South Central Ambulance Service
NHS Foundation Trust

Agenda

Public Trust Board

Date: Thursday 31 July 2025
Time: 09.45 – 12.45
Venue: Newbury Education & Recruitment, Centre Bone Lane, Newbury RG14 5UE

Members:

Ian Green OBE	Non-Executive Director & Deputy Chair
David Eltringham	Chief Executive Officer
Harbhajan Brar	Non-Executive Director
Gary Ford	Non-Executive Director
Mike McEnaney	Non-Executive Director
Mark Ainsworth	Executive Director of Operations
Dr John Black	Chief Medical Officer
Kate Hall	Interim Deputy Chief Executive Officer
Danny Harriman	Interim Chief People Officer
Paul Kempster	Chief Transformation Officer
Stuart Rees	Chief Finance Officer
Becky Southall	Chief Governance Officer
Helen Young	Chief Nurse Officer

In attendance:

David Ruiz-Celada	Joint Strategic Lead, SCAS, SECAmb
Ann Utley	Associate of NHS Providers
Susan Wall	Corporate Governance and Compliance Manager

Apologies:

Professor Sir Keith Willett CBE	Chair
Les Broude	Non-Executive Director
Ruth Williams	Non-Executive Director
Katie Kapernaros	Non-Executive Director
Craig Ellis	Chief Digital & Information Officer
Gillian Hodgetts	Director of Communications, Marketing and Engagement
Duncan Robertson	Chief Paramedic Officer

Item		BAF	Action	Time
	OPENING BUSINESS			
1	**Chair's Welcome and Apologies for Absence** Ian Green OBE	**-**	**Verbal For Noting**	09.45
2	**Declarations – Directors' Interests and Fit and Proper Persons Test** Ian Green OBE	**-**	**Verbal For Noting**	
3	**Minutes from the meeting held on 29 May 2025** Ian Green OBE	**-**	**For Approval**	
4	**Board Actions Log** Ian Green OBE/ Becky Southall	**-**	**For Approval**	09.50
5	**Chair's Report** Ian Green OBE	**-**	**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 29 May 2025** Ian Green OBE	**-**	**For Noting**	-
8	**Patient Story** Helen Young	-	**For Information**	10.15
9	**Integrated Performance Report** Stuart Rees & Executive Director Leads	**-**	**For Assurance**	10.30
	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	**Chief Medical Officer's Report** John Black		**For Noting**	-
11	**Assurance Upward Report** Quality and Safety Committee 14 July 2025 Katie Kapernaros	**-**	**For Noting**	11.00
12	**Quality Accounts 2024/25** **&** **Quality Priorities 2025/26** Helen Young	**-**	**For Approval**	11.05
	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 3 Update** Stuart Rees	**SR24 20**	**For Assurance**	11.20
14	**Hampshire and Isle of Wight ICB Month 3 Finance Report** Stuart Rees	**SR24 20**	**For Noting**	11.35

Item		BAF	Action	Time
15	**Buckinghamshire, Oxfordshire and Berkshire West ICB M2/3 Finance Report** Stuart Rees	**SR24 20**	**For Noting**	-
16	**Assurance Upward Report** Finance and Performance Committee, 24 July 2025 Les Broude	-	**For Noting/ Assurance**	11.40
17	**Refreshed Green Plan** Stuart Rees	-	**For Approval**	11.45
18	**Assurance Upward Report** Audit Committee, 17 June 2025 Mike McEnaney	-	**For Noting/ Assurance**	11.55
19	**Assurance Upward Report** Charitable Funds Committee, 2 July 2025 Ian Green OBE	-	**For Noting/ Assurance**	12.00
20	**Questions submitted by Board Members on agenda items: 15-16, 18-19**	-	-	
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.			
21	**Assurance Upward Report** People and Culture Committee, May 2025 Ian Green OBE	-	**Verbal For Noting**	12.05
	Partnership & Stakeholder Engagement- We will engage with stakeholders to ensure SCAS strategies and plans are reflected in system strategies and plans.			
22	**Communications, Marketing and Engagement Update** Gillian Hodgetts	-	**For Noting**	12.10
	Technology transformation – We will invest in our technology to increase system resilience, operational effectiveness and maximise innovation.			
23	**Chief Digital Officer Report** Craig Ellis	**SR20 16**	**For Noting**	12.15
24	**Questions submitted by Board Members on agenda items: 22-23**	-	-	-
	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	**Chief Governance Officer Report** • **Board Committees Annual Report and Terms of Reference** Becky Southall	-	**For Noting/ Approval**	12.25
26	**Board Assurance Framework 2025/26** Becky Southall	-	**For Approval**	12.35

Item		BAF	Action	Time
27	**Board Site Visits** Becky Southall	**-**	**For Noting**	-
28	**Any Other Business** Ian Green OBE	**-**	**Verbal** **For Noting**	-
29	**Questions from observers (items on the agenda)** Ian Green OBE	**-**	**Verbal** **For Noting**	12.40
30	**Review of Meeting** Summary of Board Actions: Becky Southall Non-Executive Director: Mike McEnaney Executive Director: Helen Young	**-**	**Verbal** **For Noting**	12.45
31	**Date, Time and Venue of Next Meeting in Public** Thursday 25 September 2025 at 9.45am Newbury Education & Recruitment Centre, Bone Lane, Newbury RG14 5UE	**-**	**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

NHS
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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: 24 July 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 Council of the Association of Ambulance Services 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
6. Emeritus National Director of Emergency Planning and Incident Response

Current 'Other' Interests

7. Honorary Air Commodore to 4626 Squadron, RAuxAF

Interests that ended in the last six months

8. 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 NHS Shropshire, Telford & Wrekin ICB from 1st July 2025

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
6. NED, Somerset Care Ltd
7. Vice Chair, NHS Confederation LGBT Leaders Network
8. The Drawing Room Ltd, non salaried co-owner of private consultancy business

Interests that ended in the last six months

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

10. Chair of Salisbury NHS Foundation Trust

MIKE McENANEY, NON-EXECUTIVE DIRECTOR

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

1. Non-Executive Director, and Chair of Audit & Risk Committee – Royal Berkshire NHS FT
2. Director of South Central Fleet Services Ltd
3. Member of NHS Providers Finance & General Purposes Committee
4. Chair of FTN Limited (Trading subsidiary of NHS Providers charity)

Current 'Other' Interests

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

Interests that ended in the last six months

6. Member of Oxford Brookes University Audit Committee

KATIE KAPERNAROS, NON-EXECUTIVE DIRECTOR

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

7. Non-Executive Director, The Pensions Regulator
8. Non-Executive Director, Oxford University Hospitals NHS Foundation Trust
9. Non-Executive Director, The Property Ombudsman

Current 'Other' Interests

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

Interests that ended in the last six months

11. Non-Executive Director, Manx Care

RUTH WILLIAMS, NON-EXECUTIVE DIRECTOR

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

1. None

Current 'Other' Interests

2. Chair, Langley Trust Charity
3. Trustee Kings Group Academy

Interests that ended in the last six months

4. Gosport and Fareham Multi academy Trust
5. Hampshire Hospitals NHS FT (end of term March 2025)

HARBHAJAN BRAR, NON-EXECUTIVE DIRECTOR

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

1. None

Current 'Other' Interests

2. Director of HR, Imperial College London

3. Magistrate, Oxford

4. University of Bournemouth, Strategic HR advisor

5. Trustee, Multi-Academy Trust (ONE MAT, with schools in Wolverhampton and Redbridge, East London)

Interests that ended in the last six months

6. None

GARY FORD, NON-EXECUTIVE DIRECTOR

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

1. Consultant Physician / Chief Executive Office Health Innovation Oxford and Thames Valley (hosted by Oxford University Hospitals NHS FT)

2. Honorary Consultant Physician, Royal Berkshire NHS Foundation Trust

3. Non-Executive Director, NICE Board

4. Multiple NIHR research grants in which I am collaborator including SPEEDY trial of pre-hospital triage for suspected stroke with large vessel occlusion involves SCAS working with Southampton Comprehensive Stroke Centre

5. Buckinghamshire, Oxfordshire, West Berkshire ICB, Integrated Stroke Delivery Network, Chair

Current 'Other' Interests

6. Advisor to Carnall Farrarr

7. Professor of Stroke Medicine, University of Oxford

8. Governing Body Fellow, Green Templeton College

9. Health Service Research UK, Board of Trustees

10. Oxford Academic Health Partners Board

11. Accelerare, Director – company supports activities of Health Innovation Oxford and Thames Valley

12. Thames Valley and Surrey Heartlands Shared Care Record Board

Interests that ended in the last six months

13. 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 TRANSFORMATION 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. Member National Ambulance Medical Directors Group (NASMeD)
3. Investor Oxford Medical Products Ltd*
4. Oversight of commercially funded Clinical Research at SCAS which reports into CRG which I Chair

**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. Honorary Consultant Civilian Adviser in Pre-hospital Emergency Care to the Army

PROFESSOR HELEN YOUNG, CHIEF NURSE

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

1. Chief Nurse and Trustee for Across –a national charity supporting disabled and terminal patients to have respite care in Lourdes
2. Chief Nurse and Trustee for HCPT (a national charity supporting children and young people with LD, autism, physical disability or terminal illness have respite care in Lourdes and across the UK
3. Nurse Advisor to Board of Trustees for Dorothy House Hospice and Hospice at home
4. Member of Soroptimist International (Bath and Wiltshire Club) Executive (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, CHIEF FINANCE OFFICER

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 & INFORMATION 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

Interests that ended in the last six months

3. None

MARK AINSWORTH, EXECUTIVE 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

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

4. None

KATE HALL, INTERIM DEPUTY CHIEF EXECUTIVE OFFICER

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

1. Improvement Director, NHS England

Current 'Other' Interests

2. None

Interests that ended in the last six months

3. None

DAVID RUIZ-CELADA, JOINT STRATEGIC LEAD, SCAS, SECAmb

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

1. Executive Member of the Board at South East Coast Ambulance Service, Chief Strategy Officer

Current 'Other' Interests

2. Father (Luis Antonio Ruiz-Avila), is an Angel investor in the bio-technology sector, holding multiple CEO and Board Advisory positions. No direct relationship between the NHS provider Trusts I am involved with and the companies he is involved in exists

Interests that ended in the last six months

3. None

DANNY HARIRAM, INTERIM CHIEF PEOPLE OFFICER

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

1. Chief People Officer, Hampshire & Isle of Wight Integrated Care Board

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: 29 May 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
Ian Green	Non-Executive Director
Katie Kapernaros	Non-Executive Director
Mike McEnaney	Non-Executive Director
Ruth Williams	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:

David Ruiz-Celada	Joint Board Strategic Adviser SCAS/SECAmb
Kate Hall	Intensive Support Director, NHSE
Ann Utley	Associate of NHS Providers
Kofo Abayomi	Head of Corporate Governance & Compliance

Apologies:

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

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	Ian Green, Non-Executive Director announced he would soon step down as Chair of Salisbury NHS Foundation Trust and take up a new role. Ruth Williams, a new Non-Executive Director, declared her roles with Langley Trust and King's Group Academy. Other updates included resignations and role changes among Executive Board members and former NEDs. **Action: Update the declarations of interest register to reflect changes**.
2.2	**The Board noted the declarations of interests**.
3	**Minutes from the meeting held on 27 March 2025**
3.1	The minutes of the meeting held on 27 March 2025 were agreed as an accurate record of the meeting.
4	**Matters Arising and Action Log**
4.1	Becky Southall, Chief Governance Officer, led the review. Several actions were confirmed as completed, including updates to the Integrated Performance Report (IPR) and the Board Assurance Framework. Others, such as statutory training and EDI action plans, were still in progress and would return to the People and Culture Committee.
4.2	A verbal update was provided on asset management improvements, including a new system that improved efficiency and saved nearly £1 million annually. The Board acknowledged the significance of this improvement and the importance of timely data access.
4.3	The Board also discussed the need to finalize governor term tables and ensure visibility of governor terms for upcoming elections. The Chair emphasised the importance of transparency and timely updates to support governance.
4.4	The Board **NOTED** the updates to the matters arising and action log.
5	**Chairs Report**
5.1	The Chair highlighted recent changes to the NHS i.e. the Secretary of State and changes to NHS England being merged into the Department of Health and Social Care and impact on other parts of the NHS in terms of efficiencies and reduction in workforce. This provided SCAS with the opportunity to review how we do things and alignment with the Fit for the Future programme.
5.2	The Chair thanked every member of staff for their contributions to the current financial year ending 31 March 2025. It has been a very challenging year with a lot of work done to improve operational and financial performance. As we move to the next financial year, work continued to build the modernisation programme and next level efficiency improvements, patient safety, experience and outcome. The Chair also thanked the NHS England improvement team for all their support in the current financial year.
5.3	The Chair asked the Board to note his site and engagement visits since the last Board meeting. **Action: Dates of Accreditation Visits to be provided to Board members**

5.4	The Board **NOTED** the Chairs Report.
6	**Chief Executive Officer's Report**
6.1	David Eltringham (DE), Chief Executive Officer, referred to his report and presented some additional information verbally, as follows: a) Operational performance delivery particularly CAT 2 performance standard and revision made to the Trust's plan halfway through the year. DE recorded his personal thanks to the leadership team and colleagues across the organisation for their incredible hard work to get the Trust to achieve the required performance. b) In the next few weeks, many PTS colleagues will be leaving the organisation to move to the private provider company and thanked them for their hard work and contribution to the service. c) DE highlighted that the Trust is on track to deliver a slightly improved financial position at year end due to technical adjustments and non-recurrent income not previously expected which covered costs related to corporate costs thereby improving the in-year position and significantly improving the Trust's financial challenge. d) The Trust's focus now moves to the next financial year and the requirement to submit an operational and financial plan at the start of the new year to the Integrated Care Board. This was signed off at an extraordinary meeting of the SCAS Board on 20 March 2025. The plan is for the Trust to achieve operational and financial balance at the end of 2025/26. DE highlighted that there were still gaps but these would be firmed up ahead of 1 April 2025. He informed the Board that the signed off plan is without risks, but these were carefully considered by the Board prior to sign off with relevant assurances and mitigations provided. e) Work is ongoing to continue to shape the fit for the future programme with a clear message being developed for communication to all Trust staff. f) DE talked about changes to the leadership structure of NHS England and overall impacts on NHS organisation, particularly SCAS. g) Executive restructure was now completed with five directorates. The interview for the post of Chief Finance Officer had taken place with those of the Executive Director of Operations and Chief People Officer scheduled for later in the week. Plans are also in progress for the post of Deputy Chief Executive.
6.2	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 updates from the Private Board meeting held on 30 January and Extraordinary Private Board meeting held on 20 March 2025.
8.	**Feedback from Chair of the Patient Panel**
8.1	Helen Young (HY) introduced the item, noting that this was a combination of patient and staff story. The Board was asked to note that the Patient Panel had now been in existence for a year and the Chair, Roger Batterbury had key information to deliver to the Board. HY encouraged board members to attend future patient panel meetings.

8.2	The Board heard from Roger Batterbury (RB), Volunteer Patient Panel Chair. RB summarised the following key areas: • Structure of the panel • launch on 21 February 2024 • feedback on CFR ride-along • key areas of focus for the panel • work done with the Learning Disability Group including coproducing a SCAS learning disability strategy • Coproduction of mental health training • End of life care with further work to be done in this area • Patient panel expansion
8.3	Mike McEnaney (MM), Non-Executive asked for feedback on the sources of information received from the Trust, as knowledge and insight in the Trust is key for this area of work. It was noted that information required and received could be timelier. HY added that the Patient Panel reports into the Patient Experience Group therefore it is a two-way approach into receiving and providing feedback for triangulation.
8.4	The Board thanked RB and his colleagues for all their work with the Patient Panel. RB confirmed that there is good engagement and feedback from the Trust Governors. **Action: EMC to discuss issues arising – EDI/Autonomy and accountability, processes and revised Operational Structure.**
8.5	The Board **NOTED** the feedback from the Patient Panel Chair.
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 February 2025, the tenth month of the financial and operational year.
9.2	The Board received the following sections of the IPR for discussion: **<u>Operations</u>** Mark Ainsworth (MA), Executive Director of Operations provided the key highlights of the operations performance for the reporting period, noting: • 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.
9.3	Stuart Rees (SR) added an update on improvement work relating to VOR in response to a question raised by a member of the public, it was noted that a clear plan is now in place to address this through December 2026. There are two aspects to the plan i.e. making as many vehicles as possible available on the road, new ramps and workshops and replacement of the old fleet. The Finance and Performance Committee will have oversight and track improvements.
9.4	Sumit Biswas (SB), Non-Executive Director noted that PTS activity levels were declining, which was not a surprise with the recent changes, he then sought assurance that quality of the service was maintained through the transition and that it remained a focus for the team. SR provided relevant assurance by summarising all quality assurance processes in place to ensure positive patient experience.
9.5	Les Broude (LB), Non-Executive Director noted that hear and treat performance in the reporting month had declined, the forecast was for this to increase with plans put in place and sought assurance. MA summarised work ongoing to increase hear and treat and assured the Board that there will be a gradual increase over the next six months.
9.6	In response to MM's query about plans in place to achieve 111 targets, MA explained that clinical call backs are currently not achievable, the level of investments required for this was not sustainable. MA summarised plans in place for call answer with focus on recruitment, efficiencies and new systems to free up staff time. The was also focus on the re-procurement in the summer, with conversations with the ICB on what the specifications would look like. DE connected this to the piece of work done by Carnell Farrar, commissioned by NHS England and the South East region, this piece of work provided a clear direction and to capture what MA described in an action. **Action: DE to discuss Commissioning Model re: 111 following the Carnell Farrer review with commissioners**.
9.7	**Quality and Safety** The Board received the Quality and Safety performance for the reporting period and noted the following key highlights: • 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 remained insufficient data points to provide a view on assurance.
9.8	LB queried why there was no target associated with the PSIRF measurements. Helen Young (HY) explained that PSIRF are a way of measuring the number of incidents, which are then sub-categorised into investigations, learning events or plotted into a thematic review, and therefore had no targets, but there are benchmarking data and peer reviews to show us where we are against similar ambulance trusts. Further to this point DE advised that this would be taken away for development.
9.9	**People** The Board received the People performance for the reporting period and noted the following key highlights • 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 had 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 long term absence rate at 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 the 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.
9.10	Further to the Board discussion on the People section of the IPR, the following were requested: **Action: EMC to discuss how the narrative can be improved, which KPIs require process redesign/improvement activity to achieve targets and the identification of SMART actions**
9.11	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 January to February 2025.

10.2	Helen Young (HY), CNO, introduced the report and asked the Board to note content of the report. HY also explained that this would be the last of the report as the quality and safety section of the IPR was now developed and there was therefore no need for a separate report.
10.3	Further to the Board discussion around patient safety review and thematic action plans, it was requested that **Action: Mechanism to be developed for updating the board on themes and trends and what is being done to address these**.
10.4	The Board **NOTED** the Quality and Patient Safety Report.
11	**Chief Medical Officer's Report**
11.1	**The Board noted the Chief Medical Officer's Report.**
12	**Assurance Report**
12.1	Quality and Safety Assurance Upward report dated 19 March 2025.
12.2	The Board **NOTED** the report.
13	**Finance Report Month 11 Update**
13.1	Stuart Rees (SR) presented the report. The Board noted that in Month 11, the Trust recorded an in-month surplus of £0.7m, £49k better than planned. 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.
13.2	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.
13.3	Further to SB seeking clarity on the conditions attached to the ICB brokerage funding, SR confirmed the condition related to only timescales.
13.4	The Board discussed the Trust capital program in detail and requested the following:
13.5	The following actions were agreed from the Board discussions: **i. Estates Plan to be presented to FPC in May.** **ii Rolling plan to be submitted to EMC/FPC/Board.**
13.6	**The Board noted the Finance Month 11 Update**.
14	**Hampshire and Isle of Wight ICB Month 11 Finance Report**
14.1	The Board received the Hampshire and Isle of Wight ICS Month 11 finance report, The purpose of the Month 11 (M11) 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 February 2025.

14.2	The Board noted that 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 the plan to reduce to £0 (breakeven).
14.3	The Board **noted** the Hampshire and Isle of Wight ICB Month 11 Finance Report.
15	**Assurance Report**
15.1	Finance and Performance Committee 18 and 21 March 2025.
15.2	The Chair thanked the Finance and Performance Committee for their work during the financial year.
15.3	The Board **NOTED** the Finance and Performance Committee Assurance Reports.
16	**Assurance Report**
16.1	Audit Committee 19 March 2025.
16.2	The Board **NOTED** the Audit Committee Assurance Report and the Internal and External Audit Plans.
17	Charitable Funds Committee 12 March 2025
17.1	The Board **NOTED** the Charitable Funds Committee Assurance Report.
18	**Questions submitted by Board Members on agenda items: 11-12,15-17**
18.1	No questions received.
19	**Freedom to Speak Up Policy**
19.1	The Board received the updated Freedom to Speak up Policy.
19.2	MM advised that section 1, paragraph 4 was the only part of the section that was not a question, he advised that for this to be rephrased for consistency and for it to be more powerful.
19.3	The Board **NOTED** the policy.
20	**Freedom to Speak Up Reflection and Planning Tool: Self-Assessment: Annual Review 2025**
20.1	Ian Green (IG), Non-Executive Director and Chair of the People and Culture Committee highlighted that the item had no prior review or consideration at Committee level and felt that the Committee should have had sight of it before the Board.

20.2	Dhammika Perera (DP), Non-Executive Director, noted that the template was more relevant to acute trusts with little consideration for ambulance trusts and he had shared this view with the Freedom to Speak up Guardian, advising that the template is amended and summarised into a format more applicable to an ambulance trust. He also expected the next iteration to be shorter and more in line with the activities and staff of an ambulance organisation.
20.3	DE informed the Board that there is an agreed governance pathway, it appeared that this was not followed due to the People and Culture Committee March meeting being stood down.
20.4	MM highlighted that the Audit Committee had a role to ensure that the trust's freedom to speak up arrangements are effective, and this would need to feed into the Audit Committee, but it is important that this is not duplicated. ND noted the points but highlighted that there is a national requirement for this to be presented to the Board.
20.5	Further to Board discussion, it was agreed **Action: BS/IG/MM to discuss responsibilities of PCC and Audit Committee**.
20.6	The Board **NOTED** the Freedom to Speak Up Self-Assessment.
21	**National Staff Survey**
21.2	The Board received the national staff survey results which was published on 13 March 2025. The report provided an overview of SCAS's results outlining key strengths and areas requiring focus and improvement. SCAS's response rate for 2024 (50%) was the lowest it had been for 8 years and lower than the average response rate for other Ambulance Trusts participating in the Picker Staff Survey (55% response rate).
21.3	The Board discussed the survey results in detail with focus on the positive and less positive aspects of the survey.
21.4	The Board **NOTED** the National Staff Survey report.
22	**Gender Pay Analysis report 2024-2025**
22.1	The Board received the gender pay analysis report of 2024/25 and approval was sought for the report to be published on the Trust's website by end of March 2024.
22.2	The Board **APPROVED** the report to be published on the Trust website.
23	**Communications Update**
23.1	The Board **NOTED** the Communications Update.
24	**Questions submitted by Board Members on agenda item 23**
24.1	No questions were received.
25	**Standing Orders and Scheme of Reservation and Delegation**

25.1	Becky Southall (BS) presented the report and drew the attention of the Board to the Scheme of reservation and delegations and summarised the key sections.
25.2	The Board were informed of the relevant policies subject to Board approval, BS explained that further work will be done to streamline the number of policies requiring board approval.
25.3	The approval of the Board was sought for the Chief Governance Officer and Chief Finance Officer to make minor changes to the document as required.
25.4	SB queried the list of policies, he noted that most of the policies had not previously been approved by the Board. BS explained that this was the definite list as stipulated in the current Standing Financial Instructions. She also assured the Board that the list will be revised.
25.5	The Board **APPROVED** the Standing Orders and Scheme of Reservation and Delegation and delegated authority to the Chief Governance Officer and Chief Finance Officer to make minor changes when required.
26	**Code of Governance Self-Assessment**
26.1	BS presented the report and informed the Board that the code of governance self-assessment had been scrutinised by the Audit Committee. BS explained that it was good practice to carry out the self-assessment periodically which informs the annual governance statement.
26.2	The Board noted that the Trust is largely compliant, and areas of non-compliance are explained. BS summarised the areas of non-compliance and actions in place to address these areas, which would also form part of the transition criteria.
26.3	SB highlighted the issue of governors and visibility of their term of office, he stated that this was previously on the Trust website, this had also been raised by Governors and advised that this is refreshed and uploaded on the website as soon as possible.
26.4	The Board **APPROVED** the code of Governance Self-Assessment.
27	**Board Assurance Framework (BAF)**
27.1	The Board received a report setting out proposed changes to the BAF which had been previously considered by relevant Board Committees.
27.2	MM referred to SR 7 safe, valued and supportive staff and advised that this risk is reviewed considering the staff survey result. Further to MM and KK's observation of SR 10, there was a discussion around the probability of the risk. Craig Ellis (CE), Chief Digital Officer, explained that there had been four outages in the last six months and stated that we are entering into a time of cyber hostility due to AI, based on this he agreed that the risks needed to be addressed, and the digital team are currently working this through. **Action: consideration to be given to which Committee the Digital Workstream reports to and how Tier 2 programme will be reported to the Board; links to the refresh of the Board and Committee workplans.**

27.3	The Board **APPROVED** the amended Board Assurance Framework
28	**Board Site Visits**
28.1	The Board noted the Board Site Visits Report, with the following actions: **Action: EMC to discuss current process of Board Site/Service Visits, how observations/improvement areas can be fed back and followed up and define framework**
28.2	The Board **NOTED** the Board Site Visits Report and actions.
29.	**Any other business**
29.1	There was no other business at this meeting.
30	**Questions from observers**
30.1	In response to the question asked by a Governor relating to the delay of the fleet delivery and the electric vehicles, SR explained that there is an agreement and rectification in place.
31	**Executive Director Review of the meeting:**
31.1	BS summarised actions from the meeting and these were noted by the Board.
31.2	Ian Green, Non-Executive Director, reflected that: • There were a lot of data and information in the reports • Need for collective accountability • Good response from Chief Executive in areas that were challenged Stuart Rees, Executive Director of Operations, reflected that: • Recognised that there were long papers, but given the nature of some of the reports, the length was unavoidable • Good papers • IPR generated the right discussions • Good discussion on regional issues
31.3	The Chair commented on the length of the papers and within the papers there were embedded documents. He recommended that use of reading room which was previously done.
32	**Date, Time and Venue of Next Meeting in Public**
32.1	The next public meeting of the SCAS Board would take place at 9.45am on 29 May 2025 at the Ark Conference & Events Centre, Dinwoodie Drive, Basingstoke, Hampshire, RG24 9NN

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TRUST BOARD ACTION LOG						Status
Minute Ref:	**Agenda Item**	**Action**	**Owner**	**Due Date**	**Update**	
Meeting Date: 29 May						
TB/25/001	Minutes	Amendments to job titles to be made as discussed at the meeting	KA	31.07.25	Completed	**Close**
TB/25/002	Declarations of Interest	Register to be updated as per updates given at the meeting	KA	31.07.25	Completed	**Close**
TB/25/003	CEO Report	Dates of Accreditation Visits to be provided to Board members	HY	31.07.25	Dates circulated	**Close**
TB/25/004	Staff Story	EMC to discuss issues arising: EDI/Autonomy and accountability, processes and revised Operational Structure	BS	31.07.25	3 cycles of Performance Management Meetings have taken place and in line with quality improvement methodology, we are now reviewing and revising our approach in readiness for the next meetings. Autonomy/accountability are an integral element of the Culture and Leadership development programme.	**Propose to close**
TB/25/005	IPR	EMC to discuss how the narrative can be improved, which KPIs require process redesign/improvement activity to achieve targets and the identification of SMART actions	BS	31.07.25	IPR is now on the EMC agenda prior to submission to trust board. This is an on-going action related to continuous improvement, therefore propose to close.	**Propose to close**
TB/25/006	Fit for the Future	Consideration to be given to which Committee the Digital Workstream reports to and how Tier 2 programmes will be reported to the board; links to the refresh of the board and committee workplans	BS	31.07.25	Refresh of workplans is linked to the development of the Tier 1 programmes, which is work in progress as we embed the Fit for the Future Board Assurance Framework. It has been agreed that Digital will report via the Quality & Safety Committee	**Close**
TB/25/007	Board Site/Service Visits	EMC to discuss current process, how observations/improvement areas can be fed back and followed up and define a framework	BS	31.07.25	Discussion is underway. A revised framework for board/senior leadership visits will be presented to the next meeting.	**Open**

TB/25/008	IPR	DE to discuss Commissioning Model re: 111 following the Carnell Farrer review with commissioners	DE	31.07.25	The discussion has taken place with local commissioners and the national team. The development and design of a single commissioning specification regionally and nationally will deal with this matter.	**Close**
TB/25/009	Quality and Patient Safety	Mechanism to be developed for updating the board on themes and trends and what is being done to address these	HY	31.07.25	It was agreed at the last Board by BS and NEDs that to support the patient safety data in the IPR a quarterly quality and safety report including incident data, learnings and action taken and themes. Paper to be submitted for October Board covering Q2.	**Close**
TB/25/010	Freedom to Speak Up annual review	BS/IG/MM to discuss responsibilities of PCC and Audit Committee	BS	31.07.25	Verbal update at meeting	**Open**
Meeting Date: 27 March 2025						
TB/25/004	IPR - Statutory & Mandatory Training	Exception report to be presented explaining what the target comprises and performance against each training module/level of risk.	ND	29.05.25	Paper has been presented to EMC addressing several issues that have been identified at board and committee level. Overall approach to target setting and reporting/oversight included. Paper will be presented to the PAAC and will inform the next iteration of the IPR.	**Open**
TB/25/005	IPR - BAME staff representation	Clarity to be provided in relation to what actions we are intending to take to increase BAME representation across the bandings	ND	29.05.25	Being reviewed as part of Trust EDI action plan. Upwards report to PACC in July 2025 meeting	**Open**
Meeting Date: 27th May 2025						

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	29.05.25	Verbal update was provided at the May meeting	**Close**

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Meeting Report

Name of Meeting	Trust Board of Directors Meeting in Public
Title	Chair's update
Authors	
Accountable Director	Keith Willett, Chair
Date	31st July 2025

1. Purpose

The purpose of this Chair Report is to inform the Board of stakeholder engagement and site visits since the Board held in May 2025.
Since the last Public Board meeting, I have undertaken the following visits and stakeholder meetings:

June 2025

- SASC CEO and Chair Meeting
- Volunteers Week – Drop in Session, Thame
- Adanac visit – compliance visit pharmacy and logistics teams
- QAH ED visit (hosted by Chief Medical Officer, Portsmouth Hospitals)
- SCFS Ltd Board Meeting
- NHSE Succession Planning Webinar
- Royal Air Force Brize Norton Annual Formal Reception
- SCAS Public Talk online – Falls and Frailty
- SCAS Long Service Awards

July 2025

- Extra-Ordinary Finance & Performance Committee
- CQC/NHS Trust Well Led Reference Group
- AACE Chairs
- Joint Strategic Collaboration Committee
- EPRR Delivery Group
- AACE Council
- Aspiring operations Director Programme – Speaker
- BLMK ICS Research and Innovation Network Meeting
- Filming – History of Trauma Research in Oxford
- ICB Research and Innovation Function in the new Clustered ICB Function
- NHS Confed All Member Chairs Group
- Council of Governors
- Membership and Engagement Committee

Other

- Monthly: SE Senior Leaders Briefings (Anne Eden, NHSE SE Regional Director)
- SCAS Team Brief Lives
- ICS Monthly Chairs Meeting
- NED 1:1s

Recommendation

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

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Board of Directors Meeting in Public 31st July 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

30th July 2025

Performance

I am pleased to report that we started the year in a strong position from a performance perspective, although as we have moved into July the position is beginning to tighten. We committed within our Operating Plan to delivering category 2 performance within our budgets and it is imperative that we deliver on this commitment, at the same time as ensuring that the care that we deliver is safe. Our ability to respond to category 2 calls in a timely way is key to ensuring that patients in urgent need of life saving or preserving treatment receive this in a timely way and we will continue to relentlessly focus on delivering on our commitment to improve response times.

We continue to work with partners across the system to ensure that there are no handover delays and that our crews are released and are able to respond. Additionally, we are seeing an increase in Hear and Treat rates, which are above plan and mean that unnecessary conveyances to hospital are reduced and our patients are treated in the most appropriate setting and that they avoid being taken to hospital when this is not necessary.

People

Our Operational Plan ensures a tightly balanced position between our operational performance, our budgets and the workforce that we need to deliver services to our population. We have focused on building the substantive workforce that we need and on reducing our reliance on private providers and on temporary staffing solutions, and it is extremely pleasing to note that we no longer have vacancies and that our attrition rate (staff leaving the organisation) has also reduced. Whilst this is a better position than we have been in for a number of years and means that we have achieved our ambitions to recruit and retain our staff, it also means that we have taken the difficult decision to cease our highly successful International Recruitment programme, and to stop recruitment across our organisation as we no longer have vacancies to recruit to. We will continue to monitor our workforce requirements in the short, medium and longer term and will take action accordingly with regards to future recruitment.

Long Service Awards

I had the pleasure of attending the Long Service awards ceremony, along with the Countess Howe, Lord Lieutenant of Buckinghamshire, to celebrate a number of colleagues and volunteers who have provided many years of long and dedicated service to our organisation and the

population we serve. Our staff are our greatest asset and it I feel privileged to lead an organisation with such proud and dedicated staff, whether they have been in post for a short time or for many years and attending ceremonies such as this is one of the highlights of my role as Chief Executive Officer.

Pride Events

I had the privilege of attending a Pride Event in Portsmouth in June alongside colleagues, which saw the inaugural appearance of the SCAS LGBT+ and staff networks pride vehicle, which was kindly sponsored by the SCAS Charity and our union colleagues across Unite, Unison, GMB and the RCN. The event was well attended and provided a great opportunity for our staff and volunteers to engage with the public and showcase the work that we do. The Pride vehicle was designed with all our staff networks in mind and will be utilised for future events and roadshows. My thanks are extended on behalf of the board to our sponsors.

Recovery Support Programme

Much hard work has taken place, over the past two years, to ensure that we have taken the steps required to exit the Recovery Support Programme. Whilst we took immediate action to address the areas that were identified to as requiring improvement, with support from ICB colleagues and NHS England, we have also been putting in place the building blocks that will enable us to move from a regulatory framework to a more strategic footing. This will ensure that the improvement work that we have undertaken to date is sustainable and will move us towards realising our strategic ambition to be a Care Navigator across our systems, ensuring that patients receive care in the most appropriate setting.

The board approved the Fit for the Future Framework at the last meeting. This is our single Improvement plan and this will ensure that we are on track to maintain improvements once we exit recovery support in September 2025. We intend to further develop the plan to ensure that the required level of granularity is contained within it, and that we develop a detailed set of longer term plans with a 5 year horizon as you would expect to see in a Foundation Trust.

Ten Year Plan

On the 3rd July 2025 the Government published the 10 Year Health Plan for England – Fit for the Future. It's serendipitous that the plan uses the same 'Fit for the Future' sub-title as our own Fit for the Future plan and our own plans align with the vision set out in it.

NHS Chief Executives have been invited to join work to create a delivery plan for the Ten Year Plan and work on this will take place through the summer and early autumn.

SCAS/SECAmb Partnership

Work continues on the work to establish stronger partnerships with SECAmb. Executive colleagues for both organisations are working together to agree the three priority areas which we will focus on going forward, selecting these from a long list of identified opportunities. Our objective is to move to deliver a common ambulance service offer for the people of the South East NHS region and to drive value for money and productivity improvements across both organisations.

Executive Team Appointments

I am pleased to report that Duncan Robertson has been substantively appointed to the Chief Paramedic Officer role. Duncan has been seconded into this role which was newly created and I am delighted to formally confirm his substantive appointment to the Executive Team and Board.

Danny Hariram has joined us as Interim Chief People Officer for six months from Hampshire and Isle of Wight ICB and Kate Hall has joined us as Interim Deputy Chief Executive from NHS England, also for a period of six months.

David Eltringham

Chief Executive

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Trust Board of Directors Meeting in Public
31 July 2025

Report title	Update to the previous Private Board meeting held since the last Public Meeting on 29 May 2025
Agenda item	7
Report executive owner	Becky Southhall, Chief Governance Officer
Report author	Susan Wall, Corporate Governance and Compliance Manager
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 meeting held on 29 May 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 29 May

1. **Confidential Report from the Chair**

   There was no specific Chair's update.

2. **Confidential Report from the Chief Executive Officer**

   The Board received an update from the Chief Executive Officer with key points:
   a. Developments within the organisation
   b. Ofsted Inspection feedback
   c. NHS England structural changes
   d. Regulatory environment
   e. South East Coast ambulance Service collaboration

3. **Decommissioning of the Intelligent Routing Platform**

   The Board supported funding and **NOTED** the need for long-term planning around digital infrastructure and national collaboration.

4. **Southern Ambulance Service Collaborative (SASC) – Shared Procurement Decision Paper**

   The Board **RATIFIED** the decision to proceed with the shared procurement initiative.

5. **Finance Month 1 Confidential Update**

   The Board **NOTED** the Month 1 Confidential Update.

6. **Financial Recovery Plan**

   The Board **NOTED** the update report.

7. **Confidential Hampshire and Isle of Wight Integrated Care System Finance Month 1**

   NOTED the report would be formally circulated to Board members.

8. **CAD Outline Business Case**

   The Board **APPROVED** the Outline Business Case and authorised the Executive Team to proceed with the procurement.

9. **Chief Digital Officer**

   The Board received and **NOTED** the digital update for the reporting period.

10. **Any Other Business**

    The Board discussed Statutory and Mandatory Compliance.

South Central Ambulance Service NHS Foundation Trust

Trust Board of Directors Meeting in Public
31 July 2025

Report title	Patient Story
Agenda item	8
Report executive owner	Helen Young - Chief Nursing Officer
Report author	Caroline Whitworth – Head of Patient Experience & Engagement
Governance Pathway: Previous consideration	N/A
Governance Pathway: Next steps	N/A

Executive Summary

This incident highlights the tragic experience of an elderly patient who sustained a serious spinal injury after falling from her wheelchair when it struck a pothole. The patient was being pushed by a family member at the time, and members of the public helped lift her back into the chair before the ambulance crew arrived. The decision not to apply a cervical collar raised concerns from the patient's family, and the Coroner requested that the Trust record and review this incident.

Upon arrival, the ambulance crew moved the patient via manual handling into the vehicle and then onto a stretcher. A CT scan later confirmed the patient had suffered a fractured odontoid peg—an injury with serious implications. Despite medical intervention, the patient sadly died a few days later.

Following a comprehensive investigation, several key learning points were identified:

- **Clinical decision-making:** The rationale behind not using a cervical collar in this context was examined, leading to improved clarity in protocols for suspected spinal injuries in elderly and frail patients.
- **Environmental risk awareness:** The Trust is working with local authorities to explore safer patient transfer routes and flag hazards such as pavement defects that may pose risks to vulnerable individuals.

- **Manual handling practice:** Training materials and guidance are being reviewed and updated to ensure safe and respectful patient movement, particularly in cases where trauma is suspected.
- **Family engagement:** The patient's family concerns prompted vital reflections across services. Their voice has helped shape improvements in communication, compassion, and clinical responsiveness.

This incident has reinforced the importance of our learning culture, listening to families, and continuously improving our care practices. The Trust extends its deepest condolences to the patient's loved ones and acknowledges the public members who acted swiftly and compassionately.

The slides detail the investigation that took place and the learning that has been identified as a result of this incident.

Alignment with Strategic Objectives
With which strategic theme(s) does the subject matter align? (If more than one, please write manually) High Quaity Care & Patient Experience

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

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)	
The Board is asked to receive the paper for noting	

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

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Patient Story
IR 75338

July 2025

Background

Incident Summary – April 2024 (Patient: JC)

- Elderly patient with severe dementia and osteoporosis was being pushed in a wheelchair by her granddaughter.
- While crossing the road, a front wheel caught in a pothole, causing the wheelchair to tip forward.
- JC was thrown face-first onto the road striking her head; assisted back into the chair by bystanders.
- She was unresponsive, floppy, and transferred to ED via ambulance.
- Imaging revealed a cervical odontoid peg fracture with spinal cord injury.
- Planned non-operative treatment with a collar; condition deteriorated.
- JC sadly passed away two weeks later while awaiting care home transfer.

Family/Coroner Concerns

- Incident recorded on **Datix** following a **Coroner's request (inquest date May 2025)**
- Family raised concerns about **lack of cervical collar** application by SCAS crew
- Coroner highlighted concerns regarding **immobilisation** and its link to cause of death – inquest outcome "accidental death"
- Declared a **Patient Safety Incident Review (PSIR)**

Findings of Collation of Facts

Patient Safety Investigation Findings

- Evidence supported the need for a **full cervical spine (C-spine) assessment**
- No documented C-spine assessment in the **electronic Patient Record (ePR) or in the recollection of attending clinician**
- Clinical indicators included:
  - Initial **loss of consciousness**
  - **Lack of motor movement**
  - **Head hanging forward**
  - **High frailty score**
  - Reported **pain**
- A **higher index of suspicion** was warranted
- Decision-making should have been guided by **JRCALC 'Falls in Older Adults'** guidance

What happened as a result?

- **Training delivered** by Consultant Pre-Hospital Care Practitioner on *Trauma in the Elderly & Frail* (November 2024 & May 2025)
- Clinical Memo on **missed C-spine fractures** re-issued
- **PSIRF lead** reviewed trauma cases; theme likely to be added to **Patient Safety Incident Response Plan (PSIRP) Version 2** (pending PSEG approval – Aug 2025)
- **Learning Snapshot** created and shared via:
  - *Think Patient Safety* campaign
  - Monthly patient safety newsletter
  - Service line CG meetings
- **Platinum trauma** to be reviewed by Clinical Audit Review Group (Dec 2025)
- Ongoing discussions with **Education Team** to agree learning from patient safety incidents training content

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Learning Snapshot

NHS South Central Ambulance Service NHS Foundation Trust

SCAS Learning Snap Shot 2025

Description: An elderly patient being pushed along in a wheel chair. This was to take the patient out for her regular coffee with a family member.

The patient suffered from osteoporosis, had incurred skeletal injuries, notably in the spine. The patient also had dementia, verbally quite limited and blind in one eye. As the wheel chair was pushed along, it went into a pothole, which caused the patient to be thrown out of her chair onto her face / front body, with nothing to break the impact (arms not used). Post fall the patient was said to be unconscious.

Is this a trend? YES – there seems to be a trend where staff are not considering the patient's physical condition (elderly and associated frailty) – where it is known that in falls, the elderly have a high possibility of C1 (Odontoid peg), C2 and long bone fractures (NoF, Humerus, femur etc).

What happened:

The patient was picked up off the pavement and placed back into her wheel chair – by public persons helping at the incident.... **NO** C spine support or manual immobilisation. It was noted that the patient's GCS was improved (normal for patient was 13/15) now 11/15 – there was reduced arm / head movement. The attending SCAS clinician, decided to move the patient in her wheel chair into the ambulance and from there used an under-arms and lower legs lift of the patient onto the stretcher. Patient was more responsive, and arm and head movement had improved. Patient transported to A&E. CT scan showed fractured odontoid peg – patient died some days later. COD was 1(a) Cervical spine fracture. 1(b) Spinal cord injury II Frailty of old age; dementia,

Why did it happen? SCAS clinician making a decision that patient did not need C spine immobilisation, as patient moved by public and patient's improvement post fall.

What have we learnt?

a. Crews undertaking assessments MUST have a high index of suspicion, especially in the elderly or patients who have bone density problems.
b. There is a need for staff to undertake some underpinning knowledge updating with regards to the elderly or at risk of bone fractures. JRCALC has been updated and provides guidelines and flowcharts.
c. The ePR should be utilised to evidence your decision making especially where it has not followed JRCALC, SCAS etc guidelines – using the free text section.
d. 'If it hasn't been written down....it hasn't been done'

Something to ponder on:

i. The stress of knowing after the incident that you missed a serious injury – and believe us, we have ALL made those errors/omissions.
ii. Having to sit in Coroners Court, recounting all your treatment, which was Best Practise – THAT is what you want when providing evidence on the life of a patient.

Actions:

1. Highlighting spinal issues and the need for a higher index of suspicion when assessing patient.
2. RCEM_safety_alert_Silver_Trauma_Sept_201 and Falls Presentation Team Training.pdf and Clinical Memo Issue No 156 - Missed Spir

(Thanks to MaS for the PPP)

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Trust Board of Directors Meeting in Public
31 July 2025

Report title	Integrated Performance Report (IPR)
Agenda item	9
Report executive owner	Stuart Rees, Chief Finance Officer
Report author	Tina Lewis, Senior Transformation Programme Manager
Governance Pathway: Previous consideration	EMC and F&PC
Governance Pathway: Next steps	

Executive Summary

Summary of the Integrated Performance Report (IPR) – June 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 June 2025, the third month of the financial and operational year.

The IPR provides valuable insights on where the Trust is delivering as expected and highlights areas requiring process redesign and resource adjustments to meet targets and improve performance.

Key Highlights

1. **Assurance and Variation Levels**:
    - **Assurance Levels**:
        - *Pass*: 3 metrics consistently meet targets.
        - *Fail*: 10 metrics consistently fail to meet targets without process changes.
        - *Random*: 46 metrics fluctuate within control limits.

There is only one metric, relating to “Freedom to Speak up” (FTSU), where it has been agreed that no target / benchmark is provided for 2025/26 financial year and as a result no “Pass”, “Fail” or “Random” assurance level can be provided

- **Variation Levels**:
  - *Special Cause*: 13 metrics show consistent improvement; 5 show decline.
  - *Expected/Common Cause*: 35 metrics show typical variations.

There are seven metrics that have less than 15 months of data and are provided as run charts. No assurance has been provided for these.

Reporting of trajectories and action plan assurance are included in **Appendix 1.**

2. **Operational Performance**:
   - **Category 1 – 4 Response Times**: After several months of an improving picture, all response time metrics experienced a decline in performance in June, aligning with an increase in operational pressures.
   - **Category 1 Response Times**: National target of 7 minutes remains unachievable without process redesign.
   - **Category 2 Response Times**: The mean target of 30 mins has been achieved for the last 6 months, but has declined for the third consecutive month
   - **Category 3 – 4 Response Times**: Remain above target, Category 3 90th remains unachievable without a process redesign.
   - **Handover / Clear up**: The rate in the improvement of our average handover times has reduced and the target of 15 mins remains unachievable. This improvement has primarily been achieved due to the removal of excessive (> 60min) handovers, however, the number of patients experiencing a handover > 15mins has increased. Clear up times remain as expected and within target.
   - **Patient Outcomes**: Hear & Treat (HT%), See & Treat (ST%) and See, Treat & Convey to ED (STC-ED%) are all related. The uplift in HT%, which has delivered to the QTR 1 target has been achieved at the expense of ST%. STC-ED% continues to deliver as expected but the target remains unachievable
   - **999 Call Centre:** Call answer and abandonment rate are consistently delivering against target and as expected.
   - **111 Services**: All metrics continue to operate as expected, however, % call back remains unachievable without a process redesign.
   - **Vehicles Off Road (VOR)**: Metric continues to deliver as expected and in line with trajectory
   - **Patient Transport Service (PTS)**: Following the exit from the Sussex and Thames Valley contracts at the end of March and the re-baselining of data, there has been three months of delivery above the SLA target for call answer. All other metrics are operating as expected.

3. **Quality & Safety**:
   - **Clinical AQI’s**: These metrics are provided 5 months in arrears and reflect the Trust performance in February 2025. These AQI’s have a high dependency on our Category 1 and 2 response times and all metrics, whilst remaining within expected parameters, are now delivery at or better than the Target.
   - **Safeguarding:** Both Level 1 (all Staff) and Level 3 (patient facing staff) continue to deliver in line with target

- **Hand hygiene & Vehicle Cleaning:** Compliance with target continues to be stable, whilst the number of audits completed continues to fluctuate within expected parameters.
- **Patient Safety:** The Trust continues to monitor its response to Patient Safety via PSIRF, however, there remain insufficient data points to provide a view on assurance.

4. **People**:
   - There is a continuation of the positive trends in both the percentage of **BAME staff** and **staff with disabilities**.
   - **Whole Time Equivalents** (WTE) has stabilised after the sharp but expected decline, following the TUPE of NEPTS staff; **Vacancy rates** have stabilised at a negative value, and the Trust remains over plan.
   - **Sickness:** In-month and long-term sickness continue to deliver as expected,
   - **Meal break and End of Shift compliance:** After 5 consecutive months of improvements, Meal break compliance has dropped, coinciding with a worsening in our Category 1 – 4 response times, but remains above expected range. The target remains unachievable without process redesign. End of Shift compliance continues to deliver as expected and on track with the targets
   - **Statutory & Mandatory training:** This metric has been removed from the IPR for this reporting period, whilst work continues to develop against revised definitions.

Upcoming Changes, Developments

- Work will commence on version 2 of the Board IPR and the initial People and Culture Committee (PACC) papers, in terms of metrics during QTR 2, for issue for the October 2025 reporting period.
- Gaps remain within the Stroke AQI data and work is on-going to back date this.
- Revised Statutory & Mandatory training metric to be incorporated into the August 2025 reporting period.

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)
The Board asked to do: • Note this paper and associated IPR document

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

Appendix 1 – Annual Action Plan Tracker – Version 2

The action tracker that follows is designed to provide assurance to the Trust Board of the following for each of the metrics included with the Integrated Performance Report (IPR):

1) A plan exists to either move from current to the improved target position or to maintain existing compliance

2) Details of the relevant Trust Sub-Committee that is providing oversight on the progress of delivery against target / trajectory and where mitigating plans are discussed and approved.

The details contained within this tracker have been based on the following:

a) Approved national, contractual, or locally agreed year end position targets. These are the targets that are included within the IPR.

b) Trajectories as per approved either:
    a. As part of the 25/26 Trust Annual plan
    b. As per detailed Tier 1 (Strategic) or Tier 2 (Tactical) programme deliverables.

It is expected that once approved this document remains unchanged for the duration of the 2025/26 Financial year.

If circumstances arise that do require the Trust to make a change to either the Targets or the Trajectories, these will be subject to a Change Control approval process and details of any updates including rationale will be documented as part of a revised version.

Abbreviations:

FPC Finance and Performance Committee

Q&S Quality and Safety Committee

PACC People and Culture Committee

Internal References:

1. Strategic Framework Annual Plan – Board April 2025
2. IPR Target & Trajectory documentation

Operations Performance – 999 Response Times / Utilisation

Metric	Target	Trajectory	Sub-Committee
Cat 1 mean [1]	0:07:00	2025/26	FPC

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	EOY
00:08:33	00:08:52	00:08:45	00:09:04	00:08:57	00:08:52	00:08:59	00:08:48	00:08:51	00:08:47	00:08:51	00:08:35	00:08:49

Metric	Target	Trajectory	Sub-Committee
Cat 1 90th %ile [1]	0:15:00	2025/26	FPC

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	EOY
00:17:58	00:18:40	00:18:23	00:19:07	00:18:51	00:18:39	00:18:55	00:18:32	00:18:37	00:18:28	00:18:37	00:18:03	00:18:34

Metric	Target	Trajectory	Sub-Committee
Cat 2 mean [1]	0:30:00	2025/26	FPC

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	EOY
00:26:19	00:30:32	00:28:46	00:33:32	00:31:41	00:30:21	00:32:05	00:29:37	00:30:10	00:29:16	00:30:10	00:26:44	00:29:49

Metric	Target	Trajectory	Sub-Committee
Cat 2 90th %ile [1]	0:40:00	2025/26	FPC

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	EOY
00:51:00	00:59:40	00:56:02	01:05:51	01:02:02	00:59:18	01:02:51	00:57:48	00:58:55	00:57:05	00:58:55	00:51:52	00:58:27

Metric	Target	Trajectory	Sub-Committee
Cat 3 90th %ile [1]	2:00:00	2025/26	FPC

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	EOY
04:25:39	05:37:39	05:07:26	06:28:54	05:57:18	05:34:30	06:04:06	05:22:09	05:31:22	05:16:10	05:31:22	04:32:52	05:27:27

Metric	Target	Trajectory	Sub-Committee
Cat 4 90th %ile [1]	3:00:00	2025/26	FPC

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	EOY
05:22:51	06:43:52	06:09:52	07:41:31	07:05:59	06:40:19	07:13:38	06:26:26	06:36:47	06:19:42	06:36:47	05:30:59	06:32:24

Metric	Target	Trajectory	Sub-Committee
% Vehicles off the road [1]	23%	2025/26	FPC

QTR 1	QTR 2	QTR 3	QTR 4
40%	35%	25%	15%

Metric	Target	Trajectory	Sub-Committee
Average Handover[1]	0:15:00	2025/26	FPC

Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
00:20:00	00:20:56	00:20:18	00:18:48	00:19:56	00:21:08	00:20:47	00:19:52	00:22:02	00:20:33	00:18:59	00:19:16

Metric	Target	Trajectory	Sub-Committee
Handover > 15 mins	60%	Flat Trajectory	FPC
Clear up Delays	0:15:00	Flat Trajectory	FPC

Metric	Target	Trajectory	Sub-Committee
% See & Treat [2]	32.7%	2025/26	FPC

QTR 1	QTR 2	QTR 3	QTR 4
32.7%	33.0%	33.5%	33.5%

Metric	Target	Trajectory	Sub-Committee
% ST&C to ED [2]	47.0%	2025/26	FPC

QTR 1	QTR 2	QTR 3	QTR 4
47%	45%	41%	41%

Operations Performance – Clinical Co-ordination Centre / Patient Transport Service – Calls & Volume

Metric	Target	Trajectory	Sub-Committee
999 Call answer [1]	0:00:10	Flat trajectory =< 10 seconds (0:10:00)	FPC
999 Abandonment Rate	2.0%	Flat Trajectory	FPC
% Hear & Treat [1]	14.5%	2025/26 QTR 1: 14.5% | QTR 2: 16.0% | QTR 3: 18.0% | QTR 4: 18.0%	FPC
111 Call answer [1]	95%	2025/26 Apr: 67..9% | May: 61.0% | Jun: 88.1% | Jul: 97.9% | Aug: 98.5% | Sep: 95.2% | Oct: 94.1% | Nov: 95.4% | Dec: 97.2% | Jan: 83.9% | Feb: 93.2% | Mar: 97.9%	FPC
111 Abandonment Rate	3.0%	Flat Trajectory	FPC
111 Call backs	95%	Flat Trajectory	FPC
Calls answered (PTS)	90%	Flat Trajectory	FPC
Number of calls (PTS)	6672	Flat Trajectory	FPC
% Patients arrived in time	87%	Flat Trajectory	FPC
% Patients collected in time	87%	Flat Trajectory	FPC
PTS volume – no. of journeys	23,414	Flat Trajectory	FPC
No. of patients transported	5332	Flat Trajectory	FPC

Quality & Safety – Core measures

Metric	Target	Trajectory	Sub-Committee
PSI Low / no harm incidents	450	Flat Trajectory	Q&S
Monthly PSII	3	Flat Trajectory	Q&S
Monthly PSILR	9	Flat Trajectory	Q&S
PSII Cases > 6 months	0	Flat Trajectory	Q&S
Datix incidents	15	Flat Trajectory	Q&S
CD Unaccounted for losses	2	Flat Trajectory	Q&S
Level 1 Safeguarding	95%	Flat Trajectory	Q&S
Level 3 Safeguarding	90%	Flat Trajectory	Q&S
Complaints	37	Flat Trajectory	Q&S
Complaints in time	95%	Flat Trajectory	Q&S
No. Hand hygiene audits	261	Flat Trajectory	Q&S
Hand hygiene %	95%	Flat Trajectory	Q&S
No. Vehicle audits	167	Flat Trajectory	Q&S
Vehicle audit %	90%	Flat Trajectory	Q&S

People – WTE, Availability, Staff Compliance, Staff Welfare

Metric	Target	Trajectory	Sub-Committee
Number of WTE	3,753	Flat Trajectory	PACC
% Turnover	17.7%	Flat Trajectory	PACC
% Vacancy	0.2%	Flat Trajectory	PACC
Time to hire - days	84	Flat Trajectory	PACC
% Trust staff who are BAME	8.86%	Flat Trajectory	PACC
% Trust staff declared disabled	9.54%	Flat Trajectory	PACC
% Sickness in month	6.2%	Flat Trajectory	PACC
% Long term sickness	3.5%	Flat Trajectory	PACC
% DBS	95%	Flat Trajectory	PACC
Appraisals - Trust	95%	Flat Trajectory	PACC
% Stat & Mand training	95%	Flat Trajectory	PACC
FTSU cases	No target	No target	PACC
Meal Break compliance - SCAS	85%	Flat Trajectory	FPC
Over-runs> 30 mins - SCAS	15%	Flat Trajectory	FPC

NHS
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Integrated Performance Report: Jun-25



Executive Summary

Operational Performance

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

Safety and Quality

People

Executive Commentary :

Finance :

The national reporting on Ambulance response times for June shows SCAS as 8th for cat 1, 5th for cat 2 mean, 5th for cat 2 90th, 10th for cat 3 90th and 10th for cat 4 90th. These are all a deterioration from May and reflective of the actions taken to reduce operational hours back to the levels within our annual plan. Operational hours were 0.05% below the planned levels (-92hours). The contracts for two of our private providers terminated on the 29th June with circa 61 staff coming to SCAS via TUPE. This has further increased our establishment levels to circa 85 above planned levels, and we are working through options with each individual staff member during our consultation period with them. June response demand was 4.6% below forecasted levels which provided a positive impact on cat 2 of 4 minutes 52 seconds. Category 2 performance was 29:38 which was 52 seconds above target. We do however remain on target for year to date delivery.

Operational Performance :

We remain the lowest performing trust for 999 call answer with a deterioration in June of 1 second to an 11 second mean. Call demand was 7.7% above planned levels which was driven in part by a rise in duplicate calls and we exported 727 calls to other Trusts, an increase of 200 calls from May. The team continue to focus on reducing average handling time and effective management of the contact centre including meal break management. We have an agreement in principle with SECAMB for them to take some of our calls at peak periods which will improve SCAS performance and ensure patients have their calls answered quicker and we hope to have this in place by the end of July. AACE have also secured agreement with NHSE to continue the IRP process for 999 calls with London Ambulance service hosting the platform and 9 out of 10 English trusts contributing to the cost. We are also presenting the ORH review findings to EMC in July which provides a revised establishment requirement to reduce our mean call answer to 5 seconds, however we need to identify how this will be funded. Our Hear and Treat has increased further to 16.9% which is 2.4% above plan and 5th highest in the national table. This is a key priority to continue to support increasing H&T to reduce response demand. See and treat improved slightly 30.5%, however remains below target, with our performance benchmarking well nationally with the 3rd highest S&T rates.

We have seen a slight decrease in the category 1 contribution from our CET resources with a 6 second decrease in contribution to 27 seconds. There is a marginal decrease in the level of responses by 1.1%, however these resources arrived at scene first on 71% of category 1 calls that they are dispatched to. We are working with EOC teams to ensure we maintain coverage on the indirect resource desk to support a more effective dispatch of these vital resources.

Executive Commentary :

Quality & Safety:

1. Patient Safety Incidents (PSIs)

-98% of patient safety incidents reported remain Low or No Harm Incidents. No special cause variation is detected.

1.2% (5) patient safety incidents were associated with a potential for high harm. Three were delay in attendance and two were recontact following discharges on scene. We have an ongoing thematic review looking at delays and we have commissioned a new thematic review into patients needing to re contact our services. We will report the finding and learning to Exec management Committee and Q&S Committee and take actions to reduce the risk of harm to our patients. One cross organizational Patient Safety Incident investigation has been initiated this month into a maternity incident.

2. Safeguarding

- Level 1 and Level 3 Safeguarding referrals show no special cause variation and both meet the targets showing stable situation currently.

3.Complaints Handling

- Complaints responded to within timeframes are remains on target but there is a re-emerging theme caused by delays in attendance being seen in some of the recent complaints. Patient Safety teams are feeding the issues into the daily clinical governance reviews as we address the reasons for the delays.

4. Hand Hygiene Compliance

- Audit completion rates and compliance percentages are both within control limits, but we failed to meet the target in the number of hand hygiene audits required. The IPC and team leaders are undertaking additional audits at EDs to ensure we capture as many staff as possible rather than depend on station based audits.

5. Vehicle Audits

- Audit completion and compliance rates were just below target but within control limits. No special cause variation is observed. Joint auditing is ongoing with Make Ready to ensure standards are understood and met.

People:

Whole Time Equivalent (WTE) has continued to reduce due to attrition with recruitment paused in 999 operations and PTS. Forecasting of the workforce is taking place in order to manage reduced turnover and manage staff who have transferred into operations.

Sickness absence and long term absence is above target in 111 and PTS. However, Trust absence levels are at expected levels.

DBS compliance improved to 97.8%, exceeding the 95% target, reflecting the improvement programme carried out by the People directorate.

There is a decline in Performance Development Review (PDR) completion, reflecting operational pressures within 999 operations. However compliance rates within corporate services are significantly reduced, potentially due to impact of corporate restructure

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) .

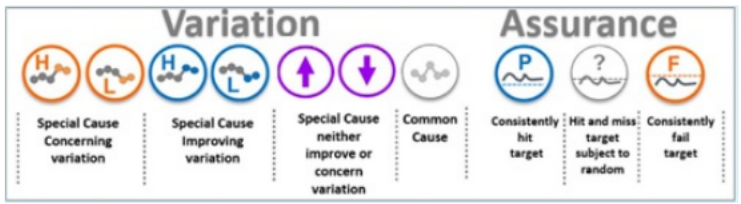
4) A run of 6 consecutive ascending or descending values (a trend).

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







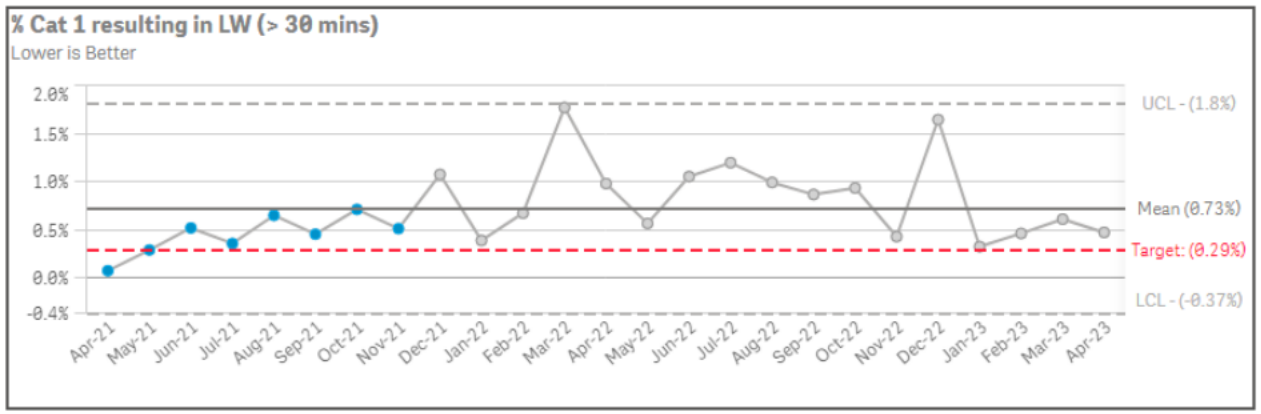
	Pass	Hit and Miss	Fail	No Target
	Special cause of an improving nature where the measure is significantly HIGHER.This process is capable and will consistently PASS the target.	Special cause of an improving nature where the measure is significantly HIGHER.This process will not consistently HIT OR MISS 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.

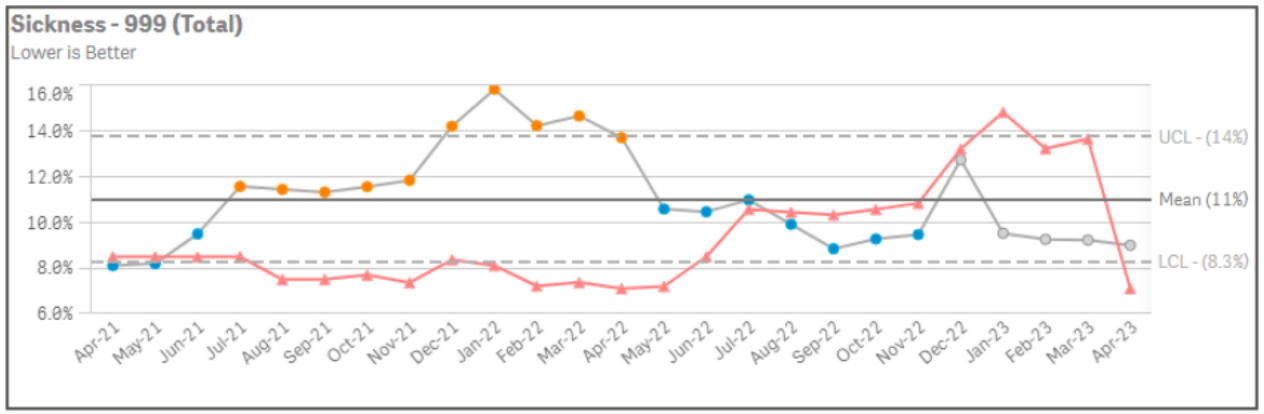
Assumptions:

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

June-25 Summary

Assurance →

Variance ↓

	Fail	Hit and Miss	Pass	No Target
H		% Arrival at hospital to handover >15mins		
L		S&T - SCAS	Number of WTE	
	111 Call back < 20 min Appraisals - Trust Cat 3 90th %ile SCAS	31	Clear up Delays - SCAS Safeguarding Adults Level 1	
L	% Vacancy Average Hospital Handover Time - SCAS Cat 1 Mean SCAS ST&C (ED 1&2) - SCAS	999 Calls abandoned % Cat 1 90th %ile SCAS Number of reported CD incidents – unaccounted for losses		
H	% Trust staff who are BAME Meal Break Compliance - SCAS PTS - Calls answered in 60 seconds	% Trust staff who are declared disabled H&T - SCAS Safeguarding Level 3		
↗				
↘				

Metrics:

Hit and Miss Common Cause Metrics:
% Long term sickness ; % Sickness in month ; % Turnover ; 111 Calls abandoned after 30 secs % ; 111 call answer in 120 Secs % ; 999 Mean Call Answer Time ; Cardiac Arrest Survival at 30 Days - All Patients ; Cardiac Arrest Survival, Utstein ; Cat 2 90th %ile SCAS ; Cat 2 Mean SCAS ; Cat 4 90th %ile SCAS ; Complaint Responses in time ; Hand Hygiene audit ; Number of Complaints ; Over-runs >30 mins - SCAS ; PTS Call Volume ; PTS Volume - No. of Journeys ; PTS Volume - No. of Patients Transported ; Patients Arrived within time ; Patients Collected within time ; Percentage of compliant Hand Hygiene audits ; Percentage of compliant Vehicle cleanliness audits ; Return On Spontaneous Circulation (ROSC) on Hospital Arrival - All Patients ; Return On Spontaneous Circulation (ROSC) on Hospital Arrival - Utstein Cohort ; STEMI - Call to angiography 90th Centile ; STEMI Call to angiography - Mean ; Stroke - Call to Hospital arrival 90th Centile ; Stroke - Call to Hospital arrival Median ; Stroke Call to Hospital arrival - Mean ; VOR - Total ; Vehicle cleanliness completed audits

NHS

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Operational Performance

NHS Operational Performance Overview

June-25 Summary

Assurance →

Variance ↓

	Fail	Hit and Miss	Pass	No Target
H		% Arrival at hospital to handover >15mins		
L		S&T - SCAS		
	111 Call back < 20 min Cat 3 90th %ile SCAS	12	Clear up Delays - SCAS	
L	Average Hospital Handover Time - SCAS Cat 1 Mean SCAS ST&C (ED 1&2) - SCAS	999 Calls abandoned % Cat 1 90th %ile SCAS		
H	PTS - Calls answered in 60 seconds	H&T - SCAS		
↗				
↘				

Metrics:

Hit and Miss Common Cause Metrics:
111 Calls abandoned after 30 secs % ; 111 call answer in 120 Secs % ; 999 Mean Call Answer Time ; Cat 2 90th %ile SCAS ; Cat 2 Mean SCAS ; Cat 4 90th %ile SCAS ; PTS Call Volume ; PTS Volume - No. of Journeys ; PTS Volume - No. of Patients Transported ; Patients Arrived within time ; Patients Collected within time ; VOR - Total

Operations - Response Times/Utilisation/Operations Centre

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Cat 1 Mean	Jun-25	00:08:36	00:07:00			00:08:48	00:08:01	00:09:35
Cat 1 90th %ile	Jun-25	00:15:30	00:15:00			00:15:57	00:14:37	00:17:16
Cat 2 Mean	Jun-25	00:29:38	00:30:00			00:28:53	00:20:39	00:37:07
Cat 2 90th %ile	Jun-25	00:56:56	00:40:00			00:56:05	00:39:13	01:12:57
Cat 3 90th %ile	Jun-25	05:46:01	02:00:00			05:33:00	02:15:08	08:50:52
Cat 4 90th %ile	Jun-25	06:57:04	03:00:00			06:52:05	02:25:32	11:18:38
% Vehicles off the road	Jun-25	42%	40.0%			39.7%	32.6%	46.7%
Ave Handover	Jun-25	00:17:15	00:15:00			00:21:06	00:17:12	00:25:00
Handover > 15mins	Jun-25	51%	40.0%			45.4%	38.8%	52.0%
Clear up Delays	Jun-25	00:14:18	00:15:00			00:14:04	00:13:40	00:14:28
% See and treat	Jun-25	31%	32.7%			32.1%	31.0%	33.2%
% ST&C to ED	Jun-25	49%	47.0%			49.9%	48.3%	51.5%
999 Call Answer	Jun-25	00:00:11	00:00:10			00:00:11	00:00:04	00:00:18
999 Ab. Rate	Jun-25	2.3%	2.0%			2.6%	1.7%	3.5%
% Hear and treat	Jun-25	17%	14.5%			14.5%	12.7%	16.3%
111 Call Answer	Jun-25	81%	95.0%			77.5%	56.3%	98.7%
111 Ab. Rate	Jun-25	3.4%	3.0%			3.6%	-0.6%	7.8%
111 Call backs	Jun-25	43%	95.0%			41.1%	28.1%	54.1%

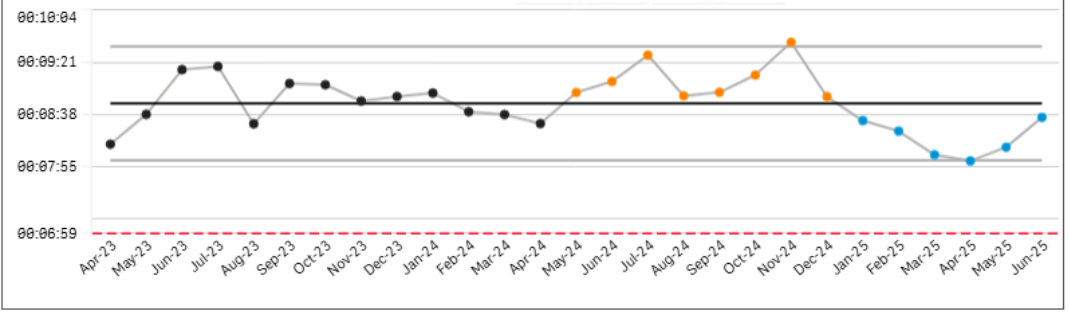
Operations - PTS Calls and Outcomes

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Calls Answered (PTS)	Jun-25	91%	90%	H	F	57.8%	26.7%	88.9%
Number of calls (PTS)	Jun-25	7,309	6,672			6,731.6	4,574.62	8,888.58
% Patients arrived in time	Jun-25	88%	87%			87.7%	83.3%	92.1%
% Patients collected in time	Jun-25	85%	87%			85.8%	83.8%	87.9%
PTS Volume - No. of Journeys	Jun-25	21,756	23,414			21,602.5	18,255.4	24,949.7
Number of Patients Transported	Jun-25	5,249	5,332			5,149.85	4,507.9	5,791.79

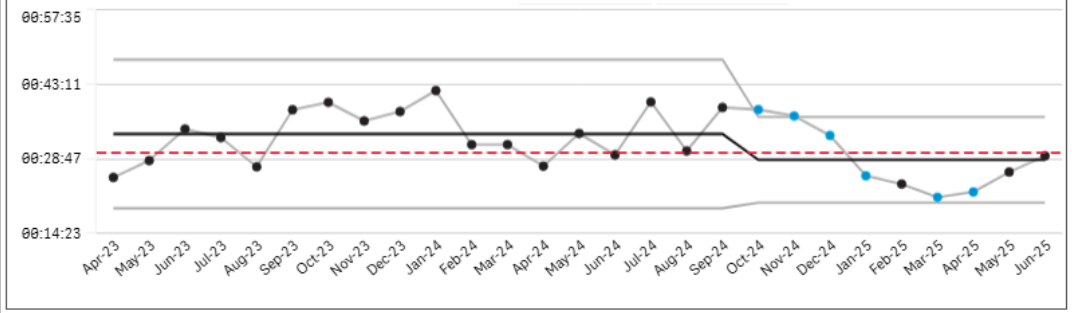
Operations - Response Times

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



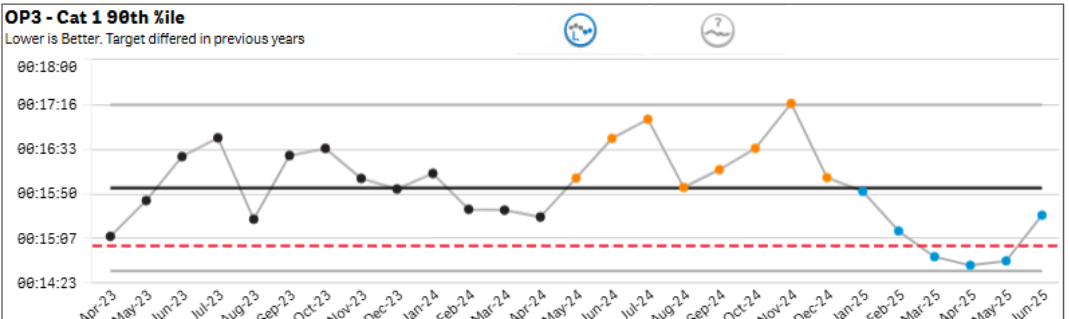
Variation	Assurance	Target	Latest
Improving	Fail	00:07:00	00:08:36

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



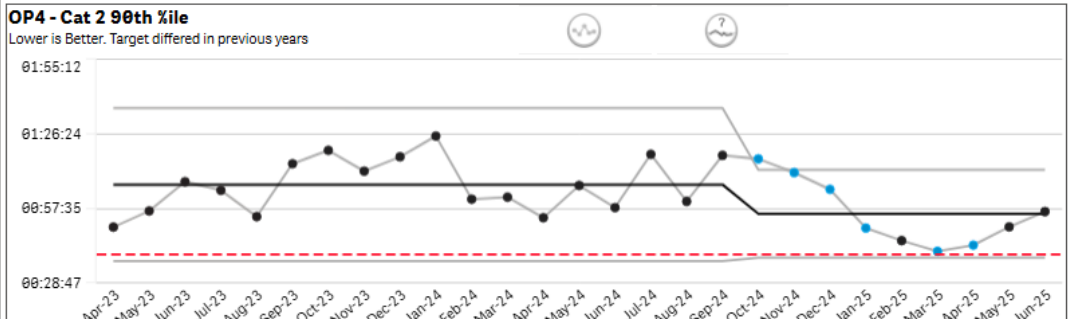
Variation	Assurance	Target	Latest
Expected	Random	00:30:00	00:29:38

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



Variation	Assurance	Target	Latest
Improving	Random	00:15:00	00:15:30

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



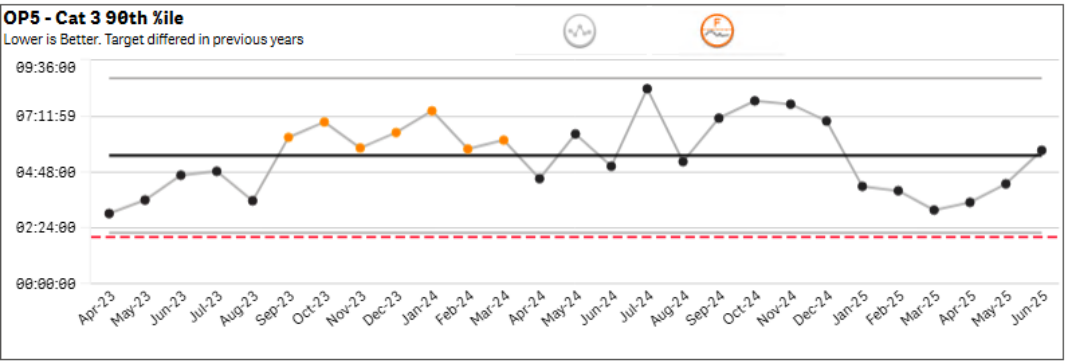
Variation	Assurance	Target	Latest
Expected	Random	00:40:00	00:56:56

Understanding the Performance:
Cat 1 increased on last month. Remaining within expected variation but failing to meet target. Cat 2 also increased however remained within target.
Performance was positively impacted by
Demand 4.6% below plan.
H&T above trajectory at 16.9 %

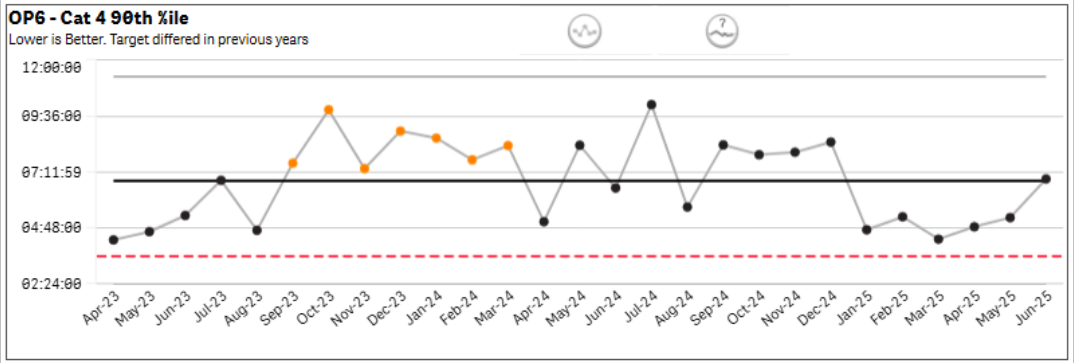
Actions (SMART):
-Focus on maintaining financial controls against new budget
- Delivery of CIPs
-Continued support of R2R
-Focus on Clinical recruitment into CSD to support delivery of the H&T trajectory

Risks:
-Establishment Pressure
-Continued delivery of R2R
-Delivery of CIPs to ensure delivery of the annual plan.

Operations - Response Times



Variation	Assurance	Target	Latest
Expected	Fail	02:00:00	05:46:01



Variation	Assurance	Target	Latest
Expected	Random	03:00:00	06:57:04

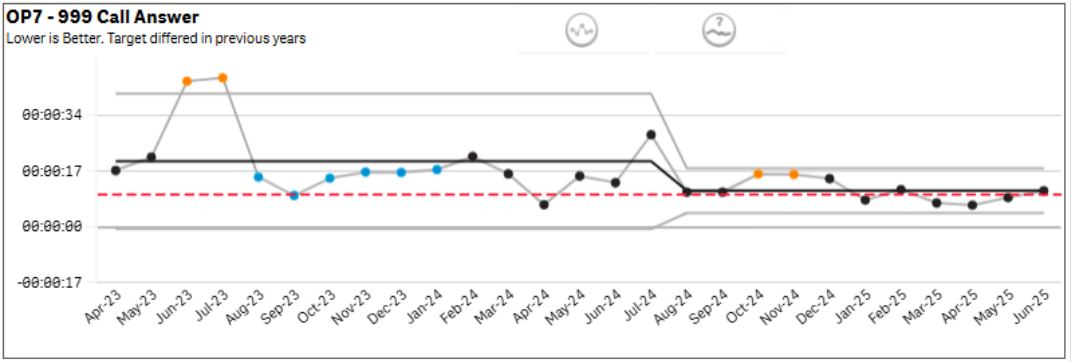
Understanding the Performance:
Both Cat 3 and Cat 4 saw an increase which took them above the mean. Both remained within the expected variance but failed to mee the target.

Actions (SMART):
-SP Model focused on Cat £&$
-Recruitment of CSD staff to support increased H&T
- Development of clinically lead dispatch model
-Delivery of the HIOW SPOA to provide alternative response to sending an ambulance to Cat 3&4

Risks:
Ability to recruit and train sufficient clinical staff to CSD to support improved H&T

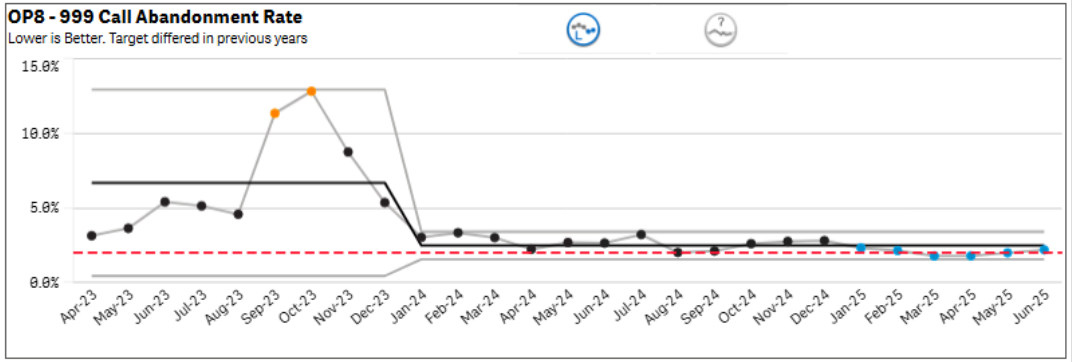
Operations - Operations Centre

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



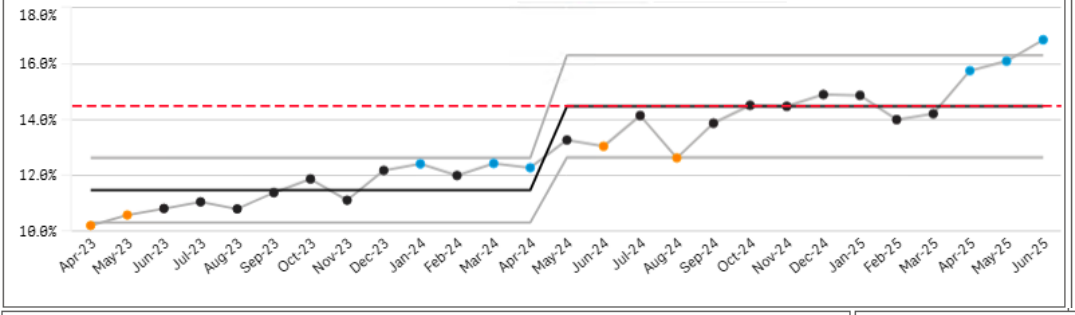
Variation	Assurance	Target	Latest
Expected	Random	00:00:10	00:00:11

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



Variation	Assurance	Target	Latest
Improving	Random	2.0%	2.3%

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



Variation	Assurance	Target	Latest
Improving	Random	14.5%	16.9%

Understanding the Performance:

Demand in June exceeded expectations, rising 7.7% above planned levels and showing an 8.4% year on year increase. This surge in demand placed pressure on key operational metrics, with OP7 and OP8 both holding steady at their respective means. Mean call answer on target at 10 seconds, and abandonment just creeping outside at 2.3%. A key contributor to the increased demand was a rise in duplicate calls, largely driven by imbalanced ambulance resource availability. As ambulance capacity became constrained and delays increased, hear and treat rate rose significantly, reaching 16.9% for June, pushing OP9 above the control limit. Despite these challenges, all performance metrics remained above trajectory levels, reflecting the ongoing improvements and resilience within CCC.

Actions (SMART):

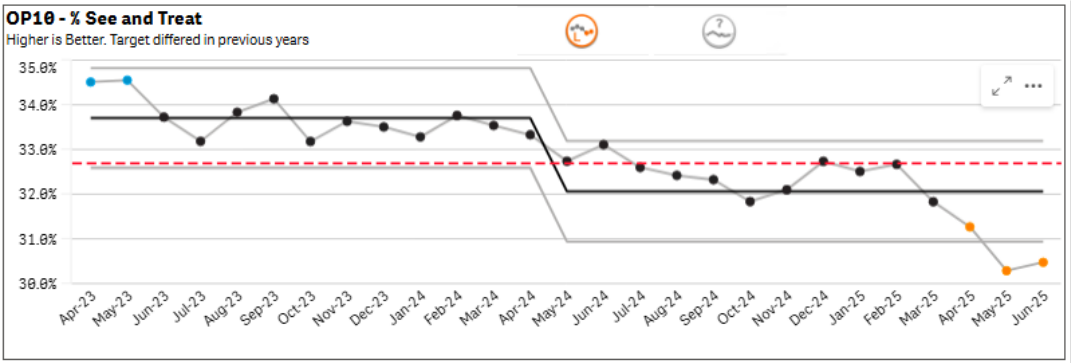
Maintain the momentum on the CCC improvement/virtual care programme, continue the weekly project meets and monthly steering group review.

- Obtain and review final report on call taking and deployment resourcing, meeting booked 15th July.
- Submit second paper to EMC (22nd July) outlining financial impact of achieving 5 second call answer mean.
- Finalise review and requirements to align staff to demand – planning and operations meeting scheduled 15th July.
- Finalise and initiate support arrangements with SECAMB, implemented by 31st July.
- Maintain clinical workforce plan with budget alignment, tracking hours against budget ongoing with monthly IWP reviews.
- Progress delayed CAD changes, agree timelines, carried forward from June actions, due to funding confirmation.

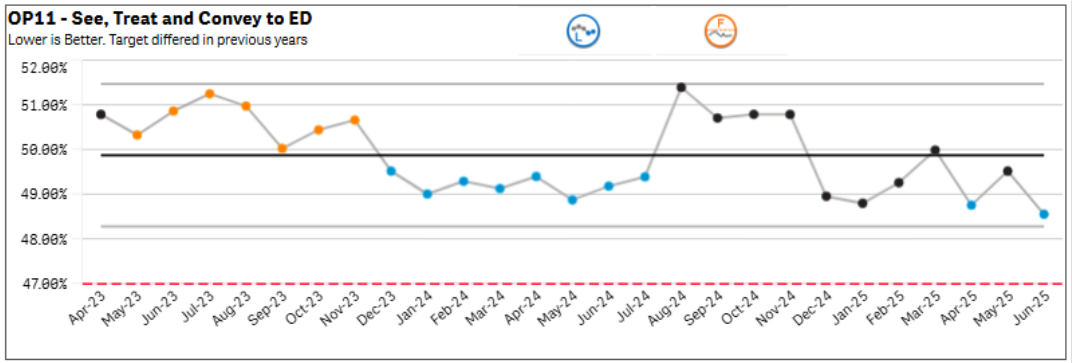
Risks:

Technical Limitations: Our current CAD and financial position may restrict our ability to implement necessary technical changes, hindering improvements in average handling time and clinical queue management.
Resource Fluctuations: Variations in demand or reductions in staffing levels could prevent us from maintaining KPIs at targeted levels.
Category 2 Performance: A decrease in cat2 performance may lead to an increase in duplicate calls beyond planned demand, impacting our ability to sustain call answer performance at target levels.
Financial pressures: ongoing financial pressures may limit the ability to offer overtime and bank shifts resulting in challenges in rota fill and reduced capacity, which may impact our ability to meet rising demand and maintain performance standards.

Operations - Utilisation



Variation	Assurance	Target	Latest
Declined	Random	32.7%	30.5%



Variation	Assurance	Target	Latest
Improving	Fail	47%	48.6%

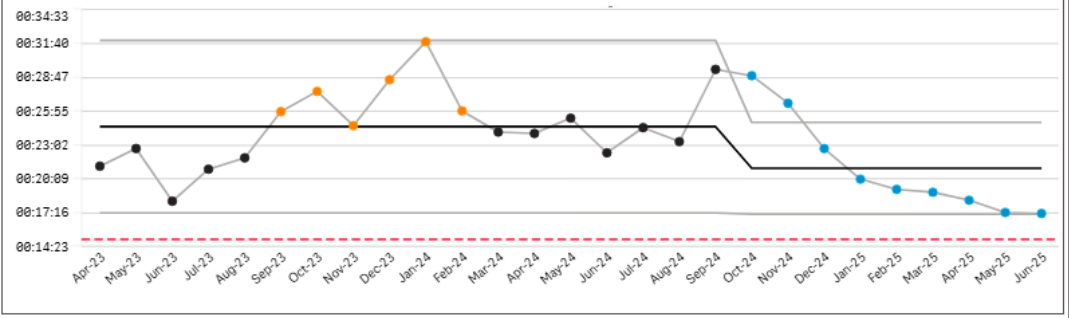
Understanding the Performance:
S&T is showing a special cause variation of a concerning nature where the measure is significantly lower than target. This is in line with the continued improved performance from H&T. ST&C to ED Transfers: This pathway demonstrates special cause variation of an improving nature where the measure is still below target. It is unlikely that this process will do anything other than fail without a redesign. It is worth noting this measure has improved through June even with a significant shift in acuity of incidents.

Actions (SMART):
The Clinical Pathways team will collaborate with acute and community services to identify and implement improvements that enhance access to appropriate care pathways for patients who do not require ED. Completion of a joint pathway review and gap analysis and published quarterly. This action will be led by the Clinical Pathways team, with support from local operational teams. This initiative supports system-wide objectives to reduce ED pressure, improve patient experience, and ensure timely access to the most appropriate care setting.

Risks:
S&T and STC to ED are both linked to the performance of H&T. These measures should be looked at as a collective and we should monitor conveyance to NON ED destinations as a measure of getting patients in to the most appropriate department.

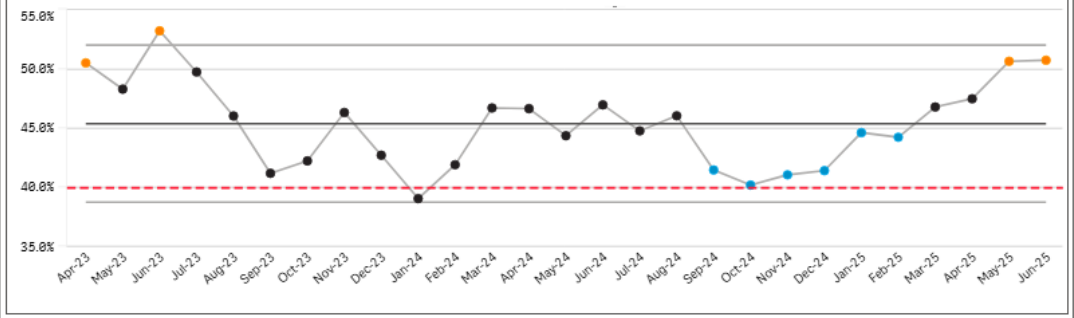
Operations - Utilisation

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



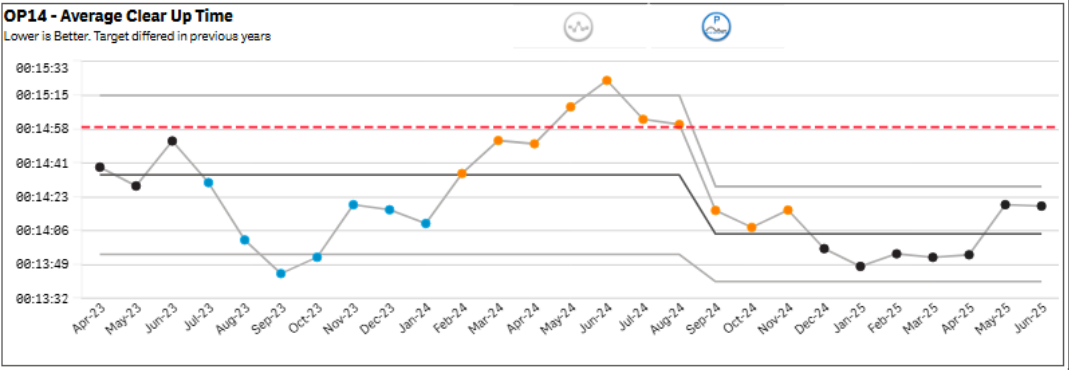
Variation	Improving
Assurance	Fail
Target	00:15:00
Latest	00:17:15

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



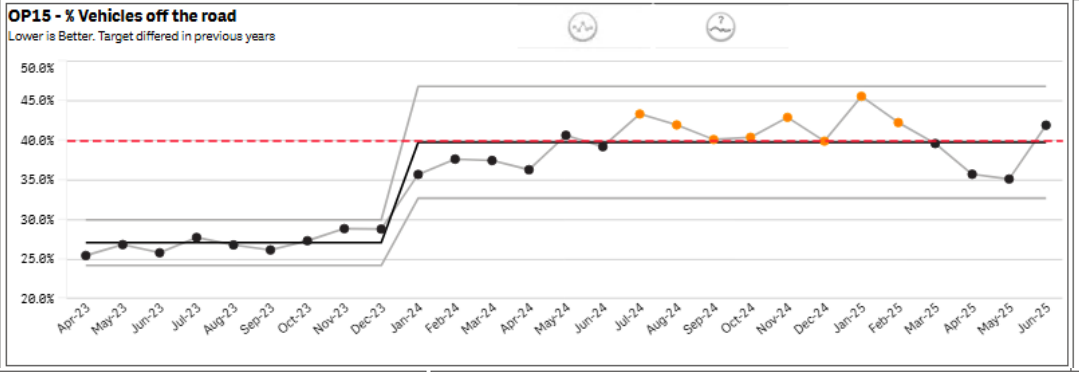
Variation	Declined
Assurance	Random
Target	40%
Latest	50.8%

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



Variation	Expected
Assurance	Pass
Target	00:15:00
Latest	00:14:18

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



Variation	Expected
Assurance	Random
Target	40%
Latest	41.8%

Understanding the Performance:

OP13 -%Arrival at hospital to handover >15 mins is showing special cause variation of a concerning nature with the measure significantly above target.

OP12 - Average hospital handover time is showing a special cause of an improving nature yet still failing the target. This is still with 9 consecutive points of improvement.

Op14- Clear up delays are showing common cause variation with little change and is consistently achieving the target.

Actions (SMART):

OP13 - The shift in performance linked to this has been raised and discussed with commissioners at PIIM and a message to acutes was to focus on achieving the 15min handover standard.

OP12 is monitored through various lenses starting with ODPR and then through to PMAF. Key focus for the area teams to work with acutes to maintain this improving picture with the aim of achieving 15mins.

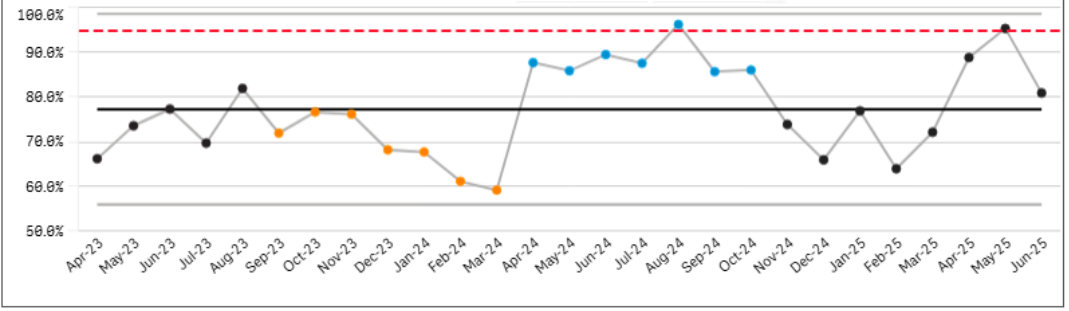
OP14 - is monitored through the same governance meetings as handover delays and the local teams are focused on what is in our direct control to influence.

