NHS
South Central Ambulance Service
NHS Foundation Trust

PUBLIC BOARD AGENDA

Date: Wednesday 3 September 2026

Time: 9:45 – 12:45

Venue: Classroom 2&3 Newbury Education & Recruitment Centre | Bone Lane | Newbury | RG14 5UE

Board Members:

Colin Dennis	Trust Chair
Harbhajan Brar	Non-Executive Director
Gary Ford, CBE	Non-Executive Director
Mike McEnaney	Non-Executive Director
Katie Kapernaros	Non-Executive Director
Karl Khan	Non-Executive Director
Peter Schild	Non-Executive Director
Ruth Williams	Non-Executive Director
Stuart Rees	Acting Chief Executive Officer
Mark Ainsworth	Executive Director of Operations
Jon Bell	Chief Finance Officer
Dr John Black	Chief Medical Officer
Craig Ellis*	Chief Digital & Information Officer
Danny Hariram	Chief People Officer / Deputy Chief Executive
Paul Kempster *	Chief Transformation Officer
Becky Murray*	Chief Governance Officer
Duncan Robertson	Chief Paramedic Officer
Helen Young	Chief Nurse

* Non-voting board member

In Attendance:

Gillian Hodgetts	Director of Communications, Marketing and Engagement
Kofo Abayomi	Head of Corporate Governance & Compliance

Apologies for Absence:

Gary Ford	Non-Executive Director
Duncan Robertson	Chief Paramedic
Helen Young	Chief Nurse Officer

Number	Item	Format	Action	Time
1	**Welcome and Apologies**	**Verbal**		

	Colin Dennis			09.45
2	**Declarations of Interests and Fit and Proper Persons Test** Colin Dennis	**ENC 1**	**Verbal**	
3	**Minutes from the Public Board meeting held on 3 June 2026** Colin Dennis	**ENC 2**	**Approval**	
4	**Board Action Log** Becky Murray, Chief Governance Officer	**ENC 3**	**Approval**	
5	**Chair's Report** Colin Dennis	**ENC 4**	**Noting**	09.55
6	**Chief Executive Officer's Report** Stuart Rees, Interim Chief Executive Officer	**ENC 5**	**Noting**	10.05
7	**Staff Story** Danny Hariram, Chief People Officer/Deputy Chief Executive	**ENC 6**	**Discussion**	10.15
8	**Fit For Future Transformation plan Month 4** Danny Hariram, Chief People Officer/Deputy Chief Executive	**ENC 7**	**Approval**	10.25
Trust Performance				
9	**Finance & Performance Committee Report: 31 July 2026** Harbhajan Brar, NED	**ENC 8**	**Assurance**	10.30
10	**Integrated Performance Report** Craig Ellis, Chief Digital & Information Officer	**ENC 9**	**Assurance**	10.35
11	**Finance Report Month 4** Jon Bell, Interim Chief Finance Officer	**ENC 10**	**Assurance**	10.50
12	**Winter Framework 2026/27** Mark Ainsworth, Executive Director of Operations	**ENC 11**	**Approval**	11.00
Strategic Theme: Enabling Services				
13	**Enabling Services Board Assurance Framework Risks** Jon Bell, Interim Chief Finance Officer	**ENC 12**	**Assurance**	11.15
Strategic Theme: Digital Transformation				

14	**Digital Transformation Board Assurance Framework Risks** Craig Ellis, Chief Digital & Information Officer	**ENC 13**	**Assurance**	11.20
Strategic Theme: Clinical Effectiveness				
15	**Quality and Safety Committee Report: 15 July 2026** Katie Kapernaros, NED Chair	**ENC 14**	**Assurance**	11.25
16	**Clinical Effectiveness Board Assurance Framework Risks** Duncan Robertson, Chief Paramedic Officer	**ENC 15**	**Assurance**	11.30
Strategic Theme: People & Culture				
17	**People & Culture Committee Report: 29 July 2026** Harbhajan Brar, NED Chair	**ENC 16**	**Assurance**	11.35
18	**People & Culture Board Assurance Framework Risks** Danny Hariram, Chief People Officer/Deputy Chief Executive	**ENC 17**	**Assurance**	11.40
19	**Lord Mann Recommendations Implementation Plan Update** Danny Hariram, Chief People Officer/Deputy Chief Executive	**ENC 18**	**Approval**	11.45
20	**Freedom to Speak Up** • **Freedom to Speak Up Annual Report** • **Freedom to Speak Up Policy** Becky Murray, Chief Governance Officer	**ENC 19**	**Approval**	11.55
Strategic Theme: Partnerships & Sustainability				
21	**Partnerships & Sustainability Board Assurance Framework Risks** Jon Bell, Interim Chief Finance Officer	**ENC 20**	**Assurance**	12.05
Governance & Regulation				
22	**Audit Committee Chair's Report: 25 June 2026** Mike McEnaney, NED Chair	**ENC 21**	**Assurance**	12.10
23	**Provider Capability Assessment 2026/27** Becky Murray, Chief Governance Officer	**ENC 22**	**Approval**	12.15
25	**Non-Executive Director Appointments** Becky Murray, Chief Governance Officer	**ENC 23**	**Approval/Noting**	12.25

Closing Business				
26	**Summary of actions from the meeting** Becky Murray, Chief Governance Officer	**Verbal**	**Noting**	12.30
27	**Questions from the public** Colin Dennis	**Verbal**	**Response**	12.34
28	**Any Other Business**	**Verbal**	**Noting**	-
29	**Review of Meeting** NED: Harbhajan Brar Executive: Mark Ainsworth	**Verbal**	**Discussion**	12.45
30	**Date and Time of Next Meeting in Public** Thursday 5 November 2026 at 9.45am Blue Light Hub, 3 Thornbury, West Ashland, Milton Keynes MK6 4BB	**-**	**Noting**	

Our vision

Right care, first time, for our patients

Our strategic themes

Our values

We are Caring

We are Professional

We are Honest

South Central Ambulance Service
NHS Foundation Trust

BOARD MEMBERS REGISTER OF INTERESTS

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

INTRODUCTION & BACKGROUND

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

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

DOCUMENT INFORMATION

Date of issue: 04 August 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 (ending Sept 2026)

Current 'Other' Interests

2. Green Square Accord (Social Housing Association) Chair
3. Green Square Homes Ltd, Non-Executive Director

Interests that ended in the last six months

4. None

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. Trustee of Kings Group Academy

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. Thames Valley ICB, Integrated Stroke Delivery Network, Chair
6. Thames Valley ICB, Population Health and Commissioning Board

Current 'Other' Interests

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

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. Investor Oxford Medical Products Ltd*
3. Oversight of commercially funded (NHIR) Clinical Research at SCAS which reports into CRG which I Chair
4. Rebecca Black (wife) , Consultant Obstetrician and Sub-specialist in feto-maternal medicine at Oxford University Hospitals NHS Foundation Trust, was appointed as Interim Post Graduate Locality Dean for the Thames Valley by NHSE on 1st August 2025

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

Current 'Other' Interests

5. None

Interests that ended in the last six months

6. None

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, INTERIM CHIEF EXECUTIVE 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

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)

1. None

Current 'Other' Interests

2. None

Interests that ended in the last six months

3. None

JON BELL, INTERIM CHIEF FINANCE OFFICER

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

1. Director of SCFS Ltd.

Current 'Other' Interests

2. Trustee of the Association of Coloproctology of Great Britain and Ireland

Interests that ended in the last six months

3. None

END

NHS
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NHS Foundation Trust

Minutes
Public Trust Board Meeting

Date: 3 June 2026
Time: 9.45am – 12.45pm
Venue: Newbury Education & Recruitment Centre, Bone Lane, Newbury, RG14 5UE

Members Present:	
Les Broude (LB) (Chairing)	Non-Executive Director
Stuart Rees (SR)	Acting Chief Executive Officer
Ian Green (IG)	Non-Executive Director
Harbhajan Brar (HB)	Non-Executive Director
Gary Ford (GF)	Non-Executive Director
Mike McEnaney (MM)	Non-Executive Director
Ruth Williams (RW)	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)	Chief People Officer & Deputy Chief Executive
Jon Bell (JB)	Interim 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
Observers:	
None	
Apologies:	
Professor Sir Keith Willett CBE (KW)	Chair
Katie Kapernaros (KK)	Non-Executive Director
Paul Kempster	Chief Transformation Officer
Gillian Hodgetts (GH)	Director of Communications, Marketing and Engagement

Item No.	Agenda Item
1	**Chair's Welcome, Apologies for Absence**
1.1	The meeting was opened by the Les Broude, Chair (LB). Apologies were noted.

1.2	It was confirmed the meeting was held in public; no public questions had been received in advance.
2	**Declarations of Interests**
2.1	The Board noted updates to members' declarations of interests. No conflicts requiring action were identified.
2.2	The Board further noted compliance with the Fit and Proper Persons Test requirements, with no concerns raised.
3	**Minutes from Public Board Meeting held on 2 April 2026**
3.1	The minutes of the public board meeting held on 2 April 2026 were approved, subject to minor corrections (including spelling and accuracy of recorded apologies).
4	**Matters Arising and Action Log**
4.1	BM, Chief Governance Officer, presented the Board Action Log and provided an update on progress against actions arising from previous meetings.
4.2	The Board noted that the majority of actions had been completed and were recommended for closure. Updates were provided on the remaining open actions, including work relating to accreditation and associated communications. Members were advised that further follow-up was required to ensure the appropriate communication of accreditation outcomes and learning across the organisation. It was confirmed that progress would continue to be monitored through the action log until completion.
4.3	The Board sought assurance that actions were being progressed within agreed timescales and that there was appropriate executive oversight of those actions remaining open. Having reviewed the updates provided, members were satisfied with the progress made.
4.4	The Board **NOTED** the action log and **APPROVED** the closure of completed actions.
5	**Chairs Report**
5.1	In the absence of the Chair, Professor Sir Keith Willett, LB invited the Board to formally recognise and record its appreciation for Professor Sir Keith's leadership and contribution to the Trust during his tenure as Chair.
5.2	Members reflected on the significant role he had played in supporting the organisation through a challenging period, including providing leadership and oversight during the Trust's response to regulatory scrutiny and subsequent recovery. The Board acknowledged his commitment to ensuring that the organisation maintained a focus on patient care, quality improvement and organisational development throughout this period.
5.3	The Board further recognised Professor Sir Keith's contribution to strengthening both the Executive and Non-Executive Director teams, helping to build a cohesive and effective Board with a strong focus on governance, accountability and strategic leadership. Members noted the positive impact of his support and mentorship across the organisation.

5.4	The Board also acknowledged the important role he had played in developing and strengthening relationships with system partners and stakeholders across the health and care sector, helping to enhance the Trust's reputation and influence within the wider NHS system.
5.5	On behalf of the Board, LB expressed sincere thanks to Professor Sir Keith for his dedication, leadership and service to the Trust and wished him well for the future.
5.6	**The Board noted the report and recorded its appreciation and thanks to Professor Sir Keith Willett for his contribution to the Trust.**
6	**Chief Executive Officer's Report**
6.1	SR, Acting Chief Executive Officer, presented his report and provided an update on key developments affecting the Trust at local, regional and national level.
6.2	The Board was advised that the Trust's Annual Plan for 2026/27 had been approved, subject to a number of conditions relating primarily to the delivery of financial improvements and organisational culture ambitions. Members noted the expectation from NHS England that the Trust finalise and fully develop its Cost Improvement Programme (CIP) schemes to ensure delivery of the required financial position. It was confirmed that further work was underway to develop and validate these plans, with completion expected by the end of June 2026.
6.3	SR also highlighted a number of developments within the national healthcare landscape, including emerging legislative reforms, ongoing workforce challenges across the NHS, and national reviews relating to maternity services and adult social care. The Board noted the potential implications of these developments for ambulance services and the wider health and care system.
6.4	Members discussed the continued importance of organisational transformation, modernisation and productivity improvement in order to meet increasing demand whilst maintaining high standards of patient care and financial sustainability. The Board noted the work underway across the Trust to support these objectives and ensure delivery against strategic priorities.
6.5	The Board **NOTED** the Chief Executive Officer's Report.
7	**Patient Story**
7.1	HY, Chief Nurse, introduced a patient and family member who attended the meeting to share their experience following a cardiac arrest incident and the care they received from SCAS and partner organisations. The Board heard a powerful account of the events leading up to the emergency, the actions taken by family members and bystanders, and the response provided by emergency services.
7.2	The patient and family highlighted the professionalism and compassion demonstrated throughout their experience. Particular emphasis was placed on the effectiveness of the initial call handling, the immediate advice provided by the Emergency Operations Centre, and the critical role of early cardiopulmonary resuscitation (CPR) in improving the patient's chances of

	survival. The Board also heard how the coordinated response from call handlers, ambulance crews, community responders and hospital teams contributed to a positive clinical outcome.
7.3	Members reflected on the significance of the story as an example of the "chain of survival" in practice, demonstrating the importance of rapid recognition of cardiac arrest, early CPR, timely defibrillation and effective clinical care. The discussion highlighted the value of teamwork, communication and collaboration across services in achieving the best possible outcomes for patients.
7.4	The Board also considered opportunities for organisational learning arising from the case, including the continued promotion of CPR awareness and training within communities, strengthening feedback mechanisms to patients and families, and exploring how developments such as video triage technology could further support emergency call assessment and patient outcomes.
7.5	LB thanked the patient and their family for sharing their experience so openly and acknowledged the valuable insights provided. The Board recognised the story as a compelling example of high-quality care and effective multi-agency working, and noted the learning and assurance provided by the patient experience.
7.6	**Actions:** • **MA to circulate details of Start a Heart Day on 16th October 2026 to NEDs.** • **EMC to discuss SLT and Board CPR training**
7.7	The Board **NOTED** the Patient Story.
8	**FIT For Future Transformation plan for 2026/27**
8.1	DH, Chief People Officer & Deputy Chief Executive, presented the Fit for the Future Transformation Plan for 2026/27 and outlined the proposed approach to delivering the Trust's transformation priorities over the coming year.
8.2	The Board heard that the programme had been developed to support the delivery of the Trust's strategic objectives, improve organisational performance and ensure long-term sustainability. Members noted the emphasis on achieving measurable outcomes and benefits for patients, staff and the organisation, rather than focusing solely on activity and project delivery. The Board welcomed the outcomes-based approach and recognised the importance of ensuring that transformation initiatives delivered demonstrable benefits aligned to the Trust's strategic ambitions.
8.3	Members considered the governance arrangements supporting the programme and welcomed the strengthened focus on accountability, programme oversight and benefits realisation. The Board sought assurance that appropriate mechanisms were in place to monitor delivery, manage risks and provide clear visibility of progress against agreed objectives.

8.4	During the discussion, Board members acknowledged the scale of the transformation portfolio and noted the potential capacity constraints associated with delivering a substantial number of programmes concurrently. Particular attention was drawn to the portfolio of 28 Tier 1 projects, and members emphasised the need for clear prioritisation to ensure organisational resources remained focused on activities that would deliver the greatest strategic benefit and were achievable within existing capacity.
8.5	The Board also discussed the relationship between transformation reporting, organisational performance reporting and strategic risk management. Members agreed that there was an opportunity to strengthen the integration of these reporting mechanisms to provide a clearer and more comprehensive view of delivery against the Trust's objectives. It was noted that improved alignment between transformation programme metrics, workforce indicators and organisational performance measures would support more effective Board oversight and assurance.
8.6	The Board requested further work to: • Develop a single integrated reporting framework aligning the Integrated Performance Report (IPR), Board Assurance Framework (BAF) and Fit for the Future programme metrics. • Establish clear executive ownership for the integrated reporting approach. • Review programme prioritisation to ensure delivery plans remain realistic and achievable. • Strengthen the links between organisational performance indicators, programme delivery and strategic risks. • Review People & Culture metrics and align Fit for the Future programme metrics and key performance indicators with the Integrated Performance Report.
8.7	**Action: Chief People Officer/Deputy Chief Executive and Chief Digital & Information Officer to review the People & Culture metrics and align Fit for the Future programme metrics and KPIs with the Integrated Performance Report.**
8.8	The Board welcomed the progress made in developing the programme and received assurance regarding the proposed governance and delivery arrangements.
8.9	The Board **APPROVED** the Fit for the Future Transformation Plan for 2026/27.
9	**Finance & Performance Committee Report: April & May 2026**
9.1	LB, Chair of the Finance & Performance Committee, presented the Committee's report and provided a verbal update on key matters discussed at the May meeting.
9.2	The Board noted that the Committee had reviewed the Trust's financial position, operational performance and progress against key objectives. Particular focus had been given to the development and delivery of the Cost Improvement Programme (CIP), financial risks, ambulance performance, workforce availability and productivity.
9.3	LB provided assurance that identified risks and performance challenges continued to receive appropriate scrutiny and oversight, and that actions were in place to support delivery of the Trust's financial and operational plans.

9.4	**The Board NOTED the Finance and Performance Committee Report.**
10	**Integrated Performance Report (IPR)**
10.1	CE, Chief Digital & Information Officer, presented the Integrated Performance Report (IPR), providing an overview of the Trust's performance across operational, quality, workforce and corporate indicators for the reporting period. The Board noted that performance remained mixed across a number of key measures.
10.2	Members discussed ambulance response standards, demand pressures, workforce availability and system factors impacting service delivery. While some indicators were showing improvement, performance against a number of national operational standards remained challenging. The Board recognised the significant work underway across the Trust to improve performance, strengthen patient safety, and deliver sustained improvements in the quality of care provided to patients.
10.3	The Board received an update on workforce performance indicators, including staffing levels, sickness absence and recruitment activity. Members noted that workforce pressures continued to present a risk to operational resilience and discussed the importance of ensuring that People and Culture initiatives remained closely aligned to performance improvement objectives.
10.4	The report also provided updates on quality and patient safety measures. The Board was assured that quality remained a key organisational priority and noted the ongoing monitoring of clinical performance indicators, incidents, patient experience and learning activities.
10.5	Members were advised of issues affecting the Trust's data warehouse and reporting infrastructure during the reporting period. The Board sought assurance regarding the impact on data quality and reporting and was informed that work was underway to understand the root cause and implement appropriate mitigations to prevent recurrence.
10.6	The Board welcomed the continued development of the Integrated Performance Report and emphasised the importance of ensuring clear alignment between performance measures, transformation programme delivery and the Board Assurance Framework to support effective oversight and decision-making.
10.7	The Board **NOTED** the **Integrated Performance Report (IPR).**
11	**Finance Report Month 1**
11.1	JBe, Interim Chief Finance Officer, presented the Month 1 Finance Report and provided an overview of the Trust's financial position at the start of the 2026/27 financial year.
11.2	The Board noted that the Trust had achieved a break-even position for Month 1, in line with the agreed financial plan. Members welcomed the positive start to the year but recognised that significant challenges remained in delivering the Trust's full-year financial objectives.
11.3	The report highlighted that delivery of the Cost Improvement Programme (CIP) was currently behind plan and that further work was required to fully develop and implement schemes capable of delivering the £19.7 million savings target for 2026/27. The Board noted that CIP

	delivery remained one of the Trust's principal financial risks and would continue to be closely monitored through the Finance & Performance Committee.
11.4	Members also considered a number of emerging financial pressures, including increases in fuel costs and uncertainty regarding estates funding, both of which could have a material impact on the Trust's financial position if not effectively managed.
11.5	The Board noted that workforce pressures, alongside wider external cost increases, continued to present risks to the delivery of the financial plan. Assurance was provided that mitigating actions were being developed and that the Executive Team would maintain close oversight of these risks throughout the year.
11.6	The Board **NOTED** the Month 1 financial position and the associated risks and agreed that ongoing scrutiny would continue through the established governance arrangements.
12	**Enabling Services Board Assurance Framework Risks**
12.1	JBe, Interim Chief Finance Officer, presented the Enabling Services Board Assurance Framework (BAF) risks and outlined the key risks relating to the delivery of the Trust's strategic objectives within the Enabling Services portfolio.
12.2	The Board reviewed the current risk profile, including risks associated with financial sustainability, estates, procurement, workforce capacity and the delivery of enabling programmes required to support operational and strategic objectives. Members noted the controls and mitigating actions in place and discussed the effectiveness of these measures in reducing the level of risk exposure.
12.3	Particular attention was given to the financial challenges facing the Trust, including delivery of the Cost Improvement Programme and wider external financial pressures. Members also discussed the dependency between enabling services and the successful delivery of transformation and operational improvement initiatives across the organisation.
12.4	The Board was assured that the risks remained under regular review through the established governance arrangements and that appropriate mitigating actions were being progressed.
12.5	Members emphasised the importance of maintaining clear links between strategic risks, performance measures and transformation work programmes.
12.6	The Board **APPROVED** the Enabling Services Board Assurance Framework Risks.
13	**Digital Transformation Board Assurance Framework Risks**
13.1	Craig Ellis, Chief Digital & Information Officer, presented the Digital Transformation Board Assurance Framework (BAF) risks and highlighted the key strategic risks associated with the delivery of the Trust's digital transformation programme.
13.2	The Board reviewed the principal risks relating to digital infrastructure, cyber security, information management, system resilience and the successful delivery of digital

	transformation initiatives. Members noted the increasing reliance on digital systems to support operational performance, patient care and organisational efficiency, and recognised the importance of maintaining robust controls and governance arrangements.
13.3	The Board discussed the status of key mitigation plans and sought assurance regarding the management of cyber security risks, system reliability and programme delivery risks. Members were advised that ongoing monitoring and assurance processes were in place and that progress against mitigating actions continued to be reviewed through the Trust's governance framework.
13.4	The Board acknowledged the interdependencies between digital transformation, organisational performance and service improvement and emphasised the importance of ensuring that digital priorities remained aligned to the Trust's strategic objectives.
13.5	The Board **APPROVED** the Digital Transformation Board Assurance Frameworks Risks.
14	**Quality and Safety Committee Report: April 2026**
14.1	In the absence of the Committee Chair, the Board received the Quality and Safety Committee report from the April 2026 meeting and noted the key areas of discussion and assurance provided.
14.2	The Committee had reviewed performance against quality and patient safety indicators, including patient harm, safeguarding, patient experience, clinical effectiveness and incident management. Members noted that quality and safety remained a core organisational priority and that the Committee had received assurance regarding the management of identified risks and the effectiveness of mitigating actions.
14.3	The Board was advised that the Committee had considered a range of quality metrics and areas of regulatory compliance and had scrutinised actions being taken to address areas requiring improvement. Members noted the continued focus on learning from incidents, maintaining patient safety standards and ensuring that improvements were embedded across the Trust.
14.4	The Board welcomed the assurance provided by the Committee and recognised the importance of maintaining strong oversight of quality and safety performance across the organisation.
14.5	The Board **NOTED** the Quality and Safety Committee Report.
15	**Clinical Effectiveness Board Assurance Framework Risks**
15.1	DR, Chief Paramedic Officer, presented the Clinical Effectiveness Board Assurance Framework (BAF) risks and provided an overview of the principal risks affecting the delivery of the Trust's Clinical Effectiveness strategic objectives.
15.2	The Board reviewed the current risk profile and noted the controls and mitigating actions in place to manage risks associated with patient outcomes, clinical quality, evidence-based practice, workforce capability and compliance with clinical standards. Members discussed the

	importance of maintaining a strong focus on clinical effectiveness to ensure the delivery of safe, high-quality care and continuous improvement in patient outcomes.
15.3	The Board received assurance that the identified risks were subject to regular review through established governance arrangements and that actions were being progressed to further strengthen controls and reduce risk exposure. Members emphasised the need to ensure that learning from incidents, audits, research and quality improvement initiatives continued to inform clinical practice across the organisation.
15.4	The Board noted the interdependencies between clinical effectiveness, workforce development and operational performance and recognised the importance of maintaining clear oversight of these risks to support the delivery of the Trust's strategic objectives.
15.5	The Board **APPROVED** the Clinical Effectiveness Board Assurance Framework Risks.
16	**Research Annual Report 2025/26**
16.1	DR, Chief Paramedic Officer, presented the Research Annual Report for 2025/26, highlighting the Trust's research activity, achievements and progress during the year.
16.2	The Board noted the continued growth and development of the Trust's research portfolio, including increased participation in research studies, publication of research findings and collaboration with academic and clinical partners. Members recognised the important contribution that research makes to improving patient care, developing clinical practice and supporting evidence-based decision-making across the organisation.
16.3	The report highlighted positive performance during the year, with a strong programme of research activity being undertaken across the Trust. Members were advised that work was continuing to strengthen the Trust's research capability and capacity, including plans to progress the organisation's ambition to become a research sponsor.
16.4	The Board welcomed the achievements outlined within the report and acknowledged the contribution of staff involved in research activities across the organisation. Members recognised the role of research in supporting innovation, clinical effectiveness and the delivery of the Trust's strategic objectives.
16.5	**Action: Feedback to be provided to team on including translation of research into clinical practice in future reports**
16.6	The Board **NOTED** the Research Annual Report 2025/26 and the progress made in strengthening the Trust's research function.
17	**People & Culture Committee Report May 2026**
17.1	IG, Non-Executive Director and Chair of the People & Culture Committee, presented the report from the Committee's May 2026 meeting and highlighted the key matters discussed.
17.2	The Board noted that the Committee had reviewed workforce performance, organisational culture, staff wellbeing, recruitment and retention, equality, diversity and inclusion, and

	leadership development. Particular consideration had been given to workforce indicators including sickness absence, turnover, vacancies and appraisal completion rates.
17.3	Members discussed the continued workforce challenges facing the Trust and noted the actions being taken to improve recruitment, retain staff and support employee wellbeing. The Committee also reviewed progress against key People & Culture priorities and received assurance that targeted interventions were in place to address areas of concern.
17.4	The Board noted the importance of understanding the relationship between workforce metrics, organisational culture and operational performance and agreed that continued focus should be maintained on improving staff experience and engagement across the organisation.
17.5	The Board **NOTED** the People & Culture Committee Report.
18	**People & Culture Board Assurance Framework Risks**
18.1	DH, Chief People Officer & Deputy Chief Executive, presented the People & Culture Board Assurance Framework (BAF) risks and provided an overview of the principal risks associated with the delivery of the Trust's People & Culture strategic objectives.
18.2	The Board reviewed the current risk profile, including risks relating to workforce recruitment and retention, staff wellbeing, organisational culture, leadership capability and workforce capacity. Members noted the continued challenges associated with maintaining a sustainable workforce in a highly competitive labour market and the potential impact of workforce pressures on service delivery and organisational performance.
18.3	The Board discussed the mitigating actions in place to address these risks, including initiatives to improve recruitment, retention, staff engagement and wellbeing. Members also considered the importance of embedding the Trust's values and behaviours and strengthening organisational culture to support the delivery of strategic objectives.
18.4	Assurance was provided that the risks were subject to regular review through the Trust's governance arrangements and that progress against mitigation plans continued to be monitored by the People & Culture Committee. The Board emphasised the importance of maintaining clear links between workforce metrics, organisational culture and operational performance measures.
18.5	The Board **APPROVED** the People & Culture BAF risks.
19	**Refreshed New SCAS Values & Behaviours Framework**
19.1	DH, Chief People Officer & Deputy Chief Executive, presented the refreshed SCAS Values & Behaviours Framework and outlined the work undertaken to review and update the organisation's values and associated behavioural expectations.
19.2	The Board heard that the framework had been developed following engagement with staff across the Trust and was intended to provide a clear and consistent foundation for organisational culture, leadership and expected behaviours. Members noted that the refreshed framework reflected feedback received from colleagues and aligned with the Trust's strategic objectives and People & Culture priorities.

19.3	During discussion, Board members welcomed the emphasis on promoting a positive and inclusive culture and recognised the importance of ensuring that the values and behaviours were embedded throughout all aspects of the employee lifecycle, including recruitment, induction, performance management, leadership development and recognition processes.
19.4	The Board noted that successful implementation of the framework would require continued engagement with staff and leaders across the organisation and that progress would be monitored through the Trust's People & Culture governance arrangements.
19.5	Members welcomed the refreshed framework and recognised its importance in supporting organisational culture, staff experience and the delivery of high-quality patient care.
19.6	The Board **APPROVED** the refreshed SCAS Values & Behaviours Framework.
20	**Partnerships & Sustainability Board Assurance Framework Risks**
20.1	JBe, Interim Chief Finance Officer, presented the Partnerships & Sustainability Board Assurance Framework (BAF) risks and outlined the principal risks relating to the delivery of the Trust's strategic objectives within this theme.
20.2	The Board reviewed the current risk profile, including risks associated with partnership working, system collaboration, stakeholder relationships and the delivery of sustainability commitments. Members noted the importance of maintaining effective relationships with Integrated Care Boards, NHS partners, emergency services and other key stakeholders to support the delivery of high-quality patient care and organisational objectives.
20.3	The Board discussed the controls and mitigating actions in place and received assurance that the identified risks were being actively managed through established governance arrangements. Members highlighted the importance of continuing to strengthen collaborative working across the wider health and care system and ensuring that sustainability objectives remained integrated within the Trust's planning and decision-making processes.
20.4	The Board noted the interdependencies between partnership working, service transformation and organisational performance, and acknowledged the importance of maintaining effective oversight of these strategic risks.
20.5	**The Board APPROVED the Partnerships & Sustainability Board Assurance Framework Risks.**
21	**Communications, Marketing and Engagement Update**
21.1	The Board received and noted the Communications, Marketing and Engagement Update. In the absence of the Director of Communications, Marketing and Engagement, the report was taken as read and no further discussion was held.
21.2	The Board **NOTED** the Communications, Marketing and Engagement Update.
22	**Board Committee Annual Reports 2025/26 and Terms of Reference**

22.1	BM, Chief Governance Officer, presented the Board Committee Annual Reports for 2025/26 together with the annual review of the Board Committees' Terms of Reference.
22.2	The Board noted that the annual reports provided assurance regarding the effectiveness of the Board's committee structure and demonstrated how each committee had discharged its responsibilities during the year. The reports included reflections from committee members on the effectiveness of each committee, the quality of debate and challenge, the adequacy of information provided, and the extent to which the committees had fulfilled their responsibilities. The feedback provided assurance that the committees continued to operate effectively and
22.3	support the Board in discharging its governance duties.
22.4	The Board also reviewed the Terms of Reference for its committees as part of the annual governance review process. Members noted that the proposed amendments reflected changes in responsibilities, reporting arrangements and good governance practice, and would support the continued effective operation of the Board's committee structure.
22.5	The Board received assurance that the annual review had confirmed that the committees remained fit for purpose and continued to provide appropriate oversight and assurance to the Board. The Board **NOTED** the Committee Annual Reports for 2025/26 and **APPROVED** the updated Terms of Reference.
23	**Audit Committee Chair's Report**
23.1	MM, Audit Committee Chair, provided a verbal update from the Audit Committee meeting held in May 2026.
23.2	The Board was advised of the key matters considered by the Committee, including internal audit activity, governance and risk management arrangements, financial controls and progress against the annual audit programme. Members noted that the Committee had continued to maintain oversight of the adequacy and effectiveness of the Trust's assurance framework and internal control environment.
23.3	The Board received assurance that no matters had been identified by the Committee that required escalation and that appropriate actions were in place to address any recommendations arising from audit reviews. The Committee remained satisfied that the Trust's governance, risk management and control processes were operating effectively.
23.4	**The Board NOTED the Audit Committee Chair's Report.**
24	**Incident Response Framework**
24.1	MA, Executive Director of Operations, presented the Incident Response Framework and provided an overview of the arrangements in place to support the Trust's preparedness and response to incidents and major events.
24.2	

	The Board noted that the framework set out the governance, roles, responsibilities and escalation processes required to ensure a coordinated and effective response to incidents affecting the Trust, its staff and patients. Members heard that the framework had been reviewed to ensure alignment with national guidance and current operational requirements.
24.3	During discussion, the Board considered the importance of maintaining robust incident management arrangements, including clear command and control structures, effective communication processes and appropriate training and exercising programmes. Members received assurance that the framework supported the Trust's ability to respond to a range of incidents while maintaining service continuity and patient safety.
24.4	The Board welcomed the framework and received assurance that appropriate arrangements were in place to support organisational resilience and emergency preparedness.
24.5	The Board **NOTED** the Incident Response Framework.
25	**Summary of Actions from the meeting**
26.1	BM summarised actions from the meeting: • Fit for the Future - People & Culture metrics to be reviewed and FFF metrics/KPIs to be aligned with the Integrated Performance Report. • Patient Story: MA to circulate details of Start a Heart Day on 16th October 2026 to NEDs. • Patient Story: EMC to discuss SLT and Board CPR training. • Research Annual Report: feedback to be provided to team on including translation of research into clinical practice in future reports.
27	**Questions from the public**
27.1	The Chair invited questions from members of the public in attendance.
	No questions were raised and no submissions had been received in advance of the meeting.
27.2	**The Board noted that there were no public questions.**
28.	**Any other business**
28.1	The Chair invited members to raise any items of urgent business not included elsewhere on the agenda.
28.2	No additional items were raised for discussion.
28.3	**The Board noted that there was no other business.**
29	**Summary Review of the meeting:**
29.1	Ruth Williams, Non-Executive Director, and Helen Young, Chief Nurse, led the review of the meeting.
29.2	

	Members reflected positively on the conduct of the meeting and noted the constructive level of engagement and discussion throughout. The Board highlighted the value of the discussions held, particularly where they supported greater understanding of strategic priorities, performance and risk.
29.3	The patient story was recognised as a particularly impactful item, providing valuable insight into the patient experience and demonstrating the positive impact of the care delivered by SCAS staff and system partners. Members noted the importance of continuing to incorporate patient stories into Board meetings to support learning and maintain a focus on patient-centred care.
29.4	**The Board noted the feedback received on the effectiveness of the meeting.**
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 September 2026 at Newbury Education & Recruitment Centre, Bone Lane, Newbury, RG14 5UE.

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TRUST BOARD ACTION LOG						Status
Minute Ref:	**Agenda Item**	**Action**	**Owner**	**Due Date**	**Update**	
Meeting Date: 3 June 2026						
TB/26/007	Patient Story	MA to circulate details of Start a Heart Day on 16th October 2026 to NEDs	Mark Ainsworth	03.09.26	Heart Day dates circulated to board members on 24.08.26	**Propose to Close**
TB/26/008	Patient Story	EMC to discuss SLT and Board CPR training	Becky Murray	03.09.26	It is proposed that interest is sought from NEDs and Executive Directors, with the option of incorporating CPR/resuscitation training into a future Board seminar. Arrangements can be made accordingly.	**Open**
TB/26/009	FFF Transformation plan 2026/27	Chief People Officer/Deputy Chief Executive and Chief Digital & Information Officer to review the People & Culture metrics and align Fit for the Future programme metrics and KPIs with the Integrated Performance Report.	Danny Hariram	18.09.26	Action in progress	**Open**
TB/26/0010	Research Annual Report	Feedback to be provided to team on including translation of research into clinical practice in future reports	Duncan Robertson	03.09.26	Translation of research into practice will be included as a specific section in future annual reports	**Propose to Close**

Trust Board of Directors Meeting in Public 3 September 2026

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

1. Purpose

The purpose of this Chair Report is to inform the Board of stakeholder engagement and site visits since the Board held in June 2026.

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

July 2026

- SCAS Long Service Awards
- Milton Keynes 111 Contact Centre Visit
- New Aylesbury Workshop Opening Event
- Surrey and Sussex Chairs
- HIOW Chairs Meeting
- BLMK Chairs Meeting

August 2026

- Defibrillator Unveiling - Reading
- Visit to Southern House
- Joint SCAS/SECAmb Exec Meeting
- SCAS Membership and Engagement Committee
- Council of Governors Meeting
- Amos and Ockenden Review Discussion
- Surrey and Sussex Chairs
- CEO/Chair Meeting – NHSE Board Development

Other

- Introductory meetings
- NED Interviews
- Team Brief Live / Open Space / Leadership Brief

- Weekly Teams/Mobile meetings with incoming Group CEO
- Monthly 1:1 meetings with Interim CEO
- Regular discussions with Chief Governance Officer re Governance Matters

Recommendation

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

TRUST BOARD OF DIRECTORS MEETING IN PUBLIC 3 September 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

NHS England NHS Oversight Framework (NOF).

The 2026/27 NOF has been published since my last report to the Board. The framework sets out a number of performance measures that alongside the Provider Capability Assessment, which is the subject of a separate item on the board agenda, informs the segmentation for each Trust and the level of oversight from NHS England (NHSE).

The NOF metrics that apply to ambulance services are regularly reported to the Board in the Integrated Performance Report (IPR), via the Fit for the Future reporting framework and the suite of other regular reports that the Board receives. As at quarter 4 of 2026/27 the Trust is in segment 3, largely attributable to metrics derived from the annual Staff Survey.

Trust Performance

Since my last report, the Trust has been operating under sustained operational pressure, in the main due to the heatwaves that resulted in unprecedented demand both on our

services and those of our partner acute hospitals. Our ability to respond to Category 2 calls was severely impacted by the increase in demand and the acuity of patients in need of our services, coupled with staff sickness, to such an extent that we called a Critical Incident and a Major Incident, as did many of our partner organisations cross the region.

These are not steps that we take lightly as they require diversion of resource to enable frontline services to meet demand, which detracts from other necessary activity across the Trust and negatively impacts our financial position. The safety of patients was however at the forefront of our decision taking.

As a result of the deterioration in our Cat2 response times, we have now been placed in escalation level 1 for Quarter 2 following NHSE's Operational Performance Review, as confirmed by the attached correspondence. We have developed a Recovery Plan to return our Cat2 performance to planned levels, which has required investment and whilst this was approved by the Board, there is a consequent impact on our financial performance creating additional savings requirements. The Board will continue to monitor performance against our Recovery Plan, and we report on a fortnightly basis to NHSE. Our Cat2 mean response time in July was 31.15 against a target of 27.30. Further detail is contained within the IPR.

This has been a difficult period for the organisation, and I would like to place on record my thanks to our frontline teams for their hard work and dedication during the extreme heat and to corporate teams and departments who have provided support to enable our crews to respond to patient need. On behalf of the Board, I would also extend our thanks to Yorkshire Ambulance Service who provided us with support during this period in the form of ambulances and crews.

The financial position at the start of 2026/27 was a challenging one and our Operational Plan was finely and carefully balanced to deliver the best performance and service quality we could within our budgets. As referenced above, the sustained operational pressure has driven the need for additional investment, which will mean that we will need to continue to make difficult decisions with regards to how we deploy our resources. Further detail is provided in the finance report which is on the agenda.

Fleet

We continue to take delivery of new fleet and July also saw the opening of our 3rd workshop in Aylesbury. This is an important milestone in our Fleet Improvement Plan as it will enable us to undertake more preventative maintenance as well as increasing our capacity to repair vehicles when faults develop. Although we are not yet meeting our Vehicles Off the Road Target (VOR), Fleet availability is less challenging, and we are developing more sophisticated measures to monitor the availability of vehicles to meet demand.

Thanks are extended to our Director of Fleet and his team and to colleagues in estates for their hard work and efforts to mobilise the workshop.

Collaborative Working

Alongside addressing immediate operational and financial pressures, the Trust continues to progress discussions regarding the development of collaborative working. The rationale for exploring this approach is to strengthen resilience, improve operational effectiveness, share scarce expertise and support greater efficiency across participating organisations whilst maintaining local accountability and service delivery.

Over recent months, work has focused on identifying opportunities with these collaboratives. Whilst this work remains at an early stage, it aligns with the wider NHS direction of travel towards greater provider collaboration and supports our ambitions within Fit for the Future.

The Board will receive further updates as the programme develops, including consideration of benefits, risks, governance arrangements and implications for our people and stakeholders.

People & Culture

NHSE has published NHS Staff Standards which set national minimum employment requirements to improve staff experience and outlines actions that employers must take and what staff can expect. Much of the content already forms part of our People & Culture workstreams within our Fit for the Future Improvement Plan and within our refreshed values and behaviours framework, but we have taken a baseline assessment of our current position against the standards and we will monitor our progress at the Board via the People & Culture Committee.

- **Sickness Absence**

As referenced in the Operational Performance section of this report, we continue to see sickness absence exceed our target; sickness absence in July was 6.7% against a target of 6.2%. We continue to focus on effective management of sickness absence and to provide our managers with the tools they need to support our people back to work as part of our People & Culture workstream.

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**

NHS England

To: Stuart Rees
Interim Chief Executive
South Central Ambulance Service

CC: Mark Ainsworth
Executive Director of Operations
Anne Eden
Regional Director (South East)
Maggie MacIsaac
Chief Executive
Hampshire and Isle of Wight ICB

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

10 July 2026

Dear Stuart

Thank you to you and your teams for your continued commitment to improving operational performance across your organisation. We recognise the sustained pressures facing ambulance services, including increasing demand, response performance, ambulance handover delays and wider system pressures, alongside the continued focus on delivering safe, timely and high-quality care for patients.

During 2026/27, Operational Performance Reviews (OPRs) continue to provide the regional framework for operational oversight, supporting earlier identification of delivery risk, proportionate escalation and targeted improvement support. The previous national tiering framework has now been replaced by the revised Providers of Concern process, with Operational Performance Reviews established for all acute and ambulance providers.

OPRs provide a structured mechanism for assessing provider-level delivery against agreed operational plans, with a particular focus on pace, trajectory and emerging risk. The reviews are intended to move beyond retrospective performance reporting and support earlier intervention where risks to delivery emerge. OPRs bring together operational performance, improvement activity and forward-looking risk assessment into a single oversight process, enabling proportionate escalation and targeted support where required.

Providers are assigned to escalation Levels 1–3, where:

- Level 1 represents the highest level of operational performance risk
- Level 3 represents the lowest level of operational performance risk

Assessments remain dynamic and may change should operational concerns escalate during the quarter. Formal review of escalation status will take place in September to inform Q3 arrangements. It is anticipated that community and mental health providers will be incorporated into this process as Q2 progresses.

Supporting guidance outlining the OPR process, escalation framework and submission requirements will be issued alongside this letter.

This letter confirms that following regional review of operational performance and delivery risk, **South Central Ambulance Service** has been assigned to **Escalation Level 1** for Quarter 2 of 2026/27.

OPRs will cover all core operational delivery areas, as part of this process providers will be expected to demonstrate:

- Delivery against agreed operational trajectories and improvement plans.
- Progress against agreed improvement actions and milestones.
- Clear oversight of emerging risks and early warning signals.
- Confidence in delivery over the coming 4–8 weeks.
- Support required from system, regional or national colleagues to mitigate operational risks.
- Responses to the Key Lines of Enquiry (KLOEs) set out in the national UEC meeting packs.

Please ensure this letter is shared with your Trust Board and relevant governance forums. Should you have any questions regarding the OPR arrangements or escalation framework, please do not hesitate to contact the regional team.

Yours sincerely

Dan Bradbury
Chief Operating Officer
NHS England | South East Region
Wellington House | Waterloo Road | London | SE1 8UG
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TRUST BOARD OF DIRECTORS MEETING IN PUBLIC
3 September 2026

Title	**Staff Story - Call Handler to Team Leader in 111**
Report Author	**Paul Lennon (111 Team Leader)** **Judith MacMillan (Head of Culture and Leadership)**
Executive Owner	**Danny Hariram (Chief People Officer)**
Agenda Item	**7**
Governance Pathway: Previous	N/A
Governance Pathway Next Steps	N/A

1. Purpose

The purpose of this report is to showcase the career journey of Paul Lennon, a NHS 111 Team Leader, demonstrating the opportunities for career development and progression within the 111 service. Through his experience, the report highlights a potential career pathway within NHS 111, while also providing insight into the key successes, challenges and rewards associated with both the service and the Team Leader role. This case study illustrates the valuable contribution of NHS 111 colleagues and the development opportunities available to support a sustainable and skilled workforce.

Paul started in SCAS on 26th February 2024 as a 111 call handler progressing to 111 team leader on 10 March 2025.

2. Executive Summary

Paul's background

Before joining SCAS 111, Paul spent over 20 years working in education in the UK and internationally, following an early teaching career in South East London and extensive global travel. Living and working across Europe and Africa developed his leadership, adaptability, and communication skills while supporting diverse communities. Returning to the UK for a new challenge, Paul joined SCAS 111 and progressed from trainee call handler to team leader in under two years.

A trainee call handler in 111

The journey began with 3 weeks of intensive training delivered by the Education Department, where Paul built the foundations of becoming a health adviser-call handler, learning clinical assessment pathways, communication skills, and how to remain calm under pressure.

Transitioning from classroom learning into real-time practice was a pivotal step; supported by mentors in the Quality Assurance team, Paul began taking live calls and applying theory to often complex and emotional situations.

As a novice call handler, each shift brought new challenges. No two calls were the same, and Paul's confidence grew steadily through experience, reflection, and feedback. One particularly challenging call involved a caller who appeared to be in significant distress but refused to provide any details. Supported calmly and professionally by a Quality Assurance Coach (QAC) and a Clinical Shift Manager (CSM), Paul was guided through the situation and later informed that the call had been a hoax. The exceptional support he received, and the measured response of his colleagues reinforced the importance of teamwork and professionalism in high-pressure situations. Mistakes became learning opportunities, resilience strengthened, and over time competence developed into capability, alongside a growing recognition that his background in education could be used to support, mentor, and develop others within the service

From call handler to coach

The next step was becoming a Coach, supporting new colleagues as they developed the skills and confidence required to succeed in the role. Paul successfully completed the two day NHS Pathways coaching course and drawing on his background in education, Paul was able to share knowledge, provide guidance, and help others overcome the challenges of their early experiences, while always recognising the responsibility that comes with supporting safe outcomes for patients.

This development was further enhanced through shadowing Team Leaders, giving Paul valuable insight into leadership, people management, performance, and the operational demands of maintaining a high-performing team.

Coach to team leader

Recognising his readiness for progression and through discussions with his team leader during his personal development review, Paul was encouraged to apply for a team leader position. Paul also undertook the CCC training package for team leaders. The selection process required him to demonstrate leadership capability, sound decision-making, and a strong understanding of service delivery. Successfully securing the role marked a significant milestone in his SCAS journey.

As a Team Leader, Paul’s focus shifted from individual performance to supporting and developing others, balancing operational demands with colleague wellbeing. Leading

through periods of high demand, particularly during winter pressures, strengthened his adaptability, resilience, and ability to maintain service quality in challenging circumstances.

Now established in the role, Paul continues to reflect on future opportunities to contribute to both leadership and service improvement. The new ICC structure allows opportunities for non-clinicians to progress above band 5 so whilst Paul's next step remains uncertain there is further opportunities for progression and his time in 111 continues to be characterised by continuous learning, professional growth, teamwork, innovation, and a commitment to delivering high-quality care.

Reflections on the 111 service

Throughout his two years and four months within the NHS 111 service, Paul has gained experience across a variety of roles, each bringing a strong sense of job satisfaction and purpose.

Despite the unpredictable nature of every shift, he has consistently observed a positive, can-do attitude among colleagues, with teams coming together to deliver the best possible service under challenging circumstances.

At the same time, he recognises the pressures faced by Health Advisers, whose workloads can at times lead to increased stress and fatigue. These pressures are often felt across the wider leadership team, reinforcing the importance of effective support and collaboration.

Through these experiences, Paul has developed an appreciation of the value of proactive approaches to managing challenges, recognising that anticipating and addressing issues early can strengthen both individual wellbeing and overall team performance.

3. Areas of Risk

4. Link to Strategic Theme

People and Culture

5. Link to Board Assurance Framework Risk(s)

SR23 - Leadership

6. Quality/Equality Impact Assessment

N/A

7. Recommendations

These need to clearly state what you are asking the Board to consider e.g.

- Receive a report/paper for noting

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

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Call Handler to 111 Team Leader

Paul Lennon's Career Journey

A journey of learning, leadership and service

Paul Lennon:
NHS 111 Team Leader, Former International Educator & Consultant

Who is Paul?

