South Central Ambulance Service
NHS Foundation Trust

Agenda

Public Trust Board

Date: Thursday 25 September 2025
Time: 09.45 – 12.45
Venue: Newbury Education & Recruitment, Centre Bone Lane, Newbury RG14 5UE

Members:

Professor Sir Keith Willett CBE	Chair
Les Broude	Non-Executive Director
Harbhajan Brar	Non-Executive Director
Gary Ford	Non-Executive Director
Ian Green OBE	Non-Executive Director & Deputy Chair
Katie Kapernaros	Non-Executive Director
Mike McEnaney	Non-Executive Director
Ruth Williams	Non-Executive Director
David Eltringham	Chief Executive Officer
Mark Ainsworth	Executive Director of Operations
Dr John Black	Chief Medical Officer
Craig Ellis	Chief Digital & Information Officer
Kate Hall	Interim Deputy Chief Executive Officer
Danny Hariram	Interim Chief People Officer
Gillian Hodgetts	Director of Communications, Marketing and Engagement
Paul Kempster	Chief Transformation Officer
Stuart Rees	Chief Finance Officer
Duncan Robertson	Chief Paramedic 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
Kofo Abayomi	Head of Corporate Governance and Compliance

Apologies:

Item		BAF	Action	Time
OPENING BUSINESS				
1	**Chair's Welcome and Apologies for Absence** Professor Sir Keith Willett CBE	-	**Verbal For Noting**	
2	**Declarations – Directors' Interests and Fit and Proper Persons Test** Professor Sir Keith Willett CBE	-	**Verbal For Noting**	
3	**Minutes from the Annual Members Meeting held on 23 October 2024 and Public Board meeting held on 31 July 2025** Professor Sir Keith Willett CBE	-	**For Approval**	09.45
4	**Board Actions Log** Professor Sir Keith Willett CBE/ Becky Southall	-	**For Approval**	09.50
5	**Chair's Report** Professor Sir Keith Willett CBE	-	**For Noting**	09.55
6	**Chief Executive Officer's Report** David Eltringham	-	**For Noting/ Information**	10.05
7	**Update to the previous Private Board meeting held on 31 July 2025** Professor Sir Keith Willett CBE	-	**For Noting**	-
8	**Staff Story** Danny Hariram	-	**For Information**	10.15
9	**Fit for the Future Framework** David Eltringham & Executive Director Leads	-	**For Assurance**	10.30
10	**Integrated Performance Report** Stuart Rees & Executive Director Leads	-	**For Assurance**	10.50
	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.			
11	**Chief Medical Officer's Report** John Black		**For Noting**	-
12	**Infection Prevention and Control Annual Report 2024/25** Helen Young		**For Assurance**	11.15
13	**Winter Plan** Mark Ainsworth	**SR 14 12**	**For Approval**	11.25
14	**Assurance Upward Report** Quality and Safety Committee 18 September 2025	-	**For Noting**	-

Item		BAF	Action	Time
	Katie Kapernaros			
	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.			
15	**Finance Report Month 5 Update** Stuart Rees	**SR24 20**	**For Assurance**	11.35
16	**Hampshire and Isle of Wight ICB Month 5 Finance Report** Stuart Rees	**SR24 20**	*Paper to follow* **For Noting**	11.45
17	**Buckinghamshire, Oxfordshire and Berkshire West ICB M4 System Reports** Stuart Rees	**SR24 20**	**For Noting**	-
18	**NHS Hampshire and Isle of Wight Green Plan 2025-2028** Stuart Rees	-	**For Approval**	12.00
19	**Assurance Upward Report** Finance and Performance Committee, 22 August & 19 September 2025 Les Broude	-	**For Noting/ Assurance**	-
20	**Assurance Upward Report** Audit Committee, 11 September 2025 Mike McEnaney	-	**For Noting/ Assurance**	-
21	**Questions submitted by Board Members on agenda items: 11,14, 19-20**	-	-	
	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.			
22	**Assurance Upward Report** People and Culture Committee, 17 September 2025 Harbhajan Brar	-	**Verbal For Noting**	-
	Partnership & Stakeholder Engagement- We will engage with stakeholders to ensure SCAS strategies and plans are reflected in system strategies and plans.			
23	**Communications, Marketing and Engagement Update** Gillian Hodgetts	-	**For Noting**	-
	Technology transformation – We will invest in our technology to increase system resilience, operational effectiveness and maximise innovation.			
	None	-	-	-
24	**Questions submitted by Board Members on agenda items: 22-23**	-	-	-

Item		BAF	Action	Time
	Well Led – We will become an organisation that is well led and achieves all of its regulatory requirements by being rated Good or Outstanding and being at least NOF2.			
25	**Board Assurance Framework 2025/26** Becky Southall	**-**	**For Approval**	12.25
26	**Non-Executive Director Lead Roles and Board Committee Membership** Becky Southall	**-**	**For Noting**	12.35
27	**Any Other Business** Professor Sir Keith Willett CBE	**-**	**Verbal For Noting**	-
28	**Questions from observers (items on the agenda)** Professor Sir Keith Willett CBE	**-**	**Verbal For Noting**	12.40
29	**Review of Meeting** Summary of Board Actions: Becky Southall Non-Executive Director: Ruth Williams Executive Director: Stuart Rees	**-**	**Verbal For Noting**	12.45
30	**Date, Time and Venue of Next Meeting in Public** Thursday 27 November 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
South Central Ambulance Service
NHS Foundation Trust

BOARD MEMBERS REGISTER OF INTERESTS

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

INTRODUCTION & BACKGROUND

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

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

DOCUMENT INFORMATION

Date of issue: 18 September 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
5. Rebecca Black (wife) , Consultant Obstetrician and Sub-specialist in feto-maternal medicine at Oxford University Hospitals NHS Foundation Trust, was appointed as Interim Post Graduate Locality Dean for the Thames Valley by NHSE on 1st September 2025

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

Current 'Other' Interests

6. None

Interests that ended in the last six months

7. 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: 31 July 2025
Time: 9.45am – 12.45pm
Venue: Newbury Education & Recruitment Centre, Bone Lane, Newbury, RG14 5UE

Members Present:	
Ian Green	Non-Executive Director & Deputy Chair
David Eltringham	Chief Executive Officer
Harbhajan Bar	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 (Teams)
Stuart Rees	Chief Finance Officer
Becky Southall	Chief Governance Officer
Professor Helen Young	Chief Nursing Officer
In Attendance:	
David Ruiz-Celada	Joint Board Strategic Adviser SCAS/SECAmb
Susan Wall	Corporate Governance & Compliance Manager
Jennifer Saunders	Head of Legal Services
Tom Stevenson	Deputy Communications Director (deputising for Gillian Hodgetts)
Observers:	
Steve Lennox	Intensive Support Team, NHS England
Sally Herne	Improvement Director, NHS England
Apologies:	
Professor Sir Keith Willett CBE	Chair
Les Broude	Non-Executive Director
Katie Kapernaros	Non-Executive Director
Ruth Williams	Non-Executive Director
Craig Ellis	Chief Digital & Information Officer
Gillian Hodgetts	Director of Communications, Marketing & Engagement
Duncan Robertson	Chief Paramedic Officer

Item No.	Agenda Item
1	**Chair's Welcome, Apologies for Absence**
1.1	IG opened the meeting and welcomed those present. Apologies were received as above.
2	**Declarations of Interests**
2.1	The Board noted the declarations of interests. No additional interests were declared.
3	**Minutes from the meeting held on 29 May 2025**
3.1	The minutes of the meeting held on 29 May 2025 were agreed as an accurate record of the meeting subject to minor amendments to sections 9.8, 10.2. SR was also present at the meeting and the attendance list needed to be amended accordingly.
3.2	**Action: amendments to the previous set of minutes to be made as discussed. HY to provide a form of words**.
4	**Matters Arising and Action Log**
4.1	The Board **NOTED** the action log and **APPROVED** the closure of completed actions.
5	**Chairs Report**
5.1	The Board **NOTED** the Chairs Report which detailed site and engagement visits.
6	**Chief Executive Officer's Report**
6.1	DE presented his report and opened by paying tribute to firefighter Martin Sadler, who tragically lost his life in the Bicester Motion fire. SCAS crews were involved in the emergency response, and the Trust was represented at the funeral. The Board acknowledged the importance of recognising the contributions of emergency service colleagues and echoed DE's reflections.
6.2	DE reported strong operational performance during quarter 1, with Category 2 response times outperforming national targets. However, performance deteriorated in July due to fleet availability issues and reduced uptake of overtime following the transition away from the usage of Private Providers. DE gave assurance that a recovery plan had been initiated in response, focusing on aligning staffing hours with demand and geography. The Board noted the challenges and endorsed the daily scrutiny measures in place.
6.3	The trust is over-established due to successful recruitment, reduced attrition and the TUPE transfer of staff from Private Providers. Whilst this was an unprecedented position for the trust, it had led to the difficult decision to pause both international and domestic recruitment, affecting two cohorts of international paramedics and newly qualified UK paramedics. The Board recognised the emotional and professional impact of these decisions and stressed the need for a clear, forward-looking workforce strategy. Actions agreed included the development of a 12–24-month workforce plan and assurance reporting to the People and Culture Committee.

6.4	The trust's planned exit from the Recovery Support Programme (RSP) had been delayed from September to October to allow for more robust preparation. The Board expressed concern about the delay but noted that the integrated Fit for the Future strategic programme that was in development would be presented to the September board and would provide clear detail on deliverables and progress against meeting the Transition Criteria.
6.5	Staff recognition events, including long service awards and the launch of a Pride-themed ambulance, which was fully funded by trade unions were noted. These initiatives were praised for promoting inclusivity and boosting morale. The Board commended the Trust's efforts to recognise and support staff, particularly Community First Responders.
6.6	DE referenced the recently published NHS 10-Year Plan, noting its alignment with SCAS's strategic priorities, particularly around prevention, digital transformation, and neighbourhood care models. The Board agreed to hold a development session to explore the implications of the plan for SCAS and ensure strategic alignment with national direction.
6.7	**Action: Board development session to be scheduled in relation to the 10-Year Plan.** The Board **NOTED** the Chief Executive Officer's 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	**Patient Story**
8.1	JS provided an overview of the case that had recently been heard in the Coroner's Court relating to a cervical spine injury. The Board noted that an elderly patient, who had advanced dementia and had fallen from her wheelchair had been moved by members of the public before the SCAS team arrived. Due to their alertness and mobility, the attending technician did not perform a cervical spine assessment or immobilise the patient's cervical spine.
8.2	The patient was conveyed to hospital where initial imaging showed no abnormalities. However, further scans taken as a result of neck discomfort revealed a cervical spinal fracture with spinal cord injury. Due to frailty and co-morbidities, surgical intervention was deemed inappropriate and they sadly died two weeks later. The incident had significant emotional repercussions for both the technician and for the patient's family members.
8.3	At the inquest, it was confirmed that no cervical spine assessment or immobilisation had been performed. The technician felt that there was insufficient training and lack of reference to clinical tools like JRCALC and whilst the coroner delivered a verdict of accidental death, concerns were raised about the adequacy of training and staff preparedness. A patient safety incident review was undertaken which identified several themes, including trauma training for elderly patients, reissuing clinical guidance, and reviewing missed trauma cases.
8.4	Questions were raised in relation to dispatch decisions, crew composition, and the broader implications for training and governance. There was consensus on the need for improved audit processes, better staff support during inquest proceedings, and consideration of additional processes where a death had occurred. The Board commended the transparency and depth

	of the presentation, recognising it as a powerful example of how patient safety incidents can drive meaningful change.
8.5	**Action: Update to be provided to the September board in relation to whether SCAS will implement a process for the investigation of patient deaths outside of the Patient Safety Incident Response Framework (PSIRF)**
8.6	**The Board NOTED the Patient Story**
9	**Integrated Performance Report (IPR)**
9.1	SR presented the IPR which reported on June 2025 data:
9.2	**Operations** MA highlighted the following:
9.3	• Strong Category 2 response times in quarter 1 which outperformed national targets. However, performance declined in July due to reduced uptake of overtime and fleet availability issues. The transition away from the usage of private providers and TUPE transfers added complexity to staffing and vehicle deployment. • The trust was 10th nationally for Category 3 and 4 performances in July • Fleet unavailability led to the loss of over 100 staff hours lost daily. • Uptake of overtime and bank shifts was lower than expected. • A team had been established to focus on recovery of the position, chaired by the Director of Planning and Forecasting. • Fleet redistribution: newer vehicles moved to Thames Valley; older ones to Hampshire. • Additional workshop capacity had been approved, including a third workshop in the north. • New scorecards had been developed to improve real time visibility.
9.4	Noting the arrangements to ensure recovery of the position, the Board emphasised the importance of maintaining daily scrutiny until performance stabilises. The financial and motivational implications of fleet issues were highlighted; specifically in terms of vehicle shortages not only disrupting service delivery and efficiency but also impacting staff morale. In response to these concerns, the Board recommended that process redesign be integrated into the Fit for the Future programme, ensuring that long-term strategic planning addresses systemic inefficiencies and supports sustainable improvements in service delivery.
9.5	**Quality and Safety** HY highlighted the following:
	• 90% of patient safety incidents resulted in low or no harm. However, 1.2% (5 incidents) resulted in moderate harm, primarily due to delays in attendance or the requirement for reconnection with services. A significant maternity case was declared a Patient Safety Incident Investigation (PSII). • Delays and patients needing to reconnect with services are emerging themes. A thematic review has been commissioned in response • IPC audits and vehicle cleanliness showed improvement but remain inconsistent. • IPC audits expanded beyond base locations to include on-scene audits

	• Platinum trauma training has been introduced to support the management of elderly and frail patients. • Clinical memos were reissued regarding missed spinal fractures.
9.6	In relation to the quality and safety section of the report, more thorough analysis of the cultural and human factors contributing to patient safety incidents was requested, recognising that understanding staff behaviours and decision-making is essential to learning and improving outcomes. The Board supported the introduction of quarterly incident reporting to provide assurance around learning and engender transparency and accountability. Additionally, proactive auditing of changes to practice was required to provide assurance that improvement activity is delivering improvement on a sustainable basis.
9.7	**Workforce and People** DH highlighted the following: • Over establishment for the reasons previously discussed • Improvement in turnover from 18.3% to 17.6% • Continuing high sickness absence at 6.1% • Appraisal completion rate at 85% (target: 95%) – task and finish group established to support improvement • A reduction in bank shifts available in line with plan • Development of a 12–24 month workforce plan • Monitoring of sickness and retention strategies • Engagement with the College of Paramedics regarding student placements
9.8	The Board acknowledged the emotional impact of the decision to pause both international and domestic recruitment, recognising the disappointment and uncertainty faced this created. In light of this, members requested the development of more robust mechanisms to assess staff morale and cultural health across the organisation as part of the IPR/reporting to the PACC. They also emphasised the need for greater nimbleness in workforce planning and risk management, highlighting the importance of anticipating staffing pressures and responding swiftly to emerging challenges to maintain service continuity and staff wellbeing.
9.9	**Finance** SR highlighted the following: • Identification of 87% of Cost Improvement Plans (CIPs), with 93% of those being recurrent. However, an additional £2.3 million in savings is needed due to over-establishment and fleet-related costs. CIP delivery is however behind schedule. • Contract negotiations with ICBs (BoB and BLMK) still ongoing. • Fleet delays impacting capital and cash flow. • Strengthening of the Financial Recovery Group • Weekly QIA panels established • Additional scrutiny on contract funding and fleet costs.
9.10	The Board made several key observations and emphasised the importance of contingency planning and proactive risk management, particularly in light of emerging cost pressures such as fleet delays and over-establishment. To support more informed decision-making, the Board requested that future financial forecasts be accompanied by a clear list of risks and

	opportunities, enabling better visibility of potential challenges and the strategies in place to mitigate these.
9.11	In addition, the Board expressed strong support for the shift toward Foundation Trust-style integrated planning, which includes multi-year financial modelling and scenario planning. They also encouraged the integration of quality improvement methodology into strategic planning processes and ensuring that financial decisions are aligned with clinical effectiveness and service improvement goals.
9.12	**IPR Action: Discussion to take place at EMC in relation to the development of cultural KPIs for inclusion in the next iteration of the IPR**.
9.13	The Board **NOTED** the Integrated Performance Report.
10	**Chief Medical Officer's Report**
10.1	JB Dr. John Black provided an update on key clinical developments and innovations. SCAS is actively participating in a national randomised controlled trial evaluating the use of cervical collars in pre-hospital spinal injury care. This research aligns with recent patient safety concerns and supports evidence-based improvements in trauma management.
10.2	In terms of digital integration, frontline clinicians now have access to the Hampshire equivalent of the Thames Valley Shared Care Record, with imminent access to the National Care Record Service. This will enhance clinical decision-making, particularly for patients visiting from outside the region as their medical history will be available.
10.3	JB also reported on recent updates to clinical practice guidelines, ensuring alignment with national standards and best practice. These updates are detailed in Appendix 1 of his report.
10.4	Significant progress was noted in cardiac arrest and stroke care. Over 300 SCAS staff have registered with the GoodSAM app, which mobilises trained responders to attend cardiac arrest cases. The app will soon be extended to members of the public, with anticipated improvements in cardiac arrest survival rates. Additionally, SCAS is working with Royal Berkshire and Winchester hospitals to streamline transfers for patients requiring mechanical thrombectomy. Paramedics now remain with patients during admission to facilitate rapid onward transfer to specialist centres, a change expected to have a profound positive impact on outcomes. The Board **NOTED** the Chief Medical Officer's Report.
11	**Quality and Safety Committee Assurance Report (July 2025)**
11.1	Noting the discussion that had already taken place under the IPR agenda item around quality and safety, the Board **NOTED** the QSC report.
12	**Quality Accounts 2024/25 & Quality Priorities 2025/26**
12.1	HY presented the Quality Account for 2024/25, which provided a retrospective overview of the trust's quality performance during the year. HY advised that the report follows a nationally mandated template and had been subject to scrutiny by the Executive Management

	Committee (EMC) and the Quality and Safety Committee, with feedback incorporated into the final version.
12.2	Key achievements were noted across several domains, including consistently high levels of incident reporting and a low proportion of incidents resulting in harm. However, the Trust self-assessed as partially compliant in one area: embedding the Patient Safety Incident Response Framework (PSIRF). Whilst more training had been delivered across the trust than in many peers, there was acknowledgement that frontline staff lacked sufficient confidence to independently lead learning responses. Most responses were facilitated by the Patient Safety Team, indicating a need for broader capability building across the organisation.
12.3	The Board **APPROVED** the Quality Account for 2024/25.
12.4	**Quality Priorities 2025/26** HY advised that the Quality Priorities for the current year had been developed in alignment with the Patient Safety Plan, commissioner priorities, and feedback from the Council of Governors, Patient Panel, EMC, and the Quality and Safety Committee. These priorities focus on improving patient safety, enhancing clinical effectiveness, and strengthening patient experience.
12.5	Whilst the priorities were well-defined, the Board noted a lack of specific metrics and improvement trajectories within the document. HY confirmed that these priorities are underpinned by the Patient Safety Plan, which includes measurable targets. Quarterly reporting to the Quality and Safety Committee will track progress and impact.
12.6	The Board supported the proposed quality priorities, noting their clear alignment with the trust's strategic goals and broader patient safety objectives. Members emphasised the importance of incorporating clearer metrics and defined improvement trajectories to enable effective monitoring of progress and impact. Additionally, the Board welcomed the commitment to quarterly progress reporting to the QSC, recognising it as a key mechanism for ensuring accountability, transparency, and visibility of outcomes throughout the year.
12.7	The Board **APPROVED** the Quality Priorities for 2025/26.
13	**Finance Report Month 3 Update**
13.1	SR presented the Month 3 Finance Report, which confirmed the trust remains on plan, albeit through non-recurrent measures totalling £1.6 million. These measures were necessary to offset emerging cost pressures, including the over-establishment position and fleet-related inefficiencies. A resultant £2.3m increase in the Cost Improvement Programme (CIP) target was therefore required.
13.2	The executive team has developed a plan to address the revised CIP target, with 87% of schemes now identified and 93% of those confirmed as recurrent. Weekly Quality Assurance panels have been established to accelerate delivery and oversight. The Financial Recovery Group and its sub-group, the Financial Sustainability Group, have also been strengthened to support this work.

13.3	Contract negotiations remain ongoing, particularly with BLMK and Bob ICBs. A resolution is expected to secure 50% of disputed funding in-year, with full recovery anticipated next year. The Trust is slightly behind on CIP delivery but is making good progress.
13.4	The Board emphasised the importance of maintaining financial discipline and delivering the financial plan without relying on non-recurrent measures. Members requested greater clarity on the remaining 13% of unidentified cost improvement plans (CIPs) and stressed the need for robust contingency planning to mitigate future financial risks. The Board supported the proposal for the Finance & Performance Committee to maintain a detailed risk and opportunity register aligned to the forecast, enabling more proactive oversight. Additionally, there was recognition of the need to link financial planning with strategic redesign, including process improvement and system-level efficiencies, to ensure long-term sustainability.
13.5	**Action: brief summary of risks and opportunities to be added to the forecasting section of the finance report.**
13.6	The Board **NOTED** the report and endorsed the actions underway to ensure financial sustainability.
14	**Hampshire and Isle of Wight ICB Month 3 Finance Report**
14.1	The Board noted that the Hampshire and Isle of Wight Integrated Care system is currently off plan. SCAS, as a system partner, is actively engaged in regional and national meetings to support system financial recovery efforts. The Trust has submitted its projections for months 4 to 6, along with associated delivery actions, in line with expectations.
14.2	Board members acknowledged the importance of system-wide financial accountability, particularly in light of the potential impact on deficit support funding. It was noted that several systems nationally have already had deficit support withdrawn due to underperformance, reinforcing the need for SCAS and its partners to deliver on plan.
14.3	The Board also discussed the implications of upcoming changes to commissioning arrangements across the Southeast. Members highlighted the need for greater visibility of transition plans to ensure decisions made now do not conflict with future structures and that the trust remains aligned to broader system objectives, and is well positioned to respond to future changes. The Board sought greater clarity on the commissioning transition plans and their potential impact on SCAS, particularly in light of evolving arrangements within NHSE. There was agreement that this emerging risk requires further exploration and assurance.
14.4	The Board **NOTED** the Hampshire and Isle of Wight ICB Month 3 Finance Report.
15	**Buckinghamshire, Oxfordshire and Berkshire West ICB M2/3 Finance Report**
15.1	The month 2/3 Finance Report showed that the system delivered a small surplus in Month 2 and is making progress towards achieving its financial targets. While the ICB is currently forecasting a breakeven position for the year, this is being supported by non-recurrent measures and system-wide efficiencies. Whilst it was noted that the ICB is on track, collective system performance remains essential for securing deficit support funding. The Board **NOTED** the BOB ICB M2/3 Finance Report

16	**Finance & Performance Committee Assurance Report – July 2025**
16.2	LB highlighted the discussion around contingency planning and the committee's support for the development of a medium-term financial strategy, developed through proactive engagement with system partners to mitigate risks and ensure sustainable delivery. The Board **NOTED** the Finance and Performance Committee Report.
F	**Refreshed Green Plan** SR presented the plan, noting its comprehensiveness and the significant infrastructure costs, particularly for fleet electrification. He emphasised these were national challenges that required coordinated lobbying to secure the necessary capital investment. The plan also includes a detailed review of the estate to assess readiness for electric vehicle (EV) infrastructure and energy efficiency upgrades. Whilst the plan was welcomed, it was noted that it was a lengthy document and MM requested a "plan-on-a-page" summary with clear targets, timelines, and a risk register was requested. DE supported this and proposed a Board development session to align the Green Plan with the long-term Estates Strategy and the new hub-based operating model. GF raised the issue of estate rationalisation, asking whether it might be more cost-effective to sell some buildings. SR confirmed that there is now a comprehensive understanding of the trust's estate, including backlog maintenance requirements. He also highlighted that recent energy efficiency measures, such as solar panel installations, have already saved the Trust around £1 million in utility costs. The Board agreed that the Green Plan is not just an environmental strategy but a key component of the trust's operational and financial planning. **Action: Board development session to be arranged in relation to Estates to include the infrastructure that would be required to support estates planning and move to Hub model**. **The Board APPROVED the Refreshed Green Plan**.
18	**Audit Committee Assurance Report – June 2025**
18.1	**Audit Committee 17 June 2025** The Board noted that the annual report and accounts had been subject to rigorous scrutiny prior to board approval at the Audit Committee. A significant milestone was the elimination of overdue internal audit actions, which was commended as a sign of improved responsiveness and accountability.
18.2	The internal audit report with a moderate conclusion relating to Mandatory Training was noted. and MM emphasised the need to ensure the actions arising from the audit are addressed and that future audits reflect the progress made.

18.3	The Board **NOTED** the Audit Committee Report.
19	**Charitable Funds Assurance Report – July 2025**
19.1	The Board **NOTED** the Charitable Funds Committee Assurance Report.
20	**Questions submitted by Board Members on agenda items: 15-16, 18-19**
20.1	No questions received.
21	**People & Culture Committee Report – May 2025**
21.1	The focus of the meeting had been on workforce planning and organisational culture. A key topic was the Trust's over-establishment as previously discussed. There was recognition of the successful recruitment and retention efforts but also concern about the impact of paused recruitment and the implications for the future pipeline.
21.2	The committee also reflected on the importance of cultural factors in workforce wellbeing and performance. Members emphasised the need to better understand and measure staff experience beyond transactional data, suggesting more nuanced approaches to assess morale and engagement. The committee agreed to support the development of a refreshed workforce plan and to provide ongoing assurance as it evolves.
21.3	The Board **NOTED** the People and Culture Assurance Report.
22	**Communications, Marketing and Engagement Update**
22.1	The Board **NOTED** the update
23	**Chief Digital & Information Officer Report**
23.1	The Board **NOTED** the report.
24	**Questions submitted by Board Members on agenda item 22-23**
24.1	No questions were received.
25	**Chief Governance Officer Report**
25.1	**Board Committees Annual Report and Terms of Reference**
25.2	BS presented the Board Committees Annual Report and updated Terms of Reference and confirmed these had been reviewed and discussed at the respective committee meetings. The purpose of the annual reports was to provide assurance to the Board on the effectiveness of each committee over the past year and to identify improvement actions that will be tracked and measured in the following year.

25.3	A key theme emerging from the committee reviews was the need to improve the quality and timeliness of papers. This issue had also been highlighted in the Trust's self-assessment against the NHS Provider Code of Governance.
25.4	BS highlighted that there had been no change to the People and Culture Committee terms of reference as these had only recently been reviewed, in addition to which there had been a change in chair. These will be reviewed at a later date and presented to the Board. BS concluded by advising that all of the terms of reference will be put into a standard template.
25.5	The Board formally noted and approved the annual reports and the revised Terms of Reference, recognising the importance of these documents in supporting good governance and continuous improvement. There was a shared understanding that the improvements identified would be monitored and revisited in the next annual cycle. The Board **APPROVED** the Board Committee Annual Report and Terms of Reference.
26	**Board Assurance Framework (BAF)**
26.1	BS presented the 2025/26 for approval, noting that the BAF risks will be a central component of the Trust's "Fit for the Future" reporting framework, which will enable the board to note progress against achievement of the strategic priorities and the risks to delivery, alongside operational performance. This integrated approach is designed to provide a more rounded and dynamic view of assurance across the organisation.
26.2	The BAF risk had already been reviewed by the committees that they are assigned to, and the document was presented as a consolidated document. From an Audit Committee perspective MM asked for the format to be reconsidered to ensure there was clear oversight of the controls, gaps in controls and mitigating actions.
26.3	The Board approved the BAF subject to further review of the format by the Audit Committee. The discussion highlighted the importance of balancing clarity and usability with comprehensive assurance, and the need for ongoing refinement to ensure the BAF remains a practical tool that drives the agenda for the board and its committees.
26.4	**Action: Format/presentation of BAF to be reviewed.**
26.5	The Board **APPROVED** the 2025/26 Board Assurance Framework
27	**Board Site Visits**
27.1	The Board noted the site visits that had taken place, but it was acknowledged that a more formal framework was required, which dovetailed into other activity such as Accreditation Visits, provided assurance on actions taken in response to issues raised during visits and good coverage across all trust sites. It was noted that an action was recorded in the May Board meeting to bring back a proposed framework for Board site visits to the September 2025 meeting.

28.2	The Board **NOTED** the Board Site Visits Report and actions.
29.	**Any other business**
29.1	No other business was raised or discussed.
30	**Questions from observers**
30.1	No formal questions were asked by observers. Alan Weir (Governor) commented positively, noting that it was good to see discussions from the Council of Governors (COG) being reflected in the Board meeting particularly around workforce challenges. This helped reinforce the connection between COG concerns and Board-level decision-making.
31	**Review of the meeting:**
31.1	BS summarised actions from the meeting.
31.2	MM commented on the: • Positive focus on governance. He once again commended the progress made in relation to the timely completion of internal audit actions and elimination of overdue actions, which he described as a significant achievement. • Constructive feedback on the format of the Board Assurance Framework • Evident commitment to continuous improvement and maintaining high standards of assurance.
31.3	HY commented on the: • Recognition of the emotional impact of patient safety incidents on staff and the importance of learning and support. • The welcome introduction of training initiatives that followed the case and highlighted the need for continued focus on trauma care for elderly patients. • The strong clinical leadership perspective, balancing compassion with a drive for quality improvement.
31.4	Overall, these reflections reinforced the Board's shared commitment to governance, learning, and patient-centred care.
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 25 September 2025 at the Ark Conference & Events Centre, Dinwoodie Drive, Basingstoke, Hampshire, RG24 9NN.

SCAS 2024 ANNUAL MEMBERS MEETING

Minutes of the South Central Ambulance Service NHS Foundation Trust 2024 Annual Members Meeting held on Wednesday 23 October 2024 via Microsoft Teams

Board members

Professor Sir Keith Willett (Chair); David Eltringham (Chief Executive); Sumit Biswas (NED); Nigel Chapman (NED); Dr John Black (Chief Medical Officer); Duncan Robertson (Chief Paramedic Officer); Craig Ellis (Chief Digital Officer); Jamie O'Callaghan (Interim Chief Governance Officer); Mark Ainsworth (Executive Director of Operations); Mike McEnaney (NED); Natasha Dymond (Interim Director of People); Stuart Rees (Interim Director of Finance); and Helen Young (Chief Nurse Officer).

Apologies

Apologies for absence were **received** from Board members: Les Broude (NED); Ian Green (NED); Dhammika Perera (NED); and Katie Kapernaros (NED).

In Attendance

Kofo Abayomi (Head of Corporate Governance & Compliance); Mike Appleyard (Public Governor, Buckinghamshire); Rachel Cook(Staff Governor); Mark Davis (Public Governor, Berkshire & Deputy Lead Governor); Margaret Eaglestone (Membership and Engagement Manager); Tim Ellison (CFR Governor); Hilary Foley (Governor) Laura Hinsley (Head of Public Sector Audit-England/Public Sector External Audit); Tony Jones (Governor); David Luckett (Public Governor, Hampshire); Anthony Nicolson (Public Governor, Hampshire); Mark Potts (Governor); Helen Ramsay, (Public Governor, Oxford & Lead Governor); Ian Sayer (Staff Governor, 999); Nick Smith (Marketing and Communications Manager); Tom Stevenson (Deputy Director of Communications, Marketing and Engagement); Alan Weir (Staff Governor, Corporate); Susan Wall (Corporate Governance Manager) and Barry Wood (Appointed Governor).

Apologies

The Annual Members Meeting was attended by a number of staff, Governors, volunteers and members of the public.

ANNUAL MEMBERS MEETING

AMM 2024 Chair's Welcome and Introduction

The Trust Chair, Sir Keith Willett opened the meeting by welcoming governors, members of the public, and representatives from partner organisations. He gave an overview of the agenda and invited attendees to submit questions in advance or during the meeting and assured that follow-up responses for any unanswered questions via email.

AMM 2024 Declarations of Interest

There were no declarations received.

AMM 2023 Minutes of the meeting held 13 September 2023

The minutes of the Annual General Meeting 2023 were **APPROVED** as an accurate record of the meeting.

AMM 2023 SCAS Review of the Year

David Eltringham, Chief Executive Officer of South Central Ambulance Service (SCAS), presented a comprehensive review of the year. He began by outlining the scale of SCAS's operations, which span approximately 4,500 square miles and cover the counties of Hampshire, Oxfordshire, Buckinghamshire, and Berkshire. The organisation delivers three core services: the 999 emergency response, the 111 triage and advice line, and patient transport services for non-emergency medical appointments.

David Eltringham highlighted several significant challenges faced during the reporting period. Notably, there was a 19% increase in demand for 999 services and a 16% rise in 111 calls. Financially, SCAS ended the year with a £25.1 million deficit against a total budget of £350 million. Additionally, the Care Quality Commission (CQC) had downgraded SCAS's rating to "Inadequate" in 2022, prompting a focused recovery effort that remains ongoing.

In response to these challenges, SCAS has prioritised its "Fit for the Future" programme, a strategic initiative built around seven pillars, including digital transformation, fleet and estate modernisation, and leadership development. The organisation has also made significant progress in clinical innovation, developing over 150 alternative care pathways to reduce unnecessary hospital conveyance. David Eltringham emphasised SCAS's strong commitment to patient safety, safeguarding, and mental health training for all staff. He also praised the vital contributions of volunteers and the SCAS charity, which continue to play a crucial role in supporting frontline services and community engagement.

AMM Financial Review and Accounts

Stuart Rees, Interim Chief Financial Officer, provided a detailed overview of South Central Ambulance Service's (SCAS) financial performance for the year ending March 31, 2024. He reported that the Trust concluded the year with a deficit of £25.1 million, falling short of its break-even target. This financial shortfall was discussed with regulators and is being addressed through a three-year financial recovery plan, which is currently at its halfway point.

Capital expenditure for the year totalled £15 million, exceeding the planned limit by £8.5 million due to delays in fleet procurement—a national issue that regulators acknowledged without penalty. Despite this, SCAS maintained a healthy year-end cash balance of £25.1 million. Staffing remained the largest area of expenditure, accounting for £260.9 million or 58% of total costs, consistent with NHS norms. The Trust also met its Better Payment Practice Code target, paying 95.8% of suppliers within 30 days.

Income levels remained relatively stable year-on-year. While COVID-related funding decreased by £11.4 million, this was offset by increases from Integrated Care Boards, including £4.8 million for Category 2 performance improvements and additional funding through the Ambulance Capacity Fund. SCAS also received £2.7 million in donated income for ventilators.

Expenditure rose by £24.4 million, driven largely by increased use of private providers for patient transport services and short-term vehicle leases due to fleet shortages. Premises costs also increased, primarily due to higher utility bills and maintenance. IT costs rose following contract extensions for key systems such as Adastra and CAD (Computer-Aided Dispatch).

A significant revaluation of assets resulted in a net impairment charge of £5.3 million. This was part of a scheduled five-year cycle, during which land values increased while building values declined due to reduced economic life. Notable adjustments included a £6 million increase in the value of Oxford land and a £12 million derecognition of the High Wycombe lease.

Capital investment rose by nearly £6 million compared to the previous year, with major projects including the opening of a new 111 control centre in Milton Keynes. Rees explained that the financial deficit stemmed from the loss of non-recurrent COVID-era funding, which had previously masked underlying cost growth. The Trust is now focused on restoring financial sustainability by 2025/26 through its recovery plan, which includes significant savings targets and structural reforms.

AMM 2023/24 Auditors Report

Laura Hinsley, (Azets SCAS's external auditor), presented the conclusions of the audit for the financial year ending 31 March 2024. She confirmed that the financial statements were found to be materially true and fair, resulting in an unqualified audit

opinion. Although the audit report was signed three weeks after the national deadline, this delay was attributed to the need to process significant prior period adjustments, and did not affect the integrity of the audit.

The auditors also verified that the financial statements were consistent with the figures reported to NHS England and aligned with the Foundation Trust Annual Reporting Manual. Additionally, the annual report and governance statement were found to be accurate and reflective of the organisation's operations, with no issues requiring attention.

A key part of the audit involved assessing SCAS's arrangements for achieving value for money, focusing on three areas: financial sustainability, governance, and economy, efficiency, and effectiveness. No significant weaknesses were identified in the latter category. However, the auditors did highlight concerns regarding financial sustainability due to the substantial deficit recorded in 2023/24 and the absence of a medium-term financial plan at the year-end. These issues were acknowledged as being addressed through the Trust's financial recovery plan, which was implemented after the reporting period.

In terms of governance, the auditors noted that SCAS had not yet established sufficient arrangements to monitor and deliver against the improvement criteria set out in response to the Care Quality Commission's (CQC) findings. While progress has been made since the year-end, the audit assessment was based on the position as of 31 March 2024. Recommendations were made to strengthen both financial planning and governance oversight moving forward.

AMM 2024 Service Presentation – Expanding Clinical Pathways

Mark Ainsworth, Interim Chief Operating Officer, presented an update on SCAS's evolving clinical care pathways programme, stepping in for Chris Jackson. Over the past five years, SCAS has significantly expanded its approach to urgent care, moving away from the traditional model of conveying patients to hospital and instead focusing on treating patients in the community where appropriate. This shift is part of a broader strategy to improve patient outcomes, reduce pressure on emergency departments, and enhance system-wide efficiency.

The programme, now known as the Clinical Care Pathways initiative, was developed in response to the growing recognition that many patients do not require hospital admission. SCAS has implemented over 150 alternative pathways, supported by robust clinical governance to ensure safety and effectiveness. These pathways are accessible to staff via SCAS Connect, a digital tool that helps clinicians identify appropriate services based on patient needs and location. It also tracks usage and availability, helping SCAS monitor service gaps and improve access.

The pathways are divided into hospital-based and community-based options. Hospital pathways include direct admissions to specialist units such as stroke, maternity, and trauma centres, bypassing emergency departments. Community pathways enable referrals to urgent care centres, GPs, specialist practitioners, and virtual wards. SCAS has also piloted a single point of access model in Hampshire, allowing paramedics to consult with hospital clinicians before conveying patients, ensuring they are directed to the most appropriate care setting.

COVID-19 accelerated the development of these pathways, highlighting the need to avoid unnecessary hospital visits. Since then, SCAS has worked closely with Integrated Care Boards and local providers to expand services such as same-day emergency care, urgent community response teams, and hospital-at-home models. These services aim to treat patients within two hours and reduce conveyance rates.
SCAS continues to innovate, introducing tools like the GoodSAM video triage app, which allows clinicians to assess patients remotely. Future developments include care home triage support, direct admissions for hip fracture patients, and enhanced diabetic care pathways. The organisation is also focused on reducing variability across regions, ensuring consistent access to care for all patients.

Staff engagement and training remain central to the programme's success. SCAS is investing in education and confidence-building to ensure clinicians feel supported in using these pathways. The ultimate goal is to ensure patients receive the right care, in the right place, at the right time—supporting SCAS's mission as a care navigator within the NHS.

AMM 2024 Council of Governors' Review of the Year

Helen Ramsay, Lead Governor for South Central Ambulance Service (SCAS), provided an overview of the role and activities of the Council of Governors. She began by explaining that governors have two core responsibilities: representing SCAS members which include public members, staff, and community first responders and holding the non-executive directors to account for the performance of the Board. This accountability structure ensures that executive directors are scrutinised by non-executive directors, who in turn are held accountable by the governors, creating a transparent governance framework.

Helen Ramsay introduced the current composition of the Council of Governors, which includes 16 public governors representing various counties, six staff governors from different service areas, and appointed governors from partner organisations. She noted that there are currently vacancies and encouraged attendees to consider applying, highlighting that individuals can become members from age 14 and governors from age 16.

Governors engage with the public and staff through various channels, including Council meetings, committee observations, and site visits. Helen Ramsay highlighted a key achievement in the past year: governors contributed to redesigning the

recruitment process to improve diversity and outreach. She also described the Membership and Engagement Committee, which advises on public engagement strategies and reports to the Council of Governors.

SCAS currently has over 8,000 members, and Helen Ramsay encouraged more people to join, noting that membership is free and provides valuable insight into the ambulance service. Governors have been active in community events, such as emergency services days and faith-based forums, and have worked closely with the patient panel to better understand mental health needs.

A major focus for governors has been addressing health inequalities. Helen Ramsay explained that SCAS, as an “anchor organisation,” has the potential to positively impact local communities through its resources and reach. The governors have formed a working group aligned with guidance from the Association of Ambulance Chief Executives (AACE) to analyse data, build community networks, and engage with underrepresented groups. Their efforts include attending health inequality forums, collaborating with voluntary organisations, and tracking feedback to inform service improvements.

Helen Ramsay concluded by inviting attendees to become members and participate in shaping the future of SCAS, reinforcing the importance of inclusive representation and community engagement in the governance of the ambulance service.

AMM 2024 Question and Answer Session

Q1: Has SCAS come close to declaring business continuity incidents recently, particularly in Berkshire? What are the key pressures this winter?

Answer (David Eltringham):

- A business continuity incident is declared when special arrangements are needed due to demand surges or operational disruptions (e.g. hospital handover delays).
- SCAS has experienced challenges with hospital handovers, not necessarily demand spikes.
- Working closely with acute hospital partners to address delays.
- Alternative pathways are being developed to reduce pressure on A&E.

Q2: Has SCAS significantly cut back on overtime due to financial pressures?

Answer (David Eltringham):

- Yes, as part of the Fit for the Future programme, SCAS is moving away from short-term staffing solutions like overtime.
- Focus is on recruiting into substantive roles and using stable private contracts.

- This shift has reduced reliance on overtime.

Q3: What happens if SCAS fails to meet expectations in the Recovery Support Programme after the three-month period?

Answer: (David Eltringham):

- SCAS is under two Recovery Support Programmes:
    1. CQC-related: Targets set for improvement by September 2025.
    2. Financial: Part of the Hampshire and Isle of Wight system recovery plan.
- If targets are not met, central controls may increase, including restrictions on discretionary spending.

Q4: What is the message to the public to help ambulance services during winter pressures?

Answer: (David Eltringham):

- Use pharmacy first, 111, and primary care where appropriate.
- Reserve 999 for life-threatening emergencies.
- Promote uptake of flu, COVID, and RSV vaccines.
- Encourage use of the NHS App for easy booking.

Q5: What is the message to hospital partners?

Answer: (David Eltringham):

- Emphasised partnership working to manage urgent and emergency care.
- Focus on:
    - Same Day Emergency Care (SDEC)
    - Urgent Treatment Centres
    - Mental health services
    - Integrated neighbourhood teams
    - Timely hospital discharge
- SCAS is committed to being part of the solution through collaborative system-wide efforts.

AMM 2024 Closure of Annual Members Meeting

- Annual Report, Quality Accounts, and Audit Report available on the SCAS website.
- Slide deck from the meeting to be published by end of the week.
- Questions can be submitted via: **communications@scas.nhs.uk**

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TRUST BOARD ACTION LOG						Status
Minute Ref:	**Agenda Item**	**Action**	**Owner**	**Due Date**	**Update**	
Meeting Date: 31st July 2025						
TB/25/010	Minutes	Amendments to the previous set of minutes to be made as discussed. HY to provide a form of words	KA	25.09.25	amended	**CLOSED**
TB/25/11	Patient Story	Update to be provided to the September board in relation to whether SCAS will implement an additional process for the investigation of patient deaths	HY	25.09.25	The Patient Safety and Legal Team are assessing the viability of introducing a separate process in the event of a patient death as a source of evidence for the Coroner. The issue is not the introduction of a process itself but the capacity to complete investigations outside of the PSIRF framework given that PSIRF was intended to drive a different approach to Serious Incident Investigations, which is focused on wider, systematic learning. A further report will be provided to the QSC when the scoping is complete	**CLOSED**
TB/25/12	CEO update	Board development session to be scheduled in relation to the 10-Year Plan	BS	25.09.25	Factored into the Board Seminar Programme	**CLOSED**
TB/25/13	IPR	Discussion to take place at EMC in relation to the development of cultural KPIs for inclusion in the next iteration of the IPR	DH	25.09.25		
TB/25/14	Finance Report	Brief summary of risks and opportunities to be added to the forecasting section of the finance report	SR	25.09.25	Included within the report	**CLOSED**
TB/25/15	Green Plan	Board development session to be arranged in relation to Estates to include the infrastructure that would be required to support estates planning and move to Hub model (BS)	BS	25.09.25	Factored into the Board Seminar Programme	**CLOSED**

TB/25/16	BAF	Format/presentation of BAF to be reviewed	BS	25.09.25	BS and MM agreed to meet to discuss re-formatting ahead of the next Audit Committee.	**OPEN**
Meeting Date: 29 May						
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 between Corporate Governance and Quality Team. A revised framework for board/senior leadership visits will be presented to the next meeting.	**OPEN**
Meeting Date: 27 March 2025						
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	

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Meeting Report

Name of Meeting	Public Trust Board Meeting
Title	Chair's update
Authors	
Accountable Director	Keith Willett, Chair
Date	25th September 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 July 2025.
Since the last Public Board meeting, I have undertaken the following visits and stakeholder meetings:

August 2025

- BOB Monthly Trust Chairs Meeting
- The Ten-Year Health Plan: Empowering the Public Webinar
- SCAS EPRR Group

September 2025

- Hope for the Future: Strategic Advisory Group
- National Security Risk Assessment Expert Challenge, Human Welfare Panel
- Compliance visit to SORT Thatcham
- RCSEd NHS Future Leaders Programme speaker
- BLMK Leaders and Chairs meeting
- Audit Committee
- Chair BLMK ICS Research and Innovation Network Meeting
- Meetings with NHSE SE Regional Director
- National Ambulance Memorial Service
- NHS Confed All Member Chairs Group
- Extra Ordinary Council of Governors (Annual Report and Accounts)
- HIOW Chairs Meeting
- Joint Strategic Collaborative Committee (JSCC)
- NHS Providers: Virtual Roundtable on implementation of the 10YHP

Other

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

Recommendation

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

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Board of Directors Meeting in Public 25 September 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 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

25th September 2025

National Context

The NHS Oversight Framework 2025/26 was published in July 2025 and sets out a clear and consistent framework for NHS England to assess the performance of Integrated Care Boards (ICBS) NHS Trusts and NHS Foundation Trusts, based on a core set of defined delivery metrics. All providers and ICBs have been placed into a segment according to their performance across this range of metrics and SCAS has been placed in Segment 4 with a ranking against other ambulance services of 8/10. The Trust continues to be in Recovery Support which technically is segment 5 in the new framework but will have different arrangements set around it.

Analysis of the calculation to arrive at the segmentation score shows that our people metrics (staff survey results, sickness levels and turnover rates) are driving the lower segmentation score. Focussed work is in place to deal with this and this is set out in the relevant section of our improvement plan linked to our 'Fit for the Future' programme.

Recovery Support Programme

Linked to our segmentation, a huge amount of work has taken place over the last 18 months to manage our exit from RSP. This includes work to modernise our services and return to financial balance in line with our Financial Recovery Plan. Importantly, the changes that we are making will ensure that SCAS achieves its ambition to become a care navigator and to deliver our strategy of *Right Care, First Time for our Patients*.

The executive team with the support of senior leaders across the organisation have been heavily focused on developing programmes of work aligned to our 5 strategic fit for the future themes, that will see us deliver the Transition Criteria that we are required to meet in order to secure our exit from RSP at the same time as making overall improvements to the way that we run and deliver our services.

Our non-executive directors have also been engaged in the development of our Fit for the Future strategic framework, which is our single Improvement Plan that captures, guides and acts as an oversight mechanism for all the work that we are doing. I am pleased that we will be presenting our Fit for the Future Framework to this September board for approval.

The approach that we are taking will ensure that as a board, we have a holistic view of the progress we are making towards achieving our ambition, by tracking our key programmes of improvement work, our performance against the metrics in the NHS Oversight Framework and our Operating Plan deliverables, with risks to delivery clearly identified, so that we can ensure these are managed and mitigated. Our board will receive regular updates on our progress and further, detailed scrutiny will take place within our board committees. Our framework has re-emphasised our direction of travel as an organisation and provides a methodical way of tracking progress through robust and effective reporting, governance and oversight.

Performance

In my last report I was pleased to report that we had started the new financial year in a positive position, but performance became more challenging during July. Our mean Category 2 response time was 27.11 minutes during August which was an improvement on the July position and above target, but we have continued to experience challenges as we have moved into September. Our ability to get to patients quickly is a key measure of safety and quality of care and it is important that we describe it in this way.

As an executive team we remain focused on delivering category 2 performance to ensure that we reach our patients in a timely way to provide the urgent and life preserving treatment that they need, and we have established a team dedicated to resolving issues and supporting our operational teams to deliver against the targets that we agreed as part of our Operational Plan.

We understand the drivers for the challenges we are experiencing, which are multifactorial in nature and include vehicle availability due to the age of our current fleet. We have plans in place to replace our fleet and to open additional workshop capacity so that any repairs and maintenance can be undertaken in a timely way, which will significantly improve the availability of vehicles and ensure that our crews are out on the road. This is a key programme of work within our enabling services' strategic theme.

As we approach the winter period, with the rise in demand that is inevitable with the onset of colder weather and seasonal illnesses, we continue to work with partners across the system to ensure there are no delays in handover that impacts the ability of our crews to respond in a timely way. In line with our modernisation plans, our Hear and Treat is delivering successfully, and performance remains above plan. Hear and Treat not only reduces unnecessary conveyances to hospitals, which relieves the pressure in Emergency Departments, but also ensures that our

patients are treated in the most appropriate setting and that our crews are available to attend to patients in the most urgent need.

Whilst we retain a sharp focus on delivering category 2 performance, we are required to do so within budget and to deliver care in a safe and effective way. We are therefore mindful of the need to constantly maintain the balance between quality, operational and financial performance as the ability to take decisions in this balanced way is a hallmark of an organisation that is well led.

Finance

Whilst we remain on plan to return to deliver on year 3 of our Financial Recovery Plan and return to financial balance at the end of 2025/26, the financial position at month 5 is extremely tight and unanticipated cost pressures that have arisen since the start of the financial year means that we are required to deliver savings over and above our Cost Improvement Plan target of £21.4m.

Resultantly, we continue to operate and review the grip and control measures we have in place to ensure that we deliver on our commitment. Our executive team scrutinises the financial position on a weekly basis to ensure that we can take timely decisions with regards to expenditure and cost savings and although we are making steady progress with regards to identifying and delivering our CIP target for 2025/26, the requirement for additional savings will inevitably lead to difficult decisions needing to be taken.

SECAmb Partnership

The executive teams and boards at SCAS and SECAmb continue to work together to identify areas where collaborative working across the two organisations would be beneficial in terms of creating efficiencies and learning and sharing best practice. Work is in train across several areas of trust business and is already proving fruitful in areas such as operations, where we are focusing on aligning the way that we deliver services for the benefit of the population across both of our geographies.

Our boards have been working together to define a direction of travel for more formalised collaborative working arrangements and the development of a roadmap that will take us to this position. A series of executive to executive and board to board meetings have and continue to take place and we have committed to signing off an Outline Business Case in October 2025.

Staff Survey

The National NHS Staff Survey is being launched on 24th September 2025, and I would like to encourage all staff to participate and give their views on what it is like to work in the trust. Whilst the results were disappointing last year, we hope that the work that we have embarked upon to listen and hear our staff, to redefine our values and behaviours and to improve our culture will have had positive impact on the experience of our staff. The results will not be published until next year and we will use the outputs, together with other sources of feedback to review and refresh the programmes of work set out in our People and Culture strategic theme, to ensure these are delivering the changes that we want to see and remain relevant**.**

Ministerial Letter

I had the pleasure of receiving a letter from the Minister of State for Health and Secondary Care acknowledging the vital contribution that our Community First Responders and Volunteers make to our organisation and the population that we serve. This acknowledgement relates to recent research carried out by King's College, which evidences the contribution made, both in terms of relieving pressure on our crews and thereby improving category 2 response times and improving outcomes for population and reducing health inequalities.

I extend my thanks on behalf of the Trust Board to our Community First Responders and indeed to all staff across our organisation, both in front line and corporate services, who work tirelessly to ensure that we deliver the best care that we can to our population.

David Eltringham
Chief Executive

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Trust Board of Directors Meeting in Public
25 September 2025

Report title	Update to the previous Private Board meeting held since the last Public Meeting on 31 July 2025
Agenda item	7
Report executive owner	Becky Southhall, Chief Governance Officer
Report author	Kofo Abayomi, Head of Corporate Governance & Compliance
Governance Pathway: Previous consideration	Not Applicable
Governance Pathway: Next steps	Not Applicable

Executive Summary

The report details agenda items that were received by the Private Trust Board, decisions made, and items noted at the meeting held on 31 July 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 31 July 2025

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. RSP Exit Slippage
   b. SCAS/SECAmb Collaboration

3. **ONH Update**

   The Board noted the use of Emergency Powers pursuant to the Standing Orders and **APPROVED** the decision to pre-pay ONH to ensure continuity of supply of fleet.

4. **Finance Month 3 Confidential Update**

   The Board **NOTED** there were no financial issues that required private discussion.

5. **Financial Recovery Plan**

   The Board **NOTED** the update report.

6. **Confidential Hampshire and Isle of Wight Integrated Care System Finance Month 3**

   The Board **NOTED** the Hampshire and Isle of Wight Integrated Care System Finance Report Month 3.

7. **EPR Contract Extension**

   The Board **NOTED** the use of Emergency Powers and **APPROVED** the Mobimed EPR Contract Extension.

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Trust Board of Directors Meeting in Public
25 September 2025

Report title	Staff Story
Agenda item	8
Report executive owner	Danny Harriam, Interim Chief People Officer
Report author	Rachael Clarke, Health and Wellbeing Manager
Governance Pathway: Previous consideration	N/A
Governance Pathway: Next steps	N/A

Executive Summary

Purpose of the Story

This story is being shared with the Board to highlight the staff journey of a newly qualified international Paramedic. It provides insight into the new starter journey and how the Trust supports newly qualified Paramedics.

Overview of the Staff Member

Kailen Pettit works as a Newly Qualified Paramedic, having worked for SCAS since April 2024.

The Story (see video)

Key Takeaways

Robust and supportive recruitment: Onboarding processes are thoughtfully designed to be staff-centric, ensuring the right individuals are placed in roles where they can thrive and contribute meaningfully.

Local leadership: Effective local management plays a vital role in helping new staff feel welcomed, settled, and part of the team, fostering a strong sense of belonging.

Cultural sensitivity and inclusion: Consideration of cultural differences is embedded throughout the onboarding experience, promoting an environment where all staff feel respected, supported, and valued.

Commitment to clinical excellence: Clinical Team Educators invest time and effort in mentoring new staff, building their confidence and competence to deliver outstanding patient care.

Celebrating contributions: There is clear recognition of individual achievements and the meaningful work staff undertake, reinforcing a culture of appreciation and professional pride.

Next Steps / Recommendations

- Maintain a strong commitment to supporting Newly Qualified Practitioners (NQPs) in delivering high-quality patient care through ongoing guidance, mentorship, and clinical development.
- Ensure the continued provision of pastoral support

Alignment with Strategic Objectives
With which strategic theme(s) does the subject matter align? People & Organisational

Relevant Business Assurance Framework (BAF) Risk
To which BAF risk is the subject matter relevant? SR7 - Staff Feeling Unsafe, Undervalued and Unsupported

Financial Validation	N/A

Recommendation(s)
What is the Committee/Board asked to do: Discuss and note the staff experience shared and what if any actions can be taken from this

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

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Trust Board of Directors Meeting in Public 25 September 2025

Report title	Fit for the Future Strategic Framework
Agenda item	9
Report executive owner	David Eltringham, Chief Executive Officer
Report author	Executive Team
Governance Pathway: Previous consideration	Board Seminar April 2025 Council of Governors – May 2025 Executive Management Committee (sign off) 16th September 20025
Governance Pathway: Next steps	None – report is for the trust board

Executive Summary

The Trust Board has been involved in and kept updated as to the progress that is being made towards developing Fit for the Future (FFF) as vehicle to deliver against the trust's overall ambition to become a Care Navigator and to deliver the *Right Care, First Time, to our Patients.*

The basis for the FFF framework was the Fit for the Future Modernisation Programme which commenced 2 years ago. As part of the review of the strategic direction of the trust, given the FFF modernisation programme was well known to staff across the organisation, this was pivoted and developed into the strategic framework that is being presented to the board today.

FFF is the trust's single Improvement Plan, which captures all improvement programmes and activities that are on-going across the trust. It is intended to provide structure and direction to the organisation when decisions are made with regards to resource allocation and prioritisation of work and to act as the 'golden thread' that runs through the organisation.

As the Trust is currently in the Recovery Support Programme, the Transition Criteria that must be satisfied in order for successful exit are embedded within the strategic themes to provide

assurance that we are continuing to progress these at the same time as adopting a more strategic, future facing approach.

The implementation of FFF will also drive a different approach to the way in which we report to the board committees and the Board, in that it provides a comprehensive framework for reporting on progress towards achievement of objectives, current performance and delivery of the Annual Operating Plan, and risks to delivery/achievement of the strategic objectives.

Given this presents a revised approach to governance and oversight, as the framework and reporting embeds and becomes business as usual, a NED chaired Strategic Oversight Committee will be established as a short-life committee of the board to provide additional scrutiny and assurance in relation to delivery of the Tier 1 programmes and the Sustainability Plan we have put in place to ensure that we continue to deliver on the Transition Criteria and on regulatory actions. This will be established during quarter 3 and will report directly to the trust board.

Alignment with Strategic Objectives
Fit for the Future sets out the trust's 5 strategic objectives and the work that is in train to progress to delivery of these

Relevant Business Assurance Framework (BAF) Risk	
The framework contains the Board Assurance Framework as an integral part of our reporting arrangements.	
Financial Validation	None required

Recommendation(s)
The Board is asked to APPROVE the Fit for the Future Strategic Framework

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FIT FOR THE future

Fit for the Future Transformation Programme and Delivery Plan

September 2025

Introduction and scope

This delivery plan provides a high-level overview of the priority programmes within the five strategic themes of our Trust-wide *Fit for the Future Strategic Framework.*

This plan provides a summary of each strategic theme, showing:

- the **outcomes** we want to achieve
- the **programmes** of work across two tiers of work at strategic and operational levels
- the key **risks** (our Board Assurance Framework), and
- specific **Transition Criteria** and/or statutory **compliance** requirements.

We outline the **governance** arrangements including Senior Responsible Officers leading individual programmes through to Trust Board oversight.

The final section of the plan highlights **2025/26 delivery actions** and the **key indicator metrics** we will use to monitor progress and our key risks.

Our Board receives **reports demonstrating our progress** against this plan on a quarterly basis with monthly strategic oversight by the Executive Management Committee designed to sure that the right actions and resources are being deployed to ensure we achieve our ambitions.

The next page outlines our engagement methodology that triangulated our internal and external intelligence gathering, including existing plans and reports, alongside feedback from staff and the patient voice.

Our five-year strategy is to strengthen the Trust's position as a ***care navigator*** within the urgent and emergency care system, delivering care into the community through 999, 111 and PTS services.

Our vision is to deliver the ***right care, first time for our patients***.

Our values of **caring, innovation, professionalism,** and **teamwork** are being refreshed as a core element of this plan, to ensure they are right to guide our work in the years ahead.

We recognise the sustainability challenges in the NHS, and we actively seek opportunities to collaborate and work with system partners to improve urgent and emergency care and the services we provide for our patients.

Our improvement plan is well aligned to the 'three shifts' set out in the 10 Year Health Plan, published by the Government in July 2025:

- **hospital to community**
- **analogue to digital**
- **sickness to prevention**

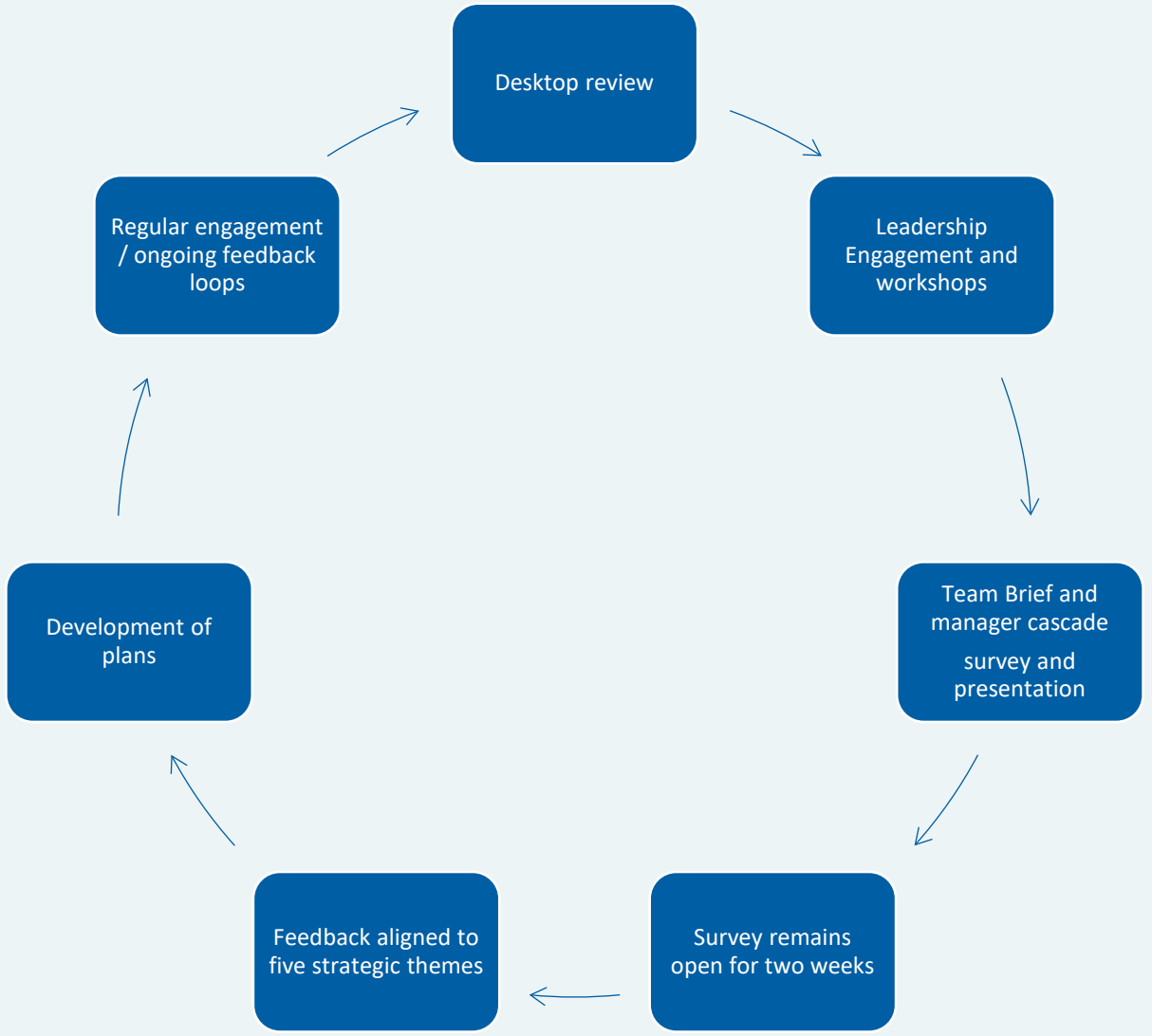
We are also closely aligned to the strategic direction for all ambulance services set in the *Vision for the NHS Ambulance Sector* published in March 2024.

