NHS
South Central Ambulance Service
NHS Foundation Trust

Quality Accounts Report

2025/2026

Contents

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

Part 1: Statement on quality from the chief executive of the South Central Ambulance Service NHS Foundation Trust (SCAS)

Chief Executive's foreword

This year has been one of consolidation, delivery, and preparing the organisation for its next phase. Across South Central Ambulance Service, our staff and volunteers have continued to provide high quality, compassionate care in the face of sustained operational and financial pressures, while also supporting significant organisational change.

Under the leadership of David Eltringham, Chief Executive Officer, the trust has continued to build on the strong foundations established in previous years. His leadership throughout this period has been instrumental in stabilising the organisation, strengthening governance, and delivering meaningful progress across performance, finance, and quality.

As we look forward, I am now honoured to be supporting the organisation as Interim Chief Executive Officer, as we move into the next phase of our development.

National context and planning for the future

Our focus is increasingly shaped by the national context and the need to plan over a longer horizon. Recently we have refined our Multi-Year Plan, setting out how we will align our workforce, operational delivery, and financial position across the next three years. This plan is central to ensuring we remain clinically effective, operationally resilient, and financially sustainable.

Our Financial Recovery Plan (2023–2026) has created strong and credible foundations for the future. The scale of delivery required to recover from a significant deficit to financial balance has been considerable, and I would like to recognise the commitment and effort of colleagues across the organisation in achieving this. While the financial environment remains highly challenging as we enter 2026/27, we are in a much stronger position to respond albeit recognising that difficult decisions will continue to be required.

At the same time, we have completed the second full year of our Fit for the Future Improvement Plan.

Operational performance

Operational delivery has remained under pressure, with demand continuing. Encouragingly, our Category 2 performance has remained around target in recent months and close to target for the year, reflecting the resilience and professionalism of our frontline teams.

However, challenges remain. Performance in Hear & Treat has been below target, driven in part by clinical workforce gaps and sickness absence. Addressing this is a priority not only to improve performance, but to ensure patients receive appropriate

care closer to home and to reduce unnecessary conveyance to Emergency Departments.

Fleet and infrastructure

Fleet continues to present a significant operational challenge, with Vehicle Off Road (VOR) levels remaining high. Through our Fleet Improvement Plan, we are taking focused action, including investment in replacement vehicles, improved maintenance planning, and changes to how our fleet is utilised.

The opening of a new workshop in Aylesbury represents an important step in increasing capacity and improving turnaround times for repairs and servicing.

The declaration of a Business Continuity Incident earlier in the year highlighted the fragility in some areas but also provided valuable organisational learning. Actions already implemented including changes to vehicle charging, utilisation, and logistics which will strengthen our resilience moving forward.

Our people and culture

The 2025 Staff Survey results, while disappointing, reflect the reality of the pressures facing our workforce. These results reinforce the need to continue our focus on culture, engagement, and staff experience.

Our “Building Trust Together” programme remains central to this effort. We are committed to ensuring our staff feel valued, heard, and supported, and to creating an environment where they can thrive. Delivering tangible improvements in this area will be a key priority over the coming year.

Collaboration and system working

Our collaboration with South East Coast Ambulance Service continues to develop, with strong oversight from both Boards. This partnership is central to our ambition to deliver high quality, consistent care across a wider geography and to build greater organisational resilience for the future.

Closing reflections

This year also marks the conclusion of David Eltringham’s tenure as Chief Executive. Over the course of his leadership, the trust has undergone significant transformation. We have exited national recovery programmes, improved regulatory ratings, restored financial balance, and strengthened both our leadership and governance arrangements.

He leaves behind a clearer, more stable organisation, with a strong strategic direction and a comprehensive improvement programme that positions SCAS well for the future. On behalf of the organisation, I would like to place on record our sincere thanks for his leadership, commitment, and service.

David often reflected on the professionalism, pride, and dedication of our staff and this is something that continues to define our organisation. Across frontline services, Emergency Operations Centres, 111, Patient Transport Services, and corporate and support teams, our people deliver extraordinary care every day, often in the most challenging circumstances.

We also recognise the invaluable contribution of our volunteers and the strength of our partnerships across the NHS and emergency services. Together, we provide a vital service to our patients and communities.

As Interim Chief Executive, I am committed to building on this legacy maintaining momentum, supporting our people, and ensuring we continue to improve the services we provide.

I would like to thank every member of Team SCAS for their continued dedication and professionalism. It is a privilege to serve alongside you, and I look forward to working together as we move into the next chapter.

Stuart Rees
Interim Chief Executive Officer
25 June 2026

About us

We employ 4,400 staff who, together with around 850 volunteers, enable us to operate 24 hours a day, seven days a week.

What we do:

- Receive and respond to 999 calls using resources including: community first and co-responders, rapid response vehicles, ambulances, and air ambulances.
- Provide the NHS 111 services for the Thames Valley and for Hampshire.
- Provide non-emergency Patient Transport Services across Hampshire and Milton Keynes.

SCAS is the monopoly provider of 999 emergency ambulance services within the South Central region (as are all English ambulance trusts in their defined geographical areas). All other services the trust delivers are tendered for on a competitive basis.

We serve a population of around 4.8 million people across four integrated care systems in 2025/26:

- Buckinghamshire, Oxfordshire & West Berkshire
- Hampshire & Isle of Wight
- Frimley
- Bedfordshire, Luton & Milton Keynes

Working with system partners

There have been significant changes in health and care and SCAS, like all ambulance services, has a pivotal role in local care systems, especially with the increasing focus on delivering care remotely or in patients' homes.

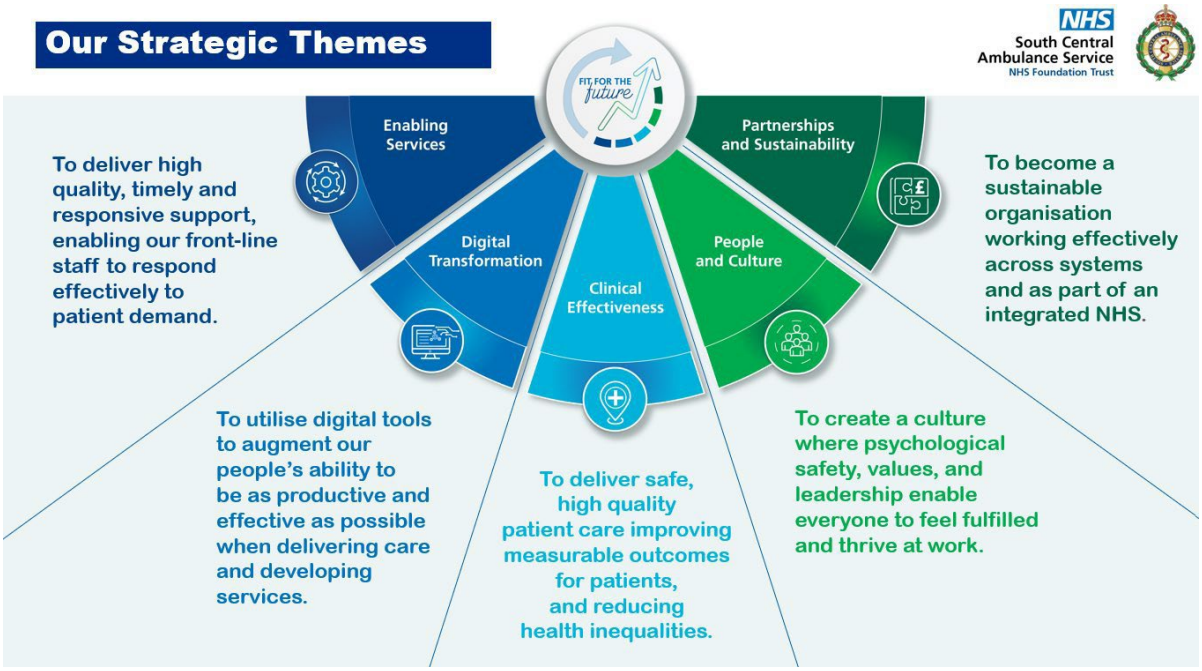
SCAS is adapting to these changes and working with partners to achieve the NHS triple aim of:

- better health and wellbeing for everyone
- better quality of health services for all
- sustainable use of NHS resources.

