NHS
South Central Ambulance Service
NHS Foundation Trust

PUBLIC BOARD AGENDA

Date: 5 February 2026

Time: 9:45 – 12:45

Venue: Newbury Education & Recruitment Centre, Bone Lane, Newbury RG14 5UE

Board Members:	
Professor Sir Keith Willett, CBE	Chair
Les Broude	Non-Executive Director
Harbhajan Brar	Non-Executive Director
Gary Ford, CBE	Non-Executive Director
Ian Green, OBE	Non-Executive Director
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
Danny Hariram	Chief People Officer / Deputy Chief Executive
Paul Kempster *	Chief Transformation Officer
Stuart Rees	Chief Finance Officer
Duncan Robertson	Chief Paramedic Officer
Becky Murray*	Chief Governance Officer
Helen Young	Chief Nursing Officer
* Non-voting board member	
In Attendance:	
Gillian Hodgetts	Director of Communications, Marketing and Engagement
Kofo Abayomi	Head of Corporate Governance & Compliance
Wassim Shamsuddin	Assistant Medical Director - North Medical Staffing
Apologies for Absence:	
Ian Green	Non-Executive Director
John Black	Chief Medical Officer
David Ruiz-Celada	Joint Strategic Lead

Right care, first time, *for our patients*

Our five strategic themes to make SCAS FIT FOR THE *future*

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

Number	Item	Format	Action	Time
1	**Welcome and Apologies** Professor Sir Keith Willett CBE, Chair	**Verbal**		09.45
2	**Declarations of Interests and Fit and Proper Persons Test** Professor Sir Keith Willett CBE, Chair	**ENC 1**	**Verbal**	
3	**Minutes from the Public Board meeting held on 27 November 2025** Professor Sir Keith Willett CBE, Chair	**ENC 2**	**Approval**	
4	**Board Action Log** Becky Murray, Chief Governance Officer	**ENC 3**	**Approval**	
5	**Chair's Report** Professor Sir Keith Willett CBE, Chair	**Enc 4**	**Noting**	09.55
6	**Chief Executive Officer's Report** David Eltringham, Chief Executive Officer	**ENC 5**	**Noting**	10.05
7	**Staff Story** Danny Hariram, Chief People Officer / Deputy Chief Executive	**ENC 6**	**Discussion**	10.15
Trust Performance				
8	**Finance & Performance Committee Report** Les Broude, NED Chair	**ENC 7**	**Assurance**	10.30
9	**Integrated Performance Report** Stuart Rees, Chief Finance Officer	**ENC 8**	**Assurance**	10.35
10	**Finance Report Month 9** Stuart Rees, Chief Finance Officer	**ENC 9**	**Assurance**	10.50
Strategic Theme: Enabling Services				
11	**Enabling Services Board Assurance Framework Risks** Stuart Rees, Chief Finance Officer	**ENC 10**	**Assurance**	11.10
Strategic Theme: Digital Transformation				

12	**Digital Transformation Board Assurance Framework Risks** Craig Ellis, Chief Digital & Information Officer	**ENC 11**	**Assurance**	11.15
Strategic Theme: Clinical Effectiveness				
13	**Clinical Effectiveness Board Assurance Framework Risks** Duncan Robertson, Chief Paramedic Officer	**ENC 12**	**Assurance**	11.25
14	**Chief Medical Officer Report** John Black, Chief Medical Officer	**ENC 13**	**Assurance**	-
Strategic Theme: People & Culture				
15	**People & Culture Committee Report** Ian Green, NED Chair	**ENC 14**	**Assurance**	11.35
16	**Freedom to Speak Up Reports** • **Annual Report 2024/25** • **Quarter 3 2025/26** Rebecca Murray, Chief Governance Officer	**ENC 15**	**Assurance**	11.40
17	**People Board Assurance Framework Risks** Danny Hariram, Chief People Officer/Deputy Chief Executive	**ENC 16**	**Assurance**	11.45
Strategic Theme: Partnerships & Sustainability				
18	**Partnerships & Sustainability Board Assurance Framework Risks** Stuart Rees, Chief Finance Officer	**ENC 17**	**Assurance**	11.50
19	**Integrated Care System Report** Stuart Rees, Chief Finance Officer	**ENC 18**	**Noting**	11.55
20	**Communications, Marketing and Engagement Update** Gillian Hodgetts, Director of Communications, Marketing and Engagement	**ENC 19**	**Noting**	12.05
Governance & Regulation				
21	**Recovery Support Programme Exit Confirmation** Becky Murray, Chief Governance Officer	**ENC 20**	**Noting**	12.10
22	**Core service reports and core service CQC action templates for regulatory breaches** Helen Young, Chief Nursing Officer	**ENC 21**	**Assurance**	12.15
23	**Audit Committee Chair's Report**	**ENC 22**	**Assurance**	12.20

	Mike McEnaney, NED Chair			
24	**Charitable Funds Committee Report** Ruth Williams, NED Chair	**ENC 23**	**Assurance**	12.25
25	**South Central Fleet Services Board Report** Mike McEnaney, NED Chair	**ENC 24**	**Assurance**	12.30
26	**Transition Committee - Committee in Common** Becky Murray, Chief Governance Officer	**ENC 25**	**Assurance**	12.35
Closing Business				
27	**Summary of actions from the meeting** Becky Murray, Chief Governance Officer	**Verbal**	**Noting**	12.40
28	**Questions from the public** Professor Sir Keith Willett CBE, Chair	**Verbal**	**Response**	12.45
29	**Any Other Business**	**Verbal**	**Noting**	-
30	**Review of Meeting** NED: Katie Kapernaros Executive: Mark Ainsworth	**Verbal**	**Discussion**	12.45
31	**Date and Time of Next Meeting in Public** Thursday 2 April 2026 at 9.45am Newbury Education & Recruitment Centre, Bone Lane, Newbury RG14 5UE	**-**	**Noting**	

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: 29 January 2026

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. Retained with NHS England and NHS Improvement to support COVID-19 public inquiry
3. Patron of IMPS (Injury Minimization Programme for Schools). An NHS charity under Oxford University Hospital NHS Foundation Trust
4. Patron of Primary Trauma Care Foundation
5. Emeritus National Director of Emergency Planning and Incident Response

Current 'Other' Interests

6. Honorary Air Commodore to 4626 Squadron, RAuxAF

Interests that ended in the last six months

7. 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
4. Trustee of the Buckinghamshire Healthcare Charity

Interests that ended in the last six months

5. None

IAN GREEN, NON-EXECUTIVE DIRECTOR

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

1. Chair of Shropshire, Telford and Wrekin and Staffordshire and Stoke on Trent ICB Cluster

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. 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. None

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

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

Interests that ended in the last six months

4. University of Bournemouth, Strategic HR advisor

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

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
13. SAS AI-Stroke, Scientific Advisory Board – company developing AI recognition FAST stroke signs
14. Merck KGaA/EMD, Serono stroke trial advisory board
15. Regeneron, Scientific Advisory 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. None

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 August 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. None

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 MURRAY, 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

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, CHIEF PEOPLE OFFICER/DEPUTY CHIEF EXECUTIVE

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: 27 November 2025
Time: 9.45am – 12.45pm
Venue: Newbury Education & Recruitment Centre, Bone Lane, Newbury, RG14 5UE

Members Present:	
Professor Sir Keith Willett CBE (KW)	Chair
Les Broude (LB)	Non-Executive Director
Ian Green (IG)	Non-Executive Director & Deputy Chair
David Eltringham (DE)	Chief Executive Officer
Harbhajan Brar (HB)	Non-Executive Director
Gary Ford (GF) *Attended part of the meeting*	Non-Executive Director
Katie Kapernaros (KK)	Non-Executive Director
Mike McEnaney (MM)	Non-Executive Director
Ruth Williams (RW)	Non-Executive Director
Mark Ainsworth (MA)	Executive Director of Operations
Dr John Black (JB)	Chief Medical Officer
Craig Ellis (CE)	Chief Digital & Information Officer
Kate Hall (KH)	Interim Deputy Chief Executive Officer
Danny Harriman (DH)	Interim Chief People Officer
Paul Kempster (PK)	Chief Transformation Officer (Teams)
Stuart Rees (SR)	Chief Finance Officer
Duncan Robertson (DR)	Chief Paramedic Officer
Becky Murray (BM)	Chief Governance Officer
Professor Helen Young (HY)	Chief Nursing Officer
In Attendance:	
David Ruiz-Celada (DRC)	Joint Board Strategic Adviser SCAS/SECAmb
Kofo Abayomi (KA)	Head of Corporate Governance & Compliance
Gillian Hodgetts (GH)	Director of Communications, Marketing and Engagement
Wassim Shamsuddin (WS)	Assistant Medical Director - North • Medical Staffing
Observers:	
None	
Apologies:	
John Black	Chief Medical Officer

Item No.	Agenda Item
1	**Chair's Welcome, Apologies for Absence**
1.1	Keith Willett (Chair) opened the meeting and welcomed those present. Apologies were received as above.
2	**Declarations of Interests**
2.1	Board members were reminded to review and update their declarations of interest. No new declarations were made.
3	**Minutes from Public Board Meeting held on 25 September 2025 and the Annual Members Meeting held on 9 October 2025**
3.1	The minutes of the public board meeting held on 25 September 2025 were agreed as an accurate record of the meeting subject to amendment of the Statutory training topics amended from 157 to 57.
3.2	The minutes of the annual members meeting held on 9 October 2025 were agreed were agreed as an accurate record of the meeting.
4	**Matters Arising and Action Log**
4.1	In addition to the actions marked as closed, the board agreed to close the following actions: • TB/25/19: Volume to be added to the ACQIs in the report. DR provided an update and advised that the action can be closed. • TB/25/13: Discussion to take place at EMC in relation to the development of cultural KPIs for inclusion in the next iteration of the IPR. IG, Chair of the People Committee advised that this action can be closed due to identified actions to be taken. • TB/25/16: Format/presentation of BAF to be reviewed (BM and MM agreed to meet to discuss re-formatting ahead of the next Audit Committee). BM confirmed that the meeting between herself and MM, Chair of Audit Committee took place as planned. • TB/25/005: Clarity to be provided in relation to what actions we are intending to take to increase BAME representation across the bandings. The Board noted that action plan in place following the WRES/WDES report. Deep dive will also be commissioned and agreed to close the action. The Board **NOTED** the action log and **APPROVED** the closure of completed actions.
5	**Chairs Report**
5.1	The Chair opened this section by providing a high-level overview of the current environment within the NHS and its impact on the organisation. He acknowledged that the NHS is facing significant system-wide changes and financial pressures, which are being driven by a

	combination of factors, including geopolitical developments, national policy shifts, and economic constraints affecting healthcare funding. These pressures are cascading down to all NHS organisations, creating a challenging operational and strategic landscape.
5.2	The Chair highlighted that these external factors have resulted in an enormous amount of work internally, as the organisation strives to adapt to new requirements and maintain service delivery standards. He noted that the complexity of these changes such as evolving commissioning models and partnership developments requires considerable effort from leadership teams and staff at all levels.
5.3	Importantly, the Chair took the opportunity to express sincere gratitude to staff across the organisation. He commended their resilience, adaptability, and commitment to patient care during this period of uncertainty and transformation. His remarks underscored that despite the turbulence, staff continue to deliver high-quality services and respond to operational demands with professionalism and dedication.
5.4	The Chair also signalled that partnership working, particularly with South East Coast Ambulance Service (SECAmb), is a critical area of focus. He emphasised that these collaborations are essential for shaping future service models and ensuring that commissioning arrangements accurately reflect the complexity of ambulance services and the needs of patients.
5.5	In closing, the Chair reiterated his appreciation for the collective efforts of the workforce, noting that their ability to navigate these challenges is fundamental to sustaining patient safety and organisational performance. He stressed that the Board recognises these contributions and remains committed to supporting staff through ongoing change.
5.6	The Board **NOTED** the Chairs verbal update and site and engagement visits report.
6	**Chief Executive Officer's Report**
6.1	DE began his report by addressing the national context, noting the recent consultation on the creation of Advanced Foundation Trusts, with an ambitious goal for all NHS trusts to achieve this status by 2035. He explained that this represents a significant shift in governance and operational expectations across the NHS. While the consultation acknowledges that very few organisations currently meet the proposed criteria, DE highlighted that SCAS is actively engaged in lobbying efforts through the Association of Ambulance Chief Executives to ensure that ambulance trusts are considered for inclusion in the initial pilot tranche. This advocacy is critical because the published list of pilot organisations currently excludes ambulance services, which could disadvantage SCAS in shaping future policy.
6.2	Moving to the Recovery Support Programme, DE confirmed that SCAS has submitted its application to exit the programme, supported by regional teams, and that the decision now rests with the national team. He expressed cautious optimism that the outcome would be positive and anticipated feedback later that day. He also clarified that the organisation has two

	recovery support programmes in place one focused on leadership and governance and the other on financial recovery both of which have seen substantial progress.
6.3	On partnerships, DE reported encouraging developments in collaboration with South East Coast Ambulance Service (SECAmb). He described the recent executive-to-executive session as constructive, noting strong functional and structural relationships and a shared ethos of partnership. These joint efforts are expected to deliver tangible benefits for patients and improve operational resilience. He acknowledged that the transition to a single chair and chief executive for both organisations is underway, with further updates anticipated in the coming weeks.
6.4	Regarding performance and finance, DE stated that SCAS remains broadly on track to achieve an income and expenditure (I\&E) balance by year-end, despite ongoing risks and the need for difficult decisions. He emphasised that this position reflects disciplined financial management and a commitment to efficiency, even as the organisation navigates external pressures and rising demand.
6.5	In terms of people, DE highlighted the continued focus on leadership development, particularly through the formation of a senior leadership group comprising individuals who report directly to executive directors. This initiative aims to strengthen organisational capacity and leadership bandwidth. He also drew attention to the ongoing flu vaccination campaign and efforts to boost participation in the NHS Staff Survey, acknowledging challenges in engagement and the need for improved communication to demonstrate the impact of staff feedback.
6.7	Finally, in his acknowledgements, DE expressed heartfelt thanks to frontline teams for their unwavering commitment to patient care, especially during a period of operational strain. He also singled out the fleet maintenance teams, praising their extraordinary efforts to keep vehicles on the road despite resource constraints and mechanical challenges. Additionally, he recognised staff who participated in recent memorial and remembrance events, noting the professionalism and compassion displayed during these occasions.
6.8	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 31 July 2025.
8	**Patient Story**
8.1	HY introduced the agenda item, by explaining that the Board alternates between patient stories and safeguarding stories to provide real-life examples of how the organisation's policies and practices impact patient care. This session focused on a safeguarding case that demonstrated the importance of professional curiosity and multi-agency collaboration.
8.2	HY presented a case study involving a young person living in supported accommodation for vulnerable individuals. The ambulance crew, which included a student paramedic, attended a call initially reported as the patient being unconscious. Upon arrival, the patient was conscious

	but displaying erratic behaviour, moving between rooms and engaging in unusual interactions with other residents. The crew observed concerning dynamics, including over-familiar and aggressive behaviour from two older males who were not expected to be in that accommodation setting.
8.3	The crew acted appropriately by prioritising the patient's immediate clinical needs while also considering the broader safeguarding context. They drew on intelligence from previous welfare checks by the police and recognised patterns of risk. HY emphasised that this demonstrated professional curiosity in action looking beyond the presenting clinical issue to identify potential safeguarding concerns.
8.4	The crew made an immediate safeguarding referral to the local authority via the Multi-Agency Safeguarding Hub (MASH), which includes representatives from health, social care, and police. The referral was assessed as high risk, triggering urgent intervention by a social worker. Subsequent investigations explored possible abuse, coercion, and trafficking risks. HY highlighted that this swift action likely prevented further harm and safeguarded the individual.
8.5	HY noted that while the organisation does not always get safeguarding right, this case exemplified best practice and the positive impact of staff vigilance. Importantly, the safeguarding team provided feedback to the crew and the student paramedic, reinforcing learning and closing the loop a step that does not always happen but is highly valued.
8.6	HY also addressed timeliness, confirming that referrals are typically made immediately via crew tablets or through team leaders, with a maximum target of 48 hours. High-risk cases, such as this one, are prioritised and acted upon within days.
8.7	In her comments, HY acknowledged ongoing challenges and outlined future improvements, including the development of a digital safeguarding referral system, planned for implementation by 2027. This system aims to streamline processes, reduce manual workarounds, and enhance reliability and auditability.
8.8	IG, Non-Executive Director praised the example and asked about the timeline for referrals, emphasizing the need for immediate response in high-risk cases.
8.9	MM, Non-Executive Director, highlighted the importance of sharing real-life safeguarding scenarios with frontline staff to reinforce training and keep safeguarding awareness "live."
8.10	LB, Non-Executive Director, raised a broader assurance question about the robustness of safeguarding processes and controls, asking whether the organisation is now in full control compared to previous years.
8.11	RW, Non-Executive Director confirmed she had reviewed safeguarding data with the Head of Safeguarding and felt assured about the processes and volume of referrals.
8.12	HY confirmed that real-life scenarios are incorporated into training and clinical supervision sessions to reinforce learning.

8.13	Questions were raised about the speed of response and assurance on safeguarding processes. HY provided data showing compliance with referral targets and noted that quality and timeliness are monitored, with feedback from local authorities indicating improvement.
8.14	The Board agreed that celebrating success and sharing positive outcomes widely is essential to motivate staff and embed best practice.
8.15	**The Board NOTED the Patient Story.**
9	**Finance & Performance Committee Report**
9.1	LB, Chair of the committee provided assurance to the Board on the work of the Finance & Performance Committee, summarising key areas of focus and discussion: • Overall Assurance: The Committee reviewed financial performance, operational delivery, and associated risks. Les confirmed that the Committee had scrutinised the integrated performance report and financial position in detail, challenging assumptions and mitigation plans. • Fleet Update: LB highlighted that the Committee had discussed the ongoing challenges with Vehicle Off Road (VOR) rates and the impact on operational performance. He noted that while no immediate action was required from the Board, the Committee agreed to continue monitoring this area closely. A specific update was requested on the additional workshop capacity to address fleet maintenance pressures. The response confirmed that the new Aylesbury workshop is scheduled to be operational in January, which should improve vehicle turnaround times and reduce VOR rates. • Financial Position: LB emphasised that the organisation is operating under significant financial pressure, with the removal of deficit funding and the need to deliver a challenging Cost Improvement Programme (CIP). He acknowledged the Executive team's efforts in identifying efficiencies and managing discretionary spend but stressed that achieving the year-end position will require continued focus and difficult decisions. He noted that the Committee had reviewed the forecast and was assured that plans are in place to achieve an income and expenditure balance, albeit with risks that will need close monitoring. • Operational Performance: The Committee examined performance against national standards, including Category 1 and Category 2 response times, and discussed the impact of winter pressures. Les confirmed that the Committee had challenged the Executive on mitigation plans to maintain performance during peak demand periods. • Future Planning: LB flagged the importance of aligning operational and financial planning with the new commissioning model and partnership developments with SECAmb. He noted that this will be a critical area for the Committee's oversight in the coming months.

9.2	The Board acknowledged the Committee's assurance and welcomed the proactive monitoring of fleet and financial risks.
9.3	LB reiterated that while progress is being made, the scale of the efficiency challenge remains significant, and all parts of the organisation must contribute ideas for improvement.
9.4	**The Board NOTED the Finance and Performance Committee Report.**
9	**Integrated Performance Report (IPR) Month 7**
9.1	SR presented the IPR which reported on month 7 data and performance:
9.2	<u>Operations</u> • 999 Call Answer Performance: MA began by highlighting improvements in 999 call answering times, which had reduced to 5 seconds in October, representing a significant achievement against national benchmarks. This improvement was attributed to successful recruitment of emergency call takers and operational efficiencies. However, he noted a slight deterioration in November, with average times increasing to 8 seconds, primarily due to a surge in demand and higher volumes of 999 calls. • Hear & Treat: MA reported that Hear & Treat performance stood at 18.8%, just below the 19% target set for the last five months of the year. He explained that while this was marginally off target, SCAS continues to benchmark strongly against other ambulance services nationally. • Patient Transport Service (PTS): PTS performance was confirmed to be within contractual parameters, with on-time arrivals meeting expectations. Interestingly, MA highlighted that early arrivals while technically outside the strict KPI were being received positively by patients, as they provided additional social interaction opportunities, particularly for those attending regular dialysis sessions. Non-Executives welcomed this insight, noting the importance of patient experience alongside operational metrics.
9.3	<u>Finance</u> SR provided a detailed financial update, confirming that £222k of deficit funding had been removed from the system allocation, increasing pressure on the year-end position. Despite this, SCAS remains on track to deliver an income and expenditure (I\&E) breakeven position, supported by rigorous cost controls and discretionary spend reviews. He acknowledged that the Cost Improvement Programme (CIP) remains challenging, with 83% of planned savings achieved to date, and stressed that further efficiencies will be required to close the gap.
9.4	
9.5	LB, Chair of Finance & Performance Committee commended the Executive team for progress but reiterated the need for contingency planning and organisation-wide engagement to identify additional savings.

	Workforce and People
9.6 9.7	DH presented workforce data, noting that SCAS remains over-established in corporate roles, a point flagged for review to ensure alignment with the redesigned corporate structure. On Performance Development Reviews (PDRs), compliance has improved to 85%, up from 82% last month, but still short of the 95% target. DH confirmed that digital PDR rollout and executive-led focus are driving improvement, though winter pressure may impact progress. Sickness absence was reported at 6.6%, above the 6.2% target, with proactive measures underway, including flu vaccination campaigns and enhanced manager support for absence management.
9.8	Non-Executives expressed concern about sickness trends and emphasised the importance of maintaining momentum on PDR completion, given its link to cultural transformation and staff engagement.
9.9	Quality and Safety
9.10	DR introduced the Quality and Safety performance update, noting that patient safety incidents resulting in moderate or severe harm remain low at 3.2%, which is a positive indicator. However, recurring themes include delays in care, particularly linked to operational pressures such as vehicle availability and end-of-shift policies.
9.11	He highlighted ongoing recontact audits for Hear & Treat and See & Treat cases, confirming that these were clinically appropriate and findings have been shared with operational teams. DR also addressed resuscitation training compliance, stating that improvement work is underway to ensure all clinicians complete face-to-face training, with a target of 95% compliance by March.
9.12	On clinical effectiveness, DR acknowledged gaps in stroke care data following the national cyber incident but assured the Board that missing data will be incorporated in the next reporting cycle. He emphasised that stroke performance correlates strongly with Category 1 response times, reinforcing the importance of operational performance for clinical outcomes.
9.13	IG queried the lack of narrative in some charts and asked for clearer links between performance and actions. DR agreed to enhance commentary in future reports. CE reminded the Board that the stroke data issue was due to a national platform outage, not local system failure.
9.14	The Board welcomed assurance on resuscitation training and requested continued visibility of compliance progress.
9.15	The Board **NOTED** the **Integrated Performance Report (IPR) Month 7.**
10	**Finance Report Month 7**
10.1	SR presented the financial position for the year-to-date, explaining that the organisation had been adversely affected by the national withdrawal of £222k of deficit funding. As a result, SCAS was now £210k off plan for the year to date. Despite this, SR reported that the Trust

	remained slightly ahead of its internal financial recovery plan due to robust financial controls and grip measures implemented across directorates. He confirmed that SCAS's cash position continued to remain stable, with no immediate liquidity concerns.
10.2	Turning to the Cost Improvement Programme (CIP), SR advised that the Trust was forecasting 83% delivery against plan. The remaining 17% shortfall was attributed to unavoidable slippage in certain schemes, cost pressures within fleet and estates, and higher-than-anticipated staffing costs. These factors continued to exert pressure on the financial position, although mitigations were being actively explored.
10.3	SR then highlighted key financial risks for the remainder of the financial year. He noted that delays in the double-crewed ambulance (DCA) conversion programme had forced capital rescheduling and could result in a potential £6 million capital reprofiling requirement. Recruitment timing also represented a material risk: recruiting too early risked returning to over-establishment and driving cost pressures, while recruiting too late risked undermining the Trust's ability to meet the Cat 2 25-minute national performance target for the following year.
10.4	During the discussion, MM challenged the reported £1.5 million overspend in pay, asking how much of this related to early-year over-establishment and how much reflected CIP under-delivery. In response, SR and MA explained that the majority of the overspend resulted from early-year over-establishment in operations, which had since begun to correct through natural attrition. They reported that attrition levels were now bringing the workforce below the funded baseline, creating a window to re-align establishment levels.
10.5	Both SR and MA emphasised that recruitment must be carefully paced: although a strong pipeline of candidates was already in place, bringing them into the organisation too quickly risked recreating previous over-establishment issues, while delaying recruitment could impair the Trust's ability to meet future CAT 2 performance standards. The Board acknowledged this delicate balance and the operational and financial interdependencies that must be managed over the coming months.
10.6	The Board **NOTED Finance Report Month 7.**
11	**SCAS Charity Annual Accounts & Audit Report**
11.1	The Board received the annual accounts and audit report presented by SR and Vanessa Casey, Chief Executive of the Charity. SR explained that the previous year had been financially challenging due to the absence of dedicated fundraising staff, which had significantly impacted income generation. He reported that this position had now improved following the appointment of two new fundraisers, and early indications showed a positive trajectory for income growth.
11.2	SR confirmed that the independent examination of the Charity's accounts had provided clean assurance, reflecting strong governance and compliance. He highlighted the essential role the Charity plays in supporting SCAS beyond core NHS funding, including the provision of Community First Responders (CFRs), volunteer training, staff wellbeing initiatives, and enhancements to patient care that would otherwise be unfunded.

11.3	During discussion, MM (NED) commended the Charity for maintaining financial integrity during a difficult year and asked whether the new fundraising strategy would include corporate partnerships to diversify income streams. SR confirmed that corporate engagement was a priority and that the team was actively exploring opportunities with local businesses. LB (NED) emphasised the importance of demonstrating the impact of charitable funds on patient outcomes to strengthen donor confidence. VC agreed and noted that future reports would include case studies to illustrate tangible benefits.
11.4	The Board welcomed the progress and acknowledged the importance of aligning future fundraising strategies with SCAS priorities to maximise impact.
11.5	**Action: It has previously been agreed to separate matters concerning the charity from SCAS Board matters. There needed to be a dedicated SCAS Charity Trustees meeting in future.**
11.6	**Acting in their capacity as Trustees, the Board formally approved the Charity's Annual Accounts and Audit Report.**
12	**Enabling Services Board Assurance Framework Risks**
12.1	The Board considered the BAF risks relating to enabling services, introduced by SR. He outlined Risk 17(Fleet Modernisation), explaining that a large volume of vehicle lease expiries was expected over the next two to three years, creating significant operational pressure. He noted that current workshop capacity was insufficient to meet demand and warned that fleet availability was likely to deteriorate further during the winter period. SR added that multiple SCAS sites could not safely accommodate additional vehicles or charging infrastructure, which compounded the challenge of modernising the fleet.
12.2	MA reinforced these concerns, cautioning that winter pressures would inevitably drive Vehicle Off Road (VOR) rates higher, posing a direct threat to response performance.
12.3	Turning to Risk 18 (Estates Capacity), SR advised that substantial capital investment would be required to address estate limitations and ensure operational resilience. He confirmed that a joint opportunity with SECAmb was being explored to optimise resources and reduce duplication.
12.4	Board members acknowledged the rising inherent risk but noted that control maturity was improving through strengthened governance and planning.
12.5	The Board **APPROVED** the updated BAF entries for both Fleet Modernisation and Estates Capacity.
13	**Digital Transformation Board Assurance Framework Risks**
13.1	The Board reviewed the BAF risks relating to digital transformation, introduced by CE. CE highlighted that while collaboration with SECAmb presented significant opportunities for

	shared platforms and efficiencies, it also introduced uncertainty into long-term planning and investment decisions. He noted that legacy systems and end-of-life platforms remained a critical vulnerability, and the mismatch between revenue and capital funding streams at national level continued to constrain progress.
13.2	CE confirmed that cyber security risk remained high, currently scored at 16, despite achieving DSPT compliance and implementing interim controls. A revised cyber strategy was in development to strengthen resilience and address emerging threats. He emphasised that digital risks were increasingly cross-cutting, touching every committee and operational area, and proposed that the Board consider a new governance mechanism to ensure oversight and accountability.
13.3	During discussion, MM expressed concern about the cumulative impact of digital risks on operational performance and asked whether the current governance structure was sufficient. CE acknowledged that existing arrangements were fragmented and reiterated the need for a consolidated approach. LB supported this view, stressing that digital transformation was now a strategic enabler and should be treated as such in Board assurance processes. The Chair agreed and requested that the Executive team return with a proposal for a strengthened governance model.
13.4	**Action: consideration to be given to establishing a Digital Committee/Group and how this will align to the governance structure**.
13.5	The Board **APPROVED** the updated BAF entries.
14	**Quality & Safety Committee Report**
14.1	The Board received a verbal update from KK, Chair of the Quality & Safety Committee. KK highlighted that the focus remained on patient safety, clinical governance, and assurance around key quality metrics. The Committee noted improvements in incident reporting and learning, as well as progress in infection prevention and control compliance.
14.2	The Board commended the Committee for its emphasis on triangulating data from multiple sources, including patient feedback and clinical audits, to strengthen assurance. It was also queried whether the Committee had sufficient visibility of safeguarding risks given recent case escalations. KK confirmed that safeguarding was a standing agenda item and that assurance mechanisms had been strengthened following previous concerns.
14.3	Board members agreed that while progress was evident, continued focus was required on embedding learning from serious incidents and ensuring consistency in clinical supervision. The Committee will provide a deeper dive on resuscitation training compliance and medicines optimisation at a future meeting.
14.4	The Board **NOTED** the verbal update.
15	**Clinical Effectiveness Board Assurance Framework Risks**

15.1	The Board reviewed the BAF risk relating to the delivery of the new operating model, introduced by BM and DR. BM explained that the operating model was a critical component of SCAS's transformation programme, designed to improve clinical effectiveness, medicines optimisation, and workforce capability. She noted that while progress had been made, the scale and complexity of the change meant the inherent risk remained high.
15.2	DR highlighted that the medicines optimisation programme was central to the new model, with initiatives such as the controlled drug nurse pilot already underway. He confirmed that governance structures had been strengthened through the establishment of a dedicated Programme Board, ensuring oversight of compliance and safety standards.
15.3	The Board questioned whether the operating model was sufficiently resourced and asked how the Board would gain assurance that benefits were being realised. DR responded that a benefits realisation framework was being developed and would be presented to the Board in the next cycle.
15.4	The Board stressed the importance of embedding clinical audit and supervision within the new model to maintain quality and safety. DR assured the Board that these elements were integral and would be monitored through regular reporting.
15.5	Action: **December seminar time to be dedicated to the Operating Model and the functional programmes of work underway with SECAmb**.
15.6	The Board acknowledged the improving control maturity and approved the updated BAF entry, subject to the agreed action.
15.7	The Board **APPROVED** the Clinical Effectiveness Board Assurance Framework Risks.
16	**Patient Safety Report**
16.1	The Board received the Patient Safety Report presented by HY. She provided an overview of incident trends, noting that 3.2% of reported patient safety incidents resulted in moderate or severe harm, which was lower than historical averages. HY highlighted recurring themes, including delays to care, which were now primarily linked to operational factors such as vehicle availability, end-of-shift policies, and CAD system ageing issues rather than hospital handover delays. Recontacts following Hear & Treat and See & Treat pathways also remained a concern, alongside resuscitation pathway compliance, with one serious incident declared in-month relating to a potential deviation from the traumatic cardiac arrest protocol.
16.2	HY reported strong performance in infection prevention and control, with 611 hand hygiene audits completed against a target of 281. She clarified that this surge was due to sites preparing for acquisition and over-auditing, and that assurance reviews focus on quarterly consistency rather than isolated spikes.
16.3	The Board praised the improvement in audit compliance but asked whether the increase reflected sustainable practice or short-term preparation. HY Helen confirmed that compliance was being monitored for consistency and that cultural embedding remained a priority. It was also queried whether lessons from the resuscitation incident had been shared widely. HY

	assured the Board that learning was disseminated through clinical supervision and training updates.
16.4	The Board raised concerns about missing stroke performance data from August to December 2024 due to the national cyber incident, stressing the importance of understanding performance trends during that period. HY confirmed that data recovery was in progress and would be included in the next report. The Board welcomed the assurance provided but agreed that continued focus was required on reducing delays to care and strengthening clinical pathway compliance.
16.5	The Board **NOTED** the Patient Safety Report.
17	**Chief Medical Officer's Report**
17.1	The Board received the report from WS, (Asst Medical Director) who provided an update on clinical priorities and assurance activities. WS highlighted that the Medical Directorate continued to focus on improving clinical effectiveness, patient safety, and compliance with national standards. He reported that resuscitation training compliance remained a key priority, with an ambition to reach 95% by the end of March and confirmed that targeted interventions were underway to support this goal.
17.2	WS also addressed performance in key clinical pathways, including stroke and cardiac care, noting that improvements in Category 1 response times were positively influencing outcomes. He emphasised the importance of embedding clinical audit and supervision across all services to maintain quality and safety standards.
17.3	The Board **NOTED** the Chief Medical Officer's Report.
18	**People & Culture Committee Report**
18.1	The Board received the report from the People & Culture Committee, presented by IG (Committee Chair). IG outlined the Committee's key focus areas, which included sickness absence, performance development review (PDR) completion and quality, over-establishment in corporate functions, workforce culture concerns, and preparations for an Equality, Diversity & Inclusion (EDI) deep dive scheduled for the coming months.
18.2	IG noted that sickness absence remained above target and questioned whether the current target was sufficiently ambitious to drive improvement. He also highlighted that while PDR compliance rates were improving, the Committee remained concerned about the quality of conversations and the risk of a "tick-box" culture. Over-establishment in corporate functions was flagged as an ongoing issue requiring tighter workforce planning.
18.3	The Committee had also reviewed cultural indicators, including bullying and harassment cases and Freedom to Speak Up (FTSU) themes. IG stressed that these issues were deeply concerning and reiterated the Committee's escalation to the Board: The Board must define its tolerance levels for bullying, harassment, sexual safety, and cultural harm across SCAS.

18.4	The Board supported the need for clarity, stating that without a defined position, cultural risks would remain unmanaged. It was also highlighted that accountability for line managers must be strengthened, and consequences for failing to address cultural harm should be explicit. DE agreed and proposed that the Board hold a dedicated development session to establish a clear cultural framework, including expectations for leadership behaviour and mechanisms for assurance.
18.5	The Board **NOTED** the verbal update from the People and Culture Committee Chair
19	**Freedom to Speak Up Guardian Report**
19.1	The Board received the FTSU report presented by KH, supported by Christine McParland (FTSU Guardian) and Simon Holbrook (FTSU Guardian). CP highlighted a concerning paradox: while the number of FTSU cases had increased, fear of detriment had also risen significantly. Staff reported feeling unsafe to speak up, citing a lack of trust in line managers and a perception that concerns were not acted upon. Common themes included a lack of care, lack of trust, and lack of autonomy within the workplace. CP warned that these issues were likely to be strongly reflected in the upcoming staff survey.
19.2	She further noted that certain managers were dismissing concerns with remarks such as *"That is simply X being X,"* while others were directing staff to the Freedom to Speak Up process rather than addressing issues directly. CP reported that the frontline workforce currently perceives the environment as psychologically unsafe, underscoring the urgent need for cultural change. KH emphasised that Freedom to Speak Up feedback should be regarded as a critical organisational barometer of culture rather than an isolated reporting mechanism.
19.3	HB observed that the discussion appeared to reflect a response to actions not currently being undertaken rather than those in progress. MM requested greater clarity on outcomes, specifically asking for data on the number of cases closed and the nature of their resolution. DH acknowledged that while multiple cultural workstreams were in place, they were not achieving the intended impact. CE emphasised the necessity for leadership accountability and the implementation of consequences where inaction occurs. BM highlighted the importance of defining what constitutes harassment, noting that the term "banter" was frequently misused as a justification for inappropriate behaviour. DE recommended convening a Board development session to establish a unified cultural improvement narrative and an associated action plan.
19.4	The Board **NOTED** the Freedom to Speak Up Guardian Report.
20	**Partnerships & Sustainability Board Assurance Framework Risks**
20.1	The Board reviewed the BAF risks associated with partnerships and sustainability, introduced by SR. The discussion focused on the strategic collaboration with South East Coast Ambulance Service (SECAmb) and the implications for governance, operational alignment, and long-term sustainability. The Executive highlighted that while the partnership presented

	significant opportunities for shared efficiencies and improved patient outcomes, it also introduced complexity in decision-making and accountability structures.
20.2	Key risks identified included the potential for misalignment in strategic priorities, resource allocation challenges, and the need for robust governance frameworks to manage joint initiatives effectively. The Board noted that sustainability risks extended beyond financial considerations to include workforce resilience, environmental commitments, and the ability to maintain service quality during periods of transformation.
20.3	The Board emphasised the importance of ensuring that partnership arrangements do not dilute SCAS's accountability for patient safety and performance. The Board also requested clarity on how benefits realisation would be measured and reported to the Board. The Executive confirmed that a benefits tracking framework was being developed and would be presented at a future meeting. The Chair stressed that sustainability must remain a core lens for all strategic decisions, particularly in relation to fleet modernisation and digital transformation.
20.4	The Board **APPROVED** the Partnerships & Sustainability Board Assurance Framework Risks.
21	**Hampshire and Isle of Wight ICB Month 7 Finance Report**
21.1	The Board noted the update on the Hampshire and Isle of Wight Integrated Care Board (ICB) financial position for Month 7, as presented during the meeting. The report highlighted continued financial pressure across the system, with a significant overspend against plan driven by increased demand, workforce costs, and inflationary impacts. The ICB confirmed that recovery actions were being implemented, including tighter expenditure controls and prioritisation of essential services.
21.2	The Board queried the potential implications for SCAS, particularly regarding commissioning arrangements and funding flows. SR assured the Board that while system-wide financial constraints were challenging, SCAS's internal grip measures and cost improvement programme remained robust. He emphasised the importance of maintaining close engagement with the ICB to mitigate any adverse impact on ambulance service funding and operational delivery.
21.3	The Board acknowledged the inherent risk posed by system financial instability and agreed that continued monitoring and proactive engagement with the ICB were essential. **Action: Consideration to be given in relation to how to report the system position to the board without presenting the full ICB finance reports.**
21.4	The Board **NOTED** the Hampshire and Isle of Wight ICB Month 7 Finance Report.
22	**Buckinghamshire, Oxfordshire and Berkshire West ICB M7 System Reports**
22.1	The Board **NOTED** the BOB ICB M7 System Report.
23	**Communications, Marketing and Engagement Update**

23.1	GH reported successful delivery of winter campaigns and strengthened partnership communications with SECAmb. Remembrance and military engagement activities were well received. She emphasised embedding cultural improvement themes in all messaging, focusing on care and kindness. The Board commended campaign clarity and asked about feedback mechanisms; GH confirmed pulse surveys and forums are in place. The Board also stressed that communications should actively support cultural change, which GH agreed to implement.
23.2	The Board **NOTED** the Communications, Marketing and Engagement Update
24	**Audit Committee Chair's Report**
24.1	The Board received the Audit Committee Chair's report, presented by MM (Committee Chair). MM highlighted the Committee's concern regarding the cumulative impact of multiple strategic changes, including commissioning reforms, digital transformation, and financial pressures. He stressed the need for a consolidated view of these changes and their associated risks to ensure effective oversight.
24.2	During discussion, MM requested that the Executive team prepare a comprehensive mapping of all system-wide and internal change programmes, including interdependencies and risk mitigation strategies. This will be addressed through a planned Board Seminar. He also noted that the recent internal audit review of Fleet Services returned a moderate assurance rating, with actions in progress to strengthen controls.
24.3	The Board acknowledged the Committee's observations and agreed that a holistic approach to change management and assurance was essential.
24.4	The Board **NOTED** the Audit Committee Report.
25	**Charitable Funds Committee Report**
25.1	The Board received the report from RW (Committee Chair). RW highlighted the critical role of charitable funds in supporting Community First Responders (CFRs), noting that this service is entirely volunteer-funded. She confirmed that a new charity strategy is being developed for implementation in April 2026, aimed at strengthening alignment between SCAS priorities and fundraising activities.
25.2	The Board asked about digital engagement and whether volunteers without SCAS email addresses could access e-learning resources. RRW acknowledged this as a challenge and confirmed that solutions were being explored. MM stressed the importance of ensuring governance clarity between the Board's role as Trustees and SCAS operational oversight. RW agreed and confirmed that this would be addressed in the forthcoming strategy.
25.3	The Board **NOTED** the report.
26	**South Central Fleet Services Board Report**

26.1	The Board received the report from MM (SCFS Board Chair). MM outlined the subsidiary's current priorities, focusing on ensuring clarity of the Service Level Agreement (SLA) with SCAS and addressing structural tax issues, including VAT treatment and deficit handling. He noted that delays in fleet acquisition continued to impact both SCAS and Fleet Services operations, creating pressure on vehicle availability and workshop capacity.
26.2	The Board queried whether the subsidiary had sufficient resilience to manage these challenges alongside SCAS's wider fleet modernisation programme. MM confirmed that mitigation plans were in place but emphasised the need for closer alignment with SCAS's strategic objectives. The Board agreed that opportunities for collaboration with SECAmb on fleet operations should be explored further to optimise resources and reduce duplication.
26.3	The Board **NOTED** the South Central Fleet Services Board Report.
27	**Summary of Actions from the meeting**
27.1	BM summarised actions from the meeting: • Board Assurance Framework; consideration to be given to establishing a Digital Committee/Group and how this will align to the governance structure (BM/CE) • Board Assurance Framework; December seminar time to be dedicated to the Operating Model and the functional programmes of work underway with SECAmb (MA) • System Financial Reports; consideration to be given in relation to how to report the system position to the board without presenting the full ICB finance reports (SR) • Charity Accounts: discussion to take place with regards to separating matters concerning the charity from SCAS board matters (BM).
28	**Questions from the public**
28.1	None received.
29.	**Any other business**
29.1	None Raised.
30	Summary Review of the meeting: • Sections of the meeting were overly detailed, though proportionate given the complexity of topics. • Culture and psychological safety require urgent Board-level focus and sustained leadership attention. • Governor recruitment is a priority, and Board members were encouraged to promote applications.

	• Board papers need greater clarity, with a stronger emphasis on the "So What?" analysis in the IPR. • Cultural issues demand immediate action, including strengthened accountability for line managers. • Patient stories should, where possible, include attending paramedics to enhance operational learning. • The Charity report was positively received. • A renewed focus on assurance is needed to ensure Board discussions remain strategic.
30 30.1	**Date, Time and Venue of Next Meeting in Public** The next public meeting of the SCAS Board would take place at 9.45am on 5 February 2026 at Newbury Education & Recruitment Centre, Bone Lane, Newbury, RG14 5UE.

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TRUST BOARD ACTION LOG						Status
Minute Ref:	**Agenda Item**	**Action**	**Owner**	**Due Date**	**Update**	
Meeting Date: 27 November 2025						
TB/25/021	SCAS Charity Annual Accounts & Audit Report	Discussion to take place with regards to separating matters concerning the charity from SCAS board matters.	BM	**05.02.26**	Agreed that the Board of Directors will meet separately when charity matters are to be considered and the Charitable Funds Committee will be a committee of the Board of Trustees.	**Close.**
TB/25/022	Digital Transformation Board Assurance Framework Risks	Consideration to be given to establishing a Digital Committee/Group and how this will align to the governance structure.	BM/CE	**05.02.26**	This will form part of the on-going review into the EMC substructures.	**Propose to close as a board action.**
TB/25/023	Clinical Effectiveness Board Assurance Framework Risks	December seminar time to be dedicated to the Operating Model and the functional programmes of work underway with SECAmb.	MA	**18.12.25**	Completed.	**Close.**
TB/25/024	Hampshire and Isle of Wight ICB Month 7 Finance Report	Consideration to be given in relation to how to report the system position to the board without presenting the full ICB finance reports.	SR	**05.02.26**	For the current reporting period, a draft a summary will be reported to the board with supporting documents available on request. From April 2026, propose that item is reported by exception only.	**Propose to close.**

Meeting Date: 29 May 2025						
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	BM	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. 27.11.25 – BM advised that this piece of work is ongoing and how this is linked to visibility. Advised to keep action open.	**OPEN**

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Trust Board of Directors Meeting in Public 5 February 2026

Title	**Chair's Update Report**
Report Author	**Jayne Waller, Senior Executive Assistant (Chair & CEO)**
Accountable Director/Executive Owner	Keith Willett, Chair
Agenda Item	**5**
Governance Pathway: Previous	Not Applicable
Governance Pathway Next Steps	Not Applicable

1. Purpose

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

December 2025

- NHS Providers' Chairs and Chief Executive Network
- SCAS Annual General Meeting
- SCAS Extraordinary Remuneration Committee
- Thames Valley Designate - Chairs meeting
- SCAS Nominations Committee
- NHS Providers – Navigating Change in CoGs - focus group
- SCAS Sexual Safety Awareness for Managers Training
- Speaker for Schools, Ruislip, High School

January 2026

- AACE Chairs Meeting
- SCAS Charitable Funds Committee
- NHS Confed Member Chairs Meeting
- New Central East ICB Chair meeting
- Thames Valley Designate – Monthly Trust Chairs Catch-up
- HIoW ICS Monthly Chairs Meeting
- BLMK ICS Research and Innovation Network Meeting
- SCAS Renumeration Committee
- SCAS People and Culture Committee
- NHSE SE Region Chairs briefing

- SCAS Finance and Performance Committee
- Primary Trauma Care Foundation Meeting
- Speak for Schools talk – Copthall School, London
- CQC Well Led inspection visit interview

Other

- SCAS Team Brief Lives
- NED, Lead Governor and Exec Catch-ups

Recommendation

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

Trust Board of Directors Meeting in Public 5 February 2026	
Title	**Chief Executive Officer's Report**
Report Author	**David Eltringham, Chief Executive Officer**
Executive Owner	**David Eltringham, Chief Executive Officer**
Agenda Item	**6**
Governance Pathway: Previous	None – the paper is for the Trust Board
Governance Pathway Next Steps	As above

1. Purpose

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.

2. Executive Summary

National Context

Recovery Support Programme

Since my last report, I am pleased to announce that formal notification has been received from NHS England of the Trust's exit from the Recovery Support Programme. There is a paper later on the agenda confirming this and as the confirmation letter suggests, it is right to take the time to reflect on the significant progress that has been made over the last 2 years, that has provided confidence in our readiness to exit the programme.

I would also like to take this opportunity to thank our staff for the hard work and commitment they have demonstrated to returning SCAS to a sustainable position as a Trust, to ensure we are able to deliver the best care that we can to our patients and the population we serve. However, whilst this is a moment to pause and reflect, we are not complacent and will remain focused on delivering further improvements through our Fit for the Future Programme.

Multi-Year Plan

Following the first submission, we continue to develop our 3-year Multi-Year Plan, which will ensure that our workforce, operational and financial plans are aligned, and we can monitor and drive our performance across all these areas, which underpin our ability to provide good quality, safe services. This is a different approach to planning and along with achieving year 3 of our Financial Recovery Plan, will ensure that SCAS is sustainable into the future. The priorities for next year under our Fit for the Future programme will reflect the commitments set out in our Multi-Year Plan and will drive our improvement work as we move into 2026/27.

CQC Well Led Inspection

At the time of writing this report, we are preparing for our CQC Well Led Inspection which is taking place on 27-29th January. We are in the process of submitting the documents that the CQC has requested to inform the inspection and over the 3 days, the CQC inspection team will hold interviews with our board members, senior leaders, subject matter experts and stakeholder panels with our governors and staff. We will report further when the report is received and remain committed to acting on the observations of the inspection team and taking any further improvement action that is required and that does not already feature in our Fit for the Future Improvement Plan.

Collaboration with South-East Coast Ambulance Service (SECAmb)

Our collaboration work is continuing alongside the work that we are focusing on internally and our respective Executive Teams continue to meet to determine how we can learn and share best practice and work in more efficient and effective way.

Colleagues in SECAmb are supporting us with additional fleet as we work through our Fleet Improvement Programme and we are continuing to work on areas such as a common operating model across the two organisations to ensure consistency in the quality and standards of care that we deliver to our populations.

In line with the decision to establish a Group Model with a single Joint Chair and Chief Executive Officer, recruitment to these posts is underway via an open and competitive process, which is expected to conclude in February and March respectively. However, as we remain two separate, statutory organisations with two boards, we have put into place governance arrangements to ensure that both boards have oversight of the work that is required during the Transition period. The terms of reference for a new Committee in Common are later on the agenda for this meeting.

Operational Performance

Since my last report, both SCAS and the system as a whole has experienced a challenging period due to winter pressures. During this time the executive team has maintained a daily focus on category 2 performance and has taken a dynamic approach to implementing actions and initiatives aimed at improving our performance.

Full details of our quality, operational and people performance is contained within the Integrated Performance Report (IPR) that forms part of this agenda. For December 2025, our category 2 mean performance was 31.54, which is above our target of 30 minutes. Whilst we put into place anticipatory measures as part of our Winter Planning exercise, including additional staffing to manage expected additional demands on the service, we continued to experience challenges with our fleet with a 43.1% vehicles off the road (VOR) rate and with staff sickness.

Our Hear & Treat performance was also below target for the first time in 4 months, which contributed to our response times, as this initiative is key to ensuring that we only send an ambulance and convey patients to hospital that need hospital treatment. Staff sickness impacted on our ability to deliver Hear & Treat, but is expected to reduce as seasonal illnesses subside.

Fleet and VOR

Our ability to respond to category 2 calls in timely way culminated in a decision to call a Business Continuity Incident on 16th January 2026. This has enabled us to seek additional

support and releases staff across the trust to focus on returning performance to target levels.

A key contributor to our ability to respond to our patients in a timely way is our Fleet position and this is reflected in our Board Assurance Framework as a strategic risk, which has board focus. The reasons for our challenges are multi-factorial but include the age of our fleet and the consequent impact on workshop demand, vehicles that are in use being overused to try and meet demand, leading to more faults developing, delays in new vehicles being delivered and the logistics of moving the fleet around our geography to match with crews.

However, we have put into place a Fleet Improvement Plan, which is aimed at tackling these issues, including opening additional workshop capacity so that we can undertake repairs and ensure vehicles are roadworthy in a timely way.

Whilst we are content that we have put into place arrangements that will increase vehicle availability and reduce VOR in the coming months, we have taken additional actions to support the availability of our fleet. This includes reviewing our current processes with a view to streamlining these, monitoring electric vehicle charging to ensure this does not become a reason for VOR, outsourcing bigger repairs to SECAmb and external providers, and establishing a logistics cell to ensure that we can swifty move our vehicles to where they are needed and reduce non-availability of our crews. The actions that we have agreed are monitored on a daily basis by our Incident Management Group, which has been established in response to our Business Continuity Incident being called.

We will remain focused on short- and medium-term actions until such time that our fleet position stabilises, with scrutiny at executive, Finance and Performance Committee and the Board.

Financial Performance

The trust remains on track to deliver year 3 of its Financial Recovery Plan and deliver a break-even position at the end of the financial year. This has without doubt been an extremely challenging year, in which we have had to make difficult decision and continually

strike a careful balance between operational performance, financial performance and ensuring that quality of care is not impacted.

The executive team continue to monitor the financial position on a weekly basis and together with other senior leaders across the trust, we are working collectively to priority areas of investment for 2026/27 and beyond, together with the identification of Cost Improvement Programmes (CIP) that will deliver our required efficiency savings.

People & Culture

- **Cultural Development – Staff Engagement**

As part of our Fit for the Future (FFF) integrated improvement plan we undertaken an extensive exercise to refresh our values and create a behavioural framework that will inform how we live our values. Our primary driver was to ensure that this was a co-creation exercise undertaken in partnership with our staff, and we have engaged extensively to develop a set of values and behaviours that will in turn enable our staff to feel valued when they come to work, which was a key message from the work that we undertook.

We will continue to develop this work over the coming weeks and ensure that we have a robust engagement and launch plan in place in readiness for formal board sign off in April 2026.

- **A day in the life of…..**

The BBC spent the day with one of our Specialist Practitioners, Chrissy Ames to learn about the crucial support that they provide to our patients. The article brings to life our strategic aim to become a care navigator and ensure that patients are treated in the most appropriate setting, enabling them to be treated at home when they do not need to be conveyed to a hospital setting.

This provides a much better experience for patients, particularly the frail elderly who can deteriorate further when they are hospitalised and also relieves pressure on our partners within the system. I am delighted that the BBC were able to spend the day with Chrissy

and enable her to demonstrate to the public that a modern ambulance service provides services that extend beyond dispatching a traditional ambulance.

3. Areas of Risk

Areas of risk have been highlighted throughout this paper and the risks around our financial position, operational performance and people and culture are linked to our strategic themes and the corresponding Board Assurance Framework (BAF) risks.

4. Link to Strategic Theme

As indicated above, this paper links to all our strategic themes.

5. Link to Board Assurance Framework Risk(s)

This paper links to the following BAF risks:

- (14) Quality performance
- (17) Fleet Improvement Plan
- (19) Efficiency and productivity
- (24) Finance
- (22) Staff Engagement
- (25) Collaboration

6. Quality/Equality Impact Assessment

Not required for this paper but elements of the work referred to will be subject to QIA/EIA as appropriate.

7. Recommendations

The board is asked to NOTE the update and to RAISE any questions arising.

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

Trust Board of Directors Meeting in Public 5 February 2026

Title	**Staff Story: Specialist Practitioner Service**
Report Author	**Megan Gray (Specialist Practitioner)** **Judith MacMillan (Head of Culture and Leadership)**
Executive Owner	**Danny Hariram (Chief People Officer)**
Agenda Item	**7**
Governance Pathway: Previous	N/A
Governance Pathway Next Steps	N/A

1. Purpose

The purpose of this report is to present the work of the Specialist Practitioner Service, through the story of Megan Gray, a Specialist Practitioner.

Megan's history with South Central Ambulance Service (SCAS) is as follows:

Dates	Role
2018 – 2021	Student Paramedic
2021- 2023	Newly Qualified Paramedic
2023 - 2024	Paramedic
2024 - present	Trainee Specialist Practitioner Paramedic

2. Executive Summary

The Specialist Practitioner team represents a highly skilled group of urgent and emergency care professionals who have undertaken additional Level 7 training in minor illness and injury. This team of 90 whole-time equivalent paramedics and nurses operates across 11 ambulance stations in Thames Valley and Hampshire, delivering care in a variety of settings. Their work spans solo response vehicles, the Urgent Care Desk, falls and frailty pathways, night-time economy support, and first aid units. This dynamic approach ensures patients receive timely, appropriate care in the most suitable environment.

Impact and Performance

The impact of the Specialist Practitioner role is significant. Equipped with enhanced clinical skills, Specialist Practitioners manage a wide range of presentations, from wound closure and catheterisation to prescribing antibiotics and analgesia.

Data from the first quarter of 2025–26 demonstrates the value of this model: while SCAS overall achieves a See & Treat rate of 36.6%, SPs deliver 69.87%, with even higher performance in Category 3 and 4 cases.

Every time a Specialist Practitioner treats a patient at home rather than conveying them to hospital, it frees up double-crewed ambulances to respond to life-threatening emergencies more quickly. The introduction of the Specialist Practitioner dispatch model has further improved efficiency, enabling rapid clinical screening and collaborative decision-making within the Emergency Operations Centre.

Patient Outcomes

The benefits to patients are clear and deeply personal. Older adults and those living with frailty, dementia, Parkinson's disease, or Chronic Obstructive Pulmonary Disease (COPD) often face significant risks when admitted to hospital, including infection and loss of independence. Specialist Practitioners help avoid these risks by providing care at home. Recent patient feedback speaks volumes: one individual expressed relief at not having to attend Accident and Emergency at midnight, knowing they would have struggled to get home. Another described the care they received as "outstanding," while a family praised the meticulous wound care that spared them a harrowing hospital visit. These stories illustrate the compassion and professionalism that underpin the SP role.

Operational Challenges

However, the team face operational challenges, the most pressing of which is vehicle availability. Since April 2025, 620 unit hours have been lost—equivalent to 65 shifts—due to a lack of vehicles. Specialist Practitioners have responded with remarkable flexibility, driving personal cars to stations where vehicles are available, using alternative SCAS vehicles not equipped for blue-light driving, and even crew-sharing when necessary. While this demonstrates resilience and commitment, it is not sustainable and requires attention and SCAS is addressing the issue with a program to replace the old fleet with new Single Response Vehicles which are starting to arrive. In the meantime, the Director of Fleet has been working in conjunction with the Specialist Practitioner management team to source all available vehicles.

Innovation

Despite these challenges, the Specialist Practitioner team remains proud of its contribution and Megan is proud to work for SCAS and believes SCAS to foster a culture of innovation and improvement, encouraging new approaches to patient care and supporting staff

development. SPs feel part of something meaningful—a service that makes a real difference to society and is committed to moving forward patient care in alignment with the 10 year NHS Health Care Plan and the shift from hospital to community.

3. Areas of Risk

Performance – vehicle availability.

4. Link to Strategic Theme

Enabling Services

5. Link to Board Assurance Framework Risk(s)

SR17 - Delivery of Fleet Improvement Plan

6. Quality/Equality Impact Assessment

A quality / equality impact assessment is not required.

7. Recommendations

- Receive a report/paper for noting

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

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Specialist Practitioner | Paramedic (SP's)

Megan Gray

Who are we?

