NHS
South Central Ambulance Service
NHS Foundation Trust

2024/25 Quality Account

Contents

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 pathway 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

About us

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

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

Mission: We deliver the right care, first time, every time.

Vision: To be an outstanding team, delivering world leading outcomes through innovation and partnership.

Values:

Caring

Innovation

Professionalism

Teamwork

Strategic themes:

- Clinically-led
- Service quality & patient experience
- People & organisational development
- Partnerships & stakeholder engagement
- Technology transformation
- Finance & sustainability

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 SE 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 (PSP) 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 making. 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 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 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 UCD 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 we have 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. 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 PE 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 – members helped coproduce the patient aspect of the Learning Disability policy
- In July – They reviewed the SCAS public website and found that images used on the public website were not inclusive of all the patients SCAS serves
- The 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 and therefore there was a suggestion to add more accessible guidance on calling 999 and what would happen when you go to hospital
- In August – An easy read guide on 'calling 999' was co-produced. This explains that the service is free and 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 – 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 – 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 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 – 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 provider for the provision of, or subcontracting of, relevant health services.	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.
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.

	Prescribed information	Form of statement
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 0% 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

	Prescribed information	Form of statement
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

	Prescribed information	Form of statement
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

	Prescribed information	Form of statement
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. **SCAS Annual Report**

	Prescribed information	Form of statement
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.
4.1	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.
4.2	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, (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.	SCAS current registration status is without conditions. A section 29a letter was received in 2022/23 and a response submitted.

	Prescribed information	Form of statement
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 2024/25 will be available in July 2025 – the trust is expected to be standards met.

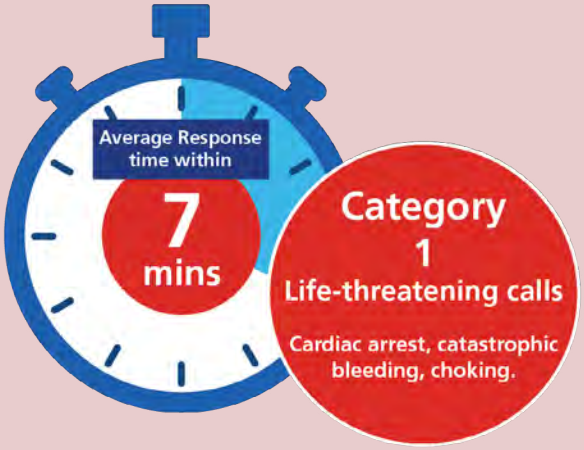
	Prescribed information	Form of statement
10	Whether or not the provider was subject to the Payment by Results clinical coding audit at any time during the reporting period by the NHSE.	SCAS was not subject to the Payment by Results clinical coding audit during 2024/25 by NHSE.
10.1	If the provider was 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

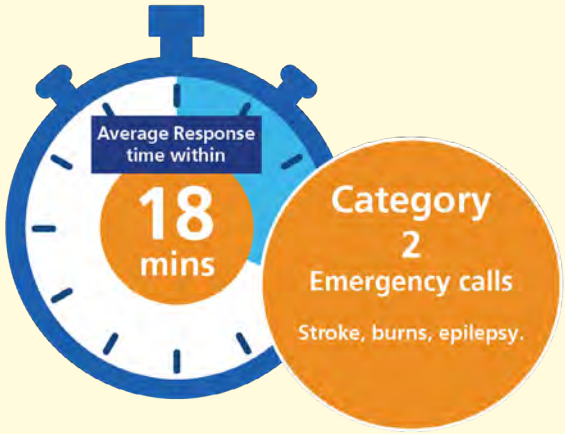
The percentage of Category 1 telephone calls resulting in an emergency response by the Trust at the scene of the emergency within 7 minutes of receipt of that call during the reporting period.