- ✓ Over 20 years' in Education and International Leadership
- ✓ Worked across the UK, Europe and Africa
- ✓ Enjoys family, travel, music, sport, reading and research
- ✓ Joined SCAS 111 in February 2024 seeking a new challenge
- ✓ Progressed from call handler to Team Leader in under 2 years

Starting the journey: becoming a call handler

- Intensive induction & training
  - Clinical assessment skills
  - Communication in difficult situations
  - Decision making under pressure
- Supported transition to live calls

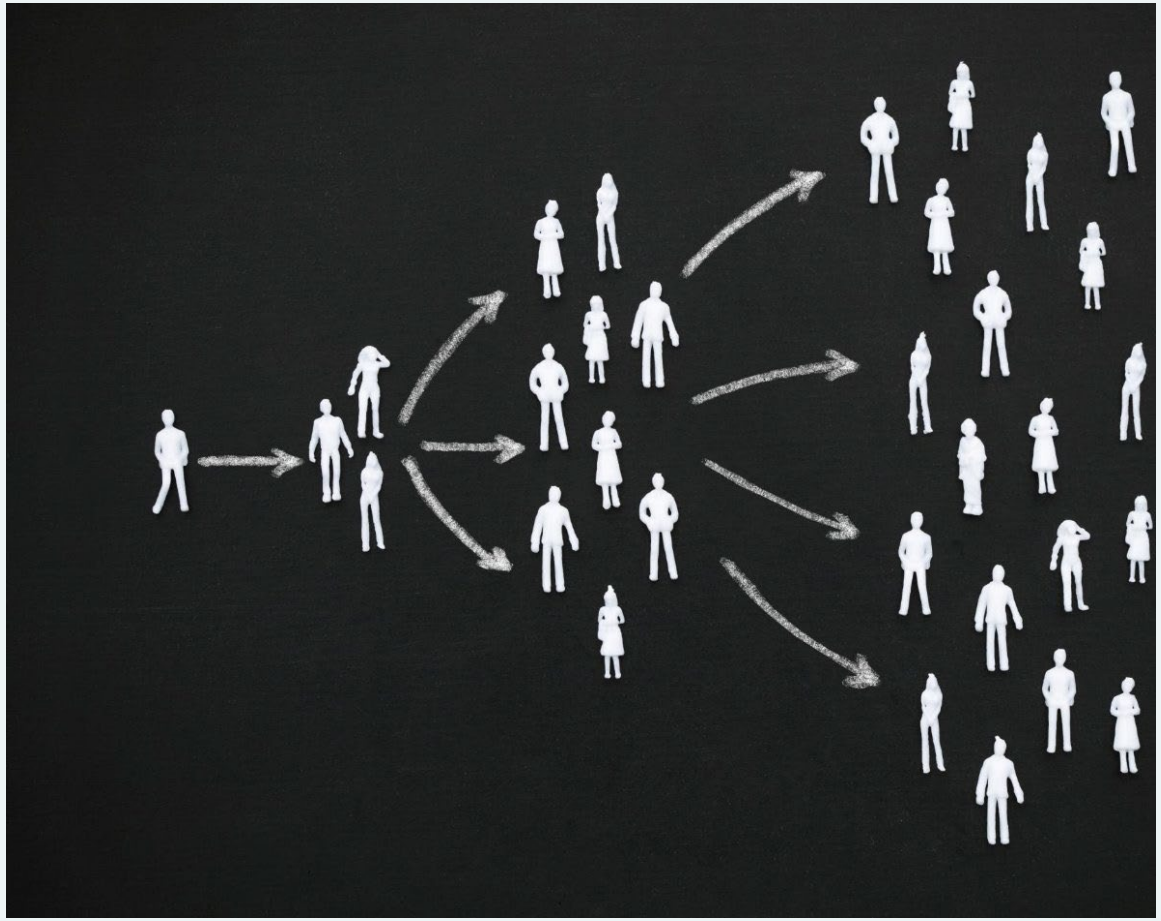
Every call provides an opportunity to learn and build confidence

Developing Others - Call Handler to Coach

South Central Ambulance Service
NHS Foundation Trust

- 2 days NHS Pathways coaching course
- Guide, mentor, facilitator
- Supported new starters
- Shared knowledge and experience
- Audits - learning so much more
- Applied coaching - positive reinforcement
- Broader understanding of how 111 operates

“Helping others succeed was as rewarding as developing myself”



Coach to Team Leader

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- Shadowed to gain leadership insight
  - PDR discussions
  - Performance management
  - Team Leadership development
  - Operational decision making
  - Service delivery
  - Supporting colleague wellbeing

- Successfully secured a Team Leader role

Life as a Team Leader

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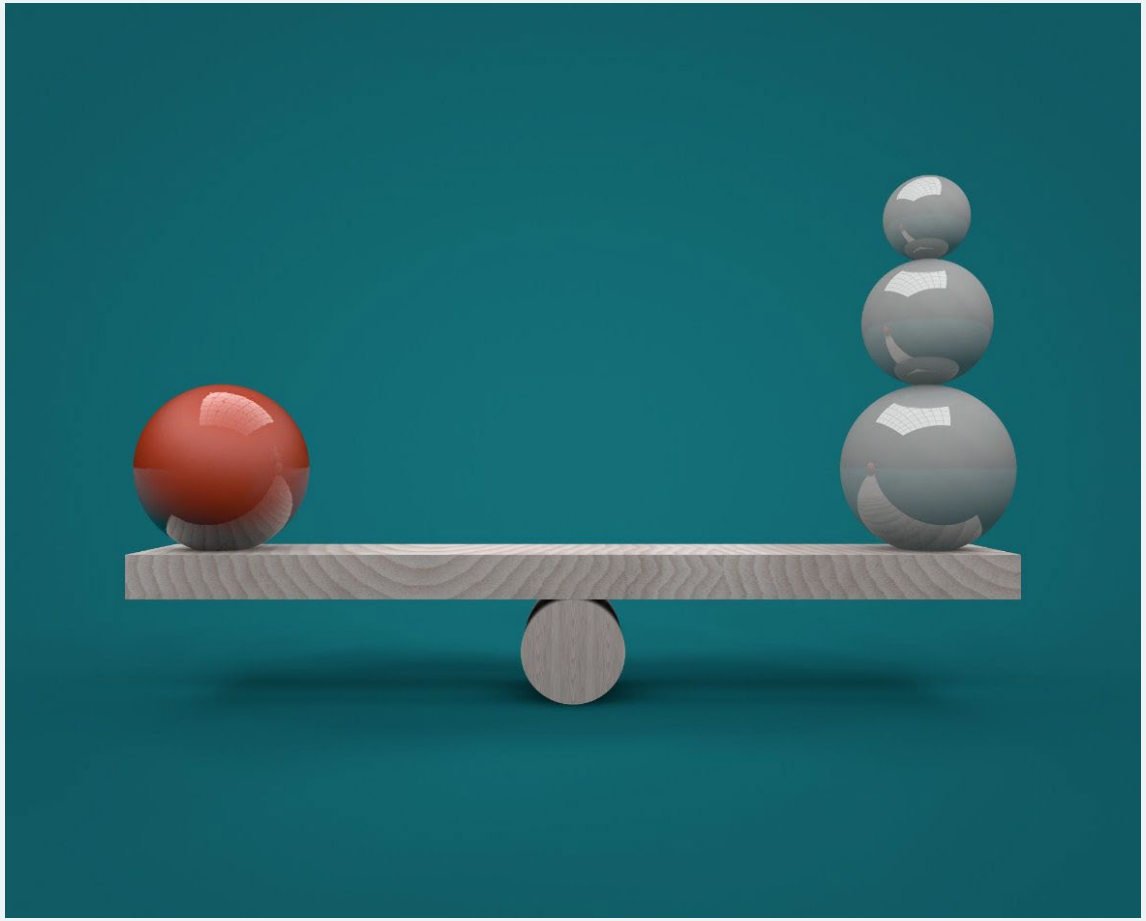
- Supporting patients and colleagues
- Leading and developing colleagues
- Balancing performance with wellbeing
- Maintaining quality during periods of high demand
- Supporting safe and effective patient care

Key skills - Leadership, coaching, resilience, adaptability, communication



Reflections on the 111 Service

The Joys

- Making a real difference
- Supporting patients when most needed
- Working alongside dedicated colleagues

The Challenges

- Unpredictable demand
- Emotionally difficult conversations
- Maintaining collective values as a group of Team Leaders when the pressure hits

Key messages to the Board

- SCAS 111 offers clear career progression opportunities
  - new structure supports more opportunities for non clincians
- Investment in learning enables internal promotion
- Coaching and leadership pathways support workforce sustainability
- Colleagues can build rewarding careers within SCAS
- Strong leadership contributes to high quality patient care
- Recruitment and retention strategy, a key area of our service

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TRUST BOARD OF DIRECTORS MEETING IN PUBLIC
3 September 2026

Title	**Transformation Plan M4 Report**
Report Author	**Caroline Morris, Director of Transformation**
Executive Owner	**Danny Hariram, Chief People Officer**
Agenda Item	**8**
Governance Pathway: Previous	• Highlight reports created by each programme workstream, signed off by SROs and reported to Executive Management Committee
Governance Pathway Next Steps	• N/A

1. Purpose

This document represents the highlight report covering Month 4 of the Tier 1 2026/27 Transformation Plan. This is the short (between quarterly reports) version of the document and represents the first month of Q2.

2. Executive Summary M4

Clinical Effectiveness

- Progress with the Virtual Care programme remains on track, however the 20% target is being missed. The programme is rated no change at Amber, with greater assurance required that the actions being taken will enable the step change required to meet the targets. Recruitment remains a priority, and staff continue to transition into new roles following the restructure. Implementation of Incident Streaming is being reevaluated as it does not appear to be reducing C2 demand as expected. Progress against this programme is a key part of the UEC Tier 1 Recovery Plan and progress will be monitored weekly for the foreseeable future.

- In Pathways of Care both milestones that were missed at the end of Q1 have now been achieved with permission given to increase the number of Specialist Practitioners to 10; and a decision to develop a joint clinical pathway focused on maternity with SECAmb. However the programme is now rated at amber as there is a delay to the start of the SP to C2 Deployment trial as clinical safety issues are

worked through. See and Treat rates continue to exceed targets and form a key part of the Government's approach to managing UEC demand over winter.

- Medicines Optimisation Programme remains on track and green. A solution to the personal issue of controlled Drugs for the HART team remains work in progress and on track to complete by the end of Q2. The business case to support phase 2 of the Safe and Secure Handling of Medicines has been approved which will allow the organisation to accelerate medicines room upgrades across the estate.

- Progress on the Time to Care Programme has accelerated in the last month as a consequence of the Tier 1 UEC Recovery Programme. Additional PM manpower has been deployed into Thames Valley to support the QI cycles that are required. A Lean Six Sigma course for 15 people to support a stronger focus on reducing variation and creating systematic and sustainable change has been purchased. The QI facilitator post which will support Operational delivery remains delayed, but has been resubmitted through the vacancy management process. This programme should move from Red to Amber in September.

Digital Transformation

- The FBC for the CAD is on track and rated at Green following approval to move to from OBC in June. Vendor engagement remains on track, however the funding gap identified in Q1 remains unresolved. Action is underway to reduce revenue costs through a range of cost reduction and performance related activities which are being negotiated with stakeholders. Edge Switch replacement is largely on track.

- F&P Committee in July emphasised the importance of the Nightingale – Data Driven programme, noting with concern the risk to progress from lack of Project Management Capacity and a Data Architect. The programme is rated Amber. The business case to support the new data warehouse is currently working through governance processes having received approval at FAMSG on 27th July. The Qlik Sense platform has been restored following the total outage following its server failure.

- Watson AI remains at amber with and falling further behind in M4. The Watson Platform is not yet stable or operationally supportable and this needs to be resolved before roll can fully commence, however engagement and development work is continuing. PM support has been assigned, but competing workloads is impacting the speed of progress. Rapid roll our of the 111 NLP solution is scheduled for September.

Enabling Services

- Work to support progress with the new Make Ready Hub in Oxfordshire is progressing with approval to identify personnel to support alongside specialist

project management. Planning Permission for redevelopment of High Wycombe has been submitted to the local authority.

- The fleet plan has been presented to EMC, and a comprehensive view of projects and dependencies established. Townhall sessions with SCFS Staff are being undertaken in August. Training for staff to undertake the VCU Lean pilot has been delayed until September due to current pressures within the VCU. While this will delay the project in year, it is still anticipated that outcomes and evaluation of the pilot will be completed before the end of the financial year.

People and Culture

- The sexual misconduct policy (which was due at the end of Q1) has now been signed off and published, however next steps in terms of training and review are being reprioritised to ensure that the NETS action plan is carried out as a priority. Risks associated with the volume of cases and delays in assigning CoF managers have been highlighted.

- A reprofiling of the Values activities is being undertaken in September following the decision to cancel the senior leadership walkabouts while the organisation was at REAP4. The Aspiring Executive succession planning project has identified 7 individuals within the organisation who following diagnostics have expressed an interest in becoming an executive leader. EMC will now review and consider next steps. The Unity and Diversity Conference planned for Q2 is in development and on track.

- The Education Modernisation Programme is being formally rephased as part of our work to ensure that the plan is realistically achievable this year. A formal request will be presented to the Transformation Oversight Group for consideration in September.

Sustainability and Partnerships

- Within the Financial Sustainability Programme emerging cost pressures and additional expenditure continue to emerge. The CIP programmes across the organisation has identified a high number of nonrecurrent CIPs which is of concern. The review of planning which was due in July has not yet concluded but is being actively progressed. Ongoing scrutiny of teams delivering CIPs is underway alongside clear governance designed to limit discretionary spend. Given the high risk in this area, outcomes for this programme have been rated red, prompting a review of the appropriateness of milestones and actions for the programme.

- The Collaboration and Partnerships Programme remains on track with all milestones met. Confirmation of the start date of the new chief executive in October has been received in August. An integration “glidepath” has been developed setting out a very high level road map, which will be further developed over the next two months.

3. Areas of Risk

While there has been material progress across each of the programmes of work, failure to meet performance targets in Q1 means the organisation is now pivoting its focus to ensuring C2 performance targets are met. While this will accelerate delivery against some programmes, such as Time to Care, it will also impact on resources available for programmes of work that are longer term or less immediately tangible (such as Values and Behaviours or Nightingale). This risks an ongoing cycle which will repeat year after year if we do not invest time and energy in fundamental transformative change.

Fragile financial sustainability remains a significant strategic risk to the transformation plan as unanticipated costs continue to emerge, and CIP plans underdeliver. From a transformation perspective, this is resulting in a freezing of experienced project and QI staff able to manage change, which in turn slows or prevents the delivery of activities which support sustainability. As of M4, there is a 26% vacancy rate in the Transformation Team equivalent to 4.6FTE.

4. Link to Strategic Theme

- This report relates to all Strategic Themes.

5. Link to Board Assurance Framework Risk(s)

- This report provides assurance against all Board Assurance Framework risks.

6. Recommendation

Executive Management Committee is asked to receive this report and to take assurance from the progress made.

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

Attached: M4 Heat Map

NHS
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Transformation Plan 26/27
M4 Highlight Report

Month 4 High level Progress Report

	Alert	Advise	Assure
Clinical Effectiveness	ICC restructure means there will be a period of adjustment before operations return to BAU Solution to the Hythe start/end shift pilot to enable issue of controlled drugs remains necessary There has been a delay in recruiting to the QI post needed to support Time to Care	Recruitment remains a priority in the ICC. C2 streaming is under review as results are not as expected. REAP 4 has impacted on delivery of workshops to support pathway development and QI based activities Recovery of vehicle-based morphine nearing completion	Virtual Care Milestones for Q2 are on track SCAS /SECAmb have agreed to focus on maternity care pathways as the first joint pathway review Business case for 10 Specialist Practitioners has been agreed and recruitment underway PCID now largely rolled out and Phase 2 Safe and Secure Handing of Controlled drugs is underway
Digital Transformation	The previously advised funding gap for the CAD/EPR programme has not yet been bridged. Dedicated PM capacity to support Nightingale – data driven is still not in place and SECAmb collaboration on data architecture remains paused Watson AI platform is still in pilot due to ongoing project commitments.	Market engagement is nearly complete for the CAD/ EPR. The business case for the new data warehouse is progressing through internal governance as expected Innovation Board needs to be further embedded and Watson technical readiness progressed.	The FBC to support the CAD/EPR is underway. The QLIK sense platform has been restored Technical and AI use-case activity is progressing and the 111 NLP Platform will go live in September. NHS.Net migration on-track and progressing to plan
Enabling Services	No matters requiring immediate attention or escalation currently.	Recruitment of specialist support for the Make Ready Hub programme is underway and necessary to make progress. Lean Training to support VCU improvement has been paused until September due to operational pressure.	Planning permission has been submitted to redevelop High Wycombe RC. A search to find suitable land for the new Make Ready Hub is underway. The fleet portfolio has been consolidated and progress being made on the initial projects

Month 4 – High level Progress Report Cont

	Alert	Advise	Assure
People & Culture	Sexual Safety programme requires reprioritisation to enable delivery of NETS action plan. There have been delays in assigning CoF managers in sexual safety cases due to ongoing operational pressures The Education modernisation programme requires rephasing to reflect a more accurate assessment of how long it will take to complete the programme	Due to funding constraints a smaller than anticipated Unity and Diversity Conference will take place at Bone lane on 11 September. Every Conversation Counts toolkits have gone live, however weekly drop-in sessions are being changed due to low numbers attending 7 Individuals have expressed an interest in being a future executive.	Sexual Safety Policy has been signed off and published There will be a values and behaviours reflection week in September. Q1 engagement activity is being evaluated. NHS Leadership and Management framework has been launched
Partnership & Sustainability	Increased pressure on finances due to unexpected expenditure and UEC recovery plans require further savings to be made which are not yet identified	CIP delivery is of concern as we move into Q2. The review of planning is not completed, however is on track to report by September.	SCAS met its financial targets at the end of Q1. Collaboration and partnerships remains on track with the development of an integration glide path at high level

How the Heat Map works

Behind the colours shown below are look up tables and formulas that determine the colours. Blue=0; Green=1 Amber=2, Red=3 and Purple =4 This allows us to apply weightings at programme and strategic theme level to provide a better picture of the progress being made

Strategic theme described here. Percentage in brackets relates to weighting given to each programme within strategic theme based on importance

The summary column presents an overall RAG rating for each programme. In determining the RAG colour, greater weight (70%) has been applied to achievement of outcomes.

Plan Delivery described across three dimensions:

- Delivery of quarterly Milestones set as part of our planning process
- Achievement of Specific Key Performance Indicators
- Identification and Mitigation of risks

A purple colour in the benefits realisation column indicates that we cannot deliver any of the value expected. This rating automatically overrides any other colour RAG for that programme and would be a major cause for concern

Example Strategic Theme	
1	Programme 1 (50%)
2	Programme 2 (40%)
3	Programme 3(10%)

Strategic Theme Overall RAG rating

Overall Programme RAG		
Summary	Delivery	Outcomes

Plan Delivery		
Milestones	KPIs	Risks

Outcomes		
Quality Improvement	Change Adoption	Benefits Realisation

Key	
Grey	Not Applicable
Blue	Delivered/Embedded
Green	On track
Amber	Off track, some progress being made
Red	Off track, in recovery
Purple	Will not deliver/cannot be mitigated

Overall strategic theme RAG. Colour is determined by summary column multiplied by weighting of each programme. In this case it is amber because greatest weight is placed on programme 1's outcomes which are met and embedded (blue), mitigating the failure of programme 3 (showing purple), which is worth only 10%

Summary programme RAG. Shown as an average of Plan Delivery and average of Outcomes. In this case plan deliver is materially off track, however outcomes are being achieved in two of the three programmes

Outcomes described across three dimensions:

- Quality Improvement - the extent to which we can see the improvement we have described in our plan
- Change adoption – the extent to which the change appears "sticky"
- Benefits realisation - the extent to which value has been delivered as defined in the plan

M4 Summary Heat Map

NHS South Central Ambulance Service NHS Foundation Trust

		Level 1	Level 2		
Clinical Effectiveness		**Strategic Theme Overall RAG rating**	**Overall Programme RAG**		
			Summary	**Plan Delivery**	**Outcomes**
1	Virtual Care (25%)				
2	Pathways of Care (25%)				
3	Medicines Optimisation (25%)				
4	Time to Care (25%)				
Digital Transformation		**Strategic Theme Overall RAG rating**	**Overall Programme RAG**		
			Summary	**Delivery**	**Outcomes**
1	Bluelight Platforms 2.0 (50%)				
2	Nightingale - data driven organisation (40%)				
3	Watson AI (10%)				
Enabling Services		**Strategic Theme Overall RAG rating**	**Overall Programme RAG**		
			Summary	**Delivery**	**Outcomes**
1	Fleet optimisation (60%)				
2	Estates Modernisation (40%)				
People and Culture		**Strategic Theme Overall RAG rating**	**Overall Programme RAG**		
			Summary	**Delivery**	**Outcomes**
1	Building Trust Together (75%)				
2	Education Modernisation (25%)				
Partnerships and Sustainability		**Strategic Theme Overall RAG rating**	**Overall Programme RAG**		
			Summary	**Delivery**	**Outcomes**
1	Financial Sustainability (80%)				
2	Collaboration and Partnerships (20)				

Key	
Grey	Not Applicable / not required
Blue	Delivered (embedded)
Green	On track
Amber	Off track, likely to recover
Red	Off track, recovery actions underway
Purple	Will not deliver/cannot be mitigated

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Upward Report of the Finance & Performance Committee

Date Meeting met **31st July 2026**
Chair of Meeting **Les Broude, Non-Executive Director**
Reporting to **Trust Board**

Items	Issue	Action Owner	Action
Points for escalation			
Critical Incident Recovery Plan	The Committee received the plan detailing the actions required to recover Cat2 performance following the critical incident that arose as a result of operational pressures during the heatwave. The plan is a balanced plan that requires £1.6m investment and therefore Board approval. The plan is recommended to the Trust Board.	BM	Extraordinary Board required to approve the plan. Scheduled for 07.08.26
Business Matters			
Finance Report	A balanced position was delivered but it should be noted that the Recovery Plan will impact the financial position.		
Fit for the Future	The committee reviewed progress against the key improvement programmes; previous concerns regarding the number of projects and therefore the feasibility of delivery, particularly in light of sustained operational pressure was re-emphasised and it was agreed that the executive team would review and re-prioritise.	BM	EMC to review the transformation programme
Areas of concern and / or Risks			
Operational Performance	Linked to the Critical Incident, there are consequent risks to delivery of targets, such as statutory and mandatory training/PDR and on the financial	N/A	Part of committee business as usual activity.

	position. These will be highlighted and overseen by the relevant committees and reported to board via the IPR.		
Best Practice and / or Excellence			
Contract Register	Continued good progress in relation to the management of contracts was noted.	N/A	N/A

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TRUST BOARD OF DIRECTORS MEETING IN PUBLIC
3 September 2026

Report title	Trust Performance Report
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)
Governance Pathway: Next steps	N/A

Executive Summary

Purpose and Scope:

The purpose of the Trust Performance Report is to provide an overview of Trust performance across Operations, Quality & Safety, Workforce and Finance. This report covers July 2026, month 4 of the 2026/27 financial year. It covers the Trusts progress against the National Oversight Framework (**Appendix 1**) and its existing Integrated Performance Report (IPR) metrics (**Appendix 2**)

SCAS has moved from Segment 3 to Segment 4 within the NHS Oversight Framework (NOF) segmentation for Quarter 4, 2025/26. In September 2026, the revised position based on Quarter 1 2026/27 will be published. The Trust is expecting to remain in Segment 4.

On 10th July 2026, the Trust also moved into escalation Level 1, within the National Operational Performance Review framework. This is focussed on recovery of our Category 2 and 999 call answer position, and a Recovery programme has been mobilised, which will report separately to EMC and onwards to sub-committee's and Board.

Overall Performance Headlines & Risks – Month 4 (July 2026)

This report covers July 2026, Month 4 for the 2026/27 Financial Year reporting period.

Overall position:

Operational and workforce performance are below plan, whilst quality and finance remain in line with targets.

- Operational performance below trajectory for Category 2, Call answer and Hear & Treat. Task time and lost hours are below requirement
- Financial position for M4, remains good, but risks exist as we move to the second half of the year. Category 2 recovery has incurred additional costs, currently off set by vacancy control

Key Risks:

- Recovery of Category 2 to an end of year sustainable position of 25 mins, Hear and Treat to 20% by October 2026 and call answer back below 10 seconds.
- Ability to enact change within operational task time and lost hours reduction
- Vehicle availability impacted by high utilisation and hot weather
- Frontline and ICC Establishment, Capacity and sickness levels
- Ability to secure additional operational overtime and private provider hours
- Financial sustainability, with risk to delivery of £19.7m CIP, particularly following approval of a further £1.65m spend on 999 operational hours.

Operational Performance:

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

Pass - Assurance	**Fail - Assurance**	**No Data for July**
% See & Treat Rate	Category 1 - Mean	n/a
Average Clear up time	Category 3 – 90th percentile	
	% Hear & Treat	
	Average time to Handover	
	Handovers < 15 mins	
	% Vehicle Off Road	
	111 Call answer	
	% 111 Call back in time	

Delivery of our Category 1 – 3 national response targets remain challenging, with the focus on sustainably delivering a Category 2 mean of 25 mins by the end of the financial year.

Call answer within 999 has been planned to deliver against the national target of 10 seconds on average and remains above this for the 3rd month. Call answer is a new metric in the NOF, and sits at 12 secs for QTR 1, which is above the maximum acceptable threshold of 10 secs.

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 is in the process of being replaced by a Fleet availability metric, which provides a clearer impact of vehicle vs demand requirement.

Patient Safety & Quality

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

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

A review of the patient safety and quality metrics, in line with NOF is on-going. In most areas of the Trust there has been an improvement against our patient safety metrics, with fewer patient safety reported incidents resulting in harm. This is driven by a combination in reduction in long waits and improved reporting of near misses.

Learning from the June 2026 Major incident continues to be worked through to fully understand impact and opportunities across all our Service Delivery lines.

People

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

Pass - Assurance	Fail - Assurance	No Data for May
Turnover Rate	Staff Appraisals	Vacancy Rate
% Disabled Staff	Meal Break Compliance	
% DBS Compliance		
Stat & Man Training Compliance		

High levels of Sickness remain a concern for the Trust, with a cross functional working group considering process, people and operational factors.

With continued operational pressures and the Trust remaining at REAP 4 for much of June July, there has been a decline in training and appraisals. This has also impacted Meal Break compliance.

Finance

The detailed finance update is reported separately. The headline for Month 4 is that whilst the Trust remains on track against the plan, there are risks due to the heavy weighting in the second half of the year. Further CIP's will need to be identified and delivered to offset additional expenditure incurred for Category 2 recovery

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

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

Financial Validation	N/A

Recommendation(s)
The Trust Board is asked to do: • **Note** this paper and associated IPR and Performance Scorecard • **Note** the key risks identified

For Assurance	✓	For decision		For discussion	✓	To note	✓

Appendix 1 – Performance Scorecard – NOF Metrics

PERFORMANCE REVIEW - BASED ON JULY 2026 DATA

Additional "Sentinal" and "contextual" metrics - particularly relating to quality of care; patient and staff safety; in-year operational plan delivery.

SEGMENT 4 (score 2.89)

					NHSE Oversight Framework (NOF)			Latest Performance - July 2026							
NOF	IPR	Group	Sub-Group	Metric	Previous NOF (QTR 3)	Current NOF (QTR 4)	Current Rank (QTR 4)	IPR SPC Trend	Target	SCAS (All)	EOC	111	TV	Hants	Corporate
NOF 1	OP4	2B – Access	Urgent care	Mean response time to Category 2 calls	0:29:52	0:30:03	6/10 ↓		00:27:30	0:31:15			0:32:54	0:29:26	
NOF 2	OP6	2B – Access	Urgent care	Mean 999 call response time					0:00:10	0:00:15					
NOF 3a	OP8	4 – Effectiveness	Outcomes	% incidents managed via hear-and-treat *				Expected / Fail	20.0%	16.80%	16.80%		17.6%	15.8%	
NOF 3b	OP9	5 – Effectiveness	Outcomes	% incidents managed via see-and-treat *				Improving / Pass	29.0%	32.7%			32.3%	33.6%	
NOF 4	P7	7 – People	People & culture	Sickness absence rate	6.65%	7.80%	6/10 ↓		6.2%	6.71%	5.63%	7.90%	7.68%	8.06%	3.72%
NOF 5		5 – Patient Safety	Safe outcomes	% safety incidents causing harm (% all PSI causing harm)	Contextual				<10%	8.30%	5.2%	16.6%	7.6%	7.7%	12.5%
NOF 6		6 – Finance	Finance	Variance to plan year-to-date (£k)	-0.24%	0.39%	7/10 ↑			1	198	166	-47	-114	280
NOF 7		3 – Experience	Experience	NHS Staff Survey advocacy rate	5.70	5.54	10/10 ↔			5.54					
NOF 8		5 – Patient Safety	Safe culture	NHS Staff Survey raising concerns sub-score	5.80	5.68	9/10 ↓			5.68					
NOF 9		7 – People	People & culture	NHS Staff Survey engagement theme score	5.74	5.60	9/10 ↔			5.60					
NOF 10		7 – People	People & culture	NHS Staff Standards score						TBC					
NOF 11		7 – People	People & culture	National Education and Training Survey satisfaction rate						TBC					
NOF 12		7 – People	People & culture	Healthcare Worker Flu Vaccination Rate						51%					
NOF 13		6 – Finance	Finance	Planned surplus or deficit (k)	-0.84%	-0.82%	10/10 ↔			-102	2,495	-177	4,026	-5,126	5,779
NOF 14		6 – Finance	Productivity	Relative cost difference (National Cost Collection Index)	95.02%	95.02%	4/10 ↔								
NOF 15		6 – Finance	Productivity	Implied productivity growth	Contextual										
NOF 16		6 – Finance	Innovation	% clinical trials set up within 150 days											
NOF 17		7 – People	Workforce	Temporary staffing cost as a % of total pay bill											

Measureable metric - update on actuals

Progress against action plans

Directorate applicable

Segment	Average metric score
1	below 1.94
2	1.94 to 2.33
3	2.34 to 2.77
4	above 2.77

"Contextual" - these are figures seen as important but that do not contribute to overall segmentation score

Appendix 1 – Performance Scorecard – Finance

		M04 - July 2026			YTD		
		Plan	Actual	Variance	Plan	Actual	Variance
South 999	Financial Position: Surplus / (Deficit) £k	5,126	5,013	(114)	20,392	19,919	(473)
	Total efficiency savings £k	333	257	(76)	1,182	1,099	(83)
North 999	Financial Position: Surplus / (Deficit) £k	4,026	4,073	47	16,264	16,302	38
	Total efficiency savings £k	333	257	(76)	1,182	1,099	(83)
EOC	Financial Position: Surplus / (Deficit) £k	2,495	2,296	(198)	9,926	9,025	(901)
	Total efficiency savings £k	30	244	214	103	902	798
111	Financial Position: Surplus / (Deficit) £k	177	344	166	873	1,169	295
	Total efficiency savings £k	23	93	70	95	160	65

Appendix 2 – Integrated Performance Report

See separate report.

NHS
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Integrated Performance Report: Jul-26

Executive Summary

Operational Performance

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

Safety and Quality

People

Key Performance Headlines:

o (OP2) Category 2 mean response time was 31:15 against the target of 27:06. The main impacting factor on cat 2 was on scene times above plan which added 2:31 to C2 and handover times above plan adding 1:46 to C2.
o (OP6) 999 call answer improved slightly to 15 seconds but remains 5 seconds above plan.
o (OP8) H&T delivery declined by 1% and remains a large focus on our cat 2 recovery plan. The newly recruited clinicians are in training now which will increase headcount to improve delivery.
o (OP9) S&T continues to improve delivering close to 33% and reducing conveyance levels to hospital.
o (OP12) Average Handover Time improved slightly but remains above plan at 17:42. (Target 16:06)

Key Risks for Period:

o Delivery of Operational improvement plan following tier 1 placement for performance recovery.
o Increased operational hours requirement not delivered due to low overtime take up.
o Sickness not reducing in line with actions being taken to achieve 2% reduction by October.
o Thames Valley Task Time not reducing in line with plan.
o H&T not recovering in line with revised trajectory to get to 20% by October.
o (OP12) – Hospital handover times are over 2 minutes off plan impacting available hours.
Unable to secure additional private provider hours for Q3/Q4

Key Rolling Actions:

o Delivery of actions within the performance recovery plan
o Increasing Operational hours to revised plan levels with increase in overtime and bank hours
o Recovery and recruitment plan for CSD to increase H&T to 20% by October.
o Local meetings with Hospitals where handover times are off plan to agree recovery actions
o Vehicle charging to reduce VOR rates
o Local focus on reducing on scene times

Forward View:

The performance recovery plan requires a significant uplift in operational hours through reducing abstractions and increasing hours through overtime and bank hours. There are weekly meetings reviewing the improvement plan which is presented to EMC weekly, followed by NHSE fortnightly. The focus remain on increasing H&T, reducing call answer, reducing sickness and abstractions and reducing on scene times.

Key Performance Headlines:

Patient Safety performance has improved; incidents resulting in moderate or severe harm, or death, reducing to 0.4% of all reported patient safety incidents, reflecting improvements in Category 2 and Category 3 response times.

Patient experience, Health Care Professional Feedback has reduced from 162 to 157 cases, during the reporting period while 128 compliments were received during the reporting period, representing 36% of all patient experience contacts.

Infection Prevention and Control (IPC) audits continue to perform well, with QS5 and QS6 remaining above target.

Safeguarding performance remains strong, with Level 1 and Level 2 compliance at 97% and 98% respectively. Level 3 training compliance remains ahead of trajectory despite the introduction of the revised training programme.

Key Risks for Period:

- A cluster Patient Safety Incident Investigation (PSII) has been declared following delays associated with the June 2026 Critical/Major Incident, involving 39 cases and 36 Duty of Candour notifications.
- Patient experience themes continue to focus on response delays linked to the Critical/Major Incident and cancelled NEPTS journeys following the withdrawal of taxi transport for mobile patients.

Reduction in training to support operational activity may impact the resuscitation training trajectory.

Key Rolling Actions:

- A joint review between the Patient Safety and EPRR teams is underway to ensure learning from the June Critical/Major Incident is captured through a single coordinated process.
- A Quality Impact Assessment has been approved to support management of NEPTS demand by declining bookings once capacity is reached and promoting alternative transport options.
- IPC leads are supporting areas below expected audit trajectory, with local improvement plans overseen through directorate governance arrangements.

Focus on the delivery of face to face resuscitation training and achieve 95% compliance by the end of March 2027

Forward View:

- The cluster PSII and associated EPRR review will continue, with a final report scheduled for completion by January 2027. This is a complicated review, and the national timescales are guided at 6 months to reflect this
- Safeguarding training compliance will be closely monitored to ensure performance remains on trajectory despite operational pressures and changes to training delivery arrangements.

Key Performance Headlines:

The Month 4 Substantive workforce is 3,781 WTE and below the M4 planned total substantive workforce of 3,843 WTE by 62 WTE.
Staff turnover at 14.3% against 17.7% target
In Month 4, Sickness was above the 6.2% target at 6.7%. Long-Term sickness is at 3.8% and Short-Term sickness at 2.8%. More accurate GRS sickness reporting is being investigated to give greater insight.
PDR compliance data currently has a technical issue with PDR App completions not being included. Compliance without these is at 78% in Month 4, below 95% target
DBS- Trust at 97% against a 95% target

Key Risks for Period:

Higher than targeted sickness levels present ongoing risk to operational resilience and staffing availability.
A lower turnover rate effecting ability to reach planned staffing costs

Key Rolling Actions:

Sickness action plan and reporting regionally as part of recovery plans. Sickness being monitored weekly, action groups and trajectories developed to reduce significantly in Operational areas in following months.
Reviewing of workforce plans to ensure a changing turnover rate is reflected in establishment and recruitment assumptions
Reviewing the timeframes for return to works to ensure individuals are supported back to work with a view to see a reduction in phased returns of 4 weeks or more.

Forward View:

Continued focus on reducing sickness absence towards target levels to strengthen workforce resilience.
Achieving stable vacancy levels and improved time to hire performance to support sustained operations.
Maintaining performance in core compliance metrics.

Statistical Process Control:

An SPC chart is a plot of data over time. It allows you to distinguish between common and special cause variation. It includes a mean and two process limits which are both used in the statistical interpretation of data. To help you interpret the data a number of rules can be applied.

The rules:

1) Any single point outside the process limits.

2) Two out of three points within 1 sigma of the upper or lower control limit.

3) A run of 6 points above or below the mean (a shift) .

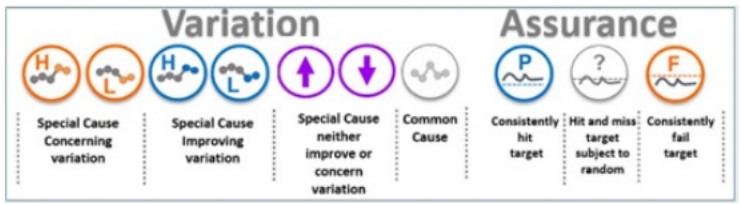
4) A run of 6 consecutive ascending or descending values (a trend).

All these rules are aids to interpretation but still require intelligent examination of the data.

This tool highlights when a rule has been broken and highlights whether this is improvement or deterioration.

If you change in your process and observe a persistent shift in your data, it may be appropriate to change the process limits. A process limit change can be added if the observed change is sustained for a longer period not just 6 points. You should try and find out the cause of the process change before recalculating the limits and annotate this on the chart. Be very cautious if you do not know what changed the process.

Icon Key



NHS Icon Descriptions

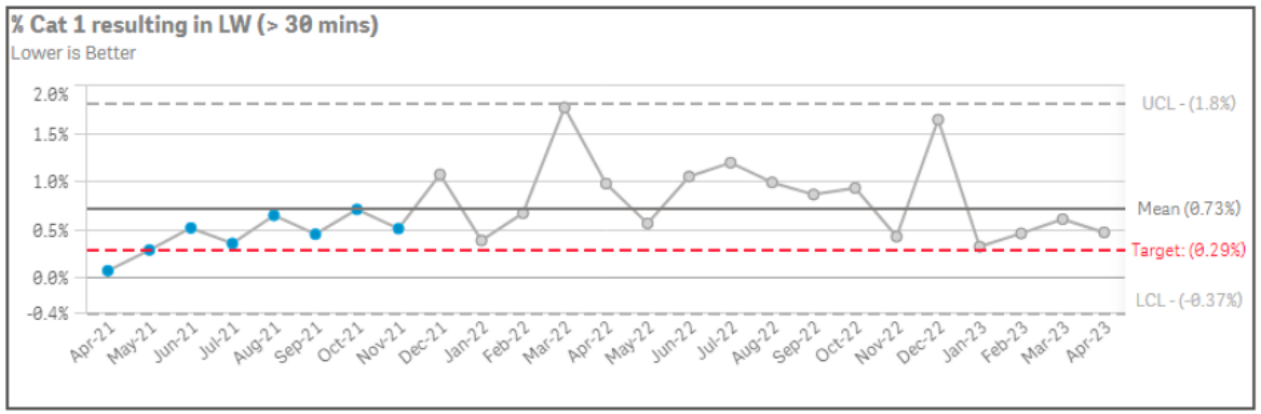
	Pass	Hit and Miss	Fail	No Target
	Special cause of an improving nature where the measure is significantly HIGHER.This process is capable and will consistently PASS the target.	Special cause of an improving nature where the measure is significantly HIGHER.This process will not consistently HIT OR MISS the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly HIGHER. This process is not capable. It will FAIL the target without process redesign.	Special cause of an improving nature where the measure is significantly HIGHER. Assurance cannot be given as a target has not been provided.
	Special cause of an improving nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target.	Special cause of an improving nature where the measure is significantly LOWER. This process is will not consistently HIT OR MISS the target.This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly LOWER. This process is not capable. It will FAIL the target without process redesign.	Special cause of an improving nature where the measure is significantly LOWER. Assurance cannot be given as a target has not been provided.
	Common cause variation , no significant change. This process is capable and will consistently PASS the target	Common cause variation , no significant change. This process will not consistently HIT OR MISS the target.This occurs when the target lies between process limits.	Common cause variation , no significant change. This process is not capable. It will FAIL the target without process redesign.	Common cause variation , no significant change. Assurance cannot be given as a target has not been provided.
	Special cause of a concerning nature where the measurs is significantly HIGHER.The process is capable and will consistently PASS the target.	Special cause of a concerning nature where the measurs is significantly HIGHER.This process will not consistently HIT OR MISS the target.This occurs when the target lies between process limits.	Special cause of a concerning nature where the measurs is significantly HIGHER. This process is not capable. It will FAIL the target without process redesign.	Special cause of a concerning nature where the measurs is significantly HIGHER.Assurance cannot be given as a target has not been provided.
	Special cause of a concerning nature where the measure is significantly LOWER.This process is capable and will consistently PASS the target.	Special cause of a concerning nature where the measure is significantly LOWER.This process will not consistently HIT OR MISS the target.This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly LOWER. This process is not capable. It will FAIL the target without process redesign.	Special cause of a concerning nature where the measure is significantly LOWER. Assurance cannot be given as a target has not been provided.

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

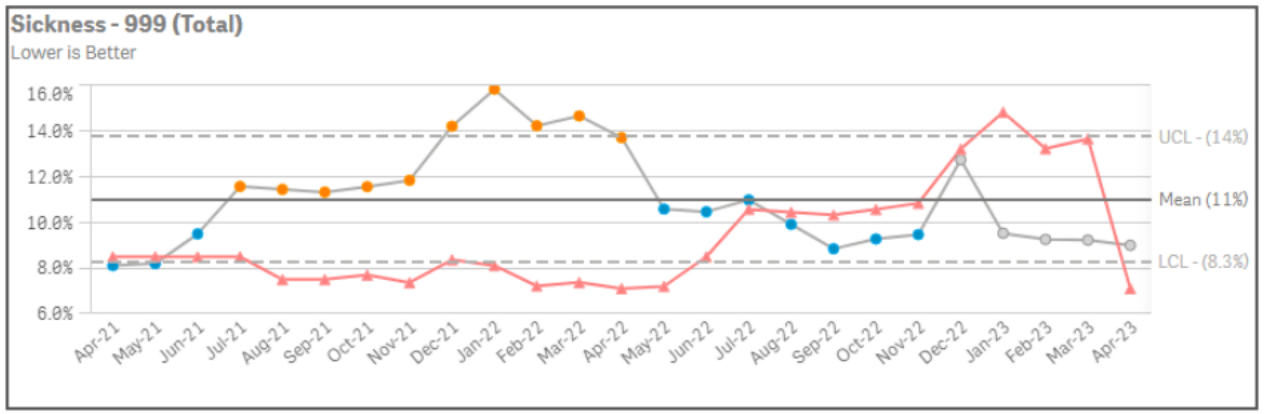
Assumptions:

The below SPC chart shows an example of the metric values per month.
The points on the line are coloured orange, grey, or blue in accordance with the SPC guidelines.
A dashed red line shows the target for the metric if there is one present.
A red line with triangle markers shows the plan projected for the metric if one is present.
The plan is different to a target, as the target is static; the plan can vary each month.
No Assurance Icon will be produced for the metric if no target value is available.
Quarterly Metrics and Metrics without data pre April 2022 will be visualised in a line chart and not an SPC Chart.

Example of Target Line Chart



Example of Plan Line Chart



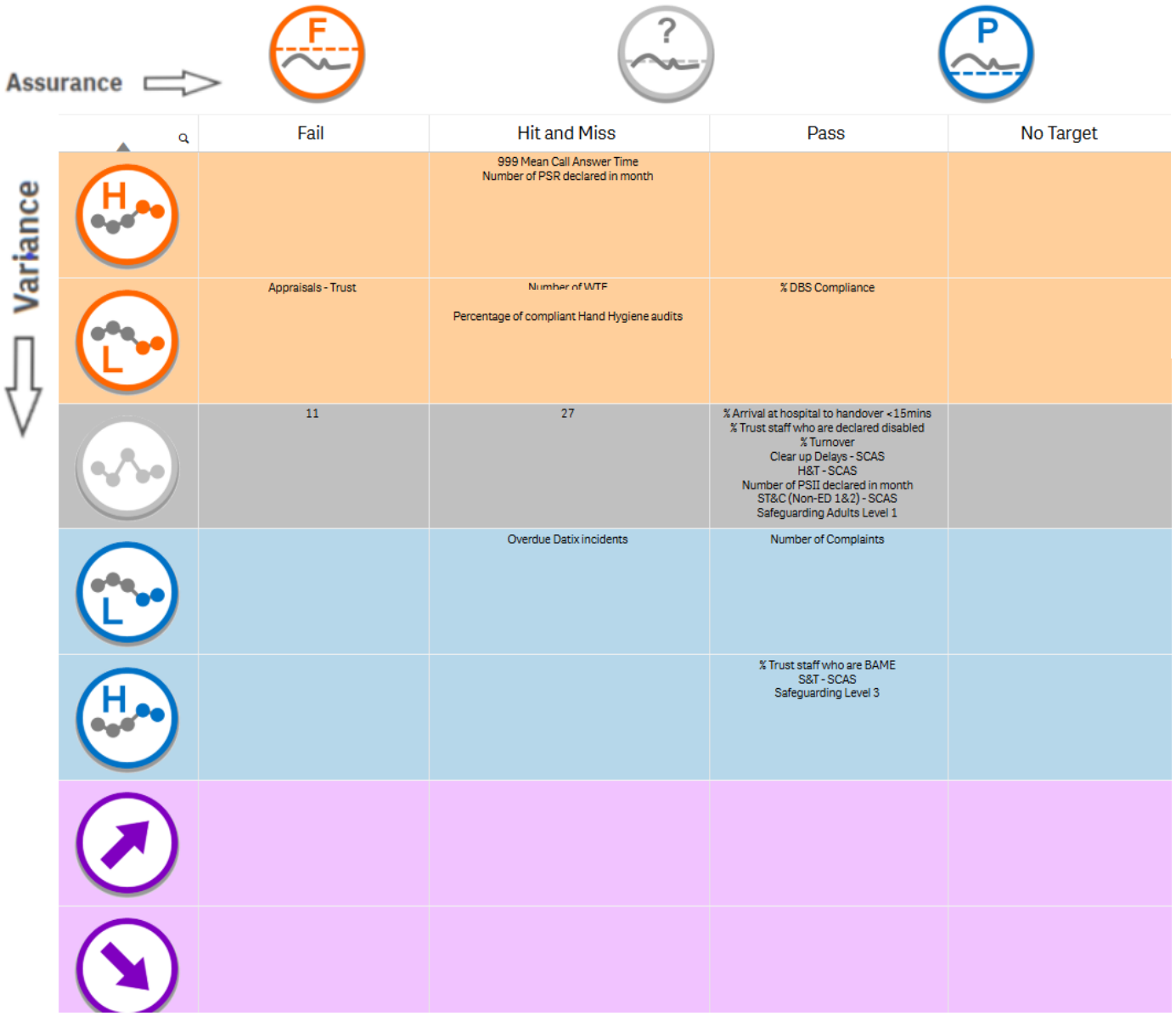
UCL & LCL:

When the variance in the values is normal within the process (common cause varition) all the points will fall above or below them mean, but within the upper and lower control limits as represented by the lines on the chart.

If values(s) fall above the UCL or below the LCL, then they are statistically not expected, special cause variation.