Our goals are to simplify access to care, to save lives, to support more people at home and to integrate care. Working with partners, we also aim to identify and address inequity of access or unwarranted variation in outcomes.

We engage with partners in commissioning and provider organisations across all systems on a range of strategic and operational forums. We work to ensure our plans are aligned to our integrated care systems' forward plans and that the needs of emergency and urgent care are appropriately considered within system plans.

Our Strategy



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 or our patients.**

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

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

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

- **Hospital to community**
- **Analogue to digital**
- **Sickness to prevention**

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

Since the publication of our Strategy, there have been a series of shifts at a regional and national level. This includes, SCAS entering the Southern Ambulance Services Collaborative and joined in a group model with South East Coast Ambulance Service (South East South Central Group) to better standardise care delivery, how services are commissioned, and seek opportunities to drive productivity and efficiency through scale.

We believe that our strategic direction remains consistent with the national ambition, particularly in supporting a move away from Emergency Departments, improved digitalisation as a driver for productivity, and contributing to a more preventative model for the health service that helps us reduce inequalities.

Part 2: Priorities for improvement and statements of assurance from the Board

2.1 Looking back at our progress

We have set out below our Quality Account priorities for 2025/26 and our progress against them.

2025/26 Quality Priority Summary			Outcome
Patient Safety	1a	Survey staff safety culture	Partially Achieved
	1b	Quality audit of After Action Reviews (AAR)	Achieved
	1c	Continued improvement in the quality of safeguarding referrals	Partially Achieved
Clinical Effectiveness	2a	To report on Category 1 - 4 performance	Achieved
	2b	To report on national STEMI care bundle compliance	Achieved
	2c	New focus of audit group	Achieved
Patient Experience	3a	Co-production of amendments to current Healthcare Professional feedback (HCP) process to ensure high level focus on clinical concerns and learning	Partially achieved
	3b	Patient panel	Achieved
	3c	Increase patient survey response rates	Partially Achieved

Partially achieved quality priorities form part of a continuous improvement cycle and further work will be completed in 2026/27.

1. Patient Safety

1a: Survey staff safety culture

Achievement
A tool was developed that takes a wider view of patient safety than the MaPSaf survey that had been used prior to this work was completed.

The survey has been piloted but received a low response rate. The trust now has a second Patient Safety Specialist with a focus on learning, who will lead the next release of the survey in January 2027. Improved communications to raise awareness of the survey and its importance to continue developing patient safety within the trust are expected to yield higher returns and more useable data.

This indicator has been included in the patient safety section for 2026/27 so that further survey and analysis can be completed. The creation and maintenance of a good safety culture is imperative to reducing avoidable harm. This is an area of continued focus for the trust.

1b: Quality audit of After Action Reviews (AAR)

Achievement
A tool has been developed to measure the quality and effectiveness of AAR. All AARs completed since the introduction of the Quality Metric Tool have had the tool applied as part of the process.

General themes:

- Good engagement from operational staff in the majority of AARs – open discussion and willingness to reflect
- Strong focus on system learning rather than individual blame, which is working well
- Good examples of multi-team involvement where needed

1c: Continued improvement in the quality of safeguarding referrals

Achievement
This priority has been partially achieved.

The previous safeguarding training model for 2025/26 was complex and difficult to monitor due to multiple components and reliance on self-declared learning. To improve compliance, consistency, and assurance, a simplified annual training model has been introduced. This comprises 4 hours of mandatory training (2 hours face-to-face and 2 hours e-learning), tailored to the ambulance context and inclusive of both Operations and the Integrated Contact Centre (ICC). The programme includes case-based learning and a pass/fail assessment. Staff are abstracted to complete the training in full, with monthly trajectory monitoring in place.

Despite improvements, feedback from partner agencies and internal audits indicates that further work is required to improve the quality of safeguarding referrals. An annual audit plan has been implemented, including routine compliance checks and quarterly deep dives into identified risk areas. Findings from these audits will directly inform ongoing training and safeguarding supervision.

To support frontline practice, close working continues with Operations and ICC teams to strengthen safeguarding knowledge and improve referral standards. In addition, a new digital safeguarding referral form has been co-designed with partner agencies, managers, and frontline staff. This form reflects the specific demands of emergency and urgent care while meeting partner information requirements. Implementation is planned for 2026/27, with oversight provided by the Safeguarding Group.

2. Clinical Effectiveness

2a: To report on Category 1 - 4 performance

Achievement
Refer to section 2.3

2b: To report on national STEMI care bundle compliance

Achievement
Refer to section 2.3

2c: New focus of audit group

Achievement
Terms of reference were developed for the monthly audit group. Each month the focus has been on the area of practice on the planner. Recommendations and actions have been reported to the Clinical Review Group.

The audit group now established continues in 2026/27.

3. Patient Experience (PE)

3a Co-production of amendments to current Healthcare Professional (HCP) feedback process to ensure high level focus on clinical concerns and learning.

Achievement
This indicator remains a priority and has been incorporated into the 2026/27 work programme. Progress had been slower than anticipated, primarily due to the extended timeframe required to engage with providers and co-produce a revised approach. The Patient Experience Team has also needed to provide additional support and guidance to some provider leads regarding the HCP feedback processes; this was not originally factored into the plan.

Continuation of this work as a quality priority is essential to ensure that HCP feedback processes consistently capture, escalate and respond to clinical concerns in a timely and robust manner. Strengthening this approach will support a more open and transparent culture, improve triangulation with patient experience and safety data, and enhance organisational learning across the system. It will also provide greater assurance that feedback from healthcare professionals is systematically used to inform service improvement and reduce the risk of missed opportunities to address emerging clinical issues. Further work is needed with external stakeholders to plan what is possible and appropriate, with a new process being agreed.

The development and implementation of revised parameters and processes will continue over the coming year, with a strengthened focus on clinical concerns, learning, and system-wide consistency.

3b: Patient panel

Achievement
The Patient Panel has continued to develop during 2025/26. Patient Panel members are still being recruited. The patient panel now consists of 46 members and youth representatives assist where representation is required on workstreams.

Regular update reports have been presented at the Patient Safety and Experience Group regarding the Panel's work including co-production of additional easy read guides.

Focus areas for the Patient Panel have been identified and an action plan has been created to address these in 2026/27.

3c: Increase patient survey response rates.

Achievement
Work has been undertaken throughout the year to develop a revised approach to collecting survey feedback, including exploring opportunities for digitalisation. A proposal outlining this work has been presented to the Patient Safety and Experience Group.

This indicator has been scheduled for inclusion in 2026/27, as a formal business case is required. Subject to approval, a detailed implementation plan will be developed. If a digital solution is approved, an associated improvement trajectory will also be established.

The SMS survey business case is currently underway. This approach has been identified as the most effective method to increase survey response rates, as we are currently reliant on paper-based surveys. Benchmarking with other trusts shows that those using SMS surveys have achieved, on average, a 15% increase in response rates.

In early last year, we attempted to improve response rates by increasing the volume of paper surveys distributed. However, this approach proved unsustainable due to competing priorities and no significant increase in returns achieved.

While the case for SMS surveys is strong, the approval process involves multiple stages, resulting in a prolonged timeline before implementation can be achieved.

2.2 Statements of assurance from the Board

	Prescribed information	Form of statement
1	The number of different types of relevant health services provided or subcontracted by the provider during the reporting period as determined in accordance with the categorization of services: a) Specified under the contracts, agreements, or arrangements under which those services are provider or b) In the case of an NHS body providing services other than under a contract, agreement, or arrangements, adopted by the provider.	During 2025/26 SCAS provided and/or subcontracted three relevant health services. • Emergency 999 Ambulance Service • Non-Emergency Patient Transport Service • NHS 111/IUC Telephone Advice Service
1.1	The number of relevant health services identified under entry 1 in relation to which the provider has reviewed all data available to it on quality of care provided during the reporting period.	SCAS has reviewed all the data available to them on the quality of care in all these relevant health services.
1.2	The percentage that the income generated by the relevant health services reviewed by the provider, as identified under entry 1.1, represents of the total income for the provider for the reporting period under all contracts, agreements and arrangements held by the provider for the provision of, or subcontracting of, relevant health services.	The income generated by the relevant health services reviewed in 2025/26 represents 100% of the total income generated from the provision of relevant health services by SCAS for 2025/26.
2	a) The number of national clinical audits and national confidential enquiries b) which collected data during the reporting period, and which covered the relevant health services that the provider provides or subcontracts.	During 2025/26, eight national clinical audits and 0 national confidential enquiries covered relevant health services that SCAS provides.