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)

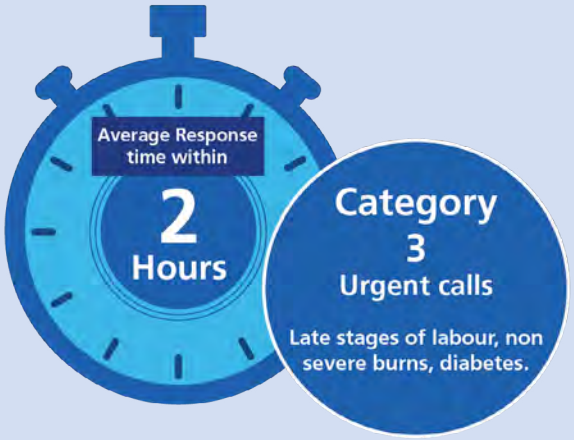
The percentage of Category 2 telephone calls resulting in an ambulance response by the Trust at the scene of the emergency within 18 minutes of receipt of that call during the reporting period.

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

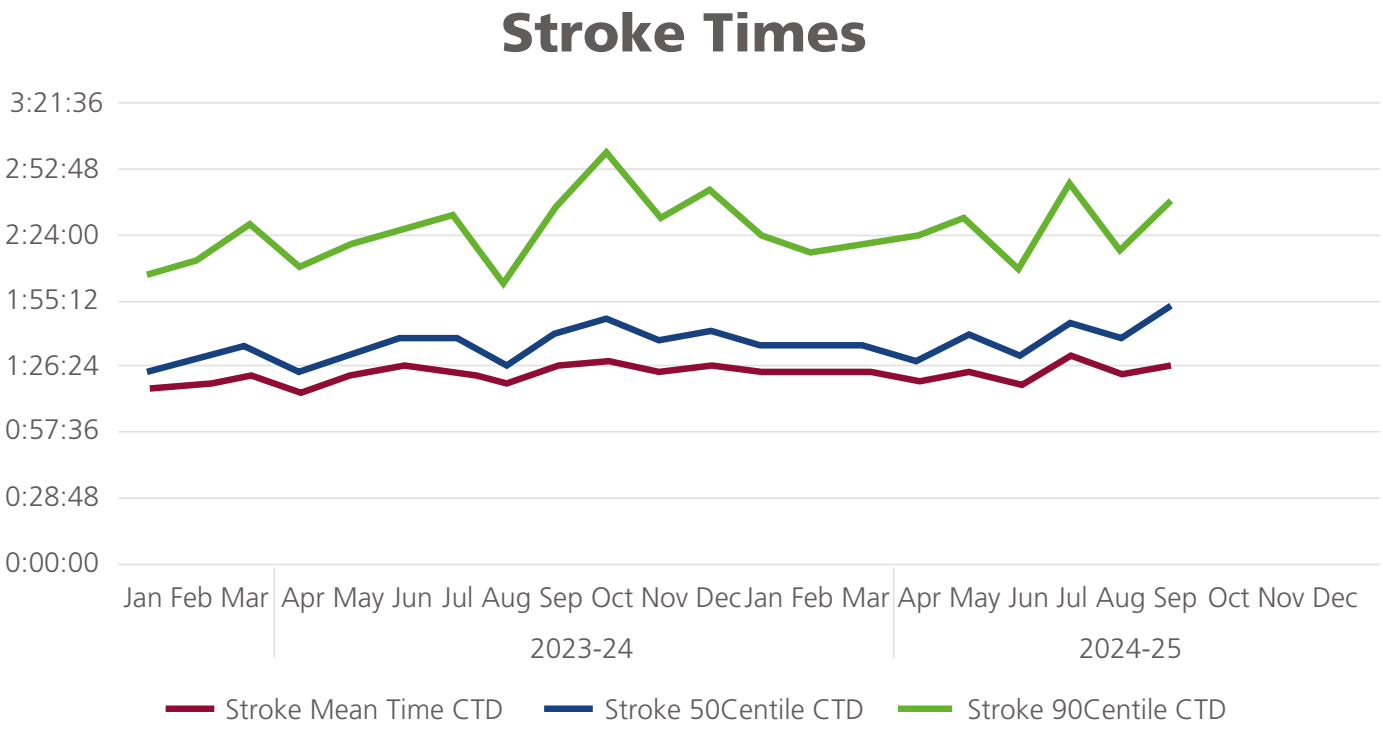
SCAS intends to take the following actions to improve this indicator and so the quality of its services:

- 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

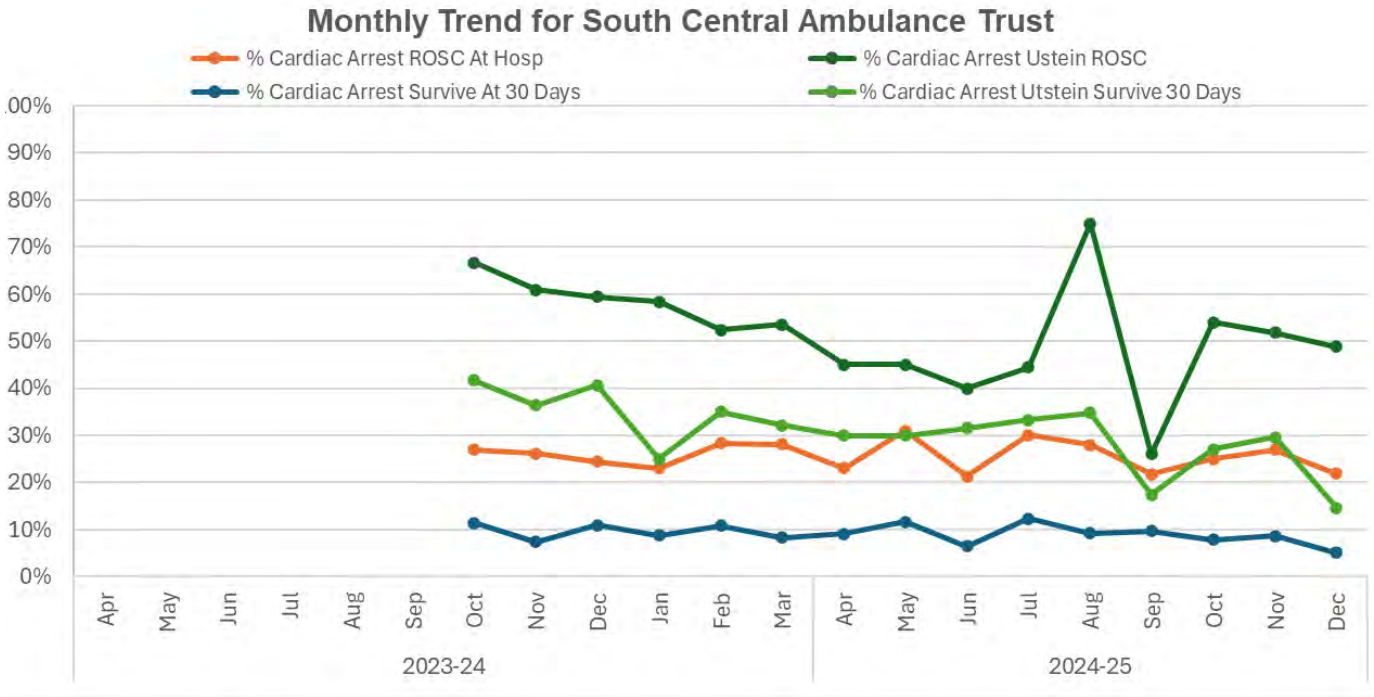
Stroke performance

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 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 December 2024, 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.	• 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: • representing 0% for the first quarter • representing 0% for the second quarter • 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 2024/2025

3.1 Regulation assurance and compliance

The table below shows the current SCAS CQC rating.

