PUBLIC BOARD AGENDA

Date: 2 April 2026

Time: 9:45 – 12:45

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

Board Members:	
Ian Green, OBE	Non-Executive Director (Chairing)
Les Broude	Non-Executive Director
Harbhajan Brar	Non-Executive Director
Gary Ford, CBE	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
David Ruiz-Celada	Joint Strategic Lead
Apologies for Absence:	
Professor Sir Keith Willett, CBE	Chair
Ruth Williams	Non-Executive Director
Gary Ford, CBE	Non-Executive Director
Duncan Robertson	Chief Paramedic Officer
Paul Kempster *	Chief Transformation Officer

Right care, first time, for our patients
Our five strategic themes to make SCAS FIT FOR THE future
Enabling Services
Digital Transformation
Clinical Effectiveness
People and Culture
Partnerships and Sustainability

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** Ian Green, OBE	**Verbal**		09.45
2	**Declarations of Interests and Fit and Proper Persons Test** Ian Green, OBE	**ENC 1**	**Verbal**	
3	**Minutes from the Public Board meeting held on 5 February 2026** Ian Green, OBE	**ENC 2**	**Approval**	
4	**Board Action Log** Becky Murray, Chief Governance Officer	**ENC 3**	**Approval**	
5	**Chair's Report** Ian Green, OBE	**Enc 4**	**Noting**	09.55
6	**Chief Executive Officer's Report** David Eltringham, Chief Executive Officer	**ENC 5**	**Noting**	10.05
7	**Volunteer Story** Stuart Rees, Chief Finance Officer	**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** Craig Ellis, Chief Digital & Information Officer	**ENC 8**	**Assurance**	10.35
10	**Finance Report Month 11** 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**	**ENC 11**	**Assurance**	11.15

	Craig Ellis, Chief Digital & Information Officer			
Strategic Theme: Clinical Effectiveness				
13	**Clinical Effectiveness Board Assurance Framework Risks** Duncan Robertson, Chief Paramedic Officer	**ENC 12**	**Assurance**	11.20
14	**Quality and Safety Committee Report** Katie Kapernaros, NED	**ENC 13**	**Verbal Assurance**	11.25
Strategic Theme: People & Culture				
15	**People & Culture Board Assurance Framework Risks** Danny Hariram, Chief People Officer/Deputy Chief Executive	**ENC 14**	**Assurance**	11.30
16	**People & Culture Committee Report** Harbhajan Brar, NED	**ENC 15**	**Assurance**	11.35
17	**Staff Survey Results 2025** 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	**Annual Review against NHS Code of Governance for Provider Trusts 2025/26** Becky Murray, Chief Governance Officer	**ENC 20**	**Noting**	12.10
22	**Audit Committee Chair's Report** Mike McEnaney, NED Chair	**ENC 21**	**Assurance**	12.20
23	**Charitable Funds Committee Report** Ruth Williams, NED Chair	**ENC 22**	**Assurance**	12.25

24	**South Central Fleet Services Board Report** Mike McEnaney, NED Chair	**Verbal**	**Assurance**	12.30
Closing Business				
25	**Summary of actions from the meeting** Becky Murray, Chief Governance Officer	**Verbal**	**Noting**	12.40
26	**Questions from the public** Ian Green, OBE	**Verbal**	**Response**	12.45
27	**Any Other Business**	**Verbal**	**Noting**	-
28	**Review of Meeting** NED: Gary Ford Executive: Stuart Rees	**Verbal**	**Discussion**	12.45
29	**Date and Time of Next Meeting in Public** Thursday 4 June 2026 at 9.45am Blue Light Hub, 3 Thornbury, West Ashland, Milton Keynes MK6 4BB.	**-**	**Noting**	

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: 23 March 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. Strategic Advisor, Prevention Access Campaign (US based charity)
4. Chair, NHS Wales Joint Commissioning Committee
5. NED, Somerset Care Ltd
6. Vice Chair, NHS Confederation LGBT Leaders Network
7. The Drawing Room Ltd, non salaried co-owner of private consultancy business

Interests that ended in the last six months

8. Chair of Salisbury NHS Foundation Trust
9. Member of Advisory Group, NHS Patient Safety Commissioner

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

Current 'Other' Interests

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

Interests that ended in the last six months

4. Member of NHS Providers Finance & General Purposes Committee
5. Chair of FTN Limited (Trading subsidiary of NHS Providers charity)

KATIE KAPERNAROS, NON-EXECUTIVE DIRECTOR

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

6. Non-Executive Director, The Pensions Regulator
7. Non-Executive Director, The Property Ombudsman

Current 'Other' Interests

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

Interests that ended in the last six months

9. Non-Executive Director, Oxford University Hospitals NHS Foundation Trust

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. None

HARBHAJAN BRAR, NON-EXECUTIVE DIRECTOR

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

1. Non Executive Director - South East Coast Ambulance Service

Current 'Other' Interests

2. Director of HR, Imperial College London
3. Magistrate, Oxford
4. AdvanceHE – People and Remuneration Committee – Co-optee

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

Interests that ended in the last six months

15. 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. None

Interests that ended in the last six months

3. Non-Executive Director for the London Cyber Resiliency Centre. Undertook this in Nov-2022

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. None

Current 'Other' Interests

2. None

Interests that ended in the last six months

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

END

Minutes
Public Trust Board Meeting

Date: 5 February 2026
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)	Non-Executive Director
Mark Ainsworth (MA)	Executive Director of Operations
Craig Ellis (CE)	Chief Digital & Information Officer
Danny Harriman (DH)	Interim Chief People Officer
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:	
Kofo Abayomi (KA)	Head of Corporate Governance & Compliance
Gillian Hodgetts (GH)	Director of Communications, Marketing and Engagement
Observers:	
None	
Apologies:	
Ian Green, OBE	Non-Executive Director
John Black	Chief Medical Officer
David Ruiz-Celada	Joint Strategic Lead
Katie Kapernaros	Non-Executive Director
Mike McEnaney	Non-Executive Director
Paul Kempster	Chief Transformation Officer

Item No.	Agenda Item
1	**Chair's Welcome, Apologies for Absence**

1.1	Keith Willett (Chair) opened the meeting, noting delays due to significant roadworks affecting attendance. The meeting was recorded for minute-taking accuracy.
1.2	The Chair welcomed members of the public, governors, staff and volunteers. Board members were asked to introduce themselves when speaking for the first time.
1.3	An exceptional acknowledgment was made to Helen Ramsay, Lead Governor, for her six years of service and leadership.
2	**Declarations of Interests**
2.1	Board members were reminded to review and update their declarations of interest.
2.2	Several Board members updated their declarations relating to external appointments or resignations.
2.3	A correction was noted regarding timing categories ("within the last six months").
2.4	No new conflicts affecting meeting items were identified.
2.5	**Action: Declarations of Interests: amendments to be made to individual declarations as discussed.**
3	**Minutes from Public Board Meeting held on 27 November 2025**
3.1	The minutes of the public board meeting held on 27 November 2025 were agreed as an accurate record of the meeting subject to the following amendments: • Typographical correction: "acquisition" to "accreditation" in section 16.2. • Wording adjustment in section 18.3 regarding "tolerance levels" for bullying and harassment (clarified as zero tolerance). • Clarification of alignment with SCAS Charity priorities.
4	**Matters Arising and Action Log**
4.1	All actions proposed for closure except TB/25/007 (NED site visits). An approach to integrate NED visits with accreditation visits was discussed and supported, noting: • Accreditation visits alone will not meet existing expectations on visit frequency. • Compliance and Governance teams will develop a combined process. • Flexibility retained for informal station visits and engagement with staff.
4.2	**Action: BM & HY to return with a revised proposal.**
4.3	The Board **NOTED** the action log and **APPROVED** the closure of completed actions.
5	**Chairs Report**

5.1	The Chair provided an overview of recent activity, beginning with an update on the completion of the three-day CQC Well-Led inspection. He noted that the inspection team had offered informal but encouraging feedback at the conclusion of their visit, commenting positively on the openness, honesty and clarity demonstrated by staff and leaders throughout the process. Importantly, the inspectors did not identify any immediate safety concerns, which the Chair highlighted as a reassuring reflection of the organisation's progress.
5.2	He also briefed the Board on the ongoing work to appoint a joint Chair and joint Chief Executive for both SCAS and South East Coast Ambulance Service (SECAmb). This process remains underway, with further developments expected over the coming weeks as both organisations move towards a more collaborative leadership model.
5.3	In closing, the Chair expressed his appreciation to all staff, volunteers and senior leaders who participated in the inspection. He emphasised that their professionalism, candour and commitment had been evident throughout and were instrumental in ensuring that the Trust was well represented during the CQC's assessment.
5.4	No questions were raised following the Chair's update.
5.5	The Board **NOTED** the Chairs verbal update and site and engagement visits report.
6	**Chief Executive Officer's Report**
6.1	DE reported that the Trust has now formally exited both the governance and leadership elements of the national Recovery Support Programme, as well as the Hampshire & Isle of Wight financial programme. NHS England's confirmation was received over the Christmas period, and a formal letter of thanks has been sent in return. He acknowledged the considerable effort across the organisation in meeting the reporting requirements and driving the improvements that enabled this outcome.
6.2	He noted that the recent CQC Well-Led inspection was conducted with high levels of openness and transparency from staff. Inspectors raised no immediate concerns, and their informal feedback contained no surprises. A feedback letter has since been reviewed at the Executive Management Committee, and all related improvement actions will be absorbed into the wider Integrated Improvement Plan while the Trust awaits the full CQC report.
6.3	DE highlighted continued operational pressures over the winter period, with increased demand and performance challenges across the system. Despite this, 999 and clinical call-handling services maintained resilience during peak activity.
6.4	A significant portion of the update focused on the ongoing fleet and Vehicle Off-Road (VOR) issues, described as a persistent and complex "wicked problem" with clear impacts on patient care. A Business Continuity Incident was declared on 7 January in response to escalating VOR levels and associated long waits. Daily Executive Huddles are monitoring progress, although challenges persist due to national delays in chassis supply, converter failures, mechanical issues linked to ageing vehicles, and shortcomings in charging infrastructure.

6.5	Progress continues within the Fit for the Future programme, particularly in executive development, strengthening of the Senior Leadership Group, and finalisation of the revised Values and Behaviours framework. DE also drew attention to recent positive media coverage, including a BBC feature following a ride-out with a Specialist Paramedic, which showcased the professionalism and quality of SCAS staff.
6.6	The Board **NOTED** the Chief Executive Officer's Report.
7	**Staff Story**
7.1	Megan Gray (MG), a Specialist Practitioner (SP) Paramedic, shared her experience of working within the SP service, highlighting the team's role in delivering urgent care for conditions such as minor injuries, acute illness, catheter issues, wound care and frailty-related needs. She explained that the SP model is highly effective in supporting patients safely at home, achieving an impressive *see-and-treat rate of around 75%*, compared with approximately 49% for double-manned ambulances. Megan illustrated the personal impact of this work through examples of vulnerable patients who benefited from timely care at home, including a frail patient who received wound closure during a night-time visit, avoiding hospital attendance.
7.2	Despite the strengths of the model, MG emphasised a significant operational challenge: the frequent shortage of suitable vehicles for SPs. This issue sometimes prevents deployment, forces cancellations or requires SPs to use their own cars or travel to alternative stations to collect a vehicle. Coverage is particularly stretched in certain geographic areas, leading to inconsistent availability. She nonetheless praised the SP team for its adaptability, innovation and strong internal culture, which help ensure patients continue to receive high-quality care despite these constraints.
7.3	In discussion, Board members recognised the value of the SP role in reducing hospital conveyance and supporting safe community-based care. They explored the potential for SPs to undertake independent prescribing in the future, which could further enhance patient outcomes and reduce unnecessary admissions. The Board also noted the need for strengthened clinical support pathways, particularly for frailty and complex comorbidities, enabling SPs to access timely senior clinical advice from secondary care.
7.4	The Board acknowledged how central the SP service is to hospital avoidance and wider system flow and agreed several follow-up actions. The operational team will review options for expanding SP coverage across the geography. SP clinicians will be linked into the forthcoming visit from the national paramedic prescribing lead to support future workforce development. Finally, Board members committed to undertaking ride-outs to better understand operational realities and the challenges facing frontline staff.
7.5	**The Board NOTED the Staff Story.**
8	**Finance & Performance Committee Report**

8.1	LB provided an update on the work of the Finance Performance Committee, confirming that the Trust is on track to meet its year-end financial position, though the margin remains tight and will require continued close oversight. He highlighted the strong collaborative approach between the Finance Performance Committee and the People and Culture Committee, which is helping ensure a cohesive understanding of financial and operational pressures. The committee also discussed the significant challenges arising from fleet pressures. While these continue to exert strain on budgets and service delivery, the committee was assured that appropriate actions and mitigations are already underway.
8.2	**The Board NOTED the Finance and Performance Committee Report.**
9	**Integrated Performance Report (IPR)** SR presented the IPR which reported on data and performance for the reporting period: <u>Operational Performance</u>
9.1	MA provided an overview of operational performance across December, January and early February. December performance showed Cat 2 responses at 31:54 against a target of 30:10, with improvement over the Christmas period due to restrictions on annual leave and a notable reduction in hospital handover delays, which averaged around 19 minutes. However, the rise in failed meal breaks continued to place pressure on staff welfare and operational efficiency.
9.2	January performance deteriorated, with Cat 2 responses increasing to 37:31 against a target of 29:16. MA explained that a Business Continuity Incident was declared on 16 January due to worsening Vehicle Off-Road (VOR) levels. Although overall demand was 2% below plan, operational hours had increased, adding further strain to an already limited fleet. VOR was estimated to have added nearly five minutes (4:46) to Cat 2 performance alone. Early February showed improvement, with Cat 2 performance at 27:43; however, performance remained off the year-to-date trajectory.
9.3	<u>Fleet and VOR Deep-Dive</u> SR delivered a detailed assessment of fleet challenges, emphasising a series of national and local constraints. The UK-wide shortage of chassis and the collapse of several vehicle converters have severely restricted supply. He also described widespread failures in Fiat Euro 6 engines, attributed to their extensive idling during ambulance operations. Comparisons with other ambulance services revealed that SCAS operates with only two workshops, while many services run up to sixteen, limiting capacity for timely repairs. Further pressures stem from insufficient charging infrastructure at several sites and the over-utilisation of existing vehicles, which accelerates mechanical failures.
9.4	A range of actions is underway, including opening a third workshop and progressing a business case for a fourth. Bulk vehicle chargers have been procured, and electrical assessments are taking place across sites. Although sixty-four rapid response vehicles have been ordered, many deliveries have been delayed. SR noted that planning for the future electric fleet will

9.5	require significant capital investment, with early estimates indicating a need of at least £20 million. Board members emphasised the importance of distinguishing between issues within SCAS control and national supply-chain constraints and highlighted the need for consistent national VOR metrics. The Board also recognised the substantial financial implications facing the Trust over the next five to ten years. **Action: consideration to be given to separating Fleet KPIs into issues within our control and issues outside of our control.**
9.6	Workforce and People DH reported that staffing levels remain below budgeted establishment, with a freeze on corporate recruitment still in place. Recruitment for 999 roles continues to be strong, and turnover is stable at 17.9%. Sickness levels stand at 6.2%, primarily driven by long-term conditions, and efforts are underway to strengthen occupational health support and wellbeing initiatives. PDR compliance has fallen back to 73%, against a target of 95%, and although meal-break compliance is improving, performance remains variable across different bases and requires further attention.
9.7	Quality & Safety HY and DR outlined quality and safety performance indicators, noting that patient safety incidents remain stable, with only 2.5% resulting in moderate or severe harm. The predominant themes continue to relate to delays and re-contact rates. Concerns were raised around the increasing risks for patients in Categories 3 and 4. Safeguarding and infection prevention and control performance remain strong and within expected thresholds. Medicines management issues, particularly around controlled drugs, are being addressed through targeted improvement work.
9.8	The Board **NOTED** the **Integrated Performance Report (IPR).**
10	**Finance Report Month 9**
10.1	SR presented the Finance Report, confirming that the year-end financial forecast remains on track, with all required mitigations identified and in progress. He also highlighted the financial and operational pressure created by the recent major incident at Southampton Hospital, which required additional support from SCAS.
10.2	The Board acknowledged the Trust's exceptional record of delivering its cost improvement plans over the past three years.
10.3	The Board **NOTED Finance Report Month 9.**
11	**Enabling Services Board Assurance Framework Risks**
11.1	SR presented the Board Assurance Framework for Enabling Services, highlighting several escalating risks across the organisation. He reported that the fleet risk rating had been increased to 20 (red), reflecting the severity of ongoing Vehicle Off-Road issues and the wider

	challenges affecting vehicle availability and reliability. Estates infrastructure was also identified as a critical organisational constraint, with increasing pressure on capacity, condition, and suitability of sites to support operational and future fleet requirements.
11.2	**Action: Board seminar to be arranged to discuss Estates and Infrastructure.**
11.3	The Board **APPROVED** the Enabling Services Board Assurance Framework Risks.
12	**Digital Transformation Board Assurance Framework Risks**
12.1	The Board discussed the digital transformation risks captured within the Board Assurance Framework, noting that the digital risk remains significant and is currently rated high due to ongoing system resilience, cyber security and infrastructure challenges. It was highlighted that the Trust continues to require substantial investment in cyber security to maintain compliance with national requirements and protect critical clinical and operational systems. Alongside this, the digital transformation programme was recognised as dependent on wide-scale organisational change, extending beyond technology improvements alone. Successful delivery will require strengthened business change capability, consistent leadership engagement, and improved end-user adoption across all services.
12.2	The Board also acknowledged that digital infrastructure constraints including ageing hardware, variable network resilience, and limited interoperability pose additional risks to the timely delivery of transformation plans. Overall, members agreed that digital risks remain a core strategic concern and will require ongoing oversight and prioritisation.
12.3	The Board **APPROVED** the updated BAF entries.
13	**Clinical Effectiveness Board Assurance Framework Risks**
13.1	The Board reviewed the Clinical Effectiveness risks and noted that response-time performance remains the most significant clinical risk, with the Category 2 risk maintained at its highest scoring level due to sustained operational pressures, system delays and the impact of fleet constraints. The increasing clinical vulnerability of patients in Categories 3 and 4 was also highlighted, with concerns that long waits are creating heightened risks of deterioration and avoidable harm. Recruitment and capability development across clinical roles continue to be essential to mitigating these risks, and progress is being made through strengthened workforce planning and targeted development programmes. The Board further discussed the ongoing challenges within medicines management, particularly around controlled drugs, and received assurance that the accelerated improvement plan is being implemented.
13.2	Overall, the Board recognised that while important progress is underway, the cumulative impact of system pressures, workforce gaps and operational constraints continues to pose material risks to clinical effectiveness and patient outcomes.
13.3	The Board **APPROVED** the Clinical Effectiveness Board Assurance Framework Risks.
14	**Chief Medical Officer's Report**

14.1	The Chief Medical Officer report was delivered by DR on John Black's behalf and provided an update across research activity, clinical development and emerging national changes. The Board heard that research recruitment remains strong, with SCAS continuing to play an active role in national studies and contributing to wider system learning. However, DR noted a national change to the research funding formula, which is expected to result in an approximate 7% reduction in income for the Trust. This presents a potential financial and capacity risk to sustaining the current level of activity, and the Board acknowledged the need to monitor the impact closely.
14.2	DR also outlined plans for SCAS to progress towards becoming a research sponsor, which would allow the organisation to lead its own studies rather than solely participating in external ones. A detailed proposal is being prepared for submission to the Board, setting out the governance, resourcing and assurance arrangements required to take on the additional responsibilities of sponsorship.
14.3	Finally, he emphasised the importance of building partnership links with Health Innovation Networks to support the spread and adoption of best practice, accelerate innovation and strengthen the Trust's position within the regional research landscape. Work will continue to align SCAS' research strategy with system priorities and ensure the organisation remains well-placed to participate in future national programmes.
14.4	The Board **NOTED** the Chief Medical Officer's Report.
15	**People & Culture Committee Report**
15.1	The Board received an update from the People & Culture Committee, outlining recent areas of focus and emerging priorities. The Committee reviewed sickness trends and employee relations activity in detail, noting that long-term sickness continues to be the primary driver of overall absence levels. Work is underway to strengthen support for staff, improve wellbeing interventions, and ensure more proactive case management.
15.2	The Committee also considered the organisation's wider workforce culture, including the progress of leadership development initiatives, which are being shaped to support the Trust's strategic direction and reinforce expected behaviours at all levels. Anu reported that the refresh of the Trust's Values and Behaviours framework is nearing completion and will be presented to the Board in March. The Committee emphasised the importance of embedding this work through consistent leadership practice and transparent communication, recognising its significance in sustaining cultural improvement.
15.3	The Board **NOTED** the verbal update from the People and Culture Committee Chair
16	**Freedom to Speak Up Reports** **<u>Annual Report 2024/25</u>**

16.1	The Board received the Freedom to Speak Up (FTSU) Annual Report for 2024/25 alongside the Quarter 3 update for 2025/26. Together, the reports highlighted a healthy speaking-up culture within the organisation, reflected in the 71 concerns raised last year and a continued steady flow of contacts into the FTSU Guardian service during the current year. The Board noted that staff are increasingly confident in raising issues, with concerns spanning themes such as behaviours, communication, working relationships, workload, and patient safety. The Annual Report also reflected positively on the work of the FTSU Guardian team, whose accessibility and impartiality were acknowledged during the recent CQC inspection, with inspectors commending the strength of SCAS's FTSU model and its integration into wider cultural improvement work. **Quarter 3 2025/26**
16.2	The Quarter 3 update emphasised ongoing efforts to improve the visibility of FTSU activity and strengthen "closing the loop" with staff, ensuring that individuals who speak up receive meaningful feedback about the actions taken. Work is underway to enhance case-tracking processes and develop more consistent reporting mechanisms. The Board also welcomed plans to broaden the publication of anonymised "you said, we did" examples to reinforce transparency and trust. The reports underscored the strong link between psychological safety, staff wellbeing and patient safety outcomes, and the Board recognised the continuing need for leaders at all levels to model open, inclusive behaviours.
16.3	The Board **NOTED** the Freedom to Speak Up Reports.
17	**People Board Assurance Framework Risks**
17.1	The Board reviewed the People-related risks within the Board Assurance Framework, noting that workforce capacity, capability and culture remain significant strategic concerns for the organisation. The risk relating to leadership capability and behaviours continues to be prominent, reflecting the need for sustained investment in leadership development and consistent application of the Trust's Values and Behaviours across all levels. Recruitment and retention pressures persist in several key operational and clinical areas, with establishment levels below plan and reliance on overtime and additional hours continuing to impact staff wellbeing. The Board also recognised the ongoing challenges associated with sickness absence, driven predominantly by long-term conditions, and acknowledged the work underway to strengthen occupational health provision and targeted wellbeing support. These workforce pressures continue to influence organisational culture, with the Board stressing the importance of maintaining psychological safety, strengthening staff engagement and ensuring equitable people processes. Overall, the Board agreed that while progress is being made, People risks remain material and require continued focus, oversight and sustained improvement activity.
17.2	The Board **APPROVED** the **People Board Assurance Framework Risks.**
18	**Partnerships & Sustainability Board Assurance Framework Risks**

18.1	The Board reviewed the Partnerships and Sustainability risks within the Board Assurance Framework, noting that external system pressures and the evolving landscape of regional collaboration continue to influence SCAS's ability to progress joint initiatives at pace. The Trust's future operating model is increasingly dependent on strong, mature partnerships particularly with neighbouring ambulance services, Integrated Care Systems, local authorities and voluntary sector partners and the Board recognised that variation in system capacity, priorities and governance arrangements presents an ongoing risk to delivery. Sustainability risks also remain significant, with the Trust facing long-term challenges related to fleet decarbonisation, estate readiness for electric vehicle infrastructure, and the broader transition to net-zero. These areas carry substantial financial implications over the coming decade and require coordinated planning across multiple partners. While good progress is being made through collaborative programmes and emerging shared leadership work, the Board agreed that both partnership dependency and environmental sustainability remain material strategic risks requiring continued oversight, investment and strong system engagement.
18.2	The Board **APPROVED** the Partnerships & Sustainability Board Assurance Framework Risks.
19	**Integrated Care System Reports**
19.1	The Board received an update on Integrated Care System (ICS) activity, noting that the report provides useful context on wider system performance, pressures and collaborative developments across the regions in which SCAS operates. Members acknowledged that the ICS environment remains complex and continues to evolve, with varying levels of maturity, capacity and strategic focus across different systems. These variations influence SCAS's ability to progress joint initiatives consistently, particularly around urgent and emergency care transformation, flow improvement and workforce collaboration. The Board recognised the value of maintaining clear visibility of ICS priorities and system-wide decisions, particularly where they have direct implications for operational delivery, financial planning or partnership working. While the report provided helpful situational awareness, it was agreed that future iterations should be refined to focus more explicitly on the key areas where ICS developments intersect with SCAS risks, opportunities and strategic objectives.
19.2	The Board **NOTED** the Integrated Care System Report.
20	**Communications, Marketing and Engagement Update**
20.1	The Board received an update on Communications, Marketing and Engagement activity, noting continued progress in strengthening SCAS's profile, supporting organisational priorities and enhancing engagement with staff, stakeholders and the public. Recent work included the successful delivery of the Governor elections campaign, which saw strong levels of candidate interest and improved visibility of the Governor role across the Trust. The team continues to provide significant support to operational and strategic programmes, including workforce campaigns, major incident communications and ongoing work linked to the Care Quality Commission inspection.
20.2	Positive media engagement was highlighted, including recent favourable coverage from a BBC ride-out feature showcasing the professionalism and compassion of frontline staff. The update

	also outlined ongoing work to support the SCAS Charity, promote key health messages, and enhance internal communication channels to ensure staff remain informed and connected.
20.3	The Board **NOTED** the Communications, Marketing and Engagement Update
21	**Recovery Support Programme Exit Confirmation**
21.1	The Board received confirmation that NHS England has formally approved SCAS's exit from the Recovery Support Programme (RSP), covering both the Trust-level governance and leadership components and the Hampshire & Isle of Wight financial recovery support arrangements. This confirmation was issued over the Christmas period and marks a significant milestone in the organisation's improvement journey. A formal letter of thanks has been sent to NHS England, and the Executive Management Committee has reviewed the internal response and the next steps required to ensure sustained progress. The Board recognised the considerable effort from staff across the Trust in meeting the extensive reporting requirements and delivering the improvements that enabled the Trust's successful release from the programme. Members acknowledged the positive reflection this represents of the organisation's strengthened governance, stability and leadership capacity.
21.2	The Board **NOTED** the Recovery Support Programme Exit Confirmation.
22	**Core service reports and core service CQC action templates for regulatory breaches**
22.1	The Board **RECEIVED** and **NOTED** the Core Service reports and Core Service CQC action templates for regulatory breaches.
23	**Audit Committee Chair's Report**
23.1	The Board **NOTED** the Audit Committee Report.
24	**Charitable Funds Committee Report**
24.1	The Board received an update from the Charity & Funds Committee, noting continued improvements in both the fundraising strategy and the overall governance supporting charitable activity. The Committee reported strengthened oversight arrangements and clearer alignment between fundraising priorities and organisational needs. The Board accepted the Committee's report.
24.2	The Board **NOTED** the Charitable Funds Committee report.
25	**South Central Fleet Services Board Report**
25.1	The Board received the South Central Fleet Services report, noting the continued pressure on workshop capacity as a result of the high volume of maintenance and repair activity required to keep the operational fleet on the road. Despite these challenges, sickness levels

	within the fleet workshops remain low, and the team continues to demonstrate strong commitment in responding to the increased demand. The report highlighted ongoing pressures linked to vehicle off-road levels and the wider national constraints affecting ambulance build, parts availability and charging infrastructure. The Board recognised the sustained efforts of the fleet teams to manage these competing pressures and ensure operational continuity.
25.2	The Board **NOTED** the South Central Fleet Services Board Report.
26	**Transition Committee - Committee in Common**
26.1	The Board received an update on the Transition Committee and the Committee in Common arrangements. BM reported that feedback from Non-Executive Directors had highlighted the need for revisions to the Terms of Reference to ensure clarity of scope, stronger definition of delegated authority, and explicit alignment with Board governance requirements. Members emphasised the importance of maintaining clear accountability during this period of joint working and transition, noting that while shared structures can support collaboration and efficiency, the SCAS Board must retain full oversight and final decision-making responsibility on all statutory matters. Given these points, the Board agreed that the current Terms of Reference required further refinement before they could be approved. BM will rework the document to reflect the feedback and return it for Board consideration at a future meeting.
26.2	**Action: Amendments to be made as discussed; clarification of duties delegated to the committee.**
27	**Summary of Actions from the meeting**
27.1	BM summarised actions from the meeting: • Declarations of Interests: amendments to be made to individual declarations as discussed (BM) • IPR: consideration to be given to separating Fleet KPIs into issues within our control and issues outside of our control (SR) • BAF - Board seminar to be arranged to discuss Estates and Infrastructure (BM) • Transition Committee Terms of Reference: amendments to be made as discussed; clarification of duties delegated to the committee (BM).
28	**Questions from the public**
28.1	During the public session, the Board received one pre-submitted question, which related to the challenges surrounding fleet availability and rising Vehicle Off-Road (VOR) levels. As the issues raised had already been covered in detail within the earlier fleet deep-dive and operational performance discussions, the Chair confirmed that the concerns were addressed through those agenda items. No additional questions were raised by members of the public.
28.2	**The Board noted the engagement and the response provided.**

29. **29.1**	**Any other business** No additional items were raised under Any Other Business. The Chair invited final comments from Board members, and with no further matters for discussion, the meeting moved to its formal close.
30 **30.1**	Summary Review of the meeting: The Board reflected on the meeting and acknowledged that, although the agenda had been lengthy, the discussions were necessary and appropriately thorough. Members agreed on the need for shorter, more focused Board papers to support clearer decision-making. It was also recognised that certain areas particularly fleet and organisational culture rightly received detailed scrutiny given their significance and current level of risk.
31 **31.1**	**Date, Time and Venue of Next Meeting in Public** The next public meeting of the SCAS Board would take place at 9.45am on 2 April 2026 at Newbury Education & Recruitment Centre, Bone Lane, Newbury, RG14 5UE.

TRUST BOARD ACTION LOG						Status
Minute Ref:	**Agenda Item**	**Action**	**Owner**	**Due Date**	**Update**	
Meeting Date: 5 February 2026						
TB/25/025	Declarations of Interests	Declarations of Interests: amendments to be made to individual declarations as discussed.	KA	02.04.26	Register updated. Action completed.	**CLOSE**
TB/25/026	Integrated Performance Report (IPR)	Consideration to be given to separating Fleet KPIs into issues within our control and issues outside of our control.	SR	02.04.26	It is assessed that separating Fleet KPIs into factors within and outside organisational control is not feasible within the IPR framework. Implementing such a distinction would introduce unnecessary complexity and would only be achievable through narrative explanation, which is unlikely to provide sufficient clarity or consistency. It is therefore proposed that this separation be reflected instead within the Fleet Reports to the FPC.	**CLOSE**
TB/25/027	Transition Committee - Committee in Common	Amendments to be made as discussed; clarification of duties delegated to the committee.	BM	02.04.26	On private board agenda.	**CLOSE**
TB/25/028	Enabling Services Board Assurance	Board seminar to be arranged to discuss Estates and Infrastructure.	BM	02.04.26	Arranged for May Board Seminar.	**CLOSE**

	Framework Risks					
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/HY	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. 05.02.26 - All actions proposed for closure except TB/25/007 (NED site visits). An approach to integrate NED visits with accreditation visits was discussed and supported, noting: • Accreditation visits alone will not meet existing expectations on visit frequency. • Compliance and Governance teams will develop a combined process. • Flexibility retained for informal station visits and engagement with staff. Action TB25007 remains open. Governance & Compliance teams to refine new model. 2 Feb 2026 update	**OPEN**

					BM & HY to return with a revised proposal.	

Trust Board of Directors Meeting in Public 2 April 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 February 2026.

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

February 2026

- Human Welfare Reference Panel Cabinet Office
- SCAS Extra-ordinary Council of Governors
- ICS Monthly Chairs Meeting
- SE NHS Region Chairs meeting
- SCAS/SECAmb Joint Chair discussion

March 2026

- New Governor Induction
- Council of Governors
- AACE Chairs Meeting
- Ambulance Leadership Forum
- SCAS Renumeration Committee
- Speaker For Schools, Aureus School, Didcot

Other

- SCAS Team Brief Lives
- All NEDs annual appraisals/PDRs
- Membership and Engagement Committee
- NATO Military-Civilian Defence Medical Services conference

Recommendation

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

Trust Board of Directors Meeting in Public 2 April 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

Multi-Year Plan

Since the last Board meeting we have continued to refine our Multi-Year Plan, covering the next 3 years. The plan will ensure that our workforce aligns to our operational plans and that we balance these whilst delivering high quality services and managing within budget.

It's important that the Board continues to drive the 'levelling up' principles which we set out when we signed off the business case to partner with SECAmb. The 3-year plan will be central to this.

Delivery of our 3-year Financial Recovery Plan (2023-2026) has stood us in good stead in terms of creating the foundations to ensure that we are a sustainable organisation going forwards. I would like to take the opportunity to reflect on and thank staff for the hard work

and effort that has been required across the organisation to achieve this. The financial position will continue to be challenging as we move into 2026/27, and undoubtedly difficult decisions will continue to be necessary to ensure that we deliver all aspects of performance across the Trust.

The end of the financial year also marks the first year of delivery of our Fit for the Future Improvement Plan and whilst we have not moved the dial as much as we would have liked in some areas – for example fleet, the built estate and the way we engage with our staff - we have refreshed the programmes that underpin the strategic themes for the coming year, and strengthened the deliverables which will tell us whether or not we are making progress.

Operational Performance

Category 2 mean performance for the month of February was 29.04 minutes against a target of 30 minutes, but we continued to face challenging periods through increased demand during the month. This has continued into March. The executive team continue to monitor performance on a daily basis.

Our Hear & Treat performance remains below target for the third consecutive month due to sickness absence and shortfalls in the clinical workforce who are essential in ensuring that we deliver a clinically safe service. We are actively recruiting additional clinicians as not only does this service contribute to improving our category 2 performance. It also ensures that patients are not conveyed to Emergency Departments unnecessarily, which provides a more positive experience and takes pressure off our partner organisations.

Fleet

We continue to experience challenges with Fleet and our Vehicle Off Road (VOR) numbers remain stubbornly high. We have in place a Fleet Improvement Plan. The plan ensures that our ageing fleet is replaced with new vehicles, which will be less liable to faults and we will ensure that our planned maintenance is optimised as a means of preventing vehicles from becoming unavailable due to faults. A new workshop will open in Aylesbury in April,

and this will enable us to repair vehicles more quickly and support more capacity for regular planned maintenance.

I reported at the last Board that Fleet challenges had resulted (in part) in us declaring a Business Continuity Incident at the beginning of the calendar year and we learned a lot about our processes through this experience. We are implementing improvements based on the learning which we drew from this – for example managing vehicle charging differently, reducing vehicle utilisation to allow charging to take place and delivering vehicles to service locations in a different way.

People & Culture

- **Staff Survey**

We received the results of the 2025 Staff Survey in early March and discussed these as an executive team and Board. The results were disappointing, but not unexpected given the difficult environment in which we are operating. We have reviewed the results against our "Building Trust Together" Culture and Organisational Development Programme, which is a core element of the People & Culture strategic theme in our improvement plan. We are confident that we have the right improvement programs in place to ensure that our staff feel valued, listened to and have a better experience at work. We will continue to deliver on each element of the programme during 2026/27 and look forward to seeing better results next year.

Collaboration with South-East Coast Ambulance Service (SECAmb)

Our collaboration work continues and progress against the workstreams that are already in train is monitored by our respective boards. These are key to ensuring that we deliver a consistent standard of care for our patients across our respective geographies.

Closing Thoughts

This is my last board meeting as Chief Executive of the Trust and my last working day will be 17th April. I have elected to spend my last days out and about with the team and will spend my last shift with our Enhanced Care colleagues on Thursday 16th April. This seems

like a fitting way to close my NHS career, which began in a clinical role in 1987 and will end with a clinical shift in 2026.

Whilst the joint Chief Executive Officer for SCAS and SECAmb has not yet been appointed, interviews are taking place soon. Stuart Rees, our Chief Finance Officer, will be acting into the Chief Executive role until a substantive appointment is made, and he will continue to receive the support of the executive team and Board.

I have seen enormous positive changes in the organisation during my time here. We have exited the two Recovery Support Programmes which were in place when I arrived and following the CQC's 2022 inspection report. We have seen improvements in CQC ratings in the two services most recently inspected, and we improved our OFSTED rating from Requires Improvement to Good. We recovered a £36m financial deficit to balance (our financial recovery programme) and we have stabilised our leadership and governance arrangements. We have a comprehensive and well thought through integrated improvement plan which sets the organisation up for the future and which will improve the culture of the organisation and morale.

During my time here I have spent a lot of time out and about in the service and I have continued to do this as my tenure comes to an end. I am constantly reminded of the pride, dedication and professionalism of our staff and the incredible services that they provide to our patients. They are extraordinary people who do extraordinary things each and every day.

I want to take this opportunity to thank each and every member of the SCAS team for their commitment and dedication to our patients and the communities we serve. Staff in our call centres (EOC and 111), on the frontline, in PTS, corporate teams and support services all do a magnificent job and the world is a safer place because of their work.

Our volunteers play a key role in delivering our services and I pay particular tribute to those who give up their time to work in this way with our patients, and to those who work in the

background to make this possible, fundraising and raising the profile of the ambulance service.

I would also like to place on record my thanks to our partners from the other blue light services, our BASICS and Air Ambulance colleagues and the wider NHS, who all work seamlessly with us to ensure that our patients receive the best possible care in their hour of need.

It has been an honour and a privilege to lead the organisation through what has been a difficult period. I am immensely proud of the journey that we have been on, and I wish the Board and the organisation all the very best for the future.

