NHS
South Central
Ambulance Service
NHS Foundation Trust

Oxfordshire
Joint Health Overview & Scrutiny Committee (HOSC)
SCAS Improvement Programme Update

8th February 2024

Introduction

The **SCAS Improvement Programme** is broken down in to four functional workstreams, each with an accountable Executive:

- **Governance & Well Led** (Daryl Lutchmaya, Chief Governance Officer)
- **Culture & Staff Wellbeing** (Melanie Saunders, Chief People Officer)
- **Performance Improvement** (Mark Ainsworth, Executive Director of Operations)
- **Patient Safety** (Helen Young, Chief Nurse)

Programme governance follows a monthly reporting cycle of internal and external reporting, led by the Chief Executive Officer (CEO), David Eltringham, with oversight provided by the Executive Management Committee (EMC) and the Trust Board. Improvement Programme delivery and governance is led by the Chief Strategy Officer, Mike Murphy. The following key meetings, provide escalating levels of assurance:

- **Workstream Delivery Groups**. Chaired by the accountable Executive, with workstream delivery leads under the direction of a Senior Responsible Officer (SRO), supported by a Programme Manager
- **Improvement Programme Oversight Board (IPOB)**. Chaired by the CEO with full SCAS Executive membership with representation from the NHS England Recovery Support Programme (RSP) and lead Integrated Care Board (ICB), HIOW ICB
- **Tripartite Provider Assurance Meeting (TPAM)**. Chaired by HIOW ICB with wide representation from NHS England (National/Regional/RSP), ICBs (BOB/HIOW) and the Care Quality Commission (CQC)

The following report pack is representative of Improvement Programme reporting to IPOB and TPAM. This report covers progress to Dec 2023 and includes:

- Progress tracking of key deliverables, measured against Must and Should Do actions from the August 2022 CQC Well Led Inspection Report and agreed Exit Criteria measures, to meet the requirements for exiting the NHS Oversight Framework, segment 4 (NOF4) by 30 Sep 2024
- Workstream highlight reporting, including reporting of progress against key metrics in the workstream scorecards
- Plans on a Page, providing context, aims, measures and milestones by Improvement Programme workstream

Reporting is transparent with a focus on delivery of key actions and the embedding of those measures, underpinned by empirical data.

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Executive Summary

NHS South Central Ambulance Service NHS Foundation Trust

Good progress continues, but some impacts of REAP 4 and the Christmas period are being felt:

- Adoption of feedback mechanisms for Patients not conveyed to hospital continues to build across the UCR footprint, moving the actions in Performance Improvement to a Green RAG rating, with the status of embedding assessed as improving to Amber as a workstream, overall
- Approval of the GAAF at EMC and Board in December sets the conditions for rapid improvements in the Governance workstream in 2024, to be delivered by a now, fully-recruited Governance team
- We have seen a dip in the number of appraisals being delivered to staff, and the assessed level of embedding for this has been downgraded to Amber as a result. Stat and Mand compliance figures will also be fully assessed on receipt of Q3 data. These areas will (continue to) be prioritised by managers across the Trust, supported by Comms across internal leadership forums/networks

Key highlights this month:

- A full review of the Fit and Proper Persons (FPP) information has been held by the Governance team, supported by HR and presented to EMC
- Early indications from internal compassionate leadership survey and National Staff Survey (NSS) show the beginnings of improvements in leadership culture and behaviours. Reduction in formal disciplinary proceedings against staff is encouraging
- Review of Category 2 performance conducted with tangible action plan in development to improve Cat 2 performance through Q4 and beyond
- Improvements in Safeguarding continue, with the cut-over to the long-awaited new Safeguarding server successfully completed and a 24/7 advice line made available to staff. However, subsequent technical issues with automatic relaying of referrals to Local Authorities (LAs) has resulted in two SIs being declared. Escalation to a senior level with the provider (Doc-works) in progress, alongside triage to assess levels of harm resulting

SCAS IMPROVEMENT PROGRAMME

Programme Overview

December 2023

NHS South Central Ambulance Service NHS Foundation Trust

	Actions	Embedding		Actions	Embedding
Governance & Well Led:			Culture & Staff Wellbeing:		
Performance Improvement:			Patient Safety:		

Improvement Programme Summary:

Key Progress:

- The Governance Assurance and Accountability Framework (GAFF) was presented at EMC and Board the week of 11th December and approved. The embedding of the GAAF will now commence with comms and agenda items at Committee meetings, alongside the flow of information for Committee meetings being aligned to the Board
- Prioritised piece of work to review the current state of the Fit and Proper Persons information we hold to ensure we are compliant moving forward. Overview provided to EMC on the 11th December
- Review and refresh of Sexual Safety campaign commenced
- Compassionate leadership survey results show starting to see a shift in leadership behaviour and results from the National Staff Survey 2023 indicate statistically significant improvement in 5 compassionate leadership indicators. Number of staff entering formal disciplinary continues to reduce (down to 24 from 47 in 22/23) and a refresh of HR policies is progressing well (39% complete)
- Additional Private provider hours secured to commence end of December adding 3 additional DCA 24/7 by the end of January
- Review of Category 2 performance completed with an additional action plan to focus on C2 improvement
- Positive increase in Safeguarding metrics, with SAAF compliance rising to 97.8% with the cut-over to the new Doc-Works SG server successfully completed on 29 Nov 2023
- New Safeguarding telephone system went live 13 Dec 2023. SG advice now available 24/7 with direct transfer to OOH Social Work teams. Communicated to all staff

Key Risks/Issues:

- BAU capacity continues to be a challenge, exacerbated by vacant positions within the workstream delivery space. Operational pressures continue to place BAU resources under significant pressure
- Scale of change across organisation may be unsettling for our staff. Improvement, Modernisation and Financial Recovery programme comms will require careful management to minimise impacts and reassure staff

RAG Assessment:

No change to previous period reporting. Q3 Metric reporting in Feb 2024.

Complete & Embedded	On Track	Off Track (<1 month), Recovery Actions in Place	Overdue (>1 month)

Update on CQC Must and Should Dos

SCAS Improvement Programme: Must Do / Should Do Update

December 2023

Governance & Well Led [Daryl Lutchmaya]:		Actions	Embedding
Must	The trust must ensure the governance and risks processes are fit for purpose and ensure the ongoing assessment, monitoring and improve the quality and safety of the services provided. Regulation 17 (1) (2) (a) (b)		
Should	The trust should consider how to improve communication and relationships between staff and senior leaders		
Should	The trust should review methods of communication between senior executives and call takers in the EOC to ensure important information is received and understood		
Should	The trust should consider asking staff and patients with less positive experiences to present to the board to allow more opportunities for learning		
Culture & Staff Wellbeing [Melanie Saunders]:		**Actions**	**Embedding**
Must	The trust must ensure it takes staff's concerns seriously and takes demonstrable action to address their concerns. This to include where staff have raised concerns relating to bullying, harassment and sexually inappropriate behaviours. Regulation 17 (2) (b)		
Must	The trust must ensure that it listens and responds to staff who raise concerns in line with their own policy and the Public Interest Disclosure Act (1998)		
Should	The trust should ensure it provides appraisals and continuous professional development to all staff		
Should	The trust should ensure that staff complete mandatory training appropriate to their roles and responsibilities		
Should	The trust should ensure it continues working towards supporting the workforce in order to reduce the pressure and improve staff morale		
Should	The trust should ensure all staff receive a timely appraisal to assure leaders that competency is maintained		
Should	The trust should review the arrangements for the role of the Freedom to Speak Up Guardian to improve the speak up culture		
Performance Improvement [Mark Ainsworth]:		**Actions**	**Embedding**
Should	The trust should ensure that it continues to work towards meeting the key performance indicators on clinical call back times, call abandonment rates and call response times		
Should	The trust should consider ways to monitor outcomes for patients who are not transferred to hospital to ensure the pathways are used effectively and that decisions are made in the patients' best interest		
Should	The trust should consider revising their diversion policy to ensure they are transferred to hospital care in a timely way		
Should	The trust should ensure ambulances are staffed by appropriately skilled crews		

