South Central Ambulance Service NHS
NHS Foundation Trust

SCAS Annual Health Scrutiny Committee Report

Buckinghamshire

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September 2017

The Purpose of this report is to provide an overview of the service provided by South Central Ambulance Service NHS Foundation Trust (SCAS) against our contractual arrangements and, at greater detail, within Buckinghamshire.

Performance

2016/2017 Summary

In 2016/17 SCAS was contracted to perform at 75% against the Red 1 and red 2, 8 minute standards and at 95% for the Red 19 minute standard, This requirement was across the Thames Valley, consisting of Oxfordshire, Berkshire and Buckinghamshire including Milton Keynes. These contractual agreements, measured on an annual basis were not met.

[1]**Red 8** – Performance target for any immediate life threatening call – response to be on scene within 8 minutes.

[1]**Red 19** – Performance target for arrival of conveying resource to Red 8 – response to be on scene within 19 minutes of the original call.

[1]**Red 1 Definition:** Are the most critical types of calls and cover patients who are not breathing or do not have a pulse, and other severe conditions such as airway obstruction. These patients account for less than 5% of all ambulance calls.

[1]**Red 2 Definition:** Are serious but less immediately time critical. And cover conditions such as stroke and fits.

([1]Department of Health, 2012)

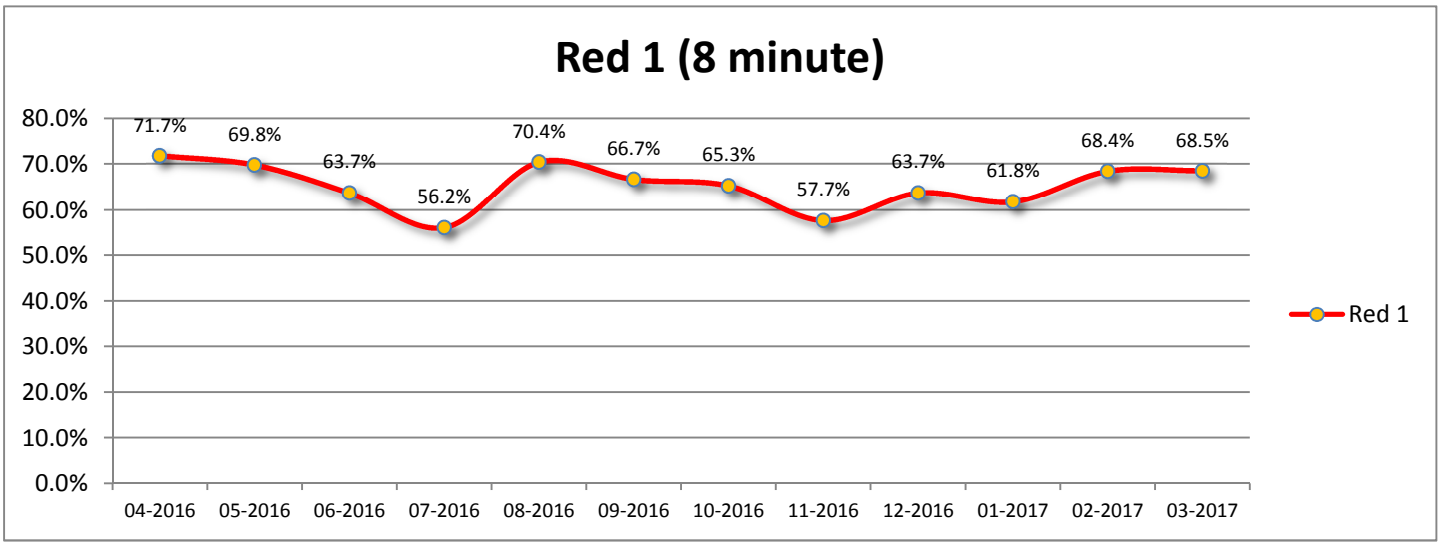
2016/17 Performance Year to date:

The current contract with South Central Ambulance Service NHS Foundation Trust (SCAS) for 2016/17 has been agreed Thames Valley wide (including Oxfordshire, Berkshire, Buckinghamshire and Milton Keynes). This is the area defined for the purposes of performance management and is measured on an annual basis in accordance with the national NHS contract. The Performance measures for 2015/16 as highlighted in this document are from last year's contract which did include Milton Keynes.

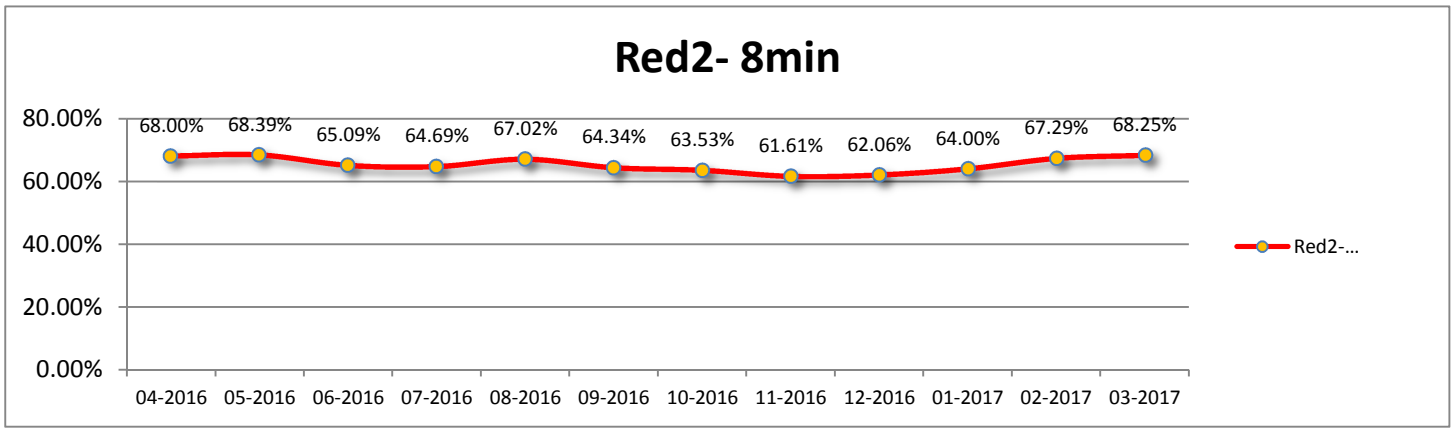
Performance measures are commissioned and reviewed at Thames Valley contract level which we did not achieve, but have seen improvements due to collaborative working with the CCG's and the Acute Trusts.

Performance – Buckinghamshire (*Aylesbury Vale & Chiltern CCG Areas*):