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

Upward Report of the Finance & Performance Committee

Date Meeting met **20th March 2026**
Chair of Meeting **Les Broude, Non-Executive Director**
Reporting to **Trust Board**

Items	**Issue**	**Action Owner**	**Action**
Points for escalation			
Cost Improvement Plan 2026/27	The Executive Directors individually presented plans to meet their directorate CIP targets and close the current £6.9m gap. Whilst joint ownership was evident, given the scale of cost improvement delivered over the last 2 financial years, and the non-recurrent elements, transformational change is required to identify the remainder and deliver savings on a recurrent basis. The Committee emphasised that transformational change required proper resourcing and project management to ensure delivery and noted that major schemes would not necessarily deliver in year. Executives were also urged to identify savings over and above the current gap as a contingency to mitigate schemes that are not delivered in year or only have part year effect and to explore opportunities with SECAmb to create efficiencies. It was noted that the Transformation/Collaboration Committee had a key role to play with regards to driving cost savings and ensuring timely decision taking.	SR	The committee will maintain a watching brief in relation to CIP identification and delivery.

	Whilst the committee was assured that the executives were committed to collectively addressing the challenge, members were not assured that the gap would be closed without transformation, and this remains a high risk.		
Key issues and / or Business matters to raise			
Integrated Performance Report	The Committee received the report and debated how the IPR could be better presented, narrated and utilised by FPC, the other committees and the Board. Executive responsibility for the IPR now sits with the Chief Digital Officer who gave assurance that plans were underway to address the concerns that had been raised. It was agreed that Board Seminar time would be dedicated to the IPR in May.	CE	Board Seminar on the IPR to be scheduled for May 2026.
Operational Performance	Fleet pressures are reducing, and it was highlighted that the increase in agency spend was to support Fleet availability during the Business Continuity Incident (BCI). Hear and Treat continues to under-perform against target for the third month due to the clinical establishment; recruitment is underway, but concern was expressed owing to the distance from the 20% target for 26/27 and the consequent impact on category 2 performance. The committee will continue to monitor the position.	N/A	N/A
Financial Performance	The Trust remains on track to deliver the control total at year end; pay is overspent in month (11) but this was due to an active decision to recruit additional staff following an increase in attrition. Work is underway to better understand patterns and fluctuation around attrition.	N/A	N/A
Areas of concern and / or Risks			
Board Assurance Framework	The BAF risks were received and no changes to the current scores were recommended based on the financial position and the CIP challenge.	N/A	N/A
Contract Register	The committee continues to have concerns around the focus on ensuring that the necessary work is undertaken well in advance of contracts expiring,		

	to ensure value for money and prevent the need for direct awards to be made. The committee will maintain a watching brief.		
Items for information and / or awareness			
None			
Best Practice and / or Excellence			
None			
Compliance with Terms of Reference			
Compliant	All papers were relevant to the committee terms of reference, and the meeting was quorate.	N/A	N/A
Policies approved*			
None			

Trust Board of Directors Meeting in Public 2 April 2026

Title	Integrated Performance Report (IPR) Month 11
Report Author	Craig Ellis, Chief Digital Information Officer
Executive Owner	Craig Ellis, Chief Digital Information Officer
Agenda Item	**9**
Governance Pathway: Previous	Finance & Performance Committee – 20th March 2026 People metrics discussed at People & Culture Committee – 16th March 2026
Governance Pathway Next Steps	None – report is for the Trust Board

1. Purpose

To present the Month 11 Integrated Performance Report to the Trust Board. Please note that the report should be read in conjunction with the Chair's reports from the relevant Board Committees, which reference discussion and challenge at the Committee meetings ahead of the Trust Board meeting.

2. Executive Summary

The IPR provides a comprehensive overview of the Trust's performance across Operational Performance, Quality & Safety and People and contains performance against Key Performance Indicators (KPIs) for month 11, February 2026. The summary below is the areas that the relevant executive directors would like to draw to the attention of the Board, following the Making Data Count principles, whereby the focus is on failing or worsening targets and on where there has been sustained improvement.

Metric Overview

- 8 Pass Metrics
  - P3 - % Vacancy
  - P10 - % DBS Compliancy
  - OP8 - Hear and Treat
  - QS21 - Safeguarding Adults (Level 1)
  - OP14 - Clear Up Delays
  - QS19 - Number of Complaints
  - P6 - % WTE Disabled

- QS22 - %Safeguarding Level 3

- 10 Failed Metrics
  - OP18 - 111 Call back <20mins
  - OP13 % Arrival at hospital to handover <15mins
  - P11 - Appraisals Trust
  - OP12 - Average Hospital Handover Time
  - OP1 - Cat 1 Mean
  - OP5 - Cat 3 90th %
  - P14 - Meal Break Compliancy
  - OP10 - ST&C (Ed)
  - OP11 - ST&C (Non-Ed)
  - OP15 - VOR Total

Operational Performance

- ***999 Services***: Incident demand was 0.2% above plan, with operational hours within 1.67% of plan. With the exception of Cat 1 – 90th the data shows that all national response times remain unachievable within current processes. Category 2 response time was 29:04 for the month, but the Trust is facing a challenging year-end to deliver a sub 30-minute Category 2 position for the full year.
- ***Hear & Treat:*** under-performance for a 4th consecutive month at 16.8%. As discussed at the March Finance & Performance Committee, this is due to clinical workforce pressures although active recruitment is underway. Achievement of the year target poses a significant challenge. Delivery of our current *ST%, STC-ED and STC-no- ED* targets all remain unachievable with current process.
- ***Call Handling***: 999 call volumes exceeded plan by 5.37%, despite a reduction in duplicated calls. However, performance remains above target at 00:05 for the month.
- ***Vehicles Off Road (VOR) %:*** VOR was 42.4% and remains significantly above target. The Fleet Improvement Plan will see increased availability of new vehicles over the coming weeks and coupled with the planned opening of the third workshop and more frequent maintenance schedules; VOR rates are expected to reduce.
- ***111 Service***: Delivery of service remains challenged and currently not in line with targets. Performance remains challenging and workforce capacity is the key limiting factor.
- ***NEPTS (Non-Emergency Patient Transport Service)***: Overall performance remains within expected parameters. Call answering improved to 84.3% and journey activity remains broadly aligned to plan. Patients collected/arrived-within-time metrics remain steady, with elements of under-performance driven by staff mix and peak-time demand.

Quality and Safety

- **Patient Safety and Experience:**
  Core indicators continue to perform within expected ranges. Low-harm Patient Safety Incident (PSI) rates increased due to improved reporting, which

demonstrates a health reporting culture. No incidents that require a Patient Safety Incident Investigation (PSII's) were declared in February. Complaints and concerns show normal variation.

- **Audit Compliance:**
  Hand hygiene audit volumes and compliance continue to perform above target. Vehicle audit numbers increased due to additional IPC Level 3 activity; compliant audit totals remain below target but performance is stable.
- **Safeguarding:**
  Safeguarding Adults Level 1 and Level 3 training performance continue to exceed target.
- **Ambulance Care Quality Indicators (ACQIs)**
  STEMI and Stroke indicators show common-cause variation, with STEMI mean exceeding target and STEMI 90th percentile just below target; Stroke mean is exceeding target, median on target and 90th percentile exceeding target. Cardiac Arrest outcomes ROSC (Return Of Spontaneous Circulation and Survival) remain consistent with expected variation.

People and Workforce

- ***Workforce Management***: Overall, Whole Time Equivalent (WTE) staffing is exceeding the target position, but the vacancy rate for the month stands at 0.4% which is above target. Recruitment freezes remain in place for corporate teams and NEPTS vacant positions.
- ***Staff Turnover*****:** Positive trend in turnover has continued for 3 consecutive months and was 16% for the period highlighted.
- ***Sickness Absence***: Sickness absence exceeds the annual and monthly target, driven by short and long-term sickness absence. As discussed in the Deep Dive at the People & Culture Committee, processes continue to be improved and there is targeted work around long-term absence. Short term sickness absence increased for to 4% which is above target.
- ***Performance Development Reviews (PDRs):*** Ongoing focus to meet the 95% target at year end. Performance is 84% for February and the executive team continue to focus on driving compliance and ensuring that all staff overdue for an appraisal have a PDR booked, even if not before the year end.
- ***Stat & Man Training***: the position remains stable although as discussed at the People & Culture Committee, there is a focus on ensuring that resuscitation training targets are met for all applicable staff by the year end.
- ***999 Shift over-run and meal break compliance***: performance remains stable at c.77%, but the data indicates that the target remains unachievable. Shift over-run compliance continues to deliver against target.

3. Areas of Risk

Failing to meet targets poses risks to all aspects of performance given the inextricable linkage between operational, financial and quality performance; workforce being a key element of the provision of high-quality services. Risks are being managed and

mitigated through the actions set out in the IPR and in our Fit for the Future tier 1 and tier 1 programmes.

4. Link to Strategic Theme

The report links to all the strategic themes.

5. Link to Board Assurance Framework Risk(s)

The report links to the majority of Board Assurance Framework risks

6. Quality/Equality Impact Assessment

Not required for this report.

7. Recommendations

The Board is asked to **NOTE** performance at Month 11 and to seek further **ASSURANCE** in relation to the corrective actions that are in train where necessary, noting the scrutiny that has already taken place at the Board Committee meetings.

For Assurance	x	For decision		For discussion		To note	

Integrated Performance Report: Feb-26

Executive Summary

Operational Performance

Safety and Quality

People

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

Key Performance Headlines:
OP2 - Category 2 mean response time was 29:04, below the monthly target of 30:10. Significant push to achieve EoY target of 29:49
OP15 - Fleet availability constraints contributed to a 02:44 minute delay in Category 2 performance.
OP2 - Ongoing challenge with rota mismatch - action plan required on new rota for 26/27. There was a decrease in hospital delays and fleet issues from January.

PTS -
OP20 - February performance improved, with 84% of calls answered within 90 seconds, although still below the 90% KPI, results remain above the lower control limit, indicating stabilisation. OP19 - Call volumes slightly above target but consistent with recent elevated demand.
OP24/21 & OP23) Following the Major Incident at UHS, activity remained stable. Collection times have improved, but inbound performance, particularly for renal patients, continues to decline due to sustained high demand.
Coverage of required hours remains variable (70% on certain days). Daily review of forecasted hours continues, with improvements from cohorting and operational efficiencies underway

Key Risks for Period:
- Cat-2 delivery within agreed budget levels as we target EoY Cat-2 target.
- Matching Operational hours between the 2 divisions with under resourcing in Thames Valley and sustaining fleet availability

PTS
- Rota Imbalance & Workforce Variability due to part-time/full-time rota misalignment during peak hours - rota review underway. Vacancies remain on TRAC pending approval. Prolonged approval or recruitment timelines risk further strain during busy periods.
- Demand across both PTS contracts may exceed capacity, affecting patient flow, performance, finances, and reputation.

Key Rolling Actions:
- Returning H&T to target levels.
- Sustaining fleet availability by reducing VOR
- Moving Hampshire crews to Thames Valley

PTS
- Revised 17% target is being actioned, with weekly oversight to improve call handler availability.
- Rota Review underway with work continuing to realign staffing with forecast demand and ensure stronger peak time coverage.
- Telephony journey confirmation ongoing (Programme continues to reduce unnecessary journeys and support efficient resource use)
- Ongoing Operational Actions, Daily monitoring of demand, hours, utilisation, and budget performance, Increased cohorting and resource optimisation, Strengthened focus on sickness management to stabilise staffing, review of renal bookings to improve predictability and inbound performance,

Forward View:
- Delivery of year end Cat-2 objective
- Operational hours in line with financial plan
- Increasing fleet availability in March to meet higher hours

PTS
- Performance is stabilising, tracking above the lower control limit. Continued progress is expected as rota redesigns are implemented.
- The combined impact of reduced Not Ready time, rota improvements, and journey confirmation to support continued recovery.
- Focus on improving inbound performance. Monitoring activity contracted capacity remains essential.

Key Performance Headlines:

QS1 - Patient Safety remains within expected targets with low % of incidents resulting in harm and consistent levels of incident reporting.

QS2 - No PSII reported this period.

QS5 - Improvement in reporting unaccounted for controlled drug losses.

QS6-10 - Infection control and prevention activity show consistent compliance with the exception of the compliance of our standard of vehicle audits.

QS21/22 - Safeguarding Level 1,2 and Level 3 face to face training remains above target.

QS9-18 - All ACQI's show common cause variation.

Key Risks for Period:

The patient safety team continue to monitor the impact of long delays linked to issues being managed in operational delivery, including VOR and the staffing mismatch.

Key Rolling Actions:

- Cardiac Arrest (QS15-18), SCAS have a recovery plan to ensure 95% compliance with attendance at face to face resuscitation training.
- Continuous focus on operational performance and vehicle availability continues as an action to improve all ACQIs.
- The IPC team conducted a number of Level 3 audits and have identified areas for improvement. Planned improvement work in April will focus on these issues.
- Although not monitored through Trust level IPR, SG Clinical supervision and CPD activity for staff requiring Level 3 compliance is below target with additional sessions offered to enable staff to meet their requirements by 31 March 2026. Weekly reminders to staff and TL is ongoing. This is being monitored by SG Committee and EMC.

Forward View:

Monitor, from a patient safety, patient experience and patient care perspective, the impact of operational actions to manage to the end of year position.

Key Performance Headlines:
P1 - WTE - 3737 WTE, +22 since M10. 999 +26, EOC - 4, 111 +8, PTS - 6, Corp - 2 WTE
P2 - T/O - 16% Vs 18% target. 999 (9), Corp (16) positive against target. EOC (37), 111 (33) and Ops Support above
P3 - VAC - 222 below budget est. EOC (35), 111 (48), PTS (65), Ops Support (62) and Corp (16). 999 3 over budget est
P4 - TTH - Median (advert close to start date) reduced from 91 to 82 days. Ad hoc sits at 48 calendar days
P5 - WRES - 8.9%, reduced from 9.4% in M10
P6 - WDES - 11.7% increase from 11.3% in M10
P7 - M11 Sickness (8.3%) above 6.3% target. 999 = 9.2, EOC = 9.0, 111 = 8.5, PTS = 8.5 above target. CORP below at 3.3%
P8 - M11 STS (3.9%) above 3.0% target. 999 = 4.4, EOC = 4.1, 111 = 4.5, PTS = 3.8 above target. CORP below at 1.2%
P9 - M11 LTS (4.4%) above 3.3% target. 999 = 4.8, EOC = 4.9, 111 = 4.0, PTS = 4.7 above target. CORP below at 2.1%
P10 - DBS - 98% compliance with all areas continue above 95% target
P11 - PDR - Trust (85%) below 95% target. 999 =90%, EOC =94%, 111 =82%, PTS =79%, Corporate =77%, OPS Support = 64%
P12 - S&M above 95% for all subjects (except Resus L2 89%, Resus L3 86%, Conflict Res 77%, FTSU Managers 91.2, Mental Health 88)

Key Risks for Period:
P1/P3 - WTE/VAC - 999 at risk of finishing above budget est by 10 WTE. Risk to financial position
P2 - T/O - 999 attrition lower than forecast, putting pressure on budget est. Recovery plans in place for Q2/Q3 WTE reduction
P1/P3 - WTE/VAC - CCC forecast to finish 90 WTE below budget est. Increased use of bank/OT and risks to performance
P2 - T/O - CCC attrition higher than new starters. Recruitment & attraction initiatives are being accelerated to mitigate
P4 – TTH – Likely to remain high while remaining on hold NQPs are processed
P7 - SICK - High rates putting pressure on performance / financial position. Positive results not expected until Q1 2026/27
P11 - PDR - Unlikely to reach 95% target, all areas being asked to focus on PDR delivery in Q4. Forecast to finish year close to 90%

Key Rolling Actions:
P1 - WTE – 3rd iteration of plan being submitted on 18/3/26. IWP working groups preparing for delivery of Q1 plan
P2 - T/O - Engagement plans in all areas. CCC Attrition deep dive completed, now under review to improve 26/27 attrition
P7 - SICK – Improved reports / analysis being developed, sickness improvement plans continuing, focus on CCC and LTS
P10 - DBS - Team now working 3 months ahead of expiry dates to maintain 95%+ compliance
P11 - PDR – Compliance actively monitored by Deputy CPO, to be discussed at Sub Board meetings. New PDR reports being distributed
P11 - PDR - All areas being asked to provide clear timelines for completing outstanding PDRs
P12 - Improvement plans in place for Resus L2/ L3. Conflict Res improvement plan for 26/27

Forward View:
P1 - WTE - YE forecast = 3750 WTE, under budget establishment of 3955 WTE
P2 - T/O - YE forecast = 16%, below 18% target. Retention forecast = 86%, above 87% target
P2 - T/O - Improvement plans in place. Minimum target of 14% turnover over a 3 year period.
P7 – SICK - YE forecast = 7.1%, above 6.2% target.
P7 - SICK - Improvement plans in place. Minimum target of 1.5 % point reduction over 3 years.
P11 - PDR - Forecast to finish between 88-90%, below 95% target.
P11 - PDR - Quality of PDR and improved delivery plan to be a focus in 26/27

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

	Pass	Hit and Miss	Fail	No Target
H (improving, higher)	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.
L (improving, lower)	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)	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.
H (concerning, higher)	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.
L (concerning, lower)	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.

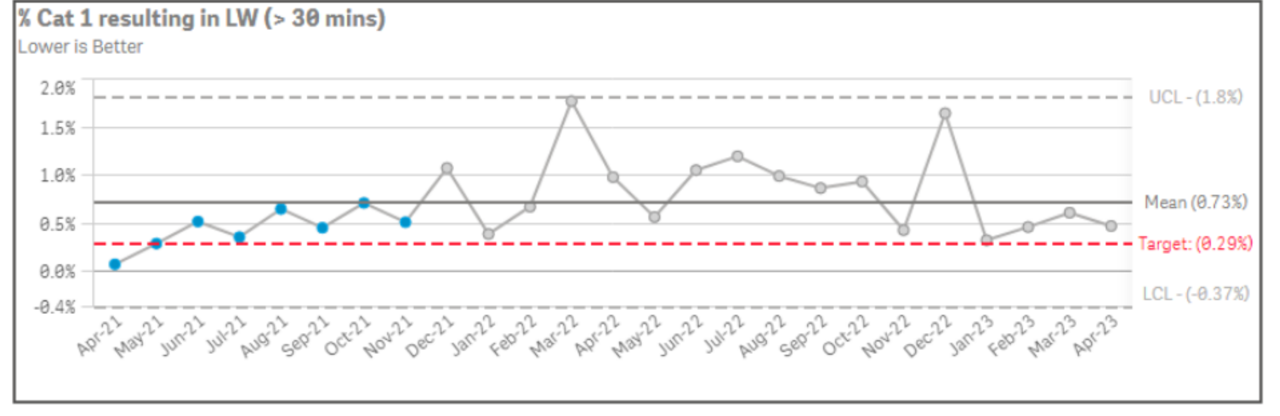
(up arrow)				Special cause variation where UP is neither improvement nor concern.
(down arrow)				Special cause variation where DOWN is neither improvement nor concern
n/a				Special cause or common cause cannot be fiven as there are insufficent number of points. Assurance cannot be given as a target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

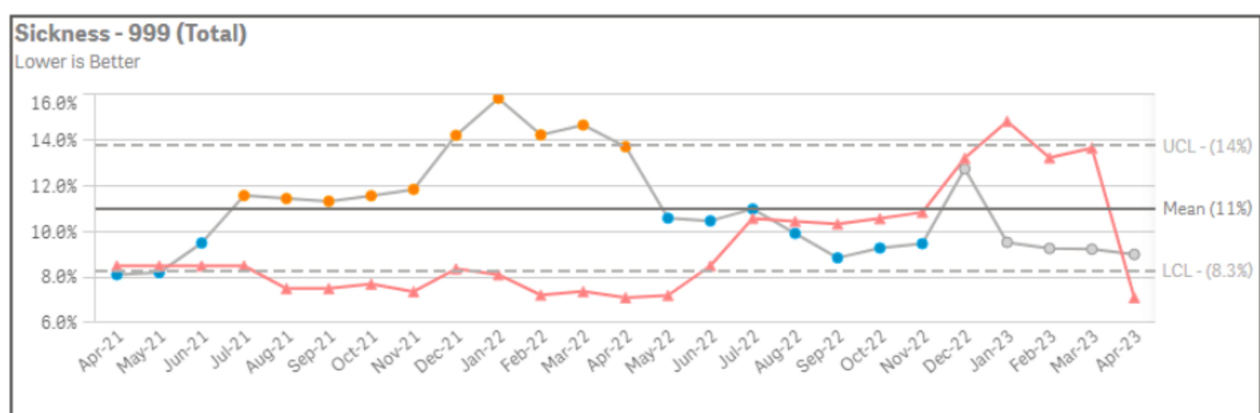
Assumptions:

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



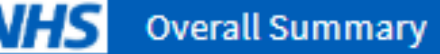


UCL & LCL:

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



Overall Summary

February-26 Summary

Assurance

Variance

	Fail	Hit and Miss	Pass	No Target
		% Sickness in month 111 Calls abandoned after 30 secs % Short term sickness	% Vacancy	
	111 Call back < 20 min	111 call answer in 120 Secs % Number of WTE Patients Arrived within time		
	% Arrival at hospital to handover <15mins Appraisals - Trust Average Hospital Handover Time - SCAS Cat 1 Mean SCAS Cat 3 90th %ile SCAS Meal Break Compliance - SCAS ST&C (ED 1&2) - SCAS ST&C (Non-ED 1&2) - SCAS VOR - Total	27	% DBS Compliance H&T - SCAS Safeguarding Adults Level 1	
		999 Calls abandoned % 999 Mean Call Answer Time Number of PSII declared in month	Clear up Delays - SCAS Number of Complaints	
	S&T - SCAS	% Trust staff who are BAME Hand Hygiene audit PTS Call Volume Patients Collected within time	% Trust staff who are declared disabled Safeguarding Level 3	

Metrics:

Hit and Miss Common Cause Metrics:
% Long term sickness ; % Turnover ; Cardiac Arrest Survival at 30 Days - All Patients ; Cardiac Arrest Survival, Utstein ; Cat 1 90th %ile SCAS ; Cat 2 90th %ile SCAS ; Cat 2 Mean SCAS ; Cat 4 90th %ile SCAS ; Number of PSI low/no harm ; Number of PSR declared in month ; Number of reported CD incidents – unaccounted for losses ; Over-runs >30 mins - SCAS ; Overdue Datix incidents ; PTS - Calls answered in 60 seconds ; PTS Volume - No. of Journeys ; PTS Volume - No. of Patients Transported ; 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 ; Time to hire ; Vehicle cleanliness completed audits

Operational Performance

February-26 Summary

Metrics:

Assurance

	Fail	Hit and Miss	Pass	No Target
H (orange)		111 Calls abandoned after 30 secs %		
L (orange)	111 Call back < 20 min	111 call answer in 120 Secs % Patients Arrived within time		
(grey)	% Arrival at hospital to handover <15mins Average Hospital Handover Time - SCAS Cat 1 Mean SCAS Cat 3 90th %ile SCAS ST&C (ED 1&2) - SCAS ST&C (Non-ED 1&2) - SCAS VOR - Total	Cat 1 90th %ile SCAS Cat 2 90th %ile SCAS Cat 2 Mean SCAS Cat 4 90th %ile SCAS PTS - Calls answered in 60 seconds PTS Volume - No. of Journeys PTS Volume - No. of Patients Transported	H&T - SCAS	Compliments
L (blue)		999 Calls abandoned % 999 Mean Call Answer Time	Clear up Delays - SCAS	
H (blue)	S&T - SCAS	PTS Call Volume Patients Collected within time		
(purple, up)				
(purple, down)				

NHS Operations - Response Times/Utilisation/Operations Centre

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

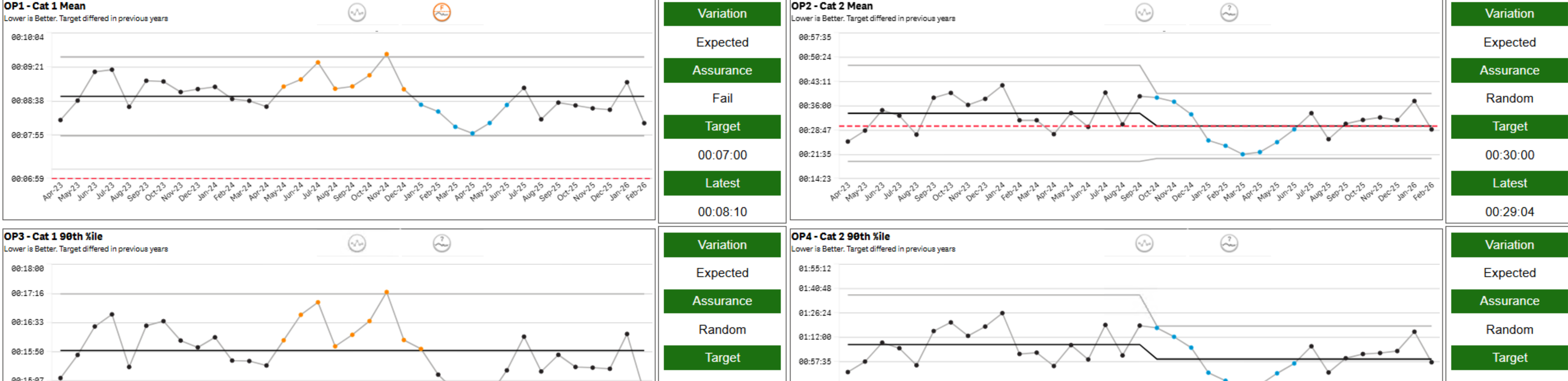
KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Cat 1 Mean	Feb-26	00:08:10	00:07:00			00:08:44	00:07:54	00:09:34
Cat 1 90th %ile	Feb-26	00:14:49	00:15:00			00:15:51	00:14:27	00:17:15
Cat 2 Mean	Feb-26	00:29:04	00:30:00			00:30:06	00:20:28	00:39:45
Cat 2 90th %ile	Feb-26	00:56:48	00:40:00			00:58:41	00:39:04	01:18:18
Cat 3 90th %ile	Feb-26	05:01:43	02:00:00			05:49:14	02:23:50	09:14:38
Cat 4 90th %ile	Feb-26	06:39:16	03:00:00			06:57:03	02:32:53	11:21:12
% Vehicles off the road	Feb-26	42.4%	15.0%			40.4%	34.0%	46.9%
Ave Handover	Feb-26	00:17:41	00:15:00			00:18:20	00:15:33	00:21:07
Handover < 15mins	Feb-26	51%	60.0%			49.4%	42.3%	56.5%
Clear up Delays	Feb-26	00:13:34	00:15:00			00:13:58	00:13:31	00:14:26
% See and treat	Feb-26	32%	33.5%			30.5%	29.0%	32.0%
% ST&C to ED	Feb-26	47%	41.0%			48.2%	46.5%	49.8%
% See and convey to non-ED	Feb-26	4%	5.4%			4.0%	3.7%	4.2%
999 Call Answer	Feb-26	00:00:05	00:00:10			00:00:10	00:00:03	00:00:16
999 Ab. Rate	Feb-26	1.2%	2.0%			1.8%	1.2%	2.5%
% Hear and treat	Feb-26	17%	18.0%			17.3%	15.3%	19.3%
111 Call Answer	Feb-26	57%	95.0%			76.1%	56.7%	95.5%
111 Ab. Rate	Feb-26	7.1%	3.0%			3.8%	0.0%	7.5%
111 Call backs	Feb-26	29%	95.0%			37.4%	28.1%	46.8%

NHS 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)	Feb-26	84%	90%			89.9%	76.2%	103.7%
Number of calls (PTS)	Feb-26	6,973	6,672			6,841.39	4,933.58	8,749.2
% Patients arrived in time	Feb-26	84%	87%			87.3%	83.2%	91.4%
% Patients collected in time	Feb-26	89%	87%			86.2%	84.0%	88.3%
PTS Volume - No. of Journeys	Feb-26	20,827	23,414			21,840.8	18,468.8	25,212.7
Number of Patients Transported	Feb-26	5,159	5,332			5,211.52	4,605.84	5,817.21

Operations - Response Times



Understanding the Performance:

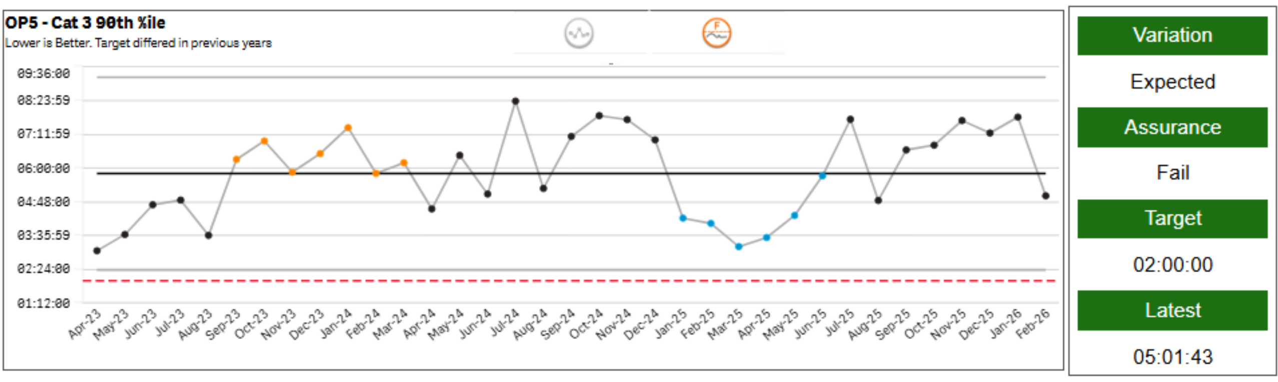
Cat 1 and Cat 2 performance improved whilst remaining within the expected variance. Demand in February was above plan by 0.2% (99 Incidents) whilst operational hours were 1.67% (3098 hours) above plan, driven in part by the night OT incentive. Fleet pressures reduced (2672 hours across the month) and hospital delays decreased. BCI recovery phase ended on 16th February, focus remains on delivery of Fleet, H&T and Task time. Cat 2 performance YTD 30:16, target 29:49 considered at risk.

Actions (SMART):

Maintain focus on delivery of 198 vehicles a day + and maintain Cat 2 below 30 mins.
Continued OT incentive for nights, additional hours agreed until mid-March 26- reviewed weekly.
Recruitment into CSD to facilitate delivery of 19% H&T - 2.56 WTE recruited in Q4, plan for 14 in Q1
Q4 and Q1 recruitment to maintain establishment and prepare for 2026/27. Q4 Recruitment 20 ECA planned - 18 booked, 30 NQP planned 24 booked. Planned recruitment for Q1 = 70 ECA + 20 NQP on track.
Daily review of previous day activity to implement immediate improvements and plans for 2026/27 as appropriate.

NHS

Operations - Response Times



Variation
Expected
Assurance
Fail
Target
02:00:00
Latest
05:01:43

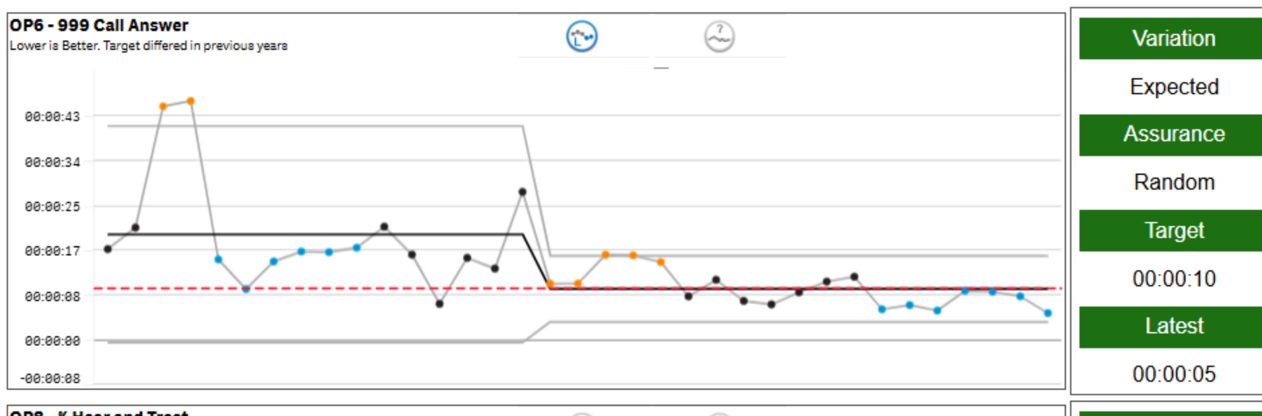
Understanding the Performance:

Cat 3 and 4 improved but failed to meet target. Both remained within expected variance. Demand in February was above plan by 0.2% (99 Incidents) whilst operational hours were 1.67% (3098 hours) above plan, driven in part by the night OT incentive. Fleet pressures reduced (2672 hours across the month) and hospital delays decreased. BCI recovery phase ended on 16th February, focus remains on delivery of Fleet, H&T and Task time.

Actions (SMART):

Maintain focus on delivery of 198 vehicles a day + and maintain Cat 2 below 30 mins.
Continued OT incentive for nights, additional hours agreed until mid-March 26- reviewed weekly.
Recruitment into CSD to facilitate delivery of 19% H&T - 2.56 WTE recruited in Q4, plan for 14 in Q1
Q4 and Q1 recruitment to maintain establishment and prepare for 2026/27. Q4 Recruitment 20 ECA planned - 18 booked, 30 NQP planned 24 booked. Planned recruitment for Q1 = 70 ECA + 20 NQP on track.
Daily review of previous day activity to implement immediate improvements and plans for 2026/27 as appropriate.

Operations - Operations Centre



Variation

Expected

Assurance

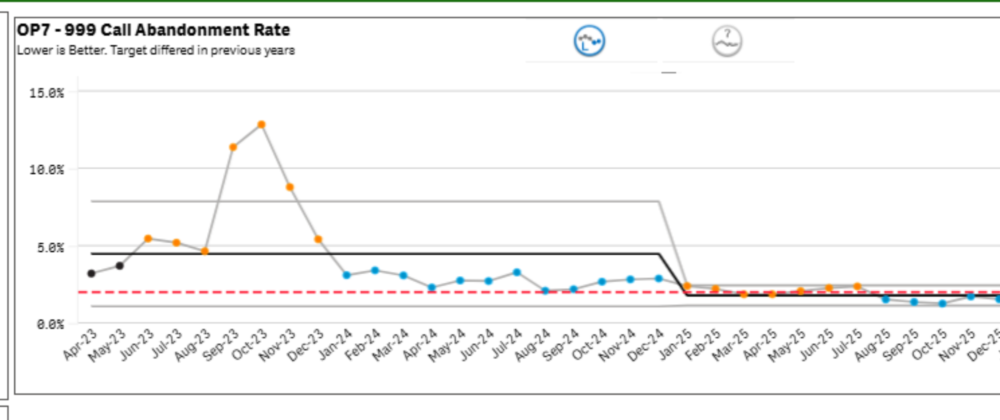
Random

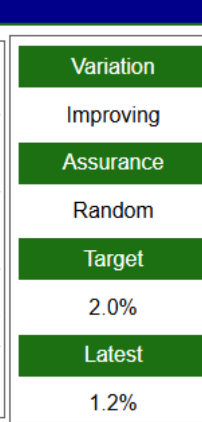
Target

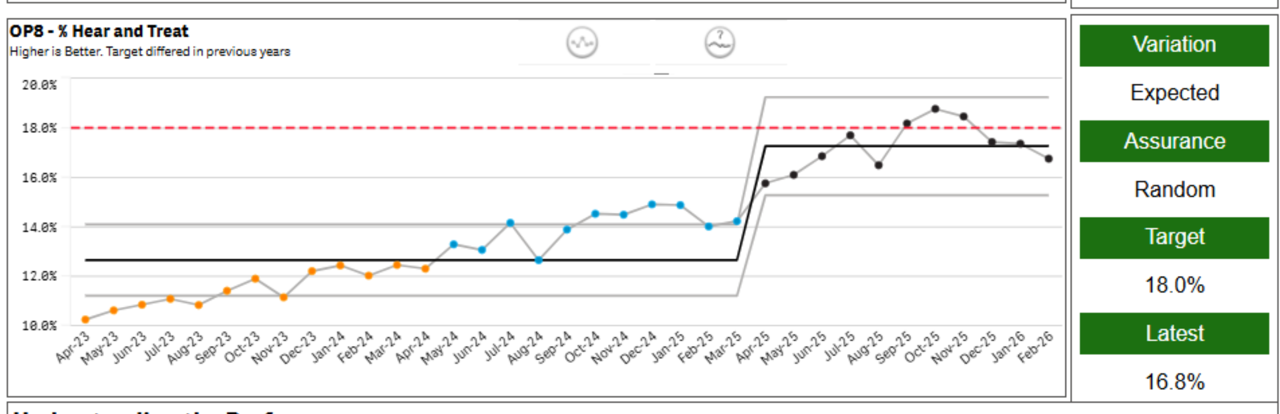
00:00:10

Latest

00:00:05







Variation

Expected

Assurance

Random

Target

18.0%

Latest

16.8%

Understanding the Performance:

Call answer performance (OP6) demonstrates sustained improvement achieving its strongest monthly result since this telephony platform was introduced in 2022. Call demand exceeded planned levels by 5.37%, despite a reduction in duplicate calls attributable to improved category 2 performance. Call taking logged in hours broadly aligned to plan, supported by improved abstraction rates. Hear and Treat (OP8) performance continues to fall short of target for the third consecutive month at 16.77% . Clinical staffing pressures persist, with logged in clinical hours below requirement.

Actions (SMART):

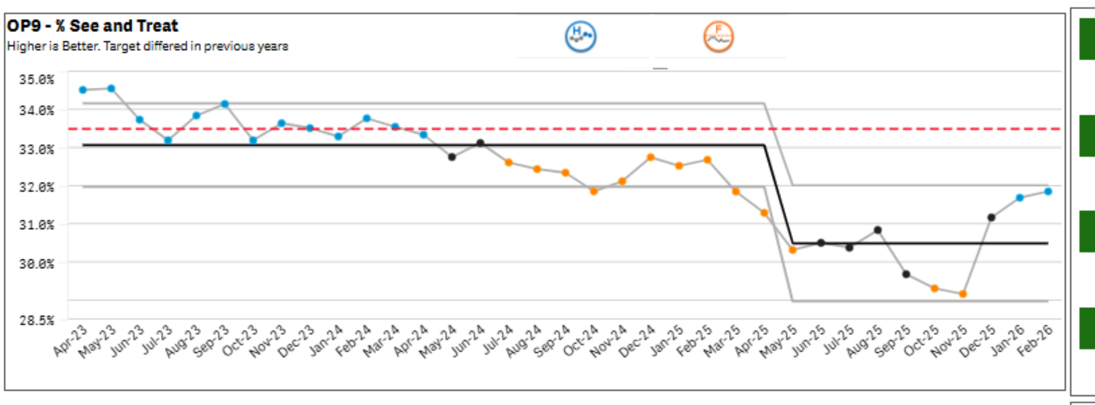
OP8 - H&T recovery action plan in place, weekly meetings to track & review progress, supported by BI. Updates via virtual care monthly steering group/Tier 1 reporting to EMC.

