NHS
South Central Ambulance Service
NHS Foundation Trust

PUBLIC BOARD AGENDA

Date: Thursday 5 November 2026

Time: 9:45 – 12:45

Venue: Classroom 1 and 2, Ground Floor; Unit 2 Talisman Business Park Bicester OX26 6HR

Number	Item	Format	Action	Time
1	**Welcome and Apologies** Colin Dennis	-	Verbal	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 September 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** Simon Ashton	ENC 5	Noting	10.00
7	**Patient Story** Helen Young, Chief Nursing Officer	ENC 6	Discussion	10.10
Trust Performance				
8	**Finance & Performance Committee Report: 25 September 2026** Peter Schild, NED Chair	ENC 7	Assurance	10.30
9	**Q2 Transformation Plan Report** Danny Hariram, Chief People Officer/Deputy Chief Executive	ENC 8	Assurance	10.35
10	**Integrated Performance Report** Craig Ellis, Chief Digital & Information Officer	ENC 9	Assurance	10.45
11	**Finance Report Month 6** Jon Bell, Interim Chief Finance Officer	ENC 10	Assurance	11.00

Strategic Theme: Enabling Services				
12	**Enabling Services Board Assurance Framework Risks** Jon Bell, Interim Chief Finance Officer	**ENC 11**	**Assurance**	11.10
Strategic Theme: Digital Transformation				
13	**Digital Transformation Board Assurance Framework Risks** Craig Ellis, Chief Digital & Information Officer	**ENC 12**	**Assurance**	11.15
Strategic Theme: Clinical Effectiveness				
14	**Quality and Safety Committee Report: 28 September 2026** Ruth Wiliams, NED	**ENC 13**	**Assurance**	11.20
15	**Clinical Effectiveness Board Assurance Framework Risks** Duncan Robertson, Chief Paramedic	**ENC 14**	**Assurance**	11.25
16	**Thirlwall Inquiry Report** Helen Young, Chief Nursing Officer	**ENC 15**	**Assurance**	11.30
17	**Quarter 1 Report on Learning from Patient Safety** Helen Young, Chief Nursing Officer	**ENC 16**	**Noting**	11.40
18	**Director of Infection Prevention and Control Annual Report 2025-2026** Helen Young, Chief Nursing Officer	**ENC 17**	**Assurance**	11.50
Strategic Theme: People & Culture				
19	**People & Culture Committee Report: 21 September 2026** Harbhajan Brar, NED Chair	**ENC 18**	**Assurance**	12.00
20	**People & Culture Board Assurance Framework Risks** Danny Hariram, Chief People Officer/Deputy Chief Executive	**ENC 19**	**Assurance**	12.05
Strategic Theme: Partnerships & Sustainability				
21	**Partnerships & Sustainability Board Assurance Framework Risks** Jon Bell, Interim Chief Finance Officer	**ENC 20**	**Assurance**	12.10

22	**Hampshire and Isle of Wight NHS Collective Commitment** Simon Ashton, Chief Executive Officer	**ENC 21**	**Noting**	12.15
Governance & Regulation				
23	**Audit Committee Chair's Report: 10 September 2026** Mike McEnaney, NED Chair	**ENC 22**	**Assurance**	12.20
24	**2026 EPRR Assurance Return** Mark Ainsworth, Executive Director of Operations	**ENC 23**	**Assurance**	12.25
25	**Heatwave Major Incident Report** Mark Ainsworth, Executive Director of Operations	**ENC 24**	**Noting**	12.30
Closing Business				
26	**Summary of actions from the meeting** Becky Murray, Chief Governance Officer	**Verbal**	**Noting**	12.40
27	**Questions from the public** Colin Dennis	**Verbal**	**Response**	-
28	**Any Other Business**	**Verbal**	**Noting**	-
29	**Review of Meeting** NED: Peter Schild Executive Director: Helen Young	**Verbal**	**Discussion**	12.45
30	**Date and Time of Next Meeting in Public** Thursday 7 January 2027, 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: 30 October 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. Magistrate, Oxford
3. 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)
6. Director of HR, Imperial College 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

SIMON ASHTON, GROUP CHIEF EXECUTIVE OFFICER

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

1. None

Current 'Other' Interests

2. A close family member is employed by BDO as a trainee accountant. BDO is the Trust's Internal Auditors. The family member works within a separate international business area and is not involved in the audit of the Trust.

Interests that ended in the last six months

None

PAUL KEMPSTER, CHIEF TRANSFORMATION OFFICER

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

3. None

Current 'Other' Interests

4. Own shares in Kainos

Interests that ended in the last six months

5. 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 MANAGING DIRECTOR

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
South Central Ambulance Service
NHS Foundation Trust

Minutes
Public Trust Board Meeting

Date: Thursday 3 September 2026
Time: 13.00 – 15.00
Venue: Classroom 2&3 Newbury Education & Recruitment Centre | Bone Lane | Newbury | RG14 5UE

Members Present:

Colin Dennis	Trust Chair
Mike McEnaney	Non-Executive Director
Harbhajan Brar (HB)	Non-Executive Director
Stuart Rees (SR)	Acting Chief Executive Officer
Mark Ainsworth (MA)	Executive Director of Operations
Danny Hariram (DH)	Chief People Officer & Deputy Chief Executive
Jon Bell (JBe)	Chief Finance Officer
John Black (JB)	Chief Medical Officer
Becky Murray (BM)	Chief Governance Officer

In attendance:

Gillian Hodgetts (GH)	Director of Communications, Marketing and Engagement
Susan Wall (SW)	Corporate Governance & Compliance Manager
Sue Heyes (SH)	Deputy Chief Nurse/Director of Nursing & Quality

Apologies:

Gary Ford (GF)	Non-Executive Director
Katie Kapernaros (KK)	Non-Executive Director
Paul Kempster (PK)	Chief Transformation Officer
Duncan Robertson (DR)	Chief Paramedic
Helen Young (HY)	Chief Nurse Officer

Item No.	Agenda Item
1	**Chair's Welcome, Apologies for Absence**
1.1	The Chair welcomed all those present to the meeting, particularly Simon Ashton who was attending his first Board meeting in public. Apologies were received and noted.
1.2	The Chair reflected on the importance of maintaining focus on operational recovery whilst continuing to deliver longer-term transformation and strategic objectives.
2	**Declarations of Interests**

2.1 **2.2**	Peter Schild declared his external appointments. No further declarations of interest were made. The Board **NOTED** the declarations.
3	**Minutes from Public Board Meeting held on 3 June 2026**
3.1	The minutes of the meeting held on 3 June 2026 were reviewed.
3.3	Members were satisfied that the minutes represented an accurate record of discussion and decisions.
3.3	The minutes were **APPROVED.**
4	**Matters Arising and Action Log**
4.1	The Board reviewed the action log and received updates on outstanding items.
4.2	Members noted that actions relating to governance development and Board training remained on track. It was confirmed that all other actions were either complete or progressing within agreed timescales.
4.3	The Board **NOTED** the action log and **APPROVED** the closure of completed actions.
5	**Chairs Report**
5.1	The Chair gave a verbal update, providing an overview of activity undertaken since the previous Board meeting. This included engagement with system partners across the Integrated Care System, discussions with regional NHS colleagues on operational recovery and service transformation, and ongoing work to strengthen relationships with key stakeholders. The Chair also updated members on recent governance developments, Board effectiveness matters and preparations for the arrival of the new Group Chief Executive. Members noted the importance of ensuring a smooth leadership transition and maintaining organisational focus during a period of significant change.
5.2	The Board discussed the increasingly complex national NHS environment, including continued financial and operational pressures facing health services and the implications of forthcoming legislative and structural changes. Members reflected on the potential impact of these developments on provider governance, accountability and partnership working and emphasised the need for the Trust to remain adaptable as national expectations evolve. The Chair noted that the Board would continue to monitor developments closely and consider any implications for the Trust's governance arrangements and strategic priorities.
5.3	The Board **NOTED** the verbal update.
6	**Chief Executive Officer's Report**
6.1	SR presented the report and highlighted that the Trust had continued to operate in an exceptionally challenging environment throughout the summer period. Demand across urgent and emergency care services had remained high, with sustained pressure across the healthcare system impacting ambulance handover delays, resource availability and response

	performance. Despite these challenges, the organisation had continued to focus on delivering safe care and progressing improvement activity.
6.2	Members discussed the Trust's recent placement within the National Operational Performance Recovery Framework and sought assurance regarding the implications of this designation. SR explained that this would provide an enhanced level of scrutiny and support from NHS England, with a clear expectation that the Trust would continue to strengthen its recovery trajectory. Members noted that while performance remained below national standards, there was evidence of improvement in a number of operational metrics and a clear understanding of the actions required.
6.3	The Board explored the impact of operational pressures on staff wellbeing and organisational culture. Members commented on the resilience demonstrated by staff throughout a particularly demanding period and emphasised the importance of ensuring that staff felt supported and listened to. Discussion also focused on preparations for the NHS Staff Survey and the importance of achieving a high response rate to enable meaningful insights into staff experience.
6.4	Members acknowledged the ongoing work being undertaken through the Fit for the Future programme and noted the challenge of balancing immediate operational recovery requirements with longer-term transformation ambitions.
6.5	The Board **NOTED** the Chief Executive Officer's Report.
7	**Staff Story**
7.1	The Board received a presentation from a NHS 111 Team Leader who shared their personal career journey and experiences of working within the Trust. The presentation provided insight into career progression opportunities within SCAS, leadership development experiences and the importance of creating an environment where staff feel supported to develop their skills and ambitions.
7.2	Members thanked the presenter for a thoughtful and engaging account which provided valuable context to Board discussions regarding workforce, culture and retention. Several members reflected on the importance of hearing directly from colleagues and noted that the presentation clearly demonstrated the opportunities available within the organisation for staff to develop their careers.
7.3	Discussion focused on staff retention, leadership development and succession planning. Members commented positively on the range of development opportunities available within SCAS and discussed how these could be further promoted to support recruitment and retention. The Board also explored the importance of ensuring consistency of management support and creating opportunities for staff to contribute ideas for service improvement.
7.4	The Chair thanked the presenter for their openness and contribution to the meeting.