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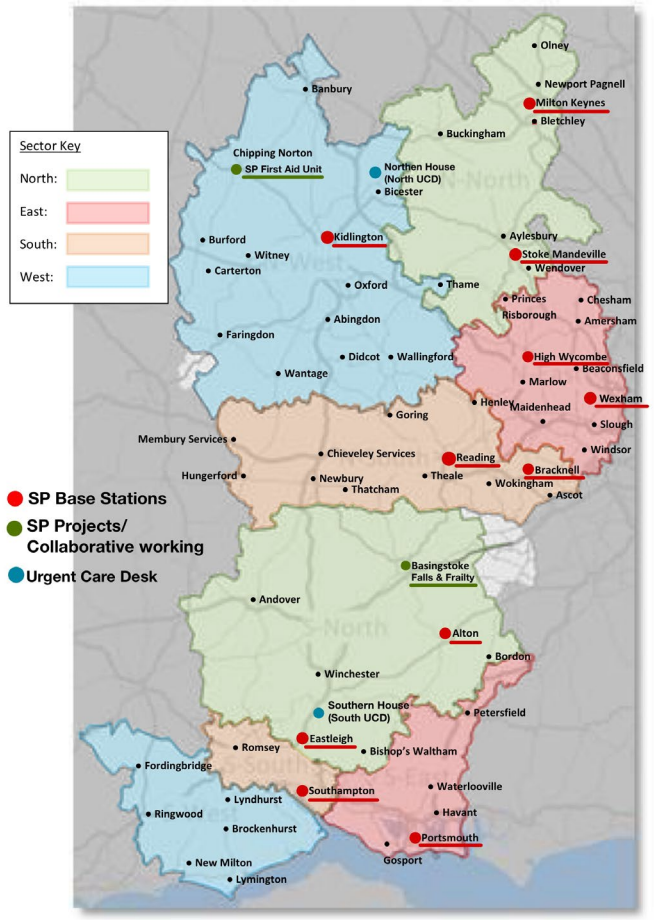

Urgent (and emergency) practitioners with additional Level 7 training in minor illness and injury.

Team of 90 (WTE) Paramedics and Nurses working collaboratively across 11 ambulance stations throughout TV and Hants.

Dynamic role: Solo Response Vehicles, Urgent Care Desk, Falls and Frailty, Night-time Economy, First Aid Unit.

What difference are we making?

South Central Ambulance Service
NHS Foundation Trust

Conjunctivitis Corneal abrasion	Eye assessment, supply of antibiotics
Urinary retention, Urinary catheter problem (leaking, came out, bypassing, blocked, suprapubic catheters)	Primary catheter insertion, change of catheter.
Urinary tract infection (please check NEWS2 score)	Advanced assessment, supply of antibiotics
Wounds/blisters/burns/ulcers/human & animal bites, Puncture wounds – thorn/rusty nail – all will be considered, check depth and size	Wound assessment/cleaning, wound closure and dressings, supply of antibiotics for infected or contaminated wounds, wound exploration
Acute otitis media – ear pain	Ear assessment, supply of antibiotics
Community Acquired Pneumonia (NEWS2 and CRB65 scores) Acute Bronchitis Lower Respiratory Tract Infection Infective exacerbation of COPD	Advanced respiratory assessment, supply of antibiotics
Acute Exacerbation of COPD Moderate Asthma	Advanced respiratory assessment, steroid
Acute sinusitis Acute sore throat Acute cellulitis Paronychia – infected finger/toe Impetigo Puncture wounds – thorn/rusty nail	Advanced assessment and supply of antibiotics
Lower back pain	Advanced assessment, supply of pain relief (diazepam, codeine, diclofenac)
Pain management	Advanced assessment, supply of additional pain relief (paracetamol, ibuprofen, naproxen, codeine)
Eyes, ears and nose - foreign body removal/advice	ENT assessment, FB removal/advice

Produced by Maggie, April 2024; v. 1.2

Treating a wide variety of presentations with enhanced assessment skills, primary wound closure, supply of antibiotics, analgesia, and urinary catheterisation.

SCAS See &Treat 36.6% (C3/4 - 49.00%)

Specialist Practitioner See & Treat 69.87% (C3/4 - 75.59%)

(Data from the first quarter of 2025-26)

Teamworking (Urgent Care Desk dispatch model): Coordinating resources and making rapid clinical decisions in EOC, benefiting patients and the trust.

My story: what do my patients have to say?

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Keeping older adults/vulnerable patients out of hospital: Avoiding risks such as hospital-acquired infections or loss of independence.

"I am so glad I didn't have to attend Accident &Emergency at midnight as **I would be unable to get home.**"

(64 YOF living with Parkinsons - August 2025)

Compassion and professionalism: Setting high standards for myself and delivering great care.

" There is only one word to describe Megan throughout her time here today. **Outstanding.**"

(94 YOF living with frailty and dementia - September 2025)

Managing complex cases at home: Ensuring patients receive the right care in the right place.

"She meticulously attended to each and every wound with sensitivity and patience. This saved us a harrowing and no doubt lengthy wait at hospital. **Being attended to in the comfort of our own home was so greatly appreciated.**"

(91 YOF living with Chronic Obstructive Pulmonary Disease and frailty – October 2025)

What challenge is the SP team facing?

South Central Ambulance Service
NHS Foundation Trust

Vehicle unavailability is our biggest operational challenge!

Lost unit hours to vehicle unavailability: 620 hours (equivalent of 65 shifts) since April 2025

How are we addressing the impact?

- Recording lost unit hours.
- Voluntarily drive personal vehicles to alternative locations where a vehicle is available/to UCD.
- Respond in alternative vehicles (e.g. Utilising SCAS vehicles not equipped for blue light driving/Double Crewed Ambulances/electric vans
- SPs crew together on Single Response Vehicles when all options have been exhausted
- Program in place to replace old fleet with new Single Response Vehicles – starting to arrive.
- Director of Fleet has been working in conjunction with management team to source available vehicles

Why am I proud to work for SCAS?

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SCAS is always looking to be innovative with its approach to patient care.

Feel part of something that makes a real contribution to society.

Exceptional support from managers both professionally and personally.

Questions?

Upward Report of the Finance & Performance Committee

Date Meeting met **23rd January 2026**
Chair of Meeting **Les Broude, Non-Executive Director**
Reporting to **Trust Board**

Items	Issue	Action Owner	Action
Points for escalation			
Integrated Performance Report – Fleet & VOR	The committee has maintained a close watching brief in relation to fleet, but following the declaration of a Business Continuity Incident, assurance was given around short-, medium- and long-term actions that are in train. This includes an increasingly data driven approach which is welcome in terms of understanding drivers of the issues. These are multi-factorial and include issues with Fiats, workshop capacity and delays in delivery of new fleet, which was out of the control of the trust. New Fleet is however being delivered, and the trust will move to scheduled maintenance to reduce unscheduled maintenance and the consequent impact on workshop capacity.	N/A	None; the committee was assured that all necessary internal action is being taken and will continue to monitor the position as part of business-as-usual oversight.

Key issues and / or Business matters to raise			
111 Contract	Negotiations are on-going around what level of service is deliverable within the financial envelope given that only an inflationary uplift is included.	N/A	Progress will be reported to the committee.
Sickness Absence	High levels of seasonal sickness absence have been observed, which had impacted the Call Contact Centres and Hear & Treat performance. It was noted that the People & Culture Committee had received a deep dive into the management of sickness absence and steps in train to improve this.	N/A	The committee will continue to monitor progress
Financial Recovery Plan	It was noted that the trust was on track to deliver although it was further noted that the non-recurrent element of delivery added further challenges as we move into 2026/27 and the impact this would have on funding cost pressures and investments. Thanks were extended to all teams for delivering on the financial position.	N/A	The committee will continue to monitor progress.
Multi-Year Plan	The committee received a further presentation detailing the work that had taken place since the first submission. It was noted that the situation was dynamic with national discussions on-going. Interdependencies were clearly set out in the presentation together with the modelling required to achieve 25-minute Cat 2 performance, which enabled visibility of the impact on care delivery of decisions taken. The committee welcomed the clarity of the presentation.	SR	A slide detailing the risks will be included in the presentation to the Trust Board.
Areas of concern and / or Risks			
As above			

Items for information and / or awareness			
None			
Best Practice and / or Excellence			
Meeting Papers	Committee members noted and welcomed the improvement in the quality and timeliness of papers.	N/A	
Compliance with Terms of Reference			
Compliant	All papers were relevant to the committee terms of reference, and the meeting was quorate.		
Policies approved*			
None			

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Trust Board of Directors Meeting in Public
5 February 2026

Report title	Integrated Performance Report (IPR)
Agenda item	9
Report executive owner	Stuart Rees, Chief Finance Officer
Report author	Tina Lewis, Head of Performance & Planning
Governance Pathway: Previous consideration	Finance & Performance Committee
Governance Pathway: Next steps	

Executive Summary

Purpose and Scope

The IPR provides a comprehensive overview of the Trust's performance across key areas of Operational Performance, Quality & Safety and People. This paper covers the reporting period of December 2025, the ninth month of the financial and operational year.

The remainder of the report provides key highlights from the December 2025 IPR. Reporting of trajectories and action plan assurances are included within **Appendix 1**.

Operational Performance

- ***999 Services***: Incident demand was 4% below forecast, with operational hours within 1.98% of plan. With the exception of Cat 1 – 90th all national response times remain unachievable with current process. Category 2 response time was 1:44min above planned trajectory and the Trust remain on track to deliver a sub 30min Category 2 position for the full year.
- *Hear & Treat rates* have dipped below target for the first time in 3 months but remain as expected, with all other patient outcomes routes experiencing some benefit, particularly See & Treat. Delivery of our current *ST%, STC-ED and STC-non ED* targets all remain unachievable with current process.
- *Call Handling*: 999 call volumes exceeded plan by 13.4%, the impact of which was compounded by high levels of absence; however, performance remains better than target.

- *VOR%:* For December this was 43.12% and remains significantly above target. The high level of VOR is having a negative impact on 999 performance, with insufficient fleet capacity to meet operational hours required.
- ***111 Service***: Delivery of service remains challenged but within expected parameters. High level of vacancy and absence coupled with high demand negatively impacted performance, with the former actively targeted as we move into January.
- ***NEPTS (Non-Emergency Patient Transport Service)***: All performance indicators delivering as expected with majority achieving target. Monitoring of capacity vs demand continues to ensure that performance levels are maintained.

Quality and Safety

- ***Patient Safety and Experience***: All indicators are performing as expecting.
- ***Audit Compliance***: All indicators exceeded the target in December and remain as expected
- ***Safeguarding***: Level 1 and Level 3 training performance exceeds targets.
- ***AQI's*:** Performance is based on August 2025 period. All metrics are performing as expected and in part follow the Category 1 & 2 performance profiles for the same month. The introduction of GoodSam in June 2025 coincides with an improvement in Cardiac arrest survival rates (All) but does not yet represent a change of significance.

People and Workforce

- ***Workforce Management***: Overall WTE and Vacancy rate have returned to target position. Recruitment freezes remain in place for Corporate and NEPTS.
- ***Staff Turnover*:** Following a sharp rise during QTR 3, turnover has seen a slight reduction but continues to sit close to target.
- ***Sickness Absence***: Sickness sits above the annual and monthly target, driven by higher long-term sickness which is the main driver impacting on attendance. Work to resolve the top cases is in progress. Short term sickness is above the annual target but below anticipated position for the month.
- ***Performance Development Reviews (PDRs):*** This has had seven consecutive months of performance below average and should consider a process control limit review. The target of 95% is not achievable with out redesign. Winter pressures and the move to REAP 4 there will further challenge the delivery of this metric.
- ***Stat & Man Training***: The revised definition of this metric was introduced in August 2025 and is showing month on month improvement beyond the target
- ***999 Shift over-run and meal break compliance***: Meal break remains stable at c.75%, but current target of 85% remains unachievable. Impact of process change during December 2025 to be tracked. Shift over-run compliance continues to deliver against target.

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: Dec-25

Executive Summary

Operational Performance

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

Safety and Quality

People

Key Performance Headlines:

December Category 2 mean response time was 31:54, above the monthly target of 30:10. Category 1 performance was above national target at 08:27. 999 incident demand was 4% below forecast, with operational hours delivered within 1.98% of plan. However, fleet availability constraints contributed to a 3.36 minute delay in Category 2 performance. We continue to have an imbalance with operational staffing levels between Thames Valley and Hampshire, and we continue to move crews daily from Hampshire to support our Thames Valley region. Average handover delays decreased slightly from 19:47 in November to 19.05 in December. While most hospital sites remained within agreed thresholds, we are seeing large spikes on Mondays which add to our operational pressure. Mean call answer time for 999 was 8 seconds, despite demand being 0.1% above November demand. Continued support from SECAMB during peak periods has been instrumental in maintaining this performance. Hear and treat (H&T) performance was 17.4%, the target being 19% from October. Call answer performance for 111 decreased to 66% within 120 seconds

Key Risks for Period:

UEC operations
- Fleet Capacity to meet operational hours demand
- Increasing handover delays through winter period reducing operational capacity
- Delays with CAD procurement delaying ICC improvements

PTS Key Risks for the Period
• Workforce Capacity Risks:
• The Call Handler establishment remains 2.4 WTE above requirement, reducing to 0.2 WTE above by Month 10. Two additional redeploys continue supporting dispatch, with budget drawn from Hampshire Operations.
• Close monitoring is required across PTS contracts to ensure activity does not exceed capacity, which may impact performance, financial position, and reputation.
• Absence levels remain high: 9.6% for SHIP and 8.8% for MK, continuing to constrain available hours

Key Rolling Actions:

UEC Operations
- close working with fleet to reduce lost hours with focus on staff and vehicle movements
- Balancing operational hours around fleet availability y
- Recruitment into ICC call handler vacancies

PTS
• Call Handling Efficiency Improvements:
• Not Ready target reduced from 20% to 17%, with weekly monitoring.
• Telephony Journey Confirmations continue reducing abortive journeys.
• Rota review commencing to address imbalance between full-time and part-time staff.
• Operational Planning & Efficiency:
• Daily monitoring of demand, resource utilisation, hours, and performance.
• Focus on improving cohorting and utilisation.
• New meal window implemented.
• Rota redesign feedback received; consultation documents being prepared.

Forward View:

UEC operations
- Recruitment into new UEC and ICC structures
- Development of CIPs for 26/27
- Recruitment into ICC vacancies to improve 111 and 999 call answer

PTS Forward View
• Call handling performance expected to remain strong if resourcing actions progress and absence reduces.
• Cohorting improvements and refined rota arrangements expected to support performance within budget pressures.
• Ongoing monitoring required to ensure PTS activity remains within contracted limits, protecting operational delivery and reputation.

NHS Executive Commentary - Quality & Safety

Key Performance Headlines:

QS1, 2 Levels of PSI with moderate and severe harm and death, as a percentage of all PSIs reported, has decreased to 2.5% but this is not statistically significant. Themes remain the same and are related to delays and incidents relating to recontacts aligned with an increased see and treat rate.

QS2 No PSII have been declared in December.

QS 6,7,8,10 Infection Prevention and Control, all indicators exceeding target, with the planned reduction in the number of over audits being completed reducing as the alternative duties staff are educated in the audit process and the correct procedures.

QS21,22 Adults Safeguarding Children and Adults Training Level 1 98% Safeguarding Children and Adults Training Level 3 94% (face to face element)

All ACQIs show common cause variation. QS17 shows fourth month of improvement for 30 day survival for cardiac arrest.

Key Risks for Period:

Risk to not achieving 90% overall compliance by 31 March 2026. This relates to the achievement of all elements of training required over 3 years, including CPD and Clinical Supervision hours

Key Rolling Actions:

QS21,22 Weekly monitoring of all of the key components of Level 3 Safeguarding training activity continues with increased oversight and additional supervision sessions being provided to front line teams.

QS15-18 focus on achieving compliance with face to face resuscitation training

Forward View:

2026/27 face to face education update will include a targeted patient safety sessions focused on safe discharges.

NHS Executive Commentary - People

Key Performance Headlines:

P1 - WORKFORCE - M9 staff reduced by 29. YTD reduction of 158. Bank/OT covering winter demand.
P1 - CORP/PTS recruitment paused, CCC recruiting patient roles, 999 to recruit 40 WTE to protect Q4 performance
P2 - Staff % Turnover (17.7) positive against target (18.0). All areas positive: 999 (9.4), EOC (29.9), 111 (29.7), PTS (20.1) and CORP (14.1)
P3 - Substantive WTE (3739) below budget establishment of 3937. Service line vacancies in 999 (23), EOC (8), 111 (56) and PTS (50)
P4 - Time to Hire reduced to 59.5 days
P5 - WRES - In year increase from 8.28% to 8.33%
P6 – WDES - In year increase from 10.13% to 10.97%
P7 – SICKNESS % (7.2) above 7.1 target. 999 (7.9), EOC (7.8), 111 (7.3) and PTS (8.5) all above M9 Target. CORP is under target with 3.6
P8 – LTS % (4.1) above the M9 target of 3.4. 999 (4.3), EOC (4.4), 111 (3.6), PTS (5.4) all above 3.5 LTS target. CORP is below LTS target with 2.2
P9 - STS % (3.1) below the M9 target of 3.7. All areas below STS target. 999 (3.5), EOC (3.4), 111 (3.7), PTS (3.0), CORP (1.4)
P10 – DBS - All areas compliant
P11 – PDR (82%) below 95% target. 999 (86%), EOC (84%), 111 (84%), PTS (78%) and Corporate (73%) all below target

Key Risks for Period:

P1/P3 - WTE/VAC - Q4 plans in all areas under review, to balance performance and financial commitments
P2 – % T/O – Increased in Q3, being closely monitored
P7 – SICKNESS – High sickness has a significant cost to the trust. M9 increased but expected to fall in Q4.
P8 – LT SICKNESS - Has biggest impact on attendance, accounting for 4.1% of the 7.2% total in M9
P8 - LT SICKNESS - Management of LTS is an essential element for reducing costs, getting staff back to work more quickly
P11 – PDR – M9 impacted by REAP levels, increasing risk of Trust not meeting 95% compliance

Key Rolling Actions:

P1/P3 - WTE/VAC – PTS & CORP recruitment freeze continues in Q4. 999 to recruit 40 WTE and CC non-Clinical recruitment being increased to fill vacancies and protect performance. Bank/OT being used meet demand.
P2 - % T/O - Engagement plans in place across most Trust areas, with managers focused on reducing attrition rates across the Trust.
P7 – SICKNESS – Weekly reports / resources to improve sickness management being sent to managers. 10-week Flu Campaign ended (54% achieved).
P8 - LT SICKNESS - Occupation Health Lead to review top 10 LTS cases each month, attending meetings. Top 20 LTS have been targeted to move to conclusion.
P11 – PDR - Digital app being widely used Post completion of PDR surveys sent to all staff. Implementation of a digital reporting solution being designed.

Forward View:

P1 – WTE - Continuous monitoring and updating of workforce plans. 3 year rolling plan submitted in Dec 2025. Final version due Feb'26
P2 - % T/O – Staff engagement, culture, shift patterns and working environment are all factors on improving staff turnover
P7 - SICKNESS – Trust key focus on reducing sickness. To deliver this we are reviewing, 1) review policies, 2) processes, 3) line management accountability.
P11 - PDR - All areas are expected to increase their compliance in Q4. The Trust is aiming to finish the year above 90% and close to the 95% compliance.

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) .

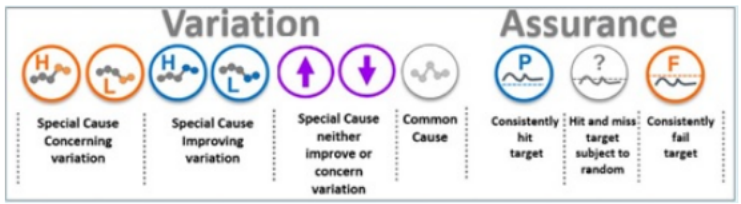
4) A run of 6 consecutive ascending or descending values (a trend).

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

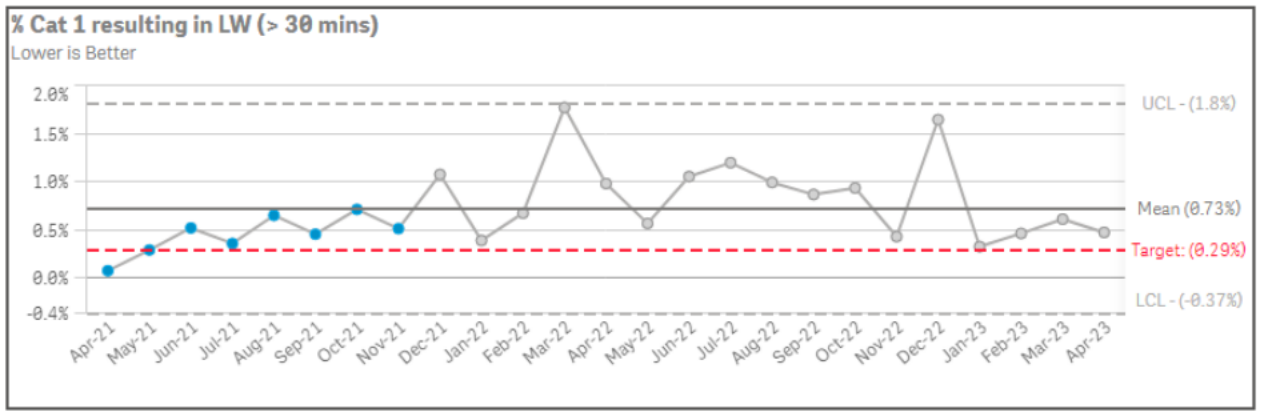
	Pass	Hit and Miss	Fail	No Target
	Special cause of an improving nature where the measure is significantly HIGHER.This process is capable and will consistently PASS the target.	Special cause of an improving nature where the measure is significantly HIGHER.This process will not consistently HIT OR MISS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

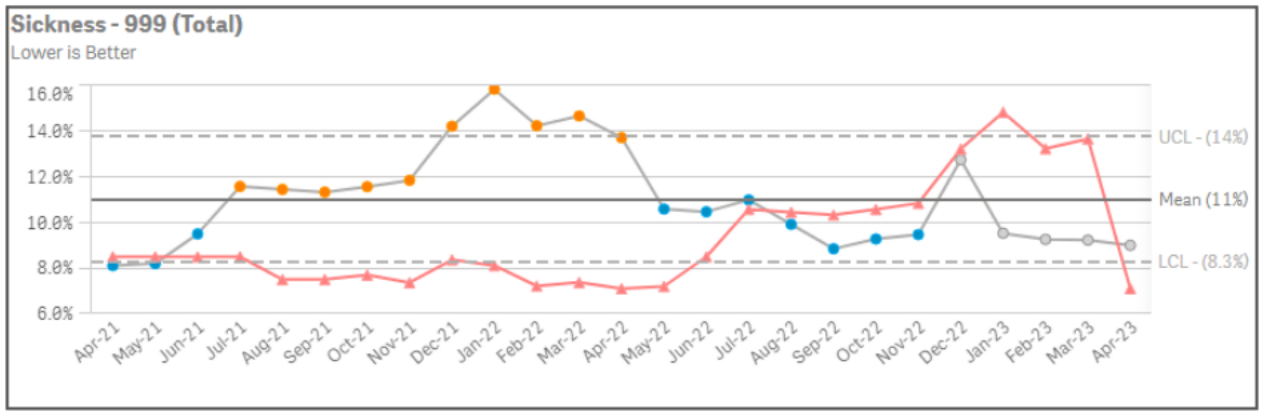
Assumptions:

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

December-25

Summary

Assurance →

Variance ↓

	Fail	Hit and Miss	Pass	No Target
H		% Turnover Number of reported CD incidents – unaccounted for losses	% Vacancy	
L	% Trust staff who are BAME Appraisals - Trust		Number of WTE	
	11	34	Clear up Delays - SCAS H&T - SCAS Number of Complaints Safeguarding Adults Level 1	
L				
H		Hand Hygiene audit	% DBS Compliance % Trust staff who are declared disabled Safeguarding Level 3	
↗				
↘				

Metrics:

Fail Common Cause Metrics:

% Arrival at hospital to handover <15mins ; 111 Call back < 20 min ; Average Hospital Handover Time - SCAS ; Cat 1 Mean SCAS ; Cat 2 90th %ile SCAS ; Cat 3 90th %ile SCAS ; Meal Break Compliance - SCAS ; S&T - SCAS ; ST&C (ED 1&2) - SCAS ; ST&C (Non-ED 1&2) - SCAS ; VOR - Total

Hit and Miss Common Cause Metrics:

% 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 Mean SCAS ; Cat 4 90th %ile SCAS ; Number of PSI low/no harm ; Number of PSII declared in month ; Number of PSR declared in month ; Over-runs >30 mins - SCAS ; 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 Hand Hygiene audits ; Percentage of compliant Vehicle cleanliness audits ; Return On Spontaneous Circulation (ROSC) on Hospital Arrival - All Patients ; Return On Spontaneous Circulation (ROSC) on Hospital Arrival - Utstein Cohort ; STEMI - Call to angiography 90th Centile ; STEMI Call to angiography - Mean ; Short term sickness ; Stroke - Call to Hospital arrival 90th Centile ; Stroke - Call to Hospital arrival Median ; Stroke Call to Hospital arrival - Mean ; Time to hire ; Vehicle cleanliness completed audits

NHS

NHS
South Central
Ambulance Service
NHS Foundation Trust

Operational Performance

December-25 Summary

Assurance →

Variance ↓

	Fail	Hit and Miss	Pass	No Target
H				
L				
	% Arrival at hospital to handover <15mins 111 Call back < 20 min Average Hospital Handover Time - SCAS Cat 1 Mean SCAS Cat 2 90th %ile SCAS Cat 3 90th %ile SCAS S&T - SCAS ST&C (ED 1&2) - SCAS	13	Clear up Delays - SCAS H&T - SCAS	Compliments
L				
H				
↗				
↘				

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 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

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.

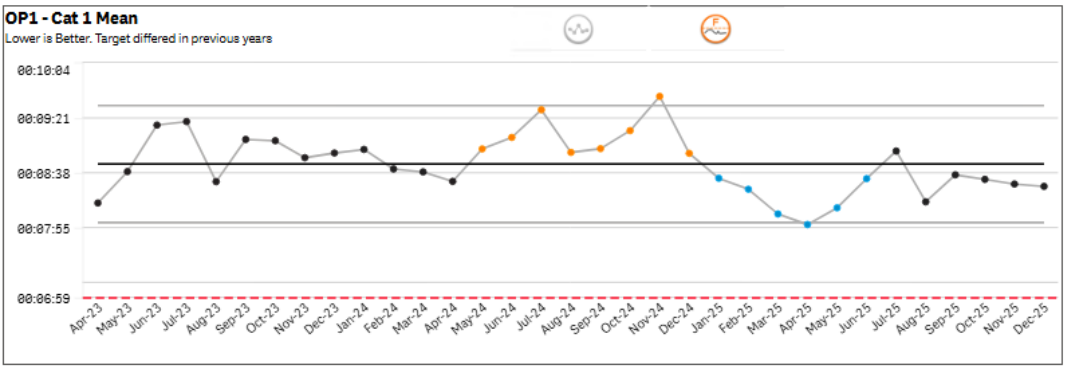
KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Cat 1 Mean	Dec-25	00:08:27	00:07:00		F	00:08:45	00:07:59	00:09:31
Cat 1 90th %ile	Dec-25	00:15:24	00:15:00		?	00:15:52	00:14:34	00:17:10
Cat 2 Mean	Dec-25	00:31:54	00:30:00		?	00:29:41	00:21:20	00:38:01
Cat 2 90th %ile	Dec-25	01:03:27	00:40:00		F	00:57:44	00:40:56	01:14:32
Cat 3 90th %ile	Dec-25	07:15:33	02:00:00		F	05:47:01	02:25:35	09:08:27
Cat 4 90th %ile	Dec-25	06:31:40	03:00:00		?	06:55:48	02:28:32	11:23:04
% Vehicles off the road	Dec-25	43.1%	25.0%		F	40.2%	33.7%	46.6%
Ave Handover	Dec-25	00:18:31	00:15:00		F	00:18:11	00:16:14	00:20:07
Handover < 15mins	Dec-25	49%	60.0%		F	49.7%	43.7%	55.6%
Clear up Delays	Dec-25	00:13:36	00:15:00		P	00:14:02	00:13:35	00:14:29
% See and treat	Dec-25	31%	33.5%		F	30.2%	28.5%	31.9%
% ST&C to ED	Dec-25	47%	41.0%		F	48.4%	46.6%	50.2%
% See and convey to non-ED	Dec-25	4%	5.4%		F	4.0%	3.7%	4.2%
999 Call Answer	Dec-25	00:00:09	00:00:10		?	00:00:10	00:00:03	00:00:16
999 Ab. Rate	Dec-25	1.6%	2.0%		?	1.9%	1.2%	2.6%
% Hear and treat	Dec-25	17%	18.0%		P	17.3%	15.1%	19.6%
111 Call Answer	Dec-25	66%	95.0%		?	77.3%	57.7%	96.9%
111 Ab. Rate	Dec-25	6%	3.0%		?	3.6%	-0.3%	7.4%
111 Call backs	Dec-25	33%	95.0%		F	38.6%	28.5%	48.6%

Operations - PTS Calls and Outcomes

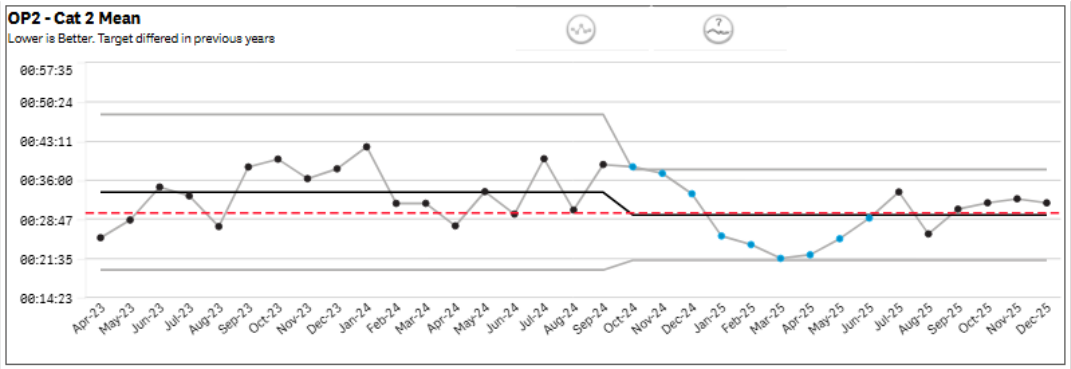
*Currently all data is aggregated on a monthly basis. We aim to provide accurate 90 days, YTD and 12 Months data when available.

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Calls Answered (PTS)	Dec-25	92%	90%			91.7%	80.4%	103.0%
Number of calls (PTS)	Dec-25	6,902	6,672			6,808.58	4,881.25	8,735.91
% Patients arrived in time	Dec-25	86%	87%			87.5%	83.2%	91.7%
% Patients collected in time	Dec-25	87%	87%			85.9%	83.8%	88.1%
PTS Volume - No. of Journeys	Dec-25	22,113	23,414			21,846.8	18,474.7	25,219
Number of Patients Transported	Dec-25	5,352	5,332			5,204.21	4,574.82	5,833.6

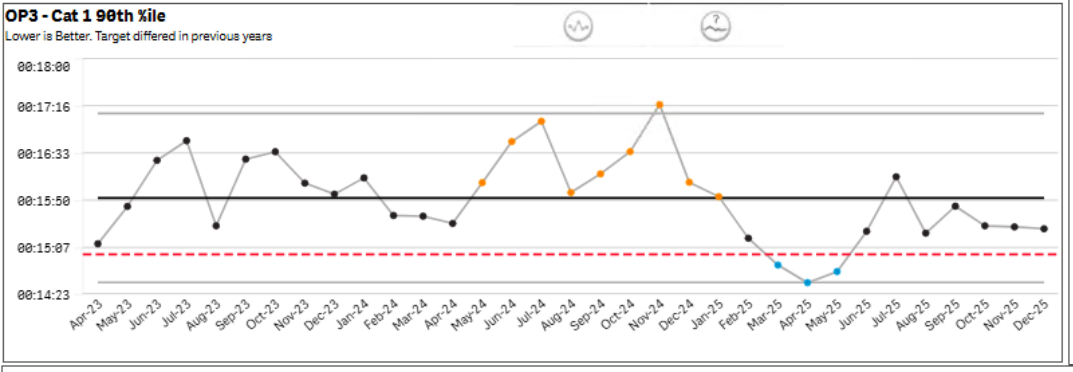
Operations - Response Times



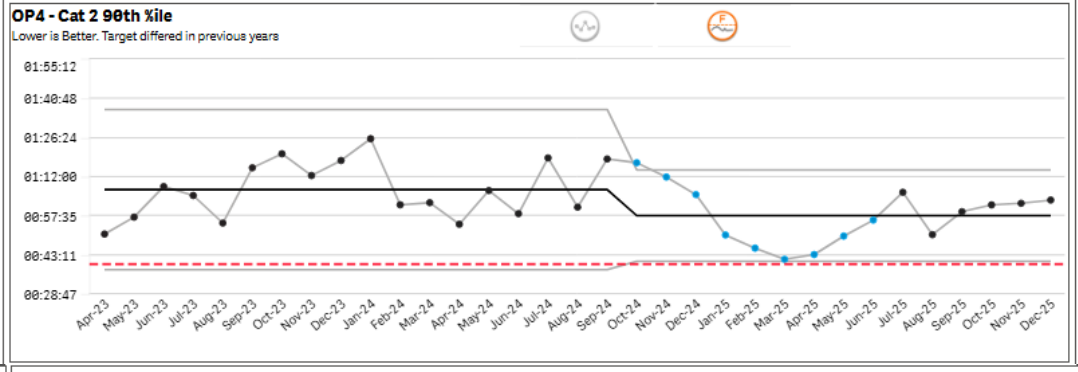
Variation	Expected
Assurance	Fail
Target	00:07:00
Latest	00:08:27



Variation	Expected
Assurance	Random
Target	00:30:00
Latest	00:31:54



Variation	Expected
Assurance	Random
Target	00:15:00
Latest	00:15:24



Variation	Expected
Assurance	Fail
Target	00:40:00
Latest	01:03:27

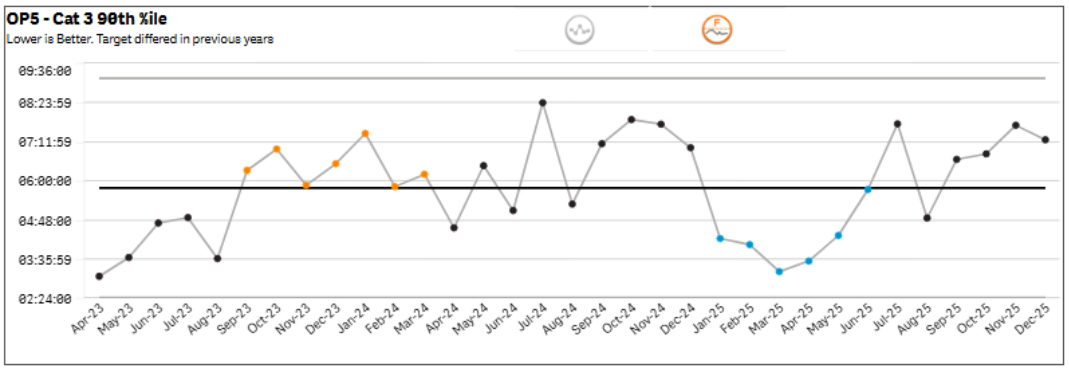
Understanding the Performance:

Cat 1 and 2 performance slightly improved but both continue to fail whilst remaining within the expected variation. The demand seen in December was below plan by 4% (2973 incidents) and the operational hours 1.98 % (4396) below plan. Significant fleet pressure exacerbated this further resulting in a loss of an additional 7500 staff hours across the month. Focus remains on balancing operational hours across the two divisions and supporting fleet to deliver enough fleet to provision to met demand. From the end of December Cat 2 performance YTD was 29.31 and we remain on track to deliver the end of year requirement of 29:49.

Actions (SMART):

48 hour Daily Rostering
OT incentive for nights at key periods
Additional hors offered to PPs
Implementing all actions against REAP levels
Delivery of CIPs
Maintaining Financial controls
Clinical recruitment into CSD to facilitate deliver 19% H&T
Increased HR support to manage sickness absence
Recruitment plan for frontline in Q4 to maintain establishment and prepare for 2026/27
Develop clinically lead dispatch model

Operations - Response Times



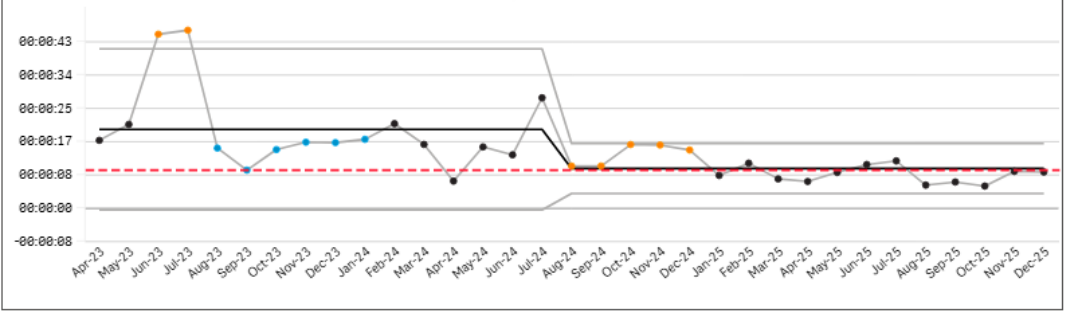
Variation	
	Expected
Assurance	
	Fail
Target	
	02:00:00
Latest	
	07:15:33

Understanding the Performance:
Both Cat 3 & 4 performance deteriorated in December but remained withing the expected variance. Both continue to fail the target.

Actions (SMART):
48 hour Daily Rostering
OT incentive for nights at key periods
Additional hors offered to PPs
Implementing all actions against REAP levels
SP model focus on Cat 3&4
Utilisation of the HIOW SPOA to provide alternative response to sending an ambulance to Cat 3&4s
Delivery of CIPs
Maintaining Financial controls
Clinical recruitment into CSD to facilitate deliver 19% H&T
Increased HR support to manage sickness absence
Recruitment plan for frontline in Q4 to maintain establishment and prepare for 2026/27
Develop clinically lead dispatch model

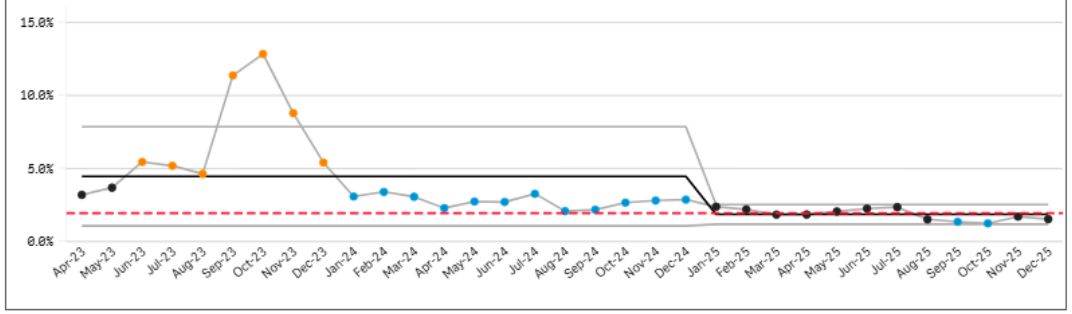
Operations - Operations Centre

OP6 - 999 Call Answer
Lower is Better. Target differed in previous years



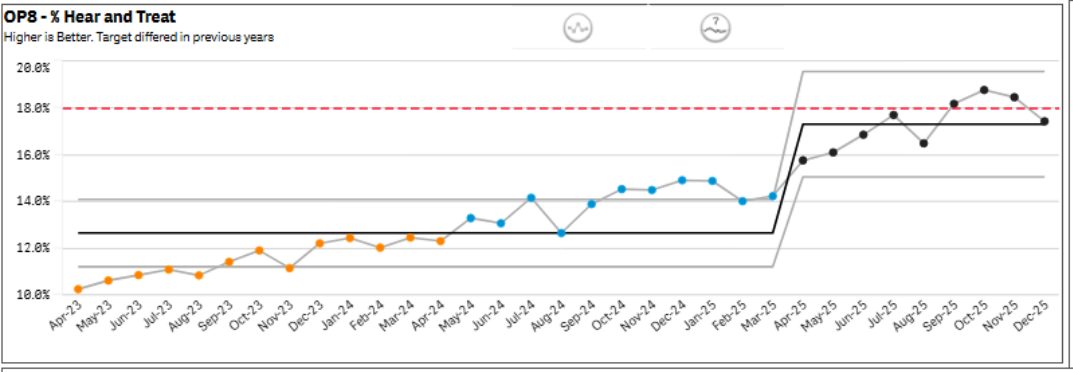
Variation	Assurance	Target	Latest
Expected	Random	00:00:10	00:00:09

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



Variation	Assurance	Target	Latest
Expected	Random	2.0%	1.6%

OP8 - % Hear and Treat
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	18.0%	17.4%

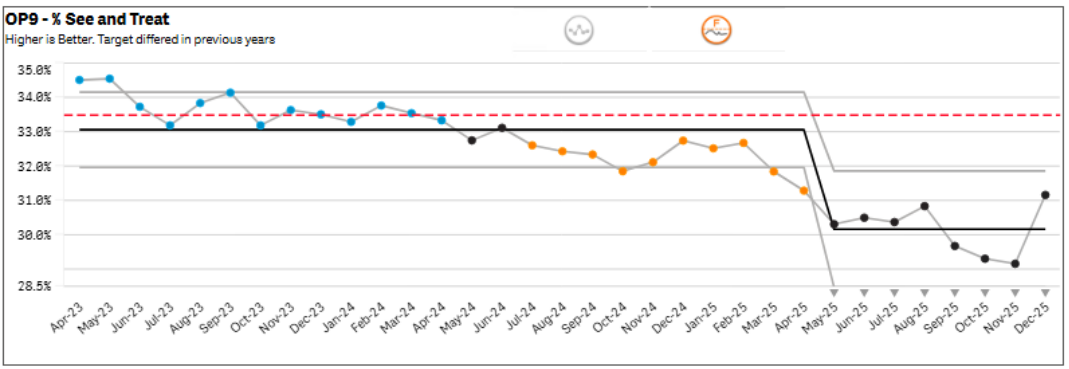
Understanding the Performance:

December presented significant operational challenges, call volumes exceeding forecasts by 13.36%, driven primarily by duplicate calls during the first half of the month. Logged-in hours were constrained by high absence rates. Staffing availability improved in the latter half of the month as annual leave abstractions reduced, helping to stabilize operations. Despite these pressures, service performance remained strong underpinned by continued reduction in AHT and call taking support from SECAMB. The mean call answer time was maintained at 9 seconds, below the 10-second target. Hear and Treat (OP8) also impacted by reduced logged in hours driven by higher sickness absence rates combined with an increase in incidents. Dropping to mean at 17.4% and not achieving target of 19%.

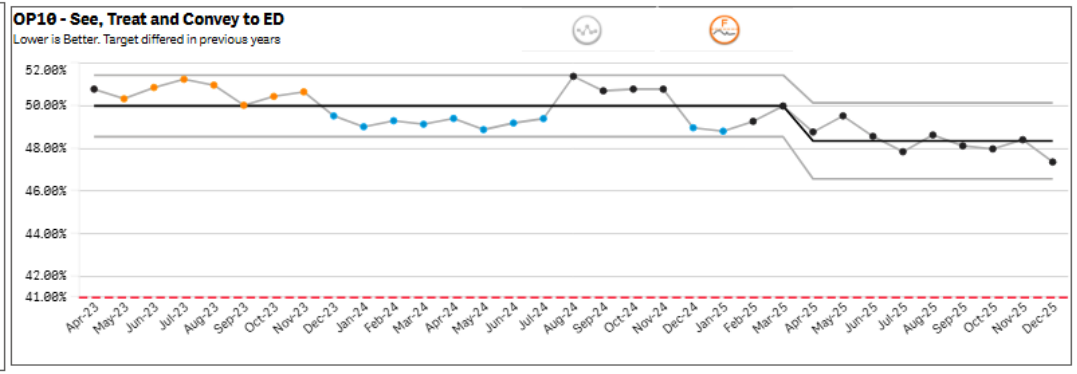
Actions (SMART):

Immediate actions were implemented during the month to strengthen sickness management and provide additional support to help staff return to work - with targeted support from 111 wellbeing officers introduced into CSD.
CAD queue development work moved into testing, but technical issues highlighted by testing were then unable to be resolved as a result of the technical freeze window. Work restarted in January with further meetings planned with Hexagon.
Ongoing recruitment into clinical roles, good response to recent advert with 6 WTE in pipeline awaiting confirmation of start dates.

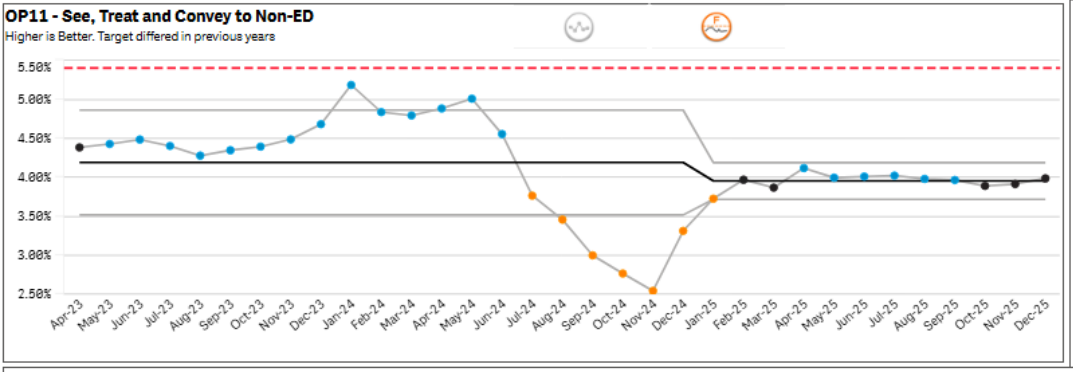
Operations - Utilisation



Variation	Assurance	Target	Latest
Expected	Fail	33.5%	31.2%



Variation	Assurance	Target	Latest
Expected	Fail	41%	47.4%



Variation	Assurance	Target	Latest
Expected	Fail	5.4%	4.0%

Understanding the Performance:

OP9 - is failing its target with common cause variation with no significant change. Dec showed an improvement back to levels last seen in April 25. This is in line with slight deterioration in H&T performance. OP10 - Is failing against its target which changed significantly in H2 to 41% but is below the mean. OP11 - is failing its target with common cause variation. The tightness of the upper and lower control limits suggest without a redesign this will consistently fail its target.

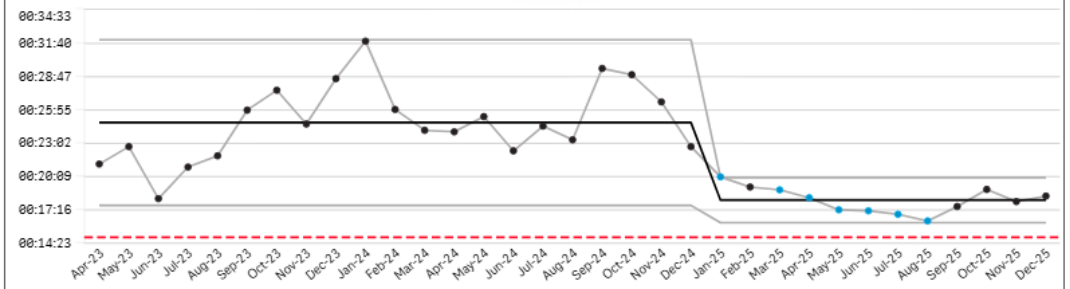
Actions (SMART):

OP 9,10 & 11 - The Clinical Pathway team and wider ops teams are promoting the use of appropriate care pathways. A quarterly pathway portfolio supports services available and highlights gaps to inform future commissioning arrangements.

NHS

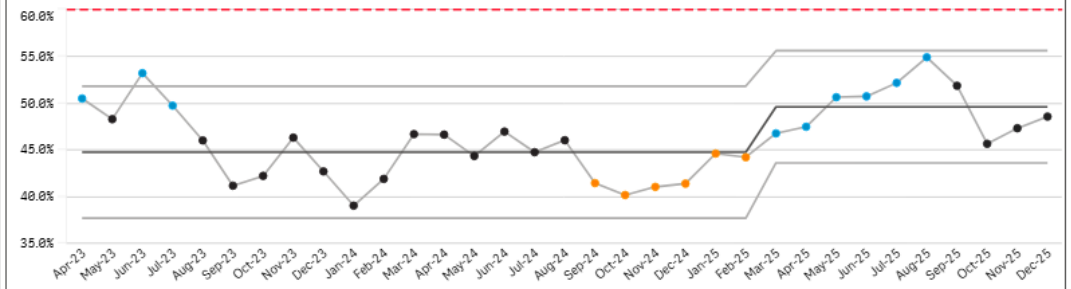
Operations - Utilisation

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



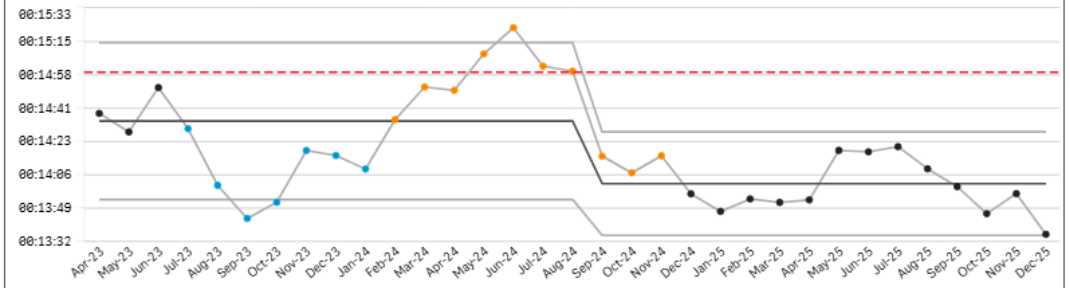
Variation	Expected
Assurance	Fail
Target	00:15:00
Latest	00:18:31

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



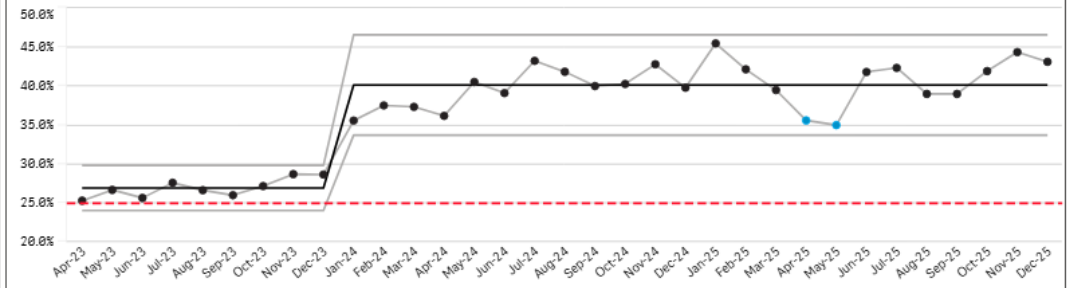
Variation	Expected
Assurance	Fail
Target	60%
Latest	48.6%

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



Variation	Expected
Assurance	Pass
Target	00:15:00
Latest	00:13:36

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



Variation	Expected
Assurance	Fail
Target	25%
Latest	43.1%

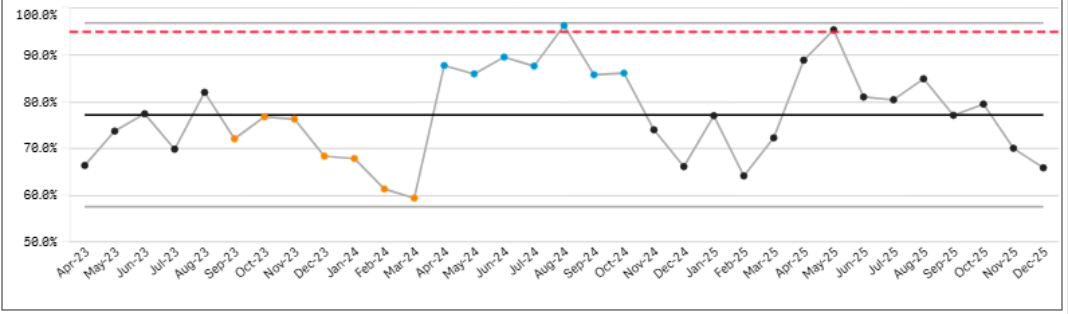
Understanding the Performance:
OP13 - is failing, showing common cause variation with no significant change. It is showing signs of improving over the last 3 points after a significant drop from August through to October. OP 12 - Is failing showing common cause variation with no significant change tracking against the mean. OP14 - This measure constantly passes the target with common cause variation and no significant change.

Actions (SMART):
OP 12- a significant hourly/daily focus for the Ops team upwardly reporting through to ODPR and PMAF. R2R procedure being rewritten to create a more proactive approach to hospital handovers due end of Feb. OP 13 - Local teams ensuring the Acutes focus is to achieve handovers within 15mins. Generally handover targets are tracking against 24/25 planning assumptions with 25/26 targets likely to be even tougher. OP 14 - local teams are fully in control of managing this process and their is still a strong focus on compliance through ODPR.

Operations - Operations Centre

OP16 - 111 Call Answer

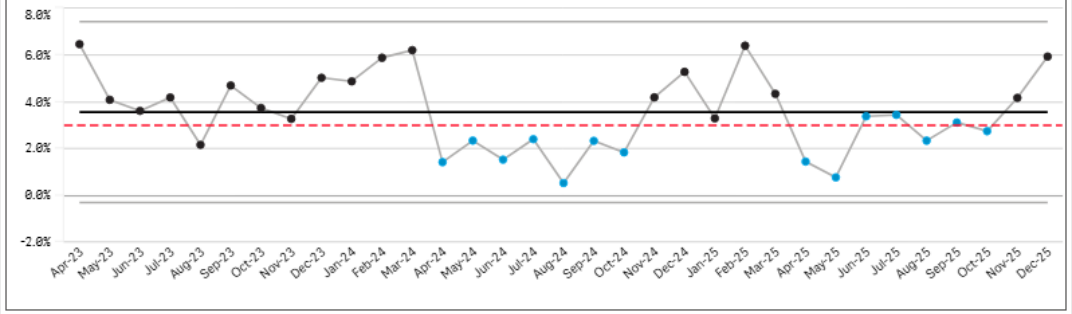
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	95%	66.0%

OP17 - 111 Call Abandonment Rate

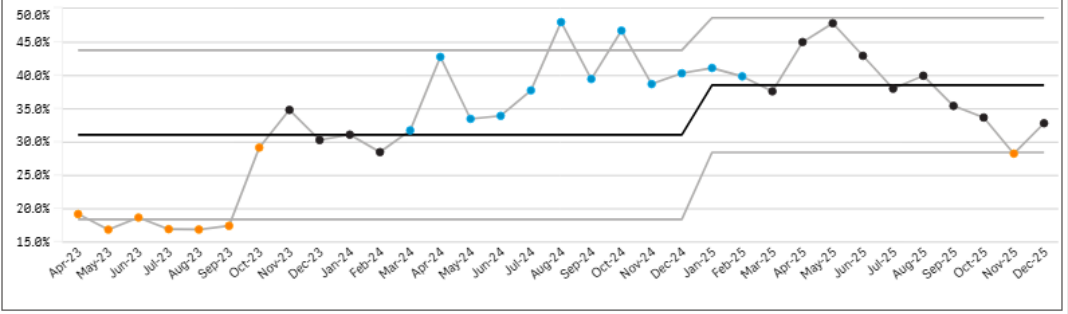
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	3%	6.0%

OP18 - 111 Call Back Percentage

Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Fail	95%	32.9%

Understanding the Performance:

- Calls offered in December increased by 18k with call answer performance (OP16) dropping in December to 66% from 70% in November.
- OP17 increased from November's 4% to 6% in December above the national target of 3%. The effect of reduced staff logged in hours and staff vacancies has contributed to this increase, along with sickness levels.
- OP18 has increased from 28.3% in November to 33% in December despite and increase in demand this demonstrates a higher volume of call backs in December . This is no longer included in the IUC/ADC reporting as previously due to the change in KPI'S where 5a and 5b are now together as No 4.

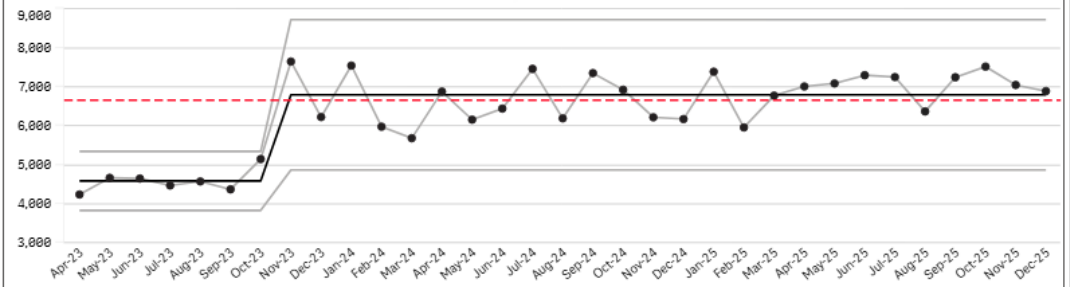
Actions (SMART):

- Health Advisor WTE continued to drop towards the end of December, a pattern we have seen in previous years at this time, with the challenges of working over this period. Flexible working resource used to back fill the gap in WTE . We have seen a large increase in applications following the festive period, often due to all temporary jobs coming to an end after the Christmas period with 133 applications across all 3 sites in the first week of January. Additional interviewing, courses and assessments are being planned across all sites.
- Clinical WTE has increased to 75.80 WTE with new Clinical staff commencing on planned courses to bridge the gap of WTE against budget. Application numbers also remain high with the Clinical staffing groups.