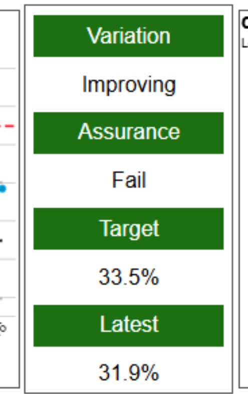
OP8 - weekly recruitment meetings, monthly IWP to track candidate pipeline against plan. Sponsored campaigns active/17 applications to date. 10 candidates in pipeline progressing to start dates.

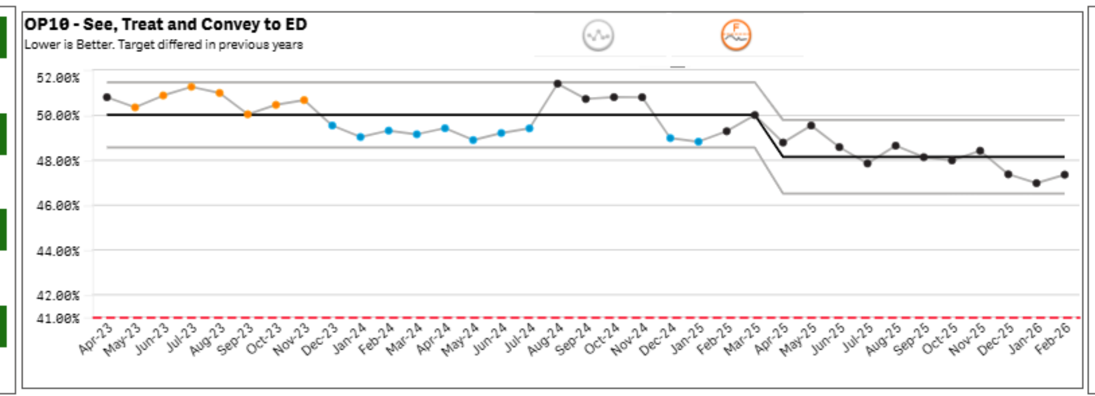
OP8 - CAD technical changes in live March, will improve clinical management of category 3 validation and category 2 segmentation.

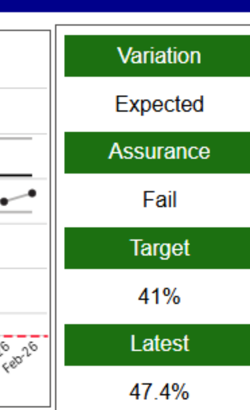
OP6 & 8 - Operational Directorate Restructure appointment to roles commenced.

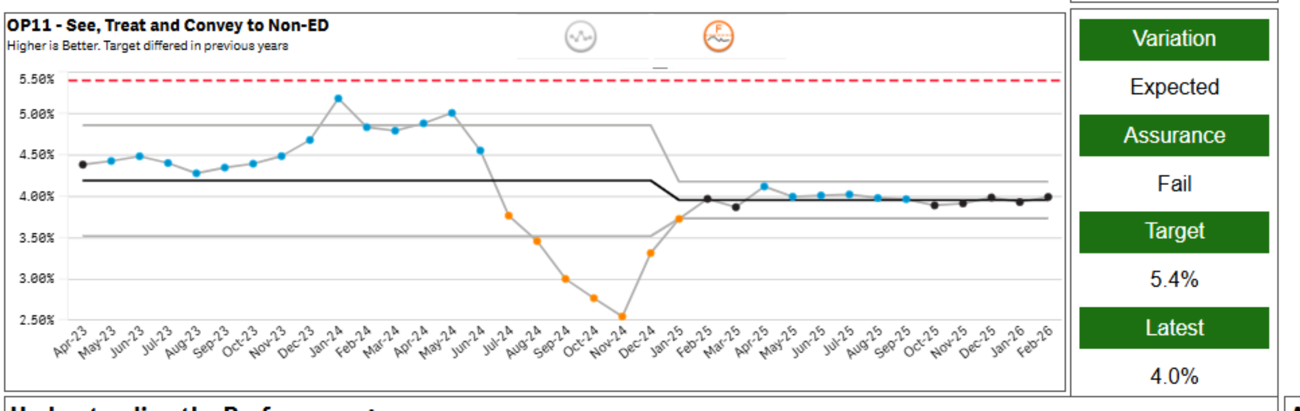
Operations - Utilisation











Understanding the Performance:

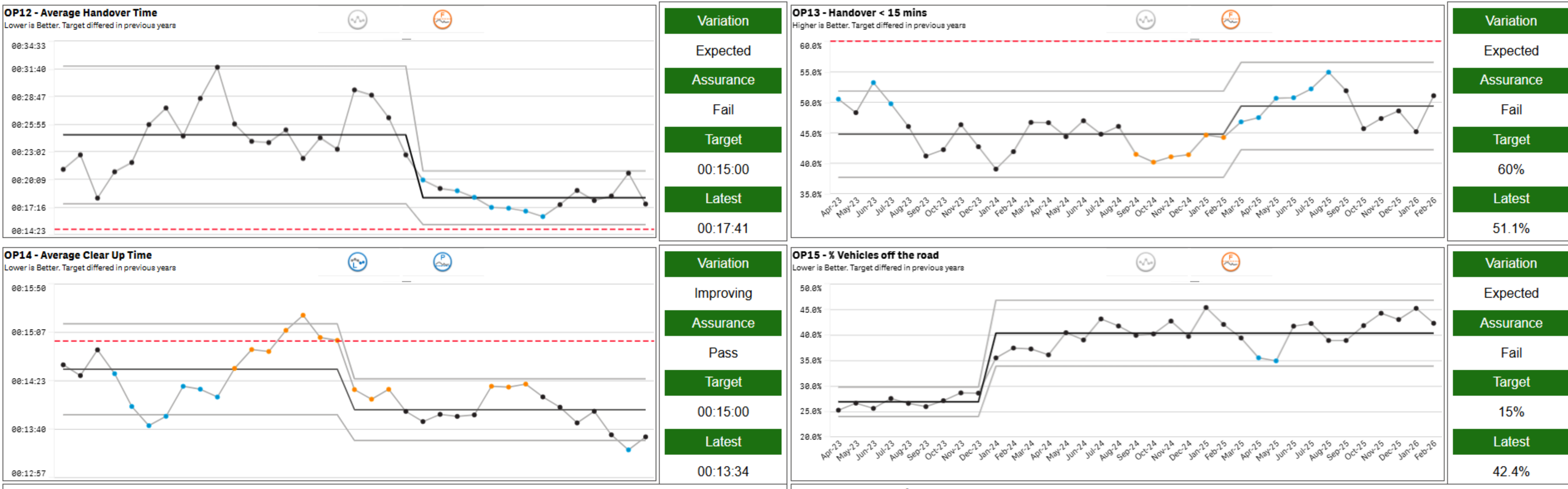
OP9 - S&T has seen another positive month with an improvement in performance likely linked to a deteriorating picture with H&T. OP10 - STC to ED has seen a slight deterioration but is still tracking under the mean and has been following an improving trajectory since Aug 24. Both measures have significant focus on them with the clinical pathways team constantly working to develop new pathways and maintaining those currently present. OP11 - Convey to non ED destinations remains consistent with TV out performing Hants which is driven by OUH and how that manages non emergency flow.

Actions (SMART):

SCAS Connect contract has been through the governance process to extend its licence ensuring we have a digital platform supporting S&T and Non ED destinations. New Clinical Operations Managers appointed in March to provide local focus on S&T improvement plans

NHS

Operations - Utilisation



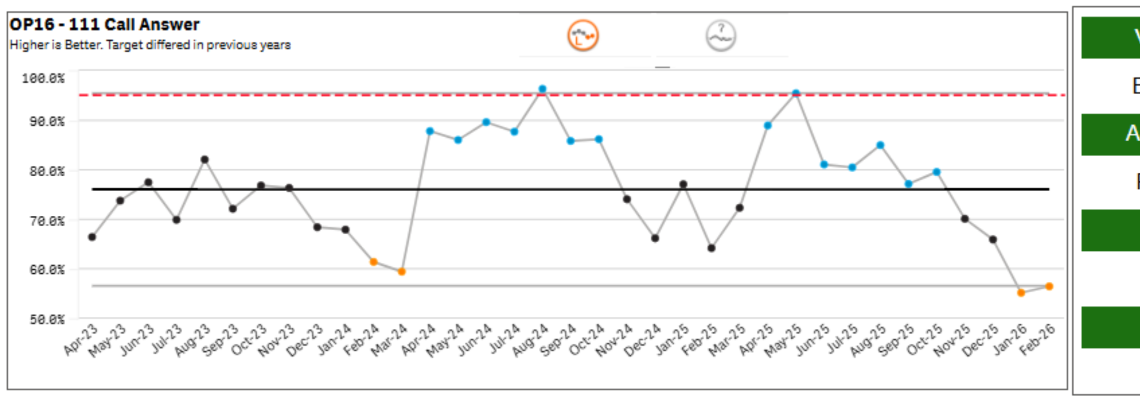
Understanding the Performance:

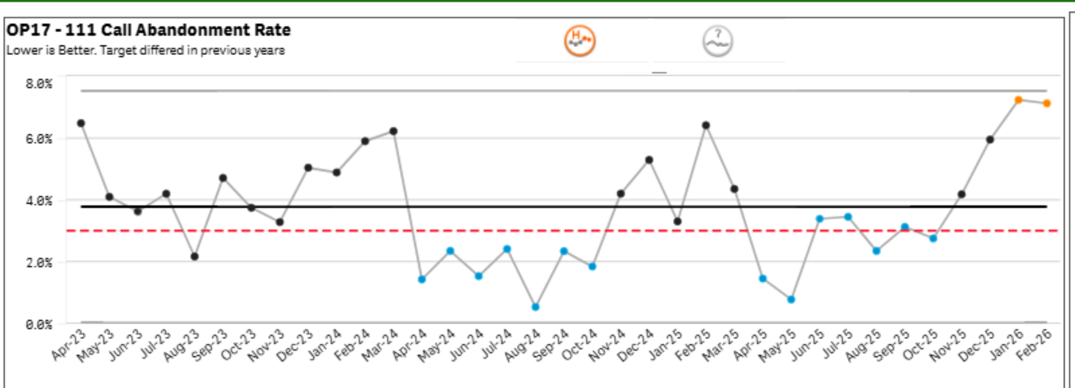
OP12/13 - Handover performance across both measures reflect the improvement we have seen throughout Feb with a 5% increase in handovers in 15 mins and the overall handover time reduced by 3 mins. OP14 - Clear up has worsened slightly but still just above the LCL. Overall VOR for Feb 26 was 42% which was a small reduction on Jan 26. Importantly overall average fleet availability increased by 15 DCAs per day to 211 at peak times.

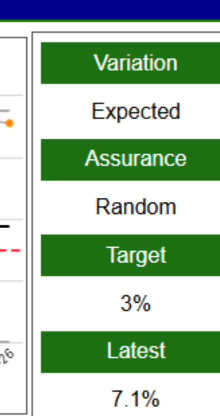
Actions (SMART):

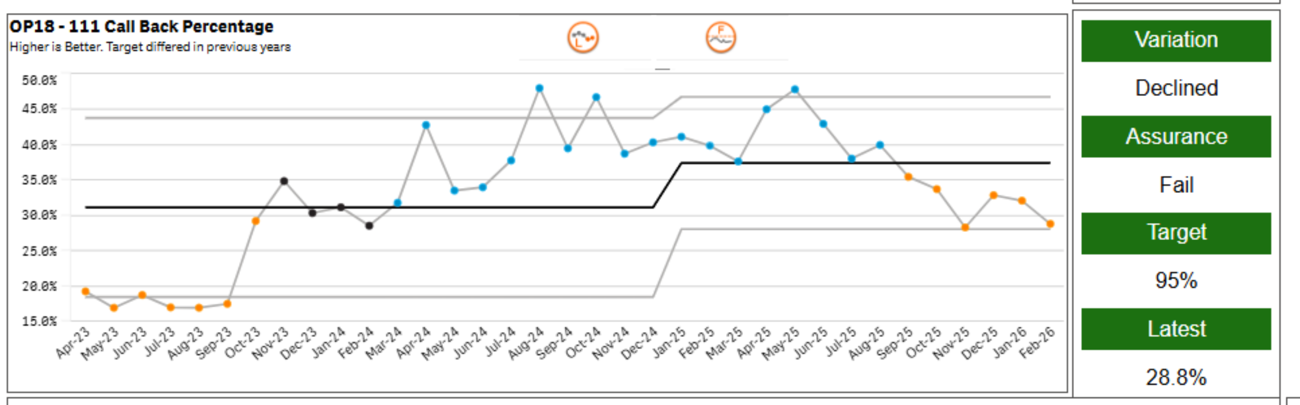
Work continues at a local level to monitor and improve handover compliance. This is managed through local monthly delivery groups with an additional focus linked to S&T/ H&T to avoid using EDs where possible. (OP15)External outsourcing and increased weekend hours have driven an increase in completed work and reduced VOR. Increase in fleet numbers is increasing availability.

Operations - Operations Centre









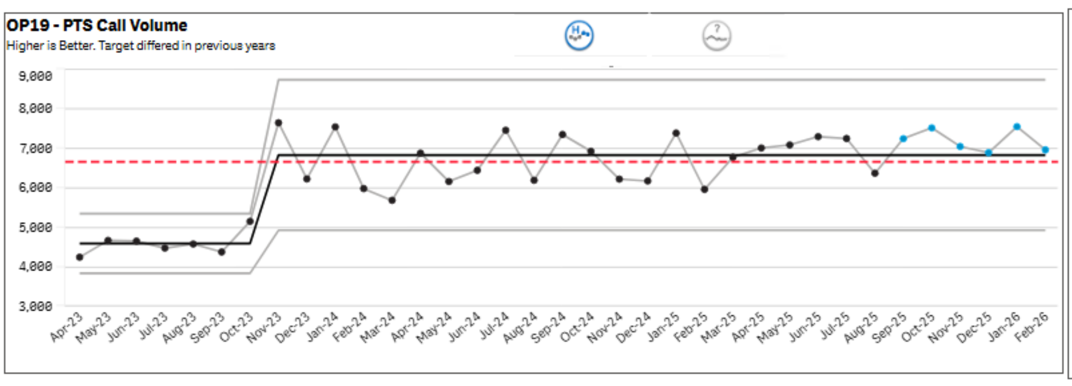
Understanding the Performance:

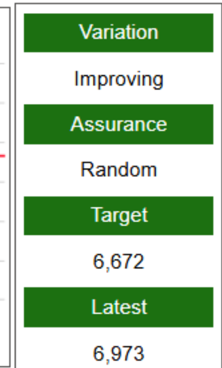
- Calls offered in February remained in line with January, which seen a slight increase in call answer performance from 55% to 57% in February (OP 16) as a result of increased Health Advisor WTE through successful recruitment.
- OP 17 remains challenged with only a slight improvement from January, being a result of Health Advisor gap in budgeted WTE, however early signs in March show a drop in demand and good recruitment numbers continuing to come through.
- OP 18 remains steady although declined in February by 3% due to the continued demand on Primary Care.

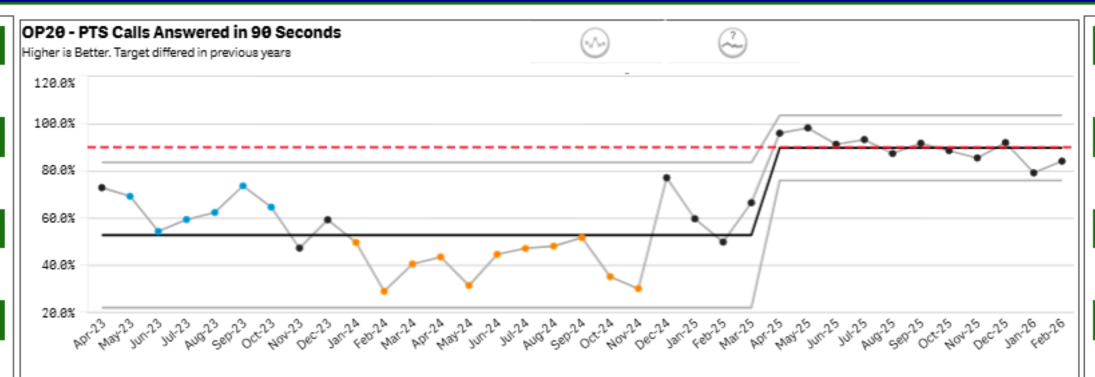
Actions (SMART):

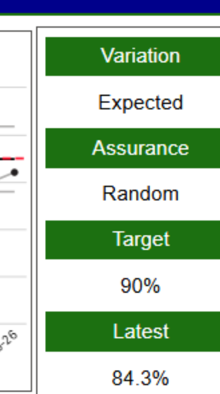
- Health Advisor recruitment continues to improve with additional courses planned through February, March and April to accommodate increase in recruitment numbers, alongside the use of flexible working resource to fill the gap in budgeted Health Advisors.
- Demand in February remained in line with January with little change, however moving into March demand has started to drop in line with the seasonal pattern expected alongside good recruitment figures improving performance.
- Weekly recruitment meetings and monthly DOPR meetings continue to monitor demand pattern and recruitment/course plan.

Operations - PTS - Calls and Outcomes









Understanding the Performance:

Call answer performance improved in February, achieving 84% of calls answered within 90 seconds. While this remains below the target, performance stays above the lower control limit, indicating a stable and recovering trend following a dip earlier in the year. Call volumes in February totalled 6,973, remaining marginally above the target level but broadly consistent with the elevated volumes seen over recent months.

• Workforce variability—particularly the mix of part time and full time colleagues—contributes to demand misalignment during peak periods.

Actions (SMART):

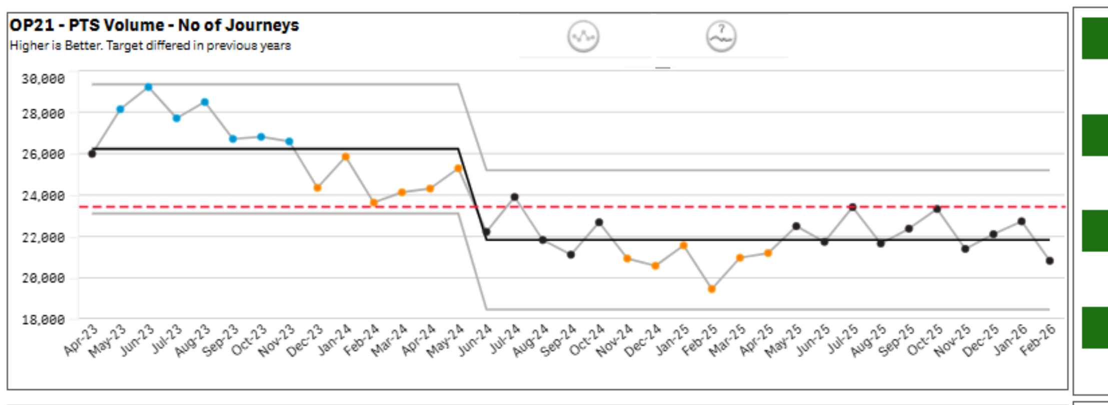
• The Not Ready benchmark has been reduced from 20% to 17% to increase call handling time. Weekly monitoring continues to track progress.

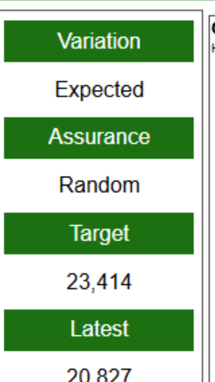
• A rota review is underway to improve alignment of staffing patterns with forecast demand, addressing the current imbalance between full and part time coverage.

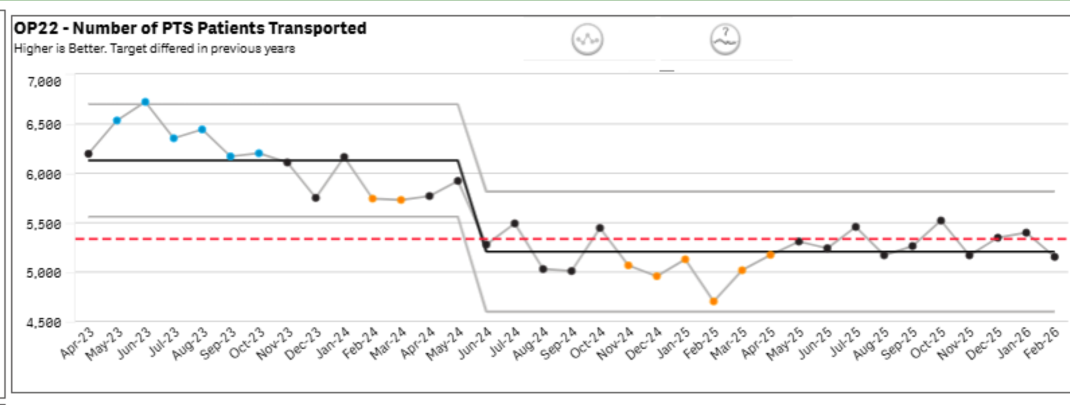
• Telephony Journey Confirmations continue to provide benefit by identifying patients who no longer require transport but have not cancelled, thus reducing same day abortive journeys, supporting more efficient vehicle utilisation.

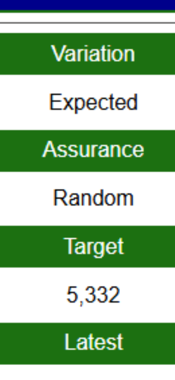
• Vacancies across contact centre are on TRAC awaiting approval.

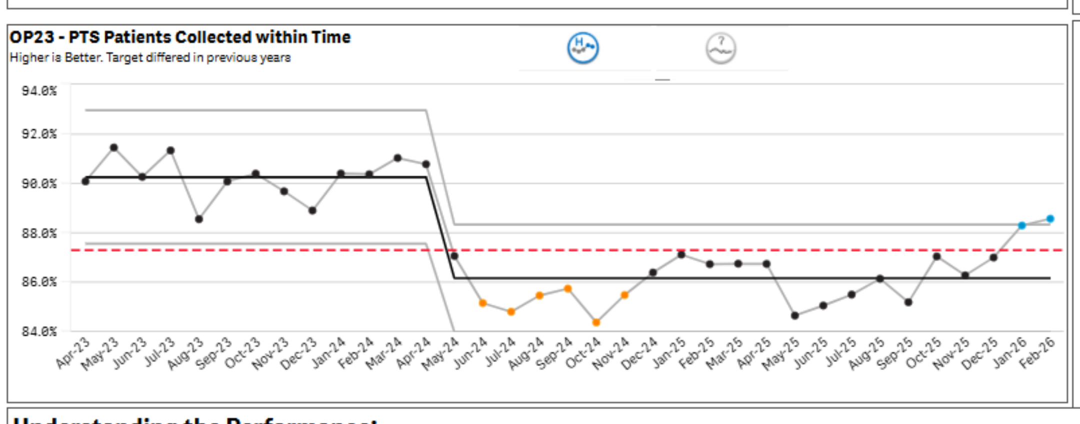
Operations - PTS - Calls and Outcomes

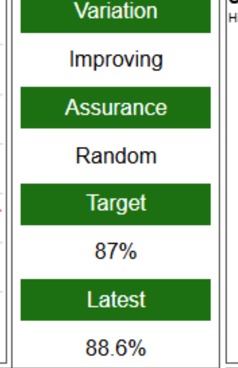


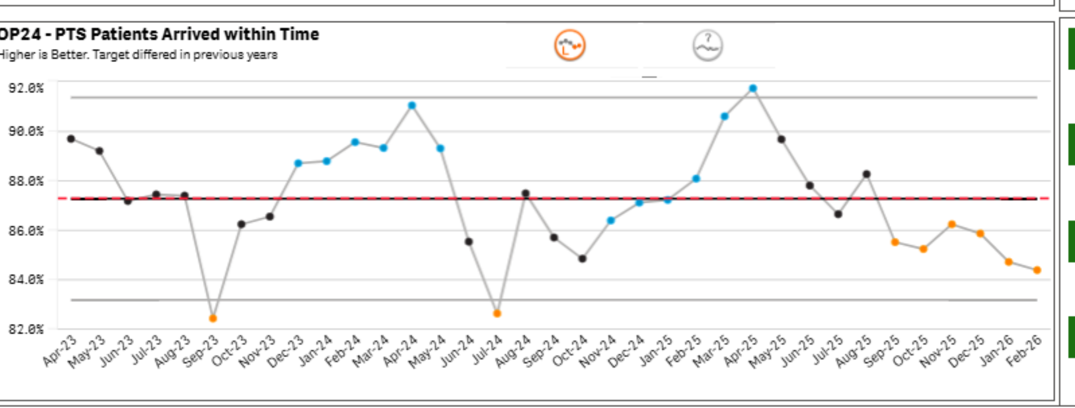












Variation

Declined

Assurance

Random

Target

87.3%

Latest

84.4%

Understanding the Performance:

We experienced challenging days following the MI at UHS. While we did not see the expected decline in outpatient activity, our response across both the hospital and the wider system was extremely strong. Patients required longer distance journeys after being relocated to other hospitals, which resulted in increased return home travel.

It is positive to see an increase in collection times; inbound performance -particularly renal—continues to decline due to high activity levels.

We continue to aim for the appropriate level of hours, but , coverage can fall as low as 70% when including SCAS hours

Actions (SMART):

Continue to monitor daily demand, hours, resource utilisation, and performance within budget. We have seen a shortfall in SCAS hours due to vacancies and other absences.

Maintain a strong focus on increasing cohorting and improving utilisation of resources.

Apply increased scrutiny to sickness absence.

Undertake a review of renal patient bookings to determine how best to manage demand and deliver greater stability and performance improvements.

Forecasted hours are reviewed daily, and we have seen improvements driven by cohorting and operational efficiencies.

Quality and Safety

Quality & Safety – Core Measures Matrix

February-26 Summary

Assurance

Variance

	Fail	Hit and Miss	Pass	No Target
H (high, concern)				
L (low, concern)				
Common cause		16	Safeguarding Adults Level 1	
L (low, improvement)		Number of PSII declared in month	Number of Complaints	
H (high, improvement)		Hand Hygiene audit	Safeguarding Level 3	
Upward				
Downward				

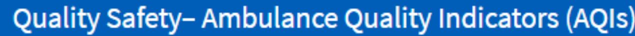
Metrics:

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 PSR declared in month ; Number of reported CD incidents – unaccounted for losses ; 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.	Feb-26	26.7	32.4			29.9	23.8	36
Monthly PSII	Feb-26	0	3			1.91	-2.2	6.02
Monthly PSILR	Feb-26	6	9			8.43	-4.5	21.4
Datix incidents	Feb-26	1.3	1.08			1.12	-0.217	2.47
CD unaccounted for losses	Feb-26	0	2			1.27	-2.72	5.26
Level 1 Safeguarding	Feb-26	96.7%	95%			96.6%	95.8%	97.4%
Level 3 Safeguarding	Feb-26	96.6%	90%			94.6%	93.3%	95.9%
Complaints	Feb-26	0.864	2.66			1.15	0.0551	2.25
Compliments	Feb-26	7.27	0		n/a	8.57	5.44	11.7
Hand Hygiene Audits Completed	Feb-26	439	261			253	-6.36	513
Hand Hygiene % Compliance	Feb-26	96.1%	95%			97.6%	93.7%	101.6%
Vehicle Audits Completed	Feb-26	197	167			210	65	356
Vehicle Audits % Compliance	Feb-26	71.6%	90%			88.9%	70.4%	107.4%

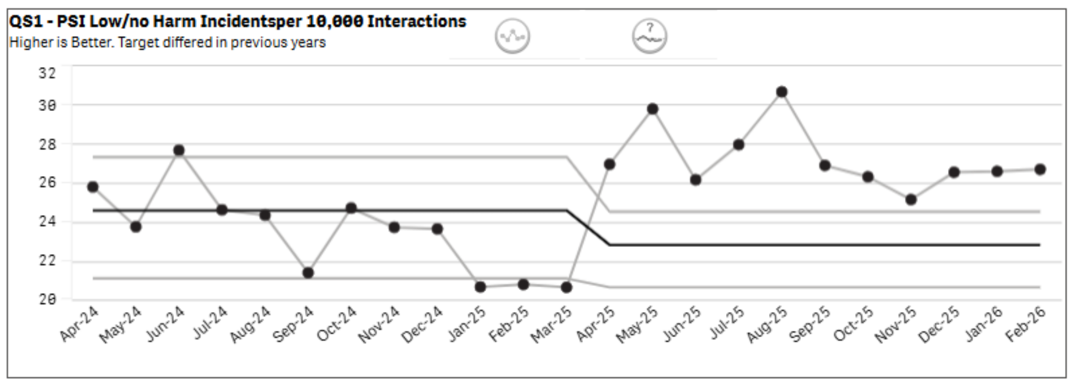


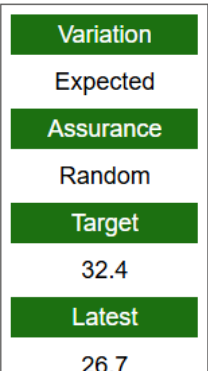
Quality Safety– Ambulance Quality Indicators (AQIs)

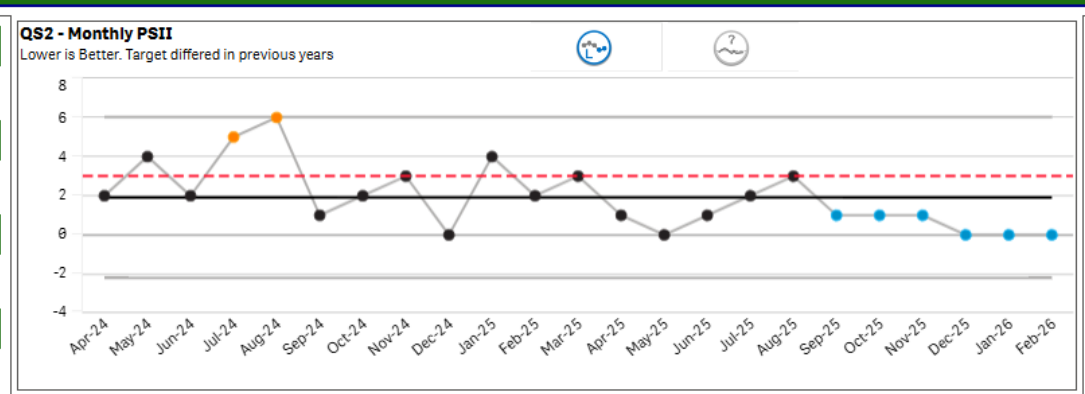
*Currently all data is aggregated on a monthly basis. We aim to provide accurate 90 days, YTD and 12 Months data when available.

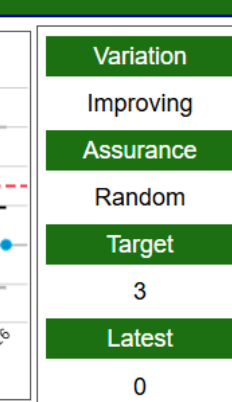
KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
STEMI Mean	Oct-25	02:23:00	02:30:00			02:18:03	01:53:03	02:43:04
STEMI 90th	Oct-25	03:29:00	03:20:00			03:20:50	01:56:25	04:45:14
Stroke Mean	Oct-25	01:31:00	01:30:00			01:34:56	01:16:24	01:53:28
Stroke Median	Oct-25	01:20:00	01:20:00			01:22:13	01:10:10	01:34:17
Stroke 90th	Oct-25	02:17:00	02:30:00			02:22:26	01:53:12	02:51:40
ROSC All	Oct-25	25.6%	25.8%			25.4%	13.7%	37.1%
ROSC Utstein	Oct-25	61.9%	48.4%			52.3%	21.3%	83.2%
CA Survival All	Oct-25	6.9%	8.9%			9.2%	1.8%	16.6%
CA Survival Utstein	Oct-25	19.0%	20.6%			31.1%	7.9%	54.4%

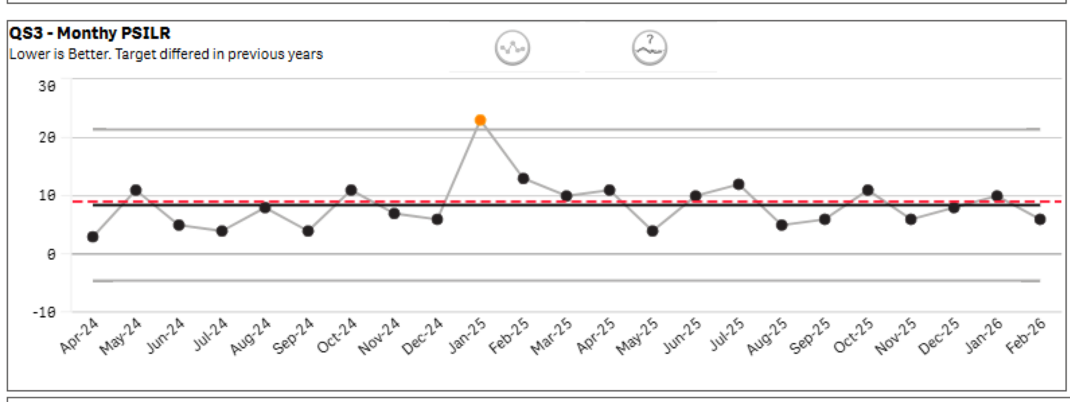
Quality & Safety – PSIRF











Variation

Expected

Assurance

Random

Target

9

Latest

6

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 1.3% linked to improved CAT1, CAT2 and CAT3 response times attributed to incentivised overnight shifts, decreased hospital delays and improved fleet availability (OP1, OP2, OP5); themes are patient recontact.

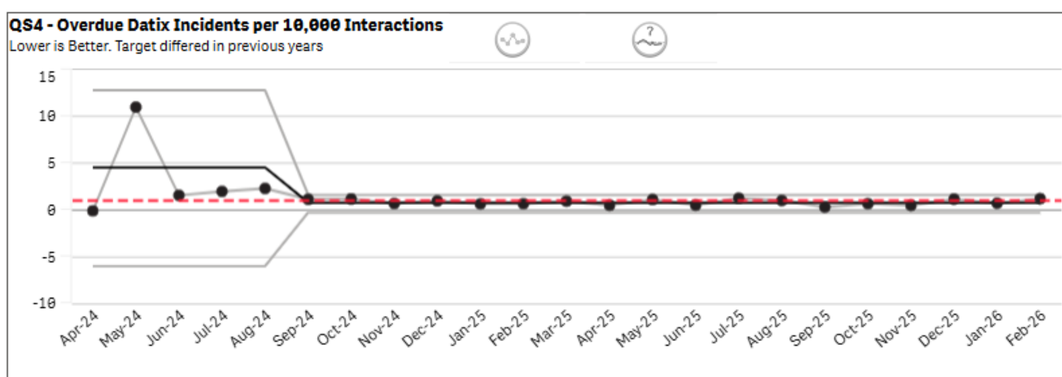
QS2 - Categories for declared PSII: none declared in February 2026.

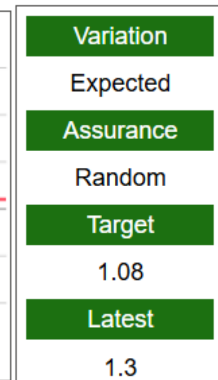
Actions (SMART):

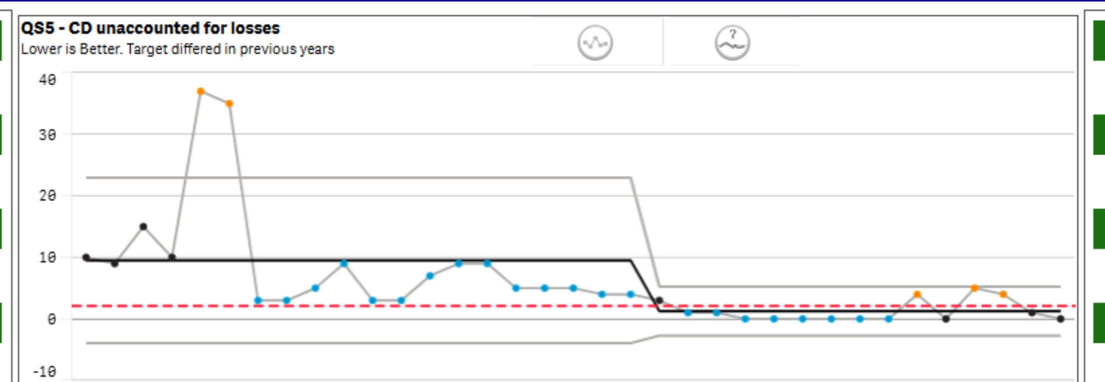
QS3 – New dispatch matrix prioritising Priority 2 backup requests implemented to reduce long waits for high risk patients.

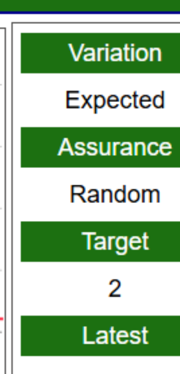
Clinical memo being developed advising staff to adopt a lower threshold for conveyance of 18-20 year olds with raised National Early Warning Score 2.

Quality & Safety – PSIRF









Understanding the Performance:

QS5 illustrates the monthly volume of unaccounted losses of Controlled Drugs (CDs) as reported through the DATIX/CDLIN system. The established target is less than 2 unaccounted losses per reporting cycle. Analysis of the data indicates that the target has been consistently met, reflecting effective control measures. Recently there has been an increase in number but reassuringly this has dropped to zero for February..