Risks:

An increase in clear up and handovers will have an increased impact on patient care due to a reduction in available resource to respond.

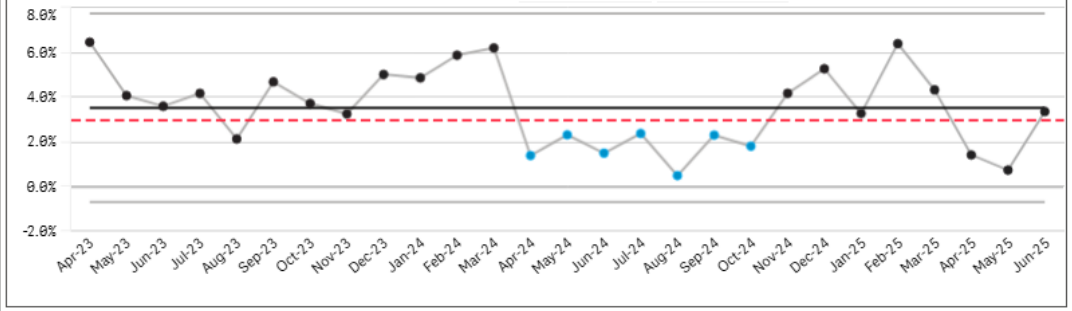
Operations - Operations Centre

OP16 - 111 Call Answer
Higher is Better. Target differed in previous years



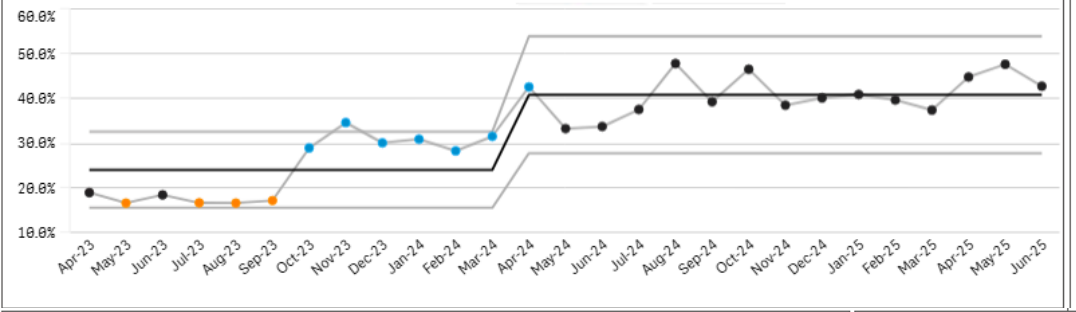
Variation	Expected
Assurance	Random
Target	95%
Latest	81.1%

OP17 - 111 Call Abandonment Rate
Lower is Better. Target differed in previous years



Variation	Expected
Assurance	Random
Target	3%
Latest	3.4%

OP18 - 111 Call Back Percentage
Higher is Better. Target differed in previous years



Variation	Expected
Assurance	Fail
Target	95%
Latest	43.0%

Understanding the Performance:

OP 16, call answer in 120 secs, in June was 81%, below the national target of 95%, with OP 17, call abandonment rate after 30 secs, at 3.4% which is below the mean but just off the national 3% target. The reduction of overtime and bank hours for Health Advisors has impacted performance whilst we align our rotas with our demand and financial deficit. OP 18, call back within 20 mins, is 43% for June which is steady although this is an unachievable target, this is due to the DX codes that fall into this category, the primary care demand 'in hours' resulting in patient demand falling into 20 min call backs from refused dispositions due to inability to contact GP's. This is a national issues with all providers, discussions have taken place at the provider forum with NHSE to challenge.

Actions (SMART):

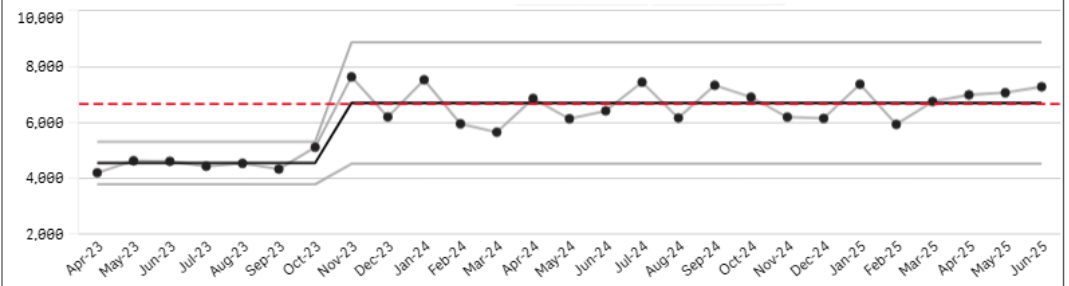
- Implementation of the text messaging interim care advice on 24th June 2025 as part of the work around decreasing AHT
- Work continues daily to embed the new text messaging interim care advice with quality assurance coaches working with individual staff to improve usage and confidence, monitoring of usage continues with daily reports from Adastra being produced and shared with staff.
- Plans continue to progress with NHSE around the implementation of National Language Process with a goal to implement this in September/October ahead of the planned January CIP. This will result in further decrease in average handling time
.- Recruitment continues with a steady flow with full courses in MK during July, work has commenced on winter recruitment planning with bi weekly meetings.

Risks:

Risk in the reduction of Health Advisor overtime and bank hours to align rotas within financial restraints challenging service delivery and performance.

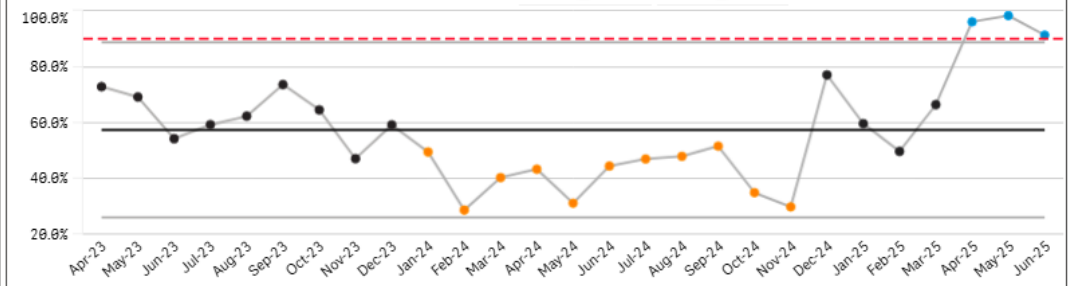
Operations - PTS - Calls and Outcomes

OP19 - PTS Call Volume
Higher is Better. Target differed in previous years



Variation	Expected
Assurance	Random
Target	6,672
Latest	7,309

OP20 - PTS Calls Answered in 90 Seconds
Higher is Better. Target differed in previous years



Variation	Improving
Assurance	Fail
Target	90%
Latest	91.4%

Understanding the Performance:

Despite there being a slight increase in inbound calls. Third consecutive month with Call Answer performance achieving above the threshold with June's outturn achieving 91.45% aggregated threshold for calls answered in 90 seconds.

Actions (SMART):

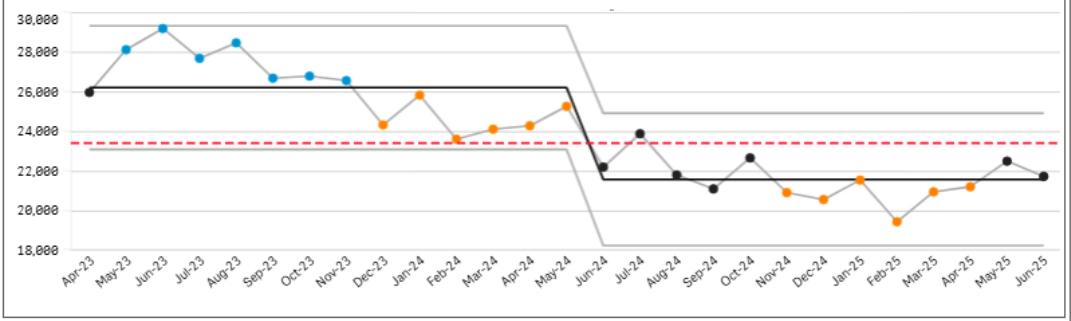
- Contact Centre operating hours adjusted in line with contract obligations to 0800-2000 Monday – Sunday. New Call Handler rota launched 14th April 2025. One member of staff remains in the consultation process due to be resolved week commencing 7th July 2025.
-Telephony Journey Confirmations continue to capture any patients that are not travelling that have failed to inform us therefore reducing abortive journeys on the day.

Risks:

- Above WTE headcount for Call Handling by 3.84 WTE, with a further 4 operational re-deploys with the contact centre.

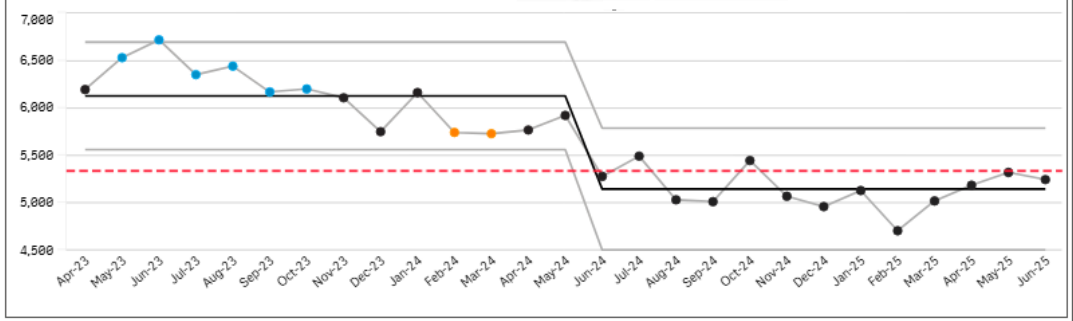
Operations - PTS - Calls and Outcomes

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



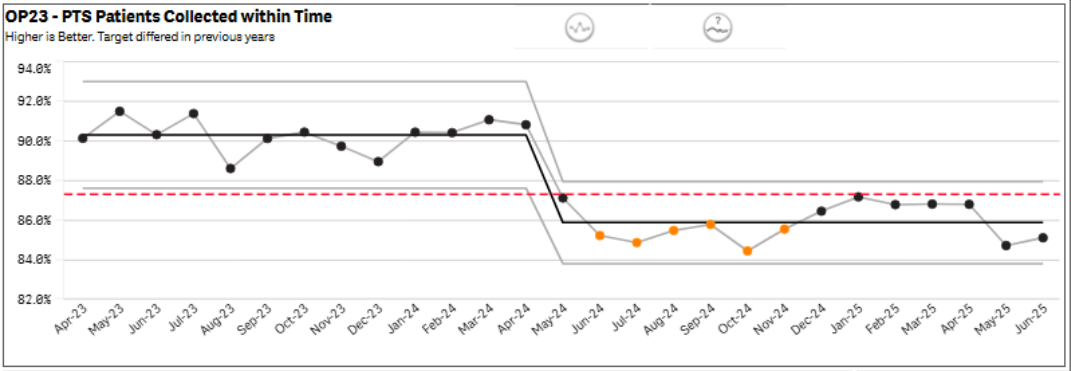
Variation	Assurance	Target	Latest
Expected	Random	23,414	21,756

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



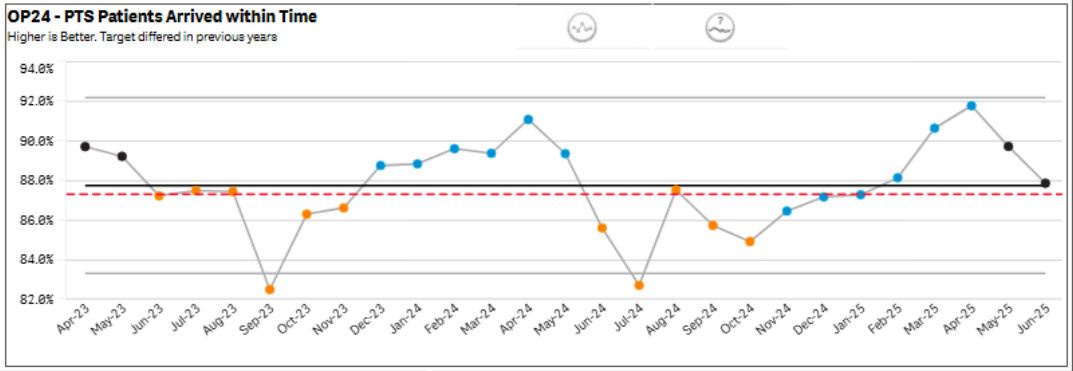
Variation	Assurance	Target	Latest
Expected	Random	5,332	5,249

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



Variation	Assurance	Target	Latest
Expected	Random	87%	85.1%

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



Variation	Assurance	Target	Latest
Expected	Random	87.3%	87.8%

Understanding the Performance:

- The activity cap was removed from cleric on the 19th June for the Hampshire contract. However, the cap remains in place for the Milton Keynes contract. Whilst the cap was lifted it is expected to take around 14-28 days for any additional activity to flow through due to the booking window.
- The forecasted hours continue to be reviewed weekly, performance for inbound journeys remained on par with previous month and the outturn for the month of June remained above the mean.
- Outbound KPI also remained on par with previous month.

Actions (SMART):

- Continue to monitor daily demand, hours, resource utilisation and performance
- Focus remains on increasing of cohorting and utilisation of resource as per the finance recovery action plan.
- Confirmation needed on what is included in the HIOW cap if all activity (in contract and ECR activity) this is so we are reporting on correct figures to the ICB.

Risks:

- Close monitoring of Hampshire activity required to ensure that it does not reach above capacity therefore impacting on patient movements, performance, financial pressures and reputation damage.
- MK contract dispute negotiations continue, initial meeting held week commencing 30.6.25

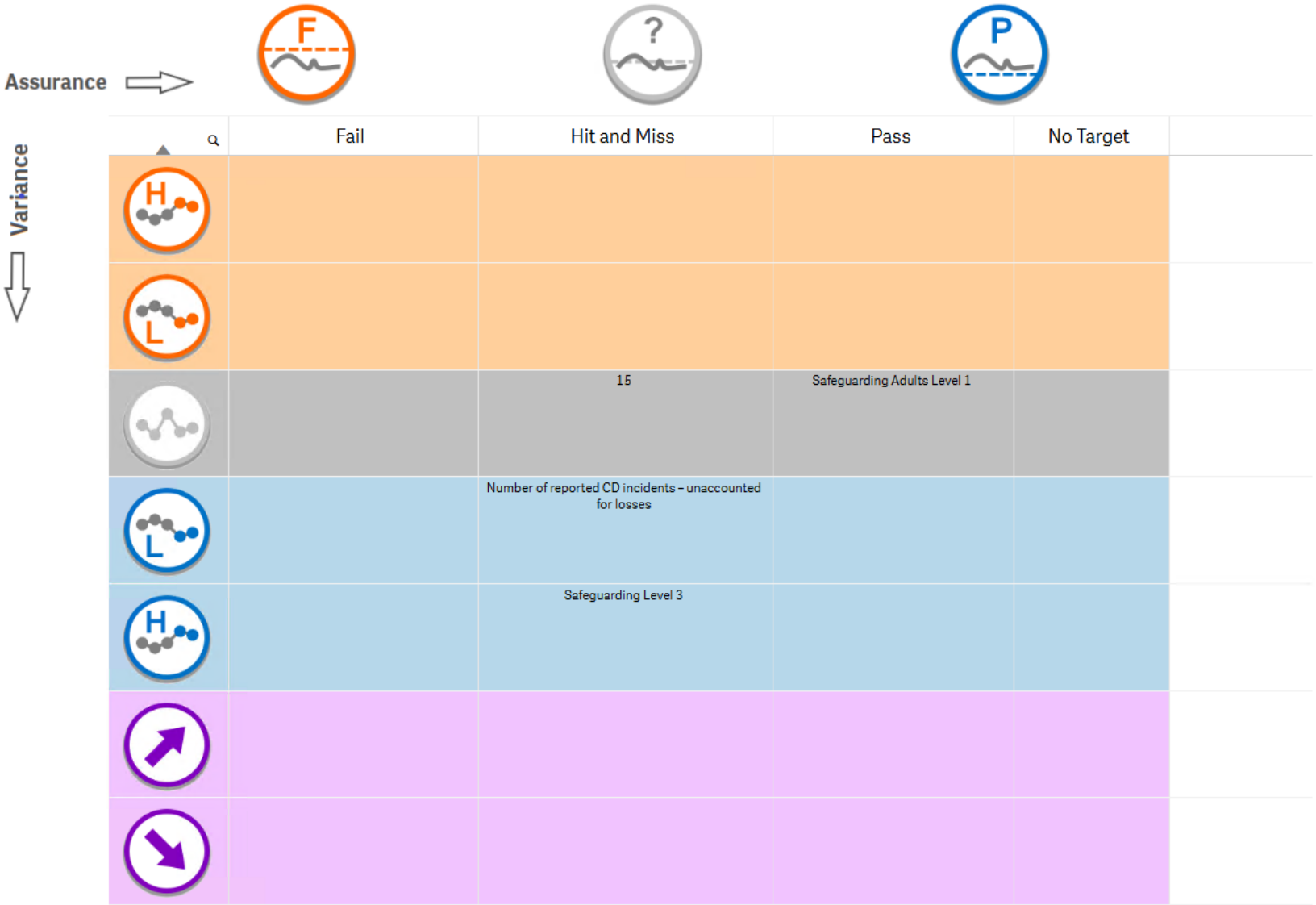
NHS

NHS
South Central
Ambulance Service
NHS Foundation Trust

Quality and Safety

Quality & Safety – Core Measures Matrix

June-25 Summary



Metrics:

Hit and Miss Common Cause Metrics:
Cardiac Arrest Survival at 30 Days - All Patients ; Cardiac Arrest Survival, Utstein ; Complaint Responses in time ; Hand Hygiene audit ; Number of Complaints ; Percentage of compliant Hand Hygiene audits ; Percentage of compliant Vehicle cleanliness audits ; Return On Spontaneous Circulation (ROSC) on Hospital Arrival - All Patients ; Return On Spontaneous Circulation (ROSC) on Hospital Arrival - Utstein Cohort ; STEMI - Call to angiography 90th Centile ; STEMI Call to angiography - Mean ; Stroke - Call to Hospital arrival 90th Centile ; Stroke - Call to Hospital arrival Median ; Stroke Call to Hospital arrival - Mean ; Vehicle cleanliness completed audits

Quality Safety– Core Measures Icon Summary

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
PSI Low/no harm inc.	Jun-25	391	450	-	?	440	332	548
Monthly PSII	Jun-25	1	3	-	?	2.4	-3.11	7.91
Monthly PSILR	Jun-25	10	9	-	?	8.67	-6.34	23.7
PSII Cases > 6 mths	Jun-25	0	0	-	?	0.267	-1.25	1.79
Datix incidents	Jun-25	9	15	-	?	35.7	-21.8	93.2
CD unaccounted for losses	Jun-25	0	2	L	?	3.76	0.171	7.35
Level 1 Safeguarding	Jun-25	96.5%	95%	~	P	96.7%	96.1%	97.3%
Level 3 Safeguarding	Jun-25	93.6%	90%	H	?	91.4%	89.5%	93.3%
Complaints	Jun-25	30	37	~	?	33.6	9.31	57.8
Complaints in time	Jun-25	97.0%	95%	~	?	0.955	0.841	1.07
Hand Hygiene Audits Completed	Jun-25	198	261	~	?	221	-9.36	452
Hand Hygiene % Compliance	Jun-25	100.0%	95%	~	?	94.4%	74.8%	114.0%
Vehicle Audits Completed	Jun-25	160	167	~	?	143	19	266
Vehicle Audits % Compliance	Jun-25	89.4%	90%	~	?	89.4%	69.7%	109.1%

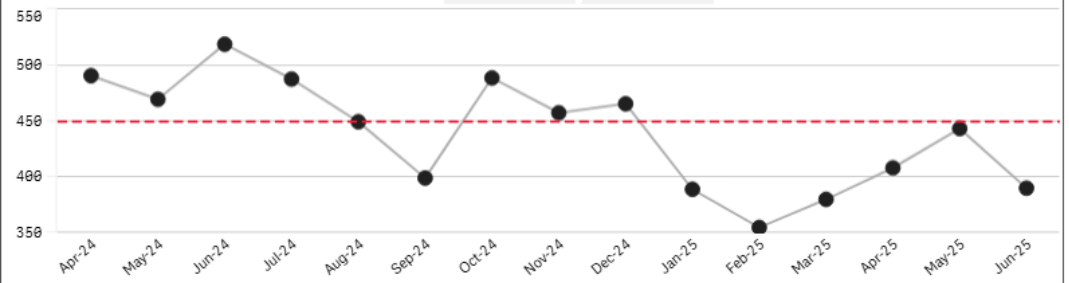
Quality Safety– Ambulance Quality Indicators (AQIs)

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
STEMI Mean	Feb-25	01:57:00	02:30:00			02:17:57	01:53:02	02:42:51
STEMI 90th	Feb-25	02:40:00	03:20:00			03:24:00	02:03:06	04:44:53
Stroke Mean	Feb-25	01:26:00	01:30:00			01:35:36	01:15:56	01:55:15
Stroke Median	Feb-25	01:14:00	01:20:00			01:21:57	01:10:34	01:33:19
Stroke 90th	Feb-25	02:11:00	02:30:00			02:24:46	01:49:04	03:00:29
ROSC All	Feb-25	24.7%	25.8%			25.5%	13.5%	37.6%
ROSC Utstein	Feb-25	74.2%	48.4%			51.6%	22.3%	81.0%
CA Survival All	Feb-25	9.8%	8.9%			9.0%	0.7%	17.4%
CA Survival Utstein	Feb-25	41.9%	20.6%			31.5%	8.9%	54.0%

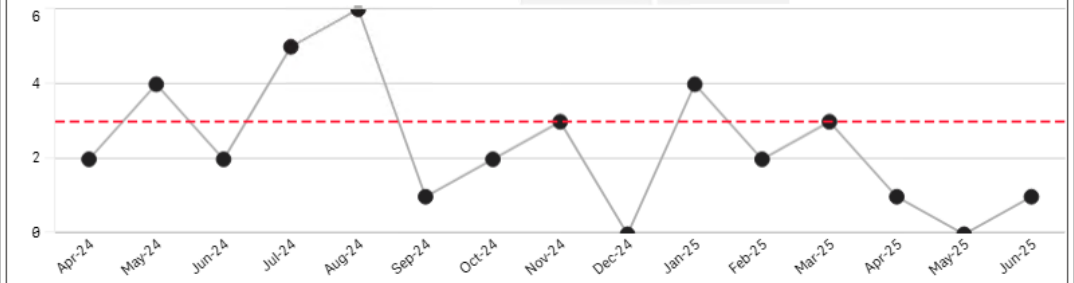
Quality & Safety – PSIRF

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



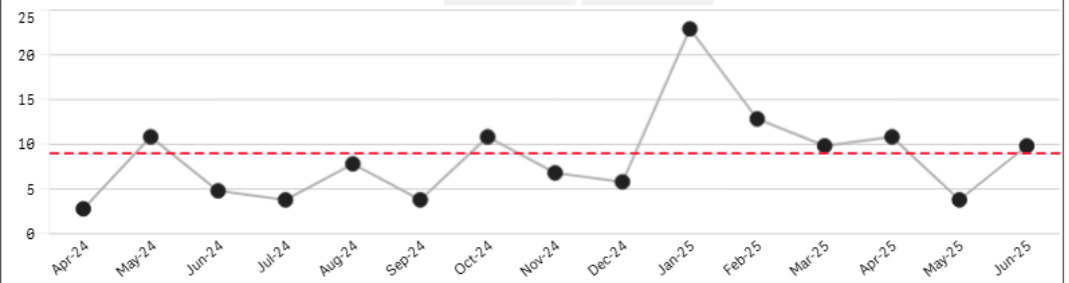
Variation	-
Assurance	Random
Target	450
Latest	391

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



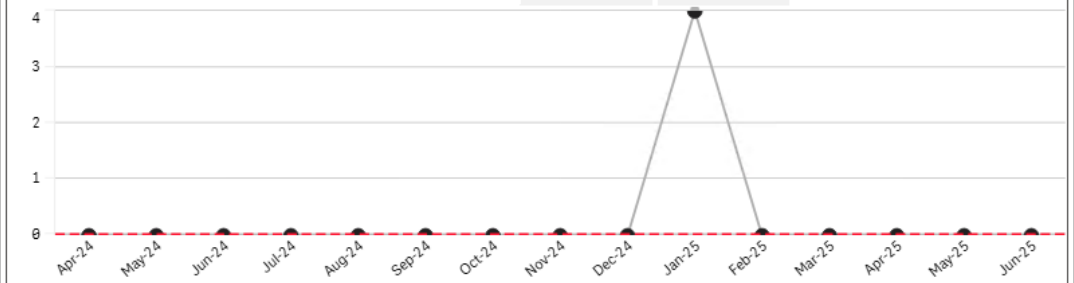
Variation	-
Assurance	Random
Target	3
Latest	1

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



Variation	-
Assurance	Random
Target	9
Latest	10

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



Variation	-
Assurance	Random
Target	0
Latest	0

Understanding the Performance:
Please note that PSIs are live incidents, which are constantly under review and therefore subject to change.

QS1 – The majority of PSI reported remain low/no harm; there were 5 PSI reported as high harm (5 of 414 = 1.2%):
- Three delays.
- Two recontacts following discharge on scene.

Categories for declared PSII:
- Cross-organisational PSII – maternity care. This case has been referred to MNSI who are reviewing.

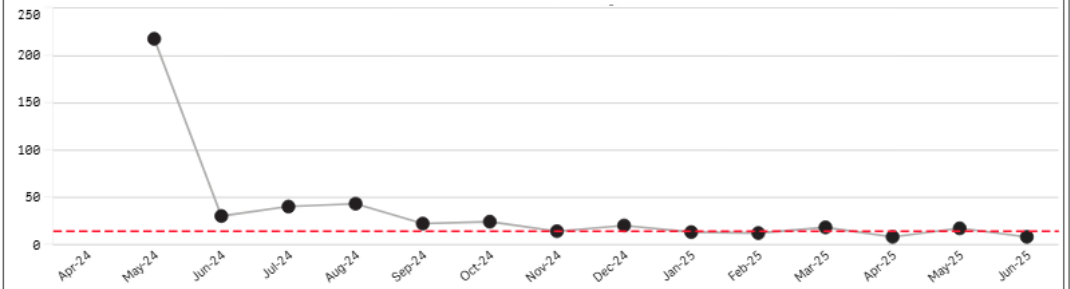
Actions (SMART):
QS1 – Delays
- Two have been referred for benchmarking against the delays' thematic analysis.
- One will be reviewed at SRP in July 2025

Recontacts
- One for EPR review and dependent on the outcome of this may come to SRP in July 2025.
- One has been allocated a swarm huddle, which will be reviewed at SRP in July 2025.

Risks:
QS1 – If the reasons behind the increase in PSIs involving delays are not understood, new learning could be missed and patients may come to avoidable harm.

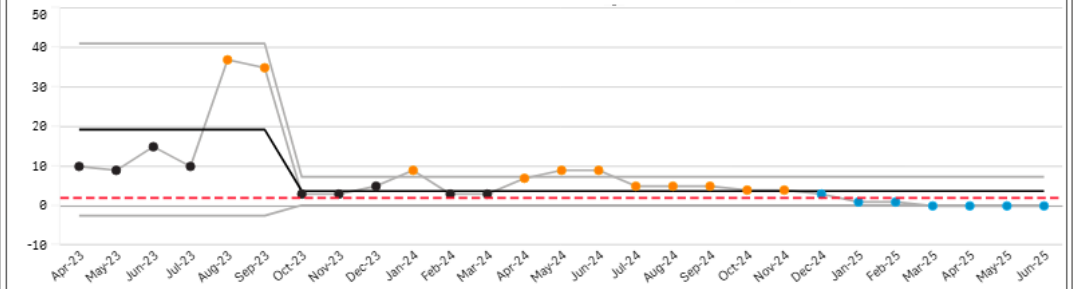
Quality & Safety – PSIRF

QS5 - Overdue Datix Incidents
Lower is Better. Target differed in previous years



Variation
-
Assurance
Random
Target
15
Latest
9

QS6 - CD unaccounted for losses
Lower is Better. Target differed in previous years



Variation
Improving
Assurance
Random
Target
2
Latest
0

Understanding the Performance:

QS6 illustrates the monthly volume of unaccounted losses of Controlled Drugs (CDs) as reported through the DATIX/CDLIN system. The established target is less than 2 unaccounted losses per reporting cycle. Analysis of the data indicates the target has been consistently met, reflecting effective control measures. Notably, since the transition to REAP2 in March, reported CD losses have reduced to zero and maintained at this level, showcasing effective governance and accountability within SCAS operations

Actions (SMART):

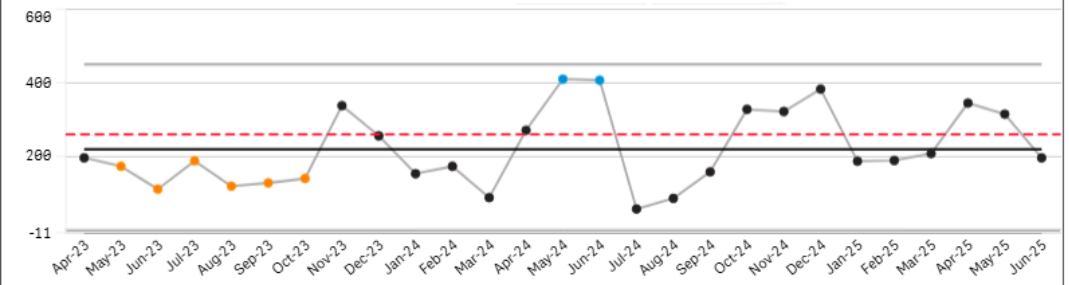
Training & Awareness
SCAS staff to be trained on CD handling and reporting procedures by Q3
Conduct mandatory refresher courses every six months reinforce documentation and reporting processes
Stock Control
Implement daily stock checks at SCAS facilities to validate CD quantities against recorded documentation by Q3
Any discrepancies identified during stock checks to be investigated in 48 hours
Enhance Reporting & Documentation
Improve DATIX, allow timely and comprehensive investigation of CD losses in reporting by Q4
Implement electronic CD registers to improve oversight by Q1 26/27
Thematic Analysis & Diversion Control
Conduct quarterly thematic analysis, identify patterns or recurring issues leading to unaccounted losses
Work with Pharmacy Team, audit CD handling aligned to trust policy

Risks:

If SCAS experiences unaccounted losses of controlled drugs this could impact on the Trust's Home Office CD licence, the availability of essential medicines for patient care is compromised, potentially leading to avoidable patient harm. Furthermore, repeated losses may indicate lapses in CD management or documentation that could trigger regulatory scrutiny. To mitigate this, enhanced training, robust stock controls, and refined reporting mechanisms are crucial. Strengthening these measures will not only maintain compliance but also safeguard patient safety and service integrity.

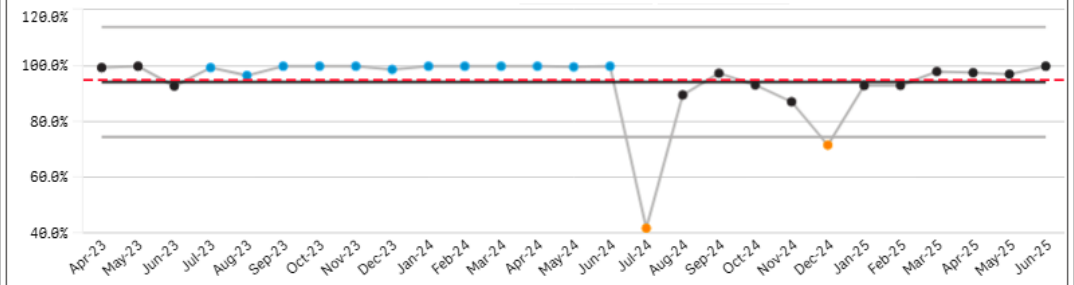
Quality & Safety - Audits

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



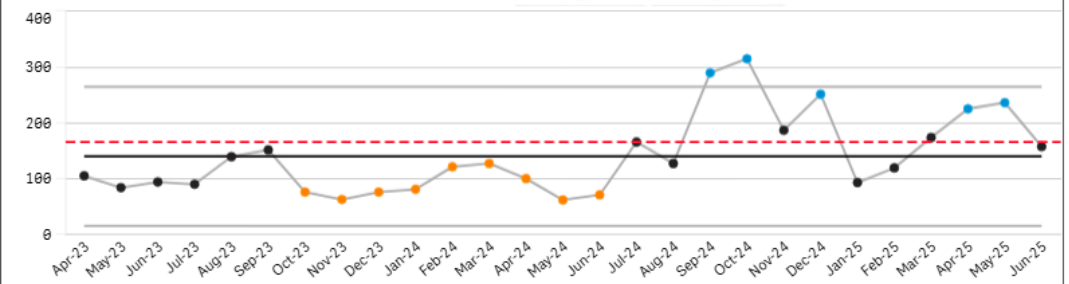
Variation	Expected
Assurance	Random
Target	261
Latest	198

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



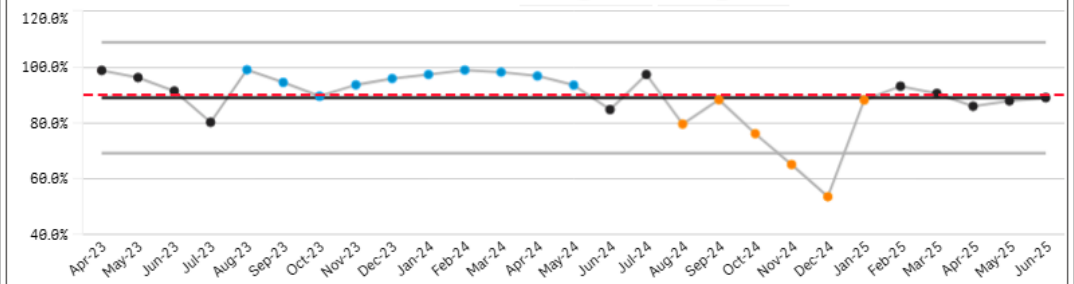
Variation	Expected
Assurance	Random
Target	95%
Latest	100.0%

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



Variation	Expected
Assurance	Random
Target	167
Latest	160

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



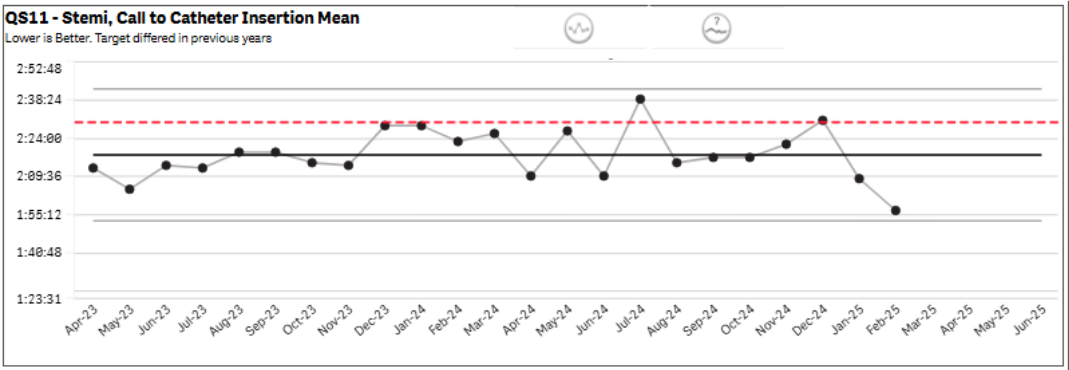
Variation	Expected
Assurance	Random
Target	90%
Latest	89.4%

Understanding the Performance:
QS7 + QS9 Common cause variation
Audits completed not consistent against plan - swings of over/under auditing
QS10 Common cause variation
Joint auditing with provider assisting with improved percentage compliant with standard.

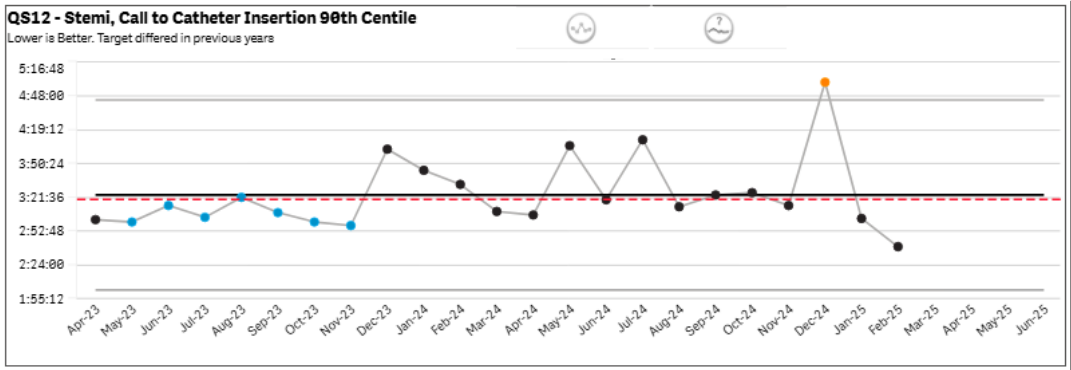
Actions (SMART):
- In July Clinical Governance meetings update by IPC lead that consistent audit numbers against plan required
- IPC specialist audits of hand hygiene at ED departments as schedule approved at IPC Committee
- Commence audit of periodic cleans in Q3 with provider.

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

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



Variation	Assurance	Target	Latest
Expected	Random	02:30:00	01:57:00



Variation	Assurance	Target	Latest
Expected	Random	03:20:00	02:40:00

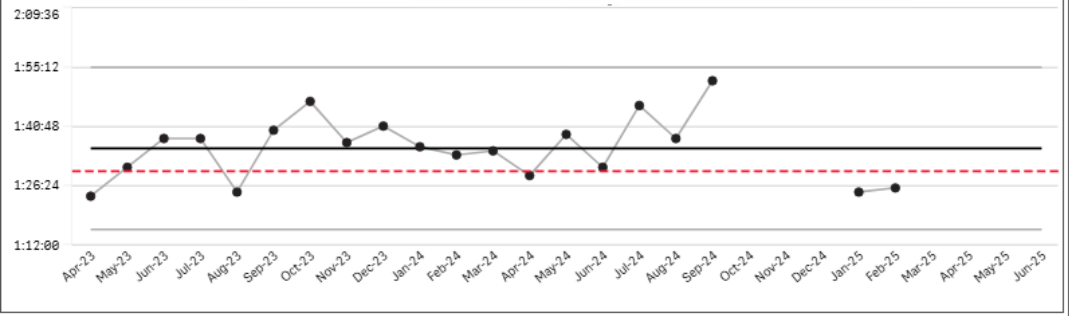
Understanding the Performance:
STEMI mean and 90th show a sustained and consistent reduction in call to catheter times in January and February 2025. Positively, SCAS are 1st of all ambulance services on STEMI mean and 2nd on 90th centile measures.
The measures are performance based and are reliant on the trust ability to quickly get to scene and the ability of the clinicians to recognise STEMI and provide the required care. It should be noted that 'Release to Respond' and the opening of the new department at QAH in December 2024 is likely to be a factor in this performance improvement.

Actions (SMART):
A poll on the Hub has identified a number of useful suggestions from our staff which will reduce on-scene times and improve patient care at the scene. A discussion paper is being taken to the July SCAS Clinical Review Group with a recommendation that we should explore individual performance reports for patients presenting with STEMI.
We need to continue to maximise vehicle availability by reducing handover delays at emergency departments and focus on Category 2 response times (OP2).

Risks:
If timely care is not provided to patients with 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 heath burden resulting in additional avoidable system pressures.

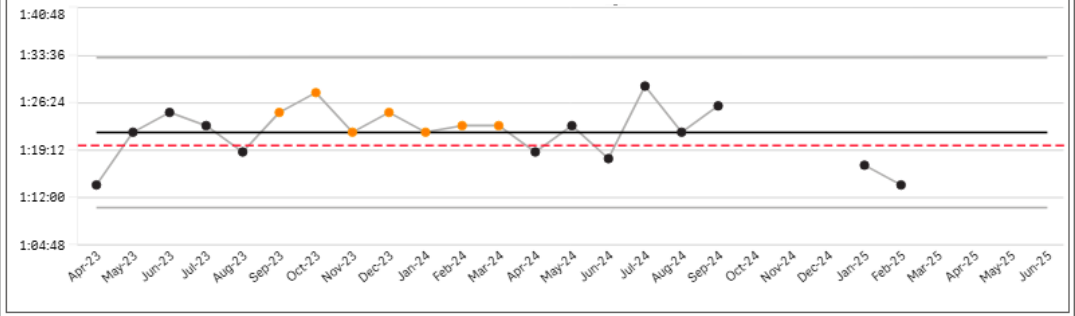
Quality & Safety – AQIs – Stroke - Chief Paramedic Officer

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



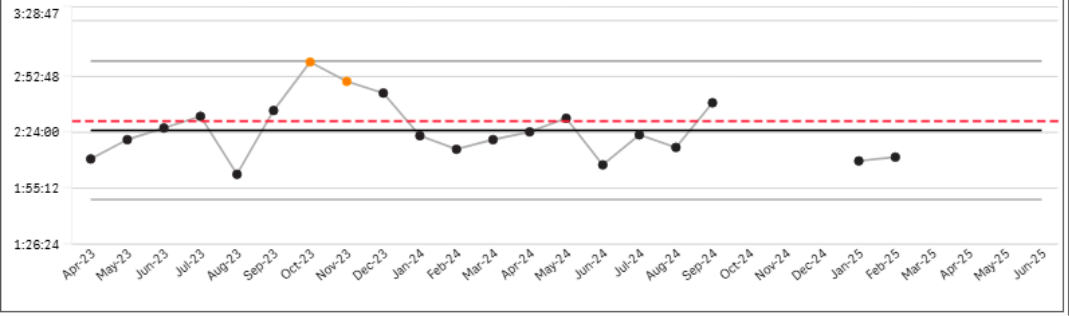
Variation	Expected
Assurance	Random
Target	01:30
Latest	01:26:00

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



Variation	Expected
Assurance	Random
Target	01:20
Latest	01:14:00

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



Variation	Expected
Assurance	Random
Target	02:30
Latest	02:11:00

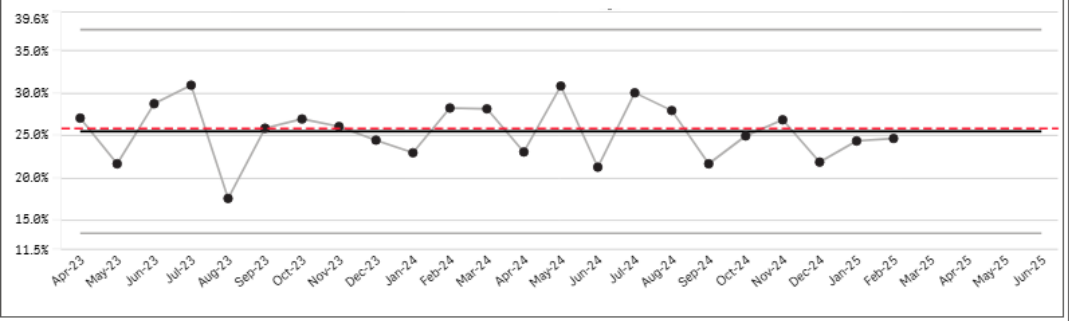
Understanding the Performance:
Due to national reporting technical issues, up to date SSNAP data was not available between the months of October to December 2024. NHSE will collect the missing data in the summer revisions period, with full reporting from September 2025. January 2025 data is now available, and shows that SCAS are below the target (good). Each of the charts is a performance based measure, and as such is reliant on the Trust's ability to identify a suitable resource, the time taken to get to the scene, and the ability of the Trust clinician to recognise a stroke and provide the required care. It also encompasses time spent on scene and time spent travelling to the hospital site.

Actions (SMART):
A poll on the Hub has identified a number of useful suggestions from our staff which will reduce on-scene times and improve patient care at the scene. A discussion paper is being taken to the July CRG with a recommendation that we should explore individual performance reports for patients presenting with Stroke.
The Trust needs to continue to maximise vehicle availability to respond by reducing handover delays at Emergency Departments and focus on Category 2 response times (OP2).

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 a stroke, then patients are at risk of increased health burden, resulting in additional avoidable system pressures.

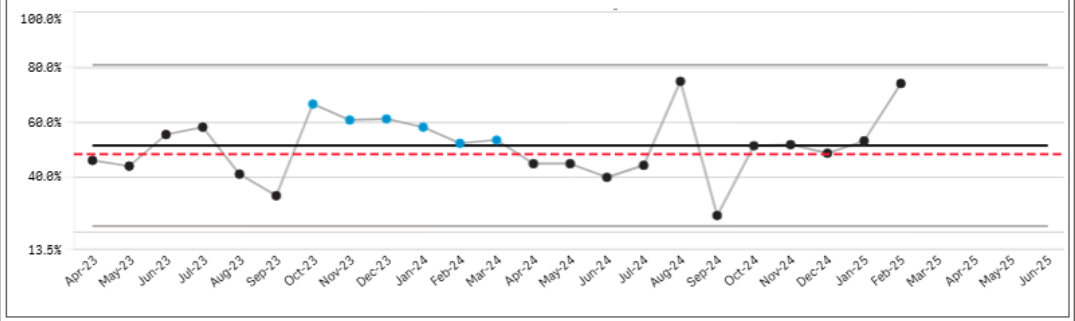
Quality & Safety – AQIs – Cardiac Arrest - Chief Paramedic Officer

QS16 - Return of Spontaneous Circulation All
Higher is Better. Target differed in previous years



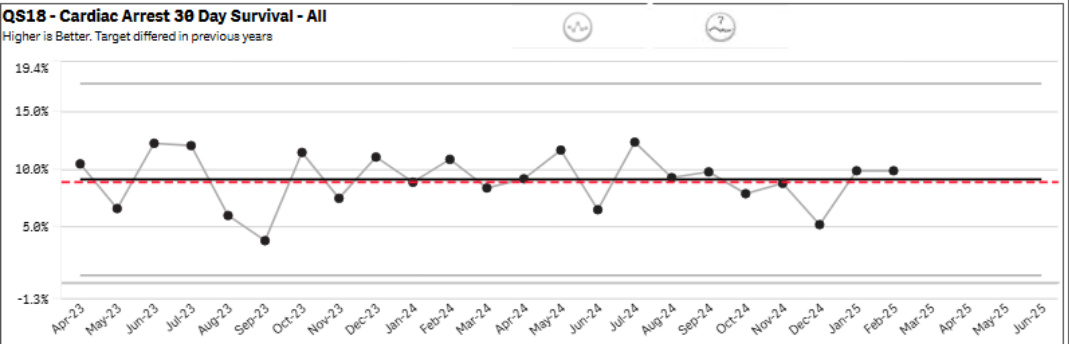
Variation	Assurance	Target	Latest
Expected	Random	25.8%	24.7%

QS17 - Return of Spontaneous Circulation Utstein
Higher is Better. Target differed in previous years



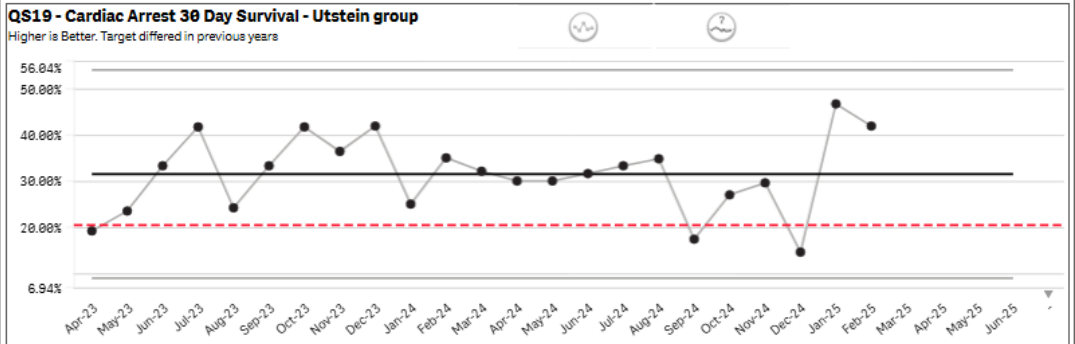
Variation	Assurance	Target	Latest
Expected	Random	48.4%	74.2%

QS18 - Cardiac Arrest 30 Day Survival - All
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	8.9%	9.8%

QS19 - Cardiac Arrest 30 Day Survival - Utstein group
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	20.6%	41.9%

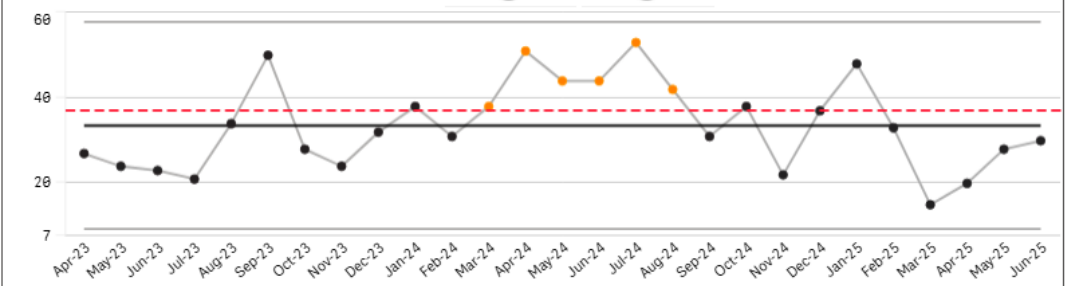
Understanding the Performance:
QS 16, 17 and 18 all show common cause variation. There has been a significant and consistent improvement in Utstein survival rates in January (46%) and February 2025 (41%) seen in QS 19.
SCAS are 1st of all ambulance services in this measure for both of January and February.
QS16,17, 18 hit and miss the target. It should be noted that 'Release to Respond' and the opening of the new department at QAH in December 2024 is likely to be a factor in this improvement measure.
Cardiac arrest metrics are reliant on identification of cardiac arrest in the community, rapid call-answering, Category 1 response times, the ability of our communities, volunteers and clinicians to enact the chain of survival through early CPR, defibrillation and resuscitative care.

Actions (SMART):
95% of clinical staff to have completed their annual resuscitation training in the annual cyclical F2F training programme.
To develop by the end of September 2025 a comprehensive resuscitation outcomes improvement plan.
Introduction of the GoodSam app, with go-live on19/6/25.
To ensure that rapid call answering occurs (OP 7) and Category 1 response times are optimised (OP 1).

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.

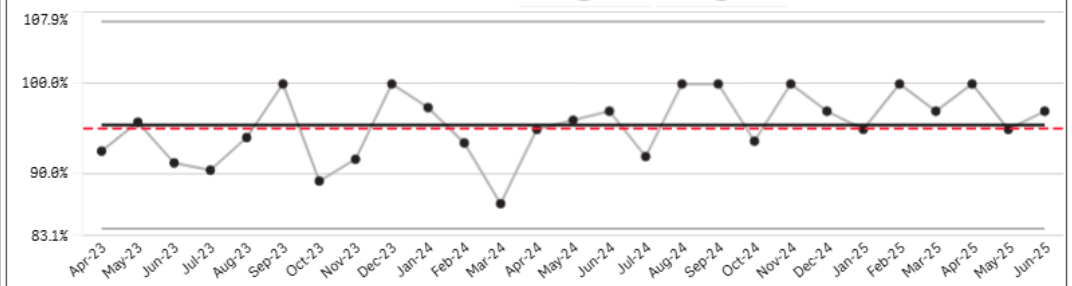
Quality & Safety – Safeguarding and Patient Experience

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



Variation	Assurance	Target	Latest
Expected	Random	37	30

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



Variation	Assurance	Target	Latest
Expected	Random	95%	97.0%

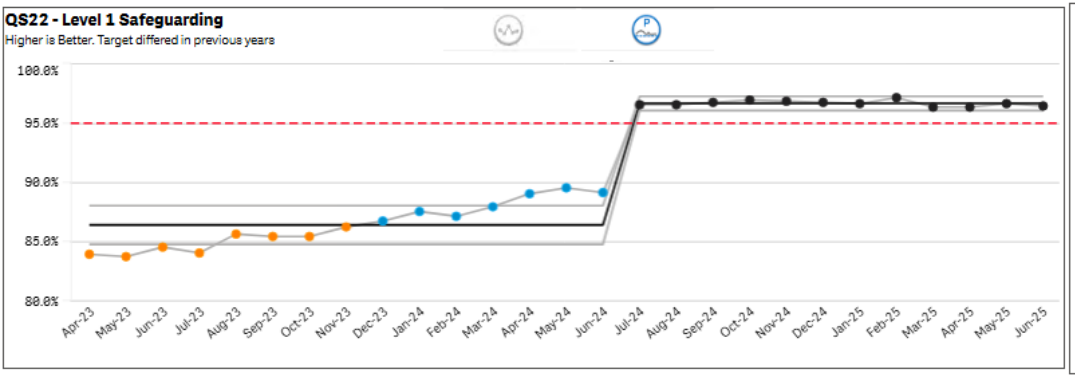
Understanding the Performance:
QS20 - Concerns increased from 48 to 77 mostly driven by concerns raised to EOC around delays; 93 compliments were received for the same period. Themes for complaints and concerns are related to delays.

Actions (SMART):
QS20 – Head of Patient Experience to work with service line leads to understand the increase noted in complaints and concerns raised; to be completed in July 2025.

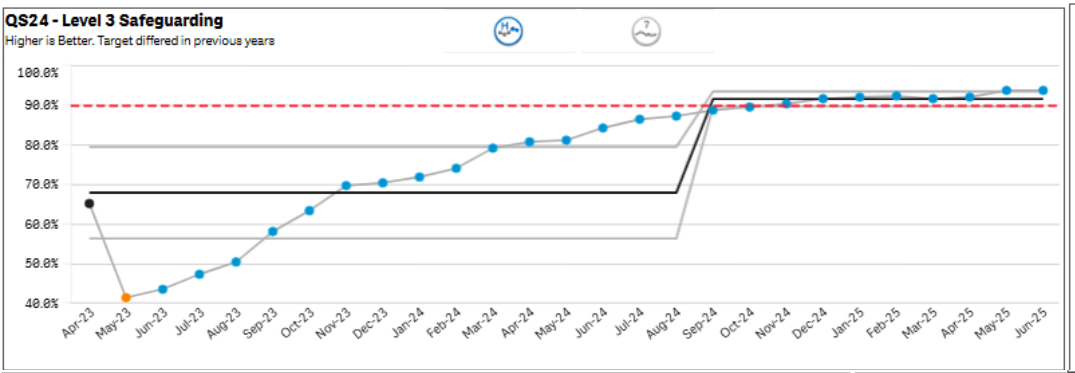
Risks:
QS20 – Non-compliance with contractual timescales.

If the reasons for an increase in complaints and concerns are not well understood then actions cannot be put in place to address them, leading to increased patient dissatisfaction.

Quality & Safety – Safeguarding and Patient Experience



Variation	Expected
Assurance	Pass
Target	95%
Latest	96.5%



Variation	Improving
Assurance	Random
Target	90%
Latest	93.6%

Understanding the Performance:

Safeguarding Level 1 training 98%. Assurance :-The latest value indicates a stable and capable process as it exceeds the trajectory set. Target is 95%, indicating the process is above target.

•Safeguarding Level 3 Training 95%. Target is 90% , indicating the process is above target. Assurance - The latest value is 95% which exceeds the trajectory of 90%, indicating the process is performing well.

Actions (SMART):

QS 21 Safeguarding Training Level 1- • Specific: Ensure all staff groups meet or exceed the 95% safeguarding training target.Maintain ≥95% compliance across all departments. Use automated training reminders and monthly compliance dashboards. Supports statutory safeguarding responsibilities and CQC standards. Sustain compliance monthly and review quarterly . QS24. Safeguarding Training Level 3- Smart Objectives • Improve Level3 safeguarding training compliance across all relevant staff groups. Achieve ≥95% compliance in all departments by 31/03/2025.Identify underperforming teams and provide targeted support or protected training time.Ensures senior staff are equipped to manage complex safeguarding cases. Reach target by the end 31/03/2025 and maintain thereafter.

Risks:

Staff may fail to recognise or respond to abuse and neglect if they lack safeguarding knowledge or have not received appropriate training while carrying out their duties

NHS

NHS
South Central
Ambulance Service
NHS Foundation Trust

People

NHS People Overview

June-25 Summary

Metrics:

Assurance ⇨ (F) (?) (P)

Variance ⇩

	Fail	Hit and Miss	Pass	No Target
H				
L			Number of WTE	
	Appraisals - Trust	% Long term sickness % Sickness in month % Turnover Over-runs >30 mins - SCAS		FTSU Cases
L	% Vacancy			
H	% Trust staff who are BAME Meal Break Compliance - SCAS	% Trust staff who are declared disabled		
↗				
↘				

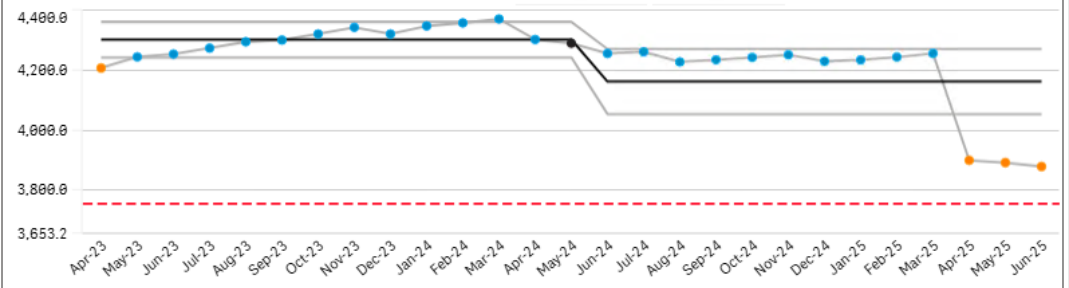
People - WTE, Availability, Staff Compliance, Staff Welfare

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Number of WTE	Jun-25	3,882	3,753	L	P	4164.7	4056.5	4272.8
% Turnover	Jun-25	17.6%	17.70%		?	17.8%	17.1%	18.5%
% Vacancy	Jun-25	-3.4%	0.20%	L	F	8.0%	4.0%	12.0%
Time to hire	Jun-25	87	84	-	?	118.6	-	-
% Trust staff who are BAME	Jun-25	8.7%	8.86%	H	F	8.3%	8.0%	8.5%
% Trust staff who are declared disabled	Jun-25	10.5%	9.54%	H	?	10.0%	9.5%	10.5%
% Sickness in month	Jun-25	6.1%	6.20%		?	6.9%	4.8%	9.1%
% Long term sickness	Jun-25	3.7%	3.50%		?	3.8%	2.5%	5.1%
% DBS Compliance	Jun-25	97.9%	95.00%	-	?	97.2%	-	-
Appraisals - Trust	Jun-25	84.5%	95.00%		F	87.5%	83.5%	91.5%
FTSU Cases	Jun-25	27			n/a	14.9	0.6	29.2
Meal Break Compliance - SCAS	Jun-25	70.5%	85%	H	F	48.5%	35.8%	61.2%
Over-runs >30 mins - SCAS	Jun-25	15.5%	15%		?	18.0%	12.2%	23.8%

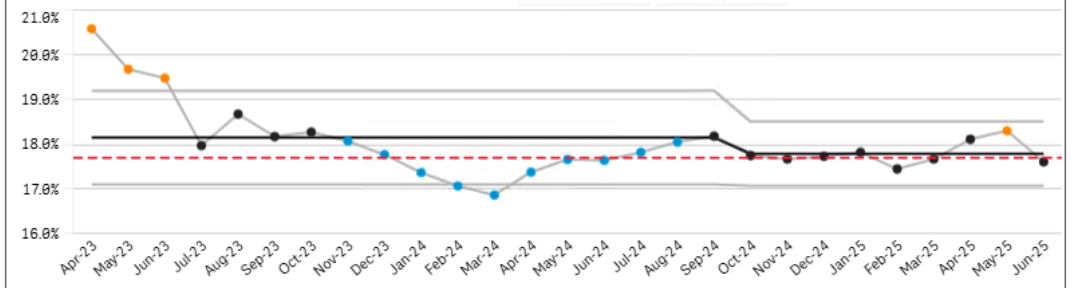
People - Workforce/WTE

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



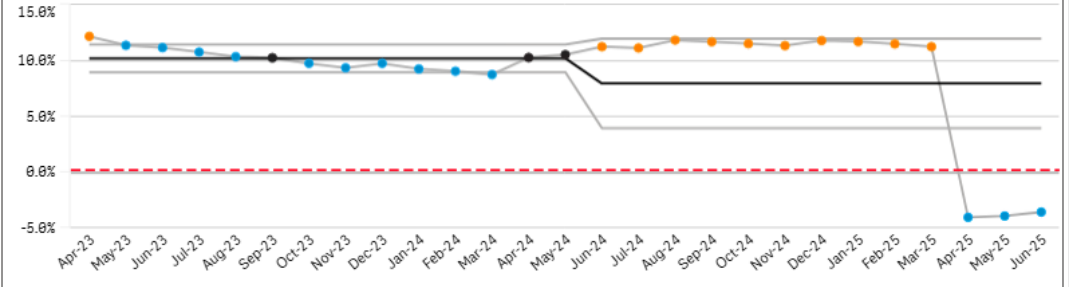
Variation	Declined
Assurance	Pass
Target	3,753.15
Latest	3882.3

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



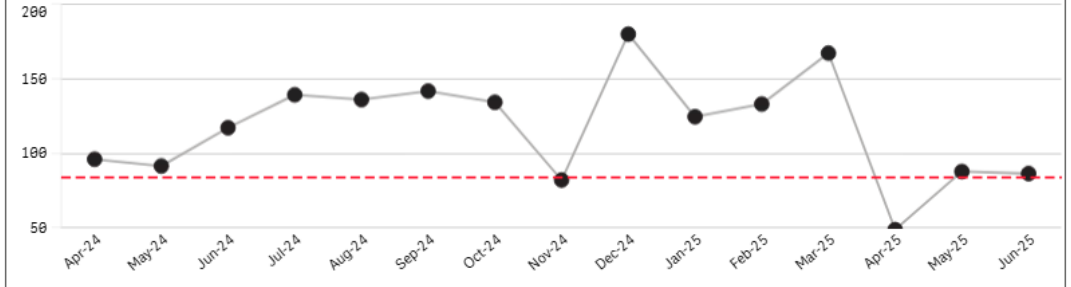
Variation	Expected
Assurance	Random
Target	17.70%
Latest	17.6%

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



Variation	Improving
Assurance	Fail
Target	0.2%
Latest	-3.4%

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



Variation	
Assurance	Random
Target	84
Latest	87.4

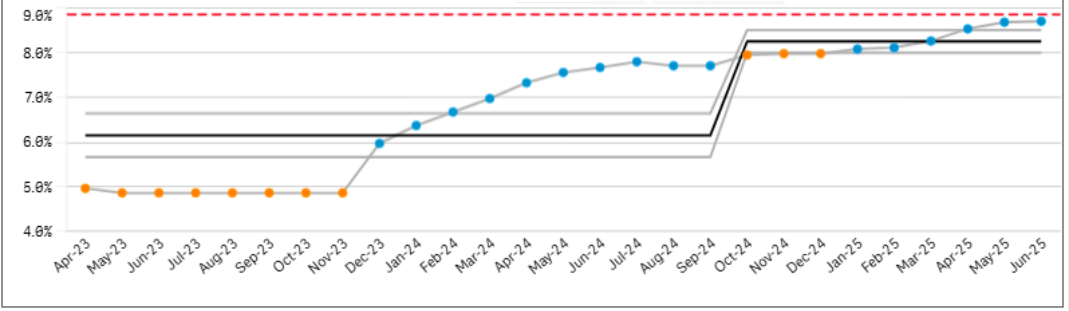
Understanding the Performance:
P1 - TOTAL WTE - Overall 13 WTE reduction from M2. Small reduction in PTS / 999. CCC = small increase. Corporate reductions delayed & not expected to be completed until M5.
P2 - % TURNOVER - Continues to improve, reducing from 18.3% to 17.6% (target of 15%). Attrition being re-forecast for full year to avoid adding pressure to staff in post v budget establishment
P2 - % 12M+ STAFF RETENTION - Improved in year from 82% to 84.8% = improved experience across all areas (target is 87% for full year).
P3 - % VACANCY - 999 = 32 WTE over-established / EOC = 15 vacancies / 111 = 32 vacancies / PTS = 9 vacancies. Vacancies causing increased use of temporary resourcing.
P4 - Time to hire slight reduction on previous month. Time to hire for ad hoc (low volume, non-workforce plan) roles is 40 days

Actions (SMART):
P1 - we expect the trend of small WTE reductions due to attrition to continue, although TUPEd private provider staff are likely to show as an upward blip in next month's reporting, before gradually reducing as the full process is completed for this group.
P2 - recruitment paused across 999 Ops and PTS should help to manage higher than expected WTE due to lower than planned attrition.
P3 - no expectation to recruit to 999 Ops or PTS for short-medium term. Continued recruitment into EOC and 111 with winter pressures meeting arranged to establish requirements.
P4 - expectation that TTH will remain fairly stable without frontline Ops recruitment.

Risks:
TUPEd staff will increase WTE numbers, but this is being managed to reduce impact as much as possible, which will in turn increase attrition/turnover, temporarily.
TTH can only be reduced by reducing stringency of pre-employment checks and bringing in new starters at risk with incomplete checks.

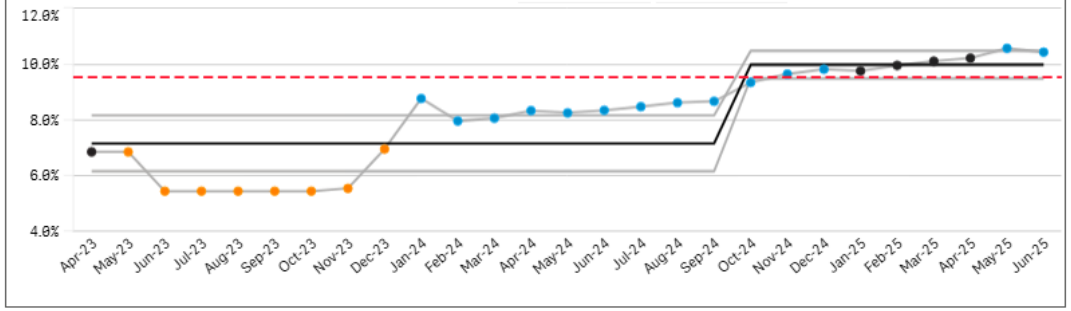
People - Workforce/Availability

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



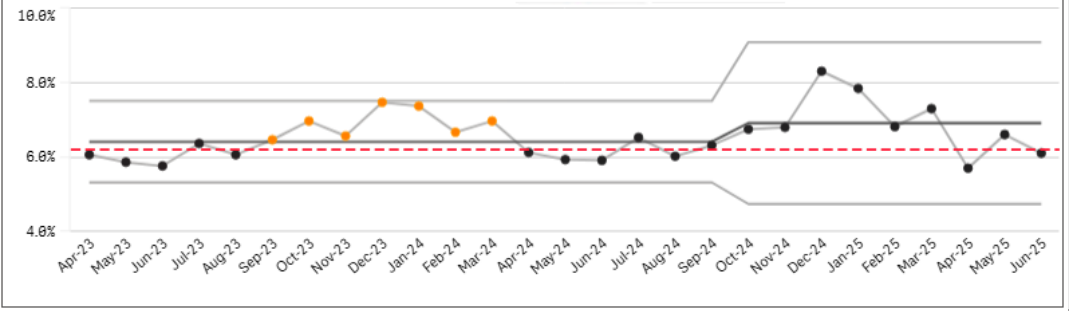
Variation	Assurance	Target	Latest
Improving	Fail	8.9%	8.7%

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



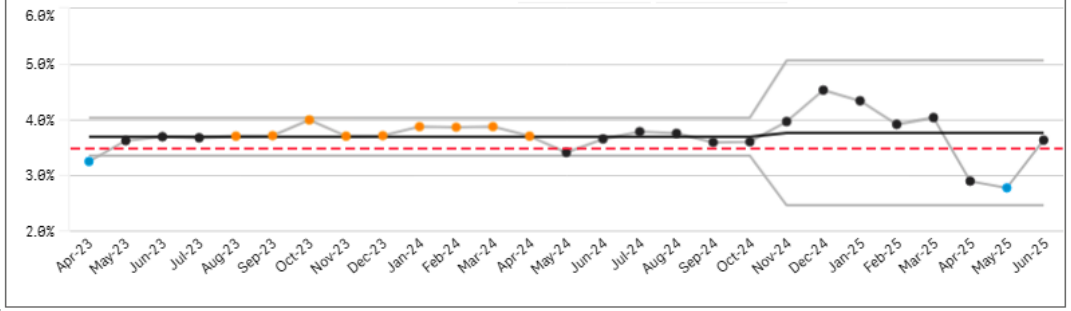
Variation	Assurance	Target	Latest
Improving	Random	9.5%	10.5%

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



Variation	Assurance	Target	Latest
Expected	Random	6.2%	6.1%

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



Variation	Assurance	Target	Latest
Expected	Random	3.5%	3.7%

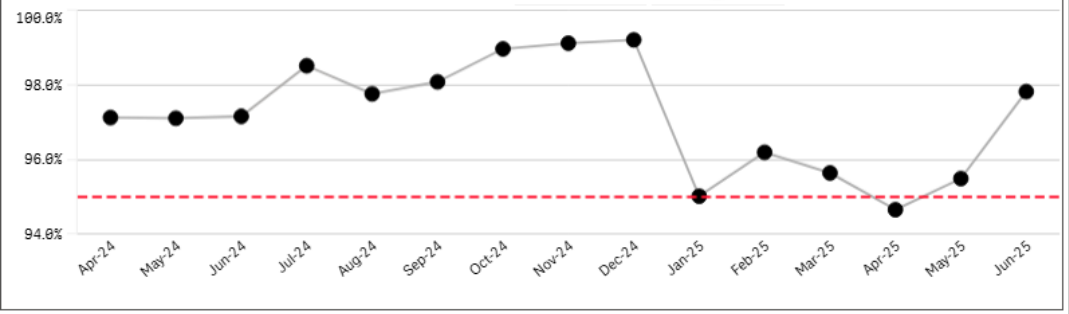
Understanding the Performance:
P5 & P6 (BAME & DISABILITY) - No Significant change
P7 (SICKNESS) - Target = 5.9% - 999 = 6.3% / EOC = 4.8% / 111 = 8.9% / PTS = 6.9% / CORP = 3.5% - Trust = 6.1% at same level as 24/25
P8 (LT SICKNESS) - Target = 3.5% - 999 = 3.6% / EOC = 1.8% / 111 = 5.2% / PTS =4.9% / CORP = 1.0% - Trust = 3.6% at same level as 24/25

Actions (SMART):
P5 & P6 (BAME & DISABILITY) - Staff to be reminded to complete EDI section of their ESR Employee Self Service to improve accuracy

Risks:
P5 & P6 - The trust should reflect demographics of our community. Only a small % of BAME and Disabled are in Band 5+ positions, reducing recruitment pool for promotion.
P7 & P8 - High sickness has a significant risk on operational performance / finances as hours may be met by temporary resourcing. Adversely, low sickness in areas should be reflected in a reduction of hrs required in bank/OT

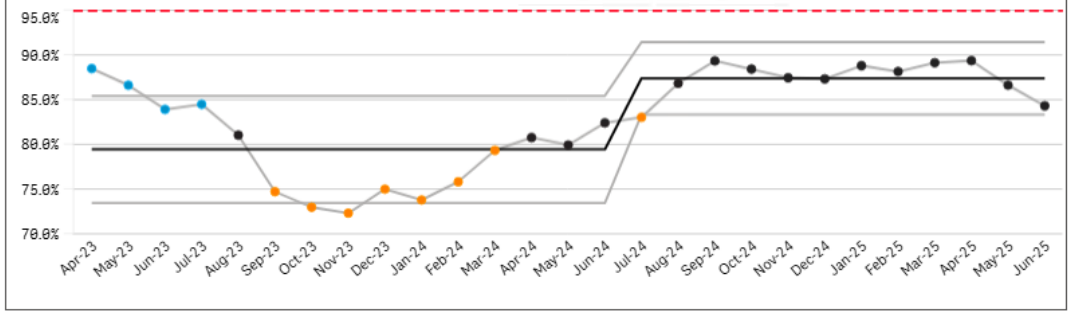
People – Workforce/Staff Compliance

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



Variation	Assurance	Target	Latest
	Random	95.0%	97.9%

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



Variation	Assurance	Target	Latest
Expected	Fail	95.0%	84.5%

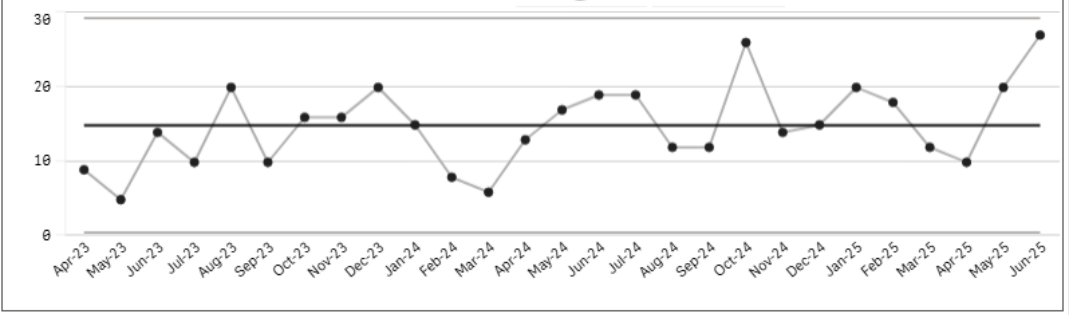
Understanding the Performance:
P9 DBS - Improved monitoring and new processes has seen an improvement in DBS compliance, now at 97.8% against a 95% target
P10 PDR - Trust has fallen for 3 consecutive months and is now at 84.5% against a target of 95% (999 = 93% / EOC = 89% / 111 = 90% / PTS = 89% / CORP = 68%

Actions (SMART):
P9 - Measures are in place to maintain high level of DBS compliance on an ongoing basis. A PDR task and finish group has been established to drive compliance and quality of PDRs, the group is multi-representative from across the Trust and will be asked to take accountability and drive compliance in their areas. People Partners have been notified of declining metrics and asked to work with managers to ensure PDRs are completed. The Chief Executive Officer highlighted the importance of PDRs and requested timely completion as well as a focus on quality in July's Team Brief.

Risks:
P9 - Currently sufficient resource in place to ensure compliance. Any reduction in resource could reduce ability to maintain this.

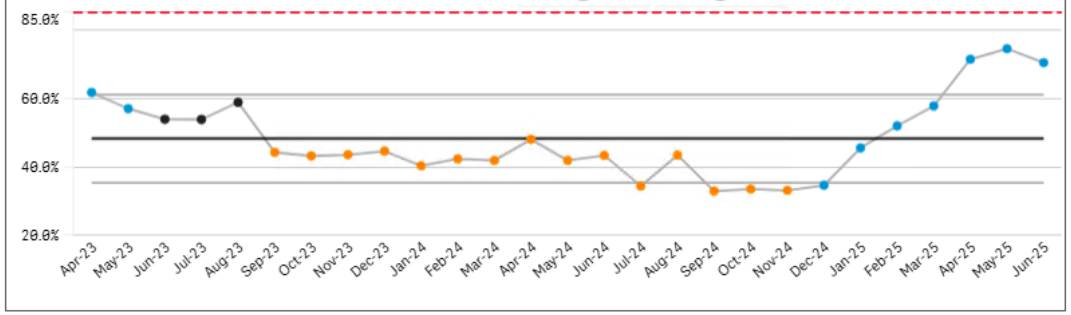
People - Workforce/Staff Welfare

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



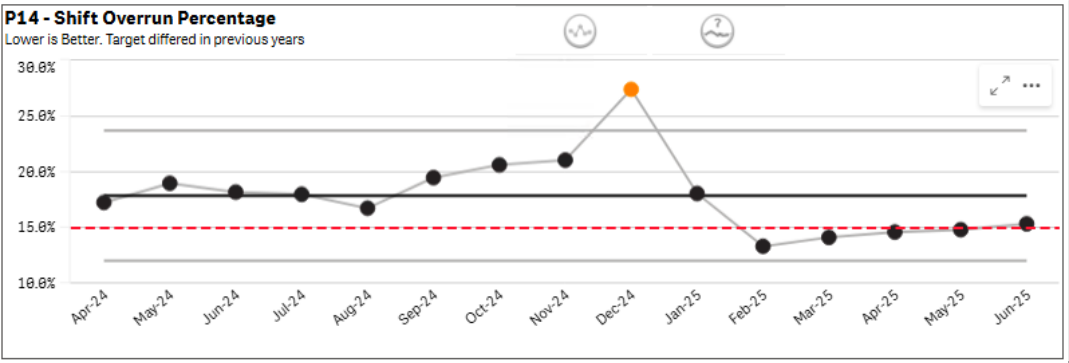
Variation	Assurance	Target	Latest
Expected	-	-	27

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



Variation	Assurance	Target	Latest
Improving	Fail	85%	70.5%

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



Variation	Assurance	Target	Latest
Expected	Random	15%	15.5%

Understanding the Performance:
P13 - Meal Break compliance - showing a special cause of an improving nature but is lower than target. The continued improvement is in line with a change in process and the introduction of a significantly higher target.
P14 -Over runs greater than 30mins - is showing a common cause variation showing no particular change and is tracking against target.
P12FTSU : A 42% year-on-year and 35% monthly rise in FTSU cases highlights persistent concerns—particularly around bullying (inc sexual safety), wellbeing, and management response—but also signals increasing trust in raising issues and the visibility of the FTSU process

Actions (SMART):
P13 - By the end of Q3 2025, continue monitoring changes to staff allocation weekly and review performance data monthly to ensure that resource deployment is optimised for maximum impact, with at least a 5% improvement in key performance indicators compared to Q2.
P14 - Establish a task and finish group by July 2025 to identify and implement at least three actionable strategies to improve compliance with scheduled end times, aiming to reduce staff overruns by 5% by the end of Q4 2025.
P12 -FTSU: Improvement actions include focused training for line managers, implementation of a panel to review sexual safety concerns to focus on consistency of approach and support; assurance of leadership commitment to a safer, more supportive culture."

Risks:
P13 &14 *the reduction in operational hours and the imbalance of hours between TV and Hants puts at risk compliance with these measures due to the nature of moving the resource to where it is needed..
*reviewing policies support the continued compliance and improvements needed.
FTSU : The rise in concerns reflects potential cultural, wellbeing, and leadership issues, posing risks to staff safety, trust, and organisational reputation if not effectively addressed

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Trust Board of Directors Meeting in Public 31 July 2025

Report title	Chief Medical Officer's Board Report
Agenda item	10
Report executive owner	John Black, Chief Medical Officer
Report author	John Black, Chief Medical Officer Dr Helen Pocock, Interim Head of Research Operations
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 Update including Annual Research Report
- JRCALC Clinical Practice Guidelines Update
- GoodSAM Application Update for out-of-hospital cardiac arrest
- Enhancements to SCAS Electronic Patient Records to support 'Care Navigation'
- Quality Improvement Pilot to improve door-in door-out times at Acute Stroke Centres for patients requiring Mechanical Stroke Thrombectomy

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**	✓

1. 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 Update
3. GoodSAM update - mobilising first responders to out-of-hospital cardiac arrest
4. Enhancements to SCAS ePR to support 'care navigation'
5. A Quality Improvement Pilot to improve door-in door-out times at 2 Acute Stroke Centres for patients requiring transfer Mechanical Stroke Thrombectomy following a major stroke.

2. Detail

1. Clinical Research update July 2025

Current research study recruitment (data cut 14 Jul 2025):

197 new patients have been enrolled in research studies since the last Board report.

- Spinal Immobilisation Study (**SIS**): 26 patients
- Early surveillance for type 1 diabetes in children (**ELSA**): 123 children
- Tranexamic acid for mild head injury in older adults (**CRASH-4**): 24 patients;
- Specialist pre-hospital redirection for ischaemic stroke thrombectomy (**SPEEDY**) 22 patients
- Randomised trial of clinical and cost effectiveness of Administration of Prehospital fascia Iliaca compartment block for emergency hip fracture care Delivery (**RAPID-2**): 2 patients.

Successful **HARMONIE** study monitoring visit. Very positive feedback from Fortrea.

New (external) studies opening:

- PREDICT-EMS. A mixed methods study exploring barriers and facilitators to implementation of pre-hospital paediatric early warning scores. (Interview, survey study).

Internal projects underway:

- Quality Improvement project aiming to enhance the efficiency and clarity of communication between ambulance clinicians and HEMS desk paramedics, ultimately improving the dispatch process for HEMS assets. Service evaluation.
- Audit of out-of-hospital cardiac arrest in prisons underway. To support development of grant application.
- Chief Pharmacist research project on Medicines Legislation. A qualitative study aiming to ascertain how UK medicines legislation can be adapted to better support the operational needs of pre-hospital care providers including ambulance services.

Studies closing:

- Cardiac Arrest Bundle of Care Trial (CABARET). This study explored the feasibility of conducting a full-scale trial of clinical effectiveness of a triple bundle of care including a heads-up CPR device. It is a collaboration between SCAS and HIOWAA. Data analysis and reporting will now commence.

Presentation delivered to SECAMB Research Summit on our experiences of the RAPID-2 trial. There is particular interest in this study as SECAMB are considering introducing fascia iliaca compartment block (RAPID-2 evaluates the clinical and cost effectiveness of this procedure in the pre-hospital setting). Presentation was well received.

Outcomes of grant applications:

- *Providing capacity to deliver Genes and Health study across the entire RRDN geography alongside a collaborative network of community and primary care sites*. NIHR Strategic funding bid. Lead applicants. SUCCESSFUL.
  This grant provides 0.2 WTE B6 and 0.2 WTE B7 dedicated time to enrol patients into this study which aims to improve understanding of genetic influence on health and illness of British Bangladeshi and British Pakistani populations.
- *Embedding research inclusion in our workforce*. NIHR Strategic funding bid. Co-applicants. Pan-SC RRDN; UHS lead applicant. SUCCESSFUL.
  This grant provides 0.4 WTE B6 dedicated time to increase diversity in research participation. This will primarily support the work of our CEDAR project (Community Engagement to increase Diversity and Accessibility in Research).
- ACCESS D – Advancing Community Collaboration and Engagement StrategieS in Dementia research. UoS lead applicant. SUCCESSFUL.
  This grant provides 0.25 WTE B6 and 0.1 WTE B4 dedicated time to support delivery of a 12-month feasibility pilot to implement and evaluate ACCESS D which aims to increase engagement in dementia studies.
- Community research hub. NIHR Capital funding bid. Pan-Hants; Hants & IoW Healthcare lead applicant. UNSUCCESSFUL.

Grant applications awaiting outcome:

- 111 AI triage project (Visibar & University of Oxford). Project to improve call time and users experience. Co-applicants.
- Primary Care Clinical Research Delivery Centre (PC-CRDC) (Oxford and North Hants practices collaboration). Submitted an expression of interest for a supporting role. Unable to be collaborator as only Primary Care practices can collaborate.

Research Governance priorities:

a. Data sharing agreement for service evaluation/research between SCAS & HIOWAA (UHS) – still awaiting final sign-off.
b. New process for signing research agreements – to be agreed with CFO.
c. Recruitment of Research & Innovation manager. Despite current healthy levels of research activity there is a shortage of new studies in the pipeline for ambulance services. We need to generate more studies, particularly with commercial companies keen to work with us to bring new technologies and devices for patient benefit. They need us to help write protocols and grant applications, but we lack capacity as research leadership time is currently spent on research governance activity. We hope to bring in an external candidate with expertise in research governance who could improve current practice and increase our capacity for new studies.

2. JRCALC Clinical Practice Guidelines Updates:

See Appendix 1 for a summary of the latest clinical updates 2/25. Teaching materials, including pod casts, video updates and clinical memos are being produced to support the rollout of these guidelines that were published on the JRCALC App on the 2nd July 2002. Further guidance has been produced in relation to termination of resuscitation in the community.

Video summaries of these changes can be found at: https://jrcalc.org.uk/publication-date-july-2025/

3. GoodSAM Update - mobilising first responders to out-of-hospital cardiac arrest:

The GoodSam Cardiac Arrest alerting system went live across SCAS and the Isle of Wight at on the 19th June 2025. The hope is that this will help improve access to early basic life support and early defibrillation for patients suffering an out of hospital cardiac arrest prior to the arrival of the ambulance service, and therefore survival.

The GoodSAM alerting platform is now fully live, following resolution of early technical issues - all of which were related to CAD integration, not the GoodSAM application itself.

GoodSAM have provided access to a Power BI dashboard, allowing near real-time monitoring of responder deployment and system usage.

Both locally approved responders (SCAS staff and volunteers with BLS training and Trust ID) and nationally governed responders (professionally registered and vetted by GoodSAM) are being alerted to eligible cardiac arrest incidents.

Current registration and activity levels in the 6 days of being live (as of 1st July 2025):

- 294 SCAS responders signed up
- 335 alerts issued
- 80 responders assigned
- 19 alerts accepted
- 1 confirmed instance of a responder providing CPR
- 255 alerts had no responder available at the time
- Full public launch is scheduled for 16th October 2025 (International Restart a Heart Day).

A Datix was logged in one case by CCC where a responder (who was a Paramedic working for a GP surgery) was alerted to an end-of-life care situation already being managed by them. They asked for the crew to be stood down, however this wasn't possible as GoodSAM is an alerting tool, not a dispatch platform. On the arrival of the crew, they had a professional discussion and the situation was resolved. This is in line with our current SOP's.

4. Enhancements to SCAS ePR to support 'care navigation'

SCAS is upgrading its electronic patient record tablet to provide frontline ambulance clinicians access to the Care and Health Care Records (CHIE) in Hampshire. This will provide access to clinical records held in primary care, hospitals, community and MH Trusts and Local Authorities. This will provide clinicians in Hampshire with much more granular clinical information to support clinical decision making and onward care navigation as required.

SCAS is also introducing access to the National Care Record Service (NCRS) imminently. When deployed it will also provide to the summary care records we see now. Shared care records will remain a more comprehensive summary of patient information (e.g. mental health, community etc) whereas NCRS/summary care is derived only from the primary care records.

There are some key additional benefits:

- Reasonable adjustments digital flag (Mandatory). This enables our clinicians to view any reasonable adjustments the patient might need.
- Child Protection Information Service (CPIS - Mandatory). This enables clinicians to be made aware of a child protection plan and provides notification to social services that we have attended a patient under a protection order or plan.
- In the Future: Access to the NRL (National Record Locater) this will provide access to shared care records (e.g. Thames Valley Shared care Record & Chie) but through one link via NCRS. This brings the benefits of shared care records for our patients who are visiting our area or patients in Milton Keynes.

5. Quality Improvement Pilot to shorten 'door-in door-out' times at Acute Stroke Centres at Reading and Winchester for patients requiring secondary transfer for Mechanical Stroke Thrombectomy (MT).

The conveying ambulance clinicians will remain with the patient after arrival at Acute Stroke Center (ASC), transfer them directly to CT Scanner for imaging and will undertake secondary transfer to Oxford or Southampton if the patient is suitable for MT after bolus thrombolytic therapy has been administered in the hope of significantly reducing ASC door-in door-out times and therefore symptom onset time to MT treatment intervention time.

This treatment is time-critical and we anticipate that this new process will significantly improve the clinical outcomes for this group of patients. If successful, this will be rolled out Trust wide.

This pilot went live on the 15th July 2025 and will be closely monitored at the Clinical Review Group**.**

- **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 and supports our clinical research activity.

- **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 into clinical practice.

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.

John JM Black

CMO

18.7.25

- **Appendices**

APPENDIX 1: JRCALC Clinical Practice Guidelines Updates July 2025 Summary

JRCALC Clinical Guideline Updates 2/2025

Summary of changes

Planned publication date: 2nd July 2025

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

Guideline/medicine	Update
Termination of Resuscitation & Verification of Death (Adults & Children)	Fully revised, now split into four separate guidelines for ease and clarity. Includes new algorithm to assist termination of resuscitation decisions. A JRCALC national podcast detailing what has changed and why and will be available on Parapass. A further link will be shared once available. There has been extensive collaboration for this review, including all trust resuscitation leads. Work is ongoing to develop a national educational package to support the changes in this guideline.
Seizures adults and children (formerly Convulsions)	Revised and updated. Includes inclusion of Midazolam for the treatment of seizures and additional detail on re-dosing.
Midazolam	New monograph for IM midazolam. Note that local trust PGDs apply. Revised buccal midazolam monograph.
Pain Management in Adult and Children (formally separated adult and children)	Now unified into adult and paediatric guideline; fully revised and updated. Includes specific guidance for different age groups and includes PAINAD scale for patients with cognitive impairment. Revised treatment section with an improved table on pre-hospital analgesia.
Pre-Eclampsia & Eclampsia (formerly Hypertension in Pregnancy)	Fully revised guideline and revised algorithm for management of seizures after 20 weeks of pregnancy and up to 14 days post-birth This guideline addresses use of magnesium for Pre-Eclampsia & Eclampsia as per NICE NG133.

Magnesium	The monograph has been fully revised and has undergone standardisation to include information on monitoring, use in pregnancy and breastfeeding. Note that local trust PGDs apply.
Shoulder dystocia	Fully revised and is now issued as standalone guidance rather than within the birth imminent guideline. It incorporates an updated management algorithm and includes lone worker guidance. Relevant images have been added to support the provision of care in emergency situations and a short video to support the management will be available and included.
Imminent birth	Updated due to the new standalone guidance for Shoulder Dystocia and updated Pre-Eclampsia and Eclampsia guidelines.
Vascular Emergencies	Fully revised and a new section on 'Other vascular bleed considerations' included. This follows consideration of a coroners preventing future death report.
Altered Level of Consciousness	Fully revised, the term 'coma' is removed following feedback on the use of this terminology. Coma is now referred to as 'Reduced level of consciousness' throughout the guideline. A new section on sudden cardiac death has been included.
Cardiac Arrhythmia and Sudden Cardiac Death (formerly Cardiac Rhythm Disturbance)	Fully revised and updated with a new section on sudden cardiac death. Revised bradycardia algorithm including consider use of adrenaline for bradycardia unresponsive to atropine. Includes an appendix of common cardiac arrhythmias and treatment pathways.
Glycaemic Emergencies in Adults and Children	Update to section: 3.1 Hypoglycaemia in the Absence of Diabetes Following review of evidence of hypoglycaemia in non-diabetic patients; no absolute threshold was described in the literature. Studies included reference to a BM between 3.0-3.9 mmol/L therefore we recommend if a non-diabetic patient has a BM <3.9 mmol/L and is symptomatic they can be considered hypoglycaemic.

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Upward Report of the Quality & Safety Committee

Date Meeting met **14th July 2025**
Chair of Meeting **Katie Kapernaros, Non-Executive Director**
Reporting to **Trust Board**

Items	Issue	Action Owner	Action
Points for escalation			
Papers	The papers received at the meeting were improved in terms of quality and content and better aided committee discussion and deliberation. A number of actions on the action log had also been completed and closed and the committee will continue to focus on ensuring that actions are followed up within agreed timescales.	N/A	None
Key issues and / or Business matters to raise			
Controlled Drugs Licence	It was noted that the licence had been received from the Home Office and in line with previous board discussion, a plan was in place to ensure compliance with the licence	DR	Plan to be submitted to the September QSC meeting with upward assurance to the trust board.

	conditions. The plan will be presented to the next QSC meeting		
Integrated/Operational Performance Report	The committee discussed operational performance through the lens of the impact on quality, noting that VOR rates had deteriorated in June due to issues with fleet and that repeat calls were increasing.	N/A	Corrective actions are described within the Integrated Performance Report and the committee will maintain a watching brief on these areas.
Quality Account 2024/25 and Quality Priorities 2025/25	The committee approved the Quality Account for the previous financial year and the quality priorities for the current year which the Chief Nurse gave assurance were linked to the Patient Safety Plan	HY	The committee requested a quarterly report detailing progress against the quality priorities and this will be built into the workplan
Areas of concern and / or Risks			
Top 3 Areas of Risk	An update on the 3 areas of risk identified at the last meeting was provided with assurances given around their management and mitigation. The digital Safeguarding Referral Process remains one of the top 3 for July and the following two risks were added: • Clinical Supervision • Medicines Packing High level mitigations were discussed and plans to manage and mitigate these will be presented to the committee for assurance	DR	Plans to mitigate the Medicines Packing and Clinical Supervision risks will be presented to the next meeting.
Items for information and / or awareness			
Quality Impact Assessment Process	Assurance was provided by the Chief Nursing Officer that there is a robust QIA process in place across the organisation.	HY	The committee requested an outline of the process and a worked example to derive

			assurance that the process is robust.
Best Practice and / or Excellence			
None noted at this meeting			
Compliance with Terms of Reference			
No issues – terms of reference are currently under review	The Committee approved the QSC Annual Report and revised terms of reference.	BS	Annual Committee Report and revised terms of reference to be presented to the July board meeting.
Policies approved			
None			

Chair: Katie Kapernaros

Title: Non-Executive Director

Date: 14th July 2025

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Trust Board of Directors Meeting in Public
31 July 2025

Report title	Quality Account 2024/25
Agenda item	12
Report executive owner	Helen Young, Chief Nurse
Report author	Jane Campbell, Assistant Director of Quality
Governance Pathway: Previous consideration	EMC – 1 July 2025 Quality and Safety Committee – 14 July 2025
Governance Pathway: Next steps	

Executive Summary

The Quality account is an annual report. There is a requirement for the report to be published on the trust website. The report follows the guidance and prescribed wording.

The sections contained in the report are an amalgamation of information that has been presented to groups and committees during the year.

Priorities 2024/25

Outcome for the priorities set for the 2024/25 year are noted in this section of the report.

2024/5 Quality Priority Summary		Outcome
1a	Recruitment of patient safety partners	Achieved

Patient Safety	1b	Ensure appropriate and proportionate management of patient safety incidents (PSI) using a quality maturity tool	Achieved
	1c	Provide assurance that the organisation has sufficiently accredited trained staff in place to support delivery of learning responses in line with PSIRF	Partially achieved
Clinical Effectiveness	2a	To report on Category 1 - 4 performance	Achieved
	2b	To report on national stroke/STEMI care bundle compliance	Achieved
	2c	To report on national falls indicator	Achieved
	2d	Enhanced CFR - falls care Year 2 Enhanced CFR - falls care	Achieved
Patient Experience	3a	Audit Healthcare Professional Feedback process to action and learn from feedback received which requires a 'Patient Safety' response / link with LFPSE	Achieved
	3b	Thematic analysis of compliments to ensure learning from 'what has gone well' and the themes to disseminate best practice across services	Achieved
	3c	Develop Patient Panel including continued recruitment; report on improvements; analyse output to inform quality improvement projects	Achieved

1c: Provide assurance that the organisation has sufficiently accredited trained staff in place to support delivery of learning responses in line with Patient Safety Incident Response Framework (PSIRF).

- ✓ Patient safety training has continued to be a focus over the last year. Externally provided courses and internal sessions have been undertaken. Over 100 staff across the Trust have been trained in undertaking SWARM huddles.
- ✓ Health Education England Patient Safety training Level 1 - 97% of Trust Staff
- ✓ Health Education England Patient Safety training Level 2 - 95% of Trust Staff
- ✓ Health Services Safety Investigations Body (HSSIB) Level 2 - 33 staff completed. Strategic decision making – 14 staff completed, Oversight training – 40+ completed.
- ✓ Training is included in the 2025/26 plan.

Part 2.2

This section provides updates on the prescribed areas of focus in the guidance.

Including national audits and research.