Engagement Methodology

To develop our strategic themes and programmes, we undertook engagement across the organisation as we developed our approach.

This ongoing annual cycle involves:

- Desktop review of all strategies and plans, including operational modernisation programme, people strategy, quality and safety data and CQC improvement plan – brought together and reflected to leadership.
- Executive Management Committee review and workshop.
- Board and Governor workshops.
- Discussion and survey with line managers and patient panel – led by Strategic Board Advisor.
- Line managers cascade to wider staff and patient groups.
- Survey remained open for two weeks following meeting to capture additional feedback.
- Feedback grouped into the five new strategic themes leading to development of delivery plans.
- Ongoing communications and regular engagement loops led by the executive team.



Our Strategic Themes

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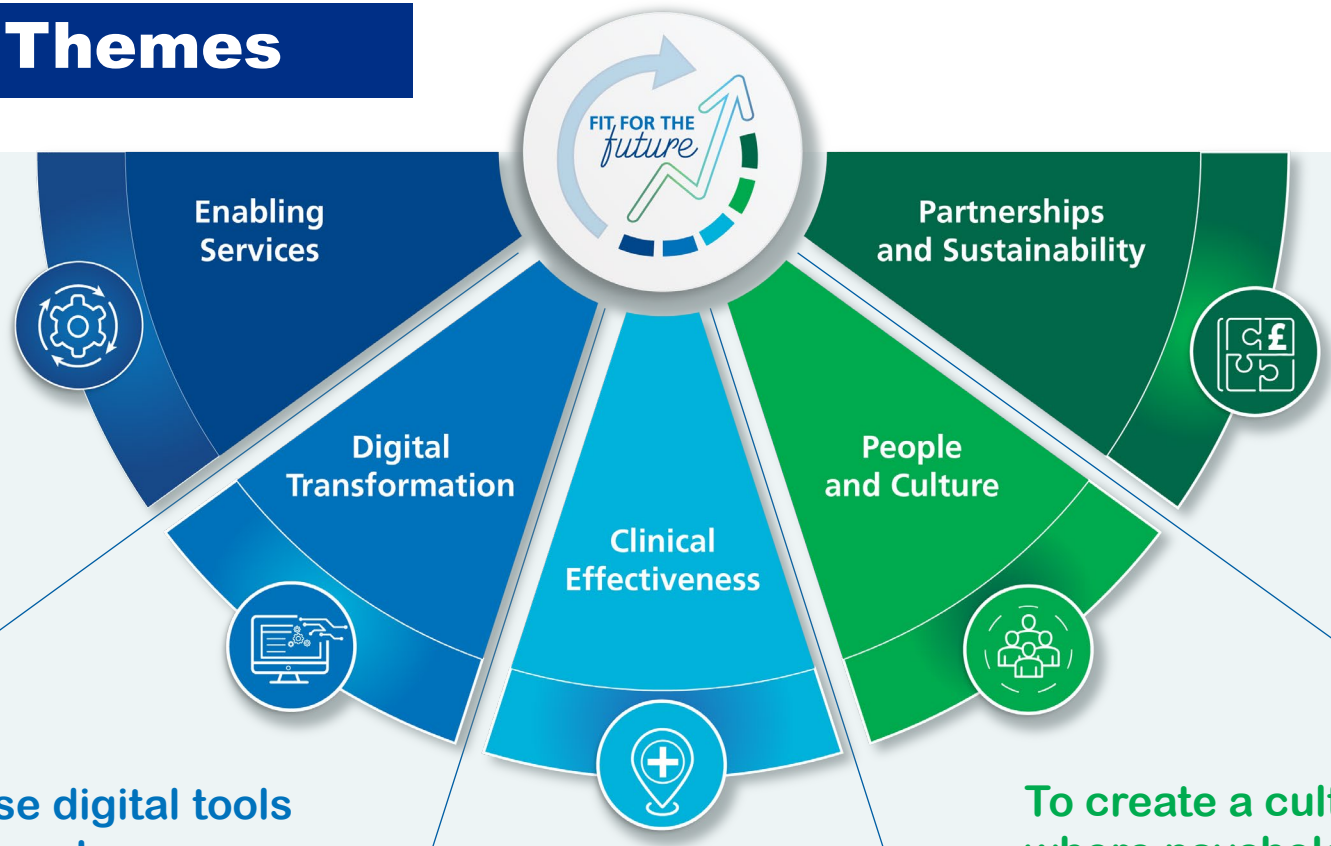


To deliver high quality, timely and responsive support, enabling our front-line staff to respond effectively to patient demand.

To utilise digital tools to augment our people's ability to be as productive and effective as possible when delivering care and developing services.

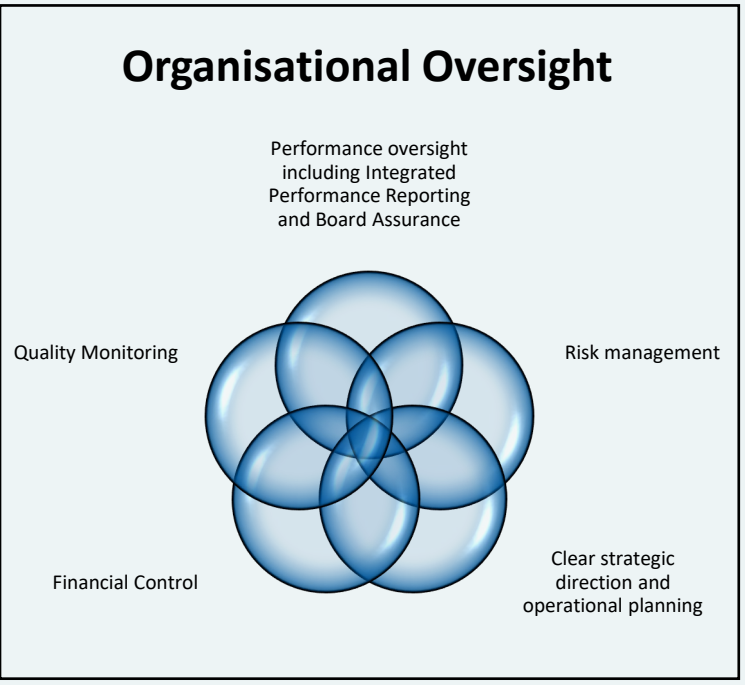
To deliver safe, high quality of patient care improving measurable outcomes for patients, and reducing health inequalities.

To create a culture where psychological safety, values, and leadership enable everyone to feel fulfilled and thrive at work.

To become a sustainable organisation working effectively across systems and as part of an integrated NHS.

Improvement Plan Governance

- The governance of our Strategic Improvement Plan sits within our wider governance oversight framework which includes effective Board scrutiny, strengthening performance oversight, quality monitoring, financial control and risk management.
- Dedicated programme governance ensures integration from the Board to project delivery level for Tier 1 and Tier 2 programmes via the Executive Management Committee.
- A new Board Committee, the Strategic Delivery Oversight Committee, has been established on a time limited basis to provide additional assurance to the Board that the plan is being delivered as described, challenging the executive team on further developing strategic and improvement capability within the organisation.



- Supporting the development of the senior leadership within the organsiation, the Transformation Oversight Group undertakes monthly detailed reviews of progress reports and highlight reports, ensuring triangulation across the organsiation and challenging colleagues to resolve constraints.
- The combined efforts from Board to Project team provide a robust environment in which we can deliver against what is a challenging and ambitious programme of change.

Strategic Improvement Plan Oversight

Trust Board
Quarterly progress reports

Strategic Delivery Oversight Committee
(Non-executive led)
Bi-monthly oversight and assurance

Executive Management Committee
Monthly strategic progress reviews

Transformation Oversight Group
Monthly detailed scrutiny against plans

Tier 1 Programme Governance
SRO-led delivery-focus
Meets as required to deliver

Tier 2 Programme Governance
SRO-led delivery-focus
Meets as required to deliver

2025/26 Improvement Plan
Project mandates for the five strategic themes

Clinical quality, safety, and learning culture throughout

Clinical Effectiveness

To deliver safe, high quality of patient care improving measurable outcomes for patients and reducing health inequalities.

Outcomes

- **Improved outcomes**. To ensure patients requiring emergency care do not wait for their treatment, we will achieve a Category 2 Mean of 29:49 over the year.
- **Improved quality**. To ensure patients receive safer care closer to home we will increase our *Hear and Treat* rate from 14% to 18% by Q4. We will increase *See and Treat* by 1%, which in turn will decrease the number of patients who need to be conveyed to Emergency Departments.
- **Increasing safety**. To improve patient experience, we will routinely answer 999 calls within 10 seconds or less by the end of Q4.
- **Improving patient outcomes**. To improve clinical outcomes, we will monitor how Category 2 performance affects our response to patients with STEMI and stroke.
- **Reducing Inequality**. In partnership with South East Coast Ambulance Service, we are harmonising clinical practice and care delivery to ensure patients in our areas receive equitable and consistent care.

Transition Criteria / Compliance

- **TC6 -** Delivery of Category 2 response time to operational plan trajectory.
- **TC7** - Sustainable demand and capacity modelling completed and compliance with the improvement trajectory for *Hear and Treat.*
- Implement the relevant regulatory/enforcement improvement actions from Care Quality Commission and NHS England.
- Comply with the Home Office Controlled Drugs License requirements.

Tier 1: Fit for the Future Strategic Transformation Priorities

Virtual Care

- To improve safety and quality and ensure we can accelerate an appropriate response, we will improve our queue management and complete our call taking improvement projects
- To improve quality and resolve more urgent care needs we will Implement interim care advice text messaging within our 111 service and natural language processing
- To ensure we maintain equity of service across all operating hours, we will maximise access to all clinical pathways including HIOW and Thames Valley Single Points of Access (SPOA)

New Clinical Operating Model

- To support staff to develop, and to improve safety, quality, outcomes and equity, we will design and implement a specialist incident desk and review the scope and practice of clinical roles
- To improve outcomes for patients we will develop the case for specialist/advanced practice (with a focus on resuscitation, falls, and frailty)
- To maintain an equitable service and meet patient needs, we will create a medium-term demand and capacity model, and design patient safety Key Performance Indicators (KPIs)

New Operations Structures

- We will implement new agreed operations leadership structure across field operations and clinical coordination centres to support county-based model
- To support our staff to improve equity, quality and access to services, we will design and implement county-based data flows and reports

Tier 2: Annual Plan Priorities

Clinical Pathway Development

- To improve quality through early resolution, we will deliver more care to patients who can be assisted by telephone or face to face by undertaking more clinical pathway development (including increasing pathway utilisation to reduce conveyance to Emergency Departments).

Proof of Concept

- We will complete a benefit realisation analysis of our hub model developed with staff using QI methodology, and if improvements have been made in safety, quality, outcomes or equality we will spread the concept to a second area.

Medicines Optimisation

- To comply with the Misuse of Drugs Regulations (2015) we will introduce individual issue of controlled drugs, improving patient experience and outcomes.
- We will implement Year 1 of the five-year Pharmacy Plan (track and trace) to ensure safe handling of medications across the Trust.

Board Assurance Framework Risks

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.

BAF Risk 15 - Medicines management: 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.

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.

Digital Transformation

To utilise digital tools to augment our people's ability to be as productive and effective as possible when delivering care and developing services.

Outcomes

- **Improved Productivity – CAD Modernisation.** We will improve the safety and quality of our service to patients by having a modern dispatch system through the implementation of a new CAD within a Board approved end date.
- **Improved Productivity - Data Driven Organisation.** Digital will support the optimisation of patient care by becoming a data-driven organisation through the development of a Data-Driven programme of work by Q3 25/26.
- **Improved Productivity - Digital Innovation.** We will seek out opportunities where AI can enhance decision-making, support staff, and improve patient experience by running a set of pilots in 25/26.
- **Increasing Effectiveness - Data Driven Organisation.** We will improve our ability to evaluate our service quality and our people by developing the IPR focusing on measures for People & Culture (Dec-25) and Quality & Patient Safety (Mar-26).
- **Increasing Effectiveness - Digital Safety.** We will achieve Data Security & Protection Toolkit (DSPT) compliance in 2025, with advancement in 2026, to strengthen data security and enable safe strategic research collaborations.

Transition Criteria/Compliance

- Data Security and Protection Toolkit (DSPT) compliance

Tier 1: Fit for the Future Strategic Transformation Priorities

CAD Modernisation

- We will improve digital productivity by procuring and delivering a new Computer Aided Dispatch (CAD) system in 25/26 and ensuring a safe and effective mobilisation that is focused on clinical care

Data Driven Organisation

- We will improve digital effectiveness by ensuring the Integrated Performance Report (IPR) will facilitates understanding and improvement
- We will improve digital productivity by developing and implementing a data-driven programme

Digital Innovators

- We will improve digital productivity by developing and implementing a AI pilot for staff training (as part of the Southern Ambulance Services Collaboration SASC)
- We will develop and implement an AI project within our NHS111 call centre to improve the quality of the service we provide to patients

Tier 2: Annual Plan Priorities

Safe and Secure Information Systems

- We will improve digital effectiveness and compliance by achieving DSPT accreditation to ensure we are safe and secure as an organisation. To protect the future, we will work with partner Ambulance Trusts to further mature our Cyber Security platform

Digital Platform Modernisation

- Business Continuity maturity (EPRR)
- Network and datacentre optimisation (SASC)
- EPR market research and business case development

Digital Workforce

- To support staff to work effectively and securely we will roll out Windows 11 upgrades & new devices and implement an enhanced IT service desk

Clinical IT Modernisation

- Renew our safeguarding application
- Enable clinical data sharing
- Improve access to clinical system records (TVS/CHIE/NCRS)
- Enhance functionality of clinical practice guideline applications (JRCAL)

Board Assurance Framework Risks

BAF Risk 20 - Digitalisation: 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.

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.

Enabling Services

To deliver high quality, timely and responsive support, enabling our front-line staff to respond effectively to patient demand.

Outcomes

- **Improving Responsiveness** - To support improvement in effective delivery of **care** and increase **responsiveness** to patients, we will increase the number of ambulances, cars and specialist vehicles available to our frontline staff. We will reduce Vehicle Off Road rates by at least 17% by the end of 25/26 and reduce further in future years.
- **Enabling high quality care** - To provide a **high-quality, safe and effective clinical working environment** that is fit for purpose, we will reduce the age of our fleet and increase our workshop capacity starting with a new Aylesbury Workshop in Q4 2025/26. By December 2026, SCAS will have no vehicles over five years old.
- **Timely care -** To enable frontline staff to deliver care in a timely way, we will develop a strategic Estate Plan by Dec 2025 aimed at ensuring that over time we will have modern and **efficient** buildings that support our staff to work **effectively** and deliver our Net Zero ambitions.
- **Enabling high quality care** - We will seek to commission our first Ambulance "Make Ready" hub aimed at delivering with a business case to secure the required capital submitted to NHS England by February 2026.

Tier 1: Fit for the Future Transformation Priorities

Fleet Modernisation

- To ensure we have sufficient vehicles to meet patient demand and provide timely and safe care, we will carry out an enhanced fleet replacement programme, catching up on delays from previous years by December 2026
- To improve reliability of our vehicles ensuring a high quality and effective working environment, we will carry out a disposal programme so we have no vehicles over 5 years old
- To minimise vehicle off road rates, ensuring our staff can respond effectively to patients, we will increase available workshop capacity, including implementing a more flexible approach to minor repairs

Estate Modernisation

- To provide a modern, efficient and safe working environment, that supports staff to deliver high quality care, we will reduce the size and age of the estate by building a fit for purpose hub-and-spoke model (long term) designed to enhance timely and responsive care delivery
- We will draft, socialise and approve SCAS overarching Estates Plan, which will set out our ambitions to develop ambulance hubs across our geography aimed at maintaining and improving response times
- We will develop a sector-by-sector Ambulance Etate plan, stating with bidding for capital for a new Make Ready hub in South Oxfordshire by February 2026. We will follow this with options for High Wycombe and Newbury

Tier 2: Annual Plan Priorities

Efficiency and Productivity

- We will optimise our ambulance "Make-Ready" services in the short term to improve our clinical working environment and ensure IPC compliance, while developing a long-term approach in collaboration with SECAmb.
- We will continue our programme of reducing our estates footprint, releasing cost to invest in frontline services.

Transition Criteria / Compliance

N/A

Board Assurance Framework Risks

BAF Risk 17 - 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.

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.

People and Culture

To create a culture where psychological safety, values, and leadership enable everyone to feel fulfilled and thrive at work.

Outcomes

- **People feel safe at work –** It is clear what our values are, what we expect as behaviours, and we tackle the unacceptable.
- People work in a climate of respect wherever they are in the organisation and their physical safety is also protected. Openness, equality and transparency are encouraged.
- **People feel valued** – People across the organisation can express what matters to them, have that heard and acted upon. They get feedback about the steps which have been taken. People have permission to make a difference where they can.
- **People feel well led** - All leaders across the Trust from Band five up to the Board are visible, compassionate, and accountable. They live our values and behaviours, communicate effectively, and set a clear direction for the organisation.
- **Devolved leadership** - Senior Leaders are supported and developed to be confidently accountable for performance, workforce and finance in their areas, ensuring we deliver on our Trust strategic and annual plan targets

Tier 1: Fit for the Future Transformation Priorities

People feel safe (values & behaviours)

- Deliver Sexual Safety Assurance & Training and create a dedicated team to respond to staff concerns
- Co-create Values & Behaviours Framework with our people and leaders
- Improved governance of Race & Disability Equality Plan (including WRES/WDES, See Me First)
- Enable and empower our Staff Networks

People feel well led (leadership)

- Leadership forums / peer support spaces
- Executive team coaching
- Sub-executive and senior leadership development plan
- First level leadership development programme
- Tackling bullying and poor behaviours head-on
- PDR improvements (digital tool and quality)

People feel valued (listening & acting)

- Establish monthly listening spaces as 2-way communication channels, to agree where action to improve care or staff experience is most valuable
- Act on staff survey feedback - flexible working processes & protocols
- Implement toolkit to support difficult conversations ensuring visible action
- Improve People Services - ER processes, data reporting and embedding the new People Service and business partnering structure

Devolved and accountable leadership

- Establish functioning Performance Management and Accountability Framework meeting structure and series for all directorates
- Accurate and reliable PM&AF reporting pack per directorate
- Undertake training needs analysis for leaders & devise and deliver training plan

Tier 2: Annual Plan Priorities

Quality Improvement rollout

- Board and senior leadership development.
- Establish and maintain QI network.
- Build in-house training packages and deliver intro to QI courses, empower staff to suggest and take forward QI on the issues they see day to day.

Transition Criteria / Compliance

- **TC1-** Approved recruited exec team structure, with evidence of effective team working.
- **TC2 -** Effective governance processes, with evidence of a developing culture of governance; Board oversight of regulatory actions with clear improvement plans and use of the BAF.
- **TC4** - Senior Leadership Development Programme in place with evidence of strengthening organisational leadership, effective delegated responsibility, and improved accountability.
- **TC5** - Improved culture throughout the organisation including safety and safeguarding culture and workforce engagement in improvement.

Board Assurance Framework Risks

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.

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.

Partnerships and Sustainability

To become a sustainable organisation working effectively across systems and as part of an integrated NHS.

Outcomes

- We will deliver a **sustainable** financial break-even plan in 2025/26, while approving the multiyear plan aligned to the medium-term financial and operational plan by December 2025.

.

- To ensure we remain **sustainable** organisation, we will work to retain Thames Valley and HIOW 111 contracts and transform Non-emergency Patient Transport services (NEPTS) within HIOW.

- To improve the **effectiveness** of our organisation and of care across the South East region, we will deliver the collaboration case for change with SECAmb by October 2025.

- To deliver our **environmental sustainability** obligations, we will start delivery of the Board agreed Green Plan to reduce carbon emissions and ensure we are an environmentally responsible member of our community.

- To ensure services are delivered in an **effective** way, and to ensure spend is focussed on front-line clinical delivery, we will establish a Subsidiary Business Plan.

Transition Criteria / Compliance

- **TC2** - Effective governance systems and processes in place, with evidence of a developing culture of governance; evidence of Board oversight of regulatory actions with clear improvement plans and use of the BAF.
- **TC3** - Clearly defined strategic direction of the organisation, including clarity around alignment of Fit for the Future programme and collaboration with SECAmb, approved by Board.

Tier 1: Fit for the Future Transformation Priorities

Financial Sustainability

- Deliver ICB-approved Multi-Year Integrated Plan including clear performance / workforce and service quality ambitions for the next three to five years
- Deliver Capital and Infrastructure plan
- Develop subsidiary business plan working in collaboration with SECAmb
- Formulate clear response to new strategic commissioning framework, including opportunities for vertical integration

Regional Service Transformation

- Working with commissioners, regional and national colleagues to design the 111 / Urgent Care services of the future
- Develop the “Case for Change” for formal collaboration jointly with South East Coast Ambulance Service (SECAmb)
- Work with regional colleagues and our new strategic commissioners to implement to the new Ambulance Commissioning Framework

System Productivity

- Deliver South East Region and Southern Ambulance Services Collaboration (included in specific strategic themes)
- Develop approach to outputs of National Productivity and Improvement Programme seeking to improve financial sustainability, reducing unwarranted variation in corporate service delivery

Tier 2: Annual Plan Priorities

- Deliver In-year Financial Recovery Plan (Cost Improvement Programme)
- Develop 26/27 (future year) Improvement Opportunities
- Southeast Collaboration: Progress functional priority areas (SECAmb / SASC)
- Deliver against Green Plans
- Right-size Non-Emergency Patient Transport Service to achieve cost effective service delivery

Board Assurance Framework Risks

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-tern objectives such as achieving net zero targets.

BAF Risk 25 - Collaboration: If there is 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.

BAF Risk 19 - Productivity: 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.

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2025/26 Improvement Plan
Delivery Actions by Quarter

Clinical quality, safety, and learning culture throughout

Tier 1 Strategic Transformation Priorities Improvement Plan 2025/26

Strategic Theme	Objectives	Q1 delivery actions	Q2 delivery actions	Q3 delivery actions	Q4 delivery actions
Clinical Effectiveness	Improve **virtual care** to strengthen care delivery and reducing ambulance conveyance	• Rotational (999/EOC) clinicians commence • Establish SPOA working group • Implement 111 text messaging	• Deliver call handling capacity review • Call Answer Wall Board goes live • SPOA delivery model designed	• Implement CAD changes for Cat2 segmentation • Complete CSD rota changes • Dispatch Wall Board goes live	• Increase rotational clinicians • Consistently deliver 10sec or below call answer mean • Sustain SPOA activity levels • Deliver new clinically-led dispatch
	Improve clinical effectiveness through implementation of new **clinical operating model**	• Project set up - SCAS/SECAmb • Clinical leads identified • Workshop set up / presentation to joint board	• Complete SCAS/SECAmb operating model review • Pathway utilisation review • Review skill mix/ scope of practice	• Analysis of demand and clinical requirements • Develop options paper for advanced practice	• Develop clinical performance indicators • Develop clinical modelling tool
	Strengthen local leadership through implementation of new **operations structure**	• Establish project governance • Plan consultation process	• Approve proposals • Launch staff consultation	• Conclude staff consultation • Start implementation phase	• Complete implementation of new structure
Digital Transformation	**CAD Modernisation** to improve operational effectiveness and productivity	• Develop outline business case for CAD replacement • Commence procurement (tender)	• Prepare full business case • Complete tender process	• Full business case approval and contract award • Commence project delivery	• Staff engagement / workshops • Ongoing project delivery
	Strengthen **data-driven** decision making through data quality and reporting improvements	• Develop Integrated Performance Report (IPR) champions • Embed IPR into Board and EMC working	• Implement IPR improvements following formal review including people and culture • Develop data driven programme	• Deliver IPR People and Culture content • Build sub-committee IPR • Approve data driven programme	• Develop Quality and Safety IPR • Data- driven programme implementation • Develop data principles with SECAmb
	Test and adopt **digital innovators** to improve patient and staff experience and drive efficiency	• Develop and implement Proof of Concept using AI to improve staff training • Scope 111 Natural Language Processing (NLP) Plan	• Start staff training Proof of Concept • Start 111 NLP project delivery	• Board approval to roll out AI training • Start AI Innovation Board • Test 111 Natural Language Processing (NLP) solution	• Deliver staff AI pilot across SASC • 111 NLP solution live • Introduce CoPilot across SCAS
Enabling Services	**Fleet modernisation** to improve resilience and efficiency	• Start use of new ramps at Didcot • Fuel bunkers expansion • Receipt of new vehicles commences	• Start mobilisation of Aylesbury workshop • Ongoing receipt of new vehicles	• Complete Aylesbury workshop • Complete expansion of fuel bunkers • Ongoing receipt of new vehicles	• Complete 25/26 new vehicle programme • Submit business case for 26/27 vehicle replacement programme
	Estate modernisation to align with sector operations plans	• Commence drafting of estates master plan	• Develop template business case • Identify partnership opportunities • Develop plans for leasehold buildings	• Approve and publish estates plan • Approve plans for leasehold buildings	• Submit business case for Hub developments • Approve plans for leasehold buildings

Tier 1 Strategic Transformation Priorities Improvement Plan 2025/26

Strategic Theme	Objectives	Q1 delivery actions	Q2 delivery actions	Q3 delivery actions	Q4 delivery actions
People and Culture	Enable **visible, compassionate and accountable leaders** who role-model expected behaviours with skills & confidence to lead effectively across all levels	• Map leadership offerings to NHS Competency Framework • Create First Level and Senior level leaders' development programmes • Scope Exec & Sub Exec development programme	• Expand digital PDR pilot • Pilot both Senior Leader & First level leader programmes & evaluate • Exec development coaching launched. • Create Sub Executive development plan	• Establish Leadership forum. • Roll out digital PDR Trust wide • Ongoing delivery of Snr & First Level leader programmes. 360-feedback for Snr Leaders • Commence delivery of Sub executive development plan.	• End of Year Leadership Summit • Evaluate all Leadership programmes, identify next steps for 26/27. • Establish a reference group to test and validate progress
	Strengthen **accountability and devolved leadership** to empower our teams	• Establish Accountability Framework • Define Operational pack • Conduct initial meetings, analyse and improve	• Review meeting framework incl IPR, actions, risks, attendance and improve • Refine Operations pack • Review Snr Leader training needs	• Develop Training plan • Review and revise IPR, including roll out of Committee level reporting	• Monitor and report progress • Roll out revised and strengthened IPR • Develop Corporate pack and establish meetings.
	Create inclusive teams with clear **values & expected behaviours**, where safety is prioritised, decisions are values-led and communication is respectful	• WRES/WDES analysis, first EDI conference, Exec Champions for Staff Networks • Design Values & Behaviours engagement programme • Establish Sexual Safety Oversight Assurance Group	• WRES/ WDES improvement plan incl Race charter, Staff Network self assessment • Values & Behaviours Sessions, gather feedback. • Sexual Safety Action plan	• See Me First campaign. • Senior leader workshop to review Values and behaviours feedback, co create next steps. • Deliver Sexual Safety Action Plan	• Continue embed See Me first campaign • Finalise Values & Behaviours Framework, agree implementation plan . • Track early actions of Sexual Safety plan
	Improve **listening and engagement** spaces, act on colleagues' feedback and address inappropriate behaviours, feeding back to colleagues on steps taken.	• Scope new listening spaces and engagement cycle. • Finalise new People Services structure • Identify 'Quick Wins' (e.g. flexible working, building relationship)	• Launch listening spaces • Commence People Services transformation • Flexible working pilots, food storage on vehicles, ER processes.	• Continue listening events. Leaders' difficult conversation toolkit • Improvement plan for ER Case processes & reporting • Continue flexible working, communicate 'you said, we did'	• Continue listening events and embed toolkit into manager practice. • Develop ER dashboard. Implement ER improvements • Evaluate impact of Quick Wins through staff survey.
Partnerships and Sustainability	Ensure **financial sustainability** approving a multi-year integrated plan	• Do nothing financial position developed • Cost Improvement Plan established • Review National Productivity and Efficiency benchmarking	• Activity/Financial Scenario evaluation in place • Revised financial control governance implemented	• Operational Plan development and sign off process set up • Board sign off multi year operating plan in December 2025	• Future annual planning and multi-year plan process established
	Deliver equity and efficiency through **regional service transformation** with SECAmb and commissioners	• Complete collaboration discovery phase • Establish joint governance with SECAmb	• Commence development of case for formal collaboration • Continue to work with the South East Ambulance Transformation Programme	• Present formal collaboration Case for change to Joint Boards • Commence transition to single strategic commissioner for ambulance services across the South East	• Commence Formal transition for SCAS / SECAmb
	Actively contribute to **system productivity**	• Agree areas of functional collaboration with SECAmb and across the Southern Ambulance Services Collaboration (SASC)	• Progress functional collaborations • Review clinical pathways	• Shadow commissioning established • Implement agreed contract principles	• Transition to "new" commissioner • Commissioning intentions published

Tier 2 Operational Objectives Improvement Plan 2025/26

Strategic Theme	Objectives	Q1 delivery actions	Q2 delivery actions	Q3 delivery actions	Q4 delivery actions
Clinical Effectiveness	Improve **resource utilisation and clinical pathway** development to maximise alternatives to ED	• Continue to develop pathways across each of sectors • Implement Stroke Video Triage	• GoodSam cardiac arrest app go live • Implement stroke thrombectomy pathway	• Agree scope of programme aligned to ICB priorities • Engage with emerging neighbourhoods	• Align to strategic commissioning approach and 10-year Plan
	Complete South East sector **hub Proof of Concept** evaluation and roll out	• Start self roster pilot • Start new clinical lead role pilot	• Review new clinical lead role • Test hot desk at sector level • Scope North-West proof of concept (multi-site model)	• Review benefits realisation • Scope potential for internal SLAs • North-West (Oxford area) POC go live	• Review improvement cycles • Start roll out across all six sectors with at least one additional sector in Q4
	Improve **pharmacy effectiveness** and medicines optimisation, including controlled drug (CD) compliance	• Home office CD licence issued • Launch CD SOP • Review CD policy and impact assessment	• Agree early adopter locations • Commence training review and workforce adaptions • Test process for personal issue	• Start station infrastructure and security updates • Full implementation in the South	• Develop business case for electronic CD register • Complete roll out for remainder of organisation
Digital Transformation	**Modernise digital platforms** to ensure colleagues are enabled to fulfil their roles.	• EPR market research • Independent datacentre & Network strategy review undertaken	• Approve EPR programme plan at EMC • Undertake SASC collaboration EPR engagement exercise	• Develop and approve EPR business case • Undertake SASC collaboration on datacentre options and consolidation	• Develop 2026/27 Business Continuity programme plan • Develop datacentre business case aligned to estates strategy
	Clinical IT modernisation	• Implement short term improvements to electronic safeguarding system	• Approval for Safeguarding application modernisation • Deliver Secure Data Environment (SDE)	• Kick-off Safeguarding Application programme	• Complete Safeguarding Application programme
	Ensure **safe and secure information systems** in place.	• Complete 2025 DSPT accreditation	• Review provisional DSPT report and key findings	• Implement against DSPT noted recommendations	• Kick-off 2026 DSPT accreditation programme
Enabling services	Deliver **efficiency and productivity** programme	• Commence programme to reduce estate footprint • Deliver CIP Plan	• Ongoing CIP delivery	• Ongoing CIP delivery • CIP plan for future years	• Continue to reduce estates footprint
	Future of **Make Ready Services**	• Commence discovery phase with SECAmb	• Ongoing discovery phase with SECAmb	• Decision on future of Make Ready services	• Commence implementation based on decision • Subsidiary Company business plan developed

Tier 2 Operational Objectives Improvement Plan 2025/26

Strategic Theme	Objectives	Q1 delivery actions	Q2 delivery actions	Q3 delivery actions	Q4 delivery actions
Culture and Leadership	Continue to implement **Quality Improvement** methodology and develop a culture of continuous improvement.	• Deliver Board Training Session • Review QI training packages • Agree approach with SECAmb	• Create comms plan • Set up internal hub pages • Participate in HIOW QI Week	• Develop internal QI facilitator role • Appoint Executive QI Champion • Design in-house QI training	• Deliver training
Partnerships and Sustainability	Achieve **financial recovery plan**	• Establish CIP Programme	• New FRG / FSMG established	• Detailed check and challenge process in place	• End of year break even position achieved • CIP plans for 2026/27 established
	Deliver year one of **Green Plan**	• Approve Green Action plan • Start Solar; SMART LED lighting and DNO upgrades	• EV infrastructure phase five roll-out	• EV charging policy approved • Waste, Utilities and Energy Manager in post	• Waste policy updated • Staff engagement commenced • Monitoring & reporting established
	Deliver an effective **Patient Transport Service**	• Review following transfer of BOB service to new provider	• Establish internal work plan	• Develop new staff structure plans • Start fleet upgrades	• Enact staff structure changes

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2025/26 Improvement Plan
Key Indicator Metrics

Clinical quality, safety, and learning culture throughout

Tier 1 Key Indicator Metrics Improvement Plan 2025/26

Strategic Theme	Objective	Key Indicator Metric	Baseline	Q1	Q2	Q3	Q4
Clinical Effectiveness	Improve **virtual care** to strengthen care delivery and reducing ambulance conveyances	Achieve a higher Hear and Treat rate	14%	14%	16%	18%	18%
		Increase See and Treat rates	33%	33%	33%	34%	34%
	Implement new **operations structure** to strengthen local leadership	Delivery planned Category 2 mean response time (full year average)	30:00	30.00	31:51	30:37	Q4 28:43 Full year 29:49
Digital Transformation	**CAD Modernisation** to improve operational effectiveness and productivity	Progress procurement and implementation timeline	Existing CAD in place	Specification drafted	Tender commenced	Tender completed and contract signed	Implementation started (Deliver in 2026/27)
	Strengthen **data driven** decision making through data quality and reporting improvements	IPR completeness	70%	70%	80%	90%	100%
		Data improvement plan in place	Plan not in place	-	Drafting commenced	Data Plan Implementation	Ongoing implementation
	Test and adopt **digital innovators** to improve patient and staff experience and drive efficiency	Number of AI projects in progress	0	0	1	2	3+
Enabling Services	**Fleet modernisation** to improve resilience and efficiency	Reduce Vehicle off Road rates	40%	40%	35%	30%	23%
	Estate modernisation to align with sector operations plans	Delivery of annual Estates Plan (% completed)	0	25%	50%	75%	100%

Tier 1 Key Indicator Metrics Improvement Plan 2025/26

Strategic Theme	Objective	Key Indicator Metric	Baseline	Q1	Q2	Q3	Q4
Culture and Leadership	Enable **visible, compassionate and accountable leaders** who role-model expected behaviours with skills & confidence to lead effectively across all levels	Improve scores on "recommend SCAS as place to work" (Quarterly Pulse Survey - QPS)	30.6%	30.6%	35%	(no QPS as NSS)	40%
	Strengthen **accountability and devolved leadership** to empower our teams	Improve % of service lines with regular performance reviews being carried out	0%	10%	20%	40%	70%
	Create inclusive teams with clear **values & expected behaviours**, where safety is prioritised, decisions are values-led and communication is respectful	Improve staff engagement score (QPS : scale 1-10) Improve workforce race and disability indicators (WRES & WDES)	5.37 2024/25 indicators	5.37	4.92	(no QPS as NSS)	6.41 Improve by 10% on 24/25
	Improve **listening and engagement** spaces, act on colleagues' feedback and address inappropriate behaviours, feeding back to colleagues on steps taken.	Improve staff reporting they feel safe (National Staff Survey - NSS) ER case investigated within guideline timeframe (28 days)	55% 59 days	- 50 days	- 45 days	60% 40 days	- 35 days
Partnerships and Sustainability	Ensure **financial sustainability** with a multi-year integrated plan	Deliver CIP programme (% delivered)	0%	15%	30%	70%	100%
		Deliver multi-year plan	No strategic model in place		Baseline and model developed	Multi-year plan developed and approved	Implementation commenced
	Deliver equity and efficiency through **regional service transformation** with SECAmb and commissioners	Deliver collaboration business case with SECAmb by October 2025				Business case approved	

Tier 2 Key Indicator Metrics Improvement Plan 2025/26

Strategic Theme	Objective	Key Indicator Metric	Baseline	Q1	Q2	Q3	Q4
Enabling Services	Deliver efficiency and productivity programme	Completion of in year disposals	0%	25%	50%	75%	100%
	Make Ready	Decision on future	N/A	-	-	Decision made	
Digital Transformation	Strengthen internal digital infrastructure to ensure colleagues are enabled to fulfil their roles	IT Business Continuity exercises undertaken	0	0	0	1	1
	Modernise Clinical IT infrastructure	% project delivery milestones achieved	0	90%	90%	90%	100%
	Ensure the trust has safe and secure information systems in place	DSPT Compliancy outstanding recommendations remediated	DSPT Compliance	N/A	N/A	100%	100%
Clinical Effectiveness	Improve utilisation of clinical pathways and SP resources ensuring right care first time, reducing unnecessary convey to ED	% See & Treat	32.5%	32.7%	33%	33.5%	34%
	Complete hub proof of concept evaluation and roll out	Number of sectors engaged in proof of concept	1	1	1	2	3
	Improve pharmacy effectiveness and medicines optimisation, including controlled drug (CD) compliance	% of sites compliant with CD regulations	0	0	0	50%	80% (100% by end of Q1 26/27)
Culture and Leadership	Continue to implement QI methodology and develop a culture of continuous improvement.	Number of Trained QI practitioners Establish organisation wide QI project		40 0	40 0	60 1	60 1
Partnerships and Sustainability	Achieve the in year and longer-term financial recovery plan (CIP)	Deliver of CIP Plan	0%	25%	50%	75%	100%
	Deliver the green agenda	Roll out electric vehicle chargers and solar panels	0			Complete	
	Deliver an effective NEPTS service	Agree ongoing commissioning arrangements				Agreement reached	

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2025/26 Improvement Plan
Key Risks

Clinical quality, safety, and learning culture throughout

Tier 1 Programmes – Key Risks

Strategic Theme	Risk Description	Impact	Mitigation Measures	Exec Owner
Enabling Services	• Fleet Replacement programme is delayed and/or workshop capacity is insufficient for organisation's needs leading to inability to repair ageing fleet	• Inability to reduce VOR rates as planned resulting in ongoing operational constraints and inefficiency	• Maximise existing capacity and increase utilisation of new mobile fitter service. Introduce proactive servicing and maximise fleet optimisation opportunities • Formal Project Management of fleet replacement	SR
Digital Transformation	• Lack of expert resource within SCAS to develop and deliver data driven programme	• Inability to drive fundamental shift in use of data to inform strategy, improvement and operational delivery	• Secure interim resource to kick start programme and then ensure clear resource planning within the BI team	CE
	• New risks associated with rapid adoption of AI technology (PESTEL changes)	• Inadvertently reduce security of digital systems potentially leading to data breaches or increased cyber security risks	• Collaborative working with NHS colleagues and across the Southern Ambulance Services Collaboration	CE
Clinical Effectiveness	• The Trust is unable to meet terms and requirements of its controlled drugs licence resulting in regulatory noncompliance due to capacity and funding constraints	• Further contraventions of the controlled drugs regulations leading to increased scrutiny and potential enforcement action • Critical components may be delayed, scaled back or omitted resulting in reduced programme effectiveness and failure to achieve compliance objectives	• Develop and submit a compliance risk mitigation plan to the Home Office • Define prioritisation of deliverables and agree contingency resources to accelerate corrective actions • Conduct formal readiness reviews and compliance checklist	DR
	• Increasing virtual care leads to poorer outcomes for patients and an increase in call volumes from repeat contacts	• Increased pressure on the service through repeated interactions with patients and potential for avoidable patient harm where key clinical information is missed	• QIA in place • Thematic quality review in train to review increase in call backs	MA
People and Culture	• Insufficient BI team support for P&MAF pack population, leading to data collection burden shifting to operational managers • Limited capacity to undertake pre-meetings with Executives and the Chair before P&MAF	• Insufficient or poor-quality data and poor executive alignment undermines impact and benefit of Performance and Accountability approach leading to disengagement at all levels of the organisation	• Create concise, actionable briefing packs; use executive summaries • Work with BI leadership to prioritise P&MAF data needs • Consider frequency of meetings	SR
	• Failure to engage staff in a psychologically safe way and maintain engagement as REAP levels increase over the winter period	• Programme does not achieve its aims, further distancing staff from organisational objectives and intentions resulting in ongoing poor engagement	• Review actions taken at higher REAP levels with a view to protecting key engagement exercises	DH
	• Leadership development funding constrained in context of investment required for Sub Executive group	• Limited development offerings we can provide reducing effectiveness of programme of work	• Utilise inhouse resources, investigate low/no cost options • Explore regional development opportunities at low/no cost	DH
Finance and Sustainability	• Demand for services is higher than expected and therefore costs more than anticipated	• Quality and performance is compromised or the organisation fails to achieve financial balance	• Align closely to development of clinical operating model	SR
	• Insufficient funding available to support regional service transformation	• Unable to invest in the change resulting in a delay in achieving potential benefits both clinical and financial	• Transition funding to be identified as part of financial sustainability component of business case	KH
	• SCAS and its partners have different priorities	• Failure to enable change to take place resulting in inability to achieve efficiency and reputational damage with NHSE	• Provider Execs and ICB leads have established programmes of work to codesign changes	KH

Appendix 1

Q1 Strategic Theme Tier 1 Highlight Reports

Q1 Clinical Effectiveness – Virtual Care

SRO	Executive Lead
Ruth Page	Mark Ainsworth

Key: Completed | On Track | At Risk | Delayed

Progress Report Against Milestones:

Previous Rag	Current Rag	Rag Summary
		Q1 Key Milestones – 100% achieved H&T performance improvements are being seen ahead of trajectory.

Q1 Key Achievements against milestones

Clinical:
- Onboarded 8 new rotational clinicians, more in pipeline. Successful clinician recruitment in line with budget.
- Cat 2 segmentation refresh underway

Call taking:
- ORH modelling outputs received
- Positive impacts on performance reported resulting from the probing and call taking workshops

Dispatch:
- Funding for CAD changes approved

SPOA:
- Project roles & responsibilities agreed, plan being worked on, focusing on Hampshire first.

111:
- Successful launch of the Interim Care Advice Texting on 24th June. Assessing impacts and adjusting accordingly
- After action review (ICT outage 20th May) debrief complete, report in draft, recommendations to be provided.

EPRR:

Q2 Upcoming activities and milestones

Clinical
- Progress SOP review across all teams and align with SECAmb where possible.
- Cat 2 segmentation refresh continues

Call taking
Dispatch
- Call Taking Wall Board Information go live.
- Develop plans with Hexagon for CAD work / changes (incident streaming and Cat 2 work)
- ORH report finalised and shared.

SPOA
- SPOA Plan finalised, and work initiated.

EPRR
- Establish EOC EPRR working group, confirm TOR. Agree plan for releasing staff for EPRR training

Escalation to Board of Directors

Nil

Risks and Issues	Score		Mitigation
If there are continued delays to changes to the current CAD, this will impact CSD and Dispatch efficiencies and H&T performance improvements	16	12	Business case now signed off. Agree timeline with Hexagon for change work.
If BI cannot provide the data required for this programme, then we may not be able to fully measure the impacts of this work	16	9	Dedicated BI resource starting to provide improvement data to the steering group.
If the New CAD is delayed further, then SCAS's ability to implement further efficiencies may be impacted	16	12	CAD out to tender with compliant bids received.

Q1 (Apr – Jun 25)	Q2 (Jul – Sep 25)	Q3 (Oct – Dec 25)	Q4 (Jan – Mar 26)
Rotational Clinicians begin			Rotational Clinicians BAU
Daily Demand Brief	Cat 2 Segmentation refresh underway	ECT Clinical Support Improvements (Hunt line)	Node/Sector CAD changes
			Rota amendments complete
1:1 Development Report	ORH modelling report (Call taking & Dispatch)	Wall board live	SOP Reviews complete & on Hub
			Rota amendments complete
			Early Predict Improvements BAU
Dispatch audit	ICD paper	CAD changes approved	CAD timeline agreed
			CAD changes Implemented
			Dispatch Wall Board go live
AAR debrief & draft report	Establish EOC EPRR working group	CCC compliance action plan	
Confirm SPOA continuation	SPOA Working Group	SPOA SOPs, MOU, DPIA & Clinical approval	Business Case for long term SPOA model
Implement 111 text messaging	111 NLP approach agreed	Test NHSE 111 NLP solution	Soft launch NHSE 111 NLP solution
			Analyse benefits 111 NLP solution

Outcomes

Improving resolution. To ensure patients receive safer care closer to home we will increase our Hear and Treat rate from 14% to 18% by Q4.

Increasing confidence. To improve patient experience, we will routinely answer 999 calls within 10 seconds or less by the end of Q4.

Q1 Clinical Effectiveness – Clinical Operating Model

SRO	Executive Lead
Michaela Morris	Duncan Robertson

Key: Completed | On Track | At Risk | Delayed

Progress Report Against Milestones:

Key Achievements against milestones

- Initial paper providing detail of proposed timeline with key dates developed and shared with clinical triumvirates across both organisations to gain support with content and proposed programme delivery.

Upcoming activities and milestones

- Side-by-side comparison of current clinical pathways across SCAS and SECAmb, broken down by Integrated Care Board (ICB) geography and functional clinical model grouping (e.g. frailty, mental health, urgent care).
- Pathway utilisation review – Detailed review of pathways and identification of areas of "quick wins" with quantifiable operational impact.
- Progress and gap analysis of Carnall Farrah Review – Identify the progress that has been made against in year and longer term recommendations within report. Gage level of ICB buy in to continue to deliver outstanding recommendations, and if required agreement of the vehicle of delivery.
- Confirmation of resource requirements – Cross organisation resource requirements to complete the review undertaken and fully costed.

Escalation to Board of Directors

- Nil

Previous Rag	Current Rag	Rag Summary
N/A		All Q1 milestones met.

Risks and Issues	Score: Inherent	Score: Residual	Mitigation
If there is insufficient project and administrative support to the programme then the programme will not meet key milestones.	16	6	Agreement of Phase 1 resourcing requirements.
If there is insufficient capacity and skilled BI support to the programme then decisions and recommendations may be based upon incorrect data	16	6	Agreement of Phase 1 resourcing requirements.
If decisions and recommendations are based upon incorrect data then the recommended model will not deliver the intended improved patient outcomes, operational efficiencies or be financially sustainable.	16	6	Agreement of Phase 1 resourcing requirements.

Q1 (Apr – Jun 25)	Q2 (Jul – Sep 25)	Q3 (Oct – Dec 25)	Q4 (Jan – Mar 26)	Outcomes
Phase 1 → Preparatory Phase		◆		**Promoting equity.** In partnership with SECAmb, we are harmonising clinical practice and care delivery to ensure every patient receives equitable and consistent care
	Phase 2 → Data validation and modelling		◆	
			Phase 3 → Aug 26 ◆ Workforce and final proposal	

Q1 Clinical Effectiveness – Operations Directorate Restructure

SRO	Executive Lead
Michaela Morris	Mark Ainsworth

Key
- Completed
- On Track
- At Risk
- Delayed

Progress Report Against Milestones:

Previous Rag	Current Rag	Rag Summary
N/A		All Q1 Milestones achieved

Q1 Key Achievements against milestones
- Draft consultation paper developed with organisational charts
- First Steering group meeting held and core team agreed with Terms of Reference
- Project plan in development which will inform milestones and timeline below (pending agreement with Executive Lead)
- Initial People Impact Assessment undertaken
- Lessons learnt from Corporate Review has been reviewed and learning embedded within programme

Q2 Upcoming activities and milestones
- Agree timeline and consultation launch date
- Develop communications plan
- Review full implications of People Impact Assessment
- Review key documents: Change Implementation Framework and Appointments Process
- Confirm full resourcing requirements

Escalation to Executive Management Committee
- Nil

Risks and Issues	Score: Inherent	Score: Residual	Mitigation
If senior leaders are not actively engaged or supportive throughout the change process, then the programme may lack strategic direction, visible sponsorship, and credibility among staff.	16	8	Secure visible and ongoing leadership sponsorship. Regular leadership briefings and involvement in key milestones. Clarify leadership roles and responsibilities in the change process.
If change is not well planned or executed, then the transformation may fail to deliver intended benefits and face resistance from staff.	15	12	Develop a robust change and communications plan. Involve staff early and often in the process. Monitor progress and adapt approach based on feedback.

Q1 (Apr – Jun 25)	Q2 (Jul – Sep 25)	Q3 (Oct – Dec 25)	Q4 (Jan – Mar 26)	Outcomes
		Consultation Period → ◆ Consultation Outcome → ◆	Phase1 (8d – 8c) Recruitment and Appointment → ◆ Phase 2 (8b – 8a) Recruitment and Appointment → ◆	By March 26 the Operations Directorate will have structures that are fit for the future with increased clinical capacity to ensure clinical and patient safety is fully embedded within the directorate. Along with clear devolved responsibility and accountability enabling our leaders to

Q1 Digital Transformation – 999 CAD Replacement

SRO	Executive Lead
Ruth Page	Craig Ellis

Key
- Completed
- On Track
- At Risk
- Delayed

Progress Report Against Milestones:

Q1 Key Achievements against milestones
- Review of server capacity at Stoke Mandeville (now awaiting external survey)
- Confirmations from 13 evaluators with deputies nominated
- BOB ICB and HIOW ICB have reviewed the BC and have given verbal commitment of support

Q2 Upcoming activities and milestones
- Receive written letter of support from HIOW ICB
- Submit Investment Agreement / Investment Justification to secure funding
- Complete financial revisions to BCs and obtain approval at FAMSG to proceed with Network Remediation

Escalation to Board of Directors
- Nothing to escalate

Previous Rag	Current Rag	Rag Summary
		100% Key Q1 milestones met. Risks are diminishing as programme progresses.

Risks and Issues	Score		Mitigation
If migration not complete by 28/02/27 CIS1 will be withdrawn disabling CAD Spine matching for 999	12	12	CE to discuss CIS1 end date with NHSE to see if date can be moved
Tender may receive no compliant bids.	12	12	Procurement are engaging with the market
The use of PA2023 may result in unexpected delays	12	12	Procurement team attending regular update sessions on PA2023

Q1 (Apr – Jun 25)	Q2 (Jul – Sep 25)	Q3 (Oct – Dec 25)	Q4 (Jan – Mar 26)	Outcomes
29-May: OBC approved at Trust Board 06-Jun: ITT Published	02-Aug: Receipt of bids	10-Oct: Publish Contract Award report 30-Oct: FBC approved at Trust Board 21-Nov: Award new contract	09-Jan: networking complete 23-Jan: Config complete 16-Jan: Implementation Plan published 13-Feb: Detailed Training plan published	

Q1 Digital Transformation – AI Innovators

SRO	Executive Lead
Anita Lines	Craig Ellis

Key
- Completed
- On Track
- At Risk
- Delayed

Progress Report Against Milestones:

Q1 Key Achievements against milestones

- Project initiated with appropriate governance, including Steering Board which meets fortnightly; and approved Terms of Reference; allocation of project roles and responsibilities and population of a SharePoint location which contains a complete corporate record of all project matters.
- Regular internal and external project communications.
- A suitable vendor, Skills.ai, has been identified who has agreed to support the PoC entirely free of charge
- Business requirements & measurable business benefits have been analysed, documented and approved.
- Compliance activities have been completed and approved, including the Data Protection Impact Assessment and Cyber Security Lead approval
- Test scenarios have been agreed, created and set up within the vendor's system.
- The vendor has provided extensive training to SCAS colleagues.
- Live PoC testing has commenced with trainers and trainees.
- Initial feedback from the SCAS testing group has been exceptionally positive.
- UCL has expressed a high level of interest in this project and is considering making funding application/s by Dec 25 to explore / support how it can work with SCAS to possibly provide funding for future projects that may have the potential to benefit the whole of the NHS.

Q2 - Upcoming activities and milestones

- Completion of live PoC testing.
- Formal assessment of measurable benefits within SCAS.
- Comparisons of results with London Ambulance Service
- Presentation of recommended next steps (e.g. whether to progress to a pilot) to SASC

Escalation to Board of Directors

- None

Previous Rag	Current Rag	Rag Summary
Not applicable	On Track	All key Q1 milestones achieved. Initiation has commenced without issue and excellent progress is being made.

Risks and Issues	Score		Mitigation
SASC wishes to run a parallel proof of concept with LAS and a different vendor but have a delayed start. This may push the final joint assessment into Q3.	5	1	Working closely with LAS CDO to support its progress & to deliver a joint assessment to SASC after both PoCs

Q1 (Apr – Jun 25)	Q2 (Jul – Sep 25)	Q3 (Oct – Dec 25)	Q4 (Jan – Mar 26)	Outcomes
Project initiation	Live testing	Completion including		

Q1 Digital Transformation – Data Driven Organisation

SRO	Executive Lead
Anita Lines	Craig Ellis

Key
- Completed
- On Track
- At Risk
- Delayed

Progress Report Against Milestones:

Previous Rag	Current Rag	Rag Summary
Not applicable	Amber	Although Milestones have been achieved, lack of expert resource could impact the ability to complete this programme

Key Achievements against milestones
- Discovery work has commenced including 2 workshops with BIDW and Digital Technical Infrastructure teams.
- Root cause analysis of BIDW issues initiated

Upcoming activities and milestones
- Completion of Data Strategy definition

Escalation to Board of Directors
- Lack of expert resource negatively impacts the ability of the team to conclude key dependencies required for the definition of the Data Strategy. A business case will be brought to EMC with options & a recommendation.

Risks and Issues	Score		Mitigation
Lack of expert resource impacts the ability of the strategy to be delivered and results in a dilution of the end result.	15	9	Business Case to be brought to EMC with options & recommendation to retain expertise

Q1 (Apr – Jun 25)	Q2 (Jul – Sep 25)	Q3 (Oct – Dec 25)	Q4 (Jan – Mar 26)	Outcomes
Embed IPR into Board and EMC working	Implement IPR improvements following People and Culture Review	Deliver IPR People and Culture content	Develop IPR Quality and Safety content	**Effectiveness – .** We will develop our ability to evaluate our service quality and our people by developing the IPR.
IPR Champions in place	Develop Data driven programme plan	Build Sub Committee IPR	Develop Data Principles with SECAmb	**Productivity.** We will optimise patient care by becoming a data-driven organisation.
Strategy discovery work commenced		Approve Data Driven Programme	Data Driven Programme Implementation Phase	

Q1 Enabling Services – Fleet Modernisation

SRO	Executive Lead
Lemuel Freezer	Stuart Rees

Key
- Completed
- On Track
- At Risk
- Delayed

Progress Report Against Milestones:

Q1 Key Achievements against milestones
- 53 new vehicles arrived to plan (30 live in service, 23 to be fault rectified/commissioned)
- Prototyping of AEV ACCT vehicles signed off and delivery schedule agreed (in conjunction with SECAmb)
- Prototyping of O&H RRVs signed off and delivery schedule agreed
- Site identified, workshop plan designed, for additional workshop capacity at Aylesbury
- Ramps at Didcot in use

Q2 - Upcoming activities and milestones
- See detail below for delivery / commissioning schedule
- Aylesbury additional workshop facilities specification to be completed upon final decision by SCAS Exec

Escalation to Board of Directors
- Final decision required on Capital funding for additional workshop capacity in order to reduce VOR rate

Previous Rag	Current Rag	Rag Summary
		Workshop capacity remains a challenge and delays to implementing additional workshop facility could impact expected outcomes

Risks and Issues	Score		Mitigation
Coach builders do not adhere to agreed delivery schedules	12	8	Robust liaison with suppliers (confidence higher with O&H and AEV)
Limited workshop capacity impacts upon Trust ability to reduce VOR rates	12	8	Maximisation of existing capacity and utilisation of alt measures, e.g. mobile fitter services
Ageing fleet will increase VOR rates if any delay to new vehicle deliveries	6	4	Proactive servicing and other fleet optimisation works to ensure serviceability

Q1 (Apr – Jun 25)	Q2 (Jul – Sep 25)	Q3 (Oct – Dec 25)	Q4 (Jan – Mar 26)	Outcomes
49/100 planned vehicles delivered and commissioned	O&H (23 DCA) – Received end July 25 (+4 weeks commissioning required) Wilker Delivery Complete (28 DCA) – Received by end of July 25 (+6 weeks commissioning)	RRV deliveries commence Sep 25 (65 vehs) – commissioning complete by end Dec 25 O&H (47 DCA) – Received early Nov 25 (+8 weeks commissioning required) 100 vehicle delivery plan complete (end Sep 25)	AEV delivery plan (70 vehs) commences (Jan 26). Will facilitate no vehs over 4 years old	• No vehicles will exceed five years in age end Jan 26 • VOR rates reduced by 20% by Mar 26

Q1 Enabling Services– Estates Modernisation

SRO	Executive Lead
Mark Finch	Stuart Rees

Key
- Completed
- On Track
- At Risk
- Delayed

Progress Report Against Milestones:

Previous Rag	Current Rag	Rag Summary
		Estates plan development continues, dependant on strategic decisions being made in a timely manner.

Q1 - Key Achievements against milestones
- Estates functionality survey completed (condition/use)
- £3.87M ICB funding secured for critical infrastructure upgrades
- Capital plan for next 5 years drafted

Q2 - Upcoming activities and milestones
- Hold estates workshop for SCAS Executive and senior leadership
- Finalise Estates Plan, incorporating key stakeholder feedback
- Business Case development for Southern CCC
- Business Case approval for Training estate (Bone Lane / Whitely)

Escalation to Board of Directors
- Decisions required on Priority 1 items (below)

Risks and Issues	Score		Mitigation
Availability of Capital resource may impact ability to deliver key works	12	8	Prioritisation of funding required to drive delivery
Timely, commercial/market driven decision-making may impact options available	12	8	Close liaison with EMC/Board incl. workshops
Market availability of suitable premises/plots	6	4	Frequent review of market availability required

Key Priorities

Priority 1 (Short Term)

- Estates plan presented, discussed and ratified
- Key decisions made on the following time-critical sites:
  - Relocation of Southern House (lease exp. Sep 28)
  - Northern House (lease exp. Jan 28) – extend?
  - Bone Lane (break clause Feb 26 to be notified NLT 2 Aug 25)
  - Whitely (lease exp. Mar 26)
  - Sale of Hythe and Whitchurch RCs
  - Acquisition of property to support VCU/Fleet Services (providing additional space at WERC)
  - SORT location (lease exp. TBC 26)

Priority 2 (Medium Term)

- Rebuild of High Wycombe RC (funding agreed, spec TBA)
- Redevelopment of sector hub for S Oxon (Oxford RC not fit for purpose)
- Relocation of Newbury RC (collocate at Bone Lane?)
- Expansion of Partis House

Priority 3

- Disposal of Northern House
- Development of further Sector hubs

South Central Ambulance Service
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People and Culture

NB: The People and Culture Highlight reports will change from Q2 following significant revision to the work programme

Q1 People and Culture– Engagement

SRO	Executive Lead
Mehvish Shaffi Ajibola	Danny Hariram

Key: Completed; On Track; At Risk; Delayed

Progress Report Against Milestones:

Previous Rag	Current Rag	Rag Summary
N/A		Engagement refresh is on track, but the values & Behaviours activities are delayed due to the postponed Exec culture session.

Key Achievements against milestones

- Established Values & Behaviours working group
- Engagement approach, including Values and Behaviours big conversations, agreed at EMC.
- 'Big Conversation' session plan created
- Develop New Engagement Cycle
- Began refresh of People Voice hub page.
- Incorporate People Voice Steering Group into the Culture Steering Group.
- Launch of 'Listening Space' has taken place with positive feedback.

Upcoming activities and milestones

- Directorate leads identifying both dates and Snr leaders to host the sessions over the summer months.
- Exec 121 sessions in planning to introduce and support the delivery of the engagement sessions.
- Second 'Listening Space' planned for the end of July.
- Begin to embed wider Trust engagement cycle into organisation, triangulating multiple feedback and data sources to provide meaningful insights that can be reviewed against engagement plan activities.
- Agree communications approach for wider programme.
- Exec Culture workshop session to review Trust core purpose

Escalation to Board of Directors

- Rag status has moved to amber due to initial engagement session with Exec Team being postponed. Exec engagement in 121 sessions and the planned culture session on the 17th July is imperative to preventing further delays.

Risks and Issues	Score		Mitigation
If fail to launch the engagement sessions as communicated, **then** may create further apathy **resulting** in reduced engagement for future sessions given immanent financial messaging	12	9	Topic has been socialised at Team Brief in July, with a plan to hold a Listening Space event at the end of July to bridge the gap prior to main sessions.
If delay launching session to after July, **then** may impact session engagement due to moving into winter pressures and staff not released to attend sessions.	12	12	121 sessions with the Exec team are in planning which will allow deeper understanding of the mitigations needed.