7.5	The Board **NOTED** the staff story and the learning arising from the discussion.
8	**Fit For Future Transformation plan Month 4**
8.1	The Board received the Month 4 update on delivery of the Fit for the Future transformation programme. Members noted that overall progress remained broadly on track despite the operational pressures being experienced across the organisation.
8.2	The Executive Team outlined progress across several transformation workstreams, including digital developments, clinical redesign initiatives and operational efficiency programmes. Whilst encouraging progress had been made in a number of areas, members were advised that several projects continued to be impacted by competing operational priorities and workforce capacity constraints.
8.3	Board members explored the programme's governance arrangements and questioned how the organisation was balancing transformation investment with immediate operational recovery requirements. Executives explained that programme priorities were being kept under regular review to ensure resources remained focused on initiatives that would deliver the greatest strategic and operational benefit.
8.4	Members emphasised the importance of maintaining momentum and ensuring that expected benefits were clearly evidenced and reported to the Board. The Board recognised that successful delivery of the transformation programme would be critical to achieving sustainable improvements in performance over the longer term.
8.5	The Board **NOTED** the report and received assurance regarding programme governance, delivery and risk management.
9	**Finance & Performance Committee Report: 31 July 2026**
9.1	The Board **NOTED** the Finance and Performance Committee Report.
10	**Integrated Performance Report (IPR)**
10.1	The Board considered the Integrated Performance Report, reviewing performance across operational, quality, workforce and financial indicators.
10.2	Members discussed ambulance response performance in detail, noting continuing challenges in achieving Category 2 response standards. The Executive Team explained that performance continued to be affected by sustained demand and significant hospital handover delays across the region. Members recognised the complexity of the challenges facing ambulance services nationally but stressed the importance of maintaining focus on improvements within the Trust's control.
10.3	The Board reviewed quality and safety indicators and was assured that robust monitoring arrangements remained in place. Members sought assurance regarding the impact of operational pressures on patient outcomes, including lessons arising from the recent major incident, and were advised that quality metrics continued to be monitored closely with escalation processes in place where concerns were identified. Members discussed the

	importance of ensuring that the Board receives timely and meaningful information on patient safety and harm during periods of heightened operational pressure.
10.4	Workforce metrics were also discussed, including sickness absence, vacancies and staff turnover. Members noted that although there had been some positive developments in recruitment and retention, workforce pressures continued to present a significant risk to service delivery. Discussion focused on actions being undertaken to improve attendance, support staff wellbeing and strengthen leadership engagement across teams.
10.5	Several members welcomed improvements in the presentation of the report and commented that the inclusion of additional narrative had improved understanding of performance trends. The Board encouraged further development of the reporting framework to strengthen the alignment between operational performance, workforce metrics and quality outcomes and to better demonstrate the impact of operational demand on service delivery and patient outcomes.
10.6	**Action: Executive Team to review how timely and triangulated patient safety and harm information is presented to the Board during periods of operational pressure, including how the impact of demand on operational performance is reflected in reporting.**
10.7	The Board **NOTED** the **Integrated Performance Report (IPR).**
11	**Finance Report Month 4**
11.1	JBe presented the Month 4 financial position and provided an overview of the Trust's performance against plan.
11.2	Members were advised that the Trust remained broadly on track to deliver its planned financial position, although a number of pressures and risks continued to require active management. These included operational recovery expenditure, inflationary pressures, non-pay cost volatility and the financial consequences of sustained system-wide demand.
11.3	Board members discussed the financial outlook for the remainder of the year and sought assurance that appropriate controls remained in place. The Chief Finance Officer outlined the measures being taken to identify efficiencies, manage expenditure and support delivery of the financial plan.
11.4	Discussion also focused on the relationship between financial sustainability and operational performance. Members acknowledged the challenge of maintaining investment in strategic priorities whilst responding to immediate operational pressures and recognised the need to balance short-term requirements with longer-term organisational sustainability.
11.5	The Board requested continued visibility of emerging risks and opportunities and agreed that financial reporting should continue to clearly demonstrate the impact of performance recovery initiatives on the financial position.
11.6	The Board **NOTED** the financial position and the associated risks and mitigations.

12	**Winter Framework 2026/27**
12.1	The Board received the Winter Framework and reviewed the Trust's preparedness for the forthcoming winter period.
12.2	Members acknowledged the significant challenges experienced during previous winters and welcomed the proactive approach being taken to planning and risk mitigation. The Executive Team outlined key elements of the framework, including workforce planning, fleet resilience, vaccination programmes, operational escalation arrangements and business continuity measures.
12.3	Members discussed potential risks associated with increased seasonal demand and asked how lessons from previous winters had been incorporated into plans. Executives provided assurance that learning had been captured and that planning assumptions had been informed by previous experience and ongoing system engagement.
12.4	The Board also explored partnership working with acute providers and integrated care system colleagues. Members stressed the importance of collaborative planning and ensuring that escalation processes remained clear and effective throughout periods of system pressure.
12.5	Recognising the importance of early intervention and preparedness, the Board expressed support for the proposed framework and thanked teams involved in its development.
12.6	The Board **APPROVED** the Winter Framework 2026/27 for submission and implementation.
13	**Enabling Services Board Assurance Framework Risks**
13.1	The Board reviewed risks relating to enabling services.
13.2	Discussion focused on fleet availability, estate requirements and supporting infrastructure needed to sustain service delivery.
13.3	Members were assured that mitigation plans remained in place and that risk ratings continued to be reviewed regularly.
13.4	The Board **APPROVED** the risks and accepted the level of assurance provided.
14	**Digital Transformation Board Assurance Framework Risks**
14.1	The Board reviewed risks relating to digital transformation and programme delivery.
14.2	Members welcomed progress made in digital infrastructure and cyber resilience. The Board discussed the importance of maintaining investment in digital services to support operational improvement and staff efficiency.
14.3	The Board **APPROVED** the risks and assurances provided.
15	**Quality and Safety Committee Report: 15 July 2026**

