



PUBLIC BOARD AGENDA

Date: Wednesday 3 June 2026

Time: 9:45 – 12:45

**Venue: Classroom 1 Newbury Education & Recruitment Centre | Bone Lane |
Newbury | RG14 5UE**

Board Members:

Les Broude

Ian Green, OBE

Harbhajan Brar

Gary Ford, CBE

Mike McEnaney

Ruth Williams

Stuart Rees

Mark Ainsworth

Jon Bell

Dr John Black

Craig Ellis*

Danny Hariram

Paul Kempster *

Becky Murray*

Duncan Robertson

Helen Young

* Non-voting board member

Non-Executive Director & Senior
Independent Director (Chairing)
Deputy Chair & Non-Executive Director
Non-Executive Director
Non-Executive Director
Non-Executive Director
Non-Executive Director
Acting Chief Executive Officer
Executive Director of Operations
Chief Finance Officer
Chief Medical Officer
Chief Digital & Information Officer
Chief People Officer / Deputy Chief
Executive
Chief Transformation Officer
Chief Governance Officer
Chief Paramedic Officer
Chief Nurse

In Attendance:

Kofo Abayomi

Head of Corporate Governance &
Compliance

Apologies for Absence:

Professor Sir Keith Willett, CBE

Katie Kapernaros

Gillian Hodgetts

David Ruiz-Celada

Chair
Non-Executive Director
Director of Communications, Marketing
and Engagement
Joint Strategic Lead

Number	Item	Format	Action	Time
1	Welcome and Apologies Les Broude	Verbal		09.45
2	Declarations of Interests and Fit and Proper Persons Test Les Broude	ENC 1	Verbal	
3	Minutes from the Public Board meeting held on 2 April 2026 Les Broude	ENC 2	Approval	
4	Board Action Log Becky Murray, Chief Governance Officer	ENC 3	Approval	
5	Chair's Report Les Broude	Verbal	Noting	09.55
6	Chief Executive Officer's Report Stuart Rees, Interim Chief Executive Officer	ENC 4	Noting	10.05
7	Patient Story Helen Young, Chief Nurse	ENC 5	Discussion	10.15
8	FIT For Future Transformation plan for 2026/27 Danny Hariram, Chief People Officer/Deputy Chief Executive	ENC 6	Approval	
Trust Performance				
9	Finance & Performance Committee Report: April (paper); May (verbal update) Les Broude, NED Chair	ENC 7	Verbal Assurance	10.30
10	Integrated Performance Report Craig Ellis, Chief Digital & Information Officer	ENC 8	Assurance	10.35
11	Finance Report Month 1 Stuart Rees, Chief Finance Officer	ENC 9	Assurance	10.50
Strategic Theme: Enabling Services				
12	Enabling Services Board Assurance Framework Risks Jon Bell, Interim Chief Finance Officer	ENC 10	Assurance	11.10
Strategic Theme: Digital Transformation				

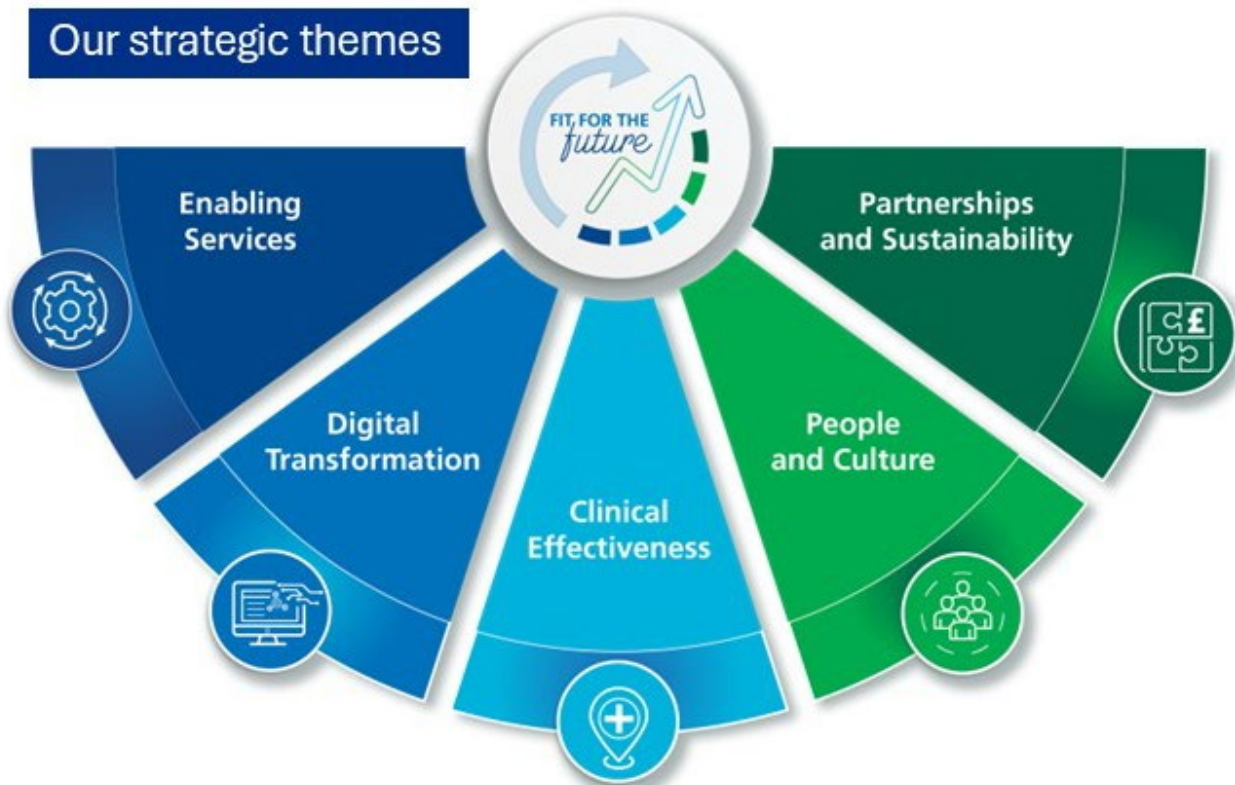
13	Digital Transformation Board Assurance Framework Risks Craig Ellis, Chief Digital & Information Officer	ENC 11	Assurance	11.15
Strategic Theme: Clinical Effectiveness				
14	Quality and Safety Committee Report: April (paper) Katie Kapernaros, NED Chair	ENC 12	Verbal Assurance	11.20
15	Clinical Effectiveness Board Assurance Framework Risks Duncan Robertson, Chief Paramedic Officer	ENC 13	Assurance	
16	Research Annual Report 2025/26 Duncan Robertson, Chief Paramedic Officer	ENC 14	Noting	11.25
Strategic Theme: People & Culture				
17	People & Culture Committee Report: May (paper) Ian Green, OBE, NED Chair	ENC 15	Assurance	11.30
18	People & Culture Board Assurance Framework Risks Danny Hariram, Chief People Officer/Deputy Chief Executive	ENC 16	Assurance	11.35
19	Refreshed New SCAS Values & Behaviours Framework Danny Hariram, Chief People Officer/Deputy Chief Executive	ENC 17	Approval	11.45
Strategic Theme: Partnerships & Sustainability				
20	Partnerships & Sustainability Board Assurance Framework Risks Jon Bell, Interim Chief Finance Officer	ENC 18	Assurance	11.50
21	Communications, Marketing and Engagement Update Gillian Hodgetts, Director of Communications, Marketing and Engagement	ENC 19	Noting	12.05
Governance & Regulation				
22	Board Committee Annual Reports 2025/26 and Terms of Reference Becky Murray, Chief Governance Officer	ENC 20	Noting	12.10
23	Audit Committee Chair's Report: May (verbal update)	Verbal	Assurance	12.20

	Les Broude, NED			
24	Incident Response Framework Mark Ainsworth, Executive Director of Operations	ENC 21	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 Les Broude	Verbal	Response	12.45
27	Any Other Business	Verbal	Noting	-
28	Review of Meeting NED: Ruth Williams Executive: Helen Young	Verbal	Discussion	12.45
29	Date and Time of Next Meeting in Public Thursday 3 September 2026 at 9.45am Newbury Education & Recruitment Centre, Bone Lane, Newbury RG14 5UE	-	Noting	

Our vision

Right care, first time, for our patients

Our strategic themes



Our values





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: 22 May 2026

Produced by: The Governance Directorate

COLIN DENNIS, GROUP CHAIR

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

1. Welsh Ambulance Service University Trust, Board Chair

Current 'Other' Interests

2. Green Square Accord Social Housing Association, Board Chair

Interests that ended in the last six months

3. None

PROFESSOR SIR KEITH WILLETT CBE, TRUST CHAIR

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

4. Professor of Trauma Surgery, University of Oxford
5. Patron of IMPS (Injury Minimization Programme for Schools). An NHS charity under Oxford University Hospital NHS Foundation Trust
6. Patron of Primary Trauma Care Foundation
7. Emeritus National Director of Emergency Planning and Incident Response

Current 'Other' Interests

8. Honorary Air Commodore to 4626 Squadron, RAuxAF, Brize Norton

Interests that ended in the last six months

9. Retained with NHS England and NHS Improvement to support COVID-19 public inquiry

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. Director of Welcombe Ltd
3. Trustee of the Buckinghamshire Healthcare Charity

Interests that ended in the last six months

4. None

IAN GREEN, NON-EXECUTIVE DIRECTOR

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

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

Current 'Other' Interests

2. Chair of Delta 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
8. Trustee, PrideWide

Interests that ended in the last six months

9. Chair of Salisbury NHS Foundation Trust
10. 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
9. Non-Executive Director, Competition & Markets Authority (CMA)

Interests that ended in the last six months

10. None

RUTH WILLIAMS, NON-EXECUTIVE DIRECTOR

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. Chair Langley Trust Charity

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. Clinical Advisor to Carnall Farrar
7. Professor of Stroke Medicine, University of Oxford
8. Governing Body Fellow, Green Templeton College
9. Oxford Academic Health Partners Board
10. Accelerare, Director – company supports activities of Health Innovation Oxford and Thames Valley
11. Thames Valley and Surrey Heartlands Shared Care Record Board
12. SAS AI-Stroke, Scientific Advisory Board – company developing AI recognition FAST stroke signs
13. Merck KGaA/EMD, Serono stroke trial advisory board
14. Coalition of Special Taskforces for Stroke, President
15. World Stroke Organisation Taskforce for Prehospital Care
16. NHS England Long Term Conditions and Prevention Board

Interests that ended in the last six months

18. None

PAUL KEMPSTER, CHIEF TRANSFORMATION OFFICER

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

1. None

Current 'Other' Interests

2. Own shares in Kainos

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 (NHIR) Clinical Research at SCAS which reports into CRG which I Chair
5. Rebecca Black (wife) , Consultant Obstetrician and Sub-specialist in fetomaternal 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. Trustee, Association of Code of Pontologists

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 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)
2. Nurse Advisor to Board of Trustees for Dorothy House Hospice and Hospice at home
3. 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

4. None

Interests that have ended in the last six months

5. Chief Nurse and Trustee for Across –a national charity supporting disabled and terminal

patients to have respite care in Lourdes

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. Co-editor of Class Professional Publishing Text Book and in joint receipt of royalty payments
Join Royal Colleges Ambulance Liaison Committee (JRCALC)

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. None

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. Co-Chair HPMA London, South Central and East

Interests that ended in the last six months

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

GILLIAN HODGETTS, DIRECTOR OF COMMUNICATIONS, MARKETING & ENGAGEMENT**Current NHS Interests (related to Integrated Care Systems and System Working)**

4. None

Current 'Other' Interests

5. None

Interests that ended in the last six months

6. None

END



Minutes Public Trust Board Meeting

Date: 2 April 2026

Time: 9.45am – 12.45pm

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

Members Present:	
Ian Green (IG)	Non-Executive Director & Deputy Chair (Chairing)
Les Broude (LB)	Non-Executive Director
David Eltringham (DE)	Chief Executive Officer
Harbhajan Brar (HB)	Non-Executive Director
Gary Ford (GF)	Non-Executive Director
Katie Kapernaros	Non-Executive Director
Mike McEnaney	Non-Executive Director
Mark Ainsworth (MA)	Executive Director of Operations
John Black (JB)	Chief Medical Officer
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:	
Professor Sir Keith Willett CBE (KW)	Chair
David Ruiz-Celada	Joint Strategic Lead
Paul Kempster	Chief Transformation Officer

Item No.	Agenda Item
1	Chair's Welcome, Apologies for Absence
1.1	Ian Green (IG) opened the meeting and welcomed Board members, staff and members of the public. Apologies for absence were noted as set out above.



1.2	The meeting was recorded for minute-taking accuracy.
2	Declarations of Interests
2.1	Board members were reminded to review and update their declarations of interest as required.
2.2	No new declarations or conflicts of interest were identified.
3	Minutes from Public Board Meeting held on 5 February 2026
3.1	The minutes of the public board meeting held on 5 February 2026 were agreed as an accurate record of the meeting.
4	Matters Arising and Action Log
4.1	The Board reviewed the action log and approved all actions for closure with the exception of the Board visit process (site and service visits). It was noted that there remained a gap in closing the feedback loop from Board visits, and the need for a more structured approach to capturing and reporting feedback was highlighted.
4.2	Action: BM to develop a strengthened feedback and reporting mechanism.
4.3	The Board NOTED the action log and APPROVED the closure of completed actions.
5	Chairs Report
5.1	The Chair's report was taken as read. No questions were raised by Board members.
5.2	The Board NOTED the report.
6	Chief Executive Officer's Report
6.1	DE presented his final Board report and provided a comprehensive reflection on organisational performance and progress over the preceding year and across his tenure. He highlighted that the Trust had successfully delivered a balanced financial position, completing a three-year recovery programme that had addressed a significant historical deficit and returned the organisation to financial stability. This achievement was recognised as a major milestone, given the scale of the challenge and the difficult decisions required to deliver it.
6.2	In relation to operational performance, DE noted that while there had been sustained improvement over the course of the year, the Trust had narrowly missed its Category 2 response time target at year end. He emphasised that this represented continued progress when compared with previous years, but also reflected the ongoing system pressures, including demand, hospital flow, and resource constraints, which continue to impact ambulance services nationally.
6.3	The Board also noted positive progress in quality and governance. DE highlighted improvements in Care Quality Commission ratings, including movement out of the lowest performance categories, as well as the Trust's progression within the NHS national oversight



6.4	framework. These improvements were presented as evidence of strengthened governance, better organisational grip, and the cumulative impact of improvement activity undertaken over recent years.
6.5	Despite these achievements, DE was clear that the most significant and enduring challenge facing the organisation relates to people and culture. He emphasised that staff experience, engagement and organisational culture must now be the central focus for the next phase of the Trust's development. Particular reference was made to the recent staff survey results, which demonstrated that further work is required to improve how staff feel supported, valued and engaged within the organisation.
6.6	The Board formally recorded its sincere appreciation for DE's leadership, recognising the substantial progress made during his tenure and the stronger organisational position from which the Trust is now able to move forward. Members acknowledged both the achievements delivered and the clear articulation of priorities for the future.
6.7	The Board NOTED the Chief Executive Officer's Report.
7	Volunteer Story
7.1	The Board received a presentation from the Chair of the Patient Panel, outlining the development and impact of patient engagement activity across the Trust. It was noted that dedicated panels focusing on learning disability and mental health had been successfully established, providing meaningful opportunities for service users to contribute to service design and improvement. The development of easy-read patient materials was highlighted as a particular success, including recognition through an external award, demonstrating the value and reach of this work.
7.2	The presentation also emphasised the strength of the patient engagement model, with panels acting as a "critical friend" to the organisation and contributing constructively to the review of policies, processes and patient-facing materials. Board members recognised the positive impact this approach has had in ensuring that services are better aligned to patient needs and experiences.
7.3	However, it was acknowledged that the current model is heavily reliant on a single member of staff to coordinate and support the activity, presenting a potential risk to its sustainability. The need for broader organisational support and resilience within the function was highlighted as an area for improvement.
7.4	The Board expressed strong endorsement of the work of the Patient Panel, formally recognising the contribution of its members and the value of patient insight in shaping services. Members welcomed the progress made and emphasised the importance of sustaining and developing this work further.



7.5	Action: Consideration to be given to strengthening team support for the patient engagement function.
7.6	The Board NOTED the Volunteer Story.
8	Finance & Performance Committee Report
8.1	LB provided an update on the work of the Finance and Performance Committee, outlining key areas of focus for the period. These included financial sustainability, continued development of the Integrated Performance Report (IPR), and strengthening contract governance arrangements. The Board noted that these areas remain critical to ensuring effective oversight of both financial performance and operational delivery.
8.2	It was further noted that work is ongoing to improve the quality and effectiveness of reporting, with an emphasis on strengthening assurance and ensuring that information presented to the Board supports informed decision-making and scrutiny.
8.3	The Board NOTED the Finance and Performance Committee Report.
9	Integrated Performance Report (IPR)
9.1	CE presented the Integrated Performance Report (IPR), highlighting that performance across the reporting period was mixed, with a number of metrics achieved alongside several areas where targets were not met. The Board noted that this reflected the continued operational and workforce challenges facing the organisation, as well as the complexity of the performance framework currently in place.
9.2	The Board held a detailed discussion on the effectiveness of the current IPR format and the extent to which it supports meaningful oversight and decision-making. Members emphasised the need to improve the clarity and usability of the report, with a stronger focus on actionable insight and forward-looking information rather than retrospective data. Concerns were raised that the current structure does not sufficiently link related data sets, making it difficult to understand cause and effect across performance indicators. It was also noted that the report does not consistently provide clear narrative on what actions are being taken to address underperformance.
9.3	Further concern was expressed regarding the proposed timescales for improving the IPR, with Board members indicating that the suggested six to twelve month timeframe was too long given the importance of having a robust and effective performance reporting framework in place. Members stressed the need to accelerate progress and ensure that improvements are prioritised appropriately.
9.4	It was agreed that a refreshed approach to performance reporting is required, aligned to the “Making Data Count” principles, to ensure that key messages, trends and risks are clearly identified and understood. The revised approach should support better triangulation of data, stronger analytical insight, and clearer articulation of the actions being taken to improve performance.



9.5	Action: IPR development to be accelerated, with proposals to be brought to the May Board seminar for further consideration and input.
9.6	The Board NOTED the Integrated Performance Report (IPR) .
10	Finance Report Month 11
10.1	SR presented the Finance Report, confirming a £1.2m surplus position at Month 11 and noting that the Trust remained on track to achieve its planned year-end financial position.
10.2	The Board noted that delivery of the capital programme was broadly in line with plan, with expenditure aligned to agreed priorities and timelines. Confidence was also provided in the organisation's ability to deliver its three-year financial plan, supported by continued focus on robust financial management and cost control.
10.3	Board members commended the achievement, recognising the significance of the financial recovery delivered over recent years. They emphasised the importance of maintaining this discipline into 2026/27, particularly given the anticipated financial challenges ahead.
10.4	The Board NOTED Finance Report Month 11 .
11	Enabling Services Board Assurance Framework Risks
11.1	SR presented the enabling services risks within the Board Assurance Framework, highlighting key pressures relating to fleet and estates.
11.2	It was noted that the fleet risk remained rated at 20, reflecting the continued operational challenges associated with vehicle availability and infrastructure constraints.
11.3	The Board acknowledged the mitigations in place and ongoing work to address these risks.
11.4	The Board APPROVED the Enabling Services Board Assurance Framework Risks.
12	Digital Transformation Board Assurance Framework Risks
12.1	CE presented the Digital Transformation risks within the Board Assurance Framework, highlighting key areas of concern relating to data maturity, system integration and cyber security.
12.2	The Board noted the increasing cyber security risk, particularly in the context of wider geopolitical factors, and the implications this may have for organisational resilience and system protection.
12.3	The Board NOTED the report.
13	Clinical Effectiveness Board Assurance Framework Risks
13.1	DR presented the Clinical Effectiveness risks within the Board Assurance Framework, outlining key areas of risk relating to operational performance, medicines optimisation and clinical outcomes.



	The Board noted that continued focus was required on response times and patient safety, particularly in the context of sustained system pressures and increasing clinical demand.
13.2	The Board APPROVED the Clinical Effectiveness Board Assurance Framework Risks.
14	Quality and Safety Committee Report
14.1	KK provided an update from the Quality and Safety Committee, confirming that the key themes discussed were consistent with those presented within the Integrated Performance Report.
14.2	No additional issues or concerns were highlighted for escalation to the Board.
14.3	The Board NOTED the update.
15	People & Culture Board Assurance Framework Risks
15.1	DH presented the People and Culture risks within the Board Assurance Framework, outlining the key areas of concern relating to workforce capacity, capability and organisational culture. Particular emphasis was placed on the continued challenges associated with staff engagement, leadership behaviours, and the delivery of a positive working environment across the Trust.
15.2	The Board noted that sickness absence, particularly long-term absence linked to mental health, remains a significant contributor to workforce pressure. In addition, concerns were raised regarding low levels of Personal Development Review (PDR) completion and the impact this may have on staff engagement, development and overall experience.
15.3	It was recognised that a range of improvement initiatives are underway through the “Building Trust Together” programme and wider leadership development activity. However, the Board discussed whether the current level of improvement was sufficient to mitigate the risks identified and noted that further focus on delivery, consistency and measurable impact is required.
15.4	The Board agreed that People and Culture risks remain a priority area for the organisation and require sustained oversight and continued challenge to ensure that meaningful progress is achieved.
15.6	The Board NOTED the position and ongoing mitigations.
16	People & Culture Committee Report
16.1	HB provided an update from the People and Culture Committee, outlining key workforce issues discussed at the meeting. These included performance in relation to Personal Development Reviews (PDRs), levels of sickness absence, and overall staff engagement.
16.2	The Committee highlighted that these areas remain significant concerns and continue to require focused attention and sustained improvement activity.



16.3	The Board NOTED the report.
17	Staff Survey Results 2025
17.1	DH presented the results of the 2025 NHS Staff Survey, noting that overall findings were disappointing and indicated that further significant work is required to improve staff experience across the organisation. Key themes emerging from the results included concerns relating to leadership, culture, staff engagement and aspects of wellbeing.
17.2	The Board acknowledged that, while some improvement activity has been underway, the results reflected a lag in impact and demonstrated that many staff have not yet felt the benefit of these changes. It was recognised that the findings reinforce the importance of the Trust's focus on people and culture as a key strategic priority.
17.3	DH outlined the ongoing response through the "Building Trust Together" programme, which aims to address behaviours, leadership capability and organisational culture. It was noted that the programme has been informed by staff feedback and that the current phase is focused on visible delivery, strengthened communication and improved local engagement with teams. Board members emphasised the need to ensure that actions arising from the survey are clearly prioritised, effectively communicated, and consistently delivered across the organisation. It was agreed that progress must be demonstrable, with clear metrics and regular reporting to provide assurance that improvements are being achieved.
17.4	The Board also discussed the importance of maintaining focus and avoiding the introduction of additional competing initiatives, instead ensuring that existing programmes are fully implemented and embedded. Members highlighted that cultural improvement will take time, but sustained leadership commitment and visible change will be critical to rebuilding trust and improving staff experience.
17.5	The Board NOTED the Staff Survey Results.
18	Partnerships & Sustainability Board Assurance Framework Risks
18.1	SR presented the Partnerships and Sustainability risks within the Board Assurance Framework, highlighting the continued dependency on system partners and the challenges associated with operating across a complex and evolving Integrated Care System landscape. It was noted that variation in system maturity and priorities across regions continues to impact the pace and consistency of collaborative delivery.
18.2	The Board recognised that sustainability risks remain significant, particularly in relation to the long-term transition to a lower carbon fleet and the associated infrastructure requirements. These challenges were noted to have substantial financial and operational implications over the coming years.
18.3	Members emphasised the importance of maintaining strong system relationships and ensuring that SCAS is well positioned to influence and respond to wider system developments. It was also agreed that greater clarity on system structures and governance would support improved understanding of risks and opportunities.



18.4	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 provided useful context on wider system developments and pressures across the regions in which SCAS operates. It was recognised that the ICS landscape continues to evolve, with varying levels of maturity, governance arrangements and strategic priorities across different systems.
19.2	Members acknowledged that these variations can impact the Trust's ability to progress collaborative initiatives consistently, particularly in relation to urgent and emergency care pathways, system flow and workforce planning. The importance of maintaining strong partnerships and ensuring effective engagement with system partners was emphasised.
19.3	The Board agreed that future reports should provide greater focus on the areas of direct relevance to SCAS, including key risks, opportunities and dependencies arising from ICS developments. Improved clarity on system structures and governance arrangements was also identified as beneficial in supporting Board understanding and oversight.
19.4	The Board NOTED the Integrated Care System Report.
20	Communications, Marketing and Engagement Update
20.1	GH presented an update on Communications, Marketing and Engagement activity, outlining ongoing work to support organisational priorities, enhance internal and external communications, and strengthen engagement with staff, stakeholders and the public.
20.2	The Board noted continued positive media coverage and the role of communications in promoting the professionalism and impact of frontline services. It was also recognised that effective communication remains critical to supporting wider organisational programmes, including cultural improvement, staff engagement and system partnership working.
20.3	Members highlighted the importance of ensuring that messaging is clear, consistent and reaches staff effectively across a geographically dispersed workforce. The need to strengthen internal communication channels and improve visibility of key messages and initiatives was emphasised.
20.4	The Board NOTED the Communications, Marketing and Engagement Update.
21	Annual Review against NHS Code of Governance for Provider Trusts 2025/26
21.1	BM presented the Annual Review against the NHS Code of Governance for Provider Trusts for 2025/26. The Board noted that the Trust is largely compliant with the requirements of the Code, with only a small number of areas identified as partially compliant.
21.2	These areas of partial compliance were discussed, with assurance provided that appropriate actions are either in place or planned to address any gaps. It was also noted that future reviews



	will place greater emphasis on demonstrating the effectiveness and impact of governance arrangements, rather than solely focusing on technical compliance.
21.3	MM emphasised the importance of moving beyond process and procedural compliance to ensure that governance arrangements are delivering meaningful impact. He highlighted the need for future reporting to better articulate how governance structures are enabling improved decision-making, organisational effectiveness and outcomes.
21.4	The Board recognised the importance of maintaining strong governance frameworks to support organisational performance and regulatory assurance and welcomed the continued focus on strengthening transparency and impact in this area.
21.5	The Board NOTED the Annual Review against the NHS Code of Governance for Provider Trusts 2025/26.
22	Audit Committee Chair's Report
22.1	MM presented the Audit Committee Chair's report, providing an update on the Committee's recent activity and areas of focus. The Board noted that internal audit work had identified a number of areas requiring improvement, including demand forecasting and planning, which had received limited assurance. It was confirmed that improvement activity is underway and is being monitored through the appropriate governance forums.
22.2	Further assurance was provided that progress continues to be made in strengthening governance processes, including improvements in policy compliance and procurement controls. The reduction in single tender waivers and increased compliance with internal processes were highlighted as positive developments.
22.3	MM emphasised the importance of maintaining strong oversight of audit findings and ensuring that actions are delivered in a timely and effective manner. He noted that the Committee would continue to focus on ensuring that control weaknesses are addressed and that improvements are embedded across the organisation.
22.4	The Board welcomed the assurance provided and recognised the role of the Audit Committee in supporting effective governance and risk management.
22.5	The Board NOTED the Audit Committee Chair's Report.
23	Charitable Funds Committee Report
24.1	MM presented the Charitable Funds Committee report, providing an overview of recent activity and performance within the SCAS Charity. The Board noted positive progress in fundraising income and the continued development of a more structured and strategic approach to charitable activity.
24.2	It was highlighted that governance arrangements have strengthened, with clearer oversight and improved alignment between charitable funding decisions and organisational priorities.



24.3	The Committee has continued to ensure that the Charity operates within its regulatory framework while maintaining appropriate independence from the Trust's core operations.
24.4	MM emphasised the importance of maintaining transparency and robust governance, noting that the Charity operates at arm's length from the Board, with its own distinct responsibilities and accountabilities.
24.5	The Board welcomed the progress made and the continued focus on enhancing both the impact and governance of charitable funds.
24.6	The Board NOTED the Charitable Funds Committee Report.
25	South Central Fleet Services Board Report
25.1	The Board reviewed the South Central Fleet Services Board report, noting the current position in relation to fleet performance and the associated operational planning. Members acknowledged the continued pressures on fleet availability and maintenance, and the importance of sustained focus to support operational delivery.
25.2	It was further noted that a number of challenges remain outside of the organisation's direct control, including wider system and supply chain constraints, which continue to impact fleet performance.
25.3	The Board NOTED the South Central Fleet Services Board Report.
26	Summary of Actions from the meeting
26.1	BM summarised actions from the meeting: • Strengthen Board visit feedback mechanism • Accelerate IPR redesign • People & Culture Committee oversight of PDR and staff survey actions • System structure schematic
27	Questions from the public
27.1	The Board received a pre-submitted question regarding the disposal of the Made Worton site. It was confirmed that the site is surplus to operational requirements and that any proceeds from the sale will be reinvested into the Trust's wider capital strategy.
27.2	The Board NOTED the response.
28.	Any other business
28.1	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.
29	Summary Review of the meeting:



29.1	The Board reflected positively on the quality of discussion and level of constructive challenge throughout the meeting. Members noted that papers had been circulated in a timely manner, supporting effective preparation and engagement. It was suggested that clearer use and definition of acronyms within Board papers would improve accessibility, particularly for new members.
29.2	The Volunteer Story was particularly well received, with members highlighting its value in grounding discussions in patient experience and recognising the contribution of volunteers.
30	Date, Time and Venue of Next Meeting in Public
30.1	The next public meeting of the SCAS Board would take place at 9.45am on 3 June 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: 2 April 2026						
TB/26/001	Matters Arising: Board site visits	HY to circulate the dates for the Accreditation Visits to board members.	HY	03.06.26		
TB/26/002	Fit for the Future	Discussion to take place at the May Seminar with regards to changes to the IPR.	BM/CE	03.06.26	IPR refresh is underway linked to new National Oversight Framework metrics and SCAS FFF priorities. Revised metrics and governance/oversight will be circulated to NEDs once complete. Committees will also receive committee specific reports rather than the entire IPR.	CLOSE
TB/26/003	IPR	People & Culture Committee to oversee trajectory for recovery of PDR position.	DH	03.06.26	Action related to achieving compliance by year end. PACC has not met since the last public board meeting at the time of writing this report, but at the March meeting a request was made for all outstanding PDRs to be booked by the year end. PDR compliance is part of the regular suite of metrics that is overseen by PACC.	CLOSE
TB/26/004	IPR	PACC to deep dive into the BAF risks.	DH	03.06.26	As above, PACC has not met since the last meeting at the time of writing this update, but BAF risks are reviewed at every meeting. Changes to the BAF risks are anticipated in any event given the refresh of FFF for Year 2.	CLOSE
TB/26/005	IPR	PACC to oversee progress against the People & Culture strategic theme and ensure that metrics feature in the IPR where possible.	DH	03.06.26	A presentation on the Culture and Leadership strategic theme was provided to the May Board Seminar. Under the revised reporting arrangements, PACC will receive a highlight report detailing progress against the tier 1 priorities at every meeting and will be able to track progress. As indicated above, work	CLOSE

					to develop the metrics in the IPR is on-going and work continues to define additional metrics that will be reported to PACC.	
TB/26/006	System Reporting	Consideration to be given to how the board better focuses on the system position	SR	03.06.26	At present there are changes to the ICB and commissioning landscape with the move to a Single Strategic Commissioner. Once resolved we will include the system position in the Finance Report to FPC and the Board.	CLOSE



TRUST BOARD OF DIRECTORS MEETING IN PUBLIC 2 April 2026	
Title	Chief Executive Officer's Report
Report Author	Stuart Rees, Acting Chief Executive Officer
Executive Owner	Stuart Rees, Acting 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 public Board, we have submitted our final Multi-Year Plan to NHS England (NHSE), which covers the 3-year period from 2026-27. The plan aligns operational performance with the workforce that we need to deliver it and ensures that we deliver within our budget. The plan was accepted by NHSE subject to some conditions.

Trust Performance

The financial position continues to be challenging for the remainder of the year and beyond, and whilst we have delivered in month 1, we are yet to identify 100% of our Cost Improvement Plan (CIP) target. This means that we have, and will continue to make difficult decisions, and to maintain a careful balance between operational performance, workforce and finance, at the same time as delivering good quality care to our patients.

We are currently in segment 3 of the National Oversight Framework (NOF), having moved from segment 4 following our exit from the Recovery Support Programme and based on our current performance. However, as an organisation, if we are not able to identify our full CIP target by the end of June, our financial enforcement undertakings that were applied across our system will not be lifted, which could in turn negatively impact our NOF rating.

As an executive team and board, we will continue to monitor all aspects of our performance and take mitigating actions where necessary, even if these involve decisions we would rather not take.

Fit for the Future

During 2025/26 we refreshed our Fit for the Future Plan and refined this into 5 strategic themes. This is our overarching Improvement and Delivery Plan, that contains all key deliverables and links to the NOF and to our Multi-Year Plan. We have reviewed our progress during 2025/26 and the plan for 2026/27 is later on the agenda.

Operational Performance

Category 2 mean performance for the month of April was 25.08 minutes, which falls short of our target for the month, and we continue to face very challenging periods. We remain committed to working with our partners to reach our patients as quickly as possible and the executive team monitors our performance daily.

Our Hear & Treat performance continues to be below target, but we are recruiting additional clinicians into the team to ensure that we only convey patients to hospitals when this is necessary; this is not only better for patients in terms of experience but also supports our partner organisations across the system. We expect our performance to improve when these staff are in post.

Fleet

We continue to take delivery of new fleet and our Vehicle Off Road (VOR) rate has improved for the second consecutive month. Whilst we are not yet meeting our VOR target,

we are monitoring vehicle availability, which is a more important metric as this tells us whether we have sufficient vehicles for our crews on shift. Availability continues to improve.

People & Culture

- **Values & Behaviours**

As part of our People & Culture workstream, we have engaged extensively across the organisation to refresh our values and to create a behaviour framework, which sets out behaviours that we expect to see in the workplace and those that we do not. We will be launching these during June and see it as a crucial element of improving our culture.

- **Sickness Absence**

We continue to see sickness absence exceed our target and we know that this impacts on operational performance. We have therefore applied a challenging target for 2026/27 to reduce this, and through the People Team, we are focusing on supporting our people to come back to work and at our health and wellbeing offer.

Collaboration with South-East Coast Ambulance Service (SECAMB)

Our collaboration work continues and progress against the functional workstreams that are already in train is monitored by our respective boards.

Since the last Board meeting, our new Joint Chair, Colin Dennis has taken up post as chair designate, formally taking up post on 5th June. Colin has spent some time orientating himself to the Trust and I would like to warmly welcome him to SCAS.

Colin's arrival marks Keith Willett's departure as Chair of SCAS and this is his last board meeting. On behalf of the executive team and the board, I would like to thank him for the strong and stable leadership that he has shown during his 6-year tenure and wish him every success 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
- (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
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TRUST BOARD OF DIRECTORS MEETING IN PUBLIC
3 June 2026

Report title	Patient Story – Patient Safety Case
Agenda item	7
Report executive owner	Helen Young - Chief Nurse & Executive Director of Patient Care
Report author	Caroline Whitworth – Head of Patient Experience & Engagement
Governance Pathway: Previous consideration	N/A
Governance Pathway: Next steps	N/A

Executive Summary

This report shares a real patient experience from September 2025, submitted as a message of thanks from the Beecher family following a cardiac arrest involving Jordan.

The story highlights;

The critical role of Emergency Call Takers in recognising cardiac arrest through auditory cues and initiating early CPR.

The importance of clear, calm and reassuring communication in enabling a family member to act in an emergency.

The effectiveness of a coordinated multi-team response, including ambulance crews and air ambulance support.

The holistic care provided, including attention to the wellbeing of Rebecca and her unborn baby.

The narrative demonstrates how clinical expertise, teamwork and compassionate communication directly influence both clinical outcomes and family experience.

Alignment with Strategic Objectives

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

High Quality Care & Patient Experience

Relevant Board Assurance Framework (BAF) Risk

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

Select BAF Risk.

Financial Validation

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

Recommendation(s)

- What is the Committee/Board asked to do:
Receive the paper for noting

For Assurance		For decision		For discussion		To note	✓
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Patient Story June 2026

Jordan's Cardiac Arrest

Why this story matters

It highlights;

- The important role of Emergency Call Takers in the chain of survival
- The impact working together as a team can have on outcomes for patients and their families.
- The importance of ensuring that Emergency Call Takers listen to auditory cues to identify the sign and symptoms of a possible cardiac arrest
- The impact the way staff cared for Rebecca and her unborn baby had.
- How clear communication, reassurance and empathy shape patient and family experience during emergencies.

Background

This case came in to the Patient Experience Team as a thank you message from the Beecher family who we had attended in September 2025.

Some background in Rebecca's words;

“Jordan and I had just celebrated our first wedding anniversary and returned home the week before from our baby moon in Crete. After trying for a few years, we were getting ready to welcome our first baby who we had conceived via IVF. In a previous life Jordan served with the parachute regiment but after losing his leg in Afghanistan in 2012 he transitioned first into the world of professional rowing before joining the NCA in 2017.

The month before Jordan had moved from a role where he was away from home a lot and for long hours to a 9-5 working from home, still within the NCA, but a job that would be far more conducive to family life. We would spend a lot of time with our Labrador Daisy, enjoying walks in the countryside surrounding us and just settling into married life and getting ready to become parents!”

On the day...

What Rebecca remembers from the day:

“Jordan had just returned home from the gym. Since being in his new role, he had found far more time to go to the gym and so when he came home saying he didn’t feel very well my initial thoughts were that he’d just over done it. However, when he didn’t feel well enough to take the bath he’d gone upstairs for and returned back downstairs and lay on the floor, I asked him if he thought we needed to call someone. After a discussion about whether to phone 111 or 999 he decided he was feeling a little better, would be ok in a minute, and maybe just needed something to drink and a sugary snack which I fetched for him before going back out of the room to feed the dog.

When I returned Jordan was unresponsive, but I didn’t recognise what was happening as cardiac arrest. After quickly trying to get a response from him and realising I could not remember the recovery position, I called 999, not knowing what to do.”

The Emergency Call

We received Rebecca's 999 call at 18.18 and the call was connected to Eleanor, the Emergency Call Taker in Otterbourne.

- Rebecca's experience of making the 999 call

Initially there was an issue that meant that my first call didn't connect, which added to my panic in the moment. I realised when asked that I did not know whether he was breathing and it hadn't yet occurred to me that he might not be. Once I had realised he was not I became far more panicky, but adrenaline certainly kicked in.

- What Rebecca remember most about how Eleanor managed her call and the difference her guidance made to Rebecca's experience in that moment

The call handler was able to help me very quickly establish that Jordan was not breathing and wasted no time in instructing me to start CPR. I believe that she heard and recognised the sounds he was making as a sign of cardiac arrest, whereas I had wrongly assumed that this meant he was breathing. I had done first aid training before, but felt so doubtful about whether I was doing it correctly. She got me to count out loud and reassured me that I was and made sure I continued. She kept me updated on where the ambulance was and when to go and open the door. I remember having to tell her that I was 7 months pregnant because I was really struggling with the CPR and getting very tired. I appreciated her calm responses to my desperation - there was nothing she could do to get the ambulance there any quicker, but she ensured that I was able to do everything I could until they did.

Working Together

As you would expect, several crew members were dispatched to Jordan, including Ian Powell, Team Leader, Abigail Cottington and Chloe Lynch. The Thames Valley Air Ambulance also attended to provide support and further care

- Rebecca's memory of how her and Jordan were cared for by the attending crew members

"Once the team arrived things do become more of a blur. They were there a significant amount of time, and it went from day to night, but it felt like minutes. Once Jordan was stabilised and on the way to hospital, I appreciated that the team took the time to advise that it might be best to get myself checked also. The time was taken to update my medical notes and log what had happened so that this was visible when I attended MAU the next day and when I next visited my midwife so she was also able to follow up with me further. Although thankfully both I and the baby were fully well, I appreciated that mine and my baby's health were looked after despite us not being the patient you were there to treat"

Final thoughts

What Rebecca wants the SCAS to take away from her experience

“I hope that you are able to see how appreciative we are of your wonderful team who do such an incredibly hard job and are there, on the other end of the phone or getting to you within minutes, to do everything they can to help. If they had not been there when we needed them then it would very likely be a different situation. To me, this is everything that the ambulance service stands for - being there for people during some of their worst moments - and we hope that it will always continue to be this way”

Questions



Are there any questions for Rebecca, Jordan or any of the SCAS staff here today?



TRUST BOARD OF DIRECTORS MEETING IN PUBLIC
3 June 2026

Title	Final Draft - Fit for the Future Transformation Plan 26/27 with Milestones and KPIs
Report Author	Caroline Morris Director of Transformation
Executive Owner	Danny Hariram Chief People Officer and Deputy Chief Executive
Agenda Item	
Governance Pathway: Previous	EMC 26 May 2026 Transformation Oversight Group Programme Governance Groups
Governance Pathway Next Steps	

1. Purpose

The Strategic Improvement Plan sets out how SCAS will deliver its **Fit for the Future** transformation in 2026/27, translating the Trust's strategy into a focused set of **Tier 1 strategic transformation programmes** and **Tier 2 annual delivery priorities**. It aligns to national NHS direction (10 Year Plan and the Vision for the Ambulance Sector) and supports the Trust's ambition to strengthen its role as a **care navigator**, delivering the **right care, first time for patients**.

2. Executive Summary

2.1 Outcomes

The outcomes that this plan is designed to deliver are:

For Patients

- Faster, safer urgent and emergency care, with improved Category 2 performance and reduced variation in outcomes.
- More care delivered closer to home through increased Hear & Treat, improved pathways and reduced avoidable conveyance.
- Stronger patient safety and experience through embedding PSIRF, clinical supervision and improved maternity and neonatal escalation.

For Staff

- A safer, more inclusive culture where staff feel valued, supported and psychologically safe.
- Improved engagement, wellbeing and retention, supported by visible leadership, refreshed values and modernised education and people services.

For Services

- More resilient and productive operations through fleet modernisation and estates improvement.
- Digitally enabled care delivery with a modern CAD, increasingly data-driven decision-making and safe use of AI.

Supporting Sustainability

- Improved financial resilience through strengthened multi-year planning, improved productivity and reliable CIP delivery.
- Stronger system collaboration and commissioning alignment across the South East, working more closely with SECamb as we develop the group model and continuing to build the relationship with the Southern Ambulance Services Collaborative (SASC).
- Continued progress towards Net Zero and environmental sustainability.

2.2 The Transformation Model

The plan is based around our five Strategic Themes and a tiered approach.

1. Clinical Effectiveness
2. Digital Transformation
3. Enabling Services
4. People and Culture
5. Partnerships and Sustainability

Tier 1 – Strategic Transformation: High-impact programmes that deliver multi-year change.

Tier 2 – Annual Delivery Priorities: Time-bound improvement actions that deliver measurable progress in 2026/27.

Progress is monitored through a defined set of **key indicator metrics**, with monthly reporting to EMC and the Board.

3. Key Areas of Risk

Seven key areas of risk have been identified and are outlined in the attached plan covering:

- Patient Safety, Quality and Outcomes
- Delivery Capacity and Pace of Change
- Digital Transformation and Technology risks
- Workforce, Culture and Leadership
- Financial Sustainability and Productivity
- System Collaboration and External dependencies
- Assurance, Oversight and Transparency

3 Link to Strategic Theme

All Strategic themes

4 Link to Board Assurance Framework Risk(s)

SR23 - Leadership

5 Quality/Equality Impact Assessment

QIAs are in development for each programme within the plan and used to inform the development of the detailed work programmes.

7. Recommendation

The Board is asked to approve the 26/27 Transformation Plan

For Assurance		For decision	✓	For discussion		To note	
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Attached: SCAS Transformation Plan 26/27



SCAS Transformation and Improvement Plan 26/27

THIS VERSION IS FOR APPROVAL TO GO TO BOARD ON 3 JUNE 2026

Contents



Page Number	
3	Introduction and Scope
4	Our Strategic Themes
5	High Level Outcomes
6	Strategic Themes - Plans on a page
12	Delivery Actions by Quarter
16	Plan Dependencies
17	Key Indicator Metrics
21	Key Areas of Risk
24	Governance
26	Glossary

Introduction and scope

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

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

- the **outcomes** we want to achieve,
- the **programmes** of work across two tiers of work at strategic and operational levels
- the key related **risks** listed in our Board Assurance Framework, and
- specific **compliance** requirements that are areas of focus.

We outline the **governance** of the work from senior responsible owners leading individual programmes through to Trust Board oversight.

The final section of the plan highlights **2026/27 delivery actions** and the **key indicator metrics** we will use to monitor progress.

The Board will receive **reports demonstrating our progress** against this plan monthly from July 2026 with oversight by the Executive Management Committee designed to assure that the right actions and resources are being deployed to ensure we achieve our ambitions.

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

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

Our new values of together we are **caring, honest and professional**, have been refreshed as part of our work in 25/26 and will be embedded in the coming year.

We recognise the sustainability challenges in the NHS, and we actively seek opportunities to collaborate and work with system partners to improve urgent and emergency care and the services we provide for our patients. This includes our formal collaboration with SECAMB as we move towards working as a group model

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

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

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



Our Strategic Themes

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



Enabling Services



Digital Transformation

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

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



Clinical Effectiveness

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



People and Culture

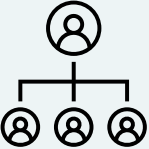
To become a sustainable organisation working effectively across systems and as part of an integrated NHS.



Partnerships and Sustainability



High Level Outcomes

	For Patients: • Faster, safer urgent and emergency care, with improved Category 2 performance and reduced variation in outcomes. • More care delivered closer to home through increased Hear & Treat, improved pathways and reduced avoidable conveyance. • Stronger patient safety and experience through embedding the Patient Safety and Incident Response Framework (PSIRF), clinical supervision and improved maternity and neonatal escalation.
	For Staff: • A safer, more inclusive culture where staff feel valued, supported and psychologically safe. • Improved engagement, wellbeing and retention, supported by visible leadership, refreshed values and modernised education and people services
	For Services: • More resilient and productive operations through fleet modernisation and estates improvement. • Digitally enabled care delivery with a modern Computer Aided Dispatch (CAD), increasingly data-driven decision-making and safe use of AI.
	Supporting Sustainability: • Improved financial resilience through strengthened multi-year planning, improved productivity and reliable CIP delivery. • Stronger system collaboration and commissioning alignment across the South East, working more closely with SECamb as we develop the group model and continuing to build the relationship with the Southern Ambulance Services Collaborative (SASC). • Continued progress towards Net Zero and environmental sustainability.



Strategic Themes: Plans on a Page

Clinical quality, safety, and learning culture throughout



Clinical Effectiveness

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

Outcomes 2026 - 2028

- Our Clinical Effectiveness plans are dependent on the Digital Transformation, Data Driven workstream
- Improved patient outcomes.** To deliver timely urgent and emergency care to our patients, we will achieve a Category 2 Mean of 27:30 in 2026/27 reducing to 18 minutes by 28/29 and we will monitor how Category 2 performance affects our clinical outcomes.
- Improved quality.** To ensure patients receive safer care closer to home we will deliver our new clinical model reducing conveyance to hospital by increasing Hear & Treat to 20% in 2026/27 rising to 25% by 28/29
- Increased safety.** To improve patient experience, we will optimise the time sensitive elements of our care to enhance patient outcomes, delivering increased operational hours.
- Reduced Inequality.** In partnership with SECamb, we will reduce variation in clinical practice and care delivery to ensure patients receive equitable and consistent care.

Compliance

- Implement the relevant regulatory/enforcement improvement actions from Care Quality Commission and NHS England.
- Comply with the Home Office Controlled Drugs License requirements.
- Clinical Supervision Framework

Tier 1: Fit for the Future Strategic Transformation Priorities

Virtual Care

- Improve access to timely clinical care for patients, by increasing clinical capacity and modernising dispatch.
- Improve job satisfaction and retention through staff feedback-informed initiatives: optimise recruitment, improve training and upskilling, implement digital interventions, and reduce inefficiencies in job roles.
- Agree joint principles and outcome measures for virtual care with SECamb.

Pathways of Care

- Improve quality & patient experience by working with our staff and our neighbourhood partners to improve pathway utilisation.
- Ensure patients with time-critical needs consistently reach the right specialist service first time aligning the SCAS and SECamb pathways exploring joint ways of working
- Begin to standardise specialist tertiary pathways across SCAS & SECamb, selecting in 2-3 exemplar pathways and agree core clinical standards.

Medicines Optimisation

- Conclude roll out of Personal Issue Controlled Drugs, implement single, standardised distribution process
- Start digital track-and-trace project, including electronic controlled drugs registers.
- Improve Safe & Secure Handling of Medicines via full station upgrades, including digital-lock cabinets
- Planning: medicines-module review

Time to Care

- Improvement Plan, embedding greater local working and delivering productivity and maximising efficiencies to achieve performance (QI approach to improvement). Will deliver financial and efficiency savings.

Tier 2: Annual Plan Priorities

Patient Safety & Experience

- Embed PSIRF – yr 2/3 roll out, devolve responsibility to sector level, ensure front-line staff utilise principles & methodology
- Experience of Care framework – enable patients to engage in co-design of future pathways and services
- Improve escalation and management of urgent maternity and neonatal cases and reduce inequalities in access and outcomes

Clinical Supervision Framework

- Create new Clinical Supervision Policy
- Establish a multi-directorate working group to build the vision and create processes and the implementation plan.
- Implement and embed the new Clinical Supervision processes.

Clinical Workforce

- Develop a coherent regional Advanced and Enhanced practice framework; undertake a high level stocktake of advanced and specialist roles across both SCAS and SECamb
- Agree a set of shared principles with SECamb on how Advanced Practice will support overall clinical model.

Board Assurance Framework Risks

Quality performance and Patient Outcome

IF we do not achieve the expected response times and implement our clinical operating model **THEN** our patients may not receive timely assessment and treatment, **RESULTING** in avoidable harm or death and unnecessary pressure on systems partners.



Digital Transformation

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

Outcomes 2026 - 2028

- **Improved quality.** To have a modern dispatch system through the implementation of new CAD and ePR systems within Board approved end dates.
- **Improved Productivity.** To deliver a Data-Driven programme of work, new Datawarehouse and full implementation of Qlik Sense. Supports Time to Care Programme.
- **Improved Productivity.** Seek out opportunities where AI can enhance decision-making, support staff, and improve patient experience by running a set of pilots in 26/27.
- **Increased Effectiveness.** Improve ability to evaluate our service quality and our people by developing the IPR focusing on analytics and insights.
- **Increased Effectiveness.** Achieve Data Security & Protection Toolkit (DSPT) compliance in 2026, with advancement in 2027, to strengthen data security and enable safe strategic research collaborations. In addition, we will drive overall cyber security maturity across our organisation
- **Increased Effectiveness.** Collaborate with SECAmb aligned to the new Group Leadership model to progress strategic and operational alignment for the benefit of the SE patients. Collaborate with Digital colleagues in SASC on the core workstreams identified.

Compliance

- Data Security and Protection Toolkit (DSPT) compliance.
- BDO Internal Audit

Tier 1: Fit for the Future Strategic Transformation Priorities

Blue Light Platforms 2.0

- Deliver a new Computer Aided Dispatch (CAD) system, ensuring a safe and effective mobilisation that is focused on safe clinical care in collaboration with SECAmb
- Improve Electronic Patient Record (ePR) system, whilst working with SASC colleagues in partnership to develop the future ePR requirements to improve and enhance patient care.

Nightingale: A Data-Driven Organisation

- Implement a data-driven transformation programme including upgrading our data infrastructure.
- Full implementation of Qlik-Sense to enable self-service analytics alongside transition to Cloud based hosting of the Qlik environment. Enables delivery of Time to Care under Clinical Effectiveness.

Watson AI\QI

- Develop and implement a AI pilot for staff training (as part of the Southern Ambulance Services Collaboration SASC).
- Develop and implement agent assistants to improve productivity and the service we provide to staff.

Tier 2: Annual Plan Priorities

Shield 24/7

- Deliver a Cyber Security Strategic plan focused on ensuring safety and availability of systems facilitating the provision of services to our patients.
- Achieve DSPT accreditation again in 2026/27 and work with partner Ambulance Trusts to further mature our Cyber Security platform.
- Continue to modernise our platforms and systems to ensure the highest levels of Confidentiality, Integrity and Availability across our core services

Caring with Digital

- Continue to modernise applications involved in the delivery of the safeguarding services.
- Deliver the M365 move to Central Tenant improving cost efficiencies and productivity.
- Embrace new technologies such as CoPilot AI & PowerApps to transform and automate our productivity processes and procedures

Board Assurance Framework Risks

Digitalisation: If we do not improve our digital capacity and capability, then our ability to modernise workplace practices could be compromised, resulting in failure to meet efficiency and operational targets and poor staff morale.

Safe and secure information systems: If we do not ensure our systems are safe and secure, then we could be the victim of a cyber security breach, resulting in a loss of service, disruption and potential regulatory action.



Enabling Services

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

Outcomes 2026 - 2028

- **Improved Responsiveness.** Support improvement in effective delivery of **care**, changing the vehicle mix to include more solo response vehicles over the next three years reflecting our emerging clinical model, and by the end of 27/28, SCAS will have no vehicles over five years old.
- **Improved Quality.** Enable frontline staff to deliver high quality and timely care, ensuring that we will have modern and **efficient** buildings that support our staff to work **effectively** and deliver our Net Zero ambitions.
- **Improve Environmental Sustainability.** Continue to enhance essential infrastructure, expanding Electric Vehicle (EV) fleet meeting a greater proportion of energy needs through renewable energy sources, contributing to SCAS financial savings targets.

Compliance

- Health and Safety at Work Act

Tier 1: Fit for the Future Transformation Priorities

Fleet Modernisation

- Ensure we have sufficient vehicles to meet patient demand and provide timely and safe care, by carrying out a “Lean” fleet QI programme.
- Develop a new Vehicle Commissioning Unit (VCU) in Eastleigh, expanding capacity with a view to expansion of services in the future. Creating a centre of excellence for vehicle commissioning.
- Secure converter capacity and capability.
- Minimise vehicles off road, ensuring our staff can respond effectively to patients by increasing available workshop capacity (Aylesbury) and work more efficiently, including the use of mobile services.

Estate Modernisation

- Provide a modern, efficient and safe working environment, that supports staff to deliver high quality care, by delivering an ongoing programme to transform and modernise sites, reducing backlog maintenance taking every opportunity to develop our Hub and Spoke estates model
- Develop, socialise and approve a Strategic Estates Plan, in collaboration with SECamb, setting out our ambitions to develop call centre capacity and capability and ambulance hubs across our geography improving response times and increasing care navigation.

Tier 2: Annual Plan Priorities

- Environmental Sustainability – Continued rollout of supporting infrastructure for fleet electrification and expand renewable energy generation and efficiency measures (including contribution to CIPs).

Board Assurance Framework Risks

Fleet Improvement Plan: IF we do not improve our fleet productivity, **THEN** we will not have sufficient vehicles to meet demand, **RESULTING** in the potential for avoidable harm or death.

Estates Modernisation: IF we do not develop and agree the strategic case for change in our estate, **THEN** we will not be able to secure capital to deliver the hub model over time, **RESULTING** in a disproportionate increase in backlog maintenance, statutory breaches, impeded operational delivery, detrimental patient care.



People and Culture

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

Outcomes 2026 - 2028

- **Improving safety** – To be clear what our values are, what we expect as behaviours and we tackle the unacceptable so that people work in a climate of respect wherever they are in the organisation and their physical and psychological safety is also protected. Openness, inclusion and transparency are encouraged.
- **People feel valued** – People across the organisation can express what matters to them, have that heard and acted upon. They get feedback about the steps which have been taken. People have permission to make a difference where they can.
- **Improving leadership** - All leaders across the Trust are visible, compassionate, and accountable and meet the core professional standards of our leadership framework. They live our values and behaviours, communicate effectively, confidently manage performance, finance and workforce ensuring we deliver on our Trust strategic and annual plan targets.
- **Improve morale** – 45% of our staff recommend SCAS as a place to work in the 2026 staff survey, rising to 55% in 2028.
- **Improving wellbeing** – improve the sickness rates with relation to mental health

Compliance

- NHSE Sexual Safety Charter Commitments & Worker Protection Act
- Equality Act
- NHSE Management & Leadership Competency Framework

Tier 1: Fit for the Future Transformation Priorities

Building Trust Together

- Improve people feeling safe - Deliver the Sexual Safety Programme to strengthen psychological safety, improve reporting confidence, embed preventative approaches, and demonstrate measurable progress against the NHS Sexual Safety Charter Principles.
- Improve behaviours - Launch and embed the refreshed co-created Trust Values and Behaviours Framework, ensuring leaders visibly role model expected behaviours and staff experience greater consistency, accountability, and respect in everyday practice.
- Strengthen Leadership Capability & Quality of Conversations - Develop confident, compassionate leaders who are equipped to hold effective conversations around wellbeing, behaviours, performance, and inclusion through implementation and continuous enhancement of leadership development programmes.
- Improve Staff Engagement & Local Voice - Deliver staff-informed engagement initiatives improving experience, responsiveness and communication. Describe positive change made through visible feedback loops.
- Improve Inclusion, Representation & Belonging - Strengthen equality, diversity, and inclusion by empowering staff networks, increasing visibility and representation through initiatives such as See Me First, and developing targeted leadership opportunities including the Women's Leadership Initiative.

Education Modernisation

- Undertake a comprehensive education review, benchmarking against latest sector standard practices, developing a case for change
- Identify and implement short term in-year efficiencies and develop a multi-year improvement plan.
- New career pathways and career progression, deliver career development opportunities for all staff

Tier 2: Annual Plan Priorities

People Services

- Embed Employee Relations (ER) process enhancements, ensuring fair and timely case resolutions
- Improve Payroll accuracies, explore joint opportunities with SECamb
- Address short and long term sickness through Wellbeing Support review, mental health deep dive and action plan, explore Occupational Health opportunities with SECamb

Recruitment Optimisation

- Ensure we have the right people and right skills via a comprehensive review of recruitment processes and policy, branding and approach, including EDI with a focus on improving recruitment into the Integrated Call Centres

Board Assurance Framework Risks

IF staff do not feel psychologically safe in their workplace and our leaders are not inclusive and compassionate, **THEN** the Trust's culture will not change, **RESULTING IN** continued high levels of sickness and attrition compromising our ability to deliver safe and effective care to patients.



Partnerships and Sustainability

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

Outcomes 2026 - 2028

- **Improve financial sustainability.** Seek equitable commissioning funding across the South East and manage our cost base to deliver a financial surplus.
- **Improve patient outcomes.** Improve the **effectiveness** of our organisation and of care across the South East region by delivering the benefits described within our collaboration programme.
- **Improve productivity.** Ensure that we increase our productivity by effectively using benchmarking to remove waste and drive down costs across the organisation.
- **Increase accountability.** Through the implementation of new operational management structures and implementation of an effective Performance and Accountability approach.

Tier 1: Fit for the Future Transformation Priorities

Financial Sustainability

- Strengthen the Multiyear Planning processes, creating an annual cycle to ensure continuous monitoring and improvement across the dimensions of performance, workforce and finance.
- Develop and begin implementation of 3-year productivity plan – linked across all five strategic pillars and including research and innovation development
- Deliver the agreed Capital and Infrastructure plan.

Collaboration and Partnerships

- **Strategic Commissioning** development across the South East (joint with SECamb) focused on levelling out commissioning expectations and funding across 999 and 111 services.
- **Organisational model** – Develop blueprint design and transitional governance.
- Formulate clear response to **new lead commissioner arrangements**, including opportunities for vertical integration.
- Continue to develop the Sothorn Ambulance Services Collaboration
- Work with ICBS to secure the future of Patient transport services

Tier 2: Annual Plan Priorities

- **Cost Improvement Plan delivery** - Deliver In-year Financial Recovery Plan
- **Performance and Accountability** - Enable leaders to be responsible & accountable for performance, finance, people and behaviours, through the implementation of a revised Performance and Accountability framework

Board Assurance Framework Risks

Sustainability: 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.

Collaboration: IF we do not effectively manage our collaboration with SECamb and other partners, THEN this will lead to financial and operational instability, and an inability to realise productivity and efficiency gains, RESULTING in reputational damage with stakeholders and partners, and increased oversight and scrutiny of SCAS's operating and strategic approach.