Operations - PTS - Calls and Outcomes

OP19 - PTS Call Volume

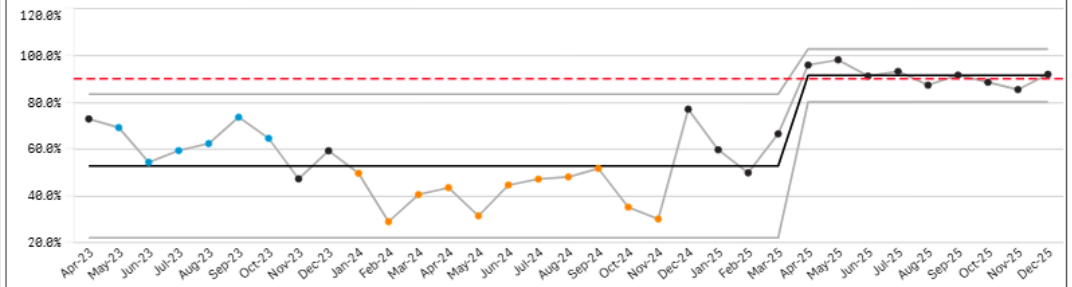
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	6,672	6,902

OP20 - PTS Calls Answered in 90 Seconds

Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	90%	92.2%

Understanding the Performance:

Call Answer performance returned above the target with Decembers outturn achieving 92.18% aggregated threshold for calls answered in 90 seconds, with call volumes remaining above the mean. Consideration needs to be given that the BLMK KPI metric is call answered in 120 seconds.

Actions (SMART):

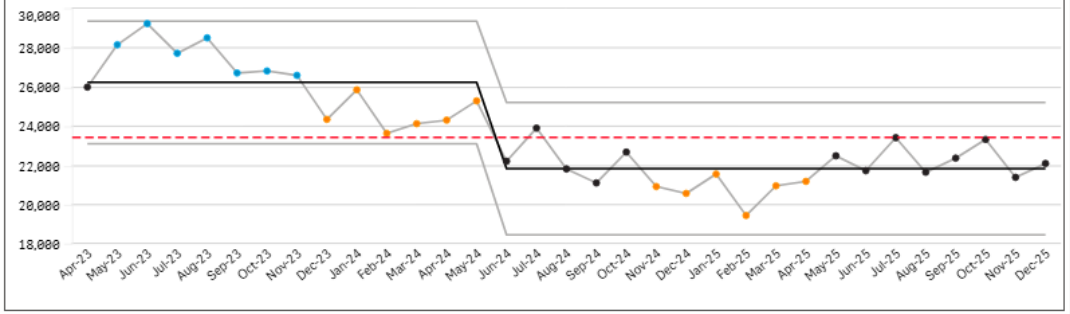
Not Ready target is set at 20% team are continuing to focus on reducing this leading to more effective time for call handlers. New target set at 17% with weekly monitoring in place.

Initial work due to commence on call handler rota to review due to imbalance of full-time vs part time rota staff.

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.

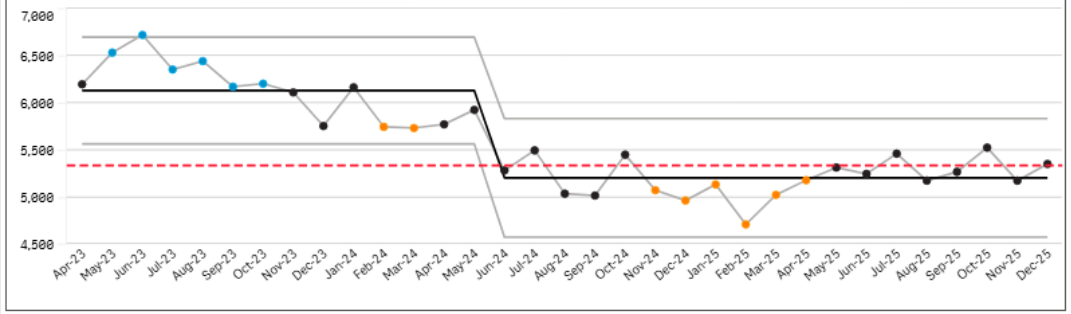
Operations - PTS - Calls and Outcomes

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



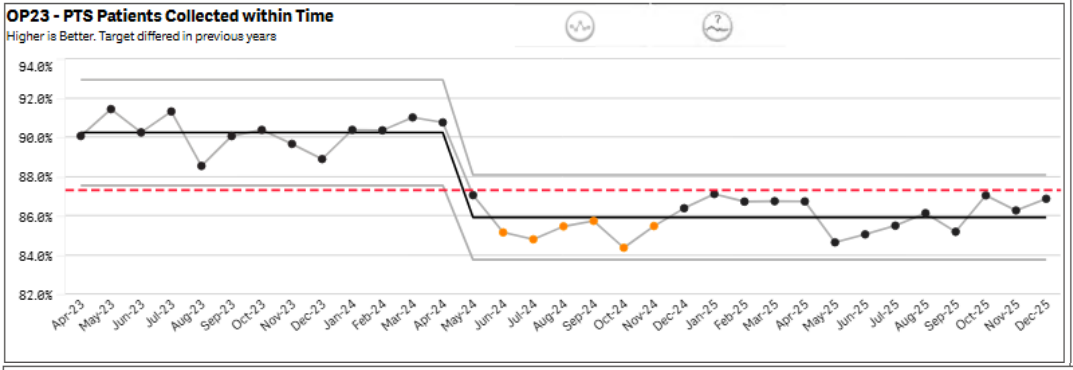
Variation	Assurance	Target	Latest
Expected	Random	23,414	22,113

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



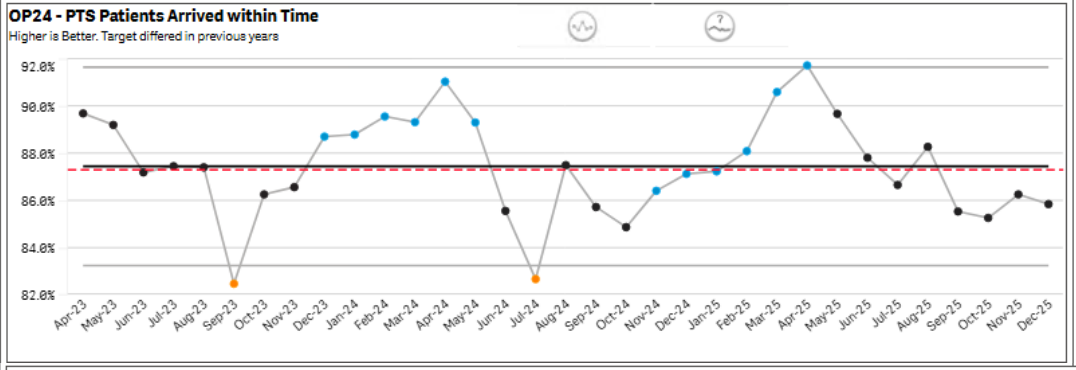
Variation	Assurance	Target	Latest
Expected	Random	5,332	5,352

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



Variation	Assurance	Target	Latest
Expected	Random	87%	86.9%

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



Variation	Assurance	Target	Latest
Expected	Random	87.3%	85.8%

Understanding the Performance:

Activity did increase during the month, over the festive period the outpatient activity was higher than expected with many outpatients still taking place including on the bank holidays which did impact discharge capacity. We have seen a decline in renal and discharge activity but an increase in other appointments.

- We did experience some performance challenges with the m27 closures but still managed consistently with performance as per other months despite being below expected levels.
- The forecasted hours continue to be reviewed daily. We have seen improvements across cohorting and efficiencies.

Actions (SMART):

Continue to monitor daily demand, hours, resource utilisation and performance within budget
Focus remains on increasing of cohorting and utilisation of resource,
increased scrutiny on sickness absence, absence levels reported at 9.6% for SHIP and 8.8% for MK for the month of December.
Initial rota designed feedback has been received from the management team. Now we are preparing documentation ready to go out to consultation in the new year.
Implemented the new meal window.

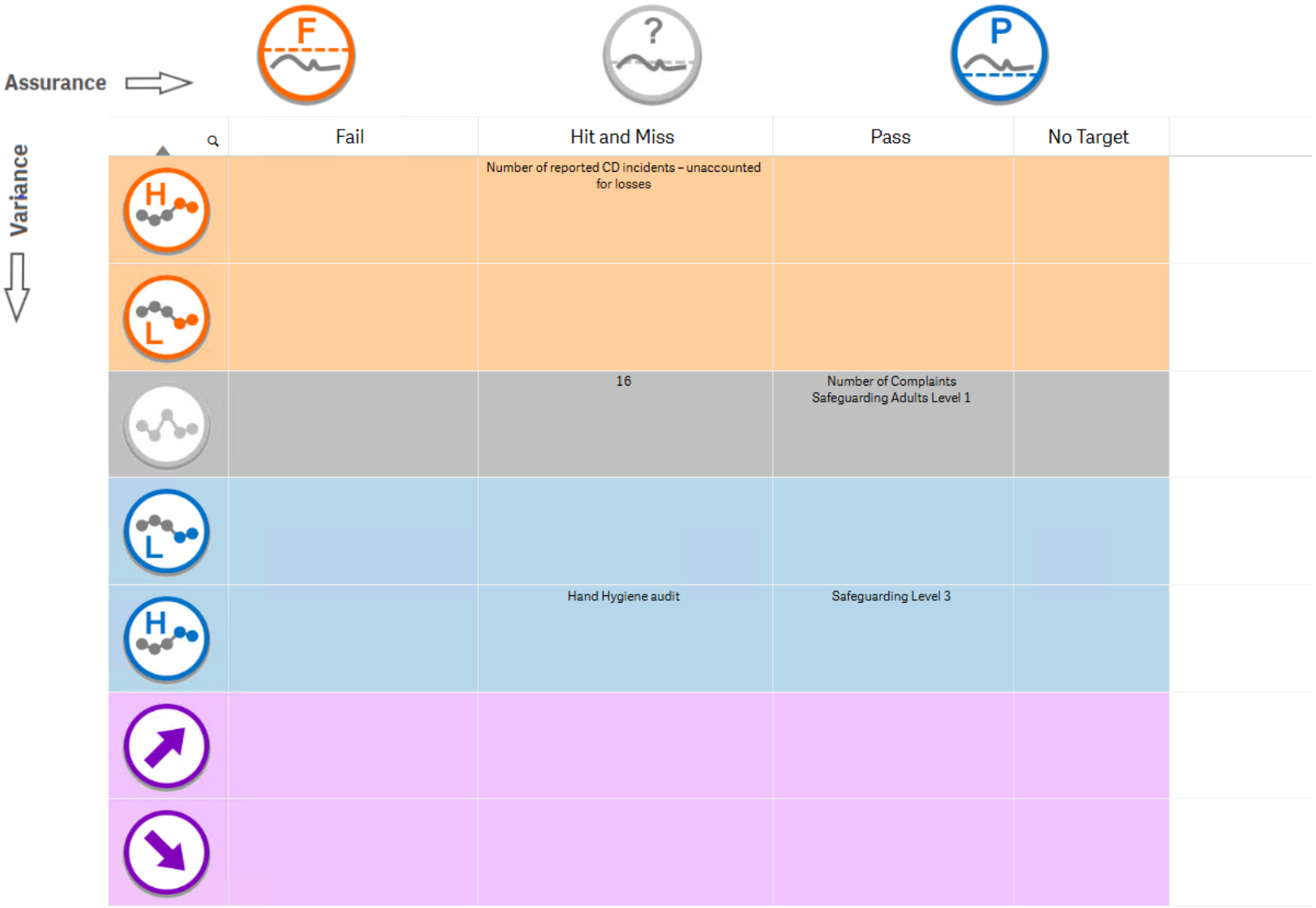
NHS

NHS
South Central
Ambulance Service
NHS Foundation Trust

Quality and Safety

Quality & Safety – Core Measures Matrix

December-25 Summary



Metrics:

Hit and Miss Common Cause Metrics:
Cardiac Arrest Survival at 30 Days - All Patients ; Cardiac Arrest Survival, Utstein ; Number of PSI low/no harm ; Number of PSII declared in month ; Number of PSR declared in month ; Overdue Datix incidents ; Percentage of compliant Hand Hygiene audits ; Percentage of compliant Vehicle cleanliness audits ; Return On Spontaneous Circulation (ROSC) on Hospital Arrival - All Patients ; Return On Spontaneous Circulation (ROSC) on Hospital Arrival - Utstein Cohort ; STEMI - Call to angiography 90th Centile ; STEMI Call to angiography - Mean ; Stroke - Call to Hospital arrival 90th Centile ; Stroke - Call to Hospital arrival Median ; Stroke Call to Hospital arrival - Mean ; Vehicle cleanliness completed audits

Quality Safety– Core Measures Icon Summary

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
PSI Low/no harm inc.	Dec-25	26.6	28.1			26.1	20.7	31.5
Monthly PSII	Dec-25	0	3			2.1	-2.43	6.62
Monthly PSILR	Dec-25	8	9			8.48	-4.96	21.9
Datix incidents	Dec-25	1.25	0.938			0.977	-0.209	2.16
CD unaccounted for losses	Dec-25	4	2			1.38	-2.38	5.15
Level 1 Safeguarding	Dec-25	96.9%	95%			96.6%	95.8%	97.5%
Level 3 Safeguarding	Dec-25	94.8%	90%			93.3%	92.0%	94.7%
Complaints	Dec-25	0.563	2.31			1.03	0.0338	2.03
Compliments	Dec-25	6.94	0		n/a	7.46	4.82	10.1
Hand Hygiene Audits Completed	Dec-25	296	261			247	-15.7	509
Hand Hygiene % Compliance	Dec-25	98.3%	95%			97.7%	93.8%	101.5%
Vehicle Audits Completed	Dec-25	176	167			215	43.6	386
Vehicle Audits % Compliance	Dec-25	94.3%	90%			89.3%	71.5%	107.0%

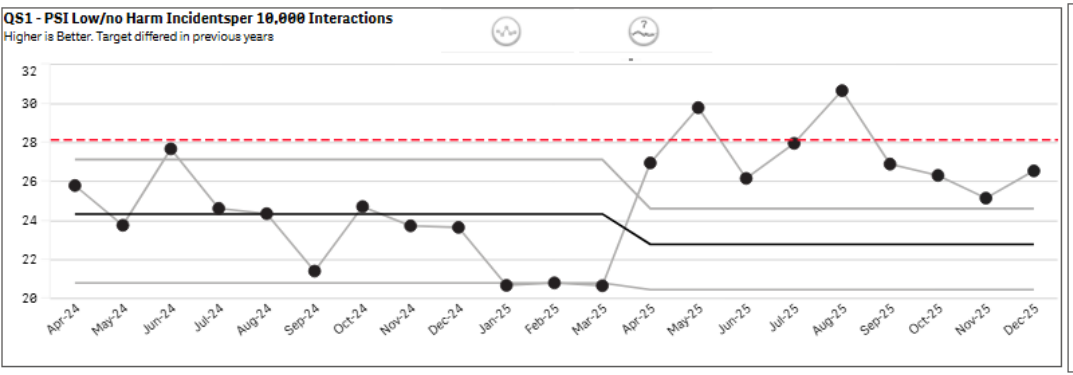
NHS Quality Safety– Ambulance Quality Indicators (AQIs)

*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	Aug-25	02:05:00	02:30:00			02:17:45	01:52:40	02:42:50
STEMI 90th	Aug-25	02:42:00	03:20:00			03:19:39	01:57:06	04:42:12
Stroke Mean	Aug-25	01:25:00	01:30:00			01:35:06	01:16:23	01:53:49
Stroke Median	Aug-25	01:14:00	01:20:00			01:22:20	01:10:11	01:34:30
Stroke 90th	Aug-25	02:11:00	02:30:00			02:22:42	01:52:32	02:52:53
ROSC All	Aug-25	24.3%	25.8%			25.4%	13.0%	37.8%
ROSC Utstein	Aug-25	55.6%	48.4%			51.8%	19.5%	84.2%
CA Survival All	Aug-25	12.7%	8.9%			9.3%	1.9%	16.7%
CA Survival Utstein	Aug-25	37.0%	20.6%			31.5%	8.3%	54.8%

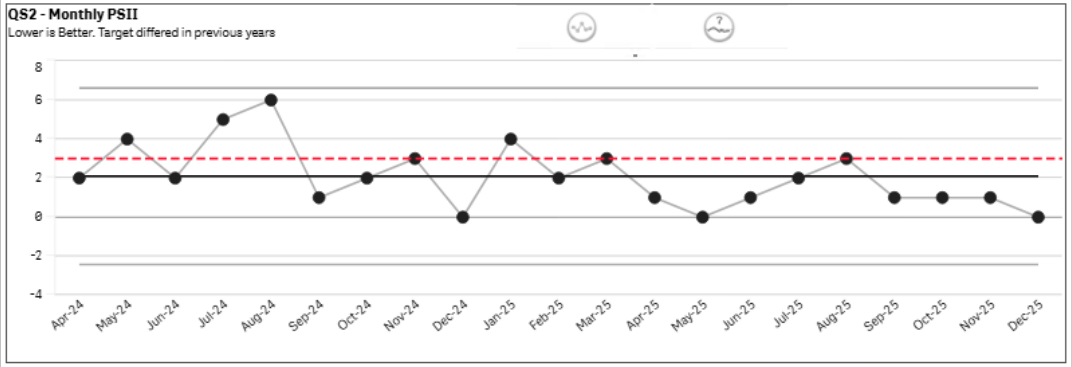
Quality & Safety – PSIRF

QS1 - PSI Low/no Harm Incidentsper 10,000 Interactions
Higher is Better. Target differed in previous years



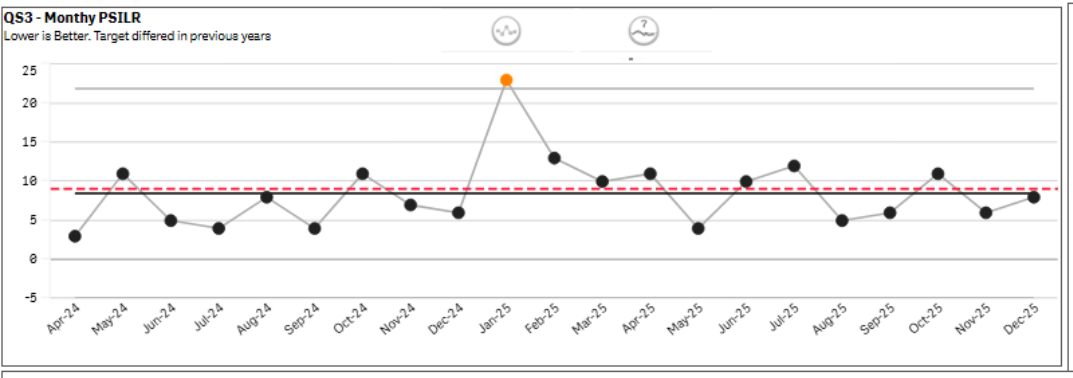
Variation	Assurance	Target	Latest
Expected	Random	28.1	26.6

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



Variation	Assurance	Target	Latest
Expected	Random	3	0

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



Variation	Assurance	Target	Latest
Expected	Random	9	8

Understanding the Performance:

Please note that PSIs are live incidents, constantly under review and therefore subject to change.

QS1 – A higher number indicates a strong safety culture.

Levels of PSI with moderate and severe harm and death, as a percentage of all PSIs reported, has decreased to 2.5% despite performance remaining above trajectory (OP2, OP5); themes remain delays in line with causes from the thematic analyses and recontacts, aligned with an increased level of see and treat in EUC (OP9).

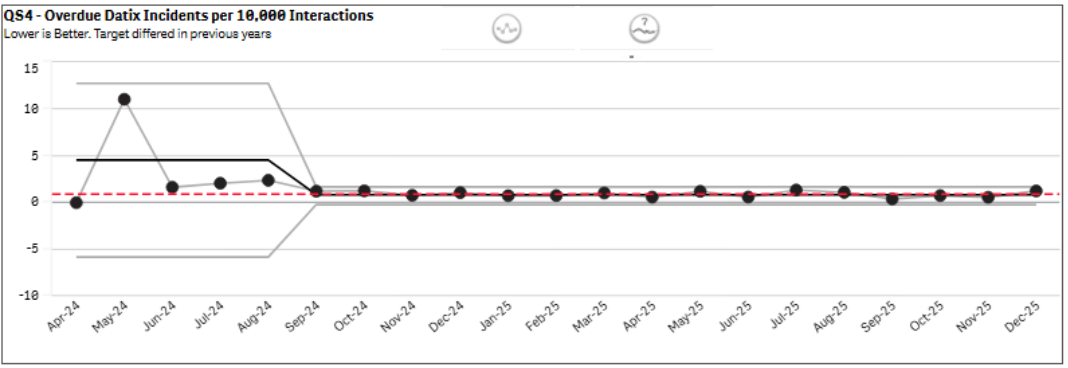
QS2 - Categories for declared PSII: none declared in December 2025.

Actions (SMART):

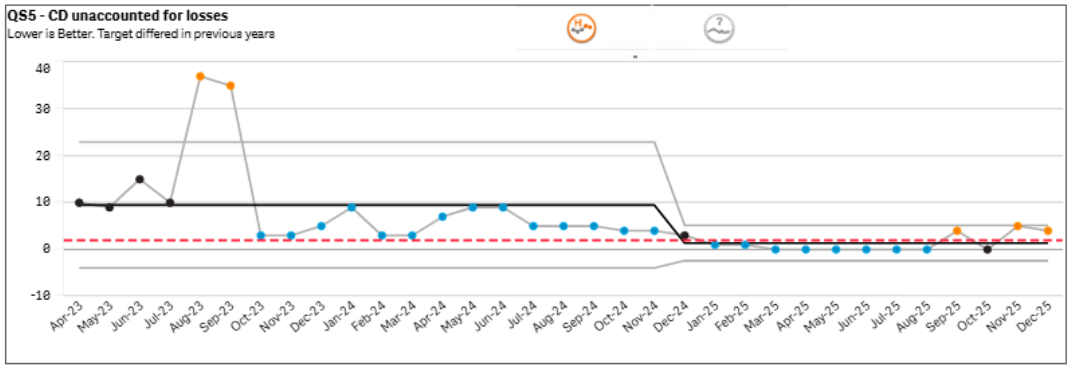
QS3 – The second thematic analysis of delays and the thematic analysis of recontacts will be re-reviewed at ORG in February 2026 for final executive approval.

2026/27 face to face education update will include a targeted patient safety session focused on safe discharges.

Quality & Safety – PSIRF



Variation	Assurance	Target	Latest
Expected	Random	0.938	1.25



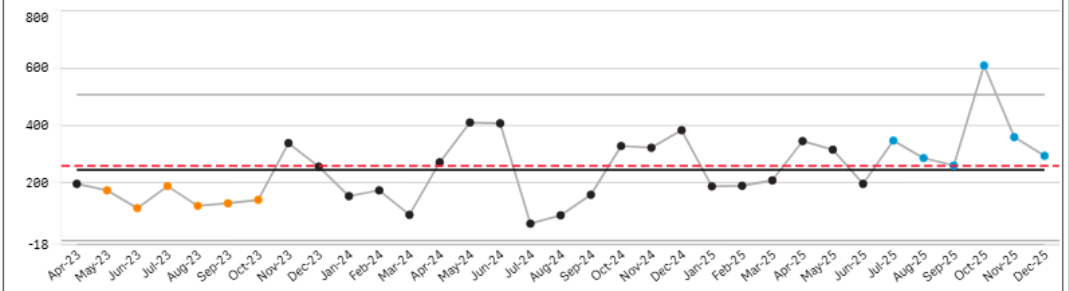
Variation	Assurance	Target	Latest
Declined	Random	2	4

Understanding the Performance:

Actions (SMART):

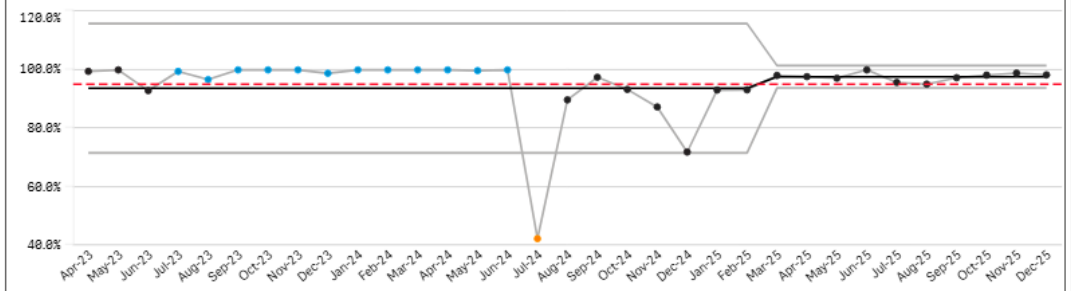
Quality & Safety - Audits

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



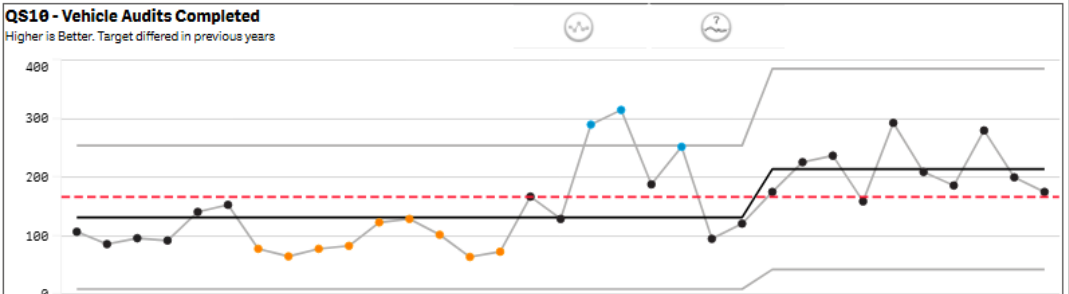
Variation	Assurance	Target	Latest
Improving	Random	261	296

QS6 - Hand Hygiene Audits % Compliance
Higher is Better. Target differed in previous years



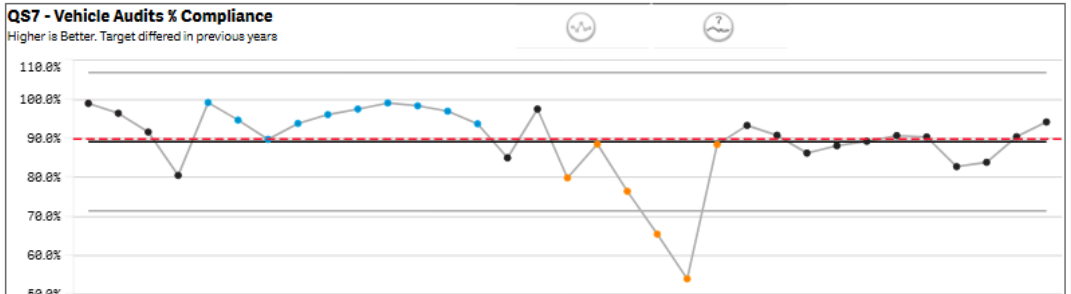
Variation	Assurance	Target	Latest
Expected	Random	95%	98.3%

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



Variation	Assurance	Target	Latest
Expected	Random	167	176

QS7 - Vehicle Audits % Compliance
Higher is Better. Target differed in previous years

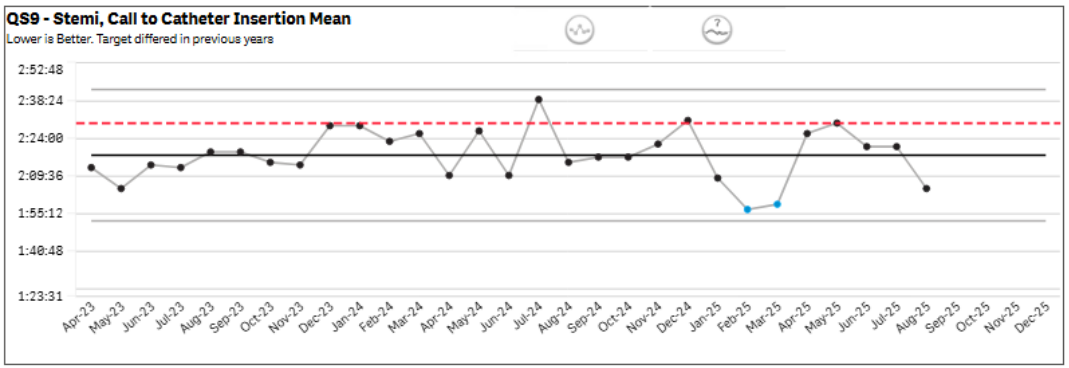


Variation	Assurance	Target	Latest
Expected	Random	90%	94.3%

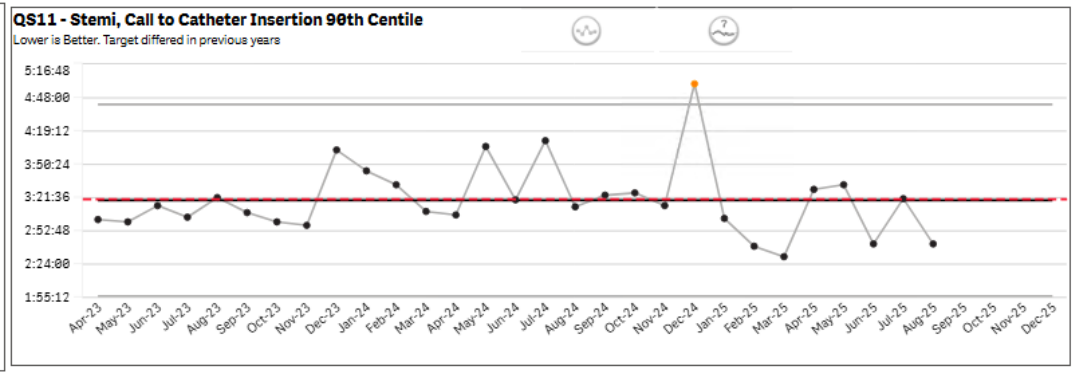
Understanding the Performance:
All indicators are exceeding target with a planned reduction in the number of hand hygiene audits completed following spike in completion due to staff on alternate duties.

Actions (SMART):
Continue with the audit plan that is in place. Monitoring via the divisional Clinical Governance Meetings and IPC committee

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



Variation	
Expected	
Assurance	
Random	
Target	
02:30:00	
Latest	
02:05:00	



Variation	
Expected	
Assurance	
Random	
Target	
03:20:00	
Latest	
02:42:00	

Understanding the Performance:

August 2025 STEMI mean (QS9) shows common cause variation. STEMI 90th (QS11) also shows common case variation and both are below the target for the month. The charts are performance based measures and as such are reliant on the ability to get to scene and the ability of the clinicians to recognise STEMI and provide the care required. Both results place SCAS as first of the reporting Trusts for these metrics. There are 64 cases of STEMI in this data set. The data pattern follows the drop in Category 2 mean for the same month (OP2).

Actions (SMART):

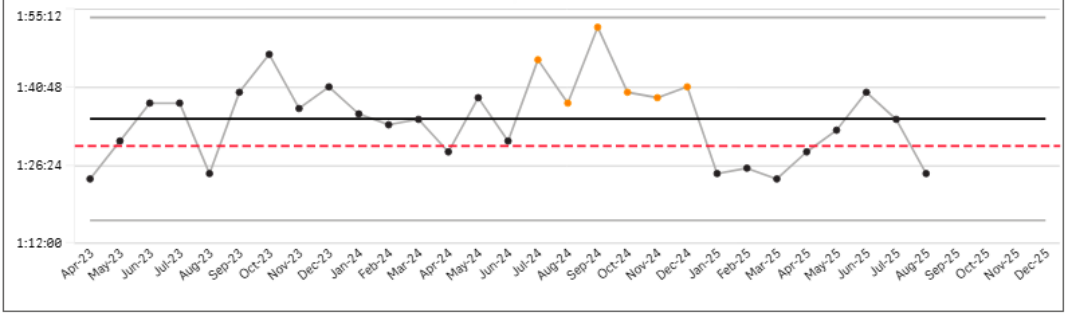
By end of April 26 understand the performance of indicators at node level to determine where to focus improvement activity.

Maximise vehicle availability by reducing handover delays at Emergency Departments (

Focus on operational delivery of category 2 response times (OP2)

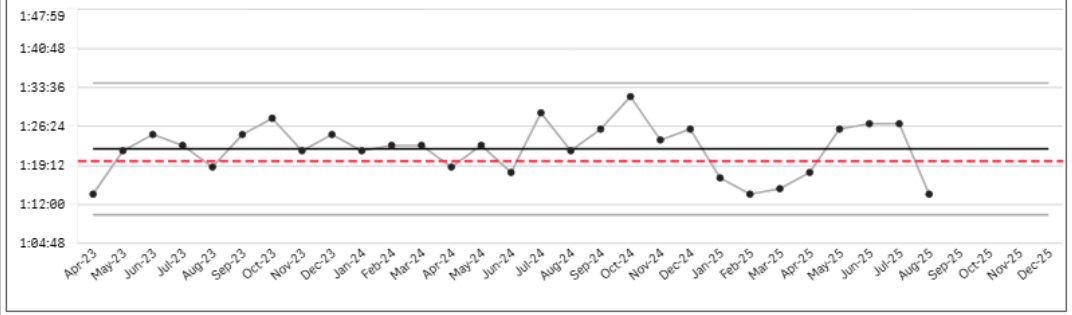
Quality & Safety – AQIs – Stroke - Chief Paramedic Officer

QS12 - Stroke Call to Hospital Arrival Time Mean
Lower is Better. Target differed in previous years



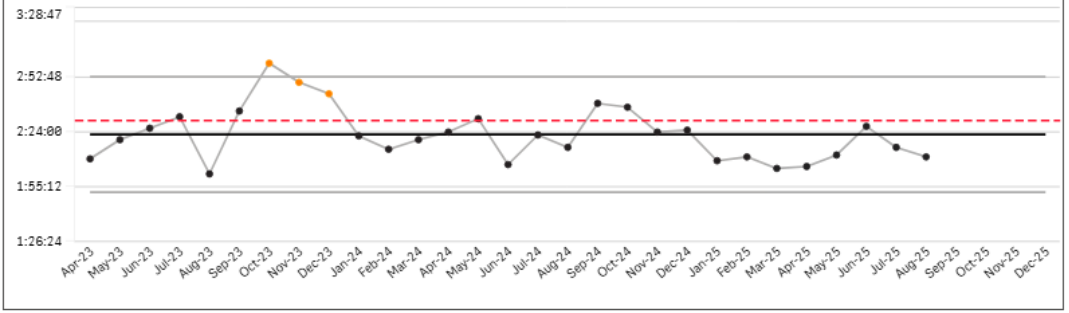
Variation	Assurance	Target	Latest
Expected	Random	01:30	01:25:00

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



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

QS14 - Stroke Call to Hospital Arrival Time 90th Centile
Lower is Better. Target differed in previous years



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

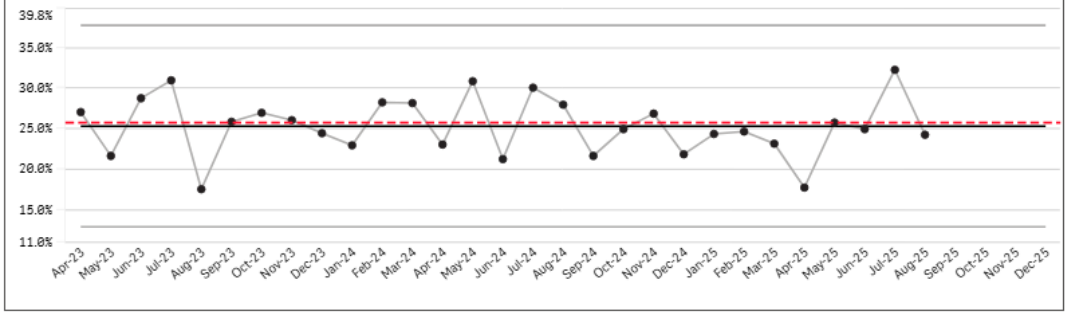
Understanding the Performance:
August 2025 all indicators show common cause variation and perform below the target and the mean, median and 90th centile lines. There were 325 stroke cases in this data set. SCAS were ranked 5th of all reporting Trusts for this period. These data are reliant on good operational performance to achieve the targets indicated.

Actions (SMART):
Focus on Category 2 mean performance (OP2).
Work with BI team on a node based performance report.

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

QS15 - Return of Spontaneous Circulation All

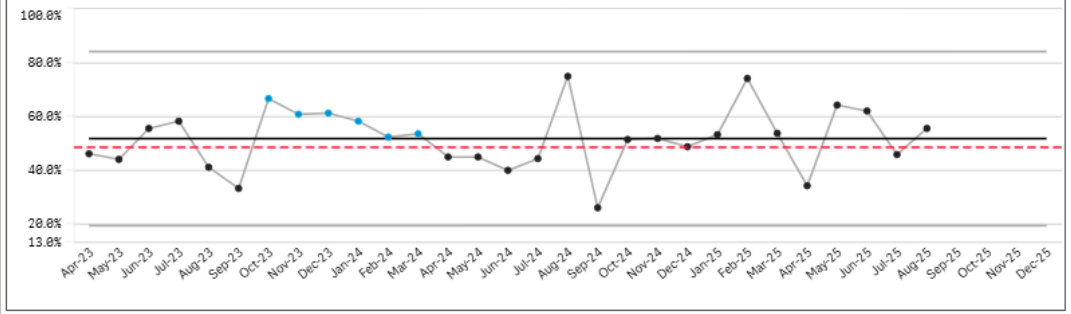
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	25.8%	24.3%

QS16 - Return of Spontaneous Circulation Utstein

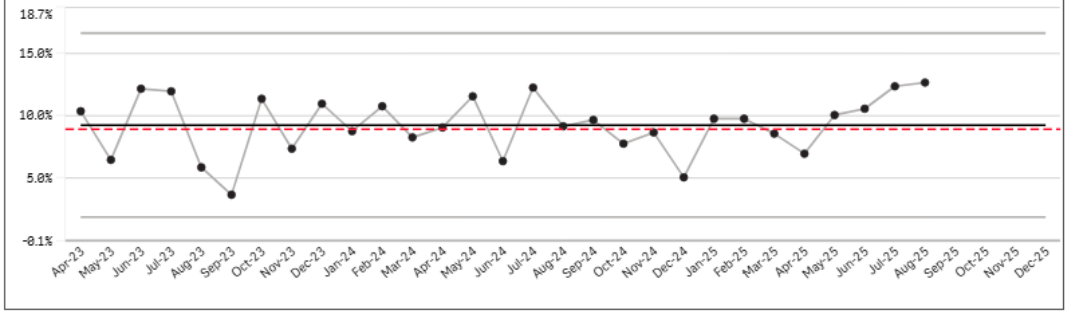
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	48.4%	55.6%

QS17 - Cardiac Arrest 30 Day Survival - All

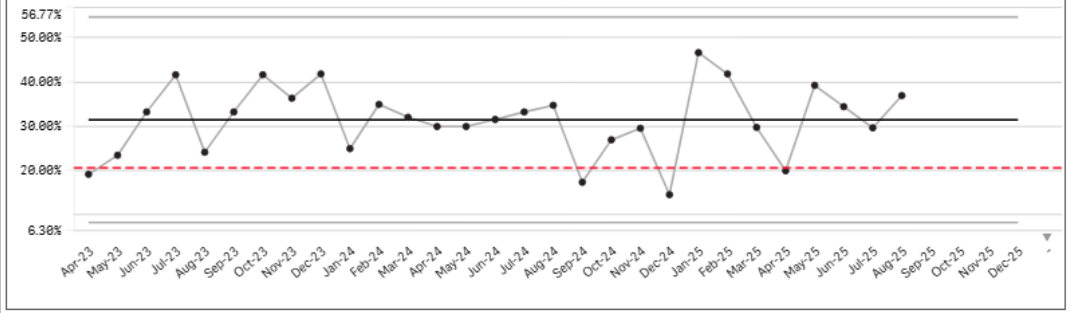
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	8.9%	12.7%

QS18 - Cardiac Arrest 30 Day Survival - Utstein group

Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	20.6%	37.0%

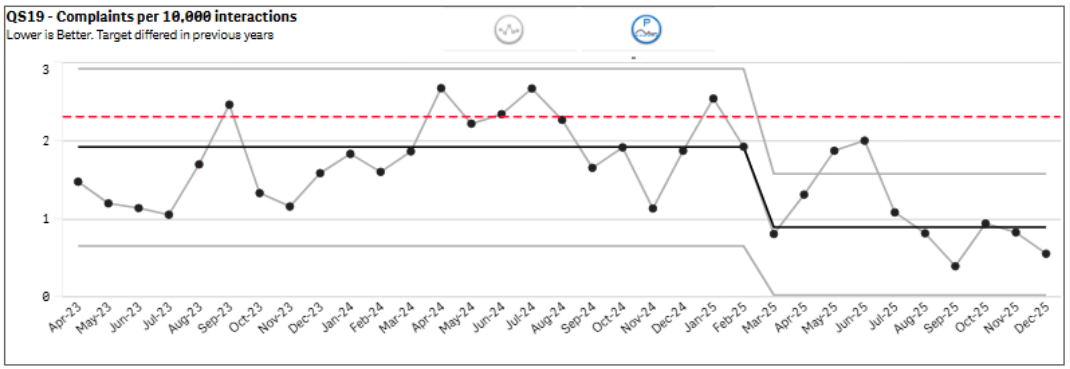
Understanding the Performance:

August 2025 data shows common cause variation across all charts. There is four months improvement in QS17 (30 Day survival for all cases). QS15 is placed 9th of 11 reporting services, QS16 & 17 are ranked 4th of 11 services and QS18 is ranked 3rd of 11 reporting services. There were 181 cases of resuscitation in this reporting period.

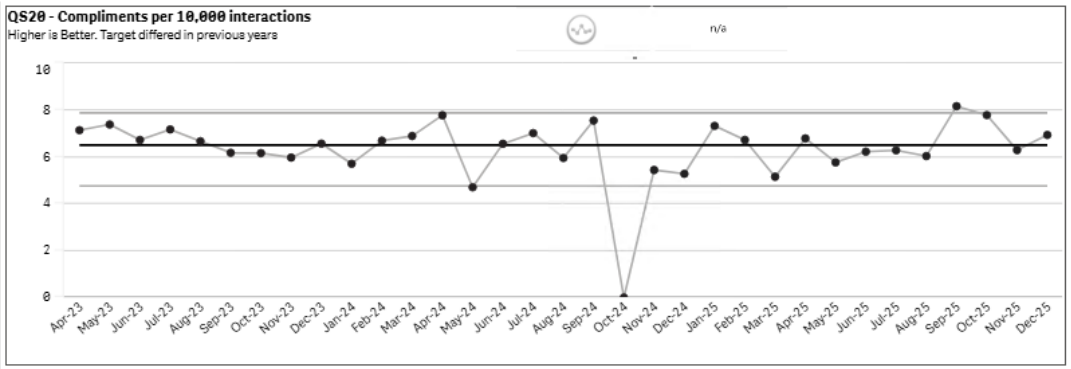
Actions (SMART):

June 2025 saw the switch on of the GoodSAM application, increasing early responder activity with the aim of improving surivial to discharge. The chain of survival is enhanced with continued focus of Cat1 Mean performance (OP1) and Call answer time (OP6)

Quality & Safety – Safeguarding and Patient Experience



Variation	Assurance	Target	Latest
Expected	Pass	2.31	0.563



Variation	Assurance	Target	Latest
Expected	-	-	6.94

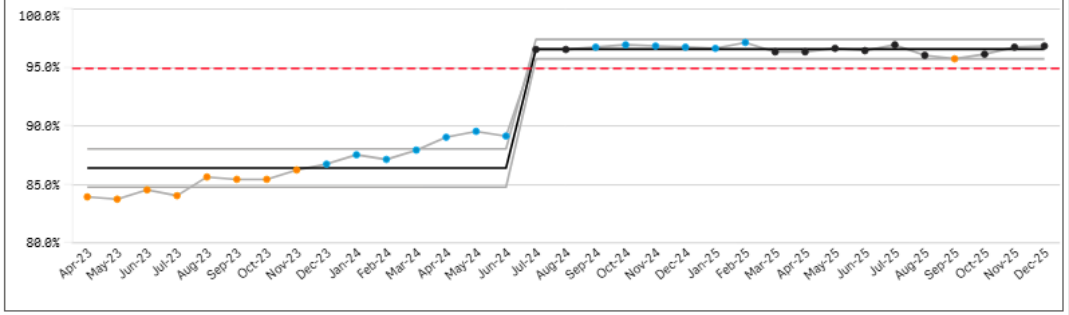
Understanding the Performance:
QS20 – Concerns decreased from 81 to 75, 111 compliments were received for the same period. Themes are inappropriate care pathway in 111, delays in EUC and NEPTS attendance.

Actions (SMART):
QS20 – The patient safety team are undertaking targeted safety improvement work regarding delays in EUC. Please see QS3.

Quality & Safety – Safeguarding and Patient Experience

QS21 - Level 1 Safeguarding

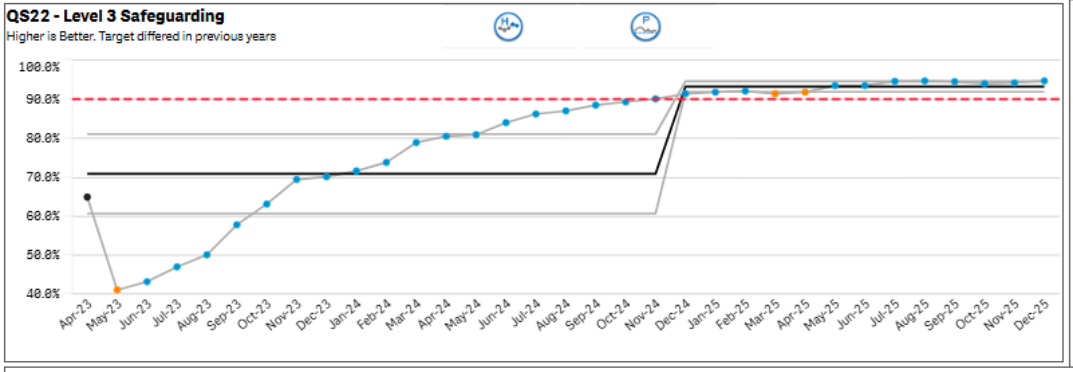
Higher is Better. Target differed in previous years



Variation	Expected
Assurance	Pass
Target	95%
Latest	96.9%

QS22 - Level 3 Safeguarding

Higher is Better. Target differed in previous years



Variation	Improving
Assurance	Pass
Target	90%
Latest	94.8%

Understanding the Performance:

Safeguarding Children and Adults Training Level 1 98% Safeguarding Children and Adults Training Level 3 94% (face to face element)

Actions (SMART):

Safeguarding Training plan continues. Weekly monitoring will be at service level and at the bimonthly Safeguarding Committee.

NHS

NHS
South Central
Ambulance Service
NHS Foundation Trust

People

NHS People Overview

December-25 Summary

Metrics:

Assurance →

Variance ↓

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

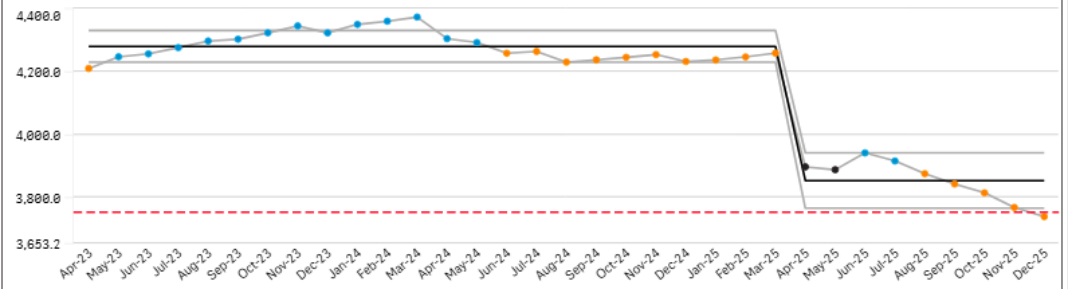
People - WTE, Availability, Staff Compliance, Staff Welfare

*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	Dec-25	3,739	3,753	L	P	3853.6	3765.6	3941.6
% Turnover	Dec-25	17.8%	17.70%	H	?	16.9%	15.6%	18.1%
% Vacancy	Dec-25	0.4%	0.20%	H	P	-2.7%	-5.0%	-0.3%
Time to hire	Dec-25	60	84		?	107.9	27.7	188.1
% Trust staff who are BAME	Dec-25	8.4%	8.86%	L	F	8.6%	8.4%	8.8%
% Trust staff who are declared disabled	Dec-25	11.0%	9.54%	H	P	10.6%	10.3%	11.0%
% Sickness in month	Dec-25	7.2%	6.20%		?	6.9%	5.5%	8.4%
Short term sickness	Dec-25	3.1%	2.70%		?	2.8%	2.0%	3.6%
% Long term sickness	Dec-25	4.1%	3.50%		?	4.0%	3.1%	4.9%
% DBS Compliance	Dec-25	99.0%	95.00%	H	P	97.6%	95.6%	99.6%
Appraisals - Trust	Dec-25	81.6%	95.00%	L	F	86.2%	81.7%	90.7%
Stat and Mand Compliance	Dec-25	98.5%	95.00%	-	?	96.6%	93.7%	99.5%
FTSU Cases	Dec-25			L	n/a	16.0	0.9	31.0
Meal Break Compliance - SCAS	Dec-25	75.5%	85%		F	71.0%	60.8%	81.1%
Over-runs >30 mins - SCAS	Dec-25	15.3%	15%		?	14.9%	12.7%	17.1%

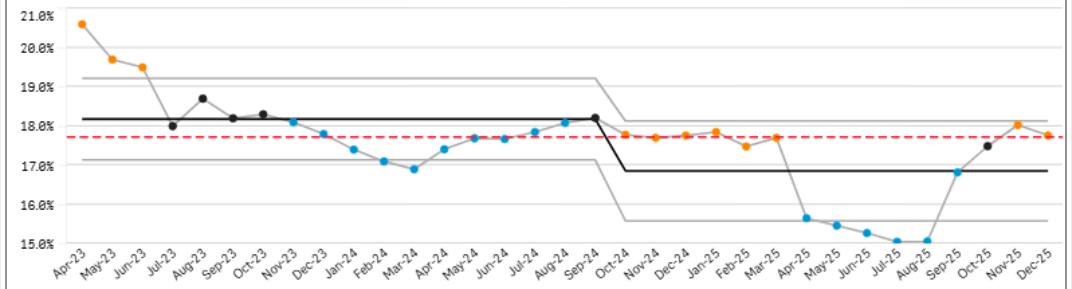
People - Workforce/WTE

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



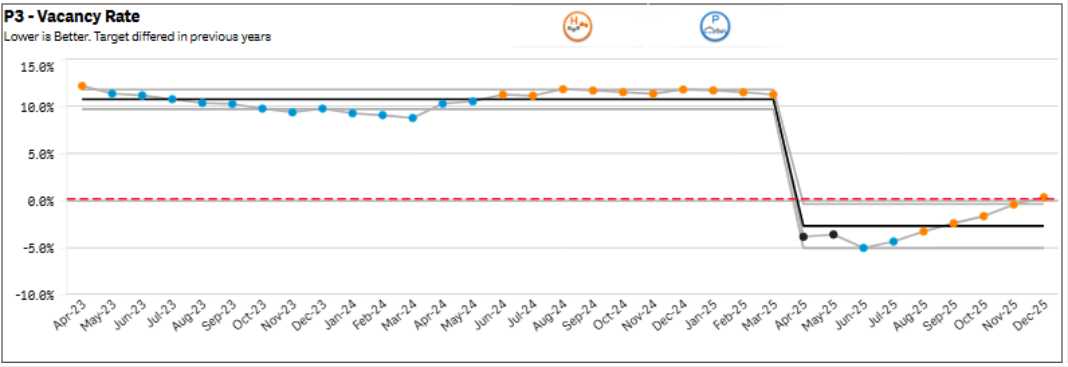
Variation	Declined
Assurance	Pass
Target	3,753.15
Latest	3739.2

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



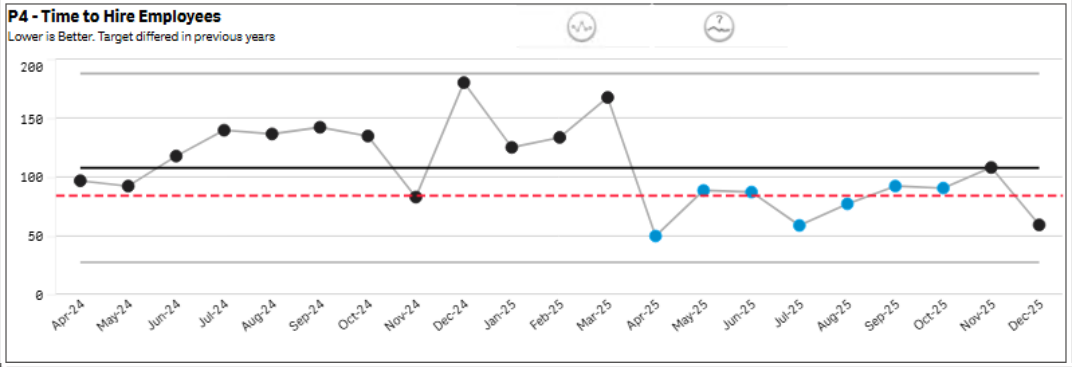
Variation	Declined
Assurance	Random
Target	17.70%
Latest	17.8%

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



Variation	Declined
Assurance	Pass
Target	0.2%
Latest	0.4%

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



Variation	Expected
Assurance	Random
Target	84
Latest	59.5

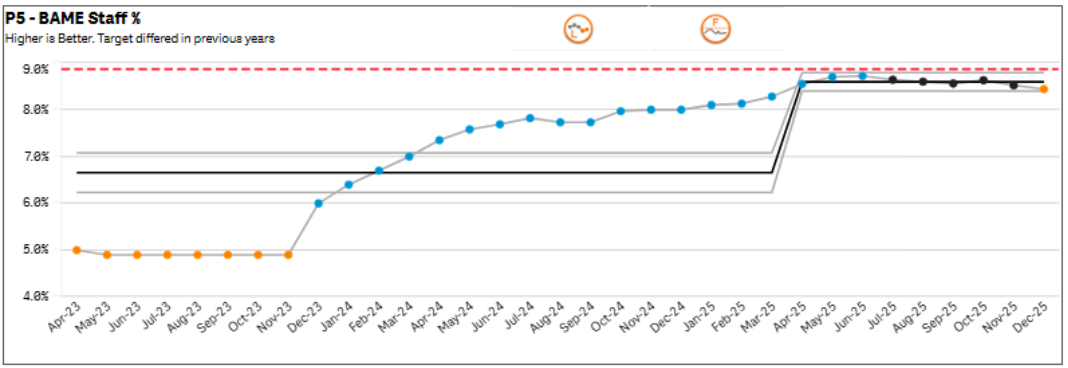
Understanding the Performance:

P1 - M9 staff reduced by 29. YTD reduction of 158. Bank/OT covering winter demand.
P1 - CORP/PTS recruitment paused, CCC recruiting patient roles, 999 to recruit 40 WTE to protect Q4 performance
P2 - Staff % Turnover (17.7) positive against target (18.0). All areas positive: 999 (9.4), EOC (29.9), 111 (29.7), PTS (20.1) and CORP (14.1)
P2 - Staff retention rate % (86.3) below target (87.0) due to corp restructure. All service lines performing above target.
P2 - Attrition rates increased for 4 months.
P3 - Substantive WTE (3739) below budget establishment of 3937. Service line vacancies in 999 (23), EOC (8), 111 (56) and PTS (50)
P4 - Time to Hire reduced to 59.5 (median) advert close to start date, based on 33 starters (111 Call Handler & Ad hoc). Offer to ready is 19.15 days (median).

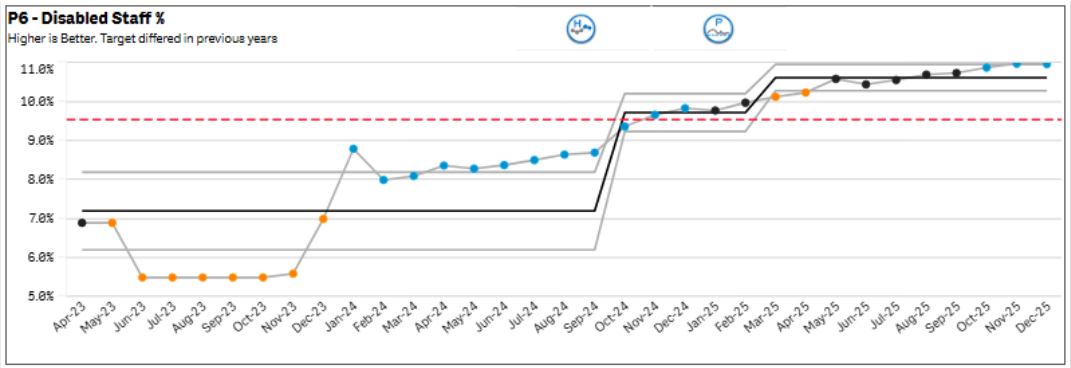
Actions (SMART):

P1 - With the relaunch of recruitment in 999 Operations and PTS, as well as the expected onboard of on hold Paramedics and ECAs, we expect to see an increase in WTE from February onwards.
P3 - Vacancies are expected to reduce from February as on hold ECAs and Paramedics are onboarded.
P4 - limited recruitment in December (12 starters in total) makes it hard to take anything meaningful from the data, however it does show that the longest delay is from ready to start to commencement in role.