Part 2.3

This section provides updates on the core indicators in the guidance. This includes Category 1 – 4 performances, ACQI and learning from deaths.

Quality Priorities for 2025/26

These are the priorities for this year. They align with the internal safety plan and as noted in the ICB statement align with those of the ICB.

2025/6 Quality Priority Summary			Rationale
Patient Safety	1a	Survey staff safety culture	Develop a 'wider view' patient survey tool. Survey staff, analyse the results and put improvements in place
	1b	Quality audit of After Action Reviews (AAR)	PSIRF quality metric tool measures the quality of PSII reports against SEIPS model. There is no equivalent national tool for AARs so this needs to be developed
	1c	Continued improvement in the quality of safeguarding referrals	The safeguarding improvement programme continues, the improved quality of referrals will lead to reduction in inappropriate referrals to partners
Clinical Effectiveness	2a	To report on Category 1 - 4 performance	Reporting against NHSi core indicators for Quality Accounts.
	2b	To report on national STEMI care bundle compliance	Reporting against NHSi core indicators for Quality Accounts.
	2c	New focus of audit group	Change the local audit focus so that 12 clinical audits are completed per year and reviewed at the monthly group
Patient Experience	3a	Co-production of amendments to current Healthcare Professional feedback process to ensure high level focus on	Continuation from 2024/25-year audit. Move the focus to clinical concern feedback
	3b	Patient panel	PSIRF prioritises the inclusion of the patient's voice in what we do. This ensures parity of care across patient groups and allows co-design of services. Continue with patient panel groups and include a youth panel.
	3c	Increase patient survey response rates	Propose a new system and process for gaining feedback from patients and others who have been involved in services. This includes the potential of digitalisation of the process.

Alignment with Strategic Objectives
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	Capital and/or revenue implications? No

Recommendation(s)
What is the Committee/Board asked to do: • Approve the document

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

South Central Ambulance Service
NHS Foundation Trust

Quality Account
2024 - 2025

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

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Part 1: Statement on quality from the chief executive of the South Central Ambulance Service NHS Foundation Trust (SCAS)

Chief Executive's foreword

I am pleased to introduce our annual Quality Account for 2024/25. This report outlines the work we have carried out in the past year to ensure the quality and safety of the care we provide is maintained and where required, improved. It also details priorities for 2025/26.

This year has been an exceptionally challenging one. Staff and volunteers across our services worked incredibly hard with our partners to continue delivering high quality safe patient care, whilst simultaneously, significant changes were being made to modernise the trust. The environment we operate in continues to be very testing, but I am confident that we will continue to modernise and improve how we work to transform SCAS and deliver the best possible service to the patients, families and communities we serve.

Service modernisation

Fit for the Future is our overall programme of modernisation and transformation. It is part of delivering our long-term strategy and making sure we can provide high quality patient care, achieve performance standards, and support staff wellbeing, whilst running within budget.

In 2024/25 we carried out a corporate services review as part of the Fit for the Future programme. I also consulted on, and implemented, a new executive structure, with the new arrangements going live from 1 April 2025. The new structure formalises the role of Chief Paramedic as one of three clinical leaders on the Board. A move I believe, is essential to ensure the voice of the paramedic profession is represented at the highest level in the trust. We now have three clinical executive roles of Chief Paramedic, Chief Nurse, and Chief Medical Officer who will jointly lead an integrated clinical directorate.

In a further significant development, we worked with four other ambulance trusts to establish the Southern Ambulance Services Collaboration (SASC). The collaboration includes ourselves, South Western, South East Coast, London, and East of England ambulance services. The collaboration is an opportunity to share best practice and learning, and to pool expertise in developing more efficient ways of working. We are focussed on three initial priorities:

- Developing shared procurement capability aimed at using purchasing power at scale to secure better value for money.
- Exploring use of Artificial Intelligence in Emergency Operations Centres, improving patient safety and supporting our staff through real-world training.
- Developing a best practice model for a Dual Crewed Ambulance shift, supporting our staff to achieve best practice in the care they offer to patients.

We also further strengthened our own collaboration with South East Coast Ambulance Service. In December 2024, following discussions between the two Boards, we

announced our intention to work towards the creation of a group model, where we can work together more formally whilst both organisations retain their independence.

In year we transitioned to the Patient Safety Incident Response Framework (PSIRF) and updated the way we review cases for learning in line with the national guidance.

Working with partners

During the year we worked with our partners in the healthcare system to implement a variety of changes that have significantly improved our performance.

For several years, handover delays at acute hospitals have had a significant impact on our ability to get to other patients in a timely way. In 2024/25 we worked with hospital trusts to introduce the Release to Respond policy to help our crews get back on the road more quickly. It means a crew will wait no longer than 45 minutes at an emergency department.

Working with primary care partners we piloted a Single Point of Access (SPOA) in South East Hampshire. This is a multi-disciplinary team, including GPs, who provide advice to our crews on scene with patients, and takes calls from the 999-call stack. The aim is to identify more appropriate care pathways for patients with less urgent needs, rather than sending an ambulance or giving the crew on scene alternatives to taking the patient to an emergency department.

Staff wellbeing and equality

I'm pleased to see important progress to support staff wellbeing and equality. There are a range of issues facing our staff and the wider NHS workforce, and we must maintain our focus on these.

We are embedding a culture of awareness throughout the trust and are dedicated to creating a safe and supportive workplace, which is reinforced by the guidance of our Equality Diversity and Inclusion Lead and Freedom to Speak Up Guardians.

As changes to the NHS nationally take effect, the next 12 months and beyond will undoubtedly bring further change. Whether working in frontline SCAS services or just as importantly, working in one of the supporting functions, everyone's contribution in the SCAS team is equally important as we travel together on this journey of improvement.



David Eltringham
Chief Executive Officer
June 2025

South Central Ambulance Service NHS Foundation Trust became an NHS Foundation Trust in 2012.

About us

We employ 4,380 staff who, together with over 900 volunteers, enable us to operate 24 hours a day, seven days a week.

What we do:

- Receive and respond to 999 calls using resources including: community first and co-responders, rapid response vehicles, ambulances, and air ambulances.
- Provide the NHS 111 services for the Thames Valley and for Hampshire.
- Provide non-emergency Patient Transport Services across six counties including Surrey and Sussex. (Hampshire only from April 2025)

SCAS is the monopoly provider of 999 emergency ambulance services within the South Central region (as are all English ambulance trusts in their defined geographical areas). All other services the Trust delivers are tendered for on a competitive basis.

During 2024 - March 2025 we serve a population of over seven million people across six Integrated Care Systems:

- Buckinghamshire, Oxfordshire & West Berkshire
- Hampshire & Isle of Wight
- Frimley
- Bedfordshire, Luton & Milton Keynes
- Surrey Heartlands
- Sussex

Working with system partners

There have been significant changes in health and care, and SCAS, like all ambulance services, has a pivotal role in local care systems, especially with the increasing focus on delivering care remotely or in patients' homes.

SCAS is adapting to these changes and working with partners to achieve the NHS triple aims of:

- better health and wellbeing for everyone
- better quality of health services for all

- sustainable use of NHS resources.

Our goals are to simplify access to care, to save lives, to support more people at home and to integrate care. Working with partners, we also aim to identify and address inequity of access or unwarranted variation in outcomes.

We work across six integrated care systems, with the Hampshire and Isle of Wight Integrated Care Board acting as our lead commissioner. We engage with partners in commissioning and provider organisations across all systems on a range of strategic and operational forums. We work to ensure our plans are aligned to our integrated care systems' forward plans and that the needs of emergency and urgent care are appropriately considered within system plans. We work with the Hampshire and Isle of Wight Integrated Care Board on a system level joint capital plan and all our capital expenditure is accounted for within that plan.

SCAS has contributed to the forward plans of all the ICBs that we partner with: Buckinghamshire, Oxfordshire and Berkshire West (BOB), Bedfordshire, Luton and Milton Keynes (BLMK), Frimley, and Hampshire & Isle of Wight (HIOW).

Our Strategy



Our strategy is rooted in the role we play as "Care Navigators", easing access to care for patients and enabling a seamless link between providers. Following the publication of our Strategy, we engaged extensively with our colleagues to develop programmes and initiatives that would deliver improvements and support our strategic ambitions. We called this approach "Fit for the Future".

Since the publication of our Strategy, there have been a series of shifts at a regional and national level including SCAS entering the Southern Ambulance Services Collaborative and started to work more closely with SECAmb and commissioners in

the South East Region to better standardise care delivery, how services are commissioned, and seek opportunities to drive productivity and efficiency through scale.

We believe that our strategic direction remains consistent with the national ambition, in particular in supporting a move away from Emergency Departments, improved digitalisation as a driver for productivity, and contributing to a more preventative model for the health service that helps us reduce inequalities.

Part 2: Priorities for improvement and statements of assurance from the board

2.1 Looking back at our progress

We have set out below our Quality Account priorities for 2024/25 and our progress against them.

2023/4 Quality Priority Summary			Outcome
Patient Safety	1a	Recruitment of patient safety partners	Achieved
	1b	Ensure appropriate and proportionate management of patient safety incidents (PSI) using a quality maturity tool	Achieved
	1c	Provide assurance that the organisation has sufficiently accredited trained staff in place to support delivery of learning responses in line with PSIRF	Partially achieved
Clinical Effectiveness	2a	To report on Category 1 - 4 performance	Achieved
	2b	To report on national stroke/STEMI care bundle compliance	Achieved
	2c	To report on national falls indicator	Achieved
	2d	Enhanced CFR - falls care Year 2 Enhanced CFR - falls care	Achieved
Patient Experience	3a	Audit Healthcare Professional Feedback process to action and learn from feedback received which requires a 'Patient Safety' response / link with LFPSE	Achieved
	3b	Thematic analysis of compliments to ensure learning from 'what has gone well' and the themes to disseminate best practice across services	Achieved
	3c	Develop Patient Panel including continued recruitment; report on improvements; analyse output to inform quality improvement projects	Achieved

Partially achieved quality priorities form part of a continuous improvement cycle and further work will be completed in 2025/26.

1. Patient Safety

1a: Recruitment of patient safety partners

Owner: Patient Safety Specialist - sponsored by Executive Chief Nurse

Two Patient Safety Partners have been recruited and started with the team in Q4.

SCAS is committed to involving diverse groups of patients and the public in its work. Patient Safety Partners (PSPs) bring unique perspectives and insights into our current safety work programmes, by bringing their knowledge of safety and improvement from their lived experience, previous roles and experience. PSPs are fundamental to challenging thinking, helping to innovate and improve what we already do.

It was agreed that the PSPs recruited would be at level three. At this level, individuals are invited to join focus groups, workshops or advisory groups but are not decision makers. This will be reviewed at the end of year one with a view to reviewing the state of readiness to move to level four. PSPs participate in demonstrating strategic and accountable leadership and decision making.

The rationale for introduction of the role at level three is to give the opportunity for the Patient Safety Incident Response Framework (PSIRF) to embed and mature. This also allows the Trust to test role three and, in collaboration with the PSPs, to develop a work programme which could be introduced within role four.

Achieved

1b: Ensure appropriate and proportionate management of patient safety incidents (PSI) using a quality maturity tool.

Owner: Patient Safety Specialist - sponsored by Executive Chief Nurse

All Patient Safety Incidents are benchmarked against the quality metric tool. This is submitted with the PSII reports to the Oversight Review Group for approval.

The Learning Response Toolkit is used as a quality metric for Patient Safety Incident Investigations (PSIIs) to ensure reports meet evidence-based standards for effective safety investigation and reporting. This tool was developed from research identifying common pitfalls in safety investigations and has been validated through pilots across approximately 20 NHS organisations. It provides structured criteria to evaluate whether reports meaningfully engage affected parties, apply systems thinking rather than blame-focused approaches, and develop effective safety recommendations. The toolkit serves both as a writing guide for investigators and a peer review framework to enhance report quality and learning outcomes.

Achieved

1c: Provide assurance that the organisation has sufficiently accredited trained staff in place to support delivery of learning responses in line with Patient Safety Incident Response Framework (PSIRF)

Owner: Patient Safety Specialist - sponsored by Education Lead.

Patient safety training has continued to be a focus over the last year. Externally provided courses and internal sessions have been undertaken.

Over 100 staff across the Trust have been trained in undertaking SWARM huddles and there is planned training for After Action Review (AAR) training. Currently the Patient safety team is undertaking the majority of learning responses under PSIRF.

Health Education England Patient Safety training Level 1 - 97% of Trust Staff

Health Education England Patient Safety training Level 2 - 95% of Trust Staff

Health Services Safety Investigations Body (HSSIB) Level 2 - 33 staff completed

Strategic decision making – 14 staff completed

Oversight training – 40+ completed

Partially achieved – Training is included in the 2025/26 plan

2. Clinical Effectiveness

2a: To report on Category 1 - 4 performance

Owner: Director of Operations

Achieved – Automated reporting of all Category Performance is provided through our reporting systems and available live or historically

Achieved

2b: To report on national stroke/STEMI care bundle compliance

Owner: Chief Medical Officer/Chief Paramedic

Reports are produced to national requirement timescales and can be produced more frequently for local use.

During 2024 the Stroke care bundle was retired as an indicator. The last data was submitted in February 2024.

Achieved

2c: To report on national falls indicator

Owner: Chief Medical Officer/Chief Paramedic

Data has been submitted as per the technical guidance for this indicator.

Achieved

2d: Enhanced CFR - falls care Year 2 Enhanced CFR - falls care

Owner: Head of Operations – Community Engagement and Training - sponsored by Director of Operations.

Data from 1 April 2024 to 31 March 2025 shows an 15% increase in the attendance of a volunteer responder to scene compared to the same period in 2023/24. The clinical intervention from the Urgent care desk (UCD) during 2023/24 saw 42% of incidents being dealt with by a volunteer responder and UCD only. For the same period in 2024/5 saw 47% of incidents being dealt with by a volunteer responder and UCD only, an increase of 4%.

We have maintained on average, 65% of all patients seen where the only resource required on scene was a volunteer responder and a remote urgent care desk clinician, therefore avoiding an unnecessary resource being dispatched.

Achieved

3. Patient Experience (PE)

3a: Audit the Healthcare Professional Feedback (HCPF) process to action and learn from feedback received which requires a 'Patient Safety' response and link with LFPSE
Owner: Patient Experience Manager

The proposed audit was completed by Patient Experience Team. The audit found that the Trust has an average of 31% of Patient Safety Incidents reported across the areas included in this audit. (9 out of 25 (36%) of Berkshire, Oxfordshire and Buckinghamshire (BOB) Patient Transport Service (PTS) cases, 6 out of 25 (24%) of Hampshire PTS cases, 9 out of 25 (36%) of Hampshire 111 and 7 out of 25 (28%) of Thames Valley 111 cases). This means that an average of 69% of cases do not pertain to Patient Safety, although they may pertain to staff attitude, delays and other issues that may cause distress to patients.

The full report from the audit was shared at the Patient Safety and Experience Group and follow up work is taking place with ICB colleagues. When HCP feedback is coming through from external providers with an LFPSE reference, this is added to the Patient Experience record. Currently with the capabilities of the LFPSE platform, we cannot identify specific incidents from the details provided.

Achieved

3b: Conduct a thematic analysis of compliments received to ensure learning from 'what has gone well' and the themes in order to disseminate best practice to service areas.

Owner: Head of Patient Experience and Engagement

This work has been linked with a Quality Improvement project concerning compliments and positive feedback and how this is recorded and disseminated in the Trust. The

final part of the project is now reviewing other ways that we can use the information we receive from these compliments in different ways throughout the Trust. A survey for the end of the project to gather further views about what would be most helpful has been included.

As an overview, 75% of the compliments received since 1 November 2024 are for our frontline 999 crews and most of these are contacts from patients and their families thanking the crews for their caring and professionalism.

Further developments in a continuous improvement cycle are ongoing, including exploring the potential for QR codes in vehicles for patients/others to use. This was feedback from a staff member into the trust 'bright ideas' programme.

Achieved

3c: Further develop the Patient Panel including continued recruitment and report on improvements then analyse the output from Patient Panel to inform quality improvement projects.

Owner: Patient and Public Engagement Facilitator

Recruitment to the patient panel continues. A summary of activity includes:

- In April 2024: Learning Disability (LD) members shared their experiences of using SCAS services and reviewed what we already have in place for LD patients.
- In June 2024: Members helped co-produce the patient aspect of the Learning Disability policy
- In July 2024: They reviewed the SCAS public website and found that images used on the public website were not inclusive of all the patients SCAS serves.
- They particularly found the 'day in the life of 111' and 999 videos useful as it will help LD patients understand what happens. The 111 video of a patient experience with adjustments. The LD members found the website complex to navigate and there was too much information to process. Therefore there was a suggestion to add more accessible guidance on calling 999 and what would happen when you go to hospital.
- In August 2024: An easy read guide on 'calling 999' was co-produced. This explains that the service is free and is open 24 hours a day, 7 days a week. It provides a guide on some of the questions that may be asked, and a few examples of when 999 should be called. It also offered advice on other services patients can contact if it is not an emergency such as the GP, pharmacy and NHS 111.
- The NHS England created NHS 111 easy guide was also reviewed.
- In October 2024: An easy read guide on '999 response times and category of calls' was co-produced. This explains the target response times for each category of 999 call and the types of emergencies that fall into each category.
- In November 2024: An easy read guide was co-produced on 'what to expect when the ambulance arrives'. This explains the different types of staff that may attend a medical emergency such as a Paramedic, Emergency Care Assistant, Ambulance Nurse etc. The observations carried out are listed as well as the

crew gaining consent to carry out each check. The document also explains decision making for conveyances to hospital and patient capacity in making these choices themselves. A list of all the things a patient may wish to take to hospital with them is also included, along with details of what happens when the ambulance arrives at the hospital or if the patient is not conveyed.

- In December 2024: The members gave suggestions and ideas for things they wanted included in the LD Strategy.
- In January 2025: The members co-produced the feedback, and complaints process easy ready guide.
- In February 2025: Co-produced the Non-Emergency Patient Transport Service booking guide.

Total number of Patient Panel volunteers 22, with 290 hours committed in 2024.

Achieved

2.2 Statements of assurance from the board

	Prescribed information	Form of statement
1	The number of different types of relevant health services provided or subcontracted by the provider during the reporting period as determined in accordance with the categorization of services: (a) Specified under the contracts, agreements, or arrangements under which those services are provider or (b) In the case of an NHS body providing services other than under a contract, agreement, or arrangements, adopted by the provider.	During 2024/25 SCAS provided and/or subcontracted three relevant health services. • Emergency 999 Ambulance Service • Non-Emergency Patient Transport Service • NHS 111/IUC Telephone Advice Service
1.1	The number of relevant health services identified under entry 1 in relation to which the provider has reviewed all data available to it on quality of care provided during the reporting period.	SCAS has reviewed all the data available to them on the quality of care in all of these relevant health services.
1.2	The percentage that the income generated by the relevant health services reviewed by the provider, as identified under entry 1.1, represents of the total income for the provider for the reporting period under all contracts, agreements and arrangements held by the	The income generated by the relevant health services reviewed in 2024/25 represents 100% of the total income generated from the provision of relevant health services by SCAS for 2024/25.

	provider for the provision of, or subcontracting of, relevant health services.	
2	a) The number of national clinical audits and national confidential enquiries b) which collected data during the reporting period, and which covered the relevant health services that the provider provides or subcontracts.	During 2024/25, nine national clinical audits and 0 national confidential enquiries covered relevant health services that SCAS provides.
2.1	The number, as a percentage, of national clinical audits and clinical audits and national confidential enquiries, identified under entry 2, that the provider participated in during the reporting period.	During that period SCAS participated in 100% national clinical audits and 100% (0 required) national confidential enquiries of the national clinical audits and national confidential enquiries in which it was eligible to participate.
2.2	A list of the national clinical audits and national confidential enquiries identified under entry 2 that the provider was eligible to participate in.	The national clinical audits and national confidential enquiries that SCAS was eligible to participate in during 2024/25 are as follows: • Acute Myocardial Infarction and other Acute Coronary Syndrome (MINAP) • Ambulance Clinical Quality Indicator S-T elevation Myocardial Infarction (STEMI) Care Bundle • Sentinel Stroke National Audit Programme (Stroke Call to Hospital Arrival times) • Ambulance Clinical Quality falls indicator • Warwick Clinical Trials Unit Out of Hospital Cardiac Arrest Outcome (OHCAO) • Ambulance Clinical Quality Indicator Cardiac Arrest ROSC rates (and separate Utstein ROSC measure)

		• Ambulance Clinical Quality Indicator Cardiac Arrest Survival to Discharge (and separate Utstein STD measure) • Ambulance Clinical Quality Indicator Cardiac Arrest Post ROSC Care Bundle • Recontact audit
2.3	A list of the national clinical audits and national confidential enquiries, identified under entry 2.1, that the provider participated in.	The national clinical audits and national confidential enquiries that SCAS participated in during 2024/25 are as follows: • Acute Myocardial Infarction and other Acute Coronary Syndrome (MINAP) • Ambulance Clinical Quality Indicator S-T elevation Myocardial Infarction (STEMI) Care Bundle • Sentinel Stroke National Audit Programme (Stroke Call to Hospital Arrival times) • Ambulance Clinical Quality falls indicator • Warwick Clinical Trials Unit Out of Hospital Cardiac Arrest Outcome (OHCAO) • Ambulance Clinical Quality Indicator Cardiac Arrest ROSC rates (and separate Utstein ROSC measure) • Ambulance Clinical Quality Indicator Cardiac Arrest Survival to Discharge (and separate Utstein STD measure) • Ambulance Clinical Quality Indicator Cardiac Arrest Post ROSC Care Bundle • Recontact audit

2.4	A list of each national clinical audit and national confidential enquiry that the provider participated in, and which data collection was completed during the reporting period, alongside the number of cases submitted to each audit, as a percentage of the number required by the terms of the audit or enquiry.	The national clinical audits and national confidential enquiries that SCAS participated in, and for which data collection was completed during 2024/25, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. *Note that the data relates to April – December 2024 and not a full year due to National Ambulance Clinical Quality Indicator reporting timelines. • Acute Myocardial Infarction and other Acute Coronary Syndrome (MINAP) Number of cases 419 • Ambulance Clinical Quality Indicator S-T elevation Myocardial Infarction (STEMI) Care Bundle Number of cases 553 • Sentinel Stroke National Audit Programme (Stroke Call to Hospital Arrival times) Number of cases 2181 (Apr – Sept) • Ambulance Clinical Quality falls indicator Number of cases 900 • Warwick Clinical Trials Unit Out of Hospital Cardiac Arrest Outcome (OHCAO) Number of cases 3858 • Ambulance Clinical Quality Indicator Cardiac Arrest ROSC rates (and separate Utstein ROSC measure) Number of cases 457 Utstein cases 126 • Ambulance Clinical Quality Indicator Cardiac Arrest Survival to

		Discharge (and separate Utstein STD measure) Number of cases 157 Utstein cases 69 • Ambulance Clinical Quality Indicator Cardiac Arrest Post ROSC Care Bundle Number of cases 608 • Recontact Audit Number of cases 52
2.5	The number of national clinical audit reports published during the reporting period that were reviewed by the provider during the reporting period.	The reports of Nine national clinical audits were reviewed by the provider in 2024/25.
2.6	A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.5.	SCAS intends to take the following actions to improve the quality of healthcare provided • Resuscitation training. • Launch of a new ACQI scorecard. • Ensure improvement in performance against ambulance response targets is maintained.
2.7	The number of local clinical audit (a) reports that were reviewed by the provider during the reporting period.	The reports of 22 local clinical audits were reviewed by the provider in 2024/25.
2.8	A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.7.	SCAS intends to take the following actions to improve the quality of healthcare provided: • QI project – stock in pouches • Pain score QI project • Local SoPs review • Individual coaching • Revised pocket guide MCA/MHA
3	The number of patients receiving relevant health services provided or subcontracted by the provider during the reporting period that were recruited during that period to participate in research approved by a research ethics committee within the National Research Ethics Service.	The number of patients receiving relevant health services provided or sub-contracted by SCAS in 2024/25 that were recruited during that period to participate in research approved by a research ethics committee was 969. Conference presentations and publications demonstrate our

		commitment to transparency and desire to improve patient outcomes and experience across the NHS. Our engagement with clinical research also demonstrates the Trust's commitment to testing and offering the latest medical treatment and techniques. *Link to annual report
4	Whether or not a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals under the Commissioning for Quality and Innovation (CQUIN) payment framework agreed between the provider and any person or body they have entered into a contract, agreement or arrangement with for the provision of relevant health services.	Not Applicable
	If a proportion of the provider's income during the reporting period was not conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, the reason for this.	Not Applicable
	If a proportion of the provider's income during the reporting period was not conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, the reason for this.	Not Applicable
5	Whether or not the provider is required to register with CQC under section 10 of the Health and Social Care Act 2008.	SCAS is required to register with the Care Quality Commission.
5.1	If the provider is required to register with the CQC: (a) whether at end of the reporting period the provider is: (i) registered with the CQC with no conditions attached to registration,	SCAS current registration status is without conditions. A section 29a letter was received in 2022/23 and a response submitted.

	(ii) registered with the CQC with conditions attached to registration, (b) if the provider's registration with CQC is subject to conditions, what those conditions are and (c) whether CQC has taken enforcement action against the provider during the reporting period.	
6	Removed 2011 amendments	
7	Whether or not the provider has taken part in any special reviews or investigations by CQC under section 48 of the Health and Social Care Act 2008 during the reporting period.	JTAI Reading March 2025. (Joint Targeted Area Inspection)
7.1	If the provider has participated in a special review or investigation by CQC: (a) the subject matter of any review or investigation (b) the conclusions or requirements reported by CQC following any review or investigation (c) the action the provider intends to take to address the conclusions or requirements reported by CQC and (d) any progress the provider has made in taking the action identified under paragraph (c) prior to the end of the reporting period.	The Safeguarding team participated. The focus was on domestic abuse, particularly regarding children aged 0 – 7 years and pregnant women. Inspectors sought assurance on multi agency collaboration and the voice of the child. Feedback from the inspectors was generally positive, highlighting: ➢ SCAS's investment in safeguarding, including the recruitment of a new Domestic Abuse Specialist to support professionals. ➢ Development of safeguarding support, including supervision and an advice line for staff. ➢ High compliance rates with safeguarding training
8	Whether or not during the reporting period the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest version of those statistics published prior to publication of the relevant document by the provider.	Not applicable

8.1	If the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data:	Not applicable.
9	The provider's Information Governance Assessment Report	The Data Security Protection Toolkit (DSPT) is aligned to Cyber Assessment Framework. In 2023/24 submission was standards met. Data for 24/25 will be available in July 2025 – the trust is expected to be standards met.
10	Whether or not the provider was subject to the Payment by Results clinical coding audit at any time during the reporting period by the NHSE.	SCAS was not subject to the Payment by Results clinical coding audit during 2024/25 by NHSE.
10.1	If the provider was subject to the Payment by Results clinical coding audit by the NHSi at any time during the reporting period, the error rates, as percentages, for clinical diagnosis coding and clinical treatment coding reported by the NHSi in any audit published in relation to the provider for the reporting period prior to publication of the relevant document by the provider.	Not applicable.
11	The action taken by the provider to improve data quality.	SCAS will be taking the following actions to improve data quality: • Integrated Quality Performance Report review and revision where indicated – includes all finance, operational, service and quality data. • Fit for the future pillars • Review and implementation of actions from internal audit reports

2.3 Reporting against NHSi core indicators

Ambulance Response Programme

Performance against national ambulance service response targets 2024/25.

	Prescribed information	Type of trust	Comment
14.	The percentage of telephone calls (Category 1 and Category 2 calls) resulting in an emergency response by the Trust at the scene of the emergency within 7 minutes of receipt of that call during the reporting period.	Ambulance Trust	In the table showing performance against this indicator, Category 1 and Category 2 calls should be separate.



Category 1 2024/2025
08:54 (Mean)
16:10 (90th Percentile)

Category 1 2023/2024
08:51 (Mean)
16:04 (90th Percentile)

Category 1 2022/2023
09:23 (Mean)
17:01 (90th Percentile)

Ambulance category 1 (C1) – life-threatening calls: response time

The percentage of Category 1 telephone calls resulting in an emergency response by the Trust at the scene of the emergency within 7 minutes of receipt of

that call during the reporting period.

The South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons.

- Computer Aided Dispatch (CAD) system has robust fallback plans.
- Ambulance response standards are measured and reported nationally.
- The Trust has a robust data quality process for ensuring performance reporting which is benchmarked, and that data is scrutinised internally by the Executives, Board and by commissioners.

SCAS intends to take the following actions to improve this indicator and so the quality of its services, by continually analysing the ambulance response data and continuing to model our staff rotas and fleet availability to meet the category requirements. Through the integrated performance report to Trust Board there will be clear visibility of the data and our actions.

	Prescribed information	**Type of trust**	**Comment**
14.1	The percentage of Category 2 telephone calls resulting in an ambulance response by the trust at the scene of the emergency within 18 minutes of receipt of that call during the reporting period.	Ambulance Trust	

	Category 2 2024/2025 31:58 (Mean) 1:03:31 (90th Percentile) Category 2 2023/2024 34:14 (Mean) 1:08:22(90th Percentile) Category 2 2022/2023 34:30 (Mean) 1:11:35 (90thPercentile)

The percentage of Category 2 telephone calls resulting in an ambulance response by the Trust at the scene of the emergency within 18 minutes of receipt of that call during the reporting period.

The South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons.

- CAD system has robust fallback plans
- Ambulance response standards are measured and reported nationally
- The Trust has a robust data quality process for ensuring performance reporting which is benchmarked, and that data is scrutinised internally by the Executives, Board and by commissioners

SCAS intends to take the following actions to improve this indicator and so the quality of its services, by continually analysing the ambulance response data and continuing to model our staff rotas and fleet availability to meet the category requirements. A performance improvement workstream is included in the trust improvement programme. Release to Respond has decreased handover delays and Hear and Treat rates are positive. Through the integrated performance report to Trust Board there will be clear visibility of the data and our actions.

Ambulance category 3 – calls: mean average response time.

	Category 3 2024/25 5:46:03 (90th Percentile) Category 3 2023/24 5:22:31(90th Percentile) Category 3 2022/23 5:14:02 (90th Percentile)

The South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons.

- CAD system has robust fallback plans.
- Ambulance response standards are measured and reported nationally.
- The Trust has a robust data quality process for ensuring performance reporting which is benchmarked, and that data is scrutinised internally by the Executives, Board and by commissioners.

SCAS intends to take the following actions to improve this indicator and so the quality of its services, by continually analysing the ambulance response data and continuing to model our staff rotas and fleet availability to meet the category requirements. Work continues to ensure that patients are navigated to the right care pathway for them to receive the care needed. Through the integrated performance report to Trust Board there will be clear visibility of the data and our actions.

Ambulance category 4 – response time

	Category 4 2024/2025 6:27:37 (90th Percentile) Category 4 2023/2024 6:44:13 (90th Percentile) Category 4 2022/23 6:16:32 (90th Percentile)

Ambulance category 4 (C4) – less urgent calls:

The South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons.

- CAD system has robust and tested fallback plans.
- Ambulance response standards are measured and reported nationally.
- The Trust has a robust data quality process for ensuring performance reporting which is benchmarked, and that data is scrutinised internally by the Executives, Board and by commissioners.

SCAS intends to take the following actions to improve this indicator and so the quality of its services, by continually analysing the ambulance response data and continuing to model our staff rotas and fleet availability to meet the category requirements. Work continues to ensure that patients are navigated to the right care pathway for them to receive the care needed. Through the integrated performance report to the Trust Board there is clear visibility of the data and our actions to improve.

	Prescribed information	Type of trust	Comment
15.	The percentage of patients with a pre-existing diagnosis of suspected ST elevation myocardial infarction who received an appropriate care bundle from the trust during the reporting period.	Ambulance Trusts	

The South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons.

- Electronic patient record data and analysis
- Report and data for national reporting requirements
- Board reports / Integrated performance report

SCAS intends to take the following actions to improve these indicators, and so the quality of its services, by utilising data collected from the electronic patient record system and analysing that data as per national reporting requirements. SCAS has an internal clinical audit programme and conducts deep dives where necessary reporting to the Clinical Review Group and Quality and Safety committee.

Ambulance Clinical Quality Indicators YTD April to December 2024/25 against national average (YTD)

Clinical Quality Indicator	Lower	Upper	Difference	National Average	South Central	Greater or lower than Average
STEMI - Care	57.76%	96.05%	38.29%	77.55%	57.76%	Lower

	Prescribed information	Type of trust	Comment
16.	The percentage of patients with suspected stroke assessed face to face who received an appropriate care bundle from the trust during the reporting period.	Ambulance Trusts	This indicator was retired. Last data submitted Feb 2024

	Prescribed information	Type of trust	Comment
21.	The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	Trusts providing relevant acute services	

	Your Trust in 2024	**Average (median) for ambulance trusts**	**Your Trust in 2023**	**Your Trust in 2022**
"If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation"	58.5 %	60.5%	60.8%	61.7%

The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.

The South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons:

- Triangulation of intelligence from Pulse Survey / new joiners / leavers surveys
- Student placement feedback
- FTSU themes
- Robust analysis at the People Committee

SCAS intends to take the following actions to improve this and so the quality of its services by:

- Continue to gather and triangulate intelligence from many sources including:
    - Annual NHS staff survey
    - Pulse Survey
    - Student placement feedback
    - FTSU themes
    - Human Resources case themes

- Continue to ensure easy access to updates including Patient safety sessions.
- Clinical audit pages on Hub to be updated and regular published updates.
- Improvement programme including operational performance and culture.
- Ensure staff feel listened to and valued.
- Build our Quality Improvement programme to give staff the capability to make change and empower them in delivering continuous improvement.

25	The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	In 2024/25 there were 5364 patient safety incidents reported. Of these, 55 (1.0%) resulted in severe harm or death.

	2022/23	2023/24	2024/25
Number of incidents	1720	2234	5365
Number and % severe harm/death	12	54	55
	(0.7%)	(2.4%)	(1.0%)

The South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons.

- Trust electronic reporting system (Datix) reports
- Clinical governance meeting reports and scrutiny of data
- Patient Safety and Experience group data analysis
- Incident report screening by Clinical Governance Lead/PS team
- LFPSE

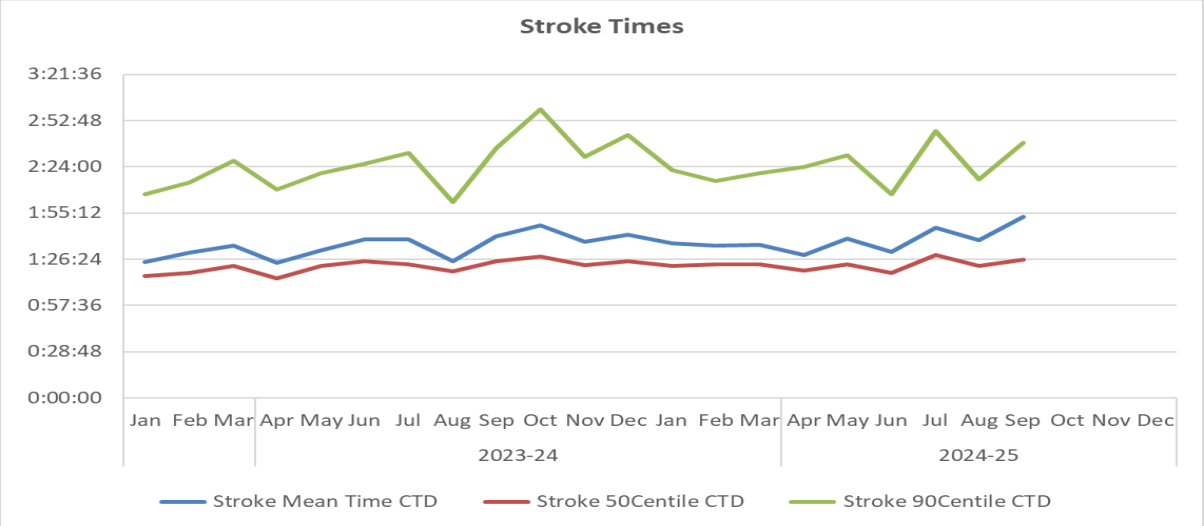
SCAS intends to take the following actions to improve this indicator and so the quality of its services:

- Ongoing training for staff on incident reporting and HEE patient safety training modules
- Reviewing numbers, severity and themes of incidents at the Patient Safety and Experience Committee
- Trust Board scrutiny
- Safety culture survey
- Campaign of awareness around incident reporting and improvement activity

Stroke 60 minutes (please see below for revised definition)	Ambulance Trusts
Return of spontaneous circulation (ROSC) where the arrest was bystander witnessed, and the initial rhythm was ventricular fibrillation (VF) or ventricular tachycardia (VT)	Ambulance Trusts

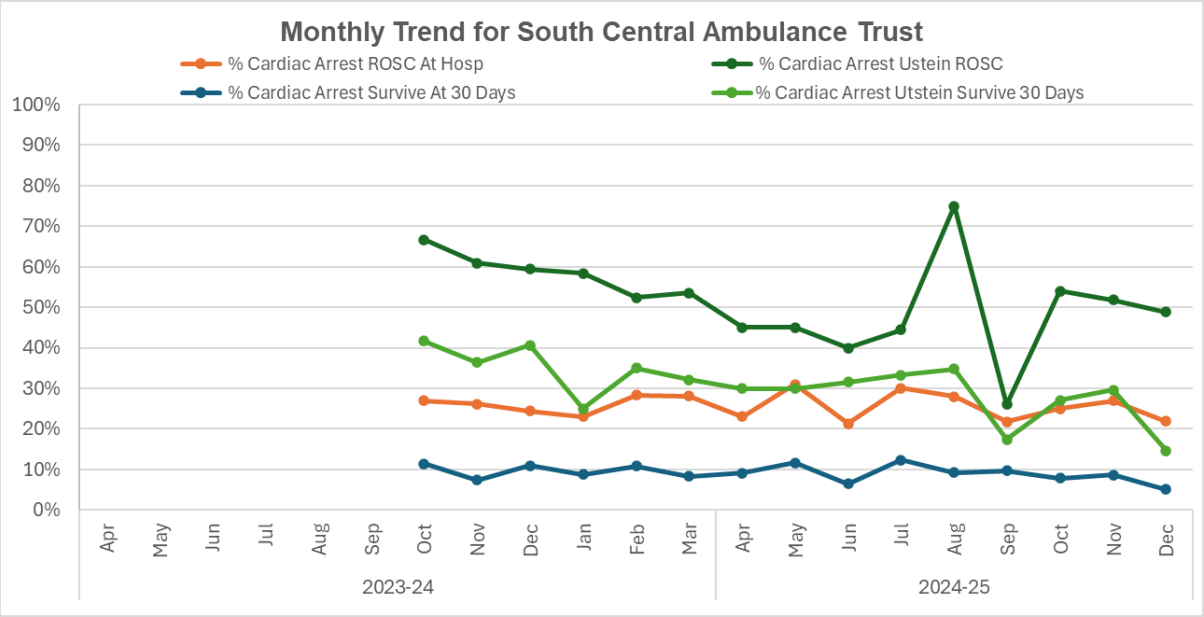
Stroke performance

The stroke ACQI datasets comprise of timeliness. The national data submission for call to door indicator is shown below. Due to a national issue with the system, October – December submission will be uploaded when the submission window opens.



Return of Spontaneous Circulation (ROSC)

The charts below detail the current and historic SCAS ROSC rates for return of spontaneous circulation (ROSC) where the arrest was bystander witnessed and the initial rhythm was ventricular fibrillation (VF) or ventricular tachycardia (VT)



Learning from Deaths

27.1	The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	During 01/04/2024-31/12/2024, 268 of SCAS patients met the Learning from Deaths criteria of requiring review following cardiac arrest. This comprised the following number of deaths which occurred in each quarter of that reporting period: 141 in the first quarter; 53 in the second quarter; 74 in the third quarter;

27.2	The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	By 31/12/24, 268 case record reviews have been carried out. In 41 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 14 in the first quarter; 12 in the second quarter; 15 in the third quarter.
27.3	An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: 0 representing 0% for the first quarter. 0 representing 0% for the second quarter. 0 representing 0% for the third quarter.
27.4	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3.	The standard of care provided by our staff is excellent in most cases. Documentation could have been improved in a small number of cases. Crew feedback was given directly in a small number of cases.

27.5	A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4).	Feedback given to SCAS crews on improving documentation. Feedback to individual crew. Further investigation commenced of delays as required.
27.6	An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.	Monitoring documentation quality continues
27.7	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period.	Covered in 27.2.
27.8	An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.	Covered in 27.3.
27.9	A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8.	Covered in 27.3.

Part 3: Other Information and Quality Priorities for 2025/2026

3.1 Regulation assurance and compliance

The table below shows the current SCAS CQC rating.

Rating for ambulance services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency operations centre (EOC)	Requires Improvement ↓ Aug 2022	Good →← Aug 2022	Good →← Aug 2022	Requires Improvement ↓ Aug 2022	Requires Improvement ↓ Aug 2022	Requires Improvement ↓ Aug 2022
Patient transport services	Requires improvement Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020	Good Jun 2020
Emergency and urgent care	Inadequate ↓↓ Aug 2022	Requires Improvement ↓ Aug 2022	Good →← Aug 2022	Requires Improvement ↓ Aug 2022	Inadequate ↓↓ Aug 2022	Inadequate ↓↓ Aug 2022
Resilience	Good Nov 2018	Good Nov 2018	Not rated	Good Nov 2018	Good Nov 2018	Good Nov 2018
Overall	Inadequate	Good	Good	Good	Inadequate	Inadequate

Overall ratings for ambulance services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Overall ratings are from combining ratings for services.

3.2 CQC inspections

The Trust had a planned core service inspection of the Emergency Operations Centre and Urgent and Emergency Care service in April 2022. The Well-Led inspection was then undertaken in May 2022. The report, including ratings matrix, for this inspection was published on 25th August 2022. Following this inspection, a trust improvement plan was commenced.

3.3 Trust Improvement Programme

The SCAS Improvement Programme was established in August 2022 in response to the published CQC well-led inspection report. It is formed of four programmes of activity:

- Governance and Well-Led (led by the Chief Governance Officer (CGO)
- Culture and Staff Wellbeing (led by the Chief People Officer (CPO)
- Performance Improvement (led by the Executive Director of Operations); and,
- Patient Safety (led by the Chief Nursing Officer (CNO)

The Programme delivery transitioned in 2023/24 to a greater focus on embedding and sustaining improvements, with a drive to achieve the required 'Exit Criteria' to exit National Oversight Framework Level 4 (NOF4) by demonstrating significant progress in how the Trust is governed and led, with a positive and safe culture for our staff and our patients. During 2024/25 there has been a focus on transition criteria.

In November 2024, an undertakings S106 assurance visit led by the ICB and NHSE colleagues took place. Following this, a compliance certificate was issued which covered some of the patient safety related 2022 undertakings. Revised undertakings under section 106 of the act were recorded, improvement programmes continue and SCAS continues to work with an NHSE improvement Director.

3.4. PSIRF

SCAS transitioned to PSIRF in April 2025 and in year, 156 learning responses were assigned. A sound governance structure has been developed around PSIRF where patient safety incidents and patient experience contacts are reviewed daily, escalated as required to Safety Panel Review to consider for learning responses and reports signed off at Oversight & Review Group for executive oversight. The board are sighted on both the daily reviews and weekly Safety Review Panel decisions.

Two Patient Safety Partners have been recruited and are undergoing orientation prior to co-producing a workplan with the Patient Safety team.

Training levels are good with HEE Level One at 97% compliance and HEE Level Two at 95%. Over 185 staff have been trained in-house to deliver SWARM huddles as a learning response and as an initial fact-finding response to patient safety incidents.

Learning from patient safety incidents is shared in multiple ways across the Trust; a monthly patient safety newsletter, Patient Safety Sessions livestream and recordings, learning snapshots shared at service line meetings and promoting safety across our digital platforms including Viva Engage and the patient safety page on The Hub.

In March 2025, we undertook a system peer review led by Hampshire and the Isle of Wight where initial feedback was positive.

3.5. Safeguarding

The improvement programme in safeguarding has continued in 2024/25. Key areas of focus are noted below.

My Referral Form

Following the recommendation from the Task and Finish Group, the new referral form, My Referral Form, was successfully launched on 1st October 2024. The rationale for implementing this new form was to:

- Provide a safeguarding/welfare triage function.
- Introduce mandatory fields to reduce held referrals.

The Safeguarding Team successfully hosted a multi-agency workshop in December 2024, allowing Local Authorities to provide feedback on the new form.

MCA

The new Mental Capacity Act (MCA) Level 2a e-learning course has been successfully developed and launched. This course ensures staff are trained, confident, and skilled

in decision-making for individuals who may lack mental capacity. It also supports compliance with legal and regulatory requirements and was a key priority for the Safeguarding Team in 2024/25.

Quarterly MCA audits have been conducted throughout 2024/25 to assess staff compliance in applying the legislation. Audit outcomes show continuous improvement, with compliance increasing from 66.67% in Q3 to 86.67% in Q4.

Training

By the end of Q4, Safeguarding Level 1, 2, and 3 training met their trajectories.

Allegations Management

Allegations Management meetings have been ongoing, with bi-monthly reports shared at the Safeguarding Group meeting.

3.6. Quality Improvement

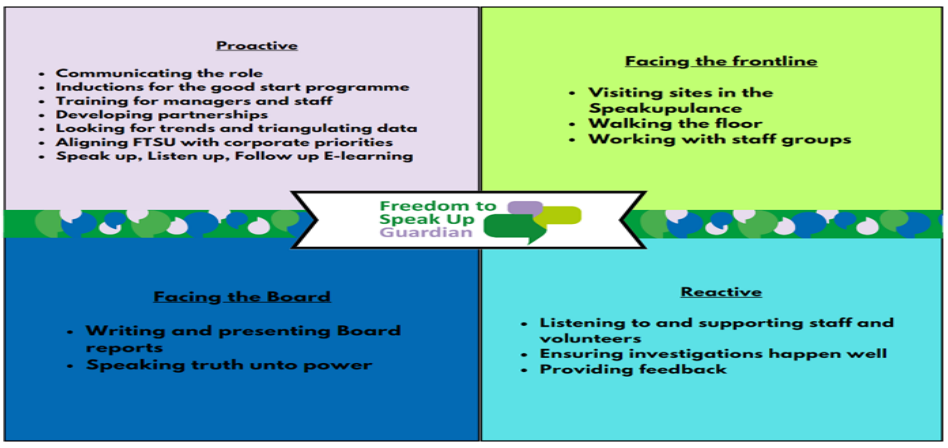
We continue to build capacity in Quality Improvement across the trust by utilising our NHS Elect membership to train cohorts of staff to become QI Champions. Forty-two staff have been trained since March 2024. These champions all have the experience of taking a small-scale QI project through to its conclusion and using improvement methodologies. The Fit for the Future proof of concept work is also QI based. There are further examples of QI projects, and the number is increasing as the champions are trained.

Engagement with improvement groups in Hampshire (HIOW) and Isle of Wight and Berkshire, Oxfordshire and Buckinghamshire (BOB) ICS continues. System wide improvement and learning is increasingly shared in these forums.

QI is one of the areas SCAS is collaborating with South East Coast Ambulance Service (SECAMB). This area of collaborative work will mature in 2025.

3.7. Freedom to Speak Up (FTSU)

The four key elements of the FTSU Guardian role can be seen in the diagram below



FTSU Champions

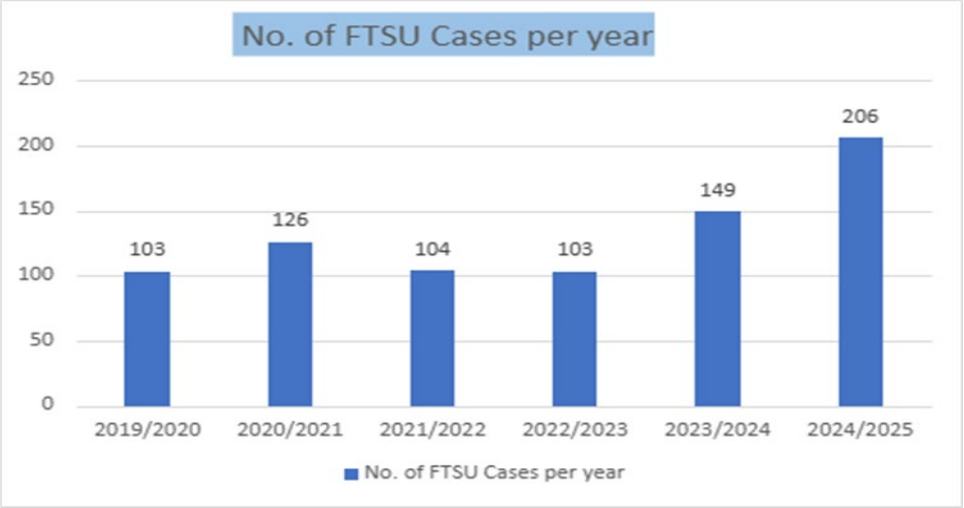
Our Freedom to Speak Up (FTSU) Guardian team is supported by a growing network of trained FTSU Champions from diverse departments across SCAS.

These staff volunteers, who carry out the role alongside their main jobs, help embed a culture of speaking up by being visible, accessible, and offering signposting and support. They receive training and ongoing support to promote psychological safety and early resolution of concerns, in line with NHS guidance and the CQC well-led framework.

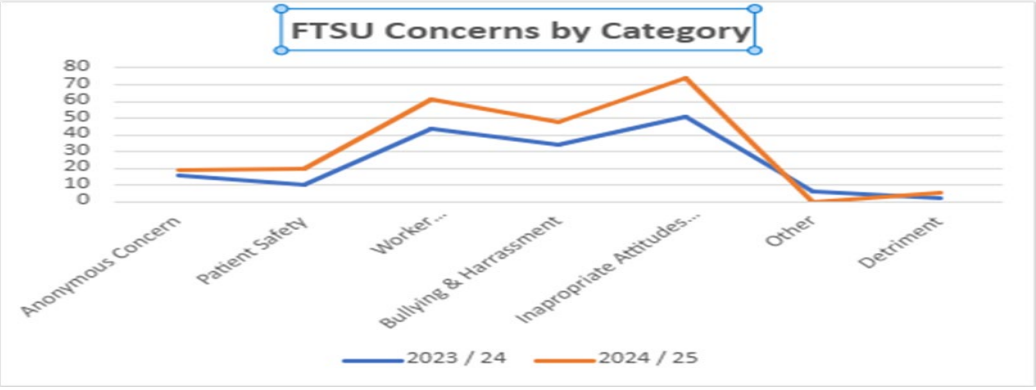
In 2024/25, the network has expanded by 68%, with 62 trained Champions now in place, including Student Paramedics. Training sessions, supportive engagement and promotion of Champions have been planned for 2025/26.

Overview of cases raised via FTSU and user feedback

During 2024/25, the Trust has seen an increase in the number of concerns raised via our FTSU team. The chart below shows that 206 concerns were reported to the Team during this period; an increase of 38%. The rise reflects the proactive work of the FTSU team and raising awareness of our work.



The primary category of concerns with SCAS, can be seen in the chart below (the national benchmarks for the year are yet to be published).



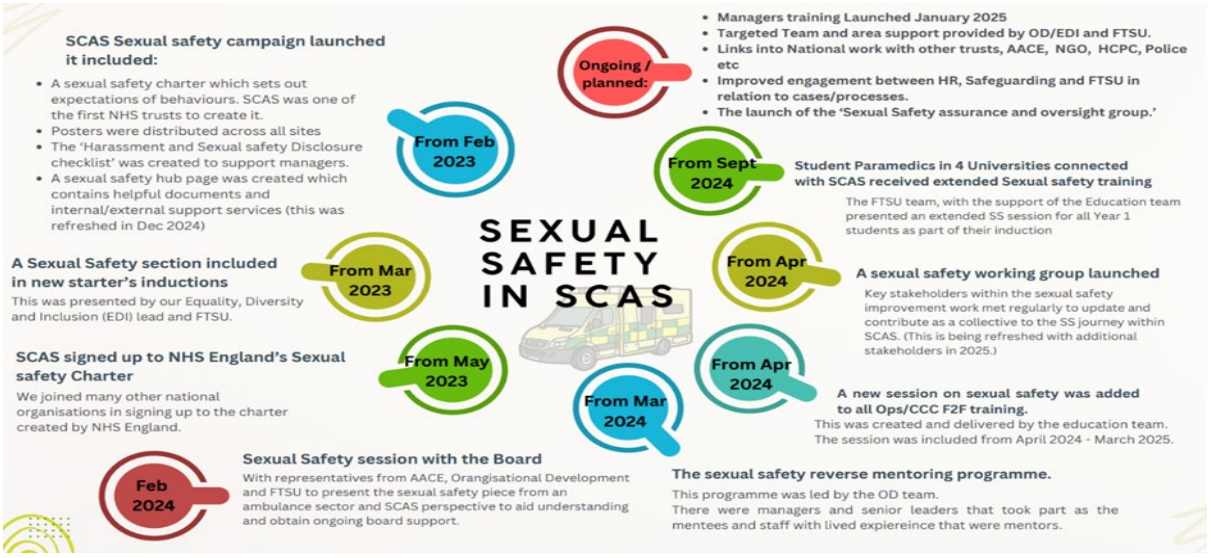
The FTSU team continue to work closely with the Safeguarding, Human Resources (HR) Culture & Leadership; Equality, Diversity & Inclusion (ED&I) and Staff network leads, in order to triangulate data and highlight themes and learning.

Sexual Safety within SCAS

FTSU has played a critical role in improving awareness around sexual safety across the Trust. Initiatives included:

- Workshops at all levels including Trust Board
- Enhanced staff induction with sexual safety awareness components
- Contributions to training packages and educational material
- Ongoing support to the **National Ambulance Sexual Safety Community of Practice (NASSCOP)** via the FTSU Guardian)

These efforts underscore the Trust's commitment to creating a safer and more respectful workplace.



FTSU eLearning

All three modules of the National eLearning 'Speak Up' 'Listen Up' and 'Follow Up' became part of SCAS's Mandatory training in 2023/24. As of 2024/25, compliance remains high:

- Speaking Up (All Staff): 97%
- Speaking & Listening Up (Managers): 98%
- Speaking, Listening & Following Up (Senior Managers): 96%

This formal eLearning is also supported by SCAS leaders, Just and learning culture, Essential Skills for People Managers (ESPM), and the Patient Safety Incident Response Framework (PSIRF) work streams.

Freedom to Speak Up Month

Freedom to Speak Up Month in October 2024 provided an opportunity to raise awareness of how much we value Speaking, Listening and Following Up at SCAS.

October's Freedom to Speak Up Month was themed #ListeningUp, highlighting the value of listening to understand, not just to respond. The campaign reached over 700 people across the Trust.

3.8. 2024 Staff Survey results

NHS Staff survey



Actions

- Participation in the 2nd cohort of the People Promise Exemplar Programme
- As part of the programme an action was undertaken to refresh all existing staff retention plans into engagement plans utilising MS Planner (cloud based)
- All operational directorates have planner cards associated to their agreed actions, alongside a SCAS wide planner column for actions that are replicated across the Trust
- Monthly highlight reports presented at local IWP meetings and into People and Culture Development Group (monthly)

Quality Priorities for 2025/26

2025/6 Quality Priority Summary			Rationale
Patient Safety	1a	Survey staff safety culture	Develop a 'wider view' patient survey tool. Survey staff, analyse the results and put improvements in place
	1b	Quality audit of After Action Reviews (AAR)	PSIRF quality metric tool measures the quality of PSII reports against SEIPS model. There is no equivalent national tool for AARs so this needs to be developed
	1c	Continued improvement in the quality of safeguarding referrals	The safeguarding improvement programme continues, the improved quality of referrals will lead to reduction in inappropriate referrals to partners
Clinical Effectiveness	2a	To report on Category 1 - 4 performance	Reporting against NHSi core indicators for Quality Accounts.
	2b	To report on national STEMI care bundle compliance	Reporting against NHSi core indicators for Quality Accounts.
	2c	New focus of audit group	Change the local audit focus so that 12 clinical audits are completed per year and reviewed at the monthly group
Patient Experience	3a	Co-production of amendments to current Healthcare Professional feedback process to ensure high level focus on clinical concerns and learning	Continuation from 2024/25-year audit. Move the focus to clinical concern feedback
	3b	Patient panel	PSIRF prioritises the inclusion of the patient's voice in what we do. This ensures parity of care across patient groups and allows co-design of services. Continue with patient panel groups and include a youth panel.
	3c	Increase patient survey response rates	Propose a new system and process for gaining feedback from patients and others who have been involved in services. This includes the potential of digitalisation of the process.

Patient Safety

1a. Survey staff safety culture

Why we have chosen this priority

The creation and maintenance of a good safety culture is imperative to reducing avoidable harm. The survey that has been used in the past is limited in its focus and response rates have been low. Results from the survey will be presented to divisional clinical governance meetings and improvement actions agreed. These will be upwardly reported to the Patient Safety and Experience Group.

What we will do

- Develop a tool so that staff are surveyed on a wider view of patient safety.
- Survey staff, analyse the results and put improvements in place.

Implementation Lead
Assistant Director of Patient Safety - sponsored by the Chief Nurse

1b. Quality audit of After Action Reviews (AAR)

Why have we chosen this priority?
The PSIRF quality metric tool measures the quality of PSII reports against the SEIPS model. There is no equivalent national tool for AARs. The quality tool will enable the quality of the reviews to be measured and inform improvements in training. This priority relates to known risks on the corporate risk register.

What will we do?

- Develop a tool that can be used to measure the quality and effectiveness of AARs.
- Approval of tool and pilot.
- Q4 2025/26 sample of AARs to be quality measured and reported to Patient Safety and Experience Group.

Implementation Lead
Assistant Director of Patient Safety - sponsored by the Chief Nurse

1c. Continued improvement in the quality of safeguarding referrals

Why have we chosen this priority?
The safeguarding improvement programme continues and the improved quality of referrals and reduction in inappropriate referrals is an important workstream. This relates to safeguarding risks on the corporate risk register.

What we will do

- Continue safeguarding training.
- Measure the reduction in the number of referrals made each quarter to the local authorities and number of referrals deemed to be of a quality standard via quarterly audits.

Implementation Lead
Head of Safeguarding - sponsored by the Chief Nurse

Clinical Effectiveness

2a. To report on Category 1 - 4 performance

Why we have chosen this priority
Reporting against NHSi core indicators for Quality Accounts.

What we will do

- Reported in the Quality Account in the section named NHS Core Indicators.

Implementation Lead

Business Intelligence - sponsored by the Executive Director of Operations

2b. To report on national STEMI care bundle compliance

Why we have chosen this priority

Reporting against NHSi core indicators for Quality Accounts.

What we will do

- Reported in the Quality Account in the section named NHS Core Indicators.

Implementation Lead

Pre hospital consultant practitioner – sponsored by Chief Paramedic

2C. New focus of audit group

Why we have chosen this priority

A change in focus of local audits is required so that 12 clinical audits are completed in year at the monthly group. In recent years, the focus has been on long waits but with improved performance times and no new learning a change needs to occur. The audit group will report to the Clinical Review Group where improvement actions will be escalated and monitored.

What we will do

- New ToR for the group where local teams review cases in their node. Monthly focused audits. The subjects of focus are:
    - Obstetric / Maternity emergency management,
    - AAA management,
    - Anaphylactic management
    - Chest pain / Panic attack. Recontact within 24hrs,
    - High NEWS2 scores, recontact within 24hrs. to include Neutropenic Sepsis questions,
    - Headaches / Strokes Recontact within 24hrs,
    - Management of End of life & Palliative care patients,
    - Management of Paediatric trauma,
    - Management of Under 5's,
    - Management of Trauma
    - Application of Mental capacity assessments.

Implementation Lead

Assistant Director of Quality – sponsored by Chief Paramedic

Patient Experience

3a. Co-production of amendments to current Healthcare Professional (HCP) feedback process to ensure high level focus on clinical concerns and learning.

Why we have chosen this priority
Continues work from last year audit. Focus needs to be on clinical concern feedback.

What we will do
- Co-produce new parameters and process for HCP feedback. This will include ICB colleagues.
- Trial new process and reaudit in Q4 2025/26.

Implementation Lead
Head of Patient Experience sponsored by Chief Nurse

3b. Patient panel

Why we have chosen this priority
Under PSIRF it is more important than ever to include the patient's voice in the work that we do. This aids parity of care across patient groups and allows co-design of services.

What we will do
- Continue with the patient panel groups and ensure the development of Patient Panels to include a youth panel.
- Work plan to be devised for all panel groups.
- Reporting to the Patient Safety and Experience Group.

Implementation Lead
Patient and Public Engagement Facilitator sponsored by Chief Nurse

3c. Increase patient survey response rates.

Why we have chosen this priority
Response rates to the patient survey are consistently low. Access to the survey is mainly via the trust website.

What we will do
- Propose a new system and process for gaining feedback from patients and others who have been involved in services. This includes the potential of digitalisation of the process.
- Once new processes are devised an improvement trajectory will be set and approved via the Patient Safety and Experience Group.

Implementation Lead
Patient and Public Engagement Facilitator sponsored by Chief Nurse

Annex 1: Statement from commissioners – NHS Hampshire and Isle of Wight Integrated Care Board:

Nursing & Quality Team
NHS Hampshire and Isle of Wight Integrated Care Board
Omega House
112 Southampton Road
Eastleigh
SO50 5PB
Phone: 0300 561 2561
Email: Team mailbox address
www.hantsiow.icb.nhs.uk

Sent via email
David
Eltringham
Chief Executive

South Central Ambulance Service NHS Foundation Trust

19 June 2025

Dear David

Re: 2024/25 Quality Account

Please find below, the formal response to your Quality Account for 2024/25 from NHS Hampshire and Isle of Wight.

Statement from commissioners – NHS Hampshire and Isle of Wight Integrated Care Board:

NHS Hampshire and Isle of Wight Integrated Care Board would like to thank South Central Ambulance Service NHS Foundation Trust (SCAS) for the opportunity to comment on their Quality Account for 2024/25. We are satisfied with the overall content of the Quality Account and believe it meets the mandated elements.

We have worked alongside your Trust to seek assurances that the service delivered has met the expected standards for safe, effective and person-centred care, acting for improvement where necessary.

We supported South Central Ambulance Service NHS Foundation Trust's 2024/25 quality improvement priorities. We recognise that whilst not fully achieving all their key priorities, SCAS has made some considerable improvements in several areas,

including a reduction in handover delays, improved response times and the recruitment of Patient Safety Partners.

Whilst not included in your Quality Account in detail, we also recognise your commitment to supporting some of the most vulnerable members of our community alongside the
strengthened working relationships with other system providers.

It is recommended that these improvements are embedded and that their impact on patient outcomes continues to be monitored during 2025/26.

We would like to thank South Central Ambulance Service NHS Foundation Trust for continuing to invite us to participate in internal quality meetings to support our quality assurance for improvement processes. Thank you for supporting local and system quality improvement by being an active, respected and valued member of the Hampshire and Isle of Wight System Quality Group, Patient Safety Specialist Network, and Learning and Sharing Network has been welcomed.

We support the 2025/26 quality priorities outlined in the Quality Account, which include a number that align with the Hampshire and Isle of Wight System Quality Priorities. We look forward to the Trust sharing improvements and examples of best practice/innovation at future System Quality Group meetings.

NHS Hampshire and Isle of Wight are pleased to endorse the Quality Account for 2024/25 and look forward to continuing to work closely with SCAS during 2025/26 in further improving the quality of care delivered to our population.

Yours sincerely



Nicky Lucey
Chief Nursing Officer
Hampshire and Isle of Wight Integrated Care

Board Cc.

Jane Campbell - Assistant Director of

Annex 2: Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2020/21 and supporting guidance Detailed requirements for quality reports 2018/19
- the content of the quality report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2024 to March 2025
    - papers relating to quality reported to the board over the period April 2024 to March 2025
    - feedback from commissioners dated 19 June 2025
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Service and NHS Complaints Regulations 2009, dated June 2024.
    - the national staff survey published March 2025.
    - CQC inspection report dated August 2022
- the quality report presents a balanced picture of the NHS foundation Trust's performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the board

Chairman
date

Chief Executive
date

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South Central Ambulance Service
NHS Foundation Trust

Trust Board of Directors Meeting in Public
31 July 2025

Report title	Month 3 (M3) Finance Report
Agenda item	13
Report executive owner	Stuart Rees, Chief Finance Officer
Report author	Alan Monks, Deputy Chief Finance Officer
Governance Pathway: Previous consideration	Finance and Performance Committee
Governance Pathway: Next steps	n\a

Executive Summary

The Trust's reported position for the month is as follows:

Key Performance Indicators				
		Plan	**Actual**	**Variance**
1	Surplus / (Deficit) In-month (£'000)	411	411	0
2	Capital Spend in-mth (£'000)	-17,788	3,103	20,891
3	Pay Costs In-Month (£'000)	17,702	18,141	-439
4	Agency Costs - in month (£'000)	87	201	-114
5	Cash - Year to date (£m)	33.9	22.4	-11.5
6	Aged Debtor >90 Days	5.00%	12.73%	-7.73%
7	BPPC - YTD - Value	95.00%	98.50%	3.50%
8	BPPC - YTD - Number	95.00%	98.60%	3.60%

Income and Expenditure (I&E) Position
The reported Trust financial position for the month is a £0.4m surplus, which required an agreement with HIOW ICB on reprofiling of funding to put the Trust in line with plan for Month 3.

The Trust reported a surplus of £0.4m for Month 3, in line with the financial plan. This position was achieved through a funding reprofile agreed with the Hampshire and Isle of Wight Integrated Care Board (HIOW ICB).

Despite meeting the in-month target, the position masks several underlying risks, including:

- Over-establishment and staffing cost pressures (£0.3m),
- Unmet Cost Improvement Programmes (CIPs) (£0.1m),
- Delays in implementing the corporate review (£0.2m).

These pressures were offset by favourable variances £0.1m and £0.5m of rephased income agreed with the ICB.

Key variances in performance are reported as:

- 999 costs were £465k worse than plan
- 111 costs were £43k worse than plan
- PTS costs were £18k worse than plan
- Corporate services were on plan
- Depreciation and financing were lower than plan by £123k

The Trust has required Non-Recurrent measures of £1.6m to achieve the YTD Financial position.

Capital Position
The Trust's YTD capital spend for June was £3.9m. The Trust overspent against its YTD capital budget by £15.5m, this was due to slippage in the sale and leaseback of Double Crewed Ambulances (DCA's) and Rapid Response Vehicles (RRV's).

Cash Position

The Trust's cash balance at the end of June stood at £22.4m. There was a net cash outflow in month 3 of £3.6m due mostly to reductions in block income contracts where ICBs have clawed back funds from M1 and M2. This is £11.5m below the plan due to the timing of DCA sale and leaseback receipts.

Aged Debt
The 90-day debtor increased to £0.129m in June (£0.08m in May). This represents 12.73% (3.97% in May) of the total debtor balance.

Key Messages:

- The reported £0.4m surplus was only possible due to one-off income rephasing,
- Unidentified CIPs, In-year Cost pressure and slip in Grip and Control measures,
- Workforce Cost Pressures - Pay and agency costs are significantly over budget,
- Commissioner contracts are not yet finalised, there remains a level of uncertainty regarding our forecast income.
- The capital forecast remains over plan.

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)

The Board is asked to:

- The Board is asked to note the report.
- Note the Reported Financial Position
    - Acknowledge the reported £0.4 million surplus for Month 3, achieved through non-recurrent measures.
    - Recognise the underlying cost pressures and risks that will impact future months.
- Note Monitor and Report Progress to the Finance and Performance Committee on:
    - Delivery of Cost Improvement Programmes (CIPs).
    - Workforce trends.

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

1. Background / Introduction

- This report is produced 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 3, the Trust's I&E position shows a £0.4m surplus position against its planned surplus of £0.4m. This is after accounting for additional Commissioner income re-phasing of £0.5m.

£m	M1	M2	M3	YTD
Plan	0.2	0.2	0.4	0.8
Actual	(0.2)	(0.2)	(0.4)	(0.8)
Variance to Plan	-	-	-	-

The Trust has required non-recurrent measures of £1.6m to achieve the YTD Financial position.

The table below details the financial position, by Division, as of June 2025 (Month 3)

£m		Month 3			Year to Date			Forecast		
		Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	Variance
999	Income	21.5	21.1	0.5	63.8	62.3	1.5	247.9	247.6	0.3
	Expenditure	(16.8)	(16.3)	(0.5)	(50.3)	(48.6)	(1.7)	(192.6)	(192.3)	(0.3)
	Contribution	**4.7**	**4.8**	**(0.0)**	**13.5**	**13.6**	**(0.2)**	**55.2**	**55.2**	**0.0**
	%	**0.0**	**0.0**		**0.0**	**0.0**		**0.0**	**0.0**	
111	Income	3.8	3.8	(0.0)	11.3	11.3	(0.0)	45.2	45.2	0.0
	Expenditure	(3.2)	(3.1)	(0.0)	(9.5)	(9.2)	(0.2)	(38.0)	(38.0)	(0.0)
	Contribution	**0.6**	**0.6**	**(0.0)**	**1.8**	**2.1**	**(0.2)**	**7.2**	**7.2**	**(0.0)**
	%	**0.0**	**0.0**		**0.0**	**0.0**		**0.0**	**0.0**	
PTS	Income	1.9	2.0	(0.0)	5.9	5.9	(0.0)	23.6	23.6	0.0
	Expenditure	(1.6)	(1.6)	(0.0)	(4.7)	(4.9)	0.2	(19.4)	(19.4)	0.0
	Contribution	**0.3**	**0.3**	**(0.0)**	**1.2**	**1.0**	**0.1**	**4.3**	**4.3**	**0.0**
	%	**0.0**	**0.0**		**0.0**	**0.0**		**0.0**	**0.0**	
Operations Total Contribution		**5.6**	**5.7**	**(0.1)**	**16.5**	**16.7**	**(0.3)**	**66.7**	**66.7**	**(0.0)**
%		**0.0**	**0.0**		**0.0**	**0.0**		**0.0**	**0.0**	
Corporate		(5.3)	(5.4)	0.1	(15.8)	(16.1)	0.3	(67.3)	(67.4)	0.1
Surplus/(Deficit)		**0.4**	**0.4**	**0.0**	**0.6**	**0.6**	**0.0**	**(0.6)**	**(0.7)**	**0.1**
Reporting Adjustments		0.0	0.1	(0.0)	0.2	0.2	(0.0)	0.6	0.7	(0.1)
Adjusted Surplus/(Deficit)		**0.4**	**0.4**	**(0.0)**	**0.8**	**0.8**	**(0.0)**	**0.0**	**(0.0)**	**0.0**
Deficit Funding		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Reportable Surplus/(Deficit)		**0.4**	**0.4**	**(0.0)**	**0.8**	**0.8**	**(0.0)**	**0.0**	**0.0**	**0.0**

Service-Specific Performance

The main points to note for Month 3 performance are:

- 999 Division reported a £465k deficit against budget, which is delivered by offsetting £450k of rephased income
- The income variance relates re-phasing of £450k Commissioning income from latter months into M3. This leaves the margin pressure to the future periods in the year as overall income remains unchanged.
- The spend variance of £465k in the month for 999 relates to:

- Fleet £68k overspent in month. There is a budgetary deficit resulting from maintenance spend. The remaining overspend is unachieved CIP.
- In month Frontline Ops was 42 WTE over-established, resulting in £322k overspend against substantive resource, over runs on private providers £52k adverse variance, which was partially offset by reduced overtime usage (£175k). Recovery plans to recoup the over establishment overspends and private providers impact are underway.
- A&E Trustwide is overspent by £360k in month. HART is £52k overspent, mainly on pay/overtime usage and consumables. The remaining overspend is due to unachieved CIP in month across the operational areas.
- 111 services overspent by £43k, pay is underspent against budget by £26k and non-pay overspent by £71k. Pay was under against budget due to reduction in AHT for CIP delivery. The non pay variance is driven by the impact of unallocated CIPs.
- NEPTS is £18k overspent before timing adjustments. The overspend of £18k is mainly due to late return of vehicles. The current 2025/26 contract offer from BLMK is £31k lower than plan for the month (£0.45m FYE).
- Corporate reported on plan in the month, despite being overspent by £216k which was in turn offset by underspends on utilities £100k and remainder due to delayed spend against agreed funded cost pressures £116k. The overspends were mainly due to slippage on implementation of the corporate review c£110k, agency spend c£40k, and high cost drugs £62k
- Depreciation and financing costs come in lower than plan at £123k.

The assumption remains that budget holders need to manage spend within budgeted levels and any shortfall arising at Month 3 will need to be recovered over the remainder of the financial year.

Financial Recovery Plan (FRP)

As updated at the Extra Ordinary Finance and Performance Committee, the Trust's Financial Recovery Plan target has now increased to £24.0m from £21.6m, due to YTD under performance against the financial plan and additional cost pressures.

The FRP is broken down into various schemes spread across all the Trust's divisions.

There is a separate paper within the agenda which picks up on the detail.

Overall, Trust Performance

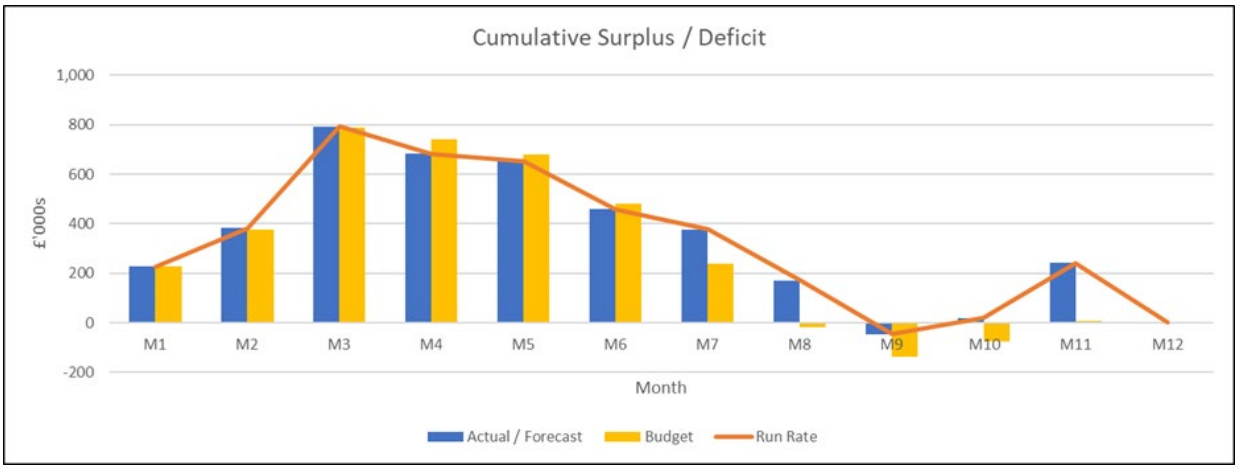
- Pay Costs:
  - Total pay expenditure for the month was £18.1 m, against a planned figure of £17.7m. With overspends driven by frontline over establishment and the delayed corporate review.

	Month 3			Year to Date		
Pay	Actual	Plan	Variance	Actual	Plan	Variance
A&E	12,975	12,713	-262	38,577	37,842	-735
111	1,714	1,742	28	5,151	5,052	-99
PTS	1,175	1,091	-84	3,454	3,272	-182
Corporate	2,277	2,155	-122	6,821	6,440	-381
Total Pay	**18,141**	**17,702**	**-439**	**54,002**	**52,606**	**-1,396**

- Agency Spend:
    - Agency costs totaled £201k, exceeding the plan of £114k.
    - The spend above plan was driven by 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 £3.2m surplus. As the Trust has bolstered its YTD position with rephased income this position is overstated, and the Trust has an in year underlying run rate of a £3.9m deficit that needs to be improved.



A paper was taken to Executive Management Committee (EMC) that sort to address the over establishment issue in frontline operations with a recommended option that increased the year to date overspend from £0.4m to a full year overspend of £0.8m. This has been built into a detailed Trustwide forecast outturn which shows the Trust will make a circa £4m deficit if unidentified CIPs and cost pressures are not covered by further savings.

To achieve the planned breakeven position for the year the Trust must now deliver circa £24m of savings inline with the projection shared with the Extra Ordinary Finance and Performance Committee on 2nd July.

Capital

The Trust's capital spend by June was £3.9m. The Trust overspent against its capital budget by £15.5m, this was due to slippage in the sale/leaseback element of capital projects.

Capital Overspend – Key Drivers

- The £15.5 million capital overspend reported in Month 3 is primarily attributable to delays and phasing issues within the Fleet programme.

- The main contributing factors are:
    - 2023/24 DCA Cohort (72 Fiat units): Delivery has been equally phased in Qtr 1, with 45 vehicles received to date. This has resulted in an in-month overspend of £6.7 million. The first tranche of the associated sale and leaseback arrangement is expected to complete in July.

- 2024/25 DCA Cohort (72 Fiat units): Delivery has been delayed. While the chassis were accounted for in 24/25, the associated conversion and equipment costs are now expected to fall in summer 2025/26.

- 2025/26 DCA Cohort (70 MAN units): Although the chassis have been paid for, the conversion and equipment costs originally planned for June are now delayed by approximately 10 weeks.

- Rapid Response Vehicles (RRVs): Chassis were purchased in 2024/25, with conversion originally scheduled for Q1 25/26. The sale and leaseback of 15 units, initially expected in June, has now slipped to July.

With no further increase in the Capital Departmental Expenditure Limit (CDEL) currently available to the Trust or ICB, SCAS is likely to have to consider delaying\rejecting capital schemes.

The Fixed Asset Management Strategy Group (FAMSG) have rejected the following business cases on the basis of available funding:

- 999 ISDN Replacement with a capital cost of £263k. This case had previously been approved however the costs had increased by £60k and it needed reapproval.
- Stock Control System Printing with a cost of £17k. In order to realise the full benefit of the stock system network upgrades are required to support label printing.
- Network Resilience and Remediation – Implementation cost of £223k, however, there is currently no capital identified for this cost. The equipment was purchased in 24-25 (£456k).

The capital forecast for the year is currently £0.8m above plan due to the increased cost of the DCA's in the year with a move to the MAN DCA's from the FIAT chassis and the slippage of the 2023/24 cohort offset by part of the MAN cohort has now slipped into 25/26 and a reduction in the estates forecast following a change in the estates fleet strategy.

Cash

The Trust's cash balance at the end of June stood at £22.4m. There was a net cash outflow in month 3 of £3.6m due mostly to reductions in block income contracts where ICBs have clawed back funds from M1 and M2. This is £11.5m below the plan due to the timing of DCA sale and leaseback receipts.

2025/26	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Income £m	30.3	29.6	25.2	32.6	31.1	38.0	31.4	38.1	27.2	26.7	32.9	35.9
Expenditure £m	(34.9)	(27.0)	(28.8)	(34.5)	(33.4)	(33.4)	(32.2)	(26.7)	(30.4)	(32.2)	(31.8)	(32.0)
Net Inflow/(Outflow) £m	(4.6)	2.6	(3.6)	(1.8)	(2.3)	4.6	(0.8)	11.4	(3.2)	(5.5)	1.0	3.8
Cash Balance £m	23.4	26.0	22.4	20.6	18.3	22.8	22.0	33.4	30.3	24.8	25.8	29.6
Cash Lowest Point	21.6	19.8	22.0									

The lowest point of cash in the month was £22m which is an increase from last month of £2.2m.

The 90-day debtor increased to £0.129m in June (£0.08m in May). This represents 12.73% (3.97% in May) of the total debtor balance. The percentage debtors has increased sharply due to the overall debt balance dropping by £1.1m. The main outstanding balance relates to operations in India.

2 Quality Impact

3 Financial Impact

As detailed above

4. Risk and compliance impact

Area of Risk

- In month 3, YTD additional income has been recognized of £1.3m. This will require to be offset in future months.
- The CIP plan needs to deliver in full to achieve the planned break-even position.
- Workforce cost pressures: Pay and agency costs are significantly over budget
- The income contracts for all Commissioners remain unfinalised. The Trust will continue to pursue income to match planned levels. Any deviation to plan may result in an in-year deficit. These contracts are now following the NHS Dispute Resolution procedure, with each ICB accordingly.
- The capital plan has been matched against the lower available funding. The capital requirements of the Trust exceeds available funding. The Trust will continue to pursue funding opportunities to meet capital requirements.
- The delay in delivery of new DCA vehicles will impact the replacement policy and may result in higher maintenance costs.
- The inability to invest in a new fleet workshop and vehicle commissioning unit will lead to higher vehicle off road (VOR) impacting frontline performance.
- Capital risk: The capital forecast is still over plan, and capital remains a significant risk.
- System-level financial pressures: The system's capital plan exceeds allocation, and NHSE rules limit support unless within 5% of allocation.

5. Equality, diversity and inclusion impact

6. Next steps

To address the underlying financial position in month 3, the following actions need to be taken:

- Continue to review frontline establishment, identifying opportunities to delay, reduce or stop recruitment.
    - There will need to be recognition of the potential impact on future periods
- Identify management strategies to control costs
    - Grip and Control measures tighten,
        - Work to correct establishment has already commenced
        - Review budgets – identify discretionary spend and add in additional approvals
        - The Trust will be required to hold vacancies in line with system agreement,
    - Over-establishment Recovery Plans: Each area to submit a plan to reduce WTEs to recover position in-year by end of June.
    - FRG review meetings to assess progress and make necessary adjustments.
- EMC will be discussing a detailed action plan
    - Specific steps for each area to address deficit or unmet CIPs
- Financial Sustainability Development Group (FSDG) to facilitate the plan with service managers and to report back to FRG

7. Recommendation(s)

The Board is asked to:

- The Board is asked to note the report.
- Note the Reported Financial Position
    - Acknowledge the reported £0.4 million surplus for Month 3, achieved through non-recurrent measures.
    - Recognise the underlying cost pressures and risks that will impact future months.
- Monitor and Report Progress to the Finance and Performance Committee on:
    - Delivery of Cost Improvement Programmes (CIPs).
    - Workforce and agency spend trends.

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Trust Board of Directors Meeting in Public 31 July 2025

Report title	Month 3 Integrated Care System Report
Agenda item	14
Report executive owner	Stuart Rees, Chief Finance Officer
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

This report provides a comprehensive overview of the Hampshire and Isle of Wight Integrated Care System's (ICS) performance against the 2025/26 NHS operational planning priorities. It evaluates progress across urgent and emergency care, planned care, diagnostics, cancer, mental health, workforce, finance, and quality, using data up to June 2025.

Key Performance Highlights

- **Urgent and Emergency Care**:
    - A&E attendances and 12-hour breaches remain below target, with Portsmouth Hospitals recording the highest breaches on record.
    - Category 2 ambulance response times are deteriorating, with early signs of further decline in July.
    - High numbers of patients with "No Criteria to Reside" (NCTR) are impacting bed availability and system flow.
- **Planned and Elective Care**:
    - 52-week waits increased to 5,551 patients; all providers are above plan.
    - 65-week and 78-week waits remain a concern, despite some improvements.
    - RTT performance (patients seen within 18 weeks) is improving but still below the 65% target.
- **Diagnostics**:
    - 32.2% of patients are waiting over 6 weeks for key tests, with significant backlogs in MRI, CT, and ultrasound.
    - PHU is the lowest performing trust; recovery plans are in place including expanded CDC capacity and AI-driven efficiencies.
- **Cancer**:
    - 28-day Faster Diagnosis Standard is 2.6% below plan but above national average.
    - Risks include workforce shortages and pathway redesign challenges, particularly in breast and gynae services.
- **Mental Health**:
    - Average Length of Stay in adult acute MH beds is above plan at 63 days, skewed by discharges from non-acute settings.
    - A new Mental Health System Improvement Group has been established to address systemic pressures.

Financial Position (as of June 2025)

- The ICS reported a £26.79m year-to-date deficit, £0.97m worse than plan.
- The system plan includes a £0.468m surplus, supported by £63.2m non-recurrent Deficit Support Funding (DSF), now released quarterly based on performance.
- Financial recovery actions focus on reducing acute pressures and shifting care to community settings.

Workforce

- The system is 229 WTE under plan, with notable shortfalls at UHS, HHFT, and HIOW Healthcare.
- Bank and agency staffing are below plan, though SCAS is significantly over its bank staffing target.
- Oversight mechanisms are in place to monitor and correct workforce trajectory.

Quality and Safety

- CQC Ratings: 125 of 129 GP practices rated Good or Outstanding.
- Patient Experience: Primary care satisfaction is high; maternity services in one trust show declining satisfaction.
- Safety: Mixed-sex accommodation breaches increased; infection control thresholds breached for MRSA and E. coli.
- Never Events: Three reported in June; system-wide actions are underway to improve surgical safety.
- Clinical Effectiveness: SHMI rates are within expected ranges; delays in hip fracture surgery persist in two trusts.

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)

It is recommended that the Board:

1. Notes the detail of this report and escalations for awareness and management of these.

2. Notes the following assurance statements:
    a. There is insufficient assurance of recovery to plan for the following metrics, based on current performance trend and lack of evidence that performance is stabilising or improving consistently:

i. A&E 4 hour performance
ii. A&E 12 hour performance
iii. Diagnostic waits
iv. 52 week elective waits

b. Recommends continuing scrutiny of the improvement and mitigation plans in relation to the above metrics through existing governance arrangements.

3. Requests clarification on any escalations, actions, or improvement or to seek further assurance.

Of note:

- Gain assurance that the Trust has robust plans in place for delivery of their 2025/26 operating plan, noting that Deficit Support Funding will now be released quarterly, based on system financial performance.

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

NHS Hampshire and Isle of Wight

Operational Delivery Report

1. Introduction

1.1 This report serves as an overview of the Hampshire and Isle of Wight Integrated Care System's performance against the national priorities and success measures outlined in the NHS operational planning guidance for 2025/26. It should be considered alongside reports noting the financial, workforce and transformation overview for the system.

1.2 Performance assessments for each area are conducted systematically. As well as monitoring progress against plan, performance is also reviewed in line with the NHS England 'Making Data Count' guidance – Statistical Process Control (SPC) mapping ensures a consistent methodology for identifying areas that require additional focus and attention, for example, the latest performance may highlight an improvement on the previous data period and achieving target in any given month, but the trend may show 'special cause variation' over a greater period, which may suggest the target is unlikely to be achieved at year end.

1.3 This report is based on data published on 10 July 2025 – up to June 2025 for Urgent and Emergency Care metrics and up to May 2025 for Planned Care, Local Care, Primary Care, Mental Health / Learning Disability and Autism metrics.

2. Operating Plan Summary

2.1 In the 2025/26 operating plan, there are a total of 42 performance metrics (not including activity metrics) – for the purpose of this report, we have categorised the performance metrics under three sub-headings: headline metrics, drivers and enablers.

For any headline metric not achieving plan, an exception report is provided, outlining current performance and actions, working assumptions and considerations.

2.2 In July 2025, the ICB is ranked red against 9 headline operating plan metrics:

- **Accident and Emergency attendances:** performance in M3 is below plan for all 3 operating plan metrics (eg. Type 1, All Types and Other attendances). The ICB also remains below the 78% national target for total mapped Emergency Department footprint with 76.1%, however this does represent improvement on previous month (74.8%).

- **Percentage of attendances in A&E over 12 hours** – M3 performance (unvalidated) is 0.8% above plan. The number of 12 hour waits from decision to admit increased significantly from 524 in M2 to 1,051 breaches

in M3 (against a zero national standard) – representing the highest number on record, with 838 breaches recorded at Portsmouth Hospital University (vs 373 previous month).

- **Category 2 ambulance response times:** Although South Central Ambulance Service (SCAS) continue to maintain the 30-minute operating plan standard in M3 with 29:30, this is above M3 plan and reflects deterioration on previous month. Early indications show significant deterioration in M4.

- **Diagnostic waits:** The end of May 2025 position shows 32.2% of patients waiting over 6 weeks for the 9 key diagnostic tests, which is 2.5% above the M2 plan, representing a 1% improvement on previous month. The total diagnostic waiting list has grown by 10.7% since Oct 2024. Main areas of concern include: Non-Obstetric Ultrasounds, MRI and CT scans, Audiology Assessments and Echocardiography.

- **52 week waits:** The end of May 2025 position shows 5,551 patients are waiting over 52 weeks, representing an increase on the previous month of 5,526 and not achieving plan. All HIOW providers are significantly above plan in M2. The number of patients waiting over 65 weeks deteriorated in M2 to 260 (compared to 220 previous month). The ICB also continues to report patients waiting over 78 weeks with 19 in M2 (improvement compared to 41 in M1) and over 104 weeks with 5 in M2 (compared to 20 previous month).

- **Percentage of patients waiting less than 18 weeks for their first appointment:** current performance is 0.9% below M3 plan (unvalidated). However, this is based on unvalidated data and may be subject to change. M2 performance achieved plan with 65.5% actual vs 65.1% plan. We will continue to monitor performance.

- **Cancer 28 days Faster Diagnosis Standard:** M2 performance is 2.6% below plan, with only Isle of Wight Trust achieving plan in month. Current ICB position is 77.3%.

- **Access to General Practice – number of available appointments:** performance in M2 is 9.4% below plan – however, it should be noted that monthly trajectories in 2024/25 were not routinely achieved, but the total number of GP appointments across the financial year increased by circa 525,000 compared to previous year. The 25/26 plan aims to achieve a further 3.7% uplift. Performance will continue to be closely monitored.

- **Average Length of Stay in Adult Acute MH beds** – performance for Hampshire and Isle of Wight ICB in May 2025 is 63 (a reduction on the 69 recorded in April 2025). Currently above plan of 57 for M2.

National priorities / success measures for 2025/26 currently achieving plan are as follows:

- **Cancer 62 days referral to treatment** – exceeding M2 plan by 3.1%. All providers achieving plan, except for Hampshire Hospitals.

- **Access to Children and Young People Mental Health Services** – exceeding M2 plan with 25,660 vs 25,350 target.

- **Adults in Inpatient Care** who have a learning disability (and may also be autistic) – achieving M2 plan with 39 vs 40 target.

The following metrics are national priorities, but there is no data currently published for the 2025/26 financial year:

- **Units of dental activity delivered** – latest position for March 2025 shows 71.4% vs 80% plan.

- **% of patients with hypertension treated according to NICE guidance** – latest position for December 2024 shows 64.4% vs 80% national target.

- **% of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance** – latest position for December 2024 shows 57.9% vs 65% national target.

Elective long waits for 65 weeks and 78 weeks have also been included in the escalation section due to the current position and increase against the 2024/25-year end position (which achieved plan). The national expectation was to eradicate any long waits over 65 weeks by March 2025. Monthly informal ICB led tiering meetings have been established with UHS and HHFT to being a more stringent process of performance review and establish what further support is required.

Driver and enabling metrics which are showing deterioration in performance or variation from expected standards can be found in the accompanying operational delivery slides to this report.

Section 2: Escalation Reports

2.1 Urgent and Emergency Care (2 metrics)

2.1.1 Performance Overview

Accident and Emergency attendances: performance in M3 is below plan for all 3 operating plan metrics (eg. Type 1, All Types and Other attendances). The ICB also remains below the 78% national target for total mapped Emergency Department footprint with 76.1%.

Percentage of attendances in A&E over 12 hours – M3 performance is 0.8% above plan. The number of 12 hour waits from decision to admit increased significantly from 524 in M2 to 1,051 in M3 (against a zero national standard).

- For **Type 1 A&E performance**, Hampshire and Isle of Wight ICB are ranked **25th out of 42** ICBs for their June performance of 60.5%. (**Interquartile**)
  The National average is 61.7%.

- For **all Type A&E performance**, Hampshire and Isle of Wight ICB are ranked **16th out of 42** ICBs for their June performance of 76.1%. (**Interquartile**)
  The National average is 75.5%.

- For **Percentage of attendances in A&E over 12 hours**, Hampshire and Isle of Wight ICB are ranked **11th out of 42** ICBs for their June performance (unvalidated) of 6.5%. (**Interquartile**)
  The National average is 8.8%.

2.1.2 Risks to Delivery

Below is a summary table of the Acute Trust 4-hour performance which includes all attendance types. Each Trust is measured against their operational plan trajectory for the year.

Acute Trust Performance for 'all type' of attendances

NHS Trust		Apr-25	May-25	Jun-25
Hampshire Hospitals	**Actual**	65.10%	65.60%	69.10%
	Operational Plan	62.30%	63.90%	65.00%
University Hospital Southampton	**Actual**	63.60%	59.30%	60.80%
	Operational Plan	63.00%	65.90%	64.90%
Portsmouth Hospitals University	**Actual**	70.20%	72.90%	74.80%
	Operational Plan	70.00%	72.90%	74.80%
Isle of Wight	**Actual**	70.10%	73.00%	69.10%
	Operational Plan	70.10%	76.20%	76.20%

University Hospital Southampton's performance remains a concern – although the position has improved marginally on previous month, M3 performance remains significantly below plan. Whilst Southampton's performance has historically been higher, it is recognised that they are the only Trust without a co-located UTC which would likely improve front door flow, increase alternative opportunities and improve overall waiting time measures.

The Isle of Wight Trust performance deteriorated in M3 and are 7% below plan, whilst Hampshire Hospitals and Portsmouth Hospitals University are meeting their operational plan trajectories for June.

All providers have set plans to achieve the 78% operating plan guidance metrics on 4hour waits by March 2026. However, each have provided varying approaches and profiles within their monthly trajectories of planned performance through the year, to achieve 78% by the close of the year. The Hampshire and Isle of Wight ICS Winter Plan for 2025/26 is currently in development and will be submitted to NHS England during Q2 25/26.

A core risk across the whole ICB continues to be the high level of patients within the acute system who occupy a bed but have 'No Criteria to Reside' (NCTR). There is a high reliance on bedded care within the system and available capacity is unable to keep pace with demand. NCTR levels are currently exceeding 730 for the system and this patient cohort are occupying approximately 24% of acute beds, which is impacting on whole system flow, including at the front door for patients requiring a timely admission.

Each provider system is also recognising a series of process and estate constraints that are identified as requiring a mitigation to ensure front door flow is as efficient as possible.

2.1.3 Mitigations and Improvement Actions

The Hampshire & Isle of Wight health system remains in Tier 1 for Urgent and Emergency Care services and the current oversight process includes a 3-weekly call with either Regional or National NHSE UEC team colleagues and all system providers. The current tiering meetings are suspended while review is undertaken of tiering process and responsibilities.

Acute Trusts have provided an ongoing log of short/intermediate term (4–6 week) actions in order to support improved function and performance at the front door. Some highlights are captured in the table below:

Hampshire Hospitals	• Focus on non-admitted front door flow, including implementation and sustained execution of revised Clinical decision maker tool approach – building on the work with '*Nexus Consulting*' who are supporting the Trust's front door improvement programme. • Implementation of review and revised 'Discharge Check List' • Progress further the Acute Admissions Unit Launch actions and carry out initial elements of an evaluation for continual improvement
University Hospital Southampton	• Co-located Urgent Treatment Centre – paper going to next Trust Investment Group on 10 July. • EMP and Primary Nurse triage pilot – trials conducted in June positively received and reduced pressure on AMBO and Minors. Further 2-week trial scheduled in July. • Dedicated portering resource – trial management of own resource in ED to start in July with aim to increase responsive/flow out and better queue management. • Initial feedback from recent ECIST visit in June 2025 demonstrated opportunities for rapid improvements in a numbers of areas including potential for an internal UTC style pathway and changes to AAU configuration. • Various action plans in place covering: ED, SDEC, Ambulatory, ECIST Pitstop, ECIST Leadership and Inpatient flow (FDBD).
Portsmouth Hospitals University Trust	• Confirm the outcome of ECC options appraisal and formulate a supporting implementation plan to imbed changes by the end of July. • Conclude Phase 2 of Medical SDEC Pilot, and review progress. Design and implement Phase 3 Test of Change to increase the number of patients treated by the service to >35% of the medical take. • Continuing onboarding progression with 10 largest DVT GP clinics. Targeting a reduction of DVT by >50% by August, releasing DVT staff back to D1 Room 5 to support core SDEC activities. • Conclude bed base model optimisation. Targeting a right-sizing of the bed base to realise co-located service synergies and to support future clinical model progression. • Develop a mechanism for weekly tracking of impact from the Discharge Working Group activities that focus on KPIs aligned to the DSF and % of P0 discharges on their discharge ready date. Focus on imbedding and sustaining an increased number of safe, timely discharges to maximise flow and bed availability.
Isle of Wight	• Embed senior leadership model of support 24/7 • SDEC: Embed ambulance referral pathway – ongoing area of focus. Additional focus on Frailty

	• Transformation Programme Ward based processes (Focus on ward round model and Discharge Ready Date), Reconditioning, Emergency Pathways and Alternative to ED. Relaunch transformation plan focus. • Ongoing focus on delivery of Discharge Standards Framework performance- Improving P0 performance

2.2 Category 2 ambulance response times

2.2.1 Performance Overview

The end of June 2025 position shows South Central Ambulance Service continue to maintain the 30-minute operating plan target with 29.30, however this represents deterioration on previous month and is not achieving M3 plan.