Q1 (Apr – Jun 25)	Q2 (Jul – Sep 25)	Q3 (Oct – Dec 25)	Q4 (Jan – Mar 26)
Develop Engagement Cycle	Embed Engagement Cycle	Analyse Engagement Cycle	Listening Space – topic tbc
Launch new Listening Spaces	Refresh People Voice Hub page	Listening Space – topic tbc	
Establish Values & Behaviours working group	Listening Space – topic tbc	Finalise Values & Behaviours	Monitor values & Behaviours progress
Values & Behaviours content online	Big Conversation event planning	Sign off by Trust Board	
Sign off V & B approach by EMC	Directorates hold engagement events	Identify people processes and policies affected by new V & B	
	Draft co-created set of Values & Behaviours		
	Test values with key stakeholders and staff		

Outcomes

- Co-created and board agreed Values & behaviours framework
- Increase in levels of engagement, improved uptake of quarterly pulse & NSS.
- Values led behaviours in all relevant people policies
- Refreshed engagement cycle and new Listening Spaces.
- Improved engagement score

Q1 People and Culture – Leadership

SRO	Executive Lead
Mehvish Shaffi Ajibola	Danny Hariram

Key: Completed | On Track | At Risk | Delayed

Progress Report Against Milestones:

Previous Rag	Current Rag	Rag Summary
		On track however delays to Exec culture session may push back the Exec leadership development progress for Q2

Key Achievements against milestones

- Mapped available leadership offerings against the NHSE leadership and management framework and the leadership competencies
- Created SCAS Leadership Directory, promoted to leaders to populate.
- Listening event focusing on leadership and what leaders need
- Sign off for Exec (including Sub Exec) & Board leadership development approach with CEO
- Leadership development pilot / framework created for Senior leaders and First level leaders
- Created Leadership Self-assessment tool for senior leaders and first level leaders
- Test site, co-collaborating with NHS England for implementation of NHSE leadership and management framework

Upcoming activities and milestones

- First level leadership pilot in POC begins
- Re-mapping leadership resources to the revised NHSE leadership and management framework
- Identify Senior leaders to take part in the Senior leadership development programme pilot.
- Commence soft launch of the digitalised PDR process.
- Agree process to finalise the Sub Exec list

Escalation to Board of Directors

Risks and Issues	Score		Mitigation
If there is difficulty identifying the Sub Exec group, then the start of Sub Exec development will be delayed	12	TBC	Engage with Execs to agree consistent approach to the list.
Exec Development SME on limited engagement. If don't utilise their skills and start Exec development in timely manner, then will impact Exec development	12	TBC	Exec development plan agreed with CEO, planning series of protected exec development days
Leadership development funding constrained which may limit the development offerings we can provide.	Issue	Issue	Utilise inhouse resources, investigate other low / no cost options.

Q1 (Apr – Jun 25)	Q2 (Jul – Sep 25)	Q3 (Oct – Dec 25)	Q4 (Jan – Mar 26)
Map offerings to NHSE leadership framework	Promote Inclusive leadership pledge	Embed revised values & Behaviours into offerings & PDR	
Create SCAS Leadership Directory	Soft Launch Digital PDR	Trust wide Digital PDR roll out	Finalise offerings for 2026/27
Design Self-Assessment tool		Launch 360-feedback process	End of Year leadership summit
Identify Sub Exec	Exec team and individual TNA		
Agree Exec development approach	Design targeted development based on key needs for Execs	Ongoing rollout of Exec offering	Evaluate Exec offering
Design Snr leadership offering	Pilot Snr Leader offering (15 leaders)	Ongoing rollout of Snr offering	Evaluate Snr offering
	Evaluate Snr Leader Pilot		
Design first level leadership offering for pilot	Deliver pilot as part of POC	Roll out 1st level leader offering	Evaluate 1st level offering
Pilot Self-Assessment tool 1st level leaders	Evaluate pilot		
	Sign off 1st level leadership proposal		

Outcomes

- Alignment of SCAS leadership offerings with NHSE leadership frameworks (Board and all leaders)
- Leaders sign up to Inclusive leadership pledge
- Self-aware leaders with knowledge of their leadership strengths and development needs and awareness of how and where to access learning needs.
- High quality PDR experience

Q1 People and Culture – Performance and Accountability

SRO	Executive Lead
Alston Owens	Danny Hariram / Stuart Rees

Key: Completed | On Track | At Risk | Delayed

Progress Report Against Milestones:

Previous Rag	Current Rag	Rag Summary
		Some milestones starting to slip, working to regain these back over next month. Need solution for the PMAF pack creation.

Key Achievements against milestones

- Operational P&MAF Pack Template and Ops Pack Reporting Timetable are now established, providing the necessary structure for performance reporting.
- Meetings have been consistently held for Operation North, Operation South, EOC, and 111, demonstrating the active implementation of the framework. Metrics have been provided across key areas including Quality, Workforce, Operational Performance, Finance, and CIP (Cost Improvement Programme) Delivery, with detailed action lists prepared to track progress.

Upcoming activities and milestones

- Communication Plan to be developed and launched, ensuring stakeholders e.g. Support Functions / Operation Managers and Executives are informed, and an Initial Feedback Mechanism in place
- Draft Corporate Metrics for their respective P&MAF packs and create draft packs.
  Refine the Operational Pack Template (v1.1), incorporating user feedback from initial meetings
- Data gathering for the training needs analysis, training planning.

Escalation to Board of Directors

Dedicated BI support to automate the data population for the PMAF pack.

Risks and Issues	Score		Mitigation
Limited Business Intelligence (BI) team support for P&MAF pack population, increasing data collection burden on operational managers.	Issue		Deliciated BI resource to automate data collection with self-service BI tool (local IPR) for managers.
Difficulty in scheduling Exec pre-meetings for the P&MAF, including briefing and agenda review for all parties due to manual population of packs	Issue		Deliciated BI resource to automate data collection with self-service BI tool (local IPR) for managers.
Limited capacity to expand the number of PAF meetings to other directorates then we may not have visibly of risks or poor performance and ability to hold to account to take action	12	6	Additional services planned on a separate day. Services held Bi-Monthly. Review meeting attendees.

Q1 (Apr – Jun 25)	Q2 (Jul – Sep 25)	Q3 (Oct – Dec 25)	Q4 (Jan – Mar 26)
Establish feedback channel Establish governance & framework	Define performance grading Map interdependencies & automations	Embed performance grading	Monitor and report impact
Create Ops Pack	Develop EMC highlight report Refine Ops pack	Develop Report Automation	Implement Report Automation
Launch Ops PMAF meetings	Draft Corporate pack Roll out PMAF meetings to PTS & Specialised	Rollout Corporate pack Rollout Corporate PMAF meetings	Ongoing PMAF cycles & refinement
Training needs analysis	Roll out foundational training	Deliver application training	Further System training and development

Outcomes

- Robust system of data collection, analysis and reporting.
- Accountability matrix with clear lines of responsibility across all performance themes.
- Culture where managers actively engage in identifying and addressing performance gaps.
- Deliver within the annual plan regards finance, workforce and performance

Q1 People and Culture– Culture Fit for the Future Programme

SRO	Executive Lead
Mevish Shaffi Ajibola	Danny Hariram

Key: Completed | On Track | At Risk | Delayed

Progress Report Against Milestones:

Engagement	Leadership	Belonging	Learning
Key Achievements against milestones • Values & Behaviours approached agreed at EMC • Big Conversation session content planned • New engagement cycle developed and launched • 1st Listening Event took place on 25th June on topic of leadership	• SCAS leadership directory launched • Agreement on Exec (incl Sub Exec) development approach • Self-assessment tool created • Pilot for first level leader developed • Snr leader development framework created.	• WRES and WDES Data analysed & headline report • See me first Campaign commenced • Baton of Hope pledge signed • Executive sponsors allocated for all Staff Networks • Disability equality action plan created.	• New Cross directorate Sexual Safety Assurance & Oversight Group established. • Developed framework for Sexual Safety learning
Upcoming activities and milestones • 2nd Listening Event on 24th July • Exec briefings to intro values & behaviours session content and support • Exec culture workshop on 17th July to review Trust core purpose • Identify directorate leads and session dates big conversation sessions over July & Aug. • Start to embed the new engagement cycle	• Begin First level leadership pilot in POC • Re-map leadership resources to revised NHSE leadership & management framework • Identify Senior leaders to take part in the Senior leader development programme pilot. • Commence soft launch of the digitalised PDR process. • Create training tools for digital PDR app.	• WRES & WDES workshops planned • Draft report for WRES and WDES to be collated • Race Equality Workstream action plan incl. Race Charter • Develop Wellbeing Action plan incl roadmap for Baton of Hope • Review options for EDI governance Framework • Toolkit for Exec Champions to Support Staff Network growth.	• Implement new learning framework meeting structure • Identify leader training needs for management of ER cases & staff wellbeing. • Begin creating micro-bite learning based on learning needs.

Previous Rag	Current Rag	Rag Summary
		Programme mostly on track but delays to the big conversation and Exec development putting at risk of going amber

Risks and Issues	Score	Mitigation
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	15	
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 harm and staff attrition**	15	

Escalations to Board of Directors

- Exec engagement in 121 sessions and the planned culture session on the 17th July is imperative to preventing further delays to 'Big Conversations'

Q1 (Apr – Jun 25)	Q2 (Jul – Sep 25)	Q3 (Oct – Dec 25)	Q4 (Jan – Mar 26)
Launch new Engagement Cycle Launch new Listening spaces Sign off V & B approach by EMC	Big Conversation sessions Draft Values & Behaviours Test values with stakeholders & staff	Finalise Values & Behaviours Sign off V&B by Trust Board	Monitor values & Behaviours progress
Map offerings to NHSE leadership framework Agree Exec dev approach Design leadership frameworks	First level leader pilot Execs TNA & design offerings Snr Leader pilot Soft Launch Digital PDR	Launch 360-feedback Trust wide Digital PDR roll out Ongoing rollout of all leadership programmes	Evaluate all leadership offerings End of Year leadership summit Finalise offerings for 2026/27
See me first Campaign commenced Executive Champions Staff networks Sign Baton of Hope pledge	Action plans created for WRES, WDES, Race Charter, disability equality, Baton of Hope Review options for ED&I governance	Publish WRES and WDES Implement engagement campaign for Baton of Hope and See Me First. Develop toolkit to support staff networks	Establish safe spaces for BAME staff to engage Leadership directly
Design framework for Sexual Safety learning Launch Sexual Safety Assurance Group	Identify ER case learning needs Develop Micro-bite learning	Analyse learning outcomes Feed learning review outcomes into policy / practice	Establish value & culture learning framework

Outcomes

- Co-Created values & behaviour framework
- Increased engagement
- Inclusive & compassionate leaders
- Improved lived experience of BAME colleagues
- Inclusive, respectful and psychologically safe workplace
- ED&I governance framework

Q1 Partnerships and Sustainability – Multi-year Integrated Plan

SRO	Executive Lead
Head of Finance / Caroline Morris	Stuart Rees (CFO)

Key
- Completed
- On Track
- At Risk
- Delayed

Progress Report Against Milestones:

Previous Rag	Current Rag	Rag Summary
		Collaboration has commenced with initial sharing of approach and T&F set up.

Q1 = Key Achievements against milestones

- Do nothing scenario using existing assumptions complete
- Task and Finish group set up with SECAmb colleagues including expert modelling support
- Strategic model in development
- Review of strategic documentation commenced, including work with commissioners

Q2 - Upcoming activities and milestones

- SCAS internal group to be formally established
- Develop scenarios including key assumptions and trajectories
- Develop BI request for data to populate model
- Key stakeholder interviews to be carried out including further review of commissioner intentions/expectations
- Presentation of suggested scenarios to F&P
- National timetable and guidance to be published

Escalation to Board of Directors
- Nil

Programme Risks and Issues	Score		Mitigation
IF there is a lack of capacity and capability **THEN** it may not be possible to develop models **RESULTING** in a lack of long term financial and strategic clarity	16	12	Work collaboratively with SECAmb using expert support. Fill internal vacancies.
IF access to data is not available **THEN** it may not be possible to undertaken detailed evaluation **RESULTING** in a sub optimal Service design	16	16	Define data request and review time required with BI
IF demand for Services are high **THEN** there may not be the capacity to balance demand **RESULTING** in a reduction in the quality of Services delivered within the financial envelope available	16	16	Align closely to development of clinical operating model

Q1 (Apr – Jun 25)

- Establish Joint Planning Group
- Commence work to develop strategic model

Q2 (Jul – Sep 25)

- Stakeholder Engagement
- Develop multi-year trajectories and assumptions
- F&P review of outline assumptions

Q3 (Oct – Dec 25)

- Review strategic documents and commissioner assumptions

Q4 (Jan – Mar 26)

- Final Draft of Plan with all sections
- Present to Board
- Submit to NHSE as required

Outcomes

- Develop a multi-year plan with a mechanism for ongoing updates in anticipation of a multiyear financial settlement following the comprehensive spending review.

Q1 Partnerships and Sustainability - Partner Collaborations

SRO	Executive Lead
Caroline Morris	David Ruiz Celada (JSA)

Key
- Completed
- On Track
- At Risk
- Delayed

Progress Report Against Milestones:

Key Achievements against milestones

- MOU signed off by Chairs at each Trust – Feb 2025
- Joint Strategic lead commenced - Feb 2025
- Phase 1 – Discovery phase completed, including analysis of strategic alignment, operational variations and identification of key business case workstreams – April 2025
- Governance established with first Joint Strategic Collaborative Committee (JSCC) held April 2025
- Joint Executive to Executive Workshop held May 2025 focused on three critical workstreams, aligned with the business case framework with outputs feeding into the Joint Board on 28 May 2025

Upcoming activities and milestones

- Continued progress and monitoring of the functional collaboration initiatives. Focus on benefits realisation and developing joint efficiency and productivity pipeline to support 25/26 and 26/27.
- Phase 2: development of strategic business case for collaboration due October 2025
- Articulation of proposed future models
- Development of clinical case and financial case to support October joint board milestone.

Escalation to Board of Directors – None

Previous Rag	Current Rag	Rag Summary
		Programme is running on track - timeline and milestones. Governance and meeting schedule established. Discovery Phase completed.

Programme Risks and Issues	Score		Mitigation
IF there is a lack of capacity and capability **THEN** it may not be possible to develop models **RESULTING** in a lack of long term financial and strategic clarity	16	12	Align joint executive objectives to collaboration priorities agreed via E2E
IF there is insufficient funding **THEN** it may not be possible to invest in the change opportunities **RESULTING** in delay in progress	16	16	Transitional funding to be identified as part of the financial sustainability component of the business case
IF the Trust and its partners have different priorities **THEN** it may not enable the culturally environment required for change **RESULTING** in ineffective partnerships and poor patient outcomes	16	16	Provider Execs and ICB leads have established programmes of work to codesign changes in organisational structures and functions

Q1 (Apr – Jun 25)	Q2 (Jul – Sep 25)	Q3 (Oct – Dec 25)	Q4 (Jan – Mar 26)	Outcomes
Joint Executive and Board Discovery Phase Report JSCC approval of BC workstreams and glidepath Define benefits and opportunities Create functional collaboration mandates	Joint Executive Micro-site framework agreed	Joint Executive Joint Board Micro-site Published Success matrix Articulation of proposed future models Implementation Planning Identify and agree transition resources Agree governance approach	Joint Executive Joint Board	• Enhance patient outcomes through collaboration to ensure high-performing sustainable services in the short, medium and longer term

Q1 Partnerships and Sustainability – System Productivity

SRO	Executive Lead
TBC	Stuart Rees (CFO)

Key
- Completed
- On Track
- At Risk
- Delayed

Progress Report Against Milestones:

SCAS, in conjunction with its System partners, will continue to seek out opportunities to enable System wide productivity and efficiency improvements. Our existing Collaborative work with SECAmb and as part of the Southern Ambulance Service Collaboration (SASC); along with Service redesign work for urgent and non-Emergency care, represent a starting point and a vehicle for future work. The objectives of this work are:

Deliver in year System productivity improvement

- Identify duplication in functional delivery within SCAS and partner organisations
- Establish Yr 1, 2 and 3 plan to remove unwarranted duplication or process variability

Establish System model for functional service delivery

- Develop a long-term plan for improving functional delivery of Corporate, Clinical and Enabling services
- Establish System / Sector wide opportunities to optimise productivity
- Support the System to bring spend under control
- Robust assurance plans in place aligning future capability and capacity in Corporate, Clinical and Enabling services.

Previous Rag	Current Rag	Rag Summary

Programme Risks and Issues	Score		Mitigation
IF access to data is not available **THEN** it may not be possible to undertaken the detailed data evaluation **RESULTING** in a sub optimal Service design	16	16	Define data request and review time requirement with BI teams
IF there is not buy in between internal parties as well as System Partners **THEN** it may not be possible to evaluate feasible options **RESULTING** in delay or missed opportunities	16	12	Specific programmes of work, with facilitation SME's to work between different parties to engage with change opportunities
IF there is insufficient resource **THEN** it may not be possible to deliver the Service Transformation and organisational Change required **RESULTING** in non-delivery of cost and productivity improvements	16	16	SCAS, System stakeholders and ICB leads to establish programme of work to codesign changes in organisational structures and functions

Key Priorities (To be confirmed)…

Establish Functional Requirements

Evaluate, via the shared use of data and benchmarking:

- Core functions required to enable delivery of Emergency, 111/ IUC and Non-Emergency Transport services
- Gap analysis between current and required.

Explore Delivery options

Establish:

- Opportunities to remove duplication in processes or handling of information (internally and external view)

Undertake a "Do, Share, Buy" review

- Explore relative strengths and weaknesses
- Define Benefits
- Identify scale of opportunity.

Implement change

Work collaboratively to:

- Implement in-year cross system / internal opportunities
- Set up an on-going system productivity delivery group?

Majority of opportunities will be longer term, and detailed plans, including specific delivery projects will need to be established.

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Trust Board of Directors Meeting in Public
25 September 2025

Report title	Integrated Performance Report (IPR)
Agenda item	10
Report executive owner	Stuart Rees, Chief Finance Officer
Report author	Tina Lewis, Senior Transformation Programme Manager
Governance Pathway: Previous consideration	Executive Management Committee
Governance Pathway: Next steps	Board Committees

Executive Summary

This Integrated Performance Report (IPR) provides a comprehensive overview of the Trust's performance across key operational; quality, workforce, and patient experience metrics for August 2025, the fifth month of the financial year. The report aligns with the Trust's strategic goals and highlights both areas of strength and those requiring focused improvement.

Operational Performance

- 999 Services: Incident demand was 2.6% below plan, with 44,572 incidents responded to. Response times improved across all categories, notably Category 2 at 27:11 minutes—over 4 minutes ahead of plan—supported by 1,485 additional staff hours.
- Call Handling: Call volumes exceeded plan by 2.61%. Strong performance in call answering (mean of 5 seconds vs. 10-second target) and Hear & Treat rates (16.51%) were maintained.
- PTS Services: Slight underperformance across key indicators due to seasonal demand and staffing constraints. No special cause variation detected. Cohorting protocols are being refined to improve punctuality and patient experience, with changes due by October.

Quality and Safety

- Patient Safety: 458 incidents reported, with over 99% resulting in low/no harm. Special cause variation in delay-related incidents is under thematic review.
- Audit Compliance: Hand hygiene and vehicle audits show stable compliance; further assurance work is underway.

- Patient Experience: Concerns decreased from 77 to 64, with 88 compliments received. Staff attitude and delays remain key themes. Targeted training and feedback mechanisms are being deployed.
- Safeguarding: Level 1 and Level 3 training performance exceeds targets. Continued monitoring ensures compliance with national guidance.

People and Workforce

- Workforce Management: Substantive workforce exceeds budgeted establishment. Recruitment is frozen in 999 and PTS, with CCC continuing to recruit. A net reduction of 40 WTE was achieved in August.
- Staff Turnover: At 15%, turnover is the lowest in a decade and 3 percentage points better than plan. Retention is improving, with 87% of staff in role for over 12 months.
- Sickness Absence: On target overall (6.2%) but forecasted to rise in Q3. Long-term sickness remains above target, especially in 111 and PTS. Management toolkits and wellbeing initiatives are being rolled out.
- DBS Compliance: Maintained at 98%, above the 95% target, with proactive renewals and process improvements.
- Performance Development Reviews (PDRs): Improved to 83% but below the 95% target. A new digital PDR application is being piloted, with Trust-wide rollout expected in M6.
- Freedom to Speak Up (FTSU): Case numbers declined in August due to seasonal factors. Themes remain stable, with continued emphasis on culture and responsiveness.

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

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Integrated Performance Report: Aug-25

Executive Summary

Operational Performance

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

Safety and Quality

People

Executive Commentary :

Operational Performance 1:

August 999 incident demand was 2.6% lower than planned levels with us responding to 44,572 incidents. Category 1 performance was 8 minutes 18 seconds (an improvement 40 seconds on July), category 2 performance was 27:11 (an improvement of 07:52 minutes on July), category 3, 90th was 04:52:04 (an improvement of 02:54: hours on July) and category 4, 90th percentile, was 05:11:46 (an improvement of 03:21 hours on July). Cat 2 performance of was planned at 31.41 so 4.30 ahead of plan this was partly due to being over planned staff hours by 1485hrs.

Calls offered to SCAS telephony switch in August were 2.61% above plan, in addition we also exported 926 calls to SECAMB and 105 to other Trusts over IRP. This indicates that demand was well above planned levels despite a drop in duplicate calls due to improved ambulance resource availability. Logged-in hours increased in comparison to July levels, which supported a strong call answer performance, achieving 5 seconds call answer mean against the 10 second target with a 90th percentile of 4 seconds. Hear and treat (H&T) levels were maintained through the month at 16.51% remaining above trajectory/target. Team focus remains on recruitment of clinicians (inc. rotational paramedics) in line with budget

Operational Performance 2:

The August performance across key PTS indicators shows a consistent pattern of slight underperformance relative to targets, largely attributable to seasonal variation and temporary staffing constraints. No special cause variation has been detected and slight reduction aligned with seasonal demand, no special cause variation.
OP20 – % Calls Answered Within 90 Seconds: near-target performance; temporary staffing issues (sickness) should be noted. Process stability maintained.
OP21 – PTS Journey Volume: There is a minor downward shift consistent with seasonal trends; no process instability.
OP22 – Number of Patients Transported: Is slightly below target, in line with journey volume. Stable process.
OP23 – % Patients Collected Within Time: Within control limits; mean trending below target due to cohorting/resource constraints
OP24 – % Patients Arrived Within Time: Stable process with common cause variation.
Current patients are arriving early linked to cohorting, to improve punctuality and patient experience, cohorting protocols are being refined to reduce early arrivals and improve collection accuracy. Enhance routing/scheduling algorithms to reflect current cohorting patterns, the changes are being implemented by end of October 2025, with impact review in November.

Executive Commentary (Continued)

Executive Commentary :

Quality & Safety:

QS1 – PATIENT SAFETY INCIDENT REPORTING (PSIRF 1)

- 458 PSIs reported; over 99% were low/no harm, indicating a stable and effective safety reporting system.
- 3 incidents (0.65%) involved severe harm or death; 4 (0.87%) involved moderate harm.
- Common cause variation observed overall.
- Special cause variation identified in incidents related to delays, prompting a second thematic analysis.

ACTIONS:

- Quarterly Patient Safety Update scheduled for Q&S Committee (18 Sept) and EMC (23 Sept).
- PSIRP2 approved by Patient Safety & Experience Group (11 Sept) and submitted to EMC (16 Sept) for final approval.

RISK:

- Without deeper understanding of delay-related PSIs, learning may be lost, increasing the risk of avoidable harm.

QS7–10 – AUDIT COMPLIANCE

QS7–8: HAND HYGIENE AUDITS

- Compliance monitored; no special cause variation noted.

QS9–10: VEHICLE AUDITS

- Compliance tracked; further assurance work needed to confirm impact of changes.

ACTIONS:

- Review audit cycles and methodology.
- Investigate and support improvement actions for outliers.
- Embed results into SPC dashboards.

QS20 – PATIENT EXPERIENCE

- Concerns decreased from 77 to 64; 88 compliments received.
- 25% of concerns related to staff attitude, 20% to delays.
- Data suggests a downward trend in concerns, indicating early signs of improvement.

ACTIONS:

- Collaborate with People Directorate to assess training and support needs for staff involved in attitudinal complaints.
- Deploy bespoke training and real-time feedback mechanisms.
- Continue safety improvement work on delays (linked to QS1).

QS21 & QS24 – SAFEGUARDING

QS22: LEVEL 1 SAFEGUARDING

- Performance remains within control limits; meeting and exceeding targets.
- Indicates a capable and predictable process.

QS24: LEVEL 3 SAFEGUARDING TRAINING (FACE TO FACE)

- Performance shows positive variation, trending above 90% target.
- Monitoring continues via Safeguarding Committee for other required components (CPD, Clinical Supervision, etc.) to ensure full compliance with national intercollegiate guidance.

ACTIONS:

- Maintain current safeguarding approach and assurance checks.
- Monitor compliance with all elements of Level 3 Safeguarding via SG Committee and report to Q&S Committee.
- Track sustained performance above 90% to confirm embedded progress.

RISK:

- No immediate risks identified. Continued monitoring recommended to ensure SCAS staff remain compliant with all Level 3 Safeguarding requirements.

Executive Commentary :

People:

WORKFORCE / VACANCY (P1 / P3)

Our substantive workforce is higher than our budgeted establishment. The recovery plan is now being implemented, with 999 and PTS freezing recruitment for the rest of the financial year, whilst CCC will continue to recruit to fill vacancies, helping to reduce temporary resourcing. Our overall workforce position improved in M5, with a reduction of 40 WTE. This reduction will continue throughout the year, with plans to consider how we achieve further reductions being considered. 999, 111, PTS and Corporate saw reductions, whilst EOC were able to fill 7 vacancies to help improve our call answer and hear and treat performance. 999 are now 58 over establishment, EOC has 11 vacancies, and 111 has 39 vacancies. PTS has no vacancies and has frozen bank usage to reduce costs.

STAFF TURNOVER (P2)

The Trust's 12 month rolling turnover rate continues to improve and is now 3 percentage points better than plan. At 15%, this is the lowest turnover rate for ten years and is 3 percentage points better than M5 2024/25. All areas are currently better than plan. Attrition in all workforce plans has been adjusted to reflect these improvements, to ensure that we only recruit to vacancies. Staff retention rate is also improving in all areas of the Trust, with 87% of all staff in their current job role for at least 12 months. Improved retention helps reduce recruitment costs and is a critical part of our workforce plan. The 2025/26 workforce planning templates, which will include a 5-year planning element, will arrive in October, with the first draft plan being submitted to the ICB in December.

SICKNESS (P7-P8)

Sickness absence is currently on target (6.2%), but this is forecasted to increase in Q3. EOC (5.1%) and Corporate (3.3%) are performing well, but 999 (6.4%), 111 (7.5%), and PTS (7.4%) are worse than target. Long Term sickness (3.8%) continues to be worse than target (3.5%), with 111 (4.3%) and PTS (4.7%) significantly high. The Employee Relations team are currently developing a suite of management toolkits to support employee relations processes, and we have prioritised sickness absence as the first toolkit. The Health and Wellbeing Team are working with the senior leadership team, providing weekly reporting, and supporting return-to-work calls / interviews. Drop-in Q&A sessions are planned in for the next 6 months, starting in M5, focussing on managing sickness.

DISCLOSING & BARRING SERVICED (P9)

DBS adherence (98%) remains above target (95%) with our dedicated team focusing on renewals ahead of time to ensure continued compliance. Streamlined ID requirements, improved processes, monthly compliance reporting ensure consistent monitoring and follow-ups. The team are continuing to improve DBS processes, including cost–benefit analysis and benchmarking against other Trusts.

PERFORMANCE DEVELOPMENT REVIEW (P10)

PDRs improved in M5 (83%) but are below the 95% target. 999 (86%), EOC (89%) and 111 (89%) are the top three areas, whereas PTS (83%) and Corporate (62%) are significantly below target. Finance and Transformation, Digital, People, and Education are showing as red and need urgent attention. The Culture and Leadership team have launched a 'Task and Finish' group, to review PDR process and monitor performance. A new digital application has been built in SCAS and is being tested by PTS, CCC and some corporate teams. The feedback has been positive, and we expect to rollout the application to all areas of the Trust in M6.

FTSU (P12) - Continues to provide a vital channel for raising concerns. Sustained focus on culture, responsiveness, and visibility of actions essential to embed trust and ensure concerns contribute to continuous improvement. Case numbers reduced in August, consistent with seasonal variation linked to annual leave. No indication that this reflects reduced willingness to speak up. Themes remain stable, with behaviours and systems/process the most common.

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) .

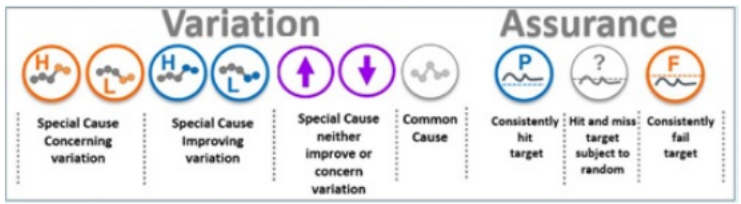
4) A run of 6 consecutive ascending or descending values (a trend).

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

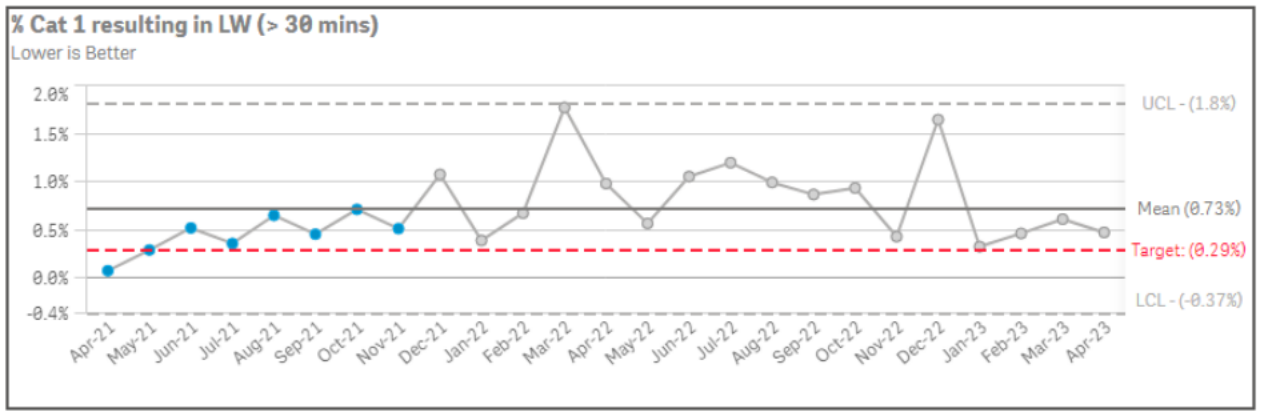
	Pass	Hit and Miss	Fail	No Target
	Special cause of an improving nature where the measure is significantly HIGHER.This process is capable and will consistently PASS the target.	Special cause of an improving nature where the measure is significantly HIGHER.This process will not consistently HIT OR MISS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

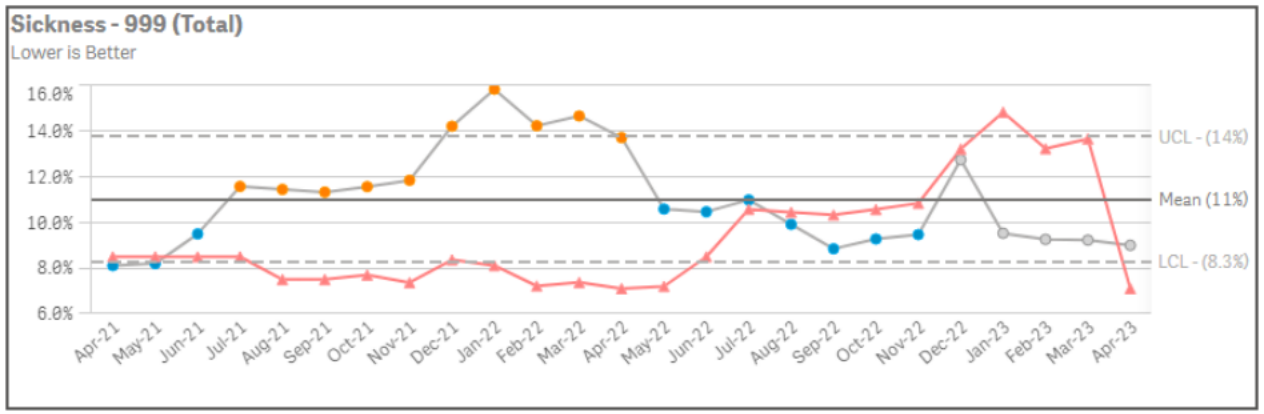
Assumptions:

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

August-25 Summary

Assurance →

Variance ↓

	Fail	Hit and Miss	Pass	No Target
H				
L	% Trust staff who are BAME Appraisals - Trust		Safeguarding Adults Level 1	
	111 Call back < 20 min Cat 1 Mean SCAS Cat 3 90th %ile SCAS Meal Break Compliance - SCAS S&T - SCAS	35	% Vacancy Clear up Delays - SCAS Number of WTE	
L	Average Hospital Handover Time - SCAS ST&C (ED 1&2) - SCAS	Number of Complaints Number of PSII cases over six months Over-runs >30 mins - SCAS	% Turnover Number of reported CD incidents – unaccounted for losses	
H	% Arrival at hospital to handover <15mins	H&T - SCAS Percentage of compliant Hand Hygiene audits Vehicle cleanliness completed audits	% Trust staff who are declared disabled Safeguarding Level 3	
↗				
↘				

Metrics:

Hit and Miss Common Cause Metrics:
% DBS Compliance ; % Long term sickness ; % Sickness in month ; 111 Calls abandoned after 30 secs % ; 111 call answer in 120 Secs % ; 999 Calls abandoned % ; 999 Mean Call Answer Time ; Cardiac Arrest Survival at 30 Days - All Patients ; Cardiac Arrest Survival, Utstein ; Cat 1 90th %ile SCAS ; Cat 2 90th %ile SCAS ; Cat 2 Mean SCAS ; Cat 4 90th %ile SCAS ; Complaint Responses in time ; Hand Hygiene audit ; Number of PSI low/no harm ; Number of PSII declared in month ; Number of PSR declared in month ; Overdue Datix incidents ; PTS - Calls answered in 60 seconds ; 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 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 ; Time to hire ; VOR - Total

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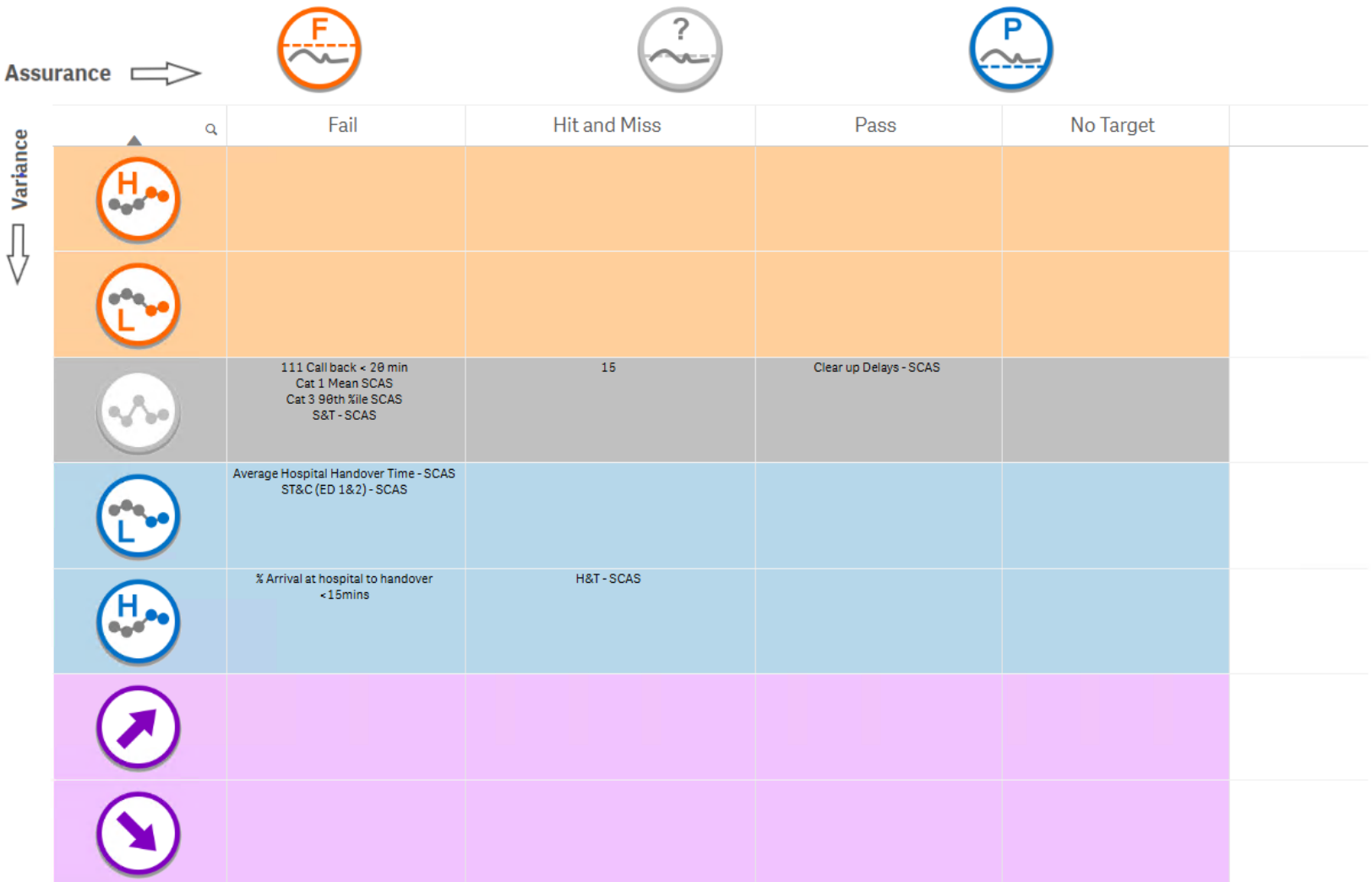
Operational Performance

August-25 Summary



Metrics:

Hit and Miss Common Cause Metrics:
111 Calls abandoned after 30 secs % ; 111 call answer in 120 Secs % ; 999 Calls abandoned % ; 999 Mean Call Answer Time ; Cat 1 90th %ile SCAS ; Cat 2 90th %ile SCAS ; Cat 2 Mean SCAS ; Cat 4 90th %ile SCAS ; PTS - Calls answered in 60 seconds ; PTS Call Volume ; PTS Volume - No. of Journeys ; PTS Volume - No. of Patients Transported ; Patients Arrived within time ; Patients Collected within time ; VOR - Total

NHS 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.

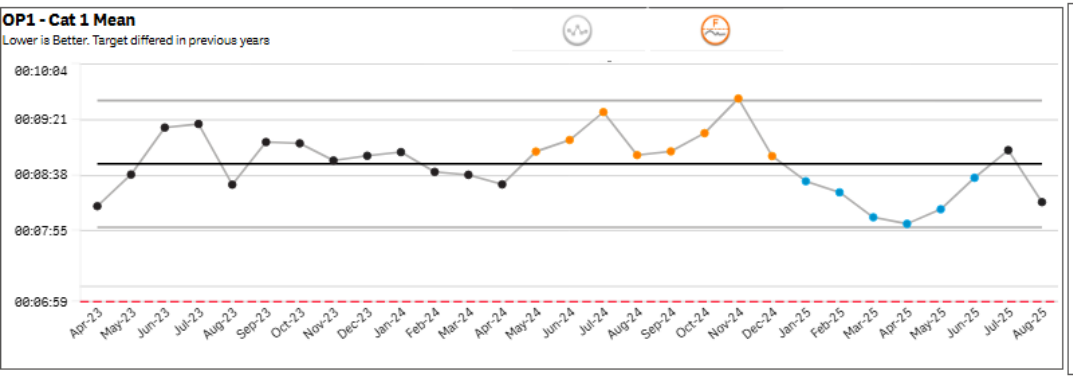
KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Cat 1 Mean	Aug-25	00:08:17	00:07:00		F	00:08:47	00:07:58	00:09:36
Cat 1 90th %ile	Aug-25	00:15:25	00:15:00		?	00:15:56	00:14:33	00:17:19
Cat 2 Mean	Aug-25	00:27:00	00:30:00		?	00:29:13	00:19:03	00:39:23
Cat 2 90th %ile	Aug-25	00:51:46	00:40:00		?	00:56:46	00:36:03	01:17:28
Cat 3 90th %ile	Aug-25	04:52:04	02:00:00		F	05:36:11	02:04:29	09:07:54
Cat 4 90th %ile	Aug-25	05:11:46	03:00:00		?	06:52:06	02:16:20	11:27:52
% Vehicles off the road	Aug-25	39%	35.0%		?	39.8%	32.9%	46.6%
Ave Handover	Aug-25	00:16:23	00:15:00	L	F	00:18:06	00:16:40	00:19:33
Handover < 15mins	Aug-25	55%	60.0%	H	F	46.0%	39.4%	52.5%
Clear up Delays	Aug-25	00:14:10	00:15:00		P	00:14:06	00:13:43	00:14:29
% See and treat	Aug-25	31%	33.0%		F	30.5%	29.8%	31.2%
% ST&C to ED	Aug-25	49%	45.0%	L	F	49.8%	48.2%	51.4%
999 Call Answer	Aug-25	00:00:06	00:00:10		?	00:00:11	00:00:03	00:00:18
999 Ab. Rate	Aug-25	1.6%	2.0%		?	2.1%	1.4%	2.8%
% Hear and treat	Aug-25	17%	16.0%	H	?	14.8%	12.9%	16.8%
111 Call Answer	Aug-25	85%	95.0%		?	77.8%	57.7%	98.0%
111 Ab. Rate	Aug-25	2.4%	3.0%		?	3.5%	-0.5%	7.5%
111 Call backs	Aug-25	40%	95.0%		F	40.8%	28.3%	53.3%

Operations - PTS Calls and Outcomes

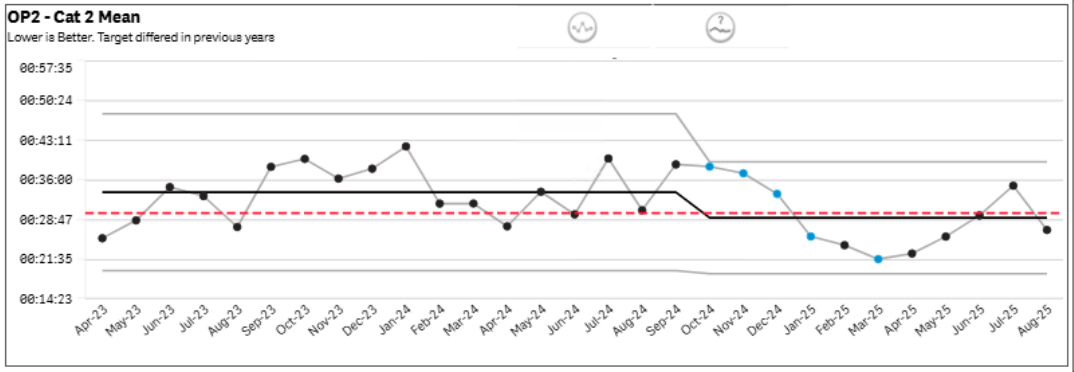
*Currently all data is aggregated on a monthly basis. We aim to provide accurate 90 days, YTD and 12 Months data when available.

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Calls Answered (PTS)	Aug-25	88%	90%			93.4%	82.1%	104.7%
Number of calls (PTS)	Aug-25	6,381	6,672			6,739.73	4,670.63	8,808.83
% Patients arrived in time	Aug-25	85%	87%			87.6%	83.2%	92.0%
% Patients collected in time	Aug-25	85%	87%			85.8%	83.9%	87.7%
PTS Volume - No. of Journeys	Aug-25	21,667	23,414			21,727	18,205.4	25,248.7
Number of Patients Transported	Aug-25	5,176	5,332			5,172.07	4,526.64	5,817.5

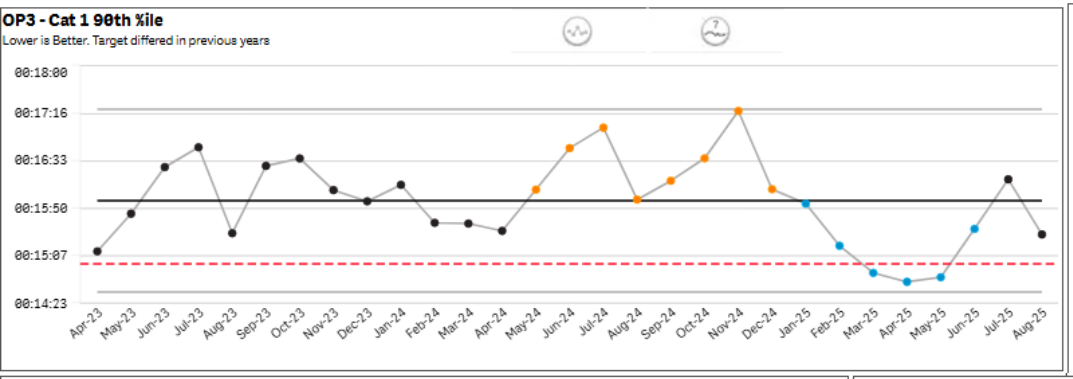
Operations - Response Times



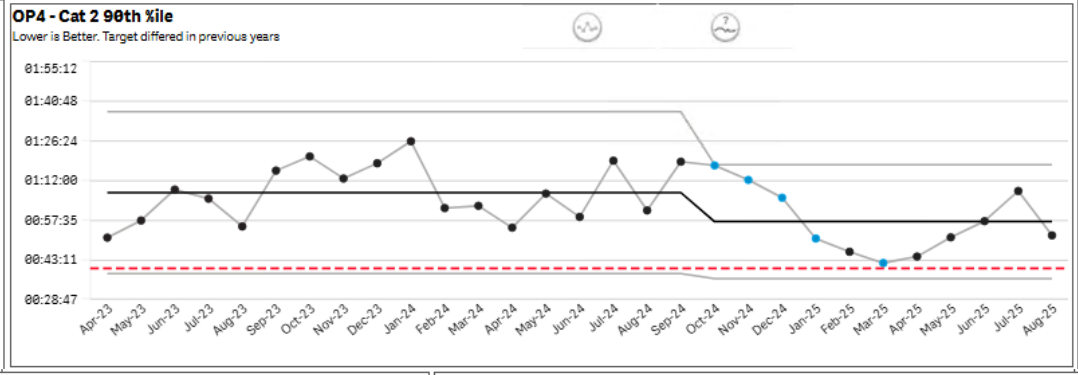
Variation	Expected
Assurance	Fail
Target	00:07:00
Latest	00:08:17



Variation	Expected
Assurance	Random
Target	00:30:00
Latest	00:27:00



Variation	Expected
Assurance	Random
Target	00:15:00
Latest	00:15:25



Variation	Expected
Assurance	Random
Target	00:40:00
Latest	00:51:46

Understanding the Performance:

Both Cat 1 & 2 improved last month with Cat 2 fallen below target. Both remained within expected variation. Demand remained below trajectory, hours provided where a better match to requirement and there was a reduction in hours lost through fleet challenges.

Actions (SMART):

Performance improvement team continues to meet bi weekly.
Investment to support timely repair of fleet
Amended Meal Break Policy Pilot agreed at JCC
Reporting issues regards multiple CSD interventions resolved, backdated to 1st April by end of October 25.
Delivery of CIPs - Review H2 resources against current performance delivery.
Maintaining financial controls
Clinical recruitment into CSD to support the delivery of H&T trajectory - 19% from 1st September

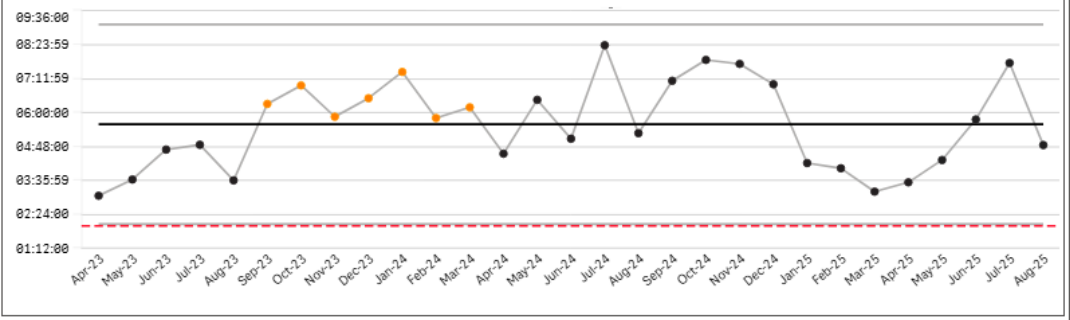
Risks:

Delivery of CIPs
Establishment pressure - Numbers and geographical location
Financial controls

Operations - Response Times

OP5 - Cat 3 90th %ile

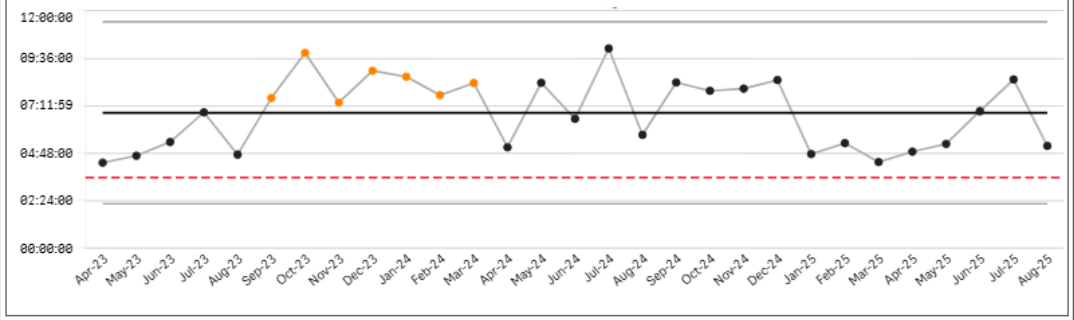
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Fail	02:00:00	04:52:04

OP6 - Cat 4 90th %ile

Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	03:00:00	05:11:46

Understanding the Performance:

Both Cat 3 and Cat 4 improved, both remained within the expected variance but failed to meet the target. There is a link to QS1 with the number of PSIs declared linked to longer response times to patients with linked actions from patient safety and operations to improve.

Actions (SMART):

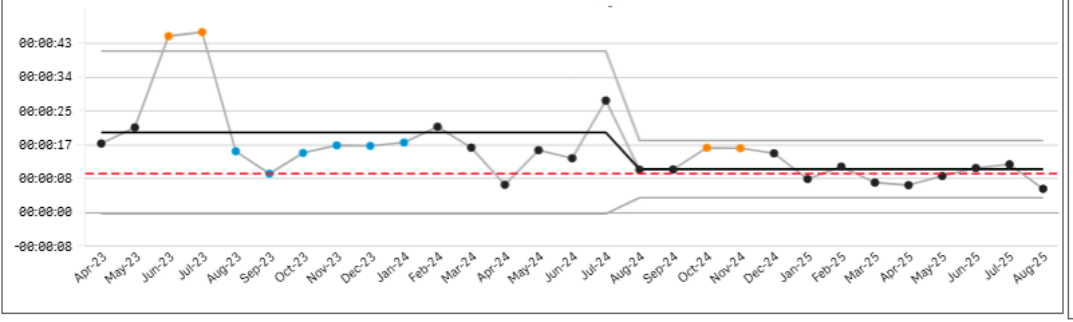
Additional DCAs to move from South to North identified at 24 hours
CSD hours moved to earlier in the day.
Delivery of CIPs
Amended Meal Break Policy Pilot agreed at JCC
Maintaining financial controls
Clinical recruitment into CSD to support the delivery of H&T trajectory - 19% from 1st September
SP model focus on Cat 3&4
Develop clinically y lead dispatch model
Delivery of the HIOW SPOA to provide alternative response to sending an ambulance to Cat 3&4

Risks:

Delivery of CIPs
Establishment pressure - Numbers and geographical location
Financial controls

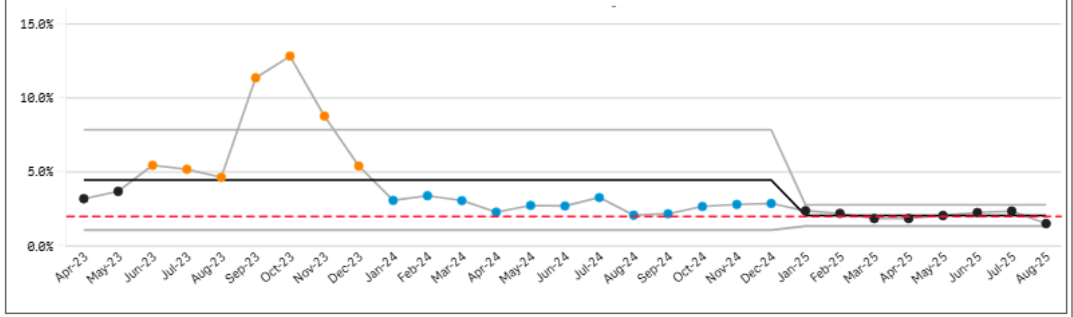
Operations - Operations Centre

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



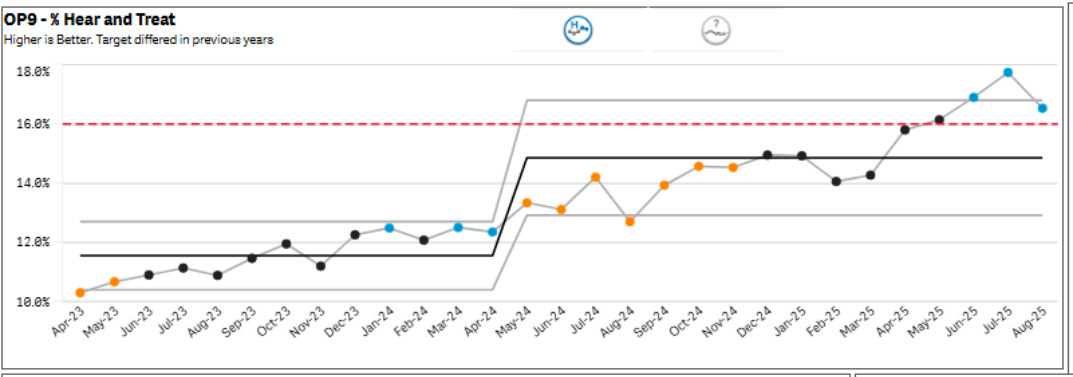
Variation	Assurance	Target	Latest
Expected	Random	00:00:10	00:00:06

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



Variation	Assurance	Target	Latest
Expected	Random	2.0%	1.6%

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



Variation	Assurance	Target	Latest
Improving	Random	16.0%	16.5%

Understanding the Performance:

Calls offered to SCAS telephony switch in August were 2.61% above plan, in addition we exported calls to SECAMB and other Trusts over IRP. Indicating that demand was well above planned levels despite a drop in duplicate calls due to improved ambulance resource availability. Logged in hours showed improvement against previous month supporting a strong call answer achieving 6 seconds. OP7 dropping below mean and target. Correspondingly OP 8 also achieved target.

Hear and Treat (OP9) levels remained above trajectory at 16.51%, with the team focused on increasing clinical workforce and embedding virtualisation process between north and south clinical support desk (CSD) teams.

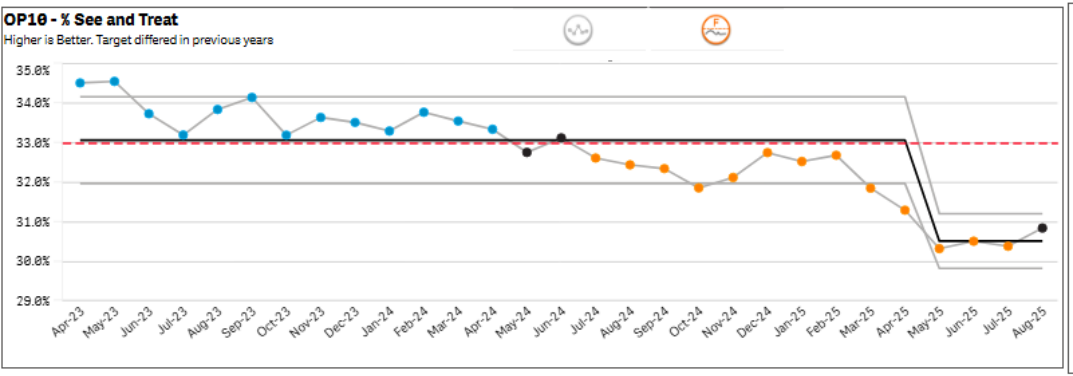
Actions (SMART):

Continue actions as detailed in CCC improvement/virtual care programme managed via monthly steering group meetings. This month particular focus on agreeing call flows for CAD queue changes to improve navigation/validation of category 3 & 4 calls as well as meet NHSE revised principals for category 2 segmentation.

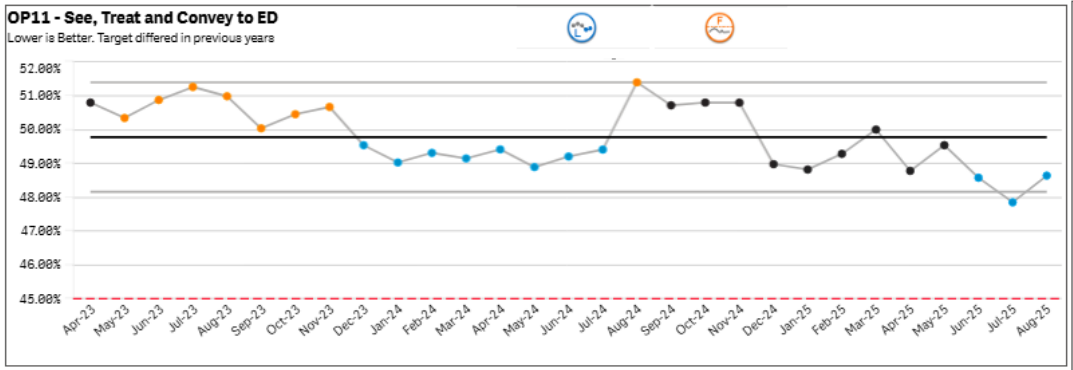
Risks:

If current CAD & finances prevent us from implementing necessary changes then we may be unable to improve AHT & manage clinical queues effectively, resulting in reduced operational efficiency & potential impact on patient outcomes. If there are significant variations in demand or reduction in staffing levels then we may struggle to maintain KPIs at target, resulting poor performance & increased pressure on staff. If cat 2 performance declines, duplicate calls may increase beyond plan, resulting in a negative impact on ability to sustain call answer performance at target. If financial pressures limit our ability to offer overtime/bank, then rota fill rates may decrease & overall capacity reduced, resulting in challenges in meeting rising demand &maintaining performance standards.

Operations - Utilisation



Variation	Assurance	Target	Latest
Expected	Fail	33.0%	30.9%



Variation	Assurance	Target	Latest
Improving	Fail	45%	48.7%

Understanding the Performance:

OP10 -S&T is showing a special cause variation of a concerning nature where the measure is lower than target. This is in line with the continued improved performance from H&T.

OP11 -ST&C to ED Transfers: This pathway demonstrates special cause variation of an improving nature where the measure is still below target. It is worth noting this measure has improved through July even with an increase acuity of incidents.

Actions (SMART):

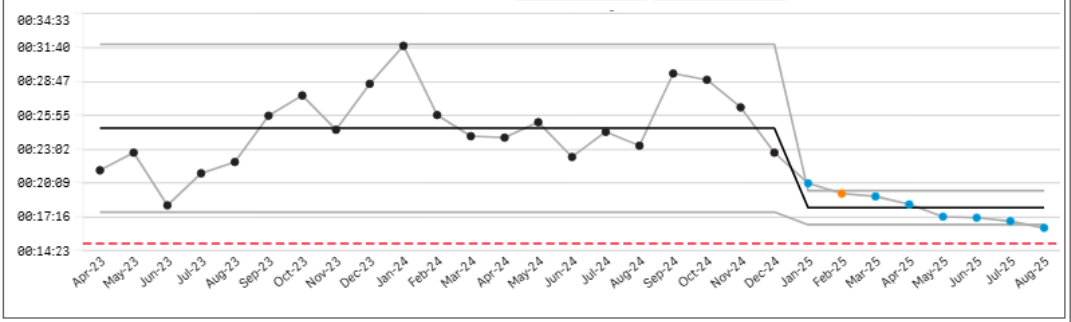
OP10&11 - The Clinical Pathways team will collaborate with acute and community services to identify and implement improvements that enhance access to appropriate care pathways for patients who do not require ED. Completion of a joint pathway review and gap analysis and published quarterly. This initiative supports system-wide objectives to reduce ED pressure, improve patient experience, and ensure timely access to the most appropriate care setting. Clinical oversight of a cohort of HCP calls to identify those where a specialist practitioner could attend with the aim of increasing S&T outcomes for these patients. Launch of a C2 SP deployment trial is currently progressing through governance pathways to S&T more of those patients.