People - Workforce/Availability



Variation	Assurance	Target	Latest
Declined	Fail	8.9%	8.4%



Variation	Assurance	Target	Latest
Improving	Pass	9.5%	11.0%

Understanding the Performance:

P5 - WRES - No Significant changes in month. Across year we have seen a small increase from 24/25 year-end position of 8.28% to 8.33%

P5 - WRES - Changes in our demographic profile may be impacted by our the reduction of recruitment activity in PTS, 999, and Corporate / Operational Support.

P6 - WDES - No Significant changes in month. Across year we have seen a significant increase from 24/25 year-end position of 10.13% to 10.97%

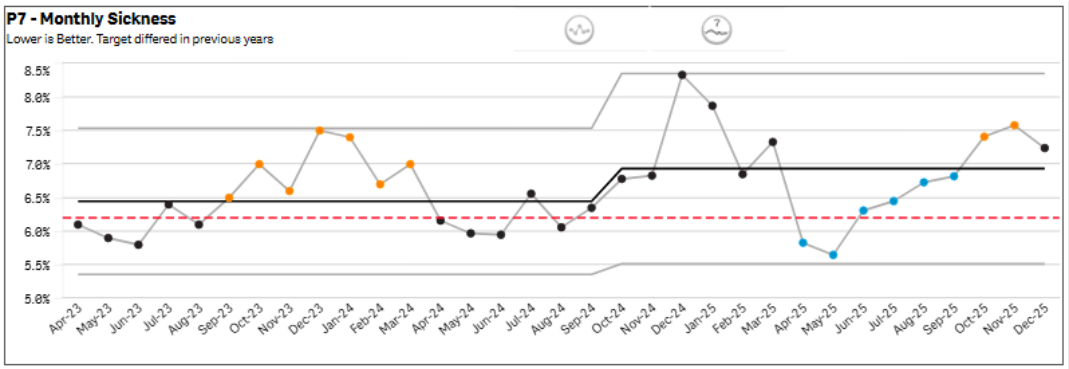
P6 - WRES - Changes of disability status in ESR of existing staff and improved declarations of new starters upon application have both improved.

Actions (SMART):

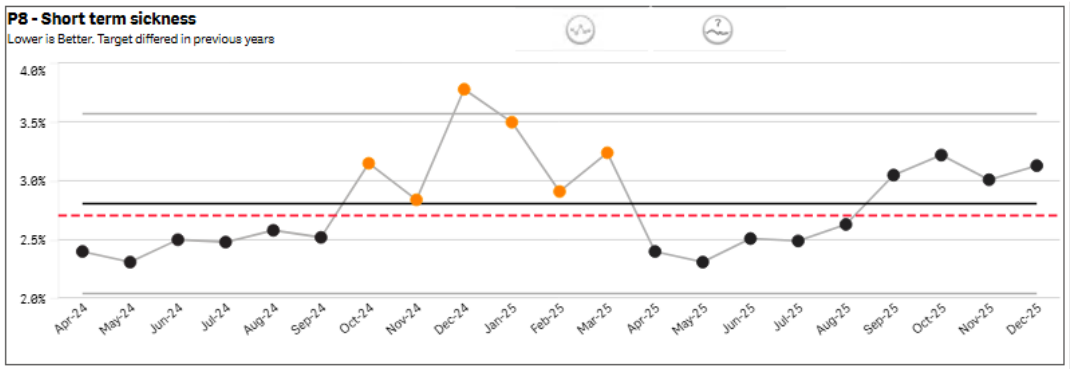
P5 - WRES - Reporting quarterly, due to be presented here in in M10

P6 - WDES - Reporting quarterly, due to be presented here in in M10

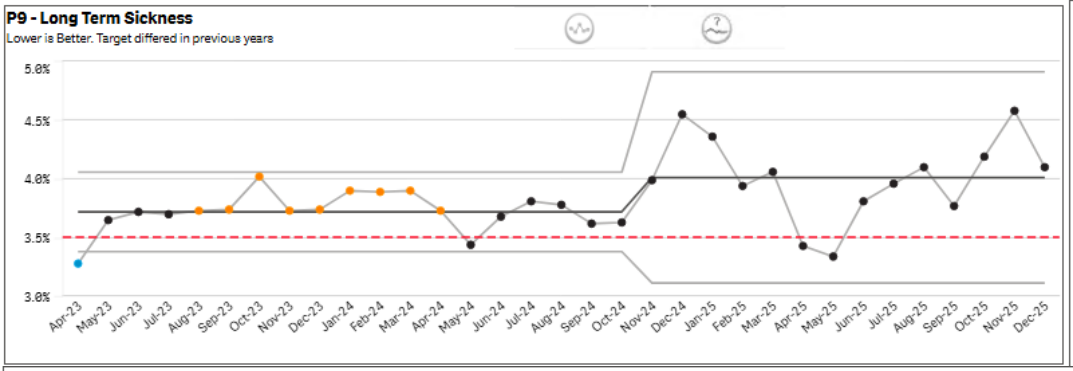
People - Workforce/Sickness



Variation	Expected
Assurance	Random
Target	6.2%
Latest	7.2%



Variation	Expected
Assurance	Random
Target	2.7%
Latest	3.1%



Variation	Expected
Assurance	Random
Target	3.5%
Latest	4.1%

Understanding the Performance:

P7 - Overall, Long-Term sickness is having the biggest impact on attendance.

P7 - M9 Sickness (7.2%) above 7.1% target. 999 (7.9%), EOC (7.8%), 111 (7.3%) and PTS (8.5%) all above M9 Target. CORP is under target with 3.6%

P7 - YTD Sickness (6.6%) above 6.2% target. 999 (7.0%), EOC (6.5%), 111 (7.5%), PTS (8.4%) all above YTD 6.2% target. YTD CORP is under target with 3.4%

P8 - Trust LTS (4.1%) above the M9 target of 3.4%. 999 (4.3%), EOC (4.4%), 111 (3.6%), PTS (5.4%) all above 3.5% LTS target. CORP is below LTS target with 2.2%

P9 - Trust STS (3.1%) below the M9 target of 3.7%. All areas below STS target. 999 (3.5%), EOC (3.4%), 111 (3.7%), PTS (3.0%), CORP (1.4%)

Actions (SMART):

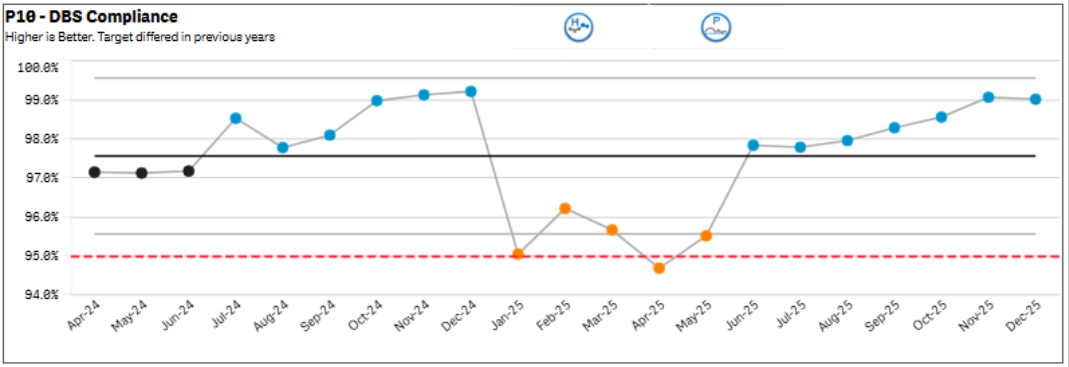
P7 - Sickness reports being proactively sent to managers, reminders sent about resources available to assist with managing absence and development of training programme.

P8 - Small increase in short-term sickness is to be expected due to seasonal illness. 10 week Flu Campaign has ended, achieved target, currently at 53.7%, staff can still obtain a vaccine at SCAS if they would like and report if they don't. Occ Health Clinical Lead will be attending sickness meetings as required as well as reviewing the top 10 long term sickness cases each month.

P9 - Top 20 Long term sickness cases have been targeted to move to conclusion with next 20 to be reviewed in January, focus on this has resulted in a reduction in LTS in December.

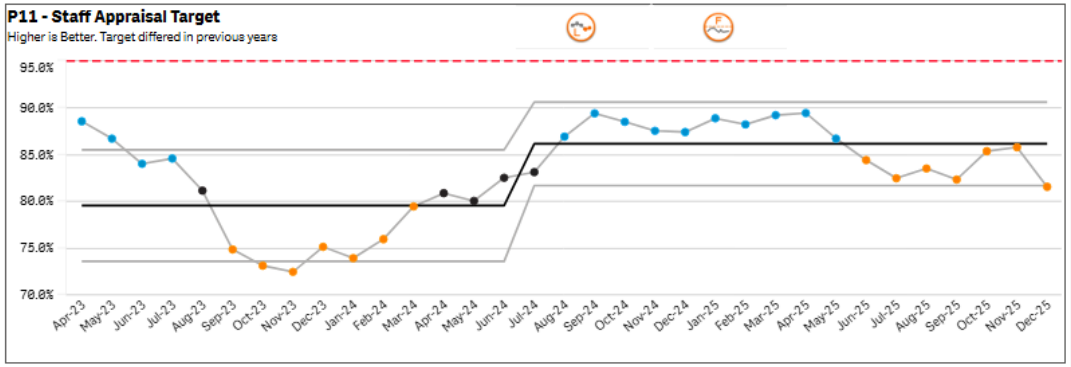
People – Workforce/Staff Compliance

P10 - DBS Compliance
Higher is Better. Target differed in previous years



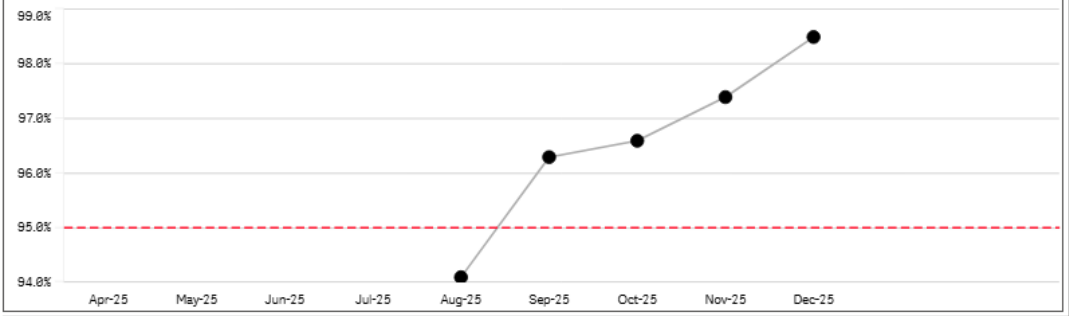
Variation	Improving
Assurance	Pass
Target	95.0%
Latest	99.0%

P11 - Staff Appraisal Target
Higher is Better. Target differed in previous years



Variation	Declined
Assurance	Fail
Target	95.0%
Latest	81.6%

P12 - Stat and Man Training Compliance
Higher is Better. Target differed in previous years



Variation	
Assurance	Random
Target	95.0%
Latest	98.5%

Understanding the Performance:

P10 - DBS compliance remains high at 99%.

P11 - Trust PDR in (82%) below 95% target. 999 (86%), EOC (84%), 111 (84%), PTS (78%) and Corporate (73%) all below target

P11 - The implementation of REAP Level 4 and cancellation of non-essential meetings has impacted PDR compliance.

P11 - Winter pressures continue and may lead to operational priorities taking precedence; however, the Trust is committed to improving PDR processes.

Actions (SMART):

P10 - Less than 40 staff without a valid DBS (a third of this long-term sick, career break, etc.). Working through 80 staff members with DBS expiring in Q4 and are seeing positive response rates.

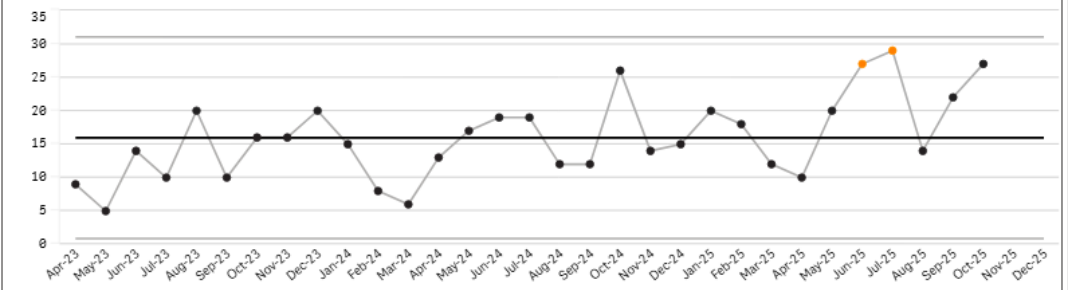
P11 - Post completion of PDR surveys sent to all staff, to measure the quality of experience. Feedback from a small sample of participants indicated strong satisfaction with the PDR process and its outcomes.

P11 - The CPO has written directly to the Sub Executive team asking that completion of PDRs is prioritised to achieve compliance with the Trust's 95% target. The team will continue to actively promote the use of the digital PDR app to streamline and support the PDR process.

P11 - The implementation of a digital reporting solution will improve the efficiency and accuracy. of reporting.

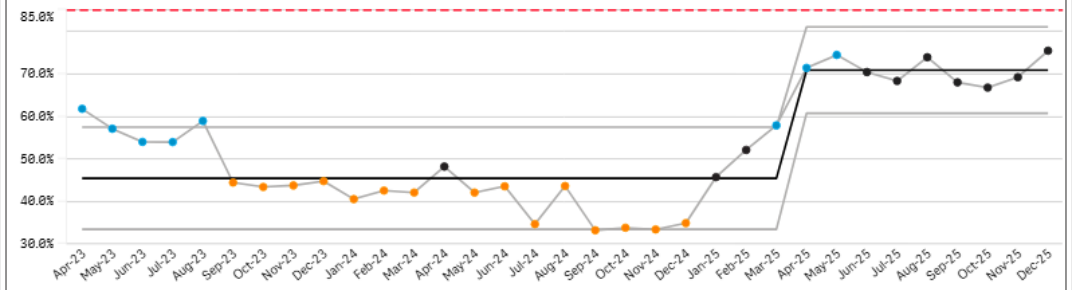
People - Workforce/Staff Welfare

P13 - Freedom to Speak Up Cases
Lower is Better. Target differed in previous years



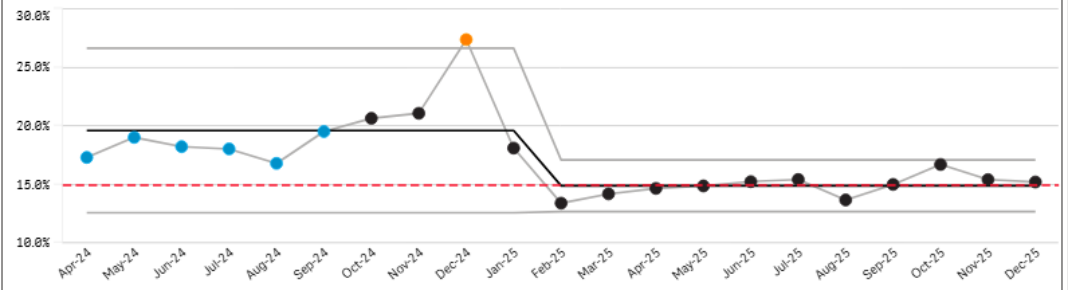
Variation
Improving
Assurance
-
Target
-
Latest

P14 - Meal Break Compliance
Higher is Better. Target differed in previous years



Variation
Expected
Assurance
Fail
Target
85%
Latest
75.5%

P15 - Shift Overrun Percentage
Lower is Better. Target differed in previous years



Variation
Expected
Assurance
Random
Target
15%
Latest
15.3%

Understanding the Performance:
P14 - Is failing showing common cause variation tracking against the mean. Changes to the MB policy are starting to play through and we have seen toward the end of December achieving the target. It is worth noting that we have seen a 40% increase in compliance compared to Dec 24 and a target that was raised to 85% from 60% in year. P15 - is showing common cause variation and tracking against the target of 15%.

Actions (SMART):
P14 - as stated above the performance through the second part of December has seen the impact of the MB allocation changes with some RCs achieving over 90% compliance of a break in window. P15 - EoS compliance has also seen an improvement through the second half of December and we are currently trying to understand if there is a link to MB changes.

Trust Board of Directors Meeting in Public 5 February 2026	
Report title	Month 9 Financial Performance
Agenda item	10
Report executive owner	Stuart Rees, Chief Finance Officer
Report author	Mariam Ali, Assistant Director of finance
Governance Pathway: Previous consideration	EMC and F&PC
Governance Pathway: Next steps	N/A

Executive Summary

Summary

Income & Expenditure

The reported Trust financial position in month is £183k deficit to plan and Year to date (YTD) is £577k deficit to plan mainly due to the loss of H2 HIOW ICB deficit funding (£1.3m, £222k/month).

The YTD underlying position includes several risks, including:

- Frontline staffing cost pressures from H1
- YTD Under delivery on the Cost Improvement Programs (CIPs)
- Delayed return of PTS vehicles.

These pressures were offset by rephased income agreed with the ICB, depreciation underspend and other favorable variances.

Capital

The Trust's YTD capital spend for Dec was £16.31m. The Trust underspent against its YTD capital budget by £9.4m. This is due to slippage in the sale and leaseback of the 25/26 cohort of Double Crewed Ambulances (DCA's) and Rapid Response Vehicles (RRV's). Brokerage of £3m has been agreed with the ICS System and this will be used on the following projects:

- To bring forward spend from 26/27 on the MAN DCA chassis and Ford E-transits
- VCU lease at Eastleigh

- Lease extension at Whiteley.

Cash

The Trust's cash balance at the end of Dec stood at £24.8m. This is £10m below plan mostly due to the timing of DCA sale and leaseback receipts.

There was a net cash outflow of £6.159m in month 9, driven by £2.9m of vehicle capital projects and £12.7m of purchases.

Key Performance Indicators

	Actual	Plan	Variance
Surplus / (Deficit) In-month (£'000)	-300	-117	-183
Pay Costs In-Month (excl. agency) (£'000)	14,959	17,680	2,721
Agency Costs - in month (£'000)	157	51	-106
Capital Spend - YTD (£'000)	16,309	25,698	-9,389
Closing Cash Position (£m)	24.8	34.8	-10.0

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

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

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

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

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

1. Background / Introduction

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

Income and Expenditure (I&E)

In month 9, the Trust's I&E position is £0.2m adverse to plan due to loss of Deficit Support Funding (DSF).

	Month 9			YTD - Month 9		
	Actual	Budget	Variance	Actual	Budget	Variance
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Income from patient care activities	25,666	25,886	(220)	235,975	234,479	1,496
Other income	-	442	(442)	2,991	3,977	(986)
Deficit Support Funding	-	222	(222)	1,331	1,996	(665)
	25,666	26,550	(884)	240,297	240,452	(155)
Pay						
Substantive	(14,707)	(17,285)	2,578	(155,418)	(156,666)	1,247
Bank	(252)	(395)	143	(2,958)	(3,555)	597
Agency	(157)	(51)	(106)	(1,404)	(543)	(861)
	(15,116)	(17,731)	2,615	(159,780)	(160,764)	984
Non Pay	(8,556)	(6,831)	(1,725)	(66,962)	(63,838)	(3,124)
Depreciation	(2,379)	(1,957)	(422)	(13,881)	(15,101)	1,220
Financing Costs	(38)	(200)	162	(976)	(1,352)	376
Other - Gains \ Losses	73	-	73	139	-	139
Other - Tax	-	(7)	7	-	(65)	65
Surplus/(Deficit)	**(350)**	**(176)**	**(174)**	**(1,163)**	**(668)**	**(495)**
Adjustments	**50**	**59**	**(9)**	**449**	**531**	**(82)**
System Reported Surplus/(Deficit)	**(300)**	**(117)**	**(183)**	**(714)**	**(137)**	**(577)**

£m	M1	M2	M3	M4	M5	M6	M7	M8	M9	YTD
Plan	0.2	0.2	0.4	(0.0)	(0.1)	(0.2)	(0.2)	(0.3)	(0.1)	**(0.1)**
Actual	0.2	0.2	0.4	(0.0)	(0.1)	(0.2)	(0.5)	(0.5)	(0.3)	**(0.7)**
Variance to Plan	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**(0.2)**	**(0.2)**	**(0.2)**	**(0.6)**

The H1 reported position included £1.9m income brought forward and a one-off technical benefit of £0.3m to deliver in line with plan. Income in H2 is being adjusted to unwind this rephasing.

	Apr-25 £'000	May25 £'000	Jun-25 £'000	Jul-25 £'000	Aug-25 £'000	Sep-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**	**2,266**	

Service-Specific Performance

For SCAS, the table below details the financial position, by Division, as of Dec 2025 (Month 9)

		Month 9			Month 9 YTD			25/26 FY		
		Actual £'m	Plan £'m	Variance £'m	Actual £'m	Plan £'m	Variance £'m	Actual £'m	Plan £'m	Variance £'m
999	Income	20.5	20.7	(0.1)	187.9	186.5	1.4	249.8	248.6	1.2
	Expenditure	(16.3)	(16.1)	(0.2)	(149.2)	(145.5)	(3.7)	(198.1)	(193.2)	(4.8)
	Contribution	4.2	4.6	(0.3)	38.7	41.0	(2.3)	51.7	55.3	(3.6)
	%	21%	22%		21%	22%		21%	22%	
111	Income	3.8	3.8	(0.0)	33.9	33.9	(0.0)	45.2	45.2	(0.0)
	Expenditure	(3.1)	(3.2)	0.1	(28.2)	(28.4)	0.2	(37.6)	(38.1)	0.4
	Contribution	0.7	0.6	0.1	5.7	5.5	0.2	7.5	7.2	0.4
	%	18%	16%		17%	16%		17%	16%	
PTS	Income	1.9	2.0	(0.0)	17.4	17.7	(0.3)	23.2	23.6	(0.4)
	Expenditure	(1.5)	(1.6)	0.1	(14.6)	(14.7)	0.0	(20.4)	(19.5)	(0.9)
	Contribution	0.5	0.4	0.1	2.8	3.1	(0.3)	2.8	4.2	(1.4)
	%	23%	18%		16%	17%		12%	18%	
Operations Total Contribution		**5.3**	**5.5**	**(0.2)**	**47.2**	**49.6**	**(2.4)**	**62.0**	**66.6**	**(4.6)**
	%	20%	21%		20%	21%		19%	21%	
Corporate		(5.4)	(5.7)	0.3	(47.7)	(50.3)	2.6	(65.1)	(67.3)	2.2

999 Division

The in-month position shows a £350k deficit against plan.

Income is £134k adverse, reflecting a reduction resulting from the initial unwinding of the rephasing of block income.

Expenditure shows an in-month deficit of £216k within the 999 service, mainly driven by the following:

- **A&E resources** are overspent by £199k due to uplifts applied to non-clinical grades that were not included in the original plan
- **Vehicle leases** are underspent by £273k, largely due to delays in the delivery of new vehicles against the budget
- **CIP** shortfall of £290k

111 Services

Vacancies are being held and overtime has been reduced in line with CIP plans. This non-recurrent benefit has resulted in an £87k in-month surplus.

Non-Emergency Patient Transport Services (NEPTS)

The NEPTS division reported a £98k surplus against budget in month. This is due to a review of vehicle lease accruals after receiving updated vehicle numbers.

Corporate Divisions

There is a £291k surplus against plan. Main variances are:

- People is £159k underspent, driven by vacancies being held and the delivery of CIP savings.
- Estates is £139k underspent, reflecting costs associated with buildings that have now been exited

Financial Risks & Planning

We continue to forecast a full-year financial position in line with our breakeven plan. This approach assumes that budget holders will manage expenditure within approved budget limits and deliver their full efficiency requirements, with any shortfall arising during 2025/26 mitigated through the delivery of additional savings.

There are a number of known risks to delivering the breakeven plan, including the current underlying cost run rate (notably additional workforce costs and underperformance against CIP) and the impact of the MARS scheme. The previously highlighted risk around depreciation funding clawback has been mitigated through an adjustment against provisions.

The ICB has confirmed that DSF has been withdrawn for Quarter 3, resulting in a reduction to monthly block income of £222k. However, there remains the opportunity for this funding to be re-earned in Quarter 4. The full-year forecast has a mitigation plan but not this is non-recurrent cost control and non-recurrent CiOS.

The Trust is also monitoring emerging risks that may have future financial and compliance implications. This includes potential exposure related to the historical Pay Progression issue. These potential risks are under review and will be assessed further as part of the Trust's ongoing financial risk management and assurance processes and the Financial and Performance committee will be kept informed on developments.

Anticipated I&E risks will need to be mitigated by additional cost savings and potential non-recurrent technical adjustments. These will provide some mitigations against our current financial risks. These will be captured in future months as they become known and quantified.

As we develop our multi-year plans through the medium-term planning process, the impact of both recurrent and non-recurrent risks and mitigations in the current financial year will inform our understanding of the underlying financial position. Where required, this will need to be addressed on a recurrent basis in future years, potentially constraining investment opportunities or increasing the ongoing efficiency requirement.

During 2025/26, the Trust has experienced the financial impact of delays in returning the PTS fleet. These costs are non-recurrent in nature and have been mitigated in-year through additional non-recurrent actions. However, other risks, such as delays in staff pay progression, are recurrent and will therefore impact the underlying financial position heading into 2026/27.

Delivery of the FRP and the mitigation of current cost pressures are critical to achieving the Year 1 breakeven target and supporting the delivery of a surplus position by Year 3. Furthermore, the Trust's financial performance directly influences its NHSE Provider Oversight Framework segment rating, which in turn affects access to capital flexibilities essential to enabling estate and digital transformation.

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.

The Financial Sustainability Delivery Group (FSDG) meets bi-weekly to challenge divisions and departments on the status, delivery progress, and risks associated with the existing efficiency

programme. As part of the multi-year planning process, the Trust is also exploring longer-term efficiency opportunities, alongside potential synergies arising from the group model with SECAMB.

Further details are contained within the separate financial recovery paper.

Trust Pay Costs

Pay	Month 9			Year to Date		
	Actual	Plan	Variance	Actual	Plan	Variance
	£000's	£000's	£000's	£000's	£000's	£000's
Substantive	14,707	17,427	2,720	155,418	156,950	1,532
Bank	252	395	143	2,958	3,555	597
Agency	157	51	(106)	1,404	543	(861)
Total Pay	**15,116**	**17,873**	**2,757**	**159,780**	**161,048**	**1,268**

Pay Costs:

- Total pay expenditure for the month was £14.7m, against a planned figure of £17.4m. Vacancies are being held across the trust to mitigate the YTD cost pressures

Agency Spend:

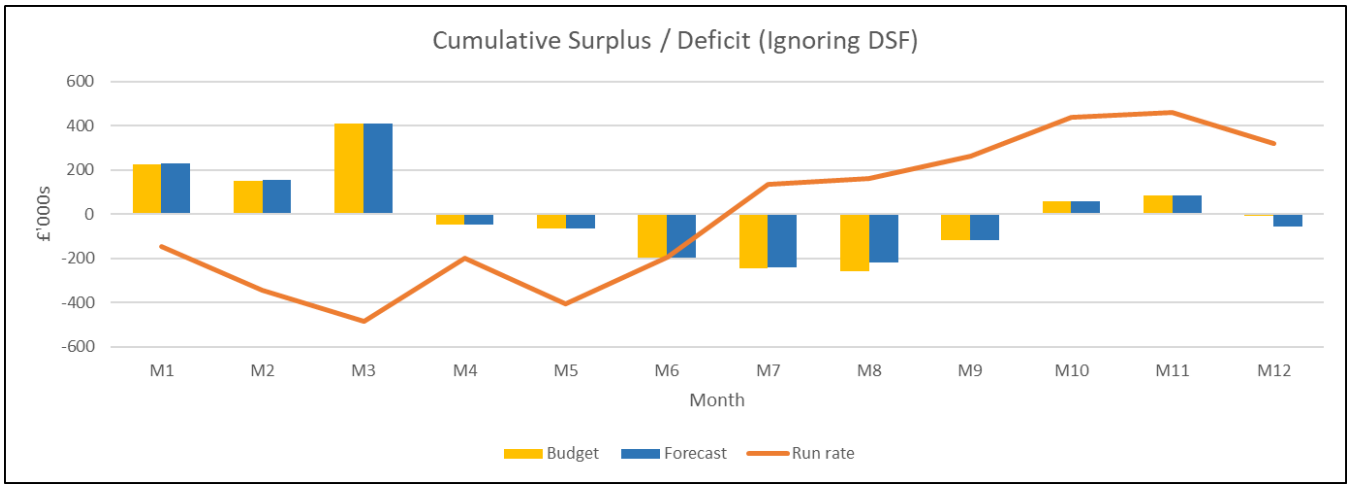
- Agency costs totalled £157k, exceeding the plan by £106k.
- The spend above plan was driven by Fleet Mechanics in SCFS.

Run Rate

The Trust has and continues to actively develop actions and mitigations addressing the financial position, including the delivery of further efficiency targets and identification of potential non-recurrent benefits. These measures, alongside the agreed non-recurrent CIPs and expenditure controls, need to continue until year-end, aligned with discussions with HIOW ICB.

As at Month 9, the Trust's operational forecast outturn without the measures control costs non-recurrently and non-recurrent CiPs, based on year-to date income and expenditure, indicates a projected deficit of approximately £1.5m.

The Trust will be delivering the full efficiency savings of £24m, as outlined in the projection shared with the Extraordinary Finance and Performance Committee on 2 July.



The ICB has confirmed the system will lose the Qtr 3 deficit support funding for 2025/26 and we have seen our income reduce by £222k. It is possible this can be regained in Qtr 4 with no overall impact to the financial position.

Capital

The Trust's capital expenditure upto December was £16.3m. There is an underspend of £9.4m against the capital budget, primarily due to slippage in the sale and leaseback elements of capital projects

Capital underspend – Key Drivers

The £9.4m capital underspend reported in Month 9 is primarily attributable to delays and phasing issues within the Fleet programme. The main contributing factors are:

- **2023/24 DCA Cohort (72 Fiat units):** All 72 Wilker vehicles have now been sold and leased back through TP Leasing Ltd. The final tranche was completed in December, with the related cash receipt received on 6 January and therefore reflected in the Month 10 cash report.The table below shows an underspend of £1.6m, which reflects the fact that costs associated with this cohort of vehicles span more than one financial year.

- **2024/25 DCA Cohort (70 Fiat units):** Delivery from O&H Venari has been delayed but are now arriving. 67 units have been received at the end of December with 3 outstanding and expected in January. These vehicles will be subject to a sale and leaseback agreement when the vehicles have passed quality checks. The sale and leaseback transaction is expected to be completed in January. Due to these delays the CDEL spend is overspent by £0.3m.

- **2025/26 DCA Cohort (70 MAN & 5 E-Transit units):** Although chassis have been paid for, the conversion and equipment costs are now expected to slip into the 2026/27 financial year. It is anticipated that 15 units will be received before year-end. The spend to date is £0.9m on a budget of £7m producing an underspend of £6.1m.

- **PDC income** of £6.785m has been received for the DCA's received in year to date. This is badged against the O&H Venari cohort. A final drawdown of £1.94m is expected to be made in February.

- **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, completed on October 8th 2025 with the lease now in effect. The rodent damage to the remaining RRV's is being repaired by O&H Venari and these vehicles are expected to be sold and leased back by March 2026.

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. It is anticipated that this £0.5m will be shown from month 9 onwards. The fit-out costs are forecast at £0.5m and the IFRS16 lease element is c£1m.

The Hampshire and Isle of Wight Integrated Care System has agreed to £3m capital CDEL brokerage in 25/26. This brokerage is not cash backed.

The Estates Safety Funding PDC has been reduced by £1.1m due to the slippage in the High Wycombe project. The total CDEL is unaffected as the reduction in PDC income is offset by a reduction in expenditure. Negotiations remain on-going with NHS England as to the possibility of moving this PDC to other Estates projects.

The sale of the Chalfont property has been delayed due to ongoing issues regarding site access. Discussions are continuing with Buckinghamshire County Council, which owns the land providing access to the station.

The sale of the Amersham property is on-going. There is a potential buyer and could complete before 31st March 2026. Only one of the possible sales has been reflected in the forecast.

The property at Maids Moreton is also to be sold. However, it is not anticipated to be in 25/26.

Capital Forecast

The capital forecast is reliant on third parties delivering to agreed schedules. Brokerage consists of the £3m brokerage plus £0.5m CDEL allowance for Aylesbury Workshop.

		Year to Date			Forecast		
	£m	Actual	Plan	Variance	Actual	Plan	Variance
Estates	Internal CDEL	1.6	2.1	(0.5)	1.4	1.4	0.0
	PDC	0.5	2.5	(2.0)	6.2	6.2	0.0
	IFRS16	2.1	0.0	2.1	2.1	0.0	2.1
	Total	**4.2**	**4.5**	**(0.4)**	**9.7**	**7.6**	**2.1**
Digital	Internal CDEL	0.3	0.5	(0.3)	1.0	1.0	0.0
	PDC	0.3	0.7	(0.4)	1.1	1.1	0.0
	Total	**0.6**	**1.2**	**(0.7)**	**2.1**	**2.1**	**0.0**
Fleet (23/24 DCA Cohort)	Internal CDEL	(5.2)	(5.9)	0.7	(5.9)	(5.9)	0.0
	IFRS16	7.2	9.5	(2.3)	9.5	9.5	0.0
	Total	**2.1**	**3.6**	**(1.6)**	**3.6**	**3.6**	**0.0**
Fleet (24/25 DCA Cohort)	Internal CDEL	0.9	(2.8)	3.7	(2.8)	(2.8)	0.0
	IFRS16	0.0	9.8	(9.8)	9.8	9.8	0.0
	Total	**0.9**	**7.0**	**(6.1)**	**7.0**	**7.0**	**0.0**
Fleet (25/26 DCA Cohort)	Internal CDEL	0.0	(10.5)	10.5	(10.5)	(10.5)	0.0
	PDC	8.1	8.4	(0.4)	8.4	8.4	0.0
	IFRS16	0.0	9.8	(9.8)	9.8	9.8	0.0
	Total	**8.1**	**7.7**	**0.3**	**7.7**	**7.7**	**0.0**
Fleet (Non-DCA)	Internal CDEL	(1.9)	(4.3)	2.4	(4.3)	(4.3)	0.0
	PDC	0.0	0.1	(0.1)	0.0	0.0	0.0
	IFRS16	2.4	5.7	(3.3)	4.0	6.1	(2.1)
	Total	**0.5**	**1.4**	**(0.9)**	**(0.3)**	**1.8**	**(2.1)**
Brokerage	Internal CDEL	0.0	0.0	0.0	3.5	3.5	0.0
	Total	**0.0**	**0.0**	**0.0**	**3.5**	**3.5**	**0.0**
Internal CDEL Total		(4.2)	(20.8)	16.6	(17.5)	(17.5)	0.0
IFRS16 Total		11.7	34.8	(23.1)	35.2	35.2	0.0
PDC Total		8.8	11.7	(2.9)	15.7	15.7	0.0
Total		**16.3**	**25.7**	**(9.4)**	**33.4**	**33.4**	**0.0**

PDC – Public Dividend Capital

Cash

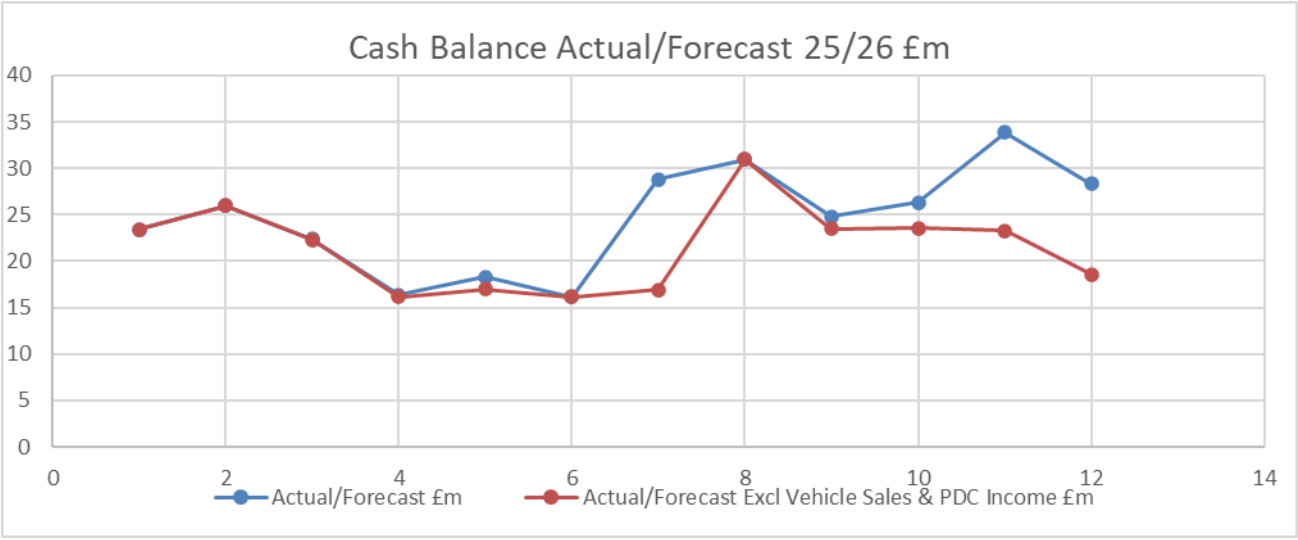
The Trust's cash balance at the end of Dec was £24.8m.

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	28.2	41.8	28.8	28.6	30.5	37.6	36.7
Expenditure £m	(34.9)	(27.0)	(28.8)	(35.6)	(27.8)	(30.3)	(29.1)	(26.7)	(34.7)	(28.9)	(30.1)	(42.3)
Net Inflow/(Outflow) £m	(4.6)	2.6	(3.6)	(6.1)	2.0	(2.1)	12.7	2.1	(6.2)	1.6	7.5	(5.6)
Cash Balance £m	23.4	26.0	22.4	16.4	18.3	16.2	28.8	30.9	24.8	26.4	33.9	28.3
Cash Lowest Point	21.6	19.8	22.0	11.9	13.8	15.4	13.9	26.7	23.8			

The lowest point of cash in the month was £23.8m which is a decrease from last month of £2.9m. The decrease in cash is mostly due to the increase in purchases, including the repayment of £1.5m of VAT.

Forecast cash at year-end has decreased by £5.3m. This is primarily due to slippage in sale and leaseback schemes of £3.6m where the sale/leaseback element is now expected in April. This doesn't impact capital CDEL as the sale and leaseback element are effectively capital neutral. In addition to the capital slippage is an increase in expenditure of £1.7m due mostly to a large VAT repayment of £1.5m in M9.

There was a net cash outflow in month 9 of £6.16m mostly due to £2.9m of capital vehicle spend and £12.7m of purchases. This is £10.0m below plan due to the timing of DCA sale and leaseback receipts.



The 90-day debtor increased to £0.209m in Dec (£0.189m in Nov). This represents 28.26% (23.38% in Nov) of the total debtor balance. The percentage debtors have increased due to the overall debt balance increasing.

Overdue debts include: Aurobindo Emergency Medical Services £81k, Dawson Group Bus and Coach Ltd £22k, FedBucks Ltd £29k, Isle of Wight NHS Trust £9k, Oxford United FC £8k, Royal Surrey County Hospitals FT £14k, Southampton City Council £2k, Stadium MK £7k and University Hospital Southampton NHS FT £37k.

Our Better Payment Practice Code (BPPC) performance continues above the 95% target at month 9.

	Month 9 - YTD BPPC			
-	Number	%age	Value	%age
NHS	582	97.7%	£5,429,305	99.9%
Non-NHS	17,917	95.7%	£144,316,545	98.7%
Total	**18,499**	**95.8%**	**£149,745,850**	**98.8%**
Target		95.0%		95.0%
Variance		**0.8%**		**3.8%**

2 Quality Impact

3 Financial Impact

As detailed above

4. Risk and compliance impact

Area of Risk

- The CIP Non-recurrent element will impact next year.
- The delay in delivery of new DCA vehicles is impacting the replacement policy and result in higher maintenance costs. This will also be impacting the delivery against our capital plan.
- The delay in a new fleet workshop and vehicle commissioning facility will result in increased vehicle off-road (VOR) levels, adversely affecting frontline operational performance and driving higher vehicle maintenance costs.

5. Equality, diversity and inclusion impact

6. Next steps

To address the underlying financial position in month 9, the following actions need to be taken:

- Continue to review and monitor establishment.
- Identify management strategies to control costs.
- FRG and Financial Sustainability Development Group (FSDG) meetings continue with the challenge to the divisional recovery plans and cost control.

7. Recommendation(s)

The Group / Committee / Board is asked to:

- The Board is asked to note the Month 9 Financial performance and current risks to delivering the FY plan.

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: New workshop planned in Aylesbury, with project management and recruitment underway to accelerate delivery.
Fleet replacement strategy in progress, including multiple vehicle builds (MAN Box DCA, Fiat O&H Van DCA, Toyota Corolla RRV, Ford EV DCA, etc.) to maintain a front-line fleet age profile under five years.
Fleet directly involved in CAT 2 Improvement meetings looking at ways to improve CAT 2 performance - Additional work scheme in place to increase outsourcing of work to reduce workshop impact
New projects in place to turn the daily VSR into a live document

Gaps in controls: Delayed VCU project, impacting fleet commissioning timelines, supply chain fragility (delays with convertors).
Workshop capacity limitations continue to cause temporary dips in fleet availability. Workshop capacity and productivity remain below demand growth; VOR events ↑114% since 2023 while capacity unchanged; ramp expansion now exhausted at current sites.
Charging infrastructure and behavioural issues affecting auxiliary charging and vehicle readiness. Estate infrastructure to charge vehicle at all sites.

Positive sources of assurance: Progress on Aylesbury workshop with lease secured and contractor appointed – Workshop management team have been interviewed and offered.
Fleet availability averaging 200 DCAs per day.
Strong progress on the new workshop with a phased delivery plan to allow a working site ASAP.
Delivery of 2026/27 Operational Plan and performance explicitly contingent on: VOR down to 30%, Aylesbury live and upto full capacity, 10 extra essential DCAs commissioned and VCU commissioned and fully operational. With further requirements need for 2027/28 onward to deliver the multi-year planning requirements.

Negative sources of assurance: Issues with supply chains starting to appear – This will need to be watched. Impact on quality of service for patients and staffing moral due to lack of vehicles. Various delays to fleet build projects – Not expected to impact year end.
Dependency on EV infrastructure readiness/funding. Mechanical VOR increased sharply since late-2023.

Gaps in assurance: No confirmed go-live date for Aylesbury workshop target early 2026.
Limited visibility and integration of fleet data systems, hindering dynamic allocation and performance monitoring.

Accountable Director	Chief Finance Officer
Committee	Finance & Performance
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 2 = 8
Risk Response	Treat
Target Date	31/03/2026

Mitigating Actions	Executive Lead	Due Date	Progress Notes
Defect reduction programme: address aux-charging, inspection cadence, oil sampling, brake roller testing across sites;	Stuart Rees, CFO	February 2026	Positive progress on improvement project for aux-charging – BI team are reviewing options to create a daily report on DCA's not placed on charge
Commission Aylesbury (licence, landlord consent, fit-out, staffing) and VCU.	Stuart Rees, CFO	March 2026	Lease secured and contractor appointed – PO's supplied to secure workshop equipment before annual price increases.
Capital re-profiling/prioritisation to secure 10 essential DCAs and Cras for Enhanced Care. Charging readiness: % stations with DNO upgrade complete.	Stuart Rees, CFO	April 2026	New fleet will be in place for April 2026 – Work is ongoing with DNO planning

BAF Risk 18 – Estates

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: Understanding of current estate condition and compliance requirements through data gathering and assessments. Estate plan aligned to Fit for the Future, sustainability goals, and national clinical priorities under development. Programme governance in place via Estates Working Groups to oversee delivery and ensure alignment with operational, digital, and green strategies. Phased funding strategy being developed and integrated into multi-year capital planning. Access to national land registers and collaboration opportunities through One Public Estate initiative. Forecasting and negotiation of rent and inflation increases embedded in budget and contract management processes.

Gaps in controls: Modelling and testing for estates utilisation and performance modelling for the sector hubs. No confirmed funding for Make Ready Hubs beyond current allocation. Limited flexibility in capital allocation; risk of overcommitment due to competing priorities. Charging infrastructure incomplete; dependency on DNO upgrades and landlord approvals. SCAS faces charging infrastructure gaps for EV fleet and insufficient parking and welfare space for expanded workforce. With further requirements need for 2027/28 onward to deliver the multi-year planning requirements.

Positive sources of assurance:
Condition and functionality assessments underway; ensure these feed into prioritised capital bids. Incremental investment and sustainment, data gathering, condition and functionality assessment, Collaboration and best practice knowledge sharing, standardisation of designs

Negative sources of assurance: Historic investment and limited estate capacity have created significant backlog maintenance and compliance risks. Current estate footprint is fragmented and lacks resilience compared to peers, impacting operational efficiency and staff welfare. Dependency on national capital allocations and brokerage introduces uncertainty and delays to critical infrastructure projects. Workforce growth and fleet electrification requirements are outpacing estate readiness, creating risk of operational disruption and non-compliance with sustainability targets.

Gaps in assurance: Historic funding and limited estate capacity versus other Trust hub model constrain SCAS's ability to deliver operational resilience. Charging infrastructure incomplete; dependency on national capital and landlord approvals. No integrated modelling of estate, fleet, and workforce growth.

Accountable Director	Chief Finance 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 3 x Likelihood 2 = 6
Risk Response	Treat
Target Date	31/03/2026

Mitigating Actions	Executive Lead	Due Date	Progress Notes
Develop phased estate plan aligned to Fit for the Future and sustainability goals, including hub strategy and DNO upgrades for EV charging. Stakeholder engagement and governance groups established, aligned to multi-year capital prioritisation and inter-Trust collaboration opportunities. and Sustainability goals. To include develop phased funding strategy.	Stuart Rees, CFO	Dec 2025	Initial Stakeholder session taken place, further session planned and implementation of Estates Groups.
Recruit Waste & Utilities Manager to oversee compliance and sustainability.	Stuart Rees, CFO	Jan 2026	Appointment made, start date agreed
Develop Estates Groups to oversee the delivery of the Estates Plan ensure alignment with the Trust's Fit for the Future and Sustainability goals such as DNO Upgrades and estates decisions support the Trust's clinical and digital strategies, Green Plan, and long-term infrastructure goals.	Stuart Rees, CFO	Ongoing	Estate Working Groups established. Currently groups developing the Estate plan containing ICC Strategy, Training Strategy and Short Form Business Case for Sector Hub, as well as lease renewals and expiries.

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	Impact 5 x Likelihood 4 = 20
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 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 closed on the 10th November and we are now providing feedback to teams on the finalised structures along with new job descriptions. Appointments process commences Jan 26. Adverts have closed for senior roles with interviews commencing 16th January. All affected staff will be notified on their indiviudal position by 12th January.
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	The joint business case is being developed with SECAMB
Cat 2 improvement programme	Executive Director of Operations	Q4 2025/2026	Programme in place and monitored through improvement meeting.

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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 with programme board and oversight established.

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 3 = 12
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. Testing being implemented at station site. Business case required additional work and is progressing through governance route.

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	Recruiting 46 new staff in Q4 to support 2026/27 delivery. Q1 recruitment plan signed off at IWP in December 26
Recruit to plan to avoid reliance on IRP	Executive Director of Operations	End Q1 2025/2026	External modelling of call taking requirement completed, funding not available to resource to that level. MOU in place with SECAMB for call taking support. Establishment versus budget monitored monthly via Integrated Workforce Meetings. Ongoing recruitment in line with plan.
Implementation of CCC and Ops structure to provide clinical leadership	Executive Director of Operations	End Q2 2025/2026	Adverts have closed for senior roles with interviews commencing 16th January. All affected staff will be notified on their indiviudal position by 12th January.

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Trust Board of Directors Meeting in Public 5 February 2026

Title	Chief Medical Officer's Board Report
Report Author	Dr. Helen Pocock, Head of Research Operations Dr John Black Chief Medical Officer
Executive Owner	Dr. John Black, Chief Medical Officer
Agenda Item	14
Governance Pathway: Previous	Clinical Review Group
Governance Pathway Next Steps	Not Applicable

1. Purpose

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

- **SCAS Clinical Research Update**

2. Executive Summary

SCAS Clinical Research Update

2.1 Current research study recruitment (data cut 02 Jan 2026):

88 new patients and 62 staff have been enrolled in research studies since the last Board report.

- Spinal Immobilisation Study (**SIS**): 40 patients
- Tranexamic acid for mild head injury in older adults (**CRASH-4**): 20 patients.
- Specialist pre-hospital redirection for ischaemic stroke thrombectomy (**SPEEDY**): 21 patients.
- Randomised trial of clinical and cost effectiveness of Administration of Prehospital fascia Iliaca compartment block for emergency hip fracture care Delivery (**RAPID-2**): 7 patients.
- Exploration of clinical advice delivery for UK ambulance service clinicians (**CLEAR**): 62 staff

2.2 Under the new NIHR national funding model, our core funding allocation for 26/27 has decreased by 7% compared to this year. The allocation is now based on three components: Historical allocation – accounts for 50%; Activity based – 30% (number of weighted recruits & number of studies); Performance – 20% (delivery metrics such

as set-up times). Funding was previously based only on historical allocation. A retrospective review of our performance metrics in the last three years revealed that we failed to meet the set-up and time-to-first-participant metrics. Since the new funding model was announced, we have developed a more efficient signatory process, and our capacity and capability assessment process now includes planning early first participant enrolment. We will not take on studies where we anticipate not meeting the targets. We have written to the CEO of the RRDN expressing our concern that the new metrics disadvantage ambulance services.

2.3 Studies opening:

- Understanding the Networks, Effects and Teams involved in Community Alternatives to ACute Hospitalisation for Older People in Hampshire and Isle of Wight Region (CAtCH-NET) (IRAS 347478). This research seeks to understand staff experiences, identify effective practices, and highlight areas for improvement in providing care at home for unwell older adults. It is a non-portfolio study.
- 999 RESPOND-2 (IRAS 347768). This is an investigation of the role of livestream video in emergency medical services triage.

2.4 Studies closing:

- SPEEDY trial (Specialist pre-hospital redirection for ischaemic stroke thrombectomy). Patient enrolment now closed. We await the results of this study which should inform future stroke pathways for patients with clinically suspected with suspected Large Vessel Occlusion (major stroke).

2.5 Grant applications in preparation

For the NIHR Invention for Innovation (i4i) funding scheme:

- **Point of care blood test for troponin I for the back of an ambulance**. Imprinted Diagnostics and University of Manchester. Co-applicants. The project seeks to design and test a portable diagnostic reader that works in varied environments, including moving ambulances, and produces a result within five minutes.

For the NIHR Health Technology Assessment (HTA) funding scheme:

- **Randomised Assessment of Pelvic Immobilisation Devices in Trauma (RAPID-Trauma).** University of Oxford and TVAA. Co-applicants. A multi-centre prospective randomized superiority trial of pre-hospital application of pelvic binders versus no binder in major trauma.
- **PARAMEDIC4**. University of Warwick. Co-applicants. A factorial study exploring pad positioning, IM adrenaline and post-ROSC steroids.

For the RRDN Strategic funding scheme:

- **Enabling wider-settings research through collaboration**. Lead applicants. Aims to develop a scalable governance toolkit and embed SCAS teams within wider settings (e.g. care homes) to enable such settings to become research active.
- **Community Engagement to increase Diversity and Accessibility in Research – Plus (CEDAR +).** Lead applicants. Aims to grow the CEDAR project by partnering

with local sports charities such as Saints Foundation in Southampton, enabling co-production of research as well as improved reach of research delivery.

- **Reducing avoidable drug deaths in Portsmouth**. Portsmouth City Council, University of Portsmouth, Portsmouth Health Determinants Research Collaborations (HDRC) Co-applicants. Aims to create a collaboration of local organisations and people with lived experience of drug addiction to explore the feasibility of a rapid, digital referral pathway linking emergency, hospital and community services.
- **ACCESS-Research.** University of Southampton. Co-applicants. Testing and expansion of a community-based platform to demystify research by inviting people to take part in low-burden research activities. Aims to generate practical evidence on increasing research reach to groups not routinely included.

For the South Central Launchpad scheme:

- Team application for SCAS Research team to develop research culture and grow the research advocate scheme.

2.6 Grant applications outcomes:

- MAD PAtCH (Helen Pocock, Duncan Robertson). Simulation study aimed at improving direct pressure application for major arterial haemorrhage. Small grants scheme, Royal College of Paramedics. UNSUCCESSFUL. Will seek alternative funder.

2.7 Research capacity building activities

- We welcome our new Research & Innovation Manager, Samantha Williams, who brings a wealth of research experience from the regional Clinical Research Network and a local university clinical trials unit.
- **Sponsorship** – to build our research capacity and capability this is an essential step otherwise we are reliant on other organisations to sponsor our research (which has a cost implication). An increasing number of ambulance services are becoming research sponsors. A roadmap has been created, with an anticipated go-live date for sponsorship of low-risk studies of October 2026. Significant groundwork will be required, with securing the Board's support as a top priority.

2.8 Research publications

- **Akhtar W, Brain N, Deakin CD, et al. British Societies Guideline on the Management of Emergencies in Extracorporeal Membrane Oxygenation. Intensive Care Medicine 2025. In Press**
  Extracorporeal membrane oxygenation (ECMO) is an increasingly vital therapy for patients with severe heart and lung failure. These guidelines were developed using a modified Delphi process involving all UK ECMO centres and eight national societies. They provide a structured approach for recognising cardiac arrest, prioritising team actions, and troubleshooting ECMO systems.

- Brown TP, Andronis L, **Deakin CD**, et al. Optimisation of the deployment of automated external defibrillators in public places in England. Health Soc Care Deliv Res. 2025; 13(5): 1-179.
  This paper evaluates strategies for AED placement to maximise survival from out-of-hospital cardiac arrest. It uses modelling and cost-effectiveness analysis to suggest improvements to the current national distribution of public-access defibrillators. The most appealing strategy was placement in halls and community centres.

- Lott C, Karageorgos V, **Deakin CD**, et al. European Resuscitation Council Guidelines 2025 Special Circumstances in Resuscitation. Resuscitation 2025; 215 (Suppl 1): 110753.
  This chapter of the ERC guidelines offers evidence-based recommendations for resuscitation in special patient and environmental contexts scenarios such as trauma, pregnancy and hypothermia.

- Soar J, **Deakin CD**, **Pocock H**, et al. European Resuscitation Council Guidelines 2025 Adult Advanced Life Support. Resuscitation. 215 (Supp 1); 110769.
  This chapter of the ERC guidelines updates protocols for advanced life support in adults, focusing on high-quality CPR, drug use, and post-resuscitation care. The latest evidence is integrated to improve survival and neurological outcomes.

- Drennan IR, **Deakin CD**, **Pocock H**, et al. Advanced Life Support: 2025 International Liaison Committee on Resuscitation Consensus on Science With Treatment Recommendations. Resuscitation 215 (Suppl 2); 110806.
  This paper presents the evidence underpinning advanced life support interventions. It outlines the scientific rationale for treatment recommendations. This is the European publication.

- Drennan IR, **Deakin CD**, **Pocock H**, et al. Advanced Life Support: 2025 International Liaison Committee on Resuscitation Consensus on Science With Treatment Recommendations. Circulation 152; (16 Suppl 1); S72-S115.
  This paper presents the evidence underpinning advanced life support interventions. It outlines the scientific rationale for treatment recommendations. This is the North American publication.

- Jaffe IS, Ren Y, **Deakin CD**, et al. Higher Ventilation Rate is Associated with Increased Return of Spontaneous Circulation in In-Hospital Cardiac Arrest Patients with Advanced Airways. Resuscitation 2025. In press.
  This paper reports a study of advanced airway use in resuscitation. It found that higher ventilation rates during CPR (12 – 26 breaths per minute) with advanced airways are linked to improved ROSC. This suggests revisiting ventilation strategies in hospital cardiac arrest protocols.

3 Link to Strategic Theme

Clinical Effectiveness

4 **Link to Board Assurance Framework Risk(s)**

SR14 - Quality Performance

5 Recommendations

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

John JM Black
CMO
27.1.2026

For Assurance		**For decision**		**For discussion**		**To note**	**X**

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Upward Report of the People & Culture Committee

Date Meeting met **21st January 2026**
Chair of Meeting **Ian Green, Non-Executive Director**
Reporting to **Trust Board**

Items	Issue	Action Owner	Action
Points for escalation			
PDR Compliance	Actions to date have not delivered the expected improvements in performance, particularly in corporate services. This metric will form part of the Performance & Accountability Framework for 2026/27, but the executive team are reviewing further actions that will shift the dial.	DH	Committee has requested an update to the next meeting in March to include a breakdown of corporate services performance.
Key issues and / or Business matters to raise			
Employee Relations Cases	Data was presented relating to Employee Relations cases and the work that was taking place to manage these more effectively and in a timely way. The committee was assured there is grip and control but there is further work to be done to improve processes, support from the People team and achieve trajectories.	DH	Committee will receive a further update at the May meeting.
Culture & Leadership Programme Update	A notable amount of work has been undertaken to date and given that this is a specific area of focus for	N/A	N/A

	the Board linked to the People & Culture strategic theme, it was agreed that there would be 2/3 key areas of focus in 2026/27 to ensure delivery of effective change. Committee will maintain a watching brief as part of the cycle of business.		
Values & Behaviour Refresh	The committee received an initial presentation detailing the outputs of the co-created exercise to refresh the values and behaviours, that has been undertaken bottom up and reflects the views of staff. This will be presented to the March board seminar ahead of formal board sign off in April	BM	Presentation to be given at the March Board Seminar
Sickness Absence Deep Dive	Noting the links to the work that is being undertaken around the values and behaviours, analysed data was presented along with a plan to improve the management of sickness absence. This includes changes to processes, effective monitoring and training managers.	DH	A progress update will be presented to the May meeting.
Resuscitation Training Compliance	The committee received a plan to ensure that compliance with the face-to-face element of resuscitation training was achieved by the end of the financial year, together with the plans in place to ensure on-going compliance going forward.	IG	A progress update will be presented to the March meeting.
Freedom to Speak Up Annual Report 2024/25	The lead Guardian presented the report detailing the number of cases across the year and the work of the Guardian team. It was agreed that the focus of future reports would be on outcomes and learning from cases.	BM	Report will be presented to the February Trust Board.
Areas of concern and / or Risks			
Board Assurance Framework Risks	The committee reviewed the People & Culture related BAF risks, and it was noted that the March Board seminar would focus on developing the BAF for	BM	BAF discussion to take place at the March Board Seminar.