Early indications also show that performance has deteriorated further in M4.

A full report will be provided in the August report against the final M4 position.

2.3 Diagnostics 6 week waits

2.3.1 Performance Overview

The operating plan performance for May 2025 shows an improving position for <6 week diagnostics but remains above the M2 operating target of 29.7%.

UHS are the best performing trust within the ICB at 15% for May 2025 but this represents gradual deterioration over the last 4 months. PHU remains the worst performing trust in the ICB at 41.5% which is an improvement compared to previous month at 44.6%. HHFT achieved 41.4% for May 2025 (vs 41.3% previous month) and IOW were at 38.8% for May 2025, an improvement on previous month (39.8%).

The total diagnostic waiting list has grown by 7.2% since Oct 2024.

Main areas of concern include: Non-Obstetric Ultrasounds, MRI and CT scans, and Echocardiography.

In M2, 3 of the 9 key tests are currently achieving plan – audiology, colonoscopy and DEXA scans.

- For **Diagnostic 6+ weeks**, Hampshire and Isle of Wight ICB are ranked **36th out of 42** ICBs for their May performance with 31.9% (**Lowest Quartile**) *The National average is 17.6%.*

2.3.2 Risks to Delivery

Performance against the 6 week wait for diagnostics continues to be a risk for the ICB with performance not achieving plan. For 2025/26 across the ICB, the plan is to limit growth in year to 10% for Gastroscopy and target a 2% reduction for Echocardiology, DEXA scan and Audiology. PHU is the worst performing trust within the ICB and expect some deterioration this year due to Audiology backlog being added. They plan for performance to be maintained rather than improve in 2025/26, which remains significantly above the constitutional standard.

The current CDC utilisation data gives a summary view of performance against plan at M2 and shows 4 of 9 CDC sites performing at less than 95%, 3 on track (between 95-105% against plan) and 2 overperforming against plan.

2.3.3 Mitigations and Improvement Actions

Current and planned actions include:

- HIOW ICB to put in place Diagnostic Oversight Committee aligned to the diagnostic strategy. Individual provider recovery plans sought to test system ability to recover diagnostic performance.

- PHU have an Audiology business case which details the building of testing facilities, software upgrading and recruitment, which will increase activity (enabling 12,000 more Audiology tests to be completed in 2025/26), which will bring waiting times comfortably within 6-weeks.

- PHU plan to utilise additional Community Diagnostic Centre (CDC) capacity for MRI and Non-Obstetric ultrasounds which is due to start within 2025/26.

- PHU plan to use Elective Endoscopy Centre (EEC) capacity and increase inefficiencies by reducing DNAs for Endoscopy and Gastroscopy.

- Implement usage of iRefer across system – HHFT Pilot has gone live and has shown initial reductions in external demand.

- Increase efficiency of tests by introducing AI where possible, such as the use of Advanced Acceleration Technology (AAT) in MRI.

- Standardise pathways where possible to ensure requests are warranted and for the least invasive diagnostic.

- Reduce duplication of community sites where not aligned to population context or efficiency could be increased.

- NHS England Regional team and ICB joint site visits taking place at PHU and HHFT to Endoscopy and Imaging services.

- Endoscopy network recovery plan in place.

- Portsmouth and Southampton CDCs opening across 2025/26 and 2026/27.

2.4 Elective Waiting Times

2.4.1 Performance Overview

The end of May 2025 position shows 5,551 patients are waiting over 52 weeks, representing an increase on the previous month of 5,526 and not achieving plan. All HIOW providers are significantly above plan in M2.

UHS are currently 531 (68.7%) above plan, PHU 159 (6.3%) above plan, IOW 47 above plan of 0 and HHFT 315 (24.3%) above plan. Latest unvalidated position from Waiting List Minimum Data Set (WLMDS) 6th July 2025 shows the ICB is 2023 over plan with all trusts over plan – UHS highest with 934, HHFT 609, PHU 433 and IOW 56 over plan.

The number of patients waiting over 65 weeks deteriorated in M2 to 260 (compared to 220 previous month). Latest unvalidated position indicates that both IOW and PHU will achieve 0 by end of July and maintain position into August. UHS position is forecasting 115 for end of July but worsening to 125 for August. HHFT position has worsened, currently forecasting 142 for July but with slight improvement to 130 for August.

The ICB also continues to report patients waiting over 78 weeks with 19 in M2 (compared to 41 previous month) and over 104 weeks with 5 in M2 (compared to 20 previous month). However, forecasts for June 2025 indicate 3 for 78/104 weeks waits and zero for July 2025.

Although the total incomplete RTT waiting list has increased for the fourth consecutive month, performance in M2 is achieving plan (0.5% below plan). Overall performance against the March 2026 operating plan target for 65% of patients to wait no longer than 18 weeks has improved to 62.23% (compared to 59.88% previous month).

Performance against completed admitted and non-admitted RTT pathways in M2 has exceeded plan for both measures.

- For **Percentage of 52+ weeks**, Hampshire and Isle of Wight ICB are ranked **29th out of 42** ICBs for their May performance with 2.9% (**Interquartile**)

The National average is 3.1%.

- For **Percentage seen within 18 weeks**, Hampshire and Isle of Wight ICB are ranked **15th out of 42** ICBs for their May performance with 62.2% (**Interquartile**)
  The National average is 61.2%.

2.4.2 Risks to Delivery

52 weeks remains a challenge for all providers in particular UHS and HHFT with the latest unvalidated position indicating performance is deteriorating further. UHS and HHFT also have risks to 65 week waits, with current forecasts showing further increases from July to August.

Time to First Appointment is showing marginally below plan in M3 with 65% vs 65.9% plan. However, this is based on unvalidated data and may be subject to change. M2 performance achieved plan with 65.5% actual vs 65.1% plan. We will continue to monitor performance.

2.4.3 Mitigations and Improvement Actions

Current and planned actions include:

- ICB have written to UHS and HHFT to highlight concerns around elective performance, monthly informal ICB led tiering meetings have been established to being a more stringent process of performance review and establish what further support is required.

- HHFT are reviewing what actions can be taken to address ENT capacity issues which are impacting on 65 week waits.

- UHS have weekly meetings with their surgery care group to review the 65 week surgical breaches. In addition, they are reviewing reasons for increase in overall waiting lists to see if any issues can be identified to address 52/65 waits. Increases have been seen in 7 specialities; Clinical Genetics and Oral surgery, Dermatology, Allergy and Immunology, Urology and Cardiology.

- Providers are focusing on improving validation of waiting lists as a result of validation sprints. Latest unvalidated position (RAIDR as at 6 July) shows 56.61% patients waiting over 12 weeks across the 4 acutes have been validated in the last 12 weeks (vs 90% national target). Performance varies from 72.6% in UHS, 65.71% in HHFT to 41.35% in PHU and 41.2% in IOW.

- Improving management of procedures of limited clinical value, to ensure only those patients needing secondary care intervention are on waiting list.

- Conducting a system wide review of dermatology advice and guidance in comparison to outpatient capacity, with a view to improving the pathway

- Work with primary care to implement the GP advice and guidance enhanced service, ensuring the approach supports increased utilisation and diversion

- Transformation work, including Audiology, Community Musculoskeletal Services and Community Urgent Eye Care Services, to maximise opportunities for demand management and left shift of activity

- Improving productivity, working with the national Getting It Right First Time (GIRFT) team, focusing on high pressure specialties including ENT, Orthopaedics, Urology, as well as cross cutting issues such as theatre utilisation

- Identifying opportunities to shift from analogue to digital, including extending the use of Dora Artificial Intelligence assistant to create a routine post-operative cataract follow up pathway, reducing the need for refraction tests and post cataract follow ups.

- Ensure mutual aid opportunities are maximised and identify opportunities for shared waiting list approaches.

2.5 Cancer 28 days Faster Diagnosis Standard

2.5.1 Performance Overview

Performance in M2 is 2.6% below plan at 77.3%. Although the ICB is below plan, performance is 2.5% above national average. Majority of providers were below plan in M2, however it should be noted that monthly trajectories vary significantly across the acute providers. IOW is the best performing trust currently with 80.8% in M2, exceeding M2 plan and the operating plan ambition.

- For **28 day Faster Diagnosis Standard**, Hampshire and Isle of Wight ICB are ranked **14th out of 42** ICBs for their May performance with 77.3% (**Interquartile**)
  The National average is 74.8%.

2.5.2 Risks to Delivery

All providers have set plans to achieve the 80% operating plan ambition by March 2026. However, each have provided varying approaches and profiles within their monthly trajectories of planned performance through the year, to achieve 80% by the close of the year.

Acute Trust Performance for 28 day FDS (operating plan ambition 80% by Mar 26)

NHS Trust		Apr-25	May-25
Hampshire Hospitals	Actual	78.30%	75.80%
	Operational Plan	74.00%	76.70%
University Hospital Southampton	Actual	81.80%	78.00%
	Operational Plan	86.30%	85.40%
Portsmouth Hospitals University	Actual	78.20%	76.00%
	Operational Plan	80.00%	80.00%
Isle of Wight	Actual	83.00%	80.80%
	Operational Plan	72.00%	72.10%

There are risks to delivery of operational performance due to long term sustained pressure on teams, increases in referrals, workforce constraints, financial and recruitment restrictions. This is leading to vacancies being held, delays to recruitment when agreed and inability to put new roles in place to support a function or service.

Breast pathway – there is no national Community Diagnostic Centre tariff in place. The NHS National Aspire Programme output has been delayed further.

Gynae pathway – national view/position clinically being pursued around onward management through radiology for scan outputs. This is still a key point of clinical contention in design and implementation of the gynae pathway. The Wessex Cancer Alliance has been progressing with the National Team and Royal College of Radiologists.

2.5.3 Mitigations and Improvement Actions

Current and planned actions include:

- Detailed work led by Wessex Cancer Alliance across a number of cancer pathways, including Gynae, Skin, Breast, Colorectal and Head and Neck.
- Cancer Managers forum remains in place with peer support on a weekly basis around pressures and mitigations.
- All opportunities for mitigations against pressures, in line with financial and workforce/recruitment constraints are being explored and exploited where possible.

2.6 Reducing Average Length of Stay in Adult Acute MH beds

2.6.1 Performance Overview

This is a new measure, with data first published in January 2025.

Average Length of Stay for Hampshire and Isle of Wight ICB in May 2025 is 63 (a reduction on the 69 recorded in April 2025). Currently above plan of 57 for M2.

- For **Average LOS**, Hampshire and Isle of Wight ICB are ranked **39th out of 42** ICBs for their May 2025 performance with 63 (**Lowest Quartile**)

Average Length of Stay for Hampshire and IOW Healthcare NHS Foundation Trust for May 2025 was 53 days (a reduction from 55 in April 2025). Currently below the plan of 57 for M2.

2.6.2 Risks to Delivery

Hampshire and IOW Healthcare NHS Foundation Trust are the main provider for acute adult mental health beds for the ICB and are currently achieving the national target. There is a discrepancy in the ICB data which shows discharges from providers, other than HIOW Healthcare NHS FT, with an average length of stay of 137 days, which is significantly skewing the ICB position. Early investigation has identified ICB performance against this metric may be skewed by patient discharges from non-acute mental health inpatient settings. This includes providers who deliver long-term placements under the MHA and Low Secure Units.

2.6.3 Mitigations and Improvement Actions

Current and planned actions include:

- Average Length of Stay had previously increased since the baseline of 59 bed days was set by NHSE, this was due to the discharge of long stay Ministry of Justice patients within the system, Average Length of Stay has started to reduce as expected, and the average length of stay for the Trust is now below the baseline (to note this is a 3-month rolling measure). Please note comment in risk regarding discrepancy between Trust and ICB published data.

- Mental Health Pathways are under sustained pressure, and work continues to ensure a system wide response to optimise pathways and ensure mental health needs are met in the right setting at the right time, including reducing Out of Area Placements (OAPs). We have agreed a new approach, setting up a Mental Health System Improvement Group co-chaired by James Lowell and Eugene Jones (HIOWHC Trust Chief Operating Officer) with agreed Terms of Reference and structured framework to concentrate on three key areas:

- Alternatives to Crisis
- High Quality Impact Care
- Onward care.

- Each programme area has an SRO and Clinical Sponsor. The group will instruct the development of improvement/recovery actions where necessary and oversee their delivery to ensure they have the necessary impact. Whilst reviewing and scrutinising performance and providing assurance and mitigating risk. Meetings will be conducted monthly, with robust actions progressed in month by those responsible.

3. Integrated Care System Financial Overview

3.1 Purpose

The purpose of the Integrated Care System (ICS) Financial Overview section is to provide an overview of the financial position for NHS organisations within Hampshire and Isle of Wight ICS throughout the financial year 2025/26.

3.2 Background

The agreed system plan for 2025/26 is a surplus of £0.468m, consisting of a £0.468m surplus plan for Hampshire and Isle of Wight (the Integrated Care Board), and a breakeven plan for all other NHS providers.

The final plan for 2025/26 includes £63.2m of non-recurrent Deficit Support Funding (DSF). Since completion of the 2025/26 planning round, NHS England has announced that DSF will only be released to ICBs to pass-through to NHS Providers on a quarterly basis, conditional upon regional confirmation that financial performance across the whole system is compliant with national expectations.

3.3 Financial Position

Table 1 below summarises the in-month and year-to-date financial position as at Month 03 (June) for all Hampshire and Isle of Wight organisations

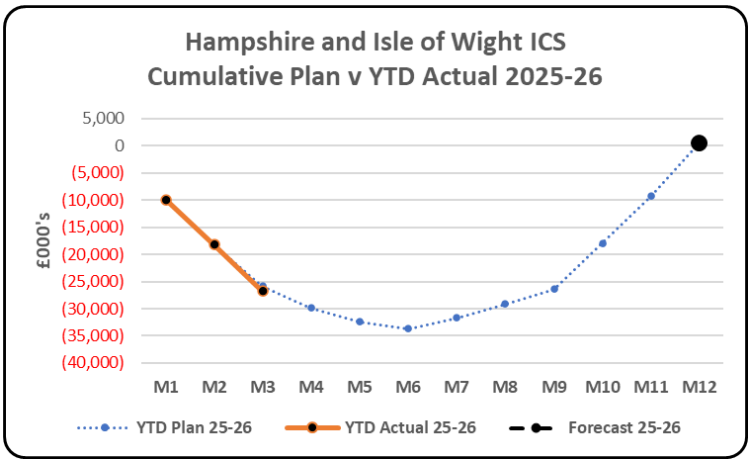
Table 1: Summary of M03 results

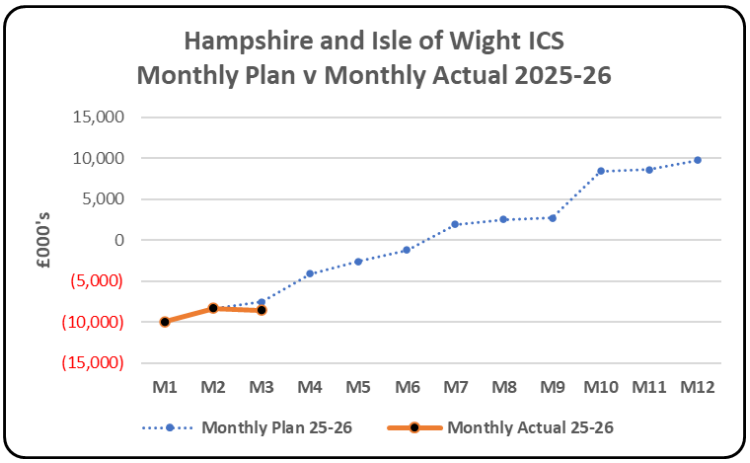
Organisation	In Month			Year to date			Forecast Outturn		
	In Month Plan £'000	In Month Actual £'000	Variance £'000	YTD Plan £'000	YTD Actual £'000	Variance £'000	Annual Plan £'000	Forecast Outturn £'000	Variance £'000
Hampshire and Isle of Wight ICS Total	(7,513)	(8,542)	(1,029)	(25,820)	(26,795)	(975)	468	469	1

In June 2025 itself, the ICS reported a deficit of £8.54m against a planned deficit of £7.51m, so £1.03m adverse variance to plan. Year-to-date the system has reported a deficit of £26.79m at Month 03 compared to a planned deficit of £25.82m, therefore £0.97m adverse variance to plan.

The graphs below summarise the ICS position reported at month 03 (June) 2025/26.

Figure 1: Summary YTD and in-month actuals 2025/26





3.4 System Actions to Support Financial Recovery

In 2023/24, additional controls were developed and implemented, aligned to those 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 2025/26.

Our system plan for 2025/26 intends to address the challenges impacting our financial position that required a system response. Together we have identified key programmes for corrective action to enable delivery of each organisation's operating plan.

Our 2025/26 plan includes actions specifically targeted at reducing pressure on our acute systems by focusing on projects that could reduce ambulance conveyance, ED attendances, non-elective admissions and occupied bed days in 2025/26.This is consistent with our commitment to a "left shift" from acute to community and from treatment to prevention.

4 Workforce

4.1 System Oversight

The system has a weekly System Workforce Oversight Committee in place to ensure grip and control of the system workforce plan. This includes provider data review against plan and course correction actions required.

4.2 M3 System Performance

Month 3 - All Staff Trajectory - Whole Time Equivalent (excluding Integrated Care Board)

- Hampshire & Isle of Wight system is 229 whole time equivalent (WTE) under plan in 2025/26.
- All Trusts are under plan except for South Central Ambulance Service (171 WTE) & Isle of Wight (32 WTE). Both are over plan for Substantive WTE whilst South Central Ambulance Service is also significantly over plan for Bank.
- Hampshire Hospitals, Hampshire & Isle of Wight Healthcare and University Hospital Southampton are all notably under plan by 110, 144 and 138 WTE respectively.

Month 3- Substantive Trajectory - Whole Time Equivalent (excluding Integrated Care Board)

- Hampshire & Isle of Wight system is 150 whole time equivalent (WTE) under plan.
- All Trusts are under plan except for South Central Ambulance Service (120 WTE) and Isle of Wight (38 WTE).
- 'NHS Infrastructure Support' and 'Support to Clinical' Staff Groups are above plan by 203 and 44 whole time equivalent, respectively.

Bank and Agency Trajectories – Whole Time Equivalent – Month 3

- Hampshire & Isle of Wight Systems Temporary staffing usage accounts for 2,687 whole time equivalent (WTE), 80 WTE (2.9%) better than the plan figure of 2,766.
- Bank & Agency usage both remain below plan by 73 and 7 whole time equivalent respectively.
- South Central Ambulance Service are notably over Bank WTE plan by c.48 WTE. Mitigation plans are in place to ensure the Trust can meet the planned end of year position.

5 Quality

The Board is asked to note that, apart from the Infection Prevention and Control data, the information included in the quality section below relates to NHS Trust provider and General Practice data and not whole System data.

5.1 Regulatory

Care Quality Commission: during June 2025, six Care Quality Commission inspection outcomes were reported, two of which related to primary care, both of which received an overall *good* outcome.

Care Quality Commission – General Practice: 125 of the 129 Hampshire and Isle of Wight GP Practices currently hold an overall *Good* (124) or *Outstanding* (1) rating with the Care Quality Commission. There is now only one GP Practice that is rated as *Requires improvement*. There are currently no GP Practices in Hampshire and the Isle of Wight that are rated as *Inadequate*.

Quality Assurance and Improvement Surveillance Levels: all the large NHS providers are in the routine quality assurance and improvement surveillance levels. This will be reviewed at the next System Quality Group in July 2025.

5.2 Patient Experience

Patient Experience – Friends and Family Test – May 2025: listening to those that use our services to help identify areas to improve or share good practice is key. The Friends and Family Test gives patients the opportunity to submit feedback to providers of NHS funded care or treatment, using a simple question which asks how likely, on a scale ranging from extremely unlikely to extremely likely, they are to recommend the service to their friends and family if they needed similar care or treatment.

- **Primary Care:** the national rate for satisfaction (positive results) in primary care was 92% in May 2025. Out of the 129 GP Practices in Hampshire and Isle of Wight, 91 submitted Friends and Family Test results in May 2025, of which 45% were performing the same as or higher than the national rate. The range of responses or those Practices that were lower than the national rate were 60% to 91%.

The following highlights those Trusts where satisfaction levels were below the national satisfaction rate and showed a declining position:

- **Acute Hospitals:**
  - **Declining position - Maternity – antenatal:** one Trust's positive satisfaction performance was 55% representing a declining position and lower than the national rate. As the data has just been published, this will be explored with the provider.

Mixed-Sex Accommodation Breaches (up to April 2025): the NHS has a policy of eliminating mixed-sex accommodation except in cases where it is deemed clinically necessary. This is to create a more comfortable, safe, and dignified environment for all patients, ultimately contributing to a better overall healthcare experience.

All providers, apart from one Trust continue to report mixed sex accommodation breaches. Across NHS Hampshire and Isle of Wight, in April 2025 there were 59,540 finished consultant episodes (an increase on the previous month) and 138 mixed-sex accommodation breaches (rate 2.3) - this represents a decline in performance in comparison to March 2025 performance.

Only one Trust saw a reduction in breaches in comparison to the previous month.

April 2025 performance:

- Trust 1 - 112↓ (144 - January, 111 – February, 113 - March 2025)
- Trust 2 – 16↑ (47 – January, 5 - February 2025, 0 – March 2025)
- Trust 3 – 1 ↔ (10 - January, 3 - February 2025, 1 – March 2025)
- Trust 4 - 3↑ (2 – January, 5 - February, 2 – March 2025).

As previously reported, Trusts manage their breaches, aiming to rectify them as soon as possible and ensuring patient privacy and dignity. The hospital estate has an impact on breaches, for examples those estates with bays including en-suite facilities are less likely to incur breaches.

National Quarterly Pulse Survey: the NHS National Quarterly Pulse Survey is a quick quarterly snapshot of staff engagement using nine core questions—focusing on motivation, involvement, and advocacy. The primary purpose of the National Quarterly Pulse Survey (NQPS) is to provide an additional and more frequent opportunity to hear from staff to help understand employee experience, and to support decision making and actions for improvement with the ambition of making the NHS the best place to work.

Two Trusts had scores which were above the national outcome and both were relating to ‘involvement’.

5.3 Safety

Infection Prevention and Control – 2025/26 thresholds: the 2025/26 infection, prevention and control thresholds were published in June 2025.

Infection Prevention and Control – May 2025: key areas to note include:

- Methicillin-resistant Staphylococcus aureus: the threshold for Methicillin-resistant Staphylococcus aureus has been breached, with four cases reported across the system. All but one acute provider has reported a case. Despite breaching the zero threshold, the data for Quarter 1 2025/26 represents an improvement from 2024/25 where there were six cases
- E. coli: one Trust is currently six cases above trajectory and three cases above for the same period last year. As part of the quarterly assurance oversight

meetings, the Trust has been asked how assured they are of meeting their E. coli trajectory for 2025/26.

Dermatology and Medication Never Events – June 2025: June 2025 was the second month during 2025/26 where no Never Events were uploaded to the Strategic Executive Information System (StEIS), however, as previously reported intelligence was received regarding three Never Events. Under the Patient Safety Incident Response Framework, Never Events should be reported on the StEIS system as soon as possible after the incident is identified. Following a request from commissioners, both Trusts have now uploaded their incidents to the system:

- two surgical Never Events (wrong site and wrong prosthesis) occurring in one Trust and
- one medication Never Event (administration of medication by the wrong route) reported by another Trust.

Actions:

- in response to provider surgical Never Event performance, thematic analysis of provider incidents and feedback during 2024/25, and through collaboration with providers, one of the key 2025/26 system quality priorities is to improve patient safety, team-working and efficiency in settings that undertake invasive procedures. All providers have agreed this as part of their 2025/26 quality contract (Schedule 4c)
- raised through joint assurance meetings with NHS England (Sout East) – deep dive presentations from providers to gain assurance regarding provider plans
- contract progress via System Quality Group
- fortnightly update meeting with one Trust regarding their safer invasive procedures action plan
- system review of 2024/25 Never Events to further support learning and improvement.

Regulation 28 - Prevention of Future Death reports: during June 2025, no Prevention of Future Death reports were issued to providers within Hampshire and Isle of Wight.

5.4 Clinical Effectiveness

Standardised Hospital-level Mortality Indicator (SHMI) – up to January 2025: all providers are reporting 'as expected' (band 2) mortality rates apart from one Trust that is performing 'lower than expected' (band 3). One Trust is showing a declining position, but remains within the 'as expected' level, discussions are taking place with the Trust to understand the potential cause of this change and to gain assurances that this has been noted as part of their mortality monitoring processes.

National Hip Fracture database – hours to operation (June 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. 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. In June 2025, two Trusts continued to not meet this standard and have not done for twelve months.

All Trust are performing better than the national 30-day mortality rate.

6 Recommendations

It is recommended that the Board:

1. Notes the detail of this report and escalations for awareness and management of these.
2. Notes the following assurance statements:
    a. There is insufficient assurance of recovery to plan for the following metrics, based on current performance trend and lack of evidence that performance is stabilising or improving consistently:
        i. A&E 4 hour performance
        ii. A&E 12 hour performance
        iii. Diagnostic waits
        iv. 52 week elective waits
    b. Recommends continuing scrutiny of the improvement and mitigation plans in relation to the above metrics through existing governance arrangements.
3. Requests clarification on any escalations, actions, or improvement or to seek further assurance.

Of note:

- Each Board needs to gain its own assurance that their organisation has robust plans in place for delivery of their 2025/26 operating plan, noting that Deficit Support Funding will now be released quarterly, based on system financial performance.

NHS
South Central Ambulance Service
NHS Foundation Trust

Trust Board of Directors Meeting in Public 31 July 2025

Report title	Month 1 & 2 BOB System Reports
Agenda item	15
Report executive owner	Stuart Rees, Chief Finance Officer
Report author	Dilani Russell and Ben Gattlin
Governance Pathway: Previous consideration	
Governance Pathway: Next steps	BOB ICB

Executive Summary

BOB ICB Finance Report – Month 2 (2025/26)

Key Highlights:

- **System Financial Position:**
    - Year-to-date (YTD) position is on plan with a £0.1m surplus.
    - Forecast outturn is breakeven across the system.
- **Efficiency & Recovery Focus Areas:**
    - De-risking the efficiency programme and identifying full plans by end of Q1.
    - Workforce affordability and triangulation.
    - Cash management planning and contract alignment.
    - Strengthening recurrent positions for 2026/27.
- **ICB Financials:**
    - Slight underspend of £20k at M02.
    - CIPs on track, though efficiency programme is behind due to delayed scheme starts.
    - Mental health forecast pressures mitigated through accruals.
- **Risks & Challenges:**
    - £16.4m CIP stretch target at risk, particularly in prescribing and primary care.
    - High-risk areas include high-cost drugs/devices and workforce vacancies.
    - Cash at bank exceeded NHSE target due to delayed invoice approvals.

BOB ICB Performance & Quality Report – Month 1 (April 2025)

Key Performance Areas:

- **Urgent & Emergency Care (UEC):**
    - 77% 4-hour standard in May 2025 (target: 78% by Mar 2026).
    - Continued focus on reducing ambulance handover delays and promoting alternatives to ED.
- **Elective Care:**
    - 173 patients waiting >65 weeks (target: zero).
    - Validation sprints underway; focus on reducing >52-week waits to <1%.
- **Cancer:**
    - 62-day performance at 65.4% (target: 75%).
    - Faster Diagnosis Standard at 77.5% (target: 80%).
- **Primary Care Access:**
    - 86.9% of GP appointments within 2 weeks (down 1.5% from March).
    - 849K appointments in April, 3.6% fewer than previous year due to Easter.

- **Learning Disabilities & Autism:**
    - On track to meet Q1 targets for inpatient reduction.
    - 15,453 CYP on waiting list; average wait times range from 66 to 95 weeks.
- **Maternity:**
    - Smoking at booking/delivery <5%; breastfeeding initiation >80%.
    - 0 stillbirths in April.
- **Quality & Safety:**
    - One Never Event reported at BHT.
    - CQC concerns at St Andrews Healthcare; ongoing PSIRF monitoring.
- **Workforce:**
    - Absence rate stable at ~4.1%; turnover trending down to 9.75%.
    - Retention programmes in place across trusts.

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 are asked to note the final ICB and System position (M2) and contents of the Performance and Quality Report.

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

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

BOB ICB BOARD MEETING

Title	Performance and Quality Report		
Paper Date:	26/06/2025	**Meeting Date:**	08/07/2025
Purpose:	Information / Discussion / Assurance	**Agenda Item:**	09 - Performance and Quality Report
Author:	Ben Gattlin Assoc. Dir. of Performance	**Exec Lead/ Senior Responsible Officer:**	Matthew Tait Interim Chief Delivery Officer

Executive Summary

The May Board paper outlined the intention to refresh the Performance & Quality report in-line with the Elective Reform paper and the 2025/26 Operational Planning Guidance. Unfortunately, that has not been possible in-time for M1 report. The ambition to refresh the report is still live and will be achieved for the next Board meeting. New metrics will be introduced, some existing ones removed, and the report will feature redesigned graphics and a revised structure.

The current report continues to give a high-level overview of the performance of the ICB and NHS partners across the Integrated Care System.

The report maintains focus on five key areas and continues to provide broader performance information.

The five areas of key focus are:

- Urgent and Emergency Care – 4 Hour standard
- Elective – Long Waits
- Learning Disabilities and Autism – Children and Young People (CYP)
- Cancer - 62 days - % and the total number of patients waiting over 62 days.
- Primary care access – (all patients given appointment within 2 weeks)

Note the report title page states M1 (April 2025) however the data contained within the report is provided as the latest publishable data, in some instances this could be December 2024 or as recent as May 2025.

The report gives a high-level overview of performance for NHS partners across the integrated care system and focuses on five key areas with additional wider performance oversight measures information.

Urgent and Emergency Care – 4 Hour standard – target 78% by end of March 2026

- Performance across Buckinghamshire, Oxfordshire, and Berkshire West (BOB) was 77% in May 2025, an improvement of 1.8% on May 2024.
- Alternatives to ED continue to be promoted to reduce the pressure on departments, including; Urgent Community Response (UCR), Virtual Wards (VWs), 111, 111 online, and Urgent Care Centres (UCCs/UTCs/MIUs).

- Trusts continue to work with SCAS to reduce ambulance handover delays, moving to an emphasis on reducing any handovers from >60 minutes to >45 minutes.
- The operational planning target for 2025/26 remains at 78% for 4-hour performance but a further ambition of a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25. This will be included in the refreshed report.

Elective – Long Waits – target zero over 65 week waits.

- BOB providers reported 173 patients waiting longer than 65 weeks at the end of April 2025.
- A validation 'Sprint' exercise has commenced to support cleansing of waiting lists to improve reporting accuracy – further validation sprint exercise confirmed by NHSE for Q2.
- The focus for 2025/26 will be to improve the percentage of patients waiting no longer than 18 weeks for treatment whilst reducing the proportion of people waiting over 52 weeks to less than 1% of the total waiting list. This will be included in the refreshed report.

Learning Disabilities and Autism – 2025/26 target; reduce reliance on mental health inpatient care for people with a learning disability and autistic people, delivering a minimum 10% reduction.

- BOB traditionally performs well for this metric, previously rated against a per million of population basis[1].
- Note the executive summary page still displays the 2024/25 targets and per million calculations however the focused page has been updated and displays actual figures against our quarterly plan.
- BOB appears on track to meet Q1 expectations, this will be reported once June data is available.

Cancer waits – target reduction in patients waiting over 62 days for treatment

- 62-day combined performance in April 2025, 65.4% which is short of the new target; to improve performance against the headline 62-day cancer standard to 75% by March 2026.
- Performance of Faster Diagnosis Standard (FDS) 77.5% in April. This is also short of the updated 2025/26 target; Improve performance against the 28-day cancer Faster Diagnosis Standard to 80% by March 2026.

Primary Care access – target to maximise appointments within two weeks.

- Percentage of GP appointments seen within two weeks was 86.9% in April a 1.5% reduction compared with the previous month (March 2025).
- 849K appointments took place in M1 3.6% fewer when compared to the previous M1 period. This reflects the impact of Easter.
- The operational planning guidance for 2025/26 places more emphasis on patient satisfaction. This will be measured by the ONS Health Insights Survey

[1] 30 per million for adults and 15 per million for children

and when available published in the new version of the performance and quality report.

Maternity – target reduction in smoking at booking and time of delivery to less than 5%; increase breastfeeding initiation rates at 80% or more and halve neonatal death rates by 2025 (from 2010 baseline)

- There were 1349 total births across the system in April which is average.
- Smoking disclosed at time of booking and smoking at the time of delivery both remain under 5%
- Breastfeeding initiation rates continue above the mean of last two years
- Neonatal deaths show common cause variation with data falling both above and below the mean. There were 0 still births across BOB in April.

Quality – Zero target for Never Events and to monitor the patient safety incident reporting framework (PSIRF) in acute and mental health trusts and CQC updates.

- The ICB awaits learning from never event patient safety incident investigation at BHT
- Following maternity insight visits the ICB is awaiting reports.
- Ongoing support to trusts with paediatric audiology visit recommendations

Action Required
The board is asked to: • Note the contents of the report. • Comment on coverage and presentation of the report

Conflicts of Interest:	Conflict noted: conflicted party can participate in discussion and decision
	This report contains information including the performance of organisations led by members of the Board. The perspective of these members is an important aspect for enable the Board to focus on where the ICB (Integrated Care Board) and system contribute to improvement.

Date/Name of Committee/ Meeting, Where Last Reviewed:	Performance reviewed 26/06/2025. System Productivity Committee.

SCW Powered by SCW BI Insights

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

NHS Performance and Quality Report

M1 - April 2025

Matthew Tait – Chief Delivery Officer

Rachael Corser – Chief Nursing Officer

Ben Riley – Chief Medical Officer

Scorecard - M1 - April 2025

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Benchmark *where there is an agreed target the colour rating will be based on a pass/fail of that target. If there is no target, the colour rating will be based on comparison to the England figure*

Metric	Period	Target	Berkshire West	Buckingham shire	Oxfordshire	BHT	OUH	RBFT	BOB ICB	South East	England
A&E attendances – Total number of attendances at A&E departments	May 2025					77.6%	75.8%	71.2%	77.%	77.5%	75.4%
Cancer Referral/Upgrade to First Treatment Standard (62-day standard) - Commissioner	Apr 2025	85%	73.2%	65.%	60.%	64.7%	56.4%	75.5%	65.4%	72.5%	71.7%
GP appointments - percentage of regular appointments within 14 days.	Apr 2025		87.3%	85.4%	87.7%				86.9%	86.4%	87.%

Planned Care Metrics

Category	Metric	Period	Target	Value	Variance	Assurance
Activity	RTT 65 Week Waits	Apr 25	0	173	L	F
Quality of Care, Access and Outcomes	GP appointments - percentage of regular appointments within 14 days.	Apr 25		86.9%		

Learning Disabilities and Autism

Category	Metric	Period	Target	Value	Variance	Assurance
Learning Disabilities & Autism	Adult inpatients with a learning disability and/or autism per million head of population	Feb 25	30	40.2	L	F
	Under 18 inpatients with a learning disability and/or autism per million head of population	Feb 25	15	13.3	L	P

The LDA data is no longer supplied to SCW by NHS E via excel. We are investigating a new Power BI product and hope to amend the source to this.

Cancer Metrics

Category	Metric	Period	Target	Value	Variance	Assurance
Cancer	Cancer Referral/Upgrade to First Treatment Standard (62-day standard) - Commissioner	Apr 25	85.0%	65.4%		F

Urgent Care Metrics

Category	Metric	Period	Target	Value	Variance	Assurance
Urgent Care	Percentage of patients who spent 4 hours or less in A&E	May 25	78.0%	77.0%	H	F

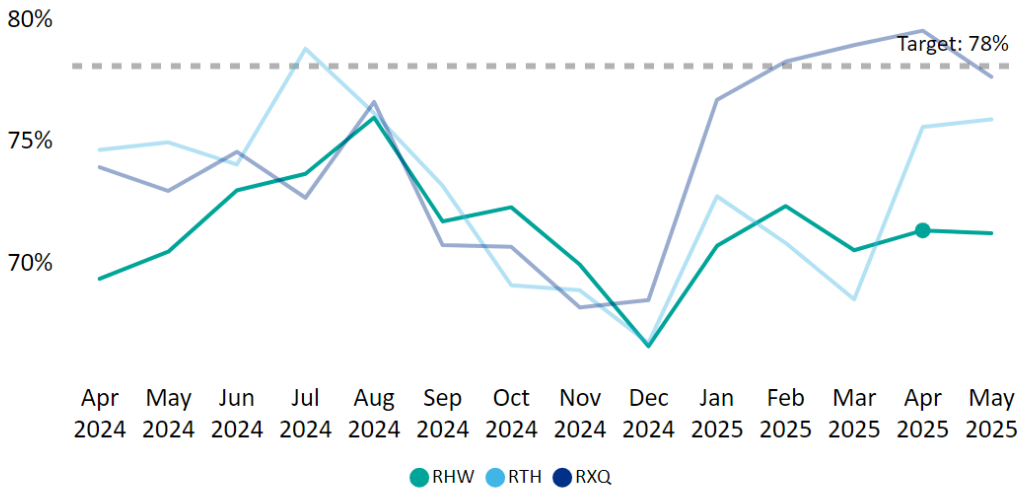
Source : NHS Statistics

Urgent and Emergency Care

May 2025

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

A&E attendances – Total number of attendances at A&E departments



This metric measures:

Our objective is to reduce the number of patients experiencing excess waiting for emergency service. We measure this through the percentage of patients who attend the Emergency Department (ED) and are seen within 4 hours of their arrival. Delivering against this standard requires cooperation across both the hospital and with partners in the wider health and care system. While the constitutional standard remains at 95%, NHS England has set Trusts a Target of consistently seeing 78% of patients within 4 hours by the end of March 2025.

How we are performing?

	Target	Prev Year	Performance	Curr Month	Diff
ICB - ALL PROVIDERS	78.0%	77.6%	↓	77.0%	-0.6%
RHW - ROYAL BERKSHIRE NHS FOUNDATION TRUST	78.0%	71.3%	↓	71.2%	-0.1%
RTH - OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	78.0%	75.5%	↑	75.8%	0.3%
RXQ - BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	78.0%	79.5%	↓	77.6%	-1.9%

Actions

- All three acutes have ED improvement plans in place to support recovery of all types with delivery overseen at place UEC Boards.
- Alternatives to ED continue to be promoted to reduce the pressure on departments, including; Urgent Community Response (UCR), Virtual Wards (VWs), 111, 111 online, and Urgent Care Centres (UCCs/UTCs/MIUs).
- System Single Point of Access (SPOA) group continues to work with partners to promote and increase utilisation to reduce ambulance conveyances where clinically appropriate
- Teams continue to drive down delayed discharges/nCtR through the Transfer of Care Hubs
- Work instigated to review Paediatric ED performance and potential improvement opportunities
- Baseline assessment being undertaken against the UEC Care Plan 2025/26 published 6th June.
- Scoping work underway for Winter preparedness

Risks

- Unmet demand in primary care/community resulting in higher ED attendances
- Increase in acuity resulting in more complex patients attending ED
- Ongoing disruption to services and demand profiles resulting from Industrial Action/GP Collective Action, adverse weather conditions and winter viruses e.g. Flu, Covid, RSV, Norovirus
- Staff sickness compounding UEC pressures
- Financial constraints impeding improvement actions/pace of delivery.

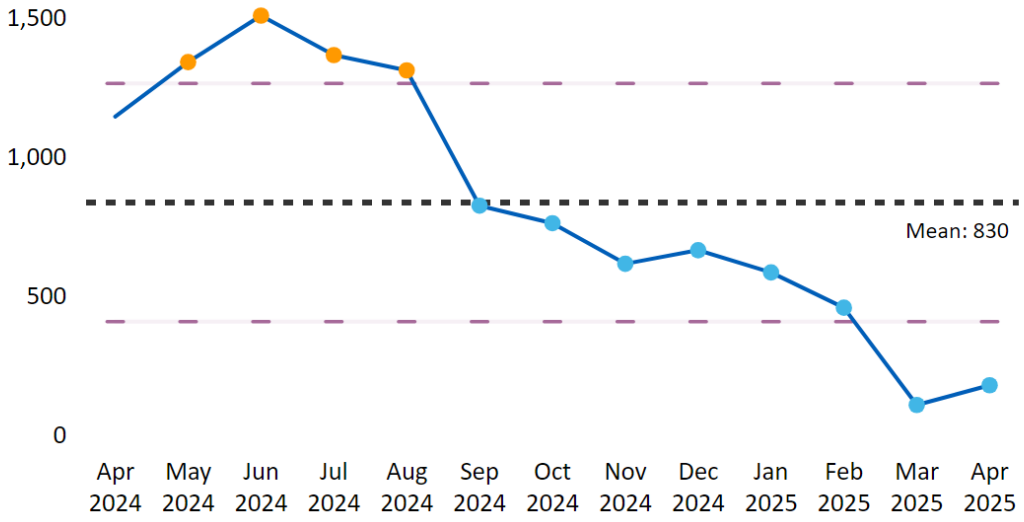
Source : NHS Statistics

Planned Care

Apr 2025

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

RTT 65 Week Waits



This metric measures:

Our objective is to reduce the number of patients experiencing excess waiting times for elective care as measured by the national Referral to Treatment time (RTT) standards. The target to eliminate all >65-week waits is the end of March 2024.

How we are performing?

	Target	Prev Month	Performance	Curr Month	Diff
ICB - ALL PROVIDERS	0	102	↑	173	71
RHW - ROYAL BERKSHIRE NHS FOUNDATION TRUST	0	1	↑	4	3
RTH - OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	0	63	↑	115	52
RXQ - BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	0	1	–	1	0

Actions

- The Acute Provider Collaborative (APC) continues to work with the ICB to minimise the volume of 65wk breaches and reduce the overall waiting list size
- Validation sprint has commenced to support cleansing of waiting lists to improve reporting accuracy – further validation sprint exercise confirmed by NHSE for Qu2
- Work is underway within the APC to agree load balancing initiatives to better align demand with capacity within challenged specialties e.g. urology and plastics
- An ICB led Advice and Guidance Working Group has been established to support delivery of the A&G framework requirements published by NHSE

Risks

- Displacement of elective activity resulting from peaks in UEC demand
- Staff sickness
- Longer term actions on workforce and capacity (e.g. in theatres) will take time to have an impact.
- Patients choosing to stay with their local provider despite offers of quicker treatment at other sites resulting in slower recovery of waiting times
- Industrial Action

Source : NHS Statistics

Learning Disabilities and Autism Inpatients

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Operational Planning 25/26

Patients on Extended S17 leave have been excluded from the Inpatient numbers from Nov-24 as per National new methodology for official inpatient count.

Autistic Adults by month



Adults with Learning disabilities by month



Children and Young people inpatients by month

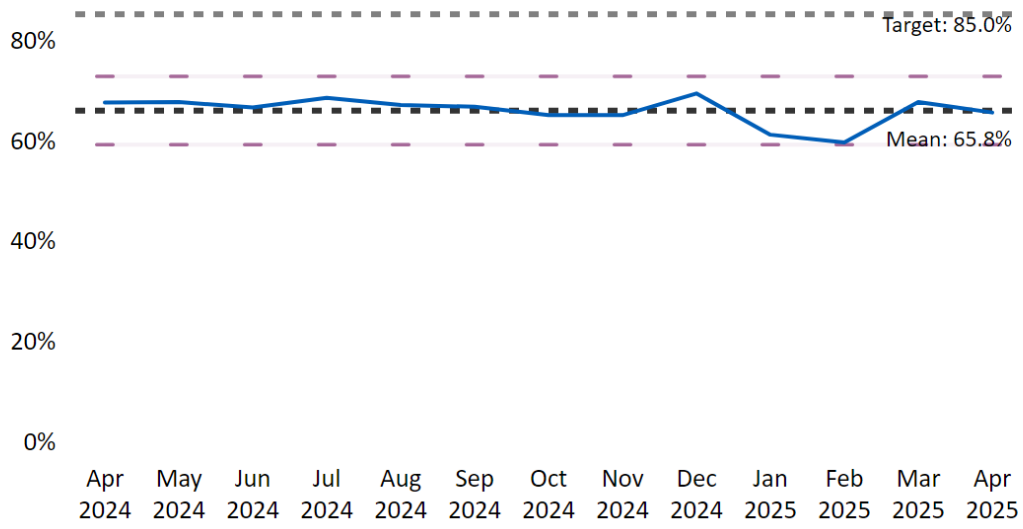


Cancer

Apr 2025

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Cancer Referral/Upgrade to First Treatment Standard (62-day standard) - Commissioner



This metric measures:

The 62-day referral to treatment standard (85%). Due to the delay in processing the cancer waiting times data the opportunity has been taken to introduce an SPC chart here. The process control shows common cause variation, latest data point is above the mean, 5 of the last 6 data points are within 1 standard deviation. This does statistically indicate that BOB providers are unlikely to achieve the national standard at the next data point.

How we are performing?

	Target	Prev Month	Performance	Curr Month	Diff
ICB - ALL PROVIDERS	85.0%	67.5%	↓	65.4%	-2.1%
RHW - ROYAL BERKSHIRE NHS FOUNDATION TRUST	85.0%	78.6%	↓	76.2%	-2.4%
RTH - OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	85.0%	59.3%	↓	54.4%	-4.9%
RXQ - BUCKINGHAMSHIRE HEALTHCARE NHS TRUST	85.0%	58.3%	↑	69.3%	10.9%

BOB ICB Performance April 2025 (validated):

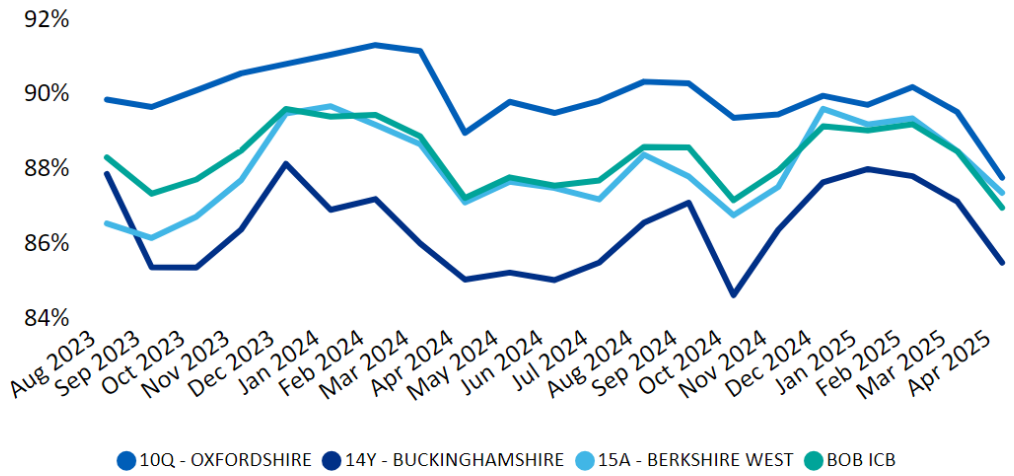
- 28-day FDS compliance for April 25, reported a position of 77.5%, a marginal dip from March's position of 79.6%. OUH (76.2%) and RBH (78.1%) saw marginal decreases from the previous month however BHT (79.6%) saw a slight increase. All 3 Trusts were non-compliant with the 25/26 National target of 80%.
- The 31-day combined position reported for April 2025 was 82.2%, down 5% in relation to March's position. The Trust driving this position is OUH (74.2%) which has seen its position drop by 6.7% compared to March 25. RBH (87.3%) and BHT (83.3%) have also seen decreases compared to March by 3.8% and 1.2%, respectively.
- At Trust level, BHT's position of 69.3% was driven by delays in urology, LGI and Skin pathways. Issues persist at the end of the urology pathway due to theatre capacity and doctor availability. LGI capacity challenges in endoscopy remain CTVC reporting times are a bottle neck for the pathway but improving with frequent escalation. 'MOPs Super Week' planned to target the skin backlog, aiming to clear 100 in a week. Impact analysis on 62-day performance shared with COO.
- OUH's position of 54.4% was driven by lung, gynae and urology. On the lung pathway, extra theatre lists are being repurposed from vascular, currently an additional 2 lists per month, hoping to increase. Capacity issues remain with gynae outpatient and inpatient hysteroscopy. A new hysteroscopy kit is being trialled currently to improve efficiency of outpatient hysteroscopy and gynae lists agreed over run each day to allow extra capacity. For urology, issues with MRI reporting- due to staff shortages, extra clinics being run in urology to catch up. Pathology currently being outsourced. All urology pathways picking up weekend operating lists and extra capacity.
- RBH's position of 76.2% was driven by gynae, LGI and UGI. There has been an increase in referral volumes particularly for gynae, LGI breast and skin. Pathology team invited to recent Gynae meetings due to delays identified in that pathway. They are now forming a dedicated CAG to address wider performance issues. Starting a full end-to-end review of LGI pathway with a focus on impact of nurse triage, surgical capacity, and demand.

Primary Care Access

Apr 2025

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Percentage of GP Appointments seen within 14 days of being booked



These metrics measure:

Our objective is to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or the next day according to clinical need.

How we are performing?

	Target	Prev Month	Performance	Curr Month	Diff
BOB ICB		88.4%	↓	86.9%	-1.5%
15A - BERKSHIRE WEST		88.4%	↓	87.3%	-1.1%
14Y - BUCKINGHAMSHIRE		87.1%	↓	85.4%	-1.6%
10Q - OXFORDSHIRE		89.5%	↓	87.7%	-1.8%

Actions

Decrease in 14-day target observed in M1 across the whole of BOB. Circa 849K appointments took place in M1 3.6% fewer when compared to the previous M1 period. This reflects the impact of Easter. Addressing improvements in Access continue to be supported through:

- Digital: ICB continues to support the core digital tools required for general practice access.
- Monitoring & support: Monitoring of practice performance being conducted through evaluation of indicators in the Primary Care Quality Dashboard and 3-year rolling programme of practice visits with 60% of visits having been conducted.
- Pharmacy First – Community Pharmacy delivered 13,722 appointments for clinical consultations for seven conditions, blood pressure monitoring and pharmacy contraception service core component of Modern General Practice releasing GP time.
- Workforce Investment: continue to provide new to General Practice fellowship programme to 76 GPs. Community of Practice for personalised care roles relaunched. CPD funding for 2025/26 identified. Establishing process for funding to reach eligible staff to support Practice needs and ICB strategic priorities.
- Planning & Primary Care Strategy: The team has been focused on developing further the plan to achieve the operating plan commitments for primary care. This will include aligning our dashboard with that regionally and the FDP and taking forward modern general practice actions with our contracting, commissioning and transformation teams.

Risks

Collective Action

BOB ICB has one current area of local action whereby primary care has served notice. This is in relation to community appliance prescribing and this is being managed by the relevant ICB team with guidance from the primary care team.

Patient Safety and Quality

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Quality Scorecard

Metric	Target	BOB ICB	RBFT	OUH	BHT
SHMI	Lower is Better		1.0484	0.9054	0.8411
Never Events	0				

These metrics measure:

Never Events our objective is to have 0 never events
The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England. The SHMI is not a measure of quality of care and a higher or lower number than expected should not be interpreted as good/poor performance, it should be viewed as a "smoke alarm" which requires further investigation
CQC updates
Progress with the implementation of the national patient safety strategy

Actions

Await learning from never event patient safety incident investigation at BHT

Awaiting maternity insight visit reports.

Ongoing support to trusts with paediatric audiology visit recommendations.

ICB quality visit to St Andrews and review of 3 patients from BOB

How are we performing?

Never Event declared at BHT : The incident involves a patient who underwent a cardiac catheterisation lab procedure on 5 June 2025. During the procedure, the wrong sequence of stents was used, resulting in the implantation of a stent different from the one intended by the operator. Consequently, this incident is classified as a Never Event, under the category of Wrong implant/prosthesis.

Maternity OUH – Maternity safety support programme continues.
Maternity insights visit to RBH undertaken, awaiting feedback letter
CQC inspection of forensic services at OH - overall rating GOOD, all 5 domains rated GOOD
CQC issued a notice of proposal (NoP) to impose conditions on St Andrews' Healthcare registration due to a failure in:

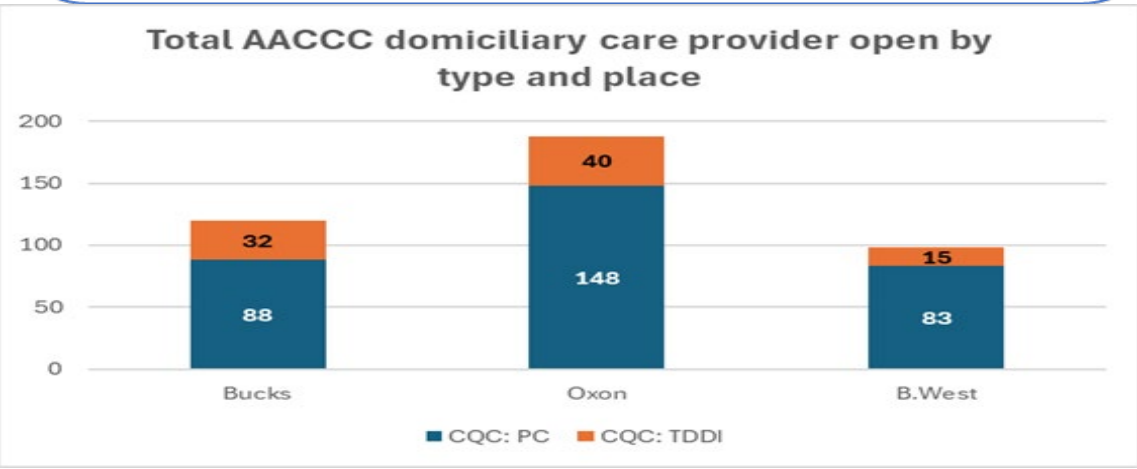
- Workforce competency (e.g. BSL-trained staff, dementia, autism, DBT care)
- Inconsistent application of care models (Kitwood's dementia care)
- Unsafe environments and infection prevention failures
- Inadequate risk management for dehydration and malnutrition
- Serious safeguarding concerns and use of blanket restrictions
- Inaccurate incident reporting and lack of oversight
- Widespread failure to meet person-centred care principles

All Age Complex and Continuing Care
Quality Assurance and Contracts

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Emerging Quality themes

- Legal challenge from an Oxfordshire domiciliary care provider due to notice served by ICB following local authority serving no fault notice in line with their contract.
- Lack of BOB ICB overarching process regarding provider failure or suspension for AACCC commissioned provider.
- Oxfordshire S75 does not delegate quality assurance or contracting to Oxfordshire County Council.
- Legal advice sought confirmed that BOB ICB should currently make its own decision regarding serving notice to AACCC provider.
- Whilst BOB ICB can use local authority intelligence, there needs to be a formal mechanism to agree internally when BOB ICB serves notice to a provider on grounds of quality assurance concerns.
- There is a gap in quality assurance of complex providers (e.g. TDDI) who the local authority does not commission with, and therefore local authority led quality assurance reviews are not completed.
- Historical issue of Oxfordshire place team not issuing Individual Placement Agreements.
- No NHS standard contracts in place for domiciliary providers spot purchased by AACCC.



Update on Quality improvement projects

- AACCC audit of all providers completed Q4 2024/25, provider directory now in place.
- Provider Assurance Criteria (PAC) process in place for new providers.
- Quality Assurance manager and Head of AACCC Commissioning drafting BOB ICB AACCC provider failure and suspension overarching policy.
- Oxfordshire S75 deep dive meeting planned Q2 2025/26 to work through issues including quality assurance.
- Report detailing AACCC providers, where gaps in quality assurance on AACCC spot purchased and complex (TDDI) providers, have been identified.

- Patient safe and well checks are completed when provider failure or suspensions are in place. Patient feedback is included in review of suspensions.
- In the case of the legal challenge, lack of an overarching process for provider failure or suspension led to a decision that upon further review has been revoked. This has led to 4 patients transferring from a provider where notice have been served by AACCC.
- Whilst there has been no gap in care, the decision did impact patients directly.

There are 406 open domiciliary care providers commissioned by AACCC. There are differing arrangements at each place regarding quality assurance and contract monitoring:
Bucks: all QA and contracts within S75, therefore BCC provider failure process followed, *Risk* Complex domiciliary care (lot 2) spot purchased by AACCC directly.
Oxford: *Risk* all domiciliary care is spot purchased and S75 states QA and contract monitoring is ICB responsibility.
Berks West: *Risk* all domiciliary care is spot purchased, no S75 or MOU in place for suspensions or provider failure with local authorities.

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Wider Performance Oversight Measures



Scorecard - wider performance measures

Buckinghamshire, Oxfordshire and Berkshire West Integrated Care Board

Ambulance Metrics

Category	Metric	Period	Target	Value	Variance	Assurance
Ambulance Handover	Average Hours Lost on Handover Delays per day at BOB Acute Trusts	Apr 25		06:44:00		
	Ambulance Handover Delays (>60 Minutes)	Apr 25		95		
Urgent Care	Ambulance Handover Delays greater than 30 minutes (as reported by NHS Acute Trusts)	Apr 25		840		

Cancer Care Metrics

Category	Metric	Period	Target	Value	Variance	Assurance
Cancer	Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis	Apr 25	96.0%	83.7%		F
	Percentage of patients receiving first definitive treatment for cancer within two months (62 days) of an urgent GP referral for suspected cancer	Apr 25	85.0%	62.6%		F
	Percentage of patients receiving first definitive treatment for cancer within 62-days of referral from an NHS Cancer Screening Service	Apr 25	90.0%	68.8%		F
	Cancer 28 days wait (faster diagnosis standard) - Commissioner	Apr 25	75.0%	77.5%		P

Emergency Care Metrics

Category	Metric	Period	Target	Value	Variance	Assurance
Urgent Care	Total A&E Attendances	May 25		52,842		
	Percentage of patients who spent 4 hours or less in A&E	May 25	78.0%	77.0%	H	F
	Over 12 hour waits from DTA to Admission	May 25		283		

GP Appointments Metrics

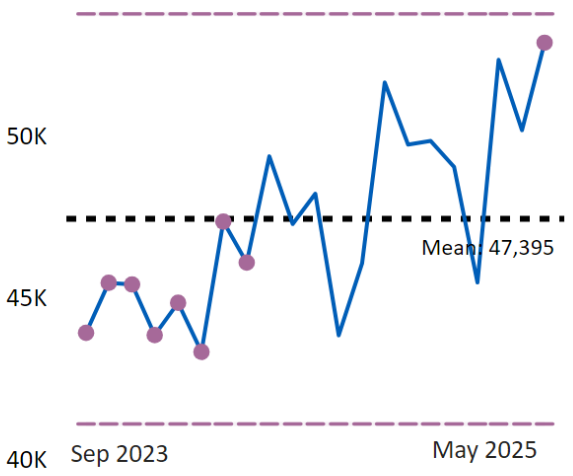
Category	Metric	Period	Target	Value	Variance	Assurance
GP Appointments	GP Appointments by Month split by modality - Video Conference/Online	Apr 25		43,635		
	GP Appointments by Month split by modality - Unknown	Apr 25		14,092		
	GP Appointments by Month split by modality - Telephone	Apr 25		269,053		
	GP Appointments by Month split by modality - Home Visit	Apr 25		10,670		
	GP Appointments by Month split by modality - Face-to-Face	Apr 25		511,856		

Source : NHS Statistics, NHS Digital

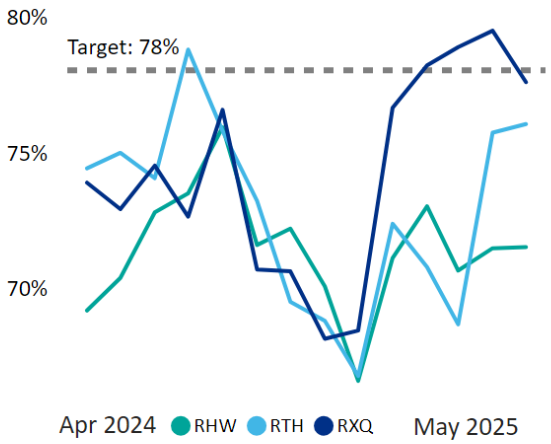
Ambulance and Urgent and Emergency Care

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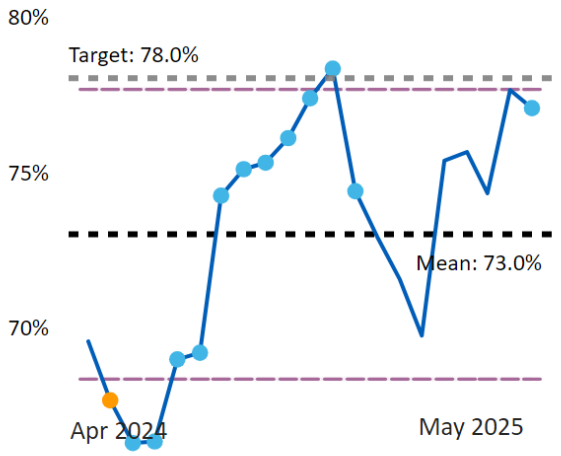
Total A&E Attendances



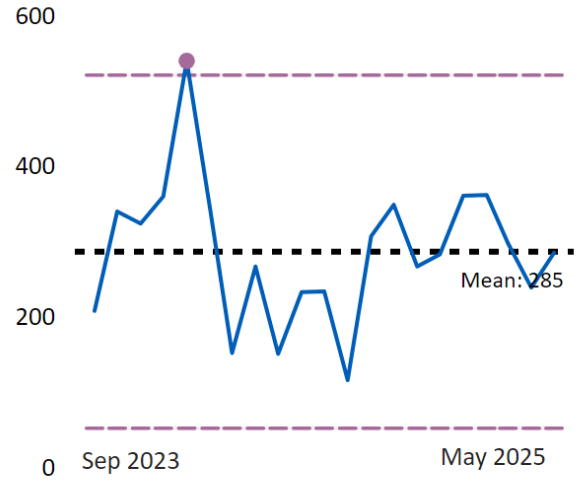
Percentage of patients who spent 4 hours or less in A&E



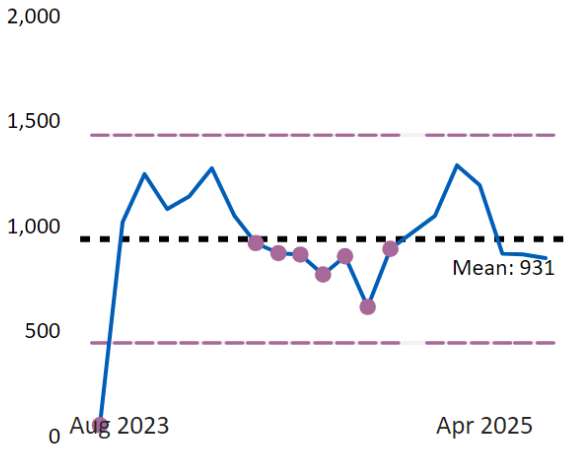
Percentage of patients who spent 4 hours or less in A&E



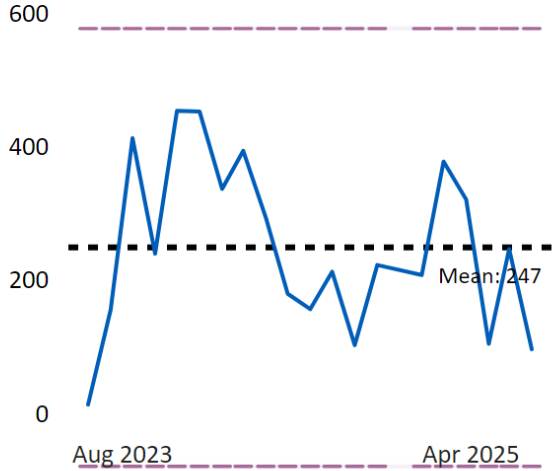
Over 12 hour waits from DTA to Admission



Ambulance Handover Delays greater than 30 minutes (as reported by NHS Acute Trusts)



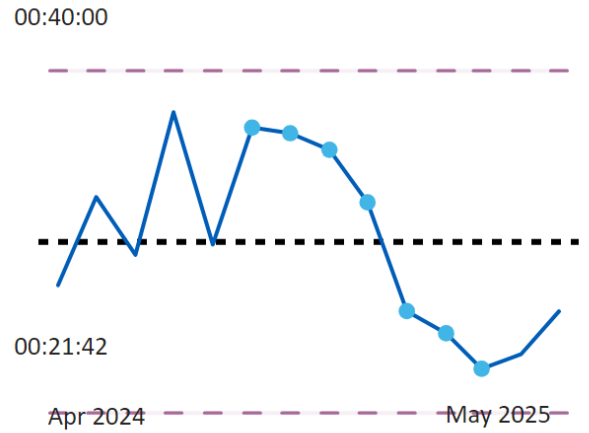
Ambulance Handover Delays (>60 Minutes)



Average Hours Lost on Handover Delays per day at BOB Acute Trusts



Ambulance Response Times - Mean Category 2

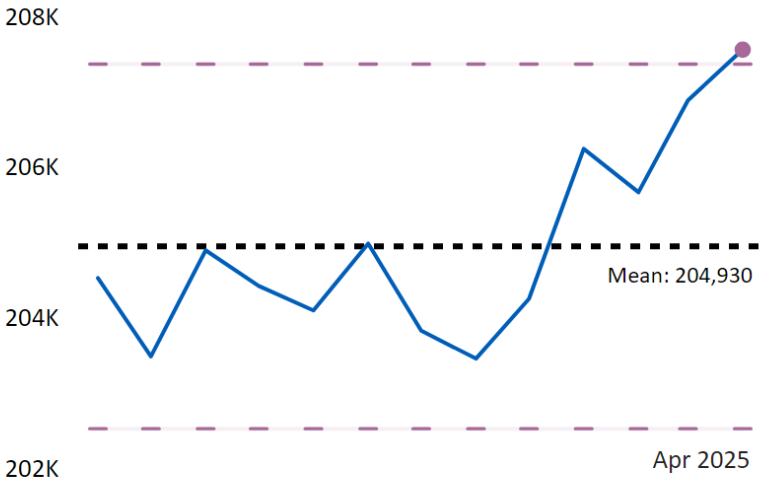


Source : NHS Statistics, A&E Daily Sit. Rep, ECDS, Covid Data Store, SCAS Scorecard

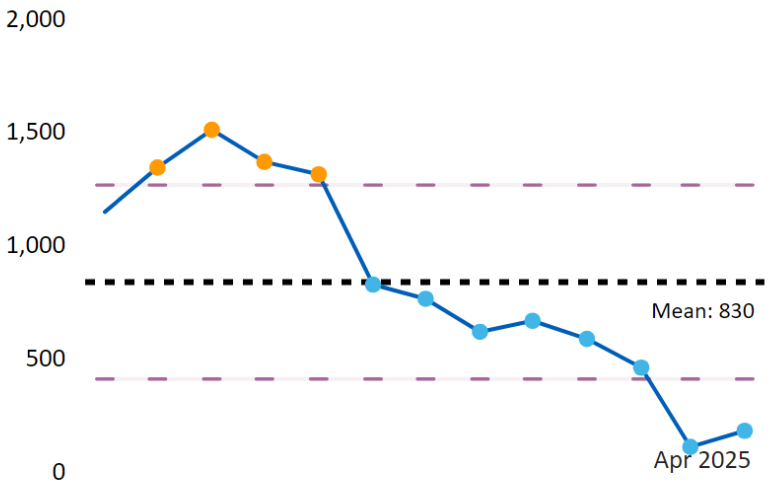
Planned Care ICB

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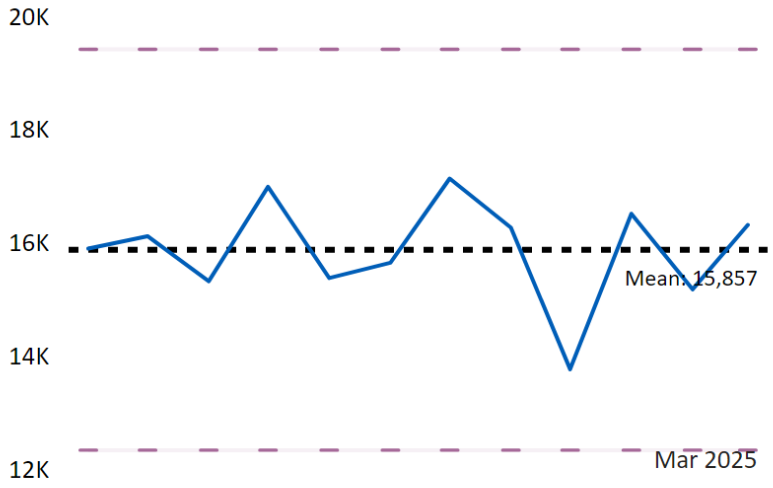
The total number of incomplete RTT pathways



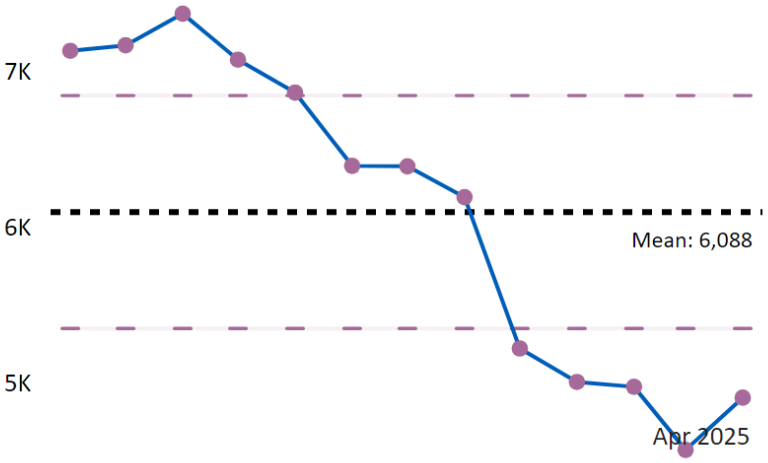
RTT 65 Week Waits



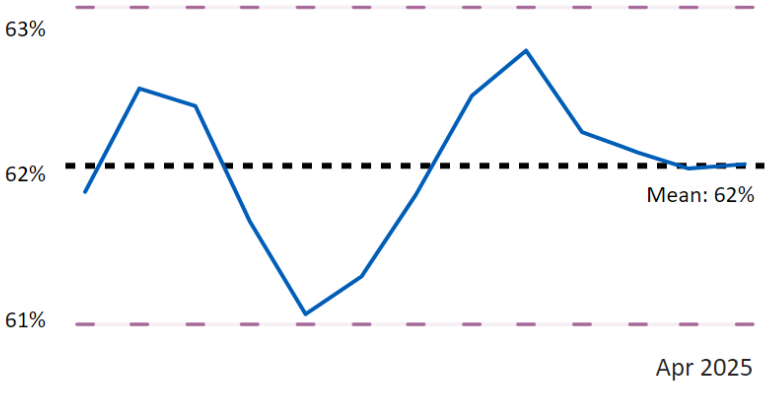
Day Case



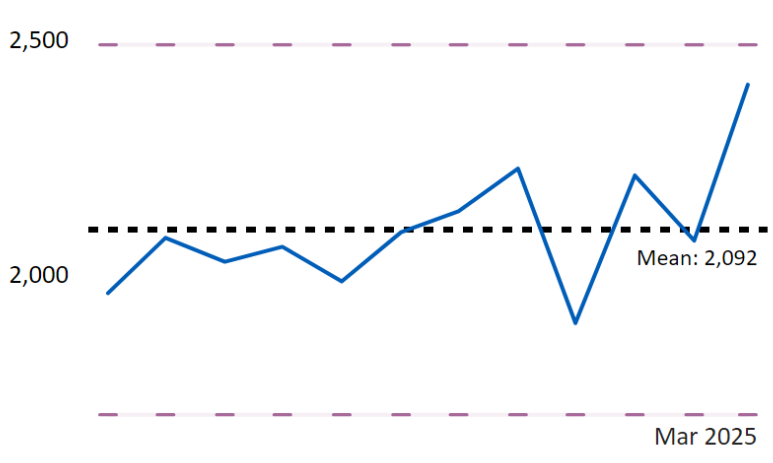
RTT 52 Week Waits



Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period



Ordinary



Source : NHS Digital, Joint Activity Data - Future NHS

Planned Care - Provider

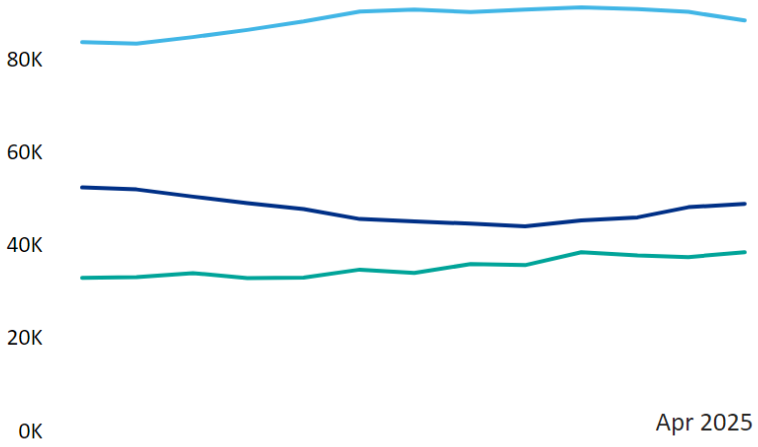
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RHW - ROYAL BERKSHIRE NHS FOUNDATION TRUST

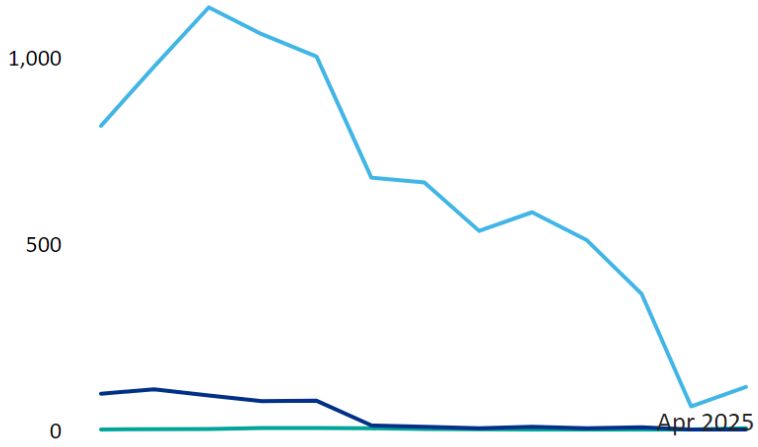
RTH - OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST

RXQ - BUCKINGHAMSHIRE HEALTHCARE NHS TRUST

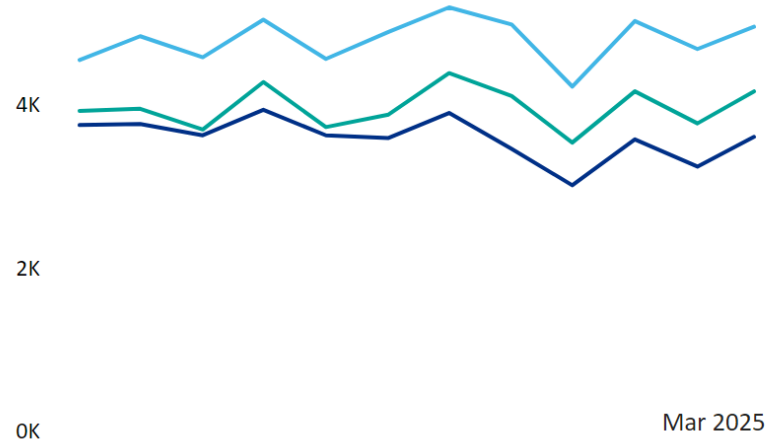
The total number of incomplete RTT pathways



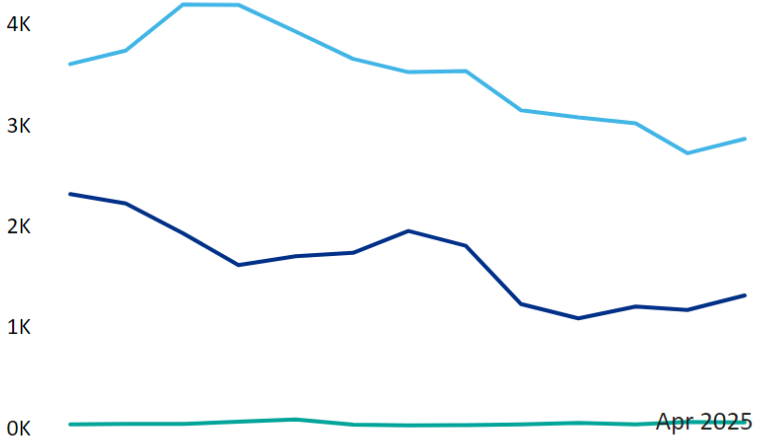
RTT 65 Week Waits



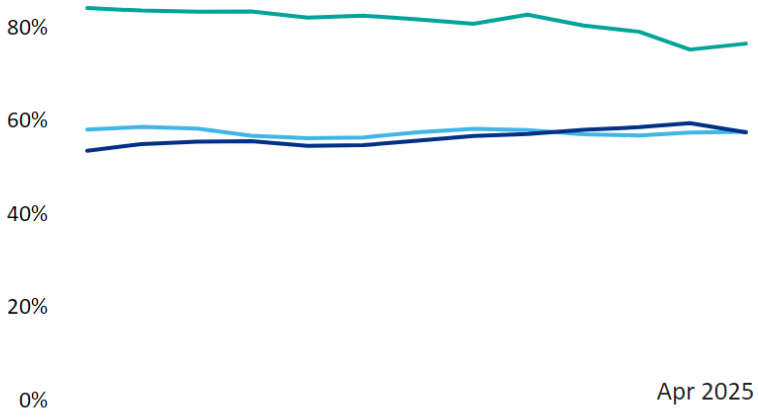
Day Case



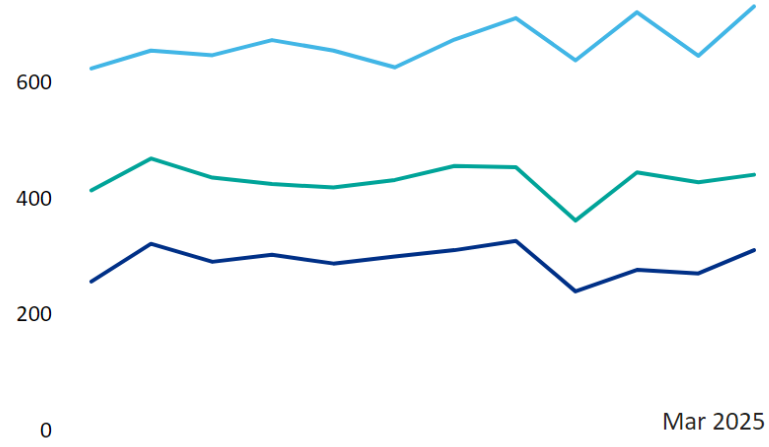
RTT 52 Week Waits



Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period



Ordinary



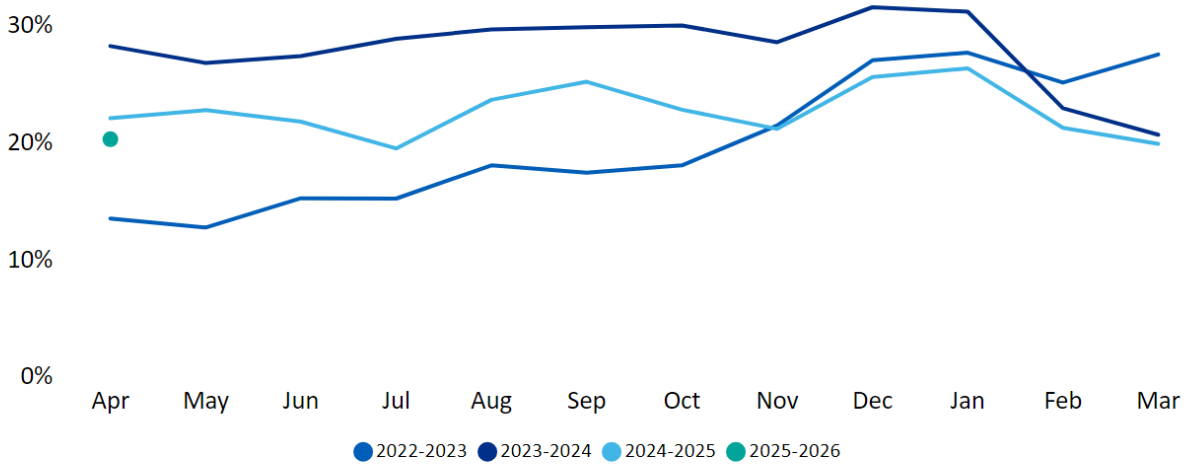
Source : NHS Digital, Joint Activity Data - Future NHS

Diagnostics

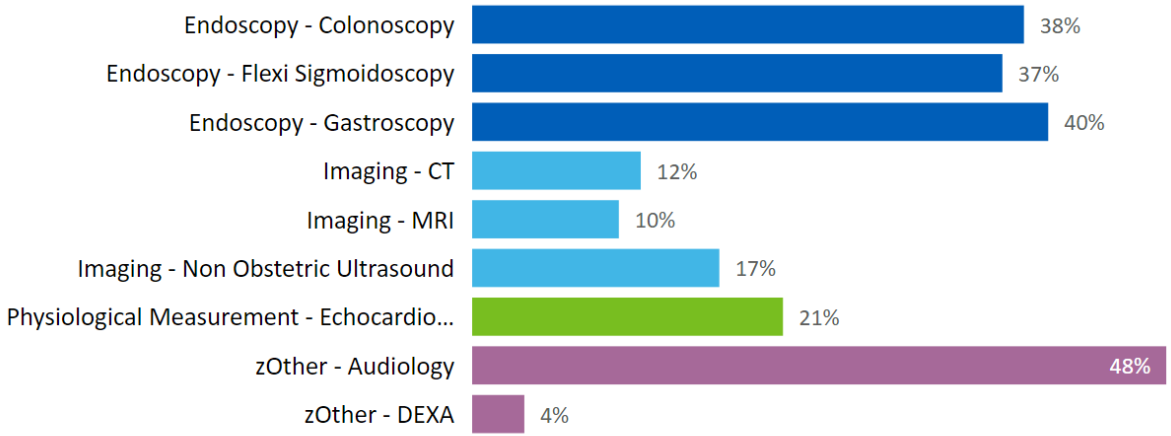
Apr 2025

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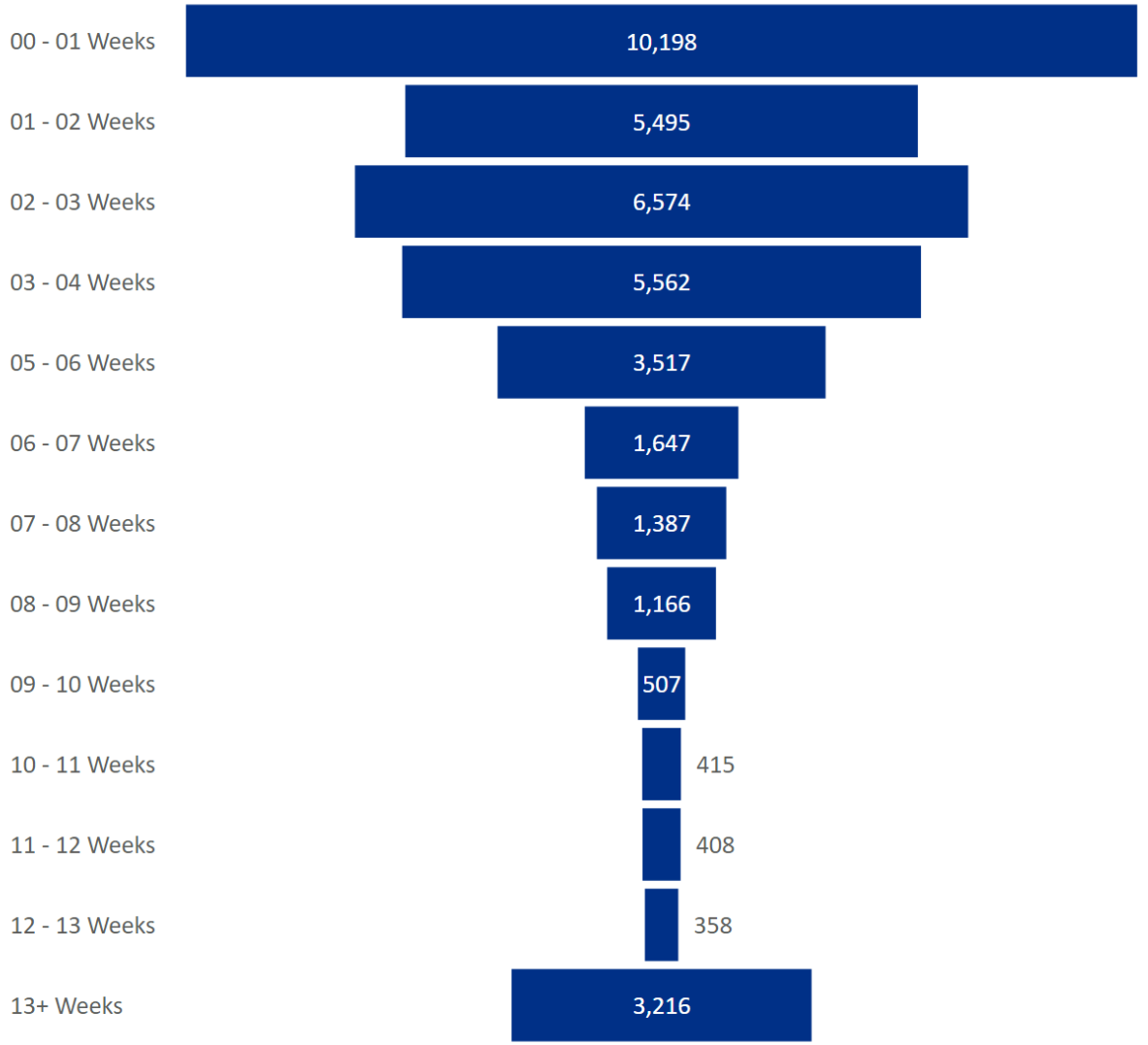
The percentage of patients waiting 6 weeks or more for a diagnostic test



Diagnostic Performance by Test



Waiters by week waited



Source : NHS Statistics

Mental Health Scorecard

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Children and Young People Metrics

Category	Metric	Period	Target	Value	Variance	Assurance
Mental Health	Children and young people (ages 0-17) mental health services access (number with 1+ contact)	Feb 25	26,531	24,990		

Dementia and Out of Area Placement (OAP) Metrics

Category	Metric	Period	Target	Value	Variance	Assurance
Mental Health	Inappropriate adult acute mental health Out of Area Placement (OAP) bed days (internal or external) - Commissioner	Apr 25	0	15		
	Estimated Diagnosis rate for people with dementia	May 25	66.7%	62.0%		

Talking Therapies Metrics

Category	Metric	Period	Target	Value	Variance	Assurance
Mental Health	Talking Therapies: Treated within 6 weeks	Apr 25	75.0%	97.4%		
	Talking Therapies: Treated within 18 weeks	Apr 25	95.0%	99.7%		
	Talking Therapies: Moving to reliable recovery (national)	Apr 25	50.0%	49.9%		
	Talking Therapies access (total numbers accessing services)	Apr 25	3,914	2,745		

Severe Mental Illness Metrics

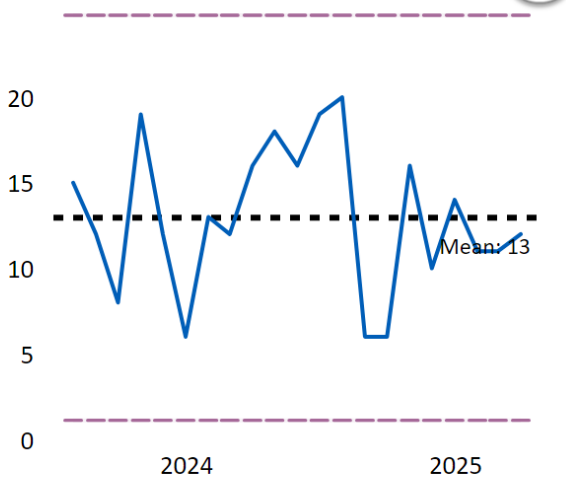
Category	Metric	Period	Target	Value	Variance	Assurance
Mental Health	People with severe mental illness receiving a full annual physical health check and follow up interventions	Mar 24	60.0%	67.8%		

Infection Prevention and Control - CDI, MRSA, MSSA

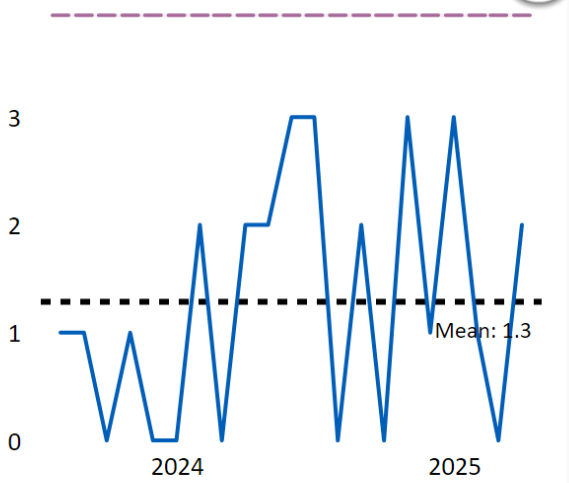
Apr 2025

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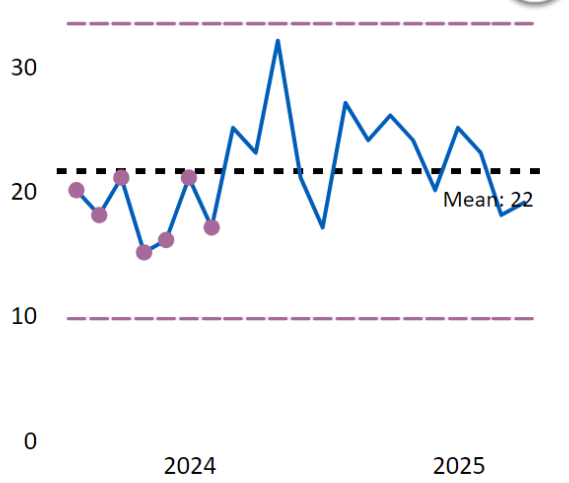
CDI - Community Associated



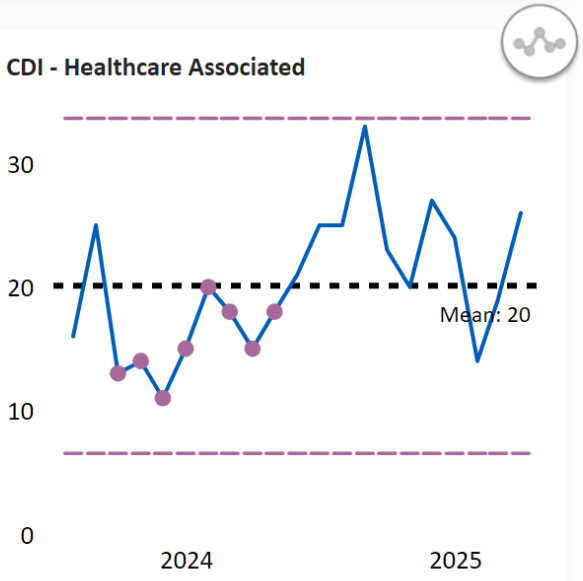
MRSA - Community Associated



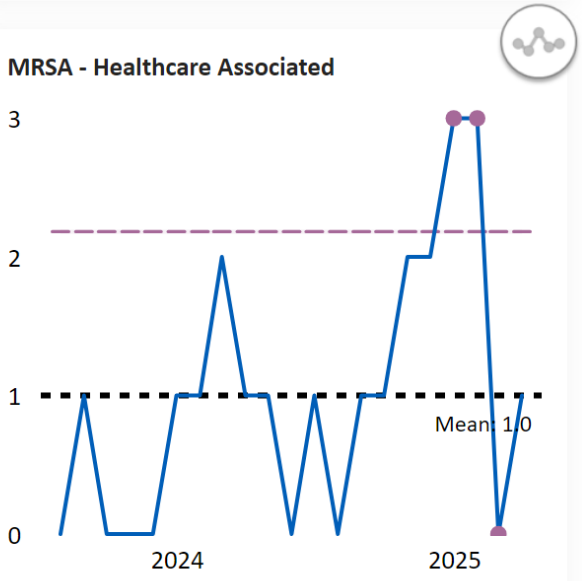
MSSA - Community Associated



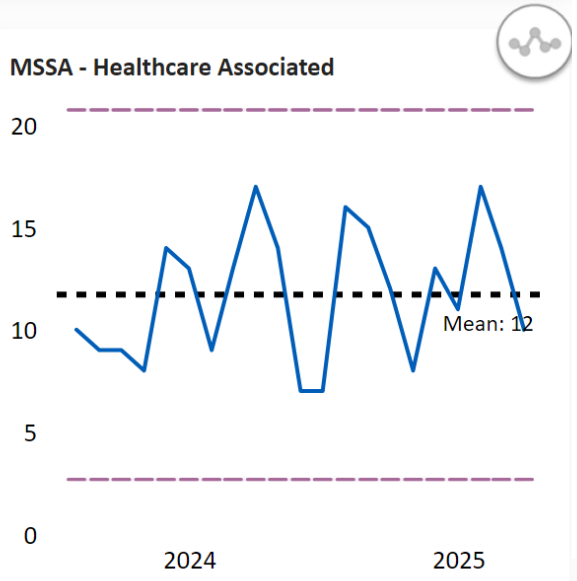
CDI - Healthcare Associated



MRSA - Healthcare Associated



MSSA - Healthcare Associated



How we are performing

The NHS Standard Contract 2025/26 Trust and ICB thresholds for CDI and GNBSI now published. In addition to Trust thresholds, publication of thresholds at sub-ICB level are included (previously published at ICB level).
Thresholds for 2025/26 CDI cases ; Buckinghamshire 103, Oxfordshire 159, Berkshire West 112.
Healthcare-associated infections (HCAIs) remain a significant challenge across NHS England, with evidence pointing to multifaceted drivers behind the rising incidence of GNBSIs, other resistant infections, and antimicrobial resistance (AMR). Contributing factors include variations in antimicrobial stewardship (AMS), diagnostic practices, and application of infection prevention and control (IPC) measures.
MRSA remains as zero tolerance, there is no set threshold for MSSA.
Bucks is under trajectory for CDI in April, Oxon and Berks are over trajectory.
In April , 3 MRSA bacteraemia's reported in Berkshire West, 2 samples from the same patient, one on admission as a community sample, the second during their admission as a hospital sample, risk factors include IVDU. The 3rd sample, although community onset has some healthcare learning opportunities from the investigation.