Complete & Embedded

On Track

Off Track (<1 month), Recovery Actions in Place

Overdue (>1 month)

SCAS Improvement Programme: Must Do / Should Do Update — December 2023

Performance Improvement [Mark Ainsworth]:		Actions	Embedding
Should	The trust should ensure that staff have enough time to report adverse incidents		
Should	The trust should ensure that staff, particularly newly qualified staff, receive appropriate clinical support and supervision to enable them to provide safe patient care		
Should	The trust should continue to identify ways to recruit staff according to their current strategy in order to improve the call handling times		
Should	The trust should improve response times in line with the Ambulance Response Programme		
Should	The trust should act to ensure the clinical welfare calls are completed within the targeted timeframes		
Should	The trust should optimise information systems to make less labour intensive for staff and improve efficiency in reporting		

Patient Safety [Helen Young]:		Actions	Embedding
Must	The trust must ensure all staff complete safeguarding training at the role appropriate level and any additional role specific training in line with the trust target. Regulation 18 (2) (a)		
Must	The trust must ensure that incidents are identified, reported and investigated in line with the NHS Serious Incident Reporting Framework, that action is taken to mitigate risks and that learning is shared across the organisation. Regulation 17 (2) (b) (e)		
Must	The board must be sighted on accurate information about serious incidents occurring at the trust to enable strategic oversight and planning. Regulation 17 (2) (b) (e)		
Must	The trust must ensure that where trends in adverse incidents are known that these are fully investigated, and action is taken to reduce future risks. 17 (2) (b) (e)		
Must	The trust must ensure that it meets the statutory requirements of the duty of candour. Regulation 20		
Must	The trust must provide a separate Mental Capacity Act (2005) Policy and ensure that staff understand the principles and application of the Mental Capacity Act (2005) Regulation 17 (1)		
Must	The trust must ensure medicines are managed in accordance with the national guidance and that only authorised persons have access to controlled drugs. Regulation 12 (2) (7)		
Must	The provider must ensure that systems and processes for managing safeguarding within the trust are adequately resourced, effective and monitored by the board. Regulation 13 (1) (2) (3)		
Should	The trust should ensure that medicines are always kept safely, whether in stations or on vehicles		
Should	The trust should ensure that any shortfalls in infection prevention and control are reviewed, and action taken where needed		

Complete & Embedded

On Track

Off Track (<1 month), Recovery Actions in Place

Overdue (>1 month)

Update on MD/SD Actions Rated RED

Governance & Well Led [Daryl Lutchmaya]:			Delivery	Embedding
Must	The trust must ensure the governance and risks processes are fit for purpose and ensure the ongoing assessment, monitoring and improve the quality and safety of the services provided. Regulation 17 (1) (2) (a) (b)			
Explanation: While the Regulation 17 gap analysis has now been completed and recorded the overall governance and risk processes of the Trust are not fit for purpose. Limited resource capacity within the teams has meant action completion has been delayed.		Mitigation: The Governance Assurance and Accountability Framework was approved at the December Board, and it was agreed that frequent reviews would be undertaken, and some amendments would be made. The subsequent actions to embed the framework will support transitioning the workstream to an amber rag status.		

Performance Improvement [Mark Ainsworth]:			Delivery	Embedding
Should	The trust should consider ways to monitor outcomes for patients who are not transferred to hospital to ensure the pathways are used effectively and that decisions are made in the patients' best interest			
Explanation: Technical solution has been implemented, is functioning well and there has been good uptake from UCR providers (on a voluntary basis). Delivery has moved from Amber to Green to reflect this.		Mitigation: Embedding has moved from Red to Amber to reflect the good uptake by UCR providers. Further stakeholder engagement is required in southern Hampshire to increase uptake (notably Southern Health and Solent).		

Update on Exit Criteria

SCAS Improvement Programme: Exit Criteria Update

December 2023

Governance & Well Led:	*Substantive improvement in governance and leadership with evidence of improved assurance and accountability*	**Daryl Lutchmaya**
1	Improved board effectiveness; use of Board Assurance Framework and significant progress in embedding recommendations from the governance review	
2	Improved assurance through effective corporate governance structures and information flows between committees and board	
3	Board development programme in place including senior leadership review completed with plan signed off and progressing	
4	Evidence of strengthened partnership working	
Culture & Staff Wellbeing:	*Board approved culture improvement programme in place, with evidence of improved engagement and experience from all staff including volunteers*	**Melanie Saunders**
1	Revised and approved People and OD Strategy to ensure SCAS has the necessary infrastructure to meet future need	
2	Culture Improvement Programme in place, including evidence of improved engagement	
3	Clear recruitment and retention plan, with agreed timeline and evidence of delivery to support the revised operating model (see below)	
4	Approved FTSU plan (strategy, process and function) with evidence of delivery against plan and impact	
Performance Improvement:	*Board approved plan for performance recovery and future operating model*	**Mark Ainsworth**
1	A clear plan for performance recovery which includes representation from quality, finance, contracting and human resources / workforce	*[Paul Kempster]*
2	Demonstration of improvement against performance recovery plans	
3	Demonstration of continued and sustained improvement in operational performance to be in line with the agreed trajectories in hear & treat and see & treat rates	
Patient Safety:	*Improvements in patient safety and experience, with evidence of effective systems and process in place around safeguarding and adverse incidents*	**Helen Young**
1	Embedded section 4.2.1 and the 11 core arrangements within the Safeguarding Accountability and Assurance Framework	
2	PSIRF plan developed, approved and published in partnership with the ICB with evidence of delivery against plan	
3	Evidence of improvement in Patient Safety and Just Culture	
4	Demonstrable improvement in learning from SIs (individual, organisation and system wide)	
5	Evidenced improved management of SIs	

Complete & Embedded

On Track

Off Track (<1 month), Recovery Actions in Place

Overdue (>1 month)

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Improvement Programme
Highlight Reports and Scorecards

Improvement Programme Highlight Report:	Governance and Well Led	December 2023	RAG:

Executive Lead: Daryl Lutchmaya ***Senior Responsible Officer: Daryl Lutchmaya*** ***Programme Manager: Amy Carden***

Workstream Summary (Incl. RAG Assessment):

The Governance Assurance and Accountability Framework was presented at EMC and Board the week of the 11th December and approved subject to quarterly reviews to ensure that it remains updated. The embedding of the GAAF will now commence with comms and agenda items at Committee meetings, alongside the flow of information for Committee meetings being aligned to the Board. These steps will transition the workstream to an amber rag status.