However, it is important to realise that even if all the points fall within the control limit lines it does not mean the process is in control. Ideally a process should have no variation, the values should all be the same. So it is important to understand what is causing the common cause variation. The wider the gap between the mean line and the control limits, the larger the variance

July-26 Summary



Variance \ Assurance	Fail	Hit and Miss	Pass	No Target
H		999 Mean Call Answer Time Number of PSR declared in month		
L	Appraisals - Trust	Number of WTE Percentage of compliant Hand Hygiene audits	% DBS Compliance	
	11	27	% Arrival at hospital to handover <15mins % Trust staff who are declared disabled % Turnover Clear up Delays - SCAS H&T - SCAS Number of PSII declared in month ST&C (Non-ED 1&2) - SCAS Safeguarding Adults Level 1	
L		Overdue Datix incidents	Number of Complaints	
H			% Trust staff who are BAME S&T - SCAS Safeguarding Level 3	

Metrics:

Fail Common Cause Metrics:

% Vacancy ; 111 Call back < 20 min ; 111 call answer in 120 Secs % ; Average Hospital Handover Time - SCAS ; Cat 1 Mean SCAS ; Cat 3 90th %ile SCAS ; Meal Break Compliance - SCAS ; ST&C (ED 1&2) - SCAS ; VOR - Total

Hit and Miss Common Cause Metrics:

% Long term sickness ; % Sickness in month ; 111 Calls abandoned after 30 secs % ; 999 Calls abandoned % ; Cardiac Arrest Survival at 30 Days - All Patients ; Cardiac Arrest Survival, Utstein ; Cat 1 90th %ile SCAS ; Cat 2 90th %ile SCAS ; Cat 2 Mean SCAS ; Hand Hygiene audit ; Number of PSI low/no harm ; Number of reported CD incidents – unaccounted for losses ; Over-runs >30 mins - SCAS

Percentage of compliant Vehicle cleanliness audits ; Return On Spontaneous Circulation (ROSC) on Hospital Arrival - All Patients ; Return On Spontaneous Circulation (ROSC) on Hospital Arrival - Utstein Cohort ; STEMI - Call to angiography 90th Centile ; STEMI Call to angiography - Mean ; Short term sickness ; Stroke - Call to Hospital arrival 90th Centile ; Stroke - Call to Hospital arrival Median ; Stroke Call to Hospital arrival - Mean ; Time to hire ; Vehicle cleanliness completed audits

NHS

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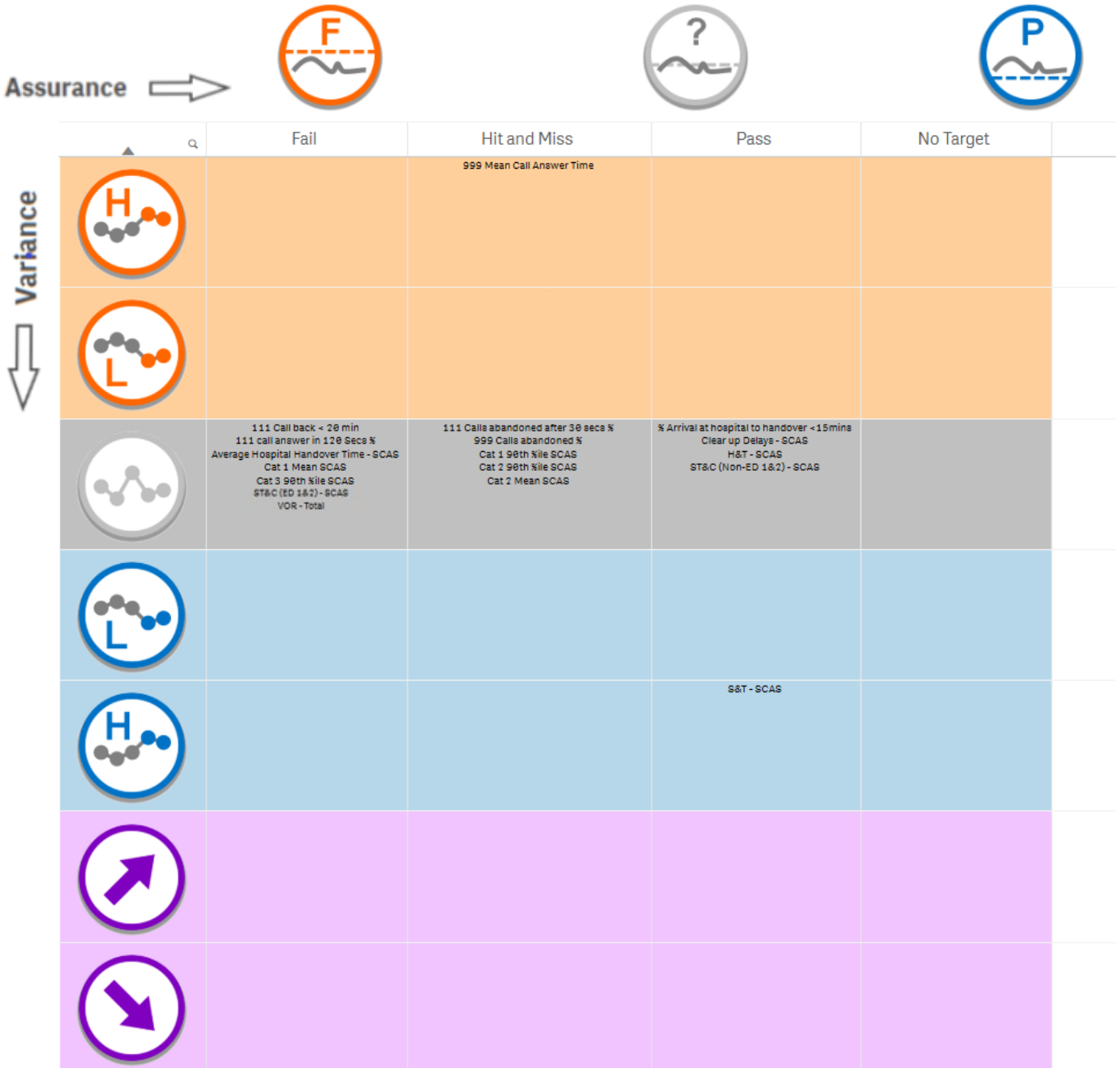
Operational Performance

July-26 Summary

Metrics:

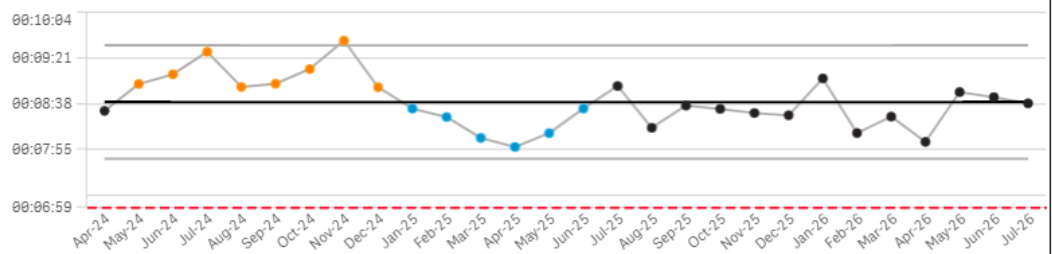


*Currently all data is aggregated on a monthly basis. We aim to provide accurate 90 days, YTD and 12 Months data when available.

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Cat 1 Mean	Jul-26	00:08:39	00:07:00		F	00:08:40	00:07:46	00:09:34
Cat 1 90th %ile	Jul-26	00:16:02	00:15:00		?	00:15:44	00:14:16	00:17:13
Cat 2 Mean	Jul-26	00:31:15	00:27:30		?	00:29:59	00:18:06	00:41:52
Cat 2 90th %ile	Jul-26	00:59:11	00:40:00		?	01:00:00	00:37:46	01:22:14
Cat 3 90th %ile	Jul-26	05:12:01	02:00:00		F	05:53:50	02:15:13	09:32:27
% Vehicles off the road	Jul-26	40.2%	15.0%		F	40.3%	32.9%	47.7%
Average Handover Time	Jul-26	00:17:42	00:15:00		F	00:18:10	00:15:35	00:20:46
Handover < 15 mins	Jul-26	49.8%	60.0%		P	50.3%	44.0%	56.7%
Average Clear Up Time	Jul-26	00:13:33	00:15:00		P	00:13:29	00:13:13	00:13:44
% See and Treat	Jul-26	32.7%	29.0%	H	P	31.8%	30.7%	33.0%
See, Treat and Convey to ED	Jul-26	46.6%	47.0%		F	47.5%	46.1%	49.0%
See, Treat and Convey to Non-ED	Jul-26	3.8%	4.0%		P	4.0%	3.7%	4.2%
999 Call Answer	Jul-26	00:00:15	00:00:10	H	?	00:00:08	00:00:01	00:00:15
999 Call Abandonment Rate	Jul-26	1.6%	2.0%		?	1.5%	0.6%	2.4%
% Hear and Treat	Jul-26	16.8%	20.0%		P	17.5%	15.9%	19.2%
111 Call Answer	Jul-26	67.2%	95.0%		F	73.5%	52.5%	94.4%
111 Call Abandonment Rate	Jul-26	5.3%	3.0%		?	3.7%	-0.1%	7.5%
111 Call Back Percentage	Jul-26	35.9%	90.0%		F	33.0%	24.0%	42.0%

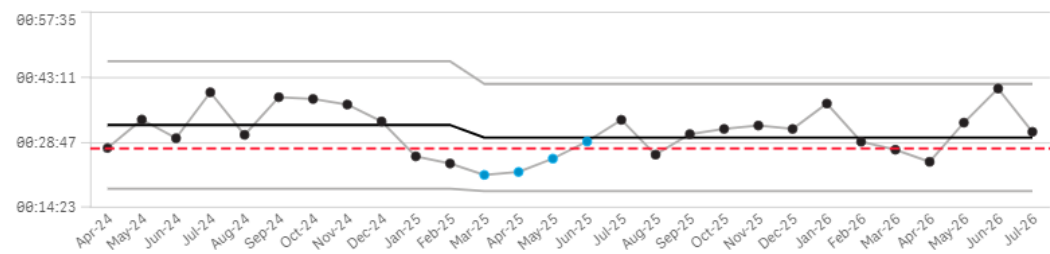
Operations - Response Times

OP1 - Cat 1 Mean
Lower is Better. Target differed in previous years



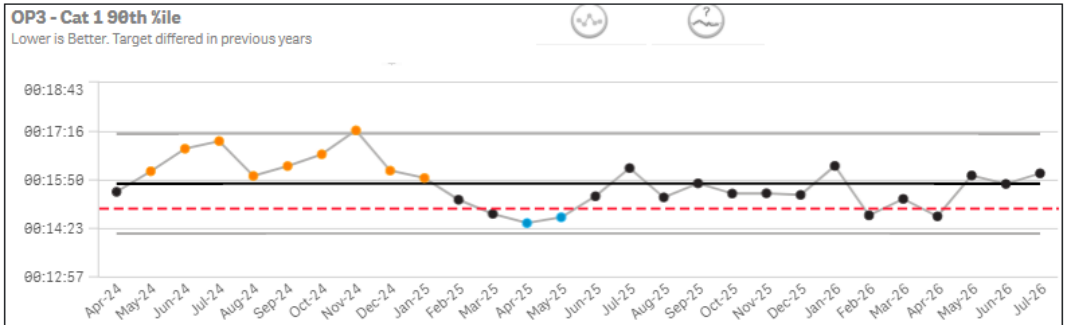
Variation	Assurance	Target	Latest
Expected	Fail	00:07:00	00:08:39

OP2 - Cat 2 Mean
Lower is Better. Target differed in previous years



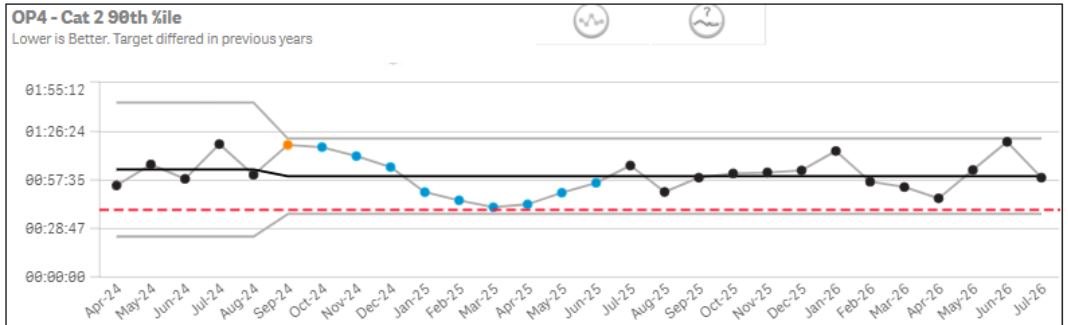
Variation	Assurance	Target	Latest
Expected	Random	00:27:30	00:31:15

OP3 - Cat 1 90th %ile
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	00:15:00	00:16:02

OP4 - Cat 2 90th %ile
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	00:40:00	00:59:11

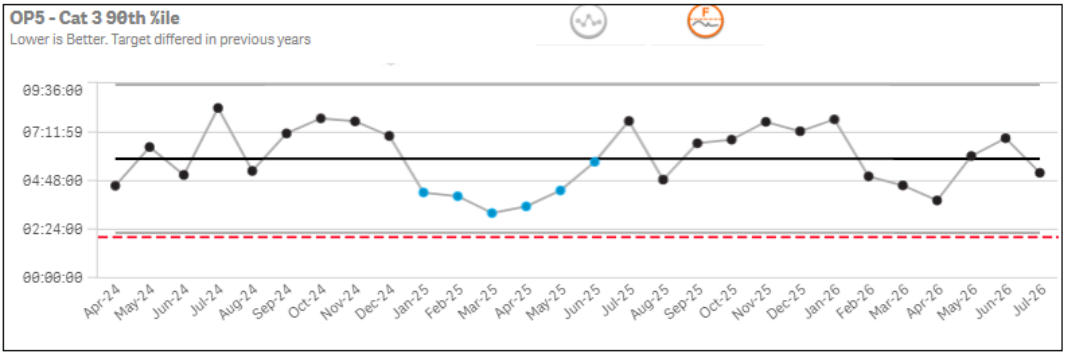
Understanding the Performance:

Improved performance in both Cat. 1 and Cat. 2 however both remain above target. Throughout July demand was 3.8% below trajectory (1782 incidents). Response demand impacted by below plan H&T driving an additional 1460 incident demand. Operational hours were 1% (2200 hours) below plan, driven by above plan sickness absence and low take up of additional hours. Hospital delays reduced but remained above plan adding 1:46 minutes to Cat.2 performance.

Actions (SMART):

Cat 2 Recover plan developed and in implemented - includes plans to support delivery of 2026/27 performance CIPs including 20% H&T, reduced abstraction and improved task time.
Recruitment team focused on recovery and delivery of recruitment plan for CSD and ECTs.

Operations - Response Times



Variation

Expected

Assurance

Fail

Target

02:00:00

Latest

05:12:01

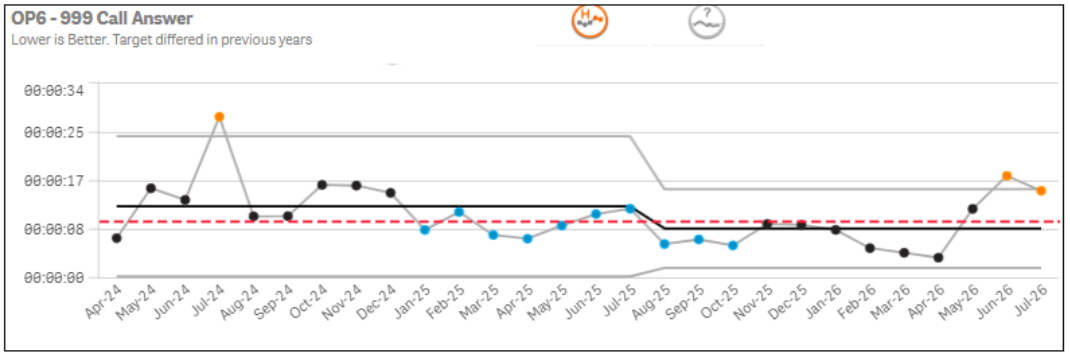
Understanding the Performance:

Improved performance but remaining above target. Throughout July demand was 3.8% below trajectory (1782 incidents). Response demand impacted by below plan H&T driving an additional 1460 incident demand. Operational hours were 1% (2200 hours) below plan, driven by above plan sickness absence and low take up of additional hours. Hospital delays reduced but remained above plan adding 1:46 minutes to Cat.2 performance.

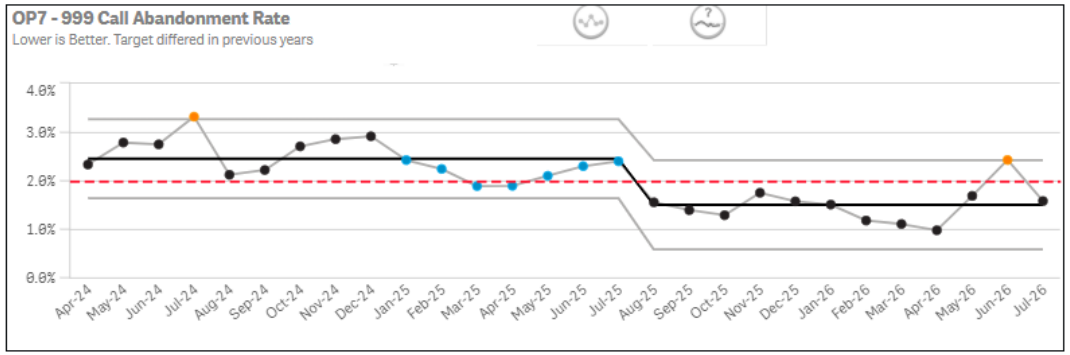
Actions (SMART):

Recover plan developed and in implemented - includes plans to support delivery of 2026/27 performance CIPs including 20% H&T, reduced abstraction and improved task time.
Recruitment team focused on recovery and delivery of recruitment plan for CSD and ECTs.

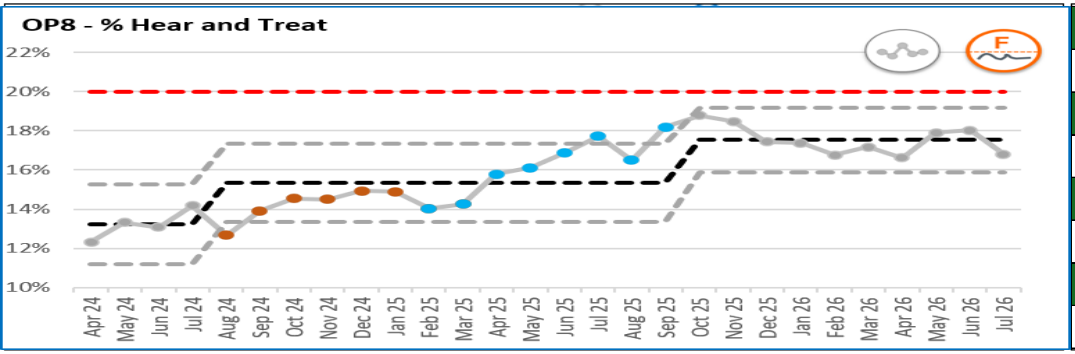
Operations - Operations Centre



Variation	Assurance	Target	Latest
Declined	Random	00:00:10	00:00:15



Variation	Assurance	Target	Latest
Expected	Random	2.0%	1.6%



Variation	Assurance	Target	Latest
Expected	Fail	20.00%	16.80%

Understanding the Performance:

OP 6 remained above 10 second target during July at 15 seconds. Despite recruitment activity, available call handling capacity has not yet matched planned requirement. Demand reduced from the levels seen end of June due to the heatwave and the variation in duplicate calls. As a result OP 6 shows recovery with the 90th percentile falling to 1 minute. Although OP 6 was challenged OP 7 shows that abandonment rates were effectively controlled showing common cause variation. OP 8 achieved 17% in July, remaining below 20% target but broadly consistent with recent performance.

Actions (SMART):

Continue recruitment and training into both emergency call taker and clinical roles to achieve planned establishment levels - monitored weekly and monthly via IWP meetings.

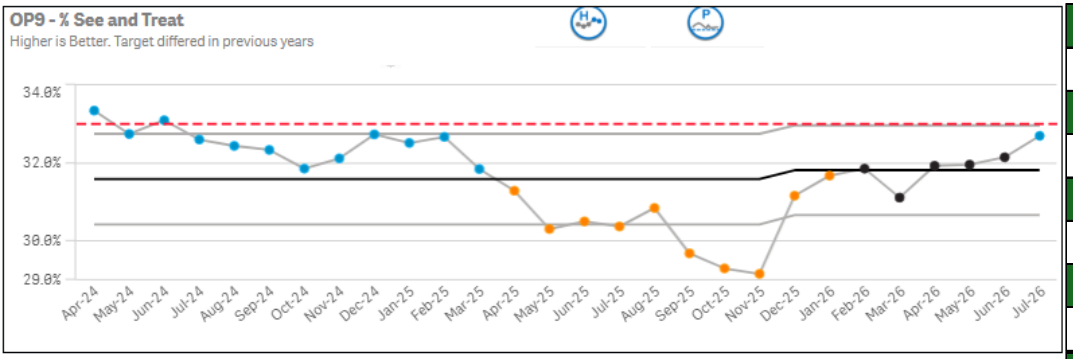
Deliver agreed actions in line with the ICC improvement programme, ensuring milestones are achieved within agreed timescales, monitored via monthly steering group meetings.

Maintain focus on attendance, wellbeing and retention initiatives to maximise productive hours, reduce avoidable absence and improve stability.

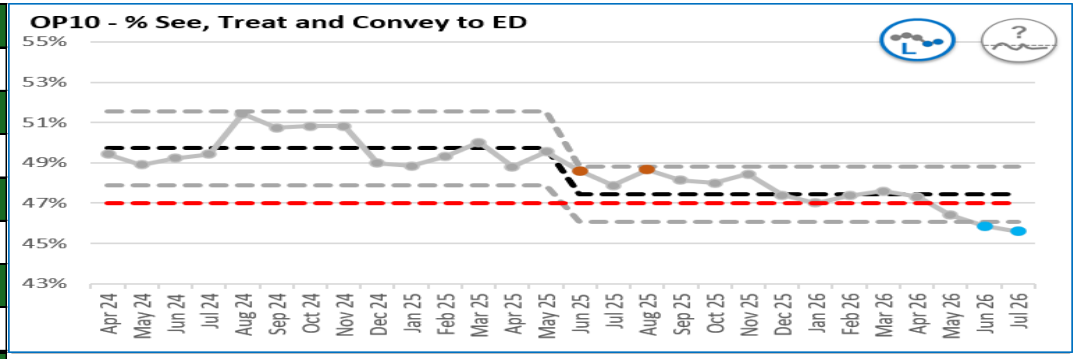
Embedding of new operational structures.

Implementation of learning from the heatwave critical/major incident revised process for 111 clinical capacity supporting CSD - process developed and implemented. Ongoing monitoring and QI type process underway - reviewed via monthly steering group meetings.

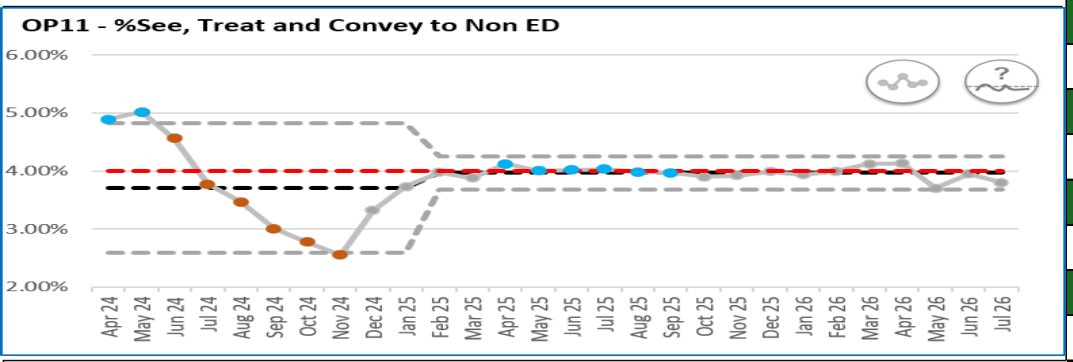
Operations - Utilisation



Variation
Improving
Assurance
Pass
Target
29.00%
Latest
32.70%



Variation
Improving
Assurance
Random
Target
47.00%
Latest
46.60%



Variation
Expected
Assurance
Random
Target
4.00%
Latest
3.80%

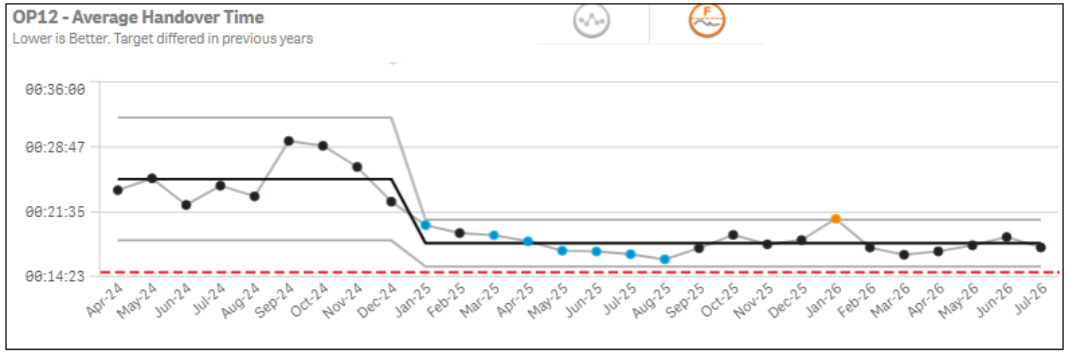
Understanding the Performance:

OP9 - continued improvement and now above the upper control limit with sustained performance above target. Op10 - another strong month with further improvements seen in convey to ed. It is the second consecutive point below the target and now below the lower control limit. (Lower is better with this measure). OP11 - expected variation seen but sustained tracking along the target line.

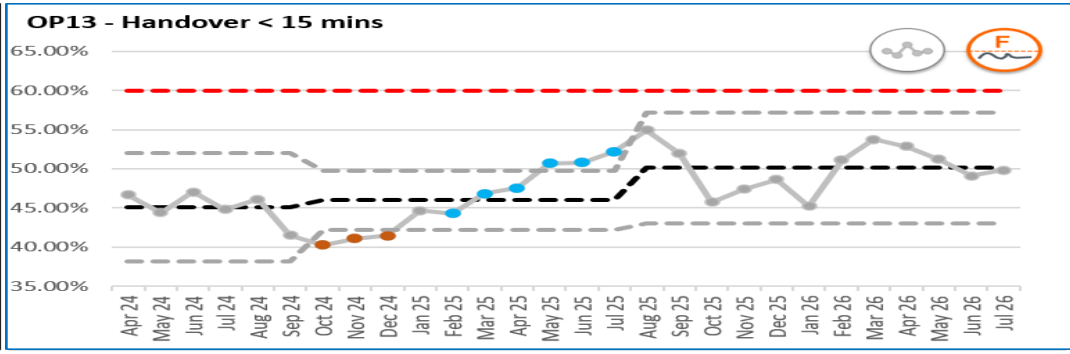
Actions (SMART):

Specific - Produce a single, upto date directory of non ED pathways. Measurable - 100% of frontline vehicles have access to SCAS connect. Achievable - Clinical Ops managers ownership at local level. Timebound - Central to delivering operational plan for 26/27

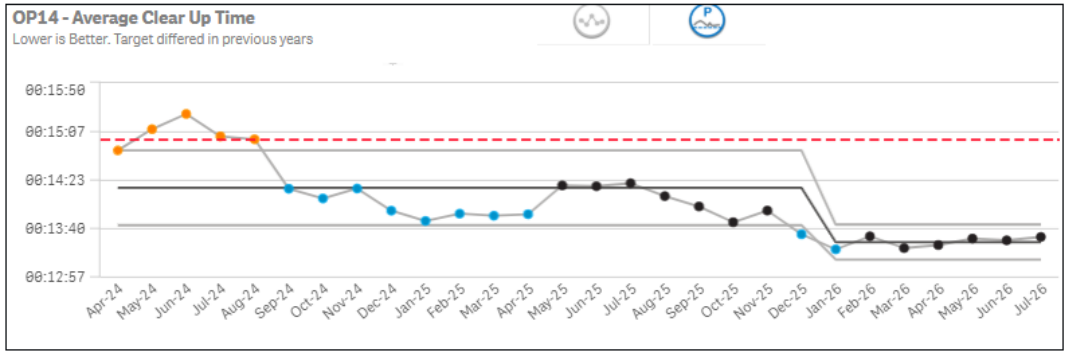
Operations - Utilisation



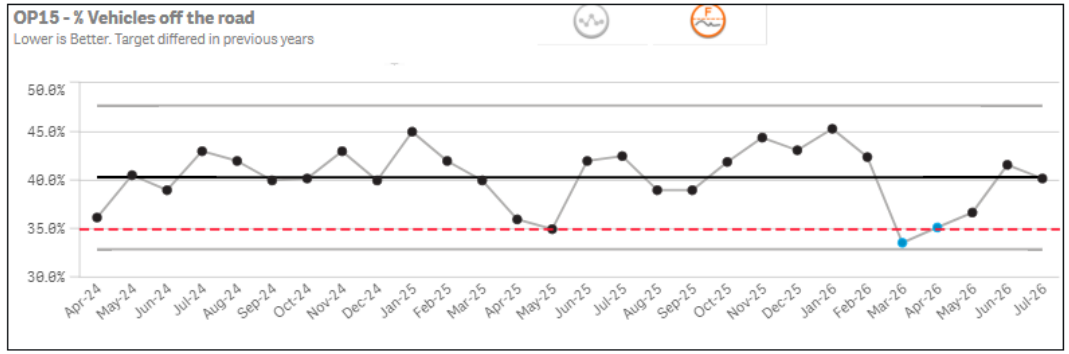
Variation
Expected
Assurance
Fail
Target
00:15:00
Latest
00:17:42



Variation
Expected
Assurance
Fail
Target
60.00%
Latest
49.11%



Variation
Expected
Assurance
Pass
Target
00:15:00
Latest
00:13:33



Variation
Expected
Assurance
Fail
Target
35.0%
Latest
40.2%

Understanding the Performance:

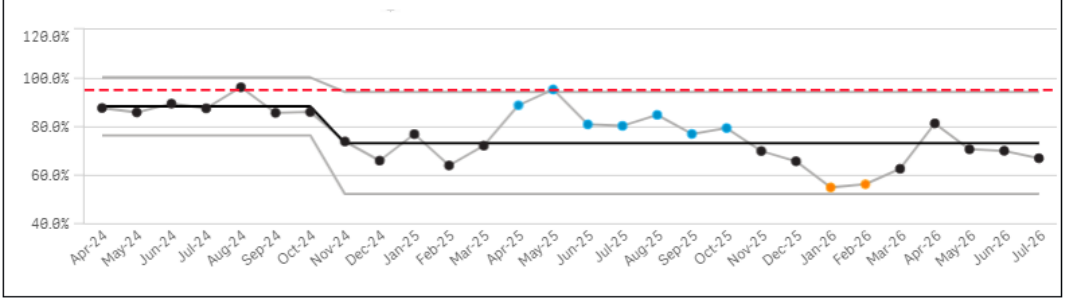
OP12/13 – following four consecutive month of deterioration in handover compØlaince and handover within 15mins, a slight improvement has been seen in July. OP14 – clear up compliance remained strong throughout July easily achieving the target of 15mins.

Actions (SMART):

Local ownership of handover process at acutes, working collaboratively to improve compliance through the sharing of data and implementation of agreed actions such as release to respond.

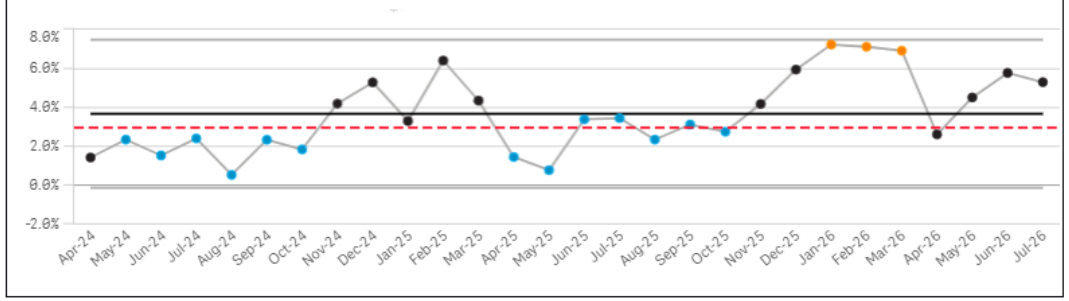
Operations - Operations Centre

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



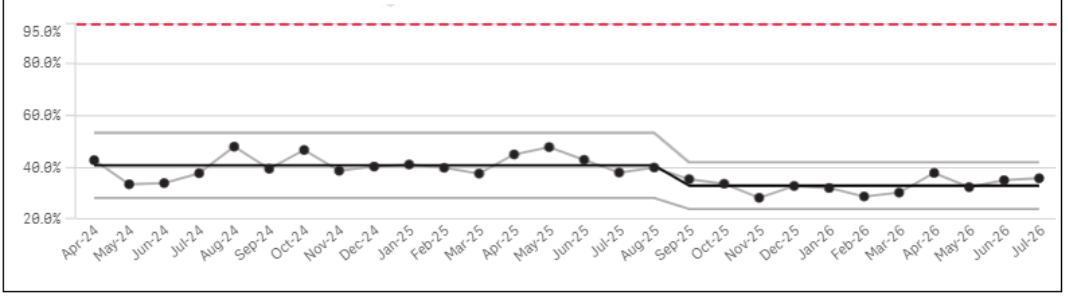
Variation	Assurance	Target	Latest
Expected	Fail	95.0%	67.2%

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



Variation	Assurance	Target	Latest
Expected	Random	3.0%	5.3%

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



Variation	Assurance	Target	Latest
Expected	Fail	95.0%	35.9%

Understanding the Performance:

111 performance remained challenged during July, with demand 6.83% above planned levels, and the greatest pressures experienced on Saturdays. This is the third month to be offered over 10,000 calls more than the same three months in FY 25-26, against which we had 795 less logged in hours across July compared to same month last year. Whilst Health Advisor staffing levels were in line with budget, current capacity remains insufficient to meet performance standards, reflecting the continued gap between planned establishment and the resource required to manage demand at current levels. OP16 achieved 67% of calls answered in 120 seconds and OP 17 at 7.6% both outside of national target of 95% and less than 3% respectively.

Actions (SMART):

Review and refresh of 111 Workforce plan by August 2026 incorporating refreshed recruitment/training plan and actual attrition rates with agreed actions monitored through weekly finance/hours meeting and monthly IWP meetings.
Working collaboratively with commissioners to establish gap between current funding and capacity to achieve contractual performance standards through monthly CRMs and planned SDIP meeting with BOB ICB in Sept.
Deliver actions in ICC improvement programme, ensuring milestones are achieved and progress reviewed through monthly ICC Steering Group.
Maintain focus on attendance and wellbeing to maximise productive hours and support recovery.
Complete the implementation of ICC Call Taking structure embedding newly appointed service delivery managers.

NHS

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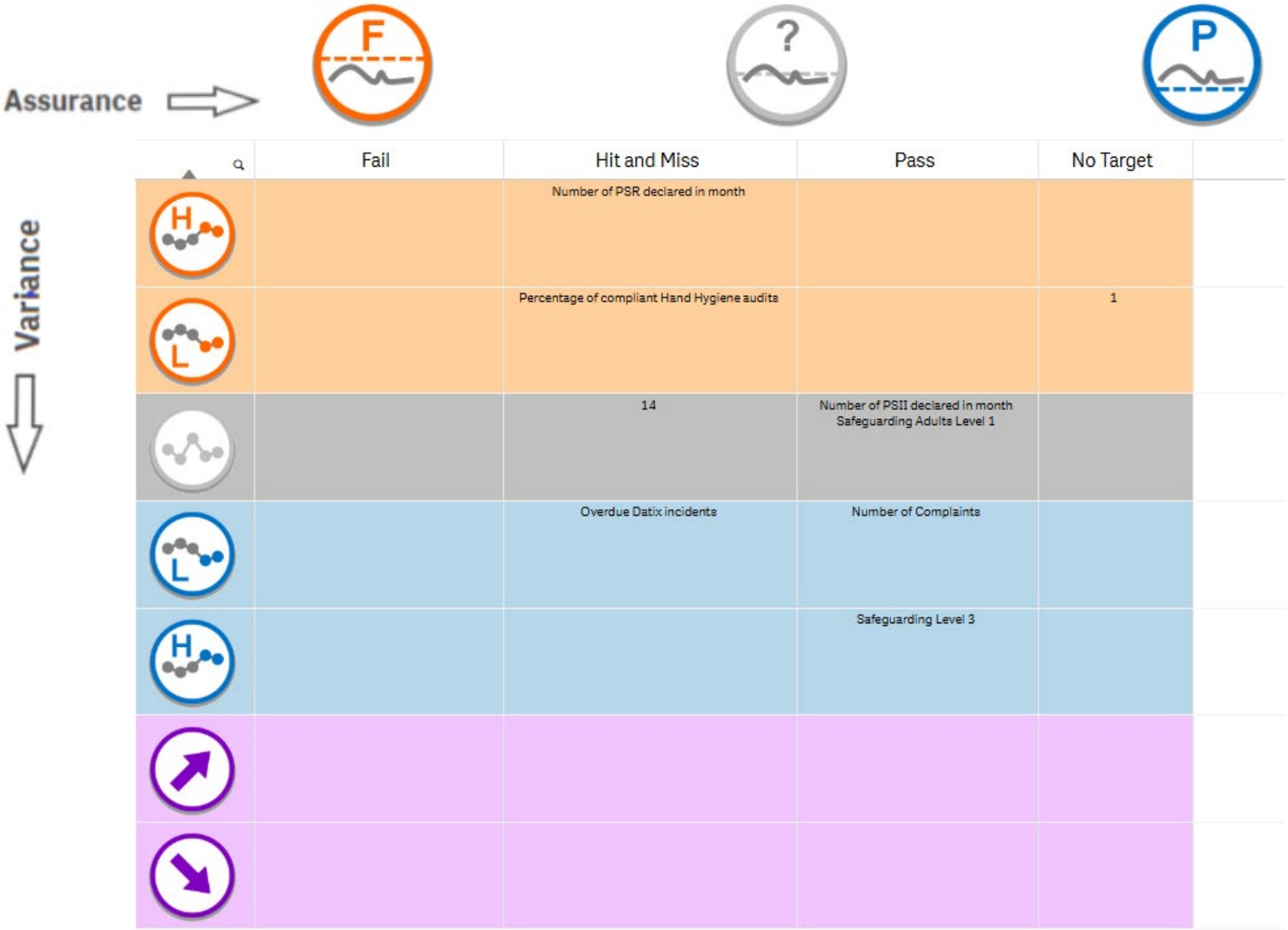
Quality and Safety

Quality & Safety – Core Measures Matrix

July-26 Summary



Metrics:

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

Quality Safety– Core Measures Icon Summary

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

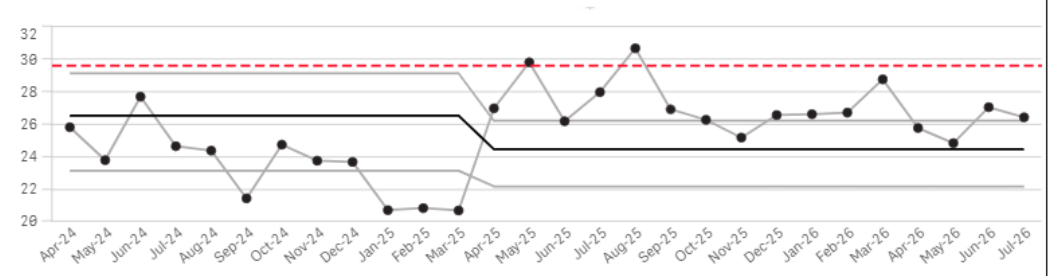
KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
PSI Low/no Harm Incidents	Jul-26	26.4	29.6			27.1	21.3	32.9
Monthly PSII	Jul-26	1	3			0.625	-1.28	2.53
Monthy PSILR	Jul-26	39	9			9.11	-5.87	24.1
Overdue Datix Incidents	Jul-26	0	0.987			0.826	-0.874	2.53
CD unaccounted for losses	Jul-26		2			1.14	-2.74	5.03
Level 1 Safeguarding	Jul-26	97.0%	95%			96.7%	95.5%	97.8%
Level 3 Safeguarding	Jul-26	97.4%	90%			95.6%	94.2%	97.1%
Complaints	Jul-26	0	2.43			0.745	-0.177	1.67
Compliments	Jul-26	8.42	0		n/a	12.8	5.31	20.2
Hand Hygiene Audits Completed	Jul-26	392	261			302	28.8	575
Hand Hygiene Audits % Compliance	Jul-26	59.4%	95%			88.9%	74.1%	103.7%
Vehicle Audits Completed	Jul-26	304	167			192	24.4	360
Vehicle Audits % Compliance	Jul-26	69.4%	90%			83.8%	59.6%	108.0%

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
STEMI Call to angiography - Mean	Mar-26	02:24:00	02:30:00			02:18:02	01:52:28	02:43:36
STEMI - Call to angiography 90th Centile	Mar-26	03:17:00	03:20:00			03:19:50	01:48:14	04:51:25
Stroke Call to Hospital Arrival Time Mean	Mar-26	01:29:00	01:30:00			01:35:44	01:17:37	01:53:51
Stroke Call to Hospital Arrival Time Median	Mar-26	01:20:00	01:20:00			01:22:44	01:10:04	01:35:24
Stroke Call to Hospital Arrival Time 90th Centile	Mar-26	02:12:00	02:30:00			02:22:41	01:49:07	02:56:15
Return of Spontaneous Circulation All	Mar-26	29.4%	25.8%			26.8%	19.5%	34.0%
Return of Spontaneous Circulation Utstein	Mar-26	55.3%	48.4%			53.3%	17.2%	89.4%
Cardiac Arrest 30 Day Survival - All	Mar-26	7.7%	8.9%			9.2%	3.9%	14.5%
Cardiac Arrest 30 Day Survival - Utstein group	Mar-26	35.7%	20.6%			30.9%	3.7%	58.1%

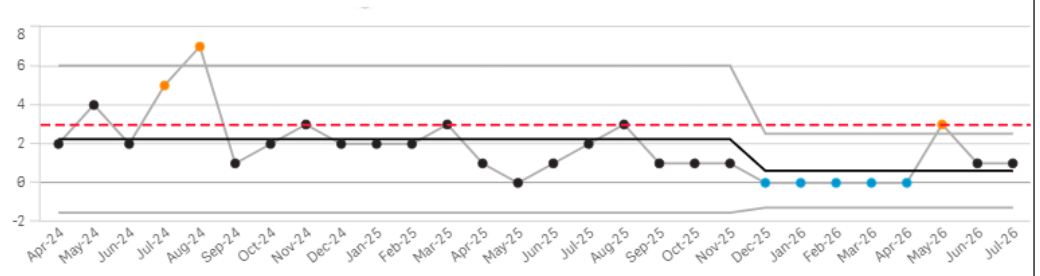
Quality & Safety – PSIRF

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



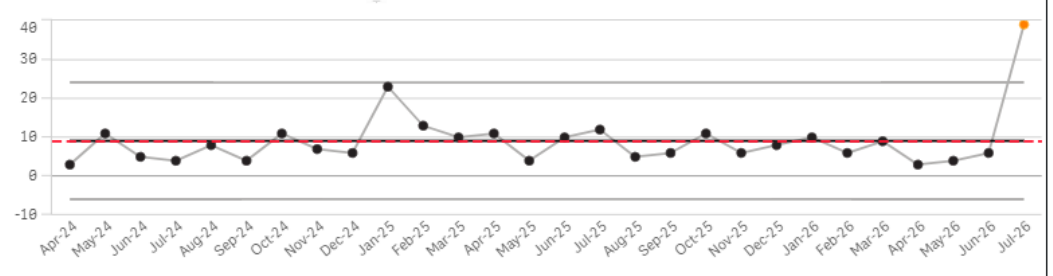
Variation	Assurance	Target	Latest
Expected	Random	29.6	26.4

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



Variation	Assurance	Target	Latest
Expected	Pass	3	1

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



Variation	Assurance	Target	Latest
Declined	Random	9	39

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.

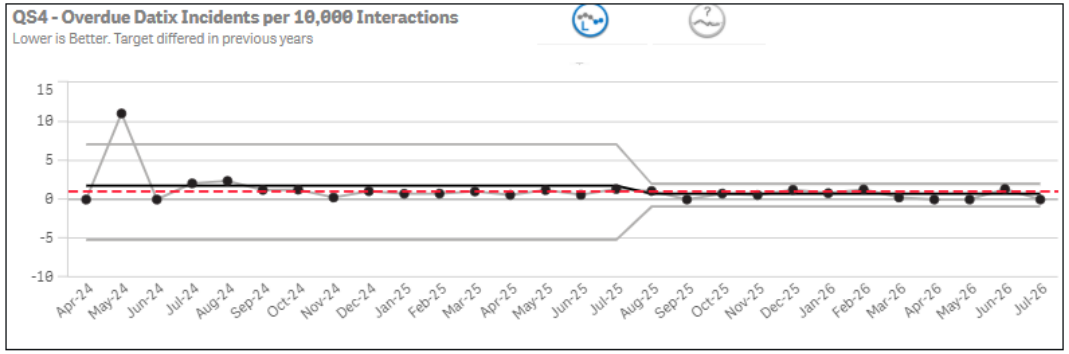
Common cause variation. Levels of PSI with moderate and severe harm and death, as a percentage of all PSIs reported, has decreased to 0.4% linked to improved performance in Cat2 and Cat3 response times in July (OP2, OP5).

QS2 - Special cause variation – declaration of an overarching cluster PSII to include all delays incidents related to the Critical/Major Incident in June 2026. 39 cases will be reviewed under this PSII and 36 statutory duty of candour were invoked under an amended process.

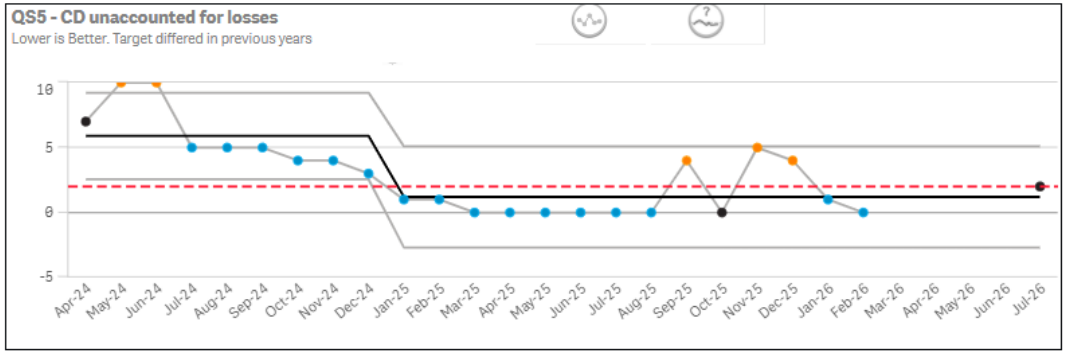
Actions (SMART):

QS3 – Collaborative working between the patient safety team and EUC team to run an Emergency Preparedness, Resilience and Response (EPRR) after action review concurrently with the cluster PSII to ensure shared learning and eliminate duplication of work. The final PSII report will be completed by January 2027.

Quality & Safety – PSIRF



Variation	Improving
Assurance	Random
Target	0.987
Latest	0



Variation	Expected
Assurance	Random
Target	2
Latest	2

Understanding the Performance:

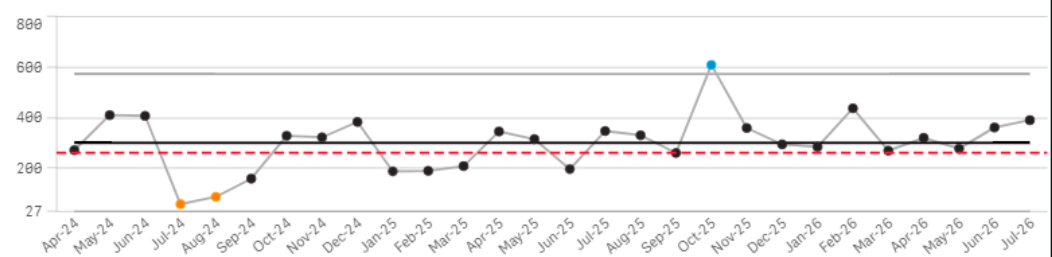
QS5 illustrates the monthly volume of unaccounted losses of Controlled Drugs (CDs) as reported through the DATIX/CDLIN system. The established target is less than 2 unaccounted losses per reporting cycle. Analysis of the data indicates the target has been consistently met, reflecting effective control measures. Reassuringly we haven't gone past this target and seen reduction since switch over to PICD.