	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.

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 25 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 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, The 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

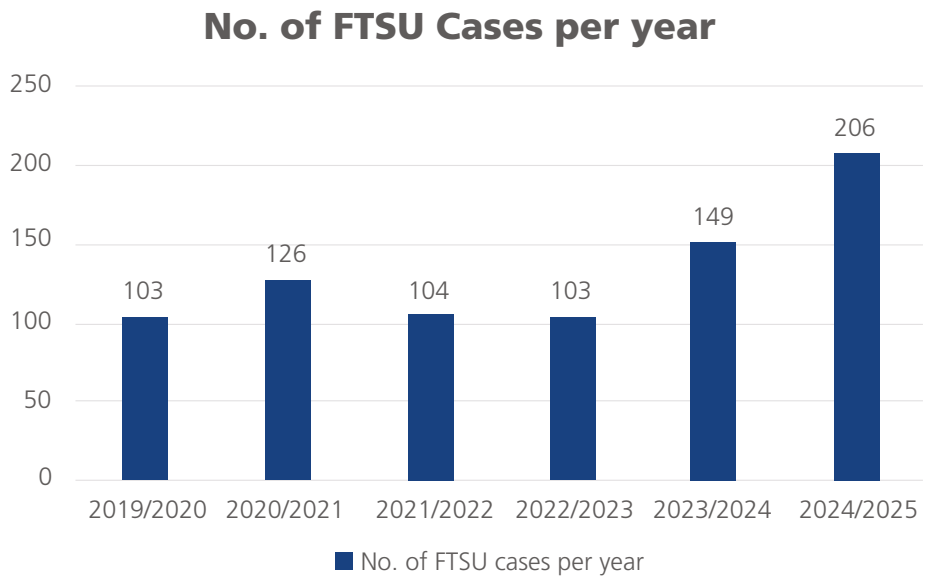
Our Freedom to Speak Up (FTSU) Guardian team is supported by a growing network of trained FTSU Champions from diverse departments across SCAS.

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.

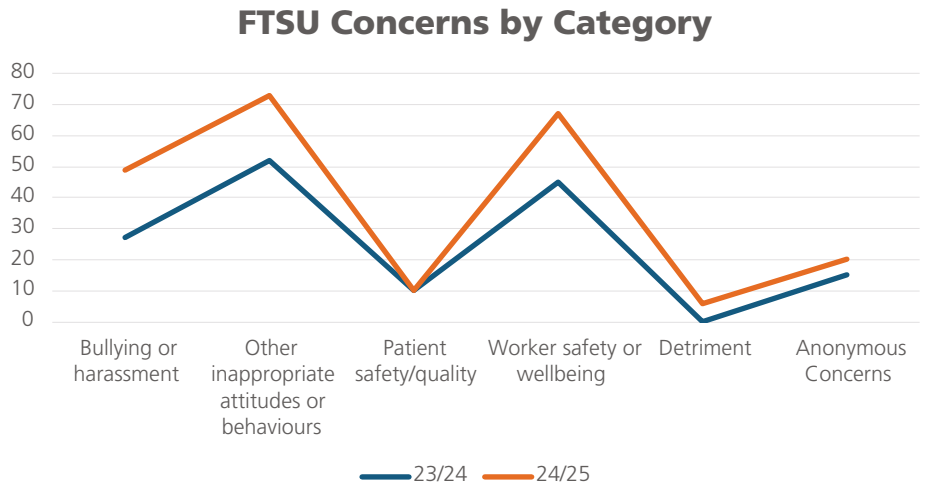
In 2024/25, the network has expanded by 68%, with 62 trained Champions now in place, including Student Paramedics. Training sessions, supportive engagement and promotion of Champions have been planned for 2025/26.

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.