Progress Against Key Outcomes / Success Criteria:

- Fit and Proper Persons Framework policy drafted.
- Prioritised piece of work to review the current state of the Fit and Proper Persons information we hold to has been undertaken to ensure we are compliant moving forward.
- Risk maturity assessment (conducted by BDO) presented to Audit Committee on the 6th December and the Board on 14th December, along with a risk framework training session for Board members.
- A draft risk appetite statement was presented at Board on the 14th December with further development to take place.

Key Activity, Month Ahead:

- Funding received from South East Leadership Academy to support the development of the talent management piece.
- Full review of ToR's scheduled for January and February, following the approval of the GAAF.
- Drafting of risk reporting through Qlik and NPrint functionality.
- Creation of additional training material for all staff on Risk.

What's Gone Well:

- New members of staff in the OD Team and Governance Team have commenced employment with the Trust.
- Progress has been made on the structure and Executive Portfolios area of the hub improvements. The Comms team are working with the Chief People Officer to make the final updates.
- Substantial progress made with the internal audit actions tracker. This will provide the ability to report progress monthly and upward report into EMC.

What's Not Gone So Well:

- Exec feedback on the QR code for November Board was low. This has been followed up with a reminder of the importance of feedback being provided and the insight it gives.
- Not all areas have inputted their risks onto the new platform. Prompts have been given and where required escalation at RACSC and Committee meetings will take place.
- In date policies has reduced to 69%. Discussions ongoing to ensure policy reviews commence allowing time for the approval process.

Workstream Key Risks:

- Although recruitment to the Governance Team is complete and will support achieving accelerated progress towards implementation of key governance actions, a period of embedding will be needed.

Workstream Issues:

- None for escalation

SCAS Improvement Programme

Complete & Embedded | On Track | Off Track (<1 month), Recovery Actions in Place | Overdue (>1 month)

SCAS Improvement Plan Scorecard: Governance & Well Led — October – November 2023

No	Metric/s	Baseline (Date)	End Target (Date)	Aim/ Actual	Quarterly Trajectories								Comments
					2022/23		2023/2024				2024/25		
					Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	
1	Average timeliness of papers received by the Board and Committees per month (5 working days before meeting)	50% Q4 22/23	90% Q1 24/23	*Aim*	*N/A*	*N/A*	*50%*	*80%*	*80%*	*80%*	*90%*	*100%*	Data collected from QR code feedback October: Board Seminar (1 response) – 100% November: Board (7 responses, 5 NED, 2 ED) – 100% score PACC (1 response) – 100% score F&P (3 responses) – 67% score Q&S (2 responses) – 100% score
				Actual	N/A	N/A	50%	55%	100%				
2	Quality of papers for Board and Committees (as above) ('P' – Poor; 'A' – Average; 'G' – Good; 'E' – Excellent)	Average Q4 22/23	Excellent Q2 24/25	*Aim*	*N/A*	*N/A*	*A*	*A*	*A*	*G*	*G*	*E*	Data collected from QR code feedback October: Board Seminar (1 response) – E November: Board (7 responses, 5 NED, 2ED) – ED G/E NED G PACC (1 response) – G F&P (3 responses) – G Q&S (2 responses) – G
				Actual	N/A	N/A	-	G	G				
3	Board Effectiveness review by survey Quality of papers for Board and Committees (as above) ('P' – Poor; 'A' – Average; 'G' – Good; 'E' – Excellent)	Average Q4 22/23	Excellent Q3 23/24	*Aim*	*N/A*	*N/A*	*N/A*	*N/A*	*E*	*N/A*	*N/A*	*N/A*	Well-led review in Q3 - Focus: Strengths of the board/ Composition of the Board/Ability to resolve conflicts/ Regular reviews and reflections/vision, goals and focus of the Board/ Clear definition of roles & responsibilities / Level of constructive challenge.
				Actual	30%	64%	N/A	N/A	N/A				
4	Partners' satisfaction with joint working from SCAS (from 6 monthly survey) (Dissatisfied – 'D', Satisfied – 'S', Very Satisfied – 'V')	Satisfied Q4 22/23	Very Satisfied Q3 23/24	*Aim*	*N/A*	*N/A*	*S*	*N/A*	*VS*	*N/A*	*VS*	*N/A*	This metric will be reviewed following the decision on the approach the Trust will take to measure partnership working. Initial plans are currently being reviewed.
				Actual		3%	-	-	-				
5	Internal audit activities are being completed to plan No (<50%) Minimal (50% - 74%) Partial (75% -89%) Substantial (90% - 99%)	Minimal Q3 22/23	Yes	*Aim*	*N/A*	*N/A*	*95%*	*95%*	*95%*	*95%*	*100%*	*100%*	For Q2 1 of 12 due audit actions was completed. Metric is only measurable quarterly.
				Actual			Partial	No					

SCAS Improvement Plan Scorecard:				Governance & Well Led									October – November 2023
No	Metric/s	Baseline (Date)	End Target (Date)	Quarterly Trajectories									
				Aim/ Actual	2022/23		2023/2024				2024/25		Comments
					Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	
6	Effectiveness of committees ('P' -Poor, 'A' - Average, 'G' -Good or 'E' - Excellent)	Average Q4 22/23	Excellent	*Aim*	*N/A*	*N/A*	*A*	*A*	*A*	*G*	*G*	*E*	Data collected from QR code feedback October: Board Seminar (1 response) – E November: Board (7 responses, 5 NED, 2ED) – ED G/E NED A/G PACC (1 response) – G F&P (3 responses) – G/E Q&S (2 responses) – G
				Actual	N/A	N/A	-	G/E	G				
7	Effective accountability structures through organisation (link to performance improvement) ('P' -Poor, 'A' - Average, 'G' -Good or 'E' - Excellent)	Poor Q4 22/23	Excellent Q2 24/25	*Aim*	*N/A*	*N/A*	*A*	*A*	*A*	*G*	*G*	*E*	Chief Governance Officer's view based on progression of Governance Framework implementation. October – P November – A The GAAF was presented and approved at EMC and Board week of the 11th December.
				Actual	N/A	N/A	P	P	P/A				
8	Governance modules completed as part of leadership development	40% Q4 22/23	95% Q1 24/25	*Aim*	*N/A*	*N/A*	*50%*	*65%*	*75%*	*80%*	*95%*	*100%*	There is appetite for some Governance modules to be added to various development courses. These are not likely to be put into place until next year.
				Actual	N/A	N/A	-	-	-				
9	Monthly updating of the BAF ensuring links to extreme risks ('Y' -Yes, 'N' - No)	Poor Q1 23/24	Excellent Q3 23/24	*Aim*	*N/A*	*N/A*	*Y*	*Y*	*Y*	*Y*	*Y*	*Y*	Monthly updating of the BAF has been completed, with an additional BAF risk created in relation to the overall Improvement Programme.
				Actual	N/A	N/A	Y	Y	Y				
10	Board development attendance	60% Q4 22/23	100% Q1 23/24	*Aim*	*N/A*	*N/A*	*100%*	*100%*	*100%*	*100%*	*100%*	*100%*	Percentage of eligible colleagues that attend Board Development sessions. October - 17 of 17 attendees were present. November - 18 of 18 attendees were present.
				Actual	N/A	N/A	71%	94%	100%				