Actions (SMART):

Training & Awareness: Ensure all staff are trained in CD handling and reporting by Q3, with refresher training every six months

Stock Control Measures: Complete daily CD stock checks at all sites with full documentation validation by Q3. Investigate discrepancies within 48 hours

Reporting & Documentation: Enhance DATIX detail to support timely investigations and CD Lin reporting by Q4. Implement an electronic CD register by Q3 26/27

Thematic Analysis & Diversion Control: Conduct quarterly thematic reviews to identify causes of unaccounted losses and audit CD handling in line with Trust policy

NHS

Quality & Safety - Audits

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

Variation	Assurance	Target	Latest
Improving	Random	261	439

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

Variation	Assurance	Target	Latest
Expected	Random	95%	96.1%

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

Variation	Assurance	Target	Latest
Expected	Random	167	197

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

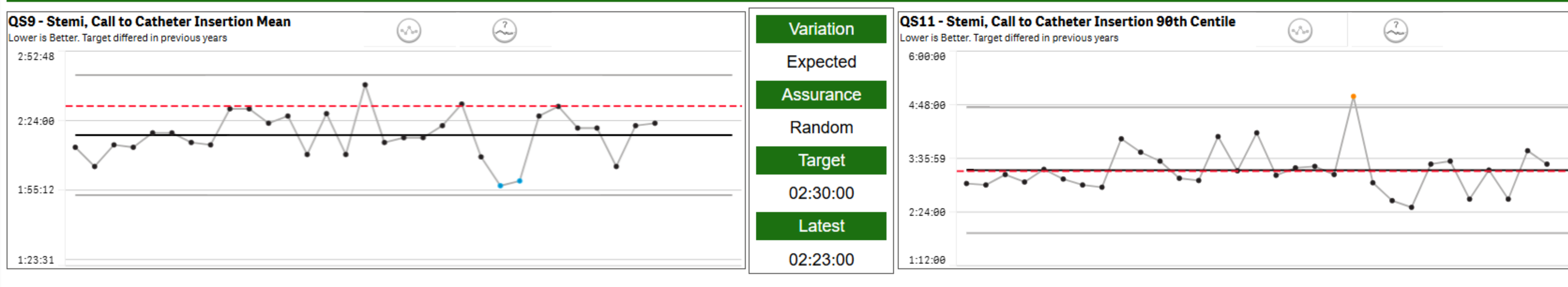
Variation	Assurance	Target	Latest
Expected	Random	90%	71.6%

Understanding the Performance:
Hand Hygiene audit numbers and compliance scores above target. Vehicle audit numbers have increased as a higher number of level 3 audits have been conducted by the IPC team. The number of compliant audits is below target.

Actions (SMART):
Audit system developed and ready for April start. This will ensure live dashboard and new style reports at local and trust level.

NHS

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



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

Understanding the Performance:

STEMI Mean (QS9) shows common cause variation and is below the target (6th of 11 reporting services).

STEMI 90th (QS11) shows common cause variation and is above the target (9th of 11 reporting services).

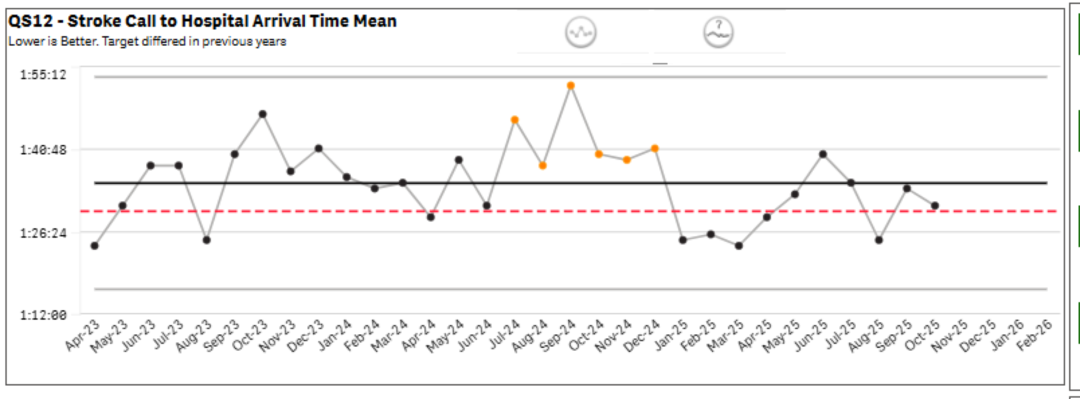
Each of the charts is a system-based performance measure that reflects the whole cycle from point of call to time to insertion of the intervention and therefore includes time taken in hospital following ambulance arrival.

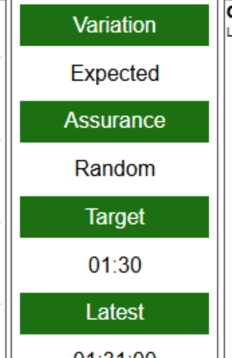
Actions (SMART):

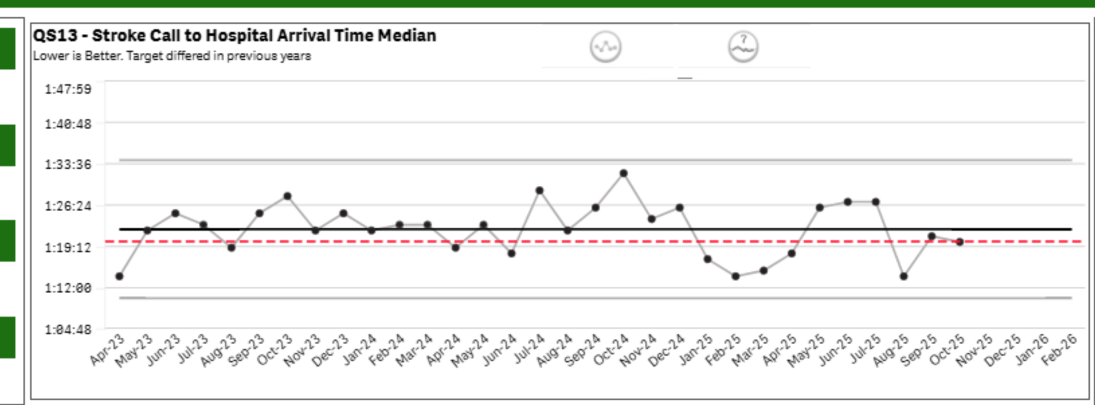
Continue to maximise vehicle availability to respond by reducing handover delays at Emergency Departments (OP 12 OP13 & OP14).

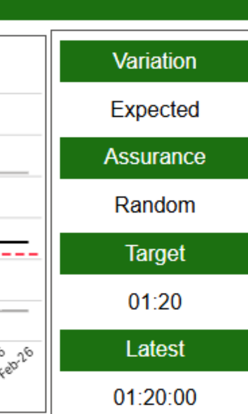
Continuous focus on operational delivery of Category 2 response times (OP2).

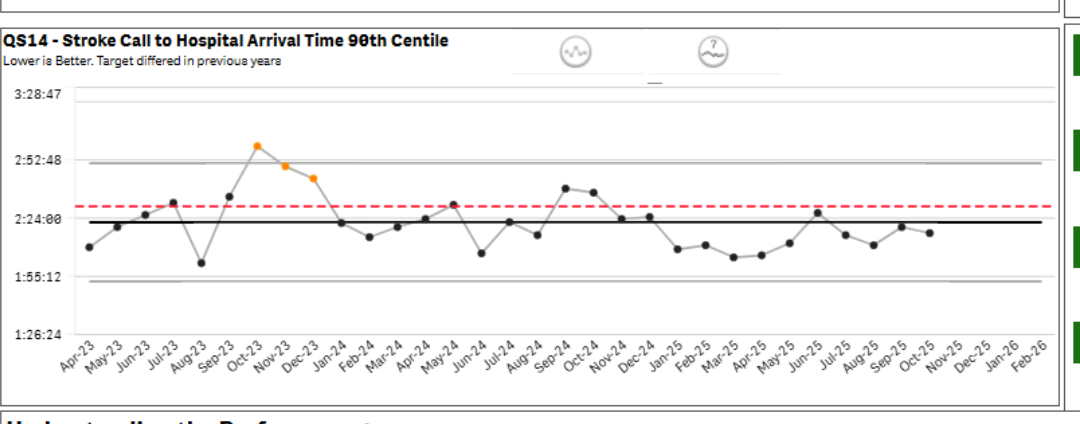
Quality & Safety – AQIs – Stroke - Chief Paramedic Officer











Variation

Expected

Assurance

Random

Target

02:30

Latest

02:17:00

Understanding the Performance:

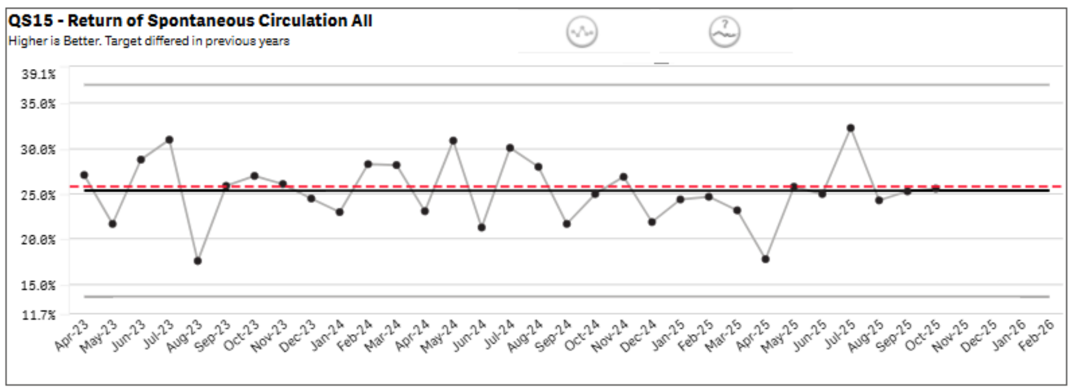
Stroke Mean (QS12) shows common cause variation & is above the target (5th of 11 reporting services).
Stroke Median (QS13) shows common cause variation & is at the target (4th of 11).
Stroke 90th (QS14) shows common cause variation & is below the target (5th of 11).

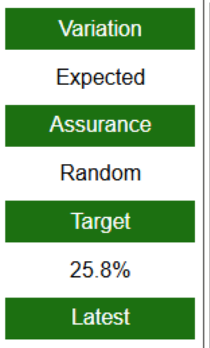
Each chart is a performance based measure & as such is reliant on the Trust's ability to identify a suitable resource, time taken to get to scene, the ability of the Trust clinician to recognise a Stroke & provide the required care, time spent on scene & time spent travelling to the hospital site.
293 cases present.

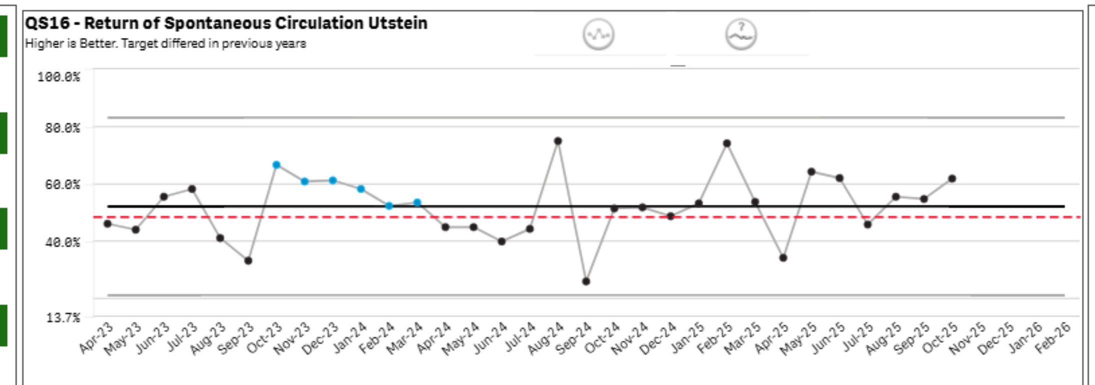
Actions (SMART):

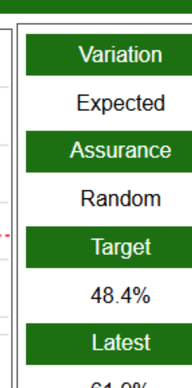
Continue to maximise vehicle availability to respond by reducing handover delays at Emergency Departments (OP 12 OP13 & OP14).
Continuous focus on operational delivery of Category 2 response times (OP2).

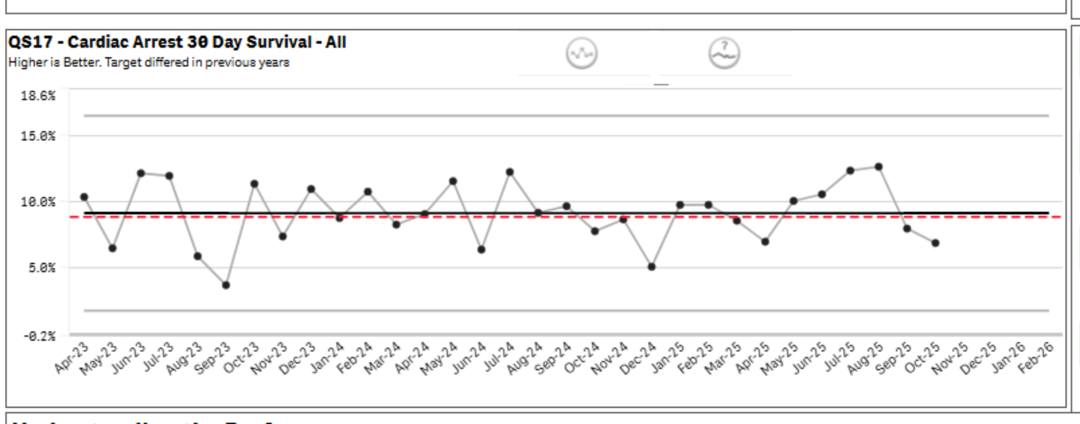
Quality & Safety – AQIs – Cardiac Arrest - Chief Paramedic Officer

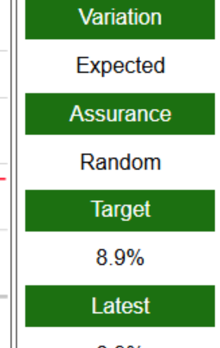


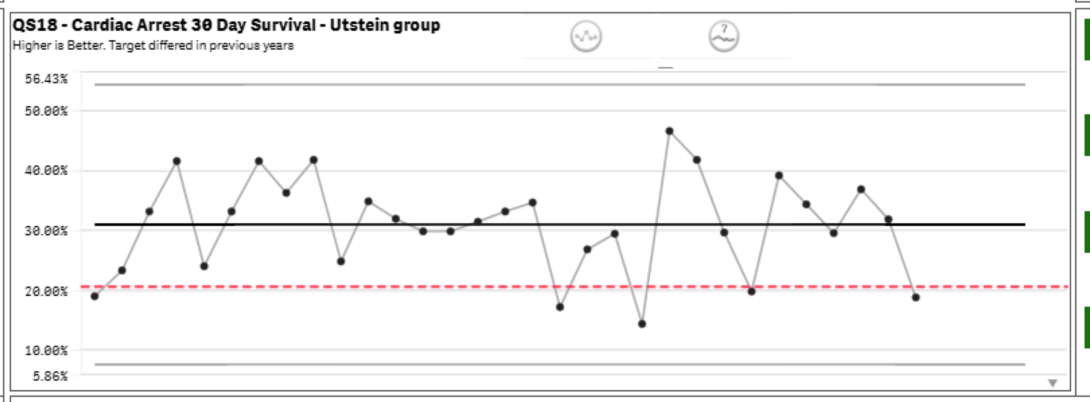


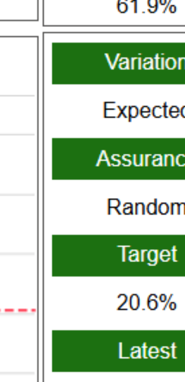












Understanding the Performance:

ROSC all (QS15)shows common cause variation, below the target (7th of 10 reporting services)

ROSC Utstein (QS16) shows common cause variation, above the target (2nd/ 10)

Cardiac Arrest Survival All (QS17) shows common cause variation below the target (9th/ 10)

Cardiac Arrest survival Utstein (QS18) shows common cause variation below the target (9th/ 10)

To improve cardiac arrest outcomes a whole system approach is required aligned to the chain of survival.

Community action prior to ambulance attendance is crucial.

This report is based on 195 cases for the month.

Actions (SMART):

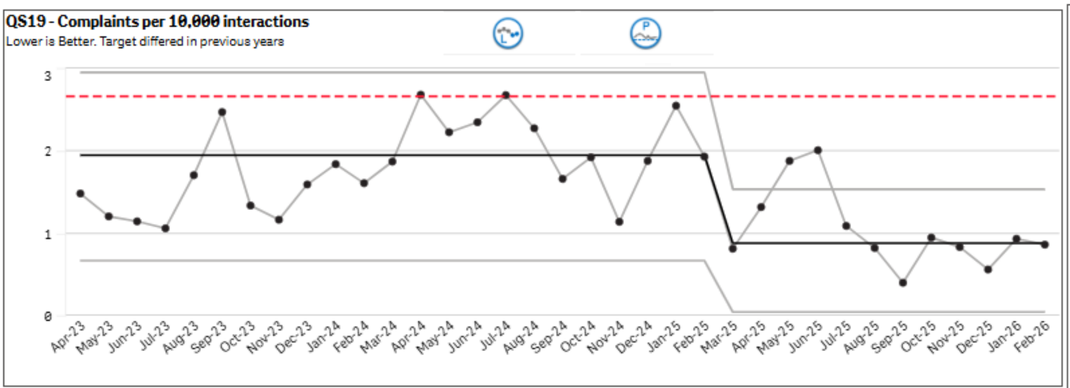
Continuous focus of call answer times (OP6)

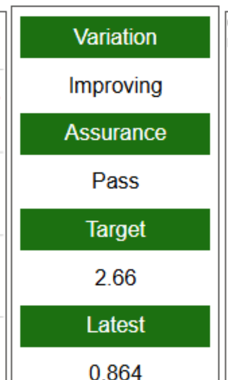
Continuous focus on Category 1 response times (OP1)

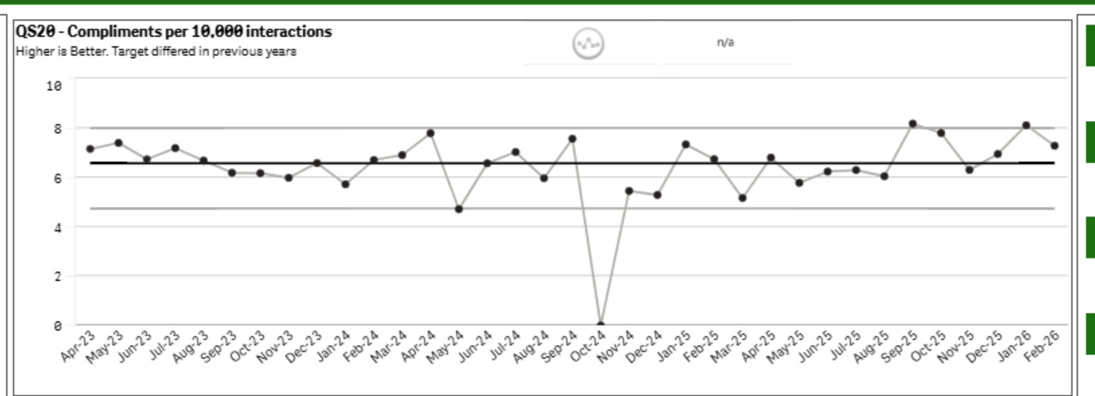
Continue to maximise vehicle availability to respond by reducing handover delays at Emergency Departments (OP 12 OP13 & OP14).

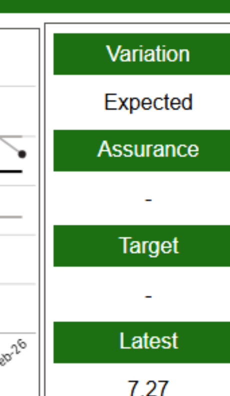
To have 95% of Trust clinical staff to have completed their annual mandatory training, both online and face to face for resuscitation, by the end of March 2026.

Quality & Safety – Safeguarding and Patient Experience









Understanding the Performance:

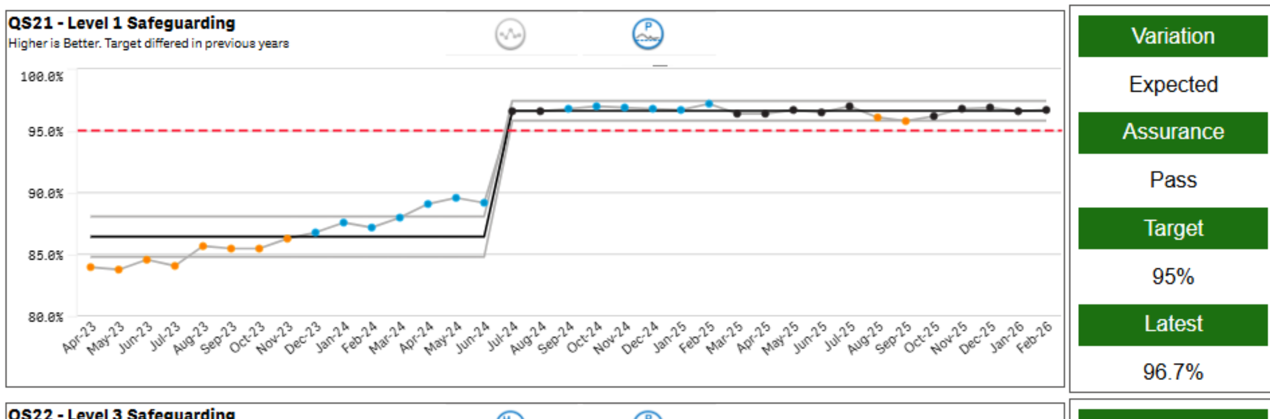
QS20 – Concerns decreased from 75 to 63 representing 19% of all patient experience contacts; 101 compliments, 31% of all patient experience contacts, were received for the same period.

Themes are delays in EUC and NEPTS attendance.

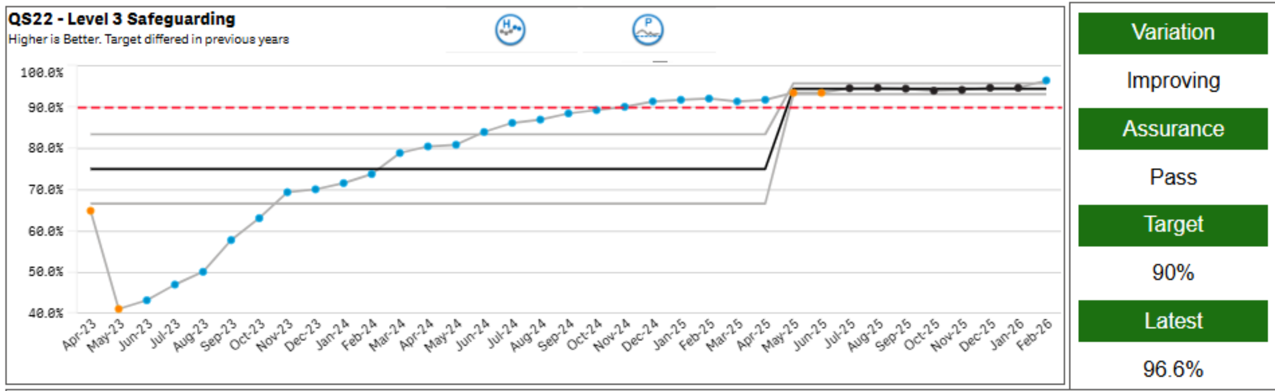
Actions (SMART):

QS20 – The clinical governance team are working with NEPTS operational teams to understand causes of delays and identify actions to reduce occurrence.

Quality & Safety – Safeguarding and Patient Experience



Variation
Expected
Assurance
Pass
Target
95%
Latest
96.7%



Variation
Improving
Assurance
Pass
Target
90%
Latest
96.6%

Understanding the Performance:

Safeguarding Children & Adults training level 1 - 98%

Safeguarding Children & Adults training level 3 (face to face only) - 96%

CPD 75%

Supervision 66%

4 hours 90%

7.5 hours 69%

Actions (SMART):

Safeguarding training plan continues and is monitored weekly at service level and bi-monthly at Safeguarding Committee

People

NHS People Overview

February-26 Summary

Metrics:

Assurance

Variance

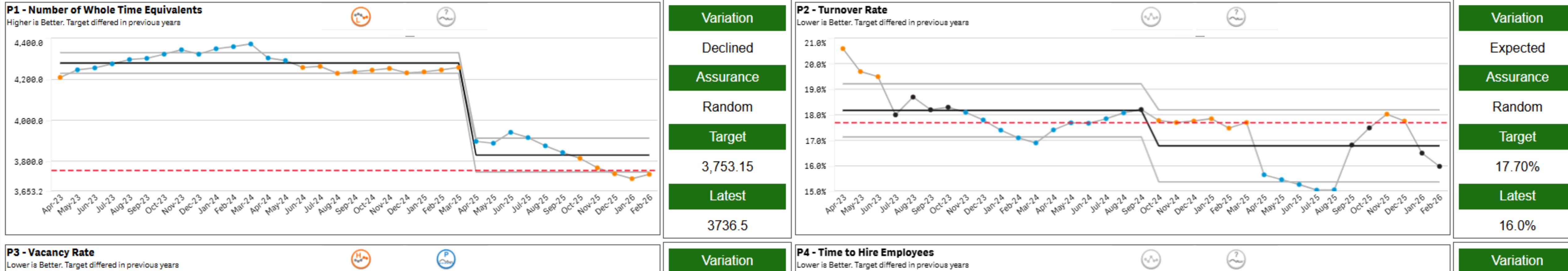
	Fail	Hit and Miss	Pass	No Target
		% Sickness in month Short term sickness	% Vacancy	FTSU Cases
		Number of WTE		
	Appraisals - Trust Meal Break Compliance - SCAS	% Long term sickness % Turnover Over-runs >30 mins - SCAS Time to hire	% DBS Compliance	
		% Trust staff who are BAME	% Trust staff who are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

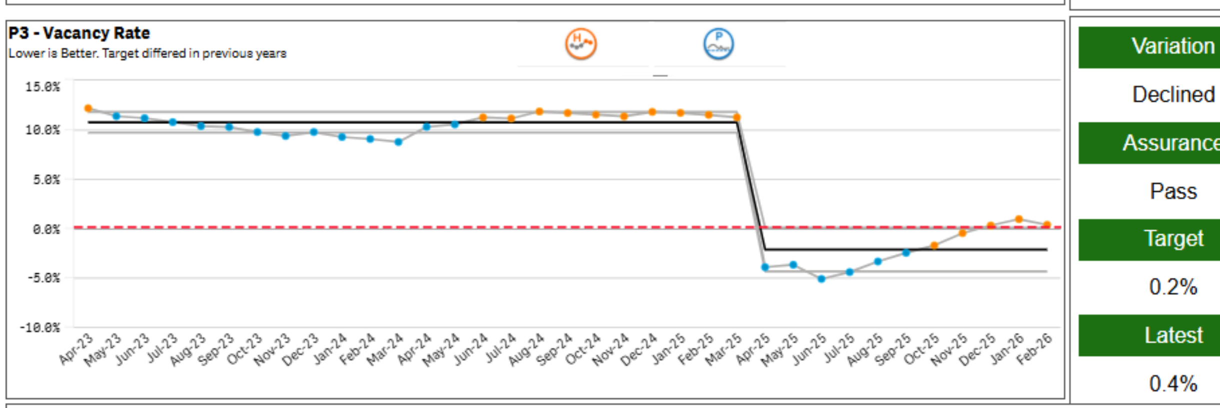
People - WTE, Availability, Staff Compliance, Staff Welfare

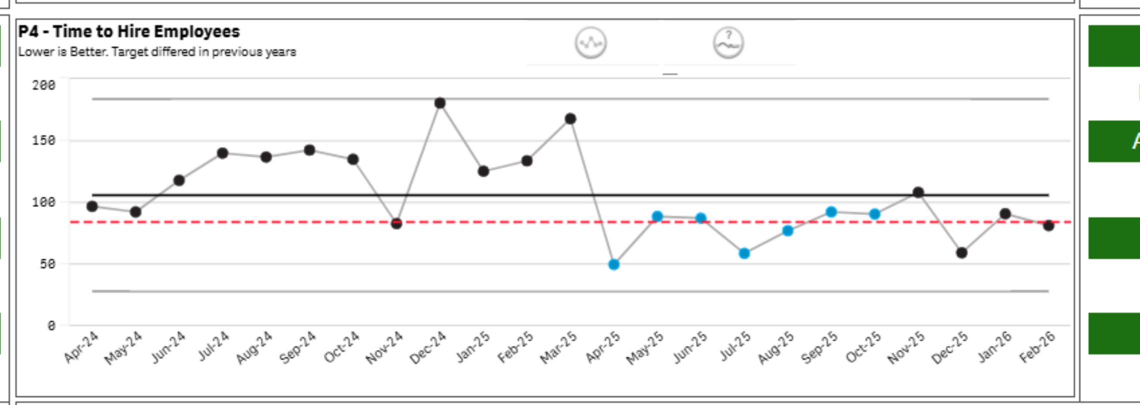
*Some of the YTD and 12 Months figures are based on aggregated data see data quality sheet for more information.

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Number of WTE	Feb-26	3,737	3,753			3830.4	3747.8	3912.9
% Turnover	Feb-26	16.0%	17.70%			16.8%	15.4%	18.2%
% Vacancy	Feb-26	0.4%	0.20%			-2.1%	-4.3%	0.1%
Time to hire	Feb-26	82	84			106.0	28.1	183.9
% Trust staff who are BAME	Feb-26	8.9%	8.86%			8.7%	8.3%	9.0%
% Trust staff who are declared disabled	Feb-26	11.8%	9.54%			10.8%	10.3%	11.2%
% Sickness in month	Feb-26	8.3%	6.20%			7.2%	5.6%	8.7%
Short term sickness	Feb-26	4.0%	2.70%			3.0%	1.9%	4.0%
% Long term sickness	Feb-26	4.4%	3.50%			4.0%	3.2%	4.9%
% DBS Compliance	Feb-26	98.3%	95.00%			98.4%	97.7%	99.1%
Appraisals - Trust	Feb-26	84.8%	95.00%			84.1%	78.1%	90.1%
Stat and Mand Compliance	Feb-26		95.00%	-		96.9%	94.6%	99.2%
FTSU Cases	Feb-26	23			n/a	16.6	2.5	30.7
Meal Break Compliance - SCAS	Feb-26	77.7%	85%			71.8%	61.9%	81.7%
Over-runs >30 mins - SCAS	Feb-26	16.0%	15%			15.1%	13.0%	17.2%

People - Workforce/WTE







Variation
Expected
Assurance
Random
Target
84
Latest
81.5

Understanding the Performance:

P1 - WORKFORCE - 3737 WTE, an increase of 22 since M10. 999 +26, EOC - 4, 111 +8, PTS - 6 and Corp - 2 WTE.

P2 - STAFF T/O - 16% Vs 18% target. 999 (9) and Corp (16) are positive against targets. EOC (37), 111 (33) and Ops Support are above target

P3 - VACANCY - 222 below budget est. Vacancies in EOC (35), 111 (48), PTS (65), Ops Support (62) and Corp (16). 999 is 3 over budget est

P4 - TIME TO HIRE - Median (advert close to start date) reduced from 81 to 81 days, despite large numbers of ECA's on hold (378 days) & NQPs (414 days) starting in February. Ad hoc sits at 48 calendar days.

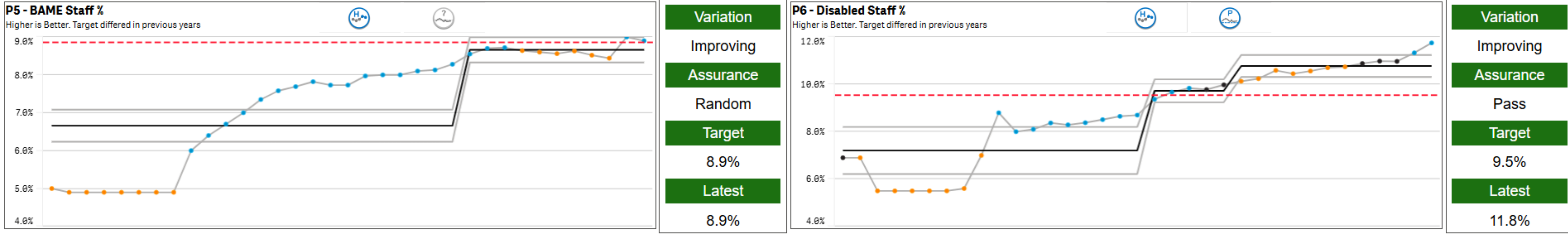
Actions (SMART):

P1 - WORKFORCE - with WFP approved and Q1 underway for Ops & PTS alongside continued recruitment to CCC, we expect to see WTE increasing month on month. Recruitment and Attrition will be closely monitored to ensure alignment.

P3 - VACANCY rate has been steadily increasing following the Ops & PTS recruitment freeze. Now that this has been lifted, we will see this reduce.

P4 - TIME TO HIRE is likely to remain high while the remaining on hold NQPs are processed. National targets allow for frontline roles to be discounted in the TTH reporting.

People - Workforce/Availability



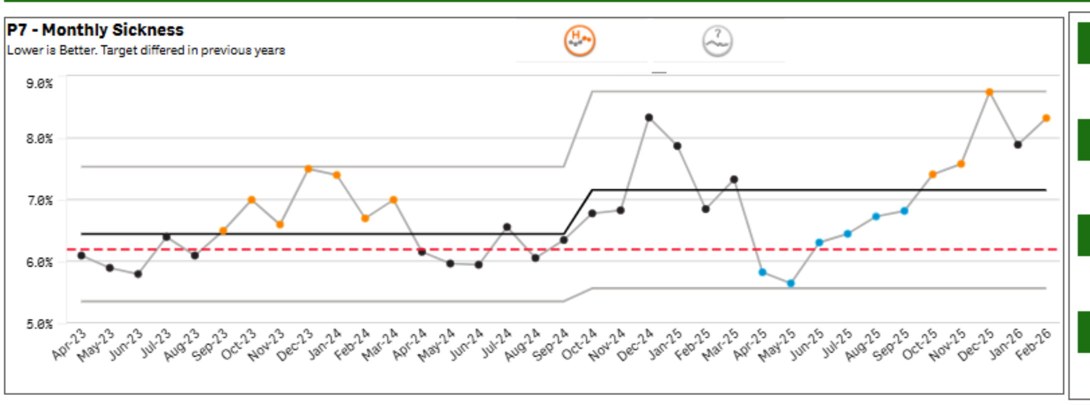
Understanding the Performance:

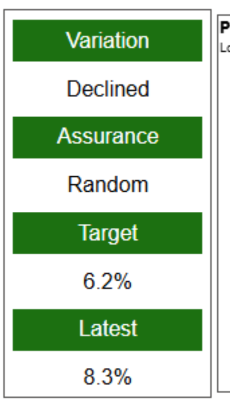
P5 - WRES - 8.9% (9.4% in M10). 17% regional average (10-year target)

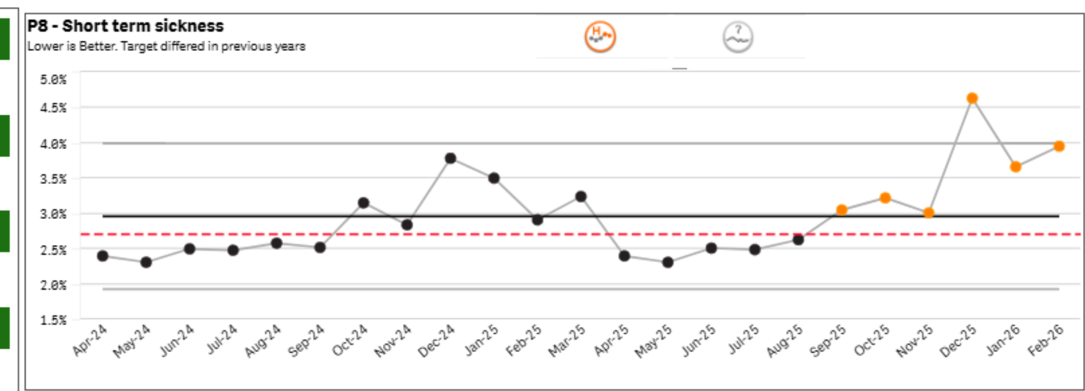
P6 - WDES - 11.7% (11.3% in M10). 14% regional average (5-year target)

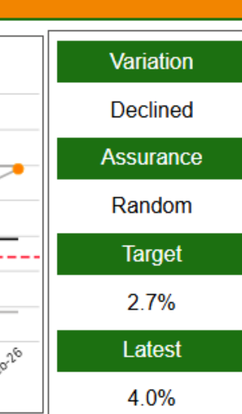
Actions (SMART):

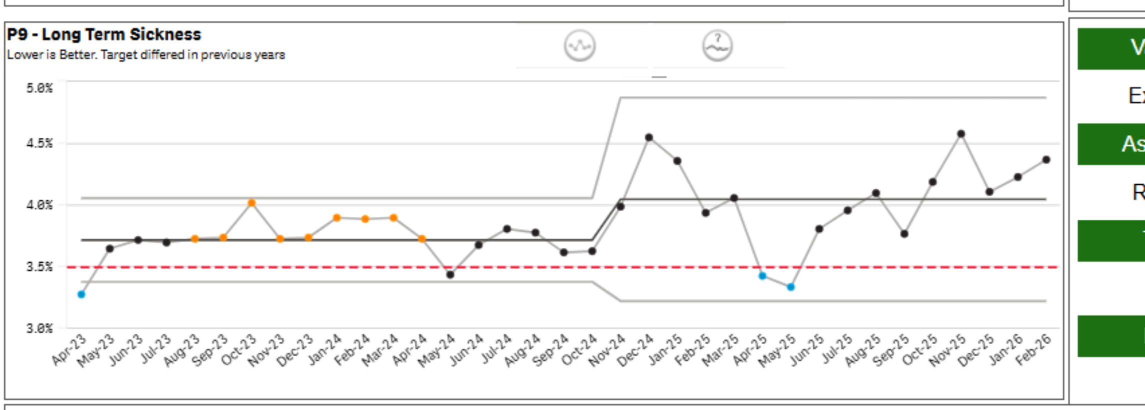
People - Workforce/Sickness











Variation

Expected

Assurance

Random

Target

3.5%

Latest

4.4%

Understanding the Performance:

P7 - YTD Sick (8.2%) is above 6.2% YTD target. 999 = 9.5, EOC = 9.0, 111 = 8.5 and PTS = 8.5 above target. CORP below target at 3.4%

P7 - YTD Estimated Cost = £12.5m

P7 - YTD Ave Sick Days per WTE = 29 days (2024/25 = 24 days)

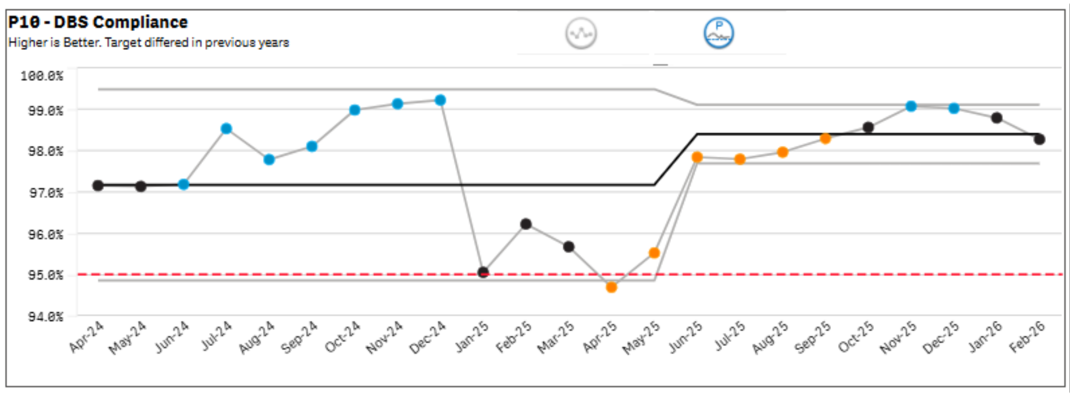
P7 - M11 Sickness (8.3%) is above 6.3% target for M11. 999 = 9.2, EOC = 9.0, 111 = 8.5, PTS = 8.5 above target. CORP below at 3.3%

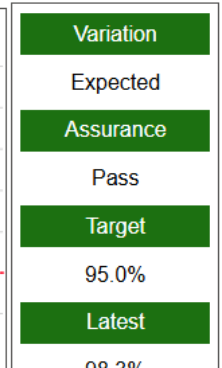
P8 - M11 STS (3.9%) is above 3.0% target. 999 = 4.4, EOC = 4.1, 111 = 4.5, PTS = 3.8 above target. CORP below at 1.2%

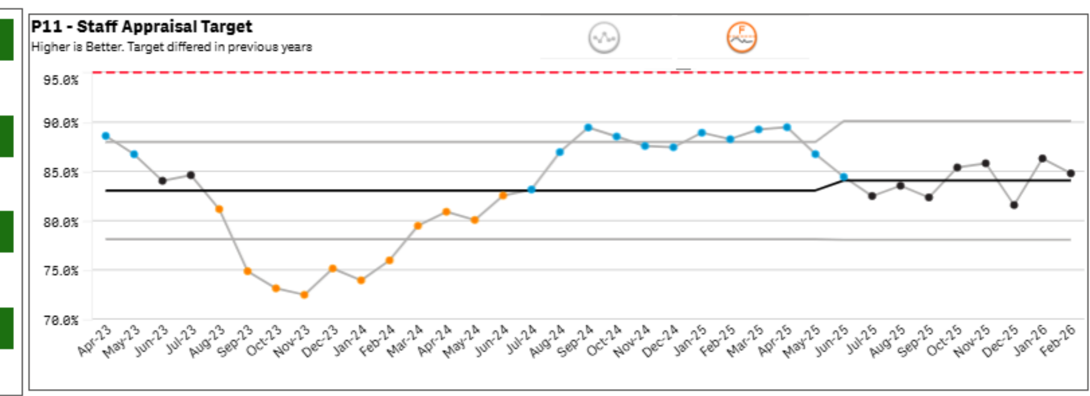
Actions (SMART):

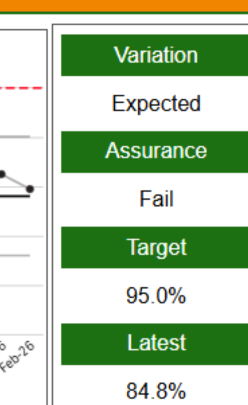
EOC and LTS are the concerning increases, all other areas have shown a decrease (to be expected for the time of year). Further reports and analysis to be undertaken to understand the increases and further highlights to local management teams on importance of managing LTS.