15.1	The Committee Chair presented the report, highlighting matters discussed at recent meeting.
15.2	Members noted positive progress in a number of quality indicators and welcomed continued focus on patient safety, learning and clinical governance.
15.3	The Board **RECEIVED** assurance from the Committee.
16	**Clinical Effectiveness Board Assurance Framework Risks**
16.1	The Board reviewed principal risks relating to clinical effectiveness.
16.2	Discussion focused on the relationship between operational pressures and quality outcomes and the need to maintain clear oversight of emerging risks.
16.3	The Board **APPROVED** the risks and agreed that current controls remained appropriate.
17	**People & Culture Committee Report 29 July 2026**
17.1	The Committee Chair provided an update on workforce matters, culture, staff engagement and employee relations.
17.2	Members discussed actions being taken to improve retention, reduce sickness absence and strengthen leadership capability across the organisation.
17.3	The Board **RECEIVED** assurance from the Committee.
18	**People & Culture Board Assurance Framework Risks**
18.1	The Committee Chair provided an update on workforce matters, organisational culture, staff engagement and employee relations, highlighting the key areas of focus and assurance considered by the Committee since its previous meeting.
18.2	Members discussed the actions being taken to improve staff retention, reduce sickness absence and strengthen leadership capability across the organisation. The Board also considered progress against a number of workforce and culture initiatives and received assurance regarding the oversight being provided through the Committee.
18.3	During discussion of the People and Culture Board Assurance Framework risk, members considered whether the current risk score remained appropriate in light of ongoing improvement activity and the benefits being delivered through the associated programme of work. The Board agreed that further review would be beneficial to ensure that the risk rating accurately reflected current performance, programme progress and evidence of benefit realisation.
18.4	**Action: Review the current People and Culture Board Assurance Framework risk scoring alongside an assessment of programme progress and delivery of anticipated benefits.**

18.5	The Board **APPROVED** the risks.
19	**Lord Mann Recommendations Implementation Plan Update**
19.1	The Board received an update on progress against the implementation plan developed in response to the Lord Mann recommendations. Members were advised that work continued across a number of areas to strengthen organisational culture, promote inclusion and ensure that policies, practices and behaviours reflected the principles set out within the recommendations. Progress against agreed actions was reported to be on track, with a number of initiatives already embedded and others progressing in accordance with planned timescales.
19.2	Members welcomed the progress that had been made since the approval of the implementation plan and recognised the significant amount of work undertaken across the organisation to drive meaningful and sustainable change. Discussion focused on the importance of ensuring that delivery extended beyond policy updates and training programmes, and that the intended improvements were translated into the day-to-day experiences of staff. Members emphasised that creating and maintaining an inclusive culture would require ongoing commitment, visible leadership and continued engagement with colleagues across all parts of the Trust.
19.3	The Board discussed how assurance regarding implementation would continue to be obtained and sought assurance that lessons learned were being appropriately reflected in organisational policies, workforce initiatives and governance arrangements. Members noted the importance of maintaining momentum and ensuring that progress continued to be monitored through established committee structures. It was also recognised that the work aligned closely with the Trust's wider people, culture and equality objectives and would support the creation of a more respectful and inclusive working environment.
19.4	The Chair welcomed the positive progress reported and thanked those involved in leading and supporting the implementation programme. Members agreed that continued oversight would be important to ensure that improvements were sustained and that the desired cultural outcomes were fully realised.
19.5	The Board **NOTED** the report, welcomed the progress achieved to date and received assurance that implementation of the Lord Mann recommendations remained on track.
20	**Freedom to Speak Up** **<u>Freedom to Speak Up Annual Report</u>**
20.1	The Board received the annual report from the Freedom to Speak Up Guardian, providing an overview of speaking up activity during the reporting period, key themes arising from concerns raised by staff, and the actions taken in response. Members welcomed the report and noted continued awareness of Freedom to Speak Up arrangements across the organisation, with evidence that staff remained willing to raise concerns through established reporting channels. Members discussed the range of issues raised throughout the year and the importance of ensuring that concerns were addressed promptly, fairly and consistently. The Board sought assurance that colleagues who spoke up were appropriately supported throughout the process and protected from any adverse consequences. The Freedom to Speak Up Guardian confirmed that robust support arrangements remained in place and that close working

	relationships had been established with Human Resources, staff networks and other governance functions to ensure concerns were managed effectively.
20.2	The Board welcomed the positive cultural indicators highlighted within the report but recognised that continued effort would be required to further strengthen confidence, trust and psychological safety across the organisation. Members emphasised the importance of visible leadership, active listening and timely feedback to staff in maintaining an open and transparent culture where concerns could be raised without fear.
20.3	The Chair thanked the Freedom to Speak Up Guardian for the comprehensive report and acknowledged the valuable contribution of the Freedom to Speak Up function in supporting organisational learning and continuous improvement.
20.4	The Board **NOTED** the Freedom to Speak Up Annual Report and received assurance regarding organisational culture, staff confidence to speak up and the effectiveness of arrangements for managing concerns.
	<u>Freedom to Speak Up Policy</u>
20.5	The Board received the revised Freedom to Speak Up Policy for approval. Members were advised that the policy had been updated to reflect current national guidance, strengthen clarity regarding available reporting routes and further align speaking up arrangements with wider workforce and governance processes.
20.5	Members discussed the proposed changes and welcomed the emphasis placed on supporting staff to raise concerns in a safe, confidential and supportive environment. The Board noted that the revised policy reinforced the Trust's commitment to openness, transparency and learning and provided greater clarity on the roles and responsibilities of managers, leaders and staff when concerns were raised.
20.6	Members sought assurance that the revised policy would be effectively communicated across the organisation and supported through appropriate training and awareness activity. Assurance was provided that implementation arrangements were in place and that compliance and effectiveness would continue to be monitored through established governance processes.
20.7	The Board **APPROVED** the revised Freedom to Speak Up Policy.
21	**Partnerships & Sustainability Board Assurance Framework Risks**
21.1	Members reviewed risks relating to partnerships, system working and sustainability objectives.
21.2	The Board discussed the importance of collaborative working with system partners and maintaining momentum in delivering environmental sustainability commitments.
21.3	The Board APPROVED the Partnerships & Sustainability risks.
22	**Audit Committee Chair's Report**
22.1	MM, Chair of the Audit Committee provided an update on the key matters considered since the previous Board meeting. This included oversight of governance, risk management, internal