Risks:

S&T and STC to ED have co-dependencies to the performance of H&T. A greater amount of H&T that doesn't take activity out of the system will have the potential to be a recontact and a STC to ED/Non ED

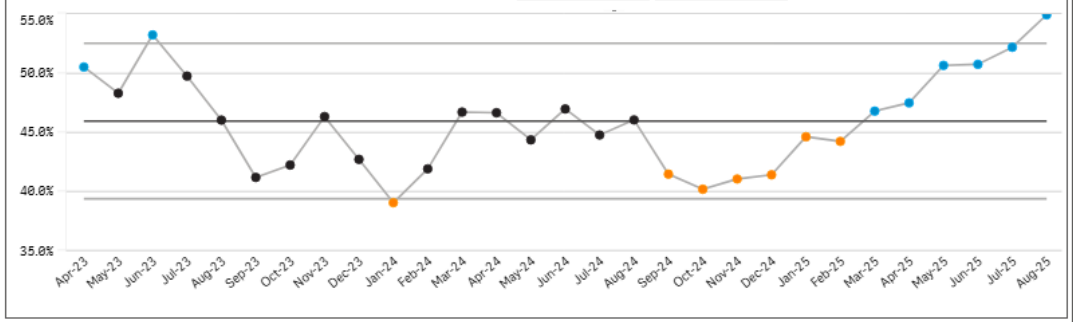
Operations - Utilisation

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



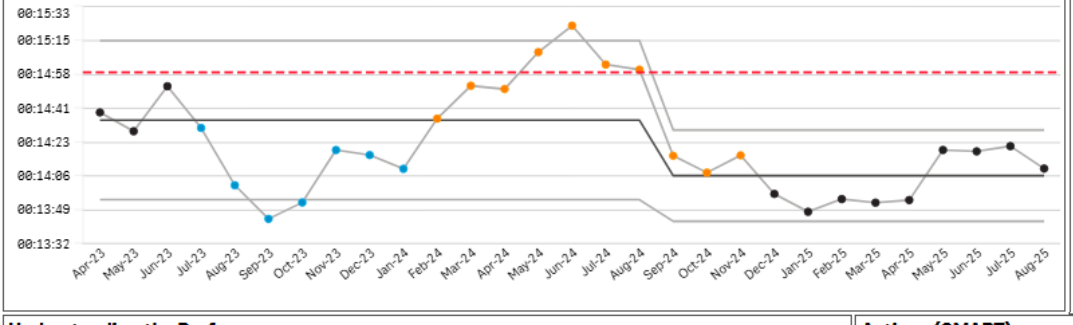
Variation	Improving
Assurance	Fail
Target	00:15:00
Latest	00:16:23

OP13 - Handover < 15 mins
Higher is Better. Target differed in previous years



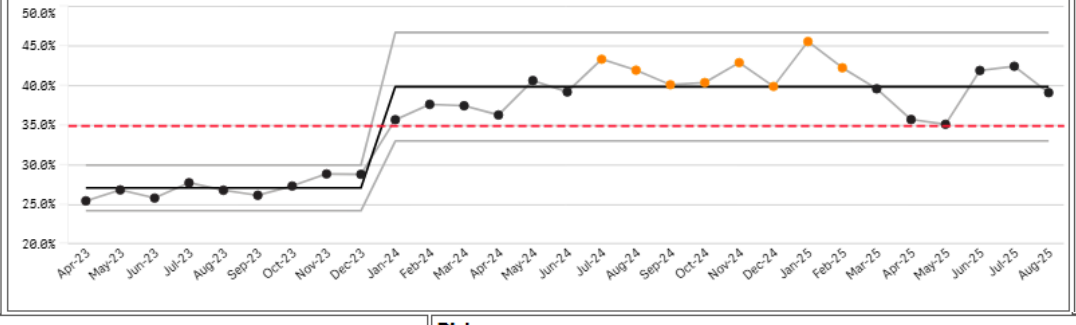
Variation	Improving
Assurance	Fail
Target	60%
Latest	54.9%

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



Variation	Expected
Assurance	Pass
Target	00:15:00
Latest	00:14:10

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



Variation	Expected
Assurance	Random
Target	35%
Latest	39.0%

Understanding the Performance:

OP12 - Average hospital handover time is showing a special cause of an improving nature and whilst not yet meeting the target it is significantly closer than it has been since 2023.
OP13 -%Arrival at hospital to handover < 15 mins continues to improve, with six points above the mean. This is linked to the general improvement in handover times seen over the last year.
OP14 - Clear up delays are showing common cause variation with little change and is consistently achieving the target.
OP15 - VOR remains volatile due to the significant increase in utilisation and mileage across the trust driven by the removal of private provision and the CAT 2 performance improvement plan - The trust is currently experiencing 8/9 additional VOR events daily when compared to April / May

Actions (SMART):

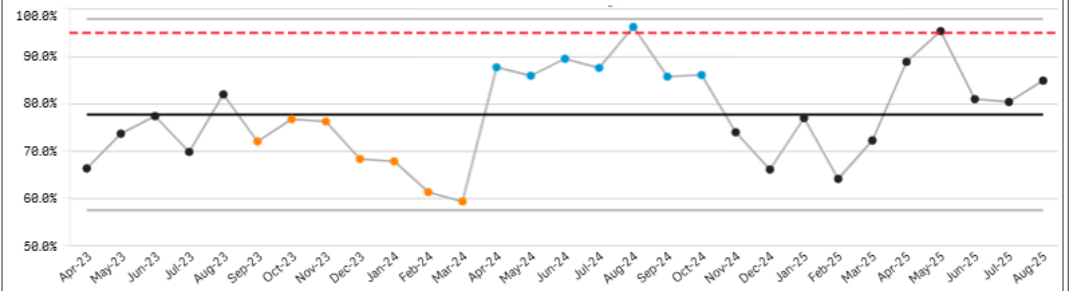
OP12 monitor through various lenses starting with ODPR and then through PMAF. Key focus for area teams to work with acutes to maintain this improving picture with aim of achieving 15mins
OP13 - Shift in performance linked to this raised and discussed with commissioners at PIIM. Message to acutes to focus on achieving 15min handover standard. Local area leaders tasked to address through place based delivery units. Handovers at individual acutes generally ahead of where planning assumptions had them but this is not following 15min handover in all cases
OP14 - Monitor through same governance meetings as handover delays. Local teams focused on what is in our direct control to influence
OP15 - VOR reduction plans in place - Aylesbury workshop and additional temp labour at Didcot workshop

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.
SCAS continues to work towards developing its workshop capacity to match its operational requirements, but due to cost constraints and lack of workshop capacity it is having to balance its response meaning that VOR rates fluctuate.

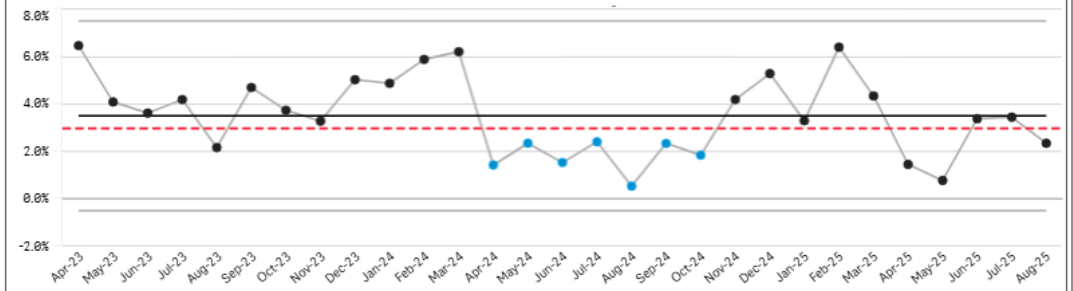
Operations - Operations Centre

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



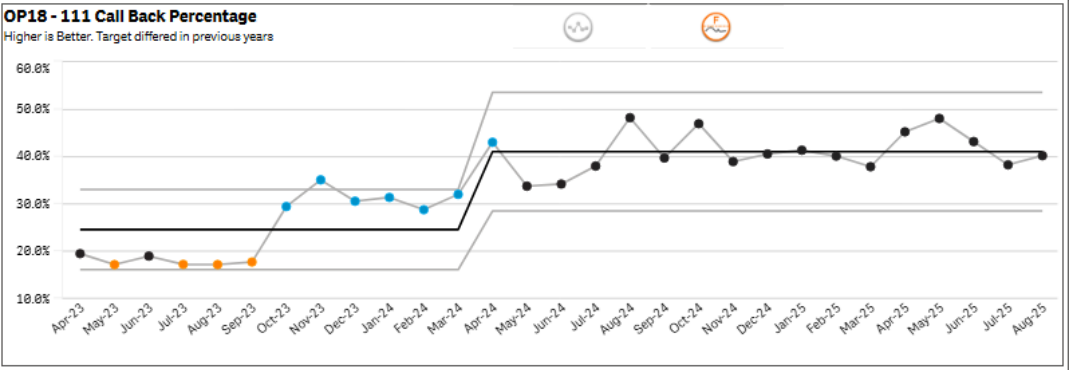
Variation	Expected
Assurance	Random
Target	95%
Latest	85.0%

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



Variation	Expected
Assurance	Random
Target	3%
Latest	2.4%

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



Variation	Expected
Assurance	Fail
Target	95%
Latest	40.0%

Understanding the Performance:

Calls offered in August decreased slightly from July driving an improvement in call answer performance (OP16) at 85.91% remaining above the mean. Correspondingly OP17 remained below the mean achieving target at 2.4%.

Actions (SMART):

- Recruitment continues to be monitored closely with weekly and monthly meetings, Health Advisor WTE at 236.78 remains below budgeted levels, with ongoing recruitment, training and coaching in place. Clinical Advisors at 72.18 WTE remain close to budgeted levels with a pipeline to ensure at establishment for winter.
- Interim care advice messaging continues to embed, with support to staff to encourage usage to support further reductions in AHT, monitored monthly via DOPR meetings.
- NLP project is underway with a drive to implement earlier than planned in Quarter 3. Progress monitored via monthly CCC virtual care steering group meetings.

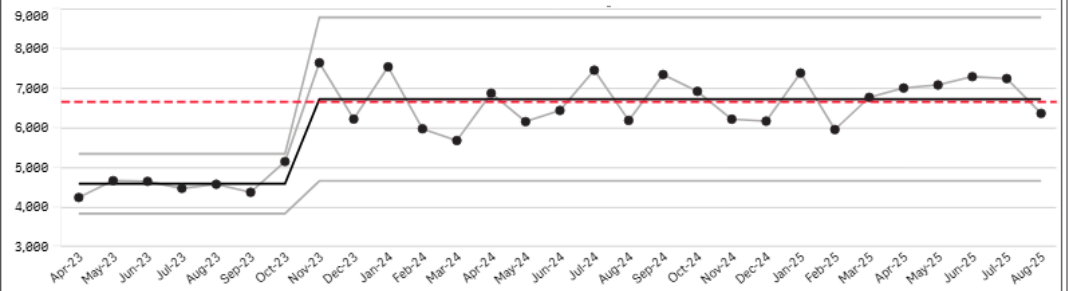
Risks:

- Risk in the reduction of Health Advisor overtime and bank hours to align rotas within financial restraints challenging service delivery and performance. If calls are not answered in a timely manner, then patients are at risk of long wait times and poor care resulting in additional pressure being placed on the system

Operations - PTS - Calls and Outcomes

OP19 - PTS Call Volume

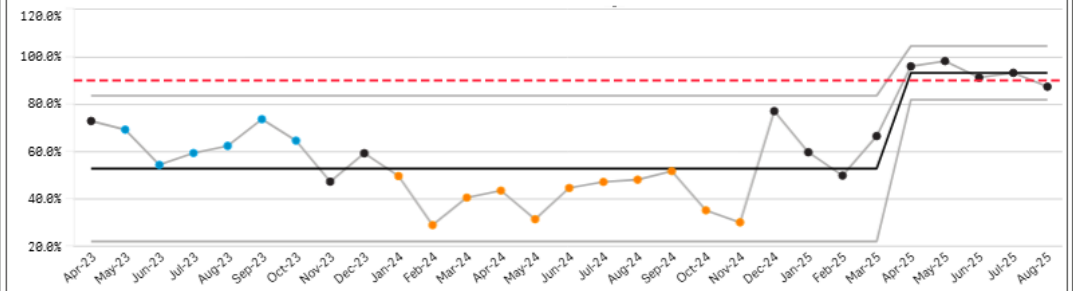
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	6,672	6,381

OP20 - PTS Calls Answered in 90 Seconds

Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	90%	87.6%

Understanding the Performance:

Call Answer performance achieving just below the threshold with August's outturn achieving 87.56% aggregated threshold for calls answered in 90 seconds, with call volumes reducing when compared to previous month as expected.

Actions (SMART):

Performance impact due to 22nd August where we had 3 call handlers report absence on the day, this was further impacted due to maximum annual leave already being approved. Absence monitoring continues daily with HR meetings embedded every three weeks.

Annual leave cap review underway with initial meeting taking place 5th September, this will lead to more work effective hours per day.

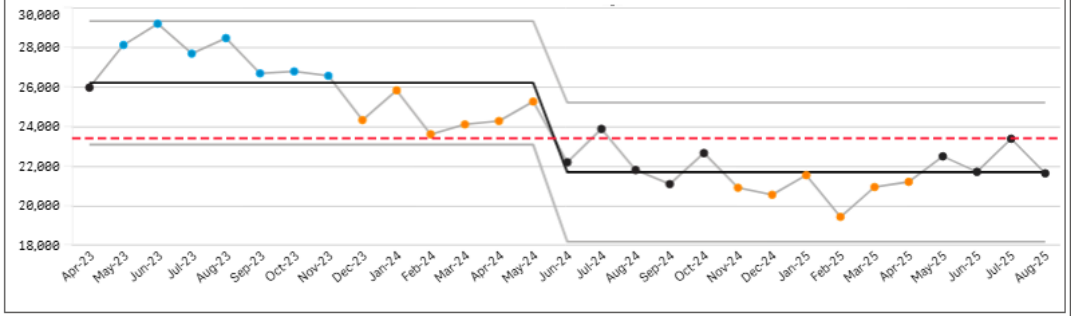
Telephony Journey Confirmations continue to capture any patients that are not travelling that have failed to inform us therefore reducing abortive journeys on the day.

Risks:

Above WTE headcount for Call Handling by 2.4 WTE which has reduced from 3.2 wte in last reporting period, with a further 3 operational re-deploys remaining in the contact centre.

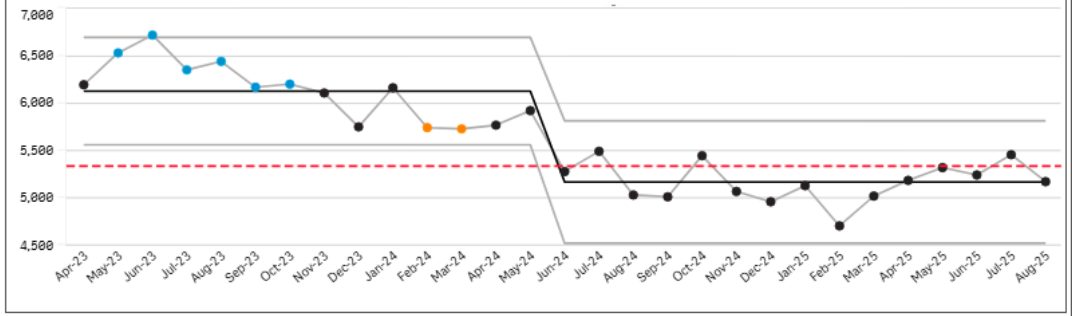
Operations - PTS - Calls and Outcomes

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



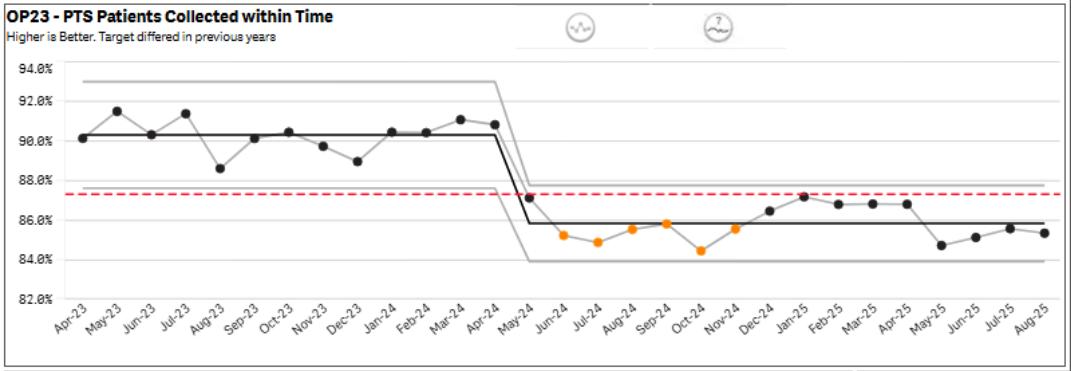
Variation	Expected
Assurance	Random
Target	23,414
Latest	21,667

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



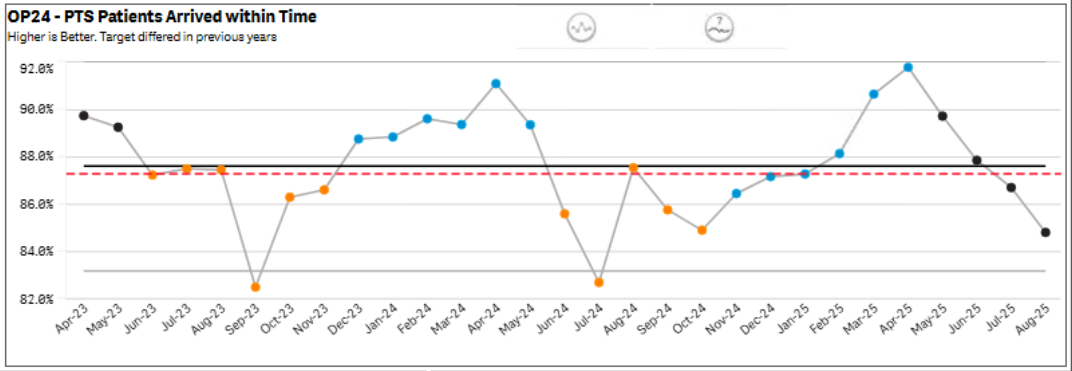
Variation	Expected
Assurance	Random
Target	5,332
Latest	5,176

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



Variation	Expected
Assurance	Random
Target	87%
Latest	85.3%

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



Variation	Expected
Assurance	Random
Target	87.3%
Latest	84.8%

Understanding the Performance:

Reduction in activity as expected during the month of August. We did see higher abstractions due to sickness and annual leave.
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 July.
The aggregated KPI shows MOM deterioration in performance which is mainly being driven across one contract due to increased journey distances and numbers of clinics, review of resources to the changes of demand underway along with working with system partners on clinic times to support cohorting and performance metrics.

Actions (SMART):

Continue to monitor daily demand, hours, resource utilisation and performance within budget
Focus remains on increasing of cohorting and utilisation of resource as per the finance recovery action plan.
Restricting bank hours to fall in line with the budgeted WTE.
Rota Review underway
Reviewing annual leave caps against station level.

Risks:

Close monitoring of both PTS Contracts activity required to ensure that it does not reach above capacity therefore impacting on patient movements, performance, financial pressures and reputation damage.
Changes to the IPC guidance has impacted on the amount of vehicle downtime thus reducing operational hours available for moving patients.
Stretcher replacement program underway to reduce high fleet costs. Will need to monitor any impact on patient movements as could led to cancellations of patients.

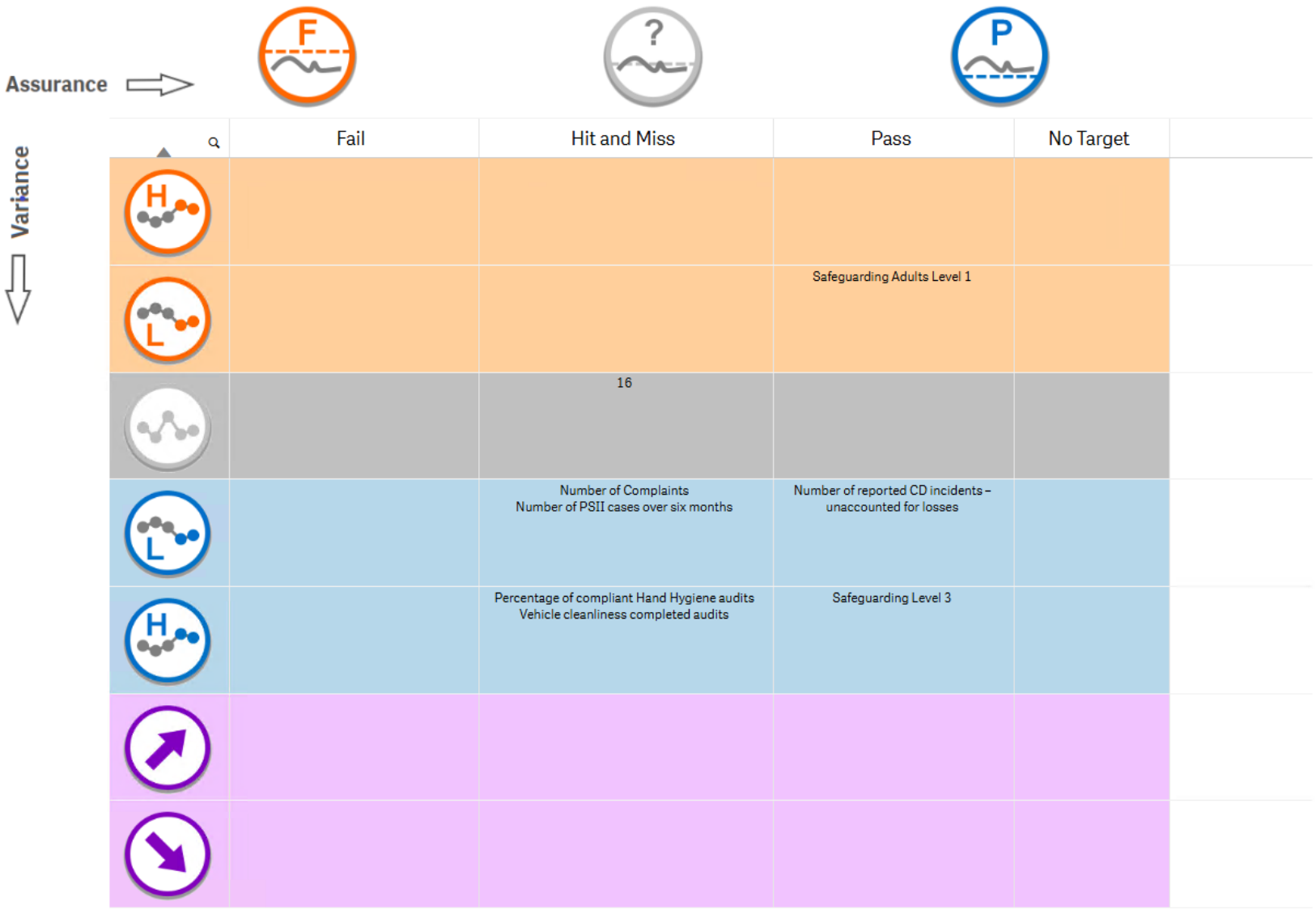
NHS

NHS
South Central
Ambulance Service
NHS Foundation Trust

Quality and Safety

Quality & Safety – Core Measures Matrix

August-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 PSI low/no harm ; Number of PSII declared in month ; Number of PSR declared in month ; Overdue Datix incidents ; 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

NHS 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.	Aug-25	447	450			440	337	544
Monthly PSII	Aug-25	3	3			2.41	-2.74	7.57
Monthly PSILR	Aug-25	5	9			8.65	-5.98	23.3
PSII Cases > 6 mths	Aug-25	0	0	L		0.235	-1.09	1.57
Datix incidents	Aug-25	16	15			16.9	-1.7	35.5
CD unaccounted for losses	Aug-25	0	2	L	P	0.556	-0.442	1.55
Level 1 Safeguarding	Aug-25	96.1%	95%	L	P	96.7%	95.9%	97.5%
Level 3 Safeguarding	Aug-25	94.8%	90%	H	P	92.9%	91.3%	94.4%
Complaints	Aug-25	12	37	L		32.2	8.02	56.5
Complaints in time	Aug-25	100.0%	95%			0.958	0.849	1.07
Hand Hygiene Audits Completed	Aug-25	288	261			228	-6.32	463
Hand Hygiene % Compliance	Aug-25	95.1%	95%	H		94.5%	75.8%	113.1%
Vehicle Audits Completed	Aug-25	210	167	H		150	14.7	286
Vehicle Audits % Compliance	Aug-25	90.5%	90%			89.5%	71.0%	107.9%

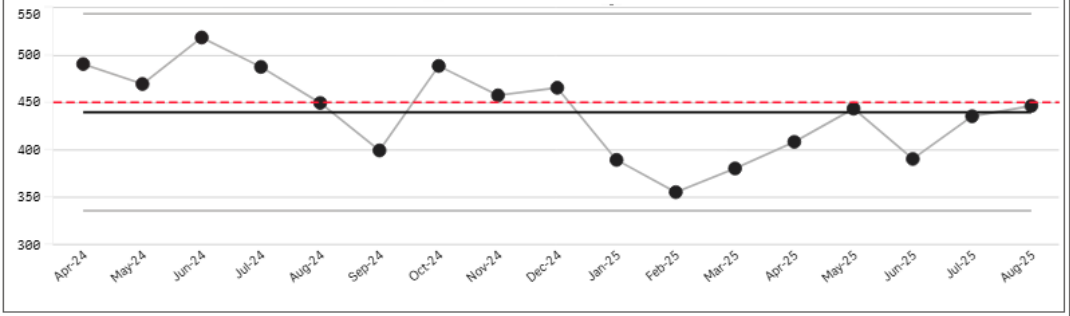
Quality Safety– Ambulance Quality Indicators (AQIs)

*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	Apr-25	02:26:00	02:30:00			02:17:31	01:51:28	02:43:33
STEMI 90th	Apr-25	03:29:00	03:20:00			03:22:04	02:00:30	04:43:39
Stroke Mean	Apr-25	01:29:00	01:30:00			01:34:46	01:16:09	01:53:23
Stroke Median	Apr-25	01:18:00	01:20:00			01:21:27	01:10:40	01:32:13
Stroke 90th	Apr-25	02:06:00	02:30:00			02:23:01	01:49:57	02:56:05
ROSC All	Apr-25	17.8%	25.8%			25.1%	13.3%	36.9%
ROSC Utstein	Apr-25	34.3%	48.4%			51.0%	19.7%	82.3%
CA Survival All	Apr-25	7.0%	8.9%			8.9%	1.0%	16.9%
CA Survival Utstein	Apr-25	20.0%	20.6%			31.0%	7.9%	54.1%

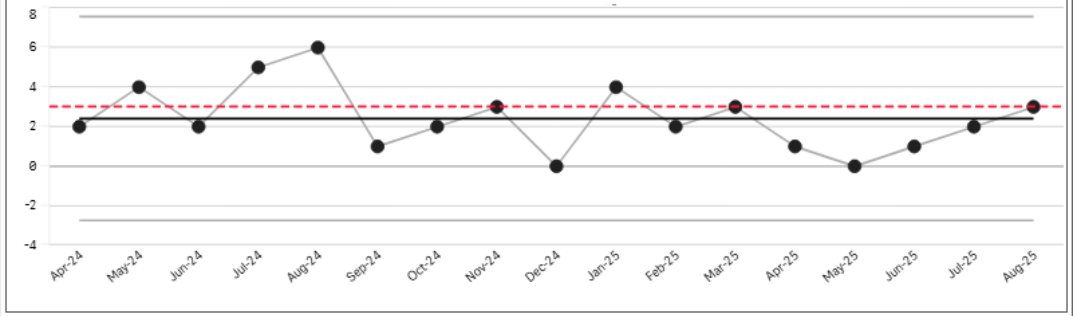
Quality & Safety – PSIRF

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



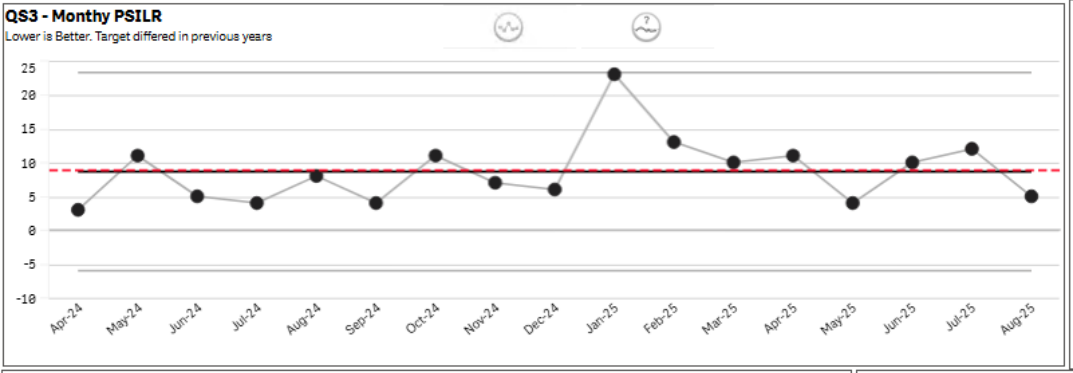
Variation	Assurance	Target	Latest
Expected	Random	450	447

QS2 - Monthly PSII
Lower is Better. Target differed in previous years



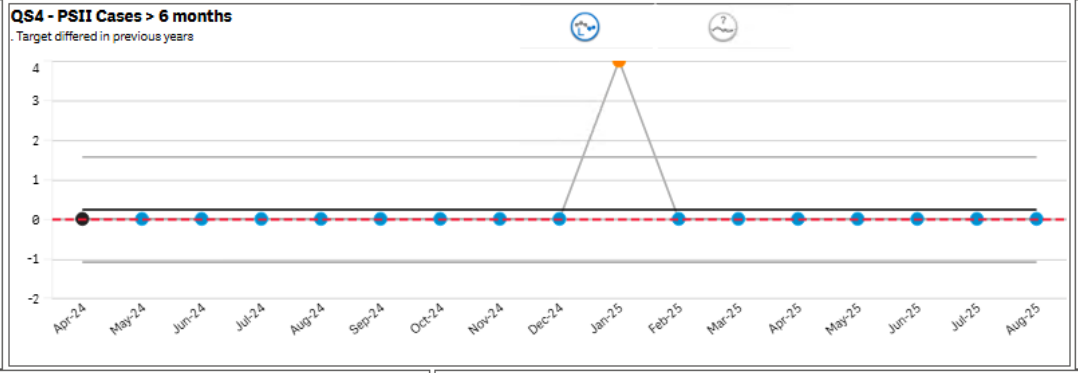
Variation	Assurance	Target	Latest
Expected	Random	3	3

QS3 - Monthy PSILR
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	9	5

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



Variation	Assurance	Target	Latest
Improving	Random	0	0

Understanding the Performance:

QS1 – High levels of reporting continue indicating a good safety culture. The majority of PSI reported remain low/no harm; there were 3 PSI reported as severe harm or death (3 of 458 = 0.65%) and 4 moderate harm (4 of 458 = 0.87%):

• One delay – to be reviewed as part of a further delay thematic analysis. This is to establish any new learning, and is the second thematic analysis to be completed.
• One issue with cardiac arrest care where fine VF may not have been shocked – Swarm huddle to be undertaken and reviewed at Safety Review Panel (SRP).
• One coroner's request for information – no further action required.

QS2- Categories for declared PSII:

• Delays.
• Non-conveyance.

Actions (SMART):

QS1 - The first iteration of the quarterly patient safety update report to be submitted to Q&S for review on 18 September 2025 and to EMC on 23 September 2025.

Patient Safety Incident Response Plan Version 2 (PSIRP2) to be reviewed at PSEG on 11 September 2025 for approval.

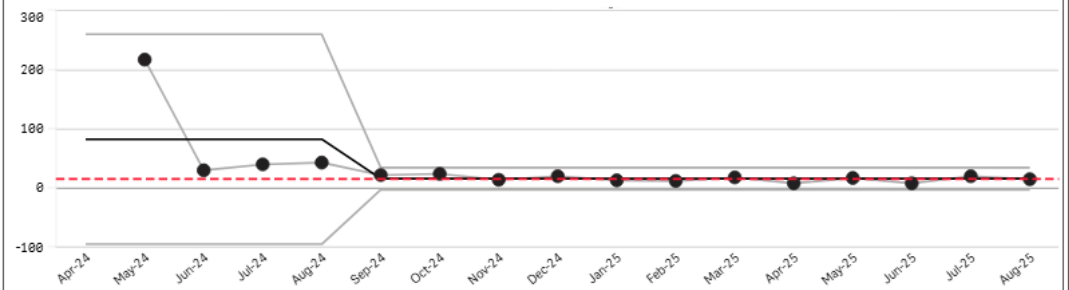
Risks:

QS1 – If the new 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

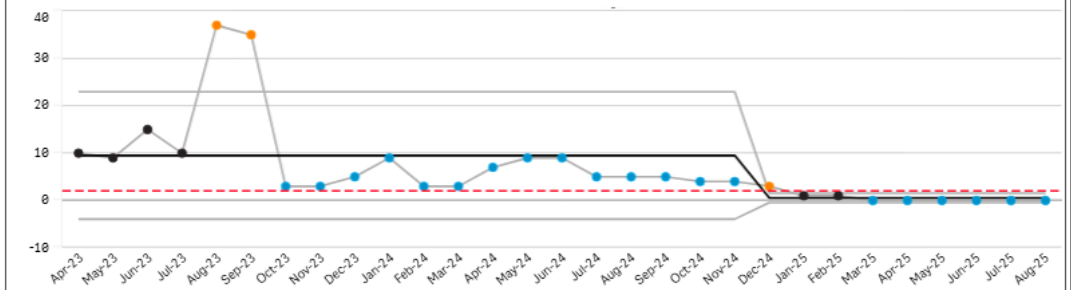
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	15	16

QS6 - CD unaccounted for losses

Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Improving	Pass	2	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. The Home Office Controlled Drugs Licence was received in May 2025.

Actions (SMART):

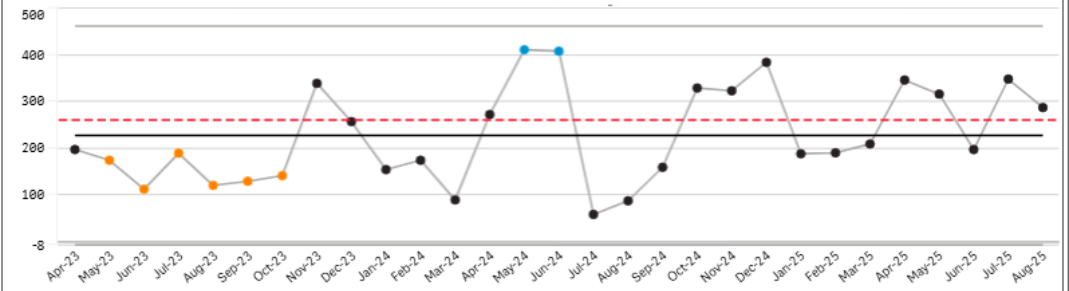
Training & Awareness
Ensure all staff fully trained on CD handling and reporting procedures by Q3
Conduct refresher courses every 6 months, reinforce documentation and reporting processes
Stock Control Measures
Implement daily stock checks at all facilities, validate CD quantities against recorded documentation by Q3
Discrepancies identified during stock checks investigated in 48 hours
Enhanced Reporting & Documentation
Improve DATIX detail to allow timely and comprehensive investigation of losses and CD Lin reporting by Q4
Implement electronic CD register improving oversight by Q1 26/7
Thematic Analysis & Diversion Control
Conduct quarterly thematic analysis, identify patterns or issues contributing to unaccounted losses
Work with Pharmacy Team to audit CD handling meeting 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.

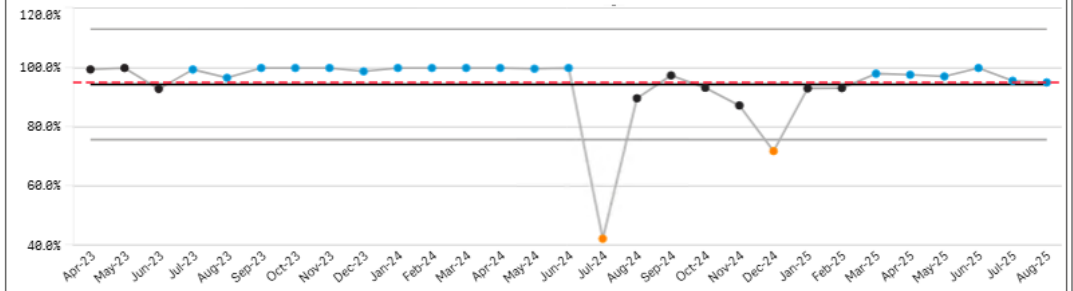
Quality & Safety - Audits

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



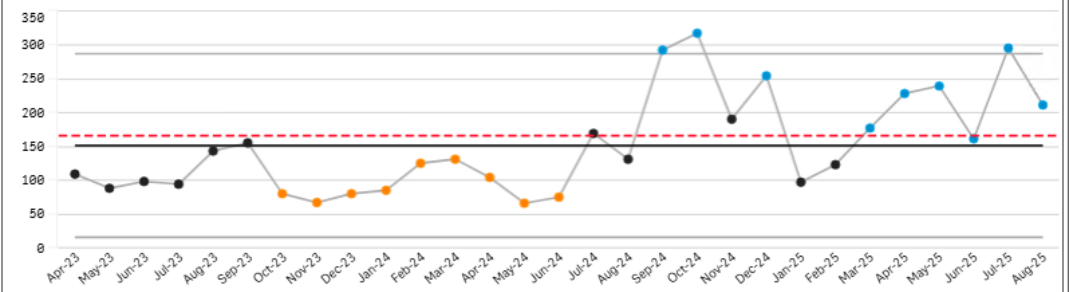
Variation	Assurance	Target	Latest
Expected	Random	261	288

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



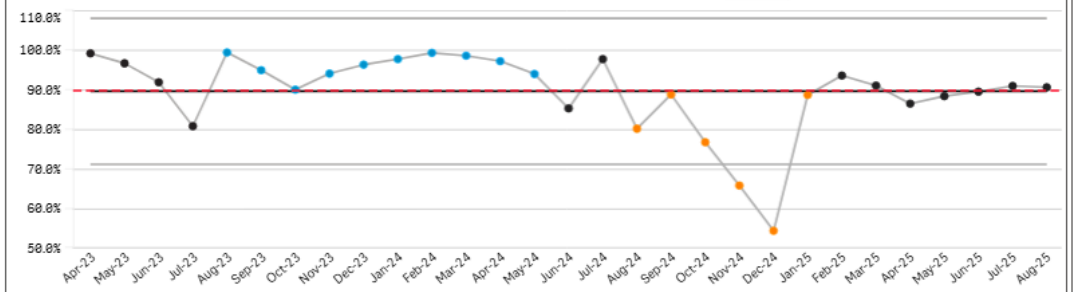
Variation	Assurance	Target	Latest
Improving	Random	95%	95.1%

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



Variation	Assurance	Target	Latest
Improving	Random	167	210

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



Variation	Assurance	Target	Latest
Expected	Random	90%	90.5%

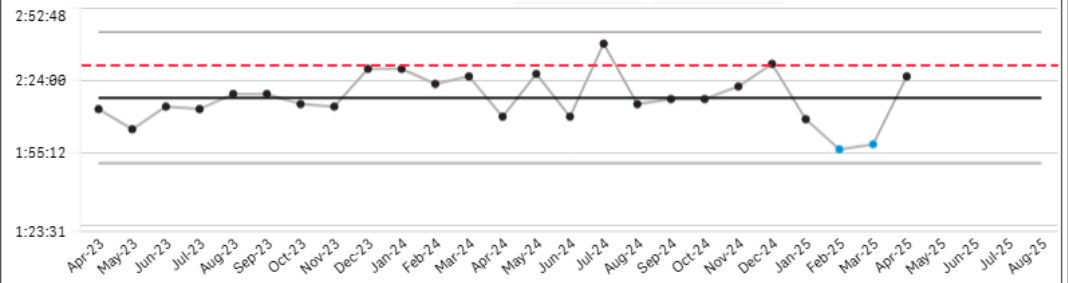
Understanding the Performance:
Indicator QS8 & 9 showing special cause variation with continued improvement and QS7 & 10 above target requirement. Improvement due to plan and actions that are in place.

Actions (SMART):
Monitoring will continue at service level and IPC Committee

Risks:
Not cleaning to standard or being non compliant with hand hygiene standards has the potential to affect patient care and patient safety

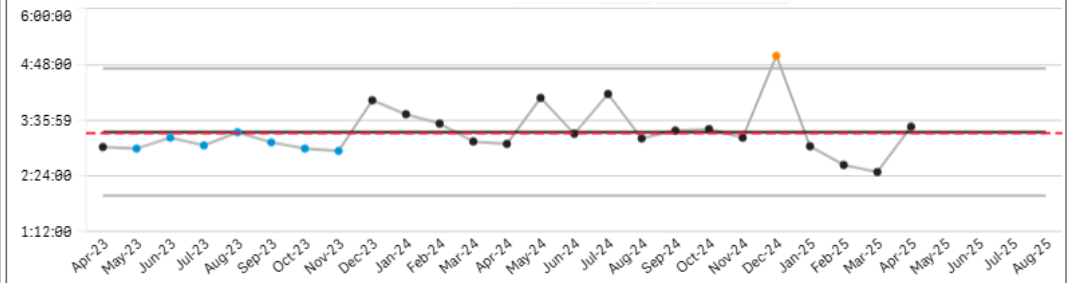
Quality & Safety – AQIs – STEMI (Heart Atack) - Chief Paramedic Officer

QS11 - Stemi, Call to Catheter Insertion Mean
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	02:30:00	02:26:00

QS12 - Stemi, Call to Catheter Insertion 90th Centile
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	03:20:00	03:29:00

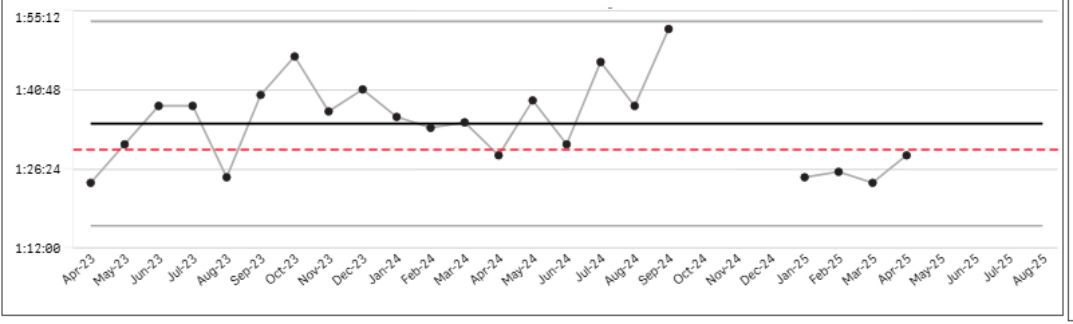
Understanding the Performance:
STEMI mean and 90th show good performance with results below the target.
Performance, while below the target, is tracking OP2, (Cat 2 mean) performance for the same time of year and may worsen over the next reporting cycles.
The metric encompasses the whole cycle until the insertion of the intervention, and therefore also includes Acute Trust activity.
The measures are performance based and are reliant on the Trust's ability to quickly get to scene and the ability of the clinicians to recognise STEMI and provide the required care.
For this month, SCAS is 6th of 11 reporting services for QS11 and 7th for QS12.

Actions (SMART):
The initial focus will be on stroke on Stroke performance metrics by individual incident continues before STEMI data will be developed.
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.

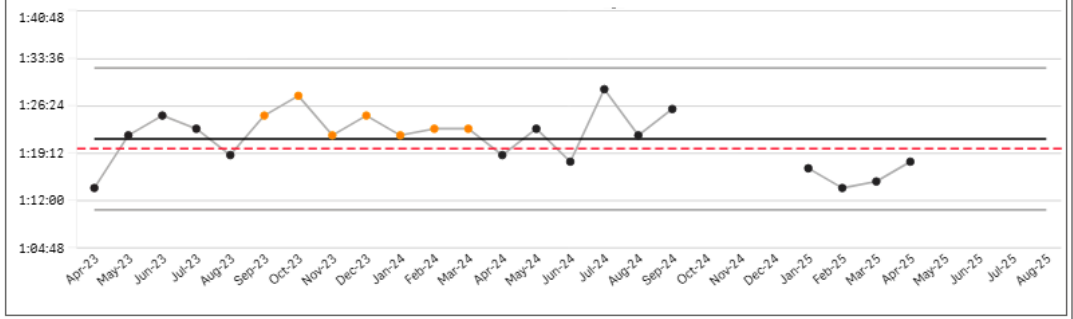
Quality & Safety – AQIs – Stroke - Chief Paramedic Officer

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



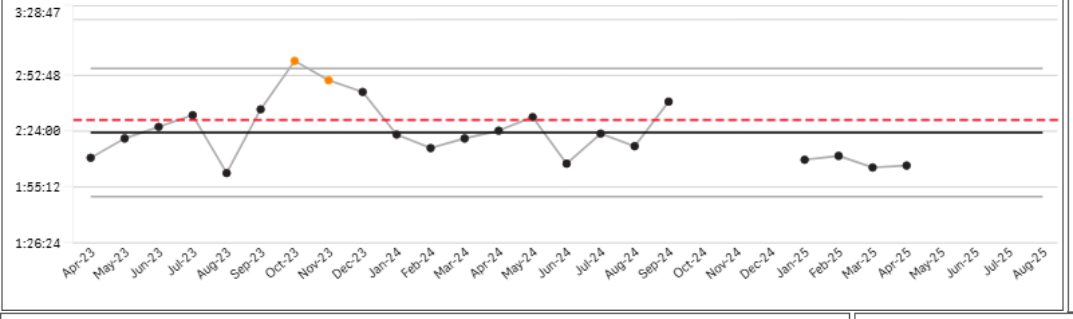
Variation	Assurance	Target	Latest
Expected	Random	01:30	01:29:00

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



Variation	Assurance	Target	Latest
Expected	Random	01:20	01:18:00

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



Variation	Assurance	Target	Latest
Expected	Random	02:30	02:06:00

Understanding the Performance:

April 2025 data shows that SCAS are below the target for each of the charts. 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.

OP2 metrics indicate a change in category 2 performance at this time. it is likely that these charts will track OP2 in future months.

Nationally, SCAS is 8th of 10 reporting services this month for QS13&14, and 5th for QS 15.

Actions (SMART):

Work continues towards mapping individual performance reports for patients presenting with Stroke. ACQI measures are being displayed at resource centres equipped with crew room monitors.

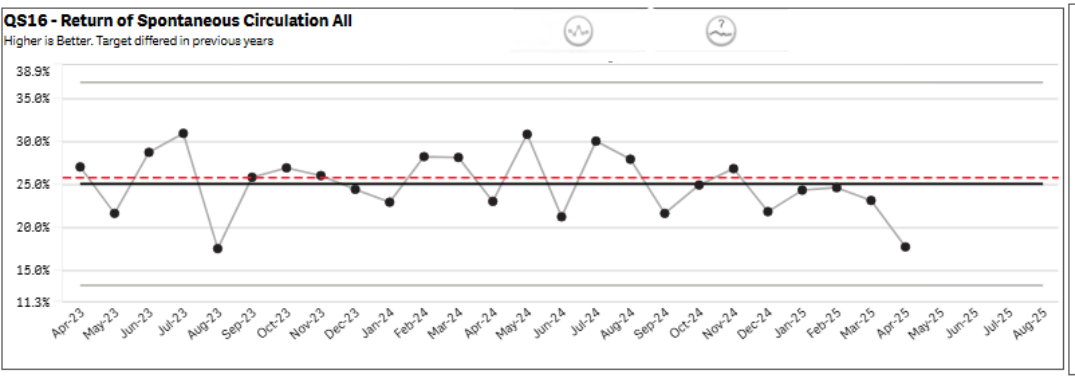
The Trust needs to continue to maximise vehicle availability to respond by reducing handover delays at Emergency Departments and focus on Category 2 response times (OP2).

Risks:

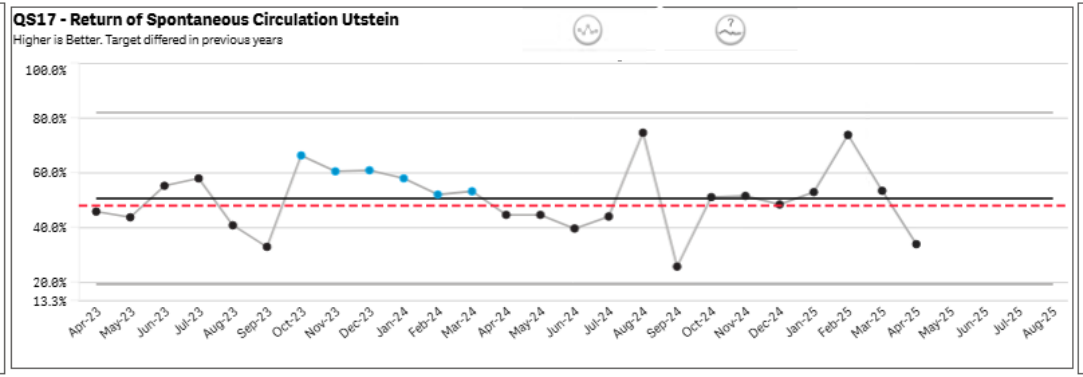
If timely care is not provided to patients with a stroke, then patients are at risk of poorer outcomes and death, resulting in avoidable harm.

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.

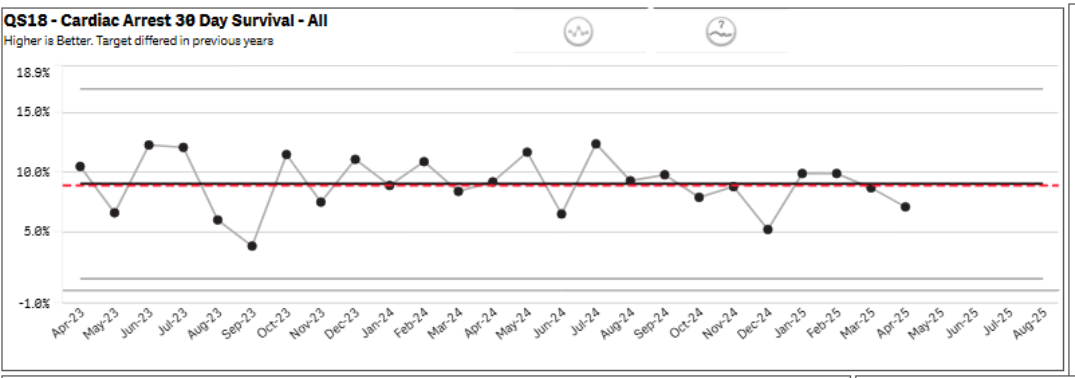
Quality & Safety – AQIs – Cardiac Arrest - Chief Paramedic Officer



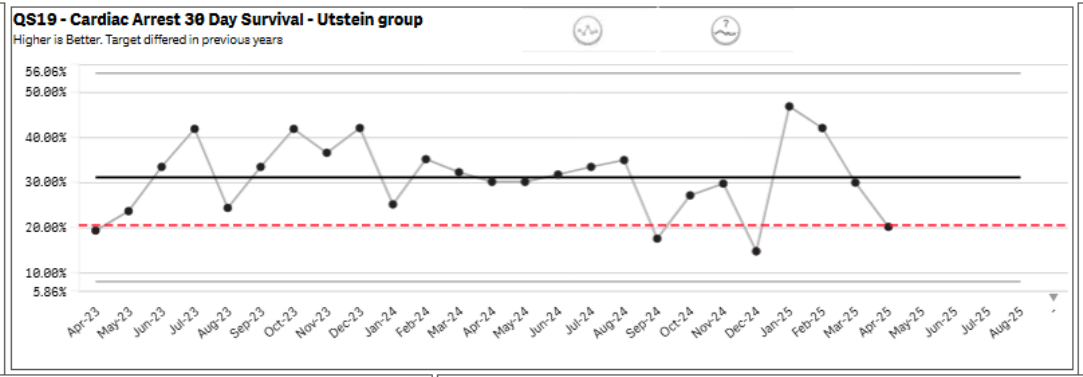
Variation	Expected
Assurance	Random
Target	25.8%
Latest	17.8%



Variation	Expected
Assurance	Random
Target	48.4%
Latest	34.3%



Variation	Expected
Assurance	Random
Target	8.9%
Latest	7.0%



Variation	Expected
Assurance	Random
Target	20.6%
Latest	20.0%

Understanding the Performance:

QS 16, 17, 18 and 19 all show common cause variation, with all except QS19 below the target. National data shows that SCAS are 9th of 10 services in all cardiac arrest survival at 30 days (QS18), and 9th of 10 services in Utstein 30-day survival.

Cardiac arrest metrics are reliant on identification of cardiac arrest in the community, rapid call-answering (OP7), Category 1 response times (OP1) and 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 Q3 2025/2026 a comprehensive resuscitation outcomes improvement plan.

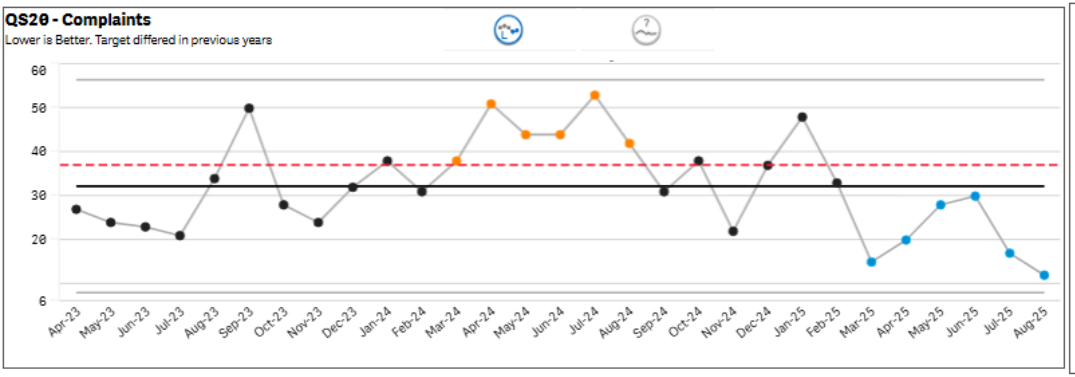
Introduction of the GoodSam app, with go-live on19/6/25 for professional responders.

To ensure that rapid call answering occurs (OP 7) and Category 1 response times are optimised (OP 1).

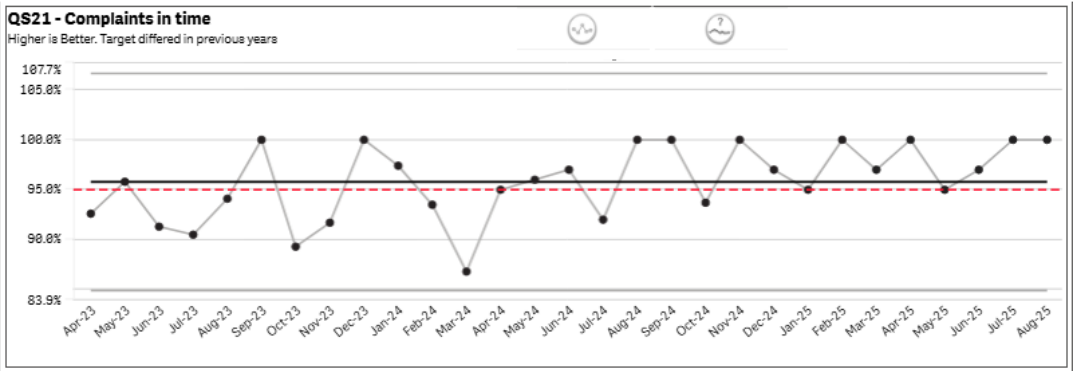
Risks:

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



Variation
Improving
Assurance
Random
Target
37
Latest
12



Variation
Expected
Assurance
Random
Target
95%
Latest
100.0%

Understanding the Performance:

QS20 - Concerns decreased from 77 to 64 during the reporting period
88 compliments were received for the same period.
25% of concerns were in reference to attitude and customer care,
20% were about delays.

Actions (SMART):

QS20 - Operational colleagues to work with the People directorate to establish what training and support provision is available to staff involved in attitudinal complaints and concerns.
The patient safety team are undertaking targeted safety improvement work with regard to delays. Please see QS1.

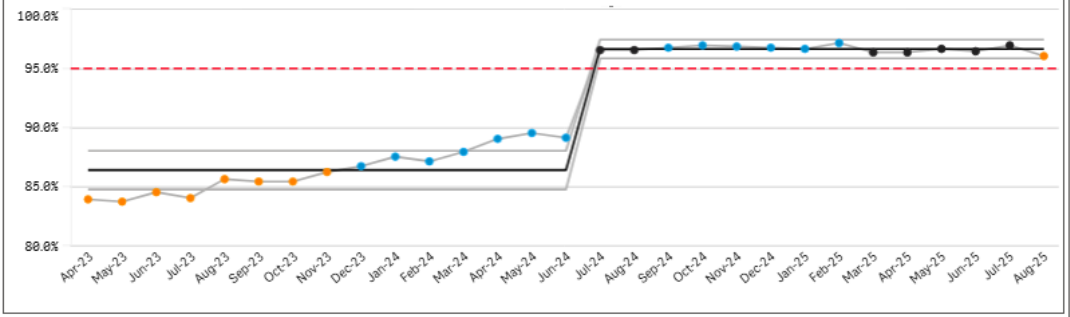
Risks:

QS20 – Non-compliance with contractual timescales.

Quality & Safety – Safeguarding and Patient Experience

QS22 - Level 1 Safeguarding

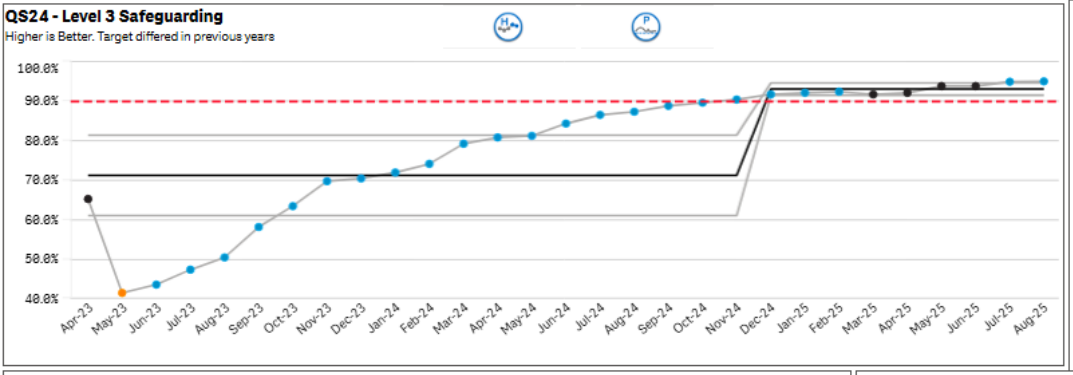
Higher is Better. Target differed in previous years



Variation	Declined
Assurance	Pass
Target	95%
Latest	96.1%

QS24 - Level 3 Safeguarding

Higher is Better. Target differed in previous years



Variation	Improving
Assurance	Pass
Target	90%
Latest	94.8%

Understanding the Performance:

Safeguarding Adults L1 - 98% Safeguarding Adults and Children L3 - 95%

Actions (SMART):

Training plan to continue. Monitoring will be at service level and at the Safeguarding Committee.

Risks:

Without sufficient safeguarding knowledge or training, staff may fail to recognise or respond appropriately to signs of abuse or neglect.

