee that it took around 3 years to develop a paramedic. Private providers help to cover gaps.
- Kate Haines went on to ask whether the relocation of the Emergency Operations Centre from Wokingham to Bicester had had an effect on response times. Keith Boyes clarified that the Wokingham centre had been a control centre and headquarters. A rapid response vehicle was available.
- Ambulance handover and crew clear delays were discussed.
- Double verification had been introduced, under which the ambulance crew and the hospital agreed when the handover and clear up times took place. Handover and clear up times at the Royal Berkshire Hospital were reducing.
- Members were informed that ambulance crews could be delayed if pieces of equipment continued to be used once the patient reached hospital.
- Hospital Ambulance Liaison Officers (HALO) would be introduced during the winter period.
- Tim Holton asked how much SCAS was fined if there was a delay in clear up times and was informed that SCAS was fined £2.44 a minute.
- Members questioned what impact traffic jams and new developments which were not on GPS systems had. Keith Boyes indicated that local authorities informed SCAS of new developments and these were programmed into the aided dispatch system.

RESOLVED: That the South Central Ambulance Service update be noted.

South Central Ambulance Service NHS
NHS Foundation Trust

SCAS OPERATIONAL PLAN 2015-16

Executive summary

SCAS is much more than a traditional ambulance service. It is also a clinical assessment and signposting service for people who are ill, injured or concerned about their health.

We are continually striving to offer the right care, first time for each individual patient. This strategic goal is well aligned with both the new models of care in the NHS Five Year Forward View and the emerging service models in our local systems of care.

The key challenges facing SCAS are to improve the quality and effectiveness of patient care, and to support local systems in managing rising demand. These improvements must be achieved in the context of tightening finances, increased commercial competition and a scarce supply of staff.

This plan sets out how SCAS will rise to these challenges and progress towards our vision.

SCAS role	Focus for 2015-16
To enable you to identify and access the care you need	To develop our assessment, signposting and advice services To explore ways to share our infrastructure with partner agencies, to facilitate coordinated care across systems
To save lives and improve outcomes	To invest in new roles and career development, in order to secure a sustainable workforce and respond to local needs
To enable you to stay safely in your own home or community	To enhance our 24/7 mobile healthcare service To work with our partners to redesign local systems of care, building on the models proposed in the NHS Forward View
To ensure you can travel safely between home and care settings	To modernise our patient transport and logistics services To offer enhanced services to support people returning home
To support efficient and effective flow around systems of care	To transform our analytical capability and capacity To offer a 'helicopter view'
To secure our competitive position as provider of choice	To transform our cost base To ensure full compliance with all contractual and regulatory standards

Contents

1 Establishing the strategic context

1.1 Service performance in 2014-15

1.1.1 Emergency 999 Service

We have achieved most contractual standards and maintained good performance against other indicators.

During the year, our focus has been on overcoming the challenges faced against emergency (red) response time targets. We achieved both the Red 1 and Red 19 targets for the year, and narrowly missed Red 2, which was impacted by demand surges and resource shortages. SCAS missed both red standards in quarter 3, due to demand surges during the winter. We recovered our emergency response times during quarter 4, and have entered 2015-16 with both Red 1 and Red 2 and Red 19 performance standards being met.

Next year, we are refining our approach to Red performance. We are refreshing our tools to forecast and position emergency resources, with the goal of ensuring resilient and sustainable performance throughout the year. As well as addressing gaps in our own performance, this approach also involves working with stakeholders to resolve challenges in the wider system.

1.1.2 NHS111 Service

SCAS's objective for for NHS111 services in 2014-15 was to maintain national and contractual standards, despite fluctuations in demand.

We have achieved contractual standards. Again, we struggled to flex our resources in time to accommodate the surges in demand over the winter. Performance over the year has been good.

We moved to a single telephony platform and introduced virtual working during 2014-15. This should help to ensure resilient and sustainable performance in the future.

1.1.3 Patient Transport Service

SCAS has a range of Patient Transport Service (PTS) contracts, with each contract having its own unique set of performance indicators. These are typically based around:

- The timeliness of collection and delivery of patients to and from their appointments for treatment.
- The length of time any individual patient spends on a vehicle, en route to and from their appointment.
- Specific metrics related to the treatment of certain patient groups, for example renal patients who are very regular users of the service, where the timeliness of collection and delivery to treatment centre is critical.
- Performance standards related to the operation of our coordination centres, which include the timeliness of call answering and the recontact timescales for those callers who leave voice-mail messages.

Performance across each of our PTS contracts is generally good, with local variations influencing our ability to meet specific measures from time to time. Drivers influencing variations included:

- Comprehensive and long term road works in some areas, which have made the planning and delivery of some services difficult without signifiacant additional resources.
- Contract activity volumes significanlty more than anticipated at any given time.
- Call centre volumes significantly higher than plan, where the options of online alternatives have not been utilised.

1.2 External environment

There have been no changes to the external environment which significantly change our strategic direction. Developments in the last year, both locally and nationally, have reiterated the need for SCAS to achieve its strategic goals.

However, it is now recognised that there is a national shortage of paramedics. Inevitably, this impacts on various areas such as recruitment and the operational model.

NHS Five Year Forward View [1]

The Forward View describes three models of care for local systems to design and implement to meet the needs of their communities. SCAS has a pivotal role in the successful delivery of any of these models. We are working with commissioners and partners to assess the most appropriate model and to agree next steps in each local system.

There are several themes running through the Forward View, all of which SCAS embrace and we will incorporate into our developments in the coming year.

New commissioning standards for NHS111 services

NHS England published new commissioning standards for NHS111 services in June 2014. These new standards will require us to make some adjustments for any new contracts, but the changes are in line with the SCAS's strategic direction of travel.

1.3 Local Commissioning

We are working closely with local commissioners and partners to understand the challenges facing each system:

- To manage the underlying growth and recent spikes in demand for unscheduled care
- To integrate services and pathways across health and social care boundaries
- To reduce hospital admissions and length of stay, for both patients and financial reasons
- To provide more 24/7 services, with a focus on improving the 'out of hours' provision

Our strategy is designed to support local systems of care in responding to these challenges. In line with our commissioners' thinking, we consider that SCAS has a pivotal role in:

- Enabling people to identify and access the care that they need first time
- Enabling more people to stay safely in their own home or community
- Ensuring people travel safely between home and care settings
- Supporting efficient and effective patient flow around systems of care

SCAS also faces the following specific issues:

- Tenders for Berkshire, Oxfordshire and Buckinghamshire PTS, with the risk of losing these to private competition, and potential exit costs from these businesses.
- Financial difficulties within local CCGs and Acute Trusts.
- Significant cost pressures from a tightening in the ambulance resource market, with other organisations attracting Paramedics to them for more pay and better working hours.
- Loss of non-recurring benefit relating to the NHSD successor body and property disposals.
- Re-procurement of NHS111 services.

[1] *NHS Five Year Forward View, published in October 2014*

1.4 Government and Regulatory Policy

As yet, there are no significant changes to government or regulatory policy which have a significant impact on SCAS strategic direction or operational plans for 2015-16.

Revised ambulance response standards

The NHS is piloting new ambulance response standards. SCAS is watching these pilots closely in order to understand the challenges, opportunities and implications if the changes are implemented nationally.

Care Quality Commission

SCAS was a pilot site for inspection against the new Care Quality Commission (CQC) regulation standards and ratings. Therefore, we have had the opportunity to work with the CQC in developing inspection processes going forward.

1.5 Strategic direction

The strategic context has evolved during 2014-15. The changes have reiterated, and if anything hastened, the need for SCAS to achieve its strategic vision. We have reviewed and refreshed our strategy informally throughout the year.

As part of the 2015 annual planning review, the Executive, Board and Governors have all reviewed the strategic context and recommitted to the strategic direction set in 2014.

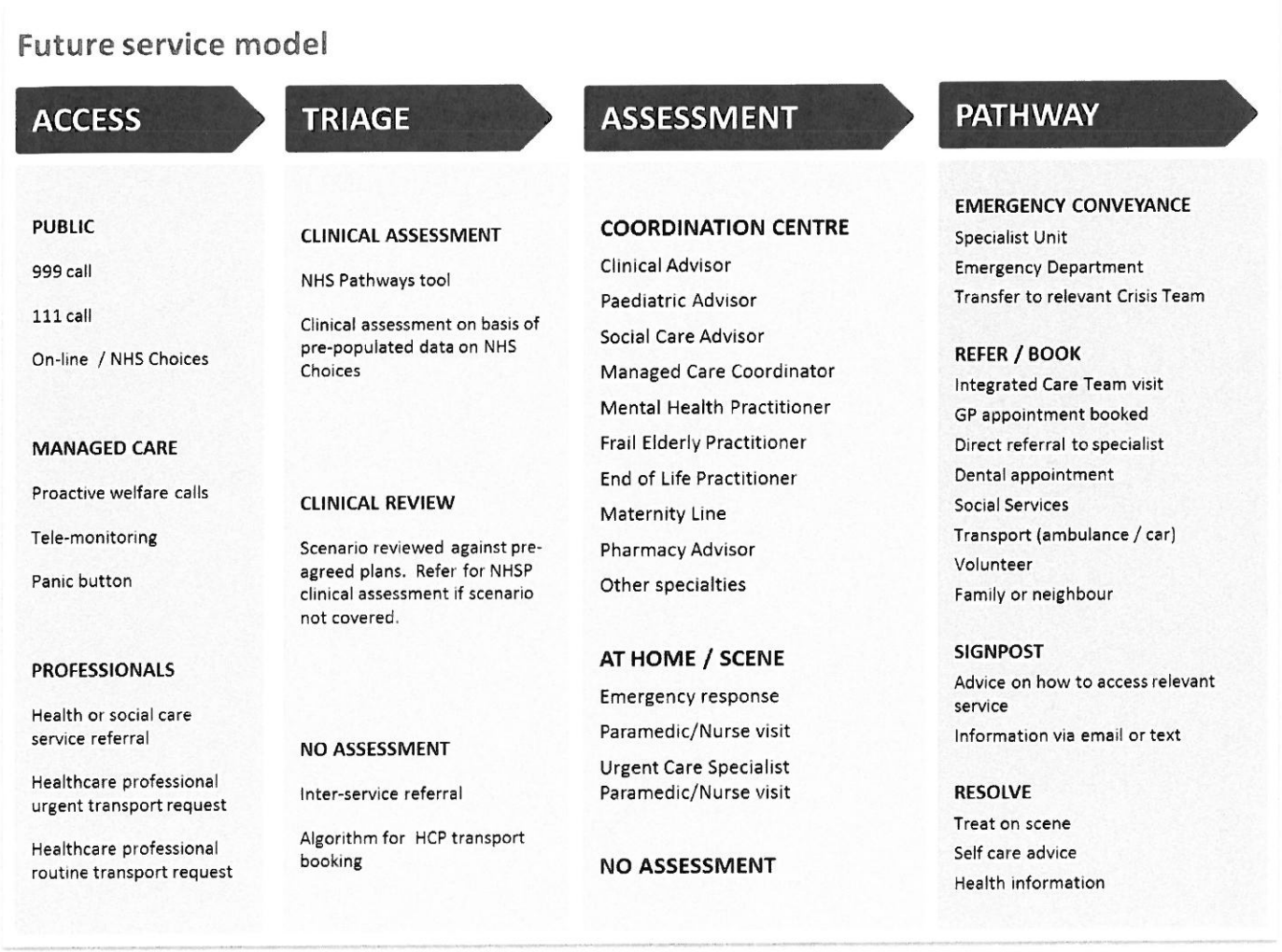
2 Progress in delivering the strategy

2.1 Response to the 'Five Year Forward View'

SCAS has a pivotal role in the successful delivery of each service model set out in the Forward View. We are working with commissioners and partners to assess the most appropriate model for each local system and to agree next steps.

- **Multi-speciality Community Provider**
  a group of GPs running community hospitals and employing a range of specialists in community, hospital, mental health and social care
- **Acute and Primary Care System**
  an integrated primary and secondary care provider, similar to the Accountable Care Organisation model that is developing in some other countries
- **Urgent and Emergency Care Network**
  other types of integration to support smaller hospitals, enable midwifery led services, improve the care of the frail elderly within their own homes

Our local systems are likely to adopt different models and, therefore, we have designed a future service model that will work with all of these concurrently.



There are also several themes running through the Forward View, all of which SCAS embraces, and we will incorporate into our developments in the coming year.

- **Health themes**
  We need to support work to address the challenges of rising obesity, smoking, alcohol, dementia, mental health, cancer and child health.
- **Prevention and support**
  We need to assist people in self-care and support carers.
- **Workforce**
  Our staff are health ambassadors, and we need to support their health and well-being.
- **Health technology**
  We need to collectively raise our game. In the next year, we will work to enable mobile clinicians to view both the Directory of Service and Summary Care Records.
- **Integration**
  We need to help break down the existing boundaries between health and social care, mental and physical health, generalist and specialist services, primary and secondary care, voluntary and statutory services.
- **Levers for change**
  The key levers for these changes are commissioning, Health and Well-being Boards, Better Care Funds and the development of personal budgets.
- **Research and innovation**

We need to support research and innovation, and our helicopter view strategy is key to this.

2.2 Translation of our strategy into goals

We have already achieved significant progress against our highly ambitious strategic plan. Here are notes on progress against some of the key goals in our transformation programme.

2.2.1 Coordination Centres

Enabling you to identify and access the care you need

Achieved so far

- Moved NHS111 and 999 onto a virtual telephony platform
- Implemented a common assessment tool (NHS Pathways) for 999 and NHS111
- Increased the proportion of calls resolved by telephone advice or referral
- Set up system for routinely collecting NHS numbers
- Enabled clinicians in NHS111 and 999 to view Summary Care Records

In progress

- Improving capacity planning and scheduling for NHS111 services
- Launching a coordination hub for community care (Cambridgeshire & Peterborough)
- Improving access to mental health advice and expertise through partnerships
- Upgrading our technical platform (including iCAD upgrade)
- Introducing health information advisors (pilot scheme)
- Piloting home-working as a way of securing access to a wider range of clinicians and flexible resource, using our virtual telephony platform

Plans for 2015-16

- To align the leadership of 999, NHS111 and other services in the coordination centres
- To address our current and future estates capacity requirements
- To redesign our NHS111 service to ensure full compliance with new specification, including consideration of infrastructure to increase connectivity across care systems
- To enable clinicians to view the care plan component of Summary Care Records
- To assess feasibility of other developments in strategy, including tele-monitoring, Skype, proactive calls, digital applications, access to social care services, etc.

2.2.2 Mobile healthcare

Saving lives – and enabling you to stay safely in your own community

Achieved so far

- Introduced electronic patient records (rolled out across 50% SCAS, remainder in 2015)
- Developed partnerships with GPs and community teams to facilitate timely assessment of people in their own homes
- Redesigned the service for urgent transport requests from health care professionals (implementation underway)
- Redesigned vehicle workshops and fleet processes

In progress

- Introducing Specialist Urgent Care Paramedics and Nurses
- Exploring use of senior clinicians in mobile teams to provide clinical advice to the coordination centres, using our virtual telephony platform
- Reviewing our fleet strategy
- Exploring partnership working with community providers

Plans for 2015-16

- To focus on improving the pathways, processes, practices and clinical leadership required to support more people in their own homes
- To enable mobile teams to view the Directory of Services and Summary Care Records
- To work with local systems to implement the service models in the NHS Forward View

- To assess the feasibility of mobile screening and diagnostics

2.2.3 Patient transport and logistics

Ensuring you can travel safely between home and care settings

Achieved so far

- Moved onto virtual telephony platform
- Implemented single technical platform across commercial services
- Mobilised new Hampshire PTS contract (phase 1)
- Developed new service offers (such as re-enablement after discharge)
- Increased role of volunteers in service offered by SCAS

In progress

- Mobilising new Milton Keynes PTS contract (with extended hours)
- Responding to areas of improvement identified by CQC
- Realising benefits of single technical platform (such as dynamic scheduling)

Plans for 2015-16

- To mobilise new Hampshire PTS contract (phase 2)
- To continue to bid for new business as opportunities arise

2.2.4 Helicopter view

Supporting efficient and effective flow around systems of care

Achieved so far

- Analysed internal and external data sources
- Designed global data model concept
- Installed and configured more resilient informatics infrastructure
- Assessed business reporting requirements
- Set up data links with electronic patient records
- Prioritised development of reports and analysis (ongoing process)

In progress

- Building data warehouse
- Creating datasets for services across SCAS
- Developing improved performance reports and analysis as per prioritisation

Plans for 2015-16

- To enhance analytical capability and capacity
- To improve data quality
- To improve and expand access of the reporting tool (QlikView)
- To introduce planning simulation tool

2.3 Managing successful delivery of change

SCAS has adopted a portfolio management approach to the design, prioritisation and delivery of the transformation programme required to deliver our strategy.

The Service Development Team operates as an internal consultancy, offering project, programme, improvement and redesign skills, and flexes in size, in order to deliver the change initiatives prioritised by the Executive Transformation Board to deliver our strategy.

Leaders of the various teams involved in change meet as a Project Advisory Board. This group reviews the business case, plans and resource requirements of each change. It also makes recommendations to the Transformation Board about inter-dependencies between change initiatives, project phasing and the prioritisation of specialist change resources.

Risks are managed and identified within each project. Major risks are escalated to the Transformation Board and, if appropriate, incorporated into the Corporate Risk Register.

We routinely review our change management against best practice models, to highlight areas for

improvement on this basis. Our focus for the next year will be to ensure more rigorous business cases and tighter management of benefits. We will also work to support the organisation to focus on continuous improvement and innovation, as well as bigger planned change programmes.

2.4 Summary of productivity, efficiency and cost improvement programmes

Transforming our cost base is a critical component of our five-year strategic plan, and the key initiatives to improve productivity, efficiency, cost and income in 2015-16 are outlined below.

2.4.1 Coordination Centres

- To realise the benefits of virtual working, so that capacity across both centres can be better matched with overall demand, especially during periods of peak demand
- To align the leadership and to create a cohort of staff working across both services, will enable SCAS to better accommodate peaks in demand
- To address the shortage of trainer and training room capacity, in order to support timely recruitment of staff as required

2.4.2 Mobile Healthcare

- To expand the recruitment and training facilities, so that more paramedics can be employed and reduce reliance on private providers (reducing cost and increasing resilience)
- To continue to expand the volunteer and co-responder schemes, in order to improve our responsiveness in an efficient and effective manner
- To enable mobile clinicians to view the Directory of Services whilst on scene, in order to support more appropriate see and treat (rather than defaulting to emergency conveyance)
- To reduce the cost of the urgent service in response to healthcare professional transport requests through lower staff skill set and lower vehicle specification.
- To improve sickness absence reporting and management, in order to reduce the reliance on private providers
- To improve management, and increase use, of bank staff
- To bring third-party fleet maintenance in house
- To improve consumables management through introduction of comprehensive stores management systems and procedures

2.4.3 Patient Transport

To realise the benefits of the new functionality and capabilities introduced in 2014-15:

- To leverage significant fuel savings from our new fleet (70/100 have already been delivered)
- To reduce fleet costs (in particular maintenance and excess lease payments associated with former ageing fleet)
- To equip the entire PTS fleet with the GPS tracking, and activate the Dynamic Dispatch functionality of the revised CAD system, in order to deliver operational efficiencies through the new real-time tracking and dispatch capability.
- To reduce private resources required to deliver the service, as a result of more efficient scheduling, driven by the new dynamic dispatch capability.
- To recruit an extended team of volunteers, who will provide portering services at hospital locations to allow SCAS staff to arrive and depart locations more expeditiously.
- To renegotiate private provider subcontract arrangements on more favourable terms, with a secure forward view of new contracts in Hampshire and Milton Keynes
- To use the extended hours in new contracts to improve the utilisation of vehicles

2.4.5 Workforce and scheduling

- To reduce attrition of front line and clinical co-ordination centre staff through staff development and the introduction of career pathways, thereby reducing recruitment costs and retaining experienced staff
- To revise rosters so that staffing levels are flexed in line with demand fluctuations
- To create a central capacity planning and staff scheduling function, in order to make further improvements to align resources with fluctuating demand
- To continue to introduce on-line processes (such as timesheets) so that manual processes can be eliminated and tighten management of overtime claims
- To introduce return to practice programmes, military conversion courses and overseas recruitment to reduce dependency on private provider staff.

3 Quality priorities

3.1 National and local commissioning priorities

The priorities for our various Clinical Commissioning Groups are broadly similar:

- To manage the underlying growth and recent spikes in demand for unscheduled care
- To integrate services and pathways across health and social care boundaries
- To reduce hospital admissions and length of stay, for both patients and financial reasons
- To provide more 24/7 services, with a focus on improving the 'out of hours' provision.

3.2 Quality goals

The proposed priorities for quality improvements in 2015-16 are outlined in the sections below.

These priorities will be confirmed and detailed in the Quality Accounts. They cover all of our services and reflect the national contract requirements: to create quality initiatives that are consistent, where measurement of outcomes can be detailed and changes implemented to ensure improved experience, safety and outcomes for patients.

Our quality priorities have been developed from the clinical risk themes emerging through the year. They have also been informed by the corporate risk register, integrated performance report, committees' upward reports, investigations and education programmes. A wide range of stakeholders have been engaged in reviewing these themes and identifying our quality priorities.

3.2.1 Patient safety

- To implement the pathway for sepsis care, and then to review its effectiveness and outcomes
- To ensure staff receive appropriate training in making safeguarding referrals across all services, in order to ensure the protection of vulnerable adults and children
- To ensure that staff receive appropriate training to gain the understanding and confidence to use the Mental Capacity Act.
- To scrutinise incidents involving medicine administration errors, in order to identify key themes and cascade aggregated learning outcomes on a Trust wide basis

3.2.2 Clinical effectiveness

- To report on the percentage of patients with stroke and heart attacks who receive an appropriate care bundle (this is a mandated indicator)
- To improve on the proportion of patients receiving an emergency ambulance response within 8 minutes and 19 minutes (again, this is a mandated indicator)
- To review the reasons for delays in patient transport which lead to service users missing appointments, and then to implement changes required to prevent future occurrences

3.2.3 Patient experience

- To analyse themes from incidents, claims, feedback, SIRI's, compliments and concerns, and to ensure aggregated learning is routinely and effectively cascaded throughout the organisation
- To increase awareness of dementia within the trust and to improve both the standards of care and the experience of patients and carers, by training for both road- and telephone-based staff
- To improve the process for handling healthcare profession feedback in the NHS111 service, in order to ensure learning and service improvements are identified and actioned.

3.2 Outline of existing quality concerns

The Care Quality Commission undertook a pilot inspection of SCAS in Autumn 2014 and reported its findings in January 2015.

As it was a pilot SCAS was not given a rating as part of this inspection but the report identified areas of outstanding and good practice. A number of improvements were detailed and an action plan has been agreed to address all areas of improvement that were identified. The key points that SCAS must address are:

- Statutory and mandatory training
- Staff understanding of the Mental Capacity Act 2005 in EOC[2] and PTS
- Safeguarding training and reporting arrangements
- Call answer and dispatch response times for emergency calls

A governance review of PTS was undertaken, aligned to the new service delivery model and a governance lead appointed. A transformation project is now underway to address training and quality schedule requirements.

