Bundle Public Board of Directors 27 March 2025

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- 0.0 Public Board Agenda 27 March 2025 FINAL
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1 Chair's Welcome and Apologies for Absence Professor Sir Keith Willett CBE -Verbal For Noting

2 Declarations – Directors' Interests and Fit and Proper Persons Test Professor Sir Keith Willett CBE -Verbal For Noting
- 02.0 Board Members Register of interests as at 13.03.25 March 2025 Board

3 Minutes from the meeting held on 30 January 2025 Professor Sir Keith Willett CBE -For Approval
- 03.0 Draft SCAS Public Board 30 January 2025 v1.0 KW

4 Board Actions Log Professor Sir Keith Willett CBE/ Becky Southall -For Approval
- 04.0 PUBLIC BOARD ACTION LOG

5 Chair's Report Professor Sir Keith Willett CBE -For Noting
- 05.0 Chair's Report Cover Sheet January 2025

6 Chief Executive Officer's Report David Eltringham -For Noting/ Information
- 06.0 CEO Report Feb 25

7 Update to the previous Private Board meeting held on 31 January 2025 & Extraordinary Private Board held on 20 March 2025 Professor Sir Keith Willett CBE -For Noting
- 07.0 Update to the previous Private Board meeting held on 30 Jan 27 Feb and 20 March 2025

8 Feedback from Patient Panel Chair Helen Young SR1 9For Information
- 08.0 Feedback from Patient Panel Cover Sheet
- 08.1 Board Update March 2025 Patient Panel V2

9 Integrated Performance Report Stuart Rees & Executive Director Leads -For Assurance
- 09.0 IPR update report for February 2025 period Board 2025 03 27
- 09.1 IPR 17.03.2025 FINAL

10 Quality and Safety Report (Clinical Directorate Update) Helen Young SR1 9For Assurance
- 10.0 Board Report Template - March 2025 - v2

11 Chief Medical Officer's Report John Black SR1 9For Noting
- 11.0 CMO Board Report - March 2025 - Final
- 11.1 JRCALC Updates Summary 1 25

12 Assurance Upward Report Quality and Safety Committee 19 March 2025 Dhammika Perera -For Noting
- 12.0 Upward Report QS - March 19th - Final

13 Finance Report Month 11 Update Stuart ReesSR5 16 For Assurance
- 13.0 Month 11 Finance Report TB March 2025

14 Hampshire and Isle of Wight ICB Month 11 Finance Report Stuart Rees SR5 16For Noting
- 14.0 Cover Sheet ICS M11 Integrated Care System Report Public
- 14.1 PUBLIC_ICS Finance Report M11_Board and Committee cover sheet_Final

15 Assurance Upward Report Finance and Performance Committee, 20 February, 18 March and 21 March 2025 Les Broude - For Noting/ Assurance
- 15.0 Upward Report Meeting FPC 18th and 21st March

16 Assurance Upward Report Audit Committee, 19 March 2025 including Internal Audit Plan 2025/26 Mike McEnaney -For Noting/ Assurance
- 16.0 Audit Committee Upward Assurance Report to Board 2025-03-19
- 16.1 South Central Ambulance Service - PSIA Audit Annual Plan 2025-26 - Draft
- 16.2 SCAS 24-25 Audit Plan DRAFT for management comment

17 Assurance Upward Report Charitable Funds Committee, 12 March 2025 Professor Sir Keith Willett CBE -For Noting/ Assurance
- 17.0 CFC Upward Report - March 2025

18 Questions submitted by Board Members on agenda items: 11-12,15-17 --

19 Freedom to Speak Up Policy Natasha Dymond SR7 12For Noting
- 19.0 Trust Public Board - FTSU Policy update January 2025 - cover sheet
- 19.1 SCAS Updated Freedom to Speak UP Policy_Jan 2025 review v2

20 Freedom to Speak Up Reflection and Planning Tool : Self-Assessment : Annual Review 2025 Natasha Dymond SR7 12For Assurance
- 20.0 Trust Public Board - FTSU Self Assessment Annual Review 2024
- 20.1 Trust Public Board - appendix FTSU Self Assessment Annual Review 2024 Q3 mid year review

21 National Staff Survey Natasha Dymond SR7 12For Noting
- 21.0 Trust Public Board - NHS Staff Survey Results 2024 report
- 21.1Trust Public Board - NHS Staff Survey Results 2024 appendix

22 Gender Pay Analysis report 2024-2025 Natasha Dymond SR7 12For Noting
- 22.0 Trust Public Board - Gender Pay Analysis report 2024 2025

23 Communications, Marketing and Engagement Update Gillian Hodgetts -For Noting
- 23.0 Communications Marketing and Engagement Public Board Paper Cover Sheet - 27 March 2025

24 Questions submitted by Board Members on agenda items: 23 --

25 Standing Orders and Scheme of Reservation and Delegation Becky Southall -For Approval
- 25.0 SFI SoRD Cover 200325
- 25.1 SCAS SFI SoRD Board FINAL 200325

26 Code of Governance Self-Assessment Becky Southall -For Approval
- 26.0 Code of Governance Coversheet 200325
- 26.1 Code of Governance Assessment March25 FINAL

27 Board Assurance Framework Becky Southall-For Approval
- 27.0 Board Assurance Framework Cover Page 202503
- 27.1 SCAS BAF - 24-25 March

28 Board Site Visits Becky Southall -For Noting
- 28.0 Board Site Visits coversheet March 2025
- 28.1 Board site visits 2024-25

29 Any Other Business Professor Sir Keith Willett CBE -Verbal For Noting

30 Questions from observers (items on the agenda) Professor Sir Keith Willett CBE -Verbal For Noting

31 Review of Meeting Summary of Board Actions: Becky Southall Non-Executive Director: Ian Green Executive Director: Stuart Rees-Verbal For Noting

32 Date, Time and Venue of Next Meeting in Public Thursday 29 May 2025 at 9.45am Ark Conference & Events Centre, Dinwoodie Drive, Basingstoke, Hampshire, RG24 9NN -Verbal For Noting

Agenda

Public Trust Board

Date: Thursday 27 March 2025
Time: 9.45 – 12.45
Venue: Ark Conference & Events Centre, Dinwoodie Drive, Basingstoke, Hampshire, RG24 9NN

Members:

Professor Sir Keith Willett CBE	Chair
Sumit Biswas	Deputy Trust Chair, Non-Executive Director
David Eltringham	Chief Executive Officer
Les Broude	Non-Executive Director
Ian Green OBE	Non-Executive Director
Katie Kapernaros	Non-Executive Director
Mike McEnaney	Non-Executive Director
Dhammika Perera	Non-Executive Director
Dr John Black	Chief Medical Officer
Helen Young	Chief Nurse Officer
Craig Ellis	Chief Digital Officer
Stuart Rees	Interim Director of Finance
Duncan Robertson	Chief Paramedic Officer
Becky Southall	Chief Governance Officer

In attendance:

Mark Ainsworth	Executive Director of Operations
David Ruiz-Celada	Joint Strategic Lead, SCAS, SECAmb
Kofo Abayomi	Head of Corporate Governance & Compliance
Natasha Dymond	Interim Director of People
Kate Hall	Intensive Support Director, NHSE/I
Ann Utley	Associate of NHS Providers
Susan Wall	Corporate Governance & Compliance Manager

Apologies:

Gillian Hodgetts	Director of Communications, Marketing and Engagement
Paul Kempster	Chief Transformation Officer

Item		BAF	Action	Time
OPENING BUSINESS				
1	**Chair's Welcome and Apologies for Absence** Professor Sir Keith Willett CBE	-	**Verbal For Noting**	09.45
2	**Declarations – Directors' Interests and Fit and Proper Persons Test** Professor Sir Keith Willett CBE	-	**Verbal For Noting**	
3	**Minutes from the meeting held on 30 January 2025** Professor Sir Keith Willett CBE	-	**For Approval**	
4	**Board Actions Log** Professor Sir Keith Willett CBE/ Becky Southall	-	**For Approval**	09.50
5	**Chair's Report** Professor Sir Keith Willett CBE	-	**For Noting**	09.55
6	**Chief Executive Officer's Report** David Eltringham	-	**For Noting/ Information**	10.05
7	**Update to the previous Private Board meeting held on 31 January 2025 & Extraordinary Private Board held on 20 March 2025** Professor Sir Keith Willett CBE	-	**For Noting**	-
8	**Feedback from Patient Panel Chair** Helen Young	**SR1 9**	**For Information**	10.15
9	**Integrated Performance Report** Stuart Rees & Executive Director Leads	-	**For Assurance**	10.35
	High quality care and patient experience - We will enhance our practice and clinical governance to provide safe, effective care and operational performance that delivers improved outcomes.			
10	**Quality and Safety Report (Clinical Directorate Update)** Helen Young	**SR1 9**	**For Assurance**	11.05
11	**Chief Medical Officer's Report** John Black	**SR1 9**	**For Noting**	-
12	**Assurance Upward Report** Quality and Safety Committee 19 March 2025 Dhammika Perera	-	**For Noting**	-
	Finance & Sustainability – We will maximise investment into our patient services whilst delivering productivity and efficiency improvements within the financial envelope and meeting the financial sustainability challenges agreed with our system partner.			
13	**Finance Report Month 11 Update** Stuart Rees	**SR5 16**	**For Assurance**	11.15

Item		BAF	Action	Time
14	**Hampshire and Isle of Wight ICB Month 11 Finance Report** Stuart Rees	SR5 16	**For Noting**	11.25
15	**Assurance Upward Report** Finance and Performance Committee, 18 March and 21 March 2025 Les Broude	-	**For Noting/ Assurance**	11.30
16	**Assurance Upward Report** Audit Committee, 19 March 2025 including Internal Audit Plan 2025/26 • Internal Audit Plan • External Audit Plan year ended 31 March 2025 Mike McEnaney	-	**For Noting/ Assurance**	11.35
17	**Assurance Upward Report** Charitable Funds Committee, 12 March 2025 Professor Sir Keith Willett CBE	-	**For Noting/ Assurance**	-
18	**Questions submitted by Board Members on agenda items: 11-12,15-17**	-	-	11.40
COMFORT BREAK (5MINS)				
	People & Organisation – We will implement plans to deliver an inclusive, compassionate culture where our people feel safe and have a sense of belonging.			
19	**Freedom to Speak Up Policy** Natasha Dymond	SR7 12	**For Noting**	11.45
20	**Freedom to Speak Up Reflection and Planning Tool : Self-Assessment : Annual Review 2025** Natasha Dymond	SR7 12	**For Assurance**	11.50
21	**National Staff Survey** Natasha Dymond	SR7 12	**For Noting**	12.00
22	**Gender Pay Analysis report 2024-2025** Natasha Dymond	SR7 12	**For Noting**	12.10
	Partnership & Stakeholder Engagement- We will engage with stakeholders to ensure SCAS strategies and plans are reflected in system strategies and plans.			
23	**Communications, Marketing and Engagement Update** Gillian Hodgetts	-	**For Noting**	-
	Technology transformation – We will invest in our technology to increase system resilience, operational effectiveness and maximise innovation.			
24	**Questions submitted by Board Members on agenda items: 23**	-	-	

Item		BAF	Action	Time
	Well Led – We will become an organisation that is well led and achieves all of its regulatory requirements by being rated Good or Outstanding and being at least NOF2.			
25	**Standing Orders and Scheme of Reservation and Delegation** Becky Southall	**-**	**For Approval**	12.20
26	**Code of Governance Self-Assessment** Becky Southall	**-**	**For Approval**	12.30
27	**Board Assurance Framework** Becky Southall	**-**	**For Approval**	12.35
28	**Board Site Visits** Becky Southall	**-**	**For Noting**	-
29	**Any Other Business** Professor Sir Keith Willett CBE	**-**	**Verbal** **For Noting**	-
30	**Questions from observers (items on the agenda)** Professor Sir Keith Willett CBE	**-**	**Verbal** **For Noting**	12.40
31	**Review of Meeting** Summary of Board Actions: Becky Southall Non-Executive Director: Ian Green Executive Director: Stuart Rees	**-**	**Verbal** **For Noting**	12.45
32	**Date, Time and Venue of Next Meeting in Public** Thursday 29 May 2025 at 9.45am Ark Conference & Events Centre, Dinwoodie Drive, Basingstoke, Hampshire, RG24 9NN	**-**	**Verbal** **For Noting**	-

Our Values

Caring:

Compassion for our patients, ourselves and our partners

Professionalism

Setting high standards and delivering what we promise

Innovation

Continuously striving to create improved outcomes for all

Teamwork

Delivering high performance through an inclusive and collaborative approach

South Central Ambulance Service
NHS Foundation Trust

BOARD MEMBERS REGISTER OF INTERESTS

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

INTRODUCTION & BACKGROUND

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

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

DOCUMENT INFORMATION

Date of issue: 13 March 2025

Produced by: The Governance Directorate

PROFESSOR SIR KEITH WILLETT CBE, TRUST CHAIR

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

1. Professor of Trauma Surgery, University of Oxford
2. Chair of the Chair' Group and Council of the Association of Ambulance Chief Executives (AACE)
3. Retained with NHS England and NHS Improvement to support COVID-19 public inquiry
4. Patron of IMPS (Injury Minimization Programme for Schools). An NHS charity under Oxford University Hospital NHS Foundation Trust
5. Patron of Primary Trauma Care Foundation

Current 'Other' Interests

6. Honorary Air Commodore to 4626 Squadron, RAuxAF

Interests that ended in the last six months

7. None

SUMIT BISWAS, NON-EXECUTIVE DIRECTOR / DEPUTY CHAIR

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

1. None

Current 'Other' Interests

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

Interests that ended in the last six months

4. None

LES BROUDE, NON-EXECUTIVE DIRECTOR / SENIOR INDEPENDENT DIRECTOR

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

1. None

Current 'Other' Interests

2. Independent member of the Buckinghamshire Healthcare NHS Trust Charitable Funds Committee
3. Director of Welcombe Ltd

Interests that ended in the last six months

4. None

IAN GREEN, NON-EXECUTIVE DIRECTOR

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

1. Chair of Salisbury NHS Foundation Trust

Current 'Other' Interests

2. Chair of Estuary Housing Association
3. Member of Advisory Group, NHS Patient Safety Commissioner

4. Strategic Advisor, Prevention Access Campaign (US based charity)
5. Chair, NHS Wales Joint Commissioning Committee NED, Somerset Care Ltd
6. Vice Chair, NHS Confederation LGBT Leaders Network

Interests that ended in the last six months

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

MIKE McENANEY, NON-EXECUTIVE DIRECTOR

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

1. Director of South Central Fleet Services Ltd.
2. Member of NHS Providers Finance & General Purposes Committee
3. Chair of FTN Limited (Trading subsidiary of NHS Providers charity)

Current 'Other' Interests

4. Governor at Newbury Academy Trust (primary and secondary education)

Interests that ended in the last six months

5. Member of Oxford Brookes University Audit Committee
6. Non-executive director and chair of Audit & Risk Committee – Royal Berkshire NHS Foundation Trust

Dr DHAMMIKA PERERA, NON-EXECUTIVE DIRECTOR

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

1. None

Current 'Other' Interests

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

Interests that ended in the last six months

4. None

KATIE KAPERNAROS, NON-EXECUTIVE DIRECTOR

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

1. Non-Executive Director, Manx Care.
2. Non-Executive Director, The Pensions Regulator.
3. Non-Executive Director, Oxford University Hospitals NHS Foundation Trust.
4. Non-Executive Director, The Property Ombudsman.

Current 'Other' Interests

5. Trustee (Company Director, Voluntary) - Wallingford Rowing Club

Interests that ended in the last six months

6. None

DAVID ELTRINGHAM, CHIEF EXECUTIVE OFFICER

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

1. None

Current 'Other' Interests

2. None

Interests that ended in the last six months

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

PAUL KEMPSTER, CHIEF OPERATING OFFICER

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

1. None

Current 'Other' Interests

2. None

Interests that ended in the last six months

3. None

JOHN BLACK, CHIEF MEDICAL OFFICER

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

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

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

Current 'Other' Interests

5. None

Interests that ended in the last six months

6. None

PROFESSOR HELEN YOUNG, CHIEF NURSE

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

1. Chief Nurse and Trustee for ACROSS (a medical charity taking terminal and very sick travellers on respite breaks travelling on a Jumbulance)
2. Chief Nurse and Trustee for HCPT (a medical charity taking terminal and very sick children and young people on respite breaks to Lourdes)

3. Clinical Advisor for Dorothy House Hospice Care
4. Chair of Soroptimist International (Bath Club) (a charitable organisation that works to empower, educate and enable women and young girls in UK and internationally).

Current 'Other' Interests

5. None

Interests that have ended in the last six months

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

STUART REES, INTERIM DIRECTOR OF FINANCE

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

1. SCFS Ltd Managing Director as of December 2023

Current 'Other' Interests

2. None

Interests that ended in the last six months

3. None

CRAIG ELLIS, CHIEF DIGITAL OFFICER

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

1. None

Current 'Other' Interests

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

Interests that ended in the last six months

3. None

MARK AINSWORTH, DIRECTOR OF OPERATIONS

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

1. None

Current 'Other' Interests

2. None

Interests that ended in the last six months

3. None

NATASHA DYMOND, INTERIM DIRECTOR OF PEOPLE

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

1. None

Current 'Other' Interests

2. Ad hoc HR advice (unpaid) to Rushmoor Royals Swimming Club: competitive swimming club affiliated to Swim England based in NE Hampshire.

Interests that ended in the last six months

3.None

DUNCAN ROBERTSON, CHIEF PARAMEDIC

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

1. None

Current 'Other' Interests

2. None

Interests that ended in the last six months

3. None

BECKY SOUTHALL, CHIEF GOVERNANCE OFFICER

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

1. Co-presenter on NHS England Making Data Count Programme (not paid)

Current 'Other' Interests

2. None

Interests that ended in the last six months

3. None

END

NHS
South Central Ambulance Service
NHS Foundation Trust

Minutes
Public Trust Board Meeting

Date: 30 January 2025
Time: 9.45am – 12.25pm
Venue: Ark Conference & Events Centre, Dinwoodie Drive, Basingstoke, Hampshire, RG24 9NN

Members Present:

Professor Sir Keith Willett CBE	Chair
Les Broude	Non-Executive Director
Nigel Chapman	Non-Executive Director
Ian Green	Non-Executive Director
Katie Kapernaros	Non-Executive Director
Mike McEnaney	Non-Executive Director
Professor Helen Young	Chief Nurse Officer
Mark Ainsworth	Director of Operations
Dr John Black	Chief Medical Officer
Craig Ellis	Chief Digital Officer
Natasha Dymond	Interim Director of People
Stuart Rees	Interim Director of Finance
Duncan Robertson	Chief Paramedic Officer

In Attendance:

Gillian Hodgetts	Director of Communications, Marketing & Engagement
Kate Hall	Intensive Support Director, NHSE
Kofo Abayomi	Head of Corporate Governance & Compliance
Susan Wall	Corporate Governance & Compliance Officer

Apologies:

Dhammika Perera	Non-Executive Director
Paul Kempster	Chief Transformation Officer

Item No.	Agenda Item
1	**Chair's Welcome, Apologies for Absence**
1.1	Keith Willett (Chair) opened the meeting and welcomed those present. Apologies were received as above.

2	**Declarations of Interests**
2.1	Mike McEnaney declared that he was no longer a member of the Audit Committee, Oxford Brookes University.
2.2	The Chair declared that he is a Patron, Primary Trauma Care Foundation.
2.3	The Board **NOTED** the declarations of interests.
3	**Minutes from the meeting held on 28 November 2024**
3.1	The minutes were agreed as an accurate record of the meeting subject to minor amendments to the attendance list.
4	**Matters Arising and Action Log**
4.1	The action log was reviewed, and the following action was agreed to be closed: Action 2 (28.11.24) - Complaints/Patient Experience: The Board requested that the output (components of the problem, three levers proposed and likely success) is reported to the Quality and Safety Committee. Action 2 (26.09.24) - Craig Ellis, CDO, agreed to provide a digital app to assess the reach of communication briefings to staff. Action (26.09.24) - Board Workshop be arranged to allow full consideration and assurance that the Urgent and Emergency Care Transformation Programme would deliver the planned outcomes and cost improvements, with an appropriate plan in place for any shortfalls. HoG to progress Board workshop on Urgent and Emergency Care Transformation Programme. Action 10 (26.09.24) - Further report to Board to be received relating to the performance of medicines management following its move back in-house.
5	**Chairs Report**
5.1	The Chair noted that it was an important day for the NHS, with the announcement of the government mandate and the planning guidance. This provided a steer on how the system will respond and work over the next 12 months.
5.2	The Chair asked the Board to note his site and engagement visits since the last Board meeting.
5.3	The Board **NOTED** the Chairs Report.
6	**Chief Executive Officer's Report**
6.1	David Eltringham, Chief Executive Officer, referred to his report and presented some additional information verbally, as follows: a) Planning guidance & briefing on NHS performance plan and delivery: there are planned briefing sessions until it is publicly available. Now that the planning guidance is available, there is a clear direction for the Trust plan in the coming financial year and beyond that. The Trust had proactively planned ahead with provisions made for

changes in the guidance. The Board would be informed of deadlines of all relevant planning submissions shortly.

b) Performance: The NHS continued to manage the significant demand on its services, with impacts on the entire system including SCAS. Staff continued to work incredibly hard to deliver care electronically and in person. Despite December seeing the highest number of ambulance incidents across England, SCAS worked more closely than ever with partners and were in the top three Trusts (Isle of Wight and South East Coast Ambulance Services included) for achieving Category 2 response times. This made the South East region the top performer region, this achievement highlighted good partnership system working. The Board were informed of David Eltringham's visit to the Queen Alexandra Hospital, he spoke to colleagues with focus on the emergency department and the primary care centre wards. The Hospital remained committed to working with SCAS on the continuous flow model to sustain performance. The Trust's attention was now focused on other challenging areas of the patch. David Eltringham thanked members of staff who were involved in various pieces of work to improve performance.

c) There are ongoing plans to improve category 3 and 4 performance, the Trust is exploring ways of working with partners to improve capacity to manage patients away from ambulance dispatch.

d) There is increased focus to ensure that the Trust operates within its planned financial envelope. The Hampshire and Isle of Wight ICS was also working hard to deliver its control total and the Trust has a significant role to play in contributing towards this as well as achieving its own financial obligations.

e) SCAS and South-East Coast Ambulance Service are progressing collaborative working to improve outcomes for patients and across a range of different areas to address increased demands and challenging finances. The Board were informed that a group model is being worked through, the organisations will retain their sovereignty whilst sharing knowledge and ideas. A Memorandum of Understanding (MOU) is expected to be presented to the private board later today. This collaboration aims to establish a joint strategy and appoint a shared advisor. Formal announcements will be made following the private board meeting.

f) The Board were informed of the Home Office pharmacy visit which took place on 25 January 2025, David Eltringham joined Duncan Robertson, Chief Paramedic Officer on this visit. Overall, it was a positive one with areas for improvements highlighted. More information will be provided to the Board in private with a public paper once formal feedback is received.

g) The Executive structure review was now completed and reported to the Remuneration Committee, and outcomes shared widely. There are ongoing discussions with teams to ensure that members of staff have clarity around implications of the structure review. The move to the five directorate structure will take effect from 1 April 2025. The job advertisement for the posts of Chief Finance, Chief People Officers and Executive Director of Operations will be published shortly. The Board noted that the post Deputy Chief Executive will be filled through the organisational change process and this will take a few more weeks to complete.

h) The Board noted that a series of Recovery Support Programme ((RSP) meetings took place during the week commencing 13 January 2025, which focused on finance, urgent and emergency care performance. There was a common theme of progress at these meetings and a clear acknowledgement that there was still more work to be done as a system and organisation.

	i) David Eltringham, on behalf of the Board formally acknowledged and expressed sincere gratitude for the contributions of Melanie Saunders, Chief People Officer and Aneel Pattni, Chief Finance Officer, during their time at SCAS. Their hard work and service was deeply appreciated. They were both wished well in their future endeavours.
6.2	Ian Green asked how quickly outcomes of the review will be communicated to colleagues impacted; and sought assurance that consideration was given to post review actions to move the process forward. David Eltringham confirmed that the path to certainty is clearly mapped out, reviewed, agreed internally and presented to the Trust Quality Assurance meeting (TPAM). The path to certainty for each individual impacted is clear. He touched on a number of other areas of uncertainty within the organisation i.e. the executive review, transfer of PTS contracts to private providers. There is clarity around the corporate and executive restructure but PTS contracts remained uncertain. In terms of next steps, there will be development work to reestablish teams. The Board noted the forums used to engage with staff on the restructure including the team briefs.
6.3	Nigel Chapman sought clarity on the statement around category 3 and 4 calls in respect to Commissioners seeking greater transparency and efficiency in our approach. David Eltringham explained that there are lots of work to re-engineer pathways across the system particularly in Hampshire. There were still uncertainties around requirements to close the gap to reduce ambulance conveyance and number of patients going into hospital, although significant amount has been done through SCAS connect data in terms of output and outcome is quite poor. A gap analysis to identify how patients are managed away or conveyed to hospital. Once this is quantified, conversations will begin on how this will be resourced. The Board noted that partners were fully engaged and in agreement with this approach. David Eltringham also informed the Board that the ICS are in the process of setting their priorities for the coming year and an area of focus is frailty. It was noted that majority of patients who fall under Category 3 are frail and elderly patients therefore there is scope for conversations in a way not previously done.
6.4	The Chair commented that a lot of Category 3 calls still required hospital attendance though there are alternative pathways. It was anticipated that the Government's announcement will cover investments to enhance community/primary care thus minimising unnecessary conveyance of patients to hospital.
6.5	Sumit Biswas highlighted that there was little NED visibility on process and management of inappropriate conveyance dispatch and asked for data to understand efficiency and care efficacy to be reported to the Board. **Action: Data relating to inappropriate ambulance dispatch to be provided to understand opportunities for efficiency and care efficacy**.
6.6	The Board **NOTED** the Chief Executive Officer Report.
7	**Update to the Public Board on the previous Private Board meeting**
7.1	The Board **NOTED** the update from the Private Board meeting held on 28 November 2024.
8.	**Volunteer Story**
8.1	The Board heard from Anthony Morris, a Community First Responder (CFR) based in Oxfordshire and noted that he was the runner up in the Student of the Year category at the

	Trust's Volunteer Awards 2024. Anthony Morris provided an overview of his experiences of being a CFR with SCAS.
8.2	Overall, Anthony Morris has had a positive experience being a CFR and plan to continue to do this throughout his stay at Oxfordshire. He particularly highlighted the support received from his training officer and local teams.
8.3	Anthony Morris suggested areas of improvement to the Board around: • Mapping system for CFRs and Ambulance crews, this issue has been escalated a number of times, he flagged the risk of a potential road incident if not managed. • The need to provide training to CFR responding to children i.e. symptoms and signs to look for while waiting for the crew to arrive. • The need to join up CFR and Crew response for smoother patient experience. • Internal delays and blocks to making claims when CFRs use their personal vehicles.
8.4	The Board noted his reflections as a medical student which included the impression that crews struggle to recognise signs and symptoms of ailments, he advised that necessary feedback from A&E would be useful and would allow quicker action in similar cases, this was also the case for CFRs who do not get the opportunity to seek feedback. Anthony Morris suggested that with patient permission, crews are copied into discharge summaries to improve this issue and CFRs receive electronic summary of diagnosis.
8.5	The Chair thanked Anthony Morris for his overview, recommendations and noted his exceptional commitment to the being a CFR and to the Trust. The Chair also reiterated the importance of volunteers and thanked CFRs for all their work.
8.6	Sumit Biswas thanked Anthony Morris for all his work and commitment and asked what more the Trust can do to utilise volunteers more in terms of matching opportunities to resources. Anthony Morris stated that sometimes when he is on call, he sees ambulances drive past which makes him wonder why he was not contacted. He felt that sometimes it takes a lot of time to get feedback on availability of jobs when he logs his availability, skills and available equipment.
8.7	John Black commented on the huge amount of work done by Anthony and medical students. He went on to talk about how the Oxfordshire scheme was originally set up and the story shared today illustrated the importance and value of the service. John Black formally recorded his thanks to Anthony Morris for the clinical feedback he provided regarding a patient who is a high intensity user of the service with complex needs that needed further complex multiprocessing referral, it was with Anthony's insight and feedback that the team were able to take that forward. Lastly John Black asked for Anthony's views on how the service can be extended to reach more medical students. Anthony Morris advised that improvement is needed around advertising the CFR role, which should be explicit about the option of using one's personal vehicle. There were currently only 2 medical students involved in the Oxfordshire area and he is aware that more medical students want to be involved.
8.8	Craig Ellis was grateful for the Anthony's story and asked to meet with him for CFR input into the Trust's digital strategy. Anthony Morris was happy to be contacted on this matter.
8.9	David Eltringham thanked Anthony Morris for his positive feedback and areas to be improved, he gave a commitment that the executive team have heard the feedback and will review the areas highlighted as challenges and feedback will be provided to Anthony Morris on the way

	forward. **Action: Feedback to be given to Anthony Morris, Community First Responder in relation to the suggested areas for improvement he highlighted**.
8.10	The Board **NOTED** the Volunteer Story.
9	**Integrated Performance Report (IPR)**
9.1	The Board received a report providing the high-level Integrated Performance information designed to give organisational oversight of all key areas across the Trust for assurance purposes. It covered performance in the areas of Quality, Operations, Workforce and Finance for the performance period of December 2024, the ninth month of the financial and operational year. The Board received the following sections of the IPR for discussion:
9.3	**Operations** The Board received the Operations performance for the reporting period and noted key highlights (including the question raised by a member of the public relating to the issue of inconsistencies in the December 2024 VOR rates).
9.4	Mark Ainsworth drew the attention of the Board to the new way of reporting operations within the IPR and summarised performance for the reporting period. It was highlighted that the meal breaks policy pilot did not deliver the anticipated benefits therefore it was agreed with Union colleagues that the Trust will revert to the old policy. There will be further discussions on a new pilot to try some other changes within the policy. The Board noted that the meal break policy did not achieve the financial savings neither did it achieve the expected improvements. The Executive Management Committee will receive a detailed analysis of the meal break policy and next steps in February 2025.
9.5	In response to the question around the inconsistency of the VoR data, Mark Ainsworth stated that there was a difference in the numbers: the original table recorded VoR at 40% and another chart which showed 39.8%, the inconsistency was due to rounding up of numbers. The exact figure for December was 39.8%, there was an error in the executive summary which stated 43%, this was November figure. The Board were asked to note the correction. Mark Ainsworth further stated that work is ongoing with the fleet team to reduce lost hours throughout fleet availability. There is ongoing work with the Director of Finance and fleet team on fleet workshop capacity and developing a third workshop. To further mitigate the issue of fleet availability, there were now improved processes of getting the vehicles back to crews quicker for the start of their shift, reducing lost hours.
9.6	The Board received a verbal update on performance for January: Category 2 performance was below plan at 26mins 19 seconds against a target of 25mins 53 seconds, Category 3 performance was 4 hours 23 minutes, an improvement compared to previous months and an overall improvement across all measures.
9.7	The Chair thanked Mark Ainsworth for the update and requested that the 2nd aspect of the VoR question is addressed i.e. why this has been a long term issue. Mark Ainsworth addressed the operational issues impacting VoR which included aging fleet causing the vehicles to break down more, inadequate charging of vehicles batteries and crews not charging during meal breaks, damage to cables on the charging facilities and engine failures. Stuart Rees added

	that to date there have been 71 engine issues which was a cost pressure to the Trust and additional pressure on the workshops, hence the need for a third workshop. Stuart Rees summarised interim arrangements in place including extra ramps at North Harbour and on-site repairs where possible. Permanent measures include replacing the old fleet but there are restrictions to this due to the national programme. The Board also noted the delay to the delivery to the Fiat fleet, 70 in total and the Trust was also in discussion with the national team on allocation of additional fleet. Stuart Rees provided assurance that the old fleet would be fully replaced by the end of 2026.
9.8	Ian Green queried whether more could be done to mitigate the risk relating to uncertainty around availability of fleet and whether there are ongoing national discussions to further mitigate this issue. Stuart Rees explained that further to FPC and EMC discussions, a plan with trajectories will be produced particularly on areas within SCAS control and areas where the national team can be influenced. Work is also ongoing with SCFS Ltd to proactively review fleet requirement and best fit for the Trust.
9.9	Katie Kapernaros asked whether further reduction in VoRs will improve Category 1 & 2 performance. She also stated that although changes to meal break policy did not yield desired results, the effort and quick recognition of this was commendable. Mark Ainsworth explained that it was challenging to accurately capture daily number of lost hours, a process was implemented recently which will enable the BI team to provide weekly reporting detailing the number of hours crews are without vehicles, the Board was asked to note that with the new process, crews still able to respond to patients by calling a car, this way they can still get to Category 1 patients but the clock does not stop with Category 2. Once enough data is collected by the BI team, Mark Ainsworth and his team will review impact of lost hours on Category 2 performance.
9.10	In response to Nigel Chapman's query on how staff morale is being managed due to fleet deployment even where there is staff availability and secondly on the issue of robust engagement and private provider relationship to fill gaps, it was noted that the impact on morale is variable depending on the situation i.e. start of shift or during shift, overall, the staff find this frustrating. In regard to the private provider hours, there is a mix of good and bad news story, for instance week commencing 3 February there will be 99% shift cover however these hours would not be required resulting in financial cost pressure. Operational hours beyond the current financial year is unknown due to ongoing planning process and contractual private provider hours not yet available.
9.11	Sumit Biswas sought assurance that the new specification fleet will not cause further challenges to the Trust when they arrive. Stuart Rees explained that the vehicle prototype have been tested and the operations staff are more than happy to receive the new vehicles. Les Broude informed the Board that the FPC received relevant assurance on this matter including timeframe for the arrival of the fleet and plans for the additional workshop, long term impact of setting up, cost of setting up the electrical charging points.
9.12	David Eltringham commented that there is a sustainability and the interrelation between all the moving parts, impacts on Category 2, 3 & 4 performance continued to be Executive team focus. He also informed the Board that EMC received a paper on the overarching view of the fleet at the end of last year, there have also been discussions around safety to patients and the Trust's ability to deploy Category 2 performance. In terms of areas of improvement, David

	Eltringham stated communication and engagement in the development of the vehicle designs, these will be discussed at EMC in the coming weeks.
9.13	Sumit Biswas sought clarity on the PTS volumes and journey as stated on page 60 of the IPR. He noted that there were 56000 journeys with 16000 patients. It appeared that the Trust is investing in a lot of resource cost, money and time for something that was not providing the required patient services. It was agreed that this would be looked into with feedback provided. **Action: Explanation to be provided in the IPR in relation to the divergence between the number of patients transported and the number of journeys**.
9.14	**Quality and Safety** The Board received the Quality and Safety performance for the reporting period and noted the following key highlights: • Improvements noted in **Level 3 Safeguarding** • Audit activity, vehicle cleanliness compliance has declined. The Board noted mitigation actions in place to improve compliance.
9.15	**People** The Board received the workforce performance for the reporting period, noting in particular that the decline in Whole Time Equivalents (WTE) continued mainly due to the target set at the beginning of the year, reduction in workforce in the course of the year, and impact of holding vacancies as we go through the corporate restructure, resulting in lower number of staff within the Trust, vacancies rates being impacted by the impending loss of PTS. This is a concern which needs to be linked to the IPR commentary. Natasha Dymond reported that despite the decline, 230 new staff have been onboarded in the operations team in the current year and an increase of 90 in comparison to last year.
9.16	Appraisals has made good progress but continues to be hit and miss, it is unlikely to achieve the 95% target due to winter pressures. There has been an increase in appraisals through a revision of ESR process and form therefore there is a level of optimism for next financial year.
9.17	Statutory and mandatory training although appears concerning at 38.5% compliance rate, relates to an average of all training and not individual modules.
9.18	The Board noted that there was a deep dive of the Trust's recruitment processes and it was the view of the Committee that more work is required to assure the Committee of the robustness of the Trust's recruitment process. A quality improvement piece of work was requested by the Committee with progress updates to be reported to the Board.
9.19	The Chair commented that with the corporate review and PTS contracts, there will be a reset of targets, he queried whether the reset will be done in April. Natasha Dymond responded that this will be done through the workforce planning process.
9.20	Further to the point raised by Ian Green on time to hire piece of work discussed at the People and Culture Committee, Natasha Dymond reported that the team had a productive meeting with Sumit Biswas. The new national guidance around measuring and reporting time to hire was recently released and the team have attended webinars to understand the requirements. The Board noted that there could be a need to review the IPR measurements as a result.

9.21	David Eltringham provided assurance on the actions taken to improve statutory and mandatory training compliance, EMC is set to receive an update, there is also an internal audit in progress. He stated that the data recorded in the IPR is misleading due to the way it is constructed. Actions agreed at EMC will feed through the People and Culture Committee and assurance provided to the Board that there is clarity on statutory and mandatory requirements.
9.22	Sumit Biswas recognised improvements in IPR reporting but there were still areas that required redesign and further work around the metrics. David Eltringham stated that this continued to be a focus of the EMC with support in Sam Riley, NHS England national team. **Action: Commentary to be provided in relation to action being taken in response to a number of KPIs with no target that are hit and miss in terms of performance.**
9.23	**Finance** The Board noted the finance section of the IPR.
9.24	The Board **noted** the Integrated Performance Report.
10	**Quality and Patient Safety Report**
10.1	The Board received the Quality and Safety Report which contained data for the period of November and December 2024.
10.2	Helen Young, CNO, introduced the report and drew out some elements for particular note, as follows: • Safeguarding Level 3 Training (Adults & Children) has achieved 94% against a 90% target. 12 Safeguarding sessions were delivered in December 2024 to achieve the latest increase. • Mental Capacity Act Level 1 training is above target at 97% against a 95% target. Audits demonstrate an overall improvement in the knowledge and skills of our staff. • Vehicle audits are above the upper control limit special cause variation. The improvement trajectories and local action plans are being effective as operational teams increase audit numbers. • Infection prevention and control level 2 compliance has increased from 90% to 91% against a 95% target during the reporting period.
10.3	Safeguarding Safeguarding referral forms have now been launched with feedback received from users and Local Authorities. There is still more work to do on the number of referrals quality but this was still a significant step forward. More information will be provided in the private meeting relating to safeguarding technical issues.
10.4	Patient Experience (PE) and Engagement The Trust received 700 PE contacts during the reporting period, no change noted in the trend remaining consistent. Themes of patient experience cases remain; inappropriate disposition (111), delay in/no attendance of frontline 999 and PTS vehicles.
10.5	Les Broude asked whether more can be done to improve the quality experienced by patients experiencing delays. Helen Young explained that a thematic review has been carried out on why patients are experiencing delays, triggers and actions for improvements and these include

	call backs checks to patients, alternative pathways and hear and treat. Mark Ainsworth added that there is also the Single Point of Access, which ensures that the right patients are directed to other services and within Category 3, audits of patients that can be sent to other providers.
10.6	Mark Ainsworth reported in the accreditation programme has commenced and received positively. The Board noted that the Patient Safety team carry out compliance visits to each site, with inspection reviews on areas such as infection prevention control, medicine storage, each site is rated according to the outcome of the visit, detailed information can be found in the quality and safety report and the Board seminar on CQC preparedness. Helen Young gave a brief summary of the accreditation programme which was linked to CQC preparedness and to provide internal assurance. Non-Executive Director colleagues were invited to take part in the accreditation programme visits. The Chair also requested that future site visits and dates should be circulated to NED colleagues. **Action: Accreditation Programme visit dates to be circulated to the NEDs**. John Black informed the Board that details of accreditation visits are on the Trust intranet Hub site to ensure that staff understand the process and what is expected of them in their various areas.
10.7	In response to Katie Kapernaros' query on whether there was a target rating for sites, Helen Young explained that the minimum rating expected of sites is blue, which indicates that urgent and significant improvements need to be made, she summarised the categories up to platinum which indicates exemplar site.
10.8	Mike McEnaney advised that the programme should be standardised as part of clinical audits and that the Audit Committee should review the effectiveness of the accreditation process on an annual basis.
10.9	The Board **NOTED** the Quality and Patient Safety Report.
11	**Chief Medical Officer's Report**
11.1	The Board received the report of the Chief Medical Officer. The Board was asked to note the epidemiology update within the report. It was also noted that Seasonal Influenza A which had been the dominant strain so far this winter are also falling having peaked in the first weekend in January with number of new cases fallen by 39% and beds occupied by 25%.
11.2	**The Board noted the Chief Medical Officer's Report.**
12	**Assurance Report**
12.1	Quality and Safety Assurance Upward report dated 13 January 2025.
12.2	The Board **NOTED** the report.
13	**Finance Report Month 9 Update**
13.1	Stuart Rees presented the report. The Board noted that in Month 9, the Trust recorded an in-month deficit of £2.4m, matching the planned deficit. The Trust received year-to-date (YTD) deficit funding of £4.8m from HIOW ICB. This reduced the reportable YTD deficit to £3.9m, compared to the planned £8.7m deficit.

13.2	In response to the question raised by a member of the public around the level of confidence that the Trust will achieve its control total, Stuart Rees stated that there is a high level of confidence, but this was without risks. Those risks are monitored regularly with weekly meetings with the budget team. There is a similar process with the ICB, with confidence also that the Trust will achieve its control total.
13.3	Stuart Rees highlighted that The Trust's capital spend to December was £5.8m, with £6.8m from vehicle sale and leaseback sales, producing a net income of £1m. The Trust is £17.2m underspent against its YTD capital budget, driven by: Digital and Estates: £6.7m behind plan, Net sales proceeds: £1.6m and DCA replacement slippage: £8.9m, now expected between January and March 2024.
13.4	The Trust's cash balance at the end of December was £22.7m, with a net cash outflow of £1.98m in Month 9, primarily due to purchase ledger payments.
13.5	Mike McEnaney pointed out that emergency operations was overspent by £1.4m, and this was a sizeable variation in the reporting period. He then queried how this issue was being managed, noting that vehicle maintenance had been discussed in detail, but wanted assurance on the other aspects. Mark Ainsworth explained that vehicle maintenance is ongoing repair cost and therefore a significant challenge to operations. He also stated that made ready is a contracts issue and the contract did not reflect the full value of the cost, as a result this will be ongoing pressure for the remainder of the year. Mark Ainsworth highlighted that The Hazardous Area Response Team (HART) was recently resolved, but not reflected in the paper due to timing of board papers published, overtime relating to Emergency Operations Centre (EOC) will be capped; frontline resourcing is also being managed with costs expected to reduce by end of January and in line with budget by March. Mike McEnaney noted the actions and asked if these areas were a risk to delivering the Trust plan. Stuart Rees explained that achieving the plan was without risks including these areas of over spend but there are robust mitigations in place, monitored weekly by the executive team, EMC and FPC.
13.5	In response to Sumit Biswas' query on the impact of the corporate review on the run rate in the new financial year, Stuart Rees explained that provision will be made for this at year end and brokerage from NHS England as part of improving the system will be included. EMC receives an update on the underlying run rate and this will include exit from this year and entry into the new financial year.
13.6	Further to Nigel Chapman's comment around managing the Trust's underlying deficit beyond the current financial year, Stuart Rees responded that there is more focus on next year and beyond as there is grip on the current year. There will also a three year rolling capital plan for the board to sign off. David Eltringham added that in reviewing the run rate, there will be real time expenditure exercise. In terms of the underlying position, there is planning beyond next year with set actions to address sustainability
13.7	**The Board noted the Finance Month 9 Update**.
14	**Hampshire and Isle of Wight ICB Month 9 Finance Report**
14.1	The Board received the Hampshire and Isle of Wight ICS Month 9 finance report, The purpose of the Month 9 (M9) Finance Report for Hampshire & Isle of Wight Integrated Care System (ICS) was to provide details of the financial position and system recovery plan for the ICS as

	at the end of December 2024.
14.2	The Board **noted** the Hampshire and Isle of Wight ICB Month 9 Finance Report.
15	**Assurance Report**
15.1	Finance and Performance Committee 21 November and 18 December 2024.
15.2	The Board **NOTED** the Finance and Performance Committee Assurance Reports.
16	**Assurance Report**
16.1	Audit Committee 19 January 2025.
16.2	The Board **NOTED** the Audit Committee Assurance Report.
17	**Questions submitted by Board Members on agenda items: 11-12 & 15 - 16**
17.1	No questions received.
18	**Assurance Report**
18.1	People and Culture Committee 16 January 2025
18.2	The Board **NOTED** the People and Culture Committee Assurance Report.
19	**Assurance Upward Report**
19.1	Charitable Funds Committee 10 January 2025
19.2	The Board **NOTED** the Charitable Funds Committee Assurance Report.
20	**Communications Update**
20.1	The Board **NOTED** the Communications Update.
21	**Chief Digital Report**
21.1	**The Board NOTED the Chief Digital Officer's report.**
22	**Questions submitted by Board Members on agenda items: 18-21**
22.1	No questions were received.
23	**Board Assurance Framework (BAF)**

23.1	The Board received a report setting out proposed changes to the BAF. It was noted that the BAF will be refreshed during the Trust's planning process ahead of the new financial year. **Action: Board session on refresh of the Board Assurance Framework for 2025/26. Session to be arranged before July 2025.**
23.2	The Board **APPROVED** the amended Board Assurance Framework
24	**Board Site Visits**
24.1	The report was asked to be amended to reflect Ian Green and Natasha Dymond's visits.
24.2	The Board **NOTED** the Board Site Visits Report.
25.	**Any other business**
25.1	There was no other business at this meeting.
26	**Questions from observers**
26.1	In addition to the questions received ahead of the meeting and covered in the course of the meeting, a question was also raised around measurable outcomes expected from the SCAS-SECAMB collaboration. David Eltringham responded that the draft Memorandum of Understanding (MOU) between SCAS and SCECAMB will be discussed at the private Board meeting. The MOU sets out the summary of work already undertaken by both organisations and further identifies areas of collaboration with six themes of prioritisation. There are real opportunities to work together in back office functions. These are still being worked up and will be measured. The final MOU will be presented in a future public Board.
27	**Executive Director Review of the meeting:**
27.1	Mike McEnaney, Non-Executive Director, reflected that: • This was a more meaningful meeting than previous ones • Papers were fine and length good, papers are now focused and succinct • There was more mention of system working and delivery • CFR story was good with significant suggestions for improvements put forward • IPR, more coherent discussion which showed progress • Complete view of Category 3 and 4 is required, proposed a summary is reported to the Board. • Executive challenge still lacking, more contributions beyond answering questions needed.
27.2	Mark Ainsworth, Executive Director of Operations, reflected that: • IPR discussion is improving • More triangulation with executive team with close working reflected. • Recognition of improvement was welcoming • Executive to Executive challenge still lacking.

28 28.1	**Date, Time and Venue of Next Meeting in Public** The next public meeting of the SCAS Board would take place at 9.45am on 27 March 2025 at the Ark Conference & Events Centre, Dinwoodie Drive, Basingstoke, Hampshire, RG24 9NN

South Central Ambulance Service NHS Foundation Trust

TRUST BOARD ACTION LOG						Status
Minute Ref:	**Agenda Item**	**Action**	**Owner**	**Due Date**	**Update**	
Meeting Date: 30th January 2025						
TB/25/001	Minutes	Attendance table to be amended to correctly reflect attendance and apologies	KA	27.02.25	Completed	**Propose to close**
TB/25/002	CEO Report	Data relating to inappropriate ambulance dispatch to be provided to understand opportunities for efficiency and care efficacy	MA	27.02.25	We do not have data to identify inappropriate dispatch as we are required to respond to all calls that we cannot deal with through Hear & Treat or a different provider. There is currently a category 3/4 review underway which will identify which categories of calls could be sent to other providers. This is due to conclude at the end of March and the findings will be reported back.	
TB/25/003	Quality & Patient Safety Report	Accreditation Programme visit dates to be circulated to the NEDs	HY	07.02.25	Verbal Update.	
TB/25/004	Volunteer Story	Feedback to be given to Anthony Morris, Community First Responder in relation to the suggested areas for improvement he highlighted.	DE/ND	14.02.25	Complete: Letter from CEO to Anthony Morris sent.	**Propose to close**
TB/25/005	Integrated Performance Report NEPTs	Explanation to be provided in the IPR in relation to the divergence between the number of patients transported and the number of journeys.	SR	28.03.25	Complete: Discussed at committee and Board.	**Propose to close**

TB/25/006	Integrated Performance Report	Commentary to be provided in relation to action being taken in response to a number of KPIs with no target that are hit and miss in terms of performance	SR	28.03.25	Agreed that targets will be added where possible to do so (Making Data Count principles accept that not all measures will have a target). Will feature in the next iteration of the IPR.	**Open**
TB/25/007	Board Assurance Framework	Board session on refresh of the Board Assurance Framework for 2025/26. Session to be arranged before July 2025.	BS		In progress, first Board session was held in February.	**Open**
Meeting Date: 28 November 2024						
TB/24/001	Patient Story	Deep Dive commissioned by People and Culture Committee on supporting staff with disabilities to include out of sector reasonable adjustments particularly the fire service	ND	March 25	Reasonable Adjustment Working Group has now been set up, chaired by a clinical operations manager and the ToRs are being developed. The Group will be tasked with the deep dive to be reported to the PACC. Action to remain open until the next meeting. *March update: Working Group has not met since previous update in January. Deep dive still outstanding*	**In progress**
Meeting Date:						
TB/24/012	Assurance Report - Audit Committee 18 September 2024	Board to receive a more detailed report on asset management within the next two meetings – DoO & HoG to facilitate.	SR	May 25	Report to be provided at the next meeting.	**Open**

NHS
South Central Ambulance Service
NHS Foundation Trust

Trust Board of Directors Meeting in Public
27 March 2025

Report title	Chair's Report
Agenda item	5
Report executive owner	N/A
Report author	Jayne Waller, Senior Executive Assistant (Chair)
Governance Pathway: Previous consideration	Not Applicable
Governance Pathway: Next steps	None

Executive Summary

The purpose of the Chair's report is to keep the Board updated of stakeholder engagement and site visits since the Board meeting held in March 2025.

Alignment with Strategic Objectives

The Chair's report aligns with the Partnership and Stakeholder Engagement objective.

Relevant Board Assurance Framework (BAF) Risk

The Chair’s report relates to BAF risk SR4 - Engagement with Stakeholders

Financial Validation	Not Applicable
Recommendation(s)	
The Board is asked to note the stakeholder engagements and site visits update.	

For Assurance		**For decision**		**For discussion**		**To note**	✓

1. Purpose

The purpose of this Chair Report is to inform the Board of stakeholder engagement and site visits since the Board held in January 2025.

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

February 2025

- BOB Integrated Care Partnership Meeting
- Human Welfare Group – Cabinet office
- Portsmouth Hospital Chief Nurse Engagement Session
- BLMK Leaders and Chairs Meeting
- Thames Hospice visit
- NHSE 10 Year Plan Finance and Contracting Working Group
- Wexham Park Hospital ramp and RC visit
- SECAMB/SCAS Chair/CEO Meeting

March 2025

- SCAS Extraordinary Charitable Funds Committee
- Ambulance leadership Forum (ALF)
- Hosted new SCAS 'Tomorrow's Paramedic' Webinar for student paramedics
- Exec Recruitment Stakeholder Session (Chief People Officer)
- AACE Chairs Meeting
- ICS Monthly Chairs Meeting
- SCAS Membership and Engagement Committee
- School Talk at John Colet School, Buckinghamshire - Speaker for Schools
- Rt Hon Kit Malthouse MP visit to SCAS Otterbourne

Other

- Monthly: SE Senior Leaders Briefings (Anne Eden, NHSE SE Regional Director)
- SCAS Team Brief Lives
- NED 1:1s and PDRs
- NED Recruitment and Extraordinary CoG for approval
- Covid Inquiry witness PPE and ventilator briefing calls

Recommendation

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

NHS
South Central Ambulance Service
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Board of Directors Meeting in Public
27 March 2025

Report title	Chief Executive Officer's Report
Agenda item	6
Report executive owner	David Eltringham, Chief Executive Officer
Report author	David Eltringham, Chief Executive Officer
Governance Pathway: Previous consideration	Not Applicable
Governance Pathway: Next steps	Not Applicable

Executive Summary

The CEO report provides an update on internal trust matters, including organisational performance and seeks to bring to the attention of the board areas to note relating to system-wide and national developments.

Alignment with Strategic Objectives

The CEO report aligns with the Well Led objective but underpins delivery of all of the trust objectives.

Relevant Board Assurance Framework (BAF) Risk

As the CEO report relates to all objectives it is also pertinent to all BAF risks.

Financial Validation	Not Applicable
Recommendation(s)	
The Board is asked to **NOTE** the report and to **RAISE** any questions.	

For Assurance		**For decision**		**For discussion**		**To note**	✓

Chief Executive Officer's update

27th March 2025

- **Performance**

Despite the continuing pressures and demand across the NHS, performance during February is positive across category 1 and 2 response times. This is as a result of the continuing hard work of our staff and with our partners across the system to ensure that patients are handed as soon as possible. This reduces lost hours and allows our crews to get back out of the road and respond to more calls. Whilst we are mindful that we are not achieving the national target response times for either category 1 or 2 calls it is pleasing that we are able to demonstrate month-on-month improvement. However, we are not resting on our laurels, and we will need to continue to work closely with partners to ensure that the hard work undertaken to date continues and that we can provide high quality care to our patients through faster response times.

- **Finance update**

There is no doubt this has been a difficult year and we have worked hard to improve our financial position and ensure that we achieve financial stability. I am pleased to report that we remain on trajectory to deliver our control total, including delivering circa £29m in recurrent savings as part of our Financial Recovery Plan. However, we have achieved this through deficit funding and brokerage from the system, which we are required to pay back over the next 2-years and our underlying financial position remains in deficit. As such, there is further work to do to return us to a sustainable position and whilst work is already underway to modernise the way we work through our Fit For the Future Programme, we will need to work differently across the organisation as we recognise this is the route to sustainability across quality, operational and financial performance.

As I have done throughout the year, I acknowledge that this has been a difficult and challenging year for the organisation, but we should be collectively proud of this achievement and our positive contribution to the overall financial position of the system.

- **Planning or 2025/26**

As I have alluded to above, whilst we should celebrate our improved position, we know that next year will be equally challenging and difficult decisions have and will continue to be made. Our planning process for 2025/26 has included a rigorous process of risk assessment and as an executive team, our focus has been on balancing quality, operational and financial risk.

From a national and regional perspective, the ask was to submit a plan that would deliver a break-even position and under 30 minutes category 2 performance. The board has had sight of our plan as it has developed, and we submitted a plan to the ICB that met these requirements on 21st March 2025. As the board is aware, the plan is not without risk, and we will need to continue to work with our partners across the system to ensure that we can deliver category 2 performance without jeopardizing our financial position.

These are not however the only components that we will need to deliver in 2025/26 and to ensure that we have the right framework in place to monitor and oversee progress, as a Board, we spent some time in February reviewing our Fit for the Future Programme. This is a well-known and well recognised brand across the organisation and whilst we have delivered against some of the key pillars, we continue to refine these so that we can develop a set of annual objectives for delivery in 2025/26. We have engaged with the organisation and look forward to taking the outputs to the Board Seminar in April.

Aligned to this, we remain in the Recovery Support Programme and have taken the opportunity to refresh our approach to making the improvements that will lead us out of Recovery Support and beyond. 2024/25 was a year of consolidation and whilst I am proud of the work that we have done to build the foundations that were required for us to move forward, we will now continue to build on these and developing an overarching Improvement Plan. This will ensure that we continue to make progress in key areas such as leadership and culture, governance and well led and operational performance.

- **Changes to National Team**

As the board will be aware, this month has seen major changes in the structure at the top of the NHS in that the abolition of NHS England was announced. Sir Jim Mackey has been charged with overseeing the process of transitioning NHSE into the Department of Health and Social Care and has met with Chairs and CEOs. The Chair and I have also attended system meetings to discuss how the way that we work as a system will need to change to reflect these changes. We recognise the impact these announcements will have on our colleagues in both organisations but remain committed to delivering on our plans and playing an active role as a system partner.

- **Executive Structure Review**

The revised executive structure will go live on 1st April 2025 and I am pleased to advise that the interview process for the following posts have been taking place in the last 2 weeks:

- Chief Finance Officer
- Chief People Officer
- Executive Director of Operations

We look forward to welcoming new colleagues to the executive team and the board once the recruitment process is complete and the successful candidates will take leadership of their new teams when they commence in post.

- **Events**

Patient Engagement Forum

I attended the forum with Duncan Robertson, our Chief Paramedic Officer and welcomed the opportunity to meet with our patient representatives to and to hear their feedback on the services that we provide. It is through engaging with our patients and users of our services that we understand where we need to improve, and I welcomed the opportunity to hear from them first hand.

Ambulance Leadership Forum (ALF) conference

I attended the above 2-day event in Leeds with the Chair and other members of the executive team and would reflect on the value of taking time out to engage with other colleagues from across the sector and to learn from one another. The event also gave us the opportunity to build stronger working relationships with our colleagues at SECAMB as we move further into our collaboration work, which will be key to unlocking opportunities to work more closely and more efficiently and effectively.

David Eltringham

Chief Executive

January 2025

NHS
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Trust Board of Directors Meeting in Public
30 January 2025

Report title	Update to the previous Private Board meeting held since the last Public Meeting on 30 2025
Agenda item	7
Report executive owner	Becky Southhall, Chief Governance Officer
Report author	Kofo Abayomi, Head of Corporate Governance
Governance Pathway: Previous consideration	Not Applicable
Governance Pathway: Next steps	Not Applicable

Executive Summary

The report details agenda items that were received by the Private Trust Board, decisions made, and items noted at the meetings held on 30 January, 27 February and 20 March 2025.

Alignment with Strategic Objectives

This reports relates to the Well Led objective.

Relevant Board Assurance Framework (BAF) Risk
This report relates to all BAF Risks.

Financial Validation	Not Applicable
Recommendation(s)	
The Board is asked to note the update.	

For Assurance		**For decision**		**For discussion**		**To note**	✓

Private Trust Board 30 January

1. **Confidential Report from the Chair**

   The Board received an update from the Chair with key points:

   a. Secondary Care Transformation
   b. SCAS/SECAmb collaborative

2. **Confidential Report from the Chief Executive Officer**
   The Board received an update from the Chief Executive Officer with key points:
   a. IPR review
   b. Update on the Collaboration with SECAmb

3. **SECAMB/SCAS Collaboration Memorandum of Understanding**
   The Board considered the collaboration memorandum of understanding

4. **Self-assessments for the current financial enforcement undertakings for Hampshire and Isle of Wight Integrated Care System (ICS Providers)**
   The Board noted the updated self-assessments for the current financial enforcement undertakings for HIOW ICS.

5. **SCAS Undertakings Letter and Compliance Certificate**

   The Board noted the SCAS undertakings letter and compliance certificate.

6. **Finance Month 9 Confidential Update**
   The Board noted the confidential update on the month 9 financial position.

7. **Financial Recovery Plan**

   The Board **NOTED** the report and progress against the plan.

8. **Update on 24/25 Operational Planning Process**
   The Board noted the update on 24/25 operational planning process.

9. **Confidential HIOW ICS Finance Report – Month 9**
   The Board noted the HIOW ICS Month 9 Finance Report

10. **Ambulance Contract 2024 / 25 HIOW and TV ICB Funding Allocations: Variations CV03 through to CV09**
    The Board approved the variation orders.

11. **SCAS NEPTS Service Findings and Options Paper**
    The Board noted the findings and options paper.

12. **Business Case for Adastra Contract Renewal**
    The Board approved the business case for Adastra contract renewal.

13. **2024/25 Quarter 1 & 2 Employee Relations Cases**
    The Board noted the report.

Any Other Business

1. The Board received a confidential update on the Home Office License Inspection.

2. **The Board received a confidential on safeguarding referral and reporting.**

Private Trust Board 27 February

1. **Confidential Report from the Chair**
   The Board received an update from the Chair with key points:
   a. NED recruitment
   b. Emergency Preparedness, Resilience and Response (EPRR)

2. **Confidential Report from the Chief Executive Officer**
   The Board received an update from the Chief Executive Officer with key points:
   a. SCAS Operational and System performance
   b. Update on Recovery Support Programme
   c. SCAS financial position
   d. Update on Executive Director recruitment
   e. NHS England leadership change

3. **Integrated Performance Report**
   The Board received the integrated Performance Report for the period covering January 2025.

4. **Finance Report – Month 10**
   The Board received the finance month 10 update.

5. **Financial Recovery Plan**
   The Board received the financial recovery plan for month 10.

6. **Confidential HIOW ICS Finance Report – Month 10**
   The Board received the HIOW ICS finance report month 10.

7. **Sussex Non-Emergency Patient Transport Services (NEPTS) Contract Variation CV02 – Pay Award Uplift Allocations**
   The Board approved the contract variation.

8. **HIOW Non-Emergency Patient Transport Services (NEPTS) Contract Variation CV01 for Lot 1 & Lot 2 – Pay Award Uplift Allocations**
   The Board approved the proposal.

9. **Digital Update**

The Board received the digital update report.

Extraordinary Private Trust Board 20 March

1. **2025/26 Operational Plan**
   The Board approved the 2025/26 Operational Plan.

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Trust Board of Directors Meeting in Public 27 March 2025

Report title	Patient Panel update
Agenda item	8
Report executive owner	Helen Young, Chief Nurse
Report author	Nikhyta Patel, Patient and Public Engagement Facilitator
Governance Pathway: Previous consideration	Not Applicable
Governance Pathway: Next steps	

Executive Summary

Take Assurance:

The Patient Panel has now been established with 22 members having been recruited.

The Panel has achieved all of the focus areas set at the introductory meeting in February 2024 and will be setting the new focus areas for 2025-26 at the next meeting on 8th April 2025.

Co-produced Easy Read Guide can now be accessed on the SCAS public website ensuring accessibility.

Alignment with Strategic Objectives

With which strategic theme(s) does the subject matter align? High Quality Care & Patient Experience

Relevant Business Assurance Framework (BAF) Risk
To which BAF risk is the subject matter relevant? SR4 - Engagement with Stakeholders

Financial Validation	N/A

Recommendation(s)
The Board asked to: Note and take assurance from the Patient Panel presentation and update which will be presented by Roger Batterbury (Patient Panel Chair).

For Assurance	✓	**For decision**		**For discussion**		**To note**	✓

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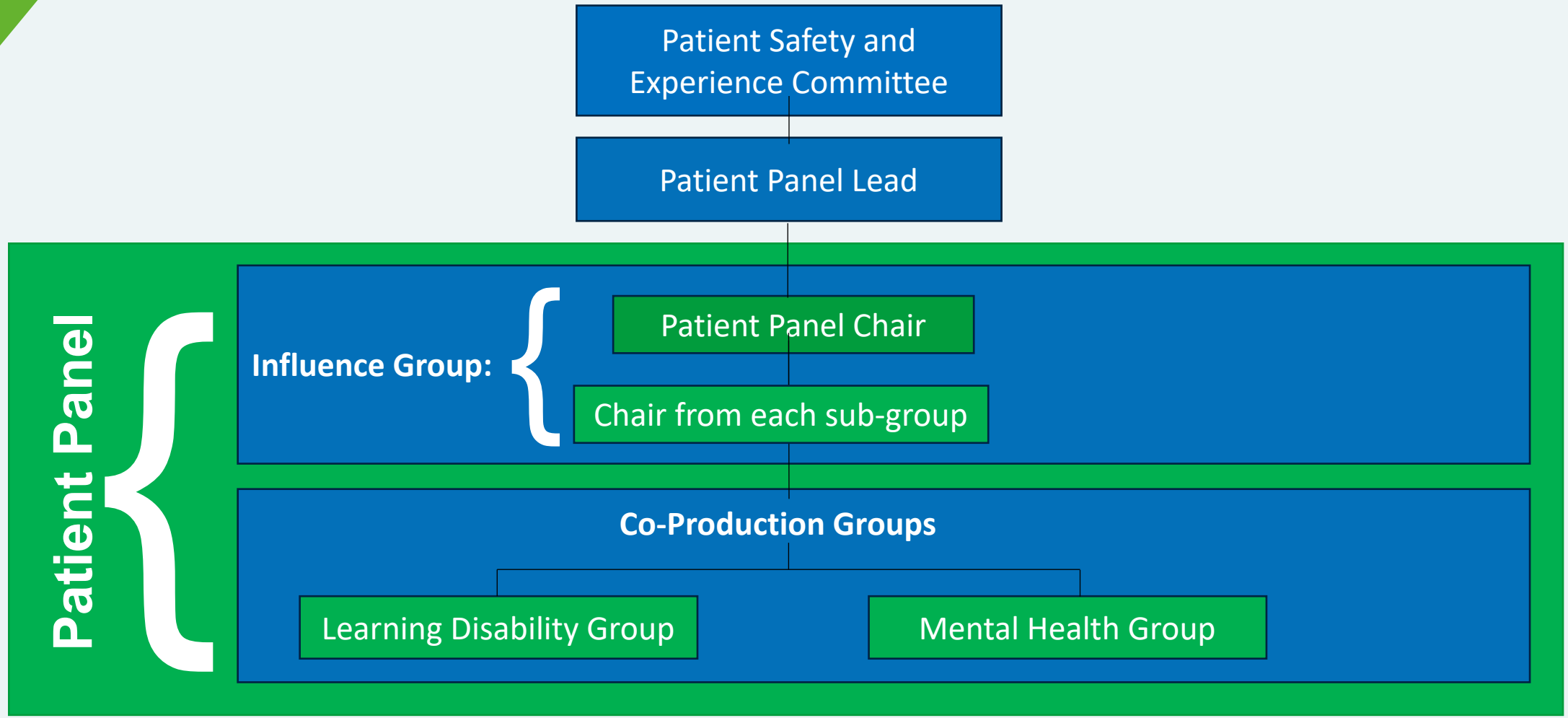
Patient Panel

Presented by Roger Batterbury

Patient Panel Chair

Patient Panel Structure

The initial Patient Panel structure:



Patient Panel Launch

The Patient Panel launched with its first introductory meeting on

21st February 2024

The Patient Panel Chair and Chairs of the two Co-production groups visited Southern/Northern House.

Feedback from CFR ride-along

There were three emergencies attended:

- A care alarm alert – this turned out to be a false alarm with the patient safe and well at another location.
- An elderly confused patient who was conveyed to hospital by the crew that subsequently arrived after the CFR. There were a lot of crew members attending this incident and therefore an opportunity to speak to frontline staff.
- An out of area baby struggling to breathe – this was an emotional attendance for all, and the baby was conveyed with their mother to the nearest paediatric department.

Key areas of focus

The key area that the patient panel members wanted to focus on were identified during this introductory meeting.

The areas of focus identified were:

- Passport use and Ambulance care plans
- Easy read and accessibility of documents
- Barriers to access 111 and 999
- Co-produced training
- End of Life care

What have the Learning Disability Group been working on?

Sharing their experiences of using SCAS services

Co-Producing SCAS Learning Disability Policy

Reviewed accessibility of the SCAS website

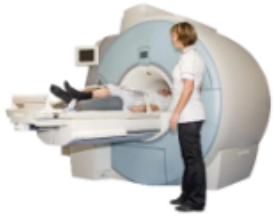
Co-producing the following Easy read guides:

- Calling 999
- 999 Response times and category of call
- What to expect when the ambulance arrives
- Complaints process

Co-producing the SCAS Learning Disability Strategy

Example Easy Read

After all the observations are complete, the crew may say that you need to go to Hospital.



This is because the Hospital can do more detailed observations to make sure you are OK.

The ambulance staff will explain the reasons why you need to go hospital and what might happen if you don't.

You can choose not to go to hospital if you wish.

It is your choice as long as you understand what might happen if you choose not to go to hospital.

This should be a joint decision between you and the ambulance crew with your best interest in mind.

If you can't understand, what might happen if you don't go to hospital, the ambulance crew may ask family or friends that know you so that they understand your decision.

If there is no one that can help the ambulance crew understand your choice they may still have to take you to hospital.

This is because you may get more unwell if you stay at home.

What have the Mental Health Group been working on?

- Sharing their experiences of using SCAS services
- Reviewing complex care plans
- Accessibility and navigation of the online NEPTS booking portal
- Finding a work around for a service user struggling to book NEPTS
- Reviewing anonymised complaints and incident's themes
- Oxford Health Mental Health Helpline & Hampshire and Isle of Wight Healthcare NHS Trust discussed the Mental Health Triage Service
- Reviewing ‘Right Care, Right Person’
- Gaining insight into multi-agency ‘Respond’ training.

Based on areas of focus identified from the initial meeting:

The Patient Panel has achieved the reviewing of:

- ✓ (Hospital) Passport use and Ambulance care plans
- ✓ Easy read and accessibility of documents
- ✓ Barriers to access 111 and 999
- ✓ Co-produced training

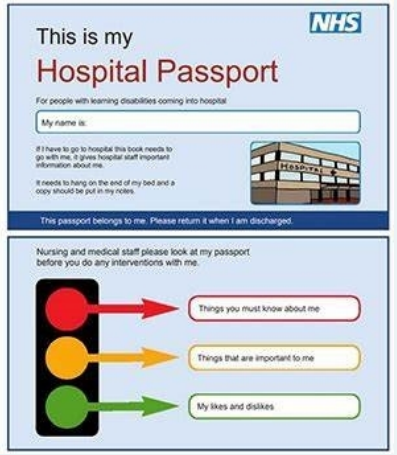
The Patient Panel is yet to review:

- End of Life Care

Hospital passports and care plans

Care plans were discussed at a Mental Health meeting held in April 2024 with oversight given by the SCAS Complex Care Team.

Hospital passports have been discussed briefly, at a few of the Learning Disability meetings.



Easy read and accessibility of documents

- ✓ Website accessibility reviewed
- ✓ Non-Emergency Patient Transport Service (NEPTS) booking portal accessibility reviewed
- ✓ Learning Disability Policy created
- ✓ Learning Disability Strategy is being created
- ✓ Easy Read guides created for:
  - ➢ Calling 999
  - ➢ 999 Response times and category of call
  - ➢ What to expect when the ambulance arrives
  - ➢ Feedback and Complaints process
  - ➢ Non-Emergency Patient Transport Service

Barriers to access 111 and 999

Can be tackled by:

- ✓ The easy read user guides that have been co-produced with the Patient Panel Learning Disability Group.
- ✓ The NHS 111 videos which are being co-produced with the Patient Panel Learning Disability Group

Co-produced training

The Mental Health Group were offered the chance to review the Mental Health Awareness Programme (MAP), training which SCAS staff can opt to undertake.

The Learning Disability Group have also been offered the chance to help with training, reviewing the call triaging for 111.

Influence meetings

The Chairs of each sub-group have been getting together to discuss:

- What is working well within the patient panel meetings, how the meetings are currently run and suggestions for improvement
- The reviewing of complaints and incidents to get a ‘patient’ perspective and see if there could be further learning/ co-production opportunities identified
- What the individual groups have been working on
- Ideas for recruitment of volunteers to the Patient Panel
- Engagement opportunities that can be utilised to speak to members of the public that have used SCAS services

Engagement events attended by the Patient Panel members

- 5th October 2024 - Volunteer Conference (Hampshire) attended by the Patient Panel Chair, Learning Disability Chair and Mental Health member
- 25th and 30th October 2024 - Learning Disability events (Buckinghamshire) attended by Learning Disability Chair
- 28th October 2024 – A refugee and asylum seeker event (Hampshire) attended by the Patient Panel Chair.
- 7th November 2024 – Learning Disability event (Hampshire) attended by Patient Panel Chair
- 20th November 2024 – Learning Disability event focused on Mental Health (Oxfordshire) attended by Mental Health Chair

Statistics

23 Total number of Patient Panel volunteers

333 hours committed

(from Feb 2024 – Jan 2025)

Patient Panel expansion

The Patient Panel has expanded to the Consult level of membership in May 2024.

The Patient Panel has also started recruiting volunteers to the Patient Panel Young Person’s co-production group in September 2024.

Consultation

Feedback on the existing design of the NHS 111 Patient Experience Survey to improve response rates.

999 survey to understand what matters most to callers having to contact SCAS emergency services.

EDI survey reviewing the Community Engagement and Training (Defibrillator awareness training) and Patient Safety Incident Response Framework

Thank you

Any questions?

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Trust Board of Directors Meeting in Public
27 March 2025

Report title	Integrated Performance Report (IPR)
Agenda item	9
Report executive owner	Stuart Rees, Interim Chief Finance Officer
Report author	Tina Lewis, Senior Transformation Programme Manager
Governance Pathway: Previous consideration	Executive Management Committee and Finance & Performance Committee
Governance Pathway: Next steps	Trust Board

Executive Summary

Summary of the Integrated Performance Report (IPR) – February 2025

Purpose and Scope
The Integrated Performance Report (IPR) provides a comprehensive overview of the Trust's performance across key areas, including **Operational Performance**, **Quality & Safety**, and **People**. This report covers February 2025, the tenth month of the financial year.

The IPR provides valuable insights but highlights areas requiring process redesign and resource adjustments to meet targets and improve performance.

Key Highlights

1. **Assurance and Variation Levels**:
    - **Assurance Levels**:
        - *Pass*: 4 metrics consistently meet targets.
        - *Fail*: 9 metrics consistently fail to meet targets without process changes.
        - *Hit or Miss*: 23 metrics fluctuate within control limits.
    - **Variation Levels**:
        - *Special Cause*: 8 metrics show consistent improvement; 2 show decline.
        - *Expected/Common Cause*: 42 metrics show typical variations.

There are 22 metrics that do not have targets for which it is not possible to provide a view on assurance. The majority of our metrics continue to exhibit expected variations; however, a significant number will not achieve the target without a change to process.

2. **Operational Performance**:
    - **Category 1 Response Times**: National target of 7 minutes remains unachievable without process redesign, however, there has been three months of improved performance.
    - **Category 2 Response Times**: Improved for the fifth consecutive month, aligning with increased clinical hours available to respond, achieved in part, by reduced hospital handover times.
    - **Patient Outcomes**: Efforts focus on increasing "Hear & Treat" rates, whilst our “See & Treat” rates, where we do not convey the patient, are consistently achieving above the target
    - **111 Services**: Sustained improvement in clinical validation callbacks within 20 minutes, however the national target of 95% remains unachievable
    - **Vehicles Off Road (VOR)**: Remains a concern for the Trust and continues to impact on our clinical availability
    - **Patient Transport Service (PTS)**: Activity has significantly declined since April 2024 due to the loss of the Surrey NEPTS contract and demand management protocols.

3. **Quality & Safety**:
    - **Clinical AQI’s** for Stroke, STEMI and ROSC patients continue to perform as expected.
    - **Safeguarding:** Both Level 1 (all Staff) and Level 3 (patient facing staff) continue to deliver in line with target
    - **Patient Safety:** The Trust continues to monitor its response to Patient Safety via the PSIRF, however, there remain insufficient data points to provide a view on assurance.

4. **People**:
    - There is a continuation of the positive trends in the percentage of **BAME staff** and **staff with disabilities**.
    - **Whole Time Equivalents** (WTE); **Vacancy rates** and **Turnover** are related metrics, and all remain stable

Upcoming Changes, Developments

- Finalise report production automation
- Complete benchmark activities for Clinical AQI’s and PSIRF to inform targets for the 2025/25 financial year
- Report, in terms of metrics, has been fully locked down, with no changes expected for a minimum of six months
- Further development of our network of IPR Champions

Challenges

- Report production timing limits full validation of metrics and quality assurance
- Technical and commentary development remain under review

Alignment with Strategic Objectives
With which strategic theme(s) does the subject matter align? Well Led

Relevant Business Assurance Framework (BAF) Risk
To which BAF risk is the subject matter relevant? SR9 - Delivery of the Trust Improvement Programme

Financial Validation	N/A

Recommendation(s)
What is the Board asked to do: • Note this paper and associated IPR document

For Assurance	✓	For decision	✓	For discussion	✓	To note	✓

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Integrated Performance Report: Feb-25

Executive Summary

Operational Performance

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

Safety and Quality

People

Executive Commentary :

Operational Performance :

Category 1, category 2 and category 3 performance improved for the third consecutive month, with Category 4 seeing a slight deterioration. (OP1 to OP6). Our category 2 target for February was 26:16 and we were 00:02:02 minutes below target delivering 24:14. The operational hours were above plan by 3,042 hours. This positively impacted on category 2 by 01:18 seconds. The improved hours were driven by lower sickness absence and lower than planned annual leave which is attributed to the high levels of leave allocated throughout the year. Handover delays were 03:14 better than plan in BOB and Frimley ICB. Hampshire delays were 1:22 minutes better than plan, with QAH being 09:11 minutes better. The improved delays North and South impacted positively on category 2 by 02:30 minutes.

999 mean call answer (OP7) was 11 seconds and did not meet the national target. We are continuing to increase the number of ECTs to meet the revised establishment levels, whilst also reducing AHT to below 8 ½ minutes. Hear and Treat (OP9) dropped slightly in February to 14.03% but remains just above target. A clinical strategy day was held on the 20th February to identify further improvements with hear and treat as well as the proposed clinically led dispatch model. The revised category 2 segmentation principles have been received, and we have undertaken a piece of work to model impact on category 2 mean, with the ask to move to up to 5 minutes for navigation and up to 10 minutes for validation. We met with the national team to discuss early findings from the modelling as this could have a negative impact on C2 if we implement both principles. CAD development will be required to enable this.

Operational Performance :

See & treat (OP10) remains within expected variation at 32.7% with operational teams focusing on call before convey and access to SPOA's to reduce conveyance rates. VOR rates (OP15) saw a slight improvement to 42%. The operations team are now accurately capturing the lost hours from fleet availability and continue to work with SCFS to improve the vehicles available to crews. Meal break compliance (P13) has improved by 20% over the last 3 months and is now at the highest level since August 23, with over runs being at the lowest level in the last 2 years, both linked to lower utilisation levels. Work continues with unions to develop the revised meal break principles, and these were agreed at JCC in March.

111 call answer in 120 seconds (OP16) fell to 64% which follows the end of the national contingency support we had where 10% of 111 demand taken by another provider. We have a robust recruitment plan underway to fill the 111 HA vacancies with courses at all 3 sites which will improve 111 call answer. PTS call answer (OP20) continues to fail and the activity management cap remains in place. The consultation for changes in the contact centre operating hours is finalised and will commence in April. PTS activity (OP21 and OP22) continue to educe in line with activity caps across all contracts. Focus remains on increasing cohorting and the utilisation level of crews to meet the finance recovery plan.

Executive Commentary :

Quality & Safety:

QS 1, 2 and three continue to show the majority of our reported incidents are low or no harm with a corresponding level of PSIIs and PSLIRs.
A case review of each Datix report over 60 days case is underway and will close the longest outstanding cases by 31 March.
Work continues to improve IPC as per the improvement plan as QS 7, 8, 9 and 10 show we are below target in the number of hand hygiene audits required and slightly below compliance required in those at 93% against a 95% target. We are also below the number of vehicles we require to audit but achieved over target on the compliance of those audits completed on vehicles.

QS 20 and 21 show Complaints fell in correlation with reduced activity which is expected, and all complaints responses were sent out in time meeting target.
Finally QS22, 23, 24 show Safeguarding training remains compliant and above target in Levels, 1, 2 and 3.

People:

WTE continues to be below target by 262.2 WTE due to holding vacancies within corporate teams and the impact of PTS contractual uncertainties which has also impacted vacancy rates which finished February at 11.5%. Turnover saw a slow reduction ending at 17.5% however, this will be negatively impacted in Q1 due to corporate role exits and PTS transfers. Absence levels for February were 7.5% with a long term absence rate of 4.1% against a target of 3.4%. Again, these rates are being negatively impacted by organisational change.
DBS rates are currently above target at 96.2% and reflect accurate recording of posts requiring DBS checks. 88.3% of Trust staff have had a PDR within the last 12 months, against a target of 95%. Improvement work continues in this area and leaders training will be developed in Q1 when the new structure is implemented in the People team. FTSU rates are at expected levels with 18 cases, most connected with the corporate review.

Statistical Process Control:

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

The rules:

1) Any single point outside the process limits.

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

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

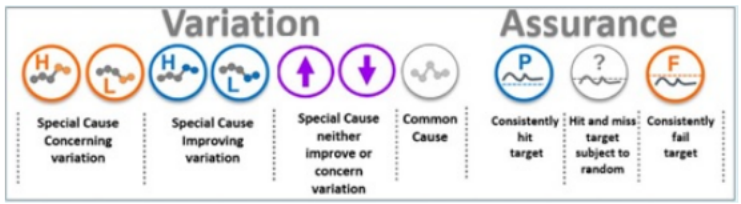
4) A run of 6 consecutive ascending or descending values (a trend).