Actions (SMART):

Training & Awareness: Ensure all staff are trained in CD handling and reporting by Q3, with refresher training planned every six months
Stock Control Measures: Complete daily CD stock checks at all sites with full documentation validation by Q3. Investigate discrepancies within 48 hours
Reporting & Documentation: Enhance DATIX detail to support timely investigations and CD Lin reporting by Q3. Implement an electronic CD register by Q1 26/27
Thematic Analysis & Diversion Control: Conduct quarterly thematic reviews to identify causes of unaccounted losses and audit CD handling in line with Trust policy

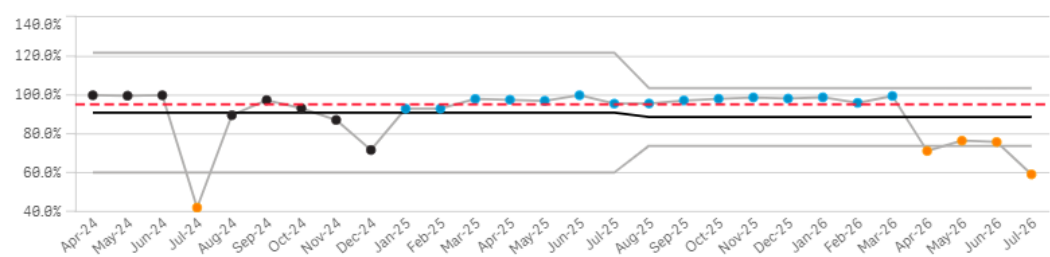
Quality & Safety - Audits

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



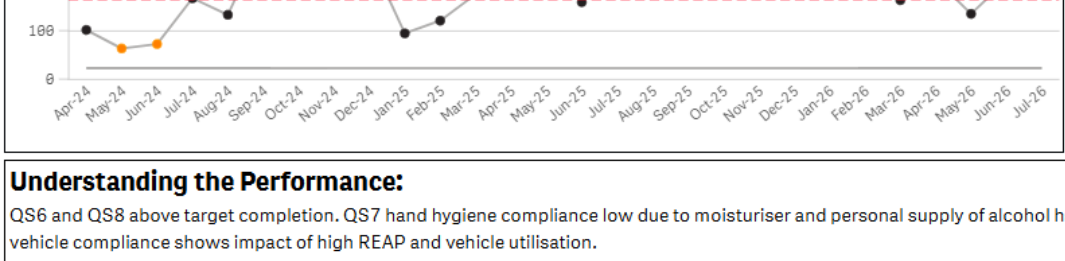
Variation	Assurance	Target	Latest
Expected	Random	261	392

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



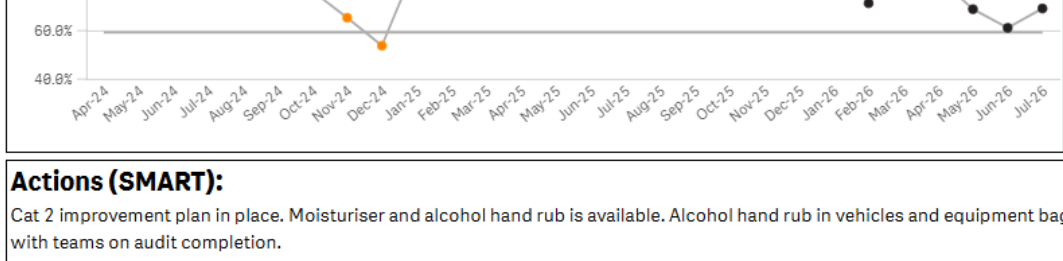
Variation	Assurance	Target	Latest
Declined	Random	95%	59.4%

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



Variation	Assurance	Target	Latest
Expected	Random	167	304

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



Variation	Assurance	Target	Latest
Expected	Random	90%	69.4%

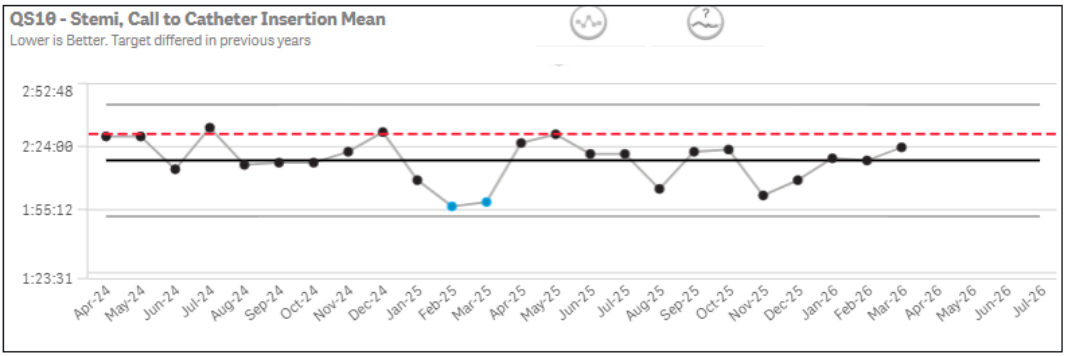
Understanding the Performance:

QS6 and QS8 above target completion. QS7 hand hygiene compliance low due to moisturiser and personal supply of alcohol hand rub questions. QS9 vehicle compliance shows impact of high REAP and vehicle utilisation.

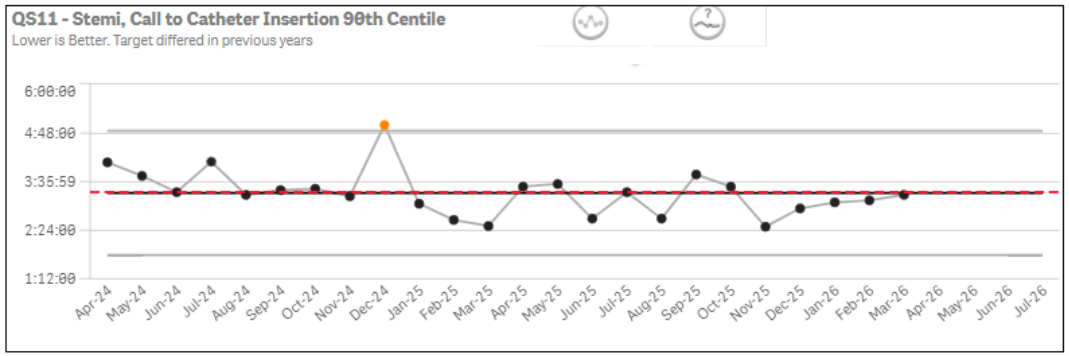
Actions (SMART):

Cat 2 improvement plan in place. Moisturiser and alcohol hand rub is available. Alcohol hand rub in vehicles and equipment bags. IPC lead working with teams on audit completion.

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



Variation	Expected
Assurance	Random
Target	02:30:00
Latest	02:24:00



Variation	Expected
Assurance	Random
Target	03:20:00
Latest	03:17:00

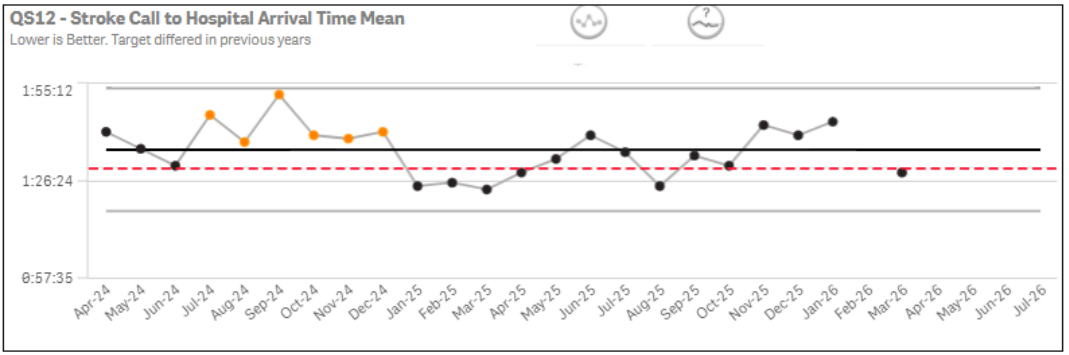
Understanding the Performance:

STEMI Mean (QS10) shows common cause variation and is below the target.
STEMI 90th (QS11) shows common cause variation and is at 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.
The chart represents data up until March 2026.

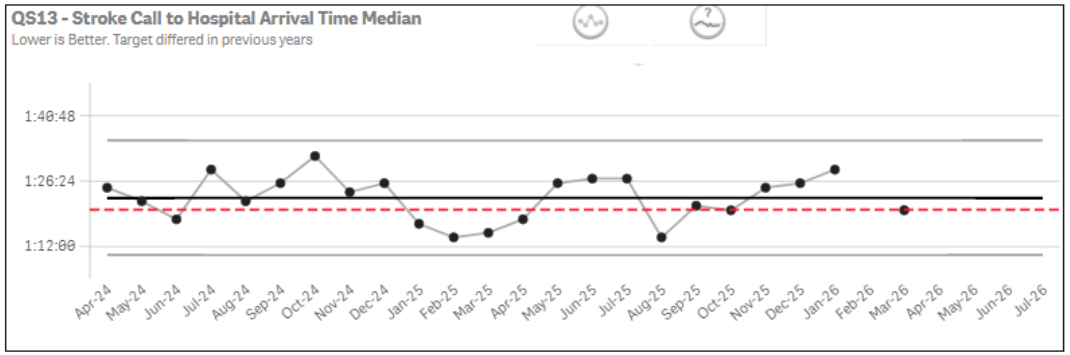
Actions (SMART):

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).

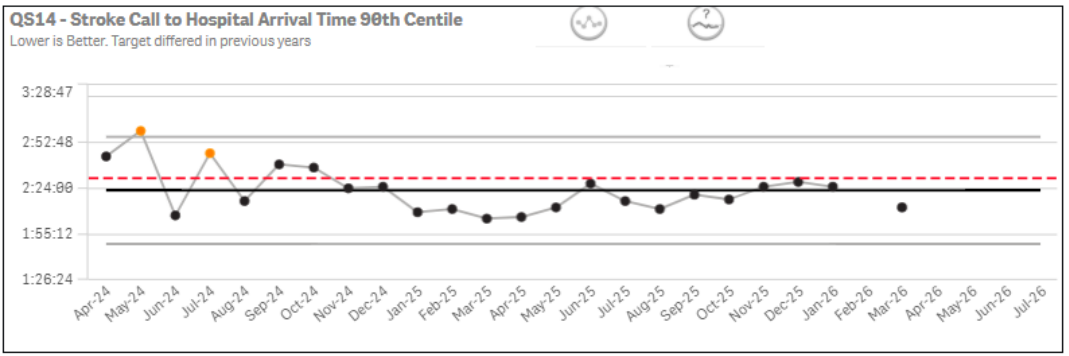
Quality & Safety – AQIs – Stroke - Chief Paramedic Officer



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



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



Variation	Expected
Assurance	Random
Target	02:30:00
Latest	02:12:00

Understanding the Performance:

Stroke Mean (QS12) shows common cause variation and is at 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.

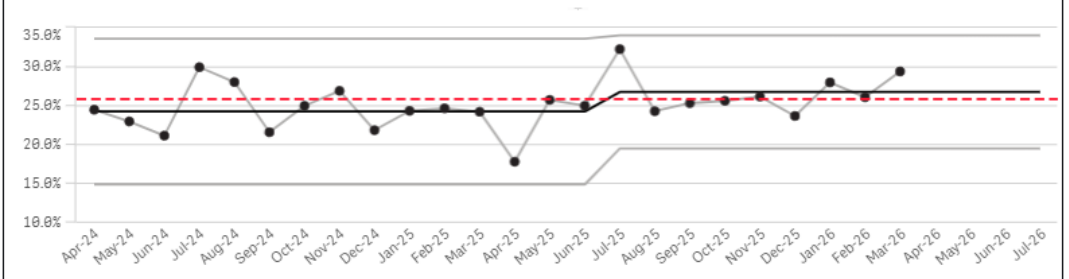
Each of the charts is a performance based measure and as such is reliant on the Trust's ability to identify a suitable resource, the time taken to get to scene and the ability of the Trust clinician to recognise a Stroke and provide the required care, the time spent on scene and the time spent travelling to the hospital site.
The charts presented here represents data up to March 2026. SSNAP data has encountered national technical issues and missing data will be available for later IPR submission.

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).

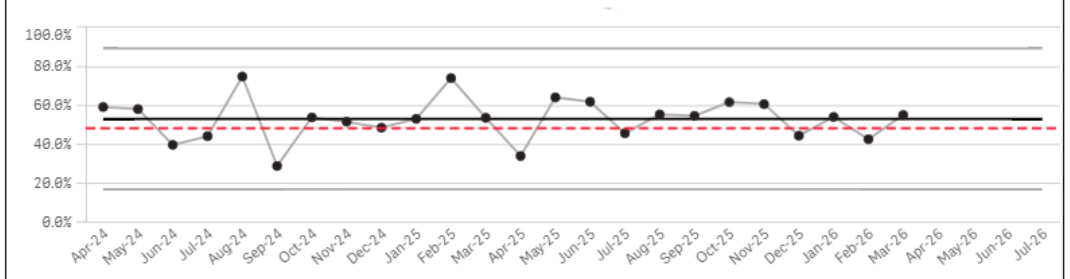
Quality & Safety – AQIs – Cardiac Arrest - Chief Paramedic Officer

QS15 - Return of Spontaneous Circulation All
Higher is Better. Target differed in previous years



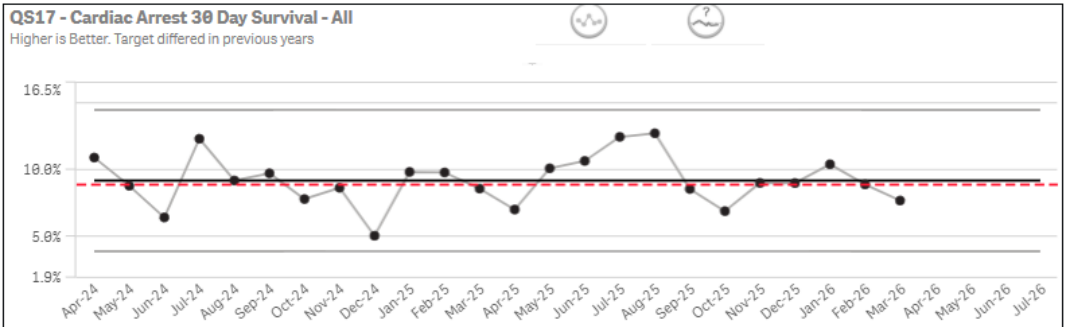
Variation	Assurance	Target	Latest
Expected	Random	25.8%	29.4%

QS16 - Return of Spontaneous Circulation Utstein
Higher is Better. Target differed in previous years



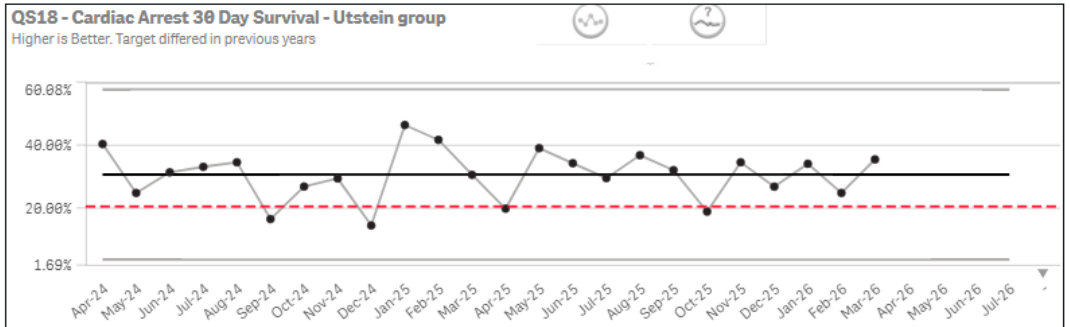
Variation	Assurance	Target	Latest
Expected	Random	48.4%	55.3%

QS17 - Cardiac Arrest 30 Day Survival - All
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	8.9%	7.7%

QS18 - Cardiac Arrest 30 Day Survival - Utstein group
Higher is Better. Target differed in previous years



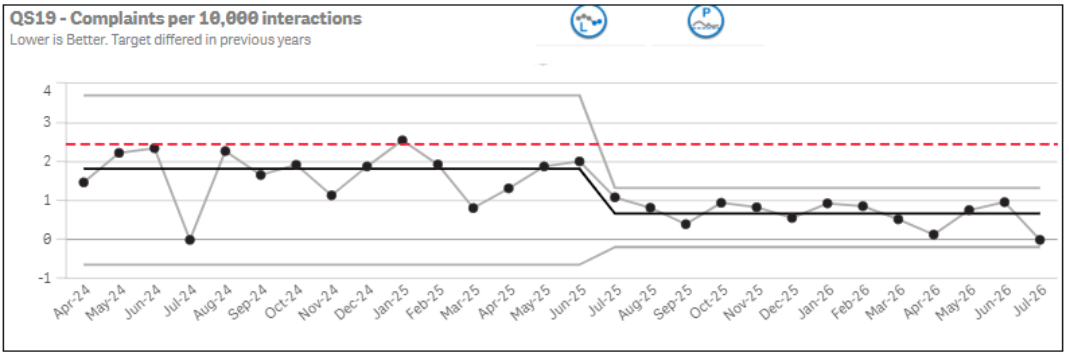
Variation	Assurance	Target	Latest
Expected	Random	20.6%	35.7%

Understanding the Performance:
ROSC all (QS15) shows common cause variation, above the target.
ROSC Utstein (QS16) shows common cause variation, above the target
Cardiac Arrest Survival All (QS17) shows common cause variation below 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.
The Charts represent data to March 2026.

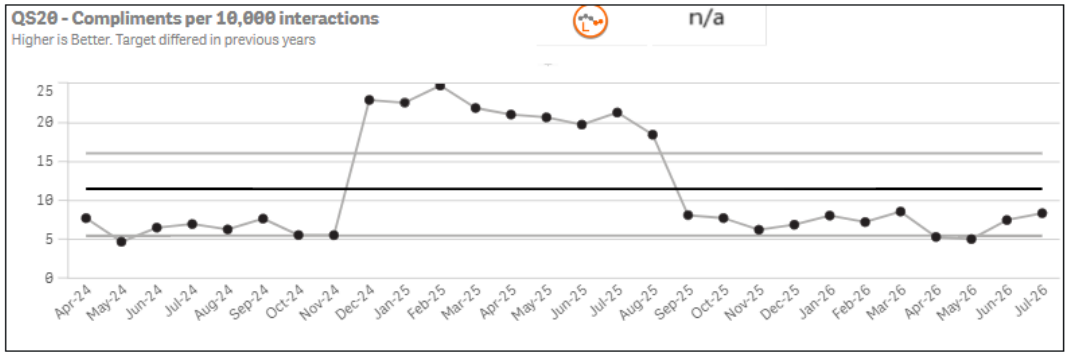
Actions (SMART):

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



Variation	Assurance	Target	Latest
Improving	Pass	2.43	0.00



Variation	Assurance	Target	Latest
Declined	-	-	8.42

Understanding the Performance:

QS20 – HCPF has decreased from 162 to 157 representing 44% of all patient experience contacts; 128 compliments, 36% of all patient experience contacts, were received for the same period. Themes are delayed response owing to the Critical and Major Incident and cancellations of NEPTS journeys owing to the cessation of taxi use to transport mobile patients.

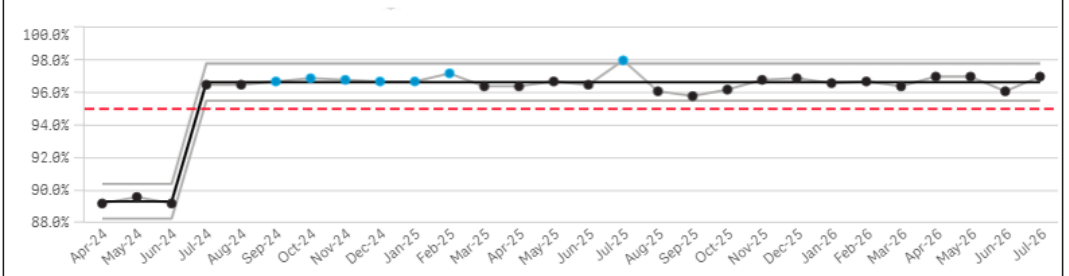
Actions (SMART):

QS20 – A Quality Impact Assessment has been approved proposing to decline NEPTS bookings when requested, once capacity has been reached and to highlight alternative transport options. Contacts regarding delays where harm has occurred are included in the cluster PSII (QS3).

Quality & Safety – Safeguarding and Patient Experience

QS21 - Level 1 Safeguarding

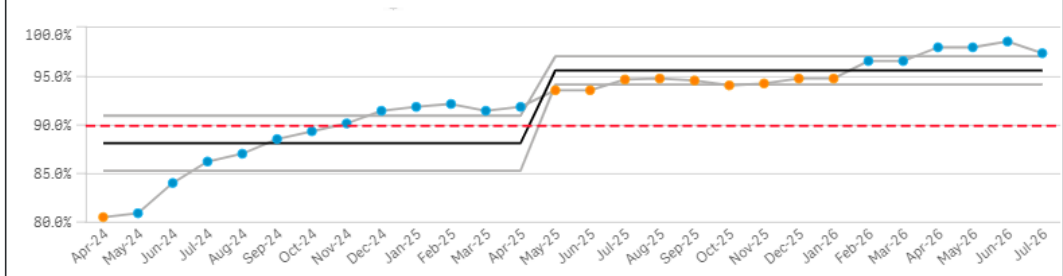
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Pass	95%	97.0%

QS22 - Level 3 Safeguarding

Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Improving	Pass	90%	97.4%

Understanding the Performance:

Actions (SMART):

NHS

NHS
South Central
Ambulance Service
NHS Foundation Trust

People

July-26 Summary

Metrics:

Assurance → F | ? | P

Variance ↓

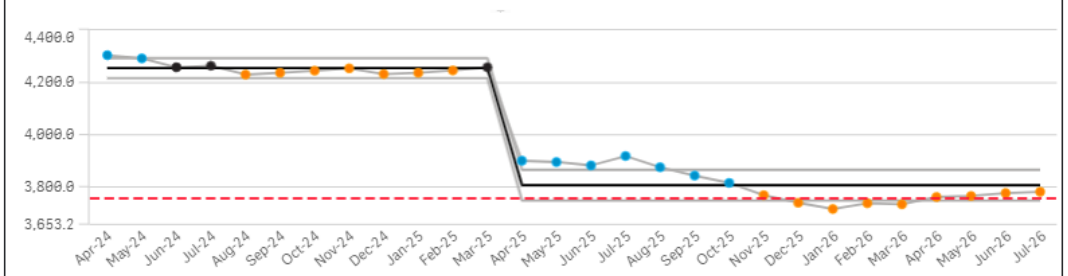
	Fail	Hit and Miss	Pass	No Target
H				
L	Appraisals - Trust	Number of WTE	% DBS Compliance	
	% Vacancy Meal Break Compliance - SCAS	% Long term sickness % Sickness in month Over-runs >30 mins - SCAS Short term sickness Time to hire	% Trust staff who are declared disabled % Turnover	FTSU Cases
L				
H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

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Number of WTE	Jul-26	3,781	3,753	L	?	3806.4	3747.7	3865.1
% Turnover	Jul-26	14.3%	17.70%		P	15.2%	14.1%	16.2%
% Vacancy	Jul-26		0.20%		F	2.1%	0.5%	3.8%
Time to hire	Jul-26	61	84		?	74.5	27.9	121.1
% Trust staff who are BAME	Jul-26	9.5%	8.86%	H	P	9.2%	8.9%	9.5%
% Trust staff who are declared disabled	Jul-26	12.4%	9.54%		P	12.0%	11.4%	12.6%
% Sickness in month	Jul-26	6.7%	6.20%		?	6.7%	5.8%	7.6%
Short term sickness	Jul-26	2.8%	2.70%		?	3.0%	1.9%	4.0%
% Long term sickness	Jul-26	3.9%	3.50%		?	4.0%	2.5%	5.5%
% DBS Compliance	Jul-26	97.4%	95.00%	L	P	98.1%	97.3%	98.9%
Appraisals - Trust	Jul-26	78.4%	95.00%	L	F	85.7%	81.3%	90.0%
FTSU Cases	Jul-26	21			n/a	18.6	4.8	32.4
Stat and Mand Compliance	Jul-26	97.6%	95.00%	–	P	-	-	-
Meal Break Compliance - SCAS	Jul-26	72.6%	85%		F	72.9%	63.3%	82.5%
Over-runs >30 mins - SCAS	Jul-26	15.9%	15%		?	15.5%	12.3%	18.7%

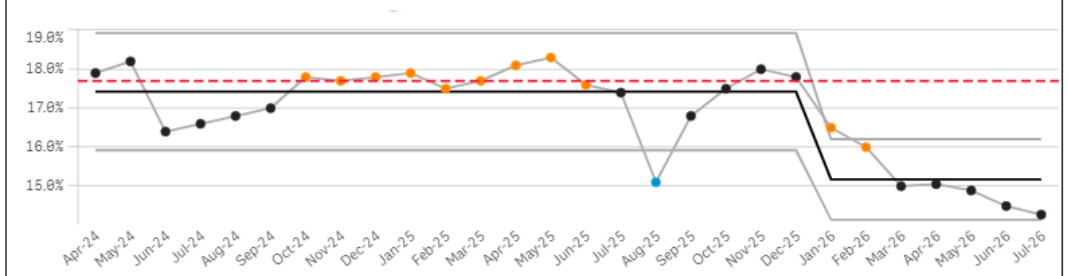
People - Workforce/WTE

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



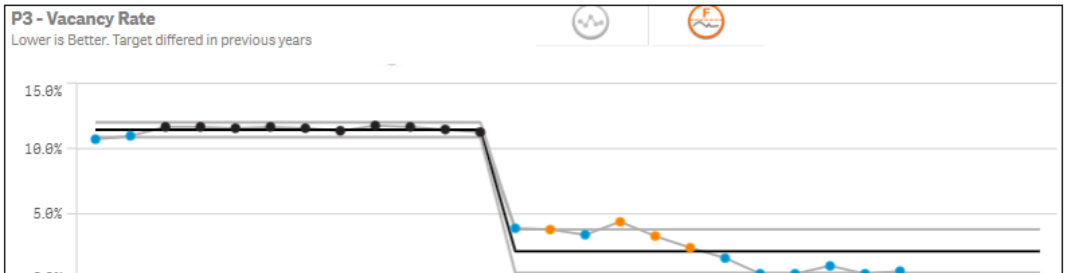
Variation	Assurance	Target	Latest
Declined	Random	3,753.15	3781.0

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



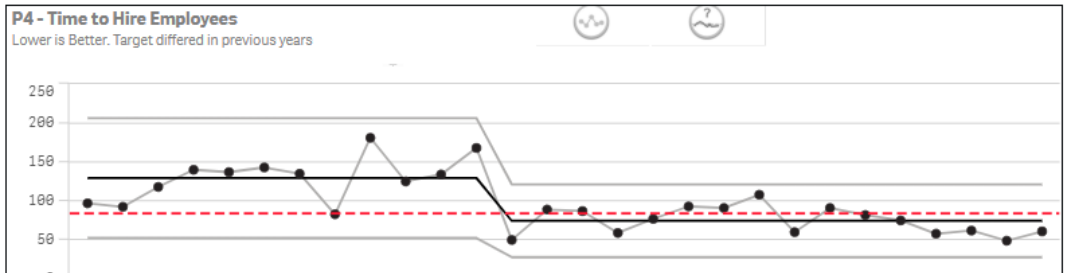
Variation	Assurance	Target	Latest
Expected	Pass	17.70%	14.3%

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



Variation	Assurance	Target	Latest
Expected	Fail	0.2%	

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



Variation	Assurance	Target	Latest
Expected	Random	8,4	61.0

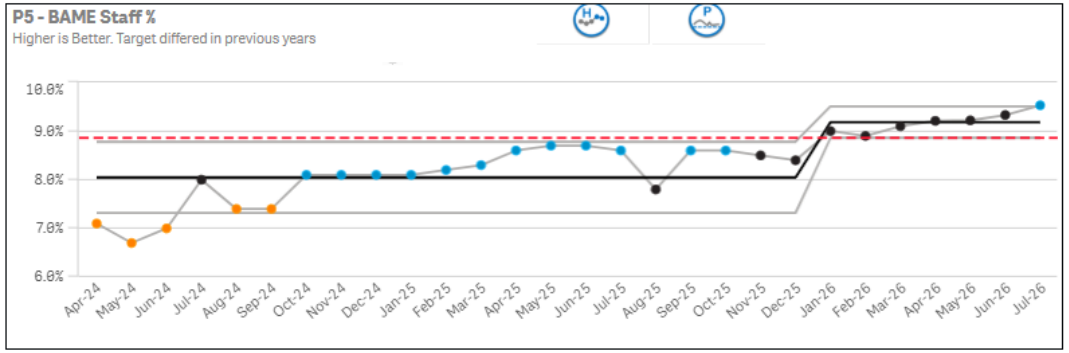
Understanding the Performance:

P1: WTE is 3781, below the monthly 3843 WTE planned target but above the end of year target of 3753
P2: Turnover is 14.3%, below the 17.7% target and reduced since last month, indicating improving retention but may affect planned recruitment levels
P4: Time to Hire - although there has been minor monthly variation, the overall recent trend is fairly stable and below the target with July at 61 calendar days (44 working days).

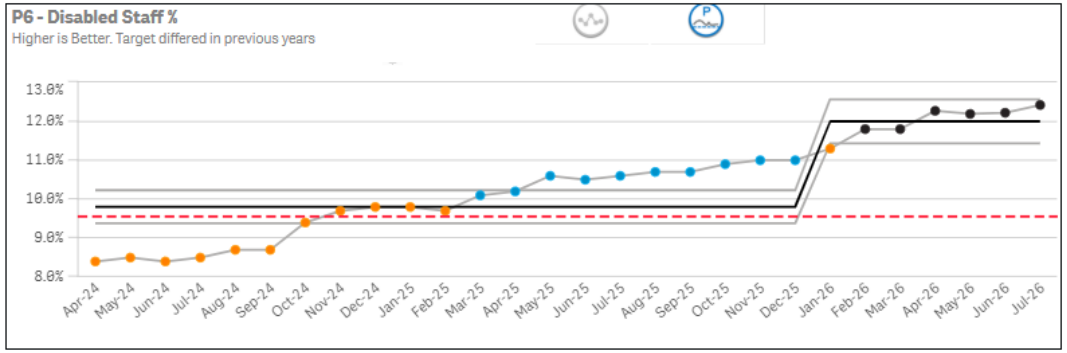
Actions (SMART):

P1: Monthly IWP meetings for the main workforce plan include close control and monitoring of attrition
P2: Work to update and evaluating workforce plans are underway to ensure a changing turnover rate is reflected in establishment and recruitment assumptions
P4: Time to Hire - delays were primarily driven by lengthy notice periods, pre-booked holidays affecting start dates, DBS processing times, and Occupational Health risk assessment requirements. These were mitigated through process efficiencies and proactive management of candidates throughout the recruitment journey.

People - Workforce/Availability



Variation	Assurance	Target	Latest
Improving	Pass	8.9%	9.5%



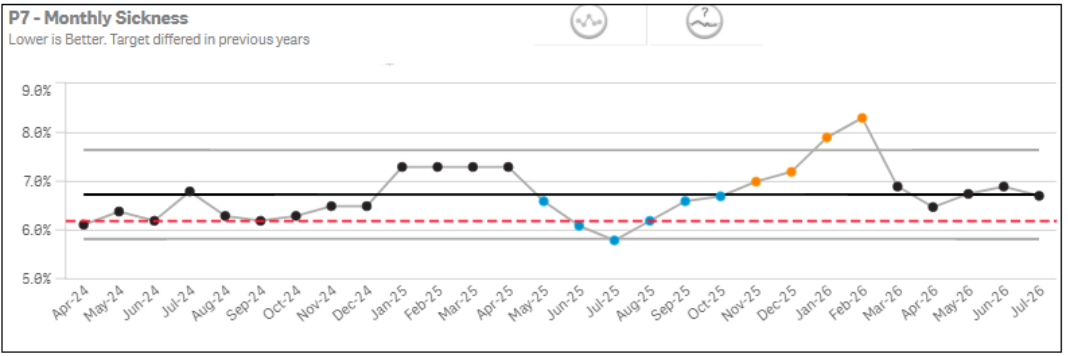
Variation	Assurance	Target	Latest
Expected	Pass	9.5%	12.4%

Understanding the Performance:

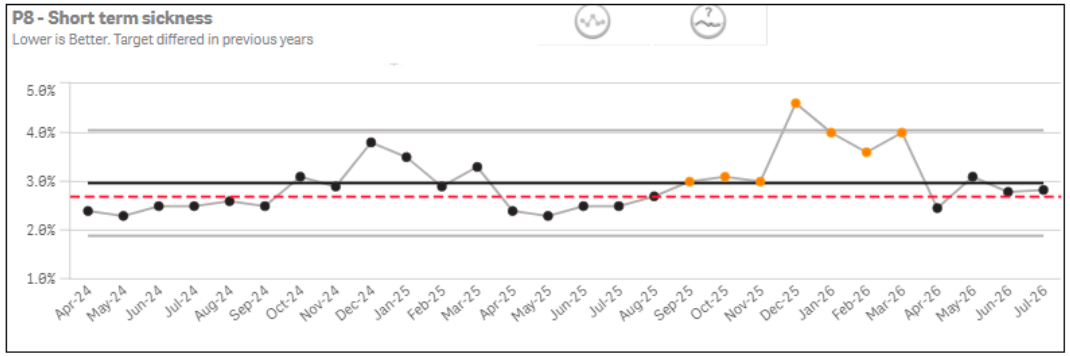
P5: BAME representation is 9.5%, above the 8.9% target and improving.
P6: Disabled staff representation is 12.4%, above the 9.54% target and improving.

Actions (SMART):

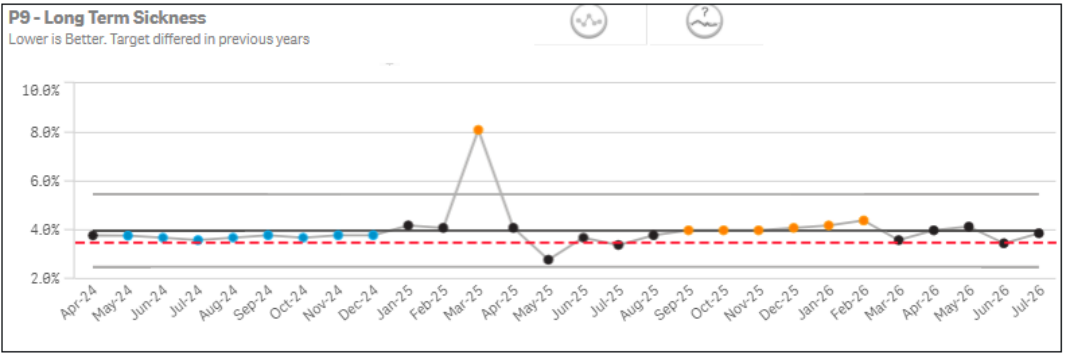
People - Workforce/Sickness



Variation	Expected
Assurance	Random
Target	6.2%
Latest	6.7%



Variation	Expected
Assurance	Random
Target	2.7%
Latest	2.8%



Variation	Expected
Assurance	Random
Target	3.5%
Latest	3.9%

Understanding the Performance:

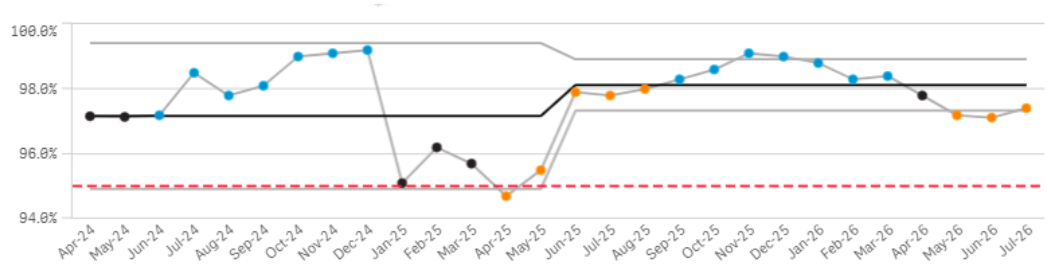
P7: Monthly sickness is 6.7%, above the 6.20% target. There is ongoing pressure and recovery actions being taken.
P8: Short-term sickness is 2.8%, above the 2.70% target and decreased since previous month.
P9: Long-term sickness is 3.8%, above the 3.50% target and risen since previous month.

Actions (SMART):

Sickness being monitored weekly, action groups and trajectories developed to reduce significantly in Operational areas by October 2026

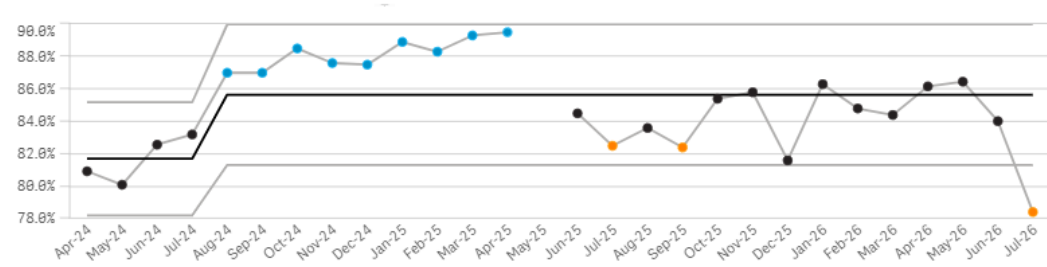
People – Workforce/Staff Compliance

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



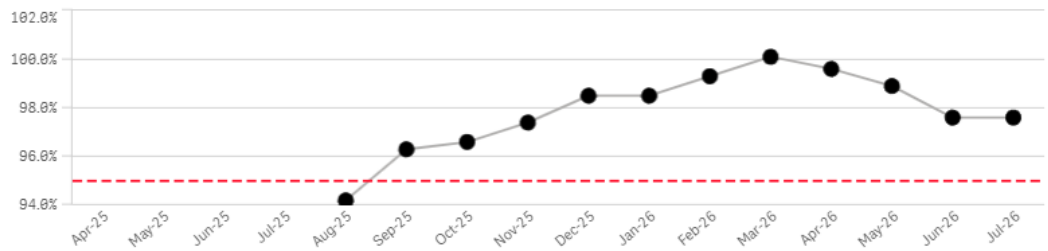
Variation	Assurance	Target	Latest
Declined	Pass	95.0%	97.4%

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



Variation	Assurance	Target	Latest
Declined	Fail	95.0%	78.4%

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



Variation	Assurance	Target	Latest
	Pass	95.0%	97.6%

Understanding the Performance:

P10: DBS - after a slight decline over recent months, the compliance total is now back on an upward trajectory. DBS compliance is 97%, above the 95% target.
P11: Appraisal completion reporting has a technical issue with PDR App inputs. Compliance with just ESR input is 78%, below the 95% target however accurate view will be provided as soon as possible.
P12: Training compliance is 97.6%, above the 95% target. Performance remains consistent

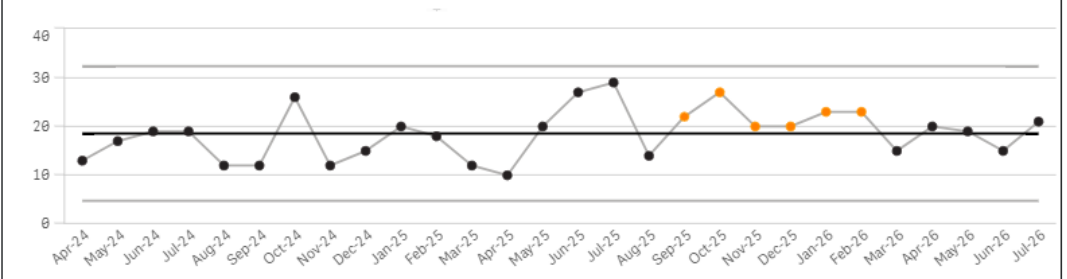
Actions (SMART):

P10: DBS - we have increased resource availability to clear the pipeline and implemented new processes to ensure continued improvement.
P11: REAP 4 and operational pressures will have affected compliance. Recovery plans will be underway. PDR training designed to improve compliance and quality of PDRs is incorporated Introduction to Management Development and after migration the team will be looking to include the NHSE leadership and management self-assessment into the PDR app which will again improve quality of PDR experience for leaders.

People - Workforce/Staff Welfare

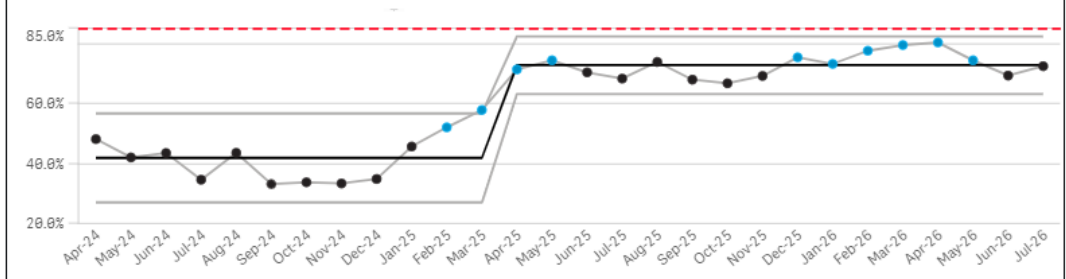
P13 - Freedom to Speak Up Cases
Lower is Better. Target differed in previous years

n/a



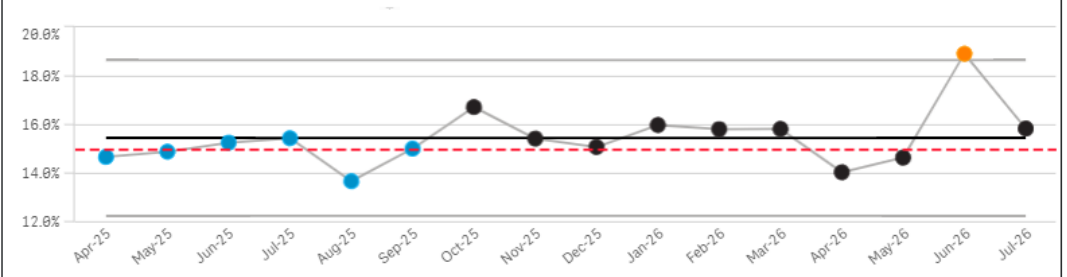
Variation	Assurance	Target	Latest
Expected	-	-	21

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



Variation	Assurance	Target	Latest
Expected	Fail	85%	72.6%

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



Variation	Assurance	Target	Latest
Expected	Random	15%	15.9%

Understanding the Performance:

P13 : 21 cases indicate recurring concerns around systems/processes, leadership and workplace behaviours, with potential implications for staff wellbeing and patient safety
P14 – whilst within expected variation, a third month of deterioration in compliance following the end of the AFB trial.
P15 - following extreme weather impacts in June the measure has returned to within expected variation for July.

Actions (SMART):

P13: improvement actions include strengthening leadership visibility, addressing behavioural concerns and reviewing process-related themes, with assurance through ongoing FTSU monitoring, thematic analysis and reporting of actions/outcomes to the appropriate areas.
P14 – modelling work shows clear operational and welfare advantages to breaks AFB. Discussions with union colleagues have now begun to change the current policy .
P15 – as part of the MB work we are looking at EoS and how we can secure staff finish on time more often than not.

NHS
South Central Ambulance Service
NHS Foundation Trust

TRUST BOARD OF DIRECTORS MEETING IN PUBLIC
3 SEPTEMBER 2026

Report title	Month 4 Financial Performance
Agenda item	11
Report executive owner	Jon Bell, Interim Chief Finance Officer
Report author	Mariam Ali, Assistant Director of Finance
Governance Pathway: Previous consideration	Executive Management Committee
Governance Pathway: Next steps	NA

Executive Summary

Income & Expenditure (I&E)

The Month 4 position is on plan, with a £1k favourable variance in-month and £5k favourable variance year-to-date. Sustaining this position will require consistent delivery against the current Cost Improvement Programme (CIP), alongside further identification of mitigations to manage emerging cost pressures, including the cost of recovering the Cat 2 performance position. Whilst the Trust remains on plan YTD and is forecasting to meet the plan for the year, emerging pressures including the cost of recovering Category 2 performance contribute to a risk of circa £3m that the Executive are working to mitigate.

Capital

Capital expenditure in Month 4 was £0.8m against a planned position of £2.9m, reflecting slippage in the estates and fleet programmes. Capital expenditure of £0.8m reflects lower-than-planned spend on estates and fleet programmes, with underspends of £7.5m on core capital, £1.7m on PDC-funded schemes and £2m on IFRS 16 budgets. These are largely offset by £9m of delayed sale-and-leaseback income arising from changes in the timing of fleet transactions.

Cash

The Trust's cash balance at the end of July was £38.5m, which is £6.6m ahead of plan due to slippage in the capital programme. In month, the Trust generated a net cash inflow of £1.4m.

Key Performance Indicators

	Actual	Plan	Variance
Surplus / (Deficit) In-month (£'000)	-101	-102	1
Pay Costs In-Month (excl. agency) (£'000)	18,451	18,270	-181
Agency Costs - in month (£'000)	97	69	-28
Capital Spend - YTD (£'000)	755	2,901	-2,146
Closing Cash Position (£m)	38.5	31.9	6.6

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

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

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

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

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

1. Background / Introduction

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

Income and Expenditure (I&E)

In Month 4, the Trust's I&E position is an adjusted deficit of £101k, which is a £1k favourable variance to plan.

	Month 4			YTD - Month 4			FY 26/27
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Income from patient care activities	27,455	27,451	4	109,862	109,805	57	329,416
Other income	241	236	4	919	946	(27)	2,837
Deficit Support Funding	-	-	-	-	-	-	-
Income Total	**27,696**	**27,688**	**8**	**110,781**	**110,751**	**30**	**332,253**
Substantive	18,205	17,931	(274)	73,036	71,244	(1,792)	213,918
Bank	246	339	93	998	1,344	346	4,040
Agency	97	69	(28)	597	462	(135)	697
Pay Total	**18,548**	**18,339**	**(209)**	**74,631**	**73,050**	**(1,581)**	**218,655**
Non Pay	**8,259**	**8,126**	**(133)**	**32,581**	**32,547**	**(34)**	**98,785**
Contingency	263	513	250	796	2,117	1,321	5,121
Injury Benefit	17	17	0	67	68	1	204
Depreciation	1,427	1,580	153	5,853	6,276	424	20,233
IFRS16 Interest	100	118	19	412	486	74	1,845
IFRS16 Credits	(828)	(906)	(79)	(3,414)	(3,687)	(272)	(12,634)
Financing Costs	28	49	21	105	195	89	585
P&L on disposal	33	5	(28)	60	22	(39)	70
Other Total	**1,039**	**1,376**	**336**	**3,879**	**5,477**	**1,598**	**15,425**
Surplus/(Deficit)	**(150)**	**(153)**	**3**	**(309)**	**(323)**	**14**	**(612)**
System Reporting Adj	**50**	**51**	**(1)**	**197**	**205**	**(8)**	**615**
Surplus/(deficit) adjusted	**(101)**	**(102)**	**1**	**(112)**	**(118)**	**5**	**3**

The Trust remains financially stable and on plan YTD; however, sustained attention to cost pressures and productivity delivery will be required to maintain financial sustainability throughout the remainder of the year and deliver the planned breakeven position.