3.3 Key quality risks

The key uncertainties are:	*Mitigations*
If SCAS cannot recruit, develop and retain enough clinicians, for either the Clinical Coordination Centres or the Mobile Teams, there is a risk that we cannot provide resilient and sustainable services or take forward our quality priorities.	Work is underway to design a new service model, create the associated workforce strategy, expand our recruitment and training functions, and to improve career progression opportunities. We already use community first responders for appropriate incidents, and we are exploring other ways for volunteers, military personnel and other emergency services to support our clinicians.
If there is not a sufficient range of 24/7 and accessible care pathways to meet patients' needs, this risks having a detrimental impact on SCAS's scope to direct patients to the most appropriate care, with the associated risk of increased conveyance rates to emergency departments.	SCAS is working closely with commissioners and partner agencies to ensure that there is a comprehensive and accessible range of pathways available in each local systems of care, helping to highlight any service gaps and identify solutions. SCAS is also working with commissioners to ensure that the local Directory of Services provides accurate and up-to-date information about the services that are already available.
If any reconfiguration of acute services results in long journeys to emergency departments or specialist units, this risks having a detrimental impact on clinical outcomes for patients with life-threatening conditions and associated reduction in SCAS outcome performance.	SCAS is working closely with commissioners and acute providers in any service redesign activities.
If GPs and other health providers develop multiple different systems to communicate electronically and share patient records, SCAS may struggle to implement an efficient and effective system.	SCAS is implementing electronic patient records, and engaging with local systems to gain access to summary care records. We are also working with partner agencies to understand any specific local issues.

[2] Emergency Operations Centres for 999 calls (EOC)

4 Operational plans

4.1 Workforce

We have staff who can assess patient needs, work autonomously and are willing to work across a 24/7 period. Such individuals are in scarce supply nationally and much sought-after locally, as they are extremely valuable to a wide range of providers.

Our workforce plans must ensure that individuals who have (or have the potential to develop) these skills apply to work for SCAS, and then choose to stay with us. We aim to be the employer of choice, enabling staff to develop professionally and maintain their health and well-being.

Our plans include the following new roles and development opportunities:

Enabling you to identify and access the care you need

- To introduce telephone access to Mental Health Practitioners, through partnership schemes
- To introduce Health Information Advisors
- To explore similar partnerships for specialist advice in mental health, paediatrics or social care
- To incorporate coordination roles for community services into our NHS111 teams

Saving lives

- To develop Specialist Critical Care Paramedic / Nurse roles, to assess and care for people who have suffered major trauma in the pre-hospital setting (this is an adaptation of ECP role)
- To expand our recruitment and training capacity, particularly to expand our Paramedic numbers and secure the workforce required to meet emergency demand.

Enabling you to stay safely in your own community

- To create Specialist Urgent Care Paramedics / Nurses will assess and treat people in their own homes or care homes
- To work in partnership with other local providers to create attractive rotational posts
- To develop partnerships with local GPs to ensure timely visits for people in their own homes

Ensuring you can travel safely between home and care settings

- To continue to implement a new service model for urgent transport requests from healthcare professionals, including the creation of dedicated dispatch and transport roles

Supporting effective patient flow around systems of care

- To engage voluntary and third sector partners to enhance our service offer, including portering for patients transported to hospital and support for vulnerable people after discharge

Offering a helicopter view

- To enhance our analytical capability and capacity, including the recruitment of extra analysts

4.2 Estates

We have commissioned a review of our Coordination Centres and Headquarters estates requirements. We will review options and agree any changes in 2015-16.

We need to expand our training capacity, both for our Mobile Healthcare Teams and Clinical Coordination Centres. This will also be taken forward in 2015-16.

4.3 Information Technology

We will continue to roll out electronic patient records and upgrade our vital signs monitoring equipment across the Trust.

We will discuss options with the national radio programme team and agree a way forward for SCAS

in relation to the requirements for a digital integrated control communications system.

We will upgrade our emergency computer aided dispatch system to iCAD version 9.3.

We will explore the potential for alternative systems (such as Adastra) to improve our connectivity with partner systems in order to facilitate more efficient booking and referral of patients.

We will also explore the requirements and potential of the Intelligent Patient Data system linked to NHS111 services.

In addition, we will explore options to analyse gaps in the Directory of Services identified when the optimal pathway is not available following clinical assessment, either on the telephone or at scene.

4.4 **Key risks**

The key uncertainties are:	*Mitigations*
If demand for unscheduled care grows above commissioner plans, there is a risk that there is insufficient capacity across systems of care. This could have a detrimental impact on SCAS operational performance if the public use 999 and 111 as an alternative option, especially if SCAS does not have sufficient resources in place or there is insufficient capacity in other services to respond to the excess demand.	A key aspect of SCAS's strategy is an increase in analytical capability and capacity, so that we can make use of the wealth of data that we have available regarding demand trends and service gaps. The intention is to use this analysis to gain a better understanding of our own performance and also to offer a 'helicopter view' of the local systems of care. SCAS will assess and signpost patients to the right care, first time to meet individual needs. This will help to prevent any increase in demand from having an onward impact on Emergency Departments unless appropriate. We will continue to engage with the public and undertake 'misuse campaigns' in attempt to encourage people not to use emergency services inappropriately, and therefore minimise the risk of any increase in inappropriate demand.
If competitive tendering results in the loss of services in some areas, SCAS would have reduced scope to make optimal use of the resources in that area or to take advantage of economies of scale. This is most likely to have a detrimental impact in rural drive zones, where there is already a single resource and utilisation rates are already low.	SCAS is actively working to build its bidding capability and capacity to increase the chance of winning and renewing contracts. The strategic plan is also to broaden the range of services offered, so that the risks associated with the loss of any single contract are minimised.
If SCAS cannot recruit, develop and retain enough clinicians, for either the Clinical Coordination Centres of the mobile healthcare teams, there is a risk that we cannot fulfil our operational commitments.	Work is underway to design a new service model, create the associated workforce strategy, expand our recruitment and training functions, and to improve career progression opportunities.
There is competition to recruit and retain skilled clinical staff, both in our Clinical Coordination Centres and for our mobile workforce. Without sufficient clinicians, SCAS is at risk of having to convey more patients to emergency departments instead of assessing clinical needs and directing	SCAS has a workforce strategy and development plan to ensure that we have the clinical workforce required.

them to the 'right care, first time'.

5 Financial context for 2015-16

Despite several years of austerity and large cost reduction programmes, the financial outlook is one of more of the same and no relaxation of the squeeze in government spending. There will therefore be a continuing tough stance on public sector pay, but with expectations of increases in private sector pay above the level of inflation, but with increasing pay expectations for ambulance staff.

The NHS environment is impacted by the election, with slight overall increases in Clinical Commissioning Group (CCG) budgets after the impact of the Better Care and Transformation Fund.

SCAS also faces the following specific issues:

- Significant cost pressures from a tightening in the ambulance resource market, with other organisations attracting paramedics to them for more pay and better working hours.
- Tenders for Oxfordshire and Bucks PTS, Berkshire PTS, with the risk of losing these to private competition, and potential exit costs from these businesses.
- Financial difficulties within local CCGs and Acute Trusts.
- Loss of non-recurring benefit relating to the NHS Direct successor body and property disposals.

The more straightforward cost improvements have now been completed within SCAS. Therefore, further improvements are increasingly challenging, and require both transformational change and continued good execution of projects.

Last year, the Board set out its strategy, and is continuing to develop the following five areas:

- Developing our telephone assessment and signposting role
- Enabling you to stay safe in your community
- Offering a helicopter view of local health systems
- Expanding our geographical footprint
- Transforming our cost base

As well as continuing to work towards the 2014-19 Strategic Plan, we must also:

- Focus on delivery of our revised cost saving plans, and transforming our cost base.
- A key area over recent years has been our ability to bid for additional non-recurrent funding relating to projects and winter. The focus on this will continue particularly in support of the transformation projects, aiming to access funds for workforce and IT transformation.
- Being perceived as an organisation willing to find and support solutions to problems for the NHS as a whole, and improving our margin as a result.

6 Board declarations for sustainability and resilience

6.1 Sustainability

Clinical

The organisation is clinically sustainable. Nevertheless, it has identified areas for improvement and development within its strategy. Actions to mitigate these risks were outlined in section 3.

Operational

The organisation is operationally sustainable. However, it has identified scope to offer more streamlined services to patients, help to address issues facing the wider care systems, and to be more efficient in terms of operational delivery. The strategy has been developed accordingly.

Financial

The Trust is financially sustainable. Whilst the financial pressures increase, and the surplus has reduced, it has a large cash balance which will provide a cushion in the event of adverse financial movements.

6.2 Resilience

Clinical

The organisation is clinically resilient. However, it has identified scope to improve our clinical resilience through a more resilient and sustainable workforce. Please see section 4.1.

Operational

SCAS has a track record of providing resilient operational services and has performed well against emergency response standards in the last year. Demand exceeded our predictions (and those of other organisations) during quarter 3, when we missed both emergency (red) response time standards.

Next year, we will reinforce our resilience in operational services. We are refreshing our tools to forecast and position emergency resources, with the goal of ensuring resilient and sustainable response times throughout the year. As well as addressing gaps in our own performance, this approach involves working with stakeholders to resolve challenges within the wider system.

Financial

The Trust has financial resilience, particularly as a result of its sound cash position and track record of delivery of cost savings.

South Central Ambulance Service NHS FT

Quality Report

Unit 7-8 Talisman Business Centre
Talisman Road
Bicester
Oxon
OX26 6HR
Tel: 01869 365000
Website: www.southcentralambulance.nhs.uk/

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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Letter from the Chief Inspector of Hospitals

South Central Ambulance Service NHS Foundation Trust (SCAS) was formed on 1 July 2006, after the merger of the Royal Berkshire Ambulance Service NHS Trust, the Hampshire Ambulance Service NHS Trust, the Oxfordshire Ambulance Service NHS Trust and part of the Two Shires Ambulance Service NHS Trust. It provides NHS ambulance services in Berkshire, Buckinghamshire, Hampshire and Oxfordshire in the South Central region. This area covers approximately 3,554 square miles with a residential population of over 4 million. On 1 March 2012, the trust achieved foundation trust status.

The trust provides an accident and emergency (A&E) service to respond to 999 calls, a 111 service for when medical help is needed fast but it is not a 999 emergency, patient transport services (PTS) and logistics and commercial services. There is also a Hazardous Area Response Team (HART) based in Hampshire. Services are delivered from the trust's main headquarters in Bicester, Oxfordshire, and a regional office in Otterbourne, Hampshire. Each of these sites includes an emergency operations centre (EOC) where 999 and NHS 111 calls are received, clinical advice is provided and from where emergency vehicles are dispatched if needed. There was a PTS contact centre at each EOC.

Our inspection took place on 10 and 11 September 2014 with unannounced visits on 30 September and 1 October. We inspected the trust as part of our first wave of comprehensive ambulance inspections. We looked at three core services: access via emergency operations centres, patient transport services and emergency and urgent care. The 111 service provided by the trust was not inspected on this occasion. The logistical and commercial training services were also not inspected as these do not form part of the trust's registration with the Care Quality Commission (CQC).

The team of 48 included CQC inspectors and inspection managers, an analyst and inspection planners and a variety of specialists: The team of specialist was comprised of a consultant physician in intensive care, two nurses working in accident and emergency departments,

Summary of findings

four paramedic staff, one emergency care practitioner, a paramedic clinical supervisor and development manager, three managers with an operations role, a head of governance, a director of service delivery, two chief executives, a pharmacist, a safe guarding lead, two people with a role in an operations centres and three experts by experience.

We did not provide ratings for this trust because this inspection was part of our first wave of ambulance inspections to apply our methodology and develop our understanding of inspecting in this sector.

Key findings

Is the trust well led?

- The trust had a vision and clinical strategy to provide excellent, sustainable services, and to coordinate mobile responsive healthcare services so that people received the right care at the right time in the right place (including care that could be closer to home).
- Governance arrangements were clear and there was an integrated performance report to benchmark quality, operational and financial information. The trust had also identified its quality priorities and could demonstrate progress against these. However, much of the data on risk and quality was at a high level and some risk issues, such as safeguarding and significant delays in patient transport services (PTS), needed a better focus.
- Many areas had team meetings and monthly operational performance meetings to review quality and operational issues. These reported to the trust's Level 2 meetings (operational leadership level) and then senior management meetings. This structure needed to be replicated in all areas to consistently identify the action taken in response to risks and performance issues.
- The leadership team showed commitment, enthusiasm and passion to develop and continuously improve services. Most staff reported that the trust culture reflected an effective and responsive service rather than a target-driven organisation. Leadership at team level varied in terms of effectiveness and the trust needed to improve in this area to develop its strategic priorities.
- Public engagement took place through a variety of means, such as liaison work, use of social media and through its membership. Patient feedback through surveys, interviews and liaison work, was being used to improve the service.
- Staff were positive about working for the trust. They said it was a friendly and positive place to work but not without its challenges; namely, managing tight resources against an increasing demand for services. The NHS staff survey 2013 demonstrated that the trust was better than average for staff engagement when compared to other ambulance trust. Staff engagement was well developed, although staff indicated the need for more ongoing dialogue around service changes.
- The trust had a highly innovative culture and staff were encouraged to suggest new ideas to improve service delivery. This was seen as important against a background of tightening resources, but also essential to develop services in response to the needs of patients. There were many examples of service improvements developed by the trust and its staff.
- The trust demonstrated proactive and effective financial management to invest in new technology and service developments, and to ensure that services were sustainable. Cost improvement programmes were demonstrating savings and were monitored. Mitigating actions were identified to reduce the potential impact although the action taken in some of these areas needed to improve.

Key findings across the core services:

- Staff were caring and compassionate, and treated patients with dignity and respect.
- Staff were positive about the quality of care they provided for patients and were proud to work for the trust. There was low morale in places and the pressures faced by the trust were recognised. Staff however "lived" the values of the organisation: "Towards excellence – Saving lives and enabling you to get the care you need".
- Patients told us their experiences of care and treatment was good. They were positive about emergency ambulance response times but there were concerns about the punctuality of patient transport services.
- Incident reporting was increasing on the newly introduced reporting system. The trust was taking action following incidents, but there needed to be

Summary of findings

earlier and quicker investigation for some incidents. Learning was shared via clinical bulletins, the trust intranet, noticeboards and email. The trust had introduced SCAScade to improve organisational learning from when things go wrong. This included anonymous cases and reflective tools for staff to use on the trust intranet. However, staff in the EOC and PTS needed to be encouraged to use and take responsibility for reporting incidents and also required feedback and shared learning in their areas.

- Staff in the emergency and urgent care service had good knowledge of the Mental Capacity Act 2005, but staff in EOC and PTS needed to have better knowledge to ensure the best interest of patients.
- Safeguarded procedures were being used but needed to improve and the safeguarding lead had a limited capacity to deliver the safeguarding agenda across the organisation. Safeguarding champions in geographical areas were to be developed but this needed to be prioritised.
- Staff had good training opportunities and specialist training on dementia care, learning disabilities and mental health was being improved. Staff were supported with funding for further qualifications and professional development, However, some staff did not always have access to computer facilities to undertake training or the dedicated time to complete it, and attendance at mandatory and statutory training was low.
- Most complaints were responded to within the trust's target time of 25 days and action was being taken to improve services as a result. Complaints were analysed to identify themes and the trust aimed to share learning, for example, through teams and noticeboards. There was evidence of actions taken as a result of complaints in all services. However, staff told us they did not always get feedback on complaints or concerns raised.
- The trust understood its duties under the Civil Contingencies Act 2004 and all staff were aware of what to do in the event of a major incident. Staff had appropriate training, there was joint working with partner organisations (such as the fire service, police and military), and rehearsals were undertaken as part of preparation and planning exercises.
- The trust had worked with partner organisations including fire and rescue, police, and the environmental agency during the floods in the Thames Valley area in early 2013. The Hazardous Area Response Team (HART) had worked throughout the region and specifically in Wraysbury, Berkshire, 24 hours a day over 4 days, to assist with the rescue and support operation.

Emergency Operation centres (EOC)

- Emergency 999 calls were triaged through NHS Pathways (which is a software system of clinical assessment for triaging telephone calls from the public based on the symptoms they report when they call). There was good compliance to prioritise and categorise calls for ambulance dispatch according to the clinical needs of patients. However, staff knowledge of appropriate dispatch times for mental health patients in crises under a Mental Health Act Section 136 and needing a place of safety, needed to improve.
- There were dedicated triage lines for GPs and healthcare professionals, and for patients who were critically unwell and needed the air ambulance (the Helicopter Emergency Medical Services, [HEMS]) or other specialist services, such as the Hazardous Area Response Team (HART).
- Safety procedures were followed but some needed to improve, such as incident reporting and raising safeguarding concerns, and some staff needed a better understanding of the Mental Capacity Act 2005.
- Staffing levels were a concern and staff worked long hours, sometimes without breaks. Action was being taken to manage peaks in demand but staff were not meeting target times to answer emergency calls.
- Overall, the trust had referral rates of 8% from NHS 111 to 999 services, and these were better than the service level agreement performance of 10% and one of the lowest in the country. Staff identified the need for further action on managing the demand created by the NHS 111 service, and the trust's long-term planning against the rising increase in demand for services was ongoing.
- The staff were supportive to patients who called in distress. They listened carefully, explained their actions and involved patients in their decisions.
- Clinical advisors were available to help staff and to support patients to manage their own health when appropriate. The clinical adviser also undertook welfare checks over the phone to ensure a patient's condition was not deteriorating while they were

Summary of findings

waiting for an ambulance. The trust was below the national average for 'hear and treat', which is the proportion of calls that are dealt with based on provision of telephone advice only. The re-contact rate within 24 hours of 'hear and treat' was higher than the national average in 2013-14 but had decreased this year and was below the national average in (April to July 2014).

- Engagement between the trust and the public and patients was being developed further.
- The trust had a clear strategy for the EOC to provide clinical coordination of care across a range of health and social care settings. However, most staff were not aware of this strategy in relation to their service. Governance arrangements needed to improve to support staff to share learning, raise concerns, manage risk and act on performance information. Staff worked well in their teams but some wanted better support from managers, particularly in the northern EOC.

Emergency and Urgent Care

- Front-line 999 services provided an emergency response to people with life threatening emergency or urgent conditions. Overall, during 2013/14, the trust was meeting national emergency response targets for 75% of calls to be responded to within 8 minutes. The national categories are for Red 1 calls (for patients who have suffered cardiac arrest or stopped breathing) and for Red 2 calls (for all other life threatening emergencies). Red 1 and Red 2 calls added together and are referred to as Category A calls. The category A target is to have a vehicle that could convey a patients to hospital arrive at the scene within 19 minutes for 95% of cases. This target was also met.
- The trust had the highest percentage of 'see and treat' in the country (that is, managing patients at the scene without the need for ambulance transfer to hospital). The re-contact rate within 24 hours of this treatment was higher than the national average in 2013-14 but was decreasing.
- The trust used a Resource Escalation Action Plan (REAP) as a way of forecasting performance and service delivery. There was moderate to high pressure on the service during our inspection and the trust was communicating effectively with hospitals to align conveyancing decisions against waiting times and the capacity to receive patients. This included having hospital ambulance liaison officers (HALOs) to support the timely handover and safety of patients in A&E departments, and to monitor and respond to situations particularly at times of increased demand for services. There was effective planning and preparation for major incidents and the trust had worked effectively with partner organisations.
- The trust was monitoring long waiting times and had introduced measures to ensure that people were monitored while waiting and that high-priority calls took precedence. There was an impact however on people who may be in a healthcare setting but awaiting transfer to another hospital for acute care and for people at a distance from an ambulance station. The trust was taking action to reduce these waiting times and projects were planned in different areas.
- The service followed safety procedures overall, but needed to improve infection control practice and the management of medicines. Staff had a good understanding of the Mental Capacity Act 2005 and of safeguarding procedures although the timeliness of reporting concerns and referrals needed to improve. The performance of the external contractor to 'make ready' ambulances (that is, to prepare ambulances, for example, in terms of cleanliness and appropriate equipment) was monitored but the quality of their work required better supervision and monitoring. Ambulance crews had allocated time to check vehicles but told us they spent more time rechecking vehicles to ensure they were ready for use.
- The trust was affected by the national shortage of paramedics and there were a high number of vacancies. The allocation and skill mix of staff were appropriate but staff worked long hours and some reported stress and fatigue. There was a rising demand for services that was above predicted levels. The trust had introduced shift changes to help manage resources to meet demand in emergency services and new rotas were being introduced to further improve the work life balance of staff. The trust used private providers to ensure service cover and these providers were appropriately monitored.
- National evidence-based guidelines were used to assess and treat patients. Patients experiencing a heart attack did receive pain relief although this was not always the pain relief that was nationally recommended. Patients experiencing a heart attack were transported quickly to hospital. Patients that had

Summary of findings

had a stroke had appropriate care but there could be delays in their transport to hospital. Some hospital staff identified the need for better pain relief for children in certain circumstances.

- The coordination of emergency care with hospitals and GPs was good overall, but needed to improve for heart and stroke care in Buckinghamshire and for mental health patients in crisis across the four counties. The trust was working with its partners and had action plans to improve care in these areas.
- The trust was ranked the best in the country for patients who had had a cardiac arrest and stopped breathing, who then after resuscitation, had a pulse/ heartbeat on arrival to hospital. This is called return of spontaneous circulation (ROSC). The trust had improved its effectiveness of action taken when staff witnessed a cardiac arrest and was fourth best in the country this year (April to August 2014) a change from eighth best in 2013-14.
- The trust was ranked the best in the country for patients who had had a cardiac arrest and survived to be discharged from hospital.
- Staff explained treatment options to patients in a way that they, or their relatives, could understand. Patients, and relatives or carers, received good emotional support if they were in distress. There was support for vulnerable patients, such as those with a learning disability, bariatric patients and people whose first language was not English.
- Engagement between the trust and the public and patients was well developed through a variety of channels, such as social media, surveys, newsletters and liaison work.
- The trust had a clear vision and strategy for the service to provide mobile healthcare and to coordinate care in hospital, the community and people's homes. Staff were supportive of the strategy and worked well together in teams and with their managers. There were good governance arrangements to monitor performance and quality and to manage risks although more action was needed on ongoing risks.