Delivery Actions by Quarter

Clinical quality, safety, and learning culture throughout

Tier 1 Strategic Transformation - Improvement Plan 2026/27

Strategic Theme	Objectives	Q1 delivery actions	Q2 delivery actions	Q3 delivery actions	Q4 delivery actions
Clinical Effectiveness	Virtual Care Improve access to timely clinical care for patients by increasing clinical capacity, modernising dispatch, improving job satisfaction and retention and agree joint principles and outcome measures with SECamb	- New ICC clinical and deployment structure in place. - Implement new team leader training. - Dispatch workshop to finalise modernisation action plan. - Recruitment and retention action plan published	- Deliver revised SOPs to reduce cognitive load on staff - CSD Recruitment to 99.0 WTE - Tactical Performance Manager role fully functional 24/7. - Develop alternative SPOA delivery model.	- Analyse impact of Pre Sieve Trial and implement positive changes - Deliver CSD rota cover benefits, cover gaps & improve performance - Complete Workforce Management Tool procurement (joint with SECamb) - Analyse impact of new NLP in 111, confirm benefits realisation.	- Delivery of CAT 1 auto-divert improvements - Full implementation of Attend Incident - Maximise use of GoodSAM across all ICC areas. - Analyse evidence & agree go / no go for an Incident Command Desk.
	Pathways of Care Improve quality and patient experience by increasing pathways utilisation and standardising specialist care access while reducing unnecessary conveyance and health inequalities.	- Joint Pathways of Care Plan agreed SCAS & SECamb - Agree Business Case to increase SP numbers	- Align SCAS and SECamb pathways - C2 deployment trials with SPOs - Complete baseline assessment of Tertiary and Specialist pathways	- Joint SCAS and SECamb pathways of care team proposal complete - Agree and implement exemplar pathways across both Trusts	- Consultation commenced for joint team if required. - Yr 1 outcome report and yr 2 pathways of care plan shared with commissioners.
	Medicines Optimisation Achieve regulatory compliance	Complete roll out Personal Issue Controlled Drugs (PICD) across Trust	- Approval for Electronic Track and Trace business case - Start Pilot Electronic Track and Trace	- Start procurement for Electronic Track and Trace system - Complete Pilot electronic track and trace	Complete procurement for Electronic Track and Trace project
	Time to Care Improve productivity, performance and staff engagement through a locally led, data-driven QI approach that empowers teams to redesign workflows, reduce variation and release clinical capacity.	- Appoint new QI facilitator. - Complete data review into 'lost hours' - Identify named QI lead per sector. - Operations QI Group in place.	- QI Champions training complete. - QI Peer network in place. - At least three QI cycles per sector (1 per month) focussed on job cycle time and/or reduction in lost hours.	- National QI week event in place - Internal QI training plan scoped	27/28 QI plan agreed.
Digital Transformation	Improved Productivity – Blue Light Platforms 2.0 - improve the safety and quality of service to patients by having a modern dispatch system through the implementation of new CAD and ePR systems .	- Gap analysis and clarification document finalised - QI and EIA for CAD project completed - Finalise Specification	Carry out and Complete formal tender process	- Full business case approval - Contract Award	Commence Mobilisation
	Improved Productivity – Nightingale: A Data-Driven Organisation. Become a data-driven organisation through the delivery of a Data-Driven programme of work, new Datawarehouse and full implementation of Qlik Sense.	- Programme mobilisation & governance established - Scope validation & stakeholder engagement - Data platform (DW) design initiated with costed options appraisal	- Data warehouse approach agreed. Work commences - Data definitions completed with SECamb for 999, 111 clinical, ESR and GRS data sources - Qlik visualisation environment proposal scoped	- Organisational data model design completed - Information Literacy programme development - Delivery programme agreed with all directorates	- Delivery of Sub Committee reporting capability - Deliver and complete data quality programme throughout SCAS - Removal of shadow DA&I functions across SCAS
	Improved Productivity – Watson AI/QI. Seek out opportunities where AI can enhance decision-making, support staff, and improve patient experience by running a set of pilots in 26/27.	- Governance & assurance established - AI Pilot Business Case completed - Baseline assessment & user case prioritised	- AI staff training plan agreed - Watson AI Agents Use Case development - Funding Approval outcome - AI Staff training Pilot mobilisation 111 NLP testing	- AI Staff training Pilot - Watson AI Pilot agent 1 mobilised 111 NLP benefits realisation	- AI Staff training Benefits Evaluation & Scale up recommendation - Watson year 2 plan defined

Tier 1 Strategic Transformation - Improvement Plan 2026/27

Strategic Theme	Objectives	Q1 delivery actions	Q2 delivery actions	Q3 delivery actions	Q4 delivery actions
Enabling Services	Fleet Optimisation and Improvement to improve resilience and efficiency	- Establish cross-Trust Programme Board - Capture all fleet initiatives into a single Portfolio - Initiate End to End Process Mapping - Identify Priority Pilot Areas - Agree Pilot areas and Objectives	- Align Priorities with Digital, Business Intelligence, Estates Fleet and Operations & agree shared KPIs and definitions - Validate , VOR, Commissioning and Capacity Data - Design Commissioning, SoP, Scheduling Pilots	- Apply Programme and KPI data for decisions - Review governance effectiveness - Establish agreed performance baselines - Consolidate data sources into centralised fleet data structure - Launch live Lean Pilot within VCU	- Complete year 1 governance review and confirm year 2 priorities - Finalise single version of truth - Evaluate outcomes from pilots - Agree scale/ amend/ stop decisions.
	Estates Modernisation to align with sector operations plans	- Trust Board approve estates plan - Secure National Funding for Make Ready Hub and set up programme of work - Agree Estates work plan for year	Further Milestones to follow based on funding recieved	Scope and commission Joint Strategic Estates Review	
People and Culture	Building Trust Together To create a safer, more inclusive and engaged workplace culture through strengthened leadership, improved behaviours and wellbeing support, meaningful staff engagement, high quality conversations and delivery of key people and ED&I initiatives.	- Finalise Sexual Misconduct Policy - Senior Leader Sexual Safety development 'The Wolf we Feed' - Organise and deliver the first Senior Leadership symposium - Formal Board sign-off of refreshed Values & Behaviours and launch - Establish Culture Champion network	- Rollout multidisciplinary sexual safety triage and review process. - Exec and Senior leaders V&B walkabouts and local leadership sessions - Create plan to update all policies with refreshed values, values into induction - Launch Every Conversation Counts toolkits & weekly drop in sessions - Unity and Diversity conference and consult on creating Anti-racism charter	- Gap analysis of Sexual Safety Self-assessment, review action plan. - Submission of Sexual Safety prevention action plan to NHSE 2nd Leadership Symposium - Continue to embed values into policies and into recruitment processes - Launch nominations aligned to values on the new Each Person Counts platform	- Deliver local sexual safety action plans - Align PDR to NHSE PDR framework - Evaluate Senior Leader Development Programme. - End of year V&B evaluation, refresh materials/activities based on feedback - Disability Confident Leader self-assessment, gap analysis and plan.
	Education Modernisation Deliver a 3-year education modernisation strategy, improve efficiency through a rolling improvement programme, and expand CPD access to at least 85% of staff groups by Q4 2026/27	- Appoint Associate Director - Complete education/TNA and cost/performance baselines (begin ICC integration). - Benchmark against best practice; identify efficiencies and agree targets. - Map provision, identify gaps, and define focussed CPD offer.	- Define priorities and operating model, complete benchmarking and gap analysis, draft strategy and roadmap (staff engagement). - Implement quick wins, track early savings (including ≥10% non-pay reduction). - Begin rollout of focussed CPD offer across wider staff groups.	- Final draft of 3-year strategy with KPIs, refine through engagement, secure executive approval. - Expand efficiency initiatives and launch 3-year continuous improvement plan. - Ensure CPD access, monitor uptake, and introduce career development pathways.	- Begin implementation of priority elements, establish reporting framework (ensure ICC integration). - Deliver ≥85% of identified efficiency actions and embed ongoing performance tracking. - Achieve ≥85% workforce access, evaluate outcomes, and refine/ embed the CPD offer
Partnerships and Sustainability	Financial Sustainability Strengthen multiyear planning processes and create continuous cycle, develop three year productivity plan and deliver agreed capital and infrastructure plan	- Complete review of planning process - Implement Innovation process - Fully work up CIP programme	- Undertake formal six-month review - Revise planning model - Review of innovation process - Ensure CIP programme of work is on track	- Commence formal planning process - Set up CIP planning process for 27/28 and beyond	- Conclude next iteration of 3-year plan - Complete CIP Plan prior to year end
	Collaboration and Partnerships Develop strategic commissioning across South East, develop blueprint for group organisational design	- Transitional governance in place - Interim chief executives appointed - Joint programmes of work signed off and started (see programmes including CAD and Clinical Model)	Group Chair to Start	Group Chief Executive to Start	

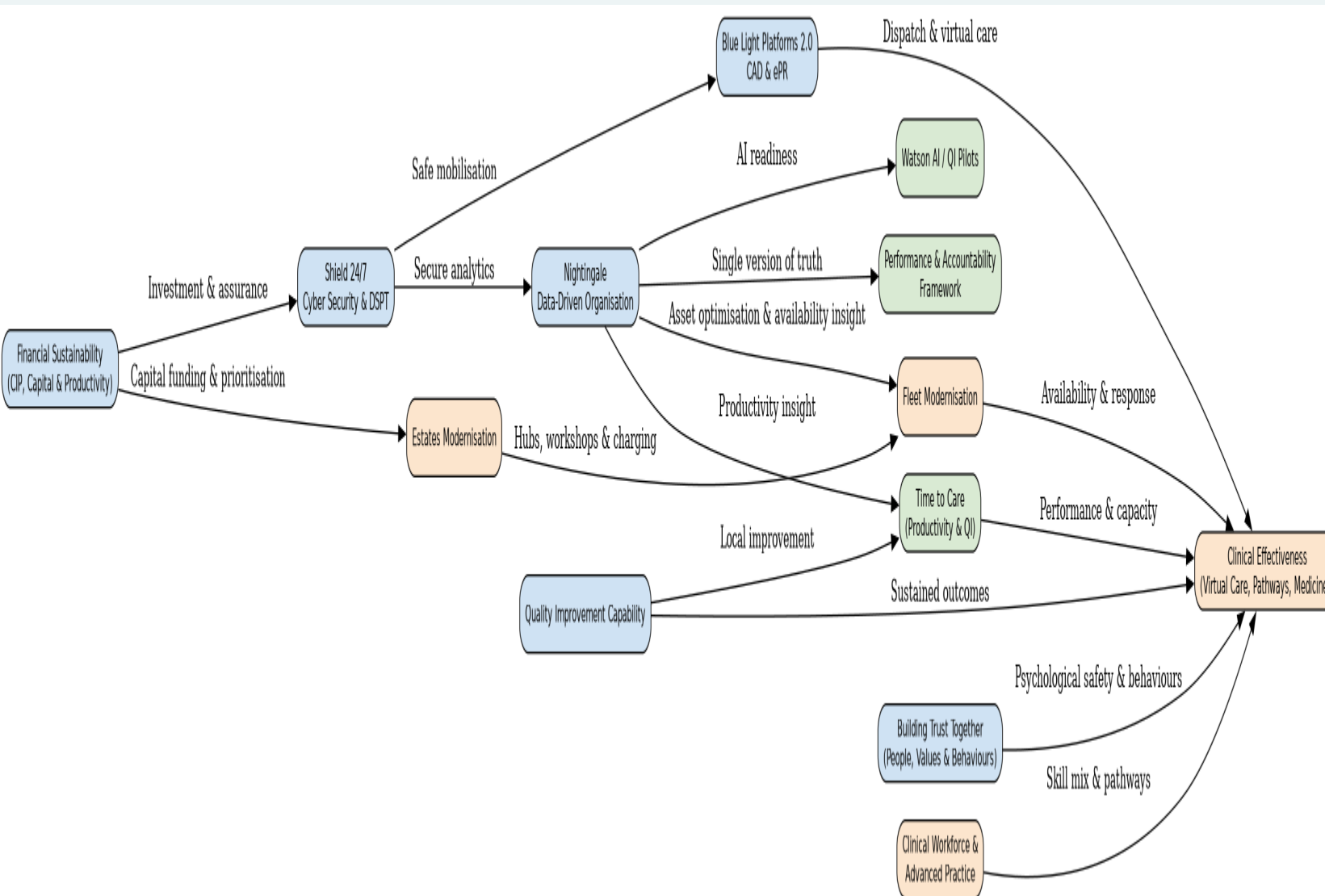
Tier 2 Operational Objectives 2026/27

Strategic Theme	Objectives	Q1 delivery actions	Q2 delivery actions	Q3 delivery actions	Q4 delivery actions
Clinical Effectiveness	Patient Safety & Experience	- Deliver PSIRF Lite training to reps - Complete gap analysis of Experience of Care Framework - Priority themes and est. baseline metrics - Design a Maternity Services Steering Group, meeting schedule established.	- Deliver module 2: Engaging Patient, Family & Staff training to reps - Begin implementation of Experience of Care improvement plan - Launch maternity & neonatal steering group and workplan agreed.	- Deliver module 3: After Action Review (AAR) training to service line reps. - Improvement in ≥ 2 key Experience of Care metrics - Deliver against steering group work plan	- Audit frequency, quality and timeliness of AARs undertaken within service lines. - Evaluate Experience of Care outcomes and evaluation report complete. - Complete thematic review on maternity and neonatal services. Review signed off and ≥3 themes identified
	Clinical Supervision Framework	- Establish steering group and T&F group - Plan in place to address skills gap - Clinical Supervision Framework ratified - Agree data reporting	- Pilot site launch - TBD following initial scoping	- Review of pilot, adapt plan if required - Create roll out plan for other organisational functions - Review framework, update if required.	- Assurance to Board that Clinical Supervision is in place - Begin roll out across 999 Ops Function
	Clinical Workforce	- Agree TOR and funding for joint Advanced practice review - Framework for business case agreed. - Gap analysis against HEE framework.	- Board endorsed business case - Complete joint SCAS & SECamb Advanced Practice review	- Develop shared principles with SECamb, agree delivery future SE Operating Model - Advanced Care workforce planning for Yr2 / 3 of multi-year plan. - Education and support plan for 27/28	External HEE funding secured for 6 WTE Advanced Care Practitioners.
Enabling Services	Environmental Sustainability	- Submit NHS National Chargepoint Accelerator Scheme (NCAS) 2026-27 bid - Submit GB Energy Solar PV bid	- Complete DNO upgrades (Basingstoke, Kidlington, Stoke Mandeville) - Aylesbury Workshops EV charging installation with Dynamic Load Management completed	Climate Adaption Plan completed and approved	- Sustainable Travel Plan approved - Ongoing grant applications through-year from Q2-Q4
Digital Transformation	Shield 24/7	Discovery Phase	Discovery Phase Continued	- Evidence of improvement required against maturity baseline - Deliver Cyber Strategy Plan	Review Cyber Plan for year 2 to 4 Activities
	Caring with Digital	- M365 Central Tenant Migration - SQL estate rationalisation - DocWorks Migration	- M365 applications implemented - Safeguarding in UAT	- CoPilot mobilisation - Safeguarding Deployment - GP Notification of Attendance	- CoPilot rollout - Falls & TIA
People and Culture	People Services	- Implement ER case dashboard - Proactive & prevention trauma support Mental Health First Aiders training - Reduce DBS backlog. Submit BC to automate Pay steps - Payroll Invitation to tender (ITT)	- ITT Occupational Health out to tender - Launch Mental Health First Aider Network - TRIM training (SECamb Collab) - BC to move Registration checks to Ops, - Manager Self Service roll out (phase 1) - Evaluate payroll tender submissions	- ITT Occupational Health contract awarded - Evaluate impact of Mental Health First Aider network and training. - Improve BI reporting from SBS portal - Award Payroll contract	- Begin implementation new OH service - Evaluation of TRIM Training, assess impact. - On board and begin payroll implementation.
	Recruitment Optimisation	- Overhaul Shortlisting process (ICC) - Hiring Manager experience survey and create action plan - Review progression pathway - Best practice sharing with SECamb	- Increase no. 'Interview skills' trained managers, improve assessment process - Vacancy control guidance & TRAC training - Establish Talent Pool - Embed Health passports, increase bias trained interviewers	- Review attraction strategy & brand - Centralised JD repository complete - Align IWPs with internal jobs, clear career pathways	- Job Evaluation centralised / controlled - Joint Talent Pool SECamb - Disability confident Leader self-assessment analyse gaps, create plan
Partnerships and Sustainability	CIP Plan delivery	- Complete CIP identification and delivery passports - Q1 delivery	- Commence CIP identification for 27/28 - Q2 delivery	- Confirm CIP requirement as part of planning process, continue - Q3 delivery	- Develop CIP Passports for 27/28 - Q4 delivery
	Performance and Accountability	- Establish Performance Reviews - Develop revised score card - Undertake Gap analysis	- Agree new Framework - Define Subcommittee scorecard - Agree plan for automation	Hold first corporate meetings	Hold first face to face corporate meetings

Plan Dependencies

The graphic below shows the key dependencies in the plan at a high level

(note this graphic does not cover all programmes in the plan as some can be managed largely as stand-alone programmes).



Foundational Enablers– shown as blue.

These are *non-negotiable prerequisites for delivery* :

- **Financial Sustainability** - underpins our ability to deliver services and engage in transformation
- **Shield 24/7 (Cyber & DSPT)** – patient safety, resilience, regulatory assurance
- **Nightingale (Data-Driven Organisation)** – single version of truth, insight, AI readiness
- **Blue Light Platforms 2.0 (CAD & ePR)** – modern mobilisation and clinical workflow
- **Quality Improvement Capability** – sustainable change, not one-off projects
- **Building Trust Together** – psychological safety, trust and culture

Operational Enablers – Shown as Green

These convert foundations into *measurable performance*:

- **Time to Care** – productivity unlocked through data + QI
- **Performance & Accountability Framework** – grip, transparency, outcomes
- **Watson AI / QI Pilots** – targeted automation and decision support

Outcome Delivery – shown as orange

These are the outcomes the system ultimately cares about:

- **Clinical Effectiveness** (virtual care, pathways, medicines optimisation)
- **Fleet Modernisation**
- **Estates Modernisation**
- **Clinical Operating model**



Key Indicator Metrics

Clinical quality, safety, and learning culture throughout

Tier 1 Key Indicator Metrics 2026/27							
Strategic Theme	Objective	Key Indicator Metric	Baseline	Q1	Q2	Q3	Q4
Clinical Effectiveness	Virtual Care Improve access to timely clinical care for patients by increasing clinical capacity, modernising dispatch, improving job satisfaction and retention and agree joint principles and outcome measures with SECamb	% Hear and Treat	17.28%	20%	20%	20%	20%
		999 mean call answer < 10 secs	4 secs	< 10 Secs	< 10 Secs	< 10 secs	<10 secs
		111 call answer SLA	62.7%	81.2%	95.8%	90.5%	98.8%
		Dispatch Response Ratio	1.13	1.12	1.11	1.11	1.10
	Pathways of Care To improve quality and patient experience by aligning SCAS and SECamb pathways, increasing utilisation and standardising specialist care access to ensure patients receive the right care first time while reducing unnecessary conveyance and health inequalities.	S&T	30.6%	29%	29%	29%	29%
		STC to Non-ED	4%	4%	4%	4%	4%
	Medicines Optimisation	Personal Issue of Controlled Drugs	8%	80%	95%	100%	100%
	Time to Care To improve productivity, performance and staff engagement through a locally led, data-driven Quality Improvement approach that empowers teams to redesign workflows, reduce variation and release clinical capacity sustainably.	Cat 2 Performance	30.02	As per monthly trajectory (IPR)			27:30
		Task Time (exc. handover) (2:25 reduction)	1:48:06	1:45:41	1:45:41	1:45:41	1:45:41
		Lost Hours (10% reduction)	61,509	13,893	27,678	41,518	55,357
Digital Transformation	Blue Light Platforms 2.0	Contract Awarded	-	-		Yes/No	
		CAD Mobilisation	0	-	-	-	20%
		CAD Edge switches replaced	0	-	19	38	38
		CAD distribution Switches replaced	0	-	7	14	14
	Nightingale – Data Driven	% reduction in manual reporting	0	0	0	+20%	+30%
		% of Qlik Dashboard utilisation	0	0	0	0	+80%
		Data Quality improvement	0	0	0	+10%	+20%
	Watson AI / QI	No of AI Pilots mobilised	0	0	1+	2+	3+

Tier 1 Key Indicator Metrics 2026/27							
Strategic Theme	Objective	Key Indicator Metric	Baseline	Q1	Q2	Q3	Q4
Enabling Services	Fleet modernisation to improve resilience and efficiency	Fleet size variance (planned/actual) at Q-end	+/-0%	+/-0%	+/-0%	+10%	+10%
		Average vehicle availability	60%	60%	60%	60%	60%
		Average VOR (Mechanical)	28.5%	26%	23.5%	21%	18.5%
	Estate modernisation to align with sector operations plans	% Estates plan delivered	0%	15%	30%	60%	>80%
		% Reduction in Backlog Maintenance	£60.5M (100%)	+/-0%	+/-0%	+/-0%	-10%
People and Culture	Building Trust Together To create a safer, more inclusive and engaged workplace culture through strengthened leadership, improved behaviours and wellbeing support, meaningful staff engagement, high quality conversations and delivery of key people and ED&I initiatives.	Average time to Commission CoF (weeks)	8.9	8.9	6.5	5	3
		Time taken for Sexual Safety CoF (weeks)	13.5	13.5	10.5	9	8
		% Staff recommend SCAS as place to work	22.7%	Sustained Increase on baseline			
		Employee engagement score (NQPS)	4.91	5%	5.2%	N/A	5.7%
	Education Modernisation Deliver a 3-year education modernisation strategy, improve efficiency through a rolling improvement programme, and expand CPD access to at least 85% of staff groups by Q4 2026/27	CPD coverage (available places across offer)	282 (Q4 25/26)	450	500	350	250
		CPD split (clinical / non-clinical)	65% : 35%	65% : 35%	65% : 35%	65% : 35%	65% : 35%
		Course capacity fill rate (All courses)	75% (25/26)	75%	78%	80%	82%
		Maintain quality while delivering change: Learner Voice – ‘overall I am satisfied with the quality of the course/learning/activity’	90% (25/26, not incl CPD	90%	90%	90%	90%
Partnerships and Sustainability	Financial Sustainability To strengthen multiyear planning processes, implement a 3-year productivity plan and deliver the capital plan	Cash Management (delivery to forecast)					
		Delivery against budget	Measured through monthly Finance Update				
		Implied Productivity	Measured through NOF framework				
		% capital plan delivered	0%	10%	40%	70%	100%
	Collaboration and Partnerships	No Metrics in this year – measurement will be through milestone achievement					

Tier 2 Key Indicator Metrics 2026/27							
Strategic Theme	Objective	Key Indicator Metric	Baseline	Q1	Q2	Q3	Q4
Clinical Effectiveness	Patient Safety & Experience Strengthen patient safety, experience and equity through embedding PSIRF, increasing front line ownership, enhancing patient co-design and improving maternity & neonatal care pathways	% of staff trained in PSIRF modules Experience of Care – completion rate of actions (35)	0% 0	Module 1: 90% 10	Module 2: 90% 20	Module 3: 90% 30	All Modules: 90% 35
	Clinical Supervision Framework	No Metrics this year – delivery will be measured through milestone achievements					
	Clinical Workforce	No Metrics this year – delivery will be measured through milestone achievements					
Digital Transformation	Shield 24/7	Cyber Maturing Improvement Plan (Year 1 of 4)	Bytes Assessment	30%	60%	100%	100%
		No. of 'denial of service' incidents	0	0	0	0	0
People and Culture	People Services	ER case investigation time (calendar days)	50	48	46	44	42
		Time taken to resolve level 3 pay queries (days)	30	25	20	18	10-15
		Reduction in overpayment / underpayments (£000)	702 pa (58pm)	50	40	30	20
	Recruitment Optimisation Deliver a skilled, diverse and sustainable workforce through streamlined, inclusive recruitment, stronger hiring manager accountability, reducing workforce gaps and costs.	Reduce Time to Hire	12 weeks	12Weeks	11 Weeks	11 Weeks	10 weeks
Partnerships and Sustainability	CIP Plan delivery	% of CIP Plan delivered	0	21%	46%	71%	100%
	Performance and Accountability	No Metrics this year – delivery will be measured through milestone achievements					



Key Areas of Risk

Clinical quality, safety, and learning culture throughout

Key Areas of Risk #1

Risk	Description	Drivers	Mitigations
Patient Safety, Quality and Outcomes	If the Trust does not deliver sustained improvement in clinical pathways, response performance and clinical workforce capability, then patients may not consistently receive timely, safe and effective care, resulting in avoidable harm, increased health inequalities, regulatory concern and loss of public confidence.	- High demand and system pressure outside Trust control, - Dependency on successful pathway redesign and system collaboration - Reliance on workforce availability and skill mix	- Clinical Effectiveness programme with defined outcomes, metrics and benefits. - Embedding PSIRF, clinical supervision and structured learning to reduce harm. - Standardisation of priority pathways across partners.
Delivery Capacity and Pace of Change	If the scale and complexity of transformation exceeds the Trust's delivery capacity, then programmes may slip, interdependencies may not be managed effectively, resulting in partial delivery, change fatigue and failure to realise intended benefits.	- Multiple concurrent Tier 1 and Tier 2 initiatives - Shared dependencies across digital, workforce and operational change - Finite leadership and programme management capacity	- Clear prioritisation with permission to stop or pause lower-value activity. - Strong programme governance, with SRO accountability and escalation routes. - Active dependency management across programmes, reported to the Board. - Board oversight focused on capacity, sequencing and benefits, not activity.
Digital Transformation and Technology Risk	If digital platforms (CAD, ePR, data and analytics) are not delivered safely, on time and adopted effectively, then operational performance, staff productivity and patient safety may be compromised, resulting in service disruption, reputational damage and scrutiny.	- Large-scale system change in a live operational environment - Reliance on suppliers, procurement and interoperability - Workforce adoption and digital maturity	- Phased, safety-led implementation with clinical assurance embedded throughout. - Clear separation between strategic digital enablement and local optimisation. - Strong cyber security and data protection controls - Board assurance on readiness, resilience and fallback arrangements.
Workforce, Culture and Leadership	If staff do not experience improved psychological safety, leadership consistency and wellbeing, then sickness absence, attrition and disengagement may persist, resulting in reduced service capacity, poorer patient experience and failure to deliver transformation.	- Legacy cultural issues and variation in leadership capability - Ongoing operational pressure on staff - Trust-wide change coinciding with system-level change	- Delivery of the People & Culture Tier 1 programme with explicit outcomes. - Clear leadership standards and accountability for behaviours. - Integration of wellbeing, sexual safety and inclusion work into "business as usual". - Board oversight of culture indicators triangulated with qualitative intelligence.

Key Areas of Risk #2

Risk	Description	Drivers	Mitigations
Financial Sustainability and Productivity	If the Trust does not deliver productivity improvement and cost control alongside transformation, then financial pressures may limit the Trust's ability to invest and sustain improvement, resulting in short-term fixes, increased external oversight and constrained strategic choice.	• Rising demand and cost inflation • Dependency on system funding and commissioning decisions • Benefits from transformation realised over multiple years	• Alignment of financial recovery, productivity and transformation into a single, coherent plan with clear ownership of benefits realisation. • Multi-year financial planning linked to workforce and service models. • Board assurance that CIPs are credible, recurrent and quality-impact assessed.
System Collaboration and External Dependency	If collaboration with system partners is not effectively governed and aligned, then expected benefits from shared models and joint programmes may not materialise, resulting in operational friction, financial instability and reputational risk.	• Different organisational priorities, incentives and timescales • Complexity of shared governance and accountability • Dependence on external decisions outside Trust control	• Transitional governance arrangements with clear escalation routes. • Explicit understanding of which risks are shared and which remain Trust-owned. • Regular Board-level review of collaboration risks and benefits.
Assurance, Oversight and Transparency	If the Board does not have clear, timely and triangulated assurance on delivery, risk and benefits, then emerging issues may not be identified early enough, resulting in reactive management and loss of confidence in the plan.	• Volume and complexity of information • Lagging indicators dominating reporting • Inconsistent assurance across programmes	• Streamlined reporting focused on risk, trajectory and benefits, not narrative. • Explicit mapping between the plan and Board Assurance Framework risks. • Regular deep dives into Tier 1 programmes, with independent challenge. • Clear triggers for escalation and intervention.



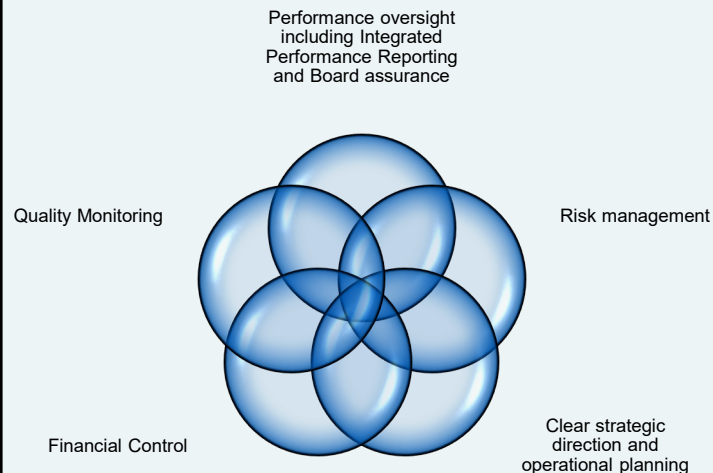
Governance

Clinical quality, safety, and learning culture throughout

Improvement Plan Governance

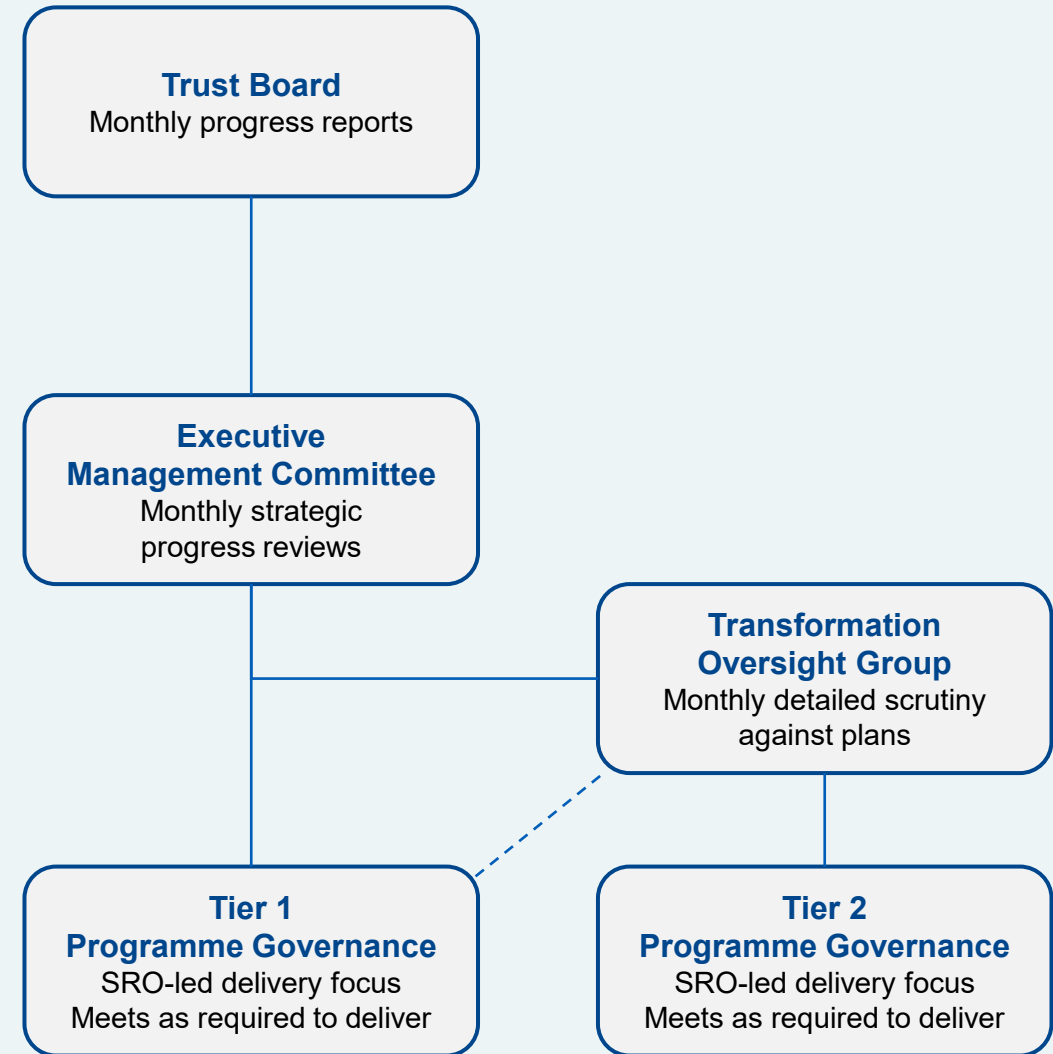
- The governance of our Plan sits within our wider governance oversight framework which includes effective Board scrutiny, strengthening performance oversight, quality monitoring, financial control and risk management.
- Our dedicated programme governance ensures integration from the Board to project delivery level for Tier 1 and Tier 2 programmes via the Executive Management Committee.
- Each Board Sub-Committee, will oversee their element of plan delivery to provide added assurance to the Board that the plan is being delivered as described, challenging the executive team on further developing strategic and improvement capability within the organisation.

Organisational Oversight



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

Strategic Improvement Plan Oversight



Glossary

AAR	After Action Review	ESR	Electronic Staff Record	PV	Photovoltaic (in relation to solar energy)
AI	Artificial Intelligence	Exec	SCAS Executive Team	QI	Quality Improvement (change methodology)
BC	Business Case	GoodSam	Video triage software	S&T	See and Treat
BDO	Accountancy firm (SCAS auditors)	GRS	Resource Management Software e.g. shift management	SASC	Southern Ambulance Services Collaborative
BI	Business Intelligence	HEE	Health Education England	SCAS	South Central Ambulance Service
C2	Category 2 (ambulance response)	ICB	Integrated Care Board	SECAmb	South East Coast Ambulance Service
CAD	Computer Aided Dispatch System	ICC	Integrated Contact Centre	SLA	Service Level Agreement
Cat 1	Category 1 (ambulance response)	IPR	Integrated Performance Report	SOP	Standard Operating Procedure
CIP	Cost Improvement Programme	ITT	Invitation to Tender	SP	Specialist Practitioner
CoF	Collation of Facts (in relation to an employee relations case)	IWP	Integrated Workforce Plan (relates largely to front line staff)	SPOA	Single Point of Access
CPD	Continuing Professional Development	JD	Job Description	SQL	Structured Query Language (used in the context of relational databases)
CSD	Clinical Support Desk (part of ICC)	KPI	Key Performance Indicator	SRO	Senior Responsible Owner
DNO	Distribution Network Operator (in relation to electricity infrastructure)	M365	Microsoft 365 software	STC	See, Treat and Convey
DSPT	Data Security and Protection Toolkit	NHSE	National Health Service Executive - refers to NHS England	T&F	Task and Finish group
DW	Data Warehouse	NLP	Natural Language Processing	TIA	Transient Ischaemic Attack (mini-stroke)
ED	Emergency Department	NQPS	National Quarterly Pulse Survey	TNA	Training Needs Assessment
EDI	Equality Diversity and Inclusion	Ops	Refers to the Operations Directorate in SCAS	TOG	Transformation Oversight Group
EIA	Equality Impact Assessment	PDR	Personal Development Review	TRiM	Trauma Risk Management
EMC	Executive Management Committee	PICD	Personal Issue of Controlled Drugs	UAT	User Acceptance Testing (in relation to software development)
ePR	Electronic Patient Record	PSIRF	Patient Safety Incident Reporting Framework	V&B	Values and Behaviours
ER	Employee Relations	PTS	Patient Transport Services	VOR	Vehicle Off Road Rate



Upward Report of the Finance & Performance Committee

Date Meeting met 24th April 2026
Chair of Meeting Les Broude, Non-Executive Director
Reporting to Trust Board

Items	Issue	Action Owner	Action
Points for escalation			
Contract Register	Concerns were raised in relation to the number of red-rated contracts on the Contracts Register. Whilst it was noted that a forward look of business cases due in the next 18-24 months had been developed and that there were good reasons for some of the delays, a request was made for the dates to be brought forward by 3-months with escalation to the executive directors in place when action was not being taken in a timely way.	BM	Action as outlined in the narrative.
Key issues and / or Business matters to raise			
Operational Performance	The year end position was noted with continuing success in reducing handover delays. Whilst performance at the year-end for Cat 2 response times did not meet target (30.03 against a target of 30) it was an improvement on the previous year. Concerns were expressed in relation to the decrease in Hear & Treat performance and whilst mitigating actions were in train, it was noted that significant improvement would be required to meet the target for the year of 20%.	MA	Actions are in train and operational performance is subject to continuous monitoring
Financial Performance	It was noted that year 3 of the Financial Recovery Plan had been successfully delivered and the committee offered thanks to the finance and	N/A	N/A

	wider teams for delivery of a challenging plan, albeit, noting that the challenges continued into 2026/27.		
Incident Response Framework	The Committee recommends the Framework to the Trust Board for approval and noted the significant work that had taken place to develop it from the former policy to a framework	N/A	N/A
Vehicle Commissioning Unit Business Case	The business case was recommended to the Board for approval and was approved at the May meeting	N/A	N/A
Fleet Update	The committee noted that vehicle availability had significantly improved owing to the new Fleet coming on stream. Concerns remain however in relation to a stagnation in the improvements in charging compliance and will retain a watching brief in this regard as part of the suite of new Fleet KPIs which provide more detail than VOR rates alone	N/A	N/A
Estates Plan	The Committee reviewed the plan and recommended it to the Trust Board for approval. This was discussed at the May Board meeting	N/A	N/A
Areas of concern and / or Risks			
Operational Performance	Areas of concern as noted above.	N/A	N/A
Items for information and / or awareness			
Medicines Packing Business Case	A post implementation review of the business case for the in-house packing of medicines revealed that whilst operational resilience had improved as a result, the costs had significantly exceeded those set out in the case. The committee requested that lessons were learned and communicated in relation to development and assurance around business cases. The committee will continue to receive post implementation evaluations to ensure that benefits are realised and that lessons are learned.	N/A	N/A
Best Practice and / or Excellence			
None	Achievement of Year 3 of the Financial Recovery Plan	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			



TRUST BOARD OF DIRECTORS MEETING IN PUBLIC
3 June 2026

Report title	Integrated Performance Report (IPR) and Performance Scorecard
Agenda item	10
Report executive owner	Craig Ellis, Chief Digital Information Officer
Report author	Tina Lewis, Head of Performance & Planning
Governance Pathway: Previous consideration	Executive Management Committee (EMC) Finance & Performance Committee (FPC)
Governance Pathway: Next steps	

Executive Summary

Purpose and Scope:

The purpose of the Integrated Performance Report and the Performance Scorecard is to provide an overview of Trust performance across Operational, Quality & Safety, Workforce and Finance. This report covers April 2026, month 1 of the 2026/27 financial year.

The IPR builds on the 2025/26 version, whilst the performance scorecard is a refreshed version, under development, to consider the new 18 national oversight framework (NOF), annual planning and the Trusts strategic aims, as outlined within the Board Assurance Framework.

The Performance Scorecard is provided in **Appendix 1**, whilst the IPR is added as a separate document, **Appendix 2**.

During May 2026, the publishing and reporting system on which the IPR is located, experienced a failure and at the time of writing, work is on-going to recover the report and associated background data infrastructure.

Overall Performance Headlines & Risks – Month 1 (April 2026)

This report covers April 2026, Month 1 for the 2026/27 Financial Year reporting period.

Overall position:

Operational and workforce performance are below plan. Quality position is maintained, but further review of our clinical metrics is required. Financial position on plan.

- **Financial Performance:** Break even position with £3k favourable variance supported by CIP phasing
- **Operational performance** below trajectory for Category 2 and hospital handovers; exceeding performance for call answer
- **Workforce** establishment above requirement with Frontline operations. Sickness and Integrated Contact Centre (ICC) requirement impacting delivery of Hear & Treat

Key Risks:

- Recovery of Category 2 and Hear and Treat
- Frontline and ICC Establishment, capacity and sickness levels
- Financial sustainability, with risk to delivery of £19.7m CIP

Operational Performance:

Table 1: Operational Performance – Summary of assurance (from IPR)

Pass - Assurance	Fail - Assurance	No Data for April
% See & Treat Rate	Category 1 - Mean	n/a
	Category 3 – 90 th percentile	
	% Hear & Treat	
	Average time to Handover	
	Handovers < 15 mins	
	% Vehicle Off Road	
	% 111 Call back in time	
	% PTS Arrived within Time	

Delivery of our Category 1 – 3 national response targets remain challenging, with the focus on delivering a Category 2 full year position of 27:30 mins. There has been 3 months of improved Category 2 response times, which follows on from changes implemented as part of our Business Continuity Incident, at the start of QTR 4 2025/26.

Call answer within 999 has been planned to deliver against the national target of 10 seconds on average, which at 4 seconds the Trust is exceeding. It is worth noting that this is a new metric within the NOF and the Sector average for April 2026 and much of 2025/26 was 2 seconds. For April, SCAS is in the bottom 3 Trusts for this metric.

Patient outcome, between resolution via virtual care (HT%); leave at scene (ST%) and Transport to hospital (STC-ED & STC-non-ED), have a high dependency. The 20% HT% target is not currently achievable, primarily due to shortages in clinical staffing within our Integrated Contact Centre (ICC). This is balanced by an increase in patients left at scene. As Hear & Treat rates recover, it is expected that See & Treat rates will drop towards target.

The current Vehicle off road metric will be replaced, within the SCAS level papers, by a Vehicle Availability metric, which aligns vehicles, people and demand.

Patient Safety & Quality

Table 2: Patient Safety and Quality – Summary of assurance (from IPR)

Pass - Assurance	Fail - Assurance	No Data for April
Monthly PSII	n/a	Datix Incidents
Complaints per 10,000		CD Unaccounted for losses
Safeguarding Level 1		
Safeguarding Level 3		

A review of the patient safety and quality metrics, in line with NOF and to ensure that they are providing assurance on quality of care provided will be undertaken during the remainder of QTR 1 2026/27.

People

Table 3: People – Summary of assurance (from IPR)

Pass - Assurance	Fail - Assurance	No Data for April
% Disabled Staff	Staff Appraisals	n/a
% DBS Compliance	Meal Break Compliance	

High levels of Sickness remain a concern for the Trust. Following a significant spike in Short Term sickness in December 2025, there has been an on-going reduction. Mental Health related sickness accounts for c. 25% of all absence and has been identified as a key area of focus for 2026/27.

NHS Staff Survey results for 2025/26 have been reported previously but are flagged within this report as they represent metrics within the NOF. SCAS has seen a decline in scoring across each of the relevant metrics (see Appendix 1, National Oversight Framework) and have maintained their rankings within the bottom grouping.

Work within the People and Culture space, via the Fit For Future – Building Trust Together (BTT) Tier 1 programme - will be considering how to embed a changed culture. It is expected that further People metrics will need to be developed, primarily for the People and Culture Committee, to support the organisation to deliver this.

Finance

The M01 position is break-even against plan, with a £3k favourable variance, representing a stable start to the financial year. However, sustaining this position will require robust financial control and accelerated progress in identifying and delivering against the Cost Improvement Programme (CIP).

The in-month position was supported by the phasing of the Cost Improvement Programme, which has been weighted lower in Months 1 and 2 to allow the Trust time to finalise and strengthen delivery plans ahead of full mobilisation from Month 3. There was a further benefit from projects that have not yet commenced or cost pressures that haven't materialised. The Finance section within **Appendix 1**, provides a further split by Service line.

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Alignment with Strategic Objectives
With which strategic theme(s) does the subject matter align? Well Led

Relevant Business Assurance Framework (BAF) Risk
To which BAF risk is the subject matter relevant? SR9 - Delivery of the Trust Improvement Programme

Financial Validation	N/A
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Recommendation(s)
The Finance & Performance Sub-Committee is asked to do: • Note this paper and associated Performance Scorecard and Integrated Performance Report • Note the key risks identified

For Assurance	✓	For decision		For discussion	✓	To note	✓
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Appendix 1 – Performance Scorecard – NOF Metrics

CURRENT NOF SEGMENTATION

SEGMENT 3 (score 2.70)

Updated on 18th March 2026: QTR 3 2025/26

No.	Group	Sub-Group	Metric	SCAS				Rank (Value)		
				2025/26	Apr-26	Target	Assurance	QTR 2 25/26	QTR 3 25/26	QTR 4 25/26
OP4	2B – Access	Urgent care	Mean response time to Category 2 calls	00:30:02	00:25:08	00:27:30	 	(8) 0:28:62	(8) 0:29:52	
OP6	2B – Access	Urgent care	Mean 999 call response time	00:00:08	00:00:04	00:00:10	 	N/A		
	3 – Experience	Experience	NHS Staff Survey advocacy rate	(10) 5.54			Annual	(10) 5.70		
	4 – Effectiveness	Outcomes	% incidents managed via hear-and-treat or see-and-treat	47.9%	48.5%	49%		N/A		
	5 – Patient Safety	Safe outcomes	% safety incidents causing harm					N/A		
	5 – Patient Safety	Safe culture	NHS Staff Survey raising concerns sub-score	(8) 5.68			Annual	(8) 5.80		
	6 – Finance	Finance	Planned surplus or deficit (k)	-708	48			(10) -0.84%		
	6 – Finance	Finance	Variance to plan year-to-date (£k)	989	3			(8) 0.00%	(10) -0.24%	
	6 – Finance	Productivity	Relative cost difference (National Cost Collection Index)					(4) 95.02%		
	6 – Finance	Productivity	Implied productivity growth					N/A		
	6 – Finance	Innovation	% clinical trials set up within 150 days	63% - based on 8 studies	N/A		Quarterly			
	6 – Finance	Innovation	Data Quality Maturity Index	Ambulance not in data set			N/A			
P7	7 – People	People & culture	Sickness absence rate	6.98%	7.46%	6.20%		(3) 5.90%	(3) 6.65%	
	7 – People	People & culture	NHS Staff Survey engagement theme score	(9) 5.60				(9) 5.74		
	7 – People	People & culture	National Education and Training Survey satisfaction rate				Annual	N/A		
	7 – People	People & culture	NHS Staff Standards score				Annual			
	7 – People	People & culture	Healthcare Worker Flu Vaccination Rate				Seasonal			
	7 – People	Workforce	Temporary staffing cost as a % of total pay bill							

Note: This report is under development, with some metrics requiring further work and sign off prior to inclusion.

Appendix 1 – Performance Scorecard – Annual Planning Metrics

No.	Strategic Pillar	Metric	SCAS			
			2025/26	Apr-26	Target / baseline	Assurance
OP4	Clinical Effectiveness	Mean response time to Category 2 calls	00:30:02	00:25:08	00:27:30	 
	Clinical Effectiveness	999 Activity (average per month) - based on 4.2% growth	53,091	53,252	55,321	
OP8	Clinical Effectiveness	% Hear & Treat Rate	17.3%	16.6%	20.0%	 
OP10	Clinical Effectiveness	% See, Treat, Convey - ED	48.1%	47.3%	47.0%	 
OP11	Clinical Effectiveness	% See, Treat, Convey - Non ED	4.0%	4.1%	4.0%	 
	Clinical Effectiveness	Lost Operational Hours - CIP (average per month)	5,126	5,347	4,613	
	Clinical Effectiveness	Task Time (assign to clear)	01:59:18	01:55:15	01:55:18	
OP6	Clinical Effectiveness	Mean 999 call response time	00:00:08	00:00:04	00:00:10	 
	People & Culture	Abstraction Rate				
	People & Culture	Frontline Establishment				
	People & Culture	EOC Clinician Establishment				
	People & Culture	Emergency Call Taker Establishment				
	People & Culture	Annual leave allocation project: Based on Start date				
	Digital Transformation	CAD programme				
	Digital Transformation	ePCR programme				
	Digital Transformation	Co-pilot roll-out with NHSE tenant				
	Enabling Services	Vehicle replacement programme				
	Enabling Services	Vehicle Availability (as opposed to VOR)				
	Partnership & Sustainability	Deliver Cost Improvement Plan				
	Partnership & Sustainability	Appoint new Chair & CEO	Complete			Activity

Note: This report is under development, with some metrics requiring further work and sign off prior to inclusion.

Appendix 1 – Performance Scorecard – Finance and table key

		M1			YTD		
		Plan	Actual	Variance	Plan	Actual	Variance
South 999	Financial Position: Surplus / (Deficit) £k	-5,047	-4,979	68	-5,047	-4,979	68
	Total efficiency savings £k	365	142	-223	365	142	-223
North 999	Financial Position: Surplus / (Deficit) £k	4,155	4,111	-44	4,155	4,111	-44
	Total efficiency savings £k	365	142	-223	365	142	-223
EOC	Financial Position: Surplus / (Deficit) £k	2,469	2,263	-206	2,469	2,263	-206
	Total efficiency savings £k	12	164	152	12	164	152
111	Financial Position: Surplus / (Deficit) £k	262	272	11	262	272	11
	Total efficiency savings £k	25	0	-25	25	0	-25
PTS	Financial Position: Surplus / (Deficit) £k	386	356	-30	386	356	-30
	Total efficiency savings £k	18	60	42	18	60	42

Note: Frontline Efficiency is not split North and South therefore split 50:50 above

Key:

No. Details which metric within core IPR this is covered by
Some will be SPC charts, some will be tables

Group
Sub Group As provided within the Oversight Documentation

Metric
SCAS Data based on SCAS internal / external reported position

2025/26 Full year declared position

Apr-26 Lastest month

Target National or annual plan target

Assurance SPCassurance / variation level

NOF Ranking Ranking provided nationally

Note: not all metrics were in the 25/26 version of the framework

Appendix 2 – Integrated Performance Report

See separate report.



Integrated Performance Report: Apr-26



Executive Summary

Operational Performance

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

Safety and Quality

People

Key Performance Headlines :

- (OP2) Cat 2 performance was 25:08 which was above plan of 22:10. Demand was 1.7% above plan and operational hours were 2% below plan. These impacted cat 2 by 2 minutes
- (OP6) 999 call demand was in line with plan and we delivered 4 second mean
- (OP8) H&T delivered 16.6% which is considerably below plan and a significant focus to recover.

Key Risks for Period :

- We were 3 minutes above plan on cat 2 and we now need to recover this during May and June to meet the quarter
- We have ceased all recruitment and therefore the movement of crews from Hampshire to Thames Valley is even more critical as all our vacancies are in Thames valley
- Not recruiting the required numbers of clinicians to deliver H&T. On going recruitment and courses to bring numbers up by Q2 with robust action plan in place

Key Rolling Actions :

- Recruitment of CSD clinicians and monitoring action plan delivery
- Balancing operational hours in line with financial plan, including reducing additional private provider hours
- Vehicle charging on sites to reduce VOR

Forward View :

Key Performance Headlines :

(QS1, QS2): Overall common cause variation with harm events < 2% of overall reported incidents. Isolated special cause (two delay-related harms) reflects local variation, not system deterioration. No PSIs declared.

(QS20): Improving within common cause variation (concerns ↓ to 65; compliments 30%). Persistent themes (NEPTS delays, Directory of Service issues) indicate known system variation drivers with actions in place.

Safeguarding: High stable compliance (94–98%) indicating a controlled system. Training changes aim to sustain reliability.

IPC: Within expected variation under new audit; early variation signals in specific areas (stretchers, cabinets) being addressed.

Overall System performance is stable (common cause) with targeted actions addressing isolated variation and known process weaknesses. All Clinical AQIs are showing common cause variation.

Key Risks for Period :

(QS1, QS2): Potential recurrence of delay-related harm linked to operational pressures.

(QS20): Continued patient dissatisfaction if delays and access issues persist.

Safeguarding: Potential dip in compliance during transition to revised training approach.

IPC: Inconsistent IPC practice if early audit findings are not fully embedded and addressed.

Key Rolling Actions :

(QS1, QS2): Daily oversight and monitoring of delays, real-time escalation, and targeted reviews of delay-related incidents to identify and mitigate emerging risks.

(QS20): Ongoing engagement with system partners to improve NEPTS performance, regular DoS accuracy reviews, and continuous monitoring of feedback trends.

Safeguarding: Phased training implementation, routine compliance monitoring, and targeted follow-up on non-compliance.

IPC: Targeted deep dives, reinforcement of standards through local leadership, and re-audit cycles to confirm improvement. ACQI: focus remains on ensuring 95% compliance with face to face resuscitation training.

Forward View :

(QS1, QS2): Strengthening early identification of delays and embedding preventative controls to reduce recurrence.

(QS20): Strengthened system collaboration and measurable reduction in delay-related concerns.

Safeguarding: Embedding new training models and sustaining high compliance across teams.

IPC: Stabilising performance under the new audit process and demonstrating sustained compliance.

Key Performance Headlines :

- OP-20-Contact Centre performance remained strong in April, with 90.69% of calls answered within 90 seconds, demonstrating continued stabilisation and recovery.
- OP19- Call volumes reduced slightly but remain above target and consistent with recent elevated demand levels.
- OP23/24-Operational performance shows variation, with increased cross-county journeys (north to south) driving additional mileage and impacting patient experience.
- Improved cohorting and daily review of forecast hours are delivering efficiency gains and better resource utilisation.

Key Risks for Period :

- Workforce gaps across both call handling and dispatch functions, including current vacancies and reliance on redeployed staff.
- Demand vs capacity pressure, with sustained high activity levels across both PTS contracts.
- Increased journey distances, particularly for North Hampshire patients travelling south, resulting in, higher mileage costs, longer patient journey times.
- Financial risk where vacancies are being absorbed operationally, creating budget pressures if unfilled long-term.
- Ongoing workforce structure challenges (part-time vs full-time mix) impacting alignment to peak demand.

Key Rolling Actions :

- Reduction of Not Ready time from 20% to 17% to increase productive call-handling capacity.
- New contact centre rota implementation (June 2026) to better align staffing with demand.
- Active recruitment to vacancies across contact centre and dispatch roles.
- Continued use of Telephony Journey Confirmations to reduce abortive journeys and improve utilisation.
- Strengthening cohorting approaches to maximise vehicle efficiency.
- Enhanced sickness absence management and scrutiny.
- Ongoing rota consultation within Hampshire operations to improve coverage and staff wellbeing.

Forward View :

- Focus on stabilising workforce capacity, ensuring vacancies are filled and rota changes deliver expected benefits.
- Continued monitoring of activity, capacity, and financial position to ensure alignment with budget constraints.
- Further optimisation of cohorting and routing, particularly to address the impact of long-distance travel on patient experience and cost.
- Sustained emphasis on demand management initiatives, including reducing unnecessary bookings and improving utilisation.
- Ongoing review of system-wide demand across both PTS contracts to mitigate risks to performance, patient flow, and organisational reputation.

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:

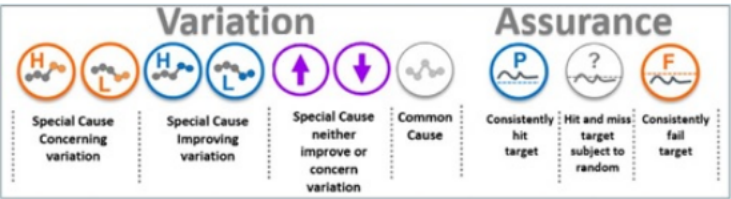
- 1) Any single point outside the process limits.**
- 2) Two out of three points within 1 sigma of the upper or lower control limit.**
- 3) A run of 6 points above or below the mean (a shift) .**
- 4) A run of 6 consecutive ascending or descending values (a trend).**

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



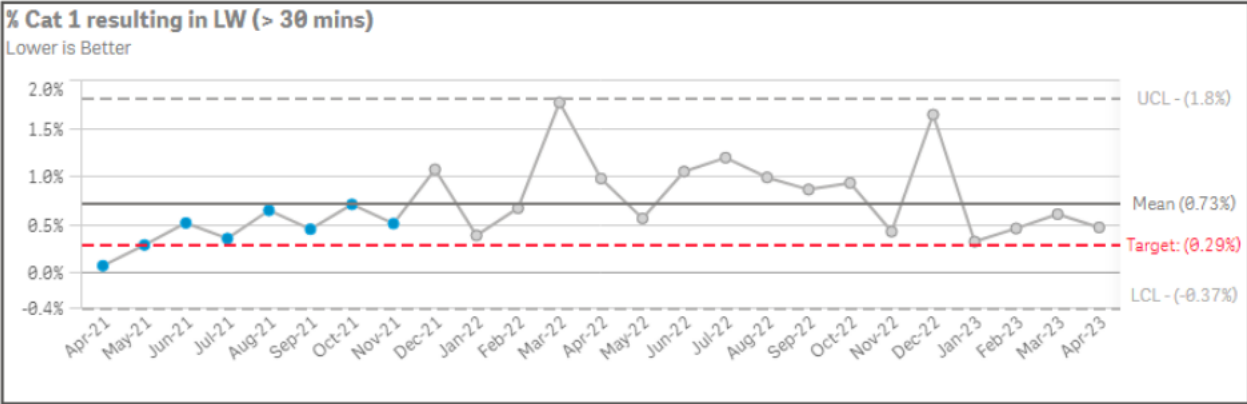


	Pass	Hit and Miss	Fail	No Target
	Special cause of an improving nature where the measure is significantly HIGHER. This process is capable and will consistently PASS the target.	Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly HIGHER. This process is not capable. It will FAIL the target without process redesign.	Special cause of an improving nature where the measure is significantly HIGHER. Assurance cannot be given as a target has not been provided.
	Special cause of an improving nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target.	Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly LOWER. This process is not capable. It will FAIL the target without process redesign.	Special cause of an improving nature where the measure is significantly LOWER. Assurance cannot be given as a target has not been provided.
	Common cause variation , no significant change. This process is capable and will consistently PASS the target	Common cause variation , no significant change. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Common cause variation , no significant change. This process is not capable. It will FAIL the target without process redesign.	Common cause variation , no significant change. Assurance cannot be given as a target has not been provided.
	Special cause of a concerning nature where the measure is significantly HIGHER. The process is capable and will consistently PASS the target.	Special cause of a concerning 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 a concerning nature where the measure is significantly HIGHER. This process is not capable. It will FAIL the target without process redesign.	Special cause of a concerning nature where the measure is significantly HIGHER. Assurance cannot be given as a target has not been provided.
	Special cause of a concerning nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target.	Special cause of a concerning nature where the measure is significantly LOWER. This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly LOWER. This process is not capable. It will FAIL the target without process redesign.	Special cause of a concerning nature where the measure is significantly LOWER. Assurance cannot be given as a target has not been provided.
				Special cause variation where UP is neither improvement nor concern.
				Special cause variation where DOWN is neither improvement nor concern
n/a				Special cause or common cause cannot be given as there are insufficient number of points. Assurance cannot be given as a target has not been provided.

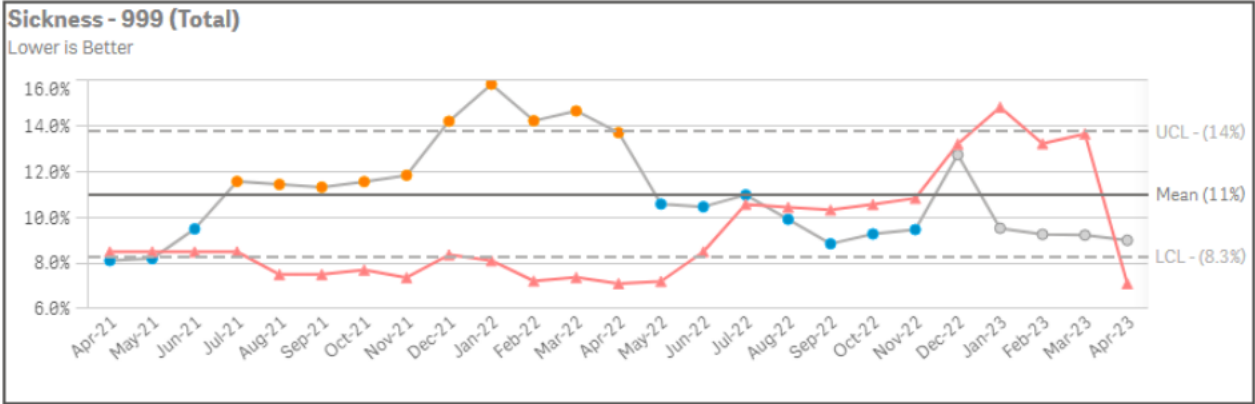
Assumptions:

- 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 variation) all the points will fall above or below the 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

April – 26 Summary

Hit and Miss Common Cause:

Cat 2 Mean, Cat 1 90th %ile, Cat 2 90th %ile, 999 Call Answer, % See, Treat & Convey to ED, % See, Treat & Convey to Non ED, 111 Call Answer, 111 Abandonment Rate, PTS Call Volume, PTS Calls Answered in 90 Seconds, PTS Number of Journeys, PTS Patients Transported, PTS Patients Collected in Time, PSI Low/No Hard Incidents, Monthly PSILR, Datix Incidents, CD Unaccounted for Losses, Hand Hygiene Audits, Vehicle Audits, Vehicle Audit % Compliance, STEMI Call to Door Mean, STEMI Call to Door 90th Centile, Stroke Call to Hospital Mean, Stroke Call to Hospital Median, Stroke Call to Hospital 90th Centile, ROSC All, ROSC Utstein, Cardiac Arrest 30 day Survival, Cardiac Arrest 30 Day Survival Utstein

Assurance →					
		Fail	Hit and Miss	Pass	No Target
Variance ↓					
			Hand Hygiene % Compliance		
		Cat 1 Mean Cat 3 90th Percentile % Hear and Treat Average Handover Time Handover < 15 mins 111 Call Backs PTS Pts Arrived in Time Staff Appraisals	29	Average Clear Up Time Monthly PSII Complaints Level 1 Safeguarding DBS Compliance	Compliments Stat and Man Training Compliance FTSU Cases
		% Vehicles Off Road	Turnover Rate	999 Abandonment Rate % See and Treat	
		Meal Break Compliance	BAME Staff %	Level 3 Safeguarding Disabled Staff %	

Operational Performance

April – 26 Summary

Metrics:

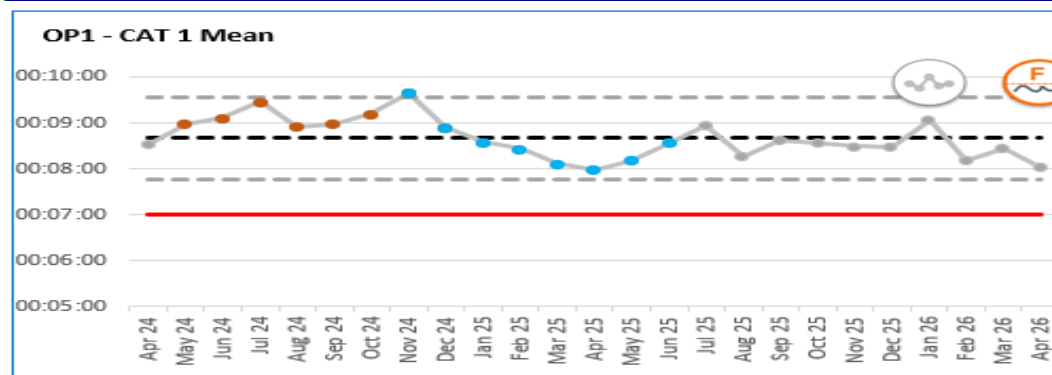
Hit and Miss Common Cause

Cat 2 Mean, Cat 1 90th %ile, Cat 2 90th %ile, 999 Call Answer, % See, Treat & Convey to ED, % See, Treat & Convey to Non ED, 111 Call Answer, 111 Abandonment Rate, PTS Call Volume, PTS Calls Answered in 90 Seconds, PTS Number of Journeys, PTS Patients Transported, PTS Patients Collected in Time

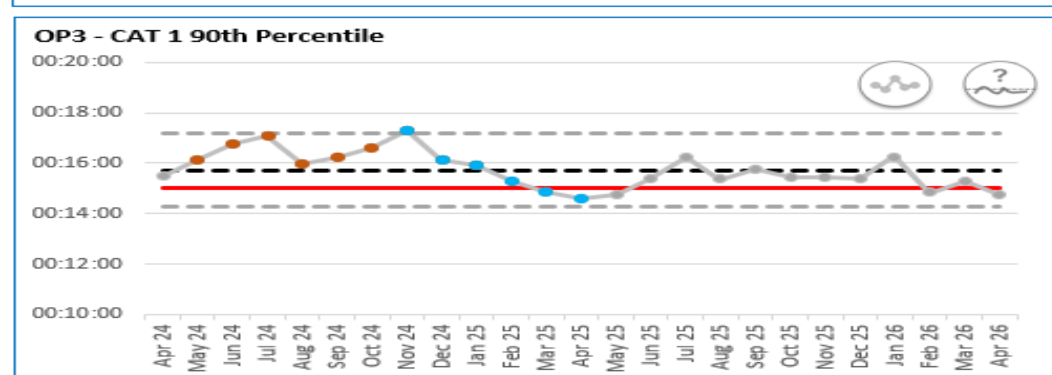
Assurance →					
		Fail	Hit and Miss	Pass	No Target
Variance ↓					
					
		Cat 1 Mean Cat 3 90th Percentile % Hear and Treat Average Handover Time Handover < 15 mins 111 Call Backs PTS Pts Arrived in Time	13	Average Clear Up Time	
		% Vehicles Off Road		999 Abandonment Rate % See and Treat	
					

KPI	Latest month	Measure	Target	Variatio	Assura	Mean	Lower process limit	Upper process limit
OP1 - CAT 1 Mean	Apr 26	00:08:02	00:07:00			00:08:40	00:07:45	00:09:34
OP3 - CAT 1 90th Percentile	Apr 26	00:14:46	00:15:00			00:15:43	00:14:15	00:17:11
OP2 - CAT 2 Mean	Apr 26	00:25:08	00:30:00			00:28:55	00:19:41	00:38:09
OP4 - CAT 2 90th Percentile	Apr 26	00:48:06	00:40:00			00:58:54	00:40:59	01:16:50
OP5 - CAT 3 90th Percentile	Apr 26	03:54:35	02:00:00			05:47:51	02:51:55	08:43:47
OP6 - 999 Call Answer	Apr 26	00:00:04	00:00:10			00:00:07	00:00:03	00:00:11
OP7 - 999 Abandonment Rate	Apr 26	1.0%	2.0%			1.4%	0.9%	1.9%
OP8 - % Hear and Treat	Apr 26	17%	20%			18%	16%	19%
OP9 - % See and Treat	Apr 26	32%	29%			31%	29%	32%
OP10 - % See, Treat and Convey to ED	Apr 26	47%	47%			48%	47%	49%
OP11 - % See, Treat and Convey to Non ED	Apr 26	4%	4%			4%	4%	4%
OP12 - Average Handover Time	Apr 26	00:17:16	00:15:00			00:18:11	00:15:34	00:20:48
OP13 - Handover < 15 mins	Apr 26	53%	60%			50%	42%	58%
OP14 - Average Clear Up Time	Apr 26	00:13:27	00:15:00			00:13:27	00:13:05	00:13:49
OP15 - % Vehicles off the Road	Apr 26	35.17%	15.00%			40.42%	32.87%	47.98%
OP16 - 111 Call Answer	Apr 26	81.5%	95.0%			74.1%	51.7%	96.5%
OP17 - 111 Abandonment Rate	Apr 26	2.6%	3.0%			3.5%	-0.4%	7.4%
OP18 - 111 Call Backs	Apr 26	37%	90%			32%	23%	42%
OP19 - PTS Call Volume	Apr 26	7158.0	6672.0			6926.8	5306.0	8547.7
OP20 - PTS Calls Answered in 90 Seconds	Apr 26	79.0%	90.0%			89.1%	73.7%	104.6%
OP21 - PTS Volume - Number of Journeys	Apr 26	22539.0	23414.0			22155.8	18750.1	25561.5
OP22 - PTS Number of Patients Transported	Apr 26	5231.0	5332.0			5271.5	4633.4	5909.5
OP23 - PTS Patients Collected Within Time	Apr 26	85.5%	87.0%			86.4%	83.7%	89.1%
OP24 - PTS Patients Arrived Within Time	Apr 26	83.8%	87.3%			85.2%	83.3%	87.1%

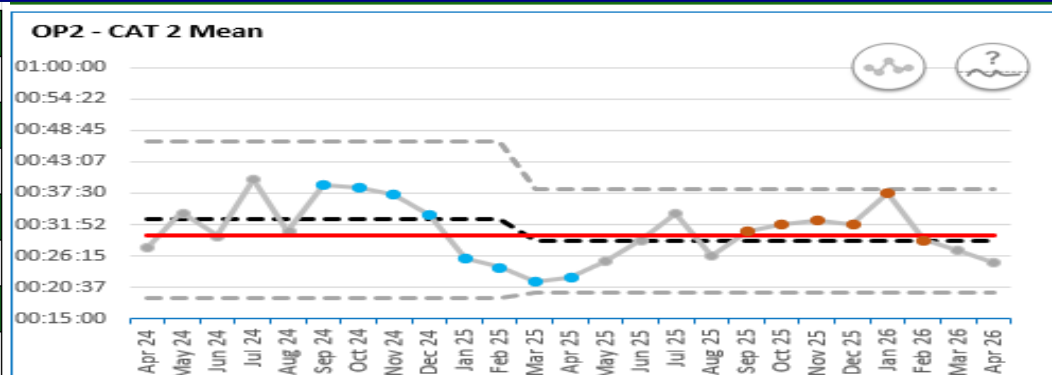
Operations - Response Times



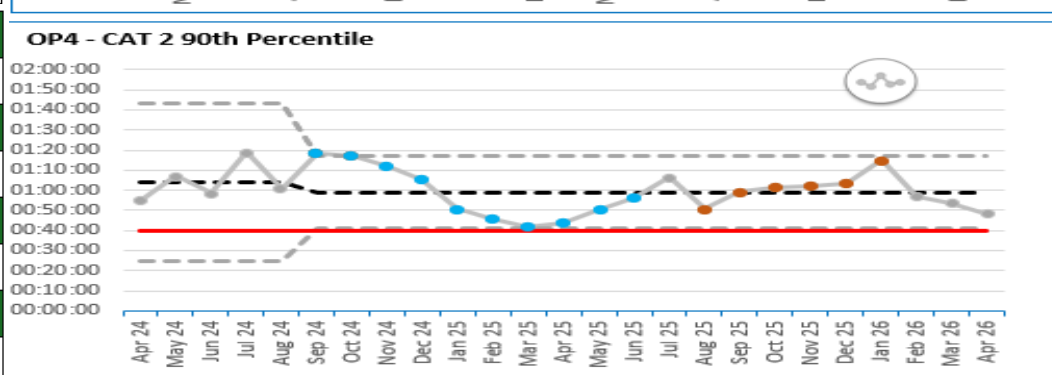
Variation
Expected
Assurance
Fail
Target
00:07:00
Latest
00:08:02



Variation
Expected
Assurance
Random
Target
00:15:00
Latest
00:14:46



Variation
Expected
Assurance
Random
Target
00:30:00
Latest
00:25:08



Variation
Expected
Assurance
Random
Target
00:40:00
Latest
00:48:06

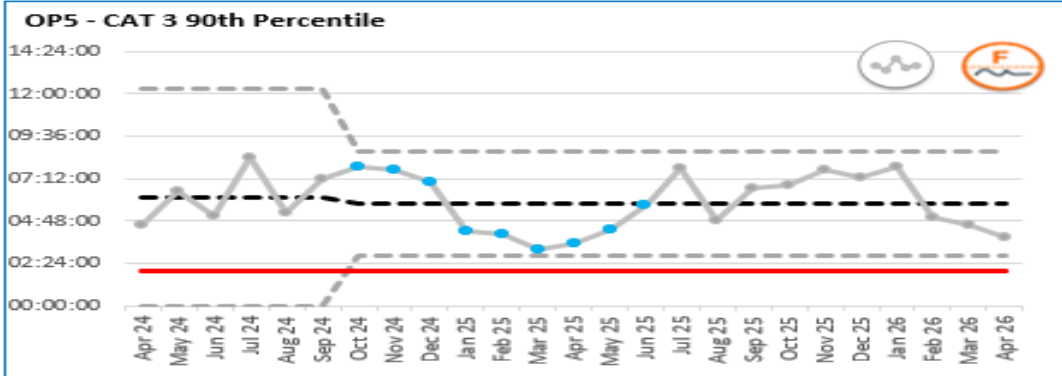
Understanding the Performance:

Improved Cat 1 and Cat 2 performance. Both remaining within the expected variance however Cat 2 fell below the April trajectory. Demand was above plan by 1.7% (747 Incidents) this was further exacerbated by below plan H&T driving an additional 1530 incidents into response requirement whilst operational hours were 2% (3979 hours) below plan. North Hospital delays above trajectory adding 28seconds to Cat 2.

Actions (SMART):

- Delivery Cat 2 above May plan of 29:30 to recover EOY position.
- Drive Recruitment into CSD to facilitate delivery of 20% H&T - Recruitment plan for 5.84 in Q1. 15 in pipeline.
- Frontline Q2 recruitment plan adjusted to reflect above trajectory EOY position and reduced attrition trajectory in Q1.
- Embed plans to deliver required 2026/27 performance CIPs including 20% H&T, reduced abstraction and improved task time. Review weekly.

Operations - Response Times



Variation
Expected
Assurance
Fail
Target
02:00:00
Latest
03:54:35

Understanding the Performance:

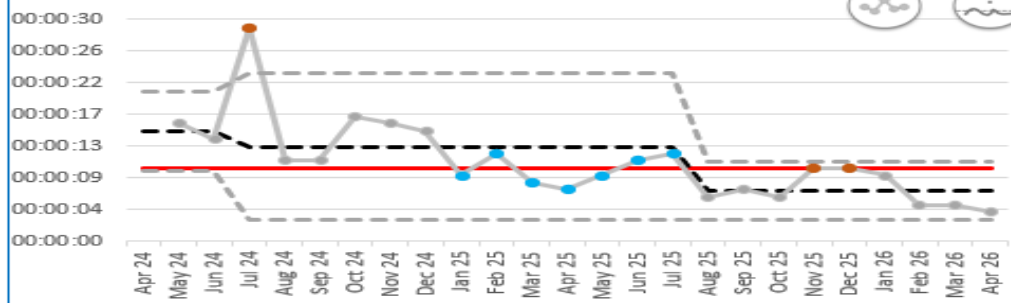
Cat 3 and 4 improved but continuing to fail to meet target. Both remained within expected variance. Demand was above plan by 1.7% (747 Incidents) this was further exacerbated by below plan H&T driving an additional 1530 incidents into response requirement whilst operational hours were 2% (3979 hours) below plan. North Hospital delays above trajectory adding 28seconds to Cat 2.

Actions (SMART):

- Delivery Cat 2 above May plan of 29:30 to recover EOY position.
- Drive Recruitment into CSD to facilitate delivery of 20% H&T - Recruitment plan for 5.84 in Q1. 15 in pipeline.
- Frontline Q2 recruitment plan adjusted to reflect above trajectory EOY position and reduced attrition trajectory in Q1.
- Embed plans to deliver required 2026/27 performance CIPs including 20% H&T, reduced abstraction and improved task time. Review weekly.