	controls, audit activity and progress against agreed management actions arising from audit recommendations.
22.2	Members noted that the Committee had received assurance regarding the effectiveness of the Trust's control environment and had maintained oversight of significant risks, compliance matters and the Board Assurance Framework. The Committee Chair highlighted ongoing scrutiny of audit findings and the importance of ensuring that improvement actions were delivered within agreed timescales.
22.3	The Board welcomed the assurance provided through the Committee's work and was satisfied that appropriate governance and control arrangements remained in place.
22.4	The Board **RECEIVED** assurance from the Audit Committee and noted the report.
23	**Provider Capability Assessment 2026/27**
23.1	The Board received a report outlining the requirements, proposed approach and timetable for completion of the Provider Capability Assessment. Members noted that the assessment represented an important opportunity to evaluate the organisation's leadership, governance and operational capability, whilst identifying areas for further development and improvement.
23.2	Discussion focused on the proposed methodology, timescales and governance arrangements for overseeing the process. Members welcomed the structured approach and emphasised the value of the assessment in supporting organisational learning, strengthening leadership capability and informing future development priorities.
23.3	The Board was assured that appropriate arrangements were in place to coordinate the assessment and that outcomes would be reported through the relevant governance committees and to the Board.
23.4	The Board **APPROVED** the proposed approach and timetable for the Provider Capability Assessment and **NOTED** the opportunities it presented to support organisational development.
24	**Non-Executive Director Appointments**
24.1	The Chair presented a report outlining proposed Board and Committee appointments following the recent appointment of new Non-Executive Directors and changes to Board membership. The recommendations had been developed to ensure an appropriate balance of skills, experience and leadership across the Board and its committees, while supporting effective governance and succession planning.
24.2	Members noted the proposed appointments and welcomed the knowledge, expertise and leadership experience that each individual would bring to their respective roles. The Board agreed that the appointments would support effective committee oversight and strengthen the Board's governance arrangements.
24.3	The following appointments were approved:

	• Peter Schild as Chair of the Finance and Performance Committee and member of the Audit Committee. • Karl Khan as Chair of the Remuneration Committee and member of the People and Culture Committee. • Katie Kapernaros as Deputy Chair of the Board. • Harbhajan Brar as Senior Independent Director.
24.4	The Chair thanked members for their willingness to undertake these additional responsibilities and expressed confidence that the appointments would support the continued effectiveness of the Board and its committees.
24.5	The Board **APPROVED** the proposed Board and Committee appointments as presented.
25	**Summary of Actions from the meeting**
25.1	BM summarised actions from the meeting: • Integrated Performance Report: executives to discuss how to provide more timely and triangulated patient safety/harm information during periods of operational pressure and how to reflect the impact of demand on operational performance. • People & Culture BAF Risk - review of current risk scoring to be undertaken alongside an assessment of the programme/progress and delivery of benefits.
26	**Questions from the public**
26.1	The Board received a question from a member of the public regarding vehicle availability and Vehicle Off Road (VOR) performance. In response, members were advised that fleet performance continued to be closely monitored and that improvements had been seen in vehicle reliability over recent months. The Board noted that work undertaken to strengthen fleet management arrangements and maintenance processes had contributed to a reduction in vehicle downtime.
26.2	Members were further advised that vehicle availability remained sufficient to support operational demand and that performance was monitored through a range of indicators to provide a comprehensive understanding of fleet resilience. Ongoing oversight was being provided through established governance arrangements, with regular reporting to ensure any emerging issues were identified and addressed promptly.
26.3	The Board welcomed the update and noted the importance of maintaining a reliable and resilient fleet to support frontline service delivery and operational performance.
26.4	The Board **NOTED** the question and the response provided.
27.	**Any other business**
27.1	The Chair invited members to raise any items of urgent business not included elsewhere on the agenda.

27.2	No additional items were raised for discussion.
27.3	**The Board noted that there was no other business.**
28	**Summary Review of the meeting:**
28.1	Members reflected positively on the meeting, noting the quality of discussion, constructive challenge and the comprehensive assurance provided through the reports presented. The Board agreed that the agenda had facilitated appropriate focus on the Trust's strategic priorities, operational performance and key areas of risk, enabling members to discharge their responsibilities effectively.
28.2	Particular positive feedback was given regarding the staff story, which members felt provided valuable insight into the experiences of frontline colleagues and helped bring a people-centred perspective to Board discussions. Members commented that hearing directly from staff strengthened understanding of organisational culture, workforce challenges and opportunities for improvement, while reinforcing the connection between strategic decision-making and its impact on colleagues and patients.
28.3	The Chair thanked members for their engagement and contributions throughout the meeting and welcomed the open and constructive nature of discussions.
28.4	The Board **NOTED** the feedback provided and the reflections on the effectiveness of the meeting.
29	**Date, Time and Venue of Next Meeting in Public**
29.1	The next public meeting of the SCAS Board would take place at 9.45am on Thursday 5 November 2026 at 9.45am at the Blue Light Hub, 3 Thornbury, West Ashland, Milton Keynes MK6 4BB.