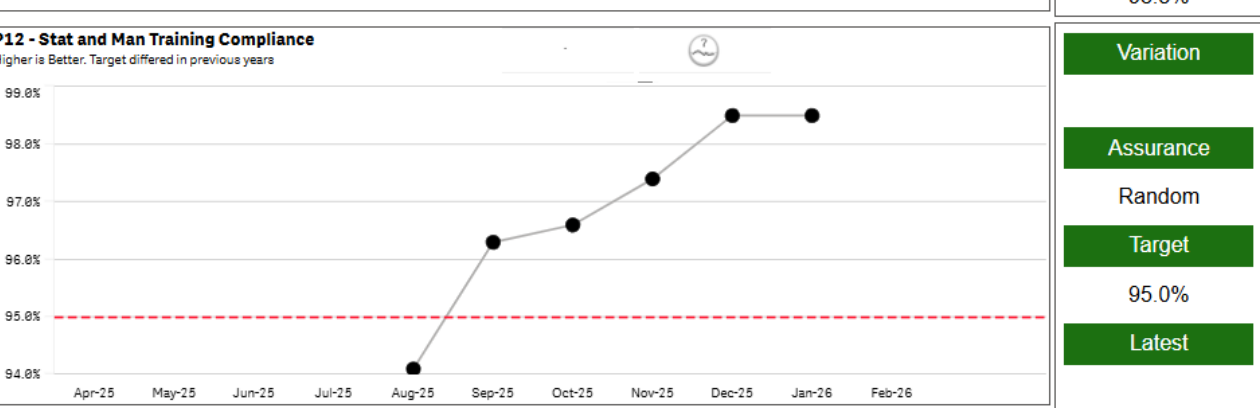
People – Workforce/Staff Compliance











Understanding the Performance:

P10 - DBS - 98% compliance with all areas continue above 95% target

P11 - PDR - Trust (85%) below 95% target. 999 =90%, EOC =94%, 111 =82%, PTS =79%, Corporate =77%, OPS Support = 64%

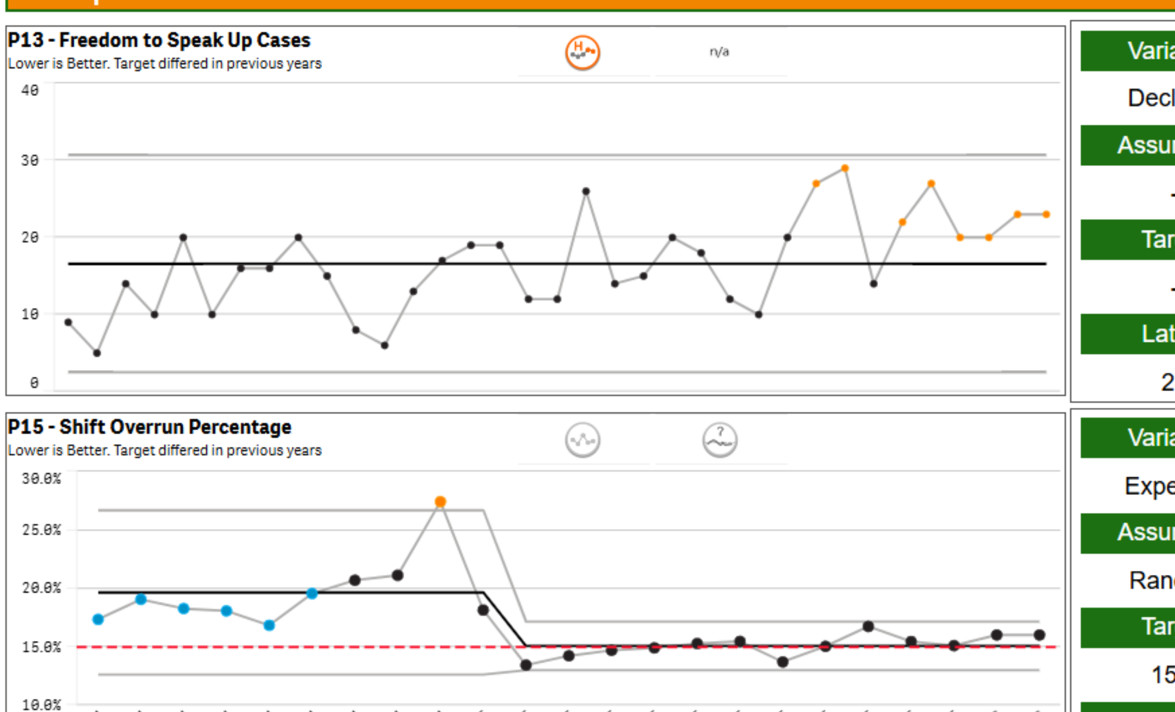
P12 - S&M compliance above 95% for all subjects except Resus L2 (89%), Resus L3 (86%), Conflict resolution (77%), FTSU (managers) (91.2) and Mental Health Act (88)

Actions (SMART):

P10 - DBS - remains above target with the team working through to end May and beginning to look ahead to those due in June & July. PDR completion is being actively monitored by the Deputy Chief People Officer and will be discussed at forthcoming Sub Board meetings (including PACC), with an emphasis on improving compliance levels. A PDR trajectory will be developed and issued to areas with lower completion rates, alongside a request for clear timelines for completing outstanding PDRs.

P12 - Improvement actions in place for resus L2 and L3. Conflict resolution is planned for next FY

People - Workforce/Staff Welfare



P13 - Freedom to Speak Up Cases

Variation	Declined
Assurance	-
Target	-
Latest	23

P14 - Meal Break Compliance

Higher is Better. Target differed in previous years

85.0%
60.0%
40.0%
20.0%

Variation	Expected
Assurance	Fail
Target	85%
Latest	77.7%

P15 - Shift Overrun Percentage

Variation	Expected
Assurance	Random
Target	15%
Latest	16.0%

Understanding the Performance:

OP14 - mealbreak compliance has stayed consistent and just below target of 85% which is due in part to the current trial enforcing a break away from base where needed. OP15 - Late finishes have also stayed consistent through Feb as a SCAS wide measure but that doesn't show the true picture of the mix of compliance between some more rural RCs. Twenty-two concerns were reported across safety, behavioral and process-related themes through a combination of anonymous, confidential, open and advice-only routes.

Actions (SMART):

Work continues looking at improving end of shift compliance with measures being explored for a potential change to policy. Work to be completed by end April 26 with the caveat that any changes cant impact our ability to respond to incidents that could increase the incidence of harm. These findings indicate the need to strengthen psychological safety, enhance leadership visibility and improve processes to increase staff confidence in raising concerns directly.

Trust Board of Directors Meeting in Public 2 April 2026	
Report title	Month 11 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	Executive Management Committee and Finance and Performance Committee March 2026
Governance Pathway: Next steps	N/A

Executive Summary

Income & Expenditure (I&E)

The Trust reported an in-month financial position of £1.1m surplus against plan, resulting in a year-to-date (YTD) position of £417k favourable to plan. This improvement is primarily driven by the confirmed receipt of H2 Deficit Support Funding (DSF).

The YTD underlying position includes several risks, including:

- Continued cost pressures within frontline staffing
- Under-delivery against Cost Improvement Plans (CIPs)
- Delays in returning Patient Transport Service (PTS) vehicles

These pressures have been partially mitigated through tight vacancy controls and underspends across corporate services.

Capital

YTD capital expenditure totals £19.9m, an underspend of £8.9m against plan. The variance is mainly due to slippage in sale-and-leaseback transactions for the 2025/26 cohort of Double Crewed Ambulances (DCAs) and Rapid Response Vehicles (RRVs). An accelerated review

of next year's capital programme has been undertaken to bring forward schemes where possible to ensure a balanced year-end capital position.

Cash

The Trust's cash balance at the end of February was £43m, which is £10.5m ahead of plan. This reflects the timing of Public Dividend Capital (PDC) receipts, income from DCA sale-and-leaseback transactions, and slippage within the capital programme.

In month, the Trust generated a net cash inflow of £12.6m, largely driven by:

- £9.3m of DCA capital sale proceeds
- £4.5m of capital PDC drawdown

Key Performance Indicators

	Actual	Plan	Variance
Surplus / (Deficit) In-month (£'000)	1,220	84	1,136
Pay Costs In-Month (excl. agency) (£'000)	18,079	17,833	-246
Agency Costs - in month (£'000)	191	51	-140
Capital Spend - YTD (£'000)	19,927	28,837	-8,910
Closing Cash Position (£m)	43.0	32.5	10.5

Alignment with Strategic Objectives

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

Finance & Sustainability

Relevant Board Assurance Framework (BAF) Risk

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

SR5 - Increasing Cost to Deliver Services

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

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

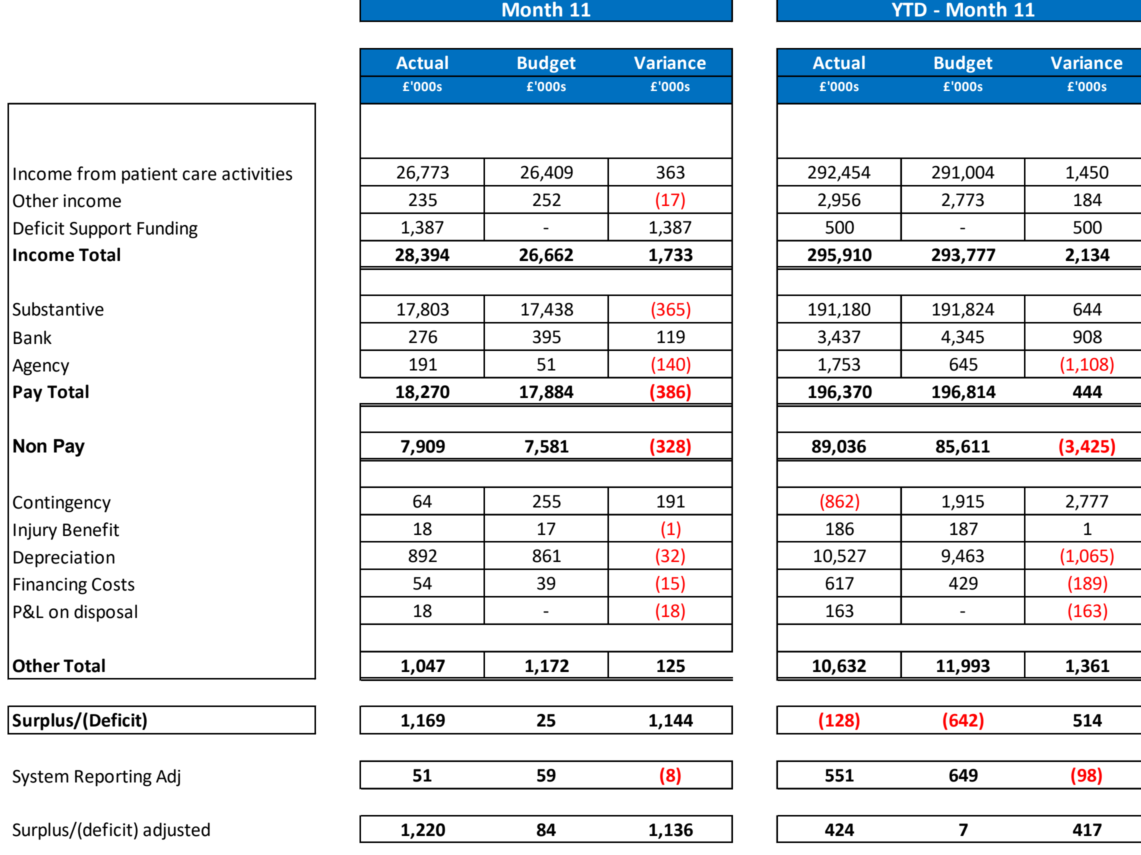
For Assurance	✓	For decision		For discussion		To note	✓

1. Background / Introduction

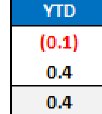
- This report is produced monthly to update the Board on the latest financial position and any risks to the achievement of financial objectives.

Income and Expenditure (I&E)

In month 11, the Trust's I&E position is £1.1m surplus to plan. This is primarily due to the gain of Deficit Support Funding (DSF).



	Month 11			YTD - Month 11		
	Actual £'000s	Budget £'000s	Variance £'000s	Actual £'000s	Budget £'000s	Variance £'000s
Income from patient care activities	26,773	26,409	363	292,454	291,004	1,450
Other income	235	252	(17)	2,956	2,773	184
Deficit Support Funding	1,387	-	1,387	500	-	500
Income Total	**28,394**	**26,662**	**1,733**	**295,910**	**293,777**	**2,134**
Substantive	17,803	17,438	(365)	191,180	191,824	644
Bank	276	395	119	3,437	4,345	908
Agency	191	51	(140)	1,753	645	(1,108)
Pay Total	**18,270**	**17,884**	**(386)**	**196,370**	**196,814**	**444**
Non Pay	**7,909**	**7,581**	**(328)**	**89,036**	**85,611**	**(3,425)**
Contingency	64	255	191	(862)	1,915	2,777
Injury Benefit	18	17	(1)	186	187	1
Depreciation	892	861	(32)	10,527	9,463	(1,065)
Financing Costs	54	39	(15)	617	429	(189)
P&L on disposal	18	-	(18)	163	-	(163)
Other Total	**1,047**	**1,172**	**125**	**10,632**	**11,993**	**1,361**
Surplus/(Deficit)	**1,169**	**25**	**1,144**	**(128)**	**(642)**	**514**
System Reporting Adj	**51**	**59**	**(8)**	**551**	**649**	**(98)**
Surplus/(deficit) adjusted	**1,220**	**84**	**1,136**	**424**	**7**	**417**



£m	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	YTD
Plan	0.2	0.2	0.4	(0.0)	(0.1)	(0.2)	(0.2)	(0.3)	(0.1)	0.1	0.1	**(0.1)**
Actual	0.2	0.2	0.4	(0.0)	(0.1)	(0.2)	(0.5)	(0.5)	(0.3)	(0.1)	1.2	**0.4**
Variance to Plan	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**(0.2)**	**(0.2)**	**(0.2)**	**(0.1)**	**1.1**	**0.4**

Service-Specific Performance

For SCAS, the table below details the financial position, by Division, as at Feb 2026 (Month 11)

		Month 11			Month 11 YTD			25/26 FY		
		Actual £'m	Plan £'m	Variance £'m	Actual £'m	Plan £'m	Variance £'m	Actual £'m	Plan £'m	Variance £'m
999	Income	20.9	20.7	0.3	229.6	227.9	1.8	251.0	248.6	2.4
	Expenditure	(17.1)	(15.9)	(1.2)	(183.4)	(177.3)	(6.1)	(200.2)	(193.2)	(7.0)
	Contribution	3.8	4.8	(1.0)	46.3	50.6	(4.3)	50.7	55.3	(4.6)
	%	18%	23%		20%	22%		20%	22%	
111	Income	3.7	3.8	(0.0)	41.4	41.5	(0.1)	45.2	45.2	(0.0)
	Expenditure	(3.2)	(3.2)	0.0	(34.5)	(34.8)	0.3	(37.8)	(38.1)	0.3
	Contribution	0.5	0.6	(0.0)	6.8	6.6	0.2	7.4	7.2	0.3
	%	14%	15%		17%	16%		16%	16%	
PTS	Income	2.1	2.0	0.1	21.4	21.7	(0.2)	23.9	23.6	0.3
	Expenditure	(1.4)	(1.6)	0.2	(17.6)	(17.9)	0.3	(19.4)	(19.5)	0.1
	Contribution	0.7	0.4	0.4	3.9	3.8	0.1	4.5	4.2	0.4
	%	34%	18%		18%	17%		19%	18%	
Operations Total Contribution		**5.1**	**5.7**	**(0.6)**	**57.0**	**61.0**	**(4.1)**	**62.7**	**66.6**	**(3.9)**
%		19%	22%		19%	21%		20%	21%	
Corporate		(5.3)	(5.7)	0.4	(57.7)	(61.6)	3.9	(63.8)	(67.3)	3.5
Surplus/(Deficit)		**(0.2)**	**0.0**	**(0.3)**	**(0.8)**	**(0.6)**	**(0.1)**	**(1.1)**	**(0.7)**	**(0.4)**
Reporting Adjustments		1.5	0.1	1.4	1.2	0.6	0.6	1.8	0.7	1.1
Adjusted Surplus/(Deficit)		**1.22**	**0.08**	**1.14**	**0.44**	**0.01**	**0.43**	**0.63**	**(0.00)**	**0.63**

999 Division

The in-month position shows a £961k deficit against plan.

Income is £271k above plan, primarily due to additional non-recurrent funding.

Expenditure shows an in-month deficit of £1,232k within the 999 service, driven mainly by the following factors:

- **A&E resources are overspent by £776k**. This is partly attributable to the Trust's response to a business continuity incident, aimed at bringing Category 2 performance within 30 minutes. This has required increased use of private provider hours and staff pay incentives. In addition, there has been increased recruitment in preparation for the 27.30 minutes and seconds Category 2 target in 2026/27.
- **CIP shortfall of £299k** has also contributed to the overall variance.
- **Fleet £352k deficit** which is associated with the business continuity and CIP shortfall.

111 Services

Vacancies are being held and overtime reduced in line with non-recurrent CIP plans. This has resulted in an **in-month deficit of £29k, £205k surplus YTD.**

Non-Emergency Patient Transport Services (NEPTS)

The NEPTS division reported a surplus of £351k against budget in month and breakeven YTD. This has been achieved by the review of the remaining number of vehicles and the release of costs related to returned vehicles.

Corporate Divisions

In month, there is a £377k surplus against plan. This is driven by underspends across all corporate services due to vacancy control. The key areas within corporate, with the largest variance are:

- **People are £88k underspent**, driven by vacancies being held, release of education income and the delivery of CIP savings.

- **Estates are £79k underspent,** reflecting savings from buildings that have now been exited and the outcome of a review of current and prior-year utility costs.
- **Digital are £221k underspent** due to the reduction in M365 Contract.

Financial Risks & Planning

Since the confirmation of the H2 DSF Income from HIOW we are now expected to move from the breakeven plan to a £0.63m surplus to plan.

The ICB has confirmed that DSF will be returned for Quarters 3 and 4.

The increased recruitment of frontline staff to support delivery of the 27:30 minutes/seconds Category 2 performance target in 2026/27 creates additional financial pressure on the Trust's position in Q4.

The Trust continues to monitor emerging operational and financial risks that could affect year-end performance and the 2026/27 planning cycle. This includes potential pressures in workforce, fleet, and non-pay expenditure, as well as risks associated with strategic initiatives and multi-year financial planning. The Board will be kept informed of any developments through regular reporting and assurance processes.

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.

The Trust's multi-year plans, developed through the medium-term planning process, reflect the impact of both recurrent and non-recurrent risks in the current financial year and provide a clear understanding of the underlying financial position. These pressures are being addressed on a recurrent basis in future years, which may influence investment priorities and the ongoing efficiency requirements.

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, an increase from the planned £21.6m, reflecting the current year-to-date underlying financial performance and additional cost pressures.

The focus is now on developing a multi-year CIP programme, considering both immediate and long-term opportunities. Efforts will concentrate on the continuous identification of productivity and efficiency initiatives through bi-weekly Financial Sustainability Delivery Group (FSDG) meetings.

Cost Improvement Plans for 2026/27 are being developed, with work ongoing to bridge the gap between the target and unidentified savings. This is being progressed both at individual Directorate level and through cross-functional discussions within the Senior Leadership Forum.

Trust Pay Costs

Pay	Month 11 Actual £000's	Month 11 Plan £000's	Month 11 Variance £000's	Year to Date Actual £000's	Year to Date Plan £000's	Year to Date Variance £000's
Substantive	17,803	17,438	(365)	191,180	191,824	644
Bank	276	395	119	3,437	4,345	908
Agency	191	51	(140)	1,753	645	(1,108)
Total Pay	18,270	17,884	(386)	196,370	196,814	444

Pay Costs:

- Total pay expenditure for the month was £17.8m, against a plan of £17.4m. The overspend is largely driven by 999s – to support cat 2 performance in 2026/27.

Agency Spend:

- Agency costs totalled £191k, exceeding the plan by £51k.
- The spend above plan was driven by Fleet Mechanics in SCFS.

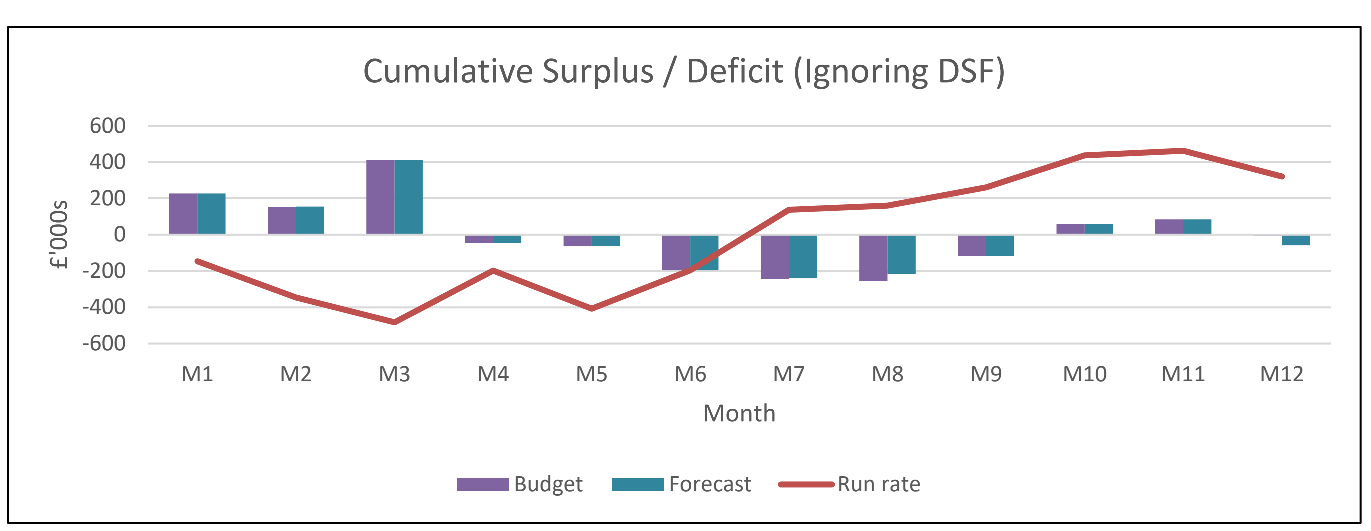
Bank Spend:

- Bank costs totalled £276k, under budget by £395k.
- The underspend is due to a lower uptake of bank shifts across service lines

Run Rate

The Trust has developed, and continues to actively progress, actions and mitigations to address the financial position. These include the delivery of efficiency targets and the identification of potential non-recurrent benefits. These measures, alongside the agreed non-recurrent CIPs and strengthened expenditure controls, will need to continue through to year-end and remain aligned with ongoing discussions with HIOW ICB.

Given the confirmation of receipt of H2 deficit support funding, the Trust is reporting a surplus position in M11.



Capital

The Trust's capital expenditure up to February was £19.9m. There is an underspend of £8.9m against the capital budget, primarily due to slippage in the sale and leaseback elements of capital projects.

Capital underspend – Key Drivers

The £8.9m capital underspend reported in Month 11 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 of all 70 units from O&H Venari has now been received. These vehicles were subject to a sale and leaseback agreement in February with £9.3m received for the disposal and £7.5m recognised as IFRS16 Right of Use Asset.

- **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 -£0.8m on a budget of £7.7m producing an underspend of £8.6m.

- **PDC income** of £8.4m 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 £0.6m was made in February and received in March.

- **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 was being repaired by O&H Venari, however, a settlement has now been agreed with O&H Venari's administrators at the beginning of March, and the damaged vehicles are being repaired and converted currently. A total of 37 units have been completed and are in the process of being subjected to a sale and leaseback transaction which is expected to complete in early April.

The Hampshire and Isle of Wight Integrated Care Board (HIOW ICB) agreed to fund SCAS an additional £0.5m CDEL to support fleet infrastructure costs. The fit-out costs are forecast at £0.5m and the IFRS16 lease element is c£1m.

Brokerage of £3m capital CDEL in 2025/26 as been agreed with the system. This brokerage is not cash backed. This brokerage is required to be repaid in 2026/27 via a £3m reduction in the trust's CDEL allocation.

Capital PDC totals £19.4m, of this £13.8m has been drawn down to M11. A further £5.782m has been drawn down and received in M12.

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 but has been delayed, it is expected to complete in early 2026/27.

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 the expansion of the required infrastructure such as Aylesbury Workshop.

		Year to Date			Forecast		
	£m	Actual	Plan	Variance	Actual	Plan (incl. additional PDC)	Variance
Estates	Internal CDEL	1.3	2.4	(1.1)	2.6	2.6	0.0
	PDC	2.1	4.7	(2.5)	7.4	7.4	0.0
	IFRS16	2.1	0.0	2.1	2.1	0.0	2.1
	Total	**5.6**	**7.1**	**(1.5)**	**12.1**	**10.0**	**2.1**
Digital	Internal CDEL	0.3	0.6	(0.4)	0.7	0.7	0.0
	PDC	0.5	1.2	(0.7)	1.3	1.3	0.0
	Total	**0.7**	**1.8**	**(1.1)**	**2.0**	**2.0**	**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	**2.0**	**3.6**	**(1.6)**	**3.6**	**3.6**	**0.0**
Fleet (24/25 DCA Cohort)	Internal CDEL	3.2	(2.8)	6.0	(2.8)	(2.8)	0.0
	IFRS16	7.5	9.8	(2.3)	9.8	9.8	0.0
	Total	**10.8**	**7.0**	**3.8**	**7.0**	**7.0**	**0.0**
Fleet (25/26 DCA Cohort)	Internal CDEL	(9.3)	(10.5)	1.2	(10.5)	(10.5)	0.0
	PDC	8.4	8.4	0.0	8.9	8.9	0.0
	IFRS16	0.0	9.8	(9.8)	9.8	9.8	0.0
	Total	**(0.8)**	**7.7**	**(8.6)**	**8.2**	**8.2**	**0.0**
Fleet (Non-DCA)	Internal CDEL	(0.8)	(4.3)	3.5	(4.3)	(4.3)	0.0
	PDC	0.0	0.1	(0.1)	2.0	2.0	0.0
	IFRS16	2.4	5.7	(3.3)	4.0	6.1	(2.1)
	Total	**1.6**	**1.4**	**0.2**	**(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		(10.4)	(20.3)	9.9	(16.6)	(16.6)	0.0
IFRS16 Total		19.3	34.8	(15.5)	35.2	35.2	0.0
PDC Total		11.0	14.4	(3.4)	19.6	19.6	0.0
Total		**19.9**	**28.8**	**(8.9)**	**38.2**	**38.2**	**0.0**

PDC – Public Dividend Capital

Cash

The Trust's cash balance at the end of February was £43.031m.

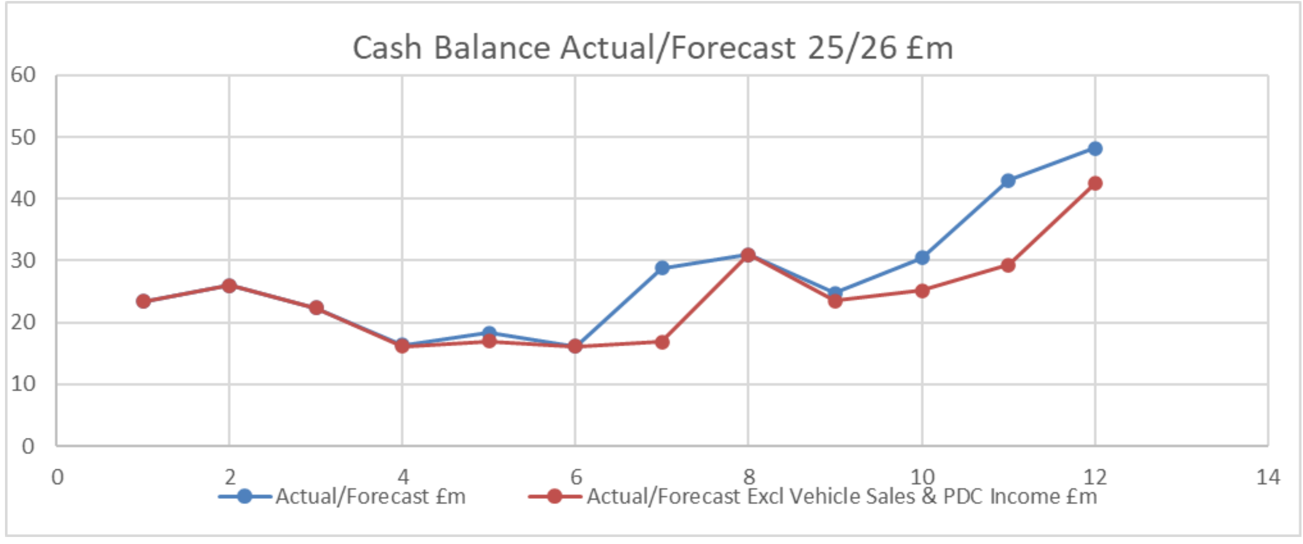
2025/26	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Income £m	30.3	29.6	25.2	29.6	29.8	28.2	41.8	28.8	28.6	34.0	43.1	36.2
Expenditure £m	(34.9)	(27.0)	(28.8)	(35.6)	(27.8)	(30.3)	(29.1)	(26.7)	(34.7)	(28.3)	(30.5)	(31.0)
Net Inflow/(Outflow) £m	(4.6)	2.6	(3.6)	(6.1)	2.0	(2.1)	12.7	2.1	(6.2)	5.6	12.6	5.2
Cash Balance £m	23.4	26.0	22.4	16.4	18.3	16.2	28.8	30.9	24.8	30.4	43.0	48.2

Cash Lowest Point	21.6	19.8	22.0	11.9	13.8	15.4	13.9	26.7	23.8	20.8	26.7	

The lowest point of cash in the month was £26.7m which is an increase from last month of £5.9m. The increase in cash is mostly due to the receipt of capital PDC and the sale of DCA vehicles.

Forecast cash at year-end has increased by £15.9m. This is primarily due to slippage in the capital programme where invoices have not yet been received. It is expected that the 30 day credit terms for March purchase invoices will mean the cash transactions not materialising until April.

There was a net cash inflow in month 11 of £12.6m mostly due to £9.3m of capital vehicle sales and £4.45m of PDC income. This is £10.47m above plan due to the timing of DCA sale and leaseback receipts.



The 90-day debtor increased to £0.167m in Feb (£0.237m in Jan). This represents 6.98% (28.71% in Jan) of the total debtor balance. The percentage debtors has decreased due to the overall debt balance decreasing.

Overdue debts include; Aurobindo Emergency Medical Services £81k, Dawson Group Bus and Coach Ltd £22k, FedBucks Ltd £29k, Newcastle Upon Tyne Hospitals FT £8k, NHS Beds Luton and Milton Keynes ICB £15k and University Hospital Southampton NHS FT £12k.

Our Better Payment Practice Code (BPPC) performance continues above the 95% target at month 11.

-	Month 11 - YTD BPPC			
	Number	**%age**	**Value**	**%age**
NHS	735	97.7%	£6,314,035	99.9%
Non-NHS	21,543	95.6%	£174,761,171	98.8%
Total	**22,278**	**95.7%**	**£181,075,205**	**98.9%**
Target		95.0%		95.0%
Variance		**0.7%**		**3.9%**

2 Quality Impact

3 Financial Impact

As detailed above

4. Risk and compliance impact

Area of Risk

- Income timing and forecasting: The YTD position reflects H1 income rephasing; careful monitoring is required to ensure any timing differences do not affect year-end forecast out-turn or future-year planning.
- Operational fleet risks: Delays in new DCA vehicles or fleet workshop facilities may increase vehicle off-road (VOR) levels, affecting frontline performance and driving higher maintenance costs.
- Workforce cost and capacity pressures: Pay and agency costs remain above budget in some areas; recruitment and retention in 999 services will need ongoing management to maintain performance targets.
- Non-pay expenditure pressures: Unexpected or discretionary spending could reduce the surplus if not carefully prioritized.
- Strategic alignment for 2026/27: Failure to integrate multi-year planning with operational and capital strategies could result in recurring pressures or misaligned resource allocation.

5. Equality, diversity and inclusion impact

6. Next steps

To address the underlying financial position in month 11, the following actions need to be taken:

- Optimising workforce deployment across all service lines to support key strategic priorities and emerging service needs.
- Review of vacancies and recruitment pipelines to ensure alignment with long-term workforce plans, rather than short-term freezes.

- Continued scrutiny of non-pay expenditure, prioritising value for money and strategic investments.
- Maintaining bi-weekly FRG and FSDG meetings to monitor performance, support sustainable growth, and identify opportunities for reinvestment.
- Embedding multi-year planning to anticipate recurring pressures, support strategic initiatives, and ensure robust 2026/27 budget alignment.

7. Recommendation(s)

The Board is asked to:

- Note the Month 11 Financial performance.

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 5 = 20
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	March 2026	3-year risk plan produced which will form the base of our 3-year annual plan and investment case.
CIO Engagement with SECAMB & SASC developing strategic collaboration benefits	Craig Ellis	Ongoing	Strong progression around key areas including CAD, EPR and Data Analytics.
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	March 2026	3-year risk plan produced which will form the base of our 3-year annual plan and investment case.
Ongoing DSPT assurance & external audit recommendations	Craig Ellis	Ongoing	DSPT assessment underway for 25/26 and seeking to drive maturity year on year
Development of Cyber Security Strategy & Programme Plan aligned to key risks identified	Craig Ellis	April 2026	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.
Capacity from external partners to support non conveyance in particular UCR capacity

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
Internal Audit report highlighting disjointed use of existing systems for planning

Gaps in assurance: Changes to demand profiles. Risk of not receiving capacity funding if plans do not deliver.
Ability to deliver CIPS within the operating plan due to external factors

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 2028/2029

Mitigating Actions	Executive Lead	Due Date	Progress Notes
Implement operational and CCC structures in the directorate	Executive Director of Operations	Q3 2025/2026	Executive Director of Operations direct reports appointed by the 15th February. Cascade roll out of next levels of recruitment to conclude by end of March for UEC Operations and end of April for ICC
Alignment of SCAS strategy to ICB priorities in relation to SPOA & clinical Pathways	Executive Director of Operations	Q3 2025/2026	Thames Valley have issued the financial and operating frameworks for new contract which is being reviewed for deliverability. Working with ICBs on SPOA capacity from providers to manage the volume of patients being passed through. Awaiting CAD upgrade to accommodate cat 5 patients being held overnight
CAD procurement and associated benefits	Executive Director of Operations	Q1 2026/2027	The joint business case is being developed with SECAMB this will also include EPR procurement
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 in place. Site visits completed, foundational project documents and logs completed, program risks identified. Testing implemented at nominated station site. Business case approved at EMC and phased roll-out plan in progress monitored by Pharmacy Programme Board.