SCAS Improvement Plan Scorecard:				Governance & Well Led									October – November 2023
No	Metric/s	Baseline (Date)	End Target (Date)	Quarterly Trajectories									
				Aim/ Actual	2022/23		2023/2024				2024/25		Comments
					Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	
11	Number of attendees at Leadership Development sessions?	80% Q4 22/23	95%	*Aim*	*N/A*	*N/A*	*60%*	*75%*	*75%*	*75%*	*95%*	*95%*	Percentage of eligible colleagues that have completed or are in the process of completing/booked on SCAS Leader and ESPM. Unable to measure SCAS Leader for Q3 currently due to resource constraints.
				Actual – SCAS Leader	N/A	N/A	47%	48.5%	51%				
				Actual - ESPM	N/A	N/A	61%	85%	87%				
12	Feedback from Leadership Development sessions (Feedback score marked out of 5)	Average Q4 22/23	Excellent Q1 24/25	*Aim*	*N/A*	*N/A*	*3*	*3*	*4*	*4*	*5*	*5*	Data provided is feedback from ESPM only. It is currently being reviewed how feedback from both SCAS Leader and ESPM can be collated collectively, and this will be added when available. November saw a reduction in the score from October. Some of the feedback suggests that actions within the Trust do not reflect what is being taught in the modules and this is reflective in the feedback.
				Actual	N/A	N/A	-	4.64	4.27				
13	Numbers of Executive visits to sites/ride outs per month (expectation is one visit per month by each) (9 Executives)	50% Q4 22/23	95% Q1 24/25	*Aim*	*N/A*	*N/A*	*50%*	*65%*	*75%*	*80%*	*95%*	*100%*	Tracked through completion of online forms and EAs calendar feedback. October – 8 of 9 visits complete 89%. November - 8 of 9 visits complete 89%.
				Actual	N/A	N/A	63%	85%	89%				
14	Number of NED visits to sites/ride outs (8 NEDs – expectation is one visit per month by each)	Poor Q1 23/24	Excellent Q3 23/24	*Aim*	*N/A*	*N/A*	*50%*	*65%*	*75%*	*80%*	*95%*	*95%*	Tracked through reports provided to Marie Gittings. October – 3 of 8 visits complete 37.5%. November – 2 of 8 visits complete 25%.
				Actual	N/A	N/A	42%	13%	31%				

Improvement Programme Highlight Report:	Culture & Staff Wellbeing	December 2023	RAG:

Executive Lead: Melanie Saunders | *Senior Responsible Officer: Nicola Howells* | *Programme Manager: Emma Manaton*

Workstream Summary (Incl. RAG Assessment):

We further consolidate our plans to improve sexual safety with a new reverse mentoring programme and development of a comms and engagement plan, including a future session with the Board scheduled for February. FTSU carried out 2 on site workshops around sexual safety & guidance and assisted an onsite listening event. Secured funding for both a People Promise Manager and a Talent Management resource, this will allow these areas to consolidate progress. NHSE funding secured for a culture diagnostic which will commence in Q4 (subject to final procurement checks in progress), the culture improvement plan continues as is making good progress with 3 more actions associated to Exit Criteria complete bringing the workstream to 80% complete against Exit Criteria and tracking Amber overall.

Progress Against Key Outcomes / Success Criteria:

- Sexual Safety discussed at Women's network session on 5th Dec with volunteers coming forward to be part of the reverse mentoring programme. Sexual safety and speaking up presented at the All SCAS Webinar with good engagement.
- Workforce: Draft 5-year workforce plan reviewed at EMC assurance now via Fit for Future programme International Paramedics: 10 Paramedics arrived & are in training with a further 8 due in February 24'. International Nurses: 7 Nurses arrived are in training with a further 9 due in January 24'
- Education: Launched SCAS bookings in Nov in doing so have increased visibility of and access to CPD opportunities.
- JLC – survey results show starting to see a shift to compassionate leadership but further work to do (leaders' perception we operate JLC low at 5.8/10). Union rep rating of JLC improved from 3.75 to 5.25. Number of staff entering formal disciplinary continues to reduce (down to 24 from 47 in 22/23).

Key Activity, Month Ahead:

- Planning for Sexual Safety brief to the Board Seminar on 29th Feb. Agree programme for reverse mentoring, pairing mentors and mentees and briefing all participants. Develop the comms and engagement plan.
- Recruitment of a People Promise Manager to support the Trust's retention work
- Scoping to broaden the CPD opportunities to cover all staff groups & a career development portal
- Present JLC survey feedback to JNCC in Jan. Review future leadership survey requirements as part of the culture diagnostic activity.
- Progress adding JLC training for managers to the Stat & Man training list.

What's Gone Well:

- Approved as part of NHSE Retention exemplar programme, cohort 2, which secures funding for a People Promise Manager. Talent Management resource approved enabling talent plans to progress.
- Improvements in recruitment and retention in the North and South, through recruiting the right people, incorporating EOC visits into the interview process, continuing to offer both F2F and Teams interview to capture a wider audience & health and wellbeing and support from first day of training.
- In the North, all ECT and Dispatch teams will be fully staffed once coaching and sign off is complete.

What's Not Gone So Well:

- Performance pressures have resulted in a decline in completion of appraisals and statutory and mandatory, we continue to monitor.
- Recruitment is currently down on plan overall but improved in M7 and M8 in Ops. The focus is now on recruiting clinicians and staff into areas where they are needed

Workstream Key Risks:

- Capacity of existing People Services Directorate resources increasingly a challenge, increasing competing priorities both within BAU and organisational change.
- Upcoming change in the organisation may affect staff morale / wellbeing / engagement which may in turn impact attrition, the staff survey results, increase in FTSU cases. Careful management of staff

Issues for Escalation (Incl. Scope / Milestone Change Requests):

SCAS Improvement Programme Scorecard: Culture & Staff Wellbeing — December 2023

No	Metric/s	Baseline (30/08/22)	End Target	Quarterly Trajectories									Comments
				Aim/ Actual	2022/23		2023/2024				2024/25		
					Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	
1	Reported cases of bullying and harassment	1	2	*Aim*	*N/A*	*N/A*	*3*	*3*	*3*	*3*	*2*	*2*	Q3 figures due in Feb report. Q2. We continue to place emphasis on mediation (where appropriate) and have seen an increase in cases dealt with under mediation, Q1 – 5, Q2 – 5. Comparably mediation cases for Q4 -3 and Q3 – 2. We can conclude from this that more cases are being resolved under mediation rather than proceeding to a formal process.
				Actual	3	2	1	3					
2	Reported cases of sexual harassment	5	2	*Aim*	*N/A*	*N/A*	*5*	*7*	*8*	*8*	*7*	*7*	Q3 figures due in Feb report. Q2. Reported numbers lower than forecast, production of posters has been delayed, new supplier being sought. Q3 renewed focus of the campaign.
				Actual	4	4	4	3					
3	Casework (investigation) completion timeline completion against policy	35	35	*Aim*	*N/A*	*N/A*	*60*	*58*	*50*	*45*	*40*	*35*	Q3 figures due in Feb report Q2. Decreased timescales due to a number of cases being resolved following a shorted collation of facts, where individuals have taken accountability for their actions.
				Actual	41	31	63	43					
4	FTSU: case numbers (overall and across service areas)	36	N/A	*Aim*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	Q3 – FTSU volumes have increased linked to Speak Up month in Oct / Nov, raising awareness of the FTSU team and sexual safety and other pressures impacting the workforce (financial, change and REAP 4) Q2- overall quarter similar to previous quarters', however during Q2 saw significant spike in July and Aug, numbers bucking previous trends, likely due to national FTSU exposure due to Countess of Chester coverage and other instabilities from change programmes, financial pressures and focus on increasing performance. As agreed, speak up sub score will be used to measure speak up culture, therefore no trajectory on this metric.
				Actual	29	38	27	34	54				
5	FTSU: Freedom to Speak Up Sub Score	5.9 (Oct 22)	6.4	*Aim*	*N/A*	*N/A*	*N/A*	*5.9*	*5.9*	*6.0*	*6.0*	*6.1*	Q3 figures due in Feb report Q2 sees a drop in sub score, questionable if this reflects the true view of organisation as initial response rate was 35. Surveys not collected over the full quarter due to delays. Will monitor during Q3, encouraging engagement during F2F interactions but without diluting the NSS message. Sub score is nationally recognised as not exclusively FTSU, ie EPR outages and issues with safeguarding referrals may have impacted the scores. Baseline is NSS from Oct 22 (5.9). Forecast Q2 24/25 (6.1) is best in
				Actual	N/A	N/A	N/A	5.2					