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TRUST BOARD ACTION LOG						Status
Minute Ref:	**Agenda Item**	**Action**	**Owner**	**Due Date**	**Update**	
Meeting Date: 3 September						
TB/26/011	Integrated Performance Report (IPR)	Executive Team to review how timely and triangulated patient safety and harm information is presented to the Board during periods of operational pressure, including how the impact of demand on operational performance is reflected in reporting.	Stuart Rees	05.11.26	Executive team have discussed this and whilst there are processes in place for the clinical executive to review reported incidents and harm daily, incidents of harm have to be investigated to understand the root cause. During periods of operational pressure, processes are in place to prioritise Cat 1 and Cat 2 calls, which facilitates improved response times to improve. These arrangements are being developed into a Patient Safety Plan. QSC and Board receive a quarterly report on Patient Safety incidents and QSC receives a report on the quality impact of operational performance at each meeting.	**Propose to Close**
TB/26/012	People & Culture Board Assurance Framework Risks	Review the current People and Culture Board Assurance Framework risk scoring alongside an assessment of programme progress and delivery of anticipated benefits.	Danny Hariram	05.11.26	We discussed at People & Culture Committee, and the committee acknowledged the current risks and the work being undertaken to address long-standing concerns relating to staff experience and engagement. The committee agreed that a programme is in place and a series of actions are being undertaken and whilst there isn't a high level of KPIs being delivered the foundation were being put in place. The Committee agreed to keep this under review and to assess whether the current controls are working or further mitigations are required.	**Propose to Close**

Meeting Date: 3 June 2026						
TB/26/008	Patient Story	EMC to discuss SLT and Board CPR training	Becky Murray	03.09.26	Board agreed that it would benefit from training and this will be factored into the Board Seminar programme.	**Propose to Close**
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 – refresh of IPR metrics underway	**Open**

Trust Board of Directors Meeting in Public 05 November 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 September 2026.

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

September 2026

- SECAmb Board Development
- Meeting with Chair, Central East ICB
- Surrey and Sussex Monthly Chairs Meeting
- SECAmb Council Of Governors
- Thames Valley Chairs Forum
- SASC Chair and CEO Formal Board
- SCAS Long Service Awards
- SECAmb 2026 Annual Members' Meeting

October 2026

- Board in Common
- SCAS Trust Board Seminar
- Rem Com Meeting in Common
- Thames Valley Chairs Forum
- AACE Chairs (In person), London
- AACE Council (in person), London
- SECAmb NED Meeting
- Meeting Chair, Surrey and Sussex ICB
- SECAmb Joint Board and Council of Governors Meeting
- SECAmb Awards (2 events)

- SCAS Council of Governors
- SCAS 2026 Annual Members' Meeting

Other

- Team Brief Live / Open Space / Leadership Brief
- Weekly Teams/Mobile meetings with Group CEO
- Regular discussions with Chief Governance Officer re Governance Matters

Recommendation

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

South Central Ambulance Service NHS Foundation Trust - Official

Trust Board of Directors Meeting in Public 05 November 2026	
Title	**Chief Executive Officer's Report**
Report Author	**Simon Ashton, Chief Executive Officer**
Executive Owner	**Simon Ashton, 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

As this is my first report since taking up post as Chief Executive Officer, I wanted to start by thanking colleagues across the organisation and the wider health system for the warm welcome that I have received. I have had the pleasure of spending time with many colleagues from across the organisation in these first weeks and I am struck by the hard work, dedication and professionalism that I have seen. Whilst staff are clearly very proud to be part of SCAS, they have also been very open and honest with regards to the challenges that they face day-to-day, for which I am grateful.

I am privileged and proud to lead the Trust as it continues its improvement journey and through the next phase of its development as we transition to creating the first Ambulance Group with South-East Coast Ambulance Services NHS Foundation Trust.

2.1 National Context

From a national perspective, the focus is very much on the fast-approaching winter season, which we know brings additional demand to all NHS services and particularly to urgent and emergency care. The Board has already approved our Winter Plan, which aims to ensure we put all the right measures into place to enable us to respond to anticipated peaks of

demand. Our Category 2 performance is already challenged however, in part because we are experiencing very high levels of sickness absence, which impacts the availability of our workforce and in turn, our ability to respond to patients in a timely way.

As an executive team and Board, we recognise the impact of sustained operational pressure on the wellbeing of our colleagues and on our ability to retain staff. We know that pressure is likely to continue to build as we enter the winter period and actions to support the resilience of our workforce are included in our Winter Plan.

Linked closely to this, a further area of national focus is flu vaccination and there are clinics taking place across our geography to allow our staff to be vaccinated. I would strongly encourage our staff to take up vaccination, to protect themselves and their families from the flu virus, but also to protect our patients and ensure that we have the staff that we need to meet the needs of our population.