Actions & Risks

The Covid 19 Spring booster campaign commenced 1st April and ran until June 17th and BOB has achieved a 61.5% uptake in eligible cohorts.
The April MRSAB investigations have resulted in a review of community Podiatry and TVN team practice, findings awaited.
A revised Community CDI analysis has been produced for 2025/26 and includes a simplified risk factor question and more details on the treatment of CDI. An abstract of this project has been submitted for the Infection Prevention Society (IPS) annual conference

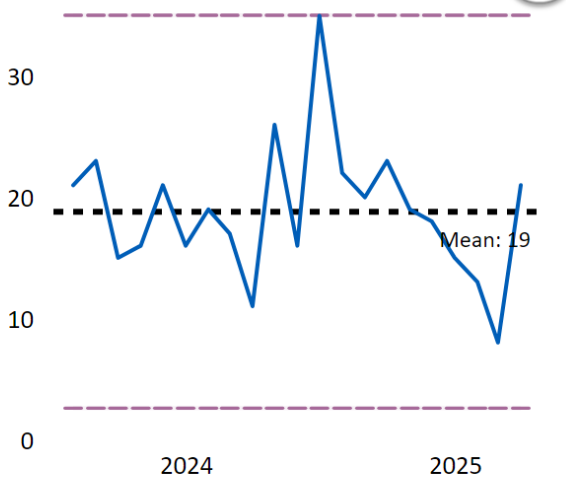
Source : Gov Statistics

Infection Prevention and Control - Kleb, E.Coli, Pseud

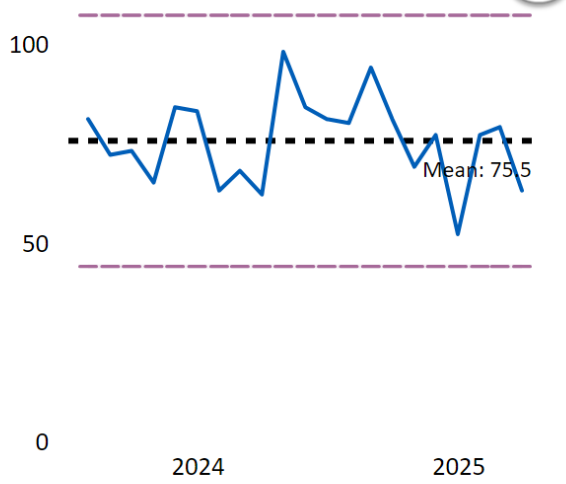
Apr 2025

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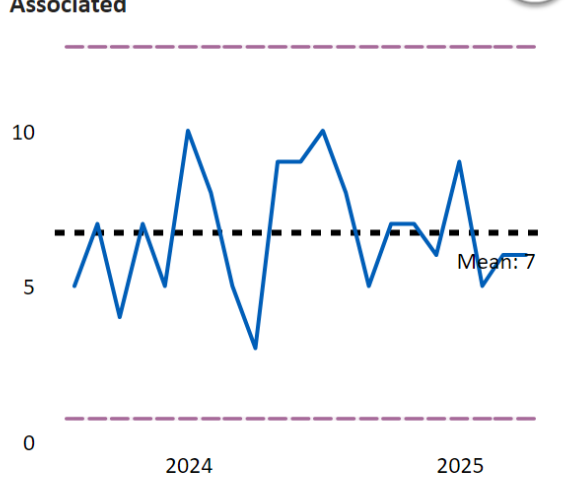
Klebsiella - Community Associated



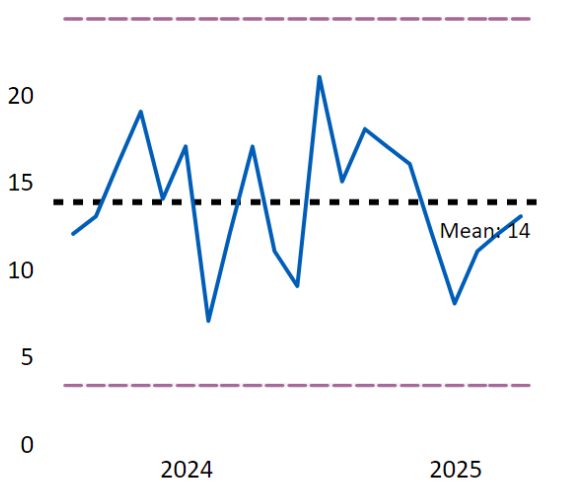
E.Coli - Community Associated



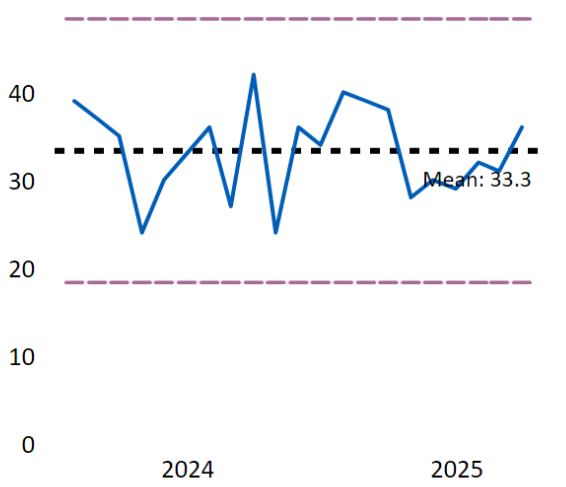
Pseudomonas aeruginosa - Community Associated



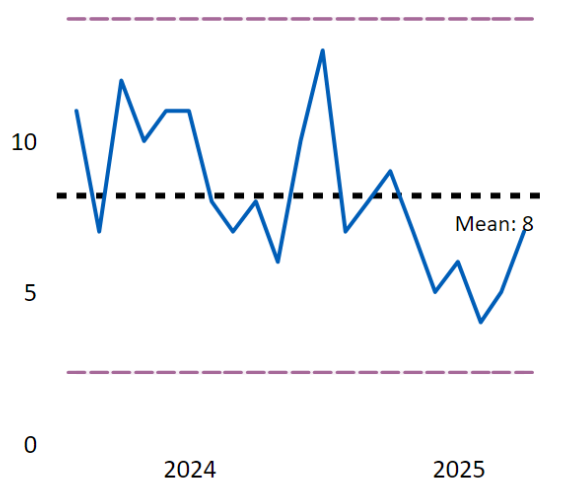
Klebsiella - Healthcare Associated



E.Coli - Healthcare Associated



Pseudomonas aeruginosa - Healthcare Associa



How are we performing

The NHS Standard Contract 2025/26 thresholds for GNBSI has been published and as CDI is divided into sub-ICB level. Bucks threshold for E.coli 378, Oxon 475, Berks 349, Kleb (108, 147, 94) respectively, P. aeruginosa (48, 76, 36) respectively.
Bucks and Oxon have exceeded the E.coli threshold in April, Berks has reached the set threshold. Bucks has exceeded Klebsiella threshold, Oxon and Berks have reached this for April. Bucks and Berks have exceeded the P.aeruginosa threshold, Oxon remains within it.

Actions & Risks

Care Home outbreaks have reduced from 15 in March to 8 in April. There has been a concern raised regarding IP&C practice in Care Homes and Domiciliary care including hand hygiene and use of personal protective equipment (PPE). A quick reference guide has been co-created as an education and training resource between ICB and the Social care provider Connect 2 Flexicare and shared across BOB Care Homes and Domiciliary care providers.

The Royal National Orthopaedic Hospital and TB GIRFT project have co-produced a TB Stakeholder Implementation Summary report following release of the National report, based on 18 categories of recommendations. The 3 TB teams and ICB are meeting to align a BOB response.

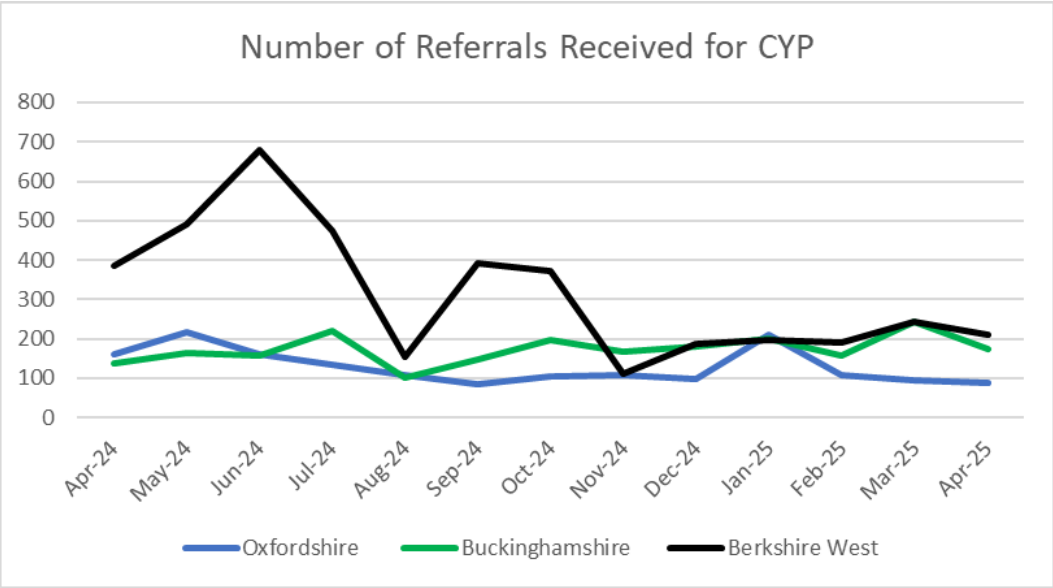
A case of Diphtheria was identified in a Berkshire West GP practice, from a patient's chronic wound resulting from scoliosis surgery. Both the patient and the 2 household contacts are fully vaccinated against Diphtheria and have no symptoms. The patient's previous occupation involved dog handling and there are a number of pets living at home. The patient and contacts have been provided with prophylactic antibiotics and advised of symptoms to be aware of. The healthcare staff risk assessed, but were wearing appropriate PPE, therefore with this good practice no further precautions were required.

Source : Gov Statistics

Autism and ADHD - CYP

*Data validation and alignment underway figures subject to change

Latest number of CYP waiting for assessment (waiting list)	
Oxfordshire CYP (Autism & ADHD)	4356 (Apr 2025)
Buckinghamshire CYP (Autism & ADHD)	3531 (Apr 2025)
Berkshire West (Reading, West Berks and Wokingham)	7388 (Apr 2025)



Average (Mean) waiting time to assessment for CYP seen	
Oxfordshire CYP (Autism & ADHD)	95 weeks (Apr 2025)
Buckinghamshire CYP (Autism & ADHD)	79 weeks (Apr 2025)
Berkshire West (Reading, West Berks and Wokingham)	Autism – 66 weeks (APR 2025)
Berkshire West (Reading, West Berks and Wokingham)	ADHD – 69 weeks (Apr 2025)

This metric measures

This measure seeks to highlight the number of patients referred for assessment for autism or ADHD. The number of children and young people currently awaiting an assessment and the mean waiting time to assessment. The data here relates to CYP (children and young people) only. Note tables contain previous months report data due to reporting timelines, chart shows latest referral numbers by Place.

How are we performing:

- The top table outlines the number of patients currently waiting for an assessment it displays 15,453 on the waiting list across BOB when using end-of-February 2025 figures for Buckinghamshire, Oxfordshire and Berkshire West.
- The chart provides an overview of the numbers of referrals received by month over the past 12 months.
- The final table highlights the mean wait time to assessment across BOB. This metric is of high importance as an indicator of demand and capacity across the System.
- Patient and carer experience here is challenged as it is unclear what level of support is required by individuals on the waiting list, there will be a differential in quality of experience whilst on the waiting list.

Actions:

- Partnerships for Inclusion of Neurodiversity in Schools (PINS) Pilot funding extended into 25/26 for further 30 primary schools (Wokingham) and embed support for 40 schools (Reading). Delivery planning taking place.
- Area Partnerships across Berkshire have employed additional support to establish a needs led approach for CYP using profile tools in education settings. To meet the needs of neurodivergent CYP early on and reduce reliance on formal diagnosis before support is put in place. First steering group meeting set for May and workshops with schools and Parent Carers Forums scheduled for June.
- Rollout and expansion from April 2024 of BOB SHaRON Online Network pilot which provides support whilst waiting. 2631 new members from launch as of April 2025. Evaluation of support taking place in May 2025.
- SPENCER3D pilot in 20 schools across Berkshire and Bucks to promote informed strengths and needs led support.
- Two projects developing automated clinical decision-making tool and using AI for Autism & ADHD Assessment being explored and implemented. Piloting ‘request for help’ (from Q3 23/24) and ‘BOB-NDQ’ (from Q3 24/25 - trial with families commenced September 2024). Expanding programme offer to incorporate early years (0-5) delivery.
- Scoping of support offer for families, children and young people while waiting for assessment taking place.
- Adult ADHD transformation programme task and finish group established (transition risk for CYP).

Risks:

- Inequality of experience whilst on waiting list – focus of SEND inspections and how CYP waiting are supported as a system.
- Children and Young People, risk to transfer of care to adult services due to services being paused in Oxfordshire and Buckinghamshire.

[1]Spencer is a web-based application for the assessment, intervention and management of mental health, developmental and learning difficulties in primary and secondary schools.

Patient Experience

Healthwatch Report Just Listen to Me – Using Women's Health Services in Oxfordshire report and recommendations received and responded to.

The ICB welcomed the insights from women and people to enhance the quality and accessibility of women's health services. It was positive to hear of good experiences particularly when care was centred around women and people's needs, and they were treated holistically rather than for individual symptoms.

Key themes:

Listening and involving patients

Information and communication

Tackling barriers and improving quality of care

The ICB have completed a number of involvement engagement activities since January 2025 when the Involvement and Insight team was formed and continue to recruit population members into our Your Voices website and develop relationships with local communities.

The ICB has developed Your Voices pages for Patient Participation Groups within BOB to enable sharing and learning of good practice across BOB and continue to conduct involvement activities. Currently working to a combination of reactive/proactive responses and have supported a number of projects within the ICB and or with partners.

BOB ICS providers and patient experience group representatives have collaborated to produce an Antibiotic patient information leaflet (PIL).

Complaints and PALS enquiries- April 2025

232 cases received, a marginal 3% increase on the previous month:

11 Formal ICB Complaints

8 POD complaints

19 MP Letters

24 POD PALS contacts

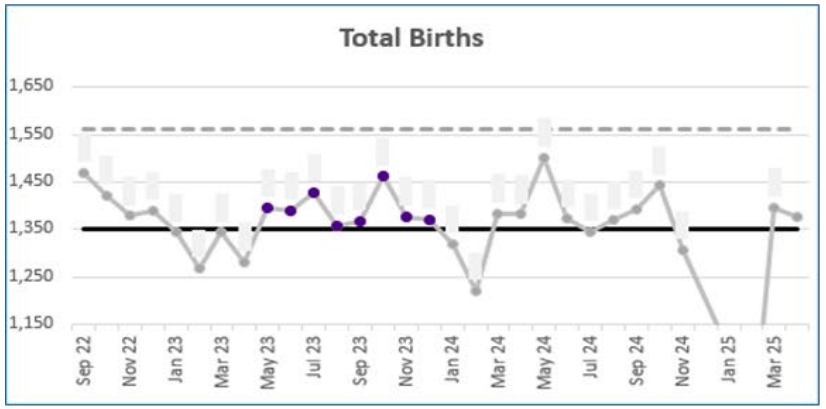
170 ICB PALS contacts.

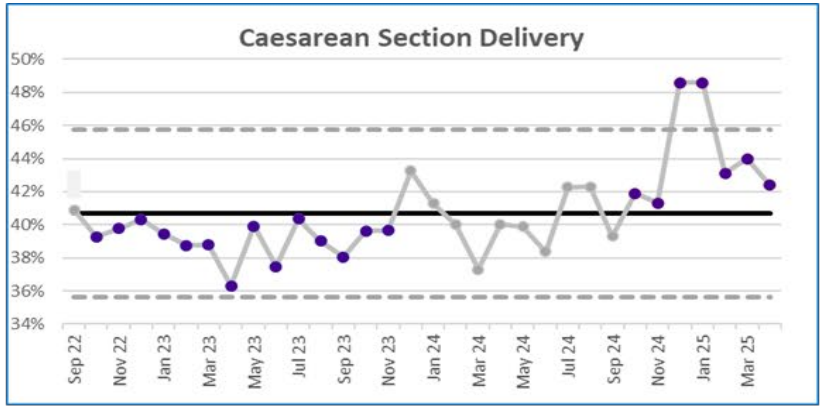
Themes: 69 ICB PALS contacts are specifically regarding Choice and Flexibility of access for services including house bound vaccines, ADHD pathways, dental services and fertility services.

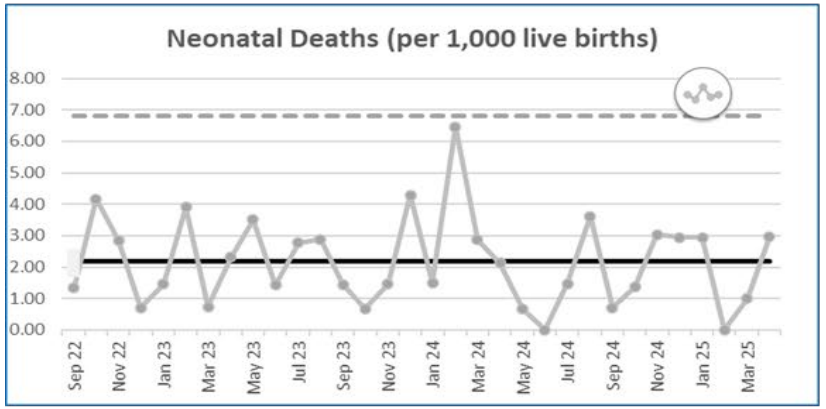
- Improvement collaborative with focus on safer surgery toolkit remains to be established , priorty of this work is increasing given another two never events related to retained foreign object. Capacity in patient safety lead role /quality team is impacting progress. This risk is identified in the SOM RAID log.
- ADHD pathway review
- Develop strategic response group with named Trust SRO's for paediatric audiology look back and recall.
- Await SCAS undertakings review report.

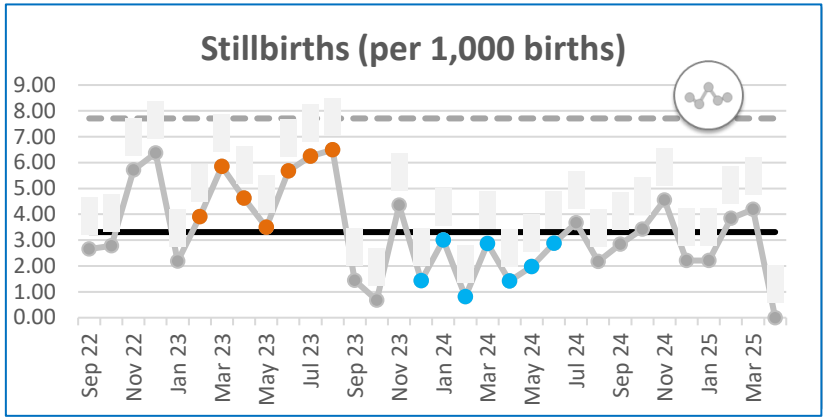
Maternity and Neonatal

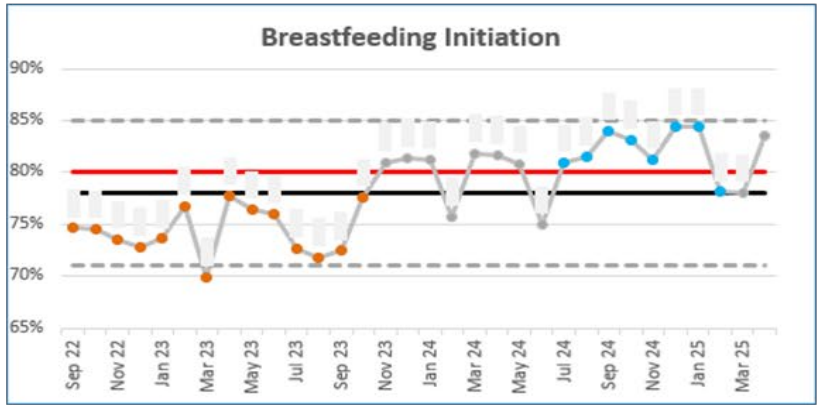
April 2025

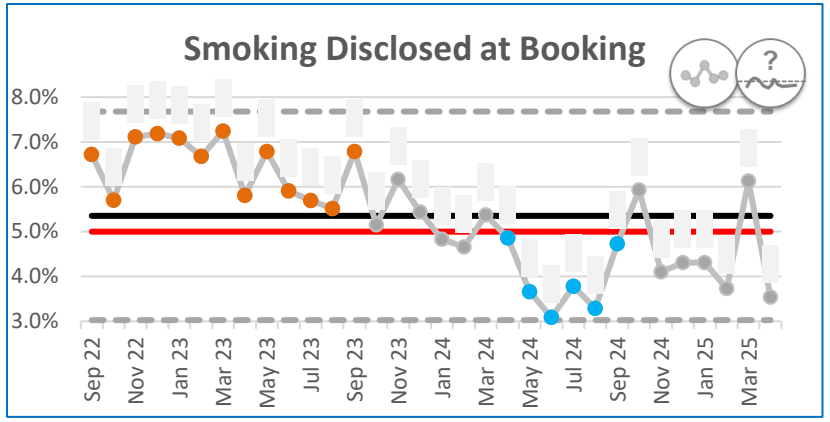












Total births: There were 1349 total births across the system in April which is about average.

Breastfeeding initiation: 84% of women and birthing people-initiated breastfeeding in April. This is above the 80% target for BOB above target after falling below for 2nd consecutive month.

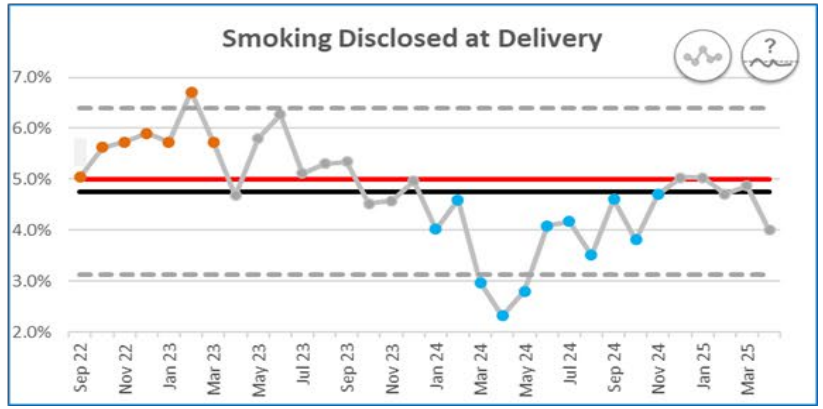
Caesarean section delivery: The percentage of births via c-section is 42% across the system. This has fallen from Feb. This indicator reflects both acuity and workload in each place.

Neonatal deaths (rate per 1000 births): 2.95 - there was 4 neonatal deaths in April which is within common cause variation.

Stillbirths (rate per 1000 births): there were 0 stillbirths across BOB in April.

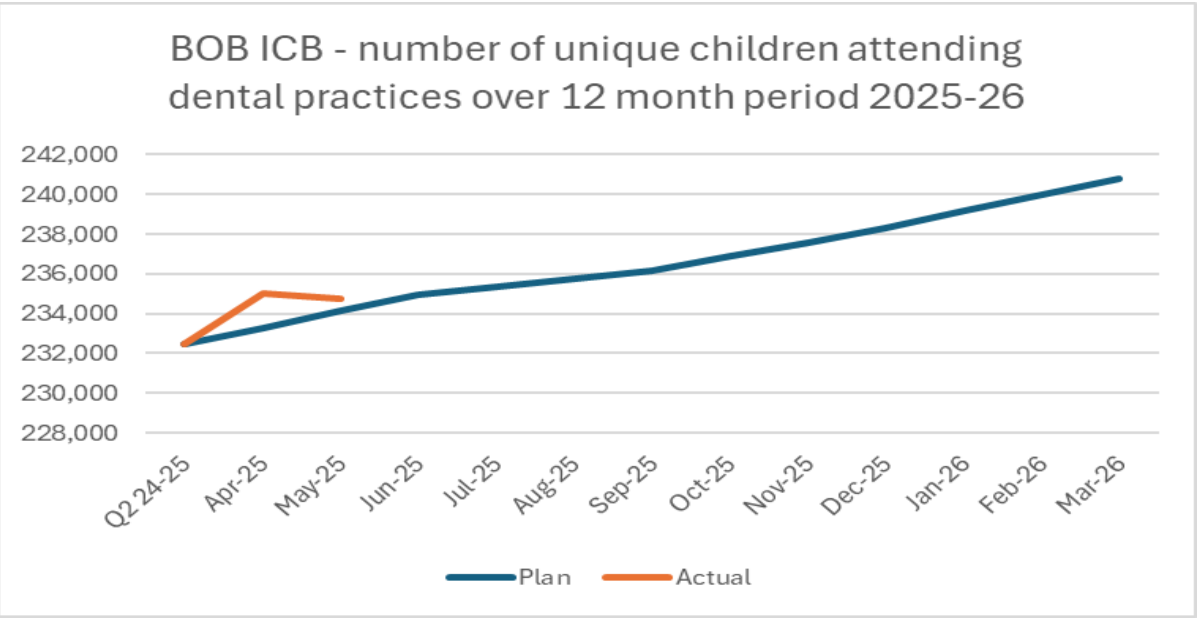
Smoking at time of booking: The percentage of women and birthing people smoking at booking remains below the 5% target.

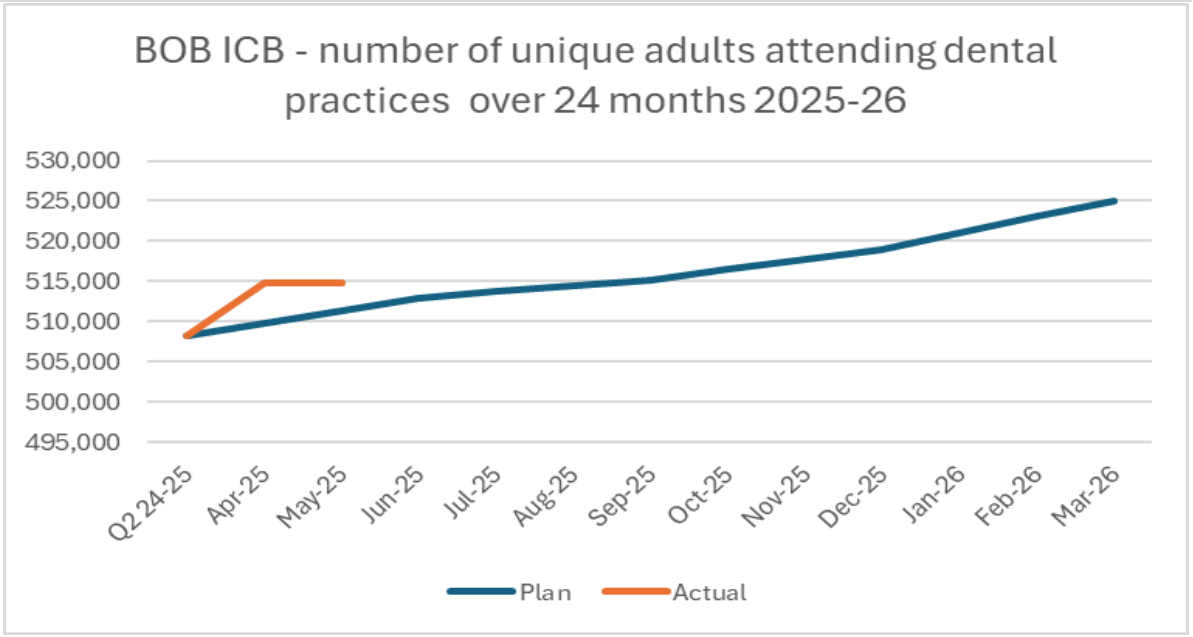
Smoking at time of delivery: The percentage of women and birthing people smoking at delivery remains just below the 5% target.



Dentistry/High Street Dental Services – Access 2025-26

May 25





Delivery against activity plan (M2)

As part of the ICB Operating Plan in 2025-26 there are targets to increase the number of children attending over a 12-month period and adults over 24 months. The baseline figures for the numbers are based on Q2 2024-25

- Children 232,487
- Adults 508,290

The targets for 2025-26 are:

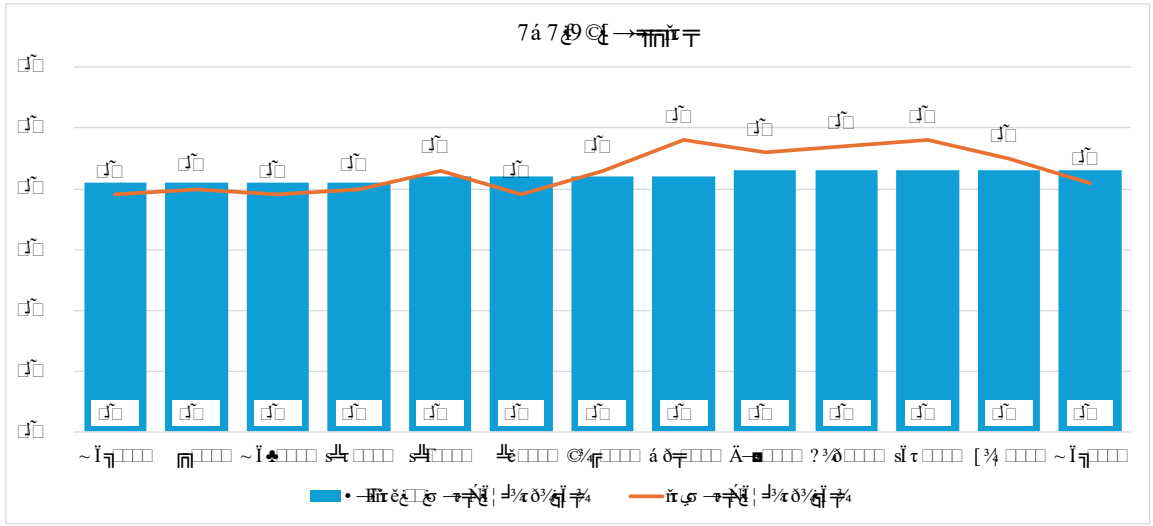
- Children 240,805
- Adults 525,011

At the end of May , the ICB was ahead of target. The ICB is pursuing the following initiatives to support improved access:

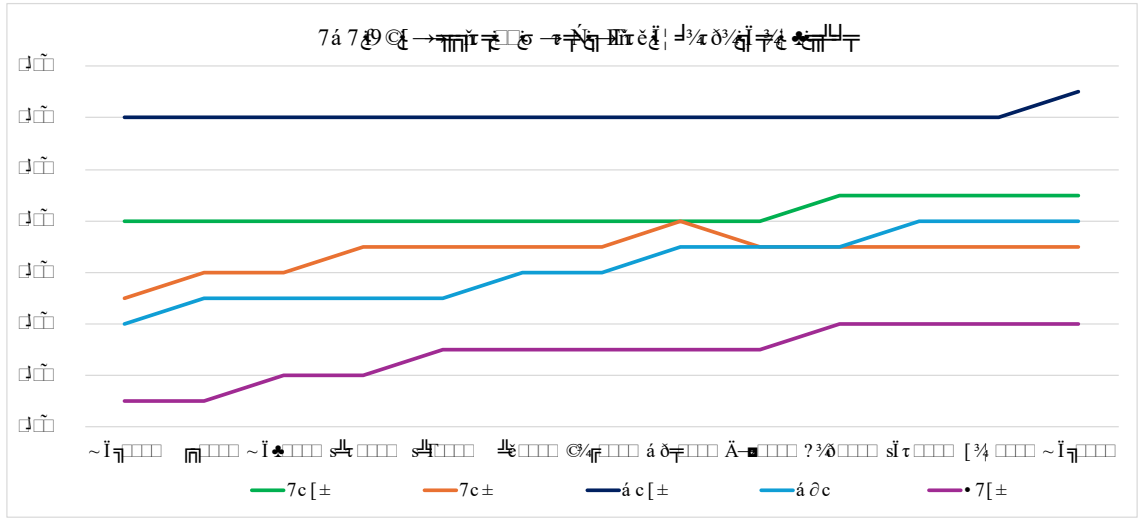
- Minimum Unit of Dental Activity (UDA) price of £28
- 70,000 additional UDAs commissioned from April 2024
- Payment for contract overperformance up to 110%
- Plans to commission a further 88,000 UDAs from 2025-26 with the additional activity to be commissioned from October 2025. The Contract Award Recommendation Report for 5 new practices has been approved with Preferred Bidders advised. Mobilisation commenced in May.
- Flexible Commissioning for patients who have struggled to access NHS dental care – 37 practices taking part in the scheme will continue in 2025-26
- In response to the new government manifesto commitment to commission an additional 700,000 urgent dental appointments nationally, practices started to provide these appointments from January. The ICB target of 15,454 Urgent and Unscheduled Dental Care appointments in 2025-26 with 36 practices providing additional appointments.

Workforce - Absence

12 month rolling Absence Rate and in-month Absence rate for BOB ICS footprint



12-Month Rolling Absence Rate by Provider Trust



This metric measures

- 12 month rolling and in month absence rate by system, March 2024 – March 2025 all staff groups.
- 12 month rolling absence rate Mar 2024 – 2025 by NHS Provider Trust - all staff groups

In-month absence rate is the % absence rate for each month
12 month rolling absence rate – each monthly data point is the average % absence rate for the previous 12 months e.g. Dec 23 is the average of absence rates for Jan -Dec 2023
Source SDSP "South East Absence" dashboard as of March 2025 Does not include BOB ICB

How we are performing

- The average sickness rate in the BOB system is lower than the SE regional average
- During the period March 2024 – March 2025, the rolling 12-month absence rate for the system has been relatively stable, varying between 4.1% to 4.3% during the year. The in-month absence rate for March 2025 (4.1%) is 0.2% higher than March 2024

- 12-month absence rates at NHS Provider Trusts have risen very slightly over the period Mar 2024 – Mar 2025, with rises ranging from 0.1% (BHFT and OHFT) to 0.4% at OUH.
- Trusts providing mental health services tend to have higher rates of sickness absence, due to such factors as higher risk of violence and aggression from service users and dealing regularly with emotionally intense situations such as severe mental health crises, self-harm and suicide.

Actions

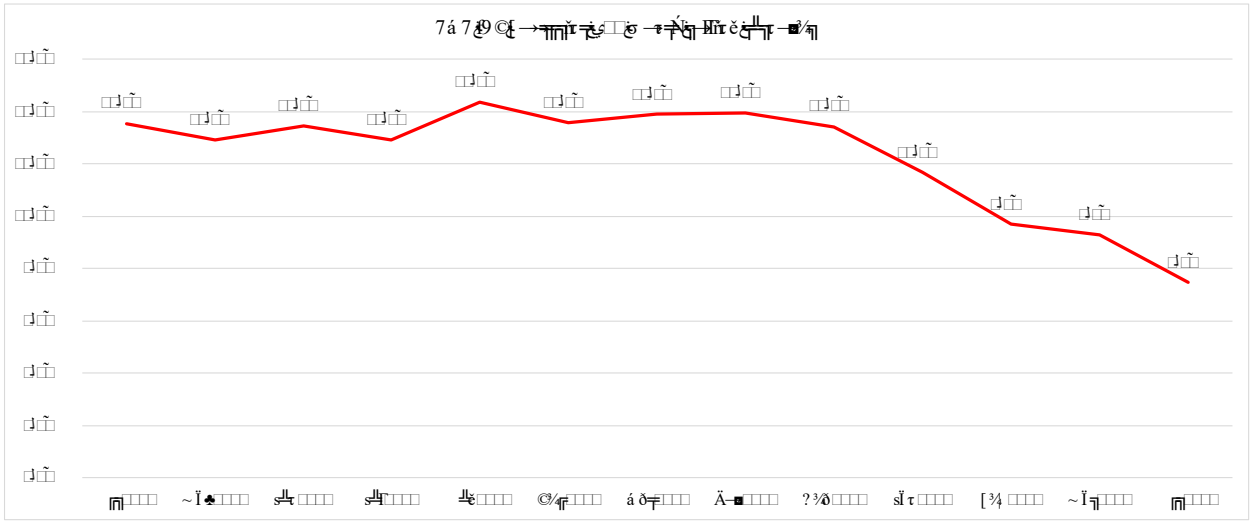
- The sickness absence trends for each trust will now form a key part of the metrics that are reviewed at the regular trust bilateral meetings. These meetings review workforce, finance and activity metrics and agree key actions required to address any deteriorating trends.

Risks:

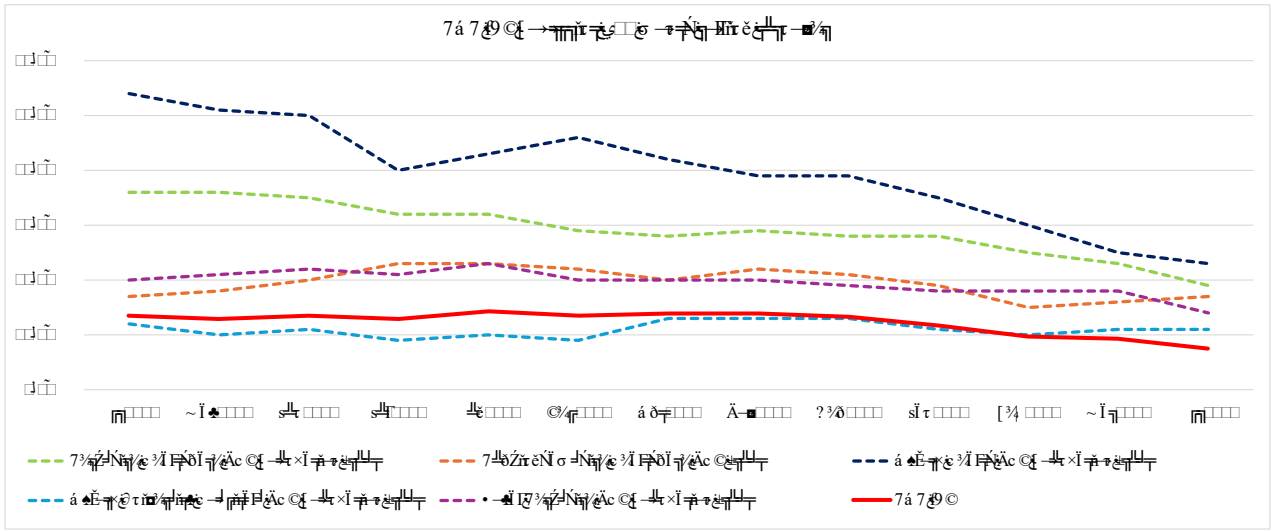
- Absence rates remain a risk on the BAF and Trust Risk Registers for relevant organisations within the System.
- These risks are being mitigated by provider initiatives to promote health and well-being and to target these initiatives to better understand and alleviate the impact of stress for the workforce.

Workforce - Turnover

12 Month Rolling Turnover by System



12Turnover by Organisation



This metric measures
12 month rolling Turnover by System, with further breakdown by organisation..
Source SDSP “Joiners, Leavers and Turnover Dashboard” as at April 2025

This rate includes all staff except for doctors in training. These staff are traditionally excluded from turnover calculations, as normal staff movement, due to the rotational nature of their posts, distorts turnover data.

How we are performing

- The overall 12-month rolling turnover rate for the BOB ICS Footprint (NHS Provider Trusts) is on a downward trend falling from 10.35% in April 2024 to 9.75% in April 2025, a fall of 0.61% over the period.
- The ICS 12 month rolling turnover rate tends to align closely with OUH, our largest trust.
- Comparing April 2024 to April 2025, the rolling 12-month turnover rate has fallen at all NHS Provider Trusts apart from BHT where is has remained the same. The fall ranges from 3.10% at OHFT, 1.7% at BHFT, 0.6% at RBFT, and 0,1% at OUH.
- In April 2025, OHFT has the highest 12 month rolling turnover rate of the NHS Provider trusts at 11.3%, followed by BHFT at 10.9%, BHT at 10.7%, RBFT at 10.4% and OUH at 10.1%

Actions
The turnover trends for each trust will now form a key part of the metrics that are reviewed at the regular trust bilateral meetings. These meetings review workforce, finance and activity metrics and agree key actions required to address any deteriorating trends.

Supportive interventions
The ICS has created a network of retention and people promise leads across the system to share good practice and effective strategies. All trusts are now well established in their retention programmes, so the lead is stepping back from this work.

Risks:

- Turnover remains a risk on the BAF and Trust Risk Registers.
- These risks are being mitigated by provider initiatives to promote health and well-being and to target retention activities for the areas most impacted by high turnover.

Glossary

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Glossary

Icon	Description
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.
	Special cause variation of a CONCERNING nature where the measure is significantly HIGHER.
	Special cause variation of a CONCERNING nature where the measure is significantly LOWER.
	Common cause variation, NO SIGNIFICANT CHANGE.
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.
	Low is good - Performance is declining
	Low is good - Performance is improving
	High is good - Performance is declining
	High is good - Performance is improving
	Performance has not changed

Icon	Description
	This process is capable and will consistently PASS the target if nothing changes.
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.
	This process is not capable and will consistently FAIL to meet the target.
	This metric currently has no performance target set

SPC chart data points

Special cause - concern
Special cause - improvement
Special cause - neither



Infection Prevention and Control

Long name
Clostridioides difficile (C. difficile) infections
Escherichia coli (E.coli) bacteraemia
Klebsiella species (Klebsiella spp.) bacteraemia
Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia
Meticillin-susceptible Staphylococcus aureus (MSSA) bacteraemia
Pseudomonas aeruginosa (P. aeruginosa) bacteraemia

Organisation Codes

Code	Org	Org Name
QU9	BOB ICB	NHS Buckinghamshire, Oxfordshire and Berkshire West ICB
RHW	RBFT	Royal Berkshire NHS Foundation Trust
RNU	OH	Oxford Health NHS Foundation Trust
RTH	OUH	Oxford University Hospitals NHS Foundation Trust
RWX	BHFT	Berkshire Healthcare NHS Foudnation Trust
RXQ	BHT	Buckinghamshire Healthcare NHS Trust
RYE	SCAS	South Central Ambulance Service NHS Foundation Trust

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

BOARD MEETING

Title	M2 Financial review/Finance recovery plan		
Paper Date:	02 July 2025	**Board Meeting Date:**	8 July 2025
Purpose:	Discussion	**Agenda Item:**	09
Author:	Dilani Russell, Interim Director of Operational Finance	**Exec Lead/ Senior Responsible Officer:**	Alastair Groom, Interim ICB/S CFO

Executive Summary

Executive Summary

All organisations are largely in line with the M02 plan submitted to NHSE.

Action Required

The board are asked to note the final ICB and System position (M2)

Conflicts of Interest	Conflict noted: conflicted party can participate in discussion and decision

This report contains information including the financial performance of organisations that partner members of the Board lead/are employed by. The perspective of these members is an important aspect to enable the Board to focus on where the ICB and system contribute to improvement.

Date/Name of Committee/ Meeting, Where Last Reviewed:	System Productivity Committee 26 June 2025

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

BOB ICB Finance Report

Month 02 - 2025/26

BOB system summary position M02

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Organisation	YTD Plan	YTD Actual	YTD Variance	Annual Plan	Forecast Outturn	Forecast Variance
	£'m	£'m	£'m	£'m	£'m	£'m
Berkshire Healthcare NHS Foundation Trust	0.6	0.6	0.0	1.7	1.7	(0.0)
Buckinghamshire Healthcare NHS Trust	(3.1)	(3.1)	(0.0)	(0.8)	(0.8)	0.0
Oxford Health NHS Foundation Trust	0.7	0.7	0.0	4.8	4.8	0.0
Oxford University Hospitals NHS Foundation Trust	(6.7)	(6.7)	0.0	2.0	2.0	0.0
Royal Berkshire NHS Foundation Trust	(7.0)	(7.0)	0.0	(7.8)	(7.8)	0.0
TOTAL In-System Providers Surplus/ (Deficit)	**(15.5)**	**(15.5)**	**0.0**	**(0.1)**	**(0.2)**	**(0.0)**
Buckinghamshire, Oxfordshire And Berkshire West ICB	(8.9)	(8.9)	0.0	0.2	0.1	(0.0)
BOB ICS Surplus/ (Deficit)	**(24.4)**	**(24.4)**	**0.1**	**0.0**	**(0.0)**	**(0.0)**

BOB ICS Overview at 2:

The system is reporting on plan (£0.1m surplus) YTD at M02 and a breakeven forecast outturn.

Further work will be carried out in the next few months to review areas of concern highlighted at M02 reviewing risks and mitigations to ensure the system remains within plan.

The key tasks to align with NHSE's deficit funding requirements will be:

- De-risking the efficiency programme: including full identification of the plan by the end of Q1
- Workforce triangulation: understanding the drivers of the pay and efficiency differential and ensure that the workforce model is affordable.
- Review of cash requirements: Develop system cash management plan by the end of June 2025 to address any cash shortfalls at a local level wherever possible. Leading to Board visibility of cash position.
- Contract agreement: Providers and commissioners need to work together to agree contract envelopes and indicative activity plans in line with the expectations of the new NHS Payment Scheme.
- Underlying position: Update and refine assessments of underlying positions, ensuring Board visibility, focusing on recurrent measures that will strengthen financial positions into 2026/27 and beyond.

ICB Finances

ICB Overall position M02

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

BOB ICB OVERALL by Service Line M02	YTD Budget	YTD Actual	YTD Variance	Annual Budget	Forecast Outturn	Forecast Variance
	£'m	£'m	£'m	£'m	£'m	£'m
Acute	339.7	339.7	0.0	1,997.7	1,997.7	0.0
Community Health Services	68.8	68.8	0.0	418.1	418.2	(0.0)
Continuing Care	37.4	37.2	0.2	224.4	224.4	0.0
Mental Health	68.0	68.0	0.0	407.7	407.7	0.0
Other Programme	2.9	3.2	(0.3)	24.4	25.2	(0.8)
Primary Care	7.7	7.6	0.1	47.9	47.0	0.9
Prescribing, Central Drugs and Oxygen	49.7	49.8	(0.0)	289.1	289.2	(0.1)
Delegated Specialised Commissioning	77.5	77.5	(0.0)	473.6	473.6	(0.0)
Pharmacy, Optometry and Dentistry (POD)	23.5	23.5	(0.0)	144.2	144.2	0.0
Delegated Co-Commissioning	64.4	64.4	0.0	386.7	386.7	0.0
Total Programme Commissioned Costs	**739.6**	**739.6**	**0.0**	**4,413.9**	**4,413.9**	**(0.0)**
Admin Costs	4.4	4.4	0.0	27.4	27.4	0.0
Total before ICB Surplus/(Deficit)	**744.0**	**744.0**	**0.0**	**4,441.3**	**4,441.3**	**(0.0)**
ICB Surplus / (Deficit)	(8.9)	0.0	(8.9)	0.2	0.0	0.2
Total after Surplus/ (Deficit)	**735.2**	**744.0**	**(8.9)**	**4,441.4**	**4,441.3**	**0.1**

At M02, the ICB is slightly underspent by £20k. At this early stage in the financial year the overall reported position at Month 2 is breakeven for YTD and FOT.

Budgets were uploaded into the ledger at Month 2 to meet the national deadline and work is ongoing with Finance Business Partners to ensure all programme pay budgets are correctly reflected and reported on, as per the current structure.

CIPs are expected to be on target at the year end and are being reported as being fully met at Month 2 though the Efficiency programme is behind plan at present as several schemes are yet to commence or be fully identified.

In Adult MH an apparent £5m increase in forecast across the three Places was mitigated, pending verification.

Within other programme, a 2-year old £0.5m mental health invoice from Oxfordshire Council has been covered by unutilised accruals elsewhere.

ICB Acute M02

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Acute M2 25/26	YTD Budget	YTD Actual	YTD Variance	Annual Budget	Forecast Outturn	Forecast Variance
	£'m	£'m	£'m	£'m	£'m	£'m
NHS providers	295.9	296.6	(0.7)	1,745.5	1,745.5	0.0
Independent Sector Providers with Contract	10.9	10.4	0.5	547.8	547.8	0.0
Discharge to assess cost	0.3	0.3	(0.0)	1.8	1.8	0.0
Equipment- Diabetic Pump	3.9	3.9	0.0	23.6	23.6	0.0
Urgent Care	0.8	0.8	(0.1)	4.5	4.5	0.0
London Providers	6.0	5.8	0.2	36.2	36.2	0.0
Voluntary Sector Grants	0.0	0.0	0.0	0.3	0.3	0.0
Winter Resilience costs	0.0	0.0	0.0	0.2	0.2	0.0
Acute LVA	2.0	2.0	0.0	12.0	12.0	0.0
Acute NCA	1.4	1.3	0.2	8.7	8.7	0.0
Ambulance Services	15.4	15.4	0.0	92.3	92.3	0.0
Patient Transport	3.0	3.1	(0.1)	17.8	17.8	0.0
Grand Total	**339.7**	**339.7**	**0.0**	**2,490.7**	**2,490.7**	**0.0**

Key reasons for variance	Acute M2 £m
Key Pressures:	
Drugs *	0.5
Devices**	(0.2)
Unbundled Radiology***	(0.3)
Other Trust / IS variances	0.0
CIP unallocated	0.0
Diabetic Pumps	0.0
Total Pressures	**0.0**

In Month 2, the ICB received one month's worth of provider activity data; however, we did not receive data for all providers. For those providers who did not submit data, contract plan values were used to populate the position.

NHS Provider variances: The YTD variance overspend of £700k under Acute NHS providers is primarily due to the Acute CIP target of £683k, which is currently held against NHS Acute providers. However, the delivery of these CIPs is being reflected within Independent Sector Providers, resulting in an apparent underspend in the Independent Sector and a corresponding overspend in NHS providers. Frimley Health NHS FT is currently overperforming by £177k against plan, driven by increased elective activity. This is being offset by underperformance against elective plans at Great Western Hospitals NHS Foundation Trust, resulting in a net neutral impact across the wider acute area.

Independent Providers: Within the Independent Sector, Circle is reporting a £341k adverse variance, primarily driven by a higher-than-anticipated Month 1 flex activity return. This has been mitigated by a favourable variance at Spamedica, where elective activity levels continue to track below plan, reflecting the downward trajectory observed across 2024/25.

Any overperformance identified to date is expected to rebalance within the overall contract envelopes and in line with the IAPs (Indicative Activity Plans) agreed for 2025/26. The ICB will continue to engage with providers through established contract management processes to ensure activity levels are managed within planned trajectories and financial parameters.

ICB Acute M02 – key provider information

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

The tables below highlights the performance of the three in-system (and out of system) Acute Trusts in BOB ICS for the key variable elements of the contract:

Analysis of Other Elective variance M2	High Cost Drugs	High Cost Devices	Unbundled Radiology / Nuclear Medicine	Total
	£m	£m	£m	£m
Buckinghamshire Healthcare NHST	0	0	0	0
Oxford University Hospitals NHSFT	0	0	0	0
Royal Berkshire NHSFT	0	0	0	0
In System NHS Acute Providers Other Elective Variance	**0**	**0**	**0**	**0**
Out of System NHS Acute Providers Other Elective Variance	0.5	(0.2)	(0.3)	0.0
All NHS Acute Providers Other Elective Variance	**0.5**	**(0.2)**	**(0.3)**	**0.0**

Other Elective (Includes HCDD): YTD underspend on High Cost Drugs relating to out of system NHS providers, with small overspends across High Cost Drugs and Devices amounting to (£0.2)m and (£0.3)m respectively.

In-System NHS Providers: At month 2 In system providers were on plan.

Out-of-System NHS Providers: Out-of-system providers are the drivers of the Other Variable Variances against plan.

ICB Community M02

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Community Health Services M2 25/26	YTD Budget	YTD Actual	YTD Variance	Annual Budget	Forecast Outturn	Forecast Variance
	£'m	£'m	£'m	£'m	£'m	£'m
NHS provider	45.5	45.5	(0.0)	272.9	272.9	0.0
BCF S75	12.7	12.7	0.0	80.0	80.2	(0.1)
Palliative care	1.0	1.0	(0.0)	6.0	6.0	0.0
Intermediate care	1.5	1.5	0.0	9.2	9.2	0.0
Child & Young Persons, TOP	1.0	1.0	(0.1)	5.8	5.9	(0.1)
Endoscopy, Ultrasound, Audiology, Physio	2.5	2.5	0.1	15.2	15.1	0.1
Non CHC NCA-Interim Health Fund	0.4	0.4	0.0	2.4	2.4	0.0
Comm-Health Inequalities	0.8	0.8	0.0	4.9	4.7	0.1
Comm-Long Term Conditions (LTC)	0.7	0.7	0.0	4.2	4.2	0.0
Community Equipment	2.6	2.6	0.0	17.5	17.5	0.0
Total	**68.8**	**68.8**	**0.0**	**418.1**	**418.2**	**(0.0)**
Prior Month						

At M02, the overall reported position is breakeven for YTD and FOT. Budgets were uploaded to the ledger and work is ongoing with service leads to accurate recoding of the budgets and hence accrual spend.

NHS Providers: Contracts have recently been agreed with Oxford Health, Berkshire Healthcare and Central & North West London. Payments on-account have been paid to the Trusts based on last year's contract values. Work is underway to ensure budgets and payments are aligned to the agreed contract values going forward.

BCF S75: NHS England has approved all 2025-26 BCF funding applications. Work is underway to identify BCF specific budgets and ensure these are correctly coded in the ledger. £0.8m of the full year £1.4m CIP has been achieved at Month 2.

Non-CHC NCA-Interim Health Fund: Work carried out by the CHC team to review all packages of care has resulted in a reduction in FOT in Broadcare, £1.1m FOT underspend at Month 2. At this early stage in the financial year a breakeven position is being reported.

Long Term Conditions (LTC): Further LTC SDF funding is expected next month.

Equipment: £0.4m of the full year £1.0m CIP has been achieved at Month 2.

ICB Mental Health & Learning Disability/Autism M02

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

By Place: NHS	YTD Budget £m	YTD Actual £m	YTD Variance £m	Annual Budget £m	Forecast £m	Variance £m
Buckinghamshire	10.7	10.7	0.0	64.1	64.1	0.0
Oxfordshire	22.5	22.5	0.0	135.3	135.3	0.0
Berkshire West	16.0	16.0	0.0	96.2	96.1	0.0
Corporate	1.4	1.4	0.0	8.5	8.5	0.0
LVAs	0.3	0.3	0.0	1.9	1.9	0.0
SDF	4.4	4.4	0.0	26.6	26.6	0.0
Total	55.3	55.3	0.0	332.6	332.5	0.0
By Place: Non NHS	**YTD Budget £m**	**YTD Actual £m**	**Variance £m**	**FOT Budget £m**	**FOT Actual £m**	**Variance £m**
Buckinghamshire	4.6	4.1	0.5	27.6	19.5	8.1
Oxfordshire	2.1	2.4	(0.3)	12.7	15.3	(2.6)
Berkshire West	4.8	5.1	(0.3)	29.1	34.3	(5.3)
Corporate	0.5	0.5	(0.1)	2.3	2.6	(0.3)
SDF	0.6	0.6	0.0	3.4	3.4	0.0
Total	12.6	12.7	(0.2)	75.1	75.1	(0.1)
Total	**68.0**	**68.0**	**0.0**	**407.7**	**407.7**	**0.0**
Prior Month	*368.9*	*388.7*	*(19.8)*	*368.9*	*386.1*	*(17.2)*

By Service	YTD Budget £m	YTD Actual £m	YTD Variance £m	Annual Budget £m	Forecast £m	Variance £m
LVAs & NCAs (NHS/Non-NHS)	0.4	0.4	0.1	2.6	2.3	0.3
CAMHS	5.5	5.5	0.0	33.2	33.1	0.1
Community placements	21.7	20.9	0.8	130.0	125.5	4.5
Supported housing	0.3	(0.2)	0.4	1.7	(0.8)	2.5
S117, individual MH/LDA	22.3	23.2	(0.9)	132.7	137.6	(4.7)
Dementia	0.5	0.5	0.0	2.8	3.1	(0.3)
ADHD Right to Choose	0.8	1.1	(0.2)	5.0	8.0	(3.0)
SDF	27.5	27.5	0.0	33.0	33.0	0.0
Other/NHS block	(11.0)	(10.9)	(0.2)	66.7	65.9	0.6
Total	**68.0**	**68.0**	**0.0**	**407.7**	**407.7**	**0.0**
Prior Month	*368.9*	*388.7*	*(19.8)*	*368.9*	*386.1*	*(17.2)*

At M02, YTD and forecast positions were in line with plan. To note:

- **NHS** MH providers (mainly OH and BHFT) were allocated £19m of additional money this year, for block contracts. Also, £29m of Service Development Funding was reclassified as core contract, per NHSE guidance.
- **Non NHS** budgets increased by £23m over last year, reflecting areas in which there is growing continuing activity.
- **ADHD Right to Choose,** for which costs grew over the last four months of 24/25. Based on trend since April 2024, an out-turn of £8m was projected.
- **Adult MH** an apparent £5m increase in forecast across the three Places was mitigated, pending verification.
- **Savings targets** achievement of £2.5m was reflected in forecast. Workstreams have commenced. The ICB is working with the MHPC to deliver a stretch target of £5m savings within the system £24m stretch.

ICB Prescribing M02

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

GP Prescribing M02 25/26	YTD Budget	YTD Actual	YTD Variance	Annual Budget	Forecast Outturn	Forecast Variance
	£'m	£'m	£'m	£'m	£'m	£'m
GP Prescribing	47.8	47.8	0.0	286.9	286.9	0.0
CIP	(1.2)	(1.2)	0.0	(16.4)	(16.4)	0.0
Drugs Met Centrally	1.5	1.5	0.0	8.9	9.0	(0.1)
Oxygen	0.3	0.3	0.0	1.7	1.7	0.0
GP Incentive Schemes	0.3	0.3	0.0	1.8	1.9	(0.1)
Dressing Products	0.9	0.9	0.0	5.6	5.5	0.1
Prescribing Decision software	0.1	0.1	0.0	0.6	0.6	0.0
			0.0			0.0
Total	**49.7**	**49.7**	**0.0**	**289.1**	**289.2**	**(0.1)**
Prior Month						

As of M02, there is no April/ May 2025 data available due to the two months' data delay. Based on the run rate and known trends, the M02 position is recorded as a breakeven position.

The forecast outturn reflects 24/25 actuals plus adjusted 4.3% growth over the past six month and NICE TA pressures, which will affect this financial year, have been factored in (largely relating to diabetes Type 2 drugs Dapaglifozin and Empaglifozin). Drugs Met Centrally has seen a 4% growth since 23/24. GP Incentive Schemes forecast is based on 24/25 data with 95% payout assumptions built in. Dressing Products is showing the downward trend from 23/24.

It must be noted that the achievement of the full £16.4m CIP is currently at risk, especially the £9m relating to the stretch target. This is because additional investment is likely to be required to realise this target. ICB management are discussing how to progress this.

ICB Primary Care & Pharmacy,Optometry,Dental (POD) M02

Primary Care M02 25/26	YTD Budget	YTD Actual	YTD Variance	Annual Budget	Forecast Outturn	Forecast Variance
	£'m	£'m	£'m	£'m	£'m	£'m
GP LCS	1.7	1.7	0.0	11.9	11.9	0.0
PC Investment	0.8	0.8	0.0	4.7	4.7	0.0
GPIT/Digital	1.5	1.5	0.0	9.1	9.1	0.0
PC Transformation	0.7	0.7	0.0	3.9	3.9	0.0
Primary Care Programme Admin	0.2	0.2	0.0	1.5	1.4	0.1
Medicines Management	0.5	0.4	0.1	2.8	3.0	(0.2)
Out of Hours	2.3	2.3	0.0	13.8	13.8	0.0
GP Delegated	64.4	64.4	0.0	386.7	386.7	0.0
POD Delegated	23.5	23.5	0.0	144.2	144.2	0.0
Total	**95.6**	**95.5**	**0.1**	**578.6**	**578.7**	**(0.1)**
Prior Month						

The month 2 position for Primary Care shows a total £0.1m underspend across all budgets.

The majority of the individual budgets are reporting a breakeven position at this time as no adverse or favourable issues have arisen to report a different position.

Prior year accruals from 24/25 are being monitored, with actual spend being recorded against them to determine whether any benefits can be realised in the 25/26 year. The majority of these accruals brought forward are part of the GP Delegated and POD Delegated budgets, the total of these being £23m.

The POD Delegated budget for 25/26 held a total reserve/contingency amount of £11.4m, of which £9.2m related to dental services and £2.2m related to general expenses. The ICB has now reallocated £8.2m to primary dental services (via various schemes), £0.5m to pharmacy services and £0.7m to ophthalmic services. This currently leaves a reserve/contingency amount of £2m to be utilised as appropriate.

ICB Continuing Health Care (CHC) M02

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Continuing Healthcare FOT M2 25/26	Annual Budget £'m	Forecast Outturn £'m	Forecast Variance £'m
Bucks	77.5	74.2	3.3
Oxon	105.5	99.8	5.7
Berkshire West	45.0	44.8	0.2
Uplift, not allocated	1.1	1.1	0.0
Anticipated CIP delivery (not on Broadcare)	(9.0)	(5.1)	(3.9)
Stretch target CIP	(5.4)	0.0	(5.4)
CHAS	9.3	9.3	0.0
Provision impact	0.4	0.4	0.0
Total	**224.4**	**224.4**	**0.0**

CHAS M2 25/26	Annual Budget £'m	Forecast Outturn £'m	Forecast Variance £'m
Depreciation	0.0	0.0	(0.0)
Interest on lease liabilities	0.0	0.0	0.0
Establishment, licences	0.2	0.2	0.0
Legal fees	0.1	0.1	0.0
Salaries and wages	7.6	5.8	1.7
Agency	0.0	1.7	(1.7)
Other professional	0.7	0.7	0.0
Supplies & services	0.7	0.7	0.0
Education & training	0.0	0.0	0.0
Total	**9.3**	**9.3**	**0.0**

CHC Budget and spend is split into 2 main areas. Packages of Care (PoC), driven by the Broadcare database and Continuing Healthcare Assessment & Support (CHAS), of which 85% of the budget is allocated to pay (substantive and agency).

Packages of care

The forecast outturn position at this early part of the year is breakeven. Within the Broadcare figures all three places are showing FOT underspends; Bucks of £3.3m, Oxon of £5.7m and Berks W of £0.2m. These figures include CIP achieved of £3.8m to the end of the year with the remainder of the original CIP of £5.1m forecast to be achieved by year end. Provider increases of 3% have been included on Broadcare where applicable.

The CIP 'stretch target' of £5.4m is not forecast to be met and there are as yet no plans against it.

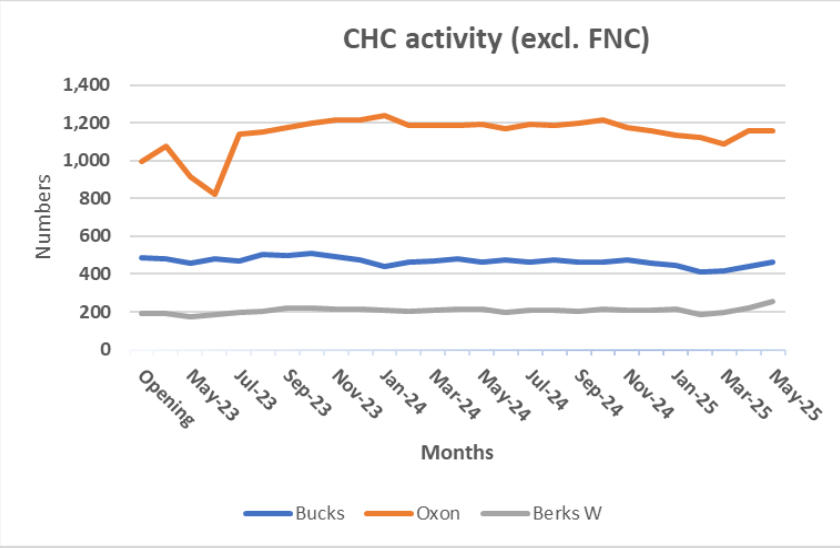
Overall net cases increased by 71 since M01.

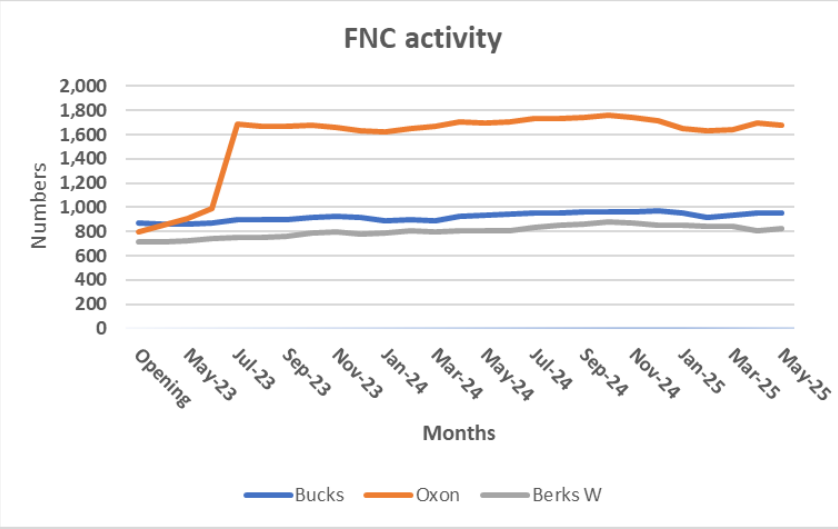
Continuing Healthcare Assessment and Support (CHAS)

This relates to the non-packages of care spend and is reporting a forecast outturn breakeven position at M02. Points to note include;

- Depreciation is for the capitalised lease costs of Saffron House as per IFRS16. At M02 the lease was extended until 30.9.25 but from M03 it will be assumed to run until 31.3.26.
- Pay costs are showing an underspend, now recruiting to the new structure where appropriate and approved.
- Agency costs are set to decrease over the year as substantive posts are filled. Work is ongoing to move agency staff onto new contracts with NHSP at lower rates.
- Overall pay is forecasting breakeven but more work will be done at M03 to improve the accuracy of forecasts.
- Other professional is for DOLS (Deprivation of Liberty Safeguards) costs.
- Supplies and services includes the costs for the CHF and PHB SLA in Oxon and the brokerage team in Bucks. It also includes the costs of the Arden Gem contract.

ICB CHC Activity M02





Movt M01 to M02 activity	Bucks		Oxon		BW		Total	
B/fwd cases, analysis below:		1,391		2,857		1,025		5,273
B/fwd cases still ongoing								
PoC unchanged	1,024		1,750		832		3,606	
PoC increases	287		926		134		1,347	
PoC decreases	14		21		12		47	
B/fwd cases now ended								
Cases ended RIP	58		102		34		194	
Cases ended other	8		58		13		79	
Cases ended RIP & other		(66)		(160)		(47)		(273)
New cases		89		131		76		296
Restarts		9		9		30		48
Total current month ongoing		**1,423**		**2,837**		**1,084**		**5,344**

Per the table above, overall activity from M01 to M02 is showing 344 new and restarted cases with 273 cases ended, made up of RIPs with some invalid cases. The net movement between M01 and M02 is an increase of 71 cases. The table also shows 1,347 on going packages having increases to their costs whilst 47 had a decrease. Increases are primarily due to provider uplifts which had been input to Broadcare in May.

The graphics on the left show CHC activity (excluding FNC) and FNC activity only, from March 2023 to date for the 3 places. There have been fluctuations in the Oxon data as a result of the introduction of the Broadcare database and work to ensure data was correct.

Costs & popn M02	Bucks	Oxon	BW	Uplift/CIP	Care costs	CHAS	Total
FOT costs per Broadcare £	74,154,085	99,800,911	44,794,583	-3,655,609	215,093,970	9,323,569	224,417,539
Popn	590,858	818,924	585,283		1,995,065		1,995,065
Cost per head £	126	122	77		108		112
Cost per 50k/popn £	6,275,119	6,093,417	3,826,746		5,390,651		5,624,316

ICB Staff WTEs M02

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

ICB Staff WTEs M02	2025/26 Pay Budget			2025/26 Permanent staff in post M02			2024/25 WTE Variances post M02		
Directorate	**Running costs**	**Programme**	**Total**	**Running costs**	**Programme**	**Total**	**Running costs**	**Programme**	**Total**
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Corporate/Senior Leadership Team	9	0	9	9	0	9	(0)	0	(0)
Medical	14	88	102	11	65	77	(3)	(22)	(25)
Delivery Performance & Oversight	35	56	91	26	42	68	(9)	(14)	(24)
Nursing	24	191	215	21	105	126	(3)	(86)	(89)
Finance & Contracting	77	0	77	55	0	56	(22)	0	(21)
People	13	0	13	5	0	5	(8)	0	(8)
Strategy Digital & Transformation	51	35	86	37	27	63	(14)	(9)	(23)
Totals	**224**	**370**	**593**	**165**	**239**	**403**	**(59)**	**(131)**	**(190)**
Prior Month									

Per the table above, overall actual Staff in Posts at M02 is showing 190 WTE less than plan across both running cost and programme budgets. This is mainly due to vacancies across Nursing, Medical, Delivery and Finance directorates. The table is now based on the new agreed structure.

The work to ensure that all staff are correctly assigned across directorates and the relevant income streams are assigned are in the main complete.

ICB Staff Costs M02

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

ICB Staff YTD M02	2025/26 Pay Budget			2025/26 Permanent staff in post M02			2025/26 Variances in post M02			Off Payroll Workers inc. Agency		
Directorate	Running costs	Programme	Total	Running costs	Programme	Total	Running costs	Programme	Total	Running costs	Programme	Total
	£m's	£m's	£m's	£m's	£m's	£m's	£m's	£m's	£m's	£m's	£m's	£m's
Corporate/Senior Leadership Team	0.3	0.0	0.3	0.3	0.0	0.3	(0.0)	0.0	(0.0)	0.0	0.0	0.0
Medical	0.3	0.8	1.1	0.2	0.8	1.0	(0.0)	(0.1)	(0.1)	0.0	0.3	0.3
Delivery Performance & Oversight	0.5	0.3	0.8	0.4	0.6	1.0	(0.1)	0.3	0.2	0.0	0.1	0.1
Nursing	0.3	1.7	2.0	0.3	1.1	1.4	(0.0)	(0.6)	(0.6)	0.0	0.3	0.3
Finance & Contracting	0.9	0.0	0.9	0.7	0.0	0.7	(0.3)	0.0	(0.3)	0.1	0.0	0.1
People	0.2		0.2	0.1		0.1	(0.1)	0.0	(0.1)	0.0	0.0	0.0
Strategy Digital & Transformation	0.7	0.5	1.2	0.5	0.4	0.9	(0.2)	(0.1)	(0.3)	0.0	0.0	0.0
						0.0						
Totals	**3.2**	**3.3**	**6.6**	**2.5**	**2.9**	**5.4**	**(0.7)**	**(0.5)**	**(1.2)**	**0.2**	**0.7**	**0.8**

The underspend is indicative of the on-going vacancies as a result of the recruitment freeze, the £1.2m variance does not include any costs of filling vacancies with agency staff or secondments and any off-payroll workers . These costs have been shown at the side of the table.

Some programme areas on the ledger need adjusting to reflect actual staff activity, so forecasts are not yes accurate. One such area is CHC where there are a large number of vacancies some of which are being filled by agency staff, but the FOT has been put into the ledger as breakeven.

ICB Running Costs M02 YTD Actuals

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Running Costs Non Pay Subjective Grouping	25/26 YTD M02 Actual Spend £m
ADMINISTRATION & BUSINESS SUPPORT	0.3
CHAIR AND NON EXECS	0.0
PRIMARY CARE SUPPORT	0.0
COMMUNICATIONS & PR	0.1
CONTRACT MANAGEMENT	0.2
CORPORATE COSTS & SERVICES	0.1
CORPORATE GOVERNANCE	0.2
ESTATES AND FACILITIES	0.2
FINANCE	1.6
GENERAL RESERVE - ADMIN	0.0
HUMAN RESOURCES	0.2
MEDICAL DIRECTORATE	0.2
NURSING DIRECTORATE	0.1
OPERATIONS MANAGEMENT	0.4
QUALITY ASSURANCE	0.2
STRATEGY & DEVELOPMENT	0.2
EXECUTIVE MANAGEMENT TEAM	0.3
Totals	**4.4**

Running Costs now exclude the Primary Care team which has been moved to Programme.

Current CSU spend within the ICB is in dispute so costs may change. Spend to date are accruals based on the 2024/25 SLA values, whilst invoices are on hold.

Running Costs Non Pay Subjective Grouping	25/26 YTD M02 Actual Spend £m
Estates and Facilities Costs	0.1
Audit Fees	0.1
Other Non-Pay Staff Related Costs (incl. Clinical Leads)	0.1
Computers and Telecoms	0.0
CSU	1.2
Consultancy, Professional and Legal Fees	0.1
Recruitment fees	0.0
Apprentice Levy	0.0
Other	0.3
Totals	**1.8**

ICB Running Costs Estates M02 YTD Actuals

Only depreciation value of most leases is included within below due to many being capitalised leases.

Running Costs Non Pay Subjective Grouping	25/26 YTD M02 Actual Spend £m
Bath Road	0.1
Unipart	0.0
Amersham	0.0
WBCH PALs Office	0.0
Study Centre - Aylesbury	0.0
IT Assets Depreciation	0.0
Totals	**0.2**

ICB CIP Summary at M02

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Scheme	Efficiency Area	Risk Rating	Plan to M2 £'000	Actual to M2 £'000	Variance to M2 £'000	Forecast M3 to M12 £'000	Full Year Forecast £'000
Equipment Services	Community	Low	472	472	0	528	1,000
Oxfordshire Short Stay Hub Beds	Community	Low	831	831	0	0	831
S117 Reviews in Berkshire West	Mental Health	Low	200	250	(50)	1,250	1,500
Opportunities/ Stretch savings - Health Inequalities	Community	Low	81	81	0	419	500
Opportunities/ Stretch savings - stretch Acute Bucks	Acute	Low	300	300	0	0	300
Opportunities/ Stretch savings - Elective IAPs stretch CIP	Acute	Low	1,179	1,179	0	3,821	5,000
Opportunities/ Stretch savings - Transformation	Other Programme	Low	334	334	0	1,666	2,000
Procedures of Limited Clinical Value (PLCV)	Acute	Medium	0	0	0	1,000	1,000
Use of BCF uplifts to fund suitable ICB budgets	Community	Medium	0	0	0	598	598
8 Schemes - AACC	AACC	Medium	1,166	1,103	63	7,860	8,963
9 Schemes re CSU delivery	DDAT	Medium	113	113	0	600	713
7 Schemes - Prescribing	Primary Care	Medium	450	450	0	6,950	7,400
CMDU (Covid Medicines Delivery Unit)	Acute	Medium	83	0	83	500	500
Contract Challenges	Acute	Medium	0	0	0	600	600
CSU Contract Reduction	Running Costs	Medium	249	249	0	1,251	1,500
Business Rates Review	Primary Care	Medium	520	368	152	1,012	1,380
Opportunities/ Stretch savings - AACHC stretch CIP	AACC	Medium	834	834	0	4,166	5,000
Opportunities/ Stretch savings - Estates stretch CIP	Other Programme	Medium	50	0	50	300	300
Opportunities/ Stretch savings - Corporate stretch CIP	Other Programme	Medium	166	166	0	834	1,000
Opportunities/ Stretch savings - stretch CIP	Acute	Medium	270	270	0	1,344	1,614
Biosimilar Switches (ustekinumab, adalimumab, etanercept)	Acute	High	600	0	600	5,000	5,000
Restriction on RTC	Mental Health	High	0	0	0	500	500
High Cost Devices	Acute	High	0	0	0	3,500	3,500
Prescribing Stretch	Primary Care	High	750	0	750	9,000	9,000
Opportunities/ Stretch savings - IAP Management	Acute	High	0	0	0	5,000	5,000
Opportunities/ Stretch savings - Medical stretch CIP	Primary Care	High	500	0	500	3,000	3,000
			9,148	7,000	2,148	60,699	67,699

Current Position (M02)

The year end forecast for CIP delivery has been retained on plan but there are considerable risks against that .

These include:

- Risk of delivery against the High Cost Drugs and Devices arising from contract negotiations totalling £8.5m
- Risks around the Prescribing and Primary Care stretch targets which still need robust schemes developing to support them totalling £12m
- Need to develop robust implementation monitoring for existing schemes to ensure delivery to plan.
- Need to keep identifying and developing new opportunities to mitigate any slippage in existing schemes.

Risk Rating	Plan to M2 £'000	Actual to M2 £'000	Variance to M2 £'000	Forecast M3 to M12 £'000	Full Year Forecast £'000
Low	3,397	3,447	(50)	7,684	11,131
Medium	3,901	3,553	348	27,015	30,568
High	1,850	0	1,850	26,000	26,000
Total	9,148	7,000	2,148	60,699	67,699

ICB Other Financial Statements – Balance Sheet M02

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Statement of financial position as at: 31 May 2025	As at 31 March 25 £m	As at 30 April 25 £m	Movement £m	As at 31 May 25 £m
Non current assets	1.59	1.54	-0.06	1.48
Total non current assets	**1.59**	**1.54**	**-0.06**	**1.48**
NHS receivables -revenue	1.22	1.10	-0.22	0.88
NHS prepayments and accrued income	1.66	0.00	45.58	45.58
Non-NHS receivables - revenue	2.06	1.23	-0.57	0.66
Non-NHS prepayments and accrued income	3.87	1.45	7.69	9.14
Other receivables	25.93	0.31	0.70	1.01
Total trade and other	**34.74**	**4.09**	**53.18**	**57.27**
Cash	1.00	10.26	-2.09	8.17
Total current assets	**37.33**	**15.89**	**51.03**	**66.92**
NHS payables - revenue	-11.89	-11.19	-66.42	-77.61
NHS accruals and deferred income	-29.61	-26.63	23.13	-3.50
Non-NHS payables - revenue	-33.51	-27.94	0.23	-27.71
Non-NHS payables - capital	-0.05	-0.05	0.00	-0.05
Non-NHS accruals and deferred income	-103.81	-4.28	-114.85	-119.13
Other payables	-55.17	-11.07	-22.99	-34.06
Borrowings	0.00	-1.09	1.03	-0.06
Provisions	-3.23	-2.49	0.00	-2.49
Total current liabilities	**-237.27**	**-84.74**	**-179.87**	**-264.61**
Total non current liabilities	**-0.63**	**-1.28**	**0.01**	**-1.27**
Total assets employed	**-200.57**	**-70.13**	**-128.83**	**-198.96**
General fund	**-200.57**	**-70.13**	**-128.83**	**-198.96**
Total taxpayers equity	**-200.57**	**-70.13**	**-128.83**	**-198.96**

The statement of financial position summarises the assets and liabilities of the ICB at a point in time.

- Receivables have increased by £53.18m and now stand at £57.27m.
- Cash ledger balance at 31 May stands at £8.17m.
- Current liabilities have increased by £179.87m and now stand at £264.61m.
- The net result is an increase in total taxpayers equity of £128.83m.

ICB Other Financial Statements Receivables and Cash M02

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

Receivables

Aged receivables	NHS receivables		Non NHS receivables		Total	
	Value (£m)	No	Value (£m)	No	Value (£m)	No
Less than 31 days (not due)	0.60	3	0.12	3	0.72	6
Between 31 - 60 days	0.09	2	0.00	4	0.10	6
Between 61 - 90 days	0.18	1	0.00	0	0.18	1
Greater than 90 days	0.01	1	0.53	6	0.54	7
Total	**0.88**	**7**	**0.66**	**13**	**1.54**	**20**

At the end of month, BOB ICB had 0 NHS and 6 non NHS overdue invoices over 90 days.

Non NHS over 90 days debts amounts are being proactively chased, and outstanding salary overpayment, efforts to recover amount is being progressed via legal route.
* Fedbucks Ltd - £0.11m (Recharge of prescribing costs for Urgent Treatment Centre and Out of Hours)

Cash drawings

Main cash drawdown to date	Prescribing to date	Total cash drawings to date	Current allocation	Drawings to date as a % of allocation
£m	£m	£m	£m	%
684.97	60.66	745.63	4,440.05	16.8%

- The ICB processed a cash drawdown of £339.23m in May resulting in a total annual figure of £684.97m.
- The drawings against prescribing stand at £60.66m (including £12.21m dental). The cash drawn down to date is £745.63m which represents a 16.8% utilisation against annual cash allocation limit of £4,440.05m
- At the end of the month BOB ICB had £8.17m cash at bank which represents 2.41% of cash drawn down for the month.
- A small number of large value invoices were not approved for payment within the period.
- As such BOB ICB has not achieved NHSE cash at bank target which should be no greater than 1.25% of cash drawn down for the month.

ICB Other Financial Statements – Payables M02

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

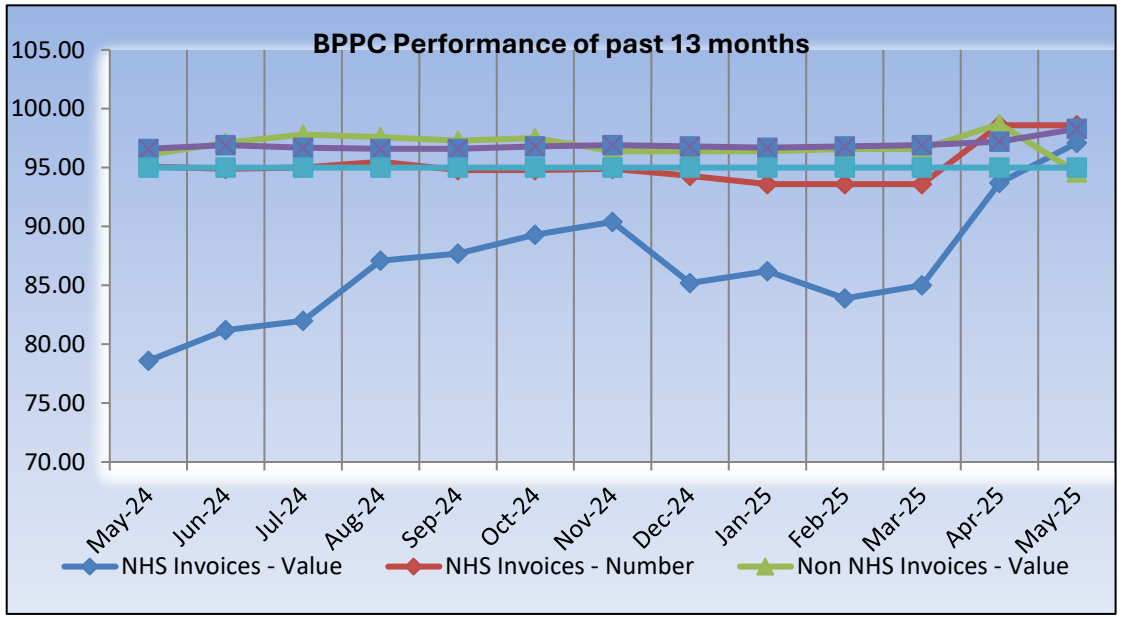
Aged payables - value	Not Due	Overdue 1-30 days	Overdue 31-60 days	Overdue 61-90 days	Overdue 90+ days	Total
	£m	£m	£m	£m	£m	£m
At 31 March	18.51	8.41	7.69	4.73	7.54	46.89
At 30 April	16.59	5.88	4.68	7.11	11.31	45.57
At 31 May	12.85	9.40	4.29	3.39	16.74	46.67
Aged payables - volume	**Nos**	**Nos**	**Nos**	**Nos**	**Nos**	**Total Nos**
At 31 March	1,355	417	209	117	1,125	3,223
At 30 April	1,407	361	226	143	1,075	3,212
At 31 May	1,414	467	304	159	913	3,257

Better payment practice code - payment within 30 days (cumulative ytd)	NHS invoices		Non NHS invoices		Total	
	Value of invoice £m	Number	Value of invoices £m	Number	Value of invoice £m	Number
Total invoices paid	7.40	208	77.82	8,160	85.22	8,368
Total invoices paid within 30 days	7.18	205	73.63	8,023	80.81	8,228
% Paid within 30 days	97.1%	98.6%	94.6%	98.3%	94.8%	98.3%
Rating	Green	Green	Amber	Green	Amber	Green

95% or more
75% to 95%
Less than 75%

The value of NHS invoices has been significantly reduced with the introduction of block payments, which are not invoiced, and therefore not included in the figures above.

The Better payment practice code requires the ICB to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The target for achievement is 95%. The ICB is achieving its target of paying NHS invoices by volume and value.



Provider Finances

Berkshire Healthcare FT provider summary

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

BHFT are reporting on plan YTD and FOT

Pay costs are under plan by £0.2m, mostly relating to substantive staff.

Efficiencies are also on plan although the split has shifted towards more non-recurrent schemes. 100% of schemes are classed as fully developed with 90% classed as low risk (7% high risk).

Income and Expenditure	M02			YTD			Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	33.0	33.2	0.2	66.0	66.7	0.7	396.1	396.1	0.0
Workforce pay cost	(25.9)	(25.8)	0.1	(51.7)	(51.5)	0.2	(312.3)	(312.3)	0.0
Non-pay cost	(6.7)	(6.9)	(0.2)	(13.4)	(14.2)	(0.8)	(80.3)	(80.2)	0.1
Non operating Items	(0.2)	(0.2)	(0.0)	(0.3)	(0.4)	(0.0)	(1.9)	(2.0)	(0.1)
Surplus/(deficit)	**0.3**	**0.3**	**0.0**	**0.6**	**0.6**	**0.0**	**1.7**	**1.7**	**(0.0)**
As % of income	**0.9%**	**0.9%**	**0.0%**	**0.9%**	**0.9%**	**0.0%**	**0.4%**	**0.4%**	**(0.0%)**

Workforce pay costs	M02			YTD			Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Substantive	(23.9)	(23.8)	0.1	(47.8)	(47.4)	0.4	(288.4)	(288.4)	0.0
Bank	(1.5)	(1.4)	0.1	(3.1)	(2.9)	0.2	(18.5)	(18.5)	0.0
Agency	(0.4)	(0.5)	(0.1)	(0.7)	(1.0)	(0.3)	(4.2)	(4.2)	0.0
All other Pay	(0.1)	(0.1)	0.0	(0.2)	(0.2)	0.0	(1.2)	(1.2)	0.0
Total workforce pay cost	**(25.9)**	**(25.8)**	**0.1**	**(51.7)**	**(51.5)**	**0.2**	**(312.3)**	**(312.3)**	**0.0**

Efficiencies	M02			YTD			Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Pay	0.7	0.4	(0.3)	1.3	0.7	(0.6)	8.0	5.0	(3.0)
Non-Pay	0.1	0.1	(0.1)	0.3	0.1	(0.2)	1.7	1.2	(0.5)
Income	0.2	0.2	0.0	0.3	0.3	0.0	1.9	1.9	0.0
Total Recurrent	**1.0**	**0.6**	**(0.4)**	**1.9**	**1.1**	**(0.8)**	**11.6**	**8.1**	**(3.5)**
Pay	0.2	0.2	(0.0)	0.5	0.5	0.0	2.8	3.4	0.6
Non-Pay	0.3	0.7	0.4	0.5	1.3	0.8	3.1	6.0	2.9
Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Non-Recurrent	**0.5**	**0.9**	**0.4**	**1.0**	**1.8**	**0.8**	**5.9**	**9.4**	**3.5**
Total Efficiencies	**1.5**	**1.5**	**(0.0)**	**2.9**	**2.9**	**0.0**	**17.5**	**17.5**	**(0.0)**

Workforce WTE	M02		
	Plan	Actual	Variance
Substantive WTE	4,972	4,868	(103)
Bank WTE	313	311	(2)
Agency WTE	37	41	5
Total workforce WTE	**5,321**	**5,221**	**(100)**

Bucks Healthcare provider summary

Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

BHT are reporting a £15k deficit to plan YTD and on plan FOT

The main driver of the YTD deficit is due to pay costs £0.8m over plan (mostly substantive) not quite being offset by underspends in non-pay.

Efficiencies are £0.7m behind plan YTD, mostly due to underachievement of pay efficiencies in line with the overall pay position. £1.1m (3%) of £37.9m FY plan remains unidentified and £7.2m (19%) high risk. High risk schemes include corporate services transformation (£0.5m), clinical service redesign / job planning (£1.6m), non patient care income (£1.8m) and non-pay procurement (£0.9m).

Income and Expenditure	M02			YTD			Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	56.9	56.6	(0.3)	113.8	113.5	(0.3)	687.2	687.2	0.0
Workforce pay cost	(35.1)	(35.3)	(0.2)	(70.3)	(71.1)	(0.8)	(411.5)	(411.5)	0.0
Non-pay cost	(22.0)	(21.5)	0.4	(43.9)	(43.1)	0.8	(260.0)	(260.0)	0.0
Non operating Items	(1.4)	(1.2)	0.1	(2.8)	(2.5)	0.3	(16.5)	(16.5)	0.0
Surplus/(deficit)	**(1.5)**	**(1.5)**	**0.1**	**(3.1)**	**(3.1)**	**(0.0)**	**(0.8)**	**(0.8)**	**0.0**
As % of income	**(2.7%)**	**(2.6%)**	**0.1%**	**(2.7%)**	**(2.7%)**	**(0.0%)**	**(0.1%)**	**(0.1%)**	**0.0%**

Workforce pay costs	M02			YTD			Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Substantive	(32.3)	(32.7)	(0.4)	(64.5)	(65.7)	(1.2)	(378.1)	(378.1)	0.0
Bank	(2.5)	(2.3)	0.2	(5.0)	(4.6)	0.3	(29.1)	(29.1)	0.0
Agency	(0.4)	(0.3)	0.0	(0.7)	(0.7)	0.0	(4.4)	(4.4)	0.0
All other Pay	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total workforce pay cost	**(35.1)**	**(35.3)**	**(0.2)**	**(70.3)**	**(71.1)**	**(0.8)**	**(411.5)**	**(411.5)**	**0.0**

Efficiencies	M02			YTD			Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Pay	0.6	0.6	(0.0)	1.2	1.0	(0.2)	11.3	11.9	0.6
Non-Pay	0.5	0.4	(0.1)	1.0	1.0	0.0	9.1	13.0	4.0
Income	0.0	0.1	0.0	0.1	0.1	(0.0)	0.9	2.2	1.3
Total Recurrent	**1.1**	**1.0**	**(0.1)**	**2.3**	**2.0**	**(0.2)**	**21.3**	**27.1**	**5.9**
Pay	0.6	0.4	(0.3)	1.3	0.6	(0.6)	11.9	6.6	(5.3)
Non-Pay	0.3	0.1	(0.1)	0.5	0.6	0.1	4.8	2.9	(1.9)
Income	0.0	0.0	0.0	0.0	0.1	0.1	0.0	1.3	1.3
Total Non-Recurrent	**0.9**	**0.5**	**(0.4)**	**1.8**	**1.3**	**(0.5)**	**16.7**	**10.8**	**(5.9)**
Total Efficiencies	**2.0**	**1.5**	**(0.5)**	**4.0**	**3.3**	**(0.7)**	**37.9**	**37.9**	**0.0**

Workforce WTE	M02		
	Plan	Actual	Variance
Substantive WTE	6,410	6,405	(5)
Bank WTE	416	381	(35)
Agency WTE	50	51	1
Total workforce WTE	**6,876**	**6,836**	**(40)**

Oxford Health FT provider summary

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

OHFT are reporting a £26k surplus to plan YTD and on plan FOT

Pay costs are £1.1m over plan YTD offset by income and non-pay favourable to plan

Efficiencies are on plan YTD. 86% of schemes are classed as fully developed with 14% where plans are in progress. £2.4m is classed as high risk (7%) and £26.1m (72%) medium risk at M02.

Income and Expenditure	M02			YTD			Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	58.9	59.2	0.4	117.8	118.5	0.7	706.7	706.7	0.0
Workforce pay cost	(34.8)	(35.8)	(1.0)	(69.6)	(70.7)	(1.1)	(416.1)	(416.1)	0.0
Non-pay cost	(23.9)	(23.4)	0.5	(47.8)	(47.5)	0.3	(286.7)	(286.7)	0.0
Non operating Items	0.0	0.2	0.2	0.4	0.4	0.1	0.8	0.8	0.0
Surplus/(deficit)	**0.2**	**0.2**	**0.0**	**0.7**	**0.7**	**0.0**	**4.8**	**4.8**	**0.0**
As % of income	**0.3%**	**0.4%**	**0.0%**	**0.6%**	**0.6%**	**0.0%**	**0.7%**	**0.7%**	**0.0%**

Workforce pay costs	M02			YTD			Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Substantive	(30.2)	(31.5)	(1.3)	(60.5)	(62.0)	(1.5)	(362.2)	(362.2)	0.0
Bank	(3.2)	(2.8)	0.4	(6.3)	(5.6)	0.8	(38.5)	(35.5)	3.0
Agency	(1.6)	(1.5)	0.1	(3.1)	(2.9)	0.2	(17.6)	(17.6)	0.0
All other Pay	0.2	(0.1)	(0.3)	0.4	(0.2)	(0.6)	2.3	(0.7)	(3.0)
Total workforce pay cost	**(34.8)**	**(35.8)**	**(1.0)**	**(69.6)**	**(70.7)**	**(1.1)**	**(416.1)**	**(416.1)**	**0.0**

Efficiencies	M02			YTD			Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Pay	0.4	0.5	0.1	0.8	1.0	0.1	9.0	9.5	0.4
Non-Pay	0.3	0.3	0.0	0.7	0.7	0.0	4.8	4.4	(0.4)
Income	0.0	0.0	0.0	0.1	0.1	0.0	0.4	0.4	0.0
Total Recurrent	**0.8**	**0.8**	**0.1**	**1.5**	**1.7**	**0.1**	**14.2**	**14.2**	**0.0**
Pay	1.6	1.6	(0.1)	3.2	3.1	(0.1)	18.3	20.0	1.7
Non-Pay	0.0	0.0	(0.0)	0.0	0.0	(0.0)	3.5	1.8	(1.7)
Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total Non-Recurrent	**1.6**	**1.6**	**(0.1)**	**3.3**	**3.1**	**(0.1)**	**21.8**	**21.8**	**(0.0)**
Total Efficiencies	**2.4**	**2.4**	**0.0**	**4.8**	**4.8**	**0.0**	**36.0**	**36.0**	**(0.0)**

Workforce WTE	M02		
	Plan	Actual	Variance
Substantive WTE	6,666	6,644	(22)
Bank WTE	653	610	(43)
Agency WTE	190	167	(23)
Total workforce WTE	**7,509**	**7,421**	**(88)**

Oxford University Hospitals FT provider summary

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

OUH are reporting a £18k surplus to plan YTD and on plan FOT

Pay costs are £0.5m over plan YTD (mostly due to substantive staff).

Efficiencies are £5.4m behind plan YTD. This is both in recurrent and non-recurrent schemes and across pay, non-pay and income CIP schemes. £7.3m (7%) of the FY £99m plan remains unidentified and £62.7m (63%) classed as an 'opportunity'. 47% of schemes are classed as high risk and 43% medium risk.