In Month 4, the largest driver of unfavourable variances was the additional costs to support frontline and fleet, to manage operational pressures due to the major incident declared linked to the extreme heat and significant increase in Cat 2 response times. There is a risk of further costs to manage potential further windows of high heat in the summer alongside recovery efforts to bring the Cat 2 performance back on plan.

However, despite the above financial pressure, the Trust managed to remain on plan due to vacancy control and delays in funded cost pressures. These actions are also helping to offset other emerging cost pressures, including increases in fuel prices driven by geopolitical factors. While these pressures are currently being managed through temporary measures, further sustainable mitigations need to be identified to ensure delivery against 2026/27 financial plan.

Trust Pay Costs

	Month 4			Year to Date		
Pay	Actual £000's	Plan £000's	Variance £000's	Actual £000's	Plan £000's	Variance £000's
Substantive	18,205	17,931	(274)	71,244	73,036	(1,792)
Bank	246	339	93	1,344	998	346
Agency	97	69	(28)	462	597	(135)
Total Pay	**18,548**	**18,339**	**(209)**	**73,050**	**74,630**	**(1,580)**

Substantive Pay Costs:

- Total pay expenditure for the month was £18.2m against a budget of £17.9m, resulting in an overspend of £0.3m. This variance is primarily attributable to the non-delivery of CIP savings within pay, leading to higher than planned staffing costs.
- Overtime for the month was £0.5m against a budget of £0.4m, resulting in a deficit of £0.1m. The YTD deficit is £50k
- Third Part Providers (inc. Taxi and Volunteer drivers) in month has a £11k deficit. The YTD spend is at £3.2m, with a plan of £3.0m causing a £0.2m deficit.

Agency Costs:

- Agency costs totalled £97k, exceeding the plan by £28k.
- The spend above plan was driven by Fleet Mechanics in SCFS. Plans are in progress to reduce this spend from Q2 onwards.

Bank Costs:

- Bank costs totalled £246k, under budget by £93k.
- The underspend is due to a lower uptake of bank shifts across service lines

Pay CIPs Risk:

A recurrent CIP gap on pay of £1.2m is being mitigated by non-recurrent vacancy savings; however, reliance on these one-off savings presents a risk to the Trust's recurrent financial sustainability.

Additionally, under-delivery against following pay schemes:

- Shared SECAMB – CEO £0.1m, Sustainability Lead £41k
- Payroll Accuracy £20k
- NEPTS Reduced Pay cost in relation to improved Fleet VOR £13.5k

Non- Pay Costs

Non-pay expenditure is reporting an adverse variance of £133k against budget, primarily driven by vehicle-related costs. This is partly offset by Digital and other areas relating to projects that have not yet started or cost pressures that haven't materialised, and Corporate over delivery on CIPs for utilities, rent and rate.

Financial Risks & Planning

The Trust continues 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 and the recovery of Cat 2 performance. The current financial risk to delivering the planned breakeven position is circa £3m. These 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, beyond 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 has a total CIP plan of £19.7m, with no unidentified gaps. However, there remains a significant reliance on non-recurrent schemes to achieve the target. It is therefore essential that all teams across SCAS continue to identify recurrent opportunities and efficiencies to mitigate against potential slippage this year as well as to support next year's financial plan. This is being progressed both at individual Directorate level and through cross-functional discussions within the Senior Leadership teams.

The FY Plan is underpinned by £11.7m (60%) recurrent delivery and £7.9m (40%) non-recurrent delivery. However, the actual YTD performance is 59% recurrent and 41% non-recurrent, with temporary measures, including vacancy freeze, offsetting under-delivery of other schemes.

In-month delivery was £1.6m (8% of the full-year plan), as set out in the table below:

	Month 4			YTD			FY 26/27		
Division	**Actual**	**Plan**	**Var**	**Actual**	**Plan**	**Var**	**Forecast**	**Plan**	**Var**
	(£'000s)	**(£'000s)**	**(£'000s)**	**(£'000s)**	**(£'000s)**	**(£'000s)**	**(£'000s)**	**(£'000s)**	**(£'000s)**
999	758	697	61	3,100	2,468	632	8,236	9,099	(863)
111	93	23	70	160	95	65	327	299	28
Fleet & OSD	110	202	(92)	338	737	(398)	2,341	2,350	(9)
PTS	(0)	18	(18)	128	72	56	265	217	48
Corporate	328	416	(88)	1,151	1,315	(164)	4,546	4,644	(99)
Central	294	287	7	742	1,049	(307)	3,982	3,088	895
Total	**1,582**	**1,642**	**(61)**	**5,619**	**5,736**	**(117)**	**19,698**	**19,698**	**-**
Recurrent	**917**	**1,139**	**(222)**	**3,280**	**4,068**	**(789)**	**11,779**	**13,180**	**(1,401)**
Non-Recurrent	**665**	**503**	**161**	**2,340**	**1,668**	**672**	**7,918**	**6,517**	**1,401**
Total	**1,582**	**1,642**	**(61)**	**5,619**	**5,736**	**(117)**	**19,698**	**19,698**	**0**

In-month, 999 delivered £0.8m of savings through vehicle hire, Make Ready and operational efficiency initiatives. 75% of which is recurrent in nature, with the non-recurrent reflecting temporary clinical vacancies within the call centre establishment.

111 delivered £93k of savings which is mostly non-recurrent, reflecting temporary vacancies within the department.

Fleet delivered £110k however is currently £400k under-delivering against its CIP YTD. The position is forecast to recover by year end.

PTS delivered £56k of savings year to date, primarily driven by reduced subsistence expenditure and temporary vacancies within the department. These savings are considered non-recurrent in nature. The in-month position is distorted by a prior-period correction.

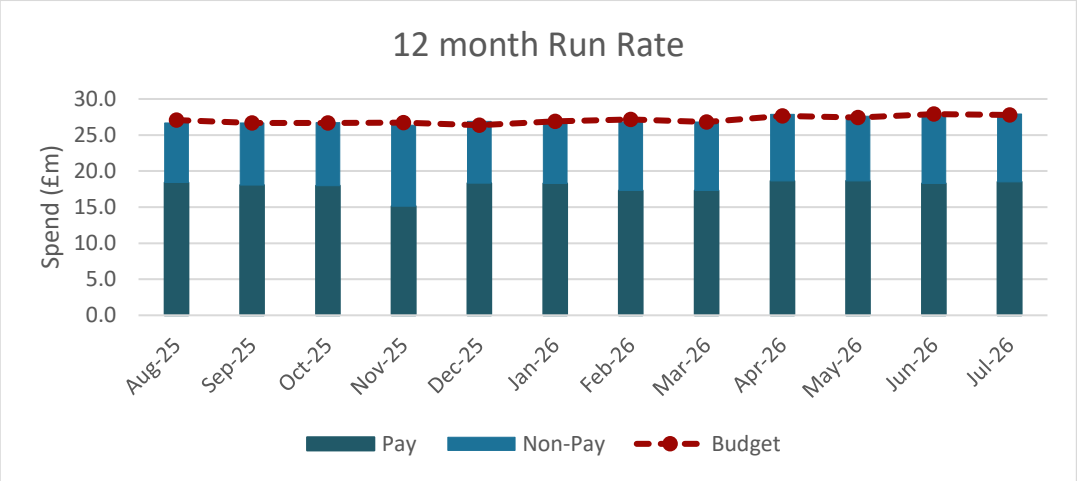
Corporate delivered £0.3m of savings through various schemes. The contributing directorates are: Chief Paramedic £49k, CEO £13k Digital £42k, Estates £51k, Governance £9k, People £64k, Quality & Patient Care £7k and Transformation £20k.

Central CIP refers to the release of contingencies held to provide for contract and income risks with Hampshire & Isle of Wight and Thames Valley ICBs.

CIP is forecast to breakeven. This includes a £0.8m deficit within 9s, offset by £0.8m forecast delivery against the Central line. However, no schemes have currently been identified to support the Central delivery, representing a £0.8m delivery risk. The 9s position reflects a £1.5m gap, partly offset by £0.7m EOC non-recurrent (NR) over-delivery.

Run Rate

The 12-month run rate demonstrates the movement in pay and non-pay expenditure against budget between Aug 25 and Jul 26. 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 position at Month 4 is underspent by £2.1m. Capital expenditure of £0.8m reflects lower-than-planned spend on estates and fleet programmes, with underspends of £7.5m on core capital, £1.7m on PDC-funded schemes and £2m on IFRS 16 budgets. These are largely offset by £9m of delayed sale-and-leaseback income arising from changes in the timing of fleet transactions.

Capital spends – Key Drivers

- **2025/26 DCA Cohort (MAN units):** The 25/26 DCA cohort of 70 x MAN DCA's and 10 x Ford Transit BEV are split between two coachbuilders – WAS and AEV. WAS are coachbuilding 35 x MAN's and 10 x BEV's with the BEV's expected to be received in Oct – Dec 26 and the MAN's expected to be received in Jan - Feb 27. The 35 x MAN's being coachbuilt by AEV are expected in Q3.
- **2026/27 DCA Cohort (MAN units):** The 26/27 DCA cohort of 70 MAN DCA's are being coachbuilt by AEV and will be delivered after the 35 MAN DCA's for the 25/26 cohort. 16 units have slipped into 27/28 (£1.6m) with the remaining 54 units expected in Q4. The underspend from the slippage has been reallocated to other vehicle cohorts and is expected to be spent in 26/27.
- **Estates spend:** Slippage in estates schemes and a revision to the Estates Safety Fund PDC budget profiling has resulted in £2.9m of underspend at M4. Spend is expected to pick up in Qtr2 following agreement of the Estates Safety Funding with NHSE.

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 completed in June, generating capital receipts of £1.1m.

The sale of the Maids Moreton property completed in July, generating capital receipts of £0.3m.

		Year to Date			Forecast		
	£m	Actual	Plan	Variance	Actual	Plan	Variance
Estates	Internal CDEL	1.3	2.0	(0.7)	4.0	4.0	0.0
	PDC	(0.0)	1.7	(1.7)	9.3	9.3	0.0
	Disposal	(1.4)	(1.1)	(0.3)	(2.1)	(2.1)	0.0
	IFRS16	(0.1)	0.2	(0.2)	0.4	0.4	0.0
	Total	**(0.2)**	**2.8**	**(2.9)**	**11.6**	**11.6**	**0.0**
Digital	Internal CDEL	0.1	0.5	(0.4)	3.9	3.9	0.0
	Total	**0.1**	**0.5**	**(0.4)**	**3.9**	**3.9**	**0.0**
Fleet (DCA)	Internal CDEL	0.3	5.7	(5.4)	11.3	11.3	0.0
	PDC	0.1	0.0	0.1	6.2	6.2	0.0
	Disposal	0.0	(7.0)	7.0	(28.9)	(28.9)	0.0
	IFRS16	0.0	0.0	0.0	25.6	25.6	0.0
	Total	**0.4**	**(1.3)**	**1.7**	**14.3**	**14.3**	**0.0**
Fleet (Non-DCA)	Internal CDEL	0.3	0.9	(0.6)	2.1	2.1	0.0
	Disposal	0.0	(2.3)	2.3	(3.9)	(3.9)	0.0
	IFRS16	(0.1)	1.6	(1.7)	3.2	3.2	0.0
	Total	**0.3**	**0.3**	**(0.0)**	**1.4**	**1.4**	**0.0**
Other (Operations, Ops Support, Education, Finance)	Internal CDEL	0.2	0.7	(0.5)	0.9	0.9	0.0
	Total	**0.2**	**0.7**	**(0.5)**	**0.9**	**0.9**	**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		2.2	9.7	(7.5)	22.3	22.3	0.0
PDC Total		0.1	1.7	(1.7)	15.5	15.5	0.0
Disposal Total		(1.4)	(10.4)	9.0	(35.0)	(35.0)	0.0
IFRS16 Total		(0.1)	1.8	(2.0)	29.3	29.3	0.0
Total		**0.8**	**2.9**	**(2.1)**	**32.0**	**32.0**	**0.0**

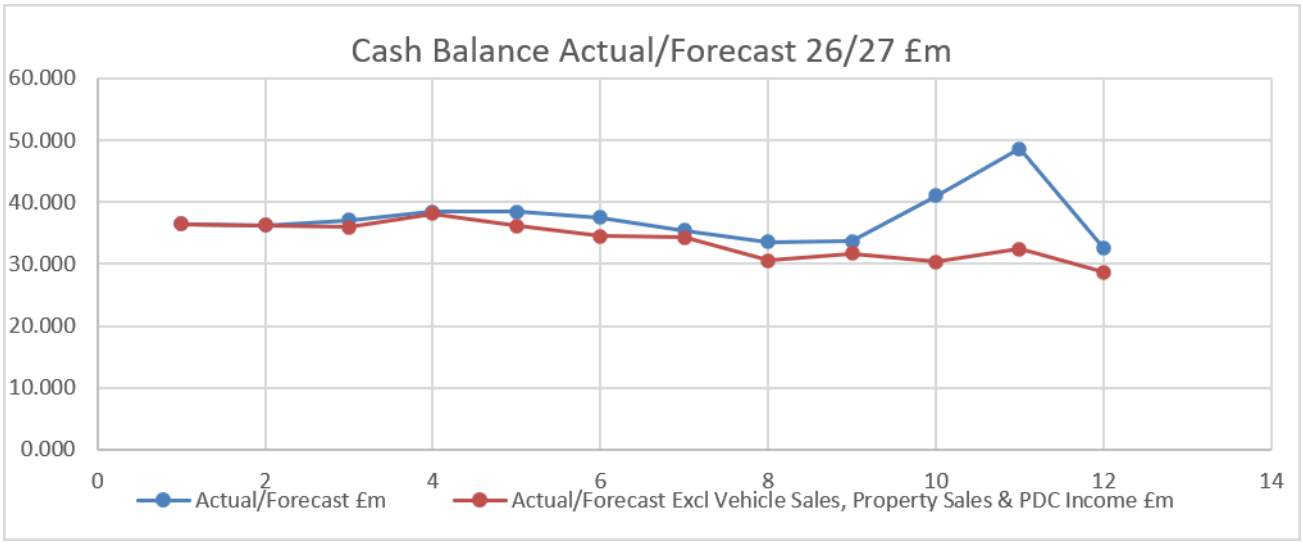
Cash

The Trust's cash balance at the end of July was £38.5m, which is £6.6m ahead of plan, primarily reflecting slippage within the capital programme and the associated timing of capital expenditure. In month, the Trust generated a net cash inflow of £1.4m due mostly to the receipt of £1.6m for VAT on purchases including a backdated £315k refund relating to 25/26 purchases (advised by VAT Liaison) and £637k refund for SCFS.

2026/27	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Income £m	28.3	27.4	29.0	30.2	30.3	31.2	29.3	31.1	30.1	38.8	44.3	33.3
Expenditure £m	(36.0)	(27.6)	(28.2)	(28.7)	(30.4)	(32.1)	(31.4)	(33.0)	(30.0)	(31.4)	(36.8)	(49.3)
Net Inflow/(Outflow) £m	(7.7)	(0.2)	0.8	1.4	(0.1)	(0.9)	(2.1)	(1.9)	0.1	7.4	7.5	(15.9)
Cash Balance £m	36.5	36.3	37.1	38.5	38.4	37.5	35.4	33.5	33.6	41.0	48.6	32.7
Cash Lowest Point	36.0	34.0	34.1	33.9								

The lowest point of cash in the month was £33.9m which is a decrease from last month of £0.2m.

There was a net cash inflow in Month 4 of £1.4m.



The 90-day debtor decreased to £0.298m in July (£0.311m in June). This represents 30.06% (42.12% in June) of the total debtor balance. The percentage debtors has decreased due to the overall debt balance decreasing.

Overdue debts include; Aurobindo Emergency Medical Services £81k, FedBucks Limited £29k, Hampshire Hospitals Foundation Trust £67k, London Ambulance Service £76k, Reading Football Club £6k, and South East Coast Ambulance Service NHS Foundation Trust £39k.

Our Better Payment Practice Code (BPPC) performance continues to be below the 95% target in Month 4.

	Month 4 - YTD BPPC			
-	Number	%age	Value	%age
NHS	316	95.9%	£2,667,716	97.9%
Non-NHS	4,302	93.3%	£53,367,965	99.0%
Total	**4,618**	**93.5%**	**£56,035,681**	**98.9%**
Target		95.0%		95.0%
Variance		**-1.5%**		**3.9%**

2 Quality Impact

N/A

3 Financial Impact

As detailed above

4. Risk and compliance impact

Area of Risk

- Recovery of Category 2 performance will require increased operational hours, workforce and fleet availability, creating significant unfunded cost pressures and a risk to delivery of the year-end financial target.
- Operational fleet risks - Delays in the delivery of new DCA vehicles may have potential impact on vehicle availability and frontline performance
- Fuel Prices - Given the evolving geopolitical situation, the impact on fuel prices remains uncertain. At current rates, this is forecast to be circa £1.2m for the full year, although this may increase. This represents unplanned expenditure and falls outside the scope of the current £19.7m Cost Improvement Programme.
- Workforce cost and capacity pressures - Pay and agency expenditure remained above budget in some areas. Recruitment and retention pressures along with high level of abstractions 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 and identify additional savings to mitigate the financial risks.
- Embed multi-year financial planning to anticipate recurring pressures, support strategic initiatives, and ensure alignment with future budget setting process.

7. Recommendation(s)

The Committee is asked to:

- The Committee is asked to note the M4 Financial performance and current risks to delivering the FY plan.

NHS
South Central
Ambulance Service
NHS Foundation Trust

TRUST BOARD OF DIRECTORS MEETING IN PUBLIC
3 September 2026

Title	SCAS Winter Framework 25/26
Report Author	Martin Blaker – Assistant Director of Operation (RSO)
Executive Owner	Mark Ainsworth, Executive Director of Operations
Agenda Item	**12**
Governance Pathway: Previous	Presented to EMC for sign off
Governance Pathway Next Steps	SCAS Board / ICB / NHSE

1. Purpose

To provide SCAS Board with assurance regarding SCAS winter preparedness. Following sign off at SCAS board the framework will be submitted to NSHE with updates during Quarter 3 as we develop our forecasting for the Q3 and Q4.

2. Executive Summary

The Winter Framework, including arrangements for adverse weather preparedness and response, has been developed to ensure that South Central Ambulance Service NHS Foundation Trust (SCAS) is able to deliver an effective, flexible and scalable response to the challenges associated with winter conditions, particularly periods of severe cold weather.

The inherently unpredictable and dynamic nature of adverse weather has the potential to place significant pressure on SCAS, partner organisations and the wider health and care system. It is therefore essential that comprehensive planning and preparedness activities are undertaken in collaboration with both the Thames Valley Local Resilience Forum (TVLRF) and the Hampshire & Isle of Wight Local Resilience Forum (HIOWLRF). This collaborative approach provides assurance that a coordinated, multi-agency response is in place to manage the anticipated weather-related and seasonal pressures associated with the 2026/27 winter period.

This framework aligns with the UK Health Security Agency (UKHSA) Adverse Weather and Health Plan 2026/27, the NHS England Southeast Winter Planning Approach 2026/27, and relevant Integrated Care System (ICS) resilience arrangements, ensuring consistency with national, regional and local preparedness requirements.

In recognition of the continued importance of preventing seasonal illness and protecting system capacity, the framework also reflects the increased vaccination ambitions set by NHS England for 2026/27. These objectives have been incorporated into the SCAS Integrated Resilience Framework (IRF), supporting organisational preparedness, workforce resilience and business continuity throughout the winter period.

This framework provides the strategic structure through which SCAS will monitor, prepare for and respond to winter-related challenges, enabling the Trust to maintain the delivery of safe and effective services whilst supporting wider system resilience.

3. Areas of Risk

To which BAF risk is the subject matter relevant?

SR1 - Safe and Effective Care

4. Link to Strategic Theme

Partnerships and Sustainability

5. Link to Board Assurance Framework Risk(s)

SR14 - Quality Performance

6. Quality/Equality Impact Assessment

This is booked in for the 26th August.

7. Recommendations

The board are asked to approve the winter framework to enable this to be passed to NHSE for assessment by the end of September.

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

South Central Ambulance Service
NHS Foundation Trust

SCAS Winter Framework including Adverse Weather Plan

VERSION	**Draft**
CLASSIFICATION	OFFICIAL
AUTHOR(s):	Martin Blaker
DEPARTMENT	Resilience and Specialist Operations: EPRR
APPROVED BY STRATEGIC LEAD/EXECUTIVE DIRECTOR	Mark Ainsworth
DATE	22/07/2026

Contents

Version Control

Version	Amendments	Author	Date
Draft	New document for Winter 25-26	Martin Blaker (Head of Resilience & Specialist Operations)	14/07/2025
Draft	Updated with 111, IUC & 999 details	Martin Blaker (Head of Resilience & Specialist Operations)	27/10/2025
Draft	Full review for Winter 2026/2027	Martin Blaker (Assistance Director Resilience and Specialist Operations)	22/07/2026

Distribution

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

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

1.0 Information

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

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

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

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

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

- Civil Contingencies Act 2004
- Joint Emergency Services Interoperability Principles Joint Doctrine Edition 3
- NHS England » Urgent and emergency care plan 2025/26
- NHS England EPRR Framework 2022
- NHS England Incident Response Plan (National)
- National Resource Escalation Plan (REAP)
- Cabinet Office 2012 Emergency Preparedness
- HM Government Emergency Response and Recovery- Non statutory guidance accompanying the Civil Contingencies Act 2004
- National Ambulance Resilience Unit 2021: The Duty of Care for Ambulance Responders
- SCAS Command Policy Version 5.0
- Emergency Operations Centre Standard Operating Procedures V.30
- SCAS Incident Response Framework (IRF) V1.1 May 2026
- SCAS Operational, Policies and Procedures No.5: Hospital Handover Procedure
- SCAS Operational, Policies and Procedures No.14: Clinical Safety Plan
- SCAS Water Incident Policy *(Including snow, ice, mud slurry).*
- Cabinet Office National Risk Register 2025
- Hampshire and Isle of Wight LRF Cold and Snow Plan
- Thames Valley LRF Cold and Snow Plan
- Hampshire and Thames Valley LRF Emergency Response Arrangements

Current Threat Level: The threat to the UK is **SEVERE** - an attack is highly likely Threat Levels | MI5 - The Security Service

Current REAP Level for SCAS can be located on the SCAS Hub Page here **REAP level**

2.0 Intention

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

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

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

Our Values: Caring, Honesty and Professionalism

2.1 Strategic Intention

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

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

3.0 Method

3.1 Key Dates

The UK Health Security Agency (UKHSA) Winter Preparedness Action Program for 2026-2027 is from TBC (This is released in October and Will be updated)

3.2 Cold Health Alerts System

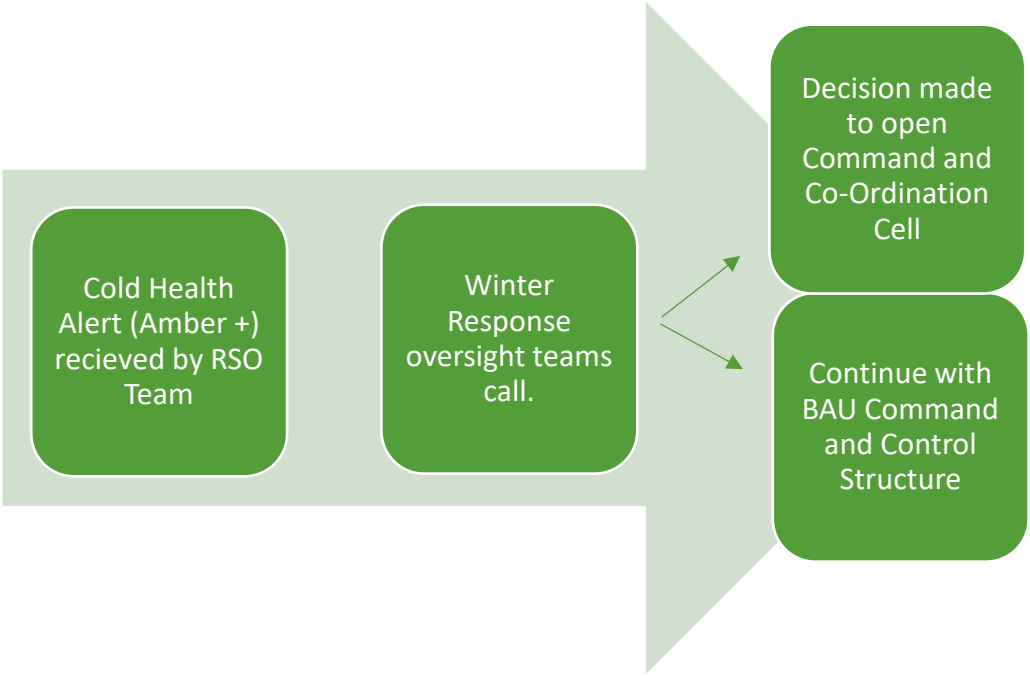
The adverse weather plan for England in conjunction with the Met Office has established four cold health alerts which will provide early insight to the Trust, staff, patients, and the public of the likely impacts throughout the winter period. SCAS has a number of considerations and potential actions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

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

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

3.2.1 SCAS Triggers

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



3.3 Command and Control Arrangements

Business as Usual:

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

Strategic Commander
Executive On Call
4x Tactical Commander (2x Hampshire and 2x Thames Valley)
Operational Commanders
2x NILO
1x Medical Incident Advisor (MIA)
ICT
Command Support Team/ Loggist
PTS On Call
111 On Call
Media On Call

Winter Preparedness Group (Strategic)-

The strategic response to the Winter period will be overseen by the Winter Preparedness Group, who will meet as required with representatives across from key SCAS departments, this group will oversee the response including the establishment of the Winter Command and Co-Ordination Cell. The Terms of Reference for this board can be found in Appendix.4.

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

Trigger Consideration: *Amber Alert or Above*.

During periods of predicted severe weather impacts as indicated by the Cold Weather alert of **Amber or above** the command cell may be established at Northern House, Southern House Integrated Coordination Centres (ICC's) Incident Control Room (ICR) or remotely as required. The decision the Implement the cell must be a Strategic decision using the Joint Decision Model.

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

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

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

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

Contact Details (SUBJECT TO CHANGE)

Duty Tactical Commander:

01869 817265 (Northern House ICR Direct Line) /**dutytactical@scas.nhs.uk**

01962 898598 (Southern House ICR)

SCAS Northern House- Tactical Performance Manager/Senior dispatchers/Dispatch Team Leaders: 0300 123 9834 (Recorded line)

SCAS Southern House: Tactical Performance Manager/Senior dispatchers/Dispatch Team Leaders: 0300 123 9817 (Recorded Line)

Northern House ICR Command and Co-Ordination Cell Landline: 01869 817264/ 01869 817265

Southern House ICR Command and Co-Ordination Cell Landline: 01962 898598/01962 898599

SCAS NILO: 0300 303 8140

Media On Call: 07623 957895 oncallmedia@scas.nhs.uk

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

NARU/ECU On Call: 0300 373 0195

SCAS PTS On Call:

Hampshire/MK: 0300 303 8141

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

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

3.4 Resilience and Specialist Operations (RSO) including Interoperable Capabilities

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

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

The RSO department will be responsible for;

- Production of the Adverse Weather framework
- NHS England Winter Assurance
- Post incident debrief (s) which may take place as a Structured debrief or After-Action Review (AAR)
- Provision of the Ambulance NILO and Tactical Advisor function within in the Command and Co-Ordination Cell.
- Liaison and co-ordination with multi-agency partners including both Local Resilience Forums (LRF)

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

3.5 Operational staff

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

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

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

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

3.6 Integrated Contact Centres including 999/111.

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

SCAS have also increased the number of Specialist Practitioners (SPs) being deployed within ICC to support Category 3 patients and assist the Urgent Care Desk (UCD) provision. In addition to GP validation of Category 3/4 dispositions in 111, there will also be GP input into Category 3/4 dispositions generated in 999.

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

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

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

3.7 Patient Transport Services (PTS)

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

PTS have reviewed their Business Continuity plans for all their contract areas.

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

3.8 Mutual Aid

All requests for mutual aid must be escalated through the NACC. In the event of severe weather there must be early consideration for the escalation to the NACC to request additional support.

3.9 Critical/Enhanced Care including Air Ambulance charities.

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

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

3.10 Private Ambulance Providers and Voluntary Aid Societies

Contact contracted Private Ambulance Providers to ascertain availability of additional resources Particularly 4x4 vehicles. Consider voluntary resources including VAS and off-road driving clubs who can provide vehicles to support staff and patient movement.

SCAS has several contracted taxi providers the use of which should be maximised both for transportation of low acuity patients and for moving staff and volunteers if necessary to operational locations.

3.11 Education

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

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

3.12 Community Engagement &Training (CET) Team

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

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

3.13 Operational Support Services (OSS)

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

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

3.14 Local Resilience Forum (LRF)

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

Throughout predicted periods of severe cold weather, a **Partner Activation Teleconference (PAT)** is likely to be triggered. The SCAS Tactical Commander must attend this PAT to provide shared situational awareness and escalation of any risks affecting the trust. The Trust are implementing a horizon scanning briefing to share situational awareness utilising the JESIP Joint Decision Model (JDM).

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

- 4x4 transport hub
- Multi-Agency Information Cell (MAIC)

- Partner Activation Teleconference (PAT), Tactical Co-Ordination Group (TCG), Strategic Co-ordination Group (SCG) as part of the Emergency Response Arrangements.
- Logistics cell
- Human aspects cell
- Link with government (E.g MHCLG - RED)
- Military Aid to the Civil Authorities (MACA)

3.15 Planning and Forecasting

The SCAS Planning and Forecasting team have provided predictions of pressure which are available in Appendix 3.

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

3.16 NHS England Incident Levels

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

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

4.0 Administration

A NARU/ECU logbook or an agreed digital log and daily situational report must be maintained by the SCAS duty Tactical Commander in the event of declared incident occurring.

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

If an incident is declared a daily situational report (SBAR) will be maintained electronically by the tactical commander, the tactical commander is responsible for ensuring that these reports are escalated to the appropriate ICB's and agencies.

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

All decisions made must be recorded using the JDM and JESIP Decision Controls. These decisions must be recorded in a NARU logbook and submitted via the SCAS logbook submission portal via the RSO page within The SCAS Hub.

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

Any immediate lessons identified which may impact on this framework must be escalated to the RSO Departments Duty NILO.

Post incident procedures will be arranged as per the SCAS Incident Response Framework.

4.1 Assurance Returns

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

4.2 Business Intelligence (BI)

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

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

5.0 Risk

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

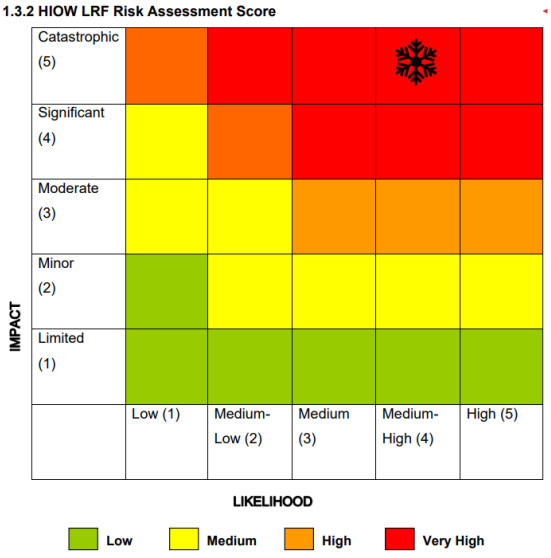
"Snow falling and lying over multiple regions of the UK and a substantial proportion of the UK population (e.g., Southwest England, Southeast England, London and the East of England - approximately 30 million people), including substantial areas of low-lying land (below 300m) for at least one week.

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

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

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

The National Risk Register (2026) provides information in an open-source document on the impacts of low temperatures and snow on the public and organisations.



Previous impacts of severe weather within the SCAS region include;

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

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

The current met office guidance from TBC identifies the following.

MET OFFICE 3 month outlook needs inserting for 2025/26 when released.

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

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

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

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

Appendix. 3 will highlight the forecasted demand and pressure for this year 2026/2027 once produced in October 2026, this will highlight the resource requirements for and impacts of staff sickness. The main risks this year (25/26) included:

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

5.1 OPEL Framework and Clinical Safety Plan

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

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

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

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

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

5.2 Enhanced Patient Safety Procedure (EPSP)

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

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

5.3 Hospital Handover Delays – UPDATE INFO For due in October 2026

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

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

5.4 Industrial Action

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

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

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

5.5 Financial Impacts

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

6.0 Communication

6.1 Proactive public messaging

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

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

6.1.1 Amplifying system messaging

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

6.2 Media management

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

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

6.3 Staff Communication

6.3.1 Winter readiness messaging

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

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

6.3.1 Operational alerts linked to weather condition / demand pressures

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

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

6.4 Major/Critical Incident Declaration

Please refer to the SCAS IRF for the definitions of critical/major incident.

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

7.0 Humanitarian

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

8.0 Vaccination Program

8.1 Vaccination Program

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

8.2 Vaccination Model for 26/27

For the 2026/27 campaign, SCAS will implement a peer-to-peer vaccination model, utilising clinically trained staff to deliver vaccines. To improve accessibility, the Trust have increased the number of vaccine fridge locations to 16 and recruited further to the pool of trained vaccinators.

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

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

In addition, the live dashboard, developed by Business Intelligence for 2025/2026 that integrates clinic data and Microsoft Forms submissions will continue to be used to monitor vaccine uptake. This dashboard will automatically update uptake figures by area and can be shared with local teams to enhance visibility and encourage participation.

8.3 Vaccination Uptake, Targets and strategy

SCAS aims to increase vaccine uptake from 52% in 2025/26 to meet the national target of 60% or higher.

To reach this goal, SCAS will:

- Expand peer-to-peer vaccination delivery

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

8.4 Vaccination Risk Analysis

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

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

9.0 Fleet Resilience planning

9.1 August – October Preparations

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

9.2 November – March Operations

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

9.3 New fleet and contingencies

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

Appendices

Appendix 1: Example LRF Partner Activation Teleconference Agenda

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

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Appendix 2: Winter Response Teams Agenda

Winter Command and Co Ordination Cell

Tac Commander Agenda

Welcome

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

Appendix 3: 2025/2026 Winter Planning Report 111 & IUC

This data will be included when it is produced in October 2026.

Appendix 4: Winter Preparedness Group Terms of Reference

Terms of Reference	
Title:	**Winter Preparedness Group**
Date created	October 2023 (updated August 2026)
Date of next Review	April 2026 (Post Winter)
Purpose	To provide oversight of the preparedness for Winter. Ensure that SCAS directorate arrangements are integrated and dovetailed with each other internally and with those developed locally and nationally by external partner agencies. To review outcome/Learning of Winter/Demand and operational hours delivered and any impacting factors. Provide Assurance to the SCAS Board through the Chair of the Winter Preparedness Group. Provide leadership and direction to the Working groups falling under the winter preparedness group. Where appropriate review progress against action plans that come from various sources: - EPRR assurance processes - Lessons identified processes. - Risk registers - Winter/IA and Power loss exercises - Non exhaustive list Identify and agree work streams with external partners such as wider Health, other Category 1 Responders and the two Local Resilience Fora (LRFs) within our region. To ensure the Trust's compliance with legislative, mandatory, and regulatory requirements in terms of the Board's scope
Membership	Divisional Director of Operations South (U&E) – (Chair) Assistant Director of Operations (RSO) Chief People Officer or deputy Chief Digital Officer Director of Commercial Services Director of Operations (ICC) Deputy Director of HR (Operations) Director of Planning and Performance forecasting or Deputy Senior Operations Representee. Assistant Director of Estates

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

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

Appendix 5: Risk and Mitigations Table

Risk	Mitigation
Fleet – Workforce availability	Fleet will work with agencies to build extra workforce capacity
Operational finance	Possible adjustments to operating model to increase efficiency will be carried out during the winter period
Operational handover delays	Close working relationships with partners will be maintained to support the use of the Release to Respond process
Operations – Maintain a Response capability during adverse weather (Snow / Ice)	Ongoing work with LRF and Partners regarding winter planning and the possible use of 4x4 assets.
Operations – Workforce availability due to Winter Flu	Internal work ongoing to develop and implement a SCAS wide Vaccination program to reduce staff sickness impacts

NHS
South Central Ambulance Service
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2026 – 2027 Board Assurance Framework – Enabling Services

August 2026

Strategic Risk Heat Map

NHS
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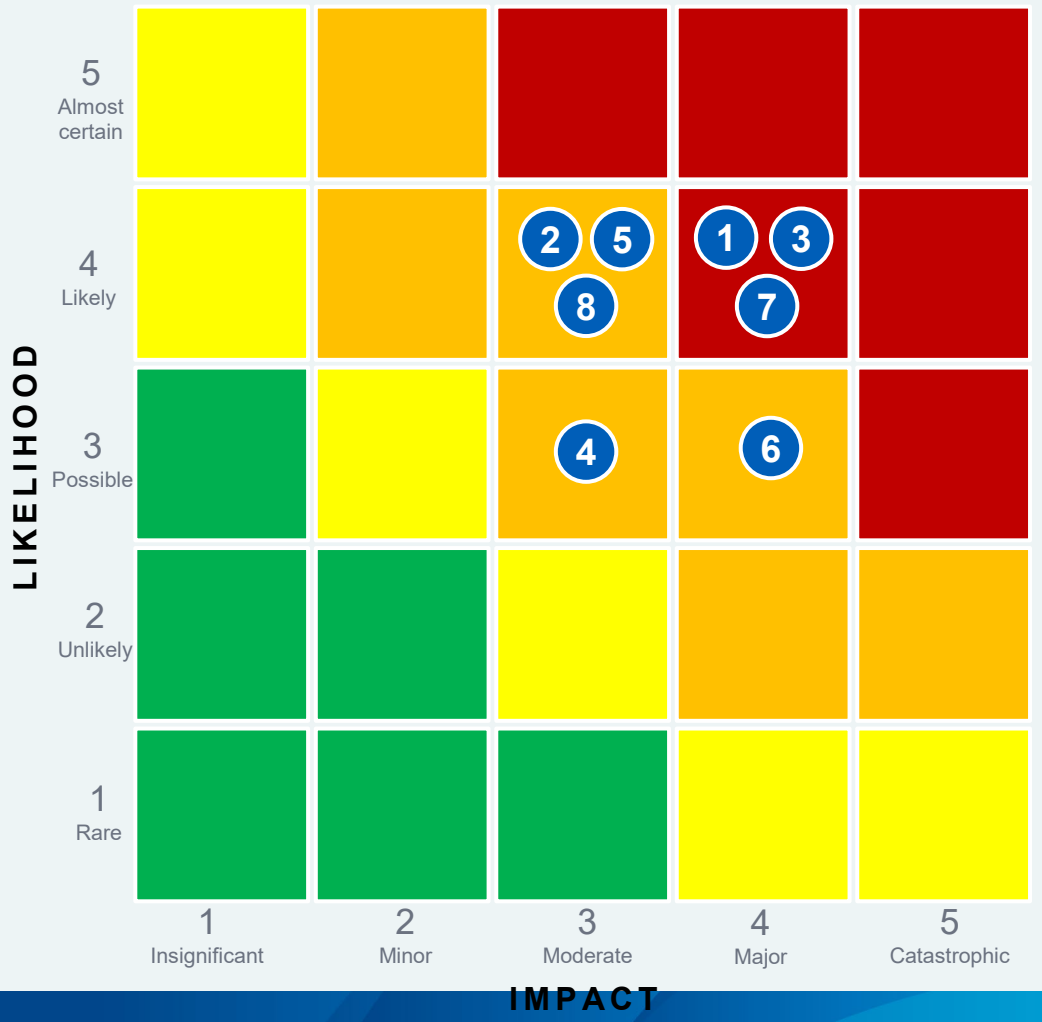
RISK MATRIX



	RISK KEY & NAME	SCORE	OWNER	MOVEMENT
1	Quality Performance and Patient Outcome	16	Executive Director of Operations	⟺
2	Digitisation	12	Chief Digital Officer	⟺
3	Cyber Security and Operational Resilience	16	Chief Digital Officer	⟺
4	Fleet Improvement	9	Chief Finance Officer	⟺
5	Estates Modernisation	12	Chief Finance Officer	⟺
6	Staff Engagement	12	Chief People Officer	⟺
7	Sustainability	16	Chief Finance Officer	⟺
8	Collaboration	12	Chief Finance Officer	⟺

Reviewed by Trust Board · Q2 2026/27 · Next review: September 2026

SR4

STRATEGIC RISKS | Fleet Improvement Plan

If we do not improve out fleet productivity, **then** we will not have sufficient vehicles to meet demand, **resulting** in the potential for avoidable harm or death.

NHS South Central Ambulance Service NHS Foundation Trust

Risk owner	Assurance Committee	Current risk score	Target risk score	Related risks
Chief Finance Officer	**Finance & Performance Committee**	**I (3) × L (3) = 9**	**I (3) × L (2) = 6**	• **ID** – title

CONTROLS IN PLACE

- ✓ Preventative Maintenance and Vehicle Off Road (VOR) Reduction Programmes
- ✓ Increased Maintenance Capacity Through the Aylesbury Workshop
- ✓ Fleet Modernisation and Asset Replacement Programme
- ✓ Fleet Performance Monitoring and Data Visibility
- ✓ Fleet Demand Planning and Governance Arrangements

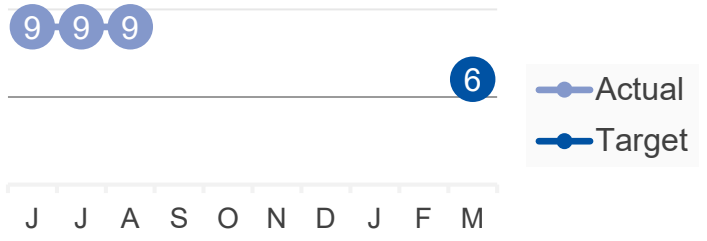
MITIGATING ACTIONS — DEADLINE

✓	Implement Predictive Maintenance Across the Fleet	Q4 2028
✓	Improve Fleet Deployment and Demand Alignment	Q2 2027
✓	Develop Real-Time Fleet Scheduling and Forecasting Capability	Q4 2027
✓	Establish Strategic Fleet Resilience and Contingency Capacity	Q1 2027
✓	Strengthen Parts Inventory and Supply Chain Management	Q3 2028

PROGRESS UPDATE

- Aylesbury workshop operational from July, improving fleet availability and productivity.
- Pipeline of new vehicles with funding in place, delivering reduction in average fleet age.
- Three-year SCFS strategy approved and in progress.

RISK MOVEMENT



Risk movement since last BAF: **Static** · Last reviewed: **August 2026** · Next review: **September 2026**

SR4

STRATEGIC RISKS | Fleet Improvement Plan

If we do not improve out fleet productivity, **then** we will not have sufficient vehicles to meet demand, **resulting** in the potential for avoidable harm or death.

NHS
South Central Ambulance Service
NHS Foundation Trust

Risk owner
Chief Finance Officer

Assurance Committee
Finance & Performance Committee

Current risk score
I (3) × L (3) = 9

Target risk score
I (2) × L (2) = 6

Related risks
- **ID** – Title

POSITIVE ASSURANCE

- ✓ Fleet availability now consistently meets planned demand
- ✓ Significant fleet growth and modernisation
- ✓ Reduction in vehicle age improving reliability
- ✓ Targeted VOR reduction initiatives delivering results
- ✓ Formal fleet improvement programme established

NEGATIVE ASSURANCE

- ✓ Vehicle Off Road (VOR) levels continue to impact performance
- ✓ Operational deployment challenges remain
- ✓ Maintenance activity remains partly reactive
- ✓ Limited data integration and real-time visibility
- ✓ Increasing fleet size and vehicle complexity and estate/charging constraints

ASSURANCE SUMMARY

Fleet availability has improved significantly through fleet modernisation, increased workshop capacity, and targeted initiatives to reduce Vehicle Off Road incidents. Current fleet numbers are sufficient to meet forecast demand; however, ongoing deployment challenges, residual VOR pressures, and the need for predictive maintenance and enhanced data capabilities mean the risk remains subject to continued management and improvement

Risk movement since last BAF: **Static** · Last reviewed: **August 2026** · Next review: **September 2026**

SR5

STRATEGIC RISKS | 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 the capital to deliver the hub model over time, **resulting** in a disproportionate increase in backlog maintenance, statutory breaches, impeded operational delivery and detrimental patient care.

South Central Ambulance Service
NHS Foundation Trust

Risk owner
Chief People Officer/ Deputy Chief Executive

Assurance Committee
Finance & Performance Committee

Current risk score
I (4) × L (3) = 12

Target risk score
I (3) × L (2) = 6

Related risks
- **None**

CONTROLS IN PLACE

- ✓ Approved Estates Plan and Strategic Case for Change
- ✓ Executive and Board Oversight of Capital Programme Development
- ✓ Stakeholder Engagement and System Alignment
- ✓ Robust Capital Planning and Business Case Process
- ✓ Backlog Maintenance and Compliance Risk Monitoring

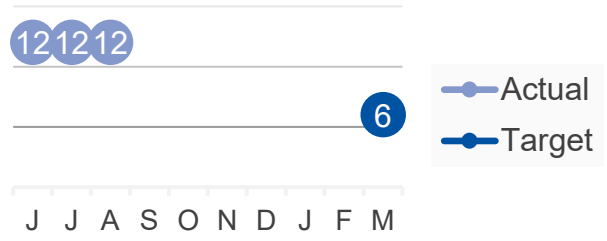
MITIGATING ACTIONS

- ✓ A Board-approved Estates Plan and Strategic Case for Change clearly articulates future estate requirements, investment priorities and alignment to the clinical and organisational strategy
- ✓ Regular governance through Executive and Board committees ensures progress against strategic estate plans, key decisions are made promptly, and barriers to approval are addressed
- ✓ Structured engagement with ICB partners, commissioners, clinicians, operational leaders and regulators to secure consensus on the estate vision and investment priorities.
- ✓ A formal programme for developing and maintaining Strategic Outline Cases, Outline Business Cases and Full Business Cases that meet NHS and HM Treasury requirements for capital investment
- ✓ Routine monitoring of backlog maintenance, statutory compliance risks and estate performance provides evidence of the need for investment and informs prioritisation decisions

PROGRESS UPDATE

- This has a significant risk and a high priority, with considerable external scrutiny and programme oversight at Board level.
- This is a multi-year programme, with in-year deliverables outlined in the programme mandate, alongside longer-term ambitions.

RISK MOVEMENT



Risk movement since last BAF: **Static** · Last reviewed: **Aug 2026** · Next review: **Sept 2026**

SR5

STRATEGIC RISKS | 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 the capital to deliver the hub model over time, **resulting** in a disproportionate increase in backlog maintenance, statutory breaches, impeded operational delivery and detrimental patient care.

NHS South Central Ambulance Service NHS Foundation Trust

Risk owner	Assurance Committee	Current risk score	Target risk score	Related risks
Chief People Officer/ Deputy Chief Executive	**Finance & Performance Committee**	**I (4) × L (3) = 12**	**I (3) × L (2) = 6**	• **None**

POSITIVE ASSURANCE

✓	Board approval records, Estates Plan, Plan Summary, bi-annual review
✓	Board/Committee reports, programme highlight reports, action logs and risk reviews
✓	Stakeholder engagement plans, consultation outputs, letters of support, ICB/NHS Bid submissions
✓	Capital plans, business case approvals, investment committee minutes, external reviews
✓	Estates, Finance and performance reports, ERIC backlog maintenance reports, compliance audits, regulatory inspection outcomes.