NHS

NHS
South Central
Ambulance Service
NHS Foundation Trust

People

August-25 Summary

Metrics:

Assurance →

Variance ↓

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

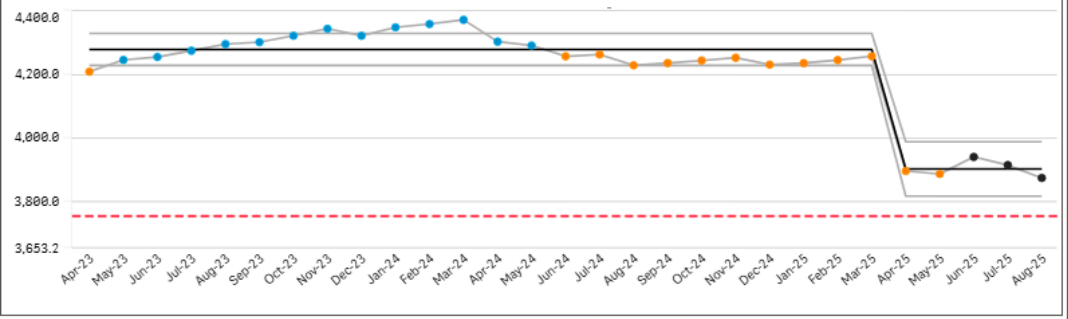
People - WTE, Availability, Staff Compliance, Staff Welfare

*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	Aug-25	3,875	3,753		P	3903.5	3818.1	3988.9
% Turnover	Aug-25	15.1%	17.70%	L	P	16.6%	15.7%	17.5%
% Vacancy	Aug-25	-3.3%	0.20%		P	-4.0%	-6.3%	-1.7%
Time to hire	Aug-25	77	84		?	112.6	26.2	199.1
% Trust staff who are BAME	Aug-25	7.8%	8.86%	L	F	8.3%	7.8%	8.7%
% Trust staff who are declared disabled	Aug-25	10.7%	9.54%	H	P	10.1%	9.7%	10.6%
% Sickness in month	Aug-25	6.2%	6.20%		?	6.8%	5.1%	8.5%
% Long term sickness	Aug-25	3.8%	3.50%		?	4.0%	3.0%	4.9%
% DBS Compliance	Aug-25	98.0%	95.00%		?	97.3%	95.0%	99.6%
Appraisals - Trust	Aug-25	83.6%	95.00%	L	F	86.9%	82.9%	90.9%
FTSU Cases	Aug-25	14			n/a	15.4	0.5	30.3
Meal Break Compliance - SCAS	Aug-25	74.0%	85%		F	71.8%	62.0%	81.6%
Over-runs >30 mins - SCAS	Aug-25	13.8%	15%	L	?	17.6%	12.2%	22.9%

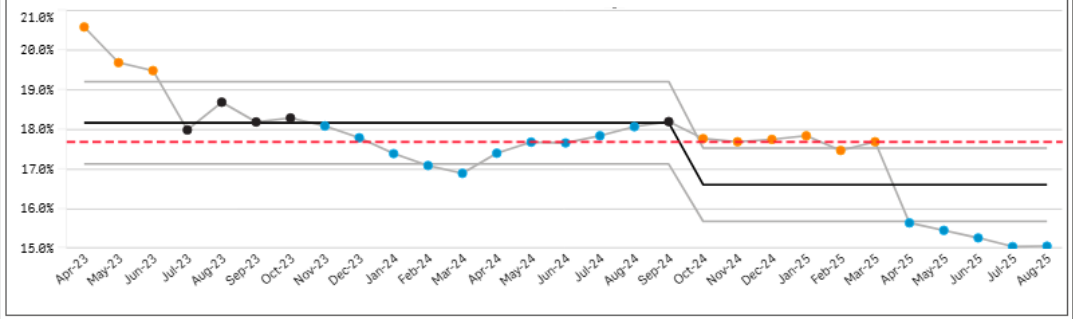
People - Workforce/WTE

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



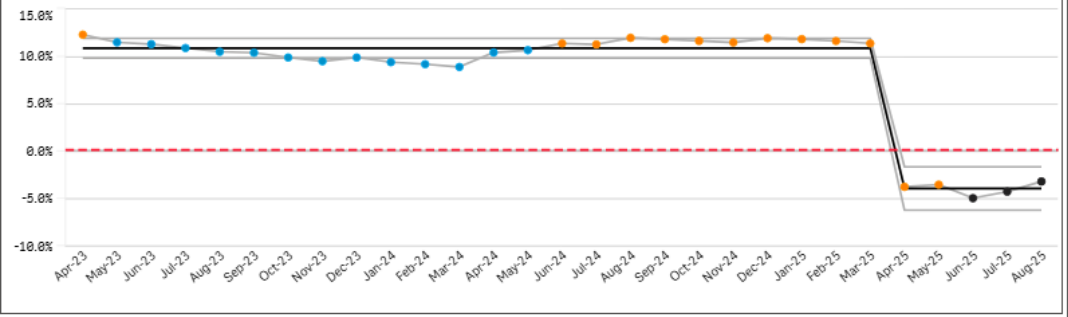
Variation	Assurance	Target	Latest
Expected	Pass	3,753.15	3875.4

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



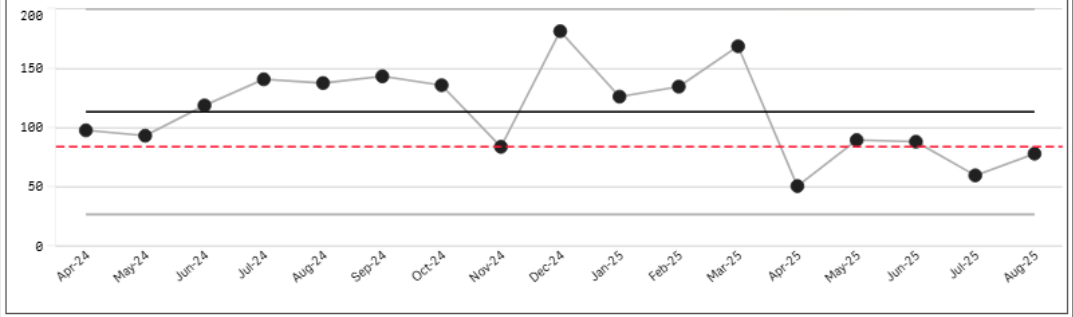
Variation	Assurance	Target	Latest
Improving	Pass	17.70%	15.1%

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



Variation	Assurance	Target	Latest
Expected	Pass	0.2%	-3.3%

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



Variation	Assurance	Target	Latest
Expected	Random	84	77.3

Understanding the Performance:

P1 (WTE) - Overall reduction of 40. 999 fell by 24 / EOC increased by 7 / 111 fell by 16 / PTS fell by 2 / CORP fell by 9
P2 (T/O) - 12 month rolling turnover continues to improve and is 3 percentage points better than plan. 999 = 8.3% / EOC = 24.4% / 111 = 27.3% / PTS = 20.2% / CORP = 14.2%
P3 (Vacancy) - 999 = 58.4 over establishment / EOC = 11.4 vacancies / 111 = 38.7 vacancies / PTS = 44.5 vacancies - although PTS establishment is under review
P4 (TIME TO HIRE) - median TTH is 77 days, which is an increase on previous months, but still below the 84 day target. Continued minimal recruitment means extremes will be starker.

Actions (SMART):

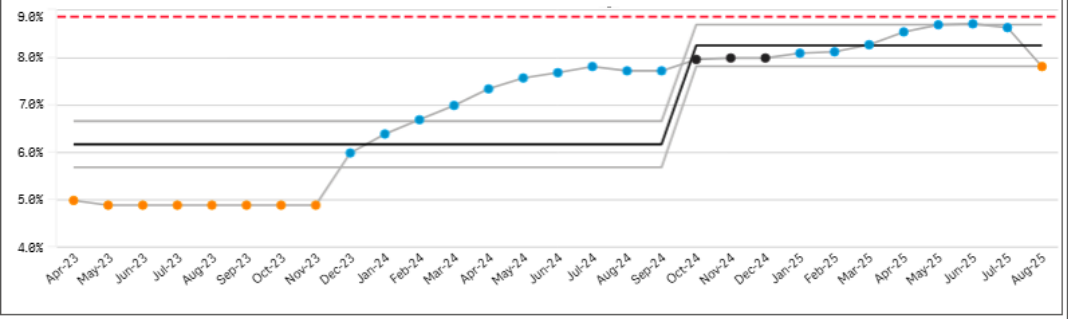
P1 (WTE) - all 999 and PTS WFP recruitment remains frozen and we should continue to see reduction in WTE due to attrition.
P2 (T/O) - turnover remained stable in part due to continuation of staff engagement plans impacting positively on retention.
P3 (Vacancy) - tightening controls around increasing hours and strict vacancy control measures remain in place, which contributes to the slightly increased vacancy rate.
P4 (TTH) – Time to hire remains below the 84 day target, although hard to gauge impact of very low recruitment numbers.

Risks:

P2 (T/O) – we continue to monitor the external job market for changes, although this remains flat for now.
P3 (Vacancy) - if sudden increase in attrition, possible gap in filling vacancies due to Recruitment and Education timelines.
P4 (TTH) - median figure masking anomalies.

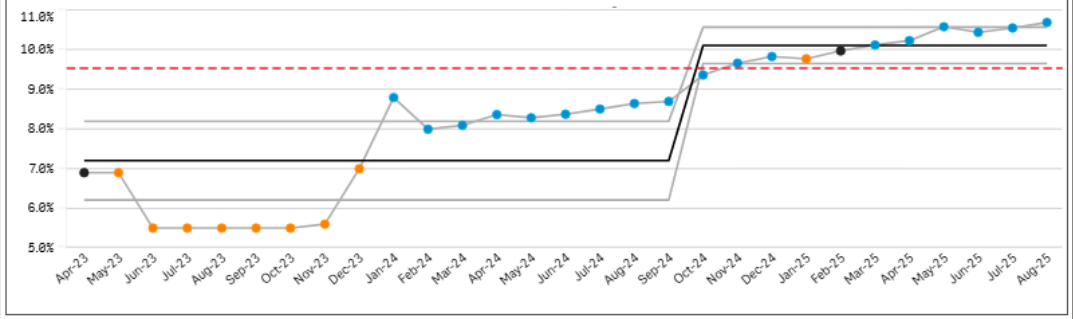
People - Workforce/Availability

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



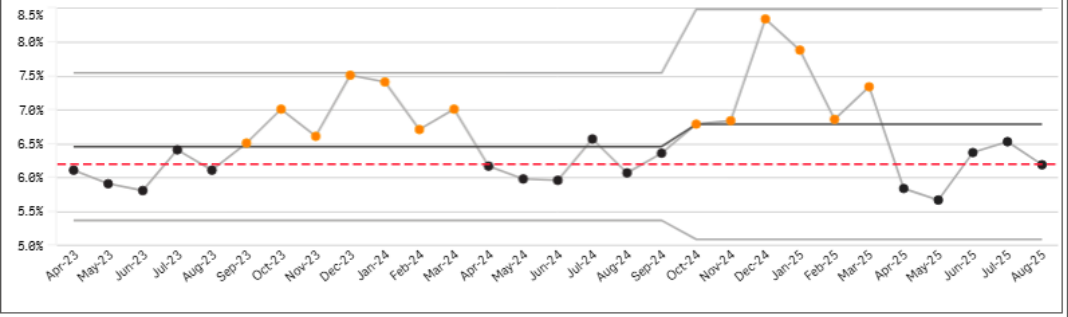
Variation	Declined
Assurance	Fail
Target	8.9%
Latest	7.8%

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



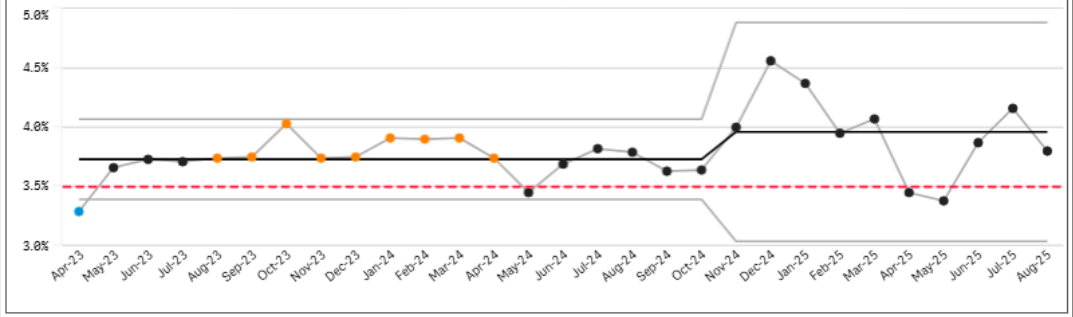
Variation	Improving
Assurance	Pass
Target	9.5%
Latest	10.7%

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



Variation	Expected
Assurance	Random
Target	6.2%
Latest	6.2%

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



Variation	Expected
Assurance	Random
Target	3.5%
Latest	3.8%

Understanding the Performance:

P5 - BAME fell by 0.8% in M5. This is under investigation as this fall is significantly below trend.
P6- Disabled staff as a % of the total workforce continues to rise. Disclosure rates for new starters and staff updating their ESR Employee self service has improved.
P7 - Trust Sickness improved in M5 and met 6.2% target. 999 = 6.4% / EOC = 5.1% / 111 = 7.5% / PTS = 7.4% / CORP = 3.3%
P8 - Long Term Sickness is 3.79% and is above target of 3.5%. 999 = 3.9% / EOC = 1.9% / 111 = 4.3% / PTS = 4.7% / CORP = 2.4%

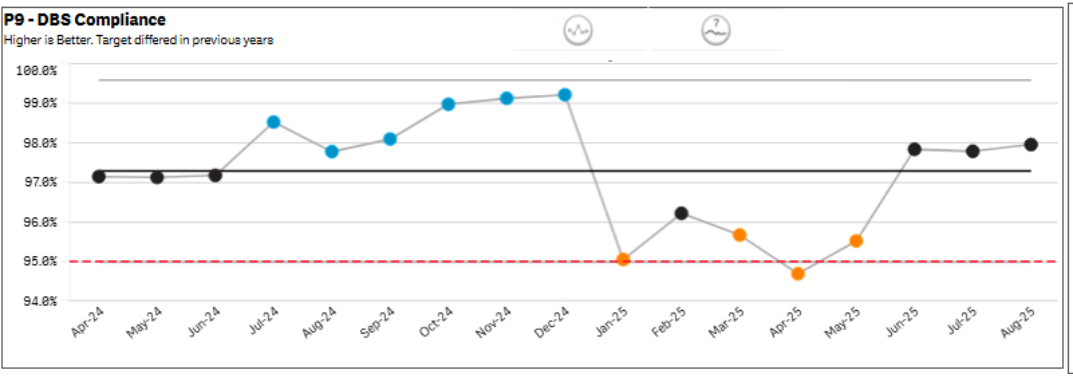
Actions (SMART):

P7 & 8 - With the ER team now fully established greater support is in place to assist managers in managing their absence cases, toolkits and training sessions launching in September. The flu vaccination programme will be promoted across the organisation as we head into the winter months to help prevent absences and the health and well being team continue to promote and provide services for staff to assist in prevention of illness and injury.

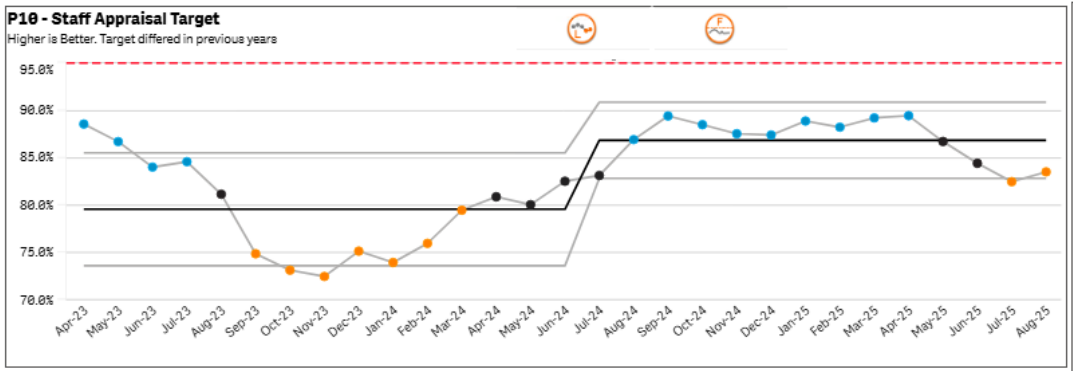
Risks:

P7 & 8 - As we head towards winter months absence is naturally more likely to increase due to the prevalence of season illnesses.

People – Workforce/Staff Compliance



Variation	Assurance	Target	Latest
Expected	Random	95.0%	98.0%



Variation	Assurance	Target	Latest
Declined	Fail	95.0%	83.6%

Understanding the Performance:

P9 - DBS compliance remains above target and all areas are better than the 95% target

P10 - PDR - At 83.4% we saw a slight improvement in M5, but is still below 95% target. 999 = 87.7% / EOC = 82.9% / 111 = 90.8% / PTS = 84.8% / CORP = 65.4%

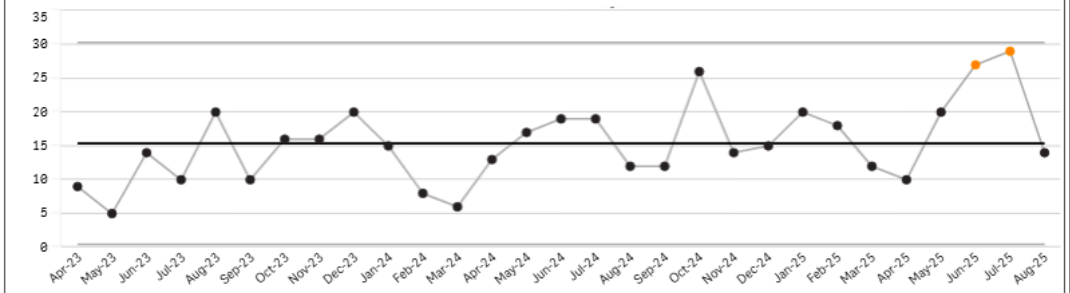
Actions (SMART):

P9 - the team have minimal staff outstanding DBS (predominantly those on career breaks and LTS). We are now completing renewals through to December due dates so expect to see compliance remain high.

Risks:

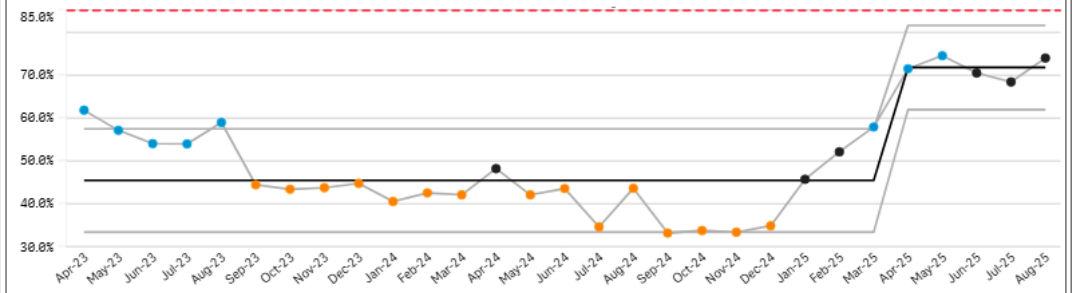
People - Workforce/Staff Welfare

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



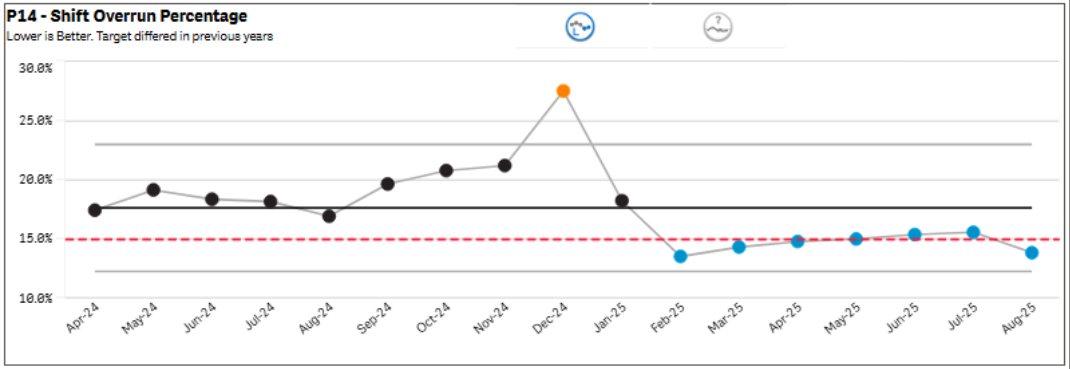
Variation	Assurance	Target	Latest
Expected	-	-	14

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



Variation	Assurance	Target	Latest
Expected	Fail	85%	74.0%

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



Variation	Assurance	Target	Latest
Improving	Random	15%	13.8%

Understanding the Performance:

P13 - Is tracking along the mean, although remains off target. Maintaining current compliance and delivering against target is put under further pressure due to the movement of resources.
P14 -Over runs greater than 30mins - is showing a common cause variation showing no particular change and is tracking against target. FTSU : Case numbers reduced in August, consistent with seasonal variation linked to annual leave. No indication that this reflects reduced willingness to speak up. Themes remain stable, with behaviours and systems/process the most common.

Actions (SMART):

P13 - Collaboration with Unions to review meal break policy has led to a paper that has been supported through Ops Group and JCC will see staff being placed on break at the nearest SCAS facility with the and not routinely returned to a home RC. It will improve compliance and operational efficiencies.
P14 - Task and finish group established to review end of shift procedures by end September 25, 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.
FTSU continues to provide a vital channel for raising concerns. Sustained focus on culture, responsiveness, and visibility of actions essential to embed trust and ensure concerns contribute to continuous improvement.

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.
FTSU: The main risks remain under-reporting due to fear of reprisal, and delays in resolving complex cases. Mitigations include improved escalation routes, closer monitoring of case closure times, and staff wellbeing support.

NHS
South Central Ambulance Service
NHS Foundation Trust

Trust Board of Directors Meeting in Public 25 September 2025

Report title	Chief Medical Officer's Board Report
Agenda item	11
Report executive owner	John Black, Chief Medical Officer
Report author	John Black, Chief Medical Officer 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:

- SCAS Clinical Research Update

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. Detail

Clinical Research update - September 2025

Current research study recruitment (data cut 1st September 2025):

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

- Spinal Immobilisation Study (**SIS**): 47 patients
- Early surveillance for type 1 diabetes in children (**ELSA**): 182 children
- Tranexamic acid for mild head injury in older adults (**CRASH-4**): 23 patients. SCAS has now recruited over 500 patients and is now one of the highest recruiting NHS organisations in England.
- Randomised trial of clinical and cost effectiveness of Administration of Prehospital fascia Iliaca compartment block for emergency hip fracture care Delivery (**RAPID-2**): 3 patients.
- Understanding prostate cancer stigma in black men (**Destigmatise**): 1 patient.

The Department of Health and Social Care is requesting additional data on commercial study set-up times. Two new Key Performance Indicators (KPIs) were introduced:

- The proportion of commercial contracts open to recruitment within 60 days of Health Research Approval Letter.
- The proportion of studies recruiting the first participant within 30 days.

Although SCAS are not currently recruiting to any commercial studies, it is our ambition to include commercial studies in our portfolio. Additionally, with our involvement in the Wessex Commercial Research Delivery Centres, these set-up times will become more relevant as SCAS-suitable research projects come on-board.

New (external) studies opening:

- DeStigmatise. A community-based study targeting Black men, aiming to reduce stigma around mental health and improve engagement with services.
- Genes & Health. Community project that looks at how our genes affect our health specifically within British Bangladeshi and British Pakistani communities. This study has the potential to help address health inequality outcomes in the future.

Internal projects underway:

- Audit of out-of-hospital cardiac arrest in prisons underway. To support development of grant application.
- Chief Pharmacist's MBA research project on Medicines Legislation. A qualitative study aiming to ascertain how UK medicines legislation can be adapted to better support the clinical / operational needs of community care providers including ambulance clinicians.

Studies closing:

- HARMONIE trial. Final documents being requested now. Due to close shortly. SCAS was 14th highest recruiting site in the UK.

Two staff members' research abstracts selected for poster presentation at 999 EMS Research Forum later this month. Topics: CPR-induced consciousness; Informing relatives of non-surviving patients of research inclusion.

Grant applications awaiting outcome:

- 111 AI triage project (Visibar & University of Oxford). Project to improve call handling time and user experience. Co-applicants.
- SAMURAI-ECG (Oxford University Hospitals, in collaboration with Oxford University) Evaluation of how artificial intelligence (AI) can support and improve the interpretation of ECGs in clinical settings. Co-applicants.

Research Governance priorities:

a. Data sharing agreement for service evaluation/research between SCAS & HIOWAA (UHS) – still awaiting final sign-off.
b. We have now established a more streamlined process for signing research agreements.
c. We have successfully recruited a Research & Innovation manager, due to start 1st Dec. She brings substantial experience and will support research governance activities such as the supporting our ambition to become a research sponsor.

- **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 and growth of the SCAS research team.

- **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 trial recruitment to our patients (and staff) and to expand our offering across a broader range of health conditions.

- **Recommendation(s)**

The Board is asked to receive this update for noting.

- **Appendices**

Not Applicable

NHS
South Central Ambulance Service
NHS Foundation Trust

Trust Board of Directors Meeting in Public
25 September 2025

Report title	DIPC Annual Report
Agenda item	12
Report executive owner	Professor Helen Young, Chief Nurse
Report author	Siobhan Fensom, Infection Prevention Control Lead
Governance Pathway: Previous consideration	IPC committee: 7 August 2025 EMC: 2 September 2025 Quality and Safety Committee: 18 September 2025
Governance Pathway: Next steps	Upward report to Trust Board

Executive Summary

The Director of Infection Prevention and Control (DIPC) is responsible for producing an annual report to inform the Trust Board of progress in delivering the Infection Prevention and Control Programme. This report provides assurance that appropriate measures are being taken to maintain the safety of patients and staff.

The purpose of this report is to provide a comprehensive overview of the IPC activity that has taken place in SCAS from the 1 April 2024- to 31 March 2025.

- IPC compliance declared in many areas but where not compliant, action plans, recommendations and timeframes are given to service lines to address IPC issues.
- Completion of Vehicle Audits below end of year trajectory for both Emergency and Urgent Care (E &UC) and Non-Emergency Transport Services (NEPTS).
- Completion of Hand Hygiene Audits below end of year trajectory for both Emergency and Urgent Care (E &UC) and Non-Emergency Transport Services (NEPTS).
- Although below end of year trajectory there was an increase of completion on the previous year 2023-2024.
- Lower compliance for Make Readies in the South of the trust.
- Assurance documented the BAF document updated and receives oversight through IPC Committee.

- IPC level 2 training under target for the year however improvement plan initiated with increase in compliance noted.
- Marginal increase in needle stick injuries. Detailed deep dive report completed, and attendance to team training and moving forwards IPC to report to Clinical Governance meetings to monitor.
- Flu campaign increase on year 2023-2024 at 29.9% to 46.3% for end of year 2024-2025.

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	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 Board asked to do: • Receive a report/paper and take assurance from it.

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

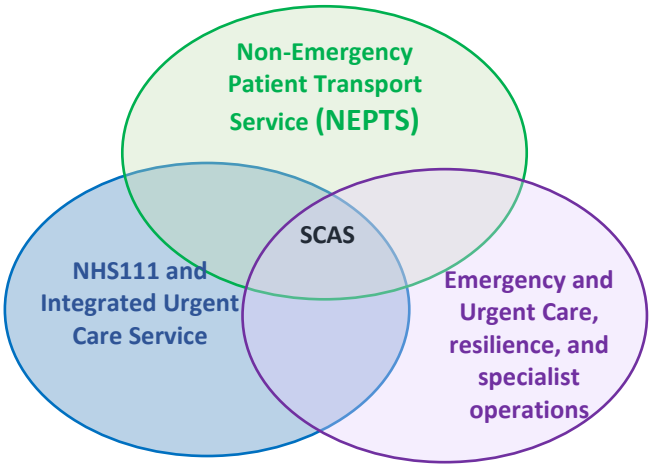
Director of Infection Prevention and Control
Annual Report 2024-2025

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

Contents

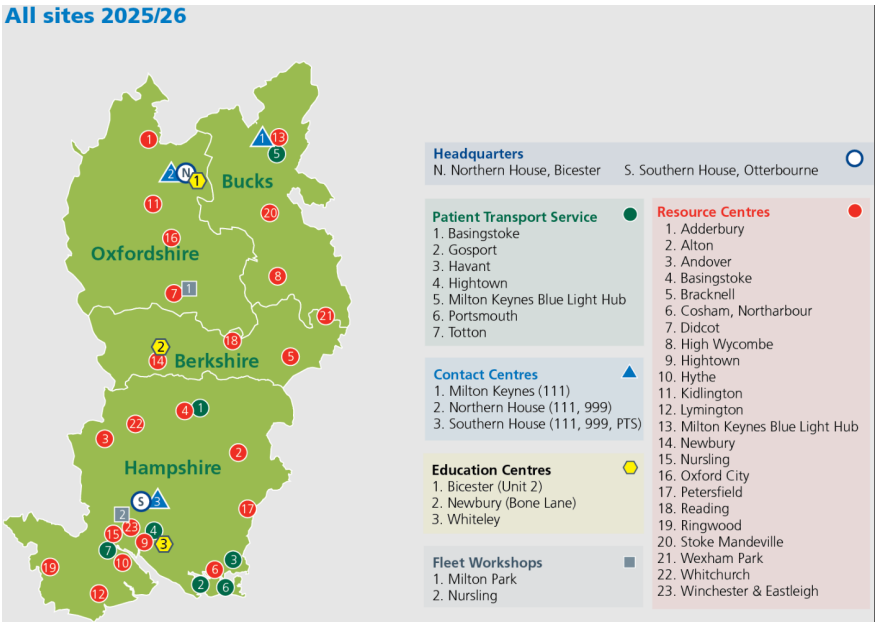
1. Overview

South Central Ambulance Service NHS Foundation Trust (SCAS) is part of the National Health Service (NHS). SCAS is one of 10 ambulance services in England and serves the counties of Berkshire, Buckinghamshire, Hampshire and Oxfordshire.

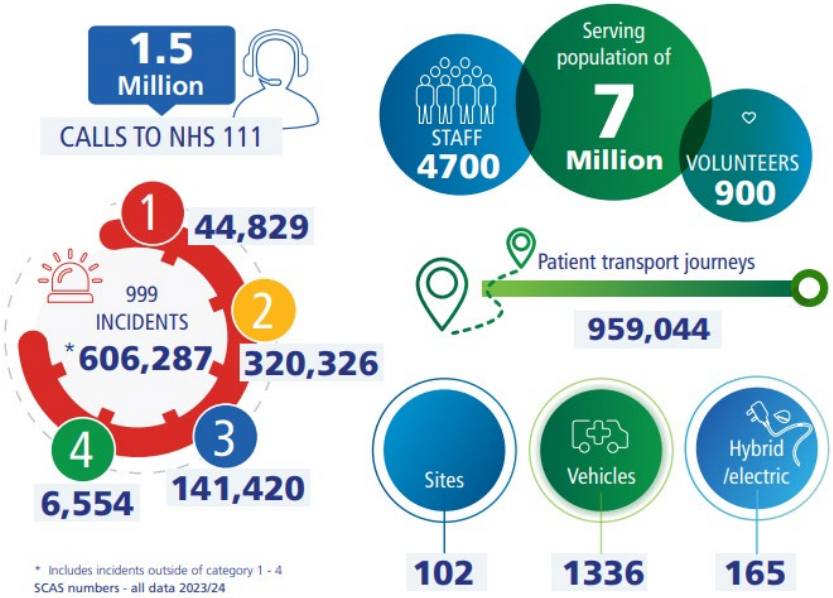


There are headquarters in Bicester, Oxfordshire and Otterbourne, Hampshire. Each of these sites also houses a Clinical Co-ordination Centre (CCC), where 999 and NHS 111 calls are received, clinical advice provided, and emergency vehicles dispatched if needed. There is also an NHS 111 facility in Milton Keynes.

There is one NEPTS Contact Centre and seven NEPTS bases, and there are 23 Ambulance Resource Centres. The Trust delivers care in the community which means the Trust supports patients at home and in their local area.

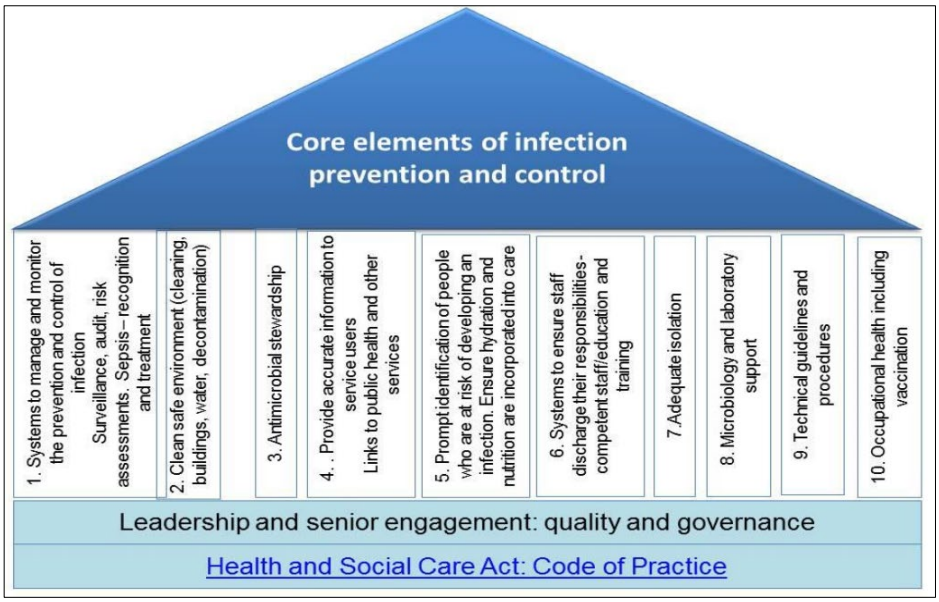


South Central Ambulance Service Summary in numbers:



Executive summary

The Trust is committed to the prevention and control of infection, minimising the risks and impact of healthcare associated infections for patients, staff and the organisation overall. The Health and Social Care Act 2015, Code of Practice on the Prevention and Control of Infections and related guidance updated 2022, states that *good infection prevention (including cleanliness) is essential to ensure that people who use health and social care services receive safe and effective care. Effective prevention and control of infection must be part of everyday practice and be applied consistently by everyone*. This approach is implemented across all SCAS services.



This approach remains key. There is a continued requirement for change for day-to-day Infection Prevention and Control (IPC) to return to pre pandemic systems and processes and a risk assessed-based approach to IPC measures. There remain areas for improvement and within SCAS there continues to be a committed approach to working in line with the Care Quality Commission (CQC) recommended 'should' action for IPC to address the shortfalls after the CQC inspection in 2022 – in relation to audit assurance, hand hygiene and culture of IPC being 'everybody's business'.

Within SCAS, the Trust Board is accountable for ensuring that there are effective IPC arrangements within the Trust. The Board receives an IPC report as part of the integrated governance report which highlights key work streams and areas of risk. The Board also receives and approves the annual IPC report and strategy.

The prevention and control of healthcare acquired infections (HCAIs) is designated as a core part of the organisation's governance and patient safety programmes. IPC is delegated through the Board to the Director of Patient Care and Service Transformation/Chief Nurse and given the role of Director of Infection Prevention and Control (DIPC). The DIPC is further supported by the IPC Lead to embed IPC practices Trust-wide (see appendix 1 and 2).

The Trust receives support from the occupational health service, Optima Health, who provide services to SCAS to aid managing all aspects of staff health and report and advise on occupation-related health compliance.

Compliance with the Health and Social Care Act requires NHS organisations to receive microbiology support for the IPC function. From 2024-2025 SCAS has had a SLA (service level agreement) with our acute partner organisation (OUH) to provide this service.

SCAS IPC is part of a wider network of IPC groups, working with our integrated care boards and national partners to ensure learning and developments in IPC are shared. Over the year 2024-2025 SCAS participated and collaborated within the Hampshire and Isle of Wight Integrated Care Board Network and Lead Meetings, and with Berkshire, Oxfordshire, and Buckinghamshire Integrated Care Board (BOB).

SCAS IPC is regulated by Hampshire and Isle of Wight Integrated Care Board, Legislation, the Care Quality Commission (CQC), the Department of Health and NHS England (NHSE). Cleanliness standards are monitored against national cleaning standards and monitored through the Trust IPC Committee and governance framework. Standards are related to policy, procedures, and outcomes, and include the provision of high-quality facilities and standards of practice. The Trust has taken measures to ensure that our policies and processes adhere to the requirements and performance outlined by the following:

- CQC, Fundamental Standards
- The National Infection Prevention and Control Manual for England
- National Cleaning Standards for Healthcare (2021)
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2015 (updated 2022)
- Health and Safety Executive advisory committee on dangerous pathogens
- NICE Guidelines

- EPIC 3 - National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England
- Standard infection control precautions: national hand hygiene and personal protective equipment policy (2019)

Compliance with relevant national and local standards, guidance and policies supports effective infection prevention and control practice Trust-wide. Success depends on personal accountability, skilled and competent staff, transparent and integrated working practices, and clear management processes. IPC practice is integrated into each new employee's induction and is continued throughout their SCAS career with additional e-learning.

Introduction

The purpose of this report is to provide a comprehensive overview of the IPC activity that has taken place in SCAS from the1st April 2024- to 31st March 2025.

The report demonstrates how SCAS has achieved compliance with the Health and Social Care Act alongside the National IPC Manual for England (NIPCM) and highlights the significant improvement the Trust has made within infection prevention and control in all areas of the organisation.

The report will inform the Trust Board of the IPC standards and risks within the organisation.

The updated annual work programme for 2025-2026 provides an overview of the priorities for the upcoming year and is attached to this report (Appendix 5).

At the end of the year 2024-2025, SCAS declared compliance in IPC practices. Where IPC non-compliance is demonstrated action plans, recommendations and timeframes are given to service lines to address IPC issues.

The table below details the 10 Criterion required for compliance with the Health and Social care Act and the actions, policies, and education in place to ensure these criterions are met.

	Criterion	Achieved through:
1.	Systems to manage and monitor the prevention and control of infection.	Annual Plan, Annual Report, Risk Assessments, Audit Requirements, Training, Policy and Procedures
2.	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	Audit programme and completion of action plans generated if non-compliance is reported and actioned. Audit assurance programme requires development

3.	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	Use of area specific antimicrobial resistance (AMR) prescribing guidelines
4.	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion	Intranet, Policy and Procedures Hospital pre-alert
5.	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	Infection status recorded on booking of all NEPTS transfers, risk of infection identified through Emergency Operations Centre dispatch and information given to response crews.
6.	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	IPC Trust intranet page Communications plan through 'Hot News', Staff Matters and clinical memos per service requirements
7.	Provide or secure adequate isolation facilities	Process of NEPTS booking allows cohort and isolation of patients with infectious disease. E & UC single patient transfer only
8.	Secure adequate access to laboratory support as appropriate	Microbiology Support SLA provided by OUH.
9.	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections	SCAS IPC Policy and Procedures. Updated 2023, A-Z Guidelines- Updated January 2024.
10.	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection	Occupational Health services provided by Optima Health.

Assurance and Governance

Robust processes are in place within SCAS in relation to IPC including environmental and Vehicle Cleanliness. The following internal and external processes are in place:

- An Online audit system (Audit Online) focusing on Observational Hand Hygiene, Vehicle and Building Cleanliness Audits. Compliance data from SCAS-specific systems is imported to Audit Online on a weekly basis to ensure staff, vehicle and building data

is accurate. The Audit Schedule consists of three levels, level 1 being provider led, Level 2 being operational colleagues and Level 3 being Subject Matter Expert (SME) and Compliance-led.
- Reporting of Audit results and Key Performance Indicator (KPI) performance through Monthly Contracts Meetings, Monthly Clinical Governance Meetings and Quarterly IPC Committee.
- IPC Committee meets on a quarterly basis and provides oversight for compliance and completeness of IPC Annual Work Plan and the IPC Board Assurance Framework (BAF). The IPCC upwardly reports to the Trust's Quality and Safety Committee.
- Upward escalation from IPC Committee to Quality and Safety Committee through to Board.
- KPI monitoring, Action Planning and Improvement Planning completed by IPC and wider Compliance and Governance Lead.
- Datix incident reporting system to capture patient safety events and non-patient incidents including needlestick injuries, exposure to body fluids and infectious diseases is utilised within SCAS. SCAS promotes an open reporting culture and encourages all staff to report all incidents and near misses.
- Reporting from Datix System through Health Safety and Risk Quarterly.

2. Annual Plan Review

A programme of work was outlined for 2024-2025 in the form of an annual plan. The annual plan has been reviewed and updates provided as Appendix 4.

3. Achievements

Significant achievements were made in the 2024-2025 financial year detailed below:

- A revised and comprehensive level 3 Audit Schedule.
- Successful completion of all CQC must do actions.
- Implementation of additional IPC Training within front line team time.
- Phase 2 Sluice Upgrade Programme commenced.
- Substantive Accreditation Programme.

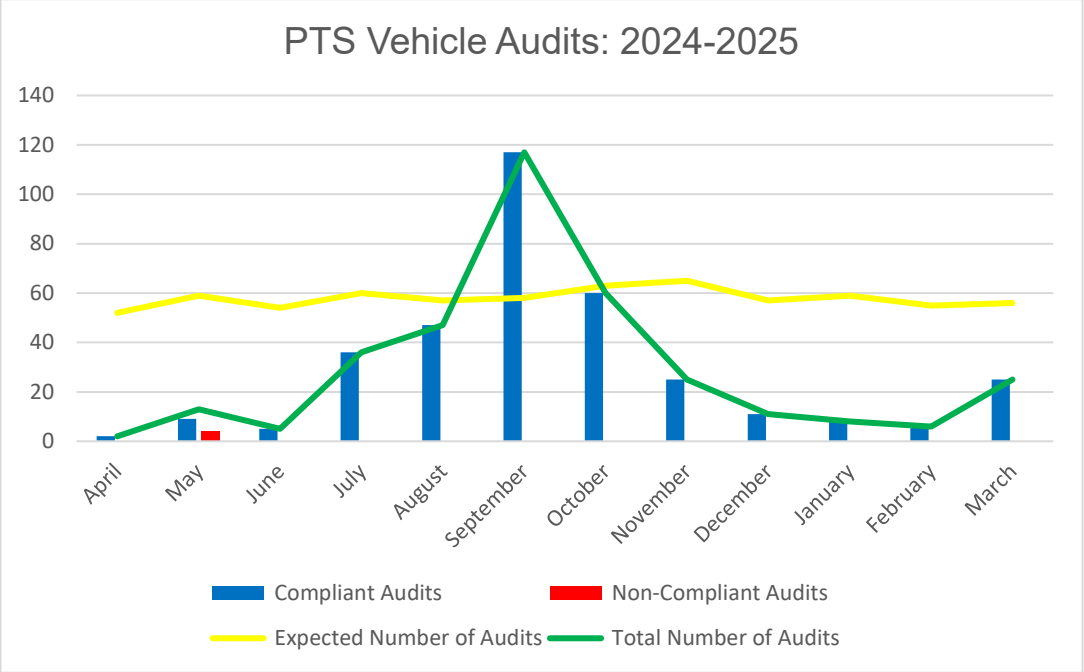
4. Infection Prevention and Control Compliance Audits

Maintaining clean clinical and working environments alongside excellent hand hygiene practices are key to the safety of our patients and staff. IPC Level 2 compliance audits are carried out by Team Leaders and Clinical Team Educators at their local stations. This audit programme encompasses vehicle, building and hand hygiene audits to ensure IPC standards are being met both within our environments and through good hand hygiene practices.

4.1 Vehicles

The graphs below detail the number of both compliant and non-compliant audits for the 2024-2025 period. The yellow line shows the number of expected audits each month to ensure a cross section of the fleet across NEPTS (Graph 1) and Emergency and Urgent Care (E & UC) (Graph 2) receive compliance audits as per national cleaning standard (2021) for the year.

Non-Emergency Patient Transport Services

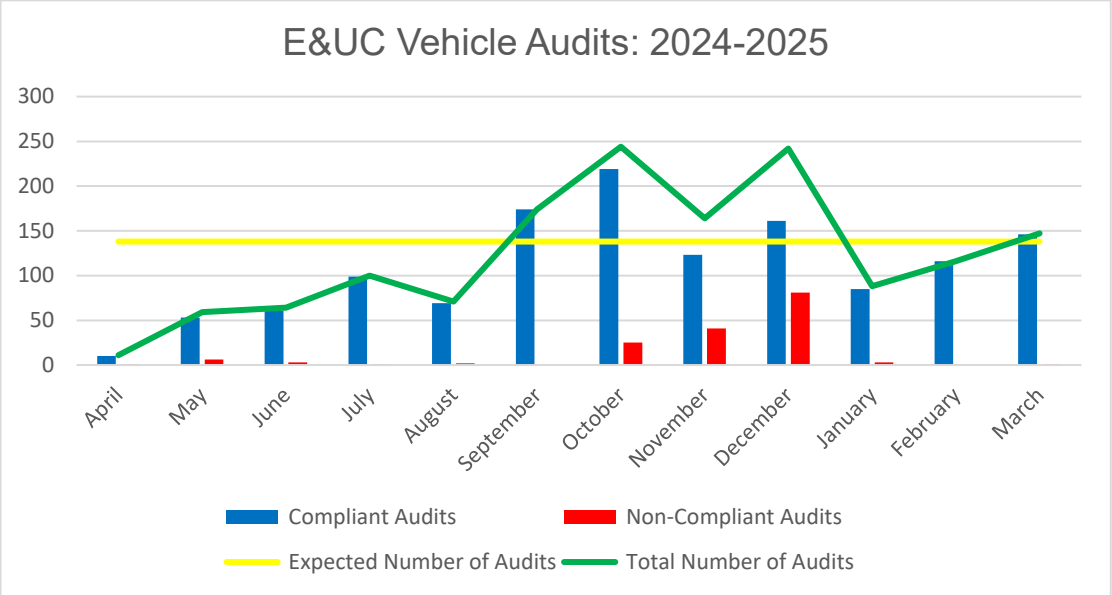


Graph 1

NEPTS vehicles remain as a Functional Risk Group (FR5) within the National Cleanliness Standards and thus requires a compliance target of 80%.

In 2024-2025 a total of 695 audits were expected to be completed in the year, however only 355 were completed. Of the 355 audits completed 351 (98.8%) achieved compliance of a target above 80%.

Emergency and Urgent Care Services (E &UC)



Graph 2

E & UC vehicles are in Functional Risk Group (FR3) of the National Cleanliness standards – with a cleanliness compliance target of 90% and an increased audit frequency from bi-annually to bi-monthly as per national cleaning standards (2021).

SCAS currently has an active Double Crewed Ambulance (DCA) fleet of 340. This figure can fluctuate during the year if a vehicle requires significant repair work and is Vehicle off Road (VOR). The schedule was devised ensuring that a cross section of the fleet was taken, and this was split across the 23 resource centres. There was a requirement for 1656 audits to take place and 1480 were completed.

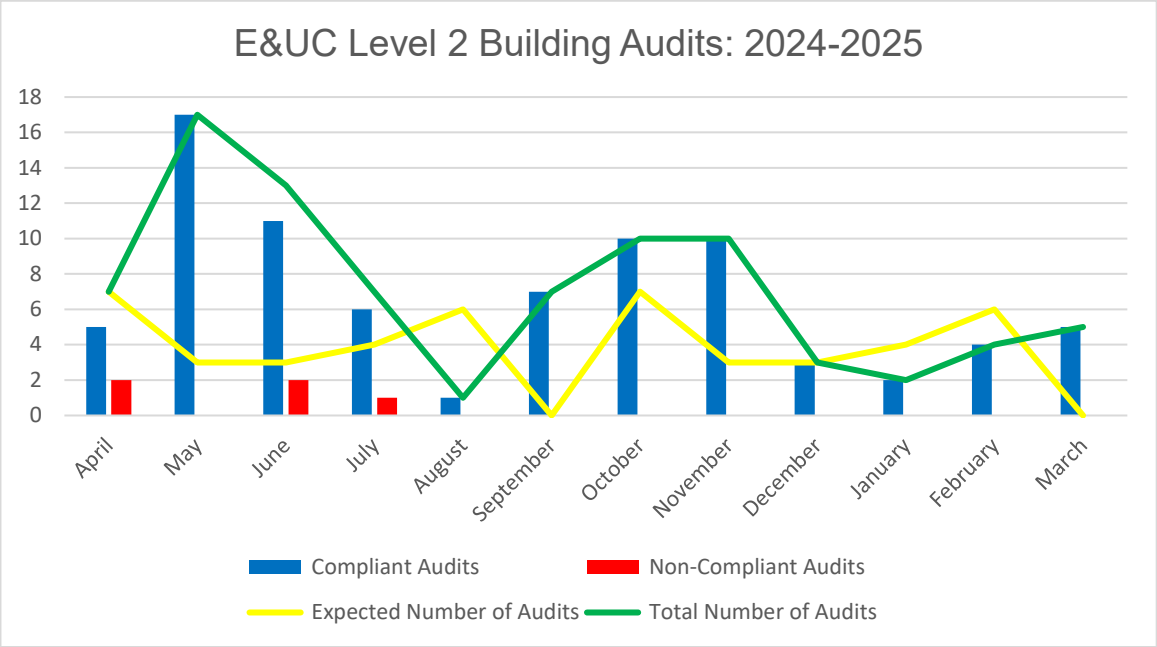
Of the audits completed, 89% achieved compliance with 11% non-compliant. It is noted the 89% that achieved compliance are above the target of 90% set against the National Cleanliness Standards. Any areas of non-compliance are rectified immediately prior to the vehicle returning to operational use. This is monitored using action plans and through communication with the Operational Support Desk (OSD).

4.2 Buildings

All buildings require bi-annual audits and should reach a compliance score of 80% (Functional Risk Group 5, FR5) in line with National Cleaning Standards. The lower required compliance rate is reflective of these buildings not being clinical environments that provide patient care. No buildings within SCAS treat patients within them. However, the focus of attention is the areas that are utilised to supply and clean all vehicles as this is deemed the clinical environment. SCAS aims to achieve higher compliance rates across

its sites to maintain a clean and functioning environment given this clinical element. The compliance team report those under 95%

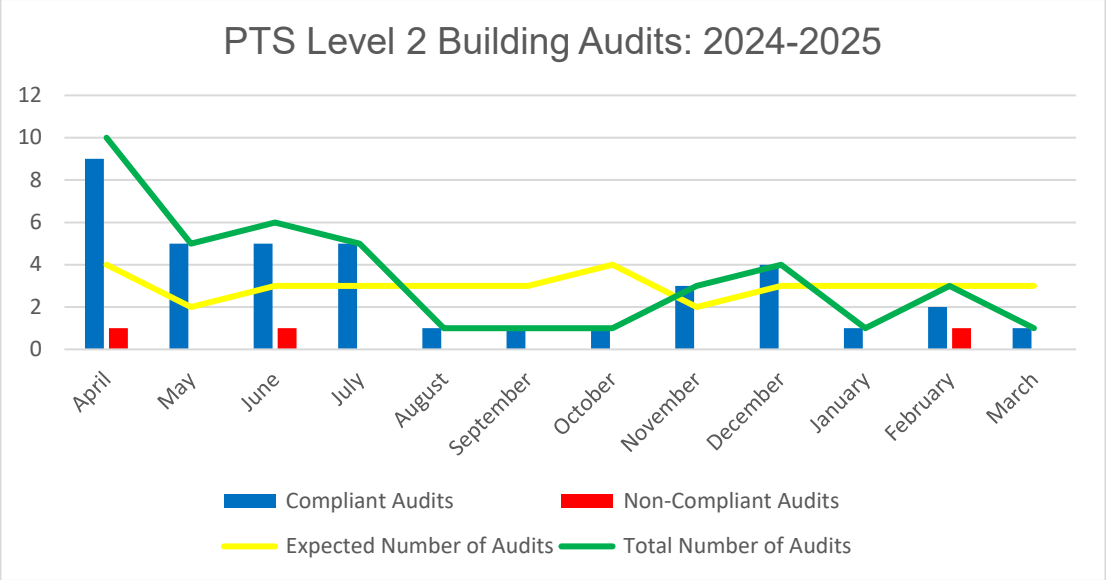
Graphs 3 and 4 below detail the number of audits completed per service against target and the overall compliance against audit.



Graph 3

Within E & UC there has been a total of 86 building audits completed which is above the expected biannual audit requirement. The universal compliance team have worked diligently to bring assurance and increase compliance around the fabric of buildings and areas that supply our clinical area in tandem with IPC.

Audits continue to be monitored and highlight when there are improvements to be made to allow compliance with IPC standards with work taking place with key stakeholders and diligent plans made.



Graph 4

Within SCAS there are combined sites for NEPTS and E & UC with NEPTS also having their own satellite stations.

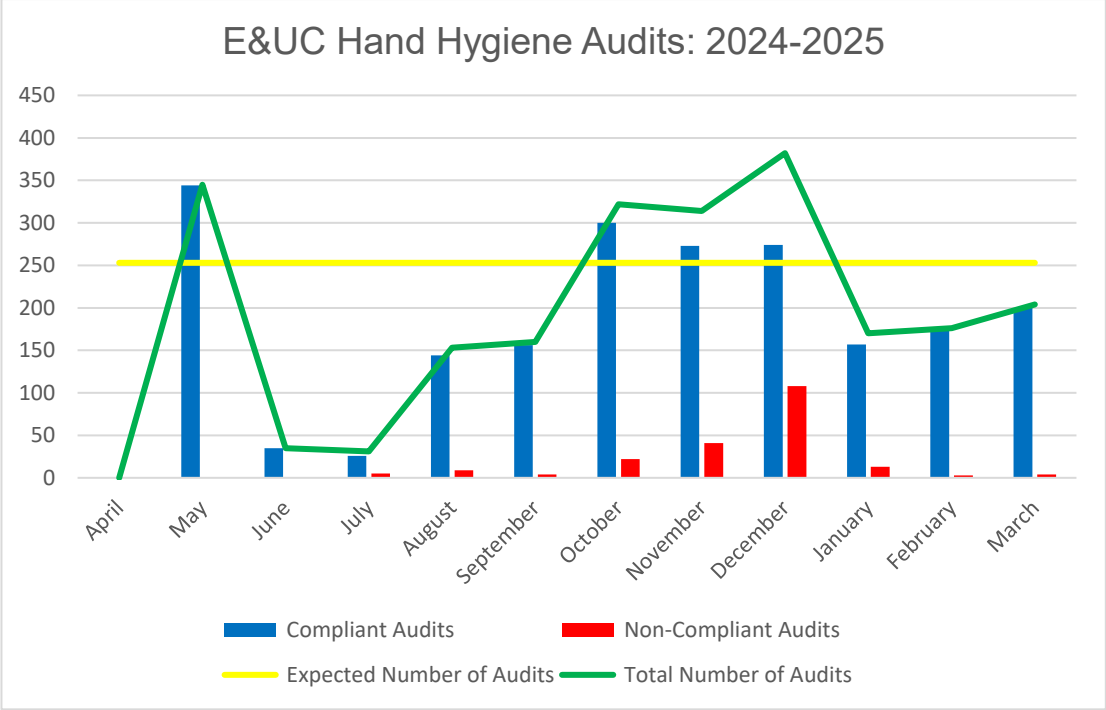
Within NEPTS a total of 41 audits were completed. Of those 41 audits a 93% compliance rate was achieved. As with E & UC, audits continue to be monitored, and improvement plans developed to improve IPC standards.

4.3 Hand Hygiene Audits

SCAS employs more than 4,400 clinical and non-clinical staff and all are responsible for complying with meticulous IPC practices. It remains imperative that all staff adopt and adhere to IPC practices to protect themselves, their patients, and their colleagues. To ensure compliance with good hand hygiene practice staff who are in patient-facing roles and encounter patients, or work within the environment where patients are seen are audited on an annual basis through a discussion audit at Personal Development Reviews. Above that observational hand hygiene audits are required to be completed by Team Leaders and Clinical Team Educators and includes IPC team conducting these across the Trust at Emergency Departments.

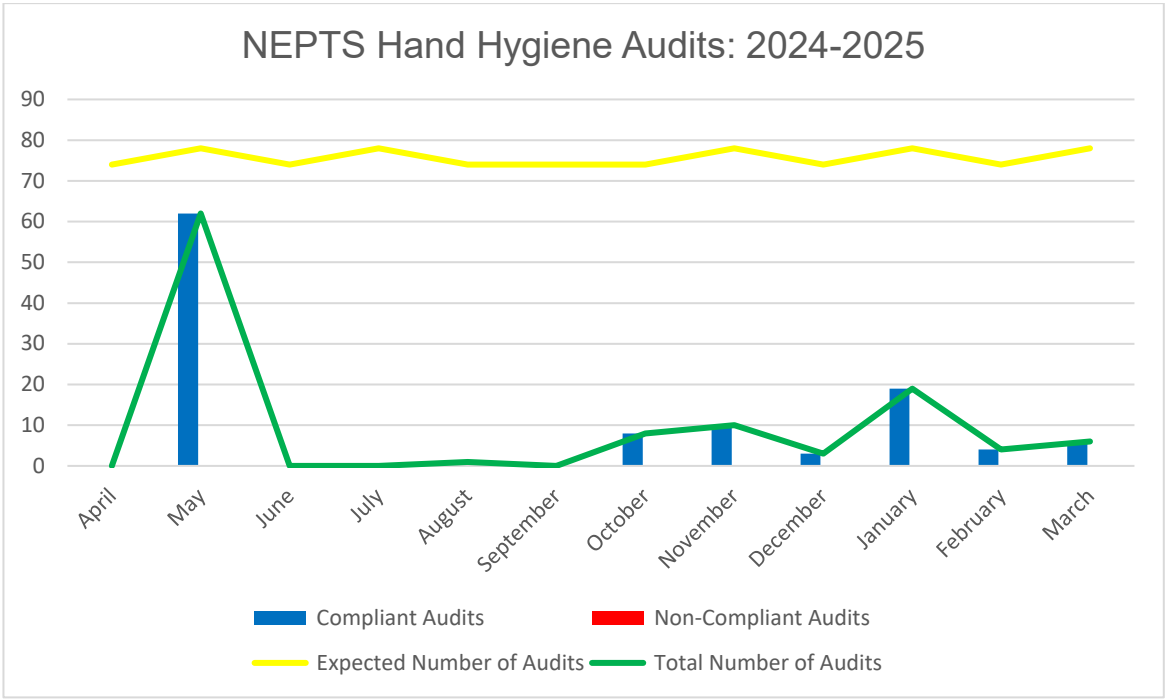
Below Graph 5 details E & UC activity and compliance of the hand hygiene audits.

There was a requirement of 3036 observational audits to be completed, of which 2292 were completed. A 75% compliance with completion, which is a significant increase on the year of 2023/24. Of these 91% were compliant. It has been noted the failure with the Hand Hygiene audits, is the noncompliance with Bare Below Elbows (BBE) and watches still being worn. There has been some significant work with the last quarter to enhance understanding of BBE and to shift culture and behaviour in the use of wrist watches within the emergency sector.



Graph 5

Below is the activity for NEPTS hand hygiene audits (Graph 6). Of the expected 918 observational audits only 113 were completed giving a completion rate of 12%. Of the audits completed 100% achieved compliance. NEPTS will continue with the agreed audit schedule and the IPC team will continue with stringent governance processes to increase completion. To note a change in contract providers destabilised the workforce and has been recognised as a factor contributing to the decrease in completion compliance.



Graph 6

To Note: The SCAS IPC team have a commitment to participate annually in the promotion of World Hand Hygiene Day in May and Infection Prevention and Control Week in October.

Audit Data Summary Table:

	Q1-Q4 21-22	**Q1-Q4 22-23**	**Q1-Q4 23-24**	**Q1-Q4 24-25**
Number of Vehicle Audits Required	800	828	1593	2351
Number of Audits Achieved	557	614	734	1835
% of Audits completed	70%	74%	46%	78%
Required % score for compliance	90	90	90	90
Achieved compliance score	94%	95%	94%	91%
Number of Building Audits Required	277	255	131	82
Number of Audits Achieved	201	201	227	127
% of Audits completed	73%	79%	173%	155%
Required % score for compliance	80	80	80	80
Achieved compliance score	75%	77%	90%	94%
Number of Hand Hygiene Audits Required	2317	2146	6150	3954
Number of Audits completed	1369	2116	1371	2405
% of Audits completed			22%	61%
Achieved compliance Score	99%	100%	99.6%	91%

4.4 IPC Assurance Audits – Level 3 Audit Assurance Programme

A bespoke level 3 (Subject Matter Expert) audit assurance programme has been developed by the IPC team in response to the CQC 'should' action to address shortfalls in IPC, to enhance governance relating to the National Standards of Health Care Cleanliness.

The assurance programme was designed for roll out across the SCAS footprint, encompassing NEPTS and E & UC services. The timescales and audit schedule is set out in Appendix 3. Work progressed with the quality assurance audit function within Audit Online, including a significant revision with ongoing development completed in 2023-2024 to create and maintain a functional system.

5. Vehicle Decontamination Specifications/ Churchill Partnership Working

Ongoing maintenance of a clean clinical environment remains key to keeping our patients and staff safe. Close partnership working has continued with Churchill, our vehicle decontamination providers, to ensure vehicles are decontaminated effectively and to the correct standards both as guided by the National Cleaning Standards 2021.

SCAS has provided guidance on required decontamination products and the correct levels of personal protective equipment (PPE) required by staff to carry out decontaminations through sharing of standard operating procedures.

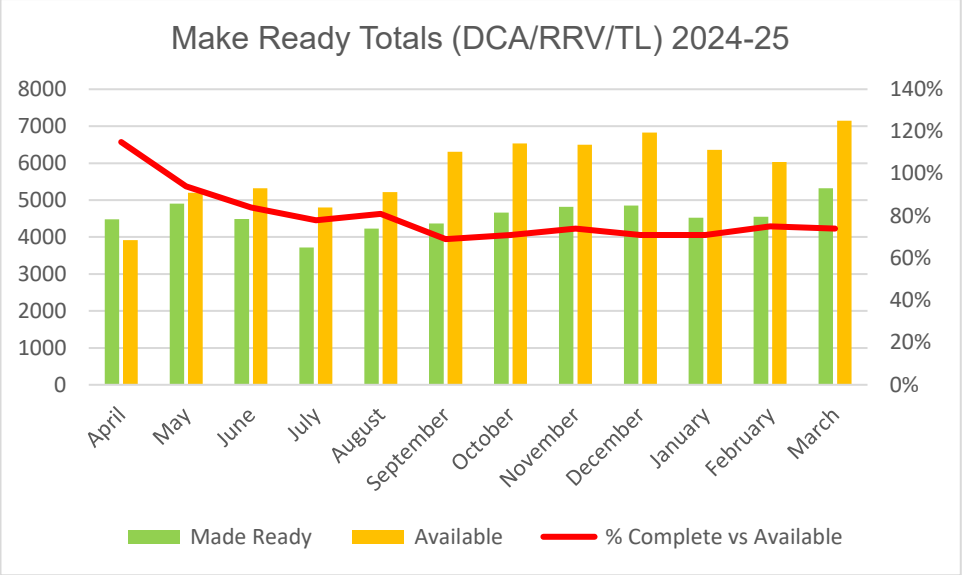
Routine periodic cleans (formally deep cleans) and 24 hour Make Ready services have been maintained at a high level throughout the last 12 months, with a robust system in place for booking vehicles for enhanced (Infectious) cleans due to infectious disease.

The requirements of specific decontamination post infectious disease are set out in the SCAS decontamination procedures alongside the SCAS A-Z guide of infectious disease, which our partners, Churchill, utilise to guide appropriate decontamination techniques.