2.1	The number, as a percentage, of national clinical audits and clinical audits and national confidential enquiries, identified under entry 2, that the provider participated in during the reporting period.	During that period SCAS participated in 100% national clinical audits and 100% (0 required) national confidential enquiries of the national clinical audits and national confidential enquiries in which it was eligible to participate.
2.2	A list of the national clinical audits and national confidential enquiries identified under entry 2 that the provider was eligible to participate in.	The national clinical audits and national confidential enquiries that SCAS was eligible to participate in during 2025/26 are as follows: • Acute Myocardial Infarction and other Acute Coronary Syndrome (MINAP) • Ambulance Clinical Quality Indicator S-T elevation Myocardial Infarction (STEMI) Care Bundle • Sentinel Stroke National Audit Programme (Stroke Call to Hospital Arrival times) • Ambulance Clinical Quality falls indicator • Warwick Clinical Trials Unit Out of Hospital Cardiac Arrest Outcome (OHCAO) • Ambulance Clinical Quality Indicator Cardiac Arrest ROSC rates (and separate Utstein ROSC measure) • Ambulance Clinical Quality Indicator Cardiac Arrest Survival to Discharge (and separate Utstein STD measure) • Ambulance Clinical Quality Indicator Cardiac Arrest Post ROSC Care Bundle

2.3	A list of the national clinical audits and national confidential enquiries, identified under entry 2.1, that the provider participated in.	The national clinical audits and national confidential enquiries that SCAS participated in during 2025/26 are as follows: • Acute Myocardial Infarction and other Acute Coronary Syndrome (MINAP) • Ambulance Clinical Quality Indicator S-T elevation Myocardial Infarction (STEMI) Care Bundle • Sentinel Stroke National Audit Programme (Stroke Call to Hospital Arrival times) • Ambulance Clinical Quality falls indicator • Warwick Clinical Trials Unit Out of Hospital Cardiac Arrest Outcome (OHCAO) • Ambulance Clinical Quality Indicator Cardiac Arrest ROSC rates (and separate Utstein ROSC measure) • Ambulance Clinical Quality Indicator Cardiac Arrest Survival to Discharge (and separate Utstein STD measure) • Ambulance Clinical Quality Indicator Cardiac Arrest Post ROSC Care Bundle
2.4	A list of each national clinical audit and national confidential enquiry that the provider participated in, and which data collection was completed during the reporting period, alongside the number of cases submitted to each audit, as a percentage of the number required by the terms of the audit or enquiry.	The national clinical audits and national confidential enquiries that SCAS participated in, and for which data collection was completed during 2025/26, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. *Note that the data relates to April – December 2025 and not a full year due

		to National Ambulance Clinical Quality Indicator reporting timelines. Acute Myocardial Infarction and other Acute Coronary Syndrome (MINAP) Number of cases 450 Ambulance Clinical Quality Indicator S-T elevation Myocardial Infarction (STEMI) Care Bundle Number of cases 355 Sentinel Stroke National Audit Programme (Stroke Call to Hospital Arrival times) Number of cases 3,250 Ambulance Clinical Quality falls indicator Number of cases 900 Warwick Clinical Trials Unit Out of Hospital Cardiac Arrest Outcome (OHCAO) Number of cases 3,807 Ambulance Clinical Quality Indicator Cardiac Arrest ROSC rates (and separate Utstein ROSC measure) Number of cases 470 Utstein cases 266 Ambulance Clinical Quality Indicator Cardiac Arrest Survival to Discharge (and separate Utstein STD measure) Number of cases 178 Utstein cases 80 Ambulance Clinical Quality Indicator Cardiac Arrest Post ROSC Care Bundle Number of cases 615
2.5	The number of national clinical audit reports published during the reporting period that were reviewed by the provider during the reporting period.	The reports of eight national clinical audits were reviewed by the provider in 2025/26.

2.6	A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.5.	SCAS intends to take the following actions to improve the quality of healthcare provided • Compliance with Resuscitation training. • Launch of a new ACQI scorecard. • Ensure improvement in performance against ambulance response targets is maintained.
2.7	The number of local clinical audit (a) reports that were reviewed by the provider during the reporting period.	The reports of 15 local clinical audits were reviewed by the provider in 2025/26.
2.8	A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.7.	SCAS intends to take the following actions to improve the quality of healthcare provided: • Documentation task and finish group to improve assessment/care documentation • Local Standard operating Procedures review • Individual coaching • Quality Improvement project – stock in pouches
3	The number of patients receiving relevant health services provided or subcontracted by the provider during the reporting period that were recruited during that period to participate in research approved by a research ethics committee within the National Research Ethics Service.	From April 2025 to March 2026, SCAS enrolled 1,022 service users and staff into NIHR portfolio research projects. **South Central Ambulance Service NHS Foundation Trust Publications 2025/26** Akhtar W, Brain N, **Deakin CD**, et al. British Societies Guideline on the Management of Emergencies in Extracorporeal Membrane Oxygenation. Intensive Care Medicine. 2025; 51(11):2013-2020. https://doi.org/10.1007/s00134-025-08142-2

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		Owen P, Hannah J, **King P**, **Deakin CD**, Plumb J, Jackson AIR. Is there an association between 30-day mortality from out-of-hospital cardiac arrest (OHCA) and deprivation levels within Hampshire? A retrospective cohort study. Resuscitation Plus. 2025;22:100898. https://doi.org/10.1016/j.resplu.2025.100898 **Pocock H, Deakin CD, Rodriguez-Bachiller I,** et al. Informing relatives of non-surviving patients about research participation following out-of-hospital cardiac arrest: a prospective cohort study. Resuscitation Plus 2025;26:101131. https://doi.org/10.1016/j.resplu.2025.101131 Ristagno G, Semeraro F, **Deakin CD**, et al., on behalf of the International Liaison Committee on Resuscitation Basic and Advanced Life Support Task Forces. Pad size, orientation and placement for defibrillation during basic life support: A systematic review. *Resuscitation Plus* 2025; 25: 101030 https://doi.org/10.1016/j.resplu.2025.101030 **Robertson D**, Peters M. Clinical audit, quality improvement, service evaluation and innovation: what are they? In: Paramedic Research: Principles, Designs and Methods. Williams J, McClelland G, editors. Bridgwater, UK: Class Professional Publishing; 2025. P.29-40. Ross J, Jan T, **Deakin CD**, et al. Consciousness in deep hypothermic circulatory arrest: a feasibility study. *Journal of Cardiothoracic Surgery* 2025; Volume 20, Article number: 242. https://doi.org/10.1186/s13019-025-03484-w

		Sidebottom D, Painting R, **Deakin CD**. Bystander availability, CPR uptake and AED use during out-of-hospital cardiac arrest. *Resuscitation Plus* 2025; 24: 100969 https://doi.org/10.1016/j.resplu.2025.100969 Soar J, Bottiger B, **Deakin CD**, **Pocock H**, et al. European Resuscitation Council Guidelines 2025 Adult Advanced Life Support. Resuscitation. 215 (Supp 1); 110769. https://doi.org/10.1016/j.resuscitation.2025.110769 Thies, KC, Metelmann C, **Deakin, CD**, et al. Barriers and enablers to public access defibrillation – an international RAND-UCLA consensus study. Scand J Trauma Resusc Emerg Med (2026). https://doi.org/10.1186/s13049-026-01589-2.
4	Whether or not a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals under the Commissioning for Quality and Innovation (CQUIN) payment framework agreed between the provider and any person or body they have entered into a contract, agreement or arrangement with for the provision of relevant health services.	Not Applicable.
4.1	If a proportion of the provider's income during the reporting period was not conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, the reason for this.	Not Applicable.