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

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

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

Icon Key



NHS Icon Descriptions

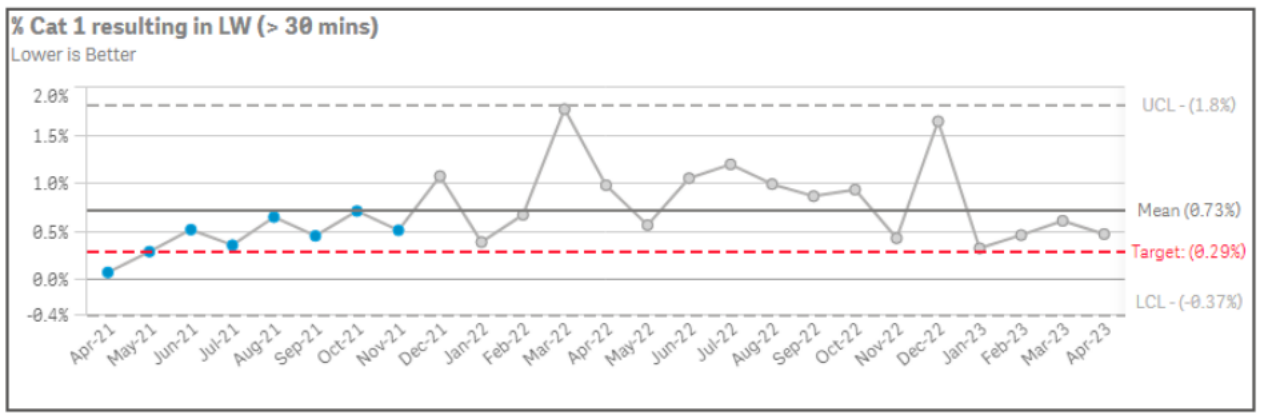
	Pass	Hit and Miss	Fail	No Target
	Special cause of an improving nature where the measure is significantly HIGHER.This process is capable and will consistently PASS the target.	Special cause of an improving nature where the measure is significantly HIGHER.This process will not consistently HIT OR MISS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

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

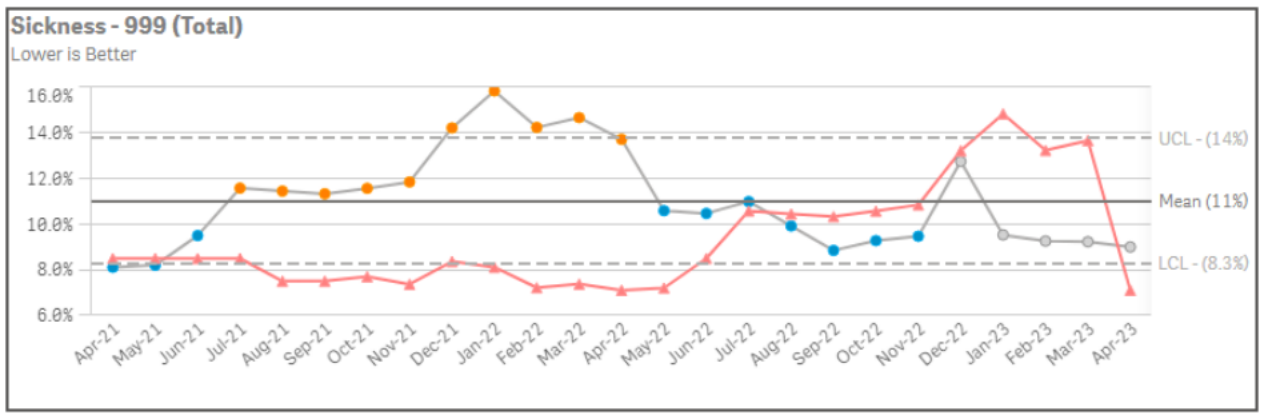
Assumptions:

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

Example of Target Line Chart



Example of Plan Line Chart



UCL & LCL:

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

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

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

February-25
Summary

Assurance → (Fail | Hit and Miss | Pass | No Target)

Variance ↓

Variance	Fail	Hit and Miss	Pass	No Target
H				
L		PTS Patients Arrived within Time		PTS Volume - No of Journeys
	Cat 1 Mean Average Handover Time % Vehicles off the road 111 Call Back Percentage PTS Calls Answered in 60 Secs Number of Whole Time Equivalents Staff Appraisal Target Meal Break Compliance	17	% See and Treat	15
L			Shift Overrun Percentage	
H		Level 3 Safeguarding Disabled Staff %	Level 1 Safeguarding BAME Staff %	

Metrics:

Hit and Miss Common Cause:
Cat 2 Mean, Cat 1 90th %ile, Cat 2 90th %ile, Cat 3 90th %ile, Cat 4 90th %ile, 999 Call Answer, 999 Call Abandonment Rate, % See, Treat and Convey, Handover > 15 mins, 111 Call Answer, 111 Abandonment Rate, PTS Patients Collected within Time, Hand Hygiene Audits %, Hand Hygiene Audits, Vehicle Audits %, Vehicle Audits, Complaints in Time, Monthly Sickness, Long Term Sickness

Hit and Miss, No Target:
PTS Call Volume, Number of PTS Patients Transported,STEMI Call to Door Mean, STEMI Call to Door 90th Centile, Stroke Call to Hospital Mean, Stroke Call to Hospital Median, Stroke Call to Hospital 90th Centile, ROSC All, ROSC Utstein, Cardiac Arrest 30 day Survival, Cardiac Arrest 30 Day Survival Utstein, Complaints, Vacancy Rate, Turnover Rate, Freedom to Speak Up Cases

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South Central
Ambulance Service
NHS Foundation Trust

Operational Performance

NHS Operational Performance Overview

February-25

Summary

Assurance →

Variance ↓

	Fail	Hit and Miss	Pass	No Target
H				
L		PTS Patients Arrived within Time		PTS Volume - No of Journeys
	Cat 1 Mean Average Handover Time % Vehicles off the road 111 Call Back Percentage PTS Call Answered in 60 Seconds	12	% See and Treat	PTS Call Volume Number of PTS Patients Transported
L	Average Handover Time			
H				

Metrics:

Hit and Miss Common Cause

Cat 2 Mean, Cat 1 90th %ile, Cat 2 90th %ile, Cat 3 90th %ile, Cat 4 90th %ile, 999 Call Answer, 999 Call Abandonment Rate, % See, Treat and Convey, Handover > 15 mins, 111 Call Answer, 111 Abandonment Rate, PTS Patients Collected within Time,

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Cat 1 Mean	Feb-25	00:08:25	00:07:00		F	00:08:51	00:07:54	00:09:49
Cat 2 Mean	Feb-25	00:24:14	00:30:00		?	00:32:39	00:19:25	00:45:53
Cat 1 90th %ile	Feb-25	00:15:15	00:15:00		?	00:16:02	00:14:19	00:17:44
Cat 2 90th %ile	Feb-25	00:45:48	00:40:00		?	01:04:39	00:37:10	01:32:07
Cat 3 90th %ile	Feb-25	04:02:50	02:00:00		?	05:30:44	01:59:56	09:01:32
Cat 4 90th %ile	Feb-25	05:20:16	03:00:00		?	06:51:29	01:58:55	11:44:03
999 Call Answer	Feb-25	00:00:11	00:00:10		?	00:00:15	00:00:00	00:00:31
999 Call Abandonment Rate	Feb-25	2.3%	2%		?	2.7%	1.7%	3.8%
% Hear and Treat	Feb-25	14.0%	14%	H	?	13.4%	11.9%	15.0%
% See and Treat	Feb-25	32.7%	32%		P	32.4%	31.7%	33.2%
See, Treat and Convey to ED	Feb-25	49.3%	49%		?	49.7%	48.2%	51.1%
Average Handover Time	Feb-25	00:19:18	00:15:00	L	F	00:25:20	00:18:32	00:32:08
Handover > 15 mins	Feb-25	44.3%	48%		?	44.5%	36.1%	52.8%
Average Clear Up Time	Feb-25	00:13:54	00:15:00	L	?	00:14:28	00:13:47	00:15:09
% Vehicles off the road	Feb-25	42%	23%		F	40%	33.8%	46.20%
111 Call Answer	Feb-25	64.3%	95%		?	76.30%	56.70%	95.80%
111 Call Abandonment Rate	Feb-25	6.4%	3%		?	3.70%	-0.20%	7.70%
111 Call Back Percentage	Feb-25	39.9%	95%		F	41.50%	27.20%	55.80%

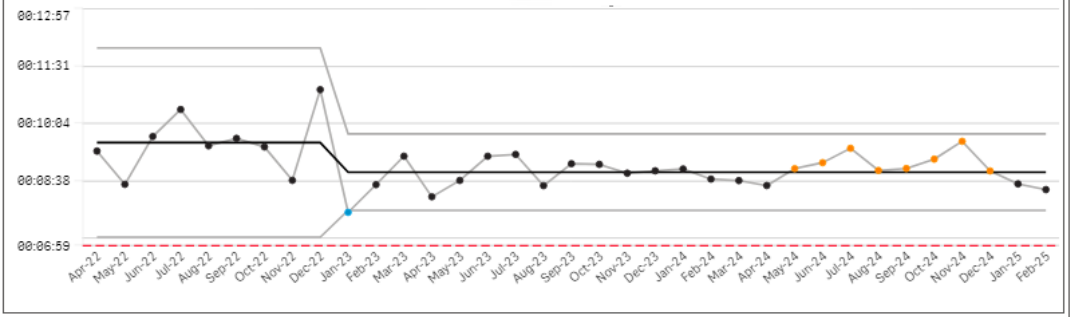
NHS Operations - PTS Calls and Outcomes

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
PTS Call Volume	Jan-25	26,931	37,744		n/a	32,665	24,491	40,839
PTS Calls Answered in 60 Seconds	Jan-25	67.2%	90%		F	60.30%	41.20%	79.40%
PTS Volume - No of Journeys	Jan-25	56,994		L	n/a	67,376	56,523	78,228
Number of PTS Patients Transported	Jan-25	15,607			n/a	18,117	15,485	20,749
PTS Patients Collected within Time	Jan-25	85.6%	87%		F	85.80%	83.90%	89.20%
PTS Patients Arrived within Time	Jan-25	86.0%	87%	L	?	85.80%	84.40%	87.20%

NHS

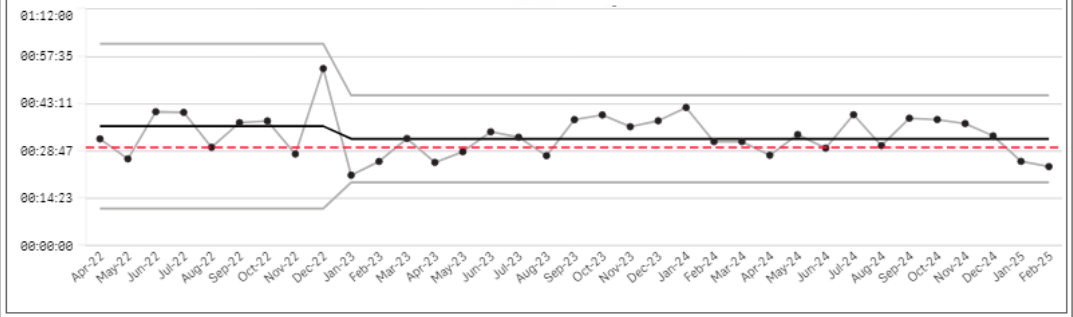
Operations - Response Times

OP1 - Cat 1 Mean
Lower is Better. Target differed in previous years



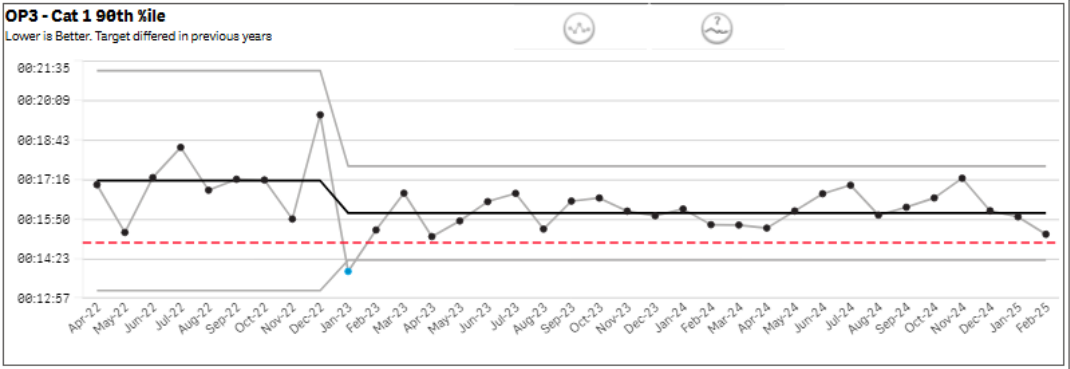
Variation	Assurance	Target	Latest
Expected	Fail	00:07:00	00:08:25

OP2 - Cat 2 Mean
Lower is Better. Target differed in previous years



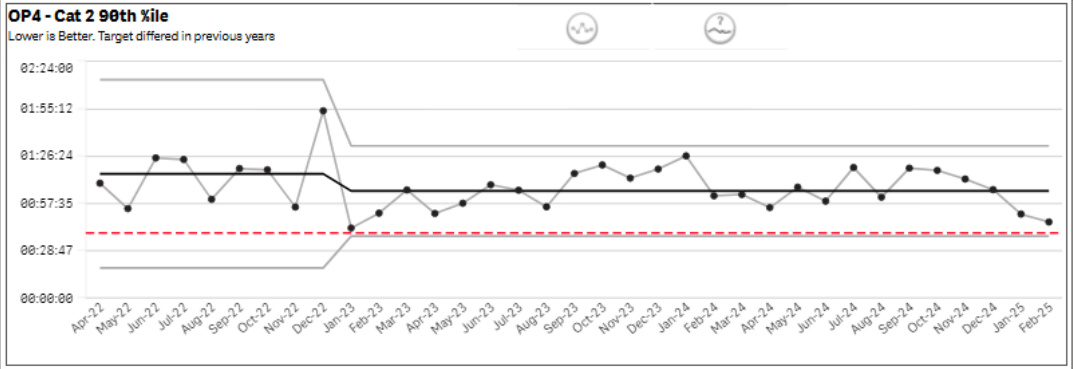
Variation	Assurance	Target	Latest
Expected	Random	00:30:00	00:24:14

OP3 - Cat 1 90th %ile
Lower is Better. Target differed in previous years



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

OP4 - Cat 2 90th %ile
Lower is Better. Target differed in previous years



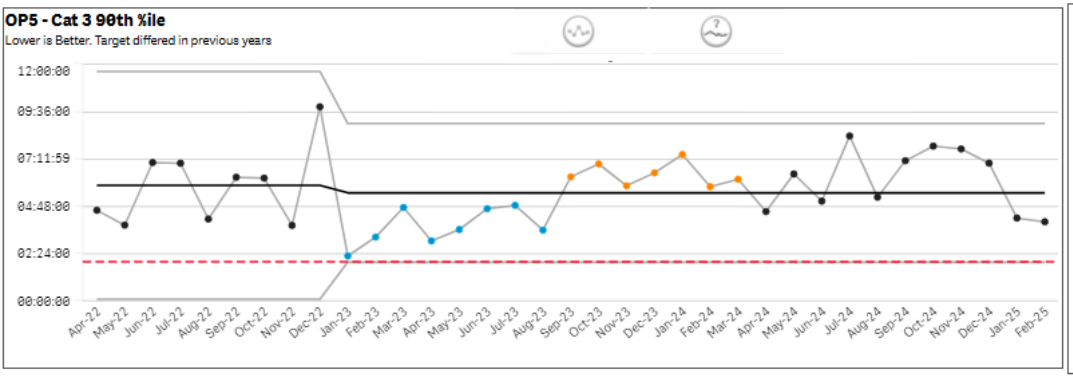
Variation	Assurance	Target	Latest
Expected	Random	00:40:00	00:45:48

Understanding the Performance:
Whilst improving Cat one continues to fail and remains within the expected variation. Cat 2 continues to show significant improvement and is below target. Demand was 2.4% above trajectory, 1044 incidents, whilst staff hours were 1.5%, 3042 hours, above budget. This was driven by lower than planned annual leave and improved sickness. The improved performance continues to be supported the improvement in handover performance across the Trust. The is most significant change being seen at the QA.

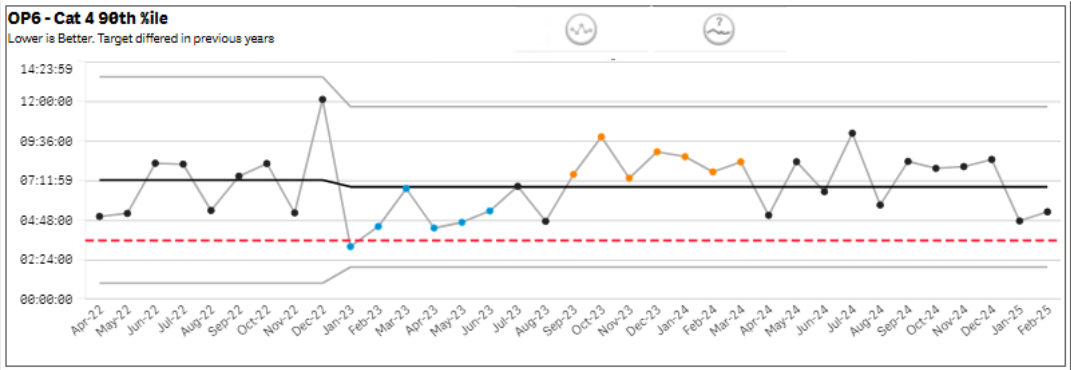
Actions (SMART):
Focus on maintaining the benefits of R2R across the Trust. Continued efforts to increase H&T. Management of hours against budget

Risks:
SCAS remains unlikely to deliver a sub 30 minute Cat 2 performance. Likely end of year for Cat 2, assuming handover trajectories are met, now 32:00

Operations - Response Times



Variation	Assurance	Target	Latest
Expected	Random	02:00:00	04:02:50



Variation	Assurance	Target	Latest
Expected	Random	03:00:00	05:20:16

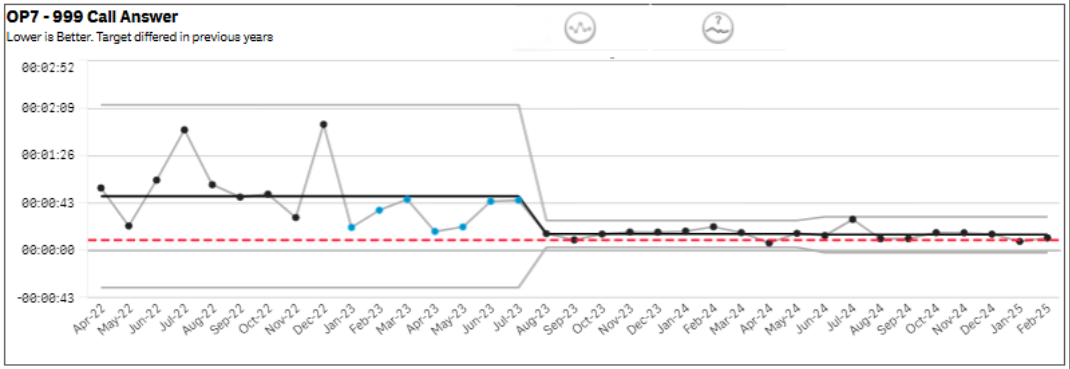
Understanding the Performance:
Cat 3& 4 failed to meet target but remained within expected variance. Overall performance driven by improved crew availability from reduced handover times.

Actions (SMART):
SP model continues to focus on Cat 3 & 4 with targeted deployments to appropriate patients. Increased H&T will reduce response demand, work continues to increase the clinical workforce in EOC to support this.

Risks:
We are unlikely to meet target for either Cat 3 or Cat 4 this year.

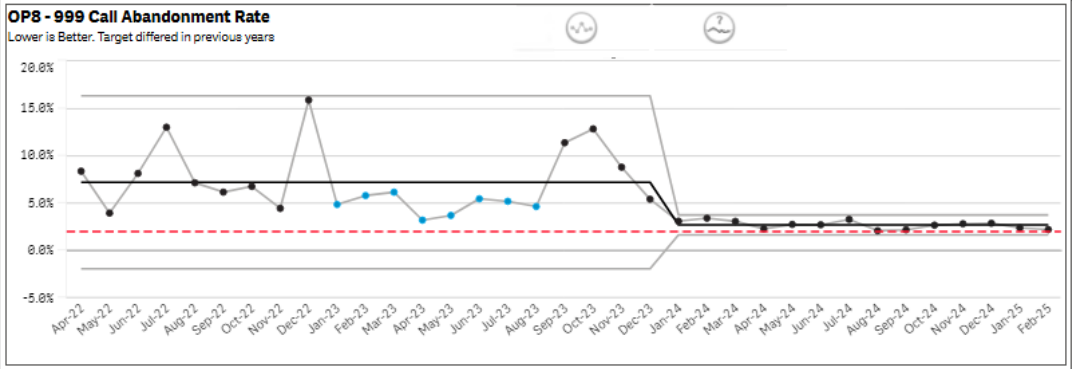
Operations - Operations Centre

OP7 - 999 Call Answer
Lower is Better. Target differed in previous years



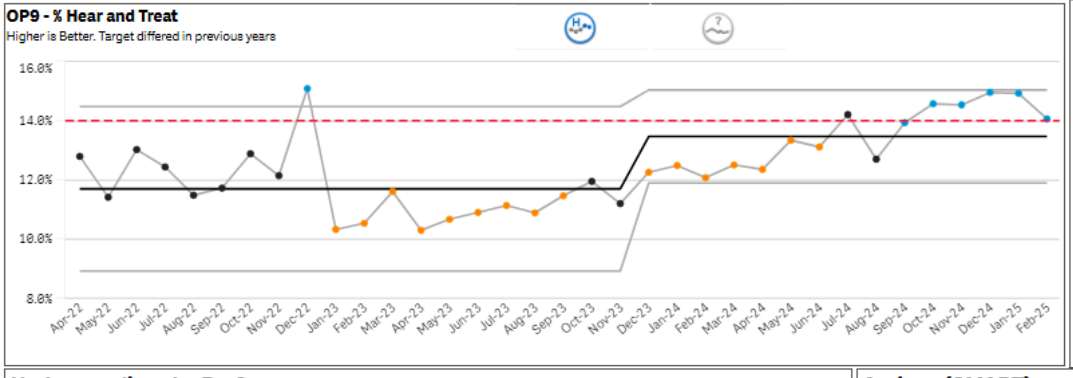
Variation	Assurance	Target	Latest
Expected	Random	00:00:10	00:00:11

OP8 - 999 Call Abandonment Rate
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	2%	2.3%

OP9 - % Hear and Treat
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Improving	Random	14%	14.0%

Understanding the Performance:

Mean call answer at 11 seconds continues to show consistency, close to but not consistently achieving target of 10 seconds. Demand rose above plan by 1% with a busier second half of the month, this was despite the reduction in duplicate calls due to resource availability remaining strong. Logged in hours whilst dropped from January were above plan, enabling us to answer patient calls without excessive delays with 90th percentile at 39 seconds. H&T performance continues to show improvement at 14.08% for February within normal variation, slightly challenged by increased resource availability/dispatch processes, and the reduction in clinical hours after the additional funding for category 2 segmentation ended.

Actions (SMART):

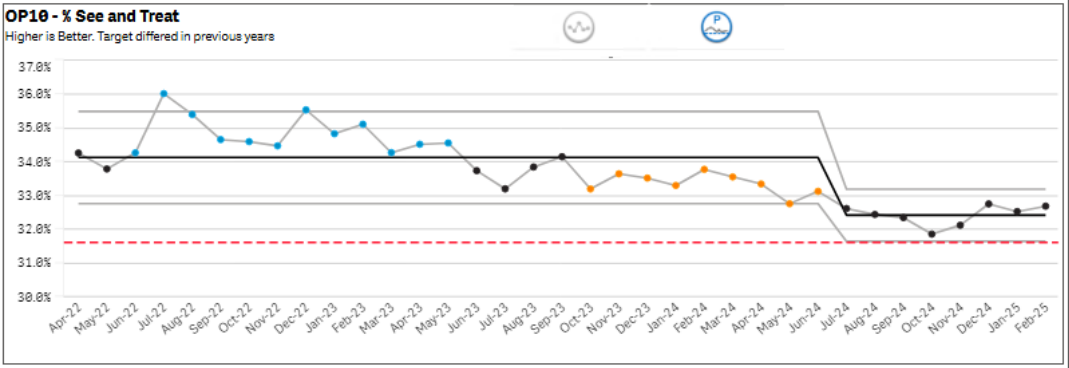
Improvement steering group continues to meet monthly, completed a stock take of our position, with number of actions complete. AHT reduced by 1 min 31 secs on last year, team continue to work through actions which will bring further efficiencies. Focus remains on maintaining required levels of work effective staff, stay interviews undertaken, results being collated to be reviewed at monthly IWP, and will be combined with staff survey data when released. Data modelling with ORH delayed but is underway, results expected end April. Quotes received from CAD supplier to enable development of clinical queues to support H&T improvements awaiting timescales for potential implementation. Clinical strategy day well attended in Feb and outputs being collated to be reviewed by steering group.

Risks:

If we do not have the required skills or capacity within the team we may fail to deliver the improvements required in the necessary timeframes, impacting on our ability to achieve KPIs.
Current position of CAD and finances may inhibit our ability to make technical changes which may impact our ability to improve in areas such as average handling time and clinical queue management.
Due to capacity and infrastructure we may not be able to get data required to measure improvements and support decision making in the improvement programme.
If we do not have adequate skilled resource we will not have the capacity to deliver KPIs at targeted levels.

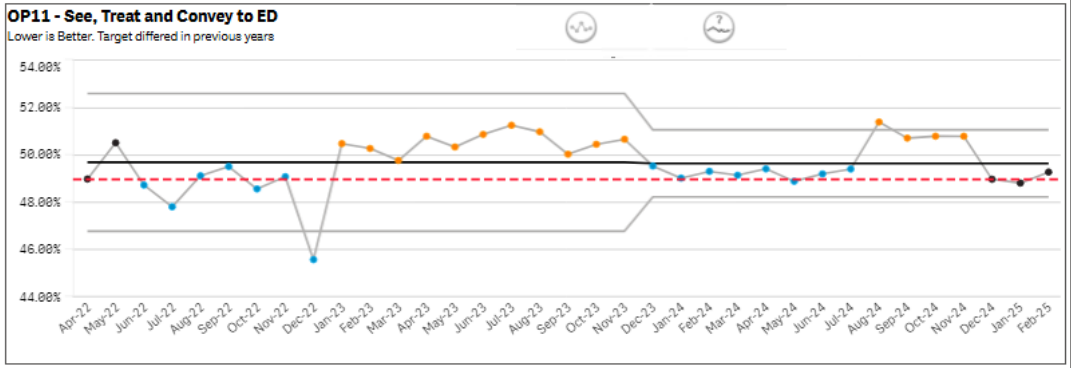
Operations - Utilisation

OP10 - % See and Treat
Higher is Better. Target differed in previous years



Variation
Expected
Assurance
Pass
Target
31.6%
Latest
32.7%

OP11 - See, Treat and Convey to ED
Lower is Better. Target differed in previous years



Variation
Expected
Assurance
Random
Target
49%
Latest
49.3%

Understanding the Performance:
S&T shows no variation and the process consistently passes the target of 32%. ST&C to ED constantly passes the target with the 4 points above the target directly linked to the reporting issues we had with the NMA system.

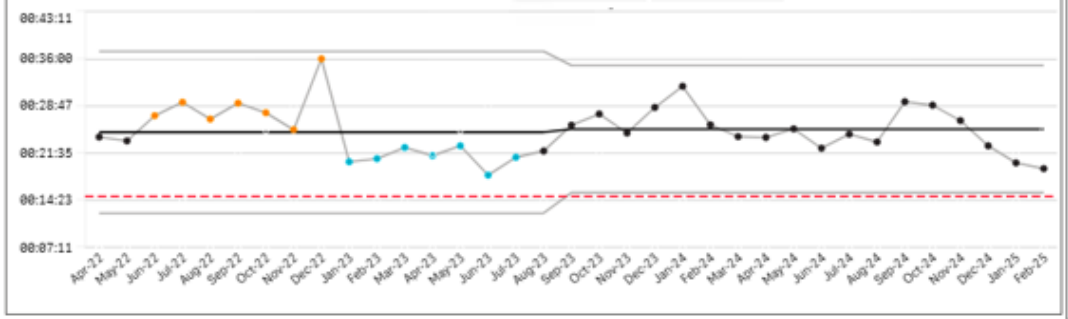
Actions (SMART):
With both S&T and ST&C to ED central the the Annual Planning return we continue to look to maximise the impact SPOAs can have along with CbC and SCAS Connect. Re-procurement of the software behind SCAS Connect (Midos) underway with that platform being key in delivering the the targets set in the mentioned metrics.

Risks:
Failure to deliver the targets set will increase the traffic at EDs creating poor patient experience and increased chances of delays at acutes. Failure to secure the Midos software will impact staff ability to access appropriate care pathways leading to increased traffic at EDs.

NHS

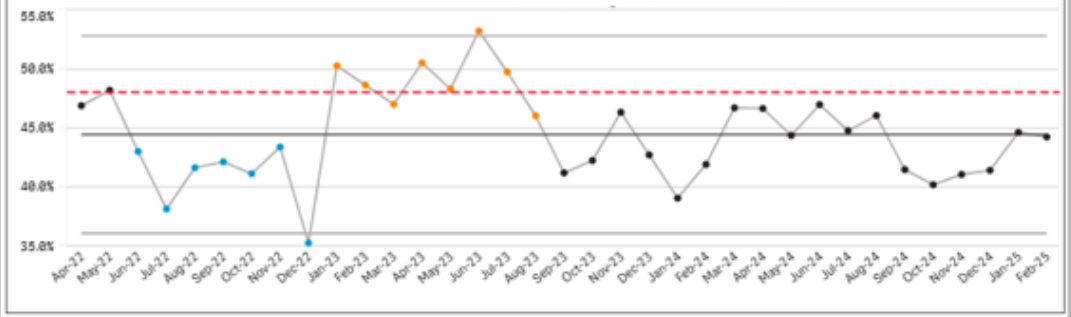
Operations - Utilisation

OP12 - Average Handover Time
Lower is Better. Target differed in previous years



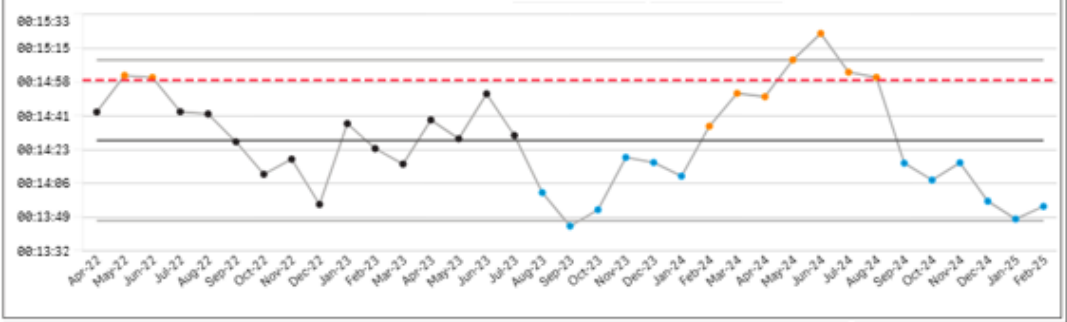
Variation	Expected
Assurance	Fail
Target	00:15:00
Latest	00:19:18

OP13 - Handover > 15 mins
Lower is Better. Target differed in previous years



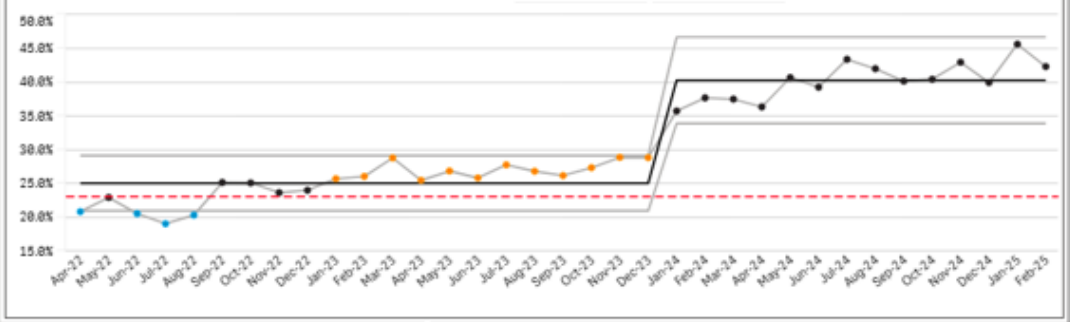
Variation	Expected
Assurance	Random
Target	48%
Latest	44.3%

OP14 - Average Clear Up Time
Lower is Better. Target differed in previous years



Variation	Improving
Assurance	Random
Target	00:15:00
Latest	00:13:54

OP15 - % Vehicles off the road
Lower is Better. Target differed in previous years



Variation	Expected
Assurance	Fail
Target	23%
Latest	42.2%

Understanding the Performance:
% Arrival at hospital to handover in >15 mins is showing common cause variation since Sept 23 and continues to fail to meet the target. Average hospital handover time has seen improvement for the last 6 points with a 10 minute improvement in that time. Clear up delays remain positive with the last 6 points being below the mean.

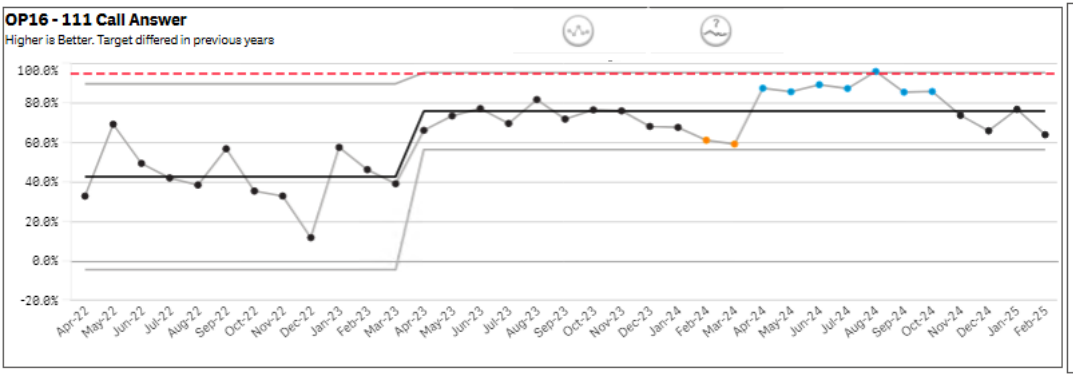
Actions (SMART):
Implementation of R2R occurred during Dec and Jan. The ongoing action is to embed the process into a sustained BAU position and withdraw the interim support that is in place at some sites - the SOP is under review with the next phase to propose withdrawal from a SCAS run cohort (where required) at 45 mins. This will be monitored through the local delivery units, Ops DPR and CIP workstreams. Continued focus on maintaining and sustaining the positive clear up position in line with next years CIP targets.

Risks:
Sustainability of current handover and clear up progress. Failure to continue with this position impacts on our ability to respond and therefore increases the risk of harm to patients.

Operations - Operations Centre

OP16 - 111 Call Answer

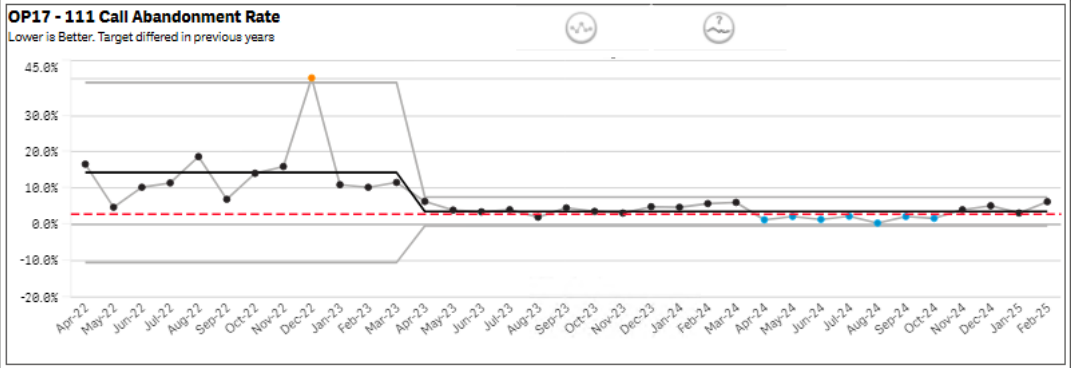
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	95%	64.3%

OP17 - 111 Call Abandonment Rate

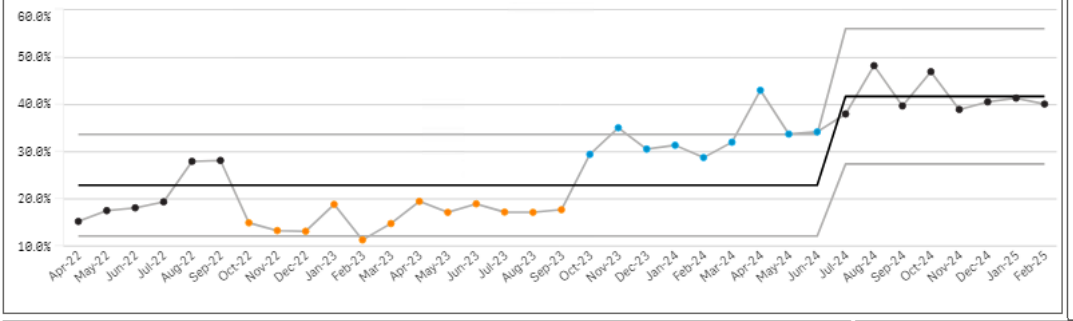
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	3%	6.4%

OP18 - 111 Call Back Percentage

Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Fail	95%	39.9%

Understanding the Performance:

Call answer in 120 secs decreased from January to 64% below the target of 95%, with the abandonment rate increasing from January to 6.4% in February. National resilience support of 10% was removed on 14th of February. Although recruitment has been positive, sign offs from training will take effect into March and April which will allow a recovery in performance through these months. Demand increased through February being a 28 day month from January being a 31 day month, by approximately 15k calls alongside a very challenging school half term and logged into hours being lower created a month of below expected performance. Clinical call backs remains similar to January at 40% which remains outside the national unachievable target.

Actions (SMART):

Workforce has seen a gradual increase since Decembers number of 209 WTE Health Advisors to currently 228.84 WTE Health Advisors, with further courses booked across all sites through March and April. We continue to see positive amounts of applications for Health Advisor positions across all sites, and work continues to ensure the current rota's fit with our service demand. There was a good response for our open days and weekly recruitment meetings continue to monitor the affect of our adverts, along with this there is additional assessment and interview dates in place for all sites. Clinicians WTE is currently 78.53 WTE with a further 3.64 WTE recruited after the recent advert, recruitment processes continue to have applicants placed on courses following recruitment checks.

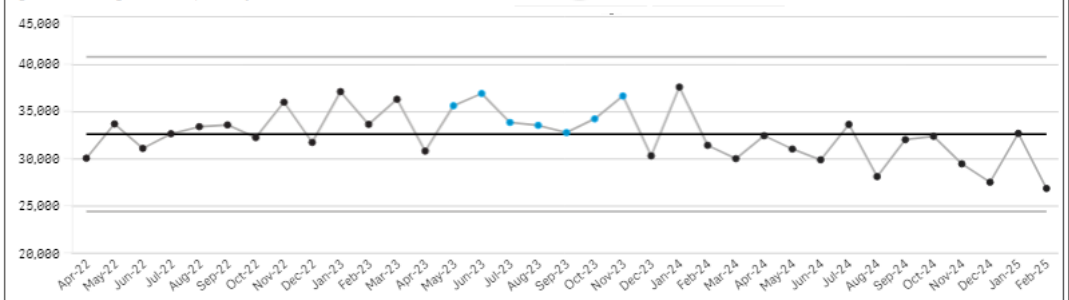
Risks:

The delay in recruiting into our support staff, previously paused as part of our CIP since October, remains a challenge, however this is an area of focus for the senior staff to ensure that the vacancies that have been requested are advertised as soon as possible and that staff are recruited into the vacant roles. The induction of these staff into new roles will take some time and for them to become embedded into their new team. A further risk will be the proposed restructuring plans in the CCC which will cause anxiety amongst the staff especially the senior team.

Operations - PTS - Calls and Outcomes

OP19 - PTS Call Volume

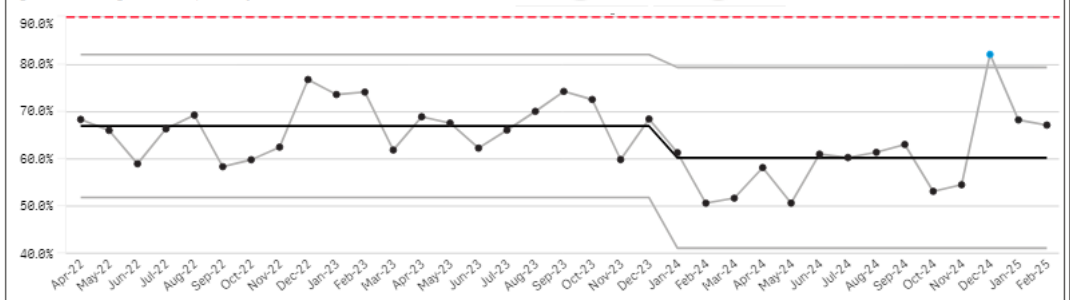
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected			26,931

OP20 - PTS Calls Answered in 60 Seconds

Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Fail	90%	67.2%

Understanding the Performance:

Call Answer performance further decreased in month with February's outturn achieving 67 % aggregated.

- Capacity Management tool process changed enabling Call Handlers sight of capacity quota preventing the need to go through entire call prior to establishing that we are at capacity.
- The activity management cap remains in place within cleric, which results in any essential bookings being required to be placed through to the Contact Centre via the telephone system.

Actions (SMART):

- Consultation process for change in contact centre operating hours in final phases, change in hours will commence 1st April to align with 25/26 Budget.
- BOB commissioners approved adjustment to Inbound KPI for call answer, aligning with HIOW from 60 seconds to 90 seconds.

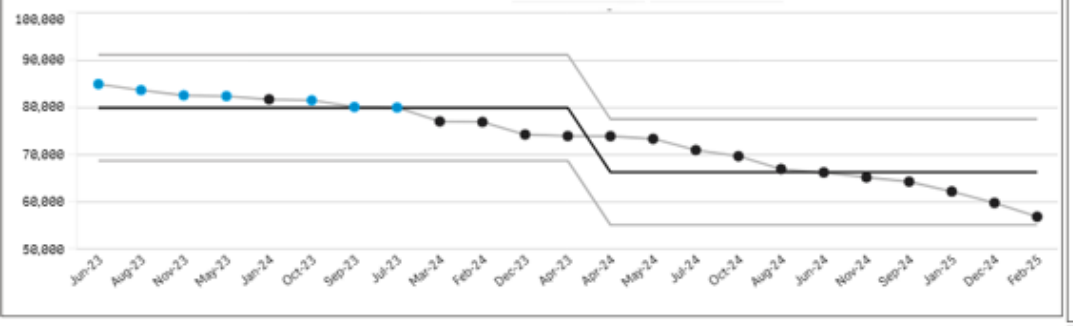
Risks:

Continued uncertainty for many staff, increased sickness being seen across CC's and risk of further attrition and no time to recruit and train prior to April 01 further impacting performance

-Booking window opened to support bookings for that are transferring to EMED due to loss of BOB and Sussex contracts.

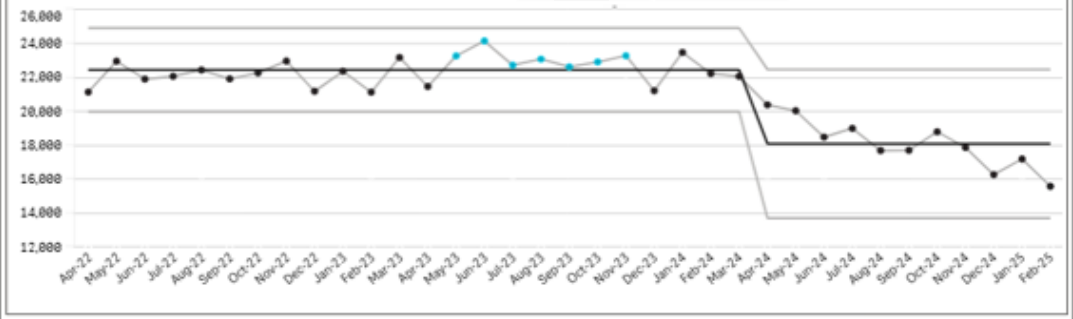
Operations - PTS - Calls and Outcomes

OP21 - PTS Volume - No of Journeys
Higher is Better. Target differed in previous years



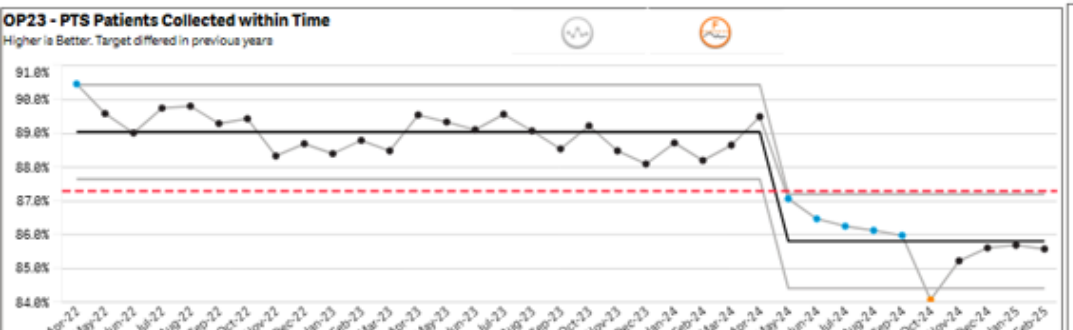
Variation	Assurance	Target	Latest
Expected			56,994

OP22 - Number of PTS Patients Transported
Higher is Better. Target differed in previous years



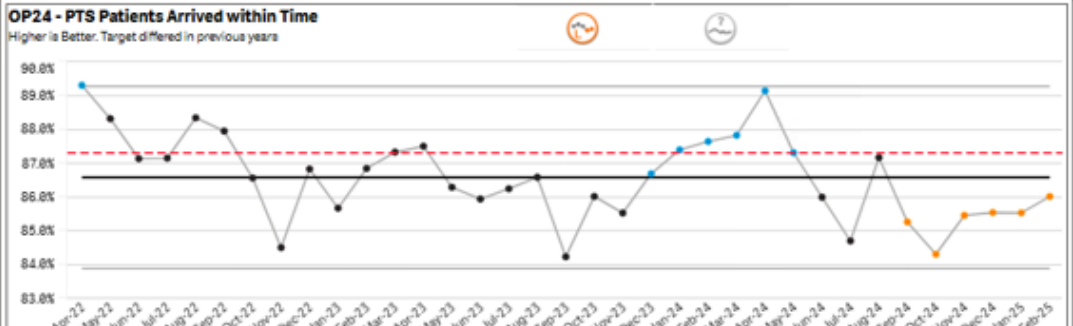
Variation	Assurance	Target	Latest
Expected	-		15,607

OP23 - PTS Patients Collected within Time
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Fail	87%	85.6%

OP24 - PTS Patients Arrived within Time
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Declined	Random	87.3%	86.0%

Understanding the Performance:

- Activity has decreased in the month due to the reduction in calendar days as expected, there was a reduction seen in activity across the BOB contract due to the IAP adjustment made in cleric in January and the time it takes to flow through the system.
- The forecasted hours are reviewed weekly, and reductions are made to align with the expected activity to ensure that we do not have excessive hours above the requirement. Therefore, Private Provider hours have reduced.

We continue to receive challenges into the eligibility mailbox from stakeholders due to the demand management tool remaining in place and reducing the capacity for non-essential activity. Awaiting, further instruction on BOB contract due to essential activity utilising all available capacity.

Actions (SMART):

- Continue to monitor daily demand, hours, and performance because of the continuation of the demand management tool being in place.
- Monitoring and reporting of hours, demand against costs through daily review call. Review of scorecard to ensure figures actualised for previous weeks. Weekly external reporting continues with ICBs.

Focus remains on increasing cohorting and utilisation of resources as per the finance recovery plan. We have seen performance beginning to stabilise across the PTS contracts with improved cohorting contributing to this.

Risks:

- Due to the reductions in the cap, SCAS has started to receive significant feedback via various mechanisms, eligibility mailbox, stakeholders, through Patient Experience and ICBs.
-continued Significant challenges from ICBs regarding the implementation of the demand management tool.
-Awaiting confirmation on further reductions made in BOB and MK contracts, due to the timings it is unclear if there will be financial benefits prior to year-end.

NHS

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Quality and Safety

Quality & Safety – Core Measures Matrix

February-25
Summary

Assurance →
Variance ↓

Variance \ Assurance	Fail	Hit and Miss	Pass	No Target
H				
L				
		Hand Hygiene Audits % Hand Hygiene Audits Vehicle Audits % Vehicle Audits Complaints in Time		10
L				
H		Level 3 Safeguarding	Level 1 Safeguarding	

Metrics:

Common Cause, No Target
STEMI Call to Door Mean, STEMI Call to Door 90th Centile, Stroke Call to Hospital Mean, Stroke Call to Hospital Median, Stroke Call to Hospital 90th Centile, ROSC All, ROSC Utstein, Cardiac Arrest 30 day Survival, Cardiac Arrest 30 Day Survival Utstein, Complaints

NHS Quality Safety– Ambulance Quality Indicators (AQIs)

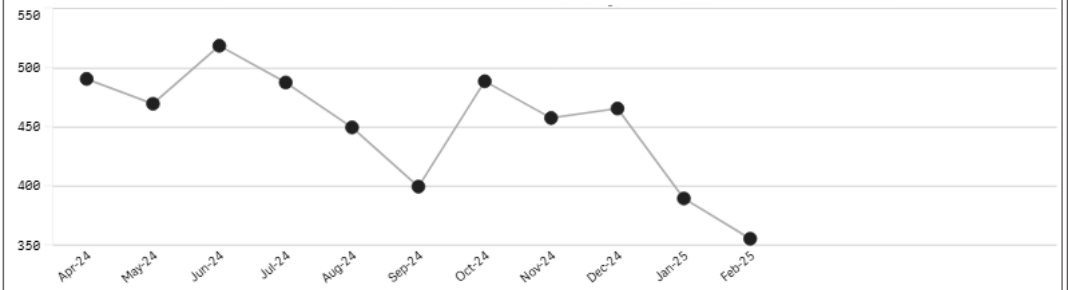
KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
PSI Low/no Harm Incidents	Feb-25	356		n/a	n/a			
Monthly PSII	Feb-25	2		n/a	n/a			
Monthly PSILR	Feb-25	13		n/a	n/a			
PSII Cases > 6 months	Feb-25	0		n/a	n/a			
Overdue Datix Incidents	Feb-25	13		n/a	n/a			
Hand Hygiene Audits %	Feb-25	93.20%	95%			95.50%	80.20%	110.90%
Hand Hygiene Audits	Feb-25	191	261			231	-10	473
Vehicle Audits %	Feb-25	93.40%	90%			91.10%	71.30%	111.00%
Vehicle Audits	Feb-25	122	167			125	5	245

NHS Quality Safety– Core Measures Icon Summary

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
STEMI Call to Hospital Door Mean	Oct-24	02:17:00			n/a	02:17:08	01:49:27	02.44:49
STEMI Call to Hospital Door 90th Centile	Oct-24	03:26:00			n/a	03:19:42	02:21:17	04:18:08
Stroke Call to Hospital Arrival Time Mean	Oct-24				n/a	01:37:00	01:10:00	02:05:00
Stroke Call to Hospital Arrival Time Median	Oct-24				n/a	01:22:00	01:08:00	01:37:00
Stroke Call to Hospital Arrival Time 90th Centile	Oct-24				n/a	02:30:00	01:37:00	03:24:00
Return of Spontaneous Circulation All	Oct-24	25.00%			n/a	25.00%	12.50%	37.50%
Return of Spontaneous Circulation Utstein	Oct-24	51.50%			n/a	50.60%	23.30%	77.80%
Cardiac Arrest 30 Day Survival - All	Oct-24	7.80%			n/a	9.10%	1.30%	16.80%
Cardiac Arrest 30 Day Survival - Utstein group	Oct-24	27.00%			n/a	30.60%	8.60%	52.60%
Complaints	Feb-25	33			n/a	35	11	60
Complaints in time	Feb-25	100.00%	95.00%		?	95.20%	83.30%	107.10%
Level 1 Safeguarding	Feb-25	97.20%	95.00%	H	P	96.80%	96.40%	97.30%
Level 3 Safeguarding	Feb-25	92.20%	90.00%	H	?	87.50%	84.50%	90.60%

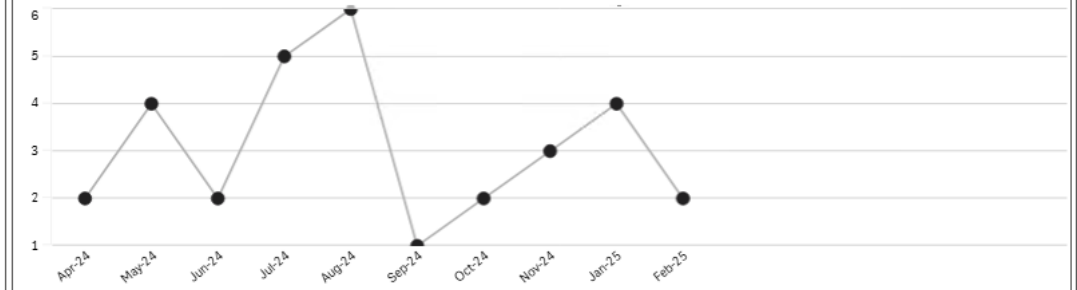
Quality & Safety – PSIRF

QS1 - PSI Low/no Harm Incidents
Higher is Better. Target differed in previous years



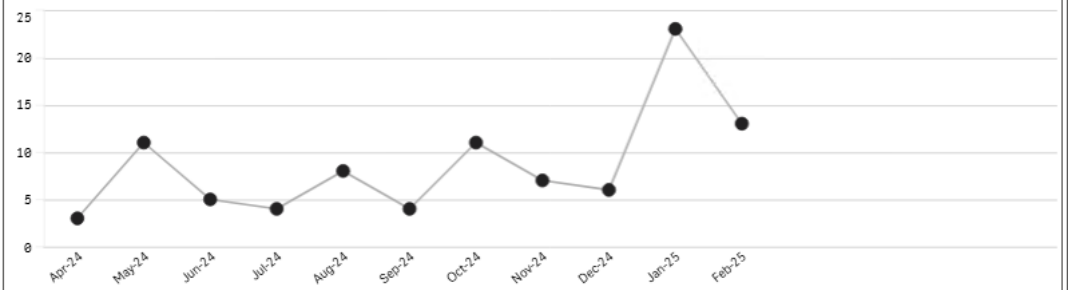
Variation: -
Assurance: -
Target: -
Latest: 356

QS2 - Monthly PSII
N/A. Target differed in previous years



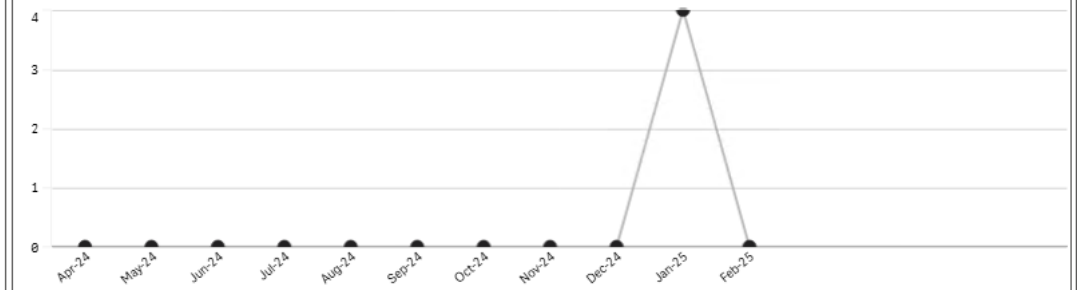
Variation: -
Assurance: -
Target: -
Latest: 2

QS3 - Monthy PSILR
N/A. Target differed in previous years



Variation: -
Assurance: -
Target: -
Latest: 13

QS4 - PSII Cases > 6 months
. Target differed in previous years



Variation: -
Assurance: -
Target: -
Latest: 0

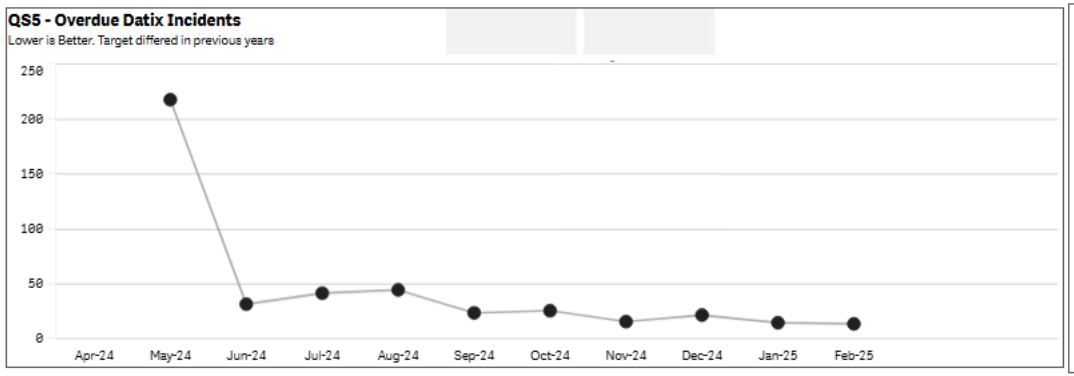
Understanding the Performance:
QS1 – The majority of PSI reported remain low/no harm (5 of 187 = 2.6%); there were 4 PSI reported as high harm:
- Paper safeguarding referrals not submitted via email as per process leading to a delay in making referrals.
- Re-contact within 24 hours following discharge on scene.
- Delay.
- IO drill defect.

Categories for declared PSII:
- Zoll battery failure.
- Wrong dose of adrenaline in cardiac arrest.

Actions (SMART):
QS1 – A scoping meeting for a thematic analysis of discharges on scene with patient recontact to be undertaken in March 2025. Chief Paramedic engaged in review

Risks:
QS1 – If the reasons behind failed discharges are not well understood then the patient safety risk will not be addressed, and patient harm could occur.

Quality & Safety – PSIRF



Variation	Assurance	Target	Latest
-	-	-	13

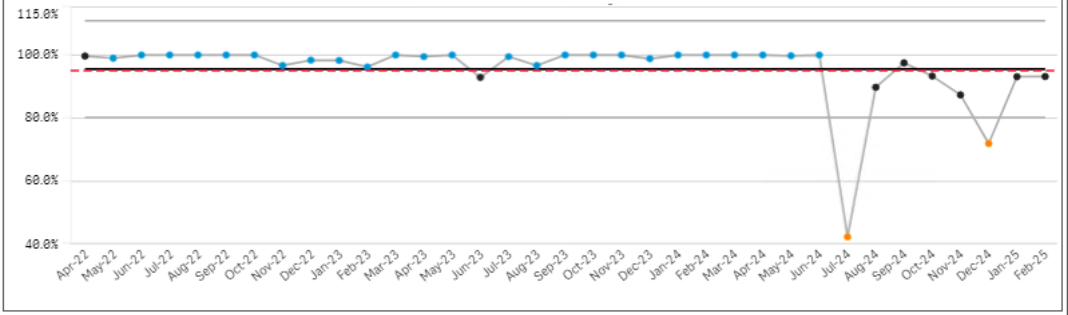
Understanding the Performance:
QS5 – Local ownership of Datix incidents embedded evidencing a sound safety culture.

Actions (SMART):
QS5 – overdue Datix records will be closed by 31 March 2025. SoP reviewed by 31 March

Risks:

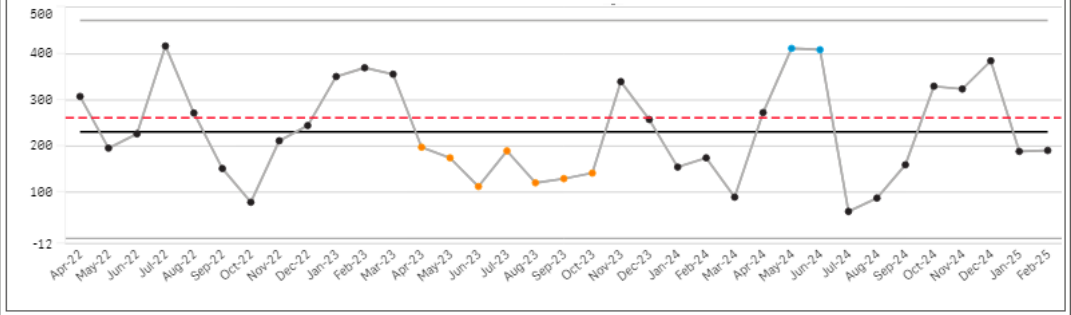
Quality & Safety - Audits

QS7 - Hand Hygiene Audits %
Higher is Better. Target differed in previous years



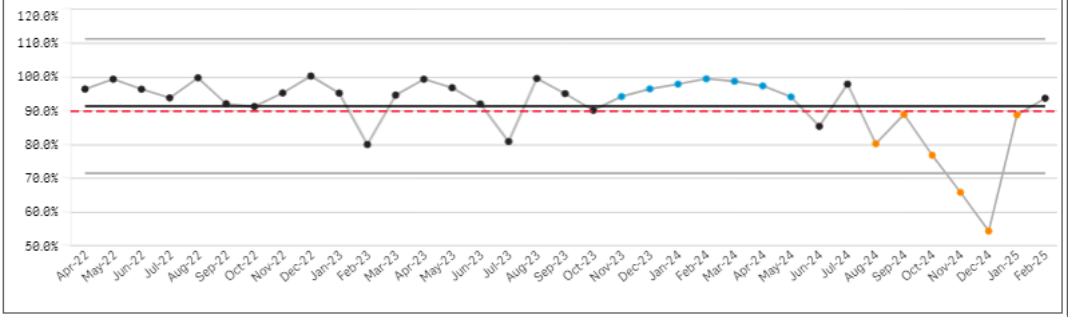
Variation	Expected
Assurance	Random
Target	95%
Latest	93.2%

QS8 - Hand Hygiene Audits
Higher is Better. Target differed in previous years



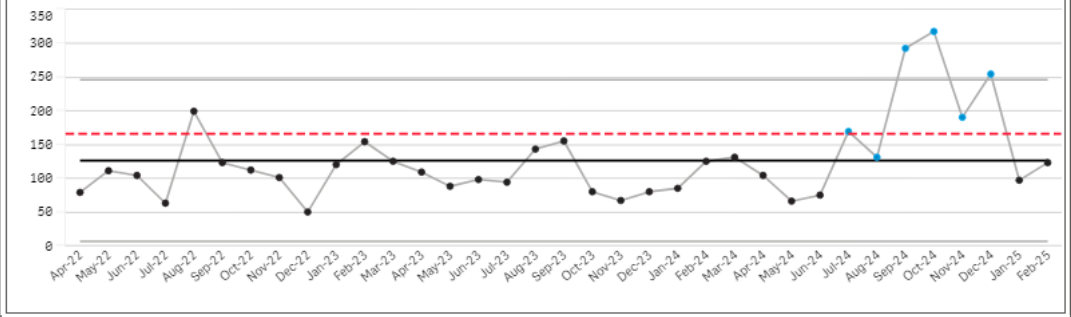
Variation	Expected
Assurance	Random
Target	261
Latest	191

QS9 - Vehicle Audits %
Higher is Better. Target differed in previous years



Variation	Expected
Assurance	Random
Target	90%
Latest	93.4%

QS10 - Vehicle Audits
Higher is Better. Target differed in previous years



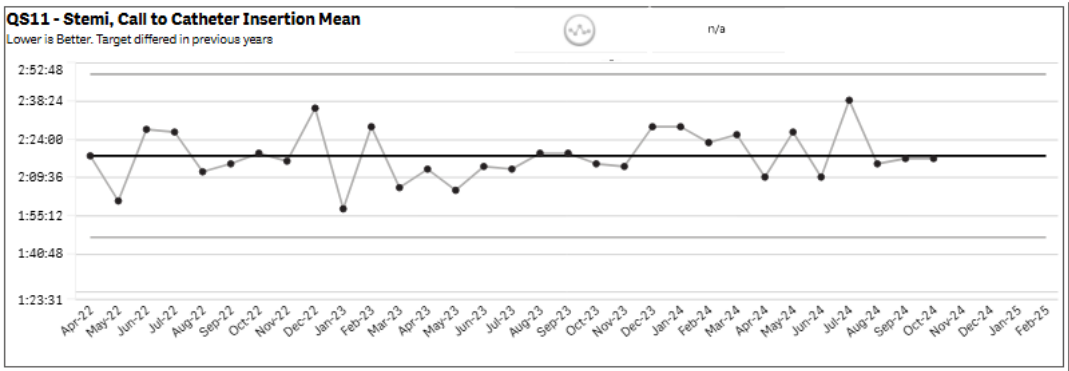
Variation	Expected
Assurance	Random
Target	167
Latest	122

Understanding the Performance:
Within expected variation. Vehicle completed audits had 4 data points of over target previously with a focus assisted by alternate duty staff. No additional resource for auditing last two months .
Local teams are ensuring processes are in place to meet and maintain audit numbers. This accounts for increase in number this month. Feedback from smaller stations stating compliance with number required is a concern. Another factor in audits completed is VOR rate. If VOR rate is high there are less vehicles that are available to be audited.
The number of audits compliant indicates the actions that have been in place are having a positive affect. This includes improvements in make ready processes.
Realtime dashboards will provide greater visibility of audit completion and compliance.

Actions (SMART):
Adjustments will be made to the number of audits required by each station from 1 April 2025. (The total number at trust and nodal level will remain the same with adjustments made at station level.)
New plan will be communicated to all areas by AD Operations .
Testing continues of hand hygiene audits with fixes required. Vehicle audit developed and will be tested next timeline dependent on hand hygiene fixes
QI group for IPC compliant pouches for consumables phase one complete 25 Feb 25.

Risks:
Cleaning below standards and poor hand hygiene has the potential to affect patient care and patient safety

Quality & Safety – AQIs – STEMI (Heart Atack) - Chief Paramedic Officer



Variation

Expected

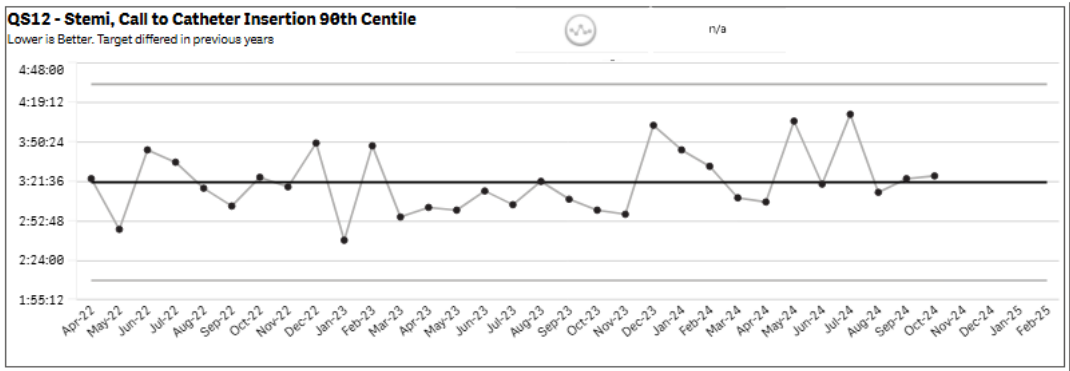
Assurance

-

Target

-

Latest



Variation

Expected

Assurance

-

Target

-

Latest

Understanding the Performance:

STEMI mean shows common cause variation. SCAS 2:17 (England 2:37)
STEMI 90th shows common cause variation
The charts are performance based measures and as such are reliant on the trusts ability to identify a suitable resource, time taken to arrive on scene and the clinician recognition of STEMI and the care required, time spent on scene and travelling to the hospital site.

Actions (SMART):

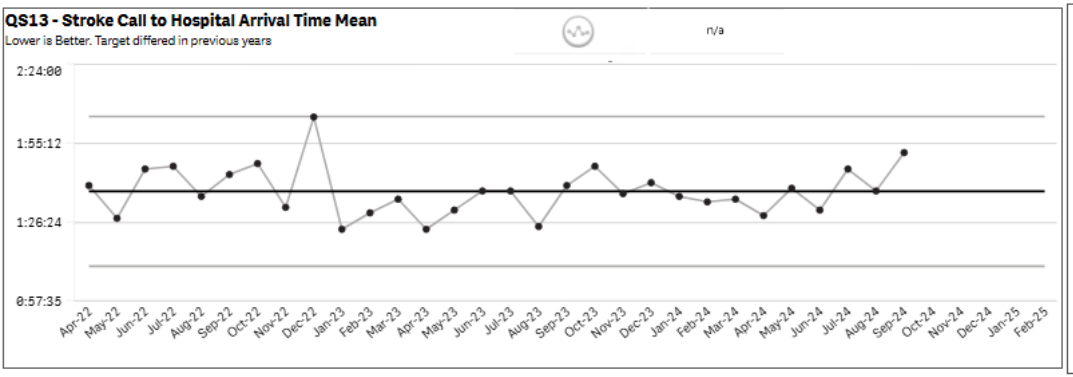
By the end of April 2025 understand performance for STEMI mean and 90th centile shown at nodal level to determine where to focus improvement activity.
By the end of April 2025, to have designed with EOC and operational colleagues a set of targeted improvement activity to reduce variation.

Risks:

If timely care is not provided to patients with a STEMI then patients are at risk of poorer outcomes and death resulting in avoidable harm
If timely care is not provided to patients with STEMI then patients are at risk of increased health burden resulting in additional avoidable system pressures.

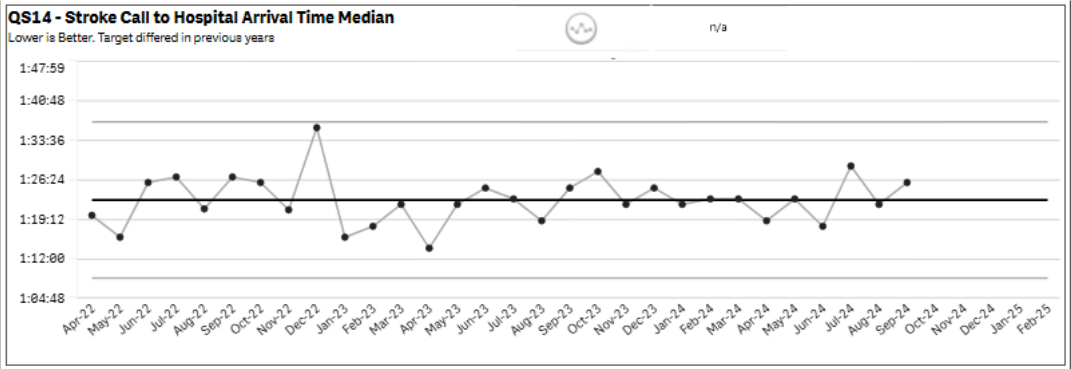
Quality & Safety – AQIs – Stroke - Chief Paramedic Officer

QS13 - Stroke Call to Hospital Arrival Time Mean
Lower is Better. Target differed in previous years



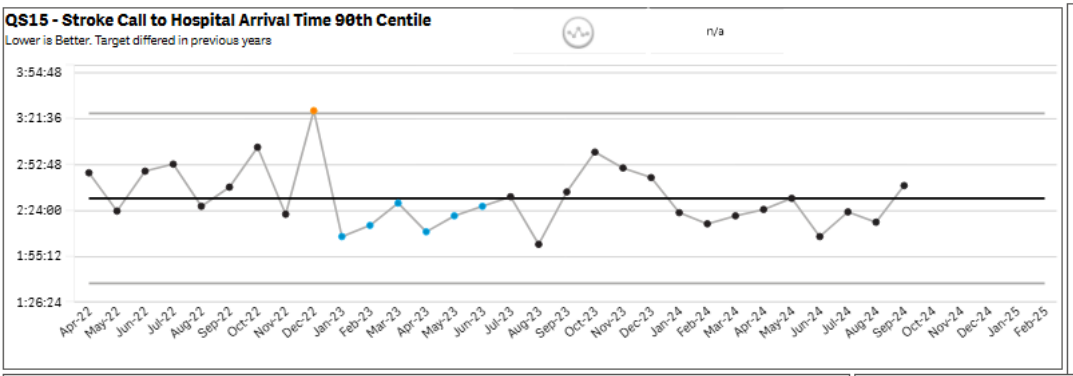
Variation
Expected
Assurance
-
Target
-
Latest

QS14 - Stroke Call to Hospital Arrival Time Median
Lower is Better. Target differed in previous years



Variation
Expected
Assurance
-
Target
-
Latest

QS15 - Stroke Call to Hospital Arrival Time 90th Centile
Lower is Better. Target differed in previous years



Variation
Expected
Assurance
-
Target
-
Latest

Understanding the Performance:
SSNAP October 2024 data is currently unavailable for all Trusts due to delay in implementation of new webtool for submissions

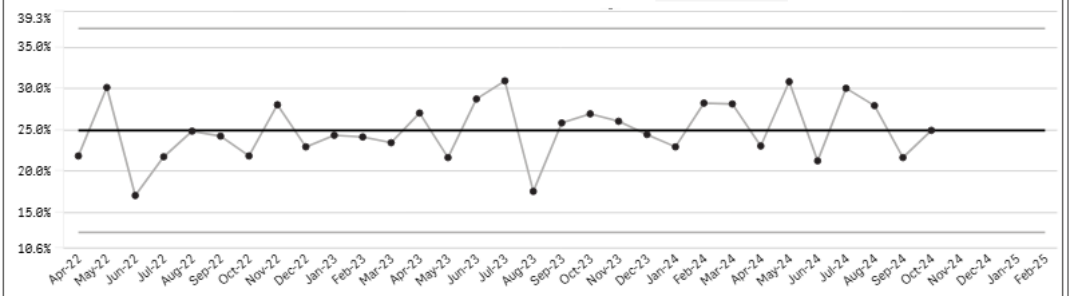
Actions (SMART):
By the end of April 2025, understand the performance for stroke mean, median and 90th centile by node to determine where to focus improvement activity.
By the end of April 2025, to have designed with EOC and operational colleagues a set of targeted improvement activities to reduce variation.

Risks:
If timely care is not provided to patients with a stroke, then patients are at risk of poorer outcomes and death resulting in avoidable harm.
If timely care is not provided to patients with stroke, then patients are at risk of increased health burden resulting in additional avoidable system pressures.

Quality & Safety – AQIs – Cardiac Arrest - Chief Paramedic Officer

QS16 - Return of Spontaneous Circulation All

Higher is Better. Target differed in previous years



Variation

Expected

Assurance

-

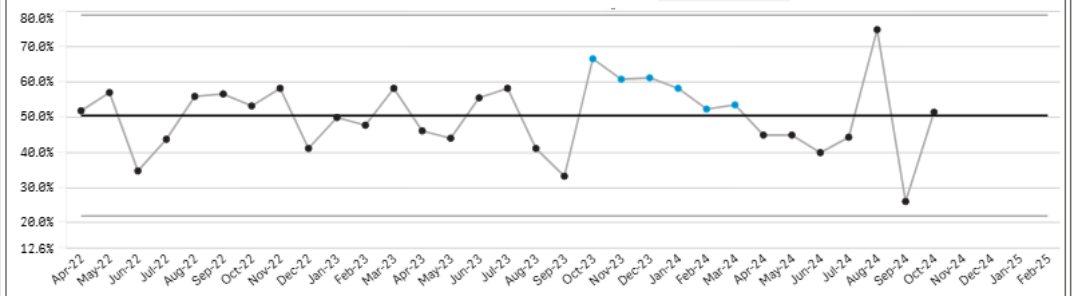
Target

-

Latest

QS17 - Return of Spontaneous Circulation Utstein

Higher is Better. Target differed in previous years



Variation

Expected

Assurance

-

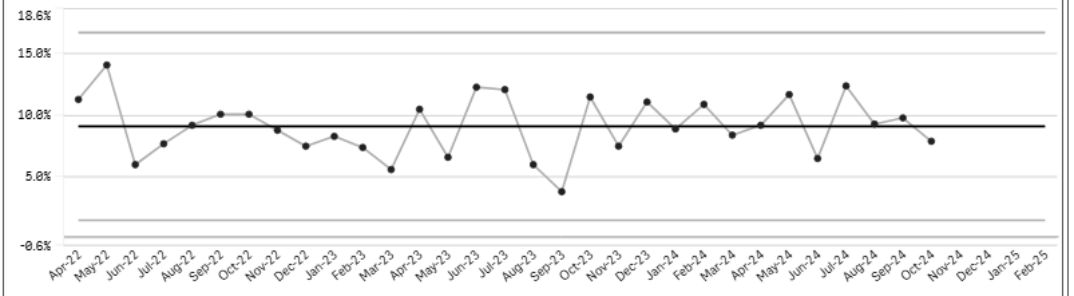
Target

-

Latest

QS18 - Cardiac Arrest 30 Day Survival - All

Higher is Better. Target differed in previous years



Variation

Expected

Assurance

-

Target

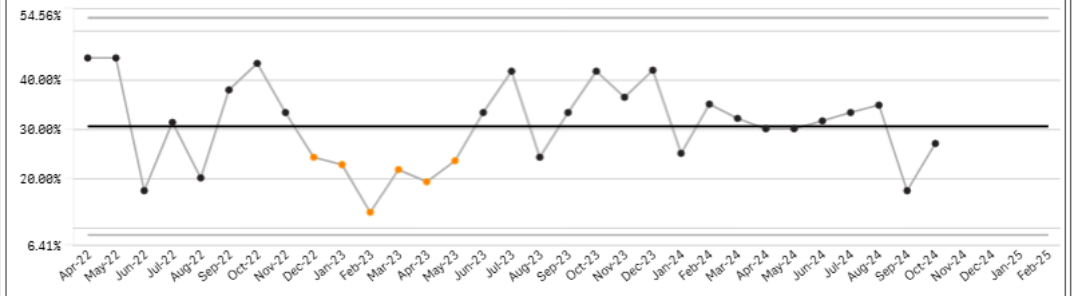
-

Latest

QS19 - Cardiac Arrest 30 Day Survival - Utstein group

Higher is Better. Target differed in previous years

n/a



Variation

Expected

Assurance

-

Target

-

Latest

Understanding the Performance:

ROSC all show common cause variation

ROSC Utstein shows common cause variation

Cardiac arrest survival All shows common cause variation

Cardiac arrest survival Utstein shows common cause variation

Actions (SMART):

By the end of April 2025, understand the performance for ROSC at nodal level to determine where to focus improvement activity.

By the end of April 2025, to have designed with EOC and Operational colleagues a set of targeted improvement activities to reduce variation and improve outcomes

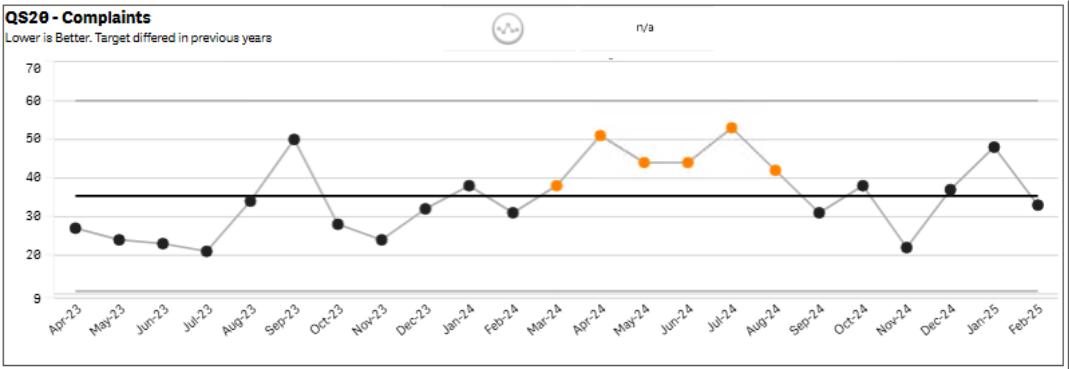
To have 95% of trust clinical staff to have completed their annual mandatory training online and face to face by the end of March 2025

Risks:

If all opportunities to enhance the entire chain of survival are not optimised then ROSC rates will not improve resulting in preventable death and avoidable patient harm.

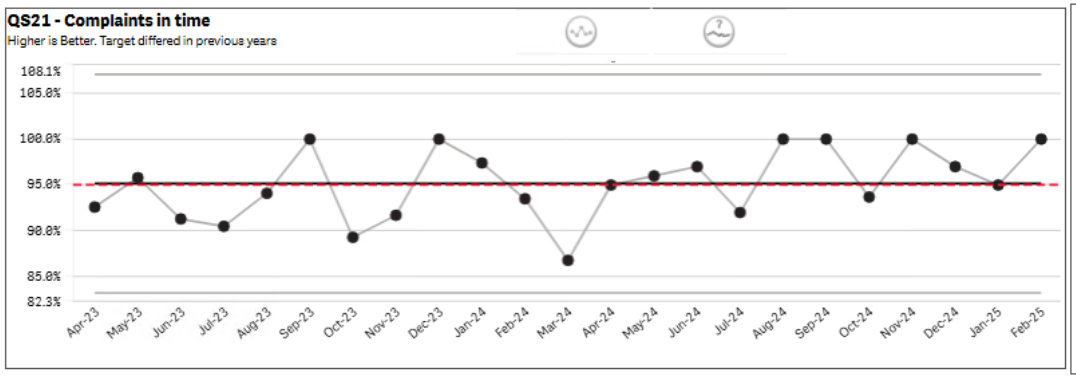
Quality & Safety – Safeguarding and Patient Experience

QS20 - Complaints
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	-	-	33

QS21 - Complaints in time
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	95%	100.0%

Understanding the Performance:
QS20 – The decrease in complaints in February is mirrored with a decrease in activity. Concerns have also decreased from 72 to 65 so we have not seen a shift from complaints to concern. 115 compliments were received for the same period. Themes for complaints and concerns remain delays in response and staff attitude/customer care.

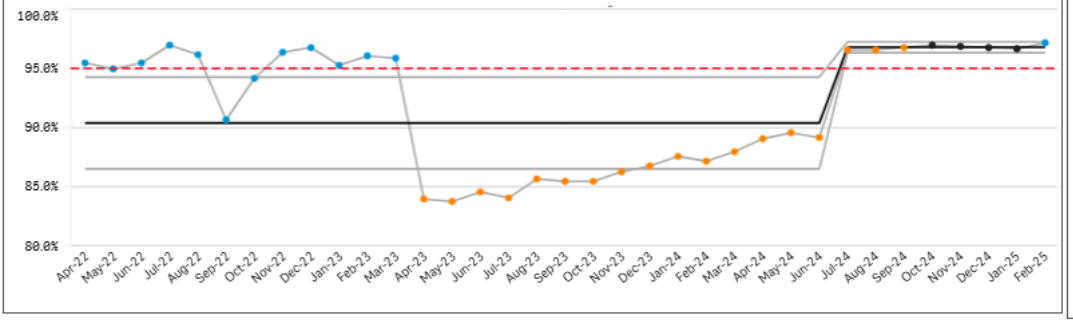
Actions (SMART):
improvement actions noted in operational performance slides 11-21

Risks:
QS20 – Non-compliance with contractual timescales.