Operations - Operations Centre

OP6 - 999 Call Answer



Variation

Improving

Assurance

Random

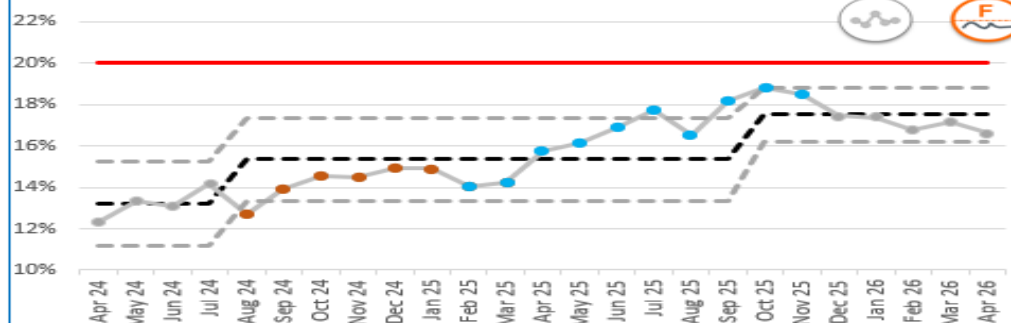
Target

00:00:10

Latest

00:00:04

OP8 - % Hear and Treat



Variation

Expected

Assurance

Fail

Target

20.00%

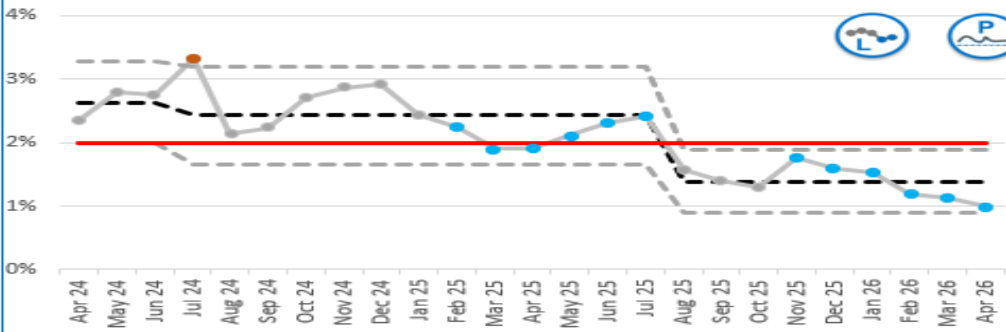
Latest

16.62%

Understanding the Performance:

OP6 remains comfortably within target at 4 seconds, showing stronger operational control with improved workforce availability. Demand in April was 5.3% above that seen in April 2025 with a 0.8% increase in logged in hours, further demonstrating the improvements made in room management and average handling time. With good speed of answer the volume exported over IRP reduced for a further month. OP8 remains within expected variation and has not deteriorated however remains below target. Clinical logged in hours improved on previous month with 57.5% of category 3/4 callers contacted.

OP7 - 999 Abandonment Rate



Variation

Improving

Assurance

Pass

Target

2.00%

Latest

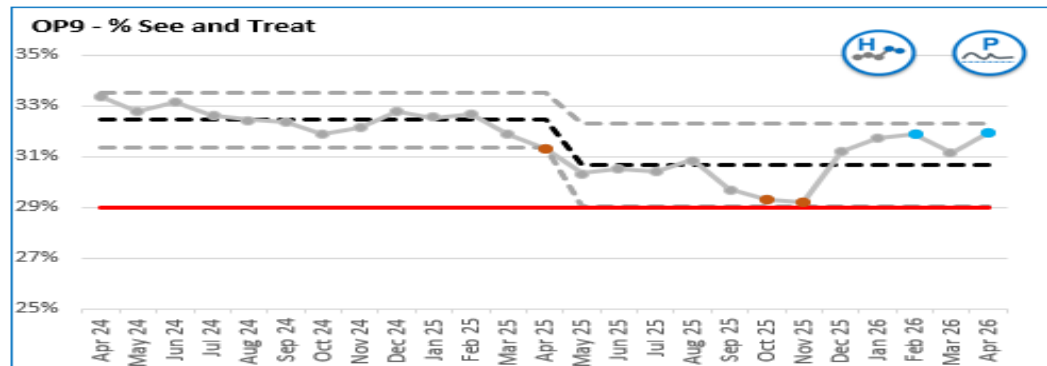
0.99%

Actions (SMART):

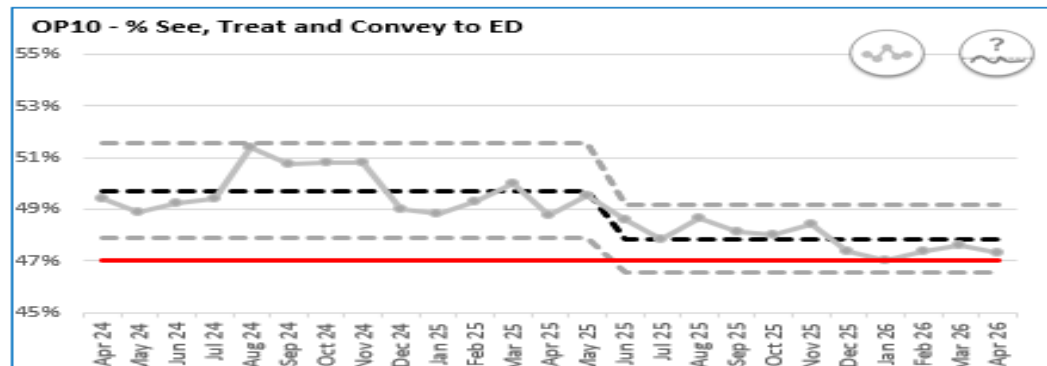
Focus remains very much on improving performance against OP8.

- Clinical queue work in CAD implemented 22nd April, now moved to embedding of processes/queue management, monitoring data for impact via monthly virtual care steering group.
- Ongoing work with recruitment to fill vacancies, tracked via weekly meetings and against plan at monthly IWP.
- Asst Director of Clinical Operations and 2/3rds of the Clinical Service Delivery Managers appointed. Moving to implementation of the new structure to bring strong leadership and deliver stability.
- Continue with actions in the virtual care improvement plan/hear and treat recovery plan.

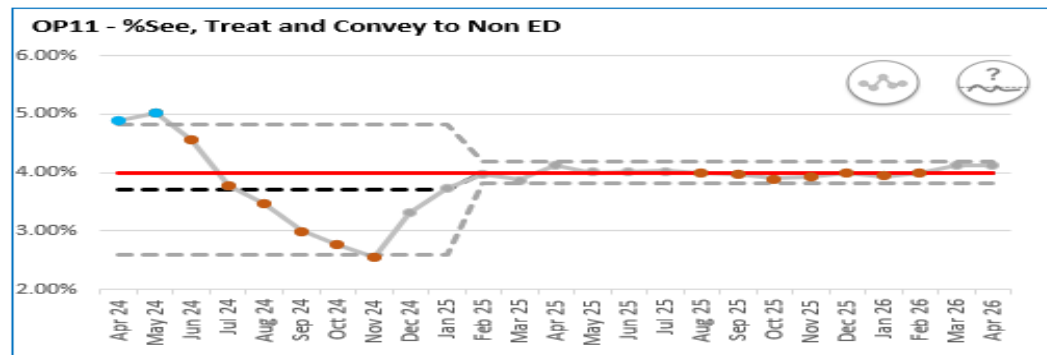
Operations - Utilisation



Variation
Improving
Assurance
Pass
Target
29.00%
Latest
31.94%



Variation
Expected
Assurance
Random
Target
47.00%
Latest
47.31%



Variation
Expected
Assurance
Random
Target
4.00%
Latest
4.13%

Understanding the Performance:

OP 9 - See and Treat following the change in target is now passing its measure that is set at 29% for the coming year. In reality the measure has been tracking around the mean for 6 months with little variation.

OP10 - See treat and Convey to ED - Showing a new target for 26/27 of 47% so for April we have achieved the target measure but as with S&T we have seen little variation for the past 12months

OP11 - See treat and Convey to Non ED - Target for 26/27 ids 4% so as with the revised targets this is also achieving its measure.

Actions (SMART):

Specific: Produce and issue a single, up to date directory of non ED pathways (Quarterly Pathway Directory, SCAS Connect).

Measurable: 100% of frontline vehicles have access (SCAS Connect).

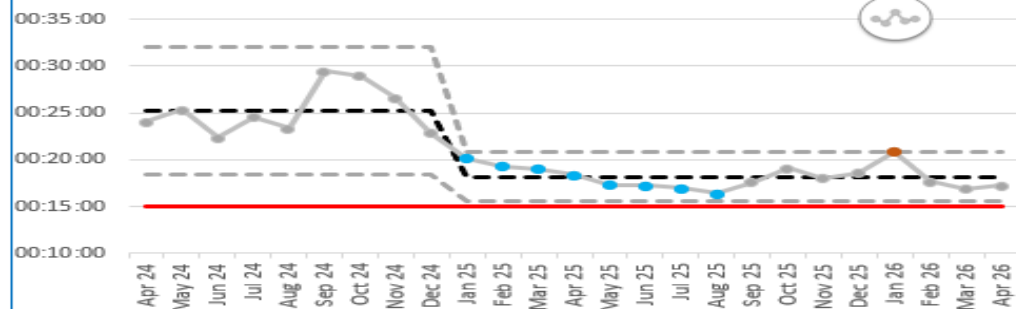
Achievable: Clinical Operations Manager ownership at local level.(Just embedding new role)

Relevant: Enables correct decision making.

Time bound: Central to delivering operational plan for 26/27.

Operations - Utilisation

OP12 - Average Handover Time



Variation

Expected

Assurance

Fail

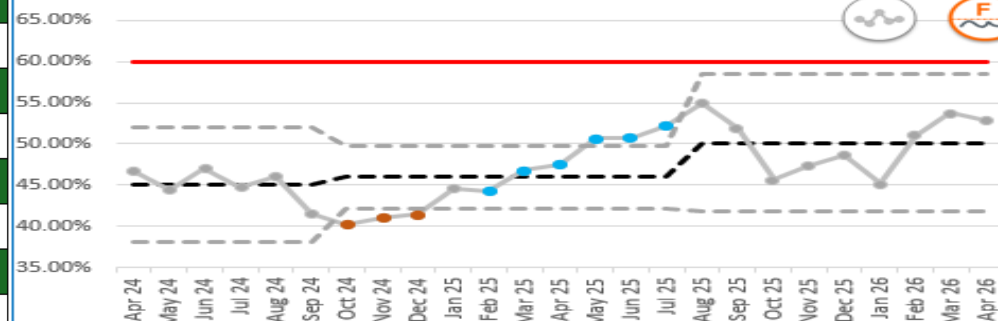
Target

00:15:00

Latest

00:17:16

OP13 - Handover < 15 mins



Variation

Expected

Assurance

Fail

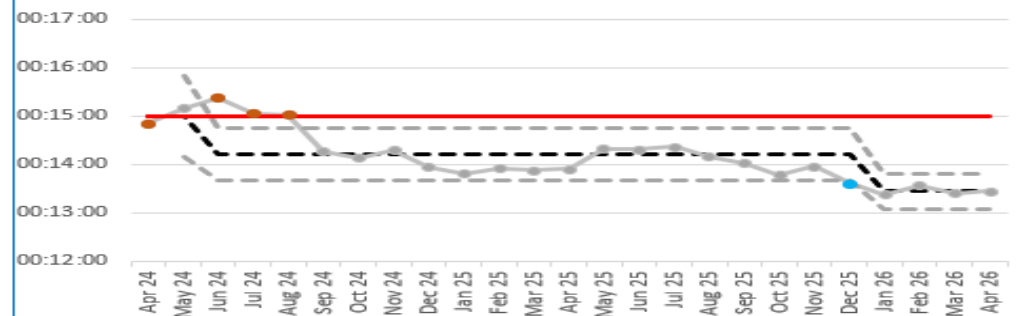
Target

60.00%

Latest

52.84%

OP14 - Average Clear Up Time



Variation

Expected

Assurance

Pass

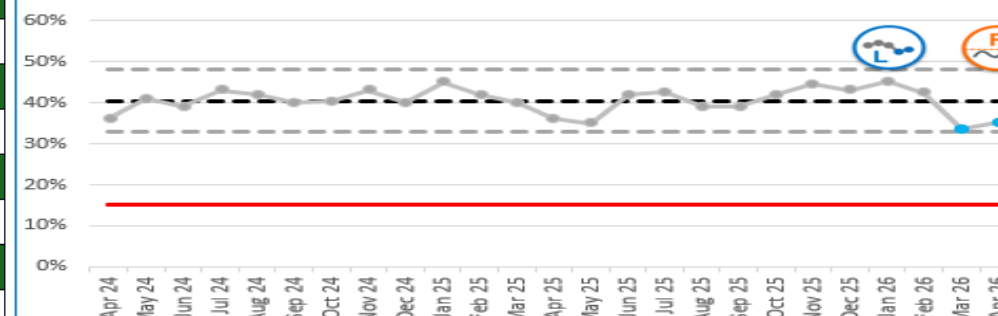
Target

00:15:00

Latest

00:13:27

OP15 - % Vehicles off the Road



Variation

Improving

Assurance

Fail

Target

15.00%

Latest

35.17%

Understanding the Performance:

OP12/13 - both measures failing their targets with the average time to handover now 3 consecutive points below the mean. Handover compliance in 15mins also tracking above its mean but still significantly below the target.

OP14 - Clear ups remain positive with it passing the target now for the past 20 months with a change in the mean seen since Dec 25.

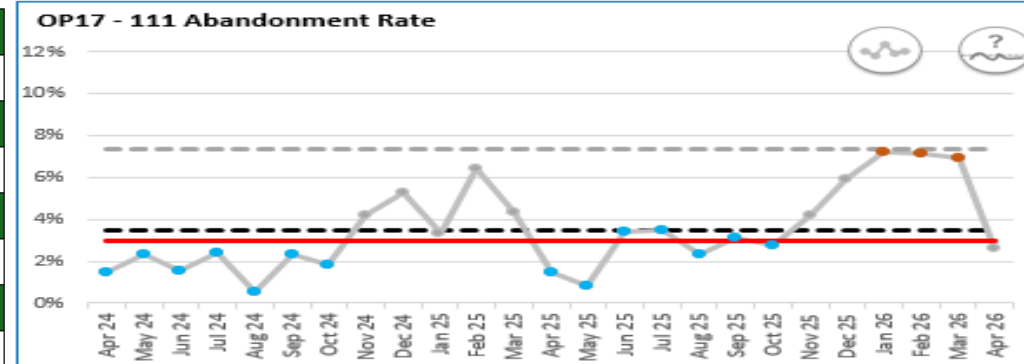
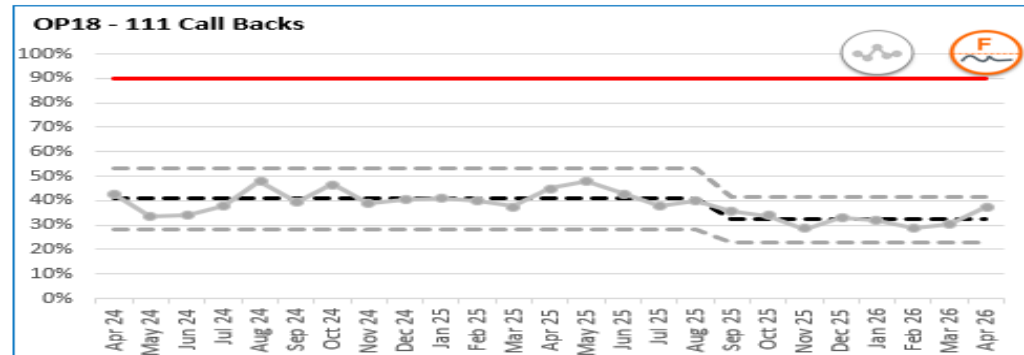
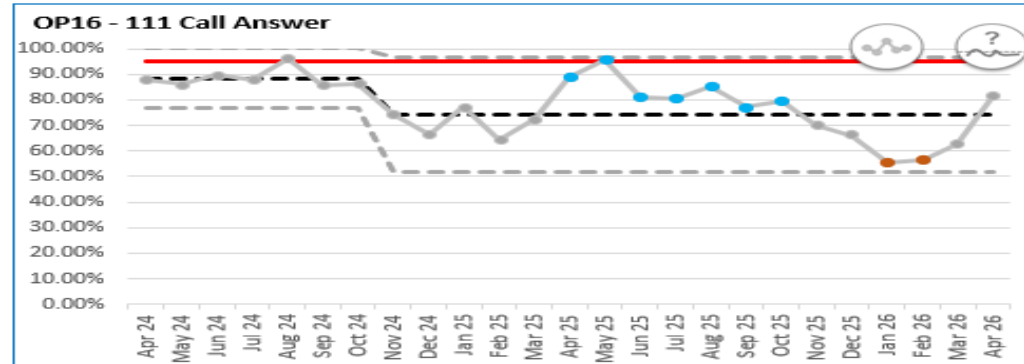
April saw another strong month in overall fleet availability due to lower utilisation and reduced demand.

Actions (SMART):

Local ownership of handover process at acutes. work closely with acutes to improve compliance, monitored at delivery boards, departmental performance reviews

Continued focus on improving aux-charge faults by highlighting station level performance to operational leads to address.

Operations - Operations Centre



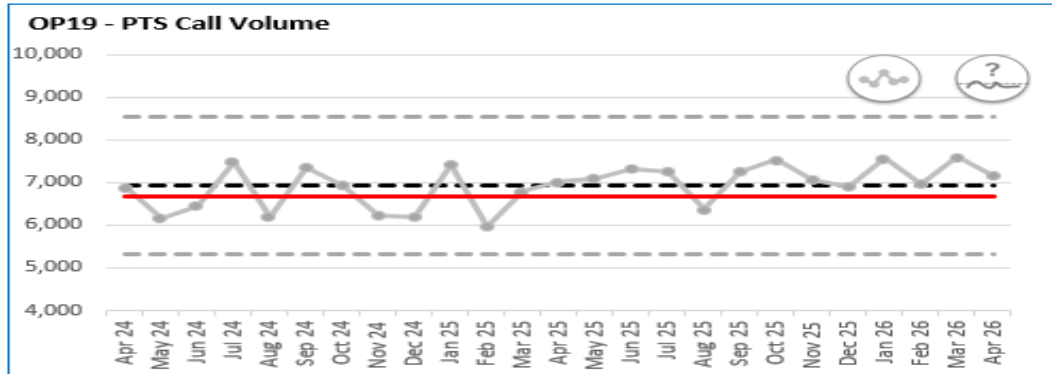
Understanding the Performance:

- Calls offered in April seen a reduction in demand from March despite Easter Bank Holidays. Calls answered in April increased to 81.40% from March call answer of 62.91%, because of reduced demand and continued increase in logged in hours (OP16).
- OP 17 again improved in April to 2.84% from 6.92% in March, again due to increased logged in hours and reduced demand. This is now under the target of 3%.
- OP 18 – remains steady and is reflective of the continued challenges with access to Primary Care.

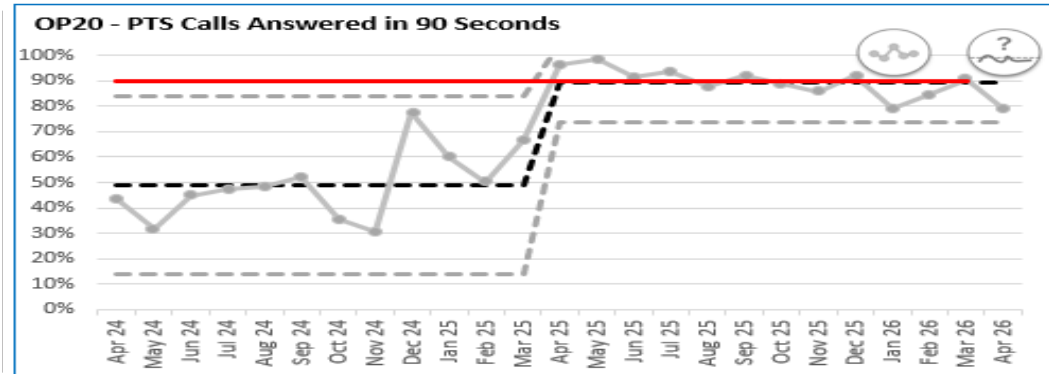
Actions (SMART):

- Health Advisor recruitment continues to increase through April with additional courses in MK 111 due to successful applicant numbers.
- Demand is April reduced in line with seasonal expectations with reduced demand on Easter Bank holiday Monday. Additional recruitment numbers and increased courses have contributed to the improved performance.
- DOPR meetings continue monthly to monitor demand patterns and performance metrics. Weekly recruitment meetings continue to monitor recruitment and ensure good course fills to me workforce plan.

Operations - PTS - Calls and Outcomes



Variation
Expected
Assurance
Random
Target
6,672
Latest
7,158



Variation
Expected
Assurance
Random
Target
90.00%
Latest
78.97%

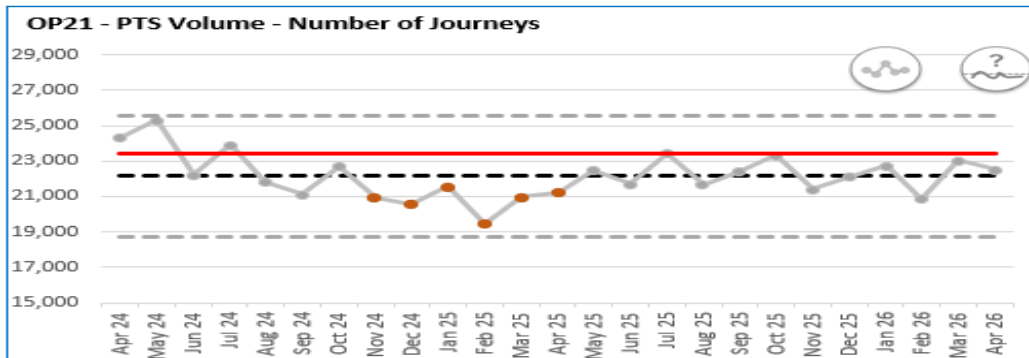
Understanding the Performance:

- Overall performance can vary however we do see a number of journeys that are travelling further afield especially North of the county to the South increasing the necessary mileage and impacting patient experience. Total extra miles per session for these patients is 1108 miles. Just the North Hampshire to QAH patients are costing us an extra 928 miles per session. If all the patients have 3 sessions per week, that totals 3324 extra miles per week.
- Forecasted hours are reviewed daily, and we have seen improvements driven by cohorting and operational efficiencies.

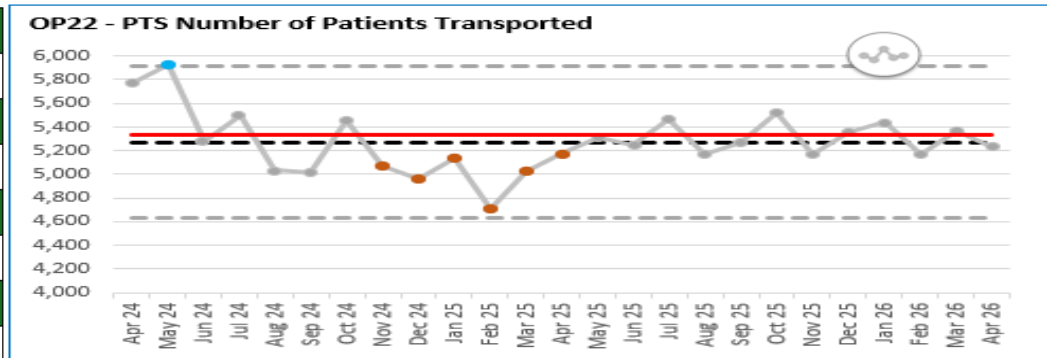
Actions (SMART):

- 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.
- Rota consultation currently underway to improve the level of shifts across the area in Hampshire to improve performance and staff wellbeing.

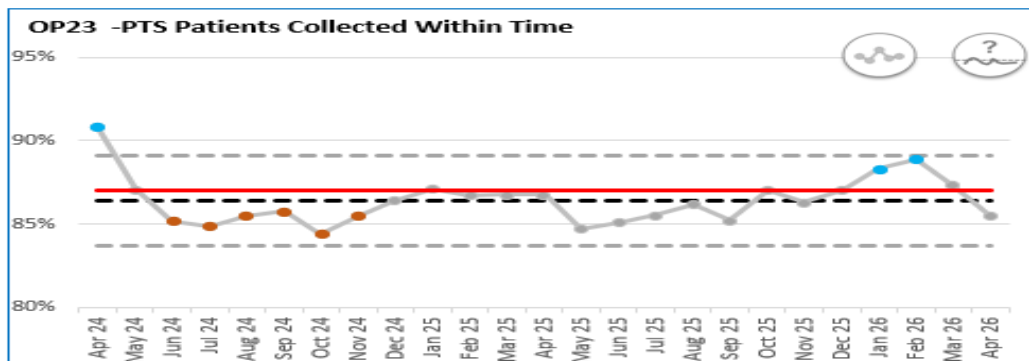
Operations - PTS - Calls and Outcomes



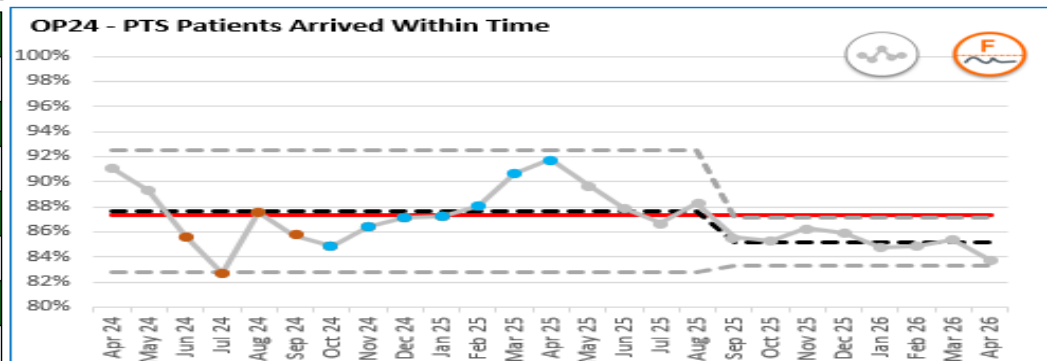
Variation
Expected
Assurance
Random
Target
23,414
Latest
22,539



Variation
Expected
Assurance
Random
Target
5,332
Latest
5,231



Variation
Expected
Assurance
Random
Target
87.00%
Latest
85.46%



Variation
Expected
Assurance
Fail
Target
87.30%
Latest
83.76%

Understanding the Performance:

- Overall performance can vary however we do see a number of journeys that are travelling further afield especially North of the county to the South increasing the necessary mileage and impacting patient experience. Total extra miles per session for these patients is 1108 miles. Just the North Hampshire to QAH patients are costing us an extra 928 miles per session. If all the patients have 3 sessions per week, that totals 3324 extra miles per week.
- Forecasted hours are reviewed daily, and we have seen improvements driven by cohorting and operational efficiencies.

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.
- Rota consultation currently underway to improve the level of shifts across the area in Hampshire to improve performance and staff wellbeing.

Quality and Safety

Quality & Safety – Core Measures Matrix

April – 26 Summary

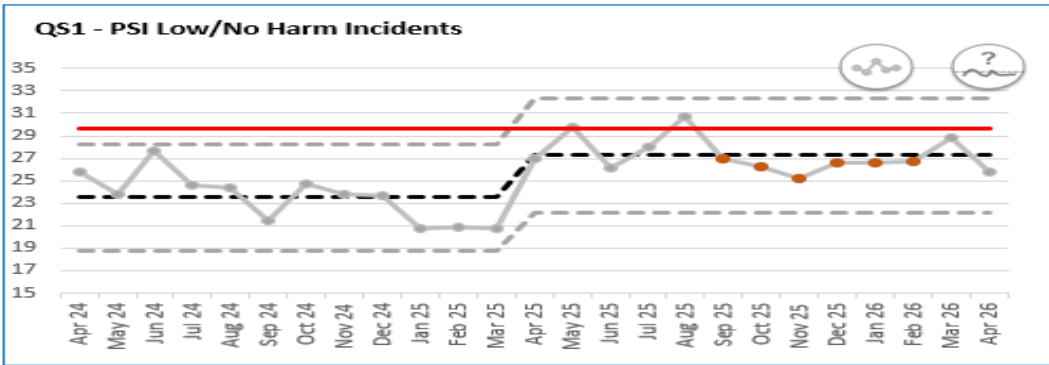
Assurance →					
		Fail	Hit and Miss	Pass	No Target
Variance ↓					
			Hand Hygiene % Compliance		
			16	Monthly PSII Complaints Level 1 Safeguarding	Compliments
					
				Level 3 Safeguarding	

Metrics:

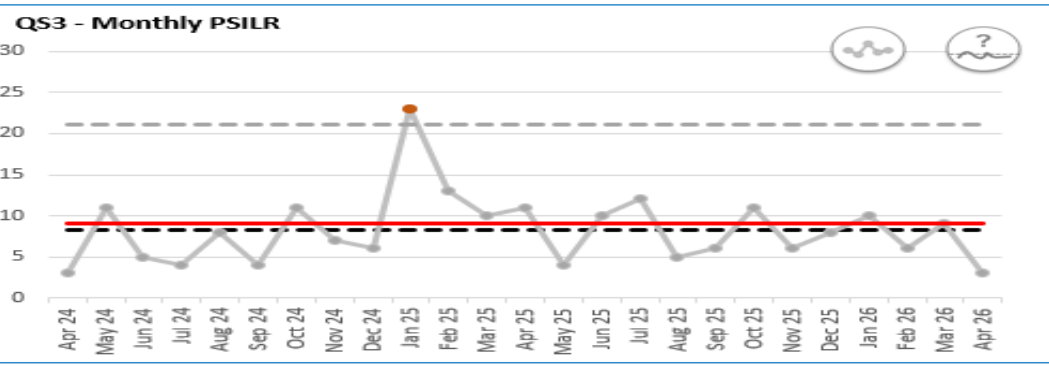
Hit and Miss, Common Cause
 PSI Low/No Hard Incidents, Monthly PSILR, Datix Incidents,
 CD Unaccounted for Losses, Hand Hygiene Audits,
 Vehicle Audits, Vehicle Audit % Compliance,
 STEMI Call to Door Mean, STEMI Call to Door 90th Centile,
 Stroke Call to Hospital Mean, Stroke Call to Hospital Median,
 Stroke Call to Hospital 90th Centile, ROSC All, ROSC Utstein,
 Cardiac Arrest 30 day Survival, Cardiac Arrest 30 Day Survival
 Utstein,

KPI	Latest Month	Actuals	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
QS1 - PSI Low/No Harm Incidents	Apr 26	25.8	29.7			27.3	22.2	32.4
QS2 - Monthly PSII	Apr 26	0.0	0.0			0.0	0.0	0.0
QS3 - Monthly PSILR	Apr 26	3.0	0.0			8.2	-4.6	21.1
QS4 - Datix Incidents	Mar 26	0.26	0.99			0.76	0.00	2.54
QS5 - CD Unaccounted for Losses	Feb 26	0.0	2.0			1.1	-2.7	5.0
QS6 - Hand Hygiene Audits Completed	Apr 26	301.0	261.0			290.4	1.3	579.4
QS7 - Hand Hygiene % Compliance	Apr 26	69.8%	95.0%			94.7%	81.0%	108.4%
QS8 - Vehicle Audits Completed	Apr 26	205.0	167.0			188.0	25.3	350.7
QS9 - Vehicle Audits % Compliance	Apr 26	82.4%	90.0%			86.0%	62.5%	109.5%
QS10 - Stemi, Call to Catheter Insertion Mean	Dec 25	02:09:00	02:30:00			02:17:09	01:47:48	02:46:31
QS11 - Stemi, Call to Catheter Insertion 90th Percent	Dec 25	02:57:00	03:20:00			03:19:20	01:27:49	05:10:51
QS12 - Stroke, Call to Hospital Arrival Time Mean	Dec 25	01:40:00	01:30:00			01:35:27	01:15:27	01:55:28
QS13 - Stroke, Call to Hospital Arrival Time Median	Dec 25	01:26:00	01:20:00			01:22:23	01:09:17	01:35:29
QS14 - Stroke, Call to Hospital Arrival Time 90th Per	Dec 25	02:28:00	02:30:00			02:20:56	01:51:29	02:50:22
QS15 - Return of Spontaneous Circulation All	Dec 25	23.7%	25.8%			26.2%	19.7%	32.8%
QS16 - Return of Spontaneous Circulation Utstein	Dec 25	44.7%	48.4%			52.3%	17.2%	87.5%
QS17 - Cardiac Arrest 30 Day Survival - All	Dec 25	9.0%	8.9%			9.3%	3.3%	15.2%
QS18 - Cardiac Arrest 30 Day Survival - Utstein group	Dec 25	27.0%	20.6%			30.5%	5.6%	55.4%
QS19 - Complaints Per 10,000 Interactions	Apr 26	0.14	2.44			0.71	-0.11	1.54
QS20 - Compliments Per 10,000 Interactions	Mar 26	8.64	0.00			6.63	4.02	9.23
QS21 - Level 1 Safeguarding	Apr 26	97.0%	95.0%			96.7%	95.6%	97.7%
QS22 - Level 3 Safeguarding	Apr 26	98.0%	90.0%			97.4%	92.6%	102.2%

Quality & Safety – PSIRF



Variation
Expected
Assurance
Random
Target
30
Latest
26



Variation
Expected
Assurance
Random
Target
9
Latest
3

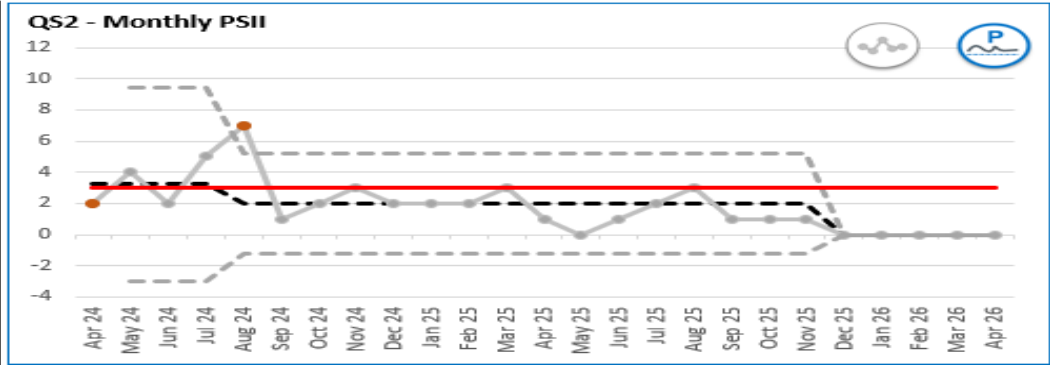
Understanding the Performance:

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

QS1 – A higher number indicates a strong safety culture.

Common cause variation. Levels of PSI with moderate and severe harm and death, as a percentage of all PSIs reported, has increased to 2%; this is aligned to levels seen throughout the year following a decrease last month related to improved performance. There were two delays causing harm, reflecting pockets of lower performance on two days against an otherwise positive picture (OP1, OP2, OP5).

QS2 - Common cause variation. Categories for declared PSII: none declared in April 2026.

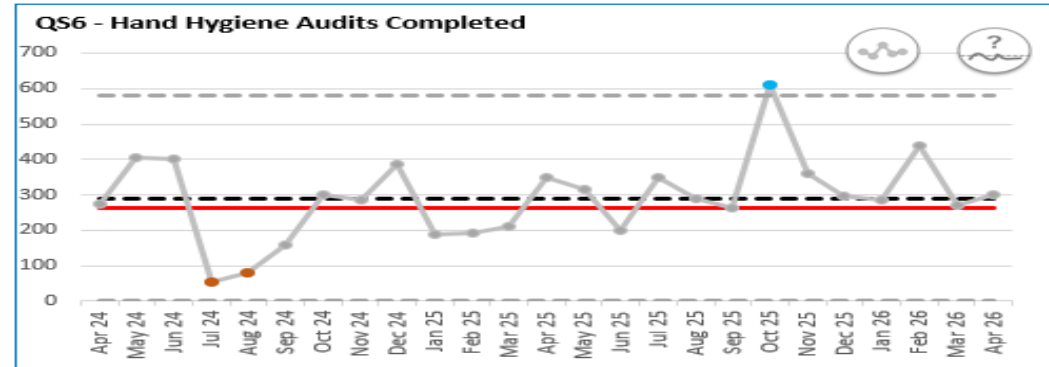


Variation
Expected
Assurance
Pass
Target
3
Latest
0

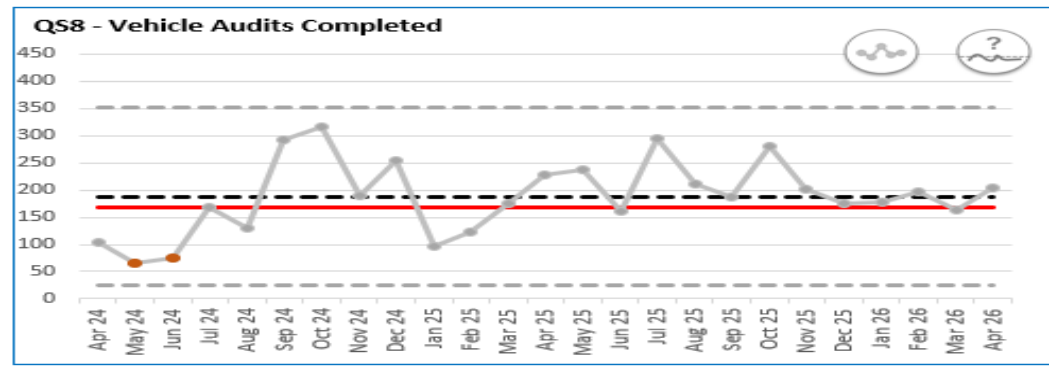
Actions (SMART):

QS3 – A thematic analysis of reattendance has been undertaken and recommendations made; a safety improvement plan has been created and is monitored by the patient safety team and at service line clinical governance to ensure all recommendations are met.

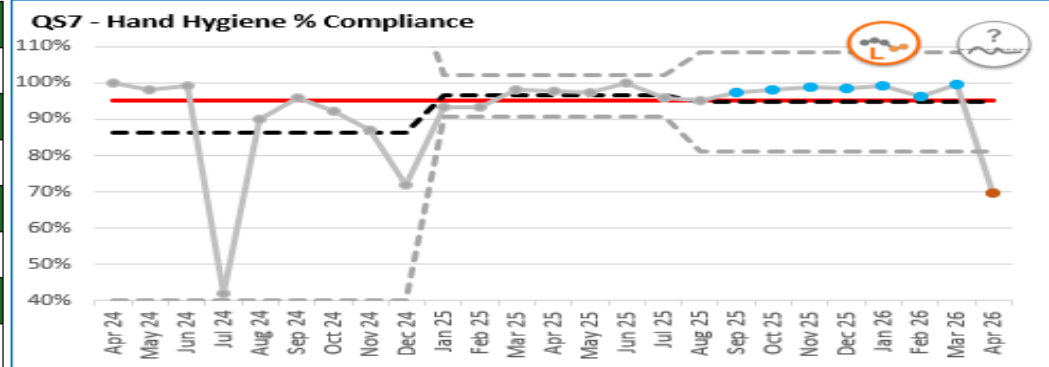
Quality & Safety - Audits



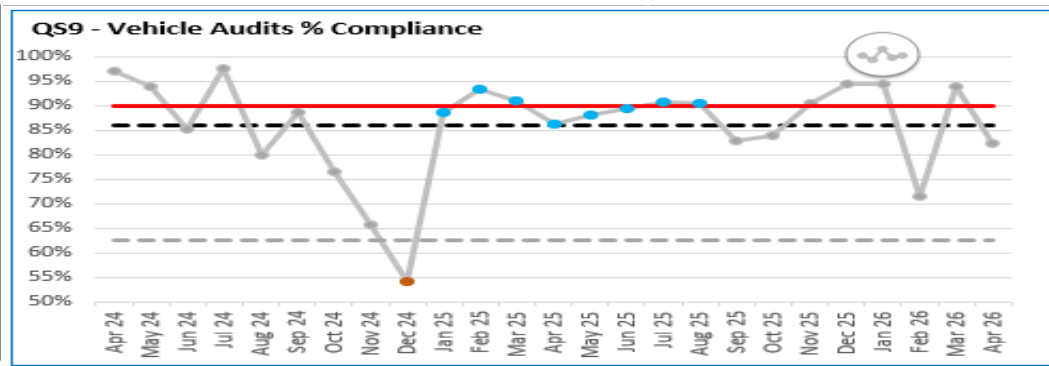
Variation
Expected
Assurance
Random
Target
261
Latest
301



Variation
Expected
Assurance
Random
Target
167
Latest
205



Variation
Declined
Assurance
Random
Target
95.00%
Latest
69.80%



Variation
Expected
Assurance
Random
Target
90.00%
Latest
82.40%

Understanding the Performance:

Within expected variation

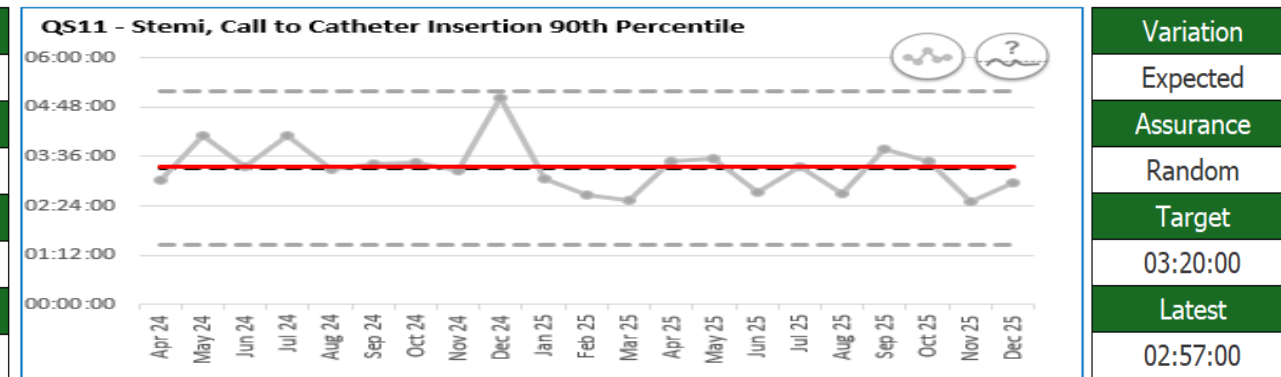
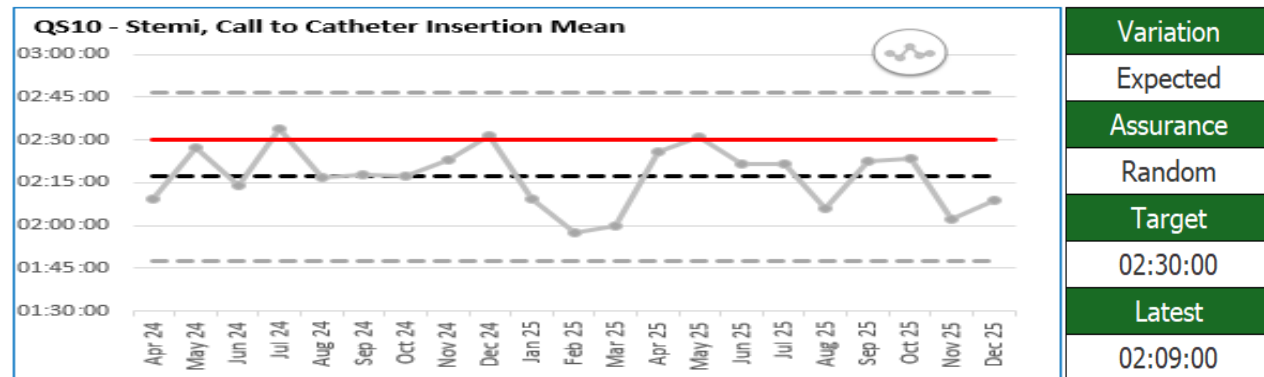
New question set now live with the audit commenced in April 2026

Actions (SMART):

Continue with the development of the Dashboard so that local teams have greater visibility of audit activity (June 2026)

Feedback on items within the audit that were lower scoring – Stretchers and inside cabinets (May 2026)

Quality & Safety – AQLs – STEMI (Heart Attack) - Chief Paramedic Officer



Understanding the Performance:

STEMI Mean (QS10) shows common cause variation and is below the target.

STEMI 90th (QS11) shows common cause variation and is below the target.

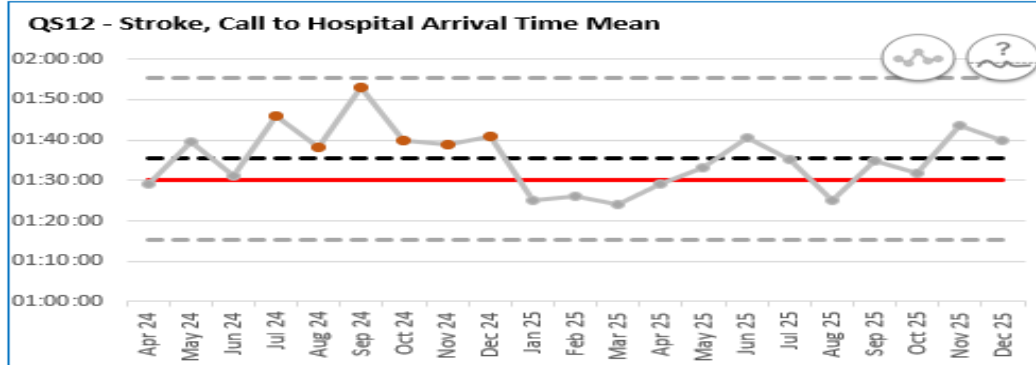
Each of the charts is a system-based performance measure that reflects the whole cycle from point of call to time to insertion of the intervention and therefore includes time taken in hospital following ambulance arrival.

Actions (SMART):

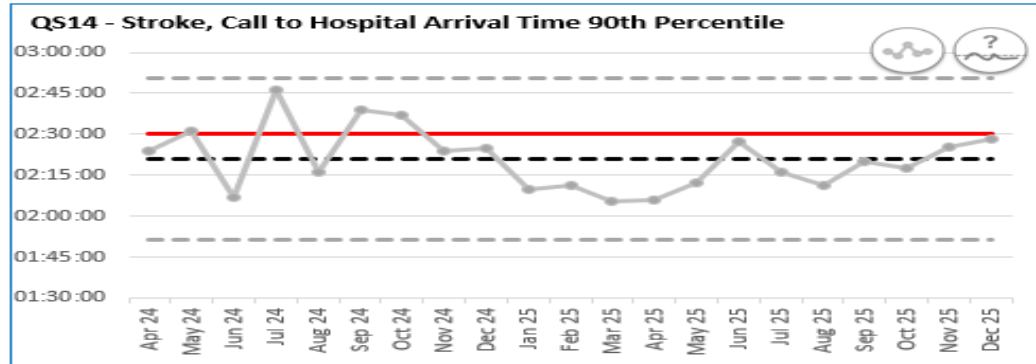
Continue to maximise vehicle availability to respond by reducing handover delays at Emergency Departments (OP 12 OP13 & OP14).

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

Quality & Safety – AQIs – Stroke - Chief Paramedic Officer



Variation
Expected
Assurance
Random
Target
01:30:00
Latest
01:40:00



Variation
Expected
Assurance
Random
Target
02:30:00
Latest
02:28:00

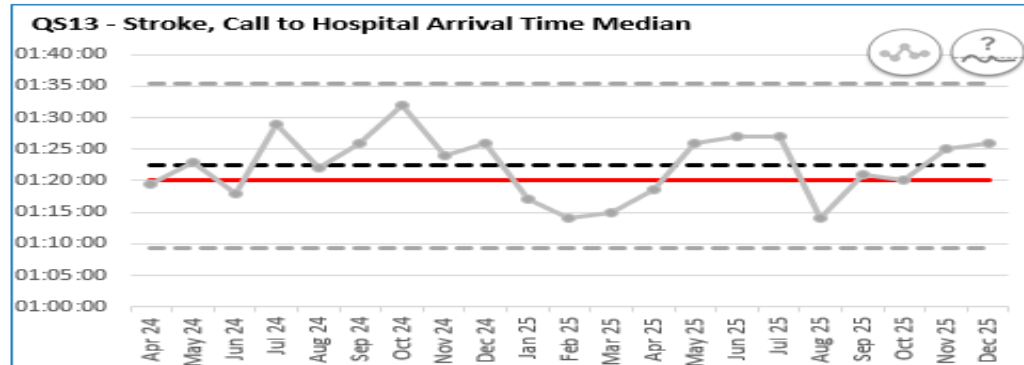
Understanding the Performance:

Stroke Mean (QS12) shows common cause variation and is above the target.

Stroke Median (QS13) shows common cause variation and is at the target.

Stroke 90th (QS14) shows common cause variation and is below the target.

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



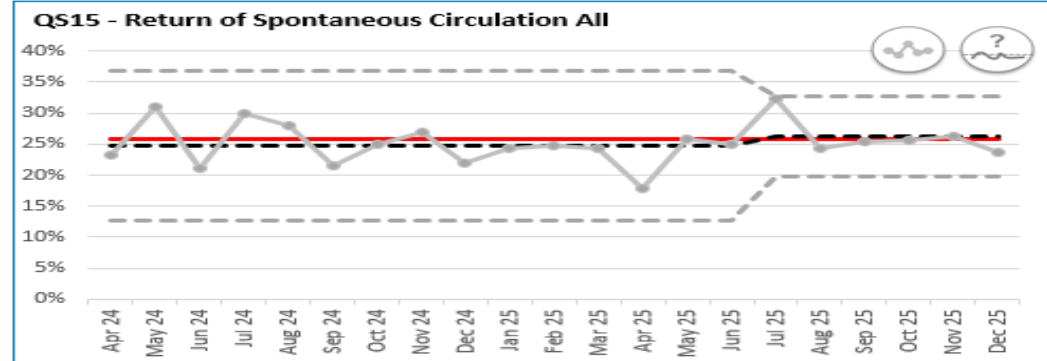
Variation
Expected
Assurance
Random
Target
01:20:00
Latest
01:26:00

Actions (SMART):

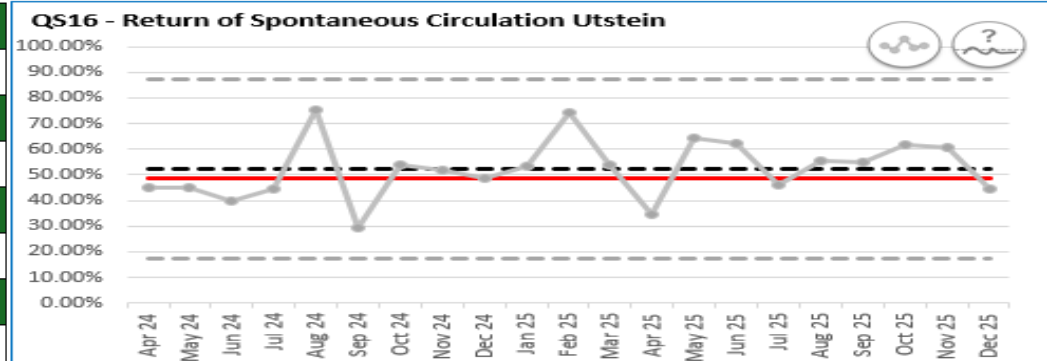
Continue to maximise vehicle availability to respond by reducing handover delays at Emergency Departments (OP 12 OP13 & OP14).

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

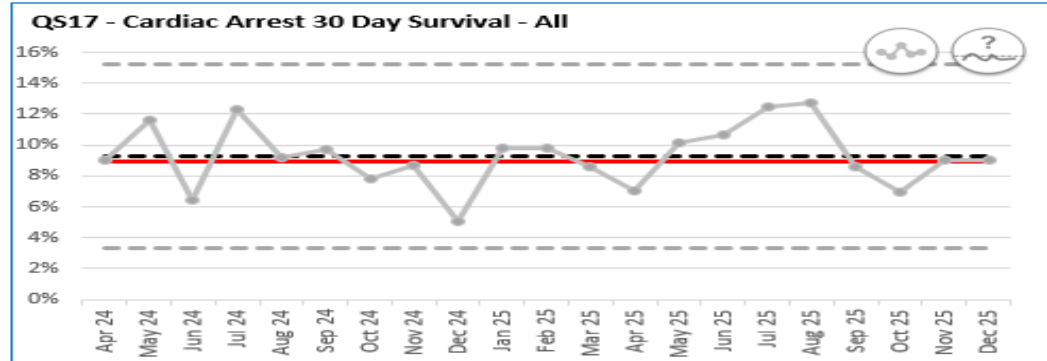
Quality & Safety – AQIs – Cardiac Arrest - Chief Paramedic Officer



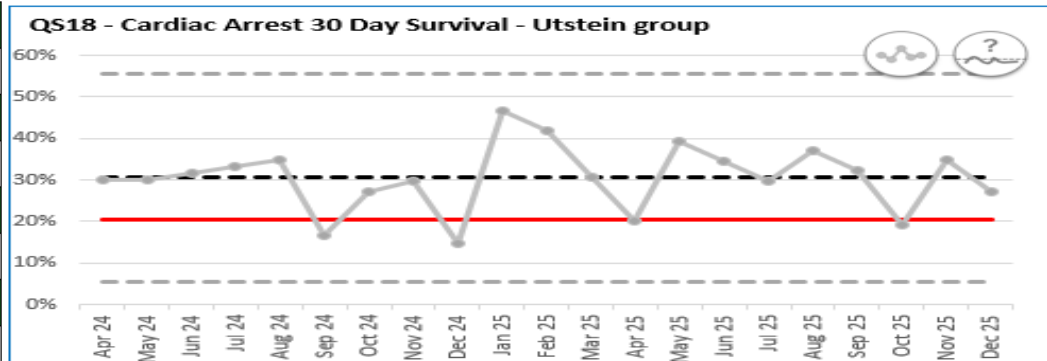
Variation
Expected
Assurance
Random
Target
25.80%
Latest
23.70%



Variation
Expected
Assurance
Random
Target
48.40%
Latest
44.70%



Variation
Expected
Assurance
Random
Target
8.90%
Latest
9.00%



Variation
Expected
Assurance
Random
Target
20.60%
Latest
27.00%

Understanding the Performance:

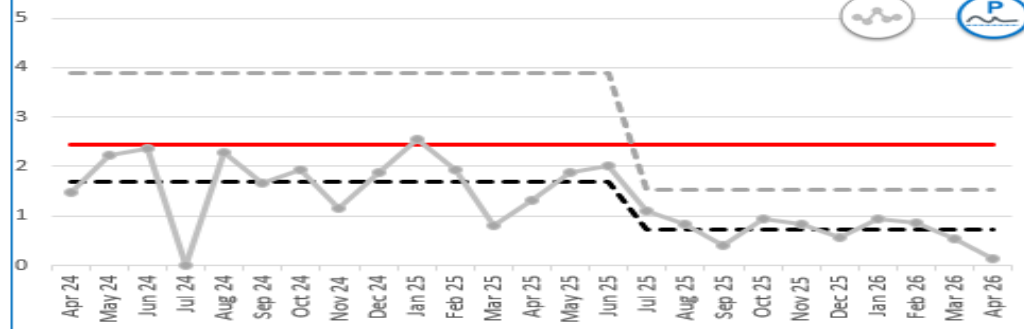
ROSC all (QS15) shows common cause variation, below the target
 ROSC Utstein (QS16) shows common cause variation, below the target
 Cardiac Arrest Survival All (QS17) shows common cause variation at the target
 Cardiac Arrest survival Utstein (QS18) shows common cause variation above the target
 To improve cardiac arrest outcomes a whole system approach is required aligned to the chain of survival.
 Community action prior to ambulance attendance is crucial.

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 2027.

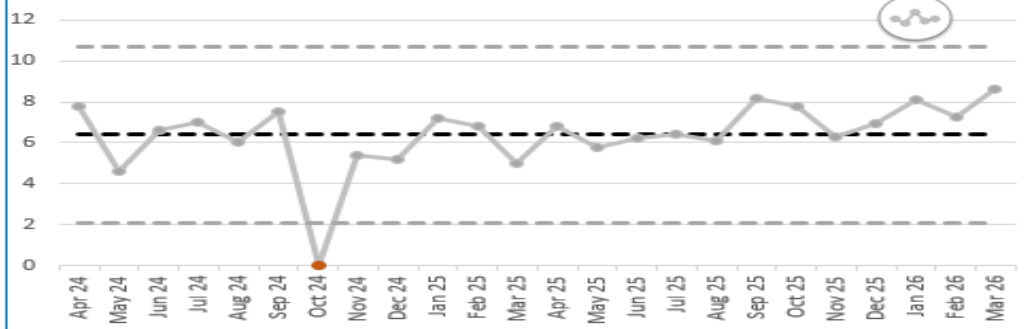
Quality & Safety – Safeguarding and Patient Experience

QS19 – Complaints Per 10,000 Interactions



Variation
Expected
Assurance
Pass
Target
2.440
Latest
0.137

QS20 – Compliments Per 10,000 Interactions



Variation
Expected
Assurance
Target
0
Latest
0

Understanding the Performance:

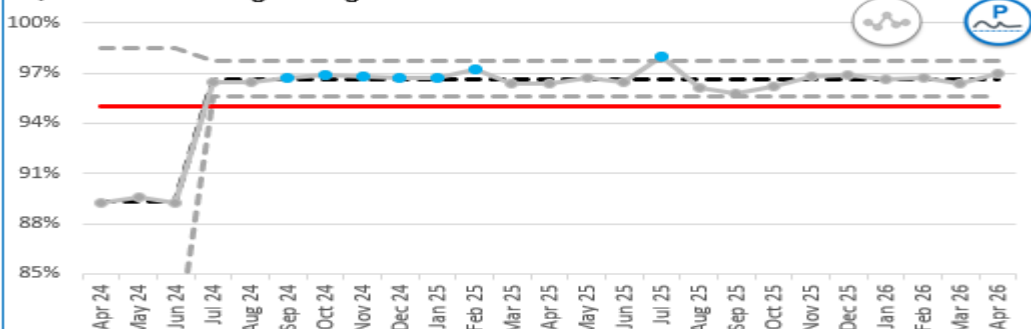
QS20 – Concerns decreased from 74 to 65 representing 24% of all patient experience contacts; 79 compliments, 30% of all patient experience contacts, were received for the same period. Themes remain delays in NEPTS collecting dialysis patients from units post treatment and inappropriate care pathways for the 111 service, mainly submitted by Urgent Treatment Centres.

Actions (SMART):

QS20 – Urgent Treatment Centres are advised on ensuring the Directory of Services is up to date as 50% of cases are owing to incorrect information. Focused training has been undertaken with 111 staff on reading the DoS correctly with quick quizzes and Quality Assurance Coach sessions.

Quality & Safety – Safeguarding and Patient Experience

QS21 - Level 1 Safeguarding



Variation

Expected

Assurance

Pass

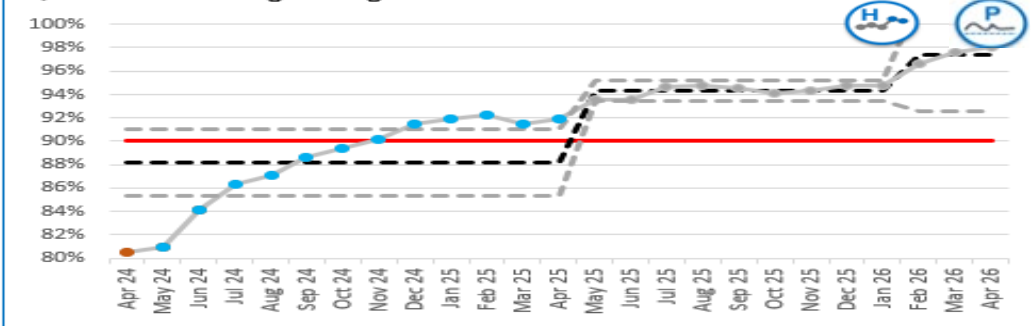
Target

95.00%

Latest

97.00%

QS22 - Level 3 Safeguarding



Variation

Improving

Assurance

Pass

Target

90.00%

Latest

98.00%

Understanding the Performance:

From April 2026 Safeguarding level 3 is being delivered in a different format which means that there will no longer be 4 different components to achieve.

New starters will get 5 hour training and do their prevent and MCA training so that they are compliant for that year.

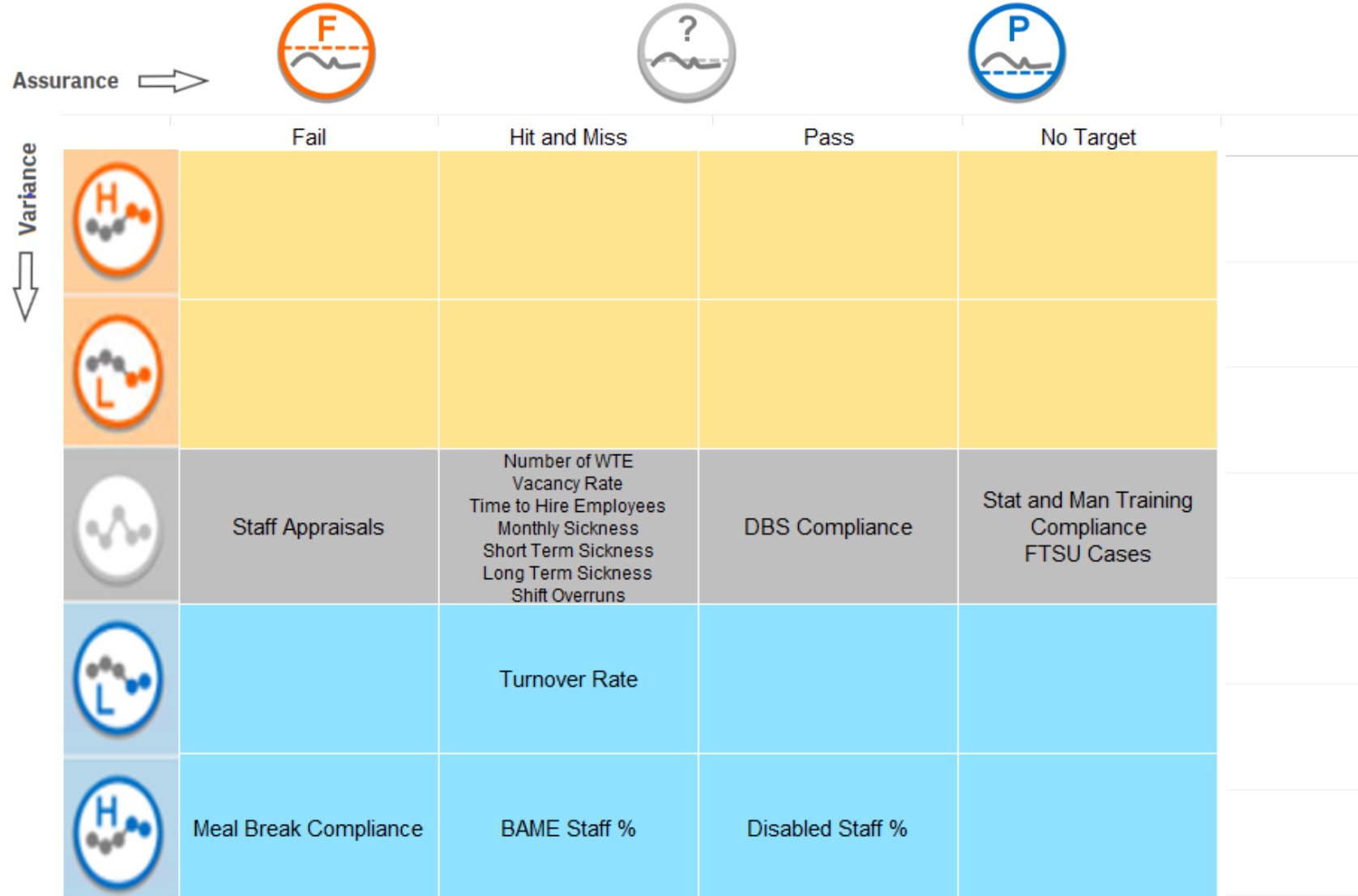
Actions (SMART):

L3 staff will then get 4 hours training every year, 2 hours delivered via teams by the Safeguarding Team and 2 hours SCAS specific eLearning package compiled by the safeguarding team. This will ensure that staff are compliant year on year and allows for specific subject focus and complies with the intercollegiate document.

People

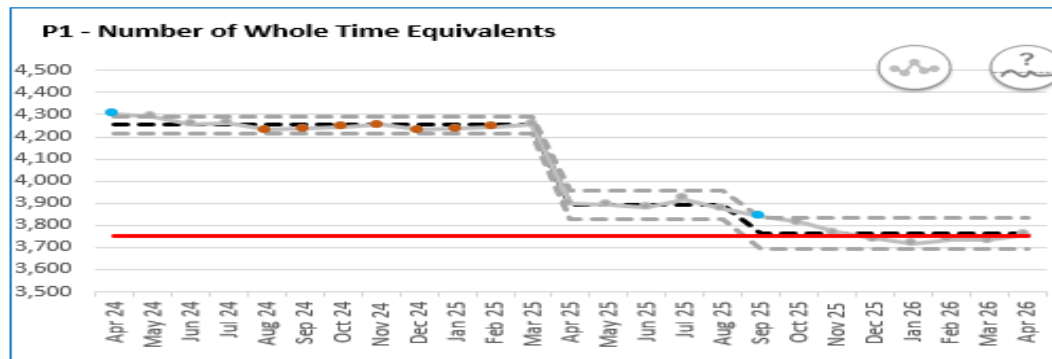
April – 26 Summary

Metrics:

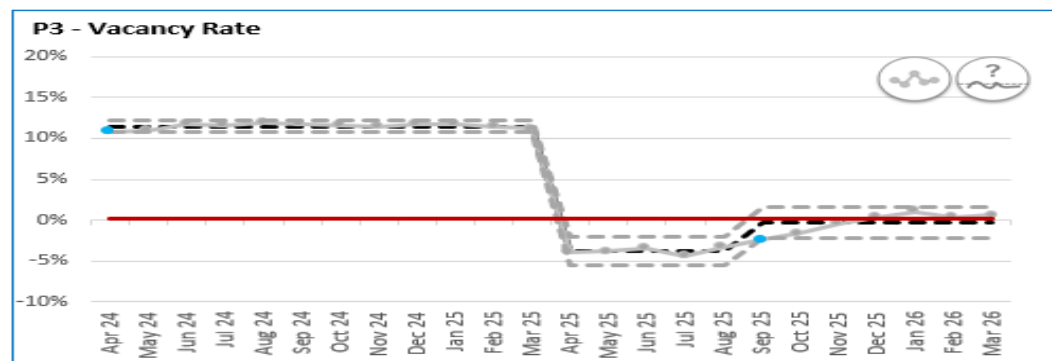


KPI	Latest Month	Actuals	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
P1 - Number of Whole Time Equivalents	Apr 26	3760.89	3753.00			3763.86	3694.74	3832.98
P2 - Turnover Rate	Apr 26	15.1%	17.7%			16.4%	14.4%	18.4%
P3 - Vacancy Rate	Mar 26	0.6%	0.2%			-0.3%	-2.2%	1.6%
P4 - Time to Hire Employee	Mar 26	75.0	70.0			104.8	0.0	180.4
P5 - BAME Staff %	Apr 26	9.21%	8.86%			8.61%	7.97%	9.26%
P6 - Disabled Staff %	Apr 26	12.27%	9.54%			11.44%	10.83%	12.05%
P7 - Monthly Sickness	Apr 26	7.46%	6.20%			7.46%	5.73%	9.19%
P8 - Short Term Sickness	Apr 26	3.19%	2.70%			3.01%	1.99%	4.03%
P9 - Long Term Sickness	Apr 26	4.27%	3.50%			3.86%	2.97%	4.74%
P10 - DBS Compliance	Apr 26	97.8%	95.0%			98.6%	97.7%	99.5%
P11 - Staff Appraisals	Apr 26	86.2%	95.0%			85.3%	81.3%	89.4%
P12 - Stat and Man Training Compliance	Mar 26	100.1%	95.0%			86.8%	84.5%	89.0%
P13 - Freedom to Speak Up Cases	Apr 26	23.0	-			18.1	2.4	33.8
P14 - Meal Break Compliance	Apr 26	80.5%	85.0%			73.1%	64.2%	81.9%
P15 - Shift Overrun Percentage	Apr 26	16.0%	15.0%			15.1%	13.0%	17.2%

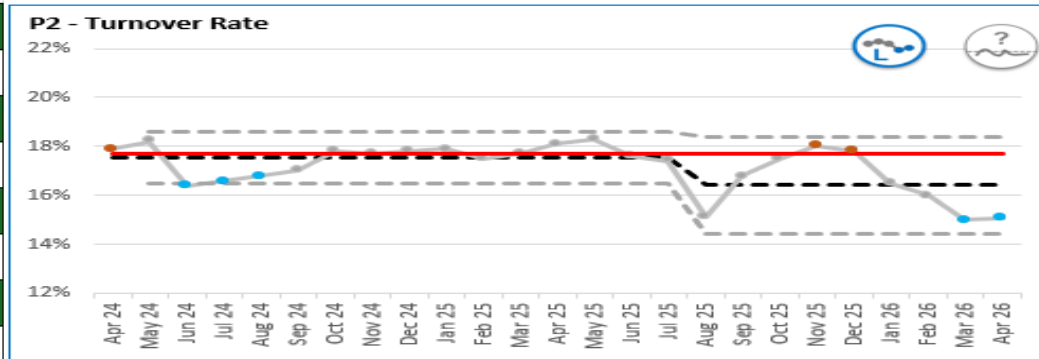
People - Workforce/WTE



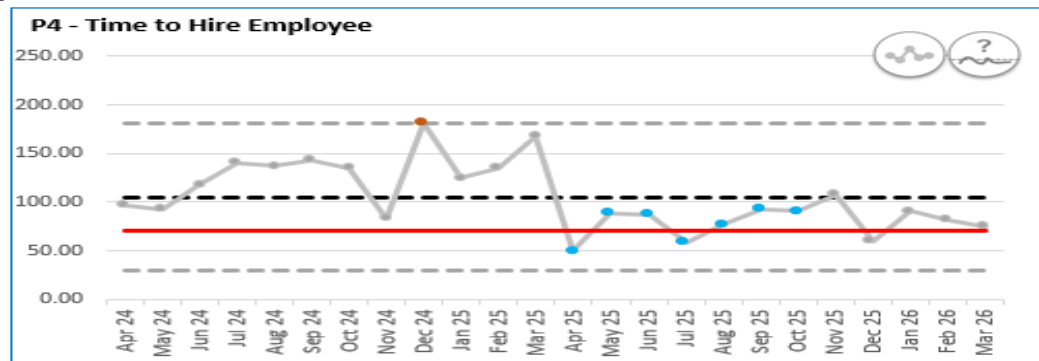
Variation
Expected
Assurance
Random
Target
3753
Latest
3761



Variation
Expected
Assurance
Random
Target
0.20%
Latest
0.00%



Variation
Improving
Assurance
Random
Target
17.70%
Latest
15.05%



Variation
Expected
Assurance
Random
Target
70
Latest
0

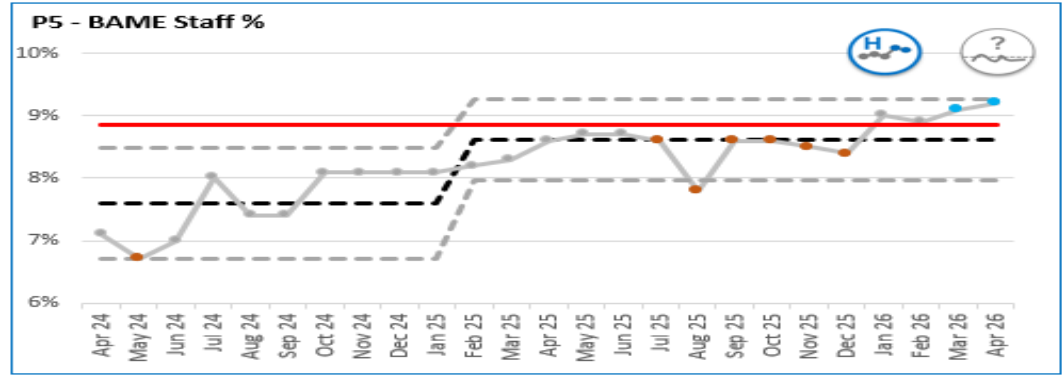
Understanding the Performance:

P4: TTH – Increased to 80.5 median calendar days. Highest TTH in NQPs (484), reflecting candidates on hold following last year's recruitment freeze, alongside broader increases driven by enhanced pre-employment assurance and later candidate start dates. Lowest TTH observed in PTS call centres (38).