4.2	If a proportion of the provider's income during the reporting period was not conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, the reason for this.	Not Applicable.
5	Whether or not the provider is required to register with CQC under section 10 of the Health and Social Care Act 2008.	SCAS is required to register with the Care Quality Commission.
5.1	If the provider is required to register with the CQC: (a) whether at end of the reporting period the provider is: (i) registered with the CQC with no conditions attached to registration, (ii) registered with the CQC with conditions attached to registration, (b) if the provider's registration with CQC is subject to conditions, what those conditions are and (c) whether CQC has taken enforcement action against the provider during the reporting period.	SCAS current registration status is without conditions.
6	Removed 2011 amendments	
7	Whether or not the provider has taken part in any special reviews or investigations by CQC under section 48 of the Health and Social Care Act 2008 during the reporting period.	None in 2025/26.
7.1	If the provider has participated in a special review or investigation by CQC: (a) the subject matter of any review or investigation	None in 2025/26.

	(b) the conclusions or requirements reported by CQC following any review or investigation (c) the action the provider intends to take to address the conclusions or requirements reported by CQC and (d) any progress the provider has made in taking the action identified under paragraph (c) prior to the end of the reporting period.	
8	Whether or not during the reporting period the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest version of those statistics published prior to publication of the relevant document by the provider.	Not applicable.
8.1	If the provider submitted records to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data:	Not applicable.
9	The provider's Information Governance Assessment Report	The Data Security Protection Toolkit (DSPT) is aligned to Cyber Assessment Framework. In 2024/25 submission was standards met. Data for 2025/26 will be available in July 2026 – the trust is expected to be standards met.
10	Whether or not the provider was subject to the Payment by Results clinical coding audit at any time during the reporting period by the NHSE.	SCAS was not subject to the Payment by Results clinical coding audit during 2025/26 by NHSE.

10.1	If the provider was subject to the Payment by Results clinical coding audit by the NHSi at any time during the reporting period, the error rates, as percentages, for clinical diagnosis coding and clinical treatment coding reported by the NHSi in any audit published in relation to the provider for the reporting period prior to publication of the relevant document by the provider.	Not applicable.
11	The action taken by the provider to improve data quality.	SCAS will be taking the following actions to improve data quality: • Integrated Quality Performance Report review and revision where indicated – includes all finance, operational, service and quality data • Fit for the future pillars • Review and implementation of actions from internal audit reports

2.3 Reporting against NHSi core indicators

Ambulance Response Programme

Performance against national ambulance service response targets 2025/26.

	Prescribed information	Type of trust	Comment
14	The percentage of telephone calls (Category 1 and Category 2 calls) resulting in an emergency response by the trust at the scene of the emergency within 7 minutes of receipt of that call during the reporting period.	Ambulance Trust	In the table showing performance against this indicator, Category 1 and Category 2 calls should be separate.

Ambulance category 1 (C1) – life-threatening calls: response time

Category 1 2025/2026

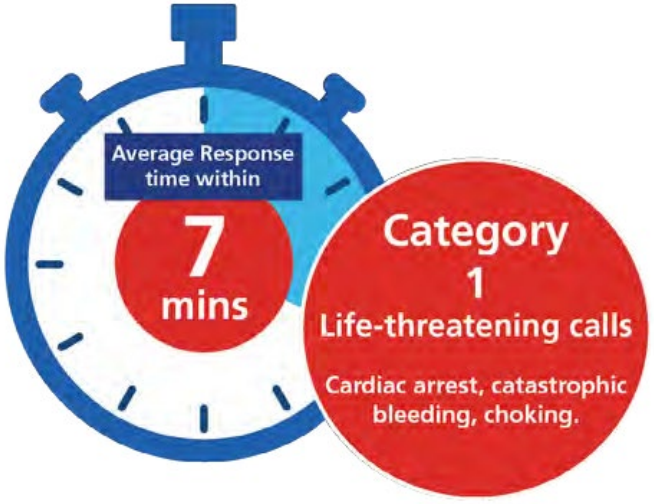
08:29 (Mean)
15:25 (90th Percentile)

Category 1 2024/2025

08:54 (Mean)
16:10 (90th Percentile)

Category 1 2023/2024

08:51 (Mean)
16:04 (90th Percentile)



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

The South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons.

- Computer Aided Dispatch (CAD) system has robust fallback plans
- Ambulance response standards are measured and reported nationally
- The trust has a robust data quality process for ensuring performance reporting which is benchmarked, and that data is scrutinised internally by the Executives, Board and by commissioners

SCAS intends to take the following actions to improve this indicator and so the quality of its services, by continually analysing the ambulance response data and continuing to model our staff rotas and fleet availability to meet the category requirements. Through the integrated performance report to trust Board there will be clear visibility of the data and our actions.

	Prescribed information	Type of trust	Comment
14.1	The percentage of Category 2 telephone calls resulting in an ambulance response by the trust at the scene of the emergency within 18 minutes of receipt of that call during the reporting period.	Ambulance Trusts.	

Ambulance category 2 (C2) – emergency calls: response time

Category 2 2025/2026 30:02 (Mean) 59:09 (90th Percentile) **Category 2 2024/2025** 31:58 (Mean) 1:03:31 (90th Percentile) **Category 2 2023/2024** 34:14 (Mean) 1:08:22(90th Percentile)	

The percentage of Category 2 telephone calls resulting in an ambulance response by the trust at the scene of the emergency with a national target of within 18 minutes of receipt of that call during the reporting period. SCAS are commissioned above 18 mins and the year-end target for 2025/26 was set at 29:49.

The South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons.

- CAD system has robust fallback plans
- Ambulance response standards are measured and reported nationally
- The trust has a robust data quality process for ensuring performance reporting which is benchmarked, and that data is scrutinised internally by the Executives, Board and by commissioners

SCAS intends to take the following actions to improve this indicator and so the quality of its services, by continually analysing the ambulance response data and continuing to model our staff rotas and fleet availability to meet the category requirements. Release to Respond has decreased handover delays and Hear and Treat rates are positive. Through the integrated performance report to trust Board there will be clear visibility of the data and our actions.

Ambulance category 3 (C3) – urgent calls: mean average response time

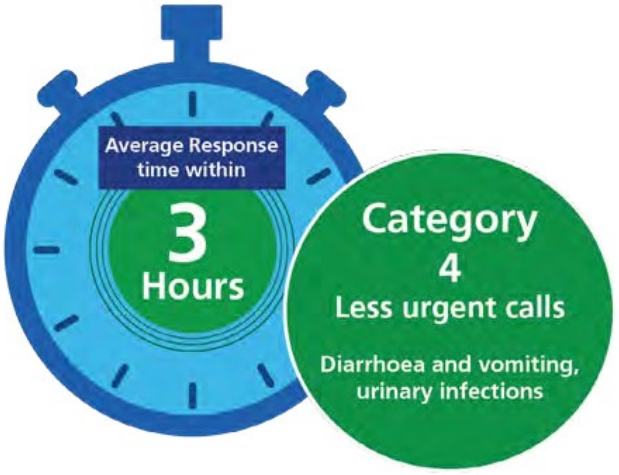
Category 3 2025/26 5:54:18 (90th Percentile) **Category 3 2024/25** 5:46:03 (90th Percentile) **Category 3 2023/24** 5:22:31(90th Percentile)	

The South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons.

- CAD system has robust fallback plans
- Ambulance response standards are measured and reported nationally
- The rrust has a robust data quality process for ensuring performance reporting which is benchmarked, and that data is scrutinised internally by the Executives, Board and by commissioners

SCAS intends to take the following actions to improve this indicator and so the quality of its services, by continually analysing the ambulance response data and continuing to model our staff rotas and fleet availability to meet the category requirements. Work continues to ensure that patients are navigated to the right care pathway for them to receive the care needed. Delivery of outcome of Hear and Treat at 20%. Through the integrated performance report to trust Board there will be clear visibility of the data and our actions.

Ambulance category 4 (C4) – less urgent calls: mean average response time

Category 4 2025/2026 6:32:05 (90th Percentile) **Category 4 2024/2025** 6:27:37 (90th Percentile) **Category 4 2023/2024** 6:44:13 (90th Percentile)	

The South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons.

- CAD system has robust and tested fallback plans
- Ambulance response standards are measured and reported nationally
- The trust has a robust data quality process for ensuring performance reporting which is benchmarked, and that data is scrutinised internally by the Executives, Board and by commissioners

SCAS intends to take the following actions to improve this indicator and so the quality of its services, by continually analysing the ambulance response data and continuing to model our staff rotas and fleet availability to meet the category requirements. Work continues to ensure that patients are navigated to the right care pathway for them to receive the care needed. Delivery of outcome of Hear and Treat at 20%. Through the integrated performance report to the trust Board there is clear visibility of the data and our actions to improve.