NEGATIVE ASSURANCE

✓	The Estates Plan not receiving full stakeholder endorsement, creating a risk that estate priorities are not sufficiently aligned across the organisation and wider health system
✓	Limited independent assurance over the quality, robustness and deliverability of estate transformation plans and associated business cases
✓	Capital funding remains dependent on external approval processes and competing national priorities, reducing assurance that required investment will be secured within the necessary timescales.
✓	Current levels of ICB oversight may not provide sufficient forward-looking analysis of the impact of delays in estate transformation on backlog maintenance growth, statutory compliance risk and operational resilience.
✓	The increasing level of backlog maintenance and ageing estate may outpace available mitigation measures, resulting in a residual risk of service disruption, statutory breaches and negative impacts on patient care before capital solutions can be implemented.

ASSURANCE SUMMARY

- Board-approved Estates Plan and Strategic Case for Change Published
- Robust governance and executive oversight of estate transformation programmes.
- Active stakeholder engagement across the organisation and wider system partners.
- Structured capital planning and business case processes in place.
- Regular monitoring of backlog maintenance, compliance, and estate performance risks.
- Dependence on external capital funding approvals outside organisational control.
- Limited independent assurance of programme deliverability and assumptions.
- Insufficient forward-looking analysis of the impact of delays on operational services.
- Backlog maintenance and compliance risks continue to grow pending major investment.

Risk movement since last BAF: **Static** · Last reviewed: **Aug 2026** · Next review: **Sept 2026**

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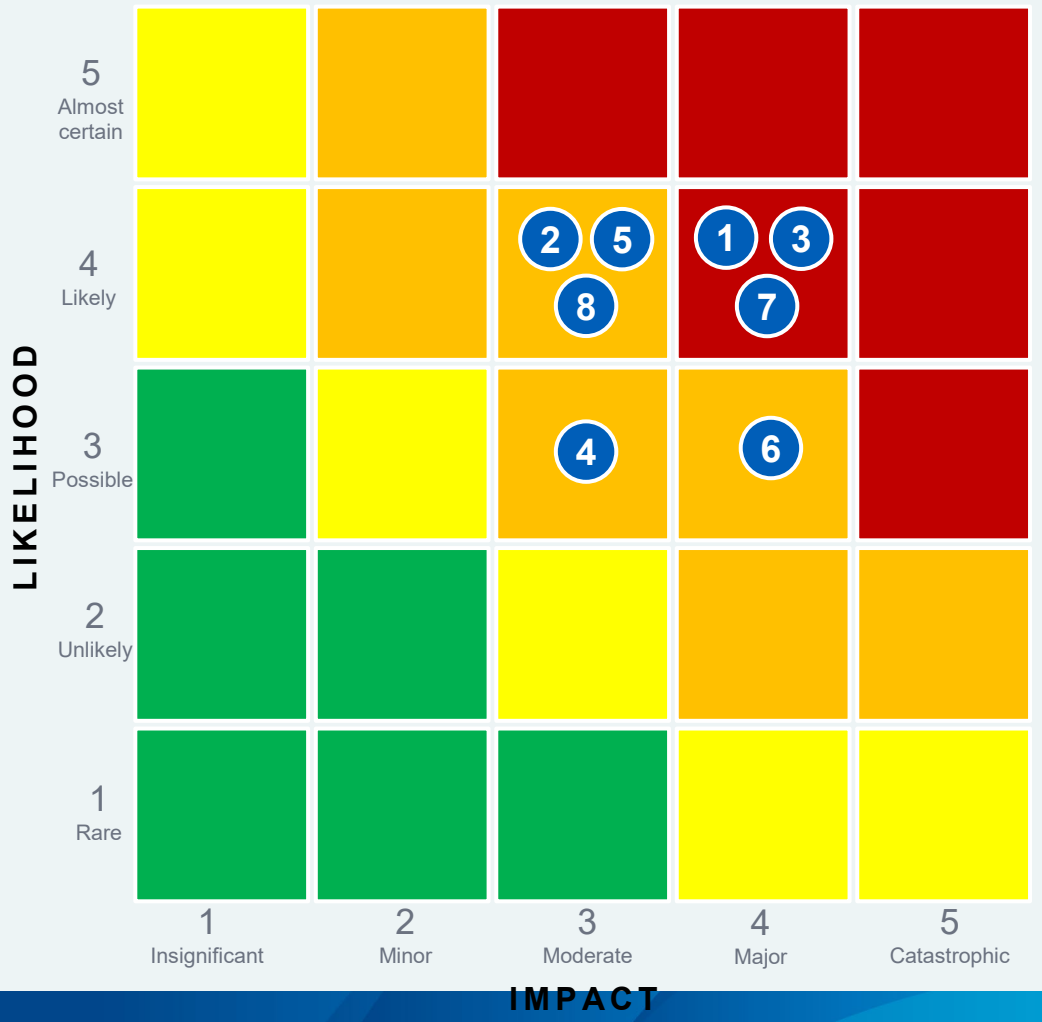
2026 – 2027 Board Assurance Framework – Digital Transformation

August 2026

Strategic Risk Heat Map

NHS
South Central Ambulance Service
NHS Foundation Trust

RISK MATRIX



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7	Sustainability	16	Chief Finance Officer	⟺
8	Collaboration	12	Chief Finance Officer	⟺

Reviewed by Trust Board · Q2 2026/27 · Next review: September 2026

SR2

STRATEGIC RISKS | Digitisation

If SCAS does not maintain & develop sufficient digital capacity, capability and investment, **then** the Trust may be unable to deliver key operational and transformation objectives, **resulting** in reduced effectiveness, lower productivity and failure to achieve Fit for the Future outcomes.

South Central Ambulance Service
NHS Foundation Trust

Risk owner
Chief Digital Officer

Assurance Committee
Quality & Safety Committee

Current risk score
I (4) × L (3) = 12

Target risk score
I (4) × L (2) = 8

Related risks
- **467 –** Workforce capacity and capability dependency risk

CONTROLS IN PLACE

- ✓ Board approved Digital Strategy embedded within the Trust's Fit for the Future programme with delivery monitored via established governance arrangements
- ✓ Digital governance through Exec Management Committee, Quality & Safety and Board Reporting
- ✓ Digital Planning process (Part of the SCAS Planning Process)
- ✓ Digital risk management framework established with external assurance and independent assessment processes
- ✓ Formal regional collaboration arrangements established with SECAMB and SASC to support Digital and Data opportunities.

MITIGATING ACTIONS — DEADLINE

✓	Secure approval and funding for CAD/EPR Full Business Case	Oct 2026
✓	Establish dedicated programme mgmt. and architecture capacity for Nightingale (Data Platform) and strategic transformation initiatives (Watson AI).	Q3 26/27
✓	Deliver independent digital risk, cyber resilience and maturity audit assessments and implement improvement actions.	Q4 26/27
✓	Progress regional collaboration opportunities across Digital and Data platforms	Ongoing
✓	Secure approval and funding for CAD/EPR Full Business Case	Oct 2026

PROGRESS UPDATE

- Draft Digital Strategy finalised.
- Continued progress with SECAMB collaboration on CAD, ePR and Data platforms.
- Digital reporting embedded across multiple Board committees to improve assurance and visibility
- AI Training Project progressing to business case within the SASC

RISK MOVEMENT

Risk movement since last BAF: **Static** · Last reviewed: **August 2026** · Next review: **September 2026**

SR2

STRATEGIC RISKS | Digitisation

If SCAS does not maintain & develop sufficient digital capacity, capability and investment, **then** the Trust may be unable to deliver key operational and transformation objectives, **resulting** in reduced effectiveness, lower productivity and failure to achieve Fit for the Future outcomes.

South Central Ambulance Service
NHS Foundation Trust

Risk owner
Chief Digital Officer

Assurance Committee
Quality & Safety Committee

Current risk score
I (4) × L (3) = 12

Target risk score
I (4) × L (2) = 8

Related risks
- **467 –** Workforce capacity and capability dependency risk

POSITIVE ASSURANCE

✓	No significant digital service outages requiring major business continuity activation during the reporting period
✓	DSPT (CAF) and external assurance reports demonstrate continued maturity improvement
✓	Tier 1 and 2 programmes continue to progress against agreed milestones.
✓	CAD Full Business Case progressing through governance approvals
✓	Delivery of digital risk management and assurance processes through established governance routes

NEGATIVE ASSURANCE

✓	CAD/EPR funding requirements remain subject to affordability and business case approval
✓	Legacy systems remain in service because of historic under-investment & poor strategic planning
✓	Digital transformation is at risk from ongoing CIP saving pressures and revenue affordability constraints
✓	Capacity constraints across digital, architecture and programme management functions present a risk to delivery timescales & transformational capability
✓	SASC collaboration currently in-limbo and focus on upcoming group model is limited resource and engagement

ASSURANCE SUMMARY

The Trust has strengthened digital governance and assurance arrangements and has established digital as a strategic enabler within Fit for the Future. However, continued financial pressures, legacy technology and limited investment capacity present a material risk to achieving the scale of transformation, productivity and workforce modernisation required to deliver strategic objectives.

This risk therefore remains significant and requires continued Board oversight

Risk movement since last BAF: **Static** · Last reviewed: **August 2026** · Next review: **September 2026**

SR3

STRATEGIC RISKS | Cyber Security and Operational Resilience

If SCAS does not establish and sustain effective cyber security governance, capability, resilience and incident response arrangements, **Then** cyber threats may disrupt critical operational services, **Resulting in** patient safety risks, service disruption to emergency and urgent care services, financial and regulatory consequences and loss of public confidence.

NHS
South Central Ambulance Service
NHS Foundation Trust

Risk owner
Chief Digital Officer

Assurance Committee
Quality & Safety Committee

Current risk score
I (4) × L (4) = 16

Target risk score
I (4) × L (3) = 12

Related risks
- **465** – Enterprise cyber security and information resilience risk

CONTROLS IN PLACE

✓	Governance: annual DSPT programme and established cyber/IG reporting routes.
✓	Capability: six ISO 27001/27002 development sessions delivered; policies, training and supplier assurance continue.
✓	Security Platforms: endpoint, network, identity and monitoring products are partially deployed.
✓	Incident management: existing escalation, business continuity and national coordination arrangements.
✓	Utilising NHSE Cyber Security platforms including migration to NHS.NET for our O365 platform

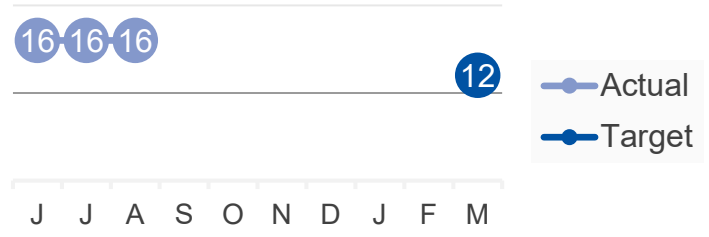
MITIGATING ACTIONS — DEADLINE

✓	Complete enterprise cyber architecture discovery and maturity assessment	Q3 26/27
✓	Develop and secure approval of the first SCAS cyber strategy and prioritised roadmap	Q4 26/27
✓	Establish PM capacity and delivery governance from NHSE funded improvements	Q3 26/27
✓	Validate current tool implementation, integration, coverage and effectiveness	Q3 26/27
✓	Define SOC/SIEM business requirements and delivery model including 24/7 monitoring	Q4 26/27

PROGRESS UPDATE

- Discovery interviews and workshop in progress
- Frontline Productivity application for funding has first round approval from NHSE regional
- Cyber Analyst in post from August 2026
- SOC business requirements analysis started
- DSPT programme now established and mitigating actions

RISK MOVEMENT



Risk movement since last BAF: **Static** · Last reviewed: **August 2026** · Next review: **September 2026**

SR3

STRATEGIC RISKS | Cyber Security and Operational Resilience

If SCAS does not establish and sustain effective cyber security governance, capability, resilience and incident response arrangements, **Then** cyber threats may disrupt critical operational services, **Resulting in** patient safety risks, service disruption to emergency and urgent care services, financial and regulatory consequences and loss of public confidence.

NHS
South Central Ambulance Service
NHS Foundation Trust

Risk owner
Chief Digital Officer

Assurance Committee
Quality & Safety Committee

Current risk score
I (4) × L (4) = 16

Target risk score
I (4) × L (3) = 12

Related risks
- **465** – Enterprise cyber security and information resilience risk

POSITIVE ASSURANCE

✓	DSPT / CAF provides a structured annual evidence framework against national requirements
✓	FPP cyber resilience funding application has received first round approval at NHSE regional level
✓	Six ISO 27001 / 27002 development sessions have strengthened internal understanding
✓	Cyber architecture discovery underway and a dedicated Cyber Security Analyst is in post
✓	Security products and incident, continuity and national NHS cyber arrangements/support exist

NEGATIVE ASSURANCE

✓	The current score of 16 and assessment of controls as 'adequate' have not yet been validated through independent discovery
✓	Several security products are not fully implemented or validated, so coverage and effectiveness cannot be assured
✓	SOC capability is materially under-resourced: limited capacity exists to detect and protect against a wide range of attacks
✓	No cyber project management capacity is available to coordinate discovery outcomes, funded improvements and remediation
✓	Legacy and resilience debt and supplier dependencies remain amid increasing national NHS cyber resilience expectations

ASSURANCE SUMMARY

The trust has matured capability within the cyber security function in the last two years; however the risk remains high due to widening cyber risks including geo-political instability and the targeting of UK critical national infrastructure. Controls and limited funding exist, but incomplete implementation and under-resourced cyber operational and delivery capacity mean effective coverage cannot be assured.

Ongoing discovery work currently underway to validate the reduction of the inherent risk score led by our new Head of Cyber Security.

The Trust's first cyber strategy will align improvement to NHS cyber-resilience expectations, set priorities and resources, and formally reassess risk scores.

Risk movement since last BAF: **Static** · Last reviewed: **August 2026** · Next review: **September 2026**

NHS
South Central
Ambulance Service
NHS Foundation Trust

Upward Report of the Quality & Safety Committee

Date Meeting met **15th July 2026**
Chair of Meeting **Katie Kapernaros, Non-Executive Director**
Reporting to **Trust Board**

Items	Issue	Owner	Action
Points for escalation			
Resuscitation Training	The committee was assured in relation to the governance, oversight and processes for ensuring that relevant staff receive the appropriate level of training. It was noted however that the sustained operational pressure had resulted in training being stood down to prioritise patient care and this could have an impact on compliance. The same will apply across other areas of training.	N/A	Business as usual governance and oversight
Home Office Controlled Drugs Licence.	The licence had not been received at the time the Committee met but confirmation was given via email the following day that the licence had been received. Arrangements are in place via the Medicines Oversight & Governance Group (MOGG) that reports to QSC to ensure on-going compliance and timely licence renewal	N/A	Business as usual governance and oversight.
Key issues and / or Business matters to raise			
Maternity & Neonatal Improvement Programme	Analysis of all recommendations arising out of national reviews into maternity services has taken place. Those that apply to ambulance services have been reviewed in the Maternity & Neonatal Steering Group and actions are in train to ensure that the Trust is compliant. NEDs	N/A	Business as usual governance and oversight

	requested assurance in relation to the impact of the actions in future reports rather than focusing on their completion within deadlines.		
Quality Account 2025/26	The Committee approved the Quality Account for publication and the quality priorities for 2026/27 which were outlined in the document. Work continues to develop Patient Safety Reporting to the committee.	N/A	Monitoring of progress against the priorities is within the QSC workplan
Areas of concern and / or Risks			
Clinical Dashboard	Work is underway to develop a dashboard that will provide more meaningful analysis and reporting in relation to patient outcomes at clinician, sector, division and trust level. This is part of the programme of work within the Digital strategic theme, and the committee emphasised the need to accelerate this.	N/A	No specific action as part of existing plans.
Items for information and / or awareness			
None			
Best Practice and / or Excellence			
Safeguarding Training	High levels of compliance with training continues despite operational pressures. Work is progressing to develop a digital reporting tool that will enhance the quality of referrals. A timeline for this work was requested for the next meeting.	HY	Timeline to be submitted to the next meeting.
Policies for approval			
None			

NHS
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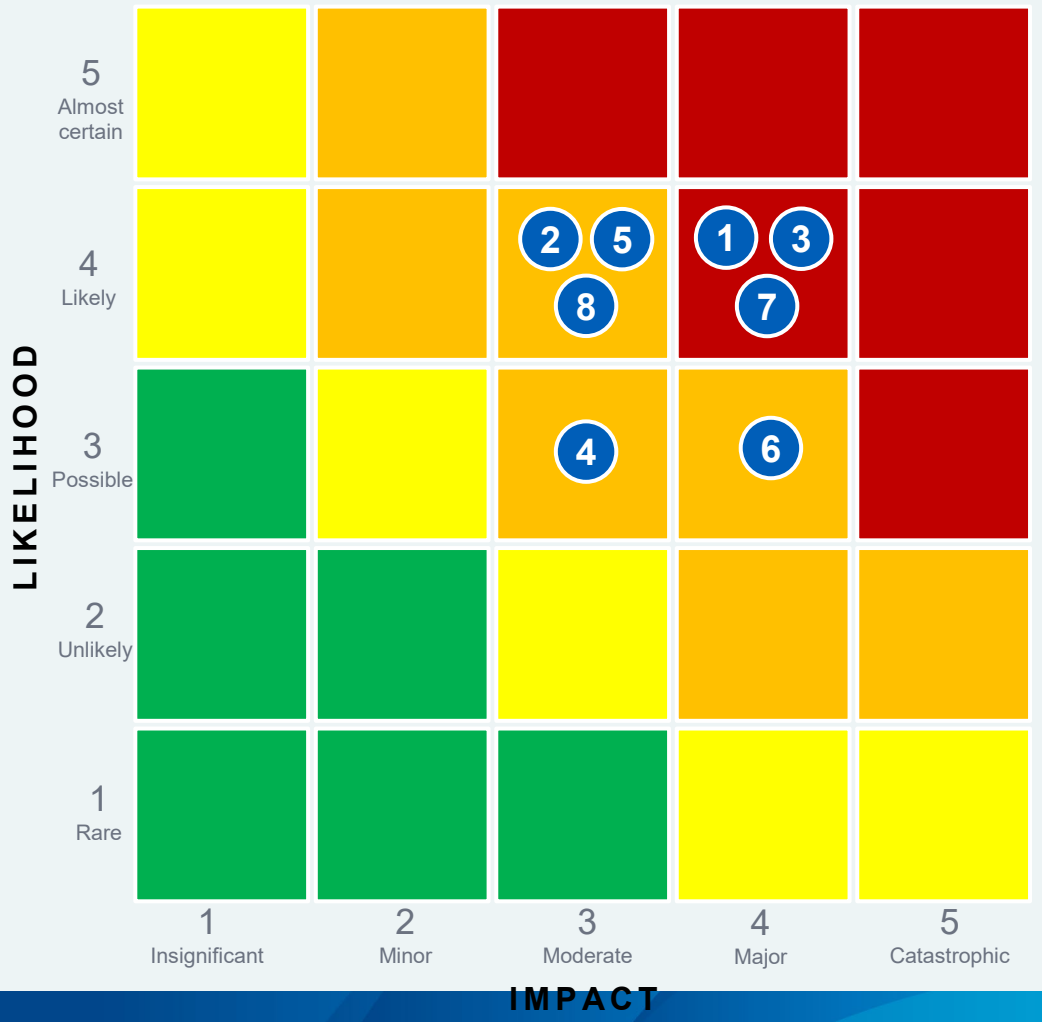
2026 – 2027 Board Assurance Framework – Clinical Effectiveness

August 2026

Strategic Risk Heat Map

NHS
South Central Ambulance Service
NHS Foundation Trust

RISK MATRIX



	RISK KEY & NAME	SCORE	OWNER	MOVEMENT
1	Quality Performance and Patient Outcome	16	Executive Director of Operations	⟺
2	Digitisation	12	Chief Digital Officer	⟺
3	Cyber Security and Operational Resilience	16	Chief Digital Officer	⟺
4	Fleet Improvement	9	Chief Finance Officer	⟺
5	Estates Modernisation	12	Chief Finance Officer	⟺
6	Staff Engagement	12	Chief People Officer	⟺
7	Sustainability	16	Chief Finance Officer	⟺
8	Collaboration	12	Chief Finance Officer	⟺

Reviewed by Trust Board · Q2 2026/27 · Next review: September 2026

SR1

STRATEGIC 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 system partners.

South Central Ambulance Service
NHS Foundation Trust

Risk owner
Executive Director of Operations

Assurance Committee
Quality & Safety Committee

Current risk score
I (4) × L (4) = 16

Target risk score
I (3) × L (3) = 9

Related risks
- **82 -** Delayed response risk

CONTROLS IN PLACE

✓	New Tactical Performance Manager role now 24/7 monitoring performance on an hourly basis
✓	New structures now in place with functional leadership structures across ICC to focus on specific area (call taking, clinical & dispatch)
✓	Development of ACQI dashboard underway to support new COM role with Clinical delivery
✓	Weekly category 2 performance review meetings which feed into weekly EMC report and Bi-weekly NHSE performance reviews
✓	Demand and capacity planning and simulation to forecast activity and resources to improve service delivery

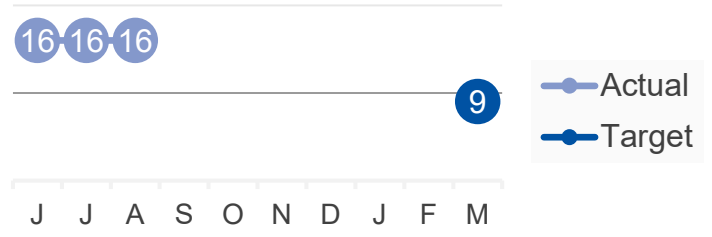
MITIGATING ACTIONS

		DEADLINE
✓	Recruitment to all CSD vacancies to increase H&T to planned levels	End Oct
✓	Scenario based modelling for annual plan	End Oct
✓	QI programme to reduce lost operational hours through sickness and abstractions	End Oct
✓	Increasing number of Specialist Practitioners to increase S&T	End Dec
✓	Wider use of GoodSam app to support virtual care delivery	End Nov

PROGRESS UPDATE

- CSD recruitment has improved with all posts now allocated to new starters who will all be in post by October.
- Lost unit hours from fleet availability is much improved
- Increasing operational hours through overtime and Bank staff

RISK MOVEMENT



Risk movement since last BAF: **Static** · Last reviewed: **August 2026** · Next review: **September 2026**

SR1

STRATEGIC 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 system partners.

South Central Ambulance Service
NHS Foundation Trust

Risk owner
Executive Director of Operations

Assurance Committee
Quality & Safety Committee

Current risk score
I (4) × L (4) = 16

Target risk score
I (3) × L (3) = 9

Related risks
82 - Delayed response risk

POSITIVE ASSURANCES

- ✓ Fleet position continues to improve with reduced lost hours
- ✓ Cat 2 recovery programme team now in place with dedicated programme support
- ✓ PSI learning is informing the development of the clinical model
- ✓ Clinical audits by Clinical team educators monitoring staff EPR completion
- ✓ Business continuity plans reviewed to ensure all plans can deliver during adverse weather

NEGATIVE ASSURANCES

- ✓ Not achieving Cat2 in Q1 in line with plan
- ✓ Workforce imbalance between Thames Valley and Hampshire impacting on ICB performance disparity
- ✓ Clinical pathways access variability across ICB and neighbourhood footprints
- ✓ Delays with CAD implementation and work force management tool to focus on group delivery of CAD
- ✓ Hospital handover delays higher than plan impacting on cat 2

ASSURANCE SUMMARY

- Challenges with covering the additional overtime agreed for August due to staff annual leave.
- Higher sickness rates with signs of improvement in Thames Valley
- Two sectors delivering task time target in Hampshire

Risk movement since last BAF: **Static** · Last reviewed: **August 2026** · Next review: **September 2026**

NHS
South Central
Ambulance Service
NHS Foundation Trust

Upward Report of the People & Culture Committee

Date Meeting met **29th July 2026**
Chair of Meeting **Harbhajan Brar, Non-Executive Director**
Reporting to **Trust Board**

Items	Issue	Owner	Action
Points for escalation			
National Education and Training Survey	An action plan was received in response to the areas of concern highlighted within the survey; sexual safety being one such concern raised by learners. The committee emphasised that delivery of the actions and the ability to demonstrate impact was pivotal. A progress update will be provided to the November meeting.	DH	Progress update to be provided to November PACC.
Mandatory Training & PDRs and Sickness Absence	Operational pressures are impacting performance in relation to these metrics and whilst the patient safety first rationale is understood and supported, the committee urged that a plan to recover performance is put into place to ensure that the risk of non-delivery does not materialise at Q4.	DH	Monitoring will continue as part of business-as-usual activity.
Key issues and / or Business matters to raise			
Recruitment	Assurance was provided that delays to the recruitment of clinical staff to the Emergency Operations Centre (EOC) had been resolved. The Committee also received a deep dive focusing on EOC recruitment and retention and the challenges. The committee was assured that focused work was underway to improve employee experience and retain staff. A positive report was received from internal audit in relation to the controls in place around recruitment.	N/A	Standing item on the committee's agenda

Employee Relations Cases	Good progress was noted although there had been an increase in the number of days that cases were on-going, which was a short-term issue rather than a trend. Following a targeted piece of work to identify inappropriate internet usage, investigations were underway and appropriate action will be taken.	N/A	Standing item on the committee's agenda
Freedom to Speak Up Annual Report, Quarter 1 Report and Policy	The Annual Report was received which summarised the work outlined in the regular quarterly report to the Board. The Q1 report was also received and there are no specific issues to escalate to the Board although the reduction in the number of anonymous or confidential concerns has reduced, which was regarded as positive Only minor changes to the policy had been made. The Annual Report and Policy are recommended to the Board for approval.	BM	Annual Report and Policy to be submitted to the September Board for approval.
Lord Mann Report Recommendations	An action plan was presented and whilst it was noted that the actions were the correct actions, the committee emphasised the need for these to form part of the People & Culture workstreams rather than be treated as stand alone. The Committee also approved on behalf of the Board, the formal adoption of HRA Definition of Antisemitism and the Government Definition of Anti-Muslim Hostility in order to meet NHSE deadlines. It was emphasised however the importance of being clear that the Trust does not accept any form of discrimination on any grounds.	DH	A report is on the agenda for the September 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			
Fit for the Future People & Culture	The highlight report indicated that good progress was being made, supported by an increase, albeit marginal in the number of staff that would	N/A	Highlight report is on the agenda for

	recommend the Trust as a place to work and in the staff engagement score in the most recent Pulse survey.		the September Board
Policies for approval			
Freedom to Speak Up Policy	Minor changes to the policy had been made and the committee recommends it to the Board for approval	BM	On the agenda for the September board meeting

NHS
South Central Ambulance Service
NHS Foundation Trust

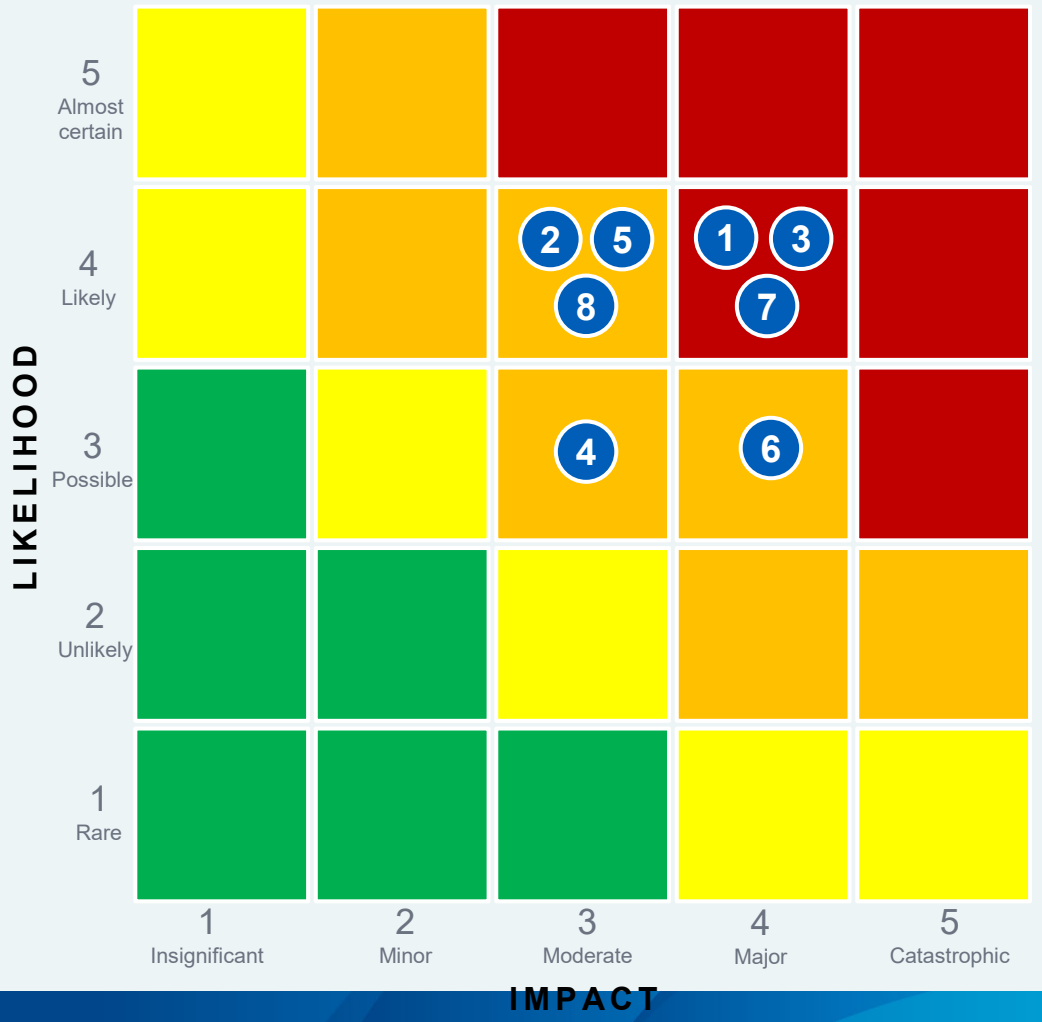
2026 – 2027 Board Assurance Framework – People and Culture

August 2026

Strategic Risk Heat Map

NHS
South Central Ambulance Service
NHS Foundation Trust

RISK MATRIX



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7	Sustainability	16	Chief Finance Officer	⟺
8	Collaboration	12	Chief Finance Officer	⟺

Reviewed by Trust Board · Q2 2026/27 · Next review: September 2026

SR6

STRATEGIC RISKS | Staff Engagement

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.

South Central Ambulance Service
NHS Foundation Trust

Risk owner	Assurance Committee	Current risk score	Target risk score	Related risks
Chief People Officer	**People & Culture Committee**	**I (3) × L (4) = 12**	**I (3) × L (2) = 6**	• **None**

CONTROLS IN PLACE

- ✓ Freedom to Speak-Up Policy and Processes
- ✓ People Strategy and Values and Behaviours Framework
- ✓ Staff Networks
- ✓ People directorate structured to support staff engagement
- ✓ Chief People Officer

MITIGATING ACTIONS DEADLINE

✓	Embedding Trusts values and behaviours framework	27/28
✓	Open Space/ Listening meetings	Ongoing
✓	Enhance Sickness Policy	Q4 26/27
✓	Leadership Meetings Monthly	Ongoing
✓	Embedding of NHS Sexual Safety Charter by ongoing appointment of Sexual Safety Lead	Ongoing

PROGRESS UPDATE

- Improving Staff Culture is a multi year programme with improved Trusts Value and Behaviour Framework being launched in Q2 2026/27.
- Enhancements of FTSU & Sexual Safety within the trust have/are taking place
- Culture & Leadership work ongoing

RISK MOVEMENT

Risk movement since last BAF: **Static** · Last reviewed: **August 2026** · Next review: **September 2026**

SR6

STRATEGIC RISKS | Staff Engagement

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.

South Central Ambulance Service
NHS Foundation Trust

Risk owner	Assurance Committee	Current risk score	Target risk score	Related risks
Chief People Officer	**People & Culture Committee**	**I (3) × L (4) = 12**	**I (3) × L (2) = 6**	• **None**

POSITIVE ASSURANCE

- ✓ Improving People Pulse Survey
- ✓ FTSU cases
- ✓ Improving National NHS Staff Survey outcomes
- ✓ Improving National NHS Staff Survey completion rate
- ✓ Positive qualitative feedback from leadership walkabouts

NEGATIVE ASSURANCE

- ✓ Increased turnover of staff
- ✓ Increased sickness absence
- ✓ Decreased staff retention rates due to disengaged staff
- ✓ Decreased engagement and satisfaction via staff surveys
- ✓ Negative qualitative feedback from leadership walkabouts

ASSURANCE SUMMARY

The Trust has an ongoing culture & leadership workstream, staff engagement plans and workforce reporting arrangements that provide assurance. However, continued increasing staff sickness, workforce funding decreases and workforce pressures present significant risks to long-term staff engagement efforts.

NHS
South Central Ambulance Service
NHS Foundation Trust

TRUST BOARD OF DIRECTORS MEETING IN PUBLIC
3 September 2026

Title	**Lord Mann Recommendations Implementation Plan Update**
Report Author	**Dipen Rajyaguru, Head of Equality, Diversity & Inclusion**
Executive Owner	**Danny Hariram, Chief People Officer / Deputy Chief Executive**
Agenda Item	**19**
Governance Pathway: Previous	**The Lord Mann recommendations have been seen at the: Equality, Diversity & Inclusion Steering group (11/06/26) Public Board 03/07/2026, People & Culture Committee Meeting (29/07/26) This paper is an update for the Board**
Governance Pathway Next Steps	**Committee Assurance & Noting**

1. Purpose

To provide assurance on progress against the Trust implementation plan responding to the Lord Mann recommendations and to highlight key actions required before October 2026 assurance reporting to NHS England

2. Executive Summary

The Trust has made significant progress implementing the Lord Mann recommendations. Board and People & Culture Committee (PACC), ACC have approved the International Holocaust Remembrance Alliance (IHRA) definition of antisemitism and the Government definition of anti-Muslim hostility. Updated ED&I training materials have been developed, and engagement has commenced with Governance, Freedom to Speak Up (FTSU), Communications, Safeguarding, Patient Experience, Workforce Planning and Employee Relations teams. We have also secured a guest speaker for the 'Unity in Diversity Conference' on the 11th September from the Health & Race Observatory who created the principles for Race Equality, that we have adopted. Key priorities remain governance oversight, reporting mechanisms, anti-racism training, culture change initiatives, data monitoring and policy implementation. A detailed table with timescales on Progress made and actions to be completed is in Appendix 1

SCAS has adopted the IHRA working definition of antisemitism and the Government definition of anti-Muslim hostility as non-statutory definitions to support consistent recognition, reporting and response to racism and religious hatred. This adoption does not create new legal offences or override existing legal protections, including freedom of expression, religion and belief. Any incident will continue to be considered on its

individual facts and context, alongside the Equality Act 2010, Human Rights Act 1998, employment law and relevant NHS policies and procedures.

We have been prudent to complete Equality Impact Assessment (EqIA) (Appendix 2) to ensure the Trust has given due regard to its responsibilities under the Equality Act 2010 when adopting the IHRA definition of antisemitism and the Government definition of anti-Muslim hostility. The assessment identified significant positive impacts for Jewish and Muslim staff by strengthening recognition, reporting and organisational responses to discrimination, while also recognising potential risks around interpretation, perceived restrictions on freedom of expression and inconsistent application. These risks have been assessed as proportionate and justifiable and will be mitigated through clear guidance, communications, training, they have also been consulted with staff networks and Unions at the ED&I Steering Group meeting.

The EqIA concludes that adoption should proceed as part of a structured implementation programme, providing assurance that the Trust has considered the potential impacts on protected groups, taken appropriate steps to minimise adverse effects, and advanced equality of opportunity while fostering good relations across all communities.

Summary of Key progress:

- Board and the People and Assurance Committee (PACC) agreed to adopt the International Holocaust Remembrance Alliance (IHRA) definition of antisemitism and the Government definition of anti-Muslim hostility. The NHSE deadline to respond by 31 June was therefore met.
- Developing a communications plan with Comms to publicise the definitions
- ED&I training materials updated to include antisemitism and anti-Muslim hostility.
- Work underway to strengthen reporting, Freedom to Speak Up, investigation processes and staff support.
- Plans to strengthen anti-racism communications, behavioural expectations and implementation of the NHS Race and Health Observatory principles (RHO). RHO guest speaking at the ‘Unity in Diversity conference’
- Further work planned to improve monitoring and transparency of complaints and racial incidents
- Review of workplace adjustments, recruitment, onboarding and behavioural standards is progressing.

Summary by Theme

1. Leadership and Accountability: ED&I and anti-racism objectives to be embedded within Board and Executive performance arrangements; governance reporting mechanisms under development; Lord Mann actions incorporated into WRES.

2. Training and Capability: Anti-racism and antisemitism training planned for Board members, awaiting NHSE Training guidance; Corporate and clinical ED&I training updated to include antisemitism and anti-Muslim hostility.

3. Reporting and Complaints: Review of reporting routes, FTSU processes, investigation arrangements and patient complaints relating to racism.

4. Workforce Support and Culture Change: Development of anti-racism communication campaign, zero-tolerance messaging and implementation of the NHS Race and Health Observatory principles.

5. Antisemitism and Anti-Muslim Hostility: Formal adoption of definitions completed by Board and PACC with implementation through policy, communication and training. Widely acclaimed EqIA of the definition adoption.

6. Data, Insight and Transparency: Review of workforce, WRES/WDES reporting and further discussion in identifying gaps such as the appropriate capture of racial incidents and religious identity,

7. Fair Treatment for Staff: Review of workplace adjustments to ensure awareness of 'workplace adjustments passport', recruitment and onboarding support, behavioural expectations and readiness for NHS Staff Standards.

8. Uniform, Branding and Political Neutrality: Local review of policies pending national NHS England guidance. Current guidance already addresses political badging in certain circumstances and provides expectations around social media use.

Next steps are concentrated around early September through to late October 2026, including strengthening governance and reporting, finalising training requirements, reviewing reporting and support arrangements, developing communications and completing policy updates.

3. Areas of Risk

Potential delays due to dependencies on NHS England guidance, Trust reporting arrangements, gaps in racism investigation tools, and capacity issues across corporate teams. Risks are being mitigated through governance oversight, and cross-directorate engagement.

4. Link to Strategic Theme

People and Culture

5. Link to Board Assurance Framework Risk(s)

SR23 - Leadership

6. Quality/Equality Impact Assessment

This paper directly relates to equality, diversity, and inclusion. An Equality Impact Assessment (Appendix) has been conducted specifically in relation the adoption of the definitions of antisemitism and of anti-Muslim hostility.

7. Recommendations

The Board is asked to:

- Receive the update and take assurance from the progress made;
- Note identified risks and dependencies

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

Appendix 1

Progress made and actions to be completed

Theme / recommendation	What has been done	What remains to do	Deadline / KPI
1. Leadership & accountability	Board and PACC have approved adoption of the Government definition of anti-Muslim hostility and the IHRA definition of antisemitism, and this has been reported to NHSE. Initial contact has been made with Governance regarding reporting arrangements.	Agree Board/Executive ED&I and anti-racism objectives; establish formal Board reporting arrangements; incorporate Lord Mann recommendations into the WRES action plan and Board reporting.	**31 Aug:** WRES alignment. **30 Sept:** Board objectives and governance arrangements. **Mid-Oct:** progress update to NHSE.
2. Mandatory training & capability	EDI training slides have been updated to include antisemitism and anti-Muslim hostility.	Confirm Board training dates; scope and update EDI/HR training; implement Board training and monitor completion.	**30 Sept:** training scope/dates confirmed. **Oct:** report uptake/progress. **Dec:** 100% Board completion.

3. Reporting, investigation & complaints	Engagement has started with FTSU, Patient Experience, Communications and relevant teams. Existing safeguarding training already includes racism/antisemitism considerations.	Review reporting routes, FTSU processes and investigation procedures; improve reporting pathways and support; establish patient reporting/feedback routes; review racism-related complaints and identify gaps in investigation/response.	**31 Aug:** reporting routes reviewed. **30 Sept:** improvements and complaints review. **31 Oct:** patient reporting arrangements.
4. Workforce support & culture change	Existing FTSU and support arrangements provide a foundation. The Pulse survey is gathering information on speaking up. The **See Me First** campaign provides an existing platform for anti-racism messaging.	Review support available to staff experiencing discrimination (draft Board paper); develop an anti-racism communications/culture plan; establish specific actions on racism (adopted HRO & principles of Race Equality); Develop Race equality campaign/Charter	**31 Aug:** support review (draft Board paper). **30 Sept:** culture/communications plan HRO principles of Race Equality) and actions. **Sept 30:** Develop Race equality campaign/Charter
5. Antisemitism & anti-Muslim hostility	**Completed in principle:** definitions approved through ED&I Steering Group, PACC and Board, and reported to NHSE.	Complete formal governance adoption/publication; update relevant policies, training and communications; embed definitions into organisational awareness activity.	**30 Sept:** formal adoption, policy and communications updates. **30 Oct:** assurance to NHSE.
6. Data, insight & transparency	Work has started to identify relevant workforce and employee-relations data, with WRES and other data sources identified for the Board assurance report.	Review workforce/patient data collection; identify gaps, including religion where appropriate; agree measures and reporting framework; use data to identify inequalities and report progress.	**30 Sept:** data review, gaps and measures. **30 Oct:** progress through WRES/NHSE reporting.

7. Fair treatment & support for all staff	Alignment with WRES and the Lord Mann review has been agreed, and work has commenced on staff standards.	Review workplace adjustment processes; identify improvements to recruitment/onboarding/support ; align policies with anticipated NHS Staff Standards; formally adopt/align with RHO Seven Principles or SCAS Charter.	**30 Sept:** reviews and improvements identified. **30 Oct:** readiness for national Staff Standards.
8. National guidance, uniform, branding & political neutrality	Existing social media guidance is in place and initial work with Communications has commenced. Current approach allows support for Trust initiatives and Staff Networks while addressing political badging.	Review local policies against national guidance; identify uniform/branding amendments; develop communications and implementation plan; confirm readiness when NHSE guidance is issued.	**30 Sept:** policy review and amendments. **30 Oct:** organisational readiness confirmed.

Appendix 2

Equality Impact Analysis screening tool (stage 1)

Directorate / Department	People & Well-being
Title & short description of Policy/Operating Procedure/Proposal/Service	Adoption of the IHRA Definition of Antisemitism and the Government Definition of Anti-Muslim Hatred/Hostility as part of implementing the Lord Mann Review recommendation
Name and role of assessor	Dipen Rajyaguru, Head of Equality, Diversity & Inclusion
Date of analysis	July 2026

Does or could the policy, procedure or proposal affect any group based on:	**YES/NO/ Potential**	**Comment/evidence**
Race, ethnic origin (including gypsies and travellers) and nationality (e.g., any specific needs identified for certain groups such as dress, diet, individual care needs? Are interpretation and translation services required and do staff know how to book these?)	Yes	Positive impact expected for Jewish and Muslim staff and communities who may experience discrimination linked to ethnicity, ancestry, nationality or perceived ethnic identity. Potential concern from some groups regarding application and interpretation of definitions.
Sex (A man or a woman) (e.g., whether men and women and have equal access to the service or benefits? What evidence do you have?)	No	No direct differential impact identified. Adoption of the definitions applies equally regardless of sex.

Gender (inc. gender reassignment (e.g., is gender neutral language used in the way the policy or information leaflet is written?	No	No direct differential impact identified. Definitions relate to religious and racial hatred rather than gender identity.
Age (e.g., are specific age groups excluded? Would the same process affect age groups in different ways?)	No	No direct age-related impact anticipated. Training and communication should be accessible to all age groups
Religion or Belief (e.g., Jehovah Witness stance on blood transfusions; dietary needs that may conflict with treatment offered.)	Yes	Significant positive impact by providing explicit recognition of antisemitism and anti-Muslim hatred and improving confidence in reporting, support and organisational response. Potential risk that some individuals perceive definitions as limiting discussion of religion, political views or current affairs if not clearly or appropriately explained.
Disability – mental, physical, and learning disability (Neuro diverse) (e.g., Are you taking steps to take account of disabled people's impairments and access needs, or providing 'reasonable adjustments?	Yes	Training, policies and reporting processes must be provided in accessible formats and reasonable adjustments made where required
Sexual orientation (including lesbian, gay and bisexual people) (e.g., is inclusive language used? Are there different access/prevalence rates?)	No	No direct differential impact identified.
Married or in a civil partnership (e.g., would there be any difference because the individual is/is not married/in a civil partnership?)	No	No direct impact identified.
Pregnancy	No	No direct impact identified.

(e.g., are procedures suitable for pregnant and/or breastfeeding women?		

Considerations	YES/ NO	Mitigation/Comment/Evidence
Is there any evidence that some groups are affected differently, less or more favourably than another?	Yes	Jewish and Muslim staff are likely to benefit disproportionately through increased recognition, protection and support. This is a legitimate and proportionate response to identified discrimination. Other groups should continue to be protected by the Equality Act 2010 and through wider anti-racism and inclusion policies.
Is the impact of the policy, procedure, or proposal likely to be negative?	Yes	A minority of staff may perceive the definitions as restricting freedom of expression or legitimate discussion regarding religion, culture or international affairs. There is potential for inconsistent interpretation by managers
If so, can the impact be justifiable?	Yes	The objective is to prevent discrimination, harassment and hate incidents and create a safer working environment. This is consistent with the Equality Act 2010, NHS values and Lord Mann Review recommendations.
Are there alternatives actions might enable achievement of the proposal without the negative impact?	Potentially	Adoption of the definitions should be accompanied by clear guidance, examples, training and case studies rather than relying solely on the definitions themselves. This reduces the risk of misunderstanding while retaining the intended benefits
Is there a need for external or user consultation?	Potentially	The adoption of the definitions has already gone through the ED&I Steering, that consists of Unions and Staff Networks and Freedom to Speak Up Guardians. Further engagement with Jewish staff, Muslim staff, staff networks, trade unions, Freedom to Speak Up Guardians and community stakeholders would strengthen implementation and legitimacy.

Impact on other identified groups: Consider and detail evidence on groups experiencing disadvantage, health inequality and barriers to access and outcomes. This can include different **socio-economic groups, Carers, veterans, geographical area inequality, income, resident status (migrants, asylum seekers).**	Yes	Positive impact for groups experiencing discrimination by improving organisational confidence in addressing hate incidents. There is also a wider benefit to staff psychological safety and organisational culture. Monitoring should ensure no unintended exclusion of other faith groups or minority communities.

Equality Impact Analysis Outcome (Select one)	**Rationale for the decision**
Option 1: No change required – the analysis is that the policy/practice is/will be robust.	
Option 2: Substantially adjust the policy or practice – this involves taking steps to remove any barriers, to better advance equality and/or to foster good relations. (**See Implementation, Monitoring & Review Plan below)**	
Option 3: Continue the policy or practice despite the potential for adverse impact, and which can be mitigated/or justified	The proposal is expected to have a significant positive impact on Jewish and Muslim staff by increasing recognition, support and organisational accountability in addressing antisemitism and anti-Muslim hatred. However, potential risks relating to interpretation, *perceived* restrictions on expression, and unequal treatment require active mitigation through training, communications, consultation and monitoring. Adoption should therefore proceed alongside a structured implementation plan rather than as a standalone policy decision.

Option 4: Stop the policy or practice as there are adverse effects cannot be prevented/mitigated/or justified.	

Implementation, Monitoring & Review Plan (for option 2 above)

Issue	Action required	Who will be responsible	Resources & Training required	Planned Outcome	Implementation Date	Progress

Where a report to the Trust Board, Executive Committee or Senior Leadership Group is recommending the adoption of a new or revised policy or service, the EQIA should be attached as an appendix to the report. Any equalities implications should be summarised on the Committee or Board coversheet.