Sexual Safety within SCAS

From Feb 2023

SCAS Sexual safety campaign launched it included:

- A sexual safety charter which sets out expectations of behaviours. SCAS was one of the first NHS trusts to create it.
- Posters were distributed across all sites
- The 'Harassment and Sexual safety Disclosure checklist' was created to support managers.
- A sexual safety hub page was created which contains helpful documents and internal/ external support services (this was refreshed in Dec 2024)

From Mar 2023

A Sexual Safety section included in new starter's inductions.

This was presented by our Equality, Diversity and Inclusion (EDI) lead and FTSU.

From May 2023

SCAS signed up to NHS England's Sexual safety Charter.

We joined many other national organisations in signing up to the charter created by NHS England.

Feb 2024

Sexual Safety session with the Board.

With representatives from AACE, Organisational Development and FTSU to present the sexual safety piece from an ambulance sector and SCAS perspective to aid understanding and obtain ongoing board support.

Ongoing / planned:

- Managers training Launched January 2025
- Targeted Team and area support provided by OD/EDI and FTSU.
- Links into National work with other trusts, AACE, NGO, HCPC, Police etc
- Improved engagement between HR, Safeguarding and FTSU in relation to cases/processes.
- The launch of the 'Sexual Safety assurance and oversight group.'

From Sept 2024

Student Paramedics in 4 Universities connected with SCAS received extended Sexual safety training.

The FTSU team, with the support of the Education team presented an extended SS session for all Year 1 students as part of their induction

From April 2024

A sexual safety working group launched.

Key stakeholders within the sexual safety improvement work met regularly to update and contribute as a collective to the SS journey within SCAS. (This is being refreshed with additional stakeholders in 2025.)

A new session on sexual safety was added to all Ops/CCC F2F training.

This was created and delivered by the education team.

The session was included from April 2024 - March 2025.

From March 2024

The sexual safety reverse mentoring programme.

This programme was led by the OD team. There were managers and senior leaders that took part as the mentees and staff with lived experience that were ment

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.

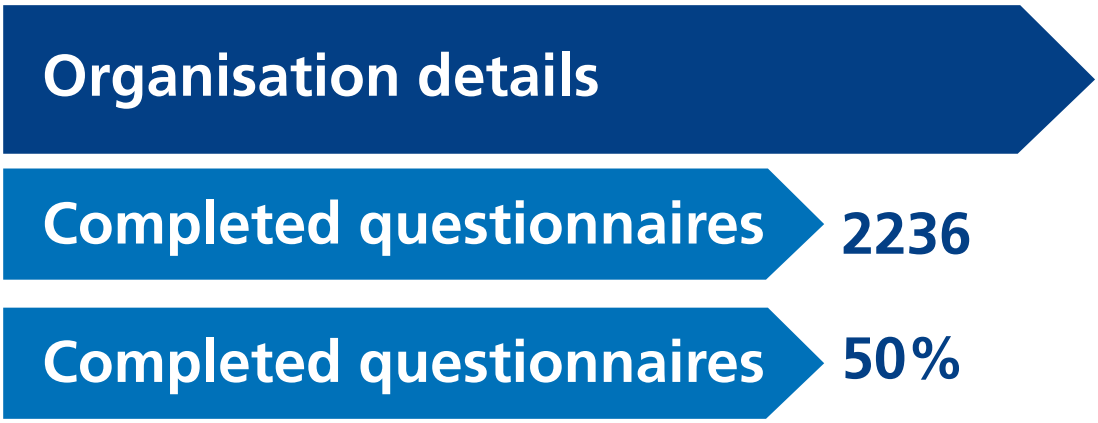
Freedom to Speak Up Month

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.

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.

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.

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.

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 and 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. Trail new process and reaudit in Q4 2025/26.

Implementation Lead

Head of Patient Experience sponsored by Chief Nurse.

Patient Experience

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.

Patient Experience

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 PSEG.

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

NHS
Hampshire and Isle of Wight

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

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.

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

Chief Executive

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