	2026/27 linked to the priorities in Fit for the Future and the Multi-year Plan.		
Items for information and / or awareness			
None			
Best Practice and / or Excellence			
Meeting Papers	Committee members agreed that there had been a marked improvement in the quality and number of board papers, with a much greater use of analysed data and deep dives to understand performance and challenges and seek assurance around plans to improve. The recent internal audit report around Sickness Absence Management that was presented alongside the deep dive was also helpful.	N/A	
Compliance with Terms of Reference			
Compliant	All papers were relevant to the committee terms of reference and the meeting was quorate.		
Policies approved*			
None			

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Trust Board of Directors Meeting in Public 5 February 2026

Title	**Freedom to Speak Up Annual Report 2024/25**
Report Author	**Simon Holbrook, Freedom to Speak Up Guardian**
Executive Owner	**Becky Murray, Chief Governance Officer**
Agenda Item	**16**
Governance Pathway: Previous	EMC 13.01.26 PACC 21.01.26
Governance Pathway Next Steps	None

1. Purpose

To present the Freedom to Speak Up Annual Report for 2024/25 for assurance.

2. Executive Summary

The board holds overall accountability for ensuring that the Trust has robust Freedom to Speak Up (F2SU) arrangements in place and that appropriate action is taken in response to concerns raised, and any emerging themes and trends. The People & Culture Committee (PACC) supports the work of the board in this regard, providing further scrutiny and challenge given the link between the work of the Guardians and the People & Culture strategic theme.

Whilst quarterly reports have been presented to the Trust Board, the Annual Report provides a summary of speaking up activity across the organisation during 2024/25 and describes the work of the 3 Freedom to Speak Up Guardians.

Whilst the data is largely historic and has already been presented to the Board via the quarterly reporting mechanism, the annual summary provides a useful overview of the activity that has been taking place in the Freedom to Speak Up space and acts as a source of assurance in relation to our arrangements for speaking up.

It should be noted that the Lead Guardian has now returned to the trust following a secondment and is taking a fresh eyes approach and using the experience gleaned from his secondment, is undertaking a review using the national tool to identify areas for improvement. This will be presented to the People & Culture Committee once complete and reported upwards to the Trust Board.

It should also be noted that following the departure of the Interim Deputy Chief Executive, executive responsibility for Freedom to Speak Up has been transferred to the Chief Governance Officer (CGO) portfolio. The Non-Executive Director lead remains with Ruth Williams. The NED lead an CGO will continue to work with and support the Guardians and will ensure that the Board is sighted on key issues arising, and that themes and trends continue to inform and drive the Trust's cultural development programme.

3. Areas of Risk

There are no specific risks associated with this document as it describes and provides assurance around arrangements that the trust has in place around Freedom to Speak Up. The risk arises from failing to take appropriate action in response to concerns raised or to use the intelligence to drive existing improvement programmes. This risk is mitigated by regular reports to the PACC, who can seek further assurance and offer supportive challenge to ensure that the service remains effective and accessible.

4. Link to Strategic Theme

The presentation links to our People & Culture theme.

5. Link to Board Assurance Framework Risk(s)

The presentation links to all our People and Culture Board Assurance Framework risks.

6. Quality/Equality Impact Assessment

No QIA/EIA is required.

7. Recommendations

PACC is asked to take ASSURANCE from the report and to raise any questions or queries.

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

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Trust Board of Directors Meeting in Public 5 February 2026

Report title	Freedom to Speak Up Report, Quarter three 2025/26
Agenda item	16
Report executive owner	Rebecca Murray, Chief Governance Officer
Report author	Simon Holbrook FTSU Guardian Lead
Governance Pathway: Previous consideration	Not applicable
Governance Pathway: Next steps	Not applicable

Executive Summary

This report provides an update to the Trust Board on Freedom to Speak Up activity for quarter three 2025/26. It includes an overview of speaking-up activity across the trust, highlights key themes, and updates on actions taken to support a culture of openness and safety. Key factors are:

The number and nature of concerns raised via FTSU:

• 67 new FTSU concerns were raised in quarter three of 2025/26, this compares to 58 in the same quarters in 2024/25.

Thank you; to those that Spoke up, Listened and Followed up.

The most commonly reported categories during quarter three were:

- Worker Safety / wellbeing (↑)
- Bullying & Harassment (↓) (including sexual safety (↑))
- Other inappropriate attitudes & behaviours (=)

Notable themes emerging from FTSU concerns during quarter three included:

- Leadership concerns
- Sexual safety
- Concerns regarding fair and consistent application of trust systems, processes, policies.
- There remains a reported fear of speaking up relating to retaliation and detriment to career progression.

Alignment with Strategic Objectives
With which strategic theme(s) does the subject matter align? All Strategic Themes.

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

Financial Validation	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: • To note the Freedom to Speak Up Report for Quarters three in particular themes and resulting actions

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

Freedom to Speak Up Report

October to December 2025

(Quarter three)

1.0 PURPOSE

1.1 This paper provides an update to the Board regarding Freedom To Speak Up, including concerns raised, emerging themes, improvement activities, and future developments.

2.0 BACKGROUND

2.1 The roles of FTSU Guardians and the National Guardians Office (NGO) were established in 2016 following events at Mid Staffordshire NHS Foundation Trust and the subsequent public inquiry and recommendations by Sir Robert Francis QC.

2.2 FTSU Guardians help protect patient safety and the quality of care, improve the experience of workers, and promote learning and improvement by ensuring that workers are supported in speaking up and that issues raised are used as opportunities for learning and improvement. The aim is to help ensure that barriers to Speaking, Listening and Following Up are understood, addressed and that a psychologically safe culture is fostered and developed.

2.3 The Trust has adopted the National FTSU Policy developed for NHS trusts by the National Guardian's Office, updated and republished in January 2025.

2.4 SCAS has 3.0 whole time equivalent (WTE) in the FTSU Guardian team, this is in line with national recommendations; during Q3 the substantive FTSU lead returned from an eighteen-month secondment with a partner Trust.

The Guardians are supported by a network of 71 FTSU Champions embedded across various departments around the trust, from diverse backgrounds and including students and volunteers.

2.5 Our FTSU Guardians work impartially and independently and have been supported by our Chief Executive Officer, the Executive Lead for FTSU and our Chief People Officer. Under the Corporate re-structure the FTSU team completed its move into the Deputy Chief Executive's portfolio in Q3.

2.6 We are pleased to update Ruth Williams, a Non-Executive Director (NED) also supports the program as FTSU NED lead.

2.7 The FTSU team have built a strong network across the South-East Region, Integrated Care Boards and Systems, and the Association of Ambulance Chief Executives (AACE) National Ambulance Network.

2.8 The FTSU Guardians retain a degree of independence and impartiality from trust management arrangements however are active stakeholders and participants in relevant trust processes, policy developments, and groups, including:

- Sexual Safety Assurance Oversight Group.
- Diversity and Inclusion Steering Group.
- Culture & Leadership Steering Group.
- Staff Networks.
- Flexible Working group
- Workplace Adjustments Group.

Additionally, FTSU Guardians supports the AACE National Ambulance Sexual Safety Community of Practice (NASSCoP).

3. CONCERNS RAISED THROUGH FTSU

3.1 Sixty seven FTSU cases were recorded during Q3 2025/26, this is compared to fifty eight the previous year, as with trends reported in Q1 & Q2 this an increase, but less acute at a 15%.

Whilst this rise could be viewed positively, as an indicator of increased staff confidence in using the confidential FTSU route to raise concerns, it also highlights that colleagues do not necessarily feel safe raising concerns directly with their line managers.

There were eight anonymous concerns raised in Q3; four in October, three in November, one in December .

A table of themes and numbers for the quarters of this and last year can be seen below:

NGO Reporting Categories	24/25	25/26		24/25	25/26		24/25	25/26
	Q1	Q1		Q2	Q2		Q3	Q3
Anonymous Concerns	4	8		5	13		5	8
Patient Safety	3	5		3	3		2	2
Worker Safety/Wellbeing	18	27		13	21		3	25
Bullying & Harassment	12	19		12	19		11	22
Inappropriate Attitudes & Behaviours	11	7		15	17		8	9
Other	0	2		0	4		5	1
Detriment	1	8		0	2		2	5

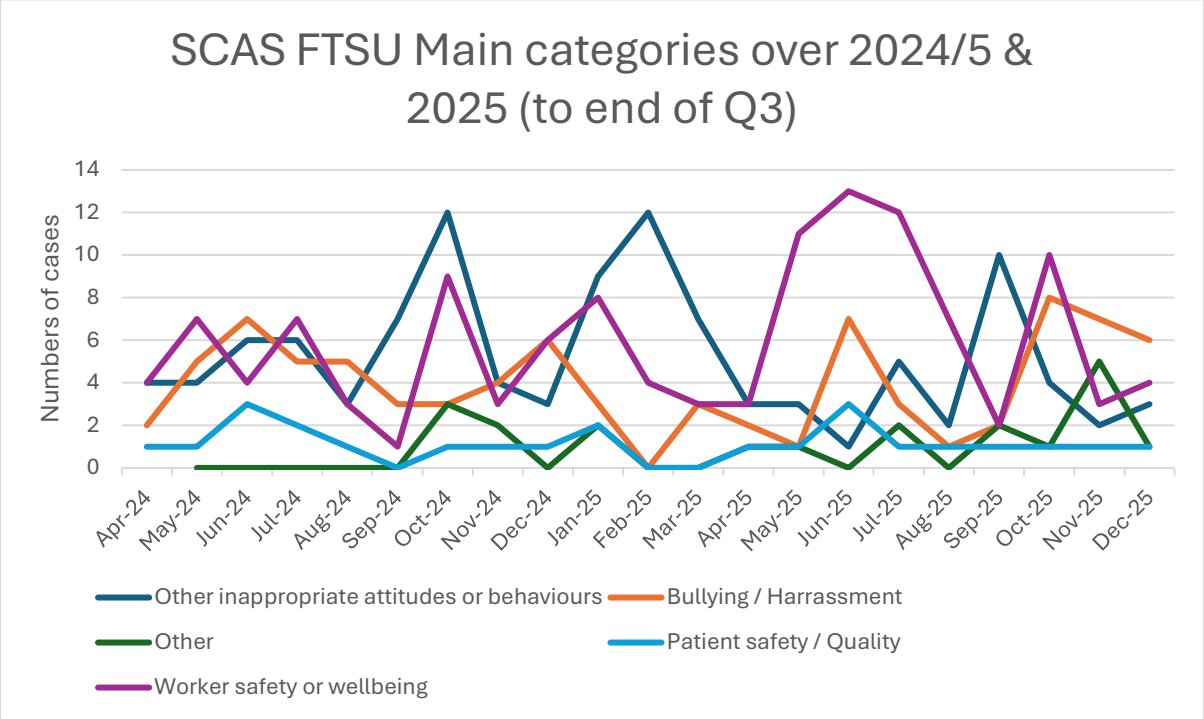
People reporting detriment when coming to FTSU is an area we continue to monitor closely. This includes concerns being raised that by speaking up people feel there might be risk to career progress/development; they will be viewed negatively, or a perception of retaliation.

The National Guardians Office guidance refers to detriment, disadvantageous or demeaning treatment by colleagues, line managers or leaders towards a worker as a result of the act of speaking up, rather than the specifics of the matter raised by speaking up. This can be a deliberate act or a failure to act or omission. Sometimes detriment can be subtle and not always easy to recognise. While these behaviours might not be intentional, the impact can still be significant if a person believes they are being treated poorly or differently. The link here provides a more detailed information

Detriment-guidance.pdf

The increase in case activity also supports the Trust's commitment to transparency and continuous improvement. It provides valuable insight into cultural and operational themes, enabling more targeted interventions and learning.

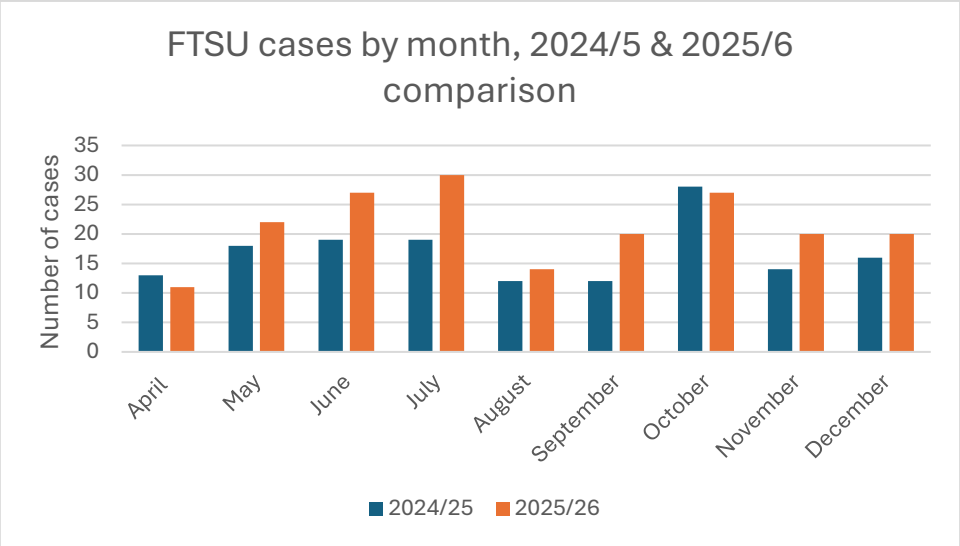
The themes outlined in the tables above reinforce the need for continued, organisation-wide focus on strengthening leadership capability and consistency in local responses to concerns. They also highlight the importance of building trust and understanding in the Freedom to Speak Up process.

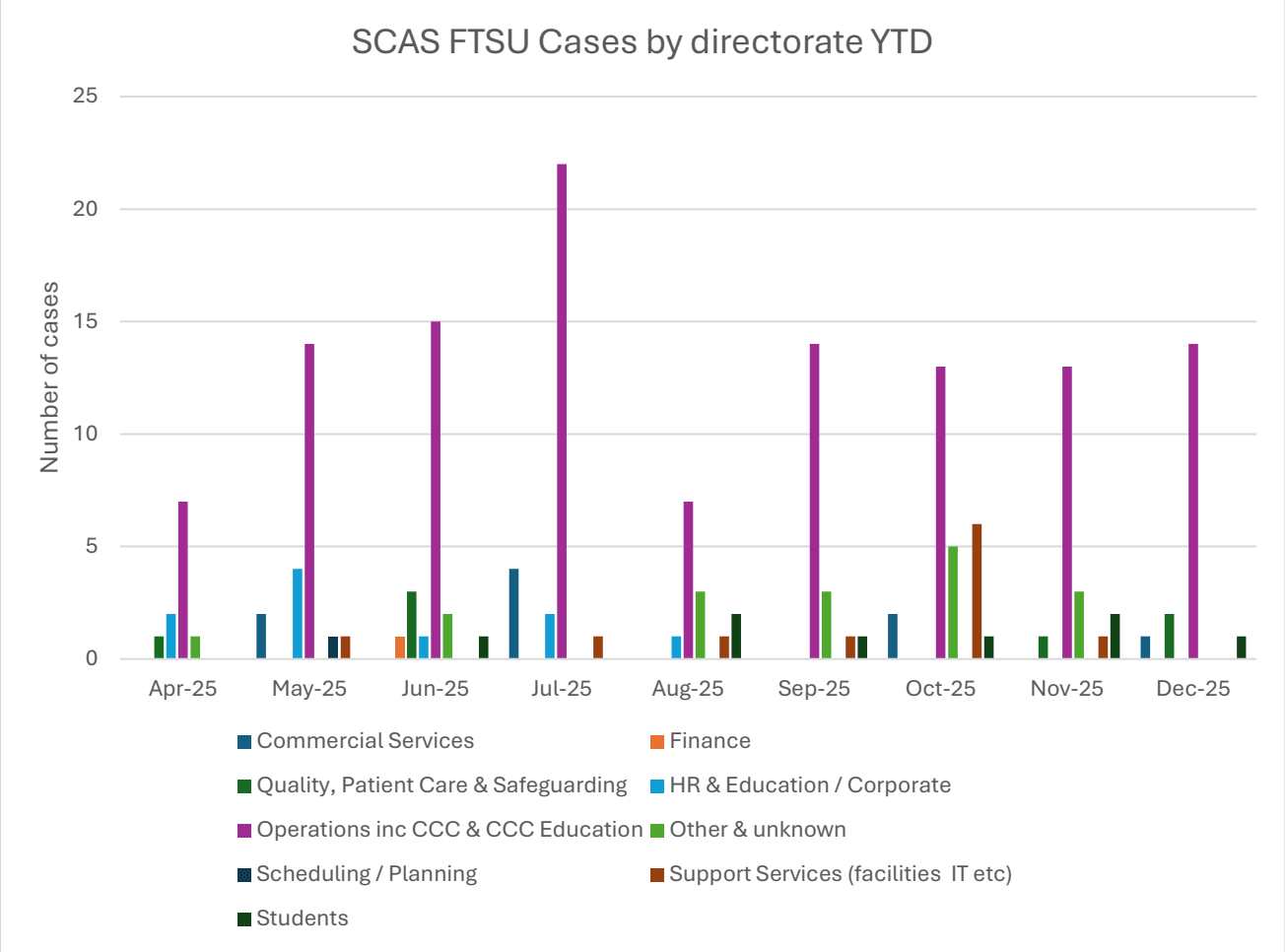


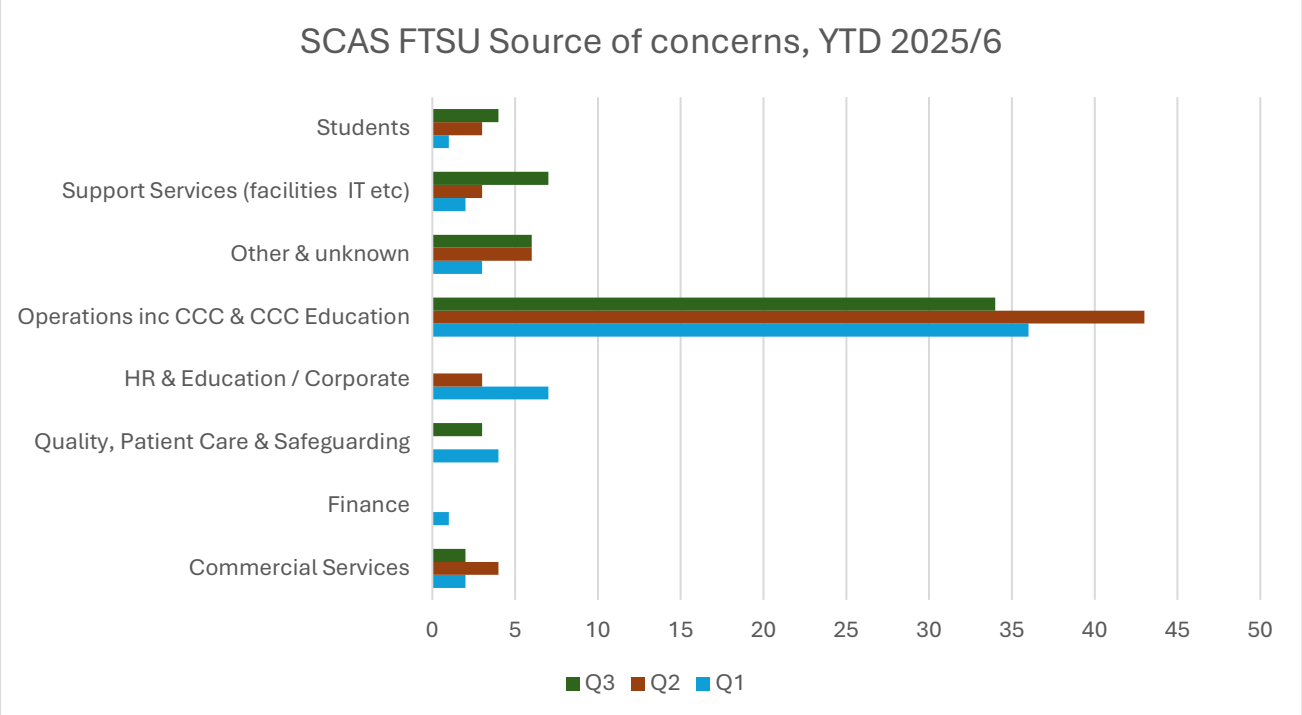
This presents a valuable opportunity to further embed a culture of timely, transparent, and proportionate responses, ensuring that concerns are not only heard but followed up in a way that reflects the principles of a Just and Learning Culture.

The return of the secondee is enabling the FTSU team, who have been operating at 66% resourcing for the majority of 2025, to continue working through all open cases to ensure that they have been reviewed and that feedback and learning has been shared. The reduced number of Guardians impacted on processing, following up and closing cases, alongside the substantial increase of cases received this created churn.

3.2 The monthly case numbers and their spread are detailed below, the Operations Directorate remain has the highest numbers of concerns which is reflective of the context of the Directorate. This year there has been an increase in concerns recorded from Corporate and Support Service teams.

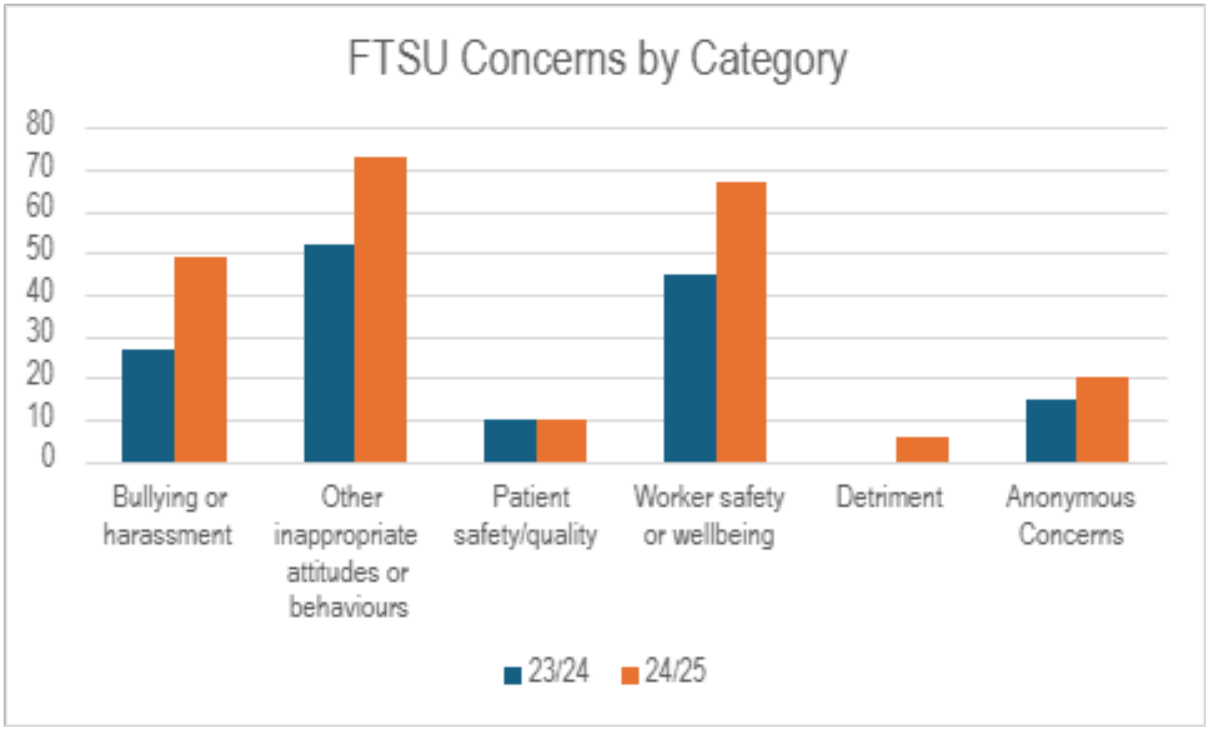






3.3 FTSU Concerns by category

The following illustrations shows the most common categories raised via FTSU during Quarters 3. ‘Bullying & Harassment’ and ‘Worker Safety / wellbeing’ were consistently the most common categories of reported concerns.



Bullying & Harassment : Sub categories	
• Behavioural/Relationships	3
• Sexual Safety	10
• Bullying	6
• Cultural	1
Other Inappropriate Attitudes & Behaviour : Sub categories	
• Behavioural/Relationships	5
• Culture	2
• Exec /Middle Management	2
• System/Process	2
Worker Safety : sub categories	
• Behavioural/Relationships	5
• Cultural	1
• Enquiry / Advice	3
• Exec Team	1
• Infrastructure	1
• Recruitment	1
• Middle Management	1
• Patient Safety / Quality	1
• Staff Safety (including Body Worn Cameras)	3
• System / Process	8
• Other	2

Patient Safety : sub categories	
• Patient Safety / Quality	2
Awaiting responses from those concerned	
	9

3.4 Leadership

Of the 67 cases raised in quarter three, 23 were recorded anonymously or in confidence, the breakdown by category is below.

There are ongoing concerns regarding the psychological safety of speaking. Listening and Following Up within the organisation. Feedback received indicates that some people perceive the Freedom to Speak Up process as unsafe.

Themes emerging from FTSU cases suggest that individuals fear detriment or retaliation after raising concerns. It has been reported that some managers actively identify and challenge those who speak up, which contributes to a culture of apprehension and mistrust.

To further expand, concerns raised through FTSU are frequently met with defensiveness or frustration, rather than with curiosity and a commitment to learning.

This response risks undermining the principles of a Just and Learning Culture and Patient Safety principles, where concerns should be welcomed as opportunities for reflection and improvement.

There is a need to reinforce leadership behaviours that support psychological safety in Listening and Following up, to ensure concerns are received constructively, and embed a culture where speaking up is seen as a valued and protected activity.

Category	Number
Advice Only	11
Anonymous	8
Confidential	15
Open	15
Not yet categorised	18

3.5 Sexual Safety

Sexual safety concerns continued to be raised via FTSU alongside other reporting routes within the organisation. Sexual Safety is reported under the Bullying & Harassment category.

The collaborative work around improving sexual safety progressed through quarter three, with the main focus on planning for the Sexual Safety Multi-Disciplinary Review Group (SSMDRG) Trail for the Southwest (SW) and Northeast (NE) nodes, this started in Q4 2025/26.

3.6 Trust Systems, Processes and Policies

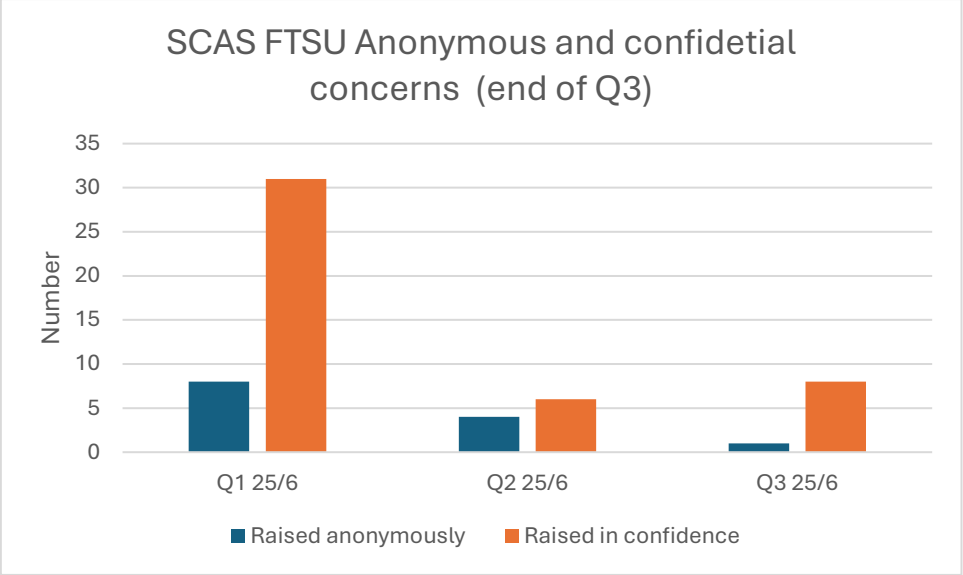
FTSU Guardians have received several concerns, generally reported under the themes of Worker Safety and Wellbeing, highlighting issues with the effectiveness and consistent application of Trust systems, processes, and policies. The following key themes have emerged:

- **Lack of communication** throughout the concern-handling process, including insufficient updates and unclear outcomes.
- **Lack of trust** in the appropriateness or effectiveness of formal processes, particularly in sensitive cases.
- **Inconsistent application** of policies and procedures across departments and teams.
- **Limited provision of meaningful support**, with staff often signposted rather than receiving proactive, local welfare support.
- **Insufficient management understanding** of reasonable adjustments during both formal and informal processes, impacting staff wellbeing and fairness.
- **Perceived conflicts of interest** in the selection of managers responsible for fact-finding, especially in cases involving sexual safety concerns.

These issues suggest a need for greater alignment between policy intent and operational practice, and for reinforcing a culture of transparency, fairness, and psychological safety.

<u>Supporting local managers</u>
The FTSU team have been working closely with line managers to strengthen trust and engagement within their teams, encouraging open discussion and the sharing of concerns.

We are seeing the green shoots of this investment, for both anonymous and confidential concerns in Q3 improved compared to previously reported quarters:



Colleagues are able to share feedback through several avenues, the NSS being one, and also People Pulse, the Values and Behaviours engagement events which started in the summer 2025 and concluded at the end of Q3.

Colleagues also share feedback and speak up about issues and concern through Surveys, Datix incident reporting, Patient Safety incidents, and the Executives when they are out visiting bases and offices across the Trust.

6.0 FTSU E-LEARNING MODULES

All three modules of the National eLearning 'Speak Up' 'Listen Up' and 'Follow Up' became part of SCAS's Mandatory training in the financial year 2023/2024.

At end of Quarter three 2025/6, 4771 colleagues completed the Speak Up Training (total in 2024/5 was 4551).

The year-to-date percentages are detailed below:

Module	(08/01/2026)
Speaking Up - All Workers	99% (↑)
Speaking & Listening Up - Managers	95 (↓)
Speaking, Listening & Following Up - Senior Managers	86% (↓)

6.1.1 **'Speak Up' e-learning** is recommended to be completed by all colleagues in the Trust. The module covers what speaking up is and why it matters. It will help you understand how you can speak up and what to expect.

6.1.2 'Listen Up' eLearning is recommended to be completed by any person in a line management role. The purpose of this training is to focus on listening to concerns and understanding the barriers to speaking up.

6.1.3'Follow Up' is the final eLearning module and completes the full package of training developed by NHSE Workforce, Training and Education and the NGO. This final module aims to promote a consistent and effective Freedom to Speak Up culture across the system which enables workers to speak up and be confident they will be listened to and action taken.

6.1.4 The National Guardian's Office expects that senior leaders (including Executive and Non-Executive Directors, lay members and governors) will complete all three modules 'Speak Up', 'Listen Up' and 'Follow Up'.

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

7.0 LEARNING FROM CONCERNS RAISED VIA FTSU

7.1 The FSTU Guardians actively seek opportunities to apply learning from concerns raised and to embed improvements in the Trust.

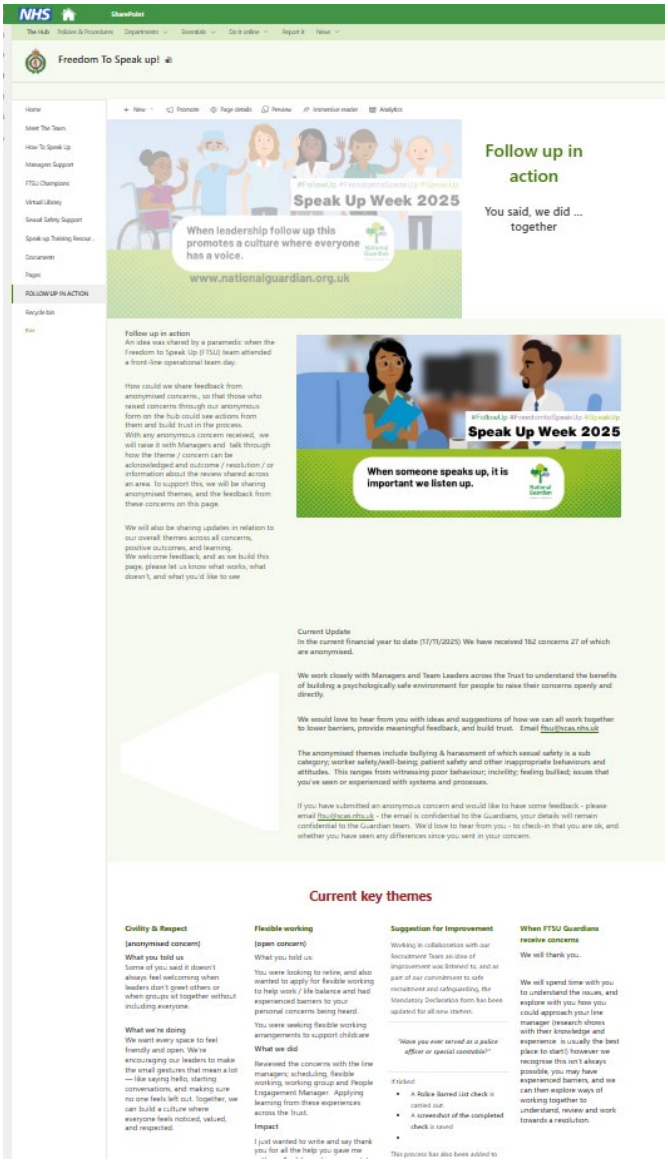
We report this balancing confidentiality and transparency and with a reminder that with some cases still being looked into, examples include:

- People undertaking personal self-reflection
- People modelling fallibility
- People receiving further support from line managers, for example in 1:1's
- A number of collations of facts have also been evoked.

The FTSU team publish learning from cases on the hub pages:

"Follow-Up in Action" was launched on the HUB following an idea from a staff member during a team training session. This now provides updates on themes from anonymous cases or cases of note, enabling learning to be shared and celebrated on our hub page.

(https://southcentralambulance.sharepoint.com/sites/SpeakingandListeningUp/SitePages/FOLLOW-UP-IN-ACTION.aspx)



Other related activities in quarter three include:

- In Q3 the CQC published its reports for Emergency and Urgent Care and Emergency Operations Centre.

Freedom to Speak Up comes under Well Led quality statement.

"We foster a positive culture where people feel that they can speak up and that their voice will be heard".

What this quality statement means:

- ***Staff and leaders act with openness, honesty and transparency.***
- ***Staff and leaders actively promote staff empowerment to drive improvement. They encourage staff to raise concerns and promote***

the value of doing so. All staff are confident that their voices will be heard.

- ***There is a culture of speaking up where staff actively raise concerns and those who do (including external whistleblowers) are supported, without fear of detriment. When concerns are raised, leaders investigate sensitively and confidentially, and lessons are shared and acted on.***
- ***When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again.***
- The CQC recognised the progress made by the organisation since the last inspection and scored this quality statement as Requires Improvement across both reports.

- October (Speak Up Week) saw 90 nominations for *"Celebrating Excellence: The Power of Meaningful Listening & Feedback."*

  We celebrated and awarded individuals who received multiple nominations and saw a wide range of valued staff from across the organisation being recognised. The FTSU team provided certificates for all nominees, with those receiving multiple nominations also receiving a bag of FTSU merchandise and a book from our recommendations.

- Speaking (truth to power), Listening and Following up in action: - the FTSU report to board in Q3 was professionally reported on via HSJ, prompting positive discussion & communication following its publication.

- Multiple team training sessions were delivered across a range of directorates, addressing cultural issues such as racism, bullying, and sexual safety.

- The *Speak Up for Patient Safety (SUPS) Café* was established, with the first session taking place in December. This is a collaboration with the Patient Safety Team and will run as a monthly drop-in session with representation from both teams.

- Learning from the secondment, we have worked with the National Library Manager for Library & Knowledge Service for NHS Ambulance Services in England (LKS ASE) creating a "Speaking, Listening and Following Up" Current Awareness page. This will be developed further on behalf of the National Ambulance FTSU Guardians Network with AACE. (https://ambulance.libguides.com/currentawareness/ftsu)

- Simon Holbrook, our Lead FTSUG, was acknowledged for their work in the "Championing workers" section of the National Guardians Annual report (pg14) NGO_AR_2025_Digital-3.pdf

National update

Further information relating to the Dash Review of patient safety across the health and care landscape, which was published in Q2, continues to emerge.

To recap, the Dash report made several recommendations including:

Placing the responsibility for Freedom to Speak Up Guardians firmly within commissioners and providers should raise the profile and importance of staff voice, and allow a more rapid response.

One of the actions as a result is the National Guardians Office (NGO) closing and the function moving to NHSE (temporarily before the Department of Health and Social Care (DHSC)).

We would like to take this opportunity to thank all the people, past and present, who have worked in the National Guardians Office supporting this movement.

A further update was received in Q3 that NGO office closure has been extended from the end of March 2026 to the end of June 2026.

There will also now be an engagement process carried out by NHSE, this is "*with NGO staff, guardians, NHS leaders and broader stakeholders about the future of the Freedom to Speak Up programme and its functions and ensures continued support for guardians during the transition*"

Further details and updates on this will be shared when released

8.0 WHAT NEXT: FUTURE PLANS AND DEVELOPMENTS

8.1 FTSU Champions. The FTSU Guardians are supported by a network of FTSU Champions embedded across departments throughout the Trust. A focussed training programme has been implemented to support ongoing recruitment, offering both face-to-face and virtual training sessions.

We currently have 71 (↑) FTSU Champions, we continue running online FTSU Champion training on a monthly basis for new FTSU Champions

Champions are actively raising concerns and encouraging colleagues to speak with their line managers, helping to strengthen our speaking-up culture.

This insight supports ongoing efforts to develop a more inclusive and responsive speaking up culture across the organisation.

Our FTSU Champions are offered regular check ins / Keep In Touch calls with the FTSU team

8.2 Case Management System / Power BI Dashboard.

We are continue exploring the option of adopting a Power BI dashboard to enhance the reporting and visibility of FTSU data.

This initiative is being considered as part of our ongoing commitment to improving transparency, consistency, and impact in how FTSU insights are used and also improving closing the virtuous Listening and Following up cycle across the Trust.

8.3 Leadership Awareness Sessions

FTSU Guardians continue to deliver tailored awareness sessions for leadership groups across the organisation. These sessions highlight the importance of speaking up, how colleagues can work collaboratively to create a culture in which all staff feel supported and safe to raise concerns, and how the Trust can learn effectively from the outcomes of concerns raised.

Executive Lead updates:

We undertook planning towards the end of Q3 as Kate Hall our Deputy CEO and FTSU Executive lead made plans to return to NHSE.

We would like to take this opportunity to thank Kate for her leadership in this area.

We are pleased to share that from Q4 2025/6, Rebecca Murray, Chief Governance Officer will be the Executive Lead for FTSU.

To provide levels of assurance and good governance during transition, we will undertake a review of the Board self-assessment in Q4 (this will be mid-life cycle)

We will also update the FTSU policy to reflect these changes in Q4 2025/6

9.0 RECOMMENDATIONS

9.1 The Board of Directors are asked:

To note this report for assurance.

To support targeted improvement around Speaking, Listening and Following Up and related themes throughout the trust, including simplifying systems, improving communication and strengthening local management.

To thank people when they raise concerns, to keep an open mindset when Listening and Following Up and continue recognising and celebrating areas that do this successfully

To not tolerate detriment, to actively protect people who speak up (in any form) from detriment, disadvantageous or demeaning treatment. This will further demonstrate that Speaking, Listening and Following up is business as usual by ensuring those who have spoken up are supported, this will also be key in removing barriers of fear of detriment that may prevent speaking up.

To champion the use of the staff survey data to strengthen local insight and drive improvements in our Speaking, Listening and Following up culture at all levels.

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	March 2026	Sessions have been completed and now in the co-creation phase. Feedback is being sought from staff.
Listening events	Chief People Officer	Q3 25-26	Session have started with 4 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	Completed	Leadership framework has now been developed in line with the NHS England Leadership Competency Framework.
Implementation of leadership framework	Chief People Officer	TBC once pilot has been completed and reviewed	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	Sessions have been completed and now in the co-creation phase. Feedback is being sought from staff.

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: The Trust has embedded a multi-year operating plan aligned to its Fit for the Future strategy and national NHS priorities, supported by robust CIP governance and performance monitoring. Efficiency gains already delivered such as the Hear & Treat, reductions in abstractions, and improvements in task time, are tracked through dashboards and reports to committees to ensure sustained impact. In addition, collaboration opportunities with SECAmb are being actively pursued to leverage shared services and procurement efficiencies, strengthening resilience and driving further productivity improvements.
Operating Plan and annual budget. With a Annual Budget setting process; Business case approval process and Management accounting and budgetary control. Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD). Performance Management and Accountability Framework. Financial Recovery Group. Group model and aligned ways of working.

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. Delayed operational benefits through the group working with SECAMB.

Positive sources of assurance: Internal Audit, External Audit and Local Counter Fraud Service reporting to Audit Committee. Model Health System productivity benchmarking. New Group Board oversight.

Negative sources of assurance: SCAS has already delivered significant efficiencies, including: Hear & Treat to c20% and Productivity improvements from hospital handover reductions (–1:20 mins task time). And has delivered negative real-term cost growth since 2023, meaning further efficiencies and productivity will need to push further and be more complex to deliver. Not operating effectively and productivity may result in not be able to deliver performance standards sustainably, patient care will suffer, and Trust will face regulatory enforcement. Workforce resilience and productivity initiatives. Historic reliance on non-recurrent savings and short-term measures creates sustainability risk. Real-term cost reduction since 2023 have eroded financial headroom, increasing pressure on CIP delivery.

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. Delays to benefits from closer group working with SECAMB. Lack of benefits realisation built into transformation programme and Business Cases.

Accountable Director	Chief Finance 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 2 = 8
Risk Response	Treat
Target Date	Q4 2025/26

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 strategic themes, Group model opportunities and system-wide productivity initiatives. Embed benefits tracking and reporting.	Chief Finance Officer	Feb 2026	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. Strengthen benefits tracking and reporting for all CIP initiatives.	Chief Finance Officer	In progress	Initial PMAF meeting undertaken, refreshing the delivery. Developing a Performance Report to include – Segmentation, FFF Milestones, etc.
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	Feb 2026	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). Financial Recovery Plan agreed at EMC; FPC and Board Annually, Capital discussions with NHSE and ICBs. Group Board oversight and agreement of business plan and financial budget.

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. Group (SASC and SECAmb) collaboration 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), Lack of confirmed capital funding for priority fleet and estate investments (e.g. DCAs, VCU), emerging historical liabilities from 2020, limited flexibility in current capital allocation requiring inter-Trust CDEL transfers.

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, Month 6 financial position reported on plan with strong BPPC compliance and cash management, active engagement with ICBs and NHSE on contract variation orders and capital funding options., financial performance is being used as the baseline for multi-year planning. New Group Board oversight.

Negative sources of assurance: The Trust has already delivered notable efficiencies, such as H&T and productivity gains from handover improvements. and has achieved, negative real-term cost growth since 2023, eroding efficiencies and productivity gain therefore financial headroom. With the Multi-year planning shows +5% CIP requirement for break-even in addition to operational productivity improvements needed. The Trust has insufficient Capital Resource to cover the minimum requirements. Historic reliance on short-term measures and non-recurrent savings creates sustainability risk.

Gaps in assurance: Limited scope for further Hear & Treat uplift without clinical model redesign. Multi-Year Financial Planning Cycles and 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, risk of capital over-commitment/Capital flexibility constrained by competing priorities (fleet vs estate). Estate acquisition opportunities may be missed without capital flexibility. Delays to benefits from closer group working with SECAMB.

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 4 x Likelihood 2 = 8
Risk Response	Treat
Target Date	Q4 2026/27

Mitigating Actions	Exec 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. Group model best practice opportunities.	Chief Finance Officer	Done	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. Explore and develop benefits from closer group working with SECAMB. Strengthen benefits tracking for all CIP initiatives and link to operational KPIs.	Chief Finance Officer	Feb 2026	All Executives have agreed target at FRG and tiger team are meeting with Executive Directors and their team. All mitigation plans to achieve breakeven now in place.
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. Group Board oversight	Chief Finance Officer	On-going	Report designed and will be reported to F&PC Work built into Internal Audit Plan (Financial Sustainability work).
Mitigation plans developed for the Deficit Support Funding and emerging historical risks	Chief Finance Officer	Jan 2026	Discussions are on-going.
Explore inter-Trust CDEL agreements to secure up to £3m in capital support for 2025/26, with repayment options.	Chief Finance Officer	Done	

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. The Trust has formalised collaboration with SECAmb through a signed Memorandum of Understanding (MoU) covering 999, 111, and Electronic Patient Records (EPR). This MoU underpins the South Central and South East Ambulance Group (SCSEAMB) model announced in October 2025, driving interoperability, shared efficiencies, and resilience. Tier 1 Programme Board and Joint Board Delivery Group established for oversight and assurance. Dedicated multi-disciplinary team with Executive Sponsor in place to deliver objectives. Alignment with broader strategic initiatives (e.g., Southern Ambulance Services Collaboration) to maximise regional integration.

Gaps in controls: Lack of shared platforms across CCC and UEC operations. No formal joint risk register and escalation process. Implementation timelines for system replacement (e.g., 999 platform by Autumn 2027) create medium-term dependency risk. Resource constraints and competing priorities may delay delivery of efficiencies and productivity and investments needed to deliver a quality patient service/response and affect staff moral. Benefits realisation framework for collaboration savings and productivity gains still under development.

Positive sources of assurance: Savings identified and implemented, structures aligned where possible, consistent delivery model.

Negative sources of assurance: Funding levels, cultural and operational differences between Trusts may slow integration. Inconsistency of service model and delivery across region. Not awarding 111 contracts. Misalignment of strategic priorities between Integrated Care Boards (ICBs). Anticipated savings from collaboration not realised or reinvested. Cultural misalignment and resistance to change.

Gaps in assurance: Finance savings not released for reinvestment. Regional commissioning priorities. NEPTS provision across region is inconsistent. Lack of joint risk register and governance framework for collaboration. No benefits realisation framework for collaboration savings, efficiencies, productivity, etc.

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 2 x Likelihood 2 = 4
Risk Response	Treat
Target Date	Q4 2025/26

Mitigating Actions	Exec 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. Formalise joint governance and risk management arrangements. Joint strategic planning workshops with commissioners Implement MoU Governance Structures: Establish and operationalise the Tier 1 Programme Board and Joint Board Delivery Group for oversight and assurance of collaboration objectives; Ensure Terms of Reference and reporting lines are agreed and embedded - addressing strategic risks identified in the MoU and Case for Change: governance gaps, cultural misalignment, resource constraints, and dependency on national capital.	Chief Finance Officer/ Chief Governance Officer	Feb 2026	**Formal Agreement Signed:** Memorandum of Understanding (MoU) signed in Feb 2025 and extended in Nov 2025 to include collaboration on 999, 111, and EPR systems. Confirms commitment to interoperability and shared digital roadmap. Work underway with SECAmb and Commissioners. **Joint Commissioning meetings in common agreed.** **111 & NEPTS Agreements:** Nearing finalisation with commissioners; Reflect regional needs and commissioning expectations **Shared Service Model (999, 111, Urgent Care):** Draft model developed; Aligns operational delivery across services; Supports regional flexibility and integration **Strategic Planning Workshops:** Goals, timelines, and resources aligned; Joint governance framework established **Operational Structure Consultation:** Launching shortly; Staff and stakeholder engagement planned; Supports implementation of new service model **Enabling Services (Fleet, Contracts, Make Ready):** Fleet strategy under review; Contract models being assessed for efficiency; Exploring shared infrastructure opportunities. **Governance Established:** Tier 1 Programme Board and Joint Board Delivery Group agreed for oversight. Collaborative Committee formed to provide assurance and steer workstreams. **Commissioner Engagement:** NHSE SE Region and lead ICBs engaged; strategic commissioning concordance in development.
Monitor and Realise Benefits: Establish a joint benefits realisation framework to track efficiency and productivity gains. Report progress regularly to the Board and F&PC.	Chief Finance Officer	3Feb 2026	Opportunities with SecAmb currenting be investigated. SASC currently work on savings and risk sharing agreement. Roadmap Development: Outline Business Case options developed and shared with Boards in July 2025. Functional Collaboration Underway: Joint workstreams launched for driver training, occupational health, and quality improvement methodology; Early scoping of joint procurement and shared corporate functions (HR, payroll, estates).
Mitigate Cultural and Capability Barriers: Provide joint training and development engagement programmes 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	**Leadership & Development:** Mapped leadership offerings to NHS Competency Framework. Piloted senior and first-level leadership programmes. Launched Executive coaching and scoped Sub-Executive development. Created SCAS Leadership Directory and self-assessment tools. **Culture & Engagement:** Established Values & Behaviours working group and launched Listening Spaces. Delivered first EDI conference

NHS
South Central Ambulance Service
NHS Foundation Trust

Trust Board of Directors Meeting in Public 5 February 2026	
Report title	Integrated Care System Report
Agenda item	19
Report executive owner	Stuart Rees, Chief Finance Officer
Report author	Various
Governance Pathway: Previous consideration	All Board in HIOW ICS/BOB and Frimley ICB Boards
Governance Pathway: Next steps	N/A

Executive Summary

This report provides the Board:

- with a summary of how the Hampshire and Isle of Wight system is performing against the 2025/26 operating plan, highlighting areas of non-delivery and what actions are being taken to mitigate key risks,
- the Month 8 financial position and Month 5 performance update for both the Frimley and BOB (Buckinghamshire, Oxfordshire & Berkshire West) Integrated Care Boards (ICBs).

Hampshire and Isle of Wight System:
Please note that Month 9 (M9) data is only available for Urgent and Emergency Care metrics – all other metrics relate to Month 8 (M8), with some exceptions depending on reporting frequency.

Performance Overview
This report provides an overview of in-month performance against operating plan metrics based on latest published data and highlights 13 headline metrics currently performing worse than plan across the Hampshire and Isle of Wight system. This represents a decrease against previous month (14 metrics). The metrics below plan in current month reporting are:

- % of beds occupied by patients not meeting the Criteria to Reside (NCTR) (M9)
- Access to Children and Young People's Mental Health Services (M8)
- Average length of stay for Adult Acute Beds (Mental Health) (M8)

- Adults in inpatient care who are autistic, with no learning disability (M8)
- Diagnostic 6 week waits (9 key tests) (M8)
- Cancer 28 day faster diagnosis (M8)
- Cancer 62 day referral to treatment (M8)
- Time to First Appointment (M9) – *unvalidated*
- RTT 52 week waits (M8)
- RTT waiting list within 18 weeks (M8)
- Emergency Department 4 hour performance (total mapped footprint) (M9)
- % of attendances in A&E over 12 hours (M9)
- Category 2 ambulance response times (M9)

Quality Overview

Quality overview can be found on pages:9-16

Financial Overview

The purpose of the Month 09 (M9) System Report for Hampshire & Isle of Wight Integrated Care System (ICS) is to provide details of the financial position for the ICS as at the end of December 2025.

The ICS position in month 9 is a deficit of £10.51m compared to a planned surplus of £2.73m, so a £13.24m off plan in-month.

The ICS is reporting a year-to-date deficit of £75.66m, compared to a planned year-to-date deficit of £26.43m, so a £49.23m off plan year-to-date.

The ICS submitted a £0.468m surplus plan for 2025/26, and forecast outturn is unchanged, in line with the plan.

Workforce Insights

- Total Workforce: 47,998 WTE, which is 789 WTE worse than nationally submitted plan. Compared to November 2025, the system saw a decrease of 211 WTE.
- Trusts better than plan: HIOWH (134 WTE).
- Trusts worse than plan: HHFT (151 WTE), IOW (105 WTE), PHU (294 WTE), SCAS (141 WTE), UHS (232 WTE).
- Substantive: 590 WTE worse than plan.
- Bank: 200 WTE worse than plan.
- Agency: 1 WTE better than plan.

- Compared to March 2025 baselines in submitted Planning templates:
    - Total Workforce: Reduced by 1,295 WTE.
    - Substantive: Reduced by 940 WTE.
    - Bank: Reduced by 260 WTE.
    - Agency: Reduced by 95 WTE.
    - The ICB continues to work with providers to monitor their agreed workforce plans to reduce workforce costs, and working with our Regional People leads to support future transition.
    - All providers except SCAS have submitted revised WF recovery action plans, and further due diligence has been discussed to ascertain levels of confidence of delivery, further work that could be undertaken and regional support.
    - UHS, PHU, IOW & HHFT all forecast a M12 position that is worse than 25/26 submitted plans.
    - Further monitoring and assurance are being decided between the ICB and Regional People teams.
    - Workforce performance and assurance will become NHS England's responsibility from 1 April 2026.

- HIOW ICB are working closely with NHS SE Regional team during this transitional period to form handover plans.

Frimley and BOB Integrated Care System:
Frimley ICB & System

- The Frimley system is slightly better than plan year-to-date, with a forecast outturn of breakeven.
- Cost pressures continue in S117 packages, ADHD Right to Choose referrals, and independent sector activity, though remedial action plans are in place to mitigate these pressures.
- Underspends in areas such as CHC and non-recurrent benefits are supporting the position.
- Receipt of Quarter 4 Deficit Support Funding remains dependent on demonstrating delivery against an agreed credible plan; the forecast assumes full receipt.
- FHFT remains broadly on plan with some industrial-action-related cost pressures, supported by a route map to breakeven.

BOB ICB & System

- The BOB system is also slightly better than plan, with a breakeven forecast.
- Elective activity is overperforming, partially offset by underperformance in other acute areas and ophthalmology activity in the independent sector.
- Community budgets face pressures from equipment costs following a national provider change, and Mental Health continues to see pressure in S117 and ADHD Right to Choose activity.
- System-wide mitigations include underspends, prior-year benefit releases, favourable dispute resolutions, and vacancy underspends.
- The system reports a £24.2m YTD deficit, which is £0.1m favourable to plan.

Performance Overview

- Performance reporting for BOB and Frimley has been aligned and combined following Joint Committee feedback.
- Differential RTT targets reflect differences in baselines and required percentage improvements for each ICB.
- Primary Care targets have been removed due to the absence of national appointment-based metrics; future national emphasis will be on patient satisfaction.
- Published data constraints mean performance data typically lags by around six weeks, limiting real-time benchmarking.
- A new task and finish group will now develop the Thames Valley Report for 2026/27, aiming for automated reporting and improved cross-system data access.

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

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

Financial Validation	N/A
Recommendation(s)	
It is recommended that the Board: Notes the detail of this report and escalations for awareness and management of these.	

For Assurance	✓	For decision		For discussion		To note	✓

Trust Board of Directors Meeting in Public 5 February 2026

Title	Communications, Marketing and Engagement Update
Report Author	Gillian Hodgetts Director of Communications, Marketing and Engagement
Executive Owner	Gillian Hodgetts Director of Communications, Marketing and Engagement
Agenda Item	**20**
Governance Pathway: Previous	N/A
Governance Pathway Next Steps	N/A

1. Purpose and summary

The purpose of this information paper is to update the Board on activities undertaken by the Communications, Marketing and Engagement team and where appropriate to highlight any challenges, special achievements or matters worthy of public interest.

This month's paper covers:

- Communications team support for SCAS Charity
- Governor Election update
- Media update – BBC NHS Day

The Board is asked to note the paper for information.

2. Link to Strategic Theme

The communications team continues to be actively involved in supporting programmes across all five of the strategic themes and in promoting wider recognition and understanding of the strategic themes themselves.

3. Link to Board Assurance Framework Risk(s)

This report does not link to specific BAF risks, though elements of the communications team's work highlighted are relevant to:

- SR22 – Staff Engagement
- SR25 – Collaboration

4. Quality/Equality Impact Assessment

This report is for information only, so no Quality/Equality Impact Assessment is required.

5. Communications Team Support for SCAS Charity

Development of SCAS Charity Communications & Engagement

We have been working with the charity to produce a communications and engagement plan to support the objectives of the overall charity strategy, which is currently in development.

The communications and engagement plan covers objectives, key messages, core channels, roles and responsibilities, audiences, and risks and mitigations. It includes an action and campaign plan covering the period up to April 2027.

The communications and engagement objectives are to:

1. Support the Charity increasing its revenue through public contributions and corporate partnerships (from £500k to £1M over 5 years)
2. Boost the recruitment of volunteers, supporters and fundraisers
3. Achieve greater exposure for the Charity through targeted communications; patient/volunteer stories; volunteer reward and recognition and fundraising success. Incorporating charity messages in wider SCAS communications
4. Raise the profile of the charity within SCAS, and identify and promote Health and Wellbeing projects and other initiatives supported by the Charity
5. Support work in the community to engage the public in supporting the ambulance service; learning CPR and defibrillator awareness training as well as encouraging people to get involved with the Charity
6. Produce messaging and materials to support corporate engagement and maximise fundraising opportunities from corporate partnerships

A draft of the plan has been shared with the Charitable Funds Committee for their comment and input.