	Prescribed information	Type of trust	Comment
15	The percentage of patients with a pre-existing diagnosis of suspected ST elevation myocardial infarction who received an appropriate care bundle from the trust during the reporting period.	Ambulance Trusts.	

Ambulance Clinical Quality Indicators year to date (YTD) April to November 2025 against national average (YTD).

Clinical Quality Indicator	Lower	Upper	Difference	National Average	South Central	Difference	Greater or lower than Average
% STEMI Care Bundle	57.81%	95.92%	38.11%	81.99%	73.52%	-8.47%	Lower

The South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons.

- Electronic patient record data and analysis
- Report and data for national reporting requirements
- Board reports / Integrated performance report

SCAS intends to take the following actions to improve these indicators, and so the quality of its services, by utilising data collected from the electronic patient record system and analysing that data as per national reporting requirements. SCAS has an internal clinical audit programme and conducts deep dives where necessary reporting to the Clinical Review Group and Quality and Safety committee.

	Prescribed information	Type of trust	Comment
16	The percentage of patients with suspected stroke assessed face to face who received an appropriate care bundle from the trust during the reporting period.	Ambulance Trusts	This indicator was retired. Last data submitted Feb 2024

	Prescribed information	Type of trust	Comment
21	The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	Trusts providing relevant acute services	

	Your Trust in 2025	Average (median) for ambulance trusts	Your Trust in 2024	Your Trust in 2023
"If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation"	56.75%	59.24%	58.28%	61.53%

The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.

- The engagement cycle will continue to be the vehicle for development/improvement, owned by the Culture and Leadership Team
- The trust will be triangulating the National Staff Survey and National Education and Training survey results, with the addition of the volunteer survey this year. This will be completed by the Culture and Leadership Team
- The Culture and Leadership Team own the SCAS-wide actions and manage the engagement plan

25	The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	In 2025/26 there were 5,152 patient safety incidents reported. Of these, 50 (0.97%) resulted in severe harm or death.

	2022/23	2023/24	2024/25	2025/26
Number of incidents	1,720	2,234	5,365	5,152
Number and % severe harm/death	12	54	55	50
	(0.7%)	(2.4%)	(1.0%)	(0.97%)

The South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons:

- Trust electronic reporting system (Datix) reports
- Clinical governance meeting reports and scrutiny of data
- Patient Safety and Experience group data analysis
- Incident report screening by Clinical Governance Lead/Patient Safety team
- Learn from Patient Safety Events (LFPSE)

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

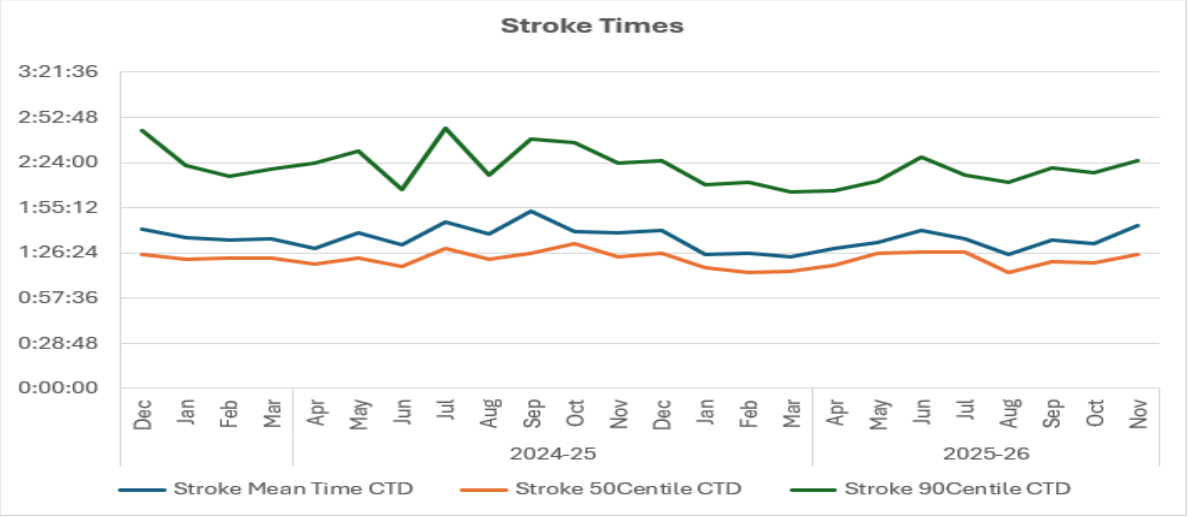
- Ongoing training for staff on incident reporting and HEE patient safety training modules
- Reviewing numbers, severity, and themes of incidents at the Patient Safety and Experience Group
- Trust Board scrutiny
- Safety culture survey

Ambulance Trust indicators

Stroke 60 minutes (please see below for revised definition)	Ambulance Trusts
Return of spontaneous circulation (ROSC) where the arrest was bystander witnessed, and the initial rhythm was ventricular fibrillation (VF) or ventricular tachycardia (VT)	Ambulance Trusts

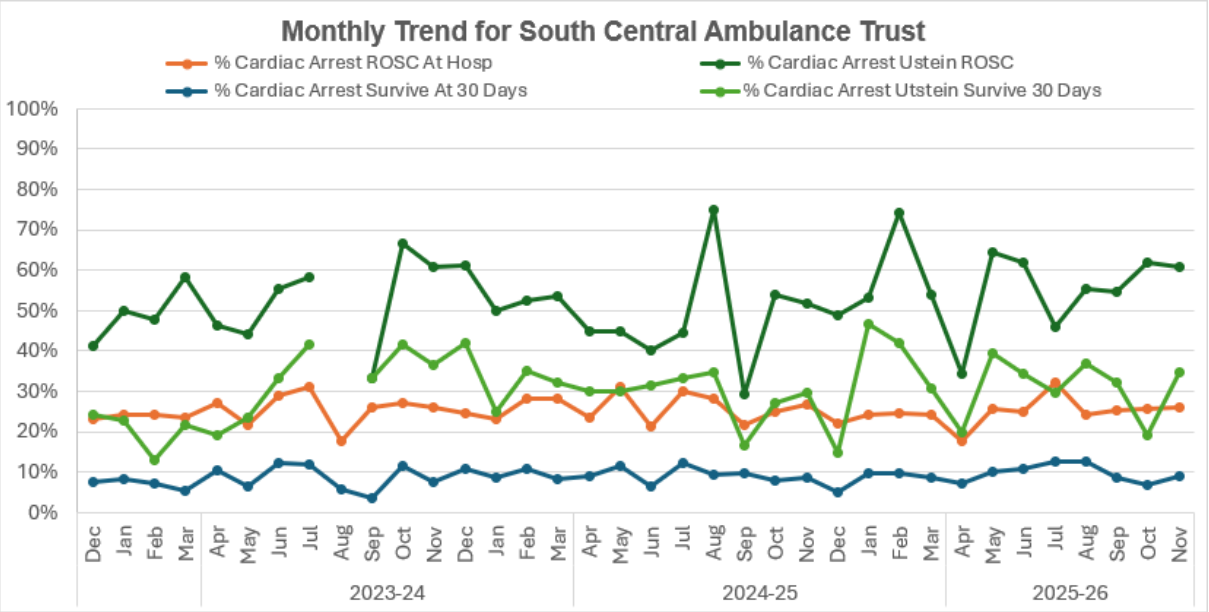
Stroke performance

The stroke ACQI datasets comprise of timeliness. The national data submission for call to door indicator is shown below.



Return of Spontaneous Circulation (ROSC)

The chart below details the current and historic SCAS ROSC rates for return of spontaneous circulation (ROSC) where the arrest was bystander witnessed and the initial rhythm was ventricular fibrillation (VF) or ventricular tachycardia (VT)



Learning from Deaths

27.1	The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	During 01/04/2025 – 31/03/2026, 282 of SCAS patients met the Learning from Deaths criteria of requiring review following cardiac arrest. This comprised the following number of deaths which occurred in each quarter of that reporting period: 74 in the first quarter; 74 in the second quarter; 77 in the third quarter; 57 in the fourth quarter.

27.2	The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	282 case record reviews have been carried out. In 89 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 38 in the first quarter; 19 in the second quarter; 24 in the third quarter; 8 in the fourth quarter.