Quality & Safety – Safeguarding and Patient Experience

QS22 - Level 1 Safeguarding

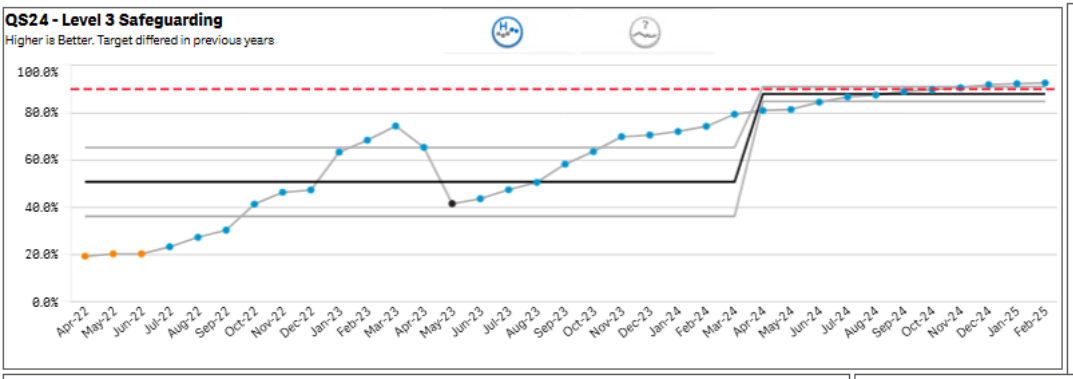
Higher is Better. Target differed in previous years



Variation	Improving
Assurance	Pass
Target	95%
Latest	97.2%

QS24 - Level 3 Safeguarding

Higher is Better. Target differed in previous years



Variation	Improving
Assurance	Random
Target	90%
Latest	92%

Understanding the Performance:

Maintaining performance

Actions (SMART):

Risks:

If Staff do not receive safeguarding training, people will be at risk of potential harm if abuse and neglect may go unrecognised

NHS

NHS
South Central
Ambulance Service
NHS Foundation Trust

People

February-25
Summary

Metrics:

Assurance →

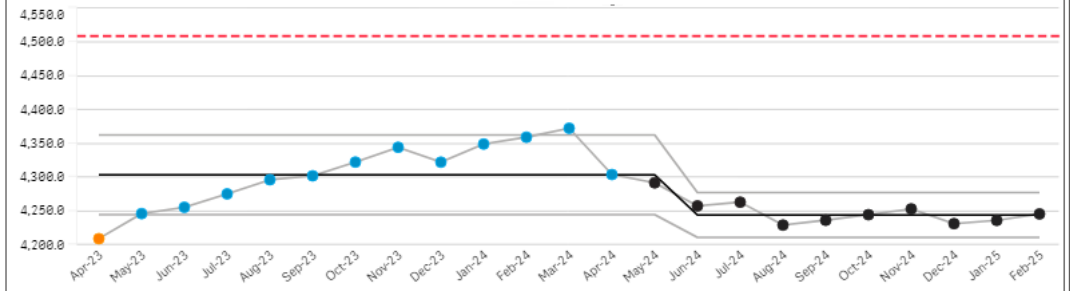
Variance ↓	Fail	Hit and Miss	Pass	No Target
H				
L				
	Number of Whole Time Equivalents Staff Appraisal Target Meal Break Compliance	Monthly Sickness Long Term Sickness		Vacancy Rate Turnover Rate Freedom to Speak Up Cases
L			Shift Overrun Percentage	
H		Disabled Staff %	BAME Staff %	

People - WTE, Availability, Staff Compliance, Staff Welfare

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Number of Whole Time Equivalents	Feb-25	4246	4508		F	4284.2	4230.1	4334.6
Turnover Rate	Feb-25	17.50%			n/a	18.10%	17.20%	19.00%
Vacancy Rate	Feb-25	11.50%			n/a	10.70%	9.60%	11.80%
Time to Hire Employees	Feb-25	133.8		n/a	n/a			
BAME Staff %	Feb-25	8.20%	6.30%	H	P	6.40%	5.80%	7.00%
Disabled Staff %	Feb-25	9.70%	8.60%	H	?	7.70%	6.70%	8.60%
Monthly Sickness	Feb-25	7.30%	7.40%		?	6.60%	5.30%	7.90%
Long Term Sickness	Feb-25	4.10%	3.40%		?	3.80%	3.30%	4.30%
DBS Compliance	Feb-25	96.20%	95.0%	n/a	n/a			
Staff Appraisal Target	Feb-25	88.30%	95.00%		F	85.00%	73.60%	96.40%
Stat and Man Training Compliance	Feb-25	41.70%		n/a	n/a			
Freedom to Speak Up Cases	Feb-25	18			n/a	13	-1	26
Meal Break Compliance	Feb-25	52.20%	70.00%		F	41.00%	26.40%	55.60%
Shift Overrun Percentage	Feb-25	13.00%	25.00%	L	P	18.40%	14.10%	22.80%

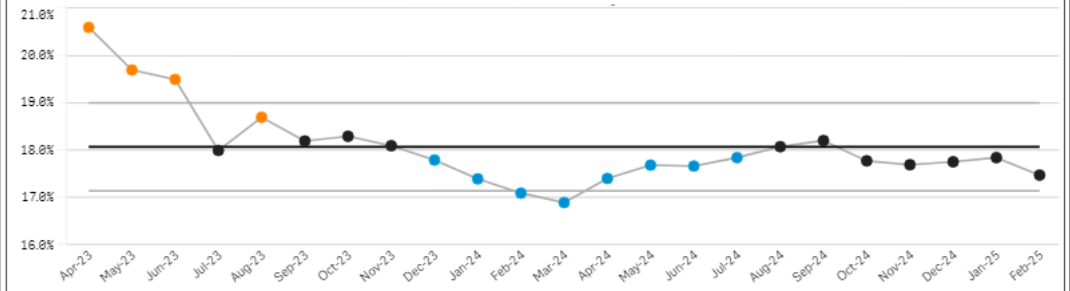
People - Workforce/WTE

P1 - Number of Whole Time Equivalents
Higher is Better. Target differed in previous years



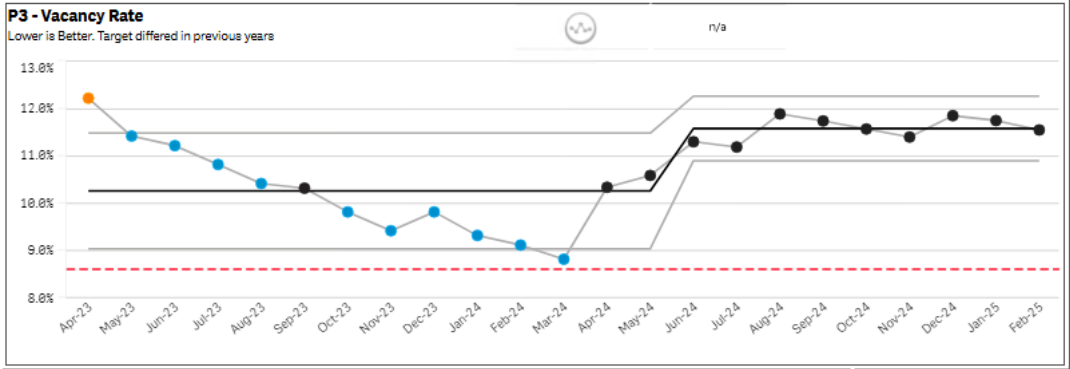
Variation	Expected
Assurance	Fail
Target	4,508.4
Latest	4246.2

P2 - Turnover Rate
Lower is Better. Target differed in previous years



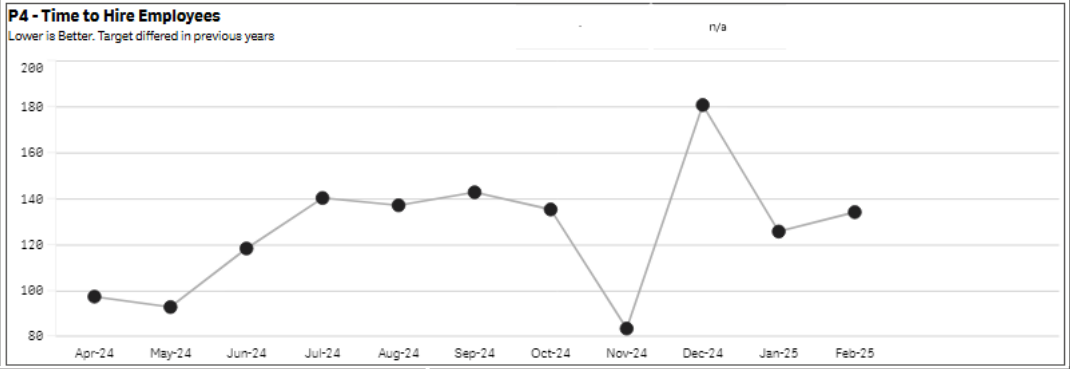
Variation	Expected
Assurance	-
Target	-
Latest	17.5%

P3 - Vacancy Rate
Lower is Better. Target differed in previous years



Variation	Expected
Assurance	-
Target	-
Latest	11.5%

P4 - Time to Hire Employees
Lower is Better. Target differed in previous years



Variation	
Assurance	-
Target	-
Latest	133.8

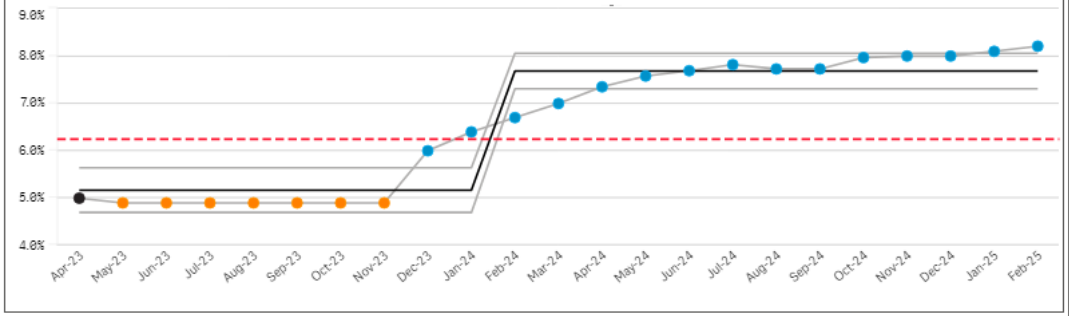
Understanding the Performance:
WTE continues to be below target in line with restructure, reduced WFP and PTS TUPE process.
% T/O - Continues to see a slow reduction, but will be seriously impacted in Q1 2025/26. Forecast for 25/26 is based on 24/25 levels.
% Vacancy - Remains below plan which has been impacted by PTS recruitment freeze, PTS TUPE, Corporate vacancies being held as part of restructure, and NHS111 funding not meeting establishment needed)

Actions (SMART):
Continuing engagement in the community and focus on retention. Engagement with community across the SCAS area to support rapid pipeline switch on when required.

Risks:
Insufficient staff to deliver service, impact on remaining staff due to workload. Financial risk of needing to cover vacancies to deliver services to patients. TTH will remain high due to the requirements of specific roles to avoid losing candidates to other Trusts.

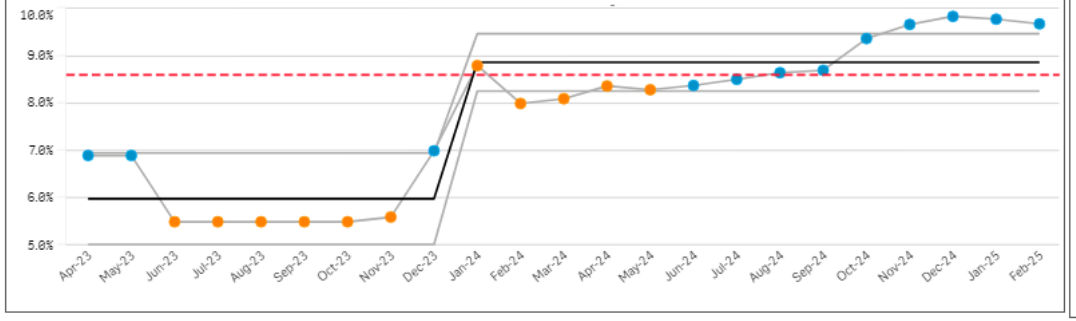
People - Workforce/Availability

P5 - BAME Staff %
Higher is Better. Target differed in previous years



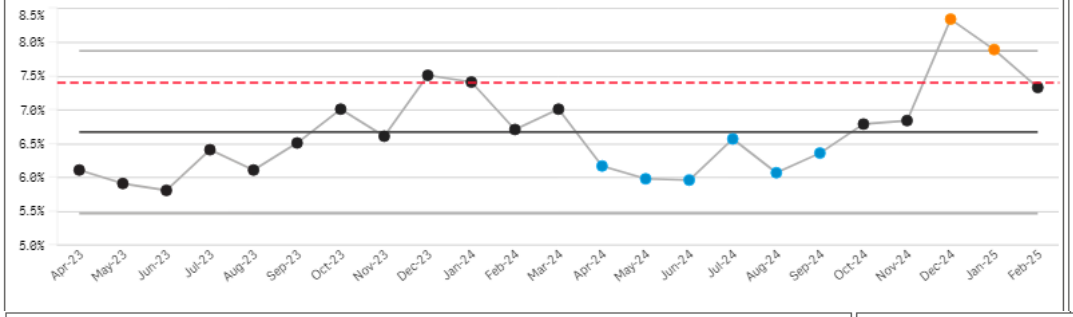
Variation	Improving
Assurance	Pass
Target	6.3%
Latest	8.2%

P6 - Disabled Staff %
Higher is Better. Target differed in previous years



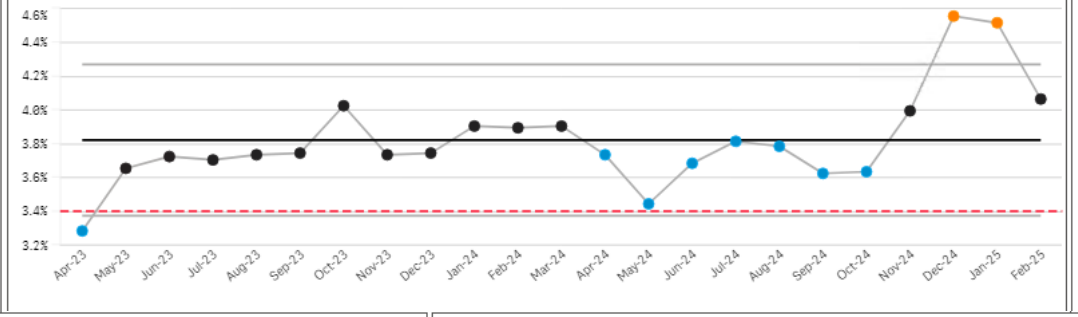
Variation	Improving
Assurance	Random
Target	8.6%
Latest	9.7%

P7 - Monthly Sickness
Lower is Better. Target differed in previous years



Variation	Expected
Assurance	Random
Target	7.4%
Latest	17.5%

P8 - Long Term Sickness
Lower is Better. Target differed in previous years



Variation	Expected
Assurance	Random
Target	3.4%
Latest	4.1%

Understanding the Performance:

Sickness - PTS absence levels have increased during the current TUPE process, whilst 999 and EOC are significantly above target.
LTS - 111 (5.2%) and PTS (6.5%) have significantly high levels of LTS.

Actions (SMART):

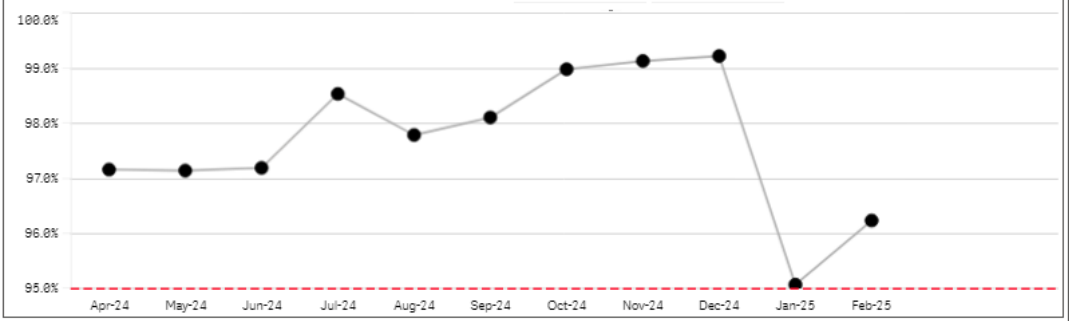
The Trust are part of the HIOW task and finish group to reduce absence, targets, approach and actions are to be defined. An additional piece to collaborate with SECAmb on the success they have had is also being explored. The new People Partnering roles in the incoming structure will conduct a deep dive into absence in these areas to assess the situation and develop improvement plans.

Risks:

Insufficient staff to deliver service, impact on remaining staff due to workload.

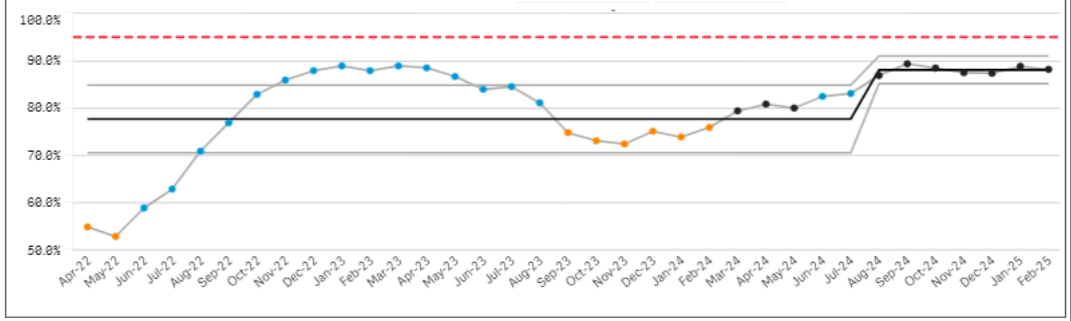
People – Workforce/Staff Compliance

P9 - DBS Compliance
Higher is Better. Target differed in previous years



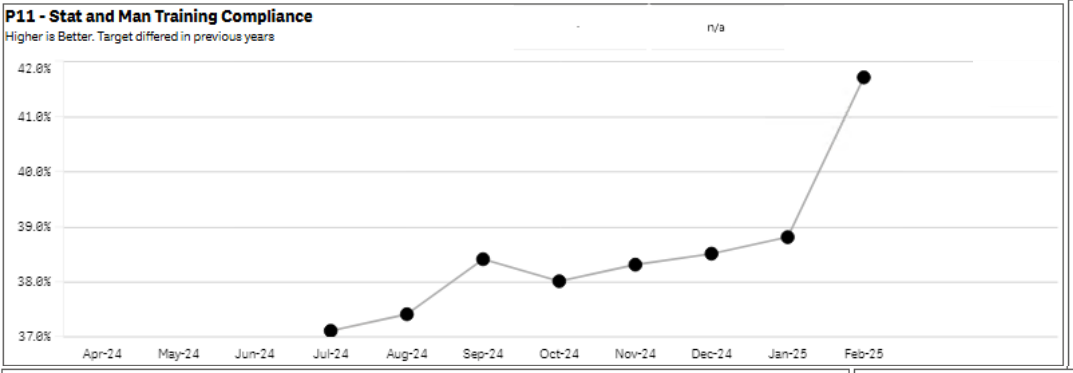
Variation	Assurance	Target	Latest
		95.0%	96.2%

P10 - Staff Appraisal Target
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Fail	95.0%	88.3%

P11 - Stat and Man Training Compliance
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
	-	-	41.7%

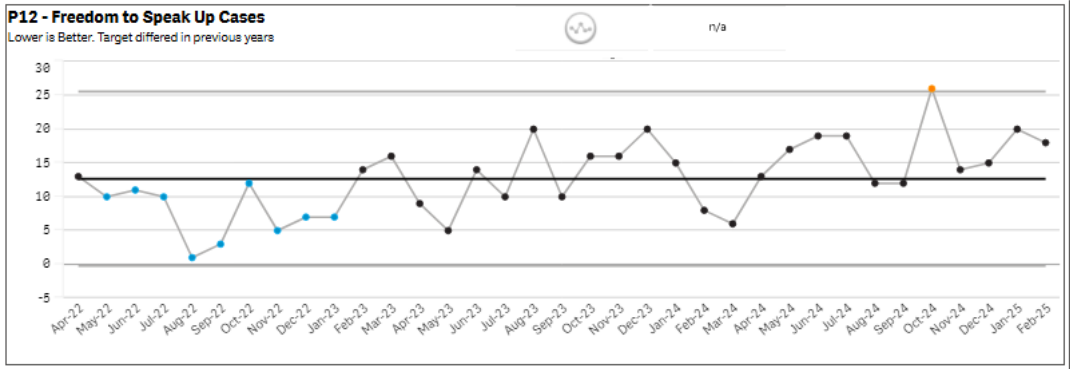
Understanding the Performance:
A historical issue has been identified in the way DBS was previously reported.Appraisals: There is no significant change in compliance rate which remains below target. The organisation continues to focus on encouraging engagement in the PDR process by contacting mangers with outstanding appraisals in their areas despite challenges from high REAP levels and corporate restructuring.

Actions (SMART):
DBS reporting has now been corrected and a taskforce created to address this and achieve 98% along with risk assessments for non-compliant staff.
Appraisals: A dashboard has been implemented to help managers track their compliance, and we send targeted reminders to those with outstanding PDRs. We've completed the analysis of the Q3 Reviewee Quality Survey and identified areas for improvement including the need for training in PDRs. We are currently testing the Power App and implementing system adjustments based on user feedback. We have completed the Reviewer survey and are using the insights to address barriers and training needs.

Risks:
Non-compliant staff either due to requiring outstanding DBS or information on disclosures. Risk that we may see higher attrition than planned.
Appraisals: Corporate restructuring and the organisation's REAP status are making it harder for managers and staff to complete PDRs on time, which may lead to delays and lower engagement. Currently no resources available to deliver PDR training.

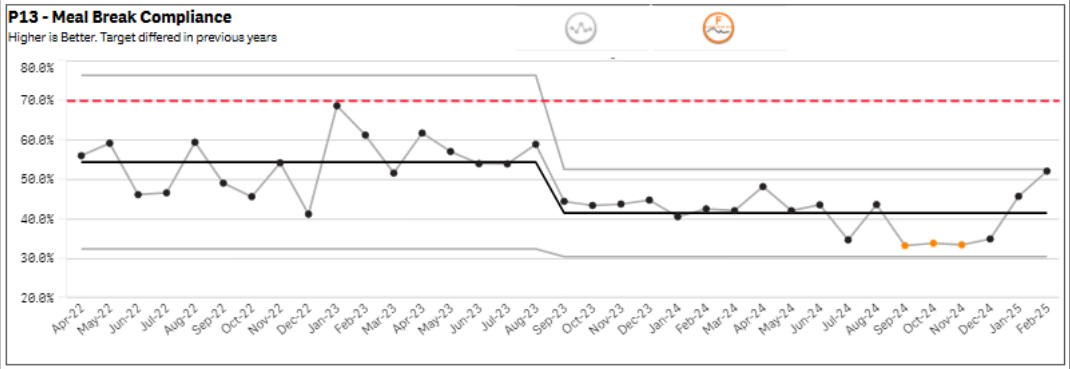
People - Workforce/Staff Welfare

P12 - Freedom to Speak Up Cases
Lower is Better. Target differed in previous years



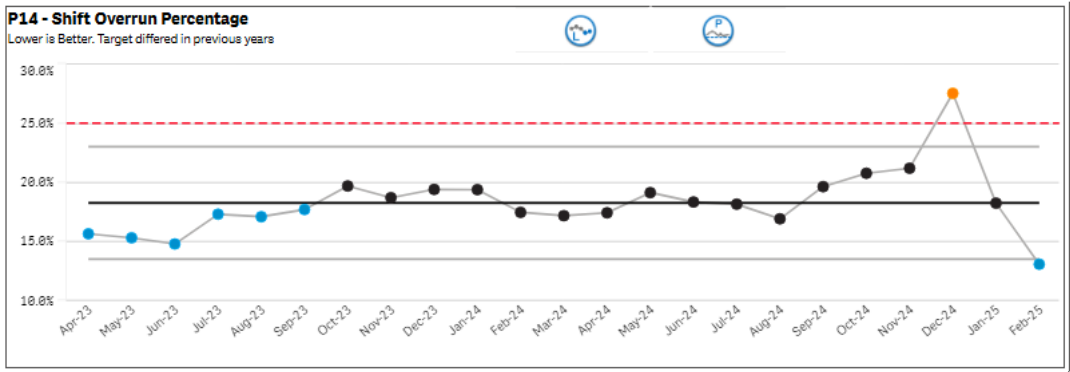
Variation	Assurance	Target	Latest
Expected	-	-	18

P13 - Meal Break Compliance
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Fail	70%	52.2%

P14 - Shift Overrun Percentage
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Improving	Pass	25%	13.0%

Understanding the Performance:
MBs, although continuing to fail the target has seen a near 20% improvement in the past 3 months. Compliance is at the highest point since Aug 23. Over runs greater than 30mins are at the lowest point since the chart began seeing another 5% improvement in February. Improvements in both MB and late finishes are reflected in an improved performance picture driven by the improvements we are seeing with performance in general.
FTSU : 12 of the 18 cases related to the corporate review; others covered payroll, behaviours, and internal recruitment.

Actions (SMART):
MBs, although continuing to fail the target has seen a near 20% improvement in the past 3 months. Compliance is at the highest point since Aug 23. Over runs greater than 30mins are at the lowest point since the chart began seeing another 5% improvement in February. Improvements in both MB and late finishes are reflected in an improved performance picture driven by the improvements we are seeing with performance in general
FTSU: reviewing self assessment and engaging senior team for input; Champion numbers increased by 6 to 62. Execs positively reviewing concerns raised.

Risks:
Failure to get staff a break and finish on time risks fatigue and an unhappy workforce. Reducing late breaks and finishes will also have a significant positive financial impact.
FTSU: People fear retaliation in raising their concerns; reporting disengagement and lack of motivation or feeling valued. Loss of trust.

NHS
South Central Ambulance Service
NHS Foundation Trust

Trust Board of Directors Meeting in Public 27 March 2025	
Report title	Quality and Safety Report (Clinical Directorate Update)
Agenda item	10
Report executive owner	Prof Helen Young, Chief Nursing Officer
Report authors	Laura Mathias, Assistant Director of Quality Jane Campbell, Assistant Director of Quality Christine Asare-Bosompem, Head of Safeguarding and PREVENT
Governance Pathway: Previous consideration	Patient Safety and Experience Group 13 March 2025 Divisional Clinical Governance Meetings EMC
Governance Pathway: Next steps	Not Applicable

Executive Summary

The Patient Safety Plan is going through consultation but guides the work to embed all ongoing patient safety work. This is due to be presented to the Quality and Safety Committee in May 2025.

Further improvement required in:

- IPC Level 2 training improving and 93% but below 95% target.
- Prevent level 3 training improved to 89% but below target 90% target.
- MCA documentation audit results are showing staff are correctly identifying patients and have more understanding of mental capacity. The new training package is due to be signed of at Safeguarding Committee and rolled from Q1.

The main themes seen in reported patient safety incidents are delay and external feedback requests.

The Trust received 570 patient experience contacts during the reporting period, which is consistent with activity in recent months.

Alignment with Strategic Objectives
High Quality Care & Patient Experience

Relevant Board Assurance Framework (BAF) Risk
SR1 - Safe and Effective Care

Financial Validation	Capital and/or revenue implications? n/a Checked by the appropriate finance lead? (for all reports) n/a Considered by Financial Recovery Group (for reports where the financial impact is not covered within existing budgets) n/a
Recommendation(s)	
The Trust Board is asked to receive the report for noting	

For Assurance		**For decision**		**For discussion**		**To note**	**x**

1. Background / Introduction

1.1 The purpose of the paper is to assure and inform the Board of key issues being addressed as part of the improvement and governance of quality and safety. The Board is asked to note the report.

1.2 The report presents the **data relating to the period January – February 2025** (unless otherwise stated), and highlights risks, issues and mitigations reflected in the Corporate Risk Register (CRR), Integrated Performance Report (IPR) and Board Assurance Framework (BAF). The information provided within the paper demonstrates evidence of compliance against Care Quality Commission (CQC) regulations where appropriate.

2. Detail

Further improvements are required in:

- IPC Level 2 training improving and 93% but below 95% target.
- Prevent level 3 training improved to 89% but below 90% target.
- MCA documentation audit results are showing staff are correctly identifying patients and have more understanding of mental capacity. The new training package is due to be signed of at Safeguarding Committee and rolled from Q1.

The main **themes seen in reported patient safety incidents are** delay and external feedback requests.
The **theme of delays in care is echoed in the complaints and feedback** received this month from patients and healthcare partner feedback.

2.1 Main Report and Service Updates

Accreditation Programme

- During January and February three accreditation visits have taken place.
- The oversight panel meetings have approved six accreditation reports for publication.
- This work is the supporting the CQC preparedness.

Infection, Prevention and Control (IPC)

- Completion of vehicle and hand hygiene audits continues to be area of focus. Operational Teams are maintaining targeted action plans and IPC are giving support with trajectories to ensure compliance with completion remains on target. IPC level 3 assurance audit schedule approved in IPC Committee and audits now underway.

- Updated National Standards of Healthcare Standards 2025 have been released. IPC lead is reviewing, ascertaining trusts position against new national standards and report with actions required.

- Quality Improvement project to improve the cleanliness of Dual Crewed Ambulances with the introduction of singular sealed, labelled and wipeable pouches to hold all consumables approved at IPC Committee and now being implemented.

- Infection prevention and control level 2 training compliance has increased from 90 % to 93% during the reporting period. The IPC lead is working with education and operational colleagues to further improve level 2 compliance within E&UC including team training sessions.

Safeguarding

- Compliance with the Safeguarding Accountability and Assurance Framework (SAAF) stands at 97.8%. This will further improve when we are able to implement the digital work to enable Child protection information service (CPiS) and rebuild the safeguarding referral application process.

- PREVENT Level 3 training compliance has increased from 84% to 89%, as a result of teams now being given training time in the new rota.

- Quarterly MCA audits are ongoing. In the last quarter, 66.67% of the records audited met the standard of recording in relation to MCA.

- Allegations Management: The total number of allegations is 61, of which 25 are open, 33 have been closed, and 3 cases are on hold. Themes are identified and discussed at people and culture committee and Safeguarding Committee. Improved working between HR, SG and Professional Standards is now in place to ensure triangulation and protection of public, patients and staff.

Mental Health and Learning Disability

- The materials for all internal training relating to mental health (CCC, AECA, TPP and IEPs) are currently under their annual review. This will also include additional reinforcement of the counterbalance between the Mental Health Act, the Mental Capacity Act and how these legislations operate. This is building upon the well-received issue of the MHA/MCA pocket guide earlier this year.

- The Mental Health Act (1983, am 2007) is currently under review by Parliament. At present, it remains in committee stage of the House of Lords where a significant number of amendments are being discussed. Not least of these is a potential change to those designated holding powers under S.136; currently restricted to warranted police officers. There is discussion whether these should be extended to registered healthcare professionals. The National Ambulance Mental Health Group, a NASMED sub-group on which SCAS is represented, is currently compiling data and a joint response to these proposed changes.

LD specialist update

- Sensory boxes are being trialled at Milton Keynes, North Harbour and Reading. Crews have given some positive feedback. The Message in a Bottle Autism Form has now gone live with a pilot in Buckinghamshire, with expectation this will expand nationally, following feedback from patients.

- AACE/NASMed have authorised a network for the Ambulance Trusts' Learning Disability and Autism Specialists. The group are meeting every six weeks to discuss joint working and shared learning.

Real Time Suicide Lead update

- Deaths by suicide in females continues to increase across our footprint and nationally, and deaths by suicide in the u15s continues to rise (54% increase in past two years), highlighting the need for further education within schools and communities.

- Workshops have been delivered in schools, SCAS feeder universities, football clubs, prisons and community groups, targeting key demographics. A schools booklet developed for key stage 1 and 2 pupils was recognised with an Ofsted accolade in late 2024.

- Internal sessions to new staff have been delivered during induction and team training days.
- Free online training for Managers and Team Leaders in compassionate communication has been sourced and place on the Health and Wellbeing pages.

Complex Care update

- 227 'Active' patients have had Complex Care Practitioner (CCP) intervention, resulting in alerts, care plan updates or new care plans put in place.

- The Complex Care Practitioners continue to work closely with the ED departments across the SCAS patch and attend a number of High Intensive Service User (HISU) meetings. They also work closely and attend the Multi Agency Collaborative (MAC) meetings that mental health providers lead and MARM, Section 42, CPA, MDT meetings, for specific individuals.
- The Chief Paramedic is now reviewing the work of the Complex care Team to see how their contribution to patient care can be maximized.

Clinical Incidents

EOC

- In the months of January and February 2025 there were 65 Patient Safety Incidents (PSI) reported by EOC North and South, which accounts for 70% of all incidents reported by this service line. This constitutes a significant reduction in reported PSIs when compared to November and December 2024 when 130 were reported and there remains a continued downward trend of PSIs over an 18-month period, with reduced delays being the main contributor to this downward trend.

- The top three reported patient safety incident categories across both EOCs during January and February were 'Delay', 'Patient Treatment / Care', and 'External Feedback Requests' to external services concerning their standard of Treatment/Care, communication issues and/or inappropriate requests for transfer.

Volunteer Responder Dispatch and Backup Audit

- Audit was undertaken covering the period September/October 2024 revealed that all incident types were appropriate for Volunteer Responders' attendance and that Cat 1 Volunteer Responder response times met target as did crew backup times. Volunteer Responder response time to Cat 2+ incidents were good but backing up Volunteer Responders at these incidents has been a challenge, but not proven to be detrimental to patient safety and care as low or no harm was reported in these cases. This will be kept under review.

HCP New Guidance Audit

- Revised Healthcare Professional Booking Guidance and an amended EOC SOP were approved by the Clinical Review Group (CRG) and rolled out in in April 2024. An audit was undertaken 6 months post implementation to measure the success of the guidance re-release. A new concern has been noted during this audit period in relation to a sharp increase in Level 1 bookings during 2024.

- The data presented by the audit suggests that the refreshed HCP booking guidance has succeeded in its objective of reducing inappropriate TECA bookings and HCPs who did not understand the booking process. However, the data demonstrates that Level 1 bookings have sharply increased, which his out of kilter with moderate increases in other booking levels.

- Actions have been taken to further educate referring HCPs through external feedback and training session, and steps have been taken to ensur e Emergency Operations Centre (EOC) staff are providing appropriate assistance for HCPs to select a booking level which aligns with NHS Pathways. The task and finish group are reviewing the approach outlined by the Association of Ambulance Chief Executives (AACE) which suggests all Level 1 and 2 booking requests should be triaged through NHS Pathways and CRG recommendations.

Dispatching to Unexpected Deaths in the Community

- Following SOP updates effective from 2 May 2024 with regard to Unexpected Deaths an audit was undertaken in order to provide assurance that the processes being followed. A review of deaths November - December 24 was undertaken. The audit's findings demonstrated that all Unexpected Deaths had appropriate dispositions. The Police were informed in all events of unexpected deaths and were also informed and/or attended when the circumstances were unclear.

EOC educational releases during the reporting period

- SOPS published including an update to Safeguarding and CP-IS SOPs – Shared 29/01/2025.

- EOC Quick Quiz January 2025 covered the following topics – Module 0 declared screens, childcare plans and safeguarding referrals, care advice and documentation in relation to it, seeking clinical advice, rectal bleeding, respiratory pathways, spontaneous shoulder dislocation, and directory of service referrals.

- EOC Quick Quiz February 2025 covered the following topics – ITK messaging for cancelled or abandoned calls, complex calls, safeguarding referrals, documentation of clinical decision making, estimating blood loss, injury and illness pathways, third party callers and sleeping patients, booking call backs and appointments and AED access codes.

999 Service

- There were 673 patient safety incidents reported equating to a decrease of just over 6% from the previous reporting period. However, the severity of cases remains low with (610) incidents being logged as low or no harm.

- The top three reported categories were External Feedback Request (179), Medicines (148) & Patient Treatment / Care (107)

- Incidents reported in the patient treatment and care category. Highlighting 2 subcategories, recontact within 24hrs and the standard of treatment/care concern codes for action. Most of these cases were low / no harm, 13 cases highlighted in which are now being reviewed under the PSIRF process for learning.

- The Medicines Category is mainly reporting inaccuracies on the documentation of medicines administration. There were 10 cases relating to the administration of medication to a patient. Actions from these reviews has seen better labelling on boxes and guidance to staff with regards to medicines errors.

111 Service

- **I**n the months of January and February 2025 there were 45 Patient Safety Incidents (PSI) reported by 111 IUC, which accounts for 76% of all incidents reported by this service line.

- There continues to be a downward trend of PSIs being reported which is also seen in the other service lines. It is noted that concerns with delays and patient treatment have seen a significant reduction.

- The top three reported categories were External Feedback Request (15), Delay (8) & Patient Treatment / Care (8).

- All incidents reported were low/no harm.

NEPTS Service

- In January and February 2025, there were a total of 88 patient safety incidents; 46 incidents in January and 42 in February.

- The top 3 categories were Slip, Trip and Fall (26), Patient treatment/care (21) and Ill Health (11)

- All reported incidents for the months of January and February 2025 were low or no harm with 22% of slip, trip and fall incidents occurring prior to arrival of NEPTS.

- In the patient treatment/care category 33% of incidents were failed discharges, which is a slight decrease on the last reporting period. Standard of treatment and care by others accounted for 23% of the incidents, which involved patient being transported with a cannula in situ, inappropriate transfer requests with untrained crews for monitoring patients and incorrect address booking made by the hospital ward which was a near miss.

- All incidents reported under Ill Health were no harm. All incidents involved patients who became unwell during conveyance.

- Demand activity management – a quality impact assessment (QIA) on the current capped activity of NPTS in BOB ICB area was presented to SCAS QIA panel. It was noted that SCAS was not able to provide the activity to the capped level and to meet the demand of clinically ringfenced cases as described in the contract, significant levels of cancellations of already booked journeys would be necessary. SCAS QIA could not mitigate the risk of these cancelled bookings, so referred back to the commissioners for a joint review of what journeys would be deemed as clinically essential.

Patient Safety

- No patient safety incidents this period where new learning in relation to delay could be identified. Nine incidents of delay have been referred for benchmarking against the delay's thematic analysis. Statutory Duty of Candor has been applied in all relevant cases.

- An emerging theme of patient recontact following discharge on scene will be subject to a thematic analysis; these incidents are low harm but are being seen more frequently at SRP. The thematic analysis will be submitted to PSEG in July 2025.
- The deep dive of vehicle unavailability was reviewed at Operations Group with further incidents to review. This review will be undertaken by the patient safety team with

support from operational and fleet colleagues. Once completed, it will be submitted to Operations Group in April 2025 for approval prior to submission to PSEG in May 2025 for oversight. Unavailability of vehicles has been added as a theme to the delays benchmarking process.

- The Trust's Patient Safety Incident Response Plan (PSIRP) and local priorities are currently under review, with data analysis underway to inform the development of the year two plan.

Patient Experience (PE) and Engagement

- The Trust received 570 PE contacts during the reporting period, no change noted in the trend remaining consistent.
    - Formal Complaint – 77 Concerns – 137 HCP Feedback – 356

- Themes of patient experience cases remain; inappropriate disposition (111), delay in/no attendance of frontline 999 and PTS vehicles.

- There are currently no cases being reviewed by the PHSO; one recent non-upheld decision has been received since the last report.

- The trust received 256 compliments for the care and service delivered by our staff across the reporting period.

3. Quality Impact

3.1 The report is presented for oversight and assurance.

4. Financial Impact

4.1 No direct financial impact.

5. Risk and compliance impact

5.1 The report is presented for oversight and assurance.

6. Equality, diversity, and inclusion impact

6.1 None to note in this paper.

7. Next steps

7.1 Relevant committees will continue to review updates.

8. Recommendation(s)

8.1 The Board is asked to receive the report for noting.

9. Appendices

9.1 None with this paper.

NHS
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Trust Board of Directors Meeting in Public 27 March 2025	
Report title	Chief Medical Officer's Board Report
Agenda item	11
Report executive owner	John Black, Chief Medical Officer
Report author	John Black, Chief Medical Officer Helen Pocock Jane Campbell
Governance Pathway: Previous consideration	Not Applicable
Governance Pathway: Next steps	Not Applicable

Executive Summary

The purpose of the paper is to update the Board on key clinical issues relating to:

- Clinical Research Updates
- JRCALC Clinical Practice Guidelines Updates April 2025
- Impact of the Opening of the New ED at Portsmouth University Hospitals

Alignment with Strategic Objectives

With which strategic theme(s) does the subject matter align?

High Quality Care & Patient Experience

Relevant Business Assurance Framework (BAF) Risk

To which BAF risk is the subject matter relevant? SR1 - Safe and Effective Care

Financial Validation	Not Applicable

Recommendation(s)
The Trust Board is asked to **note** the contents of the Chief Medical Officer's report.

For Assurance		**For decision**		**For discussion**		**To note**	✓

- **Background / Introduction**

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

1. SCAS Clinical Research Update
2. JRCALC Clinical Practice Guidelines Updates April 2025
3. Impact of the Opening of the New ED at Portsmouth University Hospitals

- **Detail**

1. Clinical Research

1.1 Current research study recruitment (data cut 03 Mar 2025):
207 new patients have been enrolled in research studies since the last Board report.

- Spinal Immobilisation Study (**SIS**): 28 patients;
- Early surveillance for type 1 diabetes in children (**ELSA**): 152 children;
- Tranexamic acid for mild head injury in older adults (**CRASH-4**): 19 patients;
- Randomised trial of clinical and cost effectiveness of Administration of Prehospital fascia Iliaca compartment block for emergency hip fracture care Delivery (**RAPID-2**): 8 patients.

1.2 Take Home Naloxone evaluation now complete. In the last 12 months, amongst calls to opiate-related overdose:

- Peak times for 999 calls were 22:00-22:59, 19:00-19:59 and 11:00-11:59
- The most frequently attended patient age group was 40-49 years old
- In 5% of cases a bystander administered Naloxone prior to ambulance arrival.
  - On arrival of the ambulance, 34 patients were not breathing; 68 were in full cardiac arrest.
- Take-Home Naloxone kits were distributed to members of the public on 36 occasions.
- Learning to be shared Trust-wide via Team Leaders and Clinical Team Educators and full report to be shared with the Local Authority who commissioned the report.

1.3 Community Engagement increasing Diversity and Accessibility in Research (**CEDAR**) **Project**: Home-grown project led by Andy Claxton, Research Paramedic. First PPIE event has been conducted and was met with great enthusiasm. We now have our first CEDAR site (in Portsmouth). Documents are in development (co-produced with PPI) for the first electronic mail-out.

1.4 New (external) studies opening:

- The Mental Health and Wellbeing of NHS Call-Handlers and Dispatchers working on 999 and 111 Helplines in England. (Survey, interview study)
- STALLED: What works to improve SafeTy, pAtient experience, outcomes, and costs reLated to deLayed ambulance handovers at Emergency Departments? A whole system approach. (Mixed methods).
- I-CARE: InCreAsing Retention of healthcare staff from Ethnic minority groups. (Survey study).
- POHCA-PHD Exploring UK Ambulance Clinicians' Experiences of Attending Out of Hospital Cardiac Arrest (OHCA) Incidents Involving Children: A Mixed Methods Study. (Survey, focus groups study).

1.5 Grant applications submitted:

- Older people – conveyance decisions and service provision mapping project (NIHR Health Services Delivery Research funding stream). Collaboration with University of Southampton, University of Portsmouth. Co-applicants.

- Improving caller experience to 111 for mental health needs. (NIHR School for Primary Care Research funding stream). Service partners.

1.6 Grant applications in development:
Helen Pocock, Interim Head of Research Operations currently undertaking a funded internship to develop a grant application seeking to improve outcomes from cardiac arrest in the prison population.

1.7 Presentations delivered to Southampton primary care researcher group and Health innovation Wessex promoting SCAS involvement in study delivery utilising our Research RRV model. Costing template developed (required to build in our involvement in commercial studies including those where we are supporting rather than leading study delivery).

1.8 Research Governance priorities:

.1 Data sharing agreement for service evaluation/research between SCAS & HIOWAA (UHS)

.2 Commercial Research Delivery Centres: SCAS a partner on a successful grant application to deliver commercial research in Wessex. Our involvement will require speedy set-up of agreements and contracts (5-6 days; currently weeks/months).

1.9 Publication:
Ji C, **Pocock H**, **Deakin CD** et al. Adrenaline for traumatic cardiac arrest: A post hoc analysis of the PARAMEDIC2 trial - ScienceDirect. This ad hoc sub-group analysis confirms that adrenaline comparted to placebo trebled survival to hospital in this small cohort of patients.

2. JRCALC Clinical Practice Guidelines update April 25.

There have been a number of significant updates to these nationally produced guidelines including a new chapter on acute behavioural disturbance that provides a framework for the assessment of potential underlying medical emergency conditions that can manifest as a change in patient behaviour. A summary of these updates is included in **Appendix 1.**

3. Impact of opening of the New Emergency Department at Portsmouth University Hospitals.

The new 'state-of-the-art' Emergency Department at PUH was formally opened by the Princess Royal on the 7 March 2025. SCAS had an opportunity on this happy occasion to join PUH Executives, Management, front line PUH clinicians, ICB directors and local politicians to thank them for all of their care and support for our patients and staff.

The significant impact on our operational response times since the new ED opened is documented in the IPR – this will also contribute to improved clinical outcomes for the sickest patients in need of time-critical emergency care.

The reduction in hand over delays and the implementation of 'Release to Respond' has had a very positive impact on staff morale. This has also reduced the need for conveyance of patients, for example those patients with non-injury falls, and has freed up Team Leaders time to be able to complete operational management tasks including staff PDRs, as they are no longer required to support patients and staff at hospital.

It has also improved the exposure of our paramedic students to patients in need of emergency and urgent care in the community during their placements with SCAS, as they are now spending far less time monitoring and caring for patients for extended periods at hospital.

- **Quality Impact**

Research aims to improve patient safety, patient experience, and clinical effectiveness.

- **Financial Impact**

Income generated by research varies depending on patient/participant recruitment.

- **Risk and compliance impact**

If the trust does not take part in research studies, then our patients may be denied access to new/innovative treatments leading to longer recruitment periods for research studies overall and longer times to implementation of research findings nationally.

Research aims to improve safe and effective care.

The NHS expects all NHS Trusts to facilitate research and embed research in its core business.

- **Equality, diversity, and inclusion impact**

We aim to offer research projects to all patient groups.

- **Next steps**

Continue to offer research to our patients (and staff) and expand our offering across a range of conditions.

- **Recommendation(s)**

The Board is asked to receive the report/paper for noting

- **Appendices**

1. JRCALC Clinical Practice Guidelines Summary

JRCALC Clinical Guideline Updates 1/2025

Summary of changes

Planned publication date: 1st April 2025

New JRCALC Guidelines/medicines:

Guideline/medicine	Update
Behavioural emergencies	A new guideline that should be used in conjunction with other existing guidelines including: agitation, delirium and acute behavioural disturbance.

Updates, Corrections, and Additional Guidance to Existing JRCALC Guidelines:

Guideline/medicine	Update
Sepsis	Following the NICE guidance (NG51) update, this guidance was fully revised. Note that JRCALC are not advising pre hospital antibiotics for suspected sepsis. The choice of fluid is crystalloid, which should ideally be started with a 250ml bolus in adults prior to transportation but should not delay on scene time, then continued en route to hospital.
Management and Resuscitation of Patients with Left Ventricular Assist Devices (LVADs)	Revised and updated. Small changes include: If possible, anterior-posterior pad positioning would be preferable based on LVAD position within the chest wall. LVAD centre emergency contacts numbers were checked for accuracy.
Adrenal insufficiency patients (formerly called steroid dependent patients)	Guideline reviewed, updated in line with NICE NG243 and note new title. • *Give 1 litre of 0.9% sodium chloride intravenous infusion over 30 minutes if having an adrenal crisis*
Abdominal pain	Revised and updated. The common causes table for adults and children has been revised and symptom indicators added to aid working diagnosis. Includes diagram of abdominal regions.
Paracetamol	Due to concerns raised over IV infusion of paracetamol having an amount of paracetamol left in the tubing new wording has been added to the additional information section in the paracetamol monograph:

	'Follow local guidance on administration of paracetamol. Where no local guidance exists, flush the giving set with 100ml sodium chloride 0.9% to ensure the full dose is administered.'
Medicines overview	We have been working in conjunction with the Royal College of Emergency Medicine (RCEM) on a project regarding the importance of patients that take time critical medicines. A new poster of the pneumonic 'MISSED' will be included and additional wording that says: • *Take time critical medicines to the hospital. If time critical medicines are unavailable, seek alternative supply from the hospital.* • *Time critical medicines should not be missed or omitted unless there is a valid clinical or safety issue. This should be discussed with a clinician.* • *Patients on time critical medicines who are delayed on an ambulance should be flagged to the receiving team, with regard to if the medicine should be administered or not.* https://aace.org.uk/resources/time-critical-medicines-poster-aace-rcem-feb-2024/
Clinical Considerations in Relation to Diversity and Equality	New wording included: *Pulse oximetry can over-estimate oxygen levels, and this inaccuracy is more likely to occur in patients with a dark skin tone than a light skin tone. The SP02 reading may misleadingly suggest the patient is within a normal oxygenation range despite oxygen saturations being low. Use caution and a wide clinical assessment to assess for possible hypoxia, particularly respiratory rate.* Reference: https://www.gov.uk/government/publications/equity-in-medical-devices-independent-review-final-report New wording has been added to the disability section: *When referring to disability it encompasses temporary and permanent, visible and non-visible conditions and impairments, physical and psychological, mental health conditions and neurodivergent conditions. It is accepted that disability is different for everyone and can result in varying levels of disruption to daily life. Not everyone will be comfortable with the term disability or impairment (or other disability related terminology) being used to refer to a particular condition, and some conditions may be labelled as 'differences'. The term disability is used, however it is recognised and accepted that there are different positions, perspectives and views on this terminology and (we) wish to acknowledge this.*

Patients with communication difficulties	Amended wording following feedback we received around patients who are deaf. New wording in introductory section: *Interpretation services may be available to support conversations where required.* *Clinicians should undertake appropriate assessments and adapt their communication accordingly to take into account the presenting condition, any communications difficulties and any concerns regarding confidentiality or safeguarding.* A new bullet point has been added: • *BSL is a recognised language in England, Scotland and Wales and qualified interpreters can be accessed through resources such as language line.* Makaton bullet point has been revised: • *Makaton is a language tool based on a system of signs to support communication. It is usually used by people with a learning disability or speech and language delay. Makaton is simple and easy. You don't have to sign every word, just key words and many signs are similar to everyday gestures.*
Ondansetron	Due to concerns about administration of ondansetron during pregnancy, breastfeeding and the risk of cleft lip, two new sections added to the monograph: ***Pregnancy*** *Not recommended in the first trimester, unless life threatening situation, due to the small in-creased risk that ondansetron may cause orofacial malformations (cleft lip and /or cleft pal-ate). However, the risk is thought to be very small with an increased risk of 3 oral clefts per 10,000 births (14 cases per 10,000 births versus 11 cases per 10,000 births in the unexposed population).* ***Breastfeeding*** *Compatible with breastfeeding. No special precautions are required in relation to breastfeeding.*
Tranexamic acid	Updated monograph. Note this medicine requires a PGD. Staff should refer to local PGD. New indication for patients with confirmed miscarriage and excessive bleeding. Amended indication : ***Post-partum Haemorrhage (PPH)*** *In primary and secondary post-partum haemorrhage (PPH). NB for PPH give tranexamic acid after uterotonics, unless uterotonics are contraindicated. See Management of Post-partum Haemorrhage (PPH) for definitions of primary and secondary PPH.*

	This includes women who are breastfeeding. Dosages for patients aged 10 and 11 have been included for confirmed miscarriage, excessive bleeding and PPH.
Advanced life support (ALS)	Due to a query we received regarding measuring blood glucose in cardiac arrest, there is a slight change to confirm that intra-osseous (IO) obtained blood may be used. Amendment to section 10.3: *When measuring blood sugar during a cardiac arrest, a venous or IO sample should be used where possible (a capillary sample may be less accurate but is acceptable if it is not possible to obtain a venous sample). Blood glucose monitors are not calibrated for venous or IO samples* (although they are likely to still be accurate).
Glycaemic Emergencies in Adults and Children	Due to a query we received regarding the blood glucose threshold to treat non-diabetic patients we have made an amendment to section 3.1: *hypoglycaemia in the absence of diabetes is diagnosed by the lower blood glucose of <3.3mmol/L.*
Spinal injury and spinal cord injury and Trauma emergencies in adults	Following further discussion around the need for JRCALC to reflect current trust practices around use of collars, wording has been further amended to say: *There are two common approaches to this (immobilisation) within UK paramedic practice:* *head blocks and scoop with collar* *head blocks and scoop without collar*

Upward Report of the Quality and Safety Committee

Date Meeting met **19th March 2025**
Chair of Meeting **Dhammika Perera, Non Executive Director**
Reporting to **SCAS Board**

Items	Issue	Action Owner	Action
Areas of concern and / or Risks			
IPR delays and IPR content quality	Board discussion required to decide sequence of IPR to Board and then out to Board Committee. CPO suggested IPR to Board and then delegated areas of scrutiny and oversight to Board Committees agreed at the Board meeting. The quality of the data is still being worked on and Q&S noted some ongoing issues with data in the IPR and had update from CDO on what would be in next iteration.	Chief Governance officer	Q&S Support this proposal Board to decide.
DBS for patient facing staff	Q&S received a report from CPO and evidence of the improved position of staff who are pt facing having the correct type and valid DBS check.	Chief People Officer	Review the progress against target again at Q&S in September
Risk of being non complaint with the Home Office Licence required to supply CDS	Discussed the risk of remaining non-compliant with the Home office License requirements as we work through supply of CD to individual paramedic rather than the existing system of allocating CDs to each vehicle. Risk of immediate implementation was seen to be too high	Chief People Officer	Further updates and the plan to be compliant with Home Office License to Q&S to May and July meetings

	risk and so further conversations with regulators and commissioners are going.		
Concerns around the recurring safeguarding referral application	Q&S received an update on the recent SG referral application issues and heard the proposed medium and long term solutions which have been agrees by EMC. The long term solution is a rebuild of the application with current provider and the medium term option moves to a web based solution “My Referral” which will be added to the devices the staff in 999 use. Q&S were asked to ratify this decision.	Chief Digital Officer/ CNO	Q&S ratified the decision and noted the costs had been provided for in the 25/26 financial plan. Q&S also received assurance that the cases that were impacted had been all been risk assessed and reviewed and to date no harm had been idientified.
Items for information and / or awareness			
Internal Audit Plan (BDO)	The internal audit plan for 25/26 was received and noted with specific reference to the areas that impact directly of quality and safety.	Chief Nursing Officer	Plan noted by Q&S
Infection prevention & control	Improvements have been made in vehicle audits and hand hygiene. However, ongoing work and supervision is critical to make sure that audits and training meet the target	Chief Nursing Officer	Update of progress on IPC improvement plan and audits to Q&S committee
Nodal breakdown of AQI performance	Inadequate visibility of performance against AQIs	Chief Paramedic	Bring a **short report on AQI performance of each node at the May Q+S**
Critical Stat Man Training (Resus) not meeting target	Resuscitation training completion rates low and Q&S concerned and looking for improvement plan in this area.	Chief People Officer	Bring a full year’s Rescuss training data to the May Q+S with plan for improving the training rate for resus.
ToR for the Q&S committee	CGO to engage KC (NED) in the review	Chief Gov Officer	ToR’s to sign off in Q&S in May meeting
Approved*			

None			

Author: Dhammika Perera

Title: Non-Executive Director

Date: 19th March 2025

NHS
South Central Ambulance Service
NHS Foundation Trust

Trust Board of Directors Meeting in Public
27 March 2025

Report title	M11 Finance Report
Agenda item	13
Report executive owner	Stuart Rees, Interim Director of Finance
Report author	Alan Monks, Deputy Chief Finance Officer
Governance Pathway: Previous consideration	Finance and Performance Committee and Executive Management Committee
Governance Pathway: Next steps	n/a

Executive Summary

The Trust's reported position for Month is as follows:

Key Performance Indicators				
		Plan	**Actual / Forecast**	**Variance**
1	Surplus / (Deficit) Year to date*	-10.4	-10.3	0.1
2	Surplus / (Deficit) In-month*	0.6	0.7	0.0
3	Surplus / (Deficit) FOT*	-10.1	-8.9	1.1
4	Capital Spend YTD	26.7	11.7	-15.0
5	Capital FOT	41.5	23.0	-18.5
6	Pay Costs In-Month	18.5	17.9	0.6
7	Agency Costs In-Month	0.1	0.2	-0.1
8	Cash - Year to date	11.5	30.7	19.2

9	Cash - Year In-month	1.3	4.5	3.2
10	Aged Debtor >90 Days	5.00%	14.24%	-9.24%
11	BPPC - YTD - Value	95.00 %	98.40%	3.40%
12	BPPC - YTD - Number	95.00 %	95.50%	0.50%

*All surplus / (deficit) figures are shown before the deficit support funding and before brokerage funding

Income and Expenditure (I&E) Position

In Month 11, the Trust recorded an in-month surplus of £0.7m, £49k better than planned. Key variances in performance include:

- 999 Service: £0.9m shortfall against plan.
- PTS Service: £0.5m surplus
- 111 Service: £0.2m surplus.
- Corporate Areas: £0.3m surplus.

The Trust received brokerage funding of £7.5m this month from HIOW ICB. This funding is intended to support the Trust's deficit position and structural change costs. As a result, the reportable year-to-date position reflects a surplus of £3.2m, a significant improvement compared to the planned deficit of £10.4m.

In-month, following a review of historic cost accruals, £2.1m was released has no longer required.

Forecast

The Trust now expects to achieve a forecast outturn of £9.0m, which is £1.1m better than the planned year-end deficit of £10.1m. Additional measures have been implemented to support an improvement in the system-wide financial forecast.

For the overall reportable position, the Trust is now forecasting a net surplus of £4.6m for the financial year. This includes £6.0m of deficit funding and £7.5m in brokerage funding.

Capital Position

The Trust's capital spend to February was £11.7m, with £7.1m from vehicle sale and leaseback sales, producing a net spend of £4.6m. The Trust is £15.0m underspent against its YTD capital budget, driven by:

- Digital: £1.2m behind plan.
- Estates: £5.6m behind plan.
- Vehicle net sales proceeds: £0.5m.
- DCA replacement slippage: £9.1m, now expected in March 2024.

Cash Position

At the end of February, the Trust's cash balance was £30.7m, reflecting a net cash inflow of £4.5m in Month 11, primarily due to capital underspends.

Looking ahead:

- The Trust is forecasting a year-end cash balance of £27.3m.
- A one-off central funding allocation of £7.5m is expected in March.

Alignment with Strategic Objectives
With which strategic theme(s) does the subject matter align? (If more than one, please write manually) Finance & Sustainability

Relevant Board Assurance Framework (BAF) Risk
To which BAF risk(s) is the subject matter relevant? (If more than one, please write manually) SR5 - Increasing Cost to Deliver Services

Financial Validation	Capital and/or revenue implications? If so: Checked by the appropriate finance lead? (for all reports) Considered by Financial Recovery Group (for reports where the financial impact is not covered within existing budgets)
Recommendation(s)	
What is the Committee/Board asked to do: • Receive a report/paper for noting	

For Assurance	✓	**For decision**		**For discussion**		**To note**	✓

1. Background / Introduction

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

Income and Expenditure (I&E)

In month 11, the Trust's I&E position shows an in-month position of £0.7m surplus, which is broadly in line with plan. This results in a year-to-date (YTD) deficit of £10.3m against a planned deficit of £10.4m.

Position before deficit funding and brokerage funding.

£m	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	YTD
Plan	(1.9)	(1.7)	(1.3)	(0.7)	(1.0)	(0.4)	0.5	0.2	(2.4)	(2.4)	0.6	(10.4)
Actual	(1.9)	(1.7)	(0.9)	(0.7)	(0.9)	(1.0)	0.6	0.2	(2.4)	(2.4)	0.7	(10.3)
Variance to Plan	**(0.0)**	**(0.0)**	**0.4**	**0.0**	**0.1**	**(0.6)**	**0.1**	**(0.0)**	**(0.0)**	**(0.0)**	**0.0**	**0.1**

The Trust has now received deficit funding of £6.0m and brokerage funding of £7.5m. This reportable financial position now sits at a surplus of £3.2m compared to the Trust's planned deficit of £10.4m.

Position after deficit funding and brokerage funding

£m	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	YTD
Plan	(1.9)	(1.7)	(1.3)	(0.7)	(1.0)	(0.4)	0.5	0.2	(2.4)	(2.4)	0.6	(10.4)
Actual	(1.9)	(1.7)	(0.9)	(0.7)	(0.9)	2.5	0.6	0.2	(1.2)	(1.2)	8.2	3.2
Variance to Plan	**(0.0)**	**(0.0)**	**0.4**	**0.0**	**0.1**	**2.9**	**0.1**	**(0.0)**	**1.2**	**1.2**	**7.6**	**13.6**

System Position

The HIOW ICS financial position at month 11 is a year-to-date deficit of £12.7m, £8.2m worse than the plan after deficit funding.

Trust Financial Position – Month 11

In Month 11, the Trust recorded an in-month surplus of £0.7m (before deficit/brokerage funding), which is broadly in line with plan.

While the overall result aligns with the plan, there were a number of significant variances to plan:

- Emergency Operations (999): £0.9m worse than plan in the month
- 111 Service: £0.1m underspend.
- PTS: £0.5m better than plan
- Corporate (including contingency): £0.3m better than plan

In-month, following a review of historic cost accruals, £2.1m was released into the financial position as it was no longer required.

	£m	Month 11 Actual	Month 11 Plan	Month 11 Variance	Year to Date Actual	Year to Date Plan	Year to Date Variance	Forecast Actual	Forecast Plan	Forecast Variance
999	Income	19.8	19.6	0.2	217.4	215.6	1.8	238.2	235.2	3.0
	Expenditure	(16.5)	(15.4)	(1.1)	(181.8)	(173.8)	(8.0)	(198.8)	(189.3)	(9.5)
	Contribution	**3.3**	**4.2**	**(0.9)**	**35.6**	**41.8**	**(6.2)**	**39.4**	**45.9**	**(6.5)**
	%	**16.5%**	**21.3%**		**16.4%**	**19.4%**		**16.6%**	**19.5%**	
111	Income	3.7	3.6	0.1	40.1	39.2	0.9	43.7	42.7	1.0
	Expenditure	(3.0)	(3.1)	0.1	(33.9)	(34.0)	0.1	(36.9)	(37.1)	0.2
	Contribution	**0.7**	**0.5**	**0.2**	**6.1**	**5.1**	**1.0**	**6.9**	**5.6**	**1.3**
	%	**18.2%**	**13.9%**		**15.3%**	**13.0%**		**15.7%**	**13.1%**	
PTS	Income	5.2	5.3	(0.2)	60.1	59.8	0.3	65.3	65.2	0.1
	Expenditure	(3.6)	(4.3)	0.7	(53.1)	(52.6)	(0.5)	(57.8)	(57.0)	(0.8)
	Contribution	**1.5**	**1.0**	**0.5**	**7.0**	**7.2**	**(0.2)**	**7.5**	**8.2**	**(0.7)**
	%	**29.9%**	**19.2%**		**11.7%**	**12.0%**		**11.5%**	**12.6%**	
Operations Total Contribution		**5.5**	**5.7**	**(0.2)**	**48.8**	**54.1**	**(5.3)**	**53.8**	**59.7**	**(5.9)**
%		**19.1%**	**20.0%**		**15.4%**	**17.2%**		**15.5%**	**17.4%**	
Corporate		(4.9)	(5.1)	0.3	(59.9)	(65.3)	5.3	(63.6)	(70.6)	7.0
Surplus/(Deficit)		**0.6**	**0.6**	**0.0**	**(11.1)**	**(11.2)**	**0.1**	**(9.8)**	**(10.9)**	**1.1**
Reporting Adjustments		0.1	0.1	0.0	0.8	0.8	0.0	0.8	0.8	0.0
Adjusted Surplus/(Deficit)		**0.7**	**0.6**	**0.0**	**(10.3)**	**(10.4)**	**0.1**	**(8.9)**	**(10.1)**	**1.1**
Deficit Funding		7.5	0.0	7.5	13.5	0.0	13.5	13.5	0.0	13.5
Reportable Surplus/(Deficit)		**8.2**	**0.6**	**7.6**	**3.2**	**(10.4)**	**13.6**	**4.6**	**(10.1)**	**14.6**

Service-Specific Performance

Emergency Operations (999):

- Income was £0.2m above budget, but total costs exceeded the plan by £1.1m, resulting in a £0.9m adverse margin.
- Key drivers of higher costs include:
  - Fleet: £0.2m over plan.
  - Make Ready: £0.1m over plan.
  - Frontline Resourcing: £0.9m over plan.

NEPTS:

- Income was £0.2m below plan, but costs were £0.7m lower than budget, leading to a favourable variance of £0.5m.
- Cost reductions were primarily driven by:
  - Lower pay costs due to a higher-than-expected number of staff leavers.
  - £0.7m of accrual releases following a review of historical costs.
  - A £0.1m reduction in fleet costs related to lease and fuel savings.

111 Service:

- Costs were £0.1m below plan as a result of vacancies being held.

Corporate (including contingency):

- Corporate costs were £0.3m below plan, driven primarily by:
  - Accrual releases across all areas of £0.9m resulting from a review of historical costs.
  - Budget underspends of £0.3m across corporate areas

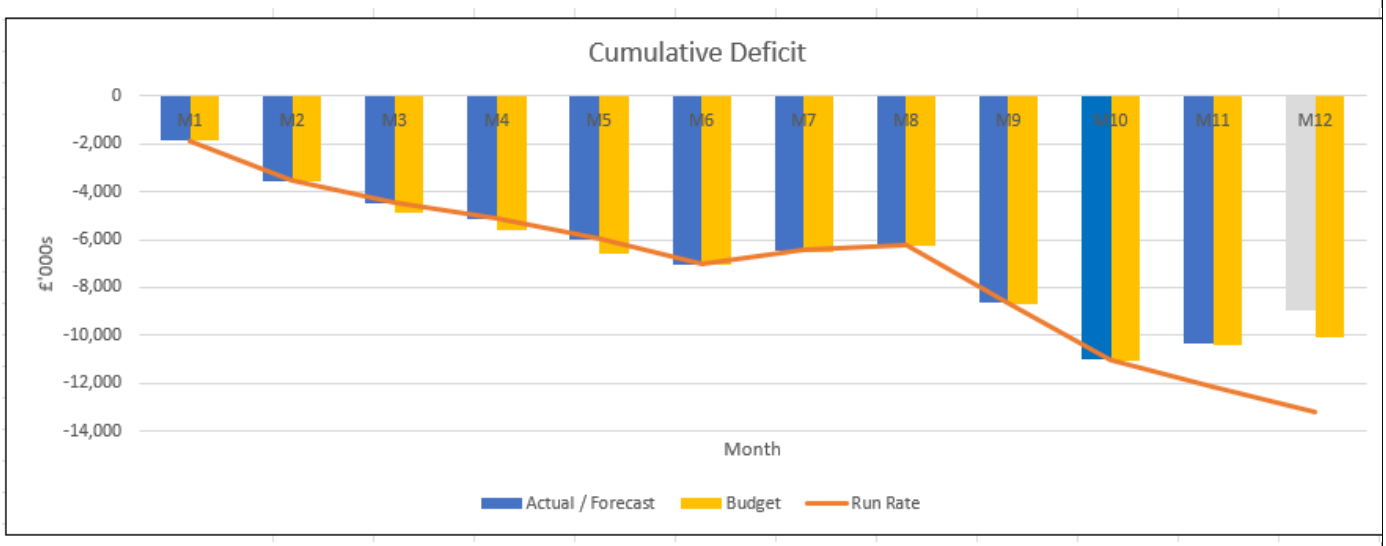
  Offset by.
  - Additional costs for audit and Executive recruitment of £0.3m
  - Provision for redundancy and insurance costs (contingency) of £0.6m
  - Lower than planned interest receivable of £0.1m

Overall Trust Performance

- Pay Costs:
  - Actual pay costs for the month were £17.9m, compared to a plan of £18.5m, driven by corporate vacancies and reduced 999 and PTS resource pay.
- Agency Spend:
  - Agency costs totaled £220k, exceeding the plan of £117k.
  - This increase was driven by additional roles supporting the Corporate Review, Pharmacy, and Fleet Mechanics.

Run Rate

The Run rate as reported in the monthly Provider Finance Return (PFR), takes the year-to-date position, and extrapolates this forward on a straight-line basis. Under this methodology the Trust has a run rate out turn of £11.3m deficit. Despite this the forecast for the year has improved to £9.0m and the Trust is confident this is achievable.



To bridge the gap between the run rate and the forecast outturn the Trust has a full identified mitigation plan that relies on non recurrent means to offset the £2.3m gap.

The reportable forecast position for the year now sits at £4.6m surplus. This is made up as follows:

- Original Deficit (£10.1)m
- Deficit Funding £6.0m
- Brokerage Funding £7.5m
- ICB Stretch Target £1.1m

Capital

As of February, the Trust's capital expenditure totaled £11.7m, with £7.1m generated from vehicle sale-and-leaseback transactions, resulting in a net spend of £4.6m. Capital Leasing to date is £7.1m. The Trust is currently underspent against its year-to-date capital budget by £15.0m, comprised of:

- Digital underspend £1.2m
- Estates projects underspend £5.6m.
- £0.5m net sales proceeds.
- £9.1m slippage in the 2023/24 DCA cohort, in March.

2023/24 DCA Cohort

The cohort of 72 DCAs (Double Crewed Ambulances) for 2023/24 has started to arrive, with 67 vehicles delivered from the coachbuilder by the end of February. However, severe production issues have been identified that must be resolved before the vehicles can be accepted.

This has meant that the sale-and-leaseback transactions for these vehicles which was anticipated in March, will no longer take place this financial year. This then has consequences for this year's operational CDEL expenditure.

2024/25 DCA Cohort

The expected cohort of Fiat chassis has now been partly received; 29 units are at Portbury Docks with 32 units en route from Italy. The MAN chassis ordered to mitigate any potential slippage in Fiat's have also partly been received, 15 units with the remaining 55 expected before the end of March.

IFRS16 CDEL:

- £7.1m has been spent up to February.
- The next IFRS16 CDEL expenditure is expected in March, with the completion of leaseback arrangements for various vehicle schemes, mental health vehicles, education vehicles, community fire vehicles and pharmacy vehicles.

Revised Forecast:

As a result of the delays with the 2023/24 DCA cohort and knock on effect with the sale-and-leaseback, the Trust will no longer meet its operational CDEL plan. The forecast CDEL spend is now £15.2m, £2.3m higher than plan.

This also affects the IFRS 16 plan reducing spend against this by £10.2m, resulting in a spend against IFRS 16 of £7.9m against a plan of £28.6m.

The ICB have been made aware of the changes in forecast.

	£m	Year to Date Actual	Year to Date Plan	Year to Date Variance	Forecast Actual	Forecast Plan	Forecast Variance
Estates	Internal CDEL	1.5	7.1	(5.6)	4.9	9.4	(4.5)
	IFRS16	1.1	0.7	0.4	1.1	2.7	(1.6)
	Total	**2.6**	**7.8**	**(5.2)**	**6.0**	**12.0**	**(6.0)**
Digital	Internal CDEL	3.1	4.3	(1.2)	4.0	4.3	(0.3)
	PDC	0.0	1.1	(1.1)	0.0	1.1	(1.1)
	PDC Income	0.0	(1.1)	1.1	0.0	(1.1)	1.1
	Total	**3.1**	**4.3**	**(1.2)**	**4.0**	**4.3**	**(0.3)**
Fleet (22/23 DCA Cohort)	Internal CDEL	(3.9)	(1.8)	(2.1)	(3.9)	(1.8)	(2.1)
	IFRS16	5.3	5.4	(0.1)	5.3	5.4	(0.1)
	Total	**1.5**	**3.6**	**(2.2)**	**1.5**	**3.6**	**(2.2)**
Fleet (23/24 DCA Cohort)	Internal CDEL	2.5	(0.6)	3.1	2.2	(2.8)	5.0
	IFRS16	0.0	7.3	(7.3)	0.0	7.3	(7.3)
	Total	**2.5**	**6.7**	**(4.2)**	**2.2**	**4.5**	**(2.4)**
Fleet (24/25 DCA Cohort)	Internal CDEL	0.0	0.0	0.0	3.8	2.2	1.6
	IFRS16	0.0	0.0	0.0	0.0	10.2	(10.2)
	Total	**0.0**	**0.0**	**0.0**	**3.8**	**12.3**	**(8.6)**
Fleet (Non-DCA)	Internal CDEL	1.4	1.6	(0.2)	4.2	1.6	2.6
	IFRS16	0.7	2.7	(2.0)	1.5	3.1	(1.7)
	Total	**2.1**	**4.3**	**(2.3)**	**5.6**	**4.7**	**0.9**
Internal CDEL Total		4.6	10.7	(6.0)	15.2	12.9	2.3
IFRS16 Total		7.1	16.1	(9.0)	7.9	28.6	(20.8)
PDC Total	Expenditure	0.0	1.1	(1.1)	0.0	1.1	(1.1)
	Income	0.0	(1.1)	1.1	0.0	(1.1)	1.1
Total		**11.7**	**26.7**	**(15.0)**	**23.0**	**41.5**	**(18.5)**

Cash

The Trust's cash balance at the end of February stood at £30.7m. There was a net cash inflow in month 11 of £4.5m due mostly to slippage in capital spend. In March there is a further £0.9m income expectation from the ICB for pay award funding.

The cash forecast for March 2025 has increased to £27.3m due mostly to additional central funding of £7.5m and slippage in capital DCA schemes.

2024/25	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Income £m	32.8	26.9	27.3	29.9	35.2	33.0	37.5	30.8	30.5	35.7	33.2	39.1
Expenditure £m	(30.6)	(32.5)	(31.4)	(30.9)	(30.8)	(30.3)	(34.9)	(32.4)	(32.5)	(32.2)	(28.7)	(42.5)
Net Inflow/(Outflow) £m	2.2	(5.6)	(4.1)	(1.0)	4.4	2.7	2.6	(1.6)	(2.0)	3.5	4.5	(3.4)
Cash Balance £m	27.2	21.6	17.5	16.5	20.9	23.6	26.2	24.7	22.7	26.2	30.7	27.3
Cash Lowest Point	22.0	21.1	17.7	14.9	13.4	16.4	17.9	23.8	20.9	19.0	21.8	

The lowest point of cash in the month was £21.8m which is an increase from last month of £2.8m.

The 90-day debtor increased to £0.2m in February (£0.1m in January). This represents 14.2% (11.2% in January) of the total debtor balance and this has increased due to a lower sales ledger debt in the month.

2. **Quality Impact**

3. Financial Impact

3.1 As detailed above

4. Risk and compliance impact

Area of Risk

- The Trust ability to deliver its control total by year end.
- Financial implications of the loss of the NEPTS contracts for Thames Valley and Sussex
- Financial implications of needing to use additional frontline resources to achieve national expectations around category 2 response times.
- There could be unforeseen consequences on the organisation of remaining within control total.
- The ability to achieve the capital plan due to conversion delays on the completion of the 2023/24 cohort of DCA's.

5. Equality, diversity and inclusion impact

6. Next steps

6.1 What will you do next?

7. Recommendation(s)

7.1 The Group / Committee / Board is asked to:

The Board is asked to note the report

8. Appendices

NHS
South Central Ambulance Service
NHS Foundation Trust

Trust Board of Directors Meeting
27 March 2025

Report title	Month 11 Integrated Care System Report
Agenda item	14
Report executive owner	Stuart Rees, Interim Director of Finance
Report author	ICB: Graham Groves, Jo Roberts, Vicki Mussert-Campbell, Jon Vaughan, Lindsay Jones
Governance Pathway: Previous consideration	
Governance Pathway: Next steps	All Board in HIOW ICS

Executive Summary

1. Purpose

1.1 The purpose of the Month 11 (M11) Finance Report for Hampshire & Isle of Wight Integrated Care System (ICS) is to provide an overview of the financial position and system recovery plan for NHS organisations within the Hampshire and Isle of Wight ICS as at the end of February 2025.

1.2 This report has been shared with all NHS organisations in the system, to ensure Boards are able to gain assurance and hold their organisation(s) to account for delivery of their operating plan as well as their contribution to recovery of the whole system.

1.3 At the close of Month 6, Southern Health NHS Foundation Trust and Solent NHS Trust merged into a new organisation called NHS Hampshire and Isle of Wight Healthcare Foundation Trust. .

2. Background

2.1 The final agreed system plan for 2024/25 was a £70.0m deficit, consisting of a £9.6m surplus plan for NHS Hampshire and Isle of Wight (the Integrated Care Board), and a combined provider deficit plan of £79.6m. This plan was agreed on the basis that NHS England would provide £70.0m of non-recurrent deficit support funding, enabling our plan to reduce to £0 (breakeven).

2.2 In month 6, NHS England confirmed the anticipated £70m in non-recurrent deficit support. This support requires a matching improvement in our plan, and took the Hampshire and Isle of Wight system plan to a combined £0 breakeven plan for the financial year. The £70m cash support is repayable as part of national business rules on repayment of deficits and will not reduce the Hampshire and Isle of Wight system historic deficit.

2.3 At month 10, following agreement with NHS England, the Hampshire and Isle of Wight system moved its forecast to a combined deficit of £18.5m by financial year end.

2.4 At month 11 the ICS revised its forecast further and moved to a combined £0 breakeven position by financial year end. Forecasts are now fixed for this financial year.

2.5 The whole system continues to be in the NHS England (NHS E) Recovery Support Programme (RSP). This requires additional assurance and reporting requirements to NHSE as well as controls around decision making.

Alignment with Strategic Objectives
With which strategic theme(s) does the subject matter align? (If more than one, please write manually) All Strategic Risks Select Strategic Objective.

Relevant Board Assurance Framework (BAF) Risk

To which BAF risk(s) is the subject matter relevant? (If more than one, please write manually) All BAF Risks Select BAF Risk.

Financial Validation	N/A
Recommendation(s)	
The Board asked to: • Seek assurance that their organisation is going to deliver on their financial landing plan, and that appropriate mitigations and recovery plans are in place where required. • Seek assurance from their executives on their organisation's contribution to each system transformation programme.	

For Assurance	✓	**For decision**	✓	**For discussion**		**To note**	✓

Month 11 System Report

1. Purpose

1.1 The purpose of the Month 11 (M11) Finance Report for Hampshire & Isle of Wight Integrated Care System (ICS) is to provide an overview of the financial position and system recovery plan for NHS organisations within the Hampshire and Isle of Wight ICS as at the end of February 2025.

1.2 This report has been shared with all NHS organisations in the system, to ensure Boards are able to gain assurance and hold their organisation(s) to account for delivery of their operating plan as well as their contribution to recovery of the whole system.

1.2.1 At the close of Month 6, Southern Health NHS Foundation Trust and Solent NHS Trust merged into a new organisation called NHS Hampshire and Isle of Wight Healthcare Foundation Trust.

2. Background

2.1 The final agreed system plan for 2024/25 was a £70.0m deficit, consisting of a £9.6m surplus plan for NHS Hampshire and Isle of Wight (the Integrated Care Board), and a combined provider deficit plan of £79.6m. This plan was agreed on the basis that NHS England would provide £70.0m of non-recurrent deficit support funding, enabling our plan to reduce to £0 (breakeven).

2.2 In month 6, NHS England confirmed the anticipated £70m in non-recurrent deficit support. This support requires a matching improvement in our plan, and took the Hampshire and Isle of Wight system plan to a combined £0 breakeven plan for the financial year. The £70m cash support is repayable as part of national business rules on repayment of deficits and will not reduce the Hampshire and Isle of Wight system historic deficit.

2.3 At month 10, following agreement with NHS England, the Hampshire and Isle of Wight system moved its forecast to a combined deficit of £18.5m by financial year end.

2.4 At month 11 the ICS revised its forecast further and moved to a combined £0 breakeven position by financial year end. Forecasts are now fixed for this financial year.

2.5 The whole system continues to be in the NHS England (NHS E) Recovery Support Programme (RSP). This requires additional assurance and reporting requirements to NHSE as well as controls around decision making.

3. Discussion

3.1 Integrated Care System Financial Overview

3.1.1 The £70m deficit cash support funding received in month 6 resulted in the ICS being required to improve its combined annual plan from a £70m deficit to breakeven. Following agreement from NHS England, the ICS revised its forecast to an £18.5m deficit at M10. Subsequent to the reported position at M10, the ICS refined its forecast at M11 to a combined £0 breakeven position, Reporting is against this revised breakeven forecast. The table below shows how the deficit cash support funding was phased into the financial position.

Organisation	M6	M7	M8	M9	M10	M11	M12	Full Year
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Hampshire and Isle of Wight ICS	55,282	2,435	2,265	5,339	2,198	1,795	684	69,998

3.1.2 The table below summarises the ICS financial position reported at month 11 (February 2025). In February itself, the ICS reported a surplus of £26.5m against a planned surplus of £3.1m, so a positive variance to plan of £23.4m.