February 2026 Charity Campaign

We have worked with the charity to develop a range of communications throughout February to support key objectives of:

- Recruiting more volunteers
- Highlighting and recognising the work done by volunteers
- Increasing the profile of the SCAS Charity
- Fundraising for the SCAS Charity

The areas covered include:

- Volunteers – celebrating the work of our volunteers, recruitment of volunteer car drivers and charity support volunteers.
- CPR and Defibrillator training for communities and corporate entities.
- 'Out Run an Ambulance' promotion.
- London Marathon runners who are supporting the charity – publicity and donation requests.

We are working with volunteers to develop content for media releases, social media assets and case studies. The campaign will be delivered using local media, SCAS social media channels, and the SCAS and charity website.

Collaboration on Public Engagement

The charity has successfully secured funding through a Community Resilience Grant aimed at reducing health inequalities in out-of-hospital cardiac arrest (OHCA).

We are working in collaboration with the charity to deliver free community Basic Life Support (BLS) training sessions. These sessions are targeted at communities experiencing health inequalities, including youth groups, and focus on areas with a high demand for emergency services and higher levels of deprivation. Locations include Portsmouth, Southampton, Gosport, Havant, Milton Keynes, and Oxford, with sessions delivered by our CFRs.

We are engaging across a range of local and system partners to identify priority communities, build sustainable relationships, and develop collaborative approaches to deliver sessions effectively within targeted areas.

The engagement programme aims to:

- Educate and empower communities in Basic Life Support skills
- Improve understanding of how to respond in an emergency
- Increase awareness of when to call 999 or 111
- Gather feedback on equity of access to SCAS services to inform future service development and address inequalities

This programme supports SCAS's wider objectives around prevention, community resilience, and reducing health inequalities, while strengthening relationships with communities most at risk.

Engagement activity and outcomes will be reported to the Board at a later stage as delivery and evaluation progress.

6. Governor Elections update

Governor Elections Campaign 2025–2026

Purpose
To provide the Board with assurance on the communications and engagement activity supporting the Governor Elections Campaign 2025–2026.

Overview
The Communications Team is delivering a comprehensive and inclusive communications and engagement plan to support the nomination and election of governors across staff, public and Community First Responder (CFR) constituencies. The campaign is designed to raise awareness of the elections, encourage nominations and maximize participation in the ballot through coordinated internal and external communications.
There is a total of eleven governor vacancies across the Trust. These include two staff governor vacancies, one CFR governor vacancy and eight public governor vacancies covering Berkshire, Hampshire, Oxfordshire and the Rest of England and Wales. All vacancies are contested with the exception of the NHS 111 staff governor vacancy, which received a single nomination.

Key Message
The central campaign message is: *Make a difference to your ambulance service: become a governor.* Nominations opened on 9 December and closed on 8 January, with voting taking place from 30 January to 24 February.

Delivery Approach
The campaign is being delivered through a range of internal and external channels to ensure broad reach and accessibility. This includes dedicated elections pages on the Trust intranet and external website, a coordinated social media campaign, digital and printed promotional materials, video messages from the Chair, Lead Governor and existing governors, and regular updates through staff and membership bulletins. Media releases and stakeholder communications are also being used to support awareness and engagement.

Risks and Mitigation
A key risk identified was the decision not to hold aspiring governor workshops, which could have reduced interest in nominations. This has been mitigated through the provision of comprehensive and accessible information online and on the Hub, outlining the governor role, time commitment and expectations. A further risk related to staff and public members not registering for Foundation Trust membership in time to nominate or vote. This has been addressed through clear and repeated messaging throughout the awareness and

nomination phase of the campaign.

Outcomes to Date
The campaign has achieved strong nomination levels across constituencies, with all public and CFR vacancies contested and the corporate staff vacancy attracting four nominations. The NHS 111 staff vacancy remains uncontested with one nomination. Overall, this reflects effective engagement and promotion of the elections.

Key Milestones Ahead
Voting packs were issued on 30 January, with a reminder email scheduled from CES on 17 February. The elections will close on 24 February, with results declared on 25 February.

Assurance
The Governor Elections Campaign is progressing as planned and is delivering strong engagement outcomes. Continued communications activity will focus on encouraging high voter turnout and maintaining clear, consistent and inclusive messaging through to the close of the elections.

7. BBC NHS Day

On Thursday, 22 January, BBC News ran its annual NHS Day where stories from across the NHS were shared on the national, regional and local news networks.

We had a number of requests from our local BBC stations in relation to this and would like to thank Chrissy Ames, one of our specialist practitioners in Oxfordshire, Niamh Young, an emergency call taker and coach based at Otterbourne, and Kim Honeyman, an emergency care assistant from North Harbour, who represented SCAS this year. Consent was obtained from all those patients and staff featured during the day of coverage.

Chrissy had BBC reporter, Martin shadowing her whilst on a 06-16.00 shift last week, with their experiences being shown across local BBC TV, radio and digital media channels. Chrissy is one of our specialist practitioners and she was able to show the BBC how they assess, treat and/or refer patients who've called 999 and help them to access the right care and treatment. This often means without the patient having to go to the emergency department for assessment first. Specialist practitioners are also able to use their enhanced clinical skills to treat more patients at home with procedures such as the suturing of wounds.

Niamh, our Emergency call taker and coach, based in our Otterbourne call centre, talked live on the BBC Radio Solent Breakfast Show giving an insight to the importance of their role and reflecting on one of her most memorable calls.

Kim, one of our emergency care assistants, talked live on the same station’s DriveTime show in the evening, along with Fareham resident, Rob Keating. Rob survived a cardiac arrest thanks to the efforts of Kim and her colleagues, Jasmine Hitchins, Toni Robinson and Donna McKee-Parker. Rob and his wife were able to thank all the team that

responded personally, when they reunited with the crew involved at the local ambulance station.

A huge thank you to Chrissy, Niamh and Kim, along with Mike Lowe, Nicky Booton and James Frampton for supporting the communications team in making the arrangements.

8. Recommendations

The Board is asked to receive the paper for noting.

For Assurance		For decision		For discussion		To note	x

NHS
South Central Ambulance Service
NHS Foundation Trust

Trust Board of Directors Meeting in Public 5 February 2026

Title	**Recovery Support Programme Exit Confirmation**
Report Author	**Becky Murray, Chief Governance Officer**
Executive Owner	**Becky Murray, Chief Governance Officer**
Agenda Item	21
Governance Pathway: Previous	None
Governance Pathway Next Steps	Trust Board

1. Purpose

To present the letter from NHS England formally confirming the Trust's exit from the Recovery Support Programme (RSP).

2. Executive Summary

Following a recommendation made to the NHSE Executive Performance, Quality and Delivery Group by the NHSE South East regional team, the Trust has received formal confirmation of its exit from the RSP.

Whilst this is a milestone and the letter encourages the Executive Team and Board to take time to reflect and acknowledge the progress that has been made and the contribution this has made to the system overall in terms of the financial position, planning and workforce controls, the letter is equally clear, as is the board that further improvement is required.

The improvement work that is required already forms part of our Fit For the Future programme and we will continue to use the framework as our mechanism for reporting our progress to the Board and to the NHSE regional team.

Areas of Risk

There are no specific risks associated with this letter. The risk lies in failing to continue with our improvement journey and the delivery of quality, operational and financial performance. This is mitigated by diligent monitoring, action and oversight.

3. Link to Strategic Theme

The letter links to all of our strategic themes as these form the basis of the Fit for the Future Improvement Programme.

4. Link to Board Assurance Framework Risk(s)

The presentation links to all Board Assurance Framework risks.

5. Quality/Equality Impact Assessment

No QIA/EIA is required.

7. Recommendations

EMC is asked to NOTE the content of the letter and the proposed next steps.

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

To:

David Eltringham, Chief Executive Officer

Professor Sir Keith Willett, Chair

South Central Ambulance Service NHS Foundation Trust

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

14 January 2026

Dear David and Keith,

Formal notice of South Central Ambulance Service NHS Foundation Trust's exit from the Recovery Support Programme (RSP)

As you will be aware, a paper was considered at NHS England's Executive Performance, Quality and Delivery Group (EPQDG) on Thursday 27 November 2025 to recommend that South Central Ambulance Service NHS Foundation Trust should transition out of the Recovery Support Programme, having demonstrated sufficient progress against RSP exit criteria for finance. This decision follows acknowledgement at EPQDG on Thursday 30 October 2025 that South Central Ambulance Service NHS Foundation Trust have demonstrated sufficient progress against RSP exit criteria for leadership and governance.

We are pleased to confirm that EPQDG has approved this recommendation. Please accept this letter as formal notification that South Central Ambulance Service NHS Foundation Trust will now exit the RSP.

Thank you for all the hard work that you and your teams have contributed to achieve this. As a System, you have achieved a marked reduction in the System's financial deficit. With the exception of two trusts, HIOW has been materially on plan year to date. You have made progress in the whole system approach to planning, finance and workforce controls, and the shared leadership and governance arrangements for transformation programmes.

There are also some significant areas of whole system working and transformation yet to impact at the scale and pace needed, particularly in relation to out of hospital

transformation and your shared priorities for local care and discharge. You have taken some important steps including planned transformation of frailty and CVD-Respiratory pathways with implementation now underway, and the refreshed approach to discharge improvement. However, the impact of these initiatives after two years in Recovery Support is still to be seen. HIOW remains a high national outlier in avoidable emergency admissions and discharge delays and this continues to impact on patient experience, outcomes and financial cost.

More progress on these priority areas remains a top priority for the System and for your Board in terms of your Trust's contribution to achieving this. We have not yet exited all organisations in the System from RSP and continued progress on shared system recovery priorities is also important to ensure the trusts still in RSP have the necessary conditions in place in their locality to also be able to exit as soon as practicable.

Thank you for all the hard work that you and your teams have contributed to improve the quality of care for the people of Berkshire, Buckinghamshire, Hampshire and Oxfordshire in a sustainable way. You have made promising strides towards tackling the complex challenges that led to the decision to support your trust via the RSP, and while there is much more to do to continue improving services for your patients, I hope you will feel able to take a moment to acknowledge the improvement you have already achieved.

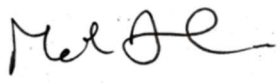
It is important to acknowledge that significant challenges still remain. As part of an agreed transition package, regional colleagues will continue to work with you to ensure you are able to build on the progress you have made during your time in RSP, with key priorities as you transition being sustaining improvements made in leadership and governance, and continuing your financial recovery, with ongoing financial oversight. Key areas of focus include moving the Trust's approach from transactional to strategic, ensuring cohesion at executive level and ongoing improvement on the culture of the organisation. As part of the transition process, we are therefore recommending that NHSE continue with close monitoring and oversight, which we will reassess on an ongoing basis. However, it is important to note that accountability for performance and improvement, including delivery and impact of the Integrated Improvement Plan (IIP),

lies clearly with the Board which is now further supported through the new governance framework in the Trust. In addition, we ask that the Board continues to support the strategic alignment with SECAmb, with the Transition Board overseeing the progress on collaboration.

Please be aware that following the publication of the VSM pay framework we are still working with DHSC and Ministers on the application of, or withholding of, the 2025/26 pay award to organisations who were in RSP as of 1st April 2025. Colleagues will be in touch to advise on next steps in due course.

The enforcement undertakings the Board agreed with NHS England to deliver system financial recovery remain in place at this stage. NHS England will review progress against these in Q1 with the aim of issuing a compliance certificate, subject to the Trust delivering its agreed financial plan for the full year. The regional team will work you on this. In addition, the well led enforcement undertakings currently agreed with the Trust were refreshed a year ago, but we will look to review these in the New Year and assess whether compliance certificates can now be raised. We would be grateful if you could respond to confirming the Board has considered this letter and has assured itself the necessary actions are in hand by 30 January. Please contact us if you wish to discuss the above or any related issues in more detail.

Kind regards,



Mark Brassington
Director of Operational Improvement and Recovery Support Programme
NHS England

Anne Eden
South East Regional Director
NHS England

Copy:

Glen Burley, Financial Reset Director and Accountability Director, NHSE

Sarah Jane Marsh, Urgent and Emergency Care and Operations Director, NHSE

Elizabeth O'Mahoney, Chief Financial Officer, NHSE

Sally Herne, Improvement Director, National Recovery Support Team, NHSE

Maggie MacIsaac, Chief Executive Officer, Hampshire and Isle of Wight Integrated Care Board

Lena Samuels, Chair, Hampshire and Isle of Wight Integrated Care Board

Jackie Huddleston, System Coordination Director, SE NHSE

NHS
South Central Ambulance Service
NHS Foundation Trust

Trust Board of Directors Meeting in Public 5 February 2026

Title	Core service reports and core service CQC action templates for regulatory breaches
Report Author	Mark Ainsworth Executive Director of Operations Duncan Robertson, Chief Paramedic Jane Campbell, Assistant Director of Quality Guy Alexander, Compliance and Quality Lead
Executive Owner	Helen Young, Chief Nurse
Agenda Item	22
Governance Pathway: Previous	EMC 20 January 2026
Governance Pathway Next Steps	n/a

1. Purpose

The purpose of this report is to present the published core service reports (Emergency Operations Centre and Emergency & Urgent Care) from CQC. It also includes the final versions of the action templates for the regulatory breaches identified in the E&UC core service review for approval to submit to the CQC.

2. Executive Summary

CQC have published the reports for the core service assessments in EOC and E&UC completed in May 2025.

2.1 The Matrix below shows the improvement in ratings for both core services.

	Safe	Effective	Caring	Responsive	Well led
EOC	Good ↑ 2022	Good	Good	Good ↑ 2022	RI ↔ 2022
E&UC	RI ↑ 2022	Good ↑ 2022	Good	Good ↑ 2022	RI ↑ 2022

2.2 Improvements and positive practice in the report for E&UC include

Strengthened Safeguarding and Safety - Improvements in safeguarding and duty of candour ensure patients are protected and safety is assured. There are now established safe systems of care in which safety was monitored and assured.

Positive Cultural Shift - The trust shows a culture of continuous improvement and alignment with national standards.

Kindness and Empathy - Consistently show kindness and empathy, ensuring patients feel valued and supported during care.

Privacy and Dignity - Staff maintain patient privacy and dignity throughout care transitions, fostering trust and comfort.

Collaborative Partnerships - Strong collaboration with healthcare partners and emergency services improves patient outcomes and operational efficiency.

Robust Infection Control Measures - Ambulance stations and vehicles maintain visible cleanliness with routine and deep cleaning schedules supported by dedicated teams

2.3 Improvements and positive practice in the report for EOC include

High Training Completion - Mandatory training completion rates with most modules exceeding the benchmark, ensuring staff competency.

Incident Reporting and Duty of Candour - Robust frameworks aligned with NHS standards addressed breaches, promoting transparent incident reporting and accountability.

Proactive Safety Culture - A culture of openness, accountability, and continuous improvement underpins patient safety and staff participation in investigations.

Improved Safeguarding Practices - Staff demonstrate clear understanding of safeguarding roles

Strategic Oversight and Accountability - Board oversight improved and service no longer in breach of this regulation.

Effective Risk Management Tools - Triage systems and special notes, including advanced care plans, manage patient risks and location-specific alerts effectively.

2.4 Regulatory Breaches

Following the core service inspections in E&UC three regulatory breaches were identified.

Regulation 1
How the regulation was not being met:
Continued concerns regarding the storage and oversight of medicine management
Regulation 17
How the regulation was not being met:
There was a lack of understanding regarding governance and risk management, with roles and responsibilities unclear.
Regulation 18
How the regulation was not being met:

There was a lack of clinical oversight to ensure staff were supported and had effective development, to consistently deliver safe care and treatment to patients.

CQC provides templates for actions which have been completed, and approval is sought from this committee for them to be submitted to CQC.

The final submission deadline is 6 February 2026.

3. Areas of Risk

Risk that the actions when completed do not ensure compliance with regulations.

4. Link to Strategic Theme

Clinical Effectiveness

5. Link to Board Assurance Framework Risk(s)

SR14 - Quality Performance

6. Quality/Equality Impact Assessment

N/A

7. Recommendations

- The Board is asked to note the core service reports and approve the action templates for submission to CQC.

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

2008, its associated regulations, or any other relevant legislation.

Please see the covering letter for the date by when you must send your report to us and where to send it. **Failure to send a report may lead to enforcement action.**

Account number	RYE
Our reference	AP15703
Location name	South Central Ambulance Service NHS Foundation Trust
Assessment Service Group	Emergency and Urgent Care

Regulated activities	Regulation
South Central Ambulance Service NHS Foundation Trust - Provider - RA5	**Regulation 12** Regulations for service providers and managers - Care Quality Commission (cqc.org.uk)
	How the regulation was not being met:
	Continued concerns regarding the storage and oversight of medicine management

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

The Trust has implemented a comprehensive medicines improvement programme (as a result of the Pharmacy fit for the future strategic plan) to ensure full compliance with statutory and regulatory requirements, including the Home Office Controlled Drugs Licence, RPS Safe and Secure Handling of Medicines Standards, MHRA expectations and CQC Regulation 12 (Safe Care and Treatment). The following actions are being taken to meet these requirements and strengthen medicines governance, safety, and operational resilience.

Controlled Drugs (CD) Compliance and Governance

Actions:

- Implementing the **Personal Issue of Controlled Drugs (PICD)** model to align with Home Office Controlled Drugs Licence requirements and strengthen individual accountability for CD possession and use.
- Reinforcing interim CD processes to ensure all current procedures are followed consistently across the Trust.
- Maintaining the **Vehicle Off Road (VOR)** process to reduce the risk of any vehicle being deployed without CDs or alternative analgesia available to maintain optimal patient care.
- Oversight of CD use through improved reporting, monitoring, and governance via the Medicines Optimisation and Governance Group.
- Completion of an annual analgesia audit to provide assurance on pain management across the Trust.

What we intend to achieve

- Compliance with Home Office CD licensing requirements.

- Improved CD security, traceability, and accountability.
- Reduced the risk of CD discrepancies, risk of diversion, or unsafe practice.
- Assurance that all operational vehicles carry appropriate analgesia to support optimal patient care.
- Oversight of analgesia management through annual audit cycles, enabling early identification of risks, variation, or gaps.

Safe and Secure Handling of Medicines (SSHM)
Actions:

- Completed a Trust-wide assessment of medicines storage facilities and identifying all estate and cabinetry requirements.
- Developing a multi-year business case to deliver the required SSHM improvements.
- Compliance with current storage and stock-checking processes.

What we intend to achieve

- Full compliance with Royal Pharmaceutical Society Safe and Secure Handling of Medicines Standards, MHRA medicines storage requirements, and Home Office CD licence conditions.
- Standardised, secure, and compliant medicines storage across all resource centres.
- Reduced risk of temperature excursions, stock loss, or unauthorised access.
- Improved assurance to regulators and the Trust Board.

Digital Medicines Assurance and Track & Trace
Actions:

- Developing a business case for a digital medicines Track & Trace system to provide real-time visibility of medicines movement, stock levels, and expiry date management.
- Planning integration with existing digital systems to reduce manual processes and improve data accuracy.
- Reinforcing current manual stock-checking and replenishment processes to ensure continuity until digital solutions are implemented.

What we intend to achieve

- An auditable, real-time digital record of medicines in circulation.
- Reduced administrative burden on operational managers and improved stock availability.
- Earlier identification of shortages and improved replenishment accuracy.
- Strengthened governance and assurance for controlled drugs and high-risk medicines.

Medicines Supply, Packing, and Operational Resilience
Actions:

- Recruitment to the Pharmacy packing unit to stabilise the workforce and increase production capacity.
- Implementing interim measures, including redeployed staff and volunteer drivers, to maintain continuity of medicines supply.
- Increasing output from the packing unit through improved processes and oversight.
- Strengthening monitoring of medicines production, quality, and distribution.

What we intend to achieve

- A resilient, reliable medicines supply chain that meets operational demand.
- Reduced risk of stockouts, delays, or incomplete medicines bags.
- Improved quality assurance and consistency of medicines supplied to frontline services.
- A sustainable workforce model that supports long-term operational delivery.

Overall Intended Outcome

Through these actions, the Trust will achieve:

- Full compliance with all relevant medicines legislation and regulatory standards.
- Improved safety, security, and governance of medicines across the organisation.
- Reliable and efficient medicines supply to frontline services.
- Enhanced assurance to the Home Office, MHRA, CQC, and the Trust Board that medicines are managed safely and effectively.
- Ongoing oversight of analgesia management, ensuring safe, effective, and compliant analgesia provision across all operational services.

Who is responsible for the action?	**Chief Pharmacist**

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

- Through reports to the Medicines Optimisation and Governance Group chaired by the Chief Paramedic.
- Via the trust reporting system to highlight potential medicines supply issues and where morphine is found to be unavailable to a clinician.
- Through delivery of the full Medicines Improvement Programme

Who is responsible?	**Chief Paramedic Officer**

What resources (if any) are needed to implement the change(s) and are these resources available?

Some actions will require financial resources following the submission of business cases.

Date actions will be completed:	**By the end of Q4 2025/206**

How will people who use the service(s) be affected by you not meeting this regulation until this date?

There is a risk that a patient would not be given optimal clinical care if medicines were not available for clinicians to administer. Improving the structures in place for a robust medicines supply chain, secure station storage and adherence to regulatory frameworks will ensure that patients are provided the necessary care and reduce the need for mitigations.

Completed by: (please print name(s) in full)	**Duncan Robertson**
Position(s):	**Chief Paramedic**
Date:	

Regulated activities	**Regulation**
South Central Ambulance Service NHS Foundation Trust – Provider – RA5	**Regulation 17** Regulations for service providers and managers – Care Quality Commission (cqc.org.uk)
	How the regulation was not being met:
	There was a lack of understanding regarding governance and risk management, with roles and responsibilities unclear.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

- Provide seminar session for senior staff to show how divisional governance systems and processes link with corporate governance structures.
- The Head of Risk attends the monthly Operations group meeting to review the board assurance framework and the highest divisional risks within Emergency and Urgent Care (E&UC).
- E&UC Clinical Governance and Integrated Contact Centre (ICC) Clinical Governance groups meet monthly. These are attended by their respective leadership teams. Risks, mitigations and scoring are reviewed at these meetings as a standing agenda item. This includes the ability of the membership to raise new risks.
- All managers have a link to their risk register. Risks are discussed at local area meetings to ensure any issue raised can be escalated onto the appropriate risk register as required.
- Briefing session held January 2026 with Team Leaders regarding the corporate risk system. This was to refresh knowledge and allow for discussion.
- In Q4 briefing sessions for TLs and Senior operational managers to explain the structures and flow through from local to corporate level governance and risk.
- We are developing “issue” logs to compliment the risk registers. It is vital that known issues are captured to allow reporting through the relevant governance groups and upwardly through the Performance and Accountability Framework.
- During 2025 we have implemented a Performance and Accountability process where the Assistant Directors of EU&C Operations and Director of ICC, meet with the executive team to review performance across their portfolio. Part of this review includes the ability

to escalate any risks where there is a requirement for additional support for mitigation and to ensure accountable executives are sighted on these.

- We have consulted on new leadership structures across E&UC Operations and ICC which will be implemented during Q4 2025/26. These new structures have clearer lines of accountability at sector level and functional level. The new structures include a new Clinical lead role in each sector. As part of this role, they will lead on any clinical risks, and the operational manager will lead on operational risks.

What we intent to achieve
Staff able to articulate risk and governance processes
New structure with clearer lines of accountability

Who is responsible for the action?	**Executive Director of Operations**

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?

- Chairs of relevant groups ensure that risk and governance are standing agenda items of the E&UC Operations Group and Clinical Governance meetings.
- Risk scores and mitigations are reviewed at every monthly meeting within each department (E&UC Operations, ICC, Planning & Forecasting).
- The board assurance framework is reviewed monthly, to update on mitigations and actions by an Executive owner.
- In April 2026 operations board a deep dive will be presented to ensure that meeting agendas, discussions and meeting structures are correct to structure.

Who is responsible?	**Executive Director of Operations**

What resources (if any) are needed to implement the change(s) and are these resources available?

- No additional resources are required

Date actions will be completed:	**May 2026**

How will people who use the service(s) be affected by you not meeting this regulation until this date?

Impact on service users would be that risks will potentially not be escalated and reviewed appropriately within the correct group or forum to allow assessment, mitigation, resolution and learning.
Unclear roles and accountability could lead to poor risk management and response that could affect patient safety.

Completed by: (please print name(s) in full)	**Mark Ainsworth**
Position(s):	**Executive Director of Operations**
Date:	

Regulated activities	Regulation
South Central Ambulance Service NHS Foundation Trust - Provider - RA5	**Regulation 18** Regulations for service providers and managers - Care Quality Commission (cqc.org.uk)
	How the regulation was not being met:
	There was a lack of clinical oversight to ensure staff were supported and had effective development, to consistently deliver safe care and treatment to patients.

Please describe clearly the action you are going to take to meet the regulation and what you intend to achieve

- Our staff work in teams with an allocated team leader (TL) and clinical team educator (CTE) who work alongside their team members and will identify any additional development, education or support that any of their team members require.
- Each team has allocated 'Team Time' within their rota where the TL and CTE can provide support for the team on any areas identified by the team. The Team Time can include subject matter experts to deliver focussed sessions for the team.
- CTE audits of EPR for completion and treatment and care
- We have implemented PSIRF and through the daily safety reviews we can identify any areas where there has been suboptimal treatment or care, or a care pathway not delivered. This process includes SWARM huddles for learning, as well as escalation of actions to avoid any repeat or patient harm. Learning is shared.
- The Chief Paramedic has executive level oversight of clinical practice and works closely with the education department.
- The Chief Paramedic is developing proposals for a formal structured clinical supervision programme with a scoping document to be presented to EMC committee.
- A task and finish group has been devised and will agree a terms of reference and work plan.
- The Trust has been focussing on improving both PDR compliance and quality to accurately identify staff development needs. There has also been a drive on statutory and mandatory training to ensure staff are compliant and have received the most recent clinical practice updates.
- During Q3 of 25/26 we consulted on a new operational structure that includes an additional Clinical Operations Manager role within each operational sector. These are additional roles and will allow us to have 2 band 8A managers in each sector, one dedicated to operational performance and delivery, and the other focussed on clinical performance and governance.
- The trust's IPR includes the Ambulance Quality indicators and progress against improving these is monitored at each trust board meeting.

Who is responsible for the action?	**Chief Paramedic** **Executive Director of Operations**

How are you going to ensure that the improvements have been made and are sustainable? What measures are going to put in place to check this?	
• PDR and statutory and mandatory compliance are monitored monthly through Divisional Clinical Governance meeting and assurance sort at the Performance Accountability Meetings with executive team. Improvement actions are issued where areas are identified as being off target. • A more robust clinical supervision process will enhance support to our staff and provide assurance on the level of care being delivered by our staff - Measures will be confirmed when model agreed. • Proactive use of ACQI data as a care quality metric to inform PDRs and allow support to be tailored. • New structure – clinical operational roles recruitment monitoring	
Who is responsible?	**Executive Director of Operations and Chief Paramedic**
What resources (if any) are needed to implement the change(s) and are these resources available?	
Resources to deliver a trust model of clinical supervision are currently being assessed and consulted. Following an assessment of resources required a quality impact assessment will be undertaken with stakeholders and subsequently a business case will be created and presented.	
Date actions will be completed:	**Q3 2026/27**

How will people who use the service(s) be affected by you not meeting this regulation until this date?
If we do not deliver the ongoing staff development support including the implementation of clinical supervision, then the Trust will not be able to provide full assurance on the quality of care being delivered to patients.

Completed by: (please print name(s) in full)	**Mark Ainsworth**
Position(s):	**Executive Director of Operations** **Chief Paramedic**
Date:	

Care Quality Commission
South Central Ambulance Service NHS Foundation Trust - Emergency and urgent care

Overview

Overall Rating: Requires Improvement

The service is not performing as well as it should and we have told the service how it must improve.

Summary

Safe	Requires Improvement
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Overall Service Commentary

Date of assessment: 07 May – 08 May 2025

We carried out this assessment to assess if improvements had been made since the last inspection in April 2022 when the emergency and urgent care service was rated as inadequate. We assessed 32 quality statements across the safe, effective, caring, responsive and well-led key questions. We found the quality of care had improved however there were still areas where improvement was needed.

At the last inspection there were trust-wide breaches of regulation in relation to:-

Safe care and treatment, safeguarding, governance, staffing and duty of candour.

In addition, at the emergency urgent care service level there were actions the service should consider improving before they became a breach in regulation. These included the storage of medicines, shortfalls in infection, prevention and control, skill mix of ambulance crews, the completion of adverse incidents, clinical support and supervision of newly qualified staff.

At this assessment, trust-wide improvements were found, and the emergency and urgent care service was no longer in breach of safeguarding and duty of candour.

However, the emergency and urgent care service was still in breach of 3 regulations in relation to safe care and treatment, governance and staffing.

At this assessment, we found that the emergency and urgent care service was still needing to embed a positive learning safety culture based on openness and honesty, where events were investigated, and learning was shared to promote good practice and continuous improvement. Staff still did not always receive effective support, supervision and development. Clinical oversight within the service was not consistently assured.There were continued concerns regarding the storage and oversight of medicine management. This posed a risk to patient safety and compromised the quality of care. Due to high demand and operational pressures, patients did not always have access to care and treatment when they needed it. Measures to ensure equity in experience and outcome were yet to be delivered and there were gaps in end-of-life oversight in the service. We found there was still a disconnect between frontline staff and senior leaders and staff did not always feel respected, supported and valued. There was an improving culture but in some parts of the service, morale continued to be low. There was a lack of understanding regarding the structures or processes to ensure effective clinical governance, supervision, and accountability across the service. Roles and responsibilities were not always clear, and governance processes were not always understood including risk management.

However, there were now established safe systems of care in which safety was monitored and assured. Staff assessed risks to patients, acted on them and kept good care records. Staff had effective and embedded understanding in how to protect patients from abuse. The environment was safe and well maintained, equipment, facilities and technology supported the delivery of safe care. The service had improved standards of infection prevention and control and there were enough qualified, skilled and experienced people who worked together effectively, to provide safe care. We found the service planned and delivered people’s care and treatment in line with legislation and current evidence-based good practice and standards. The service worked effectively across teams and services to support people. Electronic systems were used successfully to share patients’ assessment of needs when they moved between different services. People’s care and treatment were routinely monitored to continuously improve it. Outcomes were mainly positive and consistent and mostly met both clinical expectations and the expectations of people themselves. We found the service treated people with kindness, empathy and compassion. Their privacy and dignity were respected. People’s needs were listened to and staff responded to minimise any discomfort, concern or distress. The service cared about and promoted the wellbeing of staff. We found the service made sure people were at the centre of their care and treatment choices and decided, in partnership with them, how to respond to any relevant changes in their needs. The service provided appropriate, accurate and up-to-date information in formats tailored to individual needs. The service had systems and processes in place to make sure everyone could access the care, support and treatment they needed when they needed it. Staff were proud to work at the service. The service

collaborated and worked in partnership with the wider health and social care services to support care provision, service development and joined-up care in their local area, and for the wider healthcare community.

We have asked the provider for an action plan in response to the concerns found at this assessment.

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Overall People's Experience

People who used the service told us they were treated with kindness, empathy and compassion. They spoke positively about staff and said they were listened to and communicated with in ways which suited their needs. Patients commented on staff being calm and supportive, and how they explained what was happening and what was going to happen in a way they could understand. People were put at ease by staff at a time when they were feeling vulnerable and scared.

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Safe

Rating: Requires Improvement

Percentage Score: 62.00 %

► **How do we score this?**

Summary

This service is not always safe

Commentary

We looked for evidence that safety was a priority for everyone, and leaders embedded a culture of openness and collaboration. We checked that people were safe and protected from bullying, harassment, avoidable harm, neglect, abuse and discrimination. We also checked people's liberty was protected where this was in their best interests and in line with legislation.

We assessed all 8 quality statements from this key question.

At the last inspection we rated this key question inadequate.

At this inspection the rating has improved to requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was a risk that people could be harmed.

We found 2 breaches of regulations in the key question, in relation to safe care and treatment, there was a lack of an appropriate and effective system to ensure oversight of controlled drugs, and in relation to staffing, there was a lack of clinical oversight to ensure staff were supported and had effective development, to consistently deliver safe care and treatment to patients.

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Safe

Learning culture

Overall Score

1 2 **3** **4**

► How do we score this?

Summary

Requires Improvement – This service generally maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service had systems and processes in place to investigate and report safety events. However, there was a lack of oversight to ensure learning from safety events was implemented and good practice

embedded.

The service had processes to collect data from various sources, including performance and outcome data, and feedback from patients and staff. There were policies, procedures and meetings to interrogate and investigate data. The results were used to actively learn from findings and drive continuous improvement, and implement changes in practices to improve safety, care and outcomes for patients. For example, the thematic analysis on ambulance delays and the impact on patient outcomes, and changes needed to reduce delays.

Staff were encouraged to raise concerns and report incidents and near misses in line with trust policies. Staff told us they knew how to raise concerns and could give examples when they had. However, staff still said finding the time to report incidents whilst operating at high demand was challenging and gave us examples when they had not reported incidents. In addition, if they reported incidents they did not always get feedback.

Between April 2024 to March 2025 there had been 5365 incidents reported. 87% of incidents were rated as no harm, 11% rated as low harm (minimal harm – patient required extra observation or minor treatment), 0.7% rated as moderate harm (short term harm - patient required further treatment, or procedure), 0.6% rated as severe harm (permanent or long-term harm) and 0.3% deaths. The incidents were categorised to see if there were any themes or trends, the top 4 themes were, response time delays (40%), clinical care delivery issues (35%), behaviour and security (34%), medication-related incidents (10%) and non-attendance (5-7%). Incidents were reviewed and investigated according to the trust's policy and processes and action taken if required.

The trust had implemented the April 2024 NHS England's Patient Safety Incident Response Framework (PSIRF), which had changed how incidents were investigated and concentrated on the learning and improvement of patient safety.In the first year, the trust had successfully focused on the corporate oversight of the management of PSIRP to make sure systems were in place to effectively follow the framework. Further work was planned to have a devolved model, where the operational team would lead their incident responses and take on PSIRF responsibilities.

We found there was mixed understanding of PSIRF with operational staff, with some staff saying there had been no changes but others being able to explain the new process of how incidents were reviewed, categorised and investigated by either the patient safety team or by the local team. Senior operational staff felt more support and training was required as PSIRF was currently not embedded in the service. The trust had added 2 modules to the mandatory training of staff, patient safety level 1 and patient safety level 2, although this training was not PSIRF specific it gave staff an understanding of patient safety and aligned with PSIRF principles. As of March 2025, 97% of staff had completed level 1 training and 93% had completed level 2. However, not all operational staff involved in PSIRF investigations had received specific training on PSIRF.

Learning and improvement actions from incidents was shared with staff in various ways via clinical memos, SCAS learning snapshots, team meetings and the patient safety newsletter. It was acknowledged by managers that there was a reliance on staff to make sure these communications were read and changes in practice acted upon. There was no system in place to check communications had been read, understood or implemented by staff.

The service used complaint data to improve services. Between April 2024 and March 2025, there was a total of 137 formal complaints received. The main themes being clinical care (45%), staff attitude (26%) and care/handling towards patients and their property. In the same timeframe the patient experience team received 1291 patient experience cases for the emergency and urgent care service, the main themes being, delays in ambulance response (17%), inappropriate care pathway (14%), and behaviours of staff (13%).

The trust had processes and practices to ensure all complaints were reviewed, reported and responded to according to the trust's complaint policy. If a complaint was seen to be a patient safety concern, the complaint would be investigated via the patient safety team. Complaints not seen as a patient safety concern would be investigated by the patient experience team or at a local level by the operational teams.

Learning and improvement actions from complaints was dependent on the route it had been investigated and the resulting actions identified. For complaints investigated by the patient safety or patient experience teams, learnings would be shared in a similar way to learning from incidents and via a 'hot news' information sheet. Complaints investigated at a local level were usually dealt with by the team leader, and the emphasis was on the team leader to share any learnings with the rest of the service, if appropriate. Most team leaders felt they had the appropriate training to support conversations with their teams regarding complaints.

The trust had recently undertaken a quality improvement project on the way compliments were recorded and disseminated. Compliments were now recorded and reviewed in the same manner as complaints. This was seen as a way to highlight good care, share good practice, and to acknowledge when staff had performed well. Between April 2024 and March 2025, the service had received 1168 formal compliments.

Staff understood duty of candour and said they were open and transparent and gave patients and families a full explanation if and when things went wrong. We reviewed patient safety information and minutes from the safety review panel and patient experience meetings which showed duty of candour was now discussed and completed appropriately when required.

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Safe

Safe systems, pathways and transitions

Overall Score

1 2 3 4

► How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service worked with people and healthcare partners to establish and maintain safe systems of care, in which safety was managed or monitored. They made sure there was continuity of care, including when people moved between different services.

Ambulance crews explained they were briefed by call handlers before arriving to a patient and given information such as the age, patient's symptoms and the urgency of the situation to help them prepare and be able to provide efficient and effective care upon arrival.

On arrival, ambulance crews used established guidelines and their own clinical expertise to evaluate the patient and determine the necessary course of action, to ensure that each patient received the most suitable and timely care, leading to the best possible health outcomes. This process involved a structured assessment, clinical judgment and decision-making, and helped prioritise patients and direct them to the most appropriate level of care.

Staff had access to support and advice from other healthcare professionals to help manage patients safely. This included the South Central Ambulance Service (SCAS) urgent care or clinical support desks staffed by clinical staff, or phoning a patient's GP surgery. Crews said this mostly worked well but out of hours it could sometimes be hard to get immediate support.

Ambulance crews used clinical pathways for patients' onward care and treatment. Clinical pathways were available for ambulance crews on their handheld mobile device. SCAS had a dedicated team to help develop effective pathways with the local healthcare community to help alleviate pressures at hospital emergency departments and to make sure patients were receiving timely access to the appropriate care. These included same day emergency care (SDEC) units in hospitals and single point of access (SPOA) in the community, who could provide rapid coordination of community services to

meet a person's urgent need. However, staff told us these schemes were in their infancy and needed further development between SCAS and other healthcare organisations. For example, 2% of patients had been transferred to an SDEC between May 2024 to Apr 2025. Staff still tended to use see and treat, where ambulance crew could assess a patient's condition at the scene and, if appropriate, provide treatment and/or advice without the need to transfer to hospital, or transfer patients to emergency departments where their care would be continued.

Ambulance crews continuously monitored patients whilst they were being transferred to hospital, including monitoring vital signs to ensure patient stability and guide treatment decisions. Ambulance crews recorded patient data on electronic devices ensuring secure and confidential records. This data included basic patient information (name, address, date of birth), medical history, vital signs, symptoms, and treatment details. The system allowed for real-time access to patient records and integration with other healthcare systems, streamlining information sharing and improving decision-making during emergencies.

Ambulance crews had systems in place to pre-alert the receiving emergency department about the patient's arrival. This included sharing of systems that tracked the ambulances and their estimated arrival time, or crews could call ahead to inform them about a critically ill or rapidly deteriorating patient who was en route. This allowed the emergency department to prepare for the patient's arrival by freeing up resources, getting specialist staff ready, and potentially initiating time-critical treatment.

On arrival to hospital, ambulance crews handed over patients and their care to hospital staff in a thorough and structured process that involved verbal feedback and an electronic report. This process ensured a smooth transition of care, accurate information transfer, and patient safety. We observed handovers and all were carried out to a high standard, and feedback from the receiving hospitals were positive.

National guideline and best practice say that ambulance handovers should be within 15 minutes of arrival of the ambulance to the receiving hospital. However, it is recognised that handover delays across the country are significant due to system pressures across the health and social care landscape. SCAS were performing well when benchmarked against other ambulance trusts. From Oct 2024 until March 2025, SCAS, when handover data was averaged across the patch showed 43% of patients had a handover within 15 minutes, 89% of patients within 30minutes and 98% within 1hour. There was some variation across the patch due to system pressures in that area. Until handover occurred ambulance crews were responsible for monitoring the patient. SCAS had worked hard with healthcare partners to reduce handover times, as delayed handovers had been shown to impact patient safety by delaying immediate care and treatment and reducing the availability of ambulances out in the community.

The ambulance trust had brought in the release to respond initiative. This was an agreed process with the receiving hospitals which saw the safe withdrawal of the ambulance crew within 45 minutes, releasing them to respond to patients in the community, thus creating continued patient safety across all

areas of healthcare. Since the initiative went live in December 2024, there had been a significant improvement in response times to patients in the community, and lost crew hours waiting to hand patients over at emergency departments. For example, in November 2024, the average time for SCAS to reach a category 2 call was 37 minutes, in March 2025, this had reduced to 22 minutes. In addition, crew hours lost to waiting at the hospital had reduced from 5525hrs in November 2024 to 2638hrs in March 2025.

The service employed specialist paramedic practitioners who were able to self-allocate jobs to themselves and monitored the list of outstanding category 3 (urgent) calls. They could call patients back, refer to different healthcare agencies or upgrade or downgrade the urgency category of patients. Specialist paramedic practitioners were able to use their clinical judgement to make clinical decisions rather than following care pathways.

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Safe

Safeguarding

Overall Score

1 2 3 4

▶ How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service worked with people and healthcare partners to understand what being safe meant to them and the best way to achieve that. They concentrated on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. The service shared concerns quickly and appropriately.

Improvements had been made to all aspects of safeguarding. The trust had created a culture of awareness, prevention and effective response to potential harm by improving training, having clear reporting procedures, and robust

partnership working with other agencies.

Safeguarding was part of the staff induction and mandatory training. Staff working in the emergency and urgent care service had received the appropriate level of adult and children safeguarding training for their role. Training records showed that 96% of staff had completed their safeguarding training for both adults and children, which met the trust's 90% completion rate target.

The service had well-defined and easily accessible policies and procedures for safeguarding, ensuring staff knew how to identify, report and respond to potential concerns. Staff understood their role and responsibilities in protecting patients from abuse, could give examples of when they had made a safeguarding referral, and explained the process of doing so via their electronic patient record (EPR). There were back up procedures in place in case of technical failures with the EPR.

Frontline staff explained how the trust's safeguarding team was now more visible and supportive. They had worked with frontline staff to improve the quality of safeguarding referrals and used audits to ensure continued appropriateness and quality of referrals.

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Safe

Involving people to manage risks

Overall Score

1 2 3 4

► How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service worked with people to understand and manage risks by thinking holistically. They provided care to meet people's needs that was safe, supportive and enabled people to do the things that mattered to them.

When people called 999, they were assigned an urgency category based on their condition, which determined the type and time of the response from ambulances. These are category 1- calls from people with life- threatening illness or injuries, category 2- emergency calls, category 3- urgent calls and category 4 less urgent calls. These categories helped the appropriate response time and resources needed.

Crews were dispatched to emergencies by the emergency operations centre. On arrival ambulance crews used established guidelines and their own clinical expertise to evaluate the patient and determine the necessary course of action, to ensure that each patient received the most suitable and timely care, leading to the best possible health outcomes

The trust used volunteer community first responders (CFR) to respond to emergencies in their own communities. The CFR was able to relay patient information back to the urgent care desk in the emergency operations centre.

Staff completed dynamic risk assessments for each patient. These included moving and handling, violence and aggression and safeguarding. However, some staff felt they did not have the appropriate level of training to evaluate risks and manage patients that were experiencing a mental health crisis.

The electronic patient record (EPR) contained protocols and flow charts for specific conditions such as head injuries. Staff were able to make an onward referral using the EPR, for example to a patient's GP if they had identified a patient at risk of falls.

Staff had access to the SCAS urgent care and clinical support desks which were staffed by clinicians if they required additional clinical guidance. The support provided included shared decision making, help with alternative care pathways, support to crews on scene, clinical referrals and patient follow ups and discharge advice. This was particularly useful for newly qualified paramedics and for emergency care assistants. Crews said this mostly worked well but out of hours it could sometimes be hard to get immediate support.

Staff used the National Early Warning Score (NEWS2) tool, a system for scoring physiological measurements in adults, to clinically observe and promptly identify changes in the patient's condition. Data was recorded into the electronic patient record and shared with other healthcare providers.

Where a patient's condition suddenly deteriorated and a crew on scene needed additional help, a request was made via the emergency control centre and an additional resource was dispatched urgently.

When seriously ill or very unstable patients were conveyed to hospital, the crews could pre alert the hospital's emergency department prior to their arrival. This ensured the patient could be transferred to the hospital's care with the minimum of delay.

Patients arriving at the department by ambulance remained in the care of the ambulance staff until they could be handed over to the care of hospital staff. A member of the ambulance crew remained with the patient at all times, and there was on-going monitoring of observations with an electronic record of the care maintained.

When the clinical decision was made not to convey a patient to hospital, staff told us they provided advice tailored to the patient's specific situation. Guidance would be given on monitoring symptoms, when to seek further help if symptoms worsen or new symptoms develop, and how to access alternative care options if this was appropriate.

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Safe

Safe environments

Overall Score

1 2 3 4

► How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service detected and controlled potential risks in the care environment. They made sure equipment, facilities and technology supported the delivery of safe care.

We inspected 15 ambulance resources centres across the South Central Ambulance Service (SCAS) patch. These varied in size and age, some stations were small, housing only a few vehicles and staff, while others were larger, acting as operational hubs with extensive facilities and a larger workforce. Some stations had garages in which vehicles were stored when not in use. Other stations kept vehicles on forecourts either at the front or back of the premises.

All stations were secure, with entry doors requiring a staff pass to be able to access. This meant only authorised people could enter the station. Stations had CCTV cameras which monitored certain areas for security purposes. Station bases had staff locker facilities, showers, toilets and kitchen/mess areas available for staff to use. Facilities were clutter-free and clean. There had been investment in stations since the last inspection improve facilities including updates to storage areas and staff changing areas.

We inspected 18 ambulances across the SCAS patch. All were clean, but inconsistent layouts were seen, and vehicles tended to be overstocked with consumables. This could be a potential safety issue, as it could make locating and accessing items quickly during an emergency harder. It also increased the risk of supplies expiring before they could be used, both wasting resources and increasing the risk of expired items inadvertently being used.This had been highlighted by the service and a quality improvement project started to address these issues.

Vehicles were variable in age and mileage, which was resulting in mechanical issues and vehicles being taken off road to repair. SCAS were in the process of replacing vehicles, as new vehicles arrived, older ones were being decommissioned, and this was lessening the issues that had been seen with an aging fleet.

SCAS had introduced 12 hours per day fleet provision at larger stations, allowing servicing and minor vehicle repairs to be completed on site. This initiative helped ensure vehicles could return to service more quickly, improving operational efficiency and response capacity.

All stations had make ready teams. These teams were responsible for ensuring ambulances and other emergency vehicles were cleaned, restocked with essential supplies and equipment, and fully operational before each shift. These teams were employed by a service partner rather than SCAS but worked closely with SCAS personnel. SCAS staff reported good working relationships with the make ready teams, with minimum issues, but when issues did arise they would be sorted quickly and efficiently.

Equipment and consumables were stored appropriately. Equipment was available to meet patient needs, for example defibrillator and suction machines, and the emergency vehicle trolleys could carry patients with a high body mass index. Safety checks were performed on emergency equipment according to policy. Equipment was serviced, maintained and records kept ensuring quality of the service, with a central team being responsible for this.

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Safe

Safe and effective staffing

Overall Score

1 2 3 4

How do we score this?

Summary

Requires Improvement – This service generally maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service made sure there were enough qualified, skilled and experienced staff. However, they did not always make sure staff received effective training, support, supervision and development.

While the service demonstrated strong commitment to staffing, induction, and professional development, there seemed to be a disconnect between clinical focus and operational delivery in ensuring clinical effectiveness. There was an absence of a structured clinical supervision framework, no evidence clinical updates were read and embedded, and limited integration between the education team and operational teams. There were gaps in ensuring clinical standards and updates were adhered to, no consistent approach to sharing updates and learning from patient safety incidents, regulation 28 prevention of future death reports and national learning, and how evaluation of new practices had been embedded. Without a cohesive strategy to bridge these gaps, the organisation risked compromising the quality and consistency of patient care, particularly in high-pressure environments.

All staff with professional qualifications were subject to pre-employment checks to ensure their registration was active and unrestricted. New staff underwent a comprehensive induction programme tailored to their role, including both corporate and local orientation. This involved e-learning and face-to-face training, which staff reported as effective and supportive in preparing them for their responsibilities.

For the past two years, the service had operated under sustained pressure, predominantly at Resource Escalation Action Plan (REAP) levels 3 or 4, indicating major or extreme operational strain. Staff described increased workloads, stress, and fatigue during this period which impacted their ability to deliver safe care and treatment. Contributing factors to high operational pressure, included high service demand, delayed hospital handovers, and a reduced ambulance fleet. To help mitigate these pressures, SCAS engaged

third-party providers to support emergency response capacity. At the time of inspection, SCAS had moved to REAP level 2, reflecting moderate pressure. Staff noted this reduction had a positive impact on their ability to deliver care safely and effectively.

The service was fully staffed with qualified, skilled, and experienced personnel. Sickness and turnover rates were 5% and 7% respectively—both below NHS averages. Ambulance crews were composed of various roles, including paramedics, associate emergency care assistants, and ambulance nurses, working collaboratively within their clinical scope.

Local managers emphasised the goal of ensuring every crew included a qualified paramedic. Progress was evident as the proportion of category 1 calls without a paramedic had decreased from 9.3% at the last inspection to currently 5% (data derived from April 2024 to March 2025), and category 2 calls without a paramedic now stood at 14%. However, if other clinical registrants such as ambulance nurses, who could deliver the same advanced assessment and treatment as paramedics, were included in the figures the category 1 calls proportion decreased to 1.9% and category 2 calls to 5.3%.

Mandatory training was provided with protected time for completion. Overall compliance among operational staff was 88%, though 17 out of the 23, 22 out of 23 and 11 out of 17 modules required by registered clinical, non-registered clinical and non-clinical staff respectively fell short of the 95% trust target. Notably, mental health training had the lowest compliance at 75%, followed by manual handling (79%) and conflict resolution (80%). Resuscitation training modules averaged 83% compliance. End-of-life training was suspended pending policy updates. We were told new training materials would be launched later in the year, but no set date was given. Oliver McGowan elearning (learning disability and autism) was completed with compliance rate of 94% across the operational staff. Therefore, mandatory training continued to not be optimal. It was acknowledged that the high REAP levels likely impacted the ability to schedule face-to-face training. It was also noted that SCAS’s 95% compliance target exceeds that of many NHS organisations.

Although mental health and learning disability training were part of the staff’s mandatory training, staff felt it was not robust enough for patients they cared for in the community and felt they would benefit from further learning and support on these topics.

The medical director was the end-of-life clinical lead. However, there was no steering group to ensure the service had oversight and were providing high-quality care for patients nearing the end of their lives, whilst supporting their families.Training for staff was limited as the end-of-life mandatory training had been suspended while subject matter experts updated the relevant policies and training materials. We were not given a date when the new training would be launched.

The education team had training material for operational staff on when resuscitation could be discontinued and what needed to be in place for this to occur, such as a do not attempt cardiopulmonary resuscitation (DNACPR) decision or recommended summary plan for emergency care and treatment (ReSPECT) form. We were not told how many staff had received this training

and refresher training on this topic. However, the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines, which were available to all paramedics, gave guidance regarding DNACPR decisions.

Emergency drivers received specific training, with additional support provided following incidents or concerns.

Crews were assigned to teams led by a team leader and supported by a clinical team educator (CTE), who provided clinical supervision, mentorship, and professional development mainly for the Newly Qualified Paramedics (NQPs).

NQPs were now well-supported, with CTEs monitoring their practice. The NQPs acted as a third crew members until their competencies were signed off. CTEs continued to monitor their clinical practice for two years post sign off. SCAS also supported student paramedics through an apprenticeship model, which was positively received.

Qualified clinical staff were expected to maintain their skills through ongoing education, simulations, and updates from SCAS and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines. Teams received five hours of protected team time every 15–17 weeks, used for updates, training, and team cohesion. These sessions were facilitated by the team leader and the clinical team educator (CTE) and were greatly valued by teams. However, they were not formally structured or seen as dedicated education time by the organisation.

Despite these efforts, SCAS lacked a formal organisational framework for consistent clinical supervision across face-to-face and remote care. Informal clinical conversations were common and were considered a form of supervision by the service.

Annual appraisals were completed for 90% of operational staff. These appraisals included performance discussions and training needs but did not incorporate observational ride outs with the staff member on ambulance shifts, or direct clinical observation beyond the NQP stage. CTEs reported limited involvement in ride outs with more experienced staff.

The education and training team was responsible for delivering training and supporting staff development. However, when talking to operational staff it was difficult to see how they efficiently integrated with frontline operations to uphold clinical standards and maintain clinical oversight.

From discussions with operational staff, it was evident that while performance was tracked and monitored, clinical oversight at both local and trust levels lacked clarity. There were gaps in ensuring adherence to clinical standards and updates, inconsistent sharing of learning from incidents and national reports, and limited evaluation of new practices.

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Safe

Infection prevention and control

Overall Score

1 2 3 4

How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service assessed and managed the risk of infection. They detected and controlled the risk of it spreading and shared concerns with appropriate agencies promptly.

Improvement in infection prevention and control were found at this assessment. All ambulance resource centres we inspected were visibly clean and had suitable furnishings which were clean and well-maintained, with major improvements in cleanliness seen at North Harbour resource centre. Cleaning equipment was stored securely in locked cupboards. Cleaning records were up-to-date and showed that all resource centres were cleaned regularly.

The make ready team were responsible for the cleaning of vehicles and equipment, and the storage of equipment and consumables. All vehicles inspected were visibly clean and equipped with visibly clean equipment, clean and available linen, hand gel, personal protective equipment (PPE) such as aprons and gloves, and decontamination wipes.

Routine cleaning of ambulances between patients was the responsibility of the crew. We observed crews thoroughly cleaning the inside of vehicles outside of emergency departments before going to their next patient. Staff explained that if an ambulance became heavily contaminated, crews would return to base, and it would be taken out of service until it had been cleaned. Suitable clinical waste bags for infectious clinical materials were available on vehicles.

Vehicles were deep cleaned to a schedule or sooner if heavily contaminated. This was done by the make ready team. Local managers had oversight of the deep cleaning schedule and kept records for audit purposes.

Ambulance crews attending emergency departments were bare below the elbow and wearing the correct personal protective equipment, including masks and gloves, at the right time. Staff mostly demonstrated good hand hygiene practice in line with national guidance.

Staff maintained the cleanliness of their own uniform as per trust policy and explained if their uniform became severely soiled or contaminated it would be disposed of in the appropriate waste bin and a replacement requested.

SCAS ran a vaccination programme, including vaccinations for influenza and COVID-19, to protect staff, and reduce the spread of infectious diseases within the workplace and community.

Staff disposed of clinical waste safely, with clinical waste being stored and collected at the stations. Sharp bins were used on the vehicles to safely dispose of needles, syringes and other sharp medical instruments. However, we found 5 sharp bins in use that had not be dated on assembly. Sharp bins need to be disposed of after 3 months of use, or according to manufacturer's guidelines, to help prevent injuries and the spread of infection. Without dating the sharp bins, the age of the container could not be tracked and compliance with waste management regulations could not be ensured.

Audits were used to monitor and improve compliance with infection prevention and control (IPC) standards. This included hand hygiene audits and environmental IPC audits. When issues were found actions were recommended, to be completed in a set timeframe, and then a re-audit was used to ensure improvement was seen. Data reviewed for the months Feb to Apr 2025 indicated that audits were used but lacked consistency in their completion.

Infection Prevention and Control (IPC) training formed part of the trust's mandatory training programme. IPC Level 1 training had been completed by 95% of operational staff, meeting the trust's compliance target of 95%. However, IPC Level 2 training had been completed by only 88% of staff, falling short of the required threshold.

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Safe

Medicines optimisation

Overall Score

1 **2** **3** **4**

► **How do we score this?**

Summary

Inadequate - This service does not maximise the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and

communication needs with them.

Processes

The service did not make sure that medicines and treatments were safe and met people's needs, capacities and preferences. There was a lack of appropriate and effective systems to ensure clinical oversight of controlled drugs.

We were told by operational staff that vehicles were regularly deployed without morphine, usually as a result of the vehicle having the morphine medication taken off prior to going to external workshops and then being returned to a different station after the work. This had resulted in vehicles regularly sent out without morphine medication although other forms of pain relief were available on the vehicle. Ambulance crews felt, in their opinion, this had resulted in compromised treatment and quality of care they could give to patients. We saw vehicles at emergency departments that had no morphine available to crews, staff told us they felt exposed with regards to the ability to provide reasonable and appropriate options for pain relief.

We were told the issue had arisen due to a change in the management and process of storage of these medicines when vehicles were off the road. Issues were flagged by ambulance crews and at the time of the inspection this was a known issue by the pharmacy team. It had been recognised by the pharmacy team that the change in process might lead to problems with the storage and availability of morphine on vehicles, and this had been entered on the pharmacy risk register. A standard operating procedure had been written, however, this had not been implemented at the time of inspection, several months after the concerns had been raised. We were told by the pharmacy team that a temporary system had been put in place to mitigate issues whilst the new system was being developed and rolled out. However, at the time of inspection, vehicles were still in service without morphine available for crews to use, and crews could not direct us to information being sent about this issue, or any addition training being given regarding alternative pain pathways to use if morphine was found not to be on the vehicle. The trust felt additional training had not been required as guidance on all options of analgesia (pain relief) was available to paramedics via the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance.