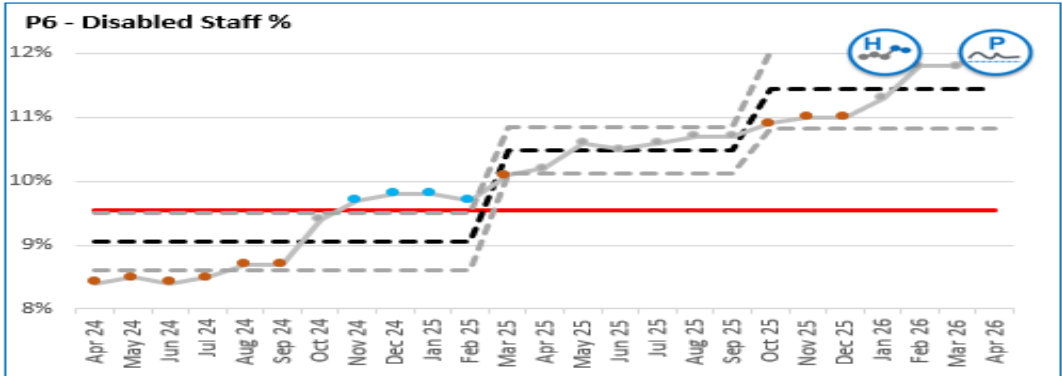
Actions (SMART):

P4: TTH – Time to hire is currently above target, driven in part by team capacity constraints, now mitigated with internal moves. Continued efforts underway to optimise delivery; recent changes, including starting ICC hires 'at risk' and increased Occupational Health capacity, are expected to help accelerate onboarding and reduce delays

People - Workforce/Availability



Variation
Improving
Assurance
Random
Target
8.90%
Latest
9.21%



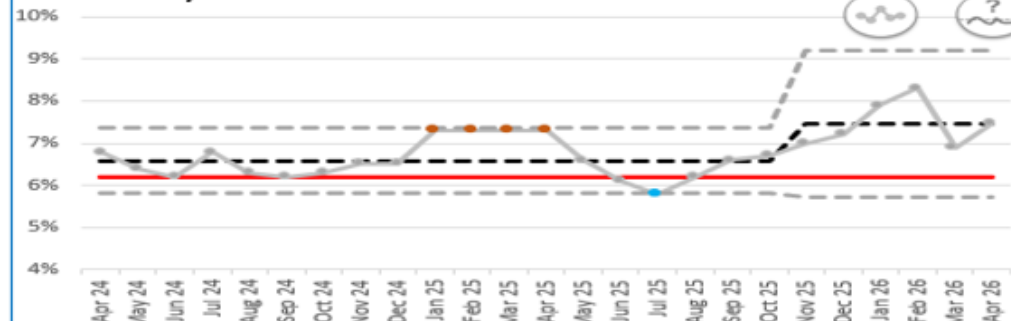
Variation
Improving
Assurance
Pass
Target
9.50%
Latest
12.27%

Understanding the Performance:

Actions (SMART):

People - Workforce/Sickness

P7 - Monthly Sickness



Variation

Expected

Assurance

Random

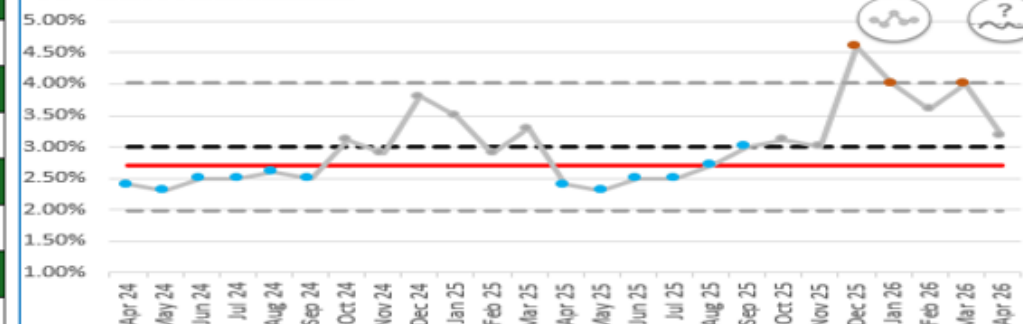
Target

6.20%

Latest

7.46%

P8 - Short Term Sickness



Variation

Expected

Assurance

Random

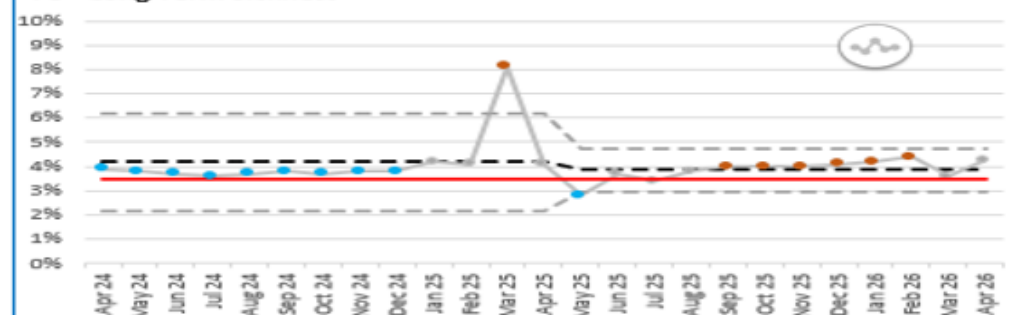
Target

2.70%

Latest

3.19%

P9 - Long Term Sickness



Variation

Expected

Assurance

Random

Target

3.50%

Latest

4.27%

Understanding the Performance:

P7: Although not statistically significant, the increase in sickness levels in April is concerning as traditionally this would be a month we would see reductions. Long term sickness has increased and short term has decreased.

P8: Short term sickness has decreased which is to be expected as short term sickness is highly affected by seasonal fluctuations, however the rates remain above both target levels and the same period for the last 2 years.

P9: The trajectory for long term sickness reflects that constant pressure on local management teams is necessary to ensure that long term sickness is managed effectively. Throughout January and February additional steps were taken to identify long term sickness cases not being managed effectively (legacy cases) and this saw a positive impact on long term absence rates.

Actions (SMART):

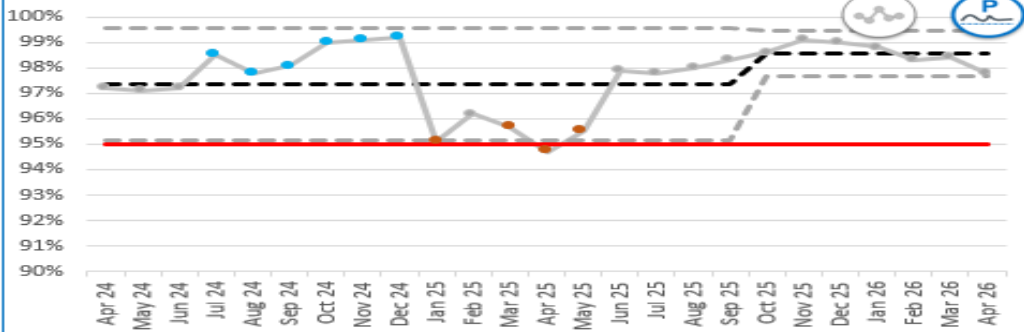
P7: The Employee Relations team have developed a new recording system for all sickness case contacts and meetings. Data has been input from 1st April 2026 and is constantly reviewed for improvements and developments. The volume of data is now reaching sufficient levels to enable analysis. Further steps include linking this information with GRS so that it can be cross referenced with cases which have hit trigger points to review management gaps.

P8: The people team are concerned that without constant pressure to manage absence the rates will continue to increase and therefore steps are in place from the Employee Relations team to ensure that support, reminders and escalations are in place.

P9: The Employee Relations team have set up additional logging and monitoring processes and all long term sickness cases are being escalated to Heads of Departments to ensure that management is undertaken in accordance with policy and in a timely manner. Failure to manage cases as per policy are also being escalated to Divisional Directors and above.

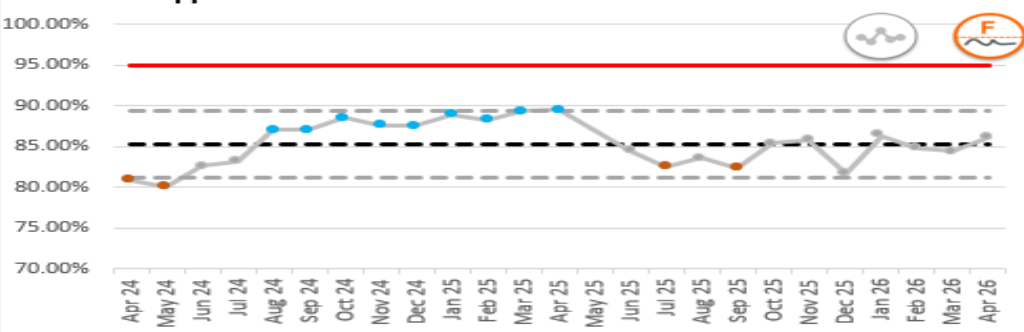
People – Workforce/Staff Compliance

P10 - DBS Compliance



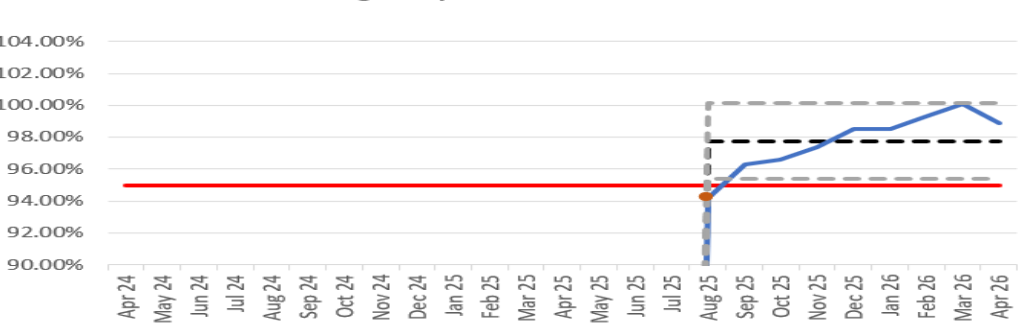
Variation
Expected
Assurance
Pass
Target
95.00%
Latest
97.80%

P11 - Staff Appraisals



Variation
Expected
Assurance
Fail
Target
95.00%
Latest
86.16%

P12 - Stat and Man Training Compliance



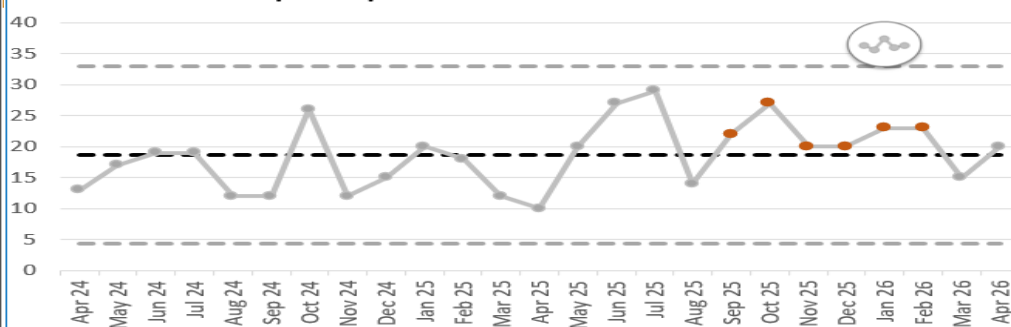
Variation
Expected
Assurance
Random
Target
95.00%
Latest
98.90%

Understanding the Performance:

Actions (SMART):

People - Workforce/Staff Welfare

P13 - Freedom to Speak Up Cases



Variation

Expected

Assurance

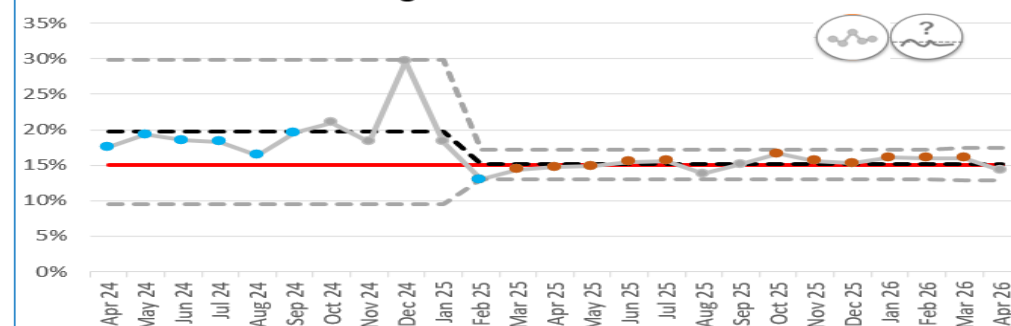
Target

0

Latest

20

P15 - Shift Overtime Percentage



Variation

Expected

Assurance

Random

Target

15.00%

Latest

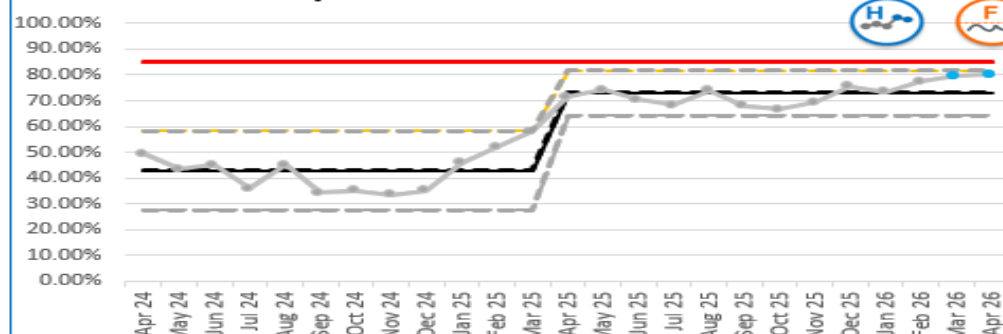
14.27%

Understanding the Performance:

P-14 - MB compliance has maintained its position just below target and has seen a step in mean performance.

P 15 - Shift overruns have maintained a consistent level just above target

P14 - Meal Break Compliance



Variation

Improving

Assurance

Fail

Target

85.00%

Latest

80.47%

Actions (SMART):

Modelling work commissioned has yet to be delivered to highlight the operational impact of breaks away from base but we have seen a consistency in compliance. Working with key stakeholders to review MB and EoS process to balance the staff needs and the needs of patients.



TRUST BOARD OF DIRECTORS
3 June 2026

Report title	Month 1 Financial Performance
Agenda item	11
Report executive owner	Jon Bell, Interim Chief Finance Officer
Report author	Spriha Dutt, Deputy Chief Finance Officer
Governance Pathway: Previous consideration	Finance and Performance Committee
Governance Pathway: Next steps	N/A

Executive Summary

Income & Expenditure (I&E)

The M1 position is break-even against plan, with a £3k favourable variance, representing a stable start to the financial year. However, sustaining this position will require robust financial control and accelerated progress in identifying and delivering against the Cost Improvement Programme (CIP).

Capital

Capital expenditure in Month 1 was £0.5m against a plan of £2.7m, reflecting slippage in estates and fleet programmes, with spend expected to accelerate from Month 3 onwards.

Cash

The Trust's cash balance at the end of April was £36.5m, which is £6.7m ahead of plan. In month, the Trust generated a net cash outflow of £7.7m, reflecting the timing of payments, including £17.8m of purchases.

Key Performance Indicators

	Actual	Plan	Variance
Surplus / (Deficit) In-month (£'000)	51	48	3
Pay Costs In-Month (excl. agency) (£'000)	18,490	18,033	-457
Agency Costs - in month (£'000)	152	127	-25
Capital Spend - YTD (£'000)	527	2,697	-2,170
Closing Cash Position (£m)	36.5	29.8	6.7

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	✓
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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 1, the Trust's I&E position is break-even, with a £3k favourable variance to plan.

	Month 1			YTD - Month 1			FY 25/26
	Actual £'000s	Budget £'000s	Variance £'000s	Actual £'000s	Budget £'000s	Variance £'000s	Budget £'000s
Income from patient care activities	27,429	27,410	19	27,429	27,410	19	328,916
Other income	322	278	44	322	278	44	3,337
Deficit Support Funding	-	-	-	-	-	-	-
Income Total	27,751	27,688	63	27,751	27,688	63	332,253
Substantive	18,179	17,699	(480)	18,179	17,699	(480)	213,918
Bank	311	334	23	311	334	23	4,040
Agency	152	127	(25)	152	127	(25)	697
Pay Total	18,642	18,160	(482)	18,642	18,160	(482)	218,655
Non Pay	8,260	8,215	(45)	8,260	8,215	(45)	99,979
Contingency	-	498	498	-	498	498	3,927
Injury Benefit	17	-	(17)	17	-	(17)	204
Depreciation	1,579	1,579	(0)	1,579	1,579	(0)	20,233
IFRS16 Interest	106	125	18	106	125	18	1,845
IFRS16 Credits	(892)	(940)	(47)	(892)	(940)	(47)	(12,634)
Financing Costs	35	49	14	35	49	14	585
P&L on disposal	3	5	1	3	5	1	70
Other Total	848	1,316	468	848	1,316	468	14,231
Surplus/(Deficit)	1	(3)	4	1	(3)	4	(612)
System Reporting Adj	50	51	(1)	50	51	(1)	615
Surplus/(deficit) adjusted	51	48	3	51	48	2	2

The in-month position was supported by the phasing of the Cost Improvement Programme, which has been weighted lower in Months 1 and 2 to allow the Trust time to finalise and strengthen delivery plans ahead of full mobilisation from Month 3.

It should be noted that had the CIP been phased in equal twelfths, the in-month plan would have been £370k higher, indicating that the current favourable position is supported by planned phasing rather than recurrent savings delivery.

Service-Specific Performance

For SCAS, the table below details the financial position, by Division, as at Apr 2026 (Month 1)

		Month 1			Month 1 YTD			26/27 FY		
		Actual £'m	Plan £'m	Variance £'m	Actual £'m	Plan £'m	Variance £'m	Actual £'m	Plan £'m	Variance £'m
999	Income	21.9	21.9	0.0	21.9	21.9	0.0	262.8	262.8	(0.0)
	Expenditure	(17.5)	(16.8)	(0.7)	(17.5)	(16.8)	(0.7)	(201.8)	(201.8)	0.0
	Contribution %	4.4 20%	5.0 23%	(0.6)	4.4 20%	5.1 23%	(0.6)	61.1 23%	61.1 23%	(0.0)
111	Income	3.5	3.5	0.0	3.5	3.5	0.0	42.4	42.4	0.0
	Expenditure	(3.3)	(3.3)	(0.0)	(3.3)	(3.3)	(0.0)	(40.8)	(40.8)	0.0
	Contribution %	0.3 8%	0.3 7%	0.0	0.3 8%	0.3 7%	0.0	1.5 4%	1.5 4%	0.0
PTS	Income	2.0	2.0	(0.0)	2.0	2.0	(0.0)	23.7	23.7	0.0
	Expenditure	(1.6)	(1.6)	(0.0)	(1.6)	(1.6)	(0.0)	(19.6)	(19.6)	(0.0)
	Contribution %	0.4 18%	0.4 20%	(0.0)	0.4 18%	0.4 20%	(0.0)	4.2 18%	4.2 18%	(0.0)
Operations Total Contribution %		5.0 18%	5.7 21%	(0.6)	5.0 18%	5.7 21%	(0.7)	66.8 20%	66.8 20%	0.0
Corporate		(5.0)	(5.7)	0.7	(5.0)	(5.7)	0.7	(67.5)	(67.5)	(0.0)
Surplus/(Deficit)		(0.0)	(0.0)	0.0	(0.0)	(0.0)	0.0	(0.7)	(0.7)	(0.0)
Reporting Adjustments		0.1	0.1	0.0	0.1	0.1	0.0	0.7	0.7	(0.0)
Adjusted Surplus/(Deficit)		0.1	0.1	0.0	0.1	0.1	0.0	0.0	0.0	(0.0)

999 Division

The Division reported an in-month deficit of £0.6m against plan, primarily due to unmet CIP targets. It is worth noting that expenditure pressures were experienced within A&E resourcing to support delivery of Category 2 performance targets. However, these pressures were largely offset by vacancies across other areas within the Division, including clinical roles within ICC which would impact the delivery of 'Hear & Treat'.

111 Services

The 111-service remained within plan; however, it is worth noting that Contact Centre resourcing overspent by £0.1m. Despite under-delivery of CIPs, the division remained within plan due to underspends across other pay lines, as well as non-pay budgets.

Non-Emergency Patient Transport Services (NEPTS)

The NEPT service reported an in-month overspend of £30k, primarily driven by resourcing. This has been offset by underspends across other pay lines within the service, due to the number of vacancies within the service, which is a temporary relief, that would need to be managed through delivery of productivity and efficiency savings. There is also a workforce risk associated with an inability to fulfil hours with substantive staff, which could lead to additional pressures through use of private providers and taxis.

Corporate Divisions

The Corporate Division reported an in-month surplus of £0.7m against plan, driven by underspends within Digital and other areas relating to projects that have not yet commenced or cost pressures that haven't materialised.

Financial Risks & Planning

The Trust will need to monitor operational and financial risks throughout the year, including workforce, fleet, and non-pay pressures, alongside risks associated with strategic and multi-year planning. Any financial risks will need to be mitigated through additional cost savings.

Budget holders are expected to manage expenditure within agreed run rate budgets and minimise discretionary spend to support delivery of the financial plan.

Workforce expenditure will continue to be closely monitored, with corporate recruitment controls, including vacancy freezes, already implemented up to Q2 to mitigate financial risk and support overall organisational affordability.

Recruitment and establishment pressures within frontline services present an ongoing operational and financial risk, including both over establishment against funded levels and shortfalls in available substantive hours due to abstraction and attrition. This creates delivery risk in relation to the 27.5 minutes Cat 2 requirement. Where substantive capacity is not available, there is a consequential risk of increased reliance on overtime or external/private providers, which will be closely monitored to ensure financial control and operational sustainability.

Cost Improvement Plan (CIP)

The Trust currently has a total CIP gap of £19.7m, of which £4.5m remains unidentified. It is therefore essential that all teams across SCAS contribute to identifying opportunities and efficiencies to support in closing this gap. This is being progressed both at individual Directorate level and through cross-functional discussions within the Senior Leadership teams.

The Plan is underpinned by £14.5m (73.4%) recurrent delivery and £5.2m (26.6%) non-recurrent delivery.

In-month delivery was £0.7m (3.5% of the full-year plan), as set out in the table below. This leaves a £0.6m gap to be recovered in later periods. At M1, the CIP scheme portfolio totalling £19.7m remains at an early stage of maturity, with a significant proportion still requiring further development and validation.

	Month			YTD		
Division	Actual	Plan	Var	Actual	Plan	Var
	(£'000s)	(£'000s)	(£'000s)	(£'000s)	(£'000s)	(£'000s)
999	447	742	(294)	447	742	(294)
111	0	25	(25)	0	25	(25)
Fleet	0	167	(167)	0	167	(167)
PTS	60	18	42	60	18	42
Corporate	187	240	(54)	187	240	(54)
Central	0	76	(76)	0	76	(76)
Total	694	1,267	(574)	694	1,267	(574)
Recurrent	465	1,155	(690)	465	1,155	(690)
Non-Recurrent	229	113	116	229	113	116
Total	694	1,267	(574)	694	1,267	(574)

In-month, 999 delivered £0.4m of savings through vehicle hire and operational efficiency initiatives. £0.3m of this is recurrent in nature, with the remaining £0.1m non-recurrent, reflecting temporary clinical vacancies within the call centre establishment.

In-month, PTS delivered £60k of savings through reduced subsistence claims and Fleet maintenance costs. Of this, £17k is recurrent, while the remaining £43k is non-recurrent, primarily reflecting temporary vacancies within the department. The pay underspend may also be partly attributable to a reduction in abstraction; however, this would need to be monitored over coming months to confirm.

In-month, Corporate delivered £0.19m of savings through various schemes. Performing Directorates are: Chief Paramedic £33k, Digital £42k, Estates £42k, Governance £9k, People £53k and Transformation £9k.

Trust Pay Costs

Pay	Month 1			Year to Date		
	Actual	Plan	Variance	Actual	Plan	Variance
	£000's	£000's	£000's	£000's	£000's	£000's
Substantive	18,179	17,699	(480)	18,179	17,699	(480)
Bank	311	334	23	311	334	23
Agency	152	127	(25)	152	127	(25)
Total Pay	18,642	18,160	(482)	18,642	18,160	(482)

Substantive Pay Costs:

Total pay expenditure for the month was £18.2m against a budget of £17.7m, resulting in an overspend of £0.5m. This variance is primarily attributable to the non-delivery of Cost Improvement Programme (CIP) savings within pay, leading to higher than planned staffing costs.

Agency Costs:

- Agency costs totalled £152k, exceeding the plan by £25k.
- The spend above plan was driven by Fleet Mechanics in SCFS.

Bank Costs:

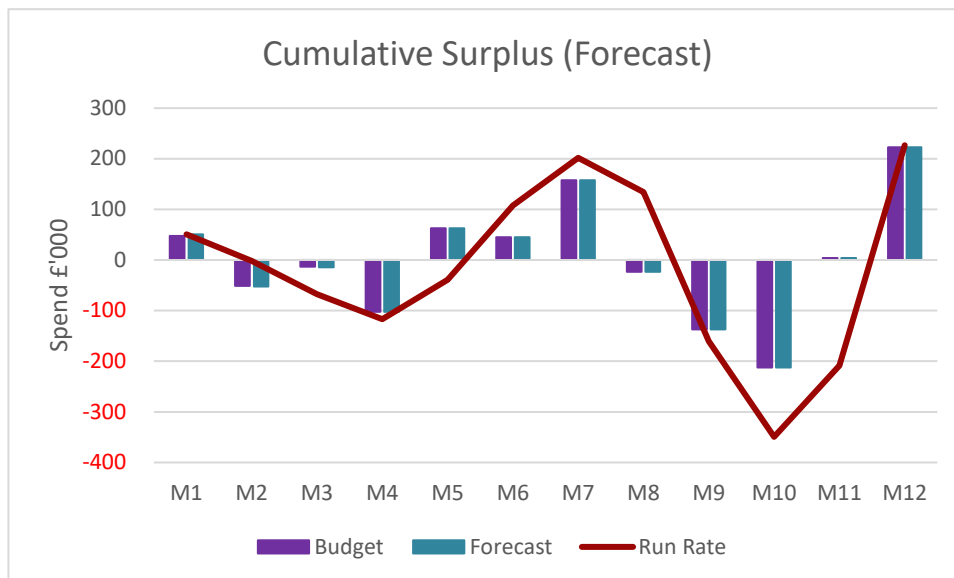
- Bank costs totalled £311k, under budget by £23k.
- The underspend is due to a lower uptake of bank shifts across service lines

Non- Pay Costs

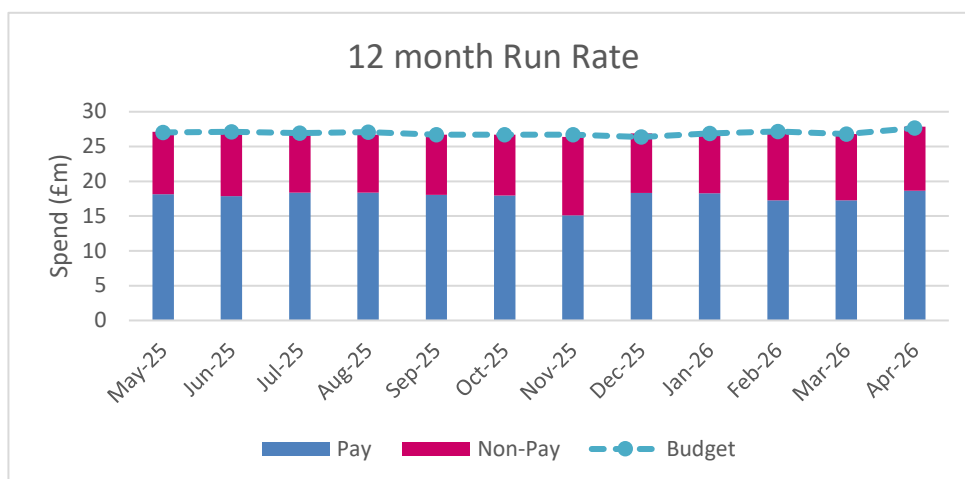
Non-pay expenditure is in line with H2 25/26 spend levels and is reporting a small adverse variance of £45k against budget. Considering ongoing geo-political uncertainty and potential supply chain disruption risks, continued focus is required on maintaining appropriate inventory levels while managing associated cost pressures.

Run Rate

The cumulative surplus trajectory reflects periods of financial pressure during the year, particularly through the winter months, before improving materially in M12. The fluctuations reflect the phasing of workforce deployment in line with demand across the reporting period.



The 12-month run rate demonstrates the movement in pay and non-pay expenditure against budget between May 2025 and April 2026. Monthly fluctuations largely reflect workforce phasing aligned to operational demand and the timing of non-pay expenditure across the financial year.



Capital

The Trust's capital expenditure up to April was £0.5m on a budget of £2.7m.

Capital spend – Key Drivers

- **2025/26 DCA Cohort (MAN units):** The delayed 25/26 DCA cohort faces further delays in 26/27 with expected spend budgeted in Q1 pushed back into Q3 due to the availability of slots at the coach builders.
- **Estates spend:** Slippage in estates schemes has resulted in £0.8m of underspend at M1. Spend is expected to pick up in M2 and M3 through the Eastleigh fit out and DNO upgrades projects.

The sale of the Chalfont property (£1m) 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 is expected to complete in early 26/27.

The sale of the Amersham property is on-going (£1.1m) but has been delayed. It is expected to complete in early 26/27. The sale of the Maids Moreton property is on-going and is expected to be sold in 26/27.

		Year to Date			Forecast		
	£m	Actual	Plan	Variance	Actual	Plan	Variance
Estates	Internal CDEL	0.0	0.4	(0.3)	4.0	4.0	0.0
	PDC	0.1	0.3	(0.3)	9.3	9.3	0.0
	Disposal	0.0	0.0	0.0	(2.1)	(2.1)	0.0
	IFRS16	0.0	0.2	(0.2)	0.4	0.4	0.0
	Total	0.1	0.8	(0.8)	11.6	11.6	0.0
Digital	Internal CDEL	0.0	0.1	(0.1)	4.2	4.2	0.0
	Total	0.0	0.1	(0.1)	4.2	4.2	0.0
Fleet (DCA)	Internal CDEL	0.1	1.5	(1.4)	11.3	11.3	0.0
	PDC	0.0	0.0	0.0	6.2	6.2	0.0
	Disposal	0.0	0.0	0.0	(28.9)	(28.9)	0.0
	IFRS16	0.0	0.0	0.0	25.6	25.6	0.0
	Total	0.1	1.5	(1.4)	14.3	14.3	0.0
Fleet (Non-DCA)	Internal CDEL	0.2	0.3	(0.1)	2.1	2.1	0.0
	Disposal	0.0	0.0	0.0	(3.9)	(3.9)	0.0
	IFRS16	0.0	0.0	0.0	3.2	3.2	0.0
	Total	0.2	0.3	(0.0)	1.4	1.4	0.0
Operations, Ops Support & Education	Internal CDEL	0.1	0.0	0.1	0.7	0.7	0.0
	Total	0.1	0.0	0.1	0.7	0.7	0.0
Other	Disposal	0.0	0.0	0.0	(0.1)	(0.1)	0.0
	Total	0.0	0.0	0.0	(0.1)	(0.1)	0.0
Internal CDEL Total		0.5	2.2	(1.8)	22.3	22.3	0.0
PDC Total		0.1	0.3	(0.3)	15.5	15.5	0.0
Disposal Total		0.0	0.0	0.0	(35.0)	(35.0)	0.0
IFRS16 Total		0.0	0.2	(0.1)	29.3	29.3	0.0
Total		0.5	2.7	(2.2)	32.0	32.0	0.0

* PDC – Public Dividend Capital

Cash

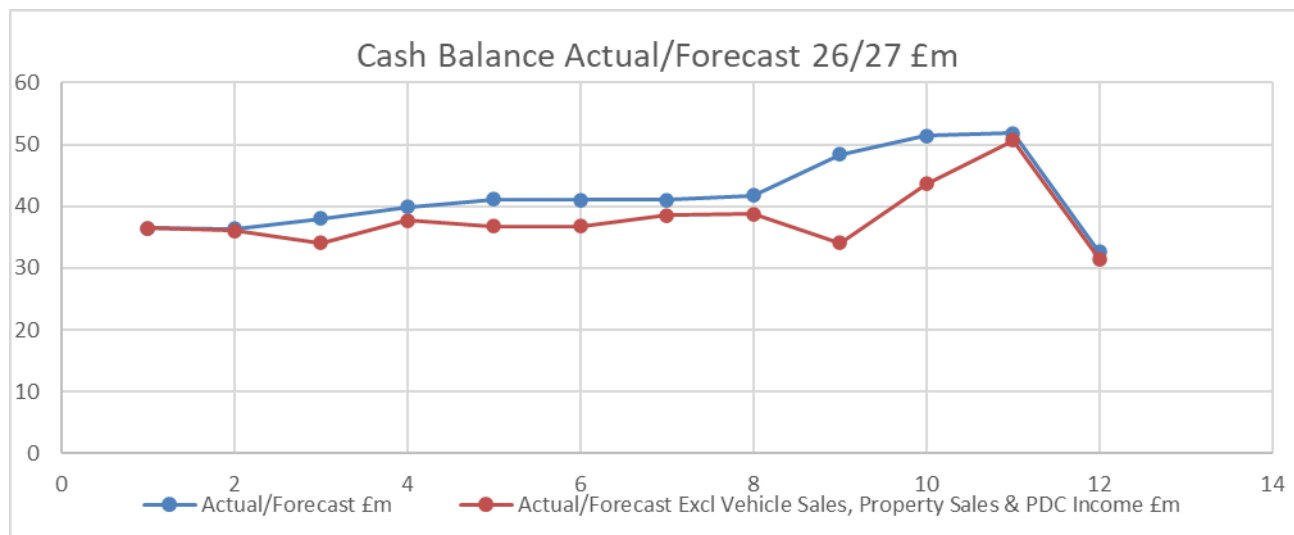
The Trust's cash balance at the end of April was £36.5m.

2026/27	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Income £m	28.3	28.7	32.1	30.3	32.5	32.4	30.6	31.1	42.4	35.9	29.3	29.4
Expenditure £m	(36.0)	(28.8)	(30.4)	(28.4)	(31.3)	(32.5)	(30.6)	(30.5)	(35.8)	(32.8)	(28.9)	(48.6)
Net Inflow/(Outflow) £m	(7.7)	(0.1)	1.6	1.9	1.2	(0.1)	(0.0)	0.7	6.7	3.1	0.4	(19.2)
Cash Balance £m	36.5	36.4	38.0	39.9	41.1	41.1	41.1	41.7	48.4	51.4	51.8	32.7

Cash Lowest Point	36.0
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The lowest point of cash in the month was £36m which is a reduction from last month by £6.1m.

There was a net cash outflow in month 1 of £7.7m, the decrease in cash is mostly due to the payment of £17.8m of purchases which included £2.6m of capital cash spend relating to the prior year.



The 90-day debtor increased to £0.17m in Apr (£0.16m in Mar). This represents 8.19% (7.66% in Mar) of the total debtor balance. The percentage debtors has increased due to the overall debt balance increasing.

Overdue debts include; Aurobindo Emergency Medical Services £80k, FedBucks Ltd £29k, NHS Beds Luton and Milton Keynes ICB £17k, NHS Frimley ICB £13k and University Hospital Southampton NHS FT £33k.

Our Better Payment Practice Code (BPPC) performance continues above the 95% target at Month 1.

Month 1 - YTD BPPC				
	Number	%age	Value	%age
NHS	108	98.1%	£642,895	96.3%
Non-NHS	1,076	94.8%	£16,189,586	99.2%
Total	1,184	95.1%	£16,832,481	99.1%
Target		95.0%		95.0%
Variance		0.1%		4.1%

2 Quality Impact

N/A

3 Financial Impact

As detailed above

4. Risk and compliance impact

Area of Risk

- Operational fleet risks: Delays in the delivery of new DCA vehicles may have potential impact on vehicle availability and frontline performance
- Workforce cost and capacity pressures: Pay and agency expenditure remained above budget in some areas. Recruitment and retention pressures within 999 services require ongoing management to support delivery of performance targets.
- Non-pay expenditure pressures: Unplanned or discretionary expenditure present a risk if not appropriately controlled and prioritised.
- Alignment in future years planning: Misalignment between multi-year planning, operational requirements, and capital investment strategies could contribute to recurring financial pressures or suboptimal resource allocation in future years.

5. Equality, diversity and inclusion impact

N/A

6. Next steps

To address the current financial position and support delivery of the FY plan, the following actions will continue to be progressed:

- Optimise workforce deployment across all service lines to support strategic priorities and evolving service needs.
- Review vacancies and recruitment pipelines to ensure alignment with long-term workforce plans; with short-term, non-recurrent vacancy controls in place until CIP plans are strengthened.
- Maintain continued scrutiny of non-pay expenditure, ensuring value for money and alignment with agreed strategic investment priorities.
- Continue bi-weekly FRG meetings alongside the introduction of assurance meetings (monthly for high-risk areas and quarterly for others) to strengthen financial performance oversight and support CIP delivery and monitoring.
- Embed multi-year financial planning to anticipate recurring pressures, support strategic initiatives, and ensure alignment with the 2026/27 budget setting process.

7. Recommendation(s)

The Board is asked to:

- The Board is asked to note the M1 Financial performance and current risks to delivering the FY plan.

BAF Risk 17 – Delivery of Fleet Improvement Plan			
If we do not deliver against the trajectory to reduce our Vehicle Off Road rate, Then we will not have sufficient vehicles to meet demand, Resulting in the potential for avoidable harm or death.			
Controls, Assurance and Gaps		Accountable Director	Chief Finance Officer
Controls: New workshop Aylesbury, with recruitment underway to accelerate delivery. Fleet replacement strategy in progress, including multiple vehicle builds (MAN Box 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		Committee	Finance & Performance
		Inherent Risk Score	Impact 4 x Likelihood 4 = 16
		Residual Risk Score	Impact 4 x Likelihood = 16
Gaps in controls: Delayed VCU project, impacting fleet commissioning timelines, supply chain fragility (delays with convertors). Charging infrastructure and behavioural issues affecting auxiliary charging and vehicle readiness. Estate infrastructure to charge vehicle at all sites.		Target Risk Score	Impact 4 x Likelihood 2 = 8
Positive sources of assurance: Aylesbury workshop now live . Delivery of 2026/27 Operational Plan and performance explicitly contingent on: VOR down to 30%, VCU commissioned and fully operational. With further requirements need for 2027/28 onward to deliver the multi-year planning requirements.		Risk Response	Treat
Negative sources of assurance: Impact on quality of service for patients and staffing moral due to lack of vehicles. Various delays to fleet build projects, Dependency on EV infrastructure readiness/funding. Mechanical VOR increased sharply since late-2023. Ongoing global supply-chain disruption and geopolitical instability are increasing lead times, costs and supplier fragility for vehicle chassis, conversions, parts and specialist equipment. Plus fuel and energy price volatility linked to the Middle East conflict. Differences in commissioning funding levels across ICBs restrict SCAS’s ability to invest in modernisation programme at a pace comparable to Group partners, creating a risk of a two-tier profile within the Group model.		Target Date	31/03/2027
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. Delivery of the Fleet Improvement Plan is now materially dependent on external factors outside the Trust’s direct control, including energy markets, global supply chains, and commissioner funding alignment. While mitigations are in place, residual risk remains heightened.			
Mitigating Actions	Executive Lead	Due Date	Progress Notes
Defect reduction programme: address aux-charging,	Executive Director of Operations	April 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 VCU.	CFO	July 2026	Lease secured and contractor appointed – PO's supplied to secure.
Capital re-profiling/prioritisation to secure 10 essential DCAs and Cars for Enhanced Care. Charging readiness: % stations with DNO upgrade underway.	CFO	May 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:
Estate Plan Developed to deliver the Fit for the Future Strategy. 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. **Waste & Utilities Manager Recruited.**

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. **Construction and utilities inflation, driven by global energy instability, is increasing the cost of estate development, backlog maintenance and day-to-day operation.**

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.	CFO	May 2026	Initial Stakeholder session taken place, further session planned and implementation of Estates Groups.
Estates Plan Sign Off.	CFO	June 2026	EMC Agree, next F&PC and then Board.
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.	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	Quality & Safety
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	Accountable Director	Chief Digital Officer
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	Committee	Quality & Safety
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.	Inherent Risk Score	Impact 5 x Likelihood 4 = 20
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.	Residual Risk Score	Impact 4 x Likelihood 4 = 16
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	Target Risk Score	Impact 4 x Likelihood 3 = 12
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	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



Upward Report of the Quality & Safety Committee

Date Meeting met 23rd April 2026
Chair of Meeting Katie Kapernaros, Non-Executive Director
Reporting to Trust Board

Items	Issue	Action Owner	Action
Points for escalation			
Sexual Safety	The Committee expressed concern with regards to the sexual safety across the Trust and noting that the People & Culture Committee is the primary committee for oversight of this agenda, committee members emphasised the need for strong evidence at board level that the actions that are being taken are effective.	N/A	PACC has oversight – Board has also received an update since QSC met.
Key issues and / or Business matters to raise			
Operational Performance	The Committee requested a data led approach to understanding the impact of the financial constraints and controls on operational performance; for example, the impact of reduced hours on Category 2 performance. This will be discussed at the next meeting.	MA	This will be monitored via the Committee.
Compliance Report	An update on outstanding actions arising out of the CQC inspection were noted but the committee made a request for assurance that the deadlines outlined in the report would be met.	HY	This will be included within the next routine report.
Data Warehouse Outage	Whilst it was welcomed that there was no patient safety impact arising out of the recent data warehouse outage, the committee sought further assurance around the root cause.	CE	This will be discussed at the next meeting.

QSC Annual Report and Terms of Reference Review	The Committee approved the annual report for submission to the Board and the revised terms of reference.	BM	For presentation to the June Trust Board
Areas of concern and / or Risks			
Risk Report	Noted that there had been a slight reduction in the number of open risks. The main area of concern related to Sexual Safety as identified above.	N/A	N/A
Items for information and / or awareness			
None			
Best Practice and / or Excellence			
Compliance Report	The Committee welcomed the verbal confirmation that the Enforcement Undertakings against the Trust's Provider Licence arising out of the 2023 CQC inspection had been lifted and certificates of compliance received.	N/A	N/A
Data Security & Protection Toolkit	The Committee welcomed the assurance offered in the internal audit report into full trust compliance with the DSPT and noted that the team had been recognised externally through receipt of an award.		
Policies approved*			
None			

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	Q1 2026/2027	Field ops structure now fully appointed to. ICC structure senior team now fully appointed. Due to external recruitment and needing to appoint top down, we have extended the final completion of the ICC structure to mid June
Alignment of SCAS strategy to ICB priorities in relation to SPOA & clinical Pathways	Executive Director of Operations	Q1 2026/2027 for tender	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	Weekly meetings with SCAS/SECAMB CAD programme group with intention to issue tender at the end of May
Cat 2 improvement programme	Executive Director of Operations	Q4 2025/2026	Programme in place and monitored through improvement meeting. Cat 2 performance will be managed through level 2 monthly performance meetings with associated recovery plans if off trajectory

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	Accountable Director	Chief Paramedic
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.	Committee	Quality & Safety
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.	Inherent Risk Score	Impact 4 x Likelihood 4 = 16
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.	Residual Risk Score	Impact 4 x Likelihood 3 = 12
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.	Target Risk Score	Impact 4 x Likelihood 1 = 4
Gaps in assurance: Monitoring of medicine stock quantity, location (modules on ambulances and stations) and temperature.	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	30/06/2026	Project team in place. Site visits completed, foundational project documents and logs completed, program risks identified. Testing implemented at nominated station sites. 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 2026/2027	Establishment numbers reduced with the final plan submission. Workforce plan now requires close monitoring to ensure we do not go over establishment in Q1. Active recruitment to CSD vacancies to be fully established by end of May and work effective by July
Recruit to plan to avoid reliance on IRP	Executive Director of Operations	End Q1 2026/2027	Reduced reliance on SECAMB taking calls via IRP due to improved SCAS staffing and reduced call length. This has enabled us to increase the time before a call passes to SECAMB to 90 seconds.
Implementation of CCC and Ops structure to provide clinical leadership	Executive Director of Operations	End Q1 2026/2027	Field ops structure now fully appointed to. ICC structure senior team now fully appointed. Due to external recruitment and needing to appoint top down, we have extended the final completion of the ICC structure to mid June

TRUST BOARD OF DIRECTORS MEETING IN PUBLIC
3 June 2026

Title	Research Annual Report 2025/26 and Annual Plan 2026/27
Report Author	Helen Pocock, Interim Head of Research Operations
Executive Owner	Duncan Robertson, Chief Paramedic Officer
Agenda Item	16
Governance Pathway: Previous	Research Steering Group. Clinical Review Group 28 th May 2026
Governance Pathway Next Steps	Quality & Safety Committee, 15 th June 2026

1. Purpose

This report presents the Trust's research activity for 2025-26 and research plan for 2026-27. Funders require Board oversight of research activity.

2. Executive Summary

- With a small team, SCAS has maintained high-quality, resilient research activity, delivering one of its widest portfolios to date across urgent, emergency and community-based settings.
- Over 1,000 participants were enrolled into NIHR portfolio studies, securing an enhanced Research Capability Funding allocation for the Trust and strengthening financial sustainability.
- SCAS maintained strong performance against the new national 150-day study set-up target, supported by improved internal processes, and strengthened governance arrangements.
- The appointment of a Research & Innovation manager, has increased research governance capacity, strengthened sponsorship readiness, and enabled leadership time to refocus on grant applications and strategic collaborations.
- The Trust delivered multiple high-profile national studies, including CRASH-4, RAPID2, ELSA and SPEEDY. The SCAS research fleet again proved central to rapid recruitment and complex prehospital study delivery.

- Several significant studies reached completion including HARMONIE, SIS, SPEEDY, REDUCE CARBON and I-CARE, with findings expected to influence both national policy and clinical practice.
- Community engagement expanded substantially, with the CEDAR project registering ten community groups and widening research access for underserved populations across the region.
- SCAS strengthened its role in regional and national leadership, contributing to Regional Research Delivery Network (RRDN) specialty and settings groups, the National Ambulance Research Steering Group (NARSG) and multiple national and international resuscitation guideline writing groups.
- Staff produced twenty-one peer-reviewed publications, two book chapters and ten research presentations, demonstrating exceptional research productivity for the Trust's size.
- The Annual Plan for 2026/7 can be found in section 12.2.
- Looking ahead, SCAS aims to:
 - Progress towards becoming a research sponsor.
 - Strengthen governance and develop a full suite of SOPs.
 - Expand community-based research.
 - Grow commercial activity via the Wessex CRDC.
 - Advance staff research training and internal research culture.
 - Host the 2026 999 EMS Research Forum conference in November 2026.

The annual report enables the SCAS Trust Board to have oversight of research activity and the Research Team will also report progress against the plan at the beginning of Q3 to the Quality and Safety Committee (in addition to routine reporting to the Clinical Review Group).

3. Areas of Risk

The main challenges for designing and delivering research within SCAS are currently:

- Limited resilience due to small team size (Risk 403).
- Inability to act as research sponsor (Risk 432).

- The cyclical nature of research funding that occurs as each funded research study is introduced, conducted and then concludes. This is a particular challenge for baseline funding to support the core research team (Risk 431).

4. Link to Strategic Theme

Clinical Effectiveness

5. Link to Board Assurance Framework Risk(s)

SR14 - Quality Performance

6. Quality/Equality Impact Assessment N/A

7. Recommendations

That the Trust Board note the contents of the paper and annual report.

For Assurance		For decision	X	For discussion		To note	X
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Appendices:

- Research Annual Report April 2025 – March 2026



Research Annual Report

April 2025 – March 2026

Version no.	1.0
Date	18 Mar 2026
Date of approval	19 May 2026
Authors	Helen Pocock, Interim Head of Research Operations Prof Charles Deakin, Research Lead

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AI statement: *Copilot supported the production of this report by assisting with drafting and summarising content based on material provided by the authors.*

1. Executive Summary

- Despite a small team, SCAS has maintained high-quality, resilient research activity, delivering one of its widest portfolios to date across urgent, emergency and community-based settings.
- Over 1,000 participants were enrolled into NIHR portfolio studies, securing an enhanced Research Capability Funding allocation for the Trust and strengthening financial sustainability.
- SCAS maintained strong performance against the new national 150-day study set-up target, supported by improved internal processes, and strengthened governance arrangements.
- A major step forward was the appointment of a Research & Innovation manager, significantly enhancing research governance capacity, strengthening sponsorship readiness, and enabling leadership time to refocus on grant applications and strategic collaborations.
- The Trust delivered multiple high-profile national studies, including CRASH-4, RAPID2, ELSA and SPEEDY. The SCAS research fleet again proved central to rapid recruitment and complex prehospital study delivery.
- Several significant studies reached completion including HARMONIE, SIS, SPEEDY, REDUCE CARBON and I-CARE, with findings expected to influence both national policy and clinical practice.
- Community engagement expanded substantially, with the CEDAR project registering ten community groups and widening research access for underserved populations across the region.

- SCAS strengthened its role in regional and national leadership, contributing to RRDN specialty and settings groups, the National Ambulance Research Steering Group (NARSG) and multiple national and international resuscitation guideline writing groups.
- Staff produced twenty-one peer-reviewed publications, two book chapters and ten research presentations, demonstrating exceptional research productivity for the Trust's size.
- Looking ahead, SCAS aims to:
 - Progress its journey towards becoming a research sponsor.
 - Strengthen governance and develop a full suite of SOPs.
 - Expand community-based research.
 - Grow commercial activity via the Wessex CRDC.
 - Advance staff research training and internal research culture.
 - Host the 2026 999 EMS Research Forum conference.

2. Context

Research is a core function of the NHS, as set out in the NHS Constitution (NHS, 2015). Every patient should have the opportunity to take part in research, as participation contributes to improved outcomes for individuals and the NHS as a whole by enabling access to cutting edge treatments, technologies, and models of care (NHS England, 2017).

It is the ambition of the Government and the National Institute for Health and Care Research (NIHR) to position the UK as a world leader in clinical research, helping to attract more studies, increase investment and give patients faster access to new treatments. A key barrier to achieving this has been the comparatively long time it takes to set up clinical trials in the UK. To address this, a new national target has been introduced: all clinical trials should be fully set up within 150 days by March 2026.

The 150-day target comprises three elements:

- 60 days for regulators to review and approve the study.
- 60 days for NHS organisations to complete all necessary steps required to open the study.

- 30 days to enrol the first participant once the study is open.

In 2025-26, 57% of studies achieved both the 60 day set-up target and the first patient enrolment target. The appointment of our Research & Innovation Manager and the implementation of revised procedures are expected to support more consistent performance against these metrics. Early indications are positive, with only one study missing one target in Q3 and full target achievement across all studies in Q4.

The key implications for NHS trusts include:

- 1. Greater focus on performance and accountability:** Trusts are expected to closely monitor how well they perform against the 150-day target, especially for commercial trials. Boards are asked to use this data actively to drive improvement. At SCAS, we produce bimonthly reports to our Trust Board, and our Research Steering Group minutes are upwardly reported through our Clinical Review Group and Quality and Safety Committee to the Board.
- 2. Impact on future NIHR funding:** From 2026/27, part of NIHR performance related funding (around 20%) will be linked to how well organisations meet key indicators, including achieving study set-up within these required timelines. Our study set-up times are closely monitored by the SCAS Research leadership team.
- 3. Importance of high-quality and timely data:** Trust must provide complete, accurate and timely set-up data through their systems. This is essential because NIHR is now tracking performance closely across all studies. Here at SCAS, we review monthly reports on our performance so that we can respond quickly to any emerging challenges.
- 4. Streamlining of internal processes:** Trusts are asked to reduce bottlenecks such as contracting, costing and local capacity and capability reviews. As part of our early capacity and capability assessment for every new study in SCAS, we review whether we are on track to meet national timelines and take proactive steps to reduce any risks. For example, we previously experienced delays in the process for completing research agreements. Over the past year, through close collaboration with our Chief Paramedic, we have established a robust and timely mechanism for contract approval, significantly reducing these

delays. We have reduced the average time taken to complete this process from seven months to less than one month.

- 5. Prioritising research workforce capacity:** The Government has clarified that research posts funded externally (e.g. by NIHR grants or commercial studies) should not be affected by NHS recruitment freezes. This enables us to ensure that research-funded roles remain in place to support timely delivery.

Faster study set-up ultimately benefits our population. It gives patients earlier access to cutting-edge treatments and clinical pathways and increases opportunities to take part in research that may improve their care. It also strengthens SCAS' reputation as a centre for high-quality, innovative research.

A new national funding model for the NIHR Research Delivery Network (RDN) will be introduced from April 2026 which replaces the current regional funding distribution models. All NHS Trusts, including ambulance services, will receive their funding allocation through the 'hospital settings' model. Primary care, residential care and community based settings will be funded through the 'wider care settings' model. Over the next three years, the proportion of budget allocated to the wider care settings will increase from 5% to 8% and the hospital settings budget will decrease by 3%. This will inevitably reduce the core funding available to SCAS from the RDN, making it even more important to secure projects funding and commercial collaborations wherever possible.

3. Strategy

At SCAS our research activity is guided by our Research Strategy 2024-27, which sets out our commitment to embedding high-quality research across all services, strengthening our research culture, and ensuring that research opportunities are accessible, inclusive, and aligned to our clinical priorities.

3.1 Aims

Our research aims align with our organisational values:

- To develop the skills required to conduct research ~ PROFESSIONALISM
- To strengthen the systems within SCAS that facilitate research ~ TEAMWORK

- To recognise and respond to opportunities to develop and conduct research ~ INNOVATION
- To put research findings into practice ~ CARING

3.2 Objectives

Our research objectives are driven by six key themes identified by Cooke (2005) and shown in Figure 1:

1. Research infrastructure
2. Developing a skilled workforce
3. Developing collaborations
4. Aligning research with practice
5. Disseminating research findings
6. Sustainability

Sections 6 – 11 of this report identify how we have addressed these objectives this year.



Figure 1: SCAS Research strategy 2024-2027

4. Performance against last year's annual plan

Challenge	Standard	Action	Lead	Progress summary
Build research infrastructure	Generic Research SOPs should be maintained to ensure they are relevant and fit for purpose.	Gap analysis of generic research SOPs	Research team & RSG	Gap analysis complete and prioritised list of required SOPs produced.
	Operation of five rapid research vehicles (R-RRVs) to attend incidents of potential interest.	Secure funds to continue to support, and ideally to expand the research fleet.	Head of Research Operations	Funds ringfenced to support maintenance of five R-RRVs for 2026-27
Upskill workforce	Every new member of SCAS staff to be aware of research function.	Research presentation to be included in all corporate induction courses.	Research team & RSG	Video produced but not currently included on corporate induction. We are exploring alternatives such as provision of written materials.
	Workshops and other CPD opportunities to be provided to SCAS staff.	New workshops/journal clubs to be developed and offered.	Research team & RSG	Two research webinars delivered, with more planned. Launchpad funding secured to develop research culture across the Trust.

	Opportunities to be facilitated for development as Chief Investigators (CIs) and Principal Investigators (PIs)	Provision of formal learning opportunities for team members and others to develop knowledge and skills. Opportunities for qualified individuals to take on Associate PI/ PI /CI roles where appropriate.	Research team and RSG	Although opportunities were facilitated, no team members identified development as Chief or Principal Investigators as a current priority. This will help inform how we tailor future development offers. Two non-medical members of research team now regularly taking on PI roles.
Developing collaborations	Work with regional research support networks to increase research offering to SCAS patients, service users, and staff.	Work with the new network leads across portfolios to broaden our research offering.	Research team and RSG	We have established an active presence within regional specialty groups and the national settings group.
	Respond to local need for research projects	Work with internal SCAS teams to identify, assess, and deliver research projects	Research team and RSG	Spreadsheet of study ideas and development opportunities created, but further development is constrained due to

				lack of sponsorship capability. This is planned for 2026-27.
	Collaborate with national and international counterparts to develop further research opportunities for SCAS	Seek collaborative opportunities through national networks and beyond.	Research team and RSG	Thirteen collaborative research bids submitted this year; four successful, five unsuccessful, four have progressed to next stage of a commissioned funding call with a potential value of tens of thousands of pounds. Four systematic reviews with international collaboration published.
Aligning research with practice	Support the development and delivery of home-grown research projects.	We will support staff in designing and delivering projects of local importance.	Research team and RSG	Support for staff-led projects remains limited by sponsorship capacity, but we are actively collaborating with the Health & Wellbeing team and the University of Exeter on a new locally relevant research project. Plans are in place to develop

				sponsorship capability by October 2026.
	Ensure patient and public involvement in all stages of research	Opening of Community Engagement to increase Diversity and Accessibility in Research (CEDAR) project. All home-grown projects to have Patient and Public Involvement and Engagement (PPIE). Development of a PPI research forum.	Research team and RSG	Ten local community groups have registered as CEDAR communities. Local PPIE incorporated into grant applications through community engagement. PPIE forum not yet developed but have actively engaged with SCAS' Patient Panel and incorporated their views and input into research projects.
Dissemination of research findings	Ensure staff and governors have access to research findings	Our completed research projects will be promoted via SharePoint and on the trust internet page.	Research team and RSG	Information regarding completed research projects available on internal SharePoint and external internet page.

	Promote SCAS research activity to the public	We aspire to fund some time for a Communications subject matter expert	Research team and RSG	Dedicated Communications support was not progressed this year due to competing priorities, and strengthening our communications activity will be a priority for 2026-27.
Sustainability	Ensure financial sustainability	Undertake financial forecasting where possible to facilitate future planning. Develop bids to national grant awarding bodies enabling us to complete home-grown research projects.	Head of Research Operations Research team and RSG.	Financial forecasting completed for 2026-27. New RRDN dashboard will allow us to monitor enrolment to studies throughout the year to enable more accurate forecasting in future. SCAS are co-applicants on six national grant applications. Five have progressed to Stage two and one was unsuccessful.

		Innovative use of our fleet to optimise our offering of research to our patients and public in our local community.	Research team and RSG	SCAS R-RRVs currently contracted to deliver follow-up visits to patients enrolled in the MepeBIO/TezeBIO respiratory studies hosted by UHS. Introduced multi-research offers at community events, broadening access and participation (e.g. ELSA, G&H, Destigmatised).
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5. Achievements

From April 2024 to March 2025, SCAS enrolled 1022 service users and staff into NIHR portfolio research projects.

4.1 Completed studies

- **A Phase IIIb Randomized open-label study of Nirsevimab (versus no intervention) in preventing hospitalizations due to respiratory syncytial virus in infants (HARMONIE) (IRAS 1005180)**

The study determines the efficacy and safety of a single intramuscular dose of Nirsevimab, compared to no intervention, for the prevention of hospitalisations due to lower respiratory tract infection caused by confirmed Respiratory Syncytial Virus (RSV). The study enrolled infants under 12 months of age who are not eligible to receive Palivizumab. SCAS has provided vaccinations to seventy patients in this project, who would not otherwise have been able to access this treatment. This year we were involved in the follow up phase of the study. The clinical trial showed that hospital admissions from a winter virus could be reduced by more than 80% if babies are given a single dose of a new antibody treatment. As a result of this trial, Nirsevimab is now included in the national immunisation programme.

The published study report is available at: [https://doi.org/10.1016/S2352-4642\(25\)00102-6](https://doi.org/10.1016/S2352-4642(25)00102-6)

- **Randomised control trial to understand whether prescribing choice for inhalers is influenced by knowledge of the CARBON footprint (REDUCE CARBON) (IRAS 285768)**

The study is looking to explore prescribing behaviours surrounding inhaler selection and what information, including knowledge of the carbon footprint, may influence this choice. The study team have invited a wide range of healthcare professionals and patients to answer an online survey. The study is now in its data analysis phase.

Further information can be accessed at: <https://rdn.nihr.ac.uk/news/reducing-carbon-emissions-inhalers>

- **Spinal Immobilisation Study (SIS) (IRAS 316755)**

This randomised controlled trial compared methods of cervical spine (neck) immobilisation in the pre-hospital emergency setting. Paramedics assessed patients' nerve function at time of injury, when they arrived at hospital and when they left hospital. Any side effects and measures of wellbeing were also monitored. The study is now closed, and data are being analysed.

Further information can be accessed via the study website: <https://spine.study>

- **Specialist pre-hospital redirection for ischaemic stroke thrombectomy (SPEEDY) (IRAS 312053)**

This study aimed to test a new specialist prehospital pathway. By redirecting patients straight to a hospital with a specialist stroke centre we may be able to reduce delays to surgery to remove blood clots from the brain in acute stroke. This may enable patients to make a better recovery. Operational teams in Hampshire enrolled patients into this study. The data collection period has now finished, and the data are being analysed.

The study protocol paper can be accessed at <https://doi.org/10.1136/bmjopen-2025-112545>

- **Cardiac arrest bundle of care trial (CABARET) (IRAS 329970)**

This home-grown randomised controlled trial aims to evaluate the feasibility of performing a new 'bundle of care' intervention for patients in cardiac arrest comprising three elements: Head up cardiopulmonary resuscitation (HUP-CPR), Active compression decompression CPR (ACD-CPR), and Impedance threshold device (ITD). This may allow us to go on to deliver a definitive randomised controlled trial examining the 'bundle of care' vs usual care. Due to limitations in the number of devices available, only our research paramedics were involved in this trial.

The study report manuscript has been submitted for publication and should be available online in May/June 2026.

- **InCreAsing Retention of healthcare staff from Ethnic minority groups (I-CARE) (IRAS 288316)**

This was an extension of the UK REACH study which was open in SCAS in 2021. Reducing attrition and improving retention are key to reducing the staffing gaps in the NHS but there is a lack of data on retention. Evidence strongly suggests that staff from minoritised groups may be at greater risk of attrition post-pandemic. This study aimed to understand personal and work-related factors related to staff's intentions to stay or leave and produce policy interventions to help NHS organisations improve staff retention.

The published study report is available at: <https://doi.org/10.1186/s12913-025-13348-7>

4.2 Ongoing studies

- **Clinical randomisation of an anti-fibrinolytic in symptomatic mild head injury in older adults (CRASH-4) (IRAS 283157)**

CRASH-4 is seeking reliable evidence about the effects of early intramuscular tranexamic acid medication on intracranial haemorrhage, disability, death, and dementia in older adults with symptomatic mild head injury. Using our unique research cars model of study delivery, SCAS has reached more patients than any other research site in the UK.

Further information is available from the study website: <https://crash4.lshtm.ac.uk>

- **EarLy Surveillance for Auto-immune type 1 diabetes (ELSA) (IRAS 309252)**

Early detection of type 1 diabetes mellitus from the general population would allow insulin treatment to be started sooner, avoid type 1 diabetes mellitus being diagnosed as an emergency, improve glycaemic control, and would identify children who can be offered novel clinical trials of therapies for diabetes prevention. Enrolment is currently being offered by Research paramedics/nurses via schools and community events. This year, the study has been extended until August 2029, specifically to increase the diversity and age range of research participants.

Further information is available from the study website:

<https://www.elsadiabetes.nhs.uk>

- **Randomised trial of clinical and cost effectiveness of administration of prehospital fascia iliaca compartment block for emergency hip fracture care delivery (RAPID-2) (IRAS 291853)**

The aim of this randomised controlled trial is to test the safety, clinical and cost-effectiveness of paramedics providing fascia iliaca compartment block (FICB) as pain relief to patients with suspected hip fracture in the prehospital environment. Due to the training requirement, only our research paramedics are engaged in this trial.

Further information is available from the study website:

<https://www.swanseatrialsunit.org/trials/rapid-2>

- **The Mental Health and Wellbeing of NHS Call-Handlers and Dispatchers working on 999 and 111 Helplines in England (IRAS 331921)**

This study aims to identify predictors and protective factors for PTSD, depression, anxiety and alcohol use amongst NHS call handlers and dispatchers.