Income and Expenditure	M02			YTD			Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	143.2	145.5	2.3	286.4	287.0	0.6	1,723.0	1,724.1	1.2
Workforce pay cost	(83.9)	(84.5)	(0.6)	(168.4)	(168.8)	(0.5)	(980.8)	(980.8)	0.0
Non-pay cost	(58.7)	(60.5)	(1.8)	(117.0)	(117.3)	(0.3)	(691.6)	(692.7)	(1.2)
Non operating Items	(3.9)	(3.8)	0.1	(7.7)	(7.5)	0.2	(48.6)	(48.6)	0.0
Surplus/(deficit)	**(3.2)**	**(3.2)**	**0.0**	**(6.7)**	**(6.7)**	**0.0**	**2.0**	**2.0**	**0.0**
As % of income	**(2.3%)**	**(2.2%)**	**0.0%**	**(2.3%)**	**(2.3%)**	**0.0%**	**0.1%**	**0.1%**	**0.0%**

Workforce pay costs	M02			YTD			Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Substantive	(79.5)	(80.5)	(1.0)	(159.4)	(160.3)	(0.9)	(930.6)	(930.6)	0.0
Bank	(3.7)	(3.4)	0.3	(7.4)	(7.2)	0.2	(42.3)	(42.3)	0.0
Agency	(0.4)	(0.4)	0.1	(0.9)	(0.7)	0.2	(4.3)	(4.3)	0.0
All other Pay	(0.3)	(0.3)	(0.0)	(0.6)	(0.6)	(0.0)	(3.7)	(3.7)	0.0
Total workforce pay cost	**(83.9)**	**(84.5)**	**(0.6)**	**(168.4)**	**(168.8)**	**(0.5)**	**(980.8)**	**(980.8)**	**0.0**

Efficiencies	M02			YTD			Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Pay	1.0	0.2	(0.9)	1.5	0.4	(1.1)	38.5	36.4	(2.1)
Non-Pay	1.5	0.8	(0.7)	3.0	1.6	(1.4)	18.0	18.0	0.0
Income	0.3	0.2	(0.1)	0.6	0.3	(0.3)	3.7	5.8	2.1
Total Recurrent	**2.8**	**1.1**	**(1.7)**	**5.1**	**2.4**	**(2.8)**	**60.2**	**60.2**	**0.0**
Pay	0.6	0.8	0.2	1.3	1.2	(0.0)	7.5	7.5	0.0
Non-Pay	1.9	0.3	(1.5)	3.7	1.5	(2.3)	22.3	22.3	0.0
Income	0.4	0.1	(0.3)	0.7	0.4	(0.4)	9.1	9.1	0.0
Total Non-Recurrent	**2.8**	**1.2**	**(1.6)**	**5.7**	**3.0**	**(2.6)**	**38.9**	**38.9**	**0.0**
Total Efficiencies	**5.7**	**2.3**	**(3.3)**	**10.8**	**5.4**	**(5.4)**	**99.0**	**99.0**	**0.0**

Workforce WTE	M02		
	Plan	Actual	Variance
Substantive WTE	14,104	13,887	(217)
Bank WTE	664	552	(112)
Agency WTE	45	47	2
Total workforce WTE	**14,813**	**14,486**	**(326)**

Royal Berkshire FT provider summary

NHS
Buckinghamshire, Oxfordshire and Berkshire West
Integrated Care Board

RBFT are reporting a £8k surplus to plan YTD and on plan FOT

Pay costs are £0.5m over plan YTD (mostly due to substantive staff).

Efficiencies are £1.1m ahead of plan YTD, particularly in non-pay schemes. £24.9m (61%) of schemes are classed as fully developed with £13.2m (33%) classed as opportunity. 42% of schemes are classed as high risk and 48% low risk.

Income and Expenditure	M02			YTD			Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	54.8	55.2	0.4	107.7	108.1	0.4	663.1	663.1	0.0
Workforce pay cost	(34.2)	(34.4)	(0.2)	(68.1)	(68.7)	(0.5)	(404.9)	(404.9)	0.0
Non-pay cost	(22.5)	(23.0)	(0.4)	(45.0)	(44.9)	0.1	(256.6)	(256.6)	0.0
Non operating Items	(0.8)	(0.6)	0.1	(1.5)	(1.5)	0.0	(9.4)	(9.4)	(0.0)
Surplus/(deficit)	**(2.7)**	**(2.7)**	**(0.1)**	**(7.0)**	**(7.0)**	**0.0**	**(7.8)**	**(7.8)**	**0.0**
As % of income	**(4.9%)**	**(5.0%)**	**(0.1%)**	**(6.5%)**	**(6.5%)**	**0.0%**	**(1.2%)**	**(1.2%)**	**0.0%**

Workforce pay costs	M02			YTD			Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Substantive	(32.5)	(32.7)	(0.3)	(64.7)	(65.3)	(0.6)	(384.2)	(381.7)	2.5
Bank	(1.6)	(1.5)	0.0	(3.1)	(3.0)	0.1	(18.7)	(21.1)	(2.4)
Agency	(0.2)	(0.2)	0.0	(0.3)	(0.3)	(0.0)	(2.0)	(2.1)	(0.1)
All other Pay	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total workforce pay cost	**(34.2)**	**(34.4)**	**(0.2)**	**(68.1)**	**(68.7)**	**(0.5)**	**(404.9)**	**(404.9)**	**0.0**

Efficiencies	M02			YTD			Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Pay	0.5	0.6	0.2	1.0	1.3	0.3	15.5	14.9	(0.6)
Non-Pay	0.5	1.1	0.5	1.0	1.9	1.0	10.2	10.9	0.7
Income	0.0	0.0	(0.0)	0.1	0.0	(0.1)	1.2	1.1	(0.1)
Total Recurrent	**1.0**	**1.7**	**0.7**	**2.0**	**3.2**	**1.2**	**26.8**	**26.9**	**0.1**
Pay	0.2	0.1	(0.1)	0.3	0.1	(0.2)	1.6	1.5	(0.2)
Non-Pay	0.2	0.3	0.1	0.5	0.5	0.1	7.8	7.8	0.1
Income	0.1	0.3	0.2	0.3	0.3	0.0	4.4	4.4	0.0
Total Non-Recurrent	**0.6**	**0.7**	**0.1**	**1.1**	**1.0**	**(0.1)**	**13.8**	**13.7**	**(0.1)**
Total Efficiencies	**1.6**	**2.4**	**0.8**	**3.1**	**4.2**	**1.1**	**40.6**	**40.6**	**0.0**

Workforce WTE	M02		
	Plan	Actual	Variance
Substantive WTE	6,013	6,022	9
Bank WTE	315	285	(30)
Agency WTE	21	15	(6)
Total workforce WTE	**6,349**	**6,322**	**(27)**

Glossary of Terms

Term	Explanation
ALOS	Average Length of stay
API	Aligned Payment and Incentive - Payment mechanism covering almost all NHS provider activity and comprises fixed and variable elements. Almost all elective activity, and all activity which forms part of the ERF, is included in the variable element and is paid for using NHS Payment Scheme unit prices.
ARRS	Additional Roles Reimbursement Scheme for Primary care. NHS E reimburse costs of additional roles such as Pharmacists, Paramedics, MH workers retrospectively i.e. after the additional costs have been incurred.
BOB	Buckinghamshire, Oxfordshire and Berkshire West
Break even	Where actual costs are the same as planned
Capital	Property, plant or equipment held for use in delivering services that are expected to be used for more than one financial year
Category M drugs	Multiple source and widely available generic drugs
CIP	Cost Improvement Plans - schemes designed to save money without impacting on services and patient safety.
CHC	Continuing Healthcare - free social care for people with long term complex health needs that is funded solely by the NHS
Deficit	Expenditure in excess of resources
ERF	Elective Recovery Funding - to support the NHS in its endeavour to increase its elective activity, which are the non-emergency procedures that have been scheduled in advance.
Fast-Track	NHS Continuing Healthcare Fast-Track pathway for those where health is deteriorating quickly or nearing the end of life
FNC	Funded Nursing Care - for people not eligible for CHC but assessed as requiring nursing care in a care home. NHS pay a contribution towards the cost of registered nursing care.
FOT/Forecast	Forecast Outturn - forecast spend at end of the financial year
ICB	Integrated Care Board
ICS	Integrated Care System - consists of ICB and provider organisations in Buckinghamshire, Oxfordshire and Berkshire West.
Mitigations	Actions taken/to be taken to reduce impact of risks
NCA	Non-contracted activity
NCSO	"No cheaper stock obtainable" - generic drug not available at tariff price, higher cost items need to be used
Overspend/Adverse	Actual costs are more than planned
POD services	Pharmacy, Ophthalmology and Dental services delegated to ICBs from NHS E regional teams from 2022-23
Under spend/Favourable	Actual costs are less than planned
Variance	Difference between actual expenditure and plan
YTD	Year to date

NHS
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Upward Report of the Finance & Performance Committee

Date Meeting met **19th June 2025**
Chair of Meeting **Les Broude, Non-Executive Director**
Reporting to **Trust Board**

Items	Issue	Action Owner	Action
Points for escalation			
Month 2 Financial Position	Concern was expressed around the under-identification and under-delivery of the CIP programme together with issues relating to the over-establishment, TUPE transfers and the impact on the month 2 and on-going financial position	SR	An urgent extraordinary FPC with members of the PACC will be arranged with all executives present to go through recovery plans.
New Clinical Dispatch Model	The new evidence-based model, which will be clinically led and ensure that patients are treated in the most appropriate setting was presented. The model will be implemented over 3/4 months.	N/A	No action required
Key issues and / or Business matters to raise			
Cyber Security Insurance	The paper received set out the challenges/limitations of obtaining insurance	N/A	CDIO will bring an update to the September meeting when the DPST

	against a cyber-attack. The committee is recommending that the trust does not pursue the option to take this further and source quotes; it was considered appropriate that costs associated with putting robust controls into place to prevent cyber-attacks would be considered following the completion of the DPST report and if they are considered necessary.		audit results and further actions required are available. A review of this decision will be put on the agenda in 12 months' time (June 2026)
Disposal of Patient Transport Services Bases	The committee agreed a proposal to sell two PTS Ambulance bases in Amersham & Chalfont. It was noted that these were PTS bases and there were no SCAS frontline ambulance staff on these sites.	N/A	No action required
BoB/Frimley NEPTS Contract	The committee approved the contract variation that related to the 2024/25 financial year and had already been included within the audited accounts. This will be submitted to board for final approval.	N/A	Recommended that the Board approves the contract variation.
Areas of concern and / or Risks			
Financial Position	As referenced above		
Items for information and / or awareness			
None			
Best Practice and / or Excellence			
Board Assurance Framework	The new BAF risks assigned to the committee were presented. The format and articulation of the risk is much clearer and was welcomed.	Members	Committee members will provide feedback, and the final version will be approved at the July meeting.
Compliance with Terms of Reference			

Committee Annual Report	The Committee Annual Report for 2024/25 was presented which was based on the work of the committee and a survey of committee members. Minor changes to the terms of reference were also made. Both were approved.	BS	Committee Annual Report and Terms of Reference to be submitted to the July board.
Policies approved*			
None			

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

South Central Ambulance Service
NHS Foundation Trust

Trust Board of Directors Meeting in Public
31 July 2025

Report title	Refreshed Green Plan
Agenda item	17
Report executive owner	Stuart Rees, Chief Finance Officer
Report author	Jonathan Guppy, Head of Sustainability
Governance Pathway: Previous consideration	Approved at Finance & Performance Committee 21st May 2025
Governance Pathway: Next steps	

Executive Summary

- This report is intended to appraise the Board of the SCAS Refreshed Green Plan, as approved by FPC on 21st May.
- Per NHS England statutory guidance published 4th February 2025, refreshed green plans should be approved by the Board, published in an accessible location on the organisation's website and shared with NHS England by 31st July 2025.

Alignment with Strategic Objectives

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

Finance & Sustainability

Relevant Business Assurance Framework (BAF) Risk

To which BAF risk is the subject matter relevant? SR9 - Delivery of the Trust Improvement Programme

Financial Validation	Capital and/or revenue implications? Yes If so: Checked by the appropriate finance lead? (for all reports) Yes Considered by Financial Recovery Group (for reports where the financial impact is not covered within existing budgets) No

Recommendation(s)
What is the Committee/Board asked to do: Approve the Refreshed Green Plan

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

1. Background / Introduction

1.1 Why are you writing this report now and what is the purpose of it?
NHS England requires all Trusts to update and refresh their Green Plans to create better alignment for Green Plan delivery within ICBs and to ensure greater consistency. Each Trust must have their Green Plan approved and published by 31st July 2025.

2. Detail

2.1 What relevant information do you need the meeting to have regard to in its consideration of your report? Attached Refreshed Green Plan v1.4

3. Quality Impact

3.1 Does the action [or decision not to act] have an impact on patient safety, patient experience or clinical effectiveness?
Implementing the Green Plan will improve all the above by enhancing long-term financial sustainability through reduced energy and fuel costs, and reducing the environmental impact of the Trust's activities.

4. Financial Impact

4.1 Does the required action [or decision not to act] have a financial impact and can this be quantified?
Energy saving measures and decarbonising the fleet will have a significant financial impact on long term operating costs, with possible annual savings in excess of £2million

5. Risk and compliance impact

5.1 What is the risk to the trust if the recommended course of action is not taken?

Multiple risks:

Reputational risk of not meeting sustainability objectives; not being compliant with NHS England mandated guidelines, which could affect future grant applications; not being part of ICB's Green Planning (BOB, HIOW etc.); not having sufficient infrastructure in place to support an electric fleet as internal combustion engines are phased out, leaving the trust with fewer alternative vehicle options; opportunity cost of not investing for long-term savings

5.2 Does it relate to any of the existing risks on the risk register (in addition to the BAF)? Which? How?

Key short-term milestone is the requirement for the Trust to purchase or lease electric vehicles (excluding ambulances) only from 2027 onwards. The Trust needs to ensure its infrastructure can support this.

5.3 Does the decision relate to a regulatory requirement or another form of compliance?

Climate Change Act 2008, Health and Care Act 2022; NHSE Delivering a Net Zero NHS 2022; NHSE Travel & Transport Strategy 2023; Zero Emission Vehicle (ZEV) Mandate 2024; Fit for the Future 10-year Health Plan for England 2025.

6. Equality, diversity and inclusion impact

6.1 Is there any impact to a particular group of individuals?

Implementing the Green Plan will help reduce health inequalities by contributing towards improved air quality across the Trust, benefitting some of the most vulnerable groups.

7. Next steps

7.1 What will you do next? Inform NHS England that the Green Plan is approved

8. Recommendation(s)

8.1 The Board is asked to: Approve the Refreshed Green Plan

9. Appendices

9.1 Appendix 1 – Refreshed Green Plan v1.4

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NHS Foundation Trust



South Central Ambulance Service NHS Foundation Trust

Green Plan 2025 - 2032

Document Control

Author: Jonathan Guppy, Head of Sustainability		
Version	**Description**	**Date**
1.1	Green Plan Refresh – first draft Key Updates on original Green Plan: 1) Material restatement of Carbon Footprint and Carbon Footprint PLUS following change in methodology 2) Development of Net Zero Procurement strategy and decarbonising the supply chain 3) Sustainability feasibility studies for Solar PV, Battery Storage and smart LED 4) Development of EV charging infrastructure requirements using Emergency Vehicle Recharging Infrastructure Tool (EVRIT) 5) Estimated 5-year Capital Budget for Estates Sustainability Upgrades	29/11/2024
1.1	Approved by Net Zero Committee	24/02/2025
1.1	Approved by EMC	15/04/2025
1.1	Considered by Finance & Performance Committee	17/04/2025
1.2	Resubmitted to Finance & Performance Committee	21/05/2025
1.3	Approved by Finance & Performance Committee. Key updates: 1) 2024/25 year-end carbon data (multiple sections) 2) Digital Transformation (Section 4.5) 3) Amended Year 1 Capital Budget (Section 5)	21/05/2025
1.4	Submitted to SCAS Trust Board Meeting	31/07/2025

REFRESH - NOT APPROVED

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Executive Summary

Climate change has been identified as the greatest threat to human health this century. Such is the scale of the problem, several local authorities within the SCAS region have already declared a Climate Emergency. As a front-line service provider, SCAS will be directly impacted by climate change. Although our organisation successfully handles thousands of emergencies daily, global warming will add a significant additional burden, whilst the effects of increased flooding and heatwaves will hamper our operations and disrupt our ability to respond.

As a major consumer of diesel, we are a large contributor to global warming from carbon dioxide emissions, but we also pollute the air in the communities we serve with toxic gases and particulates, causing harm to patients and staff.

We have an ethical duty to respond accordingly, to protect our patients, staff and wider society from pollution and the impacts of climate change.

The Government has enshrined this in law. The NHS became the first health system to embed net zero in legislation, through the Health and Care Act 2022. Statutory guidance mandates the NHS to achieve:

1) for the emissions we control directly (the *NHS Carbon Footprint*), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032

2) for the emissions we can influence (our *NHS Carbon Footprint* ***Plus***), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

This Green Plan sets out the scale of the challenge facing SCAS and how we will reach our Net Zero targets. By measuring our carbon footprint and identifying its sources, we can see that:

1) Our Fleet is responsible for 80% of the emissions we control directly (our Carbon Footprint).
2) Procurement / Supply Chain accounts for 83% of our wider emissions, including those we influence. Of this wider Carbon Footprint PLUS, transport-related activities account for 74%.

The measured data shows that, on our current trajectory, we are making good progress with reducing the emissions we can control directly (our Carbon Footprint), remaining on course so far, but the emissions we can only influence (our Carbon Footprint PLUS) have been rising each year, entirely due to a large increase in transport-related emissions from the goods and services we purchase.

This Green Plan details the specific measures we need to implement to meet our Net Zero targets. It prioritises the need for the Trust to reduce its vehicle emissions by fleet electrification. This plan also seeks to ensure that our procurement process compels suppliers to reduce their carbon footprint through similar means and contribute to other sustainable measures.

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Other actions that contribute to sustainability and carbon reduction have also been identified. These have a comparatively smaller impact than transport but also need to be addressed if we are to reach Net Zero.

This refreshed Green Plan provides specific, measurable steps to show how SCAS can remain on course to meet its Carbon Footprint Net Zero targets of an 80% reduction by 2028-32, compared to 1990 emissions.

The most important steps are:

1) 100% Electric Vehicle Fleet (excluding Double Crewed Ambulances; these will come later). The adoption of electric vehicles must follow the pathway set out by the October 2023 NHS Net Zero Travel & Transport Strategy.
2) Installation of sufficient electric vehicle charging infrastructure to support the entire Fleet.
3) Installing Solar PV with Battery Energy Storage Systems to generate our own electricity and create significant financial savings
4) Implement mandatory Carbon Reduction Plan requirements to all Procurement contracts, along with other Social Value Theme clauses
5) Reducing Nitrous Oxide emissions by 50%
6) Using synthetic fuels such as HVO to replace diesel and reduce emissions from DCAs on older vehicles with higher emissions and where the warranties have expired.

These steps will form a programme of sustainable transformation within a wider Trust Modernisation Programme, comprised of a portfolio of projects spanning multiple departments, but particularly focused on Fleet Services, Estates and Procurement. This will lead us towards achieving our sustainability goals and maintain compliance with our legal obligations.

The success of this programme requires the support of the Board, with an appropriate governance structure in place, including a Board level sponsor. A Programme Manager to coordinate the cross-departmental workstreams is also essential to success.

Funding the Green Plan requires upfront capital investment, which will be recouped long term from the reduced lifetime operating costs of adopting an electric fleet, particularly the fuel and maintenance savings, as well as savings from Solar PV and smart LED systems. NHS England expect the cost of new electric vehicles to reach parity with diesel and petrol models soon, whilst reforms to the way new grid connections are funded means the charging infrastructure requirements represent a more modest capital investment than previously. Nationwide, fully implementing the NHS Net Zero Travel and Transport Strategy will result in over £59 million saved every year, with Ambulance trusts being the main beneficiaries.

This represents an exciting, generational opportunity for SCAS to become a pioneering leader in the fight against climate change.

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1. Context & Key Drivers of the Green Plan

1.1 Trust Background

South Central Ambulance Service NHS Foundation Trust provides a range of emergency, urgent care and non-emergency healthcare services, along with patient transport services.

SCAS employs 4,380 staff across 35 main sites[1] covering a large geographical area encompassing Oxfordshire, Buckinghamshire, Berkshire and Hampshire. These are predominantly rural counties, with a higher-than-average population over the age of 65. SCAS serves a population of over 4.4 million and answers nearly a million 999 and 111 calls a year. Services are provided 24 hours a day, 7 days a week

As of 1st May 2025, the SCAS Fleet comprised 1,144 vehicles, of which 352 were front line ambulances, 341 patient transport vehicles, and a range of rapid response and staff vehicles.

In addition, SCAS has a significant "Grey Fleet" of 1,355 privately owned vehicles which are used to carry out functions on behalf of the Trust, incurring nearly 1.35 million miles of business travel, including 190,000 miles undertaken by volunteer drivers.[2]

SCAS also procures external patient transport services, which adds to the total carbon footprint PLUS of the Trust.

SCAS Fit for the Future Programme

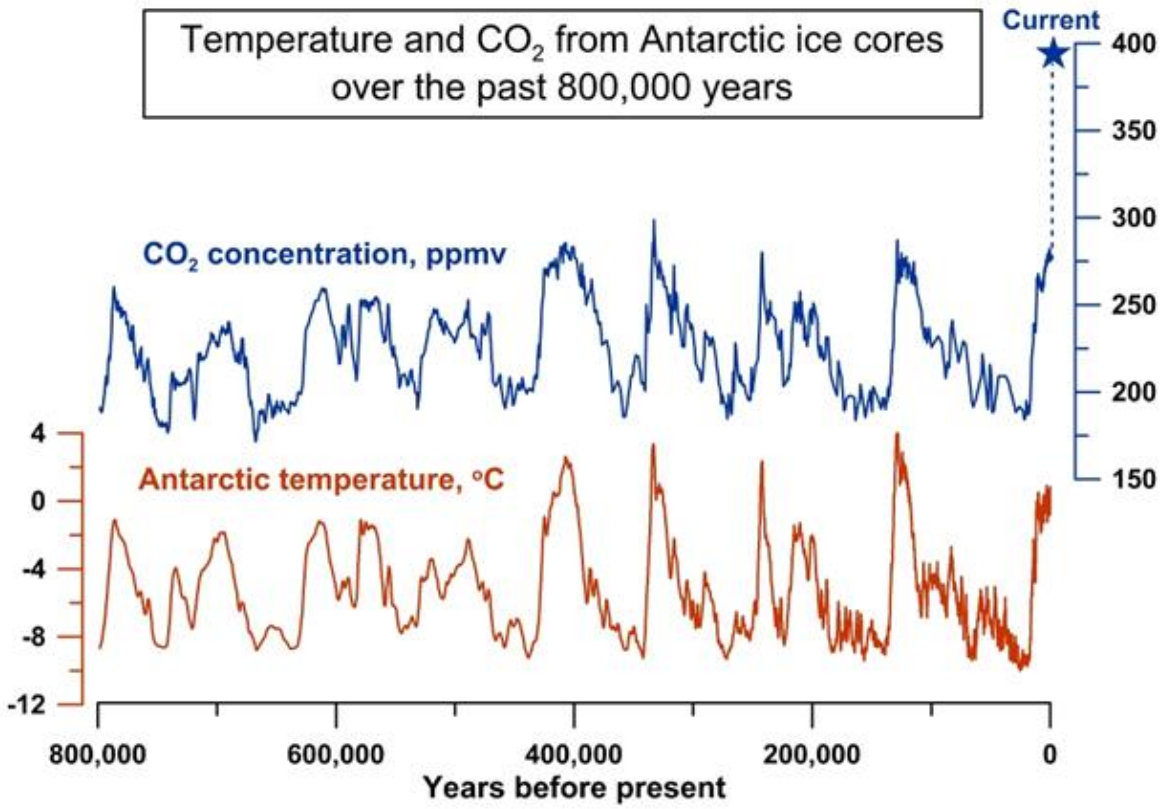
The Trust is currently embarking on a "Fit for the Future" modernisation programme which will see a reorganisation of all departments, particularly Estates and Fleet with regards to the number of buildings and ambulance station locations. The delivery of the Green Plan is intrinsically linked to this programme, and will be updated accordingly, though the carbon reduction targets remain the same.

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[1] "SCAS in Numbers", published 01/05/25. Includes Resource Centres, PTS, contact centres, education and workshops. Excludes ambulance stand-by points.
[2] SCAS Business Miles Claims Report from HR Department, 31-03-25

1.2 Climate Change – The Science

Since John Tyndall proved that carbon dioxide can absorb heat in the atmosphere in 1859, scientists have warned that altering the levels of CO_2 could change the climate. By analysing ice core samples dating from 1950 back over 800,000 years, scientists have been able to demonstrate the direct correlation between CO_2 levels and global temperatures:



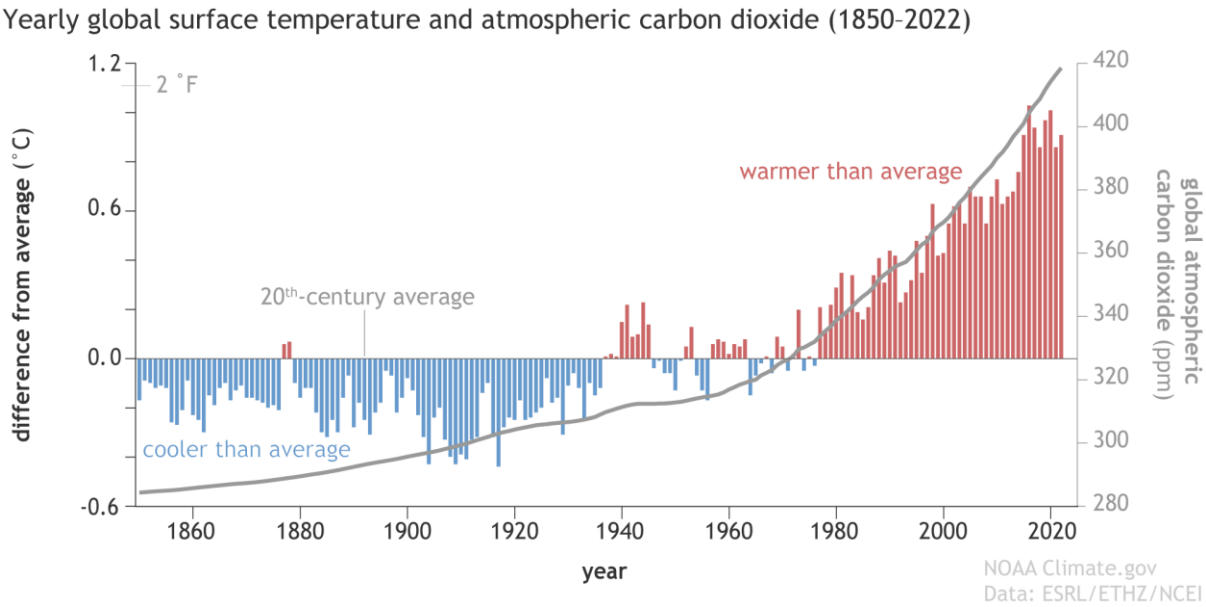
[3]

This landmark study, undertaken in 2001, analysed CO_2 and different isotopes in air bubbles trapped in the ice to reconstruct a picture of past temperatures.

Since the Industrial Revolution began in the mid-18th Century, we have released billions of tonnes of carbon dioxide into the atmosphere. In 1938, the engineer Guy Callender was the first to discover a connection between human activities and global warming[4]. Using more recent data based on actual observed temperatures and emissions since 1850, climate scientists have demonstrated the causal link between human activities and climate change:

[3] Greenhouse gases and climate sensitivity - insights from ice cores | National Institute of Water and Atmospheric Research, 2001 https://niwa.co.nz/atmosphere/research-projects/greenhouse-gases-and-climate-sensitivity-insights-from-ice-cores

[4] World Economic Forum, 2022, "*Who first discovered the human connection to global warming?*", https://www.weforum.org/agenda/2022/02/climate-change-global-warming-carbon-dioxide-fossil-fuels/



5

Since pre-industrial times the concentration of CO_2 has risen to 417 parts per million (ppm) from 280ppm (based on the average between 1,000 and 1,800 CE). As the Intergovernmental Panel on Climate Change (IPCC) observes, the last time CO2 levels were as high as present was at least 2 million years ago[6] and that human influence has warmed the planet at a rate that is unprecedented in the last 2,000 years[7]. Their modelling accounts for the effect of natural drivers of climate change such as solar and volcanic activity. The IPCC states that "it is unequivocal that human influence has warmed the atmosphere, ocean and land. Widespread and rapid changes in the atmosphere, ocean, cryosphere and biosphere have occurred."[8] IPCC reports are commissioned by the world's 195 national governments and the summary is agreed unanimously, line-by-line, by those governments. Some of those governments are engaged in conflict with each other, yet they set their differences aside to agree on this matter.

[5], National Oceanic and Atmospheric Administration, 2022, "What evidence exists that Earth is warming and that humans are the main cause?" https://www.climate.gov/news-features/climate-qa/what-evidence-exists-earth-warming-and-humans-are-main-cause, accessed 25/08/23

[6] Arias, P.A. et al., 2021 Technical Summary. In Climate Change 2021: The Physical Science Basis. Contribution of Working Group I to the Sixth Assessment Report of the Intergovernmental Panel on Climate Change, p68, https://www.ipcc.ch/report/ar6/wg1/chapter/technical-summary/ accessed on 30/08/23

[7] Figure SPM.1 in IPCC, 2021: Summary for Policymakers. In: Climate Change 2021: The Physical Science Basis. Contribution of Working Group I to the Sixth Assessment Report of the Intergovernmental Panel on Climate Change [Masson-Delmotte, V., P. et al)]. Cambridge University Press, Cambridge, UK and New York, NY,USA, pp. 3–32, https://www.ipcc.ch/report/ar6/wg1/figures/summary-for-policymakers/figure-spm-1

[8] Ibid, A.1

1.3 Impact of Climate Change on the SCAS Region

Anthropogenic climate change is already having a serious and noticeable impact on the UK, with the 10 warmest years on record having all occurred since 2002, according to analysis from the Met Office. The summer of 2022 was the joint warmest, with the hottest day ever recorded in the UK occurring in July, registering at over 40°C[9]. The more recent heatwaves across Europe in the Summer of 2023 broke records again.

The Sixth Assessment Report of the International Panel on Climate Change concluded in March 2023 it was likely that warming above pre-industrial levels will exceed 1.5°C during the 21st century, and that it would be difficult to limit warming below 2°C.[10] This will have a profound impact on our lives. At the 2024 Conference of the Parties (CoP) 29 held in Baku, the World Meterological Organization reported that:

- Jan-Sept 2024 global average temperature 1.54 °C above pre-industrial level
- Long-term warming measured over decades remains below 1.5°C
- Past 10 years are warmest on record and ocean heat rises
- Antarctic sea ice second lowest on record and glacier loss accelerates
- Extreme weather and climate events lead to massive economic and human losses[11]

Global warming is already resulting in rising sea levels and more extreme weather in the UK. Since 1901, UK sea levels have risen by 20cm, but the rate of change is accelerating, and levels are now rising by 3.7mm per year[12]. The SCAS region is particularly prone to increased flooding as result of climate change, with expected annual damage (EAD) projected to increase by more than 25% in some areas even if global warming is limited to 1.8°C above pre-industrial levels, according to recent research by Bristol University[13]. The following map shows expected annual damage (EAD), aggregated across 10 km hexagons:

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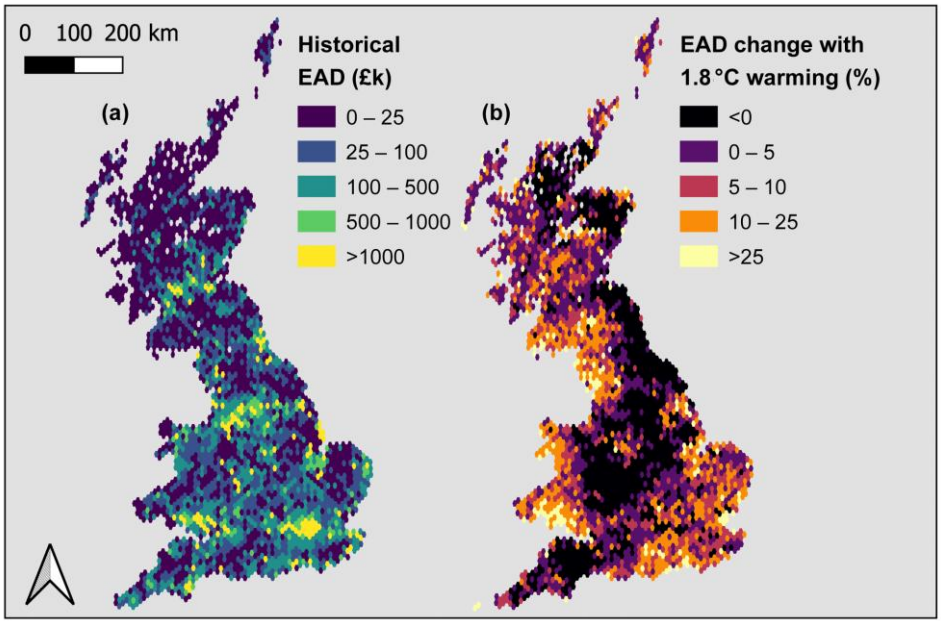
[9] https://www.metoffice.gov.uk/about-us/press-office/news/weather-and-climate/2022/joint-hottest-summer-on-record-for-england

[10] https://www.ipcc.ch/report/ar6/syr/resources/spm-headline-statements/

[11] WMO, 2024, "State of the Climate 2024 Update for CoP29", https://wmo.int/publication-series/state-of-climate-2024-update-cop29

[12] Met Office, 2023, "*Past and future sea level rise*", https://www.metoffice.gov.uk/weather/climate-change/organisations-and-reports/past-and-future-sea-level-rise, accessed 01/09/23

[13] Bates, P. D., Savage, J., Wing, O., Quinn, N., Sampson, C., Neal, J., and Smith, A.: A climate-conditioned catastrophe risk model for UK flooding, Nat. Hazards Earth Syst. Sci., 23, 891–908, https://doi.org/10.5194/nhess-23-891-2023, 2023.



Other impacts of climate change include:

- Coastal and other areas affected by rising sea levels
- Higher temperatures and drier summers
- Increased stress on water resources
- Reduced resilience, longer emergency response times due to flooding
- Increased physical health effects on the elderly and those with pre-existing conditions
- Increased mental health effects of suffering catastrophic flooding or fire

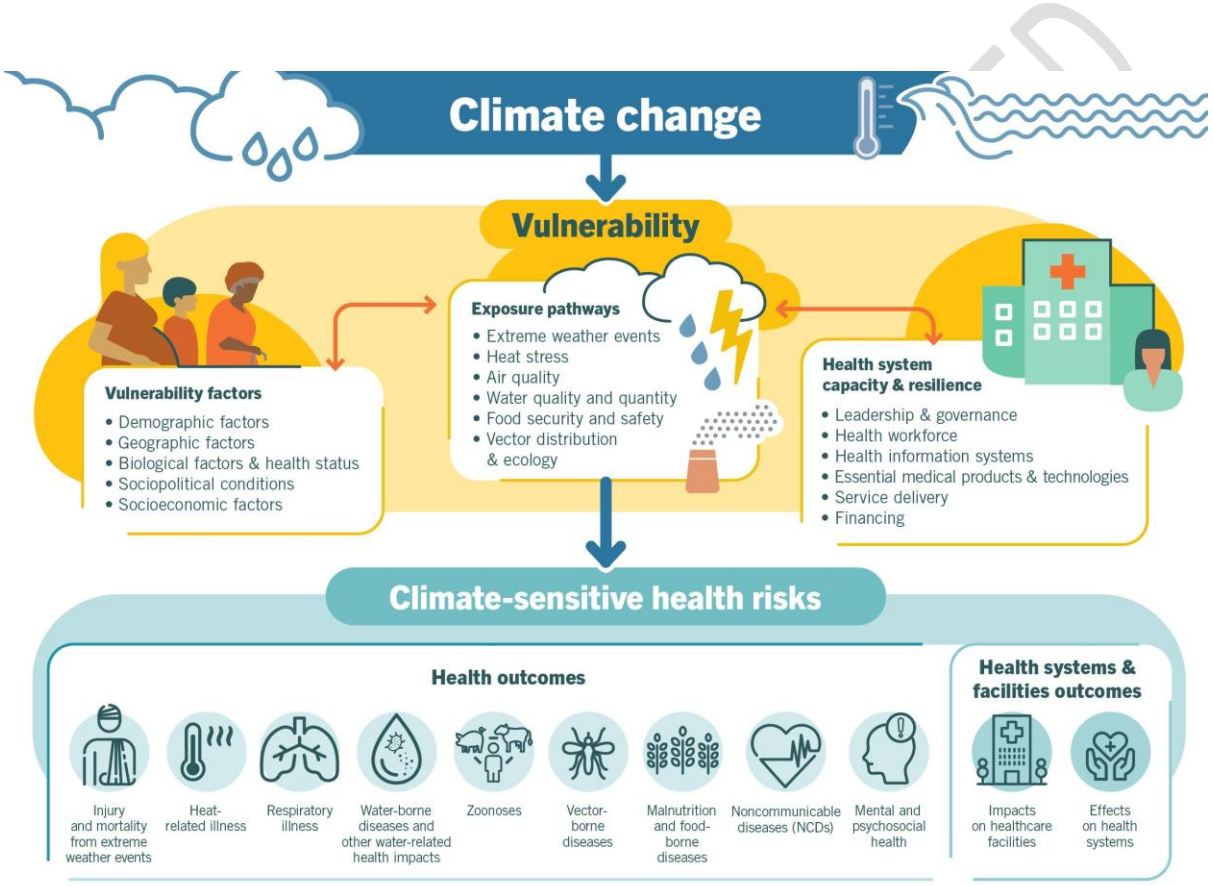
As a result of this, several local authorities within the SCAS region have declared a "Climate Emergency", including:

- Buckinghamshire County Council
- East Sussex County Council
- Hampshire County Council
- Oxfordshire County Council
- West Sussex County Council

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1.4 Health Impact of Climate Change

Climate change will impact in myriad ways, but the effects on health will have serious ramifications for SCAS, significantly increasing the demands on our resources. Climate change coincides with a rapidly ageing population, which is more vulnerable to its effects, particularly those suffering from respiratory and cardiac illness, and other chronic diseases.



World Health Organisation, "Climate Sensitive Health Risks",[14]

[14] World Health Organisation, 2023, "Climate-Sensitive Health Risks", https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health, accessed 01/08/23

1.5 Legislative Response to Climate Change

Healthcare is a major contributor to climate change, whilst also being heavily impacted by the consequences of climate change. The NHS is responsible for 4% of the UK carbon footprint. At the same time, one-third of new asthma cases might be avoided from efforts to cut emissions[15]. As a result, the Government has introduced legislation specifically aimed at the health sector:

1.5.1 Health & Care Act 2022

> ***"NHS England must, in the exercise of its functions, have regard to the need to***
>
> ***(a) contribute towards compliance with —***
>
> ***(i) section 1 of the Climate Change Act 2008 (UK net zero emissions target), and***
>
> ***(ii) section 5 of the Environment Act 2021 (environmental targets), and***
>
> ***(b) adapt to any current or predicted impacts of climate change identified in the most recent report under section 56 of the Climate Change Act 2008."***

Taking steps to mitigate the impact of the NHS on climate, the Health & Care Act 2022 established the NHS as the first health system to embed Net Zero into legislation:

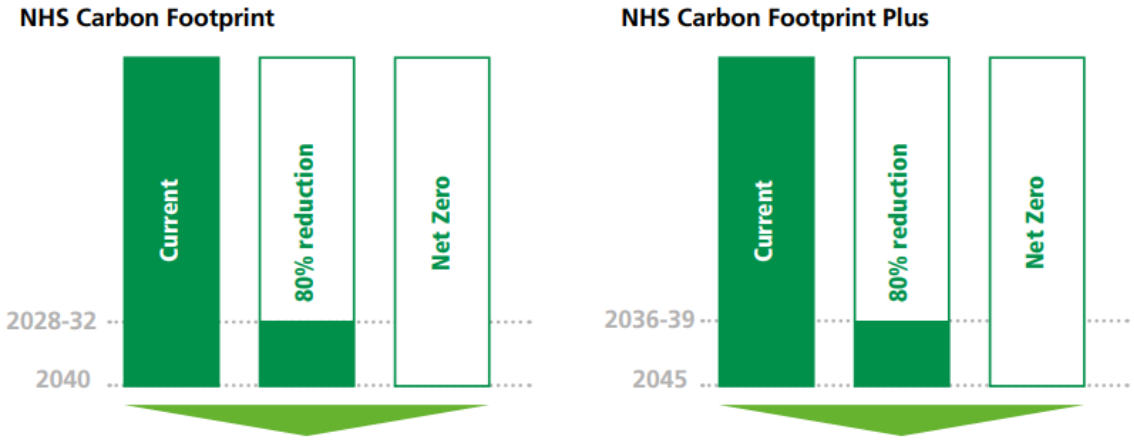
1.5.2 NHS Net Zero Targets

In response to the Health & Care Act legislation, NHS England published its **"Delivering a Net Zero National Health Service"** report in July 2022, in which it set out two "clear and feasible" targets for the NHS to meet its net zero commitment:

3) for the emissions we control directly (the *NHS Carbon Footprint*), net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032

4) for the emissions we can influence (our *NHS Carbon Footprint* ***Plus***), net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039.

[15] NHS England, "*Delivering a Net Zero NHS*", 2022, p8



However, these targets are set against a baseline year of 1990. It is difficult for some Trusts to collect relevant historical data, especially where Trusts such as SCAS have changed their composition significantly over time. The Trust that exists today is very different in size, organisation, and scope to what existed in 1990.

To address this problem, the Greener NHS Methodology for measuring Trust contributions to the NHS Carbon Footprint Plus has established a more recent **baseline of 2019/20** against which to measure progress and has adjusted the emissions reduction trajectories accordingly:[16]

As data is available to SCAS for all years since 2019/20, this makes it easier to see whether we are on track to meet the Net Zero targets.

*Defined against the new **2019/20 baseline**, the national targets are equivalent to:*

- *reducing emissions by at least 47% by 2028-2032 to reach Net Zero NHS Carbon Footprint by 2040*
- *reducing emissions by at least 73% by 2036-2038 to reach Net Zero NHS Carbon Footprint Plus by 2045*

[16] NHS England, 2023, "Trust contributions to the NHS Carbon Footprint Plus", cited in Greener NHS Carbon Footprint Plus – Trust Methodology, Greener Analytics Workspace.

1.5.3 The NHS Standard Contract 2024/25

To ensure that NHS Trusts are working to deliver a Net Zero National Health Service, the NHS Standard Contract[17] includes a list of **minimum** foundations that must be in place:

NHS Standard Contract, Section 18:

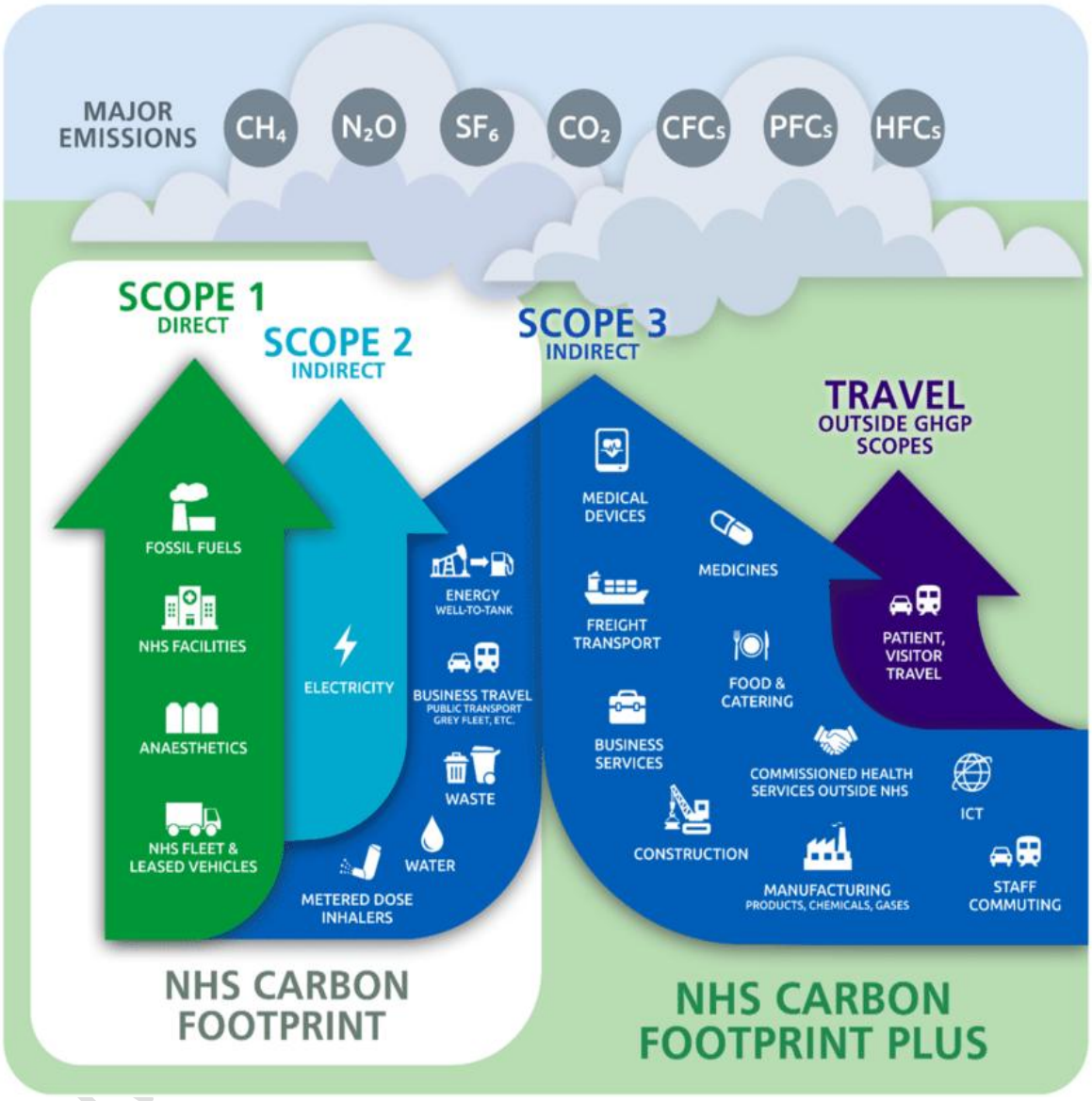
- Every trust to ensure they have appointed a Net Zero lead and are maintaining and delivering a Green Plan, approved by its Governing Body.
- Every trust must ensure that, as far as reasonably feasible, that all electricity it purchases is from Renewable Sources. NB *Currently, SCAS purchases Zero Carbon (Nuclear) energy under the Zero Carbon for Business tariff from EDF.*
- Provide detailed plans as to how it will contribute towards a 'Green NHS' with regard to delivering 'Net Zero' National Health Service commitments in relation to air pollution from Fleet and burning fossil fuels to heat buildings.
- Implement NHS Net Zero Travel & Transport Strategy
- Develop plans to adapt buildings to reduce risks associated with climate change.
- Comply with requirements set out in Net Zero Supplier Roadmap.

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[17] Section 18 Green NHS and Sustainability, NHS Standard Contract 2023/24, https://www.england.nhs.uk/wp-content/uploads/2023/04/03-nhs-standard-contract-fl-scs-2324.pdf

1.6 Understanding the Carbon Footprint and Carbon Footprint Plus

The following schematic highlights the various sources of emissions that form the NHS Carbon Footprint and Carbon Footprint Plus:



The “scopes” are derived from the Greenhouse Gas Protocol, the universally adopted standard for measuring carbon emissions.

Scope 1: Direct emissions from owned or directly controlled sources, with these emissions occurring on site e.g. from a gas boiler or fuel used by an ambulance.

Scope 2: Indirect emissions from the generation of purchased energy, mostly electricity

Scope 3: All other indirect emissions that occur in producing and transporting goods and services, including the full supply chain.

The NHS Carbon Footprint concerns the emissions *controlled directly*, whereas the NHS Carbon Footprint *PLUS* includes the additional emissions that are *influenced* by the NHS.

An example of this would be emissions from privately contracted ambulance services, where SCAS can only influence the choice of fuel and vehicle, but for which we are ultimately responsible as those emissions would not arise if we were not purchasing those services.

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2. SCAS Carbon Emissions

2.1 Organisational Boundary

SCAS reports GHG emissions on the basis of "operational control[18]" of owned and leased assets such as vehicles and estate, as well as emissions arising from the supply chain, encompassing all the direct and indirect emissions arising from SCAS activities, whether controlled or influenced.

2.2 Methodology and Approach

SCAS uses the methodology outlined in the NHS Carbon Footprint Plus Model, which uses UK and international standards on calculating emissions in a way that is consistent with the UK's GHG Inventory and the Greenhouse Gas Protocol.

METHODOLOGY:

- The carbon footprint has been calculated from applying Department of Energy Security & Net Zero GHG conversion factors to activity data, such as kWh of energy, miles travelled, and litres of fuel used.
- The Kyoto Protocol identifies seven main Greenhouse Gases (GHGs) that contribute to climate change: carbon dioxide (CO_2), methane (CH_4), nitrous oxide (N_2O), hydrofluorocarbons (HFCs), perfluorocarbons (PFCs), sulphur hexafluoride (SF_6) and nitrogen trifluoride (NF_3).
- Of these Greenhouse Gases, SCAS uses nitrous oxide (N_2O) as an analgesic. Its global warming potential is 265 times greater than carbon dioxide, expressed in terms of "kilogrammes of carbon dioxide equivalent", $kgCO_2e$. This is converted into tonnes, tCO_2e. At 6% of the carbon footprint for SCAS in 2024/25, it is the third largest source of direct emissions after transport activities and electricity.
- Emissions factors for vehicle electricity consumption, fuel well-to-tank (WTT), and transmissions & distribution (T&D) emissions are calculated using Greenhouse Gas Conversion Factors for Company Reporting
- The version of the factors that correlates most with the data being reported has been used, per Department of Energy Security & Net Zero guidelines. For example, the 2024 factors have been applied to data in reporting year 01/04/24 – 31/03/25.
- Accurately calculating the wider Carbon Footprint Plus relies on obtaining Scope 3 data from 3rd parties, or analysing procurement data. There is no data available for Staff Travel (Scope 3); a mandatory 100% staff survey is the only way to obtain this.

[18] World Resources Institute and World Business Council for Sustainable Development, 2004, updated 2015. The Greenhouse Gas Protocol: A Corporate Accounting and Reporting Standard (Revised Edition). Washington, DC: World Resources Institute, Appendix F, Categorizing GHG Emissions Associated with Leased Assets

2.3 Materiality & Restatement

A material restatement under the GHG Protocol refers to a significant revision or correction of previously reported greenhouse gas (GHG) emissions data.

Definition of Materiality:

The GHG Protocol encourages organisations to define a materiality threshold, typically as a percentage of total emissions, to determine what constitutes a significant change. While this can be subjective, generally a change is considered to be material if its value exceeds 5% of the total inventory for the part of the organisation being verified[19].

Material restatements can arise from:

- Changes in Methodology: Adoption of improved measurement techniques or updated emission factors.
- Structural Changes: Mergers, acquisitions, divestitures, or significant changes in operational boundaries.
- Discovering Omissions: Previously excluded emissions sources that are now deemed significant.
- Errors: Miscalculation, applying incorrect emission factors, or data entry mistakes.

As part of an ongoing process of continuous improvement, SCAS has worked to improve the quality of activity-based data informing the carbon footprint calculations (e.g. fuel and utility consumption data).

Previously, the carbon footprint PLUS, which includes the emissions from the supply chain, was estimated by applying carbon intensity factors to different spend categories.

Instead of relying on general estimates for supply chain emissions, SCAS has engaged the services of CO_2 Analysis to produce a more accurate evaluation of the Carbon Footprint PLUS for all years since 2019/20, using their *GreenInsight* Artificial Intelligence-assisted tool to assess individual line items of purchasing data and calculate their carbon footprint using Multi-Regional Input Output datasets.

This change in methodology has resulted in a material restatement of the Trust's Carbon Footprint PLUS due to considerable divergence from the previously estimated figures.

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[19] Ibid., p69

2.4 SCAS Carbon Footprint & Carbon Footprint PLUS

Carbon Footprint

Sub-category	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
SCOPE 1						
Building Energy - Gas	599	534	615	621	1,077	882
Fuel - Ambulance & PTS Fleet	12,185	11,586	11,372	10,447	9,858	10,361
Anaesthetic Gases - N_2O	1,765	1,436	1,508	1,278	1,105	995
Total Scope 1:	14,548	13,556	13,495	12,347	12,040	12,238
SCOPE 2						
Electricity	1,134	941	888	800	1,099	920
Total Scope 2:	1,134	941	888	800	1,099	920
SCOPE 3 (Indirect emissions arising from activities *directly controlled* by SCAS)						
Business Mileage	634	371	347	398	349	297
Upstream Fuel - Well to Tank	2,900	2,784	2,768	2,506	2,413	2,538
Upstream Electricity	254	212	316	266	359	303
Upstream Gas - Well to Tank	72	66	99	103	178	146
Water - Supply & Treatment	27	17	8	8	7	5
Waste	-	-	-	44	70	66
Total Scope 3:	3,887	3,450	3,538	3,325	3,377	3,355
SCAS Carbon Footprint:	**19,570**	**17,948**	**17,920**	**16,472**	**16,515**	**16,512**

Carbon Footprint PLUS

SCOPE 3 (Indirect emissions *influenced* by SCAS)						
e.g. Private ambulance / PTS provider, Medicines, Medical Equipment, Other Supply Chain	58,577	61,248	70,117	86,879	96,348	80,850
Staff Commuting - no accurate data available						
SCAS Carbon Footprint PLUS:	**78,147**	**79,196**	**88,037**	**103,351**	**112,863**	**97,362**

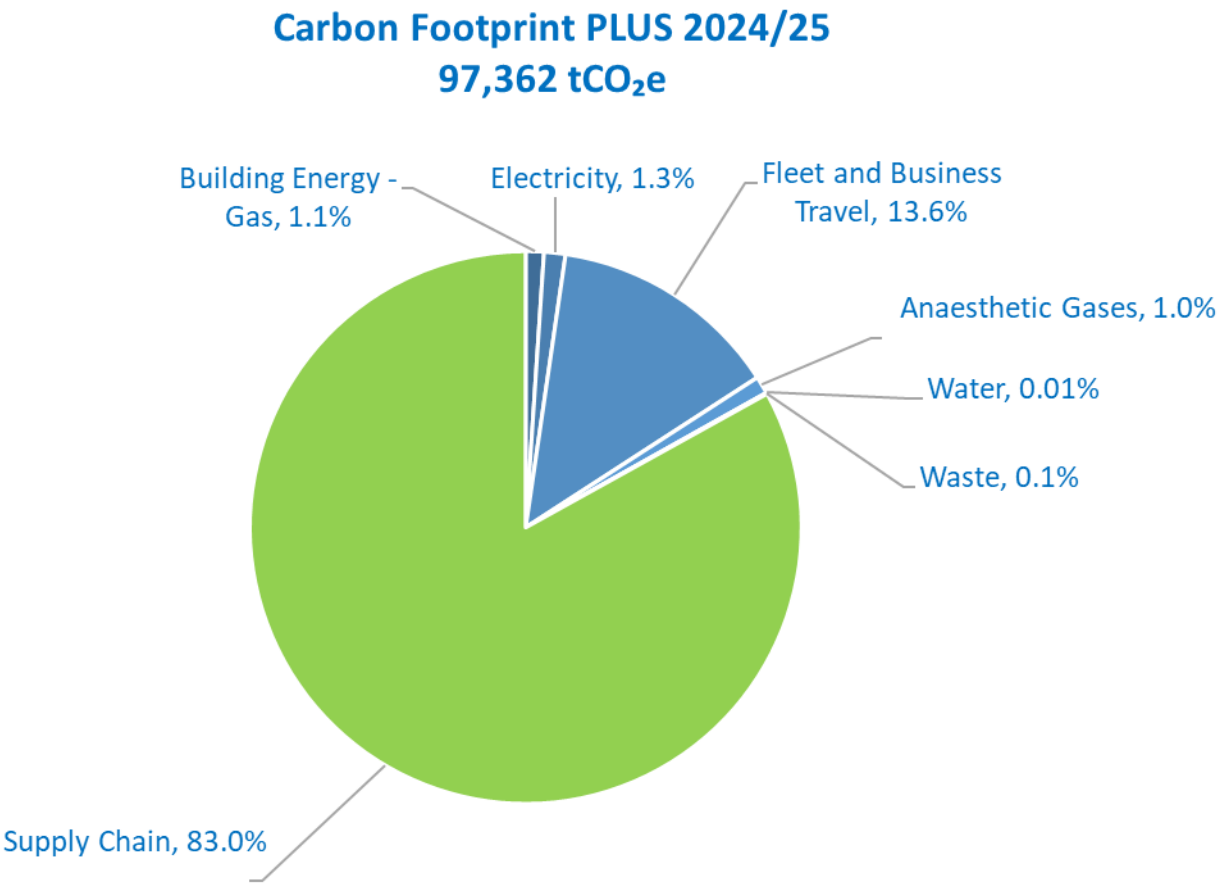
All figures expressed as tonnes CO_2 equivalent / tCO_2e.

SEE ANNEXE A1 FOR CONVERSION FACTORS

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2.5 SCAS Carbon Footprint PLUS:

(*the emissions we influence in addition to those we control directly.*



Previously**, "**Business Travel & Fleet" was assumed to be the greatest contributor to the Trust's total carbon emissions based on high-level financial analysis using carbon intensity factors applied to spending categories for the baseline year of 2019/20 only. No other data was available at the time.

Using revised methodology, conducting a detailed analysis of procurement spend using the AI-assisted GreenInsight tool reveals that the Supply Chain accounts for 83% of the Carbon Footprint PLUS for SCAS, whilst Fleet & Business Travel are only 13.6%.

Some of the reduced fleet and business travel emissions is due to the change in methodology. For example, emissions from private PTS providers were included previously in the Scope 3 data for the Carbon Footprint, based on estimated emissions from mileage data collated by SCAS. In the new methodology, this figure has been removed from the Carbon Footprint 'fleet and business travel' figure and added to the Carbon Footprint PLUS 'supply chain'.

However, the “Supply Chain” includes a significant number of transport services providers, which at first glance conceals the extent to which transport contributes to SCAS emissions.

Ten suppliers account for 46% of the SCAS Carbon Footprint PLUS and all are transport-related:

Supplier:	Emissions tCO_2e	% Total Emissions Cumulative
ELITE EMS LTD	7,008	8%
AMBULNZ COMMUNITY PARTNERS LTD	6,112	15%
ENHANCED CARE SERVICES	4,862	20%
ELITE MEDICAL AND AMBULANCE SERVICE LTD	4,104	25%
SOUTH CENTRAL FLEET SERVICES LTD*	4,092	30%
ION AMBULANCE CARE LTD	3,284	33%
MEDI4 AMBULANCE SERVICES LTD	3,156	37%
SOUTHERN MEDICAL RESCUE	3,076	40%
MEDI WAV LTD	2,348	44%
MEDICARE EMS GROUP UK LTD	2,338	46%

*wholly-owned subsidiary of SCAS

SCAS has 825 suppliers in total. If we undertake a Pareto analysis, just 39 of them account for over 80% of the Carbon Footprint PLUS. Of those 39, the majority are transport providers. According to the GreenInsight report, transportation activities account for **74% of total emissions**.

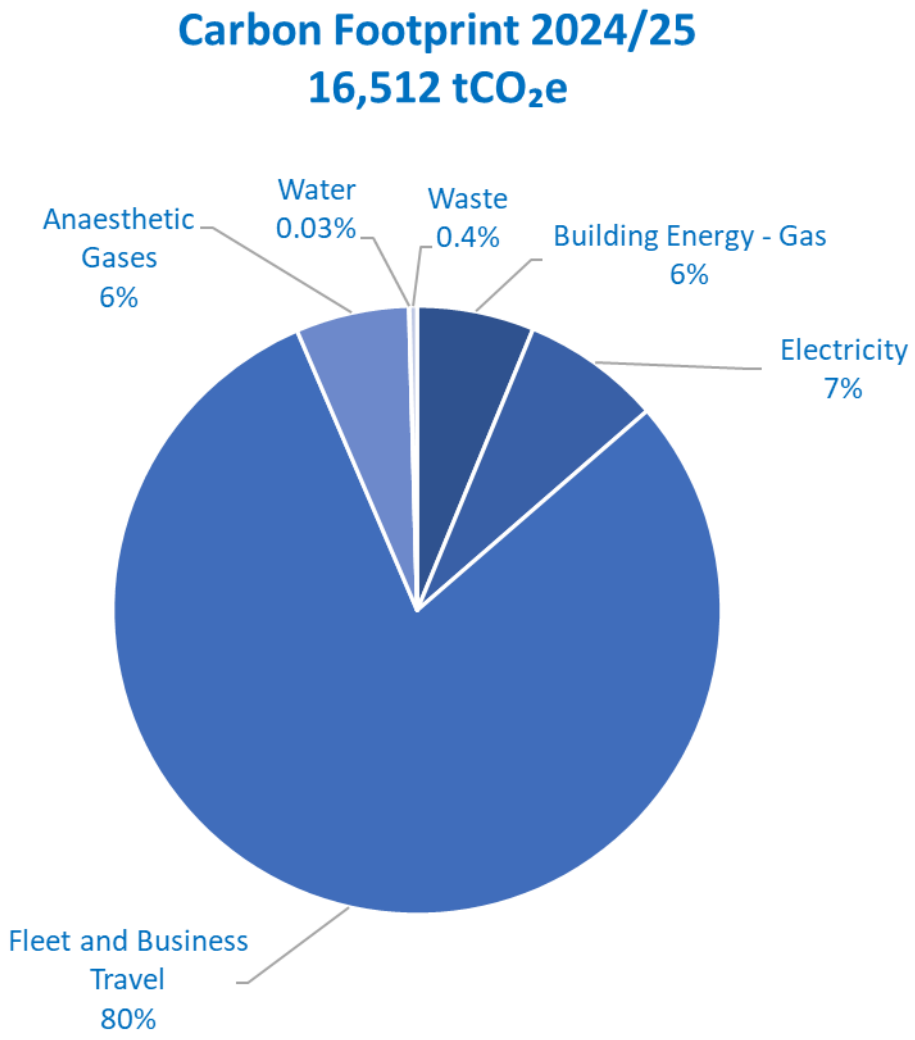
The majority of SCAS’ carbon footprint and carbon footprint PLUS is transport-related, which will directly inform the carbon reduction strategy, for both fleet and procurement.

By their very nature, ambulance trusts such as SCAS have a different emissions profile due to the extremely high number of vehicle movements compared to a hospital trust. Therefore, the focus of carbon reduction efforts will be different for ambulance trusts compared to hospital trusts.

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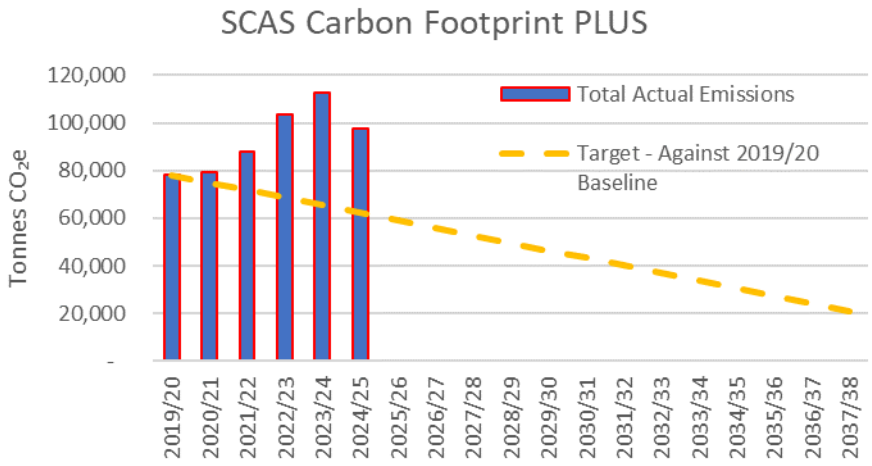
2.6 SCAS Carbon Footprint 2024/25:

(directly controlled emissions)



For the activities *directly controlled* by SCAS, Fleet and Business Travel account for 80% of the Carbon Footprint. Although private PTS emissions have been moved into the Carbon Footprint PLUS, as they are emissions SCAS can influence rather than control directly, Fleet emissions have still risen due to increased consumption of diesel. Improved modelling has also allowed for the inclusion of upstream emissions for gas and electricity, such as their transportation and distribution.

2.7 SCAS Carbon Reduction: Performance Against Targets



To be on track for Net Zero, SCAS needs to reduce its Carbon Footprint PLUS by 73% from 2019/20 emissions of 78,147 tonnes to 21,100 tonnes by 2037/38.

At first glance, the huge increase in total emissions for SCAS looks a failure, posing a seemingly insurmountable challenge. However, granular analysis in the GreenInsight model reveals that emissions from transportation activities increased from 47,528 tonnes in the baseline year of 2019/20 to a peak of 80,722 tonnes last year, but have now fallen significantly in 2024/25 to 72,048 tonnes. This reflects a reduction in transportation activity, most likely linked to the loss of PTS contracts.

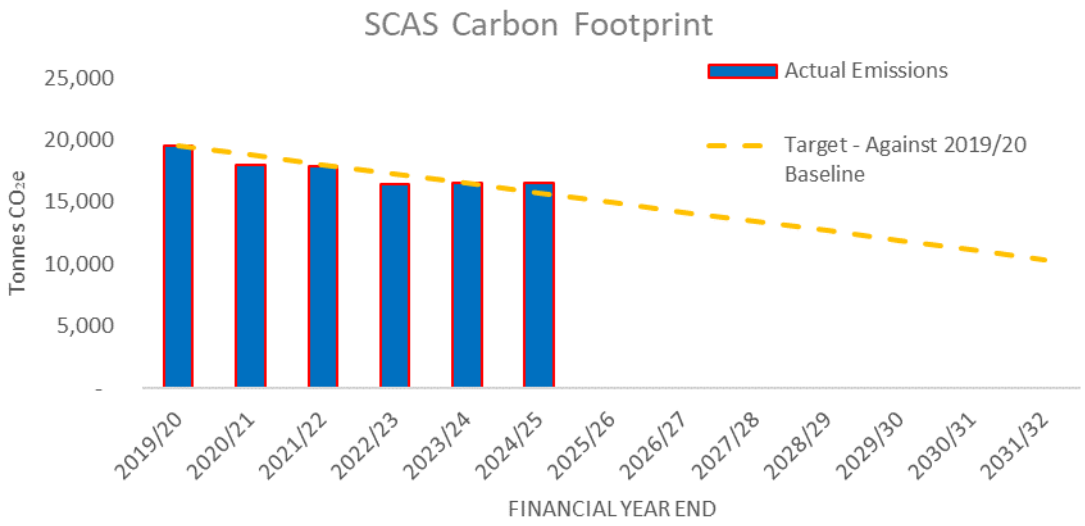
Transport accounts entirely for the overall increase in emissions since 2019/20 and reflects the higher level of transport activity in and on behalf of the Trust.

Most transportation is undertaken by third party private providers.

Effective use of procurement contracts will enable the Trust to influence carbon reduction strategies for these suppliers, whilst national legislation such as the Zero Emissions Mandate (ZEV) and the development of electric ambulances will accelerate the transition to electric fleets, which will help the Trust meet the bulk of its Carbon Footprint PLUS targets.

SCAS has made good progress reducing emissions for the activities directly within its control since 2019/20 (Carbon Footprint):

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The SCAS target is to achieve a 47% reduction in emissions for the Carbon Footprint by 2028-32 against the 2019/20 baseline, which is equivalent to an 80% reduction against 1990 figures, as calculated by NHS England.

Using the later date of 2032, deemed to be more realistic in view of the substantial work required, SCAS needs to reduce its annual emissions down to 10,250 tonnes by then.

Since 2019/20, total equivalent carbon emissions from SCAS have fallen from 19,570 tonnes to 16,512 tonnes, a drop of 15.6% against the baseline.

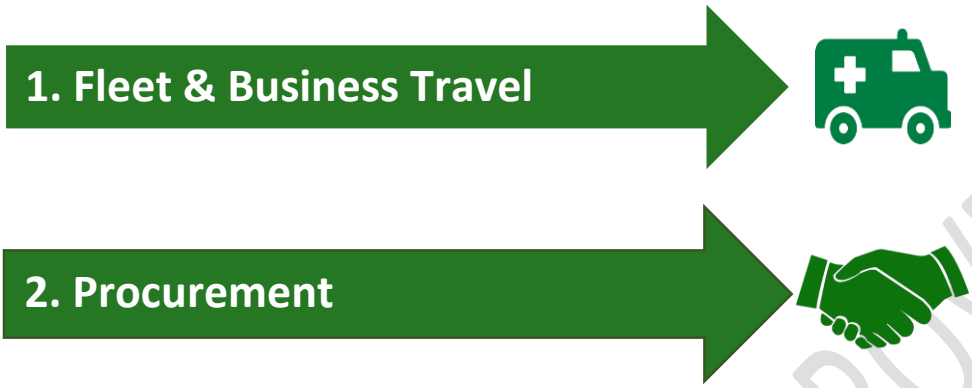
To be on track to meet Net Zero targets, directly controlled carbon emissions should have fallen by 19.6% at this point, so SCAS is slightly off target. Emissions have appeared to have stabilised over the last 3 years, so there is the risk of a growing divergence from the target trajectory. This divergence is entirely due to increased fleet emissions.

Financial Year End:	2020 (Baseline)	2024/25 Emissions		2032 (Target)
Target - Against 2019/20 Baseline	19,570	15,737		10,372
Actual Emissions	19,570	16,512		
Target Reduction against 2019/20 Baseline %	n/a	19.6%		47.0%
Actual Reduction against 2019/20 Baseline %	n/a	15.6%		

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2.8 Priority Areas for Carbon Reduction

Due to their contribution to emissions, the two key priority areas for carbon reduction are:



Whilst these are the priority areas, they should not detract from general efforts to embed sustainability throughout the Trust. Tackling these priority areas will also complement future efforts to decarbonise the heating systems, by ensuring that upgrades to the electrical supply required by electric vehicle chargers is sufficient to power heat pumps too.

Achieving carbon reduction in these areas will require collaboration across multiple directorates / departments within SCAS.

The following section will explain how the Green Plan sits within the overall organisational vision of the Trust and how it contributes towards putting the Trust on course for a more sustainable model of development.

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3. Organisational Vision



David Eltringham, Chief Executive SCAS, June 2023

3.1 Fit for the Future

This Green Plan does not exist in isolation, it must align with existing Trust policies and procedures, including the Trust's "Fit for the Future" programme of modernisation and transformation. It is a long-term programme with a range of connected projects running across 2024-2029.

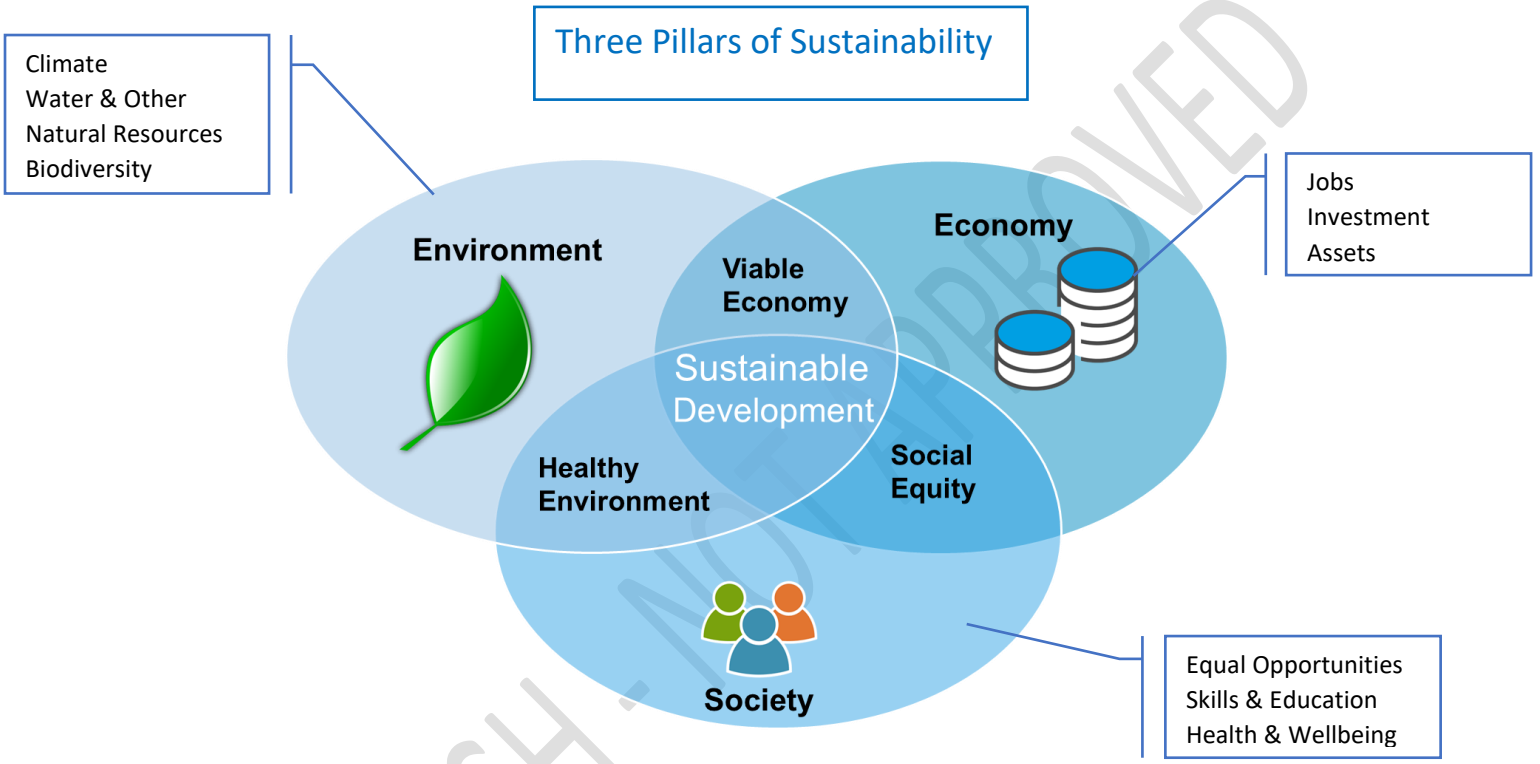
Fit for the Future is part of delivering our long-term strategy and making sure we can provide high quality patient care, achieve performance standards, and support staff wellbeing, whilst running within budget.

The Green Plan aims to meet not only the Trust's environmental performance standards, but also contribute to long term financial sustainability via projects such as investing in solar energy production, reducing energy consumption with smart LED lighting and switching from diesel to electric vehicles which are cheaper to operate and maintain. Green Plan initiatives also contribute to overall greater staff wellbeing.

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3.2 Sustainable Model of Development for SCAS

For the Trust to achieve long-term sustainability, the “three pillars” of economic, environmental, and social sustainability need to be considered in impact assessments, as a sustainable model of development can only be achieved when all three are in alignment:



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A model of sustainable development is about balance. An economy is only viable long-term if it consumes fewer resources than what the environment can provide. Likewise, an economy without social equity (or “fairness”) is likely to experience significant social tensions which would challenge its long-term future.

To understand how this relates to an ambulance trust, the Economic pillar would include assets such as buildings and the ambulance fleet, the jobs held by the staff and long-term capital investment in energy saving measures such as Solar PV.

A recent project to invest in “smart” LED lighting across the estate is a classic example of sustainable development in practice: the Trust has made a capital investment which delivers long term revenue savings far greater than the original investment, leading to reduced carbon footprint and an improved working

environment for staff. It exemplifies the Economic, Environmental and Social pillars of sustainability.

3.3 Specific improvements which benefit local communities, staff and the overall organisation

3.3.1 Incorporating the Social Value Model

The NHS is an "anchor institution" in the local economy, as a major employer and purchaser of goods and services. Social Value Themes[20] encapsulate the three pillars of economic, environmental and social sustainability. Embedding these in the procurement process will mean that local communities benefit from efforts to reduce inequalities in health, incomes, and educational opportunities, alongside measures to fight climate change.

SCAS is also a supplier of services itself, and participates in competitive tenders to win business, so it too must demonstrate it has incorporated the same Social Value Themes, which will be of direct economic, environmental and social benefit to its employees and, in turn, the organisation.

3.3.2 Regional resilience planning to protect the vulnerable from climate change

Efforts to lower CO_2 emissions, reduce costs and improve public health need to be combined with planning to mitigate the local impacts of climate change. This means adapting to improve the resilience of services and estates while protecting the most vulnerable, through measures such as climate change adaptation assessments, flood risk management and estates planning.

3.3.3 Reducing Air Pollution

The Department of Health and Social Care's advisory Committee on the Medical Effects of Air Pollutants (COMEAP) estimated that long-term exposure to man-made air pollution in the UK has an annual impact on shortening lifespans equivalent to 28,000 to 36,000 deaths.[21] The Royal College of Physicians, along with the Royal College of Paediatrics and Child Health, believes the figure may be even higher, at

[20] Government Commercial Function (2020), "Guide to Using the Social Value Model", Section 2, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/940827/Guide-to-using-the-Social-Value-Model-Edn-1.1-3-Dec-20.pdf

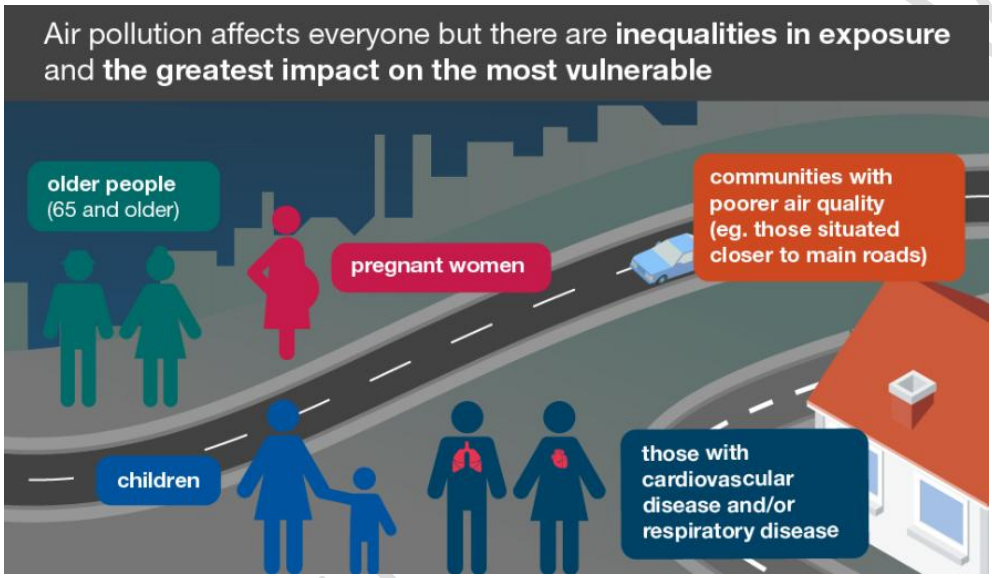
[21] DEFRA (2019), "Clean Air Strategy 2019", https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/770715/clean-air-strategy-2019.pdf

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40,000 deaths [22]. As such, it is the single greatest environmental threat to human health.

Conditions caused or exacerbated by air pollution include asthma, chronic bronchitis, coronary heart disease (CHD), and strokes. These conditions significantly reduce quality of life. They also mean that people are less able to work and need more medical care, resulting in higher social costs and greater burden on the National Health Service.

Air pollution exacerbates health inequalities, with the most vulnerable being disproportionately affected, whilst they often contribute the least to higher pollution.



Source: Health Matters – Air Pollution, Public Health England[23]

Air pollution at SCAS HQ in Bicester is in the 71st percentile of most polluted addresses in the UK, with average PM2.5 levels at 12mcg/m³, significantly above the WHO limit of 5mcg/m³.

This is important, as 19.9% of strokes are attributed to exposure for a year or more to levels of PM2.5 exceeding 10mcg/m³[24] Other areas within the SCAS region have even higher levels of pollution, amongst the highest in the UK.

Diesel engines are a significant source of PM2.5 and other pollutants such as NOx. Taking steps to reduce air pollution from travel and transport, especially by replacing diesel with EV, will mean fewer cases of asthma, COPD, cancer, strokes and heart disease.

Whilst diesel fleets are transitioning to EV, a process that will take several years to complete, interim measures such implementing ACETECH “Eco-run” engine management modules can turn off fleet engines when needed, reducing

[22] Royal College of Physicians and Royal College of Paediatrics & Child Health, 2016, “*Every breath we take: the lifelong impact of air pollution*”, pxii, https://www.rcplondon.ac.uk/projects/outputs/every-breath-we-take-lifelong-impact-air-pollution

[23] https://www.gov.uk/government/publications/health-matters-air-pollution/health-matters-air-pollution

[24] www.addresspollution.org

unnecessary idling[25]. By cutting down on idling, fleets decrease their fuel burn, toxin emission and engine wear and tear. The cost of the technology can be recouped from fuel savings within a year.

Some local authorities are introducing Clean Air Zones to tackle pollution. Within the SCAS region, Portsmouth has introduced a Class B Clean Air Zone, applicable to Buses, coaches, taxis, private hire vehicles and heavy goods vehicles, whilst Oxford has introduced a Zero Emissions Zone.

The NHS has a duty of care to support Clean Air Zones. As more authorities instigate them, it is likely that the exemptions granted to non-compliant emergency vehicles will be removed, resulting in financial penalties increasing the fleet operating costs. As of 31st October 2023, NHS vehicles operating in London were no longer exempt from ULEZ charges.

The NHS Fleet and Business Travel is a major source of air pollution, locally and nationally. Electrifying the SCAS fleet will have a direct, beneficial impact on the health of local communities and staff.

Some scientists have raised concerns that increased electrification of vehicles may lead to more air pollution from tyre wear, due to EVs being heavier. However, the introduction of solid-state batteries, along with new lighter versions of existing lithium-ion battery technology, will mean that soon (within a year or two) there will be no weight difference. The EU is also introducing the Euro 7 vehicle standard in 2025, which regulates and seeks to reduce tyre and brake dust emissions.

3.3.4 Digital Care

The mainstream provision of digitally-enabled care such as SCAS “Hear & Treat”, which accelerated during the COVID-19 pandemic can reduce transport emissions per patient and has the potential to enhance the patient experience by helping them avoid unnecessary travel, and freeing up ambulance resources for other patients.

Between January and March 2025, over **6,000** patients were treated remotely by “Hear & Treat”, whilst nearly **14,000** were treated at the scene rather than being taken to hospital as “See & Treat” cases[26].

As long as it is clinically appropriate and care is taken to avoid entrenching health inequalities, due to lack of access to digital tools, for example, this is a highly sustainable method of healthcare provision.

4. Green Plan Core Elements & Pathways

Reducing carbon emissions in line with Net Zero targets is the most important element of this Green Plan, the priorities being to electrify the fleet and decarbonise

[25] Eco Friendly Technology For Emergency Vehicles | ACETECH™, https://www.acetech.com/products/eco-friendly-technology-eco-run/

[26] SCAS Qlikview data report

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the supply chain. As the vast majority of supply chain emissions are transport-related, decarbonising that will involve similar fleet electrification.

Whilst these remain the focus, other measures can also contribute to direct carbon reduction, such as LED lighting and reducing nitrous oxide use. Broader environmental measures include rainwater harvesting, elimination of single use plastics, and reducing waste sent to landfill, all of which help SCAS move towards a more sustainable model of development.

4.1 Carbon Reduction Plan

For the emissions we **control directly**, this plan sets out a measurable and achievable route to meeting our Net Zero targets. If we use the new 2019/20 baseline, we know that we need to reduce emissions by 47% by 2028-32 to remain on track for Net Zero, according to the formula calculated by NHS England[27].

Baseline Emissions 2019/20 tCO_2e	19,570
Target Emissions for 2032 (47% reduction)	10,372
Actual Emissions in 2024/25	16,512
Emissions Reduction Required to Meet Target:	6,140
Specific carbon reduction measures:	
100% non-ambulance fleet to be electric by 2032	5,780
50% reduction in Nitrous Oxide emissions	498
Introduce HVO to fuel for older legacy vehicles (100k litres per annum)	248
Complete rollout of smart LED	165
10% reduction in business mileage	35
Total potential reductions by 2032	**6,726**

We need to reduce our emissions by 6,140 tonnes CO_2e a year by 2032 to remain on course to hit the target of 10,372 tonnes CO_2e per annum. The above plan shows how this is achievable.

It is completely impossible for SCAS to meet its carbon reduction targets without a programme of fleet electrification. Electrification enables SCAS to achieve Net Zero because the National Grid is rapidly decarbonising: Renewable sources outpaced fossil fuels for generating electricity for the first time in 2020. [28] The UK Government has committed to ambitious targets for the country to have 50 gigawatts (GW) of

[27] NHS England, 2023, "Trust contributions to the NHS Carbon Footprint Plus", cited in Greener NHS Carbon Footprint Plus – Trust Methodology, Greener Analytics Workspace

[28] National Grid, 2021, "*Road to Zero Carbon*" https://www.nationalgrideso.com/future-energy/our-progress-towards-net-zero/road-zero-carbon-report

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offshore wind installed by 2030.[29] As of May 2025, the UK has approximately 30.7 GW of offshore wind capacity either operational or under construction, with an additional 7.2 GW having received consent. This totals nearly 38 GW in the pipeline, leaving a gap of 12 GW to meet the 2030 target.

Although there are other measures which contribute towards Net Zero and other sustainability goals, their impact is comparatively, and perhaps surprisingly, small when compared to the switch to an electric fleet.

It is important to remember that the above carbon reductions do not include those arising from the supply chain, which account for 83% of the total emissions. Supply chain emissions are those we do not control directly but which we can influence. Procurement policy is vital to this, ensuring that suppliers are implementing carbon reduction plans which align to the NHS Net Zero targets. Increasingly, suppliers will be required to calculate and report their carbon emissions to SCAS so that progress to reduce them can be measured.

The following section sets out the specific actions and initiatives which will be undertaken across SCAS over the next five years to implement the Carbon Reduction Plan and achieve the broader sustainability goals of the Green Plan.

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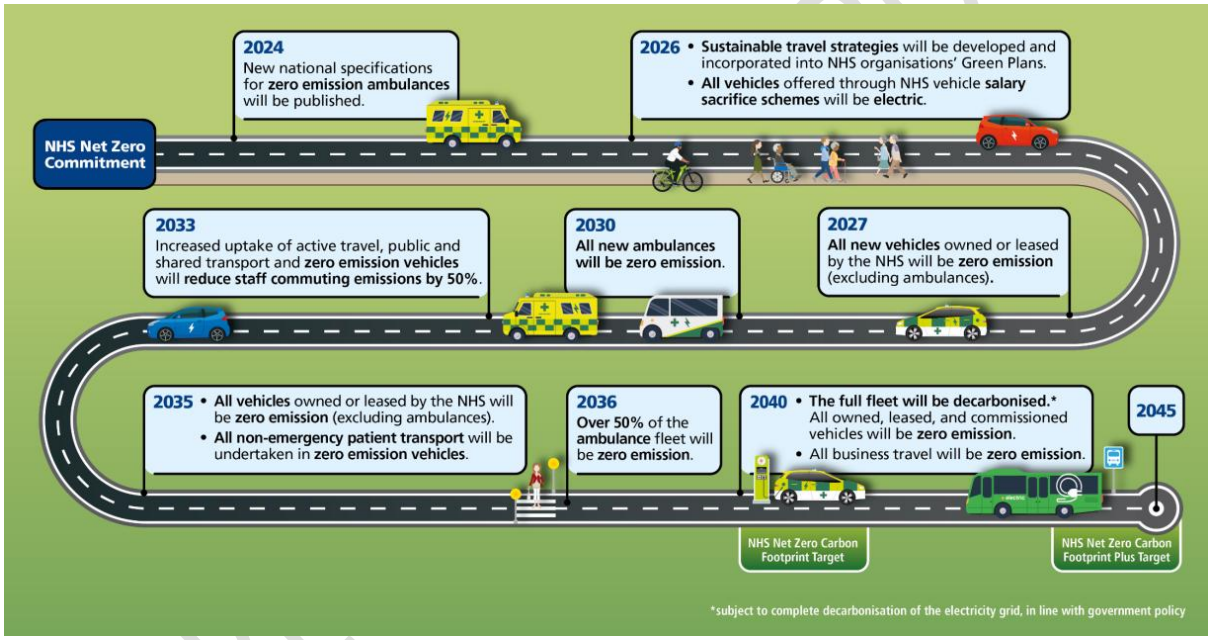
[29] National Grid, 2024, "*Moving towards Net Zero*", https://www.nationalgrid.com/electricity-transmission/who-we-are/riio-t2-performance/enable-ongoing-transition, accessed 27-11-24

4.2 Travel and Transport - Decarbonisation Roadmap

Transport related activities are responsible for the majority of carbon emissions for the Trust, accounting for 80% of **directly controlled** emissions and 74% of overall emissions, including those we **influence** (i.e. the supply chain). Investing in zero-emission vehicles for owned and leased fleets will ultimately eliminate the bulk of SCAS' carbon emissions. This will be a phased process, as older vehicles are retired from use and replaced by new electric vehicles, as mapped out by NHS England:

4.2.1 Roadmap to Net Zero Travel & Transport

The NHS Roadmap to Net Zero Travel & Transport[30] was published in October 2023, which sets out some important milestones:



The NHS will have fully decarbonised its non-ambulance fleet by 2035, with its ambulances following in 2040. Several key steps will mark the transition of NHS travel and transportation:

- By 2026, sustainable travel strategies will be developed and incorporated into trust and integrated care board (ICB) Green Plans.
- From 2027, all new vehicles owned and leased by the NHS will be zero emission vehicles (excluding ambulances).
- From 2030, all new ambulances will be zero emission vehicles.
- By 2033, staff travel emissions will be reduced by 50% through shifts to more sustainable forms of travel and the electrification of personal vehicles.

[30] NHS England (2023), "NHS Net Zero Travel and Transport Strategy",p18

The 2027 deadline has important ramifications for all Trusts, but particularly Ambulance Trusts.

Because Fleet accounts for such a large part of SCAS carbon emissions, the only way we can achieve our carbon reduction target is to aim for all new vehicles owned and leased by SCAS to be zero emission.

SCAS TARGET:

100% ELECTRIC FLEET BY 2028-2032 (excluding DCAs)

Our carbon reduction trajectory, ensuring a 47% reduction from the 2019/20 baseline, must fall between 2028 and 2032 to remain within mandated NHS targets. If we wait until the 2027 deadline for all new vehicles purchased and leased to be zero emission, it only leaves 5 years at most to achieve the target, assuming a replacement rate of 20% per annum. By starting sooner, the replacement rate will be more manageable.

Analysis of fuel card data (and apportioning this to bunker fuel use) indicates that non-ambulance emissions accounted for 5,780 tonnes CO_2 in 2024/25, which represents 34% of the SCAS Carbon Footprint.

The 2024/25 carbon footprint was 16,512 tonnes, with a target of 10,372 tonnes by 2028-32. To hit this target, SCAS needs to reduce its emissions by 6,140 tonnes by 2032.

Eliminating the 5,780 tonnes of emissions from the non-ambulance fleet will fulfil 94% of carbon reductions required to meet our target, assuming the electricity supply is fully decarbonised. In December 2024, the Government committed to achieve this by 2030.

Vehicles purchased by SCAS in the 2024/25 financial year will still be on the books in 2028/29 financial year, due to the 5-year procurement life cycle. Many of these are internal combustion engine, so a 100% electric fleet by 2028 will not be possible. However, the targets allow for the carbon reduction trajectory to fall within a window of 2028-2032. As all new vehicles purchased or leased from 2027 onwards (excluding DCAs) must be zero emission, it is realistic to assume that SCAS can meet its targets, providing sufficient charging infrastructure is in place.

Fleet Composition April 2025:[31] (*excluding* DCAs)

Diesel (excluding DCAs)	514	67%
Electric	36	5%
Hybrid	158	21%
Petrol	56	7%
Total:	764	

[31] Fleet Data Report 01/04/25

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4.2.2 Electric Vehicle Options including e-DCAs

Electric Double Crewed Ambulances are at trial stage, with London Ambulance Service putting the world's first fully electric ambulance into service on 1st January 2024.

SCAS is planning to acquire at least 5 eDCAs in late 2025 to begin its own trials. This represents an exciting opportunity for SCAS to be at the forefront of new and emerging technology. The trials will enable vehicle performance data to be gathered across urban, semi-rural and rural locations, which will help inform the operational model and planning for the EV charging infrastructure. A successful trial will see SCAS well placed for the rollout of electric DCAs, increasing the pace of carbon reduction.

Many viable options already exist for replacing the rest of the fleet, such as PTS and rapid response vehicles (RRVs), though the small number of heavier vehicles in the fleet may require alternative technologies, such as hydrogen fuel cell.

SCAS has been conducting successful trials of two fully electric Mental Health Rapid Response Vehicles as part of the ground-breaking national Zero Emission Electric Vehicle (ZEEV) Pathfinder Programme funded by NHS England, with 21 vehicles deployed across the UK.

4.2.3 Addressing Common Concerns with EVs

Carbon Footprint of EV Batteries

It is important to note that adopting EVs will not involve "outsourcing" carbon emissions from SCAS so it becomes someone else's problem. There are now concerted moves to bring EV manufacturing back from China and into Europe, where the embodied carbon in the new generation of batteries could be over 90% less than those made in China due to new low-carbon manufacturing techniques.[32]

When considering the embedded carbon in EVs, it must also be remembered that internal combustion-engined (ICE) vehicles also have a carbon footprint. The only difference is that one has an engine and a fuel tank, the other a motor and a battery. On leaving the factory gate, EVs have an initial higher carbon footprint than ICE vehicles due to the energy-intensive battery pack manufacturing processes. However, this is dwarfed by the operational CO_2 footprint of ICE vehicles burning fossil fuels throughout their lifetime, not to mention the wider environmental impacts associated with air pollution and fossil fuel extraction.

[32]Deger, F. & Schutte, M., 2022, "*Life cycle assessment of the energy consumption and GHG emissions of state-of-the-art automotive battery cell production*", https://www.sciencedirect.com/science/article/pii/S0959652621039731?ref=cra_js_challenge&fr=RR-1

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The initial 'carbon deficit' from manufacturing an EV only takes several thousand vehicle-miles to overcome according to research by Argonne National Laboratory in Chicago[33]. Depending on where the battery is made and how 'green' the energy grid is, EV carbon parity with ICE vehicles can be reached in as little as 8,000 miles, according to a European study conducted in 2020[34]. Since then, the pace of innovation has been rapid and battery production has been increasingly shifting from China into Europe, with 10 gigafactories already producing batteries and up to 40 planned to be operational by 2035[35].

Swedish battery giant Northvolt is currently producing EV battery cells with a carbon footprint of 33 kg CO_2e / kWh, two thirds less than the industry average, with plans to reduce this to 10kg CO_2e / kWh by 2030.[36] A 68kWh EV battery would have 680kg embodied carbon. This is equivalent to the emissions from burning 270 litres of diesel, or driving 2,488 miles in an average car.[37]

Battery Innovation

Innovations in battery design, such as solid-state technology, herald a transformation in weight, range and charging times, whilst eliminating the already low risk of fires posed by current lithium-ion batteries and significantly increasing the number of charging cycles a battery can withstand, therefore extending its lifecycle (and the life of the vehicle, which is of particular relevance to high mileage operators)

Many major manufacturers have now begun pilot production of solid-state batteries, including Nissan, Toyota, Samsung, SK, CATL, BYD and Prologium, with most planning to commence mass production in 2027[38].

Toyota has recently announced that it will be producing its first solid state battery-powered vehicles in 2027, with an anticipated range of 745 miles and 10-minute charging time[39].

Prologium has pioneered the development of mass-produced Lithium Ceramic Batteries, which it unveiled at the Paris Motor Show in 2024, promising fast charging from 5% to 60% in just 5 minutes and 80% in 8.5 minutes. Their new technology

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[33] When do electric vehicles become cleaner than gasoline cars? | Reuters, https://www.reuters.com/business/autos-transportation/when-do-electric-vehicles-become-cleaner-than-gasoline-cars-2021-06-29/

[34] Transport & Environment, 2020, How clean are electric cars?, https://www.transportenvironment.org/uploads/files/TEs-EV-life-cycle-analysis-LCA.pdf, accessed 04-11-24

[35] CATL plans Europe's biggest battery gigafactory, 2022, https://cen.acs.org/business/inorganic-chemicals/CATL-plans-Europes-biggest-battery/100/i29, accessed 04-11-24

[36] Northvolt, 2023, Sustainability and Annual Report 2023, https://www.datocms-assets.com/38709/1719998824-northvolt_sustainability_and_annual_report_2023.pdf, accessed 04-11-24

[37] Department for Energy Security & Net Zero, 2024, *UK Government GHG Conversion Factors for Company Reporting*.