Data provided by the trust showed there had been no significant change in morphine administration between pre and post the change in process, and there had been no patient complaints regarding analgesia (pain killers) not being available.

Following the temporary change there had been two reported incidents of morphine not being unavailable on the vehicle, neither reported incident was at the point of care.

Information taken from the pharmacy risk register highlighted the trust had recognised that a vehicle returning to active duty without replenishing its morphine stock might result in patients not receiving essential pain relief when

needed, and this could result in compromised treatment, potential harm to patients, and reduced quality of care.

When vehicles were taken off road, usually for repair, only morphine was taken off the vehicle. Other controlled drugs (controlled drugs, CDs, are medicines requiring more control due to their potential for abuse), such as diazepam ampoules and oramorph, were left on the vehicle and accessible to unauthorised personnel. These types of CDs were stored in response bags which were standard on each vehicle, including vehicles which were not paramedic staffed, meaning non-paramedics were having access to controlled drugs, along with the make ready staff.

Controlled drugs were stored safely and securely on ambulance resource centres with access restricted to authorised staff at ambulance stations. Checks were undertaken and recorded by two authorised staff at least once a day. Trust wide controlled drug audits were undertaken by the pharmacy team to ensure safe storage, recording and destruction. Any identified discrepancies or issues were reported directly to the station with advice and action agreed to ensure CDs were stored and recorded following trust policy and procedure.

A member of the trust pharmacy team had visited every station to look at the safe and secure handling of medicines which was part of the future business planning for safe medicine storage. There had been some storage space issues at some of the ambulance resource centres but overall the review found medicines were stored and managed neatly, safely and securely with access only to authorised staff.

Staff told us they had access to relevant medicine policies, procedures and guidelines including a trust medicine formulary. The availability of standard medicine protocols and checklists helped to ensure there was consistency and therefore reduced the risk of any errors.

The trust had up to date patient group directions (PGD’s) which are written instructions for the administration of authorised medicines to a group of patients. There was a well-established PGD group in place to review all the PGDs. This meant that medicines were administered to patients by staff with the legal authority to do so.

Medical gases were stored safely and securely at all locations visited. There was clear segregation between full and empty cylinders. Warning signs were visible to ensure people were aware and to ensure safety around medical gases.

A new pharmacy hub was operational from December 2023 with new packing processes introduced in November 2024. This new facility gave increased space for staff and safer medicine storage. We were shown the checking process to ensure medicines were safe to use and were within date before being packed into medicine bags. A team of pharmacy support workers prepared the medicine bags however we were told that more pharmacy technicians were needed to check the completed bags. The medicine bags were tagged and sealed to ensure safety and security. Each bag was coded so that its location was easily tracked. Returned medicine bags were ‘red’ tagged to identify they required replenishing. Pharmacy staff reported that the system

worked well. Any errors or near misses with this process were reported and action taken to ensure lessons were learnt. However, ambulance crews had been raising concerns about controlled drugs and issues remained.

We were shown a pathway for the distribution of medicine bags from the pharmacy hub to ambulance stations to ensure stocks of medicines were available. However, at one station we were shown they did not have enough supplies of one of the medicine bags which was partly due to the location being used as a central medicine collection point for other stations. Therefore, there was a potential risk of medicines not being available to treat patients. Following the inspection immediate action was taken to increase stock levels to that location.

Staff told us they received updates on medicines, including training refreshers, alerts, and reminders to complete relevant e-learning modules. While medicines management training was described as compulsory, several staff noted that the content was more hospital-focused and not sufficiently tailored to the ambulance setting, which they felt would have been more beneficial. When we requested mandatory training compliance rates following the inspection, medicines management was not listed among the mandatory training modules for operational staff. As a result, we were unable to determine the overall completion rates for medicines management training.

Any reported medicine incidents with actions and learning were shared with relevant staff through clinical memos, emails and briefings.

The service used audit to ensure medicines were safely administered. Action and recommendations were published if issues where found. And to make sure good practice was followed. For example, pain relief administration had been audited by the pharmacy team to seek assurance that patients were receiving appropriate pain-relieving treatment. However, this audit was comparing data from January to July 2022 against data collected in February 2024 before issues with morphine on vehicles had become an issue.

Effective

Rating: Good

Percentage Score: 75.00 %

▶ How do we score this?

Summary

This service is effective

Commentary

We looked for evidence that people and communities had the best possible outcomes because their needs were assessed. We checked that people's care, support and treatment reflected these needs and any protected equality characteristics, ensuring people were at the centre of their care. We also looked for evidence that leaders instilled a culture of improvement, where understanding current outcomes and exploring best practice was part of their everyday work.

We assessed all 6 quality statements from this key question.

At the last inspection we rated this key question as requires improvement.

At this inspection the rating has changed to good

This meant people's outcomes were consistently good, and people's feedback confirmed this.

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Effective

Assessing needs

Overall Score

1 **2** 3 **4**

▶ **How do we score this?**

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service made sure people's care and treatment was effective by assessing and reviewing their health, care, wellbeing and communication needs with them.

Ambulance crews explained when they were assigned an incident to attend, certain information was available to them, for example, location of the incident, nature of the emergency and if available additional information such as keypad entry codes. This information allowed the crew to prepare for the specific situation they were arriving to.

Staff completed dynamic risk assessments for each patient on arrival. These included on-the-spot evaluations of hazards and risks for both themselves and the patient. Based on the assessment, crews would implement immediate and appropriate control measures to mitigate identified risks. This could be something simple like putting a family pet into another room, to more complex situations which support would be needed from other emergency services, such as the police or fire service.

Staff assessed the communication needs of the patient to make sure there was effective communication, for example making sure they talked directly to the patient if there were hearing issues.

Crews would complete their initial assessment of the patient following set protocols and use this, with their clinical judgement, to provide the appropriate medical care, for example, administering pain medication or oxygen.

If the patient was assessed as needing further medical care beyond what the crew could provide at the scene, the crew would convey the patient to hospital or other healthcare facilities using established clinical pathways. Clinical pathways were available for ambulance crews on their mobile device.

If the decision was made not to convey the patient, the ambulance crew told us they would give appropriate advice and guidance for the patient, for example, to contact the patient's GP or talk to the local pharmacist. In some circumstances, the crew could make referrals, with the patient's consent, to other services such as the urgent community response team.

In addition, crews told us they would always assess for potential safeguarding issues for patients and other members of the household, such as carers or children, and would make safeguarding referrals according to SCAS policies and procedures if required.

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Effective

Delivering evidence-based care and treatment

Overall Score

1 2 3 4

► How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service planned and delivered people's care and treatment with them, including what was important and mattered to them. They did this in line with legislation and current evidence-based good practice and standards.

Patient care and treatment followed evidence-based guidance. Clinical guidelines and policies used in the service were developed and reviewed in line with national guidance from the National Institute for Health and Care Excellence (NICE) and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC).

Staff had access to the JRCALC guidelines, which were clinical guidelines used by paramedics to support practice. The JRCALC guidelines were regularly reviewed and updated to reflect the latest evidence and best practices in pre-hospital care.

Policies and protocols were accessible on the trust's intranet, with some being available on crew's electronic handheld devices.

Policies and procedures were approved by either a committee, group or trust board, depending on the type of document and service area to which it related and in accordance with the trust's scheme of delegation. This ensured they contained current and best practice guidance. Governance meetings provided evidence of updates being made to procedures and policy documents.

There were a variety of up to date, evidence-based pathways used in the service which staff had access to on their electronic handheld devices.

Staff were updated on changes to clinical practice in various ways, email, newsletters, memos and bulletins. We observed some displayed in crew rooms at ambulance stations. Several staff explained there could be much information to keep on top of, and it was difficult when they were operationally busy to read it all. We were unsure how senior staff ensured all staff had received, read and understood the clinical or procedural updates.

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Effective

How staff, teams and services work together

Overall Score

1 2 3 4

▶ How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service worked well across teams and services to support people. They made sure people only needed to tell their story once by sharing their assessment of needs when people moved between different services.

The service worked with many teams both internally and externally to deliver their purpose of providing and coordinating emergency and urgent care to the public. Staff we spoke with told us open communications, mutual respect and keeping the patient at the centre of what they did helped the teams work together.

There was effective working between the teams at the emergency operations centre, where emergency calls were answered and resources dispatched and the ambulance crews. Crews told us it was important to understand each other's role and they felt there was good working relationships between the teams.

Specialist paramedics staffed the urgent care desk and supported ambulance crews in complex clinical assessments and decision-making regarding patient disposition and safety. Crews said this mostly worked well but out of hours it could sometimes be hard to get immediate support.

Staff at ambulance stations worked closely with the make ready teams, a team responsible for ensuring ambulances and other emergency vehicles were cleaned, restocked with essential supplies and equipment fully operational before each shift. These teams were employed by a service partner rather than

SCAS but worked closely with SCAS personnel. SCAS staff reported good working relationships with the make ready teams, minimum issues and when issues did arise, they would be sorted quickly and efficiently.

The service worked in partnership with two helicopter emergency medical services (HEMS) to provide critical care provision and with the Thames Valley Wessex Critical Care Network to provide a dedicated transfer service for patients that needed critical care.

The SCAS hospital ambulance liaison officer (HALO) had been an invaluable member of the team especially over the last few years with growing handover delays seen between the ambulance crews and NHS emergency departments. Their role was to manage the smooth transition of patients from ambulances into hospital care and for optimising the turnaround time of ambulances. HALOs act as a bridge between ambulance crews and hospital staff, facilitating handovers and assessments, and helping to reduce pressure on both ambulance and the hospital teams. We were told they had been instrumental in the success of the release to respond initiative.

During the inspection, we observed good interactions between emergency department staff and ambulance crews during handovers and when sharing information regarding patients.

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Effective

Supporting people to live healthier lives

Overall Score

1 **2** 3 **4**

▶ **How do we score this?**

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The provider supported people to manage their health and wellbeing to maximise their independence, choice and control. Staff supported people to live healthier lives and where possible, reduce their future needs for care and support.

The service supported patients that made multiple calls to 999. Frequent callers were defined as patients aged 18 or over who made 5 emergency calls or more relating to individual episodes of care in a month or 50 or more urgent care incidents in a 12-month period. Some frequent callers had long-term physical and/or mental health conditions, and the trust gave examples of where staff worked with partners across the system to try and ensure patient's unmet needs were met, and frequent callers were reduced. The complex care team had responsibility for supporting frequent callers and whom the operational team would make referrals to.

Ambulance crews had access to the NHS directory of services. This was a platform developed by the NHS to provide a comprehensive directory of health, social care, and voluntary sector services. Staff used this platform to find and direct patients and members of the public to a range of services that they might find helpful to their health and social care needs. For example, dentists, opticians and sexual health services.

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Effective

Monitoring and improving outcomes

Overall Score

1 **2** 3 **4**

► How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service routinely monitored people's care and treatment to continuously improve it. They ensured that outcomes were positive and consistent, and that they met both clinical expectations and the expectations of people themselves.

The service had systems and processes in place to monitor, audit and benchmark the quality of services, and the outcomes for patients receiving care and treatment. Data was collected, analysed and tracked over time to understand how the service was performing against key performance indicators, NHS standards, the Association of Ambulance Chief Executives (AACE) standards and locally derived standards. Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. Data was reviewed and discussed by the relevant groups and committees, for example the clinical review group, which would then feed into the board sub-committee meetings.

The service participated in the Ambulance Quality Indicators (AQIs) which are a set of measures used to assess and improve the quality of care provided by all ambulance services in England. System indicators focused on efficiency and timeliness of ambulances responses, and clinical outcomes which including measures like 'return to spontaneous circulation' (ROSC) after cardiac arrest and survival rates for patients with specific conditions such as stroke and heart attack, were reported each month. This gave a monthly up to date picture on how ambulance services were performing individually, and when combined, an overall picture for England. Data presented showed variation each month and was influenced by early detection of condition in the community, vehicle availability and severity of handover delays.

Key performance indicators were used to track the service's performance, for example, time to respond to category 1, 2, 3 and 4 calls, time on scene, see and treat, and conveyance rate. Where performance was not optimal, the service looked to see if there were reasons and what the service could do to improve performance. For example, the serviced had developed and launched the release to respond initiative, which had seen a significant reduction in the response times of all 4 category of calls. Data from October 2024, prior to the launch of release to response, showed time to respond to category 1 calls (life-threatening) was 00:09:11hrs compared to 00:08.06 hrs in March 2025, with a target of 7minutes. Data from October 2024, prior to the launch of release to respond, showed time to respond to category 2 calls (emergency) was 00:38.31hrs compared to 00:21:42hours in March 2025, with a target of 30minutes. Data from October 2024, prior to the launch of release to respond, showed time to respond to category 3 calls (urgent) was 07:52:44 hours compared to 03:13:19, with a target of 90% of these calls responded to within 120 minutes (2 hours). Data from October 2024, prior to the launch of 'release to respond', showed time to respond to category 4 calls (less urgent) was 07:58:54 hours compared to 04:22:59, with a target of 90% of these calls responded to within 180 minutes (3 hours).

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Effective

Consent to care and treatment

Overall Score

1 2 3 4

▶ How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service told people about their rights around consent and respected these when delivering person-centred care and treatment.

The service had up-to-date policies and procedures regarding consent and the Mental Capacity Act (2005). Staff received Mental Capacity Act (MCA) training as part of their mandatory training, and was delivered in 2 modules, MCA level 2a and MCA level 2b. Registered clinical staff, paramedics and ambulance nurses, were 69% compliant with MCA level 2a, which was lower than the trust target of 95%, and 98% compliant with MCA level2b. Emergency care assistants were not compliant with either MCA level 2a or MCA level 2b, with rates of 78% and 90% respectively. The trust explained that the MCA 2a eLearning module was not available from June 2024, a replacement eLearning module was now live on the platform, and there was a trust focus to get staff to complete this module.

Many staff thought the mental health training they received was not appropriate or adequate for the situations they encountered in the community and said they would benefit from additional training. We were told there was access to mental health support within the service, however this was inconsistent, and improvements would be welcomed by the crews.

Staff understood the importance of consent when delivering care to patients. We observed staff seeking consent from patients prior to examination and treatment. In most cases, this was implied consent and not documented. When patients did not have capacity to consent, for example if they were unconscious, staff followed legislation and guidance and made decisions in their best interests. The service had carried out a deep dive audit to ensure

staff were compliant with the consent to assessment and treatment policy. Data from April to June 2023 and January to March 2024 was analysed and reviewed, and showed compliance of the recording of consent to be 85%. The service was due to reaudit in January 2025. The trust did not supply the results from this audit. Audits of the electronic patient records were also completed in the operational teams, but we were not supplied with findings from these more localised audits.

The electronic patient record system had a mandatory field to ensure MCA had been considered and assessed and contained tools for guidance. Staff we spoke with understood the Fraser guidelines and Gillick competency. Fraser guidelines and Gillick competency must be considered when offering treatment to children less than 16 years old to decide whether a child is mature enough to make decisions about their own care.

Staff we spoke with were aware of Mental Health Act (1983) holding power and section 136 requirements. Section 136 is an emergency power which allows patients to be taken to a place of safety from a public place, if the police considered the patient was suffering from mental illness and in need of immediate care. Police officers would ride with ambulance crews in these situations.

Ambulance crews had received additional training in restrictive interventions and acute behavioural disturbances (ABD). Data supplied by the trust showed between November 2024 and April 2025 there were 17 reports where restraint had been used on patients. In 9 of these cases, patients had been restrained by the police with ambulance crews in attendance, and 8 cases were where SCAS staff had used restraint. Where restraint was used these cases were reviewed internally to make sure the use of restraint was appropriate, and the least restrictive method had been used. Of the 8 cases, staff actions had been deemed to be proportionate, and there had been safe outcomes for the patients.

Staff received training on the circumstances when resuscitation would not be commenced, and the documentation that needed to be in place for that decision to be made.

Caring

Rating: Good

Percentage Score: 75.00 %

► How do we score this?

Summary

This service is caring

Commentary

We looked for evidence that people were always treated with kindness, empathy and compassion. We checked that people's privacy and dignity was respected, that they understood that they and their experience of how they were treated and supported mattered. We also looked for evidence that every effort was made to take people's wishes into account and respect their choices, to achieve the best possible outcomes for them.

We assessed all 5 quality statements from this key question.

At the last inspection we rated this key question good.

At this inspection the rating has remained as good.

This meant people felt well-supported, cared for and treated with dignity and respect.

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Caring

Kindness, compassion and dignity

Overall Score

1 **2** 3 **4**

► **How do we score this?**

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's Experience

The service always treated people with kindness, empathy and compassion and respected their privacy and dignity. Staff treated colleagues from other organisations with kindness and respect.

Staff treated patients and their families with kindness, compassion and dignity in their day-to-day care and support.

We saw pleasant interactions between staff and patients. We saw staff treat patients with warmth and care, they were respectful and non-discriminatory. Interactions were courteous, professional and demonstrated compassion to patients. Feedback from patients was positive. We were told ambulance crews introduced themselves and explained what was going to happen. Patients told us, ambulance crews were kind and caring, made people feel calm when they were feeling vulnerable and scared, and were respectful, polite and professional.

We mostly saw crews respecting people's privacy and dignity, for example, closing curtains when they transferred patients from their trolleys to hospital beds. We saw an ambulance crew go fetch a privacy screen to put around a patient queuing in the corridor of an emergency department when they were getting them settled, to make sure their dignity was maintained.

Staff understood about patient confidentiality. They used electronic patient records to log patient information. Ambulance crews made sure these were always in their possession to stop unauthorised people having access to patient information.

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Caring

Treating people as individuals

Overall Score

1 **2** 3 **4**

► How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service treated people as individuals and made sure people's care, support and treatment met people's needs and preferences. They took account of people's strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

Ambulance crews told us they always treated patients as individuals. They made sure the patient was at the centre of their care and strive to build trust and rapport with the patient.

They explained when entering a patient's home, they had to be mindful of cultural sensitivities to ensure respectful and effective care. This included understanding potential language barriers, respecting religious or cultural practices regarding modesty or physical contact, and being aware of family dynamics and decision-making processes.

Crews had access to language services and interpreters if required, and did not use medical jargon when talking to patients. They would talk to patients at their level, for example sitting on a sofa at the same height or kneeling in front of the patient, so they communication style was not intimidating to the patient.

Staff understood about protected characteristics and knew these were protected by law. Staff received training with examples around cultural, social and religious needs at induction and in the online mandatory training. Staff had also received training on cultural humility, which emphasises a commitment to understanding others, acknowledging power imbalances, and fostering mutual learning and growth.

Sensory boxes were being trialled in some of the ambulance stations, these contained cards, squeaky toys and earmuffs to see if they aided neurodivergent patients. These boxes aimed to provide a calming and supportive environment for individuals who may be overwhelmed by the sensory input of an ambulance setting. The goal was to improve the patient experience and potentially make it easier for them to receive care.

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Caring

Independence, choice and control

Overall Score

1 2 3 4

► How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service promoted people's independence, so people knew their rights and had choice and control over their own care, treatment and wellbeing.

Ambulance crews made sure they communicated clearly and openly with patients about their condition, the treatment options available and the potential to convey them to hospital. They explained the reasons behind the recommended actions, including why a particular hospital or treatment was suggested, and what alternatives might be available.

Patients were encouraged to ask questions and express their preferences regarding their care. Ambulance crews would consider these preferences when making decisions, where appropriate and safe. Staff gave us an example where a patient did not want to be transferred into the ambulance using a stretcher, so making sure the patient was safe and it would not cause further harm, supported them to walk to the ambulance.

Patients told us things had been explained to them in a way they could understand, and they never felt rushed by the crews.

Adults were generally presumed to have the capacity to make decisions about their health, including refusing treatment, unless there was evidence to the contrary. Capacity was assessed on a case-by-case basis, considering the patient's ability to understand the information, weigh the options, and make a decision.

Staff told us patients had the right to refuse treatment or transport but they would always encourage patients to get the care and treatment they needed. However, if a patient refused and had the capacity to understand the consequences of their choice, ambulance crews knew they were obligated to respect this decision. If a patient with capacity refused treatment, even if it could improve their health, the ambulance crew respected that decision and documented the patient's decision on the electronic patient record, for legal and clinical reasons.

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Caring

Responding to people’s immediate needs

Overall Score

1 2 3 4

► How do we score this?

Summary

Good – This service maximises the effectiveness of people’s care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's Experience

The service listened to and understood people’s needs, views and wishes. Staff responded to people’s needs in the moment and acted to minimise any discomfort, concern or distress.

Emergency calls were triaged by staff at the emergency contact centre. Based on the triage, the urgency of the response would be decided and rated from category 1 to 4, with 1 being the most urgent. An ambulance would be dispatched to the location depending on the triage.

When the ambulance crew arrived, they would assess the safety of the situation for both staff and the patient before deciding on the course of action. If further support was required, for example, the need for police or fire service, these would be requested.

Crews assessed patients’ conditions using established protocols alongside their clinical judgment. If immediate care was required such as cardiopulmonary resuscitation (CPR) it was initiated without delay. In some cases, administering medication, particularly pain relief, was also necessary. Patients we spoke with told us their pain had been assessed and, when appropriate, they were given pain relief.

The service had previously experienced delays in reaching patients due to high demand, which resulted in incidents of harm from delayed treatment and was the primary source of patient complaints. However, as pressure on the service had eased, response times had improved. Patients we spoke with in the emergency departments who arrived by ambulance reported that the ambulance had arrived promptly.

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Caring

Workforce wellbeing and enablement

Overall Score

1 2 3 4

► How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service cared about and promoted the wellbeing of their staff and supported and enabled staff to always deliver person-centred care.

The majority of staff, at all levels, praised their line managers and thought they cared about their well-being. However, as a collective the staff who worked in the service felt the organisation did not look after their wellbeing or emotional needs and this was evidenced in results of the recent staff survey 2024, where questions relating to wellbeing were mostly rag rated red, indicating a significant issue.

The service had a variety of programs and initiatives to help support staff. They offered access to mental health services, a 24-hour employee assistance program, occupational health services, and welfare schemes. Additionally, they provided support for managing various health conditions like obesity, diabetes, asthma, and COPD, and had a dedicated menopause support program. They offered staff the influenza vaccine to protect staff's health. In all stations, we saw notice boards advertising these services, and information for health and wellbeing resources was available on the staff intranet. We were told of webinars and events that the trust had hosted on topics such as mental health, menopause and financial wellbeing.

The service had conducted training on bullying and harassment in the workplace and launched the sexual safety charter to eliminate sexual misconduct, harassment, abuse or violence in healthcare settings.

The service used debriefs, structured conversations designed to review the actions, decisions, and outcomes of patient care incidents. These sessions aimed to enhance future practice and support staff well-being by providing a safe space for emotional processing and promoting resilience. Staff found them beneficial especially after challenging incidents or emotionally demanding situations.

The service used trauma risk management (TRIM) which used trained individuals within the organisation to provide support to colleagues to cope with traumatic or potentially traumatic events. It was not a form of counselling or therapy but a structured approach to managing the potential mental health impacts of traumatic experience. Staff spoke highly about this service.

We were also told about the sustaining resilience at work (STRAW) programme. This was a peer support programme designed to help prevent and address mental health issues in the workplace.

However, although staff appreciated all of the things the trust offered to support them with their wellbeing, they were physically and emotionally exhausted from working at such a high demand and under high operational pressure for a continued amount of time. They referenced missed meal breaks, late finishes and issues that came with an aging fleet, and the long handover delays in hospitals which impacted on the role they were employed to do, and these were some of the issues impacting on their welfare.

Senior managers at the trust were aware of the sustained pressures staff had faced and understood that these issues were reflected in the recent poor staff survey results. In response, they had focused on key performance issues such as reducing hospital handover times and procuring new vehicles, which had achieved some success in easing workload and reducing staff stress. However, they acknowledged that staff welfare remained a significant concern and confirmed it would be a central priority for 2025/2026.

Responsive

Rating: Good

Percentage Score: 71.00 %

► How do we score this?

Summary

This service is responsive

Commentary

We looked for evidence that people and communities were always at the centre of how care was planned and delivered. We checked that the health and care needs of people and communities were understood, and they were actively involved in planning care that met these needs. We also looked for evidence that people could access care in ways that met their personal circumstances and protected equality characteristics.

We assessed a total of 6 quality statements from this key question.

At the last inspection we rated this key question requires improvement.

At this inspection the rating has changed to good.

This meant people's needs were met through good organisation and delivery.

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Responsive

Person-centred Care

Overall Score

1 **2** 3 **4**

► **How do we score this?**

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service made sure people were at the centre of their care and treatment choices and they decided, in partnership with people, how to respond to any relevant changes in people's needs.

Staff always prioritised the individual patient's needs, preferences and values throughout their care journey. They explained when entering a patient's home, they had to be mindful of cultural sensitivities to ensure respectful and effective

care. This included respecting religious or cultural practices regarding modesty or physical contact.

They made a conscious effort to actively listen and understand their patients, taking their concerns, symptoms, and preferences seriously. By considering the patient's perspective, they ensured that care was both empathetic and responsive. All relevant information was documented in the electronic patient record to support ongoing care planning.

When appropriate, ambulance crews would acknowledge and respect the patient’s choice regarding their care, including the right to refuse treatment.

Crews prioritised the patient’s physical comfort and safety throughout the process, for example giving analgesia (pain relief) when appropriate or keeping a patient warm if they were being cared for outside.

When appropriate, crews involved the patient's family and friends in the decision-making process, providing emotional support and information.

Ambulance crews communicated clearly and effectively with the patient, explaining procedures and options in an understandable way. They had access to interpretation services, and aids on their electronic hand devices to aid effective communication, including pain assessments for adults, child and those with learning disabilities. Crews also received training on how to communicate with more complex patients, such as people with learning disabilities.

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Responsive

Care provision, Integration and continuity

Overall Score

1 **2** 3 **4**

► **How do we score this?**

Summary

Good – This service maximises the effectiveness of people’s care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service made sure people receive care and treatment from services that understand the diverse health and social care needs of their local communities.

The service knew it needed to work closely with other healthcare providers to be able to deliver safe, effective and timely care to the community it served.

Due to high demand and increasing pressures on the service, response times for attending to patients had fallen below optimal levels and were not meeting agreed national targets. Prolonged delays in handing over patients at hospitals further compromised ambulance crews' ability to respond to new emergencies in the community. As a result, some patients had experienced harm due to delayed access to urgent care.

The trust and senior staff in the emergency and urgent care service, had worked in collaboration with other healthcare providers and the integrated care systems to look at ways to reduce handover delays and response times. Initiatives had included the release to respond initiative, which was an agreed process between the ambulance service and receiving hospital. This saw the safe withdrawal of the ambulance crew within 45 minutes to release them to respond to patients in the community, thus creating continued patient safety across all areas of healthcare.

Since the initiative went live in December 2024, there had been a significant improvement in response times to patients in the community and lost crew hours waiting to hand patients over at emergency departments.

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Responsive

Providing Information

Overall Score

1 **2** 3 **4**

▶ How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service supplied appropriate, accurate and up-to-date information in formats that were tailored to individual needs.

The trust had an up-to-date website that people could access to find out about SCAS and the services it provided which including the emergency and urgent care services and how to access these services.

The trust was committed to making the website as accessible as possible, in accordance with the Public Sector Bodies (Websites and Mobile Applications) (No. 2) Accessibility Regulations 2018 and The Accessible Information Standard (DCB1605 Accessible Information). People could use a range of browsers, for example change colours, contrast levels and fonts and navigate most of the website using speech recognition software.

People could request information from the website in a different format, such as an accessible PDF, large print, different languages, easy read, audio recording, or braille via the patient experience team.

The service had developed and co-produced a range of accessible resources to better support people with additional communication needs when using ambulance services and to meet the accessibility standards. These included a communication booklet to help crews communicate with patients and easy read documents co-produced with people with learning disabilities which covered topics like calling 999, response times and going to hospital. However, we did not see any of these booklets on the vehicles we inspected.

The trust was piloting the "Message in a Bottle" scheme to support communication between autistic individuals and healthcare professionals. The initiative involved storing essential personal information such as allergies, current medications, and emergency contact details, and how best to communicate and engage with the individual during emergencies, in a clearly recognisable bottle. Ambulance crews were trained to look for this bottle, enabling them to quickly access critical information and provide more informed and sensitive care. One thousand bottles had been distributed, and the pilot had already been shown positive outcomes for patients helping to reduce stress and improving care quality since it was introduced in 2025. The service had also produced a 360 degrees ambulance tour video which was an interactive video to help patients explore the inside of an ambulance ahead of time.

The service used posters as a key communication tool to share important information with the public. These posters aimed to raise awareness about when it is appropriate to call 999, inform people about available healthcare services, and promote targeted health campaigns. Many of these messages were also displayed on the ambulances themselves, helping to extend their reach and visibility within the community.

Staff received General Data Protection Regulation training (GDPR). Patient records were held on a secure electronic patient record system, which was accessed by individual staff log in.

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Responsive

Listening to and involving people

Overall Score

1 2 3 4

▶ How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service made it easy for people to share feedback and ideas, or raise complaints about their care, treatment and support and acted on it.

The service actively wanted to hear the peoples' voice, as this helped them understand how care and treatment felt from the patient's perspective and their lived experience. The service used this information to improve the quality of care, enhance patient satisfaction and foster a more patient-centred approach.

The trust had launched a patient panel in February 2024, which was designed to increase the involvement of patients, as well as their families and carers, in improving and shaping the future of their services. The panel was made up of patients, family members or carers of patients who have used SCAS services, including the emergency and urgent care services, as well as representatives from voluntary groups and partner organisations. The panel had the opportunity to gain insight and have their say on service developments and improvements, which included the 999 emergency services. Members of the panel were invited to attend meetings, share views on specific areas of interest, including the design, development and delivery of services through focus groups or via surveys and other online feedback. There were sub-groups to the panel which focused on mental health, learning disabilities and a young person's group for people between 16-25 year old. These groups had helped with designing easy read and accessibility documents, highlighting barriers to accessing the services and co-produced training.

Staff from the service regularly engaged with the community and attended many and various community events, to educate the public about their role, train people in cardiopulmonary resuscitation and life-saving interventions, and promote an understanding of when and how to use emergency services. The service had attended university student fairs to help recruit volunteers to the young person's and mental health groups.

The service actively used feedback and complaints from people who had accessed their care to identify areas for improvement and drive enhancements in the overall quality of care. By listening to service users' experiences, the organisation was able to implement meaningful changes that better met patient needs and expectations.

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Responsive

Equity in access

Overall Score

1 2 3 4

► How do we score this?

Summary

Requires Improvement – This service generally maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service did not always make sure that people could access the care, support and treatment they needed when they needed it.

The service was available 24 hours a day all year round and saw people regardless of residency status.

Equity in access to emergency care meant that all individuals, irrespective of their socioeconomic status, ethnicity, disability, location, or any other characteristic, had the same opportunity to access timely and appropriate emergency healthcare services. This involved addressing barriers to access and ensuring fair treatment for all patients.

The service measured equity in access by analysing data such as, complaints, incidents, utilisation, wait times, and patient outcomes to identify and address disparities. The service worked to national operational targets and assessed their performance against those.

Due to high service demand, delayed hospital handovers and a reduced fleet, national targets had not been met. For example,

From March 2023 to February 2025 SCAS had not met national response targets of 7 minutes for category 1 calls, with SCAS being between 8 minutes 14 seconds and 9 minutes 38 seconds to respond, this was slightly higher than that of England as a whole.

From March 2023 to February 2025 SCAS had not met national response targets of 18 minutes for category 2 calls, with SCAS being between 24 minutes 14 seconds and 42 minutes 11 seconds to respond. However, no ambulance trust in England had met the national target, with England as a whole having a mean response time between 27 minutes 24 seconds and 47 minutes and 26 seconds.

From March 2023 to February 2025 SCAS had not met national response targets of 120 minutes for 90% of category 3 calls, with SCAS being between 3hours, 4 minutes and 44 seconds and 7 hours 52 minutes and 44 seconds. However, no ambulance trust in England had met the national target, with SCAS's performance being similar to or slightly higher than England overall.

The Ambulance Response Programme stipulates that category 4 incident response times should have a 90th centile of 3 hours (there is no mean target). From March 2023 to February 2025 neither SCAS nor England overall had met the 90th centile 3 hour target. SCAS's performance has been consistently worse than that of England overall, however from November 2024 to February 2025 the response times have been relatively close.

Ambulance vehicles were equipped with ramps, powered stretchers and securement systems to accommodate patients in wheelchairs and on stretchers. The service used specialist equipment such as high weight-bearing stretchers to ensure that bariatric patients could be safely and comfortably accommodated. This commitment to inclusive care helped ensure that all individuals, regardless of their physical needs, could access the service with dignity and safety.

The service recognised that some communities were less likely to access emergency services due to factors such as cultural beliefs, language barriers, or lack of awareness. In response, the service proactively engaged with these harder-to-reach groups within local communities. They provided information about the service, delivered lifesaving skills training, and encouraged appropriate use of emergency care, which all helped to build trust and improve health outcomes across diverse populations.

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Responsive

Equity in experiences and outcomes

Overall Score

1 **2** 3 **4**

▶ How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service was working towards making sure people's care, treatment and support promotes equality, removes barriers or delays and protects their rights.

The service was in the early stages of triangulating information collected to identify potential inequities in patient experience and outcomes and therefore be able to highlight disparities and take informed targeted measures to promote greater equity across all patient groups.

The service was working to understand the diversity of populations across their patch and how people accessed their services. They knew the demographics of people who used services and areas of highest deprivation, typically clustered in urban areas, and the highest populated areas. They used this information to model their services and to make sure they had resource in the right place to provide a timely response to emergency calls.

The service used patient feedback gathered through surveys, complaints, and incident reports to assess satisfaction levels and identify areas where patient experience and outcomes were not optimal. This information was used to inform service improvements and enhance the quality of care delivered.

The service used performance data to monitor key areas such as response times, clinical care quality, patient experience, and the effectiveness of interventions to know how the service was performing and where improvements needed to be made.

Well-led

Rating: Requires Improvement

Percentage Score: 61.00 %

► How do we score this?

Summary

This service is not always well-led

Commentary

We looked for evidence that there was an inclusive and positive culture of continuous learning and improvement that was based on meeting the needs of people who used services and wider communities. We checked that leaders proactively supported staff and collaborated with partners to deliver care that was safe, integrated, person-centred and sustainable, and to reduce inequalities.

We assessed a total of 7 quality statements from this key question.

At the last inspection we rated this key question inadequate.

At this inspection the rating has changed to requires improvement.

This meant the management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

The service was in breach of the legal regulation in relation to good governance. There was a lack of understanding regarding governance and risk management, with roles and responsibilities unclear.

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Shared direction and culture

Overall Score

1 2 3 4

► How do we score this?

Summary

Requires Improvement – This service generally maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service did not have a clear shared vision, strategy and culture which was based on transparency, equity, equality and human rights, diversity and inclusion, and engagement. They did not always understand the challenges and the needs of people and their communities.

Since the last inspection, there had been many changes at SCAS including a change in leadership team and a transformation programme to address challenges related to financial stability, operational performance and service delivery. This programme referred to as fit for the future, included 4 workstreams, governance and well-led, patient safety and experience, performance recovery and culture and wellbeing.

Staff understood the need for change. However, the uncertainty it brought and with the high operational workload it was having a negative effect on staff morale. This was highlighted in the most recent staff survey 2024, where questions related to the organisation were mostly RAG (Red, Amber, Green) rated as amber or red, indicating serious concerns about how operational staff felt about the organisation. However, despite the staff survey results, staff continued to be proud to work for the trust, wear the uniform, and the service they delivered to their patients.

Staff still believed in the mission and vision of the organisation 'we deliver the right care, first time, every time' and 'to be an outstanding team, delivering world leading outcomes through innovation and partnership'. The vision was underpinned by the trust values of caring, innovation, professionalism and teamwork.

The trust was committed to eradicating bullying and harassment from the organisation and the emergency and urgent care service, which had been highlighted as areas of concern previously. There was now an allegations policy which outlined the procedures and guidelines for handling accusations of misconduct or wrongdoing by employees. However, there was a mixed view from operational staff, with some saying they had seen no incidents of bullying and harassment and others saying it was still occurring and not always dealt with effectively or appropriately according to policy by senior managers.

Nationally, sexual safety in ambulance trusts was a serious concern, with recent increases in reported incidents of sexual harassment and misconduct. The trust had launched it's sexual safety charter and there was increased training in awareness and what was actually meant by sexual safety. Again, there were mixed views from operational staff regarding occurrence and how seriously it was taken by managers.

There was a clinical strategy 2023 – 2028 which prioritised emergency care, including cardiac arrest, heart attacks and stroke patients, as well as urgent care for mental health crises and frail elderly patients. Delivery against the strategy was reviewed through a combination of audits, data analysis and feedback mechanisms.

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Well-led

Capable, compassionate and inclusive leaders

Overall Score

1 2 **3** **4**

▶ How do we score this?

Summary

Requires Improvement – This service generally maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

Not all leaders understood the context in which the service delivered care, treatment and support. They did not always embody the culture and values of their workforce and organisation. Leaders did not always have the skills, knowledge, experience and credibility to lead effectively, or they did not always do so with integrity, openness and honesty.

The operational service was led by the executive director of operations, and they were supported by three assistant directors of operations, one for the north of the patch, one for the south and one who headed up urgent care.

There were 7 areas across the patch, known as nodes, 4 in the north and 3 in the south. Each node was managed by a head of operations (HOO) and supported by the clinical operations manager (COM). Within each node were operational teams, the number dependent on the size of the area it covered. Each operational team was managed by a team leader and supported by the clinical team educator (CTE).

The organisation had recently employed a chief paramedic, and along with the chief nurse and chief medical officer, had responsibility for clinical oversight of the service, including the processes and tools implemented to ensure the integrity and safety of clinical practice. Operational staff saw the appointment of a chief paramedic as a positive change for the service.

Operational teams consistently spoke highly of their team leaders and CTEs describing them as visible, supportive and approachable, and team leaders and CTEs had peer support from each other in their nodes. However, views were more mixed regarding management beyond this level, with some concerns raised about the visibility and supportiveness of higher-level managers.

Service leaders could not articulate how cross-node working occurred and how consistency was being maintained between nodes, and across the service as a whole. While heads of operations (HOOs) and clinical operations managers (COMs) referenced meetings with their counterparts, they did not explain these to be formal forums where operational efficiency, clinical quality, staff well-being, and best practices were systematically shared.

The service had made investment in their leadership training, and we were told about the transformational leadership courses. Transformational leadership is a leadership style focused on inspiring and motivating staff to achieve a shared vision, often through personal growth and innovation. However, when we asked team leaders what training they had received for their role, many reported they had received no formal management training to prepare them for the position.

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Well-led

Freedom to speak up

Overall Score

1 2 **3** **4**

► **How do we score this?**

Summary

Requires Improvement – This service generally maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

People did not always feel they could speak up and that their voice would be heard.

The service leaders acknowledged that, historically, staff did not feel safe raising concerns related to patient safety, quality of care, or workplace issues due to fear of blame or detriment. Addressing this was one of the trust's key focuses within the people and culture transformation workstream, which aimed to foster a more open, supportive, and transparent organisational culture.

The trust had grown the freedom to speak up team since the last inspection. There was now a lead freedom to speak up guardian (FTSUG) and two further FTSUGs in the organisation. In addition, the trust had a network of FTSU champions across the organisation, who raised awareness about the importance of speaking up, were points of contact for staff, and provided initial support to colleagues who wanted to raise concerns. The FTSU champion role was voluntary, and appointees carried out this work alongside their substantive posts. Each operational node in the emergency and urgent care service had a FTSU champion for local staff to contact. Staff knew who their FTSU guardians and champions were.

However, we found mixed feelings amongst operational staff. Some staff told us they felt it was safe to speak up, while others believed it was not safe to do so due to past negative experiences. Other staff members felt comfortable speaking up to their team leaders but not at a higher level and felt action would be taken via this route.

Information from the staff survey 2024 showed that 50% of operational staff felt safe to speak up with anything that concerned them in the organisation, however, 68% of staff felt the organisation would not address concerns raised.

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Well-led

Workforce equality, diversity and inclusion

Overall Score

1 2 3 4

► How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service valued diversity in their workforce. They worked towards an inclusive and fair culture by improving equality and equity for people who worked for them.

The trust had established staff forums to create a safe and inclusive space for employees to share experiences, discuss concerns and to contribute to the equality, diversity and inclusion (EDI) initiatives within the organisation. These forums also provided a platform for raising awareness about EDI priorities and progress, offering advice on related policies, and ensuring that diverse perspectives were considered in decision-making. Staff networks included disability awareness, representation and equality; race equality and inclusion network, and multi faith. All networks had an executive sponsor which meant they had direct access to the board. Staff in the emergency and urgent care service contributed to staff forums and belonged to staff networks and found them a good way to get their voice heard.

The trust's workforce was a 50/50 male, female mix which included many women at a senior level at both trust and service level.

The 2024 staff survey showed that 70% of operational staff felt colleagues were polite and treated each other with respect, and 87% of operational staff had not experienced discrimination from other staff. These findings suggested a generally positive working environment, though they also highlighted that nearly a third of staff may not consistently experience respectful interactions, and a minority still reported instances of discrimination.

It was acknowledged that the current service workforce lacked ethnic diversity and did not reflect the demographic makeup of the community it served, with Black and Asian groups notably underrepresented. We were informed of ongoing initiatives aimed at identifying and addressing the barriers that may discourage individuals from these communities from pursuing careers within the ambulance service. These barriers included cultural or familial expectations, as well as perceptions about the demands and challenges associated with the role.

The service was 24 hours a day, 7 days a week service which meant operational staff were expected to work unsocial shifts and flexible working opportunities were limited. The service were piloting initiatives such as self-

rostering and rota changes in an effort to improve work-life balance. However, flexible working remained a significant concern amongst staff, with only 26% of operational staff reported being satisfied with the opportunities for flexible working patterns in the 2024 staff survey.

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Well-led

Governance, management and sustainability

Overall Score

1 2 3 4

► How do we score this?

Summary

Requires Improvement – This service generally maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

There was a lack of understanding regarding the structures or processes to ensure effective clinical governance, supervision, and accountability across the service. Roles and responsibilities were not always clear, and governance processes were not always understood including risk management.

The trust had a governance framework, a system of rules, procedures and responsibilities that guided the organisation's operations, to ensure accountability and continuous improvement across clinical, corporate, staff and financial performance, and the service contributed to this.

Senior operational staff told us they attended many meetings, and the same information could be repeated in several of them. However, they were unable to clearly explain the governance structure or processes in place to ensure effective clinical governance.

There was also notable confusion regarding the use and structure of risk registers. At some operational nodes, senior staff reported the existence of local risk registers, while at others, we were informed that only a single corporate risk register was maintained. We requested copies of the risk registers and were provided with the corporate risk register. Upon review, we noted that key risks raised during our visit such as handover delays and delayed response times were appropriately captured. We also observed that these risks were being discussed at clinical governance meetings. However, it remained unclear whether there were consistent, clear, and effective processes across the service for identifying, recording, managing, and mitigating risks. The lack of clarity among staff and inconsistencies suggested a lack of understanding amongst staff.

System and processes to ensure clinical oversight showed gaps. For example, there were no formal processes in place to ensure information disseminated down to staff, including changes in clinical practice was read, put into practice and embedded.

The service had clear service performance measures, which were recorded and monitored by the service and wider trust. Data collection was detailed and included data on a range of performance measures and quality indicators, which included audit results and patient feedback. Areas of good and poor performance were highlighted and used to challenge and drive forward improvements. Monthly reports were produced and discussed at the relevant governance meetings.

Where relevant, performance was tracked over time to identify unexpected variations that warranted further investigation. This approach enabled staff to quickly pinpoint areas of improved performance as well as those requiring attention and improvement.

However, we observed that discussions in meetings were heavily weighted towards operational performance metrics, with comparatively less emphasis on clinical quality measures. This imbalance could limit the organisation’s ability to fully assess and respond to clinical risks or opportunities for improving patient care, treatment and outcomes.

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Well-led

Partnerships and communities

Overall Score

1 **2** 3 **4**

► How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service understood their duty to collaborate and work in partnership, so their services worked seamlessly for people. They shared information and learning with partners and collaborated for improvement.

The service had positive and collaborative relationships with external partners to support care provision, service development and joined-up care.

The service was represented at the local integrated care board meetings regarding emergency and urgent care medicine and together, with other stakeholders, built a shared understanding of challenges within the health and care system and looked at ways to meet the health needs of the local population, improve patient outcomes, relieve pressure on the services and ensure equitable access to emergency healthcare.

The head of operations (HOO) role was mainly externally facing. They and the clinical head of operations (COM) and hospital ambulance liaison officers (HALO) had been instrumental in building relationships with the acute trusts in their area, especially with the emergency departments (ED), to launch the release to respond initiative and other ED avoidance pathways.

The service had close working relationships with the local police force and fire service, who they would frequently collaborate with to ensure a coordinated and efficient response to incidents, often sharing resources and expertise, and initiatives like the Joint Emergency Services Interoperability Programme (JESIP) which improved how emergency services worked together during major incidents.

The service worked with the local community, for example in schools, local events, and care homes, to increase public awareness and understanding of the ambulance service, ensuring timely and appropriate emergency care, maximizing the chances of a positive outcome, and preventing strain on emergency services. By fostering stronger connections with the community and improving public knowledge, the service hoped it would contribute to more effective and efficient use of emergency resources.

Staff attended local safety advisory group meetings, which along with other agencies, provided guidance and advice to event organisers on safety aspects of their events.

The service was represented at many meetings to ensure vulnerable people received the appropriate support from the right emergency services. This included the frequent attenders meetings, the right care right person (RCRP)

tactical delivery group, and the mental health vulnerable patients steering group.

The service worked with patient representatives and patient forums to help shape and improve the care and treatment people received from the ambulance service. This included patients of different age ranges and equality groups.

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Well-led

Learning, improvement and innovation

Overall Score

1 **2** 3 **4**

▶ How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service focussed on continuous learning, innovation and improvement across the organisation and local system. They encouraged creative ways of delivering equality of experience, outcome and quality of life for people. They actively contribute to safe, effective practice and research.

The service used quality improvement projects (QIP), a structured approach to identify areas for improvement, implementing change, and measured the impact of interventions, to support continuous learning, improvement and innovation work. The trust had trained 42 members of staff in QI methodology. We were given examples where QIP was being used to improve performance and patient experience in the emergency and urgent care service. For example, the double crewed ambulance load list and pouches QI Project. This project focused on the comprehensive restocking of double-crewed ambulances to ensure that only essential and required items were loaded. The primary objectives were to reduce cognitive load on ambulance crews in

emergency situations, to eliminate overstocking and reduce unnecessary duplication of supplies, and reduce the weight of ambulances and consumables wastage for cost saving and sustainability.

The SCAS Bright Ideas scheme was a programme designed to encourage and facilitate staff suggestions for service improvements. It provided a structured process for staff to submit, develop, and potentially implement their ideas, ultimately enhancing the service provided to patients and staff.

The North Harbour resource centre was being used as a proof of concept (POC) hub. There was a POC working group overseeing this work. This was where new ideas of working could be trialled and evaluated to validate whether a concept could be successfully implemented and met requirements, before committing significant resources to full-scale development. There were 4 workstreams which were testing concepts such as alternative roster options, staffing structures, hub mechanics and communication channels.

There was an active research team within the trust whose research activity levels were amongst the best throughout the UK ambulance services and had a national reputation for delivering high quality research data. The service worked with the medical director to deliver these programmes. They had been the second highest recruiting site for the PARAMEDIC3 trial, which was looking at the most effective way to treat someone when their heart suddenly stopped working outside of hospital by giving drugs through a vein or into the bone. Answering this question would help to improve future treatment of people who had a cardiac arrest. The trust was the highest recruiter for the CRASH-4 trial which was aiming to provide reliable evidence about the effects of early intramuscular tranexamic acid on intracranial haemorrhage, disability, death and dementia in older adults with symptomatic head injury. Currently, SCAS with help from the service were recruiting and taking part in 9 research trials. Investing in research was seen as a way to influence and improve care in the future and therefore invested resource into the programme.

Care Quality Commission
South Central Ambulance Service NHS Foundation Trust - Emergency Operations Centre

Overview

Overall Rating: Good

The service is performing well and meeting our expectations.

Summary

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires Improvement

Overall Service Commentary

"Date of Assessment: 6 and 7 May 2025. This was a fully comprehensive assessment of the Emergency Operations Centres (EOC) at South Central Ambulance Service (SCAS) based at Bicester and Otterbourne. An EOC receives and triages 999 calls from members of the public as well as other emergency services. It provides advice and dispatches an ambulance to the scene as appropriate. The EOC also provides assessment and treatment advice to callers who do not need an ambulance response. We assessed all areas of the EOC on both sites, including call handling, dispatch, clinical support specialisms, for example, maternity and mental health. We also met the education and Information Technology (IT) teams. We also interviewed leaders at all levels. The helicopter emergency medical service (HEMS) was not run by SCAS; however, they worked onsite with the EOC. Therefore, we observed interactions between teams. The reason for the assessment was that the trust had an overall rating of Inadequate from the previous assessment in 2022, with EOC rated as Requires Improvement. Since then, the trust had been through a period of transformation and managerial changes. This assessment was to measure the effectiveness of the transformation process to date. We found a team that were passionate about their roles, and proud to work for the ambulance trust. Staff were optimistic about the future direction of the service and understood the reasons for change. However, staff advised us the pace of change was rapid, and communication was not always effective. Focus had been primarily on front facing services and and meant that support services such as the education and IT teams did not feel listened to. The services rating has increased from requires improvement to good".

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Overall People's Experience

The patients and families we spoke with were all positive about the staff. They told us staff treated them with warmth and kindness and provided effective care and treatment.

Patients said they did not feel anxious about raising concerns.

Local acute NHS trusts had been contacted regarding their experiences of working with South Central Ambulance Service NHS Foundation Trust. Most said communication with them was good.

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Safe

Rating: Good

Percentage Score: 72.00 %

▶ How do we score this?

Summary

This service is safe

Commentary

We looked for evidence that safety was a priority for everyone, and that leaders embedded a culture of openness and collaboration. We checked that people were safe and protected from harm. However, staff did not always receive annual appraisals and quality varied across managers, and software systems were old.

We assessed 7 out of 8 quality statements.

At our last assessment, we rated this key question requires improvement. At this assessment, the rating has increased to good.

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Safe

Learning culture

Overall Score

1 2 3 4

▶ How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's Experience

The service had a proactive and positive culture of safety, based on openness and honesty. Staff listened to concerns about safety and investigated and reported safety events. Lessons were learnt to continually identify and embed good practice.

The service was previously in breach of the legal regulation in relation to the governance of reporting, reviewing and learning from incidents. Improvements were found at this assessment, and the service was no longer in breach of this regulation.

Incidents were now reported and investigated in line with theNHS Patient Safety Incident Reporting Framework. We saw the framework was referenced throughout policies related to incidents.

Training was delivered through a mixture of e-learning and face to face sessions. Mandatory training modules varied depending on job role. Staff and managers received a notification when training was due to ensure modules did not expire. We viewed mandatory training dashboards and noted the average completion rate across all modules and staff groups was 97%. All modules met the 95% benchmark for completion apart from 2, where 89% of clinicians had completed the training. However, 100% of all other staff groups were up to date.

All incidents were included as part of the Monitoring and Quality Dashboard Report which was reviewed monthly. Concerns from this report were raised with the Trust Patient Safety and Experience Group, then escalated to the Quality and Safety Committee and then to the Board.

Sharing of learning across the organisation had improved. Managers shared the findings from incidents with staff via fact sheets available on the intranet. Incident reports from all departments were included to ensure cross-service learning.

Managers updated the process for cancelling calls following an incident where a family member cancelled an ambulance, only to require an urgent transfer later that day. Following this incident, all call handlers were required to speak directly with patients to assess whether it was appropriate for a call to be cancelled.

The service was previously in breach of the legal regulation in relation to Duty of Candour (the duty to be open and transparent with people receiving care). Improvements were found at this assessment and the service was no longer in breach of this regulation. Staff now understood their responsibilities regarding Duty of Candour. Staff received training in Duty of Candour as part of the incident framework training, reviewer training and engagement courses. Actions and responsibilities regarding Duty of Candour was included throughout policies related to complaints, incidents and learning.

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Safe

Safe systems, pathways and transitions

Overall Score

1 2 3 4

► How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service worked with people and healthcare partners to establish and maintain safe systems of care, in which safety was managed or monitored. Staff made sure there was continuity of care, including when people moved between different services. However, theComputer Aided Dispatchrequired replacement.

Staff used NHS pathways to categorise all calls, whether they came in via 999 or 111 calls. Once categorised, the calls appeared on the dispatch screen in order that the team could allocate resources. Pathways were universal across all systems. This ensured that both EOC and ambulance crews had access to the same information and medical records.

The service's systems ensured consistency of care across providers. The maternity clinicians were able to directly book patients into post-natal or labour wards at local NHS trusts via the system. The booking immediately appeared on the hospital's booking system. We listened to a call from a patient who stated they had spoken with their GP that morning, but their symptoms had worsened since then. Staff were able to access the GP's updated notes which supported a more effective triage process.

Patient records were completed and stored on an online system. The triage system used prompt questions and answers to navigate an algorithm, which then determined which pathway the patient followed. Records also used a 'pop up' information board that included significant events in the patient's medical history, for example, a red 'pop up' indicated the patient had had a significant previous health condition, for example a stroke.

However, managers at all levels advised us the CAD System was old, slow and in need of replacing. The service used an ongoing replacement plan, with regular review and updates by the board. At the time of assessment, the contract for the system was out for procurement. CAD performance and impact on patient delays was monitored by senior leadership and documented via a risk register. However, the shortest time frame for replacement was by the end of 2026. The service had a back-up system in place in case of electrical failure or if the CAD system itself failed.

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Safe

Safeguarding

Overall Score

1 2 3 4

► How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service worked with people and healthcare partners to improve people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect.

Staff understood their role and responsibilities in protecting patients from abuse and could describe triggers from a call that would alert them to raise a safeguarding concern. Staff could identify their safeguarding leads and knew how to refer safeguarding concerns to outside agencies.

Staff demonstrated how they completed safeguarding questions as part of the triage process. Patient profiles included a safeguarding special note section with different colour coded flags highlighting the type of risk associated with that patient. For example, purple notified staff of mental health concerns and yellow highlighted there was a history of domestic violence.

Staff received training specific to their role on how to recognise and report abuse. Staff working in the control room were trained to level 2 and clinicians and staff in specialist teams received level 3 training. We saw training records that showed 95% of staff had completed safeguarding training for both adults and children, which met the 90% benchmark. The service was previously in breach of the legal regulation in relation to safeguarding, as staff were not trained to the appropriate level and there was no specific EOC safeguarding training. This has since been implemented; improvements were found during this assessment, and the service was no longer in breach of this regulation.

The service was also previously in breach as safeguarding oversight was not monitored by the board. At this assessment, we saw improvements as the board now had oversight and the service was no longer in breach of this regulation.

Staff safeguarding training included; Oliver McGowan training, as well as Female Genital Mutilation training. Oliver McGowan Mandatory Training is a specialised training programme focused on Learning Disability and Autism.

The service had a backup safeguarding paper system should the electronic system fail, which staff demonstrated to us.

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Safe

Involving people to manage risks

Overall Score

1 **2** 3 **4**

► **How do we score this?**

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service worked with people to understand and manage risks by thinking holistically. Staff provided care to meet people's needs that was safe.

Staff used a triage system, maps and special notes to assess and respond appropriately to patient risks. We observed special note flags being used in several calls. One flag noted there was a communal defibrillator near to the patient. Another flag stated the patient had an Advanced Care Plan (ACP) (advanced care planning offers people the opportunity to plan their future care and support, including medical treatment, while they have the capacity to do so). These flags supported staff to triage and care for patients based on their individual risk and circumstances.

Staff responded appropriately to the recognition of deterioration and risk. During one call we listened to, the patient reported their breathing had worsened. Staff acted appropriately by updating the triage tool, which then prompted further questions. The patient was re-triaged and the call category increased.

The midwifery specialism team did not have a clinical lead, however the external partner provider service was in the process of recruiting. However, if there were concerns with a call, staff contacted the maternity triage line, the maternity day unit or the Early Pregnancy Unit for support.

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Safe

Safe environments

Overall Score

1 **2** 3 **4**

► **How do we score this?**

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service ensured facilities supported the delivery of safe care.

Equipment on call centre desks were neatly arranged including all cables and leads. Staff used multiple screens, had their own headsets and sat on 24 hour chairs (Designed to provide maximum comfort for all day use).

Managers regularly reviewed the ergonomics of equipment (the study of people's efficiency in their working environment) to ensure staff were physically comfortable and supported. Where staff members required specific equipment, for example, screen tinting for visual challenges, the desk was labelled to ensure it was reserved for a specific person.

Senior managers reviewed environmental factors as part of a transformation programme known as ‘fit for the future’. This included fitting solar panels at the Otterbourne site, (the structure of the Bicester site meant panels could not be installed) and increasing the amount of recycling available at both sites.

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Safe

Safe and effective staffing

Overall Score

1 2 3 4

► How do we score this?

Summary

Good – This service maximises the effectiveness of people’s care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service ensured there were enough qualified, skilled and experienced staff to keep patients safe. Staff worked well together to provide safe care that met people’s individual needs. However, there was inconsistent quality of appraisals.