Patient Transport Services

- Patient transport services (PTS) provided non-emergency transport for patients who attend, for example, outpatient clinics or day hospitals, or were discharged from hospital. Commissioners had identified eligibility criteria for the service and the trust was working with 12 clinical commissioning groups to monitor performance and compliance.
- Staff followed the eligibility criteria designed by commissioners and were also working to improve the signposting of people to other services if they did not meet the criteria.
- Procedures to ensure the safety of services needed to improve, specifically around incident reporting, equipment checks and safeguarding procedures. Most vehicles were visibly clean. 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) orders were understood and used appropriately, but staff had limited awareness of the Mental Capacity Act 2005.
- There were staffing vacancies and staff felt stretched, particularly in the dispatch team where this had an impact on the planning and scheduling of transport. The trust was using volunteers and private providers to cover driving shifts. There needed to be better governance arrangements for private providers and for driving and employment checks for volunteers.
- The trust had made significant changes to the IT system in the PTS on the day of our inspection. Anticipated resource and capacity risks needed to be better managed, for example, problems with the new IT system had caused a serious disruption to transport arrangements for many patients during our inspection
- Dispatch staff did not always have appropriate assessment information, from hospitals or patients or from their own records. Patients sometimes did not have an appropriate vehicle or equipment, and transport sometimes had to be reorganised. The system to plan journeys was manual and often reactive based on a lack of timely and coordinated information and this had caused delays to patient transport.
- The trust was not meeting performance targets and this was having an impact on patients' care and treatment. Patients were experiencing delayed and missed appointments for outpatient consultations and diagnostic scans, and renal dialysis, and some were choosing to curtail their treatment in order not to risk missing their transport home for fears of excessive delay. Some hospitals had reorganised clinics, for example, to finish early to accommodate the vagaries of the PTS. There were good examples of multi-

Summary of findings

disciplinary working with GPs and health professionals in hospitals. The trust had been working with other providers to improve the coordination of care and some progress had been made.

- Patient surveys were regularly undertaken; these were positive about the service but identified delays. Patients we spoke with were positive about the care and compassion of staff. However, they were concerned that the service was not effective and that they were not given enough information about delays, missed appointments and the eligibility criteria.
- Many patients told us they had been distressed and anxious waiting for transport, but did not know whom to contact within the service. Call handlers were overwhelmed with calls about service delays and only half of all calls were answered.
- There was good support for vulnerable patients (for example, those with dementia or a learning disability), and carers and escorts could travel in the ambulances too. A policy for the transport of children needed to be developed.
- The trust had a clear strategy for the development of PTS to support safe non-emergency travel between people's homes and healthcare settings, but most staff were unaware of this strategy. Governance arrangements needed to improve in order to assess and manage risks. Although staff worked effectively in teams, many wanted the management and leadership of the service to improve and for the trust to prioritise PTS alongside the emergency 999 service.

We saw several areas of outstanding practice:

- We observed many examples where staff demonstrated outstanding care and compassion to patients despite sometimes working in very difficult and pressured environments. Staff "lived" the values of the trust "Towards excellence – Saving lives and enabling you to get the care you need".
- Representatives of the trust attended local youth organisation meetings, village fetes and school assemblies. The trust had developed a child-friendly first-aid book printed specially for schools and the wider local community.
- The trust provided an innovative learning resource to their frontline staff using the educational resource centre and film centre at Bracknell. The staff were involved in making films which supported learning around new guidelines from the Joint Royal Colleges Ambulance Liaison Committee (JRCALC).
- The trust had introduced a lifesaving automatic external defibrillator (AED) locator mobile phone application. By using GPS, this app locates the nearest AED in the event of a cardiac arrest. In total, the app identified over 800 AEDs across four counties.
- A new initiative was the introduction of a 'Simbulance': a large command vehicle fully equipped with simulation learning activities. It was an innovative virtual classroom facility in that it gave ambulance staff the opportunity to experience realistic medical situations inside an ambulance saloon.
- Operation centres had direct access to electronic information held by community services, including GPs. This meant that the staff could access up-to-date information about patients (for example, details of their current medication).
- Trauma risk management (TRiM) was in place to provide confidential support to staff who may have been affected by traumatic incidents or conditions. Staff were assessed 3 days after a traumatic event and again after 28 days. Thirty-two TRiM practitioners gave peer support and advice, and there was also an external counselling service. The early intervention had both reduced sickness absence and improved the welfare of staff.
- The Helicopter Emergency Medical Services (HEMS) showed innovative practices and learning taken from combat zones. The team now had the equipment and skills to give blood transfusions and perform ultrasound and blood gas tests. In some circumstances, this bypassed or reduced the time a patient had to spend in the accident and emergency (A&E) department, and meant they could receive treatment immediately on arrival at the hospital. HEMS was also planning to introduce a night service, so it would operate 24 hours every day.
- The introduction of a midwife to the clinical support desk (CSD) in the Southern House emergency operation centre had improved the outcomes for expectant mothers and their new babies. The 24-hour labour line started as a pilot in May 2014. It gave women in labour access to advice and support,

Summary of findings

whereas the 'professional's line' enabled medical professionals to speak to a midwife 24/7 during a woman's labour and birth. The service had over 1,600 calls in the first eight weeks.

- The trust provided a service on Friday and Saturday nights in the city centres of Portsmouth (Safe Place) and Southampton (ICE Bus) to provide support, first aid and transfer to hospital if required for the public enjoying a night out. This had been set up in partnership with other organisations such as the Hampshire Police, the local council, volunteers and the local street pastors
- The trust had a clinical lead in mental health and learning disability. This role was unique among ambulance trusts. The lead had established a national mental health group for ambulance trusts, and worked with partner agencies such as the Royal College of Psychiatrists and the College of Policing. The introduction of mental health practitioners into the EOC was supporting operational practice and care to mental health patients.
- The trust had worked in partnership with Oxford Brookes University to provide staff with extra opportunities to develop their careers by becoming a paramedic, and to counter the national shortage of paramedics. A foundation degree course was to start in January 2015. The training covered an 18-month period and included in-hours training. The trust's investment had been significant in terms of the time taken to negotiate the resources and facilities for the programme and the release of staff from work duties.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the trust must ensure that:

- Staff uptake of statutory and mandatory training meets trust targets
- Staff in EOC and PTS understand the Mental Capacity Act 2005
- All EOC and PTS staff receive safeguarding training to the required level so that they are able to recognise signs of abuse and ensure there are robust arrangement in place for staff to report concerns within the agreed timescale.
- Emergency call takers answer calls, and the emergency medical dispatchers dispatch an ambulance within target times

In addition the trust should ensure that:

- Procedures for incident reporting continue to improve and staff in EOC and PTS have appropriate training and are able to report incidents directly. There must be timely investigation of incidents, staff must receive feedback and learning must be shared.
- The risks around IT vulnerability in the EOC and PTS are appropriately managed.
- Infection control practices are followed and ambulance stations (resource centres) and vehicles are effectively cleaned and deep cleaned.
- There are suitable arrangements to ensure that equipment is regularly checked and fit for purpose.
- Staff are aware of the appropriate steps to take to reduce the risks to patients left unattended in PTS ambulances because of staff working alone.
- Appropriate equipment is available in all areas for the transport of children in PTS and this continues to be rolled out for emergency transport.
- Volunteer drivers in PTS have the appropriate safety and employment checks before working within the service.
- The trust to continue to work with partners and ensure the planning and scheduling of PTS improve to prevent delays and missed appointments, and to reduce the impact on the clinical care, treatment and welfare of patients.
- The governance and security arrangements for the management of controlled drugs need to be improved in Hampshire.
- Recruitment of staff in all areas continues and there are specific staff retention plans in response to identified reasons as to why staff leave.
- Staff in PTS receive appropriate training on dementia care, learning disabilities and all staff continue to received training in mental health conditions.
- Anticipated resource and capacity risks in PTS continue to be appropriately identified, assessed and managed.
- Pain relief continues to be appropriately administered for patients with ST segment elevation myocardial infarction (STEMI) and pain relief for children is effectively monitored.
- Continue to work with acute trusts to review protocols for the non- critical transfer of hospital patients.

Summary of findings

- There is better coordination of care between providers, in particular for cardiac and stroke services in Buckinghamshire and mental health services.
- Complaints are responded to within the trust's target of 25 days. All staff in EOC and PTS receive feedback from complaints and learning is shared.
- Operations staff in PTS are appropriately resourced to be able to answer telephone calls.
- Patients (or people acting on their behalf) using the PTS are made of aware of how to complain or send compliments about the service.
- Staff in PTS have regular supervision and the trust should raise awareness amongst staff about the professional and career development opportunities within the trust.
- The formal structure of team meetings is in place for all staff groups and staff are given the opportunity to attend, share information and raise issues or concerns.
- Staff have a better understanding of the trust's vision and strategy as it applies to their service in EOC and PTS and staff communication continues around service changes and development.
- Leadership in the northern EOC and PTS supports staff and action is taken to improve staff morale where this is low.
- Staff in PTS receive feedback from the completed patient satisfaction surveys.
- There are better governance arrangements within EOC and PTS to share information with staff, so that staff can raise concerns and risks are appropriately identified, assessed and managed.
- There are better governance arrangements for private providers in PTS and make ready services.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to South Central Ambulance Service NHS FT

South Central Ambulance Service NHS Foundation Trust (SCAS) was formed on 1 July 2006, after the merger of the Royal Berkshire Ambulance Service NHS Trust, the Hampshire Ambulance Service NHS Trust, the Oxfordshire Ambulance Service NHS Trust and part of the Two Shires Ambulance Service NHS Trust. It provides NHS ambulance services in Berkshire, Buckinghamshire, Hampshire and Oxfordshire in the South Central region. This area covers approximately 3,554 square miles with a residential population of over 4 million. On 1 March 2012, the trust achieved foundation trust status.

The trust provides an accident and emergency (A&E) service to respond to 999 calls, a 111 service for when medical help is needed fast but it is not a 999 emergency, patient transport services (PTS) and logistics and commercial services. There is also a Hazardous Area Response Team (HART) based in Hampshire. Services are delivered from the trust's main headquarters in Bicester, Oxfordshire, and a regional office in Otterbourne, Hampshire. Each of these sites includes an emergency operations centre (EOC) where 999 and NHS 111 calls are received, clinical advice is provided and from where emergency vehicles are dispatched if needed.

The trust currently owns or leases 27 ambulance stations (resource centres), two HQ/operation centres plus additional standby points, aerial sites and support buildings, as well as 312 front-line ambulances spread across Berkshire (Berkshire consists of the following unitary authorities: West Berkshire, Reading, Wokingham, Bracknell Forest, Windsor and Maidenhead, and Slough), Buckinghamshire, Hampshire and Oxfordshire. South Central Ambulance Service NHS Foundation Trust operates a fleet of front-line emergency ambulances, a fleet of rapid response vehicles and supports the operation of two air ambulance helicopters.

The inspection included the emergency service and PTS. The 111 service provided by the trust was not inspected on this occasion. The logistical and commercial training services were also not inspected as these do not form part of the trust's registration with the Care Quality Commission (CQC).

Our inspection team

Our inspection team was led by:

Chair: Leslie Hamilton, Consultant Cardiac Surgeon, The Newcastle upon Tyne Hospitals NHS Foundation Trust

Head of Hospital Inspections: Joyce Frederick, Care Quality Commission

The team of 48 included CQC inspectors and inspection managers, an analyst and inspection planners and a variety of specialists: The team of specialist was comprised of a consultant physician in intensive care, two nurses working in accident and emergency departments, four paramedic staff, one emergency care practitioner, a paramedic clinical supervisor and development manager, three managers with an operations role, a head of governance, a director of service delivery, two chief executives, a pharmacist, a safe guarding lead, two people with a role in an operations centre and three experts by experience

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?

Summary of findings

- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

The inspection took place on 10 and 11 September 2014 with unannounced visits on 30 September and 1 October.

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the South Central Ambulance Service. These included local clinical commissioning groups (CCGs); local quality surveillance groups; the health regulator, Monitor; NHS England; Health Education England (HEE); College of Emergency Medicine; General Dental Council; General Medical Council; Health & Safety Executive; Health and Care Professions Council; Nursing and Midwifery Council; National Peer Review Programme; NHS Litigation Authority; Parliamentary and Health Service Ombudsman; Public Health England; the medical royal colleges; local authorities, local NHS Complaints Advocacy Service; local Healthwatch groups; and local health overview and scrutiny committees. We also reviewed information collected by Speak Out who hosted a listening event.

During our inspection, we spoke with a range of staff in the organisation including call handlers, dispatchers, paramedics, ambulance technicians, emergency care assistants, emergency care practitioners, community first responders, patient transport services (PTS) staff, the lead pharmacist, the safeguarding lead, the infection prevention and control lead, the mental health lead, operational managers, emergency operation centre managers, resilience staff and staff at director level.

We visited 10 ambulance stations, the northern and southern EOC (where we listened in to calls and observed dispatchers for the emergency service and PTS. We also visited 10 acute hospitals and one community hospital: John Radcliffe, Oxford; Churchill, Oxford; Wexham Park, Slough; Bicester Community, Bicester; Stoke Mandeville, Aylesbury; Wycombe; Royal Berkshire, Reading; Milton Keynes; Southampton General; Basingstoke and North Hampshire, Basingstoke; Queen Alexander, Portsmouth. At these hospitals, we observed the interaction between ambulance staff and hospital staff in the accident and emergency (A&E) areas, direct admission wards, outpatient areas and discharge lounges. We noted how people were being cared for and spoke with patients using the emergency ambulance service and PTS. We spoke with staff from the hospitals we visited about the ambulance service. We rode and observed on three emergency ambulances and two patient transport vehicles.

We would like to thank all staff, patients and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment provided by the South Central Ambulance Service.

Facts and data about this trust

South Central Ambulance Service NHS Foundation Trust: Key facts and data

1. Context

- Service covers - Berkshire, Buckinghamshire, Hampshire, Oxfordshire and Milton Keynes and the resident population approximately £4million (Significant rural areas).
- Health Summary: Health of population generally better than England average; Deprivation is lower than average; life expectancy is higher than the England average.
- The services has 40 sites; 27 ambulance stations; 489 vehicles of which 312 are frontline ambulances; and supports the operation of two Air Ambulance helicopters.
- The services covers 10 acute hospital sites, 2 Major Trauma Centres, 7 specialist site, 5 mental health trusts.
- Staff: 3,000.
- Community First Responders: 946
- Co-responders: 359
- The total income for the service was £162,4million in 2013/14 (£118m spent on emergency services)
- Cost improvement challenge £6.2m (2013/14): Trust achieved this target.

Summary of findings

2. Activity

- Calls to 999: 416,000 (2013/14)
- Calls to 111: 873,000 (2013/14)
- Patient Transport service Journeys: 678,000 (2013/14)

3. Safe

- **National Reporting and Learning System (NRLS reporting):** Between April 2013 and March 2014, 15 serious incidents were reported by the trust. No Never Events. Summer 2013 had significantly more incidents reported to NRLS than any other four month period.
- **Staff survey**: Worse than average for three questions relating to % of staff witnessing potentially harmful errors, reporting of errors and near misses and availability of hand washing materials.
- **Staff survey**: Better than average for % of staff felt satisfied with the quality of work and patient care they are able to deliver
- **Central Alert System:** Worse than expected for acknowledging with 2 days; similar to expected for completion according to deadline.

4. Effective

DH ambulance quality indicators

- **Better than expected:** proportion of suspected Stroke patients who receive an appropriate care bundle.
- **Similar to expected:**
  - STEMI patients being transferred to centre capable of delivering PPCI and receive angioplasty within 150 minutes of the call.
  - Ambulance calls closed with advice (where clinical appropriate)
  - Ambulance calls managed without transport to A&E (where clinically appropriate)
- **Tending towards worse than expected:**
  - Re-contact rate <24 hours following discharge of care by telephone
  - Re-contact rate <24 hours following discharge of care at the scene
- **Much worse than expected:**
- Proportion of STEMI patients receiving appropriate care bundles.

Ambulance clinical performance indicators (comparison between trusts) 2013/14*

- ROSC at time of arrival at hospital (Overall) (%) : **Rank 1 (best of all 11 ambulance trusts)**
- ROSC at time of arrival at hospital (Utstein Comparator Group *) (%) **Rank 8**
- Cardiac - survival to discharge - overall survival rate (%): **Rank 1**
- Cardiac - survival to discharge –(Utstein comparator group *) survival rate (%): **Rank 1**
- % of patients suffering a STEMI who are directly transferred to a centre capable of delivering PPCI and receive angioplasty within 150 minutes of call. **Rank 6**
- % of patients suffering a STEMI who receive an appropriate care bundle. **Rank 11 (worse)**
- % of FAST positive stroke patients who arrive at a stroke unit within 60 minutes of call. **Rank 11**
- % of suspected stroke patients who receive an appropriate care bundle. **Rank 3**

Category Red calls (2103/14; April to June 2014)

- **Emergency response**
- Red 1: 75% of calls within 8 minutes - Target met overall
- Red 2: 75% of calls within 8 minutes - Target met overall
- **Vehicle capable of transporting a patient at the scene**

Category A calls (Red 1 and Red 2) - 95% in 19 minutes - Target met overall.

5. Caring

Hear and Treat survey 2013/14 national NHS survey programme.

25 questions on call handling, clinical advice, outcome and overall service.

- 23 questions - same as average
- 1 question - Best trust in explaining why an ambulance would not be sent
- 1 question - Worst trust in not mentioning the caller would receive a call back

6. Responsive

- **Conveyancing:** Above England average for emergency calls – proportion of incidents managed without the need for transport to A&E

Summary of findings

- **Telephone Advice:** Below the England average for emergency calls dealt with by telephone advice only.

7. Well led

- **NHSLA Risk Management Standard**. Level 1 achieved October 2012 (worse than expected)
- **Department of Health, Information Governance Toolkit -** attained either levels 2 (similar to expected) or level 3 (better than expected) on the indicators when compared to other trusts. .
- **Complaints:** 86% of complaints are being resolved within 25 days against a target of 95%.
- **NHS Staff Survey (2013).** The trust scored significantly better than average on 63 out of 91 questions; the trust was similar to average for 25 questions; the trust was rated as worse than average on 3 of the 91 questions.

8. CQC inspection history

- Four inspections had taken place at the trust since its registration in April 2010.

Compliant at last inspection in October 2013.

Summary of findings

Our judgements about each of our five key questions

Rating

Are services at this trust safe?

Patients were appropriately triaged for emergency services and there were welfare checks for patients when an ambulance might be delayed. The use of special notes ensured that patient's receive safe and appropriate care. These detailed clinical information for patients with complex needs or risk information if there was a safety concern. Patient records were maintained to a high standard and patients were appropriately identified and escalated for treatment if their condition deteriorated. 'Do not attempt cardio-pulmonary resuscitation' (DNA CPR) orders were used appropriately and staff had training and understanding about end of life care across all services.

Vehicles were well maintained and serviced, and most were visibly clean. Infection control procedures were followed but needed to improve in a few areas. Appropriate equipment was available and well maintained and this was standardised across the trust. Some automated external defibrillators (AEDs), for use in patient transport services (PTS), needed to be more accessible or regularly checked. Medicines were appropriately stored and tagged for ease of use in an emergency and PTS crews were able to administer oxygen when this was required. There needed to be better arrangements to check the safe storage of medicines in some areas. Driving standards were monitored and action taken was taken to improve performance.

Safeguarding procedures were followed but the timeliness of reporting and documentation needed to improve. Incident reporting was improving following the introduction of a new electronic reporting system and learning was effectively shared in emergency services, although this needed to improve in EOC and PTS. Staff in EOC and PTS needed a better understanding of the Mental Capacity Act 2005, and of dementia care and all staff wanted to improve their knowledge of mental health conditions. The trust had introduced mental health practitioners into the EOC and was working with local mental health trusts to better coordinate and support care patient care.

The trust had a high number of staff vacancies and was feeling the impact of a national shortage of paramedics. Staff worked agreed roster patterns, but many worked long hours, some without breaks, and those in emergency services were reporting stress and fatigue. There was a rising demand for services that was above predicted levels. The trust had introduced shift changes to help manage resources to meet demand in emergency services and new rotas

Summary of findings

were being introduced to further improve the work life balance of staff. There was moderate to high pressure on the service during our inspection and the trust was communicating effectively with hospitals to align conveyancing decisions against waiting times and the capacity to receive patients. Planning and preparation to respond to a major incident were effective, and done in conjunction with partner organisations.

Are services at this trust effective?

The trust used national evidenced-based guidelines to prioritise and categorise emergency calls based on the clinical needs of patients. The service needed to improve for mental health patients in crisis and/or in need of place of safety (Section 136 of the Mental Health Act 1983). The answering of emergency calls was not within the trust target of 5 seconds and the trust had average time of 40 seconds. Rapid response vehicles (RRVs) or ambulance crews were dispatched in just over 1 minute, but this was above the trust targets of 30 and 60 seconds, respectively. Overall, national response times for emergency and urgent care were being met and most treatment and care was meeting national standards. Patients who had had a heart attack received pain relief, although not always the pain relief that was nationally recommended. This was improving following a campaign by the trust to reiterate and train staff to use the appropriate pain relief. Patients who had a heart attack did have a timely arrival at hospital. Those who had had a stroke had appropriate care, but there were delays in their arrival at hospital. The trust had good outcomes overall for the survival of patients who had had a cardiac arrest, but needed to improve the effectiveness of action taken when staff witnessed a cardiac arrest.

The trust was below average for the number of 'hear and treat' calls, which is the proportion of calls dealt with based on telephone advice only; but it had the highest percentage (the best in the country) for treating patients without the need for transport to hospital ('see and treat'). Re-contact rates following these interventions were higher than national average in 2013-14 but was now below national average for 'hear and treat' this year (April to July 2014) and was decreasing for 'see and treat'.

Emergency care for A&E and maternity services was well coordinated with the acute hospitals across Oxfordshire, Buckinghamshire, Berkshire and Hampshire, and there was effective multidisciplinary working with acute hospitals, community organisations and GP teams. There was also coordination of care along specialist pathways, for example, for critical care, and the care

Summary of findings

of children with diabetes. However, care pathways for cardiac and stroke patients in Buckinghamshire and for mental health patients across the county needed better coordination. The trust had action plans to improve the coordination of care in these areas.

The service followed eligibility criteria from clinical commissioning groups to ensure patients were appropriate for patient transport services (PTS). National clinical guidelines were used in the event of any patient needing urgent medical care. Overall, the service was not meeting performance criteria and many patients experienced delayed or missed appointments; this in turn had an impact on the timeliness (and length) of outpatient consultations, diagnostic scans and renal dialysis treatment. The service needed to be better coordinated with hospitals, but staff worked well in multidisciplinary teams to share information with GPs, hospital and community staff.

Not all staff had dedicated time to complete training and consequently, the uptake of some mandatory and statutory training was low. Staff could apply for funding to support their continuing professional development and career aspirations. The trust had worked in partnership with Oxford Brookes University to provide staff with extra opportunities to develop their careers by becoming a paramedic, and to counter the national shortage of paramedics. A foundation degree course was to start in January 2015. The training covered an 18-month period and included in-hours training. The trust's investment had been significant in terms of the time taken to negotiate the resources and facilities for the programme and the release of staff from work duties. There was access to specialist training, which included learning disabilities, dementia care, end of life care, infection control and mental health awareness. However, staff in PTS and EOC needed a better knowledge of the Mental Capacity Act 2005, and of dementia care and mental health conditions.

Are services at this trust caring?

Staff were caring and compassionate when delivering services, and they treated patients with dignity and respect. Patients were involved in discussion about their treatment and care, including why they may not need to be taken to hospital. Staff listened carefully to what patients said, and they explained procedures and treatments in a way that the patients, or their relatives or carers, could understand. In patient transport services (PTS), patients needed more information about whom to contact in the event of a delayed or missed appointment.