Assessor's Name: Dipen Rajyaguru, Head of Equality, Diversity & Inclusion	Date: July 2026

A full EQIA is required **if**:

• The impact is potentially discriminatory under equality or anti-discrimination legislation

• Any equality groups or communities identified as being potentially and unjustifiably disadvantaged or negatively impacted by the policy or service

• The policy or service is assessed to be of high significance or a major change affecting a large population

Recommendation: Full Equality Impact Analysis required: **No** If yes, move to stage 2 (contact the Head of Equality, Diversity & Inclusion)

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TRUST BOARD OF DIRECTORS MEETING IN PUBLIC 3 September 2026

Title	**Freedom to Speak Up Annual Report 2025/26 and Freedom to Speak Up Policy**
Report Author	**Christine McParland, Freedom to Speak Up Guardian**
Executive Owner	**Becky Murray, Chief Governance Officer**
Agenda Item	**20**
Governance Pathway: Previous	People & Culture Committee July 2025
Governance Pathway Next Steps	None – report is for the Trust Board

1. Purpose

To present the Freedom to Speak Up Annual Report for 2025/26 for assurance and the revised Freedom to Speak Up Policy for approval.

2. Executive Summary

The Board is responsible for ensuring that the Trust has robust arrangements in place for staff to Speak Up when they have concerns that are not being effectively addressed via existing means and for ensuring that appropriate action is taken in response. These arrangements are a key component of the work that is being undertaken to improve organisational culture as concerns raised are a valuable source of intelligence that can be triangulated with other sources of intelligence and used to inform improvement programmes and activities.

The Board and the People & Culture Committee (PACC) have received quarterly reports in relation to the number and nature of the concerns raised and the learning that has been derived. The information provided within the Annual Report is not therefore new information, as it has been subject to discussion at both PACC and the Board. It does however provide a useful overview of the activity that has been taking place in the Freedom to Speak Up space and acts as a source of assurance in relation to the effectiveness of the arrangements in place.

The Freedom to Speak Up policy has also been routinely reviewed and although the changes that were made were minor, mainly relating to changes in executive leadership, and a revised foreword from the Chief Executive Officer, the policy is presented to the Board for approval, on the recommendation of the PACC.

3. Areas of Risk

There are no specific risks associated with the Annual Report as it sets out the arrangements that the trust has in place around Freedom to Speak Up and the policy is drafted in line with national principles. The risk arises from failing to take appropriate action in response to concerns raised or to utilise the intelligence derived to inform and drive improvement programmes. This risk is mitigated by regular reports to the Board, with more detailed scrutiny at PACC, which seeks further assurance and offers supportive challenge to ensure that the service remains effective and accessible.

4. Link to Strategic Theme

The Annual Report and Policy links to our People & Culture theme.

5. Link to Board Assurance Framework Risk(s)

The Annual Report and policy links to all People and Culture Board Assurance Framework risks.

6. Quality/Equality Impact Assessment

No QIA/EIA is required.

7. Recommendations

The Board is asked to take **ASSURANCE** from the Annual Report and to **APPROVE** the Freedom to Speak Up Policy.

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

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Freedom to Speak Up Annual Report

April 2025 to March 2026

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1. **Purpose**
   This report provides an overview of Freedom to Speak Up (FTSU) activities from April 2025 to March 2026, including concerns raised, emerging themes, improvement work, and future priorities.

2. **Key Context**

   2.1. FTSU remains a core mechanism for strengthening **patient safety, staff experience, and organisational learning** following the Francis Inquiry.

   2.2. The FTSU Guardian function supports a **culture of psychological safety**, ensuring staff feel able to speak up and that concerns lead to meaningful action.

3. **FTSU Infrastructure and Capacity**

   3.1. The Guardian team is established at **3.0 WTE**, however capacity reduced to **2.0 WTE for over half the year** in 2025/26, due to a recruitment freeze. This impacted proactive delivery.

   3.2. A strong network of **79 FTSU Champions (↑)** continues to embed FTSU across services, including students and volunteers.

4. **Leadership and Governance**

   4.1. Continued **support from the CEO** demonstrates organisational commitment.

   4.2. Executive oversight for FTSU transitioned during the year and is now aligned within the **Governance Directorate** with our **Chief Governance Officer** having **Executive responsibility**, strengthening integration with assurance processes.

   4.3. The **NED FTSU Lead role was vacant for 6 months**, presenting a temporary gap in independent oversight, this was resolved in the latter half of the year.

5. **System Integration and Influence**

5.1. The FTSU team is well-connected regionally and nationally, supporting **shared learning and benchmarking**.

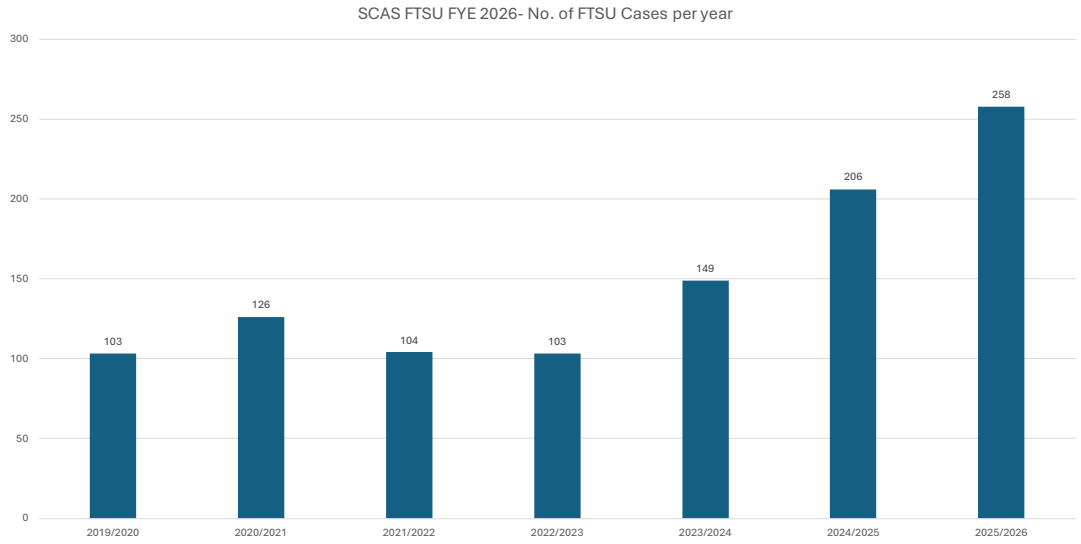
5.2. Our FTSU Guardians contribute to a wide range of Trust groups (e.g. Sexual Safety, Patient Safety, Culture & Leadership), ensuring **FTSU intelligence informs organisational decision-making**.

6. Policy Position

6.1. The Trust remains aligned with the updated **NHSE National FTSU Policy (Jan 2025)**, with no significant local amendments.

7. Concerns Raised Through FTSU

7.1. Two hundred and fifty-eight (258) new FTSU cases were recorded in 2025/26 (2024/25 = 204), a 26% increase.



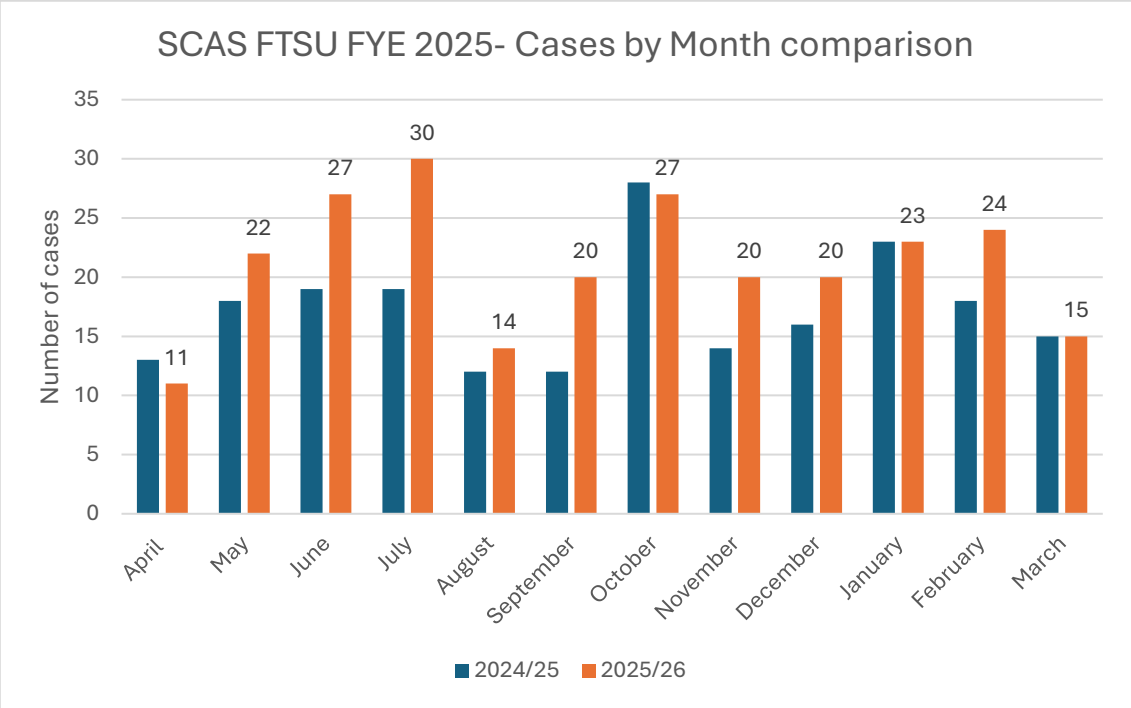
7.2. This increase is a positive indicator of improved confidence in using FTSU and reflects ongoing work to build trust. It reinforces the need for timely, transparent and proportionate responses, and consistent local leadership handling.

7.3. The high-level breakdown of concerns in 2025/26 was:

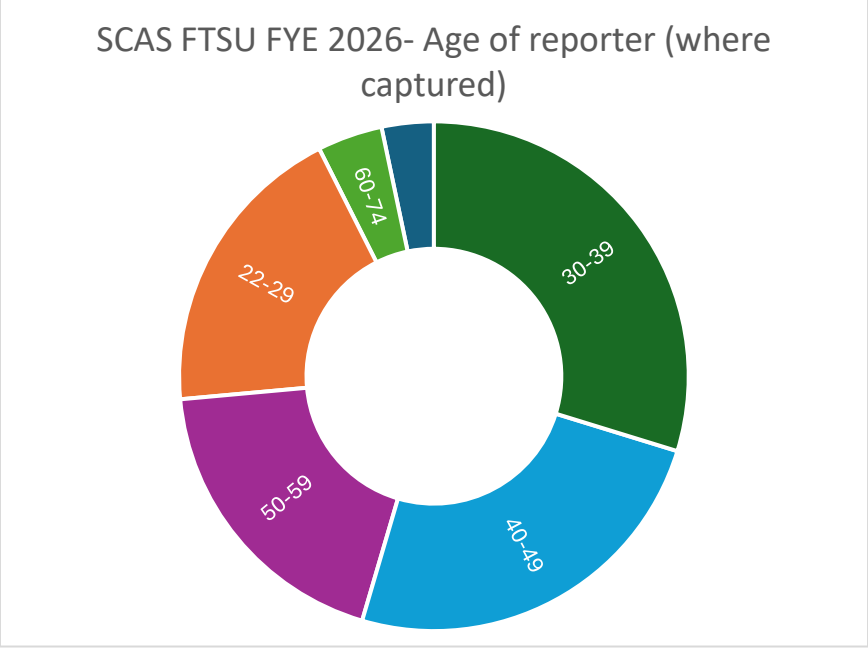
- Something has gone wrong: 80%
- Something might go wrong: 10%
- Something that is good but could be even better: 2%

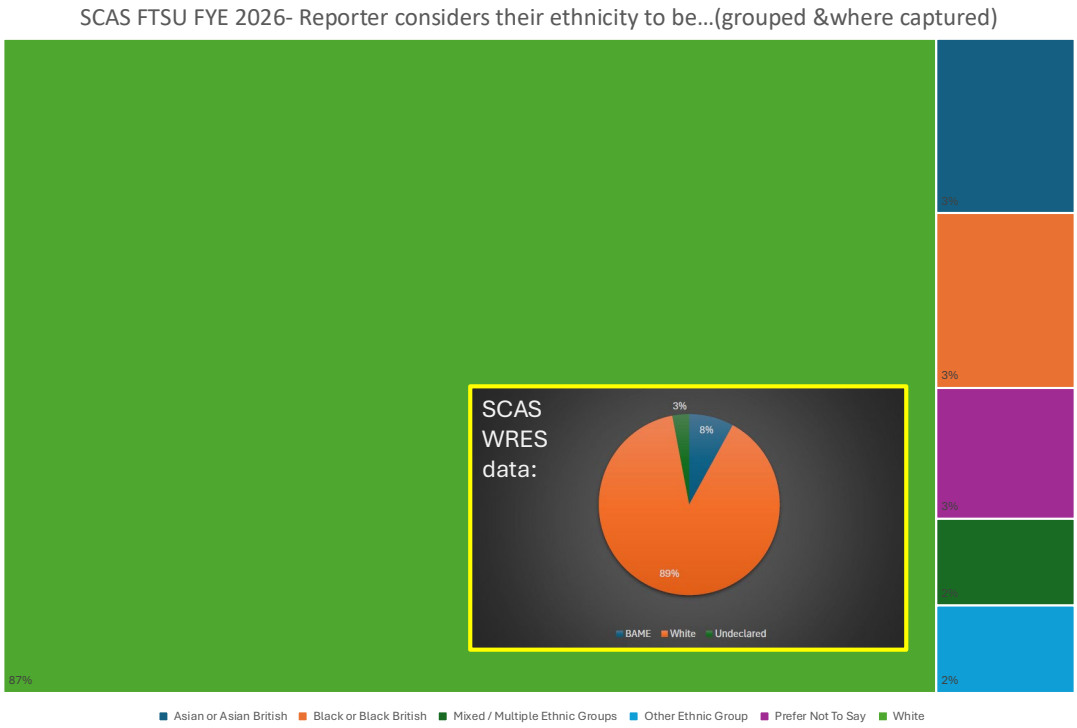
7.4. At time of writing no directly comparable national Ambulance Trust FTSU case data is currently available.

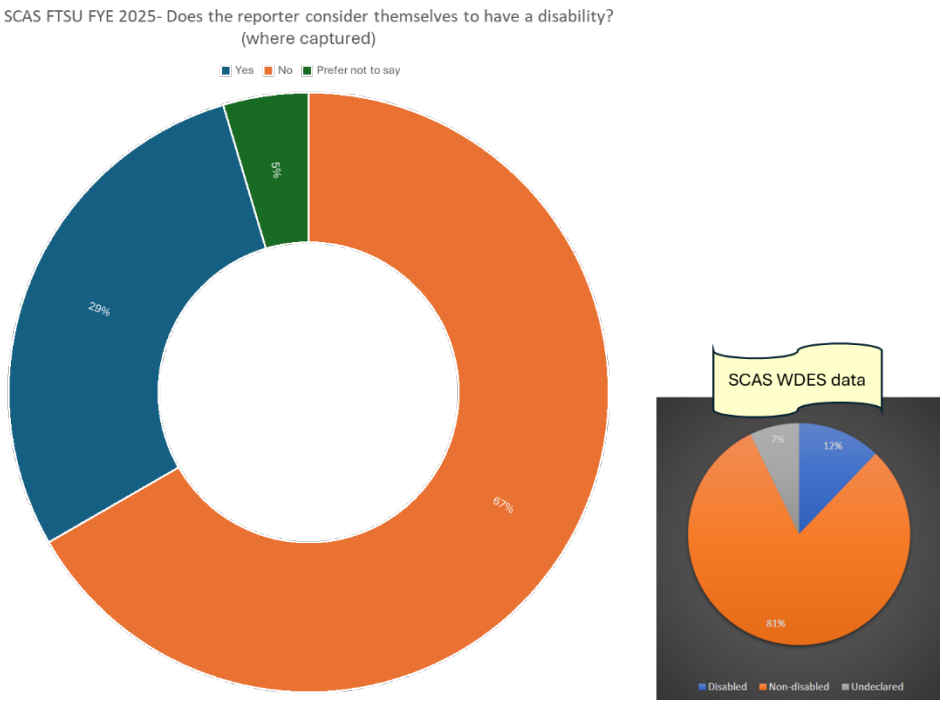
7.5. Monthly case data is shown in the illustrations below. Cases span all services, with the highest volume consistently in Operations (reflecting scale and complexity). Corporate concerns have increased, largely linked to organisational restructuring.
(Insert monthly cases graph)



7.6. Demographic data (average n=104) of people raising concerns can be seen in the charts below:







8. National Staff Survey (NSS): We Each Have a Voice That Counts

8.1. FTSU themes align with NSS findings: were some staff do not feel safe to speak up, or confident that concerns will be addressed.

8.2. Reduced survey engagement mirrors increased use of the confidential FTSU route. Actions have focused on strengthening line manager capability and team-level trust.

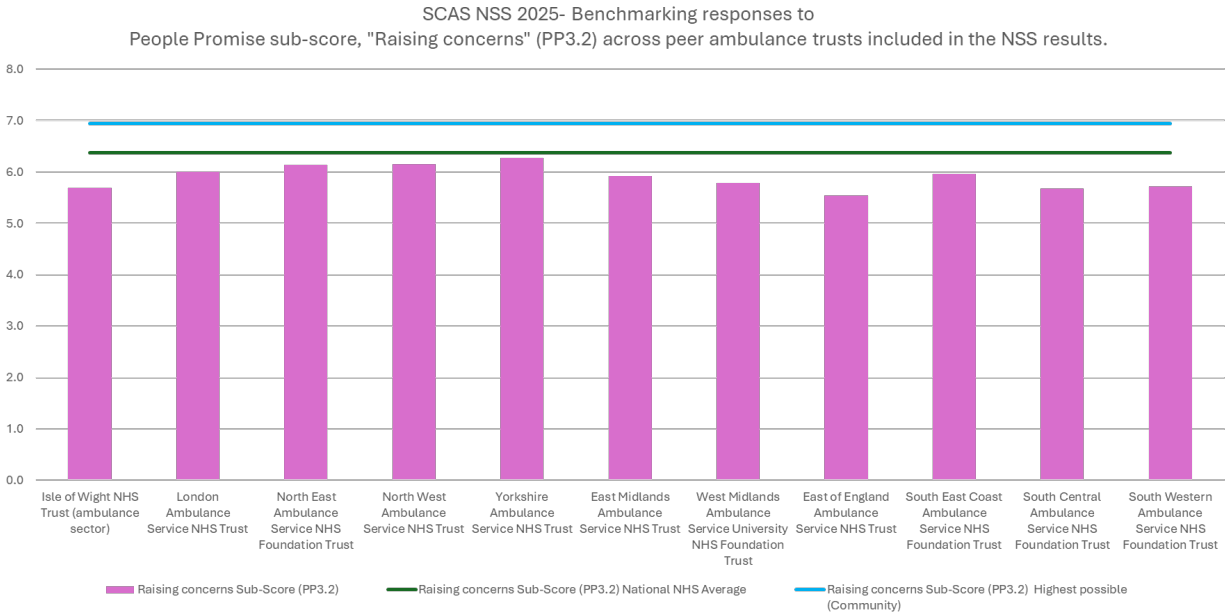
8.3. Benchmarking (see illustrations below) shows SCAS remains broadly stable across speaking up indicators (2023–2025), with only marginal movement. However, there is a modest decline in confidence that concerns will be acted upon;

PP3_2. Raising concerns

		Historical					External	
		2021	2022	2023	2024	2025	Average	Organisation
q20a	Would feel secure raising concerns about unsafe clinical practice	75%	66%	69%	67%	68%	66%	68%
q20b	Would feel confident that organisation would address concerns about unsafe clinical practice	59%	49%	51%	48%	45%	48%	45%
q25e	Feel safe to speak up about anything that concerns me in this organisation	62%	55%	58%	55%	54%	53%	54%
q25f	Feel organisation would address any concerns I raised	46%	39%	44%	37%	35%	38%	35%

8.4. The sector continues to exhibit consistently lower scores; however, it is important that any decline is not regarded as solely system-wide or beyond influence.

8.5. There remains a significant opportunity to align local mitigation strategies with broader sector recovery, thereby reducing the risk of misattributing trends and ensuring that areas we can target intervention, are appropriately addressed.



8.6. Reduced psychological safety presents an ongoing patient safety risk through delayed escalation and resolution.

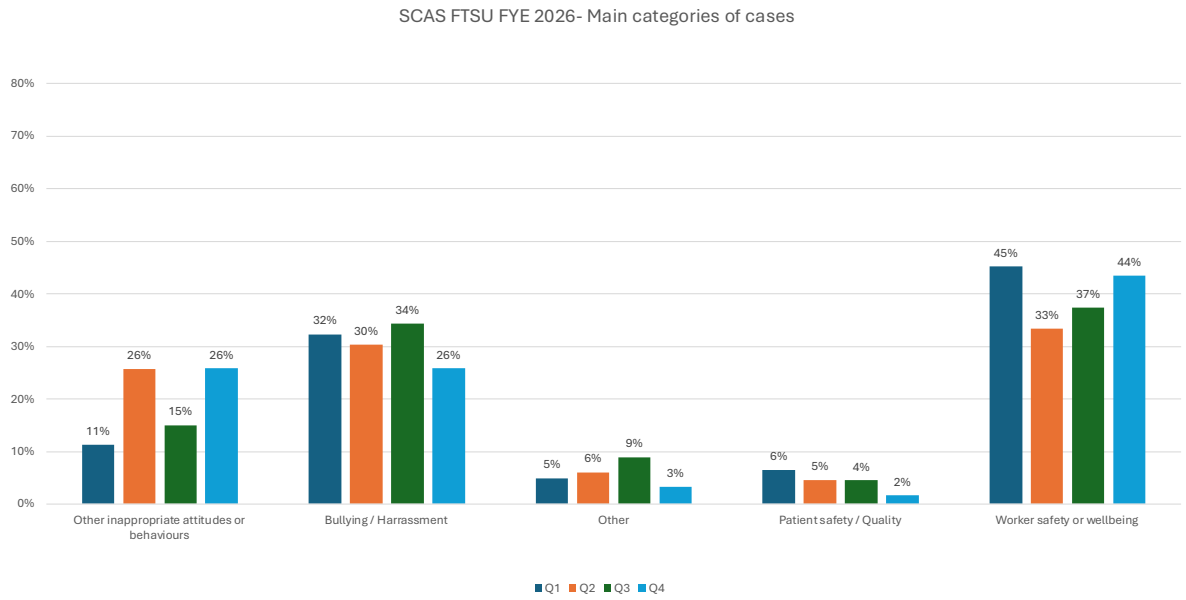
8.7. It is for these reasons that FTSU operates alongside other mechanisms as highlighted in this report.

9. SCAS FTSU Concerns by Category

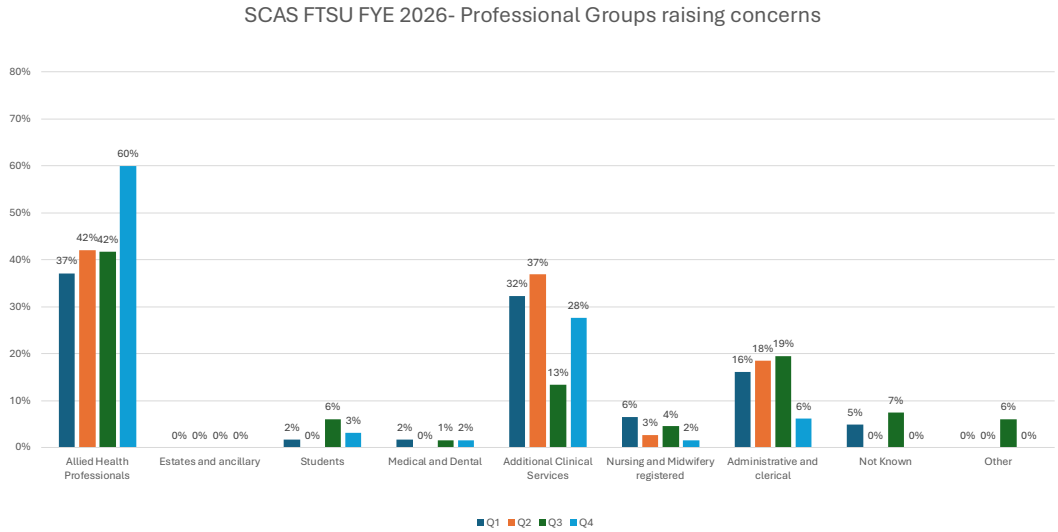
9.1. The most common categories are:

- Worker safety/wellbeing
- Bullying/harassment
- Inappropriate behaviours

9.2. Detailed breakdown of cases can be seen below:



9.3. Reported patient safety concerns appear proportionally lower, **however**, as can be **seen 77% of concerns raised came from people in patient facing roles:**



Leadership

9.4. Increased Board visibility of FTSU has supported organisational engagement.

9.5. Perceived detriment remained a key issue, including concerns about career impact, professional relationships and retaliation. A Q3 deep dive relating to this identified:

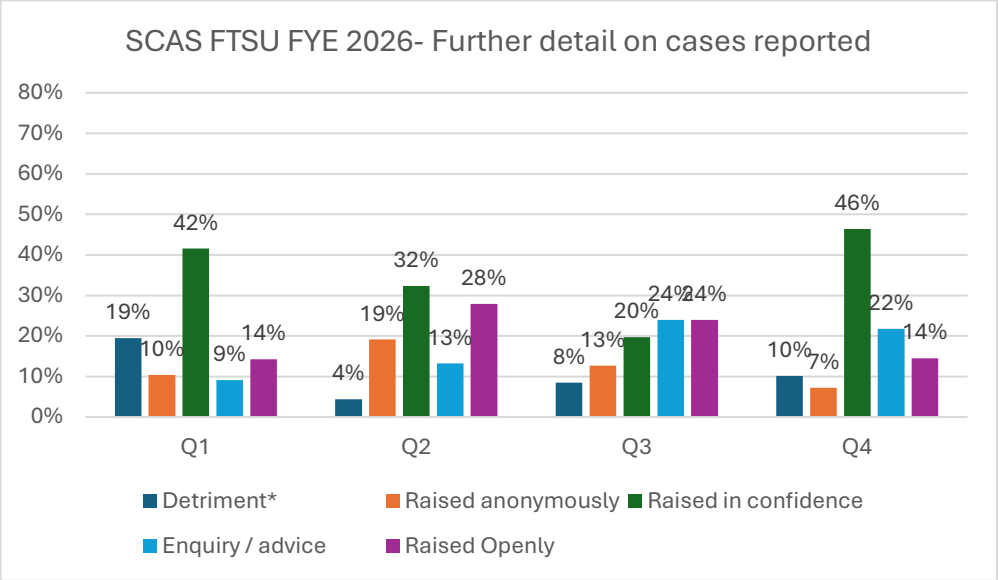
- Entrenched power dynamics discouraging speaking up
- Resistance to challenge
- Marginalisation of individuals raising concerns
- Ongoing fear of detriment
- Reluctance to escalate serious issues

9.6. Detriment may be subtle but has significant impact when perceived. In the context of 2025/26 these themes indicate fear of retaliation and defensive responses can undermine a Just and Learning Culture and discourage future speaking up openly.

9.7. Confidence in organisational response remains critical; anonymous cases have increased, indicating ongoing psychological safety concerns during 2025/26.

23/24	18
24/25	22
25/26	35
Grand Total	75

9.8. Our data for 2025/26 (see below) shows a reduction in anonymous reporting and sustained high advice-seeking, though confidential reporting remains prevalent:



9.9. This data plus limited feedback suggests a number of people are still perceiving the FTSU process as unsafe.

9.10. FTSU intelligence is driving improvement across leadership, culture and workforce initiatives, including training, engagement forums, leadership development, and inclusion programmes.

10. Supporting Leaders and Managers

10.1. FTSU Guardians continue to support leaders to build trust and encourage speaking up. Multiple feedback routes remain in place (NSS, People Pulse, Datix, Patient Safety, Executive engagement etc).

11. Sexual Safety

11.1. Sexual safety cases increased to 41 (2024/25 = 25) *(Included within Bullying & Harassment category)*

11.2. Key actions included:

- Supporting the ongoing trust wide campaign
- Supporting the shift towards a more person centred, trauma informed approach for those involved, supporting colleagues effectively
- Workshops at all levels including Trust Board
- Enhanced staff induction with sexual safety awareness components
- Contributions to training packages and educational material
- Ongoing support to the Association of Ambulance Chief Executives (AACE) National Ambulance Sexual Safety Community of Practice

(NASSCOP) with one of our FTSU Guardian being the national group co-chair
- Supporting our newly formed Sexual Safety Multi-Disciplinary Review Group (SSMDRG) and Assurance Oversight Group

11.3. These efforts underscored the Trust's commitment to creating a safer and more respectful workplace.

12. **FTSU eLearning & Compliance for 2025/26**

12.1. Engagement remained high overall, with **4,762** staff trained (↑ from 4,551).

12.2. However, compliance was **mixed**:
- Speaking Up (All Workers): **99%** ↑
- Managers: **95%** ↓
- Senior Managers: **86%** ↓.

12.3. FTSU eLearning and training is aligned with broader culture and safety programmes (Just Culture, Civility Saves Lives, PSIRF), but declining senior-level / managers compliance **presented a risk to culture leadership**.

13. **Freedom to Speak Up – Key Themes and Learning (2025/26)**

13.1. FTSU intelligence in 2025/26 highlighted ongoing concerns regarding the effectiveness, consistency and perceived fairness of Trust processes.

13.2. While progress was made, these factors continued to influence staff confidence, psychological safety and willingness to speak up.

13.3. **Key themes from concerns raised include:**

- **Communication and feedback**: Staff report limited updates, unclear processes and insufficient feedback on outcomes, contributing to uncertainty and reduced psychological safety.
- **Consistency and fairness**: Variability in the application of policies led to diminished confidence in processes and outcomes.
- **Trust in processes**: Confidence was particularly low where outcomes are not accepted or clearly explained.
- **Perceived conflicts of interest**: Concerns persisted around independence in fact-finding, notably in sexual safety cases.
- **Wellbeing support**: Support is not always experienced as meaningful, with over-reliance on signposting rather than proactive, sustained intervention. Awareness of reasonable adjustments, including neurodiversity, remained variable.

14. **Systemic learning from FTSU intelligence**

14.1. Systematic themes emerging from cases in 2025/26 reflected wider organisational pressures and cultural factors:

- **Capacity and system pressure**: Delays, unclear ownership and resource constraints eroded trust and increased anxiety.
- **Governance and process clarity**: Need for more visible fairness, transparency and user-centred application of policies to reduce escalation and repeat concerns.
- **Leadership and culture**: Day-to-day leadership behaviours remained critical in shaping psychological safety. Leaders who actively invite challenge and model openness strengthened speaking-up culture.
- **Informal resolution and wellbeing**: Early, proactive and sustained support is essential; informal processes must include follow-through and evaluation of outcomes.
- **Confidentiality and professionalism**: Leadership behaviour sets the tone for organisational culture; reflective and accountable practice is key.
- **Workforce changes:** Staff experience organisational change more positively where communication is person-centred, and timelines and ownership are clear.

15. Impact and organisational learning

15.1. FTSU Guardians continue to proactively identify and apply learning from cases, balancing confidentiality with transparency. Learning is shared through Board reporting and internal communications, including anonymised “Follow-Up in Action” updates to demonstrate impact and reinforce learning.

15.2. Examples of improvements included; ***strengthened line management support, greater emphasis on reflective practice, and enhanced understanding of the importance of timely, clearer communication.***

16. Role and value of FTSU

16.1. Early engagement with FTSU supports timely resolution and reduces escalation. FTSU themes continued to act as an early warning system for organisational risk, informing leadership practice, cultural development and continuous improvement across the Trust.

16.2. Overall, FTSU intelligence demonstrated steady progress in embedding transparency, strengthening learning systems, and supporting a more open and responsive organisational culture**.**

17. Other Key FTSU Activities and Developments in 2025/26:

Freedom to Speak Up (FTSU) Week-

17.1. The 2025/26 national FTSU campaign was delivered as a focused week centred on “turning listening into meaningful action”. This built on previous messaging and reinforced the NHS People Promise commitment to ensuring every voice counts.

17.2. Emphasis was placed on effective managerial follow up, recognising its role in driving improvement and strengthening psychological safety.

17.3. The Trust received 90 nominations for the “***Celebrating Excellence: The Power of Meaningful Listening & Feedback***” initiative, demonstrating strong engagement across the organisation.

17.4. Recognition activity supported a culture were speaking up is visibly valued and rewarded**.**

FTSU Seminar-

17.5. The Trust hosted its **inaugural FTSU Seminar**, attended by 29 colleagues (Champions and Leaders), with CEO sponsorship.

17.6. This included a Civility Saves Lives workshop, reinforcing behavioural expectations and respectful cultures.

17.7. Feedback was highly positive, indicating strong appetite for continued leadership development in speaking up culture.

CQC Inspections-

17.8. FTSU was assessed within the *Well-Led* domain in both Emergency and Urgent Care and Emergency Operations Centre inspections and reports.

17.9. The Trust demonstrated **progress since previous inspections**, although the domain remains rated **Requires Improvement**.

17.10. Our FTSU Guardians also contributed directly to the **Trust-wide Well-Led inspection in 2025/26**, supporting organisational assurance.

Speak Up for Patient Safety (SUPS) Cafés-

17.11. A joint initiative with the Patient Safety Team established **SUPS cafés** to strengthen the link between speaking up and safety.

17.12. These forums promote early risk identification, reinforce learning, and support a **preventative safety culture**.

Frontline Engagement-

17.13. The Guardian team maintained a strong visible presence, engaging with **800+ staff** across operational and corporate services.

17.14. Engagement provided assurance of accessible speaking up routes and insight into staff confidence levels.

17.15. Focus areas included civility, behaviours, and peer challenge, with consistent messaging on early escalation and line manager responsibility.

17.16. Learning has directly informed FTSU priorities and Board assurance on **culture and psychological safety**.

System Learning and Secondment-

17.17. An **18-month cross-organisational secondment** strengthened system working and internal capability.

17.18. This was recognised nationally as an **innovative model of collaboration and service continuity**.

17.19. This delivered tangible outputs, including a national **"Speaking, Listening and Following Up" knowledge resource** for ambulance services.

National work / recognition-

17.20. In 2025/26 a member of the FTSU team was acknowledged in the **National Guardian's Office 2024/25 Annual Report**, reflecting external recognition of impact.

National Ambulance Leadership Forum (ALF2026)-

17.21. As host Trust, the SCAS FTSU team led delivery of the collaborative National Ambulance Network (NAN) FTSU Guardian stand.

17.22. This enabled international engagement on speaking up culture, including pledges, shared learning, and cross Trust collaboration.

17.23. Also, this reinforcing FTSU as a visible and integral part of leadership dialogue.

17.24. Working with Ambulance Guardians from; Welsh Ambulance Service University NHS Trust, Southeast Coast Ambulance Service NHS Trust, Northwest Ambulance Service NHS Trust, East Midlands Ambulance Service NHS Trust we collectively helped bring the stand to life in person.

Submitting Articles-

17.25. In 2025/26 our FTSU Guardians submitted articles for case studies as the NGO prepares its final annual report ahead of closure in June 2026.

18. **National Policy and Future Direction from 2025/26**

Dash Review and National Changes-

18.1. The Dash Review (2025) recommended aligning FTSU with wider staff voice functions and embedding accountability within providers and CQC oversight.

18.2. The 10-Year Health Plan confirms integration of National Guardian functions into NHS England, then Department of Health and Social Care (DHSC) structures.

18.3. Despite structural changes, FTSU remains a core cultural and safety priority, with FTSU Guardians continuing to play a critical role.

18.4. AACE continued to reaffirmed sector-wide commitment to embedding speaking up as business as usual.

Temporary Workers, Permanent Voices Review-

18.5. This NGO review published at the end of Q4 2025/26 highlighted the speaking up experience of temporary workers, issuing six national recommendations focused on standards, protection, and inclusion.

18.6. We continue to assess and align local arrangements to ensure compliance and strengthen support for temporary staff.

19. **Key Board Assurance Messages-**

19.1. Speaking-up culture continues to **strengthen through visibility, engagement, and leadership focus**.

19.2. There is **clear alignment with national priorities** and emerging policy direction.

19.3. FTSU is increasingly embedded as a **core component of patient safety, organisational learning, and staff experience**.

19.4. We have made progress, but further work is required to fully meet **CQC Well-Led expectations**, with targeted action underway.

20. **Future plans and developments**

FTSU Dashboard and Insight Development

20.1. We are exploring the introduction of an FTSU dashboard to share non-identifiable data, enabling proactive team conversations and clearer understanding of local themes. This will enhance visibility and reporting of FTSU insights.

20.2. We are grateful to the SCAS PMO and SECAMB colleagues for their support and shared learning. The work aligns with the Trust-wide M365

migration and supports our commitment to transparency, consistency, and a strengthened Listening and Following Up cycle.

Values and behaviours

20.3. Our FTSU Guardians were actively invited into the process, well supported throughout, and able to contribute meaningful input to the development of the organisation's refreshed values and behaviours.

20.4. This is a further example of listening and following up in action.

20.5. From a FTSU perspective our approach was shaped by our cases, NSS data and underpinned by the importance of psychological safety in shaping a positive, Just and open culture

20.6. We will continue to support the roll out in 2026/27

21. Call to Action for All:

21.1. Remain **curious** and support targeted improvements in Speaking, Listening and Following Up, including simplifying systems, modelling fallibility, improving communication, and strengthening leadership.

21.2. **Thank people** who Speak Up; maintain openness when Listening and Following Up; recognise and **celebrate good practice**.

21.3. **Do not tolerate detriment**. Actively protect those who speak up from unfair or demeaning treatment to reduce fear and reinforce safety.

21.4. **Use staff survey data** to build local insight and drive cultural improvement.

21.5. **Promote and complete** national and mandated eLearning.

21.6. **Continue shifting FTSU from a "service" to a core part of everyday leadership**, communication, and team culture; embedding speaking up, listening well, following up, and learning as standard practice across all levels

22. RECOMMENDATIONS

22.1. The Board is asked to receive the annual report from the FTSU Guardians.

SCAS FREEDOM TO SPEAK UP POLICY

Version 5.5

Equality and Health Inequalities Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values.

Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

- Given regard to the need to reduce inequalities between patients with access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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

Contents

DOCUMENT INFORMATION

Author: Simon Holbrook, Lead Freedom to Speak Up Guardian

Ratifying Committee/Group: People & Culture Committee

Date of ratification: July 2026

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Revision date : July 2026

Version: 5.5 (this version updates version 5.4 and updates key roles, CEO introduction and names only)

A MESSAGE FROM STUART REES, INTERIM CHIEF EXECUTIVE OFFICER

The review of this policy comes at an important time for SCAS as we launch our Values and Behaviours Framework. Central to our values is ensuring that every member of Team SCAS feels able to speak up, has their voice heard, and feels safe, respected and empowered to raise concerns when something is not right.

This policy is a cornerstone of our commitment to one another. We recognise that raising concerns can sometimes feel difficult, but it is only by understanding the challenges we face and addressing them openly that we can build a culture of trust, transparency, and continuous improvement.

Speaking up plays a vital role in keeping our patients, our communities and each other safe. We are committed to ensuring that when concerns are raised, they are listened to, taken seriously and responded to appropriately. Just as importantly, we are committed to learning from concerns and making positive changes that help make SCAS an excellent place to work and receive care.

Creating a culture where people feel confident to speak up is everyone's responsibility. Whether you are raising a concern, listening to a colleague, or taking action in response to feedback, each of us has a role to play in supporting an open and inclusive environment.

I encourage you to read this policy carefully and embrace its principles alongside our Values and Behaviours Framework. If you see something that concerns you, or if something does not feel right, please speak up. Your voice matters, and together we can make a difference.

By working together, we can continue to build a culture where everyone feels safe to speak up, confident that they will be heard, and assured that concerns will be addressed fairly and appropriately.

Best Wishes
Stuart Rees
Interim Chief Executive Officer

1. SPEAK UP – WE WILL LISTEN

We welcome speaking up and we will listen. By speaking up at work you will be playing a vital role in helping us to keep improving our services for all patients and the working environment for our staff.

This policy is for all our workers. The NHS People Promise commits to ensuring that "we each have a voice that counts, that we all feel safe and confident to speak up, and take the time to really listen to understand the hopes and fears that lie behind the words".

We want to hear about any concerns you have, whichever part of the organisation you work in. We know some groups in our workforce feel they are seldom heard or are reluctant to speak up. You could be an agency worker, bank worker, locum or student. We also know that workers with disabilities, or from a minority ethnic background or the LGBTQ+ community do not always feel able to speak up.
This policy is for all workers and we want to hear all our workers' concerns.

We ask all our workers to complete the online training on **speaking up**. The online module on **listening up** is specifically for managers to complete, and the module on **following up** is for senior leaders to complete. **Go to https://my.esr.nhs.uk/ then to your Learner Homepage, then select Learning Certifications in the Search section and put 'Freedom' into the search box. Please feel free to complete all the modules if you would like to.**

You can find out more about what Freedom to Speak Up (FTSU) is in these videos

2. THIS POLICY

All NHS organisations and others providing NHS healthcare services in primary and secondary care in England are required to adopt this national policy as a minimum standard to help normalise speaking up for the benefit of patients and workers. Its aim is to ensure that all matters raised are captured and considered appropriately.

3. WHAT CAN I SPEAK UP ABOUT?

You can speak up about anything that gets in the way of patient care or affects your working life. That could be something which doesn't feel right to you: for example, a way of working or a process that isn't being followed; you feel you are being discriminated against; or you feel the behaviour's of others is affecting your wellbeing, or that of your colleagues or patients. Speaking up is about all of these things.

Speaking up, therefore, captures a range of issues, some of which may be appropriate for other existing processes (for example, HR or patient safety/quality) this link will take you to a list of SCAS policy/procedure documents Policies and Procedures As an organisation, we will listen and work with you to identify the most appropriate way of responding to the issue you raise.

4. WE WANT YOU TO FEEL SAFE TO SPEAK UP

You, speaking up to us is a gift because it helps us identify opportunities for improvement that we may not otherwise know about.

We will not tolerate anyone being prevented or deterred from speaking up or being mistreated because they have spoken up. Employees exercising their rights and entitlements under the regulations will suffer no detriment as a result.

5. WHO CAN SPEAK UP?

Anyone who works in NHS healthcare, including pharmacy, optometry and dentistry. This encompasses any healthcare professionals, non-clinical workers, receptionists, directors, managers, contractors, volunteers, students, trainees, junior doctors, locum, bank and agency workers, and former workers.

6. WHO CAN I SPEAK UP TO?

Speaking up internally

Most speaking up happens through conversations with supervisors and line managers where challenges are raised and resolved quickly. We strive for a culture where that is normal, everyday practice and encourage you to explore this option – it may well be the easiest and simplest way of resolving matters.

However, you have other options in terms of who you can speak up to, depending on what feels most appropriate to you.

- Our Freedom to Speak Up Champions who are located throughout the Trust and are there to listen and guide you also. Use this link to find your nearest Champion Freedom To Speak up! - Home

  You can apply to be a Champion by emailing ftsuchampions@scas.nhs.uk

- Senior manager, partner or director with responsibility for the subject matter you are speaking up about.

- The patient safety team or clinical governance team (where concerns relate to patient safety or wider quality) patientsafety@scas.nhs.uk and clinicalgovernanceleads@scas.nhs.uk

- Local counter fraud team (where concerns relate to fraud) Heather.Greenhowe@rsmuk.com

- Our Freedom to Speak Up Guardian's, Rebecca Webb, Christine McParland and Simon Holbrook (Lead Guardian) can support you to speak up if you feel unable to do so by other routes. **Email** : ftsu@scas.nhs.uk The Guardians will ensure that people who speak up are thanked for doing so, that the issues they raise are responded to, and that the person speaking up receives feedback on the actions taken. They will also escalate to the Trust Board any indications that you are being subjected to detriment for raising your concern. You can find out more about the guardian role here.

- Our HR team : Lynn Lane, Interim Deputy Chief People Officer & Assistant Director of HR Operations

- Our Executive Lead responsible for Freedom to Speak Up is Rebecca Murray, Chief Governance Officer - who provides senior support for our speaking-up guardians and is responsible for reviewing the effectiveness of our FTSU arrangements.

- Our non-executive director responsible for Freedom to Speak Up is Ruth Williams this role is specific to organisations with Boards and can provide more independent support for the guardian; provide a fresh pair of eyes to ensure that investigations are conducted with rigor; and help escalate issues, where needed.

Speaking up externally

If you do not want to speak up to someone within our organisation, you can speak up externally to:

- Care Quality Commission (CQC) for quality and safety concerns about the services it regulates – you can find out more about how the CQC handles concerns here.

- NHS England for concerns about:

    - GP surgeries
    - dental practices
    - optometrists
    - pharmacies
    - how NHS trusts and foundation trusts are being run (this includes ambulance trusts and community and mental health trusts)
    - NHS procurement and patient choice
    - the national tariff

NHS England may decide to investigate your concern themselves, ask your employer or another appropriate organisation to investigate (usually with their oversight) and/or use the information you provide to inform their oversight of the relevant organisation. The precise action they take will depend on the nature of your concern and how it relates to their various roles.

Please note that neither the Care Quality Commission nor NHS England can get involved in individual employment matters, such as a concern from an individual about feeling bullied.

NHS Counter Fraud Authority for concerns about fraud and corruption, using their online reporting form or calling their freephone line **0800 028 4060**.

If you would like to speak up about the conduct of a member of staff, you can do this by contacting the relevant professional body such as the General Medical Council, Nursing and Midwifery Council, Health & Care Professions Council, General Dental Council, General Optical Council or General Pharmaceutical Council.

Appendix B contains information about making a 'protected disclosure'.

How should I speak up?

You can speak up to any of the people or organisations listed above in person, by phone or in writing (including email).

Confidentiality

The most important aspect of your speaking up is the information you can provide, not your identity.

You have a choice about how you speak up:

- **Openly:** you are happy that the person you speak up to knows your identity and that they can share this with anyone else involved in responding.

- **Confidentially:** you are happy to reveal your identity to the person you choose to speak up to on the condition that they will not share this without your consent.

- **Anonymously:** you do not want to reveal your identity to anyone. This can make it difficult for others to ask you for further information about the matter and may make it more complicated to act to resolve the issue. It also means that you might not be able to access any extra support you need and receive any feedback on the outcome.

In all circumstances, please be ready to explain as fully as you can the information and circumstances that prompted you to speak up.

7. ADVICE AND SUPPORT

You can find out about the local support within SCAS available to you through our intranet link Health and Wellbeing - Home Your local staff networks also available on the Trusts Hub/Intranet can be a valuable source of support SCAS staff networks

Coaching is also available for all staff in the Trust and is your personal opportunity to explore and achieve your goals with the support of a dedicated coach SCAS Coaching

You can access a range of health and wellbeing support via NHS England:

- Support available for our NHS people.

    - As the NHS England's Speak Up Support Scheme has now closed, the priority is to review and share the learning from the scheme across local Freedom to Speak Up arrangements, helping organisations continue to provide psychologically safe environments for colleagues to speak up. We recognise the importance of support when raising concerns and remain committed to ensuring all NHS colleagues feel safe, heard, and supported. Support continues to be available through local Freedom to Speak Up guardians and employee assistance programmes, and additional wellbeing resources can be found on our website.

      You can also contact the following organisations:

    - Speak Up Direct provides free, independent, confidential advice on the speaking up process.

    - The charity Protect provides confidential and legal advice on speaking up.

    - The Trades Union Congress provides information on how to join

a trade union.

- The Law Society may be able to point you to other sources of advice and support.

- The Advisory, Conciliation and Arbitration Service gives advice and assistance, including on early conciliation regarding employment disputes.

8. WHAT WILL WE DO?

The matter you are speaking up about may be best considered under a specific existing policy/process; for example, our process for dealing with bullying and harassment. If so, we will discuss that with you. If you speak up about something that does not fall into an HR or patient safety incident process, this policy ensures that the matter is still addressed.

What you can expect to happen after speaking up is shown in Appendix C.

Resolution and investigation

We support our managers/supervisors to listen to the issue you raise and take action to resolve it wherever possible. In most cases, it's important that this opportunity is fully explored, which may be with facilitated conversations and/or mediation.