SCAS Improvement Programme Scorecard: Culture & Staff Wellbeing — December 2023

No	Metric/s	Baseline (30/08/22)	End Target	Quarterly Trajectories									Comments
				Aim/ Actual	2022/23		2023/2024				2024/25		
					Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	
6	FTSU: audit of time taken to complete initial investigation (% within guidelines)	93 (Q1 23 figures)	93	*Aim*	*N/A*	*N/A*	*N/A*	*93*	*86*	*86*	*93*	*93*	Q3 figures due in Feb report. Q2 – drop to 80%. The expected drop to 86% in Q3 has, in practice, been brought forward by the spike in cases because of national Countess of Chester coverage as well as environmental impact to managers such as performance pressures and finance sustainability. Baseline figures are Q1 23 (not measured previously). No guideline for this figure, suggest we maintain at this level while we build data. Forecast: drop to 86% is potential combination of winter pressures on managers & possible increase in FTSU cases during / after speak up month in Oct (86% is 2 cases breaching).
				Actual	N/A	N/A	93	80					
7	Appraisal and PDR: completion (%)	89	95	*Aim*	*95*	*95*	*95*	*95*	*95*	*95*	*95*	*95*	Q3 – decrease and below trajectory; PDRs paused during September due to demand/performance pressure, have now recommenced from October.
				Actual	88	89	84	75	73				
8	Q21c – would recommend the organisation as a place to work (%)	36.5 (July 22)	59.4	*Aim*	*37*	*38*	39	40	41	42	43	44	Q3 –NSS report received however under NHS embargo. Forecast: Q2 24/25 is sector average (44%), end target is best in sector (59.4%). 46% in Q3 due to higher survey completion rate as NSS - suggesting NQPS may not be a true reflection of staff view & to treat as indicative only.
				Actual	46	36	41	35					
9	Staff feeling able to make suggestions to improve the work of their team/department (%)	47.7 (July 22)	61.7	*Aim*	*48*	*48*	*50*	*50*	*50*	*52*	*52*	*54*	Q3 –NSS report received however under NHS embargo. Forecast: Q2 24/25 is sector average (54%), end target is the best in sector (61.7%). 53% in Q3 due to higher survey completion rate as NSS, suggesting NQPS may not be a true reflection of staff view & treat as indicative only.
				Actual	53	44	46	46					
10	Retention / Stability Index Rate (%)	82	82	*Aim*	*82*	*82*	*82*	*82*	*83*	*83*	*84*	*84*	Q3 – maintaining 85% from Q2, ahead of trajectory.
				Actual	82	82	84	85	85				
11	Vacancy Rate (%)	15	10	*Aim*	*13*	*14*	*14*	*13.5*	*12*	*11*	*10*	*10*	Q3 – is on track with workforce plan and continued improvement since Q2
				Actual	13	13	12	12	11				

Improvement Programme Highlight Report:	Performance Improvement	December 2023	RAG:

Executive Lead: Mark Ainsworth | *Senior Responsible Officers: Luci Papworth, Mark Ainsworth* | *Programme Manager: Emma Manaton*

Workstream Summary (Incl. RAG Assessment):

As the Fit for the Future Programme is now fully in the mobilisation phase it is being governed separately and no update is included

Feedback loop through SCAS Connect now live across SCAS with no reported issues with the technology. Continuing to work with providers on capturing feedback themes and then understanding if there are actions needed from the feedback.

Progress Against Key Outcomes / Success Criteria:

- Focus continues to be on Cat 2 response and EOC call answer times (as at 31 Dec 2023):
  - Cat 2 Mean – QTD: 00:38:09
  - Call Answer Mean – QTD: 00:00:17
- Agreement received to extend Cat 3/4 (GP) Validation pilot

Key Activity, Month Ahead:

- Continue to monitor PIP actions for timely delivery and increase PP hours in line with new contracted hours
- Embed immediate Handover process across all Acute Trusts
- Further develop Cat 2 recovery plan

What's Gone Well:

- The Performance Improvement Plan is reviewed weekly for progress against each action. Positive feedback from NHSE on the PIP and actions included
- Cat 2 Segmentation -4,962 calls appropriate Segmentation Clinical Navigation:
  - 18.7% of eligible C2 Calls underwent Clinical Navigation
  - 38.8% of these remained on the C2 dispatch stack with 57.9% going for Clinical Navigation
  - Of these sent for Clinical Navigation 52.9% received Clinical Validation
  - Of these 23.4% were Closed as Hear and Treat – of these 62% were closed as refer to ED / 20.6% were closed referring to GP
- SCAS Connect User Testing (non-ED conveyance feedback loop) has been completed within the MK UCR footprint with no issues. Has now also made it across the SCAS footprint so believe we are able to close (CQC_39)

What's Not Gone So Well:

- Due to capacity constraints, there is no dedicated programme / project support; plan agreed for resolving this going forward.
- A significant level of excess handovers (~6700 hrs in December) have negatively impacted on our ability to deliver performance

Workstream Key Risks:

- New private provider contracts commenced 2nd October. After showing improvement in fill %, current fill has returned to 80% due to the inclusion of new contracts for 3 DCA lines, which are currently ramping up
- Clinical capacity for Cat 2 Segmentation, as well as delivering BAU Clinical Support Desk requirements

Workstream Issues:

Complete & Embedded | On Track | Off Track (<1 month), Recovery Actions in Place | Overdue (>1 month)

SCAS Improvement Programme Scorecard: Performance Improvement — November 2023

No	Metric/s	Baseline H2 – 22/23	End Target	Aim/ Actual	Quarterly Trajectories								Comments
					2022/23		2023/2024				2024/25		
					Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	
1	Improved category 2 ambulance response times	00:34:08	00:18:00	*Aim*	00:18:00	00:18:00	00:27:59	00:26:43	00:28:56	00:29:37	00:25:00	00:20:00	Assumptions behind these trajectories include no demand growth and hospital delays at agreed levels. Revised trajectory has been shared with Exec and board and being presented to NHSE on 5th October prior to submission
				Actual	00:40:33	00:26:53	00:29:42	00:33:09	0:38:09				
2	Increase in Hear and Treat rates	12.20%	14%	*Aim*	13.5%	12.5%	10.5%	11.5%	12.0%	12.5%	14.0%	14.0%	Cat 2 Segment now live (as per NHSE directive) with the 9s GP CAS also live from 28th Sept. Review of H&T improvement plan following AACE review
				Actual	13.4%	10.8%	10.6%	11.1%	11.8%				
3	Increased See and Treat rates	34.8%	35%	*Aim*	34.0%	34.0%	35.0%	35.0%	35.0%	35.0%	35.0%	35.0%	Higher acuity in 999 calls is affecting the ability to S&T higher number of patients. 63% of demand C1 and C2 in Sept an increase of 5% from August
				Actual	34.9%	34.7%	34.3%	33.7%	33.5%				
4	Improved Mean 999 call answer time	00:00:51	00:00:10	*Aim*	00:00:10	00:00:10	00:00:24	00:00:11	00:00:20	00:00:11	00:00:10	00:00:10	Q2 performance behind plan. WMAS support commenced 11.08.23. Review of IOW staffing levels as below agreed levels.
				Actual	00:01:06	00:00:32	00:00:25	00:00:22	00:00:17				