Patients spoke positively about the kindness of staff. The staff were extremely sensitive, supportive and reassuring to vulnerable patients. Patients, their relatives and others received emotional

Summary of findings

support when experiencing distressing events, including when someone had died. Patients were supported to manage their own health by using non-emergency services when it was appropriate to do so.

Are services at this trust responsive?

Emergency calls were allocated and triaged to appropriate patient pathways. These could be an ambulance, a GP appointment, or care in their own home or another community setting. Patients who were critically unwell and needed the air ambulance or specialist services had a separate triage process. GPs and staff in community hospitals had a direct line to call. The trust was monitoring long waiting times and had introduced measures to ensure that people were monitored while waiting and that high-priority calls took precedence. There was an impact however on people who may be in a healthcare setting but awaiting transfer to another hospital for acute care, and for people at a distance from a resource centre. The trust was taking action on these issues

Patient transport services (PTS) provided non-emergency transport for patients who attended hospital outpatient clinics, or who were admitted to or discharged from hospital. The services across Oxfordshire, Buckinghamshire, Berkshire and Hampshire had different eligibility criteria from clinical commissioning groups. The trust was compiling a directory of services to signpost people appropriately if they did not meet the criteria. There needed to be a policy for transporting children in PTS.

There was support for people who could not speak English, or who had hearing difficulties or speech impairment, to access the 999 emergency call services. Information was available to meet the needs of patients who had a complex or chronic clinical condition. The trust had begun to analyse the needs of frequent callers to better coordinate services with GPs and other healthcare professionals to manage demand. There was support for bariatric patients and those with a learning disability or dementia. Ambulance staff had less training and experience to deal effectively with people with a mental health condition. Care pathways to coordinate responsive services for people in crisis were not well developed. People whose first language was not English were supported with advice and language aids where available in the ambulance.

The trust was not meeting 'pick up' and 'drop off' times for PTS and patients did not know where to send complaints or compliments. Complaints, when received, were handled appropriately but the

Summary of findings

investigation and response sometimes took longer than the trust target time of 25 days. There was evidence of action as a result of complaints, but some staff had not received feedback and learning was not consistently shared.

Are services at this trust well-led?

The trust had a vision and clinical strategy to provide excellent, sustainable services. These included coordinating mobile responsive healthcare services so that people received the right care at the right time and in the right place; this could be care closer to home. Governance arrangements were clear and there was an integrated performance report to benchmark quality, operational and financial information. The trust identified quality priorities and could demonstrate progress. However, much of the data on risk and quality was at a high level and some risk issues, such as safeguarding and significant delays in PTS, needed a better focus. The leadership team of the service showed commitment, enthusiasm and passion to develop and continuously improve services. Most staff reported that the trust culture reflected an effective and responsive service rather than a target-driven organisation. Leadership at team level varied and the trust needed to improve this area to develop its strategic priorities.

Public engagement took place through a variety of means, such as liaison work, use of social media and trust membership. Patient feedback through surveys, interviews and liaison work, was being used to improve the service. Staff were positive about working for the trust. They said it was a friendly and positive place to work but not without its challenges: namely, managing tight resources against an increasing demand for services. Staff engagement was well developed although staff indicated the need for more ongoing dialogue about service changes. The trust had a highly innovative culture and staff were encouraged to suggest new ideas to improve service delivery. This was seen as important against a background of tightening resources, but also essential to develop services in response to the needs of patients. There were many examples of service improvements developed by the trust and the staff. The trust could demonstrate proactive and effective financial management to invest in new technology and service developments, and to ensure the sustainability of services. Cost improvement programmes were demonstrating savings and were monitored. Mitigating actions were identified to reduce the potential impact but the action taken on some of these needed to improve.

Vision and strategy for this service

Summary of findings

- The trust had a five-year strategy that would develop the service into more than a traditional one providing transport. The strategy intended for the trust to lead on the coordination of mobile healthcare services that would ensure that people would receive the right care at the right time and in the right place. The service would aim to guide patients around emergency and urgent care services, and improve the range and availability of services offered in each local area. This would include clinical assessment, signposting people to appropriate services, treating them in their own homes and, locally, improving pre-hospital care and taking people to an appropriate healthcare setting.
- The trust had identified the key challenges to improving patient care and supporting local systems to manage the rise in demand, within the context of tightening finances and increased competition. The strategy was developed in February 2014 and was quality driven. There were clear objectives that were regularly reviewed.
- Current developments to improve services included
  - better monitoring and refinement of staff rotas to more accurately and flexibly align capacity with overall demand;
  - implementing the electronic patient records system to personalise care and link 'special notes' (which detailed clinical information for patients with complex needs or risk information if there was a safety concern)from GPs and other health professionals to the electronic records;
  - modernising PTS with a single virtual computer-aided dispatch system, scheduling and electronic communication with road staff;
  - establishing a team to analyse the needs of frequent callers;
  - and implementing a tool to accurately predict emergencies in each dispatch area, based on modelling historical data and adding in factors such as weather or unforeseen events.
- The trusts' organisational values for 2014/15 aimed at delivering high performance through teamwork, innovation, professionalism (setting high standards) and caring. Its vision was encompassed in the strapline "Towards excellence – Saving lives and enabling you to get the care you need".
- Most staff we spoke with were not aware of the trust's overall vision and strategy but were aware of changes that were happening in their services, and all staff were aware of the values of the organisation. Some staff knew that there was information on the intranet that they could access. Staff in PTS, however had the least knowledge,
- Most staff were aware of, and showed, that they 'lived' the values of the organisation.

Summary of findings

Governance, risk management and quality measurement

- The trust governance structure was managed through the quality and safety committee, which reported to the board on clinical effectiveness , patient safety and patient experience. There were sub- committees to manage specific areas of governance, such as medicines management or serious incidents requiring investigation.
- The trust used internal quality indicators, mandated quality metrics and external reports, such as the Francis Inquiry, the Berwick Report and the Keogh review on Urgent care, to develop its strategy and quality account. An action plan had been produced. It focused on three priority areas based on clinical quality, patient safety and patient experience.
- The trust quality account 2013/14 showed a focus on priority areas around clinical quality, patient safety and patient experience. Improvements were noted for most areas, with work ongoing to achieve compliance where priorities had not been met (that is, promoting a patient safety culture and using the care bundle for patients who had had a heart attack).
- Many areas had team meetings and monthly operational performance meetings to review quality and operational issues. These reported to the trust's Level 2 meetings (operational leadership level) and then senior management meetings. This structure was not replicated in all areas and documented minutes of discussion and actions from these meetings did not consistently identify the action taken in response to risks and performance issues.
- Quality, operational and financial data was monitored through an integrated performance report. This included information on areas that could be benchmarked with other ambulance services and performance against national targets. The report was being developed so that the trust could focus on localities and use a predictive model of risk based on local information. It was not always clear what specific action was being taken in an area identified as a risk but not included as an indicator for example, under safeguarding or significant delays in PTS.
- The corporate risk register included clinical, organisational and financial risks, and used likelihood and severity criteria for risks to develop a rating score. There were mitigating actions and controls. The register identified high-level risks for an ambulance trust and contributed to the board's assurance framework, which was used as a strategic predictive tool. Some risks, however, based on the trust's actual delivery of services (such as safeguarding issues, medicines management, incident reporting or infection control issues) had not been identified or assessed.

Summary of findings

- The trust worked in a complex environment and there was an array of data collected. Action was being taken to ensure that the data was being centralised for use, but data was not always used effectively when it was collected.
- Contracts were monitored effectively for private providers in emergency care but this was inconsistent in PTS and some security and employment checks had not been done for volunteers.
- The trust monitored progress against the trust's strategy and quality account every two months and a risks summit was held once a year to review progress. The board assurance framework was monitored at every board meeting.

Leadership of service

- The trust leadership was relatively stable. The Chief Executive and key directors had been in post for a number of years. The Director of Patient Care joined the trust in June 2013 and the Chief Operating Officer in July 2013. There was a new non-executive director in January 2014.
- The leadership team showed commitment, enthusiasm and passion to develop services. They were rising to the challenge of continuous quality improvement alongside a rising demand for services and tightening budgets and resources. Governors of the trust were invited to sit on specific groups (for example, the patient experience and clinical review groups). The board and governors had had strategy sessions so that the board could obtain the views of governors about the strategic direction of the trust. The trust undertook annual effectiveness reviews to ensure that the governors were delivering their statutory duties
- Leaders were supported to develop their roles, for example, the Medical Director told us that he was taking part in a national leadership training programme and non-executive directors told us they were supported with specific learning and development opportunities to fulfil their role. The governors told us they were well supported by the trust leadership and had received relevant training to fulfil their roles.
- The trust had a team structure to make 'leadership' visible and clear at locality level, and to lead the service changes identified in the strategy. There had been three leadership days in the trust to support team leaders, area managers and operational leads.
- The NHS Staff Survey 2013 identified that the trust was similar to other trusts for the percentage of staff reporting good communication between senior management and staff. It was understood that the diverse nature and spread of the workforce

Summary of findings

made visibility difficult. Staff reported that they knew who their team leaders were; they also knew the senior management team and the leadership team of the trust although. Many staff said the Chief Executive was visible.

- The leadership team was clear about the strategic direction of the trust, but messages were being diluted through the operational tiers of the organisation. Staff were not always aware of the reasons for some changes, or the opportunities available to them as employees. When the reasons were clearer (such as when resources were diverted to meet demand), staff asked for engagement and communication to be more of a dialogue, rather than messages sent down from the top.
- Team leaders were supported with specific training and development opportunities. The trust acknowledged that there was variation in the leadership skills of some team leaders. This was particularly evident in PTS where many team leaders needed more support. The capacity of leaders to deal with specific areas (safeguarding, medicines management and infection control) also varied.
- The trust had a clinical lead in mental health and learning disability. This role was unique among ambulance trusts. The lead had established a national mental health group for ambulance trusts, and worked with partner agencies such as the Royal College of Psychiatrists and the College of Policing.

Culture within the service

- We held focus groups for staff but these were not well attended. We spent time seeking out staff on duty, so as to be able to talk to as many as possible. Some staff reflected that they were too busy to attend the focus groups; others were unaware that they were being held. A few told us that it might have been more helpful to have held them in non-trust locations.

- Most staff were very positive about the service they provided. They wore their uniforms with pride, acknowledging that their service was held in high esteem by the public. Many were concerned about the challenges of meeting the rising demand for services, and the impact these were having on their working hours, terms and conditions, and roles. Staff indicated, and we observed, that morale was low in some areas. However, many were positive and resilient because of the critical nature of the service they provided. They 'lived' their values, which was "Towards excellence – Saving lives and enabling you to get the care you need".

Summary of findings

- The trust had identified a number of services to support staff, for example, a confidential counselling service and trauma risk management [TRiM] service to support staff that had dealt with a distressing or traumatic incident, and to assess their need for further intervention.
- The leadership team was clear that the service it provided was not target driven but about the effectiveness of response. Many staff at all levels identified that the culture was driven first by quality, which was not sacrificed for targets or finance. There was some concern, however, about the pressure to meet targets in the northern operations centres.
- Staff had a sense of collective responsibility and were focused on care pathways for patients. As an organisation, however, there was a north/south divide in management culture with staff reporting more support and understanding from managers in the south, particularly in the emergency control centres. There was also a distinct difference within PTS, where staff considered they were the 'Cinderella' service of the trust.
- The trust did a staff survey in 2013/14 using the Manchester Patient Safety Framework (MaPSaf). This is a system where an organisation can have its current patient safety culture evaluated by its employees, and responses are categorised along a scale from 'pathological' (such as blame and denial of risk) to 'generative', where there is anticipation, response and learning from risk. The trust was still analysing this information. Most staff told us they would raise concerns about patient safety, but many also commented that they did not have formal opportunities (such as in regular team meetings) to do this.
- As an ambulance trust, there was a wealth of stakeholders from commissioners, acute hospitals, local authorities and local Healthwatch groups. These stakeholders identified that the trust was an open and transparent organisation, worked well in partnership and was increasingly responsive to concerns. It was acknowledged that the trust managed difficult circumstances well.

Staff engagement

- The leadership team undertook walkarounds to engage with staff and promote the culture of safety. The team discussed issues with staff and did environmental checks. Areas for action were reported to the trust's quality and safety committee for monitoring. Operational and clinical leads undertook walkarounds focusing on environmental standards and health and safety.
- The trust had produced two documents with the input and direction of staff. These were called 'Room for Improvement'

Summary of findings

and 'What SCAS Does Well'. The documents identified where the trust needed to improve, and the innovation and improvement work undertaken by the staff and leadership team over the past year. The documents were produced in preparation of the Care Quality Commission inspection, but the process and outcome had proved popular with staff and the trust intended to continue to produce them.

- The trust was above average in 14 (50%) of the 28 questions in the NHS Staff Survey 2013. It was in the top 20% of trusts for staff engagement overall and for questions on support from immediate managers; appraisal; lower levels of physical violence from staff; and bullying and abuse from the public. It was in the bottom 20% of trusts for the availability of hand-washing materials; job training; reporting errors, near misses and incidents; effective teamworking; and equal opportunities to career progression. The trust scores had deteriorated compared to 2012 on work related stress, equal opportunities to progress, staff appraisal and motivation at work. Trust scores had improved compared to 2012 on equality and diversity training and health and safety training.
- The trust used a variety of means to support good staff communication (for example, the Chief Executive's blogs, newsletters, screens at control centres and electronic communications). Many staff told us communication was good considering the logistical difficulties. However, the reliance on electronic communication was a concern for those who had little access to computers.
- All policies and procedures were signed off with the joint consultative committee and staff groups, and the trust had good relationships with its staff. Staff told us that there had been effective engagement around key changes, such as those to shifts and rotas, and working unsociable hours, and the decision that the new emergency care assistant should work alongside paramedics rather than technicians. However, as the changes had progressed and their impact was clearer, the staff wanted ongoing engagement and dialogue on these issues.
- The team structure was valued by staff. They identified that it was improving effective teamworking, and that clinical mentoring was now embedded within teams.
- The trust required a vehicle capacity of 135% to take account of repairs and maintenance, but it was running at 128%. It was replacing 32 dual crew ambulances in 2014, 22 were replaced routinely (which happened every 7 years); 4 were replaced due to an increase in demand; 6 were replacing damaged vehicles. Sixty-three new PTS vehicles were to be purchased as part of the new contract for the PTS in Hampshire starting on 1 October

Summary of findings

2014. Staff were engaged in the procurement, selection and layout of vehicles, as well as the selection of equipment, through the equipment and vehicle working group and the recently established vehicle planning and procurement group.

- There was an annual award ceremony called the 'AMBIES'. Staff had the opportunity to nominate individuals who showed dedication and commitment in their work every day. There was a judging panel and staff were considered against the core values of the organisation, which were professionalism, caring and compassion, teamwork, innovation, taking responsibility, a 'can do' attitude and demonstrating pride. The AMBIES covered all staff groups although there was no defined category for staff working in PTS

Public engagement

- The trust board heard patients' stories and concerns at alternate board meetings. These helped the board to identify where changes could be made to improve services.
- The Chief Executive was the chair of the trust's patient experience group and the governors of the trust identified that they had a major public engagement role and lead on these issues. The trust had over 12,000 foundation trust members gathered through a sustained campaign to increase support and awareness about the trust.
- The trust had increased its number of community first responders and co-responders (with medical students, fire services personnel, the military and the police), recognising that it needed to maintain the level of services (and increase exposure to patients) through co-production. The trust had approximately 946 community first responders and 349 co-responders and was working towards 10 to 15,000 people based on the 'Seattle Model', in which everyone was trained in cardio-pulmonary resuscitation as a community.
- The trust had identified effective public engagement as an important way to improve patient care and had undertaken a number of initiatives and public education work. These included roadshows, patient forums and meetings with local community groups; health events with private companies; a 'Name the Bear' competition in schools to improve children's awareness of 999; a fall prevention scheme in residential homes and day centres; and educational talks to secondary schools, colleges and universities. Twitter and other social media were also used.
- The trust provided a service on Friday and Saturday nights in the city centres of Portsmouth (Safe Place) and Southampton (ICE Bus). This offered support, first aid and transfer to hospital

(if needed) for the public enjoying a night out. The service had been set up in partnership with other organisations, such as the Hampshire Police, the local councils, volunteers and local street pastors.

- The trust had started a campaign to minimise the misuse of 999. To directly combat hoax and inappropriate calls, it was asking members of the public to only call 999 for emergencies and life-threatening situations. The campaign provided information and a hard-hitting video to the public that illustrated how lives can be put at risk when 999 is called inappropriately.
- Patient feedback through surveys, interviews and liaison work, was being used to improve the service. The PTS in particular undertook regular surveys and there were good examples to demonstrate service improvement in response to concerns. For example, the new fleet of vehicles and renal patient's project to improve drop off and pick up times.

Innovation, improvement and sustainability

- The trust had a highly innovative culture and staff were encouraged to suggest new ideas to improve service delivery. This was seen as important against a background of tightening resources, but also essential to develop services in response to the needs of patients. There were many examples of service improvements developed by the trust and the staff.
- The trust had produced a report on its innovation in the past year or so. This was called 'What We Do Well' and gave many examples of where its action and those of its staff had improved services. This included the automatic external defibrillator (AED) locator mobile phone application, a trauma triage tool, the 24-hour labour line and blood transfusions on the air ambulance.
- The trust had analysed the factors that affected its clinical, operational and financial sustainability, such as recruitment, reconfiguration of acute services, a growth in demand for services and competition from other providers. Mitigating actions were introduced and monitored.
- The trust, as a foundation trust, is regulated by Monitor. As part of its regulatory regime, Monitor assigns risk ratings to each foundation trust. In 2013/14, the trust had a four-risk rating (no evidence of concerns) for continuity of service, and a green-risk rating (no evidence of concerns) for governance. Its annual business plans were rated amber/green.
- The trust could demonstrate proactive and effective financial management to invest in new technology and service developments, and ensure the sustainability of services.

Summary of findings

Budgets were pre-planned and resources identified on a monthly basis. Data was being used to identify where resources may need to be diverted, for example, to areas of low performance.

- The trust identified that any financial surplus should be used to bolster performance, and that being a foundation trust and providing a quality service had helped it to win tenders. There was a large exit fee if contracts were lost, so the trust was working to maintain and increase the number of contracts won for services. A surplus of £0.5 million in 2012/13 had been used to improve quality. The trust had also secured a £7 million capital loan over 5 years to secure its financial position and make the necessary investments. In 2013/14, the trust had invested in its development and change programme, which included investment in IT, the electronic patient record system and a university programme to train future paramedics.
- The trust was financially stable in its current configuration. It had a surplus of £1.5 million in 2013/14 and a year end cash balance of £8.3 million, which it used to pay off £1 million of the capital loan.
- The trust was investing to improve effectiveness (for example, with private providers to improve response times due to the shortage of paramedics, by supporting 30 university paramedic places and by replacing the vehicle fleet with high-quality vehicles that would last longer). Some investments were still being rolled out but were produced some inequalities in the interim (for example, staff in the south had protected learning time but this had yet to happen in the north).
- The trust had cost improvement programme targets of £6.2 million in 2013/14 and these were achieved. Quality impact assessments were undertaken, and the Director of Patient Care and the Medical Director approved planned projects to ensure that there was no detrimental impact on quality. The trust had forecasted a £0.5 million surplus this year. Each cost improvement programme was monitored in an integrated performance report and given a risk rating according to its potential impact on service quality and delivery; mitigating actions were identified to reduce the potential impact but the action taken on some of these needed to improve. For example, arrangements for deep clean had changed from 8 to 12 weeks but some vehicles were not being cleaned at 12 weeks; and in PTS there was recruitment of band 2 assistants instead of band 3 but monitoring of complaints and incidents needed to improve.

Responsibilities under the Civil Contingencies Act 2004

Summary of findings

- The ambulance service was classified as a Category 1 responder under the Civil Contingencies Act 2004. **Category 1 responders** are the organisations at the core of an emergency response. The trust would need to assess the risk of emergencies occurring and use this to inform contingency planning. The service had arrangements in place to inform the public about civil protection matters and to warn, inform and advise the public in the event of an emergency.
- The trust had a command and control policy whereby a bronze, silver or gold command structure would carry out an authoritative command in the event of a major incident or emergency as described in Civil Contingencies Act 2004. Senior staff were aware of the categories of response (bronze, silver or gold) and the actions entailed within this in the event of a major incident.
- The trust is a member of local resilience forums (LRFs) across South Central area. Within the Thames Valley region, for example, the LRF is chaired by Thames Valley Police. There are a series of working groups that deliver the LRF's strategic goals and discharge the duties specified in the Act.
- The trust had worked with the Joint Emergency Service Interoperability Programme (JESIP). This was a partnership set up to improve the ways in which police, fire and ambulance services worked together at major and complex incidents. Staff received joint training with these other services at varying levels, depending on their role within the trust.
- The trust participated in emergency plans and rehearsals in 2014 relating to a Chemical, Biological, Radioactivity and Nuclear (CBRN) incident scenario.

Outstanding practice and areas for improvement

Outstanding practice

- We observed many examples where staff demonstrated outstanding care and compassion to patients despite sometimes working in very difficult and pressured environments. Staff "lived" the values of the trust "Towards excellence – Saving lives and enabling you to get the care you need".
- Representatives of the trust attended local youth organisation meetings, village fetes and school assemblies. The trust had developed a child-friendly first-aid book printed specially for schools and the wider local community.
- The trust provided an innovative learning resource to their frontline staff using the educational resource centre and film centre at Bracknell. The staff were involved in making films which supported learning around new guidelines from the Joint Royal Colleges Ambulance Liaison Committee (JRCALC).
- The trust had introduced a lifesaving automatic external defibrillator (AED) locator mobile phone application. By using GPS, this app locates the nearest AED in the event of a cardiac arrest. In total, the app identified over 800 AEDs across four counties.
- A new initiative was the introduction of a 'Simbulance': a large command vehicle fully equipped with simulation learning activities. It was an innovative virtual classroom facility in that it gave ambulance staff the opportunity to experience realistic medical situations inside an ambulance saloon.
- Operation centres had direct access to electronic information held by community services, including GPs. This meant that the staff could access up-to-date information about patients (for example, details of their current medication).
- Trauma risk management (TRiM) was in place to provide confidential support to staff who may have been affected by traumatic incidents or conditions. Staff were assessed 3 days after a traumatic event and again after 28 days. Thirty-two TRiM practitioners gave peer support and advice, and there was also an external counselling service. The early intervention had both reduced sickness absence and improved the welfare of staff.
- The Helicopter Emergency Medical Services (HEMS) showed innovative practices and learning taken from combat zones. The team now had the equipment and skills to give blood transfusions and perform ultrasound and blood gas tests. In some circumstances, this bypassed or reduced the time a patient had to spend in the accident and emergency (A&E) department, and meant they could receive treatment immediately on arrival at the hospital. HEMS was also planning to introduce a night service, so it would operate 24 hours every day.
- The introduction of a midwife to the clinical support desk (CSD) in the Southern House emergency operation centre had improved the outcomes for expectant mothers and their new babies. The 24-hour labour line started as a pilot in May 2014. It gave women in labour access to advice and support, whereas the 'professional's line' enabled medical professionals to speak to a midwife 24/7 during a woman's labour and birth. The service had over 1,600 calls in the first eight weeks.
- The trust provided a service on Friday and Saturday nights in the city centres of Portsmouth (Safe Place) and Southampton (ICE Bus) to provide support, first aid and transfer to hospital if required for the public enjoying a night out. This had been set up in partnership with other organisations such as the Hampshire Police, the local council, volunteers and the local street pastors
- The trust had a clinical lead in mental health and learning disability. This role was unique among ambulance trusts. The lead had established a national mental health group for ambulance trusts, and worked with partner agencies such as the Royal College of Psychiatrists and the College of Policing. The introduction of mental health practitioners into the EOC was supporting operational practice and care to mental health patients.
- The trust had worked in partnership with Oxford Brookes University to provide staff with extra opportunities to develop their careers by becoming a paramedic, and to counter the national shortage of paramedics. A foundation degree course was to start in January 2015. The training covered an 18-month

Outstanding practice and areas for improvement

period and included in-hours training. The trust's investment had been significant in terms of the time taken to negotiate the resources and facilities for the programme and the release of staff from work duties.