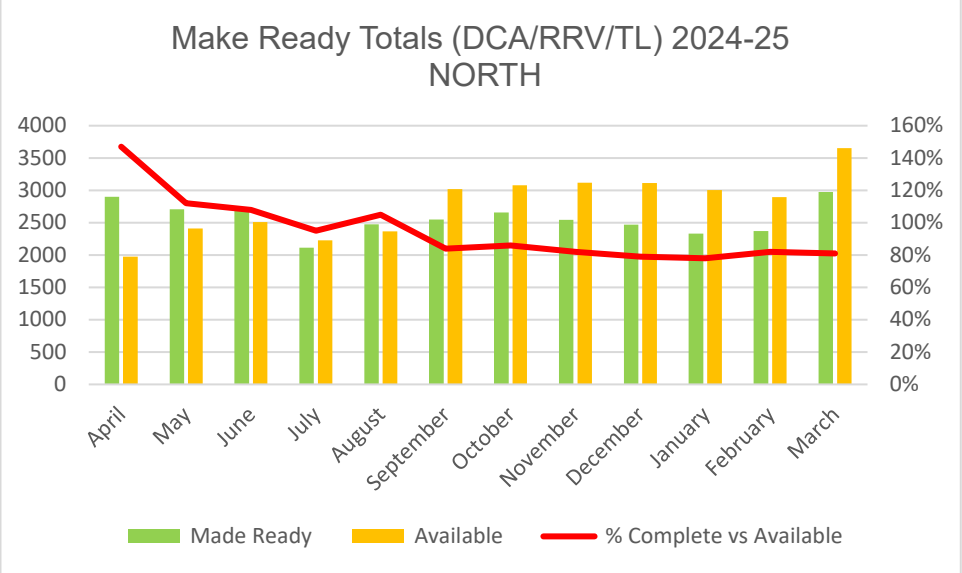
Graphs 7 below tables the Make Ready Totals for the Trust on Dual Crewed Ambulances, (DCA) Rapid Response Vehicles (RRV) and Team Leader Cars (TL). Graphs 8 and 9 provide the break down for the North and South of the Trust. It can be noted South has a lower compliance. A further break down can then be noted for the split for DCA, RRV and TL, overall and then North and South (Graphs 10, 11 and 12 respectively). Robust Actions and recovery plans were in place to ensure the required number Make Readies were completed. This notes assurance.

As noted above routine periodic cleans take place for E & UC and NEPTS every 12 weeks in addition to a 24 hour Make Ready.

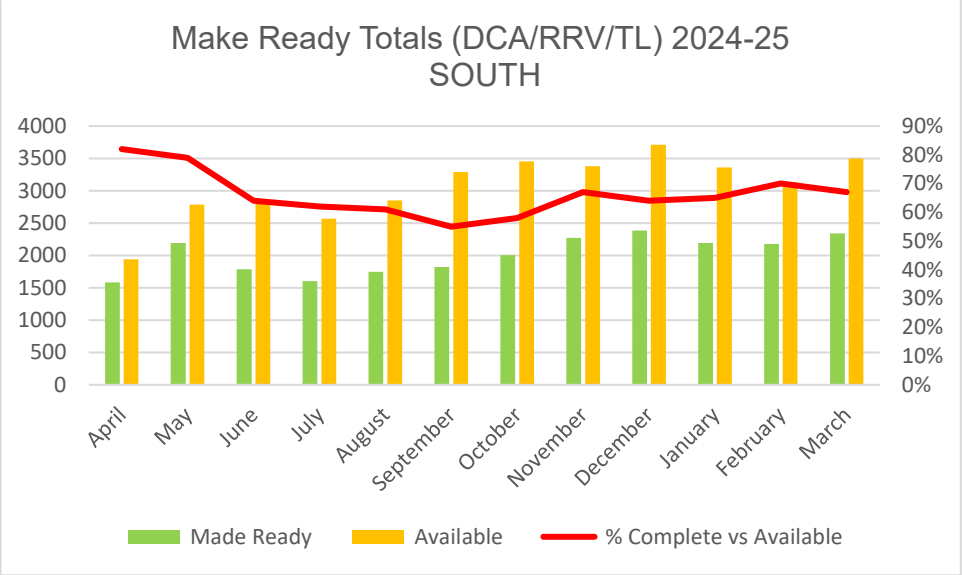
Below in Graphs 13, 14 and 15 the totals for the Trust, then North and South are displayed broken down documenting totals for E & UC and NEPTS.



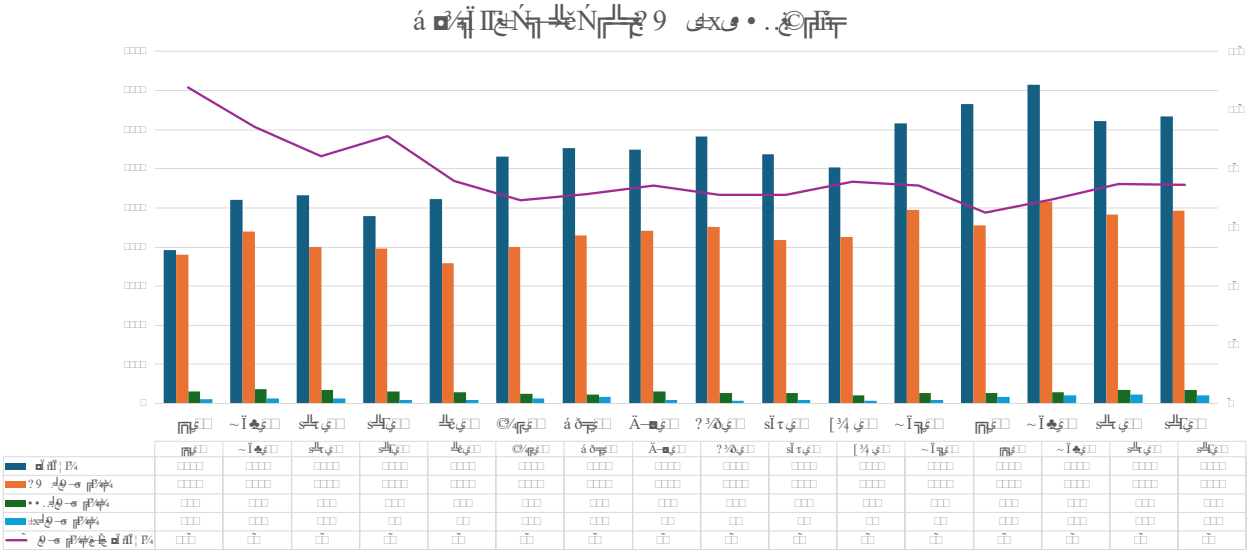
Graph 7



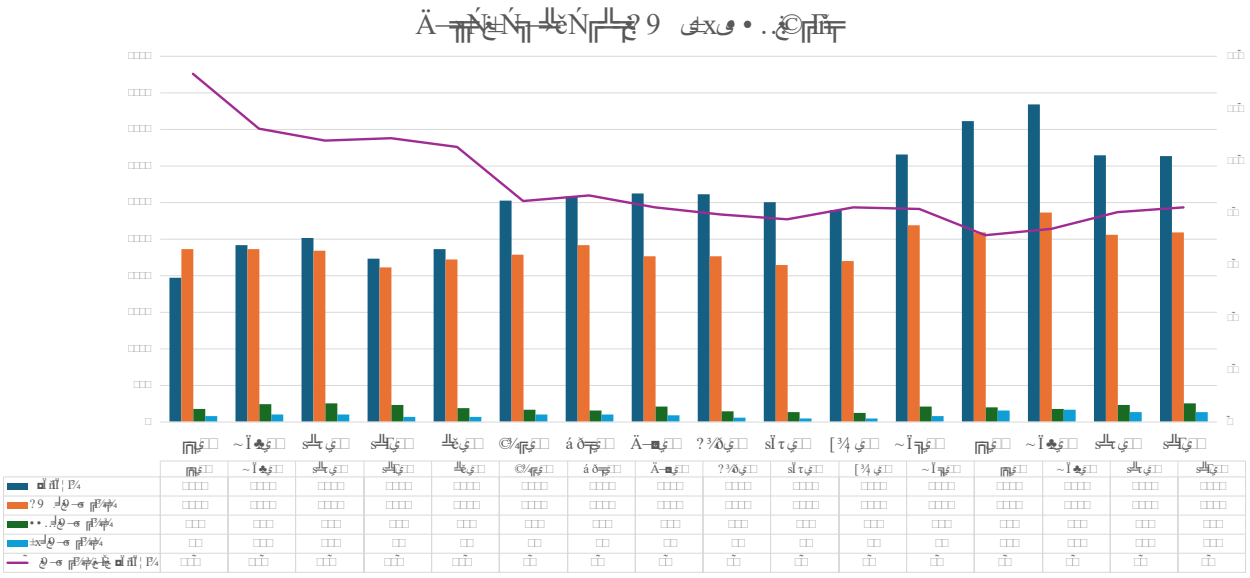
Graph 8



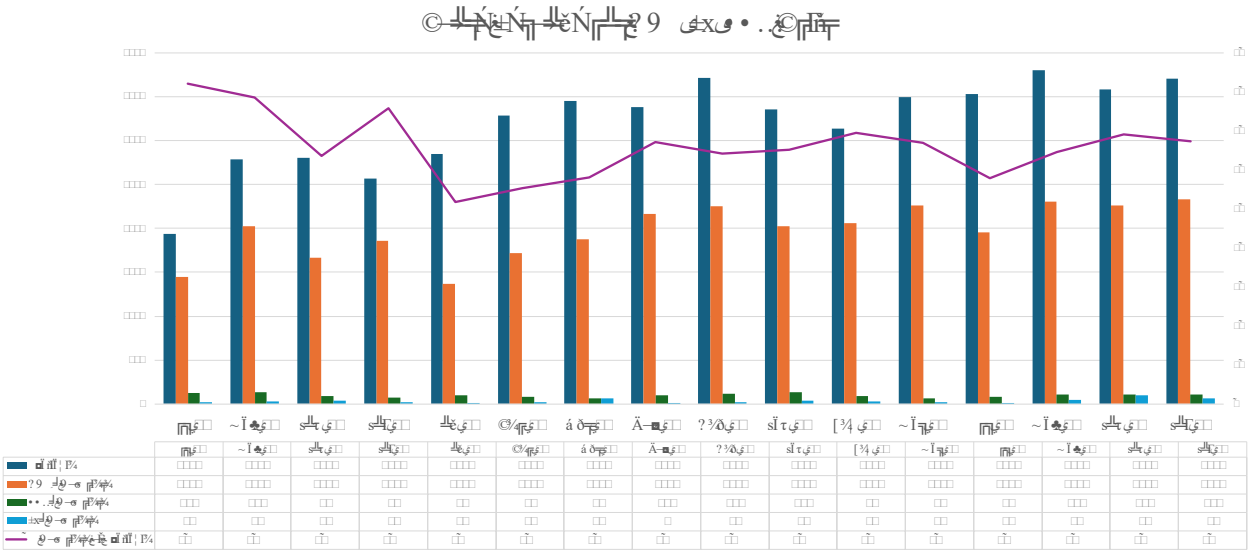
Graph 9



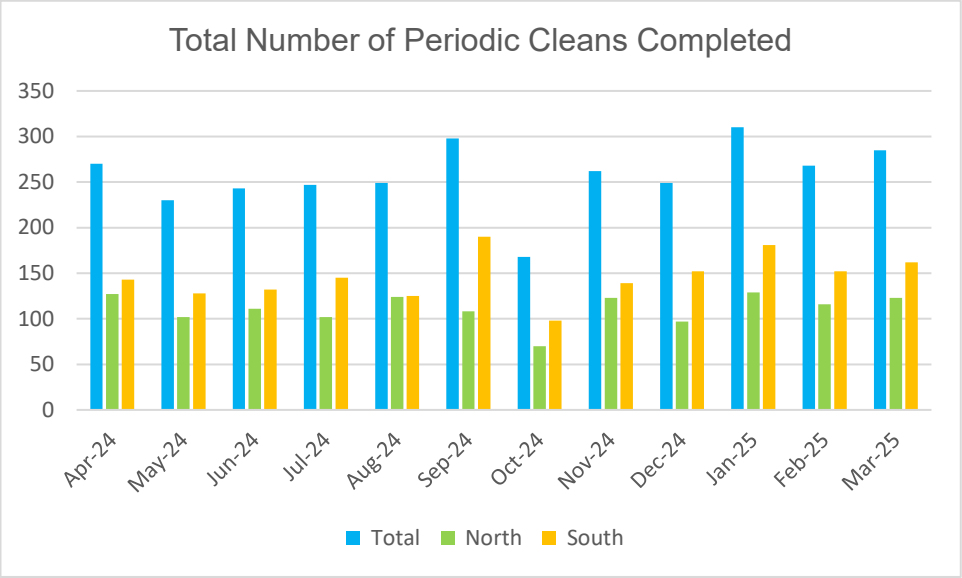
Graph 10



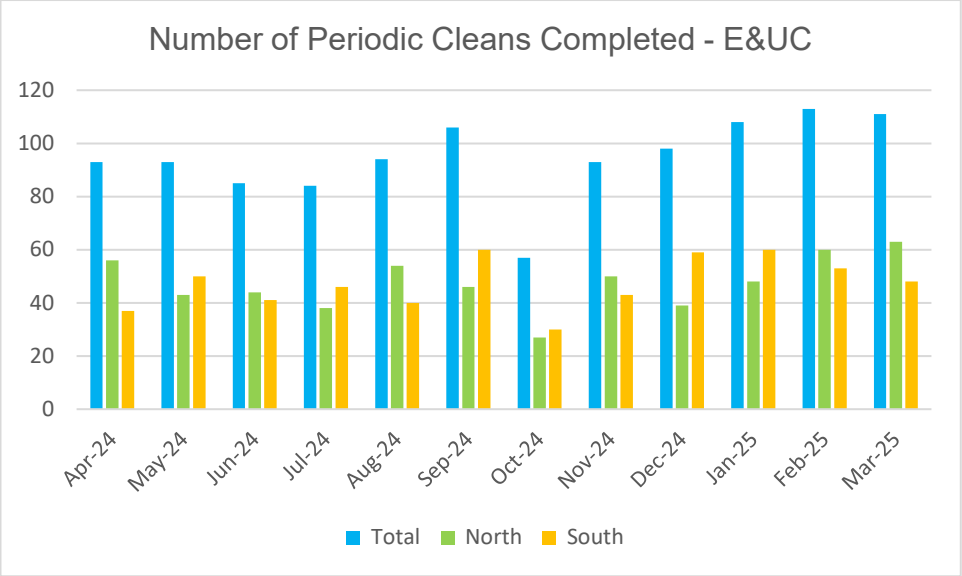
Graph 11



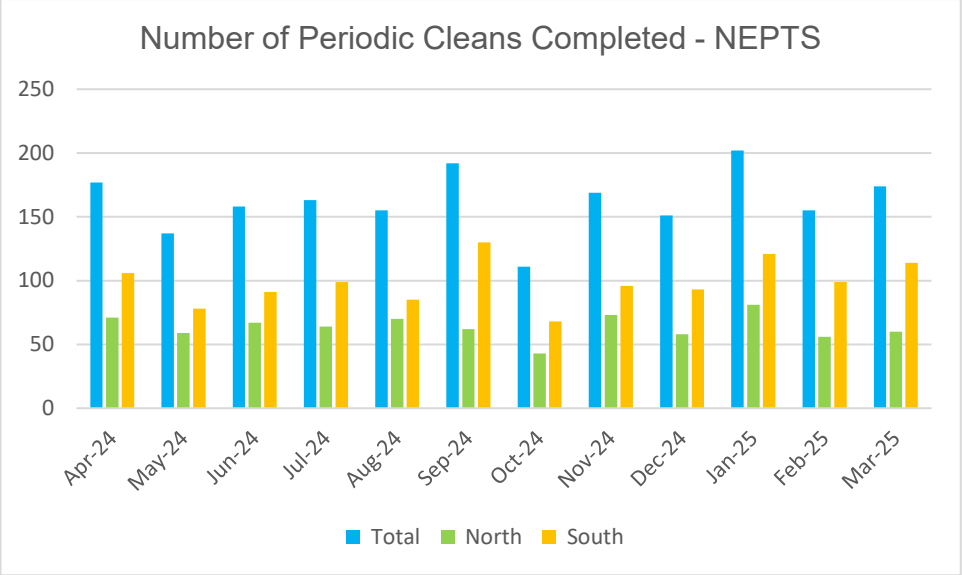
Graph 12



Graph 13



Graph 14



Graph 15

5.1 Estates Cleaning Scores Next Generation Contract

Contractors Nexgen conduct self-audits, visiting every site monthly. Audits are then forwarded, and a sample size are reviewed, and all are filed.

These audit results are included in the Nexgen monthly reporting and presented at a monthly meeting. Work has taken place with Nexgen to make the report succinct and provide valuable information as detailed within the contract. This includes cleaning scores, attendance, training data, an issues log and resolution information.

6. Estates refurbishment and new build works

The IPC Lead continues to work closely with our Estates and Facilities Team. During 2024-2025 reporting year upgrades to the sluice programme across the SCAS estate was completed.

The IPC team remain actively involved with future site development plans and their progress in collaboration with Estates and Facilities Team.

7. Board Assurance Framework.

The IPC BAF is updated quarterly and receives oversight by IPC Committee and upward reports to assure the Board and the public that SCAS has assurance in line with national guidance, but also areas of partial compliance with action sets to works towards achieving full compliance.

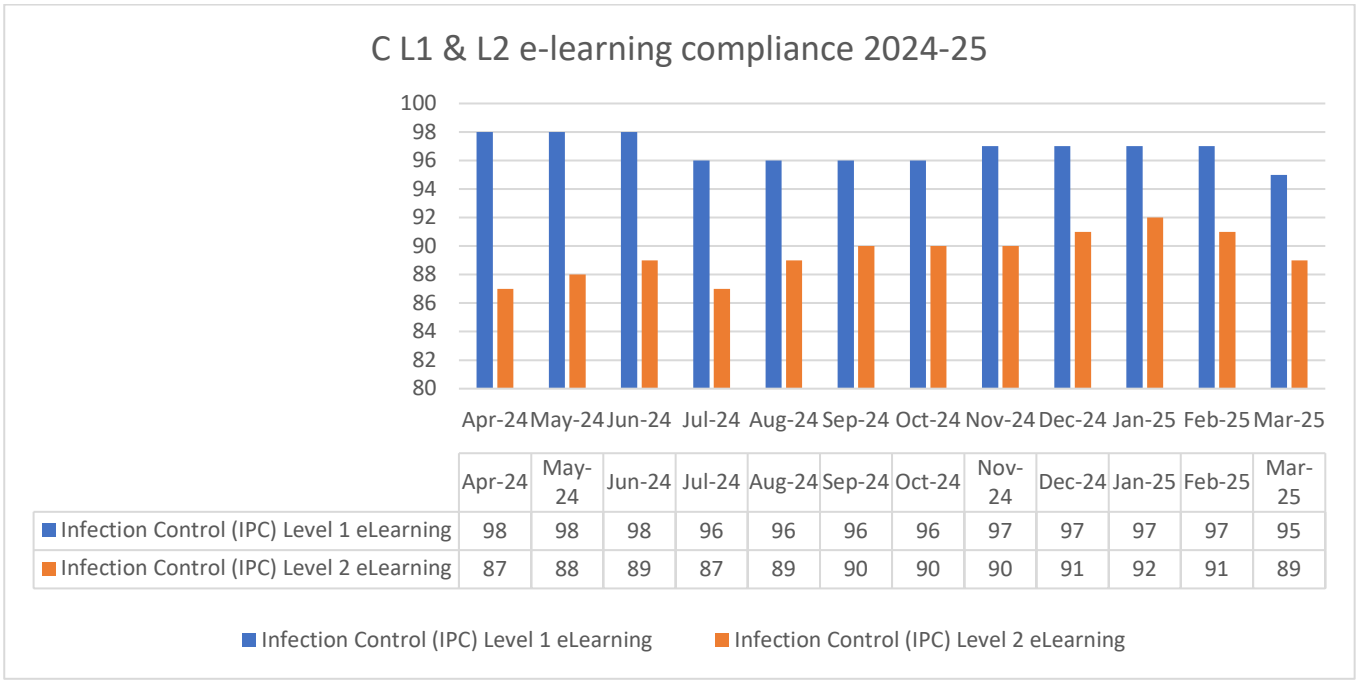
8. Education

IPC training is included in the SCAS corporate induction provided to all new starters. Training covers IPC Level 1 and Level 2 training. The training packages have been tailored to the various job roles within SCAS and are delivered by the Education department. The content of all material is reviewed and ratified by the IPC Lead and ensures content/material is compliant with Skills for Health Framework, linked to Health Education England, the National Cleaning Standards and complies with the requirements of the CQC Fundamental Standards and the Health and Social Care Act.

Employees remain up to date with IPC learning through mandatory e-learning modules.

Below Graph 16 details Trust-wide compliance month on month for Level 1 and Level 2 training. Level 1 training has remained compliant with the 95% target.

Level 2 training remains separated from the overall figure to allow monitoring for compliance for clinical staff who require enhanced further IPC training in clinical roles.
Level 2 training remains under the target compliance level, but robust measures are in place to address this. These communicated action plans, working alongside Education to increase compliance.



	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Infection Control (IPC) Level 1 eLearning	98	98	98	96	96	96	96	97	97	97	97	95
Infection Control (IPC) Level 2 eLearning	87	88	89	87	89	90	90	90	91	92	91	89

Graph 16

9. Staff Health

Optima Health was the awarded provider of SCAS Occupational Health Services. Broadly they cover the following:

- Telephone Support Services
- Online Portal
- Referrals from the Trust
- Attendance Management Advice and Assessments
- Attendance Management Reports
- Case Conferences
- Ill Health Retirement
- Pre-Appointment and Pre-Employment Checks
- Surveillance Services
- Fitness for Task and Safety Critical Work Services: Hearing Tests and Baseline Hearing Tests
- Immunisations, Vaccinations, Inoculations, Medications and Blood Tests.
- Health Screening Services
- Publicity and Promotion

Optima Health Reports:

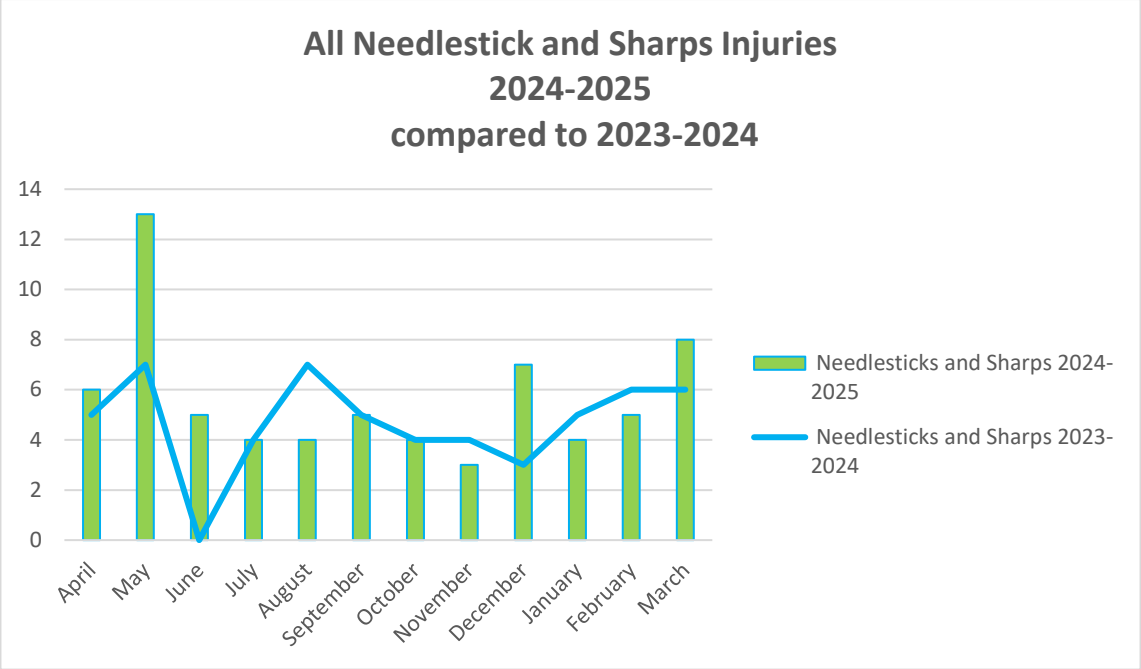
In the past 12 months there have been 87 Blood Borne Viruses Risk Assessments carried out. Of the 87 assessments table (graph 17) below notes the classification of Injury:

Graph 17

9.1 Needlestick and Sharps Datix

It is a requirement under European Union (EU) regulations (2010/32/EU) that all needlestick injuries are reported and investigated. Within SCAS needlestick injuries are investigated by the Team Leader, Optima Health, the Clinical Governance Team and Infection Prevention and Control. All needlestick injuries are upwardly reported through the Health and Safety Risk Group.

Graph 18 details the number of needle stick and sharps injuries for the reporting period of 2024-2025.



Graph 18

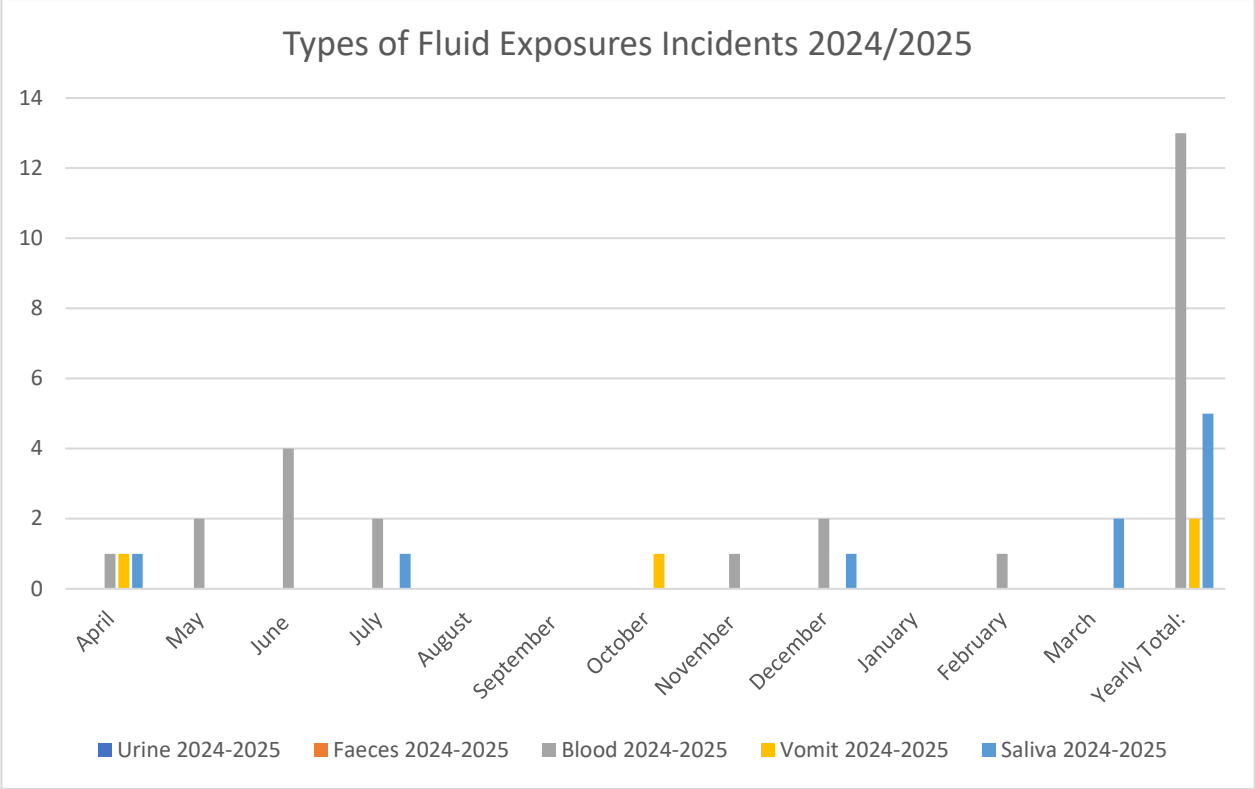
There has been a marginal increase in incidents from 2023-2024 where there was a total of 56 incidents to 2024-2025 there has been a total of 68 incidents. The robust plan that was put in place to identify and address the previous increase which involved the IPC team delivering additional training and completing a deep dive into the data to ascertain themes/trends or specific areas of incidents was successfully completed. The IPC lead has worked, and will continue to work, with Optima Health investigating the mechanism of injury, for themes and trends to continue to tailor required education on sharps safety. A bespoke CPD module working alongside Braun has been drafted and to be fully implemented in the coming year.

To note: The data is accurate to the date it was pulled from the Trust's Datix System. There can be marginal difference if Datix's are recategorized after the data is extracted.

9.2 Exposure to blood/body fluid incidents

Graph 19 below highlights the total number of exposures to bodily fluids a total of 20 incidents that have been reported using the Trust's Datix System during 2024-2025. There has been a significant decrease of 14 incidents from 2023/2024 where there was a total of 34 incidents.

It is noted that the blanket approach to wearing PPE through the pandemic has ceased IPC completed focused educational work, using a risk-based approach and updated risk assessments to ensure clinicians have an increased incompliance with PPE.



Graph 19

9.3 COVID-19 Test and Trace service for staff.

The Test and Trace Service in relation to COVID-19 was dissolved in accordance with the change in national guidance.

10. Influenza Vaccine Campaign

The national flu immunisation programme is essential in protecting vulnerable people and supporting the resilience of the health and care system.

SCAS carried out the flu vaccination campaign as a peer-to-peer vaccination programme via a number of SCAS flu clinic locations. As in previous years, staff could also be vaccinated via a Covid/flu hub, via their GP or at a community pharmacy. All staff, including those who declined to be vaccinated, were expected to complete a flu vaccination record form.

Overall vaccine uptake in SCAS for eligible frontline staff was 46.3%.

Factors have been considered as challenges to achieving a greater uptake by our frontline staff included:

- Vaccine lethargy
- Location and accessibility of the flu vaccination clinics

An issues log, which is collaboratively collated by the internal Seasonal Vaccination Team to highlight any lessons learnt, risks and issues, is reviewed, and performance monitored of the flu vaccination campaign annually to determine lessons learnt, identify areas of good practice, and suggest areas for improvement in future campaigns. This will be considered in the 2025/2026 planning.

Benchmarking

NHS trusts are required to submit data regarding vaccine uptake of eligible frontline staff via Immform each month.

The table below shows the overall percentage vaccine uptake from UK Health Security Agency (UKHSA) reported for frontline staff by NHS ambulance services in England over the period 1 September 2024 to 28 February 2025. For comparison, the uptake data for 2023/24 and 2022-23 is displayed.

Ambulance Service	01/09/2022 – 28/02/2023	01/09/2023 – 29/02/2024	01/09/2024 - 28/02/2025
East of England	no data	no data	no data
London	49.7%	31.8%	34.4%
East Midlands	82.3%	73.5%	68.3%
West Midlands	71.6%	61.3%	62.6%
North East	35.5%	33.2%	no data
Yorkshire	42.1%	32.2%	no data
North West	48.5%	48.1%	42.5%
SCAS	56.7%	29.9%	46.3%
South East Coast	56.9%	72.9%	73.7%
South Western	50.6%	52.2%	42.9%

In 2024-2025 SCAS significantly improved uptake and has participated in collaborative working in the southern region with SECamb to ensure learning is shared.

At the time of this report the planning for the 2025/2026 season has commenced.

11. IPC Annual Work Programme 2024-2025

The IPC Annual Work Programme can be viewed as a separate detailed document. The fundamental aim of the 2025-2026 IPC work programme will be to continue the promotion of sound Infection Prevention and Control practice in line with the Health and Social Care Act 2008.

In order to facilitate this the IPC team will continue to positively engage with all staff, encourage ownership and provide a forum where good practice is shared. The focus for the 2025 -2026 time period will be the following:

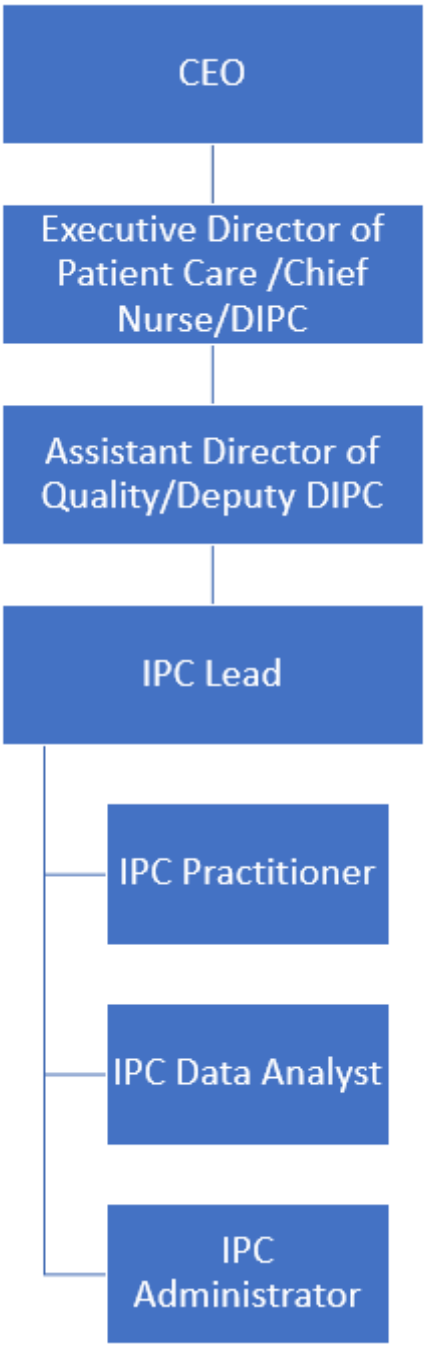
- Ensure the Infection Prevention and Control Link Practitioner Programme is enhanced and embedded within the organisation to facilitate sound two-way communication between the care setting and Infection Prevention and Control.
- Providing accurate information to our service users.
- The successful implementation of electronic assurance audits and dashboard will support the IPC quality agenda. This will incorporate completion of the audit cycle, widening the dissemination of audit findings and the reporting accuracy of Audit compliance.
- Development and delivery of IPC training across the organisation
- Work collaboratively within the Integrated Care System (ICS) on current and future work Streams.
- To develop and enhance Antimicrobial workstreams in collaboration with key stakeholders.
- To provide scrutiny and review of decontamination procedures in response to the National Standards of Healthcare Cleanliness 2025.

APPENDIX 1 - Infection Prevention and Control Structures

The Trust Board and the Director of Infection Prevention and Control (DIPC) have overall responsibility for patient safety and that all infection prevention and control issues ensuring they are managed safely and appropriately. The DIPC sits on Trust Board and Quality and Safety Committee.

IPC Reporting Structure:

IPC Team Structure



APPENDIX 2 – Infection, Prevention and Control Statement

The SCAS Trust Board- is committed to compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections (updated July 2015) and as amended to prevent and control Health Care Associated Infections (HCAI). The Code is presented under three headings which form the basic Code, and the Trust has pledged to undertake these duties by:

1. Management, organisation, and the environment

- Protect patients, staff, and others from HCAI.
- Put in place appropriate management systems to prevent and control infections.
- Assess the risks of acquiring an HCAI in the pre-hospital environment and take action to reduce or control these risks.
- Provide a clean and appropriate environment.
- Provide information on HCAI to patients and the public.
- Provide information when a patient moves from the care of one healthcare body to another.
- Always co-operate with other health care professionals
- Provide facilities to prevent or minimise the spread of HCAI.
- Acquire micro-biology and laboratory support.

2. Clinical care protocols:

- Have in place appropriate evidence-based core policies and protocols that are monitored and maintained to provide clear guidance on the prevention and control of HCAI in the Ambulance Service.

3. Health care workers:

- Ensure so far as is reasonably practicable that ambulance staff are free of and protected from exposure to communicable infections.
- Access to relevant occupational health services is provided to all staff.
- Ensure that all staff are educated in the prevention and control of HCAI.

APPENDIX 3 - Audit schedule 2024-2025 Level 2

Audit Schedule 2024-2025 Level 2.pc

APPENDIX 4 - Review of IPC Annual Plan and IPC workstream 2024-2025.

IPC Annual Plan elements update**:**

All areas of the work plan completed except for the below areas:

- Section 2- Decontamination Policy In draft format. Introduction of new chemical with provider. Continues in 2025/26
- Section 8- Waste Management and transition to tiger stripe, paused by Estates awaiting recruitment of waste Manager. Waste segregation covered in IPC training. Continues in 2025/26.
- Section 11- Embedding of link Practitioners challenged due to operational availability. Strategy to be reviewed. Continues 1015/26.
- Section 9-To develop antimicrobial workstream in conjunction with Pharmacy. Not progressed due to capacity within pharmacy and IPC. Continues 1015/26.
- Section 12- Information available on external internet for patients/services users. Not progressed due to team capacity. Continues 1015/26.

APPENDIX 5 - IPC Annual work programmes for 2024-2025 and 2025-2026.

IPC Annual workplan 2024-25.p

IPC Annual workplan 2025-26.p

NHS
South Central Ambulance Service
NHS Foundation Trust

Trust Board of Directors Meeting in Public
25 September 2025

Report title	SCAS Winter Framework 25/26
Agenda item	13
Report executive owner	Mark Ainsworth
Report author	Martin Blaker – Head of Resilience and Specialist Operations
Governance Pathway: Previous consideration	EPRR Delivery Group EMC F&PC
Governance Pathway: Next steps	ICB / NHSE

Executive Summary

The Winter Framework, encompassing adverse weather preparedness, has been developed to ensure South Central Ambulance Service NHS Foundation Trust (SCAS) can deliver an effective, flexible, and scalable response to the challenges posed by winter conditions—particularly severe cold weather.

Given the inherently unpredictable and dynamic nature of severe weather, its impact on SCAS and the wider NHS multi-agency system can be considerable. It is therefore essential that robust planning is undertaken in collaboration with both the Thames Valley Local Resilience Forum and the Hampshire & Isle of Wight Local Resilience Forum. This coordinated approach provides assurance of a comprehensive multi-agency response to the anticipated weather-related pressures during the 2025/2026 winter period.

The framework is aligned with national guidance, specifically the United Kingdom Health Adverse Weather and Health Plan 2025/2026 and the NHS England South-East Winter Planning Approach 2025/2026, ensuring consistency and strategic integration across all levels of preparedness.

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	Capital and/or revenue implications? There are no identified winter specific financial impacts

Recommendation(s)
What is the Committee/Board asked to do: Please amend as appropriate. The following is intended as a guide only. • Receive a report/paper and take assurance from it • Confirm decision to proceed to submit to the ICB / NHSE

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

1. Background / Introduction

Why are you writing this report now and what is the purpose of it?

1.1 To provide the SCAS Trust Board with assurance regarding SCAS winter preparedness

1.2 Obtain a Board assurance and confirmation of the Board Assurance Statement

1.3 To seek approval to submit the paper to next stage governance as required by NHSE – to ICB / NHSE

2. Detail

What relevant information do you need the meeting to have regard to in its consideration of your report?

2.1 SCAS are required to ensure appropriate winter preparedness to enable a safe delivery of service. Whilst most of the risks highlighted are not winter specific their effects can be exacerbated during the winter period.

2.2 Appendix 1 is the draft winter 25/26 framework which encompasses the planning and delivery of services, alongside risks and mitigations. This has been developed across SCAS departments and in collaboration with external partner agencies.

2.3 SCAS are required to undertake and assurance process on winter preparedness, to include a Board assurance statement for submission to the ICB/NHSE.

2.4 To note – the document is in draft format as there is some information that is not yet available – this is usual for this stage in the process.

3. Quality Impact

Does the action [or decision not to act] have an impact on patient safety, patient experience or clinical effectiveness?

3.1 The winter framework supports the ongoing delivery of safe, high-quality care.

4. Financial Impact

Does the required action [or decision not to act] have a financial impact and can this be quantified?

4.1 No specific identified winter financial impact

5. Risk and compliance impact

What is the risk to the trust if the recommended course of action is not taken? (If / then / leading to)

5.1 If the Trust does not submit an effective winter framework, then service delivery may be compromised leading to patient safety incidents.

5.2 If the Trust does not submit an effective winter framework, then assurance will not be available leading to reputational damage.

Does the decision relate to a regulatory requirement or another form of compliance?

5.3 ICB/NHSE requirement to have an effective winter framework.

5.4 Civil contingencies Act duties as a Cat 1 responding agency.

6. Equality, diversity and inclusion impact

Is there any impact to a particular group of individuals?

6.1 None identified

7. Next steps

What will you do next?

7.1 Submit the Winter Framework to the ICB/NHSE

8. Recommendation(s)

The Group / Committee / Board is asked to:

8.1.1 Receive a report/paper and take assurance from it

8.1.2 Confirm decision to proceed to submit to the ICB / NHSE

9. Appendices

9.1 Appendix 1 – SCAS Winter Framework 2025/2026

South Central Ambulance Service
NHS Foundation Trust

SCAS Winter Framework including Adverse Weather Plan

VERSION		**Draft**
CLASSIFICATION		OFFICIAL
AUTHOR(s):		Martin Blaker
DEPARTMENT		Resilience and Specialist Operations: EPRR
APPROVED BY STRATEGIC LEAD/EXECUTIVE DIRECTOR		Mark Ainsworth
DATE		14/07/2025

Contents

Version Control

Version	Amendments	Author	Date
Draft	New document for Winter 25-26	Martin Blaker (Head of Resilience & Specialist Operations)	14/07/2025

1.0 Information

This Winter Framework, including adverse weather, has been produced to provide an effective, flexible, and scalable response to the demands of Winter and specifically cold weather on South Central Ambulance Service NHS Foundation Trust (SCAS).

Severe weather by its nature is unpredictable, dynamic and its impacts on the Ambulance Service and wider NHS multi-agency partners can be significant, therefore it is imperative that effective planning occurs across both the Thames Valley Local Resilience Forum and Hampshire & Isle of Wight Local Resilience Forum to provide assurance of a multi-agency approach for this year's weather impacts.

This framework is underpinned by the United Kingdom Health Adverse Weather and Health Plan 2025/2026 and the NHS England South-East Winter Planning Approach 2025/2026.

In addition, all activities will be undertaken in line with the Joint Emergency Services Interoperability Principles (JESIP).

This document should be read in conjunction with the following policies, procedures, and guidance.

- Civil Contingencies Act 2004
- Joint Emergency Services Interoperability Principles Joint Doctrine Edition 3
- NHS England » Urgent and emergency care plan 2025/26
- NHS England EPRR Framework 2022
- NHS England Incident Response Plan (National)
- National Resource Escalation Plan (REAP)
- Cabinet Office 2012 Emergency Preparedness
- HM Government Emergency Response and Recovery- Non statutory guidance accompanying the Civil Contingencies Act 2004
- National Ambulance Resilience Unit 2021: The Duty of Care for Ambulance Responders
- SCAS Command Policy Version 5.0
- Emergency Operations Centre Standard Operating Procedures V.30
- SCAS Operational, Policies and Procedures No.5: Hospital Handover Procedure
- SCAS Operational, Policies and Procedures No.14: Clinical Safety Plan
- SCAS Water Incident Policy *(Including snow, ice, mud slurry).*
- Cabinet Office National Risk Register 2025
- Hampshire and Isle of Wight LRF Cold and Snow Plan
- Thames Valley LRF Cold and Snow Plan
- Hampshire and Thames Valley LRF Emergency Response Arrangements

Current Threat Level: The threat to the UK is Substantial- an attack is likely.

Current REAP Level: TBC at time of publishing

Distribution

Internal: This plan should be distributed internally to all SCAS Strategic, Tactical and Operational Commanders, Managers including CCC, 111 and PTS Managers. All SCAS staff via "The Hub".

External: NHS England, **Integrated Care Board (ICB)** Emergency Preparedness, Resilience and Response (EPRR) Leads, partner agencies if required via Resilience Direct.

2.0 Intention

The intention of this document is to provide an oversight of the SCAS response to Winter including adverse weather. It is not intended to cover all local business continuity arrangements in detail but provides a framework of the SCAS response and align to the wider SCAS strategic emergency preparedness, resilience and response to the winter period and adverse weather in line with the SCAS, vision, and values.

Our Mission: We deliver the right care, first time, for our patients.

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

Our Values: Caring, Professionalism, Innovation and Teamwork

2.1 Strategic Intention

To monitor the impact of Winter on patient safety, to identify and mitigate risk through effective resource allocation against availability and demand. Furthermore, SCAS intends to align to the NHS England letter "*Delivering operational resilience across the NHS this winter"* including the initiatives this year to improve our response to patients.

- Ensure appropriate number of deployed hours on the road over winter in line with agreed financial, recruitment and resourcing plans.
- Maximise call handler, clinical assessment and specialist functions capacity within the call centre.
- Ensure efficient electronic processes are in place for the transfer of patients who do not need a face-to-face response to services more appropriate for their needs, including SPOA/urgent community response, urgent treatment centres and Same Day Emergency Care (SDECs).

3.0 Method

3.1 Key Dates

The UK Health Security Agency (UKHSA) Winter Preparedness Action Program for 2025-2026 is from the TBC to the TBC.

3.2 Cold Health Alerts System

The adverse weather plan for England in conjunction with the Met Office has established four cold health alerts which will provide early insight to the trust, staff, patients, and the public of the likely impacts throughout the winter period. SCAS has a number of considerations and potential actions with each of these alerts to mitigate their impacts.

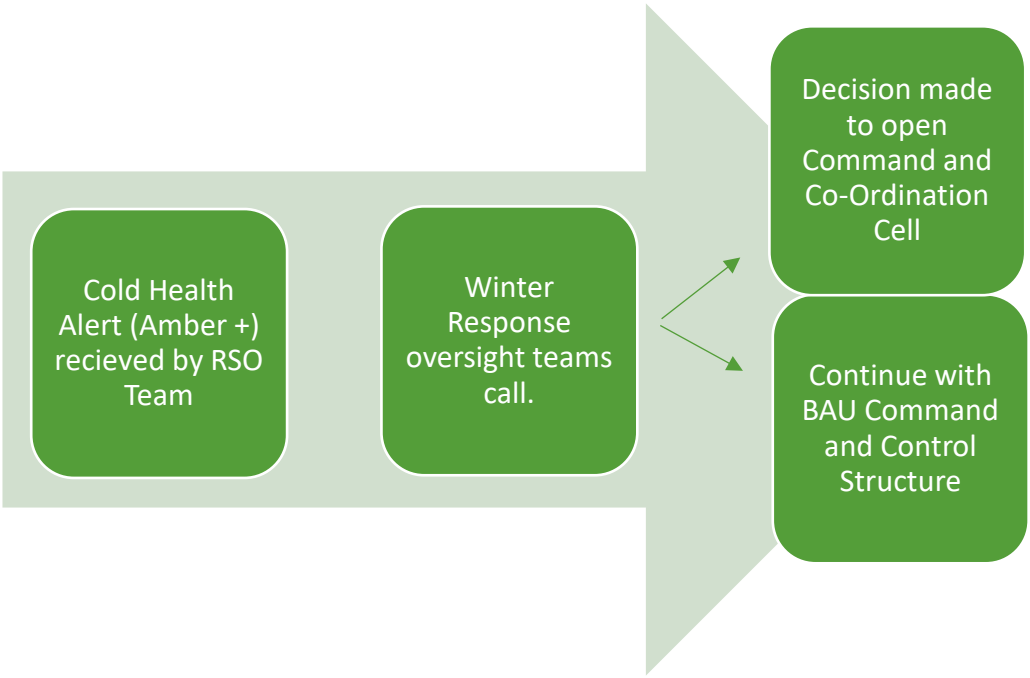
Cold Health Alerts will be circulated by the Resilience and Specialist Operations (RSO) Department to the command structure on a regular basis.

Cold Health Alert Level	Information	SCAS Action(s)
Green (Preparedness)	No alert will be issued as the conditions are likely to have minimal impact and health; business as usual and summer/winter planning and preparedness activities.	• Review of previous lessons identified to review the Adverse Weather (Winter) Framework. • Communication to staff around Winter preparedness and "Weather Ready campaigns" • Preparation and roll out of the seasonal vaccination program
Yellow (Response)	These alerts cover a range of situations. Yellow alerts may be issued during periods of heat/cold which would be unlikely to impact most people but could impact those who are particularly vulnerable.	• Internal comms will advise staff of the yellow warning if required • Daily tactical call agenda to ensure all stations have appropriate preparations in place including grit, shovels and engage with Estates to maintain supplies • Consideration of accommodation requests. • Ensure access points to Ambulance stations including CCC's is maintained via escalation through the LRF. • Consideration to approved 4x4 use via the LRF. • Moderate health risk communicated to public – focus on vulnerable groups
Amber (Enhanced Response)	An amber alert indicates that weather impacts are likely to be felt across the whole health service, with potential for the whole population to be at risk. Non-health sectors may also start to observe impacts and a more significant coordinated response may be required.	• Everbridge alert informing of Amber warning. • Consideration of the establishment of the Command and Co Ordination Cell. • Ensuring ambulance stations are proactively cleared of snow/ice through Estates team • Consideration of approved 4x4 use via LRF. • Participation in LRF PAT/TCG/SCG if required. • High health risk messages communicated to the public
Red (Emergency Response)	A red alert indicates significant risk to life for even the healthy population.	• Everbridge communication to all staff of red warning with strategic director approval • Consideration of Major Incident/Critical Incident declaration in line with Incident Response Framework triggers • Review of REAP

		• Consideration of 4x4 use and muster points to enable staff to access workplaces via LRF. • Major health risk messages communicated to public

3.2.1 SCAS Triggers

During periods of expected severe weather indicated by a Cold Health Alert Amber or above. The RSO team will receive the Cold Health Alert. If **Amber or above,** this should indicate for a **Winter Response Oversight call**- Chaired by a Strategic Commander and using the Joint Decision Model to decide whether to set up the dedicated Command and Co Ordination Cell and to invoke the Winter Response model as documented below.



3.3 Command and Control Arrangements

Business as Usual:

SCAS will routinely follow its normal command and control arrangements with a dedicated on-call rota consisting of the following:

Strategic Commander
4x Tactical Commander (2x North, 2x South)
Operational Commanders
2x NILO
1x Medical Incident Advisor (MIA)
ICT
Command Support Team/ Loggist
PTS On Call
111 On Call
Media On Call

Winter Preparedness Group (Strategic)

The strategic response to the Winter period will be overseen by the Winter Preparedness Group. Meeting on a bi-weekly basis with representatives across from key SCAS departments, this group will oversee the response including the establishment of the Winter Command and Co-Ordination Cell. The Terms of Reference for this board can be found in Appendix.7.

Winter Command and Co-Ordination Cell (Winter Response Model).

Trigger Consideration: *Amber Alert or Above*. This will supplement the command cell already in place.

During periods of predicted severe weather impacts as indicated by the Cold Weather alert of **Amber or above** the command cell will be enhanced at Northern House or Southern House Clinical Coordination Centres (CCC's) Incident Control Room (ICR). The decision the enhance the cell must be a Strategic decision using the Joint Decision Model, in consultation with the Winter Preparedness Group.

This command and co-ordination cell will support the delivery of the Adverse Weather (Winter) Plan.

- Situational Reporting
- Identification of additional requirements e.g staffing with scheduling teams,
- Regular review of weather impacts
- Identification of patient safety incidents.
- The initial response to a declared major or critical incident prior to handing over to the command structure.
- Strategic and Tactical command dedicated to Adverse Weather.
- Link to IICB's and partner agencies.
- Liaison with partner supporting agencies.
- National Interagency Liaison Officer (NILO) function from multi-agency partners to assist in the shared situational awareness and rapid identification of incidents/information which may impact on SCAS resource requirements.

The Adverse Weather Command and Co Ordination Cell should be staffed with the following.

Tactical Commander
Tactical Advisor /NILO
Trust approved Loggist/ Staff Officer
Medical Incident Advisor (On Call)
EOC Representative (CSO Dedicated to Cell)
111 Representative (Hybrid Option)
PTS Representative (Hybrid Option)
Estates representative (Hybrid Option)
Fleet and Support Services representative
Logistics
Business Continuity & Assurance Manager (Hybrid Option)
Media (On Call)
Scheduling (Hybrid Option)
HR Representative (hybrid)
Business Intelligence (hybrid)
Partner Agency NILO(s)

Contact Details (SUBJECT TO CHANGE)

Duty Tactical Commander:

01869 817 265 (Northern House ICR Direct Line) /**dutytactical@scas.nhs.uk**

01962898598 (Southern House ICR)

SCAS Northern House- Control Duty Manager/Shift Officer: 0300 123 9834 (Recorded line)

SCAS Southern House: Control Shift Officer: 0300 123 9817 (Recorded Line)

Northern House ICR Command and Co-Ordination Cell Landline: 01869 817 264/ 01869 817 265

Southern House ICR Command and Co-Ordination Cell Landline: 01962898598/01962898599

SCAS NILO: 0300 303 8140

Media On Call: 07623 957 895 oncallmedia@scas.nhs.uk

National Ambulance Co Ordination Centre (NACC): 01384 679 041/ nacc@wmas.nhs.uk

NARU/ECU On Call: 0300 373 0195

SCAS PTS On Call:

Hampshire/MK: 0300 303 8141

Both CCC's will be utilised during the adverse weather as per business-as-usual arrangements (BAU) for the handling of 999/111 calls.

In the event of a declared major incident the tactical commander must decide whether to utilise another SCAS control room ICR to run the incident or suspend the Adverse Weather Command and Co-Ordination cell. This must be documented in the NARU logbook.

3.4 Resilience and Specialist Operations (RSO) including Interoperable Capabilities

SCAS will continue to maintain the national standards for the interoperable capabilities including the Hazardous Area Response Team (HART) and Specialist Operational Response Team (SORT). These resources are available for all major or critical incidents and **must be considered early.**

The PROCLUS dashboard will be utilised to record these figures and provide assurance to the National Ambulance Coordination Centre (NACC).

The RSO department will be responsible for;

- Production of the Adverse Weather framework
- NHS England Winter Assurance
- Post incident debrief (s) and subsequent After-Action Review (AAR) process including production of the AAR Report.
- Provision of the Ambulance National Interagency Liaison Officer (NILO) and Tactical Advisor function within in the Command and Co-Ordination Cell.
- Liaison and co-ordination with multi-agency partners including both Local Resilience Forums

(HART must be considered early for any incidents which fall under the water incident policy including patients who may have entered ice environments e.g frozen lakes.

3.5 Operational staff

All operational staff will be supported by an Operational Commander as per local plans.

Dedicated Hospital Ambulance Liaison Officers (HALO's) will also be dispatched to hospitals to support staff and patients if required.

HALOs should refer to the SCAS Hospital Handover Policy provide regular situation reports to the tactical commander at least every two hours via phone or radio.

All operational staff must have the correct Personal Protective Equipment (PPE) for the duration of their shift. During periods of Amber (and above) cold health alerts staff should be reminded of the importance of being "weather ready" including packing additional clothing. It is recommended that regular communications are provided with staff through Internal communication processes.

3.6 Clinical Coordination Centres including 999/111.

Clinical advice should continue to be sought through the Clinical Support Desk (CSD) and if required with escalation to the duty Medical Incident Advisor (MIA).

South Central Ambulance Service have also increased the number of Specialist Practitioners (SPs) being deployed within Emergency Operations Centre (EOC) to support Cat 3 work and assist the Urgent Care Desk (UCD) provision. In addition to GP validation of Category (Cat) 3/4 dispositions in 111, there will also be GP input into Cat 3/4 dispositions generated in 999.

Electronic Patient Records (ePR) and e-transfer of patients and patient records are used to handover at acute trusts, to general practice, and Urgent Care Providers as well as within the 111 services. The use of SPOA/UCR by increasing volume and consistency of referrals to improve patient care, ease pressure on ambulance services and avoid admission is an ongoing workstream. South Central Ambulance Service Clinicians can access SPOA/UCR teams in all South Central Ambulance Service regions. SCAS continue to work with System Partners to improve this position regarding the transfer of electronic records to some providers.

As part of the preparedness for this winter additional mental health practitioners are available within the EOC. This provision is available 24/7 in both Northern House (provided by Oxford Health within EOC and Berkshire Health remotely). In Southern house the service is provided by Southern Health. The team is currently fully staffed, and plans are in place for further recruitment.

Additional clinical/ non-clinical floor walkers will be considered within both EOCs. Where appropriate SCAS Medical Directors/ Medical Incident Advisors will be available in control rooms when there is a Cold Health alert Red.

3.7 Patient Transport Services (PTS)

SCAS provides Patient Transport Services (PTS) across Hampshire and Milton Keynes. PTS during peaks in demand will follow actions as part of the PTS demand management plan which is reviewed daily in line with OPEL status and actions required including hours vs activity, across operational areas and contact centres.

Patient Transport Services have reviewed their Business Continuity plans for all their contract areas.

Any issues related to PTS should be escalated to the PTS on call representative via the Command and Co-Ordination cell.

3.8 Mutual Aid

All requests for mutual aid must be escalated through the National Ambulance Co Ordination Centre (NACC).

In the event of severe weather there must be early consideration for the escalation to the NACC to request additional support.

3.9 Critical/Enhanced Care including Air Ambulance charities.

The SCAS Adult Critical Care Transfer Service will continue to operate as usual to provide critical care inter facility transfers.

Enhanced clinical support can also be sought through Thames Valley Air ambulance, Hampshire and Isle of Wight Air Ambulance and BASICS as per usual procedures.

3.10 Auxiliary Ambulance Service

The Auxiliary Ambulance Service contract expired in May 2025 and, as a result, this is no longer a resource we can access should the need arise.

3.11 Education

The SCAS Education team will be able to offer additional clinical resource during periods of predicted spikes in demand in line with Resource Escalation Action Plan (REAP) actions including regularly reviewing.

- Training abstractions
- Pausing or cancellation of training courses would give planning and scheduling extra resource to provide increase operational resource cover.
- Re deployment of clinically trained staff to operational resources or Clinical Co-Ordination Centres.

3.12 Community Engagement &Training (CET) Team

The Community Engagement Team will continue to support the trust with the following resources during periods of adverse weather:

- Community First Responders (CFR)
- Co-Responders (Including Fire Service)
- Military Co Responders
- Support for frontline operations from clinically trained staff.

3.13 Operational Support Services (OSS)

Operational Support services will support periods of adverse weather by providing:

- Predicted Vehicle Requirements including Out of Service
- Additional vehicles including hire.
- Service and maintenance to ensure vehicle preparedness.
- Make Ready provision to ensure vehicle preparedness.
- The supply and distribution of winter equipment e.g shovels, grit.
- Management of Estates including out of hours contractors.

3.14 Local Resilience Forum (LRF)

All year-round planning has been underway in conjunction with both Local Resilience Forum's (Thames Valley and Hampshire/Isle of Wight) that SCAS are members of. This plan should be read in conjunction with the LRF Snow and Cold Weather Plans for both.

Throughout predicted periods of severe cold weather, a **Partner Activation Teleconference (PAT)** is likely to be triggered. The SCAS Tactical Commander must attend this PAT to provide shared situational awareness and escalation of any risks affecting the trust.

The Local Resilience Forum can offer assistance by providing a multi-agency approach to the requests of the Ambulance service during periods of cold weather including.

- 4x4 transport hub
- Multi-Agency Information Cell (MAIC)
- Partner Activation Teleconference (PAT), Tactical Co-Ordination Group (TCG), Strategic Co-ordination Group (SCG) as part of the Emergency Response Arrangements.
- Logistics cell
- Human aspects cell
- Link with government (E.g RED and MHCLG)
- Military Assistance (MACA)

3.15 Planning and Forecasting

The SCAS Planning and Forecasting team have provided predictions of pressure which are available in Appendix 6.

Planning and Forecasting will be responsible for the oversight of predicted staff/demand pressures ensuring that scheduling ensuring resource is available, within the agreed financial envelope, to assist in spikes of demand.

3.16 NHS England Incident Levels

NHS England has four incident levels which are likely to be utilised during periods of significant demand, which provide an overview on the co-ordination by NHS England and ICB's.

Incident level	
Level 1	An incident that can be responded to and managed by a local health provider organisation within their respective business as usual capabilities and business continuity plans in liaison with local commissioners.
Level 2	An incident that requires the response of a number of health providers within a defined health economy and will require NHS coordination by the local commissioner(s) in liaison with the NHS England local office.
Level 3	An incident that requires the response of a number of health organisations across geographical areas within a NHS England region. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.
Level 4	An incident that requires NHS England National Command and Control to support the NHS response. NHS England to coordinate the NHS response in collaboration with local commissioners at the tactical level.

4.0 Administration

A NARU logbook and daily situational report must be maintained by the SCAS duty Tactical Commander.

Patient report forms and EPR should be completed for all patient contacts as usual.

The daily situational report will be maintained electronically by the tactical commander, the tactical commander is responsible for ensuring that these reports are escalated to the appropriate ICB's and agencies.

An electronic log will be maintained throughout the periods of adverse weather **(Amber+ Alert)**. These logs must be retained for future reference, any decisions must be recorded in the NARU logbook with the unique number cross referenced in the electronic log.

All decisions made must be recorded using the Joint Decision Model and JESIP Decision Controls. These decisions must be recorded in a NARU logbook and submitted via the SCAS logbook submission portal.

Lessons identified: During periods of adverse weather, if there are any safety related issues these should be initially raised via the incident reporting system - Datix (including patient safety incidents). The command and co-ordination cell should also update the log with any lessons identified.

Any immediate lessons identified which may impact on this plan must be escalated to the Resilience and Specialist Operations Department Duty NILO.

An After-Action Review (AAR) will be arranged as per the SCAS Incident Response Plan.

4.1 Assurance Returns

SCAS will need to provide regular assurance to LRF partners and NHS England on their preparedness for Winter. This assurance will be co-ordinated by the RSO department but will require input from individual department leads.