At our previous assessment, we recommended the service should ensure all staff received a timely appraisal to assure leaders that competency is maintained. The number of staff who had completed an appraisal within the 12 months prior to inspection was 96%, 1% over target. However, some staff in ‘support’ departments advised us they had not had an appraisal in years. Opinion on the quality of appraisal varied greatly dependent on who their manager was. Some staff advised us appraisal was a useful discussion, whilst others stated managers had pre-populated their report. These staff advised us they did not feel safe to dispute the contents of the appraisal. Operational staff

usually completed their appraisal during quieter night shifts and team leaders advised us they did not have allotted time to prepare for appraisals. Therefore, they had to prepare in their own time, or whilst “juggling my job, which is not ideal”.

The service used a staff rota that was divided between the North and South called the ‘on-call board’. This board was displayed above the dispatchers and managers. One manager was allocated to ensure oversight of who may be needed and where. Managers attended the daily teleconference call to discuss that day’s resources and any upcoming gaps in the rota.

Staff ensured that a crew with the appropriate skill mix was dispatched to the patient. The dispatch team had a ‘crewing sheet’ that included details of skill mix. When crews logged onto an ambulance, their details were sent to the dispatch team, who could then assign them a job.

Two years ago, the service had 42 clinicians, this had since increased to 70.4. From November 2024 to March 2025, the total number of actual Whole Time Equivalent (WTE) staff exceeded the planned number. However, in April 2025 actual WTE was less than planned. Managers advised us that recruitment was ongoing.

Managers sent messages to staff work email addresses if last minute cover was required for a shift. In the 6 weeks prior to assessment, actual versus planned staffing levels matched.

The service had a list of bank staff, usually former employees, to support the team. Bank staff were required to complete at least 1 shift every 3 months and to ensure they were up to date with their mandatory training.

All staff, including bank, maintained a ‘Pathway License’, which was proof of competency for the role. This was renewed annually, and staff were required to work a minimum of 40 hours each month to maintain the license.

Staff advised us their shifts were flexible and supported good work/life balance. We spoke with one part-time staff member; they gave managers their availability 3 months in advance, which they advised worked well for them.

Call handlers were supported in career progression. We saw Band 3 staff had received training to become coaches. When they had completed their competencies, they could apply to become a Band 4 quality assurance lead. Staff in Band 4 could branch out into either audit or team leader Band 5 roles.

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Safe

Infection prevention and control

Overall Score

1 2 3 4

► How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service assessed and managed the risk of infection. Staff detected and controlled the risk of it spreading and shared concerns with appropriate agencies promptly.

We observed staff wiping down their desk areas with antibacterial wipes.

All staff working in operations call centres had their own headsets. Staff were responsible for ensuring headsets were clean, which we observed. Our team were provided headsets during assessment in order that we could listen to calls. The headsets we were provided had covers that were wipeable.

Effective

Rating: Good

Percentage Score: 75.00 %

► How do we score this?

Summary

This service is effective

Commentary

We looked for evidence that people and communities' needs were assessed. We checked that people's care, support and treatment reflected these needs and any protected equality characteristics, ensuring people were at the centre of their care. Understanding current outcomes and exploring best practice was part of the everyday work. However, leaders did not always instil a culture of improvement.

We assessed 5 out of 6 quality statements.

At our last assessment, we rated this key question good. At this assessment, the rating has remained good. This meant people's outcomes were consistently good, and people's feedback confirmed this.

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Effective

Assessing needs

Overall Score

1 2 3 4

► How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service made sure people's care and treatment was effective by assessing and reviewing their health, care, wellbeing and communication needs with them.

At our previous assessment, we recommended that the service should ensure clinical welfare calls were completed within targeted timeframes. Whilst the service was not yet meeting targets, we reviewed their action plans for improvement. Plans included; support from outside agencies such as the Association of Ambulance Chief Executives in reviewing how to improve answer times, redesigning rotas, increasing the spread of shifts to minimise shift changeover shortages, and increasing clinical support. The service was also completing a remodelling exercise. This included identifying the number of Emergency Call Takers required to deliver the future expected operational demand, an external review of the staffing capacity model, as well as a review of the dispatch model and continued recruitment across operational departments.

Staff followed the system's algorithms to monitor and record pain levels as described by callers. Staff also advised patients who were waiting for a crew to pack any regular medication. This ensured the patient had a full supply of

required medicines should they need transfer to hospital.

If a patient with a mental health concern called the service, they were triaged and added to a call back list. The lists were prioritised into 1 hour, 2 hour and 6-hour time frames, depending on presentation. If a patient required immediate assistance, the dispatch team could allocate an alternative resource of 2 vehicles crewed by paramedics and mental health practitioners. These vehicles were available 7 days a week between midday and 10pm, a third vehicle and crew were available Thursday to Sunday between 4pm and 2am. Staff could access patient mental health records via a shared system with the mental health trusts within the patch.

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Effective

Delivering evidence-based care and treatment

Overall Score

1 **2** 3 **4**

► **How do we score this?**

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service planned and delivered people's care and treatment in line with legislation and current evidence-based good practice and standards.

Staff were able to access policies via the service's intranet. We reviewed 10 policies and noted they were appropriately ratified and reviewed within the last 12 months.

The Risk and Policy Group met monthly and maintained oversight of policies to ensure they contained up to date information. This group reported to the Executive Management Committee. The divisional clinical governance meeting chaired by the service director also maintained oversight.

The audit and education team were responsible for reviewing new NHS pathway releases and communicating any changes to staff. Once a new release was due, the team ensured staff were trained and internal testing was completed before going live.

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Effective

How staff, teams and services work together

Overall Score

1 2 3 4

▶ How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service worked well across teams and services to support people. Staff shared their assessment of needs when people moved between different services.

The service had a joint arrangement with the police and had a direct line to call them. When the police used the direct line, staff received a 'pop up' to show the call was coming via that route. This line could also be used for staff requiring Police support as well as redirecting any 'misrouted' calls.

The service had good relationships with the NHS trusts within their patch. If staff had any feedback regarding a specific trust or provider, this could be escalated through their manager. The head of operations met with trusts monthly for engagement meetings.

On each shift, a senior member of staff was allocated as the 'floorwalker'. It was their job to offer help to staff and support teams if anyone needed any further assistance or escalation.

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Effective

Monitoring and improving outcomes

Overall Score

1 2 3 4

▶ How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's Experience

The service routinely monitored people's care and treatment to continuously improve it. Staff ensured that outcomes were positive and consistent, and that they met both clinical expectations and the expectations of people themselves.

The service used up to date methods for assessment and triaging patients. For example, we observed staff used the clinical toxicology database (this database calculates whether a toxic dose has been consumed). Since introducing this tool, the service had seen a decrease in the number of deployed ambulances and attendances to the emergency department (ED) in relation to toxicity.

Since the introduction of 'Hear and treat', the service had seen a reduction in the number of minor cases being transferred to hospitals. 'Hear and treat' is a system used by ambulance clinicians to manage emergency calls where a patient's condition indicates ambulance dispatch is not necessary.

We observed clinical staff using camera links on patients' phones to be able to visually assess a patient, when description was insufficient to determine if help was required, or assistance was needed whilst an ambulance was on-route. The maternity team used this system when supporting a woman and pregnant people giving birth to assess dilation and assist with the birth of their baby if crews could not reach the woman in time. We also observed a clinician use the system to determine whether a child's rash needed urgent attention, when the mother was struggling with a description. Audits demonstrated this had reduced the length of time taken to assess patients.

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Effective

Consent to care and treatment

Overall Score

1 2 3 4

▶ How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service told people about their rights around consent and respected these when delivering person-centred care and treatment.

The service was previously in breach of regulations relating to governance as staff did not have access to a policy specifically related to the Mental Capacity Act (2005). At this assessment, we reviewed the new policy, and found the contents were up to date and ratified. Therefore, improvements were made, and the service was no longer in breach of this regulation.

Staff understood their role and responsibilities regarding applying the Mental Capacity Act (2005). Staff understood they had to assume capacity unless they found evidence to suggest otherwise.

Staff described how they assessed capacity of children and young people. Staff followed best practices in line with Gillick and Fraser guidelines.

Staff did not conduct mental capacity assessments whilst on a call with a patient. If staff had reason to question a patient's capacity, this was communicated to the crew via dispatch, in order that the crew could assess whilst onsite.

Caring

Rating: Good

Percentage Score: 75.00 %

► How do we score this?

Summary

This service is caring

Commentary

We looked for evidence that people were always treated with kindness, empathy and compassion. We checked that people's privacy and dignity was respected. We also looked for evidence that every effort was made to take people's wishes into account and respect their choices.

We assessed 4 out of 4 quality statements.

At our last assessment we rated this key question good. At this assessment the rating has remained good. This meant people felt well-supported, cared for and treated with dignity and respect.

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Caring

Kindness, compassion and dignity

Overall Score

1 2 3 4

► How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

People's Experience

The service always treated people with kindness, empathy and compassion and respected their privacy and dignity. Staff treated colleagues from other organisations with kindness and respect.

We observed staff interacting considerately with patients. Staff did not try to rush patients but were also encouraging and got their attention when patients got distracted.

Staff spoke with patients in a supportive manner. We listened to calls and heard staff telling patients they were “doing great”. However, staff understood in which circumstances they needed to have firm conversations in order to direct the call when the patient was distressed.

We observed staff supporting a patient who was having a mental health crisis. Police were onsite with the patient and staff and police worked together, spoke to the patient compassionately and supported the patient to safety.

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Caring

Treating people as individuals

Overall Score

1 **2** 3 **4**

► **How do we score this?**

Summary

Good – This service maximises the effectiveness of people’s care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service treated people as individuals and made sure people’s care, support and treatment met people’s needs and preferences. Staff took account of people’s strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

Staff understood the needs of patients and how those needs differentiated from person to person. For example, staff were speaking with a carer on behalf of the patient, as the patient had severe dementia. When staff spoke with the patient, they were aware that the answers provided may not always be correct as per carer's advice. However, staff personalised their approach to the call appropriately. They kept the number of questions to a minimum and kept all questions as simple as possible. We observed staff were very kind and gentle when speaking to the patient.

If a patient requested a female-only crew, staff explained in emergencies they may not be able to accommodate this, but staff always tried to deliver and communicated this request to the dispatch team.

When a patient was identified as requiring extra assistance, this was added to their file as a special note. One patient's note stated they were autistic and required information to be repeated. We observed staff ensured all parts of their conversation were repeated, and staff also double checked the patient's understanding.

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Caring

Independence, choice and control

Overall Score

1 2 3 4

► How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service promoted people's independence.

The midwife specialist team received calls from women who were concerned about their pregnancy and unsure what to do. We observed the team were able to reassure and signpost to other agencies where appropriate. For example, local community support, such as the National Childbirth Trust, breast feeding groups, GPs etc.

Staff ensured they signposted patients to recognised websites, and encouraged patients, friends and family to check sources of online information to ensure accuracy.

The midwife team offered choice to callers. For example, one patient had not yet registered her pregnancy with a trust. Staff discussed details of different local trusts they could attend for their current concern, as well as potential locations to give birth.

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Caring

Workforce wellbeing and enablement

Overall Score

1 **2** 3 **4**

▶ **How do we score this?**

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

Staff were able to summon help when needed. We observed managers regularly check in with staff. Managers were located throughout the call centre floor for good visibility and accessibility. Staff raised their hand if they needed immediate assistance from a manager, or they could send a message via email or call if help was required from a specific person or team.

Staff were supported during and after difficult calls, and managers provided live support as well as assistance after a call. Staff could also mark themselves as having a 'difficult call'. Staff advised us that after a difficult call, they could rest in the quiet room. Managers could refer staff to an external trauma risk management (TRIM) service. TRIM practitioners are trained to spot signs of distress in people that may go unnoticed. Call handlers received badges to put on their lanyard if they successfully guided someone on the phone through CPR or a birth. Additionally, this was displayed with the name of the call handler and date of the call.

Each site had allocated well-being officers, these were staff available to support teams after a difficult call or when further mental health support was required. Staff also had access to well-being areas where they could relax in a non-clinical, calm environment. These areas included sofas, plants, low lighting, bean bags and access to books as well as outdoor areas including gardens and benches. Both Bicester and Otterbourne sites also provided staff with a prayer area that included a prayer mat and various religious texts. Each site had allocated well-being champions, these were staff available to support teams after a difficult call or when further mental health support was required. There was variation in staff opinion regarding the effectiveness of these, some staff loved the areas whilst others thought they were a ‘token’ gesture. Although all staff advised us they thought the well-being champions were very supportive.

We observed posters displayed in staff areas for domestic abuse, health and well-being charities and sexual harassment support telephone lines. We also saw a poster detailing how SCAS employees could receive benefits from local vendors, shops and services.

Responsive

Rating: Good

Percentage Score: 71.00 %

▶ How do we score this?

Summary

This service is responsive

Commentary

We looked for evidence that people and communities were always at the centre of how care was planned and delivered. We also looked for evidence that people could access care in ways that met their personal circumstances and protected equality characteristics.

We assessed 6 out of 6 quality statements.

At our last assessment we rated this key question requires improvement. At this assessment the rating has increased to good.

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Responsive

Person-centred Care

Overall Score

1 2 3 4

▶ How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service made sure people were at the centre of their care and treatment choices and staff decided, in partnership with people, how to respond to any relevant changes in people's needs.

The service had a patient experience team, whose role included finding out the experiences of patients, friends and family and compiling feedback on how services could be improved.

Staff could access person centred patient information via the special notes on the system. These included Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions. Questions around DNACPR were included as part of the algorithm triage process.

If a patient had a history of violence and was deemed 'dangerous', a 'Patient of Interest' alert notified staff to proceed with caution. This was linked to both the patient's file and their address, in case a call came from their home or a public location.

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Responsive

Care provision, Integration and continuity

Overall Score

1 2 3 4

▶ How do we score this?

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service understood the diverse health and care needs of people and their local communities, so care was joined-up, flexible and supported choice and continuity.

Staff could access an interpretation telephone service with the ability to translate 240 different languages. We observed a call where the patient required a Bulgarian interpreter. The system for accessing the interpreter was quick, professional and helpful. Staff understood their responsibility in using an official interpretation service rather than reliance on family members and friends.

Staff had access to systems to support patients with hearing difficulties and advised us they would prioritise those patients in the queue.

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Responsive

Providing Information

Overall Score

1 2 3 4

▶ How do we score this?

Summary

Requires Improvement – This service generally maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service did not always provide appropriate, accurate and up-to-date information.

Staff at the EOC who worked in clinical teams advised us they learned most of the transformation changes from their managers as they had insufficient time to check emails. Staff received a 6 minute 'grace period' from when they logged on, to when they had to be available for calls. Therefore, staff either did not read email communication notices, or had to do so in their own time. This was further impacted when information was not always shared before being implemented. For example, senior leaders made the decision to remove access to internet search engines, however, this was not communicated to staff prior to removal. This resulted in the IT department being inundated with tickets as staff were unaware of the change.

At the previous assessment we recommended the trust should review methods of communication between senior executives and staff to ensure important information was received and understood. Managers demonstrated the various methods introduced to communicate with staff. However, staff advised us they were either overwhelmed with too much information, had begun to disengage with the transformation programme, or found they did not have the time to review updates. Therefore, the service was still struggling to effectively communicate internally.

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Responsive

Listening to and involving people

Overall Score

1 **2** 3 **4**

▶ **How do we score this?**

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with

them.

Processes

The service made it easy for people to share feedback and ideas, or raise complaints about their care, treatment and support.

We spoke with patients who had used the service. They advised us they knew how to make a complaint or raise a concern. All patients we spoke with knew which trust was looking after them and that it was South Central Ambulance Service, who had transferred them to hospital.

We reviewed the service's complaints policy, and it was up to date and ratified. It included steps for escalating a complaint and details of the Parliamentary and Health Service Ombudsman. The policy defined complaint categorisation, based on urgency and included a timeframe for responses. The service introduced a complaints manager in August 2021, whose role was to co-ordinate the response to formal complaints. The patient experience team responded to urgent and immediate replies within 28 days, and standard replies were provided within 56 days. We saw data that confirmed, the team were meeting these timeframes.

Staff also said they received feedback once a complaint file had closed.

At the previous assessment, we advised the service should share learning from complaints across departments. Staff advised us changes to practice after a complaint were shared across all areas of service. This was communicated via managers and the intranet. Therefore, the service had improved since the last assessment.

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Responsive

Equity in access

Overall Score

1 **2** 3 **4**

► **How do we score this?**

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with

them.

Processes

The service did not always make sure that people could access the care, support and treatment they needed when they needed it.

Performance statistics were divided by each site into North and South. The service used a traffic light system to show if staff were hitting targets for call times. Each member of staff in operations had their own traffic light system to keep them updated on whether they were hitting targets.

In the 12 months prior to assessment, the service received around 77,235 to 95,282 calls per month. Key Performance Indicators were based on individual commissioned targets.

Data showed in the 12 months leading up to the assessment, 95% of call answering times were above (worse) that the national provider median. During the same period, the services 99th centile answering time was consistently worse than the average of all ambulance trusts.

Whilst the trust was not performing when compared against their peers, between February and April 2025 there was a sustained improvement in call answering times, a reduction in calls that were abandoned and improved clinical call back times, with the trust meeting their expected targets. However, there was not sufficient time to demonstrate this was sustainable over a long period or embedded in the culture of the trust.

Trust leaders had actions plans in place to ensure continued improvement of call response times. For example, the service was introducing a new CAD system which was on plan to be implemented by the end of 2026. The trust was also increasing call handler staffing numbers, and had plans demonstrating improvements in staffing turnover and retention.

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Responsive

Equity in experiences and outcomes

Overall Score

1 **2** 3 **4**

► **How do we score this?**

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

Staff and leaders actively listened to all information about people who were most likely to experience inequality in experience or outcomes and tailored their care, support and treatment in response to this.

Managers continuously monitored call and ambulance stacks. They liaised with their local operational commander if pressures were increasing, and resources were tight. The local operational commanders managed ambulance crews and liaised with hospitals if pressures increased.

Clinicians could refer patients to Urgent Community Response (UCR) teams to avoid hospital admissions. This team included a variety of professionals, including doctors, district nurses, occupational therapists, etc. They carried out same-day assessments and treatment within the community. The Urgent Care desk clinicians were able to directly dispatch specialist paramedics themselves, rather than go via the dispatch team. The specialist paramedics mostly drove cars rather than ambulances, this saved ambulance vehicles for other, more high risk, jobs.

Well-led

Rating: Requires Improvement

Percentage Score: 57.00 %

▶ How do we score this?

Summary

This service is not always well-led

Commentary

We looked for evidence that there was an inclusive and positive culture. We checked whether staff felt able to speak up, and that leaders had the knowledge and experience to drive the service. We found communication was not always consistent or given in a timely way. Staff had not 'bought into' the

transformation process. Senior leaders were aware of this and had plans to improve the culture that was impacted by the transformation. This was impacted by structural changes within the department, as well as future planning.

We assessed 7 out of 7 quality statements.

At our last assessment we rated this key question requires improvement. At this assessment the rating has remained requires improvement.

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Well-led

Shared direction and culture

Overall Score

1 2 **3** **4**

► **How do we score this?**

Summary

Requires Improvement – This service generally maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service had a shared vision, strategy and culture. The managerial team and staff fully supported the vision and strategy of the service. However, staff advised us that specific details were not always effectively shared with teams.

The Fit for the Future programme had five programmes and seven pillars and this had developed into Fit for the Future five strategic themes, Enabling Services; Digital Transformation; Clinical Effectiveness;People and Culture; Partnerships and Sustainability. Each programme had a clear pathway and provided focus for managers as well as oversight. The Clinical Effectiveness programme's operations function split tasks into tiers, based on impact, Tier one projects included a Category 2 improvement programme, with the aim of reducing Category 2 response times by reducing task time, including hospital hand over times, improving vehicle availability, reviewing the response model and reducing demand via telephone clinical triage.

Staff advised us they understood the reasoning for the transformation, but were impacted by ‘change fatigue’. For example, the contracts for both sites where the EOCs were based were due to expire in the next few years. This meant it was likely the service was going to move to a different location. The senior leadership team were unable to share the specifics, in line with the Royal Institute of British Architects (RIBA) guidelines. Senior leaders arranged engagement events to ensure staff consultation. However, staff we spoke with advised us this had taken an enormous emotional toll on them, as well as impacting their ability to move and buy homes, as they were unsure where their job would be located.

A service, and its staff had recently moved from South Central Ambulance Service to another provider. Staff across the EOC stated they felt the strain of this move and were worried about their own jobs.

As part of the transformation process, the trust was completing a financial review that included potential redundancies. At the time of assessment, the corporate team review had completed, however the operational review was yet to proceed. Operational staff we spoke with were aware of the upcoming changes and were nervous about their potential impact. Staff within corporate services described the stress related to being categorised as an ‘at risk’ team, worrying about the risk of redundancy, and the preparations they made to re-interview for their jobs. However, many staff advised us that natural attrition meant staffing numbers had reduced, meaning their team was no longer at risk and “the stress was all for nothing”. Staff at both sites said the methods and communication for the review were poor and they were hoping lessons were learned prior to the operational review commencing.

The service held several staff engagement events to give staff the opportunity to discuss their thoughts and worries regarding the transformation programme. Although the trust, provided evidence they had consultations with the education team regarding leadership. Staff in the education team advised us they were told their team was not part of the transformation plans for the upcoming year. Therefore, they did not attend the engagement events. Two staff advised us they later found out their team was a part of upcoming plans; however, they had missed their opportunity to join the event.

Managers advised us they were introducing staff polls to determine whether the pace of change was appropriate. However, all the above had impacted staff morale and this was reflected in the most recent NHS Staff Survey results completed in October 2024.

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Well-led

Capable, compassionate and inclusive leaders

Overall Score

1 2 3 4

How do we score this?

Summary

Requires Improvement – This service generally maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

Not all leaders embodied the culture and values of their workforce and organisation.

Non-clinical teams advised us they struggled to get managers onboard with new ideas and ways of working. Staff advised us that in pockets of the service there was a resistance to change from the leadership team, and this impacted on staffs' ability to do their role. Staff in IT advised us they raised concerns regarding a lack of a document library at their weekly team meetings. This meant there was no official policy, process or procedure for responding to a wide range of service-related risks. However, managers did not provide the resources to complete this project. Therefore, staff were compiling documents themselves, ad hoc around their usual duties.

The education team was previously overseen by a head of department, a manager and a team leader. At the time of assessment, one member of staff was covering all three roles with support from an assistant, who did not have an educational background. Therefore, the team were not getting the support, challenge and oversight they would have from three separate managers.

At the time of assessment, the executive team were looking into ways of improving their visibility. The chief executive currently worked ad hoc shifts with crews; however, he was looking at widening his footprint to include the EOC service.

We observed there was a display showing photographs of managers, details of names and positions and lines of responsibility. This ensured staff knew who was leading each team that day and who to escalate concerns to.

Managers used notice boards and email bulletins to communicate changes with staff. The exec team also published a weekly ‘topical’ message on the service’s intranet.

Staff we spoke with were complimentary of their team leaders, control duty managers and shift managers. Staff were especially complimentary of the Head of EOC and the Head of Call Centres.

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Well-led

Freedom to speak up

Overall Score

1 2 **3** **4**

▶ **How do we score this?**

Summary

Requires Improvement – This service generally maximises the effectiveness of people’s care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

Most staff felt that they could speak up, however, there were mixed opinions as to whether action would be taken.

The service was previously in breach of the legal regulation in relation to good governance. This was regarding listening to staff concerns and demonstrating action against bullying, harassment and sexually inappropriate behaviour. Improvements were found at this assessment regarding the service’s approach to preventing harassment and sexually inappropriate behaviors. Senior managers had completed an annual review of trust oversight of Freedom to Speak Up that included an action plan for the upcoming year. This was focused on bringing staff onboard, improving trust in senior managers and developing a specific Freedom to Speak Up Policy, a Reflection and Planning Tool, and including Speak Up training as part of the mandatory training catalogue.

The service was focused on reviewing inappropriate behaviours and sexual safety, including a specific sexual safety training for managers. Senior managers met the Freedom to Speak Up Team monthly and reviewed and

developed values around behaviours. Managers had also developed a performance and accountability framework, which was to be included as part of transformation work on people and culture.

Whilst the service had made many improvements, we found staff were not yet assured that they would be listened to, or that speaking up would lead to change. Therefore, there was still work to be done in supporting staff to 'buy in' to the culture change.

Staff we spoke with knew who the Freedom to Speak Up Officers were at their locations.

Staff in support roles at both sites stated they still found it difficult to speak up, and that suggestions for change were looked upon by their managers as complaints rather than recommendations for improvement.

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Well-led

Workforce equality, diversity and inclusion

Overall Score

1 **2** 3 **4**

▶ **How do we score this?**

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service valued diversity in their workforce. Staff worked towards an inclusive and fair culture by improving equality and equity for people who work for them.

The trust had an Equality, Diversity and Inclusion (EDI) Lead who produced an annual report of staff diversity and the work of the EDI networks. All staff support networks were active and each had a sponsor who was part of the executive team. Staff were supported to attend PRIDE events, and the Women's Network was involved in the trust's review of behaviours, especially around sexual safety.

All staff we spoke with were extremely proud to work for the trust. They were passionate about their work and wanted to provide a good service to the public.

We observed that the workforce at both sites were inclusive and people with protected characteristics were supported to work onsite. We noted an office desk located in an easy access area that had a bed nearby for a guide dog. Staff on both sites had access to disabled parking and lifts for employees with mobility issues.

All recruitment processes were anonymised, this ensured bias did not sway managers, supported staff with protected characteristics and ensured staff with the most appropriate qualifications and experience were recruited.

Staff completed a monthly survey, which enabled senior managers to understand and review issues from a staff point of view. Current staff also completed stay interviews with their team leaders. This gave staff the opportunity to state why they remained in their role, what they would change, whether they needed reasonable adjustments (employers must make reasonable adjustments to make sure workers with disabilities or health conditions are not substantially disadvantaged), and discussions regarding how they liked to be managed. Staff advised us they appreciated these opportunities as they felt very passionate about their jobs and the importance of the service.

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Well-led

Governance, management and sustainability

Overall Score

1 2 **3** **4**

▶ **How do we score this?**

Summary

Requires Improvement – This service generally maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

Not all areas of the service had clear responsibilities, roles, systems of accountability or evidenced good governance.

The service was in breach of the legal regulation relating to governance as there was a lack of oversight of non-clinical services.

Reviews of IT tickets were undertaken on a daily, weekly and monthly basis by the Head of Service Desk. KPI's are presented at the Digital Steering Group (bi-monthly) and reviewed with the stakeholders. However, none of the IT staff we spoke with were aware of this analysis and stated they did not known what themes were coming out of ticket analysis. Therefore, there was a disconnect between managers and staff.

Staff in the IT department advised us there was no formal system for managing IT issues out of hours. Staff stated they added their names to a contact list, and were unaware of a hierarchy or pathway for escalation of issues and concerns. The trust submitted evidence to us demonstrating the IT out of hours was part of the formal on call 24/7 rota, with escalations to the Silver, Gold and Duty Directors as needed.There was a formal incident management, group chat to alert and engage on issues and a daily report was presented to IT managers detailing themes from the last 24hrs. Again, all IT staff we spoke with were unaware of this system and was a further example of poor communication between managers and staff.

There was no decommissioning process for either IT systems or equipment. An official process would ensure the secure disposal of equipment, protect data and sensitive information, as well as ensuring compliance with regulatory requirements. Therefore, the service could not guarantee the safe disposal of IT equipment and its contents.

'Support' service reviews were reactive rather than proactive. For example, managers commissioned the development of a software approval process, when they determined the service did not have one. However, this did not trigger a full review of whether there were other gaps in their oversight of the service.

The audit department had a separate team who reviewed clinical audits with the education team, including the auditing of call compliance. We found whilst there were formal standardised processes for reviewing and marking calls. We were given examples where staff opinion differed as to whether the audit was a pass or fail, therefore the outcome of an audit depended on opinion rather than process, meant there was a risk of inconsistencies across the service, which could also impact call handler's pathway license.

the Director of Clinical Coordination Centres had monthly meetings to review performance, as well as catch up calls with their Executive Director, 3 times a week.

The senior management team including the Head of EOC and Head of Call Centres had formal weekly meetings to review performance, as well as catch up calls with their director, 3 times a week.

A member of the board was the lead on quality governance. A monthly trust level performance report had service input. This was reviewed by the Trust Board. The service now used the findings from these committees to produce a monthly performance report that was reviewed by the board.

Managers received governance and risk assessment training to support them in ensuring consistency on how to report risks, complete a thorough investigation, and write reports for example coroners reports.

The trust developed a performance and accountability framework for managers to follow.Team leaders escalated risks in their monthly operational meetings with the head of EOC and head of call centres, who would then escalate to the divisional clinical governance meeting. Any risks that needed further escalation were reported to the governance lead who sat on the board.

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Well-led

Partnerships and communities

Overall Score

1 **2** 3 **4**

▶ **How do we score this?**

Summary

Good – This service maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service understood their duty to collaborate and work in partnership, so services work seamlessly for people. Staff shared information and learning with partners and collaborated for improvement.

The service had national contingency plans and systems with other trusts, including NHS trusts in case of external events, for example a national disaster or terror attack. There were also clear plans in place, including roles and responsibilities to support internal services in case of a targeted attack, power outage, phone outage etc. The service had an in date IT Major incident policy which was aligned to NHS Emergency Preparedness, Resilience and Response (EPRR). However, all staff we spoke with in the IT department were

unaware of the document and advised us they had no process to follow in the event of an emergency.Therefore, staff awareness and understanding of the policies did not provide sufficient assurance that staff would act in accordance with them.

Managers advised us they had worked hard to improve relationships with partners, especially those who also worked onsite. For example, the Helicopter Emergency Medical Service. Managers arranged regular engagement meetings and worked with another air ambulance service to implement a common model of partnership working.

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Well-led

Learning, improvement and innovation

Overall Score

1 2 **3** **4**

▶ **How do we score this?**

Summary

Requires Improvement – This service generally maximises the effectiveness of people's care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Processes

The service was focused on continuous learning and improvement. However, there were some areas where managers were not supporting innovative approaches to learning.

Staff told us they were involved in changes to practice, learning and improvement. For example, a crew was delayed in attending to a patient as they struggled to gain access to the building where the patient was injured. In response to this incident, the EOC team developed a tool to notify crews if there were concerns or issues with access to a particular address. This enabled staff to inform the crew of how-to best gain entry. The service audited that this initiative reduced delays in accessing addresses during future attendances.

The service’s education initiative programmes were not always followed through. Staff advised us projects were abruptly ended; however, they did not receive any reasoning behind the decision to stop.

Targets for the education department were based on statistics for training completion, rather than evidence of quality improvement. Staff in the education advised us that when they suggested introducing new methods, training and scenarios, they did not feel they had managerial support to implement this. However, the trust followed the NHS Pathways training programme.

We observed the service had ‘You said, We did’ boards where staff made suggestions for service improvement and managers stated what they had done in response. Staff we spoke with said they were encouraged to write on it.

Operational staff at both sites advised us they were encouraged to raise any issues or concerns with their managers.

Managers had also developed a Virtual Care Improvement Steering Group consists of seven work streams that detail the improvement work going across EOC and 111.

Upward Report of the Audit Committee

Date Meeting met **15th January 2026**
Chair of Meeting **Mike McEnaney, Non-Executive Director**
Reporting to **Trust Board**

Items	Issue	Action Owner	Action
Points for escalation			
Internal Audit Report – Sickness Absence Management	A limited assurance report was received with regards to the effectiveness of the controls that are in place. This was noted by internal audit to be a theme in terms of policy not being effectively implemented. The Committee noted that sickness absence management was on the agenda for the January People & Culture Committee meeting and requested that the report and management response be give further consideration there.	BM	Circulated with the papers for the PACC meeting on 21st January 2026.
Internal Audit Report – Medicines Management	A limited assurance report was received with regards to the design and effectiveness of the controls in place. The committee was given assurance that the actions were already embedded within the Pharmacy Strategic Plan which reports to the Medicines Management	BM	Added to the agenda for the February Quality & Safety Committee

	and Governance Group. The audit report will be submitted to the Quality & Safety Committee in February for further assurance to be obtained around the plans in place to address the areas highlighted.		
Key issues and / or Business matters to raise			
Board Assurance Framework	Noted that the planning process for 2026/27 was underway and the BAF would then be refreshed. Dedicated time on the March Board Seminar for Board input into the BAF.	BM	Item is already scheduled on the March Board Seminar
Internal Audit Plan 2026/27	The committee approved the plan for the year noting that the plan would remain flexible to accommodate any issues/risks arising in year.	N/A	The committee will monitor progress against the plan and will receive all completed reports.
Areas of concern and / or Risks			
As per the areas for escalation.			
Items for information and / or awareness			
Annual Accounts Submission	The timetable was received, and an extraordinary Audit Committee is planned in June to consider the accounts and annual report and recommend these to the board for approval	BM	Meeting already scheduled for June, but the date will be amended now the submission date has been issued.
Best Practice and / or Excellence			
Internal Audit Actions	There were no outstanding overdue action arising out of internal audits and no actions remaining open on the committee action log.	N/A	
Single Tender Waivers	The number of Single Tender Waivers has dramatically reduced and the controls that have been put into place via the Procurement Team are effective.	N/A	On-going monitoring at Audit Committee.

Policy Position	Compliance with policies in date is 89% and the committee was assured that there were trajectories in place for all out-of-date policies to be refreshed and approved at the relevant meeting	N/A	Monitoring of progress will take place via EMC and via the Risk & Policy Group, alongside regular updates to Audit Committee.
Compliance with Terms of Reference			
Compliant	Meeting was quorate and all items were pertinent to the terms of reference.		
Policies approved*			
Anti-Fraud Policy	The policy was approved and will be published on The Hub.	N/A	N/A

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

Upward Report of the Charitable Funds Committee

Date Meeting met 5 February 2026
Chair of Meeting Ruth Williams, NED
Reporting to SCAS Board

Items	Issue	Action Owner	Action
Points for escalation			
Key issues and / or Business matters to raise			
Charity Strategy	Work has begun on a new five-year strategy and we have identified 7 strategic pillars that will form the basis of the strategy. These are: 1. To increase income from £500k to £2m 2. To build and create corporate partnerships 3. To respond to strategic priorities set by Community Engagement Team (CET) for volunteer responders 4. To fund health and wellbeing projects and initiatives for staff and volunteers 5. To ensure financial sustainability and resilience for the Charity	**Charity CEO**	These pillars were presented to the CFC along with the inputs needed to ensure success, the mechanisms for change and the likely short term and longer-term outcomes. The next step is to build this out into a full strategy, which will have a clear strategy on a page alongside a more comprehensive plan and a five-year financial plan. As part of this work it has been agreed that some more formal

	6. To create volunteer excellence across the Trust 7. To effectively use communications to build the profile of the Charity, increase awareness, support and funding.		agreements between SCAS and the Charity will be needed to manage the expectation to support the charity in areas such as IT and Operational delivery.
Charity Budget 2026-2027	The Charity budget was approved by the CFC with the agreement that it would be reviewed when the strategy and 5-year financial plan was available in March. The budget reflects a deficit outturn on unrestricted funds of £43k. Following two years of a deficit budget the aim is to move to a break-even position. Expenditure figures included in the budget are still not based on actual need in terms of volunteer uniform and replacement equipment and clearer identification of need is required from the Ops Department to ensure the budget is as accurate as possible. It is agreed that a more forward looking financial plan to manage major equipment replacement is needed to avoid reliance on our reserves.	**Charity CEO**	26-27 to be reviewed following submission of the 5-year strategy and financial plan. Charity financial plan to be benchmarked against similar charities and to be reviewed from a 'going concern' perspective aligned with the Charity Commission expectations.
Staff Health & Wellbeing	Our application for NHS Charities Together funding for a Workforce Wellbeing Grant has been submitted. The application, supported by Danny Hariram, is for £250k to support the education of new starters and student paramedics to equip staff with tools to prepare them for the trauma they are about to be exposed to. This support will include six scheduled proactive coaching sessions made available to all new CCC/999 new starters in their first six months to discuss exposure to trauma and to develop healthy coping	**Charity CEO / Health & Wellbeing Team**	The outcome of our application will be known in March 2026.

	mechanisms and long-term mental health resilience.		
Areas of concern and / or Risks			
Items for information and / or awareness			
Annual Report and Accounts 2024-2025	The Annual report and accounts have been uploaded to the Charity Commission website prior to our 31 January 2026 deadline.	**Charity CEO**	
Best Practice and / or Excellence			
Charity Committee/Board	The Charitable Funds Committee needs to be explicitly a committee of the board of trustees for the Charity and not the Trust. This work is ongoing and will also support the pillars outlines in the strategy to support the understanding of all the relationships between the Board and the Charity.	**Chief Governance Officer**	
Compliance with Terms of Reference			
Policies approved*			

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

Author: Vanessa Casey

Title: SCAS Charity CEO
Date: 15.01.26

Upward Report of the – South Central Fleet Services Board

Date Meeting met 08/01/2026
Chair of Meeting Mike McEnaney - NED
Reporting to SCAS Board

Items	Issue	Action Owner	Action
Points for escalation			
Key issues and / or Business matters to raise			
Finance report	Performance is behind budget by £317k due higher replacement part usage and a shortfall on CIP both impacted by the aged fleet and the unreliability of the Fiat vehicles.		
Operational performance	Vehicle Off Road ratio remains high at 37% of which Aux Charging accounts for 38% of this. Without the Aux Charging problem VOR would be reduced to 22%.Engines is the second biggest problem. DCA availability has increased 11% in 2025 – this with the increased VOR means the total fleet is much increased and costly.	Lem Freezer Mark Ainsworth	Urgently resolve the Aux Charging issue.

	Workshop VOR activity has increased by19% over 24/25 and 59% over 23/24. The Aylesbury workshop will contribute significantly to the repair capacity.		
Fleet replacement	Delivery of new vehicles has improved but remains behind plan. The quality of the fitout of received vehicles is a cause for concern and creates additional delays.		
Areas of concern and / or Risks			
Appraisals	Appraisal completion rate is down to 52.78%. The plan for getting back to compliance is delayed due to the high work demand.		
Items for information and / or awareness			
Risk Register	This was reviewed in line with the business plan, the key risks being delay to the supply of new vehicles and risk to the supply chain of spare parts availability.		
Best Practice and / or Excellence			
Absence levels	Absence continues to be low at 2%		
Compliance with Terms of Reference			

Policies approved*			

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

Author: **Mike McEnaney**

Title: **Chair of Audit Committee**

Date: **29/01/26**

Trust Board of Directors Meeting in Public 5 February 2026

Title	**Transition Committee – Committee in Common**
Report Author	**Becky Murray, Chief Governance Officer**
Executive Owner	**Becky Murray, Chief Governance Officer**
Agenda Item	**26**
Governance Pathway: Previous	None
Governance Pathway Next Steps	Trust Board

1. Purpose

To seek approval from the Trust Board to establish a Transition Committee as a formal committee of the board, which will meet as a Committee in Common at the same time as the South East Coast Ambulance NHS Foundation Trust's (SECAmb) Transition Committee.

2. Executive Summary

Following board discussion and emphasis on retaining strong board oversight of the collaboration between South Central Ambulance Services (SCAS) and SECAmb and the transition to a Group Model, it was agreed that a Transition Committee would be established as a formal committee of the Board. The purpose of the committee is set out in the terms of reference, which are identical for both organisations, but essentially, it will perform the following oversight functions:

- Progress with the functional workstreams that are on-going as part of the collaboration
- Transition to a Group Model
- Ensuring that any joint decisions are properly governed and taken.

It is important to note that SCAS and SECAmb remain separate legal entities and as such, each board must resolve to establish its own Transition Committee and approve the terms of reference, but the two committees will meet at the same time, as a Committee in Common.

Membership of the Committee from SCAS is as follows:

- Chief Finance Officer
- Chief People Officer

- Chief Digital Officer
- Les Broude, Non-Executive Director and Senior Independent Director
- Harbhajan Brar, Non-Executive Director (People & Culture Committee focus)
- Ruth Williams, Non-Executive Director (Quality & Safety Committee focus)

It is also important to note that as each trust has its own Standing Orders and Standing Financial instructions, the terms of reference are expressly clear that no decisions taken by the Committee in Common will cause or commit either trust to go beyond current financial limits, and decisions that require the approval of the respective trust boards will be referred to the boards for decision.

Areas of Risk

There are no specific risks associated with establishing the committee. The risk lies in failing to have in place robust oversight of this work and the inability to assure the Board that the work is progressing, is properly governed and is not exposing the Board to unknown or unacceptable risk. Establishing the committee mitigates this risk.

3. Link to Strategic Theme

The letter links to all of our strategic themes but particularly to our Partnerships & Sustainability strategic theme.

4. Link to Board Assurance Framework Risk(s)

The presentation links to all Board Assurance Framework risks.

5. Quality/Equality Impact Assessment

No QIA/EIA is required.

7. Recommendations

EMC is asked to NOTE the content of the letter and the proposed next steps.

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

South Central Ambulance Service
NHS Foundation Trust

South Central Ambulance Service NHS Foundation Trust

Transition Committee - Terms of Reference

1 CONSTITUTION

The Board hereby resolves to establish a Committee of the Board to be known as the Transition Committee. It will meet at the same time as the Transition Committee of South East Coast Ambulance Service NHS Foundation Trust, as a 'Committee in Common'.

2 PURPOSE

2.1 The primary responsibility of the Committee in Common is to oversee the delivery of the benefits set out in the Group Model Outline Business Case (OBC) and ensure a cohesive plan is developed into our 26/27 and medium-term plans.

2.2 The Committee in Common will provide strategic oversight, to ensure robust decision-making and resource allocation for the agreed joint programmes of work, ensuring timely progression of critical initiatives where timeline imperatives and/or investment decisions could impact the benefits realisation window.

3 STRATEGIC CONTEXT

3.1 On 8 October 2025, the Boards of South Central Ambulance Service NHS Foundation Trust (SCAS) and South East Coast Ambulance Service NHS Foundation Trust (SECAmb) approved an Outline Business Case to establish a South Central and South East Ambulance Group.

3.2 On 10 November 2025, the Trusts received a commissioning intent letter that set out expectations for joint planning between the two organisations to start delivering benefits of the group from 26/27. In response to commissioning intentions, both organisations agreed to establishing a Board Committee to meet in common, as the primary Board governance mechanism for joint planning and delivery during the transition period. This approach recognises that while the two organisations remain separate legal entities, a collaborative approach is essential to begin delivering the benefits of a Group model as outlined in the approved Business Case.

3.3 The Committee in Common is established to accelerate progress on joint planning areas that require early decision-making. This proactive approach is to maximise benefits realisation and prevent missed opportunities arising from external timelines or funding windows. These joint planning areas form the core set of priorities that will create a cohesive foundation, enabling the future Group Chair and CEO to build upon a well aligned and strategic plan.

3.4 The Committee in Common will be reviewed once the Group CEO is in post, which is expected in Autumn 2026 and more substantive Group governance structures are established.

3.5 The effectiveness of the Committee in Common will be assessed externally by the joint Strategic Commissioning Group (SCG), hosted by the SE single strategic commissioner, and internally by the respective Boards as they oversee and approve plans for 26/27 ensuring alignment with the commitments set out in the OBC.

4 INTEGRATION PRINCIPLES

4.1 The aim of the Committee in Common is to initiate integration through joint decision-making for 2026/27 and medium-term planning supporting the delivery of benefits outlined in the OBC.

4.2 Ensuring time-critical decisions are taken promptly to avoid missed opportunities and that investment decisions are made with appropriate pace to maximise benefits realisation.

4.3 Ensuring joint planning areas are adequately resourced and that joint plans are in in place for Board approval as part of the 2026/27 planning process.

5 PRIMARY OBJECTIVES

5.1 Provide oversight for **Joint Planning Areas** for 2026/27 as set out to commissioners in the response to the commissioning intent letter received on 10 November 2025.

Joint Planning Area	Expected outcome in 26/27
Joint CAD/ePCR and digital infrastructure	A joint CAD/ePCR programme will be put in place, development of a single specification for CAD 999/111/ePCR will be developed and suitably taken through a procurement process, to be implemented in 2027/28. Enabling digital infrastructure will also be aligned as required to ensure we achieve the aim of migrating to a common overall platform.
Joint Clinical Model	Development of a single ambulance clinical model proposition, aligned to both providers' strategies, and the 10-year plan ambitions to support a shift into the community. This agreed common model will be fundamental to underpinning the C2 trajectories, patient outcomes, workforce plans, and medium-term financials. We do not expect these to be aligned in 26/27, but the common model sufficiently understood to reflect any changes from 27/28 planning onwards.
Corporate Services Consolidation	We expect a degree of corporate and support functions to consolidate through 26/27. These are yet untested and may not realise benefits until 27/28 given the complexities associated with coordinating this type of re-structuring across two organisations during transition

Strategic Estates	With consolidation of our systems and clinical models, there exists significant opportunity to align our strategic estates and achieve a leaner overall footprint. The focus will be to have a cohesive plan that enables rationalising call centres across the south-east such that we don't miss out on key opportunities that may present to us with key leases terminating through 2028.
Performance Improvement and Patient Outcomes	Each organisation will develop its own plans and trajectories to meet a C2 Mean of 25 minutes on average through 26/27 in line with planning guidance. We will be aligning productivity assumptions such that each plan can be tested against the other and no opportunities for improvement are missed (i.e. across H&T, Job Cycle Time, etc.) As part of the medium-term planning, we expect to develop a common narrative and build on the joint clinical model to describe how we return to an 18-minute C2 constitutional standard in an equitable way across the whole of the South-East. In the development of our trajectories, we will expect to work closely with the pan-ICB strategic commissioner on defining a clear and consistent approach to pathway improvement, and in particular establishing joint improvement in outcomes for patients who fall, are frail, or living with older age.

5.2 Oversee the development and delivery of joint **communications plans** for internal and external stakeholders, ensuring and consistent narrative, with a strong focus on the delivery of the clinical benefits.

5.3 **Other Functional Collaboration**, as outlined in appendix 1, will continue through existing channels. Issues requiring joint decision that cannot be resolved by individual executive leads will be escalated to the Committee in Common by exception.

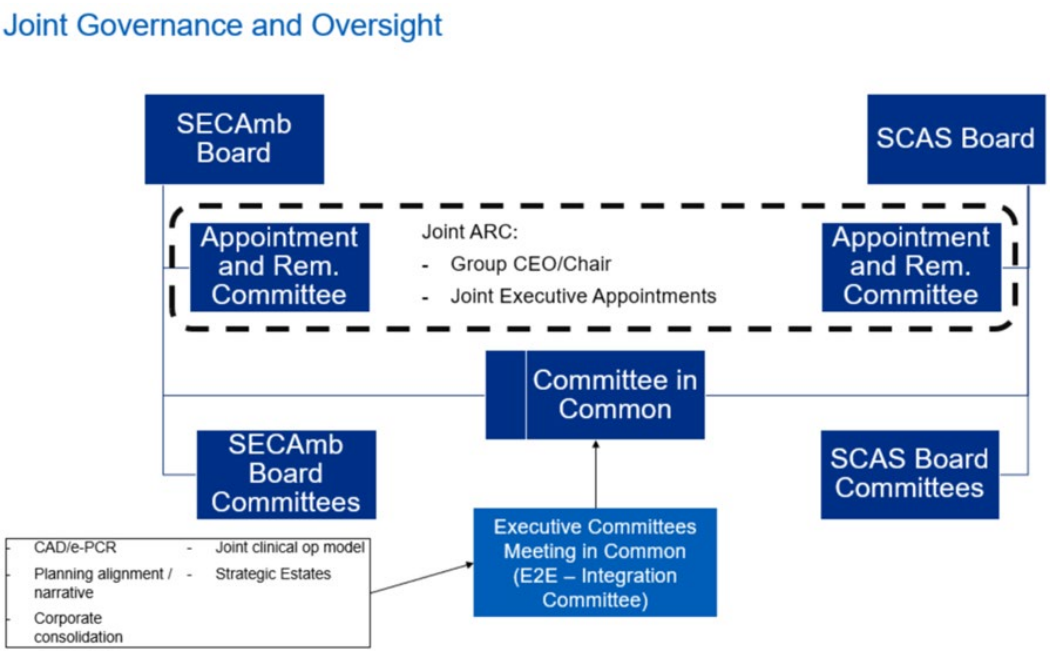
6 ACCOUNTABILITY AND DELEGATED AUTHORITY

6.1 Delegated Authority

The Committee in Common is authorised by the Board in accordance with these Terms of Reference. It is empowered to act as a Committee in Common, reducing duplication and enabling streamlined decision making across both organisations.

6.2 Reporting Lines

The Committee in Common will seek assurance from the work of the Executive Integration Committee and will report progress / assurance to the Trust Board.



6.3 Decision-Making Authority

The Committee in Common has authority to:

- Agree overall budget and financial envelopes for joint areas of work for 26/27 planning purposes, for Board approval.
- Allocate resources and funding in line with each organisation's SFIs and SO.
- Approve programme mandates, scope, timelines and business cases
- Approve procurement strategies and supplier selection for joint programmes (subject to appropriate governance processes and thresholds)
- Make any other decisions that require joint decision-making as identified and escalated for the Functional Collaboration areas
- Approve specifications and requirements for joint systems and services
- Commission external support and professional services for joint programmes
- Make decisions on programme sequencing and interdependencies

The Committee in Common does **not** have authority to:

- Commit either Trust to expenditure beyond agreed integration budget envelopes without approval in accordance with the SFIs
- Make decisions that would materially alter the strategic direction agreed in the Outline Business Case
- Make structural or organisational changes to Executive teams or reporting lines (reserved to ARC)
- Alter existing contractual commitments or service delivery models without appropriate Board approval
- Make decisions that would compromise operational performance or patient safety
- Override individual Trust Board decisions on matters within their statutory responsibilities

6.4 Conflict Resolution

Conflicts that cannot be resolved by the Committee in Common would be taken to the individual Boards for discussion and resolution would be sought through the Chairs or Group Chair once appointed.

7 MEMBERSHIP

7.1 The Committee in Common will be chaired by one of the Non-Executive Directors They will agree co-chairing arrangements with the Chair of the SECAmb Transition Committee

7.2 Core members of the Committee in Common

- Three NEDs (including the Committee Chair)
- CEO
- Two Executive Directors
- Joint Strategic Lead

7.3 Briefed deputies are welcome where the Executive member cannot attend.

7.4 Additional Attendees

In addition to the members, the following individuals shall regularly attend meetings:

- Chief Governance Officer
- Programme Senior Responsible Owners where they are leading key programmes and providing SME or operational input to ensure alignment.
- PMO leads for both organisations to provide clear visibility of progress against the plans, development of agreed mandates, and ensure cohesive development of upward assurance reports for Boards and Commissioners.

7.5 Administration and Secretariat

The Chief Governance Officer is responsible for ensuring appropriate administrative support is provided to the Committee in Common. The support provided by the person(s) identified by the Chief Governance Officer will include the planning of meetings, setting agendas, collating and circulating papers, taking minutes of meetings, and maintaining records of attendance for reporting in the Trust's Annual Report

As a minimum, papers will be shared 3 working days in advance, and will include collaboration programme-level RAID, and highlight reports for each agreed joint planning area.

Where joint decisions are required, these will be clearly outlined.

An action log will be kept and managed outside the meeting to ensure time is used effectively.

An agenda-type will be as follows

- Welcome, minutes of previous meeting, action log by exception
- Approval of new programme mandates (for the initial meetings)
- Progress update for approved programmes
- Communication plan review and look-forward
- Key risks for escalation

8 MEETING ARRANGEMENTS

8.1 Frequency

- The Committee in Common will meet bi-monthly commencing January 2026.
- Additional extraordinary meetings may be convened by the Chair where time-critical decisions are required between scheduled meetings.

8.2 Quorum

The meeting will be quorate with at least three members, as follows

- The Chair, or a nominated deputy
- At least one Executive Director
- At least one NED

9 REVIEW AND DISSOLUTION

9.1 These Terms of Reference will be reviewed **quarterly** to ensure they remain fit for purpose as the transition progresses and requirements evolve.

The Committee in Common is anticipated to operate for 6-9 months, with formal dissolution or refresh expected by September/October 2026 following a review by the Group Chair and CEO.

10 SUCCESS MEASURES

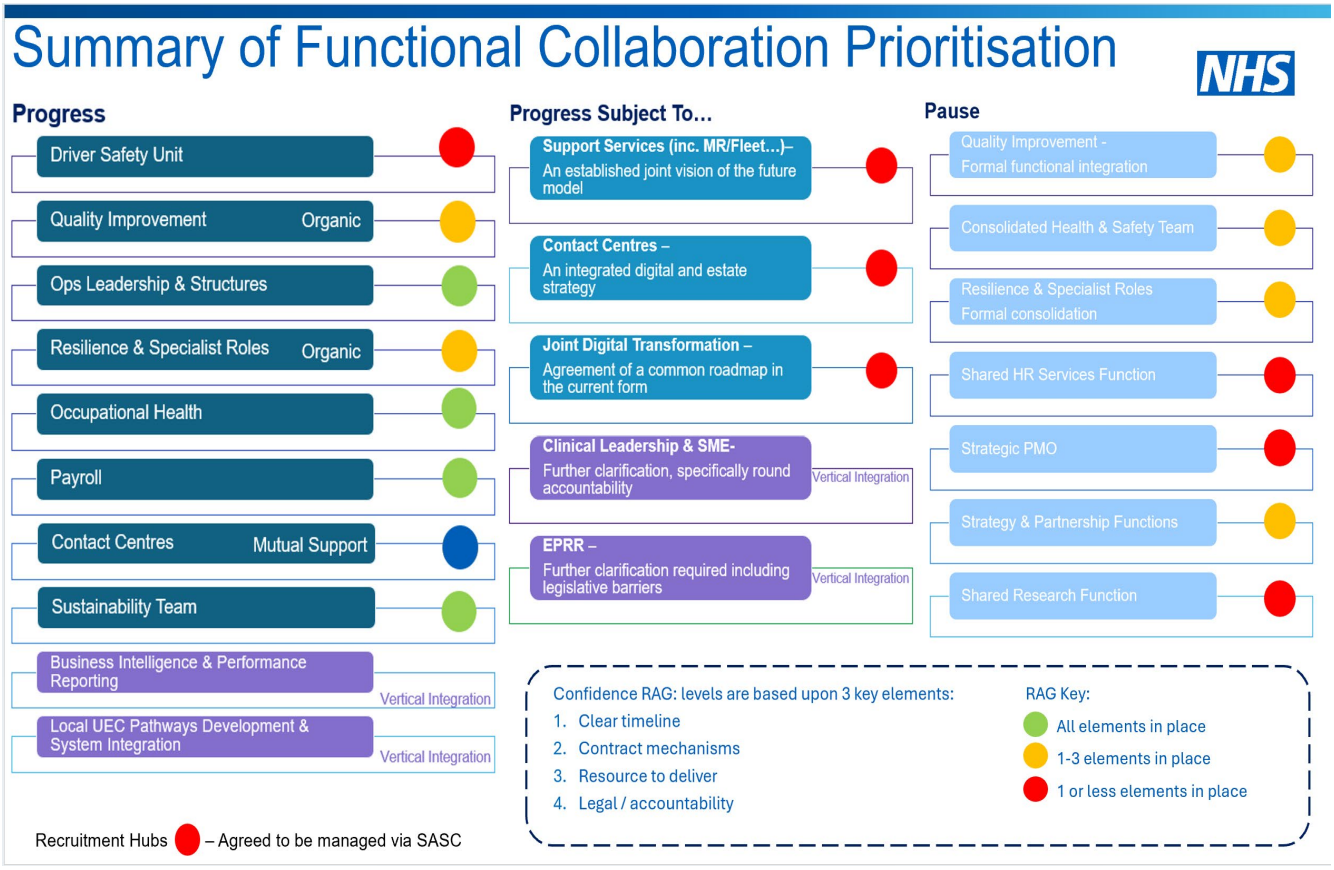
10.1 The Committee in Common will be considered successful if:

- All joint planning areas demonstrate measurable progress against agreed 2026/27 outcomes
- Time-critical investment decisions are made within the required opportunity windows
- Benefits realisation remains on track for delivery in 2027/28 and beyond
- Operational performance and patient safety are maintained or improved throughout transition
- Resources are deployed efficiently across joint programmes, supported by a clear cohesive plan reflected in the Board Assurance Frameworks. This plan should outline individual organisational priorities alongside joint programmes of work.

APPROVAL AND VERSION CONTROL

Date	Version	Approved By	Status	Changes
07/01/2026	0.1	Claire Webster	Draft	Initial draft for review
08/01/2026	0.2	David Ruiz-Celada	Draft	Review and feedback Joint Strategic Lead

Appendix 1


Summary of Functional Collaboration Prioritisation
NHS
Progress
Driver Safety Unit
Quality Improvement
Organic
Ops Leadership & Structures
Resilience & Specialist Roles
Organic
Occupational Health
Payroll
Contact Centres
Mutual Support
Sustainability Team
Business Intelligence & Performance Reporting
Vertical Integration
Local UEC Pathways Development & System Integration
Vertical Integration
Progress Subject To...
Support Services (inc. MR/Fleet...)–
An established joint vision of the future model
Contact Centres –
An integrated digital and estate strategy
Joint Digital Transformation –
Agreement of a common roadmap in the current form
Clinical Leadership & SME-
Further clarification, specifically round accountability
Vertical Integration
EPRR –
Further clarification required including legislative barriers
Vertical Integration
Pause
Quality Improvement -
Formal functional integration
Consolidated Health & Safety Team
Resilience & Specialist Roles
Formal consolidation
Shared HR Services Function
Strategic PMO
Strategy & Partnership Functions
Shared Research Function
Confidence RAG: levels are based upon 3 key elements:
1. Clear timeline
2. Contract mechanisms
3. Resource to deliver
4. Legal / accountability
RAG Key:
All elements in place
1-3 elements in place
1 or less elements in place
Recruitment Hubs – Agreed to be managed via SASC