SCAS Improvement Programme Scorecard: Performance Improvement — November 2023

No	Metric/s	Baseline H2 – 22/23	End Target	Quarterly Trajectories									
				Aim/ Actual	2022/23		2023/2024				2024/25		Comments
					Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	
5	Improvement in % of staff having meal breaks	54.9%	85%	*Aim*	85.0%	85.0%	63.0%	64.0%	65.0%	66.0%	75.0%	80.0%	Changes are being planned to re-design of seven SCAS operational nodes, to implement new work patterns during Q3/Q4 2023-24, that will support improving meal break "windows" built into the rosters.
				Actual	48.1%	61.5%	58.7%	53.8%	45.3%				
6	Improvement in % of staff shifts finishing no later than 30 minutes past finish time.	71.8%	90%	*Aim*	66.0%	66.0%	85.0%	85.0%	87.0%	88.0%	89%	90%	Project to design new rosters to incorporate 'overlapping shifts patterns' across all 23 resource centres is underway, this will support improved resource cover throughout the 24/7 period, so that 'oncoming shifts' will aid staff finishing on time at the end of their shift in Q3/Q4 - 2023/24. Review of EOC process for night shifts with unions has failed to reach agreement for change. QIA also rejected due to staff impact. Negotiations with unions to continue
				Actual	69.0%	83.0%	84.0%	82.3%	80.5%				
7.	Progress against infrastructure development programme			*Aim*	N/A	N/A	Programme Brief	Programme Plan	Initial Board Approval of Plan	Final Board Approval of Plan			An operational development plan for SCAS 999 Ops Services is now in development with project workstreams, as part of the Trust improvement programme. Performance Improvement Plan 2023-24 actions approved by Exec.
				Actual	*N/A*	*N/A*	Complete						

Improvement Programme Highlight Report:	Patient Safety	December 2023	RAG:

Executive Lead: Helen Young | *Senior Responsible Officer: Sue Heyes* | *Programme Manager: Dai Tamplin*

Workstream Summary (Incl. RAG Assessment):

Quarter to Date (QTD) metrics are encouraging with figures reported to end of Nov 2023. Continued improvement in SG, not least with the long-awaited cut-over to the new SG server, increasing SAAF compliance to 97.8%. However, this has not been without challenge with an issue arising where SG referrals were not automatically sent when received from frontline users, using Ortivus ePR devices. This has caused an element of reputational damage with Local Authorities (LAs) but AD SG engaged with senior stakeholders to minimise impact. Escalation to REAP 4 is having some impact on IPC audit and Stat & Mand compliance but this is being watched closely at the local level. Of note is the move of SCAS Pharmacy resources to the new facility in Adanac Park, Nursling – move completed pre-Christmas 2023.

Progress Against Key Outcomes / Success Criteria:

- Positive increase in SG metrics, with SAAF compliance rising to 97.8% with the cut-over to the new Doc-Works SG server successfully completed on 29 Nov 2023
- 3rd audit cycle of SI/DI investigations (50/50 split) completed for Q3. Monitoring continuous improvement of investigation/report quality.
- Patient Panel Chair undertaking induction/site visits. Recruitment to wider panel continues (with a focus on proportionate representation from religious/ethnic minority groupings)

Key Activity, Month Ahead:

- Positive SG Peer Review report received; action planning for any additional areas of development identified. Risk assessment of latest delayed SG referrals required (because of delays from new SG server automation failure). Development of comms/training package for new SG referral form
- SI/DI audit evaluation report to be completed. Low/No Harm audit reliant upon development of a fit for purpose quality metric tool (current tool not suitable)
- NHS 111 complaints process review – mapping exercise completed with actions on delays in audits requested to reduce agreed extensions (review Dec 23/Jan24)
- Induction programme for new IPC Lead (from 2 Jan 2024). Development of IPC Practitioner BC for inclusion in budget setting for FY 24/25 (to create additional IPC capacity in Thames Valley)

What's Gone Well:

- New SG telephone system went live 13 Dec 2023. SG advice now available 24/7 with direct transfer to OOH Social Work teams. Communicated to all staff
- Draft PSIRP compiled and submitted to PSIRF Project Board. Current on circulation for comment. Feedback received to-date encouraging
- Pharmacy move to new distribution premises in Adanac Park, Nursling due for completion by 22 Dec 2023. Significantly improved facilities but 999 pharmacist recruitment still a challenge

What's Not Gone So Well:

- As of 18 Dec 2023, Doc-Works have identified that SG referrals from Ortivus devices (frontline staff) were not automatically processed between 30 Nov and 18 Dec 2023. Mitigations have been put in place. Two SIs have been declared (delay and Pt harm) and referrals have now been sent to respective LAs
- New SG referral form implementation may be delayed as a result of remedial works required to address SG Server automation failure (Doc-Works capacity issue)
- PSIRF Implementation lead post remains vacant following unsuccessful recruitment. Continued impact on progress being felt due to reduced capacity but recoverable within mandated timeframes

Workstream Key Risks:

- Escalation to REAP 4 with potential impact on Stat & Mand and IPC compliance
- Transition to new SG server (a benefit of which was to improve reputation of SCAS/SG Service); subsequent technical issues are proving reputationally detrimental, with a risk of potential Pt harm

Workstream Issues:

- Nothing for escalation

Complete & Embedded | On Track | Off Track (<1 month), Recovery Actions in Place | Overdue (>1 month)