4.2 Business Intelligence (BI)

To ensure accurate data recording. The BI team will provide information on

- 999 and 111 demand.
- Hospital delays
- Out of service
- Staff sickness
- Trends

5.0 Risk

The National Security Risk Assessment (NSRA) identifies low temperatures and snow (R074) as **very high risk.** This is described as;

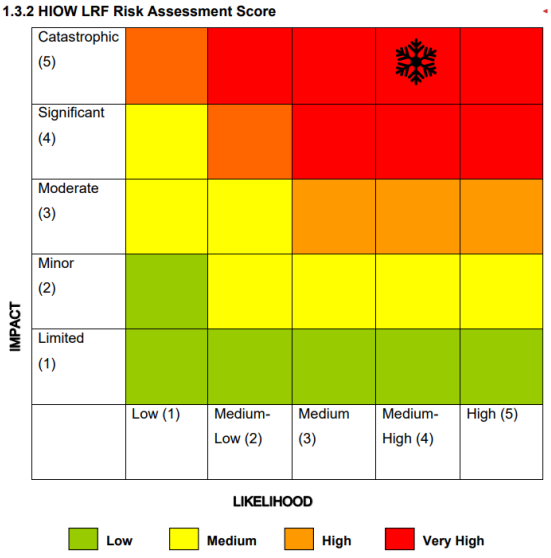
"Snow falling and lying over multiple regions of the UK and a substantial proportion of the UK population (e.g., Southwest England, South East England, London and the East of England - approximately 30 million people), including substantial areas of low-lying land (below 300m) for at least one week.

After an initial fall of snow, there is further snow fall on and off for at least seven days, with brief periods of freezing rain also possible. Most lowland areas experience some falls in excess of 10cm at a time, a depth of snow in excess of 30cm and a period of at least seven consecutive days with daily mean temperature below minus 3°C.

Overnight temperatures would fall below minus 10°C in many areas affected by snow. Such a spell of weather would affect vulnerable communities, particularly older people, and those with pre-existing conditions, such as cardiovascular and respiratory disease. An increase in falls, injuries (e.g., fractures), road accidents and hypothermia would also be expected by a prolonged period of cold, snow and ice.

There will be a large number of excess morbidity/ mortality deaths above the number experienced in a normal winter, with potentially thousands of casualties and fatalities. This will place significant pressure on health and social care services. Considerable impact to human welfare and essential services, along with economic impact, is likely due to disruption to transport, networks, power or heating fuel supplies, telecommunications, and water supplies. Schools and businesses would be impacted by such disruption".

The National Risk Register (2025) provides information in an open source document on the impacts of low temperatures and snow on the public and organisations.



Previous impacts of severe weather within the SCAS region include;

- 2009 - 1000 residents were stranded in their cars on the A3
- 2018 - the A31 near Pickets Post was blocked in both directions and up to 10,000 vehicles were backed up to junction 2 on the westbound M27. People were trapped in their vehicles for many hours.
- 2019 – Met Office warnings were issued, and multi-agency command and control meetings were stood up. Impacts were not as severe as initially thought and the response was stood down. Weather reports changed and Basingstoke was heavily impacted by snow fall.
- 2022 – Consecutive days of temperatures not rising above 0 degrees Celsius

The Met Office will provide regular updates (3 monthly updates) and forecast of predicted weather which may impact on decision making.

The current met office guidance from TBC identifies the following.

MET OFFICE 3 month outlook needs inserting for 2025/26

The Resilience and Specialist Operations department will be able to provide regular information to command structures on likely weather impacts using the Hazard Manager platform.

Local Risk Assessments must be completed by Clinical Operations Managers (COM's) or equivalent to identify local risks which should be escalated to the Winter Command and Co-Ordination Cell (if established) or the Duty Tactical Commander.

A SCAS Winter risk register will be maintained as part of the Winter Preparedness Group.

Current UK Threat Level: The threat to the UK is **Substantial- an attack is likely.**

Dynamic Risk Assessments must continue to be used during periods adverse weather in line with the NARU Duty of Care for Ambulance Responders Briefing April 2021 Duty of Care Briefing.

Appendix. 6 highlights the forecasted demand and pressure for this year, highlighting the resource requirements for and impacts of staff sickness. The main risks for this year (25/26) include:

- Finance
- Demand
- Workforce capacity
- Handover delays
- Fleet availability

5.1 OPEL Framework and Clinical Safety Plan

During periods of increased demand, the OPEL framework and Clinical Safety Plan provides a number of actions that should be undertaken to protect patient safety.

OPEL 1	ACTIONS	Lead
ALL	- Business as usual	All
EOC	- Notify all relevant staff/managers via text service of the OPEL status at **0800hrs and 2000hrs** (as per appendix 3) - Update wallboards with current OPEL levels	SECT / EOCSO
CSD	- Business as usual	CSD TL
111	- Business as usual	111 TL
Field Ops	- Support the maintenance of normal operational staffing and vehicle cover	OPS TL
Scheduling & Planning	- Business as usual	TLs
OSD	- Business as usual	TLs

OPEL 2	ACTIONS	Lead
ALL	- Ensure all actions from the previous level are completed / ongoing	All
EOC	- Notify all relevant staff/managers via text service of the OPEL status (as per appendix 3) - Update wallboards with current OPEL level - EOCDM / EOCSO to assess situation on the floor and ensure actions / support where required - Review vehicles that are in unavailable status and obtain update / contact local management - Contact Ops TL/COM to mobilise to ED experiencing delays. - Duty Manager to liaise with 111 Clinical Shift Manager and ensure they are aware of the increase in OPEL level(s). 111 clinicians will target clinical validation of all Cat 3 and Cat 4 ambulance dispositions to areas with increased demand and increase in OPEL level. - Duty Manager to liaise with 111 Clinical shift Manager to advise of any issues with local hospitals. e.g Queueing of ambulance resources at ED and impact on operational ability to respond to emergency calls. - Ensuring a non-clinical member of staff is assigned to welfare check patients - Consider the availability to transfer vehicles across dispatch sectors to balance vehicles vs demand. - - Message sent via ICAD requesting CFRs to log on.	EOCSO / EOCDM
CSD	- Welfare checks of long waits (If any) - Clinician disposition event outcomes and queue scanning – (upgrades / H&T / alternative transport) - CSD clinicians will target any 111 events that have been passed over by clinical validation of all Cat 3 and Cat 4 ambulance dispositions to areas with increased demand and increase in OPEL level.	CSD TL
111	In line with Action cards within 111 Escalation Plan	111 TL
Field Ops	- Actively support the reduction in LUH • Review vehicle availability with OSD • Review staffing with scheduling • Review skill mix and vehicle ratios with OSD / EOC - Support flow and turnaround at Hospitals where required	TLs / Ops Managers
Planning & Scheduling	- Business as usual	Planning Managers
OSD	- Review unavailable vehicle resources	OSD TLs

OPEL 3	Actions	
ALL	- Ensure all actions from the previous level are completed / ongoing	All
EOC	- Notify all relevant staff/managers via text service of the OPEL status (as per appendix 3) - Consider availability of EOC Training/Development Dept for support - EOC CSO to review the available units in all sectors and deploy as appropriate to mitigate long waits. Priority dispatch should be given to the sector(s) with the patients at the highest level of risk. - Consideration to crewing RRVs to DCUs dependant on REAP levels and in line with current EOC guidance	EOCSO / EOCDM
CSD	- Welfare checks (inc HCP calls) - Consideration for GP conversation to rebook / redirect or alternative transport - Cat 3 and 4 calls reviewed to assess H&T and use own transport - CSD to provide support to area under pressure (i.e. virtual working if required unless SCAS wide)	CSD TL
111	- In line with Action cards within 111 Escalation Plan	111 TL
Field Ops	- Team leaders/ Clinical Team Educators on management time log on and to be available to respond as required. - Managers to be logged on - Consideration to crewing up solo resources to crew ambulances. - Specialist Paramedic Hub support for lower acuity calls. Liaise with EOC Duty Manager / Shift Officer. - Consider requesting additional staff through Private Providers / Overtime / Shift extensions - Authorise the movement of SCAS assets Trust wide - Contact on-call press team and consider appropriate media and social media releases	Ops Managers
MI Gold/ Senior Performance Lead (SPL)	- Convene a SCAS wide Gold call to confirm all previous actions completed / ongoing and determine any further actions required to prevent escalation to OPEL 4. - Consideration for Command Structure and Cells (virtual or co-located) - Consideration to implement Enhanced Patient Safety Procedure –	MI Gold
Planning & Scheduling	-Consider additional Private Provision Overtime -In collaboration with OSD consider additional shifts, Overtime / Shift extensions	Planning Managers/ Field Ops
OSD	- Review unavailable vehicle resources - Consider additional driver hours if required	OSD TL

OPEL 4	Actions	
ALL	- Ensure all actions from the previous level are completed / ongoing	All
EOC	- Notify all relevant staff/managers via text service of the OPEL status (as per appendix 3) - Head of EOC and CSD manager to be available to duty EOC management and consideration to attend EOC if required - Consideration to crewing RRVs to DCUs dependant on REAP levels and in line with current EOC guidance.	EOCSO / EOCDM
CSD	- Clinician / Clinicians to complete stack management and further Triage of incidents - Triage of the longest waits to ascertain clinical need/ priority	EOCSO / EOCDM
111	In line with Action cards within 111 Escalation Plan	111 TL
Field Ops	- Notify local system partners and CCG. - Consider arranging for refreshments to be distributed to staff on duty - Attendance at Tactical Command Cell if required - Consideration for 'Immediate Handover' at Acute sites - Invoke MI IRP if required	Ops Managers / Duty Officers
MI Gold	- Activate Enhanced Patient Safety Procedure if at REAP 3	
Planning & Scheduling	- Consider additional shifts on Skillstream. - Contact Private Providers for additional availability above plan - In collaboration with OSD consider additional shifts for SCAS staff - Overtime / Shift extensions	Planning Managers
OSD	- Utilise additional driver hours	OSD TLs

5.2 Enhanced Patient Safety Procedure (EPSP)

The Enhanced Patient Safety Procedure has been designed to reduce the risk of Category 1 (Life Threatening) and Category 2 (Emergency) patients experiencing long delays. Other categories of patients that are less urgent (Category 3, 4 and 5) will be managed differently during periods of high escalation using alternative care pathways following a telephony assessment that may mean the non-allocation of an ambulance response to a patient.

This can only be authorised by the SCAS Strategic Commander. The decision to invoke this procedure must be documented on an approved NARU logbook.

5.3 Hospital Handover Delays – UPDATE INFO For due in October

Previous years has identified that hospital delays tend to increase during extended periods of adverse weather.

Budget level Task Time was set using tbc. Turnaround times forecasted at trust level range from tbc depending on Node and seasonality.

The SCAS Hospital Handover procedure outlines the process that SCAS and hospital trusts will take to protect handover delays. This includes the release to respond process, which can be authorised by a SCAS Tactical Commander to ensure that SCAS resources are released from the hospital within 45 minutes.

5.4 Industrial Action

In comparison to 2023/24 the impacts of Industrial Action (IA) on South Central Ambulance Service have reduced since the agreement of the new national pay scale for Ambulance staff. However, it is likely that impacts will continue to be seen on the ambulance service and wider NHS as other health staff take part in Industrial Action including nursing and other health service staff.

Furthermore, impacts on delivery of services through industrial action of other groups including public transport may impact the organisation indirectly due to staff availability.

SCAS continues to engage with both Local Resilience Forums to identify Industrial Action risks which may impact on the delivery of services.

5.5 Financial Impacts

It must be noted of the financial impacts the winter period will have on ambulance providers. Incentivised shifts may be utilised to assist in increase of staffing; however, this comes at a significant cost and with the current fiscal pressures this is less likely than in previous years.

6.0 Communication

6.1 Proactive public messaging

The communications team will prepare core messaging linked to the national weather alert levels covering. This will be tailored to specific context at any given time in discussion with operational leads.

Alert level	**Message focus** (subject to specific circumstances)
Yellow	• Raising awareness of risk to vulnerable groups, and advice on avoiding common issues exacerbated by cold weather • Encouraging family and friends to check on vulnerable people • Preventative care messaging – winter vaccine take-up, self-care planning etc
Amber	• Road safety messaging for heavy rain/ice/snow • Falls risk awareness • Raising awareness of risks to wider groups
Red	• Road safety messaging for ice/snow • Warning of immediate risk to whole population • Looking in on vulnerable neighbours • Highlighting pressure on services and appropriate alternatives

6.1.1 Amplifying system messaging

Through system, ICB and LRF communications networks the SCAS communications team will co-ordinate with other winter messaging campaigns and use our channels to promote wider messages around winter readiness and appropriate use of services.

6.2 Media management

The communications team will co-ordinate proactive media messaging linked to winter preparation and in response to specific weather events – using identified operational spokespeople for interviews.

Reactive requests for comment on specific issues will be co-ordinated through the communications team, with 24/7 on-call media support available to operations via pager on **07623 957 895**. All media responses will be signed off by the strategic and/or tactical commander.

6.3 Staff Communication

6.3.1 Winter readiness messaging

Established internal communications channels will be used ahead of and during winter to promote key messages to staff and volunteers, including:

- Vaccination requirements and clinic information
- Winter preparedness while at work, cross departmental focus
- Weather warnings

6.3.1 Operational alerts linked to weather condition / demand pressures

For routine operational updates on winter issues we will use the established internal communications channels for operational teams for example, this could be Operation Bulletins and Hot news (all communications are subject/priority/audience dependant).

In the event of predicted demand due to cold weather or under the authorisation of a strategic commander our mass notification system “Everbridge” will be used to communicate with staff including the actions as per the cold health alerts. This will not be used as a routine messaging platform.

6.4 Major/Critical Incident Declaration

Major Incident Definition: The Cabinet Office, and the Joint Emergency Services Interoperability Principles (JESIP), define a Major Incident as an event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder agency. In the NHS this will cover any occurrence that presents serious threat to the health of the community or causes such numbers or types of casualties, as to require special arrangements to be implemented.

Critical Incident Definition: Any localised incident where the level of disruption results in an organisation temporarily or permanently losing its ability to deliver critical services; or where patients and staff may be at risk of harm. It could also be down to the environment potentially being unsafe, requiring special measures and support from other agencies, to restore normal operating functions. A Critical Incident is principally an internal escalation response to increased system pressures/disruption to services.

Business Continuity Incident: An event or occurrence that disrupts, or might disrupt, an organisation’s normal service delivery, to below acceptable pre-defined levels. This would require special arrangements to be put in place until services can return to an acceptable level. Examples include surge in demand

requiring temporary re-deployment of resources within the organisation, breakdown of utilities, significant equipment failure or hospital acquired infections. There may also be impacts from wider issues such as supply chain disruption or provider failure.

In the event of a Major or Critical Incident declaration within the SCAS region, **all partner agencies must be informed of the declaration using a METHANE message**. This should follow the usual procedure as per the SCAS Incident Response Plan (IRP).

7.0 Humanitarian

As per any SCAS response, the Human Rights Act, specifically Article 2 Right to Life and NARU Duty of Care Briefing for Ambulance Responders must be followed during any decision-making process.

8.0 Vaccination Program

8.1 Vaccination Program

Flu vaccination remains a vital public health intervention aimed at reducing morbidity and mortality among high-risk groups, including older adults, pregnant women, and individuals with underlying health conditions. It also plays a key role in alleviating winter pressures on the health and social care system by decreasing demand for GP consultations and reducing hospital admissions. Vaccinating health and care workers is essential to limiting transmission, safeguarding both staff and patients, and minimising sickness-related absences.

8.2 Vaccination Model for 25/26

For the 2025/26 campaign, SCAS will implement a peer-to-peer vaccination model, utilising clinically trained staff to deliver vaccines. To improve accessibility, the Trust will increase the number of vaccine fridge locations and expand the pool of trained vaccinators.

Staff are encouraged to report vaccinations received externally to ensure accurate uptake data. The campaign will run for ten weeks, commencing upon vaccine arrival—typically in early October.

Electronic reporting via QR code and Microsoft Forms, introduced in 2024/25 for staff who decline vaccination or receive it outside SCAS clinics, will continue this year to support comprehensive data collection.

In addition, Business Intelligence has developed a live dashboard for 2025/26 that integrates clinic data and Microsoft Forms submissions. This dashboard will automatically update uptake figures by area and can be shared with local teams to enhance visibility and encourage participation.

8.3 Vaccination Uptake, Targets and strategy

SCAS aims to increase vaccine uptake by 5% in 2025/26. The 2024/25 campaign targeted a 50% uptake, with a final reported figure of 46.3%, representing a 17% improvement from the previous year. The target for this year is to achieve 52% or higher.

To reach this goal, SCAS will:

- Expand peer-to-peer vaccination delivery
- Increase local vaccine site availability
- Boost the number of trained vaccinators
- Enhance reporting through Qlik and the BI dashboard, including data from staff vaccinated externally

8.4 Vaccination Risk Analysis

The flu vaccination campaign is aligned with BAF and CRR risks related to operational performance, workforce wellbeing, and quality of care. Key risks include:

- Low reporting rates, which may negatively impact the Trust's reputation
- Increased staff sickness absence due to low vaccine uptake, affecting service delivery and patient experience
- A designated immunisation coordinator is in place to lead and oversee the campaign
- Ongoing reporting to all teams and submission to the national ImmForm platform, with oversight from the Integrated Care Board (ICB)

9.0 Fleet Resilience planning

9.1 August – October Preparations

The focus is on preparing for winter and the Christmas period. In August, all saloon heaters must be serviced by the end of the month, and MOT schedules—especially for HGVs—are reviewed. Planning begins for Christmas staffing and shift coverage. September emphasises reviewing summer A/C failures, stocking winter workshop supplies, and sending reminders to avoid peak MOT periods. Staff holidays are assessed, and MOTs for new fleet vehicles are scheduled to stagger registrations. October ramps up MOTs and inspections to ease the Christmas load, checks antifreeze levels during servicing, finalizes holiday leave applications, and orders supplies like wall planners and discounted air con gas.

9.2 November – March Operations

November is about finalizing Christmas rotas, arranging agency cover, and reviewing December service forecasts. Flu jabs and workshop air con servicing are scheduled, and HGV MOT planning continues. December is highly operational: demand figures are reviewed, tyre and fluid stocks checked, supplier coordination tightened, and festive messages sent to staff. January reflects on holiday performance, plans for next year's coverage, and continues MOT scheduling. February smooths out booking peaks and refines ongoing support programs. March wraps up air con servicing, begins heater servicing, and analyses winter heater failures for future prevention.

9.3 New fleet and contingencies

SCAS is currently rolling out a new fleet of Double Crewed Ambulances (DCAs). Should any issues arise with the scheduled delivery of four new DCAs per week, as outlined in the fleet plan, the decommissioning of the existing vehicles would need to be postponed.

Appendices

Appendix 1: Example LRF Partner Activation Teleconference Agenda

Use the generic ERA AGENDA. **Partner Activation Teleconference (SNOW) Agenda – additional considerations**	
1. Gather information and intelligence	
What has happened?	*Should a Major Incident be declared, based on the scale, duration and impact of the incident? (See trigger table in Plan)*
What is happening now?	Update from attendees on activity: • *Met Office – how severe is it now, and how severe is it likely to get?* • *Strategic Road network? – Highways England and Roads Policing Unit updates?* • *NHS update on system pressures? Operational Pressures Escalation Level (OPEL 1-4).* • *Any issues on hospital mortuary capacity?* • *Water company supplies and/or any repair work issues?* • *Other agencies (by exception) – e.g. EA flooding*
What is being done about it?	• *What is the strategy from SCG (if active)?* • *Other considerations (i.e. task & finish groups).*
Additional information from individual attendees *Any other specific vulnerable groups or individuals to be cognisant of?*	
2. Assess Risks and Develop a Working Strategy	
Risks *Consider the information on other weather forecasts, not just the Met Office. What are the differences?* **The worst case forecast should be the default consideration.**	
3. Consider Powers, Policies and Procedures	
Emergency Plans / Supporting Information *Specific Plans – HIOW-TV LRF ERA; TVLRF Cold and Snow Plan* *Individual Agency Business Continuity Plans; Other plans (which ones?)* **State which ones so that a written record of plans used is kept.**	
Communication with the Public *Are there any issues to escalate to SCG and inform the media strategy, if active?* *If asked, what should responding staff say to the public/ media?* *Who is the lead agency for media – consider individual agencies pre-level 3 trigger. Police for level 3.*	
4. Identify Options and Contingencies	
5. Take Action and Review What Happened	
For discussion when consideration of stand-down: *What staff rostering do agencies need to put in place?* *Further period post stand-down for the Logistics cell to stay operational.*	

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Appendix 2: Winter Response Teams Agenda

Winter Command and Co Ordination Cell

Tac Commander Agenda

Welcome

1) Any urgent updates?
2) Current performance and common operating picture.
3) Directorate updates
    - EOC 999
    - EOC 111
    - Operational Commanders
    - PTS
    - Media
    - Scheduling
    - Estates/ Operational Support Services
4) Risks and Issues
5) Actions
6) AOB

Appendix 3: 2024/2025 Winter Planning Report U&E and 111 (UPDATE WITH 25/26)

Appendix 4: Winter Preparedness Group Terms of Reference

Terms of Reference	
Title:	**Winter Preparedness Group**
Date created	October 2023 (updated September 2024)
Date of next Review	April 2025 (Post Winter)
Purpose	To provide oversight of the preparedness for Winter . Ensure that SCAS directorate arrangements are integrated and dovetailed with each other internally and with those developed locally and nationally by external partner agencies. To review outcome/Learning of Winter/Demand and operational hours delivered and any impacting factors . Provide Assurance to the SCAS Board through the Chair of the oversight Board. Provide leadership and direction to the Working groups falling under the Oversight Board. Where appropriate review progress against action plans that come from various sources: - EPRR assurance processes - Lessons identified processes. - Risk registers - Winter/IA and Power loss exercises - Non exhaustive list Identify and agree work streams with external partners such as wider Health, other Category 1 Responders and the two Local Resilience Fora (LRFs) within our region. To ensure the Trust's compliance with legislative, mandatory, and regulatory requirements in terms of the Board's scope
Membership	Assistant Director of Operations (U&E) – (Chair) Chief People Officer or deputy Chief Digital Officer Director of Commercial Services Director of Operations (CCC) Deputy Director of HR (Operations) Director of Planning and Performance forecasting or Deputy Asst. Director of Operations Head of Resilience and Specialist Operations Assistant Director of Estates **Non – core members:**

		Important specialist input will be required on an ad hoc basis – these members will be invited to meetings that will deal specifically with their work areas,
Chair		Assistant Director of Operations (U&E) – (Chair)
Deputy Chair		Assistant Director of HR (Operations) –
Quorum		A quorum shall be five members.
Frequency of Review		These terms of reference will be reviewed no less than annually.
Secretariat		Admin Manager – PA to Exec Director of Operations
Frequency of Meeting		2 weekly unless we enter a response phase such as Met Office amber alert
Issuing of Agenda and Minutes		Agenda – five working days before the meeting Minutes – five working days after the meeting (subject to approval at the next meeting.)
Attendance at meetings		Attendance at meetings is mandatory. Deputies are allowed but not encouraged.
Authority/Tolerances:		Oversee any investigation of activities within its Terms of Reference. Request reports and positive assurances from working group chairs. Obtain legal advice or other independent professional advice as required. Secure the attendance/participation of external/internal stakeholders with relevant experience and expertise. Establish time limited working groups to undertake specific pieces of work.
Function	**Decision Making**	Approve appropriate Assurance documents. Approve the Trust's Winter Framework and Adverse weather Response plan
	Advising	To recommend annually that the Trust response plan is approved by the Board. Propose effective measures are put in place to ensure resilience of the Trust
	Monitoring	To ensure SCAS's duties under the Civil Contingencies Act to provide a safe service responding to incidents. To monitor and oversee all winter, activities occurring within the Trust. To monitor and scrutinise major (large) public entertainment events within the operational area to ensure consistency and assurance of adequate

		preparation internally and externally. This includes events where SCAS provides medical and/or managerial cover and those where private providers provide the cover through the Winter and periods. To review all audits and returns making comment on any drafts prior to submission. Ensure each Trust Department and the organisation is fully compliant with Business Continuity standards, working to align themselves to ISO 22301. Demonstrate every Trust department and the organisation has completed an effective cycle of the Business Continuity Management System (BCMS)
Standing Agenda Items		• Apologies • Minutes of the last meeting - Chair • Matters arising - Chair • Winter planning update • Any contributing issues / factors • AOB • DONM

Appendix 5: Risk and Mitigations Table

Risk	Mitigation
Fleet – Workshop availability	An additional workshop is being precured to build in further capacity and resilience.
Fleet – Workforce availability	Fleet are working with agencies to build workforce capacity.
Fleet – Delay in arrival of new Fleet	Fleet will delay the decommissioning of Old vehicles
Operations – Finance	Adjustments to operating model to increase efficiency
Operations – Handover delays	Close working relationships with partners and the continued use of the Release to Respond process
Operations – Maintain a Response capability during adverse weather (SNOW/ICE)	Ongoing work with LRF and Partners regarding the planning and use of 4x4 assets and LRF winter frameworks
Operations – Workforce availability due to Winter Flu	Internal work ongoing to develop and implement a SCAS wide Vaccination program to reduce staff sickness impacts

Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust

Introduction

1. Purpose

The purpose of the Board Assurance Statement is to ensure the Trust's Board has oversight that all key considerations have been met. It should be signed off by both the CEO and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

Provider:	Double click on the template header to add details

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.		To be agreed by the Board
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	Currently being completed, by Martin Blaker, supported by Emma Vince for escalation to the Review group.
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Yes	Regional Exercise held on 8th September. Outcomes and learning will be reviewed by EPRR group when available, and lessons built into revised plan
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	AEO
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.		To be agreed by the Board
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.		To be agreed by the Board
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.	N/A	

Provider:	Double click on the template header to add details

Provider CEO name	**Date**	**Provider Chair name**	**Date**

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	An outline of the Vaccination plan has been added to the framework which outlines the link to the 5% increase
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.		Modelling to be completed in October. Annual plan is based on 12 months demand data – currently ahead of plan and will continue to deliver to plan over winter
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	N/A	
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	N/A	
Infection Prevention and Control (IPC)		
6. IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	Vaccination program and targets are included in the framework, with an outline of the plan

7.	Fit testing has taken place for all relevant staff groups with the outcome recorded on ESR, and all relevant PPE stock and flow is in place for periods of high demand.	Ongoing Risk	Risk on Ops risk register owned by KWD – MA to contact KWD
8.	A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	N/A	
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	N/A	
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	N/A	

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Upward Report of the Quality & Safety Committee

Date Meeting met **18th September 2025**
Chair of Meeting **Katie Kapernaros, Non-Executive Director**
Reporting to **Trust Board**

Items	Issue	Action Owner	Action
Points for escalation			
Papers	The quality of papers continues to improve although greater usage of data to provide assurance was requested and a strong focus on the "so what". The action log has reduced substantially and there were no overdue actions.	N/A	None
Controlled Drugs Licence	The board is asked to note that the trust has received the Home Office Controlled Drugs licence and a report was received detailing the work that is underway to address contraventions. QSC was assured in relation to the governance and oversight arrangements that are in place, via a combination of reports to QSC and the upward reports from the Medicines Optimisation and Governance Group (MOGG), which now reports to the QSC	DR	The committee will maintain a watching brief in relation to progress.
Key issues and / or Business matters to raise			

Quarterly Patient Safety Report	QSC received the Quarterly Patient Safety report ahead of presentation to the Trust Board meeting as per the agreement at the PSIRF Board Seminar. QSC also received a positive report from the ICB relating to a review that was undertaken in relation to the implementation of PSIRF in the trust.	N/A	The quarterly report will be presented to the Trust Board.
Areas of concern and / or Risks			
Top 3 Areas of Risk	Previously reported risks: • Safeguarding Referral; short- and medium-term mitigation in place pending implementation of a new electronic solution • Medicines Packing; short- and medium-term mitigations in place to manage staff shortages Newly reported risks: • Medicines Compliance and Controlled Drugs – the risk relates to the contravention of the licence, the actions required to address these and the need for dedicated project management. • Delay Related Patient Safety Incidents; emerging theme that is part of the Patient Safety Plan for the next 12 months, which will be presented to and overseen by the QSC	HY DR DR HY	QSC will be advised of implementation date QSC will be advised when team is recruited to substantively QSC will retain oversight as described above QSC will retain oversight via the Quarterly Patient Safety Report and progress against Patient Safety Plan
Items for information and / or awareness			
Quality Impact Assessment Process	The process was presented to the committee for assurance although it was noted that there was further work to do to ensure that QIAs are carried out, as required, at every level of the trust.	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			
Patient Safety Incident Response Framework (PSIRF) Implementation	A positive assurance report was received following a review undertaken by the ICB in relation to the implementation of PSIRF	N/A	N/A
Compliance with Terms of Reference			
Compliant	The meeting was quorate and all papers were appropriate the committee's terms of reference	N/A	N/A
Policies approved			
None			

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Trust Board of Directors Meeting in Public
25 September 2025

Report title	Month 5 Financial Performance
Agenda item	15
Report executive owner	Stuart Rees, Chief Finance Officer
Report author	Mariam Ali, Assistant Director of finance
Governance Pathway: Previous consideration	Executive Management Committee and Finance & Performance Committee
Governance Pathway: Next steps	n\a

Executive Summary

As of Month 5 (August 2025), the Trust's financial performance remains broadly in line with the full-year breakeven plan, supported by rephasing and non-recurrent measures. The underlying year-to-date (YTD) position reflects a £2.3m adverse variance before these non-recurrent adjustments, driven by cost pressures in frontline staffing, under-delivery of Cost Improvement Programmes (CIPs).

Key Highlights:

- Income & Expenditure:
  - In-month deficit of £65k in line with plan.
  - Year-to-date a surplus £685k in line with plan.
  - Pay costs exceeded plan by £589k, largely due to over-establishment in frontline operations.
  - Agency spend is £115k above plan.

Key Performance Indicators

	Plan	Actual	Variance
Surplus / (Deficit) In-month (£'000)	-64	-65	-1
Pay Costs In-Month (£'000)	17,778	18,367	-589
Agency Costs - in month (£'000)	51	166	-115
Capital Spend in-Month (£'000)	16,664	8,181	8,483
Closing Cash Position August (£m)	27.2	18.3	-8.9

- **Capital:**
  - YTD capital spend was £8.2m, underspending by £8.5m due to delays in sale and leaseback transactions for Double Crewed Ambulances (DCAs) and Rapid Response Vehicles (RRVs).
  - Forecast remains on track to break even, though pressures exist due to increased DCA costs and limited CDEL availability.
- **Cash:**
  - Month-end cash balance was £18.3m, £8.9m below plan due to timing of leaseback receipts.
  - Net cash inflow of £1.96m in August, supported by vehicle sales and reduced purchases.
- **Financial Risks:**
  - Loss of system deficit support funding and continued cost pressures pose risks to breakeven delivery.
  - Mitigations are being developed through the Financial Recovery Plan (FRP), which now targets £24.4m in savings.
- **Contracts & Income:**
  - Ambulance and Integrated Urgent Care contracts for 2025/26 have been agreed.

Alignment with Strategic Objectives

With which strategic theme(s) does the subject matter align? (If more than one, please write manually)

Finance & Sustainability

Relevant Board Assurance Framework (BAF) Risk

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

SR5 - Increasing Cost to Deliver Services

Financial Validation	Capital and/or revenue implications? If so: Checked by the appropriate finance lead? (for all reports) Considered by Financial Recovery Group (for reports where the financial impact is not covered within existing budgets)

Recommendation(s)
• What is the Board asked to do: Receive a report/paper for noting

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

1. Background / Introduction

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

Income and Expenditure (I&E)

In month 5, the Trust's I&E position is in line with the FY breakeven plan. This is after accounting for re-phasing and non-recurrent measures of £0.3m.

£m	M1	M2	M3	M4	M5	YTD
Plan	0.2	0.2	0.4	(0.0)	(0.1)	**0.7**
Actual	0.2	0.2	0.4	(0.0)	(0.1)	**0.7**
Variance to Plan	-	-	-	-	-	-

The YTD underlying position is now £2.3m worse than plan, with £1.9m re-phasing a one-off technical benefit of £0.3m to deliver the YTD reported position

	Apr-25 £'000	May25 £'000	Jun-25 £'000	Jul-25 £'000	Aug-25 £'000	FY 25/26 £'000
Income Rephasing	375	500	543	152	344	1,914
Non Recurrent Adjustment	-	-	352	-	-	352
Other						
Income Rephased	375	500	895	152	344	2,266
Cumulative	375	875	1,770	1,922	2,266	

For SCAS, the table below details the financial position, by Division, as of Aug 2025 (Month 5)

£m		Month 5			Year to Date		
		Actual	Plan	Variance	Actual	Plan	Variance
999	Income	21.2	21.0	0.2	105.9	103.9	2.0
	Expenditure	(16.7)	(16.3)	(0.4)	(83.3)	(80.9)	(2.4)
	Contribution	4.5	4.7	(0.2)	22.6	22.9	(0.4)
	%	21%	22%		21%	22%	
111	Income	3.8	3.8	(0.0)	18.8	18.8	(0.0)
	Expenditure	(3.2)	(3.2)	0.0	(15.8)	(15.5)	(0.2)
	Contribution	0.6	0.6	(0.0)	3.1	3.3	(0.2)
	%	16%	16%		16%	17%	
PTS	Income	1.9	2.0	(0.1)	9.7	9.8	(0.2)
	Expenditure	(1.4)	(1.7)	0.3	(8.2)	(8.2)	0.0
	Contribution	0.5	0.3	0.2	1.5	1.7	(0.1)
	%	27%	16%		16%	17%	
Operations Total Contribution		**5.6**	**5.6**	**(0.0)**	**27.2**	**27.9**	**(0.8)**
%		21%	21%		20%	21%	
Corporate		(5.7)	(5.7)	0.0	(26.7)	(27.5)	0.8
Surplus/(Deficit)		**(0.1)**	**(0.1)**	**0.0**	**0.4**	**0.4**	**0.0**
Reporting Adjustments		0.0	0.1	(0.0)	0.2	0.3	(0.0)
Adjusted Surplus/(Deficit)		**(0.1)**	**(0.1)**	**(0.0)**	**0.7**	**0.7**	**(0.0)**

Service-Specific Performance

The main points to note for Month 5 performance is:

999 Division

£222k deficit against budget, an underlying position of £566k has been offset by £344k of rephased income which moves the risk of financial delivery into H2.

The Expenditure variance of (£378k) deficit in the month for 999 relates to:

- Resource Frontline Ops are 60 wte over- established, mainly due to TUPE staff. This is driving £385k overspend on substantive SCAS staff. We are seeing benefits within our flexible resource (Overtime & Private Providers) and is currently £225k underspent offsetting some of the additional staff costs.
- Frontline non-pay is underspent £116k mainly due to vehicle leases budget for New Vehicles however delays in delivery.
- Frontline plans to recoup over establishment overspend are underway and part of the FRP.
- Fleet £121k overspent due to the YTD CIP delivery
- Emergency Operations Centre (EOC) are £73k underspent mainly due to vacancies 5wte Clinicians, 15 wte Audit & Training.
- A&E Trust-wide is overspent by £286k due to under delivered CIP in month across the operational areas.

111 Services

Breakeven against budget

Non-Emergency Patient Transport Services (NEPTS)

The NEPTS division reported a £198k surplus against budget, including a one-off £352k non-recurrent benefit.

Operational expenditure continues to be adversely impacted by delays in finalising the optimal fleet configuration and returning surplus vehicles. These delays have resulted in sustained costs that were expected to reduce in 2025/26, particularly in relation to repairs and maintenance. The anticipated savings from operating a newer, leaner fleet have not materialised due to the extended retention of older vehicles, leading to unfunded maintenance and MOT expenses.

A number of vehicles have now been identified for return; however, associated costs will persist until the contractual notice periods have expired.

Additionally, the division is experiencing increased expenditure following the implementation of revised Integrated Care Partnership (ICP) guidance. This has introduced extended cleaning requirements and associated costs. Further financial pressure has arisen from unanticipated large-scale vehicle damage and legal advisory costs related to Private Provider (PP) contracts.

Corporate

£93k deficit against plan.

- Finance is overspent in month by £25k mainly due to the YTD CIP delivery.
- Education is overspent by £69k mainly due to the apprenticeship levy income shortfall, which is a result of there being less trainee staff within SCAS.

Depreciation and financing costs
Lower than plan at £118k due to the continued phasing differences of the capital programme.

Financial Risks

We continue to forecast a FY financial position in line with our breakeven plan. The current approach assumes that budget holders will manage spend within budgeted levels, deliver their full efficiency requirement with any shortfall throughout the 2025/26 mitigated through additional savings.

There are a few known risks to delivering the breakeven plan, these include the current underlying run rate (additional workforce costs and underperformance of CIP), the now confirmed loss of the deficit support funding for the system. These will need to be mitigated by additional cost savings which has already been identified in the Financial Recovery Plans, however, this requirement will also need to expand to cover the loss of the DSF.

There are potential further non recurrent benefits which we are working to clarify over the next month, these will provide some mitigations against our current financial risks. These will be captured in future months as they become known and quantified.

Risks	£'000s
Month 5 YTD Underlying run rate continues	(£5,438)
Further Cost Pressures	-
Slippage of Efficiencies	-
Other	-
Trust Risks	**(£5,438)**
Mitigations	
Developing Mitigations from :	£5,438
- Increase in Savings Delivery	
- Further Additional Efficiencies	
- Further Non Recurrent Benefits	
Total Mitigations	**£5,438**
Unmitigated Risk	-

Further Potential System Risks	£'000s
Deficit support Fundng Lost (Qtr 3 & 4)	(£1,330)
Deficit support Fundng clawback (Qtr 2)	-
DSF Risk	**(£1,330)**

Financial Recovery Plan (FRP)

The Trust's Financial Recovery Plan target was revised in July to £24.4m, this has increased from the planned £21.6m, due to current YTD underlying financial performance and additional cost pressures.

Further work has been undertaken during August challenging the current delivery and risks within existing efficiency programme using a RAG rating. The initial feedback has been reviewed at executive level with targeted action plans being developed.

The FRP is broken down into various schemes spread across all the Trust's divisions, these are covered in in the Financial recovery paper.

Trust Pay Costs

Pay	Month 5			Year to Date		
	Actual	Plan	Variance	Actual	Plan	Variance
Substantive	17,941	17,332	(609)	87,433	86,519	(914)
Bank	260	395	135	1,964	1,975	11
Agency	166	51	(115)	846	339	(507)
Total Pay	**18,367**	**17,778**	**(589)**	**90,243**	**88,833**	**(1,409)**

Pay Costs:

- Total pay expenditure for the month was £18.3m, against a planned figure of £17.7m mainly due to the over establishment within frontline Ops.
- The 2025/26 AfC pay award was received by our staff in August, this was higher than initially budgeted and the Trust has received additional income for the increased pay costs. We are not seeing any noticeable or further pay cost pressures from this pay award.

Agency Spend:

- Agency costs totaled £166k, exceeding the plan by (£51k).
- The spend above plan was driven by Fleet Mechanics.

Run Rate

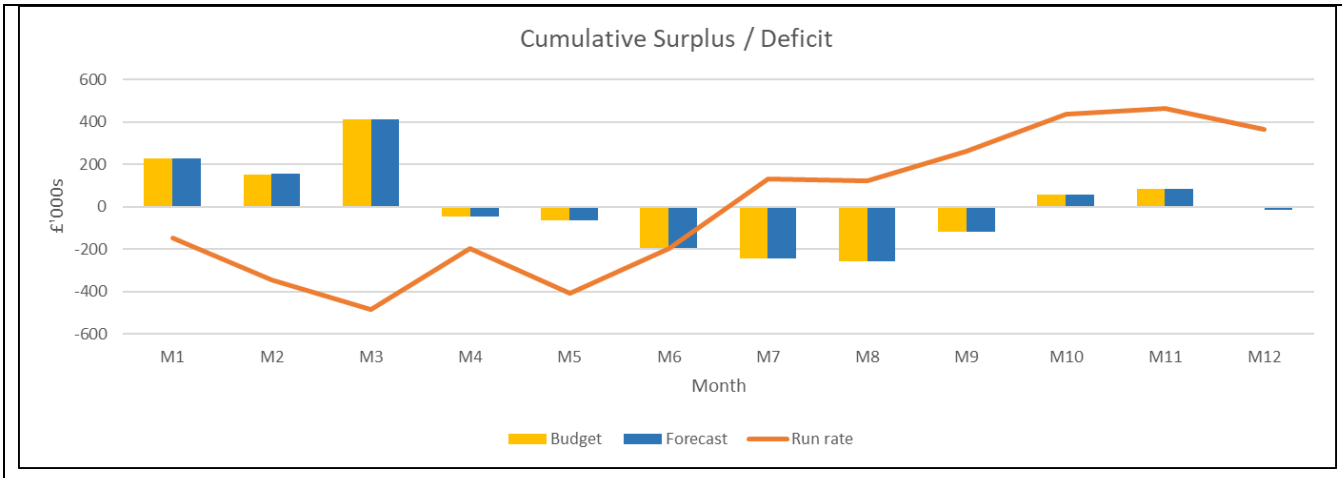
Using the reported extrapolated YTD run rate on a straight-line basis adjusted for the income rephasing and non-recurrent benefit in the Trust will out turn at £5.4m deficit.

This is an intended as an indication only and is based on the current underlying monthly position. Actions and mitigations have and continue to be actively developed including the further efficiency target alongside potential further non recurrent benefits. It is anticipated these will fundamentally close the risks within the Trusts immediate control.

A paper has been taken to Executive Management Committee (EMC) that looked 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 Trust wide forecast outturn which shows the Trust will make a circa £4m deficit if CIPs delivery and cost pressures are not covered by further savings.

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

The ICB has indicated the system will lose the Qtr 3 & 4 deficit support funding for 2025/26, if this cannot be reinstated by NHSE this will further increase the Trust's additional savings required.



Income & Contracting

Ambulance Service Contract 2025/26

The Ambulance Service Contract 2025/26 now reflects the agreed financial settlement, following dispute resolution in July.

Thames Valley Integrated Urgent Care Contract (TV IUC) 2025/26

The Thames Valley Integrated Urgent Care Contract Commissioners have agreed with SCAS the financial values for the Integrated Urgent Care contract for 2025/26.

Hampshire Surrey Heath (HSH) Integrated Urgent Care (IUC) Contract 2025/26

The Trust's lead Commissioning ICB are working with SCAS to agree a Contract Variation Order to reflect the 2025/26 funding and Indicative Activity Plan (IAP) for the Hampshire Surrey Heath (HSH) Integrated Urgent Care (IUC) Contract.

Capital

The Trust's capital spend by Aug was £8.2m. The Trust underspent against its capital budget by £8.5m, this was due to slippage in the sale/leaseback element of capital projects.

Capital underspend – Key Drivers

- The £8.5m capital underspend reported in Month 5 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 flat-phased across April to Aug, with 62 vehicles received to date with 45 in the process of being subject to a sale and leaseback transaction. Due to delays the IFRS16 lease underspend is £9.5m offsetting Capital Department Expenditure Limit (CDEL) spend of £7.7m. This has resulted in an in-month underspend of £0.2 million. The first tranche of the associated sale and leaseback arrangement—covering these 45 units—was expected to complete in Aug but has slipped into October.
    - 2024/25 DCA Cohort (72 Fiat units): Delivery has been delayed. While chassis were accrued in 2024/25, the associated conversion and equipment costs are now expected to begin in September 2025. Due to delays the IFRS16 lease underspend is £4.9m offsetting CDEL spend of £4m
    - 2025/26 DCA Cohort (70 MAN units): Although chassis have been paid for, the conversion and equipment costs are now expected in early 2026.
    - Rapid Response Vehicles (RRVs): Chassis were purchased in 2024/25, with conversion originally scheduled for Q1 2025/26. The sale and leaseback of 15 units, initially expected in June, has now slipped and is expected to be received in early October.

- HART vehicles were purchased partly in 2024/25 and partly in 2025/26, the conversion has been completed for 8 of the 9 units and these were subject to a sale and leaseback agreement that completed in August. The income generated from the sale of the first 8 vehicles was expected to be £1.337m + VAT.

The Hampshire and Isle of Wight Integrated Care Board (HIOW ICB) has agreed to fund SCAS an additional £0.5m CDEL for the purposes of fitting out and leasing the Aylesbury Workshop. The fit-out costs are forecast at £0.5m, however, no CDEL room was allowed for the IFRS16 lease element of £1m.

The sale of the Chalfont property is progressing.

The Amersham now has a potential buyer.

With no other improvement to the current level of CDEL made available to the Trust by the HIOW ICB the Trust is now having to delay or reject capital schemes.

Forecast

		Year to Date			Forecast		
	£m	Actual	Plan	Variance	Actual	Plan	Variance
Estates	Internal CDEL	1.1	0.9	0.1	1.4	1.4	0.0
	PDC *	0.0	0.8	(0.8)	5.1	5.1	0.0
	IFRS16	0.0	0.0	0.0	0.0	0.0	0.0
	Total	**1.1**	**1.7**	**(0.6)**	**6.5**	**6.5**	**0.0**
Digital	Internal CDEL	0.2	0.3	(0.1)	1.0	1.0	0.0
	PDC *	0.2	0.0	0.2	1.1	1.1	0.0
	Total	**0.4**	**0.3**	**0.1**	**2.1**	**2.1**	**0.0**
Fleet (23/24 DCA Cohort)	Internal CDEL	1.9	(5.9)	7.7	(5.9)	(5.9)	0.0
	IFRS16	0.0	9.5	(9.5)	9.5	9.5	0.0
	Total	**1.9**	**3.6**	**(1.8)**	**3.6**	**3.6**	**0.0**
Fleet (24/25 DCA Cohort)	Internal CDEL	4.0	0.5	3.5	(2.8)	(2.8)	0.0
	IFRS16	0.0	4.9	(4.9)	9.8	9.8	0.0
	Total	**4.0**	**5.4**	**(1.4)**	**7.0**	**7.0**	**0.0**
Fleet (25/26 DCA Cohort)	Internal CDEL	0.0	(5.3)	5.3	(10.5)	(10.5)	0.0
	PDC *	0.5	5.1	(4.6)	8.4	8.4	0.0
	IFRS16	0.0	4.9	(4.9)	9.8	9.8	0.0
	Total	**0.5**	**4.7**	**(4.2)**	**7.7**	**7.7**	**0.0**
Fleet (Non-DCA)	Internal CDEL	(1.1)	(1.7)	0.5	(4.2)	(4.2)	0.0
	IFRS16	1.5	2.6	(1.1)	6.1	6.1	(0.0)
	Total	**0.3**	**0.9**	**(0.6)**	**1.9**	**1.9**	**(0.0)**
Internal CDEL Total		6.0	(11.0)	17.1	(20.9)	(20.9)	0.0
IFRS16 Total		1.5	21.9	(20.4)	35.2	35.2	0.0
PDC * Total		0.7	5.8	(5.2)	14.6	14.6	0.0
Total		**8.2**	**16.7**	**(8.5)**	**28.9**	**28.9**	**0.0**

* PDC – Public Dividend Capital

The capital forecast for the year is to break even, there is a managed pressure of £0.158m due to the increased cost of the DCA's in the year which is being managed in year to return the forecast to plan by month 12. In addition to the DCA's there is a £0.5m overspend agreed by the HIOW ICB, this will be reflected in future months.

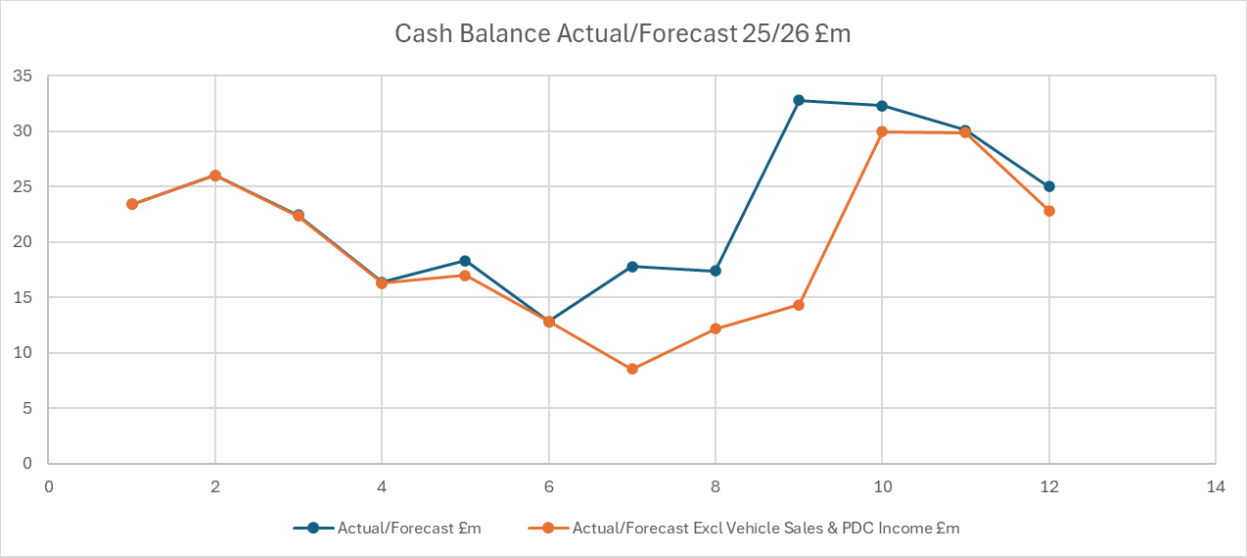
Cash

The Trust's cash balance at the end of Aug was £18.3m.

2025/26	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Income £m	30.3	29.6	25.2	29.6	29.8	28.3	35.9	31.8	45.1	29.0	26.8	28.8
Expenditure £m	(34.9)	(27.0)	(28.8)	(35.6)	(27.8)	(33.8)	(30.9)	(32.2)	(29.7)	(29.4)	(29.0)	(33.9)
Net Inflow/(Outflow) £m	(4.6)	2.6	(3.6)	(6.1)	2.0	(5.5)	5.0	(0.4)	15.4	(0.5)	(2.2)	(5.1)
Cash Balance £m	23.4	26.0	22.4	16.4	18.3	12.8	17.8	17.4	32.8	32.3	30.1	25.0
Cash Lowest Point	21.6	19.8	22.0	11.9	13.8							

The lowest point of cash in the month was £13.8m which is an increase from last month of £1.9m. The increase in cash is mostly due to the receipt of sale/leaseback monies and a decrease in purchases.

There was a net cash inflow in month 5 of £1.96m due mostly to £1.3m on vehicles sales and a decrease in purchases. This is £8.9m below the plan due mostly to the timing of DCA sale and leaseback receipts this was due to slippage in the sale and leaseback of Double Crewed Ambulances (DCA's) and Rapid Response Vehicles (RRV's). The March 2026 cash forecast has decreased by £4.64m due to the slippage of the sale and leaseback income of the 2025/26 MAN cohort into 2026/27 into April 2026.



The 90-day debtor increased to £0.297m in July (£0.121m in July). This represents 30.24% (14.36% in July) of the total debtor balance. The percentage debtors has increased sharply due to the overall debt balance increasing, due partly to NHS Dorset not paying their 25/26 Dental Contract invoice.

Our Better Payment Practice Code (BPPC) performance continues above the 95% target at month 5.

	Month 5 - YTD BPPC		
	Target	Actual	Variance
Value	95.0%	98.7%	3.7%
Number	95.0%	95.4%	0.4%

2 Quality Impact

3 Financial Impact

As detailed above

4. Risk and compliance impact

Area of Risk

- In month 5, YTD re-phasing of £1.9m. This will require a reduction in expenditure in future months to offset this phasing into earlier months.
- The CIP plan needs to deliver in full to achieve the planned break-even position.
- The capital plan has been reduced in line with available funding. The capital requirements of the Trust exceeds available funding. The Trust will need to continue to pursue funding opportunities to meet capital requirements.
- The delay in delivery of new DCA vehicles will impact the replacement policy and 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 and will so lead to higher maintenance costs.
- Workforce cost pressures: Pay and agency costs are significantly over budget
- 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 5, the following actions have been taken:

- Further push the workforce recovery plans.
- Continue to review frontline establishment, identifying opportunities to delay, reduce or stop recruitment.
- Identify management strategies to control costs
- FRG and Financial Sustainability Development Group (FSDG) meetings have be refocused and provide challenge to the divisional recovery plans.
- EMC will be review the detailed action plan and specific steps for each area to address CIPs requirement.

7. Recommendation(s)

The Board is asked to:

- The Board is asked to note the Month 5 Financial performance and current risks to delivering the FY plan.

NHS
South Central Ambulance Service
NHS Foundation Trust

Trust Board of Directors Meeting in Public 25 September 2025

Report title	Month 4 BOB System Reports
Agenda item	17
Report executive owner	Stuart Rees, Chief Finance Officer
Report author	Dilani Russell, Interim Director of Operational Finance Ben Gattlin, Associate Director of Performance
Governance Pathway: Previous consideration	
Governance Pathway: Next steps	BOB ICB

Executive Summary

The BOB Integrated Care System (ICS) reports a Year-to-Date (YTD) breakeven position at Month 4, with a favourable variance to plan across the system. This is partly due to the early implementation of mitigations originally planned for later in the year, aimed at offsetting the financial impact of industrial action (IA) in July, which incurred direct costs of approximately £1.1m.

Key financial highlights:

- ICB Position: Breakeven YTD and Forecast Outturn (FOT).
- Acute Services: Forecast overspend of £10.4m, driven by overperformance in Frimley Health, Circle, and Ramsay.
- Community Services: Forecast overspend of £2.1m, mainly due to equipment costs and increased activity in diagnostics and physiotherapy.
- Mental Health & LD: Forecast overspend of £7.7m, with pressures from Section 117 packages and ADHD/Autism services.
- Prescribing: YTD overspend of £1.5m, with risks from NICE guidance and ADHD-related prescribing.
- Primary Care: Forecast overspend of £1.6m, primarily due to slippage in GP Locally Commissioned Services (LCS) and CIP delivery.
- Continuing Care: Forecast breakeven, with a favourable movement from M3 due to improved package management.
- Capital Programme: YTD underspend of £14.7m, with a forecast underspend of £9.0m, largely due to profiling and project phasing.

The system-wide Cost Improvement Plan (CIP) delivery is behind plan by £3.5m YTD, though the full-year forecast remains on target. However, several schemes are rated high risk, particularly in prescribing and estates.

Overview of system performance across five priority areas, supplemented by broader quality and operational metrics. Data spans from February to July 2025, depending on availability.

Key Performance Areas:

1. Urgent and Emergency Care (UEC):
    - July performance at 81% for the 4-hour standard, exceeding the March 2026 target of 78%.
    - Continued promotion of alternatives to ED and utilisation of Single Point of Access (SPOA).
    - Winter planning underway, aligned with NHSE Board Assurance requirements.
2. Elective Care:
    - 64% of patients seen within 18 weeks; efforts ongoing to reduce 52-week breaches.
    - Validation exercises and load balancing initiatives in progress.
3. Learning Disabilities & Autism:
    - System shows a reduction in inpatient reliance, aligned with the target of a 10% reduction.

- Quarterly figures now used for more accurate tracking.

4. Cancer:

    - 62-day standard performance at 66.4% in June, below the 75% target but improving.
    - Faster Diagnosis Standard (FDS) at 78.6%, above plan.

5. Primary Care Access:

    - GP numbers slightly increased; patient satisfaction remains high.
    - 889K appointments delivered in M3, an increase from the previous period.

Additional Highlights:

- Maternity: Smoking rates at booking (3.77%) and delivery (4.76%) are within target; breastfeeding initiation above 80%.
- Quality & Safety: One Never Event reported; system-wide improvement collaborative under development.
- Autism & ADHD (CYP): Over 15,500 children on waiting lists; mean wait times range from 68 to 100 weeks.
- Dentistry: Ahead of targets for children and adult access; urgent dental appointments progressing.
- Workforce: Absence and turnover rates below regional averages; retention initiatives in place.
- Infection Control: Mixed performance across CDI, MRSA, MSSA, Klebsiella, and E. coli; proactive planning for winter outbreaks.

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 (M4) and contents of the Performance and Quality Report.

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

NHS
South Central Ambulance Service
NHS Foundation Trust

Trust Board of Directors Meeting in Public
25 September 2025

Report title	**NHS Hampshire and Isle of Wight Green Plan 2025-2028**
Agenda item	18
Report executive owner	Stuart Rees, Chief Financial Officer
Report author	HIOW ICS
Governance Pathway: Previous consideration	N/A
Governance Pathway: Next steps	N/A

Executive Summary

Executive Summary: ICS Green Plan 2025–2028
The Hampshire and Isle of Wight Integrated Care System (ICS) Green Plan 2025–2028 sets out a strategic framework to accelerate the region's transition to a sustainable, net zero health and care system. Building on the achievements of the previous Green Plan (2022–2025), this refreshed plan outlines the collective ambition and coordinated actions required to address the dual challenges of climate change and public health inequalities.

Strategic Context
Climate change poses a significant threat to health and wellbeing, with many of its drivers also contributing to poor health outcomes and inequalities. The ICS, serving 1.9 million people, recognises its responsibility to lead on environmental sustainability while improving population health. The NHS has committed to achieving net zero emissions by 2040 for directly controlled emissions and by 2045 for emissions it can influence.

Current Position
The ICS's carbon footprint in 2019/20 was estimated at:

- NHS Carbon Footprint: 150,980 tonnes CO_2e
- NHS Carbon Footprint Plus: 767,200 tonnes CO_2e

Progress has been made in areas such as reducing desflurane use, increasing LED lighting, expanding low-emission vehicle fleets, and implementing active travel schemes. However, challenges remain, particularly in energy consumption and emissions from medicines and inhalers.

Key Priorities and Deliverables
The plan identifies 10 thematic workstreams aligned with NHS England's Green Plan guidance:

1. Workforce and Leadership: Strengthening sustainability leadership and staff engagement.
2. Net Zero Clinical Transformation: Embedding low-carbon care pathways and quality improvement projects.
3. Digital Transformation: Expanding virtual care and digital infrastructure to reduce emissions.
4. Medicines: Reducing emissions from prescribing practices and promoting sustainable alternatives.
5. Air Quality, Travel and Transport: Electrifying fleets, promoting active travel, and improving air quality.
6. Estates and Facilities: Decarbonising buildings, enhancing energy efficiency, and increasing renewable energy use.
7. Supply Chain and Procurement: Aligning procurement with net zero goals and promoting circular economy principles.
8. Food and Nutrition: Reducing food waste and promoting low-carbon, nutritious diets.
9. Adaptation: Enhancing climate resilience across services and infrastructure.
10. Governance and Accountability: Establishing robust oversight mechanisms, including a potential provider collaborative.

Legal and Regulatory Compliance
The plan aligns with statutory obligations under the Climate Change Act 2008 and the Health and Care Act 2022. NHS organisations are required to publish and report on Green Plans, monitor progress, and ensure supplier compliance with the NHS Net Zero Supplier Roadmap.

Alignment with Strategic Objectives
With which strategic theme(s) does the subject matter align? Partnership & Stakeholder Engagement

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

Financial Validation	N/A

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

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

NHS
Hampshire and Isle of Wight

Green Plan 2025-2028

Making our health and care system and population healthier and greener.

ICS Green Plan 2025 to 2028: Making our health and care system and population healthier and greener

Foreword

"Given the global health imperatives, the NHS must stick to its net zero ambitions. There is no trade-off between climate responsibilities and reducing waiting lists. Indeed, often health and climate are mutually reinforcing goals: cleaner air is good for the environment and good for respiratory health."
Independent investigation of the NHS in England, Lord Darzi, September 2024

Our region faces significant risks from climate change - many of the causes of climate change are also the causes of ill health and health inequalities in our region.

The carbon footprint of the Hampshire and Isle of Wight Integrated Care System is over 760,000 tonnes CO_2e. (tonnes of carbon dioxide equivalent)

In support of the NHS becoming the world's first health service to commit to reaching carbon 'net zero', primary and secondary care organisations in the ICS have been undertaking some great work in delivering the previous Green Plan (2022 to 2025)- see page 11 – but more needs to be done.

To speed and scale up carbon reduction across primary and secondary care we need to continue to integrate and coordinate good practice across the ICS.

This Plan will describe the role of the ICS and the Trusts within Hampshire and the Isle of Wight, working collectively, in:

- Acting as a catalyst for transformation within communities and partners.
- Ensuring system wide collective accountability and leadership.
- Enhancing collaboration across the ICS and beyond.
- Aligning with local authorities and other key partners.
- Ensuring consistency in approach.

This will help NHS organisations progress faster than they would alone, reduce costs across the system, prevent unnecessary duplication of effort and enhance protection of the most vulnerable from climate change.

Introduction

Many of the causes of ill health and health inequalities are also the causes of climate change. NHS organisations, in collaboration with local government, communities, patients and other partners therefore have a vital role in the system to integrate economic, environmental and social sustainability as the 'new norm' in everything we do, reducing harmful carbon emissions and improving health.

Climate change is the biggest threat to future health. Action now can both mitigate against the impacts of climate change and improve health and reduce inequalities

About Us

Hampshire and Isle of Wight Integrated Care System (ICS) - NHS	
	126 GP practices 42 Primary Care Networks
	900 suppliers of domiciliary, nursing and residential care
	Over 300 community pharmacies
	200 providers of dental services providing a range of general dentistry and orthodontics and nearly 200 providers of optometry services
	Acute, mental health and community NHS care by Hampshire Hospitals NHS Foundation Trust, Isle of Wight NHS Trust, Portsmouth Hospitals University NHS Trust, Hampshire and Isle of Wight Healthcare Trust, South Central Ambulance Service NHS Foundation Trust, and University Hospital Southampton NHS Foundation Trust

The Hampshire and Isle of Wight Integrated Care System (ICS) is a partnership of NHS and local government working together to improve the health and wellbeing of our local communities.

It is one of the largest health and care systems in the country, serving 1.9 million people, and is one of 42 ICSs in England.

Hampshire and Isle of Wight faces an aging population, rising obesity rates and health inequalities. Air quality, a major public health risk, which impacts the most vulnerable, is particularly poor in parts of the region.

Net zero NHS

In October 2020, the NHS became the world's first health service to commit to reaching carbon 'net zero[i]', in response to the growing threat to health posed by climate change. There is a clear ambition, set out in statute, and two evidence-based targets:

NHS Carbon Footprint

Directly controlled emissions arising from the use of energy and water, the generation of waste, the use of travel for Trust business, anaesthetic gases and metered dose inhalers.

Target: to reach 'net zero' by 2040 and an ambition to reach an 80% reduction by 2028 to 2032 (compared with a 1990 baseline).