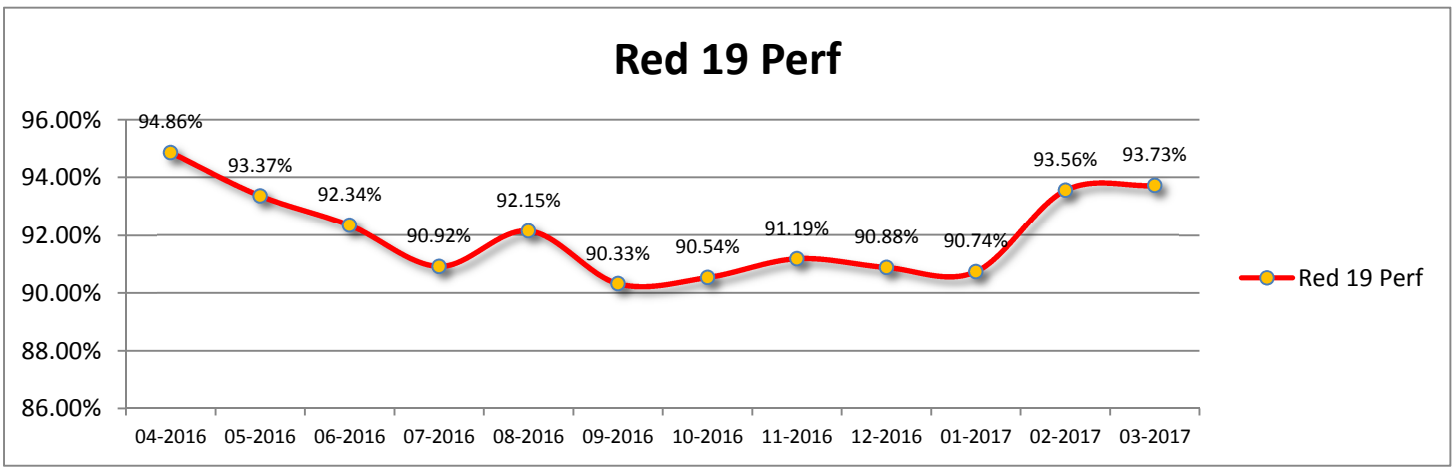
RED1 8 performance



Red 2 8 Performance



Red 19 Performance

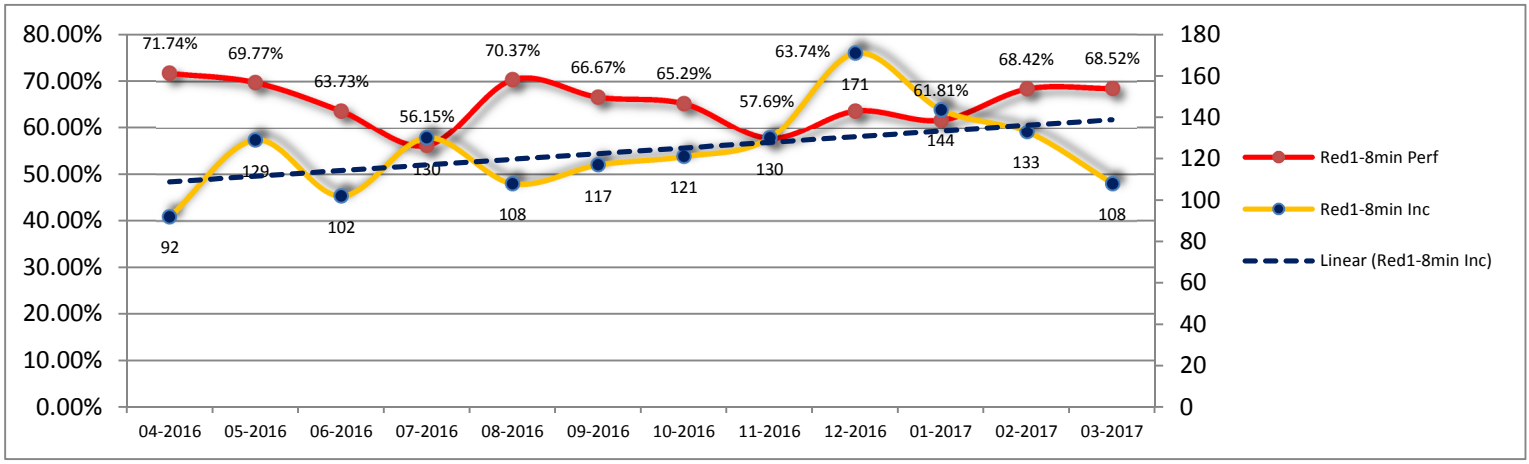


Whilst the performance contract is held at a Thames Valley level, SCAS continues to work in collaboration with the Buckinghamshire Clinical Commissioning Groups (CCG's) to improve

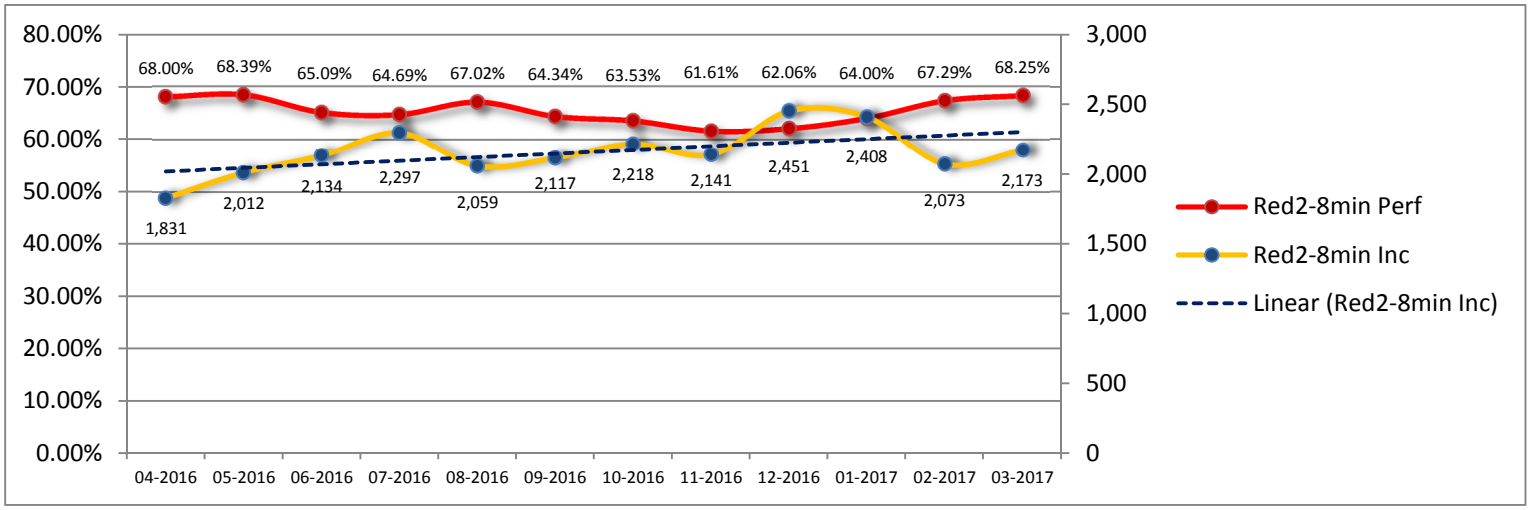
the performance specifically for the Buckinghamshire County area. Since 2014/15 SCAS has been reviewing cases where patients have waited longer than expected with a view to identifying causes, themes, gaining learning and potential for improvement by any mitigating actions in order to prevent repeats. This continues to be a focus for commissioners and SCAS