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. SP vacancies due to recruitment freeze and need to wait for education courses from external providers which will delay some S&T improvement.

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. Still waiting BI to produce pathway data. Decrease in H&T levels due to higher absence levels and vacancies

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	Q4 2028/2029

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. Full workforce plan for 26/27 submitted to NHSE within planning return. Increase in ECT and CSD clinicians included in plan
Recruit to plan to avoid reliance on IRP	Executive Director of Operations	End Q1 2025/2026	SECAMB continue to provide call handling support. 26/27 planning return workforce profile to deliver 10 second mean will still have reliance on IRP. Review of IOW call handling provision to be completed.
Implementation of CCC and Ops structure to provide clinical leadership	Executive Director of Operations	End Q2 2025/2026	Executive Director of Operations direct reports appointed by the 15th February. Cascade roll out of next levels of recruitment to conclude by end of March for UEC Operations and end of April for ICC. New COM roles to be advertised 12th Feb.

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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 = 16
Residual Risk Score	Impact 5 x Likelihood 3 = 12
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	May 2026	Feedback from staff in the co-creation phase has been reviewed and the proposed values have been through governance routes in preparation for finalisation in April and launch in May/ June 2026
Listening events	Chief People Officer	Q3 25-26	Listening sessions were paused from November whilst feedback was collated with first new session held 25th February 2026, followed by monthly Building Trust Together sessions.

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 = 16
Residual Risk Score	Impact 5 x Likelihood 3 = 12
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	May 2026	leadership is the engine for improvement, bringing our values and behaviours to life through consistent leadership practice. Regular monthly Leadership Forums held with a Leadership Symposium on 23 April to build momentum and bring this to life in practice.

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Upward Report of the People & Culture Committee

Date Meeting met 16th March 2026
Chair of Meeting Harbhajan Brar, Non-Executive Director
Reporting to Trust Board

Items	Issue	Action Owner	Action
Points for escalation			
PDR Compliance	Despite continued targeted efforts from the executive team, the PDR rate remains at 86% in month 10. It was noted that owing to winter pressures the year end target of 95% would disappointingly not be met. The committee requested that dates for all outstanding appraisals be booked before the year end.	DH	Committee will continue to oversee performance, and DH will reinforce the need for all outstanding appraisals to be booked before the end of the month.
Sickness Absence	The committee received a helpful deep dive into sickness absence at the previous meeting, but the trust remains off target. Assurance was given that new processes have been put into place to support managers to better manage sickness absence and ensure that employees return to work, but these were yet to make a demonstrable impact due to the high levels of sickness absence across the trust.	N/A	The committee will continue to maintain a watching brief around the position, and a stretch target will be developed for 2026/27.
Key issues and / or Business matters to raise			

Gender Pay Gap Report	The report was received and discussed including the underlying rationale for the differences between male and female pay. This aligned to the national work that had been undertaken in this regard, and it was noted that the national working group were developing a toolkit to support trusts to improve the number of females in first line leadership roles. It was agreed that the Gender Pay Gap report would be published on the trust's website.	N/A	N/A
EDI Deep Dive	The committee received a deep dive following receipt of the WRES and DES reports at Trust Board. It was noted that work to address inequalities was taking place via the existing Culture and Leadership programme, so no separate action plan was required.	N/A	N/A
Staff Survey	The committee received a more detailed breakdown of the staff survey. Whilst the results were disappointing, it was encouraging that work aimed at addressing the areas of poor performance is already in train via the Culture & Leadership workstream and it was agreed that a Single Improvement Plan remained the right approach.	N/A	N/A
Areas of concern and / or Risks			
Board Assurance Framework Risks	The BAF risks were noted and would be refined following discussion at the March BAF Board Seminar. It was also noted that there had been a decrease in score for some of the red-rated operational risks, which was positive.	N/A	None
Items for information and / or awareness			
None			

Best Practice and / or Excellence			
Meeting Papers	Committee members agreed that the quality of papers continued to improve in that the key issues were more visible, but it was noted that there was duplication of the same data/metrics across some papers. It was agreed that DH would address this.	DH	Continue to refine paper content and avoid duplication,
Compliance with Terms of Reference			
Compliant	All papers were relevant to the committee terms of reference, and the meeting was quorate.		
Policies approved*			
None			

Trust Board of Directors Meeting in Public 2 April 2026

Title	NHS Staff Survey 2025 – Organizational Analysis and Building Trust Together Programme Response
Report Author	Mehvish Shaffi-Ajibola, AD of Culture & Leadership (Interim)
Executive Owner	Danny Hariram, Chief People Officer & Deputy Chief Executive Officer
Agenda Item	17
Governance Pathway: Previous	National staff survey results high level Briefing – 1st March 2026
Governance Pathway Next Steps	

1. Purpose

This paper provides an overview of the 2025 NHS Staff Survey results for SCAS, highlighting key organisational findings and benchmarking against the ambulance sector. It also sets out how these findings will inform the next phase of the Building Trust Together (BTT) programme and the development of a targeted organisational action plan.

The 2025 results present a disappointing but important reflection of staff experience across SCAS. The Trust achieved a 50% response rate (2,092 responses), consistent with 2024 but below the ambulance sector benchmark of 55%. While participation levels have remained stable, overall workforce numbers have reduced since the previous survey year, meaning the staff voice captured represents a smaller proportion in volume than previously. This may limit the breadth of insight; however, it does not diminish the significance of the results.

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2. Executive Summary

The 2025 NHS Staff Survey results show that SCAS continues to face challenges across the majority of People Promise themes, performing below the ambulance sector benchmark in 8 out of 9 areas. The strongest area remains 'We are a team', indicating positive local team dynamics; however, this is not consistently reflected in the wider organisational experience. Key areas of concern include staff engagement, morale, wellbeing and flexible working, alongside continued low levels of staff advocacy, including recommending SCAS as a place to work and to receive care.

The findings reinforce that the Building Trust Together programme remains the right strategic vehicle for improvement. Over the past six months, the programme has focused on listening to staff and establishing the foundations for culture change. The next phase will focus on visible delivery, including the continuation of the culture improvement plan informed by the staff survey findings, strengthened directorate-level accountability, and targeted action in key areas such as wellbeing, staff voice and leadership visibility.

2.1 Overall Position

The table below summarises SCAS performance across the nine People Promise themes, benchmarked against the ambulance sector:

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	6.82	5.15	5.64	5.35	4.77	4.96	6.42	5.60	5.19
Best result	7.25	5.62	6.23	5.91	5.30	5.83	6.74	6.29	6.06
Average result	6.93	5.37	5.91	5.65	4.92	5.55	6.23	5.93	5.54
Worst result	6.48	4.91	5.60	5.35	4.50	4.75	5.66	5.49	5.19
Responses	2090	2089	2081	2085	1972	2081	2088	2090	2090

The 2025 NHS Staff Survey results show that, while there remains a positive foundation in local team working, the wider organisational experience continues to be less positive indicating that improvement has not yet translated into a consistently stronger staff experience across the organisation.

2.2 Key Strengths and Areas of Pressure

The results present a clear and consistent picture of relative strengths alongside sustained areas of organisational pressure

Relative strengths

- ‘We are a team’ (6.42 vs 6.23) remains the strongest performing theme, reflecting positive local team relationships and peer support.
- There are modest improvements in areas such as workload, access to clinical supervision, and retention intent, indicating some early progress in specific operational areas.

Areas of greatest pressure

- Morale (-0.35), we are safe and healthy (-0.30) remain among the lowest scoring areas, reflecting ongoing pressure and stress within the workforce.
- Staff voice and engagement (-0.33) have declined, indicating reduced confidence that staff views are heard and acted upon.
- Flexible working (-0.59) and day-to-day experience continue to fall below sector expectations.
- There has been a decline in confidence in organisational priorities and wellbeing support, alongside increased reporting of negative experiences, including inappropriate behaviour

2.3 Advocacy and Organisational Confidence

The survey highlights continued challenge in the organisation's core advocacy and confidence measures. These indicators are significant because they provide a direct sense of how staff view SCAS as an employer and as a provider of care.

Measure	Average	Survey 2025	Survey 2024
Care of patients/service users is the organisation's top priority	58.3%	52.7%	57.5%
Would recommend the organisation as a place to work	44.6%	37.7%	41.5%
If a friend or relative needed treatment, would be happy with the standard of care provided by the organisation	56.8%	57.6%	60.3%

While confidence in the standard of care provided remains slightly above the 2025 comparator average, it has declined from 2024 and remains significantly below previous years. More notably, there has been a marked reduction in the proportion of staff who see patient care as the organisation's top priority and who would recommend SCAS as a place to work.

These findings indicate that staff confidence in the organisation has weakened. This is particularly important given that willingness to recommend SCAS as a place to work is a key indicator of staff experience, trust and organisational advocacy.

2.4 What the results mean for SCAS

The 2025 results show that SCAS is not yet achieving a sufficiently consistent staff experience across the organisation. The relative strength of local team working is not being matched by confidence in the wider organisation, indicating that the core challenge is organisational rather than localised. Staff are more likely to experience support within their

immediate teams than to feel confident in the organisation's wider leadership, priorities and follow-through.

3. Building Trust Together BTT – Programme Response

The 2025 Staff Survey results reinforce that the Building Trust Together (BTT) programme remains the right organisational response. The programme was established to address the core drivers of staff experience through a structured focus on three key areas: People Feel Safe, People Feel Valued, and People Feel Well Led.

The findings do not change the direction of the programme; however, they do sharpen the expectation that the organisation must now move at pace from listening and insight to visible, consistent delivery.

3.1 Foundations Established in the last 6 months

Over the past six months, the programme has focused on establishing the core foundations for sustainable culture change and beginning delivery across each of the three workstreams – People Feel Safe, People Fell Wel Led and People Feel Valued.

This has included:

- Launching new all staff listening spaces and engagement activity, alongside continued monthly staff engagement
- Progressing the Values and Behaviours work, including design activity, staff feedback sessions and preparation for senior leader
- Established the Sexual Safety Oversight Assurance Group and developing the Sexual Safety Action Plan
- Scoping and launching key leadership development programmes, including first level, senior leader and executive development offers
- Rolled out digital PDR across the Trust
- Established wider monthly leadership forum
- Progressing practical improvement actions linked to staff experience, including, ER process improvements

This phase has moved the programme beyond initial listening and into early delivery. It has also created a stronger foundation for the next phase of implementation, where greater focus will be placed on pace, visibility, delivery and local accountability.

3.2 Next Phase of Delivery

The next phase of the programme will focus on accelerating delivery and ensuring that improvement is experienced consistently across the organisation. The emphasis will be on visible, practical action, with clear ownership at both organisational and directorate level.

In direct response to the survey findings, the following actions will be prioritised:

- Strengthening communication and visibility of action, working closely with the Communications Team to provide clearer, more regular updates on programme activity and progress, including a more consistent “You said, we did / we are doing” approach
- Embedding directorate-level ownership and delivery, ensuring that leaders are actively engaging with their local results, discussing them with teams, and progressing visible actions in response to staff feedback
- Continued delivery and embedding of key programme components, including:
  - implementation of the Sexual Safety Action Plan
  - Launch and rollout of Values and Behaviours
  - Improving PDR compliance and the quality of conversations
  - Strengthening leadership fundamentals, including getting the basics right, improving statutory and mandatory training, and increasing leadership visibility across the organization
  - Relaunching SCAS Staff Recognition Awards
  - Embedding the ‘See Me First’ campaign, with a clear focus on race equity and tackling inequity in staff experience, and aligning day-to-day behaviours with the Trust’s expected values of respect, dignity and humanity
- Strengthening focus on wellbeing and day-to-day staff experience, including identifying and progressing practical improvements that support staff in their working environment and respond to key pressure points highlighted through the survey
- Continuing delivery of monthly Building Trust Together all staff sessions, ensuring ongoing dialogue with staff and transparency on progress
- Establishment of a People-Led Reference Group / Culture Champions Network, providing ongoing staff insight and acting as a critical friend to the programme
- Strengthening governance and oversight through clearer reporting of progress, actions and impact to Executive and Board, underpinned by a culture dashboard with defined measures and metrics that are actively monitored and managed to ensure the programme remains on track.

These actions will be taken forward over the next two quarters with a clear focus on visible delivery and measurable progress, so that staff can see stronger organisational follow-through through improved communication, greater leadership visibility, and practical improvements in their day-to-day working experience.

4. Link to Strategic Theme

People and Culture

5. Link to Board Assurance Framework Risk(s)

SR23 - Leadership

6. Quality/Equality Impact Assessment

n/a

7. Recommendations

The Board is asked to:

- Note the key findings from the 2025 NHS Staff Survey and the implications for organisational culture, staff experience and leadership
- Support the continued delivery of the Building Trust Together programme as the Trust's primary vehicle for responding to the findings and strengthening staff experience
- Support the next phase of delivery, including stronger communication with staff, greater directorate-level accountability, a continued focus on wellbeing, leadership visibility, and the introduction of clear measures and metrics to monitor progress through a culture dashboard

For Assurance	√	For decision		For discussion		To note	√

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. Across all three planning years, a high proportion of the required savings remain unidentified, particularly in the first year

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 5 = 20
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. Challenge to deliver further efficiencies and productivity .e.g. H&T already at 20%. Across all three planning years, a high proportion of the required savings remain unidentified, particularly in the first year.

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

Accountable Director	Chief Finance Officer
Committee	Finance & Performance
Inherent Risk Score	Impact 4 x Likelihood 4 = 16
Residual Risk Score	Impact 4 x Likelihood 5 = 20
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 produ
Resulting in reputational damage with stakeholders and partners, and increased oversight and scrutiny of SCAS's operating and strate

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 2 x Likelihood 2 = 4
Risk Response	Treat

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. The move towards the Group model with SECAmb introduces clear benefits and synergies but also creates interdependent risks, including: alignment of capital planning across two differently funded organisations shared programme resourcing (integration, CAD replacement, clinical model development, digital and procurement alignment) variations in baseline estates and fleet infrastructure differing levels of financial flexibility between the two trusts. 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

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

Trust Board of Directors Meeting in Public 2 April 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 10 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

Please note that Month 11 (M11) data is only available for Urgent and Emergency Care metrics – all other metrics relate to Month 10 (M10), 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 (no change on previous month):

- % of beds occupied by patients not meeting the Criteria to Reside (NCTR) (M11)
- Access to Children and Young People's Mental Health Services (M10)
- Average length of stay for Adult Acute Beds (Mental Health) (M10)

- Adults in inpatient care who are autistic, with no learning disability (M10)
- Adults in inpatient care with a learning disability (who may also be autistic) (M10)
- Diagnostic 6 week waits (9 key tests) (M10)
- Cancer 28 day faster diagnosis (M10)
- Cancer 62 day referral to treatment (M10)
- Time to First Appointment (M11) – *unvalidated*
- RTT 52 week waits (M10)
- RTT waiting list within 18 weeks (M10)
- Emergency Department 4 hour performance (total mapped footprint) (M11)
- % of attendances in A&E over 12 hours (M11)

Quality Overview
Quality overview can be found on pages: 9-16

Financial Overview
The purpose of the Month 11 (M11) System Report for Hampshire & Isle of Wight Integrated Care System is to provide details of the financial position for the System as at the end of February 2026.

The System position in month 11 is a deficit of £0.423m compared to a planned surplus of £8.65m, so £9.08m off plan in-month.

The System is reporting a year-to-date deficit of £78.54m, compared to a planned year-to-date deficit of £9.33m, so a £69.21m off plan year-to-date.

The System submitted a £0.468m surplus plan for 2025/26. At M11 the System received £8.18m of previously held back Deficit Support Funding (DSF) from NHS England. This improved the system year end forecast from a deficit £89.71m at M10 to £81.53m at M11.

NHS England continue to withhold Q3/Q4 DSF of £19.15m in total. This is a component part of the deterioration in the system forecast reported this year.

Workforce Insights

- Total Workforce: 47,940 WTE, which is 1,208 WTE worse than nationally submitted plan. Compared to January 2026, the system saw a decrease of 38 WTE.
- Trusts better than plan: HIOWH (105 WTE).
- Trusts worse than plan: HHFT (408 WTE), IOW (127 WTE), PHU (332 WTE), SCAS (82 WTE), UHS (363 WTE).
- Substantive: 792 WTE worse than plan.
- Bank: 417 WTE worse than plan.
- Agency: 1 WTE better than plan.
- Compared to March 2025 baselines in submitted Planning templates:
- Total Workforce: Reduced by 1,354 WTE.
- Substantive: Reduced by 1,053 WTE.
- Bank: Reduced by 182 WTE.
- Agency: Reduced by 119 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.
- Workforce performance and assurance will move to NHS England from 1 April 2026. HIOW ICB are working closely with NHS SE Regional team during this transitional period to form handover plans.
    - Progress against plans monitored at System Workforce Oversight Committee (SWOC) for both weekly trends and month position.

Frimley and BOB Integrated Care System:
This report provides the Joint Committee with an overview of the financial position and system performance for both NHS Buckinghamshire, Oxfordshire & Berkshire West (BOB) ICB and NHS Frimley ICB as at Month 10 (2025/26). Overall, both systems remain on track to deliver breakeven at year end, despite sustained operational pressures and increasing demand across key service areas.

1. Financial Position

Across both systems, the financial position at Month 10 is marginally favourable to plan:

- Frimley ICB reports being £63k better than plan YTD, with a forecast breakeven outturn. Cost pressures continue within Section 117, ADHD Right to Choose activity, prescribing (notably weight-loss medication), and independent sector utilisation. These are being mitigated through underspends in Continuing Healthcare (CHC) and non-recurrent benefits.
- BOB ICB remains slightly better than plan, also forecasting breakeven. Acute elective over-performance is being offset by underspends in radiology and the Elective Recovery Fund (ERF). Community services continue to experience pressures in equipment, audiology, endoscopy and physiotherapy. Mental health budgets continue to see demand-driven pressures in Section 117 and ADHD.
- System providers have absorbed industrial action costs, which will be fully reimbursed. Efficiency delivery is behind plan in some areas, although 95% of planned efficiency schemes are now fully developed.

2. Performance Overview

Performance reporting continues to highlight areas of resilience alongside significant operational challenges:

- Elective care performance is broadly stable. BOB is performing close to the national RTT target trajectory (67% vs the 65% standard), despite industrial action. Some Trusts, including BHT and Frimley Health, continue to face longer waits.
- Cancer performance has been strengthened by intensive system-wide work, particularly on the 62-day pathway, with improvements noted across several providers.
- Demand pressures continue to drive activity increases, particularly in cancer referrals and urgent care, requiring ongoing mitigation.
- Dental activity reached 61.1% of the annual target by November 2025, with expected uplift in Q4 following national system processing delays.

3. Quality Themes

- Both ICBs continue to see a high volume of complaints relating to access and waiting times, clinical care, and communication, particularly in primary care, ADHD services, weight-management pathways, and vaccination queries.
- Two Never Events were reported at Royal Berkshire FT (RBH), with investigations underway; Frimley Health reported none.
- Notable escalations include ongoing issues with wheelchair service transition, patient transport performance, and mental health bed availability.

4. Workforce Summary

- Workforce levels across both systems remain broadly stable.
- Frimley ICS: absence 2.4–5.3%, vacancy 5.8–9.7%, turnover up to 16.1%.

- BOB ICS: absence 3.8–5.6%, vacancy up to 10.9%, turnover 14.8%.
- Continued reductions in reliance on temporary staffing have been achieved, with the South East region reporting a 38% reduction in agency expenditure year-on-year.

5. Transition to Thames Valley ICB

The report aligns with the broader organisational transition:

- Transition to Thames Valley ICB remains on track for 1 April 2026.
- Significant interdependencies exist between financial planning, workforce changes, and reporting structures.
- Development work on a new Thames Valley Board Performance Report has commenced, in line with NHS England's *Insightful Board* standards.

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**	✓

1. Introduction

This report serves as an overview of the Hampshire and Isle of Wight Integrated Care System's performance against the national priorities and success measures outlined in the NHS operational planning guidance for 2025/26 and financial, workforce and quality plans and indicators.

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

This report is based on data published on 12 March 2026 – up to February 2026 for Urgent and Emergency Care metrics and up to January 2026 for Planned Care, Local Care, Primary Care, Mental Health / Learning Disability and Autism metrics.

2. Operating Plan Summary

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

In March 2026, NHS Hampshire and Isle of Wight is ranked red against 13 headline operating plan metrics:

- **% of beds occupied by patients not meeting the Criteria to Reside (NCTR) (M11)** – % of beds occupied by patients not meeting the criteria to reside remains significantly above the 12% target (no operating plans set in 25/26), decreasing in M11 to 21.4% (compared to 23.2% in M10).

- **Access to Children and Young People's Mental Health Services (M10)** – – below M10 plan with 25,000 vs 25,518 target, deterioration on M9. The known data quality issue with a new Provider has been resolved and analysis is underway to determine where we are seeing under performance against planned figures with other Providers, and where existing data quality issues may still be affecting the rate.

- **Average length of stay for Adult Acute Beds (Mental Health) (M10)** – Performance in M10 shows an improvement on previous month but remains above plan (e.g. not achieving plan) with 62 days vs 50 plan.

- **Adults in inpatient care who are autistic, with no learning disability (M10)** – performance in M10 remains significantly above plan (34 vs 22 plan), but improvement was seen in month. There remains a shortage of admission alternatives for Autistic Adults (aged 25+) - in the year to date these represent 50% of all admissions of people with a Learning Disability and/or Autism.

- **Adults in inpatient care with a learning disability (who may also be autistic) (M10) -** Performance in M10 is above plan (31 vs 26 plan) – performance remained the same as previous month, but the gap has widened against a reduced plan. There remains a shortage of admission alternatives for Autistic Adults (aged 25+) - in the year to date these represent 50% of all admissions of people with a Learning Disability and/or Autism.

- **Diagnostic 6 week waits (9 key tests) (M10)** – Performance in M10 shows 2.5% improvement on previous month for the diagnostic 9 key tests and remains above the in-month operating plan of 26.05%. Total diagnostic activity increased in month and remains 0.9% below plan (e.g. not achieving).

- **Cancer 28 day faster diagnosis (M10)** – Performance in M10 deteriorated and is 12.9% below plan at 67.1%. Performance is 5.7% below national average of 72.8%, and NHS Hampshire and Isle of Wight rank 34 of 42 systems nationally (lowest quartile).

- **Cancer 62 day referral to treatment (M10)** – Performance in M10 deteriorated to 69.5% (compared to 72.8% in M9) and remains 5.4% below in-month plan. Although NHS Hampshire and Isle of Wight is below plan, performance is above national average of 68.4% and rank 17 of 42 systems nationally (interquartile).

- **Time to First Appointment (M10) – *unvalidated*** – Latest M11 position shows NHS Hampshire and Isle of Wight is 5.4% below plan, however, this is based on unvalidated data and is subject to change. M10 was 6.9% below plan.

- **RTT 52 week waits (M10)** – In M10, 4,835 patients are waiting over 52 weeks, representing a decrease on M9 (4,951) but not achieving plan.

- **RTT waiting list within 18 weeks (M10)** – Overall performance against the March 2026 operating plan target for 65% of patients to wait no longer than 18 weeks has declined to 60.0% in M10 (compared to 60.7% previous month) – not achieving in-month plan by 3.9%.

- **Emergency Department 4 hour performance (total mapped footprint) (M11)** – Performance in M11 improved significantly to 77.1% (compared to 73.6% previous month) – not achieving the 78% standard.

- **% of attendances in A&E over 12 hours (M11)** – Waits from decision to admit (DTA) decreased significantly in M11 to 1,226 (compared to 1,771

previous month) and % over 12 hours from arrival decreased significantly in M11 to 9.4% above M11 plan (e.g. not achieving).

The following metrics are national priorities for 2025/26, but are currently not achieving national target:

- **% of patients with hypertension treated according to NICE guidance (CVDP007HYP) (M6)** – latest published position for September 2025 shows 67.19% vs 70.5% local target (national target is 77%), representing a 2.74% increase on the September 2024 position. National average is 68.71%. The gap between the top performing ICB and NHS Hampshire and Isle of Wight has decreased since September and there is now a difference of 5% between NHS Hampshire and Isle of Wight and the top performing ICB (North East and North Cumbria), with NHS Hampshire and Isle of Wight ranking 31 out of 42 systems, improving from a position of 4th worst nationally / historically. There has been consistent improvement in performance since March 2022. In terms of local data, the latest position in February 2026 shows an improving position to 72.22% in relation to the blood pressure treated to target measure, the highest percentage achieved to date.
- **% of patients with no GP recorded CVD and a GP recorded QRISK score of 20% or more, who are currently treated with lipid lowering therapy (CVDP003CHOL) (M6)** – latest published position for September 2025 shows 58.81% vs 60% national target, representing a 3.03% increase on September 2024 position. National average is 64.10%. The gap between the top performing ICB and NHS Hampshire and Isle of Wight has decreased and there is now a difference of 10.94% between NHS Hampshire and Isle of Wight and the top performing ICB (South Yorkshire), with NHS Hampshire and Isle of Wight ranking worse nationally.
- **% of patients with GP recorded CVD, who have their cholesterol levels managed to NICE guidance (CVDP012CHOL) (M6)** – latest published position for September 2025 shows 47.17% vs 65% national target. National average is 49.00%. NHS Hampshire and Isle of Wight ranking 27 out of 42 systems.

National comparators (where available) for headline metrics not achieving plan are reflected below:

- **% of beds occupied by patients not meeting the Criteria to Reside (NCTR) (M11)** – NHS Hampshire and Isle of Wight are ranked 38 out of 42 Integrated Care Boards for their February performance with 671 patients with no CTR as at 15 March 2026, which is 23.00% of total G&A beds available**.** (Lowest quartile)
- **Access to Children and Young People's Mental Health Services (M10)** – NHS Hampshire and Isle of Wight are ranked 11 out of 42 Integrated Care

Boards for January 2026 data (Interquartile)

- **Diagnostic 6 week waits (9 key tests) (M10)** NHS Hampshire and Isle of Wight are ranked 32 out of 42 Integrated Care Boards for their January performance with 30% (Lowest quartile)
The National average is 24.7%.

- **Cancer 28 day faster diagnosis (M10)**, NHS Hampshire and Isle of Wight are ranked 38 out of 42 Integrated Care Boards for their January performance with 67.1% (Lowest quartile)
The National average 72.8%

- **Cancer 62 day referral to treatment (M10)**, NHS Hampshire and Isle of Wight are ranked 17 out of 42 Integrated Care Boards for their January performance with 69.5%. (Interquartile)
The National average is 68.4%

- **RTT 52 week waits (M10)** – NHS Hampshire and Isle of Wight are ranked 38 out of 42 Integrated Care Boards for their December performance with 2.5% (Lowest quartile)
The National average is 2.2%

- **RTT waiting list within 18 weeks (M10)** – NHS Hampshire and Isle of Wight are ranked 29 out of 42 Integrated Care Boards for their January performance with 60% (Interquartile)
The National average is 60.8%

- **Emergency Department 4 hour performance (total mapped footprint) (M11)** – NHS Hampshire and Isle of Wight are ranked 7 out of 42 for their January performance with 77.1%. (Highest quartile)
The National average is 74.1%

- **% of attendances in A&E over 12 hours (M11)** – NHS Hampshire and Isle of Wight are ranked 7 out of 42 Integrated Care Boards for their January performance with 8.5% (Highest quartile)
The National Average is 11.3%

3 Quality

The Board is asked to note that, apart from the Care Quality Commission and Infection Prevention and Control data, the information included in the quality section below relates to NHS Trust providers and General Practice data and not whole System data. Due to business intelligence workforce challenges, the usual quality scorecard which includes statistical process control charts is not available. However, data tables have been included within the report to highlight latest quality performance data.

The intelligence from thematic analysis of system quality, safety and patient feedback and collaboration with system providers over the year has informed our 2026/27 quality contract development processes, which is highlighted in relevant points throughout this section.

3.1 Regulatory

3.1.1 Care Quality Commission – General Practice: the table below shows the Care Quality Commission inspection **current** overall ratings:

CQC Rating	GP Practices	Details & Date CQC Rating Published
Unrated	2	Eastleigh Medical Practice (Merger of Archers and Parkside) Medina Healthcare (previously Wooton Bridge)
Outstanding	1	Swan Medical Group (April 2020)
Good	122	As per published ratings on CQC website
Requires Improvement	3	Gudge Heath Lane Surgery (November 2025) Emsworth Medical Practice (January 2026) Tower House Surgery (December 2025)

3.1.2 Care Quality Commission – Large System Trusts:

Care Quality Commission - large system Trusts:

- **Isle of Wight NHS Trust - unannounced Care Quality Commission Inspection:** on 10 February 2026, the Care Quality commission commenced an unannounced inspection of their Emergency Department and Urgent and Emergency Care

- **University Hospital Southampton NHS Foundation Trust - unannounced Care Quality Commission Visit and announced Well-led:** as previously reported, the Care Quality commission undertook a two-day inspection at University Hospital Southampton NHS Trust on the 25 and 26 November 2025. The focus of the visit was the Children and Young People’s Service, Learning Difficulties and End of Life care. Feedback from the visit remains awaited. It should be noted that the well-led visit referenced in the previous report was an agreed well-led review with NHS England by Value Circle and not an announced Care Quality Commission review.

- **Hampshire and Isle of Wight Healthcare:** as previously reported, the outcomes of the Trust's unannounced inspections which took place during April and September 2025 and their well-led inspection in November 2025 remain awaited.

- **South Central Ambulance Service NHS Foundation Trust:** following an inspection in May 2025, the Care Quality Commission (CQC) published two reports covering the Trust's Emergency Operations Centre (EOC) (which moved from *Requires Improvement* to *Good*) and Emergency and Urgent Care (which moved from *Inadequate* to *Requires Improvement*). The Trust's overall rating will not change until after the outcome of the Trust-wide well-led inspection in January 2026.

3.2 Contract: Quality Schedules

3.2.1 2026/27 Quality contract elements: quality contracts for 2026/27 have been developed in partnership with the large system provider organisations to support strategic commissioning, with priorities focused on improving quality, safety, and experience. Since January 2026, a series of joint contract negotiation workshops have been held involving the acute, community, and mental health providers.

Negotiations with Portsmouth Hospitals University NHS Trust, University Hospital Southampton NHS Foundation Trust, Hampshire Hospitals NHS Foundation Trust, and Hampshire and Isle of Wight Community Healthcare NHS Foundation Trust were concluded on 12 March, ahead of the planned completion date of 16 March.

All elements of the Isle of Wight NHS Trust contract were also agreed on 12 March. Two local quality indicators with the Isle of Wight ambulance service remain under discussion, with final agreement anticipated during the week beginning 16 March 2026.

All core quality elements have been included in the schedules along with the following four focused areas, identified following thematic learning and analysis during 2025/26:

- **Improving transfer of care and discharge processes (Year 1):** providers will implement a systematic process, embedded with their quality management systems (QMS) to triangulate feedback relating to transfer of care and discharge processes. Improvement plans will be developed in response and measurable outcomes agreed and reported on.
- **Together for Better Care: Every Voice Matters (Year 1):** providers will increase the use of Patient Reported Experience Measures (PREMs) to listen, understand, and act on patient feedback, using organisational and system intelligence and thematic analysis to drive service improvements and enhance patient experience. A patient experience summit will be held towards the end of 2026/27 to share learning and best practice and plan areas of focus for 2027/28 based on system themes from PREMS.

- **Learning from Lives and Deaths (LeDeR) (Year 1):** improving communication and engagement with patients with a learning disability and/or who are autistic and their families/carers. This local quality indicator requires providers to work together to improve the delivery of a coordinated and person-centred approach to planning care.
- **Fundamentals of Care (Year 2):** supporting relevant organisations to have implemented the six core standards of Martha's Rule by 31 March 2027. This includes organisations establishing a multidisciplinary team to support full implementation, assuring performance and governance structures in place to ensure learning is embedded in practice.

All provider leads involved have been thanked for their leadership and collaboration, which enabled the process to run smoothly and effectively.

3.3 Patient and Staff Experience

3.3.1 Friends and Family Test – January 2026: overall, Hampshire and Isle of Wight Friends and Family performance remains positive. From an Integrated Care Board (ICB) perspective, all areas apart from maternity (postnatal community) performed above or the same as the national rate for positive responses.

Areas to note include:

- **General Practice:** improvements were seen in positive feedback in January 2026 with performance at 94% which was just higher than the national rate. Negative feedback was 3%, the same as both the national and regional rate.
- **Dental:** improvements were seen in positive feedback with performance at 97%, which was the same as the national rate, but lower than the regional rate. Negative feedback performance was 2% - higher than both the national and regional rate.
- **Ambulance:** the Isle of Wight ambulance service achieved 100% positive feedback from 23 responses (out of a possible 1,312)
- **Acute providers:** system performance remained better than the national positive feedback performance for the month in all areas except postnatal community Key area to note:
    - **Emergency Department:** negative performance at University Hospital Southampton NHS Foundation Trust (20%) was worse than the national rate (15%)
    - **Inpatients:** negative and positive feedback performance for Portsmouth Hospitals University NHS Trust was worse than the national rate
    - **Maternity:** antenatal care at Portsmouth Hospitals University NHS Trust saw performance worse than the national rate in both positive and negative feedback. UHS' postnatal ward and community positive feedback was lower than the national rate.
- **Mental Health:** the latest data shows Hampshire and Isle of Wight Healthcare Community NHS Foundation Trust performing worse than the

national rate for positive and negative feedback. It should be noted that the number of responses for each area was low, ranging from 3 – 28. Areas with particularly high levels of negative feedback were:
  - Primary care – 11% negative feedback (19 responses)
  - Secure and forensic – 60% (5 responses)
  - Specialist services – 11% (19 responses)
- **Community:** community (physical) services at Hampshire and Isle of Wight Healthcare Community NHS Foundation Trust performed better than the national rate for both positive and negative feedback.

As part of the 2026/27 quality schedules, providers will be expected to support the recommendations in the Picker Report – *Reforming the NHS Friends and Family Test* (December 2025). This includes providing evidence that a report is taken to the provider Board which demonstrates how the Friends and Family Test is used locally to drive improvement.

Whilst the NHS Friends and Family Test (FFT) does not mandate the national collection of inequalities data as part of its core survey, providers are strongly encouraged to collect this data locally to identify and address health inequalities in patient experience.

Mixed-Sex Accommodation (MSA) breaches – January 2026: the NHS has a policy of eliminating mixed-sex accommodation except in cases where it is deemed clinically necessary. This is to create a more comfortable, safe, and dignified environment for all patients, ultimately contributing to a better overall healthcare experience. The NHS Standard Contract has a threshold of >0 cases of mixed-sex accommodation (MSA) breaches.

Despite a decline in performance, NHS Hampshire and Isle of Wight's performance remained better than that of England (rate of 2.6). Of note, the South East region has the highest rate of MSA breaches (5.4) with the other regions breach rates ranging from 0.9 (North West) to 5.2 (South West).

Mixed sex accommodation (MSA) breach number (breach rate) 2025/2026										
2025/26	January	December	November	October	September	August	July	June	May	April
University Hospital Southampton NHS Foundation Trust	93 (4.6)	99 (5.2)	77 (3.9)	117 (5.7)	73 (3.9)	88 (4.7)	109	120	115	112
Portsmouth Hospitals University NHS Trust	21 (1.2)	0 (0)	8 (0.5)	3 (0.2)	7 (0.4)	0 (0)	12	0	0	16
Isle of Wight NHS Trust	0 (0.0)	1 (0.2)	1 (0.2)	1 (0.2)	1 (0.2)	1 (0.2)	No data	1	0	1
Hampshire Hospitals NHS Foundation Trust	6 (0.4)	0 (0)	5 (0.4)	3 (0.2)	2 (0.1)	1 (0.1)	3	3	4	3
Hampshire and Isle of Wight Healthcare NHS Foundation Trust	0 (0.0)	0 (0)	6 (5.9)	2 (1.7)	2 (2.0)	0 (0)	No data	0	0	0

Providers undertake measure to protect patient privacy and dignity and to rectify cases of mixed sex accommodation as soon as possible.

The *Delivering same-sex accommodation guidance* remains under review following the ruling from the Supreme Court in the *For Women Scotland Ltd* (Appellant) v *The Scottish Ministers* (Respondent) case published 16 April 2025. Providers must continue using the existing 2019 guidance until the revised version is released. As part of local contract requirements, once the new guidance has been published providers will share their mixed sex accommodation policy with commissioners to demonstrate it reflects the updated current national guidance. Providers will be expected to highlight deviations from national guidance and provide the associated rationale.

NHS Hampshire and Isle of Wight – primary care complaints backlog: as of 16 March 2026, the backlog of 212 complaints transferred on 1 February 2025 from the South East Complaints Hub has reduced to 17 open cases.

NHS Hampshire and Isle of Wight Patient Experience and Complaint themes: in February 2026, the Patient Experience and Complaints Team received 373 contacts (January 389, December 330, November 339, and October 322) and closed 404 (386 January; December 363). Some complaints and queries the team manage are redirected to the providers, who have not received them directly and had the opportunity to explore the issues and resolve them with the complainant.

The team continue to receive feedback from patients regarding:

- Dental care – main themes include access to an NHS dentist and charging issues
- Primary Care – contacts are centred around access, communication, medication safety, and delays in clinical decision making
- Mental Health – regarding waiting times for assessments and Right To Choose
- Procedures of Limited Clinical Value
- Independent Sector Activity Management Plans.