2.2 Regional Context

As I have alluded to above, we are not meeting the Category 2 response times we committed to delivering in our Annual Operating Plan. In addition to the regular oversight meetings that we attend with NHSE regional colleagues, our category 2 performance has put us into level 1 in performance terms, which means that we meet regularly with NHSE colleagues to provide progress updates. Regional colleagues have also offered to provide some support to address some of the challenges that we face on a more sustainable basis, and we are in close discussion with regards to the best means by which to achieve this.

We also continue to work in partnership with our commissioning colleagues and Integrated Care Systems to develop pathways and alternative ways of accessing care, in addition to maintaining a focus on reducing handover delays at our acute hospital Emergency Departments, which frees up our crews to attend our sickest patients. I have had the pleasure of meeting with several colleagues across the system in recent weeks and look forward to continued partnership working as we move towards establishing our Group, and beyond.

2.3 Trust Performance

Our Integrated Performance Report, which is later on the agenda, provides more detail but in September 2026, our Category 2 performance was 31 mins and 42 seconds against a target of 27 mins 30 seconds. It is important to emphasise that although our response times are referred to as operational performance targets, they are in fact a quality and safety measure as the sooner we reach our sickest patients, the better their outcome is likely to be.

Our Hear and Treat service is pivotal in managing our demand and demand across the system in that it ensures that patients receive care in the most appropriate setting and that they are only conveyed to hospital when necessary. As well as providing a better experience for patients, this frees up our ambulance crews to reach our sickest patients and eases pressure on Emergency Departments across our region.

We set a target to improve the number of patients that we manage through our Hear & Treat service during 2026/27 and unfortunately, our performance at month 6 is 17.1% against a target of 20%. We are actively recruiting to our clinical workforce in order to improve this and to maximise the benefits that are outlined above.

Whilst our performance year to date has been impacted by unforeseen events, such as the heatwaves that we saw throughout the summer, an item that also features later on this agenda, we know that we have underlying challenges with regards to achieving our targets on a sustainable basis.

The financial position at the start of 2026/27 was a challenging one and the additional investment required to improve our Category 2 performance, whilst necessary and in the interests of our patients, has made the position more challenging. Whilst we are delivering in line with our Operating Plan at month 6, we know that if we are to deliver on our commitments at year end, we will face some difficult decisions in the months ahead, and there is a longer-term financial sustainability challenge that we need to address.

As outlined in the Integrated Performance Report, our performance is impacted by several interconnected factors; our category 2 performance, Hear & Treat performance, the availability of our workforce and our financial sustainability. Many of the initiatives and workstreams aimed at addressing these are already set out within our Fit for the Future Transformation Plan, which features on the Board agenda. Whilst good progress has been made, these are areas that we will need to remain focused upon throughout the remainder of this year and as we continue to plan into 2026/27 and beyond.

We recognise however that delivery of the benefits of our transformation programme is dependent on organisational capacity and operational stability and we will leverage the opportunities that the Group Model presents to support us to deliver transformational activity, which in turn will address our long term financial and operational performance challenges on a sustainable basis.

In summary, whilst our performance is not where we would like it to be, I would like to acknowledge and thank both frontline staff and staff in our corporate teams and departments, for the work that they do to support the patients that we serve.

People & Culture

The NHS Staff Survey for 2026 is currently live and at the time of writing this report, 1581 colleagues have completed the survey, which equates to 37.7% of our workforce. Although staff that I have met have openly shared the challenges with me, I am aware that we work across a very large geography and I am very keen to hear views from across the breadth of the organisation.

The Staff Survey presents an opportunity for every member of staff to have a voice. Along with the executive team and wider board, I am committed to acting upon the survey outputs and to ensuring that we review our Culture and Leadership Programme and refine and adjust accordingly, to ensure the actions we are taking will improve those areas where we are not doing as well as we could be.

I cannot emphasis enough the importance of participating in the Staff Survey, which is completely anonymous. I would encourage every member of staff to complete this, as it is only by understanding how it feels to work at SCAS, that we can turn listening into action and make changes and enhance the experience of our people.

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 all of the risks on our Board Assurance Framework.

6. Quality/Equality Impact Assessment

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

7. Recommendations

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

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

Trust Board of Directors Meeting in Public 05 November 2026

Title	**SECAMB Patient Story: Oliver's Story: Learning from a Patient Safety Incident and System Improvement**
Report Author	**Patient Safety Team**
Executive Owner	**Jo Turner, SECAMB Chief Nurse**
Agenda Item	**7**
Governance Pathway: Previous	N/A
Governance Pathway Next Steps	N/A

1. Purpose

This paper presents Oliver's story and the learning arising from a significant patient safety incident involving an incorrectly triaged 999 call. The report outlines the findings of the subsequent investigation, the key themes identified through review, and the actions implemented to improve patient safety. The Board is asked to receive the report, take assurance from the actions undertaken, and support the continued monitoring of improvement measures.

2. Executive Summary

Oliver was a fit and healthy 17-year-old who became seriously unwell in July 2024. Following the development of a non-blanching rash and significant deterioration in his condition, a 999 call was made requesting an ambulance. Despite concerns being raised by Oliver's parents, the incident was incorrectly triaged to a non-ambulance response. Oliver was subsequently taken to hospital by his parents, where he later died.

The incident was identified through Trust safeguarding processes and reviewed by the Incident Review Group. A Patient Safety Incident Investigation was commissioned to understand the contributory factors and identify opportunities for improvement.