27.3	An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: 0 representing 0% for the first quarter. 0 representing 0% for the second quarter. 0 representing 0% for the third quarter. 0 representing 0% for the forth quarter.
27.4	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3.	The standard of care provided by our staff is excellent in most cases. Documentation could have been improved in a small number of cases. Crew feedback was given directly in a small number of cases. Cases involving delays and where concerns on the level of care provided were investigated by the Patient Safety Team.
27.5	A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4).	Feedback given to SCAS crews on improving documentation. Feedback to individual crews. Hospitals informed where a cardiac arrest occurred shortly after patients were discharged from hospital. Primary Care asked to consider carrying oxygen on home visits

27.6	An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.	Monitoring documentation quality continues. A documentation review group is in place. The Electronic Patient Report form is due for replacement, and the project team have been asked to consider ways that the design and functionality can help improve the quality of documentation.
27.7	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period.	Covered in 27.2.
27.8	An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.	Covered in 27.3.
27.9	A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8.	Covered in 27.3.

Part 3: Other Information and Quality Priorities for 2026/27

3.1 Regulation assurance and compliance

The table below shows the current SCAS Care Quality Commission (CQC) rating.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency operations centre (EOC)	**Good ▲ May 2025**	**Good May 2025**	**Good May 2025**	**Good ▲ May 2025**	**RI ⋈ May 2025**	**Good ▲ May 2025**
Patient transport services	**RI ▼ June 2020**	**Good June 2020**	**Good Jun 2020**	**Good June 2020**	**Good June 2020**	**Good June 2020**
Emergency and urgent care	**RI ▲ May 2025**	**Good May 2025**	**Good May 2025**	**Good May 2025**	**RI ▲ May 2025**	**RI ▲ May 2025**
Resilience	**Good Nov 2018**	**Good Nov 2018**	**Not rated**	**Good Nov 2018**	**Good Nov 2018**	**Good Nov 2018**

3.2 CQC inspections

The trust had unannounced core service inspections of the Emergency Operations Centre and Urgent and Emergency Care services in May 2025. The Well-led inspection was then undertaken in January 2026.

The Emergency Operations Centre and Urgent and Emergency Care service assessment reports were published on 19 December 2025. The service rating for the Emergency Operations Centre improved from *requires improvement in 2022* to *good*, while the rating for Emergency and Urgent Care improved from *inadequate in 2022* to *requires improvement.*

Emergency and Urgent Care (E&UC) breached three regulations (safe care, governance, staffing).

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

Regulation 18
How the regulation was not being met:
There was a lack of clinical oversight to ensure staff were supported and had effective development, to consistently deliver safe care and treatment to patients.

Action templates have been submitted to the CQC, and internal work programmes are in place. Updates are provided to relevant groups and committees.

At the time of writing the Well-led inspection report was awaited. The Well-led assessment is separate from core service reports but the outcome of this will impact the overall trust rating.

3.3 Trust Improvement Programme

Trust improvement programmes have continued during 2025/26. Following a recommendation made to the NHSE Executive Performance, Quality and Delivery Group by the NHS England South East regional team, the trust has received formal confirmation of its exit from the Recovery Support Programme (RSP) in January 2026.

NHS England wrote to the trust in March 2026 to confirm a full review of the existing 2024 undertakings and determine progress. The South East Regional Support Group (RSG) approved the recommendation on 15 April 2026 to issue a compliance certificate and therefore removal of the SCAS 2024 undertakings. The existing September 2023 Finance undertakings will remain as is and will be reviewed during Quarter One 2026/27. The removal of the 2024 Undertakings is a positive step in the improvement journey of SCAS.

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

3.4. Patient Safety Incident Response Framework (PSIRF)

SCAS transitioned to the Patient Safety Incident Response Framework (PSIRF) in April 2025. Since implementation, a total of 272 learning responses have been undertaken, with 116 assigned during 2025/26**.**

A robust governance structure now underpins PSIRF. Patient safety incidents and patient experience contacts are reviewed daily**,** with escalation to the Safety Panel Review where appropriate. Decisions regarding learning responses are then subject to executive oversight through the Oversight and Review Group. The Board receives regular visibility of both the daily review process and the weekly Safety Review Panel outcomes.

Two Patient Safety Partners (PSPs) were successfully recruited; however, one subsequently chose not to continue in the role. Recruitment is therefore underway to

appoint a second PSP to maintain the expected level of patient contribution to safety governance.

Training compliance remains strong, with HEE Levels One and Two exceeding the trust target of 95%**.** More than 200 staff have received in-house training to deliver SWARM huddles, supporting both immediate fact-finding and learning responses to patient safety incidents. Training for the newly appointed Clinical Operations Managers, following the Operations restructure, is planned and expected to be completed by the end of the calendar year.

Learning from patient safety incidents is shared widely across the organisation. This includes a monthly patient safety newsletter, the Patient Safety Sessions (livestreamed and recorded), learning snapshots presented at service line meetings, and regular updates across digital platforms such as Viva Engage and the Patient Safety Hub page. Learning snapshots are now also converted into case studies with accompanying quizzes and uploaded to Parapass**,** enabling monitoring and tracking of staff engagement and completion.

3.5. Safeguarding

The improvement programme in safeguarding has continued in 2025/26. Key areas of focus are noted below.

My Referral Form
The launch of *My Referral Form* did not have the anticipated impact on referral quality, and improvement has not yet reached the desired standard. In response, during 2025/26, we worked closely with partner agencies, managers, and frontline staff to design a new digital safeguarding referral form. This form is tailored specifically to reflect the nuances of emergency and urgent care, while also meeting the information requirements of partner agencies. The new form is planned for launch in 2026/27.

Mental Capacity Act (MCA)
During 2025/26, the trust continued to embed and sustain high-quality Mental Capacity Act (MCA) practice across frontline services, building on the successful implementation of the MCA training programme.

Training compliance remains consistently high, with 98% of staff having completed MCA Level 1 training and 99% having completed Level 2a/b. This demonstrates a sustained organisational commitment to ensuring staff have the knowledge and confidence to apply MCA principles in practice.

Since April 2025, the Safeguarding Specialist MCA/LPS Lead has delivered 19 bespoke MCA training sessions directly to operational crews. These sessions focused on the practical application of MCA within time-critical and complex operational environments. In addition, MCA has been embedded into the Operational Commanders' induction programme, which is delivered to four cohorts each year, strengthening leadership oversight and decision-making capability.

Training
By the end of Quarter 4, Safeguarding Levels 1 and 2 and 3 met their targets for training trajectories. 93% of staff attended the Level 3 four-hour training. To go further for patient safety, the trust sought to ensure compliance with all elements of the intercollegiate guidance however, challenges with staff abstraction, recording of compliance, and requirement complexity meant that stetch targets were not met for safeguarding supervision, CPD, and 7.5-hour training.

In Quarter 4 of 2025/26, the Safeguarding Team worked closely with Education and Scheduling to develop a bespoke safeguarding training package for SCAS. This will be delivered annually from 2026/27, improving staff abstraction, compliance recording, and the ability to update training content in line with new guidance and learning.

3.6. Quality Improvement (QI)

We continue to build capacity in Quality Improvement across the trust by utilising our NHS Elect membership to train cohorts of staff to become QI Champions. A further 33 staff have been trained between April 2025 and March 2026. These champions all have the experience of developing a small-scale QI project using improvement methodologies. The Fit for the Future proof of concept work is also QI based.

QI is one of the areas SCAS is collaborating with South East Coast Ambulance Service (SECAmb). This area of collaborative work will continue to develop in 2026/27.