- **Exploring UK Ambulance Clinicians' Experiences of Attending Out of Hospital Cardiac Arrest (OHCA) Incidents Involving Children (POHCA-PhD) (IRAS 344286)**

This mixed methods study aims to explore views of ambulance clinicians with respect to their preparedness to attend cardiac arrest incidents involving children (survey) and experiences/reactions of ambulance clinicians following attendance at cardiac arrest incidents involving children (interviews/ focus groups).

- **Mixed methods study to understand the scale, impact and care trajectory for patients who have a long lie after a fall (Long Lies) (IRAS 350537)**

This national mixed methods study aims to understand the scale, impact and care trajectory who have a long lie after a fall. It involves a survey of 999 Emergency Operations Centre ambulance service clinical leads to understand what interventions are currently in place to reduce the impact of a long lie after a fall, local guidance, and any local initiatives for crews to understand how to manage long lies.

Further information is available from the study website:

<https://sheffield.ac.uk/cure/current-trials/long-lies-study>

- **PREDICT-EMS. A mixed methods study exploring barriers and facilitators to implementation of prehospital paediatric early warning scores (IRAS 350298)**

Paediatric early warning scores (PEWS) are now used to aid patient assessment in most hospitals. However, there is currently no universally accepted prehospital version. This study explores barriers and facilitators may exist in relation to their implementation.

- **Understanding prostate cancer stigma in black men (Destigmatise) (IRAS 338375)**

Ethnicity is a major predictor of prostate cancer incidence and outcomes as the disease disproportionately affects Black men at a younger age (1-in-4), in more aggressive form and advanced stages compared with White (1-in-8) and Asian men (1-in-13). This community-based study aims to understand who stigma influences public health messaging, decision-making and early help-seeking for prostate cancer among Black men in the UK.

Further information is available from the study website:

<https://www.hyms.ac.uk/research/research-centres-and-groups/cancer-awareness-screening-and-diagnostic-pathways/projects/destigmatise>

- **Exploration of clinical advice delivery for UK ambulance service clinicians (CLEAR) (IRAS 359052)**

This is an exploration of clinical advice delivery for UK ambulance service clinicians. It comprises a document review and survey.

- **What works to improve safety, patient experience, outcomes, and costs related to delayed ambulance handovers at Emergency Departments? A whole systems approach (STALLED) (IRAS 340963)**

This investigation explores the factors that influence patient experience, safety, outcomes, and costs associated with ambulance queuing at emergency departments. It aims to identify and describe initiatives designed to reduce ambulance queuing, minimise delayed handovers and mitigate related harms. The study will compare outcomes between hospitals with low and high levels of ambulance queuing with the aim of producing guidance to reduce patient handover delays and improve overall patient flow.

Further information is available from the study website:

<https://primecentrewales.yolasite.com/stalled.php>

- **Understanding the Networks, Effects and Teams involved in Community Alternatives to ACute Hospitalisation for Older People in Hampshire and Isle of Wight Region (CAAtCH-NET) (IRAS 347478).**

Many older people within Hampshire and Isle of Wight (HIOW) live with several health conditions, which may suddenly worsen, requiring rapid assistance from healthcare professionals. Often it is best to provide this in the person's own home, so urgent community-based services have expanded. This research seeks to understand staff experiences, identify effective practices, and highlight areas for improvement in providing care at home for unwell older adults in the Hampshire area.

Further information is available from the study website:

<https://www.southampton.ac.uk/research/projects/understanding-the-networks-effects-teams-involved-in-community-alternatives-to>

- **Emergency dispatch decisions using video consultation (999 RESPOND-2) (IRAS 347768)**

Advances in technology have enabled ambulance services to test live-stream video during an incident to help staff assess the level of help needed. Although live-stream video can overcome some limitations of 999 calls, how it affects communication is currently unknown. This study explores the role of livestream video in emergency medical services, particularly around how it aids communication of risk/severity, helps with dispatch decisions and impacts staff and callers.

- **Genes & Health: a population based DNA sequencing, medical records, and recall BioResource study of British-Bangladeshi and British-Pakistani communities (IRAS 146051)**

This community project is working to improve health outcomes for British Bangladeshi and British Pakistani communities by linking genetic data with health records from approximately 100,000 volunteers. This information will help to better understand, prevent, and treat conditions such as heart disease, diabetes and metabolic disorders which disproportionately affect these populations. This study is being offered to staff and our local population at community engagement events.

Further information is available from the study website:

<https://www.genesandhealth.org>

- **Identifying the prevalence of social isolation and loneliness in the community setting across England (INTERACT) (IRAS 305483)**

Loneliness has a significant impact on mental health, life expectancy, and quality of life, which became particularly evident following the national pandemic lockdowns. The study aims to investigate the prevalence of social isolation & loneliness (SI&L) at local authority level across England using the UCLA Loneliness Scale & the Direct Measure of Loneliness. This information will guide local authorities and the NHS in finding better ways to support those affected.

Further information is available from the study website:

<https://www.imperial.ac.uk/school-public-health/primary-care-and-public-health/research/scaru/measuring-loneliness-in-uk-interact-study/>

Collectively, these studies reflect our strategic focus on priority areas including urgent and emergency care, community and population health, and the application of emerging technologies such as genomics to improve patient outcomes.

6. Infrastructure Supporting Research

Our team remains small, as illustrated in the organogram in Figure 2. We combine hands-on delivery with a strong research governance function, ensuring every study

we support is well-designed, appropriately funded and truly meaningful for our organisation. This year, we welcomed a new Research & Innovation manager, bringing fresh expertise and expanding our ability to support high-quality, impactful research across the organisation.

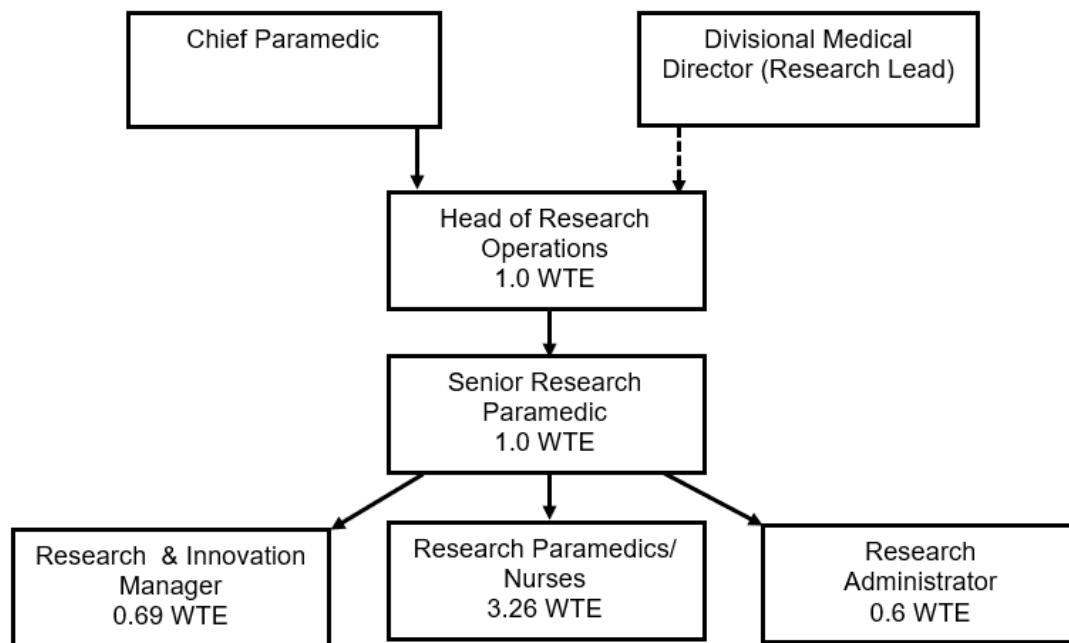


Figure 2: Organogram for Research team

6.1 Alignment with SCAS' Clinical Strategy

SCAS' commitment to expand participation in high quality clinical research aligns directly with the SCAS Clinical Strategy. Specifically, this ambition has been met through:

- **Expanding participation in high quality research:** broadening the range of studies delivered within SCAS.
- **Involvement in studies validating Paediatric Early Warning Scores (PEWS):** the PREDICT-EMS study exploring barriers and facilitators to the implementation of early warning scores to identify clinical deterioration in children.

- **Continued contribution to the CRASH-4 study:** sustained involvement in this important national study supporting evidence generation in prehospital trauma care.
- **Participation in high-quality clinical research on out-of-hospital cardiac arrest therapies:** completed delivery of the CABARET study testing a novel treatment combination..

Our collaborative approach strengthens clinical decision making by informing evidence-based clinical practice guideline. Better decision making, through robust, research-driven guidelines, has been showed to lead to improved patient outcomes (Connor et al, 2023).

6.2 Research governance

The Health Research Authority (HRA), an arm's length body of the Department for Health and Social Care, is the body responsible for reviewing and approving research projects conducted in the NHS. Through application to the HRA, researchers can seek all regulatory reviews and approvals, such as independent ethical review of projects by NHS Research Ethics Committees, including the Confidentiality Advisory Group.

Prior to starting to recruit patients to research studies, prospective researchers must first approach SCAS to consider collaboration and delivery on their projects. In line with HRA requirements, the SCAS Research team assesses the Trust's *capacity* (available resources and infrastructure) and *capability* (skills and expertise of staff) to deliver projects (each project has different resource and infrastructure requirements). As part of this assessment, the project is reviewed and approved by two SCAS committees. Firstly, the Research Steering Group (RSG) which comprises research Subject Matter Experts (SME), and then the Clinical Review Group (CRG) comprising the clinical and operational leaders within the Trust. The study set-up process can then begin.

With the introduction of our new Research & Innovation Manager during this year, our research governance processes are currently undergoing a comprehensive review. A new Standard Operating Procedure (SOP) suite is being developed to provide clearer, more robust oversight of all research activity within SCAS, specifically addressing how capacity and capability assessments are conducted. This is scheduled for completion by October 2026.

When the research project is underway, the SCAS research team provides ongoing research governance and SME oversight to any research project accepted via the Research Steering Group. External monitors provide additional oversight either through central monitoring processes or by visiting the Trust to inspect our research operations.

6.3 Managing budgets and grants

Each research project brings funding in order that the activity does not detrimentally impact on the other important day-to-day functions of the Trust. We closely monitor project income against expenditure and forecast projected income across the duration of each study. This enables timely and accurate invoicing and helps to ensure that all research activity remains financially sustainable and appropriately resourced.

Each year Trusts may be eligible to receive Research Capability Funding allocations awarded by the Department of Health and Social Care. This is linked to the Trust's recruitment figures (the number of people enrolled into research projects). This year we are delighted to report that we were eligible for an enhanced non-commercial allocation, since we enrolled over 1,000 patients into NIHR portfolio studies. This brought extra funding into the Trust which we have used to support research salary costs.

In line with NHS England guidance, all research income is ringfenced for the sole purpose of supporting research activities. Utilisation of our NIHR funding allocation is reported quarterly to the South Central Region Research Delivery Network (SC-RRDN), ensuring transparency and accountability in how resources are deployed. In addition, our research activity is upwardly reported through the SCAS committee structure and ultimately reported to the SCAS Board, providing top-level oversight and assurance.

6.4 IT infrastructure

This year we invested in referencing software which has significantly improved the quality and efficiency of organising and formatting research references, saving time during the preparation of research outputs and grant applications. We are currently exploring centralised research database systems that support the secure storage and tracking of research documentation and governance records. Implementing such a

system would strengthen our research sponsorship activities by enhancing oversight, consistency, and operational efficiency.

6.5 Posts and roles responsive to need

We have recently appointed a Research & Innovation Manager, bringing valuable experience from a university research environment and enhancing the diversity of skills and perspectives within the team. Previously, limited capacity meant that research leadership time was largely absorbed by governance processes, leaving little opportunity to develop new studies and collaborations. By recruiting an external candidate with strong expertise in research governance, we are strengthening and improving our existing processes while increasing our overall capacity to support and broaden our research portfolio. This appointment has also enabled the research leadership team to refocus their specialist expertise on developing new studies and preparing high-quality grant applications, further advancing SCAS's research ambitions.

6.6 Operation of the research fleet

This year we have continued to operate our dedicated research fleet of Research Rapid Response Vehicles (R-RRVs), ensuring that research activity remains responsive, visible, and well-integrated within frontline operations. The fleet enables research-trained clinicians to reach patients quickly, support study delivery in real-world emergency settings and collect high-quality data without disrupting core service provision. The RAPID-2 trial has relied exclusively on this fleet for effective delivery, supported by the fact that our research team operates outside the standard response plan and can therefore undertake the extensive training required to deliver the study safely and consistently. Maintaining this capability has strengthened our ability to run complex pre-hospital studies, enhanced recruitment opportunities and reinforced SCAS's position as a leading contributor to urgent and emergency care research.

7. Developing a skilled workforce

Research remains a fundamental part of NHS core business, and we continue to embed research engagement throughout the career journey of our workforce. We aim to create opportunities not only for our patients, but also for our other service users

and our staff to participate in, and benefit from, research. Our Research Paramedics regularly deliver in-person or remote training to frontline teams, covering both general topics and study-specific requirements. We actively promote opportunities for learning, development, and involvement in research across the Trust via our SharePoint page and Staff Matters, our weekly internal e-magazine. We also strengthen our research culture through consistent representation at Trust committees and groups, clear communication with staff, and ongoing support for evidence-based practice.

Our core research function is delivered by a team of nine (6.8 WTE), spanning a range of clinical and non-clinical roles. Together, the team brings extensive experience from across the ambulance, air ambulance and hospital frontline, clinical coordination centres, primary care, academia, and professional administrative services. All team members maintain up-to-date Good Clinical Practice (GCP) training, with new staff completing this as part of their induction. The team also holds formal qualifications in UK GDPR and AGILE/PRINCE2 project management. This expertise enhances our ability to safeguard patient rights, maintain high-quality and accurate data, streamline data processing, and ensure full compliance with Trust information governance requirements. Importantly, it enables us to embed strong data-protection principles into every stage of study set-up and delivery.

Alongside our core team, we welcome colleagues who require a temporary period of alternative duties. Each temporary team member receives a tailored induction and is assigned tasks aligned to both service needs and their existing skills. During their time with us, they have the chance to gain hands-on experience supporting national and local studies, broadening their understanding of research in practice. Feedback from these colleagues has been consistently positive and many return to their substantive roles with strengthened knowledge, enhanced confidence and valuable experience that contributes to their professional development and CVs.

We encourage and support individuals to apply for internships and fellowships to support development of their research skills and experience. One of our Research Paramedics is currently undertaking a Master's degree in research (MRes), part-funded by an NHS bursary and part by SCAS Continuing Professional Development (CPD) funding. They have now completed four modules and are due to start their dissertation next year. We are also providing clinical academic mentorship to a SCAS

paramedic who is currently undertaking an NHSE/NIHR ICA Pre-doctoral Clinical and Practitioner Academic Fellowship. Another member of our team is developing an application for an NIHR Postdoctoral award, enabled by a regional internship award. While SCAS does not have a formal research mentorship programme in place, funding secured year through the Launchpad scheme will support the development of our research culture across the Trust. This will be delivered through the reconfiguration and reinvigoration of our Research Advocate scheme, alongside targeted investment in research training and individual mentorship to build capability and confidence among staff.

8. Developing collaborations

8.1 Regional Research Delivery Network (RRDN)

This year we strengthened our engagement with the newly established South Central RRDN structures. Our team now contributes actively to several RRDN groups, helping shape operational delivery, specialty development, and cross-sector collaboration. We participate in the following groups:

- SC-RRDN Research & Development Managers Group
- SC-RRDN Clinical Delivery Team Leads Group
- SC-RRDN Trauma & Emergency Care Specialty Group
- SC-RRDN Community Settings Group

These collaborations enhance shared learning, improve the consistency of research delivery across the region, and support the development of new regional initiatives.

A fantastic example of our collaborative working was our joint attendance with the SC-RRDN Agile team at CarFest 2025 held in Laverstoke Park Farm in Hampshire. This high-profile public event provided a successful platform to showcase the innovative CEDAR delivery strategy, promote collaboration and support public involvement in health and care research. Across the weekend, the team engaged with 850 visitors, enrolling 57 children into the ELSA study and enrolling an adult participant into the Destigmatise study. Awareness of the NIHR 'Be Part of Research' platform was also significantly raised, with 380 visits to the webpage via the festival QR code and a notable increase in public registrations to be contacted about future studies.

8.2 Commercial Research Delivery Centres

SCAS is part of the Wessex Commercial Research Delivery Centre (CRDC), a seven-year NIHR contract to deliver commercial research. The CRDC operates a hub and spoke model, with SCAS acting as one of the spokes. Year 1 has been a slow start with very few studies available across the CRDC, and none were suitable for SCAS involvement. However, we have begun to play an active part in the CRDC, contributing both operational and strategic input. Our involvement includes active membership of:

- CRDC Board
- CRDC Operational group
- CRDC Pharmacy group
- CRDC Finance group
- CRDC QA and Governance Group

Membership of these groups enables us to support the coordination and delivery of regional commercially funded research programmes. As an Ambulance service, we can contribute a strong patient-focused regional delivery perspective to wider system discussions.

8.3 Local project collaborations

This year saw the launch of the Community Engagement to Increase Diversity and Accessibility in Research (CEDAR) project, which aims to bring research closer to the communities who are often least represented in studies. Led by our Senior Research Paramedic, the project focuses on taking research activity out of traditional clinical settings and into the everyday spaces where people live, meet and feel comfortable. By working directly with groups who are typically underserved or hard to reach, the project aims to build trust and ensure that research opportunities are genuinely accessible to a wider and more diverse population. Since opening, we have built strong relationships with a wider range of community partners across the region. Through the Raising Voices in Research (RviN) network in Hampshire and the Thames Valley Research Engagement Network (TVREN), we have been able to engage a wide range of local cultural and faith communities, sports organisations, health providers, and community lunch clubs. We have also delivered activities within residential and supported living settings, as well as at tea gatherings and neighbourhood hubs. Together, these collaborations are helping to create a more inclusive research

environment and ensure that the voices and experiences of all communities are reflected in future studies. Across our engagement events this year we reached over 1,100 members of the public to raise awareness of and discuss participation in research.

We continued to broaden our collaborations with academic partners across the region. A key example is our work with the University of Southampton's Dementia research group on the ACCESS-D study. This aims to make dementia research more approachable and inclusive. The study offers people the opportunity to try simple low-burden research activities such as digital memory tests, short questionnaires and finger-prick blood tests delivered by research paramedics and nurses in familiar local settings. It also invites participants to register their interest in hearing about future research opportunities, helping to widen participation among groups who are often under-represented. Co-designed with people affected by memory problems or dementia, ACCESS-D focuses on reducing barriers, building trust, and understanding what different communities need in order to feel confident taking part in research. The work aligns with national priorities, including NIHR INCLUDE and the Dementia Mission, which call for more inclusive and community-centred research.

8.4 National Ambulance Research Steering Group (NARSG)

The National Ambulance Research Steering Group (NARSG) is the official body representing NHS and HSC ambulance research across the UK. Its membership brings together research managers and representatives from every UK Ambulance Service, providing a unified voice and a coordinated approach to advancing prehospital research. The group plays a central role in facilitating research projects, supporting external teams with new projects, and identifying emerging areas of research need within prehospital care. NARSG operates as a sub-group of the Association of Ambulance Chief Executives (AACE), ensuring that prehospital research is embedded within national strategic leadership and remains a priority across the NHS ambulance sector. Through active membership of this group SCAS' Head of Research Operations helps influence national priorities and strengthens the UK's prehospital research landscape.

8.5 National collaboration

We continue to play a central role in delivering some of the most innovative national out-of-hospital research studies. Our involvement has spanned both the design and delivery of the CRASH-4 study, and early-phase engagement influenced study design in other important projects such as SIS, which concluded during this year. Our Research-RRV model has continued to support the successful delivery of the RAPID-2 study, while our Communities Team has maintained strong recruitment to the ELSA and successfully opened the Genes and Health study this year.

Our Senior Research Paramedic, in his capacity as Regional Community Settings Lead, works closely with his national counterparts, helping to shape research in this setting and ensuring that ambulance services are represented and involved in research in this area. In addition, both our Head of Research Operations and our Senior Research Paramedic are active members of the National Trauma and Emergencies Group, ensuring that SCAS has a strong voice in national discussions and is well positioned to maximise emerging research opportunities.

Both our Research Lead and our Head of Research Operations have been actively engaged in collaborating with the Resuscitation Council UK (RCUK) guideline writing groups, this year delivering the 2025 updates to the RCUK Advanced Life Support and Resuscitation in Special Circumstances guidelines.

8.6 Commercial collaboration

We have continued to proactively engage with a wide range of potential commercial partners, recognising the value that industry-sponsored research can bring to the region. This work often involves significant early-stage activity, such as scoping potential opportunities, establishing initial relationships and exploring areas of mutual interest. While not all of these exploratory discussions progress to formal studies, the process remains an important part of building visibility, strengthening partnerships, and positioning the ambulance service to respond quickly when viable opportunities do arise. Our efforts have helped refine our understanding of where commercial alignment is strongest, enabling us to focus future engagement where it is most likely to generate meaningful research activity. This year we have worked with a University of Manchester spin-out company on a funding application to develop a portable

diagnostic device for use on ambulances. We were successful at Stage 1 and are now collaborating on our Stage 2 application.

9. Aligning research with practice

We continue to emphasise the importance of standard 13.11 of the Standards of Proficiency for HCPC Paramedics which requires that paramedics need to “*engage service users in research as appropriate.*” We provide staff with guidance on how to accurately document research involvement within clinical records, including any reasons for ineligibility where relevant.

9.1 Audits informing research and practice

During this year, we have completed ‘**Staff reported experience of CPR-Induced Consciousness (CPR-IC).**’ This project explored the phenomenon whereby patients display signs of awareness, such as eye opening, muscle tone, movement, or speech, despite having no measurable cardiac output during CPR. We conducted a 10-year search of electronic patient records alongside a staff questionnaire to better understand the frequency, presentation, and impact of CPR-IC on patient care. Findings suggest that CPRIC is witnessed more often than current records indicate, highlighting the need for improved documentation within electronic patient care systems to support future research and clearer clinical guidance. This work was presented at the 999 Emergency Research Forum national conference.

We have now submitted a manuscript to a peer-reviewed journal for the ‘**Emergency response to cardiac arrest in prisons**’ project, which aimed to characterise out-of-hospital cardiac arrests (OHCA) occurring within prisons and to better understand how emergency medical services respond in this unique and complex environment. Using a retrospective review of clinical and operational data from six prisons served by SCAS, the study examines ambulance response, bystander intervention, and key clinical features. This evaluation represents the first contemporary regional description of OHCA response patterns in UK prisons and will help build a clearer understanding of the factors that influence patient management and outcomes in custodial settings.

9.2 Research to inform clinical practice guidelines

Two members of our research team, Prof. Charles Deakin and Dr. Helen Pocock, hold voluntary positions with the International Liaison Committee on Resuscitation (ILCOR). ILCOR is the global body responsible for evaluating evidence and producing the Consensus on Science and Treatment Recommendations (CoSTRs) that underpin resuscitation guidelines worldwide. Through their roles within ILCOR, both contribute directly to systematic evidence reviews, appraisal of emerging research and the development of internationally aligned treatment recommendations. Their involvement ensures that the organisation remains connected to the latest scientific developments and maintains influence in shaping future resuscitation science agendas. In addition, Prof. Deakin and Dr. Pocock serve as members of the European Resuscitation Council (ERC) 2025 Guideline writing group and the Resuscitation Council UK (RCUK) 2025 Guidelines writing group. This year, these groups worked to translate the ILCOR CoSTRs into updated ERC and RCUK clinical guidelines. Prof. Deakin is also the lead for the evidence-based JRCALC adult and paediatric resuscitation guidelines. Together, these contributions demonstrate the significant and ongoing impact of our research team on the development of trusted, evidence-based clinical practice guidelines used by clinicians across the UK, Europe and beyond.

10. Disseminating research findings

We maintain a dedicated research section on the SCAS website, available at <https://www.scas.nhs.uk/about-scas/research/>. This page was refreshed during the year to improve accessibility of information and continues to host our Research Strategy and Annual Report. It also provides information for patients about how their data may be used in research, along with guidance for researchers seeking approval to conduct studies within the Trust. In addition, we share details of our active studies and publish summaries of completed projects, including links to associated research papers where available.

We have attended numerous community events across the region during this period, using these opportunities to share our findings in clear, accessible language tailored to the interests and needs of different public groups.

Internally, we continue to raise the profile of our research outputs by sharing updates on our Research SharePoint page. These outputs are also incorporated into our face-to-face and virtual engagement activities with colleagues across the wider Trust. This year, we also took the opportunity to showcase our work to the Senior Leadership Group, further strengthening organisational awareness of our research activity.

During this period, we have also communicated our research to our public and professional peers through more formal and traditional routes. SCAS staff produced twenty-one peer-reviewed journal publications, two book chapters, and delivered ten conference or meeting presentations. Full details are provided in appendices A & B.

11. By ensuring research evidence is effectively shared and applied our dissemination activity enables organisational learning and practice change to improve care quality and outcomes. Sustainability

Sustainable research delivery relies on funding models that protect core clinical services while enabling high-quality research to flourish. Each research project brings funding in order that the activity does not detrimentally impact on the other important day-to-day functions of the Trust. These funds are ring-fenced for spending on research delivery, governance, infrastructure, and research capacity building. In addition, the Trust may receive annual Research Capability Funding from the Department of Health and Social Care, allocated in proportion to the number of participants we enrol into research studies. Together, these funding streams strengthen the long-term sustainability of our research ecosystem, supporting a resilient infrastructure and embedding research practice throughout the organisation.

Our jointly delivered medical student placements, hosted by the Research team and the Clinical Coordination Centre (CCC), contribute to the sustainability of the future healthcare workforce by building early understanding of the ambulance service and the complexities of urgent and emergency care. Each placement provides students with a half-day introduction to the ambulance service, the function of the CCC, types of emergency and urgent calls, how healthcare providers organise ambulance transport, and anonymised 999 call scenarios. Students then spend a further half-day within the CCC observing live 999 and 111 calls, gaining real-time insight into clinical triage and system pressures. These placements help strengthen future clinical

decision-making and support a deeper appreciation of prehospital care pathways. Next year we plan to formally evaluate the programme to ensure its continued impact and to enable our insights to be shared more widely.

Our relatively small team, combined with a very significant workload, means that any reduction in the size of our team, even for a short period, has a noticeable impact on our research resilience. For much of the year we have operated with reduced staffing levels, which has placed additional pressure on the team while we have worked hard to maintain continuity of research.

The main challenges for designing and delivering research within SCAS are currently:

- Limited resilience due to small team size.
- Inability to act as research sponsor.
- The cyclical nature of research funding that occurs as each funded research study is introduced, conducted and then concludes. This is a particular challenge for baseline funding to support the core research team.

12. Future Plans

In the year ahead, several major national studies, including RAPID2 and CRASH-4 will reach completion. As these trials conclude, we will support the national dissemination of their findings and contribute to the wider discussions that help translate new evidence into clinical practice. A central ambition for the year ahead is to progress towards becoming a research sponsor, strengthening our ability to lead studies from inception through to delivery and expanding the impact we can make across the research landscape.

Strengthening the stability of our team remains a key priority, and we will continue progressing toward a more permanent leadership structure. With this in place, we will be well positioned to pursue new research opportunities and grow our portfolio in line with our long-term goals. Despite the operational pressures of the last year, we remain committed to supporting the development of both the Research team and colleagues across the wider Trust. We aim to strengthen our research governance function and increase the number of staff trained in research delivery, thereby supporting our

transition towards becoming a sponsoring organisation and increasing the opportunities available for patients to take part in high-quality research.

12.1 Research projects currently in set-up

We are excited to shortly commence participation in a vaccine study of in partnership with the Wessex CRDC. We also are currently setting up two studies associated with the NIHR BioResource Research Tissues Bank (IRAS 313104), which recruits volunteers who provide health and lifestyle information and a biological sample to add to a national database for researchers to study genetic and environmental influences on health and disease. IBHO focusses on improving representation of people of African and Caribbean heritage in health and genomic research addressing long-standing gaps in the understanding and treatment of conditions that disproportionately affect these communities. D-CYPHR builds a genomic resource supporting research into childhood conditions and early-life contributors to later-life disease.

12.2 Annual plan

Challenge	Standard	Action	Lead	Progress summary
Build research infrastructure	Suite of generic research SOPs relevant and fit for purpose.	Develop suite of research SOPs according to prioritised list.	Research & Innovation Manager and RSG	Monthly to CRG
	Operation of rapid research vehicles (R-RRVs) to attend incidents of potential interest.	Ensure funds available to maintain fleet. Explore grants for additional vehicle/equipment to enable expansion of research portfolio.	Head of Research Operations	Six monthly to CRG
Upskill workforce	Every new member of SCAS staff to be aware of research function.	Research presentation to be included in all corporate induction courses.	Research team and RSG	Six monthly to CRG
	Developing research culture across the Trust.	Reinvigoration of research advocates' scheme. Continuation of research webinar series.	Research team and RSG	Six monthly to CRG
	Opportunities to develop research skills.	Talent spotting and provision of support for staff applying for internship/ fellowship opportunities and	Research team and RSG	Six monthly to CRG

		formal mentorship throughout programmes.		
Developing collaborations	Collaborate with regional partners to increase research offering to SCAS patients, service users, and staff.	Submission of at least two collaborative regional research bids.	Research team and RSG	Monthly to CRG
	Build relationships with national/international partners.	Development of successful grant application with national partner(s).	Research team and RSG	Monthly to CRG
Aligning research with practice	Design and deliver research projects in response to local need.	Work with internal SCAS teams to identify need. Develop research protocols and secure sponsorship (and funding where applicable).	Research team and RSG	Monthly to CRG
	Participation in large-scale high-quality external research projects.	Submit expressions of interest to high-quality projects.	Head of Research Operations	Six monthly to CRG
	Ensure patient and public involvement in all stages of research	Expansion of Community Engagement to increase Diversity and	Senior Research Paramedic and RSG	Six monthly to CRG

		Accessibility in Research (CEDAR) project. Development of a PPI research forum.		
Dissemination of research findings	Effective knowledge mobilisation.	Work closely with Education team to translate research findings into practice.	Research team and RSG	Six monthly to CRG
	SCAS presence at major paramedic research conferences.	SCAS to host national 999 EMS Research Forum conference 2026. Investigator fund to support attendance at national/international conferences/meetings where possible.	Research team and RSG. RSG	Monthly to CRG Six monthly to CRG
	Promote SCAS research activity to the public	We aspire to fund some dedicated time for a Communications subject matter expert	Research team and RSG	Six monthly to CRG
Sustainability	Ensure financial sustainability	Grow our involvement in the Wessex CRDC to attract commercial funding.	Research team and RSG.	Six monthly to CRG

		Creation of investigator fund to support dissemination and development.	Head of Research Operations	
	Organisation acts as research sponsor.	Build infrastructure to enable safe and effective research sponsorship.	Research team and RSG.	Monthly to CRG
	Resilience building and succession planning	Cross-training essential functions to ensure that expertise and responsibilities are sustained without disruption when required.	RSG	Six monthly to CRG

Studies status 2026-27

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Studies	CRASH4												
	ELSA												
	RAPID-2												
	STALLED												
	Genes & Health												
	Destigmatise												
	INTERACT												
	MepeBIO/TezeBIO												
	Non-HRA studies												
Projects	UoS placements												

Key

	- actively recruiting/engaged
	- closedown/archiving
	- data analysis/write-up
	- possible extension
	- enrolling patients but not 'counted' towards annual figures

13. References

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Appendix A – Publications

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<https://doi.org/10.1007/s00134-025-08142-2>
- Aljanoubi M, Brown TP, Booth S, **Deakin CD**, Fothergill R, Nolan JP, Soar J, Perkins GD, Couper K. The impact of the AIRWAYS-2 randomised controlled trial on clinical practice in out-of-hospital cardiac arrest in England: a registry based cohort study. *Resuscitation*. 2025.
<https://doi.org/10.1016/j.resuscitation.2025.110820>
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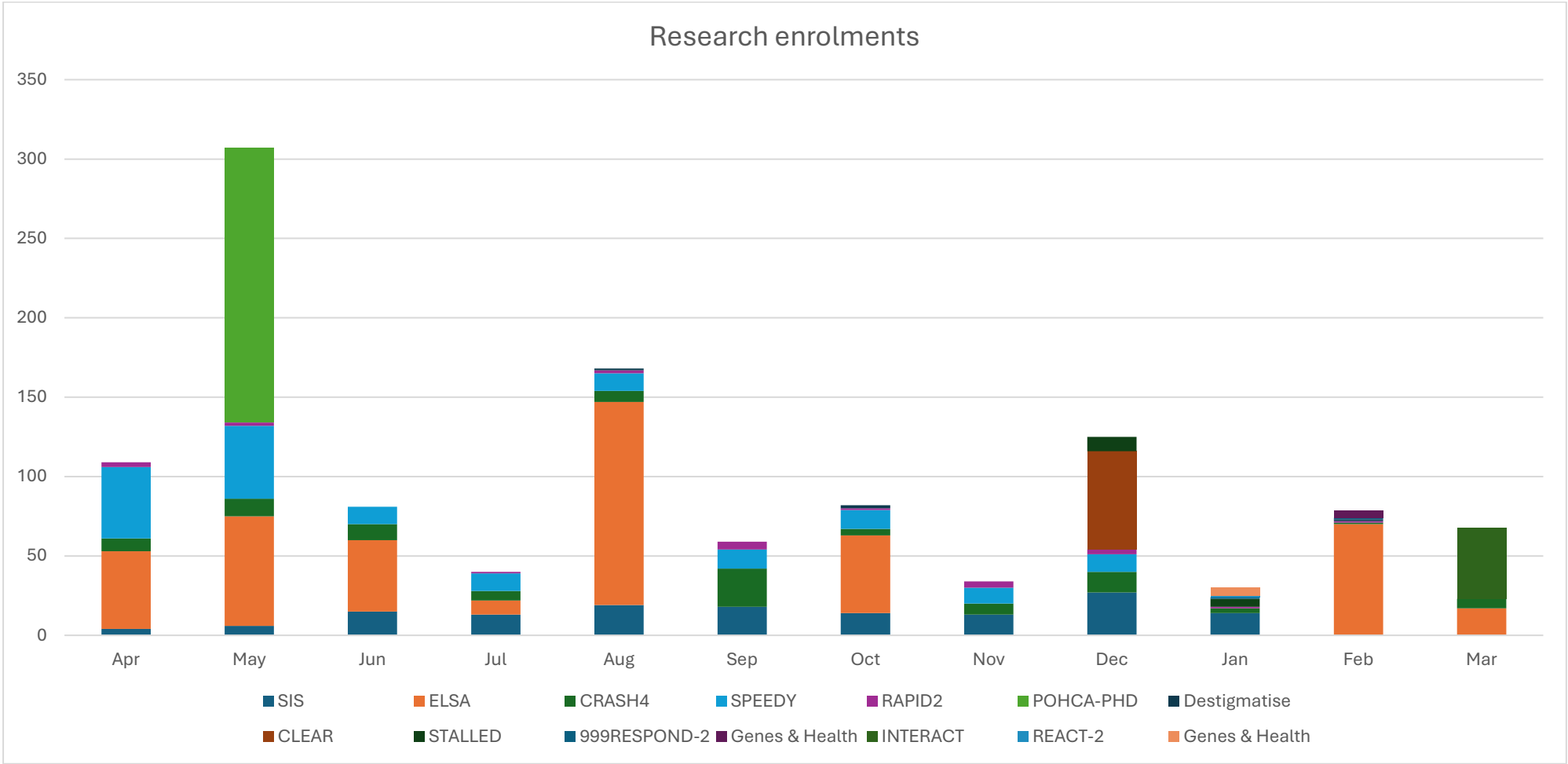
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Appendix B – Presentations

- Deakin, CD. Medical aspects of tasers in relation to cardiac arrest. MO19 Specialist Firearms Command. Metropolitan Police Service. April 2025.
- Deakin, CD. Medical Aspect of Tasers: Case Reports. MO19 Specialist Firearms Command. Metropolitan Police Service. April 2025.

- Deakin, CD. Resuscitative Thoracotomy. Regional Intensive Care Medicine study day. Southampton. April 2025.
- Deakin, CD. On the Stand: How the Use of TASER Devices impacts a court case from a Medical perspective. National Police Chiefs Council (NPCC) International Taser Conference. Birmingham. June 2025.
- Deakin, CD. Resuscitation in low-resource settings: global health perspectives: Digital apps to improve coordination of resuscitation efforts in the community. European Society of Cardiology. Madrid, Spain. August 2025.
- Deakin, CD. An Electrical Brawl: Standard defibrillation vs. Dual sequential defibrillation. Resuscitation Science Symposium. American Heart Association. New Orleans. November 2025.
- Jackson C. Staff reported experience of CPR-induced consciousness. 999 EMS Research Forum conference. Newcastle. September 2025.
- Maunick L. Evolution of UK medicines legislation for pre-hospital care ambulance services. Ambulance Leadership Forum. Windsor. March 2026.
- Pocock H. Informing Relatives of Non-Surviving Patients About Enrolment in Out-of-Hospital Cardiac Arrest Research. 999 EMS Research Forum conference. Newcastle. September 2025.
- Pocock H. Resuscitation during pregnancy. Resuscitation Council UK. Birmingham, November 2025.

Appendix C – Participant enrolment into research projects (April 2025 – March 2026)





Upward Report of the People & Culture Committee

Date Meeting met 28th May 2026
Chair of Meeting Ian Green, Non-Executive Director
Reporting to Trust Board

Items	Issue	Action Owner	Action
Points for escalation			
Recruitment	Whilst it is noted that there is a positive report from internal audit around recruitment processes, which will be reviewed at the next meeting, concerns were expressed around recruitment challenges in areas of our organisation, like the Call Contact Centres and in different parts of our geography. Whilst it is acknowledged that the position is more positive than it has been historically, risks remain. A deep dive will therefore be presented to the next meeting.	DH	Recruitment Deep Dive to be presented to the July meeting
National Education and Training Survey	The Committee received the survey results and whilst there were some positives, members were very concerned about the experience of our students and learners in areas such as bullying and harassment and sexual safety. Executives gave assurance that whilst this was part of the overall Culture & Leadership work, a focused action plan would be developed to take immediate targeted action. This will be presented to the next meeting. There is an existing action on the committee action log for a Board Seminar on bullying and harassment and whilst sexual safety has been discussed by the Board previously and as recently as last month, it was agreed that the	DH/BM	Seminar slot to be secured. NETS Action Plan to be presented to the next meeting.

	seminar session would be expanded to include sexual safety and violence and aggression.		
Sexual Safety	The Committee noted several positive steps that had been taken to improve the robustness and timeliness of investigations relating to sexual safety concerns that are raised. Whilst there was assurance the plans were robust and stronger infrastructure/processes are being built, the Committee is less assured that there is an effective communication and messaging strategy around this important area and requested this be strengthened.	DR	Communications Plan to be strengthened.
NED Training Requirements	Following review and given that NEDs are not employees of the Trust, the current training requirement has been reviewed, and the Committee supported the proposal to limit this to subjects relevant to the role and remit of a NED, namely, Safeguarding, Infection Prevention and Control and Information Governance & Security. It is also proposed training will be delivered in a seminar setting. The Board is asked to endorse this proposal.	BM	Board endorsement sought
Key issues and / or Business matters to raise			
Employee Relations Cases	The Committee noted that good progress continues to be made in terms of progressing cases in a timelier way with assurance around increasing grip and control and offered thanks to the People Team.	N/A	This will continue be monitored via the Committee.
Values & Behaviour Framework	The Committee recommends the values refresh and the accompanying Behaviour Framework to the Board for approval. Additional assurance was sought around the communication and launch plan and Non-Executive Directors are invited to attend the launch sessions that are planned/	N/A	For presentation to the June Board for approval.
Face to Face Resuscitation Training	The committee commended the efforts undertaken to improve in this key area and noted that the training had been front loaded for the current year to avoid the busier winter months. The Committee was also assured there was robust governance and oversight of take up.	N/A	
PAAC Annual Report and Terms of Reference Review	The Committee approved the Annual Report for submission to the Board, noting the significant improvements that had been made to the functioning of the Committee. The revised terms of reference were also approved and are recommended to the Board for approval.	BM	For presentation to the June Trust Board

Areas of concern and / or Risks			
N/A	Key areas of risk are as per the escalation section of this report.		
Items for information and / or awareness			
None			
Best Practice and / or Excellence			
People Team	Although it was noted that the Trust was carrying risk in relation to several areas, the Committee reflected on the progress that had been made and commended the People Team for their efforts.	DH	DH to pass on thanks to the team
Policies approved*			
None	There was discussion around policies that are reserved for the Board/committees given the historic position of presenting many of the People related policies to PACC and noting that policy approval is not a core function of a Board committee that has an assurance function. It was further noted that the Audit Committee has oversight of the policy framework and work was progressing via that route to assign all Trust Policies to the relevant Group or Committee.		

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 4 x Likelihood 4 = 16
Residual Risk Score	Impact 4 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 4 x Likelihood 4 = 16
Residual Risk Score	Impact 4 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.

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			Accountable Director	Chief Finance Officer	
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 (with further increases required, which include increase WTE) 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. Inflationary pressures (fuel, estates, supply chain, workforce costs) are eroding the financial benefit of productivity gains. Workforce sickness, retention pressures and rising cost-of-living impacts further constrain productivity delivery. Gaps in assurance: There is a risk that we may not operate effectively, and may not be able to deliver sustainable performance Standard: Board approved multi-year operating plan that includes cost improvement targets and productivity goals. Dedicated resources to deliver CIP. Efficiency and			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
Shift from Short-Term CIPs to a Structured Multi-Year Transformation Programme Establish and maintain a Trust-wide, multi-year transformation programme that clearly differentiates recurrent structural efficiencies from short-term mitigations. This programme will prioritise system-enabled productivity over further marginal cost reduction, with explicit benefits realisation tracking approved by FP&C. This will reduce reliance on non-recurrent actions and improve the sustainability of productivity gains.			Chief Finance Officer	June 2026	Progress underway, monitoring through FRG, 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			Chief Finance	June 2026	MOU, Model Developing, also joint version with SecAmb and

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		Accountable Director	Chief Finance Officer	
Controls: Annual and multi-year planning cycles in place and supported by the board. NHS England has formally accepted the Trust’s Medium-Term Plan (2026/27–2028/29) and Five-Year Integrated Delivery Plan as compliant, subject to conditions.		Committee	Finance & Performance	
Gaps in controls: CIP, operational and workforce plans are not currently multi-year hindering the development. Group (SASC and SECAmb) collaboration have not yet developed their plans which will impact the Trusts financial plans. 32% of Cost Improvement Plans (CIPs) identified as high-risk and unidentified at submission. The financial plan remains highly sensitive to: External inflationary pressures (fuel, energy, supply chains), Interest-rate impacts on capital, leasing and sale-and-leaseback arrangements, Variability in commissioning decisions across ICBs, including partial or withdrawn funding for agreed service commitments.		Inherent Risk Score	Impact 4 x Likelihood 4 = 16	
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- the Trust’s carbon baseline and other related measures). Model Health System productivity benchmarking, New Group Committee oversight.		Residual Risk Score	Impact 4 x Likelihood 5 = 20	
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. Failure to demonstrate rapid and sustained progress against the NHS England conditions would increase the likelihood of enhanced regulatory intervention, restrict financial flexibility, and limit the Trust’s capacity to invest in fleet, estates and workforce transformation. A material proportion of the Cost Improvement Programme remains unidentified and assessed as high risk, with insufficiently explicit ownership at Executive and Senior Leadership levels. This limits assurance over accountability for delivery, weakens collective grip on financial sustainability, and increases reliance on late-stage or non-recurrent mitigations. In the absence of clearly assigned Executive leadership responsibility for closing the unidentified gap, there is an increased risk that financial pressures escalate at pace, reducing the Trust’s ability to respond proactively and heightening the likelihood of regulatory intervention.		Target Risk Score	Impact 4 x Likelihood 2 = 8	
Gaps in assurance: SCAS has already delivered exceptional productivity gains, leaving limited remaining internal headroom for further efficiency without system support. . Delays to benefits from closer group working with SECAMB.		Risk Response	Treat	
		Target Date	Q4 2026/27	
Mitigating Actions		Exec Lead	Due Date	Progress Notes
Deliver a Time-Limited Financial Delivery and Assurance Programme Establish a focused, time-limited Financial Delivery and Assurance Programme to move the Trust from “plan accepted” to “plan delivered”. This will include strengthened executive ownership of Cost Improvement Programme (CIP) delivery, formal weekly monitoring of CIP maturity and phasing (as required by NHS England), and clear Board-level escalation thresholds for under-performance. This mitigation directly addresses the regulatory conditions attached to the acceptance of the Trust’s Medium-Term Plan and reduces the risk of enhanced regulatory intervention.		Chief Finance Officer	June 2026	Work Underway
Actively Manage Commissioner, System-Level and External Financial Risk Introduce a strengthened, structured approach to managing financial risks outside the Trust’s direct control, encompassing commissioner behaviour, system-level dependencies and wider macro-economic and geopolitical pressures. This will include early identification and escalation of funding misalignment with ICBs, clear documentation of financial pressures arising from commissioning decisions, and proactive engagement with NHS England where delivery assumptions are destabilised. In parallel, the Trust will maintain active monitoring of external risk drivers, including energy and fuel price volatility, global supply-chain disruption and geopolitical instability (such as the Iran conflict), to assess their impact on cost base, liquidity, capital affordability and medium-term sustainability. This mitigation ensures transparency, protects organisational resilience, and reduces the risk of unplanned financial deterioration driven by factors beyond Trust control.		Chief Finance Officer	June 2026	Work Underway
Strengthen Financial Ownership, Governance and Accountability Through the F&PC Reinforce leadership and governance of the Trust’s financial performance through the F&PC, ensuring robust oversight and accountability for financial outcomes. This includes regular reporting to the Board and the F&PC, and ensuring the F&PC has the necessary resources and authority to manage financial risks effectively.		Chief Finance Officer	June 2026	Work Underway

BAF Risk 25 - Collaboration			
If there is a failure to agree on a way forward with SECamb, Then this will lead to financial and operational instability, and an inability to realise productivity savings. Resulting in reputational damage with stakeholders and partners, and increased oversight and scrutiny of SCAS’s operating and strategic decisions.		Accountable Director	Chief Finance Officer
Controls, Assurance and Gaps		Committee	Finance & Performance
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.		Inherent Risk Score	Impact 4 x Likelihood 4 = 16
Gaps in controls: Lack of shared platforms across CCC and UEC operations. The Group model assumes convergence of service standards, investment and risk; however commissioning models and funding levels remain materially misaligned. SCAS is exposed to disproportionate delivery risk where local funding decisions diverge from regional or system intent. Non-recurrent funding used to initiate Group working is uncertain, placing sustainability of collaboration at risk.		Residual Risk Score	Impact 4 x Likelihood 4 = 16
Positive sources of assurance: Savings identified and implemented, structures aligned where possible, consistent delivery model.		Target Risk Score	Impact 2 x Likelihood 2 = 4
Negative sources of assurance: Funding levels, cultural and operational differences between Trusts may slow integration. Inconsistency of service model and delivery across region.		Risk Response	Treat
Gaps in assurance: Finance savings not released for reinvestment. Regional commissioning priorities. NEPTS provision across region is inconsistent. Lack of joint risk register and governance framework for collaboration. No benefits realisation framework for collaboration savings, efficiencies, productivity, etc.		Target Date	Q4 2025/26
Mitigating Actions	Exec Lead	Due Date	Progress Notes
Formalise Structured Regulatory Engagement to Address System Asymmetry Establish a structured and ongoing engagement framework with NHS England and lead ICBs to ensure clear, shared understanding of the structural differences in commissioning, funding and delivery models between Trusts operating within the Group. This will include proactive discussion of risk allocation, funding equity and delivery feasibility, supported by transparent evidence and joint assurance reporting. The aim is to secure regulatory support in resolving asymmetries that undermine collaboration, align expectations across the system, and ensure that Group working reduces rather than amplifies organisational risk.	All Executives	June 2026	Working On-going
Strengthen Group Leadership and Accountability Through Appointment of a Group Chair and Group CEO Progress the appointment of a Group Chair and Group Chief Executive to provide visible, single-point leadership for the Group operating model. This will create clearer accountability for decision-making, risk ownership and delivery across Trust boundaries, enabling more effective engagement with regulators and commissioners. Strong, unified Group leadership will support consistency of direction, accelerate resolution of cross-Trust issues, and ensure that collaboration is underpinned by authority, transparency and shared responsibility.	Chair/CEO	May 2026	Recruitment Underway
Mitigate Cultural and Capability Barriers: Provide joint training and development engagement programmes for leadership and operational teams to foster a collaborative	Chief People Officer	Oct 2025	Leadership & Development: Mapped leadership offerings to NHS Competency Framework. Piloted senior and first-level leadership programmes. Launched Executive coaching and scoped Sub-Executive development. Created SCAS Leadership Directory and self-



**Trust Board of Directors Meeting in Public
3 June 2026**

Title	Communications, Marketing and Engagement Update
Report Author	Gillian Hodgetts Director of Communications, Marketing and Engagement
Executive Owner	Danny Hariram, Chief People Officer and Deputy Chief Executive
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:

- Community engagement and public awareness raising
- Media activity – proactive and reactive
- Communications activities for the SCAS Charity
- Microsoft 365 migration latest
- Communications activity for the new SCAS Values and Behaviours launch
- SCAS Annual report update

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. Community Engagement and Public awareness raising

A significant aspect of the communication team's work is engaging with the public to raise awareness of medical conditions and of how to access the most appropriate services. Through on-going partnership working, SCAS delivered a successful public stroke awareness event at the John Radcliffe Hospital, Oxford, focused on early recognition and emergency treatment of stroke. The event supported the wider "Act FAST" public awareness campaign and received highly positive feedback, with attendees reporting greater confidence in recognising stroke symptoms and understanding of when to call 999.

Duncan Roberston, Chief Paramedic, also presented on Stroke management to Governors at the Membership & Engagement Committee on the 19 May. Through this session, key messages were shared as part of a wider campaign on stroke awareness. Cardiopulmonary Resuscitation (CPR) and defibrillator demonstrations were delivered by Community First Responders, alongside presentations from leading stroke specialists.

Recognition and Partnership Working

SCAS Public Governor for Hampshire, Chas McGill MBE, received a special award recognising his 60 years of service to the emergency services, during the Gang Warily Emergency Services Day. The award highlighted his longstanding contribution to emergency care, community engagement and public service. Sir Julian Lewis MP attended the event to recognise Chas's exceptional commitment.

Emergency Services Day – Community Impact

Approximately 40 SCAS staff and volunteers participated in the Gang Wary Emergency Services Day over the May bank holiday weekend.

The event showcased a broad range of SCAS services including frontline operations, Specialist Operations Response Team (SORT), Adult Critical Care Transfer, Driving Education, Community Engagement and Community First Responders.

Public engagement activities included CPR training, emergency vehicle displays, live multi-agency demonstrations and public safety education focused on e-scooters, water safety and equine-related incidents.

The event demonstrated our strong commitment to partnership working with other agencies, including Hampshire Police and local community organisations.

Violence Prevention and Youth Engagement

SCAS supported the “No Knives, Just Vibes” Anti-Knife Crime Community Football Match in partnership with Thames Valley Police and community organisations.

SCAS paramedics delivered practical demonstrations on CPR and responding to knife injuries, helping provide lifesaving skills and promote community safety messages to young people and families.

Health Inequalities and Community Resilience

Community engagement activity continued through the Community Resilience Grant programme aimed at addressing health inequalities linked to out-of-hospital cardiac arrest.

SCAS teams participated in multiple community outreach events including:

- Health fairs at Medina Mosque and Portsmouth community venues
- Cancer awareness events
- School engagement activities
- Carers’ support events
- Community basic life support and heart health training sessions

These activities strengthened relationships with diverse communities and supported wider prevention, education and public health objectives.

Overall Impact

Recent engagement activity has continued to strengthen SCAS visibility within local communities, increased public awareness of emergency response and lifesaving interventions, and demonstrated the commitment of staff, volunteers and governors to partnership working and community resilience.

6. Media activity April – May 2026 – proactive and reactive

Press releases

- Group Chair confirmed [Group Chair confirmed | South Central Ambulance Service](#)
- SCAS Charity secures £250,000 grant for additional mental health support [SCAS Charity secures £250,000 grant for additional staff mental health support | South Central Ambulance Service](#)
- Group Chief Executive appointed [Group Chief Executive appointed | South Central Ambulance Service](#)
- Patient reunite stories:
 - Donna Mason: [Donna meets some of her lifesavers | South Central Ambulance Service](#)
 - Mick Harvey: [Happy tears flow as cardiac arrest survivor meets his lifesavers | South Central Ambulance Service](#)

Reactive media enquiries

- National and regional interest generated by Adam Ankers inquest conclusion
- Impact of increasing petrol prices on Trust operations
- Category 2 response time target agreed with commissioners for 2026/27
- Impact of heatwave on operational demand

Social media

- Operational demand support messaging during Easter weekend and two May bank holidays
- Resident doctors strike messaging and potential impact on wider NHS
- Support for SCAS Integrated Contact Centre Open Days
- SCAS volunteers and staff running London Marathon for SCAS Charity
- COVID-19 Spring vaccination campaign
- International Day of the Midwife
- International Nurses Day
- Hot weather messaging focusing on vulnerable at-risk patients and water safety

7. Communications activities for the SCAS Charity

The Communications and Engagement team continue to support the charity in delivering its marketing and communication objectives.

The two teams are jointly working on a campaign to publicise the value of the charity and volunteers to local communities with the theme of 'neighbours'. There is also a campaign in development to highlight the work done by volunteer car drivers, to both recognise their

contribution to patients and to recruit more in areas of shortage.

Work is also under way to engage with local media on two big charity events: the Spinnaker Abseil in Portsmouth on 12 September and the 'CPR-athon' involving several local Football League clubs on 24 September.

Volunteer Week runs from 1 June 2026, and the Communications and Engagement team are supporting and amplifying charity messages during the week, including developing a press release to generate interest in the creation of the new Community CPR Advocate role.

8. Microsoft 365 migration latest

365 Migration – the Communications team is an active member of the migration project team and programme board. We are working to raise awareness of the migration and the impact on staff so all teams are properly prepared. After the switchover, there will be a significant piece of work to do within the communications team, and with department level content managers, to reset many intranet links which will break as part of the migration.

9. Communications activity for the new SCAS Values and Behaviours launch

The Communications team is working closely with the Culture and Leadership team, as part of the project team to plan for the new values and behaviours launch and implementation. The full communications and engagement plan is set out in the separate agenda item on values.

10. SCAS Annual report and accounts update

The draft SCAS 2025/6 Annual Report and Accounts document has been compiled and was submitted to the external auditors to the agreed deadline. Their feedback was responded to and amends made to the document.

The document was then shared with the Executive Management Committee for review and comments, and it is now being received by the Board at today's meeting (3 June 2026).

Final internal sign-off for the document will come with formal approval from the SCAS Audit Committee on 25 June (following a week of scrutiny), before it is submitted to NHS England on 26 June.

Following this, the design of the document will be adjusted, with changes to some tables and graphs, to make it suitable for laying before Parliament and publishing on the SCAS website in September.

11. Recommendations

The Board is asked to receive the paper for noting.

For Assurance		For decision		For discussion		To note	x
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**Trust Board of Directors Meeting in Public
3 June 2026**

Title	Refreshed New SCAS Values & Behaviours Framework
Report Author	Mehvish Shaffi-Ajibola, Interim Associate Director of Culture & Leadership
Executive Owner	Danny Hariram, Chief People Officer & Deputy CEO
Agenda Item	19
Governance Pathway: Previous	Private Board, 4th May 25, 2026 Executive Management Committee, 21 April 2026
Governance Pathway Next Steps	n/a

1. Purpose

This paper presents the refreshed SCAS Values and Behaviours Framework for Public Board approval. It provides assurance that the framework has been developed through a structured, inclusive, and evidence-based process, shaped by the voices of our people, and informed by organisational insight.

The paper is accompanied by two appendices.

- ✓ Appendix 1 – Values and Behaviours Framework.
- ✓ Appendix 2 – Communications and Engagement Plan

2. Executive Summary

The Board is asked to approve the refreshed SCAS Values and Behaviours Framework for Caring, Professional and Honest including the accompanying Communications and Engagement Plan, enabling SCAS to move forward with formal launch and embedding as part of the next phase of the Building Trust Together culture programme.

The framework was first presented to Private Board in May 2026. Feedback and engagement from that session was encouraging and helped strengthen the framework further. As a result of that discussion, the framework was tightened to ensure it is bold and unambiguous addressing not only the behaviours SCAS expects, but being explicit about the behaviours it will not tolerate. This reflects the Board's commitment to creating a culture where everyone feels safe, valued, and well led.

The refreshed framework has been developed through a structured, inclusive, and evidence-based process, drawing on NHS Staff Survey findings, Quarterly People Pulse, Freedom to Speak Up, Employee Relations, Patient Safety intelligence, and joiner and leaver feedback. Through discovery and co-design phases that started in August 2025 thorough to December 2025 involving colleagues, volunteers, students, and Patient Panel representatives, SCAS has moved from four values to three retaining Caring and Professional, and introducing Honest as a refreshed core value. Teamwork, which featured strongly in engagement feedback, is embedded across all three values rather than standing alone. Other key points.

- ✓ **Sexual safety is a key part of this framework.** The framework explicitly names sexual safety as a shared responsibility, making clear that sexualised language, inappropriate touching, harassment, and sexual misconduct are unacceptable. These are not listed as aspirational standards they are named as behaviours SCAS will not tolerate. This sits alongside the broader Sexual Safety programme of work and the See Me First race equity campaign as part of a coherent, organisation-wide commitment to dignity and safety.
- ✓ **Equity underpins the entire framework.** Equity is not presented as an aspiration but as a structural principle recognising that fairness is not only about applying the same standard to everyone, but that people may experience SCAS differently and may need different support to achieve fair outcomes. Optional Equality, Diversity, and Inclusion data were used throughout the co-design process to ensure diverse perspectives shaped the final framework, and to sense-check whether different demographic and experiential groups were aligned on what matters most.

The framework translates each value into clear behavioural expectations, what good looks like for everyone, what additional responsibilities leaders carry, and what behaviours will not be accepted at any level. It is structured around 'We are,' 'We will' and 'I will' to reflect both collective and individual accountability.

We seek to launch the new framework on 22nd June 2026 (once approved), and implementation will be delivered in three phases with the Communications and Engagement Plan (Appendix 1) setting out the full detail.

- ✓ **Pre-launch activity (March to 21 June)** has already engaged culture champions, staff networks, unions, Health and Wellbeing Champions, Speak Up Champions, established a staff led reference group and leaders at all levels building understanding and readiness ahead of formal launch.
- ✓ **The launch phase (22 June to end of July)** opens with an all-staff event led by executives and an external speaker, followed by a sustained four-week mobilisation programme: daily Visible Values Walkabouts across sites, 25 to 30 in-person roadshows across stations and sites, Values and Behaviours Clinics using real-scenario case examples to build practical confidence, and targeted virtual sessions for staff networks, unions, volunteers and students. Leaders at every level are expected to personally role model the framework, hold value-based conversations,

name behaviours that fall below the standard, and use the PDR process to assess and close gaps.

- ✓ **The mobilising phase (August 2026 to March 2027)** integrates the framework into induction, appraisal, recruitment, priority people policies, and reward and recognition, with an ePDR rebuild planned for 2026/27. A dedicated Values Week in September 2026 will celebrate positive practice ahead of the National Staff Survey. Sexual safety programme activity, Freedom to Speak Up campaigns, and race and disability equality work will all make explicit connections to the framework throughout. Delivery is overseen through the Values and Behaviours Delivery Group with PMO support, and evaluated quarterly from September 2026 through staff surveys, People Pulse, People Voice feedback, and People and Culture KPIs.

3. Areas of Risk

The primary risk is one of inaction or delay. Colleagues, volunteers, and staff networks have invested in this process through discovery, co-design, and pre-launch engagement. Delay in approving and launching the framework risks undermining that momentum and eroding staff confidence in the organisation's commitment to culture improvement at a time when the 2025 NHS Staff Survey confirms that trust, consistency, and clarity are already areas of concern.

The implementation plan is ambitious in scope and pace, running alongside significant BAU pressures across all services. The risk of uneven rollout is real — particularly where first-line managers carry the greatest responsibility for local embedding but face the most competing demands on their time. This is mitigated through the dedicated Values and Behaviours support pack and leaders' toolkit, a Culture Champions network and staff led reference group providing local reach, and a programme of road shows and clinics designed to go to staff across sites rather than requiring staff to come to a central event. The Values and Behaviours Delivery Group and PMO oversight will monitor delivery and identify gaps early, with quarterly evaluation enabling the plan to be adapted in response to feedback.

There is also a risk that staff who have experienced previous culture initiatives engage with cynicism rather than confidence, particularly if they do not see visible follow-through from leaders at all levels. This is directly addressed through the framework's explicit 'We will not' and 'I will not' language, which signals a step-change from aspirational values statements to named behavioural accountability. The co-design process in which colleagues shaped the framework themselves provides a credible foundation for that message. Leadership consistency will be monitored by the delivery group and through the quarterly evaluation cycle, with People Voice feedback, Culture Champion insight and People and Culture KPIs providing early warning of where reinforcement is needed.

4. Link to Strategic Theme

People and Culture

5. Link to Board Assurance Framework Risk(s)

SR22 - Staff Engagement

6. Quality/Equality Impact Assessment

Equity is central to the framework and to how it was developed. Optional EDI data was used throughout the co-design process to understand whether perspectives varied across demographic and experiential groups, ensuring the framework reflects diverse experiences. The implementation approach includes targeted activity to reach all staff across different job roles, shift patterns, and locations.

7. Recommendations

The Board is asked to.

- ✓ Approve the refreshed SCAS Values and Behaviours Framework and the accompanying Communications and Engagement Plan, enabling the Trust to move forward with launch and embedded.
- ✓ Support the phased implementation approach, including the Values and Behaviours support pack, leadership cascade, Visible Values Walkabouts, Values and Behaviours Clinics, and the delivery, governance and evaluation arrangements set out in the Appendices

For Assurance	✓	For decision	✓	For discussion		To note	
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Values and Behaviours Communications and Engagement Plan (May 2026 – March 2027)

This paper accompanies the June 2026 Board report on the values and behaviours framework.

The framework aims to deliver a sustained shift in how it feels for our people to be part of SCAS and, in turn, how it feels for those receiving care from us.

It is recognised that establishing the refreshed values and behaviours will take time and will be done progressively across all aspects of our work, including through leadership practice, induction, appraisal, recruitment, policies, recognition approaches, and everyday interactions within and across teams.

The ongoing implementation plan includes communications and engagement activities alongside system and process changes to incorporate the values and behaviours into:

- How individuals and teams deliver their work
- How leaders and managers guide and support others
- How the trust makes decisions from the Board through to daily operations

The plan is phased across three stages up to March 2027, and will then be reviewed and updated for 2027/28:

- Pre-launch (March – 21 June 2026)
- Launch and mobilisation (22 June – end July 2026)
- Embedding (August 2026 – March 2027)

The implementation approach recognises that sustainable culture change requires consistent leadership visibility, repeated communication, practical application and ongoing reinforcement over time. The framework will therefore be embedded progressively through leadership practice, induction, appraisal conversations, recruitment, people policies, recognition approaches and everyday team interactions.

A phased approach supports long-term behavioural change and recognises this transformational work must run alongside all teams continuing to deliver on business-as-usual and the performance, quality, and financial priorities for 2026/27.

Behaviour change objectives

The refreshed values and behaviours framework provides a clearer and more consistent standard for how we work together, how we lead, and how we care for patients and one another across SCAS.

The framework sets new organisational standards which everyone will be expected to meet. Leaders and managers will be key in role modelling and embedding the new framework. They will be supported to name behaviours, call in concerns early, hold values-based conversations, record and review patterns where appropriate, and escalate through policy routes where behaviour does not improve.

Specific issues, identified through staff surveys, speak-up concerns, and wider engagement activity, the values and behaviours framework will address include:

- People feeling valued and recognised for the work they do
- Reducing inappropriate behaviours linked to sexual safety
- Increasing civility in how teams and individuals interact
- Increasing openness in how decisions are made with consistency and equity

Reaching all audiences

We have varied staff groups working different shift patterns across a wide geography. For both the launch phase and subsequent work to embed the values and behaviours we will use tailored approaches to reach different groups; taking into account who they are and how they work.

Roles	Locations	Contract / work patterns
Work area: • Frontline • Support / corporate Leadership levels • Service leader • Team/department leader • Line manager/supervisor • Subject matter expert	Majority of time spent in: • Vehicles • Stations • Contact centres • Workshops • Corporate offices • Home working	Contract type • SCAS staff • Students • Volunteers/Charity • Fleet Services Work patterns • Shifts • 9-5 • Part-time • Volunteer

Support from local leadership is key to ensure we reach all audiences. They will be supported to cascade essential information, promote the resources available to all, and set the local context of how the new values and behaviours need to be adopted within their areas.

Beyond the values and behaviours programme we will be reviewing internal communications during 2026/27 and identifying opportunities to strengthen central channels and build local skills to provide greater reassurance that information on all priority programmes and campaigns are reaching all staff, students and volunteers.

Shared responsibility across all levels of leadership

Delivering this plan relies on active engagement from all levels of leadership in the organisation including the executive team and board, the strategic leadership group, operational leaders, and first-line managers.

Leaders at all levels will need to make the connections between everyday work and the values and behaviours framework, bringing it to life within their teams and sharing examples of progress and good practice to help us fully embed the framework.

All levels of leadership have shared responsibilities for promoting and embedding the values and behaviours within their services:

- Personally role model the behaviours set out in the framework.
- Identify, celebrate and promote positive examples from within their services.
- Promote the framework within teams and gain assurance that direct reports are also acting on their responsibilities.
- Use the PDR process for themselves and their direct reports to assess capability and confidence in embedding the framework, and take up leadership development opportunities to close any gaps.

The trust's wider leadership development programme is part of equipping leaders with the skills and tools they need to make this happen. The training and support materials used in these programmes is being designed/refreshed to incorporate the new values and behaviours, and the skills leaders need to embed them. The leadership development offer is summarised in Appendix 1 for information.

Support materials and messaging is being developed by the Culture and Leadership and Communications teams to help all levels of leadership adopt and embed the values and behaviours within their services.

Monitoring and evaluation will be led by the Culture and Leadership team and will be used to adapt plans as needed to maximise impact.

Pre-launch

This phase includes engagement work and preparation of materials. The engagement activity, led by the Culture and Leadership team, included feeding back on the co-design stage of developing the new values and socialising the new framework and plans for launching. This has helped build support and understanding with a range of key groups that will be essential to fully embed the framework:

- Recently recruited Culture Champions
- Staff networks
- People & Wellbeing Directorate
- Unions
- Health & Wellbeing Champions
- Speak Up Champions
- Line managers, operational and strategic leaders

Specific activity included briefings and discussion with:

- A new network of culture champions
- Union representatives
- Education team (14 Apr)
- People and Wellbeing team (15 Apr)
- Operational leadership - symposium (23 Apr)
- All line managers – Team Brief (11 May)
- Strategic Leadership Forum (13 May)
- Senior operational management team (14 May)

Timing	Pre-launch activity
4 June – post Board approval	Publish launch event invites and initial online materials to trail full launch.
8 June	Team Brief – update line managers on launch plans and actions required to support cascade and awareness raising
10 June	Council of Governors – verbal update on framework approval and launch plans
On-going pre-launch	Ongoing pre-launch engagement: • Volunteers (TBC) • Union representative (5 Jun) • SCAS Champions (11 Jun) • Staff Network leads (11 Jun) Finalising materials and distributing printed elements across sites. Materials required for the launch week are being prioritised, additional material to support embedding the framework will follow post-launch.