[38] PV Magazine, 2024, "Solid-State batteries enter pilot production", https://www.ess-news.com/2024/10/31/solid-state-batteries-enter-pilot-production-costs-expected-to-drastically-drop/ , accessed 05-11-24

[39] Toyota Reveals the Future of Cars with Next-Generation Battery and Hydrogen Technologies (toyotatimes.jp), https://toyotatimes.jp/en/report/technical_workshop_2023/001_1.html#anchorTitles

increases energy density while maintaining fast-charging capability without degrading the battery.[40]

As the new generation of solid-state batteries evolves they are anticipated to have a higher energy density existing lithium-ion batteries, making them lighter and smaller. This has very positive implications for the development of electric ambulances, helping to address vehicle weight concerns.

EV Battery Recycling

It is a complete myth that EV batteries go into landfill at the end of their life, certainly within Europe:

The UK Waste Batteries and Accumulators Regulations 2009 made it illegal to send automotive batteries to landfill or dispose of by incineration.

The UK maintains regulatory alignment with the EU, which adopted Regulation (EU) 2023/1542 on 12 July 2023. Building on earlier legislation, this introduced comprehensive measures covering the entire lifecycle of batteries, including sustainability, safety, labelling and waste management[41].

The Regulation explicitly prohibits the disposal of industrial and automotive batteries in landfills or via incineration and promotes a circular economy by requiring that materials from end-of-life batteries be reclaimed and reused.

An emerging sustainable practice is to repurpose EV battery cells into battery energy storage systems (BESS). Even when they have degraded beyond the minimum performance requirements for a car, EV batteries typically retain a substantial portion of their storage capacity (up to 70-80%). This can significantly extend the useful life of batteries, before they are eventually recycled and the raw materials extracted to manufacture new batteries, supporting a more circular economy.

In October 2024, Mercedes-Benz opened Europe's first battery recycling plant with an integrated mechanical-hydrometallurgical process making it the first car manufacturer worldwide to close the battery recycling loop with its own in-house facility[42].

The facility has an expected materials recovery rate of more than 96 percent and net carbon-neutral operation, and is expected to generate enough recycled materials to produce more than 50,000 new battery modules per year.

Environmental Impact of Lithium Extraction

Lithium extraction has received increasing scrutiny and criticism for its environmental impact; the main method involves evaporation of brine containing lithium salt, in

[40] Prologium, 2024, Prologium Debuts World's First 100% Silicon Composite Anode, https://prologium.com/prologium-2024-paris-motor-show-pressrelease/, accessed 04-11-24

[41] Regulation (EU) 2023/1542 of the European Parliament and of the Council of 12 July 2023 concerning batteries and waste batteries, amending Directive 2008/98/EC and Regulation (EU) 2019/1020 and repealing Directive 2006/66/EC

[42] Mercedes-Benz, 2024, "Mercedes-Benz opens own recycling factory to close the battery loop", https://media.mercedes-benz.com/article/fe521181-3b57-4915-a51a-b5f6f352c574, article accessed 04-11-24.

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purpose-built lakes exposed to sunlight. There are concerns about high water consumption and impact on water tables in areas prone to drought, particularly in the 'Lithium Triangle' in South America, though this can be addressed by new direct extraction techniques[43]. Unlike fossil fuels, lithium only needs to be mined once as it can be recycled continuously, and its impact on the environment is minimal compared to the colossal damage associated with oil, coal and gas extraction, not to mention their CO_2 and particulate emissions when combusted.

The EU and UK are also in the process of diversifying the supply of rare earth elements away from dependency on China, to ensure a more economically, environmentally, and socially sustainable battery supply chain. This includes the new rare earth processing facility being constructed in the Humber Freeport, the first of its kind in Europe, with support from the UK Automotive Transformation Fund. It is expected to open in 2025/26. The ores will be sourced from a newly developed state-of-the-art mine in Longonjo, Angola, as part of an independent and sustainable supply chain to ensure a cost-effective, transparent and ultra-low embedded carbon range of rare earth products.[44] This also addresses concerns over the provenance of metals and associated workforce conditions.

Manufacturers are also experimenting with other materials for the cathode, such as sodium and iron, to move away from dependence on critical minerals such as cobalt.

The Grid Can't Cope with EVs…

The National Energy System Operator (NESO) is responsible for managing demand for electricity, making sure power is available when it's needed, second by second.

Most EV drivers charge their vehicles overnight at home using trickle chargers, when commercial demand on the grid is lowest.

Through smart charging, EVs can help to balance the system, helping consumers use green power when it's plentiful (and often cheaper) and avoid times when there's more load on the network. Vehicle-to-grid technology could even send that power back to the grid when needed. The UK Government has introduced Electric Vehicle Smart Charge Points Regulations to ensure that EV charge points include this smart functionality.

It's also important to bear in mind that a significant amount of electricity is used to refine oil for petrol and diesel. It is estimated that refining 1 gallon of petrol would use around 4.5kWh of electricity – so, as we start to fewer petrol or diesel cars, some of that electricity capacity could become available for charging[45].

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[43] Schlumberger, 2024, SLB achieves breakthrough results in sustainable lithium production, https://investorcenter.slb.com/news-releases/news-release-details/slb-achieves-breakthrough-results-sustainable-lithium-production, accessed 05-11-24

[44] Mining Weekly, 2023, "Pensana close to finalising $550m financing for Saltend, Longonjo", https://www.miningweekly.com/article/pensana-close-to-finalising-550m-financing-for-saltend-longonjo-2023-04-03

[45] National Grid, 2024, "Busting the Myths and Misconceptions about Electric Vehicles", https://www.nationalgrid.com/stories/journey-to-net-zero/electric-vehicles-myths-misconceptions

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The International Energy Agency reports that electricity consumption per capita in the United Kingdom has actually fallen by 32% since 2000[46]. However, the transition to electrified heating and transport systems will add significant demands to the grid.

The UK Government has committed to ambitious targets for the country to increase offshore wind from 30 GigaWatts (GW) installed capacity in 2025 to 50 GW by 2030[47].

4.2.4 The Role of Hydrogen

According to the Government's current Hydrogen Strategy, "Hydrogen is likely to be fundamental to achieving net zero in transport, potentially complementing electrification across modes of transport such as buses, trains and heavy goods vehicles (HGVs). It is also likely to provide solutions for sectors that will not be able to fully decarbonise otherwise, including aviation and shipping"[48].

The Government's Transport Decarbonisation Plan 2021 mapped out a realistic pathway to net-zero by 2050. The Government expects battery electrification to remain the dominant zero emission technology for passenger cars and vans. By contrast, "Hydrogen is likely to be most effective in transport in areas that batteries cannot reach, where energy density requirements or duty cycles, weight and volume restrictions and refuelling times make it the most suitable green energy source".[49]

The focus of hydrogen is on heavier modes of transport which require the energy density, rapid refuelling times and longer ranges afforded by hydrogen fuel cells. However, where possible, electrification is the better option due to its lower cost and higher "well to wheel" energy efficiency.

Electricity is always the starting point in any hydrogen manufacturing process, either through electrolysis of water using renewable electricity (green hydrogen) or steam reformation of methane (blue hydrogen). It then needs to be compressed and transported. Due to inefficiencies, heat losses and escape of gas at each stage, the resulting hydrogen will always cost more than electricity per unit of energy. Further costs are incurred if methane is used to make hydrogen, as the resulting CO_2 emissions will need to be captured and stored, otherwise it would continue to contribute to global warming in the same way as simply burning the methane.

There is already a comprehensive electrical distribution network in place, with EV chargers being installed at an exponential rate. According to ZapMap, at the end of

[46] IEA, 2024, Electricity consumption per capita, https://www.iea.org/countries/united-kingdom/electricity, accessed 21-11-24

[47] National Grid, 2024, Enable the ongoing transition to the energy system, https://www.nationalgrid.com/electricity-transmission/who-we-are/riio-t2-performance/enable-ongoing-transition, accessed 21-11-24

[48] HM Government, 2021, "UK Hydrogen Strategy", https://assets.publishing.service.gov.uk/media/64c7e8bad8b1a70011b05e38/UK-Hydrogen-Strategy_web.pdf, accessed 05-11-24

[49] Department for Transport (2021), "*Decarbonising Transport – A Better Greener Britain*", p71

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April 2025, there were 79,654 electric vehicle charging points across the UK, across 39,427 charging locations [50]. In addition to this, homeowners can install their own private charge points. The Government estimates there are 1.2 million EVs in the UK, the majority of which will have home charging available.

By contrast, as of November 2024 only seven publicly accessible hydrogen refuelling stations existed across the entire UK[51]. No hydrogen distribution network currently exists. It is envisaged that a few tens of kilometres will exist to support industrial clusters by 2030, but that potential national level distribution will not be available until 2050, according to the Hydrogen Strategy. The majority of the UK's existing hydrogen production is fossil-fuel based, though there are plans for half of production to be green by 2030.[52]

All these factors mean that hydrogen does not form part of the current NHS Net Zero Travel & Transport Strategy.

However, SCAS is planning to participate in research trials to ascertain the potential for hydrogen fuel cell range-extenders in predominantly rural areas where range is a serious problem, or for some of its heavier specialist vehicles.

4.2.5 Alternative Fuels - HVO

Hydrotreated Vegetable Oil (HVO) as a drop-in diesel alternative can serve as a "transitional" fuel to reduce carbon emissions whilst the fleet is electrifying, particularly useful if there are delays introducing electric DCAs or older vehicles are still in active use. It has a 90% lower net carbon footprint than diesel. Every 100,000 litres of HVO used to replace diesel directly saves 248 tonnes of CO_2. The Trust currently uses 4.16 million litres of diesel per annum. However, using HVO relies on manufacturers' consent to preserve vehicle warranties, which may not be forthcoming. However, HVO could still be effective in older and more polluting vehicles that have exceeded their warranty period.

Several local authorities, such as Horsham District Council, have successfully switched their entire fleets over to HVO as an interim measure.

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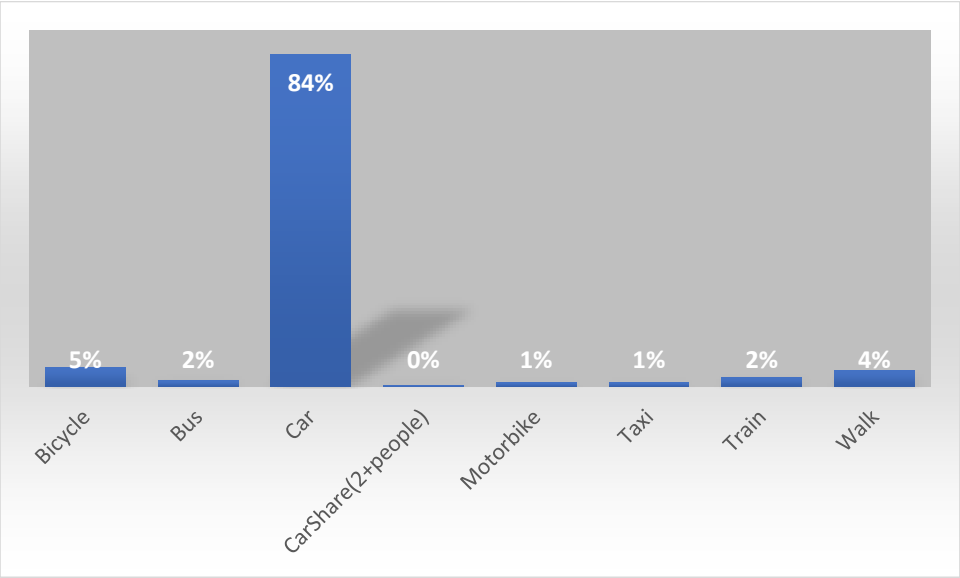
[50] ZapMap, 2024, "How Many Charging Points are there in the UK?", https://www.zap-map.com/ev-stats/how-many-charging-points, accessed 05-11-24

[51] Driving Electric, 2024, "Where can I buy hydrogen and where is my nearest hydrogen filling station?", https://www.drivingelectric.com/hydrogen/1363/where-can-i-buy-hydrogen-and-where-is-my-nearest-hydrogen-filling-station, accessed 05-11-24

[52] HM Government, 2021, Hydrogen Strategy, https://assets.publishing.service.gov.uk/media/64c7e8bad8b1a70011b05e38/UK-Hydrogen-Strategy_web.pdf, accessed 05-11-24

4.2.6 Modal Shift and Active Travel

A Travel Survey conducted in May 2023 indicated that 84% of staff commuting is by car:



There was considerable reluctance to change commuting habits, with over a third of respondents stating that nothing would persuade them to use public transport, whilst most sought improvements in fares, reliability and frequency of service before they would consider it.

There was a very positive response to switching to electric vehicles with two thirds stating they would definitely like to use or would consider using electric.

9% of respondents already cycle or walk to work, but only 25% of staff live within 5 miles of their usual place of work, so it is unlikely that this figure can be improved on by much. Many respondents cited issues such as childcare commitments, road safety, personal safety during antisocial work hours, carrying equipment, and distance as reasons why they could not consider cycling or walking to work.

Switching to electric vehicles will achieve the greatest reduction of carbon emissions from staff travel, though the Trust must encourage and facilitate alternatives for active travel as far as possible, to give staff more choice. If someone can walk or cycle for only one or two days a week, this will improve their health, save them money and help to reduce their carbon footprint.

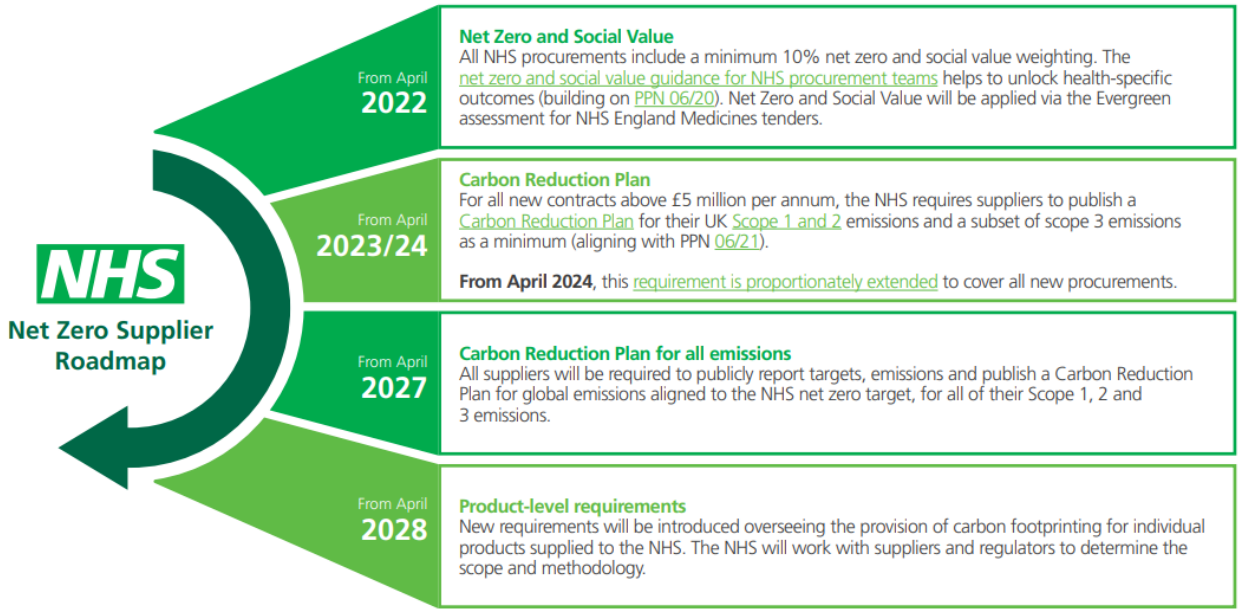
4.2.7 Reducing Business & Staff Travel Emissions

Teams meetings can reduce unnecessary business travel, as long as this does not conflict with other SCAS policies for managers to be more visible in workplaces. The Travel Survey revealed that there is some scope to reduce business travel, with 16% of respondents stating they could possibly reduce the number of meetings they attend in person.

4.3 Supply Chain and Procurement

To help suppliers align with our net zero ambition between now and 2030, NHS England Public Board has approved a roadmap setting out the evolution of Government procurement policy towards Net Zero procurement:

4.3.1 Net Zero Supplier Roadmap



From April 2022: All NHS procurements include a minimum 10% net zero and social value weighting.

From April 2023: for all new contracts above £5 million per annum, the NHS requires suppliers to publish a Carbon Reduction Plan for their UK Scope 1 and 2 emissions and a subset of Scope 3 emissions as a minimum (aligning the NHS with Procurement Policy Note PPN06/21 – Taking Account of Carbon Reduction Plans in the Procurement of Major Government Contracts). The Carbon reduction plan and net zero commitment requirements for the procurement of NHS goods, services and works guidance outlines what is required from suppliers and how it should be implemented.

From April 2024: The NHS has proportionately extended the Carbon Reduction Plan requirements to cover all new procurements.

From April 2027: All suppliers will be required to publicly report targets, emissions and publish a Carbon Reduction Plan for global emissions aligned to the NHS net zero target, for all of their Scope 1, 2 and 3 emissions.

From April 2028: New requirements will be introduced overseeing the provision of carbon footprinting for individual products supplied to the NHS. The NHS will work with suppliers and regulators to determine the scope and methodology.

From 2030: Suppliers will only be able to qualify for NHS contracts if they can demonstrate their progress through published progress reports and continued carbon emissions reporting.[53]

4.3.2 Applying Net Zero & Social Value to Procurement of NHS Goods and Services

NHS England's stated policy objective is to meet its Net Zero carbon targets while achieving its wider Social Value priorities. In 2022, it clarified this further:

"The principal aim of procurement undertaken by NHS organisations is to deliver essential goods and services and improve patient outcomes, while increasing value from every pound spent in the NHS. NHS procurement also has an essential role to play in the delivery of the NHS commitment to reach net zero by 2045, as more than 60% of NHS carbon emissions occur in the supply chain. Social value, when incorporated effectively, will help reduce health inequalities, drive better environmental performance, and deliver even more value from procured products and services."[54]

From April 2022, all NHS procurements must include a **minimum 10% net zero and social value weighting**.

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[53] NHS England 2021, "*Net Zero Supplier Roadmap*", https://www.england.nhs.uk/greenernhs/get-involved/suppliers/, accessed 28-11-24

[54] NHS England 2022, "*Applying net zero and social value in the procurement of NHS goods and services*", https://www.england.nhs.uk/greenernhs/wp-content/uploads/sites/51/2022/03/B1030-applying-net-zero-and-social-value-nhs-goods-and-services.pdf

There are five Social Value Themes, of which Fighting Climate Change is compulsory in all contracts:

Social Value Model Theme	NHS Priority Areas
1. Fighting Climate Change (**must** be included in all procurement)	• Reduce emissions • Reduce air pollution • Promote circular economy principles • Reduce consumption and waste
2. Wellbeing	• Support physical & mental health
3. Equal Opportunity	• Support a diverse workforce • Equity by design • Eliminate modern slavery
4. Tackling Economic Inequality	• Employment as an economic and health intervention • Living wages
5. COVID-19 Recovery	• Supports individuals affected by COVID-19

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4.3.3 NHS supplier Carbon Reduction Plan and Net Zero Commitment

This sets out the supplier requirements for a Carbon Reduction Plan and Net Zero Commitment for the procurement of NHS goods, services and works[55].

From 2023, for all new contracts above £5 million per annum, the NHS required suppliers to publish a Carbon Reduction Plan for their UK Scope 1 and 2 emissions and a subset of Scope 3 emissions as a minimum. This aligned the NHS with Procurement Policy Note PPN06/21 – Taking Account of Carbon Reduction Plans in the Procurement of Major Government Contracts.

From April 2024: The NHS has proportionately extended the Carbon Reduction Plan and Net Zero Commitment requirements to cover all new procurements:

[55] NHS England 2024, "*Carbon reduction plan and net zero commitment requirements for the procurement of NHS goods, services and works*", https://www.england.nhs.uk/long-read/carbon-reduction-plan-requirements-for-the-procurement-of-nhs-goods-services-and-works/, accessed 28-11-24

Policy Application	Procurements in Scope	Implementation Date	Procurement Stage	Demonstration of Commitment
Carbon Reduction Plan (CRP) requirement	Contracts ≥ £5m per annum (exc. VAT)	1 April 2023	Pass/fail check in Standard Selection Questionnaire	URL provided as part of the Selection Questionnaire
	New frameworks where it is anticipated that the individual value of any contract to be awarded under the agreement is £5m per annum (exc. VAT) or more			
	All new frameworks operated by in-scope organisations, irrespective of the value of the contract	1 April 2024		
Net Zero Commitment requirement	Contracts below £5m per annum and above £10k (exc. VAT)	1 April 2024 – for contracts above the relevant Public Contracts Regulations (PCR) threshold	Pass/fail check in Standard Selection Questionnaire	URL of the commitment shared upon contract award
		1 April 2026 – for contracts below the relevant PCR threshold	Condition of Award	

A **Carbon Reduction Plan (CRP)** identifies a supplier's current carbon footprint and their plan to achieve net zero emissions by 2050 or earlier for their UK operations.

The supplier will be expected to provide their baseline and current emissions for the sources included in scope 1 and 2 of the GHG Protocol and, at a minimum, the five GHG Protocol scope 3 categories of:

- upstream transportation and distribution
- waste generated in operations
- business travel
- employee commuting; and
- downstream transportation and distribution.

Suppliers will also need to identify environmental management measures in effect, including any certification scheme (e.g. ISO14001), and specific carbon reduction measures adopted.

A **Net Zero Commitment** is a publicly stated commitment to achieve net zero by 2050 or earlier, and a confirmation that the supplier is taking steps to reduce their

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GHG emissions over time. It does not involve the detail required of a CRP and applies to lower value contracts.

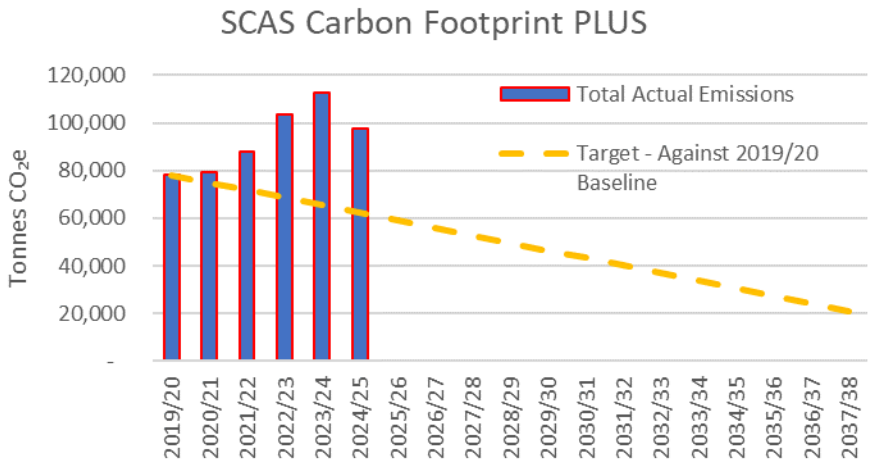
A 'Net Zero Commitment' is required for all new procurements above the relevant threshold up to the value of £5M per annum, where it is deemed that CRP requirements not to be proportionate and relevant to the nature of the framework.

To comply with the NHS Net Zero Commitment requirements, a supplier can state:

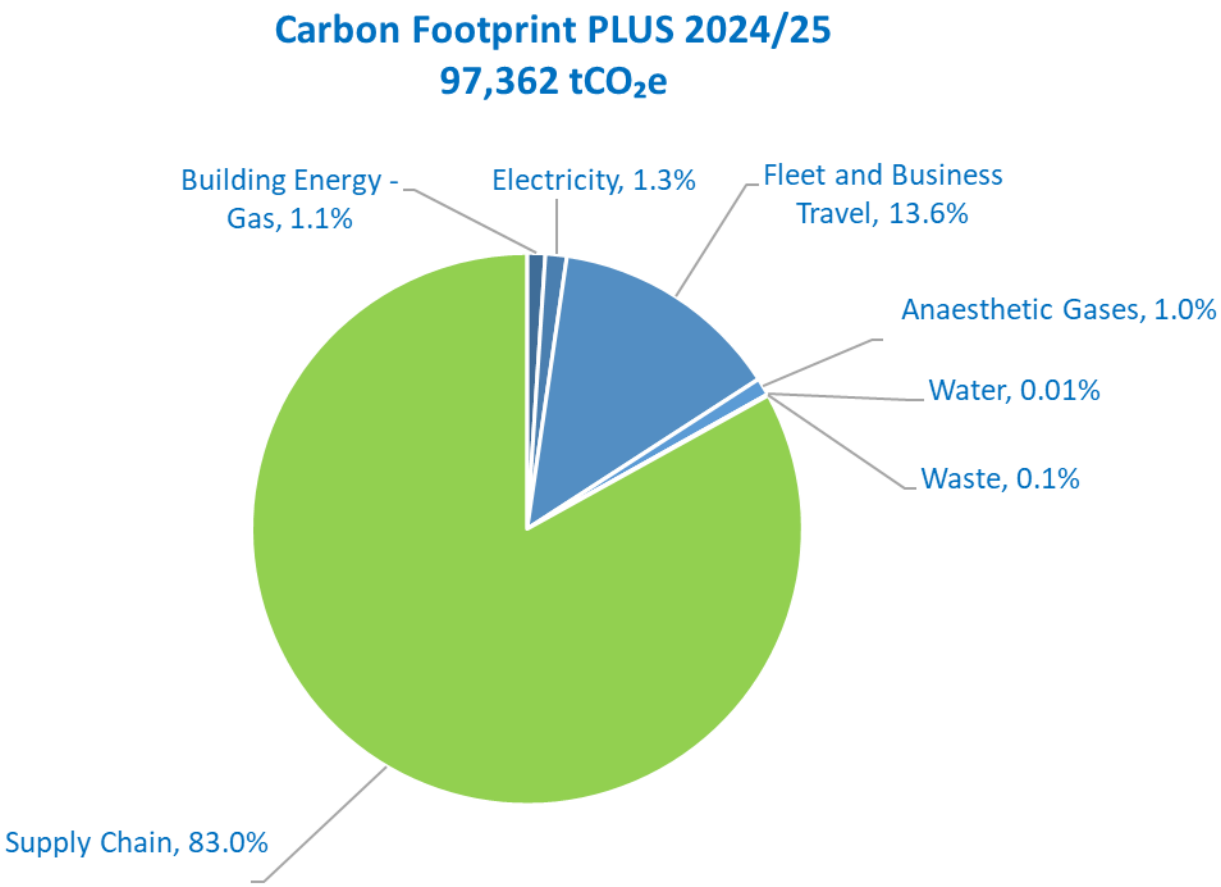
> "*[Supplier name]* is committed to achieving Net Zero emissions by 20XX for emissions scopes X, X and X. The commitment was made on DD/MM/YY by the *[approving board/equivalent management body]*"

4.3.4 Decarbonising the SCAS Supply Chain

Emissions from SCAS supply chain are included in the Carbon Footprint PLUS, which includes all the emissions we control directly (our Carbon Footprint) ***plus*** all the emissions we influence via the goods and services we purchase. Unfortunately, since 2019/20 these emissions have risen significantly (though appear to have peaked in 2024/25):



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The supply chain accounts for 83% of SCAS' total Carbon Footprint **PLUS** emissions.

At first glance, it seems that Fleet & Business Travel is a low proportion of emissions, but we also know from the analysis undertaken by CO_2Analysis / GreenInsight that **74%** of the Carbon Footprint PLUS is related to transport activities and that **all** of the increase in emissions since 2019/20 is attributable to transport.

This is a really encouraging insight for SCAS, as we know that transport emissions can be eliminated through fleet electrification.

NHS organisations can use their individual or collective purchasing power and decisions to reduce the carbon embedded in their supply chains. Ambulance trusts will be able to influence transport service providers via contractual obligations to transition to zero emission fleets, which will transform the trajectory of the SCAS Carbon Footprint PLUS and put us back on track to meet our Net Zero target of 2045.

Whilst the overwhelming focus for SCAS will be on reducing transport-related emissions, carbon emissions also arise from less obvious activities, such as medical supplies and data processing and storage. Data centres and data transmission accounted for 3% of global electricity demand and 1% of global greenhouse gas emissions in 2022. To put this into context, the entire aviation industry accounts for

1.9% of total global emissions [56]. Sending a single email can add 26g to the carbon footprint[57], which may come as a surprise to many.

Along with other suppliers, data centre service providers will need to demonstrate that they are implementing their own carbon reduction plans and report their progress back to SCAS.

The procurement contract tender process offers opportunities to:

- Reduce the use of clinical and non-clinical single-use plastic items
- Use lower carbon alternative supplies, such as recycled paper or products with a lower environmental impact
- Reduce or eliminate waste going to landfill

4.4 Estates

(With reference to the August 2021 Estates Net Zero Delivery Plan[58]):

4.4.1 Installing the EV Charging Infrastructure

42 new EV charge points were installed in the 2024/25 financial year, bringing the total available to 93, the majority being 22kW output. This has largely exhausted the available electrical supply capacity across the SCAS estate and any further additions to the EV charging infrastructure will require DNO supply capacity upgrades such as new substations and high / low voltage cabling.

To support electrification of the fleet, it is essential to establish the number and capacity of chargers required. At the end of 2024/25 financial year, the total fleet comprised 1,154 vehicles[59]. Modelling must consider future requirements (e.g., changes to PTS contracts, and the Fit for the Future modernisation programme), daily operational requirements and the specification for electric Double Crewed Ambulances.

The charging requirements will be data driven and informed by the Emergency Vehicle Recharging Infrastructure Tool (EVRIT) developed by NHS England in conjunction with Cenex. This model estimates electrical demand for a fully electric ambulance fleet by calculating most of its outputs on a per-vehicle basis, then multiplying by the maximum number of vehicles onsite, using data supplied by Fleet.

The model has produced estimates of the peak demand and **minimum** infrastructure needed.

[56] IEA (2022), Data Centres and Data Transmission Networks, IEA, Paris https://www.iea.org/reports/data-centres-and-data-transmission-networks, License: CC BY 4.0

[57] Mike Berners-Lee (2020) "*How Bad are Bananas? The carbon footprint of everything*", cited in OVO Energy, *The Carbon Footprint of the Internet*, https://www.ovoenergy.com/blog/green/the-carbon-footprint-of-the-internet

[58] NHS England (2021), "Estates Net Zero Carbon Delivery Plan", PAR1059.

[59] Fleet Data Report 01/04/25

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Opportunistic Charging Model

The model assumes that sites with EV chargers are supporting an opportunistic charging strategy, where ambulances top up their battery during every eligible visit to an NHS site, rather than relying on a long recharge period (e.g. overnight charging). The underlying assumption of the model is that ambulances arriving at one site have access to opportunistic charging at any other hospital or ambulance station they visit, so charging infrastructure requirements at hospitals are also included in this model. SCAS will need to liaise with hospitals to ensure that adequate infrastructure is provided, as they are essential for the viability of this EV charging model.

Previous analysis work by Cenex on historic ambulance journeys has suggested that supplying every ambulance with ultra-rapid chargers is not always required to support fleet charging. A more efficient approach may be to deploy managed charging hubs across an estate: providing enough sockets to ensure every vehicle could be plugged in at peak times, whilst prioritising charging of low state of charge (SoC) vehicles, linked with more intelligent dispatch information accounting for each vehicle's battery and charging status. On this basis, 22kW chargers may be adequate in most cases.

Installation Costs

Installation costs are approximations only, to provide an estimate at 2024 prices from blended costs across a number of suppliers. It is important to note that these **do not include any grid upgrade costs**, which may double the costs shown. Actual costs will be site specific and also dependent on hardware and software specifications.

The estimated costs include:

- A distributed energy system where the power required at site is a distributed from a central power unit across multiple DC (direct current) charging sockets
- Hardware: DC power modules with the capability to dynamically load manage each charging socket, Charging sockets costs
- Installation: Typical costs for installation and groundworks associated with the hardware
- Chargepoint management: Software costs for enabling dynamic management and performance of each charging socket
- Maintenance: Annual equipment maintenance cost

*The estimated costs produced by EVRIT do **not** include VAT

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	SCAS Resource Centre	Existing Installed Charging Capacity (Nov 24) kW	Recommended Minimum Site Charging Capacity kW (EVRIT)	Estimated Installed Infrastructure Net Cost £ (EVRIT)
1	*Abingdon Fleet Services OX14 4SD (part of SCFS)	0	434	£166,000
2	Adderbury RC OX17 3FG	33	355	£215,000
3	Alton RC	0	311	£188,000
4	Andover RC SP10 3RJ	0	311	£188,000
5	Basingstoke RC RG24 9LY	40	355	£215,000
6	Bracknell RC RG12 7AE	33	355	£215,000
7	Cosham Northarbour RC PO6 3TJ	0	761	£484,000
8	Didcot RC OX11 8RY	11	355	£215,000
9	High Wycombe RC HP11 2JQ	0	398	£229,000
10	Hightown RC SO19 0SA	33	355	£215,000
11	Hythe RC SO45 5GU	0	159	£100,000
12	Kidlington RC OX5 1RF	33	355	£215,000
13	Lymington	0	214	£131,000
14	Milton Keynes Blue Light Hub	7	355	£215,000
15	Newbury RC RG14 1LD	22	355	£215,000
16	Nursling RC SO16 0YU	0	553	£345,000
17	Oxford City RC OX3 7LH	22	355	£215,000
18	Petersfield RC GU31 4AN	0	159	£100,000
19	Reading RC RG1 7DA	0	311	£188,000
20	Ringwood RC BH24 3EU	0	159	£100,000
21	Southampton LPU SO16 0BT	7	Not included for EVRIT as not frontline	

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22	Stoke Mandeville RC HP21 8BD	0	398	£229,000
23	Wexham Park RC SL3 6LT	22	398	£229,000
24	Whitchurch RC RG28 7BB	0	159	£100,000
25	Winchester & Eastleigh RC/HART SO50 4ET	40	311	£188,000
			Total SCAS Estate:	**£4,900,000**
1	**HOSPITALS:**			
2	John Radcliffe		214	£131,000
3	Horton		159	£100,000
4	Luton & Dunstable		478	£287,000
5	Stoke Mandeville		214	£131,000
6	Wexham Park		159	£100,000
7	Bedford MK		214	£131,000
8	Basingstoke & NH		214	£131,000
9	Royal Hampshire		214	£131,000
10	Portsmouth		355	£215,000
11	Royal Berkshire		214	£131,000
12	Southampton General		214	£131,000
			Total Hospitals:	**£1,619,000**
			Total Cost	**£6,519,000**

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*Abingdon Fleet Services is part of South Central Fleet Services Ltd. and was not included in the EVRIT model, but an estimate has been prepared based on the maximum charging capacity available for the site.

Total estimated EV infrastructure cost: £6,519,000 +VAT = £7,822,800

Total recommended charging capacity: 10,881kW

Average estimated cost to install: £719 / kW

This is lower than the average installed cost to date (£1,085/kW), which may reflect economies of scale, though allowance should be made for future inflation over a multi-year project, as the EVRIT model provides assumptions based on current prices only. To date, SCAS has installed only 3% of the minimum recommended capacity to support a fully electric fleet.

Additional Costs – DNO supply upgrades

The EVRIT model advises that grid upgrade costs "may double the costs shown". Therefore, SCAS should make provision for a **minimum** total EV infrastructure budget of **£15,645,600** at 2024 prices, as well as a sum for contingency and supply chain inflation. With 10% contingency and 10% inflation over 5 years, this amounts to **£18,774,720.**

4.4.2 Open Charge Point Protocol and Back Office Software

The success of the EV programme depends on having an effective back-office function to collect data, manage physical access to charging points and maintain financial controls. Ensuring that all charging equipment meets with Open Charge Point Protocol (OCPP) standards as approved by the Open Charge Alliance will future proof the EV charging infrastructure, allowing a range of equipment to communicate seamlessly with OCPP compliant software or online portals. This will be implemented by Estates as part of the installation commissioning process but managed by Fleet Services on an operational basis (with input from Finance).

For Estates to deliver a successful EV charging infrastructure programme, it is vital that Fleet Services share information on vehicle numbers, locations and movements, along with the desired ratio of vehicles to chargers, so that operational need is matched with provision as far as practicable within the constraints of the estate portfolio. Estates also needs to be advised of operational requirements when planning the future configuration of the portfolio in the **SCAS Fit for the Future Modernisation Programme**.

4.4.3 EV Charging Policy

As EVs are increasingly adopted by staff, access to chargers will become of increasing concern. EVs offer huge opportunities to reduce the emissions associated with business travel and commuting. Whilst frontline operations will be prioritised, the need to provide access for some staff vehicles on a carefully managed basis will grow. This requires adoption of a SCAS policy governing access to charge points, including charging rates for personal vehicles, requiring input from all affected departments, such as Estates, Operations, HR and Finance.

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4.4.4 Managing Fire Risk

The estate must also consider the different type of fire risk posed by electric vehicles compared to internal combustion engine vehicles. Whilst the incidence of fire is much lower for EVs, the severity of the blaze is often worse and harder to extinguish. Professional advice from fire safety experts will be required to manage this different type of risk appropriately, particularly at locations where vehicles are being charged inside buildings.

To determine the risk of EV fires, researchers on behalf of the US car insurance market have examined data from the National Transportation Safety Board (NTSB), Bureau of Transportation Statistics (BTS), and government recall data from Recalls.gov.[60] The data included all the causes of fire, such as collisions, electrical failures, oil or fuel leaks, poor maintenance, vehicle battery damage, and smoking cigarettes. They concluded that the fire risk from 100% electric vehicles was far lower than other vehicle types:

Fuel Type	Fires per 100k sales	%
Hybrid	3,474.5	3.47%
Petrol	1,529.9	1.53%
100% Electric	25.1	0.025%

Tesla have also released their own data from vehicle telemetry, which shows that from 2012 – 2021, there has been approximately one Tesla vehicle fire for every 210 million miles travelled. By comparison, data from the National Fire Protection Association (NFPA) and U.S. Department of Transportation shows that in the United States there is a vehicle fire for every 19 million miles travelled.[61] This implies over a 90% reduction in fire risk per mile travelled by Teslas.

The new generation of solid-state batteries being developed will ultimately eliminate the fire risk from flammable electrolyte, with French company Bolloré already testing prototypes and new Spanish gigafactory firm Basqevolt due to commence production in 2027[62]. Global production data shows many major manufacturers in pilot production phase and planning mass production from 2027 onwards[63]:

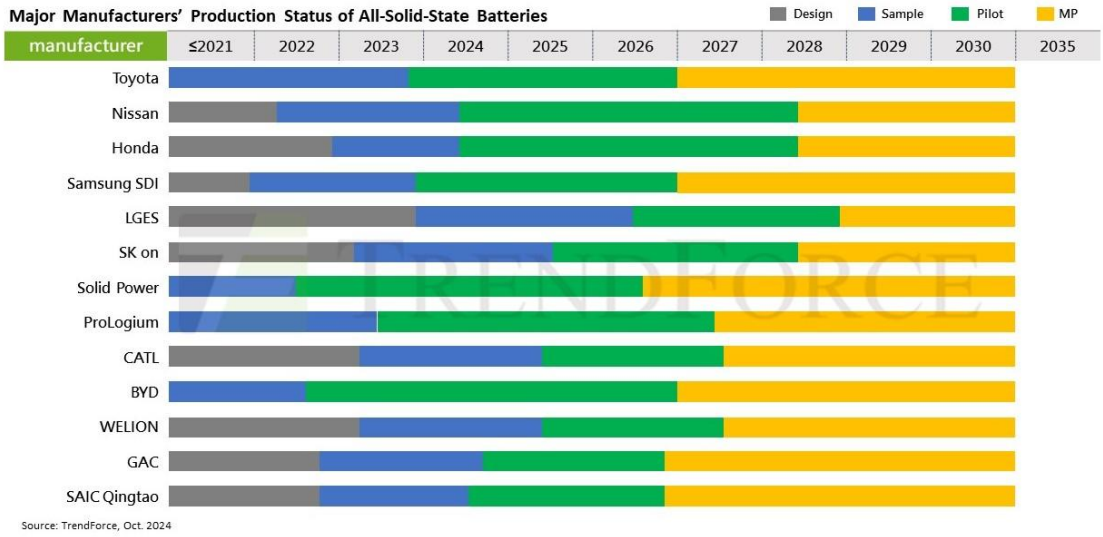
[60] AutoinsuranceEZ, 2023, "*Gas vs. Electric Car Fires [2023 Findings]*", https://www.autoinsuranceez.com/gas-vs-electric-car-fires/

[61] Tesla, 2023, "*Vehicle Safety Report*", https://www.tesla.com/VehicleSafetyReport

[62] European Battery Alliance, 2023, "Solid-state batteries on the rise in Europe", https://www.eba250.com/solid-state-batteries-on-the-rise-in-europe/

[63] Trendforce, 2024," Solid-State Batteries Enter Pilot Production", https://www.trendforce.com/presscenter/news/20241031-12346.html, accessed 28-11-24

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4.4.5 Solar PV and Battery Energy Storage Systems

Investing in on-site generation using solar PV will offset some of the cost of increased electricity demand from EVs and heat pumps. Every kWp of solar PV installed saves a UK average of 164kg CO_2 per annum[64], equivalent to £182 savings[65]. However, the more southerly location of SCAS achieves a higher solar yield, so each megawatt peak (MWp) installed could save up to 191 tonnes CO_2 per annum and £212,000 annual benefit, assuming SCAS can use all the generated electricity.

In practice, electricity generation from solar PV will not always match consumption patterns; in the summer months, more electricity will be generated than is being used on site, so the excess will be exported into the grid. Although the grid pays for the electricity, it is at a far lower rate per unit (typically 6p/kWh) than what SCAS pays to buy back the electricity later in the day (23p/kWh).

Investing in a battery energy storage system will minimise the amount being exported and ensure that SCAS derives maximum benefit from the solar PV.

Winchester & Eastleigh Resource Centre (WERC) has become the first SCAS site to be equipped. A 277kWp solar PV system was installed in April 2025, along with a 345kWh battery system, yielding projected annual savings of £41k per annum. This assumes some electricity would still be exported at 6p/kWh based on existing consumption patterns. However, the increased future needs of EV charging will ensure that no electricity is exported, and the total savings will increase by an extra £16k to give potential annual savings of £57k.

[64] https://pvfitcalculator.energysavingtrust.org.uk/

[65] Assumes rate of £0.23/kWh and specific annual yield of 923kWh/kWp installed and that all energy generated is used on site.

345kWh Battery System at Winchester & Eastleigh Resource Centre, using Lithium Iron Phosphate chemistry:



277kWp Solar PV system at Winchester & Eastleigh Resource Centre:



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Investing in solar PV with battery energy storage represents excellent value for money, allowing SCAS to realise significant annual savings whilst contributing to the decarbonisation of the Trust.

Installation costs for Solar PV range from £660/kWp to £1,000/kWp, depending on the scale of the installation and complexity. Smaller sites will incur higher costs, whereas larger sites will benefit from economies of scale.

If SCAS aims to install 2MWp of solar PV at a mid-range cost of £830/kWp, it should budget £1.66million + VAT= **£1.992million**. This will provide coverage of a roof area equivalent to 8x that of WERC.

Installing 8x the battery capacity (2.76MWh) will cost an estimated **£1.44million** inc. VAT.

SCAS should prioritise larger sites initially to keep costs down and optimise yields, with the savings used to fund the installation of solar in smaller sites later on. SCAS has been successful in securing £1.2million GB Energy funding to install Solar PV in 4 Resource Centres. Centres with EV charging represent excellent candidate sites due to their higher electrical demand.

As the rollout of EVs continues, there will be a transfer in cost from fossil fuels to electricity, some of which can be offset directly by Solar PV. The call centres are operating 24/7, so onsite generation and storage can also mitigate some of these running costs, even if the solar PV is located at other sites.

In addition to optimising the performance of Solar PV, investing in battery storage systems will also provide resilience and reduce pressure on the grid during peak demand periods.

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4.4.6 LED lighting and “Daylight Harvesting”

In efforts to make every kWh count, investing in no-regrets energy saving measures, such as LED lighting offer excellent financial returns whilst minimising the carbon footprint of lighting. Approximately 70% of the estate is now fitted with LEDs. Prior to the installation of LEDs, it is estimated that 35% of the electricity consumption was lighting[66], contributing about 2-3% to the overall direct carbon footprint. Completing this programme should save up to 1% of the carbon footprint, around 165 tonnes CO_2e per annum.

Lighting and Lighting Control

[66] https://www.nextsystems.co.uk/blog/electrical/why-use-led-lighting-in-your-office/#:~:text=On%20average%2C%20for%20many%20UK%20businesses%2C%20lighting%20takes,as%20much%20as%2035%25%20of%20their%20electricity%20consumption.

A sustainability feasibility study conducted for the Winchester & Eastleigh Resource Centre noted that existing LED lighting had been installed as a replacement when existing lighting units expire. Although well-intended, this *ad hoc* approach has led to a mismatch of various lighting throughout the building. It was also observed that many areas still retained fluorescent lighting.

The report recommended "wholesale replacement would provide better lighting conditions throughout and tailor the new lighting system for the current use of the areas, with better lighting in training areas and workshop. Replacing the LEDs would allow for better control, including the integration of daylight sensors and Passive Infra-Red (PIR) controls, and would yield significant operational savings if done as part of a coordinated project rather than through incremental maintenance. Newer LED models are also more efficient, further reducing energy consumption. Existing LEDs that have been recently installed could be reused in key areas, avoiding waste. The installation of sun pipes in the main office area could be considered as they would enhance lighting levels whilst reducing energy consumption."

An analysis of energy consumption of the existing lighting revealed that considerable energy savings could be achieved by installing a new LED system which would respond to natural daylight levels and room occupancy:

Winchester & Eastleigh RC	Total Annual Running Cost (inc. maintenance)	Total Annual Emissions tCO_2e
Existing lighting system	£45,219	43.8
New "Daylight Harvesting" smart LED system	£13,192	8.2

Estimated annual savings from upgrading the LED lighting of £32,027 mean that the new system could pay for itself within 2 years, based on a cost of £56k, and reduces carbon emissions from lighting by 81% at current grid carbon intensity.

If similar smart lighting systems were installed across the Trust, the cumulative financial and carbon savings would be significant, especially with a 10-year system warranty. Larger buildings in the Trust include 23 resource centres, 2 data centres, and 2 head offices/EOCs. Assuming a similar average cost, an investment of **£1.8 million** should pay for itself in 2-3 years and contribute towards Net Zero targets by reducing lighting emissions significantly.

A £494k grant from the National Energy Efficiency Fund was obtained in January 2025 to fit smart LED lighting across the estate, commencing with Winchester & Eastleigh and Cosham sites.

4.4.7 Waste Management

Improving waste management offers considerable potential annual savings and reductions in carbon emissions for SCAS, particularly if we fully adopt the

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recommendations of Health & Technical Memorandum (HTM) 07-01, Safe and Sustainable Management of Healthcare Waste.

This aims to implement the NHS Clinical Waste Strategy, which aims to eliminate avoidable waste and support efforts to prevent "offensive" waste being incorrectly classified and segregated as "infectious" waste in order to improve the effectiveness of waste management systems and reduce costs.

The following targets are set out:

- 20% of waste segregated to be sent to incineration, with only 4% of that being hazardous/clinical incineration
- 20% of waste segregated to be sent to alternative treatment
- 60% of waste segregated to be classified as offensive waste[67]

Currently, SCAS does not segregate any of its waste as "offensive", with the result that all waste is either sent to high temperature incineration or alternative treatment. This is expensive and produces a high carbon footprint. Offensive waste can be disposed of by sending to Energy from Waste (EfW) facilities where it can be burnt to generate electricity. HTM07 recommends that EfW should be the most commonly used option for offensive waste and non-recyclable domestic waste because it provides an opportunity to recover energy and resources. [68]

SCAS needs to update its Waste Policy to reflect the recommendations for Ambulance Trusts as outlined in HTM07.

4.4.8 Additional Sustainability Measures

In addition to supporting the priority of Fleet electrification, Estates has a vital function to play in meeting sustainable objectives by:

- Preparing buildings for electricity-led heating by upgrading building fabric (insulation, ventilation, double glazing etc.)
- Switching to non-fossil fuel heating: Investing in heat pumps
- Reducing water consumption and cost by installing rainwater harvesting in buildings with high usage, particularly resource centres with ambulance washing facilities: Cosham, Nursling RC, Portsmouth PTS, Bracknell RC and Ringwood RC use a combined 7,409m³ of water per annum. If 50% of this could be saved through rainwater harvesting, 3,705m³ of water would be preserved, enhancing water resource sustainability. The carbon saving would be 1.56 tonnes CO_2e.

[67] NHS England (2022), "Health Technical Memorandum 07-01: Safe and sustainable management of healthcare waste", https://www.england.nhs.uk/wp-content/uploads/2021/05/B2159iii-health-technical-memorandum-07-01.pdf, p10
[68] Ibid., p27

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- Building design and refurbishments: “Replace like with unlike” and ensure compliance with the Net Zero Building Standard 2023[69], which mandates achieving BREEAM Excellent for all new buildings and BREEAM Very Good for refurbishments, as a **minimum**.[70]
- Incorporating Green clauses into lease agreements, per the NHS Memorandum of Understanding Documents PAR1594(iii and iv)[71]
- Using HVO fuel for back-up power generators: sustainable, 90% less carbon, no fuel polishing costs, and 10-year shelf life.
- Preparing the estate for severe weather / creating a climate change adaptation plan, especially in light of increased flooding events.
- Committing to active travel, especially providing the infrastructure for cycling. This extends beyond bike racks and includes facilities for showering and secure locker storage.
- Assessing opportunities for tree planting

4.5 Workforce and System Leadership

- Create Net Zero Committee with regular meetings to monitor and deliver the Green Plan
- Named Board level SRO for Sustainability
- Increase staff awareness of Sustainability – access sustainability training via ***“Building a Net Zero NHS”*** eLearning module” on ESR
- Regular communication via Staff Matters / Yammer / Viva Engage
- Regular Travel Surveys
- Create network of “Green Champions” to identify and promote sustainability micro-initiatives, e.g. ensuring waste goes into the correct recycling bins, lights are turned off, windows are closed to save heat
- Implement an ISO14001-compliant Environmental Management System

4.5 Digital Transformation

Care Pathways

The direct alignments between the digital transformation agenda and a Net Zero NHS are clear. The SCAS policy of Hear & Treat, as outlined in the Improvement Programme (01/10/22)[72] to deliver some care remotely saw over 14% of 66,200 calls

[69] NHS England (2023), “Net Zero Building Standard 2023”, https://www.england.nhs.uk/wp-content/uploads/2023/02/B1697-NHS-Net-Zero-Building-Standards-Feb-2023.pdf
[70] Ibid., p132
[71] NHS England (2022), “Green Lease - Provisions for inclusion in Lease of Part of Commercial Premises”, PAR1594-iv, https://www.england.nhs.uk/wp-content/uploads/2022/06/B1594-iv-model-form-green-lease-clauses-template.pdf
[72] SCAS Improvement Programme Briefing, 01/10/22, p12

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dealt with remotely during January – March 2025. This represented over 9,000 saved vehicle journeys and freed up those resources to be allocated to other urgent cases.

JANUARY – MARCH 2025
66,200 calls
43,000 incidents
14% Hear & Treat 32% See & Treat 50% treated and taken to A&E 4% treated and taken to other services

Datacentre & Platforms

To ensure its data centre and network are sustainable, the Trust should consider moving to third-party data centres that are green and effective. Partnering with providers who prioritise renewable energy sources, such as solar or wind power, can significantly reduce carbon emissions. These third-party data centres often employ advanced cooling technologies, like liquid cooling or free cooling, to minimise energy consumption.

Selecting data centres with certifications such as LEED or ISO 14001 ensures adherence to high environmental standards. These facilities are designed to optimise energy efficiency and reduce waste, contributing to a lower environmental footprint. By leveraging the expertise and infrastructure of green data centres, the trust can benefit from state-of-the-art energy management systems that monitor and optimise energy usage in real-time. Third-party green data centres often have robust recycling programmes for electronic waste, ensuring responsible disposal and repurposing of outdated equipment. This not only reduces waste but also supports a circular economy. Collaborating with green data centre providers would allow the Trust to focus on its core mission while ensuring its IT operations are environmentally sustainable and resilient.

SCAS IT is currently developing a long-term datacentre strategy to ensure we have modern, efficient and effective datacentres and sustainability is a primary requirement. The current high-level thinking is as below:

- Strategic Development 2025-2026
- Short-Term Consolidation and Optimisation – 2026-2028
- Long-Term Strategic Migration – 2028 onwards

IT Application Management Strategy

SCAS IT is currently developing our IT Application Management Strategy and this will incorporate the reduction of the number of used applications and a continued focused on IT Asset management optimisation. Where applicable we will look at cloud based products who are sustainable by design.

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IT Innovation Sustainability Themes

IT sustainability innovation within SCAS is still in an early-adoption stage but could potentially play a crucial role in driving Net Zero and sustainability goals. At the present time we are still identifying key initiatives and themes. This is a work in progress during 2025/26 with a key focus on utilising Artificial Intelligence (AI) to drive optimisation and efficiencies across all areas of IT and wider business units.

Building Management Systems

Digital transformation offers huge potential for the management of the Trust estate. As more equipment, such as “smart” LED lighting and Solar PV, is installed, the need for integrated building management systems to monitor and control these systems is required. Such systems capitalise on the “internet of things” emerging technology and can yield huge efficiencies in energy use and maintenance.

4.7 Medicines

The NHS Standard Contract identifies inhalers and anaesthetic gases as two key areas requiring early action.

6.7% of the Carbon Footprint for SCAS is attributable to nitrous oxide (N_2O)*. It is the second largest source of direct emissions after the vehicle fleet (NB Supply Chain / Procurement is the largest source when indirect emissions are factored in)

Research into capturing N_2O at point of use or installing portable devices to remove it from the air in enclosed spaces such as ambulances, is now urgently required.

Nitrous Oxide is identified as a hazard to NHS staff, so efforts to remove/capture it will have wider health benefits, whilst other efforts to reduce its use or prevent waste will save money.

Opportunities to use lower carbon alternatives (Penthrox) should also be considered and implemented where medically and practically feasible, and this is likely to be decided at a national level.

Tackling Nitrous Oxide emissions within ambulances depends on technological advances and changes in medical practice, which will be kept under review, but it forms an essential component of reducing the Trust’s direct emissions and achieving Net Zero.

(*Nitrous Oxide (N_2O) must be distinguished from NOx, the various nitrogen oxides found in exhaust fumes from internal combustion engines.)

4.8 Adaptation Planning

SCAS plans to mitigate the risks or effects of climate change and severe weather conditions on its business and functions, particularly the impact of flooding or

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heatwaves on the organisation's infrastructure, patients, and staff. Repeated flooding has already affected one of sites, and higher rainfall is being predicted as a result of climate change.

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5. Affordability & Funding the Green Plan

Meeting mandatory Net Zero targets will require significant investment across the NHS. Some aspects have been provisioned for, but others will have to be funded from existing budgets.

5.1 Electric Vehicle Acquisition

NHS England created a £60 million 3-year budget for new ambulance acquisition, with £6.5 million allocated to SCAS from 2022 to 2025. Of this, 10% was to be ring-fenced for zero emissions ambulances.

Non-DCA electric vehicle acquisitions must be funded from existing budgets. Fortunately, as the NHS Net Zero Travel & Transport Strategy points out, electric vehicles are already cheaper than petrol and diesel vehicles over their lifetime due to lower energy and maintenance costs and are expected to reach full purchase price parity in 2027.[73]

5.2 EV Charging Infrastructure

Initial data provided by NHS England based on field testing and research suggests that average emergency response EVs are 21% cheaper to own over their lifecycle[74]. It is these savings that will recoup the cost of infrastructure upgrades and installation of EV charging equipment. The annual direct operational savings to the NHS are calculated to be £59 million. The wider benefits of the transition to net zero NHS travel and transport are estimated to be over £270 million a year[75].

Following their recent success with trialling electric RRVs, Northwest Ambulance Service has decided to purchase 7 fully electric fleet support vehicles this year, with anticipated fuel savings *per vehicle* of £3,500 per annum and 20% reduced maintenance costs. Initial data from the two electric Mental Health RRVs being trialled by SCAS under the ZEEV Pathfinder Scheme suggest similar savings.

5.3 Grid Connection & Upgrade Costs

Upgrades to the grid and electrical infrastructure to meet the requirements of the NHS Travel & Transport Strategy are estimated to cost just over £100 million across the UK. However, reforms implemented by Ofgem from April 2023 are expected to significantly change current connection costs, by reducing or removing the customer contribution to costs for new connections by 'socialising' them across the network.

[73] NHS England, 2023, "Net Zero Travel & Transport Strategy",p19
[74] Ibid.
[75] Ibid.

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Some of the capital investment associated with increasing electrical capacity at NHS sites is therefore expected to be met within the broader decarbonisation of the national electricity grid[76]. However, there will still be significant network upgrading and connection costs. The EVRIT model advises Trusts to budget the same amount to cover Distribution Network Operator costs as they are allocating to their own EV infrastructure budgets. Ofgem rules also allow for Independent Distribution Network Operators (iDNOs) to acquire newly installed network upgrades for which SCAS can receive an "Asset Adoption Value", recouping a considerable proportion of the upgrade cost.

5.4 Procurement / Scope 3 Emissions Analysis

Using specialist software to analyse embedded CO_2 emissions in the goods and services purchased by the Trust offers the possibility of generating financial savings, by using AI to identify duplicated orders, overcharging by suppliers, inefficient stock control and the prevalence of expensive single-use items rather than re-usable alternatives. NHS Supply Chain and Northern Care Alliance have both reported £multimillion savings from deploying such technology, whilst also building an accurate picture of their carbon footprint plus, rather than relying on applying carbon intensity factors to general spending.

5.5 External Funding / Grants

The Public Sector Decarbonisation Scheme (PSDS) represented the largest grant funding opportunity, though eligibility criteria precluded SCAS from applying, as the emphasis has been on heating decarbonisation projects more suited for hospitals, rather than transport decarbonisation. The PSDS programme has now ended. Preparing grant applications also requires upfront investment in consulting fees, design work and heat decarbonisation planning.

SCAS has successfully applied for £492k funding for smart LEDs from the National Energy Efficiency Fund (NEEF) and £1.2 million for Solar PV installations from GB Energy in 2025. Other applications are being prepared for EV charging infrastructure.

Commercial funding opportunities are also available, particularly for Solar PV, where third party organisations install equipment and sell the electricity back to SCAS for a set period of time in lieu of capital investment by SCAS. Hire purchase and specialist loan schemes also exist, though finance costs will increase the payback period. Such opportunities would have to be considered within the context of the SCAS Fit for the Future Modernisation Programme and alterations to the estates portfolio.

[76] Ibid, p20

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5.6 Estimated 5 yr Capital Budget for Estates Sustainability Improvement

Description	Value (including VAT)					Total £000
	25/26** £000	26/27 £000	27/28 £000	28/29 £000	29/30 £000	
Electric Vehicle Charging Infrastructure - 10,881kW (EVRIT Model)*	2,000	5,000	6,000	3,000	3,000	19,000
Solar PV - 2MW	700	700	600			2,000
Battery Energy Storage Systems - 2.76MWh	500	500	500			1,500
Smart LED / "Daylight Harvesting" systems	900	900				1,800
Surveys inc. heat decarbonisation plans	225	225				450
Total:	4,325	7,325	7,100	3,000	3,000	**24,750**

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***10% contingency and 10% inflation has been allowed only for the EV charging infrastructure due to its timescale, risks of unknowns and magnitude.**

Although this budget represents a significant upfront investment for SCAS, it will result in financial benefits which will ultimately see a return on the investment, leading to net overall savings for the Trust.

**The internal capital budget for sustainability is zero for 2025/26. Any sustainability work being undertaken by the Trust in 2025/26 will be funded by external grants. Applications and expressions of interest for Solar PV, LED lighting and EV charging infrastructure have been submitted to NEEF, GB Energy and OZEV. No applications have been submitted to PSDS (Public Sector Decarbonisation Scheme) due to lack of seed capital to fund the surveys and preparation of heat decarbonisation plans which are essential components of any bid.

The available electrical supply capacity across the SCAS estate has now been exhausted for most sites and any further additions to the EV charging infrastructure will require DNO supply capacity upgrades such as new substations and cabling.

The long timescales and associated cost of DNO upgrade work pose a considerable corporate risk to SCAS, which could affect the future rollout of electric vehicles.

To facilitate the arrival of at least 5 eDCAs (and possibly an additional 10), it is proposed that, for Year 1 (2025/26), SCAS focuses on developing two proof-of-concept all electric resource centres, one in the North (Kidlington) and one in the South (Basingstoke), and postpone all other DNO upgrade work until the next financial year when capital budgets may become available. Stoke Mandeville is also included as a priority site, as none of the newly installed EV chargers can be switched on or the new grant-funded solar PV system connected to the grid without a DNO upgrade.

Year 1 2025/26 Detail:

Description	Cost	Funded?
Electric Vehicle Charging Infrastructure, including DNO upgrade works:		
Kidlington RC	£326k (quoted)	Unfunded at 13/05/25
Basingstoke RC	£355k (quoted)	Unfunded at 13/05/25
Stoke Mandeville RC	£405k (quoted)	Unfunded at 13/05/25 Grant applications submitted to OZEV, decision pending
Solar PV – 4 Resource Centres	£1.2million	GB Energy Grant
Smart LED	£494k	NEEF Grant

Total cost of sustainability works 2025/26: £2.780 million

External funding obtained at 13/05/25: £1.694 million

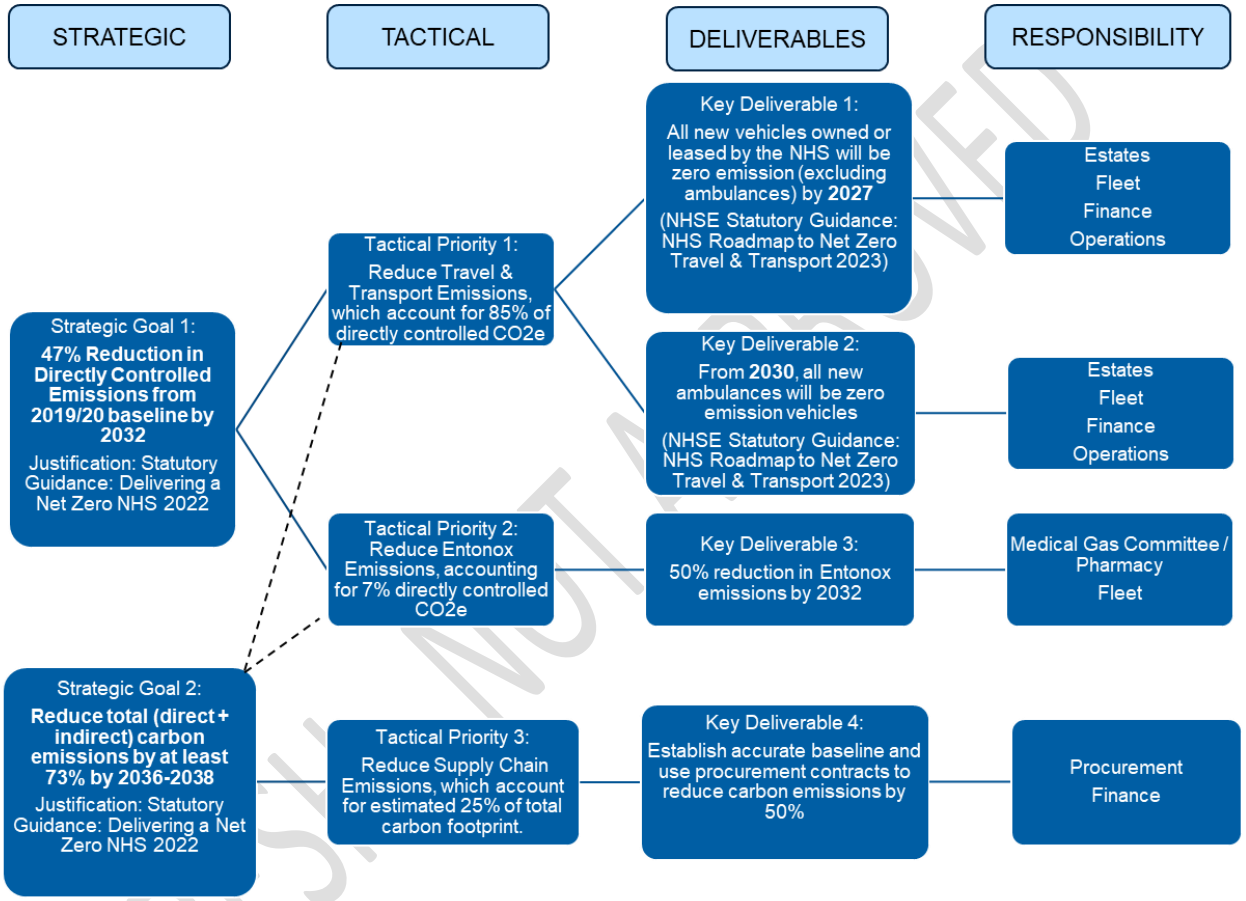
Funding gap: £1.086 million

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6. Delivering the Green Plan

6.1 Strategy, Tactics and Deliverables:

This high-level implementation plan identifies the most important tactics and deliverables required to meet strategic carbon reduction goals:



6.2 Actions and Responsibilities

The key deliverables have been broken down into granular actions that have been incorporated into a “Green Action Plan” formal delivery programme. Once specific actions have been identified, the necessary agreement and commitment has (or will be) sought from appropriate stakeholders, so that those who are accountable and responsible for specific workstreams are clearly defined. Progress reviews at regular intervals via the Net Zero Committee will keep the programme on track, whilst keeping the Board informed.

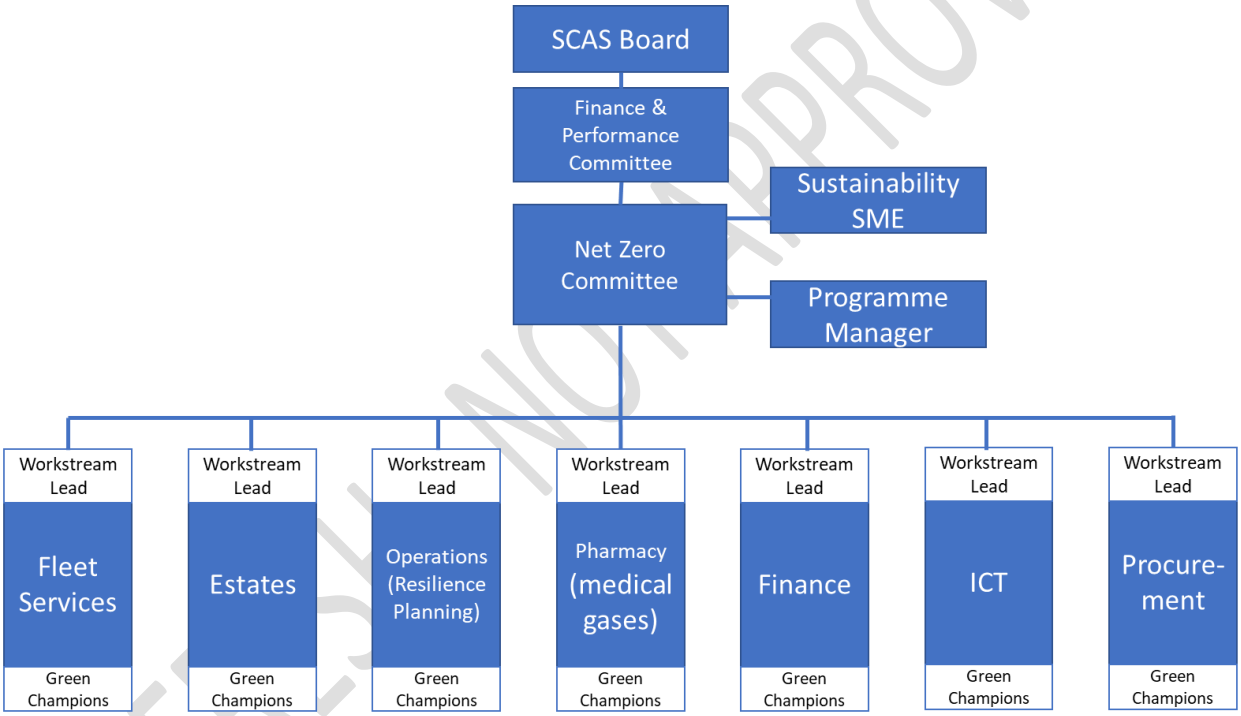
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Some actions will have a far greater impact on reducing carbon emissions, and it is important to prioritise these to meet key deliverables. Other actions may have a lower impact on reducing carbon emissions but will still have a high impact on wider sustainability and may be useful as “quick wins” to demonstrate the Trust’s visible commitment to sustainability. The actions have been identified as essential in delivering the core components of the Green Plan, especially the Carbon Reduction Plan. Please see **Appendix** for list of actions.

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6.3 Green Plan Governance Structure

Delivering the Green Plan will involve multiple workstreams across multiple departments; each workstream will have a lead whose work will be coordinated by the Programme Manager. The following structure is not exhaustive, as other departments e.g. Communications, Business Intelligence will also have vital roles in supporting the delivery of the Green Plan:



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7. Green Plan Key Success Factors

7.1 Board Support – The Green Plan requires top-down support, with a Senior Responsible Officer assuming executive responsibility for its implementation.

7.2 Set up Green Plan delivery as a programme of transformation within the wider **SCAS Fit for the Future Modernisation Programme**, with clear lines of accountability and agreed roles and responsibilities.

7.3 Clearly defined objectives, prioritising those that have the biggest impact or bring the most value.

7.4 Develop an effective marketing strategy to communicate the Green Plan to all stakeholders, engaging the staff at all levels of the organisation.

7.5 Foster SCAS staff buy-in from the bottom up using “Green Champions”. As this is a process of transformation across the organisation, each directorate will require champions to help drive change, not just from an education perspective but encouraging ideas and input from staff. This will take all users in SCAS along the journey, providing them with ample and regular communications and opportunities to propose micro-initiatives.

7.6 Identify “Quick Wins” – initiatives such as installing bike racks and rainwater harvesting tanks may have a relatively small carbon impact, but are highly visible commitments to sustainability, helping with stakeholder buy-in.

7.7 Sustainability Impact Assessments - Where decisions require impact assessments, managers should consider whether a sustainable impact assessment is applicable. This will help embed sustainability in the decision-making process.

7.8 Apply principles of Deming Cycle (Plan Do Check Act), with an Annual Review of the Green Plan, checking its progress, implementing key learnings, and updating the Green Plan accordingly.

7.9 Collaborative working between departments: Creating a more sustainable Trust requires cooperation and information sharing across multiple departments. As fleet electrification is the most important activity to achieve Net Zero, it is vital that fleet managers communicate vehicle procurement plans with the Estates department so that the necessary charging infrastructure is installed in the most suitable locations, to the correct specification. Because the rollout of EV charging equipment will occur in stages, as budgets allow, optimising the locations is essential. If upgrades to the electrical supply are required, it can take many months to plan and install.

7.10 Effective back-office function: The success of the electric vehicle programme relies on installing and managing an effective back-office function for vehicle charging, such as the Allstar fuel card system. Similarly, bunkered fuel requires greater back-office supervision, especially with its importance for financial sustainability as a cheaper alternative to forecourt fuel, and later as environmentally sustainable alternative fuels such as HVO are used.

7.11 Effective contract management: Making procurement more sustainable affects stakeholders across all departments within the Trust, collaborative working and evaluation of the Social Value themes in contract tenders are essential for a successful outcome.

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7.12 Accurate reporting against sustainability objectives requires obtaining information from many sources within SCAS, including Finance, HR, Business Intelligence, ICT, Fleet, Procurement. This emphasises the need for a carefully managed programme to deliver the Green Plan.

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Annexe A1 – Carbon Factors

Emissions Category	Activity	Activity Unit	Scope 1	Scope 2	Scope 3	Notes & Detailed list of all Department of Energy Security & Net Zero Factors
Energy Use	Electricity (including green electricity)	kWh		0.207074289	0.067785	Electricity generated - Electricity: UK T&D UK electricity - Electricity: UK WTT Electricity generated - Electricity: UK WTT T&D UK electricity - Electricity: UK
Energy Use	Natural Gas	kWh	0.182928926		0.03021	Natural gas - kWh (Gross CV) WTT Natural gas - kWh (Gross CV)
Water	Water Supply	Cubic metres			0.176685	Water supply
Water	Water Treatment	Cubic metres			0.201318	Water treatment
Travel & Transport	Diesel	Litre	2.512063885		0.61101	Liquid fuels – Diesel (average biofuel blend) WTT - liquid fuels – Diesel (average biofuel blend)
Travel & Transport	Petrol	Litre	2.097473128		0.58094	Liquid fuels – Petrol (average biofuel blend) WTT - liquid fuels – Petrol (average biofuel blend)

Travel & Transport	Battery EV	kWh		0.207074289	0.067785	Electricity generated - Electricity: UK T&D UK electricity - Electricity: UK WTT Electricity generated - Electricity: UK WTT T&D UK electricity - Electricity: UK
Anaesthetic Gases	Nitrous Oxide	kg	265			Factor does not include supply chain emissions associated with gas manufacture. Uses GWP100 factor for N_2O = 265, consistent with IPCC AR5 report

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Annexe A2 Green Action Plan – High Level Summary of Strategic Goals

NB Details of granular activity and progress of deliverables contained within separate document, “SCAS Green Action Plan”.

Strategic Goal 1 – Reduce direct carbon emissions by 47% from 2019/20 baseline by 2032
Justification: Statutory Target Mandated by NHS England “Delivering a Net Zero NHS”
Tactical Priority 1: Reduce Travel & Transport Emissions
KEY DELIVERABLE 1: **All new vehicles owned or leased by the NHS will be zero emission (excluding ambulances) by 2027.** **(NHSE Statutory Guidance: NHS Roadmap to Net Zero Travel & Transport 2023)**

Based on a lifecycle of 5 years per vehicle, this should ensure that entire non-ambulance fleet is converted to zero emission vehicles by 2032. The **SCAS Carbon Reduction Plan** calculates this will keep SCAS on course to meet statutory NHS emission reduction targets, reducing CO2 emissions by 5,533 tCO2e as part of an overall target reduction of 6,143 tCO2e.
Strategic Goal 1 – Reduce direct carbon emissions by 47% from 2019/20 baseline by 2032
Justification: Statutory Target Mandated by NHS England "Delivering a Net Zero NHS"
Tactical Priority 1: Reduce Travel & Transport Emissions
KEY DELIVERABLE 2: **From 2030, all new ambulances will be zero emission vehicles** **(NHSE Statutory Guidance: NHS Roadmap to Net Zero Travel & Transport 2023)**

Strategic Goal 1 – Reduce direct carbon emissions by 47% from 2019/20 baseline by 2032
Justification: Statutory Target Mandated by NHS England "Delivering a Net Zero NHS"
Tactical Priority 2: Reduce Entonox Emissions (which account for 7% of directly controlled CO_2 equivalent emissions)
KEY DELIVERABLE 3 : **50% reduction in Entonox emissions by 2032** (Entonox / Nitrous Oxide is 298 times more potent than CO2 as a greenhouse gas, accounting for 7% of SCAS carbon footprint)

Strategic Goal 2 – Reduce total (direct + indirect) carbon emissions by at least 73% by 2036-2038 to reach Net Zero NHS Carbon Footprint Plus by 2045
Justification: Statutory Target Mandated by NHS England "Delivering a Net Zero NHS"
Tactical Priority 3: Reduce Supply Chain Emissions
KEY DELIVERABLE 4: **Establish accurate baseline and use procurement contracts to reduce supply chain carbon emissions by 50% by 2038**

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Annexe A3 Other Actions to Support Sustainable Goals

Other Actions to Support Sustainable Goals:

3	High Carbon Reduction Impact	3
2	Medium Carbon Reduction Impact	2
1	Low Carbon Reduction Impact	1

Action	Detail	Owner / Responsibility	Carbon Reduction impact	Target Completion Date *
Fleet Electrification	Install 495 chargepoints per EVRIT model; acquire electric vehicles	Sustainability / Fleet / Estates	**3**	2030 for estate work
LED Lighting	100% of buildings to be fitted with LED lighting	Estates	**2**	Dec 2025
Solar PV Survey	Survey portfolio and identify suitable sites	Estates	**2**	Dec 2024
Solar PV installations	Install on all suitable buildings within portfolio	Estates	**2**	2028
Battery Energy Storage Systems	Installed in conjunction with Solar PV to optimise the performance of Solar PV	Estates	**2**	2028

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Rainwater Harvesting - survey	Conduct survey to identify sites with high water consumption e.g. Resource Centres. Low carbon impact, but an “easy win” and a highly visible commitment to sustainability.	Estates	**1**	July 2024
Sustainability Survey	Understand staff awareness of sustainability	Head of Sustainability	**1**	July 2024
Travel survey	Understand staff travel patterns, calculate carbon emissions from commuting, identify areas to introduce active travel measures.	Head of Sustainability	**1**	2023 -2028 annually
Active / Green Travel Plan	Identify measures arising from Travel Survey and implement	Head of Sustainability	**2**	2026
Heat Decarbonisation Plans	Site surveys, heat loss modelling, mechanical & electrical designs for replacing gas heating systems with electric	Estates	**2**	2025
Heat Pump Installations	As identified in Heat Decarbonisation Plans	Estates	**2**	2028
Make “Building A Net Zero NHS” e-learning module	Develop staff awareness of sustainability	Education	**2**	December 2023 - ongoing

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available to all staff				
Reduction in Business Mileage	Linked to Financial Sustainability; encourage more home working and Teams meetings where feasible; requires direct mandate from Board to implement	Head of Sustainability with support from HR, Finance	**2**	Ongoing
Climate change adaptation plan	Identify impact of climate change on all departments and design measures to mitigate it	Multiple	**1**	2026
Flood risk assessment / resilience planning	Identify areas at increased risk flood risk due to climate change, formulate strategies to mitigate	Multiple departments	**1**	2026
Bike rack installations	Supporting Active Travel, reducing personal car use for commuting. Install in sites where Travel Survey identifies high demand	Estates	**1**	Dec 2025
Waste policy – update policy, zero to landfill target & eliminate single use plastics	Ensure that waste policy reflects latest sustainability goals and legislation, and that this is communicated to Suppliers	Estates / Head of Sustainability / Procurement	**1**	March 2025

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Network of Green-Champions”	Encouraging more sustainable activities at a personal / micro level, promoting positive messages about sustainability	Head of Sustainability	**1**	December 2024
Green clauses incorporated into leases	Ensuring that leases allow for green upgrades / adaptations to buildings	Estates	**2**	2023 - in progress
EMS to ISO14001	Design and implement an Environmental Management System to ISO14001 standards to support Green Plan governance and facilitate SCAS legislative compliance	Head of Sustainability	**1**	December 2025
Communicate the Green Plan across SCAS	Create and implement a communications strategy to publish the Green Plan via different media including intranet, public posters and presentations and seminars	Communications / Head of Sustainability	**1**	2024 ongoing
Develop Sustainability Impact Assessment template	Create a template that managers can use and apply to decision making process, to ensure that sustainability is embedded throughout all areas of the Trust.	Head of Sustainability	**1**	March 2025

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Upward Report of the – Audit Committee

Date Meeting met **17/06/25**
Chair of Meeting **Mike McEnaney - NED**
Reporting to **SCAS Board**

Items	Issue	Action Owner	Action
Points for escalation			
Internal Audit actions	There were no overdue actions for the first time in 3 years at least, A good job done.	Mike McEnaney	Make the Board aware.
Key issues and / or Business matters to raise			
Review of the final Annual accounts, Going Concern Review and Annual report	These annual reports were reviewed and the committee commended those involved for finalising them in line with the national deadlines for submission – a good improvement over the past 2 years.		
Externa Audit Report, including the audit findings report, annual audt report, letter of representation and draft audit opinion.	Over all a very thorough and detailed piece of work leading to a “true and fair view” outcome and unqualified accounts. A significant improvement in the Value For Money assessment resulted from the improved delivery of CIP. The committee thanked the auditors, AZETS, and again the finance team.	Stuart Rees	Create the improvement plan.

	As expected, there were a number of small adjustments identified and the consequent recommendations for improvement were discussed. An aggregated improvement plan would be put together and progress against it reviewed at subsequent committee meetings.		
Head of Internal Audit – statement of assurance	The overall statement is for "moderate" assurance, the same as last year, however, there has been substantial improvement in the audit outcomes so this represents an improvement.		
Areas of concern and / or Risks			
Internal audit report – Mandatory Training	Moderate outcome for both design and effectiveness with two key findings: a lack of training needs assessment and matrices across the Trust and insufficient monitoring of compliance levels and escalation processes.	Danny Hariram	Will be managed as part of the overall internal audit improvement monitoring.
Trust Policy Register	Whilst significant progress has n=been made with control and bring policies up to date there remain a number that are long overdue for review and subsequent approval.	Becky Southall	Bring to EMC for review and action.
Items for information and / or awareness			
Internal Audit – annual mandatory Data Security and Protection Toolkit assessment	This was the first year of a new and expanded assessment covering a wider scope and more detail – SCAS was assessed at an "acceptable" level. Areas highlighted for improvement were managing risk and management of identity verification, authentication and authorisation.	Craig Ellis	Will be managed as part of the overall internal audit improvement monitoring.

Best Practice and / or Excellence			
Audit Committee Annual Report and Terms of Reference	The annual report and ToRs were reviewed and approved. A self-assessment survey was carried out and would form the basis for an improvement plan.	Becky Southall	Improvement plan
Compliance with Terms of Reference			
Late papers	It was noted a number of papers were submitted late, not including the annual report, year end accounts and external audit.		
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: **23/07/25**

Upward Report of the Charitable Funds Committee

Date Meeting met **2 July 2025**
Chair of Meeting **Keith Willett (Interim Chair) with Ruth Williams in attendance**
Reporting to **Trust Board**

Items	Issue	Action Owner	Action
Points for escalation			
Contactless Donation App	We have been trying to set up a new contactless app for use on SCAS phones since 2022 and have had little success in progressing further. We are now working with Chris Cheetham in Cyber Security to take this forward and to ensure compliance with the new Payment Card Industry Data Security Standard (PCI DSS). Since the CFC meeting, I have met with Chris and understand the issues we currently have around non-compliance. This is essentially the initial part of the process as people enter their financial data on to our website where it is held before being passed on to Stripe to action the transaction. There has been some difficulty in getting things actioned by our Website	**Charity CEO / SCAS Cyber Security Consultant**	Chris Cheetham to review the self assessment questionnaire and request any outstanding points with our website designer. Chris to complete and submit the self-assessment questionnaire and to research and identify an independent Approved Scanning Vendor for the Charity website. App to then be set up with the Charity and SCAS phones to be reviewed for compliance.

	Designer, who is a third-party supplier. I have asked Chris to copy me in on everything so we can take necessary action to chase the work that needs doing or to another supplier to complete the work. Chris then needs to complete and submit a self-assessment questionnaire. We are also required to appoint an external Approved Scanning Vendor to carry out a quarterly scan of our website and any other donation portals. Following the submission and approval of the self-assessment, we will be in a position to begin getting the app set up and ready.		
Key issues and / or Business matters to raise			
DRV Fleet	The 30 Dacia Dusters are being decommissioned by SCFS and inspected and returned to the lease company. There are various amounts of damage for these vehicles and we anticipate a bill of around £3000-£5000 from the lease company. There are also decommissioning costs that will be payable to SCFS. Currently an average of 6 hours work per vehicle plus an inspection cost of £379 per vehicle so an overall invoice from SCFS of £23,000. This is a much higher than anticipated cost due to vehicles having to be taken to Lymington to decommissioning and SCFS charging for travel time to and from Lymington from Eastleigh. I have questioned	**Charity CEO**	Work is ongoing with SCFS to return the vehicles and costs not yet finalised. These costs were not known or budgeted for at the start of the year so will be additional, out of budget expenditure. We will be creating an action plan from the volunteer concerns received and will work through this with the CET team reporting through the CFC. We will review how we communicate progress on the action plan to our volunteers.

	this element of the recharge as Lymington was the suggested location of SCFS and was also a difficult location for volunteers resulted in high volunteer mileage claims in addition. This remains a difficult and unpopular decision with some of our volunteer cohort. We remain clear that any fundraising in CFRs communities needs to be for the ongoing costs of uniform, equipment and training of CFRs, the remaining fleet of 18 vehicles which need to be maintained with 10 being purchased from the lease company, as well as replacing the remaining c160 old defibs that still need replacing. The issue around analgesia is still a concern with no Entonox now being available if CFRs are using their own vehicles, unless they go via a SCAS station and collect from there at the beginning of a shift and return at the end. The CFR meeting on 3 July discussed this and other volunteer concerns but it remains the case that 65% of CFRs have always used their own vehicle to respond. CFRs using DRVs to respond to Cat 1 vehicles was 11% of the total attended by CFRs and Cat 2 15% attended using a DRV.		In addition to the action plan we are creating some Charity workshops for volunteers in September and also having ongoing discussions with some and exploring ideas that have been suggested.
Current Financial Position	Last year was a challenging year for the Charity. This year the deficit has been reduced	**Charity CEO**	Our Community Fundraisers are working hard on developing new

	in the budget to £128k on our unrestricted funds. Outstanding restricted funds are, wherever possible, being used (in line with their restrictions). The year has started on a positive note and while we are only at month 2, it is encouraging that unrestricted fundraising income is 100% up on this time last year. We have been successful in our Community Resilient Grant application to NHS Charities Together which will fund the purchase of 50 new Zoll AEDs (a further 55 will be purchased from Charity funds), four of the current DRV fleet (a further 6 will be funded from Charity funds) and some mannikins and training defibs for community engagement. Expenditure continues to be carefully manged and is £10k under budget at M2. We have received an unrestricted legacy of £42000.		events and initiatives and our CFRs are fully engaged in their communities over the summer months. We will continue to monitor progress on a monthly basis and quarterly at CFC meetings.
Annual Plan	An annual plan has been created to focus on key areas to enable the Charity to achieve current targets for this year and to grow in the longer term. We will be looking at digital fundraising engagement including a key appeal during the year and new legacy promotional information on our website.	**Charity CEO**	Specific KPIs are being added to the action plan for review at the next CFC in October.

	Our Community Fundraisers have developed a plan for the year, working alongside our volunteers as well as on independent initiatives. Or golf day is planned for October and we now have four keen runners (and fundraisers) lined up for the London Marathon in 2027. We hope to grow the number of Charity/fundraising volunteers to support this area. The key area for new income is our corporate programme. It has taken some time to move this forward as we are looking at developing strategic, longer term partnerships rather than one off transactional donations. This will give us a better return on investment and longer term pipeline. The corporate pipeline will be discussed at CFC meetings and progress reviewed. Our top prospects currently are APCOA; Red Engineering and Oxford Instruments. All of which have been introduced to us by CFRs in the workplace. Expenditure will continue to be carefully managed against budget and we are highlighting the costs of expenditure and reporting monthly expenditure to the CET team so they can better understand the challenges faced by the Charity and how they can support the management of this expenditure.		
Areas of concern and / or Risks			

Items for information and / or awareness			
CFC NEDs	Ruth Williams attended the July meeting of the CFC and will take up her role as Chair from the October meeting. Gary Ford will join Ruth and Mike McEnaney as the third NED for the Committee.	**Trust Chair**	
Best Practice and / or Excellence			
Compliance with Terms of Reference			
Policies approved*			

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

Author: Vanessa Casey

Title: SCAS Charity CEO

Date: 10/7/2025

NHS
South Central Ambulance Service
NHS Foundation Trust

Trust Board of Directors Meeting in Public
31 July 2025

Report title	Communications, Marketing and Engagement Update
Agenda item	22
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

Long Service Awards presentation

Eligible SCAS staff were welcomed to the King's Medal and Long Service Award ceremony that took place at De Vere Latimer Estate, Chesham, Buckinghamshire on 30 June 2025.

These awards celebrate the long service, good conduct and professionalism of all our recipients and thank recipients for their hard work and dedication to our patients.

Falls and Frailty Campaign update

Throughout 2025, we are running four public campaigns centred around common causes of ambulance attendances. This is to raise awareness of these issues, to manage demand on the service and to ensure the provision of appropriate care.

Community Engagement and partnership working

During Spring and Summer, SCAS has been busy delivering engagement across the South Central area. Alongside many events, that have involved much partnership working, targeted engagement opportunities with diverse communities across the patch have been well supported.

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.

1.3 Long Service Awards presentation

Eligible SCAS staff, along with one guest each, were welcomed to the King's Medal and Long Service Award ceremony that took place at De Vere Latimer Estate, Chesham, Buckinghamshire on 30 June 2025.

These awards are a great opportunity for us to celebrate the long service, good conduct and professionalism of all our recipients and to thank recipients for their hard work and dedication to our patients, our service and the job which they do so diligently every day.

This year was particularly notable, as it was one of the final years that we also presented the Queens's Long Service and Good Conduct Medal to those who achieved their service during the reign of Queen Elizabeth II. This will undoubtedly hold a greater significance than ever, for those fortunate enough to be awarded one.

Our Chief Executive David Eltringham, and Chair Professor Sir Keith Willett were joined by Countess Howe, Lord-Lieutenant for Buckinghamshire and the King's representative, who very kindly presented the medals. Recipients then enjoyed meeting colleagues and other staff from across our services over afternoon tea, on what had to be one of the hottest days of the year so far.

The King/Queen's Medal for Long Service and Good Conduct

The King/Queen's medal for Long Service and Good conduct is presented to ambulance service staff who have an aggregate record of 20 years or more frontline operational service (now including control room staff), and who have been serving the Trust with good conduct.

This year there were 5 staff eligible for the Queen's medal and 38 staff eligible for the King's medal. Out of those who were eligible and invited, 25 staff were presented with their medal in person at this year's awards. 18 staff who were unable to attend, will either be invited to the next event or will receive their medals in their local areas if they prefer.

SCAS Long Service Awards

The afternoon ceremony also included Long Service Awards presented by South Central Ambulance Service NHS Foundation Trust, to staff and volunteers from all parts of our ambulance service who have completed an aggregate record of 20 years' service with the NHS.

This year, 90 staff and volunteers were eligible for the SCAS Long Service Medal and 55 of these staff and volunteers were also presented with their medal at this year's awards. The 35 staff who were unable to attend, will have the option to have their medals sent to their nearest base location or will be invited to attend a ceremony next year.

We have a large number of staff who are reaching their 30 and 40 years of service in the ambulance service and the NHS this year. We are currently working on plans to recognise these in the coming months.

1.4 Falls and Frailty Campaign update

As mentioned in previous board papers, throughout 2025, we are running four public campaigns centred around common causes of ambulance attendances. This is to raise awareness of these issues, to manage demand on the service and to ensure the provision of appropriate care. For the second campaign, delivered in June, the theme was falls and frailty – as these jobs constitute over 10% of the demand of 999/111 services.

The campaign ran throughout the month with a different focus each week. Week one centred around the falls and frailty partnership that runs in North Hampshire. This initiative involves one specialist practitioner from SCAS and one member of North Hampshire's Urgent Community response, usually a frailty nurse. Based out of Basingstoke, the two staff can self-dispatch or be requested by crews to attend falls. Once on scene, they can assess patients, help them up from the floor, take point-of-care blood tests and provide equipment at home to prevent further falls such as rails/walkers/commodes. This significantly reduces the need for patients to go to hospital. We filmed a 'day in the life' video and followed them to three different patients (having gained consent to do so). This resulted in substantial media interest; there were multiple newspaper reports as well as radio and TV interview requests which have continued with the last being on 25/6.

During the second week, the focus was on Community First Responders (CFRs) and their role in managing falls. CFRs are able to go to non-injury falls and using the iStumble App and with support from clinicians in the emergency control room, can help get patients up without needing a frontline crew to be dispatched. We created social media posts highlighting this, as well as highlighting that CFRs are charity funded and therefore donations are very important in keeping the service going.

The third week provided information about how to prevent falls. We used Artificial Intelligence to create images highlighting common trip hazards in a standard home, as well as providing a falls prevention checklist that people can use to reduce these risks.

The final week included reels that we had created, involving 111 call takers and clinicians. The first one explained what happens when you phone 111 about a fall and the second one, involving a paramedic, explained that dehydration in the elderly is a common reason for falls, so how to recognise and prevent this. This coincided well with a hot weather warning for the end of the month. We also aligned the 'Your Health Matters' public talk on 19 June to the falls and frailty theme.

1.5 Community Engagement and partnership working

Your Health Matters

Your Health Matters is a series of public talks delivered either online or in person, aimed at SCAS members and the wider public. These events are often held in partnership with other NHS Foundation Trusts and focus on raising awareness of SCAS services, health education, and current campaigns, while also gathering valuable feedback.

On 19 June, SCAS partnered with University Hospital Southampton to host a public talk on the link between falls and frailty in later life. The session covered practical steps for prevention, what happens following a fall, and what patients can expect during hospital care and recovery.

The event featured presentations from:

- **Mark Ainsworth-Smith**, SCAS
- **Harry Pun**, Occupational Therapist, Proportionate Care and Medicine for Older People Team, University Hospital Southampton
- **Hannah Foxley**, Advanced Specialist Occupational Therapist, Proportionate Care Team

The event was introduced by **Helen Ramsay**, Lead Governor, and chaired by **Tim Ellison**, Community First Responder Governor, who facilitated a lively and engaging Q&A session.

Out of 200 registered participants, just over 100 attended live. Attendees received a follow-up email with a recording of the talk, a falls prevention checklist, and a short survey. Feedback has been positive. One delegate commented:

“I found the stats surrounding the whole issue very informative and raised my awareness of just how important prevention is, together with rehabilitation.”

Further talks are planned throughout the year alongside wider communications campaigns, more details to follow soon.

Events

Our Stakeholder and Engagement Manager has continued to coordinate a busy schedule of community events during the spring and summer, working closely with internal teams and external partners. These engagement opportunities are one of the key ways we showcase SCAS services, helping to educate and inform about the care we provide and also working closely with partners to provide health information and details of how to access appropriate services.

Highlights include:

- **Emergency Services Day (24 May, Calshot)** – Organised by **Chas McGill**, Public Governor. Over 3,000 members of the public attended to engage with local emergency services and learn about SCAS.
- **Berkshire County Fayre (15 June, Newbury)** – SCAS staff and volunteers interacted with over 3,000 visitors.
  Matthew Stanley, Paramedic, shared:

  “SCAS received a lot of heartfelt thanks from members of the public for the emergency service we provide. People truly recognise the dedication and effort we put into saving lives.”
- **HMS Collingwood Open Day (28 June)** – A valuable opportunity for public engagement and recruitment.

The events are supported by SCAS staff and volunteers, and the public are warmly invited to attend and engage with us. The South Central Ambulance Charity, the education, recruitment and communications teams all work closely together to achieve a variety of events, details below of those that have taken place over the last few weeks. Details of up-and-coming events can be found on the SCAS website.