3.7. Freedom to Speak Up (FTSU)

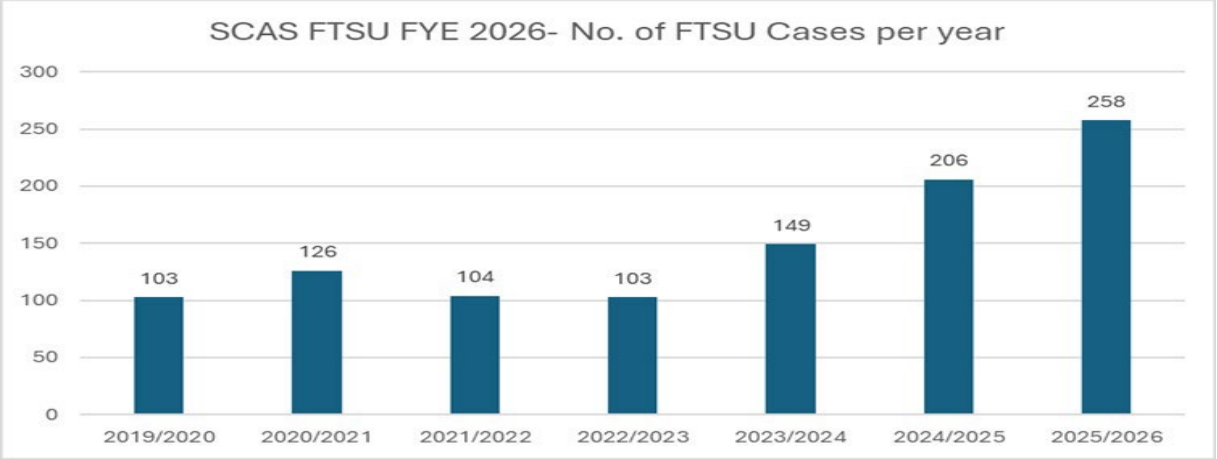
FTSU Guardians and FTSU Champions
The FTSU Guardian team is established at 3.0 whole-time equivalents (WTE) aligned with national recommendations.

Our FTSU Guardian team are supported by a growing network of FTSU Champions who are embedded across various departments and roles throughout SCAS.

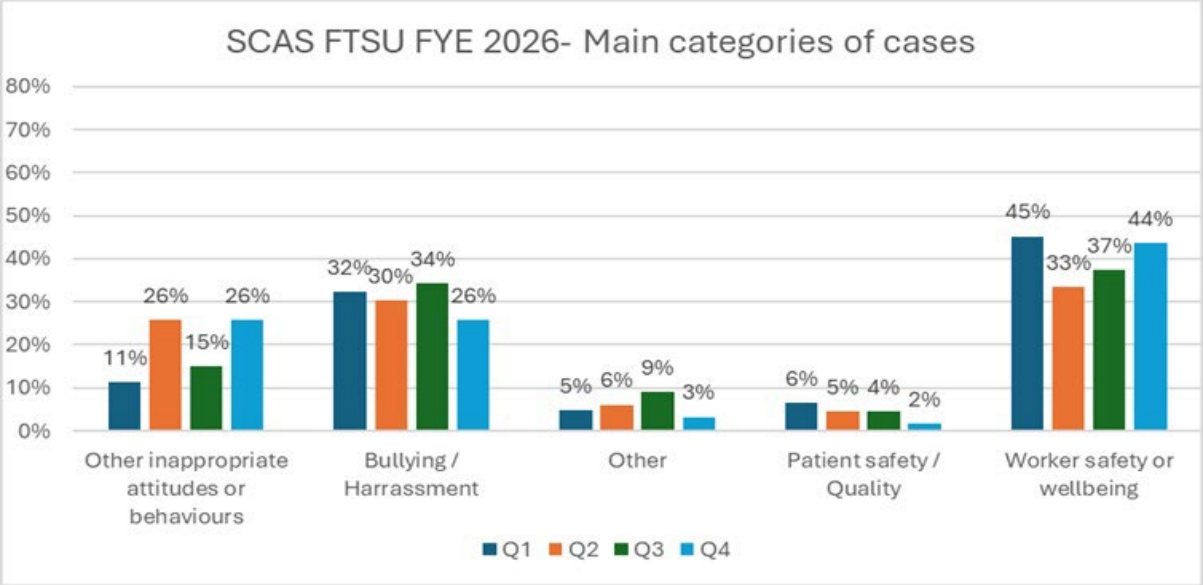
In 2025/2026, the FTSU Champion network continued its expansion increasing to 79 trained Champions, who are actively raising concerns, supporting colleagues, and providing valuable insights that contribute to a more inclusive, responsive and continuously improving speaking-up culture across the organisation.

Overview of cases raised via FTSU and user feedback
During 2025/2026, the trust saw the continued increase in the number of concerns raised via our FTSU team. The chart below shows that 258 concerns were reported during this period. This reflects the work of the FTSU team and increased awareness of the service.

The continued rise in anonymous concerns suggests increasing engagement with reporting mechanisms but also highlights persistent concerns about psychological safety and fear of reprisal, requiring targeted cultural and leadership interventions, these are underway.



The primary categories of concerns with SCAS, can be seen in the chart below (the national benchmarks for the year are yet to be published).



Whilst cases reported as patient safety can seem low, it must be remembered that this is in the context of a majority of FTSU concerns being raised by those in clinical or additional clinical services.

Our FTSU team continues to work closely with the Safeguarding, People Directorate, Culture and Leadership; Equality, Diversity and Inclusion (ED&I), Operations and Clinical teams and Staff network leads, to triangulate data and highlight themes and learning.

Our FTSU Guardian service and Champions continue to play a role in improving awareness around sexual safety across the trust.

National Staff Survey (NSS)
In Quarter 4 2025/26, the National Staff Survey (NSS) results were published. The NSS includes four key questions on Speaking up, Listening, and Following Up. Together, these form the *Raising Concerns* sub-score, which is one of two components of “We each have a voice that counts.”

This year’s results suggest that while staff feel consistently safe to raise concerns, confidence that the organisation will act on those concerns is not strong. This creates a risk of a widening trust gap where people feel able to speak up, but are less certain that change will result.

FTSU eLearning
All three modules of the National eLearning ‘Speak Up’ ‘Listen Up’ and ‘Follow Up’ continue to be part of SCAS’s Mandatory training.

At the end of Quarter 4 2025/26, 4,762 people had completed a module of the Speak, Listen or Follow Up training (total in 2024/5 was 4,551).

However, compliance fluctuates with a mixed picture at the end of Quarter 4:

- Speaking Up (All Staff): 99% (↑)
- Speaking & Listening Up (Managers): 95% (↓)
- Speaking, Listening & Following Up (Senior Managers): 86% (↓)

This formal eLearning offer contributes to our leadership interventions delivered and planned by Trust Subject Matter Experts, as well as the ongoing workstreams associated with our Just and Learning Culture, and the Patient Safety team and Patient Safety Incident Response Framework (PSIRF).

Learning
We report this balancing confidentiality and transparency and with a reminder that with some cases are still being investigated.

As well as reporting to trust Board, the FTSU team publish learning from cases on our internal the hub pages:

- *“Follow-Up in Action”* was launched on the Hub (SCAS intranet) following an idea from a staff member during a team training session. This now provides updates on themes from anonymous cases or cases of note, enabling learning to be shared and celebrated on our Hub page.

Speak Up for Patient Safety (SUPS) Cafés
Understanding how FTSU and Patient Safety are inseparable, and that a culture that enables workers to raise concerns without fear is fundamental to identifying risks early, preventing harm, and embedding continuous learning, in 2025/26 we established a series of collaborative online *Speak Up for Patient Safety (SUPS) Cafés*, with our Patient Safety Team.

3.8. Accreditation Programme

The first cycle of the trust model of accreditation has been completed giving a high-level picture of compliance across the trust; in terms of infection prevention and control, premises, vehicles and audit, safe and secure handling of medicines and staff competence and training.

Resource centres that did not meet the threshold for an award have been supported to work through an action plan to ensure they reach the required standard. This is reported through the performance and accountability framework.

We have seen the accreditation programme drive improvement in premises and vehicle cleanliness, as well as audit compliance and consistency. We continue to develop the model as data sets become available, such as clinical dashboards. We have had productive and beneficial improvement conversations with management teams across the trust. The manual of accreditation has been revised following the first cycle.

Quality Priorities for 2026/27

Patient Safety

1a. Ensure relevant staff are trained in accordance with PSIRF requirements – as per training plan and business case.

Why we have chosen this priority
The Patient Safety Strategy (2019) focuses on improving patient safety and building on the foundations of safer systems and a safer culture within the NHS. To adhere to this national mandate SCAS is required to ensure that all the staff who are delegated roles pertaining to the management of patient safety incidents are appropriately trained and supported. There have been divisional restructures during 2025/26 with new roles and post holders in place.