	Key materials to be ready for launch include: Values and behaviours support pack – for all staff including the full values and behaviours framework. Leaders and Managers toolkit – additional detail for leaders with support for how to embed within teams and 1-2-1s (will be published on intranet for visibility to all staff). Culture champions pack – additional detail to help champions promote values within their team/service. At-a-glance summary – one-pager covering values and behaviours framework. Printable for reference as handout or use as poster. Pocket guide – printed credit card sized fold out leaflet with core elements of framework and links to full information on intranet. Site display packs – pack of posters and pocket guides distributed across sites ahead of the launch week. Pop-up banners for key sites and roadshow use. Launch event merchandise – selection of additional values branded promotional items to support launch period. Pens, lanyards, sweets, mugs.
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Launch and Mobilisation

The launch and mobilisation phase begins on 22 June with an all staff open invite meeting led by executives and with support from an external speaker. Core messages and materials will be published and cascaded throughout the trust.

Following the initial launch week, mobilisation activity will continue through to end of July, including a programme of site visits and service-based sessions delivered by the executive, strategic leaders, and members of the People directorate to raise awareness and build strong recognition of the new values across all parts of the trust. Recognising the realities for a dispersed and shift based workforce, where people cannot come to the launch, we will come to them.

This phase is also key to gaining commitment from operational and first-line leaders to fully understand the new framework and plan local activity to promote embed the new values and behaviours in the months ahead.

Week 1 (22-28 June)

Timing	Launch week activity
Monday	AM • All materials and refreshed intranet content published • Hot News published with video message from CEO and chair • Drop-in stands manned across Contact Centres, Education sites and larger resource centres (Culture champions/People directorate) • Digital screens and computer desktop images updated with values content PM • all staff launch meeting (12:00-13:30) • Staff Matters published with links to new materials, launch event recording, programme of coming events
Tue – Fri	• Daily Visible Values Walkabouts led by executives and strategic leadership – updates posted to Viva Engage to promote wider visibility of walkabouts • Service based discussions and presentations delivered by service leads. Wednesday Strategic Leadership Forum time released for leaders to meet with teams and lead values and behaviours sessions. Larger services to include plans for wider rollout in sessions led by local leaders.
Late shifts and weekend	• Shift leaders briefed to highlight launch messaging and materials to teams working late/weekend shifts.

Mobilisation period (weeks 2 – 6)

Recognising the challenges of reaching our entire workforce, the second part of the launch phase will focus on events and messaging to: raising awareness of the framework; how local leaders are expected to embed it; and the support available.

For all event-based activity a simple feedback form will be used to track delivery of events and numbers reached.

Timing	Launch and mobilisation month activity
Ongoing through launch month	In-person roadshows – a combination of advertised drop-in timeslots and walk-about conversations across trust sites. Led by a combination of execs, strategic leaders and members of the people directorate.
	Values and behaviours clinics using case examples to build shared understanding, confidence and practical application – led by the Culture and Leadership team.
	Virtual sessions for specific groups engaged during co-creation, including staff networks, unions, volunteers and students, to update them on the final framework and confirm the refreshed values – led by the Culture and Leadership team.

	Service level meetings – all leaders required to present on values and behaviours at pre-planned team meetings during launch month. Presentation/facilitator notes provided to support consistent delivery across the trust. Education and Training sessions – Presentation insert highlighting the new values and behaviours, with links to online materials. To be used by facilitators/educators in all training and education sessions during the launch period. Pocked guides to be handed out at all sessions during launch period. Executive video messages communications team to support executives to identify and include values and behaviours related messaging in the six exec messages that will publish during the launch period. Staff Matters (weekly all staff email) & Hub – communications and culture & leadership teams co-ordinate publication of regular values and behaviours related stories during launch period. • Hub homepage spotlight content linking to values and behaviours. • Phased publication of additional values-based bite-sized videos and supporting materials.
	Culture champion development – Culture and Leadership team continue to support local culture champions to promote the framework, encourage attendance at events, share stories of values in action, and feedback to identify any areas of confusion, cynicism or resistance, and where additional engagement is needed.
	Clinical systems messaging – Explore potential to use clinical systems like JRCALC for promoting values and behaviours information to frontline staff.
Date specific:	
9 July	Long service awards – presentations and event materials to make connections to new values.
13 July	Team Brief – Further promotion and awareness raising. Gather initial feedback from line managers.
22 July	Strategic Leadership Forum Gather initial feedback from strategic leaders.
27 July	Open Space – all staff meeting. Promoting next steps moving into embedding phase. Gather initial feedback from staff.

Embedding (August 2026 – March 2027)

To embed the framework into everyday practice we must make visible leadership and role modelling a consistent part of routine working practices. In this phase:

- Executives and strategic leaders must sustain visible promotion of and adherence to the framework.
- Operational and first-line leaders must be equipped to promote and use the framework at a local level.
- Systems, processes and policies used across the trust must be seen to incorporate the framework.
- Wider campaigns and programmes must make visible connections to the values and behaviours e.g. sexual safety, health and wellbeing, equality.

A rhythm of positive messaging

Throughout the embedding phase we will integrate values and behaviours related messaging into regular communications and engagement channels, using the Communications team's forward plan for executive and corporate communications, to ensure a steady rhythm of stories highlighting positive examples of values and behaviours in practice.

In the embedding phase the communications focus must shift away from basic awareness raising of the values themselves, in favour of stories that link everyday practice across the trust to the values and behaviours.

Throughout the embedding phase **established channels and events** will be used to promote the values and behaviours work, these include:

- Executive video message (weekly)
- Staff Matters (weekly all staff email bulletin linking to content on intranet)
- Team Brief (monthly session with supporting written document for managers)
- Open Space (monthly session for all staff)
- Strategic Leadership Forum (monthly in-person meetings for direct reports of executive team)

External social media will be used for appropriate messaging related to the values and behaviours work; identifying champions who are active with personal accounts and planning relevant use of the trust's official accounts. A review of how social media could be used to reach staff audiences will be undertaken.

Values and behaviours references will also be incorporated into **wider topics / campaigns** where clear links can be shown:

- Sexual safety programme activities
- Race and disability equality work
- Freedom to Speak Up campaigns
- Health and Wellbeing campaigns

Confirmed dates of monthly events are noted in the quarterly activities lists below. Topics for specific sessions will be planned after a review of the launch phase. Values and behaviours related content will also seek feedback on the rollout to identify gaps / challenges and adapt embedding activities accordingly.

Quarter 2 embedding (August – September 2026)

Timing	Activity
August	Sense check on embedding activities Review feedback from July Team Brief, Strategic Leadership Forum and Open Space events and adapt embedding activities if required.
	Recruitment – update materials to include new values and behaviours: • template text for job descriptions and job adverts • values based recruitment guide for recruiting managers • sample values-based interview questions.
	Inductions – update materials to ensure clear focus on introducing values and behaviours framework to new starters. Consistent approach across all inductions for corporate, operations, students and volunteers.
	Leadership communications – establish online areas for strategic, operational, and first-line leaders groups providing dedicated areas and distribution groups to share materials and updates (utilise for, but not specific to, values and behaviours).
	Board meeting patient and staff stories – work with Governance team to develop new template to make specific connections to values and behaviours.
	Bite-sized learning videos case studies demonstrating effective and ineffective approaches: • Appraisals • 1-2-1 conversations • Difficult conversations
10 Aug	Team Brief – line managers meeting
19 Aug	Strategic Leadership Forum
24 Aug	Open Space – all staff meeting
September	Initial evaluation of launch and early rollout – using focus groups, quarterly people pulse introducing values questions, review of wider People Voice feedback.
9 Sept	Council of Governors meeting – update on values and behaviours launch and on-going implementation activities.
14-20 Sept	Values week – extensive publicity to celebrate good practice in delivering new values and behaviours and linking to showing progress against staff feedback ahead of national staff survey opening. Combination of online and in-person activities.
14 Sept	Team Brief – line managers meeting
23 Sept	Strategic Leadership Forum
24 Sept	Long service awards – second event of 2026/27. Repeat links to values as in July session.
28 Sept	Open Space – all staff meeting

Ongoing through quarter 2	Policies and processes – update priority people policies to incorporate new values and behaviours.
	Training and Education – work with education teams to review all in-house training courses and identify ways to build in relevant values and behaviours references.
	Leadership support to embed locally • Leadership development activity will support leaders to use reflective, appreciative enquiry and psychologically safe approaches to conversations, team culture and behavioural accountability. • Leader workshops – standalone values and behaviours related sessions if needed beyond existing sessions. • Leaders using Values prompts in team meetings asking the question as standard practice’ “Have we lived our values?” • Targeted manager / team leader development sessions focusing on - psychological safety, feedback conversations, accountability, early resolution, values-based leadership. • Support for managers to hold high-quality values-based conversations focused on performance, wellbeing, development, behaviour and accountability
	Culture champions network – on-going development of network, using members to feedback on rollout, develop case studies and identify positive stories of people living the values.
Ongoing through quarter 2	Refreshed reward and recognition programme – finalise and roll out refreshed reward and recognition initiatives, incorporating values and behaviours so good practice can be celebrated. • Design and launch staff awards scheme (November celebration event) • Build and launch online recognition tool (Each People platform)
	Begin ePDR rebuild – incorporate new values and behaviours into PDR app as part of rebuilding post Microsoft365 migration.
	Connection with sexual safety programme actions – incorporate values and behaviours references into internal campaign and promotion activity as sexual safety programme delivers on key actions.
	Campaigns and awareness events to connect to values: • World Patient Safety Day (17 Sept) • Infection Prevention Control Week (Oct - TBC) • Allied Healthcare Professional Day (Oct - TBC)

Details of specific topics to be covered in quarters 3 and 4 will be developed in response to evaluation of launch and quarter 2 activities. We will continue to use established channels and events plus relevant other campaigns to make links to values and behaviours and celebrate good practice. Evaluation of from quarter 2 may also identify additional support materials/sessions for leaders to further embed the framework into everyday working practices across the trust.

Quarter 3 embedding (October – December 2026)

Timing	Activity
October	Speak-up Month – include stories within wider Speak Up activities to highlight honesty value and related behaviours.
7 Oct	Annual Members Meeting – Presentation on development and implementation of values and behaviours.
12 Oct	Team Brief
15 Oct	Leadership Symposium – programme to include values and behaviours specific items.
21 Oct	Strategic Leadership Forum
26 Oct	Open Space
9 Nov	Team Brief
18 Nov	Strategic Leadership Forum
23 Nov	Open Space
November	Staff awards event – reinstated celebration event. Categories and content of presentations and event material will promote positive examples of values and behaviours in action.
7 Dec	Team Brief
16 Dec	Strategic Leadership Forum
21 Dec	Open Space
	Campaigns and awareness events to connect to values: • National Staff Survey completion • Vaccination uptake • Infection Prevention Control Week (Oct - TBC) • Allied Healthcare Professional Day (Oct - TBC)

Quarter 4 embedding (January – March 2027)

Timing	Activity
Ongoing through quarter 4	Appraisal promotion campaign – support material and awareness raising to ensure 2027/28 PDR sessions fully incorporate setting values based performance review and future priority/objective setting. Complete ePDR rebuild – to be complete in time for 2027/28 appraisal/PDR setting.
March	Year 1 Evaluation - Review all feedback, refresh support materials if needed and develop values and behaviours related activities for 2027/28.
11 Jan	Team Brief
TBC	Strategic Leadership Forum
25 Jan	Open Space
8 Feb	Team Brief
TBC	Strategic Leadership Forum
22 Feb	Open Space
8 Mar	Team Brief
TBC	Strategic Leadership Forum
22 Mar	Open Space

Appendix 1 - Leadership Development Offer

Foundation Level (New & First Line Managers)

- 3-day Management Development Programme building essential operational and people leadership capability.
- Focus areas include:
 - Workforce management and HR processes
 - Operational systems and governance (ESR, Datix, risk, compliance)
 - Core leadership skills (feedback, coaching, delegation, difficult conversations)
- NHS Elect Leadership Series:
 - 6-module programme with strong engagement (161 leaders to date)
 - Supports foundational leadership capability across the organisation

Senior Leadership Development

- Pilot programme incorporating:
 - NHSE-aligned leadership self-assessment
 - 360° feedback and PDR-led development planning
 - Coaching and mentoring support
- Targeted interventions:
 - *The Art of Showing Up* (influence, communication, leadership presence)
 - Strategic Leadership of Change
 - Coaching for Quality Improvement
- First cohort completed (18 leaders); evaluation underway with further rollout planned.

System Leadership and Engagement

- Biannual Operational Leadership Symposium:
 - Strengthens alignment, collaboration, and peer learning
 - Provides a platform for strategic engagement and shared priorities
- Sub-Executive Development:
 - Monthly forums to enhance strategic capability and cross-team collaboration
 - Embedded development (e.g. leadership insight tools, thematic learning such as sexual safety)
 - Structured assessment and development planning in progress

Continuous Professional Development (CPD)

- Trust-wide Training Needs Analysis (March 2026) completed to identify organisational priorities.
- Insights drawn from TNA, leadership forums, and PDR processes.
- Shift from fragmented CPD allocation to a coordinated, strategic model:
 - Partnerships with selected universities and approved providers
 - Improved consistency, value for money, and alignment to organisational priorities

Wider Leadership & Workforce Development

- Accessible development opportunities for all staff, including:
 - Change management and coaching programmes
 - Psychometric tools and facilitated conversations
 - Mediation and conflict resolution training
- Key culture and safety initiatives:
 - Sexual Safety programme (including 80 trained investigators)
 - *Be Safe, Speak Up & Be Heard* campaign (2026 rollout)
 - Allyship and bystander training
 - *See Me First* awareness campaign
- Practical leadership tools:
 - *Every Conversation Counts* toolkit (launching June 2026) supporting high-quality conversations

External Partnerships & Digital Learning

- NHS Elect membership providing 24/7 access to a broad leadership development portfolio, including:
 - Leadership, quality improvement, and operational skills
 - Digital, innovation, and AI capability
 - Core professional skills (communication, resilience, stakeholder engagement)



TRUST BOARD MEETING IN PUBLIC
3 June 2026

Title	Committee Annual Reports 2025/26 and Terms of Reference
Report Author	Becky Murray, Chief Governance Officer
Executive Owner	Becky Murray, Chief Governance Officer
Agenda Item	21
Governance Pathway: Previous	Annual Reports and Terms of Reference have been presented to the relevant Committee
Governance Pathway Next Steps	None

1. Purpose

To present the Board Committee Annual Reports for the 2025/26 period and the revised terms of reference for approval.

2. Executive Summary

Best practice in corporate governance suggests that the Committees of the Board should undertake an Annual Assessment of their performance and effectiveness and present this to the Board for assurance.

The following reports for the standing committees of the board for the year 2025/26 are attached:

- Audit Committee
- Quality & Safety Committee
- People & Culture Committee
- Finance & Performance Committee

The Annual Reports are based on a survey issued to members, and areas for further improvement are highlighted within each document, along with a summary of progress against the improvement actions highlighted in the previous Annual Report. Each report and the revised terms of reference have been presented to the Committee and are recommended to the Board by the Committee Chairs and members. Notably, the outputs of the surveys indicate that the Committees are functioning effectively and are undertaking

robust scrutiny on behalf of the Board, and the Board can therefore take assurance in this regard.

It should be noted that this exercise has not yet concluded for the Remuneration Committee as it meets less frequently and has a narrower, defined scope. The Annual Report will be presented to the Board following the next Remuneration Committee meeting. It should also be noted that for brevity, the survey outputs referred to in the Annual Reports have not been provided for the purpose of Board presentation.

The Committee terms of reference have also been reviewed as part of the Annual Assessment Process. Whilst no major changes have been made to the duties or membership for any of the Committees, a consistent template has been adopted, and the documents are more concise and have a stronger assurance and strategic focus than the previous versions.

3. Areas of Risk

There are no specific areas of risk to highlight as there were no major concerns identified within the survey outputs and the revisions to the terms of reference ensure that the Trust has clear, effective governance arrangements in place.

4. Link to Strategic Theme

The report does not relate to any one specific theme but forms part of the Trust's overall corporate governance arrangements, which support delivery of the Trust's strategy and statutory/regulatory requirements.

5. Link to Board Assurance Framework Risk(s)

As above, because the report does not relate to any one strategic theme, there is no link to any one BAF risk. However, the Board Assurance Framework risks are considered by the relevant Committees.

6. Quality/Equality Impact Assessment

Not required

7. Recommendations

The Board is asked to take **ASSURANCE** from the Committee Annual Reports 2025/26 and **APPROVE** the terms of reference for each Committee.

For Assurance	x	For decision	x	For discussion		To note	
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Audit Committee Annual Report 2025/26

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Appendix 1 Terms of Reference for the Audit Committee

Appendix 2 Member survey outputs

Section 1 Reporting Period

This report covers the financial year 2025/26 and details the work of the Audit Committee during that period.

Section 2 Introduction

The Audit Committee is one of only two statutory committees of the Board of Directors ("Board") which is comprised solely Non-Executive Director membership. It plays an important, independent role in assessing the effectiveness of the trust's corporate governance and system of risk management and internal control. Its core function is to ensure that the organisation operates effectively and meets its statutory and strategic objectives and provide assurance to the Board in this regard.

The Committee achieves this through scrutiny of a combination of reports from the trust's Internal and External Audit functions and Counter Fraud service and reports from management around core elements of the trust's business.

Best practice set out in the Audit Committee Handbook indicates that that in addition to reporting regularly to the Trust Board, it should prepare an annual report that sets out how the committee has discharged its duties, and this report aims to achieve that for the financial year 2025/26.

Section 3 Terms of Reference

The Committee's terms of reference are attached at Appendix 1. These have been reviewed, taking into account the views of members on the functioning of the committee following the annual members survey. Whilst there are no material changes to content, membership or duties of the committee, which are in line with the NHS Audit Committee handbook, the template has been revised and streamlined and will be used across the board committees.

The main changes to the terms of reference are:

- The accountable Executive Director will be required to attend the Committee in the event of an audit report with a conclusion of limited or no assurance
- The addition of a policy statement that requires prior Committee approval of any non-audit activity carried out by the Trust's External Audit provider

Section 4 Meetings of the Committee

The Committee met eight times during the 2025/26 financial year, exceeding the minimum requirement set out in its terms of reference, and maintained quorum at seven of the eight meetings.

Committee membership comprises 3 NEDs, all of whom meet the independence criteria, as was confirmed in the annual assessment against the Code of Governance for NHS Provider

Trusts, which was presented to the last meeting of the Committee and the Board. Two members of the Committee have recent and relevant financial experience.

The chair of the Finance & Performance Committee (FPC) and the Quality & Safety Committee (QSC) are members of the Committee to ensure there is effective cross-over between the committees of the board.

From an executive perspective the Chief Finance Officer (CFO) and Chief Governance Officer (CGO) regularly attend the committee. Other executive directors and leaders of functions pertinent to the terms of reference for the committee attend when asked to do so by the Chair.

Section 5 Reporting to the Board of Directors

The committee chair presents a written report to the Trust Board in the public meeting that follows the Audit Committee meeting and highlights all relevant risks, issues, concerns and successes. These reports can be found within the public board papers.

Section 6 Work of the Committee

The committee has a dedicated work-plan to manage the workload over the year. The full gambit of reports received by the committee are not listed here, but during 2025/26 the committee has received reports relating to the following:

- Annual Accounts and Financial Statements (2024/25)
- Annual Report and Annual Governance Statement (2024/25)
- Head of Internal Audit Assurance Opinion (2024/25)
- Compliance with internal audit standards and KPIs
- Internal Audit Reports:
 - Fleet Management
 - Sickness Absence
 - Medicines Management
 - Demand Planning and Forecasting
 - Financial Sustainability
- Counter Fraud and Security Management
- The Trust's Policy Framework
- Losses and Special Payments
- Single Tender Waivers
- Self-assessment against the NHS Code of Governance for Provider Boards

Of the 5 internal audit reports issued in the year, 2 were rated moderate and 3 limited. Whilst it is disappointing to receive reports with limited assurance conclusions, it is reflective of the internal audit function being used effectively to identify areas of weakness and put actions in train to bring about improvement.

6.1 Internal Audit Plan

The Internal Audit Plan is approved each year by the committee and is linked to the Board Assurance Framework (BAF). The plan also covers mandated areas such as the Data Protection and Security Toolkit (DPST).

All reports reference the BAF risk that it relates to. The Executive Directors input into the plan to ensure that all areas of risk and key areas of internal control are independently audited. The committee also ensures that actions agreed by management are followed up in a timely way and this has continued to be a key area of focus during 2025/26. The trust once again ends the year with no overdue actions from the current or previous year, which represents sustained improvement.

6.2 Head of Internal Audit Opinion

At the time of writing this report, the Head of Internal Audit opinion for 2025/26 is not yet available given the financial year has just ended. The report will be presented to the next meeting of the Committee.

Section 7 Review of Improvement Areas 2025/26

Following the members survey last year, a number of actions were identified that would bring about improvement to the way that the Committee functions. These are outlined below with a summary of progress:

Area	Improvement Action	Progress Update
Committee Workload	Ensure there are 5 scheduled meetings plus one extraordinary meeting to sign off the Annual Accounts and Report	An extraordinary meeting has been arranged to sign off the 2025/26 accounts.
	ensure that all non-internal/external audit reports that are submitted are scheduled across the year to avoid agenda congestion	The workplan has not had a wholesale review because of changes to the meeting scheduling in year to accommodate the shift in the Board meeting date. However, the meetings have not overrun during the year, and agenda management is improving.
Clinical Audit	Receive an annual report around our Clinical Audit Framework and processes to ensure these are sufficiently robust	Responsibility for Clinical Audit has shifted to the Chief Paramedic who is actively making improvements to clinical audit processes, reporting and oversight. Some audit measures are reported in the IPR but an Annual Report for 2025/26 detailing the arrangements that are in place will be

		presented to the Committee later in the 2026/27 financial year
Administration	Improve management response times to draft reports and identification of actions	There has been no delay in internal audit reports being presented to the Committee due to lack of management response and EMC is now taking an active role in receiving and discussing all reports prior to submission
	Improve the timeliness of paper circulation	Papers have been circulated in line with the expected standard.
	Maintain zero overdue internal audit actions and zero on the committee action log	As reported, for the second year there are no overdue actions arising out of internal audit reports and the actions on the action log are being dealt with in a timely way.
	Ensure that all policies reviewed in a timely way and do not fall out of date	95% of policies are within date and work has taken place to streamline the number of policies that are required – converting these to Standard Operating Procedures or guidance and amalgamating policies where appropriate

Section 8 Member Survey

A survey of committee members was undertaken in line with the self-assessment checklists set out in the Audit Committee handbook. This was undertaken with a view to identifying any changes that needed to be made to improve the effectiveness of the committee and set improvement objectives. The outputs of the survey are included at appendix 2.

The main areas of focus for improvement are:

Area	Recommended Improvement
Action tracking	Strengthen monitoring of agreed actions to ensure delivery to timescale
Paper quality	Introduce clearer expectations for concise, risk-focused reporting
Clinical audit assurance	Enhance clarity, consistency, and impact reporting
Internal audit engagement	Encourage broader contribution across agenda items
Board interaction	Strengthen two-way challenge and feedback with the Board

Section 9 2026/27 Improvement Actions

Whilst the committee will continue to monitor the areas for improvement identified for 2026/27 and ensure that standards do not slip, the following actions have been identified for 2026/27:

- Clinical Audit – receive and Annual Report setting out the governance and oversight arrangements that are in place in relation to Clinical Audit activity across the organisation
- Roll out training on Writing for Assurance to enhance and improve the quality of papers that are submitted to the Board and the Board committees

Section 10 Conclusion

As Audit Committee Chair, I conclude that the committee is operating effectively and has discharged the duties delegated to it by the Trust Board.

Mike McEnaney
Audit Committee Chair
April 2026



Audit Committee Terms of Reference

1. Constitution

The Board of Directors (“the Board”) hereby resolves to establish a formally constituted, standing committee of the Board to be known as the Audit Committee (“the Committee”).

The Committee has no executive powers other than those specifically delegated to it via these terms of reference. The Standing Orders adopted by the Board are applicable to the Committee in as far as they are relevant.

2. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference and seek any information that it requires from any member of staff. All members of staff are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain legal or other independent professional advice and to secure the attendance of others from outside of the Trust with relevant experience and expertise if it considers this necessary. Any such advice must be commissioned in line with the trust’s Standing Financial Instructions and related procedures.

3. Purpose of the Committee

The purpose of the Committee is to provide the Board with independent, objective assurance that the organisation operates effectively and has a system of internal control that enables it to meet its regulatory and statutory duties and achieve its strategic aims and objectives.

The Committee will function in accordance with the requirements of the NHS Code of Governance for Provider Trusts, the Trust’s constitution, the NHS Audit Committee Handbook and relevant NHS England guidance.

4. Committee Membership

Membership of the Committee membership shall be appointed by the Board from amongst the Non-Executive Directors and shall consist of not less than three members. The Trust Chair shall not be a member of the committee.

Of the 3 Non-Executive Director members, one will be a member of the Trust’s Quality and Safety Committee and one a member of the Finance & Performance

Committee, to reinforce the relationship between the committees in respect of seeking assurance over the management of risk and other relevant control issues.

Each Committee member shall meet the criteria for independence as set out in the Code of Governance for NHS Provider Boards and the Board will satisfy itself that the membership has sufficient skills to discharge its responsibilities effectively. The Board will ensure that at least one member of the Audit Committee has recent and relevant financial experience.

4.1 Attendees

Although not members, the following will be in regular attendance at the Committee:

- Chief Finance Officer
- Chief Governance Officer
- Internal Audit Representative
- External Audit Representative
- Counter Fraud Representative
- Trust Governors may also attend in an observational capacity with the prior agreement of the Committee Chair

Other executive directors and members of Trust staff will attend the committee at the invitation of the Chair when matters under discussion are relevant to their areas of responsibility.

Executive Directors are expected to attend when there is a report with a limited or no assurance conclusion relating to their areas of accountability.

5. Quorum

The meeting will be quorate when 2 members are present. The absence of any regular attendee listed in (4.1) will not affect meeting quoracy.

In the absence of a quorum, the meeting shall continue to be held, at the discretion of the Chair but no decisions shall be taken. Lack of quoracy will be reported to the Trust Board in the Committee Chair's report.

6. Frequency

The committee will meet at least 5 times per year and will hold one extraordinary meeting for the purposes of scrutinising and the Trust's Annual Accounts and Report and recommending their approval by the Board. Other meetings will be called as necessary if there is urgent business or the Committee Chair requests an additional meeting.

7. Reporting to the Board

The Committee Chair will report in writing to the Board at the Board meeting that follows the Committee meeting. This report will summarise the main points of

discussion and will draw attention to any issues that require Board or Executive action.

8. Sub-Groups

The Committee is authorised to establish short life task and finish Groups to support its work subject to terms of reference that shall be approved by the Committee but shall not delegate the powers conferred upon it by these terms of reference to any other body without the express authorisation of the Board.

9. Duties/Responsibilities

The Committee shall review the establishment and maintenance of an effective system of governance, risk management and internal control, across the whole of the trust's activities (both clinical and non-clinical) that support the achievement of the strategic objectives.

In particular, the Committee will review the monitor and scrutinise the following:

- All risk and control related disclosure statements, in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commission Essential Standards, together with any accompanying Head of Internal Audit Assurance statement, external audit opinion or other appropriate independent assurances, prior to approval by the Board.
- The underlying assurance processes (BAF and risk register) that indicate the degree of achievement of the strategic objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- Policies for ensuring compliance with relevant regulatory, legal and regulatory requirements including the NHS Provider License, NHS Code of Governance for Provider Boards and relevant NHS England guidance.
- The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Counter Fraud and Security Management Service.
- The Trust's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation, making recommendations to the board for approval and reviewing any decisions to suspend the provisions outlined within these documents
- The Trust's Conflicts of Interest Policy and compliance with Registers of Interests, Gifts, Hospitality and Sponsorship
- Single Tender Waivers, losses and special payments
- The internal controls in place in any subsidiary company of the trust (e.g. South Central Fleet Services Limited)
- The governance arrangements and internal controls in place in relation to the

trust's Charity.

- The risk management framework to ensure that Trust policies, systems and processes are effective in the management of all risks within the Trust and escalating risks appropriately.
- The effectiveness of the arrangements by which Trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern via the Freedom to Speak Up and other related processes.
- The accuracy of the data behind the reports received by the Committee and Board to gain assurance of robustness and quality.
- Compliance with the Trust's Policy Framework

In carrying out this work the Committee will primarily utilise the independent work of Internal Audit, External Audit and other assurance functions, but will not be limited to these. It will also seek reports and assurances from other Board committees, executive directors and managers as appropriate.

9.1 Internal Audit

The Committee shall ensure there is an effective, adequately resourced internal audit function that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Committee, Chief Executive and the Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the service and any questions of resignation and dismissal, including involvement in the selection process in the case of a change in provider
- Monitoring the performance of the internal audit function via agreed KPIs and undertaking an annual review of performance.
- Reviewing and approving the Internal Audit strategy, operational plan, reporting system, and more detailed programme of work, ensuring this meets the needs of the organisation. This includes approval of any in-year changes to the plan
- Consideration of the findings of internal audit work, the adequacy of management responses and monitoring the implementation of recommendations.

9.2 External Audit

The Committee shall review the work and findings of the External Auditor appointed by the Trust and consider the implications and management's responses to its work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor, as far as the rules governing the appointment permit.
- Discussion and agreement with the External Auditor, before the audit commences around the nature and scope of the audit as set out in the Annual Plan and ensure coordination as appropriate with other External Auditors in the local health economy.
- Review of the Annual Report and Accounts (ARA) before submission to the Board to determine their completeness, objectivity, integrity and accuracy.
- Discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- Review all external audit reports, including the report to those charged with governance, agreement of the Annual Audit Letter before submission to the Board and any work undertaken outside the annual audit plan together with the appropriateness of management response and monitor progress on the implementation of recommendations.
- Working with the Council of Governors to establish the criteria for appointing, re-appointing and removing external auditors and ensuring the Council meets its statutory duties in this regard.
- As a point of policy, any engagement of the external auditor to supply non-audit services will require the prior approval of the Committee.

9.3 Counter Fraud

The Committee shall ensure the appointment of a Local Counter Fraud Service (LCFS) provider with adequate qualifications, resources and appropriate standing within the Trust and will:

- Approve the Annual Work Plan at the start of each year and approve any in-year changes to planned activity
- Receive an update of Counter Fraud activity at each meeting and the Annual Report
- Receive assurances on effectiveness of the service

9.4 Other Assurance Functions

- The Committee will review the work of other Board Committees within the organisation that provides relevant assurance to the Committee's own scope of work. In particular, the Committee will rely on the assurance provided by other Committees in respect of specific risks in the BAF designated to them.
- In reviewing the work of the Quality and Safety Committee, and issues around clinical risk management, the Committee will seek to satisfy itself that there is an effective and robust clinical audit framework in place.

10. Delegation

By approval of these terms of reference the Board delegates the duties and responsibilities outlined in section 9 to the Committee.

11. Committee Effectiveness

The committee will review its own performance and these terms of reference on an annual basis and will prepare a report for the Trust Board, describing its work and proposing any changes to these terms of reference.

12. Administration

A member of the Corporate Governance Team will act as Committee Secretary and will agree the agenda with the Chair of the Committee, in conjunction with the Chief Finance Officer.

13. Review

These terms of reference will be reviewed in April 2027 unless there is a requirement to do so earlier.

Date of Audit Committee approval	
Date of Trust Board Approval	

Becky Murray, Chief Governance Officer



Quality & Safety Committee Annual Report 2025/26

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Appendix 1 Terms of Reference for the Quality & Safety Committee

Appendix 2 Member survey outputs

Section 1 Reporting Period

This report covers the financial year 2025/26 and details the work of the Quality & Safety Committee (“the Committee”) during that period.

Section 2 Introduction

The Quality & Safety Committee (QSC) is a formally constituted committee of the South-Central Ambulance Service (SCAS) board of directors (“Board”). Its membership comprises executive and non-executive (NED) membership and its purpose is to support the work of the Board by providing additional scrutiny and challenge that is not possible within the confines of a Board meeting, in respect of the quality of services we provide.

The Committee achieves this through scrutiny of a combination of regular and ad hoc reports relating to quality performance, which allows the Committee chair to provide assurance and to escalate risks, issues and concerns to the trust board.

Best practice in corporate governance suggests that board committees should undertake an annual assessment of their performance, review their terms of reference and present an Annual Committee report to the Board to provide assurance that the committee is functioning effectively and is discharging the duties delegated to it by the Board. This report is intended to fulfil that function for the financial year 2025/26.

Section 3 Terms of Reference

The revised terms of reference for the committee are attached at appendix 1. These were reviewed by the Chief Governance Officer and the Committee Chair in April 2026, with input from the Clinical Directors and in conjunction with the outputs of the survey of members that was undertaken. Whilst the duties of the Committee have not changed, the previous version has been streamlined to ensure that there is a stronger focus on assurance around the quality agenda and a more strategic focus. In line with the other Board Committees, the template has also been revised. The terms of reference will be presented to the Trust Board for approval following discussion at the Committee in April 2026.

Section 4 Meetings of the Committee

The Committee is scheduled to meet bi-monthly and met 5 times during the financial year 2025/26. The scheduled January 2026 meeting was deferred to February owing to the CQC Well Led inspection taking place at the same time, as several attendees were required to attend interviews. The Committee was quorate on all occasions as at least 2 NEDs and 1 executive director were present.

At present, committee membership comprises 3 NEDs, the Chief Nursing Officer, Chief Medical Officer and Chief Paramedic Officer. The Chief Governance Officer and Executive Director of Operations are regular attendees and following the decision taken by the Board for the Digital agenda to fall under the Committee’s terms of reference, the Chief Digital and Information Officer has also been a regular attendee.

All Non-Executive Directors continue to meet the independence criteria, as assessed through the annual evaluation against the NHS Code of Governance for Provider Trusts, which was presented to both the Audit Committee and the Trust Board in March 2026.

The Committee Chair is also a member of the Audit Committee, which has supported effective cross-committee working, strengthened assurance mechanisms and has facilitated the escalation of risks. During the year, 2 new NED members with clinical backgrounds joined the Committee. Their combined experience provides a robust source of independent clinical challenge and insight across matters relating to quality, patient safety, and clinical performance. This clinical expertise is complemented by the Committee Chair's strong governance and risk management skills, resulting in a balanced and effective Committee composition that supports high-quality oversight, challenge and assurance.

From an executive perspective, the committee benefited from the Chief Paramedic Officer (CPaO) joining the committee from July 2025 and from the Chief Digital and Information Officer becoming a regular attendee.

Section 5 Reporting to the Board of Directors

The Committee chair presents a written report to the Trust Board in the public meeting that follows the QSC meeting, which highlights relevant risks, issues, concerns and successes. These reports can be found within the public board papers.

Section 6 Work of the Committee

The Committee has a dedicated work-plan to manage the workload over the year, although as outlined at section (9), this requires review to better align to Fit for the Future. The full gambit of reports received by the committee are not listed here, but during 2025/26 the committee has received regular reports relating to the following:

- Integrated Performance Report (IPR) – quality and performance metrics
- Patient Safety; including independent assurance around the Trust's approach to the implementation of PSIRF
- Workforce and Education updates (although this is now within the remit of the People & Culture Committee)
- Board Assurance Framework Risks assigned to the committee
- Reports relating to risks to quality that arose during the year
- CQC and other regulatory actions
- Policies that fall within the committee's remit
- Quality Impact Assessments

The committee has also received regular reports from the committees that report to it:

- Safeguarding Committee
- Infection Prevention and Control Committee
- Clinical Review Group
- Patient Safety & Experience Group

- Health and Safety Group (from November 2025)
- Medicines Optimisation and Governance Group
- Digital Steering Group
- Information Security and Governance Steering Group

Through receipt, scrutiny and challenge of these regular reports, the Committee has enhanced its oversight of areas of risk and this has enabled the Committee Chair to request further assurance and to escalate to the board as required.

Section 7 Review of 2025/26 Improvement Objectives

A number of improvement objectives for the committee for 2025/26 were identified in the last Committee Annual Report and a progress update is provided below:

Area	Improvement Action	Progress Update
Risk	Greater focus on emerging risks to quality and using these to drive the agenda	The Clinical Directors report at each meeting on the top 3 risks or areas that are concerning them.
Administration	Robust planning and agenda setting	The agenda has been significantly reduced, which allows the time for focus on areas of concern and for fuller discussion, coupled with regular reporting on areas that require committee oversight.
Oversight	Regular oversight of key areas across the quality agenda; patient safety, patient experience and clinical effectiveness via regular reporting	This has improved but there is further work to do to enhance oversight and reporting in relation to Patient Experience, Clinical Audit and Research
	Greater assurance through regular reporting in relation to areas of statutory responsibility including Safeguarding, Infection Prevention and Control and Health & Safety	The Groups are now reporting regularly to the Committee and the Chairs of the meetings that report to QSC are members or attendees of the Committee
	Greater oversight of incident management and learning through regular reporting.	A quarterly Patient Safety Report is now being submitted to the Committee prior to submission to the Board. Whilst the content remains a work in progress, this has enhanced oversight at Committee and Board level

Section 8 Committee Member Survey

As in the previous year, a survey of committee members was undertaken with a view to identifying any changes that needed to be made to improve the effectiveness of the committee and to set improvement objectives for 2026/27. The outputs of the survey are

included at appendix 2. The outputs indicate that members and attendees are broadly satisfied with the way in which the Committee is operating.

The main areas of focus for improvement as identified by respondents disagreeing with the statements are:

- Introduction of clearer standards for concise, risk-focused, decision-oriented reporting
- Tracking and assurance of delivery against agreed actions
- Capturing and reporting of clearer examples of Committee-driven quality and safety improvements
- Enhancing assurance reporting for major projects and transformation programmes

Section 9 Areas for Improvement 2026/27

- Roll out training on Writing for Assurance to enhance and improve the quality of papers that are submitted to the Board and the Board committees (applies across all Committees)
- Ensure that actions are completed within the stated deadline on the action log
- Ensure strong oversight of progress against Tier 1 projects in the Clinical Effectiveness strategic theme
- Ensure more regular reporting on Research & Development activity and Clinical Audit across the Trust (this was not identified by Committee members within the survey but is included within the Committee Terms of Reference)

We are now moving into year 2 of the Fit for the Future Integrated Improvement Plan as the vehicle by which we track our progress against the achievement of our strategic themes and monitor the risks to delivery through the Board Assurance Framework. When the tier 1 improvement projects for 2026/27 are approved by the Board, the committee workplan will be updated to ensure that there is robust oversight of progress. Enhanced reporting against the Tier 1 projects that fall within the remit of the Committee will address the majority of the actions highlighted above, as the reporting mechanism that is being developed will allow the Committee to oversee progress in the context of the impact the improvement work is having on performance and risk.

Section 10 Conclusion

As Committee Chair, I am satisfied that Committee effectiveness has improved over the year, although as noted above, there is further work to do to ensure that the Committee fulfils its terms of reference in their entirety. I am confident however that with the revised membership and the direction that I have set, the Committee will continue to improve during 2026/27.

Katie Kapernaros
Quality & Safety Committee Chair
April 2026



QUALITY & SAFETY COMMITTEE TERMS OF REFERENCE

1. Constitution

The Board of Directors (“the Board”) hereby resolves to establish a formally constituted, standing committee of the Board to be known as the Quality & Safety Committee (“the Committee”).

The Committee has no executive powers other than those specifically delegated to it via these terms of reference. The Standing Orders adopted by the Board are applicable to the Committee in as far as they are relevant.

2. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference and seek any information that is requires from any member of staff. All members of staff are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain legal or other independent professional advice and to secure the attendance of others from outside of the Trust with relevant experience and expertise if it considers this necessary. Any such advice must be commissioned in line with the Trust’s Standing Financial Instructions and related procedures.

3. Purpose of the Committee

To provide scrutiny and challenge of the areas outlined in section (9) of these terms of reference and assure the trust board that standards of care provision meet statutory duties and regulatory requirements, that there are robust quality governance structures and processes in place to provide oversight from point of care delivery to the Board and ensure that risk is effectively managed.

4. Membership and Quorum

Membership of the Committee membership shall be appointed by the Board from amongst the Executive and Non-Executive Directors and shall include:

- 3 Non-Executive Directors
- Chief Nursing Officer
- Chief Medical Officer
- Chief Paramedic Officer

4.1 Attendees

Although not members, the following will be in regular attendance at the Committee:

- Chief Digital and Information Officer
- Executive Director of Operations
- Chief Governance Officer

Other executive directors and members of Trust staff will attend the committee at the invitation of the Chair when matters under discussion are relevant to their areas of responsibility.

5. Quorum

The meeting will be quorate when 2 Non-Executive and 1 Executive member are present. The absence of any regular attendee listed in (4.1) will not affect meeting quoracy.

In the absence of a quorum, the meeting shall continue to be held, at the discretion of the Chair but no decisions shall be taken. Lack of quoracy will be reported to the Trust Board in the Committee Chair's report.

6. Frequency

The Committee will meet on a bi-monthly basis. Additional meetings will be called as necessary if there is urgent business or the Committee Chair requests a meeting.

7. Reporting to the Board

The Committee Chair will report in writing to the Board at the Board meeting that follows the Committee meeting. This report will summarise the main points of discussion and will draw attention to any issues that require Board or Executive action, or to any risks that require escalation to Board.

8. Sub-Groups

The Committee is authorised to establish Groups to support its work subject to terms of reference that shall be approved by the Committee, but shall not delegate the powers conferred upon it by these terms of reference to any other body without the express authorisation of the Board

The following are sub-groups of the Committee, and the Chair shall provide a written report into the next Committee meeting after the Group has met:

- Patient Safety and Experience Group
- Clinical Review Group
- Safeguarding Committee
- Infection Prevention and Control Committee
- Medicines Optimisation and Governance Group

- Health & Safety Group

9. Duties and Responsibilities

Review the following and recommend to the Board for approval:

- Quality Account and annual Quality Priorities prior to submission to the trust board and monitor progress against deliver of the quality priorities
- Annual clinical audit programme ensuring that it is sufficiently risk based
- Patient Safety Plan ensuring that the priorities are data driven and aligned to areas of known risk
- Infection Prevention & Control Annual Report and Plan
- Safeguarding Annual report
- Health & Safety Workplan

Monitor progress against the Fit for the Future Tier 1 programmes under the Clinical Effectiveness strategic theme and the associated Board Assurance Framework risks and significant risks.

Approve policies that fall within the remit of the committee as outlined in the Scheme of Reservation and Delegation

Make recommendations to the Audit Committee concerning the annual programme of internal audit work, to the extent that it applies to matters within these terms of reference

Seek assurance of the trust's compliance with quality and safety standards, through regular reports, including but not limited to:

- Care Quality Commission registration and compliance with essential standards
- Home Office Controlled Drugs Licence
- Safeguarding legislation
- Infection Prevention and Control legislation
- Health & Safety legislation
- External Accreditation/Peer Reviews
- National Confidential Inquiries or national reports relevant to Ambulance Services
- Internal audit reports relating to the Committee's terms of reference

Quality of Care:

Seek assurance that there are effective processes in place to monitor patient safety, patient experience and clinical effectiveness across the organisation. This will be achieved through regular reporting on:

- Patient safety incidents and patient experience feedback; ensuring that themes and trends are identified and that appropriate action is being taken in response

- Clinical Audit activity
- Medicines management and medicines safety
- Evidence based clinical practice including adherence to JRCALC Clinical Practice Guidance and best practice
- Ambulance Care Quality Indicators
- Research & Development activity
- Health and Safety
- Progress against delivery of Quality Priorities
- Progress against delivery of the Patient Safety plan

Quality & Safety Risk

Seek assurance that risks to quality and safety are being effectively managed, mitigated and escalated to the Board where necessary. This will be achieved through regular reporting on:

- Board Assurance Framework risks assigned to the Committee
- Significant operational risk register
- Quality Impact Assessments

Digital

- Ensure that the Trust has a Digital Strategy in place that supports the delivery of care
- Seek assurance in relation to:
 - Data quality and infrastructure
 - Data Management
 - Digital Service Responsiveness
 - Cyber preparedness

10. Delegation

By approval of these terms of reference the Board delegates the duties and responsibilities outlined in section (9) to the Committee.

11. Committee Effectiveness

The committee will review its own performance and these terms of reference on an annual basis and will prepare a report for the Trust Board, describing its work and proposing any changes to these terms of reference.

12. Administration

A member of the Corporate Governance Team will act as Committee Secretary and will agree the agenda for meetings with the Chair and the Clinical Directors.

13. Review

These terms of reference will be reviewed in April 2027 unless there is a requirement to do

so earlier.

Date of Quality & Safety Committee approval	
Date of Trust Board Approval	



People & Culture Committee Annual Report 2025/26

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Appendix 1 Terms of Reference for the People & Culture Committee

Appendix 2 Member survey outputs

Section 1 Reporting Period

This report covers the financial year 2025/26 and details the work of the People & Culture Committee (“the committee”) during that period.

Section 2 Introduction

The People & Culture Committee (PACC) is a formally constituted committee of the South-Central Ambulance Service (SCAS) board of directors (“the board”). Its membership comprises executive and non-executive (NED) membership and its purpose is to support the work of the board by providing additional scrutiny and challenge in respect of the trust’s People & Culture agenda, which is a strategic theme within Fit for the Future.

The Committee achieves this through scrutiny of a combination of regular and ad hoc reports relating to all aspects of the People agenda, which allows the Committee chair to provide assurance and to escalate risks, issues and concerns to the trust board.

Best practice in corporate governance suggests that board committees should undertake an annual assessment of their performance, review their terms of reference and present an Annual Committee report to the trust board to provide assurance that the committee is functioning effectively as intended. This report is intended to fulfil that function for the financial year 2024/25.

Section 3 Terms of Reference

The revised terms of reference for the committee are attached at appendix 1. These were reviewed by the Chief Governance Officer May 2026, in conjunction with the outputs of the survey of members that was undertaken. Whilst the duties of the Committee have not changed, the previous version has been streamlined to ensure that there is a stronger focus on assurance around the people agenda and a more strategic focus. In line with the other Board Committees, the template has also been revised. The terms of reference will be presented to the Trust Board for approval following discussion at the Committee in May 2026

Section 4 Meetings of the Committee

The committee is scheduled to meet on a bi-monthly basis. The committee met 6 times during the year although it should be noted that the March meeting was rescheduled to April and technically fell within the current financial year. The meeting was quorate on all occasions as there were 2 non-executive directors and one executive director present.

Committee membership comprises 3 NEDs, all of whom meet the independence criteria plus the Chief People Officer, Chief Nursing Officer, Chief Paramedic and the Executive Director of Operations.

Independence of the NEDs was assessed as part of the annual assessment process against the Code of Governance for NHS Provider Trust, which was presented to the Audit Committee and the Trust Board.

There has been no change in the Committee Chair since the last Annual Report, and the additional NED membership comprises NEDs from the Quality & Safety Committee and Finance & Performance Committee to ensure appropriate cross cover and the ability to triangulate issues given the inextricable link between workforce, quality and financial performance.

Section 5 Reporting to the Board of Directors

The Committee Chair presents a written report to the Trust Board in the public meeting that follows the PACC meeting and highlights all relevant risks, issues, concerns and successes. These reports can be found within the public board papers.

Section 6 Work of the Committee

The committee has a dedicated work-plan to manage the workload over the year. The full gambit of reports received by the committee are not listed here, but during 2024/25 the committee has received regular reports relating to the following:

- Key people metrics as set out in the Integrated Performance Report (PDR/sickness absence/attrition etc.)
- Cultural Development Programme/Activity
- People related Board Assurance Framework risks
- Freedom to Speak Up
- Education & Training
- Gender Pay Gap
- Equality, Diversity & Inclusion
- Workforce Race Equality Standard (WRES)
- Workforce Disability Equality Standard (WDES)
- Staff Survey
- Health & Wellbeing
- Employee Relations Case work
- Deep Dives: e.g. sickness absence
- Time to hire
- People related policies
- People related risks

Through receipt, scrutiny and challenge of these regular reports, the Committee Chair has been able to provide assurance to the board and to highlight risks and concerns relating to the committee's role and remit, via the Chair's Report.

The refresh of the trust's strategic Fit for the Future Framework in 2025/26 provided the opportunity to re-focus the committee's agenda on the cultural development aspect of the People agenda and a workshop was held to shape the direction and agenda for the committee. The agreed output was for the committee to become more data driven, which in turn enabled a stronger focus on areas of risk and concern and the ability to track improvement. The agendas for the meetings changed significantly following the workshop

and the committee now has a greater strategic and assurance focus and has benefitted from a series of deep dives, which will continue into 2026/27.

Section 7 Review of Improvement Objectives 2025/26

A number of improvement objectives for the committee for 2025/26 were identified in the last Committee Annual Report and a progress update is provided below:

Area	Improvement Action	Progress Update
Agenda	Regular oversight of progress against the Cultural Development Programme	The programme was developed during the year and the committee has received progress updates
Administration	Improved timeliness of circulation of papers	Timeliness of papers has improved and there has not been the requirement to cancel the meeting owing to late papers as there was in the previous year
Data	Improved analysis of data from multiple sources within papers to create intelligence	Deep dives are providing the committee with more robust data than was received previously, although there is further work to do to prevent duplication of data across the papers received and refine KPIs.

Section 8 Member Survey

A survey of committee members was undertaken with a view to identifying any changes that needed to be made to improve the effectiveness of the committee and to set improvement objectives for 2026/27. The outputs of the survey are included at appendix 2.

The main areas of focus for improvement as identified by respondents disagreeing with the statements are as set out in the improvement objectives in section 9 below. Overall, respondents feel that the committee functioning has improved during the financial year.

We are now moving into year 2 of the Fit for the Future Integrated Improvement Plan as the vehicle by which we track our progress against the achievement of our strategic themes and monitor the risks to delivery through the Board Assurance Framework. When the tier 1 improvement projects for 2026/27 are approved by the Board, the committee workplan will be updated to ensure that there is robust oversight of progress. Enhanced reporting against the Tier 1 projects that fall within the remit of the Committee and risks to delivery will address the majority of the actions highlighted above, as the reporting mechanism that is being developed will allow the Committee to oversee progress in the context of the impact the improvement work is having on performance and risk. It should therefore follow that committee members will be able to provide examples of the committee's positive impact on performance

Section 9 Committee Improvement

Objectives 2026/27

The following improvement objectives for the committee for 2026/27 have been agreed. Actions will be put into train, and we will report on progress in the 2026/27 Annual Committee Report.

Area	Recommended Action
Demonstrating impact	Strengthen capture and reporting of Committee-driven improvements
Action follow-up	Enhance assurance over delivery to agreed timescales
Member participation	Encourage consistent contribution from all members
Programme visibility	Improve structured reporting on major workforce and culture programmes

Section 9 Conclusion

As PACC Chair, I conclude that whilst there is further work to be done to strengthen the committee, it's functioning improved during the year and it operated effectively in discharging the duties delegated to it by the Trust Board.

Ian Green
People & Culture Committee Chair
May 2026



People & Culture Committee
27 May 2026

Title	People & Culture Committee Terms of Reference
Report Author	Rebecca Murray, Chief Governance Officer
Executive Owner	Rebecca Murray, Chief Governance Officer
Agenda Item	13b
Governance Pathway: Previous	PACC
Governance Pathway Next Steps	SCAS Board

1. Purpose

Following a review of the current terms of reference for the People and Culture Committee, they have been updated to reflect changes within the Executive team and include a greater emphasis on the culture improvement programme.

2. Link to Strategic Theme

People and Culture

3. Link to Board Assurance Framework Risk(s)

SR22 - Staff Engagement

4. Recommendations

The Committee is asked to review and approve the ToR



PEOPLE & CULTURE COMMITTEE TERMS OF REFERENCE

1. Constitution

The Board of Directors (“the Board”) hereby resolves to establish a formally constituted, standing committee of the Board to be known as the People & Culture Committee (“the Committee”).

The Committee has no executive powers other than those specifically delegated to it via these terms of reference. The Standing Orders adopted by the Board are applicable to the Committee in as far as they are relevant.

2. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference and seek any information that is requires from any member of staff. All members of staff are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain legal or other independent professional advice and to secure the attendance of others from outside of the Trust with relevant experience and expertise if it considers this necessary. Any such advice must be commissioned in line with the Trust’s Standing Financial Instructions and related procedures.

3. Purpose of the Committee

To provide scrutiny and challenge of the areas outlined in section (9) of these terms of reference and provide assurance to the board that there are effective systems and processes in place to monitor, report upon and improve all aspects of people management and organisational culture and development taking a data and intelligence led approach.

4. Membership and Quorum

Membership of the Committee membership shall be appointed by the Board from amongst the Executive and Non-Executive Directors and shall include:

- 3 Non-Executive Directors
- Chief People Officer/Deputy CEO
- Chief Paramedic Officer
- Executive Director of Operations

4.1 Attendees



Although not members, the following will be in regular attendance at the Committee:

- Chief Nursing Officer
- Chief Governance Officer

Other executive directors and members of Trust staff will attend the committee at the invitation of the Chair when matters under discussion are relevant to their areas of responsibility.

5. Quorum

The meeting will be quorate when 2 Non-Executive and 1 Executive member are present. The absence of any regular attendee listed in (4.1) will not affect meeting quoracy.

In the absence of a quorum, the meeting shall continue to be held, at the discretion of the Chair but no decisions shall be taken. Lack of quoracy will be reported to the Trust Board in the Committee Chair's report.

6. Frequency

The Committee will meet on a bi-monthly basis. Additional meetings will be called as necessary if there is urgent business or the Committee Chair requests a meeting.

7. Reporting to the Board

The Committee Chair will report in writing to the Board at the Board meeting that follows the Committee meeting. This report will summarise the main points of discussion and will draw attention to any issues that require Board or Executive action, or to any risks that require escalation to Board.

8. Sub-Groups

The Committee is authorised to establish Groups to support its work subject to terms of reference that shall be approved by the Committee, but shall not delegate the powers conferred upon it by these terms of reference to any other body without the express authorisation of the Board

The following are sub-groups of the Committee, and the Chair shall provide a written report into the next Committee meeting after the Group has met:

- People & Culture Development Group
- Joint Consultative Committee

9. Duties and Responsibilities



Strategy

Monitor progress against the Tier 1 Programmes in the Fit for the Future People & Culture strategic theme along with the Board Assurance Framework risks and significant operational risks.

People & Culture Risk

Seek assurance that risks to quality and safety are being effectively managed, mitigated and escalated to the Board where necessary. This will be achieved through regular reporting on:

- Board Assurance Framework risks assigned to the Committee
- Significant operational risk register

Culture & Engagement

- Monitor delivery of the Culture & Leadership Development Programme and relevant metrics to seek assurance that it is driving improvement
- Seek assurance that existing plans will drive improvement in the Staff Survey
- Monitor the effectiveness of the Trust's Freedom to Speak Up arrangements and ensure that actions are in train to address themes and trends

Performance & Workforce Planning

Seek assurance that there are sufficiently robust systems and processes in place to drive effective workforce planning and receive assurance on its implementation.

Monitor delivery against the key People metrics in the Integrated Performance Report and committee designated metrics. seeking assurance that corrective actions are being taken.

Health & Wellbeing

Seek assurance that there are appropriate processes in place to support the Health & Wellbeing of the workforce and monitor relevant metrics and intelligence.

Reports and Reviews



Review the findings of internal audit reports, Peer Reports and Reports undertaken by external bodies and ensure that there are plans in place to address any actions arising

Education & Training

Ensure there are processes in place to support management and leadership development and provide effective training and education and monitor compliance with related KPIs.

Equality, Diversity & Inclusion

Scrutinise the Trust's annual Gender Pay Gap (GPG), Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports before submission to the Board and ensure there are corrective actions in train to address areas of concern

10. Delegation

By approval of these terms of reference the Board delegates the duties and responsibilities outlined in section (9) to the Committee.

11. Committee Effectiveness

The committee will review its own performance and these terms of reference on an annual basis and will prepare a report for the Trust Board, describing its work and proposing any changes to these terms of reference.

12. Administration

A member of the Corporate Governance Team will act as Committee Secretary and will agree the agenda for meetings with the Chair and the Clinical Directors.

13. Review

These terms of reference will be reviewed in April 2027 unless there is a requirement to do so earlier.

Date of Quality & Safety Committee approval	
Date of Trust Board Approval	



Finance & Performance Committee Annual Report 2025/26

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10. Conclusion

Appendix 1 Terms of Reference for the Finance & Performance Committee

Appendix 2 Member survey outputs

Section 1 Reporting Period

This report covers the financial year 2025/26 and details the work of the Finance & Performance Committee (“the committee”) during that period.

Section 2 Introduction

The Finance & Performance Committee (FPC) (“the Committee”) is a formally constituted committee of the South-Central Ambulance Service (SCAS) board of directors (“Board”). Its membership comprises executive and non-executive (NED) membership and its purpose is to support the work of the Board by providing additional scrutiny and challenge in respect of delivery of the financial and operational performance of the Trust, in line with the trust strategy and underpinning agreed strategy, plans and trajectories of the Trust.

The Committee achieves this through scrutiny of a combination of regular and ad hoc reports relating to all aspects of financial and operational performance that is not possible within the confines of a board meeting and allows the committee Chair to provide assurance and to escalate risks, issues and concerns to the Board.

Best practice in corporate governance suggests that board committees should undertake an annual assessment of their performance, review their terms of reference and present an Annual Committee report to the Board to provide assurance that the committee is functioning effectively as intended. This report is intended to fulfil that function for the financial year 2025/26.

Section 3 Terms of Reference

The terms of reference for the committee are attached at appendix 1. These were reviewed by the Chief Governance Officer and the Chair of the Committee in May 2026 in conjunction with the outputs of the survey of members that was undertaken. Whilst the duties of the Committee have not changed, the previous version has been streamlined to ensure that there is a stronger strategic and assurance focus around the trusts financial and operational performance. In line with the other Board Committees, the template has also been revised. The terms of reference will be presented to the Board for approval following discussion at the Committee in May 2026.

Section 4 Meetings of the Committee

The Committee is scheduled to meet each month, but extraordinary meetings are convened where necessary to discuss urgent matters that arise outside of the usual meeting schedule. The Committee met 14 times (including 1 joint meeting with People & Culture Committee) during the financial year 2025/26 and was quorate on all occasions as at least 2 NEDs and 1 Executive Director were present.

Committee membership comprises 3 NEDs, all of whom meet the independence criteria plus the Chief Finance Officer, Executive Director of Operations and Chief Paramedic Officer.

Independence of the NEDs was assessed as part of the annual assessment process against the Code of Governance for NHS Provider Trust, which was presented to the April 2026 Audit Committee and the Board. Two members of the Committee have recent and relevant financial experience, and the Chair is a member of the Audit Committee, which ensures that pertinent issues can be raised in that Committee and ensures effective cross cover between the committees of the board. Of the other two NED members, one is a member of the Quality and Safety Committee and the other a member of the People & Culture Committee and issues have been referred from FPC to PACC and QSC during the year.

One of the NED committee members moved to Chair the People & Culture Committee at the end of Q1 of the 2025/26 financial year. Two other NEDs were appointed to the committee during Q2 for the remainder of the financial year to ensure quoracy and to bring in additional clinical and workforce expertise.

From an executive perspective the Chief Finance Officer (CFO), and Executive Director of Operations (EDO) are Committee members and the Chief Governance Officer (CGO). The Chief Digital & Information Officer (CDIO) attended up to October 2026 when the digital portfolio transferred to the Quality & Safety Committee. The Chief Paramedic Officer also joined the membership during the year, creating stronger links between operational performance and clinical care delivery. Other executive directors and leaders of functions pertinent to the terms of reference for the committee attend when invited to do so by the Chair.

Section 5 Reporting to the Board of Directors

The Committee Chair presents a written report to the Board in the public meeting that follows the FPC meeting and highlights all relevant risks, issues, concerns and successes. These reports can be found within the public board papers.

Section 6 Work of the Committee

The Committee has a dedicated work-plan to manage the workload over the year. The full gambit of reports received by the Committee are not listed here, but during 2025/26 the following regular reports have been received:

- Multi-Year Plan
- All aspects of financial performance including:
 - Monthly financial performance
 - CIP Performance
 - Capital Programme
 - Financial Recovery Plan
- Business cases (for recommendation to the Board for approval)
- Quarterly Fleet Management Report
- Contract Register
- Operational Performance
 - Performance against ambulance response times
 - Fleet and fleet management

- Procurement Activity
- Estates & Facilities
- Sustainability
- Emergency Preparedness, Resilience & Response
- Board Assurance Framework risks aligned to the committee's agenda
- Relevant finance policies

Through receipt, scrutiny and challenge of these regular reports, the Committee has been in a position to provide assurance to the Board and to highlight risks and concerns relating to financial and operational performance.

Financial year 2025/26 saw the Trust achieve the final year of its 3-Year Financial Recovery Plan and the Committee played a key role in ensuring that the control total was successfully delivered alongside an ambitious CIP programme. Recognising that the Trust has been on a journey to recover its financial position, a keen focus of the Committee during the year, even prior to the requirement to produce a Multi-Year Plan has been to move towards medium-term financial planning and forecasting to achieve medium-term and longer-term financial sustainability. The Multi-Year Plan had significant scrutiny and input from the Committee during the development phase and links finance, operational performance and workforce.

The Committee will continue to scrutinise performance against the plan over the coming year alongside the other areas as highlighted above.

Section 7 Review of 2025/26 Improvement Objectives

A number of improvement objectives for the committee for 2025/26 were identified in the last Committee Annual Report and a progress update is provided below:

Area	Improvement Action	Progress Update
Administration	Improved timeliness of paper circulation	This has improved however there is further work to do. Timeliness should be improved by the FPC meeting being moved from the 3 rd to 4 th week of the month when the IPR will be available at the time of paper circulation.
	Improved quality of papers/focus on assurance	The quality of papers was considered generally to support effective scrutiny, however there was further work to do as some feedback suggested a variation in clarity, focus, or completeness.
	Regular reporting on key projects/initiatives	The Committee is appropriately sighted on significant projects and programmes throughout their lifecycle, although there was room for improvement with regards to comprehensive coverage. This

		should be addressed by presenting the Fit for the Future highlight reports to the Committee on a monthly basis during 2026/27.
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Section 8 Committee Member Survey

A survey of Committee members was undertaken with a view to identifying any changes that needed to be made to improve the effectiveness of the Committee and to set improvement objectives for 2026/27. The outputs of the survey are included at appendix 2.

The main areas of focus for improvement as identified by respondents disagreeing with the statements are:

- The timeliness of papers
- Quality of papers
- Forward planning
- Regular reporting on key projects/initiatives .

Section 9 Areas for Improvement 2026/27

The following improvement objectives for the committee for 2026/27 have been agreed. Actions will be put into train, and we will report on progress in the 2026/27 Annual Committee Report.

- Improved timeliness of paper circulation
- Improved quality of papers/focus on clarity and assurance
- Forward planning for emerging risks and major programmes
- Committee members being appropriately sighted on key projects for assurance mapping for complex or cross-cutting programmes.

The Board approved the Fit for the Future Board Assurance Framework in 2025/26 and year 2 is currently in development and scheduled for Board approval in June 2026. This captures all key programmes of work that are scheduled to take place during the year and the cycles of business for the board and committees thereof will be aligned to this and ensure that the strategic ambitions of the Trust are overseen and delivered. This, together with the Fit for the Future highlight reports should address forward planning and regular reporting on key projects. Writing for Assurance training will also be rolled out, which should assist with paper quality

Section 10 Conclusion

As Finance & Performance Committee Chair, I conclude that the Committee is operating effectively and has discharged the duties delegated to it by the Board.

Les Broude
Finance & Performance Committee Chair
May 2026



FINANCE & PERFORMANCE COMMITTEE TERMS OF REFERENCE

1. Constitution

The Board of Directors ("the Board") hereby resolves to establish a formally constituted, standing committee of the Board to be known as the Finance & Performance Committee ("the Committee").

The Committee has no executive powers other than those specifically delegated to it via these terms of reference. The Standing Orders adopted by the Board are applicable to the Committee in as far as they are relevant.

2. Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference and seek any information that is requires from any member of staff. All members of staff are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain legal or other independent professional advice and to secure the attendance of others from outside of the Trust with relevant experience and expertise if it considers this necessary. Any such advice must be commissioned in line with the Trust's Standing Financial Instructions and related procedures.

3 Purpose of the Committee

To provide scrutiny and challenge in relation to all aspects of the Trust's financial and operational performance as outlined in section (9) of these terms of reference and provide assurance to the Board that there are effective systems and processes in place to monitor, report upon and improve all aspects of financial and operational performance taking a data and intelligence led approach.

4. Membership and Quorum

Membership of the Committee membership shall be appointed by the Board from amongst the Executive and Non-Executive Directors and shall include:

- 3 Non-Executive Directors
- Chief Finance Officer
- Executive Director of Operations
- Chief Paramedic Officer

4.1 Attendees

Although not members, the following will be in regular attendance at the Committee:

- Chief Governance Officer
- Chief People Officer (Estates Portfolio)

Other executive directors and members of Trust staff will attend the committee at the invitation of the Chair when matters under discussion are relevant to their areas of responsibility.

5. Quorum

The meeting will be quorate when 2 Non-Executive and 1 Executive member are present. The absence of any regular attendee listed in (4.1) will not affect meeting quoracy.

In the absence of a quorum, the meeting shall continue to be held, at the discretion of the Chair but no decisions shall be taken. Lack of quoracy will be reported to the Board in the Committee Chair's report.

Where a member is unable to attend the meeting, they may send an appropriately briefed deputy with authority to take decisions. Officers deputising for the member shall not count towards the quorum and shall not have a vote.

6. Frequency

The Committee will meet on a monthly basis. Additional meetings will be called as necessary if there is urgent business or the Committee Chair requests a meeting.

7. Reporting to the Board

The Committee Chair will report in writing to the Board at the Board meeting that follows the Committee meeting. This report will summarise the main points of discussion and will draw attention to any issues that require Board or Executive action, or to any risks that require escalation to Board.

8. Sub-Groups

The Committee is authorised to establish Groups to support its work subject to terms of reference that shall be approved by the Committee, but shall not delegate the powers conferred upon it by these terms of reference to any other body without the express authorisation of the Board

The following are sub-groups of the Committee, and the Chair shall provide a written report into the next Committee meeting after the Group has met:

- Emergency Preparedness Resilience & Response Steering Group
- Net Zero Group

9. Duties and Responsibilities

9.1 Strategy

Monitor progress against the Tier 1 Programmes in the Fit for the Future Partnerships & Sustainability and Enabling Services strategic theme and oversee the development and monitor the progress of the Multi-Year Plan which facilitates medium term financial planning and aligns operational performance and workforce requirements.

9.2 Risk

Seek assurance that risks to financial and operational performance are being effectively managed, mitigated and escalated to the Board where necessary. This will be achieved through receipt of the Board Assurance Framework and significant operational risks relating to the Committee's terms of reference and any emerging risks arising out of reports received in relation to (9.3) - (9.9) below:

9.3 Financial Performance

Seek assurance that the Multi-Year Plan balances financial and operational performance with workforce requirements and that the Trust can deliver within budget

Monitor progress against the Multi-Year Plan and seek assurance that any risks are being effectively mitigated

Monitor delivery against trajectories and recovery plans required under the NHS Oversight Framework, including system-level performance where relevant.

Monitor financial performance against plan on a monthly basis and seek assurance that risks to delivery are being managed and mitigated

Monitor performance against the Cost Improvement Programme and seek assurance around delivery and that there are effective mitigations in place to manage any areas of risk

Monitor delivery against the agreed Capital Programme and seek assurance that risk is being effectively managed and mitigated.

Review relevant NHS benchmarking reports and seek assurance around plans in place to improve the Trust's performance

Monitor the Contract Register and ensure seek assurance that action is being taken to renew contracts and derive best value for money and that procurement legislation is adhered to.

Ensure that budget setting processes are robust

9.4 Operational Performance

Monitor delivery against Operational Performance targets set out in the NHS Oversight Framework and in the trust's Integrated Performance Report and seek assurance that there are appropriate actions in train to improve performance and mitigate risk

Ensure that any risks to quality or workforce arising out of operational performance are referred to other Committees of the Board as appropriate.

9.5 Fleet Performance

Monitor Key Performance Indicators (KPIs) relating to the management of the Trust's Fleet and ensure that mitigating action is taken where required to ensure that fleet availability supports operational delivery requirements.