Areas for improvement

Action the trust MUST take to improve

The trust must ensure that:

- Staff uptake of statutory and mandatory training meets trust targets.
- Staff in EOC and PTS understand the Mental Capacity Act 2005.
- All EOC and PTS staff receive safeguarding training to the required level so that they are able to recognise signs of abuse and ensure there are robust arrangement in place for staff to report concerns within the agreed timescale.
- Emergency call takers answer calls, and the emergency medical dispatchers dispatch an ambulance within target times.

Action the location SHOULD take to improve

The trust should ensure that:

- Procedures for incident reporting continue to improve and staff in EOC and PTS have appropriate training and are able to report incidents directly. There must be timely investigation of incidents, staff must receive feedback and learning must be shared.
- The risks around IT vulnerability in the EOC and PTS are appropriately managed.
- Infection control practices are followed and ambulance stations (resource centres) and vehicles are effectively cleaned and deep cleaned.
- There are suitable arrangements to ensure that equipment is regularly checked and fit for purpose.
- Staff are aware of the appropriate steps to take to reduce the risks to patients left unattended in PTS ambulances because of staff working alone.
- Appropriate equipment is available in all areas for the transport of children in PTS and this continues to be rolled out for emergency transport.
- Volunteer drivers in PTS have the appropriate safety and employment checks before working within the service.
- The trust to continue to work with partners and ensure the planning and scheduling of PTS improve to prevent delays and missed appointments, and to reduce the impact on the clinical care, treatment and welfare of patients.
- The governance and security arrangements for the management of controlled drugs need to be improved in Hampshire.
- Recruitment of staff in all areas continues and there are specific staff retention plans in response to identified reasons as to why staff leave.
- Staff in PTS receive appropriate training on dementia care, learning disabilities and all staff continue to received training in mental health conditions.
- Anticipated resource and capacity risks in PTS continue to be appropriately identified, assessed and managed.
- Pain relief continues to be appropriately administered for patients with ST segment elevation myocardial infarction (STEMI) and pain relief for children is effectively monitored.
- Continue to work with acute trusts to review protocols for the non- critical transfer of hospital patients.
- There is better coordination of care between providers, in particular for cardiac and stroke services in Buckinghamshire and mental health services.
- Complaints are responded to within the trust's target of 25 days. All staff in EOC and PTS receive feedback from complaints and learning is shared.
- Operations staff in PTS are appropriately resourced to be able to answer telephone calls.
- Patients (or people acting on their behalf) using the PTS are made of aware of how to complain or send compliments about the service.
- Staff in PTS have regular supervision and the trust should raise awareness amongst staff about the professional and career development opportunities within the trust.

Outstanding practice and areas for improvement

- The formal structure of team meetings is in place for all staff groups and staff are given the opportunity to attend, share information and raise issues or concerns.
- Staff have a better understanding of the trust's vision and strategy as it applies to their service in EOC and PTS and staff communication continues around service changes and development.
- Leadership in the northern EOC and PTS supports staff and action is taken to improve staff morale where this is low.
- Staff in PTS receive feedback from the completed patient satisfaction surveys.
- There are better governance arrangements within EOC and PTS to share information with staff, so that staff can raise concerns and risks are appropriately identified, assessed and managed.
- There are better governance arrangements for private providers in PTS and make ready services.

South Central Ambulance Service NHS
NHS Foundation Trust

Wokingham CCG Performance
April 14 – October 2015

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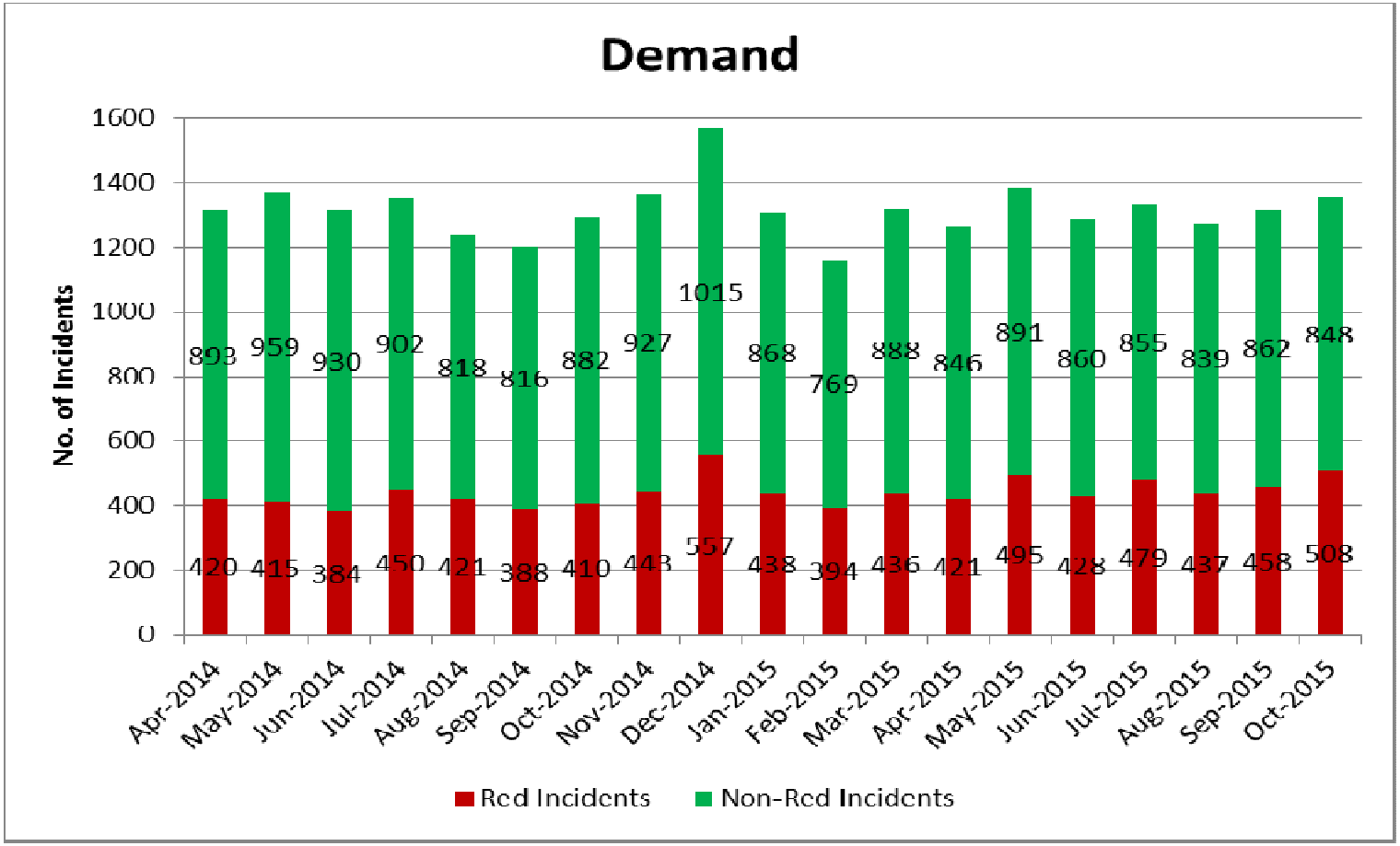
Demand



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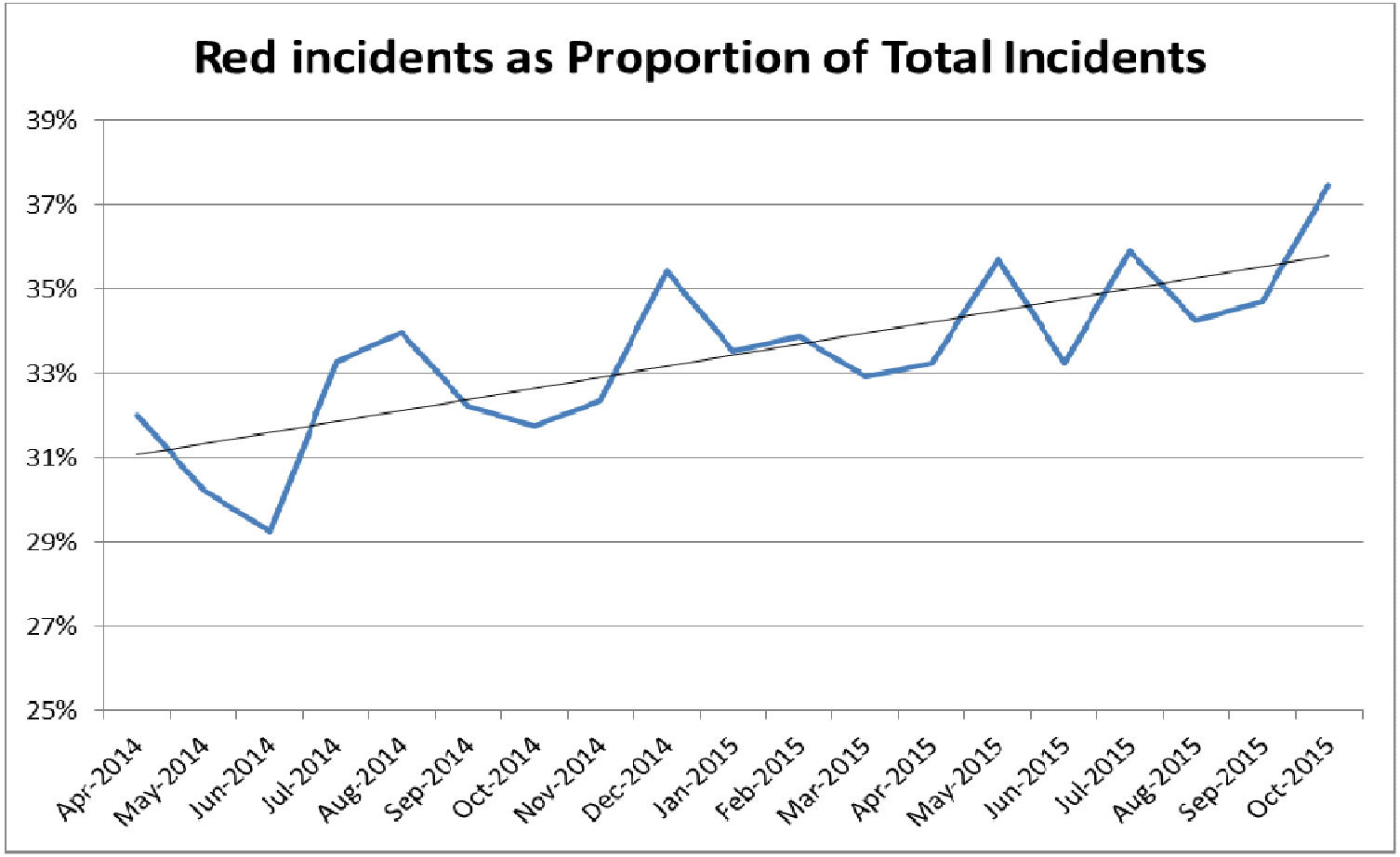

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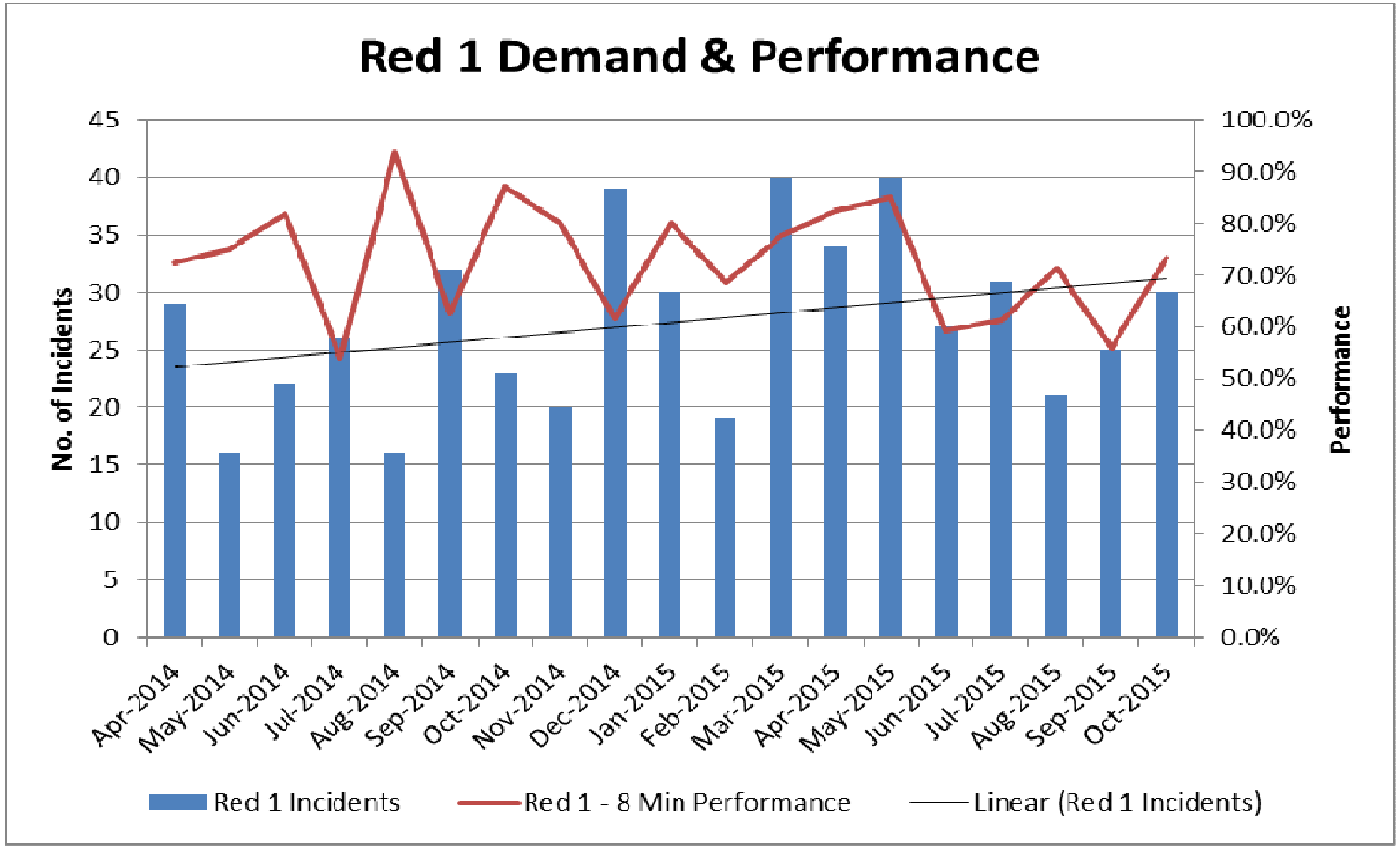
Performance



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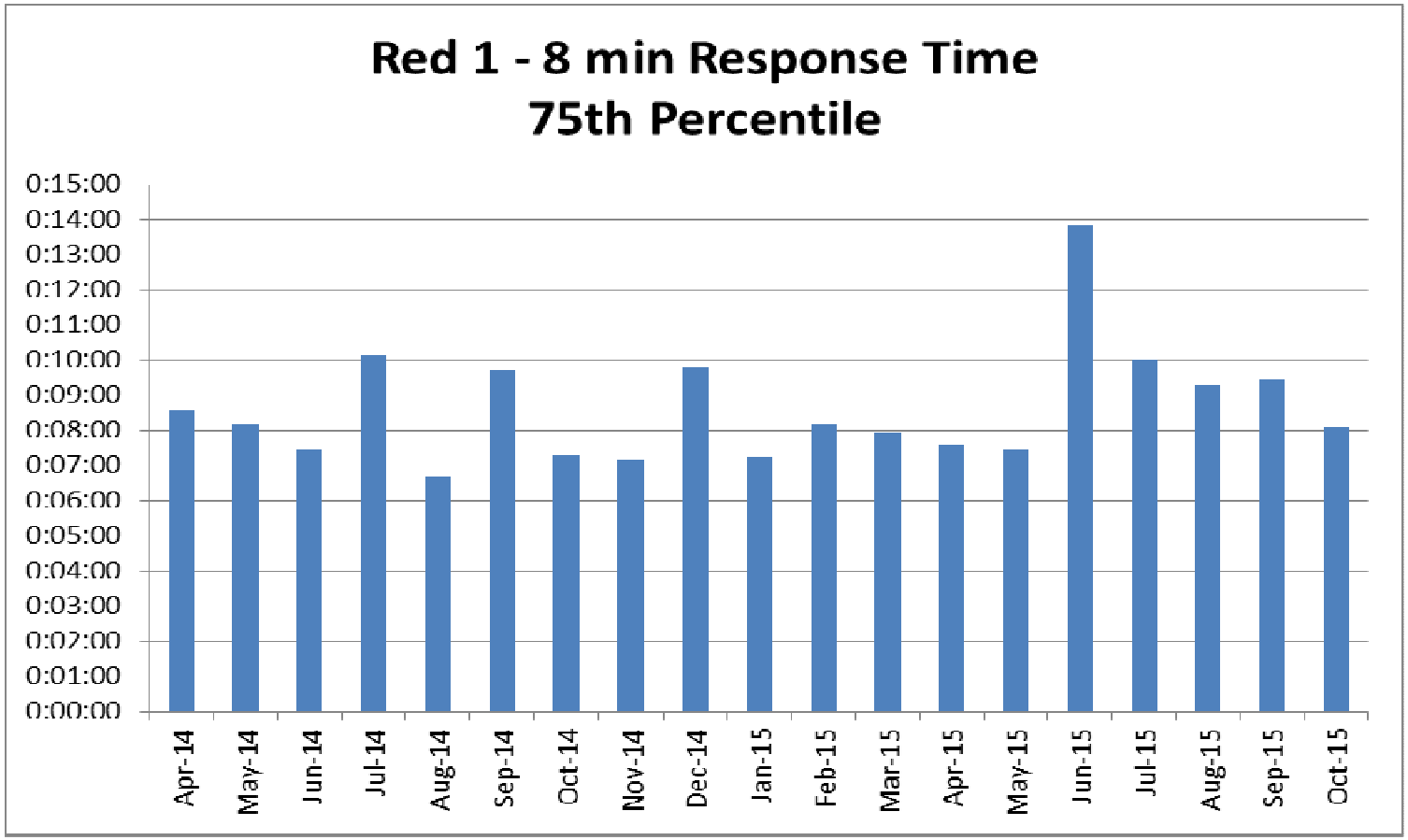
Performance