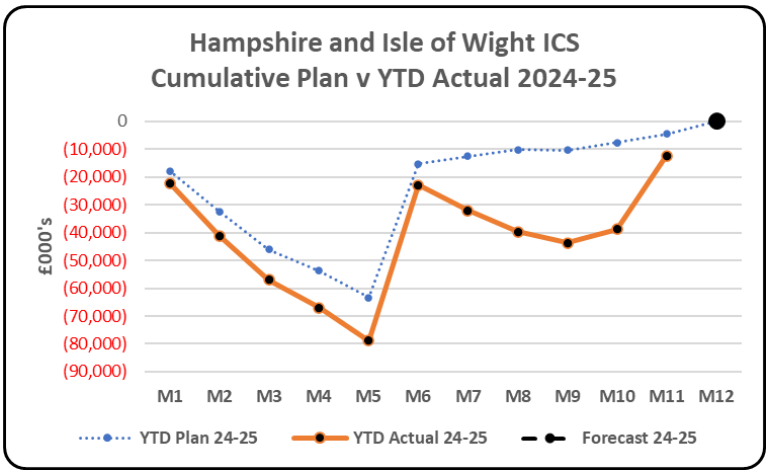
Organisation	In Month			Year to date			Forecast Outturn		
	In Month Plan £'000	In Month Actual £'000	Variance £'000	YTD Plan £'000	YTD Actual £'000	Variance £'000	Annual Plan £'000	Forecast Outturn £'000	Variance £'000
Hampshire and Isle of Wight ICS Total	£3,082	£26,525	£23,443	(£4,488)	(£12,320)	(£7,832)	£0	£0	£0

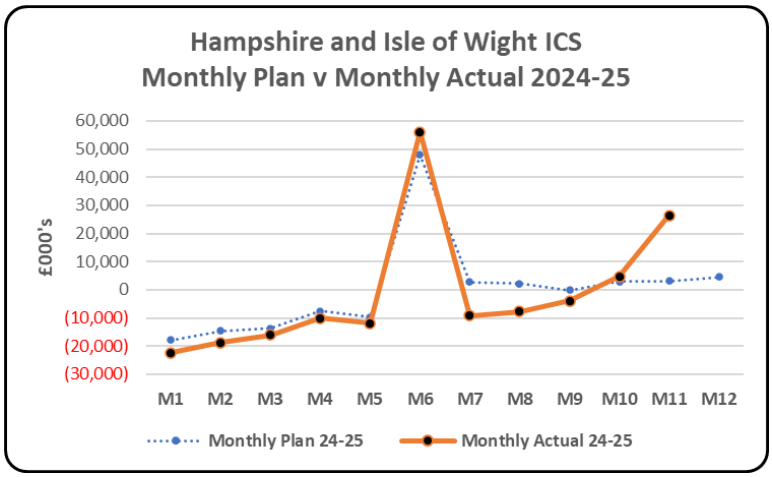
3.1.3 The system is currently reporting a year-to-date deficit of £12.3m at month 11 compared to a planned £4.5m deficit, therefore a £7.8m adverse variance to plan.

3.1.4 The ICS revised its forecast at month 11 and is now forecasting a combined £0 breakeven position

3.1.5 The ICS will continue to prioritise the implementation of the agreed system plan and transformation programmes to support the achievement of our financial plan in the financial year 2024/25.

3.1.5 The graphs below summarise the ICS position reported at month 11:





3.2 System Actions to Support Financial Recovery

3.2.1 In 2023/24, additional controls were required by NHS England as a consequence of our deficit plan. Individual providers may also have had enhanced conditions as described in undertakings letters and where revenue or capital cash support was required, additional conditions will apply, including assessment of affordability of capital plans. All our existing system business rules, conditions and controls remain extant in 2024/25.

3.2.2 System financial recovery and delivery of our system transformation programmes is overseen by a monthly System Recovery and Transformation Board, which is attended by all Provider Chief Executives and chaired by the ICB Chief Finance Officer and Deputy CEO.

3.2.3 System leaders have agreed additional steps in 2024/25 to strengthen our delivery of plans, including:

- A system vacancy control panel, to review all proposed external recruitment and identify opportunities to recruit to roles from within the existing NHS workforce
- Chief Executive-level leadership for each system transformation programme
- Organisation and system-level delivery units focused on our system transformation programmes, coordinated by a system Programme Management Office (PMO).

3.2.4 Additional external support has been commissioned for some organisations within the local system, either to support continued delivery of their 2024/25 plan, or to support recovery where organisations are already materially off-plan.

3.3 System Transformation Programmes

3.3.1 Our system plan for 2024/25 is intended to address the challenges impacting our financial position that required a system response. Together we identified six key programmes for corrective action to reduce our system deficit in 2024/25 and enable delivery of each organisation's operating plan. Our system transformation programmes are:

Programme	Lead Chief Executive	Lead ICB Executive
Discharge	Penny Emerit	Caroline Morison
Local Care	Alex Whitfield	Lara Alloway
Urgent and Emergency Care	David Eltringham	Nicky Lucey
Mental Health	Ron Shields	Nicky Lucey
Planned Care	David French	Lara Alloway
Workforce (including Corporate Right-Sizing)	David French	Danny Hariram

3.3.2 Each transformation programme reports on progress and key metrics into the monthly System Recovery and Transformation Board, which is attended by all provider Chief Executives. Reporting is supported by a system Programme Management Office.

3.4 Elective Recovery Fund

3.4.1 The Elective Recovery Fund (ERF) aims to increase elective activity in the NHS by providing additional funding to Integrated Care Boards (ICBs). The funding was initially uncapped meaning that additional funding would be given to ICBs and NHS Providers that over performed and exceeded their individual targets.

3.4.2 In December/January 2025 it was confirmed that there would be a ceiling on ERF funded activity for 2024/25 and that there would be no reconciliation of adjustments for 2024/25 overperformance in 2025/26. The ceiling has been confirmed by NHS England and remains fixed for this financial year.

3.4.3 Prior to the introduction of the ceiling, each organisation had a specific target level of activity growth (compared to 2019/20) above which additional income was earned. For Hampshire and Isle of Wight as a whole, our target level is 108.7% of 2019/20 activity, but our operating plans for 2024/25 were based on achieving 120.5%. At Month 11, initial data estimates show achievement of 122.7%, although it is important to note that additional funding will not flow to Hampshire and Isle of Wight beyond the fixed ERF funding ceiling.

4. Quality

4.1 Regulatory

Care Quality Commission: during February 2025, 14 Care Quality Commission inspection outcomes were published – nine were rated good; four were rated as Requires Improvement and one was rated as Inadequate. Three providers showed a worsening position. One of the published reports related to a GP practice and one to an Independent Hospital.

Quality Assurance and Improvement Levels: all providers, apart from one remain in the routine quality assurance and improvement level. One provider remains in the Intensive level of quality assurance and improvement while they are in the National Recovery Support Programme (RSP).

4.2 Patient Experience

Friends and Family Test Performance: the latest Friends and Family Test performance data relates to December 2024. Three of our acute Trusts were flagging lower than the national positive rate in two or more areas. Due to the timing of the report and the publication of the national data, these areas will be followed up

with the Trusts and reported on next month, with a particular focus on maternity and Emergency Departments (EDs).

ADVISE Mixed-Sex Accommodation Breaches (December 2024): due to the timing of reports, the latest data has not changed since the last report**.** The threshold for mixed sex accommodation breaches is >0. All providers of NHS funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient (Statistics » Mixed-Sex Accommodation Data):

- **One Trust:** reported 21 (↑8 from previous month) mixed sex accommodation breaches.
- **One Trust:** reported 105 (↓16 from previous month) breaches; the Trust has consistently not met the target this financial year.

It is anticipated that the work being undertaken in relation to improving hospital and system flow should have an impact on some of the mixed-sex accommodation breaches.

As a System, this metric continues not to be met, although December 2024 performance represents an improving position.

4.3 Safety

SO40a Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream infections: 2023/24 saw an increase in Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream Infection (BSI), in particular healthcare associated cases. NHS Hampshire and Isle of Wight is predicted to have a similar number of MRSA BSI compared to 2023/24. While the Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream Infection oversight framework data was calculated on count, a rate takes into consideration the size of Integrated Care Board populations.

There has been an increasing trend in contaminated Methicillin-resistant Staphylococcus aureus (MRSA) bloodstream samples, these cases cannot be removed from the Integrated Care Board and Trusts total.

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Table 1: Methicillin-resistant Staphylococcus aureus (MRSA) Blood Stream Infection infections - current position

Total number of cases - financial year to date*	No learning/ lapses in care	Lapse in care	Incidental Learning post Methicillin-resistant Staphylococcus aureus Blood Stream Infections	Cases under review	Qtr 3 Quartile position against latest OF metrics
28	7	10	2	9	**Count = 29/42 Rate = 19/42**

*** The June case has been successfully appealed but it has not yet been reallocated.**

The overall trend is encouraging, however, there is concern that some Trusts are not impacting their numbers as much as others. NHS Hampshire and Isle of Wight Infection Prevention and Control team continues to link with the Trusts for oversight and to support improvements through the sharing of learning from themes.

S041a: Clostridium difficile infection rate: the monthly trajectory for Clostridium difficile is 44.5 – the February 2025 data currently shows that this has not yet been exceeded (44 cases). Laboratories may report more cases.

The January 2025 oversight framework metrics show a significant improving trend when compared to the oversight framework metrics in March 2024 (20/42). NHS Hampshire and Isle of Wight will finish the year above threshold, however we have significantly improved our ranking position compared to 2023/24.

Since 2021/22, NHS Hampshire and Isle of Wight has seen a 9-18% year-on-year increase in Clostridium difficile cases. This annual increase is predicted to be reduced this year to 5.5% against an NHS England average increase of 16.5%

Table 2: Clostridium difficile infections - current position			
Number of cases reported* in month (February 2025)	**Total number of cases financial year to date***	**Performance against 2024/25 trajectory***	**Quartile position against latest OF metrics**
44	540 (+49)*	540/535	12/42
Narrative: February 2025* case number is likely to increase by a further 5 cases before the data capture system closes. The Integrated Care Board has now used 101% of its annual trajectory in month ten against a target of 92%.			
** February 2025 data will not be confirmed until the 16 March, the information is based on data submitted the Health Care Associated Infection Data Capture System but may not be a true reflection of February 2025 cases.*			

ALERT: SO42a Escherichia coli (E. coli) bloodstream infections (BSI): the monthly trajectory for Escherichia coli (E. coli) bloodstream infections is 102 cases. NHS Hampshire and Isle of Wight will finish the year above threshold and a slightly worse oversight framework ranking position compared to 2023/24. The annual increase is predicted to be stable at 10%. The oversight framework calculations have slightly worsened from 29/42 in December 2025 to 30/42 in January 2025. However, when the Integrated Care Board is ranked by rate per 100,000 population, NHS Hampshire and Isle of Wight ranks at 23/42.

Table 3: Escherichia coli (E. coli) bloodstream infections - current position			
Number of cases reported* in month (February 2025)	**Total number of cases financial year to date***	**Performance against 2024/25 trajectory**	**Quartile position against latest OF metrics**
97	1274 (+156)*	1274/1219	**30/42**
Narrative: the Integrated Care Board has now used 104% of its annual trajectory in month 11 against a target of 91%. However there are likely to be a further 10 -20 cases added to January before the reporting system closes on the 16 March.			
** February 2025 data will not be confirmed until the 16 March, the information is based on data submitted the Health Care Associated Infection Data Capture System but may not be a true reflection of February 2025 cases.*			

It is of concern that the trajectory for Escherichia coli (E. coli) bloodstream infections is not being met. Support is being provided to those Trusts that have exceeded their 5% trajectory for the month and learning from the cases is shared across the System. The main change seems to be associated with community onset, healthcare associated cases, however the reason for this is not yet known. NHS Hampshire and Isle of Wight is assured that very few cases are associated with initial treatment failures in primary care. The majority are spontaneous events.

Never Events: the national threshold for Never Events is zero. During 2024/25 to end of February 2025, there were 19 Never Events formally reported within our system. So far, during March 2025 (up to 9 March 2025) there have been three further Never Events reported. This means there have been 22 Never Events reported, which exceeds last year's outturn of 20.

During February and March 2025 (up to 9 March 2025), there were two incidents relating to wrong site surgery, two involving a retained foreign object post procedure and one wrong implant. The incidents were reported by three acute Trusts.

At the end of the financial year a Never Event deep dive into the 2024/25 incidents will be undertaken. It will be shared with providers to support their improvement work in relation to safer invasive procedures which is also a requirement of the 2025/26 contract and has been a continued area of focus during 2024/25.

Hampshire and Isle of Wight Report Under Regulation 28 process: the Hampshire and Isle of Wight Report under Regulation 28 process for escalation and learning has been updated and has been agreed as part of 2025/26 quality contract negotiations.

4.4 Clinical Effectiveness

Standardised Hospital-level Mortality Indicator (SHMI) – October 2023 - September 2024: all providers are reporting 'as expected' (band 2) or 'lower than expected' (band 3) mortality rates, with all Trusts showing improving variation or normal variation.

National Hip Fracture database – hours to operation (January 2025): early surgery for hip fractures has been shown to reduce mortality rates and surgical complications. The national target is for patients to have surgery within 36 hours. This is because delays beyond this are shown to have increased mortality. Within Hampshire and Isle of Wight Portsmouth Hospitals University NHS Trust continued to be the only Trust to meet this target.

The Trusts are above the national rate, two of which are flagging due to a declining variation.

4.5 Quality Impact Assessments

NHS Hampshire and Isle of Wight holds a weekly panel in place which reviews all Quality Impact Assessments that are linked to our financial recovery (i.e., not linked to a usual business case) and financial recovery savings that exceed £50,000 requiring higher level Integrated Care Board or potential Integrated Care System scrutiny. The panel reviews all Quality Impact Assessments that meet the above criteria and makes recommendations based on the information presented.

During February 2025, one Quality Impact Assessment was formally submitted to the Hampshire and Isle of Wight panel for review. It was agreed that it should come back to panel following additional stakeholder engagement.

5. Recommendations

5.1 Each Board needs assurance that their organisation is going to deliver on their financial landing plan, and that appropriate mitigations and recovery plans are in place where required.

5.2 Each Board needs assurance from their executives on their organisation's contribution to each system transformation programme.

NHS
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Upward Report of the Finance and Performance Committee

Date Meeting met **18th and 21st March 2025**
Chair of Meeting **Les Broude, Non-Executive Director**
Reporting to **Board of Directors Meeting 27th March 2025**

Items	Issue	Action Owner	Action
Points for escalation			
Key issues and / or Business matters to raise			
18th March - 2025/26 Draft Plan	The committee discussed the annual plan for both the finance and performance targets. Constructive discussions and challenges on key issues were noted. It was recommended for Approval at the Board.	**Stuart Rees**	Planning paper to be taken to the Trust Extraordinary Board 20th March 2025.
Integrated Performance Report	The committee noted progress on the development of the IPR and discussed the Trust's performance across various measures. It was observed that: • The Trust is consistently meeting targets in 4 measures.	**Relevant Executive Directors**	

	• 9 measures are unlikely to meet targets unless process changes are implemented. • 23 measures are variable and may hit or miss targets. • 16 measures currently lack defined targets. The committee emphasized the importance of addressing these areas to improve overall performance and ensure alignment with strategic goals, with discussion on the QI Process and Change Agents within the Trust.		
Financial Position	The Committee discussed the financial position and endorsed forecast of £9 million deficit before deficit and provision funding.	**Stuart Rees**	**Manage Year End Position**
E&U Private Provider Reduction 2025/26	The committee reviewed and approved the E&U Private Provision Contracted Hours 2025/26 for submission to the Trust Board.	**Mark Ainsworth**	**For Board approval**
2025/26 Operational Plan: changes following Board approval 20th March	The committee reviewed and approved the Operational Plan for Submission on 21 March 2025 to ICB, of a compliant plan of Break-even and Cat 2 of 29:57 mins, which should also be accompanied with explanation narrative of assumption and system requirements.	**Stuart Rees**	**Submission 21 March 2025 to ICB**
Areas of concern and / or Risks			
2025/26 Operational Plan	Delivery of the 25/26 plan is achievable but challenging. There will need to be a focus on the continuous delivery of targets and assessing risks at each meeting.	**All Executive Directors**	**Reporting and appropriate actions at EMC, F&P and Board**

Items for information and / or awareness			
Financial Recovery Plan	Financial Recovery Plan was discussed, with constructive discussions, challenges and what lesson could be learnt for future years. Also, linked to the Internal Audit Report on CIPs .e.g. Ownership wider that Finance Department and in-year CIP business cases and developments more challenging to deliver.	**Relevant Executive Director**	
VOR Improvement Plan Fleet Availability Trajectory	The committee reviewed and discussed the VOR Improvement Plan re Fleet Availability Trajectory report. Constructive discussions and challenges focused on key issues, acknowledging the recent improvements while also noting that the trajectory forecast reflects the projected availability of DCAs, contingent on the successful delivery of ongoing orders. The committee further requested exploration of opportunities to accelerate progress and improve the trajectory.	**Stuart Rees**	
Contract Variations	The committee reviewed and approved the following contract: • HSH IUC Head Contract and Sub-Contract Variations - 24/25 Finance • Ambulance Contract 2024 / 25 HIOW and TV ICB Funding Allocations: Variations CV10 through to CV11.	**Stuart Rees**	
Board Assurance Framework (BAF)	The committee discussed the BAF and emphasised the need to review and align it with the Trust's strategic objectives. It was agreed that updates to the BAF would include a comprehensive	**Becky Southall**	

	reassessment of risks, ensuring they accurately reflect the challenges and priorities of the Trust.		
Best Practice and / or Excellence			
Action Log & Matters Arising	Chair commented positively on the continued tracking and delivery of the committee actions.	**Relevant Executive Director**	
Compliance with Terms of Reference			
Compliant			
Policies approved*			
None			

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

Author: **Les Broude**

Title: **Non Executive Director**

Date: **23 March 2025**

Upward Report of the – Audit Committee

Date Meeting met **19/03/25**
Chair of Meeting **Mike McEnaney - NED**
Reporting to **SCAS Board**

Items	Issue	Action Owner	Action
Points for escalation			
Standing Financial Instructions and Scheme of Reservation and Delegation	Both documents had been completely revised by Governance and Finance and are recommended to the Board for approval.	Mike McEnaney	Present to the Board for approval
Key issues and / or Business matters to raise			
Internal Audit – Key financial systems – Fixed Asset Register	Audit report received at the committee with substantial assurance for design and moderate assurance for effectiveness. The Medium finding is resolved.	Stuart Rees	Implement recommendations
Internal Audit – CIP Delivery Control	Audit report received at the committee with moderate assurance for both design and effectiveness. The need for better ownership of the initiatives, better attendance at meetings and a Medium Term Financial Plan.	Stuart Rees	Implement recommendations
Areas of concern and / or Risks			

Items for information and / or awareness			
Interna Audit Plan – 25/26	The annual plan for audits was finally reviewed, after consultation with a number of NEDs and the EMC, and subsequently approved.		
External Audit Plan	AZETS provided their year end audit plan which identified key areas of risk for particular scrutiny and the overall schedule for the audit. It was reported that the Interim Audit had gone to plan.		
Counter Fraud – Work Plan 25/26	The annual plan for counter fraud activity was reviewed and approved after considering the SCAS Counter Fraud strategy and risks.		
Best Practice and / or Excellence			
Internal Audit Actions	Overdue actions have been reduced to 5, 4 of which are set to be complete by end March 25. This is a significant improvement and has resolved a number of legacy actions. This discipline needs to be maintained.	Stuart Rees	
Annual Review of NHS Code of Governance for Provider Trusts	The review requires trusts to consider the governance arrangements in place and to assess whether the trust complies or otherwise an explanation of the status is to be provided. The categories reviewed are: - Board leadership and purpose - Division of responsibilities - Composition, succession and evaluation - Audit, risk and internal control - Remuneration	Mike McEnaney Rebecca Southall	Update the Board

	The review also considered the governance improvement initiatives resulting from the CQC inspection and a single governance improvement plan has been created.		
Compliance with Terms of Reference			
	Quorate and a good quality of timely papers.		
Policies approved*			

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

Author: **Mike McEnaney**

Title: **Chair of Audit Committee**

Date: **24/03/25**

INTERNAL AUDIT PLAN - DRAFT

South Central Ambulance Service NHS Foundation Trust

2025/26

IDEAS | PEOPLE | TRUST

CONTENTS

AUDIT RISK ASSESSMENT

BACKGROUND

Our risk-based approach to internal audit uses South Central Ambulance Service NHS Foundation Trust 's own risk management process and risk register as a starting point for audit planning as this represents the client's own assessment of the risks to it achieving its strategic objectives.

The extent to which we can rely on management's own perception of risk largely depends on the maturity and effectiveness of the Trust's own risk management arrangements. In estimating the amount of audit resource required to address the most significant risks, we have also sought to confirm that senior management's own assessment of risk accurately reflects the Trust's current risk profile.

PLANNED APPROACH TO INTERNAL AUDIT 2025/26

The indicative Internal Audit programme for 2025/26 is set out on pages 7 to 10. We met with the Executive Directors and the Audit Committee (AC) Chair to bring together a full plan which will be presented to the AC meeting for formal review and approval. We will keep the programme under continuous review during the year and will introduce to the plan any significant areas of risk identified by management during that period.

The plan is set within the context of a multi-year approach to internal audit planning, such that all areas of key risks would be looked at over a three-year audit cycle. We have suggested future areas of focus as part of the three-year strategic internal audit plan, set out on pages 5 to 6.

INDIVIDUAL AUDITS

When we scope each review, we will reconsider our estimate for the number of days needed to achieve the objectives established for the work and to complete it to a satisfactory standard in light of the control environment identified within the Trust. Where revisions are required, we will obtain approval from the appropriate Executive Director prior to commencing fieldwork.

In determining the timing of our individual audits, we will seek to agree a date which is convenient to the Trust, and which ensures availability of key management and staff and takes account of any operational pressures being experienced.

VARIATIONS TO THE PLAN

We review the three-year strategic plan each year to ensure we remain aware of your ongoing risks and opportunities. Over the coming pages we have mapped your key risks along with the audit work we propose to undertake, demonstrating we are focussing on your most important issues.

As such, our strategic audit programme follows the risks identified during our planning processes and confirmed via discussions with the Executive Directors. If these were to change, or emerging risks were to develop during this period, we would take stock and evaluate our coverage accordingly.

OUR NEXT GEN INTERNAL AUDIT APPROACH

Our innovative Next Gen approach to internal audit ensures you maximise the potential added value from BDO as your internal audit provider and the expertise we bring from our dedicated Public Sector Internal Audit team and wider BDO specialist teams.

The Next Gen approach allows us to deliver a healthy mix of assurance that is forward looking, flexible and responsive and undertaken in partnership with yourselves. The key components to this approach are outlined below and underpin our proposed plan coverage:

CORE ASSURANCE

Reviews of fundamental finance and operational systems to provide assurance that core controls and procedures are operating as intended.

SOFT CONTROLS

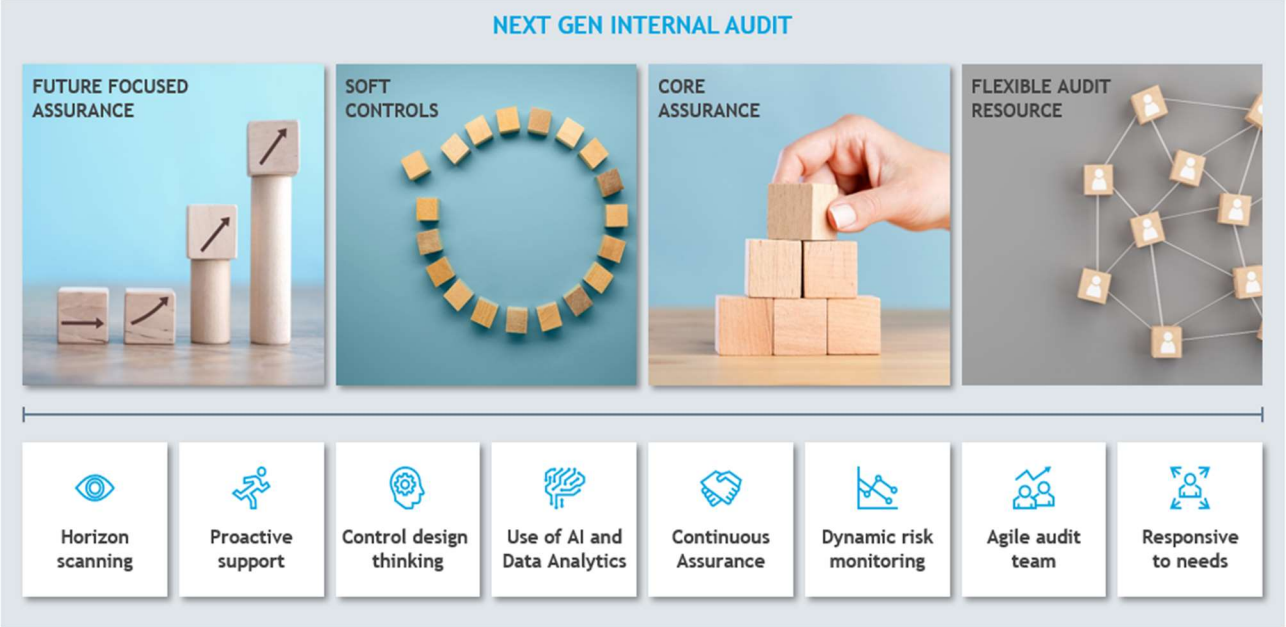
Reviews seek to understand the true purpose behind control deficiencies and provide a route map to enhance their effectiveness.

FUTURE FOCUSED ASSURANCE

Rather than wait for implementation and then comment on identified weaknesses, we will work with you in an upfront / real time way.

FLEXIBLE AUDIT RESOURCE

Undertake proactive work across the Trust, perhaps in preparation for regulatory reviews or change management programmes.



MAPPING YOUR STRATEGIC RISKS

REF	STRATEGIC RISKS FROM YOUR BAF	LIKELIHOOD	CONSEQUENCE	NET SCORE	RATING
1	Safe and effective care: If we have insufficiently equipped and trained workforce, then we will fail to provide safe and effective care, Leading to poor patient outcomes.	3	3	9	
2	Ability to meet fluctuating demand: If we do not have or use effective and agile operational delivery systems, then we will not be able to meet demand and provide a responsive service to patients Leading to delays in treatment and increased morbidity and mortality.	4	5	20	
5	In Year Financial control: If demand, operational standards and external factors (such as inflation, interest rates, taxation and cost of living) continue to increase then the total costs to deliver our services will increase and result in a deficit greater than the control total agreed leading to additional pressures on our ability to deliver a sustainable financial plan and safe services.	4	4	16	
6	Sufficient skills and resources: If we fail to implement resilient and sustainable workforce plans then we will have insufficient skills and resources to deliver our services leading to ineffective and unsafe patient care and exhausted workforce.	4	4	16	
7	Safe, valued, and supported staff: If we fail to foster an inclusive and compassionate culture then our staff may feel unsafe, undervalued, and unsupported leading to poor staff morale, disengagement, low retention and impacts on patient safety and care.	3	4	12	

REF	STRATEGIC RISKS FROM YOUR BAF	LIKELIHOOD	CONSEQUENCE	NET SCORE	RATING
8	Digital Capacity: If we are unable to resource required digital opportunities then we will have insufficient capacity and capability to deliver the digital strategy leading to system failures, patient harm and increased cost.	3	5	15	
10	Cyber risk: If technology, IT applications & services are insufficiently robust and secure then there is a risk that the Trust will not be able to operate effectively leading to reduced ability to provide a safe service.	4	5	20	
11	Modernisation / Fit for the Future: If the Trust does not modernise its structures, systems and support services over the next five years then the Trust may not deliver its strategy for a modern sustainable ambulance service that meets the needs of the public, and adoption of relevant government policies leading to outdated and inadequate care delivered to patients.	3	3	9	
14	Partnership Working: If we don't work collaboratively and have effective relationships with a wide range of stakeholders then we will fail to deliver our strategy of being an effective partner and care navigator on behalf of our systems leading to poor patient experience and suboptimal outcomes.	3	4	12	

MAPPING YOUR BAF TO THE STRATEGIC PLAN

REF	STRATEGIC RISKS FROM YOUR BAF	2024/25 COVERAGE	2025/26	2026/27	2027/28
1	Safe and effective care	• Medical Devices • Business Continuity and Disaster Recovery	• Fleet Management • Medicines Management	• Duty of Candour	• Education • Infection Prevention and Control • Health and Safety
2	Ability to meet fluctuating demand		• Demand Planning and Forecasting	• Long Waits • Clinical Applications (including Safeguarding)	
5	In Year Financial control	• Key Financial Systems - Cost Improvement Programmes • Key Financial Systems - Fixed Asset Register	• Key Financial Systems - Financial Sustainability	• Key Financial Systems	• Key Financial Systems
6	Sufficient skills and resources	• Mandatory Training	• Sickness Absence Management • Demand Planning and Forecasting	• Recruitment	• Retention
7	Safe, valued, and supported staff	• Freedom to Speak Up	• Sickness Absence Management		• Health and Safety
8	Digital Capacity	• DSP Toolkit Follow Up	• Digital Strategy	• Clinical Applications (including Safeguarding)	• IT Infrastructure (Data Centre and Networks)

REF	STRATEGIC RISKS FROM YOUR BAF	2024/25 COVERAGE	2025/26	2026/27	2027/28
10	Cyber risk	• Data Security and Protection (DSP) Toolkit	• Data Security and Protection (DSP) Toolkit	• Data Security and Protection (DSP) Toolkit	• Data Security and Protection (DSP) Toolkit
11	Modernisation / Fit for the Future		• Digital Strategy	• BAF & Board Governance	• IT Infrastructure (Data Centre and Networks)
14	Partnership Working		• System Wide Review	• System Wide Review	• System Wide Review

INTERNAL AUDIT OPERATIONAL PLAN 2025/26

AREA	BAF	DAYS	TIMING	DESCRIPTION OF THE REVIEW	REASON FOR INCLUSION
Core Assurance					
Demand Planning & Forecasting	2	17	Q3	To undertake a review of the controls and processes in place for demand planning and forecasting. This will include an assessment of reporting, profiling and initiatives in place to minimise the impact of high demand on Trust resources such as use of clinical pathways and Release to Respond.	Key area of focus for the Trust at the moment, to ensure that the Trust is resilient and prepared for the future. Requested by Audit Committee.
Medicines Management	1	16	Q2	This review will assess the Trust's controls for medicines management, including controls over stock balances to ensure that stock is physically protected, and accurately and effectively tracked. Additionally, we will review the processes for managing incidents involving controlled drugs.	NHS Trusts are required to establish, document and maintain an effective system to ensure that service users are protected from the risks associated with unsafe use and management of medicines and that medicines are handled in a safe and secure manner.
Fleet Management	1	17	Q1	Review of key fleet management processes, including a review of the long term strategy and plan for fleet. We will review how the long term plan has been developed and managed.	High cost area for ambulance sector, and prone to mismanagement.
DSP Toolkit	10	16	Q4	The purpose of this review is to provide an independent high-level review of the assertions and evidence items in the DSP Toolkit self-assessment and to identify how compliance could be improved for year-end returns	Given the importance of protecting patient data, which has been heightened following the introduction of the GDPR, there is a greater level of public awareness of key principle of information governance.
Total		**66**			

AREA	BAF	DAYS	TIMING	DESCRIPTION OF THE REVIEW	REASON FOR INCLUSION
Soft Controls					
Sickness Absence Management	6, 7	17	Q3	To review and record the design and operational effectiveness for the recording, management and prevention of sickness absence within the Trust, both within HR and wider operational management. This will include a review of sickness absence as a result of incidents of violence and aggression.	All absence has a significant impact on service pressures. The Interim Chief People Officer has requested this review, with the inclusion of a view on the work the Trust is currently undertaking to reduce the impact of incidents of violence and aggression on sickness absence rates as this is a current area of focus.
Total		**17**			

AREA	BAF	DAYS	TIMING	DESCRIPTION OF THE REVIEW	REASON FOR INCLUSION
Future Focused Assurance					
Digital Strategy	8, 11	17	Q4	Review of the design, implementation, management and governance of the Trust's digital strategy. This will include a high level review of the Trust's preparation for AI and replacement of key IT infrastructure.	Key area of focus for the Trust at the moment, to ensure that the Trust is resilient and prepared for the future.
Key Financial Systems – Financial Sustainability	5	17	Q4	The purpose of this review will be to assess the control framework over the Trust's budget and cash-flow forecasting to assess the extent to which the Trust has challenged the reliability of cash-flow assumptions and tested the resilience of its financial plans. It will include an assessment of the assumptions used to develop the Trust's Medium Term Financial Plan, progress against the and the governance structure established to ensure the successful completion of the plan.	Each year Internal Audit undertakes a cyclical review of key systems and controls to provide assurance on the core financial controls in place.
System Wide Review	14	10	TBC	To be utilised for a Hampshire ICS review.	Leverage our position as provider to the health economy.
Total		**44**			

AREA	BAF	DAYS	TIMING	DESCRIPTION OF THE REVIEW	REASON FOR INCLUSION
Contract Management					
Planning / liaison / management	N/A	11	Q1 - Q4	Creation of audit plan, meeting with Executive Directors	Effective contract management
Recommendations follow up	N/A	6	Q1 - Q4	Assessment and reporting of status of implementation of recommendations raised	Assurance for Executive Team and AC
Audit Committees	N/A	6	Q1 - Q4	Attendance at AC meetings, pre-meets and AC Chair liaison	Effective contract management
Total		**23**			

SUMMARY	DAYS
Core Assurance	66
Soft Controls	17
Future Focused Reviews	44
Contract Management	23
Total days	**150**

APPENDIX I

INTERNAL AUDIT CHARTER

This charter is a requirement of internal audit standards.

The charter formally defines internal audit's purpose, authority and responsibility. It establishes internal audit's position within South Central Ambulance Service NHS Foundation Trust ('the Trust') and defines the scope of internal audit activities.

Final approval of this charter resides with the Audit Committee (AC) on behalf of the Trust Board.

STANDARDS OF INTERNAL AUDIT PRACTICE

To fulfil its purpose, internal audit will perform its work in accordance with the *Global Internal Audit Standards in the UK Public Sector,* which encompass:

- The global Institute of Internal Auditors (IIA) *Global Internal Audit Standards* (GIAS) effective from January 2025
- The Internal Audit Standards Advisory Board (IASAB) *Application Note Global Internal Audit Standards in the UK Public Sector* effective from 1 April 2025.

The GIAS refer to the 'board' as 'the highest-level body charged with governance, such as a board of directors, an Audit Committee, a board of governors or trustees, or a group of elected officials or political appointees.' For the Trust, 'the board' is the AC acting on behalf of the Trust Board.

The GIAS also refer to the 'chief audit executive' as the 'leadership role responsible for effectively managing all aspects of the internal audit function and ensuring the quality performance of internal audit services in accordance with Global Internal Audit Standards.' For the Trust's internal audit function, 'the chief audit executive' is the BDO-assigned partner acting as the Head of Internal Audit (HoIA).

INTERNAL AUDIT'S PURPOSE AND MANDATE

Purpose

The purpose of the internal audit function is to strengthen the Trust's ability to create, protect, and sustain value by providing the AC and management with independent, risk-based, and objective assurance, advice, insight, and foresight.

The internal audit function enhances the Trust's:

- Successful achievement of its objectives
- Governance, risk management, and control processes
- Decision-making and oversight
- Reputation and credibility with its stakeholders
- Ability to serve the public interest.

The Trust's internal audit function is most effective when:

- Internal auditing is performed by competent professionals in conformance with the GIAS in the UK Public Sector
- The internal audit function is independently positioned with direct accountability to the AC
- Internal auditors are free from undue influence and committed to making objective assessments.

The role of the Trust's internal audit therefore includes:

- Supporting the delivery of the Trust's strategic objectives by providing risk-based and objective assurance on the adequacy and effectiveness of governance, risk management and internal controls
- Championing good practice in governance through assurance, advice and contributing to the Trust's annual governance review
- Advising on governance, risk management and internal control arrangements for major projects, programmes and system changes
- Access to the Trust's collaborative and arm's-length arrangements.

Mandate - Authority

The AC grants the internal audit function the mandate to provide the AC and senior management with objective assurance, advice, insight, and foresight.

The internal audit function's authority is created by its direct reporting relationship to the AC. Such authority allows for unrestricted access to the AC.

The AC authorises the internal audit function to:

- Have full and unrestricted access to all functions, data, records, information, physical property, and personnel pertinent to carrying out internal audit responsibilities; internal auditors are accountable for confidentiality and safeguarding records and information
- Allocate resources, set frequencies, select subjects, determine scopes of work, apply techniques, and issue communications to accomplish the function's objectives
- Obtain assistance from the necessary organisation's personnel in relevant engagements, as well as other specialised services from within or outside the organisation to complete internal audit services.

Mandate - Independence, position, and reporting relationships

- The HoIA will be positioned at a level in the organisation that enables internal audit services and responsibilities to be performed without interference from management, thereby establishing the independence of the internal audit function
- The HoIA will report functionally to the AC and administratively to the Chief Finance Officer.
- This positioning provides the organisational authority and status to bring matters directly to senior management and escalate matters to the AC, when necessary, without interference and supports the internal auditors' ability to maintain objectivity
- The HoIA will confirm to the AC, at least annually, the organisational independence of the internal audit function
- The HoIA will disclose to the AC any interference internal auditors encounter related to the scope, performance, or communication of internal audit work and results. The disclosure will include communicating the implications of such interference on the internal audit function's effectiveness and ability to fulfil its mandate.

AUDIT COMMITTEE OVERSIGHT

To establish, maintain, and ensure that the Trust's internal audit function has sufficient authority to fulfil its duties, the AC will:

- Discuss with the HoIA and senior management the appropriate authority, role, responsibilities, scope, and services (assurance and/or advisory) of the internal audit function
- Ensure the HoIA has unrestricted access to and communicates and interacts directly with the AC, including in private meetings without senior management present
- Discuss with the HoIA and senior management other topics that should be included in the internal audit charter
- Participate in discussions with the HoIA and senior management about the "essential conditions", described in the GIAS, which establish the foundation that enables an effective internal audit function

- Review and approve the internal audit function's charter annually, which includes the internal audit mandate and the scope and types of internal audit services
- Approve the risk-based internal audit plan
- Approve the internal audit function's human resources administration and budgets
- Collaborate with senior management to determine the qualifications and competencies the Trust expects in a HoIA
- Authorise the appointment and removal of the HoIA and outsourced internal audit provider
- Approve the fees paid to the outsourced internal audit provider
- Review the HoIA's and internal audit function's performance
- Receive communications from the HoIA about the internal audit function including its performance relative to its plan
- Ensure a quality assurance and improvement program has been established and review the results annually
- Make appropriate inquiries of senior management and the HoIA to determine whether scope or resource limitations are inappropriate.

Changes to the Mandate and Charter

Circumstances may justify a follow-up discussion between the HoIA, AC, and senior management on the internal audit mandate or other aspects of the internal audit charter. Such circumstances may include but are not limited to:

- A significant change in the GIAS in the UK Public Sector
- A significant acquisition or reorganisation within the Trust Board
- Significant changes in the HoIA, AC, and/or senior management
- Significant changes to the Trust's strategies, objectives, risk profile, or the environment in which the Trust operates
- New laws or regulations that may affect the nature and/or scope of internal audit services.

Support for Internal Audit

Internal audit's activities require access to and support from senior management, the AC and those charged with governance. Support allows internal audit to apply the mandate and charter in practice and meet expectations.

The Trust will support the internal audit function by:

- Championing the role and work of internal audit to the staff within the Trust and to partner organisations with whom internal audit works
- Facilitating access to senior management, the AC and the Trust's external auditor
- Assisting, where possible, with access to external providers assurance such as regulators, inspectors and consultants
- Engaging constructively with internal audit's findings, opinions and advice
- Building awareness and understanding of the importance of good governance, risk management and internal control for the success of the Trust and of internal audit's contributions.

The Trust will also put in place conditions to enable the internal audit work:

- Ensuring that the reporting line of the HoIA is not lower than a member of the senior management team and that the HoIA has access to all members of the team
- Ensuring that client responsibility lies with a member of senior management.

The AC will support internal audit by:

- Enquiring of senior management and the HoIA about any restrictions on the internal audit's scope, access, authority or resources that limit its ability to carry out its responsibilities effectively
- Considering the audit plan or planning scope, and formally approving or recommending approval to those charged with governance
- Meeting at least annually with the HoIA in sessions without senior management present.

Senior management will establish and safeguard internal audit's independence by:

- Ensuring internal audit's access to staff and records, as set out in regulations and the charter, operates freely and without any interference
- Ensuring that the HoIA reports in their own right to the AC on the work of internal audit
- Providing opportunities for the HoIA to meet with the AC without senior management present
- Where there are actual or potential impairments to the independence of internal audit, working with the HoIA to remove or minimise them or ensure safeguards are operating effectively
- Recognising that if the HoIA has additional roles and responsibilities beyond internal auditing, or if new roles are proposed, it could impact on the independence and performance of internal audit; in such cases the impact must be discussed with the HoIA and the views of the AC sought
- Where needed, appropriate safeguards will be put in place by senior management to protect the independence of internal audit and support conformance with professional standards. Matters around the appointment, removal, remuneration and performance evaluation of the HoIA will be undertaken by senior management, but these arrangements must not be used to undermine the independence of internal audit. The AC will provide feedback on the performance evaluation of the HoIA, which should include feedback from the Chair of the AC.

Interaction between the Audit Committee and Internal Audit

The AC will support internal audit's independence by reviewing the effectiveness of safeguards at least annually, including any issues or concerns about independence from the HoIA. The HoIA will have the right of access to the Chair of the AC at any time. The AC can escalate its concerns about internal audit independence to those charged with governance.

To ensure there is good interaction between the AC and internal audit, the AC will agree its work plan with the HOIA to ensure there is appropriate coverage of internal audit matters within AC agendas. The AC workplan will provide for the internal audit mandate and charter, strategy, plans, engagement reporting and the annual conclusion, and quality reports.

The AC is familiar with the Trust's assurance framework, governance, risk management and internal control arrangements to facilitate its interactions with internal audit.

Senior management will engage with the AC on any significant changes to governance, risk and control arrangements and any concerns they may have on assurance. The AC will have oversight of the annual governance statement before final approval.

Where there is disagreement about the management of risks or agreed audit actions between internal audit and senior management, the AC will review and make their recommendation to either management or those charged with governance.

Internal Audit Resources

The AC and senior management will engage with the HOIA to review whether internal audit's financial, human and technological resources are sufficient to meet internal audit's mandate as set out in the

regulations and achieve conformance with GIAS in the UK public sector. Where there are concerns about internal audit's ability to fulfil its mandate or deliver an annual conclusion, the concerns will be formally recorded and reported to those charged with governance.

If resource issues result in a limitation of scope on the annual conclusion, this will be reported and disclosed in the annual governance statement. Decisions on internal audit resourcing by senior management and those charged with governance must take account of the longer-term risks to the governance and financial sustainability of the Trust and internal audit's role in supporting those objectives. Where there are temporary resource constraints, senior management must work with the HOIA to establish longer-term plans for sustainable internal audit resources.

Quality

Annually, the AC will review the results of the HOIA's assessment of conformance against GIAS in the UK public sector including any action plan. The AC will review the HOIA's annual report, including the annual conclusion on governance, risk management and control, and internal audit's performance against its objectives. To meet the requirements of the regulations (the mandate) for internal audit, the AC will satisfy itself on the effectiveness of internal audit. They will take into account conformance with the standards, interactions with the AC, performance and feedback from senior management. Their conclusions will be reported to those charged with governance, for example, as part of the AC's annual report.

External Quality Assessment

On behalf of those charged with governance and the AC, senior management will ensure that internal audit has an external quality assessment at least once every five years of its conformance against GIAS in the UK public sector.

Senior management and the HoIA will discuss the timing of the review and report the options and their recommendation to the AC. The proposals for the scope, method of assessment and assessor will be brought to the AC for agreement. The AC will receive the complete results of the assessment and consider the HoIA's action plan to address any recommendations. Progress will be monitored. Where the AC does not have delegated authority, the committee will report the overall results of the external quality assessment to those charged with governance.

HEAD OF INTERNAL AUDIT ROLES AND REPONSIBILITIES

Ethics and Professionalism

The HoIA will ensure that internal auditors:

- Conform with the GIAS in the UK Public Sector, including the principles of Ethics and Professionalism (integrity, objectivity, competency, due professional care, and confidentiality) and the Seven Principles of Public Life (the 'Nolan Principles') (selflessness, integrity, objectivity, accountability, openness, honesty and leadership)
- Understand, respect, meet, and contribute to the legitimate and ethical expectations of the organisation and be able to recognise conduct that is contrary to those expectations
- Encourage and promote an ethics-based culture in the organisation
- Report organisational behaviour that is inconsistent with the organisation's ethical expectations, as described in applicable policies and procedures.

Objectivity

The HoIA will ensure that the internal audit function remains free from all conditions that threaten the ability of internal auditors to carry out their responsibilities in an unbiased manner, including matters of engagement selection, scope, procedures, frequency, timing, and communication. If the HoIA determines that objectivity may be impaired in fact or appearance, the details of the impairment will be disclosed to appropriate parties.

Internal auditors will maintain an unbiased mental attitude that allows them to perform engagements objectively such that they believe in their work product, do not compromise quality, and do not subordinate their judgment on audit matters to others.

Internal auditors will have no direct operational responsibility or authority over any activities they review. Accordingly, internal auditors will not implement internal controls, develop procedures, install systems, or engage in other activities that may impair their judgment.

Internal auditors will:

- Disclose impairments of independence or objectivity, in fact or appearance, to appropriate parties and at least annually, such as the HoIA, AC, management, or others
- Exhibit professional objectivity in gathering, evaluating, and communicating information
- Make balanced assessments of all available and relevant facts and circumstances
- Take necessary precautions to avoid conflicts of interest, bias, and undue influence.

Managing the Internal Audit Function

The HoIA has the responsibility to:

- Understand the Trust's governance, risk management and control processes, and the importance in the UK public sector of securing value for money, in developing an effective strategy and plan
- At least annually, develop a risk-based internal audit plan that considers the input of the AC and senior management; discuss the plan with the AC and senior management and submit the plan to the AC for review and approval
- Communicate the impact of resource limitations on the internal audit plan to the AC and senior management
- Review and adjust the internal audit plan, as necessary, in response to changes in the Trust's business, risks, operations, programs, systems, and controls
- Communicate with the AC and senior management if there are significant interim changes to the internal audit plan
- Ensure internal audit engagements are performed, documented, and communicated in accordance with the GIAS in the UK Public Sector
- Follow up on engagement findings and confirm the implementation of recommendations or action plans and communicate the results of internal audit services to the AC and senior management periodically and for each engagement as appropriate
- Ensure the internal audit function collectively possesses or obtains the knowledge, skills, and other competencies and qualifications needed to meet the requirements of the GIAS in the UK Public Sector and fulfil the internal audit mandate (in public sector internal audit, the HoIA is required to have a CMIIA, or a CCAB qualification, or an equivalent professional qualification which includes training on the practice of internal audit, and suitable internal audit experience)
- Identify and consider trends and emerging issues that could impact the Trust and communicate to the AC and senior management as appropriate
- Consider emerging trends and successful practices in internal auditing
- Establish and ensure adherence to methodologies designed to guide the internal audit function
- Ensure adherence to relevant policies and procedures unless such policies and procedures conflict with the internal audit charter or the GIAS; any such conflicts will be resolved or documented and communicated to the AC and senior management
- Coordinate activities and consider relying upon the work of other internal and external providers of assurance and advisory services; if the HoIA cannot achieve an appropriate level of coordination, the issue will be communicated to senior management (including the barriers to effective co-ordination with other assurance providers) and if necessary escalated to the AC.

Communication with the Audit Committee and Senior Management

The HoIA will report periodically eg quarterly to the AC and senior management regarding:

- The internal audit function's mandate
- The internal audit plan and performance relative to its plan
- Internal audit budget
- Significant revisions to the internal audit plan and budget
- Potential impairments to independence, including relevant disclosures as applicable
- Results from the quality assurance and improvement program, which include the internal audit function's conformance with the GIAS in the UK Public Sector and action plans to address the internal audit function's deficiencies and opportunities for improvement
- Significant risk exposures and control issues, including fraud risks, governance issues, and other areas of focus for the AC
- Results of assurance and advisory services
- Resource requirements
- Management's responses to risk that the internal audit function determines may be unacceptable or acceptance of a risk that is beyond the Trust's risk appetite.

Quality Assurance Improvement Programme

The HoIA will develop, implement, and maintain a quality assurance and improvement program (QAIP) that covers all aspects of the internal audit function.

The program will include external and internal assessments of the internal audit function's conformance with the GIAS in the UK Public Sector, as well as performance measurement to assess the internal audit function's progress toward the achievement of its objectives and promotion of continuous improvement.

The plan will assess the efficiency and effectiveness of internal audit and identify opportunities for improvement.

Annually, the HoIA will communicate with the AC and senior management about the internal audit function's QAIP, including the results of internal assessments (ongoing monitoring and periodic self-assessments) and external assessments.

External assessments will be conducted at least once every five years by a qualified, independent assessor or assessment team from outside BDO. Qualifications must include at least one assessor holding an active Certified Internal Auditor credential. For public sector internal audit, such a person should have an understanding of the GIAS commensurate with the Certified Internal Auditor designation, including internal audit relevant continuing professional development and an understanding of how the GIAS are applied in the UK public sector.

SCOPE AND TYPES OF INTERNAL AUDIT SERVICES

The scope of internal audit services covers the entire breadth of the Trust, including all the Trust's activities, assets, and personnel.

The scope of internal audit activities also encompasses but is not limited to objective examinations of evidence to provide independent assurance and advisory services to the AC and management on the adequacy and effectiveness of governance, risk management, and control processes for the Trust.

The nature and scope of advisory services may be agreed with the party requesting the service, provided the internal audit function does not assume management responsibility. Opportunities for improving the efficiency of governance, risk management, and control processes may be identified during advisory engagements. These opportunities will be communicated to the appropriate level of management.

Internal audit engagements may include evaluating whether:

- Risks relating to the achievement of the Trust's strategic objectives are appropriately identified and managed
- The actions of the Trust's officers, directors, management, employees, and contractors or other relevant parties comply with organisational policies, procedures, and applicable laws, regulations, and governance standards

- The results of operations and programs are consistent with established goals and objectives
- Operations and programs are being carried out effectively and efficiently
- Established processes and systems enable compliance with the policies, procedures, laws, and regulations that could significantly impact the Trust
- The integrity of information and the means used to identify, measure, analyse, classify, and report such information is reliable
- Resources and assets are acquired economically, used efficiently and sustainably, and protected adequately.

INTERNAL AUDIT PERFORMANCE MEASURES AND INDICATORS

The tables below contain some of the performance measures and indicators that are considered to have the most value in assessing the efficiency and effectiveness of internal audit.

The AC should approve the measures which will be reported to each meeting and / or annually as appropriate. In addition to those listed here we also report on additional measures as agreed with management and included in our Progress Report.

TABLE ONE: PERFORMANCE MEASURES FOR INTERNAL AUDIT

MEASURE / INDICATOR
Audit Coverage Annual Audit Plan delivered in line with timetable. Actual days are in accordance with Annual Audit Plan.
Relationships and customer satisfaction Customer satisfaction reports – overall score at average at least 3.5 / 5 for surveys issued at the end of each audit. Annual survey to AC to achieve score of at least 70%. External audit can rely on the work undertaken by internal audit (where planned).
Staffing and Training At least 60% input from qualified staff.
Audit Reporting Issuance of draft report within 3 weeks of fieldwork `closing' meeting. Finalise internal audit report 1 week after management responses to report are received. 90% recommendations to be accepted by management. Information is presented in the format requested by the customer.

MANAGEMENT AND STAFF PERFORMANCE MEASURES AND INDICATORS

The management and staff of the Trust commit to the following:

- Providing unrestricted access to all of the Trust's records, property, and personnel relevant to the performance of engagements
- Responding to internal audit requests and reports within the agreed timeframe and in a professional manner
- Implementing agreed recommendations within the agreed timeframe
- Being open to internal audit about risks and issues within the Trust
- Not requesting any service from internal audit that would impair its independence or objectivity

- Providing honest and constructive feedback on the performance of internal audit.

The following three indicators are considered good practice performance measures, but we go beyond this and report on a suite of measures as included in each AC Progress Report.

TABLE TWO: PERFORMANCE MEASURES FOR MANAGEMENT AND STAFF

MEASURE / INDICATOR
Response to Reports Audit sponsor to respond to terms of reference within one week of receipt and to draft reports within two weeks of receipt.
Implementation of recommendations Audit sponsor to implement all audit recommendations within the agreed timeframe.

BDO CONTACTS

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South Central Ambulance Service NHS Foundation Trust

External audit plan

Year ended 31 March 2025

March 2025

Your key team members

Laura Hinsley
Key Audit Partner
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Appendices

Introduction

Adding value through the audit

All of our clients demand of us a positive contribution to meeting their ever-changing business needs. Our aim is to add value to the Trust through our external audit work by being constructive and forward looking, by identifying areas of improvement and by recommending and encouraging good practice. In this way, we aim to help the Trust promote improved standards of governance, better management and decision making and more effective use of resources.

Purpose

This audit plan highlights the key elements of our proposed audit strategy and provides an overview of the planned scope and timing of the statutory external audit of South Central Ambulance Service NHS Foundation Trust (the 'Trust') and its Group for the year ended 31 March 2025 for those charged with governance.

The core elements of our work include:

- An audit of the 2024/25 Statement of Accounts for the Trust and its Group; and
- An assessment of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (our Value for Money work).

We will conduct our audit in accordance with International Standards on Auditing (ISAs) (UK), the National Health Service Act 2006 (the 'Act'), and the National Audit Office Code of Audit Practice. The Code of Audit Practice sets out what local auditors of relevant local public bodies are required to do to fulfil their statutory responsibilities under the Act.

Auditor responsibilities

As auditor we are responsible for performing an audit, in accordance with the Local Audit and Accountability Act 2014, the Code of Audit Practice issued by the National Audit Office and ISAs UK. Our primary responsibility is to form and express an independent opinion on the Trust's and its Group's financial statements, stating whether they provide a true and fair view and have been prepared properly in accordance the Department of Health and Social Care Group Accounting Manual (DHSC GAM).

We are also required to:

- Report on whether the other information included in the Annual Report and Accounts (including the Performance and Accountability Report and Annual Governance Statement) is consistent with the financial statements;
- Report by exception if the disclosures in the Annual Governance Statement are incomplete or if the Annual Governance Statement is misleading or inconsistent with our knowledge acquired during the audit;
- Report on whether the audited elements of the Remuneration Report and Staff report have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual (FT ARM);
- Report by exception any significant weaknesses identified in arrangements for securing value for money and a summary of associated recommendations;
- Report by exception on the use of our other statutory powers and duties; and
- Certify completion of our audit.

continued…..

Introduction

We will conduct our audit in accordance with International Standards on Auditing (ISAs) (UK), the National Health Service Act 2006 (the 'Act'), and the National Audit Office Code of Audit Practice. The Code of Audit Practice sets out what local auditors of relevant local public bodies are required to do to fulfil their statutory responsibilities under the Act.

This planning letter has been prepared for the sole use of those charged with governance and management and should not be relied upon by third parties. No responsibility is assumed by Azets Audit Services to third parties.

Auditor responsibilities *(....continued)*

In addition, we are required to provide an opinion on whether the trust accounts consolidation (TAC) schedules submitted to NHS England are consistent with the audited financial statements.

We will issue our Audit Findings Report and an Auditors Annual Report to the Audit Committee setting out the findings from our work.

Under the Act we have a broad range of reporting responsibilities and powers that are unique to the NHS Foundation Trust's in the United Kingdom. These include:

- Reporting matters in the public interest;
- Making a referral under section 10 of the Act in relation to unlawful expenditure.

On completion of our audit work, we will issue an Audit Findings Report (prior to the approval of the financial statements), detailing our significant findings and other matters arising from the audit on the financial statements, together with an Auditor's Annual Report including our commentary on the value for money arrangements.

If, during the course of the audit, we identify any significant adverse or unexpected findings that we conclude should be communicated, we will do so on a timely basis, either informally or in writing.

The audit does not relieve management or the Audit Committee of your responsibilities, including those in relation to the preparation of the financial statements.

Trust's responsibilities

The Trust has responsibility for:

- Preparing financial statements which give a true and fair view, in accordance with the applicable financial reporting framework and relevant legislation;
- Preparing and publishing an Annual Report, including the financial statements;
- Maintaining proper accounting records and preparing working papers to an acceptable professional standard that support its financial statements and related reports disclosures; and
- Ensuring the proper financial stewardship of public funds, complying with relevant legislation and establishing effective arrangements for governance, propriety and regularity.

Audit scope and general approach

This section of our letter sets out the scope and nature of our audit and should be considered in conjunction with the Engagement Letter signed on 13 June 2024.

General approach

Our objective when performing an audit is to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement and to issue an auditor's report that includes our auditor's opinion.

As part of our risk-based audit approach, we will:

- Perform risk assessment procedures including updating our understanding of the Trust and its Group, including its environment, the financial reporting framework and its system of internal control;
- Review the design and implementation of key internal controls;
- Identify and assess the risks of material misstatement, whether due to fraud or error, at the financial statement level and the assertion level for classes of transaction, account balances and disclosures;
- Design and perform audit procedures responsive to those risks, to obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion; and
- Exercise professional judgment and maintain professional scepticism throughout the audit recognising that circumstances may exist that cause the financial statements to be materially misstated.

We will undertake a variety of audit procedures designed to provide us with sufficient evidence to give us reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error.

Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

We include an explanation in the auditor's report of the extent to which the audit was capable of detecting irregularities, including fraud and respective responsibilities for prevention and detection of fraud.

Audit scope and general approach

Materiality

We apply the concept of materiality both in planning and performing the audit, and in evaluating the effect of identified misstatements on the audit and of uncorrected misstatements.

Judgments about materiality are made in the light of surrounding circumstances and are affected by our perception of the financial information needs of users of the financial statements, and by the size or nature of a misstatement, or a combination of both. The basis for our assessment of materiality for the year is set out in Appendix I.

Any identified errors greater than:

£300,000 (for the Group audit); and
£299,000 (for the Trust audit)

will be recorded and discussed with you and, if not adjusted, confirmed as immaterial as part of your letter of representation to us.

Accounting systems and internal controls

The purpose of an audit is to express an opinion on the financial statements. We will follow a substantive testing approach to gain audit assurance rather than relying on tests of controls. As part of our work, we consider certain internal controls relevant to the preparation of the financial statements such that we are able to design appropriate audit procedures. However, this work does not cover all internal controls and is not designed for the purpose of expressing an opinion on the effectiveness of internal controls. If, as part of our consideration of internal controls, we identify significant deficiencies in controls, we will report these to you in writing.

Specialised skill or knowledge required to complete the audit procedures

We will use audit specialists to assist us in our audit work in the following areas:

- The audit of property valuations, should the need arise during the audit

We will consult internally with our Technology Risk team for them to support the audit team by assessing the information technology general controls (ITGC) of the following systems:

- Microsoft GP Dynamics

Audit scope and general approach

Significant changes in the financial reporting framework

The Department of Health and Social Care issued the Group Accounting Manual for 2024/25 in August 2024. This sets out two key changes from the prior year:

- Inclusion of stage 2 guidance relating to Taskforce for Climate related Financial Disclosures; and
- Inclusion of reporting requirement relating to delivery against green plans.

The NHS Foundation Trust annual reporting manual (FT ARM) is yet to be published for 2024/25 at the time of this report.

Significant changes in the Trust's and Group's functions or activities

There have been no significant changes to the functions and activities of the Trust or its Group structure. We have not been made aware of any significant changes in the functions or activities of the other components in the Trust's Group. Our Group audit scope and risk assessment is set out in Appendix II.

Going concern

Management responsibility

Management is required to make and document an assessment of whether the Trust and Group is a going concern when preparing the financial statements. The review period should cover at least 12 months from the date of approval of the financial statements. Management are also required to make balanced, proportionate and clear disclosures about going concern within the financial statements where material uncertainties exist in order to give a true and fair view.

Going concern

Auditor responsibility

Under ISA (UK) 570, we are required to consider the appropriateness of management's use of the going concern assumption in the preparation of the financial statements and consider whether there are material uncertainties about the Trust's or Group's ability to continue as a going concern that need to be disclosed in the financial statements.

In assessing going concern, we will consider the guidance published in Department of Health and Social Care Group Accounting Manual 2024/25 (GAM) and Practice Note 10 (PN10), which focuses on the anticipated future provision of services in the public sector rather than the future existence of the entity itself.

Audit scope and general approach

Related party transactions

ISA 550 requires that the audit process starts with the audited body providing a list of related parties to the auditor, including any entities under common control. During our initial audit planning you have informed us of the individuals and entities that you consider to be related parties. Please advise us of any changes as and when they arise.

Additional procedures for the NAO

The National Audit Office (the 'NAO') issues group audit instructions which set out additional audit requirements. We expect the procedures for this year to be similar to previous years.

The NAO audit team for the WGA request us to undertake specific audit procedures in order to provide them with additional assurance over the amounts recorded in the Trust's consolidation schedules. The extent of these procedures will depend on whether the Trust has been selected by the NAO as a sampled component for 2024/25. As at the date of this report, the draft instructions have not yet been issued by the NAO and the NAO have not yet confirmed which entities will be sampled components.

We will seek to comply with the instructions and to report to the NAO in accordance with their requirements once instructions have been issued.

Significant risks of material misstatement

Significant risks are risks that require special audit consideration and include identified risks of material misstatement that:

- Our risk assessment procedures have identified as being close to the upper range of the spectrum of inherent risk due to their nature and a combination of the likelihood and potential magnitude of misstatement; or
- Are required to be treated as significant risks due to requirements of ISAs (UK), for example in relation to management override of internal controls.

Significant risks at the financial statement level

The table below summarises significant risks of material misstatement identified at the financial statement level. These risks are considered to have a pervasive impact on the financial statements as a whole and potentially affect many assertions for classes of transaction, account balances and disclosures.

Identified risk	Planned audit procedures
Management override of controls (Group and Trust) Auditing Standards require auditors to treat management override of controls as a significant risk on all audits. This is because management is in a unique position to perpetrate fraud by manipulating accounting records and overriding controls that otherwise appear to be operating effectively. Although the level of risk of management override of controls will vary from entity to entity, the risk is nevertheless present in all entities. Specific areas of potential risk including manual journals, management estimates and judgements and one-off transactions outside the ordinary course of the business. **Risk of material misstatement: Very high**	Procedures performed to mitigate risks of material misstatement in this area will include: • Documenting our understanding of the journals posting process and evaluating the design effectiveness of management controls over journals; • Analysing the journals listing and determining the criteria for selecting high risk and/or unusual journals; • Testing high risk and/or unusual journals posted during the year and after the draft accounts stage back to supporting documentation for appropriateness, corroboration and to ensure approval has been undertaken in line with the Trust's and Group's journals policy; • Gaining an understanding of the key accounting estimates and critical judgements made by management. We will also challenge assumptions and consider for reasonableness and indicators of bias which could result in material misstatement due to fraud; and • Evaluating the rationale for any changes in accounting policies, estimate or significant unusual transactions.

Significant risks of material misstatement

Significant risks at the assertion level for classes of transaction, account balances and disclosures

The table below summarises significant risks of material misstatement at the assertion level for classes of transaction, account balances and disclosures.

Identified risk	Planned audit procedures
Fraud in revenue recognition (Group and Trust) Material misstatement due to fraudulent financial reporting relating to revenue recognition is a rebuttable presumed risk in ISA (UK) 240. As at November 2024, the Trust has a deficit of £3.214m against a forecasted deficit position of £4.873m. Having considered the nature of the revenue streams at the Trust, pressures within the wider healthcare system, and the financial position at month 8, we consider that the risk of fraud in revenue recognition cannot be rebutted. **Inherent risk of material misstatement:** • **Revenue (Occurrence and Accuracy): High** • **Receivables (Existence): High**	We will perform the below procedures based on their value within the financial statements: • Documenting our understanding of the Trust's systems for income to identify significant classes of transactions, account balances and disclosures with a risk of material misstatement in the financial statements; • Evaluating the design of the controls in the key accounting systems, where a risk of material misstatement was identified, by performing a walkthrough of the systems; • Evaluating the Trust's accounting policies for recognition of income and compliance with the GAM; • Testing pre and post year end transactions to assess cut-off of income recognition; • Substantively testing a sample of income transactions recognised during the period by tracing amounts to contracts, invoices and other third-party evidence; • Substantively testing a sample of receivables recognised at year end by tracing amounts to contracts, invoices and other third-party evidence; and • Reviewing the Agreement of Balances mismatch report to identify any unmatched items above/under the lower of our trivial threshold or NAO threshold of £300k. Where mismatches or disputed balances are identified, confirm balances and review correspondence with mismatched organisation.

Significant risks of material misstatement

Identified risk	Planned audit procedures
Fraud in expenditure recognition (Group and Trust) We have also considered Practice Note 10, which comments that for certain public bodies, the risk of manipulating expenditure could exceed the risk of the manipulation of revenue. We have therefore also considered the risk of fraud in expenditure at the Trust. We consider that the risk can be rebutted on payroll expenditure of staff, depreciation, amortisation, and interest payable but cannot be rebutted on other operating expenditure for the reasons set out above. We have also identified significant risk in the completeness and existence of the related expenditure accruals. **Inherent risk of material misstatement:** • **Non-pay expenditure (Completeness): High** • **Accruals (Completeness): High**	We will perform the below procedures based on their value within the financial statements: • Documenting our understanding of the Trust's systems for expenditure to identify significant classes of transactions, account balances and disclosures with a risk of material misstatement in the financial statements; • Evaluating the design of the controls in the key accounting systems, where a risk of material misstatement was identified, by performing a walkthrough of the systems; • Evaluating the Trust's accounting policies for recognition of expenditure and compliance with the GAM; • Test a sample of expenditure to third party supporting documentation to confirm it has been recognised in the correct accounting period and where appropriate agree to the corresponding accrual; • Test a sample of after date payments to ensure all appropriate expenditure has been included in the financial statements; • Reviewing management's processes for identifying accruals to ensure the completeness of these balances; • Substantively testing a sample of expenditure transactions recognised during the period by tracing amounts to contracts, invoices and other third-party evidence; • Test a sample of accruals and third-party supporting documentation to confirm they have been recognised correctly in line with accounting standards and the GAM; and • Reviewing the Agreement of Balances mismatch report to identify any unmatched items above/under the lower of our trivial threshold or NAO threshold of £300k. Where mismatches or disputed balances are identified, confirm balances and review correspondence with mismatched organisation.

Significant risks of material misstatement

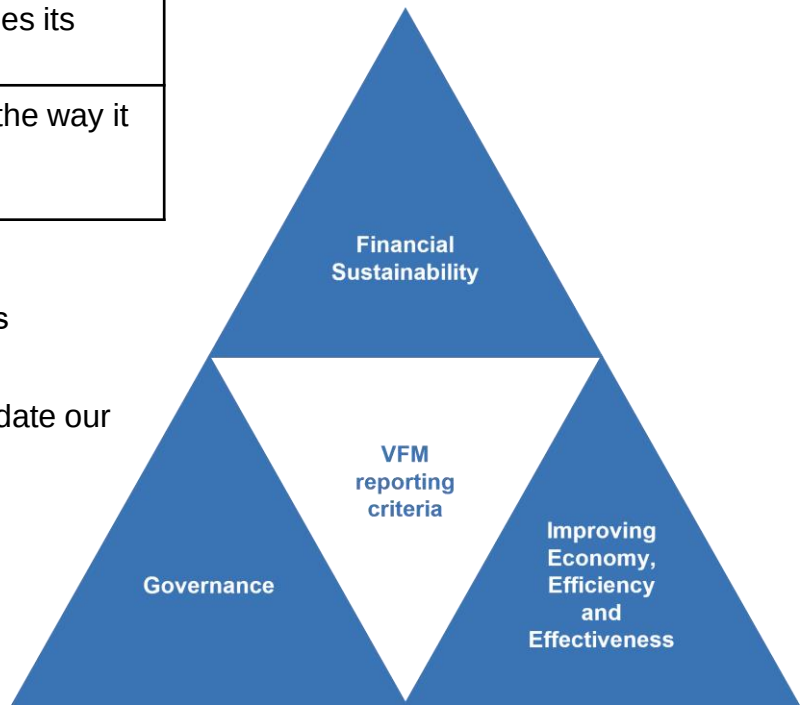
Identified risk	Planned audit procedures
Valuation of land and buildings (key accounting estimate) (Group and Trust) The Trust undertakes a full revaluation of its land and buildings annually, to ensure that the carrying value is not materially different from the fair value. The last full valuation was undertaken in the prior year. For the year ending 31 March 2025, a desktop valuation exercise will take place which is in line with our expectation. Management engage the services of Savills, who are a Regulated Member of the Royal Institute of Chartered Surveyors (RICS) to undertake these valuations as of 31 March 2025. The valuations involve a wide range of assumptions and source data and are therefore sensitive to changes in market conditions. ISAs (UK) 500 and 540 require us to undertake audit procedures on the use of external expert valuers and the methods, assumptions and source data underlying the fair value estimates. This represents a key accounting estimate made by management within the financial statements due to the size of the values involved, the subjectivity of the measurement and the sensitive nature of the estimate to changes in key assumptions. We have therefore identified the valuation of land and buildings as a significant risk. We will further pinpoint this risk to specific assets, or asset types, on receipt of the draft financial statements and the year-end updated asset valuations to those assets where the in-year valuation movements falls outside of our expectations. **Inherent risk of material misstatement:** • **Land and Buildings (valuation): High**	Procedures performed to mitigate risks of material misstatement in this area will include: • Evaluating management processes and assumptions for the calculation of the estimate, the instructions issued to the valuation experts and the scope of their work; • Evaluating the competence, capabilities and objectivity of the valuation expert; • Considering the basis on which the valuations are carried out and challenging the key assumptions applied; • Evaluating the reasonableness of the valuation movements for assets revalued during the year, with reference to market data. We will consider whether we require an auditor's expert; • For unusual or unexpected valuation movements, testing the information used by the valuer to ensure it is complete and consistent with our understanding; • Ensuring revaluations made during the year have been input correctly to the fixed asset register and the accounting treatment within the financial statements is correct; and • Evaluating the assumptions made by management for any assets not revalued during the year and how management are satisfied that these are not materially different to the current value.

Value for Money arrangements

Under the Code of Audit Practice, we must satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources (referred to here as “Value for Money”, or “VFM”).
NAO Auditor Guidance Note 03 ‘Auditors’ Work on Value for Money Arrangements’ (“AGN 03”) was updated and issued on 14 November 2024 and requires us to provide an annual commentary on arrangements, which will be published as part of the Auditor’s Annual Report. Such commentary will highlight any significant weaknesses in arrangements, along with recommendations for improvements.

When reporting on such arrangements, the Code of Practice requires us to structure our commentary under three specified reporting criteria:

Financial sustainability	How the body plans and manages its resources to ensure it can continue to deliver its services
Governance	How the body ensures that it makes informed decisions and properly manages its risks
Improving economy, efficiency and effectiveness	How the body uses information about its costs and performance to improve the way it manages and delivers its services



As part of the planning process, we are required to perform procedures to identify potential risks of significant weaknesses in the Trust’s arrangements to secure VFM through the economic, efficient and effective use of its resources.

We are required to re-evaluate this risk assessment during the course of the audit and, where appropriate, update our work to reflect emerging risks or findings that may suggest a significant weakness in arrangements.

Where we identify significant weaknesses in arrangements as part of our work, we are required to make recommendations setting out:

- Our judgement on the nature of the weakness identified;
- The evidence on which our view is based;
- The impact on the local body; and
- The action the body needs to take to address the weakness.

Value for Money arrangements

Risks of significant weakness in VFM arrangements

We have carried out an initial risk assessment to identify any risks of potential significant weakness in respect of the three specific areas of proper arrangements using the guidance contained in AGN 03.

We will re-evaluate this risk assessment during the course of the audit and, where appropriate, update our work to reflect emerging risks or findings that may suggest a significant weakness in arrangements.

When considering the Trust's arrangements, we will have regard to the three reporting criteria set out in AGN03, as well as performing additional work in the areas identified below which are the potential areas of significant weaknesses, we have identified at the planning stage.

Value for Money arrangements

Criteria	Potential risk of significant weakness	Our risk based procedures and evaluation approach includes (but is not limited to)
Financial sustainability	Two significant weaknesses were identified as part of our prior year audit. These were as follows: 1. The Trust did not have adequate arrangements in place to identify, monitor and deliver its 2023/24 efficiency targets leading to a deficit position of £21.7m. The Trust set itself a £36.3m Cost Improvement Plan (CIP) target for 2023/24, but only delivered £9.6m of savings of which £4.8m were non-recurrent leading to an adjusted deficit position of £21.7m for the year. The Trust has set itself an ambitious CIP target of £27.7m for 2024/25. 2. During the 2023/24 year the Trust did not have a MTFP in place and this is still outstanding. **We have therefore rolled forward these significant weaknesses as areas of potential risk of significant weakness in 2024/25 as follows:** **1. The Trust set itself an ambitious CIP target of £27.7m for 2024/25 and there is a risk that the Trust is unable to deliver this in 2024/25.** **2. The Trust does not have a MTFP in place and this is still outstanding during 2024/25.**	• Obtaining an update of the Trust's progress against recommendations made in our 2023/24 Auditor's Annual Report; • Assessing the Trust's actual position against the budgeted position for 2024/25, including achievement of CIPs. • Considering the impact of the loss of PTS contracts on the Trust's financial position; • Assessing the Trust's arrangements for agreeing a 2025/26 financial plan, including cost improvement programmes (CIP) and plans to monitor these; • Considering the arrangements that are in place at the year-end in line with available guidance and information received centrally; • Scrutinising financial performance reports to Board and Audit Committee to understand the financial position and variances from plans as well as management's response; and • Meeting with senior management (including the Interim Director of Finance and Chair of the Audit Committee) to understand plans to control the underlying deficit position and to discuss the concerns over the Trust's ability to deliver services and to understand the priorities and key action points to mitigate this risk.

Value for Money arrangements

Criteria	Potential risk of significant weakness	Our risk based procedures and evaluation approach includes (but is not limited to)
Governance	One significant weakness were identified as part of our prior year audit. This was as follows: 1. The Trust did not have adequate arrangements in place within 2023/24 to deliver and monitor against the criteria agreed within the Improvement Programme. **We have therefore rolled forward this significant weaknesses as an area of potential risk of significant weakness in 2024/25 as follows:** **1. The Trust does not have adequate arrangements in place in 2024/25 to deliver and monitor against the criteria agreed within the Improvement Programme.**	• Obtaining an update of the Trust's progress against recommendations made in our 2023/24 Auditor's Annual Report; • Reviewing the Trust's latest improvement programme and progress against this; and • Meeting with senior management (including the Chief Governance Officer) to understand progress the Trust is making against the improvement programme.
Improving economy, efficiency and effectiveness	We have not, at this stage, identified any risks of significant weakness that require specific audit procedures. We will consider the delays of the ambulance fleet replacement programme and the arrangements the Trust has in place surrounding this.	

Weaknesses or risks identified by auditors are only those which have come to their attention during their normal audit work in accordance with the Code of Audit Practice and may not be all that exist.

Value for Money follow up of prior year recommendations

As part of our planning work, we have obtained an update of the Trust's progress against the recommendations made in the 2023/24 Auditor's Annual Report

Criteria	Recommendation	Date raised	Management response on progress (as at January 2025)	Audit comment
Financial Sustainability	We recommend that the Trust closely monitor the achievement of recurrent and non-recurrent efficiency targets for 2024/25, ensuring full engagement and accountability from efficiency owners within the Trust. Developing an action tracker for PTS and monitoring against this will be critical to the Trusts FRP success and should be regularly monitored, reported and constructively challenged by the Board.	2023/24	The Trust has been closely monitoring recurrent and non-recurrent efficiency targets through established governance structures, including weekly FRG meetings and formal committees such as EMC, F&PC, and the Board. Additionally, NEPTS recovery has been supported by a dedicated weekly meeting and ongoing discussions with commissioners. We acknowledge the importance of robust tracking mechanisms and will ensure that efficiency owners within the Trust remain fully engaged and accountable. The Development of the action tracker for NEPTS, as suggested, is a valuable step, and we will integrate this into our governance framework, with NEPTS update now also being report 3 times a week at the Executive Daily Huddles. Regular reporting, constructive challenge, and oversight by the Board will remain central to driving the success of the Trust's FRP for 2024/25 and going forward.	As at the time of planning, we are aware of the Trust losing a number of PTS contracts. From discussions with the interim director of finance, CIPs have all been identified and are on track to be delivered. We will consider the Trust's position as at 31 March 2025 as part of our completion of the VFM work in April and May 2025. We have therefore identified this as a risk for our VFM planning as set out on page 15.

Value for Money follow up of prior year recommendations (continued)

Criteria	Recommendation	Date raised	Management response on progress (as at January 2025)	Audit comment
Financial Sustainability	We continue to recommend that an MTFP is developed, evaluated for robustness, and approved by the Board as soon as practicable.	2022/23 2023/24	The Trust is actively developing its 5-year plan, with the first draft expected by April. Workshops are being organised to support this process and ensure comprehensive input and alignment. We recognise the importance of having a robust Medium-Term Financial Plan (MTFP) and will ensure that it is thoroughly evaluated and presented for Board approval at the earliest opportunity. This will form a critical part of our strategic planning and financial sustainability efforts.	As at the time of planning, the Trust are yet to implement the recommendation to produce a Medium Term Financial Plan (MTFP). We will consider the Trust's progress against this recommendation as at 31 March 2025 as part of our completion of the VFM work in April and May 2025. We have therefore identified this as a risk for our VFM planning as set out on page 15.

Value for Money follow up of prior year recommendations (continued)

Criteria	Recommendation	Date raised	Management response on progress (as at January 2025)	Audit comment
Governance	We recommend that the Trust closely monitors its progress of the Improvement Programme and that the responsible executive leads are held accountable for non-delivery by the Board. Where progress is delayed, mitigating actions should be determined in a timely way, with realistic and achievable actions set to enable the Trust to continue to deliver, promoting shared responsibility for delivery between the executive leads. The Board should satisfy itself that revised delivery arrangements are robust.	2023/24	The Trust is committed to closely monitoring the progress of its Improvement Programme. This commitment is exemplified by initiatives such as the introduction of the NEPTS weekly meetings, which have proven effective in driving accountability and addressing challenges promptly. We will ensure that executive leads remain accountable for their areas of responsibility, with regular updates provided to the Board. In cases where progress is delayed, timely mitigating actions will be identified, and realistic, achievable plans will be set to maintain momentum. The Board will actively review and challenge these delivery arrangements to ensure they are robust and support the Trust's overall objectives, fostering a culture of shared responsibility for delivery across the executive team.	As at planning, we have requested a copy of the latest Improvement Programme which the Trust is working to. We have not been provided with a response to this request and therefore we are unable to confirm management's response. We will therefore continue to chase this and consider this as part of our work in April 2025. We have therefore identified this as a risk for our VFM planning as set out on page 16.

Audit team and logistics

Your audit team

Role	Name	Contact details
Key Audit Partner	Laura Hinsley	Laura.Hinsley@azets.co.uk
Director	Rebecca Lister	Rebecca.Lister@azets.co.uk
Assistant Manager	Christian Jay Abellera	CJ.Abellera@azets.co.uk

Timetable

Event	Date
Planning and risk assessment	December 2024 and January 2025
Reporting of plan to Audit Committee	March 2025
Interim audit	February 2025
Year end audit	April – June 2025
Reporting of Audit Findings (ISA260)	June 2025
Auditor's Annual Report (AAR)	June 2025
Target date of approval of accounts	June 2025
Accounts publication deadline	30 June 2025

Our expectations and requirements

For us to be able to deliver the audit in line with the agreed fee and timetable, we require the following:

- Draft financial statements to be produced to a good quality by the deadlines you have agreed with us. These should be complete including all notes, the Performance and Accountability Report and the Annual Governance Statement;
- The provision of good quality working papers at the same time as the draft financial statements. These will be discussed with you in advance to ensure clarity over our expectations;
- The provision of agreed data reports at the start of the audit, fully reconciled to the values in the accounts, to facilitate our selection of samples for testing
- Ensuring staff are available and on site (as agreed) during the period of the audit;
- Prompt and sufficient responses to audit queries within three working days, unless otherwise agreed, to minimise delays.

The audit process is underpinned by effective project management to ensure that we co-ordinate and apply our resources efficiently to meet your deadlines. It is therefore essential that the audit team and the Trust's finance team work closely together to achieve this timetable.

Independence, objectivity and other services provided

Auditor independence

We confirm that we comply with the Financial Reporting Council's (FRC) Ethical Standard and are able to issue an objective opinion on the financial statements. We have also complied with the NAOs Auditor Guidance Note 01, issued in September 2022, which contains supplementary guidance on ethical requirements for auditors of local public bodies.

We have considered our integrity, independence and objectivity in respect of audit services provided to the Trust and the Group. We do not believe that there are any significant threats or matters which should be brought to your attention.

Other services

No non audit services were provided by Azets the Trust or Group. However, we do note that Azets Audit Services provide external audit services to the Trust's subsidiary South Central Fleet Services Limited. Similarly, no non audit services are provided to this entity.

We have not identified any other potential threats for which we have considered it appropriate to apply safeguards.

Fees

Our estimated fee (excluding VAT) is as follows:

Audit fee	2024/25 £
Base fee for the audit of the Group and Trust financial statements	207,600
Total audit fee for South Central Ambulance Service NHS Foundation Trust	**207,600**

This fee is estimated based on our understanding at this point in time and may be subject to change. Our planned fee is on the basis that our expectations set out on page 4 are met and the group structure is unchanged.

It is our policy to bill for overruns or scope extensions e.g., where we have incurred delays, deliverables have been late or of poor quality, where key personnel have not been available, or we have been asked to do extra work.

Our policy is to raise fees to account at appropriate stages of the audit such as during the audit planning, the interim visit, the final audit and once the financial statements have been signed.

We also audit the following subsidiary companies of the Trust (which are outside the Trust contract and subject to separate fee negotiations:

- South Central Fleet Services Limited

The approximate total fees charged to the Group for the provision of services in 2024/25 is as follows:

Audit fee	2024/25 £
Audit of the Trust (as above)	207,600
Audit of other components of the Group audited by Azets for 2024/25 (proposed fee)	39,500
Total fees	**247,100**

Appendix I: Materiality

Whilst our audit procedures are designed to identify misstatements which are material to our audit opinion, we also report to those charged with governance and management any uncorrected misstatements of lower value errors to the extent that our audit identifies these. Under ISA (UK) 260 we are obliged to report uncorrected omissions or misstatements other than those which are 'clearly trivial' to those charged with governance. ISA (UK) 260 defines 'clearly trivial' as matters that are clearly inconsequential, whether taken individually or in aggregate and whether judged by any quantitative or qualitative criteria.