Performance and Demand

Red 1 (8 minute) – Chiltern & Aylesbury Vale



Red 2 (8 minute) – Chiltern & Aylesbury Vale



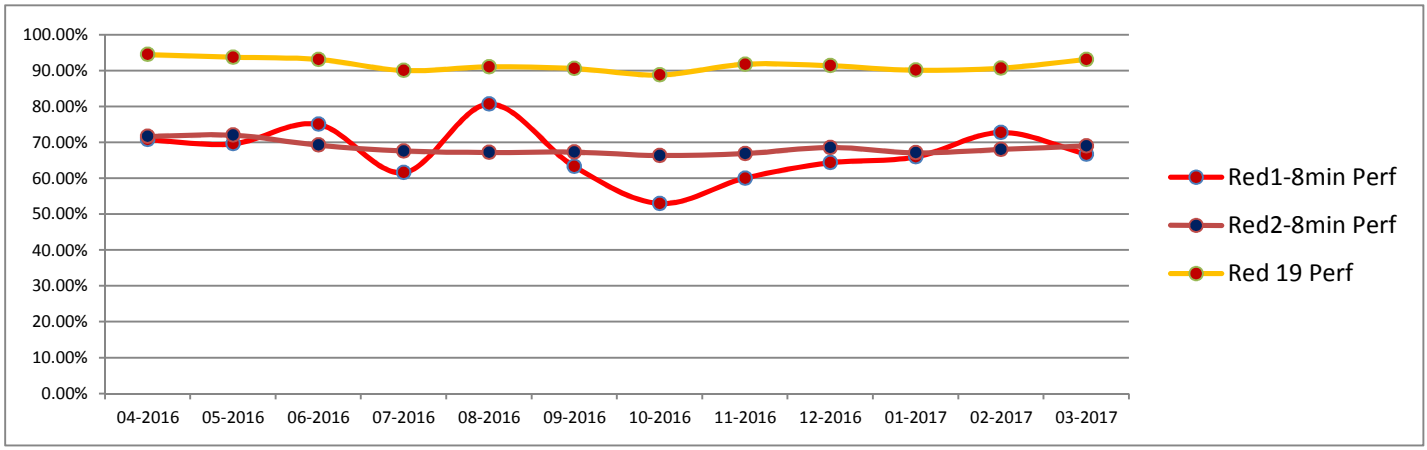
The above charts demonstrate the direct correlation to performance and demand. Both Aylesbury Vale and Chiltern CCG areas have experienced an increase in demand compared to previous years, performance has maintained or improved on previous years, despite a continued increase in demand across the whole of Bucks.

Aylesbury Vale	Red 1 = 5.54%+	Red 2 = 16.81%+
Chiltern	Red 1 = 7.14%+	Red 2 = 20.37%+
Bucks	Red 1 = 6.52%+	Red 2 = 20.37%+

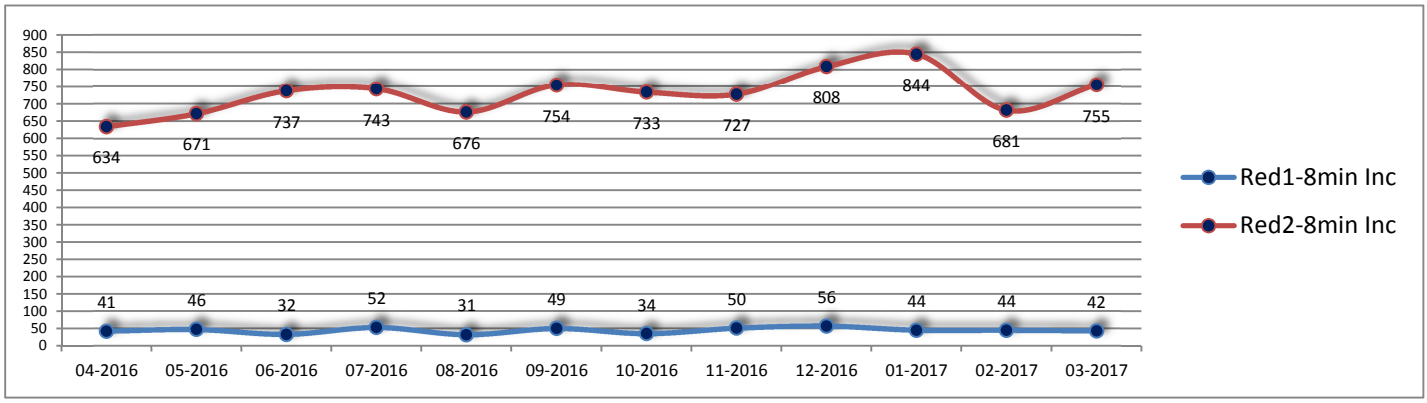
As demand increases, performance can fall, mainly as the increase of demand has surpassed the anticipated level, availability of resource is the reason for reduction in performance, this is multi-factorial in cause.

By Local Authority

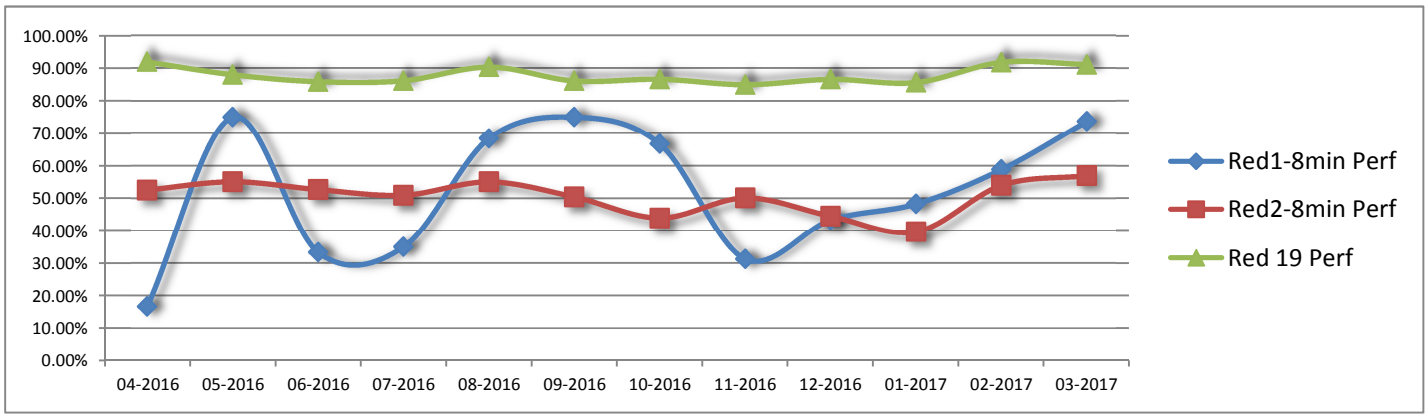
Red 1, Red 2 (8 minutes), Red 19 Performance (Aylesbury Vale LA)



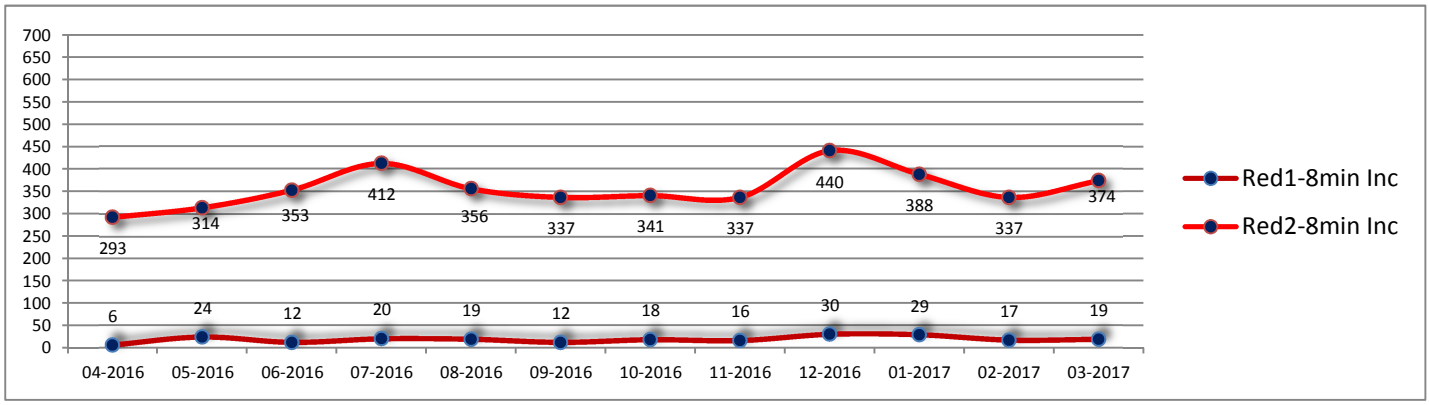
Demand – (Aylesbury LA)