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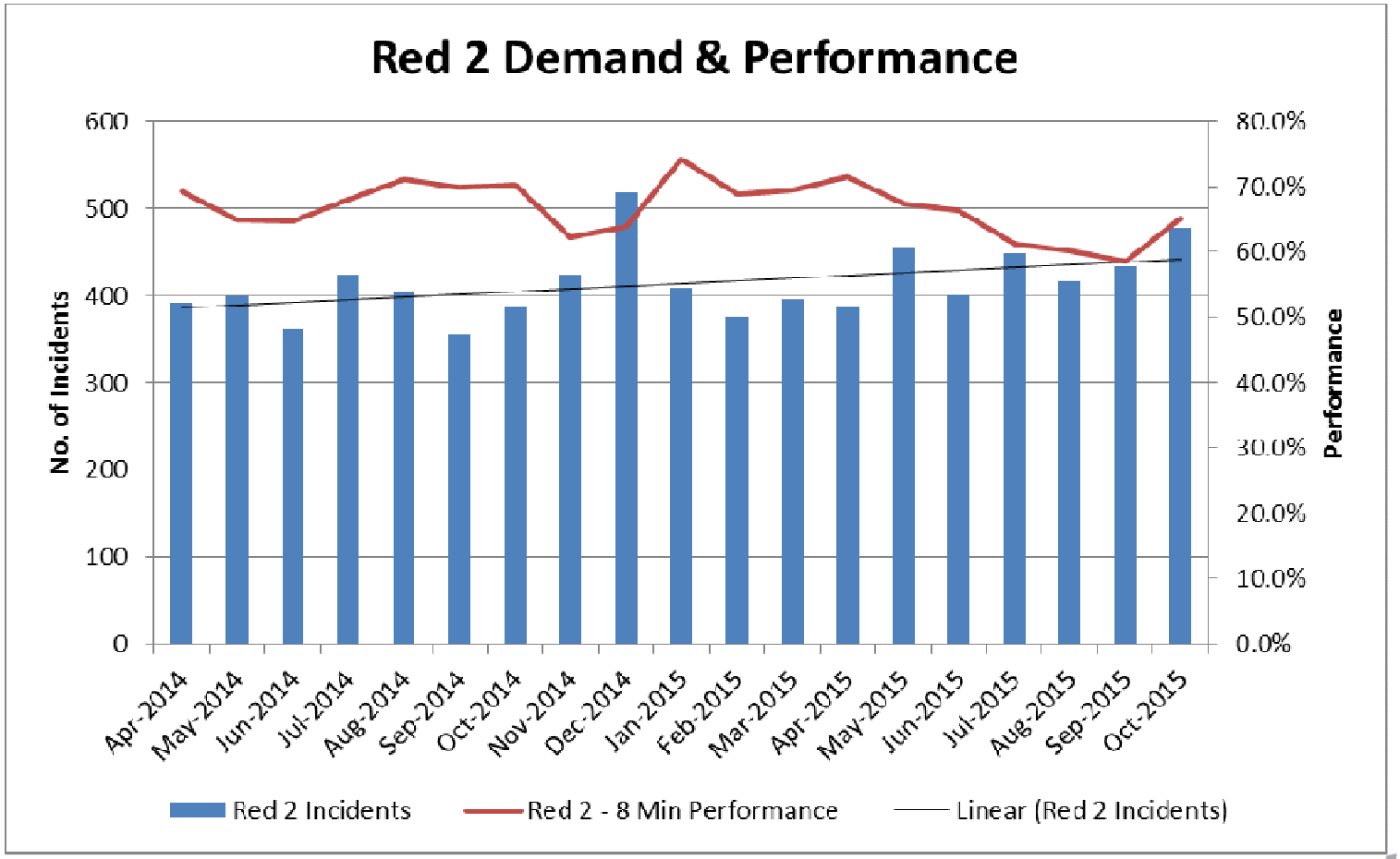
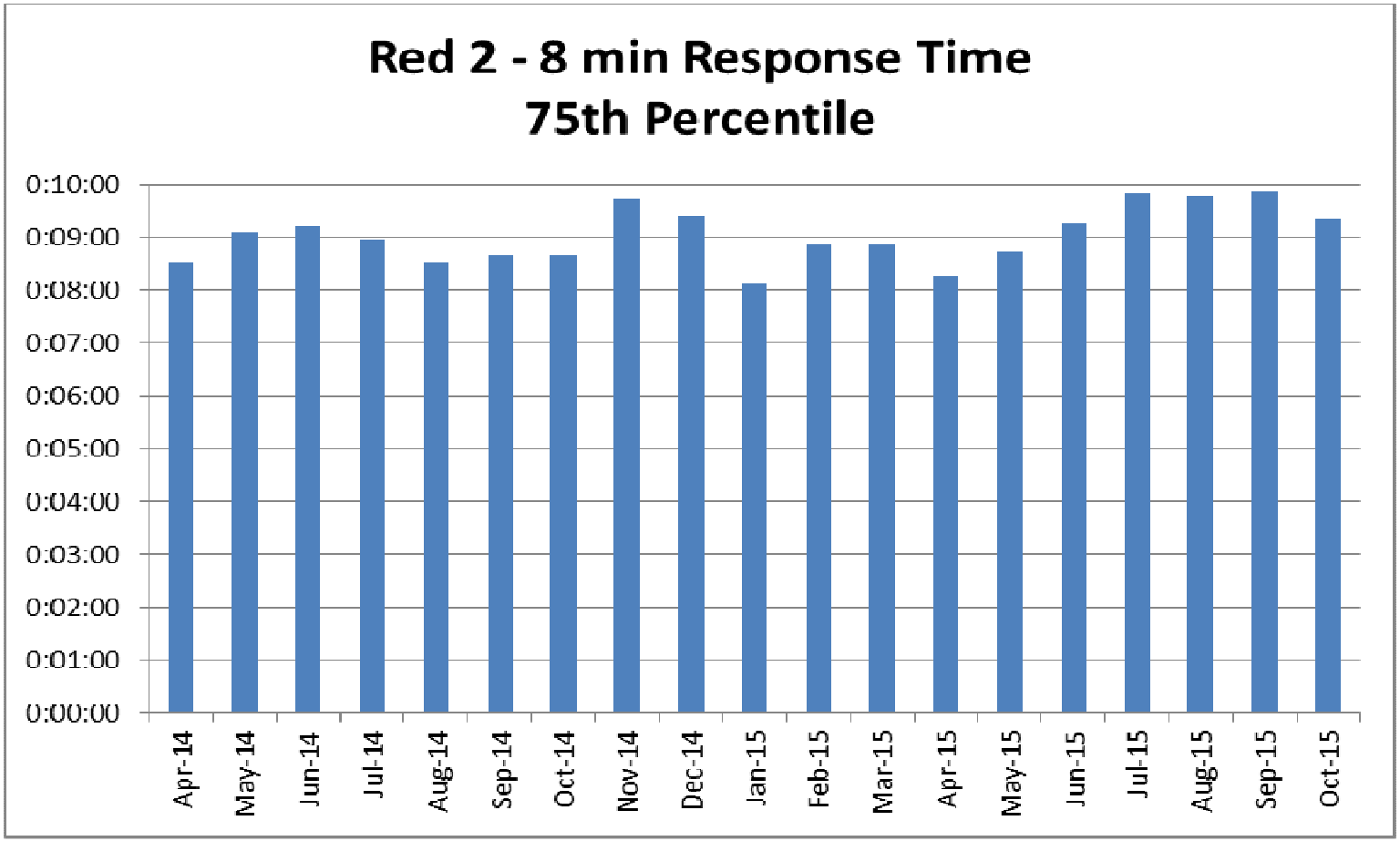
Performance



Get involved

South Central Ambulance Service NHS
NHS Foundation Trust

Performance



Get involved

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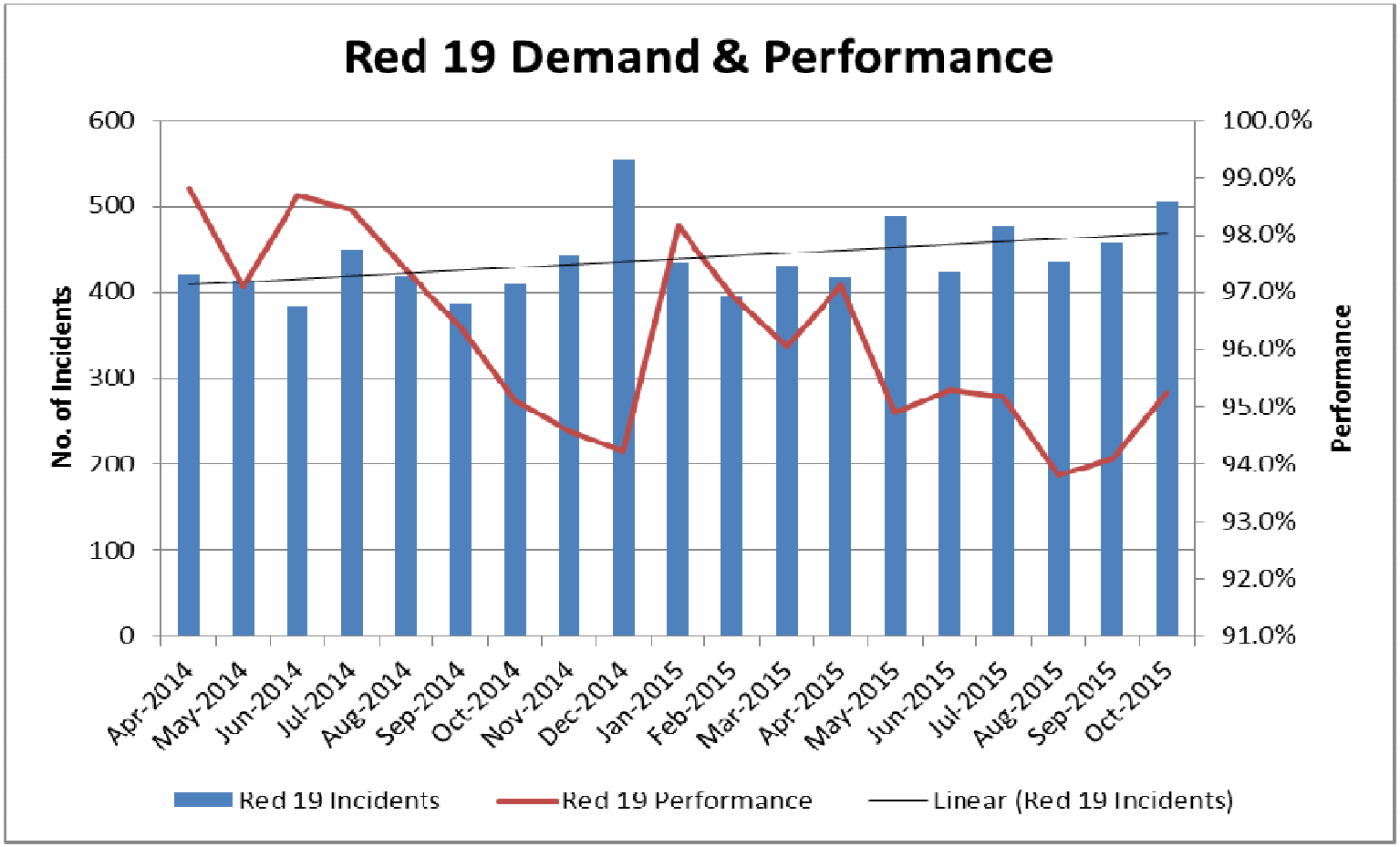
Performance



Get involved

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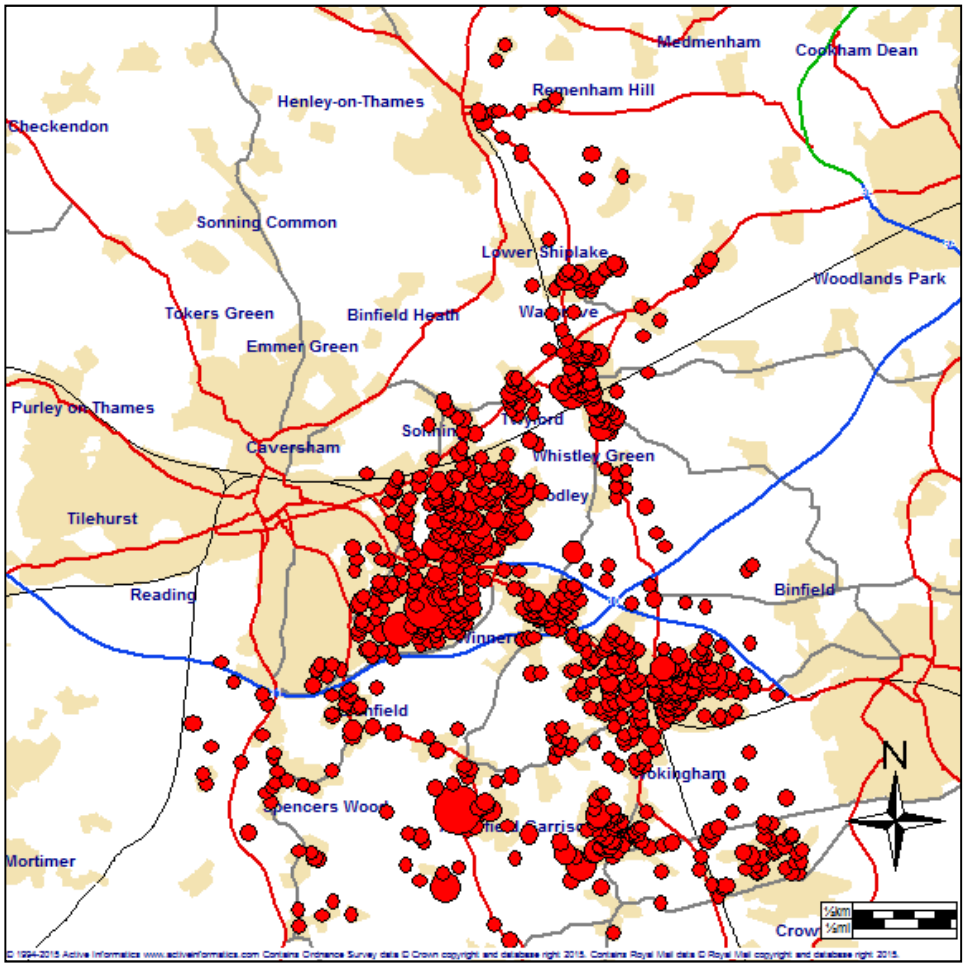
NHS Foundation Trust