Themes and learning from feedback are triangulated with other feedback and intelligence to inform commissioning decisions.

3.4 Safety

3.4.1 **Infection Prevention and Control – February 2026:** the latest Infection Prevention and Control data for Methicillin-resistant Staphylococcus aureus (MRSA) blood stream infection, Clostridioides difficile infections and Escherichia coli bloodstream infections is shown in the table below and shows that the 2025/26 performance trajectories have been exceeded.

February 2026:		
Methicillin-resistant Staphylococcus aureus (MRSA) Blood Stream Infection		
Number of cases reported in month	Total number of cases financial year to the end of January 2026	Performance against 2025/26 trajectory
1	25*	Annual trajectory is zero cases
Clostridioides difficile infections		
Number of cases reported in month	Total number of cases financial year to date	Performance against 2025/26 trajectory
41	538 (+60)	538/521
Escherichia coli (E. coli) bloodstream infections		
Number of cases reported in month	Total number of cases financial year to date	Performance against 2025/26 trajectory
117	1365 (+219)	1365/1250

**Plus one out of area MRSA BSI Hospital Onset Hospital Acquired identified at University Hospitals Southampton NHS Foundation Trust which is still under investigation.*

Performance by Trust is shown in the table below:

Running total 2025/26 YTD (February 2026)	HHFT	UHS	PHU	IOW	ICB	Target
Methicillin-resistant Staphylococcus aureus (MRSA) Blood Stream Infection	2 (0)	8 (0)	8 (1)	3 (0)	25 (1)	Zero
Clostridium difficile infections	61 (4)	95 (3)	87 (9)	55 (9)	538 (41)	Based on trajectories for 2025/26.
Escherichia coli (E. coli) bloodstream infections	95 (8)	142 (8)	153 (17)	57 (8)	1365 (117)	
Klebsiella spp BSI	32 (4)	48 (2)	55 (3)	16 (0)	388 (30)	
Pseudomonas aeruginosa BSI	10 (1)	27 (2)	17 (1)	7 (0)	142 (12)	
MSSA BSI	38 (2)	59 (3)	61 (5)	22 (0)	394 (34)	No threshold

HHFT – Hampshire Hospitals NHS Foundation Trust; UHS – University Hospital Southampton NHS Foundation Trust; PHU – Portsmouth Hospitals University NHS Trust; IOW – Isle of Wight Trust; ICB – NHS Hampshire and Isle of Wight.

The 2026/27 quality contract has been developed to support providers in embedding the learning from their infections during 2025/26 and in delivering the requirements of the National Action Plan for Antimicrobial Resistance.

3.4.2 **Never Events:** the total number of Never Events reported during 2025/26 (up to 15 March 2026) is 25. During February, two Never Event incidents were reported by two Trusts in the Hampshire and Isle of Wight system. Both are in the process of being investigated.

Thematic learning is shared across the system via the System Quality Group, ensuring that local insights and best practice are adopted more widely to prevent incidents and improve outcomes across all organisations and the population.

During 2025/26 the majority of Never Events have been surgical, in response, 2026/27 contract requires providers to share the outcome of their National Safety Standards for Invasive Procedures audits and associated actions following review.

3.4.3 Venous thromboembolism (VTE) Risk Assessment: the NHS contract requires providers to achieve the operational standard of 95% of patients aged 16 and over being risk assessed for VTE on admission each month. National VTE Risk Assessment data is published on a quarterly basis and so there are no performance updates to report this month.

The Quarter 3, 2025/26 data shows that NHS Hampshire and Isle of Wight did not meet the operational standard – achieving 93.3%. In the South East region NHS acute providers achieved 93% compliance, whilst independent sector providers achieved 97.3%.

The Quarter 3, 2025/26 data shows that Hampshire Hospitals NHS Foundation Trust and the Isle of Wight Trust consistently meet and/or exceed the 95% threshold.

3.5 Clinical Effectiveness

3.5.1 Fractured Neck of Femur Best Practice Tarriff – January 2026: the Best Practice Tariff percentages show how much of provider care delivered meets nationally agreed standards. Higher percentages assure that patients are more likely to receive care aligned with best outcomes.

In January 2026, England saw a decline in performance for all elements of the Best Practice Tariff. Across the Hampshire and Isle of Wight system, orthogeriatric assessment saw a decline in performance during January 2026, this will be monitored. Ongoing recruitment challenges at the Isle of Wight NHS Trust continue to impact performance in this area.

Portsmouth Hospitals University NHS Trust continues to report the best performance and, unlike the other Trusts, exceeds national performance in delivering care that meets the best practice criteria.

Best Practice Tariff improvement plans are monitored via usual contractual routes and quality oversight for improvement.

3.5.2 Summary Hospital Mortality Indicator (SHMI): SHMI is the ratio between the actual number of patients who die following hospitalisation at a Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths which occurred in hospital and deaths which occurred outside of hospital within 30 days (inclusive) of discharge. The latest data (up to 30 October 2025) published in March 2026 shows that no Hampshire and Isle of Wight provider had a higher-than-expected observed number of deaths within 30 days of discharge from hospital.

The SHMI guidance continues to highlight that there is a high percentage of invalid diagnosis codes for one Trust and therefore their values should be interpreted with caution. As reported previously, this has been escalated to the Trust who are in the processes of reviewing it.

3.6 Quality and Equality Impact Assessments

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

During February 2026, no Quality and Equality Impact Assessments were moved from the NHS Hampshire and Isle of Wight panel to the next stage of decision-making

4. Integrated Care System Financial Overview

4.1 Purpose

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

4.2 Background

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

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

The Hampshire and Isle of Wight system has received Q1 and Q2 Deficit Support Funding (M1 to M6). Deficit Support Funding for the period (M7 to M12) had previously been communicated as being withheld in full by NHS England. However, at M11 £8.18m was released to the System.

NHS England previously advised Hampshire and Isle of Wight organisations to assume that any Deficit Support Funding withheld could be earned back in Q4 (M10 to M12), but this will be conditional upon regional confirmation that financial performance across the whole system is compliant with national expectations.

Following the movement in forecast at M10 to a deficit £89.71m, the System had assumed no further DSF would be received in 2025-26 financial year. However, in M11 the System received £8.18m of previously held back DSF from NHS England resulting in an improvement to the year end forecast, moving to a reported £81.53m deficit.

4.3 Financial Position

Table 2 below summarises the in-month and year-to-date financial position as at Month 11 (February) for all Hampshire and Isle of Wight organisations:

Table 2: Summary of M11 results (using original plan not adjusting for lost DSF)

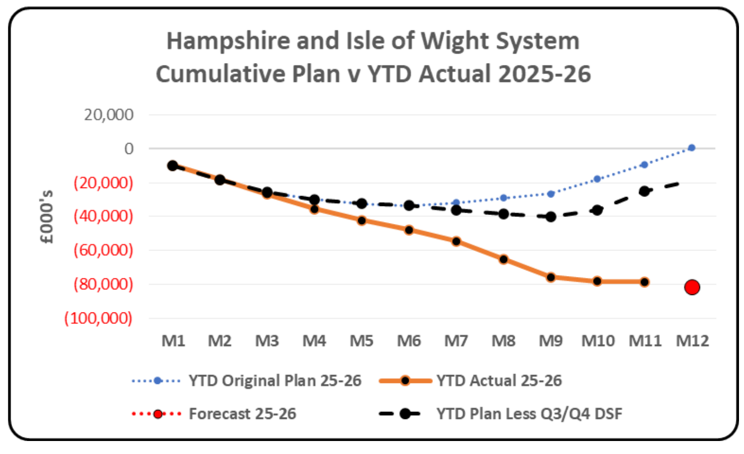
Organisation	In Month			Year to date			Forecast Outturn		
	In Month Plan £'000	In Month Actual £'000	Variance £'000	YTD Plan £'000	YTD Actual £'000	Variance £'000	Annual Plan £'000	Forecast Outturn £'000	Variance £'000
Hampshire and Isle of Wight ICS Total	8,653	(423)	(9,076)	(9,334)	(78,541)	(69,207)	469	(81,525)	(81,994)

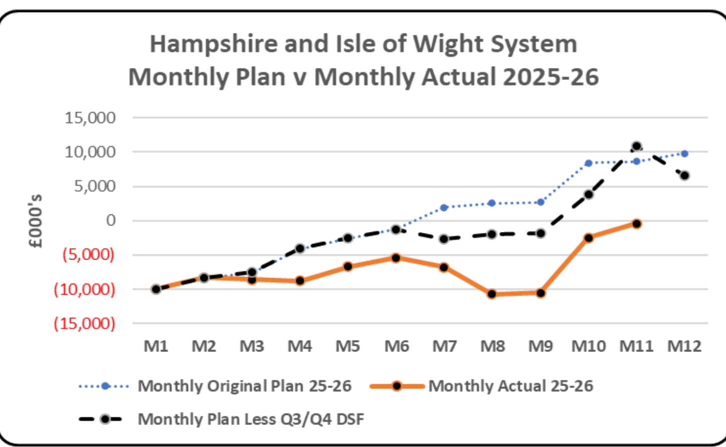
In February 2026 itself, the ICS reported a deficit of £0.423m against a planned surplus of £8.653m, so a £9.076m adverse variance to plan. Year-to-date the system has reported a deficit of £78.54m at Month 11 compared to a planned deficit of £9.33m, therefore a £69.21m adverse variance to plan.

Of the £60.13m adverse variance to plan year-to-date, £18.22m relates to withheld Deficit Support Funding.

The graphs below summarise the ICS position reported at month 11 (February) 2025/26.

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





4.4 System Actions to Support Financial Recovery

In 2023/24, additional controls were developed and implemented, aligned to those required by NHS England as a consequence of our deficit plan. Individual providers may also have had enhanced conditions as described in undertakings letters and where revenue or capital cash support was required, additional conditions will apply, including assessment of affordability of capital plans. All our existing system business rules, conditions and controls remain extant in 2025/26.

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

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

5. Workforce

Month 11 - All Staff Trajectory - Whole Time Equivalent (excluding Integrated Care Board)

- Hampshire & Isle of Wight system is worse than plan by 1,208 WTE in Month 11 2025/26, broken down by Substantive (729 WTE), Bank (417 WTE) and Agency (-1 WTE).
- Compared to the previous month (January 2026), the system has seen an overall decrease of 38 WTE.
- Trusts worse than plan are Hampshire Hospitals (408 WTE), University Hospital Southampton (363 WTE), Portsmouth Hospitals University (332 WTE), Isle of Wight NHS Trust (127 WTE) & South Central Ambulance Service (82 WTE). Only Hampshire & Isle of Wight Healthcare is better than plan by 105 WTE.

Month 11 - Substantive Trajectory - Whole Time Equivalent (excluding Integrated Care Board)

- Hampshire & Isle of Wight system is 792 Substantive whole time equivalent (WTE) worse than plan.
- Trusts worse than plan are University Hospital Southampton (364 WTE), Hampshire Hospitals (278 WTE), Portsmouth Hospitals University (217 WTE), Isle of Wight (111 WTE) and South Central Ambulance Service (27 WTE). Only Hampshire & Isle of Wight Healthcare is better than plan by 204 WTE.
- ‘Support to Clinical’ is better than plan by 76 WTE, as well as ‘Any Other Staff’ by 1 WTE, respectively. Whilst ‘NHS Infrastructure Support’ is worse than plan by 415 WTE, alongside ‘Medical & Dental’ at 248 and ‘Registered Qualified Scientific’ at 166 WTE.

Month 11 - Bank & Agency Trajectories – Whole Time Equivalent (excluding Integrated Care Board)

- In Month 11, Total Temporary staffing (Bank & Agency) usage is 2,747 WTE and 416 WTE (17.8%) worse than the plan of 2,331 WTE.
- Bank use, worse than plan by 417 WTE (20.1%).
- Agency use is better than plan by 1 WTE (0.4%).
- All Provider Trusts in Hampshire & Isle of Wight are worse than Temporary Staffing plan, except for University Hospital Southampton who are aligned to plan. Hampshire Hospitals shows the most significant variation to plan by 130 WTE (25.4%).

6. Strategic Integrated Commissioning and Better Care Fund (BCF) Monthly Update – March 2026

6.1. Metrics Update

6.1.1 BCF Performance Summary (Latest Position): : [Jan '26; Month 10 local data]

For M10, all four Places met monthly targets for emergency admissions (65+) and the target for long-term care home admissions, reflecting strong prevention and community support. Discharge delays remain a challenge for all Places.

Note: Latest position reflects Month 10 (January 2026) local data, with national validated data included where available. National data typically lags by 1–2 months and may not align exactly with local reporting periods. M10 reflects performance against revised Q4 targets.

Metric	Southampton	Hampshire	Isle of Wight	Portsmouth
Emergency admissions to hospital for people aged 65+ per 100,000 population	**Plan:** rate:2348.5 admissions:835 **Performance** ***Local data:*** rate: 2129 admissions: 757	**Plan:** rate:1714.1 admissions:5567 **Performance** ***Local data:*** rate: 1479 admissions: 4803	**Plan:** rate:1579.2 admissions:675 **Performance** ***Local data:*** rate: 1432 admissions: 612	**Plan:** rate: 1927.4 admissions:616 **Performance** ***Local data:*** rate:1821 admissions: 582
Average length of discharge delay for all acute adult patients	**Plan:** 1.30 **Performance** ***Local data:*** 1.82	**Plan:** 1.22 **Performance** ***Local data:*** 1.55	**Plan:** 1.34 **Performance** ***Local data:*** 1.41	**Plan:** 1.22 **Performance** ***Local data:*** 1.60
Long-term admissions to residential care homes and nursing homes for people aged 65+ per 100,000 population	**Q4 plan target:** rate: 140.6 admissions: 50 **Performance** ***Local data:*** 50.62	**Q4 plan target:** rate: 133.9 admissions: 435 **Performance** ***Local data:*** Unavailable	**Q4 plan target:** rate: 168.4 admissions: 72 **Performance** ***Local data:*** 42.11	**Q4 plan target:** rate: 178.3 admissions: 57 **Performance** ***Local data:*** Unavailable

Performance Summary	
Southampton	**Avoidable admissions:** Performance remains on track, supported by neighbourhood working, Urgent Community Response and improved emergency department (ED) pathways. The focus was on sustaining gains through winter and embedding consistent delivery at neighbourhood level. **Discharge:** Place-level discharge plans, daily multi-agency grip and shared flow dashboards remain in place, with actions focused on home-first practice, transport optimisation and faster onward care. **Overall:** The system shifted from planning to delivery. The priority continues to be focussed on pace, consistency and grip to secure admission avoidance gains and accelerate discharge flow.

	Delivery is being overseen through Place-level discharge and avoidable admissions improvement plans, with progress and risks reviewed via the Discharge and Admissions Group (DAG).
Hampshire	Local data for January showed that performance for emergency hospital admissions and long-term admissions to residential care and nursing homes was within target and on track. The average length of discharge delay for all acute adult patients was 1.55 days against a plan of 1.22. The local DAG continues to review the improvement plan progress and regular system escalation meetings are in place, with a focus on reviewing discharge performance, addressing barriers, and coordinating actions across the system. The following improvement interventions identified continue: • Additional ICB staff resource has been assigned to local systems through a six-week sprint aimed at accelerating delivery of the discharge plan. • A weekly ICB discharge group and new system-wide CEO sprint group have been established to focus on removing discharge barriers with bi-monthly up-dates provided to Executive teams. • Increased focus on P1 and P2 delays and optimisation of P0 where medically possible.
Isle of Wight	**Supporting DRD Metric:** Adelaide P2 reablement unit reopened in January following refurbishment. 26/27 planning has clarified full funding alignment for beds across both Adelaide and Gouldings including withdrawal of day-care–linked funding, and separation of health and respite bed budgets. Positive outcomes at Gouldings and improved patient flow have also informed initial discussions on D2A pathway development (as per DIP). A D2A workshop is scheduled for March. **Supporting Improved Performance in Avoidable Admissions:** HIOW Falls workstream held the fourth workshop in its inaugural series, alongside a February outcomes and next-steps session. A first draft of the business case is now complete. Isle of Wight secured BCF representation on the NHSE *Leadership for Change* programme, with a focus on the CVD pathway and Sport England place-based programme tackling physical inactivity and associated inequalities. Frailty and respiratory anticipatory care virtual ward beds are operational (c.77% combined occupancy), jointly run with community nursing and UCR, and supported by weekly geriatrician MDT input. **Supporting Both Metrics:** Business case approved to re-procure Carers Support (Health) services on a 3+2 basis from August 2026. LGA-supported HWB development session held to initiate neighbourhood planning and readiness work held.
Portsmouth	Local data for January indicates achievement against the revised ambitions for the admissions avoidance metric. National data for the discharge metric is currently only available up to December, Local data up to January indicates that performance was not on track against the revised metric plan, with an average length of discharge delay of 1.60 against a plan of 1.26. The local DAG continues to review the improvement plan progress and regular system escalation meetings are in place, with a focus on reviewing discharge performance, addressing barriers, and coordinating actions across the system. Local unvalidated data for November indicated performance was on track against plan in Q3 for the residential and nursing admission metric.

6.2 Finance Summary

6.2.1 Headline Finance Overview

6.2.2 BCF Overall Summary Position – Month 11, 2025/26 – (source: ICB BCF Central Expenditure Report

Place	Total BCF Value (£'000)	NHS Spend (£'000)				YTD Actuals (£'000)	YTD Variance (£'000)
		NHS Providers (£'000)	Local Authority (£'000)	Other (£'000)	Total NHS (£'000)		
Hampshire	178,686	73,234	47,075	2,104	122,413	112,212	0
IOW	30,732	7,028	8,933	1,181	17,142	15,914	201
Portsmouth	52,433	16,556	10,695	296	27,547	25,339	87
Southampton	41,925	12,023	11,512	2,065	25,601	23,263	-204
Total	303,777	108,842	78,214	5,646	192,703	176,727	83

(The table above summarises the total BCF value and associated NHS spend across the HIOW system by Place. The "Total BCF Value" column includes both NHS and Local Authority contributions. The breakdown under "NHS Spend" only reflects the portion of funding commissioned or managed by the ICB. This is split into: NHS Providers, Local Authority-commissioned services funded via NHS contributions, and Other ICB-commissioned services. The "YTD Actuals" column shows reported spend to date, while the "YTD Variance" column highlights any difference against planned NHS spend. Please note, Local Authority financial data is not centrally held.)

6.2.3 Key BCF Financial Highlights (Month 11):

Southampton: the position reflects scheme-level adjustments within community wellbeing and prevention, reablement variance associated with discharge to assess (D2A) funding movements, and expected variability in the joint equipment service post-provider transition.

Isle of Wight: there is a forecasted overspend on the equipment service. As this is a jointly funded service, the NHS HIOW proportion of the overspend is reflected in the BCF spend. Business case has been developed to aid with right-sizing future envelope and is progressing through financial review process.

Portsmouth: overspend relates to the Community Equipment Service, due to an unforeseen change in provider which incurs additional costs in comparison to the previous provider. The forecast remains variable due to the nature of this change in provider.

Hampshire: spending in line with the financial plan for 2025-26.

6.3 Strategic Integrated Commissioning – Using BCF as the Driver

6.3.1 Workstream updates

Area	Performance Update	Key Issues/Actions	Next Steps & Milestones
Strategic Integrated Commissioning – BCF programme	• National BCF 2026/27 planning guidance was published in February 2026. Place-based BCF leads within the ICB are now working with local authority partners to develop their respective BCF plans in line with the national framework. • System priorities agreed at the BCF Planning Summit continue to provide a shared direction for BCF development beyond 2025/26, including strengthening Health & Wellbeing Board (HWB) leadership for neighbourhood delivery. • Local Government Association (LGA) support secured following successful expression of interest application. • Actions arising from the Summit are being progressed, with updates shared with stakeholders.	• Progress actions from the BCF Planning Summit, including System Priority 3: strengthening governance and delivery accountability through HWBs. • Use the BCF Maturity Assessment to support targeted review of existing BCF schemes, as well as consideration of schemes operating outside the current BCF framework. • Finalise Section 75 deed of variations by the end of Q4.	• Develop and agree the 2026/27 BCF Plans in partnership with local authority colleagues. • Use LGA support resources to inform HWB leadership discussions and neighbourhood health/BCF planning for 2026/27. • Progress the agreed BCF planning governance timetable across the system, including informal national review, ICB finance assurance and executive sign-off ahead of the 19 May 2026 submission deadline. • Establish a system learning forum to share learning from Isle of Wight and Portsmouth National Neighbourhood Health Implementation Programme (NNHIP) activity. • Continue to align Neighbourhood Health and BCF planning, recognising that much of the narrative development will sit within the wider neighbourhood health context.

6.4. Governance & Forthcoming Quarter Returns

6.4.1 Better Care Fund 2026/27 Planning

National BCF planning guidance for 2026/27 was published in February 2026. Place-based BCF leads within the ICB are now working with local authority partners and wider system colleagues to develop their respective BCF plans in line with the national framework.

The submission will comprise a numerical return and supporting narrative setting out how BCF investment will support integrated and preventative care, including admission avoidance, discharge optimisation and improved independence outcomes.

A coordinated governance timetable has been agreed across the system to support plan development, assurance and approval ahead of the national submission deadline of 19 May 2026. This includes informal national review, ICB Finance validation and executive sign-off.

Due to the timing of Health and Wellbeing Board meetings across Places, some areas will utilise appropriate governance mechanisms (including Chair's Action where required) to ensure plans are formally endorsed in line with national requirements. In some areas, governance approval is being sought ahead of the local authority pre-election period beginning on 25 March 2026.

The agreed planning timeline is set out below.

Milestone	Date
Pre-planning support assessment	31 March
Draft v1 to BCF team (informal review)	17 April
Feedback returned	~24 April
Final to ICB Finance	25 April
ICB Finance approval	2 May
Exec / Chair sign-off	5–9 May
Submission	12–16 May
National deadline	**19 May**
National review period (BCMs review numerical returns)	from 20 May
Resubmission window closes	26 May

6.2 Looking Forward - Better Care Fund 25/26 Quarterly Reporting

Quarter	Template Available to HWB Areas	Signed off HWB Submission Date
Quarter 1	16-Jun-25 ✅	15-Aug-25 ✅
Quarter 2	29-Sep-25 ✅	11-Nov-25 ✅
Quarter 3	15-Dec-25 ✅	30-Jan-26 ✅
End of Year	23-Mar-26	5-Jun-26

HWBs will be expected to submit a signed off report to the national Better Care Fund team.

7. Recommendations

It is recommended that the Board notes the detail of this report and escalations for awareness and management of these.

Trust Board of Directors Meeting in Public 2 April 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:

- Operations Directorate restructure
- Media activity
- Microsoft 365 migration
- Personal issue controlled drugs
- Values and behaviours refresh

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. Operations Directorate Restructure (ODR)

The Communications team have been supporting the Operations directorate throughout their restructure; through consultation and into the go live. We have written and sent regular email updates to staff affected by the restructure, on behalf of Mark Ainsworth to 999 Operations and Ruth Page to control room staff. This has ensured the relevant staff have up-to-date information on the timescales for recruitment and appointments, the processes in place and support available. Interview training has been put in place to support those who are having an interview as part of the appointment process.

The intranet page has been regularly updated to provide a central point for staff to get information on the programme and access links to communicate directly with the change team. The site provides access to information such as the final organisation charts and job descriptions, the consultation outcome report, and support for affected staff such as guidance on the check and challenge process and frequently asked questions.

We are currently developing trust-wide communications to share the outcomes from the restructure programme to all staff, including the move from seven nodes to six operational sectors.

6. Media activity

Cardiac arrest survivor meets lifesaving team – multi-agency working

Ian Drewry suffered a cardiac arrest whilst travelling on a train from Swindon to London in September last year. Cardio Pulmonary Resuscitation (CPR) commenced on board almost immediately, provided by Great Western Railway (GWR) staff and a General Practitioner who was travelling on the same train. A team from South Central Ambulance Service (SCAS) and the Thames Valley Air Ambulance (TVAA) met the train at Reading station and took over treatment. Ian's heart was restarted, he was stabilised on platform 14 and then taken to the Royal Berkshire Hospital.

He went on to make a full recovery and in February, the SCAS communications team organised a visit to Reading Station where Ian was met by some of the people from GWR, SCAS and TVAA who saved his life. This extraordinary story was covered by the local BBC South news team: Mystery GP on Great Western Railway train saves passenger's life - BBC News as well as local radio and newspapers.

Public relations (PR) support for SCAS Charity

February saw a month-long PR campaign to highlight the work of the SCAS Charity, its volunteers and raise awareness of how and where the money raised by the charity is spent. A key focus was on the three people who are running next month's London Marathon, aiming to raise £9,000. The runners featured on local radio, digital TV stations and local newspapers, as well as on the main SCAS social media channels.

Wider topics for media releases and social media promotions have included:

- Cold snap sees 20% rise in calls to 999 | South Central Ambulance Service (picked up extensively across our local and regional media),
- Support for national campaign to get more schools signed up to The Circuit (SCAS urges local schools to register defibrillators on The Circuit | South Central Ambulance Service),
- Support for governor elections, and
- Calls led by SCAS chief paramedic for people aged over 40 to get a free blood pressure check if they don't know their numbers: Chief paramedic urges public to get a blood pressure check | South Central Ambulance Service This comes on the back of latest figures released by NHS Digital showing that online searches on the NHS website for blood pressure rocketed in 2025 making it the 2nd most visited condition, compared to being the 30th in 2024.

Royal visit

The Communications Team in SCAS supported both the trust and Local Resilience Forum in preparation for the State Visit of President Bola Tinubu of Nigeria which took place on 18 March 2026.

With operational crews on scene in Windsor and a command structure in place, the SCAS Communications Team played a part in the multi-agency media cell in the run up to the event, rehearsal, and on the actual event days.

Supporting such events is part of ensuring that, as part of the Civil Contingencies Act, we were able to work with partners to warn and inform the public should we need to. Equally, we are keen to document these events internally to showcase SCAS and the high profile events that our staff and volunteers play a significant part in.

7. Microsoft 365 migration

The Trust's move to @nhs.net accounts for Microsoft365, with data held on the NHS Digital national tenant, is a significant project that needs high levels of awareness and engagement from across all SCAS teams.

Communications is an active member of the project team, and we have a detailed action plan using all existing communications channels to share progress and key actions staff need to take during the migration. The project is using a mix of push and pull communications activity:

Push – direct notification
Where individuals need to take specific action there will be a proactive push of information via email, plus direct requests to line managers through Team Brief on key issues they need to discuss with their staff.

People using specific Microsoft systems that will need manual migration are being identified and dedicated messages and online sessions run to ensure they know what actions are needed and have plenty of time to raise questions.

Pull – central information source for people to access as needed
For the wider migration information there is a section on the intranet which is building as the project progresses. It currently covers:

- Project overview
- Impact by individual Microsoft system
- Timeline
- Questions and Answers
- Change Freeze (a specific phase of the project)
- Manual migration guidance
- Teams channel for raising queries with the project team

The migration will have a significant impact on key internal communications channels with considerable time commitment from our 100 intranet content managers post-migration, to check and update links which will break when content is moved to the national tenant.

Together with the Project Management Office we are working hard to maximise awareness of the impacts to make sure the actual migration goes as smoothly as possible with no surprises for staff.

Personal issue controlled drugs

We are working with Operations and Pharmacy to support the switch from controlled drugs safes in vehicles to station-based safes. We have been advising on communications planning and activity through the pilot phase and now moving into the roll-out in the Hampshire divisions. Roll-out in Thames Valley will then follow as a final stage.

Focus of the communications is on:

- raising awareness of the reasons for and benefits of the change
- promoting the training clinical staff need to complete
- showing how the project is adapting to staff feedback during the pilot and early launch phase.

Values and behaviours

The Communications team is working with the Culture and Leadership team to plan the launch of the trust's refreshed values. A range of launch activities and materials are being planned together with toolkits and guides to help leaders and teams embed the new values across the trust. More to follow in future Board reports.

8. Recommendations

The Board is asked to receive the paper for noting.

For Assurance		For decision		For discussion		To note	x

Trust Board of Directors Meeting in Public 2 April 2026

Title	**NHS Code of Governance for Provider Trusts Annual Self Assessment 2025/26**
Report Author	**Kofo Abayomi, Head of Corporate Governance & Compliance**
Executive Owner	**Becky Murray, Chief Governance Officer**
Agenda Item	**21**
Governance Pathway: Previous	Audit Committee – 19th March 2026
Governance Pathway Next Steps	None – report is for the Board

1. Purpose

To present the findings of a self-assessment exercise against the NHS Code of Governance for Provider Trusts.

2. Executive Summary

Best practice dictates that the Trust should undertake an assessment against the Code of Governance periodically to provide assurance to the Trust Board, via the Audit Committee, that the trust is compliant with the provisions of the Code. Undertaking this exercise will also support the Trust Board to sign off the Annual Governance Statement as it acts as a source of assurance that the organisation is compliant with core corporate governance requirements and standards. An assessment of the Trust's position against each of the provisions is set out within the attached paper on a comply or explain basis.

The Trust demonstrates strong overall adherence to the NHS Code of Governance, with the majority of provisions fully met. The limited areas of partial or non-compliance are process-related rather than structural, and corrective actions are planned and time-bound and are due for implementation in 2026/27.

The main areas where the Trust is not fully compliant with the Code provisions are as follows:

- Strengthening governance transparency (public availability of terms of reference for the committees of the board.
- Formalising leadership and governor development processes, including succession planning and governor evaluation.

- Further improving governance processes, such as timely circulation of board papers and formalising policy in relation to the use of external audit for non-audit related activity.

The paper was discussed at Audit Committee and there was a degree of reflection on whether the Trust could confirm compliance given some of the challenges across the organisation that the Board is aware of. This is a pertinent question, particularly around culture, but whilst we are not yet driving the improvement that we want to see, we have a greater degree of confidence that we have the mechanisms in place to monitor and oversee improvement and to that extent, we are compliant with the requirements of the code.

3. Areas of Risk

Overall, the trust demonstrates a good level of compliance with the Code of Governance and the areas of partial compliance do not represent a high degree of risk. Plans are already in place to ensure that the Trust reaches full compliance, the risk of breaching the Code is therefore low.

4. Link to Strategic Theme

Whilst not relevant to one objective, the overall effectiveness of the trust's governance arrangements underpins delivery of all the strategic aims.

5. Link to Board Assurance Framework Risk(s)

The overall effectiveness of the trust's governance arrangements underpins mitigation of all the BAF risks.

6. Quality/Equality Impact Assessment

Not required as the Code is mandatory.

7. Recommendations

The Audit Committee is asked to:

- NOTE the self-assessment
- SEEK any further assurance as required
- REPORT the outcome to the Trust Board

For Assurance		For decision		For discussion		To note	x

Code of governance for NHS provider trusts – assessment for South Central Ambulance Service NHS Foundation Trust (2025/26)

March 2026

Schedule A: Disclosure of corporate governance arrangements

Trusts are required to provide a specific set of disclosures to meet the requirement of the Code of Governance. These should be submitted as part of the annual report (as set out for foundation trusts in the NHS foundation trust annual reporting manual and for NHS trusts in DHSC group accounting manual.

The provisions listed below require a supporting explanation in a trust's annual report, even in the case that the trust is compliant with the provision. Where the information is already in the annual report, a reference to its location is sufficient to avoid unnecessary duplication.

For the provisions listed below, **the basic 'comply or explain' requirement applies**. The disclosure in the annual report should therefore contain an explanation in each case where the trust has departed from the code, explaining the reasons for the departure and how the alternative arrangements continue to reflect the principles of the code. Trusts are welcome but not required to provide a simple statement of compliance with each individual provision. This may be useful in ensuring the disclosure is comprehensive and may help to ensure that each provision has been considered in turn. In providing an explanation for any variation from the code, the trust should aim to illustrate how its actual practices are consistent with the principles to which the particular provision relates. It should set out the background, provide a clear rationale, and describe any mitigating actions it is taking to address any risks and maintain conformity with the relevant principle. Where deviation from a particular provision is intended to be limited in time, the explanation should indicate when the trust expects to conform to the provision.

Section A: Board leadership and purpose		
Provision	**Requirement**	**SCAS Comply or Explain**
A 2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	**Comply** The Board has regularly reviewed the economy, efficiency and effectiveness of resources through the Integrated Performance Report (IPR) and a suite of other reports received at the board and its committees. Further assurance is provided via internal and external auditors via the Audit Committee. The Trust, as a system partner, remains actively engaged across the four Integrated Care Boards. Building on the previous Memorandum of Understanding with SECAmb, the two organisations have now agreed to enter into a Group Model with a single Joint Chair and Chief Executive Officer. Functional workstreams across the two organisations are underway, which enable the sharing of knowledge and resources to drive improvement and deeper collaboration across both organisations. SCAS continues to be a part of the Southern Ambulance Services Collaboration (SASC), a partnership between: ▪ East of England Ambulance Service NHS Trust (EEAST), ▪ London Ambulance Service NHS Trust (LAS),

Section A: Board leadership and purpose		
Provision	**Requirement**	**SCAS Comply or Explain**
		▪ South Central Ambulance Service NHS Foundation Trust (SCAS), ▪ South East Coast Ambulance Service NHS Foundation Trust (SECAmb) and ▪ South Western Ambulance Service NHS Foundation Trust (SWAST). The Trust describes in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance contributes to delivery of the overall Trust strategy.
A 2.2	The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place- based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and intended outcomes and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners, and other decisions.	**Comply** During 2025/26 the Trust refreshed it's Fit for the Future (FFF) strategy which sets out the Trust's ambition to be a Care Navigator, thus supporting the wider system by ensuring that patients are treated in the appropriate setting. All work programmes aimed at continuous improvement and delivery of targets are aligned to one of 5 strategic objectives. During the year the trust also refreshed its values through a process of co-creation with staff. Following on from this a clear statement of behaviours aligned to these values will be developed in 2026/27.

Section A: Board leadership and purpose		
Provision	**Requirement**	**SCAS Comply or Explain**
		The Trust has involved the ICSs in developing the Multi-Year plan which details financial, operational and workforce planning for 2026-27 and beyond.
A 2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	**Comply** The Board monitors culture through a number of mechanisms and reports including the staff survey, FTSU Guardian Reports, pulse surveys and Employee Relations Reports. The board has also considered the findings and recommendations of the national ambulance culture review. During 2025/26 we have focused on using this intelligence in a more triangulated way and have developed programmes of work under our People & Culture strategic theme; some of which have been delivered (values and behaviours) and the establishment of our Senior Leaders Group. Further work is planned for 2026/27 and will be reported via the People & Culture Committee (PACC) and the Board. The way that the agendas for the PACC meetings has also been refreshed during 2025/26 and there is now dedicated time to undertake deep dives into areas of concern. The Trust's annual report explains our approach.

Section A: Board leadership and purpose		
Provision	**Requirement**	**SCAS Comply or Explain**
A 2.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five- year joint plan for health services and annual capital plan agreed by the ICB and its partners, and to ensure that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.	**Comply** The FFF strategy is aligned to the 10-Year Plan and sets out our aspiration to become a Care Navigator, which supports the wider system. Also relevant to wider system performance is the work with SECAmb that is aimed at creating a common offer across our respective geographies and achieving efficiencies. The Board regularly reviews the Trust's effectiveness, efficiency and economy and the quality of its healthcare delivery via the IPR and a suite of other assurance-based reports. The Trust also monitors the National Ambulance Quality Indicators Dashboard and its performance against the NHS Oversight Framework and utilises benchmarking data where this is appropriate and relevant.
A 2.5	The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, e.g. from the internal audit function, to provide an adequate and reliable level of assurance.	**Comply** The Board monitors performance through the IPR and finance reports which contain a number of KPIs against which performance is monitored and measured. We continue to adopt SPC reporting to enable the board to understand themes and trends and ensure action is being taken in response. Internal audit has been utilised throughout the year to test our key

Section A: Board leadership and purpose		
Provision	**Requirement**	**SCAS Comply or Explain**
		internal control mechanisms linked to areas of risk outlined in our Board Assurance Framework.
A 2.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.	**Comply** The Quality & Safety Committee (QSC) supports the board in monitoring clinical quality and has clear terms of reference and membership. The meeting has benefitted from a new Chair and increased NED members with a clinical background during 2025/26. A number of quality related meetings report into QSC. One of the trust's strategic themes under FFF is Clinical Effectiveness and there are a number of workstreams underway aimed at modernising and improving clinical care delivery, including joint work with SECAmb around adopting a common clinical model. The board reports on the effectiveness of its clinical governance arrangements through its annual report and the Quality Account. The Quality Account also identifies the Trust's quality priorities for the year.
A 2.7	The chair should regularly engage with stakeholders including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's	**Comply** The Trust Chair regularly engages with colleagues from the ICS across the Trust's geography, this includes meeting with ICB Chairs and with chairs of our partners across the system.

Section A: Board leadership and purpose		
Provision	**Requirement**	**SCAS Comply or Explain**
	vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of the stakeholders including system partners. NHS foundation trusts must hold a members' meeting at least annually.	The Chair and NEDs engage with staff via site visits to ambulance stations and call centres and with our Governors who represent our staff and the communities that we serve. The Chair presents regular reports to the Trust Board on his engagement activity. NED Committee Chairs actively seek to engage with stakeholders on significant matters related to their areas, for example by connecting with committee chairs across the systems, liaison with governors, and proactive engagement in national networks/briefings. The Trust also holds an Annual Members Meeting to promote wider engagement.
A 2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective.	**Comply** The Board describes the requirements of this provision in its annual report. The Trust employs engagement mechanisms with stakeholders as outlined above and specifically with our patients, via our Patient Engagement Panel. The Trust works closely with system partners in the provision and development of services across the Southeast and has

Section A: Board leadership and purpose		
Provision	**Requirement**	**SCAS Comply or Explain**
		forged strong working relationships with SECAmb during 2025/26.
A 2.9	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.	**Comply** The Trust has adopted the national Freedom to Speak Up Policy and has appointed new executive and non-executive leads during the year to support the team of 3 Freedom to Speak Up Guardians. The PACC and Board receives quarterly reports from the FTSU team, which include themes, learning, number of cases and all activity throughout the year. A self-assessment is also undertaken annual to identify areas for improvement. The trust's policy has been reviewed and updated during the year and contains the process for investigation and follow-up action, and guidance on detriment.
A 2.10	The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement.	**Comply** The Board has a Register of Interests which is compiled in accordance with the Trust's Gifts, Hospitality and Conflicts of Interest Policy. The policy was last approved in September 2024.