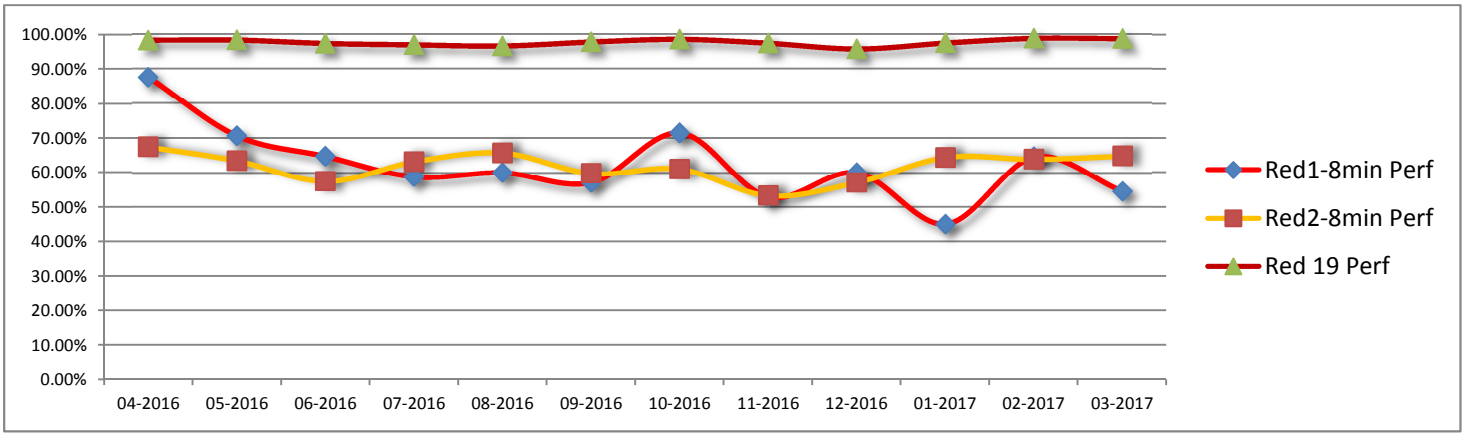
Red 1, Red 2 (8 minutes), Red 19 Performance (Chiltern LA)



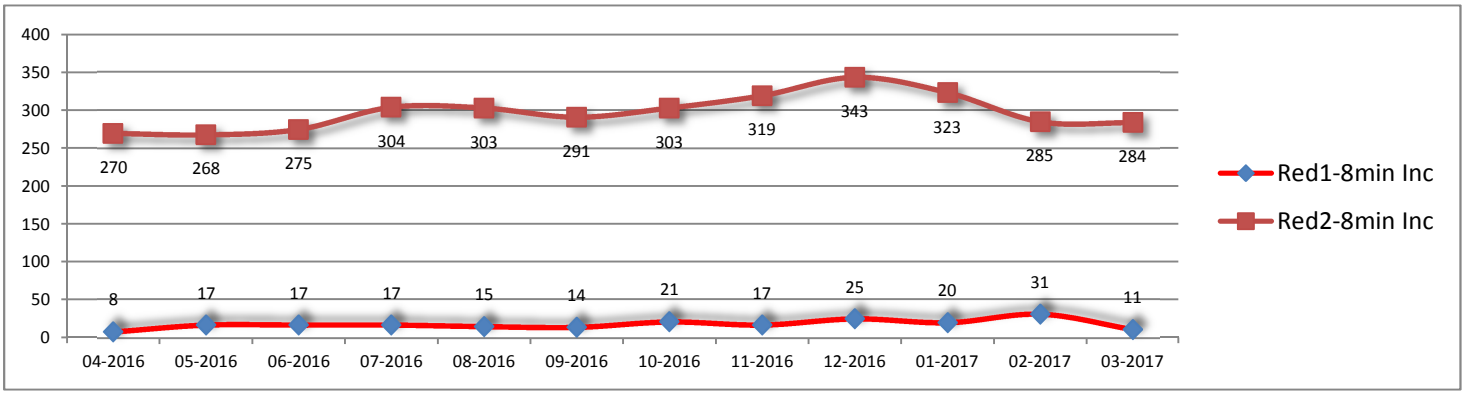
Demand (Chiltern LA)



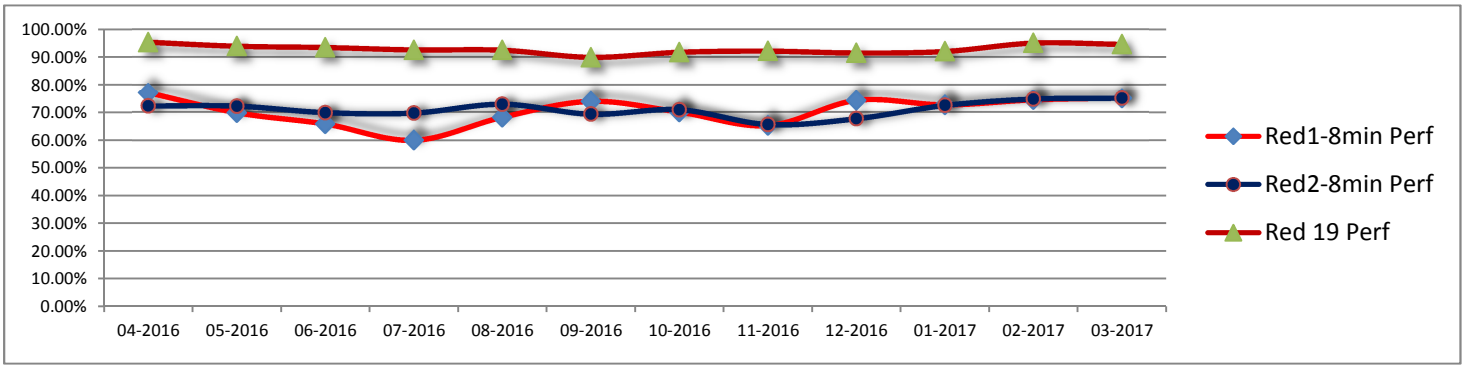
Red 1, Red 2 (8 minutes) Red 19 (19 minutes) Performance (South Bucks LA)



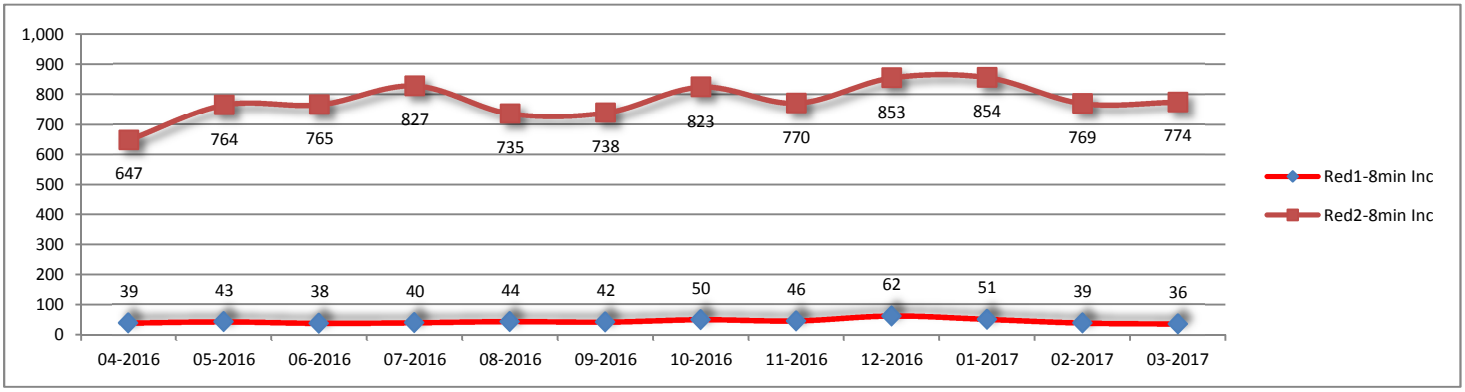
Demand (South Bucks LA)



Red 1, Red 2 (8 minutes) Red 19 (19 minutes) Performance (Wycombe LA)



Demand (Wycombe LA)



SCAS also provides the 111 in Buckinghamshire and through greater integration of the two services is amongst the lowest providers in the country for calls transferred from 111 to 999 now at 7%.