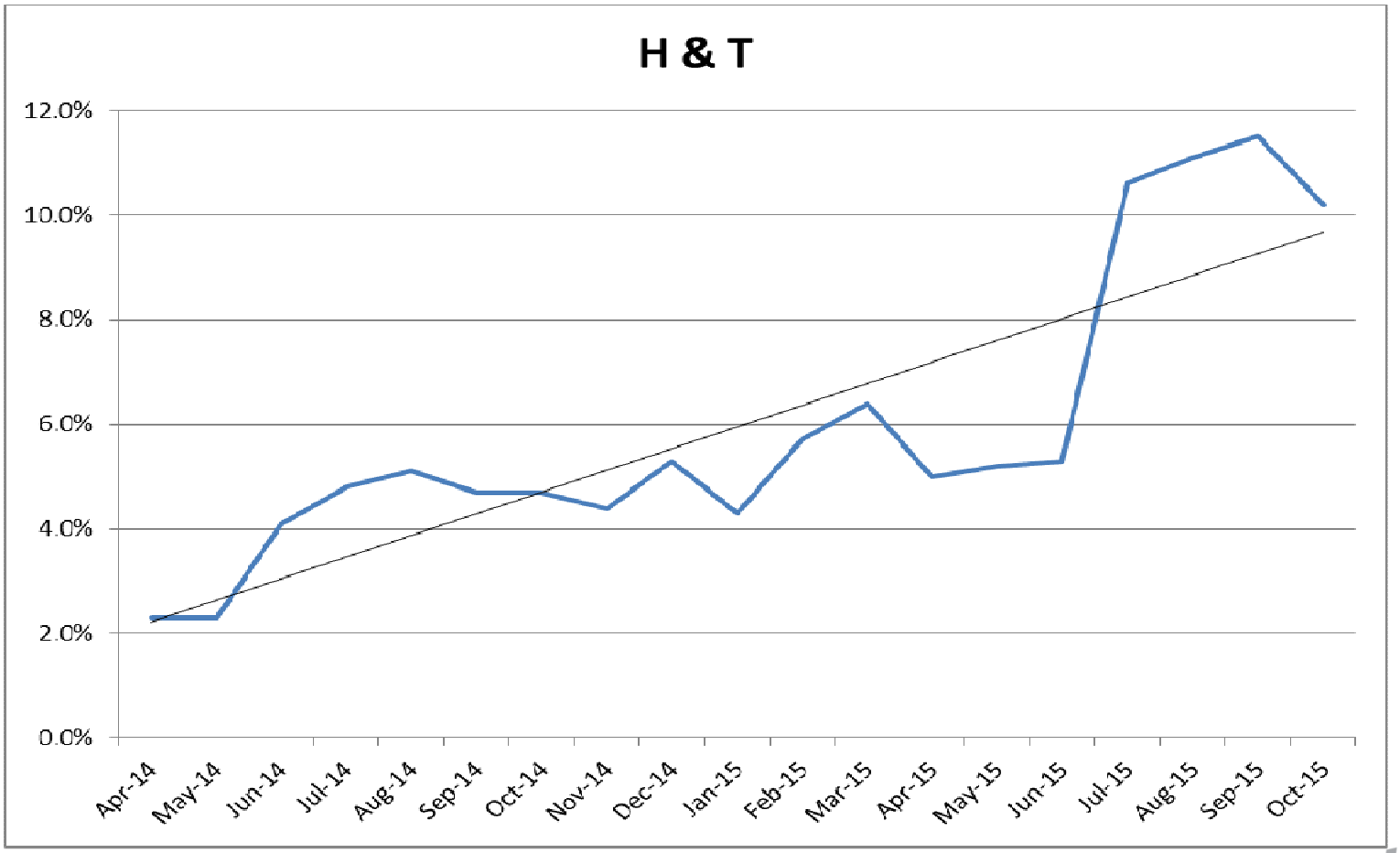
Red Misses 01.04.15 – 31.10.15



Get involved

South Central Ambulance Service NHS
NHS Foundation Trust

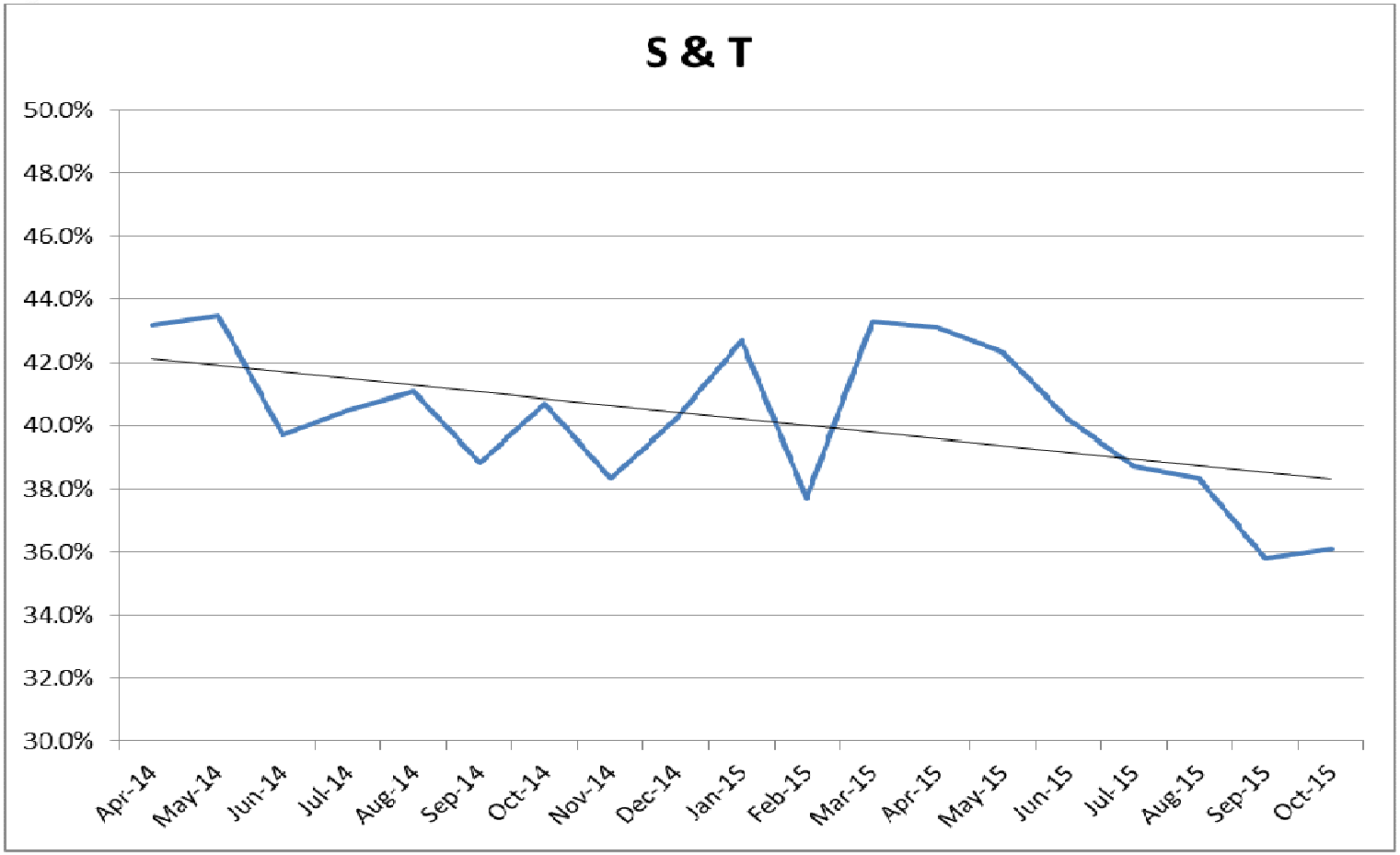
Hear & Treat



Get involved

South Central Ambulance Service NHS
NHS Foundation Trust

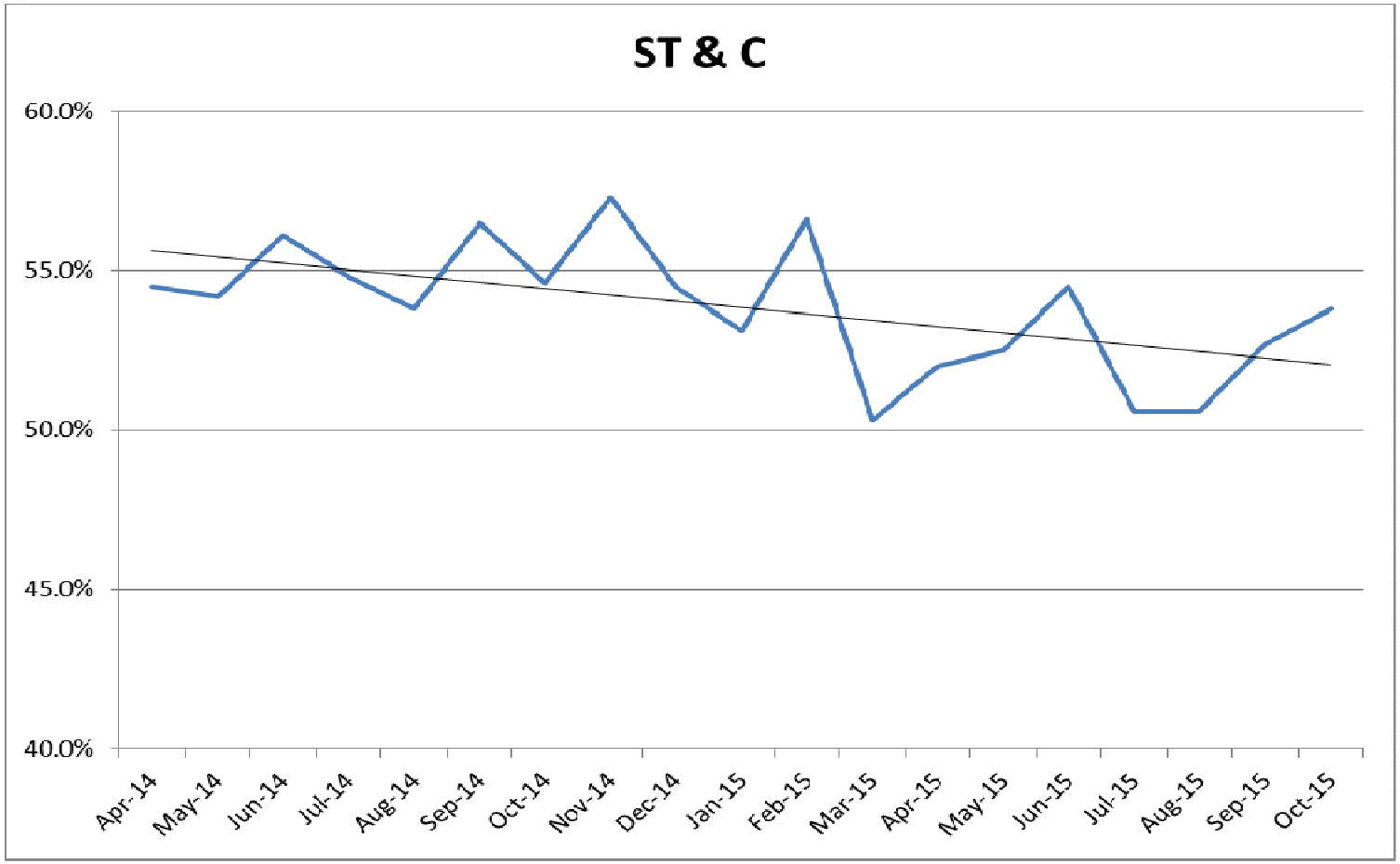
See & Treat



Get involved

South Central Ambulance Service NHS
NHS Foundation Trust

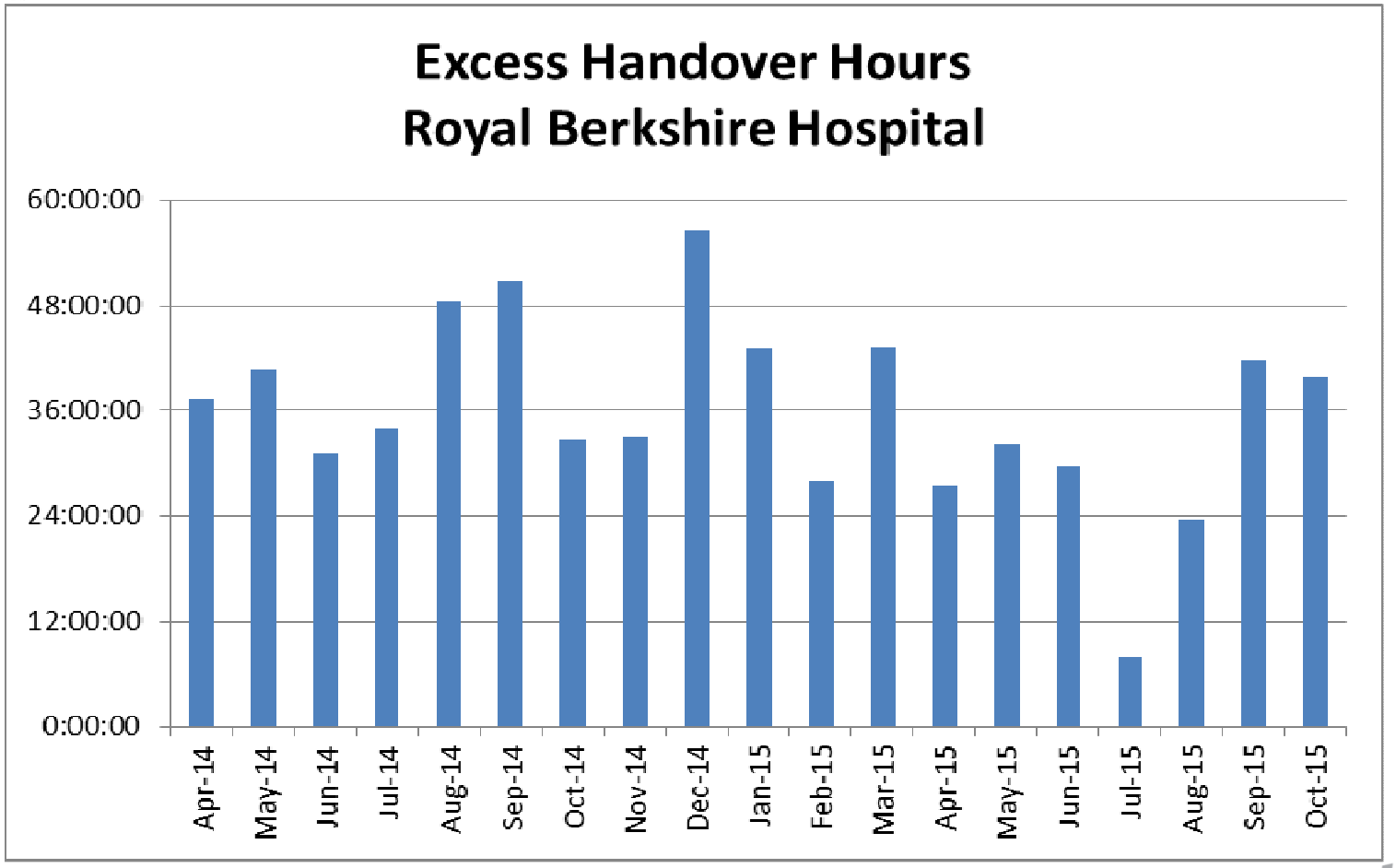
See, Treat & Convey



Get involved

South Central Ambulance Service NHS
NHS Foundation Trust

Hospital Handover Delays



Get involved

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TITLE:	**Joint Strategic Needs Assessment**
FOR CONSIDERATION BY	Health Overview and Scrutiny Committee
WARD	None Specific
STRATEGIC DIRECTOR	Stuart Rowbotham, Director of Health and Wellbeing

OUTCOME / BENEFITS TO THE COMMUNITY

A comprehensive, user friendly and "live" assessment of the Borough's health, care and wellbeing needs is essential for effective and efficient commissioning of services, not just by WBC itself but also our CCG colleagues and the wide range of partners and stakeholders in all sectors.

Ensuring priority is given to commissioning services that meet need; are evidence-based and offer good value will be crucial to improving and maintaining the good health of the Borough's population, whilst taking into account our changing demographic.

The JSNA seeks to be a user friendly product for professionals and the community to use and make informed decisions that tells the 'One Truth' for Wokingham Borough.

RECOMMENDATION

To be informed of the JSNA chapters update, and the journey towards the successful completion of the JSNA refresh and redesign.

SUMMARY OF REPORT

During the Autumn of 2015; the data behind the Wokingham JSNA is being fully updated by the Public Health Berkshire Intelligence based (central team) in Bracknell Forest Council.

Progress on the JSNA update is good with 13 new chapters written. There are currently 23 chapters out with officers and in the process of being updated, with a further 13 waiting for availability. One of the main issues recently has been due to the Ofsted inspection during October; causing updates to be put on hold. However, things are beginning to get back on track but the workload remains high for all those involved in Ofsted and backlogs need clearing. A secondary issue identified is the presence of a few core individuals that are responsible for the vast majority of updates, this leads to a bottleneck due to balancing JSNA responsibilities with normal work responsibilities.

Work on the new JSNA microsite has begun, with some initial design and concepts being formulated. Good examples have been identified and trawled over (Kent, Bracknell, Surrey, Wakefield) and new brand identities discussed. Wokingham's JSNA previously did not use the JSNA acronym, which led to difficulty in partners being able to find it. Following a design meeting on the 1st of November it was decided that the acronym must feature on the page as it is what professionals are familiar with, the url will also feature the JSNA (jsna.wokingham.gov.uk). In addition to this in order to increase the general user experience the JSNA will have a colloquial title on the front page in bold, similar to the layout of the Bracknell JSNA– currently this is set to be 'How

Healthy Is Wokingham?'. Initial page navigation and site design has begun.

Council officers across a number of services have raised several population projection / demographic questions; and these are being followed up by a small task and finish group. Firstly, all such demographic questions are being collated and the wider group will meet shortly afterwards to discuss the skills needed to answer these; to discuss the tools already available to us to help answer them (e.g. using the new homes survey) and to devise a plan to fill the knowledge gaps as soon as possible. Please let public health know of any additional questions you may have.

Conclusion

The JSNA update and redesign process is progressing well, with good buy in from many services within the Council, however it must be stressed that the JSNA is a fluid document with new data being added as and when it is released. The JSNA website proposal is scheduled to go to the Health and Wellbeing board on the 10th of December. Final launch is scheduled for January 2016.

FINANCIAL IMPLICATIONS OF THE RECOMMENDATION

The Council faces severe financial challenges over the coming years as a result of the austerity measures implemented by the Government and subsequent reductions to public sector funding. It is estimated that Wokingham Borough Council will be required to make budget reductions in excess of £20m over the next three years and all Executive decisions should be made in this context.

	How much will it Cost/ (Save)	Is there sufficient funding – if not quantify the Shortfall	Revenue or Capital?
Current Financial Year (Year 1) 14/15	N/A	N/A	N/A
Next Financial Year (Year 2) 15/16	N/A	N/A	N/A
Following Financial Year (Year 3) 16/17	N/A	N/A	N/A

Other financial information relevant to the Recommendation/Decision
N/A

Cross-Council Implications
This proposal has the potential to effect major change in the way the Council undertakes commissioning and discharges its legal responsibilities for health and wellbeing. It has the potential to enable all departments to contribute to working as "One Council" to deliver its vision and priorities for all our residents.

Reasons for considering the report in Part 2
Not applicable

List of Background Papers
Joint Strategic Needs Assessment Wokingham (online) Joint Health and Wellbeing Strategy for Wokingham Borough 2014-17 Public Health Outcomes Framework

JSNAs for Kent; Surrey; Bracknell Forest and Wakefield.

Contact Darrell Gale	**Service** Public Health
Telephone No 0118 908 8195	**Email** darrell.gale@wokingham.gov.uk
Date 17th November 2015	**Version No.** 1

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healthwatch Wokingham Borough

Intelligence & Engagement Report

1st July – 30th September 2015

Summary of key findings

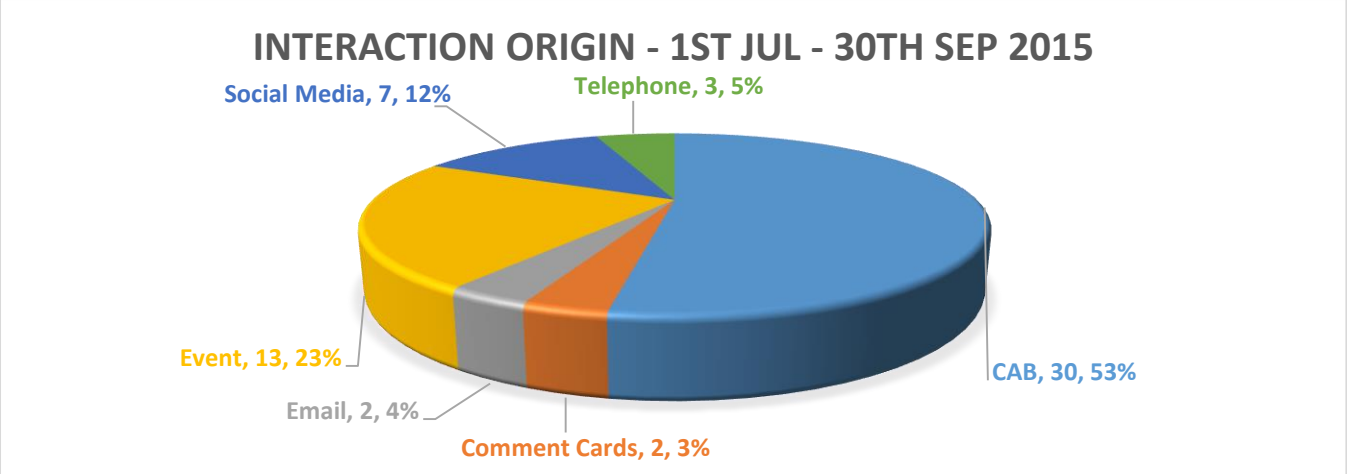
Key issues by Service Type

Table below summarises the key issues reported.

Hospital Services	• Medical jargon in consultants letter means patient doesn't understand consultant diagnosis and plan for treatment • After initial consultation patient has to wait further 6 months for follow up appointment whilst in severe pain • Parking issues at hospital (2 issues) • Patient had appointment for injections but no one at hospital knew where patient had to go for injection • Patient had cancer and after consultation and treatment wasn't sign posted to any support agencies e.g. McMillan, Sue Ryder • Year after patient had operation he was still unwell, follow up operation found cotton swab in stomach from initial operation
GP Services	• Unable to get Doctors appointment (3 issues) • Misdiagnosis. Patient provided medication but when symptoms didn't clear one patient insisted on referral, another patient went to private hospital. Both were subsequently diagnosed with cancer • Letter from dentist to GP identifying treatment patient should receive was not acted on by GP Surgery until patient questioned GP Surgery • Copy of letter from GP to Hospital consultant contained medical jargon which patient couldn't understand • Delay in signing repeat prescriptions for patients
Finance	• Financial viability and transparency of fees for care homes (9 issues raised)

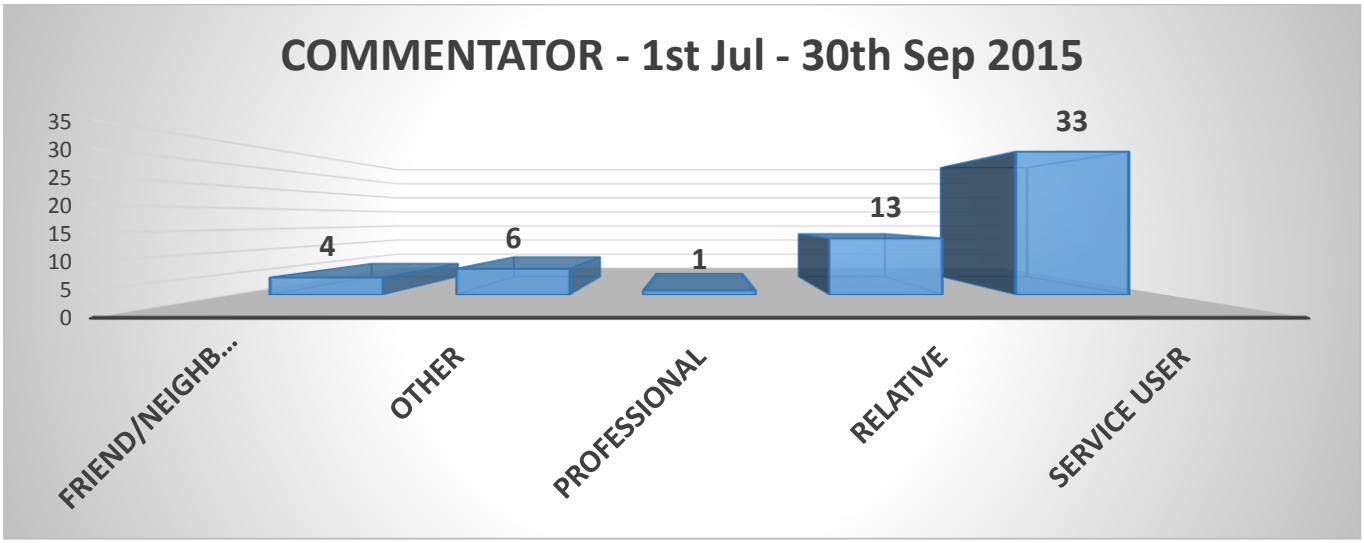
Where does our data come from?

We receive public's comments in various ways. For the 3 month period Jul-Sep we received 57 comments from Wokingham Borough residents. Comments to the Citizens Advice Bureau accounted for 53%, events attended by Healthwatch accounted for 23% and comments via Social Media were 12%. The remainder of comments came via telephone, email and comment cards.



Commentator Type

For the 3 month period Jul - Sep the majority of contacts, 33, were from the service user. 12 comments came from the service users' relative. The remainder came from a professional, friend/neighbour and 'other'.



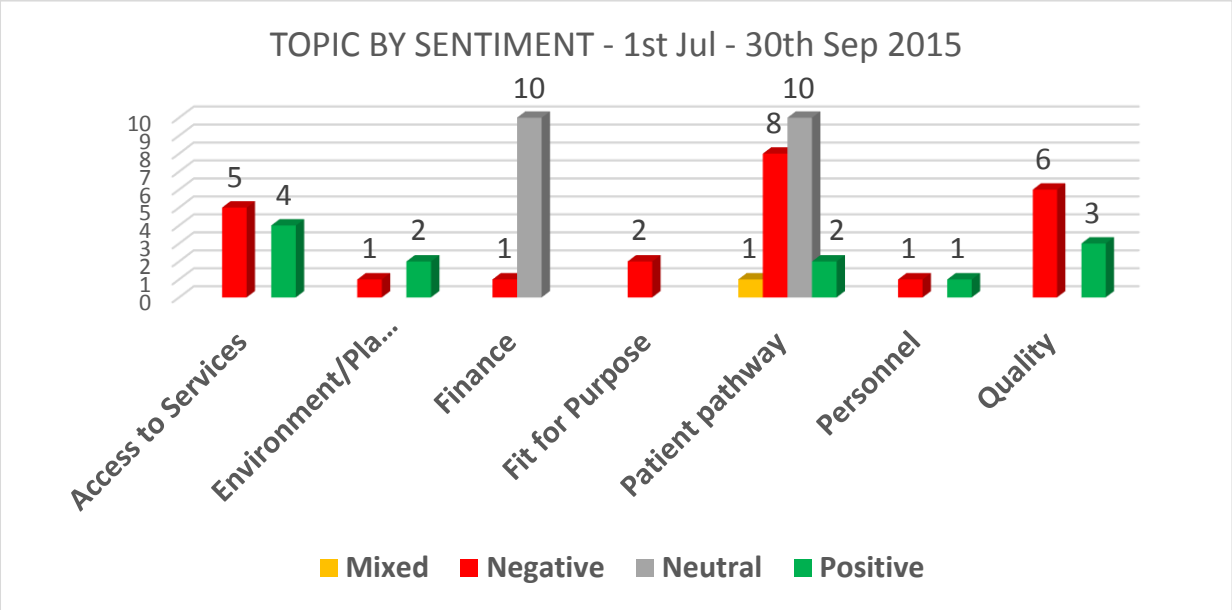
What issues were reported?

Topics are broad categories of issues, giving a general idea of the subject of comments received. We also record the 'sentiment' of comments, as for example, a comment could be positive or negative.

The most comments related to Patient Pathway, 37 %. Comments related to Finance accounted for 19%. The comments were primarily related to queries about the cost

of care and a lack of understanding about how much an individual would have to pay towards the care costs. 9% of comments related to Quality and 9% for Access To Service.

Taking into account all comments, 42% were negative in sentiment, 35% were neutral, 21% were positive and 2% mixed in sentiment



So What Difference Did Healthwatch Make?

We met with Support Horizons, LD Provider. At the meeting Support Horizons told us that they weren't being invited to reviews of their service users and were concerned that their input about the user was not being heard and that could potentially have an impact on the user.

We arranged a meeting with WBC brokerage team where we discussed the concerns. It became clear, at that meeting, that there was confusion about terminology used between professionals, for example the words 'review' and 'assessment' meant different things to Social Workers as to what it meant to Service Providers.

Other issues were also highlighted, including meeting invites or information requests being sent from the brokerage team to Support Horizons key workers; however those key workers may have moved on so the requests were never seen or acted upon. The Council brokerage team organised an 'away' day to look at the issues and as a result new processes were implemented around service user reviews and assessments.

Our Deaf Blind Champion has been actively involved in the town centre regeneration meetings – raising points that often would not have been thought of by the developers and planners.

Healthwatch Reports published this quarter

Frimley Park Report – July 2015

Westmead Day Centre Report – September 2015
http://www.healthwatchwokingham.co.uk/sites/default/files/westmead_report_0.pdf

Transport You Tube Video - October 2015
(http://www.healthwatchwokingham.co.uk/)

Engagement

A key task for Healthwatch is to engage with local residents. The purpose of this is three fold. Firstly, it raises awareness with local residents of our role and provides them with information so they know how to contact us. Secondly it enables us to collect residents' stories, at engagement events, if they have something they want to share at that time. Thirdly, if residents raise a query about other services that might be useful to them we are able to sign post them to appropriate services.

The table below shows where Healthwatch has been engaging between Jul-Sep.

JULY	POP UP IN COMMUNITY	EVENTS	USER GROUPS
6th July		St Crispin School Assembly	
7th July		St Crispin School Assembly	
9th July			Age Concern Twyford
15th July			Alzheimer's Café Wokingham
21st July		Children Provider Event	
23rd July	Woodley Town Centre		
AUGUST			
4th August			Age Concern Twyford
12th August			Berkshire Carers
27th August	Arborfield Garden Centre		
SEPTEMBER			
7th September			Market Place Regeneration Accessibility Group
8th September			Mencap Carers Lunch Club BME Forum
22nd September	Twyford Train Station	Town Council Meetings x2	
24th September	Wokingham Town Centre		
25th September		Flu Clinics at WMC, Woodley and Parkside Surgeries	Market Place Regeneration Accessibility Group

NHS
Wokingham
Clinical Commissioning Group

Agenda Item 12: WOK15.11.09

Report of Wokingham CCG Governing Body – 3 November 2015

Title	M5 2015-16 Performance Outcomes Report
Sponsoring Director	Debbie Daly, Nurse Director
Author(s)	Debbie New, Head of Performance
Purpose	To inform the Governing Body of the performance against CCG Clinical Indicators
Previously considered by	None
Risk and Assurance	As detailed within report
Legal implications/regulatory requirements	None
Public Sector Equality Duty	N/A
Links to the NHS Constitution (relevant patient/staff rights) *All NHS organisations are required by law to take account of the NHS Constitution in performing their NHS functions*	All
Consultation, public engagement & partnership working implications/impact	N/A

Executive Summary

Under performance:	High performance & improvement to green:
• Referral to treatment 18 and 52 week weeks • Cancer wait times • Ambulance response times • Ambulance handover and crew clear delays • 111 Call Answer Time • Antibiotic Prescribing • Mixed Sex Accommodation • Cdiff	• Diagnostics % waiting 6 weeks or more • % of patients who spent 4 hours or less in A&E • MRSA

Recommendation

Note the level of compliance with the operating targets and support the actions being taken to improve performance where necessary.

Elective Care

NHS Constitution and Quality Premium Pre-requisite	Referral to Treatment (RTT) within 18 and 52 Weeks	Current Period	YTD
		Red	Red

Wokingham CCG did not achieve the admitted RTT standard in August. The admitted standard was 87.7% against a target of 90%. This was due to continued under performance at RBFT against the RTT standards, although performance is improving at the Trust month on month. The recovery trajectory was due to recover in August once the backlog of patients waiting was cleared but this was not achieved. The Trust has submitted a draft recovery plan to the CCG which is currently being refined following comments and questions from the CCG. The admitted RTT standard has now been removed from the national requirements to ensure the focus is on incomplete pathways where patients are still waiting. Therefore the focus of the recovery plan with RBFT is also focusing on backlog clearance to ensure the number of patients waiting beyond 18 weeks reduces.

There continues to also be a number of 52 week wait breaches at RBFT and the Trust reported that 11 patients were still waiting at the end of August who had waited longer than 52 weeks. The CCG reviews the patients one by one with RBFT on a regular basis and there is a plan for each patient with the expectation that all 52 week waits will be cleared by the end of November.

NHS Constitution	Cancer Wait Times	Current Period	YTD
		Red	Red

Although the CCG is held to account on quarterly performance of cancer waiting times and therefore the performance figures have not been updated in the detailed performance report, it is important that the Governing Body receives an update on the latest cancer wait times position at RBFT. A remedial action plan was agreed in August which included a monthly trajectory for the 2ww standard from GP referral, the 2ww standard for symptomatic breast referrals and the 62 day standard from GP referral. Performance has now been reviewed against these trajectories for August and the 2ww for symptomatic breast and the 62 day from GP referrals standards were on track with the trajectory. The 2ww standard from GP referral was not on track with the trajectory with 62.6% of patients having an appointment in 2 weeks against a trajectory of 85.7%. This under performance primarily relates to issues within the Dermatology pathway as RBFT has had Consultant vacancies that have not been filled due to a national shortage. There was a locum Consultant who was in post but left at short notice during August. The CCG is therefore working very closely with RBFT to determine what can be done in the short term to increase capacity for dermatology and there is also a more strategic meeting planned to look at a longer term solution.