An omission or misstatement is regarded as material if it would reasonably influence the users of the financial statements. The assessment of what is material is a matter of professional judgement and is affected by our assessment of the risk profile of the Trust and Group and the needs of the users. When planning, we make judgements about the size of misstatements which we consider to be material, and which provide a basis for determining the nature and extent of our audit procedures. Materiality is revised as our audit progresses, should we become aware of any information that would have caused us to determine a different amount had we known about it during our planning.

Our assessment, at the planning stage, of materiality for the year ended 31 March 2025 was calculated as follows.

	Group £'000	Trust £'000	Explanation
Overall materiality for the financial statements	6,244	6,070	Our initial assessment is based on approximately 1.65% of gross expenditure for the Group and 1.60% of gross expenditure for the Trust as disclosed in the 2023/24 audited annual report and accounts. We consider this to be the principal consideration for the users of the financial statements when assessing financial performance of the Group and Trust. The financial statements are considered to be materially misstated where total errors exceed this value.
Performance materiality	4,058	3,950	65% of materiality (adjusted to take into account the Trust component materiality allocation for the group accounts) Performance materiality is the working level of materiality used throughout the audit. We use performance materiality to determine the nature, timing and extent of audit procedures carried out. We perform audit procedures on all transactions, or groups of transactions, and balances that exceed our performance materiality. This means that we perform a greater level of testing on the areas deemed to be at significant risk of material misstatement. Performance materiality is set at a value less than overall materiality for the financial statements as a whole to reduce to an appropriately low level the probability that the aggregate of the uncorrected and undetected misstatements exceed overall materiality.

Appendix I: Materiality (continued)

	Group £'000	Trust £'000	Explanation
Trivial threshold	300	299	5% of overall materiality for the Trust and Group. Trivial misstatements are matters that are clearly inconsequential, whether taken individually or in aggregate and whether judged by any quantitative or qualitative criteria. Individual errors above this threshold are communicated to those charged with governance.

In addition to the above, we consider any areas for specific lower materiality. We have determined that no specific materiality levels need to be set for this audit.

Appendix II: Group audit scope and risk assessment

As Group auditor under ISA (UK) 600 (Revised September 2022) we are required to obtain sufficient appropriate audit evidence regarding the financial information of the components and the consolidation process to express an opinion on whether the group financial statements are prepared, in all material respects, in accordance with the applicable financial reporting framework.

The auditing standard for group engagements has been revised, as a result the key changes that you may see reflected in the audit plan are:

- Revisions to the definitions of a group and component extend the scope of the ISA to encompass a wider range of group scenarios. This means that a single legal entity could fall under the scope of the group's ISA based on its internal structure, while multiple legal entities may sometimes be defined as a single component;
- There is increased leadership responsibilities and involvement requirements for the group engagement leader, particularly when component auditors are utilised;
- There is a specific requirement for all component auditors to confirm their ability and willingness to comply with the FRC's Ethical Standard;
- The analytical/desktop review designation has been removed from the scope of procedures performed over a component in response to risk.

Group audit scope

The Group consists of the following entities:

Component	Nature and extent of further audit procedures	Planned audit approach
South Central Ambulance Service NHS Foundation Trust	Full Scope	Full scope statutory audit, as set out in this audit plan.
South Central Fleet Services Limited	Specific Scope	Specific scope procedures to be performed by the Group engagement team.
South Central Ambulance Charity	None	No procedures planned.

Full Scope Design and perform further audit procedures on the entire financial information of the component.
Specific Scope Design and perform further audit procedures on one or more classes of transactions, account balances or disclosures.
None No further audit procedures required.

Appendix II: Group audit scope and risk assessment (continued)

Risks at the component-level

The risks identified at the Trust are set out in this external audit plan. There are no other risks identified in any of the other components above in respect of the Group audit.

Note that a component may require a statutory audit under UK or overseas company law irrespective of whether an audit is required for group reporting purposes. Management should therefore satisfy themselves that all UK and overseas company law requirements are adhered to on a company-by-company basis.

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Upward Report of the Charitable Funds Committee

Date Meeting met **10 March 2025**
Chair of Meeting **Keith Willett**
Reporting to **Trust Board**

Items	Issue	Action Owner	Action
Points for escalation			
Volunteer DRV Fleet	The CFC discussed the current vehicle leases for CFRs which will end in July. We have 40 vehicles on this lease scheme. An additional 7 vehicles are also in use by CFRs, 6 of which are owned by the Trust and another lease vehicle which will end in 2028. The CFC discussed the paper presented and will recommend the way forward to the full board meeting for final decision.	Charity CEO	Decision Paper to be discussed at the private March Board meeting
Key issues and / or Business matters to raise			
Charity Budget for 2025-2026	The CFC discussed and agreed the Charity budget for next year. The budget again again see a deficit end of year position which will further erode the Charity's unrestricted reserves. The reserves will however, be maintained at c£500k but continued deficit budgets cannot be maintained.	Charity CEO	KPIs to be set and reported on at CFC meetings. Clear guidance on what the Charity aims to support to be provided.

Areas of concern and / or Risks			
Economic climate and fundraising	The CFC is aware of the impact of the economic climate on fundraising and all charities. Concern was however raised around the continued deficit budget position. This will be carefully monitored over the next year and a 5 year financial report is being prepared.	Charity CEO	Base line costs to be prepared along with strategic recruitment of volunteers, monitoring the number and location of volunteer recruitment.
Items for information and / or awareness			
None	None	-	-
Best Practice and / or Excellence			
None	-	-	-
Compliance with Terms of Reference			
Policies approved*			
None	-	-	-

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

Author: Vanessa Casey

Title: Charity CEO

Date: 12/3/25

NHS
South Central Ambulance Service
NHS Foundation Trust

Trust Public Board
27th March 2025

Report title	Freedom to Speak Up Policy - updated
Agenda item	19
Report executive owner	Natasha Dymond, Interim Director of People
Report author	Christine McParland, Freedom To Speak Up Guardian
Governance Pathway: Previous consideration	People and Culture Development Group People Policy Refresh Group Executive Management Committee
Governance Pathway: Next steps	Publish Policy on the Trust Intranet site.

Executive Summary

The FTSU policy, which was put in place as per national deadlines and published in January 2024; the policy required a review in January 2025. The updates include :

- a refresh of the CEO's introduction, and the
- Management Template has been updated.

Previously, SCAS inputted in a number of ways into the national policy consultation

The national policy has been written based on feedback from a range of stakeholders and and to be as accessible as possible, we also sought advice and input from peers in the South East Guardian Network (circa 260 members) and the AACE FTSU National Ambulance Network.

Alignment with Strategic Objectives

With which strategic theme(s) does the subject matter align? All strategic Themes

Relevant Business Assurance Framework (BAF) Risk
To which BAF risk is the subject matter relevant? SR7 - Staff Feeling Unsafe, Undervalued and Unsupported

Financial Validation	N/A

Recommendation(s)
What is the Committee/Board asked to do: Please amend as appropriate. The following is intended as a guide only. • Note the updated FTSU Policy and take assurance from it

For Assurance	✓	**For decision**		**For discussion**		**To note**	✓

SCAS FREEDOM TO SPEAK UP POLICY

Version 5.3 (for ratification) January 2025

Equality and Health Inequalities Statement

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

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

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

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

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

Contents

DOCUMENT INFORMATION

Author: Christine McParland, Freedom to Speak Up Guardian

Ratifying Committee/Group: EMC, PACC & JNCC

Date of ratification: 25th January 2024

Date of Issue: January 2024

Revision date : 3rd January 2025

Version: 5.3

A MESSAGE FROM DAVID ELTRINGHAM, CHIEF EXECUTIVE OFFICER

Your voice matters.

At South Central Ambulance Service NHS Trust (SCAS) we're committed to creating a workplace where everyone feels safe, heard, and empowered to speak up.

This Speak Up policy is a cornerstone of that commitment, and I'm proud to introduce it to you.

Speaking up can sometimes feel difficult or intimidating. However, it's a vital act of courage that can make a real difference. A culture of openness and transparency is not just about doing what's right; it's essential to our success. By speaking up when something doesn't feel right, you're directly contributing to a safer environment for our patients, a more supportive workplace for your colleagues, and ultimately, a stronger organization.

When you raise a concern, you deserve to be heard. We are committed to ensuring that every concern is listened to carefully, taken seriously, and acted upon appropriately. We will also learn from each experience, sharing those lessons to prevent similar issues in the future.

I encourage you to read this policy carefully and embrace its principles in your daily work. Your active participation is crucial. If you see something, say something.

Together, we can build a workplace where everyone feels safe to speak up, confident that their voice will be heard, and assured that their concerns will be addressed.

Best wishes

David

David Eltringham
Chief Executive Officer

1. SPEAK UP – WE WILL LISTEN

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

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

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

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

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

2. THIS POLICY

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

3. WHAT CAN I SPEAK UP ABOUT?

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

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

4. WE WANT YOU TO FEEL SAFE TO SPEAK UP

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

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

5. WHO CAN SPEAK UP?

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

6. WHO CAN I SPEAK UP TO?

Speaking up internally

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

However, you have other options in terms of who you can speak up to, depending on what feels most appropriate to you.

- Our Freedom to Speak Up Champions who are located throughout the Trust and are there to listen and guide you also. Use this link to find your nearest Champion Freedom To Speak up! - Home

  You can apply to be a Champion by emailing ftsuchampions@scas.nhs.uk

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

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

- Local counter fraud team (where concerns relate to fraud) Heather.Greenhowe@rsmuk.com

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

- Our HR team : Phillip Smith, Assistant Director of HR Operations

- Our Executive Lead responsible for Freedom to Speak Up is Natasha Dymond, Interim Director of People - who provides senior support for our speaking-up guardians and is responsible for reviewing the effectiveness of our FTSU arrangements.

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

Speaking up externally

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

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

- NHS England for concerns about:

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

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

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

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

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

Appendix B contains information about making a 'protected disclosure'.

How should I speak up?

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

Confidentiality

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

You have a choice about how you speak up:

- **Openly:** you are happy that the person you speak up to knows your identity and that they can share this with anyone else involved in responding.

- **Confidentially:** you are happy to reveal your identity to the person you choose to speak up to on the condition that they will not share this without your consent.

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

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

7. ADVICE AND SUPPORT

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

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

- Support available for our NHS people.

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

    - NHS England has a Speak Up Support Scheme that you can apply to for support. You can also contact the following organisations:
    - Speak Up Direct provides free, independent, confidential advice on the speaking up process.

    - The charity Protect provides confidential and legal advice on speaking up.

    - The Trades Union Congress provides information on how to join a trade union.

    - The Law Society may be able to point you to other sources of advice and support.

    - The Advisory, Conciliation and Arbitration Service gives advice

and assistance, including on early conciliation regarding employment disputes.

8. WHAT WILL WE DO?

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

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

Resolution and investigation

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

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

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

Communicating with you

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

How we learn from your speaking up

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

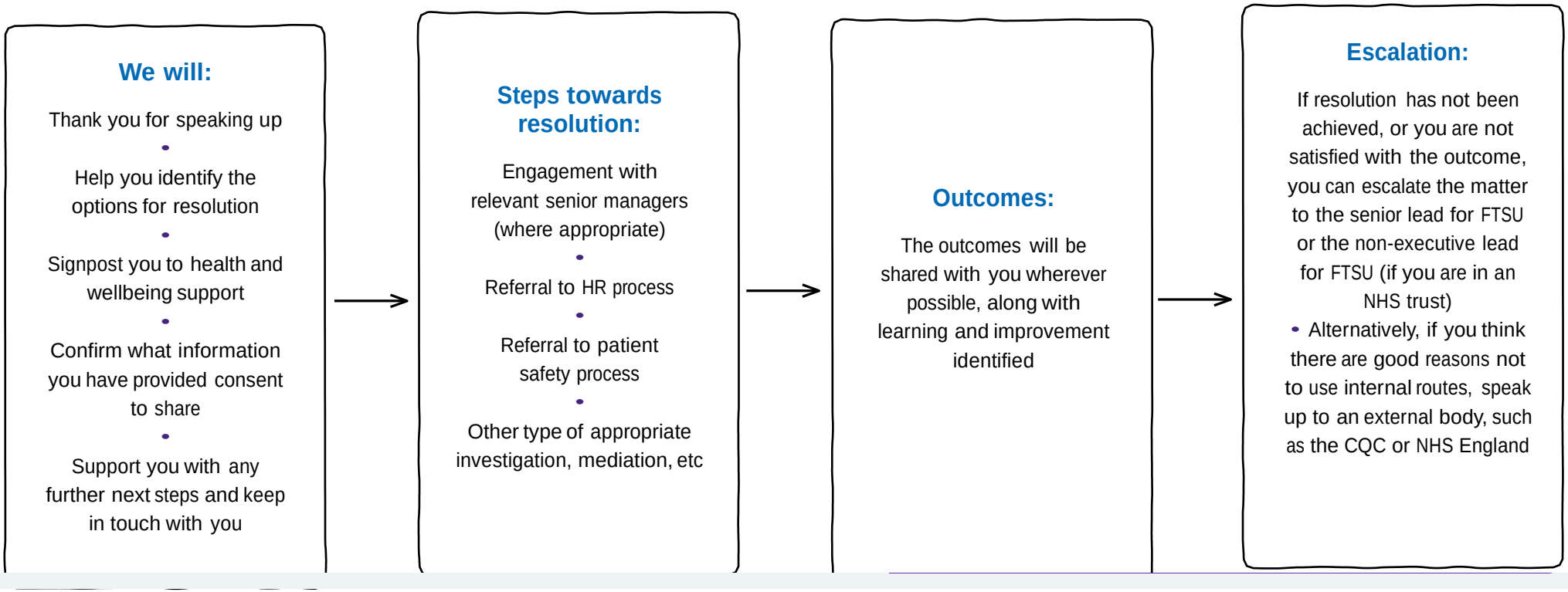
Review

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

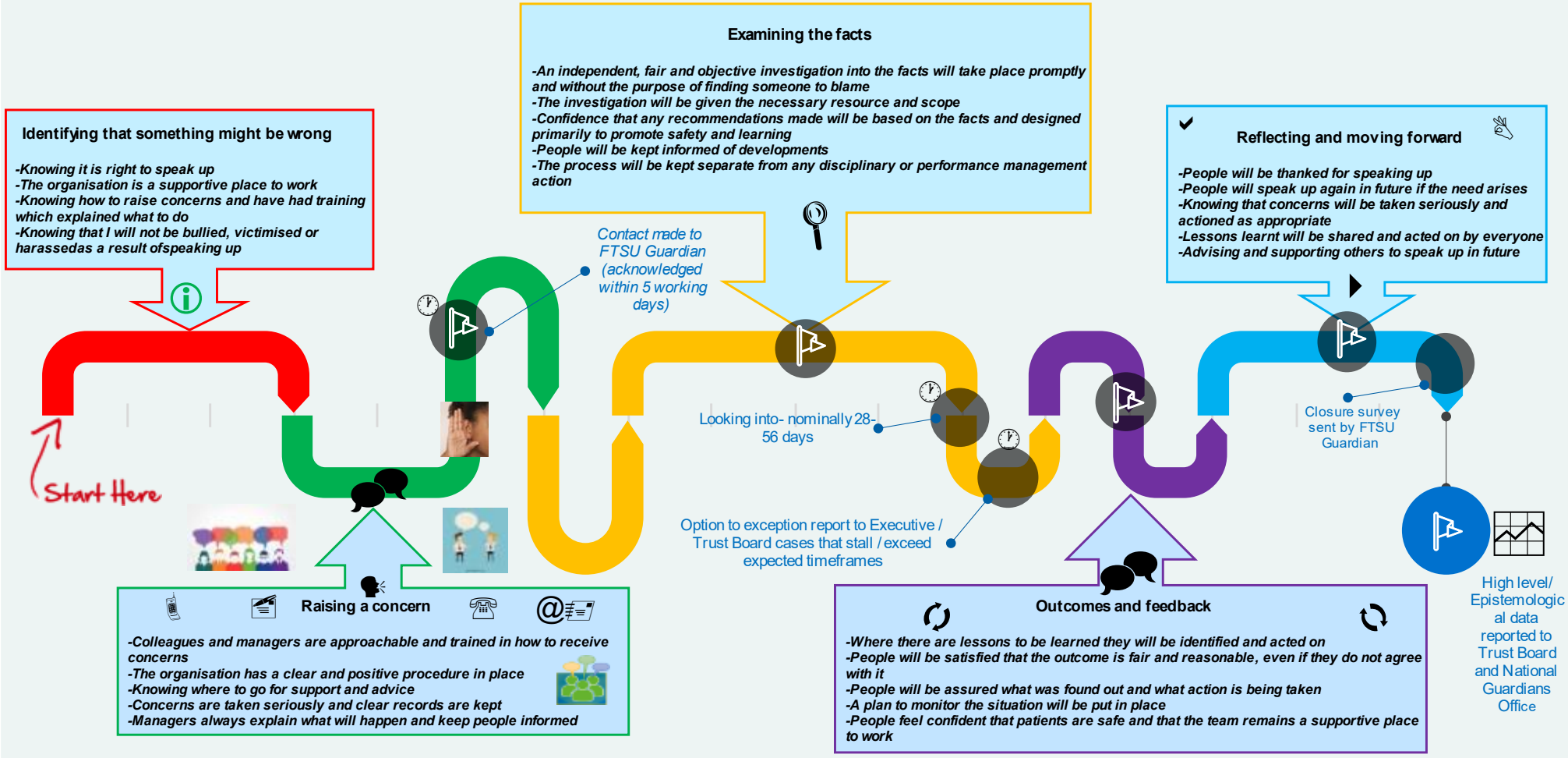
Senior leaders' oversight

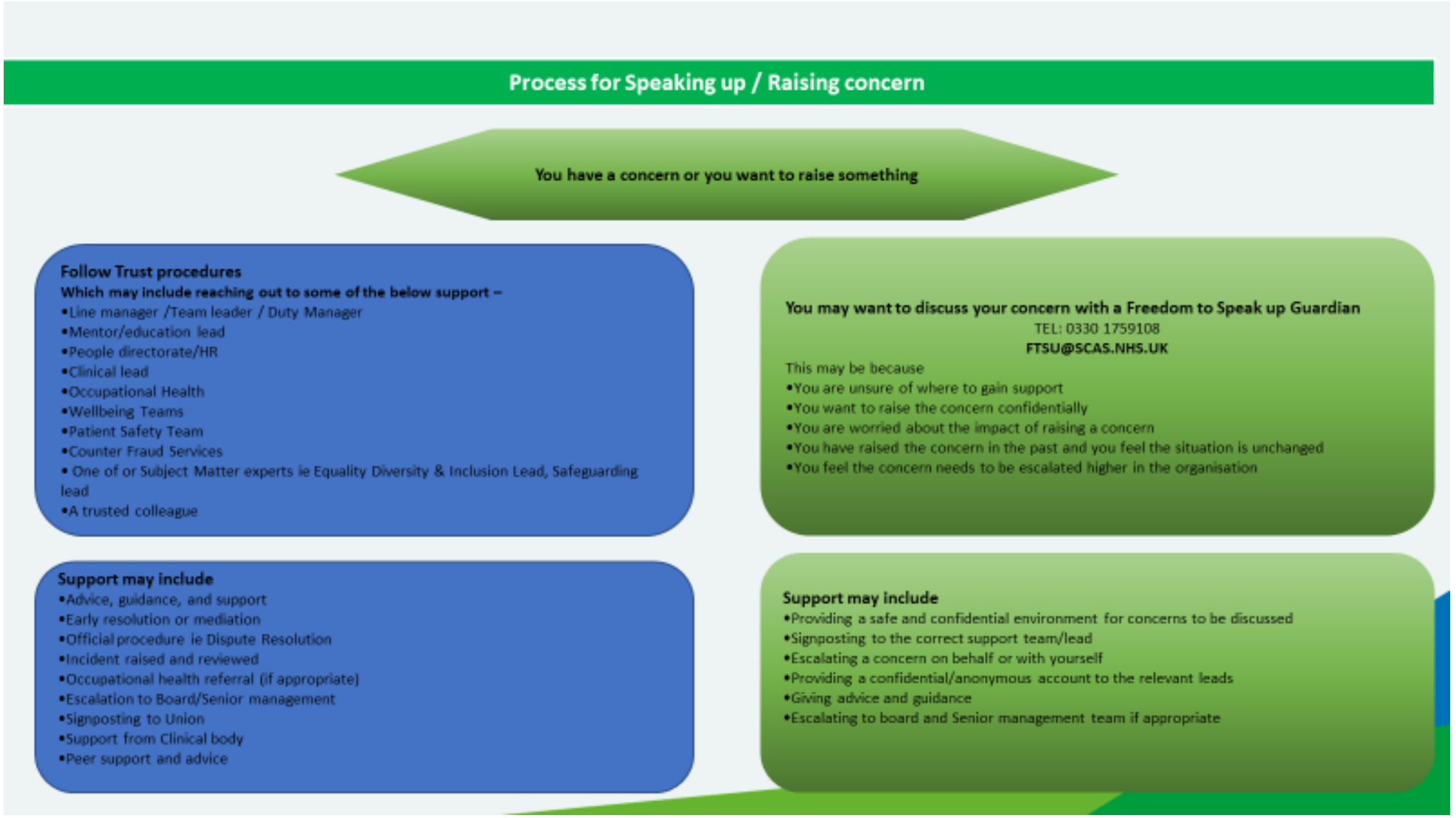
Our most senior leaders will receive a report at least annually providing a thematic overview of speaking up by our staff to our FTSU guardian(s).

APPENDIX A: WHAT WILL HAPPEN WHEN I SPEAK UP?



The roadmap for people raising and listening to a FTSU concern in SCAS




Process for Speaking up / Raising concern
You have a concern or you want to raise something
Follow Trust procedures
Which may include reaching out to some of the below support –
•Line manager /Team leader / Duty Manager
•Mentor/education lead
•People directorate/HR
•Clinical lead
•Occupational Health
•Wellbeing Teams
•Patient Safety Team
•Counter Fraud Services
• One of or Subject Matter experts ie Equality Diversity & Inclusion Lead, Safeguarding lead
•A trusted colleague
You may want to discuss your concern with a Freedom to Speak up Guardian
TEL: 0330 1759108
FTSU@SCAS.NHS.UK
This may be because
•You are unsure of where to gain support
•You want to raise the concern confidentially
•You are worried about the impact of raising a concern
•You have raised the concern in the past and you feel the situation is unchanged
•You feel the concern needs to be escalated higher in the organisation
Support may include
•Advice, guidance, and support
•Early resolution or mediation
•Official procedure ie Dispute Resolution
•Incident raised and reviewed
•Occupational health referral (if appropriate)
•Escalation to Board/Senior management
•Signposting to Union
•Support from Clinical body
•Peer support and advice
Support may include
•Providing a safe and confidential environment for concerns to be discussed
•Signposting to the correct support team/lead
•Escalating a concern on behalf or with yourself
•Providing a confidential/anonymous account to the relevant leads
•Giving advice and guidance
•Escalating to board and Senior management team if appropriate

APPENDIX B: MAKING A PROTECTED DISCLOSURE

Making a 'protected disclosure'

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

APPENDIX C: MANAGERS GUIDANCE

FREEDOM TO SPEAK UP MANAGERS / LEADERS CASE TEMPLATE

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

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

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

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

<table>
<tr><td></td><td colspan="2">FTSU CASE TEMPLATE (completed by FTSU Team)</td></tr>
<tr><td></td><td colspan="2">DETAILS OF MATTERS RAISED</td></tr>
<tr><td>FTSU Case Reference</td><td></td><td>Date sent:</td></tr>
<tr><td>FTSU Guardian</td><td colspan="2"></td></tr>
<tr><td>Service / Department Concern relates to :</td><td colspan="2"></td></tr>
<tr><td>Line Manager / Leader responsible for review/responding</td><td colspan="2"></td></tr>
<tr><td>Detail of concern provided</td><td colspan="2"></td></tr>
<tr><td>The Concern is relating to :</td><td colspan="2"><table>
<tr><td></td><td>Something that has / did go wrong</td></tr>
<tr><td></td><td>Something that might go wrong</td></tr>
<tr><td></td><td>Something that is good but could be better</td></tr>
</table></td></tr>
<tr><td>Have they spoken to their Line Manager</td><td colspan="2"><table>
<tr><td>Yes</td><td>What led them to coming to FTSU ?</td></tr>
<tr><td>No</td><td>What barriers are there ?</td></tr>
<tr><td></td><td></td></tr>
</table></td></tr>
<tr><td>What is their perception of speaking up ?

How do they feel ?</td><td colspan="2"></td></tr>
</table>

<table>
<tr><td></td><td></td></tr>
<tr><td>Desired action and resolution</td><td></td></tr>
<tr><td>The level of confidentiality agreed is…</td><td>
<table>
<tr><td>Open</td><td>Happy for their identity to be known to the FTSU Team and the Manager reviewing/responding and resolving the matter</td></tr>
<tr><td>Confidential</td><td>Identity only known to FTSU Team</td></tr>
<tr><td>Anonymous</td><td>Identity not known to FTSU Team</td></tr>
</table>
</td></tr>
<tr><td>Contact details of individual(s) (if consent given):</td><td>Please directly acknowledge receipt of the concern with the person who has raised it. We advise that arranging to have a conversation with the person helps to reduce mis-understandings, and in the majority of cases helps to resolve their concern quickly.</td></tr>
</table>

ACTION PLAN (to be completed by manager)

A FTSU concern is an opportunity for the Senior Lead/Line Manager to review the issues with curiosity;

We take the concerns raised at face value and do ask the concernee if they have approached their Line Manager. We would recommend that if the person has shared their name, that you take the opportunity to have a chat with them to understand the detail behind the brief outline we have given here, and to have a non-judgemental and open approach. Please be mindful of this before forwarding on the template to a member of your team to review.

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

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

FEEDBACK / LESSONS LEARNED

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

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

Please complete the sections below and return to the Freedom to Speak Up Guardian

What changes have been made as a result?	
What lessons have been learnt?	
How will you ensure learning is embedded and shared?	
What learning is transferable across the organisation and how will you share this?	
What information will be fed back to the person speaking up?	

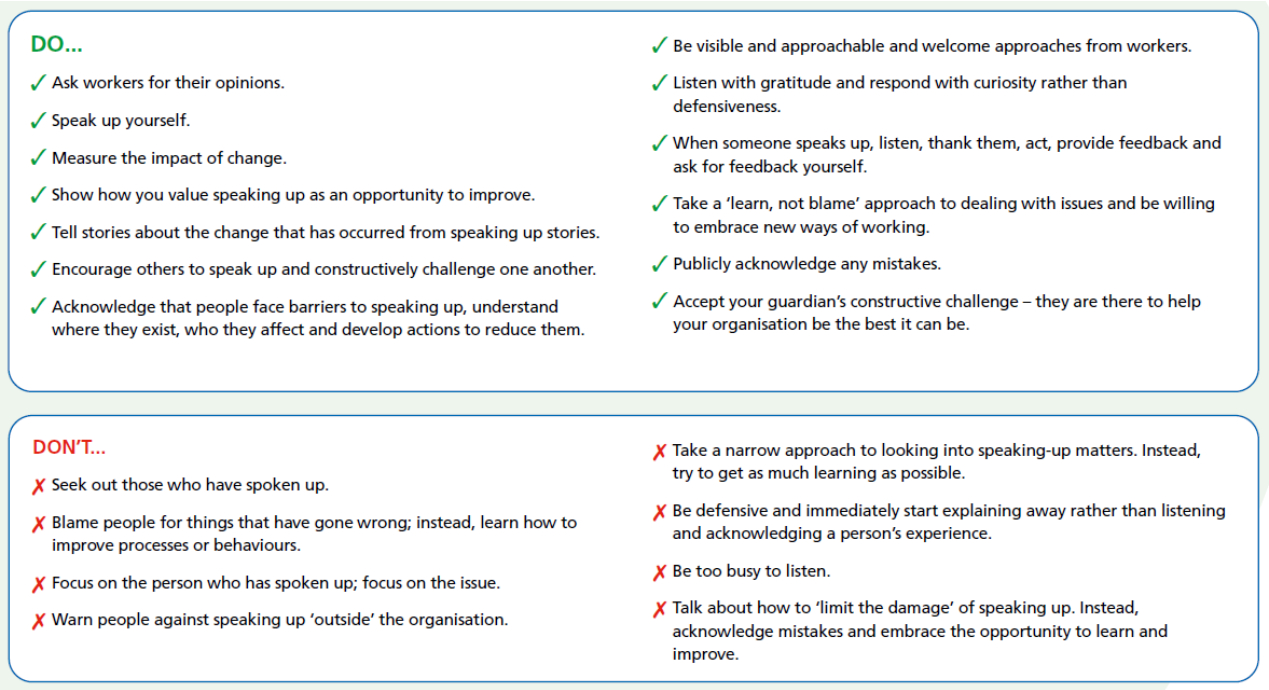
Is there any feedback that you would like to give the FTSU Team, either for reflection or for wider learning?	

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

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

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

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



DO...

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

DON'T...

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

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

APPENDIX D: DETRIMENT

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

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

Introduction

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

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

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

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

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

Guiding Principles

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

- We will keep colleagues informed and updated throughout the process

What we mean by disadvantageous /demeaning treatment

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

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

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

Responsibilities

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

As individuals we share a responsibility to:

- create a psychologically safe environment where speaking, listening and following up is business as usual
- treat our colleagues well when they speak up
- speak up and be an ally when we witness disadvantageous and/or demeaning treatment
- listen up and learn from speaking up

As an organisation we have a responsibility to:

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

Recording

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

What to do

Route 1 .

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

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

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

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

Manager to inform FTSU Guardian

Issue reported to FTSU Guardian

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

Within 72 hours
or immediately if significant risks identified

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

*(*delete/amend as appropriate)*

- Consider if any immediate action is required to protect the worker from disadvantageous or demeaning treatment. *(particularly important in the case of perceived bullying and/or harassment)*
- Consider any potential patient safety issues and immediate action required
- Receive assurance line management arrangements are in place to support anyone who might be affected
- With consent
-

Follow your organisations speak up process

In line with Speak Up Process:

- Clarify matters of confidentiality
- Not guradian Tor set by those investigating
  Agree how and what to be explored (terms of reference), and timescales for completion
- Identify independent lead for any review/investigation
- Agree arrangements for monitoring and feedback
- Share and record key actions, outcomes, learning and recommendations.
- Share wider learning across the organisation
- consider signposting the worker to NHS England's Speaking Up Support Scheme

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

NHS
South Central Ambulance Service
NHS Foundation Trust

Trust Board of Directors Meeting in Public
27th March 2025

Report title	Freedom to Speak Up Reflection and Planning Tool : Self Assessment : annual review 2025
Agenda item	20
Report executive owner	Natasha Dymond, Interim Director of people
Report author	Christine McParland, Lead FTSU Guardian
Governance Pathway: Previous consideration	People and Culture Development Group Executive Management Committee People and Culture Committee
Governance Pathway: Next steps	Next steps are to implement feedback sessions with the relevant senior leads; provide specific survey questions to the Board, to include in the updated assessment

Executive Summary

The FTSU (Freedom to Speak Up) Self Assessment tool, was first completed in 2022 and submitted to P&CC in January 2023.

NHS England and the NGO recommend that the senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

:

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

Alignment with Strategic Objectives
With which strategic theme(s) does the subject matter align? All strategic Themes

Relevant Business Assurance Framework (BAF) Risk
To which BAF risk is the subject matter relevant? All BAF Risks

Financial Validation	NA

Recommendation(s)
What is the Group/Committee/Board asked to do: • To note the self assessment and support the proposed next steps

For Assurance	**x**	**For decision**		**For discussion**		**To note**	**x**

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1. Background / Introduction

In 2022 NHSE updated its FTSU board self-assessment tool kit.

The FTSU Lead Guardian completed the self-assessment in 2022/23 which was previously submitted to PACC in January 2023. It was requested at the time that, with support from our FTSU Guardian, and following NHSE guidance, the senior lead for FTSU in the organisation should take responsibility for completing the reflection tool and to review the self-assessment after 2 years.

The purpose of this paper is to provide an update on progress made to date., and to note that the self-assessment is now due a 2 year review.

The guide, and the accompanying self-reflection tool*, will help us to:

- ✓ build a culture and behaviours that is responsive to feedback from workers
- ✓ ensure that our organisation focuses on learning, to continuously improve quality of care and the experience of staff, patients and service users alike
- ✓ improve staff survey scores and other worker experience metrics
- ✓ demonstrate to regulators or inspectors the work we are doing to develop our speaking, listening and following-up arrangements

The Trust Board is asked to note and support this self-review process.

2. Detail

The updated report is attached; however please note that with the absence of some key roles, that the FTSU team have input updates, however some sections will require further review and input in due course.

Our next steps are to implement feedback sessions with the relevant senior leads; provide specific survey questions to the Board, to include in the updated assessment.

3. Quality Impact

Does the action [or decision not to act] have an impact on patient safety, patient experience or clinical effectiveness?

- Yes – in order to have a robust and supported speaking, listening and follow up culture within the Trust, led by the Senior Team

4. Financial Impact

Does the required action [or decision not to act] have a financial impact and can this be quantified?

- No

5. Risk and compliance impact

:

5.1 What is the risk to the trust if the recommended course of action is not taken? Risk may impact CQC transition criteria

5.2 Does it relate to any of the existing risks on the risk register (in addition to the BAF)? No

5.3 Does the decision relate to a regulatory requirement or another form of compliance? No

6. Equality, diversity and inclusion impact

Is there any impact to a particular group of individuals?

- No

7. Next steps

Next steps are to implement feedback sessions with the relevant senior leads; provide specific survey questions to the Board, to include in the updated assessment

8. Recommendation(s)

The Trust Board are invited to note progress to date and to support the self-review now due

9. Appendices

9.1 Background to original self-assessment (below)

9.2 FTSU Self Assessment updated to December 2024 (separate document)

:

Appendix 9.1

Background and Links to Previous Papers and initial scoring

For this new process there are **Two** key documents**:** ***"A guide for leaders in the NHS and organisations delivering NHS services"*** plus the ***"Freedom to Speak up: A reflection and planning tool"****

Document one; *Guide for leaders in the NHS*… has two parts:

Part 1 (Guidance for leaders):

This is the main guidance with each section covering the eight principles for leaders and managers which are the fundamentals of a healthy speaking-up culture. Sets out the transactional information that you need to carry out the Freedom to Speak Up process.

Part 2 (Building widespread cultural change) this shows how speaking *(& listening and following)* up sits within the wider context and has 7 elements;

1- Carry out wider cultural improvement

2- Compassionate, inclusive leadership

3- Just and learning culture

4- Worker voice

5- Equality, diversity and inclusion

6- Civility and respect

7- Health and wellbeing

Document two, the *Freedom to Speak up: A summary of the reflection and planning tool* has three stages (please see illustration 1 below)

Using document two, the FTSU Guardian has undertaken a first review of scoring to aide discussions and priorities (see tables below) but as the process defines, this 'first pass' will need to be reviewed by our various roles, leads and SME's in the organisation

Due to the nature and timelines given this is intended to be a 'live' assessment piece rather than a 'tick box' in a defined window of time.

The NHSE scoring system for this is:

5	confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)
4	an evidenced strength (e.g., through data, feedback) and a strength to build on
3	generally applying this well, but aware of room for improvement or gaps in knowledge/approach
2	concern or risk which warrants discussion to evaluate and consider options
1	significant concern or risk which requires addressing within weeks

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Illustration 1

Stage 1	Stage 2	Stage 3
Review our Freedom to Speak Up arrangements against the guide	Summarise our high-level development actions for the next **6 – 24** months	Summary of areas of strength to share and promote
Sets out statements for reflection under the **eight** principles outlined in the guide. It is designed for people in our organisation's board and senior leadership team to mark the statements to review our position and indicate the current situation. **People will need to**: ✓ Summarise evidence to support their score. ✓ Enter any high-level actions for improvement **(we will bring these together in Stage 2).** ✓ Make a note of any areas we score 5 in and how we can promote this good practice **(we will bring these together in Stage 3).**	Summarising the high-level actions we will take over the next 6–24 months to develop our Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning. **The organisation will need to identify:** ✓ Development areas to address in the next 6–12 months ✓ Target date ✓ Action owner *We can work through the sections from start to finish or*	Summarise the high-level actions you need to take to share and promote your strengths. This will enable others in your organisation and the wider system to learn from you. **The organisation will need to identify:** ✓ High-level actions needed to share and promote areas of strength (focus on scores 4 and 5) ✓ Target date ✓ Action owner

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	focus on areas of highest need for our organisation	

Month 1-> -> -> ->-> -> -> -> -> Months 6 to Month 24-> -> -> ->-> -> -> -> -> - > ->-

Initial scoring tables

	a) Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score
Principle 1: Value speaking up **For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.**	*i. I am knowledgeable about Freedom to Speak Up*	5
	ii. I have led a review of our speaking-up arrangements at least every two years	5
	iii. I am assured that our guardian(s) was recruited through fair and open competition	5
	iv. I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	3
	v. I am regularly briefed by our guardian(s)	4
	vi. I provide effective support to our guardian(s)	3
	a) Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	**Score**
	i. I am knowledgeable about Freedom to Speak Up	5
	ii. I am confident that the board displays behaviours that help, rather than hinder, speaking up	5

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	iii. I effectively monitor progress in board-level engagement with the speaking-up agenda	5
	iv. I challenge the board to develop and improve its speaking-up arrangements	5
	v. I am confident that our guardian(s) is recruited through an open selection process	5
	vi. I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	3
	vii. I am involved in overseeing investigations that relate to the board	2
	viii. I provide effective support to our guardian(s)	5

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture **Role-modelling by leaders is essential to set the cultural tone of the organisation.**	***a) Statements for senior leaders***	**Score**
	i. The whole leadership team has bought into Freedom to Speak Up	4
	ii. We regularly and clearly articulate our vision for speaking up	3
	iii. We can evidence how we demonstrate that we welcome speaking up	3
	iv. We can evidence how we have communicated that we will not accept detriment	2
	v. We are confident that we have clear processes for identifying and addressing detriment	2
	vi. We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	3
	vii. We regular discuss speaking-up matters in detail	3
	b) Statements for the person responsible for organisational development	**Score**
	i. I am knowledgeable about Freedom to Speak Up	5
	ii. We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	3

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	iii. We have adapted our organisational culture so that it becomes a just and learning culture for our workers	2
	iv. We support our guardian(s) to make effective links with our staff networks	3
	v. We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	3
	c) Statements about how much time the guardian(s) has to carry out their role	**Score**
	i. We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	3
	ii. We have reviewed the ringfenced time our Guardian has in light of any significant events	4
	iii. The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	4
	iv. We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	3
Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so **Regular, clear and inspiring communication**	***a) Statements about your speaking-up policy***	**Score**
	i. Our organisation's speaking-up policy reflects the 2022 update	2
	ii. We can evidence that our staff know how to find the speaking-up policy	3
	b) Statements about how speaking up is promoted	**Score**
	i. We have used clear and effective communications to publicise our guardian(s)	3
	ii. We have an annual plan to raise the profile of Freedom to Speak Up	2
	iii. We tell positive stories about speaking up and the changes it can bring	2

:

is an essential part of making a speaking-up culture a reality.	*iv. We measure the effectiveness of our communications strategy for Freedom to Speak Up*	2

Principle 4: When someone speaks up, thank them, listen and follow up **Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.**	***a) Statements about training***	**Score ***
	i. We have mandated the National Guardian's Office and Health Education England training	2
	ii. Freedom to Speak Up features in the corporate induction as well as local team-based inductions	4
	iii. Our HR and OD teams measure the impact of speaking-up training	3
	b) Statements about support for managers within teams or directorates	**Score**
	i. We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	3
	ii. All managers and senior leaders have received training on Freedom to Speak Up	2
	iii. We have enabled managers to respond to speaking-up matters in a timely way	2
	iv. We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	3

Principle 5: Use speaking up as an opportunity to learn and improve	***a) Statements about triangulation***	**Score**
	i. We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	2
	ii. We use triangulated data to inform our overall cultural and safety improvement programmes	3

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The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.	***b) Statements about learning for improvement***	**Score**
	i. We regularly identify good practice from others – for example, through self-assessment or gap analysis	5
	ii. We use this information to add to our Freedom to Speak Up improvement plan	4
	iii. We share the good practice we have generated both internally and externally to enable others to learn	3

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements	***a) Statements about how our guardian(s) was appointed***	**Score**
	i. Our guardian(s) was appointed in a fair and transparent way	5
	ii. Our guardian(s) has been trained and registered with the National Guardian Office	5
	b) Statements about the way we support our guardian(s)	**Score**
	i. Our guardian(s) has performance and development objectives in place	4
	ii. Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	5
	iii. Our guardian(s) has access to a confidential source of emotional support or supervision	2
	iv. There is an effective plan in place to cover the guardian's absence	4
	v. Our guardian(s) provides data quarterly to the National Guardian's Office	4
	c) Statements about our speaking up process	**Score**
	i. Our speaking-up case-handling procedures are documented	5

:

	ii. We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	3
	iii. We are assured that confidentiality is maintained effectively	5
	iv. We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	2
	v. We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	2

Principle 7: Identify and tackle barriers to speaking up However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.	***a) Statements about barriers***	**Score**
	i. We have identified the barriers that exist for people in our organisation	4
	ii. We know who isn't speaking up and why	3
	iii. We are confident that our Freedom to Speak Up champions are clear on their role	2
	iv. We have evaluated the impact of actions taken to reduce barriers?	3

	a) Statements about your speaking-up strategy	**Score**

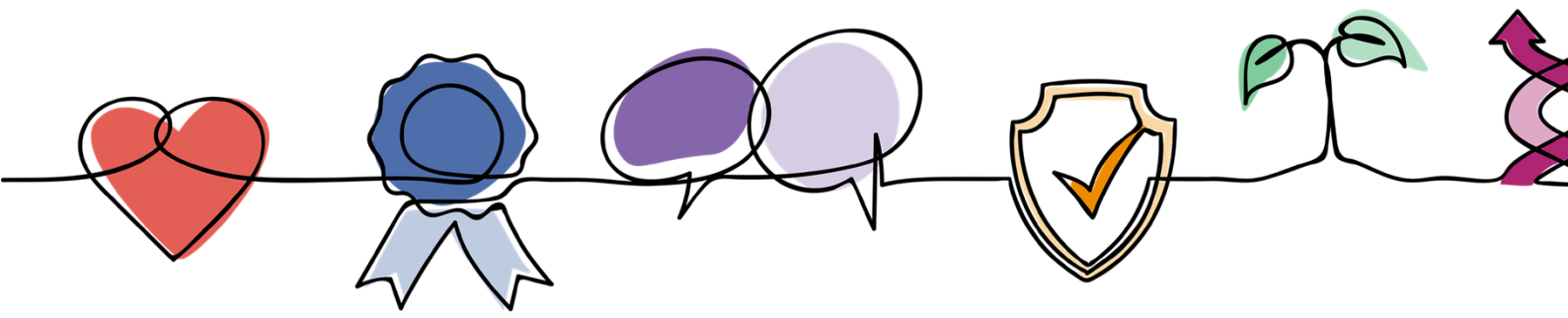
:

Principle 8: Continually improve our speaking up culture **Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.**	*i. We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture*	4
	ii. We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	5
	iii. We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	3
	iv. Our improvement plan is up to date and on track	3
	b) Statements about evaluating speaking-up arrangements	**Score**
	i. We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	4
	ii. Our plan follows a recognised 'plan, do, study, act' or other quality improvement approach	4
	iii. Our speaking-up arrangements have been evaluated within the last two years	5
	c) Statements about assurance	**Score**
	i. We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	4
	ii. We have we evaluated the content of our guardian report against the suggestions in the guide	5
	iii. Our guardian(s) provides us with a report in person at least twice a year	5
	iv. We receive a variety of assurance that relates to speaking up	4
	v. We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	3

National Guardian
Freedom to Speak Up

Freedom to Speak up

A reflection and planning tool



Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable othersin your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

1 = significant concern or risk which requires addressing within weeks
2 = concern or risk which warrants discussion to evaluate and consider options
3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach
4 = an evidenced strength (e.g., through data, feedback) and a strength to build on
5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

*NB-colours aligned across all documents during this 2023/2024 Q3 review

- Summarise evidence to support your score.
- Enter any high-level actions for improvement (you will bring these together in Stage 2).
- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

a) Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no	Update Dec 23	Update Dec 24
i. I am knowledgeable about Freedom to Speak Up	5		2. Senior Lead left Trust Sept 2024. Team moving to Deputy CEO to be appointed
ii. I have led a review of our speaking-up arrangements at least every two years	5		4 BDO audit completed Dec 2024
iii. I am assured that our guardian(s) was recruited through fair and open competition	5	3 No change, BC underway to substantiate	5 recruited to national guidelines
iv. I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	3	4	4
v. I am regularly briefed by our guardian(s)	5		5
vi. I provide effective support to our guardian(s)	3		3. Exec Lead on LTS. Senior Lead left the Trust

Enter summarised commentary to support your score.

i. **Score 2 – The drop in score** relates to the Executive Lead being on long term sickness absence from May 2024, and leaving the Trust in December 2024. The Senior Lead for FTSU (Assistant Director of OD) Left the Trust in September 2024. The FTSU team and function is currently being supported by the Interim Chief People Officer. The Corporate Review has confirmed that the FTSU Team will move under the direction of the Deputy CEO once in post, which will provide greater independence from Human Resources (HR), but also aligns it with Diversity & Inclusion (ED&I) and the leadership & cultural work. Although the FTSU Lead continues to prepare reports for EMC, P&CC and the Board, there has been a change in attendance in that FTSU are not invited in to the meetings to provide any further assurances and have not received feedback on the reports, themes and learning., and what work the Execs and Senior Team are doing to support the FTSU strategy., The flow of information from FTSU is up and out; however there is a lack of information flowing back in, unless sought out by the FTSU team.

ii. **Score 4** In Q1 22/23 NHSE published updated self-review guidance with a recommended 2 year window to complete, this was started it in Q3 22/23 and is ongoing. This reflection tool requires a review by the incoming senior lead for FTSU as the recommended two years is now due.
   - FTSU elearning modules on speaking, listening and following up mandated for all staff including Board members
   - National Guardian, Jayne Chidgey-Clark, delivered session at Board seminar on 27th April 2023
   - FTSU team attended board seminar August 2024

iii. **Score 5 –** The Trust has had a FTSU Lead in post since 2018; with 2 further FTSU Guardians recruited in November 2022 (1 x secondment, 1 x FTE) with the seconded post confirmed as substantive from April 2024. All positions were recruited to the permanent roles using a fair and open competitive process in accordance with the example job description and other guidance published by the National Guardian Office, NHSE/I, NHS Employers.

iv. **Score 4 –**The appointment of 2.0wte FTSU Guardian posts has substantially improved diversity, visibility, availability, capacity and resilience within the FTSU function. It has also allowed differentiation of tasks between the lead and deputy roles to ensure individual cases, governance and service development can each be given better attention. However, the FTSU process of speaking, listening and following up currently remains administratively time consuming, not least because NHSE/NGO guidance dictates it can only be done by a trained FTSU Guardian. Though much improved, capacity and resilience is still a risk for the team given FTSU case numbers are rising and can be expected to continue to do so, this is an area that requires focused planning

	and consideration including how we might continue with 3.0wte and ways to streamline and automate administrative tasks where possible. On review from other Trusts they recruit Guardians as volunteers who have substantive posts and provide them with protected time to work on cases, carry out proactive work.		
v.	**Score 5 –** FTSU has been part of the OD team, and although previously, we held fortnightly 1:1s and weekly team meetings focussing on both individual support and the FTSU work as an integral part of the OD agenda the level of support was affected due to change in OD leadership since September 2024. In relation to support and assistance with unblocking issues, the Team have leant into the Chair, CEO and CPO., who have been a vital link. We struggled to access the regular briefings to triangulate themes between FTSU cases and other sources of organisational intelligence (People Voice)., and instead held individual meetings to review data. We have since put in place meetings with Safeguarding, and Patient Safety teams; and we have requested a joint meeting with HR and Safeguarding to triangulate and review sexual safety case themes.		
vi.	**Score 3 –** as above, the FTSU Lead and deputies have regular and ad hoc meetings with the OD lead and wider OD team. Annual objectives have been agreed with the team in Q1 2023/24; 1:1s, PDRs and a mid-year refresh have all been booked with protected time for the coming year. Notwithstanding recent expansion and initial training, consideration is yet to be given to ongoing development for the current team as well as further career pathways and succession planning. As with all our people, the team has access to a full suite of Health & Wellbeing support., and since April 2024 has external supervision sessions in place individually and as a team, as the role is often isolating. The FTSU team is networked regionally and nationally.		
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)			

Item i (score 2)

- *Confirmation of who the Senior Lead and Executive Lead will be for the FTSU function*
- *Confirmation of the expectations of the reporting structure, oversight and embedding of FTSU across the Trust – e.g., attendance at Committees, Board, and group meetings;*

Item vi (score 3)

- *Objectives to be shared with Team impact of Chief People Officer on LTS, and Snr Lead leaving Trust. A continuous struggle to be 'included' in strategic work, eg culture and leadership piece; triangulation of data; FTSU "not needed" mind set; lack of understanding of FTSU ethos, just seen as processing cases and not for the wider proactive work of working together for a healthy speaking, listening and following up culture.*
- *Further development for the current team as well as ongoing career pathways and succession planning*

b) Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no	Update Dec 23	Update Dec 24
i. I am knowledgeable about Freedom to Speak Up	5		4
ii. I am confident that the board displays behaviours that help, rather than hinder, speaking up	4		3
iii. I effectively monitor progress in board-level engagement with the speaking-up agenda	4		4
iv. I challenge the board to develop and improve its speaking-up arrangements	5		Yes
v. I am confident that our guardian(s) is recruited through an open selection process	5		Yes

vi.	I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	3	3	4
vii.	I am involved in overseeing investigations that relate to the board	4		Yes
viii.	I provide effective support to our guardian(s)	4		Yes

Enter summarised evidence to support your score.

i) Score 5 – In 2023 the current NED FTSU lead took over from the Trust chair. He actively supports the FTSU function
ii) Score 3 – the FTSU Guardian is required to deliver a quarterly report to Trust Board and the People and Culture Committee (PACC) and has been invited to join the ED&I steering group. The FTSU Guardian has not regularly attended Board or P&CC in 2024/25
vii :Score 4 - Our flow charts and escalation processes clearly demonstrate that the non-Executive lead would be involved if concerns were raised about the Board or if other organisational concerns needed to be escalated beyond the Guardians or Exec Lead.
viii : Score 4 - The FTSU Guardians and NED lead meet regularly to ensure the Board remains informed on key themes raised

c) High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	d)	e)

Item ii (score 3)

- *Executive and Board development around trust, conflict and psychological safety which impact a speak up culture*

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

a) Statements for senior leaders	Score 1–5 or yes/no	Update Dec 23	Update Dec 24
i. The whole leadership team has bought into Freedom to Speak Up	3	4 In the professional level category chart below, it can be noted that the numbers of managers and team leaders raising concerns is increasing, this highlights the importance of these roles in fostering a Speaking, Listening and Following Up culture and how setting the tone for the organisation cannot be understated; role-modelling by leaders is essential to set the cultural tone of the organisation Best ever face to face support from Executive and Board members including- Trust Chair, CEO, CPO, CN, COO, AD OD, AD of Q, AD Commercial services and support from SME's including; ED&I lead, Research Team, IPC team, H&WB team. Regular KIT with CEO, Exec lead, NED lead, EMC and board attendance Staff webinar Staff matters articles Elearning completion	4 CEO supporting FTSU function by including information in Team Brief. CEO, Chair, NED and CPO (Interim) & Dir of Ops provide on-going support and regular catch ups FTSU continue to challenge the mindset of 'not needing FTSU'

ii.	We regularly and clearly articulate our vision for speaking up	3	3	3
iii.	We can evidence how we demonstrate that we welcome speaking up	3	4 In the professional level category chart below, it can be noted that the numbers of managers and team leaders raising concerns is increasing, this highlights the importance of these roles in fostering a Speaking, Listening and Following Up culture and how setting the tone for the organisation cannot be understated; role-modelling by leaders is essential to set the cultural tone of the organisation HY ted talk MS attends champs training 4 = an evidenced strength (e.g., through data, feedback) and a strength to build on	4 CEO includes FTSU info at Team Brief; request for shared calendar of Speak upulance to include in Exec diaries to support/attend. Regular meetings with Senior Leads to review cases and themes
iv.	We can evidence how we have communicated that we will not accept detriment	2	3- Appendix D in the new FTSU policy3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach	3 FTSU team using detriment risk assessment due to increase in cases where people state fear retaliation from speaking up

v.	We are confident that we have clear processes for identifying and addressing detriment	2	4- we based our work on the sought advice and input from peers in the South East Guardian Network (circa 260 members) and the AACE FTSU National Ambulance Network Also attached is the slide deck relating to detriment for background / information Ref Midlnads Region, SE region, Kark 2018, NHSE p43, SCAS policy	NGO published updated guidelines 2025.
vi.	We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	3	4 see above 4 = an evidenced strength (e.g., through data, feedback) and a strength to build on	4
vii.	We regular discuss speaking-up matters in detail	3	4 FTSU updates to EMC 4 = an evidenced strength (e.g., through data, feedback) and a strength to build on	4 with the CEO, Asst Dir of Ops With various Senior Leads at request of FTSU.

Enter summarised evidence to support your score.

i) ***Score 4 –*** *when a concern arises, the FTSU team pass it to the relevant senior lead to pursue. In the majority of cases, this has worked well and senior leaders have acted promptly to resolve the concern. The CEO has demonstrated good role modelling in publicly thanking people for speaking up and raising questions. We want to ensure this is replicated through all our leaders and that all senior leaders understand the importance and benefit of listening and following up.*

ii)	**Score 3 –** The published People Strategy prioritises speaking up and this is a key workstream in the improvement plan. Listening exercises were held in the autumn to invite people to speak up about what gets in the way of their best work – these were framed as being part of the speak up culture we wish to develop. Speaking up (which includes FTSU) is central to our work on People Voice and in ensuring the organisation hears frontline views and concerns. This work is ongoing and is not yet fully embedded.
iii)	**Score 4 -** Starting to happen. We have shared some 'you said we did' items (sexual safety) but need to do more on this including in clinical/patient safety examples. FTSU team working with Patient Safety and Safeguarding, and HR to triangulate data and provide feedback to the Execs.
iv)	**Score 3 –** the refreshed policy is clear and explicit on detriment. We now need a process to ensure the reality matches it.
v)	**Score 4 -** the refreshed policy is clear and explicit on detriment. We need a process / system to ensure reality matches it.
vi)	**Score 4 –** the FTSU questions in the annual staff survey are a benchmark for workforce confidence in speaking up. We monitor this closely every year in addition to other People Voice data., and FTSU survey data. Case closure surveys demonstrate satisfaction with the process, however, response rates are low though improving with renewed focus from the team and only capture reported FTSU cases not the wider workforce
vii)	**Score 4 -** FTSU is a standing agenda item at PACC and included in the EDI steering group. We do not yet have a specific FTSU steering group.

High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)		

Item ii (score 3)

- Continue to embed People Voice and FTSU as a specialist element within this – include FTSU within the working group reviewing PV data.

Item iv & v (score 3)

- Review how to provide understanding and guidance of detriment and the impact – NGO updated guidance shared January 2025.

Item vii (score 4)

- consider the need for a FTSU steering group and progress accordingly

b) Statements for the person responsible for organisational development		Score 1–5 or yes/no	Update Dec 23	Update Dec 24
i.	I am knowledgeable about Freedom to Speak Up	5		4
ii.	We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	4		4
iii.	We have adapted our organisational culture so that it becomes a just and learning culture for our workers	3	4 J&L update 4 = an evidenced strength (e.g., through data, feedback) and a strength to build on	4
iv.	We support our guardian(s) to make effective links with our staff networks	3	4 EDI Steering group, JNCC webinars, drop ins 4 = an evidenced strength (e.g., through data, feedback) and a strength to build on	4
v.	We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	3	4 NSS data, WAW data, P&CC	4

		4 = an evidenced strength (e.g., through data, feedback) and a strength to build on	

Enter summarised evidence to support your score.

The Culture Review has impacted on our ability to update this section due to OD Lead leaving in Sept 24.. The information below is from the previous self-assessment.

Points to note is that FTSU is not an active member of P&CC. Reports are submitted, and presented by CPO. PSG has changed, however regular triangulation meetings have been put in place.

i) **Score 5 -** The OD lead is also the senior lead for FTSU – see Principle 1 section a.

ii) **Score 4 -** The published People Strategy prioritises speaking up as a key element and this is a key workstream in the improvement plan over and above the FTSU function. Listening exercises were held in the autumn to invite people to speak up about what gets in the way of their best work – these were framed as being part of the speak up culture we wish to develop. Speaking up (which includes but is not restricted to the FTSU function) is central to our work on People Voice and in ensuring the organisation hears frontline views and concerns. This work is ongoing and is not yet fully embedded but it is certainly included.

iii) **Score 3 –** in 2022/23 over 300 managers have attended training on Just and Learning Culture and civility. This complements the SCAS Leader programme (launched April 2019), which focuses on compassionate, inclusive and collaborative leadership. The impact on the organisational culture is starting to show with a marked reduction in employee relations cases but there is still work to be done to ensure the relevant behaviours are truly embedded.

iv) **Score 3 -** During September/October 2022, the FTSU portfolio transitioned to the OD team within the People Directorate. The decision to align FTSU within OD places it alongside the Equality, Diversity & Inclusion (ED&I) lead, the culture and leadership work and a direct link to staff networks. When staff network events have happened, eg. International Women's Day, our FTSU team have been key contributors. The FTSU Guardian is an active member of the EDI steering group with all the networks and we are supporting the networks to make more use of the EDI, FTSU and OD functions.

v) **Score 3 –** the FTSU Guardian is an active member in the People and Culture Committee (PACC) and the Patient Safety Group (PSG). FTSU themes are shared with OD, ED&I and the Safeguarding team. This intelligence is fed into training material and case studies in addition to cross-referencing particular cases or clusters within an area.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)		
Item iii (score 3) • *Continue to develop and reinforce compassionate leadership behaviours including JLC, civility, inclusion and collaboration*		

c) Statements about how much time the guardian(s) has to carry out their role	Score 1–5 or yes/no	Update Dec 23	Update Dec 24
i. We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	3		4
ii. We have reviewed the ringfenced time our Guardian has in light of any significant events	4		4
iii. The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	4		4
iv. We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	2		

Enter summarised evidence to support your score.

i) ***Score 3 -*** *From 2018 to 2022, the FTSU Guardian role was fulfilled by a single postholder. The growth of the role, operational restrictions on travel during the pandemic and the improving culture of speaking up led to an urgent review of the resource in the team. The appointment of 2.0wte Deputy FTSU Guardian posts (1.0wte fixed term until Oct '23) has substantially improved diversity, visibility, availability, capacity and resilience within the FTSU function. It has also allowed differentiation of tasks between the lead and deputy roles to ensure individual cases, governance and service development can each be given better attention. However, the FTSU process of speaking, listening and following up currently remains administratively time consuming, not least because NHSE/NGO guidance dictates it can only be done by a trained FTSU Guardian. Recent (temporary) administrative support proved advantageous but only a small element of the work could be shared with the role. Though much improved, capacity and resilience is still a risk for the team and one that will increase if the fixed term 1.0wte Deputy post ends in Oct 2023. Given FTSU case numbers are rising and can be expected to continue to do so, this is an area that requires focused*

planning and consideration including how we might continue with 3.0wte and ways to streamline and automate administrative tasks where possible.

ii) ***Score 4 –*** *as above – the FTSU resource and capacity started being reviewed in early 2022 and the CQC report in the spring lent further weight to this. The CQC feedback demonstrated that having 1.0wte Guardian did not allow staff sufficient access to share and progress their concerns in a timely manner without the Guardian carrying a greatly excessive workload. The appointment of two deputies has greatly improved this but will remain a risk if the seconded 1.0wte deputy role is removed in October '23.*

iii) ***Score 4 –*** *as above – the FTSU resource was discussed by the senior team and much of the immediate improvement work was focused on getting the extra FTSU resource appointed as quickly as possible. The risk around continuing capacity has been and will continue to be highlighted. The new National Guardian attended the Board seminar in April 2023 to discuss roles and responsibilities around FTSU.*

iv) ***Score 2 –*** *as above – 1.0wte Lead and 1.0wte Deputy roles are permanently established in the OD budget. The second deputy has been extended to Oct '23 using external HEE funding carried over from 2022/23. The Exec Lead recommends that the Trust follows the guidance within the National Ambulance FTSU review of appointing 3wte guardians, however there is currently no funding secured to make the third role permanent. In addition, there is no budget for FTSU merchandise, design work, travel/subsistence costs across the SCAS area or maintaining the Speak-up-ulance vehicle which has proven key to their connection with the frontline.*

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)		
Item iv (score 2) • *a business case will be required to ensure the team has enough resource to maintain the service after Oct '23, including the maintenance of the Speak-up-ulance*		

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

a) Statements about your speaking-up policy	Score 1–5 or yes/no	Update Dec 23	Update Dec 24
i. Our organisation's speaking-up policy reflects the 2022 update	3	4 4 = an evidenced strength (e.g., through data, feedback) and a strength to build on	5
ii. We can evidence that our staff know how to find the speaking-up policy	3	3 as part of new policy consultation we picked up some staff confused / see current location (HR) as a barrier as part of new publication we will publicise this, but cannot evidence at this stage 3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach	4
Enter summarised evidence to support your score.			

i) ***Score 5 -*** *Our FTSU Policy was updated and fully encompasses the 2022 update and an annual review carried out in January 2025.*

ii) ***Score 4 –****We have developed a range of Supporting Our People webpages that will signpost to the FTSU site and the associated policy. This work is part of the SCAS improvement plan and new People Strategy.*

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)		

b) Statements about how speaking up is promoted	**Score 1–5 or yes/no**	**Update Dec 23**	**Update Dec 24**
i. We have used clear and effective communications to publicise our guardian(s)	4	4	4
ii. We have an annual plan to raise the profile of Freedom to Speak Up	4	3	3
iii. We tell positive stories about speaking up and the changes it can bring	3	4	4

		Induction, people voice, all staff webinar, people voice 4 = an evidenced strength (e.g., through data, feedback) and a strength to build on	
iv. We measure the effectiveness of our communications strategy for Freedom to Speak Up	3	3	3

Enter summarised evidence to support your score.

i) ***Score 4 -*** *we have a mixed media approach including posters on locations, dedicated FTSU newsletter, all staff newsletters, merchandise, mention in welcome letters, Hub, Teams and Viva Engage pages & a dedicated session on inductions. The CQC improvement work and listening exercises emphasised the increased investment in the team. They have regularly been out in the Speak-up-lance, do Walkabout Wednesdays on different sites and offer manager virtual drop-ins*

ii) ***Score 3 –*** *we have a published People Strategy which prioritises the FTSU work as part of People Voice and developing a compassionate culture of speaking up. The People Directorate, and OD in particular, are now setting annual objectives for 2023/24 which will dictate the annual plan around the FTSU work. The FTSU team are working within their own objectives and plan due to impact of absence from CPO and Senior Lead and no objectives for 24/25 set.*

iii) ***Score 4 -*** *we have developed training materials in leadership and management courses around FTSU including the purpose, the barriers and the benefit. We have also trained 11 cohorts of FTSU champions to be change leaders in their areas of work. We have implemented a FTSU Newsletter to share 'You said, We did' and a pipeline for all People Voice themes including FTSU - this will build workforce confidence in a positive outcome.*

iv)	***Score 3 –*** *we have started to measure the effectiveness of our internal communications as an organisation but not specifically FTSU. However, the annual staff survey demonstrates awareness of the FTSU team and function which we monitor and report each year. Communication Team are actively including FTSU when required.*		
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)			
Item ii & iv (score 3) • **Understand the People Directorate plan and objectives to work alongside them.**			

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

a) Statements about training	Score 1–5 or yes/no*	Update Dec 23	Update Dec 24
i. We have mandated the National Guardian's Office and Health Education England training	3	4 = an evidenced strength (e.g., through data, feedback) and a strength to build on	4

ii. Freedom to Speak Up features in the corporate induction as well as local team-based inductions	4		4
iii. Our HR and OD teams measure the impact of speaking-up training	3		3

Enter summarised evidence to support your score.

i) ***Score 4 –*** *from April '23, FTSU elearning has been mandated for all staff as part of the stat/mand training requirements. The take up is manually reviewed by the FTSU team, action is taken if non-compliance is on-going to explore what the barriers are.*

ii) ***Score 4 -*** *FTSU Guardian attends as many inductions as possible. An enhanced FTSU/EDI/Staff engagement session has been designed and implemented for all new recruits as part of a refreshed induction called A Good Start.*

iii) ***Score 3 -*** *the annual staff survey (22/23) demonstrates an awareness of and confidence in the FTSU function which we monitor and report each year. The team have set up their own case closure surveys although these have a low response rate (~7%). We are exploring the possibility of access to other People Voice data sets such as student placement feedback, new starter and exit interviews as well as speak up training forming part of the SCAS Leader programme.*

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

Item i (score 4)

- *Actively monitor elearning compliance across SCAS and set a realistic timeline to achieve 95% org compliance on Module 1 – Speaking Up*
- *Actively monitor elearning compliance in the strategic leadership group (SLG) and set a realistic timeline to achieve 95% compliance on Modules 1-3 – Speaking, Listening & Following Up*

b) Statements about support for managers within teams or directorates	Score 1–5 or yes/no	Update Dec 23	Update Dec 24

i.	We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	3	2 Managers guidance include the do's and donts 2 = concern or risk which warrants discussion to evaluate and consider options	4
ii.	All managers and senior leaders have received training on Freedom to Speak Up	2	4 mandated training compliance increasing 4 = an evidenced strength (e.g., through data, feedback) and a strength to build on	4
iii.	We have enabled managers to respond to speaking-up matters in a timely way	2	3- template in use, now on version 3, includes NHSE do's and don'ts for managers, learning and communications issued. Temp spreadsheet in use to assist in calculating / tracking timeliness, reported to P&CC in q2 report. Part of the	4

		build spec for new system 3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach	
iv. We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	3	4 staff maters, drop ins , webinars	4

Enter summarised evidence to support your score.

i) ***Score 4 –*** *Speaking up is a key element in our leadership and management development courses where we discuss why it is hard and what gets in the way of doing it well. Listening and thanking people who speak up has been explicitly role-modelled by our CEO in all SCAS meetings and when FTSU cases are fed back to senior leaders, the approach taken is supportive of managers who understandably might initially feel defensive or threatened. As an historically hierarchical organisation based on command structures, this is a key part of our desired culture shift which will take perseverance and frequent reinforcement to embed.*

ii) ***Score 4 –*** *The HEE eLearning is a mandatory requirement for all staff (Module 1); all line managers (Modules 1-2); and for all managers of managers (Modules 1- 3). The modules have been uploaded to ESR/OLM and set as a mandatory competency for the whole organisation. We now need to establish a trajectory for the increasing compliance and, once achieved, a method for ongoing monitoring. This has some challenges as we cannot currently identify between a manager and a manager of managers on ESR.*

iii) ***Score 4 –*** *As soon as a case is reported and taken on by the FTSU team, it is passed to the manager of the relevant team to pursue and investigate as necessary. This allows a quick response for the concernee and usually results in swift resolution. We have introduced specified timescales for responding to a case (equivalent to FOI or patient complaint targets) as they vary widely. However, the risk is that this introduces a delay in resolving some issues and increases the administrative burden.*

iv) ***Score 4 -*** *This is stronger in some areas than others. Although many managers consider themselves open to speaking up and responsive to their teams' concerns, the reality in many cases is that factors such as psychological safety, busy schedules, high demand and stress levels, historic ways of working and human nature can all conspire against us in getting it right. We are improving as evidenced by the increasing frequency of formal and informal examples of speaking up but there is some distance to go.*

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)		

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

a) Statements about triangulation	Score 1–5 or yes/no	Update Dec 23	Update Dec 24
i. We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	2	4 Exec & senior leaders listening supportive and receptive, have clear escalation routes if barriers apparent Examples include sexual safety, repeat names in cases, boys club, feedback from FTSU month, access to ED&I networks, services etc 4 = an evidenced strength (e.g.,	4

		through data, feedback) and a strength to build on	
ii. We use triangulated data to inform our overall cultural and safety improvement programmes	3	4 people pulse, PACC	4
Enter summarised evidence to support your score. i. ***Score 4 –*** *All cases are logged and cross-referenced with other FTSU cases to ensure any repeated areas, practices or individuals of concern are identified and followed up accordingly. The administrative processes are currently cumbersome and time consuming but these are improving. There is now a central FTSU number that diverts to the on call FTSU Guardian and each case is dealt with by the same Guardian wherever possible. Our Guardians have access to all managers at all levels and can expect a prompt and constructive response when required. When this hasn't been the case, the senior lead for FTSU has stepped in to address ineffective behaviours as necessary.* ii. ***Score 4 –*** *Triangulation of data has the potential to be one of our principal strengths. The People Voice portfolio aims to triangulate feedback and themes from many (11) different feedback channels including FTSU. We currently have an example of sexual safety concerns coming through several People Voice channels which, despite the sensitivities, are requiring triangulation to take coherent and appropriate action. Triangulation meetings are being put in place between HR, Safeguarding and FTSU. FTSU Guardian implementing review meetings with Safeguarding and Patient Safety leads.*			
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)			
Item ii (score 4): • *Establish formal method to analyse and triangulate data and themes within the constraints of confidentiality with other teams.*			

b) Statements about learning for improvement	Score 1–5 or yes/no	Update Dec 23	Update Dec 24
i. We regularly identify good practice from others – for example, through self-assessment or gap analysis	5		
ii. We use this information to add to our Freedom to Speak Up improvement plan	4		
iii. We share the good practice we have generated both internally and externally to enable others to learn	3	5, AACE, SE region, NGO	
Enter summarised evidence to support your score. Not updated for Dec 24. *i)* ***Score 5 -*** *We can evidence monitoring of good practice via the refresh of board self-assessments and gap analyses, shared with others in the sector and our regional ICBs.* *ii)* ***Score 4 -*** *We have an overarching FTSU action plan which includes standards and requirements from the national FTSU review; external reviews and advice from ICB and NHSE FTSU experts; our 2022 CQC visit and subsequent improvement plan; and from our newly published People Strategy.* iii) ***Score 3 -*** *In addition to being an integral member of PACC, the EDI steering group and the OD culture work, the FTSU Guardians attend safeguarding and clinical governance meetings to ensure cross-referencing of themes and inputs to organisational learning. Our Guardians regularly attend ambulance sector FTSU network which ensures external sharing and learning.*			
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)			
Item iii (score 3) *FTSU and OD to attend new LfE meetings and ensure patient and workforce themes are cross-referenced and triangulated for organisational learning*			

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

a) Statements about how our guardian(s) was appointed	Score 1–5 or yes/no	Update Dec 23	Update Dec 24
i. Our guardian(s) was appointed in a fair and transparent way	5		5
ii. Our guardian(s) has been trained and registered with the National Guardian Office	5		5
Enter summarised evidence to support your score. *i)* ***Score 5 -*** *The FTSU Guardian roles were recruited using a fair and competitive process in accordance with the example job description and other guidance published by the National Guardian Office, NHSE/I, NHS Employers.* *ii)* ***Score 5 -*** *Our Lead and Deputy guardians are all compliant with the latest NGO guidance. We are now training cohorts of FTSU champions to be change leaders in their areas of work. This includes an enhanced mental health awareness module.*			
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)			
Previous actions cover the work needed in this section ie. continued career development/succession			

b) Statements about the way we support our guardian(s)	Score 1–5 or yes/no	Update Dec 23	Update Dec 24
i. Our guardian(s) has performance and development objectives in place	4		4
ii. Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	5		4
iii. Our guardian(s) has access to a confidential source of emotional support or supervision	2	5 having trialled in house supervision opted for external supervision, this happens on monthly basis for the team. Team have also undertaken MHFAT to assist in monitoring themselves and each other 5 = confident that we are	5

			operating at best practice regionally or nationally (e.g., peers come to use for advice)	
iv.	There is an effective plan in place to cover the guardian's absence	4		4
v.	Our guardian(s) provides data quarterly to the National Guardian's Office	4		5

Enter summarised evidence to support your score.

i) ***Score 4 -*** *The team have regular 1:1s, annual and mid year PDRs, The team are also working through the NGO FTSU Guardian's education and training guide to ensure all areas are covered.*

ii) ***Score 4-*** *All the guardians have regular 1:1s with their respective line managers, with the senior lead & Exec lead. The team are also well networked across the region and nationally for specialist support.*

iii) ***Score 5 -*** *As with all of SCAS, the full health & wellbeing offer is available to the FTSU Guardian team. The team have independent external psychological supervision in place. In the meantime, the team are personally supported within the OD team and well networked regionally and nationally for specialist support.*

iv) ***Score 4 –*** *The increased resource to 3.0wte has ensured effective resilience. This is an area of marked improvement in the recent 12mths but the risk remains In an emergency, the Exec lead has access to the root file on the secure server.*

v)	***Score 4 –****The local data is available and will be updated in accordance with NGO recommendations when the data window opens*		
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)			

c)	**Statements about our speaking up process**	**Score 1–5 or yes/no**	**Update Dec 23**	**Update Dec 24**
i.	Our speaking-up case-handling procedures are documented	4		4
ii.	We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	4		4
iii.	We are assured that confidentiality is maintained effectively	5		4
iv.	We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	2	3- template in use, now on version 3, includes NHSE do's and don'ts for managers, learning and communications issued. Temp spreadsheet in use to assist in calculating / tracking timeliness, reported to P&CC in q2 report. Part of the build spec for new system	4

		3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach	
v. We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	2	3- high uptake of eLearning, WAW and rolling q'rs Some areas variable 3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach	3

Enter summarised evidence to support your score.

i) ***Score 4 –*** *Our case handling procedure is in line with current national best practice, guidance and information governance (IG) regulations. With greater resource in the team, there is now sufficient capacity to complete the required records in a timely manner and set realistic goals/trajectories of case numbers over the coming year. We are also looking to audit the timeline from reporting to closing a case. We have consulted with other ambulance trusts on how to do this effectively. An audit in November 2024 gave a good level of assurance both for design & operational effectiveness.*

ii) ***Score 4 -*** *Following feedback, we produced a manager investigation guide and are now teaching all managers the principles of civility and a Just and Learning Culture. This forms part of the Essential Skills for People Managers (ESPM) suite and complements our first line leadership programme, SCAS Leader. Launched in April 2019, SCAS Leader contains a specific section on FTSU, what gets in the way and the role of the inclusive leader in speaking, listening and following up.*

iii) ***Score 4 -*** *Our case handling procedure, including standards of confidentiality, is in line with current national best practice, guidance and information governance (IG) regulations. With greater resource in the team, there is now more diversity and sufficient capacity to hold the cases amongst themselves. This ensures a consistent approach and allows the service to remain fully functioning even during team member absence. We encourage that confidentiality is not broken when templates are shared with Managers and their ongoing review of the case.*

iv) ***Score 4 –*** *With increased resource, there is improved capacity to progress cases as they arise and the team are good at sharing the workload between them. However, we do not currently have an audit trail which can evidence the timeline from a case opening to closing. This is an area for development.*

v) ***Score 3 –*** *much work has gone into raising awareness of the benefits of FTSU, civility, Just & Learning Culture and compassionate leadership. All staff have been mandated to do the HEE elearning pertinent to their level of management and we are starting to demonstrate improvements in employee relations cases. The FTSU cases are rising and several have explicitly thanked the team for resolving their concern. That said, we have some way to go before we can be "confident of a consistently positive experience" in every case. It will remain hard to hear difficult things and leaders will require continuous reinforcement and support to embed this mindset shift into our everyday culture. Thanking individuals, publicising positive outcomes, and role modelling and rewarding the desired behaviour will help to reinforce it.*

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)		
Item iv (score 4) *Develop an audit of the time taken from first receiving a case to resolution and closure*		
Item v (score 3) • *Build a 'You said, We did' process to explicitly demonstrate positive outcomes of speaking up. Continue to provide support and guidance to Line managers., providing them with a safe space to explore how they can be more curious and reflect upon their own reactions.*		

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

a) Statements about barriers	Score 1–5 or yes/no	Update Dec 23	Update Dec 24
i. We have identified the barriers that exist for people in our organisation	3	4 4 = an evidenced strength (e.g., through data, feedback) and a strength to build on Via, case data, walking the floor, NSS sub scores data, ED&I & sub groups, national events and data,	4

			WAW data, speakup month, remaining inquisitive,	
ii.	We know who isn't speaking up and why	3	4 as above	4
iii.	We are confident that our Freedom to Speak Up champions are clear on their role	3	4 trained iaw national guidance and regional best practise	4
iv.	We have evaluated the impact of actions taken to reduce barriers?	3		3

Enter summarised evidence to support your score.

i) ***Score 3 –*** *increasing to 3.0wte has had the added benefit of introducing greater diversity within the team in addition to increasing their visibility, accessibility and capacity for conversations with staff around the week. These were some of the barriers articulated in the CQC report which have been improved. In addition, moving FTSU into OD has provided greater independence from the clinical directorate and human resources both of which had been reported as a barrier to speaking up for some. However, these are undoubtedly only part of the story and work is still required to effect greater change with regards to cultural barriers, psychological safety and workforce engagement all of which get in the way of speaking, listening and following up. The extensive work around People Voice, civility, Just & Learning Culture, use of champions, understanding diversity, role modelling and the HEE elearning are all aimed towards reducing the barriers.*

The FTSU team have undertaken enhanced NGO training to provide insights, knowledge, skills, tools, and techniques specifically to improve the Speaking Up culture for black and minority ethnic staff in healthcare organisations. This has led to diverse representation within the FTSU champions which will help to lower barriers to speaking up locally. *ii)* ***Score 3 –*** *We know from Edmondson's work (1999) that the teams* reporting *fewer errors do not correlate with the teams* making *fewer errors and therefore it is vital we understand which teams are not appearing in the data and why that might be. Where available, we monitor the source and spread of FTSU cases to capture the clusters but it also forms only one part of the People Voice data set. People Voice data comes from 11 different sources designed to be diverse in terms of respondents. It includes new starters, leavers, students, bank/volunteers, ER and FTSU cases as well as monthly and annual whole workforce surveys which can be analysed by protected characteristics. The next step is to consider where we might have voices that could be described as 'seldom heard' or 'easy to ignore'.* *iii)* ***Score 3 -*** *we have trained two cohorts of FTSU Champions with a third due in June. The group are diverse in organisational spread and personal demographics. They have a full day of FTSU training using the latest NGO guidance but also participate in a specialist module on mental health awareness both for their own benefit and for those around them who may need immediate support.* iv) ***Score 3 –*** *the impact of the extensive work surrounding speaking up throughout the year will be measured in the annual staff survey in terms of workforce confidence in speaking up. The rising number of cases is appositive sign that there is an impact but we would expect there to be more to come. The NSS22 metrics around confidence in speaking up dropped significantly from 2021 to 2022. If this was associated with the CQC focus on safeguarding and FTSU then we would hope to see a recovery in 2023 as the impact of all the work starts to be realised.*		
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)		
Item iii (score 3) • *Appraise People Voice inputs and outputs for diversity of voices and any gaps*		
Item iv (score 3) • *monitor workforce confidence and faith in speaking up in NSS23*		

Statements about detriment	Score 1–5 or yes/no	Update Dec 23	Update Dec 24
i. We have carried out work to understand what detriment for speaking up looks and feels like	2	4we based our work on the sought advice and input from peers in the South East Guardian Network (circa 260 members) and the AACE FTSU National Ambulance Network Also attached is the slide deck relating to detriment for background / information	

		Ref MidInads Region, SE region, Kark 2018, NHSE p43, SCAS policy 4 = an evidenced strength (e.g., through data, feedback) and a strength to build on	
ii. We monitor whether workers feel they have suffered detriment after they have spoken up	2	2 = concern or risk which warrants discussion to evaluate and consider options Policy implementation	
iii. We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	2	4	
iv. Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	2	3 law pathway in policy	
Enter summarised evidence to support your score.			

i – iv) ***Score 2 –*** *Our refreshed FTSU policy makes it clear that detriment will not be tolerated but currently we cannot provide assurance that this is the experience people have when they speak up in SCAS. We have some understanding of what detriment looks and feels like from People Voice comments and from anecdotal stories in our leadership and management training courses. However, we have yet to introduce formal monitoring or an investigatory approach where it is reported to have happened. For the same reason, our NED for FTSU is not yet involved in reported detriment. This is a clear priority for development.*		
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)		
Item i – iv (score 2) • *Understand the work that is required to ensure detriment from speaking up does not occur* • *Explore and understand what detriment looks and feels like in SCAS* • *Develop a method to monitor any detriment as part of the casework timeline* • *Clarify an investigation process where this is felt to have happened* *Agree NED involvement in allegations of detriment*		

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

a) Statements about your speaking-up strategy		Score 1–5 or yes/no	Update Dec 23	Update Dec 24
i.	We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	5		
ii.	We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	5		
iii.	We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	3		
iv.	Our improvement plan is up to date and on track	4		

Enter summarised evidence to support your score.

i – ii) ***Score 5 -*** *Our newly published People Strategy is a comprehensive piece of work that prioritises the creation of a compassionate culture of speaking up, including but not restricted to the FTSU function. The People Strategy, CQC improvement work and the SCAS 10 point plan are being aligned into one coherent approach and, with regards to FTSU, this also includes the recent NGO review. FTSU is one of the four principle themes of the immediate improvement work with clear tasks and timelines identified in the plan.*

i) ***Score 3 –*** *whilst we do have access to some qualitative and quantitative FTSU measures, there is still work to be done to evaluate the FTSU strategy and provide clear assurance at Board level beyond the principle themes in each quarter.*

ii) ***Score 4 –*** *As per i-ii, the culture improvement work (incl FTSU) is being aligned into one coherent plan with dedicated project managers overseeing and supporting progress as part of the overarching delivery of the People Strategy. Despite temporary absence of the Lead Guardian, the increased resilience in the team has meant that the work has largely remained on track.*

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)		
Item (score 3) • *Develop a trajectory of improvement using qualitative and quantitative measurements that provide evaluation of the strategy and clear assurance at Board level*		

b) Statements about evaluating speaking-up arrangements	**Score 1–5 or yes/no**	**Update Dec 23**	**Update Dec 24**
i. We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	4		
ii. Our plan follows a recognised 'plan, do, study, act' or other quality improvement approach	5		
iii. Our speaking-up arrangements have been evaluated within the last two years	5		

Enter summarised evidence to support your score.

i) ***Score 4 –*** *The annual staff survey (NSS) has specific questions around confidence and faith in the speaking up process which we monitor every year and will continue to do so as a clear indicator of the impact of the FTSU work. Once developed, triangulation of the data in the People Voice portfolio has the potential to provide good intelligence on how safe and confident people feel on an ongoing basis and the FTSU team regularly run their own polls when on site around the Trust.*

ii) ***Score 5 –*** *PDSA methodology of continuous improvement is part of the SCAS Leader programme. The FTSU team have all attended the programme and understand the principles of Lean methodology, process mapping, root cause analysis and PDSA. The recent selection and training of successive champion cohorts was a good example where PDSA was used and applied to the second and third iterations.*

iii)	***Score 5 –*** *the FTSU arrangements in SCAS have been evaluated more than once in the last three years with the latest being the CQC visit in 2022. This provided some valuable feedback and impetus to support the improvement now underway. The FTSU Guardian remains in contact with the NHSE FTSU team and has been the co-chair of the National Ambulance FTSU Network which has given opportunities for informal peer review and consultation.*		
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)			
Previous actions cover the work needed in this section ie. completion of People Voice			

	c) Statements about assurance	**Score 1–5 or yes/no**	**Update Dec 23**	**Update Dec 24**
i.	We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	4		
ii.	We have evaluated the content of our guardian report against the suggestions in the guide	5		
iii.	Our guardian(s) provides us with a report in person at least twice a year	5		
iv.	We receive a variety of assurance that relates to speaking up	4		
v.	We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	3	4 4 = an evidenced strength (e.g., through data, feedback) and a strength to build on	

		FTSU part of LFE, people voice,	

Enter summarised evidence to support your score.

i) ***Score 4 –*** *Reports are provided to the Board each quarter. They have been well-received but would benefit from a review to understand what more could be included to provide greater transparency without risking a breach of confidentiality*

ii) ***Score 5 –*** *the current structure of the report meets the recommended requirement*

iii) ***Score 5 –*** *the FTSU Guardian attends the Board meetings when required, and at least bi-annually, to present the upward report*

iv) ***Score 4 –*** *in addition to the quarterly FTSU reports, the Board receive an analysis of the annual staff survey (NSS) which always highlights the FTSU questions, regular staff stories and feedback from leadership visits. The People and Culture Committee also receive assurance around the wider People Voice themes.*

v) ***Score 3 –*** *the new Learning from Experience (LfE) forum is led by the clinical quality team and attended by the FTSU and OD leads. This allows cross-referencing and application of learning across both the people and culture work and patient safety. There is still work to do in ensuring awareness and providing assurance about this at Board level.*

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)		
Item v (score 3) • *Ensure organisational learning and FTSU-inspired improvement are captured on Board reports and shared on a quarterly basis*		

Stage 2: Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 6–12 months	Target date	Action owner	Update Dec 23	Update Dec 24
1. Detriment • Understand the work that is required to ensure detriment from speaking up does not occur • Explore and understand what detriment looks and feels like in SCAS • Develop a method to monitor any detriment as part of the casework timeline • Clarify an investigation process where detriment is felt to have happened • Agree NED involvement in allegations of detriment	By end of Q4	FTSU Guardian (SH)	Completed and included in new policy	
2. Plan and take necessary action to sustain FTSU performance after October 2023 • Evaluate the 2nd deputy role and the likely impact of reducing to 2.0wte • Streamline administrative processes to free up more time	Oct 2023	FTSU Guardian (SH) and Senior Lead (NH)	Number of business cases have been rejected Score reduced from 2 to 1 (red)	
3. Regular psychological supervision for the team to be established	By end of Q4	FTSU Guardian (SH)		

			Completed and established	
4. Develop a robust 'you said, we did' feedback loop including specific examples around clinical/non-clinical FTSU cases	By end of Q2	FTSU Guardian (SH) & Comms (TS/MA)	You said we are doing as part of inductions and all staff webinars, people voice LFE Managers template update to capture the communications of learning	
5. Monitor completion of HEE elearning • Actively monitor elearning compliance across SCAS and set a realistic timeline to achieve 95% org compliance on Module 1 – Speaking Up • Actively monitor elearning compliance in the strategic leadership group (SLG) and set a realistic timeline to achieve 95% compliance on Modules 1-3 – Speaking, Listening & Following Up	By end of Q2	FTSU Guardian (SH) and Education Compliance, Assurance & Technologies (JS)	eLearning rates increasing but short of the 95% Target	
6. Develop an audit of the time taken from first receiving a case to resolution and closure	By end of Q2	FTSU Guardian (SH)	Speadsheest updated to include this data, data	

			presented to P&CC, part of build specification for new system	
7. FTSU and OD to attend new LfE meetings and ensure patient and workforce themes are cross-referenced and triangulated for organisational learning		FTSU Guardian (SH) and OD Lead (NH)	With resilience in team able to attend	
8. Refresh the policy to reflect the 2022 update following consultation in Q2 '23/24			Completed	
New **Development areas to address in the next 6–12 months based on Q3 assessment**				
a) *appropriate financial investment in place for the speaking-up programme and for recruiting guardians (*Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture)				
*We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared (*Principle 4: When someone speaks up, thank them, listen and follow up)				
b) used clear and effective communications to publicise our guardian(s) (Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so)				
c) We have an annual plan to raise the profile of Freedom to Speak Up (Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so)				

Development areas to address in the next 12–24 months		Target date	Action owner
1.	Further development of current team including ongoing career pathways & succession planning	Mar 24	SH/NH
2.	Monitor NSS23 for improvement in workforce confidence in speaking up – in 2022 this dropped for the first time in 5 years	Jan 24	SH/NH
3.	Develop a trajectory of improvement using qualitative and quantitative measurements that provide evaluation of the strategy and clear assurance at Board level	Jan 24	SH
4.	Continue to build Supporting our People webpages which signpost to the FTSU site and associated policy	Mar 24	CJ

Stage 3: Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner
1. The increased diversity, visibility, accessibility and capacity in the FTSU team is a strength. They are energetic, impassioned, dedicated individuals who hold themselves to a high standard of care and confidentiality and who strive to innovate and improve team performance on a continuing basis. They should each be encouraged to consider next steps both in terms of annual team objectives and of succession / personal career plans.	In 2023/24	FTSU team
2. Triangulation of People Voice themes, including FTSU cases. We still have some work to do on this to analyse feedback fully and collate the output but this is an area of potential strength.	Q3 23/24	ODBP - CU
3		
4		
5		
6		
7		
8		

NHS
South Central Ambulance Service
NHS Foundation Trust

Trust Public Board
27 March 2025

Report title	Annual NHS Staff Survey Report 2024
Agenda item	21
Report executive owner	Natasha Dymond, Interim Director of People
Report author	Judith MacMillan, HR Manager Graham Thorpe, Workforce Planning Manager Amy Carden, People Promise Manager
Governance Pathway: Previous consideration	Executive Management Committee (EMC) People and Culture Development Group
Governance Pathway: Next steps	People and Culture Committee

Executive Summary

The 2024 National Staff Survey results for the NHS were published on 13 March 2025. This report provides an over-view of SCAS's results outlining key strengths and areas requiring focus and improvement. SCAS's response rate for 2024 (50%) was the lowest it has been for 8 years and lower than the average response rate for other Ambulance Trusts participating in the Picker Staff Survey (55% response rate).