Section A: Board leadership and purpose		
Provision	**Requirement**	**SCAS Comply or Explain**
		The Register is presented to every board meeting and any additional declarations are requested at the start of each Board and Committee meeting. Any conflicts that arise are managed in accordance with the policy.
A 2.11	Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.	**Comply** Any specific concerns raised about the Board or management of the Trust would be explicitly recorded in the minutes of the relevant meeting. Any member of the Board/Director may request that their specific views are recorded. There has been no specific instances of non-executive director's resigning over concerns during 2025/26, however if they did, the Chief Governance Officer would ensure circulation of those concerns to the Board. The Trust also has a Senior Independent Director (SID) with whom concerns can be raised.

Section B - Division of responsibilities		
Provision	**Requirement**	**SCAS Comply or Explain**
B 2.1	The chair is responsible for leading on setting the agenda for the board of directors and, for foundation trusts, the council of governors, and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.	**Comply** The Trust Chair, with advice from the Chief Executive and Chief Governance Officer, sets the agenda for each Board of Directors meeting and Council of Governors meeting; regular agenda setting meetings are held in that regard. The Chief Governance Officer maintains an overall work programme for the Board, its committees and Council of Governors on behalf of the Chair.
B 2.2	The chair is also responsible for ensuring that directors and, for foundation trusts, governors receive accurate, timely and clear information that enables them to perform their duties effectively. A foundation trust chair should take steps to ensure that governors have the necessary skills and knowledge to undertake their role.	**Comply** A standard cover sheet and report template is used across the board and committees to promote clarity and consistency. This was revised during 2025/26. The Board receives performance data via the IPR and the scheduling of meetings has been amended during the year to ensure the committees have the opportunity to scrutinise the IPR prior to presentation to board and ensure that any risks and gaps in assurance are escalated to the board via the Committee Chair’s report. Led by the Chair, there is a process of reflection on the

Section B - Division of responsibilities		
Provision	**Requirement**	**SCAS Comply or Explain**
		quality of papers submitted for consideration during which feedback on required improvements can be provided e.g. requesting more comparative data or trajectories for improvement. There is also a formal process for an evaluation of the board committees which includes an assessment of the quality of papers. The Trust Chair ensures that new governors receive an induction and keeps them updated on developments within the Trust and wider NHS via a regular Council of Governors (CoG) bulletin and Chair/CEO reports at the start of each CoG meeting. The Chair meets regularly with the Lead Governor. The Council of Governors has a programme of scheduled workshops, linked to FFF. The Council of Governors meet before each meeting to identify areas of concerns or interest. These are presented to Non-Executive Directors and the Chief Executive Officer for a response and discussion at the Council of Governors meeting. **Explain**

Section B - Division of responsibilities		
Provision	**Requirement**	**SCAS Comply or Explain**
		The trust has set a standard of all board and committee papers being circulated 7 days before the meeting. Compliance has improved during the year but a focus on this will be maintained.
B 2.3	The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular and ensuring a constructive relationship between executive and non-executive directors.	**Comply** The Chair continues to promote a culture of honesty, openness, trust and debate and reminds the board of the trust's values prior to each board meeting. Private boards are no longer routinely held prior to Board seminars and where the need arises due to urgent business, only papers that should properly be taken in a private setting are discussed.
B 2.4	A foundation trust chair is responsible for ensuring that the board and council work together effectively.	**Comply** The Chair of the Trust takes proactive steps to promote effective working between the Board of Directors and Council of Governors. Governors are invited to attend the Board meetings in public and they are invited to observe Board Committee meetings with the exception of the Remuneration

Section B - Division of responsibilities		
Provision	**Requirement**	**SCAS Comply or Explain**
		Committee. Non-Executive Directors attend Council of Governors meetings and Committee Chairs provide a briefing on the work of their committee, on a rotational basis. Non-Executive Directors also respond to specific areas of concern or interest highlighted by Governors relating to their committee or NED portfolio. The Chair of the Trust ensures the agendas of Council of Governors meetings reflects its statutory duties and brings relevant updates from the Board via the Chair and CEO reports.
B 2.5	The chair should be independent on appointment when assessed against the criteria set out in Section B, provision 2.6. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice	**Comply** The Chair was independent on appointment to the role in 2022. The roles of Chair and Chief Executive are separate and held by different postholders. As per Provision 26 of the Constitution and 2.4.1 of the Board's Standing Orders, the Council of Governors appoints the Deputy-Chair; this position is currently held by one of the Non-Executive Directors.

Section B - Division of responsibilities		
Provision	**Requirement**	**SCAS Comply or Explain**
	chair or senior independent director.	The Board also has appointed one of the Non-Executive Directors as Senior Independent Director as per Standing Orders provision 2.4.2. The Chair is not a member of the Audit Committee, and this is reflected in the Committee's terms of reference.
B 2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees I holds cross-directorships or has significant links with other	**Comply** The Trust can confirm the following with regards to the Non-Executive Directors: • None have been an employee of the Trust within the last two years • None receive personal renumeration in the form of performance related pay and they are not members of the NHS pension scheme • None has close family ties with any of the Trust advisors, directors or senior employees as evidenced in the declaration of interest register • One Non-Executive Director has served on the Board for more than six years, which were approved by the Trust's Council of Governors. • All Non-Executive Directors can therefore be considered to be independent

Section B - Division of responsibilities		
Provision	**Requirement**	**SCAS Comply or Explain**
	directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of their first appointment • is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.	
B 2.7	At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.	**Comply** At the time of this self-assessment, in line with the Trust's Constitution, the Trust Board comprises up to seven non-executive directors (excluding the chair) and up to seven voting executive directors. Changes to the voting executive directors were made during the year following the restructure of the Executive Team and were approved by the Remuneration Committee. All non-executive directors are considered to be independent.

Section B - Division of responsibilities		
Provision	**Requirement**	**SCAS Comply or Explain**
B 2.8	No individual should hold the positions of director and governor of any NHS foundation trust at the same time.	**Comply** No individual holds a position of director and governor at the same time.
B 2.9	The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.	**Comply** The Chair considers the membership of committees at least annually and is responsible for appointing the committee chairs. In doing so, the Chair considers the skills set, diversity and experience of the non-executive directors against the remit of each committee. Following the commencement in post of 3 NEDs during 2025/26, membership of the committees was refreshed, and new Chairing arrangements were put into place for QSC. There is now robust cross cover in all of the committees, e.g. enhanced clinical executive and non-executive director membership of the Finance & Performance Committee (FPC) and the QSC. The Council of Governors has due regard to the skill set and diversity of the Board when making appointments, led by the chair who has undertaken a skills assessment during the year.

Section B - Division of responsibilities		
Provision	**Requirement**	**SCAS Comply or Explain**
B 2.10	Only the committee chair and members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.	**Comply** Only the Committee members and Chairs of Remuneration Committee and Audit Committee are members of that committee. Officers of the Trust attend by invitation to support agenda items, where not conflicted, as set out in the Terms of Reference.
B 2.11	In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders.	**Comply** As per Standing Orders provision 2.4.2, the Board, has appointed a Senior Independent Director to provide a sounding board for the Chair and act as an intermediary for the other directors when necessary. The Senior Independent Director seeks input from key stakeholders (ICB Chairs, AACE Chair, Provider Trust Chairs in the South East Collaborative) as part of the Chair's appraisal.
B 2.12	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed	**Comply** The Remuneration Committee which comprises NED membership is responsible for appointing and removing executive directors, in accordance with national guidance.

Section B - Division of responsibilities		
Provision	**Requirement**	**SCAS Comply or Explain**
	performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.	The Remuneration Committee terms of reference set out this requirement. The Committee also, as per its Terms of Reference, agrees annual performance objectives of the Chief Executive and executive directors.
B 2.13	The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available. The annual report should give the number of times the board and its committees met, and individual director attendance.	**Comply** The annual report sets out the number of times the Board and its committees met, and individual director attendance. The roles of the Chair, Chief Executive and Senior Independent Director are available on the SCAS Board Members | South Central Ambulance Service The Annual Report provides a summary of individual director attendance at board and committee meetings.
B 2.14	When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on additional external	**Comply** Disclosure of significant time commitments is required as part of the recruitment process for executive and non-executive directors. The time commitment required of non-executive directors is at least three to four days per month

Section B - Division of responsibilities		
Provision	**Requirement**	**SCAS Comply or Explain**
	appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.	in line with national requirements. None of the Trust's executive directors currently holds a non-executive directorship of another trust or organisation of comparable size and complexity as evidenced by the Board Register of Interests.
B 2.15	All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.	**Comply** The Trust's Chief Governance Officer was appointed by a panel that included the Chair, Chief Executive Officer and external stakeholders and is available to all directors to provide advice on governance matters.
B 2.16	The board of directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the trust and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies.	**Comply** The Board as a whole is responsible for this provision but has established the following dedicated board committees for additional scrutiny and assurance: • People and Culture Committee; receives reports on compliance with statutory and mandatory training and education. • Quality and Safety Committee receives reports on clinical quality and safety, the Trust's research activity, Health & Safety and compliance with CQC

Section B - Division of responsibilities		
Provision	**Requirement**	**SCAS Comply or Explain**
		standards.
B 2.16	All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.	**Comply** As a unitary Board, all board members carry equal responsibility for decisions taken. All directors have a responsibility to constructively challenge during board discussion and help develop proposals on priorities, risks, mitigation, values, standards and strategy. The board was actively engaged in the refresh of FFF during 2025/26 and in the identification of the strategic risks through the development of the Board Assurance Framework. The Trust received a moderate rating in the Head of Internal Audit Opinion for 2024/25 relating to the effectiveness of the system of internal control.
B 2.17	All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the chief executive as the accounting officer. The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters	**Comply** The Board operates as a unitary Board with all directors being equally responsible for decisions taken. The Board meets in public on a bi-monthly basis, with Board Seminars taking place in the intervening month. Individual Director attendance at board meetings is set out in the Annual Report. In addition to the provisions set out in the Trust's constitution, the Board approved a comprehensive Schedule of Matters

Section B - Division of responsibilities		
Provision	**Requirement**	**SCAS Comply or Explain**
	should be reserved specifically for its decisions. For foundation trusts, this schedule should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by the board, the council of governors, board committees and the types of decisions that are delegated to the executive management of the board of directors.	Reserved to the Board in March 2025, following review by the Audit Committee.

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
C 2.1	The nominations committee or committees of foundation trusts, with external advice as appropriate, are responsible for the identification and nomination of executive and non-	**Comply** The recruitment panels for executive director and non-executive posts follows best practice. The Trust engages

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
	executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust, and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from a relevant ICB, and the foundation trust should engage with NHS England to agree the approach.	with the ICB and NHS England for the recruitment of board directors and external assessors are always utilised, together with stakeholder panels. The Chair considered the skills required on the board for the appointment of new NEDs during 2026/27 in readiness for the end of term for 2 of the current NEDs based on a board skills assessment.
C 2.2	There may be one or two nominations committees. If there are two, one will be responsible for considering nominations for executive directors and the other for non-executive directors (including the chair). The nominations committee(s) should regularly review the structure, size and composition of the board of directors and recommend changes where appropriate. In particular, the nominations committee(s) should evaluate, at least annually, the balance of skills, knowledge, experience and diversity on the board of directors and, in the light of this evaluation, describe the role and capabilities required for appointment of both executive and non-executive directors, including the chair.	**Comply** The Trust has a Remuneration Committee which appoints executive directors. A Nominations Committee of the Council of Governors considers appointments and re-appointments of non-executive directors and the Chair and makes related recommendations to the Council of Governors.

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
C 2.3	The chair or an independent non-executive director should chair the nominations committee(s). At the discretion of the committee, a governor can chair the committee in the case of appointments of non-executive directors or the chair.	**Comply** The Chair of the Board chairs the Nominations Committee of the Council of Governors and the Deputy Chair of the Board, chairs the Remuneration Committee.
C 2.4	The governors should agree with the nominations committee a clear process for the nomination of a new chair and non-executive directors. Once suitable candidates have been identified, the nominations committee should make recommendations to the council of governors.	**Comply** Appointments of the new Chair and non-executive directors are made following agreement of an open and transparent process. These processes are discussed and agreed at the Remuneration Committee and Nominations Committees respectively for Executive and Non-Executive Directors.
C 2.5	Open advertising and advice from NHS England's Non-Executive Talent and Appointments team is available for use by nominations committees to support the council of governors in the appointment of the chair and non-executive directors. If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.	**Comply** The Nominations Committee of the Council of Governors is aware of this support. The trust has utilised external consultancies to run an open and competitive process for executive and non-executive director appointments during 2025/26 and this will be referenced in the annual report.
C 2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the	**Comply** The Nominations Committee for non-executive directors

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
	appointment of non-executive directors should have governors and/or independent members in the majority. If only one nominations committee exists, when nominations for non-executives, including the appointment of a chair or a deputy chair, are being discussed, governors and/or independent members should be in the majority on the committee and also on the interview panel.	and the Chair is comprised majority governor membership. Governors have been involved in the recruitment and selection process for the Chair and Non-Executive Director appointments.
C 2.7	When considering the appointment of non-executive directors, the council of governors should take into account the views of the board of directors and the nominations committee on the qualifications, skills and experience required for each position.	**Comply** The Chair, Chief People Officer and Chief Governance Officer work closely with and supports the Council of Governors on recruitment of NEDs/Chair and will ensure there is reference to the qualifications, skills and experience required in advertisements for posts.
C 2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	**Partially Compliant/Explain** The Council of Governors oversees a formal, rigorous and transparent process for the appointment and reappointment of the Chair and Non-Executive Directors. This process is supported by the Governors' Nomination Committee, which advises the Council at each stage of the appointment cycle, including recruitment, selection and recommendation for approval.

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
		The Trust is undertaking a review of its webpages for the Board and Council of Governors. As part of that, the terms of reference of the committees will be published once the annual cycle of review has concluded and the terms of reference are approved by the board. We will be compliant with this provision by May 2026.
C 2.9	Elected governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information.	**Comply** The Trust's Constitution states that re-election should take place at regular intervals, not exceeding three years. An election process was undertaken during 2025/26 to appoint to vacant posts and posts that would become vacant due to governors reaching the end of their term. The process was led by an external elections company as per requirements, and all relevant guidance and rules were followed.
C 2.10	**Statutory requirement** A requirement of the National Health Service Act 2006 as amended (the 2006 Act) is that the chair, the other non-executive directors and – except in the case of the appointment of a chief executive – the chief executive are responsible for deciding the appointment of executive	**Comply** The Trust meets this requirement as is demonstrated by the recent appointment of the Chief People Officer and the input and oversight of the Remuneration Committee .

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
	directors. The nominations committee with responsibility for executive director nominations should identify suitable candidates to fill executive director vacancies as they arise and make recommendations to the chair, the other non-executives directors and, except in the case of the appointment of a chief executive, the chief executive.	
C 2.11	**Statutory requirement** It is for the non-executive directors to appoint and remove the chief executive. The appointment of a chief executive requires the approval of the council of governors.	**Comply** This requirement is reflected in section 27 of the Trust's Constitution. The current Chief Executive's appointment was approved by the Council of Governors. There is an ongoing recruitment for the Joint Group Chief Executive which has had appropriate input from the Council of Governors with regards to the appointment process.
C 2.12	**Statutory requirement** The governors are responsible at a general meeting for the appointment, re-appointment and removal of the chair and other non-executive directors.	**Comply** This requirement is reflected in the Trust's Constitution. The re-appointment of the Chair for a second term was approved at a meeting of the Council of Governors following a recommendation from the Nomination Committee.

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
C 2.13	**Statutory requirement** Non-executive directors, including the chair, should be appointed by the council of governors for the specified terms subject to re-appointment thereafter at intervals of no more than three years and subject to the 2006 Act provisions relating to removal of a director.	**Comply** All Non-Executive Directors have a term of office of no more than three years that is renewable once. One of the NEDs is outside of this timeframe but the extension beyond 6-years was approved by the council of governors based on sound rationale.
C 4.1	Directors on the board of directors and, for foundation trusts, governors on the council of governors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.	All directors undergo a Fit and Proper Person Review (FPPR) upon appointment and are asked to make a declaration annually thereafter. This includes completion of the national self-attestation template and verification checks undertaken by the Trust. The Trust maintains a Fit and Proper Persons Policy, aligned with CQC Regulation 5, which was last reviewed and approved by the Remuneration Committee in May 2025. The Chair is the responsible officer for ensuring that all board members meet the required standards. The Trust also complies fully with the annual regional NHS England FPPR submission process. Both the Nominations Committee and the Remuneration

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
		Committee receive regular assurance reports confirming that all relevant post holders meet the Fit and Proper Persons requirements. This assurance is formally reported to the Trust Board in public.
C 4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience. Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.	**Comply** The SCAS Annual Report 2024/25 references board member profiles and these are also publicly available on the Trust's website: SCAS Board Members | South Central Ambulance Service
C 4.3	Chairs or NEDs should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment a chair was an existing non-executive director. The need for all extensions should be clearly explained and should have been agreed with NHS	**Comply** In accordance with this requirement, the Trust reviewed the tenure of one NED whose third term concluded in January 2026. Following a rigorous assessment, the Board agreed that a short extension was justified to ensure continuity and maintain effective oversight during year three of the Trust's Financial Recovery Plan. The NED's term was therefore extended for up to six months, to 30 June 2026.

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
	England. A NED becoming chair after a three-year term as a non-executive director would not trigger a review after three years in post as chair.	Approval for this extension was granted by NHS England Southeast Region on an exceptional basis. The decision was reported publicly at the September Board meeting.
C 4.4	Elected foundation trust governors must be subject to re-election by the members of their constituency at regular intervals not exceeding three years. The governor names submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information. Best practice is that governors do not serve more than three consecutive terms to ensure that they retain the objectivity and independence required to fulfil their roles.	**Comply** This provision is set out in the Trust's Constitution and is followed in practice. No governor has served more than three consecutive terms.
C 4.5	There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. For NHS foundation trusts, the council of governors should take the lead on agreeing a process for the evaluation of the chair and non-executive directors. The governors should bear in mind that it may be desirable to use the senior	**Comply** The Council of Governors agrees the process for evaluation of the Chair and non-executive directors and the Senior Independent Director leads the evaluation of the Chair. The Trust has introduced a process for annual

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
	independent director to lead the evaluation of the chair. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts.	effectiveness evaluations of the Board Committees during 2025/26, which is now in place for 2025/26. The Board also undertook a robust self-assessment exercise against the Provider Capability Assessment Tool, which is based on the Insightful Board during the year.
C 4.6	The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.	**Compliant** The Annual Committee Review process has been used to inform improvement objectives for each Committee and to make changes to the terms of reference, thus ensuring that the functioning of the committees and their support to the board is optimised. The Board has continued with is Board Seminar Programme throughout the year and all board members have been subject to appraisal and objective setting. The Remuneration Committee had sight of the Executive Objectives for the year, which are linked to delivery of FFF.

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
C 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors or governors.	**Comply** An externally facilitated Well-Led review was completed by NHS England in June 2025 in preparation for the Trust's planned exit from the programme. The Trust also underwent a formal Well Led inspection by CQC during the course of the year and the outcome of the inspection will be utilised to inform improvement activity.
C 4.8	Led by the chair, foundation trust councils of governors should periodically assess their collective performance and regularly communicate to members and the public how they have discharged their responsibilities, including their impact and effectiveness on: • holding the non-executive directors individually and collectively to account for the performance of the board of directors • communicating with their member constituencies and the public and transmitting their views to the board of directors • contributing to the development of the foundation trust's forward plans.	**Explain** Whilst the Council of Governors holds NEDs to account at every meeting by seeking responses to areas of concern and were given the opportunity to input into the refresh of FFF, a formal process for enabling the Council of Governors to periodically assess their collective performance will be developed and implemented in 2026/27.

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
	The council of governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice. Further information can be found in Your statutory duties: a reference guide for NHS foundation trust governors and an Addendum to Your statutory duties – A reference guide for NHS foundation trust governors.	
C 4.9	The council of governors should agree and adopt a clear policy and a fair process for the removal of any governor who consistently and unjustifiably fails to attend its meetings or has an actual or potential conflict of interest that prevents the proper exercise of their duties. This should be shared with governors.	**Comply** The Trust's Constitution (provision 14) sets out the process by which a governor could be removed if in breach of any required standard.
C 4.10	In addition, it may be appropriate for the process to provide for removal from the council of governors if a governor or group of governors behaves or acts in a way that may be incompatible with the values and behaviours of the NHS foundation trust.	**Comply** The Trust's Constitution (provision 14) sets out the process by which a governor could be removed if in breach of any required standard(s).

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
C 4.11	The board of directors should ensure it retains the necessary skills across its directors and works with the council of governors to ensure there is appropriate succession planning.	**Explain** A formal skills assessment was undertaken by the Chair in February 2026 ahead of the planned appointment of 2 new Non-Executive Directors. The trust took part in the regional talent and succession planning exercise during the year, but there are no formal succession plans in place. These will be developed during 2026/27 as part of broader work under the People & Culture Strategic theme as part of the wider work that is underway around Leadership Development.
C 4.12	The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.	**Comply** The Remuneration Committee considers all executive director resignations. No executive directors have resigned from the trust during the year other than in accordance with the terms of their contract of employment.
C 4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both	**Comply** The Annual Report includes reference to the role of the Nominations Committee of the Council of Governors and the Remuneration Committee of the Board, including the

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
	support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors, governors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion, including in relation to disability, its objectives and linkage to trust strategy, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports.	detail required to meet this provision.

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
C 5.1	All directors and, for foundation trusts, governors should receive appropriate induction on joining the board of directors or the council of governors and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.	**Comply** The Trust has induction processes in place for both new directors and new governors, which are then tailored to their individuals needs/roles. The Board Seminar Programme is refreshed at least annually and ensures directors update and refresh their skills and knowledge. Relevant policy briefings on developments in the NHS and wider aligned sectors are included within the Chief Executive's reports to the Board.
C 5.2	The chair should ensure that directors and, for foundation trusts, governors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, the council of governors and committees. The trust should provide the necessary resources for its directors and, for foundation trusts, governors to develop and update their skills, knowledge and capabilities. Where directors or, for foundation trusts, governors are involved in recruitment, they should receive appropriate training including on equality diversity and inclusion, including unconscious bias.	**Comply** The Board Seminar Progamme supports the board in developing and updating their skills, knowledge and capabilities and there is development objectives set out for each executive director commensurate with their portfolios. The Executive Team has also participated in an externally facilitated development programme during the year. The Trust offers Recruitment Skills Training, which includes unconscious bias. At least one interview panel member should be trained in Recruitment Skills and where

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
		this is not possible, a member of the recruitment team joins the panel.
C 5.3	To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors and governors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.	**Comply** The Trust's current value are visible in publications and on the Trust's website and are referenced by the Chair at the start of each board meeting. The values have been refreshed for 2026/27 and will be utilised when approved by the board. Trust staff are invited to and attend board committee meetings and Non-Executive Directors take part in engagement activity across the trust, including site visits where they can interact with staff and hear from them first hand.
C 5.4	The chair should ensure that new directors and, for foundation trusts, governors receive a full and tailored induction on joining the board or the council of governors. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent	**Comply** The Trust has an induction programme in place for new directors and governors. This includes opportunities to meet with a broad range of staff and stakeholders as appropriate. All directors have access, at the Trust's expense, to training courses and/or materials that are consistent with

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
	with their individual and collective development programme.	their individual and collective development programme. A record is kept of external training undertaken by governors and directors.
C 5.5	The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.	**Comply** The Chair meets with each non-executive director to agree their training and development needs as they relate to their role on the board as part of their appraisal and PDR. The Chief Executive meets with each executive director to agree their training and development needs. The Chair and the Chief Executive meet regularly and in doing so, cover any matters relating to development needs for Board members (executive or non-executive) and the board as a whole.
C 5.6	A foundation trust board has a duty to take steps to ensure that governors are equipped with the skills and knowledge they need to discharge their duties appropriately.	**Comply** This requirement is met via the Trust's new governor induction programmes and briefings to the Council of Governors on their role and wider developments within the NHS. The governors are offered external training, e.g. with NHS Providers, as required. Workshop style presentations linked to the strategic themes in FFF have also been

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
		delivered within meetings of the Council of Governors.
C 5.7	The board of directors and, for foundation trusts, the council of governors should be given relevant information in a timely manner, form and quality that enables them to discharge their respective duties. Foundation trust governors should be provided with information on ICS plans, decisions and delivery that directly affect the organisation and its patients. Statutory requirements on the provision of information from the foundation trust board of directors to the council of governors are provided in Your statutory duties: a reference guide for NHS foundation trust governors.	**Comply** The Chief Executive provides a regular update on ICS engagement, activity and plans at Board and Council of Governors meetings. The Council of Governor receives the IPR which details trust performance and has also been fully briefed on the collaboration work with SECAmb and the intended benefits for patients and the wider health economy.
C 5.8	The chair is responsible for ensuring that directors and governors receive accurate, timely and clear information. Management has an obligation to provide such information but directors and, for foundation trusts, governors should seek clarification or detail where necessary.	**Comply** The Board receives the most up-to-date data available to it via the IPR and the scheduling of committee meetings has been changed from April 2026 to ensure the committees have the opportunity to scrutinise and challenge all aspects of performance ahead of the board meeting. Directors and governors seek clarification on data/information as required to ensure understanding and

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
		seek assurance. Work has been on-going to produce a Data Strategy during the year and will be subject to board discussion during 2026/27.
C 5.9	The chair's responsibilities include ensuring good information flows across the board and, for foundation trusts, across the council of governors and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required.	**Comply** The Chief Governance Officer assists the Chair in ensuring good information flows across the Board, the Council of Governors and between the directors and senior management. There has been an increase in the referral of issues between committees in the year which indicates that governance processes are maturing. Governors have observed board committee meetings during the year to help them understand the trust's business and the effectiveness of Non-Executive Director scrutiny and challenge, which supports them to hold the Non-Executive Directors to account.
C 5.10	The board of directors and, for foundation trusts, the council of governors should be provided with high-quality information appropriate to their respective functions and	**Comply** There is a review of each board and board committee meeting and this incudes reflections on the quality of

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
	relevant to the decisions they have to make. The board of directors and, for foundation trusts, the council of governors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.	papers/reports with feedback on improvement where required. Feedback towards the latter part of 2025/26 suggests that the quality of papers is improving with increased use of data to support the provision of assurance and facilitate more effective triangulation. A standard report template assists colleagues in writing reports in a consistent format. Bespoke Writing for Assurance Training will be rolled out during 2026/27 to further support improvement in the quality of papers.
C 5.11	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may	**Comply** Non-executive directors challenge the assurance provided by management in board and board committee meetings. Where necessary, they request specific assurance reports on complex or high-risk matters, particularly to triangulate different forms of evidence and enable deeper analysis. Non-Executive Directors are aware that they could request external assurance, for example via an internal audit, to provide additional assurance or seek external expertise where required. There has been a number of internal

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
	reasonably decide that external assurance is appropriate.	audit reports with an opinion of limited assurance during the year, which indicates that the Internal Audit function is being used appropriately to understand areas of risk within the trust's key controls and ensure that improvement activity is undertaken.
C 5.12	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of non-executive directors. The availability of independent external sources of advice should be made clear at the time of appointment.	**Comply** The Board can access independent professional advice, including legal advice, at the Trust's expense as required. The terms of reference for each committee expressly refer to this.
C 5.13	Committees should be provided with sufficient resources to undertake their duties. The board of directors of foundation trusts should also ensure that the council of governors is provided with sufficient resources to undertake its duties with such arrangements agreed in advance.	**Comply** Each Committee and the Council of Governors is supported by a dedicated secretariat to coordinate and support its work. The Chief Governance Officer oversees all arrangements to support information flows.

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
C 5.14	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.	**Comply** Non-Executive Directors are appointed based on their skillsets and the experience they bring to the role, via an open and competitive process. The requirements of the role are clearly set out in the recruitment process. During the year NEDs have sought additional information and assurance in committees where appropriate.
C 5.15	Foundation trust governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	**Comply** Governors undertake a variety of ways of working to engage with staff and members and this is reported via the Membership and Engagement Committee of the Council of Governors. Commentary will be provided in the Annual Report.
C 5.16	Where appropriate, the board of directors should in a timely manner take account of the views of the council of governors on the Trust's forward plan, and then inform the council of governors which of their views have been incorporated in the NHS foundation trust's plans and	**Comply** The board of directors follow NHS Foundation Trust best practice and is supported by the Chief Governance Officer and the Director of Communications, Marketing and Engagement. Views of the Council of Governors are sought through

Section C - Composition, succession and evaluation		
Provision	**Requirement**	**SCAS Comply or Explain**
	explain the reasons for any not being included.	workshops, regular webinars and up to date information on the Trust intranet site. Governors feedback their views to the Trust, and these are discussed at Council of Governors meetings/ workshops. The Council of Governors was involved in the refresh of FFF.
C 5.17	NHS Resolution's Liabilities to Third Parties Scheme includes liability cover for trusts' directors and officers. Assuming foundation trust governors have acted in good faith and in accordance with their duties, and proper process has been followed, the potential for liability for the council should be negligible. While there is no legal requirement for trusts to provide an indemnity or insurance for governors to cover their service on the council of governors, where an indemnity or insurance policy is given, this can be detailed in the trust's constitution.	**Comply** The Trust has appropriate insurance via membership of the NHS Resolution schemes.

Section D – Audit, risk and internal control		
Provision	**Requirement**	**SCAS Comply or Explain**

D 2.1	The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.	**Comply** The Trust has established an Audit Committee comprising Non-Executive Director membership. The Committee Chair is not the Senior Independent Director, and the Trust Chair is neither a member or, nor attends the Audit Committee. At least one member of the Committee has recent and relevant financial experience, as required by the HMFA Audit Committee Handbook.
D 2.2	The main roles and responsibilities of the audit committee should include: • monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them • providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and	**Comply** The terms of reference of the Audit Committee include these roles and responsibilities (last approved, July 2025).

	strategy • reviewing the trust’s internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself • monitoring and reviewing the effectiveness of the trust’s internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors • reviewing and monitoring the external auditor’s independence and objectivity • reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements reporting to the board of directors on how it has discharged its responsibilities.	
D 2.3	A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years. An NHS foundation trust should re- tender its external audit at least every 10 years and in most cases more frequently than this.	**Comply** A procurement process is underway to appoint a new external auditor as the current contract will expire in 2026.

D 2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	**Comply** The Trust's annual report includes all of the matters listed in this provision. The Trust external auditors do not provide non-audit services.
D 2.5	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services.	**Explain** The Trust does not have a specific policy on purchase of non-audit services from the external auditor but does not engage them in non-audit activity. This will be included in the terms of reference when they are reviewed in May 2026.

D 2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	**Comply** The Trust's annual report includes such a statement.
D 2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	**Comply** The Board and its committees proactively reviews and assesses emerging and principal risks via the Board Assurance Framework and is supported to do so by the Audit Committee. The relevant disclosures are made in the Trust's annual report.
D 2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	**Comply** This requirement is reflected in the Trust's annual report. The Board regularly reviews the Board Assurance Framework, and the Audit Committee is responsible for seeking assurance on behalf of the Board on the effectiveness of the Trust's overall risk management framework. This includes receiving the Head of Internal Audit Opinion an annual basis. A moderate opinion was received for 2025/26.

D 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual, which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over a going concern are expected to be rare.	**Comply** The Trust's annual report and accounts includes an explicit statement on going concern.

Section E - Remuneration		
Provision	**Requirement**	**SCAS Comply or Explain**
E 2.1	Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels.	**Comply** The Trust does not operate any performance related pay arrangements and has excluded these from all new director contracts.
E 2.2	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.	**Comply** The levels of remuneration for the Chair and non-executive directors follows NHS England requirements.

Section E - Remuneration		
Provision	**Requirement**	**SCAS Comply or Explain**
E 2.3	Where a trust releases an executive director, e.g. to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	**Comply** This situation has not arisen at SCAS. The Trust will follow all NHS best practice and guidance if required.
E 2.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.	**Comply** The Trust follows all NHS best practice and guidance and takes independent legal advice as appropriate.
E 2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity.	**Comply** The Trust follows all applicable NHS best practice and guidance.
E 2.6	The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration	**Partial Comply** The Board has established a Remuneration Committee, comprising independent Non-Executive Director

Section E - Remuneration		
Provision	**Requirement**	**SCAS Comply or Explain**
	committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.	membership. The Chief People Officer is the HR advisor to the Committee. The Trust has not engaged any remuneration consultants. **Explain** The Committee's terms of reference were reviewed and amended during the year and are on the Trust's website.
E 2.7	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.	**Comply** The Trust follows all NHS best practice and guidance, including the provisions listed and takes independent legal advice as appropriate.
E 2.8	The council of governors is responsible for setting the remuneration of a foundation trust's non-executive directors and the chair.	**Comply** The Council of Governors undertakes this statutory duty on the recommendation of the Nominations Committee.

Upward Report of the Audit Committee

Date Meeting met **19th March 2026**
Chair of Meeting **Mike McEnaney, Non-Executive Director**
Reporting to **Trust Board**

Items	**Issue**	**Action Owner**	**Action**
Points for escalation			
Internal Audit Report – Demand, Forecasting & Planning	A limited assurance report was received relating to this key area; this was not unanticipated as it is a known area of risk, hence the involvement of internal audit. The issues identified are multifaceted, but a key component is the use of multiple systems resulting in manual, labour intensive and inefficient processes. A more in-depth review is being commissioned with a view to developing a trust-wide project that will become a Tier 1 project under Fit for the Future given the efficiency gains that this will drive and the risks that it will address. Monitoring of the plan will take place via the Finance & Performance Committee	N/A	No specific action as further work is planned which will be developed into a project.
Key issues and / or Business matters to raise			
External Audit Plan, Internal Audit Plan, Counter Fraud Plan and Annual Report Plan	The plan for external audit of the trust's accounts was received. Noted that the fee had been reduced due to improvements in the trust's internal processes from the previous year. A schedule to ensure timely drafting of the	N/A	N/A

	Annual Report was also received along with the Internal Audit and Counter Fraud work plans for 2026/27.		
Areas of concern and / or Risks			
Board Assurance Framework	The BAF was received, and it was noted that the assigned risks had been discussed by the relevant committees. As discussed at the March Board seminar, the BAF risks will be refined for 2026/27 to ensure they accurately reflect the risk to deliver of the strategic objectives and scores will be reviewed.	N/A	N/A
Items for information and / or awareness			
None			
Best Practice and / or Excellence			
Internal Audit Follow Up Actions	There continues to be no overdue actions although it was noted that the deadline for some actions relating to the Fleet Audit had been extended, albeit for valid reasons therefore the committee approved the extension. Management was urged to ensure that realistic dates are set.	N/A	SR will reinforce the message around setting realistic dates for completion of actions.
Policy Position and Single Tender Waivers	Good assurance in relation to both areas; compliance with policies within date is now 95%. Work is on-going to reduce the number of policies that are in place, replacing these with guidelines and Standard Operating Procedures or combining/streamlining policies where this is appropriate.	N/A	N/A
Compliance with Terms of Reference			
Compliant	All papers were relevant to the committee terms of reference, and the meeting was quorate.	N/A	N/A

Policies approved*			
None			

Upward Report of the Charitable Funds Committee

Date Meeting met 6 March 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	The draft strategy and 5-year financial plan was discussed by the Committee. There was broad agreement to the content of the strategy. The Committee requested some additional statistics around volunteer numbers as well as identification of some of the detail needed in order to fulfil the strategy as well as the impact that would be achieved. The CFC found the benchmarking and fundraising ratio information helpful	**Charity CEO**	Revisions will be made to the strategy, and work will begin on creating draft SLAs for how the Charity will work with other departments. Further meetings will be held with Operations to develop the strategic plan for funding CFRs. The Strategy will be discussed by the CFC on 11 May and will then be presented to the Board for approval.

Financial Position 2025-2026	As at M10: • Income is £30,413 ahead of budget • Expenditure is £33,852 worse than budget that that relates to the spend on previously received restricted funds. • Unrestricted expenditure is £23,170 better than budget End of year position is expected to be: • £49,969 better than budget on income • Expenditure expected to be on budget • Overall end of year expected to be £49,880 better than budget	**Charity Finance Manager**	End of year position to be monitored.
Staff Health & Wellbeing	Our application for NHS Charities Together for Proactive and Preventative Trauma Support for Ambulance Staff was successful. Post committees news - We have been awarded £250,000 and will support new starters in frontline and EOC and student paramedics We will now begin working with the Health and Wellbeing team to plan the project and how we will move forward.	**Charity CEO** **Chief People Officer** **Health & Wellbeing Team**	Initial meetings with NHSCT grant team and internal meeting set up to plan the project.

Areas of concern and / or Risks			
Volunteering	After the recent volunteering employment tribunal appeal of Groom v Maritime Coastguard Agency the original outcome was upheld. This has raised a lot of questions regarding volunteers within government agencies including NHS England. The case initially was about payments and expenses, however when looking at the appeal the tribunal reviewed the bigger picture. Through this review, including policies and procedures and handbooks a risk has been identified. The risk relates to ensuring that volunteers are recognised as not being part of the paid workforce and this needs to be reflected in all communications. The Trust needs to ensure that when staff communicate with volunteers their language (both written and verbal) is appropriate and reflects that they are talking to volunteers. The Trust cannot have a "one size fits all" communication, specifically around more generic policies such as social media. When communicating directly with volunteers the Trust must ensure the content is appropriate to their role and needs. All staff need to be aware of the differences between volunteers and staff and ensure that they are behaving appropriately.	**Volunteer Manager**	The risk of volunteer employment litigation if SCAS do not make efforts to ensure a notable difference between staff and volunteer roles in all aspects of their work to be added to the corporate risk register. The Volunteer Manager must be included in all draft communications, projects and proposals that affect volunteers to ensure that the risk is mitigated. SCAS recognises that all departments need to understand the potential issues, risks and outcome around language used when communicating to volunteers.

Items for information and / or awareness			
Best Practice and / or Excellence			
Compliance with Terms of Reference			
Terms of Reference	The Charity's Terms of Reference were reviewed at the meeting on 6 March. The TOR were accepted for the new financial year.	**Charity CEO**	
Policies approved*			

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

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