SCAS is very much involved in the implementation and delivery of the Thames Valley Integrated Urgent Care (IUC) working with partner Trusts in various ways including referral of patients to clinicians to avoid a Hospital admissions where possible.

MOBILISATION FOR TV INTEGRATED URGENT CARE:

What is new for Go live 05 September 2017?

New service	Process	Benefit
GP Enhanced triage	Warm transfer by Clinical Navigator to GP to review calls for Complex, Green, Paediatric, Frail patients. (See examples in Appendix 1) GP Liaison with Acute Consultants and Ambulatory Pathways to reduce admission.	• Increase Call closure for patients • Support to 111 Clinicians • Direct liaison with Acute Consultants to support to IUC improves pathways available and reduces hand offs for patients
IUC Clinical Navigator - Call Streaming to additional Clinicians • MHP • Pharmacist • Dental • Single Point of Access (SPA) – Access to Community & Ambulatory pathways Future development to Allied Health Professionals, End Of Life, others	Warm transfer or referral to specialist clinicians within the IUC service. Direct referral to SPA/ Community services Post Event Messages to Buckinghamshire SPA based in Aylesbury (to add Oxfordshire in the future)	Increased access and specialist clinical advice to callers closing more calls in real time within the clinical assessment service. Increased joint working and relationship building across services. Learning and increased senior clinical support to 111 clinicians.

Direct booking to East Berkshire Out of Hours Direct Booking to Westcall (West Berkshire)	Ability to directly book calls to Out of Hours GP services in Berkshire Midweek then extend to Weekends	Direct booking on the first call reduces the need for callbacks from the OOH service. Well received by patients Increased clinical streaming by symptom group to GP out of Hours e.g. Urinary Tract Infections. Westcall. To pilot and extend to other OOOH services (Bucks/Oxfordshire)
Direct booking to MIU/UCCs	Oxfordshire MIIUs Berkshire UCC Berkshire MIU Buckinghamshire MIU (awaiting technical link)	Direct booking is well received by patients. May improve alternative outcome away from A&E This may support future A&E booking. Learn from booked vs walk in model. This is ahead of schedule, included within our SDIP as a year 1 objective.
Extended Health Care Professional lines to support Thames Valley/ Care Homes	Additional lines to support	Direct line for Health Care Professionals and Care Homes

Further key developments (including SDIP year 1)		
On line symptom checker/ Apps pilot with Capita	Joint working with NHSE/Capita to pilot software . Timetable provided to be confirmed • August/Sept - Scoping • October/November- development/testing with Bucks GPs. • December/Jan - 111 Go live • Jan/Feb - Primary Care Go live.	Additional entry point for callers on line. May increase call closure Additional resource away from telephony to support Winter pressures?
Increase access to more clinicians from the Clinical Assessment service	Increasing the referral pathways for IUC clinicians and access to receive direct specialist advice as per the Integrated Urgent Care national vision	Increased access and support to IUC clinicians and callers to the service
Text Messaging for sending of Health Information advice	Callers will receive health information advice over the phone and then supportive text messages	Callers will receive a record of the advice given to support them
Enhanced EOL support	24/7 access to TV Specialist Palliative Care line from IUC	Draft Model agreed with Thames Hospice supported by other providers. Costs/pilot tbc with commissioners
IUC Links into SPAs	Further IUC access to Community services and increased interoperability and working with local authorities via SPA.	Development opportunities • Direct booking • Colocation • Workforce/training

Appendix 1

Examples of GP review from Clinical Streaming pilot

- 26 year old Ongoing headache, cyst on the brain. Complex Call, warm transferred by CN to GP. Patient had an MRI one month prior and due to meet consultant the following week due to previous headaches and discovery of the cyst. Following a fainting episode today, patient was concerned that the cyst was cancerous and/or growing. GP was confident that it wasn't cancerous as the consultant would have seen her quicker than one month and diagnosed a simple fainting episode due to stress. Advised to see consultant and review with GP if any further concerns. Call closed.

- 20 year old called with Abdo pain which was being directed towards Ambulance. Warm transferred to GP to review. Patient gave the birth 12 weeks ago by Caesarean, now pregnant again and diagnosed with Chlamydia on Friday. PV bleeding. Warm transferred to GP who referred as an emergency to Acute Gynae clinic – with suspected ectopic pregnancy.

- 14year old with nervous twitch. Call from father very concerned as she was sent home from school uncontrollably hitting herself in the chest. Also had neck spasm/twitching on Monday. There was a delay in returning the DoS from the sending electronic referral data due to a BHFT Adastra issue. The father was called back. The GP suspected Dystonia which can develop in puberty. She was referred to Acute Paediatrics.

- 26 month Toddler had a high temperature for three days and now a widespread rash. The call handler called the Clinical advice line for support and Mum was warm transferred to the GP. The call was closed with advice.

Lynda Lambourne

Director of Integrated Urgent Care

07 August 2017

Patient Transport Service (PTS):

SCAS PTS continues to not only deliver but is one of the few services that has expanded outside of the SCAS footprint with its proven record of delivering and putting our patients at the forefront of our service. PTS in Bucks has adapted to meet the current demands.

TV/OHFT/MK KPI Spec & crib sheet			
Planned cut off times:	**Thames Valley**	**OHFT**	**MK**
Outpatients	15:00 the day before	Not applicable	12:00 the day before
Discharges & Transfers	17:00 the day before	Not Applicable	12:00 the day before
Book Ready function:	**Thames Valley**	**OHFT**	**MK**
only applies to on the day discharges and transfers and bookings made after the cut off times stated above	Applies	Not Applicable	Not Applicable
Additional Information:			
Thames Valley NEPTS			
2300-0600 discharges and transfers only out of A&E, EAU, AOU (Depts within the Hospital)			
EMU clinics are able to book OTD transport. These clinics include Abingdon EMU, Witney EMU, Wycombe MUDAS, St Marks RAU, Townlands RACU, Thame Hospital and Marlow Hospital Community Assessment and Treatment Units.			
End of Life upstairs/downstairs journeys			
If crews are running late and clinics agree revised times, time is to be changed on Cleric			
No wait and returns in contract			
End of life patients are priority and must travel alone			
The only prison we convey from in Thames Valley is HMP Bullingdon.			
The latest time a Thames Valley same day discharge or transfer out of a ward can be 'booked ready' is 2000 hours to allow for the KPI			
The following exclusions from NEPTS will apply:- • Transport for prisoners • Stretcher outpatient wait and return journeys • Home to Home journeys • Home address to Nursing Home (unless going to an Intermediate Care Bed) • Nursing Home to Nursing Home (unless going to an Intermediate Care Bed) • Paediatric intensive care retrieval • Neonatal intensive care retrieval • Non NHS funded patients • Conveyance of supplies • Patients requiring transport outside of England, Scotland and Wales			