9.6 Estates

Oversee the development and delivery of the Estates Strategy and plans to ensure this meets operational delivery requirements and represents best use of Trust resources.

9.7 Sustainability

Ensure that the Trust has a Green Plan in place that delivers against legislative requirements and monitor delivery.

9.8 Business Cases

In line with the Scheme of Delegation, scrutinise business cases that exceed the limits of the Executive Management Committee and provide assurance to support the Board approval process.

Review business cases that have been approved and implemented and ensure that benefits are delivered and that learning is identified and taken forward.

9.9 Reports and Reviews

Review the findings of relevant internal audit reports, Peer Reports and Reports undertaken by external bodies and ensure that there are plans in place to address any actions arising

10. Delegation

By approval of these terms of reference the Board delegates the duties and responsibilities outlined in section (9) to the Committee.

11. Committee Effectiveness

The Committee will review its own performance and these terms of reference on an annual basis and will prepare a report for the Trust Board, describing its work and proposing any changes to these terms of reference.

12. Administration

A member of the Corporate Governance Team will act as Committee Secretary and will agree the agenda for meetings with the Chair and the Chief Finance Officer.

13. Review

These terms of reference will be reviewed in April 2027 unless there is a requirement to do so earlier.

Date of Finance & Performance Committee approval	
Date of Board Approval	



TRUST BOARD OF DIRECTORS MEETING IN PUBLIC
3 June 2026

Title	Trust Incident Response Framework (EPRR)
Report Author	James Hunt, Resilience Manager
Executive Owner	Mark Ainsworth, Executive Director of Operations
Agenda Item	23
Governance Pathway: Previous	Emergency Preparedness Resilience & Response (EPRR) Delivery Group & Executive Management Committee (EMC)
Governance Pathway Next Steps	Finance & Performance Committee

1. Purpose

Following approval at the Emergency Preparedness, Resilience and Response (EPRR) Delivery Group and Executive Management Committee (EMC), this paper seeks formal ratification of the Trust's new Incident Response Framework (IRF).

This Framework has been developed to replace the previous Incident Response Plan, providing a more comprehensive, structured and contemporary approach to incident management across the organisation. It reflects current best practice, aligns with national EPRR guidance, and ensures that the Trust remains prepared to respond effectively to a wide range of potential disruptions and emergencies.

2. Executive Summary

The Incident Response Framework (IRF) sets out the Trust's overarching approach to managing a broad range of incidents, including major incidents, significant service disruptions, and complex multi-agency emergencies. The Framework provides a structured and systematised methodology for incident management and has been designed to ensure compliance with the NHS England Emergency Preparedness, Resilience and Response (EPRR) Core Standards, while also aligning with wider national doctrine issued by NHS England, the NHS Resilience and Emergency Capabilities Unit, and the Joint Emergency Services Interoperability Principles (JESIP).

A resilient and coherent response structure is essential to enable the Trust to deliver a flexible, scalable, and coordinated approach during disruptive events, many of which occur under highly stressful, time-critical, and ambiguous circumstances. The ability to work effectively with partner agencies is fundamental to maintaining safe, effective patient care. This is particularly important in the context of national lessons identified from major incidents, and notably from the Manchester Arena Inquiry, which highlighted significant

shortcomings in communication, shared situational awareness, and multi-agency coordination during the emergency response. The Inquiry identified failings in timely information-sharing, clarity of command roles, and interoperability between emergency services, which collectively contributed to delays and confusion in the early stages of the response. It also emphasised that poor communication and inadequate preparedness had compromised the ability of emergency responders to work cohesively and make timely, informed decisions during the incident.

In addition, the second report of the Inquiry identified that significant elements of the emergency response went wrong due to gaps in JESIP application, insufficient coordination, and delays in multi-agency joint working. These findings reinforce the necessity of embedding JESIP principles, strengthening command-and-control structures, and ensuring staff are trained and exercised in joint decision-making, the establishment of shared situational awareness, and the early declaration of major incidents.

The IRF therefore places strong emphasis on effective command and control, clear and timely communication, coordinated operational response, and the rapid identification and deployment of specialist responders and mutual aid. These components are essential to safeguarding patients, maintaining staff safety, and enabling decision-making that is proportionate, informed, and aligned with established emergency management doctrine.

The Manchester Arena Inquiry also highlighted the need for organisations to maintain high levels of situational vigilance and ensure appropriate risk assessments, supported by well trained personnel with the necessary competencies to identify emerging threats and respond effectively. The updated Framework reflects these lessons by strengthening expectations around preparedness, training, exercising, and coordinated risk assessment across the Trust.

A suite of supporting guidance documents, procedures, checklists, and operational tools underpin the Incident Response Framework. These will be systematically reviewed and updated to ensure consistency with the new Framework and to embed the lessons identified from national inquiries, including the Manchester Arena Inquiry. This process will further strengthen organisational readiness, improve interoperability with local and regional partners, and sustain a culture of continuous improvement in line with national best practice.

3. Areas of Risk

The approval of the Incident Response Framework (IRF) will contribute directly to risk reduction by providing an updated, better-structured, and more operationally manageable document. The Framework offers a clear, consistent, and evidence-based approach to incident management, replacing legacy documentation that no longer reflects current organisational needs or national best practice. Its implementation will strengthen organisational resilience, improve interoperability with partner agencies, and provide staff with accessible and authoritative guidance during times of operational pressure.

The Trust Risk Register currently identifies Risk 247: "Incident Response Planning", which highlights an increased level of organisational risk arising from the existence of an outdated Major Incident Response Plan. The introduction of the new IRF provides an effective

mitigation to this risk by ensuring the Trust has a modern, fit-for-purpose framework that aligns with national expectations, incorporates lessons from recent major incident inquiries, and supports consistent application of emergency preparedness, resilience, and response principles across all services.

Approval of the IRF will therefore not only meet compliance obligations but will also provide demonstrable assurance that the Trust is actively addressing a known organisational risk and strengthening its overall readiness to respond to a wide range of potential incidents.

4. Link to Strategic Theme

Clinical Effectiveness

5. Link to Board Assurance Framework Risk(s)

SR23 - Leadership

6. Quality/Equality Impact Assessment

A Quality Impact Assessment has been completed.

7. Recommendations

These need to clearly state what you are asking the Board to consider e.g.

- Approve a recommendation/paper/proposal
- Receive a report/paper and take assurance from it
- Discuss a report/paper and establish what further action is required
- Receive a report/paper for noting

For Assurance		For decision	✓	For discussion	✓	To note	
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Incident Response Framework (IRF)

Version 1.1

Date	28.05.2026
Review Date	28.05.2029
Written by	Resilience & Specialist Operations Department
Authorised by	Mark Ainsworth
Document Classification	OFFICIAL

Version Control

Version	Name	Changes	Date
V0.1	RSO Team	Full review of the Trust IRP	09.03.2026
V0.2	J Hunt	Post EPRR Delivery Group (16.03.26) Reference added to SCAS Move to Critical Plan Reference to NACC Mutual Aid Plan Additional supporting documentation listed Appendix 13 IIMARCH added Appendix 14 SBAR Template added	23.03.2026
V0.3	J Hunt	Post EMC Links to action cards / EOC IRF added Appendix 4 – added column for Media on-call Appendix 15 – acronyms & Abbreviations added	08.04.2026
V1.0	J Hunt	Final version signed off at Finance & Performance Committee	07.05.2026
V1.1	J Hunt	Post TTX (May 2026) Section 1.15 BCI escalation added Section 5.03 Evacuation signal added Section 10.6 updated	27.05.2026

Distribution

All SCAS Staff / Managers / Commanders	
NHS England	
Integrated Care Boards	
SCAS Hub	
SCAS Resilience Direct page	

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Accountable Emergency Officer (AEO) Foreword

As the Accountable Emergency Officer, I am committed to ensuring that SCAS maintains a robust, legally compliant Incident Response Framework that reflects the full breadth of our statutory and contractual obligations. This includes the requirements set out in the Civil Contingencies Act 2004, the Civil Contingencies Act 2004 (Contingency Planning) Regulations 2005, the NHS Act 2006, the Health and Care Act 2022, and the NHS Standard Contract, alongside the NHS Emergency Preparedness, Resilience and Response (EPRR) Framework and the associated Core Standards.

Our strategic intent is to ensure that this framework is not merely a documented set of procedures but a fully embedded, organisation wide system that strengthens operational readiness and enhances resilience. We will achieve this by integrating incident response expectations into our governance structures, decision making processes, leadership behaviours, and workforce training programmes.

Through clear accountability, rigorous assurance, and continuous improvement, we will maintain the organisational capability required to respond effectively to any incident or emergency. This commitment ensures that we safeguard our patients, protect our staff, and contribute meaningfully to the resilience of the wider health and care system.

Mark Ainsworth, Executive Director of Operations.

1.0 Information

1.01 Introduction

The Incident Response Framework (IRF) provides a structured approach and guidance across the Trust to enable an effective response to incidents aligned to legal obligations and national guidance. The IRF is applicable to all departments across the Trust and forms a central point of reference for all other internal supporting plans and response arrangements to be produced.

This document aligns to the NHS England Emergency Preparedness Resilience and Response (EPRR) Framework 2022 and NHS England EPRR Core Standards.

The Accountable Emergency Officer (AEO) a designated Trust Executive has overall responsibilities for the discharging of duties under section 252A (9), outlined in appendix 1. The AEO will provide assurance to the Board that strategies, systems, training, policies and procedures are in place to ensure an appropriate response for their organisation in the event of an incident.

The IRF is informed by key legislation including:

Civil Contingencies Act (CCA) 2004

NHS organisations are Category 1 responders, legally required to plan for and respond to emergencies while maintaining critical services. Duties include risk assessment, emergency planning, business continuity, and cooperation with multi-agency partners.

Health and Safety at Work etc. Act 1974

Imposes a duty on employers to ensure, so far as reasonably practicable, the health, safety, and welfare of employees and others affected by their work. This includes safe systems of work, risk assessments, and provision of PPE.

NHS Act 2006 & Health and Care Act 2022

Reinforces organisational accountability for patient safety and emergency preparedness within integrated care systems.

The objectives of this framework are:

- Provide guidance, direction and information to ambulance staff and other NHS personnel.
- Enable an effective and coordinated response to major incidents or emergencies.
- To assist in the identification and mobilisation of specialist resources.
- Ensure an effective command structure has been instigated.
- Ensure that the Trust responds to a declared major incident as an integral part of the NHS team.
- To demonstrate assurance and compliance against our statutory and contractual obligations.

1.02 Statutory, Contractual Obligations and Associated Guidance

This framework should be read in conjunction with the following Legislation and Guidance:

- Civil Contingencies Act 2004
- Emergency Preparedness (Cabinet Office, 2012)
- Emergency Response and Recovery (HM Government, 2013)
- EPRR Framework (NHS England, 2022)
- Hampshire & IOW and Thames Valley Emergency Response Arrangements (2024)
- Health and Care Act (2022)
- JESIP Initial Operational Response (IOR) to Incidents Suspected to Involve Hazardous Substances or CBRN Materials (2024)
- JESIP Joint Doctrine (2024)
- JESIP Joint Operating Principles (JOPS) for a Marauding Terrorist Attack Edition 3 (2023)
- JESIP Joint Operating Principles (JOPS) for a CBRN Incident Edition 1 (2025)
- National Ambulance Resilience Unit Duty of Care for Ambulance Responders (2021)
- National Ambulance Resilience Unit (NARU) Command and Control Guidance (2024).

1.03 SCAS Linked Documents

- Airwave & ESN Technology Policy (2024)
- Driving and Care of Trust Vehicles Policy (2025)
- EOC Annex to IRF (2025)
- Business Continuity Management System Policy (2025)
- Command Policy (2023)
- CBRN Operational Arrangements (2024)
- EPRR Policy (2024)
- Exercise Policy (2023)
- Events Policy (2025)
- Everbridge/Mass Notification SOP (2025)
- Move to Critical Plan (2015)
- MTA Operational Arrangements (2024)
- Tasking of Tactical Commanders Framework (2025)
- VIP & Protected Person Policy (2024)
- Water Incident Policy (2025)

1.04 Other Documentation & Guidance

- National Ambulance Coordination Centre (NACC) Plan (2025)

1.05 Joint Emergency Services Interoperability Programme (JESIP)

South Central Ambulance Service ensures that JESIP is at the centre of all its plans, policies, and procedures. This framework has been centred on the JESIP principles as a framework for the response to all incidents, occurrences, and situations. The core principles of JESIP are:



These principles should be applied for any incident response working with one or more partner agency. These principles enable compliance with statutory obligations under the Civil Contingencies Act (CCA) 2004. It improves efficiency and safety by enabling coordinated, evidence-based decisions.

SCAS works with blue light partners using the JESIP principles to deliver a multi-agency response to ensure we're able to deliver the best care and treatment to any casualties, which minimises disruption to other healthcare services and brings about a speedy return to our normal service.

1.06 Joint Decision Model

Decisions made at all command levels (Strategic, Tactical and Operational) should be made using the Joint Decision Model (JDM) which provides a structured approach to decision-making under pressure. The JDM ensures:

- Shared situational awareness by considering information from all agencies.
- Assessment of risks and options before committing resources.
- Alignment with organisational values, legal duties, and JESIP principles.
- Continuous review as the incident evolves.



1.07 Action Cards

Action cards are available for staff to utilise; these are available from:

- Control rooms [EOC Annex to IRF V1.1 \(01.12.2025\)](#)
- JRCALC+ (NHS Resilience and Emergency Capabilities Unit action cards) [NARU Major Incident Action Cards Version 2 June 2021](#)
- Departmental Business Continuity Plans

Departments are encouraged to develop their own action cards to support their teams during an incident response.

1.08 Business Continuity Management System (BCMS)

South Central Ambulance Service (SCAS) has an effective BCMS that is aligned to the international standard – ISO 22301 and the Good Practice Guidelines.

SCAS will expect commitment to Business Continuity Management to be present in its suppliers of critical goods and services. Procurement will ensure this is managed through the standard contracting arrangements with Third Party Suppliers.

SCAS has overall accountability for developing a Business Continuity culture, providing leadership from the top of the organisation and ensures that Business Continuity activities are carried out in line with the Policy.

Directors (Executive and Non-Executive) acting on behalf of the Board have overall responsibility for specific new and revised policies.

The Accountable Emergency Officer has overall responsibility for ensuring effective Business Continuity management within the Trust.

Procedures required to address both short and long-term issues impacted by increased demand levels, impacting on staffing, estates, supply chains and ICT systems of Trust departments and teams supporting an incident response must have made considerations within their own departmental Business Continuity plans.

1.09 Training and Validation

The Civil Contingencies Act 2004 requires that every plan maintained by a Category 1 responder includes provision for:

The carrying out of exercises for the purpose of ensuring that the plan is effective; this will be in accordance with the NHS EPRR Framework.

Training of:

- a. an appropriate number of suitable staff.
- b. such other persons considered appropriate for the purposes of ensuring that the plan is effective.

SCAS staff with incident response roles in the plan and those who potentially have a role in an incident response will take part in a targeted training and exercising programme to ensure their competency in those roles.

It is important that managers (operational and non-operational), ambulance personnel and other Trust staff are familiar with this plan. New entrants into the Trust receive initial awareness as part of the Trust induction programme. The training of key staff is an ongoing process throughout the year and forms part of the core update process in line with controls assurance and current legislation i.e., Civil Contingencies Act 2004.

The plan will be exercised in accordance with national guidance:

- Six Monthly Communications Exercise
- Annual Tabletop Exercise
- Three Yearly Command post exercise
- Three Yearly Live Exercise

The only exemption to this is when the plan has been tested due to a declared Major incident. The above are the minimal requirements for the Trust.

1.10 Incident Definitions

Business Continuity Incident	An event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, to below acceptable pre-defined levels. This would require special arrangements to be put in place until services can return to an acceptable level. Examples include surge in demand requiring temporary re-deployment of resources within the organisation, breakdown of utilities, significant equipment failure or hospital acquired infections. There may also be impacts from wider issues such as supply chain disruption or provider failure. (NHSE EPRR Framework, 2022)
Critical Incident	Any localised incident where the level of disruption results in an organisation temporarily or permanently losing its ability to deliver critical services; or where patients and staff may be at risk of harm. It could also be down to the environment potentially being unsafe, requiring special measures and support from other agencies, to restore normal operating functions. A Critical Incident is principally an internal escalation response to increased system pressures/disruption to services. (NHSE EPRR Framework, 2022)
Major Incident	An event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder agency (Cabinet Office)
Mass Casualty Incident	An incident (or series of incidents) causing casualties on a scale that is beyond the normal resources of the emergency and healthcare services ability to manage. (NHSE EPRR Framework, 2022)

NHS England Regional / National Management

Following an incident declaration and notification to NHS England. This may result in a regional NHS England incident being declared (appendix 2) and an appropriate incident management structure across the broader NHS region being stood up to support the health response and coordination.

1.11 Types of Major Incident

Rapid onset – develops quickly, and usually with immediate effects, thereby limiting the time available to consider response options (in contrast to rising tide) e.g. a serious transport accident, explosion or series of smaller incidents.

Rising tide – a developing infectious disease epidemic or a capacity/staffing crisis or industrial action.

Cloud on the horizon – a serious threat such as a significant chemical or nuclear release developing elsewhere and needing preparatory action.

Headline news - public or media alarm about an impending situation, significant reputation management issues.

Chemical, Biological, Radiological, Nuclear – CBRN terrorism is the actual or threatened dispersal of CBRN materials (one or several, or in combination with explosives), with deliberate criminal, malicious or murderous intent.

Hazardous materials (HAZMAT) – accidental incident involving hazardous materials.

Cyber security incident – a breach of a system's security policy to disrupt its integrity or availability or the unauthorised access or attempted access to a system.

Mass casualty – an incident (or series of incidents) causing casualties on a scale that is beyond the normal resources of the emergency and healthcare services ability to manage.

(Defined within NHS England EPRR Framework, 2022)

1.12 Activation & Stand Down

Any no-notice incident declaration should be reviewed by a Trust qualified and competent Tactical Commander with the support of a Tactical Advisor within 60 minutes.

Type	No-Notice Incident / Rapid Onset	Developing Incident
Business Continuity Incident	Strategic Commander	
Critical / Major Incident	• Senior ICC Commander on duty • Any Trust Commander • Tactical Advisor / National Interagency Liaison Officer (NILO) • Any member of staff at scene (Provide full METHANE report). A Major Incident activation should be made for a Police declared Operation PLATO (Marauding Terrorist Attack) or confirmed Chemical Biological Radiological & Nuclear (CBRN) incident.	Tactical Commander (or above)
Mass Casualty Incident	Tactical Commander (or above)	

The decision to stand down or cancel an incident declaration should be made by the most senior Commander (often the Strategic Commander) following adequate situational awareness and with advice from a Tactical Advisor.

1.13 Incident Declaration Guidance

Incident Response Matrix to Support Declarations					
Patient Numbers	30+	Major	Major	Major	Major
	20-30	Critical	Major	Major	Major
	10-20	Critical	Critical	Major	Major
	3-10	Operational Command	Critical	Critical	Major
	<3	Standard Response	Operational Command	Critical	N/A
		Level 1	Level 2	Level 3	Level 4
	Incident Type				

Deployment	Incident	Explanation
Standard Response		Standard response with DCA / RRV
Operational Command		Standard response with Operational Commander +/- *Specialist resources (HART / HEMS) *Tactical Advisor support
Critical	Critical Incident	As above with mobilisation of additional resources +/- *specialist vehicles (ISV, MassCas) *Specialist responders (SORT)
Major	Major Incident	As above with consideration for Mutual Aid request

Incident Type	Explanation
Level 1	Any normal incident involving medical or trauma patients with no more than low risk hazards present and no specialist resource required (e.g. two car RTC)
Level 2	An incident requiring specialist advice or scene management, where partner agencies may be involved e.g. transport (trains/planes) or hazardous materials
Level 3	Any incident of significant size, complexity or types of patients (trauma, burns, paediatrics) that require a large number of resources and extended command structure. E.g. large fire with persons reported, transport incidents, building collapse, hazardous materials
Level 4	An incident of such size, hazard or involving multiple sites that require the immediate declaration of a major incident and may require the request for mutual aid. e.g. major train or plane crash, mass casualty event, marauding terrorist Attack (MTA) or Chemical, Biological, Radiological or Nuclear (CBRN) incident.

1.14 Notification and initial Cascade

The declaration of a major incident should be communicated in a timely manner with internal and external partners.

The primary tool for completing this initial notification is Everbridge, the Trusts mass notification system that has built in template to communicate information with partners. Access to log into the Everbridge system for designated users: [Everbridge CAS](#). Further information can be found within the Trusts Everbridge/Mass Communication SOP.

As a minimum a full METHANE report is expected to be communicated. The SCAS on-call communications lead will then coordinate public, stakeholder and wider staff communication. Operational communications to actively involve staff remains with the incident command.

M	MAJOR INCIDENT	Has a major incident been declared? (Yes/No – If 'No', then complete ETHANE message)	<i>Include the date and time of any declaration.</i>
E	EXACT LOCATION	What is the exact location or geographical area of the incident?	<i>Be as precise as possible, using a system that will be understood by all responders.</i>
T	TYPE OF INCIDENT	What kind of incident is it?	<i>For example, flooding, fire, utility failure or disease outbreak.</i>
H	HAZARDS	What hazards or potential hazards can be identified?	<i>Consider the likelihood of a hazard and the potential severity of any impact.</i>
A	ACCESS	What are the best routes for access and egress?	<i>Include information on inaccessible routes and rendezvous points (RVPs). Remember that services need to be able to leave the scene as well as access it.</i>
N	NUMBER OF CASUALTIES	How many casualties are there, and what condition are they in?	<i>Use an agreed classification system such as P1; P2; P3 and dead.</i>
E	EMERGENCY SERVICES	Which, and how many, emergency responder assets and personnel are required or are already on-scene?	<i>Consider whether the assets of wider emergency responders, such as local authorities or the voluntary sector, may be required.</i>

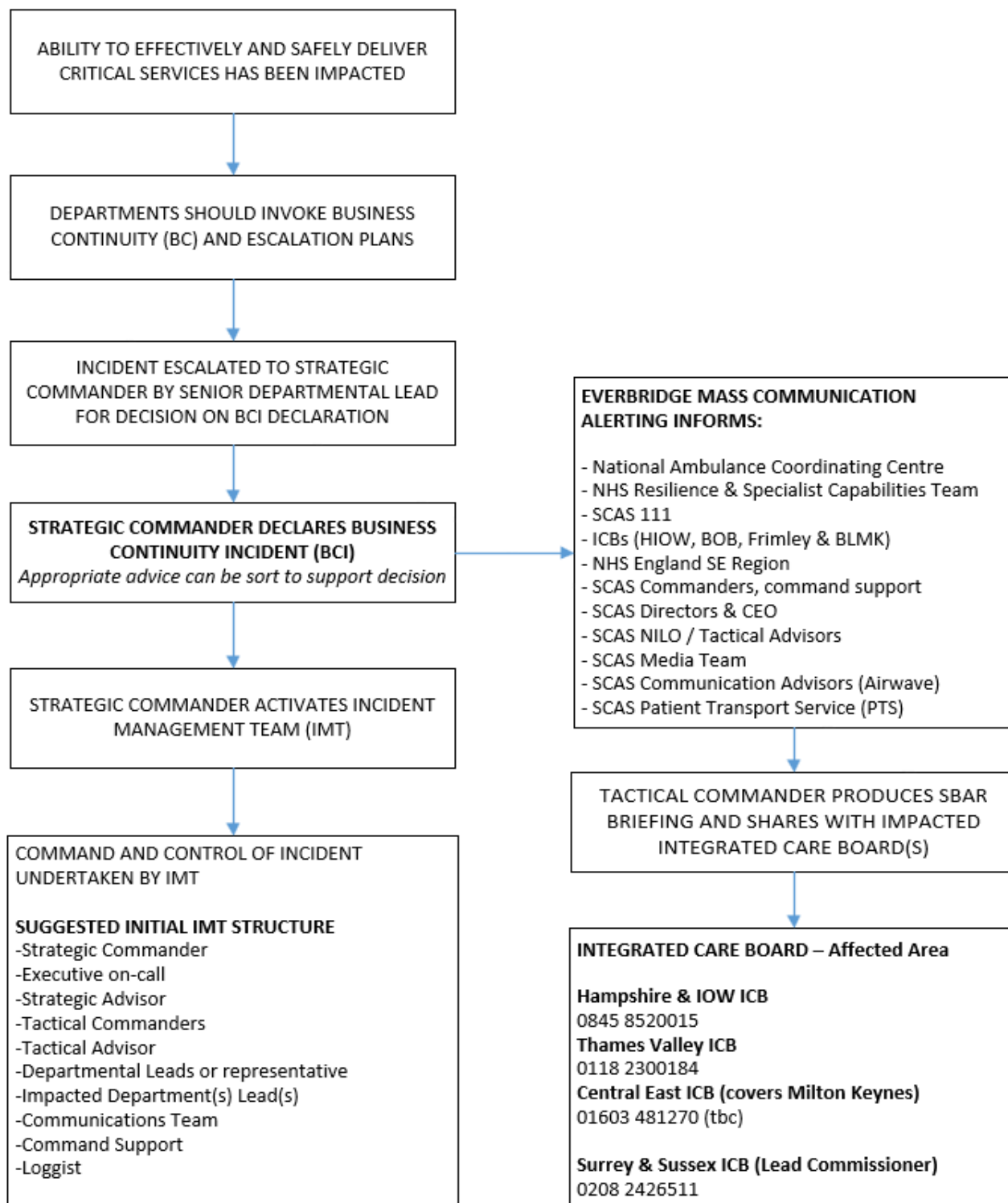
Business Continuity / Critical Incidents:

For a major incident, the expected template to communicate information is using an initial METHANE report. Whilst this also remains acceptable for other incident types (Critical, Business Continuity) it is expected that the Tactical Commander will provide the ICB with an SBAR report (appendix 14) within 60-minutes of the declaration.

1.15 Business Continuity Incident Escalation Process

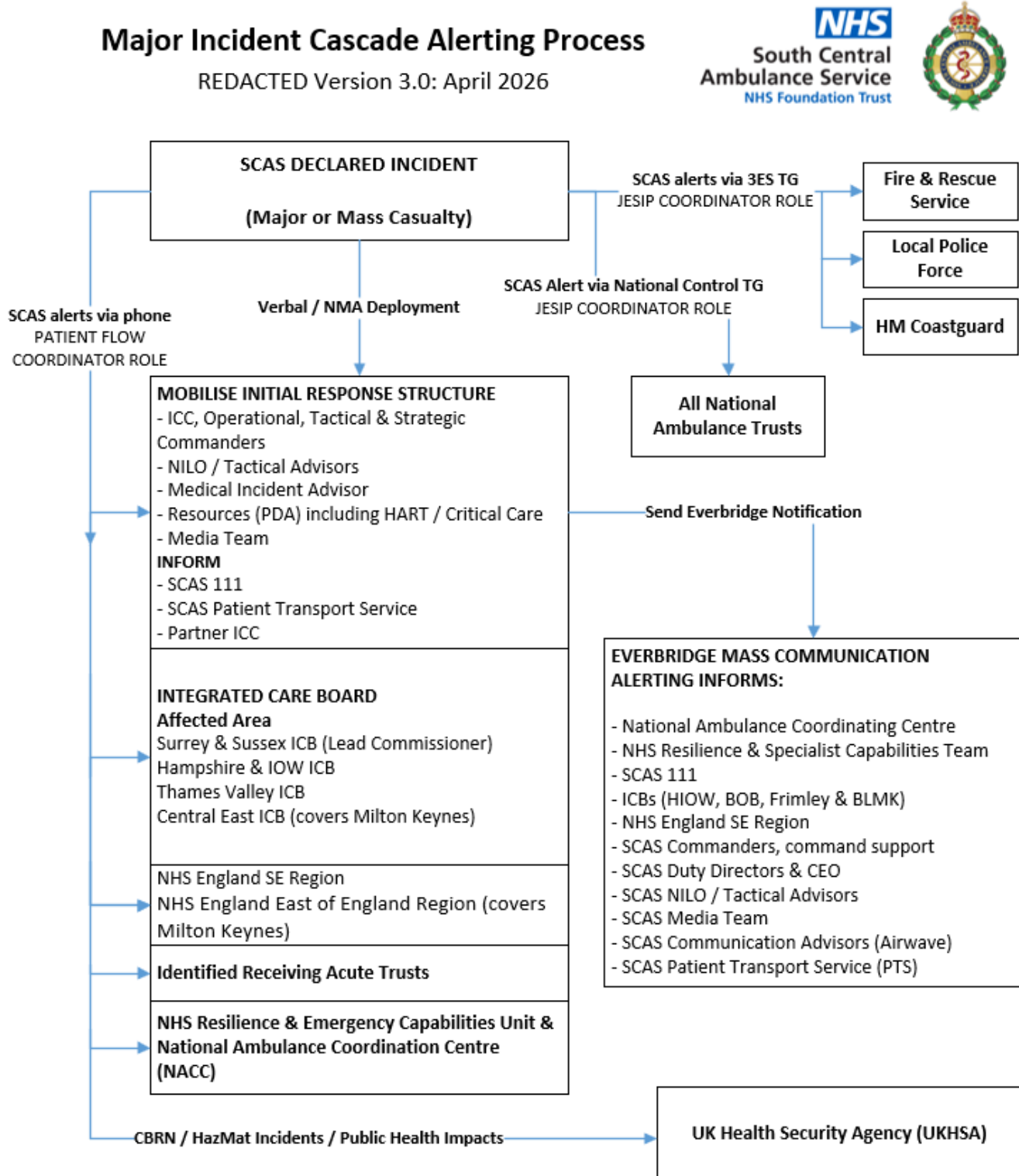
Business Continuity Incident Escalation Process

Version 1.0: May 2026



The full major incident communication cascade undertaken by ICC follows the below process:

1.16 Declaration of a Major Incident by SCAS Cascade notification

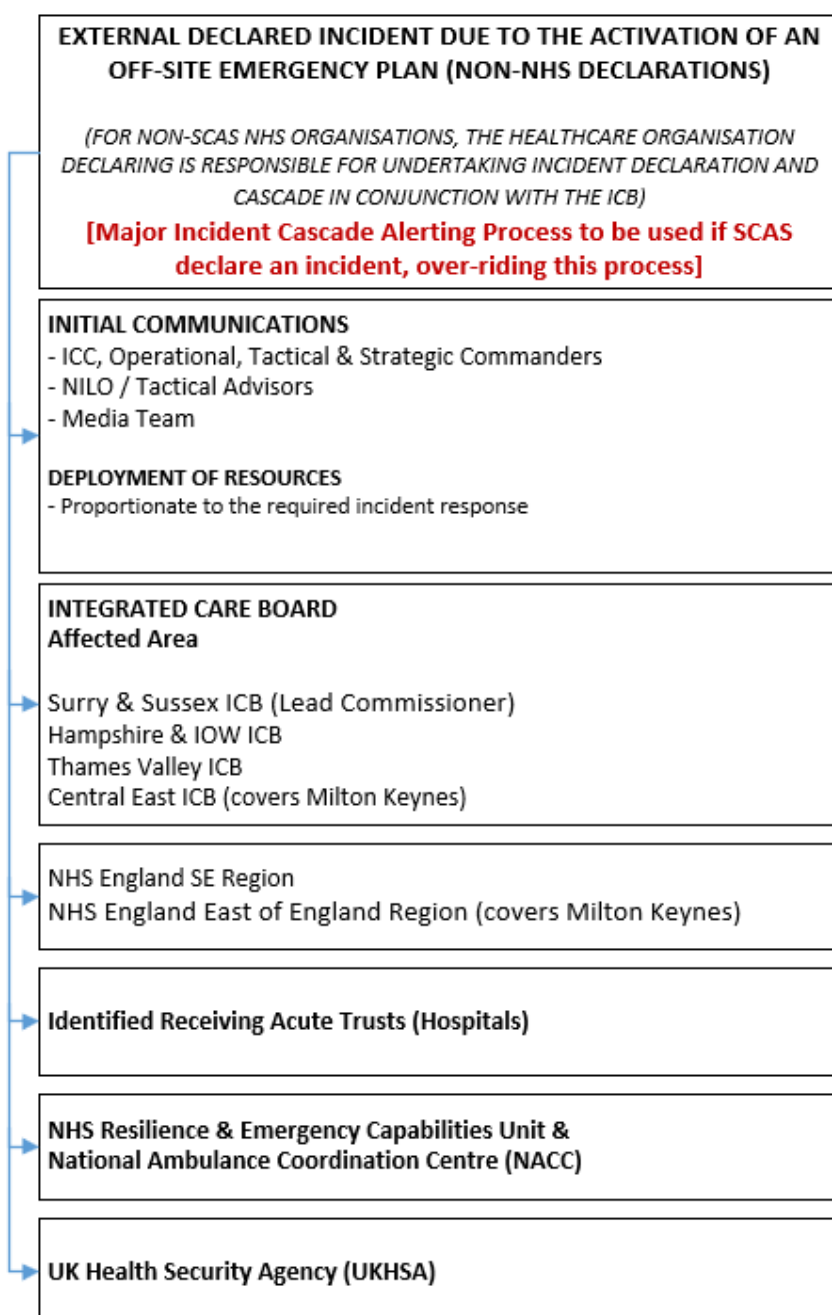


1.17 Declaration by Partner Agency / Activation of Site-Specific Plan

When a Major Incident is declared by a non-NHS partner organisation or a specific off-site emergency plan is activated, these plans state that SCAS will cascade this declaration to specific Health partners. This will still likely require a SCAS response, but the following agencies should be informed regardless as to whether SCAS has declared a major incident:

EXTERNAL Incident Declaration Communication Cascade

REDACTED Version 1.0: April 2026



2.0 Intention

As an ambulance service we form the first part of the NHS response to a major incident and as such are responsible for alerting, mobilising and coordinating the NHS response to large-scale or declared major incidents. Our responsibilities include:

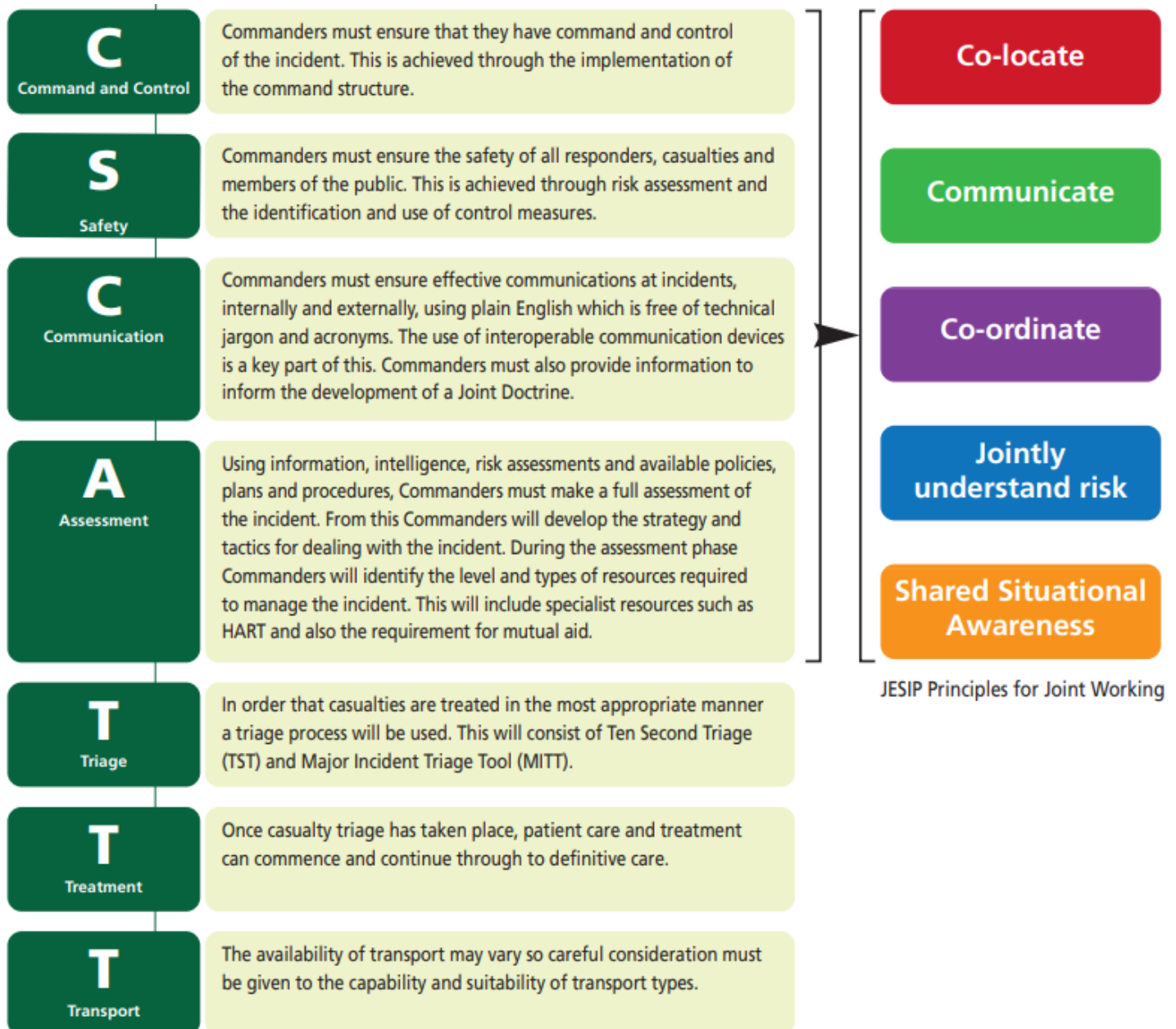
- Initiating and maintaining a Command-and-Control system to provide appropriate support and guidance to all NHS responders and other agencies.
- Coordination of all NHS operational communications on scene.
- The management of the health, safety and welfare of all NHS responders.
- Providing casualty triage, treatment and transport, including the selection of appropriate receiving hospitals.
- The provision of specialist incident response capabilities, including hazardous area working, decontamination of casualties and a marauding terrorist incident.

The NARU Command and Control guidance outlines a set of core strategic objectives that should be considered by commanders and provide guidance in the initial stages of the incident response until the strategic direction can be set by the Trust Strategic Commander. This can be found in Appendix 3.

This document aligns to the SCAS Vision and Values and provides a framework for SCAS response arrangements to a wide range of incident types.

3.0 Method

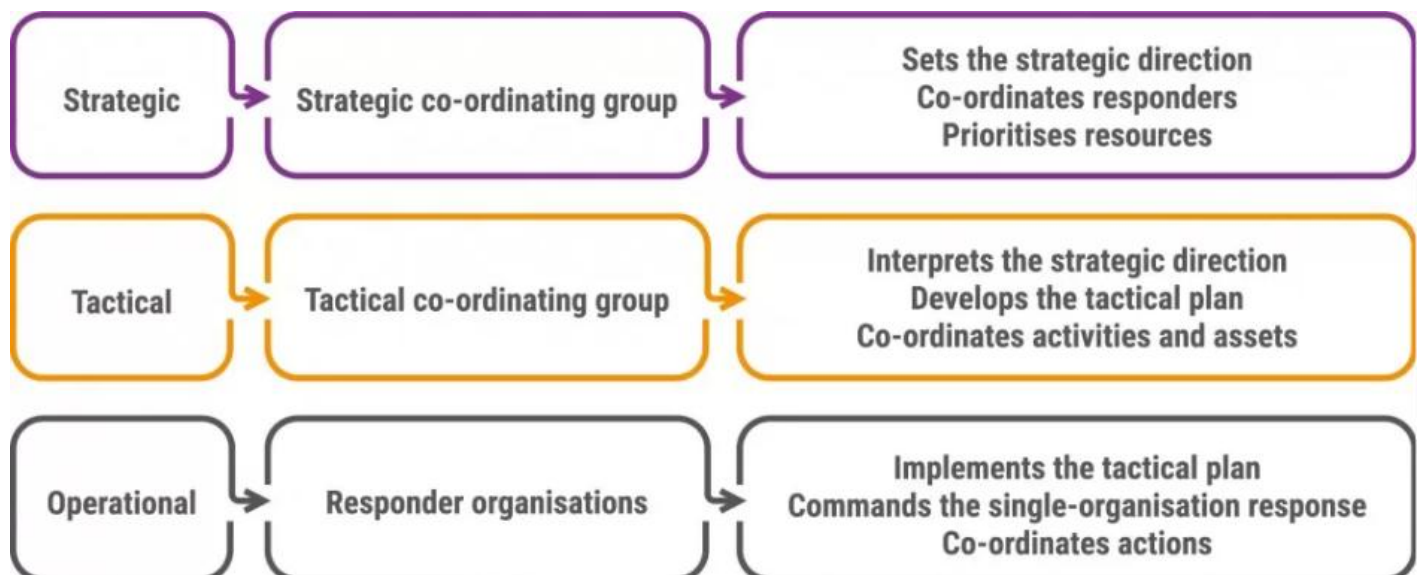
This Response Framework is based on the Command Safety Communication Assessment Triage, Treatment and Transport (CSCATTT) which is recognised as an effective method for Incident Management by the Ambulance Services.



4.0 Command

SCAS operates a command structure based on NHS Resilience Emergency Capabilities Unit Command and Control Guidance. Comprising a command structure based around Strategic, Tactical and Operational tiers of command. Supported by functional and advisory roles, which may be provided by supporting departments such as Fleet, Communication Team or People Services.

This structure is supported by the Integrated Contact Centres (ICCs) within the Trust which are also led by ICC Tactical & Operational Commanders.



All SCAS Commanders and Tactical Advisors/NILO will be suitably competent and qualified having attended nationally accredited command courses, maintaining ongoing continuous professional development.

Appendix 4 provides a suggested escalation criteria to stand up appropriate command and control arrangements, but this is not exhaustive.

Security Clearance / Vetting

The following groups of staff should maintain appropriate levels of Security Clearance and Vetting relevant to their role:

Tactical Commanders (ICC and Operations)
Strategic Commanders
Tactical Advisors/NILO

4.01 First Resource on Scene

The first resource on scene should follow the First Responder on Scene action card (located on JRCALC) which outlines the actions and responsibilities to undertake initial scene assessments.

4.02 Strategic Command

The Trust will always have one Strategic Commander on duty. The Strategic Commander has overall responsibility for the command and recovery of an incident. The Strategic Commander will set the Ambulance Service providers strategic aims (the strategy) for the incident, providing a framework for the Tactical Commander(s) to work within. The Trust Strategic Commander will work alongside the on-call Executive Director; however, the Strategic Commander is responsible for the strategy and decisions made.

Specialist Operational Events as outlined within the Events Policy will have a Strategic Commander appointed by the Executive Director of Operations. This Strategic Command holds strategic oversight and responsibility for the successful delivery of the event.

Should an incident occur at an Event with a Strategic Commander in place, they retain overall command of the response to the incident, supported by the Trust duty Strategic Commander who will retain accountability for the overall organisational response.

The Strategic Commander is responsible for informing the Trust Board of a declared incident.

4.03 Tactical Command

The Trust maintains a 24/7 on call Tactical Commander rota, with commanders geographically spread throughout the SCAS footprint. This includes the ICC Tactical commanders, who will take the role of the tactical commander in the first instance whilst the on call tactical commander responds to the appropriate command location. A clear handover and briefing must be provided when this transition takes place.

In the initial stages of an incident, first responders are responsible for tactics. Once the scale and nature of the incident is known, emergency services will appoint officers to act as Tactical Commanders for their organisation. Those working at a tactical level should be co-located at a mutually agreed location where they can maintain effective joint command of the operation. The Tactical Commander may be in place before the strategic commander and to be the first appropriate officer taking command of the incident. In the early stages of an incident, the tactical commander may set priorities before the strategic commander has set a strategy (JESIP, 2021).

Personnel discharging the Tactical Commander role should have a thorough working knowledge of NHS Ambulance Service operations and should have completed a Tactical Command course and have sufficient knowledge and experience to manage operational assets, including both general and specialist assets. It is critical that the Tactical Commander has a comprehensive knowledge of all tactical options available to them and the extent of the capabilities under their command. The Tactical Commander has responsibility for developing the Tactical Plan including casualty management.

Tactical Commanders to provide comprehensive briefings to the Strategic Commander on the risks and benefits of all practices detailed in the National Ambulance Command and Control Guidance, it is not sufficient for the Tactical Commander to be reliant on the NILO/Tactical Advisor to cover gaps in their competence or to place the advisor in command of the incident.

4.04 Operational Command

SCAS operates an on-duty Operational Commander rota spread throughout the SCAS geography.

Operational Commanders will be working with colleagues from other responder organisations. This will most likely be at, or close to, the scene of the incident. They will control and deploy the resources of their respective organisation within a functional or geographical area and will implement the tactical plan as directed by the Tactical Commander (JESIP, 2021).

The Operational Commander has responsibility for activities undertaken at the scene, as such they will be located at the incident scene and ideally co-located with the incident commanders of other responding agencies at a Forward Command Post (FCP). Where this is not possible the Operational Commander should ensure regular multi-agency face-to-face briefings take place. The Operational Commander will also provide leadership and management to the functional roles and any other direct reports.

4.05 Incident Management Team (IMT)

A Strategic or Tactical Commander may determine that a multi-disciplinary SCAS team is formed to support the consequence management of an incident. The make up of this team will be determined by the Commander on duty and incident requirements depending on the type, scale, and duration of the incident.

It is likely that this team would most effectively operate remotely (at the discretion of the Commander) given the various work locations across SCAS and the readily available use of Microsoft Teams.

An IMT may be assembled in relation to a range of incidents including Business Continuity, Critical and Major Incidents.

Beyond SCAS's operational departments (ICC, Operations and PTS), consideration should be given to the support that can be provided by corporate and support services with skills and resources across (not limited to):

- Communications Team
- ICT Teams
- Legal Services
- Logistics (including Central Logistics Unit (CLU) & Pharmacy)
- Scheduling & Planning
- People and Financial services (including Health and Wellbeing Team)
- Infection, Prevention and Control (IPC)
- Fleet & Operational Support Desk (OSD)
- Business Intelligence
- Administrative and Loggist support

4.06 Command Support Roles

Strategic Advisor:

Appointed by the Strategic Commander according to their field of expertise and the requirements of an event or emergency. The Strategic Advisor is not necessarily the same as a NILO or Tactical Advisor, and while they may provide direct advice to the Strategic Commander, their advice may support all levels of command. The Strategic Advisor will be selected by the Strategic Commander based on their expertise relevant to the strategic challenges of the incident.

Tactical Advisor:

Tactical Advisors have the depth of subject knowledge regarding Trust specialist and non-specialist capabilities and associated risk and the benefits of deploying / utilising such capabilities. The Tactical Advisor can utilise that knowledge and provide concise advice to commanders regarding the risk and benefit of deploying Trust specialist and non-specialist capabilities during an incident response.

The Tactical Advisor is not a Commander or decision maker. The responsibility for the decisions and course of action taken rests with the relevant Commander. However, the Tactical Advisor is both responsible and liable for the advice they provide. They should be credible and competent individuals (NARU Command and Control Guidance 2024).

National Interagency Liaison Officer (NILO):

A NILO should have a similar skill set to the Tactical Advisor, but these individuals have undertaken a nationally accredited course to liaise with other responder agencies.

NILO's should maintain an up-to-date understanding of the response arrangements for other specialist agencies, particularly, Police, Fire and Rescue, Military, Coastguard, and the Security Services. NILO's will provide advice to all levels of the command structure on how to work effectively with the other agencies and help other agencies interface effectively with the NHS aims and objectives. That means NHS Ambulance NILOs may be deployed and embedded within other agencies structures as required (NARU Command and Control Guidance 2024).

NILO will also adopt the role of On Scene Commander in high threat incidents such as a Marauding Terrorist Attack (MTA). *See SCAS MTA operational arrangements 2025 for further information.*

Radiation Protection Supervisors:

The trust is required to provide a Radiation Protection Supervisor (RPS). Individuals have received suitable training from the UK Health Security Agency (UKHSA) to provide advice on radiation incidents in line with associated legislation and guidance. This role is provided by the Resilience and Specialist Operations Department.

UKHSA provides the RPS with Radiation Protection Advice as the designated Radiation Protection Advisor (RPA).

Medical Support Roles:

Strategic Medical Advisor, Medical Advisor and Operational Medical Advisor are not command roles. They are advisory roles and carry no command authority. Their advice will directly influence the command decisions, so personnel discharging these functions should have the relevant skills and experience commensurate to the advisory role.

Strategic Medical Advisor: Responsible for monitoring overall hospital capacity and ensuring the tactical level has access to clinical resources it requires.

Medical Advisor: Principally responsible for casualty distribution from the incident. They will support the Tactical and Strategic Ambulance Commanders to transfer patients from the scene into the appropriate medical facilities.

Operational Medical Advisor: Co-ordinate and direct the clinical care provided at the Casualty Clearing Station or equivalent.

As per NARU Command and Control guidance (2024).

Loggist:

All commanders are trained loggists and are responsible for ensuring that all decisions they make are captured and recorded in an appropriate manner. Trained loggists are available across SCAS 24/7 to support all command levels and can be deployed to incidents via ICC or the Resilience and Specialist Operations command support team under emergency conditions if required. The loggist skillset is added to individuals Global Rostering System (GRS) to aid deployment to incidents and ongoing CPD is provided to the loggist cadre, including commanders.

4.07 Integrated Contact Centre (ICC) Commanders

ICC Tactical Commander

- Supports incident response with resources until the responding Tactical Commander is in position to take command.
- Link between organisation Command and Control structure: Operations and ICC.
- Responsible for internal and external escalation and communications with partner agencies.
- Ensures adequate resources are available to manage the impact of the incident on core business.

ICC Operational Commander

- Initial response and resource allocation decisions based on the need and available capabilities balanced against demand.
- Single point of contact for Operational Commander for on scene updates and the agreed model for incident information sharing e.g. METHANE.

Further information relating to the ICC can be found within the ICC Annex to IRF on the SCAS Hub.

4.08 Command Handover

Commanders should be providing a handover utilising the IIMARCH briefing tool (appendix 13), when a change or handover of command (at any level) is completed. The handover of command should be clearly communicated and documented within decision logs.

A commander should only assume command once they have sufficient situational awareness.

The duty Strategic Commander should ensure command resilience across the whole incident, considering the duration and complexity of the incident in addition to the time individuals have been on-duty.

Any concerns for the welfare of a commander or responder, should be escalated to the next level of command to ensure appropriate support is put in place, this may include the substitution of a commander or resource.

4.09 Functional Roles

In the early stages of a major incident the functional roles will need to be assigned to personnel. Operational Commanders assigning roles should consider individual skills and experience when allocating roles. The national action cards (or local action cards where available) should be used by those appointed to these roles. As soon as practicable, the functional roles should be filled by personnel that have been trained to discharge them. This does not apply to the Decontamination Officer or Entry Control Officer for CBRN / HazMat incidents as these functional roles should only be discharged by trained and competent staff in the respective discipline. (NARU Command and Control Guidance 2024).

See appendix 5 for a list of Functional Roles at scene and within the ICC.

4.10 Command Locations

Incident Control Rooms (ICRs)

The trust operates two primary Integrated Contact Centre (ICC) based at Northern House (Thames Valley) and Southern House (Hampshire). Core functions of the ICCs are to:

- Answer and triage 999 calls
- Deploy ambulance resources, critical care and specialist responders
- Undertake clinical signposting
- Support the coordination, communication and command of incidents

Each ICC has an Incident Control Room (ICR) which provides a dedicated area for the command and control of pre-planned and spontaneous incidents. The ICR's functionality is regularly tested.

The activation of an ICR is a command decision that should be made by the most senior ICC Commander on duty. If the ICR is occupied, it should be vacated within 15 minutes of the decision to activate it. The ICR can be activated to support a range of incidents including business continuity and does not require a formal declaration to be made.

In the event of an internal incident (Business Continuity or Critical Incident) which does not require external arrangements/co-ordination, an internal command structure should still be established to provide an effective structure throughout the response and to recovery.

This should involve setting up an internal "Strategic" group supported by Tactical/ Operational/departmental representatives. These responses can be virtual, however early consideration should be made to the establishment of an in-person command cell at either of the dedicated ICR's located in the Trust ICCs.

During the response to an incident the following response mechanism(s) will be established if the incident involves multi-agency partners or requires a coordinated response.

In the event of a Widespread Electricity Loss (WEL) resulting in a regional/national loss of power and potentially effective communication methods. On-Call Trust Strategic and Tactical Commanders should self-deploy to the closest ICC/TCG/SCG location to establish Trust wide command and control. This is due to ICC having resilient power and communication methods.

Forward Command Post (FCP):

The forward command post will be established by the lead agency in a suitable location at the incident. Commanders should ensure that they are present at the FCP and request the establishment of an FCP if one has not been established on their arrival. Each agency should provide appropriate command representation at the FCP. The location of the FCP should be regularly reviewed to ensure its suitability. Commanders should seek to co-locate as soon as possible, if this is physically not possible, then emergency services talk groups should be utilised to enable commanders to share information or via Microsoft teams.

4.11 Interagency Notifications, Command & Control

In addition to the inter-control room and at scene mechanisms to support the incident response additional methods exist within the Local Resilience Forum Emergency Response Arrangements (Hampshire & IOW and Thames Valley Local Resilience Forum), namely:

Partner Activation Teleconference (PAT):

Used to share initial information with partner agencies within a set criteria. PAT notifications are received by the Resilience and Specialist Operations (RSO) team, ICC and duty Tactical Commander. Out of hours, ICC should escalate the PAT notification to the duty Tactical Advisor and Tactical Commander.

[Handbook A Partners Activation Teleconference \(resilience.gov.uk\)](https://resilience.gov.uk/handbook-a-partners-activation-teleconference)

Tactical Co-ordinating Group (TCG):

The purpose of the tactical level of command is to devise a tactical plan that considers impacts wider than the immediate scene of the incident and co-ordinate operational resources in order to achieve this. Where formal coordination is required, local responders may convene a Tactical Coordinating Group (TCG) and it may meet as a physical or virtual meeting.

[Handbook C Tactical Coordinating Group \(resilience.gov.uk\)](https://resilience.gov.uk/handbook-c-tactical-coordinating-group)

Strategic Co-ordinating Group (SCG):

The role of the SCG is to take overall responsibility for the multi-agency management of the emergency, and to establish the policy and strategic framework within which the Tactical level of command will work. It will usually be formed in response to a rapid-onset emergency or as a result of escalation from the Partner Activation Teleconference (PAT), and it may meet as a physical or virtual meeting.

[Handbook D Strategic Coordinating Group \(resilience.gov.uk\)](https://resilience.gov.uk/handbook-d-strategic-coordinating-group)

4.12 Activation of Emergency Response Arrangements

Where an incident indicates the requirement to share information with partner agencies or stand up a multi-agency response to an incident, SCAS is authorised to do so utilising the Emergency Response Arrangements (ERA) held by Hampshire & IOW and Thames Valley Local Resilience Forums.

Access to these arrangements and the activation procedures is via Resilience Direct.

4.13 Resilience Direct

Resilience Direct is an online repository for multi-agency plans, incident updates and collaboration. Those with a requirement to access multi-agency response plans (such as Commanders and Subject Matter Experts) can register for an account here: [Resilience Direct Hub Dashboard](#).

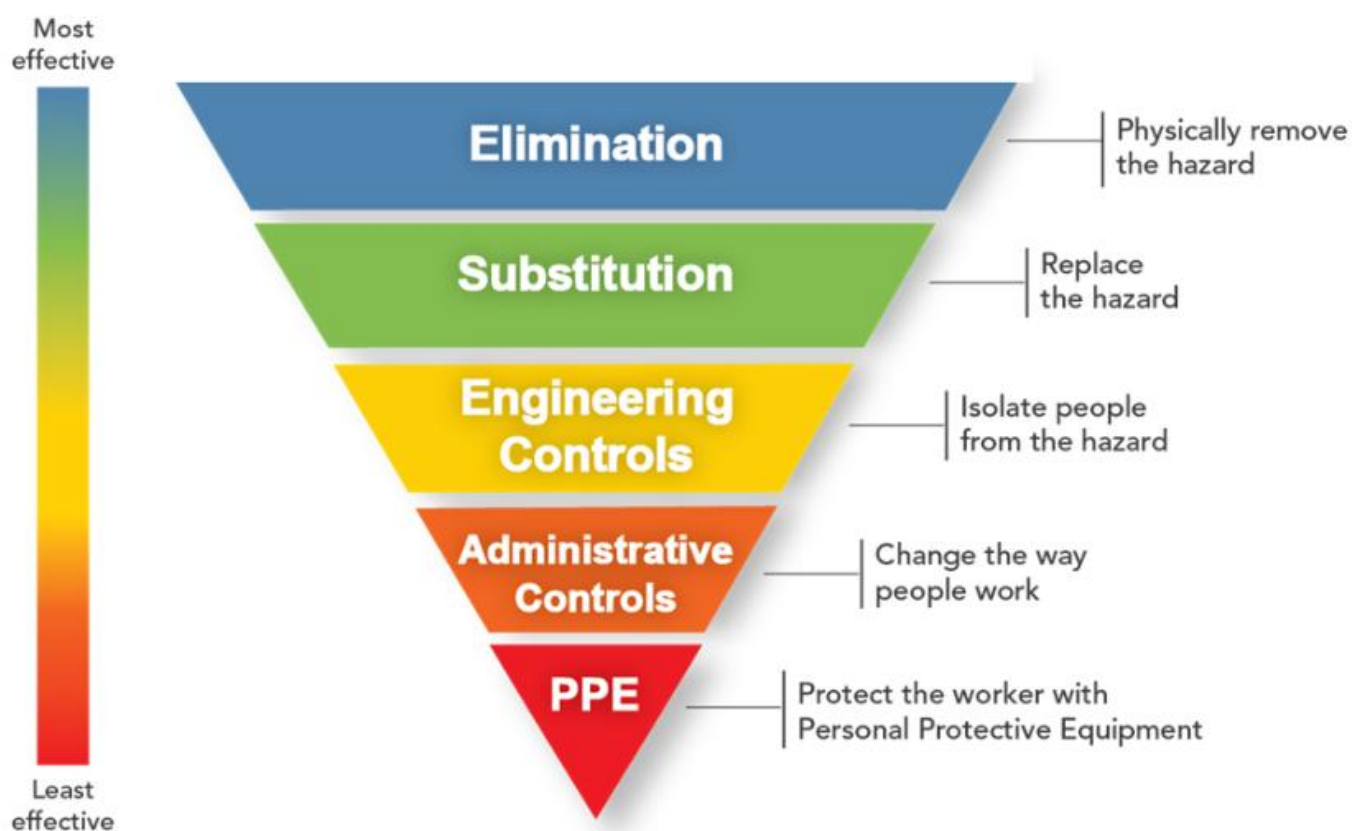
5.0 Safety

During the response to an incident, it is important that Ambulance Service personnel and Commanders undertake dynamic risk assessments. Using a system of hierarchical controls to ensure that the risk is effectively identified, mitigated, managed or control measures in place to allow effective treatment of casualties.

Dynamic Risk Assessments (DRA) are defined as:

“Dynamic risk assessment is a continuous process that involves the ongoing identification, assessment, control, monitoring, and review of risks. Unlike traditional methods, it does not rely on a fixed set of assumptions or a single point in time. Instead, it acknowledges the dynamic nature of risks and adapts to changing circumstances in real time.” (HSE, 2023).

Hierarch of Controls Risk control measures



This risk assessment starts from the initial 999 call and any further information/intelligence received from either partner agencies or other 999 calls where threats and hazards may be identified, documented and shared with responders.

Control Rooms have pre-established methods of communicating incident and risk information to partner agencies. This should be passed to other responding agencies via the Emergency Services Inter-Control (ESICTRL) talk group regularly to ensure a joint understanding of risk. The ESICTRL talk group is a TG that is mandated to be monitored 24/7 by dedicated blue-light agencies.

All completed risk assessments to be documented and retained once completed. These risk assessments may form evidence and are to be collated as part of the post-incident procedures.

Where applicable risk assessments should be undertaken jointing with multi-agency partners to capture pertinent information and subject matter expertise. The allocation of a Safety Officer should be considered to support risk management and apply appropriate mitigation, to ensure all responder safety.

Guidance for the process of undertaking a risk assessment is identified below, with specific reference to application to JESIP principles and joint working.



(JESIP Risk Assessment Model, 2026)

5.01 Rendezvous Points (RVP)

During an incident an RVP may be established where the immediate vicinity of an incident is unsafe. An RVP if established, should be communicated to all responders, including critical care assets. The RVP additionally should be shared with all partner agencies and circulated on the **ESICTRL** talk group.

The requirement for an RVP should be regularly reviewed, and if indicated, appropriately searched for other potential threats. However, this activity should not hinder the rapid deployment of responders to save lives.

Appendix 6 outlines guidance for the selection of an RVP.

5.02 Operational Discretion

Learning from previous major incidents outlines the requirement for flexibility in some circumstances to make effective decisions to save lives. Appendix 7 provides reference to specific NARU Command and Control guidance (2024).

5.03 Evacuation Signals

Should there be a requirement for rapid evacuation of staff from an incident site due to an identified risk to life for staff and patients the following signal should be used:

“Evacuate, Evacuate, Evacuate”. Using any available communication methods, including verbally (shouting). Additionally, continuous whistles also indicate the requirement to evacuate.

5.04 Move to CRITICAL

The United Kingdom Joint Terrorism Analysis Centre (JTAC) is responsible for setting the current threat level from terrorist activity. These levels are defined as following:

- LOW - an attack is highly unlikely
- MODERATE - an attack is possible, but not likely
- SUBSTANTIAL - an attack is likely
- SEVERE - an attack is highly likely
- CRITICAL - an attack is highly likely in the near future

Where the threat level is escalated to CRITICAL, the highest risk of an imminent terrorist attack SCAS can initiate additional security measures and response arrangements which are held within the Trusts “Move to Critical” Plan.

6.0 Operational Incident Communication

Internal Communication during the response to an incident, event or occurrence will primarily be via Airwave radio. All SCAS resources and commanders should have access to an Airwave radio to allow the effective passing of information from the scene to the control room and with partner agencies. Any Airwave talk group monitored within ICC will be recorded.

Alternative methods of communication include:

- Telephone & mobile phone
- Everbridge (Mass Communication tool)
- Microsoft Teams (video conferencing)
- Electronic data transfer via operational NMA devices
- GoodSam (video link)

The Trust utilising a range of Single Point of Contact (SPOC) numbers for commanders and advisors which can be utilised.

Everbridge can be utilised to undertake internal warning and informing. Utilising either pre-determined message templates for specific groups or incident types or allowing free text messages to be sent to either all SCAS staff or specific groups.

Everbridge is utilised to notify and mobilise Specialist Operations Response Team (SORT) responders and other specialist responders such as Communication Tactical Advisors and 7.5 Tonne vehicle drivers (used to mobilise some CBRN vehicles).

Contact details for key Commanders, Advisors and Managers can be found within the SCAS on call rota and are also held within the list of Everbridge contacts.

6.01 Interoperable Communication (Airwave)

Emergency Services Inter-Control Talk Group (ESICTRL):

The ESICTRL is a mandated multi-agency radio channel open to all emergency services control rooms and is monitored 24/7 365 days a year, which is tested by ICC monthly. This is the primary method of communication between agencies during the response to an incident; alongside other methods e.g. telephone.

During the response to a declared Major Incident- SCAS will ensure this talk group is monitored by an assigned operator within the control room following the JESIP co-ordinator action card and will share information being received by the organisation and those at the incident across this talk group in the M/ETHANE format.

Interoperable Talk groups:

SCAS can access a number of multi-agency talk groups via the airwave system. These are available to commanders and responding agencies to use to aid interoperability and should be considered in the response to an incident to assist in the sharing of situational awareness and joint understanding of risk. *Further advice should be sought from an Airwave Communications Tactical Advisor.*

Mutual Aid Talk Groups:

SCAS will nominate a mutual aid talk group for declared Major and Critical Incidents if required, to ensure that other Ambulance trusts that may be providing cross-border assistance are able to access information and effective communication with the SCAS control room. *Further advice should be sought from an Airwave Communications Tactical Advisor.*

A dedicated range of Airwave talk groups have been pre-defined for the initial stages of any incident requiring command and control. A set of talk groups have been defined for the North region (Thames Valley) and the South region (Hampshire) this allows adequate Airwave communications for two simultaneous incidents to be managed effectively.

MAJOR INCIDENT – DESIGNATED TALK GROUPS			
CHANNEL TYPE	ICC ROLE (Action Card)	NORTH	SOUTH
Resources	Resource Dispatcher	TG245	TG246
Command	Command Dispatcher	TG081	TG084
Emergency Services Inter-control (3ES INTR-CTRL – Must be monitored by ICC 24/7)	CSO/JESIP Co-ordinator (ICC ONLY)	TG243	TG243
ES1-ES3 (<i>Request via Police</i>)	JESIP Co-ordinator (once activated)	TG792-TG794 (TVP)	TG634-TG636 (HIOWC)
Mutual Aid	Mutual Aid Co-ordinator	TG248	TG249
PLATO Command*	Monitor for recording only	TG114	TG114
PLATO Resources*	Monitor for recording only	TG250	TG250

MANDATED TALK GROUPS	
NATIONAL CONTROL (VIA LIFEX TERMINAL ONLY) (Must be monitored by ICC 24/7)	TG069
SCAS Sharers Hailing (Must be monitored by ICC 24/7)	TG244
Emergency Services Inter-control (3ES INTR-CTRL) (Must be monitored by EC 24/7)	TG243

Communication Tactical Advisors (CTA):

Accredited via the College of Policing to provide reliable and consistent advice regarding the use of the Airwave digital radio systems. The Communications Tactical Advisor can provide tactical advice to mitigate network coverage and capacity issues. CTA have knowledge and expertise in the available radio talk groups including interoperability with partner agencies. Support can be provided for both pre-planned and spontaneous incidents which can be done remotely if required. They can support development of communication plans and should be included in the response at the earliest opportunity. CTAs can be contacted via the Trust's mass communication system, Everbridge. CTA advice can also be sort from partner agencies which holds the same accreditation.

Currently CTAs are available on a best endeavours approach, but a request can be made via Everbridge to access support if available.

7.0 Assessment

On receipt of an emergency call, the control room will start to assess the incident including seeking information from other agencies via ESICTRL. Information should be constantly communicated between agencies throughout the incident to ensure shared situational awareness.

It may become clearly apparent from the initial 999 call details that the incident meets the criteria to declare an incident. If this is the case, the incident should immediately be reviewed by the senior ICC Manager on duty and an early declaration be made.

The ICC based on the incident details may also refer to additional plans to support the assessment of the incident such as:

- Site Specific Plans
- Incident Specific Plans
- Business Continuity Plans
- Deployment guidance for specialist responders (HART, SORT, Critical Care)

Operational crews are encouraged to assess the scene upon their arrival using a “**Windscreen Report**”. Prior to leaving their vehicle they should contact ICC and provide an assessment of the scene from the windscreen, including potential number of patients, type of incident and other agencies on scene.



1: WINDSCREEN REPORT: Before leaving your vehicle, contact CCC via priority message to describe the incident, exactly as you see it.

2: (M/C)ETHANE REPORT:

M	Major or Critical Incident Declared? If not send an ETHANE message
E	Exact location of Incident
T	Type of Incident
H	Hazards-present and potential
A	Access/Egress- provide details of the best access and egress
N	Number and type of casualties (P1/P2/P3/Dead)
E	Emergency services on scene or required

Request CCC to contact the on-duty Ambulance National Interagency Liaison Officer (NILO) for further advice.

This report should then be followed by a full METHANE report as soon as practicable. Any METHANE reports received in the ICC should then be shared within the appropriate command structure, with other responders and partner agencies.

Where there is any doubt around decision making for the deployment of resources, specialist assets and declaring an incident. The duty Tactical Advisor can be contacted.

Following an initial METHANE report Commanders should continue to provide timely and pertinent updated METHANE reports proportionate to the type and pace of the incident they are dealing with.

7.01 Pre-determined Attendance (PDA)

Based on the type of incident declared the PDA provides guidance and support in the deployment decisions made by ICC and Commanders. The decision to deploy resources is dynamic and needs to reflect the unique needs of each incident. A careful balance needs to be made between the appropriate resourcing levels at the incident and the provision of resources to other “business as usual” emergency calls in the wider community. Such resources may be provided internally by the Trust but also with the support of mutual aid.