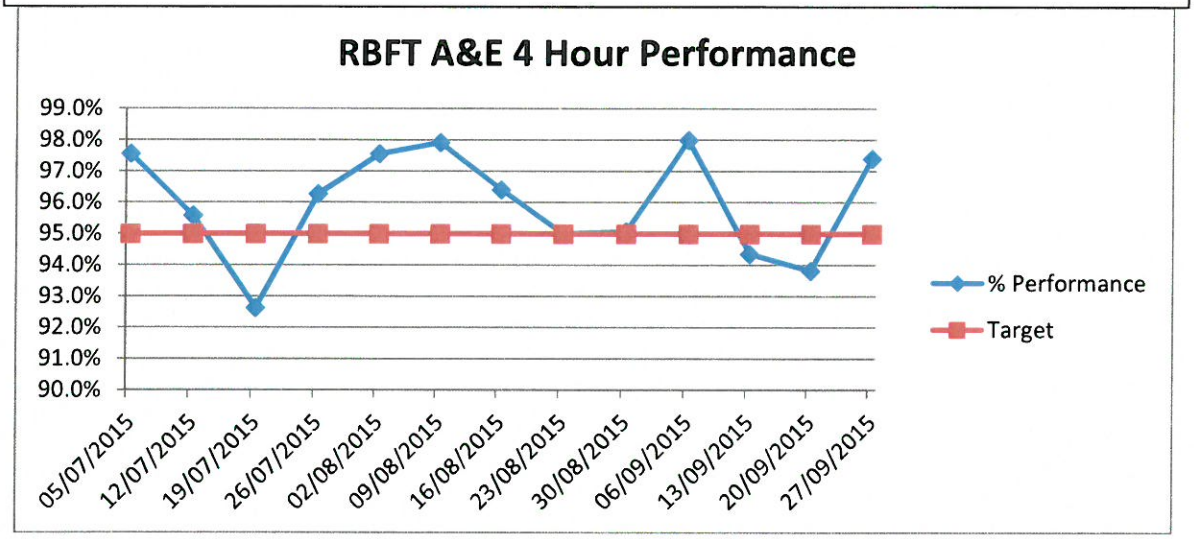
NHS Constitution	Diagnostics % waiting 6 weeks or more	Current Period	YTD
		Green	Green

At the end of August, 0.97% of the Wokingham CCG patients waiting for a diagnostic test had waited longer than 6 weeks against a target of 1%. YTD performance is 0.7%.

Urgent Care

NHS Constitution and Quality Premium Pre-requisite	% of Patients Who Spent 4 Hours or Less in A&E	Current Period	YTD
		Green	Green

During August, 96.1% of patients spent 4 hours or less in Accident and Emergency at RBFT and the target for this indicator is 95%. YTD performance is 95.9%.



NHS Constitution and Quality Premium Pre-requisite	Ambulance response times	Current Period	YTD
		Red	Red

The ambulance service contract requires the national performance standards for ambulance response times to be achieved on a Thames Valley basis annually. The 2015/16 contract also includes performance standards for each of the CCGs to improve the variation from CCG to CCG. The national standard for the Red 1 and Red 2 8 minute response time is 75% and the Wokingham CCG target is 73% for Red 1 calls and 70% for Red 2.

During August neither the Thames Valley wide nor CCG level standards were achieved for Red 1, Red 2 or Red 19 calls. Performance in August continued to be affected by the IT system upgrade that took place in July. SCAS are undertaking a review to understand the gap in delivery as a result of the IT system versus resources on the road. The Thames Valley Commissioners met on 1st October to review the latest performance and to agree what action Commissioners would take to address the performance. Following this, a letter was sent to SCAS highlighting the CCG concerns and within this there was a contractual performance notice and financial withholding notice. A further meeting is now being arranged with all commissioners and SCAS so that SCAS can present their plans for recovery and provide assurance to Commissioners.

Supporting Measure for NHS Constitution	Ambulance Handover and Crew Clear Delays	Current Period	YTD
		Red	Red

During August, 12 ambulances were delayed longer than 30 minutes and 1 ambulance over an hour for handover to the A&E department at RBFT. RBFT continue to work with SCAS to ensure the number of handover delays are minimised wherever possible. The CCG continue to serve the appropriate contractual fines of £1000 per delay over 60 minutes and £200 per delay over 30 minutes.

During August, SCAS had 54 crew clear delays at RBFT over 30 minutes and 4 over an hour which was a deterioration from previous months. These breaches result in a fine to SCAS for the delay and these are being addressed via the contractual meetings with the Trust. SCAS has reported that these delays are due to extenuating circumstances, for example a trauma event where the crew spend more time with the hospital after handover to support the patient care and also the ambulance may take longer to complete the deep clean due to extenuating circumstances.

National Standard	111 Call Answer Times	Current Period	YTD
		Red	Green

During September, 94.9% of 111 calls were answered within 60 seconds across Berkshire against a target of 95%. The YTD performance remains above standard at 96.4%. During September, SCAS has reported an altered demand profile in the evenings and early mornings resulting in staff numbers not always matching demand. SCAS are therefore re-profiling their forecasts and will amend staffing levels accordingly.

Other

Quality Premium	Antibiotic Prescribing	Current Period	YTD
		Red	Red

The CCG is required to reduce the overall levels of antibiotics prescribed in primary care (including community services) and to also ensure that less than 11.3% of all antibiotics prescribed in primary care are broad spectrum antibiotics (aka 4 C's). The CCG has made an improvement in August on the 12 month rolling position for overall antibiotics prescribed and is currently below the target. The medicines optimisation team will now continue to work with practices to ensure this can be sustained going forward. There has been an increase in broad spectrum antibiotics prescribed during August to 11.9% against the 11.3% target. The medicines optimisation team will work with practices, and Westcall (who are included in Wokingham CCG figures), to support improvement.

NHS Constitution	Mixed Sex Accommodation Breaches	Current Period	YTD
		Red	Red

Wokingham CCG had 12 mixed sex accommodation breaches at RBFT during August. This was due to RBFT reporting a number of breaches on the acute medical unit. These breaches occurred when RBFT had higher numbers of admissions late into the evening and

the department has identified this as a challenge relating to whether to move a patient late in the evening to avoid a mixed sex breach or not. The Trust has now implemented a new process during September to avoid this happening in the future whereby a better prediction of admissions is made in the evening at which point changes may take place to avoid moving patients in the night once settled. Each breach results in a £250 fine to RBFT.

Outcome Ambition Supporting Measure	MRSA	Current Period	YTD
		Green	Green
Wokingham CCG had zero MRSA bacteraemia cases reported during August 2015.			

Outcome Ambition Supporting Measure	Cdiff	Current Period	YTD
		Red	Green
Wokingham CCG had six Clostridium Difficile cases reported during August against a monthly trajectory of 4 meaning there have been 10 cases YTD against a trajectory of 14. The Community Infection Control Nurse is in the process of completing root cause analyses of the cases with the GP practices and will report findings of these to the CCG Quality Committee.			

Glossary

CCG	**Clincial Commissioning Group**
CQN	Contract Query Notice
RTT	Referral to Treatment
Admitted RTT Pathways	Patients whose RTT clock has stopped as a result of a treatment provided on admission, i.e. day case or elective procedure
Non-Admitted RTT Pathways	Patients whose RTT clock has stopped without the need for an admission. This could be treatment in outpatients or a decision in outpatients not to treat the patient
Incomplete RTT Pathways	Patients whose RTT clock has not stopped yet so the patients are still waiting for treatment or a decision not to treat
CQUIN	Commissioning for Quality and Innovation
CQRG	Clinical Quality Review Group
EPR	Electronic Patient Record
CVD	Cardiovascular Disease
NEL	Non-Elective
HCAI	Healthcare Acquired Infection
CDiff	Clostridium Difficile
MRSA	Methicillin-Resistant Staphylococcus Aureus
A&E	Accident & Emergency
2ww	Two week wait
MSA	Mixed Sex Accommodation
CPA	Care Programme Approach
OOH	Out of Hours
IAPT	Improved Access to Psychological Therapies
COPD	Chronic Obstructive Pulmonary Disease
VTE	Venous Thrombus Embolism
TIA	Transient Ischemic Attack
C&B or CaB	Choose & Book
OP	Outpatient
RBFT	Royal Berkshire Foundation Trust
GWH	Great Western Hospital (Swindon)
HHFT	Hampshire Hospitals Foundation Trust

HEALTH OVERVIEW AND SCRUTINY COMMITTEE

Work Programme 2015/16 from June 2015

Please note that the work programme is a 'live' document and subject to change at short notice.

The order in which items are listed at this stage may not reflect the order they subsequently appear on the agenda / are dealt with at the scrutiny meeting.

All Meetings start at 7pm in the Civic Offices, Shute End, Wokingham, unless otherwise stated.

DATE OF MEETING	ITEMS	PURPOSE OF REPORT AND REASON FOR CONSIDERATION	REPORTING OFFICER AND OFFICER CONTACT	COUNCIL PRIORITY/ UNDERPINNING PRINCIPLE	COMMENTS
Tuesday 26 January 2016	**Update on CQC**	To gain a better understanding of the work of the CQC	CQC	Improve health, wellbeing and quality of life	
	Report of the possible implications for scrutiny of the Francis Report Working Group – follow up of recommendations	To follow up on recommendations of possible implications for scrutiny of the Francis Report Working Group	Madeleine Shopland	Look after the vulnerable Improve health, wellbeing and quality of life	
	Update from Council's representative on Berkshire Healthcare NHS Foundation Trust and Royal Berkshire Hospital Foundation Trust – Board of Governors	Councillor Pitts, be invited to provide an update on his role and share information where appropriate.	Democratic Services	Improve health, wellbeing and quality of life Look after the vulnerable	
	Update from Health and Wellbeing Board	To inform HOSC of the work of the HWB and for HOSC to hold the Board to account	Chairman Health & Wellbeing Board	Look after the vulnerable Improve health, wellbeing and quality of life	
	Performance Outcomes Report	To monitor performance and identify any areas of concern	CCG	Improve health, wellbeing and quality of life	
	Health Consultation Report	Challenge item	Democratic	Improve health,	

DATE OF MEETING	ITEMS	PURPOSE OF REPORT AND REASON FOR CONSIDERATION	REPORTING OFFICER AND OFFICER CONTACT	COUNCIL PRIORITY/ UNDERPINNING PRINCIPLE	COMMENTS
			Services	wellbeing and quality of life	
	Healthwatch update	Challenge item	Healthwatch Wokingham Borough	Look after the vulnerable Improve health, wellbeing and quality of life	
	Work Programme	Standing item	Democratic Services		

DATE OF MEETING	ITEMS	PURPOSE OF REPORT AND REASON FOR CONSIDERATION	REPORTING OFFICER AND OFFICER CONTACT	COUNCIL PRIORITY/ UNDERPINNING PRINCIPLE	COMMENTS
Wednesday 23 March 2016	**Suicide prevention - update**	To receive a further update regarding suicide prevention in the Borough.	Public Health	Look after the vulnerable Improve health, wellbeing and quality of life	
	Performance Outcomes Report	To monitor performance and identify any areas of concern	CCG	Improve health, wellbeing and quality of life	
	Health Consultation Report	Challenge item	Democratic Services	Improve health, wellbeing and quality of life	
	Healthwatch update	Challenge item	Healthwatch Wokingham Borough	Look after the vulnerable Improve health, wellbeing and quality of life	

Currently unscheduled topics:

- Draft Quality Accounts
  - Berkshire Healthcare NHS Foundation Trust
  - Royal Berkshire Hospital NHS Foundation Trust
  - South Central Ambulance NHS Foundation Trust
- Update on Berkshire Healthcare Foundation Trust
- Independent Living Fund – update once reviews have been completed

HEALTH OVERVIEW AND SCRUTINY COMMITTEE
TRACKING NOTE 2015/16

ITEM NO.	ITEM/SUBJECT	OFFICER RESPONSIBLE	DATE OF MEETING	DUE DATE	COMMENTS	RESPONSE
1.	**Minute 6 Royal Berkshire Hospital** • It was suggested that a senior manager or physician provide an update on the GP in admissions pilot.	**Royal Berkshire Hospital - TBC**	**03.06.15**	**TBC**		
2.	**Minute 7 – Suicide Audit** • That an update on the suicide audit be provided at a future meeting.	**Helene Dyson**	**03.06.15**	**TBC**		
3.	**Minute 11 – Work Programme**		**03.06.15**			
	• The Committee agreed that it wished to receive an update on NHS 111 at its July meeting.	**TBC**		**28.07.15**	**Complete**	
	• Members requested a briefing on the impact of the closure of the Independent Living Fund at its September meeting.	**Stuart Rowbotham**		**29.09.15**		
	• Members also agreed that they wished to receive an update on Wokingham hospital.	**David Cahill, BHFT**		**TBC**		
	• Members wished to receive updates on the work of South Central Ambulance Service, the Clinical Commissioning Group, the CQC and Berkshire Healthcare Foundation Trust during the municipal year.	**TBC**		**30.11.15, 26.01.16, 23.03.16**	**Programmed**	
	• Councillor Richards proposed that the Committee looked at the local policy towards use of the European Health Card. It was agreed that further information be sought.	**Madeleine Shopland**			**Complete**	
	• The Committee agreed to undertake a review of the following Better Care Fund schemes; Neighbourhood	**Task and Finish Group**		**September 2015**		

ITEM NO.	ITEM/SUBJECT	OFFICER RESPONSIBLE	DATE OF MEETING	DUE DATE	COMMENTS	RESPONSE
	clusters, Primary prevention and Self-Care and Access to General Practice					
4.	**Minute 18 – Sexual Health Services Recommissioning** • Information regarding the age range and genders of those using the sexual health treatment services and the different infections and treatments, was requested to give the Committee a clearer picture of local service users and the different infections and treatment.	**Darrell Gale**	**28.07.15**	**Asap**		
5.	**Minute 20 – Work Programme**					
	• Members requested that Councillor McGhee-Sumner be invited to provide an update on his area, including the impact of the delay of the second phase of the Care Act, at the September meeting.	**Madeleine Shopland**	**28.07.15**	**29.09.15**	**Complete**	
	• It was suggested that the Council's representative on Berkshire Healthcare NHS Foundation Trust and Royal Berkshire Hospital Foundation Trust – Board of Governors, Councillor Pitts, be invited to the Committee's September meeting to provide an update on his role and share information where appropriate.	**Madeleine Shopland**	**28.07.15**	**29.09.15**		
	• It was agreed to programme an update on the JSNA for the September meeting and an update on the HWBS for the Committee's January meeting.	**Darrell Gale**	**28.07.15**	**29.09.15 and 26.01.16**	**Deferred to November meeting 30.11.15**	

ITEM NO.	ITEM/SUBJECT	OFFICER RESPONSIBLE	DATE OF MEETING	DUE DATE	COMMENTS	RESPONSE
6.	**Minute 26 - Update on Health and Wellbeing Board** • The Committee was informed of the Frail Elderly Pathway which looked to track individuals through the health and social care system. The Director of Health and Wellbeing offered to bring the data sets for the Frail Elderly Pathway to the Committee's November meeting. • Councillor McGhee-Sumner added that care home fees had been held for the last 4-5 years but this too was becoming unsustainable as the National Living Wage increased. Councillor Miall requested that the Committee be kept updated on the matter.	**Stuart Rowbotham**	**29.09.15** **29.09.15**	**30.11.15** **Ongoing**		
7.	**Minute 28 Independent Living Fund update** • Councillor Swaddle asked what the situation was of the 19th individual of the cases identified pre transfer. The Director of Health and Wellbeing agreed to look into this and to feed back to the Principal Democratic Services Officer. • A further report be provided to the Committee once all reviews have been completed.	**Stuart Rowbotham**	**29.09.15** **29.09.15**	**As soon as possible** **TBC**	**Complete**	
8.	**Minute 30 – Work Programme** • It was…proposed that the items on the Report of the Possible	**Madeleine Shopland**	**29.09.15**	**26.01.15**		

ITEM NO.	ITEM/SUBJECT	OFFICER RESPONSIBLE	DATE OF MEETING	DUE DATE	COMMENTS	RESPONSE
96	Implications for Scrutiny of the Francis Report Working Group – follow up of recommendations and Update from Council's representative on Berkshire Healthcare NHS Foundation Trust and Royal Berkshire Foundation Trust – Board of Governors, be deferred to the Committee's January meeting to ensure a more manageable agenda. • Members were requested to email the Principal Democratic Services Officer with any questions they had or areas that they wished to focus on regarding the Joint Strategic Needs Assessment and the South Central Ambulance Service. • Councillor Haines raised an issue regarding community responders and the provision of defibrillator equipment. The Principal Democratic Services Officer agreed to follow this up. • A member of the public informed the Committee of NHS Wokingham CCG's consultation on its vision for the future of GP and primary care services and the public event on 20 October. It was suggested that some Committee members may wish to attend.	**Health Overview and Scrutiny Committee** **Madeleine Shopland** **Health Overview and Scrutiny Committee**	**29.09.15** **29.09.15** **29.09.15**	**30.11.15** **As soon possible** **20.10.15**	**Completed**	

Glossary:

- **Bariatrics** – branch of medicine that deals with the causes, prevention, and treatment of obesity.
- **BCF** – Better Care Fund
- **BHFT** – Berkshire Healthcare NHS Foundation Trust
- **C&B** – **(Choose and Book)** is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic.
- **CAM** - Confusion Assessment Method
- **CAMHS** – Child and Adolescent Mental Health Services
- **CCG** – Clinical Commissioning Group
- **CDU** – Clinical Decisions Unit
- **CHIS** - Child Health Information Systems - patient administration systems that provide a clinical record for individual children and support a variety of child health and related activities, including universal services for population health and support for statutory functions.
- **CNS** – Clinical Nurse Specialist
- **Community Enhanced Service** - a service provided in a community setting which goes above and beyond what is normally commissioned by NHS England, including primary care services that go beyond the scope of the GP contract.
- **Contract Query Notice** - A specific action taken by the commissioner against the Provider as per the contract. It is a notice served when a contractual target is not being met. As a result of such a notice, an action must be agreed that results in recovery of performance within a set timescale.
- **COF** - Commissioning Outcomes Framework
- **CoSRR** - Continuity of Services risk rating
- **CPA** - **Care Programme Approach** - is a system of delivering community mental health services to individuals diagnosed with a mental illness
- **CPN** - Community Psychiatric Nurse
- **CQC** – Care Quality Commission
- **CQUIN** – **Commissioning for Quality and Innovation** - Is an incentivised money reward scheme that has been developed to allocate payments to providers if they meet quality outcomes identified to improve local quality issues.

- **CST** - Cognitive Stimulation Therapy
- **CSU** - Commissioning Support Unit
- **Cytology** – the study of cells
- **DPH** – Director of Public Health
- **DTOC** – Delayed Transfer of Care
- **EDT** – Electronic Document Transfer
- **ECO** – Emergency Operations Centre
- **EOL** – end of life care
- **EPR** – **Electronic Patient Record** – means of viewing a patient's medical record via a computerised interface.
- **ESD** – Early Supported Discharge service - pathways of care for people transferred from an inpatient environment to a primary care setting to continue a period of rehabilitation, reablement and recuperation at a similar level of intensity and delivered by staff with the same level of expertise as they would have received in the inpatient setting.
- **FFCE** - **First Finished Consultant Episode** - first completed episode of a patient's stay in hospital.
- **FPH** – Frimley Park Hospital
- **GMS** – General Medical Services
- **GRACe** - General Referral Assessment Centre
- **GSCC** – General Social Care Council
- **HALO** - Hospital Ambulance Liaison Officer
- **HASU** - Hyper-Acute Stroke Unit
- **HWPFT** - Heatherwood and Wexham Park Hospitals NHS Foundation Trust
- **JSNA** – Joint Strategic Needs Assessment
- **LA** – local authority
- **LES** – Local Enhanced Service
- **LOS** - Length of Stay

- **LTC** – long term conditions
- **MDT** – multi disciplinary team
- **MH** – Mental Health
- **MHP** - mental health practitioner
- **MIU** – Minor Injuries Unit
- **Monitor** - Oversees the performance of NHS Foundation Trusts
- **MSA** - Mixed sex accommodation
- **NARP** – National Ambulance Response Pilot
- **Never Events -** Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented
- **NHSCB** – National Health Service Commissioning Board (now NHS England)
- **NHS Safety Thermometer** –tool to measure 4 high volume patient safety issues – falls in care; pressure ulcers; urinary infections (in patients with a urinary catheter); and treatment for VTE
- **NICE** – National Institute of Health and Care Excellence
- **NEL** - Non elected admissions
- **OHPA** – Office of the Health Professions Regulator
- **ONS** – Office for National Statistics
- **OOH** – Out of Hours
- **Ophthalmology** – branch of medicine that deals with diseases of the eye
- **OPMHS** – Older Persons Mental Health Services
- **Orthopaedics** - branch of surgery concerned with conditions involving the musculoskeletal system
- **OT** – Occupational Therapy
- **Outlier** - a person or thing situated away or detached from the main body or system.
- **PALS** – Patient Advice and Liaison Service
- **PHE** – Public Health England

- **PPCI** – Primary Percutaneous Coronary Intervention

- **PPIs** - Proton Pump Inhibitors

- **PROMs** - **Patient Reported Outcome measures** are questions asked of patients before and after a specific treatment, to measure improvements to quality of life from the patient's point of view.

- **QIPP** - **Quality, Innovation, Productivity and Prevention.** The purpose of the programme is to support commissioners and providers to develop service improvement and redesign initiatives that improve productivity, eliminate waste and drive up clinical quality.

- **RAT** – Rapid Access Treatment

- **RBFT/ RBH** - Royal Berkshire NHS Foundation Trust

- **RCA** – **Root Cause Analysis** - When incidents happen, Roots Cause Analysis Investigation is a means of ensuring that lessons are learned across the NHS to prevent the same incident occurring elsewhere.

- **RGN** - Registered General Nurses

- **RMN** - Registered Mental Health Nurses

- **RTT** - **referral to treatment time** – waiting time between being referred and beginning treatment.

- **SCAS** – South Central Ambulance Service

- **SCR** – **Summary Care Record** - electronic record which contains information about the medicines you take, allergies you suffer from and any bad reactions to medicines you have had in the past.

- **SEAP** – Support Empower Advocate Promote - confidential, independent advocacy service (health and mental health)

- **SHMI - Summary Hospital-level Mortality Indicator -** ratio between the actual number of patients who die following treatment at a trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. Covers all deaths reported of patients who were admitted to non-specialist acute trusts in England and either die while in hospital or within 30 days of discharge.

- **SIRI** – Serious incidents that require investigation

- **SLA** – Service Level Agreement

- **SPOC** – Single point of contact

- **SSNAP** - Sentinel Stroke National Audit Programme
- **STAR-PU** - **Specific Therapeutic group Age-sex Related Prescribing Units** - a way of weighting patients to account for differences in demography when distributing resources or comparing prescribing.
- **SUSD** – Step Up Step Down
- **Talking Therapies** – free and confidential counselling service with a team of advisors and therapists.
- **Thrombolysis** – breakdown of blood clots by pharmacological means
- **TIA** - transient ischemic attack – mini stroke
- **TTO** – to take out
- **TVPCA** – Thames Valley Primary Care Agency
- **UCC** – Urgent Care Centre
- **VTE** - venous thrombosis -blood clot that forms within a vein
- **WBCH** – West Berkshire Community Hospital
- **WIC** – Walk in Centre
- **WISP** – Wokingham Integration Strategic Partnership
- **WTE** - whole-time equivalents (in context of staff)
- **YLL** – years of life lost
- **YPWD** - Younger People with Dementia
- **YTD** – Year to date

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