66% of questions answered saw no change from the 2023 survey whereas one third of questions answered showed a significant decrease in satisfaction. Fewer staff would recommend SCAS as a place to work or feel that patients is SCAS's top priority.

PDR compliance has significantly increased from 78% in 2023 to 82% in 2024. It is concerning that 45% of respondents fed back that they often think of leaving SCAS.

The context for the 2024 staff survey was during the corporate review and the loss of PTS contracts and SCAS leadership understand the significant impact these events have had on these groups of staff. However, the feedback is an important indicator of how staff were feeling when the survey was completed and interventions are required to improve staff satisfaction and engagement across the Trust.

The Executive team is committed to putting patients first, getting to patients quickly and providing high quality care. Leadership and cultural interventions will be put in place to support this and rebuild the goodwill and good feeling that has been lost.

Directors, managers and team leaders will also work with their teams to share the results and develop local engagement and action plans to drive continuous improvement at departmental levels across the organisation.

Progress will be monitored via the People and Culture Development Group, the People and Culture Committee.

Alignment with Strategic Objectives
With which strategic theme(s) does the subject matter align? People & Organisational

Relevant Business Assurance Framework (BAF) Risk
To which BAF risk is the subject matter relevant? SR7 - Staff Feeling Unsafe, Undervalued and Unsupported

Financial Validation	No financial implications.

Recommendation(s)
The Group is asked to: • Receive this report and take assurance from it.

For Assurance	✓	**For decision**		**For discussion**		**To note**	✓

1. Background / Introduction

1.1 The purpose of this report is to provide an overview of the 2024 Staff Survey results for SCAS and outline plans for improvement.

1.2 For the previous 5 years SCAS has adopted an organisational response to the feedback (e.g. holding “big virtual conversations” across the organisation) which did not always involve local management leads.

1.3 This seems to have resulted in lesser engagement with the survey as a 50% response rate is the lowest SCAS response rate for 8 years and a 2% decrease from the 2023 survey.

1.4 This year there will be a return to the mixed approach of local and Trust pledges / action plans which will feed into core local business process via departmental engagement leads.

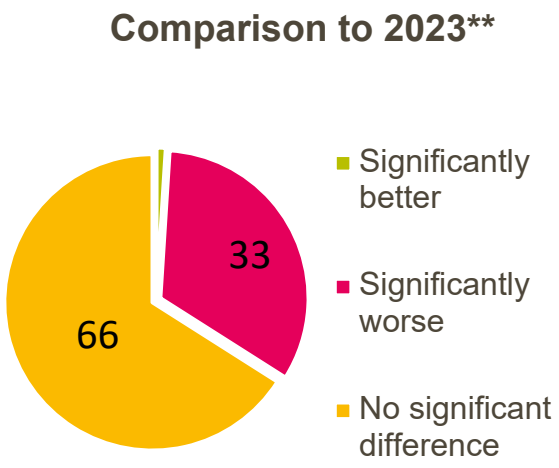
2. Detail

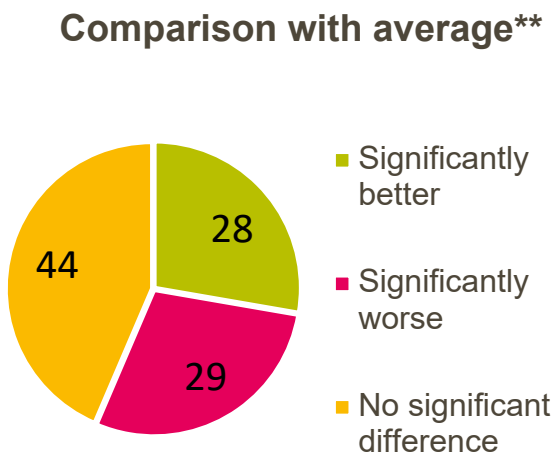
2.1 It is important to note the organisational context in which the staff survey took place.

2.2 When respondents were completing the survey (October – December 2024) the Trust was in the midst of the corporate restructuring and the transfer of Patient Transfer Services to a new provider.

2.3 However, the results provide an important baseline of how people were and are potentially still feeling. SCAS leaders across the Trust must acknowledge this, take action to discuss the results with their teams and make necessary changes within their areas of responsibility.

2.4 The pie charts below outline the changes in responses compared to 2023 and with the sector average.





2.5 The tables below compare SCAS results with the 7 other Picker Ambulance Trusts that ran the NHS Staff Survey. The tables show the top 5 and bottom scores measured against the average sector score.

Top 5 scores vs Picker Average	SCAS 2024	Picker Avg
q9e. Immediate manager values my work	69%	62%
q9b. Immediate manager gives clear feedback on my work	65%	58%
q9c. Immediate manager asks for my opinion before making decisions that affect my work	53%	46%
q9d. Immediate manager takes a positive interest in my health & well-being	71%	64%
q11e. Not felt pressure from manager to come to work when not feeling well enough	76%	70%

Bottom 5 scores vs Picker Average	SCAS 2024	Picker Avg
q26b. I am unlikely to look for a job at a new organisation in the next 12 months	40%	48%
q3i. Enough staff at organisation to do my job properly	28%	35%
q25c. Would recommend organisation as place to work	41%	48%
q24f. Able to access clinical supervision opportunities	40%	47%
q26c. I am not planning on leaving this organisation	47%	53%

2.6 The tables below compare the 2024 results with the 2023 results.

Most improved scores since 2023	SCAS 2024	SCAS 2023
q23a. Received appraisal in the past 12 months	**82%**	**78%**
q7b. Team members often meet to discuss the team's effectiveness	**43%**	**41%**
q14a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	**61%**	**59%**
q3i. Enough staff at organisation to do my job properly	**28%**	**27%**
q7a. Team members have a set of shared objectives	**66%**	**65%**

Most declined scores since 2023	SCAS 2024	SCAS 2023
q25c. Would recommend organisation as place to work	41%	49%
q25f. Feel organisation would address any concerns I raised	37%	44%
q2c. Time often/always passes quickly when I am working	48%	54%
q25a. Care of patients/service users is organisation's top priority	58%	64%
q26c. I am not planning on leaving this organisation	47%	53%

2.7 It is worth noting that respondents generally feel supported by immediate Management (71% agree that our immediate manager takes a positive interest in our health and wellbeing and 69% recognise that our immediate manager values our work).

2.8 However, 45% of respondents fed back that they often think of leaving SCAS which suggests staff are not feeling engaged with the wider organisation.

2.9 The Executive team are working with the People and Well-Being Directorate to draw up interventions for cultural reform and leadership development to address some of the issues raised.

2.10 Meetings are taking place across the Trust to present Departmental Directors, Heads of departments and team leaders the results for their areas.

2.11 Local teams and Directorates will identify areas of focus because of the results for their areas and incorporate actions into their departmental engagement plans.

2.12 Governance will be via this group, People and Culture Committee and the Trust's Board.

3. Quality Impact

3.1 The results are concerning in terms of patient safety, patient experience and clinical effectiveness.

3.2 For example, only 48% of respondents feel that SCAS would address concerns about unsafe clinical practice and only 55% feel safe to speak up about anything that concerns them.

3.3 Research has shown that a disengaged workforce can negatively impact on patient care. In order to maximise the engagement and motivation of staff SCAS needs to create and embed reinforcing people and culture interventions which will positively impact on the quality of patient care delivered (NHS Staff Management and Health Service Quality)

4. Financial Impact

4.1 Investment required for leadership development is currently under consideration in the Trust's financial planning round and has been discussed with the Trust's Financial management.

5. Risk and compliance impact

5.1 If interventions are not put in place retention and increased absenteeism are a risk to the Trust.

5.2 Significant increases in attrition will result in less staff to treat patients, placing additional pressure on staff still employed by SCAS. This in turn can result in lower staff morale, increased absence and a SCAS workforce stretched beyond capacity which will impact the quality of care provided to patients.

5.3 The results are a risk to BAF risk 6: Sufficient skills and resources, should attrition increase. The results are a risk to BAF risk 7: Safe, valued and supported staff.

5.4 It is a regulatory requirement for the Trust to participate in the NHS Staff Survey, the Trust is free to address the feedback as it deems appropriate.

6. Equality, diversity and inclusion impact

6.1 The results relate to all staff and did not suggest that any group of staff is impacted differently. The actions put in place will be inclusive to all staff.

7. Next steps

7.1 To work with the Executive team to address the cultural change and leadership development interventions required to produce sustainable culture change.

7.2 Senior management in local Directorates are to work with their managers and teams to discuss the results, identify areas of focus and action and feed these into to local engagement plans.

8. Recommendation(s)

8.1 The Trust Board is asked to:

Receive this report and take assurance from it.

9. Appendices

9.1 Appendix 1 – Full results

South Central Ambulance Service
NHS Foundation Trust

NHS STAFF SURVEY RESULTS 2024

- Response rate, Overview, and key findings

Staff Survey 2024

Your Views Matter

2024 NHS STAFF SURVEY
Participation / Response Rates

4512	50%	55%	52%
Invited to complete survey	Completed survey (2236)	Ave Ambulance sector response rate	2023 response rate

RESPONSE RATES: BY ORGANISATION / AREA

SCORE	Eligible	Responses	TO REACH 51%	WEEK 9
CCC CAT	89	74	ACHIEVED	83%
QUALITY AND PATIENT CARE DIRECTORATE	79	61	ACHIEVED	77%
DIGITAL DIRECTORATE	77	59	ACHIEVED	77%
OPERATIONAL SUPPORT SERVICES	130	94	ACHIEVED	72%
PEOPLE DIRECTORATE	211	146	ACHIEVED	69%
FINANCE DIRECTORATE	46	31	ACHIEVED	67%
CCC 111	527	342	ACHIEVED	65%
INDIRECT RESOURCES	101	61	ACHIEVED	60%
CORPORATE SERVICES	54	32	ACHIEVED	59%
SPECIALIST PARAMEDICS	91	53	ACHIEVED	58%
CCC EOC	378	218	ACHIEVED	58%
999 NE	217	113	ACHIEVED	52%
999 SW	316	155	6	49%
999 NW	377	173	19	46%
999 NS	245	100	25	41%
999 SN	294	110	40	37%
999 NN	198	73	28	37%
999 SE	304	108	47	36%
PTS	754	232	153	31%

Response Rates

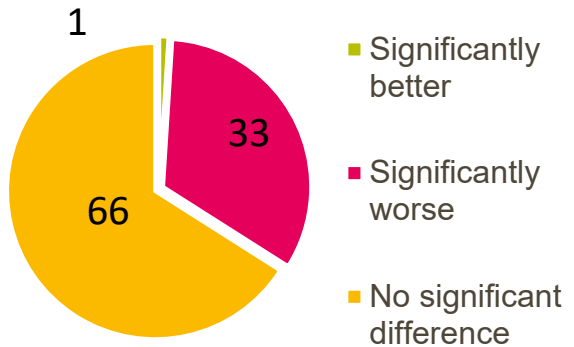
- Lowest SCAS response rate for eight years.
- PTS TUPE and apathy towards the survey significantly impacted the response rate.
- 999 Front Line was also significantly down on 2023 rates.
- Consider introducing incentives (prizes, vouchers, etc.)
- Allocate time for all operational staff to complete the survey.
- Return to the mixed Local / Trust pledges and action plans, which was far more successful than the 100% Trust-wide approach.

Results Overview

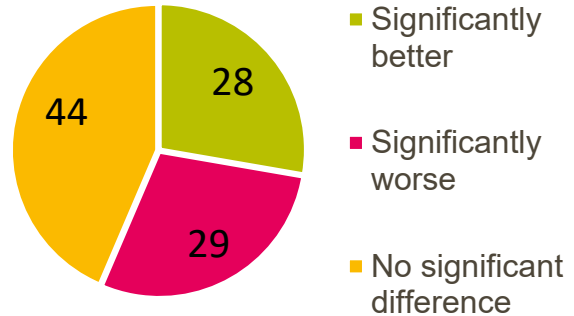
4610	4512	50%	55%	52%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (2236)	Average response rate for similar organisations	Your previous response rate

41%	Would recommend organisation as place to work
60%	If friend/relative needed treatment would be happy with standard of care provided by SCAS
58%	Care of patients/service users is organisation's top priority

Comparison to 2023**

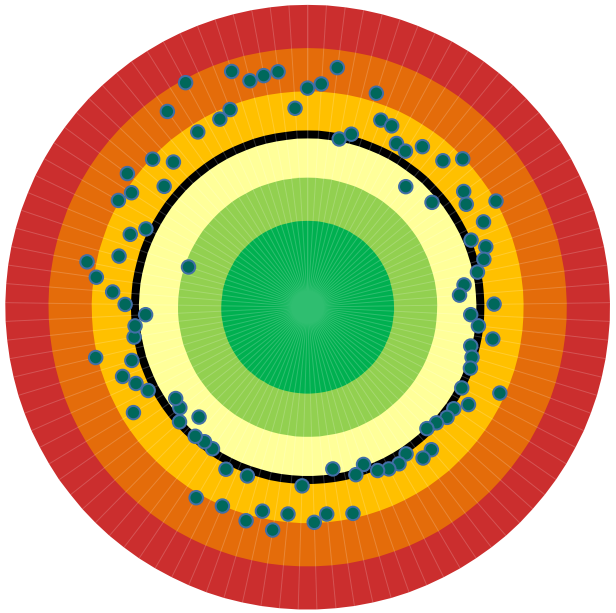


Comparison with average**

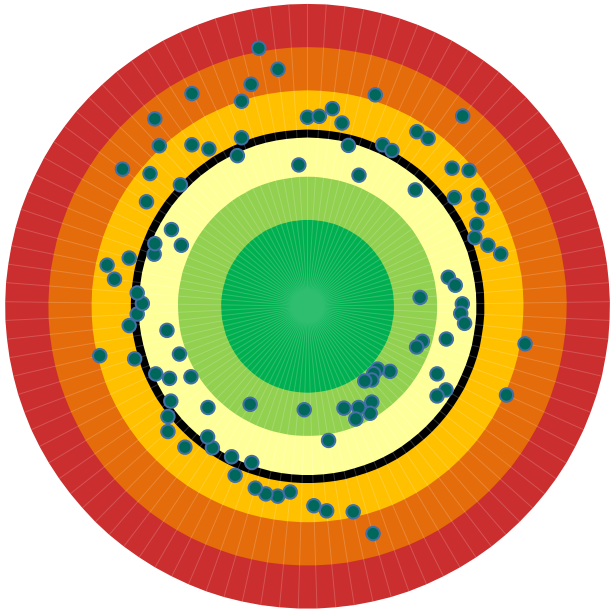


Results Overview

2024 SCAS scores vs. 2023



SCAS scores vs. Ave Ambulance



KEY

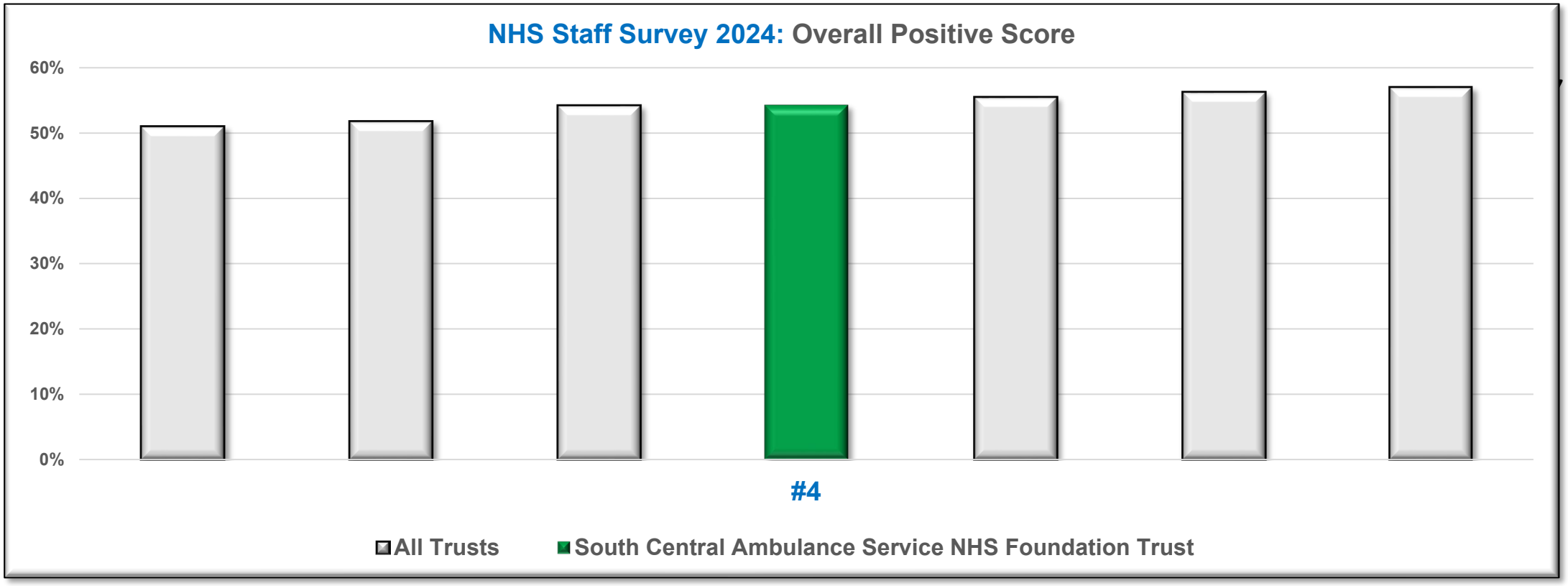
This score is considerably better than the comparison score

This score is considerably worse than the comparison score

The dartboard charts show you the difference between the SCAS score and a comparison score.
The comparison is against the 2023 survey (left) and the Picker average for each question (right).

Each dot on the chart represents a question.
The closer a dot is to the centre (the “bullseye”) of the chart, the better you did on that question.

Sector Benchmark: Overall positive score



The league table shows how our overall positive score is ranked in comparison to the overall positive score of every other Ambulance Trusts organisation that ran the NHS Staff Survey 2024 with Picker.

The overall positive score is the average positive score for all positively scored questions in the survey.

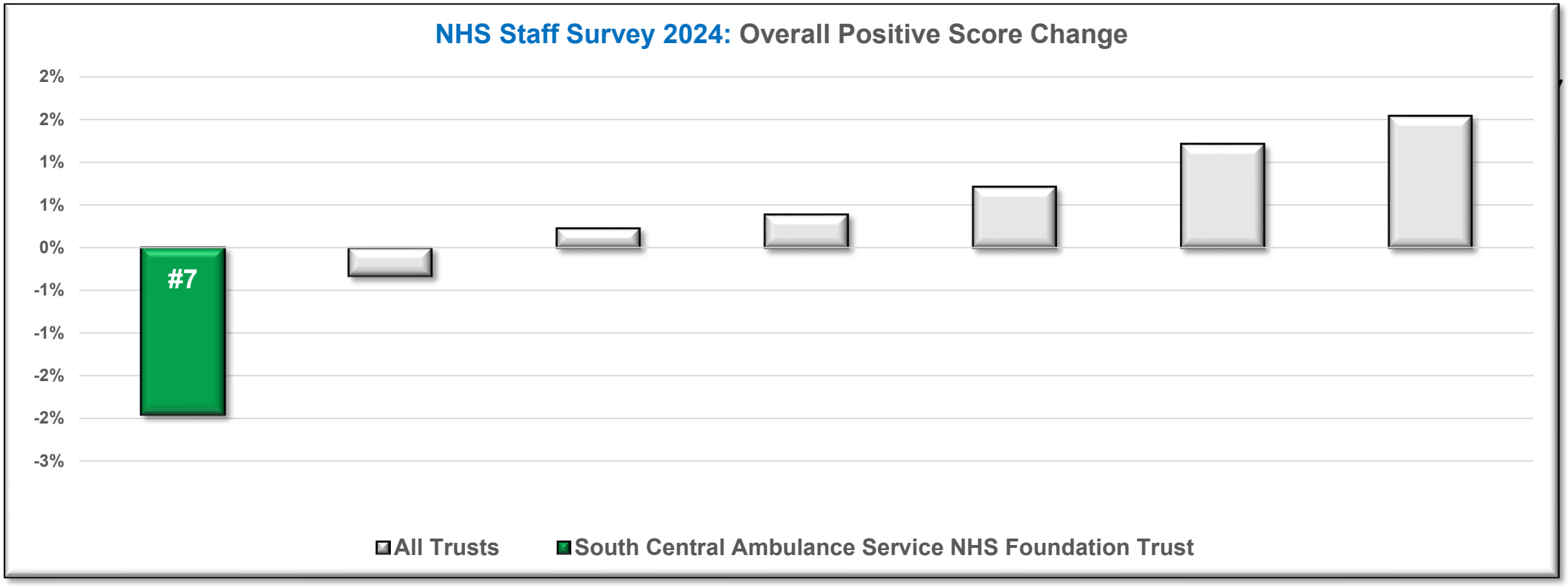
Sector Benchmark: Top/Bottom Scores

Top 5 scores vs Picker Average	SCAS 2024	Picker Avg
q9e. Immediate manager values my work	69%	62%
q9b. Immediate manager gives clear feedback on my work	65%	58%
q9c. Immediate manager asks for my opinion before making decisions that affect my work	53%	46%
q9d. Immediate manager takes a positive interest in my health & well-being	71%	64%
q11e. Not felt pressure from manager to come to work when not feeling well enough	76%	70%

Bottom 5 scores vs Picker Average	SCAS 2024	Picker Avg
q26b. I am unlikely to look for a job at a new organisation in the next 12 months	40%	48%
q3i. Enough staff at organisation to do my job properly	28%	35%
q25c. Would recommend organisation as place to work	41%	48%
q24f. Able to access clinical supervision opportunities	40%	47%
q26c. I am not planning on leaving this organisation	47%	53%

The tables above compare the SCAS survey results with the 7 other Ambulance Trusts that ran the NHS Staff Survey 2024 with Picker.
These are the top 5 and bottom 5 scores measured against the average sector score.

Sector Benchmark: historical changes 2023-24



The historical league table shows how our overall positive score changed from the previous survey, and how this change compares to other organisations Ambulance Trusts who ran the NHS Staff Survey 2024 with Picker.

Key Historical changes – SCAS 2023-24

Most improved scores since 2023	SCAS 2024	SCAS 2023
q23a. Received appraisal in the past 12 months	**82%**	**78%**
q7b. Team members often meet to discuss the team's effectiveness	**43%**	**41%**
q14a. Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	**61%**	**59%**
q3i. Enough staff at organisation to do my job properly	**28%**	**27%**
q7a. Team members have a set of shared objectives	**66%**	**65%**

Most declined scores since 2023	SCAS 2024	SCAS 2023
q25c. Would recommend organisation as place to work	41%	49%
q25f. Feel organisation would address any concerns I raised	37%	44%
q2c. Time often/always passes quickly when I am working	48%	54%
q25a. Care of patients/service users is organisation's top priority	58%	64%
q26c. I am not planning on leaving this organisation	47%	53%

The tables above compare the 2024 SCAS survey results with the 2023 SCAS survey results.
These are the 5 most improved and 5 most declined scores.

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NHS STAFF SURVEY RESULTS 2024

- People Promise Results

1. We are compassionate & inclusive

PP1_1. Compassionate culture		2021	2022	2023	2024
q6a	Feel my role makes a difference to patients/service users	83%	80%	82%	82%
q25a	Care of patients/service users is organisation's top priority	65%	63%	64%	58%
q25b	Organisation acts on concerns raised by patients/service users	68%	59%	63%	60%
q25c	Would recommend organisation as place to work	51%	48%	49%	41%
q25d	If friend/relative needed treatment would be happy with standard of care provided by organisation	72%	63%	63%	60%

PP1_2. Compassionate leadership		2021	2022	2023	2024
q9f	Immediate manager works with me to understand problems	67%	66%	68%	68%
q9g	Immediate manager listens to challenges I face	70%	69%	72%	71%
q9h	Immediate manager cares about my concerns	69%	68%	71%	70%
q9i	Immediate manager helps me with problems I face	66%	64%	68%	67%

PP1_3. Diversity and equality		2021	2022	2023	2024
q15	Organisation acts fairly: career progression	59%	56%	56%	53%
q16a	Not experienced discrimination from patients/service users, their relatives or other members of the public	89%	88%	87%	86%
q16b	Not experienced discrimination from manager/team leader or other colleagues	91%	91%	91%	90%
q21	Feel organisation respects individual differences	65%	63%	65%	60%

PP1_4. Inclusion		2021	2022	2023	2024
q7h	Feel valued by my team	65%	65%	66%	66%
q7i	Feel a strong personal attachment to my team	58%	58%	59%	59%
q8b	Colleagues are understanding and kind to one another	73%	72%	70%	70%
q8c	Colleagues are polite and treat each other with respect	74%	72%	71%	70%

2. We are recognised & rewarded

PP2. We are recognised and rewarded			2021	2022	2023	2024
q4a	Satisfied with recognition for good work		41%	42%	41%	39%
q4b	Satisfied with extent organisation values my work		35%	33%	31%	27%
q4c	Satisfied with level of pay		24%	18%	25%	26%
q8d	Colleagues show appreciation to one another		69%	68%	65%	65%
q9e	Immediate manager values my work		69%	69%	71%	69%

3. We each have a voice that counts

PP3_1. Autonomy and control		2021	2022	2023	2024
q3a	Always know what work responsibilities are	85%	84%	83%	83%
q3b	Feel trusted to do my job	85%	83%	83%	82%
q3c	Opportunities to show initiative frequently in my role	61%	60%	61%	**56%**
q3d	Able to make suggestions to improve the work of my team/dept	54%	55%	53%	50%
q3e	Involved in deciding changes that affect work	28%	30%	28%	26%
q3f	Able to make improvements happen in my area of work	29%	32%	30%	29%
q5b	Have a choice in deciding how to do my work	37%	39%	40%	**36%**

PP3_2. Raising concerns		2021	2022	2023	2024
q20a	Would feel secure raising concerns about unsafe clinical practice	75%	66%	69%	67%
q20b	Would feel confident that organisation would address concerns about unsafe clinical practice	59%	49%	51%	**48%**
q25e	Feel safe to speak up about anything that concerns me in this organisation	62%	55%	58%	**55%**
q25f	Feel organisation would address any concerns I raised	46%	39%	44%	**37%**

4. We are safe and healthy

PP4_1. Health and safety climate		2021	2022	2023	2024
q3g	Able to meet conflicting demands on my time at work	32%	34%	37%	36%
q3h	Have adequate materials, supplies and equipment to do my work	55%	56%	59%	56%
q3i	Enough staff at organisation to do my job properly	19%	19%	27%	28%
q5a	Have realistic time pressures	18%	18%	23%	21%
q11a	Organisation takes positive action on health and well-being	47%	48%	47%	43%
q13d	Last experience of physical violence reported	72%	73%	76%	76%
q14d	Last experience of harassment/bullying/abuse reported	47%	48%	52%	53%

PP4_2. Burnout		2021	2022	2023	2024
q12a	Never/rarely find work emotionally exhausting	16%	19%	20%	17%
q12b	Never/rarely feel burnt out because of work	21%	24%	27%	22%
q12c	Never/rarely frustrated by work	11%	13%	15%	11%
q12d	Never/rarely exhausted by the thought of another day/shift at work	27%	29%	30%	25%
q12e	Never/rarely worn out at the end of work	12%	13%	13%	13%
q12f	Never/rarely feel every working hour is tiring	40%	45%	47%	43%
q12g	Never/rarely lack energy for family and friends	28%	28%	29%	28%

PP4_3. Negative experiences		2021	2022	2023	2024
q11b	In last 12 months, have not experienced musculoskeletal (MSK) problems as a result of work activities	60%	62%	63%	64%
q11c	In last 12 months, have not felt unwell due to work related stress	44%	46%	49%	46%
q11d	In last 3 months, have not come to work when not feeling well enough to perform duties	38%	37%	37%	33%
q13a	Not experienced physical violence from patients/service users, their relatives or other members of the public	75%	77%	80%	75%
q13b	Not experienced physical violence from managers	99%	99%	99%	99%
q13c	Not experienced physical violence from other colleagues	98%	98%	98%	99%
q14a	Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	58%	62%	59%	61%
q14b	Not experienced harassment, bullying or abuse from managers	89%	87%	86%	86%
q14c	Not experienced harassment, bullying or abuse from other colleagues	84%	83%	81%	82%

5. We are always learning

PP5_1. Development		2021	2022	2023	2024
q24a	Organisation offers me challenging work	68%	67%	67%	**63%**
q24b	There are opportunities for me to develop my career in this organisation	56%	52%	52%	**47%**
q24c	Have opportunities to improve my knowledge and skills	64%	63%	64%	63%
q24d	Feel supported to develop my potential	48%	48%	51%	**47%**
q24e	Able to access the right learning and development opportunities when I need to	49%	49%	50%	48%

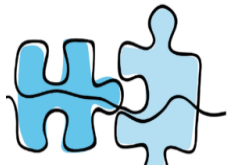
PP5_2. Appraisals		2021	2022	2023	2024
q23b	Appraisal helped me improve how I do my job	19%	19%	19%	17%
q23c	Appraisal helped me agree clear objectives for my work	29%	27%	28%	28%
q23d	Appraisal left me feeling organisation values my work	30%	28%	28%	**24%**

6. We work flexibly

PP6_1. Support for work-life balance		2021	2022	2023	2024
q6b	Organisation is committed to helping balance work and home life	33%	33%	33%	32%
q6c	Achieve a good balance between work and home life	40%	40%	43%	42%
q6d	Can approach immediate manager to talk openly about flexible working	61%	60%	66%	66%

PP6_2. Flexible working		2021	2022	2023	2024
q4d	Satisfied with opportunities for flexible working patterns	37%	38%	43%	41%

7. We are a team



PP7_1. Team working		2021	2022	2023	2024
q7a	Team members have a set of shared objectives	66%	65%	65%	66%
q7b	Team members often meet to discuss the team's effectiveness	36%	41%	41%	43%
q7c	Receive the respect I deserve from my colleagues at work	68%	68%	69%	68%
q7d	Team members understand each other's roles	77%	74%	75%	75%
q7e	Enjoy working with colleagues in team	83%	81%	81%	81%
q7f	Team has enough freedom in how to do its work	44%	45%	45%	43%
q7g	Team deals with disagreements constructively	48%	47%	47%	48%
q8a	Teams within the organisation work well together to achieve objectives	49%	45%	47%	43%

PP7_2. Line management		2021	2022	2023	2024
q9a	Immediate manager encourages me at work	69%	69%	72%	71%
q9b	Immediate manager gives clear feedback on my work	63%	63%	65%	65%
q9c	Immediate manager asks for my opinion before making decisions that affect my work	50%	51%	53%	53%
q9d	Immediate manager takes a positive interest in my health & well-being	68%	68%	73%	71%

South Central Ambulance Service
NHS Foundation Trust

NHS STAFF SURVEY RESULTS 2024

- Next Steps

Staff Survey 2024

Your Views Matter

Next Steps

1. Timeline agreed by Staff Survey Team
2. Survey Results (under embargo) shared with key stakeholder groups (detailed below)
   - This shall include Executive, PACC, and JCC.
3. Local + Trust pledges and action plan process to be agreed and implemented.
4. Communications prepared and released after Embargo lifted.

REPORTING PACK SENT TO STAKEHOLDERS

- Trust survey results – Picker.
- Trust survey results – NHSE.
- People promise results by Trust, Area, and Individual Department.
- Survey results RAG report, by Trust, Area, and individual Department.
- WRES/WDES results, by Trust, Area and individual Department.
- Consultation time with HR Team representative to assist in action plans and pledges

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Trust Board of Directors Meeting in Public
27 March 2025

Report title	Gender Pay Analysis report 2024-2025
Agenda item	22
Report executive owner	Natasha Dymond, Interim Director of People
Report author	Dipen Rajyaguru, Head of ED&I
Governance Pathway: Previous consideration	ED&I Steering group Executive Management Committee People and Culture Development Group People and Culture Committee
Governance Pathway: Next steps	The Trust Board is to note the report and be assured of duty to publish our analysis of Gender pay

Executive Summary
Since April 2017, all organisations with more than 250 employees have been required to publish details of their gender pay analysis (gaps). The Board is asked to provide approval for prior to the report to be published on the Trust's website by end of March 2024

Alignment with Strategic Objectives
With which strategic theme(s) does the subject matter align? People & Organisational

Relevant Business Assurance Framework (BAF) Risk
To which BAF risk is the subject matter relevant? Select BAF Risk.

Financial Validation	N/A

Recommendation(s)
What is the Committee/Board asked to do: The Board is invited to **note**: the contents of the report and **approve** the Gender Pay Analysis report 2024/25 for publication by 30th March 2025.

For Assurance	✓	For decision		For discussion		To note	✓

1. Background / Introduction

The gender pay analysis (gap) shows the difference in the average pay between all men and women in an organisation. It is reflective snapshot of our organisation on 31st March 2024. Reporting the workforce composition (male and female), mean and median pay gaps and the proportion of men and women within each quartile pay band. The Gender Pay Analysis report 2023/24 has been published on our website as per NHSE mandate.

2. Detail

The purpose of a gender pay gap report (audit) is to focus on comparing the pay of male and female employees and shows the difference in the average earnings.

This report provides information on the following indicators:

As of 31 March 2024, the (rounded) gender split remains as 45% male and 55% female.

- Men have a greater Mean hourly pay rate than women by a gap of 4.88%. This is a reduction from the previous year when the Mean gender hourly pay gap was 5.7% greater for men.
- The Median hourly pay is also slightly greater for men by a gap of 0.78% and has slightly increased form the previous year when it was 0.50%

- There is relative parity in the representation of men and women in Quartile 1 (lowest paid), with a difference of 0.08%. There are more men in Quartile 4 (highest paid) but has the second smallest gender split, with a difference of 1.94%. The most difference in gender representation occurred in Quartile 2 with 21.14% more women followed by Quartile 3 with 18.60% more women.
- A detailed analysis of data across a 4 year period by department and their individual service functions was undertaken. The overall data from our 5 principal departments (Finance, Commercial services, HR & Education, Operations, Chief Executives office), found, all but the Commercial services and NHS 111 departments had a pay gap (men being paid more) for women.

We found some possible explanations and mitigation around the disparities for example many of the functions within these departments had gender disparities, where some were very small in number of staff that happened to be predominantly or exclusively either male or female. Anecdotally, women took maternity leave and frequently came back in part-time (reduced hours) positions, this could lead to women coming back to a lower banded position. There was also potential mitigation that more women are taking up flexible working opportunities and suggestions that this may be due to caring requirements that has led to some disparity.

We are also required to publish the mean bonus gender pay gap, the median bonus gender pay gap and proportion of males and females receiving a bonus payment. However, as we do not pay bonuses, this was not applicable.

South Central Ambulance Service NHS Foundation Trust has utilised the standard NHS Gender Pay Report provided as part of the NHS Business Intelligence Tool. This ensures that information is accurate, reliable, and easily contrastable and comparable with other healthcare partners and wider employers.

3. Quality Impact

The decision by this Board does not impact on patient safety, patient experience or clinical effectiveness.

4. Financial Impact

The decision by this Board has no quantifiable financial impact

5. Risk and compliance impact

As a public sector body employing above 250 people, we are statutorily required to publish this report under The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017.

6. Equality, diversity and inclusion impact

Requirement to publish this report under The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 and Supports Equality Act 2010 Public Sector Equality Duty (section 149).

7. Next steps

Upon Board approval to publish on our website.
Actions and progress will be monitored by the Equality and Diversity Steering Group on a quarterly basis.

8. Recommendation(s)

The Board is invited to **note** the contents of the report and **approve** The Gender Pay Analysis report 2024/25 for publication by 30/03/2025.

9. Appendices (below)

Gender Pay Analysis Report 2024/2025

Appendix

South Central Ambulance Service
NHS Foundation Trust

Gender Pay Analysis Report 2024/2025*

***As of 31 March 2024 (snapshot date)**

Content

1. Introduction

Since April 2017, all organisations with more than 250 employees have been required to publish details of their gender pay gap. Gender pay reporting is different to equal pay which deals with the pay differences between men and women who carry out the same jobs, similar jobs, or work of equal value. The gender pay gap shows the difference in the average pay between all men and women in an organisation. Although we are only required to report on pay differentials between men and women, we do recognise that Gender is a spectrum that extends beyond the binary definition of male/female and men/women. We hope that national and local data gathering becomes more sophisticated and as more people feel comfortable to define their non-binary status (to prevent identification of individuals) to include and analyse wider (non-binary) pay.
This gender pay gap report for South Central Ambulance Service (SCAS) provides a 'snapshot' on 31 March 2024. The data for this report has been drawn from the organisation's Electronic Staff Records (ESR) and pay roll database.

2. Equality and our Values

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

Our Values Based behaviours:

3. Message from Chief People Officer

“I confirm this report is accurate and reflects a snapshot of our organisation on 31st March 2024. We have identified several actions we will continue to undertake to improve the gender pay parity. We will undertake annual audits and publish data on our website as required by the regulations.”

Natasha Dymond, Interim Director of People

4. What this Audit covers

The purpose of a gender pay gap audit is to focus on comparing the pay of male and female employees and shows the difference in the average earnings.
This report provides information on the following indicators:
Mean gender pay gap in hourly pay – adding together the hourly pay rates of all male or female full-pay and dividing this by the number of male or female employees. The gap is calculated by subtracting the results for females from results for males and dividing by the mean hourly rate for males. This number is multiplied by 100 to give a percentage.
Median gender pay gap in hourly pay – arranging the hourly pay rates of all male or female employees from highest to lowest and find the point that is in the middle of the range.
Proportion of males and females in each pay quartile – ranking all of our employees from highest to lowest paid, dividing this into four equal parts (‘quartiles’) and working out the percentage of men and women in each of the four parts.
Mean bonus gender pay gap – add together bonus payments for all male or female employees and divide by the number of male or female employees. The gap is calculated by subtracting the results for females from results for men and dividing by the mean hourly rate for men. This number is multiplied by 100 to give a percentage.
Median bonus gender pay gap – arranging the bonus payments of all male or female employees from highest to lowest and find the point that is in the middle of the range.

Proportion of males and females receiving a bonus payment – total males and females receiving a bonus payment divided by the number of relevant employees. South Central Ambulance Service NHS Foundation Trust has utilised the standard NHS Gender Pay Report provided as part of the NHS Business Intelligence Tool. This ensures that information is accurate, reliable, and easily contrastable and comparable with other healthcare partners and wider employers.

5. Our Workforce Gender profile

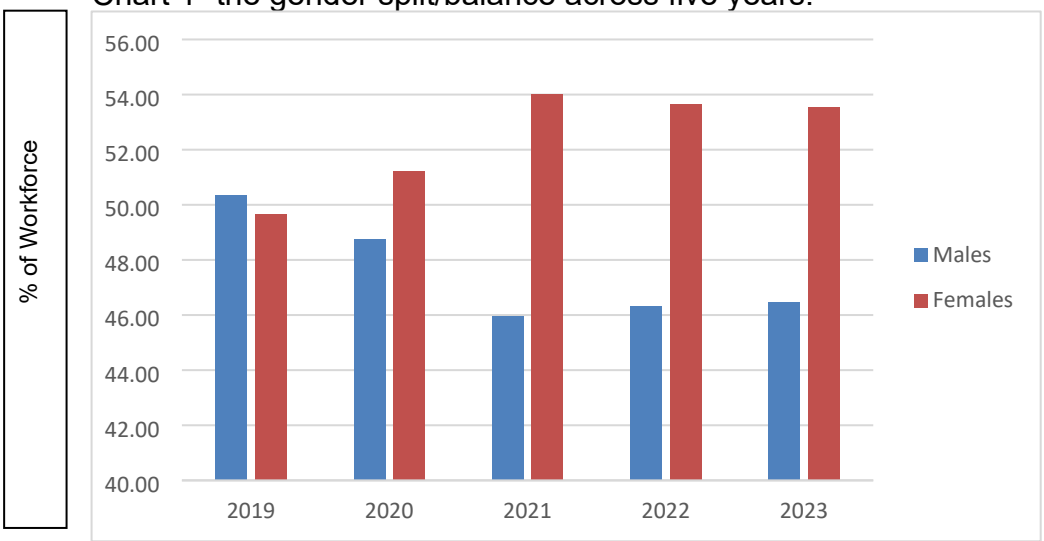
As of 31 March 2024, there were 4940 staff in post (an increase of 163 from the previous reporting period), the rounded gender split is now **45%** (2222) **male** employees and **55%** (2557) **female**. Table 1 below shows the profile over a 5 year period (on 31st March each year).

Table 1- Gender split over 5 years.

	2019	2020	2021	2022	2023	2024
Males	**50.35**	**48.77**	**45.97**	**46.33**	**46.47**	**45.26**
Females	**49.65**	**51.23**	**54.03**	**53.67**	**53.53**	**54.74**

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

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



6. Our Gender Pay audit

6.1 The Mean and Median gender pay gap

Table 2 - Mean pay gap (hourly rate)

	Male	Female	% Gap
Mean Gender Pay Gap (hourly rate)	£18.85	£17.93	4.88%

The table above shows that men have a greater **Mean** hourly pay rate than women by a gap of 4.88%. This is a reduced gap from the previous year when the Mean gender hourly pay gap was 5.79% greater for men (a change of 0.91%). The changes of the percentage Mean hourly pay gap over a 5 year period show fluctuation generally in favour of men. The anomaly in 2021 suggests an impact due to the pandemic and other contributory factors such as the drop in workforce and reduction of national services.

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

	2020	2021	2022	2023	2024
Mean hourly % pay gap	**0.74**	**-9.7**	**2.41**	**5.7**	**4.88**

The **Median** hourly pay is also slightly greater for men by a gap of 0.78%. However, this is a shift (an increase of 0.2.8%) from the previous year when Median hourly rate figure for men was greater at 0.50%.

Table 4 - Median pay gap (hourly rate)

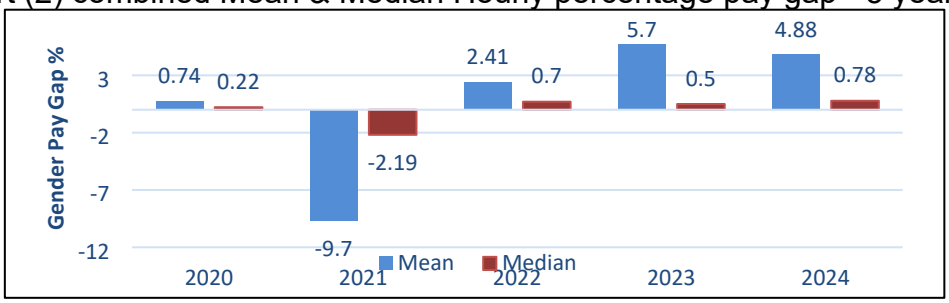
	Male	Female	% Gap
Median Gender Pay Gap (hourly rate)	£16.26	£16.13	0.78%

The changes of the percentage Median hourly pay gap over a 5 year period show that the gap has been fluctuating but has increased this year. The ‘blip’ in 2021 again, suggests an impact due to the pandemic and other contributory factors such as the drop in workforce and reduction of national services.

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

	2020	2021	2022	2023	2024
Median	**0.22**	**-2.19**	**0.7**	**0.5**	**0.78**

The Chart (2) combined Mean & Median Hourly percentage pay gap - 5 year period.



6.2 Ambulance Trusts Comparison Data reported (to AACE as of February 2025)

Table 6 - Comparison of Mean & Median Gender pay gaps in England & Wales

Ambulance Trust - Mean	% Difference (hourly rate)
North East Ambulance Service NHS Foundation Trust	0.29%
London Ambulance Service NHS Trust	4.53%
South Central Ambulance Service NHS Foundation Trust	**4.88%**
Welsh Ambulance Service	5.60%
East Midlands Ambulance Service	6.80%
North West Ambulance Service NHS Trust	7.27%
Yorkshire Ambulance Service NHS Trust	9.78%
South East Coast Ambulance Service NHS Foundation Trust	9.96%
South Western Ambulance Service Foundation Trust	%
East of England Ambulance Service NHS Trust	%
West Midlands Ambulance Service NHS Foundation Trust	%

Ambulance Trust -Median	% Difference (hourly rate)
North East Ambulance Service NHS Foundation Trust	0.31%
South Central Ambulance Service NHS Foundation Trust	**0.78%**
Welsh Ambulance Service	6.00%
East Midlands Ambulance Service	7.51%
South East Coast Ambulance Service NHS Foundation Trust	8.54%
Yorkshire Ambulance Service NHS Trust	8.87%
London Ambulance Service NHS Trust	9.74%
North West Ambulance Service NHS Trust	11.17%
South Western Ambulance Service Foundation Trust	%
East of England Ambulance Service NHS Trust	%
West Midlands Ambulance Service NHS Foundation Trust	%

6.3 Our Pay Quartiles

This data ranks all our employees and dividing them into **four equal parts** or quartiles and calculating the percentage of men and women in each of the quartiles (by hourly pay rate). However, this does not include any Over-Time payment (only hourly pay rate not 'take home' pay) or which gender is taking more over-time. Table 7 below contains data that ranks all our employees from lowest (Quartile 1) to highest paid (Quartile 4). The percentage figures given are a breakdown of each quartile gender split. The gender split overall for the Trust is 45% males and 55% female.

Table 7 – Quartile proportions by gender and % pay differences

	Male	***Female***	***Difference***
Gender Proportions in Pay Quartile 1	49.96%	50.04%	**-0.08%**
Gender Proportions in Pay Quartile 2	39.43%	60.57%	**-21.14%**
Gender Proportions in Pay Quartile 3	40.70%	59.30%	**-18.60%**
Gender Proportions in Pay Quartile 4	50.97%	49.03%	**1.94%**

There is relative parity in the representation of men and women in Quartile 1 (lowest paid), with a difference of 0.08%. There are more men in Quartile 4 (highest paid) but has the second smallest gender split, with a difference of 1.94%. The most difference in gender representation occurred in Quartile 2 with 21.14% more women followed by Quartile 3 with 18.60% more women.

6.4 Mean and Median Bonus pay gap

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

7. Our 2023/24 Actions and Conclusions

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

- Undertaken a further and disaggregated analysis of directorate and departmental data across a 4 year period and reported disparities by department.

- Taking positive action in our recruitment adverts to now include part time and flexi working (where possible).

- Having the recruitment team are prompted to speak and to encourage to managers to consider when roles are available to include part time and flexi working (where possible.

- Getting Managers to consider People who took maternity or paternity leave to provide flexible working options or a ‘staged’ return.

- For Executive Board recruitment the’ Agencies’ we used were briefed to ensure that their strategies were diverse and inclusive in order to have more female applicants. This has resulted in offers to a female Non-Executive Director |(NED) and a female applicant to an Executive role

- We looked into a tool that tried to gender neutralise our adverts which actually then had the opposite effect when we proofed them – so we came away from this.

- Taking a holistic approach to our employee health and wellbeing to further support our female workforce, we are focusing on issues that affect them such as our menopause café that provides a ‘safe space’ to discuss issues and find support.

Conclusion:

A detailed analysis of data across a 4 year period by department and their individual service functions was undertaken. The overall data from our 5 principal departments (Finance, Commercial services, HR & Education, Operations, Chief Executives office), found, all but the Commercial services departments had a pay gap (men being paid more) for women. We found some possible explanations and mitigation around the disparities for example many of the functions within these departments had gender disparities such as Finance (estates) was exclusively male until 2023, however it had less than 10 staff. Conversely, in the Chief Executives Office the Executive support function was all female also HR (operations) was exclusively female in 2022 with less than 10 staff but as more came in after that year and were in higher pay bands this had a significant impact on the pay gap. Another outlier was within the Operations department where NHS 111 was the only department in 2023 that paid women slightly more than men and has consistently the narrowest pay gap.

Anecdotally, women took maternity leave and frequently came back in part-time (reduced hours) positions (more so than men taking paternity leave and coming back to part-time positions), this could lead to women coming back to a lower banded position. There was also potential mitigation that more women are taking up flexible working opportunities and suggestions that this may be due to caring requirements that has led to some disparity.

While some progress has been made, the data indicates that a gender pay gap persists within South Central Ambulance Service (SCAS) with this trend remaining largely unchanged over the past few years. It is important to note that this challenge is widespread across the NHS and local government sectors and is not unique to SCAS.

There may be mitigating factors and anecdotal evidence that help explain aspects of the gap; however, the Trust remains committed to addressing this issue. We are actively implementing a series of targeted initiatives to improve our overall position, which are outlined in our Next Steps for 2024/25.

8. Our next steps for 2024/25

Objective	Action	Lead	Timeline	Improvement measure
Collate and assess data to build on our positive outcomes and understand any imbalances within our Trust	Continue to undertake further analysis of directorate and departmental data	HR and Head of EDI	Reporting period 2024/2025	Data and reports of and to departments to identify local and targeted actions to gain equitable pay differential
Continue to promote positive action to bring about pay equity and promote women into leadership	Ensure that we safeguard against any bias (conscious or unconscious). Look at positive action measures for retention: •Stretch assignments: Offer challenging projects or opportunities that build visibility and experience in	HR and Head of EDI	Reporting period 2024/2025	Narrowing of Mean hourly Gender pay gap

	senior-level responsibilities. Outreach programs: Partner with women's networks, and external universities, or NGOs to identify and encourage female candidates.			
Encourage the uptake of flexible working	Advertise and offer all jobs as having flexible working options, such as part-time work, remote working, job sharing or compressed hours Allow people to work flexibly, where possible Encourage senior leaders to role model working flexibility and to champion flexible working Encourage men to work flexibly, so that it isn't seen as only a female benefit. Utilise flexible reporting information in ESR through Manager self-serve Supportive return-to-work	HR and Recruitment People Promise manager Men's health Network	Reporting period 2024/2025	More staff taking advantage of flexible working Roll out of manager self-serve

	programs: Provide re-skilling and confidence-building initiatives for women returning after career breaks.			
Maternity & Paternity leavers supported	People who took maternity or paternity and stayed on leave longer than statutory limit are encouraged to come back to the Trust with 'staged' support Explore offering options for women to remain full time (if they wish to) with different flexible working options other than just reducing their hours. Encourage men's rights to shared leave	Recruitment Men's Network	Reporting period 2024/2025	More staff coming back to the Trust after any prolonged maternity or paternity leave
To understand reasons why women are not applying to more senior positions or receiving same hourly pay as men	Create a survey to get qualitative data to understand any 'barriers' or 'ceilings' to career or pay progression Blind applications: • Remove identifying details (e.g., names, gender) to reduce unconscious bias in the initial screening	HR	Reporting period 2024/2025	A better understanding of issues that prevent career or pay progression to enable action implementation planning

	•Targeted mentoring: Pair aspiring women leaders with mentors or role models already in senior positions. •Leadership training: Provide tailored programs to develop skills and confidence for senior roles.			
Board Leadership visibility	CEO/Executive Board engagement to promote & prioritise Gender Equality For Executive Board recruitment continue with the Agencies that have used attraction strategies with a review of how they would be fully inclusive within their recruitment / advertising campaign • Highlight women leaders: Showcase successful women in senior roles through case studies, blogs, or events.	CEO/ Executive Board Recruitment	Reporting period 2024/2025	To increase applications for Board position from women
Engagement with the national Ambulance	Further engaging the Women's Network in with other gender staff	Women's Network	Reporting period 2024/2025	The Trust adapts and adopts good practice from other Trust's

(and other NHS) Staff networks	networks across UK, particularly the NHS to source and adopt good practice. Work with BOB ICS inclusive recruitment strategies. • Networking opportunities: Facilitate connections within and outside the organisation to enhance access to role models.	Recruitment/ Head of EDI		staff Women's/Gender networks.
NHSE ED&I Improvement plan High Impact Action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity	Report on specific metrics for High Impact Actions (HIAs) HIA 2 is specifically a measuring equitable recruitment	HR Recruitment ED&I	Reporting period 2024/2025	The measure for this is the Annual chair and chief executive appraisals on these EDI objectives
Recruitment and selection practices are inclusive for all staff and of all genders	Continue to review and analyse inclusivity of recruitment materials (including where adverts are placed) Ensuring our adverts are fully inclusive on social media for	Recruitment Communications HR Operations	Reporting period 2024/2025	Recruitment policies and literature is reviewed to ensure that all genders feel welcome to apply for roles. To find out and analyse any negative experiences and

	our roles (in terms of photos and good news stories). Active promotion (on social media). • Diverse panels: Ensure recruitment panels include women and individuals trained in unconscious bias.	Recruitment		seek to reduce them (ER cases)

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Board of Directors Meeting in Public
27 March 2025

Report title	Communications, Marketing and Engagement Update
Agenda item	23
Report executive owner	Gillian Hodgetts, Director of Communications, Marketing and Engagement
Report author	Gillian Hodgetts, Director of Communications, Marketing and Engagement
Governance Pathway: Previous consideration	N/A
Governance Pathway: Next steps	N/A

Executive Summary

Knife crime awareness campaign

Working with operational teams, partners in other emergency services, local authorities, knife crime prevention charities and campaigners, we developed a knife crime awareness campaign that ran throughout February. The aim was to raise awareness of the impact of knife crime on victims, their families and local communities; and to promote the potentially life-saving emergency first aid members of the public can provide to victims whilst emergency services are on their way.

Patient Transport Service long service awards

On 17 February we held a Long Service Awards event to mark the dedication of Patient Transport Service colleagues from Sussex and Thames Valley who will be transferring out of South Central Ambulance Service's (SCAS) employment to that of a new private provider from 1 April 2025.

Your Health Matters public talk

The latest in our series of public engagement talks took place on 4 March at 7pm. The event was a partnership with the Association of Ambulance Chief Executives (AACE) covering out

of hospital cardiac arrests and how addressing health inequalities can save more lives.

Intranet improvements

With the new executive structures coming into effect from 1 April 2025, we have been undertaking a significant piece of work to reorganise department sites/pages on our intranet. We are also taking the opportunity to refresh the site and bring in improved features.

Alignment with Strategic Objectives
With which strategic theme(s) does the subject matter align? All Strategic Objectives

Relevant Business Assurance Framework (BAF) Risk
To which BAF risk is the subject matter relevant?

Financial Validation	Capital and/or revenue implications? If so: Checked by the appropriate finance lead? (for all reports) Considered by Financial Recovery Group (for reports where the financial impact is not covered within existing budgets)

Recommendation(s)
What is the Committee/Board asked to do: Please amend as appropriate. The following is intended as a guide only. • Approve a recommendation/paper/proposal • Receive a report/paper and take assurance from it • Discuss a report/paper and establish what further action is required • Receive a report/paper for noting

For Assurance		**For decision**		**For discussion**		**To note**	✓

1. Background / Introduction

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

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

Knife crime awareness campaign – February 2025

In line with our communications strategic objectives to increase public awareness, we have been working with operational teams, partners in other emergency services, local authorities, and knife crime prevention charities and campaigners on a knife crime awareness campaign that ran throughout February.

The aim was to raise awareness of the impact of knife crime on victims, their families and local communities; and to promote the potentially life-saving emergency first aid members of the public can provide to victims whilst emergency services are on their way.

Within the SCAS area, the Office National Statistics reported over 2,160 stabbings between September 2023 - September 2024. The highest levels of incidence were in Oxfordshire and south-east Hampshire, but there have been serious incidents across the whole region. Throughout the month we issued press releases, participated in events and posted multi-media content with a key focus for each of the four weeks of the campaign as follows:

- Week 1 – core messaging around knife crime statistics both nationally and in the SCAS operational area, along with common myth busting.

- Week 2 – interview filmed with Kirsten Willis-Drewett, Assistant Director of Operations, who visited Amanda and Stuart Stephens, the parents of Olly Stephens who was stabbed and killed in Reading in January 2021

- Week 3 – engagement event with partners in Langley to teach local young people how to provide immediate first aid to someone who has been stabbed, including using a bleed kit

- Week 4 – launch of first aid film created with the SCAS education team demonstrating how to treat a variety of stabbing injuries

Thanks to in-depth desk research carried out in January and early February, establishing strong links with external partners and bringing hard-hitting personal stories from SCAS staff and victims/victims' families, we secured a significant amount of public relations coverage across regional broadcast, press and digital media, as well as national digital media take-up, featuring on the home page of BBC News (twice) and ITV News.

Overall, we secured 47 different items of media coverage across print, broadcast and websites; securing a reach of over 7 million people and an Advertising Value Equivalency of over £550,000 (this is the estimate of how much it would cost to buy the same amount of media coverage). There was no cost to the campaign apart from people/time resource.
Activity on the main SCAS corporate social media channels enabled us to reach a further 106,000 people.

The campaign has generated additional requests from council, police and fire colleagues to support related public engagement activities later in the year. These include:

- Slough Borough Council has contacted us to explore opportunities for collaboration.

- Reading College and Banbury College have also made contact about delivering engagement sessions to students.

- Hampshire Police have asked us to attend a beat surgery in Portsmouth in May, and Thames Valley Police have asked us to get involved with some partnership work with BAME UK (Black, Asian and Minority Ethnic) delivering community engagement work in Milton Keynes, and a community event in Slough.

- Buckinghamshire Fire Service have asked us to attend an awareness and fundraising event in Milton Keynes in May.

Patient Transport Service long service awards

Recognising and rewarding good conduct and long service continues to be a priority for the trust. On 17 February we held a specific Long Service Awards event for Patient Transport Service (PTS) colleagues from the Sussex and Thames Valley area where we have been providing a patient transport service. It was an occasion of mixed emotions as we marked the dedication of PTS colleagues who from the 1 April 2025, will be transferring out of SCAS's employment, to that of a private provider, EMED.

Twenty members of staff and their guests joined David Eltringham (Chief Executive), Paul Stevens (Director of Commercial Services) and other senior leaders at Ampfield Golf & Country Club for the celebration. A further 24 staff were not able to attend on the day but have been presented with their medals at local bases. Everyone came together to celebrate the long service, commitment and professionalism of all the recipients of the long service medal, for service ranging from 20 to 37 years.

David and Paul both spoke about the importance of the PTS to our patients, not just as a transport service but also for ensuring that every patient, regardless of their condition, receives the care, comfort, and dignity they deserve. There were several memorable and heart-warming stories of PTS colleagues showing enormous care, compassion, and often humour with their patients and demonstration of committed and supportive teams, many of whom have worked together for a number of years.

Congratulations to everyone who received their long service medal; and an enormous thank you to every single member of the PTS teams leaving SCAS, for their dedicated and committed service to our patients and to each other. We wish you all the very best for the future both personally and professionally.

'Your Health Matters' public talk

One of our key strategic communications objectives is to engage with our communities, both to share information and to gain insights and feedback on the services that we provide.
The latest in our series of public engagement talks took place on 4 March at 7pm. We often work in partnerships with other organisations both national, regional and local to convey information on our services and to talk about innovative new practices in clinical care. The event was a partnership with the Association of Ambulance Chief Executives (AACE) and the talk

focused on ‘out of hospital’ cardiac arrests and how addressing health inequalities can save more lives.

The key speakers for the session were Duncan Robertson, Chief Paramedic at SCAS and Liam Saagi, AACE National Strategic Lead for Out-of-Hospital Cardiac Arrest. The session was chaired by Professor Sir Keith Willett.

Liam gave an interactive Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) demonstration, and the discussion session covered information on CPR training and AED purchase. We had a great turnout of 85 people who joined the event, and feedback gleaned so far has been very positive.

Intranet improvements

Our intranet site is a very important source of information for staff right across our organisation. Given the challenges of shift working, the nature of some of roles, dispersed sites all across our four counties footprint and the demands on the service, many staff use the site as their primary source of information and as such we are working hard to keep it up to date, relevant, interesting and informative.

With the new executive structures coming into effect from 1 April 2025, we have been undertaking significant amounts of work to reorganise department sites and pages on our intranet. We are also taking the opportunity to refresh the site generally and to bring in improved features.

The main home section is being updated to the latest version of SharePoint and each of the executive directorates will have a new section with all their sub-departments linked to it. This will hopefully make it easier for staff to find each other and to know who is reporting to who in the organisation.

The updates make the latest functionality available so we can improve both the look and feel and the search functionality. A significant improvement to the search function addresses a main point of concern from the staff feedback that we received, when we undertook our recent internal communications survey.

We now have over 100 staff trained as content managers for departmental sections of the intranet. The communications team has been working closely with these content managers to update their sections so essential information is easy to find for the wider workforce.

2. Quality Impact

N/A

3. Financial Impact

N/A

4. Risk and compliance impact

N/A

5. Equality, diversity and inclusion impact

N/A

6. **Next steps**

N/A

7. Recommendation(s)

7.1 The Board is asked to:

7.1.1 Receive a report/paper for noting.

8. Appendices

N/A

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Trust Board of Directors Meeting in Public
27 March 2025

Report title	Standing Orders and Scheme of Reservation and Delegation
Agenda item	25
Report executive owner	Stuart Rees, Interim Chief Finance Officer
Report author	Becky Southall, Chief Governance Officer
Governance Pathway: Previous consideration	Audit Committee 19th March 2025
Governance Pathway: Next steps	None – Board of Directors is the final approving body

Executive Summary

The Board of Directors is required to develop and approve a Scheme of Reservation and Delegation (SoRD), which sets out its statutory and regulatory responsibilities and provides clarity around decisions that must be taken by the board and those that it delegates to either its formally constituted committees or to the executive directors and other officers of the Trust.

It would neither be possible nor desirable for the board to take every decision that has to be made in the day to day running and operation of the trust and developing the SoRD provides a clear framework to ensure that decisions are taken by an appropriately authorised individual or committee within the structure.

To accompany this, the Board a custodian of public money is also required to adopt Standing Financial Instructions, which are the 'rules' by which every individual working for, or on behalf of the trust has to follow with regards to utilisation of trust money. This ensures that there is appropriate financial prudence and control commensurate with stewardship o public finances.

These two documents form an integral part of the Trust's Standing Orders and together, this forms the Corporate Governance Framework for the Trust, which is the cornerstone of the Trust's system of internal control.

The Audit Committee has a key role in scrutinising these documents and ensuring they are robust and fit for purpose. Discussion took place at the March 2025 Audit Committee and amendments requested by the Audit Committee are made within the attached documents in red for ease of reference. Subject to these amendments being made, as the Chair's Report confirms, the Audit Committee is recommending the adoption of the Standing Financial Instructions and the approval of the Scheme of Reservation and Delegation of Powers.

Alignment with Strategic Objectives
These documents related primarily to Finance & Sustainability but also contribute to the Trust's ability to demonstrate that it is a well led and well governed organisation.

Relevant Business Assurance Framework (BAF) Risk
The documents relate primarily to SR5 - Increasing Cost to Deliver Services but financial stewardship and governance underpins each of the BAF risks.

Financial Validation	Capital and/or revenue implications? If so: None Checked by the appropriate finance lead? (for all reports) Approved by the Chief Finance Officer Considered by Financial Recovery Group (for reports where the financial impact is not covered within existing budgets) Not applicable

Recommendation(s)
The Board is asked to ADOPT the Standing Financial Instructions and to APRROVE the Scheme of Reservation and Delegation of Powers.

For Assurance		**For decision**	✓	**For discussion**		**To note**	

1. Background / Introduction

- The board is required to develop and approve a Scheme of Reservation and Delegation of its Powers to ensure that decisions are taken appropriately and by properly authorised individuals or forums within the governance structure.
- The board is also required to develop and approve Standing Financial Instructions that sets out expenditure limits that it formally delegates to individual officers of the trust and the duties of officers and directors. This document also provides the 'business rules' that anyone working for, on behalf of the trust are obliged to follow. Failure to do so could result in disciplinary action.

2. Detail

The attention of the Board is drawn to the following sections:

- **Standing Financial Instructions;** this sets out the key roles and responsibilities of the Chief Executive Officer (CEO) and Chief Financial Officer (CFO) as Accountable Officer and Accounting Officer respectively. It also covers key areas of financial and internal control, such as budgetary management, internal and external audit, fraud, bribery, procurement and security management.
- **Appendix 1:** this sets out the level of expenditure that is delegated to officers of the trust and levels of expenditure that must be approved by the trust board (or committees thereof) and any external approval(s) required.
- **Appendix 3: Scheme of Reservation of Powers to the Board;** sets out the decisions that can and must only be taken by the trust board, albeit it the board can formally delegate decision taking to the committees that it has established where this is appropriate and necessary.
- **Appendix 4: Scheme of Delegation;** sets out the specific accountability of directors and officers of the trust and the management leads. It should be noted that not all management leads are identified owing to the corporate restructure which remains underway.
- **Appendix 5: Policies reserved for Board approval;** this sets out the policies that require the approval of the board or its committees. This is currently subject to review with the principle that policies will be delegated to the committee or group in the trust to whom they are most relevant and where the relevant expertise forms part of the membership. The list of policies reserved for board approval is therefore expected to change when this work is complete.

Whilst these documents will be subject to thorough review every 3 years, in an ever-changing environment, provision has been made for minor amendments, such as changes in job titles and in organisational structures to be made by the CFO and Chief Governance Officer (CGO). Any such changes will be reported to the Audit Committee.

3. Quality Impact

There is no direct impact on quality related to the approval of these documents as they relate primarily to good financial stewardship, albeit it, quality, operational and financial performance are inextricably linked and are also linked to sustainability.

4. Financial Impact

There is no direct financial impact arising from approval of these documents. There could however be financial implications arising from failing to have clear arrangements in place for governing and controlling expenditure across the organisation.

5. Risk and compliance impact

If the trust does not put into place clear arrangements for prudent financial control and rules for the conduct of its business, then there is the risk that individuals will take decisions or commit to expenditure that is outside of their remit. This could result in consequences for that individual and risks the ability of the trust to exercise prudent control over public money and deliver on its statutory duty to achieve a break-even position. Failure to deliver financial sustainability could impact the ability of the trust to deliver on all its strategic imperatives and could lead to regulatory intervention.

6. Equality, diversity and inclusion impact

The document is equally applicable to all staff and there is specific reference to this at section 26 of the document. It is appreciated however that the document is complex, and provision is made for trust staff to seek advice and guidance from the CFO or the CGO where necessary.

7. Next steps

- Following approval, the document will be published on the Governance section of the intranet so that it is available to all staff
- It will also be communicated to all officers of the trust with a signpost to where it can be accessed

8. Recommendation(s)

The Board is asked to **APPROVE** the Standing Financial Instructions and Scheme of Reservation and Delegation of Powers.

9. Appendices

- Standing Financial Instructions; incorporating the appendices referred to above.

South Central Ambulance Service
NHS Foundation Trust

Standing Financial Instructions, Reservation of Powers & Scheme of Delegation

Approved by the Board of Directors: XX XX 2025

Table of Contents

Introduction to Standing Financial Instructions and Scheme of Delegation

1. What are the Standing Financial Instructions and Scheme of Delegation?

1.1. This document combines the Standing Financial Instructions (SFIs) and Reservation and the Scheme of Delegation (SoD) for South Central Ambulance Services NHS Foundation Trust (the 'Trust'). This document, together with the Trust's Standing Orders (SO) comprises the Corporate Governance Framework and is the definitive business and financial framework, which ensures that there is clarity in relation to the business rules within which directors, officers, staff and third parties contracted to the trust are required to work. For the duration of this document, "staff" applies to directors, officers, trust staff and third parties conducting business for, or on behalf of the trust.

1.2. Together they cover all aspects of financial and management control, together with some areas of non-financial corporate governance, and set out the responsibilities of individuals including the levels of responsibilities clearly delegated to Executives, other senior trust officers and staff. This framework is mandatory, is applicable to all staff as per the definition set out in 1.1), all of whom are required to follow it. Failure to follow the provisions outlined in this document is a serious matter which could result in disciplinary action as outlined at (3.3) below. Adherence to this framework will ensure:

- The trust operates within statutory, legislative and regulatory requirements at all times
- The interests of the trust are protected
- The conduct of the Trust, its directors, officers and agents in relation to all financial matters is subject to clear rules and can be regulated
- Staff are provided with a framework within which they can be confident they are acting properly, with prudence and integrity which is commensurate with a publicly funded organisation.

1.3. Any questions relating to the SFIs and SoD should be referred to the Chief Finance Officer. Any questions relating to the SOs should be referred to the Chief Governance Officer. The SFIs and SoD are formally adopted by the Board and shall be reviewed every three years. Any minor revisions that are required in the intervening period, for example to reflect changes in job titles/roles or changes in organisational form will be agreed by the Chief Financial Officer and Chief Governance Officer and reported to the Audit Committee.

1.4. All directors and all members of staff should be made aware of the existence of these documents and be familiar with all relevant provisions. The rules set out in these documents fulfil the dual role of protecting the trust's interests and protecting the staff from any possible accusation that they have acted improperly.

1.5. The SFIs and SoD do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes and all relevant policies.

2. Where can I find the information I need?

2.1. The SFIs and SoD set out how the Trust governs itself and provide a clear set of rules so that staff understand what they are and are not able to do under their delegated powers. This can however be complex. The table below is designed to help signpost and direct staff to where they can find the information needed quickly and easily. Appendix 4 contains the Trust's detailed Scheme of Delegation and Reservation of Powers as approved by the Board.

2.2. Table 1

Where can I find information on…	**Help can be found here**
An overview of individuals' responsibilities and general description of my duties	SFIs - *Section 3 and 5*
Schedule of financial delegated limits	Appendix 1
Who needs to approve my business case	Appendix 4
Who needs to sign a contract that I have been working on	See Standing Orders / Appendix 4
What I am allowed to accept as gifts, hospitality or sponsorship	See Gifts, Hospitality and Conflicts of Interests Policy
How many quotes I need to obtain and when I need to formally tender	Appendix 4
The powers that are reserved to the Board of Directors	SFIs – *Section 1* and Appendix 5
Fraud and Bribery	*Section 6.5*. See also Anti-Fraud and Bribery Policy.

3. Why are the SFIs and SoD important?

3.1. The Health and Social Care Act 2003 created NHS Foundation Trusts as new legal entities. The legislation constituted NHS Foundation Trusts with a governance regime with both local and external accountabilities. The framework of local accountability is to members through the Council of Governors. Externally, while remaining part of the NHS, Foundation Trusts are licenced by, and accountable for, the operation of their licence to NHS England (NHSE), sector regulator for health services in England. NHSE describes part of its role as:

"To ensure that the boards of NHS Foundation Trusts focus on good leadership and

governance, in line with their duty to be effective, efficient and economic"

3.2. In addition, the trust is subject to external scrutiny each year and the external auditors have a duty to seek and provide assurance that there are proper arrangements in place to ensure economy, efficiency and effectiveness in its use of resources.

3.3. Given the importance of these duties and requirements to comply with the legal duties outlined in the Provider Licence, it is essential that the Trust has in place good governance and financial controls. As such, **failure to comply with the SFIs, SoD and SOs may be a disciplinary matter which could result in dismissal.**

3.4. These SFIs shall have effect as if incorporated in the Standing Orders (SOs) of the Trust. As the Board approves the SOs, SFIs and SoD, they may only be overridden with the express authority of the Board. Any breaches will be reported to the Audit Committee and escalated to the trust board.

3.5. This document identifies the financial responsibilities which apply to everyone working for or on behalf of the Trust as defined in (1.1). They do not provide detailed procedural advice, which is available elsewhere (see table above). **The Chief Finance Officer must approve all financial procedures or specifically delegate their approval on a case-by-case basis.**

3.6. The SFIs and SoD apply to any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this. They also apply to those representing the Trust in relation to any of its joint ventures, or other special purpose vehicles in which the Trust has an ownership interest, but do not apply to Trust staff with roles in other entities in which the Trust does not have an ownership interest. See *Section 16* for further guidance.

3.7. Should any difficulties arise regarding the interpretation or application of the SFIs and the SoD, **the advice of the Chief Finance Officer must be sought before acting**. Staff should also ensure they are familiar with and comply with the provisions of the SOs.

4. Definitions and Terminology

4.1. Wherever the title Chief Executive, Director, or other nominated officer is used in these instructions, it should be deemed to include such other officers who have been duly authorised to represent them, for example through a formal and documented acting up arrangement or a deputised position. However, no individual is authorised to empower anybody who is not under his or her own organisational control, and delegation of responsibility does not remove accountability from the individual delegating.

4.2. References in these instructions to **"officer"** shall be deemed to include all staff of the Trust, including nursing and medical staff, consultants practicing upon Trust premises, and staff of third parties contracted to the Trust when acting on behalf of the Trust and within the Trust's control.

4.3. Further definitions can be found at Appendix 2.

5. Overview of Responsibilities and Delegation

5.1 General

5.1.1 The purpose of the Scheme of Delegation (SoD) is to define those powers that are reserved to the Board while at the same time delegating to the appropriate level the detailed application of Trust policy and procedures. Therefore, some powers and responsibilities are reserved to the Board (see Appendix 3) whilst others are delegated (see Appendix 4), which is representative of the delegated authority and accountability structure that the trust operates.

5.1.2 However, the Board remains accountable for all its functions, even those delegated to the Chair, individual Directors or officers, and should expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring and oversight role. In addition, there may be circumstances in which the Board can determine that it is appropriate to resume any or all its delegated powers. The Trust's Constitution and the Standing Orders describe the powers of the Council of Governors.

5.1.3 A detailed SoD can be found in Appendix 4. This is approved by the Board and may only be changed with Board's approval. It is important to note that delegation of a function to a lower level does not relieve the person delegating that function of responsibility.

5.2 Role of the Trust Board

5.2.1 The Trust Board is responsible for giving final approval to updated versions of the SFIs and SoD.

5.2.2 the Board shall exercise financial supervision and control by:

(a) formulating the financial strategy and agreeing the medium-term financial model.

(b) requiring the submission and approval of budgets within approved allocations/overall income.

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money).

(d) defining specific responsibilities placed on members of the Board and staff as indicated in the Scheme of Delegation and Reservation document.

5.2.3 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session. These are set out in the Scheme of Delegation and Reservation.

5.2.4 The Board will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Trust.

5.3 Role of the Chief Executive

5.3.1 The Chief Executive is accountable to the Board, and as Accounting Officer, for ensuring the

Board meets its obligation to perform its functions within the available financial resources. They has overall executive responsibility for the Trust's activities; is responsible to the Chair and the Board for ensuring that its financial obligations and targets are met; and has overall responsibility for the Trust's system of internal control.

5.3.2 The Chief Executive shall exercise all powers of the Trust that have not been retained as reserved by the Board (see Appendix 3) or specifically delegated to an executive committee or sub-committee. The SoD identifies functions that he/she shall perform personally, and functions delegated to other Directors and officers. All powers delegated by the Chief Executive can be re-assumed by them should the need arise.