Since 2010 the NHS has cut its carbon footprint by 30%.

NHS Carbon Footprint Plus

As well as the above this includes other emissions which can be influenced; arising from NHS supply chains (from goods and services procured) and within communities, such as those arising from staff commuting and patient and visitor travel to NHS sites.

Target: reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039 (compared with a 1990 baseline).

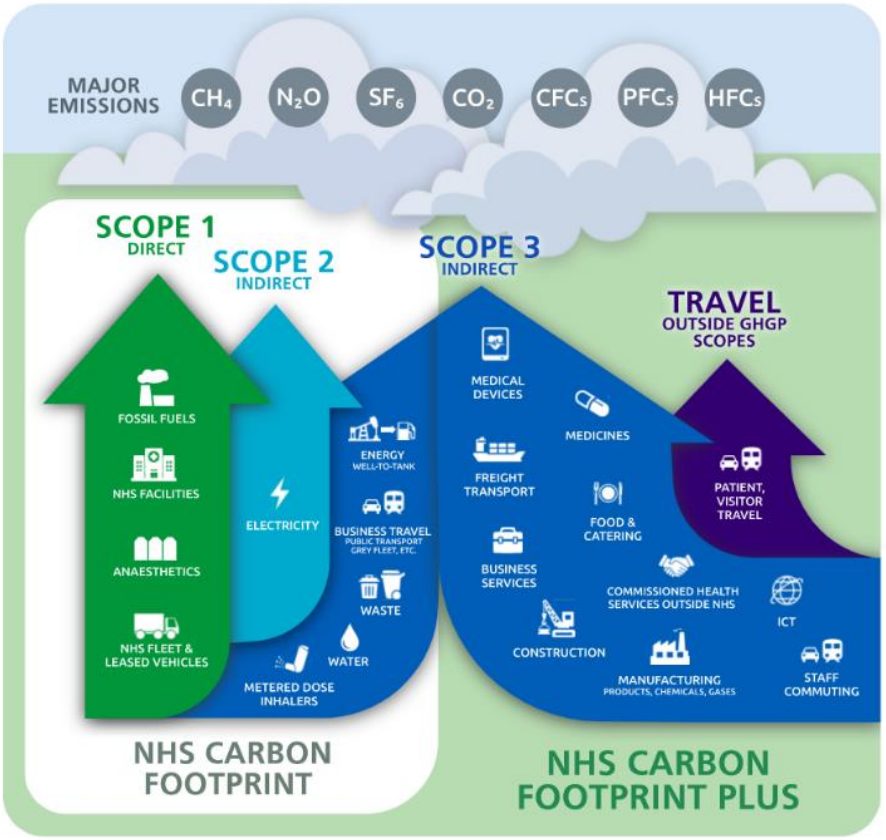


Figure 1: NHS Carbon Footprint and Carbon Footprint Plus (source: NHS)

NHS organisations therefore need to embed sustainability in all aspects of high-quality healthcare.

All NHS primary care and secondary care, in conjunction with local authorities, businesses, the third sector and others, need to take collective responsibility and collaborative action to deliver net zero.

At a local, level action on sustainability is aligned with the integration and coordination aims of the Hampshire and Isle of Wight ICS and wider South East NHS priorities. This goes beyond just a focus on net zero targets - to capture related wider environmental and social improvement in our region where possible.

Where are we now?

Based on indicative calculations by Greener NHS, the ICS Carbon Footprint in 2019/20 amounted to:

NHS Carbon Footprint:

150,980 tonnes CO_2e.

NHS Carbon Footprint Plus:

767,200 tonnes CO_2e.

The breakdown of these is shown in Figure 2.

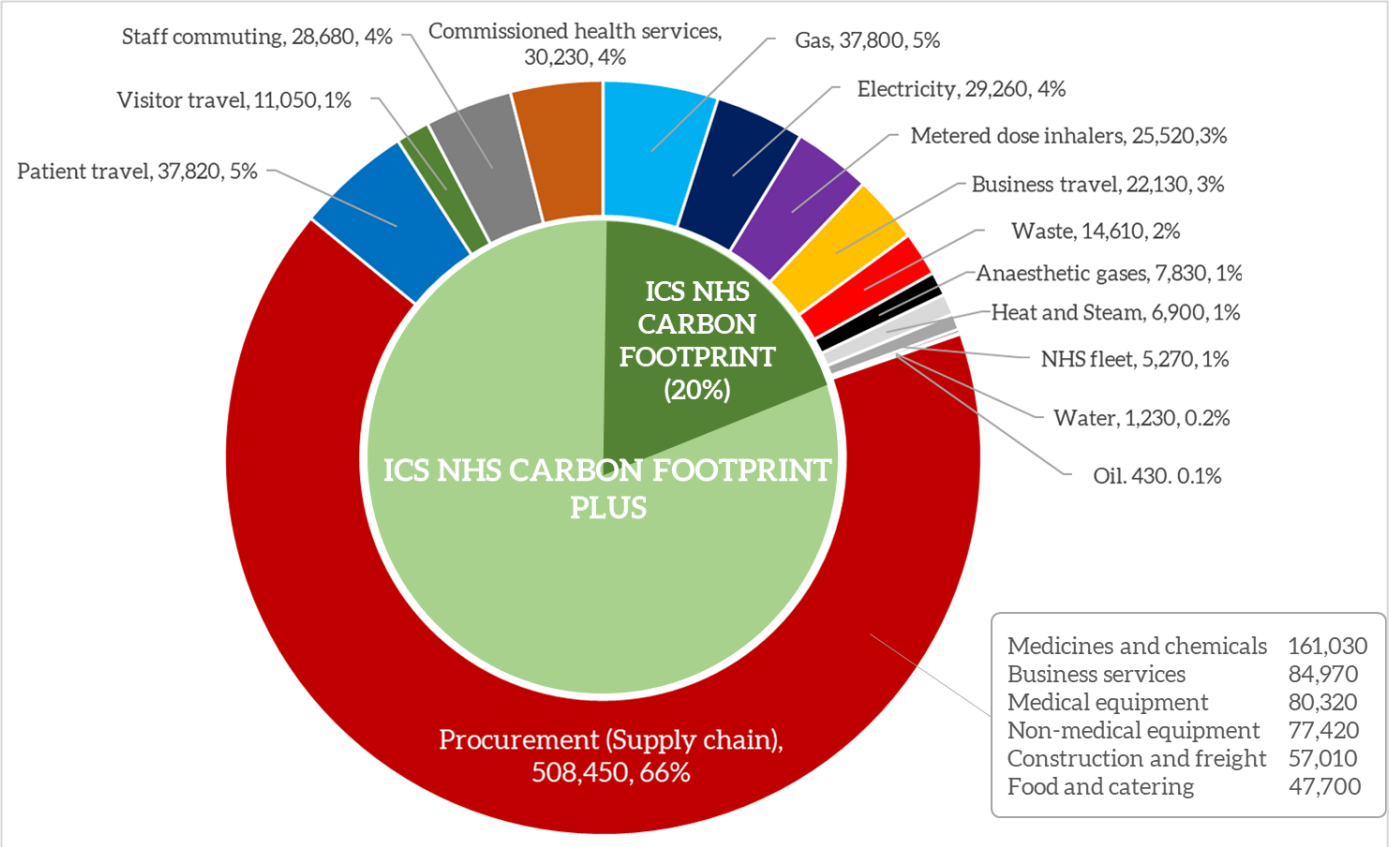


Figure 2: HIOW ICS NHS Carbon Footprint – tonnes CO2e (source: Greener NHS) 2019/20

Although indicative carbon footprints for our Trusts for 2023/24 have been published by the NHS, these have been produced on a top-down basis and as such are not suitable for comparison across periods and across organisations. Only the Carbon Footprint has been calculated thus far, not the Carbon Footprint Plus. Although they indicate a reduction in the system carbon footprint from 140,000 tCO2e per year to 115,000 tCO2e, some of this may be down to changes in methodology and better data. They do however provide a good indicator of the size of the challenge still facing the system. Reductions in emissions on fleet and travel, anaesthetic gases and inhalers have been offset by an increase in building energy emissions.

Figure 3 below also highlights the sources of carbon emissions by activity type and setting of care, which influences priorities within this plan and actions by NHS organisations.

It clearly shows the significant impact of medicines and inhalers within Primary care.

It also highlights the distinction in carbon impacts of different types of secondary care trusts. What it does not do is show the carbon impact on secondary care of decisions made in primary care or other parts of secondary care.

As well as practical measures undertaken by NHS organisations to reduce carbon emissions, it is recognised that the HIOW ICS carbon footprint will be affected by external factors such as the UK's energy supply mix (the increase in UK renewable energy supply has, for example, significantly reduced emissions from electricity), the ban on new diesel and petrol cars in due course as well as carbon reduction undertaken by regional partners.

It is also understood that, only after all practical measures have been undertaken to reduce emissions, it may be appropriate to offset these, but only where this is credible and verifiable and supports the region's natural capital.

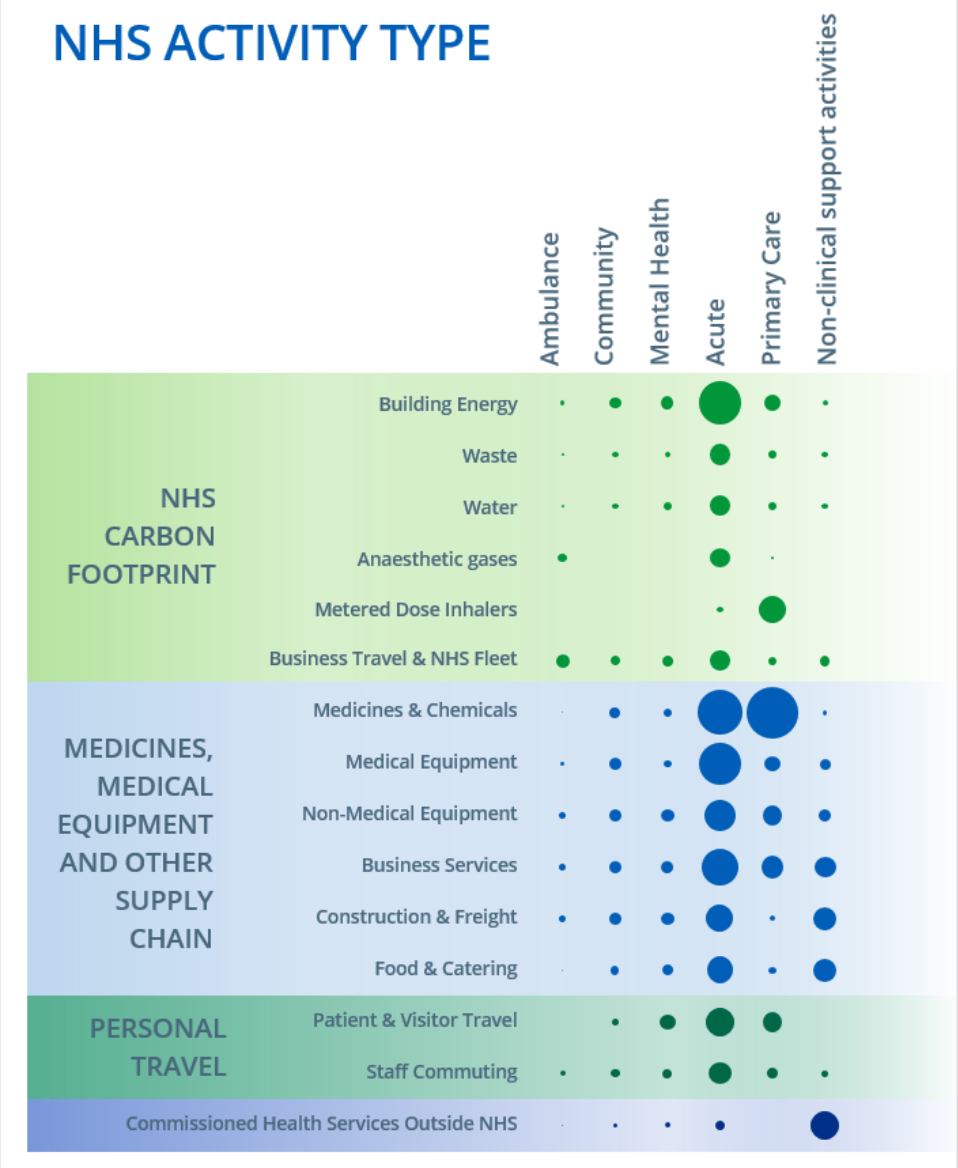


Figure 3: HIOW ICS NHS Carbon Footprint – tonnes CO2e (source: Greener NHS) 2019/20

What are we seeking to achieve? The Case for Change

The Hampshire and Isle of Wight region is vulnerable to the impacts of a changing climate. For example:

- Coastal and other areas from rising sea level and extreme weather events,
- Higher temperatures and drier summers,
- Increased stress on water resources,
- Impacts on the resilience of healthcare services,
- Physical health impacts from climate change are greatest on the elderly and those with pre-existing conditions,
- Mental health is greatly impacted by heatwaves and flooding, with flood victims up to nine times more likely to suffer mental health problems, including post-traumatic stress disorder.

Mitigating emissions, to support Greener NHS targets, reduce costs and improve public health needs to be combined with planning for the impacts of climate change and adapting to improve the resilience of services and estates while protecting the most vulnerable, such as through climate vulnerability and adaptation assessments and specific measures including flood risk management, utilising green infrastructure, estates planning and others.

Air pollution

This is the single greatest environmental threat to human health, accounting for 1 in 20 deaths In some areas, up to 38,000 deaths a year nationally– parts of our region have higher rates than this. *(source - Office for Health Improvement and Disparities 2022)*

As Figure 4 highlights, those most vulnerable are often those who contribute the least to higher air pollution (such as from Nitrous Oxide and Particulate Matter2.5), exacerbating health inequality.

Figure 4: The health impacts of air pollution. Public Health England (now UKHSA)

Preventing emissions of pollutants to air, such as from travel and transport, taking steps to reduce air pollution and avoiding exposure to air pollution, will mean fewer cases of asthma, COPD, cancer and heart disease, while enabling active travel will mean healthier lives.

Prevention of ill-health

Preventing ill-health, promoting wellbeing and reducing health inequalities is a priority, as the NHS Long Term Plan highlighted. This is threaded through the plan's priority topics; the focus on air quality, the promotion and enabling of physical activity and active travel. Systematically tackling the main preventable risk factors causing death and ill health in our region requires collaboration and complementary action by the NHS, local government, companies, third sector and individuals. The costs of heat-related mortalities alone from climate change are estimated at £6.8 billion per

year in the 2020s, rising to £14.7 billion per year in the 2050s. *(source: 4th Health and Climate Adaptation Report)*

Resources and resilience

We need to reduce pressure on finite NHS resources through, for example, preventive healthcare, enhanced resource efficiency and waste avoidance, while enhancing resilience of supply and services through, where relevant, local sourcing. This requires collaboration across and within primary and secondary care, partners and our communities.

As well as the compelling reasons for delivery of net zero for the planet and our health, there are also legal requirements which the ICB will need to meet.

Opportunities from going green

Emerging case studies and evidence from the last few years has identified opportunities for Trusts to save both money and reduce carbon emissions from relatively straightforward changes.

- Reducing waste and in particular moving away from single use items such as surgical caps, gowns, tourniquets and sharps bins have proven to result in a significant and quick cost savings, without impacting or compromising on patient safety and or infection prevention and control practices. University Hospital Southampton has one of the highest incineration rates of clinical waste (with associated costs) in the country.
- Saving energy through decarbonisation measures and funds have also help trusts to significantly reduce costs after seeing a 53% increase in energy costs since 2019. Government grants to decarbonise are competitive but generous to support the NHS's legal obligation to be Net Zero by 2040. Some of our Trusts have the lowest proportion of LED lighting in the Region, and the highest energy usage (measured in KwH) per m2.
- The UK Emissions Trading Scheme (ETS) are also increasingly issuing civil penalties from the Environment Agency to enforce compliance – NHS has been issued with £12.34million in penalties in 2024 alone, (£1.5m for the South East, mostly in Hampshire). It is anticipated fines will increase in number and size, so putting decarbonisation and energy saving measures in place can deliver real savings.
- There are efficiencies to be realised from lean pathway redesign, for example by using the GIRFT Greener Pathways Guidance, and by switching to low carbon alternatives for equipment and medication

Legal Responsibilities

NHS organisations have several legal responsibilities regarding climate change and achieving net zero emissions, primarily outlined in the Health and Care Act 2022. Several pieces of legislation oblige the NHS to act to protect patients from the effects of Climate Change and opens organisations to legal challenge for inaction or under delivering on plans that need to be published and reported on.

The legislation includes:

- Compliance with Climate Change Act 2008: NHS organisations must contribute towards compliance with section 1 of the Climate Change Act 2008, which mandates the UK to achieve net zero emissions by 2050.
- Green Plans: Integrated care boards (ICBs), NHS trusts, and foundation trusts are legally required to develop and implement green plans. These plans must align with statutory emissions and environmental targets.
- Supplier Requirements: NHS suppliers must disclose their emissions and publish carbon reduction plans in accordance with the NHS Net Zero Supplier Roadmap.
- Monitoring and Reporting: NHS organisations are legally obligated to annually monitor and report their progress towards achieving net zero emissions.

The Role of the Integrated Care System

Working with our system partners including our partner Trusts

The ICS has sought to play a role in bringing sustainability leaders together across the county, sharing best practice and coordinating reporting and engagement with the support from NHS England.

The future challenge facing sustainability leaders in Hampshire and the Isle of Wight is how to work collaboratively together to the best effect. As the Model ICB blueprint makes it clear that ICBs will not have a continuing leadership role in delivery of the Green agenda, it is important that existing sustainability leaders in our providers work collaboratively to:

- Share best practice, support collaboration and facilitate engagement with relevant research and innovation activities
- Provide a culture of challenge and holding to account for delivery of the net zero targets.
- Engage our wider partners and stakeholders in delivery of the Greener NHS agenda.

The continuing role of the ICB in strategic commissioning will include the commissioning of low carbon pathways of care and incentivise delivery of the net zero agenda within Trusts.

Trusts will need to speak with one voice with our local authority partners, particularly as they move towards devolution and reorganisation. Local Trust engagement with the unitary authorities has been successful, particularly on air quality, and engagement with Public Health has been good across the county.

Supporting our primary care providers

Primary care currently contributes 23% of the NHS Carbon footprint, driven largely by the carbon footprint of medicines it prescribes. The standard NHS primary care contract and the Premises Cost Directions currently do little to incentivise primary care to adopt carbon reducing initiatives, although there are some practices that have taken action independently, usually in areas where there are cost savings and efficiencies to be made eg Solar panels, LED lighting.

The future role of the primary care support currently provided by the Integrated Care Board is unclear, although the expected strategic direction in the Ten Year Plan will be for this function to be carried out in neighbourhood hubs , each of which will have an integrator organisation at its heart.

Embedding green plan priorities system-wide

As a strategic commissioner, the Integrated Care Board will ensure that net zero compatible outcomes are incentivised via its contracting processes, ensuring that as a minimum our Trusts comply with the Greener NHS requirements set out in the NHS Standard Contract. (NHS Standard Contract service conditions, section 18). The ICB will maximise opportunities to reduce emissions and improve population health when planning and commissioning NHS services, and ensure that Greener NHS priorities are reflected in the ICB Joint forward plan, capital plans, and other relevant system-wide plans in line with the 4 core purposes of the ICS.

The ICB will work with the Primary Care Collaborative to ensure that primary care is encouraged to deliver the net zero agenda.

The ICS Infrastructure Strategy sets out 4 high level priorities linked to sustainability:

Develop a capital prioritisation criterion for sustainability
Continue to strengthen ICS sustainability networks for support and sharing of best practice
Gather cohesive sustainability/NZC data at ICS level
Support the achievement of existing sustainability/NZC objectives and targets such as EPC ratings to meet the required standards set by law

Our Progress so far

Nationally, significant progress towards achieving net zero has been made since the launch of the Greener NHS initiative, including:

- over £1 billion in funding secured by NHS trusts through the Public Sector Decarbonisation Scheme (PSDS), which is expected to reduce NHS energy costs by over £260 million a year
- NHS-wide decommissioning of desflurane, an environmentally damaging anaesthetic gas with a higher global warming potential than its readily available alternatives
- ongoing reduction in waste from nitrous oxide, responsible for the largest overall volume of emissions from anaesthetic and medical gases, saving around £5 million annually

- progressing high-quality, lower-carbon respiratory care, supporting patients to improve their lung health while reducing inhaler emissions by around 300 kilotonnes of carbon (Kt/CO_2e) a year
- the introduction of requirements for NHS suppliers to disclose their emissions and publish a carbon reduction plan, in line with the NHS Net Zero Supplier Roadmap

Within Hampshire and the Isle of Wight, we have:

- Begun to reduce the amount of nitrous oxide delivered from manifold cylinders, although we have not yet seen a sizeable reduction in resulting emissions. We have however seen a 28% reduction in emissions from gas and air since 2018.
- Introduced walking aid recycling schemes so that these are now available at all our acute hospitals.
- Reduced emissions from waste considerably.
- Introduced Active Travel schemes in most of our hospitals
- Increased the number of low emission vehicles in our fleet from 53% to 90%
- Increased the proportion of LED lighting used both in our hospitals, offices and in primary care.
- Secured nearly £60m of funding since 2020 to support decarbonisation initiatives, although energy consumption has continued to grow.
- Reduced the emissions from high emission SABA and non-SABA inhalers by a third.
- Reduced the usage of Desflurane as a percentage of all volatile anaesthetic gases from 22.2% to 0.1% since 2018.

Developing this plan

This refresh of the Green Plan has been developed following a workshop with Trust sustainability leads, to consider how we best work together, what our collective priorities should be and how the System can add value to each Trust's delivery of the Greener NHS Agenda. The plan is focussed on delivering the national commitments over the next 3 years, and preparing for the commitments in the years after, as set out in the two diagrams below.

Areas of Focus

The Greener NHS requirements require delivery across a broad agenda of themes.

Set out below are the main deliverables for the system over the next 3 years. The workstreams are in line with the priority areas set out by NHS England in their Green Plan guidance; they reflect the richness and breadth of the net zero agenda in the NHS.

Workforce and Leadership

Leadership teams and a workforce knowledgeable about Net Zero and the impact of climate change can help mitigate the health effects of that change through preventative care and sustainable healthcare delivery.

Net zero care will only be delivered if organisational leaders place environmental sustainability at the forefront of decision making. This includes clinical leaders, who are in a strong position to design and lead changes to the services they deliver and play a pivotal role in educating and influencing others. Prioritising sustainability, unlocking resources and investing staff time and training in decarbonising care all rest with leaders.

A 2021 survey revealed that 90% of NHS staff support the organisation's commitment to achieving Net Zero emissions. While support is high, a Health Foundation briefing noted that only 27% of NHS staff were aware of the Net Zero

ambitions. Efforts need to be improved to educate and empower the 1.4 million staff and leaders about the impact they can have on supporting a more sustainable NHS.

Where we are now:

- All Trusts and the ICB have appointed a designated board-level net zero lead to oversee green plan delivery with clearly identified operational support
- ICS NHS organisations have established awareness raising for staff regarding sustainability and climate change, although completion of these is not mandatory and uptake is not routinely collected.

Action	KPI(s)
Trusts should collectively carry out an assessment of the capacity and skill requirements for delivering the system Green Plans, including the ability to work in partnership across organisations.	Skills assessment in place
Ensure that NHS staff across the system will be required or encouraged, according to their role, to undertake climate change awareness training, as part of Trust mandatory training requirements.	% of staff completing climate change awareness training
Ensure that all Trusts develop Green Champions and wider staff sustainability engagement networks.	Number of Green Champions

Net Zero clinical transformation

Net zero clinical transformation should ensure high-quality, preventative, low-carbon care is provided to patients at every stage. Organisations in the ICS should consider net zero principles in all service change, reconfiguration programmes and pathway redesign.

Where we are now:

- We have pockets of good practice in our Trusts, and some instances of quality improvement projects aimed at providing sustainable pathways of care.
- Some Trusts have established meetings and governance processes in place and have engaged with organisations such as the Centre for Sustainable Healthcare and their Sustainable Quality Improvement Programme (SusQI).

Action	KPI(s)

The system should ensure that each Trust has identified a clinical lead with oversight of net zero clinical transformation, with formal links into board-level leadership and governance	Trust clinical leads in place
The system should ensure that there are processes for sharing learning and outcomes, for example, through clinical networks, the ICB and NHS England	
Each provider organisation will identify at least one clinical area where they will deliver a quality improvement project focused on a measurable reduction in emissions, with co-benefits for outcomes and quality of care, efficiency and reducing healthcare inequalities	Number of clinically led sustainable quality improvement projects
The system should put in place arrangements to host placements under the Chief Sustainability Officer's Clinical Fellow Scheme.	

Digital Transformation

We need to do much more to harness the potential for the use of digital technology and information. In doing so, we can improve access and join-up our services in a way that will fundamentally transform the experience for our local population and workforce. At the same time, we can reduce emissions by reducing travel, avoiding paper- based solutions and streamlining care pathways.

The What Good Looks Like (WGLL) framework from NHS England provides clear guidance for health and care leaders to digitise, connect and transform services safely and securely.

Where we are now:

- System wide Digital Strategy in place
- Annual digital maturity assessments (DMAs) are undertaken at ICB, primary care and NHS Provider level to measure progress being made in relation to the seven WGLL success measures. For environmental sustainability, (which is part of the 'Smart Foundations' success measure), the DMA includes a review of progress towards net zero carbon emissions, environmental sustainability and resilience ambitions.
- Virtual Wards are in place across the whole HIOW footprint

- Use of virtual appointments is widespread, particularly in primary care.

Action	KPI(s)
Deliver campaign to promote and champion virtual consultations, virtual interventions, remote diagnostics, and point of care testing, increasing the percentage of non-face to face outpatient appointments to 25% of all outpatient appointments.	% of appointments that are not face to face
Undertake digital self-assessments using the RPS Greener Pharmacy Toolkit at each of our hospital pharmacies	Number of self-assessments completed
Promote digitally enabled flexible working for the workforce	Proportion of staff time spent working at home
Ensure the use of circular and low carbon approaches to IT/digital system procurement, hardware management and online storage. Including procuring energy efficient and lower carbon digital products and services. Ensure cloud storage is managed in a low carbon way.	

Medicines

Medicines account for around 25% of NHS emissions. A few medicines account for a large portion of these emissions, for example, anaesthetic gases (2% of NHS emissions) and inhalers (3%). By ensuring the right medicines are used at the right time, in the right dose, and for the right duration, we can significantly reduce waste and improve patient outcomes.

Where we are now:

- Excellent progress has been made in reducing the use of desflurane, a very environmentally damaging anaesthetic gas, in our theatres.
- Work is in hand to reduce our use of piped nitrous oxide, reducing wastage and moving to bottled supplies.
- Good progress has been made in engaging with primary care to encourage substitution away from the more damaging inhalers (considering clinical

appropriateness, the environmental impact of inhalers and patient preference).
- Inhaler recycling schemes have been put in place.
- Trusts have processes and committee in place to review the sustainability of prescribing practices and to reduce waste.

Action	KPI(s)
Reduce medicines wastage across the system with a specific focus on medications with high environmental impactsby encouraging better prescribing .,	To be determined
Continue work to reduce nitrous oxide and entenox use and leakage by stopping unnecessary use and replacing manifold based solutions	Emissions (tCO2e) and volume (litres) of nitrous oxide by trust; E missions (tCO2e) and volume (litres) of nitrous oxide and oxygen (gas and air) by trust
Cease use of the volatile anaesthetic agent desflurane in line with national guidance, allowing exceptional use only as published by the Neuro Anaesthesia and Critical Care Society	Emissions (tCO2e) from Desflurane
Deliver a Medicines Optimisation Incentive Scheme identifying and prioritising specific categories of patients for a face-to-face comprehensive respiratory review to optimise their care in line with the new guidelines; reduce their need for unplanned emergency care; and reduce SABA inhaler prescribing in favour of cost-effective lower carbon emission inhalers if appropriate.	
Continue to encourage the switching of inhalers to more sustainable alternatives by engaging with primary care and secondary care clinicians	Average inhaler emissions per 1,000 patients; Mean emissions of Short-acting beta-2 agonists (SABAs) inhalers prescribed; % of non-SABA inhalers that are MDIs
Establish more inhaler recycling points	Number of recycling points

Air Quality, Travel and Transport

The NHS fleet is the second largest in the country, consisting of over 20,000 vehicles traveling 460 million miles a year. It directly contributes to harmful air pollution. The NHS Net zero travel and transport strategy outlines a roadmap to decarbonise NHS travel and transport, while also providing cost-saving and health benefits.

Air quality, a major public health risk, which impacts the most vulnerable, is particularly poor in parts of the region. We want to improve air quality in our communities by shifting our travel and transport activities towards active travel and the use of safer and cleaner fuels by our NHS fleet. Our focus for the next three years is to raise awareness of the health effects of poor air quality and to ensure that we meet our statutory obligations in terms of establishing the infrastructure for electric vehicles and reducing our emissions.

Where we are now:

- National travel survey completed several times to give us a baseline for electrification of our fleet
- Active Travel Plans in place in some Trusts
- The ICS has worked with Global Action Plan to self -assess against the ICS Clean Air Framework
- Good air quality networks are in place across the county.
- Two-year programme of emissions testing in loading bays, to identify sources of high emissions, in place at Hampshire Hospitals Trust. This has been successful in identifying high emissions and in changing delivery schedules and practices to better combine/co-ordinate deliveries and reduce emissions.

Action	KPI(s)
Engage with Hampshire County Council/ the new Strategic Combined Authority on a joined up approach to active travel, with **practical action on joint priorities such as L**ocal **C**ycling and **W**alking **I**nfrastructure Plans**, behaviour change programmes and route improvement.**	
Ensure that Trust sustainable travel plans, due by December 2026, are coherent and work for the system as a whole, focusing on active travel, public transport and zero-emission vehicles, supported by a clear understanding of staff commuting	All Trusts have a Travel Plan (or Plans) in place
Trusts in the system should complete transition to zero-emission vehicles only through vehicle salary sacrifice schemes by December 2027 (for new lease agreements)	All Trusts provide access to only ULEV / ZEV vehicles through staff lease schemes

Trusts in the system should make arrangements to purchase, or enter into new lease arrangements for, zero-emission vehicles only from December 2027 onwards (excluding ambulances)	% of owned and leased fleet that is ultra-low emission vehicle (ULEV) or zero-emission vehicle (ZEV); Total fleet emissions
Ensure that SCAS and IoW Ambulance support and fund zero-emission ambulance pilots, followed by evaluation and at-scale transformation in readiness for the procurement of zero-emission ambulances from 2030	% of ambulance fleet that is ultra-low emission vehicle (ULEV) and zero-emission vehicle (ZEV); Total fleet emissions
Gain support and implement ICS wide schemes to support sustainable and active travel and the implementation of Trust Travel Plans	Number of multi-provider or ICS wide travel schemes operating across the region
Collaborate where necessary on EV strategy across the system and region, including review of fleet, challenges and enabling mechanisms within primary and secondary care, potential procurement frameworks, outsourcing of EV charging.	

Estates and Facilities

There are significant opportunities across the NHS estate to reduce emissions and lower costs, while improving energy resilience and patient care. As a system, we need to focus on:

- improving energy efficiency by installing measures such as LED lighting, insulation and double-glazed windows
- replacing fossil fuel heating systems with lower carbon alternatives, such as heat pumps or connecting to a heat network system
- increasing use of renewable energy by investing in on- or near-site renewable energy generation to meet NHS energy demand

Where we are now:

- The ICS Infrastructure Strategy, which amongst other things sets out our sustainability priorities, is in place and approved by our member Trusts
- As a system, we have attracted nearly £60m of Public Sector Decarbonisation Scheme (PSDS) and Low Carbon Skills Funding (LCSF), although this has not been evenly distributed across our Trusts

- Successful bids have been made in the current year to introduce solar panels
- Good progress has been made across the system in improving the utilisation of our estate.

Action	KPI(s)
The system should identify opportunities to support primary care estates decarbonisation, such as through the Boiler upgrade scheme	
Trusts that have not accessed PSDS funding previously should be supported to develop applications (this may include exploring joint bids between trusts or other partners)	
Each Trust should develop and maintain a heat decarbonisation plan (HDP), which includes: • identifying and prioritising the phasing out of all existing fossil-fuel primary heating systems by 2032 and seeking to remove all oil primary heating systems by 2028 • considering Local Area Energy Plans and opportunities from heat networks and other low-carbon solutions • identifying any installations in scope of the UK Emissions Trading Scheme and outline plans to reduce emissions in line with allocated targets	Number /% of sites with a heat decarbonisation plan. Emissions from fossil-fuel-led heating sources; Number of oil-led heating systems
Trusts should collaborate on the identification of funding opportunities and the development of business cases to deliver the measures outlined in the HDP, where projects cannot be financed through internal budgets	Investment attracted to the system for HDP and estates & facilities measures
Trusts should ensure all applicable new building and major refurbishment projects are compliant with the NHS Net Zero Building Standard **and achieve BREEAM**	Number of Schemes with BREEAM certification of Very Good or Excellent

Very good (refurbishment) and Excellent (New).	
Promote greener practice within primary care and encourage and enable monitoring and reporting of energy within the primary care estate - through adoption of the Green Impacts for Health Toolkit, transition to purchasing renewable energy and practical cost-saving measures e.g. LED lighting.	% of gross internal area of primary care estate covered by LED lighting % of primary care sites with renewable energy
All should collaborate on optimising estates utilisation within NHS and potentially wider; as part of estates transformation plan and primary care estates strategy across the system.	M2 void space being charged
Increase the % of energy supplied through local renewable energy generation	% energy from solar / wind and other alternative fuels

Supply Chain and Procurement

The NHS net zero supplier roadmap outlines steps suppliers must follow to align with the NHS net zero ambition between now and 2030. Roadmap implementation is a shared responsibility across trusts, systems, regional procurement hubs and nationally. Organisations should also seek to embed circular solutions, such as using reusable, remanufactured or recycled solutions when clinically appropriate, which are often cost saving.

Where we are now:

- Regional procurement group in place to look at system wide opportunities for more sustainable procurement
- Most procurements now have a weighting for social value/ sustainability as part of their evaluation methodology
- Tendering suppliers must have a Carbon Reduction Plan in place together with a commitment to reach net zero in line or better than the NHS commitment.

Action	KPI(s)
Continue to embed NHS net zero supplier roadmap requirements into all relevant procurements and ensure they are monitored via KPIs	% of procurements having minimum social value/ net zero 10% weighting, and % of procurement >£1m with a Carbon Reduction Plan. % of procurements over threshold and below £1m with a Net zero Commitment

Encourage suppliers to go beyond minimum requirements and engage with the Evergreen Sustainable Supplier Assessment to support a single conversation between the NHS and its suppliers on sustainability priorities	Number / % of suppliers signing up to the Evergreen Framework
Investigate ways to embed a circular economy approach and reduce reliance on unnecessary single-use products, considering how to safely build this work into clinical improvement projects. Seek opportunities to collaborate at scale on procurements and share learning.	To be determined

Food and nutrition

Food represents a major source of carbon emissions as well as being a key public health tool. While NHS Trusts focus on nutritious food as well as relevant local sourcing, the potential changes as a result of the independent review of hospital food requires collaboration on best practice digital menus and ordering. It also can leverage enhanced social value and environmental improvement, such as through local supply and waste minimisation, while supporting packaging and the avoidance of single use plastic.

Where we are now:

- National standards for healthcare food and drink, requiring NHS organisations to deliver high-quality, healthy and sustainable food and minimise waste, are in place.
- There have been several successful initiatives within our Trusts to incentivise healthy food choices by patients and reduce waste. For example, UHS have begun to put plant-based menu options at the top of the menu, which has led to a fourfold increase in vegan / vegetarian meals being chosen. They have also substituted beef with pork, which has considerably lower emissions.

Action	KPI(s)
Trusts should measure food waste in line with the Estates Returns Information Collection (ERIC) and set reduction targets	Total weight (tonnes) of food waste, with further break down by spoilage, production, unserved and plate waste
Trusts should consider opportunities to make menus healthier and lower carbon by supporting the provision of seasonal menus high in fruits and	

vegetables and low in heavily processed foods	

Adaptation

Climate change threatens the ability of the NHS to deliver its essential services in both the near and longer term. Resilience and adaptation should be built into business continuity and longer-term planning to avoid climate-related service disruptions. Partnership working between sustainability leads, public health, emergency response teams and estates leads at trust and system level is crucial.

Where we are now:

- Trusts have emergency response plans in place for most climate related incidents
- There has been little consideration of wider mitigation and adaptation issues
- Flooding and overheating incidents are now being reported via ERIC.

Action	KPI(s)
All providers and commissioners of NHS-funded services must comply with the adaptation provisions within the NHS Core Standards for emergency preparedness, resilience and response (EPRR) and the NHS Standard Contract to support business continuity during adverse weather events	
Trusts should set out actions to prepare for severe weather events and improve climate resilience of local sites and services, including digital services	All Trusts have a current heatwave plan. Number of overheating occurrences triggering a risk assessment (in line with trust's "heatwave" plan); Number of flood occurrences triggering a risk assessment
In partnership with other Trusts, emergency response colleagues and others, all Trusts should identify interdependencies between services and the necessary mutual aid requirements to prevent service disruptions	To be determined

Working collectively, Trusts should carry out a Climate Change Risk Assessment for Hampshire and the Isle of Wight and prepare a system wide Adaptation Plan	System wide climate risk assessment and adaptation plan
There should be a **joined up communications approach between NHS/Public Health around** the **health impacts of adverse weather on the population**	

Governance and accountability

Future governance arrangements for the delivery of the net zero agenda in Hampshire and the Isle of Wight are unclear, given that the Model ICB documents state that system sustainability will no longer be a function of the Integrated Care Boards. We are discussing the creation of a provider collaborative to oversee and deliver those aspects of sustainability that are best delivered at scale. As an example, in Sussex they already have a "Care without Carbon" programme hosted by one Trust, funded by contributions from the other Trusts, to promote and deliver the sustainability agenda.

Unless there is a change of primary legislation there is still a legal requirement for Integrated Care Boards to deliver the net zero targets; arrangements will need to be put in place to ensure oversight and accountability as these targets are delivered by the Trusts.

[i] Net Zero: The UK Government has set a legally binding goal to be 'carbon zero' by 2050. The NHS has set a goal to reach net zero by 2040.
'Net Zero' emissions means: any emissions remaining, after all possible efforts to mitigate them have been undertaken, would be balanced by verified schemes to offset an equivalent amount of greenhouse gases from the atmosphere, such as planting trees or using technology like carbon capture and storage. Only after all possible emissions have been mitigated, reflecting relevant cost benefit analysis, should offset be considered.

NHS
South Central
Ambulance Service
NHS Foundation Trust

Upward Report of the Finance & Performance Committee

Date Meeting met **22nd August 2025**
Chair of Meeting **Les Broude, Non-Executive Director**
Reporting to **Trust Board**

Items	Issue	Action Owner	Action
Points for escalation			
Financial Position	Continuing concern was expressed around full identification of the original target of £21.6m plus additional savings requirements of circa £2.9m generated by unfunded cost pressures that have emerged. The Committee was clear that members needed to see a clear explanation of the plan to meet the original target plus the additional savings ahead of the next FPC meeting, together with the risks and mitigations that are in place.	SR	The committee will continue to maintain scrutiny over CIP performance and delivery.
Category 2 Performance	The committee had expressed concern in relation to category 2 performance at the last meeting and is assured that there is appropriate grip, control and real time monitoring/corrective actions in place including the establishment of a	N/A	No specific action is required but the committee will continue to monitor performance to ensure that delivery of the Operational Plan remains on track.

	dedicated team focused on delivery and identifying and unblocking issues. The increase in Hear & Treat continues to positively impacting performance and it was noted that the Quality & Safety Committee would be receiving a report at the September meeting in relation to Hear & Treat to provide assurance that it is not having a negative impact on quality.		
Key issues and / or Business matters to raise			
Establishment Report	The report detailed the position on the over-establishment against budget, the reasons for this and the plan to return to budgeted establishment. It was noted that the work that was being undertaken would stand the trust in good stead in terms of meeting recently published planning requirements, including the development of a Multi-Year plan.	N/A	No further action required but the committee will maintain a watching brief given the position with regards to the transfer of Private Provider PTS staff into SCAS.
Areas of concern and / or Risks			
Financial Position	As referenced above		
Items for information and / or awareness			
None			
Best Practice and / or Excellence			
Action Tracker	All actions were completed within their due dates		The committee will continue to monitor progress against actions and ensure these are dealt with in a timely way.

Establishment Report	Whilst this was a complex area, committee members felt that the report was clear and welcomed the collaborative approach to authorship from the relevant teams.	N/A	
Compliance with Terms of Reference			
Compliant	The meeting was quorate as per the terms of reference, although consideration is being given to including a clinical executive in the terms of reference to create better linkages between operational performance and quality.		LB and BS to discuss and make changes to the terms of reference in readiness for the September meeting, as appropriate.
Policies approved*			
None			

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

NHS
South Central Ambulance Service
NHS Foundation Trust

Upward Report of the Audit Committee

Date Meeting met **11th September 2025**
Chair of Meeting **Mike McEnaney**
Reporting to **Trust Board**

Items	Issue	Action Owner	Action
Points for escalation			
None			
Key issues and / or Business matters to raise			
Fleet Management Internal Audit Report	Conclusion of moderate assurance. Actions required to improve weaknesses in controls already identified and in hand.	Audit Committee	Audit Committee will continue to monitor progress against delivery of the agreed actions.
South Central Fleet Services Annual Accounts 2024/25	An unqualified opinion issued with continuing evidence of improvement in processes and outcomes. Accounts adopted by the SCFS Board.	N/A	None required
Areas of concern and / or Risks			
None			
Items for information and / or awareness			

Scheme of Reservation & Delegation (SoRD)	A number of changes were noted to ensure the SoRD reflects the Standing Orders (SO) and Standing Financial Instructions (SFI). Primarily as housekeeping exercise with no changes to the SFIs or SOs that required Audit Committee/Board approval.	BS	BS will circulate the SFIs/SOs and SoRD to all board members for completeness
Best Practice and / or Excellence			
Internal Audit Progress Report	Continuing good performance in relation to actions arising from internal audit activity. Second meeting where there were no overdue actions or requests for extensions. Thanks are extended to management for progressing actions in a timely way.	N/A	Audit Committee will continue to carefully monitor action completion.
Internal Audit Benchmarking Report	SCAS benchmarks in line with other trusts within the client portfolio in terms of the Head of Internal Audit opinion. Notably only one high priority action was issued to the trust in 2025/26.	N/A	
Compliance with Terms of Reference			
Confirmed	Meeting was quorate and all items on the agenda were pertinent to the committee's terms of reference	N/A	None required
Policies approved*			
None	Audit Committee continues to receive regular reports relating to Policies. A review is underway to determine whether all policies named as such require policy status.	**N/A**	None required

***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 25 September 2025

Report title	Communications, Marketing and Engagement Update
Agenda item	23
Report executive owner	Gillian Hodgetts, Director of Communications, Marketing and Engagement
Report author	Gillian Hodgetts, Director of Communications, Marketing and Engagement
Governance Pathway: Previous consideration	N/A
Governance Pathway: Next steps	N/A

Executive Summary

Internal Communications

There is a considerable amount of internal communications activity within the Trust at the moment, with multiple projects and programmes of work requiring communications support. The launch of the staff survey and the Flu vaccination campaign are highlighted in this report.

Public facing campaigns

A key strategic aim for the Communications team is to increase awareness and understanding of our services as well as to promote the health and wellbeing of our population. Many initiatives are undertaken throughout the year, water safety and NHS 111 repeat prescriptions campaign are featured this time.

Community engagement and partnership working

Much effort from SCAS staff, both operational and support goes in to delivering a programme of engagement events throughout the year. It is important to highlight that this is a close cooperation including Communications, the SCA Charity, Community engagement

teams and the recruitment and education teams. Some of the events are joint ventures with our partners and are received very positively by those who attend.

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 Internal communications

Annual NHS staff survey

Working with the People Directorate, internal publicity is underway to encourage as many staff as possible to share their views through this year's national NHS staff survey. The survey launch has been delayed from 16 September, and at the time of writing, is now planned to go live on the 24 September. The Trust achieved a response rate of over 50% last year and is aiming to build on this in the 2025 survey. Feedback from the survey will support progress with the People and Culture strategic theme and runs alongside staff engagement activity to refresh the Trust values and behaviours.

Staff vaccination programme

The Communications team has been working closely with a cross departmental team and a group of trained vaccinators, to plan the staff vaccination programme ahead of the winter. As always this is a high priority campaign and one that the trust takes very seriously in guarding both patients and staff from hopefully catching the flu. Our Flu vaccination programme begins on 6 October this year, with a number of clinics planned across the SCAS area, coupled with the usual options such as getting the vaccine from the pharmacy or GP for staff who are eligible.

The Trust showed a significant improvement in vaccination rates last year compared to 2023/24 and earlier this month we were invited to present our best practice to a national communications network for the vaccination programme. We shared our experiences and thoughts on what works well in encouraging take up of vaccinations and year on year aim to keep improving our uptake. The SCAS executive team will be visible in supporting the campaign and will be able to have their vaccinations alongside other staff, as soon as the campaign gets going.

1.4 Public facing campaigns

Water Safety Awareness – August 2025

As the SCAS patch, not only includes many inland waterways but has a large stretch along the Solent, it has always been imperative that we work closely with the RNLI, HM Coastguard, environment agency and others to keep our public safe and cared for, whether on water or on land. A key strategic objective for the Communications team and indeed SCAS, is to maintain and build effective and long-lasting partnerships that benefit the community as a whole and working together on campaigns such as this is one good example.

The communications team worked with operational teams, local partners and charities, to develop a water safety awareness campaign to run throughout August. The aim was to reduce the volume of water-related 999 emergencies we typically see over the school summer holidays at the coast or on inland water. With the very high and prolonged temperatures that we experienced this summer, it was even more important for us to share our messages far and wide and to use social media to engage across all age ranges.

Around 400 people a year drown in the UK, with the majority of these being accidental drownings of people who did not intend to end up in the water. Between 2020-24, young people (aged 10-29) made up a quarter of all drowning victims. Males, aged 25-59, are five times more likely to drown than similarly aged females.

In the South Central region, there have been a number of drowning accidents that have garnered significant media attention, such as Oxford University student, Wesley Akum-Ojong, in 2024 and an 11-year-old girl at a water park in Windsor in 2022.

Unfortunately, initial plans to involve the family of one of the recent high-profile drownings as part of the campaign did not come to fruition, however we proceeded with a comprehensive and planned programme of activities.

The campaign plan included press releases, an engagement talk, social media posts and digital videos to reinforce some key water safety themes, including:

Checking the environment for potential hazards before entering the water
Learning the RNLI 'float to live' technique if you find yourself in the water unexpectedly
Who to ask for when calling 999 for different types of water emergencies
The importance of always wearing a lifejacket or buoyancy aid

As well as utilising SCAS staff to help reinforce the campaign's messages in engaging and effective ways, we were also able to build on our existing links with local RNLI and HM Coastguard teams.

The campaign secured press, radio and digital media coverage, reaching over 250,000 people and delivering an advertising value equivalency (AVE) of £2,000 at no cost to the trust.

On the trust's digital communication channels – Facebook and Instagram – a series of reels (featuring SCAS HART and operational staff members) and posts reached over 132,000 people on Facebook and over 52,000 on Instagram.

Our next quarterly campaign will focus on road safety, running in November linked to the national Road Safety Week (16-22 Nov) led by the charity Brake.

111 repeat prescriptions – August Bank Holiday

The NHS 111 repeat prescriptions campaign was launched to address a 61% year-on-year rise in calls from patients who had run out of medication, with demand peaking during bank holidays.

The campaign focused on encouraging patients to plan ahead, check their medication regularly, and allow up to five working days for repeat orders, while promoting faster, alternative options such as the NHS App and 111 online.

Using a mix of press releases, regional broadcast media, digital news, social media reels, and static graphics, our campaign delivered clear, practical messages to patients and carers on how to avoid unnecessary calls. The campaign achieved significant reach, with more than 4.8 million people engaged across regional TV, radio, press, and digital news channels, generating an advertising value equivalent of over £216,000. Crucially, early data shows a positive impact: calls to NHS 111 for urgent repeat prescriptions are now on a downward trend, with volumes reducing by 7% week-on-week.

This indicates that the campaign is not only raising awareness but also successfully signposting patients towards faster, more sustainable alternatives, helping to reduce pressure on NHS 111 and to improve patient experience.

Campaigns are a significant and important part of our work. Whether generated within our own Trust or supporting nationally led campaigns, significant behavioural change can be achieved for the benefit of individuals and for the wider population. Our challenge has been and continues to be how to create and deliver campaigns at the lowest possible cost, achieving the highest possible effectiveness.

1.5 Community Engagement and partnership working

Our Stakeholder and Engagement Manager has continued to coordinate a busy schedule of events over the summer and into the Autumn. Whilst the primary aim is to build awareness and enhance communications between our population and our services, it has proved invaluable in working with not only our own teams but with our external partners.

Highlights over the summer include:

- **Gosport and Fareham Inshore Rescue Service Emergency Service Day (18 July)** - Richard Brady, Clinical Team Educator, commented on the success of the event: "Everyone had a great day. The mass casualty vehicle ISU attracted a lot of attention for the day with people understanding that it is not just an ambulance that could arrive on scene but the units to support them."

- **Lyndhurst Fire Station (18 July) -** HART joined local fire services

- **Quainton Rail Centre Emergency Services Day (18 July) –** a long-standing popular event which SCAS attends every year

- **High Wycombe shopping centre (10 August) -** David Vickery said “It was fantastic to see so many families, young people, and residents engaging with us, asking questions, and even having a go at some hands-on activities. Events like this not only build trust and awareness, but also help people feel more confident about what to do in an emergency.”

- **Community engagement (18 July)** - Helen Ramsay, Lead Governor, and Stacey Elliott, Paramedic, recently joined a local community group in Oxford—**African Families in the UK (AFiUK)**—to share information about their roles, teach basic life support skills, and demonstrate how to use a defibrillator.

Events planner:

Event	Date	Location
Gunwharf Quays	30 & 31 August	Gunwharf Quays
Reading Pride	30 August	BERKS
Community Action Day	28 August	BUCKS
Port Solent 999 Day	6 September	HANTS
Blue Light Hub Emergency Services Day	7 September	Milton Keynes
MK Pride	13 September	Milton Keynes
Basingstoke Fire Station Open Day	13 September	HANTS
Oxford Fire Station Open Day	13 & 14 September	OXON
Cosham Fire Station Open Day	27 September	HANTS
TVP Open Day	28 September	BERKS
Charity Fun Day	28 September	BERKS

Please note that these events are in collaboration with SCAS Charity, and some dates may be subject to change. Do contact Margaret Eaglestone if you would like any further information. More information can be found here: https://www.scas.nhs.uk/get-involved/events/

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
South Central Ambulance Service
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Trust Board of Directors Meeting in Public
25 September 2025

Report title	Board Assurance Framework (BAF)
Agenda item	25
Report executive owner	Becky Southall, Chief Governance Officer
Report author	Steven Dando, Head of Risk Management
Governance Pathway: Previous consideration	Quality & Safety Committee, People & Culture Committee, Finance and Performance Committee, Audit Committee.
Governance Pathway: Next steps	None

Executive Summary

The Board Committees have received the Board Assurance Framework (BAF) risks that are relevant to their terms of reference and assigned to the committee. The full Board Assurance Framework was also presented to the Audit Committee on 11th September 2025

The BAF is the mechanism for capturing the risks to the achievement of the trust's 5 strategic objectives and either provides assurance that these risks are being managed and mitigated or indicates that there are further steps to be taken to prevent risks from materialising. The BAF also drives the agenda for the board and its committees to ensure that the board remains focused on delivering the trust's strategy in addition to monitoring organisational performance and adherence to plans and trajectories.

The BAF is aligned to the Fit for the Future Framework which sets out the short-, medium- and long-term deliverables aimed at achieving the 5 strategic priorities and the framework provides a mechanism for reporting on progress, performance and risks to allow for greater triangulation. BAF risks are an integral part of the framework and as such, moving forwards, the BAF risks will be presented to the board and committees alongside the highlight reports and will not be presented to the Board each month as a separate document. The Audit Committee will continue to receive the BAF as one document periodically to allow it to fulfil its

function in maintaining oversight of the trust's risk and control framework. Following discussion at the last board meeting, the Audit Committee Chair and Chief Governance Officer are meeting to discuss the current format/presentation of the BAF to ensure there is robust oversight of mitigating actions and progress towards these.

Each BAF risk is assigned to an executive director and is discussed at the relevant board committee. The board is therefore invited to raise any questions with regards to the management and mitigation of any specific risk(s) to the relevant executive.

Alignment with Strategic Objectives
The Board Assurance Framework aligns with all of the strategic objectives.

Relevant Business Assurance Framework (BAF) Risk	
The BAF contains all risks to delivery of the objectives.	
Financial Validation	None required

Recommendation(s)
The Board is asked to **NOTE:** • the Board Assurance Framework • that future Board Assurance Framework reporting to the board will be via the Fit for the Future Framework • the format/presentation of the BAF is under review Board members are **INVITED** to raise questions relating to BAF risks with the relevant executive director and to **DELEGATE** any concerns to the relevant board committee for further scrutiny.

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	Consultation on new structures commences 22/09/25 with robust timeline for completion and implementation
Alignment of SCAS strategy to ICB priorities in relation to SPOA & clinical Pathways	Executive Director of Operations	Q3 2025/2026	Work continues with HIOW on SPOA and we are also working with all ICBs on the new 111 IUC contract offer
CAD procurement and associated benefits	Executive Director of Operations	Q1 2026/2027	Programme continues to deliver on schedule

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 regulatory** action being taken and potential clinical harm or poorer experience for patients.

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. Delivery of the Pharmacy and Medicines Optimisation Programme (including its eight projects) underway.

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. Full resourcing for the Personal Issue CD Project required, Medicines Distribution Project has not been initiated.

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 4 x Likelihood 4 = 16
Residual Risk Score	Impact 4 x Likelihood 4 = 16
Target Risk Score	Impact 4 x Likelihood 1 = 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	Project team partially in place (not all roles/resources). Site visits completed, foundational project documents and logs completed, program risks identified. Report to EMC completed.

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	Q2 2025/2026

Mitigating Actions	Executive Lead	Due Date	Progress Notes
Integrated work force plan	Executive Director of Operations	End Q1 2025/2026	We remain over establishment due to TUPE staff. Revised operating plan presented to EMC and due at FPC prior to going to HIOW ICB
Recruit to plan to avoid reliance on IRP	Executive Director of Operations	End Q1 2025/2026	Over establishment has led to us cancelling IEP recruitment and delaying all UK recruitment to Q4 at the earliest
Implementation of CCC and Ops structure to provide clinical leadership	Executive Director of Operations	End Q2 2025/2026	Consultation on new structures commences 22/09/25 with robust timeline for completion and implementation

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, CFO	WC 7/7/25	Temporary staff recruited.
Outsourcing of non-DCA's work to free up w/shop capacity	Stuart Rees, CFO	WC 7/7/25	Non DCA outsourced.
OT added to OSD and Workshop (only for at risk time zones)	Stuart Rees, CFO	WC 7/7/25	Temporary increase in overtime agreed.

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: Capacity of estates team to deliver Estates Plan and capital programme.

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	31/03/2026

Mitigating Actions	Executive Lead	Due Date	Progress Notes
Develop and approve Estate Plan alignment with the Trust's Fit for the Future and Sustainability goals.	Stuart Rees, CFO	Dec 2025	Initial Stakeholder session taken place, further session planned and implementation of Estates Group.
Recruit Waste & Utilities Manager to oversee compliance and sustainability.	Stuart Rees, CFO	Nov 2025	Advert out.
Develop an Estates Group to oversee the delivery of the Estates Plan ensure alignment with the Trust's Fit for the Future and Sustainability goals and estates decisions support the Trust's clinical and digital strategies, Green Plan, and long-term infrastructure goals.	Stuart Rees, CFO	Sept 2025	Paper to EMC 26/08/2025

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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	Impact 5 x Likelihood 4 = 20
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
Development of the Trusts values and behaviours framework	Chief People Officer	Q4 25-26	Session have started with 18 now completed and 14 further booked with more being added.
Listening events	Chief People Officer	Q3 25-26	Session have started with 3 completed so far. Feedback from listening events will be collated and reviewed by EMC with actions being taken based off the feedback. Engagement is dependent on continuing Executive commitment and focus to implement changes.

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	Leadership framework has now been developed in line with the NHS England Leadership Competency Framework.
Implementation of leadership framework	Chief People Officer	TBC once leadership framework developed	Leadership Framework is being socialised with 20 senior leaders on the pilot as well as the frontline leaders. They are doing a self-assessment against the framework to identify training needs.
Development of the Trusts values and behaviours framework	Chief People Officer	March 2026	Session have started with 18 now completed and 14 further booked with more being added.

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	Continuous Assessment

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.	Chief Finance Officer	Dec 2025	Financial Model Developed, also joint version with SecAmb. Timeline approved by EMC and F&PC.
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	In progress	Initial PMAF meeting undertaken, refreshing the delivery.
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	18th Dec 2025	Financial Model Developed, also joint version with SecAmb and work SASC and the opportunities being developed.

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 Financial 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	29/08/2025	Paper taken and agreed to EMC, new processes being implemented.
Improve Cost Improvement Programme (CIP) Delivery: Ensure all CIP plans are identified and owned by directorates with clear accountability.	Chief Finance Officer	22/08/2025	All Executives have agreed target at FRG and tiger team are meeting with Executive Directors and their team.
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	19/09/2025	Report designed and will be reported to F&PC

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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
SCAS and SECAmb have joint boards and executive 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. NEPTS 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	Q4 2025/26

Mitigating Actions	Executive Lead	Due Date	Progress Notes
Align Strategic and Operational Priorities: Conduct joint strategic planning workshops to ensure alignment of goals, timelines, and 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 .e.g. Make Ready.	Chief Finance Officer	Oct 2025	Work underway with SecAmb.
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	31/10/2025	Opportunities with SecAmb currenting be investigated. SASC currently work on savings and risk sharing agreement.
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	Oct 2025	

South Central Ambulance Service NHS Foundation Trust

Trust Board of Directors Meeting in Public
25 September 2025

Report title	Non-Executive Director Lead Roles and Board Committee Membership
Agenda item	26
Report executive owner	Becky Southall, Chief Governance Officer
Report author	Becky Southall, Chief Governance Officer
Governance Pathway: Previous consideration	None – report is for the Trust Board
Governance Pathway: Next steps	None

Executive Summary

Following the appointment of 3 new Non-Executive Directors (NEDs) to the Board, a review of committee membership and lead roles has been undertaken. The purpose of this paper is to set out:

- Allocation to NED roles required under the trust's constitution
- Allocation to nationally stipulated NED lead roles
- Allocation of NEDs and executive directors to the committees of the board
- An extension to a current term of office for one of the NEDs

Constitutional NED Roles
Deputy Chair; following the departure of Sumit Biswas, the previous Deputy Chair, Ian Green has been appointed as Deputy Chair
Senior Independent Director: Les Broude (no change)

1. NED Lead Roles

Over time, a number of requirements for NED lead/champion roles were set out in various policy documents and this was subject to review by NHS England in December 2001. Given the breadth of a NED role in the NHS and growing expectations, the trust has determined

that it will appoint to the lead roles set out in this document. The following appointments are therefore confirmed:

- Wellbeing Guardian (incorporating Sexual Safety) – Harbhajan Brar
- Freedom to Speak Up – Ruth Williams
- Security Management – Mike McEnaney

The remaining two roles referred to in the document do not apply to SCAS as an Ambulance Trust.

2. Committee Membership

The membership of the board committees has been reviewed in line with changes to board members and the Annual Review of Committee Effectiveness and Terms of Reference as reported to the July Trust Board meeting. The allocation of NEDs to committees as set out below also:

- Reflects their skillset and experience
- Ensures that there is cross cover across the committees to promote effective triangulation across quality, people, operational and financial performance
- Seeks to ensure that committee duties are equally shared between the NEDs

NED membership of the Board Committees is therefore as set out at below:

Audit Committee	Remuneration Committee	Quality & Safety Committee	Finance & Performance Committee	People & Culture Committee	Charitable Funds Committee
Mike McEnaney (Chair)	Ian Green (Chair)	Katie Kapernaros (Chair)	Les Broude (Chair)	Ian Green (Chair)	Ruth Williams
Les Broude (FPC Chair)	Harbhajan Brar	Gary Ford	Harbhajan Brar	Harbhajan Brar	Mike McEnaney
Katie Kapernaros (QSC Chair)	Katie Kapernaros	Ruth Williams	Gary Ford	Ruth Williams	Gary Ford
	Keith Willett				

3. Extension of Tenure

Les Broude's term of office as a NED is due to conclude at the end of January 2025. Given the trust is 2 years into a 3 year Financial Recovery Plan, following discussion with the regional team at NHSE, it has been agreed that his term of office will be extended for 6 months from 1st February 2025 to ensure continuity in the final year of the Financial Recovery Plan, at the conclusion of which, the trust is expected to achieve break even position and return to financial sustainability.

Alignment with Strategic Objectives

This paper relates to all of the trust's strategic objectives

Relevant Business Assurance Framework (BAF) Risk
The paper relates to all BAF risks as NEDs as board members are pivotal in overseeing delivery of the trust's objectives and ensuring that risks to delivery are managed and mitigated.

Financial Validation	Capital and/or revenue implications? If so: None Checked by the appropriate finance lead? (for all reports) N/A Considered by Financial Recovery Group (for reports where the financial impact is not covered within existing budgets) N/A

Recommendation(s)
The Trust is asked to **NOTE:** • The appointment to NED Lead Roles • The allocation of NEDs to the board committees • The extension to the tenure of Les Broude

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