SCAS Improvement Programme Scorecard: Patient Safety December 2023

No	Metric/s	Baseline (Date)	End Target (Date)	Quarterly Trajectories									Comments (Quarter to Date (QTD))
				Aim/ Actual	2022/23		2023/2024				2024/25		
					Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	
1	Increased number of Safeguarding referrals indicative of +ve reporting	12153 (30/09/22)	17956 (30/09/24)	*Aim*	*12761*	*13399*	*14069*	*14772*	*15511*	*16287*	*17101*	*17956*	Baseline Q2 2022 figures. 5% target increase per Qtr. Q3. QTD, 94% of trajectory
				Actual	13728	14221	16311	20458	14637				
2	Compliance against trajectory of Level 3 Safeguarding training	6% (30/09/22)	90% (31/03/24)	*Aim*	*20%*	*30%*	*46%*	*60%*	*70%*	*90%*	*>90%*	*>90%*	Trust-wide compliance figure (Clinician + ECA) Q3. QTD, 12% above trajectory
				Actual	18%	31%	49%	60.75%	82%				
3	Self-assessed compliance against SAAF to safeguard children, young people & adults	20% (30/09/22)	100% (Q4 23/24)	*Aim*	*30%*	*60%*	*70%*	*80%*	*90%*	*95%*	*>70%*	*>80%*	Calculated percentage against tasks aligned to SAAF Q3. QTD, 7.8% above trajectory with transition to new SG server
				Actual	30%	64%	94.5%	94.5%	97.8%				
4	Improvement in Patient Safety Culture Survey (MaPSaF) response rates	3% (28/02/23)	7.5% (30/09/24)	*Aim*	*N/A*	*3%*	*N/A*	*N/A*	*5%*	*N/A*	*N/A*	*7.5%*	Repeated every 6/12 Next report post Q3
				Actual	N/A	3%	N/A	N/A		N/A	N/A		
5	Incident report audit using a Quality & Maturity tool to evidence Well Led and cultural change	0 (31/03/23)	40 (31/03/24)	*Aim*	*N/A*	*N/A*	*10*	*10*	*10*	*10*	*10*	*10*	Audits to assess quality of SIs, DIs and Low/No Harm reporting Q3. 10 x Low/No Harm audits complete
				Actual	N/A	N/A	10	10	10				
6	Medical Device Audit – % compliance against schedule (Zoll X-Series)	Not Known (30/09/22)	>95% (Q1 24/25)	*Aim*	*>80%*	*>90%*	*>90%*	*>90%*	*>90%*	*>90%*	*>95%*	*>95%*	Increase dependent on intro of enhanced Asset Management system Q3. QTD, 6% above trajectory
				Actual	80%	90%	93%	93.4%	96%				
7	Decrease in number of medicines unaccounted for/loss	New for 23/24 IPR	TBC (Post Q3)	*Aim*	*N/A*	*N/A*	*N/A*	*N/A*	*TBC*	*TBC*	*TBC*	*TBC*	IPR compliance data (new for 23/24) Trajectory TBC after Q2 data Q3. QTD, reduction following known incident under investigation in Q2. Trajectory to follow
				Actual	N/A	N/A	34	82	6				
8a.	IPC audit: % compliance against buildings cleanliness target	80% (30/09/22)	95%	*Aim*	*N/A*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	IPR compliance data Q3. QTD, below trajectory. Impacted by operational pressures
				Actual	N/A	74%	80%	77.9%	84.4%				
8b.	IPC audit: % compliance against vehicles cleanliness target	91% (30/09/22)	95%	*Aim*	*N/A*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	*95%*	IPR compliance data Q3. QTD, below trajectory. Impacted by operational pressures
				Actual	N/A	91%	96.5%	93.1%	91.7%				

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Plans on a Page (For Reference)

Improvement Plan on a Page: December 2023

Workstream:	Governance & Well Led
Executive Lead:	Daryl Lutchmaya
Senior Responsible Officer:	Daryl Lutchmaya
Programme Manager:	Amy Carden

Background

The CQC report published in August 2022 identified the need for improved governance compliance across the trust, with a need to ensure effective governance systems and processes are in place from the Board throughout the trust to enable robust internal assurance.

There is a need to ensure staff at all levels are clear about their roles and accountability in relation to quality & risk management, through strengthening local management and governance. There is a need to ensure effective systems are in place for the identification, reporting, investigation and learning from Serious Incidents.

Aim/s

To ensure robust internal assurance and leadership is in place through:

- Improved processes and procedures from Board through to front line
- Clear accountability structures throughout the organisation to ensure effective performance management
- A culture of governance and the associated behaviours are in evidence throughout the organisation

Key benefits

- Improved board effectiveness
- Strengthened assurance
- Strengthened partnership working
- Improved decision making

Benefit measures / Outcomes

- Effective Board assurance framework in place
- All Board and Executive members attend development programme
- Regular executive & NED assurance
- All governance recommendations embedded into BAU
- Improving Partnership and Provider Survey results (engagement and feedback)
- Revised IPR in place

Alignment with other workstreams / key stakeholders

- Clear alignment to Culture and Performance Improvement Workstreams - culture of improvement and development of effective internal accountability structures
- Regional and ICB colleagues – improved assurance of internal trust assurance processes
- Trust Board members – improvement work involves all board members

Key outcomes / success criteria

22/23	Q3	• Independent Governance Review to identify areas of focus and to develop improvement action plan
	Q4	• Recruitment of Chief Governance Officer • Completion of BAF and start development programme (NHSP training / workshops
23/24	Q1	• Board observation work to commence (supported by NHSE and NHSP) • Executive Team and Individual Coaching commenced • Action plans developed for improved board, committee and key meeting management and accountability
	Q2	• Improved board, committee and key meeting management and accountability evidenced through quality and timeliness of papers • Impact from supportive board observation and coaching beginning to be evidenced • Improved accountability throughout the organisation
	Q3	• Well-led review to be undertaken by NHSE (led by ISCS team with wider support) with improvements evidenced
	Q4	• Evidence of improved accountability throughout the organisation

Key Risks

- Engagement of key individuals in improvement efforts
- Volume of BAU and improvement mean capacity to deliver is limited

Issues

- Resource and changing personnel impact on improvement
- Board Development Programme identifies further areas requiring development
- On-going concern around effectiveness of internal governance through key assurance meetings (TPAM / RSP)

Communications and Engagement approach

- Communication cascades – both formal and informal through trust structures and through Executive Director briefings to teams
- Clear articulated plan to highlight areas of focus and reasons for this

Possible external resource requirements	Cost (£)
• Additional support for improvement focus for a defined period of time • Board Development funding secured through NOF4 funding for 23/24	? Support from NHSE

Improvement Plan on a Page: December 2023

Workstream:	Culture & Staff Wellbeing
Executive Lead:	Melanie Saunders
Senior Responsible Officer:	Nicola Howells
Programme Manager:	Emma Manaton

Background

The CQC report published in August 2022 identified a need for improved effectiveness between the Trust Board and wider trust teams.

The trust needs to ensure that all members of staff (including students and volunteers) need to feel respected, supportive and valued and that if concerns and / or allegations are raised, these are responded to appropriately and in a timely manner.

The trust need to ensure volunteers are managed effectively and that policies and procedures are in place to ensure concerns and issues are effectively identified and raised (safeguarding).
Engagement between the trust board, senior leads and the organisation needs strengthening, so staff feel listened to, engaged and involved.

Aim/s

To develop a culture of engagement, inclusivity and safety within the organisation by:

- Improved focus on staff engagement and feedback from the board and wider teams to the front line
- Focus on appropriate / acceptable behaviours and evidence of addressing issues in a timely way when needed
- The development of both accountability and support through appraisals, PDR and development opportunities
- Improved culture being part of everyone's roles, every day
- Development of Trust wide and localised Recruitment plans and Retention schemes

Key Benefits

- Improved patient safety
- Improved staff, student & volunteer experience
- Compassionate leadership across all levels of organisation

Benefit Measures / Outcomes

- Refreshed People and OD strategy to reflect the current workforce challenges / risks and the work required to improve on culture and Safety
- Culture improvement programme in place with clear methodology to improve trust-wide engagement and board ownership
- Completion of organisational-wide review of operating model, including benchmarking
- Clear recruitment plan and retention scheme and recruitment timelines
- FTSU policy, function & process approved by board and firmly embedded

Key Stakeholders / Alignment with Other Workstreams

Culture improvement to have a clear focus and plan within each of the workstreams aligning to the -People Strategy

Key Outcomes / Success Criteria

22/23	Q3	• Listening events undertaken to understand staff views in more depth • Culture improvement initial action plan in place
	Q4	• Delivery of key improvement actions • Finalise and launch People Strategy outlining Culture plan for next 3 yrs.
23/24	Q1	• Expanded FTSU champions, including from diverse & vulnerable groups, and FTSU e-learning mandatory. • Recruitment and Retention Plans in place for implementation • Regular measures established for PDR's, ER cases, FTSU, retention and staff surveys • Develop staged culture improvement plan, including SMART 1 yr. actions, aligning to new People Strategy
	Q2	• Improved partnership working with TU colleagues and staff networks. • Continue implementation of retention plans • Action plans in place for 2 FTSU self assessment improvement areas. • Implementation of the Culture improvement Programme begins
	Q3	• Embed awareness of EDI strategy, sexual safety, civility campaign, FTSU, J&LC, evidence through People Voice feedback. • Recruitment and Retention plans on track.
	Q4	• Clear evidence of culture improvement beginning, evidenced through staff feedback and other key metrics

Key Risks

- Engagement of key individuals in improvement efforts
- Volume of improvements mean capacity to focus on improvements required is impacted.
- Financial constraints may impact delivery of some improvements (resources).