5.3.3 It is a duty of the Chief Executive to ensure that existing Directors of the Board and staff and all new appointees are notified of their responsibilities within these instructions.

5.3.4 The Chief Executive and Chair must ensure suitable recovery plans are in place to ensure business continuity in the event of a major incident taking place.

5.3.5 The Chief Executive and Chief Finance Officer will delegate their detailed responsibilities, but they remain accountable for financial control.

5.3.6 The Chief Executive is responsible for ensuring that financial performance measures with reasonable targets have been defined and are monitored, with robust systems and reporting lines in place to ensure overall performance is managed and arrangements are in place to respond to adverse performance.

5.3.7 The Chief Executive may determine that powers devolved under this document and the detailed SoD (Appendix 4) be taken back to a more senior level – for example, areas of the Trust that are not meeting financial or other targets may be given a reduced level of devolved autonomy.

5.3.8 In accordance with guidance issued by NHSE, the Chief Executive is responsible for ensuring that the Trust provides an annual forward plan to NHSE and the ICB each year, together with quarterly reports (or more frequent if required by NHSE), which should be appropriately communicated to the Board and Council of Governors (Council).

5.4 Role of the Chief Finance Officer

5.4.1 The Chief Finance Officer is responsible for the following (see also *Section 5.3* for the Chief Finance Officer's responsibilities in relation to audit):

a) Advising on and implementing the Trust's financial policies.

b) Design, implementation and supervision of systems of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions.

c) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, to report, with reasonable accuracy, the financial position of the Trust at any time.

5.4.2 Provision of financial advice to other Directors of the Board and staff

5.4.3 Preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

5.5 Role of Board Directors and Staff

5.5.1 In addition to conforming with the requirements of the SOs, SFIs and SoD, all Directors of the Board and staff, severally and collectively, are responsible for:

a) Security of the property of the Trust and avoiding loss.

b) Ensuring economy, efficiency and effectiveness in the use of resources, taking seriously the Trust's duty to ensure value for money in everything that it does.

c) Conforming with the requirements of financial procedures that the Board may approve (or delegate approval of) from time to time.

5.5.2 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

5.5.3 For any and all directors of the Board and staff who carry out a financial function, the form in which financial records are kept and the manner in which members of the Board and staff discharge their duties must be to the satisfaction of the Chief Finance Officer.

5.6 Public Service Values

5.6.1 There are four crucial public service values that must underpin the work of all staff within the health service:

a) **Accountability** – everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.

b) **Probity** – there should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired during NHS duties.

c) **Openness** – there should be sufficient transparency about NHS activities to promote confidence between the NHS organisation and its staff, patients and the public.

d) **Value for Money** – all staff committing the Trust's resources have a duty to ensure value for money and may be asked to provide a value for money declaration for commitments that they have made.

5.6.2 Nothing in this document shall impair the discharge of the direct accountability to the Board of Directors of the Chief Finance Officer or other Executive Directors to advise the Board in accordance with statute or the requirements of NHSE.

5.6.3 In the absence of a director or officer to whom powers have been delegated those powers must be exercised by that Director or officer's manager unless the Board has approved alternative arrangements. If the Chief Executive is absent powers delegated to them may be exercised by the Deputy Chief Executive or in the absence of the Deputy Chief Executive the Acting Chief Executive after taking appropriate advice from the Chief Governance Officer, and consulting with the Chair as necessary.

5.6.4 All powers are reserved to the Board unless stated otherwise in the SoD. The Board also has the right to resume its delegated powers at any time as it sees fit.

5.6.5 The nominated Gold Commander (i.e., the most senior person on-call out of hours), when on duty in that role, may authorise expenditure or commit the Trust in excess of their usual delegated limits, as agreed by the Chief Executive, insofar as this does not exceed the Chief Executive's own powers delegated by the Board.

6. Audit

6.1 Audit Committee

6.1.1 The Trust shall comply with the directions of NHSE and the prevailing legislation in relation to its audit requirements.

6.1.2 In accordance with SOs, the Board shall establish an Audit Committee, with clearly defined terms of reference and following guidance from the NHS Audit Committee Handbook and in accordance with the NHS Foundation Trust Code of Governance, to provide an independent and objective view of internal control.

6.1.3 Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board.

6.1.4 Exceptionally, the matter may need to be referred to NHSE by the Chief Finance Officer.

6.1.5 It is the responsibility of the Chief Finance Officer to ensure an adequate internal audit and counter fraud service is provided and the Audit Committee shall be involved in the selection process for the internal audit and counter fraud service providers.

6.2 Chief Finance Officer's Role in Audit

6.2.1 In relation to audit, the Chief Finance Officer is responsible for:

(a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an effective internal audit function, ensuring that internal audit plans are adequate and meet the mandatory audit standards.

(b) Production of the Annual Governance Statement, and audited document for inclusion within the Trust's annual report, prepared in accordance with the prevailing guidance from NHSE.

(c) Provision of annual reports including a strategic audit plan covering the coming three years, a detailed plan for the coming year, and progress against plan over the previous year, and regular reports on progress on the implementation of internal audit recommendations.

6.2.2 The Chief Finance Officer, designated auditors, Local Counter Fraud Specialist and Local Security Management Specialist are entitled without necessarily giving prior notice to require and receive:

(a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature

(b) Access at all reasonable times to any land, premises or Directors of the Board and staff of the Trust

(c) Any cash, stores or other property of the Trust under a Director of the Board and employee's control.

(d) Explanations concerning any matter under investigation.

6.3 Role of Internal Audit

6.3.1 Internal Audit will review, appraise and report upon:

(a) Extent of compliance with relevant established policies, plans and procedures, and the financial impact of non-compliance

(b) Adequacy and application of financial and other related management controls

(c) Suitability of financial and other related management data

(d) Extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from fraud, waste, extravagance, inefficient administration, poor value for money or other causes.

6.3.2 Internal Audit shall also independently assess the process in place to ensure the assurance frameworks are in accordance with current guidance from NHSE.

6.3.3 The Head of Internal Audit is accountable to the Audit Committee (but managed by the Chief Finance Officer), will normally attend Audit Committee meetings, and has a right of access to all Audit Committee members, the Chair and Chief Executive of the Trust.

6.3.4 The reporting system for internal audit shall be agreed between the Chief Finance Officer, the Audit Committee and the Head of Internal Audit.

6.4 Role of External Audit

6.4.1 It is for the Council to appoint or remove the external auditors at a general meeting based on recommendations from the Audit Committee, who must ensure that external audit is providing a cost-effective service that meets the prevailing requirements of NHSE.

6.4.2 The Trust must ensure that the external auditor appointed by the Council meets the prevailing criteria from NHSE, at the date of appointment and on an on-going basis throughout the term of their appointment.

6.4.3 External audit responsibilities will vary from time to time in compliance with the requirements of NHSE, and are to:

(a) Be satisfied that the statutory accounts, quality account and annual report (and the external auditor’s own work) comply with the prevailing guidance and foundation Trust annual reporting manual, including relevant accounting standards.

(b) Be satisfied that proper arrangements have been made for securing economy, efficiency and effectiveness in the use of resources, reported by exception.

(c) Consider the issue of a public interest report, certify the completion of the audit and express an opinion on the accounts.

(d) To refer the matter to NHSE if the Trust, or a director or employee of the Trust, makes or is about to make decisions involving potentially unlawful action likely to cause a loss or deficiency.

6.4.4 External auditors will ensure that there is a minimum of duplication of effort between, themselves, Internal Audit and other relevant regulators e.g. NHSE, Care Quality Commission, recognising the limitations that apply to external audit being able to rely on other work to inform their own work.

6.4.5 The Trust will provide the external auditor with every facility and all information which it may require for the purposes of its functions.

6.5 Fraud and Bribery

6.5.1 In line with best practice, the Chief Executive and Chief Finance Officer shall monitor and ensure compliance with Secretary of State Directions on fraud and bribery.

6.5.2 **Fraud** - Any person who dishonestly makes a false representation to make a gain for himself or another or dishonestly fails to disclose to another person, information which he is under a legal duty to disclose, or commits fraud by abuse of position, including any offence as defined in the Fraud Act 2006.

6.5.3 **Bribery** – A bribe is offering, promising, or giving a financial, or otherwise, advantage to another person with the intention of bringing about improper performance or reward. The Bribery Act also states that a person is guilty of an offence if they request, agree to receive, or accept a financial or other advantage intending that a relevant function or activity should be performed improperly by them or another. It further states that offering or agreeing to accept a bribe is an offence even if no money or goods have been exchanged.

6.5.4 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud.

6.5.5 Specialist (LCFS) as specified by the NHS Counter Fraud and Corruption Manual and guidance, managed by the Chief Finance Officer. Regular (at least annual) written reports will be provided by the LCFS to the Audit Committee, to include both proactive and reactive work, a “heat map” of fraud risks and a horizon scan of emerging fraud risks.

6.5.6 The Chief Finance Officer will prepare an Anti-Fraud and Bribery Policy that sets out the action to be taken by those detecting a suspected fraud and those investigating it.

6.6 Security Management

6.6.1 The Chief Executive has overall responsibility for controlling and coordinating security.

6.6.2 The Trust shall nominate a suitable person to carry out the duties of the Local Security Management Specialist (LSMS) as specified by the Secretary of State for Health guidance on NHS security management.

6.6.3 The Chief Governance Officer shall prepare a Security Policy that sets out measures to protect staff, visitors, premises and assets.

6.6.4 Each employee and officer has a responsibility for the security of property of the Trust. Any breach of agreed security practices must be reported in accordance with defined policies and procedures.

7. Financial Targets

7.1 The Trust is required to meet such financial targets as are specified by the Regulator, either under the terms of the initial authorisation agreement or subsequently. These include specifically the requirement to:

(a) contain external borrowing within a prudential borrowing limit set out within the Authorisation agreement and reviewed annually thereafter.

(b) restrict income from private patient charges in any year, as a proportion of the Trust's total income for that year, to the percentage specified in the Authorisation agreement or any other target level as directed by the Regulator.

7.2 Whilst there is no specific target regulating overall revenue performance in Foundation Trusts, the Regulator has the power to intervene in the Trust's affairs and potentially revoke its Authorisation agreement where financial viability is being seriously compromised.

7.3 The Chief Executive has overall responsibility for the Trust's activities and in this capacity is responsible for ensuring that the Trust maintains its financial viability and meets any specific financial targets set by the Regulator. In this capacity the Chief Executive is responsible for setting appropriate internal targets in order to ensure financial viability.

7.4 The Chief Finance Officer is responsible for:

(a) advising the Board and Chief Executive on progress in meeting these targets recommending corrective actions as appropriate.

(b) ensuring that adequate systems exist internally to monitor financial performance.

(c) managing the cash flow and external borrowings of the Trust in order to remain within the Prudential Borrowing Limit.

(d) providing the Regulator with such financial information as is necessary to monitor the financial viability of the Trust.

8. Business Planning, Budgets, Capital Expenditure and Monitoring

8.1 **Preparation and Approval of Business Plans and Budgets**

8.1.1 Under the terms of Schedule 7 of the 2006 Act and its Constitution, the Trust is required to provide the Regulator with information concerning its forward plans for each financial year. In this respect, the Council of Governors is responsible for providing the Board with its views on those forward plans when they are being prepared and the Board has a duty to consult them.

8.1.2 The Chief Executive will ensure that there is a Medium-Term Financial Plan in place and will compile and submit to the Board an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

(a) a statement of the significant assumptions on which the plan is based.

(b) details of major changes in workload, delivery of services or resources required to achieve the plan.

8.1.3 Prior to the start of the financial year the Chief Financial Officer will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will:

(a) be in accordance with the aims and objectives set out in the Trust's integrated business plan and its medium-term financial model.

(b) accord with activity and workforce plans.

(c) be produced following discussion with appropriate budget holders

(d) be prepared within the limits of available funds and

(e) identify potential risks to delivery

8.1.4 The Chief Financial Officer shall monitor financial performance against the budget and the business plan, periodically review them, and report to the Board.

8.1.5 All budget holders must provide information as required by the Chief Financial Officer to enable budgets to be compiled and financial performance against budgets to be monitored.

8.1.6 The Chief Financial Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

8.2 **Budgetary Delegation**

8.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) the amount of the budget

(b) the purpose(s) of each budget heading.

(c) individual and group responsibilities.

(d) authority to exercise virement

(e) achievement of planned levels of service; and

(f) the provision of regular reports

8.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

8.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

8.2.4 Non-recurring expenditure budgets or income should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Chief Finance Officer.

8.3 **Budgetary Control and Reporting**

8.3.1 The Chief Finance Officer will devise and maintain systems of budgetary control. These will include:

(a) Monthly financial reports to the Board in a form approved by the Board containing:

i. income and expenditure to date showing trends and forecast year-end position

ii. movements in working capital

iii. capital project spend against the Trust's capital plan by sub-group of the Capital Committee and projected outturn against annual plan

iv. explanations of any material variances from plan

v. details of any corrective action where necessary and the Chief Executive's and/or Chief Financial Officer's view of whether such actions are sufficient to correct the situation

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible

(c) investigation and reporting of variances from financial, activity and manpower budgets

(d) monitoring of management action to correct variances and

(e) arrangements for the authorisation of budget transfers

8.3.2 Each Budget Holder is responsible for ensuring that:

(a) any likely overspending or reduction of income that cannot be met by virement is not incurred without the prior consent of the Board except where authority has been given under 6.2.2 above.

(b) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement and budget transfer.

(c) no permanent employees are appointed without the approval in writing of the Chief Executive other than those provided for within the available resources and workforce establishment as approved by the Board.

8.3.3 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Plan and a balanced budget.

8.4 **Capital Expenditure**

8.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. All capital procurement shall be carried out in accordance with the Tendering and Contract Procedures. (The particular applications relating to capital investment and financing are contained in Section 16 of these Standing Financial Instructions.)

8.5 **Monitoring Returns**

8.5.1 The Chief Executive is responsible for ensuring that all weekly, monthly, quarterly and annual financial monitoring forms are submitted to NHSE, the trust regulator, in accordance with the

prescribed deadlines.

8.5.2 The Chief Executive, on behalf of the Trust, is also responsible for ensuring that the Trust contributes to standard national NHS data flows which are required for NHS policy development/funding decisions as well as performance assessment by the Care Quality Commission.

9 Annual Accounts and Reports

9.1 In accordance with Schedule 7 (para 25) of the 2006 Act and the Trust's Constitution, the Trust must keep accounts, and in respect of each financial year must prepare annual accounts, in such form as the Regulator may, with the approval of Treasury, direct. These responsibilities will be undertaken by the Chief Finance Officer, who, on behalf of the Trust will:

(a) prepare financial accounts and returns in accordance with the accounting policies and guidance given by the Department of Health & Social Care (DHSC) and the Treasury, the Trust's accounting policies, and International financial reporting standards

(b) prepare and submit annual financial reports to the DHSC certified in accordance with current guidelines and

(c) submit financial returns on a monthly, quarterly and annual basis to the regulator and/or DHSC in accordance with the timetable prescribed by the DHSC.

9.2 The Trust's annual accounts must be audited by the Trust's External Auditor. The Trust's audited annual accounts must be presented to a public meeting and made available to the public.

9.3 In accordance with Schedule 7 (para 26) of the 2006 Act, the Trust will also prepare an annual report which, after approval by the Board, will be presented to the Council of Governors. It will then be published and made available to the public and also submitted to the Regulator. The annual report will comply with the Regulator's Annual Report Guidance for NHS Foundation Trusts and will include inter alia:

(a) information on the steps taken by the Trust to ensure that the actual membership of the various stakeholders (public, patients and staff) is representative of those eligible for membership

(b) the Annual Accounts of the Trust in full or summary form

(c) details of relevant directorships and other significant interests held by Board members

(d) composition of the Audit Committee and of the Remuneration and Nominations Committee

(e) remuneration of the chair, the Non-Executive Directors and Executive Directors, on the same basis as those specified in the Companies Act

(f) a statement of assurance by the Chief Executive in respect of organisational controls and risk management within the Trust

(g) any other information required by the Regulator.

9.4 The Trust is to comply with any decision that the regulator may make as to the form of the annual report, the timing of its submission and the period to which it relates.

10 Bank Arrangements

10.1 General

10.1.1 The Chief Finance Officer is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will consider guidance issued from time to time by NHSE; the Board must approve these banking arrangements.

10.2 Bank Accounts

10.2.1 The Chief Financial Officer is responsible for the operation of all the Trust's bank accounts and for:

(a) ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made

(b) reporting to the Board all instances where bank accounts may become or have become overdrawn (together with remedial action taken, and monitoring compliance with DHSC guidance on the level of cleared funds

10.3 Banking Procedures

10.3.1 The Chief Financial Officer will prepare detailed instructions on the operation of all Trust bank accounts that must include:

(a) the conditions under which any bank account shall be operated, including the limit to be applied to any overdraft.

(b) those authorised to process bank transfers and sign cheques drawn on the Trust's accounts.

10.3.2 No-one except the Chief Financial Officer shall open or maintain a bank account in the name of the Trust.

10.4 Debit/ Credit Card Receipts

10.4.1 All arrangements to utilise collection of monies using debit/credit cards shall be approved by the Chief Financial Officer.

10.4.2 Debit/credit card machines shall only be operated by suitably trained and authorised persons who will comply with the Payment Card Industry Data Security Standard (PCI DSS) rules and procedures.

10.5 External Borrowing

10.5.1 The Chief Financial Officer will advise the Board concerning the Trust's ability to pay dividend on and repay Public Dividend Capital (PDC) and any proposed new borrowing, within the limits set by the DHSC. The Chief Financial Officer is also responsible for reporting periodically to the Board concerning the PDC debt and all loans and overdrafts.

10.5.2 Any application for a loan or overdraft shall only be made by the Chief Financial Officer or by an employee so delegated by him or the Trust board.

10.5.3 The Chief Financial Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.

10.5.4 All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short-term borrowing requirement must be

authorised by the Chief Financial Officer.

10.5.5 All long-term borrowing must be consistent with the plans outlined in the current financial plan as reported to NHSE.

10.6 Investments

10.6.1 Temporary cash surpluses must only be held in such investments as authorised by the DHSC and the Board.

10.6.2 The Chief Financial Officer is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

10.6.3 The Chief Financial Officer will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

11 Financial Systems and Transaction Processing

11.1 Income Systems

11.1.1 The Chief Finance Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper and prompt recording, invoicing, collection, banking and coding of all monies due. In this capacity, the Chief Financial Officer will establish systems in order to ensure that timely and appropriate invoices are raised for income due under the terms of contracts with NHS commissioners.

11.1.2 The Chief Financial Officer is also responsible for the prompt banking of all monies received.

11.2 Fees and Charges

11.2.1 The Trust shall follow DHSC advice in setting prices for NHS service agreements.

11.2.2 The Chief Financial Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the DHSC or by statute. Independent professional advice on matters of valuation shall be taken as necessary.

11.2.3 All employees must inform the Chief Financial Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

11.3 Debt Recovery

11.3.1 The Chief Financial Officer is responsible for the appropriate recovery action on all outstanding debts.

11.3.2 Income not received should be dealt with in accordance with losses procedures.

11.3.3 The Chief Financial Officer is responsible for ensuring that systems are in place to prevent overpayments. Where overpayments occur systems should be in place for their detection and recovery immediately initiated.

11.4 Security of Cash, Cheques, and other Negotiable Instruments

11.4.1 The Chief Financial Officer is responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable

(b) ordering and securely controlling any such stationery

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines and

(d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust

11.4.2 Official money shall not under any circumstances be used for the encashment of private cheques, or for the granting of personal loans of any kind.

11.4.3 All cheques and cash receipts shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Financial Officer.

11.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

11.5 Free of Charge: Donated Goods and Services

11.5.1 Free of charge or donated goods or equipment from any supplier or would be supplier to the Trust must not be used to avoid the procurement regulations.

11.5.2 A Level 2 or 3 Officer must approve in writing the acceptance of such goods or services prior to delivery. If the goods are to be donated or accepted on loan, whether for service provision or testing, before such approval may be given:

(a) an official order number must be allocated if the acquisition by this method is part of a procurement process by the Trust

(b) the owner must provide a written indemnity to the Trust, which will be signed, if necessary, on the Trust's behalf by the Chief Executive or an officer authorised by the Chief Executive

(c) responsibility for maintenance and other revenue consequences must be agreed in writing and must be approved in accordance with these Standing Financial Instructions

11.5.3 The acceptance of any such goods or services must be confirmed in writing to the donor/owner and, except in the case of charitable donations, such confirmation shall include a notice that the acceptance does not amount to an express or implied obligation on the Trust to continue to use the goods/services or to purchase any other goods/services.

11.5.4 The donation of clinical equipment shall undergo the same rigour as applied to an NHS funded

purchase.

11.5.5 Where there are revenue consequences arising out of the donation of any asset then the donation shall not be accepted or put into use until a budget has been agreed with the Chief Financial Officer in respect of the revenue consequences.

12 NHS Service Agreement for Provision of Services

12.1.1 The Chief Executive, as the accountable officer, is responsible for ensuring the Trust enters into suitable contracts or service level agreements (SLAs) with service commissioners for the provision of NHS services. All contracts and SLAs should aim to implement the agreed priorities contained within the Commissioning Agreement and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

(a) the standards of service quality expected.

(b) the relevant national service framework (if any).

(c) the provision of reliable information on cost and volume of services.

(d) the Operating Framework for the NHS.

(e) that all agreements build where appropriate on existing partnership arrangements.

13 Payments to Board Directors, Staff and Other Workers

13.1 Board Directors (Chairman and Non-Executive Directors)

13.1.1 The Trust will pay allowances to the Chairman and Non-Executive Directors of the Board in accordance with instructions issued by the Secretary of State for Health & Social Care.

13.2 Remuneration and Terms of Service (Executive Directors and Staff)

13.2.1 In accordance with Standing Orders, the Board shall establish a Remuneration, Nominations and Terms of Service Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

13.2.2 Remuneration and terms and conditions of employment shall follow those nationally agreed by the DHSC/NHS England except where specifically agreed otherwise by the Board.

13.2.3 The Board shall approve procedures presented by the Chief Executive or the Chief People Officer for the determination of remuneration and terms and conditions of service which are not agreed nationally or for any variations to nationally agreed arrangements.

13.3 Funded Establishment

13.3.1 The workforce plans incorporated within the authorised annual budget will form the funded establishment.

13.3.2 The funded establishment of any Department, Directorate, etc. may not be varied in any way

which causes expenditure to exceed the authorised annual budget without the prior written approval of the Chief Financial Officer. This includes temporary or interim positions.

13.4 Staff Appointments

13.4.1 No Executive Director or other employee may engage, re-engage, or re-grade employees, either on a permanent or temporary basis, or agree changes to any aspect of remuneration unless:

(a) he or she is exercising economy and efficiency in the use of human resources.

(b) it is within the limit of his or her approved budget and funded establishment.

13.4.2 Any monies due to employees as a result of all employments with the Trust howsoever arising shall be paid through the Trust payroll.

13.5 Contracts of Employment

13.5.1 The Board shall delegate responsibility to the Chief People Officer for:

(a) ensuring that all employees are issued with a Contract of Employment in a form which complies with employment legislation and;

(b) dealing with variations to, or termination of, contracts of employment in accordance with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation and advising employees of the need to conform to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation and Reservation.

13.6 Professing Payroll

13.6.1 The Chief Financial Officer is responsible for:

(a) specifying timetables for submission of properly authorised time records and other notifications.

(b) the final determination of pay and allowances.

(c) making payment on agreed date; and

(d) agreeing method of payment.

13.6.2 The Chief Financial Officer will issue instructions regarding:

(a) verification and documentation of data.

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances.

(c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay.

(d) security and confidentiality of payroll information.

(e) checks to be applied to completed payroll before and after payment.

(f) authority to release payroll data under the provisions of the Data Protection Act

(g) procedures for payment by cheque, bank direct credit (including BACS), or cash to employees and officers.

(h) procedures for the recall of bank direct credits (including BACS) and stopping of

(i) cheques.

(j) pay advances and their recovery.

(k) maintenance of regular and independent reconciliation of pay control accounts.

(l) separation of duties of preparing records and handling cash, and;

(m) a process to ensure the recovery from employees and leavers of sums of money and property due from them to the Trust.

13.6.3 Appropriately nominated managers have delegated responsibility for:

(a) submitting time records and other notifications in accordance with agreed timetables.

(b) submitting appointment forms and change forms in the prescribed form, immediately upon knowing the effective date of an employee's appointment or change in circumstances.

(c) completing time records and other notifications in accordance with the Chief Financial Officer's instructions and in the form prescribed by the Chief Financial Officer, and

(d) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employees or worker's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Chief Financial Officer must be informed immediately.

13.6.4 Regardless of the arrangements for providing the payroll service, the Chief Financial Officer shall ensure that the chosen method is supported by appropriate and adequate procedures with internal controls and audit review and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

13.7 **Off Payroll Workers (Including Agency, Self-Employed or Third-Party Contractors)**

13.7.1 Where exceptional circumstances exist within a department and agency, self-employed workers or workers supplied via a third party are to be retained then:

(a) the contract may only be entered into by a budget holder having sufficient resources within the limit of his budget who is authorised for that purpose by the Chief Executive or his delegated officer; and

(b) the Chief Financial Officer shall be consulted if the contractor is not on the current list of authorised suppliers; and

(c) the Chief People Officer shall be consulted with regard to the remuneration package in which the hourly rate of pay of any workers employed through an agency shall be "rate cap" compliant, as determined by NHSE. Any deviation from this should be exceptional

and only on the grounds of patient safety and authorised in writing by the Chief People Officer; and

(d) contractual provisions shall be put in place which allow the Trust to seek assurance Regarding the income tax and national insurance contribution obligations of the person engaged and the ability to terminate the contract if that assurance is not provided; and

(e) their employment status shall be reviewed by the Chief Financial Officer prior to the commencement of their engagement to ensure that income tax deductions and national insurance contributions for both the Trust and worker are properly made and paid to HM Revenue & Customs in line with current legal and regulatory requirements.

13.7.2 If there is any doubt as to the correct taxation treatment or the engagement is potentially novel or contentious then the agreement of the Chief Financial Officer and the Chief People Officer shall be obtained before entering into such an arrangement.

14 Non-Pay Expenditure

14.1 Delegation of Authority

14.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

14.1.2 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services and

(b) the maximum level of each requisition and the system for authorisation above that level

14.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services and this shall be followed when entering into any agreement. Contract terms and conditions used in contracts shall only be those approved by the Trust.

14.1.4 Where consultants are to be engaged on any project with a contracted cost exceeding £50,000 the permission of NHSE must be obtained through the submission of a business case, setting out the requirement, before entering into the contract.

14.1.5 Any agreement for the supply of workers shall only be entered into after fully considering and ensuring compliance with any relevant provisions contained in section 6.7.7 of these instructions and where necessary obtaining advice from the Chief Financial Officer and the Chief People Officer.

14.1.6 Before entering into contracts for the supply of goods and services or works contracts and especially overseas contracts, taxation advice (including where appropriate customs advice) shall be obtained from the Chief Financial Officer. Agreement of the Chief Financial Officer and also where relevant the Chief Strategy Officer shall be obtained before entering into any potentially novel or contentious arrangement with a supplier or contractor.

14.2 Choice Requisitioning, Ordering, Receipt and Payment for Goods and Services

14.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Head of Procurement shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Financial Officer (and/or the Chief Executive) shall be consulted.

14.2.2 The Chief Financial Officer shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

14.2.3 The Chief Financial Officer will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in standing orders and regularly reviewed.

(b) prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds

(c) be responsible for the prompt payment of all properly authorised accounts and claims

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i. A list of Board directors and employees (including specimens of their signatures) authorised to certify invoices.

ii. Certification which shall confirm that:
- goods have been duly received, examined and are in accordance with specification and the prices are correct.
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct.
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality and price, and the charges for the use of vehicles, plant and machinery have been examined.
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained.
- the account is arithmetically correct, with discounts having been taken where appropriate.
- VAT has been correctly accounted for with recovery being identified where appropriate, and
- the account is in order for payment.
- be responsible for ensuring that payment for goods and services is only made once

(e) the goods and services are received (except as below).

14.2.4 Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e., cashflows must be discounted to Net Present Value) and the intention is not to circumvent cash management arrangements.

(b) The appropriate Executive Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments.

(c) Exceptions to the requirements of sections (a) and (b) above:

i. service and maintenance contracts which require payment when the contract commences.

ii. minor services such as training courses and conference bookings for individuals or magazine subscriptions.

iii. prepayments of up to £500 where a value for money and financial risk assessment demonstrates clear advantage in early payment.

(d) The Chief Financial Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account relevant public procurement rules where the contract is above a stipulated financial threshold).

(e) The budget holder is responsible for ensuring that all items due under a prepayment contract are received in a timely manner and he must immediately inform the appropriate Director or Chief Executive if problems are encountered.

14.2.5 Official Orders must:

(a) be consecutively numbered.

(b) be in a form approved by the Chief Financial Officer.

(c) state the Trust's terms and conditions of trade; and

(d) only be issued to, and used by, those duly authorised by the ChiefExecutive.

14.2.6 Officers must ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer and that:

(a) all contracts (other than for simple purchases permitted within the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Chief Financial Officer in advance of any commitment being made.

(b) contracts above specified thresholds are advertised and awarded in accordance with the relevant rules on public procurement.

(c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by NHSE and the DHSC.

(d) no order shall be issued for any item or items to any firm which as made an offer of gifts, reward or benefit to directors or employees, other than:

i. isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars.

ii. conventional hospitality, such as lunches in the course of working visits.

14.2.7 Reference shall be made to the Trust's Gifts, Hospitality and Conflicts of Interests Policy.

(a) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Financial Officer on behalf of the Chief Executive.

(b) all goods, services, or works are ordered on an official order except works and services

purchased from petty cash or items bought using purchasing cards executed in accordance with the contract. For clarification the Chief Financial Officer will determine the nature of expenditure which does not require control through an official purchase order and review this on an annual basis.

(c) Contracts shall be put in place with verbal orders only being issued very exceptionally - by an employee designated by the Chief Executive in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order".

(d) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds.

(e) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase.

(f) changes to the list of directors, employees and officers authorised to certify invoices are notified to the Chief Financial Officer.

(g) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Financial Officer; and

(h) petty cash records are maintained in a form as determined by the Chief Financial Officer.

14.2.8 The Chief Executive and Chief Financial Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and Health Building. The technical audit of these contracts shall be the responsibility of the relevant Director.

15 Special Purpose Vehicles, Joint Ventures, Equity Investments, Dissolutions, Mergers and Acquisitions and Divestment of Services

15.1.1 The Board of Directors is responsible for the review and approval of special purpose vehicles, joint ventures with other entities, whether private, public or third sector, divestment of existing services and purchases of shares in a company over the thresholds laid out in the detailed scheme of delegation (see Appendix 4). These decisions must be demonstrated to be in patients' and taxpayers' best interests without a material impact upon choice and competition, to ensure high quality standards of care and value for money.

15.1.2 The Board of Directors and the Council of Governors must approve any Dissolutions, Mergers or Acquisitions. For all the above, advice should be sought from the appropriate project finance or commercial teams prior to taking proposals for approval, and it is essential that current legislation, including procurement and competition law as well as the prevailing Health and Social Care Act, is adhered to in the process.

16 Capital Investment, Private Financing, Leases and Assets

16.1 Capital Investments

16.1.1 The Chief Executive shall:

(a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans.

(b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

(c) shall ensure the availability of resources to finance all revenue consequences, including VAT and any charges levied on capital developments.

16.1.2 For every capital expenditure proposal, the Chief Executive shall ensure:

(d) that a business case (in line with the current Department of Health guidance) is produced setting out:

i. an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and

ii. appropriate project management and control arrangements are in place; and

iii. advice is taken and acted upon to minimise the VAT and other taxes payable; and

iv. the appropriate Trust personnel and external agencies have been involvement; and

v. that the Chief Financial Officer has certified professionally to the costs and revenue consequences detailed in the business case.

16.1.3 Where the sum involved exceeds delegated limits (Appendix 1), the business case must be referred to the NHSE and/or Department of Health in line with current guidelines.

16.1.4 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of CONCODE.

16.1.5 The Chief Financial Officer shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with HM Revenue & Customs guidance.

16.1.6 The Chief Financial Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure, which as a minimum shall include reporting to the Board on:

(a) an individual scheme/project

(b) the source and level of funding, and

(c) the expenditure incurred against the annual profile

16.1.7 The approval of a capital programme shall not constitute approval for the initiation of expenditure on any individual scheme, because it is also necessary to undertake the mandatory procurement processes of the Trust and ensure that Business Cases are developed and approved.

16.1.8 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with current Department of Health guidance and the Trust's Standing Orders.

16.1.9 The Chief Financial Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account the latest delegated limits for capital schemes as notified by the Department of Health.

16.1.10 Any capital monies spent should be in accordance with the requirements of the Department of Health & Social Care Group Accounting Manual.

16.2 Private and External Finance

16.2.1 When the Trust proposes to finance capital investment other than through internally generated cash, the following procedures shall apply:

16.2.2 The instructions contained in the Tendering and Contract Procedures relating to Private Finance shall be followed.

16.2.3 The Chief Financial Officer shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

16.2.4 Where the sum involved exceeds delegated limits, the business case must be referred to the Regulator

16.2.5 The proposal must be specifically agreed by the Board.

16.2.6 The Chief Financial Officer shall demonstrate that the use of external finance to support capital investment is secured under the Department of Health's borrowing procedures.

16.2.7 Where the equipment leasing arrangements are proposed these should be authorised by signature by the Chief Financial Officer.

16.3 Leases (Finance and Operating)

16.3.1 Where it is proposed that leasing (either operating or finance) shall be considered in preference to capital procurement then the following should apply:

(a) the selection of a contract/finance company shall be on the basis of competitive tendering and quotations sought via the Procurement Department.

(b) the Chief Financial Officer or nominated deputy shall ensure that the proposal demonstrates best value for money; and

(c) all proposals to enter into a leasing agreement shall be agreed in writing by the Chief Financial Officer or nominated deputy prior to acceptance.

16.4 Asset Registers

16.4.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Financial Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

16.4.2 The Trust shall maintain an asset register for recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Group Manual for Accounts as issued by the Department of Health.

16.4.3 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architects certificates, suppliers' invoices and other documentary evidence in respect of purchases from third parties.

(b) stores, requisitions and wages records for own materials and labour including appropriate

overheads; and

(c) lease agreements in respect of assets held under a finance lease and capitalised.

16.4.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

16.4.5 The Chief Financial Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

16.4.6 The value of each asset shall be depreciated using methods and rates as specified by the Trust's accounting policies.

16.5 Security of Assets

16.5.1 The overall control of fixed assets is the responsibility of the Chief Executive.

16.5.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Financial Officer. This procedure shall make provision for:

(d) recording managerial responsibility for each asset.

(e) identification of additions and disposals.

(f) physical security of assets.

(g) periodic verification of the existence of condition of, and title to, assets recorded.

(h) identification and reporting of all costs associated with the retention of an asset; and

(i) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

16.5.3 All discrepancies revealed by verification of physical assets to the fixed asset register shall be notified to the Chief Finance Officer.

16.5.4 Each employee has a responsibility for the security of the property of the Trust and for ensuring that any borrowing or private use of Trust equipment, goods, services and facilities is authorised by their line manager or head of department. It is the responsibility of Executive Directors and senior employees in all disciplines to apply appropriate routine security checks and practices in relation to Trust and NHS property. Any breach of agreed security practices must be reported in accordance with these Standing Financial Instructions, the Trust's policy on Fraud, Bribery and Corruption.

16.5.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Board members and employees in accordance with the procedure for reporting losses.

16.5.6 Where practical, assets should be marked as Trust property.

17 Store and Receipt of Goods

17.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum.

(b) subjected to annual stock take.

(c) valued at the lower of cost and net realisable value except where otherwise determined by the Trust's accounting policies.

17.2 Subject to the responsibility of the Chief Financial Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Financial Officer. The control of any pharmaceutical stocks shall be the responsibility of a designated Director; as will the control of any fuel oil and coal.

17.3 The responsibility for security arrangements and the custody of keys for any stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as NHS property/health service property.

17.4 The Chief Financial Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

17.5 Stocktaking arrangements shall be agreed with the Chief Financial Officer and there shall be a physical check covering all items in store at least once a year.

17.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Financial Officer.

17.7 The appropriate Director shall be responsible for a system approved by the Chief Financial Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles.

17.8 The designated officer shall report to the Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice (see also section 6.11, Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

17.9 For goods supplied via NHS Supply Chain, the Chief Executive shall identify those authorised to requisition and accept goods via this route. The authorised person shall check receipt against the delivery note and report discrepancies to the Chief Financial Officer to avoid overpayment where such discrepancies cannot be resolved via the Procurement Team.

18 Disposals, Losses and Special Payments

18.1 Disposals and Condemnations

18.1.1 Under the terms of the authorisation agreement, the approval of the Regulator is required prior to the disposal of any protected assets (above any 'de minimis' limit where specified). There are no external restrictions on the disposal of other assets providing that the proceeds are used to further the Trust's public interest objectives.

18.1.2 The Chief Financial Officer must prepare detailed procedures for the disposal of assets including condemnations and ensure that these are notified to managers.

18.1.3 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Chief Financial Officer of the estimated market value of the item, taking account of professional advice where appropriate.

18.1.4 All unserviceable articles shall be:

(a) Condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Financial Officer.

(b) recorded by the Condemning Officer in a form approved by the Chief Financial Officer that will indicate whether the articles are to be condemned, converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Financial Officer.

18.1.5 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Financial Officer who will take the appropriate action.

18.2 Losses and Special Payments

18.2.1 The Chief Financial Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

18.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Chief Financial Officer or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Chief Financial Officer and/or Chief Executive. Where a criminal offence is suspected, the Chief Financial Officer must immediately inform the police if theft or arson is involved. The Chief Financial Officer should comply with any requirements to report fraud as determined by the Regulator/Secretary of State.

18.2.3 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Financial Officer (or the Local Counter Fraud Specialist on the Director's behalf) must notify the Audit Committee which will consider approval of write off on behalf of the Board.

18.2.4 The Chief Financial Officer shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

18.2.5 For any loss, the Chief Financial Officer should consider whether any insurance claim can be made.

18.2.6 The Chief Financial Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

18.2.7 All losses and special payments must be reported to the Audit Committee at every meeting.

19 Finance and Procurement System

19.1 The Chief Finance Officer, who is responsible for the accuracy and security of the computerised financial data of the Trust, shall:

(c) Devise and implement appropriate technical and organisational measures necessary to ensure adequate and reasonable protection of the Trust's data

(d) Follow the Trust's existing Information and Security Governance Policy.

(e) Ensure that adequate and reasonable controls exist over Trust IT network to ensure confidentiality, integrity, security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system
(f) Ensure that adequate controls (including separation of duties) exist
(g) Ensure that an adequate audit trail exists through the computerised system.

19.2 The Chief Finance Officer must ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. These requirements apply equally if systems are jointly developed or procured in conjunction with other organisations, with suitable warranties, indemnities and audit rights provided.

19.3 The Chief Finance Officer and Chief Digital Officer must satisfy themselves that, where other computer systems may have an impact upon the finance and procurement system, the integrity of the finance and procurement system is not compromised.

19.4 Where possible, the Chief Digital and Information Officer (CDIO) should ensure that systems are developed in such a way to review and audit compliance with the SFIs and SoD – for example through security reports to identify invalid sign on attempts and other potential breaches.

19.5 The Chair and Chief Executive shall ensure that risks to the Trust arising from the use of the finance and procurement system are effectively identified and considered and appropriate action is taken to mitigate or control risk in relation to business continuity and the requirements of the data protection act.

20 Unclaimed and Found Property

20.1 Any unclaimed or found property shall be handed in to one of the Trust Offices via the relevant line manager.

20.2 Every effort shall be made to reunite the property with the rightful owner, ensuring that a patient's right to confidentiality is not compromised.

20.3 Items of low value not claimed within three months shall be disposed of as appropriate and any cash or proceeds of sale banked into the Trust's exchequer account.

20.4 Items other than clothing found by members of the public may be reclaimed by the finder on production of the property receipt after three months, providing in the case of clothing the intention to claim the item was made clear at the time of depositing with the Trust.

20.5 Any items found by an employee are construed as being found in the course of their duties and therefore staff are unable to claim ownership of such found items.

21 Funds Held on Trust

21.1 **Corporate Trustee**

21.1.1 Standing Order No. 2.8 outlines the Trust's responsibilities as a corporate trustee for the management of funds it holds on trust. The Trust shall comply with Charities Commission latest guidance and best practice.

21.1.2 The discharge of the Trust's corporate trustee responsibilities are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

21.1.3 The Chief Financial Officer shall ensure that each trust fund which the Trust is responsible for

managing is managed appropriately with regard to its purpose and to its requirements.

21.2 Accountability to the Charity Commission

21.2.1 The trustee responsibilities must be discharged separately, and full recognition given to the Trust's dual accountability to the Charity Commission for charitable funds held on trust.

21.2.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Trust Board members and Trust officers must take account of that guidance before taking action.

21.3 Applicability of Standing Financial Instructions to Funds Held on Trust

21.3.1 In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.

21.3.2 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

22 Acceptance of Gifts, Hospitality and Sponsorship

22.1 The Gifts and Hospitality and Conflicts of Interests Policy describes the obligations of staff in relation to accepting gifts, hospitality or sponsorship.

23 Return of Records

23.1 The Lifecycle Policy describes the obligations of staff in relation to retention and management of records.

24 Risk Management and Insurance

24.1 Risk Management Programme

24.1.1 The Chief Executive shall ensure the Trust has a programme of risk management, in accordance with current NHS Audit Committee Handbook, Care Quality Commission and NHSE requirements, which must be approved and monitored by the Board.

24.1.2 The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities.

b) engendering among all levels of staff a positive attitude towards the control of risk.

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk.

d) contingency plans to offset the impact of adverse events.

e) audit arrangements including internal audit, clinical audit, health and safety review.

f) decision on which risks shall be insured.

g) arrangements to review the risk management programme.

h) appropriate levels of external accreditation.

24.1.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of Internal Control within the Annual Report and Accounts as required by DHSC guidance.

24.1.4 The Board shall decide if the Trust will insure through the various schemes administered through NHS Resolution or self-insure for some or all of these risks. If the Board decides not to use the NHS Resolution schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

24.2 **Insurance**

24.2.1 With four exceptions the Trust may not enter into insurance arrangements with commercial insurers. The exceptions are:

a) insuring motor vehicles owned by the Trust including third party liability arising from their use.

b) where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into.

c) where income generation activities take place. Income generation activities should normally be insured against all risks using commercial insurance. If the income generation activity is also an activity normally carried out by the Trust for a NHS purpose the activity may be covered in the risk pool. Confirmation of coverage in the risk pool must be obtained from NHS Resolution.

d) where it is necessary to ensure that the Trust is able to continue providing a service where adequate levels of insurance are not available under any of the schemes administered by NHS Resolution, the Trust arranges a policy in the name of "the employees of the Trust" or "members, for the time being, of a specific team". In such cases, the premium must be:

i. Paid by the use of charitable funds, providing the Trust establishes 1 through the Charity Commission, or other relevant regulatory body, whether this is an appropriate use of funds, or
ii. Paid by members of the team and then reimbursed by the Trust, or
iii. Paid by the Trust, provided this is with the recognition, and approval, of the Chief Financial Officer and/or Internal Audit.

24.2.2 In any case of doubt concerning a Trust's powers to enter into commercial insurance arrangements the Chief Financial Officer should first consult the NHS Resolution.

24.2.3 Where the Board decides to use the schemes administered by NHS Resolution, the Chief Financial Officer shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme.

24.2.4 The Chief Financial Officer shall ensure that documented procedures cover these arrangements.

24.2.5 Where the Board decides not to use the schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Chief Financial Officer shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Chief Financial Officer will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses that will not be reimbursed.

24.2.6 Where NHS Resolution schemes require members to make some contribution to the settlement of claims (the 'deductible element') the Chief Financial Officer will ensure

documented procedures also cover the management of claims and payments below the deductible element in each case.

25 Miscellaneous

25.1 Partnership Agreements

25.1.1 The Trust shall ensure, through the Chief Executive, that there are processes in place for establishing and reviewing the effectiveness of all partnership arrangements and that these are appropriate for the local circumstances.

25.2 International Financial Reporting Standards (IFRS)

25.2.1 The Trust is required to report all its financial transactions in compliance with IFRS subject to amendments issued by the DHSC through the NHS Group Accounting Manual (GAM). It is important that the reporting requirements of IFRS are anticipated and provided for when making decisions which have an impact on the Trust's financial position. This is particularly the case in respect of capital investment, leasing, use of external private finance and contractual relationships with other parties. The Chief Financial Officer and his team should be consulted for advice in such instances.

26 Equality Impact Assessment

26.1.1 The Trust is committed to promoting positive measures that eliminate all forms of unlawful or unfair discrimination on the grounds of age, marital status, disability, race, nationality, gender, religion, sexual orientation, gender reassignment, ethnic or national origin, beliefs, domestic circumstances, social and employment status, political affiliation or trade union membership, HIV status or any other basis not justified by law or relevant to the requirements of the post.

26.1.2 By committing to a policy encouraging equality of opportunity and diversity, the Trust values differences between members of the community and within its existing workforce, and actively seeks to benefit from their differing skills, knowledge, and experiences in order to provide an exemplary healthcare service. The Trust is committed to promoting equality and diversity best practice both within the workforce and in any other area where it has influence.

26.1.3 The Trust will therefore take every possible step to ensure that this procedure is applied fairly to all employees regardless of race, ethnic or national origin, colour or nationality; gender (including marital status); age; disability; sexual orientation; religion or belief; length of service, whether full or part-time or employed under a permanent or a fixed- term contract or any other irrelevant factor.

26.1.4 Where there are barriers to understanding e.g. an employee has difficulty in reading or writing or where English is not their first language additional support will be put in place wherever necessary to ensure that the process to be followed is understood and that the employee is not disadvantaged at any stage in the procedure. Further information on the support available can be sought from the People Directorate.

APPENDIX 1

Schedule of financial delegated limits

Authorisation of Purchase Requisitions (all Revenue and Capital items)

For all term related agreements, e.g. leases or long term maintenance contracts the authorisation limit relates to the total value of the contract and must be within budget unless with prior express agreement. As an example a lease car with an annual value of £4,000 and with a three year agreement would have a contract value of £12,000 (£4,000 x 3) in terms of authority for signature.

Post holder	Level	Authorisation limits (including VAT)
Chief Executive	1	Up to £499,999
Director of Finance	2	Up to £249,999
Voting Director	3	Up to £99,999
Non-voting Director	4	Up to £49,999
Area Directors	5	Up to £49,999
A4C Band 8d/9	6	Up to £24,999
A4C Band 8b / 8c	7	Up to £9,999

Note:

Expenditure of £500,000 and above requires authorisation by the Board of Directors as detailed in Reservation of Powers to the Board. In these cases, authorisation of requisition forms will be completed by the Chief Executive following appropriate Board approval.

Authorisation of Purchase Orders (all Revenue and Capital items)

For all term related agreements, e.g. leases or long-term maintenance contracts the authorisation limit relates to the total value of the contract and must be within budget unless with prior express agreement. As an example, a lease car with an annual value of £4,000 and with a three-year agreement would have a contract value of £12,000 (£4,000 x 3) in terms of authority for signature.

Post holder	Authorisation limits (including VAT)
Procurement Officer	Up to 999
Operational Procurement Officer	Up to £9,999
Senior Procurement Officer	Up to £24,999
Procurement Manager	Up to £49,999
Head of Procurement	Up to £99,999
Deputy Director of Finance	Up to £499,999
Chief Executive or Director of Finance (Deputy Director of Finance in the absence of Director of Finance)	>£500,000

Note:

Purchase Orders for all lease agreements must be authorised by the Chief Finance Officer regardless of value.

DEFINITIONS AND SUPPORTING REFERENCES

Any expression to which a meaning is given in the National Health Service Act 1977, National Health Service and Community Care Act 1990, the NHS Act 2006 and other Acts relating to the National Health Service or in the Financial Regulations made under the Acts shall have the same meaning in this interpretation and in addition:

- "Accountable Officer" means the NHS officer responsible and accountable for funds entrusted to the Trust. He shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

- “Associate Director” means a person, who is appointed to sit on a committee, sub-committee, officer group or working party appointed by the Trust.

- “Audit Committee” means the committee of the Board whose responsibility is to provide assurance to the Board that effective risk management, internal control and governance processes are maintained and that the Trust’s activities comply with the law, guidance and codes of conduct governing the NHS. The committee provides a formal independent mechanism for ensuring a co-ordinated approach for achieving sound financial and managerial control.

- "Board" means the chairman, executive and non-executive directors of the Trust collectively as a body.

- "Budget" means a resource, expressed in financial terms, proposed by the Trust for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

- “Budget Holder” is an executive director, or other officer, with delegated authority to manage finances (income and expenditure) for a specific area of the organisation.

- “CFS” means Counter Fraud Specialist
.
- "Chairman of the Board (or Trust)" is the person appointed by the Secretary of State for Health as advised by the NHS England (NHSE) to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression “the Chairman of the Trust” shall be deemed to include the vice-chairman of the Trust if the chairman is absent or is otherwise unavailable.

- "Chief Executive" means the chief officer of the Trust.

- “Chief Finance Officer” means the chief financial officer of the Trust.

- "Committee" means a committee established by the Trust.

- "Committee members" mean those people formally appointed by the Board to sit on and/or chair specific committees.

- "Contracting and procuring” means the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

- “Establishment Order” shall mean the South Central Ambulance Service NHS Foundation Trust (the Trust) is a statutory body which came into existence on 1 July 2006under the South Central Ambulance Service NHS Foundation Trust (Establishment) Order 2006 No. 1624.

- "Executive Director" means the Chief Executive and Directors who are appointed in accordance with the 1990 National Health Service Trusts (Membership and Procedure) Regulations [SI 1990/2024].

- “Legal Adviser” is a properly qualified person (not necessarily an employee) appointed by the Trust to provide legal advice.

- “Level 1 Officer” } Refer to
- “Level 2 Officer” } Scheme of
- “Level 3 Officer” } Delegation ‘List of
- “Level 4 Officer” } Officers’
- “Level 5 Officer” }
- “Level 6 Officer” }
- “Level 7 Officer” }

- "Membership, Procedure and Administration Arrangements Regulations" means NHS Membership and Procedure Regulations and subsequent amendments.

- "Nominated officer" means an officer charged with the responsibility for discharging specific tasks within Standing Orders and Standing Financial Instructions.

- "Non-Executive Director" means a Director of the Trust who is not an officer of the Trust and is not to be treated as an officer by virtue of regulation 1(3) of the Membership, Procedure and Administration Arrangements Regulations.

- "Officer" means employee of the Trust or any other person holding a paid appointment or office with the Trust.

- "The Chief Governance Officer” - a person appointed to act independently of the Board to provide advice on corporate governance issues to the Board and the chairman and monitor the Trust's compliance with the law, Standing Orders, and Department of Health guidance and is undertaken by the Chief Governance Officer.

- "SFIs" mean Standing Financial Instructions.

- "SOs" mean Standing Orders.

- “Trust” – South Central Ambulance Service NHS Foundation Trust

    - “Tendering and Contract Procedures” refers to the procedures within Finance Policy & Procedure, Tendering and Quotation Procedure.

- "Vice-Chairman" means the Non-Executive Director appointed by the Board to take on the chairman’s duties if the chairman is absent for any reason.

All references in this document expressed in the masculine shall be deemed to also include the feminine.

Wherever the title Chief Executive, Chief Finance Officer, Chief Governance Officer or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

Legislation

- Criminal Procedure and Investigation Act, 1996 Government Resources and Accounts Act, 2000 Proceeds of Crime Act, 2002
- National Health Service Act 2006 Fraud Act 2006
- Bribery Act 2010
- Health and Social Care Act, 2012
- The Government Resources and Accounts Act 2000 (Estimates and Accounts) Order, 2016
- Finance Act, 2017
- Criminal Finances Act, 2017

- The Money Laundering, Terrorist Financing and Transfer of Funds Information on the Payer) Regulations 2017 9.2

National Guidance

- Model Standing Financial Instructions - Department of Health HSG 93/5 – Standards of Business Conduct for NHS Staff
- The Code of Conduct for NHS Managers (October 2002)
- The Green Book – HM Treasury (2003) Code of Accountability in the NHS (2004)
- Managing Public Money – HM Treasury (2013 with amendments in 2018) Monthly Financial Monitoring Guidance for NHS Trusts - NHS Improvement Department of Health Group Accounting Manual, 2016-17.
- Department of Health NHS Finance Manual
- Guidance note regarding requirements for approval, assurance, and oversight of exit and severance payments for Integrated Care Boards - Version 1.3 (September 2023)
- NHS oversight framework
- Cabinet Office Spending Controls
- Associated SCAS Policy Documents
- Trust Standing Orders
- Counter Fraud, Bribery and Corruption Policy
- Trust Tendering and Contract Procedure
- Secure Management of Patient's and Found Property Policy
- Conflicts of interest policy, bribery and fraud policies

APPENDIX 3

Reservation of Powers to the Board

1. Introduction

1.1 Standing Order 2.1 requires that the Trust must adopt a Reservation of Powers and Scheme of Delegation which define the powers retained by the Board. Those powers so determined are detailed below.

2. General enabling provision

2.1 The Board may determine any matter, for which it has delegated or statutory authority, it wishes in full session within its statutory powers.

2.2 The Board may also delegate functions and matters to the formal committees of the board that it has established.

3. Powers reserved to the Board

3.1 Regulations and control

3.1.1 Approval of Standing Orders, a schedule of matters reserved to the Board and Standing Financial Instructions for the regulation of its proceedings and business.

3.1.2 Suspension of Standing Orders.

3.1.3 Approve variations or amendments to the Standing Orders, schedule of matters reserved to the Board and Standing Financial Instructions.

3.1.4 Ratify any urgent decisions taken by the Chair and Chief Executive in public session in accordance with SO4.2

3.1.5 Approval of a scheme of delegation of powers from the Board to its committees and to officers.

3.1.6 Require and receive the declaration of Board members' interests that may conflict with those of the Trust and determining the extent to which that member may remain involved with the matter under consideration.

3.1.7 Require and receive the declaration of officers' interests that may conflict with those of the Trust.

3.1.8 Approve arrangements for dealing and responding to complaints.

3.1.9 Receive reports from committees, including those that the Trust is required by the Secretary of State for Health and Social Care or other regulation to establish, and take appropriate action.

3.1.10 Confirm the recommendations of the Trust's committees where the committees do not have executive powers.

3.1.11 Approve arrangements relating to the discharge of the Trust's responsibilities as a corporate trustee for funds held on trust.

3.1.12 Establish terms of reference and reporting arrangements for all committees and sub-committees that are established by the Board.

3.1.13 Receive reports on instances of use of the seal.

3.1.14 Ratify, or otherwise, instances of failure to comply with Standing Orders or Standing Financial Instructions brought to the Chief Executive's attention.

3.2 Appointments and dismissals

3.2.1 Approve and adopt the organisational structures, processes and procedures to facilitate the discharge of business by the Trust; and modifications thereto.

- Appoint the Chief Executive
- Appoint the Executive Directors

Require, from directors and officers, the declaration of any interests which might conflict with those of the Trust; and consider the potential impact of the declared interests.

3.2.2 Agree and oversee the approach to disciplining directors who are in breach of statutory requirements of the Trust's Standing Orders.

3.2.3 Approve the disciplinary procedure for officers of the Trust.

3.3 Strategy, plans and budgets

3.3.1 Define the strategic aims and objectives of the Trust.

3.3.2 Approve all Trust strategies

3.3.3 Approve proposals for ensuring quality and developing clinical governance in services provided by the Trust, having regard to any guidance issued by the Secretary of State for Health and Social Care.

3.3.4 Approve the Trust's policies and procedures for the management of risk.

3.3.5 Approve Final Business Cases for Capital Investment schemes where the value exceeds £500,000

3.3.6 Approve the Trust's annual revenue and capital budgets.

3.3.7 Ratify proposals for acquisition, disposal or change of use of land and/or buildings.

3.3.8 Approve PFI proposals.

3.3.9 Approve the opening of bank accounts.

3.3.10 Approve proposals on individual contracts (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to over £500,000 during the duration of the contract.

3.3.11 Approve proposals in individual cases for the write-off of losses or making of special payments above the limits of delegation to the Chief Executive and Chief Finance Officer (for losses and special payments) previously approved by the Board.

3.4 Policy determination

3.4.1 Approve the process for approval, dissemination and implementation of policies.

3.4.2 Approval of policies is delegated to the Executive Directors however the Board shall maintain responsibility for approving specific policies and will delegate the approval of other policies and procedures to relevant committees within the structure

3.4.3 The list of policies reserved for board approval are included at appendix 5. The This may be varied from time to time and reported to the

3.5 Audit Arrangements

3.5.1 The Council of Governors is responsible for appointing the Trust's External Auditor, taking into account the recommendation made by the Audit Panel, which will be established by the Audit Committee.

3.5.2 Approve external auditors' arrangements for the separate audit of funds held on Trust, and submission of reports to the Audit Committee meetings which will take appropriate action.

3.5.3 Receive the Auditors Annual Report from the external auditor and agree action on recommendations of the Audit Committee, where appropriate.

3.6 Annual report and accounts

3.6.1 Receive and approve the Trust's Annual Report and Annual Accounts

3.6.2 Receive and approve the Annual Report and Accounts for funds held on trust

3.6.3 Receive and approve the Trust's Quality Account.

3.7 Monitoring

3.7.1 Receive Escalation and Assurance Reports from Chairs of Committees in respect of their exercise of delegated powers. The remit of each Committee is specified within the relevant Committee Terms of Reference available via the Trust's website and staff intranet.

3.7.2 Continuous appraisal of the affairs of the Trust by means of the provision to the Board of reports from directors, committees and officers of the Trust as set out in management policy statements. All monitoring returns required by the Department of Health and Social Care and the Charity Commission shall be reported, at least in summary, to the Board.

3.7.3 Receive reports from the Chief Finance Officer on financial performance against budget.

4. Review

4.1 This Reservation of Powers to the Board document will be reviewed every three years in conjunction with the annual review of Standing Orders, Standing Financial Instructions and the Scheme of Delegation. In accordance with (1.3) any minor amendments required will be approved by the Chief Finance Officer and Chief Governance Officer and reported to the Audit Committee.

APPENDIX 4

Scheme of Delegation

Delegated Matter	Delegated Authority	Operational Delivery	Cross Reference to: Standing Orders (SO) Reservation of Powers (RoP) Standing Financial Instructions (SFIs) Trust Policy/Procedure
1. Corporate Governance			
Approval of the Trust's Standing Orders and Reservations of Powers for the Board of Directors, Standing Financial Instructions and Scheme of Delegation of Powers (including variations and amendments)	Board of Directors	Chief Governance Officer Chief Finance Officer	SO 14.2
Final authority in interpretation of Standing Orders	Chair, advised by Chief Executive and Director of Corporate Affairs	Chair, advised by Chief Executive and Chief Governance Officer	SO 1.2
Notifying Directors and employees of their responsibilities within the Standing Orders and Standing Financial Instructions and ensuring that they understand the responsibilities	Chief Executive	All Directors and employees	
Suspension of Standing Orders for the Board of Directors / Standing Financial Instructions	Board of Directors	Audit Committee	SO 14.1
Review suspension of Standing Orders for the Board of Directors / Standing Financial Instructions	Chief Executive	Chief Governance Officer	
Use of emergency powers relating to the authorities retained by the Board of Directors	Chairman & Chief Executive after having consulted with 2 NEDs & 2 Executive Voting Directors	Chairman & Chief Executive after having consulted with 2 NEDs & 2 Executive Voting Directors	SO 5.2
Advice on the interpretation or application of the Standing Financial Instructions	Chief Finance Officer	Deputy Chief Finance Officer	SFI 3.7
Advice on the interpretation or application of the Scheme of Reservation and Delegation of Powers	Chief Governance Officer	Head of Corporate Governance	SO 2.1
Establishment and Disestablishment of Formal Committees of the Board	Board of Directors	Chief Governance Officer	SO 5
Register of Interests, Gifts and Hospitality - Register of Interests for Board of Directors - Register of Interests for Staff - Gifts and Hospitality Register	Chief Executive Chief Governance Officer Chief Governance Officer Chief Governance Officer	 Head of Corporate Governance Head of Corporate Governance Head of Corporate Governance	SO 6 SFII 22 Gifts, Hospitality and Conflicts of Interests Policy
Annual Report - Approval of Annual Report - Recommendation Annual Report for approval by Board of Directors - Preparation of Annual Report in line with DHSC Group Accounting Manual	 Board of Directors Audit Committee Chief Governance Officer	 Audit Committee Chief Governance Officer Head of Corporate Governance	RoP 3.6
Common Seal - Receipt of a bi-annual report on use of Common Seal - Authorise use of Common Seal - Custody of Common Seal and Register of all sealings	 Board of Directors Chief Executive, Deputy Chief Executive and Chief Finance Officer Chief Governance Officer	 Chief Governance Officer Chief Governance Officer Head of Corporate Governance	SO 12
Receiving Sponsorship	Board of Directors		SFI 22
Waiver of Standing Orders / Standing Financial Instructions	Chief Governance Officer/Director of Finance/Chief Executive	Executive Management Committee	SO 14
Approval of Strategies, Policies & Procedures: - Approval of all strategies - Approval of policies reserved for Board - Approval of other policies and procedures	Board of Directors Board of Directors Board of Directors Executive Lead	Chief Governance Officer Lead Executive Risk and Policy Group, reporting into Executive Management Committee	 RoP 3.3 RoP 3.4 Policy on the development of Trust Policies
Appointment of Internal Auditors	Audit Committee	Chief Finance Officer	SFI 6
Annual Governance Statement	Chief Executive	Chief Governance Officer Head of Corporate Governance	SFI 6
Risk Management	Chief Governance Officer	Head of Risk Management	SFI 24 Risk Management Policy
Non-clinical incident management and reporting	Chief Governance Officer	Head of Risk Management	Incident Reporting Policy

Delegated Matter	Delegated Authority	Operational Delivery	Cross Reference to: Standing Orders (SO) Reservation of Powers (RoP) Standing Financial Instructions (SFIs) Trust Policy/Procedure
Complaints & PALS Management - Level 1-3 - Level 4 and 5	Chief Nursing Officer Deputy Chief Nursing Officer Chief Nursing Officer	Head of Pt Experience	Patient Experience Policy
Claims: Employer's Liability, Public Liability and Medical Negligence - Employers Liability up to £25k - Employers' Liability up to £500k - Employers' Liability £500k+ - Public Liability and Property Damage up to £25k - Public Liability and Property Damage up to £500k - Clinical Negligence upto £500k - Clinical Negligence over £500k	Chief Governance Officer Head of Legal Services Head of Legal Services Chief Governance Officer Head of Legal Services Chief Governance Officer Head of Legal Services Chief Governance Officer	Head of Legal Services	Claims Management Policy
Litigation Papers	Chief Governance Officer	Head of Legal Services	Claims Management Policy
Health, Safety and Security and Fire Management	Chief Governance Officer	Head of Risk and Security	Health and Safety Policy and Procedure Fire and Emergency Response Policy
2. Finance			
Annual Accounts	Board of Directors	Audit Committee	SFI 9 DHSC Group Accounting Manual Audit Committee Terms of Reference
Approval of Capital Programme	Chief Finance Officer	Programme Capital Department Expenditure Limit (CDEL) approved by Board along with IFRS16 Programme, Fixed Asset Management & Strategy Group manages capital CDEL and IFRS16 CDEL.	SFI 16
Approval of Individual Capital and PFI Schemes	Chief Finance Officer	Fixed Asset Management & Strategy Group manages capital programme CDEL and IFRS16 CDEL	RoP 3
Appointment of External Auditors	~~Board of Directors~~ Council of Governors	Audit Committee	RoP 3
Asset Register, Capital Charges and Security of Assets	Chief Finance Officer		SFI 16
Banking Arrangements and Cash	Chief Finance Officer	Cash and banking arrangements managed by the Financial Services Manager and Chief Accountant.	SFI 10
Budget Setting	Chief Finance Officer	Deputy Chief Finance Officer	SFI 8
Charitable Funds Expenditure - Upto £2,499 - £25,000 to £50,000 - Above £50,001	 Deputy Chief Finance Officer or Chief Governance Officer Chief Finance Officer or Chief Executive Charitable Funds Committee or Board of Directors	Chief Finance Officer	SFI 21 & 24
Charitable Funds Annual Accounts	Board of Directors	Chief Finance Officer/ Chief Governance Officer	XX
External Borrowing	Chief Finance Officer	Board of Directors	SFI 10
Investments	Board of Directors	Chief Finance Officer	SFI 10
Other Income (including Income Generation)	Chief Finance Officer	Deputy Chief Finance Officer	SFI 11
Petty Cash	Chief Finance Officer	Senior Managers	SFI 14
Scheme of Budgetary Control	Chief Executive	Director of Finance	SFI 8
Fraud and Bribery	Chief Executive	Director of Finance	SFI 6
3. Strategy, Partnerships and Transformation			
Trust Strategy	Deputy CEO (TBC)	Trust Board	Trust Strategy
Business Planning	Deputy CEO (TBC)	Trust Board	Annual Plan National Planning Guidance
Reconfigurations of Services and Clinical Pathway Changes	Deputy CEO	Clinical Reference Group	
Freedom of Information	Chief Digital Officer	Information Governance Manager/Data Protection Officer	Freedom of Information Policy and Procedure
Corporate Communications and Engagement	Director of Communications, Marketing and Engagement	Senior Marketing & Engagement Manager Stakeholder and Engagement Manager	Communications Strategy VIP and media visitors access, policy Social Media guidance
Patient and Public Engagement	Director of Communications, Marketing and Engagement	Senior Marketing & Engagement Manager Stakeholder and Engagement Manager	Communications Strategy VIP and media visitors access, policy Social Media guidance
Patient and Public Panel (patient involvement and engagement)	Chief Nurse	Head of Patient Experience	Patient Experience Policy
Approval and Management of Projects: - Approval authority outlined in SFI Requirements to Obtain Quotes and Tenders	Chief Finance Officer	Head of Procurement	Procurement Policy
4. Service Delivery			
Resilience/Emergency Planning	Executive Director of Operations	**Head of Resilience & Specialist Operations**	SCAS Incident Response Plan

Delegated Matter	Delegated Authority	Operational Delivery	Cross Reference to: Standing Orders (SO) Reservation of Powers (RoP) Standing Financial Instructions (SFIs) Trust Policy/Procedure
5. Procurement			
Disposals - Board of Directors to approve disposal of land, buildings and equipment with a value in excess of £250,000 on completion of tender action. - Trust Management Committee to approve disposals between £25,000 to £249,999 (subject to formal tender action to disposal) - Director of Finance to approval disposal of surplus equipment between £2,500 and £24,999 on completion of competitive quotation process - Directors to approve disposal of surplus equipment with a value of up to £2,499	Chief Finance Officer	Head of Procurement	SFI 18
Lease Car Arrangements	Chief Finance Officer	Head of Fleet	
Purchasing and New Tender Specification Authorisation	Chief Finance Officer	Head of Procurement	SFI 16
Authorisation of Requisition Forms for goods and services (all Revenue and Capital): - £100,000+ - Up to £100,000 - Up to £50,000 - Up to £10,000	Board of Directors Chief Executive Chief Finance Officer Executive Directors	Proactis Scheme of Delegation,	SFI Annex A
Approval of Competitive Tendering Awards and Appointment of Tender Evaluation Panels - Refer to SFIs for Requirements to Obtain Quotes and Tenders	Chief Finance Officer	Head of Procurement	SFI Requirement to obtain Quotes and Tenders (all Revenue and Capital items)
Pool Vehicle Arrangements	Chief Finance Officer	Head of Fleet and Logistics	
Insurance (Motor and Workshops)	Chief Finance Officer	Deputy Chief Finance Officer	
6. Information Management			
Clinical Records Management - Overall accountability to ensure the Trust adheres to the Clinical Records Management legislation, Trust Policies and procedures and NHS Standards - Review and agree internal protocols governing the protection and use of patient identifiable information by Trust staff - Ensure adoption and adherence to confidentiality policies and procedures are in line with Caldicott Guardian accountability	Chief Nurse (Caldicott Guardian) Chief Nurse (Caldicott Guardian) Chief Nurse (Caldicott Guardian)		Data and Information Quality Policy Digital Clinical Safety Policy ICT Incident Response Policy Change Management Policy Clear Desk Policy Data Backup Policy Data Breach Response Policy Disaster Recovery Plan Policy Encryption & Key Management Policy End User Encryption Key Protection Policy Monitoring & Logging Policy Personnel Security Policy Remote Access Policy Secure Systems Management Policy Sensitive Information Handling Policy User Identification Authentication & Authorisation Policy Password PolicyConfidentiality Policy Code of Conduct for Employees in Respect of Confidentiality Patient Clinical Record Policy & Procedure
Corporate Records Management	Chief Digital & Information Officer SIRO	Data Protection Officer Deputy SIRO	Data and Information Quality Policy Digital Clinical Safety Policy ICT Incident Response Policy Change Management Policy Clear Desk Policy Data Backup Policy Data Breach Response Policy Disaster Recovery Plan Policy Encryption & Key Management Policy End User Encryption Key Protection Policy Monitoring & Logging Policy Personnel Security Policy Remote Access Policy Secure Systems Management Policy Sensitive Information Handling Policy User Identification Authentication & Authorisation Policy Password PolicyConfidentiality Policy Code of Conduct for Employees in Respect of Confidentiality
Disclosure of Patient Identifiable Information	Medical Director (Caldicott Guardian)		Clear Desk Policy Data Breach Response Policy Secure Systems Management Policy Sensitive Information Handling Policy User Identification Authentication & Authorisation Policy Password PolicyConfidentiality Policy Code of Conduct for Employees in Respect of Confidentiality Patient Clinical Record Policy & Procedure

Clinical Records Management - Overall accountability to ensure the Trust adheres to the Clinical Records Management legislation, Trust Policies and procedures and NHS Standards - Review and agree internal protocols governing the protection and use of patient identifiable information by Trust staff Ensure adoption and adherence to confidentiality policies and procedures are in line with Caldicott Guardian accountability	Chief Nurse (Caldicott Guardian) Chief Nurse (Caldicott Guardian) Chief Nurse (Caldicott Guardian)	Deputy SIRO and Chief Digital & Information Officer Chief Digital & Information Officer	Data and Information Quality Policy Digital Clinical Safety Policy ICT Incident Response Policy Change Management Policy Clear Desk Policy Data Backup Policy Data Breach Response Policy Disaster Recovery Plan Policy Encryption & Key Management Policy End User Encryption Key Protection Policy Monitoring & Logging Policy Personnel Security Policy Remote Access Policy Secure Systems Management Policy Sensitive Information Handling Policy User Identification Authentication & Authorisation Policy Password PolicyConfidentiality Policy Code of Conduct for Employees in Respect of Confidentiality Patient Clinical Record Policy & Procedure

legated Matter	**Delegated Authority**	**Operational Delivery**	**Cross Reference to:** **Standing Orders (SO)** **Reservation of Powers (RoP)** **Standing Financial Instructions (SFIs)** **Trust Policy/Procedure**
7. Medical			
Medicine Management	Chief Paramedic	Chief Pharmacist	Medicine Management Policy
Clinical Effectiveness	Chief Paramedic	TBC when structure developed	Q&S TORs
Ambulance Quality Indicator Reporting	Chief Paramedic	Chief paramedic	CRG /Q&S TORs
Research and Development	Chief Medical Officer	Deputy MD/ Senior research paramedic/manager	Research Strategy
Public Health	NA	NA	Not a specific role in SCAS.
Freedom to Speak Up	Chief Executive	Chief People Officer	Freedom to Speak Up Policy
8. Quality, Innovation and Improvement			
Patient Safety Management	Chief Nursing Officer	Deputy Chief Nursing Officer Assistant Director of Patient Safety and Experience	Patient Safety Incident Response Policy
Patient Safety Incident Response Framework (PSIRF) - Declaration of Patient Safety Incident Investigation (PSII) - Approval of patient Safety Incident Investigation (PSII)	Chief Nursing Officer	Deputy Chief Nursing Officer Assistant Director of Patient Safety and Experience	Patient Safety Incident Response Policy
Infection Prevention & Control	Chief Nursing Officer	Deputy Chief Nursing Officer Assistant Director of Compliance and IPC	Infection Prevention and Control Policy
Vulnerable Persons Management (Safeguarding)	Chief Nursing Officer	Deputy Chief Nursing Officer Head of Safeguarding and PREVENT	Safeguarding Adults Policy Safeguarding Children Policy Safeguarding Supervision Policy
Single Oversight Framework: - Reporting of National Oversight Framework through Integrated Performance Report - Delivery of National Oversight Framework	Chief Finance Officer All Executive Directors	Deputy Director of Finance Deputy Directors/Direct Report	N/A
CQC Registration - Accountable Officer - Registered Manager	Chief Executive Chief Nursing Officer	Deputy Chief Nursing Officer Assistant Director of Compliance and IPC	N/A
Quality Account	Chief Nursing Officer	Deputy Chief Nurse AD Compliance	Quality Account

Violence and Aggression (VPR Standards)	Chief Governance Officer	Head of Health and Safety	Health & Safety Policy
9. Duties of Individuals			
Code of Conduct for NHS Managers	Chief Executive	Chief People Officer	N/A

Delegated Matter	**Delegated Authority**	**Operational Delivery**	**Cross Reference to:** **Standing Orders (SO)** **Reservation of Powers (RoP)** **Standing Financial Instructions (SFIs)** **Trust Policy/Procedure**
10. Workforce			
Recruitment and Appointments: - Recommend appointment of Chief Executive - Involvement in selection panel for Non-Executive Directors - Approve appointment of Chief Executive and Executive Directors (subject to salary approval by NHSE - Determine skill set and person specification for members of the Board of Directors both voting and non-voting and approval selection process - Development and implementation of Trust Recruitment and Selection Policy. - Statement of Written Particulars of Employment for Very Senior Managers. - Confirmation of appointments / contracts of employment. - Compliance with Fit and Proper Person Regulations	 Chairman Chairman Nominations and Remuneration Committee Nominations and Remuneration Committee Chief People Officer Chief People Officer/Chair	Chief People Officer Assistant Director of HR Assistant Director of HR	Recruitment and Selection Policy Fit and Proper Persons Policy
Disciplinary Arrangements & Appeals - Hearing Officer for dismissal of Chief Executive - Hearing Officer for disciplinary cases against Directors - Appeal panel members for disciplinary cases against Chief Executive & Executive Directors - Hearing Officers for Disciplinary cases as required/ Panel members for appeals against dismissal - Hearing Officers for disciplinary cases / appeals officer for probationary period dismissals or cases heard by one of their managers. - Hearing Officers in cases where sanction available is up to and including a final written warning.	Director of People Chairman Chief Executive Non-Executive Directors Director (Executive Director/Area Director/Deputy Director) Senior Manager (Deputy Director/Area Heads of Operations/Heads of Dept) Middle Managers or above (e.g. Sector Managers, ICC Middle Managers)	Assistant Director of HR	Discipline & Conduct Policy and Procedure
Grievance Procedure - Hearing Officer for grievance cases from Directors - Hearing Officers for Grievance from immediate staff or panel members for Stage 3 Grievance Appeal cases. - To hear Grievances at Stage 2 and from immediate staff / panel members for Stage 3 Grievance Appeal cases. - To hear Grievances at Stage 2 and for their immediate staff. To hear Stage 3 Grievance appeals associated with D@W complaints. - To hear Stage 2 grievances associated with Dignity At Work complaints. - To hear grievances from immediate staff at Initial Grievance Meeting (stage 1)	Director of People Immediate Line Manager Immediate Line Manager OR More Senior Manager than Stage 2 More Senior Manager than at Stage 1/ 2 More Senior Manager than at Stage 1 / 2 More Senior Manager than at Stage 1 Ordinarily grievances should be heard by an appropriate manager as close to the aggrieved employee as possible and in most cases, this will be the employees direct line Manager. Subsequent stages of the grievance process should then be heard by a more senior Manager than at the previous stage. Immediate line Manager (In cases where the grievance relates to the line Manager then a more senior Manager or a manager from an alternative department will Chair).	Assistant Director of HR	Resolution Policy
Workplace Performance Management - Hearing Officer for dismissal of Chief Executive - Hearing Officer for cases against Directors. - Appeal panel members for cases against Chief Executive & Executive. Directors - Hearing Officers for cases against Deputy Directors. Panel members on appeals against dismissal. - Panel members on appeals against dismissal. - Hearing Officers for cases at Stage 3 of policy, where dismissal is an option, or hear cases at Stage 1 and/or 2 where employee reports to their immediate reports. Act as Appeal Officer where sanction was imposed by one of the managers reporting directly to them (up to final written warning). - Hearing Officers in cases where sanction available is up to and including a final written warning. Appeals Officers against formal written warning sanction (Stage 1). - To manage initial informal performance management of staff and monitor the performance of staff who report into them and are being managed under the Performance Management Policy.	Chief People Officer Chairman Chief Executive Non-Executive Directors Director (Exec Director / Area Director) Deputy Directors Senior Manager (e.g. Deputy Director/Area Heads of Operations/Heads of Dept) Middle Managers or above (e.g. Sector Managers, 111 Service Delivery Managers) Line Managers	Assistant Director of HR	Performance Improvement Policy
Dignity at Work - Respond to Dignity At Work complaints received from direct reports; take immediate steps to address inappropriate behaviour and work with individuals involved to improve work relationships.	Director of People Line Managers	Assistant Director of HR	Dignity, Respect and Civility at Work Policy
Funded Establishment: - Approval of funded establishment as part of annual budget setting - Approval of restructure proposals affecting Directors subject to Very Senior Manager Pay arrangements - To authorise in-year all increase, decreases or other changes to establishments following appropriate authorisation by Finance - Approve in year proposals for restructure within budget establishment changes Approve in-year proposals for re-structure resulting in establishment changes not affecting Directors subject to Very Senior Manager Pay Arrangements where there is a cost pressure	Board of Directors Nominations and Remuneration Committee Chief Executive Executive Directors Executive Management Committee	Chief Executive	Organisational Change Procedure

Remuneration and Conditions of Service: Very Senior Manager Pay arrangements: - Authorisation of all pay, benefits and grading issues for Directors subject to Very Senior Manager Pay arrangements and NHS England (NHSE) approval. - Recommendation of non-contractual termination payments to the NHSE and Treasury for approval - Approval of costs incurred in relation to Directors subject to Very Senior Manager Pay arrangements, Senior Managers and other cases where the cost exceeds £50,000. - Approval of business cases for redundancy where the costs exceed £50,000. - Recommend contractual terminations to the NHSE where costs exceed £100,000 - Jointly approve business cases for redundancy/premature retirement applications where the cost does not exceed £50,000	Nominations and Remuneration Committee Chief People Officer and Chief Finance Officer	Chief People Officer	SFI 13

ated Matter	**Delegated Authority**	**Operational Delivery**	**Cross Reference to:** **Standing Orders (SO)** **Reservation of Powers (RoP)** **Standing Financial Instructions (SFIs)** **Trust Policy/Procedure**
Payroll Processes: - Security and auding of all payroll processes - Establish procedures and documentation for new starters, variations and terminations and other changes affecting payments to individuals - Agreement of dates and methods of payment - Management of payroll - Review contract for payroll services	 Chief Finance Officer Chief People Officer	 Deputy Chief Finance Officer Assistant Director of HR	Starters and Leaver processes
Education and Learning	Chief People Officer	Assistant Director Education	
Performance Appraisal Policy & Procedure	Chief People Officer	Assistant Director of HR	PDR Guidance
Pay Progression Deferral - Deferring individual pay progression - Appeal against pay progression	Chief People Officer Line Manager Senior Manager	Assistant Director of HR	Pay Progression Policy
Sickness Warning Arrangements - Hearing Officer for dismissal of Chief Executive - Hearing Officer for cases of Executive Directors - Appeal panel members for cases against Chief Executive and Executive Directors. - Hearing Officers for cases involving Deputy Directors / Heads of Department / Area Heads of Ops. - Panel members on appeals against dismissal - Any cases where dismissal is a possible sanction - Hearing Officers for Stage 4 & Health Capability hearings / cases against staff for whom they are the immediate line manager. Appeals Officers for appeals against final written warning and cases heard by one of the managers who reports directly to them - Hearing Officers in cases where sanction available is up to and including a final written warning (Stages 1-3). - Hearing Officer for cases where the sanction applied may be up to and including a written warning (Stage 2). - Conduct Stage 1 sickness review meetings with immediate staff.	Chief People Officer Chair Chief Executive NEDs Director (Exec Dir/Area Dir) Executive Director/Area Director or Deputy Director Senior Manager Middle Managers or above (e.g. Sector Managers, ICC Middle Manager) First Line managers	Deputy Directors/Senior Managers	Supporting Attendance Policy
Decisions on Injury Allowance Applications	Chief People Officer	Associate Director of People and Wellbeing	Supporting Attendance Policy
Agency Rules	Chief People Officer	Associate Director of People and Wellbeing	NHSE Agency Rules April 2023
Recovery of overpayments - Overpayments write off	Chief People Officer Chief Finance Officer	Deputy Chief Finance Officer / Associate Director of People and Wellbeing	

LIST OF POLCIES RESERVED TO THE BOARD

- Risk Management Policy
- Medical Devices Policy
- Quality Impact Assessment Policy
- Patient Experience Policy
- Incident Reporting Policy
- Policy Management Policy
- Fit and Proper Persons Policy
- Conflicts of Interest Policy
- Credit Card Policy
- Treasury Management Policy
- Anti-Fraud & Bribery Policy
- Policy for Entering into Service Agreements for New Business
- Contractor Management Policy
- Estates and Facilities Management Policy
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations Policy
- Personal Protective Equipment Policy
- Management of Violence & Aggression Policy
- Lone Working Policy
- Homeworking/Hybrid Working Policy
- Health & Safety Policy
- Equal Opportunities and Diversity Policy
- Discipline and Conduct Policy
- Performance Improvement Policy
- Confidentiality Policy
- Stress Policy
- Supporting Attendance Policy
- Freedom to Speak-Up: Raising Concerns Policy
- Resolution Policy
- Recruitment and Selection Policy
- Pay Protection Policy
- National Ambulance Services Infection Prevention and Control Policy
- Safeguarding Supervision Policy
- Safeguarding Children Policy
- Safeguarding Adults Policy
- Prevent Policy
- Domestic Abuse Policy (SCAS Staff)
- Domestic Abuse Policy (Patients and Service Users)
- Allegations Policy
- Stroke Care Policy
- Safe and Secure Handling of Medicines Policy
- Resuscitation Policy and Recognition of Life Extinct
- Mental Health Policy
- Medicines Management Policy
- Medicines Administration Policy
- Learning from Deaths Policy
- Controlled Drug Policy
- Consent to Examination and Treatment Policy
- Clinical Audit and Service Improvement Policy
- Patient Safety Incident Response Policy
- Worked Hours Policy
- Events Policy
- Clinical Safety Plan Policy

NHS
South Central Ambulance Service
NHS Foundation Trust

Trust Board of Directors Meeting in Public
27 March 2025

Report title	Code of Governance Self-Assessment
Agenda item	26
Report executive owner	Becky Southall, Chief Governance Officer
Report author	Kofo Abayomi, Head of Corporate Governance & Compliance
Governance Pathway: Previous consideration	Audit Committee 19th March 2025
Governance Pathway: Next steps	Trust Board for approval

Executive Summary

Best practice dictates that the Trust should undertake an assessment against the Code of Governance periodically to provide assurance to the Trust Board, via the Audit Committee, that the trust is compliant with the provisions set out therein. Completion of the self-assessment will also support the Trust Board to sign off the Annual Governance Statement as part of the Annual Report/Annual Accounts process as it provides assurance of compliance with governance requirements.