What will we do?
Deliver:

- Module One: PSIRF Lite training to service line representatives
- Module Two: Engaging Patients, Family and Staff training to service line representatives
- Module Three: After Action Review (AAR) training to service line representatives
- Audit the frequency and quality of After Action Reviews undertaken within divisions

Implementation Lead
Assistant Director of Patient Safety sponsored by the Chief Nurse.

1b. Develop the patient safety survey tool so that staff are surveyed on a wider view of patient safety.

Why have we chosen this priority?
The creation and maintenance of a good safety culture is imperative to reducing avoidable harm. This is an area of continued focus for the trust.

What will we do?
- Survey staff as per schedule
- Develop improvement plans following review of results
- Review the survey tool developed in 2025/26

Implementation Lead
Assistant Director of Patient Safety sponsored by the Chief Nurse.

1c. Audit of patient safety improvement actions

Why have we chosen this priority?
Patient safety is a fundamental pillar of high-quality healthcare and a core value that underpins everything we do. Our aim is to deliver care that is consistently safe, compassionate, and free from avoidable harm. This requires a proactive, learning-focused approach that embeds safety into every level of our organisation from frontline practice to Board-level governance.

What we will do
- Develop an audit plan
- Conduct audits as per plan and identify areas and share of good practice and improvement.
- Report progress to Patient Safety and Experience Group

Implementation Lead
Assistant Director of Patient Safety sponsored by the Chief Nurse.

Clinical Effectiveness

2a. To report on Category 1 - 4 performance

Why we have chosen this priority
Reporting against NHSi core indicators for Quality Accounts.

What we will do
- Report in the Integrated Quality and Performance report to the trust Board
- Reported in the Quality Account in the section named NHS Core Indicators

Implementation Lead
Business Intelligence sponsored by the Executive Director of Operations.

2b. To report on national STEMI care bundle compliance

Why we have chosen this priority
Reporting against NHSi core indicators for Quality Accounts.

What we will do
- Report in the Integrated Quality and Performance report to trust Board
- Report to Clinical Review Group
- Reported in the Quality Account in the section named NHS Core Indicators

Implementation Lead
Consultant Paramedic sponsored by Chief Paramedic.

2c. Ensure patients receive appropriate analgesia based on pain scores

Why we have chosen this priority
Improvement workstream in recent years has focused on pain scores and analgesia. Changes were made to the analgesia available and updated management for moderate pain published. Staff were provided with education on the analgesia pain ladder guidelines.

What we will do
- We plan to re-audit this year to ensure there has been sustained improvement in the management of pain across the organisation
- An action plan will be in place, if necessary, from the findings and monitored via the Medicines Optimisation Governance Group

Implementation Lead
Chief Pharmacist sponsored by Chief Paramedic.

Patient Experience

3a. Co-production of amendments to current Healthcare Professional (HCP) feedback process to ensure high level focus on clinical concerns and learning.

Why we have chosen this priority
Builds on work undertaken during 2025/26. We are committed to refining our feedback systems - such as the Healthcare Professional (HCP) feedback process - to ensure that clinical concerns are not only addressed promptly but are also used to inform meaningful learning and service development.

What we will do
- Co-produce new parameters and process for HCP feedback. This will include ICB colleagues. Trial new process and re-audit in 2026/27.

Implementation Lead
Head of Patient Experience sponsored by Chief Nurse.

3b. Patient Survey – increase response rates

Why we have chosen this priority
We place strong emphasis on co-production, shared learning, and strengthening the patient voice at every level of care delivery and decision-making. We plan to enhance patient surveys, ensuring that feedback is easier to provide and more widely captured. This will allow more detailed thematic review for both positive and negative responses and for improvement actions to be developed for areas that require action.

What we will do

- QI project focused on increasing patient survey responses. This includes the digitalisation of the process
- Business case to be submitted
- Once digital solution in place, an improvement trajectory will be set and approved via Patient Safety and Experience Group

Implementation Lead
Patient and Public Engagement Facilitator sponsored by Chief Nurse.

3c. Adopt the Experience of Care Improvement Framework and complete a Gap Analysis and action plan to improve Pt Experience

Why we have chosen this priority
The Experience of Care Improvement Framework has been developed by NHS England, aimed at enhancing outcomes and experiences for service users, unpaid carers, staff, volunteers, and communities. It covers five key domains: Leadership, Culture, Feedback Collection, Feedback Analysis, and Learning for Improvement.

What we will do

- Experience of Care Improvement Framework Task and Finish Group to complete gap analysis and develop an action plan
- Improvement actions identified and allocated to Subject Matter Experts to complete
- Audit of framework improvement actions - embedding and outcomes

Implementation Lead
Head of Patient Experience sponsored by Chief Nurse.

Annex 1: Statement from commissioners – NHS Hampshire and Isle of Wight Integrated Care Board:

NHS
Hampshire and Isle of Wight

Nursing & Quality Team
NHS Hampshire and Isle of Wight Integrated Care Board
Omega House
112 Southampton Road
Eastleigh
SO50 5PB
Phone: 0300 561 2561
Email: Team mailbox address
www.hantsiow.icb.nhs.uk

Sent via email
Stuart Rees

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

26 June 2026

Dear Stuart

Quality Account

Please find below, the formal response to your Quality Account for 2024/25 from NHS Hampshire and Isle of Wight.

Statement from Commissioners:

NHS Hampshire and Isle of Wight Integrated Care Board (ICB) welcome the opportunity to comment on the Quality Account for the 2025/26 reporting period, as part of its statutory commissioning and quality oversight responsibilities. We have incorporated feedback from our Associate Commissioners and are satisfied that the Quality Account meets the mandated requirements and provides an appropriate overview of the organisation's quality priorities and performance.

Through ongoing engagement with South Central Ambulance Service NHS Foundation Trust, the ICB has sought assurance that commissioned services are delivered in line with expected standards of safety, effectiveness and person-centred care. Where required, the ICB has supported and overseen agreed improvement actions through established governance and assurance arrangements.

While the Trust has not fully achieved all its 2025/26 priorities, the ICB recognises the progress made, including the introduction of a patient panel, achievement of response time standards, compliance with the STEMI care bundle, and the embedding of a refreshed audit programme. Where variability remains, the ICB is

assured that improvement plans are in place and, where appropriate, the Quality Account incorporates these into the priorities for the coming year.

The 2026/27 priorities focus on embedding progress, strengthening patient safety culture, additional Patient Safety Incident Response Framework (PSIRF) staff training with the aim to improve compliance with the national framework.

The ICB also commends the Trust on its successful exit from the Recovery Support Programme (RSP) and the positive outcomes of the Care Quality Commission (CQC) inspection of the Emergency Operations Centre and Emergency and Urgent Care divisions in May 2025. Both achieving improved ratings, and evidence of positive feedback from patients and families, who reported that staff treated them with compassion and kindness while delivering effective care and treatment.

We welcome the partnership working with South East Coast Ambulance Service, through the new group model.

The ICB acknowledges and values South Central Ambulance Service NHS Foundation Trust engagement in quality governance arrangements, including facilitating ICB participation in internal quality meetings to support assurance and commissioning oversight. We also recognise the Trust's contribution to local and system-wide quality improvement through its active participation in the Hampshire and Isle of Wight System Quality Group

The ICB looks forward to continued opportunities for shared learning through relevant system quality forums, including the Hampshire and Isle of Wight System Quality Group.

Overall, the ICB considers the Quality Account for 2025/26 to be a fair and accurate reflection of the services provided. The ICB will continue to work with South Central Ambulance Service NHS Foundation Trust during 2026/27 through established assurance and oversight arrangements to support ongoing improvement.in the quality of care delivered to the population we serve.

Yours sincerely

Wendy Newnham
Interim Chief Nursing Officer

Annex 2: Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- The content of the quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2020/21 and supporting guidance Detailed requirements for quality reports 2018/19
- The content of the quality report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2025 to March 2026
    - papers relating to quality reported to the Board over the period April 2025 to March 2026
    - Feedback from commissioners dated 26 June 2026
    - The trust's complaints report published under regulation 18 of the Local Authority Social Service and NHS Complaints Regulations 2009, dated June 2025.
    - the national staff survey published March 2026.
    - CQC inspection report dated December 2025.
- The quality report presents a balanced picture of the NHS foundation trust's performance over the period covered
- The performance information reported in the quality report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board

Stuart Rees

Interim Chief Executive Officer

30 June 2026