Issues

- Capacity and existing infrastructure of the People Services Directorate not able to manage the scope of improvement required
- Workforce and recruitment plans budget not yet signed off, plans running at risk.

Communications and Engagement Approach

- Communication cascades – both formal and informal through trust structures, webinars, Team Briefs and through Executive Director briefings to teams
- Clear articulated plan to highlight areas of focus and reasons for this
- Planned, recurrent engagement events and feedback loops

Possible External Resource Requirements	Cost (£)
Specific funding through NOF4 for specialist support to ensure the programme of work considers all aspects (performance improvement and approach, culture improvement, accountability etc.)	Through NOF4

Improvement Plan on a Page

December 2023

Workstream:	Performance Improvement
Executive Lead:	Paul Kempster / Mark Ainsworth
Senior Responsible Officers:	Mark Ainsworth / Luci Papworth
Programme Manager:	TBC

Background

The CQC report published in August 2022 identified improvement was required in some areas to ensure safe patient care, including capacity and responsiveness.

Focus on performance improvement is required in key performance areas and longer term review of care pathways, infrastructure and associated support functions is required to ensure the trust is fit for the future.

Aims

To strengthen the operational performance of the trust through:

- An agreed operational improvement recovery plan, including benchmarking delivery and resource with others
- A multi year operational improvement development programme (care pathways, infrastructure, support) to be developed, approved by the trust board and delivered.

Key Benefits

- Improved patient outcomes
- Achievement of national targets
- Staff satisfaction and engagement
- Foundations in place for the future

Benefit Measures/Outcomes

- Plan in place for performance improvement meeting timelines and targets
- Board approved longer term infrastructure and associated development Engagement with system partners
- Improved staff satisfaction and engagement (sickness and retention)
- Improved accountability and performance

Alignment with Other Workstreams / Key Stakeholders

Culture workstream and governance workstream in relation to ensuring the right capacity and capability and infrastructure (links to People Strategy), and supports the improved governance and well-led work, strengthening accountability and internal performance.

Key Outcomes / Success Criteria

22/23	**Q3**	• Focused improvement on key aspects of operational improvement
	Q4	• Start to develop the plan for the future operating model • Begin development of operational improvement plan (ODP)
23/24	**Q1**	• Continue development of ODP, including trajectories and measures in place • Workshops to define operating model for the future
	Q2	• Initial Board approval for infrastructure development for the future • Leadership Development programme developed, aligned to Culture Workstream
	Q3	• Development programme commenced, based on ODP • Final Board approval for infrastructure development for the future • Key milestones from ODP commenced • Leadership Development assessments starts
	Q4	• Sustained improvement and development of internal infrastructure in process • Improved morale across operational teams

Key Risks

- Operational pressure meaning internal focus is limited
- Culture of improvement not in place meaning difficult to ensure delivery
- Engagement and ownership
- Financial sustainability

Issues

- Changing demand within the system might create additional pressure
- Attrition rate increases
- Handover delays
- Continued IA

Communications and Engagement Approach

- Formal and informal information cascade in place for operational teams, including standardised information to the nodes
- Clear plans in place articulating aims of the longer term programme
- Engagement sessions for wider team members to engage in future improvements

Possible External Resource Requirements	Cost (£)
Additional resource funded through NOF4 funding till end of financial year – to focus on supporting the longer term operating model and infrastructure development.	TBC

Improvement Plan on a Page: December 2023

Workstream:	Patient Safety
Executive Lead:	Helen Young
Senior Responsible Officer:	Sue Heyes
Programme Manager:	Dai Tamplin

Background

The CQC report published in August 2022 highlighted the need for improvement in safeguarding in the trust, as well as ensuring effective processes are in place for identifying and responding to adverse incidents and preventing avoidable harm.

Improved focus on internal oversight through improved internal governance and a developed safety culture
is needed.

Aim/s

To strengthen the oversight of quality and safety within the trust by:

- Development of effective and sustainable systems, processes and governance for patient safety assurance (safeguarding and incidents)
- Proactive safety culture and supportive learning culture development
- Effective learning from incidents
- Raising the focus of quality and safety at trust board

Key Benefits

- Effective internal assurance from board to front line of issues around quality and safety
- Improved patient safety culture within the trust
- Robust systems and processes in place to support safeguarding of children and adults

Benefit Measures/Outcomes

- Patient Safety and Safeguarding oversight, escalation and improvement is consistently demonstrated in BAF and Corporate Risk Registers and Board papers
- Improved maturity of Culture demonstrated in Patient Safety Culture tool
- Staff Survey results show improved response rate and scores
- Robust PSIRF Patient Safety Plan
- Embedded quarterly Incident investigation quality reviews process reviewed
- Section 4.2.1 and 11 core arrangements are embedded
- Improved Board level leadership of Patient Safety & Safeguarding

Key Stakeholders / Alignment with other workstreams

- Board engagement and oversight
- Culture and Performance Improvement workstreams

Primary Drivers / Key Success Criteria

22/23	Q3	Robust Patient Safety Improvement Plan in place for quality and safety improvement
	Q4	Clearly demonstrable evidence of timely delivery against key actions within the Patients Safety and Experience workstream
23/24	Q1	Confirming process for assessing the embeddedness and sustainability of safeguarding and serious incident improvement actions. Demonstrated through clear trajectories and metrics
	Q2	Evidence of improving patient safety culture (through improved safety culture survey) and on-going improvement in other areas
	Q3	Achievement of trajectories for improvement in key areas Supportive independent review of safety improvement within the trust
	Q4	Clearly demonstrable evidence of embedded and sustained improvement Significant improvement in safety culture

Key Risks

- Impact of on-going operational pressures might impact on ability to get time to embed and audit improvements and patient safety work
- Financial pressures may impact on capacity to implement all improvement work if posts are frozen or disestablished

Issues

- Delays in recruitment processes and speed of filling vacancies impacting the delivery of the workstream improvement programme as capacity is limited
- Financial challenges (£650K CIP) impact programme delivery

Communications and Engagement Approach

- In place currently but being improved following feedback from SLG and staff
- Overall comms and engagement plan (next 12 months) developed in conjunction with SCAS Comms (with Delivery Group sign-off, July 2023)

Possible external resource requirements	Cost (£)
• Continued support from ICB colleagues • Peer reviews • QI support from NHS Elect and NHSE	