Suggested Resources Required	Incident							
	Business Continuity Incident Declared	Critical Incident Declared	Major Incident Declared	Marauding Terrorist Attack / Op PLATO	Hazmat / CBRN Incident			
					1-5 patients	6-10 patients	11-20 patients	20+ patients
Command & Support Resources:								
*Operational Commander	*	2	4	4	1	1	2	4
Operational Commander (HALO)		1 per ED	1 per ED	1 per ED		1 per ED	1 per ED	1 per ED
Tactical Commander	1	1	2	2		1	1	2
Tactical CBRN Commander						*	1	1
Tactical Advisor (NILO)	1	1	2	2	1	1	2	2
Strategic Commander	1	1	1	1			1	1
Strategic CBRN Commander							*	1
Executive On-Call		*	1	1				1
Medical Incident Advisor (MIA)	*	1	2	2		*	1	2
Command Support		1	1	1	*TA	*TA	1	1
Loggist	1	2	3	3			1	1
Communication Tactical Advisor (CTA)	*	1	1	1			1	1
Media / Communications Team	1	1	1	1	*	*	1	1
Specialist Resources:								
Specialist Practitioner (SP)		1	2	2		1	1	2
Enhanced Care / BASICS (where available)		1	2	2		1	1	2
Critical Care Teams (inc HEMS)		1	2	2		1	1	2
Hazardous Area Response Team (HART)		1	1+	1+	1	1	1	1+
Specialist Operations Response Team (SORT)				35	*TA	*TA	*TA	*TA
Incident Support Vehicle (MTA)		1	2	3			1	2
CBRN Lorry					*TA	*TA	*TA	*TA
Mass Casualty Vehicle (MCV)		1	2	2			1	2
Operational Resources:								
Double Crewed Ambulances (DCA)	The number of ambulances should be determined by the number of casualties at an incident. During initial stages of response, information is limited, EOC should deploy an appropriate response and make preparations to escalate / deescalate accordingly. Following additional information / METHANE reports from the scene or partner agencies: DCA can be deployed in line with the following guidance: - 1 DCA per P1 / P2 / non-ambulant patient - 1 DCA per 3 x P3 patients Note, these are references to triage categories (P1 P2 P3) and not priority of backup which uses a similar classification.							
Supporting Guidance	* = consider based upon incident type *TA = on advice of Tactical Advisor HART 1+ = consider cross-border assistance / mutual aid for further assets 1 per ED = one commander to each receiving ED to act as HALO							

7.02 Interoperable / Specialist Assets

Deployment overview of specialist responders for declared incidents		
Incident Type	Hazardous Area Response Team (HART)	Specialist Operational Response Team (SORT)
Mass Casualty Incident	✓	✓
Mass Decontamination (CBRN/HazMat)	✓	✓
Marauding Terrorist Attack (MTA)	✓	✓
Interoperable Capabilities: • High Consequence Infectious Disease (HCID) • Water Operations • Safe Working at Height • Confined Space • Unstable Terrain • Support to Security Operations	✓	
Other specific medical response & support to operational response	Guidance held by ICC	

7.03 Hazardous Area Response Team (HART)

The core role of HART:

- To clinically assess casualties in high-risk areas and provide initial clinical interventions
- To inform and implement the casualty management plan in high-risk areas
- To supervise the extraction of casualties from high-risk areas
- To provide NHS coordination of casualty management activities by other agencies working inside the high-risk area
- To provide medical cover for other agencies operating in high-risk areas in response to an emergency

HART will work in partnership with operations and/or partner agencies to support clinical care and extrication of patients safely.

HART Mutual Aid:

Assistance from bordering Trusts for the use of their HART teams can be requested directly to support local incidents when the SCAS HART team is either not available (committed) or has a longer run time. This process is undertaken via the ICC and advice can be sought from the duty Tactical Advisor.

Additionally, a formal request for HART mutual aid can be requested via the NACC and NHS Resilience and Emergency Capabilities Unit (NHSRECU) to support a large-scale response.

Appendix 8 identifies the locations of HART assets across SCAS and bordering Trusts.

HART Deployment:

Four HART personnel should be available or released and mobilised to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. This does not apply to pre-planned operations.

The standard will not apply if the nearest HART unit is already deployed dealing with a higher priority incident requiring HART capabilities. If the HART team is already deployed on an incident requiring specialist HART capabilities, the Trust should take steps to mobilise another HART team to the new incident (either from within its own geography or via national mutual aid) within 15 minutes of that call being received by the Trust.

Once a HART capability is confirmed as being required at the scene (with a corresponding safe system of work) SCAS should ensure that six HART personnel are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised. Confirmation of this requirement would usually come from; the HART Team Leader based on information from the call, one of the four HART Operatives already mobilised or from other emergency service personnel (including Ambulance personnel) in attendance at the scene. Delays in the deployment of all six HART staff could create a direct risk to the application of a safe system of work at the scene.

7.04 Specialist Operations Response Team (SORT)

SORT teams deploy to Marauding Terrorist Attack (MTA), mass decontamination (CBRN/Hazmat) and mass casualty incident.

There should be a minimum of 35 on duty between the hours of 0600 and 0200 daily, 365 days a year.

On receipt of an emergency call or notification by a partner agency of a potential incident requiring SORT deployment, NHS Ambulance Trusts should immediately identify all SORT staff on duty within their system and prepare to deploy those that are not committed at other incidents or that can be made available from lower priority calls. Refer to CBRN Operational Arrangements.

Once a SORT capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations should ensure that at least 30 SORT staff are allocated to respond to the incident (or a designated holding area) within 60 minutes. This includes the SORT staff that may have already been deployed and this can include off duty staff who have made themselves available through recall to duty. This is achieved through an Everbridge notification.

Any SORT staff available to respond in less than 60 minutes, should be tasked as quickly as possible. The 60 minutes is the total envelope in which a minimum of 30 SORT responders should be assigned to the incident.

SCAS can use less SORT staff to resolve a smaller scale incident without breaching this standard, providing the decision is based on clear information or intelligence indicating that 30 staff would not be required due to the nature or scale of the incident. Any decision to limit the number of SORT responders sent to the incident should be approved by a Tactical or Strategic Commander and should be clearly documented. The decision will be subject to external review post incident.

7.05 Mass Casualty Vehicles (MCV)

There are 24 Mass Casualty Vehicles which are strategically placed across England in the custody of English ambulance trusts.

SCAS currently has two MCV's based within the Operational area (appendix 9). Each vehicle holds enough equipment to treat up to 180 patients of varying clinical priority. There are nine Clinical Response Modules in total on each vehicle, each module will enable continued care for a minimum of 10x P1/P2 patients, and 10x P3 patients (20x patients overall). They include a mass oxygen system and additional drugs that can be used by clinicians at the scene or at a receiving hospital. They should be mobilised early to incidents involving multiple patients by a qualified driver and mobilised in line with the PDA or at the request of the tactical advisor.

NHS Ambulance Trusts should maintain appropriate mobilisation arrangements for the vehicles which should include criteria to identify any incidents or events which may benefit from the deployment of the asset(s). Trusts should ensure that their mass casualty vehicle (MCV) assets maintain a **30-minute notice** to move anywhere in the United Kingdom following a mutual aid request endorsed by ECU. An exception to this standard may be claimed if the MCV is already deployed at a local incident or is non-operational.

Appendix 8 identifies the locations MCV resources across SCAS and bordering Trusts.

7.06 Incident Support Vehicles (ISV)

The trust has a range of Incident Support Vehicles (ISV's) which are strategically located across the trust. These are part of the pre-determined attendance (PDA) for Major and Critical Incident, providing additional equipment including CBRNe equipment, stretchers, and equipment for SORT responders.

Appendix 9 identifies the locations specialist assets across SCAS.

8.0 Triage

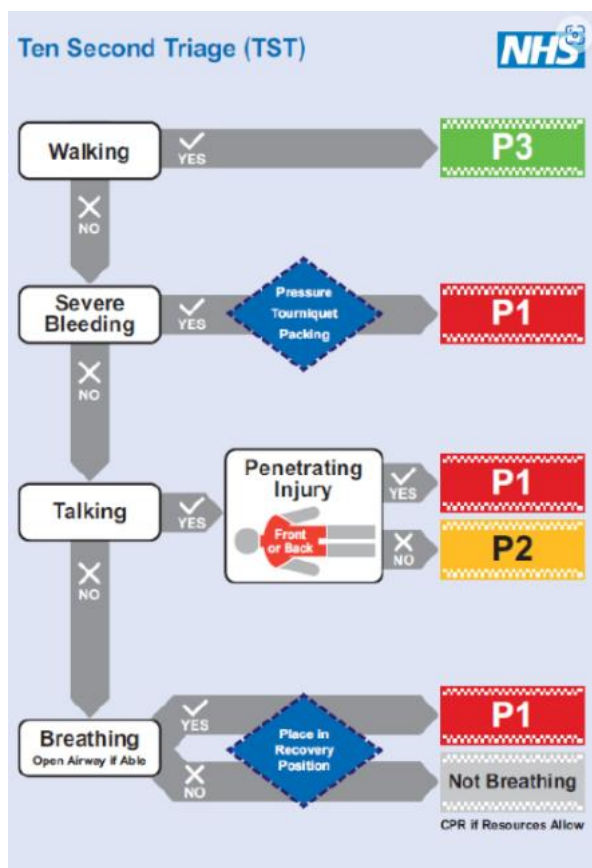
8.01 Ten Second Triage (TST)

TST is the primary scene triage tool that has been developed for use by all first responders to any incident with multiple casualties. Primary scene triage is used in multiple casualty incidents to identify the most severely injured casualties, prioritise those who need immediate lifesaving interventions (LSI) and help to guide evacuation decisions.

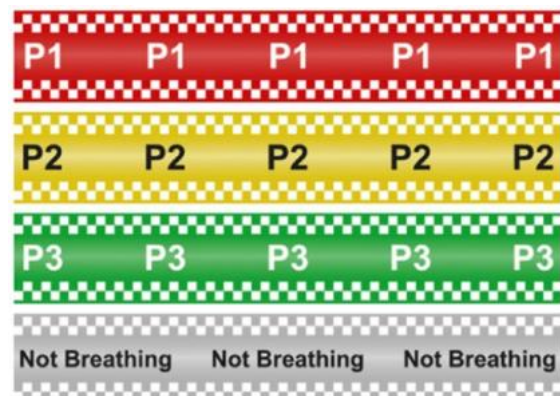
TST is recommended as the first line prehospital triage tool for all emergency services including the Ambulance service. It should be used by all responders until all casualties have received a TST assessment and tag or until senior clinical decision making is available on scene.

All casualties will be marked with the nationally agreed method of labelling casualties. SCAS uses SmartTriage™ TST tags, which are attached to the patient conforming to the NHS England colour, visibility, and size requirements. TST is not a “once only” assessment. Responders should re-triage if a casualty’s condition has changed during reassessment, removing the original TST tag and replacing it with the new category.

The tactical situation will affect when re-triage will be possible but on average approximately every 15 minutes is a reasonable starting point (especially if waiting for stretchers and / or sufficient responders to evacuate casualties).



TST Colours and Tags



TST Priority	Colour	Description
1 (Immediate)	Red	Requires life-saving treatment immediately and has time critical life-threatening injuries.
2 (Urgent)	Yellow	Requires significant intervention as soon as possible.
3 (Delayed)	Green	Requires medical intervention but not with any urgency. Can walk to treatment.
Not breathing	Silver	Breathing not detected. This group requires urgent clinical review in situ to decide if the casualty is amenable to resuscitation or not.

Once TST has been completed and casualties are being extricated to a Casualty Collection Point (CCP) or a Casualty Clearing Station (CCS) the main decision for the Ambulance Commander at the scene of the incident will be whether to follow up TST with:

1. Business As Usual (BAU) -standard clinical practice.
2. Major Incident Triage Tool (MITT)

This decision should be made in conjunction with input from the Medical Advisor where appropriate and logged accordingly.

8.02 Major Incident Triage Tool (MITT)

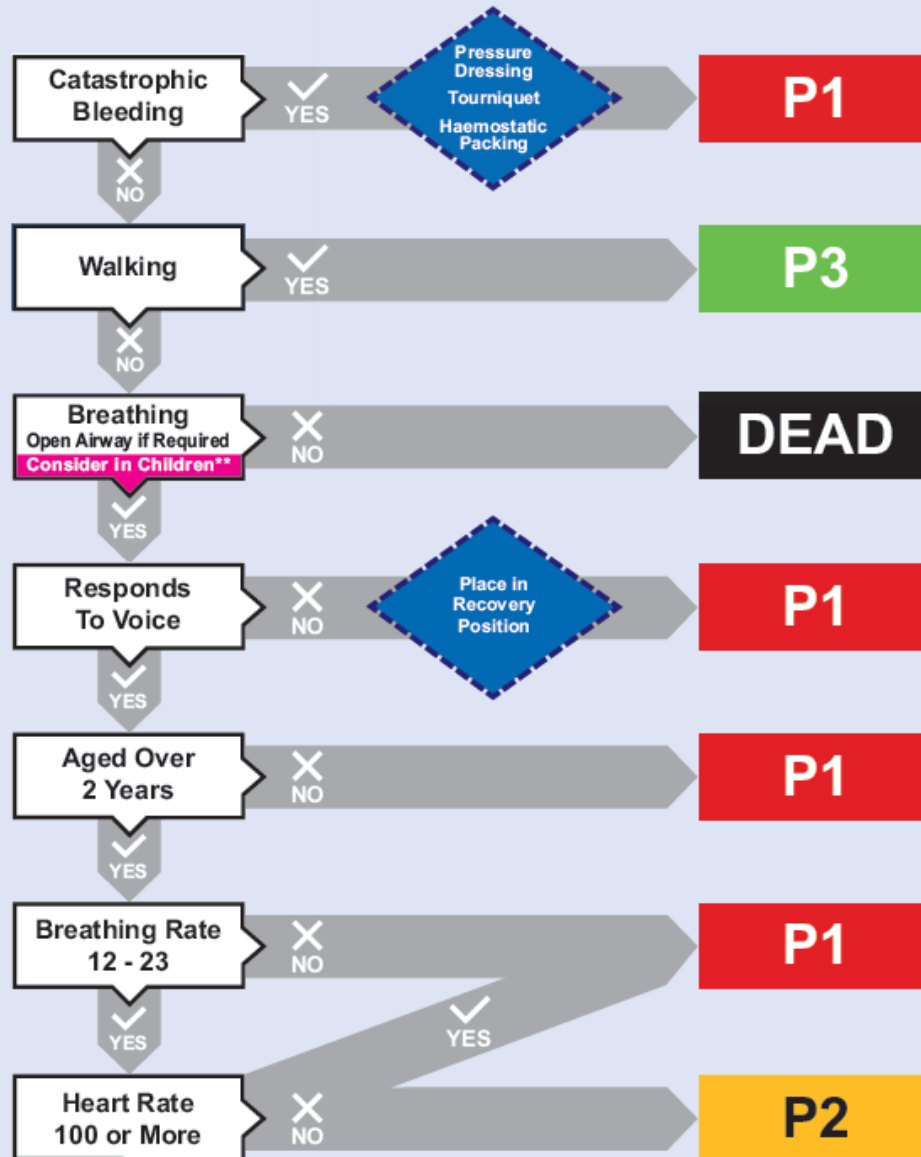
The NHS MITT has been designed and validated as a unified replacement to the NASMeD Triage Sieve, Sort and Paediatric triage tape that can be used **by clinically qualified healthcare responders** (Doctor, Paramedic, Nurse, AAP) **after** TST and when sufficient resources allow. It is possible that MITT will not be used at all incidents.

Those who have had MITT undertaken will be re-labelled using the existing SMART Triage Tag based on their triage category; this labelling conforms with the NHS England guidance for casualty labelling.



**Casualty
Labelling
Products
(MITT)**

NHS Major Incident Triage Tool (MITT)



**** In Children (<12 years) who are not breathing****
If resources allow, consider 5 Rescue Breaths if: Submersion / Immersion / Smoke Inhalation

MITT Priority	Colour	Description
1 (Immediate)	Red	Casualties who require immediate life-saving interventions (Advanced Life Support and/or primary surgery within 2 hours).
2 (Urgent)	Yellow	Casualties who require surgical or other interventions within 2-4 hours.
3 (Delayed)	Green	Casualties whose treatment may be safely delayed beyond 4 hours.
Dead	Black	Casualties who have been triaged as 'Not Breathing' and not amenable to resuscitation or ongoing resuscitative measures that are available on scene are likely to be futile, then the casualty should be labelled with a black 'DEAD' tag. If resources allow, this should be done with a formal Verification of Death (VOD).

8.03 Survivors

Any individual found at the scene of a major incident that has been involved but not injured, should be directed to a place of safety, and asked to remain there until their welfare can be confirmed and their details collected by the police. There is no requirement to triage survivors using Ten Second Triage. Such individuals may not be physically affected but may need other support in respect of their exposure to traumatic circumstances. They may also prove to be vital witnesses for the police in any subsequent investigation.

8.04 Mass Casualty Incident Assumptions

National NHS England guidance provides planning assumption for a mass casualty incident that outline the proportion of patients by category that may be expected:

Priority 1 (P1)	25%
Priority 2 (P2)	25%
Priority 3 (P3)	50%

These assumptions are broadly based on historical data, so each incident will be different, but this may help guide planning assumptions.

8.05 Management of the Deceased

It is essential that patients who have been triaged as “not breathing” are reassessed by a clinician as soon as possible. If a patient is assessed and triaged as “Dead”, the clinician must record the time this decision was made and other key information within the triage card such as date, time location, and clinician details. This triage card should be visible to other responders. The Verification of Death process must be undertaken for all dead patients when resources allow.

Triaging a casualty as dead can be undertaken in situ (after TST Not Breathing') or at the CCP, where an injured casualty may subsequently die of their injuries.

Where casualties are declared dead in situ, staff should remain forensically aware that the casualty is now part of a crime scene and should not be moved. The only exception to this would be to move the deceased patient out of the way to facilitate access to another living casualty.

As part of the JESIP multiagency meetings, the Ambulance Commander should update partner agencies of casualty numbers and triage categories, including the number of deceased. This should include the location of any patients who have been triaged as dead. Where living patients brought to the CCP subsequently die from their injuries, the Ambulance and Police commanders should jointly nominate a Body Holding Area at the incident to which these casualties should be moved to.

The decision to cover any dead bodies should be made jointly between the multiagency commanders, considering the need to maintain dignity to the deceased from public view, the welfare of responders operating near deceased casualties and environmental considerations.

Once Verification of Death has been established, the casualty passes to the coronial process and police. It is not standard practice for SCAS to convey deceased patients to a mortuary but may be undertaken in some exceptional scenarios. The decision to do so should be agreed by a Tactical Commander and documented accordingly. SCAS ambulances and specialist incident support vehicles do not carry standard body bags.

9.0 Treatment

9.01 Duty of Care

Ambulance clinicians have a duty to provide care to their patients but establishing exactly how that duty applies to some emergency situations can be challenging.

The duty of care represents moral, professional and legal obligations. The moral obligation to provide care is a matter of individual and social conscience. The professional obligation arises from the clinician's professional registration and organisational procedures or national practice guidelines. The legal obligation arises from several sources which are summarised in "The Duty of Care for Ambulance Responders NARU April 2021 Version 2.0".

9.02 Treatment Locations

Casualty Collection Point (CCP): The CCP is considered as a place for patients to be extricated away from areas of danger or to provide initial clinical input prior to being extricated to a designated casualty clearing station or definitive care.

Casualty Clearing Station (CCS): A CCS may be established, if there is the requirement for several patients to be treated whilst awaiting transport to definitive care. The CCS should be overseen by a Casualty Clearing functional commander and supported by appropriate medical advisors.

Ambulance Loading Point (ALP): Located in a safe area at/near the scene of an ambulance to load patients onto ambulances for conveyance to hospital.

Survivor Reception Centre (SRC): The police working alongside the Local Authority are responsible for the management of the SRC. Those who have been affected by the incident, including potentially walking/wounded may present at the SRC. The Tactical Commander should ensure there is, if required, appropriate medical provision at this site. This could include the use of Community First Responders (CFR) if appropriate. Any patient that presents at an SRC should be appropriately triaged.

Rest Centre (RC): A rest centre may be established by the Local Authority for the management of those who are not directly affected by the incident but may be indirectly affected e.g they have been evacuated from their property due to being within a cordon.

9.03 Critical Care

SCAS works in partnership with Hampshire and Isle of Wight Air Ambulance and Thames Valley Air Ambulance to deploy Helicopter Emergency Medical Services (HEMS) and Critical Care assets by road. HEMS providers operate 0700-0200 each day.

All Critical Care assets (including HEMS) follow and work under the command of SCAS.

SCAS also operates a BASICS scheme for volunteer Doctors and Paramedics with enhanced skills. The ICC can activate BASICS responders through internal notification processes.

Critical Care cross-border assistance and mutual aid (see section 10.6) requests can be made with appropriate authorisation based on incident requirements.

During an incident, critical care desk operatives will liaise with other critical care providers neighbouring SCAS. The critical care desk should use the appropriate Action Card within the control room to ensure that the response to an incident is co-ordinated effectively and proportionate to the incident.

10.0 Transport

Within the ICC a patient flow co-ordinator role will be established in the early stages of an incident, this role is key to ensuring casualties are distributed to the appropriate hospital for their condition. This role will allocate hospitals according to the casualty distribution model. Casualty Clearing Officer or if a loading officer has been established should ensure a link with this role to ensure that patients are distributed appropriately to nominated hospitals.

10.01 Patient Flow Co Ordinator

The Patient flow co-ordinator based in ICC will nominate hospitals based on the casualty dispersal model and with advice from the Medical Advisor and Tactical Commander. The patient flow-coordinator is responsible for contacting hospitals to advise. When notifying an acute hospital of an incident, it is essential that the dedicated “major incident” telephone numbers are utilised, and a full METHANE report is provided to enable the Command team within the hospital to make an informed decision as to what internal action and declaration they will in turn make. The messaging should be standardised and follow the format as per the NHS England EPRR Framework 2022.

A predefined Patient Dispersal Model identifying pre-agreed capacity estimates for receiving patients is identified in Appendix 10. This model was jointly produced with SCAS and the regional trauma networks. It identifies the number of patients by category (P1/P2/P3) that each acute hospital anticipates being able to safely accept within the first 2 hours of an incident.

10.02 Use of Helicopters/Aircraft

The two Air Ambulance charities operating in the SCAS region use aircraft which can be used to transport patients/critical care teams to/from the incident site. Commanders should consider requesting additional air assets if required through agencies including His Majesty's Coastguard (HMCG) if patients/or staff require rapid extrication or to minimise the time to reach definitive care. HMCG can be contacted through ICC.

It may be necessary for a combined tactical air cell to be established to manage multi-agency air assets at the scene of an incident and further guidance can be sought through [JESIP Combined Tactical Air Cell Guidance](#).

10.03 Other Transport Considerations

During the response to an incident, it is likely that other transport options may be available to commanders to consider. This could include public transport, local authority transport, voluntary agencies, these options are not recommended but commanders should consider the risk vs benefit of utilising these options and the impact on reaching definitive care.

Prior to using any other transport options commanders should ensure;

- Patient have been appropriately triaged and labelled appropriately prior to placing patients on other transport.
- Clinicians are made available on that mode of transport at an appropriate ratio.
- All other transport options have been exhausted.
- The receiving unit needs to be made aware that several patients may be arriving via an alternative method e.g multiple patients on one vehicle. This includes urgent treatment centres and minor injury units, where confirmation of acceptance is required based on clinical presentation.
- Each patient has a separate patient record completed.

10.04 Private Providers & Voluntary Aid Sector

SCAS maintains a limited number of Private Ambulance Provider contracts. These providers can be requested to provide additional support.

The national St John Ambulance auxiliary contract was not renewed by NHS England as of 2025, but contact can be made with St John Ambulance directly to request support.

Local Resilience Forums additionally coordinate a wide range of voluntary aid providers ranging from humanitarian assistance, search and rescue and welfare support. Requests for such support would be via a Tactical Coordinating Group (TCG).

10.05 Adult Regional Critical Care Transfer Service (ARCC)

The trust Adult Critical Care Transfer Service will assist the trauma network in ensuring patients are transferred between hospital facilities. The team will not deploy directly to the scene of an incident.

10.06 Mutual Aid

Mutual Aid vs Cross-border assistance: Cross-border assistance is the routine sharing of resources and requests to support the timely response to patients day to day. Mutual Aid is the formal mechanism used to request additional resources when the host service is unable to maintain effective service delivery without external support. Cross-border assistance can be requested and coordinated locally, whereas a Mutual Aid request should only be authorised by the Trusts Strategic Commander and formally made via the National Ambulance Coordination Centre (NACC).

SCAS can request Mutual Aid for additional resources, which may include ambulance crews and interoperable responders such as HART/SORT. A mutual aid request will be authorised by the Trust Strategic Commander and be directed to the National Ambulance Coordination Centre (NACC).

Contact will also need to be made with NHSRECU to support this coordination, particularly around specific support for interoperable capabilities. The ICC hold contact details and the activation process for the NACC.

The process for requesting mutual aid is outlined within the most recent NACC plan.

10.07 Multi-Agency Strategic Holding Area (MASHA)

A MASHA may have been pre-identified as a mustering point for mutual aid. They should have suitable space and facilities to accommodate large numbers of vehicles, equipment and staff.

10.08 Patient Transport Service (PTS)

PTS helps sustain the wider system by managing non-emergency patient movement, supporting hospital flow and can if agreed support low-acuity transfers allowing emergency ambulances to respond to the incident. PTS will be alerted as part of the incident cascade and requested to support the incident response. This may include providing representation in the ICC to support the response and work under the direction of the Trust Tactical Commander.

10.09 Non-Emergency Driving

Reference should be made to the Trusts guidance for driving of Trust vehicles. Specifically in reference to non-SCAS staff such as Police Officers driving Trust vehicles.

11.0 Administration

11.01 Record Keeping

Patient Records:

It is imperative that all patients receive a patient care record, this includes patients that meet Verification of Death (VOD) criteria.

This should include images of any triage tags or supporting documentation taken and documented via the ePR. Responders must ensure no images of the deceased are included within the picture.

Every patient seen and assessed by SCAS has an individual record completed. In the event of technology failure, responders resort back to paper patient report forms.

Incident Log (CAD system):

ICC should maintain a running log of decisions and actions within the dedicated CAD system. Command teams who have access to add notes to this system can ensure they document any key actions in both the CAD system or the trust issued Logbook.

Logbooks:

All commanders log decisions at an incident in a trust issued logbook. This includes actions/decisions at pre-planned events and exercises. The logbook is signed off by the commander and sent to the Resilience administrator for safe and secure retention, to ensure accurate tracking. The unique logbook reference number should be added to the CAD system and the logbook submission portal on the hub used to submit the logbook. Further guidance relating to Logbook submissions can be found within the Trusts Command policy.

Other documentation:

Any documentation not already listed should be retained as it may become evidence and a vital record for any internal/external investigation. This includes public inquests and criminal or civil proceedings. Other documentation may include (not limited to):

- Risk assessments
- Written notes
- Body worn camera footage
- Emails/text messages
- Call recordings

Some of these will already have pre-defined processes for capturing and storing information. Any records will need to be centrally retained and stored, with the Resilience and Specialist Operations team leading this process.

Consultation with the Trusts Information Governance and Legal teams may also be required to ensure appropriate and proportionate information capture.

Personal Accounts:

All staff who are involved in a major incident, should be encouraged to write a personal account immediately after the incident to document their actions and any immediate lessons, whilst fresh in their mind. These personal statements will assist in the Post Incident Procedure process and may be submitted as part of an inquiry.

Retention Period:

The minimum retention timeframe for decision logbooks and incident related documents including plans and organisational structures, paper and electronic records is 30 years. (NHS England EPRR Framework, 2022) However, public inquiries have been made beyond this timeframe and therefore documentation may be required to be retained beyond this timeframe. Further guidance in appendix 11.

It is important to note that Information Governance policies within the Trust dictate that specific records will expire prior to this timeframe and may be destroyed. We therefore need to review all pertinent documentation and ensure it is appropriately stored and accessible beyond the retention timeframes specified within Trust policy in some circumstances.

Consideration should also be given to access to legacy systems (such as CAD) and technologies that may in future become redundant and inaccessible.

11.02 Post Incident Procedure (PIP)

The Trust is currently in the process of developing a PIP framework. The PIP Framework details a number of actions that can be undertaken following an incident which are scalable. This means they can be used to support post-incident activities across a broad range of incidents - from small scale debriefs, up to and including a full in-depth review following a major incident. Each incident should be considered on its own individual circumstances and post-incident actions undertaken proportionately as deemed necessary. These should be agreed with the tasking Strategic lead where one has been appointed.

The framework covers post-incident activity under 4 main pillars:

1. Staff welfare & Support
2. Debrief activity
3. Identifying learning
4. Securing evidence and preparing for scrutiny

All staff are expected to contribute to debrief activity where possible and a range of debrief options are available for use. The purpose of debriefing is not to apportion blame for any mistakes or errors made. Debrief activity should be undertaken to understand what happened during an incident, to identify any learning and to provide closure for those involved in the response. Any learning identified will be logged and used to improve existing Trust processes, policies & plans with the overarching aim of continuous improvement. A debrief tracking function exists via the RSO page on the Hub to support this.

To support the Trust to secure any support evidence, where a personal account has been requested, staff should be given protected time to complete these within 48 hours. Commanders are also expected to provide their completed logbooks, written risk assessments & Tactical plans within this timeframe. A logbook submissions function exists via the RSO page on the Hub to support this.

Hot Debrief:

A hot debrief should occur immediately after the incident or period of duty but within 48 hours of stand down, which is likely to be completed by an operational or tactical commander. This debrief should include all relevant staff, where possible, including utilising technology such as MS teams to ensure that ICC are included. This is centred around the welfare of staff and any safety critical learning. Welfare checks for all those involved in the incident should be undertaken at the earliest opportunity by an appropriate manager.

Cold Debrief:

A cold or structured debrief should occur within 28 days post incident. This can be arranged by the Resilience and Specialist Operations department.

Multi Agency Debrief:

The multi-agency debrief should be arranged within 8 weeks of the close of the incident. The lead organisation will be responsible for arranging this debrief in partnership with the Local Resilience forum via the Continuous Improvement Group (CIG).

Post-incident report should be completed within 4 weeks of the debrief taking place.

The above is taken from the NHS EPRR Framework 2022.

Lessons identified are captured through debriefing and training and exercising internally and externally with our partner agencies. This allows the Trust to review plans and processes to embed learning through continuous improvement. Once gathered, the Trust actively review Joint Organisational Learning submissions and share these with trust staff. See JOL process in appendix 12.

12.0 Risk

12.01 National Risk Register

The National Security Risk Assessment (NSRA) covers a wide range of key national risks that category 1 responders consider in risk assessment and mitigations with emergency plans. This document is marked as Official Sensitive and can be accessed on Resilience Direct through the Local Resilience Forum.

12.02 Threat Assessment

The Joint Terrorism Analysis Centre (JTAC) is the UK's independent authority for all-source terrorism assessment. JTAC is based within MI5 and reports to the Director General, but their assessments are made independently. JTAC sets the national terrorism threat level and issues warnings of threats and other terrorism-related subjects to government departments and law enforcement. The current threat level can be found on the JTAC Website: [Threat Levels | MI5 - The Security Service](#).

13.0 Stakeholder Communications

There is a legal obligation under the Civil Contingencies Act (CCA) to warn and inform the public during a major incident. The main considerations should include who needs to be communicated to (all stakeholders including those directly affected and wider audiences both internally and externally) and outline the desired communications outcome (compliance; reassurance).

The SCAS communications team will lead on internal and external stakeholder communications for all major incidents. An incident specific plan will be agreed with the strategic and operational commanders. Sign-off on all messaging will sit with the strategic commander.

Operational communication to staff directly involved in the incident remains the responsibility of the incident commanders. See section 6 for details.

Contacting the SCAS communications team

The communications team can be contacted 24/7. When a Major Incident is declared the on-call communications lead **must be paged using 07623 957 895** stating “MI declared” and requesting an urgent call back.

The email address oncallmedia@scas.nhs.uk can be used for on-going communication once initial contact has been made and basic information past to the on-call media officer verbally.

Media Advisory Cell (MAC):

In the event of the activation of Emergency Response Arrangements (ERA) within either Local Resilience Forum, a Media Advisory Cell will be established. SCAS are part of these arrangements to support a comprehensive and consistent multi-agency response to ensure appropriate, and accurate communications to/with staff/volunteers, partners media and the public.

External communication

Coordinating with MAC, the SCAS communications team will manage all external communications including Warning and Informing the public as per the Civil Contingencies Act (CCA) 2004.

The team are responsible for the strategic advice and operational delivery of external communications including social media activity, drafting and releasing of press releases, coordinating press conferences etc. They will agree appropriate operational spokespeople with the incident commander.

Internal communication

It is essential to keep our wider workforce informed during a major incident. The communications team will lead on this aspect of communications, in agreement with the Strategic Commander.

A range of internal channels controlled by the communications team and cascade routes via line managers are available. Relevant channels will be used depending on the nature of individual incidents.

Everbridge: If necessary, the Everbridge system can be used for mass notifications to all staff. Urgent operational alerts to staff can be sent without communications team involvement. Wider use of Everbridge for general messaging should be agreed with the communications team.

14.0 Humanitarian

The **Human rights Act 1998** is a significant piece of legislation in the United Kingdom.

Its key provisions are:

1. **Convention Rights**: The Act gives further effects to the rights and freedoms guaranteed under **European Convention on Human Rights (ECHR)**. These rights include fundamental principles such as the right to life, freedom of expression and protection against torture and inhuman or degrading treatment.
2. **Interpretation of the Convention Rights**: The Act ensures that the ECHR rights are directly enforceable in the UK. It allows individuals to rely on these rights in domestic courts, rather than having to go to the European Court of Human Rights (ECtHR) in Strasbourg.
3. **Acts of Public Authorities**: Public authorities, including emergency services such as the police, ambulance service and fire departments must follow the Human Rights Act. If a public authority breaches an individual's human rights, legal action can be taken under the Act.
4. **Freedom of Expression and Thought**: The Act protects freedom of Expression and thought, allowing individuals to express their opinions and beliefs without unwanted interference. It also safeguards the right to hold personal convictions and religious beliefs.
5. **Derogations and reservations**: while the Act upholds most ECHR rights, it allows for certain derogations (temporary exceptions) and reservation (limitations) in specific circumstances. These provisions strike a balance between protecting rights and addressing exceptional situations.

All those involved have Article 2 Rights to Life. This includes patients, assailants, responders and members of the public.

All casualties should be treated with the same level of care (NHS Duty of Care 2005)

Staff welfare

Across SCAS there are several welfare and support options available to support staff following such events, which are accessible via the following. More details on the Hub within the Health and Wellbeing page.

- Occupational Health – Optima Health
- Employee Assistance Programme
- Trauma Risk Management (TRiM)
- Clinical Lead, Mental Health, and Learning Disabilities
- Mind Blue Light Programme
- The Ambulance Service Charity
- Sustaining Resilience at Work (StRaW)

15.0 Appendices

15.01 Appendix 1 – Accountable Emergency Officer (AEO) Role & Responsibilities

The NHS Act 2006 places a duty on relevant service providers to appoint an individual to be responsible for discharging the duties under section 252A (9), outlined below. This individual is known as the AEO.

NHS England expect all NHS-funded organisations to have an AEO with regard to EPRR. Chief Executive Officers (CEOs) may designate the responsibility for EPRR as a core part of their organisation's governance and its operational delivery programmes. CEOs will be able to delegate this responsibility to a named director. The AEO will be a board-level director (or equivalent in organisations without a board) responsible for EPRR. They will have executive authority and responsibility for ensuring that the organisation complies with legal and policy requirements. They will provide assurance to the board that strategies, systems, training, policies, and procedures are in place to ensure their organisation responds appropriately in the event of an incident. AEOs will be aware of their legal duties to ensure preparedness to respond to an incident within their health community to maintain the public's protection and maximise the NHS response.

Specifically, the AEO will be responsible for ensuring that their organisation:

- Itself and any sub-contractors are compliant with the EPRR requirements as set out in the CCA 2004, the 2005 Regulations, the NHS Act 2006, the Health and Care Act 2022 and the NHS Standard Contract, including the NHS EPRR Framework and the Core Standards.
- Is properly prepared and resourced to deal with an incident itself and any sub-contractors it commissions have robust business continuity planning arrangements in place that align to ISO 22301 or subsequent guidance that may supersede this.
- Due diligence should be completed during contracting of supplier, with an ongoing assurance process and partaking in exercising of business continuity planning as outlined in the NHS procurement Framework.
- Has a robust surge capacity plan that provides an integrated organisational response and has been tested with other providers and partner organisations in the local area served.
- Complies with any requirements of NHS England, in respect of monitoring compliance provides NHS England with such information as it may require for the purpose of discharging its EPRR functions.

Is appropriately represented by director-level engagement with and effective contribution to any governance meetings, sub-groups or working groups of the LHRP and/or LRF, as appropriate.

15.02 Appendix 2 – NHS England Incident Levels

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

15.03 Appendix 3 – Ambulance Service Strategic Objectives

AMBULANCE SERVICE STRATEGY

It is the intention of the Ambulance Service Provider to respond to and manage the ongoing incident in a way which promotes and saves life, reduces humanitarian suffering and is compatible with the vision and values of the Ambulance Service Provider. Through effective coordination, sound planning and good leadership the Strategic Commander will:

1. Maintain public confidence and minimise the impact of the incident by ensuring that the Ambulance Service Provider is responding effectively to the incident.
2. Ensure that the Ambulance Service Provider response is coordinated and integrated with the wider health and responding agencies.
3. Maintain effective capacity management within the Emergency and Non-Emergency Service, and the Emergency Control Rooms, by:
 - a. Assessing and identifying any gaps in the response capability of the organisation for dealing with this incident.
 - b. Identification and request for mutual aid.
4. So far as is reasonably practicable, take all measures and employ all appropriately identified control measures to safeguard the following people under the terms of Health and Safety Legislation:

Ambulance staff and other responders

Local communities
5. Ensure public messages are coordinated with other agencies and partners.
6. Ensure effective Business Continuity and Recovery arrangements are in place across the organisation and review where necessary.
7. Provide support and representation at the sub-regional level where appropriate.
8. Create and maintain a well documented, auditable plan and decision log for the incident at all levels of command.
9. Review this strategy every 4 hours.

(NARU Command and Control Guidance, 2024)

15.04 Appendix 4 – Recommended Escalation Criteria

Criteria	Operational Commander	Tactical Commander	Tactical Advisor/ NILO	Strategic Commander	On call Executive Director	Command Support Team	Media On-Call
Business Continuity Incident	✓	✓	✓	✓	✓	✓	✓
Major/Critical Incident	✓	✓	✓	✓	✓	✓	✓
Multi-Agency / Multi-Casualty Response	✓	4+ serious or 10+ casualties					✓
High Risk Incidents (e.g. Fires, Water, Firearms, Railway, Aircraft, suspect packages)	✓	✓	✓			MTA	✓
CBRN / Hazmat Incidents	✓	✓	✓	✓		Mass Decon	✓
High Media Interest / Reputational Impact	✓	✓	Consider	✓	✓		✓
Staff or patient Injury	✓	Serious injury / Death	Serious injury / Death	Serious injury / Death	Serious injury / Death		✓
Hospital queueing / escalation	✓	✓			✓		✓
SCAS Vehicle/Estate Incidents (eg. Theft/RTC/Fire/Break in)	✓	Serious Incident			Serious Incident		✓
Mutual aid requests/deployment of cell	✓	✓	✓	✓			✓
Intelligence led Police operation	At TacAd request	At TacAd request	✓				✓
Any Mass Evacuation	✓	✓	✓	✓	✓		✓
Activation of Strategic or Tactical Coordinating Group		✓	✓	✓			✓
Electronic Personal Dosimeter which has alarmed			✓				

15.05 Appendix 5 – Functional roles (Definitions and diagram provided by NARU Command & Control guidance 2024)

The Operational Commanders' responsibilities in line with their Minimum Occupational Standard performance criteria are:

Ambulance - Safety Officer

Responsible for the health and safety of all NHS responders entering and working within the cordons of the incident. The Ambulance Safety Officer will work closely with the Operational Commander ensuring appropriate control measures are employed to mitigate against identified risks through the risk assessment process. The Safety Officer should, where possible, work alongside the Safety Officers of the other agencies.

Ambulance - Primary Triage Officer

Responsible for coordinating the initial Ten Second Triage (TST) of all casualties at the incident. The Triage Officer should work closely with the Casualty Clearing Officer (CCO). Dependent on the size of the incident, there may be a requirement to allocate an Officer for Primary and Secondary triage. The Triage Officer is responsible for maintaining a record of the number and categories of casualties triaged.

Ambulance - Casualty Clearing Officer (CCO)

A Casualty Clearing Station (CCS) should only be considered if there is an unacceptable delay in patient transportation. Responsible for the management of the CCS, they work closely with the Triage, Parking and Loading Officers and the Casualty Clearing Medical Lead (CCSML) to ensure an efficient triage and treatment of all casualties, and the appropriate use of available transport resources. The CCO is responsible for keeping a log of the number and categories of casualties who pass through the CCS.

Ambulance - Secondary Triage Officer

Responsible for coordinating the secondary triage using NHS Major Incident Triage Tool (MITT) of all casualties within the CCS. The Triage Officer should work closely with the CCO and Medical Advisor. The Triage Officer is responsible for maintaining a record of the number and categories of casualties triaged and the regular re-triage of casualties (at least every 15 minutes).

Casualty Loading Officer

The Loading Officer works very closely with the Casualty Clearing Officer (CCO) to ensure that casualties who require transportation from the CCS are accommodated. The Loading Officer is responsible for keeping a log of the number and destinations of casualties transported from the CCS.

Ambulance - Equipment Officer

The Equipment Officer will ensure the supply and re-supply of equipment to all responding NHS resources.

Ambulance – Casualty Liaison Officer

Responsible for communicating agreed messages to groups of casualties. They will liaise with the Ambulance Command team to ensure consistent messages are relayed.

Hospital Ambulance Liaison Officer (HALO)

Assists at A&E Departments to maintain efficient ambulance turnaround and re-equipping of ambulances. They will also liaise with the police documentation teams. An important role is to arrange relief for members of staff suffering from fatigue or stress on arrival at the hospital. The Hospital

Ambulance Liaison Officer (HALO) will liaise with the hospital Management Team to ensure it is aware of the hospital's capability to receive casualties and relay information back to the Emergency Operations Centre. This officer's job is to also keep EOC updated with the current status of the hospital's Resus Bays, Theatres and ITU.

Hazardous Area Response Team Leader (HART)

The HART Team Leader will provide direct line management for all HART resources; they will report through to the Operational Commander ensuring they carry out the objectives of the Ambulance Service response in line with the Tactical Plan.

Sector Commander

It may be necessary to divide an incident into different sectors. Where this is the case each sector should have a sector commander. This will reduce the number of reporting lines into the Operational Commander ensuring the span of control is not exceeded.

When deploying a sector commander to a complex incident involving the interoperable capabilities (HART / SORT) such as a collapsed structure or working at height, the sector commander must be qualified and competent in the specific capability being deployed.

Casualty Clearing Station Medical Lead (CCSML)

Responsible for coordinating, supporting and advising paramedics and medical staff in the Casualty Clearing Station (CCS) to optimise the clinical care of all casualties attending the CCS and appropriate onward journeys to suitable receiving hospitals.

Ambulance - Forward Doctor

Responsible for ensuring the most appropriate medical management of casualties is undertaken within the area they are designated to (CCP, CCS or incident ground). Working closely with the Medical Advisor and Operational Commander and ensuring appropriate records are maintained for casualties.

SUPPORT ROLES

Ambulance – Loggist

Responsible for capturing key information and decision making made by the ambulance command team during an incident.

Ambulance - Communications Officer

Responsibilities include the provision of robust communications at the scene of the incident. This may include the deployment of any mobile control units where available.

Ambulance - Decontamination Officer

Where casualties require decontamination, a Decontamination Officer will be nominated to manage that facility. This will also require the appointment of a suitably trained individual to undertake the Entry Control Officer role (ECO).

Ambulance - Media Liaison Officer

All incidents have the ability to attract media interest. The Media Liaison Officer will develop and coordinate the release of Ambulance Service Provider media statements. This will often be achieved

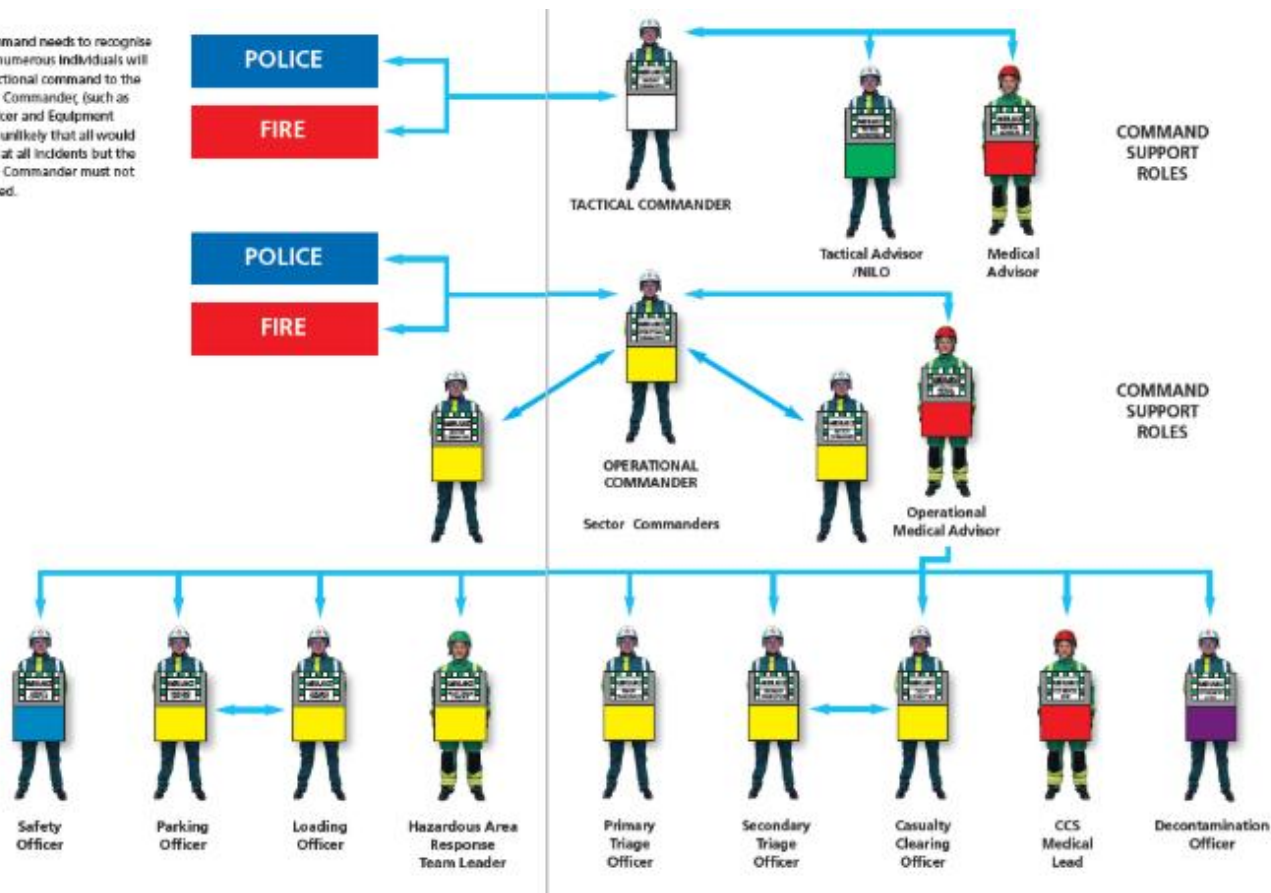
in a multi-agency setting; however, it should always be done in line with the Ambulance Service Provider Strategy.

National Ambulance Coordination Centre (NACC)

The NACC is hosted by West Midlands Ambulance Service with back up facility within North West Ambulance Service. The NACC Plan identifies key objectives and benefits of this facility. The NACC is to provide the focal point for the collection, collation and assessment of data regarding all Ambulance Service Providers in the UK; specifically, their ability to provide mutual aid if called upon for non-interoperable capabilities (these are managed through NHS ECU on call).

The NACC facility is not a standing arrangement and will be stood up for specific incidents.

Span of command needs to recognise that whilst numerous individuals will provide functional command to the Operational Commander (such as Parking Officer and Equipment Officer) it is unlikely that all would be required at all incidents but the Operational Commander must not be overloaded.



Functional Roles within ICC (Internal Roles)

ROLE	CORE OBJECTIVE
EOC Tactical Commander	Provide initial tactical command of incident & EOC resources until relieved by Trust duty Tactical Commander.
Trust Tactical Commander	Provide tactical command of incident on behalf of the Trust and implementing the strategic objectives.
EOC Operational Commander	Provide operational command of EOC resources and co-ordinate initial response actions.
EOC Loggist(s)	To record formal documentation of decisions, actions, options and rationale for an assigned decision maker in accordance with current guidance, policy and legislation as specified by the nominated Decision Maker.
Patient Flow Co-ordinator	To co-ordinate communications across acute hospitals and obtain hospital capacity information to effectively support the effective distribution of patients across a region and avoid overwhelming the local hospital department(s).
Mutual Aid Co-ordinator	Ensure effective deployment & co-ordination of mutual aid resources.
Everbridge Operator	To ensure effective use of Everbridge during an incident to support mass communication with internal/external contacts and where required coordinate the mobilisation of a SORT deployment.
Sector Dispatcher (initial response)	Co-ordinate the initial resource deployment and response of incident.
Command Dispatcher	Ensure effective deployment & communication of Trust commanders & command support
Resource Dispatcher	Ensure effective deployment & co-ordination of resources deployed to an incident
JESIP Co-ordinator	To ensure effective communication across emergency services
HEMS/Critical Care Desk	Co-ordination of critical care and air assets to the incident

15.06 Appendix 6 – Guidance for the selection of an RVP

Guidance for selecting an RVP:

- Located in the cold zone
- Easy to locate
- Enable the rapid deployment of resources and assets to the scene
- Of suitable size and configuration to meet the operational requirement
- Regularly reviewed by commanders
- RVP to be shared with all relevant responders/agencies

(MTA JOPS, 2023)

Other considerations include;

- Lighting
- Security
- Access/egress

15.07 Appendix 7 – Operational Discretion

OPERATIONAL DISCRETION

- 3.13** The term 'operational discretion' is used within the emergency services to describe decisions made by individuals which may depart from organisational protocol or standard operating procedures.

Clinicians are used to using their professional discretion to apply clinical practice guidelines to a range of different situations. In the context of complex or major incidents, operational discretion is usually used to describe command decisions.

Emergency plans and procedures are written generically to cover anticipated incidents. However, by their nature, emergencies are often dynamic with unique features.

When managing an incident, emergency service commanders or responders may need a degree of flexibility to adapt plans and procedures to achieve a desired outcome. This will often be within the context of life saving operations or situations where events are deteriorating despite existing plans and procedures being put in place.

Operational discretion should be used to provide some flexibility within a defined scope of practice. Organisations should have a policy or framework which defines the use of operational discretion by their commanders or front-line responders whilst still allowing the individual to tailor their decisions in response to the unique characteristics of the incident.

Operational discretion should not be used where existing plans and procedures fit the circumstances. Discretion is not a substitute for gaps in knowledge of what is already covered by existing provisions or what existing capabilities can achieve.

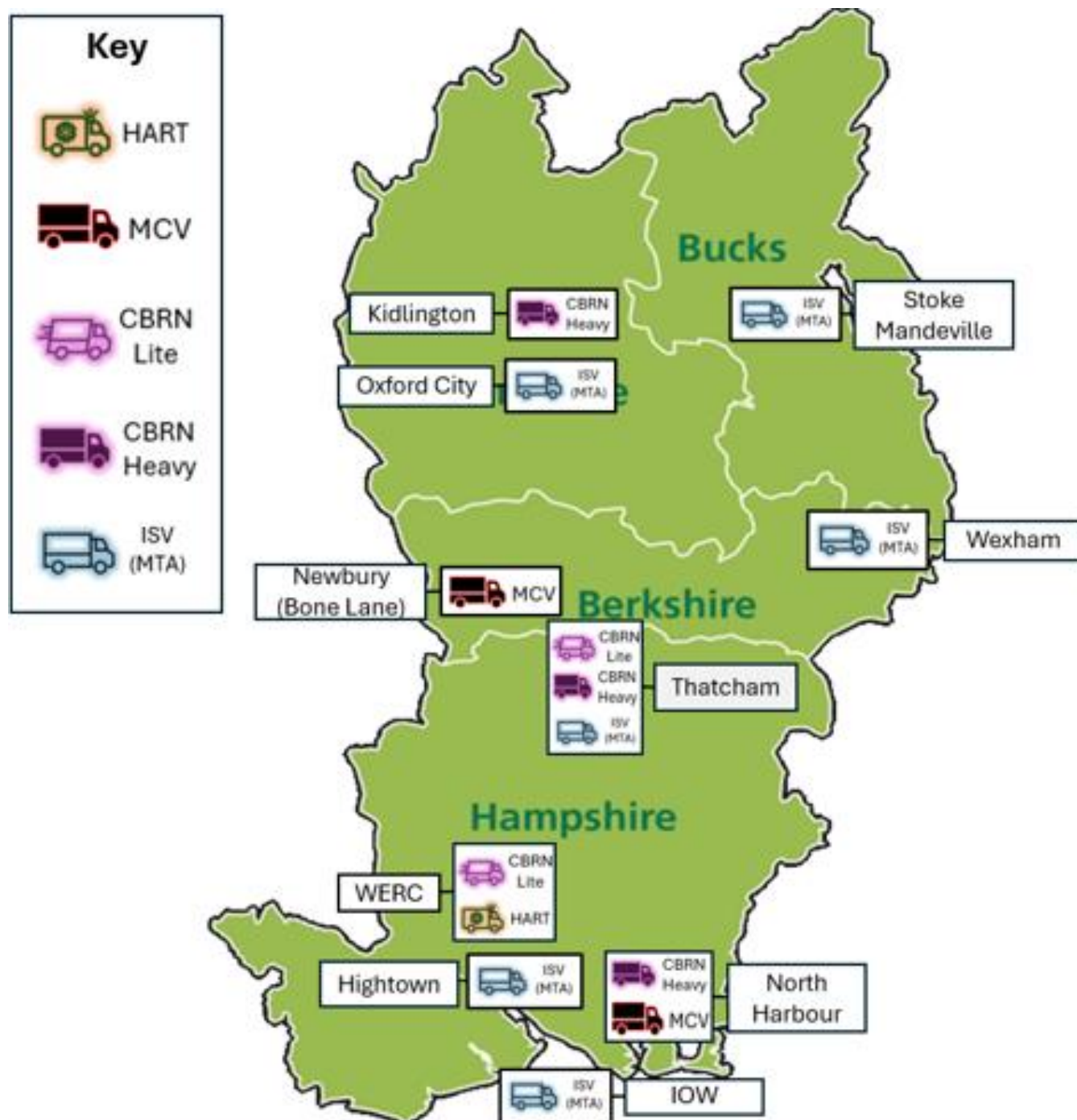
Organisations plan carefully for emergency incidents. Preparations include risk assessments, training, equipment provisions and operational procedures. Specialist capabilities also provide an increased range of capability options. These things combine to create a safe system of work which the organisation has a duty of care to maintain for its staff. Using discretion to depart from these carefully considered provisions is not without risk. Use of discretion by individuals who are employed professionals within an organisation is, therefore, limited. Any departure from approved plans and procedures will be subject to considerable post incident scrutiny. The use of operational discretion needs to be proportionate and justifiable. The amount of discretion used by an individual and the amount of flexibility exercised should also be in direct proportion to the individual's experience and competence.

The duty of care balance between providing a safe system of work for responders and taking carefully considered risks to save life or improve clinical outcomes for patients provides an important basis for justifying the use of operational discretion [note the duty of care table on page 8 of this C2 guidance].

15.08 Appendix 8 – HART and MCV Assets (SCAS & Bordering Trusts)



15.09 Appendix 9 – SCAS Specialist Asset Map



15.10 Appendix 10 – Patient Dispersal Model

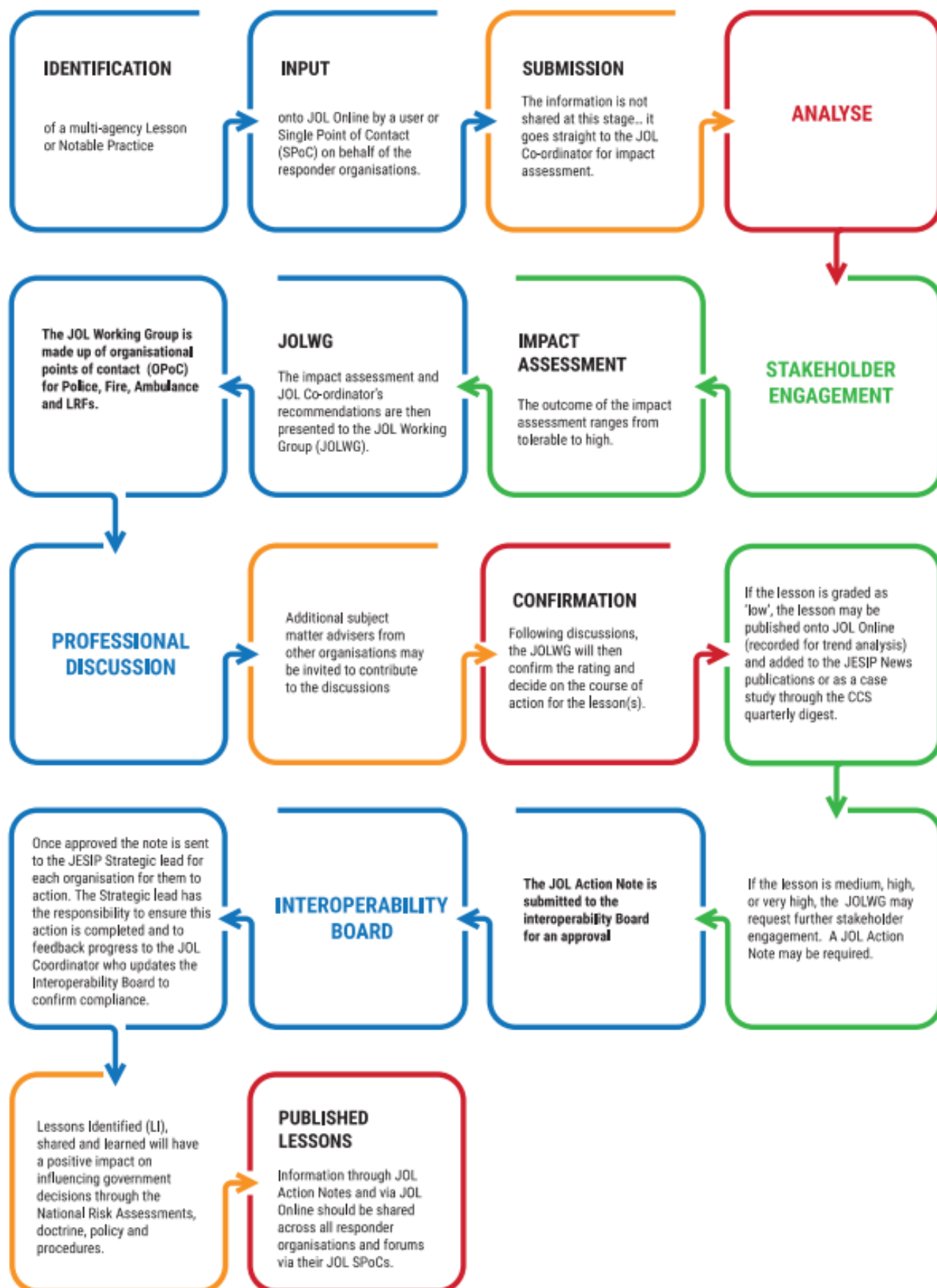
Type	Hospital	1 st Hour	2 nd Hour	1 st Hour	2 nd Hour	1 st Hour	2 nd Hour
		P1		P2		P3	
Major Trauma Centre	JR Oxford University Hospital	20 x adult / 6 x children		20 x adult 10 x children		100	
Trauma Unit	Milton Keynes Hospital	10		15		30	
Trauma Unit	Royal Berkshire Hospital	10		12		40	
Trauma Unit	Stoke Mandeville Hospital	4	6	4	11	30	
Trauma Unit	Wexham Park Hospital	8		25		30	
Major Trauma Centre	University Hospital Southampton <i>(for a mass casualty incident)</i>	5 (10)	5 (10)	9 (10)	6 (10)	30 (25)	20 (25)
Trauma Unit	Basingstoke North Hants Hospital	4	3	6	3	20	10
<i>Local Emergency Hosp</i>	Royal Hampshire County Hospital	3	3	5	3	15	10
Trauma Unit	Portsmouth University Hospital	4	10	6	8	40	
Trauma Unit	St Mary's Hospital (IOW)	3	3	10		20	
Trauma Unit	Poole Hospital	4		18 (15 nights)		30 (15 nights)	
Trauma Unit	Dorchester County Hospital	4 3 (nights)		5	3	20	10
Trauma Unit	Salisbury District Hospital	6 (3 nights)		10 (6 nights)		22 (12 nights)	
<i>Local Emergency Hosp</i>	Royal Bournemouth Hospital	4		15 (5 nights)		30 (10 nights)	

15.11 Appendix 11 – Retention Period Guidance

Category	Examples	Minimum retention period	Final action
Incidents (declared)	Decision logbook, on-call logbook, incident-related documents including plans and organisational structures Paper and electronic records	30 years	Review, archive or destroy under confidential conditions
Exercise	Paper and electronic records	10 years	Review, archive or destroy under confidential conditions
On-call (routine – non-Major Incident)	Decision log, on-call log, handover records Paper and electronic records	10 years	Review, archive or destroy under confidential conditions
EPRR	Incident response plans, guidance, standard operating procedures, core standards for assurance Electronic records	30 years	Review, archive or destroy under confidential conditions
EPRR	Information sharing protocols, memorandum of understanding, service-level agreements Paper and electronic records	10 years	Review, archive or destroy under confidential conditions
EPRR	LHRP and sub-group minutes, papers, action logs Risk registers Electronic records	30 years	Review, archive or destroy under confidential conditions

(NHS England EPRR Framework 2022)

15.12 Appendix 12 – JESIP Joint Organisational Learning (JOL) Process



15.13 Appendix 13 – IIMARCH Briefing Tool

INFORMATION	What, where, when, how? So what? What might? How many?	Timeline and history (if applicable)Key facts reported using M/ETHANE: Major Incident (declared or not?)
		Exact Location
		Type of Incident
		Hazards
		Access
		Number of casualties
		Emergency services
INTENT	Why are we here? What are we trying to achieve?	Strategic aim and objectives Joint working strategy
METHOD	How are we going to do it?	Command, control and coordination arrangements Tactical and operational policy and plans Contingency plans
ADMINISTRATION	What is required for effective, efficient and safe implementation?	Identification of commanders Tasking Timing Decision logs Equipment Dress code & PPE Welfare, food and logistics
RISK	What are the relevant risks? What measures are required to	To reflect the JESIP principle – joint understanding of risk Using the ERICPD hierarchy for risk control as appropriate Decision controls
ASSESSMENT	mitigate them?	
COMMUNICATIONS	How are we going to initiate and	Radio Call signs Other means of communication Understanding of interagency communications Information assessment Dealing with the media, develop a joint media strategy and plan
	maintain communications with all partners	
	and interested parties?	
HUMANITARIAN ISSUES	What humanitarian assistance and	Requirement for humanitarian assistance
	human rights issues arise	Information sharing and disclosure
	or may arise from this event and the	Potential impacts on individuals' human rights
	response to it?	

15.14 Appendix 14 – SBAR Template (Critical or Business Continuity Incidents)

Date:		Time:	
Completed by:		Title:	
Telephone number:		Email address:	
Approved for release by:		Title:	
1) Situation Overview: <i>(Describe situation/incident that has occurred.)</i>			
2) Background: <i>(Explain history and impact of incident on services / patient safety.)</i>			
3) Assessment: <i>(Confirm your understanding of the issues involved.)</i>			
4) Response & Action Summary For This Week:			

15.15 Appendix 15 – Acronyms & Abbreviations

The following abbreviations refer to terms found within this document and other terminology commonly used within the Ambulance Service. The Lexicon of UK Civil Protection Terminology, produced by the Cabinet Office, contains a full set of definitions of terms which are used across responding agencies and aims to create a single point of reference for civil protection terminology as one of the underpinning elements of interoperable communications and coherent multi-agency working. The Lexicon can be found at [Emergency responder interoperability: lexicon - GOV.UK](#).

AAP	Associate Ambulance Practitioner
AEO	Accountable Emergency Officer
ALP	Ambulance Loading Point
ARCC	Adult Regional Critical Care Transfer Service
BAU	Business As Usual
BCMS	Business Continuity Management System
BASICS	British Association for Immediate Care (volunteer doctors/paramedics scheme)
CAD	Computer Aided Dispatch
CCA	Civil Contingencies Act
CBRN	Chemical, Biological, Radiological, Nuclear
CCP	Casualty Collection Point
CCS	Casualty Clearing Station
CEO	Chief Executive Officer
CFR	Community First Responder
CIG	Continuous Improvement Group
CLU	Central Logistics Unit
CTA	Communications Tactical Advisor
DRA	Dynamic Risk Assessment
ECU	Emergency Capabilities Unit (NHS England)
EOC	Emergency Operations Centre
EPRR	Emergency Preparedness, Resilience and Response
ERA	Emergency Response Arrangements
ERICPD	Eliminate, Reduce, Isolate, Control, PPE, Discipline (risk control hierarchy)
ESICTRL	Emergency Services Inter-Control Talk Group
ESN	Emergency Services Network
FCP	Forward Command Post
GRS	Global Rostering System (skills/competency recording)
HART	Hazardous Area Response Team
HCID	High Consequence Infectious Disease
HEMS	Helicopter Emergency Medical Services
HMCG	His Majesty's Coastguard
ICC	Integrated Contact Centre
ICB	Integrated Care Board
ICT	Information and Communications Technology
IIMARCH	Information, Intent, Method, Administration, Risk, Communications, Humanitarian
IMT	Incident Management Team
IPC	Infection Prevention and Control
IRF	Incident Response Framework
ISV	Incident Support Vehicle
JDM	Joint Decision Model
JESIP	Joint Emergency Services Interoperability Programme
JOL	Joint Organisational Learning
JTAC	Joint Terrorism Analysis Centre
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum
MAC	Media Advisory Cell
MASHA	Multi-Agency Strategic Holding Area

MCV	Mass Casualty Vehicle
METHANE	JESIP Multi-agency communication template
MITT	Major Incident Triage Tool
MTA	Marauding Terrorist Attack
NACC	National Ambulance Coordination Centre
NASMeD	National Ambulance Service Medical Directors
NARU	National Ambulance Resilience Unit (Replaced by NHSRECU)
NHSE	National Health Service England
NHSRECU	NHS Resilience and Emergency Capabilities Unit
NILO	National Inter-Agency Liaison Officer
NSRA	National Security Risk Assessment
OSD	Operational Support Desk
PAT	Partner Activation Teleconference
PDA	Pre-Determined Attendance
PIP	Post-Incident Procedure
PPE	Personal Protective Equipment
PTS	Patient Transport Service
RPA	Radiation Protection Advisor
RPS	Radiation Protection Supervisor
RSO	Resilience and Specialist Operations
RVP	Rendezvous Point
SBAR	Situation, Background, Assessment, Recommendation
SCAS	South Central Ambulance Service
SCG	Strategic Coordinating Group
SIRO	Senior Information Risk Owner
SORT	Specialist Operations Response Team
SRC	Survivor Reception Centre
StRaW	Sustaining Resilience at Work
TCG	Tactical Coordinating Group
TRiM	Trauma Risk Management
TST	Ten Second Triage
UKHSA	UK Health Security Agency
VOD	Verification of Death
WEL	Widespread Electricity Loss