• Transport to Windsor Renal Dialysis Unit for all single crewed patients (SC Inpatient's in Wexham Park can travel on SCAS resources) • Transport to routine GP appointments • We are not to move any Mental Health patient who is under section. (This is as per exclusions under section 3.4 within the specification.)
Milton Keynes NEPTS
The latest time a same day booking in Milton Keynes can be booked is 1900 hours to allow for the KPI. This includes all journey types. On Sunday the latest time booked is to be 1300 unless capacity allows for a later collection
Milton Keynes CCG patients are not to be collected from prisons to be taken to outpatient appointments
Milton Keynes CCG patients travelling to hospitals that fall outside of the MK contract (London/Cambridge hospitals etc) are **NOT** to book this transport via the eligibility line
OHFT NEPTS (Oxfordshire & Buckinghamshire Mental Health)
OHFT journey KPI remains at 15 mins for arrival and collection
OHFT Most frequently used sites include Whiteleaf, Warneford, Fulbrook Centre, Chiltern Day Hosp (Valley Centre), Littlemore Hospital, Elms Centre, Fiennes Unit.
A same day booking for OHFT must be collected within 2 hours from the booked time.
Sectioned patients are in contract within OHFT only however they must not be transported if the patient is under section 135 or section 136 as these are covered by the 999 contract.
Patients can be collected from Police Stations for OHFT providing the patients are not under Section 135 or Section 136
Secure journeys **ARE** in contract for the OHFT contract only.
Transport outside geographical area Quotes may be requested by the Trust for journeys outside the geographical area and acceptance of the quote requires authorisation by a senior person within the Division requesting the transport.

Increased demand continues to present a challenge and we have worked with commissioners and the Acute Trust to minimise delays therefore improve efficiency throughout the local Health economy to gain winter funding to support extra vehicles to assist with Health Care Professional bookings over the winter months. This will free up a proportion of frontline ambulance time to respond to Red category calls.

Journey Times by Local Authority:

The rural aspect of large parts of Buckinghamshire can make journey times a challenge. Following the closure of Wycombe Emergency Medical Centre to the public in October 2012, SCAS saw and increase in journey times to hospital as a result of the additional mileage of Ambulances travelling to Stoke Mandeville and Wexham Park Hospitals from the High Wycombe area. Journey times from this area have remained broadly consistent since the initial increase seen immediately after the High Wycombe EMC Closure.

In Line with a national move towards specialist treatment centres, we also transport patients to a range of hospitals dependent on their particular need, in order to access specialist treatment. This includes Wycombe Hospital (cardiac and stroke); Harefield (cardiac); John Radcliffe and St Mary's, Paddington (trauma centres). This area continues to add to our challenges of achieving performance

Community First Responders:

Community Responders are members of the public, trained by the Ambulance Service, who volunteer to help in their community by responding to medical emergencies before the arrival of an Emergency Ambulance.

There are currently 53 active Community Responders schemes operating in the Buckinghamshire area (excluding Milton Keynes). Work continues with communities across the county.

South Buckinghamshire/Chiltern and Aylesbury areas identified as benefiting responder schemes are

- Amersham
- Aston Clinton
- Beaconsfield
- Buckingham
- Chesham
- Denham
- Gerrards Cross
- Princes Risborough
- Steeple Claydon
- Winslow
- Wing

First Responder schemes work with community volunteers responding within a small radius of their home or work address to immediately life threatening calls, where having someone with training and a defibrillator present a short time scale could make the difference between life and death for the patient. In all instances Community First Responders are backed up and supported by a SCAS clinical response.

We continue to work hard in evaluating new areas and expanding our Community First Responder Schemes in rural areas to continue with our successful campaign placing more defibrillators in villages and training local communities to use them.

Co Responder Schemes

We have been working with the Bucks Fire & Rescue in training their staff in First Person on Scene and emergency driver training. They have already attended many incidents and are proving to be valuable and effective. The response ranges from specific Co-Responding cars to attending in a Fire Truck. The move forward is the use of cars only to attend a range of life threatening calls. This is a similar position as for Community Responders, but with the added bonus of a blue light capable response, some additional training and an agreed number of hours of cover.

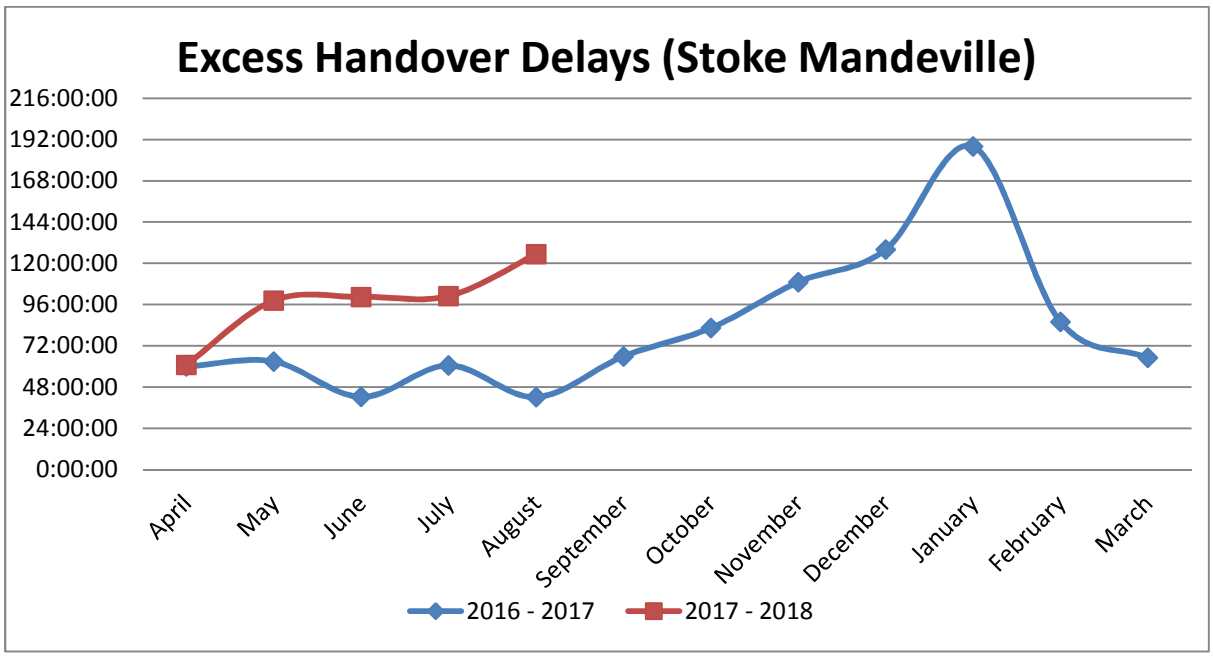
We have also been working with colleagues from Buckinghamshire & Milton Keynes Fire & Rescue Service to provide a similar scheme as the RAF, responding initially from Fire Stations.