Key Events – May to June

Event	Date	Location	Lead
Hungerford Juniors Football Tournament – Fleet Event	3–5 May	Hungerford	SCAS Charity
Marriott's Walk Shopping Centre	10 May	Witney	SCAS Charity
Access All Areas (LD and autism event)	15 May	Shaw House, Newbury	Learning Disabilities Team
Downley WI	13 May	Downley	David Hamer
Emergency Services Day	24 May	Calshot	Public Engagement
Volunteer Fair	26 March	Oxford	SCAS Charity
North Hinksey School Visit	29 March	Oxford	SCAS Charity
Newport Pagnell Vintage Event	7 June	Newport Pagnell	SCAS Charity
Portsmouth Pride	7 June	Portsmouth	Recruitment
Wantage Fun Day	8 June	Wantage	SCAS Charity
Berkshire County Fayre	15 June	Newbury	Public Engagement
Fareham 999 Day	21 June	Fareham	SCAS Charity
Bloxham Steam Rally	26–29 June	Bloxham	SCAS Charity
Fort Brockenhurst Day	28 June	Brockenhurst	SCAS Charity
HMS Collingwood Open Day	28 June	Fareham	Public Engagement
Hurst Show	28–29 June	Hurst	SCAS Charity

Engagement with Communities

Our engagement is not of course limited to events and SCAS continues to prioritise engagement with underrepresented communities, helping to raise awareness about when to call 999 or 111,

and identifying barriers to accessing care. This supports our goal of reducing health inequalities across the South-Central region.

Recent community engagement activity includes:

- **Southampton Council of Faiths Friendship Lunch** – Attended by Governors to strengthen local relationships.
- **Barbados and Friends Association (BAFA), Reading** – Introduced by **Tony Jones**, Public Governor. SCAS representatives demonstrated CPR and AED use at BAFA's Health Awareness Day. BAFA is now applying for a community defibrillator.
- **University of the Third Age (U3A)** – **Mark Potts**, Public Governor, presented at Reading U3A; SCAS has been invited to present at Southampton U3A.
- **African Families in the UK & Sudanese Women's Group** – **Helen Ramsay** and **Margaret Eaglestone** are collaborating to understand equity of access and reduce health inequalities in out-of-hospital cardiac arrest (OHCA) through CPR/AED demonstrations.
- **Asylum Seekers and Refugees** – our engagement lead is working with Windrush GP Surgery and the Oxford Witney Hotel to provide health information and CPR training, aiming to reduce inappropriate 999 calls and improve OHCA outcomes.

Make Every Contact Count (MECC)

MECC encourages all staff to use routine interactions to promote health and wellbeing, offering brief interventions that can make a significant difference. The engagement lead is working with SCAS's Continuing Professional and Personal Development (CPPD) team to promote MECC training and with the education team to include MECC and health inequalities awareness in this year virtual update training day for frontline staff and staff induction.

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

NHS
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Trust Board of Directors Meeting in Public
31 July 2025

Report title	Digital Board Update – July 2025
Agenda item	23
Report executive owner	Craig Ellis, Chief Digital Information Officer
Report author	Craig Ellis, Chief Digital Information Officer
Governance Pathway: Previous consideration	N/A
Governance Pathway: Next steps	N/A

Executive Summary

- To provide an update to the SCAS board of directors and executives on key issues, achievements, and upcoming plans within the Digital Function.

Alignment with Strategic Objectives

With which strategic theme(s) does the subject matter align? (If more than one, please write manually)

Technology Transformation

Relevant Board Assurance Framework (BAF) Risk

To which BAF risk(s) is the subject matter relevant? (If more than one, please write manually) SR8 - Ability to Deliver the Digital Strategy

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 Why are you writing this report now and what is the purpose of it?

- **To provide a monthly update on the Digital directorate and to highlight positive initiatives, risk and issues and upcoming plans.**

2. Detail

2.1 What relevant information do you need the meeting to have regard to in its consideration of your report?

- **N/A**

3. Quality Impact

3.1 Does the action [or decision not to act] have an impact on patient safety, patient experience or clinical effectiveness?

- **N/A**

4. Financial Impact

4.1 Does the required action [or decision not to act] have a financial impact and can this be quantified?

- **N/A**

5. Risk and compliance impact

5.1 What is the risk to the trust if the recommended course of action is not taken? (If / then / leading to)

5.2 Does it relate to any of the existing risks on the risk register (in addition to the BAF)? Which? How?

5.3 Does the decision relate to a regulatory requirement or another form of compliance?

- **Not directly applicable but any associated risk or compliancy impacts would be called out.**

6. Equality, diversity and inclusion impact

6.1 Is there any impact to a particular group of individuals?

- N/A

7. Next steps

7.1 What will you do next?

- **Take any questions related to the report.**

8. Recommendation(s)

8.1 The Group / Committee / Board is asked to:

- **Receive a report/paper for noting**

8.2 Ensure recommendations on page 1 are identical to those which appear above.

9. Appendices

Meeting Report

Name of Meeting	SCAS Private Board (July 2025)
Title	Digital Update
Author	Craig Ellis
Accountable Director	Craig Ellis
Date	July 2025

1. Purpose

The report is to provide a high-level overview of the Digital Function (IT, Business Information and Cyber Security), and to call out key achievements, issues and noted concerns.

2. Background and Links to Previous Papers

N/A

3. Rationale for Private Paper

N/A

4. Executive Summary

A progressive month with no major noted issues. Overall, no major issues to note and a focus around areas such as BI, medium-term strategic planning and assisting colleagues in Ops (performance) and Finance (CIP) has occurred. The CAD tender is current in tender with a one-week extension provided based on feedback with a due-date now early August (no impact to programme timeline).

In addition – the below are high-level highlights of core initiatives

1. Windows 11 Deployment & New laptops continue to progress well. Over 1,000+ devices now rolled out from a total of 1,300 and no major issues.
    - Please ensure as a NED/Exec you have scheduled and upgraded
2. Staff-AI Training Proof-of-Concept (SASC) progressing well. POC's ran in Northern House & Southern House with really positive feedback.
3. DSPT submitted with provisional marking as "standards met". This is really positive and is a result of a really well planned assessment over the last 9-months, a strong focus and a maturity in the department. Big thank you to Tina Massey, Barbara Sansom, and the ICT technical teams. Next steps are

to focus on maturing across the partial areas in-line with NHS recommendations.
4. No major IT issues related to the hot weather due to good planning and monitorijng.
5. Kick-off meeting held with the 5 regional CIO's under SASC chaired by Simon Weldon. A number of collaboration opportunities identified as below.

System & Partner Engagement:

Workshop held on the 14th July with 4 fellow CIO's, Simon Weldon and Nic Daw. The all-day workshop was to explore collaboration opportunities amongst the 5 trusts and to develop aligned thinking. Areas for collaboration are now developing and further papers to come back.

Digital Financial Update:

CIP/Revenue

- The Digital CIP update was presented to the extraordinary F&P and no noted issues to date.

Capital

- Significant capital challenges for 25/26 remain with recently announced saving initiatives hit SCAS. Digital Risk Register updated in June to reflect current situation and 2 risks have moved from 12 to 16 accordingly based on current 25/26 capital view.

Cyber Update

- No noted Cyber Security incidents in July with the DSPT submission completed. Focus now on recruiting the permanent Head of Cyber, and developing the Cyber Security strategy aligned to FFF.

Data/BI Update

- Ongoing work for SCAS to connect into the Thames Valley Secure Data Environment (SDE) which enables research and data collaboration across the Trust and Thames Valley Care Sector.
- Focus on performance Cat-2 reporting aligned to the Cat2IT tiger team

Key Achievements

- 24/25 DSPT assurance provisional marked as "standards met" aligned to the framework and NHS guidance.
- Rollout of W11 continues well without major incident
- Staff-AI POC very positively received..

Key IT Issues

During June there were no note major incidents.

5. Areas of Risk

The Digital department and associated remit bring associated risk across all the below key areas within SCAS. Each of the below risk areas are relevant for IT and are managed accordingly within our IT risk-management framework.

- Clinical/Quality
- Financial*
- Business
- Reputational
- Performance

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

SR8 - Ability to Deliver the Digital Strategy

7. Governance

N/A

8. Responsibility

Chief Digital Information Officer

7. Recommendations

To Note

NHS
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Trust Board of Directors Meeting in Public
31 July 2025

Report title	Board Committee Annual Reports 2024/25
Agenda item	25
Report executive owner	Becky Southall Chief Governance Officer
Report author	Becky Southall Chief Governance Officer
Governance Pathway: Previous consideration	The Annual Reports and terms of reference have been discussed at each of the committees
Governance Pathway: Next steps	N/A – report is for board assurance and on-going monitoring

Executive Summary

The purpose of this paper is to present the Annual Reports and revised terms of reference for the formal committees of the Trust board.

Best practice in corporate governance indicates that the committees of the Board should review their performance annually and report to the board on their effectiveness. The review has been undertaken by the Chief Governance Officer and was informed by a survey of members to understand their views on committee performance and effectiveness and to determine whether changes to the terms of reference were required.

The Annual Reports and terms of reference were discussed with the lead executive and committee chair prior to presentation to the committee and changes to the terms of reference were approved where necessary.

Of note:

- It has been agreed that the reporting line for Digital services will transfer from the Finance & Performance Committee to the Quality & Safety Committee as digital is a frontline enabling service
- No changes have been made to the People & Culture Committee terms of reference as these were only reviewed in May 2025 and a new Chair has recently been

appointed. A review will be undertaken, and the revised terms of reference will be presented to the Board for approval
- The survey results have not been included within this paper due to volume but were presented to, and discussed with each of the committee chairs and to the meeting
- Further work will be undertaken to ensure that the terms of reference are put into a consistent template across all committees

Alignment with Strategic Objectives
This report aligns to all of the trust's strategic objectives.

Relevant Business Assurance Framework (BAF) Risk
SR9 - Delivery of the Trust Improvement Programme

Financial Validation	Not required

Recommendation(s)
The Committee is asked to **NOTE** the Committee Annual Reports and **APPROVE** the terms of reference for each committee.

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

South Central Ambulance Service
NHS Foundation Trust

Audit Committee Annual Report 2024/25

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1 Reporting Period

2 Introduction

3 Terms of Reference for the Audit Committee

4 Meetings of the Committee

5 Reports made to the Board of Directors

6 Work of the Committee during 2024/25

7 Committee Member Survey

8 Improvement Objectives 2025/26

9. Conclusion

Appendix 1 Terms of Reference for the Audit Committee

Appendix 2 Member survey outputs

Section 1 Reporting Period

This report covers the financial year 2024/25 and details the work of the Audit Committee during that period.

Section 2 Introduction

The Audit Committee is one of only two statutory committees of the Board of Directors ("Trust Board") which is comprised solely Non-Executive Director membership. It plays an important, independent role in the trust's corporate governance and system of internal control. Its core function is to ensure that:

- The organisation operates effectively and meets its statutory and strategic objectives, and
- Provides assurance to the Trust Board that this is the case

The Committee achieves this through scrutiny of a combination of reports from the trust's Internal and External Audit functions and reports from management around core elements of the trust's business.

Best practice set out in the Audit Committee Handbook indicates that that in addition to reporting regularly to the Trust Board, it should prepare an annual report that sets out how the committee has discharged its duties, and this report aims to achieve that for the financial year 2024/25.

Section 3 Terms of Reference

The terms of reference for the committee are attached at appendix 1. These were reviewed by the Chief Governance Officer and the Chair of the Committee in June 2025 in conjunction with the survey of members to determine whether any changes were required. The terms of reference will be presented to the Trust Board for approval at the July 2025 meeting alongside this report.

Section 4 Meetings of the Committee

The committee met 8 times during the financial year 2024/25, which exceeds the 4 times stipulated within the terms of reference and was quorate on all occasions as 2 NEDs were present. Committee membership comprises 3 NEDs, all of whom meet the independence criteria. Independence of the NEDs was assessed as part of the annual assessment process against the Code of Governance for NHS Provider Trust, which was presented to the committee and the Trust Board. Two members of the Committee have recent and relevant financial experience.

Two of the NED committee members left the trust at the end of the 2024/25 financial year, including the former Quality & Safety Committee (QSC) Chair and the new QSC Chair has

subsequently taken up membership. The chair of the Finance & Performance Committee (FPC) is also a member of the committee to ensure there is cross-over between the committees of the board.

A further 2 Non-Executive Directors (NEDs) will reach the end of their term during financial year 2025/26 and membership of all board committees will be reviewed when the incoming NEDs are in post to ensure this remains optimal in terms of oversight of all aspects of the trust's business.

From an executive perspective the Chief Finance Officer (CFO) and Chief Governance Officer (CGO) regularly attend the committee. Other executive directors and leaders of functions pertinent to the terms of reference for the committee attend when asked to do so by the Chair.

Section 5 Reporting to the Board of Directors

The committee chair presents a written report to the Trust Board in the public meeting that follows the Audit Committee meeting and highlights all relevant risks, issues, concerns and successes. These reports can be found within the public board papers.

Section 6 Work of the Committee

The committee has a dedicated work-plan to manage the workload over the year. The full gambit of reports received by the committee are not listed here, but during 2024/25 the committee has received reports relating to the following:

- Annual Accounts and Financial Statements
- Annual Report and Annual Governance Statement
- Head of Internal Audit Assurance Opinion
- Compliance with internal audit standards and KPIs
- Internal Audit Reports:
    - Medical Devices
    - Business Continuity and Disaster Recovery
    - Freedom to Speak Up
    - CIP Delivery and Control
    - Fixed Asset Register
    - Data Security & Protection Toolkit
- Counter Fraud and Security Management
- The Trust's Policy Framework
- Health & Safety Arrangements
- Losses and Special Payments
- Single Tender Waivers
- Self-assessment against the NHS Code of Governance for Provider Boards

Of the 6 assurance audit reports issued in the year, 3 were rated substantial and 3 moderate. The assurance rating on the Medical Devices audit was limited and a follow up audit has now taken place.

The committee has also received and approved the following:

- Standing Financial Instructions and Scheme of Reservation & Delegation (approved)
- Assessment of compliance with the NHS Provider Code of Governance

6.1 Internal Audit Plan

The Internal Audit Plan is approved each year by the committee and is linked to the Board Assurance Framework (BAF). The plan also covers mandated areas such as the Data Protection and Security Toolkit (DPST).

All reports reference the BAF risk that it relates to. The Executive Directors input into the plan to ensure that all areas of risk and key areas of internal control are independently audited. The committee also ensures that actions agreed by management are followed up in a timely way and this has been a key area of focus during 2024/25. The trust ends the year with no outstanding actions from the current or previous year, which is a marked improvement.

6.2 Head of Internal Audit Opinion

The report was received at the May meeting and gave a conclusion of moderate assurance in relation to the adequacy and effectiveness of the trust's system of internal control based on the work undertaken during the year. This opinion, together with the independent assessment reached by the NED members enables the committee to give assurance to the Trust board that the system of internal control, risk management arrangements and the Board Assurance Framework are operating effectively and are supporting the Trust Board to achieve its objectives and comply with statutory, legislative and regulatory requirements.

Section 7 Member Survey

A survey of committee members was undertaken in line with the self-assessment checklists set out in the Audit Committee handbook. This was undertaken with a view to identifying any changes that needed to be made to improve the effectiveness of the committee and set improvement objectives. The outputs of the survey are included at appendix 2.

The main areas of focus for improvement are:

- Confidence that actions will be followed up in a timely way, albeit this has improved considerably during the year and there are no actions outstanding from internal audit reports at year end
- Quality of papers and timelines of circulation; these issues were also identified in the self-assessment against the Code of Governance for NHS Provider boards and form part of overall governance improvement activity

- The assurances received from the other board committees and this will be an area of focus for 2025/26.

Section 8 Improvement Objectives 2025/25

Committee Workload

- **Scheduling** 5 business as usual meetings plus one extraordinary meeting to consider the Annual Accounts and Annual Report, in line with external audit completion of audit and with submission deadlines. *I say this because in my experience, most trusts have one meeting dedicated to the ARA rather than having it in with business as usual. They usually also have a extraordinary board straight afterwards for formal adoption.*
- **Workplan;** ensure that all non-internal/external audit reports that are submitted are scheduled across the year to avoid agenda congestion - *whilst the internal audit work is sometimes not in our gift as it depends on when assignments are completed, our internal reporting like IG/H&S are within our gift and we can try and balance that across the year and prevent agenda congestion*
- **Clinical Audit**; receive an annual report around our Clinical Audit Framework and processes to ensure these are sufficiently robust

2. **Management Response**
   - **Improve management response times to draft reports and identification of actions -** *I appreciate that internal audit have KPIs and want to get reports onto the next agenda but my observation is that this is sometimes a bit close to the wire and results in papers going out later or before we have had time to consider them at EMC. I have asked IA to copy me into all draft reports when they are sent to execs so that I can monitor this and ensure we are turning them around quickly. This will help with adherence to deadlines for the circulation of papers*
   - I**mprove timeliness of paper circulation** *(we can measure throughout the year whether we meet our 5-working day target)*
   - **Maintain zero overdue internal audit actions and zero on the committee action log**
   - **Policies: ensure that all policies reviewed in a timely way and do not fall out of date**

Section 9 Conclusion

In addition to the assurances set out in section (6.1) above, as Audit Committee Chair, I conclude that the committee is operating effectively and has discharged the duties delegated to it by the Trust Board.

Mike McEnaney
Audit Committee Chair
June 2025

Terms of Reference – Audit Committee

June 2025

Document Status	Approved
Version	V.2.0
Document Change History *(to include Executive changes, external review, Committee effectiveness)*	Replaces version 1.0 that was approved in May 2024
Initiated by	Becky Southall, Chief Governance Officer June 2025
Document Owner	Chief Governance Officer
Recommended at: Date:	Audit Committee June 2025
Approved at: Date	Board of Directors July 2025
Valid Until Date	June 2026
Linked Policy Documents	Standing Orders Reservation of Powers of Delegation Other Committee Terms of Reference Standing Financial Instructions Code of Governance for NHS Provider Boards NHS England guidance on audit and assurance
Dissemination requirement	Cascade to Board members and Senior Leaders and forms part of Board level induction pack
Part of the Trust's publication scheme	Yes – the terms of reference will be published on the trust's website following approval

Audit Committee Terms of Reference 2024 – 25

1.0	**Constitution**
1.1	South Central Ambulance NHS Foundation Trust Board of Directors ("the board") hereby resolves to establish a Committee of the Trust Board to be known as the Audit Committee ("the Committee").
1.2	It is a legal requirement for every NHS Board to establish an Audit Committee to provide objective and independent scrutiny of the Trust's system of risk management and internal controls. The Board has therefore established the committee as a formally constituted and standing committee of the Board. The Committee is a Non-Executive Committee of the Board and does not have any executive powers, other than those specifically delegated in these terms of reference.
1.3	The functioning of the Audit Committee will take into account the requirements of the NHS Code of Governance for Provider Trusts, the Trust's constitution, the NHS Audit Committee Handbook and NHS England guidance on audit and assurance.
1.4	Its constitution and terms of reference shall be as set out below. Any amendments will be subject to Board approval
2.0	**Purpose**
2.1	The purpose of the Committee is to provide the Board with assurance that the organisation operates effectively and has a system of internal control that enables it to meet its regulatory and statutory duties and achieve its strategic aims and objectives.
2.2	The responsibilities of the Committee are as follows: i. Ensure that management of the Trust's activities are in accordance with all statutory, legislative and regulatory requirements ii. Ensure the establishment and maintenance of a sound system of internal control and risk management that provides assurance that assets are safeguarded, waste or inefficiency is avoided, reliable financial information is produced, and that value for money is continuously sought. iii. Provide assurance of the independence of the trust's external and internal audit services iv. Scrutinise the findings of completed audit reports and oversee the delivery of remedial actions. v. Ensure that appropriate standards are set and compliance with them is monitored, in non-financial, non-clinical areas that fall within the remit of the Committee. vi. Maintain oversight of the Board Assurance Framework (BAF) and ensure that the risks to delivery of the objectives are monitored and aligned to the annual internal audit programme vii. Ensure that the Trust's systems of governance and risk management are effective and adhered to (e.g. compliance with key governing frameworks such as the NHS Code of Governance for Provider Trusts, NHS England guidance on

	audit and assurance Standing Orders, Standing Financial Instructions, maintenance of Registers of Interests.
3.0	**Authority**
3.1	The Committee is authorised by the Board to: • Act within or investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. • Obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions. Any costs incurred must be within the remit of the Scheme of Delegation and Standing Financial Instructions. • Obtain such internal information as is necessary and expedient to the fulfilment of its functions. • Liaise, as necessary, with other Committees of the Board; Chairs of other the Committees have a responsibility for ensuring that the Audit Committee and the Board are advised of any risks, concerns or transgressions
3.2	The Committee may establish, subject to Board approval, sub-groups to execute the delegated powers within these terms of reference.
3.3	Trust Standing Orders and Standing Financial Instructions apply to the operation of the Committee.
3.4	The Audit Committee will have oversight of the Trust's strategy, systems and processes for the management of risk to ensure that this is effective and that risks are being effectively mitigated.
4.0	**Duties and Responsibilities**
4.1	**Governance, Risk Management and Internal Control**
4.1.1	The Committee shall review the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the trust's activities (both clinical and non-clinical) that support the achievement of the organisation's objectives. In particular, the Committee will review the monitor and scrutinise the following: i. All risk and control related disclosure statements, in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commission Essential Standards, together with any accompanying Head of Internal Audit Assurance statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board. ii. The underlying assurance processes (BAF and risk register) that indicate the degree of achievement of the trust's strategic objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements. iii. Policies for ensuring compliance with relevant regulatory, legal

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

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

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

4.5.3	Monitor the performance of both reactive and proactive fraud work in line with the terms of the Standard NHS Contract and in accordance with the NHS Counter Fraud Authority (NHSCFA) Standards for Providers: Fraud, Bribery and Corruption, to ensure that appropriate counter fraud measures are in place. Review the reports from the LCFS, consider the major findings of fraud investigations, and management's response, and ensure co-ordination between the LCFS, internal and external auditors.
4.5.4	Consider the annual report of the NHS Counter Fraud Authority. Consider and take appropriate action regarding any NHSCFA quality assurance recommendations arising from the assessment process.
4.6	**Other Assurance Functions**
4.6.1	The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation. These will include, but will not be limited to, any reviews by relevant NHS bodies or Regulators/Inspectors (e.g. NHS England, Care Quality Commission, NHS Resolution etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.).
4.6.2	The Committee will review items referred to it and the work of other Committees within the organisation and whose work can provide relevant assurance to the Audit Committee's own scope of work. In particular, the Audit Committee will rely on the assurance provided by other Committees in respect of specific risks in the BAF designated to them.
4.6.3	In reviewing the work of the Quality and Safety Committee, and issues around clinical risk management, the Audit Committee will seek to satisfy itself on the assurance that can be gained from the clinical audit function. In particular, the Audit Committee will seek assurance that there is an effective and robust clinical framework and arrangements in place.
4.6.4	The Committee will review issues around the management of charitable funds and will seek to satisfy itself on the assurance that can be gained from the Charitable Funds Annual Report and Financial Statements before submission to the Board.
4.6.5	The Committee will: i. Examine any other matter referred to it by the Board and initiate investigation as determined by the Committee. ii. On behalf of the Board seek assurance on the appointment of outside contractors for financial services e.g. Internal Audit, Banking, Payroll Services, and procurement compliance matters e.g. Single Tender Waivers. etc
4.6	**Management**
4.6.1	The Committee shall request and review reports and assurances from relevant Directors and Managers on the overall arrangements for governance, policy management, risk management and internal control, including regular updates on the BAF and risk register.

	The Committee may also request specific reports from individual functions within the organisation (e.g. clinical audit), as they may be appropriate to the overall arrangements.
4.7	**Standing Orders, Standing Financial Instructions, Governance Assurance and Accountability Framework and Standards of Business Conduct**
4.7.1	Review all suspensions of Standing Orders and variation or amendment to Standing Orders.
4.7.2	Review, on behalf of the Board, the operation of, and proposed changes to, the Standing Orders and Standing Financial Instructions, Codes of Conduct and Standards of Business Conduct; including maintenance of Registers of interests, gifts, hospitality and sponsorship.
4.7.3	Examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.
4.7.4	Review the Scheme of Reservation and Delegation of Powers
4.8	**Digital/Cyber Agenda and Information Governance**
4.8.1	Ensure an effective IG management framework and policies are in place to ensure compliance with the requirements of NHS Data Security and Protection Toolkit.
4.9	**Freedom to Speak Up**
4.9.1	The Audit Committee will review the arrangements by which staff and volunteers of the Trust may raise, in confidence, concerns about possible improprieties in matters relating to: ▪ Financial reporting and control ▪ Clinical quality ▪ Patient safety ▪ Staff experience ▪ Other matters The Committee will ensure that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow up action.
4.10	**Other Matters**
4.10.1	On an annual basis, the Committee will review its own effectiveness by reference to the NHS Audit Committee Handbook (latest version – 2018) and the Code of Governance for NHS Provider Trusts. These terms of reference should be reviewed annually and will be made publicly available in accordance with the NHS Foundation Trust Code of Governance.
5.0	**Membership and Quoracy**
5.1	The Committee membership shall be appointed by the Board from amongst the Non-Executive Directors and shall consist of not less than three designated members. Each member shall meet the criteria for independence as set out in the Code of Governance for NHS Provider Boards and the Board will satisfy itself that the membership has sufficient skills to discharge its responsibilities effectively, including

	ensuring that at least one member of the Audit Committee has recent and relevant financial experience.
5.2	Of the 3 Non-Executive Director members, one will be a member of the Trust's Quality and Safety Committee and one a member of the Finance & Performance Committee, in order to reinforce the relationship between the committees in respect of seeking assurance over the management of risk and other relevant control issues.
5.3	Members are required to attend at least two thirds of the meetings held in each financial year. Where a member is unable to attend a meeting, they should notify the Committee Chair or Secretary of the Committee in advance.
5.4	In the absence of the Committee Chair, the remaining members present shall elect one of themselves to chair the meeting.
5.5	The Chair of the Board shall not be a member of the Committee.
5.6	The Committee will be deemed quorate to the extent that two of its members are present. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of its authorities and powers.
5.7	Any member of the Committee may participate by means of telephone conferencing, video conferencing or similar communications equipment whereby all persons participating in the meeting can hear each other, and participation in the meeting in this manner shall be deemed to constitute presence in person at such meeting.
6.0	**Attendance at Meetings**
6.1	In addition to the membership the following will attend each meeting: ▪ Chief Finance Officer ▪ Chief Governance Officer ▪ External Audit Provider lead ▪ Internal Audit Provider lead ▪ Counter Fraud provider lead (every other meeting) Those who may also attend with the committee chair's agreement: ▪ Any Executive or Non-Executive Director ▪ Trust Chair ***(at least once a year)*** ▪ A Governor, or Governors, may also attend and observe a meeting of the Committee, by invitation and with the prior agreement of the Committee Chair, for the purposes of further developing their understanding of SCAS and the NED role. ▪ For clarity, those in attendance are not members of the Committee for the purposes of quorum or decision-making however are expected and welcome to play a full and active part in Committee discussions and considerations. ▪ The Committee may invite other colleagues to be in attendance or attend as appropriate for timed business to provide assurance on key issues. ▪ The Chair of the committee can require the attendance of any director or member of staff.

6.2	When one of those required to attend (6.1) is unable to do so, they should ensure that a fully briefed and duly authorised deputy attends on their behalf.
6.3	Other Board Members, Executive Directors, officers and relevant representatives shall have the right of attendance (for all or part of the meeting), subject to invitation by the Committee Chair, particularly when the Committee is discussing areas of risk or operations that are the responsibility of that individual.
7.0	**Meetings**
7.1	Meetings of the Committee shall be formal, minuted, and compliant with relevant statutory and good practice guidance.
7.2	Ordinary meetings of the Audit Committee shall be held not less than four times a year. Additional meetings may be held; for example, for the purposes of reviewing the draft and audited annual financial accounts. The External Auditor or Head of Internal Audit may request a further meeting if considered necessary.
7.3	Additional meetings may be convened on an exceptional basis at the request of the Committee Chair to consider business that requires urgent attention.
8.0	**Reporting and Accountability**
8.1	Minutes of the Committee meetings shall be recorded formally and ratified by the Committee at its next meeting. The meeting may be formally recorded to aid in the production of written minutes and the recording deleted in line with Trust guidance.
8.2	The Committee Chair shall prepare an assurance report (upward report) following each meeting for submission to the Board at its next formal business meeting.
8.3	This report should include details of any matters in respect of which adequate actions or improvements are needed. The Committee Chair shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action. The following triggers outline the framework to be used for escalating an item from the Committee to the Board: i) Risks scoring 15 or higher on the Risk Register that have inadequate mitigating actions in place, or with actions overdue and no robust plans in place to resolve them. ii) Internal controls that are inadequate and which require strengthening. iii) Any qualified opinion from the External Auditors. iv) Outstanding actions and Limited Assurance arising from any Internal Audit exercise v) Losses that will have a significant impact upon the Trust. vi) Deviation from the requirements of the Data Protection & Security Toolkit vii) Performance of out-of-date policies. viii)Fraud and Anti-Bribery issues.

8.4	The Committee shall be directly accountable to the Board.
8.5	The Committee will provide an annual report to the Board setting out how it has discharged its responsibilities as set out in these terms of reference. This will include identified committee improvement objectives for the forthcoming financial year.
8.6	Meeting papers will be circulated to members 1 week (5 working days) prior to the meeting.
9.0	**Secretary and Committee Support**
9.1	A member of the Governance Team will act as Secretary to the Committee. The Chief Governance Officer shall provide independent advice to the Committee Chair and Committee Members on compliance with the law and regulatory matters relevant to the Committee's delegated authority in accordance with Standing Orders.
9.2	The Secretary to the Committee will maintain the Committee's administrative function, to include: i) preparation of the draft agenda for agreement with the Committee Chair, ii) collation and circulation of papers, iii) minuting the proceedings and resolutions of all meetings of the Committee including recording the names of those present and in attendance, iv) keeping a record of matters arising and actions to be carried forward, v) drafting minutes of the meetings to be available within 5 working days but no longer than 10 working days from the date of the meeting, vi) creating and maintaining a Forward Plan of business to come before the Committee.
10.0	**Review, Monitoring and Effectiveness**
10.1	Members of the Committee will monitor the effectiveness of these terms of reference by: i) Recording the attendance of members. ii) Number and frequency of meetings iii) Annual member survey iv) Preparing an Annual Committee report for submission to the Board
10.2	The Trust's Annual Report shall include a section describing the work of the Audit Committee in discharging its responsibilities.
	The Chair of the Committee will produce an Annual Report to the Board on the work of the Committee in its fulfilment of its functions in connection with these terms of reference. The report will support the production of the Annual Governance Statement, specifically commenting on the fitness for purpose of the BAF, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment against the Care Quality Commission Essential Standards and any pertinent matters in respect of which the Audit Committee has been engaged.

10.3	The Committee will review its own performance, based on a self-assessment at least annually, review its constitution and Terms of Reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the Board for approval.
10.4	The Chair of the Board will receive a copy of all meeting papers.
10.5	Set an annual Forward plan for its work to form part of the Board's annual Forward Plan and report to the Board on its progress.
10.6	Where the Audit Committee considers there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wishes to raise, the Chair of the Audit Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to NHS England, via the Director of Finance in the first instance.
10.7	The Audit Committee will report to the Council of Governors (CoG) by exception, identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken. The CoG will also have the opportunity to hear from External Audit (i.e. annually) as part of their formal statutory duty of appointing/reappointing the Trust's External Auditors.

South Central Ambulance Service
NHS Foundation Trust

Finance & Performance Committee Annual Report 2024/25

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Appendix 1 Terms of Reference for the Audit Committee

Appendix 2 Member survey outputs

Section 1 Reporting Period

This report covers the financial year 2024/25 and details the work of the Finance & Performance Committee ("the committee") during that period.

Section 2 Introduction

The Finance & Performance Committee (FPC) is a formally constituted committee of the South-Central Ambulance Service (SCAS) board of directors ("trust board"). Its membership comprises executive and non-executive (NED) membership and its purpose is to support the work of the trust board by providing additional scrutiny and challenge in respect of delivery of the financial and operational performance of the Trust, in line with the trust strategy and underpinning plans. agreed strategy, plans and trajectories of the Trust.

The Committee achieves this through scrutiny of a combination of reports relating to all aspects of financial and operational performance that is not possible within the confines oof a board meeting allows the committee chair to provide assurance and to escalate risks, issues and concerns to the trust board.

Best practice in corporate governance suggests that board committees should undertake an annual assessment of their performance, review their terms of reference and present an Annual Committee report to the trust board to provide assurance that the committee is functioning effectively as intended. This report is intended to fulfil that function for the financial year 2024/25.

Section 3 Terms of Reference

The terms of reference for the committee are attached at appendix 1. These were reviewed by the Chief Governance Officer and the Chair of the Committee in June 2025 in conjunction with the outputs of the survey of members that was undertaken, to determine whether any changes were required. The terms of reference will be presented to the Trust Board for approval at the July 2025 meeting alongside this report.

Section 4 Meetings of the Committee

The committee is scheduled to meet each month, but extraordinary meetings are convened where necessary to discuss urgent matters that arise outside of the usual meeting schedule. The committee met 16 times during the financial year 2024/25 and was quorate on all occasions as at least 2 NEDs and 1 executive director were present.

Committee membership comprises 3 NEDs, all of whom meet the independence criteria plus the Chief Finance Officer and Executive Director of Operations. Independence of the NEDs was assessed as part of the annual assessment process against the Code of Governance for NHS Provider Trust, which was presented to the Audit Committee and the Trust Board. Two members of the Committee have recent and relevant financial experience and the Chair

is a member of the Audit Committee, which ensures that pertinent issues can be raised in that committee and ensures effective cross cover between the committees of the board.

One of the NED committee members left the trust in quarter 4 of the 2024/25 financial year. Another NED was appointed to the committee for the remainder of the financial year to ensure quoracy and will continue to attend until the new complement of NEDs commence in post in July 2025.

From an executive perspective the Chief Finance Officer (CFO), Chief Digital & Information Officer (CDIO) and Executive Director of Operations (EDO) attend meetings along with the Chief Governance Officer (CGO). Other executive directors and leaders of functions pertinent to the terms of reference for the committee attend when asked to do so by the Chair.

Section 5 Reporting to the Board of Directors

The committee chair presents a written report to the Trust Board in the public meeting that follows the FPC meeting and highlights all relevant risks, issues, concerns and successes. These reports can be found within the public board papers.

Section 6 Work of the Committee

The committee has a dedicated work-plan to manage the workload over the year. The full gambit of reports received by the committee are not listed here, but during 2024/25 the committee has received regular reports relating to the following:

- Annual Operational Plan
- All aspects of financial performance including:
    - Monthly financial performance
    - CIP Performance
    - Capital Programme and capital spending
    - Financial Recovery Plan
- Business cases (for approval or recommendation to the board for approval)
- Fleet and fleet management
- Non-Emergency Patient Transport Services
- Contract Register
- Operational Performance
    - Performance against ambulance response times
    - Fleet and fleet management
- Procurement
- Relevant finance policies
- Digital agenda
- Estates & Facilities
- Sustainability
- Board Assurance Framework risks aligned to the committee's agenda

Through receipt, scrutiny and challenge of these regular reports, the committee has been in a position to provide assurance to the board and to highlight risks and concerns relating to financial and operational performance.

Financial year 2024/25 saw the trust achieve the second year of its financial recovery plan and the committee has played a key role in ensuring that the control total was successfully delivered alongside an ambitious CIP programme. Recognising that the trust has been on a journey to recover its financial position, a keen focus of the committee during the year has nevertheless been to move towards medium-term financial planning and forecasting to achieve medium- and longer-term financial sustainability. This has commenced with the production of an Annual Operating Plan for 2025/26 that links finance, operational performance and workforce and brings the trust back into financial balance by the end of 2025/26, in line with its statutory duty to do so.

The committee will continue to monitor progress against the Annual Operating Plan over the coming year and to oversee the development of the medium-term financial plan as part of an overall Integrated Business Plan to ensure that the linkage and interdependencies between financial, operational performance, workforce and quality is clear and fully set out.

Section 7 Member Survey

A survey of committee members was undertaken with a view to identifying any changes that needed to be made to improve the effectiveness of the committee and to set improvement objectives for 2025/26. The outputs of the survey are included at appendix 2.

The main areas of focus for improvement as identified by respondents disagreeing with the statements are:

- The timeliness of papers
- Quality of papers and avoiding duplication
- Committee members being appropriately sighted on key projects
- The potential to shorten the length of meetings, which links to the points made above around the timeliness of submission and quality of papers

The board has now approved the Fit for the Future Board Assurance Framework which captures all key programmes of work that are scheduled to take place during the year and the cycles of business for the board and committees thereof will be aligned to this and ensure that the strategic ambitions of the trust are overseen and delivered. This should in turn address the areas for improvement outlined above, alongside the overall governance improvement work that is taking place. It should be noted that the issues with regards to the timeliness of papers were identified during the self-assessment against the NHS Provider Code of Governance and apply equally across the committees and the board.

Section 8 Committee Annual Improvement Objectives

The following improvement objectives for the committee for 2025/26 have been agreed. Actions will be put into train, and we will report on progress in the 2025/26 Annual Committee Report.

- Improved timeliness of paper circulation
- Improved quality of papers/focus on assurance
- Regular reporting on key projects/initiatives

Section 9 Conclusion

As Finance & Performance Committee Chair, I conclude that the committee is operating effectively and has discharged the duties delegated to it by the Trust Board.

Les Broude
Finance & Performance Committee Chair
June 2025

Terms of Reference – Finance & Performance Committee

June 2025

Document Status	Approved
Version	V2.0
Document Change History *(to include Executive changes, external review, Committee effectiveness)*	Replaces v1.0 - approved in May 2024
Initiated by	Becky Southall, Chief Governance Officer June 2025
Document Owner	Chief Governance Officer
Recommended at Date	Finance and Performance Committee May 2025
Approved at Date	Board of Directors July 2025
Valid Until Date	June 2026
Linked Policy Documents	Standing Orders Scheme of Reservation and Delegation of Powers Other Committee Terms of Reference Standing Financial Instructions Code of Governance for NHS Provider Boards Provider Licence
Dissemination requirement	Cascade to Board members and Senior Leaders and forms part of Board level induction pack
Part of the Trust's publication scheme	Yes

Finance & Performance Committee Terms of Reference – May 2024

1.0	**Constitution**
1.1	The board of directors ("board") of South Central Ambulance Service NHS Foundation Trust ("the trust") hereby resolves to establish a Committee of the Board to be known as the Finance and Performance Committee ("the Committee").
1.2	The Committee is constituted as a standing committee of the Board and may only exercise the powers formally delegated to it via these terms of reference.
1.3	The Committee will support the work of the board in ensuring that the trust acts in accordance with statute, legislation and regulatory requirements. It will be fully appraised of all aspects of the trust's financial and operational performance in furtherance of achievement of the trust's overall strategic aims and objectives.
1.4	Its constitution and Terms of Reference are set out below. Any changes will be subject to trust board approval.
2.0	**Purpose**
	The Committee is a formal, standing committee of the trust board and was established to support the work of the board by providing scrutiny in respect of all aspects of financial and operational performance. It will also support the work of the board in ensuring that the financial strategy supports long term service delivery on a sustainable basis As part of an integrated approach, the Committee must have effective relationships with other Board Committees to avoid duplication.
3.0	**Authority**
3.1	The Committee is an assurance committee but is authorised by the Board to make decisions within these terms of reference, including matters specifically referred to it by the Board.
3.2	The Committee is authorised by the Board to investigate any activity within its terms of reference and to request any information it requires in order to discharge its duties. This authority includes the following, where it is necessary or expedient to do so: • Obtaining outside legal or other independent professional advice and securing the attendance of individuals at meetings • Seeking any information that it requires from any officer or employee of the trust and all officers and employees are directed to cooperate with any request made by the committee • Obtaining any such internal information as is necessary to fulfil these terms of reference
3.3	Any costs incurred in connection with (3.2) must be within the remit of the Scheme of Delegation and Standing Financial Instructions.
3.4	The Committee is authorised by the Board to liaise, as necessary, with other committees of the Board. The chair of the committee has responsibility for ensuring that the Audit Committee and the Board

	are advised of any risks or potential conflicts.
3.5	It is not the duty of the Committee to carry out functions that properly belong to the Board itself or to other Board Committees.
3.6	The Committee may establish, subject to Board approval, sub-groups to execute the delegated powers within these Terms of Reference.
3.7	Trust Standing Orders and Standing Financial Instructions apply to the operation of the Committee.
3.8	Whilst the Audit Committee has responsibility for ensuring that the trust's risk management framework is effective and operating as intended, the committee will review Board Assurance Framework (BAF) risks as assigned to it and any risks on the risk register relating to areas that fall within these terms of reference that are designated as significant risks as per the Trust's Risk Management Framework
4.0	**Duties and Responsibilities**
4.1	**Governance**
4.1.1	Ensure that all statutory and regulatory elements of financial and operational governance are adhered to within the Trust.
4.1.2	Receive and scrutinise the monthly Finance Report prior to receipt by the Board.
4.1.3	Approve financial, estates and digital policies and procedures that are not reserved to the trust board and in line with the trust's policy framework.
4.1.4	Make recommendations to the Audit Committee concerning the annual programme of internal audit work based on identified areas of risk arising out of committee business.
4.1.5	▪ Review BAF and significant risks relating to the committee's remit ▪ Review internal audit reports and subsequent management actions pertinent to the duties and responsibilities of the committee ▪ Receive upward reports from the committee's sub-groups
4.1.6	The principal duties of the Committee are set out below:
5.2	**Finance**
5.2.1	▪ Oversee the development of the Trust's medium and long financial strategy ▪ Scrutinise annual, three and five-year financial plans and make recommendations to the Board (5 yr only when implemented.) ▪ Review the Integrated Business Plan and make recommendations to the board in relation to approval ▪ Review the annual Cost Improvement Plan and make recommendations to the trust board in relation to approval ▪ Review the Annual Operating Plan and make recommendations to the board in relation to approval ▪ Oversee performance against the trust's Financial Recovery Plan and seek assurance that appropriate financial controls are in place ▪ Monitor progress against these plans and financial forecasting and ensure that remedial action is taken where required ▪ Ensure that the budget setting process is robust

	▪ Oversee the movement on reserve accounts, cash flow and balance sheet ▪ Ensure that the Capital Expenditure Plan is robust and that is developed using a risk-based approach ▪ Receive assurance on the delivery of the Capital Programme and the escalation of any risks identified and mitigating actions proposed ▪ Receive and review relevant NHS benchmarking reports ▪ Approve business cases in line with the value set out in the Scheme of Delegation and make recommendations to the trust board on business cases that require board approval ▪ Monitor progress against business cases and ensure that benefits are realised post implementation ▪ Review the effectiveness of appropriate policies (including Standing Financial Instructions) within the Committee's remit ▪ Maintain oversight of the Trust's approach to bidding for new business
5.3	**Performance**
5.3.1	▪ Review operational performance via the key KPIs set out in the Integrated Performance Report (IPR) and ensure that any corrective actions are followed up and drive improvement ▪ Refer issues/risks to other committees of the board as appropriate
5.4	**Estates**
5.4.1	▪ Ensure that the trust has a robust Estates Strategy in place and monitor delivery against associated plans ▪ Monitor the implementation of the Sustainability Plan. ▪ Property & Asset Strategy ensure that the strategy reflects the Trust's purpose, aims, strategic and corporate objectives and that the Trust's property and assets are developed and maintained to meet the needs of service models and are sustainable and achieve value for money
6.0	**Relationship with Audit Committee**
6.1	The Chair of the committee will be a member of the Audit Committee and is responsible for ensuring that any risks or issues that require Audit Committee attention are escalated to the committee and the board where appropriate and necessary.
7.0.	**Membership and Quorum**
7.1	Committee membership shall be appointed by the Board from amongst both the Executive Directors and Non-Executive Directors and shall consist of not less than three Non-Executive Directors members, at least one of whom should have recent and relevant financial experience and two Executive members. One Non-Executive member will act as Chair of the Committee.
7.2	Membership: • 3 Non-Executive Directors • Chief Finance Officer • Executive Director of Operations In attendance:

	• Chief Governance Officer • Chief Digital Officer
7.3	Members are required to attend at least two thirds of the meetings held in each financial year. Where a member is unable to attend, they should notify the Committee Chair or Secretary of the Committee in advance.
7.4	In the absence of the Committee chair, the remaining members present shall elect one of themselves to chair the meeting.
7.5	The Chair of the Board shall not normally be a member of the Committee. He/she will have automatic rights as a member of the Committee at times when the quorum cannot be met or there are vacancies at Non-Executive Director level that warrant temporary Committee membership. The Chair of the Board may also attend at other times by advising the Committee Chair
7.6	The Committee will be deemed quorate to the extent that there are 2 Non-Executive Directors and one Executive Director present. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of its authorities and powers.
7.7	Officers and employees of the trust who are members of the committee are present in a corporate director capacity and not to represent or advocate for their respective department, division, or service area.
7.8	Any member of the Committee may participate by means of telephone conferencing, video conferencing or similar communications equipment whereby all persons participating in the meeting can hear each other, and participation in the meeting in this manner shall be deemed to constitute presence in person at such meeting.
8.0	**Attendance at Meetings**
8.1	In addition to the membership requirements outlined in (7.1) and (7.2) above, the following may also be invited to attend committee meetings: ▪ Deputy Chief Finance Officer ▪ Heads of Finance and Finance Managers ▪ Assistant Directors of Operations ▪ Head of Transformation ▪ Assistant Director of Digital ▪ Director of Estates ▪ Chair of the Board ▪ Chief Executive Officer
8.2	When an executive member or attendee is unable to attend a meeting, a fully briefed deputy with authority to act should attend on their behalf.
8.3	Other board members shall have the right of attendance (for all or part of the meeting), subject to invitation by the Committee Chair, particularly when the Committee is discussing areas of risk that are the responsibility of that individual.
9.0	**Meetings**

9.1	Meetings of the Committee shall be formal, minuted, and compliant with relevant statutory and good practice guidance as well as the Trust's Standing Orders and Standing Financial Instructions and the Code of Governance for NHS Provider Boards.
9.2	Meetings of the Finance and Performance Committee shall be held monthly and scheduled to support the business cycle of the Board.
9.3	Additional meetings may be convened on an exceptional basis at the request of the Committee Chair to consider business that requires urgent attention.
10.0	**Reporting and Accountability**
10.1	Minutes of the Committee meetings shall be recorded formally and ratified by the Committee at its next meeting. The meeting may be formally recorded to aid in the production of written minutes and the recording deleted in line with Trust guidance.
10.2	The Committee Chair shall prepare an assurance report (upward report) following each meeting for submission to the Board at its next formal business meeting.
10.3	This report should include details of any matters in respect of which adequate actions or improvements are needed. The Committee Chair shall draw to the attention of the Board any issues that require disclosure to the full Board or require executive action. The following triggers are triggers for escalation to the Board: i. Non-compliance with indicators for 2 consecutive months, or off track against agreed trajectory ii. Risks that sit within the committees remit that are significant (15+) with inadequate mitigating actions or with actions overdue and no assured plan for resolution iii. Variation of 10% from target or agreed trajectory iv. Variation from the year end projection v. CIP milestone non-delivery with no clear plan – red RAG rating. vi. Business case review and recommendation to the Board
10.4	The Committee shall be directly accountable to the Trust Board.
10.5	The Committee will provide an annual report to the Board setting out how it has discharged its responsibilities as set out in these Terms of Reference.
10.6	The following Sub-Committees shall report to the Committee as the primary reporting line using the standard upward reporting template: ▪ Financial Recovery Group ▪ Fixed Asset Management Steering Group ▪ Digital Steering Group
10.7	Meeting papers will be circulated to members 1 week (5 working days) prior to the meeting.
10.8	The Committee will report to the Audit Committee on the following areas for assurance:

	▪ The work it has undertaken in support of the Annual Governance Statement ▪ Strategic objectives aligned to this Committee ▪ BAF and significant risks monitored by the Committee ▪ Assurances and effectiveness of the Committee
10.9	The Committee will liaise with the Quality & Safety Committee and People and Culture Committee in respect of the review of the Integrated Performance Report, where appropriate.
11.0	**Secretariat and Committee Support**
11.1	A member of the Governance Team will act as Secretary to the Committee. The Chief Governance Officer shall provide independent advice to the Committee Chair and Committee Members on compliance with the law and regulatory matters relevant to the Committee's delegated authority in accordance with Standing Orders.
11.2	The Secretary to the Committee will maintain the Committee's administrative function, to include: i) preparation of the draft agenda for agreement with the Committee Chair, ii) collation and circulation of papers, iii) minuting the proceedings and resolutions of all meetings of the Committee including recording the names of those present and in attendance, iv) keeping a record of matters arising and actions to be carried forward, v) drafting minutes of the meetings to be available within 5 working days but no longer than 10 working days from the date of the meeting, vi) creating and maintaining a Forward Plan of business to come before the Committee.
12.0	**Review Monitoring and Effectiveness**
12.1	Members of the Committee will monitor the effectiveness of these Terms of Reference by: i) Recording the attendance of members and how often they send a representative. ii) Number and frequency of meetings in line with the Finance and Performance Terms of Reference as per section 9.2 iii) Preparing an Annual Report as outlined in (10.5)
12.2	The Trust's Annual Report shall include a section describing the work of the Committee in discharging its responsibilities.
12.3	The Chair of the Board will receive a copy of all meeting papers and will attend at least one meeting per annum for monitoring and assurance purposes.
12.4	Set an annual Forward plan for its work to form part of the Board's annual Forward Plan and report to the Board on its progress.
13.0	**Strategies ratified and approved by this Committee**
13.1	Strategies:

	• Procurement Strategy • Contract Strategy • Financial Strategy • Performance/Operational Strategy • Estates Strategy • Green / Sustainability Strategy • Digital Strategy
14.0	**Policies ratified and approved by this Committee**
14.1	The Policies ratified by this committee are detailed in the Policy for the Development of Trust Policy.

South Central Ambulance Service
NHS Foundation Trust

People & Culture Committee Annual Report 2024/25

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9. Conclusion

Appendix 1 Terms of Reference for the People & Culture Committee

Appendix 2 Member survey outputs

Section 1 Reporting Period

This report covers the financial year 2024/25 and details the work of the People & Culture Committee ("the committee") during that period.

Section 2 Introduction

The People & Culture Committee (PACC) is a formally constituted committee of the South-Central Ambulance Service (SCAS) board of directors ("trust board"). Its membership comprises executive and non-executive (NED) membership and its purpose is to support the work of the trust board by providing additional scrutiny and challenge in respect of the trust's People & Culture agenda, which is a strategic theme within the Fit for the Future framework.

The Committee achieves this through scrutiny of a combination of reports relating to all aspects of the people agenda, that is not possible within the confines of a board meeting, and this allows the committee chair to provide assurance and to escalate risks, issues and concerns to the trust board.

Best practice in corporate governance suggests that board committees should undertake an annual assessment of their performance, review their terms of reference and present an Annual Committee report to the trust board to provide assurance that the committee is functioning effectively as intended. This report is intended to fulfil that function for the financial year 2024/25.

Section 3 Terms of Reference

The current terms of reference for the committee are attached at appendix 1. These have been subject to review and amendments over the course of the year and were last approved in May 2025. A committee survey was undertaken and is appended to this report (appendix 2). Further revisions to the terms of reference are likely to be required based on the feedback, the renewed focus on Culture & Leadership as a strategic theme in the Fit for the Future programme and in the advent of a new Chair taking up role. These will be agreed at the next committee meeting and will be presented to the Board once the review and any amendments are complete.

Section 4 Meetings of the Committee

The committee is scheduled to meet on a bi-monthly basis. The committee met 6 times during the year although it should be noted that the March meeting was rescheduled to April and technically fell within the current financial year. The meeting was quorate on all occasions as there were 2 non-executive directors and one executive director present.

Committee membership comprises 3 NEDs, all of whom meet the independence criteria plus the Chief People Officer, Chief Nursing Officer, Chief Paramedic and the Executive Director of Operations.

Independence of the NEDs was assessed as part of the annual assessment process against the Code of Governance for NHS Provider Trust, which was presented to the Audit Committee and the Trust Board.

The former NED committee chair left the board at the end of May 2025 and a new chair appointment has been made. One of the NEDs on the committee was also a member of the Quality & Safety Committee to ensure appropriate cross cover and the ability to triangulate issues given the strong linkage between workforce and the quality agenda. This arrangement has continued into 2025/26 when the NED membership has been refreshed in line with the newly appointed NEDs taking up post.

Section 5 Reporting to the Board of Directors

The committee chair presents a written report to the Trust Board in the public meeting that follows the PACC meeting and highlights all relevant risks, issues, concerns and successes. These reports can be found within the public board papers.

Section 6 Work of the Committee

The committee has a dedicated work-plan to manage the workload over the year. The full gambit of reports received by the committee are not listed here, but during 2024/25 the committee has received regular reports relating to the following:

- Key people metrics as set out in the Integrated Performance Report (PDR/sickness absence/attrition etc.)
- People related Board Assurance Framework risks
- Freedom to Speak Up
- Education & Training
- Gender Pay Gap
- Equality, Diversity & Inclusion
- Workforce Race Equality Standard (WRES)
- Workforce Disability Equality Standard (WDES)
- Staff Survey
- Health & Wellbeing
- Human Resources Case work
- Time to hire
- People related policies

Through receipt, scrutiny and challenge of these regular reports, the committee has been in a position to provide assurance to the board and to highlight risks and concerns relating to the committee's role and remit.

The refresh of the trust's strategic Fit for the Future Framework provides the opportunity to re-focus the committee's agenda on the cultural development aspect of the People agenda and the committee will monitor progress against the tier 1 programmes set out in the strategic theme.

Section 7 Member Survey

A survey of committee members was undertaken with a view to identifying any changes that needed to be made to improve the effectiveness of the committee and to set improvement objectives for 2025/26. The outputs of the survey are included at appendix 2.

The main areas of focus for improvement as identified by respondents disagreeing with the statements are:

- The timeliness of papers
- The quality and content of papers
- The level of assurance offered within papers and the ability to triangulate across the different sources of assurance
- Oversight of significant projects and plan
- The level of focus on the organisational and cultural development aspects of the People agenda

As referenced above, the board has now approved the Fit for the Future Board Assurance Framework which captures all key programmes of work that are scheduled to take place during the year and the cycles of business for the board and committees thereof will be aligned to this and ensure that the strategic ambitions of the trust are overseen and delivered.

This should in turn address the areas for improvement outlined above, alongside the overall governance improvement work that is taking place. It should be noted that the issues with regards to the timeliness of papers were identified during the self-assessment against the NHS Provider Code of Governance and apply equally across the committees and the board.

Section 8 Committee Improvement Objectives

The following improvement objectives for the committee for 2025/26 have been agreed. Actions will be put into train, and we will report on progress in the 2025/26 Annual Committee Report.

- Regular oversight of progress against the Cultural Development Programme
- Improved timeliness of circulation of papers
- Improved analysis of data from multiple sources within papers to create intelligence

Section 9 Conclusion

As a former member of the PACC and now the Chair, I conclude that whilst there is further work to be done to strengthen the committee, it operated effectively during 2024/25 and has discharged the duties delegated to it by the Trust Board.

Ian Green
People & Culture Committee Chair
July 2025

South Central Ambulance Service
NHS Foundation Trust

Quality & Safety Committee Annual Report 2024/25

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Appendix 1 Terms of Reference for the Quality & Safety Committee

Appendix 2 Member survey outputs

Section 1 Reporting Period

This report covers the financial year 2024/25 and details the work of the Quality & Safety Committee ("the committee") during that period.

Section 2 Introduction

The Quality & Safety Committee (QSC) is a formally constituted committee of the South-Central Ambulance Service (SCAS) board of directors ("trust board"). Its membership comprises executive and non-executive (NED) membership and its purpose is to support the work of the trust board by providing additional scrutiny and challenge in respect of delivery of quality performance in line with the trust strategy and underpinning plans.

The Committee achieves this through scrutiny of a combination of reports relating to quality performance that is not possible within the confines of a board meeting, which allows the committee chair to provide assurance and to escalate risks, issues and concerns to the trust board.

Best practice in corporate governance suggests that board committees should undertake an annual assessment of their performance, review their terms of reference and present an Annual Committee report to the trust board to provide assurance that the committee is functioning effectively as intended. This report is intended to fulfil that function for the financial year 2024/25.

Section 3 Terms of Reference

The terms of reference for the committee are attached at appendix 1. These were reviewed by the Chief Governance Officer and the Chair of the Committee in June 2025 in conjunction with the outputs of the survey of members that was undertaken, to determine whether any changes were required. The revised terms of reference will be presented to the Trust Board for approval at the July 2025 meeting alongside this report.

Section 4 Meetings of the Committee

The committee is scheduled to meet bi-monthly and met 6 times during the financial year 2024/25. It was quorate on all occasions as at least 2 NEDs and 1 executive director were present.

At present, committee membership comprises 3 NEDs, with the Chief Nursing Officer, Chief Medical Officer and Chief Operating Officer listed as essential attendees. This is now out of date and doesn't reflect the composition of other committees of the board, with the exception of the Audit Committee that comprises NED membership. Changes to the core membership and those in regular attendance have been made in the revised Terms of Reference attached.

All the NED members meet the independence criteria, which was assessed as part of the annual assessment process against the Code of Governance for NHS Provider Trusts, that

was presented to the Audit Committee and the Trust Board. The former NED Chair was a clinician by background and therefore had the relevant clinical quality related skills and background.

The committee saw a change in NED chair towards the end of the financial year and the newly appointed Chair is also a member of the Audit Committee, which allows for cross cover and the ability to raise issues and concerns across the committees. The trust Chair provided clinical input and expertise as a temporary committee member when the former NED left the trust.

Going forward, one of the newly appointed NEDs with a clinical background joined the committee at the start of 2025/26 and a further NED with a clinical background will also be joining. This will further strengthen the committee in terms of independent expertise in relation to clinical quality performance, supplemented by a Chair with strong skills in risk management.

From an executive perspective, the committee benefited from the Chief Paramedic Officer (CPaO) joining the committee after their appointment and the refresh of the executive membership should drive further improvements in the committee's reporting, oversight and functioning during 2025/26.

Section 5 Reporting to the Board of Directors

The committee chair presents a written report to the Trust Board in the public meeting that follows the QSC meeting and highlights relevant risks, issues, concerns and successes. These reports can be found within the public board papers.

Section 6 Work of the Committee

The committee has a dedicated work-plan to manage the workload over the year. The full gambit of reports received by the committee are not listed here, but during 2024/25 the committee has received regular reports relating to the following:

- Integrated Performance Report (IPR) – quality and performance metrics
- Patient Safety workstream updates, including PSIRF implementation
- Workforce and Education updates
- Board Assurance Framework Risks assigned to the committee
- Reports relating to risks to quality that arose during the year
- Policies that fall within the committee's remit
- Quality Impact Assessments

The committee has also received regular reports from the committees that report to it:

- Safeguarding Committee
- Infection Prevention and Control Committee
- Clinical Review Group
- Patient Safety & Experience Group

Through receipt, scrutiny and challenge of these regular reports, the committee Chair has been able to highlight risks and concerns relating to quality performance to the trust board.

Section 7 Member Survey

A survey of committee members was undertaken with a view to identifying any changes that needed to be made to improve the effectiveness of the committee and to set improvement objectives for 2025/26. The outputs of the survey are included at appendix 2.

The main areas of focus for improvement as identified by respondents disagreeing with the statements are:

- Pre-meetings and meeting preparation
- The timeliness and quality of papers
- Understanding of the committee's role and purpose
- Understanding of the risks to quality and the mitigations in place
- Oversight of key projects aimed at improving quality of care delivery
- Understanding of quality assurance sources across the organisation

The board has now approved the Fit for the Future Board Assurance Framework which captures all key programmes of work that are scheduled to take place during the year and the cycles of business for the board and committees thereof will be aligned to this and ensure that the strategic ambitions of the trust are overseen and delivered. This should in turn address the areas for improvement outlined above, alongside the overall governance improvement work that is taking place. It should be noted that the issues with regards to the timeliness of papers were identified during the self-assessment against the NHS Provider Code of Governance and apply equally across the committees and the board.

Section 8 Committee Improvement Objectives

The following improvement objectives for the committee for 2025/26 have been agreed. Actions will be put into train, and we will report on progress in the 2025/26 Annual Committee Report.

- Greater focus on current and emerging risks to quality and using these to drive the agenda
- Robust agenda planning and setting
- Regular oversight of key areas across the quality agenda; patient safety, patient experience and clinical effectiveness via regular reporting
- Greater assurance through regular reporting in relation to areas of statutory responsibility including Safeguarding, Infection Prevention and Control and Health & Safety
- Greater oversight of incident management and learning through regular reporting

Section 9 Conclusion

As incoming Chair, new into post in 2025/26 and a relative newcomer to the committee, it is not possible to provide an assurance statement in relation to the effectiveness of the committee during 2024/25. However, the feedback that has been provided in relation to committee performance provides sufficient feedback on areas for improvement and these will be progressed at pace during 2025/26, aided by refreshed approach to agenda setting, a refresh of NEDs with clinical experience and revised executive membership.

Katie Kapernaros
Quality & Safety Committee Chair
June 2025

South Central Ambulance Service
NHS Foundation Trust

QUALITY AND SAFETY COMMITTEE

TERMS OF REFERENCE

Date issued:	**June 2025 V.3**
Next Review date:	**Annual review due June 2026**
Review dates:	**Approved by the Quality & Safety Committee July 2025**
Person Responsible:	**Non-Executive Director, Chair of Quality and Safety Committee**

1. Authority

1.1 The Quality and Safety Committee ("the committee") is constituted as a standing committee of the Trust's Board of Directors ("the trust board"). Its constitution and Terms of Reference shall be as set out below and any changes will be subject to trust board approval.

1.2 The Committee is authorised by the Board to act within its Terms of Reference. All members of staff are directed to co-operate with any request made by the Committee.

1.3 The Committee is authorised to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience (e.g. external auditors and expertise if it considers this necessary for, or expedient to, the exercise of its functions). Any external advice that is commissioned must comply with the trust's Standing Financial Instructions.

1.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2. Role

To provide scrutiny and challenge and assure the trust board that high standards of care that meet statutory duties and regulatory requirements are provided by the Trust and that there are robust quality governance structures, processes and controls in place from point of care delivery to the trust board.

3. Duties

3.1 In respect of general governance arrangements:

3.1.1 Seek assurance that there are processes in place to monitor patient safety, patient experience and clinical effectiveness performance across the organisation and identify risks to delivery

3.1.2 Approve the Quality Account and annual Quality Priorities prior to submission to the trust board and monitor progress against deliver of the quality priorities

3.1.3 Approve the annual clinical audit programme ensuring that it is sufficiently risk based

3.1.4 Approve the Patient Safety Plan prior to submission to the trust board and ensure that the safety programmes are driven by data and aligned to areas of known risk

3.1.5 Approve the Infection Prevention & Control Annual Report and Plan and the Safeguarding Annual Report before submission to the trust board

3.1.6 Approve policies that fall within the remit of the committee

3.1.7 Make recommendations to the Audit Committee concerning the annual programme of internal audit work, to the extent that it applies to matters within these terms of reference

3.2 In respect of the provision of high quality, sustainable services the committee will:

3.2.1 Monitor the Trust's compliance with the required standards of quality and safety, in order to provide relevant assurance to the Board that supports the signing of Annual Governance Statement. This will be done by ensuring that relevant standards are set and monitored, including (without limitation):

- Care Quality Commission registration criteria to continue to be met and that any

identified improvement actions are completed
- NHS Provider licence requirements relevant to quality and patient safety.

3.2.2 Monitor progress against the Tier 1 programmes under the Clinical Effectiveness strategic theme

3.2.3 Seek assurance that the trust is responding appropriately to patient safety incidents through receipt of regular reports relating to themes/trends, learning and improvement activity

3.2.4 Monitor Quality Improvement Programmes and activity relating to Patient Safety and Patient Experience and seek assurance that actions are driving improvement and reducing risk

3.2.5 Monitor progress against the Board Assurance Risks assigned to the committee and the significant risk register to ensure that risk is being effectively managed and mitigated

3.2.6 Ensure that the trust is meeting statutory duties in relation to Safeguarding through receipt of regular reports relating to Safeguarding activity across the trust and any lessons learned

3.2.7 Ensuring that the trust is meeting statutory duties in relation to health and safety through regular reports in relation to health and safety incidents and the plans in place to manage and mitigate risks

3.2.8 Ensure that the trust is responding adequately to any recommendations arising out of external accreditation or Peer Reviews and that any risks are escalated to the board as appropriate

3.2.9 Ensure that the trust is responding to any National Confidential Inquiry or national reports that are issued relevant to ambulance services and monitor progress against any actions arising

3.2.10 Monitor progress against delivery of the annual Infection Prevention and Control plan and ensure that risks are being managed and mitigated

3.2.11 Ensure that the trust is managing medicines safety and governance effectively and is compliant with statutory and regulatory requirements through receipt of regular reports

3.2.12 Monitor progress against the trusts Annual Clinical Audit plan and ensure that actions identified as a result of audits are being followed up

3.2.13 Receive all internal audit reports relating to the committee's terms of reference and ensure that actions are followed up in a timely way

3.3 In respect of efficient and effective use of resources through evidence-based clinical practice:

3.3.1 Monitor the impact on the Trust's quality of care of cost improvement programmes and

service changes/developments and seek assurance that QIAs are monitored on an on-going basis to mitigate the risk of quality impact

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3.3.2 To ensure that care is based on evidence of best practice/national guidance.

3.3.3 To ensure that there is an appropriate process in place to monitor and promote compliance across the trust with clinical standards and guidelines including but not limited to NICE guidance.

3.3.4 Ensure that the trust has robust processes in place to ensure that the implementation of all new procedures and technologies are managed safely and risks mitigated

3.3.5 To ensure the research programme and governance framework is implemented and monitored.

3.4 In respect of the trust's Digital services the committee will:

- Oversee the development of the trust's Digital Strategy and the associated delivery plan and receive exception reports, as appropriate
- Receive assurance on the delivery of the Trust's digital services including:

  i) Data quality and infrastructure
  ii) Data management
  iii) Digital Service responsiveness
  iv) Cyber preparedness
- Receive updates on work being undertaken with partner organisations across the ICS in relation to digital solutions

4. Membership

4.1 Membership of the Quality and Safety Committee shall consist of[1]:three Non-Executive Directors plus the Chief Nursing Officer, Chief Medical Officer and Chief Paramedic Officer.

4.2 The following executive directors will be in regular attendance:

4.2.1 Executive Director of Operations

4.2.2 Chief Governance Officer

Other executive directors may be invited to attend the committee where there are agenda items that are pertinent to their portfolios

4.3 The Committee will be deemed quorate to the extent that 2 Non-Executive Directors and one of the Executive director members are present

4.4 Trust employees who serve as members of the Quality and Safety Committee do not do so to represent or advocate for their respective department, division, or service area but to act in the interests of the Trust as a whole and as part of the Trust-wide governance structure.

5. Attendance

[1]

5.1 List of those required at each meeting:

- Assistant Directors of Quality and Patient Safety
- Corporate Risk Manager
- Compliance and Quality Lead
- Patient representatives (e.g. Patient Safety Partner)
- Any nominated deputy attending in place of a member or essential attendee of Committee
- Any other person who has been invited to attend a meeting by the Committee to assist in deliberations.

5.2 Members listed at paragraph 4.1 are required to attend at least two thirds of the meetings held annually.

5.3 The Corporate Governance team will act as secretary to the Committee.

6. Frequency of meetings

6.1 Meetings shall be held bi-monthly.

6.2 Additional meetings may be held on an exceptional basis at the request of the Chairman of the Committee.

7. Minutes and reporting

7.1 The minutes of all meetings of the Committee may be formally recorded to aid in the production of written minutes and the recording will be deleted in line with Trust guidance.

7.2 The Committee will report to the Board after each meeting by way of an upward report.

7.3 The following sub-committees shall report using the standard upward reporting mechanism to the Executive Management Team as the primary reporting line and will for information purposes send a copy of the upward report to the Committee:

- Patient Safety and Experience Committee
- Clinical Review Group
- Safeguarding Committee
- Infection Prevention and Control Committee
- Medicines Optimisation and Governance Group
- Health & Safety Group
- Infection Prevention and Control Committee

7.4 Meeting papers will be circulated to members 1 week (5 working days) prior to the meeting.

8. Review

8.1 The Committee shall review its Terms of Reference annually as part of its overall review of committee effectiveness and will recommend any changes to the trust board as part of the Committee Annual Report.

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Trust Board of Directors Meeting in Public
31 July 2025

Report title	Board Assurance Framework 2025/26
Agenda item	26
Report executive owner	Becky Southall Chief Governance Officer
Report author	Becky Southall Chief Governance Officer
Governance Pathway: Previous consideration	BAF risks have been discussed at the assigned board committees
Governance Pathway: Next steps	N/A – report is for board assurance and on-going monitoring

Executive Summary

The purpose of this paper is to present the Board Assurance Framework (BAF) for 2025/26 for Board approval.

In May 2025 the Board approved the Fit for the Future (FFF) Board Assurance Framework as the Trust's single Improvement Plan, which is aimed at:

- Sustaining the improvements made as part of the Recovery Support Programme
- Delivering the Operating Plan for 2025/26
- Delivering on longer term, strategic priorities

The FFF framework is a comprehensive mechanism for reporting and providing assurance to the board in relation to progress against the 5 strategic themes that are aimed at delivering our strategic vision, and will allow the board to monitor:

- Progress against delivery of Tier 1 plans (using milestones and metrics); in the context of
- Current performance, and;
- Risks to delivery

The risks outlined in the attached paper are the risks to the delivery of the trust's 5 strategic objectives. In line with best practice, each risk is owned by the relevant Executive Director

and they are assigned to board committees for monitoring and scrutiny. The risks presented in the attached paper have been discussed at the relevant board committee prior to presentation to the trust board for final approval.

The BAF risks will be presented to the board on a regular basis as an integral part of the FFF reporting and assurance framework but as the risks have recently been developed and approved, they are presented as one document for formal approval. Monitoring will then take place at the board committees and the tier 1 programmes and risks will drive the committee workplans and agendas and will inform the Internal Audit Plan for 2025/26.

The board is asked to approve the Board Assurance Framework for 2025/26.

Alignment with Strategic Objectives
This report aligns to all of the trust's strategic objectives.

Relevant Business Assurance Framework (BAF) Risk
The paper is the Board Assurance Framework for 2025/26

Financial Validation	Not required

Recommendation(s)
The Committee is asked to **NOTE** the report.

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

BAF Risk 14 – Quality Performance

If we do not achieve expected response times, **Then** our patients may not receive timely treatment, **Resulting in** the potential for avoidable harm or death.

Controls, Assurance and Gaps
Controls: System partners across the patch have signed up to release to respond mandate, Clinical pathways for specific conditions and geographies with support from system partners. Robust plans to deliver Tier 1 and Tier 2 operational outcomes.
Gaps in controls: Long-term demand and capacity modelling in CCC, and UEC operations. SPOA strategy from ICB's.
Positive sources of assurance: Delivery of key metrics within annual plan including cat 2, hear and treat, call answer and handover delay. Reduction in number of patient safety incidents relating to response times.
Negative sources of assurance: Financial plan and operational plan misalign
Gaps in assurance: Changes to demand profiles. Risk of not receiving capacity funding if plans do not deliver.

Accountable Director	Executive Director of Operations
Committee	Quality & Safety, Finance & Performance Committee
Inherent Risk Score	Impact 5 x Likelihood 5 = 25
Residual Risk Score	Impact 4 x Likelihood 3 = 12
Target Risk Score	Impact 3 x Likelihood 2 = 6
Risk Response	Treat
Target Date	Q4 2025/2026

Mitigating Actions	Executive Lead	Due Date	Progress Notes
Implement operational and CCC structures in the directorate	Executive Director of Operations	Q3 2025/2026	
Alignment of SCAS strategy to ICB priorities in relation to SPOA & clinical Pathways	Executive Director of Operations	Q3 2025/2026	
CAD procurement and associated benefits	Executive Director of Operations	Q1 2026/2027	

BAF Risk 15 – Medicines Optimisation

If we do not implement modern systems for the administration and tracking of drugs, **Then** we may not be able to meet statutory and regulatory requirements, **Resulting in** action being taken.

Controls, Assurance and Gaps

Controls: Pharmacy fit for the future 5-year strategy has been developed which links to annual Medicine improvement plan and Pharmacy fit for the future 2-year program. Review of Pharmacy by peers conducted with output feeding into plans. Chief Pharmacist in place.

Gaps in controls: Lack of fit for purpose medicine stock control system and medicines tracking. Limited budget for pharmacy operations and improvements. Lack of appropriately secure storage for medicines on stations.

Positive sources of assurance: Monitoring of operational process to highlight any issues and resolve before any impact is seen. Program developed and projects underway to address gaps in compliance including safe storage of medicines.

Negative sources of assurance: Peer review of pharmacy highlighted significant gaps. Reliance of limited number of key individuals to deliver improvements. Insufficient financial resources to deliver comprehensive pharmacy reform.

Gaps in assurance: Monitoring of medicine stock quantity, location (modules on ambulances and stations) and temperature.

Accountable Director	Chief Paramedic
Committee	Quality & Safety
Inherent Risk Score	Impact 5 x Likelihood 4 = 20
Residual Risk Score	Impact 5 x Likelihood 4 = 20
Target Risk Score	Impact X x Likelihood X = 4
Risk Response	Treat
Target Date	31/03/2027

Mitigating Actions	Executive Lead	Due Date	Progress Notes
Track and Trace for medicines	Chief Paramedic	31/03/2027	Business case submitted to EMC in Feb 25, rewrite requested and now needs alignment with newly developed program
Secure storage upgrades	Chief Paramedic	31/03/2027	Business case submitted to July FAMSG. Overall cost of works in the region of £1.5million so work to be staggered across several years
CD personal issue	Chief Paramedic	31/03/2026	Focus groups arranged and options to progress being explored so the business case can be formulated

BAF Risk 16 – Operating Model

If we do not implement a new operating model, **Then** our ability to treat patients in the appropriate setting could be compromised, **Resulting in** poorer patient experience and unnecessary pressure on acute hospitals through unnecessary conveyances.

Controls, Assurance and Gaps
Controls: Recruiting to required ECT and clinical staffing levels within CCC. Alignment of operational skill mix. Access to clinical pathways and clinical triage support.
Gaps in controls: Inconsistencies of clinical pathways across the geography. Enhanced skills for clinicians to support clinical decision making. Balance of financial and operational delivery misalign.
Positive sources of assurance: Delivery of Operational plan incl. H&T, Call answer and cat 2. Improved patient experience. Reduced re-attendance. Average handover times reduce to below 15 minutes
Negative sources of assurance: Increase in recontact, Longer response times, increase in conveyance, increase in Patient Safety Incidents
Gaps in assurance: Data on patient pathways and outcomes

Accountable Director	Executive Director of Operations
Committee	Executive Management
Inherent Risk Score	Impact 4 x Likelihood 5 = 20
Residual Risk Score	Impact 4 x Likelihood 3 = 12
Target Risk Score	Impact 3 x Likelihood 2 = 6
Risk Response	Treat
Target Date	

Mitigating Actions	Executive Lead	Due Date	Progress Notes
Integrated work force plan	Executive Director of Operations	End Q1 2025/2026	
Recruit to plan to avoid reliance on IRP	Executive Director of Operations	End Q1 2025/2026	
Implementation of CCC and Ops structure to provide clinical leadership	Executive Director of Operations	End Q2 2025/2026	

BAF Risk 17 – Delivery of Fleet Improvement Plan

If we do not deliver against the trajectory to reduce our Vehicle Off Road rate, **Then** we will not have sufficient vehicles to meet demand, **Resulting in** the potential for avoidable harm or death.

Controls, Assurance and Gaps

Controls: VOR improvement plan presented to reduce VOR to 10% by the end of 2026 – Includes, increase to workshop capacity (completed) New North Workshop – New VCU – New Fleet – New fleet planning team using technology to manage fleet performance

Gaps in controls: The trusts current financial situation is limiting progress on aspects of the plan meaning current pauses on the workshop and VCU buildings – Challenges with O&H cash flow, is posing risk around the delivery of new fleet – Supply chain issues are impacting parts supply – Front line vehicles are not always being placed on charge, meaning VOR rates are impacted.

Positive sources of assurance: New fleet is coming into the trust – workshop efficiency is at record levels

Negative sources of assurance: Issues with the trusts telematics system is impacting effective control of over utilisation of the fleet

Gaps in assurance: Will struggle to deliver the plan without the workshop and VCU

Accountable Director	Chief Finance Officer
Committee	Finance & Performance
Inherent Risk Score	Impact 4 x Likelihood 4 = 16
Residual Risk Score	Impact 4 x Likelihood 3 = 12
Target Risk Score	Impact X x Likelihood X = 4
Risk Response	Treat
Target Date	31/03/2026

Mitigating Actions	Executive Lead	Due Date	Progress Notes
Additional staff added to the workshop	Stuart Rees	WC 7/7/25	
Outsourcing of non-DCA's work to free up w/shop capacity	Stuart Rees	WC 7/7/25	
OT added to OSD and Workshop (only for at risk time zones)	Stuart Rees	WC 7/7/25	

BAF Risk 18 – Estates Funding

If we do not develop and agree the strategic case for change in our estate, **Then** we will not be able to secure capital to deliver the hub model over time, **Resulting in** a disproportionate increase in backlog maintenance, statutory breaches, impeded operational delivery, detrimental patient care.

Controls, Assurance and Gaps

Controls:

- Base decisions on an accurate and comprehensive understanding of the built environment and current estate conditions.
- Secure agreement on the programme plan and associated benefits cases.
- Conduct rigorous root cause analysis of systemic issues.
- Develop and implement solutions that are aligned with both the overarching Clinical Strategy and the broader National Strategy. Explore and drive collaboration opportunities through the One Public Estate initiative.
- Identify and progressively pursue opportunities, mapping risks with mitigations and delivering to a realistic timeline.
- Ensure all activities remain sensitive to and realistic within existing funding constraints.

Gaps in controls: Inflationary increases, rent increases, land availability, National Infrastructure Projects, influence within local town planning. Modelling and testing, digitalising and building utilisation and performance modelling

Positive sources of assurance: Incremental investment and sustainment, data gathering, condition and functionality assessment, Collaboration and best practice knowledge sharing, standardisation of designs

Negative sources of assurance: Succession planning, resilience and attrition. National and local political agenda.

Gaps in assurance:

Accountable Director	Chief Finance Officer
Committee	Finance & Performance
Inherent Risk Score	
Residual Risk Score	Impact 4 x Likelihood 3 = 12
Target Risk Score	Impact X x Likelihood X = 4
Risk Response	Treat
Target Date	

Mitigating Actions	Executive Lead	Due Date	Progress Notes

BAF Risk 20 – Digitisation

If we do not improve our digital capacity and capability, **Then** our ability to modernise workplace practices could be compromised, **Resulting in** failure to meet efficiency and operational targets and poor staff morale.

Controls, Assurance and Gaps

Controls: Digital established as a core pillar in our Fit For The Future Strategy. Digital maturity assessed across several committees (Audit, F&P, Q&S). Digital Risk Management matured and regularly assessed with formal external assurance.

Gaps in controls: Digital investment to date prioritised as "back-office" whereas Digital is a key enabler of frontline services and business capability. Legacy systems and applications still in operations due to under-investment and short-term planning (1-years planning subject to change)

Positive sources of assurance: Maturity in our formal assurance reports (DSPT/Azets). Limited major outages or business continuity activation. Strategic direction shaping within SCAS & SASC.

Negative sources of assurance: Inconsistency of investment and risk remediation. Assurance reports focused on "base-level" not proactive maturity to industry benchmarks.

Gaps in assurance: Financial savings (CIP) hindering maturity and investment cuts impacting transformation. Lack of specialised knowledge and "spend to save/maturity". Seen as cost-centre not a business enabler. Innovation uncontrolled in SCAS impacting Digital and Cyber Security maturity

Accountable Director	Chief Digital Officer
Committee	Finance & Performance
Inherent Risk Score	
Residual Risk Score	Impact 4 x Likelihood 4 = 16
Target Risk Score	Impact 3 x Likelihood 3 = 9
Risk Response	Treat
Target Date	2027

Mitigating Actions	Executive Lead	Due Date	Progress Notes
Development of a 3-year annual plan (Capital & Revenue) with board prioritisation as an enabler key	Craig Ellis	October 2025	3-year risk plan produced in 2024 will form the base of our 3-year annual plan and investment case.
CIO Engagement with SECAMB & SASC developing strategic collaboration benefits	Craig Ellis	September 2025 (Blueprint)	Initial opportunities and discussions ongoing in regard to opportunity and outline business case development
Digital Reporting & Committee Assurance	Craig Ellis	Ongoing	Digital is reporting and engaging with a range of board committees monthly to drive assurance and engagement

BAF Risk 21 – Safe and secure information systems

If we do not ensure our systems are safe and secure, **Then** we could be the victim of a cyber security breach, **Resulting in** a loss of service, disruption and potential regulatory action.

Controls, Assurance and Gaps

Controls: Digital established as a core pillar in our Fit For The Future Strategy inc Cyber Security. Cyber Security maturity assessed yearly via DSPT and external audit reporting into the Audit committees. Cyber Security Risk Management maturing and further reviews to occur in coming 18-months

Gaps in controls: Cyber Security Strategy & Programme Plan still in design due to resource, capability and investment. Currently in the lower-quartile (Ambulance) and significant maturity work required to reach required external levels. Limited investment and widening risk posture poses significant risk.

Positive sources of assurance: Positive maturity in our 25/26 DSPT assessment and external audit but no of risks held. Opportunity for engagement via SASC and Region including strategic direction.

Negative sources of assurance: Inconsistency of investment and risk remediation. Assurance reports focused on "base-level" not proactive maturity to industry benchmarks. Competing financial priorities

Gaps in assurance: Financial savings (CIP) hindering maturity and investment cuts impacting transformation. Lack of specialised knowledge and "spend to save/maturity". Seen as cost-centre not a business enabler. Innovation uncontrolled in SCAS impacting Digital and Cyber Security maturity

Accountable Director	Chief Digital Officer
Committee	Finance & Performance
Inherent Risk Score	
Residual Risk Score	Impact 4 x Likelihood 4 = 16
Target Risk Score	Impact 4 x Likelihood 3 = 12
Risk Response	Treat
Target Date	Continuous Assessment

Mitigating Actions	Executive Lead	Due Date	Progress Notes
Development of a 3-year annual plan (Capital & Revenue) with board prioritisation as an enabler key	Craig Ellis	October 2025	3-year risk plan produced in 2024 will form the base of our 3-year annual plan and investment case.
Ongoing DSPT assurance & external audit recommendations	Craig Ellis	Dec 2025	DSPT assessment completed (June 25) and maturity of areas now underway (limited investment & resource)
Development of Cyber Security Strategy & Programme Plan aligned to key risks identified	Craig Ellis	Dec 2025	Ongoing assessment of key risk and focal areas aligned to limited investment and revenue budgets

BAF Risk 22 – Staff Engagement

If staff do not feel heard and psychologically safe in their workplace, **Then** the Trusts culture will not change, **Resulting in** a rise in sickness and attrition and patient services may be compromised.

Controls, Assurance and Gaps

Controls: Freedom to Speak-Up Policy and Processes; Chief People Officer; People Strategy; Staff Networks; People directorate structured to support staff engagement

Gaps in controls: Values aligned with staff attitudes, effective up and downstream communications, communication of key messages across the Trust. Responsiveness to concerns is not at the required levels.

Positive sources of assurance: Improving People Pulse Survey, FTSU cases, Improving National NHS Staff Survey outcomes and completion rate.

Negative sources of assurance: Increased turnover of staff, increased sickness absence and decreased staff retention rates due to disengaged staff

Gaps in assurance: How cases are managed and resolved. Oversight of outcomes.

Accountable Director	Chief People Officer
Committee	People & Culture
Inherent Risk Score	Impact 5 x Likelihood 4 = 20
Residual Risk Score	Impact 5 x Likelihood 3 = 15
Target Risk Score	Impact 3 x Likelihood 2 = 6
Risk Response	Treat
Target Date	December 2026

Mitigating Actions	Executive Lead	Due Date	Progress Notes
Values & Behaviours co-design framework	Chief People Officer	Q4 25-26	
Listening events	Chief People Officer	Q3 25-26	

BAF Risk 23 - Leadership

If we do not develop inclusive and compassionate leaders who role model and uphold our values and behaviours, **Then** we will not achieve a culture shift or improve psychological safety, **Resulting in** potential patient harm and increased staff attrition.

Controls, Assurance and Gaps
Controls: People strategy**,** personal development reviews for all staff, culture and leadership development prioritised through the fit for the future work, Coaching network available for leaders. Executive leads for staff networks.
Gaps in controls: Lack of clear leadership behaviours and values, lack of succession planning.
Positive sources of assurance: National compliance requirements included within high impact actions, EDI, WRES & WDES.
Negative sources of assurance: Low levels of engagement with development opportunities, increased staff attrition levels for people looking for development.
Gaps in assurance: We need competent values-based leadership; understanding the competence of mid-level management.

Accountable Director	Chief People Officer
Committee	People & Culture
Inherent Risk Score	Impact 5 x Likelihood 4 = 20
Residual Risk Score	Impact 5 x Likelihood 3 = 15
Target Risk Score	Impact 3 x Likelihood 2 = 6
Risk Response	Treat
Target Date	December 2026

Mitigating Actions	Executive Lead	Due Date	Progress Notes
Development of leadership framework	Chief People Officer	Sept 2025	
Implementation of leadership framework	Chief People Officer	TBC once leadership framework developed	
Development of the Trusts values and behaviours framework	Chief People Officer	March 2026	

BAF Risk 19 – Efficiency and Productivity Plans

If we do not deliver on our efficiency and productivity plans, **Then** we may be unable to break even, **Resulting in** our ability to deliver care to our patients.

Controls, Assurance and Gaps

Controls: Operating Plan and annual budget. Budget setting process. Business case approval process. Management accounting and budgetary control. Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD). Performance Management and Accountability Framework. Financial Recovery Board.

Gaps in controls: Strategic Trust wide transformational approach to longer-term efficiency plans; Imbalance between total operating cost and total operating income reliant on short-term actions and non-recurrent income ahead of sustainable financial improvement. Lack of grip. Poor control of pay and non-pay budgets. Lack of delivery of productivity goals.

Positive sources of assurance: Internal Audit, External Audit and Local Counter Fraud Service reporting to Audit Committee. Model Health System productivity benchmarking.

Negative sources of assurance: Not operating effectively and productivity will result in not be able to deliver performance standards sustainably, patient care will suffer, and Trust will face regulatory enforcement.

Gaps in assurance: There is a risk that we may not operate effectively and may not be able to deliver sustainable performance Standard. Board-approved multi-year operating plan that includes cost improvement targets and productivity goals. Dedicated resource to deliver CIP, Efficiency and Productivity Plans.

Accountable Director	Chief Finance Officer,
Committee	Finance & Performance
Inherent Risk Score	Impact 5 x Likelihood 4 = 20
Residual Risk Score	Impact 5 x Likelihood 4 = 20
Target Risk Score	Impact 5 x Likelihood 2 = 10
Risk Response	Treat
Target Date	

Mitigating Actions	Executive Lead	Due Date	Progress Notes
Develop a Strategic Transformation Programme: Establish a Trust-wide, multi-year transformation plan focused on sustainable efficiency improvements. Align this with the Fit for the Future programme and system-wide productivity initiatives.	Deputy CEO	TBC	
Embed a Culture of Accountability and Performance: Introduce a Performance Management and Accountability Framework that links individual and team performance to financial and productivity outcomes. Provide training and support to managers on financial management and productivity improvement.	Chief Finance Officer	TBC	
Collaborate Across Systems: Work with partners (e.g., SECAmb, SASC) to identify shared service opportunities and reduce duplication. Participate in joint planning and delivery of system-wide productivity initiatives.	Chief Finance Officer	TBC	

BAF Risk 24 - Finance

If there is insufficient funding to meet the growing demand for healthcare services, **Then** this can lead to financial instability and an inability to invest in modernised and sustainable infrastructure, **Resulting in** failure to deliver on long-term objectives such as achieving net zero targets.

Controls, Assurance and Gaps

Controls: Annual and multi-year planning cycles in place and supported by the board. Board level Senior Responsible Officer (Chief Finance Officer).

Gaps in controls: CIP, operational and workforce plans are not currently multi-year hindering the development. ICBs have not yet agreed and communicated their multi-year plans. SASC and SECAmb collaborations have not yet developed their plans which will impact the Trusts financial plans. Trust Estates Plan. The Trust does not currently have a balanced understanding of risk across its entire infrastructure (including all key fleet, digital and estate).

Positive sources of assurance: Financial plans and actual spend are monitored through the Trusts governance routes. Trust's Green Plan. Green Plan: Annual Report content. National reporting through the annual Estates Return Information Collection (ERIC) return in relation to the Trust's carbon baseline and other related measures. Model Health System productivity benchmarking.

Negative sources of assurance: Unidentified CIPs and a main contract is yet to be agreed. Green Plan: Reliance on a very small number of key individuals to deliver Trust commitments with regards to our environmental responsibilities. The Trust has insufficient Capital Resource to cover the minimum requirements.

Gaps in assurance: Contract not agreed with BOB, Frimley and BLMK ICBs. Multi-Year Financial Planning Cycles and a Integrated Business Planning with structured planning processes that align operational, workforce, and capital plans with financial forecasts and strategic goals, alignment of CIP, workforce, estates, and digital plans into a single integrated financial strategy.

Accountable Director	Chief Finance Officer
Committee	Finance & Performance
Inherent Risk Score	Impact 5 x Likelihood 4 = 20
Residual Risk Score	Impact 5 x Likelihood 4 = 20
Target Risk Score	Impact 5 x Likelihood 2 = 10
Risk Response	Treat
Target Date	Q4 2026/27

Mitigating Actions	Executive Lead	Due Date	Progress Notes
Strengthen Financial Controls and Oversight: Enhance budgetary control mechanisms and ensure strict adherence to Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD) and address Pay and Non-Pay Budget Control. Conduct a deep-dive review into pay and non-pay expenditure to identify inefficiencies.	Chief Finance Officer	TBC	
Improve Cost Improvement Programme (CIP) Delivery: Ensure all CIP plans are identified and owned by directorates with clear accountability.	Chief Finance Officer	TBC	
Strengthen Assurance Mechanisms: Increase the scope and frequency of internal audits focused on productivity and efficiency. Regularly report progress to the Finance & Performance Committee and escalate risks early	Chief Finance Officer	TBC	

BAF Risk 25 - Collaboration

If there is a failure to agree on a way forward with SECAmb, **Then** this will lead to financial and operational instability, and an inability to realise productivity and efficiency gains, **Resulting in** reputational damage with stakeholders and partners, and increased oversight and scrutiny of SCAS's operating and strategic approach.

Controls, Assurance and Gaps

Controls: Working groups for UEC Operations, CCC and EPRR. Identified savings from each Trust. SECAmb and SCAS have join executive and board meetings.

Gaps in controls: Lack of shared platforms across CCC and UEC operations.

Positive sources of assurance: Savings identified and implemented, structures aligned where possible, consistent delivery model.

Negative sources of assurance: Inconsistency of service model and delivery across region. Not awarding 111 contracts

Gaps in assurance: Finance savings not released for reinvestment. Regional commissioning priorities. PTS provision across region is inconsistent

Accountable Director	Chief Finance Officer
Committee	Finance & Performance
Inherent Risk Score	Impact 4 x Likelihood 3 = 12
Residual Risk Score	Impact 4 x Likelihood 3 = 12
Target Risk Score	Impact 2 x Likelihood 2 = 4
Risk Response	Treat
Target Date	

Mitigating Actions	Executive Lead	Due Date	Progress Notes
Align Strategic and Operational Priorities: Conduct joint strategic planning workshops to ensue alignment of goals, timelines, resource allocation. Develop a shared service model for 999s, 111, and urgent care that reflects regional needs and commissioning expectations and enabling services e.g. Fleet and Contracts (Make Ready).	Chief Finance Officer	TBC	
Monitor and Realise Benefits: Establish a joint benefits realisation framework to track efficiency and productivity gains. Report progress regularly to the Board and Finance & Performance Committee	Chief Finance Officer	TBC	
Mitigate Cultural and Capability Barriers: Provide joint training and development for leadership and operational teams to foster a collaborative culture. Deploy facilitation support to manage change and resolve conflicts across organisations	Chief People Officer	TBC	

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Trust Board of Directors Meeting in Public
31 July 2025

Report title	Board Site Visits 2025 - 26
Agenda item	27
Report executive owner	Becky Southall, Chief Governance Officer
Report author	Susan Wall, Corporate Governance & Compliance Manager
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	✓

NHS South Central Ambulance Service NHS Foundation Trust

Non-Executive & Executive Directors Site Visits report

Non-Executive Directors

Professor Sir Keith Willett CBE – KW

Harbhajan Brar - HB

Les Broude – LB

Gary Ford - GF

Ian Green OBE – IG

Katie Kapernaros – KK

Mike McEnaney – MM

Ruth Williams- RW

NED Location visited in 2025/26	NED Visited	Month of Visit		Locations	Last Visit
Abingdon Fleet Services OX14 4SD	KK KW	Apr Apr		Adderbury RC OX17 3FG	Aug 24
Nursling RC SO16 0YU	LB	Apr		Bracknell RC RG12 7AE	Jul 24
Didcot RC OX11 8RY	LB	Apr		High Wycombe RC HP11 2JQ	Mar 25
Winchester & Eastleigh RC/HART SO50 4ET	LB	Apr		Kidlington RC OX5 1RF	Dec 24
Northern House E&UCC and 111 CCC OX26 6HR	KK RW LB	Jun Jun Jul		Milton Keynes Blue Light Hub MK6 4BB	May 24
Basingstoke RC RG24 9LY	LB	May		Newbury RC RG14 1LD	None in 24/25
Reading RC RG1 7DA	LB KW	Jun Jul		Oxford City RC OX3 7LH	Mar 25
Southern House E&UC CCC SO21 2RU	RW	Jun		Stoke Mandeville RC HP21 8BD	Jun 24
Whitley Education Centre PO15 7AH	RW	Jun		Wexham Park RC SL3 6LT	Dec 24
Cosham RC Northarbour RC PO6 3TJ	RW	Jun		Alton RC GU34 2QL	Sept 24
Unit 2 OX26 6HR	RW	Jun		Andover RC SP10 3RJ	Dec 24
Southampton Logistic Pharmacy Unit SO16 0BT (Adanac)	KW RW	Jun Jun		Basingstoke PTS RG24 8QL	None in 24/25
Thame Education and Training Centre	KW	Jun		Gosport PTS PO12 3SR	Sept 24
				Havant PTS PO9 2NA	None in 24/25
				Hightown RC SO19 0SA	Jun 24
				Hythe RC SO45 5GU	None in 24/25

				Lymington RC SO41 8JD	Nov 24
				Petersfield RC GU31 4AN	Dec 24
				Portsmouth PTS PO3 6EJ	None in 24/25
				Ringwood RC BH24 3EU	Aug 24
				Totton PTS SO40 3AP	None in 24/25
				Whitchurch RC RG28 7BB	Aug 24
				Southern House 111 CCC SO21 2RU	Nov 24
				Southern House PTS CCC SO21 2RU	Nov 24
				Milton Keynes Partis House MK5 8HJ	Feb 25
				Newbury Bone Lane RG14 5UE	Sept 24
				Thatcham SORT RG19 4AE	None in 24/25

Exec Visits

		Visit Recorded

2025/26	Quarter 1			Quarter 2			Quarter 3			Quarter 4			
Name	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**Total**
Craig Ellis	**0**	**0**	**0**	**0**									**0**
Rebecca Southall	**0**	**0**	**0**	**0**									**0**
David Eltringham	**11**	**10**	**5**	**8**									**34**
Helen Young	**5**	**0**	**5**	**8**									**18**
Duncan Roberston	**3**	**5**	**1**	**6**									**15**
John Black	**8**	**0**	**5**	**9**									**22**
Mark Ainsworth	**7**	**4**	**9**	**1**									**21**
Natasha Dymond	**2**	**5**	**0**	**0**									**7**
Paul Kempster													
Stuart Rees	**0**	**0**	**0**	**0**									**0**