An assessment of the Trust's position against each of the provisions is set out within the attached paper on a comply or explain basis. Areas of non-compliance are as set out below. Corrective actions are set out in the Governance Improvement Plan that was developed to improve the Trust's overall governance following observations made in the CQC report and to reflect the requirements set out in the Trust's transition criteria:

- Circulation of board and committee papers within the 7-day timeframe stipulated in the Trust's Standing Orders
- Publication of the terms of reference for the committees of the board
- Annual evaluation of the effectiveness of the board, its committees and the Council of Governors

- Succession planning for board positions as part of the Trust's approach to Leadership Development
- Policy for engaging auditors in non-audit activity
- One of the Non-Executive Directors has served over 2 terms, but this was approved by the Council of Governors based on sound rationale and business need
- Preparation of a Scheme of Delegation and Reservation of Powers (which will be addressed by approval of the documents at the March Boar meeting)

Additional work will take place to review and refresh the information that is provided to the Council of Governors and to ensure the Council of Governor Development Plan reflects the needs of the Governors and supports them to fulfil their role and execute their statutory duties effectively.

As is reflected in the Chair's report to the board, the self-assessment was subject to scrutiny and debate at the March Audit Committee and amendments requested by the committee have been incorporated into the attached document. The board can therefore be assured that the self-assessment has been subject to independent scrutiny.

Alignment with Strategic Objectives
The overall effectiveness of the trust's governance arrangements aligns with the delivery of all of the strategic objectives but is particularly pertinent to Well Led.

Relevant Board Assurance Framework (BAF) Risk
The overall effectiveness of the trust's governance arrangements aligns with all of the BAF risks given that the role of the board is to set the strategic direction for the organisation and ensure that risks to delivery are managed and mitigated.

Financial Validation	There are no direct financial implications associated with the self -assessment as this was undertaken by the trust's Governance Team.
Recommendation(s)	
The Board is asked to note the position against each of the provisions laid out in the Code of Governance, the areas of non-compliance and plans to address these and to **APPROVE** the self-assessment on the recommendation of the Audit Committee.	

For Assurance		**For decision**	✓	**For discussion**		**To note**	

Code of governance for NHS provider trusts – assessment for South Central Ambulance Service NHS Foundation Trust (2024/25)

March 2025

Schedule A: Disclosure of corporate governance arrangements

Trusts are required to provide a specific set of disclosures to meet the requirement of the Code of Governance. These should be submitted as part of the annual report (as set out for foundation trusts in the NHS foundation trust annual reporting manual and for NHS trusts in DHSC group accounting manual.

The provisions listed below require a supporting explanation in a trust's annual report, even in the case that the trust is compliant with the provision. Where the information is already in the annual report, a reference to its location is sufficient to avoid unnecessary duplication.

For the provisions listed below, **the basic 'comply or explain' requirement applies**. The disclosure in the annual report should therefore contain an explanation in each case where the trust has departed from the code, explaining the reasons for the departure and how the alternative arrangements continue to reflect the principles of the code. Trusts are welcome but not required to provide a simple statement of compliance with each individual provision. This may be useful in ensuring the disclosure is comprehensive and may help to ensure that each provision has been considered in turn. In providing an explanation for any variation from the code, the trust should aim to illustrate how its actual practices are consistent with the principles to which the particular provision relates. It should set out the background, provide a clear rationale, and describe any mitigating actions it is taking to address any risks and maintain conformity with the relevant principle. Where deviation from a particular provision is intended to be limited in time, the explanation should indicate when the trust expects to conform to the provision.

Section A: Board leadership and purpose		
Provision	**Requirement**	**SCAS Comply or Explain**
A 2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	**Comply** The Board has regularly reviewed the economy, efficiency and effectiveness of resources through the regular Integrated Performance Report and finance reports, and quality and safety reports which are considered at each meeting. Further assurance is provided via internal and external auditors via the Audit Committee. The Trust as a system partner is actively engaged across the four Integrated Care Boards and has developed a Memorandum of Understanding with SECAmb to share knowledge and resources and explore opportunities for collaboration. SCAS is also a part of the Southern Ambulance Services Collaboration (SASC), a partnership between: ▪ East of England Ambulance Service NHS Trust (EEAST), ▪ London Ambulance Service NHS Trust (LAS), ▪ South Central Ambulance Service NHS Foundation Trust (SCAS),

Section A: Board leadership and purpose		
Provision	**Requirement**	**SCAS Comply or Explain**
		▪ South East Coast Ambulance Service NHS Foundation Trust (SECAmb) and ▪ South Western Ambulance Service NHS Foundation Trust (SWAST). The collaboration was launched in May 2024 to enable member trusts to support each other more effectively, share best practice, and work together to provide high quality, sustainable care across the sector. In September 2024, the collaboration partners took an update paper to their Trust Board meetings: **Collaboration manifesto board paper and poster**. The Trust describes in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance contributes to delivery of the overall Trust strategy.
A 2.2	The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place- based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and intended outcomes and the	**Comply** As a Trust we have a clear vision, values and set of objectives, including a specific objective related to stakeholder engagement, systems and partnerships. The Trust strategy was re-launched in December 2023 through a process of co-design with staff, stakeholders and partners.

Section A: Board leadership and purpose		
Provision	**Requirement**	**SCAS Comply or Explain**
	behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners, and other decisions.	In February 2025, the board has reviewed the strategy and has undertaken work to align this to Fit for the Future (FFF), which is widely known across the organisation and will become the strategic direction of travel underpinned by 5 strategic themes under which our programmes of work will be organised. The trust's Board Assurance Framework for 2025/26 will be aligned to the 5 strategic themes and supporting delivery plans will be developed aligned to our medium-term and annual objectives. The Trust has involved the ICSs in our financial operational and workforce planning for 2025-26.
A 2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	**Comply** The Board monitors culture through a number of mechanisms and reports including the staff survey, FTSU Guardian Reports, pulse surveys and Employee Relations Reports. The board has also considered the findings and recommendations of the national ambulance culture review. Whilst corrective actions have been outlined in regular reports to the People & Culture Committee (PCC), we have used these sources of intelligence to develop a of broader set of strategic

Section A: Board leadership and purpose		
Provision	**Requirement**	**SCAS Comply or Explain**
		priorities and actions relating to leadership and culture; this being one of the 5 strategic themes in FFF. This also links to our Recovery Support Programme (RSP) Transition Criteria, our CQC must and should do actions and our enforcement undertakings. The board recognises however that there is further work required to improve organisational culture. In addition to assurance being provided to the PCC around the health and wellbeing of our workforce, the Trust's annual report explains its approach to investing in, rewarding and promoting this.
A 2.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five- year joint plan for health services and annual capital plan agreed by the ICB and its partners, and to ensure that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.	**Comply** The Board regularly reviews the Trust's effectiveness, efficiency and economy and the quality of its healthcare delivery. This is achieved via scrutiny of the Integrated Performance Report at committee and board level and additional sources of assurance via other reports. The Trust also monitors the National Ambulance Quality Indicators Dashboard and its performance against the NHS Oversight Framework. System related strategic risk is captured within the stakeholder engagement objective element of our Board Assurance Framework.

Section A: Board leadership and purpose		
Provision	**Requirement**	**SCAS Comply or Explain**
A 2.5	The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, e.g. from the internal audit function, to provide an adequate and reliable level of assurance.	**Comply** The Board monitors performance through the Integrated Performance Report which contains a number of KPIs which are presented in SPC format to allow the board to understand themes and trends and take action accordingly. Internal audit has been utilised throughout the year to test our key internal control mechanisms linked to areas of risk outlined in our Board Assurance Framework. In addition, we have secured external expertise around a number of areas, such as NEPTS and strengthening our clinical operational delivery to ensure that patients are treated in the most appropriate clinical setting. This will not only ensure greater clinical efficacy but will contribute to stronger operational performance against ambulance response time targets and better flow through our partner hospitals.
A 2.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board	**Comply** The Trust monitors the effectiveness of its clinical governance arrangements via the sub-group structure of the Quality and Safety Committee. It also reports on the effectiveness of its clinical governance arrangements through its annual report and

Section A: Board leadership and purpose		
Provision	**Requirement**	**SCAS Comply or Explain**
	should record where in the structure of the organisation clinical governance matters are considered.	the Quality Account. The Quality Account also identifies the Trust's quality priorities for the year.
A 2.7	The chair should regularly engage with stakeholders including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of the stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually.	**Comply** The Trust Chair regularly engages with colleagues from the ICS across the Trust's geography, this includes meeting with ICB Chairs and with chairs of our partners across the system. The Chair engages with staff via site visits to ambulance stations and call centres and with our Governors who represent our staff and the communities that we serve. The Chair presents regular reports to the Trust Board on his engagement activity. NED Committee Chairs actively seek to engage with stakeholders on significant matters related to their areas, for example by connecting with committee chairs across the systems, liaison with governors, and proactive engagement in national networks/briefings. The Trust also holds an Annual Members Meeting to promote wider engagement.

Section A: Board leadership and purpose		
Provision	**Requirement**	**SCAS Comply or Explain**
A 2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective.	**Comply** The Board describes the requirements of this provision in its annual report. The Trust employs engagement mechanisms with stakeholders as outlined above and specifically with our patients, via our Patient Engagement Panel. The Trust works closely with system partners in the provision and development of services across the Southeast. It has a range of agreed collaborations in place as outlined above to pilot new ways of working, or implement best practice working between providers, largely managed via MOU's, SLAs and formal contracts, which are regularly reviewed through our governance and assurance mechanisms.
A 2.9	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.	**Comply** The Trust has adopted the national Freedom to Speak Up Policy and has appointed an executive and non-executive lead, together with 3 Freedom to Speak Up Guardians to support staff where they do not feel confident enough to report concerns via our existing internal mechanisms. This includes the ability to raise concerns anonymously via our Hub intranet page.

Section A: Board leadership and purpose		
Provision	**Requirement**	**SCAS Comply or Explain**
		The Board receives quarterly reports from the FTSU team, which include themes, learning, number of cases and all activity throughout the year. A self-assessment is also undertaken annual to identify areas for improvement. The trust's policy has been reviewed and updated during the year and contains the process for investigation and follow-up action, and guidance on detriment.
A 2.10	The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement.	**Comply** The Board has a Register of Interests which is compiled in accordance with the Trust's Gifts, Hospitality and Conflicts of Interest Policy. The policy was last approved in September 2024. The Register is presented to every board meeting and any additional declarations are requested at the start of each Board and Committee meeting. Any conflicts that arise are managed in accordance with the stipulations of the policy.
A 2.11	Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes.	**Comply** Any specific concerns raised about the Board or management of the Trust would be explicitly recorded in the minutes of the

Section A: Board leadership and purpose		
Provision	**Requirement**	**SCAS Comply or Explain**
	If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.	relevant meeting. Any member of the Board/Director may request that their specific views are recorded. There has been no specific instances of non-executive director's resigning over concerns, however if they did, the Chief Governance Officer would ensure circulation of those concerns to the Board. The Trust has also appointed a Senior Independent Director (SID) with whom concerns can be raised.

Section B - Division of responsibilities		
Provision	**Requirement**	**SCAS Comply or Explain**
B 2.1	The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.	**Comply** The Trust Chair, with advice from the Chief Executive and Chief Governance Officer, sets the agenda for each Board of Directors meeting and Council of Governors meeting; regular agenda setting meetings are held in that regard. The Chief Governance Officer maintains an overall work programme for the Board, its committees and Council of Governors on behalf of the Chair.
B 2.2	The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.	**Comply** A standard cover sheet and report template is used across the board and committees to promote clarity and consistency. The Board receives performance data via the Integrated Performance Report and any data or information that is required outside of Board/Committee cycle is circulated via email. Led by the Chair, there is a process of reflection on the quality of papers submitted for consideration during which feedback on required improvements can be provided e.g.

Section B - Division of responsibilities		
Provision	**Requirement**	**SCAS Comply or Explain**
		requesting more comparative data or trajectories for improvement. The Trust Chair ensures that new governors receive an induction and keeps them updated on developments within the Trust and wider NHS via a regular Council of Governors (CoG) bulletin and Chair/CEO reports at the start of each CoG meeting. The Chair meets regularly with the Lead Governor. The Council of Governors has a programme of scheduled workshops to assist governors in undertaking their role. The Council of Governors meet before each meeting to identify areas of concerns or interest. These are presented to Non-Executive Directors and the Chief Executive Officer for a response and discussion at the Council of Governors meeting. **Explain** Whilst the trust has set a standard of all board and committee papers being circulated 7 days before the meeting, this is not being met consistently. As part of the

Section B - Division of responsibilities		
Provision	**Requirement**	**SCAS Comply or Explain**
		Governance Improvement Plan, clear timetables will be set alongside expectations with regards to timeliness and standards of papers.
B 2.3	The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular and ensuring a constructive relationship between executive and non-executive directors.	**Comply** The Chair has promoted a culture of honesty, openness, trust and debate as evidence by their appraisal in 2023/24. There is ongoing work with Board and Committees in terms of observing and feedback aimed at improving the efficiency and effectiveness of each meeting. Feedback is given to the Committee/Board as a whole, but there are more detailed conversations with the NED Chair and the executive lead. These are particularly focused on development of effective challenge and holding to account to ensure that key issues are addressed in a timely manner.
B 2.4	A foundation trust chair is responsible for ensuring that the board and council work together effectively.	**Comply** The Chair of the Trust takes proactive steps to promote effective working between the Board of Directors and Council of Governors. Governors are invited to attend the Board meetings in public and they are invited to observe Board Committee

Section B - Division of responsibilities		
Provision	**Requirement**	**SCAS Comply or Explain**
		meetings with the exception of the Remuneration Committee. Non-Executive Directors attend Council of Governors meetings and Committee Chairs provide a briefing on the work of their committee, on a rotational basis. Non-Executive Directors are also responsible for responding to specific areas of concern or interest highlighted by Governors relating to their committee or NED portfolio. The Chair of the Trust ensures the agendas of Council of Governors meetings reflects its statutory duties and considers relevant updates or briefings from the Board.
B 2.5	The chair should be independent on appointment when assessed against the criteria set out in Section B, provision 2.6. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the	**Comply** The Chair was independent on appointment to the role in 2022. The roles of Chair and Chief Executive are separate and held by different postholders. As per Provision 26 of the Constitution and 2.4.1 of the Board's Standing Orders, the Council of Governors appoints the Deputy-Chair; this position is currently held

Section B - Division of responsibilities		
Provision	**Requirement**	**SCAS Comply or Explain**
	audit committee, ideally, should not be the deputy or vice chair or senior independent director.	by one of the Non-Executive Directors. The Board also has appointed one of the Non-Executive Directors as Senior Independent Director as per Standing Orders provision 2.4.2. The Chair is not a member of the Audit Committee, and this is reflected in the Committee's terms of reference.
B 2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees I holds cross-	**Comply** The Trust can confirm the following with regards to the Non-Executive Directors: • None have been an employee of the Trust within the last two years • None receive personal renumeration in the form of performance related pay and they are not members of the NHS pension scheme • None has close family ties with any of the Trust advisors, directors or senior employees as evidenced in the declaration of interest register • Two Non-Executive Directors have served on the Board for more than six years, which were approved by the

Section B - Division of responsibilities		
Provision	**Requirement**	**SCAS Comply or Explain**
	directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.	Trust's Council of Governors. Their terms ended in 2024/25. • All Non-Executive Directors can therefore be considered to be independent **Explain** One of the existing Non-Executive Directors has served for more than 2 terms. A further term (to 2026) was approved by the Council of Governors as their particular skillset and significant experience was required to improve financial governance across the organisation. The board does not however consider this has impacted their independence.
B 2.7	At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.	**Comply** At the time of this self-assessment, the Trust Board comprises up to seven non-executive directors (excluding the chair) and up to seven voting executive directors. All non-executive directors are considered to be independent.

Section B - Division of responsibilities		
Provision	**Requirement**	**SCAS Comply or Explain**
B 2.8	No individual should hold the positions of director and governor of any NHS foundation trust at the same time.	**Comply** No individual holds a position of director and governor at the same time.
B 2.9	The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.	**Comply** The Chair considers the membership of committees at least annually and is responsible for appointing the committee chairs. In doing so, the Chair considers the skills set, diversity and experience of the non-executive directors against the remit of each committee, for example ensuring there is at least one NED with clinical skills or knowledge on the Quality and Safety Committee and at least one NED with an accountancy qualification on the Audit Committee. The Board has also established a People & Culture Committee in addition to a Remuneration Committee. The Council of Governors has due regard to the skill set and diversity of the Board when making appointments.
B 2.10	Only the committee chair and members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.	**Comply** Only the Committee members and Chairs of Remuneration Committee and Audit Committee are members of that committee. Officers of the Trust attend by

Section B - Division of responsibilities		
Provision	**Requirement**	**SCAS Comply or Explain**
		invitation to support agenda items, where not conflicted, as set out in the Terms of Reference.
B 2.11	In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders.	**Comply** As per Standing Orders provision 2.4.2, the Board, has appointed a Senior Independent Director to provide a sounding board for the Chair and act as an intermediary for the other directors when necessary. The Senior Independent Director seeks input from key stakeholders (ICB Chairs, AACE Chair, Provider Trust Chairs in the South East Collaborative) as part of the Chair's appraisal. This process is in progress for the 2024/25 annual appraisal.
B 2.12	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.	**Comply** The Remuneration Committee is responsible for appointing and removing executive directors, in accordance with national guidance. The Remuneration Committee terms of reference set out this requirement. The Committee also, as per its Terms of Reference, agrees annual performance objectives of the Chief

Section B - Division of responsibilities		
Provision	**Requirement**	**SCAS Comply or Explain**
		Executive and executive directors.
B 2.13	The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available. The annual report should give the number of times the board and its committees met, and individual director attendance.	**Comply** The annual report sets out the number of times the Board and its committees met, and individual director attendance. The roles of the Chair, Chief Executive and Senior Independent Director are available on the SCAS Board Members | South Central Ambulance Service and these will be further refined by 31 March 2025. The Annual Report provides a summary of individual director attendance at board and committee meetings.
B 2.14	When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or	**Comply** Disclosure of significant time commitments is required as part of the recruitment process for executive and non-executive directors. The time commitment required of non-executive directors is at least three to four days per month in line with national requirements. None of the Trust's executive directors currently holds a non-executive directorship of another trust or organisation of comparable size and complexity as evidenced by the

Section B - Division of responsibilities		
Provision	**Requirement**	**SCAS Comply or Explain**
	organisation of comparable size and complexity, and not the chairship of such an organisation.	Board Register of Interests.
B 2.15	All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.	**Comply** The Trust's Chief Governance Officer was appointed by a panel that included the Chair, Chief Executive Officer and external stakeholders and is available to all directors to provide advice on governance matters.
B 2.16	The board of directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the trust and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies.	**Comply** The Board as a whole is responsible for this provision but has established the following dedicated board committees for additional scrutiny and assurance: • People and Culture Committee; receives reports on compliance with health and safety, statutory and mandatory training and education. • Quality and Safety Committee receives reports on clinical quality and safety, the Trust's research activity and compliance with CQC standards.
B 2.16	All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular,	**Comply** As a unitary Board, all board members carry equal responsibility for decisions taken. All directors have a responsibility to constructively challenge during board

Section B - Division of responsibilities		
Provision	**Requirement**	**SCAS Comply or Explain**
	non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.	discussion and help develop proposals on priorities, risks, mitigation, values, standards and strategy. This is evidenced via the minutes and meeting review at the end of each board meeting.
B 2.17	All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the chief executive as the accounting officer. The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions. For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of	**Comply** The Board operates as a unitary Board with all directors being equally responsible for decisions taken. The Board meets in public on a bi-monthly basis, with Board Seminars taking place in the intervening month. Individual Director attendance at board meetings is set out in the Annual Report. **Explain** In addition to the provisions outlined in the Trust's constitution, a schedule of matters reserved for the Board has been developed and is subject to Audit Committee and Board approval in March 2025.

Section B - Division of responsibilities		
Provision	**Requirement**	**SCAS Comply or Explain**
	governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions that are delegated to the executive management of the board of directors.	

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
C 2.1	The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust, and the skills and expertise required within the board of directors to meet them. Best practice is that the selection	**Comply** The recruitment panels for executive director and non-executive posts follows best practice. The Trust engages with the ICB and NHS England for the recruitment of board directors. The Chair considered the skills required on the board for the recent Non-Executive Director appointments.

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
	panel for a post should include at least one external assessor from NHS England and/or a representative from a relevant ICB, and the foundation trust should engage with NHS England to agree the approach.	
C 2.2	There may be one or two nominations committees. If there are two, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the chair.	**Comply** The Trust has a Remuneration Committee which appoints executive directors and very senior managers. A Nominations Committee of the Council of Governors considers appointments and re-appointments of non-executive directors and the Chair and makes related recommendations to the Council of Governors.
C 2.3	The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.	**Comply** The Chair of the Board chairs the Nominations Committee of the Council of Governors and the Deputy Chair of the Board, chairs the Remuneration Committee.

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
C 2.4	The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors.	**Comply** Appointments of the new Chair and non-executive directors are made following a clear process, including discussion at the Nominations Committee with subsequent recommendations to the Council of Governors.
C 2.5	Open advertising and advice from NHS England's Non-Executive Talent and Appointments team is available for use by nominations committees to support the council of governors in the appointment of the chair and non-executive directors. If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.	**Comply** The Nominations Committee of the Council of Governors is aware of this support. The trust has utilised external consultancies to run an open and competitive process for executive and non-executive director appointments during 2024/25 and this will be referenced in the annual report.
C 2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent members should be in the majority on the committee and also on the interview panel.	**Comply** The Nominations Committee for non-executive directors and the Chair is comprised majority governor membership. Governors have been involved in Non-Executive Director recruitment and selection process.

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
C 2.7	When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.	**Comply** The Chair, Chief People Officer and Chief Governance Officer work closely with and supports the Council of Governors on recruitment of NEDs/Chair and will include reference to the qualifications, skills and experience required in advertisements for posts.
C 2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	**Explain** The Trust is undertaking a review of its webpages for the Board and Council of Governors. As part of that, the terms of reference of the committees will be published once the annual cycle of review has concluded and the terms of reference are approved by the board. We will be compliant with this provision by May 2025.
C 2.9	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.	**Comply** The Trust's Constitution states that re-election should take place at regular intervals, not exceeding three years. The last election process that ran in 2023/24 included the names of governors submitted for election or re-election with accompanying biographical details and other relevant information to enable members to take an informed decision.

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
C 2.10	**Statutory requirement** A requirement of the National Health Service Act 2006 as amended (the 2006 Act) is that the chair, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive are responsible for deciding the appointment of executive directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chair, the other non-executives directors and, except in the case of the appointment of a chief executive, the chief executive.	**Comply** The Trust meets this requirement as demonstrated by the recent appointment processes for the Chief Paramedic Officer and Chief Governance Officer in 2024 and ongoing executive director recruitment in 2025.
C 2.11	**Statutory requirement** It is for the non-executive directors to appoint and remove the chief executive. The appointment of a chief executive requires the approval of the council of governors.	**Comply** This requirement is reflected in section 27 of the Trust's Constitution. The Chief Executive's appointment was approved by the Council of Governors.
C 2.12	**Statutory requirement** The governors are responsible at a general meeting for the appointment, re-appointment and removal of the chair and other non-executive directors.	**Comply** This requirement is reflected in the Trust's Constitution. The re-appointment of the Chair for a second term was approved at a meeting of the Council of Governors following a recommendation from the Nomination

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
		Committee.
C 2.13	**Statutory requirement** Non-executive directors, including the chair, should be appointed by the council of governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director.	**Comply** All Non-Executive Directors have a term of office of no more than three years and are within that timeframe.
C 4.1	Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not	**Comply** On appointment and annually, each director is subject to an annual fit and proper person review (FPPR). This includes a self-attestation, using the new national template. The Trust has a Fit and Proper Persons Policy to ensure compliance with the CQC Regulation 5. The Policy was last updated and agreed by the Remuneration Committee in May 2024. The Chair is the responsible officer for ensuring board member compliance and the first regional

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
	bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.	NHSE submission was completed by the deadline of 30 June 2024. The Nominations Committee and the Remuneration Committee will receive a report to confirm that all relevant post holders meet the FRRR requirements and this will be reported publicly to the Trust Board.
C 4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience. Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.	**Comply** Annual report - SCAS Annual Report 2023/24 Board member profiles are publicly available on the trust's website SCAS Board Members | South Central Ambulance Service
C 4.3	Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment a chair was an existing non-executive	**Comply** There were 2 NEDs who were coming to the end of their third term (nine years) on the board during the year. The Trust has therefore recently undertaken a Non-Executive Director recruitment exercise to recruit to these posts.

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
	director. The need for all extensions should be clearly explained and should have been agreed with NHS England. A NED becoming chair after a three-year term as a non-executive director would not trigger a review after three years in post as chair.	
C 4.4	Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.	**Comply** This provision is set out in the Trust's Constitution and is followed in practice. No governor has served more than three consecutive terms.
C 4.5	There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should	**Comply** The Council of Governors agrees the process for evaluation of the Chair and non-executive directors and the Senior Independent Director leads the evaluation of the Chair.

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
	bear in mind that it may be desirable to use the senior independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts.	**Explain** The Trust has not in the recent past undertaken annual evaluations of effectiveness of the Board of Directors or committees thereof; this will be introduced for 2025/26.
C 4.6	The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.	**Partially Compliant/Explain** As part of reintroducing a process for annual reviews of effectiveness for the Board and its committees, the process will include how the Chair will use the outcomes to inform continuous improvement of the effectiveness of the Board. This will be reflected within the Board development plan. On an individual basis, the Chair undertakes an annual appraisal and PDR of each of the non-executive directors and the Chief Executive does the same with executive directors, in addition to regular 1:1 meetings. These regular touch-points, as well as end of year appraisals, ensure that any development needs are identified and actioned.

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
C 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors or governors.	**Explain** The last externally facilitated developmental review of the Trust leadership using the well-led review framework was between 2019 and 2020 with the report issued in January 2020. The trust subsequently underwent a CQC well-led inspection in 2022 and has taken action in response to the findings, including the executive team and corporate restructure and foundation work to improve the trust's overall governance arrangements. As part of the Recovery Support Programme, NHSE undertook a governance review in 2024 and will undertake a further well-led review in June 2025 ahead of the Trust's planned exit.
C 4.8	Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on: • holding the non-executive directors individually and collectively to account for the performance of the board of directors	**Explain** A process for enabling the Council of Governors to periodically assess their collective performance will be developed and implemented in 2025.

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
	• communicating with their member constituencies and the public and transmitting their views to the board of directors • contributing to the development of the foundation trust's forward plans. The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS foundation trust governors and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors.	
C 4.9	The council of governors should agree and adopt a clear policy and a fair process for the removal of any governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest that prevents the proper exercise of their duties. This should be shared with governors.	**Comply** The Trust's Constitution (provision 14) sets out the process by which a governor could be removed if in breach of any required standard. A Code of Conduct for the Council of Governors will be co-developed in 2025.
C 4.10	In addition, it may be appropriate for the process to	**Comply**

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
	provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust.	The Trust's Constitution (provision 14) sets out the process by which a governor could be removed if in breach of any required standard(s).
C 4.11	The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.	**Explain** No formal board skills assessment has been carried out recently, but the Chair gave due consideration to the skillset required to inform the Non-Executive Director recruitment process in February 2025. There are no formal succession plans in place, but these will be developed during 2025/26 as part of broader work in relation to Leadership Development.
C 4.12	The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.	**Comply** The Remuneration Committee considers all executive director resignations. No executive directors have left the trust other than in accordance with the terms of their contract of employment.

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
C 4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors, governors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion, including in relation to disability, its objectives and linkage to trust strategy, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports.	**Comply** The Annual Report includes reference to the role of the Nominations Committee of the Council of Governors and the Remuneration Committee of the Board, including the detail required to meet this provision.

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
C 5.1	All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.	**Comply** The Trust has induction processes in place for both new directors and new governors, which are then tailored to their individuals needs/roles. The Board Development Plan is refreshed at least annually and ensures directors update and refresh their skills and knowledge. Relevant policy briefings on developments in the NHS and wider aligned sectors are included within the Chief Executive's reports to the Board.
C 5.2	The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive	**Comply** The Board Development Plan supports directors in developing and updating their skills, knowledge and capabilities. It also includes annual training on equality, diversity and inclusion. The Trust offers Recruitment Skills Training, which includes unconscious bias. At least one interview panel member should be trained in Recruitment Skills and where

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
	appropriate training including on equality diversity and inclusion, including unconscious bias.	this is not possible, a member of the recruitment team joins the panel.
C 5.3	To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.	**Comply** The Trust's values are referenced in several publications and on the website. Trust staff are invited to and attend board committee meetings and Non-Executive Directors take part in engagement activity across the trust, including site visits where they can interact with staff and hear from them first hand.
C 5.4	The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent	**Comply** The Trust has an induction programme in place for new directors and governors. This includes opportunities to meet with a broad range of stakeholders as appropriate. All directors have access, at the Trust's expense, to training courses and/or materials that are consistent with their individual and collective development programme. A

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
	with their individual and collective development programme.	record is kept of external training undertaken by governors and directors.
C 5.5	The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.	**Comply** The Chair meets with each non-executive director to agree their training and development needs as they relate to their role on the board as part of their appraisal and PDR. The Chief Executive meets with each executive director to agree their training and development needs. The Chair and the Chief Executive meet regularly and in doing so, cover any matters relating to development needs for Board members (executive or non-executive) and the board as a whole.
C 5.6	A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.	**Comply** This requirement is met via the Trust's new governor induction plan and briefings to the Council of Governors on their role and developments within the NHS. The governors are offered external training, e.g. with NHS Providers, as required.

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
C 5.7	The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties. Foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients. Statutory requirements on the provision of information from the foundation trust board of directors to the council of governors are provided in Your statutory duties: a reference guide for NHS foundation trust governors.	**Comply** The Chief Executive provides a regular update on ICS engagement, activity and plans at Board and Council of Governors meetings. The Council of Governors also receives details of the Trust's performance via briefings and receipt of the Integrated Performance Report.
C 5.8	The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.	**Comply** The Board receives the most up-to-date data available to it via the Integrated Performance Report. Directors and governors seek clarification on data/information as required to ensure understanding and provide assurance. **Explain** Whilst the trust has set a standard of all board and committee papers being circulated 7 days before the meeting, this is not being met consistently. As part of the

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
		Governance Improvement Plan, clear timetables will be set alongside expectations with regards to timeliness and standards.
C 5.9	The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required.	**Comply** The Chief Governance Officer assists the Chair in ensuring good information flows across the Board, the Council of Governors and between the directors and senior management. This has included a programme of governors observing board committee meetings to help them understand the trust's business and the effectiveness of Non-Executive Director scrutiny and challenge, which supports them to hold the Non-Executive Directors to account.
C 5.10	The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be	**Comply** There is a review of each board and board committee meeting and this incudes reflections on the quality of papers/reports with feedback on improvement where required, for example information/or data to be provided in the Integrated Performance report. A standard report template assists colleagues in writing reports in a consistent format. Further work will be

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
	clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.	undertaken during 2025/26 as part of the Governance Improvement plan to improve the quality and conciseness of papers to Board/committees/Council of Governors.
C 5.11	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.	**Comply** Non-executive directors challenge the assurance provided by management in board and board committee meetings. Where necessary, they request specific assurance reports on complex or high-risk matters, particularly to triangulate different forms of evidence and enable deeper analysis. Non-Executive Directors are aware that they could request external assurance, for example via an internal audit, to provide additional assurance or seek external expertise where required.
C 5.12	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser	**Comply** The Board can access independent professional advice, including legal advice, at the Trust's expense as required.

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
	should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.	
C 5.13	Committees should be provided with sufficient resources to undertake their duties. The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.	**Comply** Each Committee and the Council of Governors is supported by a dedicated secretariat to coordinate and support its work. The Chief Governance Officer oversees all arrangements to support information flows.
C 5.14	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.	**Comply** Non-Executive Directors are appointed based on their skillsets and the experience they bring to the role, via an open and competitive process. The requirements of the role are clearly set out in the recruitment process.

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
C 5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	**Comply** Governors undertake a variety of ways of working to engage with staff and members and this is reported via the Membership and Engagement Committee of the Council of Governors. Commentary will be provided in the Annual Report.
C 5.16	Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the Trust's forward plan, and then inform the council of governors which of their views have been incorporated in the NHS foundation trust's plans and explain the reasons for any not being included.	**Comply** The board of directors follow NHS Foundation Trust best practice and is supported by the Chief Governance Officer and the Director of Communications, Marketing and Engagement. Views of the Council of Governors are sought through workshops, regular webinars and up to date information on the Trust intranet site. Governors feedback their views to the Trust and these are discussed at Council of Governors meetings/ workshops. Buddying arrangements are also in place between Non-Executive Directors and governors to enhance working relationships.

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
C 5.17	NHS Resolution's Liabilities to Third Parties Scheme includes liability cover for trusts' directors and officers. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.	**Comply** The Trust has appropriate insurance via membership of the NHS Resolution schemes.

Section D – Audit, risk and internal control		
Provision	**Requirement**	**SCAS Comply or Explain**
D 2.1	The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant	**Comply** The Trust has established an Audit Committee comprising Non-Executive Director membership. The Committee Chair is not the Senior Independent Director, and the Trust Chair is neither a member or, nor attends the Audit Committee. At least one member of the Committee has recent and

	financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.	relevant financial experience, as required by the HMFA Audit Committee Handbook.
D 2.2	The main roles and responsibilities of the audit committee should include: • monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them • providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy • reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself	**Comply** The terms of reference of the Audit Committee include these roles and responsibilities (last approved, May 2024).

	• monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors • reviewing and monitoring the external auditor's independence and objectivity • reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements reporting to the board of directors on how it has discharged its responsibilities.	
D 2.3	A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re- tender its external audit at least every 10 years and in most cases more frequently than this.	**Comply** The Trust's current external auditor has been engaged for 3-years with an option to extend the contract for a further 2 years.
D 2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the	**Comply** The Trust's annual report includes all of the matters listed in this provision. The Trust external auditors do not provide non-audit services.

	independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	
D 2.5	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services.	**Explain** The Trust does not have a policy on purchase of non-audit services from the external auditor but does not engage them in non-audit activity. Specific reference to this will be included in the terms of reference when they are reviewed.
D 2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	**Comply** The Trust's annual report includes such a statement.
D 2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The	**Comply** The Board proactively reviews and assesses emerging and principal risks via the Board Assurance Framework

	relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	and is supported to do so by the Audit Committee. The relevant disclosures are made in the Trust's annual report.
D 2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	**Comply** This requirement is reflected in the Trust's annual report. The Board regularly reviews the Board Assurance Framework, and the Audit Committee is responsible for seeking assurance on behalf of the Board on the effectiveness of the Trust's overall risk management framework. This includes receiving the Head of Internal Audit Opinion an annual basis.
D 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual, which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over a going concern are expected to be rare.	**Comply** The Trust's annual report and accounts includes an explicit statement on going concern.

Section E - Remuneration		
Provision	**Requirement**	**SCAS Comply or Explain**
E 2.1	Any performance-related elements of executive directors'	**Comply** The Trust has a PRP policy, and any performance related

Section E - Remuneration		
Provision	**Requirement**	**SCAS Comply or Explain**
	remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels.	elements of executive directors' pay is remunerated in accordance with the policy. The trust has taken the decision to exclude PRP from all future director contracts.
E 2.2	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.	**Comply** The levels of remuneration for the Chair and non-executive directors follows NHS England requirements.
E 2.3	Where a trust releases an executive director, e.g. to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	**Comply** This situation has not arisen at SCAS. The Trust will follow all NHS best practice and guidance if required.
E 2.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.	**Comply** The Trust follows all NHS best practice and guidance and takes independent legal advice as appropriate.

Section E - Remuneration		
Provision	**Requirement**	**SCAS Comply or Explain**
E 2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity.	**Comply** The Trust follows all applicable NHS best practice and guidance.
E 2.6	The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.	**Partial Comply** The Board has established a Remuneration Committee, comprising independent Non-Executive Director membership. The Chief People Officer is the HR advisor to the Committee. The Trust has not engaged any remuneration consultants. **Explain** The Committee's terms of reference are currently not on the Trust website but there are plans in place to publish all board terms of reference when the annual review cycle has been completed.
E 2.7	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior	**Comply** The Trust follows all NHS best practice and guidance, including the provisions listed and takes independent legal advice as appropriate.

Section E - Remuneration		
Provision	**Requirement**	**SCAS Comply or Explain**
	management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.	
E 2.8	The council of governors is responsible for setting the remuneration of a foundation trust's non-executive directors and the chair.	**Comply** The Council of Governors undertakes this statutory duty on the recommendation of the Nominations Committee.

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Trust Board of Directors Meeting in Public
27 March 2025

Report title	Board Assurance Framework
Agenda item	27
Report executive owner	Rebecca Southall, Chief Governance Officer
Report author	Steven Dando, Head of Risk Management
Governance Pathway: Previous consideration	Quality & Safety Committee – 19 March 2025 Finance & Performance Committee – 21 March 2025 People & Culture Committee – 31 March 2025
Governance Pathway: Next steps	None

Executive Summary

BAF Risk 1: Safe and effective care: Score 9
Risk is at the target level of 9 and stable. Work continues with the implementation of the new medical devices management platform which is currently being rolled out to staff.

BAF Risk 2: Ability to meet fluctuation demand: Score 15
Risk remains outside of target and high rated however the residual risk has reduced from 20 to 15 following the sustained improvement in handover delays seen across the acute Trusts, especially the Queen Alexandra Hospital. There has been a delay to the implementation of the new rotas due to some challenges with the build. The Command Cell paper didn't go to Finance and Performance Committee due to other priorities however it is being rescheduled. The delivery of the replacement fleet has been delayed due to issues with the build and a paper is being sent to Board with a rectification plan.

BAF Risk 5: In Year Financial Control: Score 16
Risk remains stable and rated 16 (Major x Likely), above the target of 12. Finances continue to be managed and reviewed through the Finance Recovery Group on a weekly basis. The Business Sub-Committee now in place reviews business case spend before submission to

EMC for additional oversight. Annual plan being discussed at an extraordinary FPC this month.

BAF Risk 6: Sufficient skills and resources
Risk remains stable and rated 16 (Major x Likely), above the target of 12. Work continues to be progressed in order to deliver the actions, including the 5-year workforce plan. The Corporate Restructure work continues to progress with letters having been sent out and the two-week check and challenge process completed.
New action added relating to the culture work including leadership development/talent management.

BAF Risk 7: Safe, valued and supported staff
Risk remains stable and rated at 12 (Major x Possible) against a target of 8. Sexual Safety training course for managers taking place. Added action relating to culture review which covers the Trusts values and behaviours. People promise actions added to cover the ongoing work programme.

BAF Risk 8: Digital Capacity: Score 15
Risk remains stable and rated at 15 (Catastrophic x Possible) against a target of 12. The interim Head of Cyber has now started along with the Cyber Security Analyst. The Corporate and Executive Restructures continue to progress. Risk management action complete with dynamic reviews and scores in place.

BAF Risk 10: Cyber: Score 20
Risk remains stable and rated at 20 (Catastrophic x Probable) against a target of 12. Work has now completed on the Multi-Factor Authentication project with all applications requiring it, either enabled or they have an approved exemption. The Committee should note that this is an ongoing process for all new systems and Information Asset Owners have to work towards MFA enablement for all exempt applications, including assessing the need to replacements when it is not possible. A DSPT project has been set up and is running, managed by the Information Governance team to manage the Trust's evidence collection and assessment against the new standard. The Cyber Security Strategy and Programme Plan action has been delayed as the Head of Cyber left their role however an interim is now in place.

BAF Risk 11: Modernisation / Fit for the Future: Score 9
Risk has decreased from 9 to the target rating of 6, with the impact reducing from Moderate to Minor. Actions relating to the Alignment of the Ops Modernisation Programme and Southern Ambulance Collaboration activities and the Benefits Framework have been completed. New action relating to a reframing of the overarching strategy has been added.

BAF Risk 14: Partnership Working: Score 12
Risk remains stable and rated at 12 (Major x Posible) against a target of 4. The Strategic Lead has now been appointed and is in place with work around developing the Trust's strategic aims and priorities for the upcoming year ongoing. Feedback has been requested from staff to help shape the priorities.

Alignment with Strategic Objectives

With which strategic theme(s) does the subject matter align? (If more than one, please write manually)

All strategic objectives

Relevant Board Assurance Framework (BAF) Risk
To which BAF risk(s) is the subject matter relevant? (If more than one, please write manually) All BAF risks

Financial Validation	Capital and/or revenue implications? No
Recommendation(s)	
The committee is asked to note and discuss the information in the Board Assurance Framework and gain assurance that the Trust is managing the relevant strategic risks.	

For Assurance	✓	For decision		For discussion		To note	

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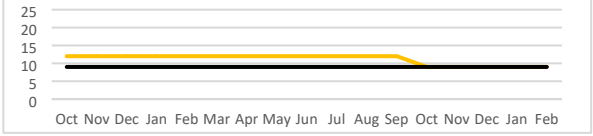
Board Assurance Framework

Steven Dando
March 2025

NHS South Central Ambulance Service NHS Foundation Trust

Objective 1: High quality care and patient experience: We will enhance our practice and clinical governance to provide safe, effective care and operational performance that delivers improved outcomes.		Risk score 9
Strategic Risk No. 1: Safe and effective care	Update: February 2025	
If we have insufficiently equipped and trained workforce	***Then*** we will fail to provide safe and effective care	***Leading to*** poor patient outcomes.

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



Accountable Owner	Assurance Committee
Helen Young, Chief Nurse, John Black, Chief Medical Officer	Quality & Safety Committee

Controls	Gaps in Controls	Actions	Owner / Due Date
• Workforce recruitment programme • Equipment audits and concern reporting process in place • Adverse Incident Reporting Process • Clinical Standard Operating Procedures • Private Provider strategy and governance framework • Clinical training • Safeguarding Improvement Plan • National clinical practice guidelines (JRCALC) • National ambulance standards • PTS contracted standards • Make ready contract and effective contracting • Fleet and make-ready strategy • Fleet and make-ready KPIs • Operational escalation procedures (e.g., OPEL, REAP) • Internal training for staff • Equipment training logs • Chief Medical Officer link to local and national forums • Patient Safety Improvement Workstream • Patient Safety Incident Response Framework Policy and Processes	• Variability in pathways • Developing clear strategy for learning from incidents and data	Development of CPs in remaining acutes and systems	Mark Ainsworth / Ongoing – Now part of BAU
		Rota review	Mark Ainsworth / Implementation – Q1 to ~~Q2~~ 2024-2025 North nodes live by end of ~~Q4~~ July 25

Assurances		Gaps in Assurances	Actions	Owner / Due Date
First and second line (internal) assurances Reports to: • Quality & Safety Committee • Patient Safety & Experience Group • Clinical Review Group • Medicines Optimisation and Governance Group • Workforce Development Board • Integrated Workforce Planning groups • Finance & Performance Committee • People & Culture Committee • Medical Devices Review Group	**Third line (external) assurances** • Internal Audits • CQC Inspections • Clinical Governance Audits • Commissioner contract review meetings	• Real-time tracking of clinical equipment and medicines • Supplies from external procurement (e.g., vehicles)	Procure system for managing safe deployment and maintenance of medical equipment	Lem Freezer / Go Live – ~~July 2024~~ ~~Feb 2025~~ Rollout taking place

Associated Risks on the Trust Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score
335	Thames Valley MHRV service non-implementation Risk	IF there continues to be a lack of investment from ICBs in regard to the implementation of a Mental Health Response Vehicle in the Thames Valley THEN there is an ongoing risk of poor care being delivered to patients in mental health crisis in a pre-hospital care environment RESULTING in potential harm coming to patients and the subsequent negative impact on staff, resource availability and Trust reputation.	15

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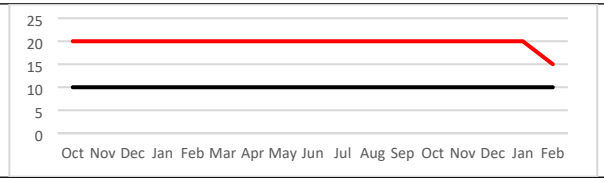
Objective 1: High quality care and patient experience: We will enhance our practice and clinical governance to provide safe, effective care and operational performance that delivers improved outcomes.		Risk score 15
Strategic Risk No. 2: Ability to meet fluctuating demand	Update: February 2025	
If we do not have or use effective and agile operational delivery systems	***Then*** we will not be able to meet demand and provide a responsive service to patients	***Leading to*** delays in treatment and increased morbidity and mortality.

	Impact	Likelihood	Score
Inherent	5	5	25
Current	**5**	**~~4~~ 3**	**~~20~~ 15**
Target	5	2	10



Accountable Owner	Assurance Committee
Mark Ainsworth, Executive Director of Operations	Finance and Performance Committee Quality & Safety Committee

Controls	Gaps in Controls	Actions	Owner / Due Date
• Demand forecasting and profiling using models which are adjusted based on experience • Daily Operational MI reports detailing performance against set metrics • Mutual aid process exists and works • Cat. 2 response segmentation • Effective local and regional escalation • National REAP process and actions • OPEL escalation plans • Enhanced Patient Safety Procedure • Clinical Pathways • Working with systems and Hampshire place-based delivery units • Performance Cell • Private Providers • Category 3 GP reviews in 111 • Performance Improvement Workstream • Release to Respond 45-minute handover limit – embedding process at each acute Trust. • SOP for deployment of Jumbulance at QAH • QAH – Internal immediate handover process	• Insufficient clinical advisory support (e.g., 111, 999, IUC) • Quality Improvement Process and Culture • Clinical Pathways are not consistently available. • Hospital handover escalation procedures • Fleet controls • Ambulance divert protocols held by ICB	Rota review	Mark Ainsworth / Implementation – Start Q1 2024-2025 with North nodes live by end of ~~Q4~~ July 25
		Development of Clinical Pathways in remaining acutes and systems	Mark Ainsworth / Ongoing – Now part of BAU
		Scoping for command cell situated within CCC	CDM/TCPP paper – Ops Group – Complete FPC – ~~February 2025~~ TBC
		Review clinical capacity (including cat 2 segmentation) in CCC to deliver all clinical functions	Ruth Page / ~~Nov 2024~~ March 2025
		Single Point of Access process for all ICBS	HoIW ICB & Trust review outcomes – Meeting complete – awaiting outcomes to be sent from ICB Frimley Planning meeting – March 2025
		Delivery of 71 replacement and new DCAs	Lemuel Freezer / March 2025 *16 sent back to supplier
		ORH modelling: Call & Dispatch	Ruth Page / ~~March~~ May 2025

Assurances		Gaps in Assurances	Actions	Owner / Due Date
First and second line (internal) assurances Reports to: • Emergency & Urgent Care Boards • Quality & Safety Committee • Integrated performance report • Ops Board • Performance Improvement Delivery Group • Finance & Performance Committee	**Third line (external) assurances** • ICS system management across region • National performance standards • PTS contractual standards • TPAM • Performance Insight Improvement Group • NHSE Performance Reviews			

Associated Risks on the Trust Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score
52	QAH Handover Delays Risk	if QAH continue to have increased handover delays over and above agreed parameters then there is a risk to staff not being released resulting in negative impacts to service delivery, end of shift, meal breaks and patient care	20
119	Ambulance turnaround delay at A&E Risk	IF there is a delay in ambulance turnaround at A&E THEN there will be queue of ambulances RESULTING in risk to patient safety	16
210	Supply Chain Risk	IF there is disruption or delays to the supply chain THEN there is a risk that SCFS will not be able to effect repairs or replacements in a timely manner RESULTING in delays to servicing and poor vehicle availability for the customer.	16

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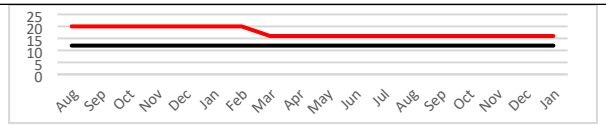
Objective 3: Finance & Sustainability: We will maximise investment into our patient services whilst delivering productivity and efficiency improvements within the financial envelope and meeting the financial sustainability challenges agreed with our system partners.		Risk score **16**
Strategic Risk No. 5: In Year Financial control	Update: January 2025	

If demand, operational standards and external factors (such as inflation, interest rates, taxation and cost of living) continue to increase	***Then*** the total costs to deliver our services will increase and result in a deficit greater than the control total agreed	***Leading to*** additional pressures on our ability to deliver a sustainable financial plan and safe services.

	Impact	Likelihood	Score
Inherent	4	5	20
Current	**4**	**4**	**16**
Target	4	3	12



Accountable Owner	Assurance Committee
Stuart Rees, Interim Director of Finance	Finance and Performance Committee

Controls	Gaps in Controls	Actions	Owner / Due Date
• Planning and approval process for the Trust's budget • Budget setting and monitoring processes • Financial plan • Capital programme • Financial governance framework in place • Standing Financial Instructions Reviewed and Updated • Scheme of Reservation & Delegation Written • Financial Recovery Plan approved • Monitoring run rate & cash report now part of F&PC • Financial Recovery Group spend reviews and monitoring (including corporate workforce and Weekly proxy data used for run rate) • Scrutiny from Finance and Performance Committee. • Proactive engagement with regulators and System colleagues. • "Commercial initiatives to increase income and reduce Trust costs." • Cost improvement plan linked to system transformation programme reporting to board • Performance Management and Accountability Framework (PMAF) • Mitigations for Financial Recovery Plan slippage agreed	• Lack of a medium-term plan including Medium Term Financial Plan (MTFP) • Business Planning process and objectives not sufficiently aligned with organisation requirements including liquidity / cash support requirements. Cash/liquidity are reported are included as part of normal reporting cycles. • Financial Data in Integrated Performance Report (IPR) needs to capture core metric and financial performance challenges. • The loss/reduction of NEPTS Services and the wider implications require to be worked through.	Medium Term Financial Plan (MTFP) to developed alongside Trust Medium Term Plan	Stuart Rees / To be included in the medium-term financial plan (5 year) – ~~October 2024~~ Baseline financial model – completed. Rest of plan to be finalised in line with the annual planning cycle (March 2025)
		Non-recurrent measures will be utilised to offset slippage experienced against recurrent schemes	Stuart Rees / On-going
		Recovery plan for NEPTS in year and future operation model being developed	Stuart Rees / Jan 2025
		Implementation of PMAF	Stuart Rees / Q4 2025/26
		Financial data to be included in IPR	Stuart Rees / Q3 2025/26

Assurances		Gaps in Assurances	Actions	Owner / Due Date
First and second line (internal) assurances • Finance and Performance Committee • Audit Committee • Executive Management Team meeting • Finance reports / Financial position monitored at each meeting of Finance & Performance Committee, including CIP delivery. • Integrated Performance Report • Financial Recovery Group	**Third line (external) assurances** • External audit • Internal audit • Counter fraud • Commissioners • System Recovery Group (ICB level group) • Recovery Support Programme meetings (System) • Monthly financial provider return to NHS England • ICB Self-Assessment against Financial Undertaking			

Associated Risks on the Trust Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score
086	PTS Contracts Contact Centre Risk	IF these contracts are not awarded to SCAS, or extended or SCAS are not able to submit a tender as the incumbent provider THEN there is a risk of not being able to supply PTS services for the remainder of the contract term due to loss of staff with no alternative resources RESULTING in risk to operational staff, increased pressure on reducing staff numbers, reputation damage and impact on patient experience.	20
013	Financial Risk	IF the Trust is not able to operate within the agreed financial budgets THEN there is a risk that the Trust recovery action will be needed; RESULTING in reduced monies available to directorates and departments and subsequent impact on services and projects	16
084	Financial Impact Risk	IF the cost of delivering services are higher than the funding received THEN there is a risk to continued holding of Contracts for both PTS and Logistics RESULTING in poor Trust reputation, increased uncertainty for team members and increased costs exiting contracts increasing costs to other departments and running the services at a loss.	16
121	Financial Targets Not Being Met Risk	IF targets for financial sustainability, performance and cost savings are not achieved THEN there could be NHSI investigations and/or sanctions RESULTING in reputational damage	16
305	Budget Sign-off Risk	IF the annual budget and hours required plans are delayed THEN there is a risk that the planning team will not be able to plan abstractions and determine Private provider hours on time RESULTING in delays to awarding contracts	15

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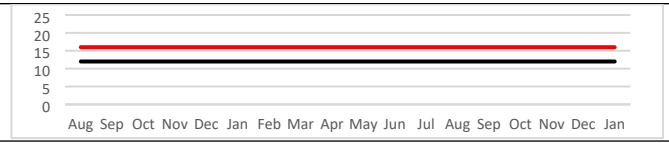
Objective 4: People & Organisation: We will implement plans to deliver an inclusive, compassionate culture where our people feel safe and have a sense of belonging.		Risk score 16
Strategic Risk No.6: Sufficient skills and resources	Update: March 2025	
If we fail to implement resilient and sustainable workforce plans	***Then*** we will have insufficient skills and resources to deliver our services	***Leading to*** ineffective and unsafe patient care and exhausted workforce.

	Impact	Likelihood	Score
Inherent	5	4	20
Current	**4**	**4**	**16**
Target	4	3	12



Accountable Owner	Assurance Committee
Natasha Dymond, Interim Director of People	People and Culture Committee

Controls	Gaps in Controls	Actions	Due Date
• Integrated Workforce Plans for the Trust, including the delivery of a 5-year workforce plan • Recruitment & attraction plan and retention plan health and wellbeing plan and flexible working • Apprenticeship programmes • International recruitment programmes • Return to practice programme • Use of private providers to help deliver services, private provider workforce strategy • Quality Impact Assessments • Culture and Staff Wellbeing Workstream • Delivery of education and training programmes • People & Culture Committee • People & Culture Development Group • Integrated Workforce Planning Groups	• Integrated Talent management programme	NHS England People Promise Exemplar Programme. 12-month programme	Natasha Dymond / Q4 2024/25
		5-year Workforce Plan	Natasha Dymond / Stuart Rees / ~~Q2 3 2024/25~~ ~~EMC – November 2024~~ ~~Board – Provisionally January~~ Year 1 Plan – Under construction / Incorporated into annual plan Years 2 - 4 Plan – Q2 2025/26
		Evaluate initial talent management and succession progamme pilot.	Natasha Dymond / Complete
		Corporate Restructures	David Eltringham / April 25
		TUPE of private provider front line staff when contracts are not renewed.	Natasha Dymond / First contract - Complete ~~2~~ 4 additional contracts Q1 2025/26
		Develop programme of work to review culture and leadership within the Trust. To include review of Trust values and behaviours and leadership development programme.	Natasha Dymond / David Eltringham / March 2026

		Ensure that ED&I budgets are included in the annual budgeting process, including potential ringfenced amounts.	Natasha Dymond / April 2025

Assurances		Gaps in Assurances	Actions	Due Date
First and second line (internal) assurances • Integrated Performance Report • Workforce reporting (e.g., sickness absence, staff survey, turnover)	**Third line (external) assurances** • Commissioner reporting (to ICBs) • Internal audit (BDO) • OFSTED • NHSE/HEE quality assurance visits	• Staff wellbeing metrics via IPR	Embed IPR into Trust Board and Sub-Committees	Stuart Rees / Ongoing

Associated Risks on the Trust Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score
321	Student Paramedic Placement Capacity Risk	IF there is a continued reduction of CTEs & suitable Clinicians to support students THEN the placement capacity will be insufficient to meet the obligations of the trust as a placement provider for Student Paramedics RESULTING in effecting future workforce numbers, contractual agreements with the Universities, compliance with the National Education contract and the wider NHS workforce plan and impacting the increase of our Clinical workforce.	20
142	Pharmacy Operational Staffing and Resilience Risk	IF the Pharmacy workforce is not expanded to meet the demand of the Trust; THEN there is a risk that medicines will not be supplied for clinical use; RESULTING in harm to patients.	16
11	Leadership Capacity Risk	IF there is insufficient leadership capacity (at SLT, directorate and divisional level), THEN there is a risk that staff and/or projects will not be sufficiently well supported; RESULTING in attrition and inability to meet service/ project needs	16
331	Lack of Pharmacist Capacity	IF there is not an adequate number of Pharmacists working for the Trust THEN there is a risk that services will be impacted RESULTING the potential cessation of frontline services / research requiring medicine.	15

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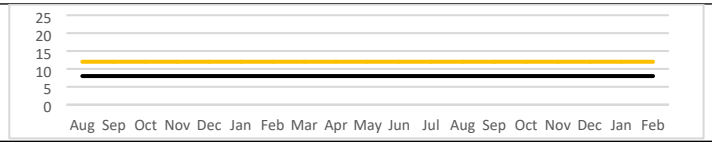
Objective 4: People & Organisation: We will implement plans to deliver an inclusive, compassionate culture where our people feel safe and have a sense of belonging.		Risk score 12
Strategic Risk No. 7: Safe, valued, and supported staff	Update: February 2025	
If we fail to foster an inclusive and compassionate culture	***Then*** our staff may feel unsafe, undervalued, and unsupported	***Leading to*** poor staff morale, disengagement, low retention and impacts on patient safety and care.

	Impact	Likelihood	Score
Inherent	4	4	16
Current	**4**	**3**	**12**
Target	4	2	8



Accountable Owner	Assurance Committee
Natasha Dymond, Interim Director of People	People and Culture Committee

Controls	Gaps in Controls	Actions	Owner / Due Date
• People strategy, EDI strategy and associated enabling plans • Freedom to Speak Up (FTSU) guardian and supporting programme in place • 'Supporting our people' website, including EAP and Occupational Health • SCAS leader and ESPM leadership training • Sexual safety charter • Allegations management process and associated Employment policies. • Staff forums and TLL relationships • Appraisal process • Communications strategy • Culture and Staff Wellbeing Workstream • JNCC • People & Culture Committee • People & Culture Development Group • Equality, Diversity and Steering Group	• Support for staff, including those with protected characteristics. • Understanding of culture	Culture Reset to the SCAS way programme	Executive Team / Q4 2025-26
		Executive oversight and engagement in ED&I, including staff networks.	Executive Team / Q1 2025-26
		SCAS People Portal (online employee resource hub)	Rachel Newell / Phase 1 – Complete
		NHSE Sexual Safety Assurance Framework alignment	Sarah Turtle / Complete
		NHSE Sexual Misconduct E-Learning module	Sarah Turtle / Complete
		NHS England People Promise Exemplar Programme. 12-month programme	Natasha Dymond / Q4 2024/25
		Engagement post in new structure with associated delivery activity	Natasha Dymond / April 2025
		Develop programme of work to review culture and leadership within the Trust. To include review of Trust values and behaviours and leadership development programme.	Natasha Dymond / David Eltringham / March 2026
		Understand and update directorate engagement plans following analysis of staff survey data	Natasha Dymond / Q1 2025/26
		Staff survey results to be used as a basis for the development of an Organisational Development plan covering 2025 - 2027	Natasha Dymond / Q2 2025/26

Assurance		Gaps in Assurances	Actions	Owner / Due Date
First and second line (internal) assurances • Staff networks • People Voice feedback • Student placement feedback • WDES / WRES publication • NHS National Staff Survey and Quarterly Pulse Survey	**Third line (external) assurances** • Workforce Race Equality Standard & Workforce Disability Equality Standard results • CQC inspections & reports • Internal audits (BDO) • Peer reviews			

Associated Risks on the Trust Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score
None			

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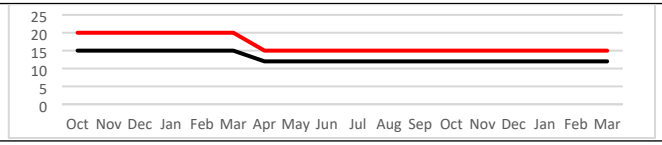
Objective 5: Technology transformation: We will invest in our technology to increase system resilience, operational effectiveness and maximise innovation.		Risk score **15**
Strategic Risk No. 8: Digital Capacity	Update: March 2025	
If we are unable to resource required digital opportunities	***Then*** we will have insufficient capacity and capability to deliver the digital strategy	***Leading to*** system failures, patient harm and increased cost.

	Impact	Likelihood	Score
Inherent	5	4	20
Current	**5**	**3**	**15**
Target	4	3	12



Accountable Owner	Assurance Committee
Craig Ellis, Chief Digital Officer	Finance & Performance Committee

Controls	Gaps in Controls	Actions	Owner / Due Date
• Base Digital Strategy in place across SCAS • Regular Digital Programme Portfolio reporting, and project prioritisation through the Executive Transformation board • IT Project Management governance controls are in place • Financial reporting up to the Executive Management Team (Fixed assets/capital/revenue) • Compliancy with required NHS Cyber Security Standards (DSPT) • Digital Steering Group in place • Technical Design Authority • Control Advisory Board • Digital Annual planning cycle currently in place	• Limited IT Business Continuity capability and a lack of formal testing across SCAS. • No formal Information Technology Infrastructure Library (ITIL) processes in place, with weak internal controls currently in place. • Limited maturity in our BI platform and processes • Limited control around new project initiation or shadow-IT initiatives across SCAS • No resource management process in place across the Digital department • Digital organisational Structure currently inappropriate for Technology Transformation with a number of gaps, and limited definition of roles/responsibilities • Limited maturity in our IT contract management, and a number of contracts at-risk or low governance compliance	To develop a BI strategy and delivery plan to bring about a long-term maturity in the function.	Craig Ellis / In Progress / March-25
		To ensure the Digital organisation is able to deliver the Technology Transformation needs in the long-term aligned to relevant budgets.	Craig Ellis / In-Progress / ~~Dec 24~~ March 25
		To bring resource management into the Digital Function to enable clearer financial and operational IT management.	Craig Ellis / Pending / June 25 (proposed move due to corporate restructure)
		To mature Digital Risk-management in the organisation, with a focus on Residual and Target Score progress and tracking. *Propose to close, risk mgmt scores in place and dynamically reviewed*	Craig Ellis / Complete / March 25

Assurances		Gaps in Assurances	Actions	Owner /Due Date
First and second line (internal) assurances • Reports to Finance and Performance Committee • Annual report on digital strategy to Trust board • Quality assurance process in PMO	**Third line (external) assurances** • Internal audit • External audit • DSP toolkit • Digital maturity assessments	• No KPIs in place • Regular reporting on digital strategy at board level • Fixed Asset Management Steering Group reporting • Limited assurance around digital projects	Undertake review of digital project assurance	Craig Ellis / In Progress / ~~Dec 24~~ June 25 (new head under corporate restructure from April)

Associated Risks on the Trust Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score
281	DCB0160 Digital Clinical Safety Compliance	IF more resource is not available within the Digital Directorate and the scale of the work continues to increase. THEN compliance with DCB0160 cannot be achieved. RESULTING in lack of compliance with the Health and Social Care act, regulatory consequences, harm to patients (clinical risk not identified and mitigated), reputational damage.	20

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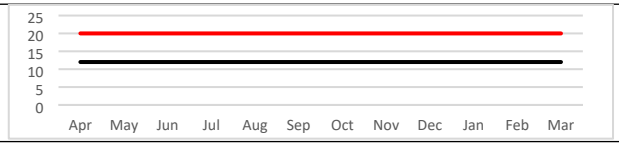
Objective 5: Technology transformation: We will invest in our technology to increase system resilience, operational effectiveness and maximise innovation.		Risk score **20**
Strategic Risk No. 10: Cyber risk	Update: March 2025	

If technology, IT applications & services are insufficiently robust and secure	***Then*** there is a risk that the Trust will not be able to operate effectively	***Leading to*** reduced ability to provide a safe service

	Impact	Likelihood	Score
Inherent	5	5	25
Current	**5**	**4**	**20**
Target	4	3	12



Accountable Owner	Assurance Committee
Craig Ellis, Chief Digital Officer	Finance and Performance Committee

Controls	Gaps in Controls	Actions	Owner / Due Date
• Anti-virus software • Standardised Window Builds • Penetration Testing • Privileged Access Management • Patching • Information Security training. • Yearly DSPT Cyber Security Assurance Testing	• No Cyber Security Strategy or Programme Plan to date. • No external auditing/benchmarking of our overall Cyber Security maturity levels. • Limited/No investment in appropriate Cyber Security Platform. • Limited communications to employees on a regular basis. • Lack of understanding at a board/executive/senior-manager level on the function or associated high-level Cyber Security risks. • Limited investment assigned to maturity. • Cyber Security organisational Structure currently inappropriate for the associated risks with limited resource and overall maturity as a function. • Limited maturity in our Cyber Security contract management, and a number of contracts at-risk or low governance compliance. • CS Risk-management at a low-maturity with regular review not currently in place. • Limited assurance in our overall Information Security assurance training. • Limited Multi-Factor Authentication across the IT Estate	To establish a Cyber Security Strategy and Programme Plan Delayed due to loss of HoCS. Proposed date of July now interim in place.	Craig Ellis / In Progress / ~~Mar-25~~ July 25
		To deploy Multi-Factor Authentication onto all our applicable systems and application aligned on the NHS MFA assurance programme	Craig Ellis / In-Progress / ~~July Dec-24~~ Complete with update to region

Assurances		Gaps in Assurances	Actions	Owner / Due Date
First and second line (internal) assurances • Information Security & Governance Steering Group • Digital Steering Group • Finance & Performance Committee	**Third line (external) assurances** • Internal Audit of DSPT • DSPT Submission • External Audit of Cyber Security Function	• Limited board oversight • Limited board challenge • Limited scenario planning • Lack of external best practice	CDO to provide continuous training and briefings to both the execs and board around Cyber Security	Craig Ellis / In-Progress / Ongoing
			NHSE Cyber Assurance Assessment of all UK Ambulance Trusts	Craig Ellis / In Progress / Ongoing

Associated Risks on the Trust Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score
349	Cyber Maturity Risk	IF SCAS has a low cyber security maturity, THEN we will be more vulnerable to cyber-attacks and data breaches, RESULTING in compromised patient data, disruption of our emergency services, and significant reputational and financial damage	20
352	IT Business Continuity Risk	IF SCAS lacks mature IT Business Continuity THEN we face an increased risk of extended IT downtime affecting critical operations RESULTING in delays in patient care, compromised patient safety, and significant reputational and governance risk	15

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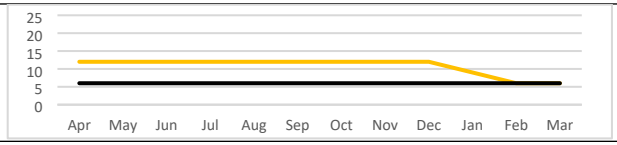
Objective 3: Finance & Sustainability: We will maximise investment into our patient services whilst delivering productivity and efficiency improvements within the financial envelope and meeting the financial sustainability challenges agreed with our system partners.	Risk score **6**
Strategic Risk No. 11: Modernisation / Fit for the Future	Update: March 2025

If the Trust does not modernise its structures, systems and support services over the next five years	***Then*** the Trust may not deliver its strategy for a modern sustainable ambulance service that meets the needs of the public, and adoption of relevant government policies	***Leading to*** outdated and inadequate care delivered to patients.

	Impact	Likelihood	Score
Inherent	4	3	12
Current	~~**3**~~ 2	**3**	~~**9**~~ 6
Target	2	3	6



Accountable Owner	Assurance Committee
Paul Kempster, Chief Transformation Officer	Trust Board

Controls	Gaps in Controls	Actions	Owner / Due Date
• Dedicated team and resource in place • Revised programme governance in place with new Executive SRO appointed • External SMEs programme support through AACE supporting demand and capacity modelling. • CCC improvement programme in place supported by AACE. • Engagement with other ambulance Trusts and collaboration work with SECAmb and the Southern Ambulance Services Collaborative • Incorporation into the five year and annual operational planning process, with clear targets in development for 25/26 • Reframe of Board Objectives and BAF around Fit for the Future Strategic ambitions • Ongoing engagement programme with staff and unions • Modelling of hub locations complete – impact to be picked up as part of Estates Strategy • Sector plans in place supported by development of local Performance and Accountability Framework development	• ~~Funding gap to support long term change.~~ • ~~Clear scope and plan (feasibility, ERF, finance)~~ • ~~Benefits realisation thesis for Proof of Concept~~ • Public / Political support • Revised Workforce Strategy • Insufficient BI capacity to support data requirements of programme	Decision on approach to hubs ~~and sectors~~ required	EMC / ~~October 2024~~ ~~February 2025~~ realign to estate strategy development
		Alignment to the development of the wider Trust 5-year strategic plan in conjunction with development of the Case for Change	Caroline Morris / ~~October 2024~~ Q4 ~~2024/25~~ Q3 25/26
		AACE call off contract in place and supporting the Trust to develop scenarios for a new Operational Model	Caroline Morris / ongoing until May 2025
		Negotiate BI support to provide data to inform the operational model redesign	Caroline Morris / ~~October 2024~~ ~~February 2025~~ Ongoing constraint
		Align of SE Ambulance Collaboration and Southern Ambulance Collaboration activities with the Ops Modernisation Programme	Caroline Morris / Complete
		Benefits framework to be presented to Finance & Performance Committee	Caroline Morris / Complete
		Ongoing engagement with Health overview and Scrutiny Committees	Caroline Morris / HOOs / As Required
		Reframe overarching strategy to focus around five fit for the future themes and republish strategy	David Ruiz-Celeda / April 2025

• Delivery against Detailed proof of concept plans in train, to improve current operational processes across the virtual EOC • Communication resources in place with revised approach in development for 25/26 • CCC improvement programme underway • CCC activity/demand modelling commissioned due for delivery in May 2025 • Proof of concept approach underway at North Harbour supported by team training in improvement methodologies • Estates plan in development which will in part address investment requirements and plans.			

Assurances		Gaps in Assurances	Actions	Owner / Due Date
First and second line (internal) assurances • Programme Board • Transformation Oversight Group • EMC • COG Engagement • Board • F&P Sign-off of Benefits realisation framework for PoC	**Third line (external) assurances** • Recovery Support Programme Oversight meetings (monthly) • Provider Quality Oversight and Assurance Framework meetings (quarterly with ICB)	• ~~Board sign-off of proof of concept and expected benefit realisation.~~	Terms of Reference for Operational Modernisation Programme Board and TOG being reviewed to ensure clear escalation and schedule of authority flows	Caroline Morris / Complete

Associated Risks on the Programme Risk Register (15+)			
Risk No.	Risk Title	Description	Residual Score
OMP risks: 01023; 01027	Subject Matter Expert Staffing Risk	IF departments are not able to release Subject Matter Experts THEN we may not be able to access the expertise, data and insights to enable modelling to be completed, plans defined and resourced for Proof of Concepts and communications and engagement effectively undertaken RESULTING in the delay or non-delivery of key elements of the Strategic Roadmap	16
OMP Risk: 01011	Leadership Capacity Risk	IF there is insufficient leadership capacity (at SLT, directorate and divisional level), THEN there is a risk that staff and/or projects will not be sufficiently well supported; RESULTING in attrition and inability to meet service/ project needs	16
	ISSUE	We have an “issue” on our log relating to the corporate restructure – which is 3-fold – two are immediate – poor staff motivation during change period, capacity constraint of leadership team. The final part is that elements of the redesign may not work (for e.g. Business partners co-located at Hubs) as proposed structures have removed the posts that would require this to work.	

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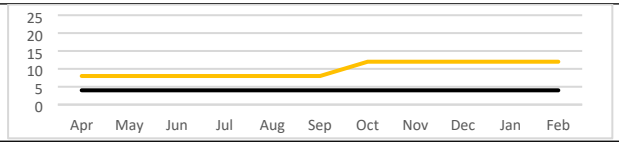
Objective 2: We will engage with stakeholders to ensure SCAS strategies and plans are reflected in systems strategies and plans.		Risk score **12**
Strategic Risk No. 14: Partnership Working	Update: February 2025	

If we don't work collaboratively and have effective relationships with a wide range of stakeholders	***Then*** we will fail to deliver our strategy of being an effective partner and care navigator on behalf of our systems	***Leading to*** poor patient experience and suboptimal outcomes

	Impact	Likelihood	Score
Inherent	4	4	16
Current	**4**	**3**	**12**
Target	4	1	4



Accountable Owner	Assurance Committee
David Eltringham, Chief Executive Officer	Trust Board

Controls	Gaps in Controls	Actions	Owner / Due Date
• Formal Memorandum of Understanding; SLAs and other written agreements • Formal Contracts • Meeting infrastructure • Existing professional relationships • Chairs Network • Chief Exec/ICS Exec Leadership forum • AACE • Southern Ambulance Service Collaborative • Regular 1:1s with SECAmb • 2:2 with ICS CEOs regarding SECAmb Partnership • Legal duty to collaborate. • Development activities with partners • Internal governance processes • Exec leadership of specific workshops • Commissioner led Co-ordination meeting • Nominated executive lead for each ICB	• Relationships with voluntary sector • Relatively immature system relationships and working arrangements (maturing)	Focus on relationships with HIOW as co-ordinating commissioner. Include HIOW Monthly Report in SCAS Board Papers	David Eltringham - Ongoing
		SCAS to participate in the ICS planning work for 2025-26	David Eltringham – Ongoing
		Attendance at meetings as part of ICS and leadership of UEC Transformation Programme	David Eltringham - Ongoing
		Stand ready to engage with SECAmb and Region to address changes in Board memberships at either organisation	David Eltringham – Ongoing until April 2025 then review
		Respond to concerns raised by BOB ICS relating to PTS activity and transition	David Eltringham, March 2025

Assurances		Gaps in Assurances	Actions	Owner / Due Date
First and second line (internal) assurances • Board maturity matrix • Report out from meetings / encounters (Chair / CEO reports into board) •	**Third line (external) assurances** • Report out from ICB from provider representatives • Soft intelligence / emotional intelligence • Regulatory reviews (TPAM / NHSE / RSP) • Feedback from RSP and TPAM meetings	• Harder measures (data / intelligence) • Independent scrutiny / assessment and formally report into committee/board • Appraisal processes – external feedback on degree of engagement (Chair / CEO / Officers) • Routine reporting of system interventions into Trust Board.	Continue to develop relationships with HIOW as co-ordinating commissioner	David Eltringham – ongoing
			Establish a systematic and regular report of progress against the ICS Transformation. Chief Governance Officer to build into regular reporting cycle. ICS to provide report to Boards so that this is consistent. CEO to brief on this at Board and against ICS report	Chief Governance Officer / Complete
			Appoint a Joint Strategic Lead in partnership with SECAmb to develop the statement of intent and enact the MoU	David Eltringham F/ Complete
			Sign off the MoU with SECAmb at January Board	David Eltringham / Complete

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

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Trust Board of Directors Meeting in Public
27 March 2025

Report title	Board Site Visits 2024-25
Agenda item	28
Report executive owner	Becky Southall, Chief Governance Officer
Report author	Kofo Abayomi, Head of Corporate Governance & Compliance
Governance Pathway: Previous consideration	Not Applicable
Governance Pathway: Next steps	Not Applicable

Executive Summary

Board member approachability and visibility to the wider organisation is key to becoming a well-led Trust. As part of this journey, the Governance team is monitoring Non-Executive Directors and Executive Directors site visits accordingly to ensure that the Trust maintains a high level of Board visibility across all of its sites. The attached table provides a record and future site visits that are planned.

One aspect of monitoring Board members' site visits which is reported via a metric in the 'Governance and Well-Led' Improvement Programme workstream, is to ensure that visits are being undertaken by both Non-Executive Directors and Executive Directors and that Visit Reports are being completed and returned to the Compliance Team.

The aim is for each Executive Director to make at least one visit per month to the various SCAS sites. This is also applicable to the Non-Executive Directors. Multiple visits to SCAS sites in a month are discounted, and only one visit is included in the metric.

Alignment with Strategic Objectives
The site visit report aligns with the Well Led

Relevant Board Assurance Framework (BAF) Risk
The report is relevant to all BAF risks.

Financial Validation	Not Applicable
Recommendation(s)	
The Board is asked to **Note** the Report.	

For Assurance		**For decision**		**For discussion**		**To note**	✓

Non-Executive & Executive Directors Site Visits report

Non-Executive Directors

Professor Sir Keith Willett CBE – KW

Sumit Biswas -SB

Les Broude - LB

Nigel Chapman (NED until Feb 2025) – NC

Ian Green OBE – IG

Katie Kapernaros – KK

Mike McEnaney – MM

Dhammika Perera - DP

NED Location visited in 2024/25	NED Visited	Month of Visit		Locations that have had no visits during 2024/25
Adderbury RC OX17 3FG	NC SB	May Aug		Didcot RC OX11 8RY
Bracknell RC RG12 7AE	LB	Jul		Maidenhead St Marks Hospital PTS/ASAP SL6 6DU
High Wycombe RC HP11 2JQ	KW LB	Nov Mar		Newbury RC RG14 1LD
Milton Keynes Blue Light Hub MK6 4BB	SB	May		Amersham PTS HP6 5AR
Kidlington RC OX5 1RF	NC	Dec		Reading PTS RG30 1DZ
Oxford City RC OX3 7LH	LB KW SB KK	May Jun Jan Mar		Witney Hospital PTS OX28 6JJ
Reading RC RG1 7DA	LB	Apr		Basingstoke RC RG24 9LY
Stoke Mandeville RC HP21 8BD	NC	Jun		Hythe RC SO45 5GU
Wexham Park RC SL3 6LT	LB	Dec		Nursling RC SO16 0YU
Chalfont PTS SL9 9QA	LB	Feb		Thatcham SORT RG19 4AE
Didcot PTS OX11 7HP 3-05-509	LB	Jun		Basingstoke PTS RG24 8QL
Maids Moreton PTS MK18 1QF	NC	Nov		Havant PTS PO9 2NA
Alton RC GU34 2QL	SB KW	Jun Sept		Milford on Sea Hospital PTS SO41 0FR
Andover RC SP10 3RJ	KW KW	Sept Dec		Portsmouth PTS PO3 6EJ
Northarbour RC PO6 3TJ	SB KW	Jun Oct		Totton PTS SO40 3AP
Hightown RC SO19 0SA	DP	Jun		Chichester Fire Station PTS PO19 1BD

Lymington RC SO41 8JD	KW SB	Aug Nov		East Preston Fire Station PTS BN11 1DA
Petersfield RC GU31 4AN	KW	Dec		Eastbourne PTS RC BN23 6FB
Ringwood RC BH24 3EU	KW	Aug		
Whitchurch RC RG28 7BB	IG	Aug		Lancing Fire Station PTS BN15 8PB
Winchester & Eastleigh RC/HART SO50 4ET	IG DP	Apr Jun		Dorking Hospital PTS RH4 2AA
Camberley PTS GU15 3SY	LB SB	Aug Oct		Durrington PTS BN11 1DJ
Gosport PTS PO12 3SR	SB	Sept		Eastbourne PTS CC BN23 6FA
Northern House E&UC CCC OX26 6HR	NC SB KW	Jul Sept Jan		Abingdon Fleet Services OX14 4SD
Northern House 111 CCC OX26 6HR	NC KW LB KW	Jul Jul Oct Jan		
Southern House E&UC CCC SO21 2RU	IG	Nov		
Southern House 111 CCC SO21 2RU	IG	Nov		
Southern House PTS CCC SO21 2RU	IG	Nov		
Unit 2 PTS CCC/ Education Centre OX26 6HR	SB	Jul		
Milton Keynes Partis House MK5 8HJ	SB LB	May Feb		
Newbury Bone Lane RG14 5UE	LB	Sept		
Whitley Education Centre PO15 7AH	KW	Oct		
Southampton Logistic Pharmacy Unit SO16 0BT (Adanac)	IG	Feb		

Exec Visits

		Visit Recorded											
2024/25	**Quarter 1**			**Quarter 2**			**Quarter 3**			**Quarter 4**			
Name	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**Total**
Craig Ellis	**1**	**1**	**0**	**0**	**3**	**0**	**0**	**0**	**2**	**0**	**0**	**0**	**7**
Rebecca Southall										**0**	**0**	**0**	**0**
David Eltringham	**3**	**5**	**8**	**19**	**13**	**2**	**10**	**9**	**7**	**3**	**18**	**5**	**105**
Helen Young	**2**	**4**	**4**	**5**	0	**3**	**7**	**7**	**3**	**4**	**4**	**6**	**49**
Duncan Roberston							**21**	**8**	**1**	**6**	**6**	**0**	**42**

John Black	6	5	3	5	4	3	5	8	3	0	6	0	48
Mark Ainsworth	6	3	2	8	7	0	11	5	7	8	8	4	96
Natasha Dymond		2	0	0	0	0	0	0	0	1	0	0	3
Paul Kempster	1	1											2
Stuart Rees	0	0	0	0	2	1	0	0	0	0	0	0	3