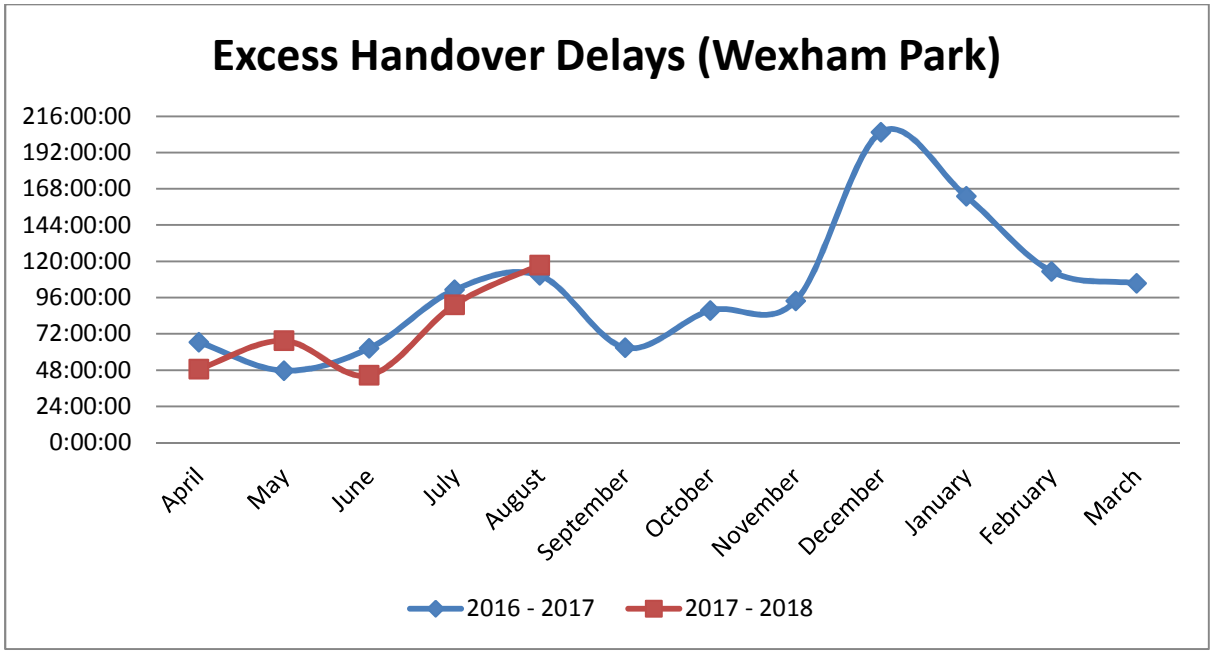
Currently there are 4 Stations running, Buckingham, High Wycombe, Marlow and Chesham. The main difference currently between this and the RAF schemes is the ability to respond on blue lights. Nationally the Fire Services have agreed to attend cardiac arrest patients in Fire tenders if they are the closet available resource.

Hospital Handovers:

Receiving Hospitals are required to facilitate a handover of arriving ambulance patients within 15 minutes of arrival. Local Commissioner fines are no longer applicable to acute hospitals although there is a clear steer that all Acute Trusts **must** focus on minimising delays. Handover is deemed to have occurred when a clinical handover has taken place, the patient is transferred on to the hospital trolley and all ambulance equipment/apparatus is returned (NHS England, 2014).

The chart below details excess handover delays (over 15 minutes) in house by month for the local acute hospitals.





The work started last year with colleagues from the Acute Trusts has continued, however with the increase in demand on both SCAS and the acute Trusts, handover delays have remained a challenge. 2016/17 SCAS lost ***16,182*** hours of which ***992*** hours were lost at Stoke Mandeville Hospital and ***1219*** hours at Wexham Park Hospital due to handover delays. This is the equivalent of losing just over 221 ambulances completing a 10 hour shift. Double verification of handover time between the SCAS crew and receiving hospital clinician is now standard practice across all the major hospitals Emergency Departments (ED's) and Medical Assessment Units within the SCAS area, via a web-based handover screen. As with all processes we are always looking at ways to streamline or improve and this continues in continued dialogue with the Acute Trusts. SCAS has worked with the ED's to provide a more streamlined handover (pit stop style) area whereby SCAS crews can handover their patient to a senior clinician within the area the patient will be transferred to a Hospital bed. This has been successful and provides the patient a much better experience than previously.

During high handover delays, SCAS will provide a Hospital Ambulance Liaison Officer (HALO) as the interface between SCAS and the hospital staff to manage issues and assist with patient flow. HALO's will help by reducing the number of SCAS staff looking after patients (double up) and improve the efficiency of the queue.

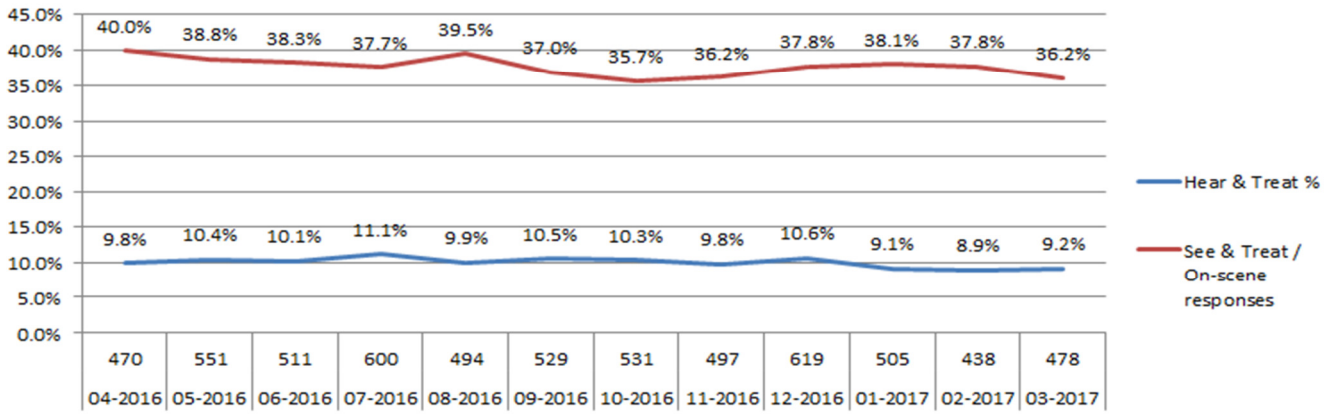
Emergency Journeys and Final Disposition

Hear and Treat:	Emergency calls are dispatched over the telephone without the attendance of an ambulance resource to scene.
See and Treat:	Ambulance resource attends the scene and treats and discharges or refers to another service without transporting the patient to a Type 1/2 (Consultant Led) Hospital Emergency Department.
See, Treat and Convey:	Ambulance resource attends the scene, treats and transports the patient to a type 1/2 (Consultant Led) Hospital Emergency Department.

GP Urgent: Urgent Hospital admission booked by a GP or Health Care Professional.

2016/2017

The tables below detail the number of 999 calls in Buckinghamshire and the H & T, S & T %



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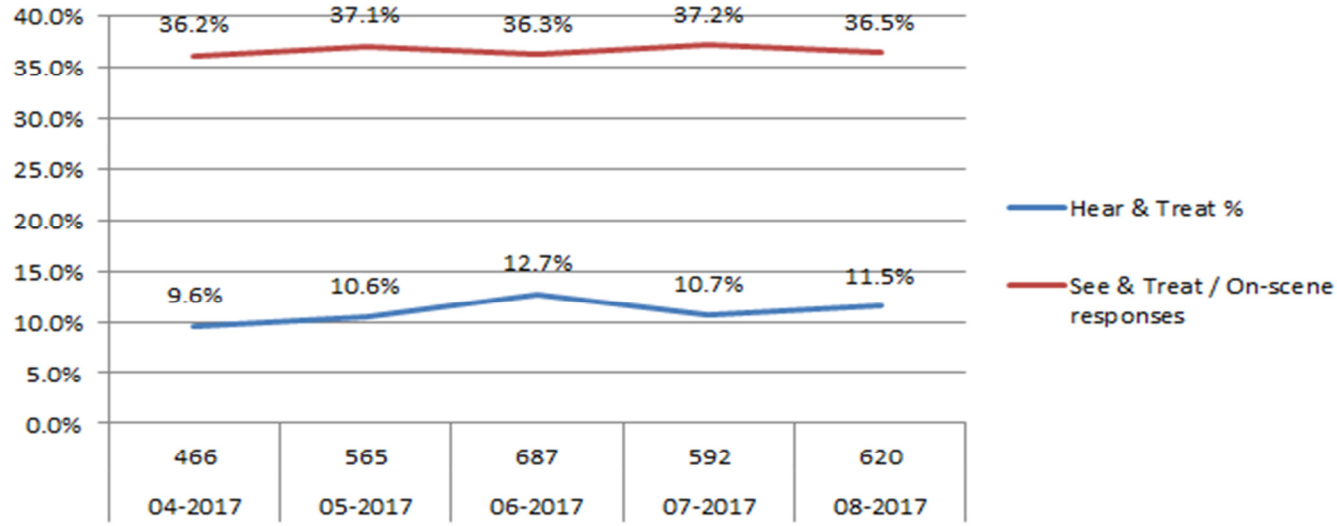

We have virtualised our Emergency Operations Centre to ensure calls are directed to the next available operator and to build further resilience within the operation. In addition we have implemented an electronic patient record and moving away from the current paper based system, which will support improved and more rapid decision making when assessing patients by offering the clinician the ability to review key tools such as Mobile DOS which the staff can access on their ePR, however this is still in its early stages and “work in progress”. These tools will assist the clinician to ensure the patient has the opportunity to follow a more appropriate pathway for their needs rather than direct to the ED.