Where an investigation is needed, this will be objective and conducted by someone who is suitably independent (this might be someone outside your organisation or from a different part of the organisation) and trained in investigations. It will reach a conclusion within a reasonable timescale (which we will notify you of), and a report will be produced that identifies any issues to prevent problems recurring.

Any employment issues that have implications for you/your capability or conduct identified during the investigation will be considered separately.

Communicating with you

We will treat you with respect at all times and will thank you for speaking up. We will discuss the issues with you to ensure we understand exactly what you are worried about. If we decide to investigate, we will tell you how long we expect the investigation to take and agree with you how to keep you up to date with its progress. Wherever possible, we will share the full investigation report with you (while respecting the confidentiality of others and recognising that some matters may be strictly confidential; as such it may be that we cannot even share the outcome with you).

How we learn from your speaking up

We want speaking up to improve the services we provide for patients and the environment our staff work in. Where it identifies improvements that can be made,

we will ensure necessary changes are made, and are working effectively. Lessons will be shared with teams across the organisation, or more widely, as appropriate.

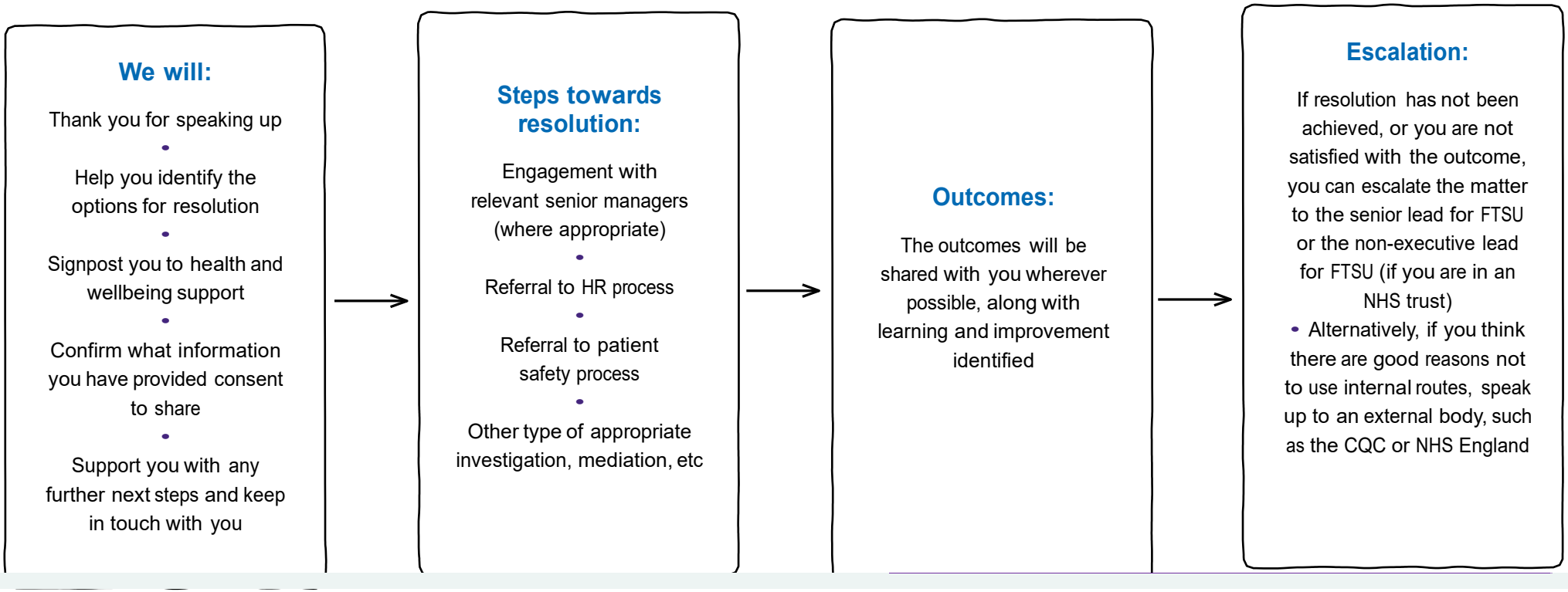
Review

We will seek feedback from workers about their experience of speaking up. We will review the effectiveness of this policy and our local process annually, with the outcome published and changes made as appropriate.

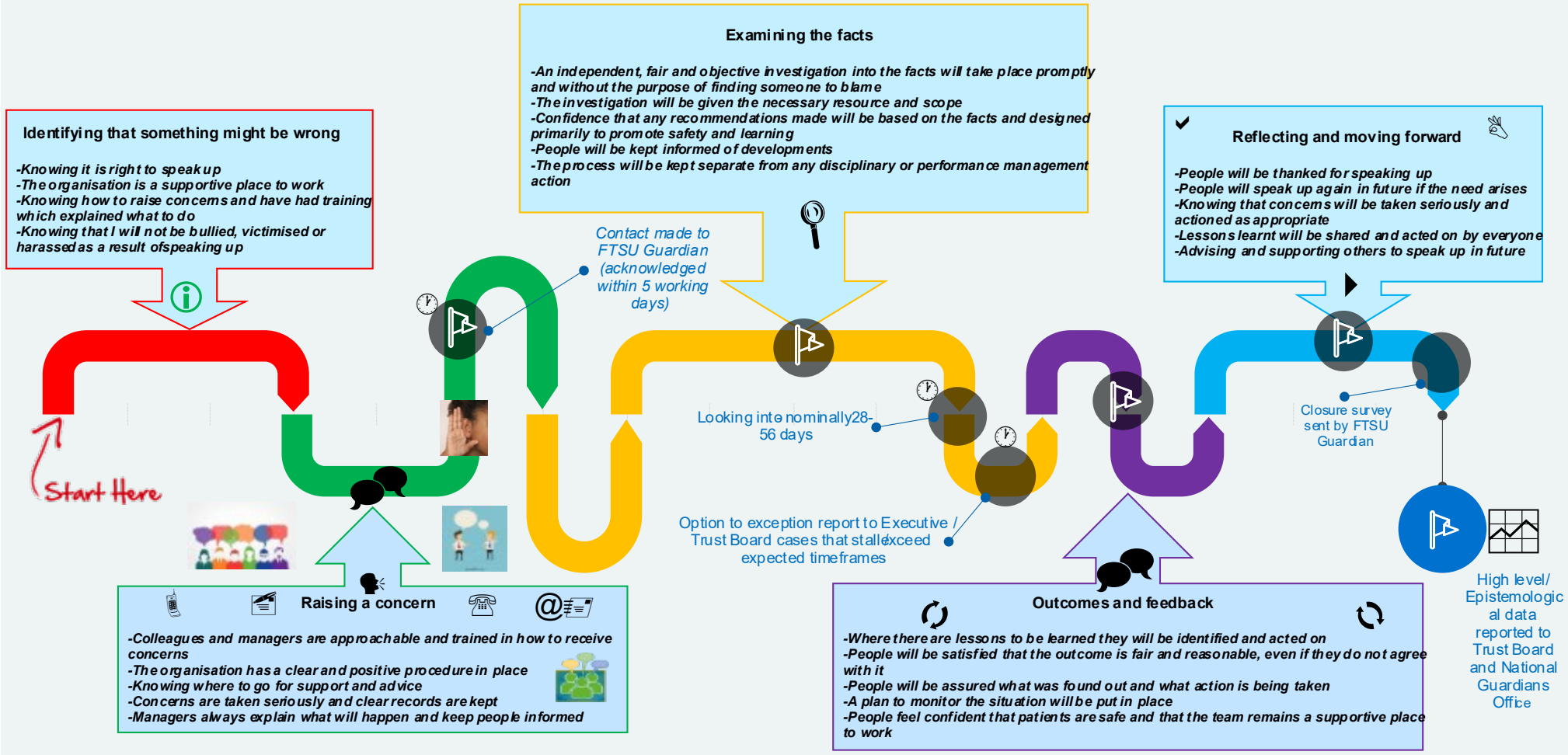
Senior leaders' oversight

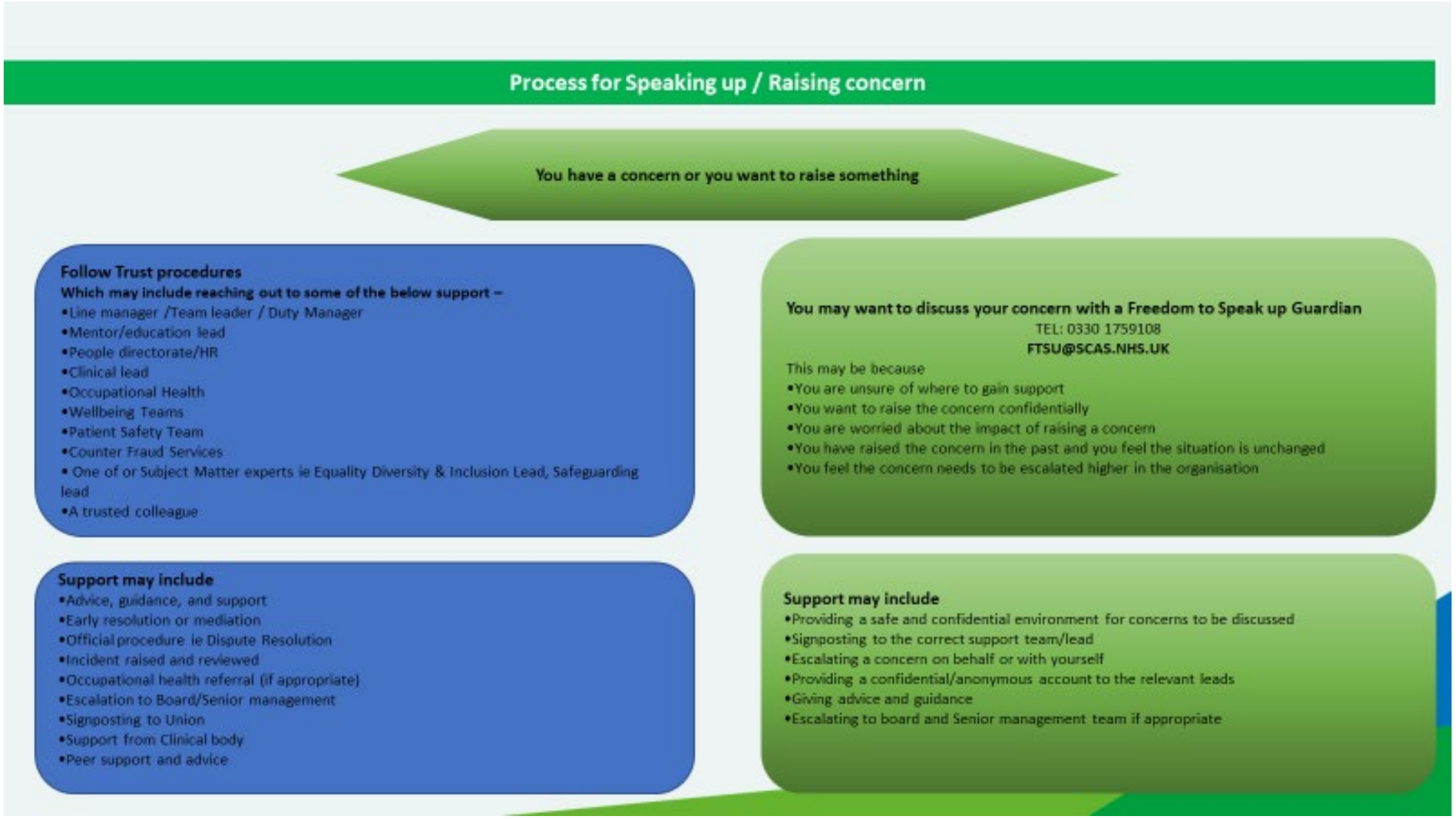
Our most senior leaders will receive a report at least annually providing a thematic overview of speaking up by our staff to our FTSU guardian(s).

APPENDIX A: WHAT WILL HAPPEN WHEN I SPEAK UP?



The roadmap for people raising and listening to a FTSU concern in SCAS




Process for Speaking up / Raising concern
You have a concern or you want to raise something
Follow Trust procedures
Which may include reaching out to some of the below support –
•Line manager /Team leader / Duty Manager
•Mentor/education lead
•People directorate/HR
•Clinical lead
•Occupational Health
•Wellbeing Teams
•Patient Safety Team
•Counter Fraud Services
• One of or Subject Matter experts ie Equality Diversity & Inclusion Lead, Safeguarding lead
•A trusted colleague
You may want to discuss your concern with a Freedom to Speak up Guardian
TEL: 0330 1759108
FTSU@SCAS.NHS.UK
This may be because
•You are unsure of where to gain support
•You want to raise the concern confidentially
•You are worried about the impact of raising a concern
•You have raised the concern in the past and you feel the situation is unchanged
•You feel the concern needs to be escalated higher in the organisation
Support may include
•Advice, guidance, and support
•Early resolution or mediation
•Official procedure ie Dispute Resolution
•Incident raised and reviewed
•Occupational health referral (if appropriate)
•Escalation to Board/Senior management
•Signposting to Union
•Support from Clinical body
•Peer support and advice
Support may include
•Providing a safe and confidential environment for concerns to be discussed
•Signposting to the correct support team/lead
•Escalating a concern on behalf or with yourself
•Providing a confidential/anonymous account to the relevant leads
•Giving advice and guidance
•Escalating to board and Senior management team if appropriate

APPENDIX B: MAKING A PROTECTED DISCLOSURE

Making a 'protected disclosure'

A protected disclosure is defined in the Public Interest Disclosure Act 1998. This legislation allows certain categories of worker to lodge a claim for compensation with an employment tribunal if they suffer as a result of speaking up. The legislation is complex and to qualify for protection under it, very specific criteria must be met in relation to who is speaking up, about what and to whom. To help you consider whether you might meet these criteria, please seek independent advice from the Protect or a legal representative.

APPENDIX C: MANAGERS GUIDANCE

FREEDOM TO SPEAK UP MANAGERS / LEADERS CASE TEMPLATE

This template is intended to support the response to colleagues speaking up via Freedom to Speak Up Guardian (FTSUG) by:

- ✓ Capturing all the essential details of the matter the individual(s) want to raise
- ✓ Providing prompts and a checklist framework to note and record actions
- ✓ Allowing us to collate and celebrate lessons learned as a result of speaking, listening and following up
- ✓ We encourage you to contact the person who has raised the issue to encourage listening up, and following up., providing them with an acknowledgement that they are being listened to, and feedback.
- ✓ ***6 Coaching Questions*** are available to aid you in your meeting if required, please contact us to share them with you
- ✓ Demonstrating we foster a Speaking, Listening and Following up culture*

The table below gives the timescales by which the template needs to be returned. The priority level for this concern has been highlighted

Level	Category	Examples	Return feedback / lessons learned (p.3&4) within…
1	Immediate **Please confirm immediate contact**	• Immediate safety / safeguarding issue • Physical or verbal abuse • Potential criminal offence	28 days
2	Urgent	• Quality of care/service • Patient safety • Staff safety	28 days
3	Standard	• Culture of bullying • Fraud **(if not passed to counter fraud)** • Adherence to policy / procedure • All other concerns	56 days

	FTSU CASE TEMPLATE (completed by FTSU Team)	
	DETAILS OF MATTERS RAISED	
FTSU Case Reference		**Date sent:**
FTSU Guardian		
Service / Department Concern relates to :		
Line Manager / Leader responsible for review/responding		
Detail of concern provided		
The Concern is relating to :	***Something that has / did go wrong*** ***Something that might go wrong*** ***Something that is good but could be better***	
Have they spoken to their Line Manager	**Yes** What led them to coming to FTSU ? **No** What barriers are there ?	
What is their perception of speaking up ? **How do they feel ?**		

<table>
<tr><td>Desired action and resolution</td><td></td></tr>
<tr><td>The level of confidentiality agreed is…</td><td>
<table>
<tr><td>Open</td><td>Happy for their identity to be known to the FTSU Team and the Manager reviewing/responding and resolving the matter</td></tr>
<tr><td>Confidential</td><td>Identity only known to FTSU Team</td></tr>
<tr><td>Anonymous</td><td>Identity not known to FTSU Team</td></tr>
</table>
</td></tr>
<tr><td>Contact details of individual(s) (if consent given):</td><td>Please directly acknowledge receipt of the concern with the person who has raised it. We advise that arranging to have a conversation with the person helps to reduce mis-understandings, and in the majority of cases helps to resolve their concern quickly.</td></tr>
</table>

ACTION PLAN (to be completed by manager)

A FTSU concern is an opportunity for the Senior Lead/Line Manager to review the issues with curiosity;

We take the concerns raised at face value and do ask the concernee if they have approached their Line Manager. We would recommend that if the person has shared their name, that you take the opportunity to have a chat with them to understand the detail behind the brief outline we have given here, and to have a non-judgemental and open approach. Please be mindful of this before forwarding on the template to a member of your team to review.

Immediate actions taken: *(Essential for priority 1 / immediate concerns – patient/staff safety)*	
Protections agreed with the individual: *(Essential if individual has reported or is concerned about negative treatment as a result of speaking up)*	
What actions do you plan to take ? *(E.g. Informal conversation, mediation, desk top review, investigation, appreciative enquiry, cultural review, Just & Learning decision tree, Detailed Clinical Incident Report (DCI) etc)*	

Please email the completed form to the FTSU Team via ftsu@scas.nhs.uk

FEEDBACK / LESSONS LEARNED

FTSU can make a significant contribution to our learning by identifying the themes, lessons learnt and changes to working practice from staff speaking up. To support the focus on quality and drive for continuous improvement please can you give an outline of any lessons learnt as a result of staff speaking up?

The information you give in this section is for understanding and learning, it will not be assessed in any way and will be completely anonymised.

Please complete the sections below and return to the Freedom to Speak Up Guardian

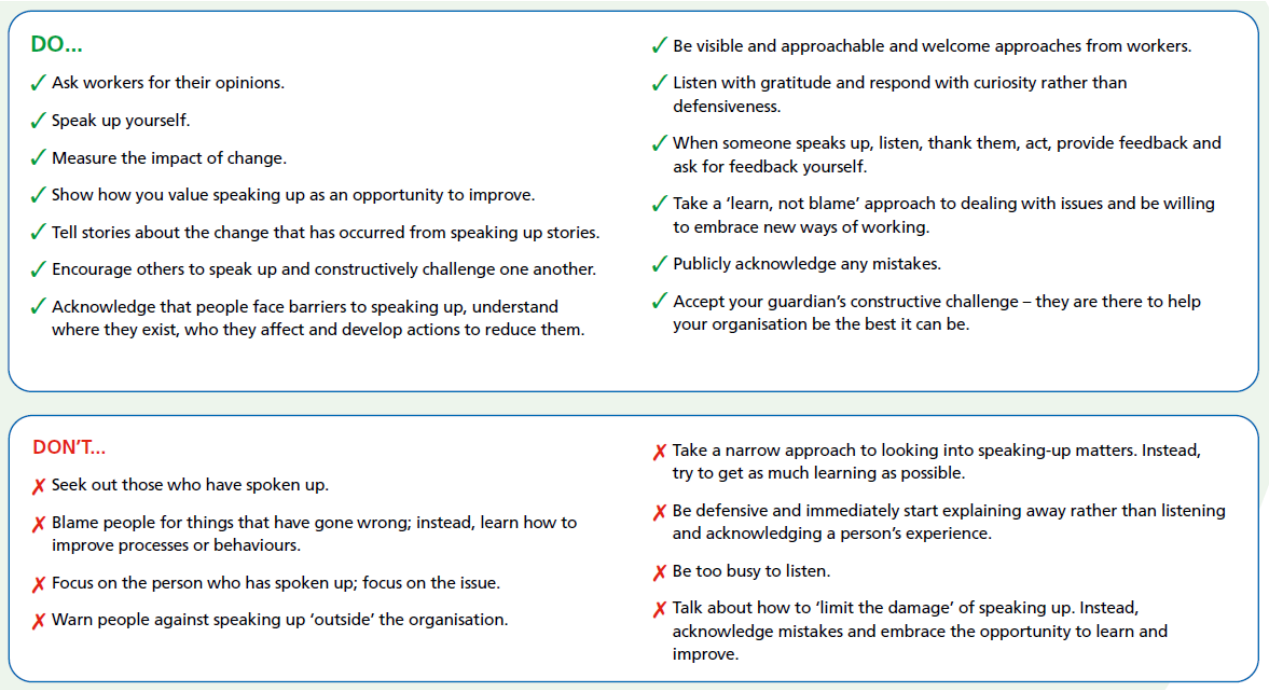
What changes have been made as a result?	
What lessons have been learnt?	
How will you ensure learning is embedded and shared?	
What learning is transferable across the organisation and how will you share this?	
What information will be fed back to the person speaking up?	
Is there any feedback that you would like to give the FTSU Team, either for reflection or for wider learning?	

*Speak Up & Listen Up eLearning is available:➢Go to “My ESR”, ➢Go to “learner Homepage”,

➢Search course: 000 Speak Up - **Core training for all workers**, ➢Once completed you can search course: 000 Listen Up - Training for all Managers, ➢Once completed you can search for the final course: 000 Follow Up - For Senior Managers

Please email the completed form to the FTSUGs via ftsu@scas.nhs.uk

Speaking-up behaviours for leaders: do's and don'ts



DO...

- ✓ Ask workers for their opinions.
- ✓ Speak up yourself.
- ✓ Measure the impact of change.
- ✓ Show how you value speaking up as an opportunity to improve.
- ✓ Tell stories about the change that has occurred from speaking up stories.
- ✓ Encourage others to speak up and constructively challenge one another.
- ✓ Acknowledge that people face barriers to speaking up, understand where they exist, who they affect and develop actions to reduce them.
- ✓ Be visible and approachable and welcome approaches from workers.
- ✓ Listen with gratitude and respond with curiosity rather than defensiveness.
- ✓ When someone speaks up, listen, thank them, act, provide feedback and ask for feedback yourself.
- ✓ Take a 'learn, not blame' approach to dealing with issues and be willing to embrace new ways of working.
- ✓ Publicly acknowledge any mistakes.
- ✓ Accept your guardian's constructive challenge – they are there to help your organisation be the best it can be.

DON'T...

- ✗ Seek out those who have spoken up.
- ✗ Blame people for things that have gone wrong; instead, learn how to improve processes or behaviours.
- ✗ Focus on the person who has spoken up; focus on the issue.
- ✗ Warn people against speaking up 'outside' the organisation.
- ✗ Take a narrow approach to looking into speaking-up matters. Instead, try to get as much learning as possible.
- ✗ Be defensive and immediately start explaining away rather than listening and acknowledging a person's experience.
- ✗ Be too busy to listen.
- ✗ Talk about how to 'limit the damage' of speaking up. Instead, acknowledge mistakes and embrace the opportunity to learn and improve.

(NHSE & NGO (2022)) Guidance for leaders, Principle 2: Role-model speaking up and set a healthy Freedom to Speak Up culture.

APPENDIX D: DETRIMENT

Responding to experiences of disadvantageous or demeaning treatment as a result of speaking up

A Best Practice Guide developed by representatives in the Freedom to Speak Up Regional Networks

Introduction

Speaking up is a gift – an opportunity for us to engage with colleagues. A chance to hear different ideas and suggestions, enhance worker experience, prevent patient harm, and learn and improve when things don't go to plan or could be better.

One of the biggest barriers to speaking up is a fear of reprisals. Over 600 healthcare colleagues who spoke up in 2020/21, believed they experienced some form of disadvantageous and/or demeaning treatment as a result.

The impact for individuals can be devastating and long-lasting. Our health and wellbeing suffer, and these experiences often lead to sickness absence and resignation. We cannot work at our best when our environment feels psychologically unsafe and this impacts on communication, effective teamwork, and safe patient care. It is important that we hear as soon as possible if someone believes they, or others, are in that position so we can work to resolve the situation.

In our networks, Freedom to Speak Up (FTSU) Guardians have come together to develop this best practice guide to help us respond consistently when colleagues tell us about these experiences. Healthcare organisations are welcome to use this guide to support their own Freedom to Speak Up policy and process.

We call on the support of all healthcare workers to make it as safe as possible for us all to speak, listen and follow up by living our organisational values, treating each other with civility and respect, and creating a safe, just culture where listening and learning happens every day.

Guiding Principles

- We can expect to be thanked and treated with dignity and respect when we speak up
- We expect all colleagues to create a psychologically safe environment where speaking up is business as usual
- We won't tolerate mistreatment or poor behaviour towards colleagues who speak up
- We appreciate speaking up can affect people in different ways and will do all we can to support everyone involved fairly and with compassion
- Our focus will be on learning and improving
- We encourage colleagues to report any concerns about disadvantageous and/or demeaning treatment
- We will refer all concerns about disadvantageous and/or demeaning treatment to the NED lead, Chief Executive Officer / Executive Lead for Freedom to Speak Up /or other nominated Board member
- We will follow our Freedom to Speak Up process to ensure any such concerns are fully explored and any necessary steps taken
- We will keep colleagues informed and updated throughout the process

What we mean by disadvantageous /demeaning treatment

This guide refers to treatment as a result of the act of speaking up, rather than the specifics of the matter raised by speaking up. It can be a deliberate act or a failure to act /omission. Sometimes these actions can be subtle and not always easy to recognise. Whilst behaviours might not be intentional, the impact can still be significant if a person believes they are being treated poorly or differently.

Such treatment may include: (these are examples and not limited to)

- experiencing poor behaviours not in line with our organisational values e.g., being ostracised, gaslighting, gossiping, incivility Vision, values and behaviours
- given unfavourable shifts; repeated denial of overtime/bank shifts; being denied shifts in a certain area/department without good reason; changes to shifts at short notice with no apparent reason
- repeatedly denied annual leave; failure on a regular basis to approve in reasonable time; or leave cancelled without good reason
- micro-managing; excessive scrutiny
- sudden and unexplained changes to work responsibilities, or not being given adequate support
- being moved from a team or inexplicable management of change
- being denied access to development opportunities; training or study leave without good reason
- being overlooked for promotion
- Being dismissed, a contract not being renewed or being made redundant
- Receiving a negative performance appraisal or disciplinary action
- Being moved to less-desirable duties or locations, or being demoted or suspended
- Being denied the information or resources to do the job properly
- Being overlooked or denied accesses to promotion or training
- Being criticised for speaking up
- Being refused support to manage the stress associated with speaking up
- Being bullied, excluded or treated negatively
- Being perceived as a troublemaker

Responsibilities

We appreciate that speaking up can at times, feel challenging, particularly when we are involved in the issues that are being raised. However, we rely on each other to do the right thing and we all share a responsibility to speak up when we see something that doesn't feel right. By working together and supporting everyone affected by speaking up, we can prevent colleagues experiencing poor treatment.

As individuals we share a responsibility to:

- create a psychologically safe environment where speaking, listening and following up is business as usual
- treat our colleagues well when they speak up
- speak up and be an ally when we witness disadvantageous and/or demeaning treatment
- listen up and learn from speaking up

As an organisation we have a responsibility to:

- protect workers who speak up from disadvantageous / demeaning treatment
- ensure the working environment is a safe one
- respond to concerns of disadvantageous / demeaning treatment by examining the facts, reviewing outcomes, providing feedback, and reflecting and learning
- When it does occur, it is important that you act – and are seen to act
- to communicate that detriment will not be tolerated
- ensure ideally, a senior speaking-up lead, such as the non-executive director (NED), should have sight of any grievances that involve allegations of detriment.

Recording

- Reports of disadvantageous/demeaning treatment will be recorded by the Freedom to Speak Up Guardian on the central speak up database.
- Information will be kept strictly confidential, only shared on a need-to-know basis.
- Freedom to Speak Up Guardians are required to report speak up activity on a quarterly basis to the National Guardian's Office. The number of people sharing concerns relating to perceived disadvantageous/demeaning treatment as a result of speaking up is included in this data.

What to do

Route 1 .
I /my colleague spoke up and now I believe *I am/my colleague is* experiencing disadvantageous or demeaning treatment as a result.

Speak to a manager or the Freedom to Speak Up Guardian as soon as possible
(or see FTSU policy for other options of who to speak to)

- Your concern will be taken seriously
- You will be supported whilst your concern is reviewed
- You will be kept informed and provided with feedback
- You will be signposted to wellbeing support if needed
- the matter should be looked into by their manager or someone more independent, or through your formal grievance procedure

Route 2
A colleague reports (or thinks they are seeing) disadvantageous or demeaning treatment after speaking up to a manager or the Freedom to Speak Up (FTSU) Guardian

Manager to inform FTSU Guardian

Issue reported to FTSU Guardian

- Clarify matters of confidentiality, what information will be shared and with whom
- FTSU Guardian will undertake a (Protect) risk assessment
- FTSU Guardian will record on the central FTSU database

Within 72 hours
or immediately if significant risks identified

FTSU to inform the Non-executive lead *Chief executive officer/ executive lead for speaking up /other
*(*delete/amend as appropriate)*

- Consider if any immediate action is required to protect the worker from disadvantageous or demeaning treatment. *(particularly important in the case of perceived bullying and/or harassment)*
- Consider any potential patient safety issues and immediate action required
- Receive assurance line management arrangements are in place to support anyone who might be affected
- With consent
-

Follow your organisations speak up process

In line with Speak Up Process:

- Clarify matters of confidentiality
- Not guradian Tor set by those investigating
  Agree how and what to be explored (terms of reference), and timescales for completion
- Identify independent lead for any review/investigation
- Agree arrangements for monitoring and feedback
- Share and record key actions, outcomes, learning and recommendations.
- Share wider learning across the organisation
- consider signposting the worker to NHS England's Speaking Up Support Scheme

If investigation reveals any unresolved issues relating to individual performance or conduct, consult with human resources colleagues according to local policies/process.

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2026 – 2027 Board Assurance Framework – Partnerships and Sustainability

August 2026

Strategic Risk Heat Map

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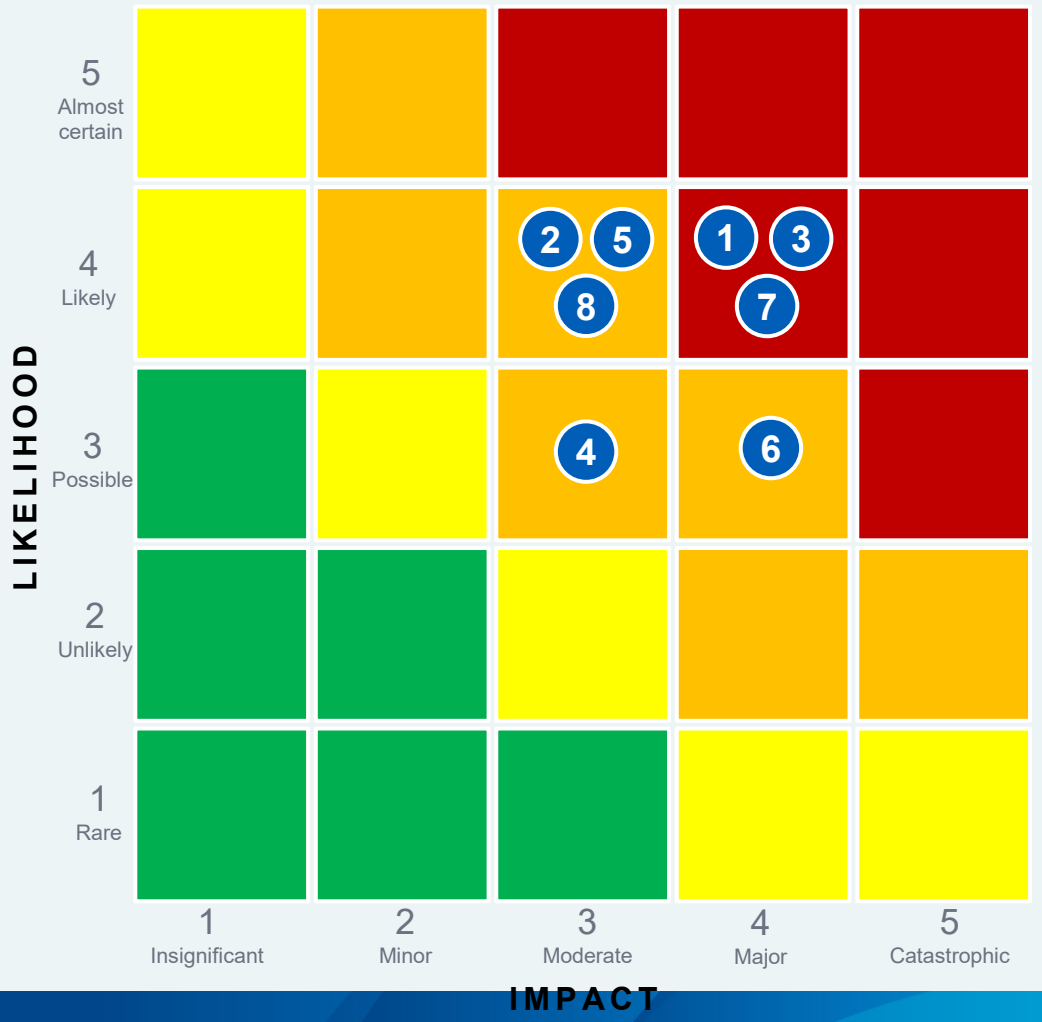
RISK MATRIX



	RISK KEY & NAME	SCORE	OWNER	MOVEMENT
1	Quality Performance and Patient Outcome	16	Executive Director of Operations	⟺
2	Digitisation	12	Chief Digital Officer	⟺
3	Cyber Security and Operational Resilience	16	Chief Digital Officer	⟺
4	Fleet Improvement	9	Chief Finance Officer	⟺
5	Estates Modernisation	12	Chief Finance Officer	⟺
6	Staff Engagement	12	Chief People Officer	⟺
7	Sustainability	16	Chief Finance Officer	⟺
8	Collaboration	12	Chief Finance Officer	⟺

Reviewed by Trust Board · Q2 2026/27 · Next review: September 2026

SR7

STRATEGIC 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.

South Central Ambulance Service
NHS Foundation Trust

Risk owner
Chief Finance Officer

Assurance Committee
Finance & Performance Committee

Current risk score
I (4) × L (4) = 16

Target risk score
I (3) × L (3) = 9

Related risks
- **13** – Financial Risk
- **388** – Financial Impact Risk
- **425** – Financial Cost Saving Plans

CONTROLS IN PLACE

✓	1. Annual and Multi-Year Financial Planning Framework
✓	2. Financial Governance and Performance Oversight
✓	3. Cost Improvement Programme (CIP) Governance and Delivery
✓	4. Capital, Estates and Net Zero Investment Planning
✓	5. System Partnership and External Funding Risk Management

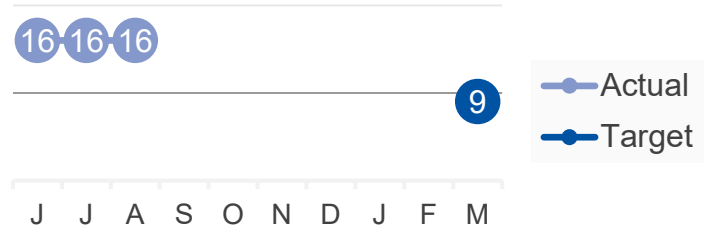
MITIGATING ACTIONS DEADLINE

✓	1. Financial Sustainability and Recovery Programme with weekly oversight	Q2 2026
✓	2. Three-year integrated financial, workforce and operational plan	Q3 2026
✓	3. Identify recurrent CIPs through service redesign, productivity improvements, and collaboration with Group partners	Q3 2026
✓	4. Establish a strategic funding and investment strategy for fleet, estates, digital and net zero	Q4 2026
✓	5. Strengthen commissioner and system engagement arrangements	Q4 2026

PROGRESS UPDATE

- The Trust has delivered the financial plan as at M4 with all CIPs identified
- Adverse forecast position reflects significant underlying risks relating to slippage on CIP and additional cost pressures, including the recovery of Cat 2 performance.
- Higher level of non-recurrent CIP to be addressed.

RISK MOVEMENT



Risk movement since last BAF: **Static** · Last reviewed: **August 2026** · Next review: **September 2026**

SR7

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Related risks
- **13** – Financial Risk
- **388** – Financial Impact Risk
- **425** – Financial Cost Saving Plans

POSITIVE ASSURANCE

- ✓ 1. Board-approved Medium-Term Financial Plan and Five-Year Integrated Delivery Plan
- ✓ 2. Regular Financial Performance Oversight
- ✓ 3. Established Cost Improvement Programme (CIP) Governance
- ✓ 4. Strong Liquidity and Cash Management
- ✓ 5. Net Zero and Infrastructure Monitoring

NEGATIVE ASSURANCE

- ✓ 1. Reliance on High-Risk and Non-Recurrent Savings
- ✓ 2. Growing Cost Pressures Outpacing Funding Growth
- ✓ 3. Forecast Financial Deficit and Emerging Service Pressures
- ✓ 4. Dependence on External Funding and Commissioner Decisions
- ✓ 5. Limited Headroom for Further Efficiency Gains

ASSURANCE SUMMARY

The Trust has robust financial planning, governance, cash management and sustainability reporting arrangements that provide assurance over financial resilience. However, continued reliance on high-risk savings, increasing operational cost pressures, external funding uncertainty and limited efficiency headroom present significant risks to long-term financial sustainability and investment capacity

Risk movement since last BAF: **Static** · Last reviewed: **August 2026** · Next review: **September 2026**

SR8

STRATEGIC RISKS | 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.

NHS South Central Ambulance Service NHS Foundation Trust

Risk owner	Assurance Committee	Current risk score	Target risk score	Related risks
Chief Finance Officer	**Finance & Performance Committee**	**I (4) × L (3) = 12**	**I (4) × L (2) = 8**	• **None**

CONTROLS IN PLACE

- ✓ Formal SCAS-SECAmb Memorandum of Understanding established
- ✓ Executive Committee in Common operating with formal decision-making arrangements
- ✓ Work on Joint Decision-Making Principles providing clarity on accountability, and collective decision-making
- ✓ Clinical Group Steering Committee established
- ✓ Formal Programme Board oversight for CAD/ePCR and wider collaboration programmes

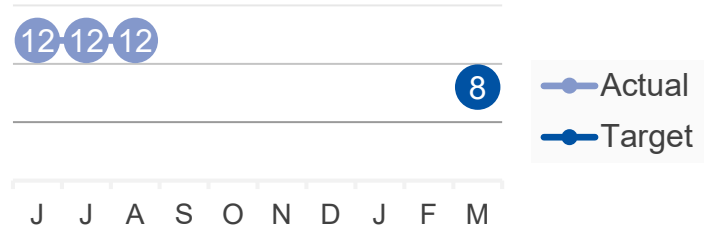
MITIGATING ACTIONS — DEADLINE

✓	Finalise and approve Joint Decision-Making Principles	Q3 2026
✓	Develop and approve Group Integration Plan	Q3 2026
✓	Align South East commissioning and funding models	Q4 2026
✓	Establish collaboration benefits realisation framework with measurable KPIs	Q4 2026
✓	Complete financial scenario modelling and funding strategy for CAD programme	Q3 2026

PROGRESS UPDATE

- Collaboration arrangements continue to mature supported by a formal MoU, joint governance structures, interim leadership arrangements and multiple shared programmes
- CAD, clinical pathways and commissioning development progressing

RISK MOVEMENT



Risk movement since last BAF: **Static** · Last reviewed: **August 2026** · Next review: **September 2026**

SR8

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NHS
South Central Ambulance Service
NHS Foundation Trust

Risk owner	Assurance Committee	Current risk score	Target risk score	Related risks
Chief Finance Officer	**Finance & Performance Committee**	**I (4) × L (3) = 12**	**I (4) × L (2) = 8**	• **None**

POSITIVE ASSURANCE

- ✓ Savings identified and delivered through collaboration initiatives
- ✓ Joint governance framework further developed through Integration Committee, Programme Board and Executive Committee in Common
- ✓ Interim Group leadership appointments progressing
- ✓ Active work underway on shared workforce management capability and strategy
- ✓ Strategic plans embedded within Trust improvement programme

NEGATIVE ASSURANCE

- ✓ Funding and commissioning models remain misaligned
- ✓ Collaboration dependent upon uncertain non-recurrent funding
- ✓ Cultural and operational differences slowing integration
- ✓ Collaboration savings not yet released for reinvestment
- ✓ No joint risk register or benefits framework established

ASSURANCE SUMMARY

Moderate assurance. Strong governance, leadership commitment and active joint programmes demonstrate positive progress towards collaboration objectives. However, unresolved funding disparities, incomplete benefits realisation arrangements and the absence of fully developed shared risk management mechanisms continue to constrain overall assurance.

The clinical operating model programme is progressing to plan ad the CAD outline business case has been approved with the development of the full business case underway.

Risk movement since last BAF: **Static** · Last reviewed: **August 2026** · Next review: **September 2026**

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Upward Report of the Audit Committee

Date Meeting met **25th June 2026**
Chair of Meeting **Mike McEnaney, Non-Executive Director**
Reporting to **Trust Board**

Items	Issue	Owner	Action
Points for escalation			
Annual Accounts 2025/26	The external auditors issued an unqualified opinion on the Annual Accounts; Audit Committee approved these for submission following delegation of authority to do so from the Board as agreed at the June Board meeting. Of the recommendations for improvement made, it was noted that the implementation of the new Finance Ledger would address these and external auditors were aware of the limitations of the current system. The Annual Accounts for 2025/26 were submitted in accordance with the 27th June deadline.	N/A	N/A
Annual Report 2025/26	A final draft of the Annual Report was received; it was noted that external audit was awaiting some information at the time of the meeting and it was agreed that the Audit Chair would approve the updated version as the final version when this had been provided.	N/A	N/A
Key issues and / or Business matters to raise			
None			

Areas of concern and / or Risks			
None			
Items for information and / or awareness			
Best Practice and / or Excellence			
Accounts Process	Auditors noted continued improvement in the management of the audit and timely provision of information/preparation of the Annual Report. Thanks were offered to the teams for the work they had undertaken.	N/A	N/A
Policies for approval			
N/A			

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TRUST BOARD OF DIRECTORS MEETING IN PUBLIC
3 September 2026

Title	**Provider Capability Assessment 2026/27**
Report Author	**Becky Murray, Chief Governance Officer**
Executive Owner	**Becky Murray, Chief Governance Officer**
Agenda Item	**23**
Governance Pathway: Previous	Executive Management Committee 4th August 2026
Governance Pathway Next Steps	None – report is for Board assurance

1. Purpose

To advise the Board on the requirements and process for undertaking the NHS England (NHSE) Provider Capability Assessment for 2026/27.

2. Executive Summary

As part of NHSE's oversight mechanisms, Boards are required to undertake a self-assessment against the six domains in the Insightful Board, as was the case in 2025/26 when the requirement was first introduced. The Provider capability rating, together with performance against the NHS Oversight Framework metrics determines the provider's segmentation, which in turn influences the approach that NHSE takes to oversight and any decisions around support requirements.

The guidance has been updated and the previous requirement to declare full/partial/non-compliance against each of the domains has been replaced with a modified red/amber/green (RAG) rating system. Providers are also no longer required to provide an overall capability rating as was the case last year; the overall rating that the provider will receive will be determined via the regional and national moderation process based on self-assessment and intelligence derived from stakeholders.

It has also been confirmed that NHSE's judgement on the provider's capability will not be linked to metrics alone; the level of confidence that the regional team has in the provider's ability to identify and address issues and demonstrate improvement over time will also influence the rating. This reflects recognition that there are inherent, long-standing issues that exist within providers, which materially impact operational, financial or quality performance.

The full requirements are set out in the guidance, and it is proposed that the same process as was undertaken last year is adopted, whereby each board member was asked to provide a rating against each of the statements set out within the six domains. This process allows for a properly considered, holistic submission to be made, and the output can be used to inform board development needs over the coming year.

The submission date for the Board Approved self-assessment is 2nd October 2026, which is prior to the scheduled October Board meeting. However, arrangements will be put into place to ensure board sign-off and meet this deadline. The self-assessment material will be circulated to board members at the start of September to optimise response times and allow for discussion and debate ahead of the submission date.

Following submission, a regional moderation process will be undertaken using intelligence gathered from their oversight processes and from wider stakeholders. This will be followed by a national moderation process.

3. Areas of Risk

There are no risks associated with the process outlined above as it is compliant with NHSE requirements and the timetable outlined above should allow sufficient time for a robust assessment to take place ahead of the submission deadline.

The risk arises from submitting a self-assessment that is subject to external challenge as this could give rise to questions around the board's level of insight and ability to lead the organisation, particularly through a period of change.

4. Link to Strategic Theme

This paper links to our People and Culture strategic theme in that it relates to leadership capacity and capability.

5. Link to Board Assurance Framework Risk(s)

Links to BAF risk SR23 - Leadership

6. Quality/Equality Impact Assessment

Not required.

7. Recommendations

The Board is asked to **NOTE** the requirements and take **ASSURANCE** that the process that has been put into place will be compliant with requirements and meet submission deadlines.

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

Trust Board of Directors Meeting in Public 3 September 2026

Title	**Non-Executive Director Appointments**
Report Author	**Colin Dennis, Chair**
Executive Owner	**Becky Murray, Chief Governance Officer**
Agenda Item	**25**
Governance Pathway: Previous	Council of Governors meeting 7th August 2026
Governance Pathway Next Steps	None – report is for the Trust Board

1. Purpose

To formally confirm the appointment of 2 Non-Executive Directors (NED) to the South Central Ambulance Service NHS Foundation Trust (SCAS) Board and to seek Board approval of proposed appointments to key NED roles.

2. Executive Summary

2.1 Non-Executive Director Appointments

Following the departure of Ian Green, Deputy Chair and Les Broude, Senior Independent Director from the Board at the end of their tenures in June and July respectively, arrangements were made to appoint 2 NEDs to the Board. Given the existing collaboration with South East Coast Ambulance Service NHS Foundation Trust (SECAmb) and the move to create a Group Model, the opportunity was taken to appoint existing SECAmb NEDs to the SCAS Board rather than appoint externally for what could potentially be a limited period, owing to anticipated changes to current governance arrangements as the Group is established.

SECAmb ran an open, competitive process to appoint both NEDs to their Board and it was on this basis, and the basis of the skills and experience they will bring to the SCAS Board that the Council of Governors considered and approved the appointments of Peter Schild and Dr Karl Khan as NEDs for a 1-year period at an Extraordinary Meeting on 7 August 2026.

It should be noted that these are not joint appointments as the two organisations remain separate legal entities and each is therefore required to have in place a Board of Directors,

which is established in line with their Foundation Trust Constitution. The 2 NEDs are therefore separately appointed to both Boards. The appointment of NEDs is a responsibility reserved to the Council of Governors under the Trust Constitution and accordingly, the NED appointments are presented to the Trust Board for noting.

2.2 Appointment to NED Roles

The roles of Deputy Chair and Senior Independent Director were previously undertaken by Ian Green and Les Broude respectively and arrangements must be put into place to appoint to these roles.

The following is therefore proposed for Board approval:

Deputy Chair – Katie Kapernaros
Senior Independent Director – Harbhajan Brar

3. Areas of Risk

There are no significant risks associated with the appointments proposed in this paper; the risk arises from having vacant posts on the Board which could impact our ability to demonstrate that we are well led organisation with a Board that has the leadership skills, capacity and capability to effectively oversee and govern the organisation.

4. Link to Strategic Theme

This paper relates to our People and Culture strategic theme.

5. Link to Board Assurance Framework Risk(s)

The paper relates to BAF risk SR23 – Leadership in that it mitigates the risk around leadership capacity and capability.

6. Quality/Equality Impact Assessment

This is not required as Equality, Diversity and Inclusion factors were considered an integral part of the recruitment process.

7. Recommendations

The Trust Board is asked to:

1. **NOTE** the appointment of Peter Schild and Dr Karl Khan as Non-Executive Directors of South Central Ambulance Service NHS Foundation Trust by the Council of Governors at its Extraordinary Meeting on 7 August 2026.

2. **APPROVE** the appointment of Katie Kapernaros as Deputy Chair.

3. **APPROVE** the appointment of Harbhajan Brar as Senior Independent Director.

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