Private Provider Usage

With the increasing levels of demand, aligned to the challenges faced with staffing levels, has meant that we recognise a continued need to utilise private providers.

Our private providers undergo a strict assessment process before being accepted as a suitable provider. This followed up by regular reviews, undertaken by senior members of SCAS who monitor, review and assess their performance, clinical practice, standards of care and ensure they are maintaining their agreed standards.

As part of the Private Provider cadre, SCAS utilises 5 different providers, including the existing voluntary aid societies, but on a commissioned basis. This varies in use from providing fully equipped Emergency Ambulance or Rapid Response Vehicle to vehicles appropriate to Health Care Professional requests, where an Emergency Ambulance has been deemed not necessary.

Recruitment and Vacancy Rates

Workforce planning continues to be challenging for ambulance trusts nationally. SCAS have had undertaken a partnership with Oxford Brooks University and Northampton University, to fund places for both internal and external candidates to train to become a paramedic. This is now coming to an end with Portsmouth University running the last course.

The trust continues looking at wider options including international recruitment, agency working and collaboration with the armed services.

The trust has redesigned services for response to Health Care Professional calls which has increased the number of non-clinical posts, this is reflected below and these posts are currently being recruited into.

The trust has launched an Associate Ambulance Practitioner (AAP) role. Successful candidates will move into an autonomous clinical role treating patients treating and managing patients across a broad range of emergency, urgent and social care settings. This role will give a good grounding for moving on to a Paramedic.

Current Position – Buckinghamshire

The main staff vacancies are in South Bucks where the cost of living is very high. This is not specific to SCAS but reflects the challenges on the NHS in this area. Work streams are going ahead to include NHS specific low cost housing schemes but unfortunately these do take time to establish.

Ambulance Response Programme:

Content

- Why are we moving to the new national standards
- What are the new national categories 1 – 4
- What are the key benefits?

We are mandated to move to the new standards

18 month Ambulance Response Programme (ARP) trial included over 14 million calls tested using the new operating model and standards.

Key findings / changes:

- Ambulance services dispatch model changed, giving emergency call handlers staff more time to identify patients' needs and allowing quicker identification of urgent conditions.
- New target response times which cover every single patient, not just those in immediate need. For the most urgent patients we will collect mean response time in addition to the 90th percentile.
- "Stop the Clock " rules changed - standards only achieved by ensuring the correct clinical care for the patient dependant on their needs.
- Recognition of life-threatening conditions, particularly cardiac arrest, will improve. London Ambulance Service (LAS) trial estimated that up to 250 additional lives could be saved in England every year.
- Nationally up to 750,000 patients every year would receive an immediate ambulance response, rather than joining a queue.
- The differences in response time between patients living in rural areas and

those in cities should be reduced.

What are the new categories:

CATEGORY 1 - LIFE-THREATENING

Time critical life-threatening event needing immediate intervention and/or resuscitation e.g. cardiac or respiratory arrest; airway obstruction; ineffective breathing; unconscious with abnormal or noisy breathing; hanging.

CATEGORY 2 - EMERGENCY

Potentially serious conditions (ABCD problem) that may require rapid assessment, urgent on-scene intervention and/or urgent transport.

CATEGORY 3 – URGENT

Urgent problem (not immediately life-threatening) that needs treatment to relieve suffering (e.g. pain control) and transport or assessment and management at scene with referral where needed within a clinically appropriate timeframe.

CATEGORY 4 – NON-URGENT

Problems that are not urgent but need assessment (face to face or telephone) and possibly transport within a clinically appropriate timeframe.

TYPE S – SPECIALIST RESPONSE (HART)

Incidents requiring specialist response i.e. hazardous materials; specialist rescue; mass casualty

EXISTING RESPONSE STANDARDS		
TYPE	% of calls / Demand	National Standard
Red 1	3%	75% within 8 minutes 95% within 19 minutes
Red 2	47%	75% within 8 minutes 95% within 19 minutes
Green	50%	No National Standard – Locally agreed Green 30 mins or Green 60 mins

NEW RESPONSE STANDARDS		
TYPE	% of Calls / Demand	National Standard
Cat 1	8%	7 minutes mean response time 15 minutes; 90th centile response time
Cat 2	48%	18 minutes mean response time 40 minutes; 90th centile response time
Cat 3	34%	120 minutes; 90th centile response time
Cat 4	10%	180 minutes; 90th centile response time

% of activity many vary slightly and is dependent on which call triage assessment tool in use by each Trust (NHS Pathways or AMPDS)

Categories	National Standard	How long does the ambulance service have to make a decision?	What stops the clock?
Category 1	7 minutes mean response time 15 minutes 90th centile response time	The earliest of: •The problem is identified •An ambulance response is dispatched •30 seconds from the call being connected	The first ambulance service-dispatched emergency responder arrives at the scene of the incident (There is an additional Category 1 transport standard to ensure that these patients also receive early ambulance transportation)
Category 2	18 minutes mean response time 40 minutes 90th centile response time	The earliest of: •The problem is identified •An ambulance response is dispatched •240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport the first ambulance service-dispatched emergency responder arrives at the scene of the incident
Category 3	120 minutes 90th centile response time	The earliest of: •The problem is identified •An ambulance response is dispatched •240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport the first ambulance service-dispatched emergency responder arrives at the scene of the incident
Category 4	180 minutes 90th centile response time	The earliest of: •The problem is identified •An ambulance response is dispatched •240 seconds from the call being connected	Category 4T: If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock.

Key Benefits:

- Ensuring a timely response to patients with life-threatening conditions
- The most appropriate clinical resource to meet the needs of patients based on presenting conditions not simply the nearest
- Fewer multiple dispatches = increased efficiency
- Reduction in diversion of resources
- Increasing the ability to support patients through hear and treat, see and treat
- Having a transporting resource available for patients who need to be taken to a definitive place of care
- Improved patient experience
- Provides staff with greater role satisfaction – doing the right thing for patients

Conclusion

Demand has continued to increase throughout SCAS including Bucks. Despite the increase challenges and financial constraints, SCAS has remained focused on delivering a High Standard of pre-hospital care to its patients in the form of both 111 and the 999 service. Our PTS teams have adapted to increase demand but have continued to serve its patients to a high standard making sure wherever possible targets are met.

SCAS has been integral to the future of Integrated Urgent Care in many areas by its professionalism and ability to deliver. Our 111, 999 and PTS services is at the heart of the new IUC by being an important partner and leading on areas of which SCAS is an expert in.

We don’t always get it right, but we learn from our mistakes and welcome all comments which help us to improve.