A subsequent Task and Finish Group reviewed the wider system implications and identified several key themes:

- Patients presenting with multiple symptoms may be at increased risk when a dominant symptom is difficult to identify.
- Staff require additional support and confidence to escalate concerns where clinical intuition indicates a higher level of risk.
- Systems and processes should enable safer clinical decision-making and reduce the potential for inappropriate dispositions.
- Organisational learning should be translated into sustainable improvements in practice, culture and governance.

Actions arising from the review have focused on improving recognition and management of patients presenting with multiple symptoms, strengthening escalation pathways for staff, and enhancing system safeguards to support safer triage decisions.

3. Areas of Risk

Clinical / Quality

Risk of harm to patients where serious illness is not recognised during telephone triage, particularly when multiple symptoms are present. Mitigation includes review of triage processes, learning dissemination, staff education, and strengthened escalation mechanisms.

Performance

Changes to escalation and triage processes may increase demand for clinical review. Performance impact will be monitored through governance and quality assurance processes.

Business

Failure to implement learning could adversely affect organisational reputation and public confidence. Ongoing oversight through governance structures will support delivery of improvement actions.

Financial

Potential costs associated with implementation of improvement actions, training programmes, and system enhancements. These are considered proportionate to the benefits of reducing patient safety risk.

4. Link to Strategic Theme

Clinical Effectiveness

5. Link to Board Assurance Framework Risk(s)

SR1 Quality Performance and Patient Outcomes

6. Quality/Equality Impact Assessment

N/A

7. Recommendations

1. Receive Oliver's story and acknowledge the experiences of Oliver and his family.
2. Take assurance from the Patient Safety Incident Investigation and the actions implemented in response.
3. Note the findings of the Task and Finish Group regarding patients with multiple symptoms and system decision-making.
4. Support continued monitoring of improvement actions and their effectiveness.
5. Promote organisational learning to strengthen patient safety and reduce the likelihood of recurrence.

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

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From Patient Story to System Improvement

Learning from Oliver’s story



August 2026

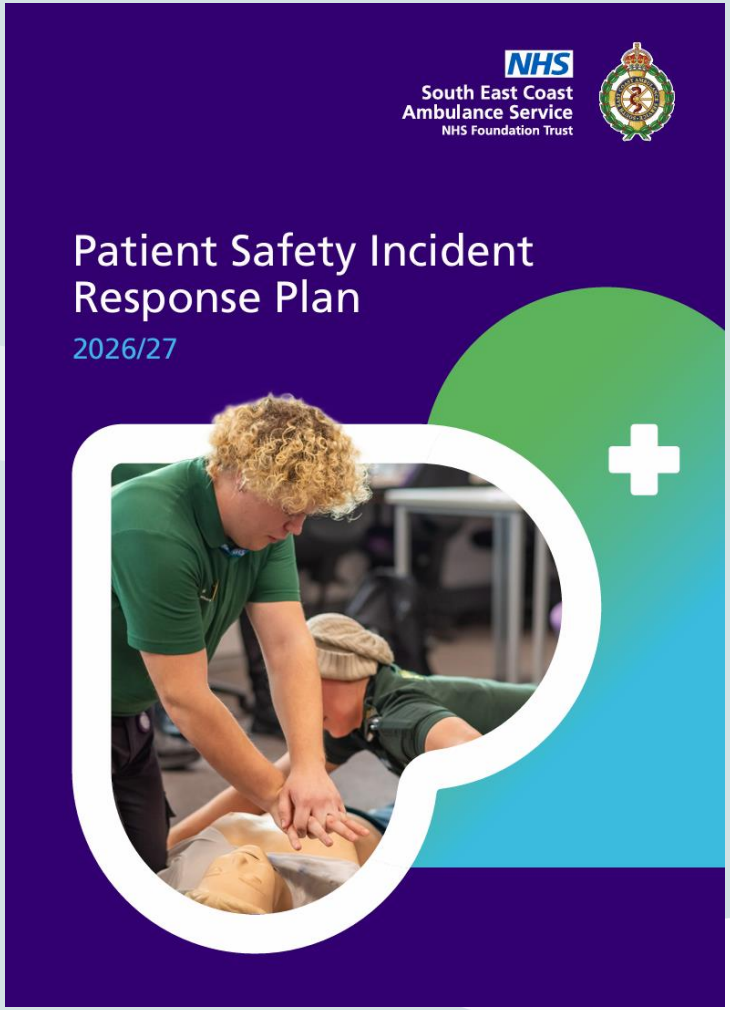
Oliver's story

- Oliver was described by his family as a fit, healthy and popular 17-year-old.
- On Saturday 20th July 2024 Oliver reported feeling tired but otherwise well following a trip to Thorpe Park.
- On the evening of Sunday 21st July Oliver started to suffer with a headache and felt sick.
- By early afternoon on Monday 22nd July Oliver was seriously ill with a non-blanching rash covering most of his body.
- A 999-call requesting an ambulance was made and despite Oliver's parents trying to explain what was wrong the incident was incorrectly triaged to a non-ambulance disposition.
- Oliver was taken to hospital by his parents where he later died that evening.
- The Trust patient safety team became aware of this incident following review by the Trust's safeguarding team. The case was reviewed at the Incident Review Group, and a Patient Safety Incident Investigation was commissioned.



Patient Safety Incident Investigation (PSII)

- Following the commissioning of the PSII the Investigating Manager (IM) took immediate action to reach out and start engaging with the family.
- Over the course of the investigation a strong relationship was built between the family and the IM. The family appreciated the honesty and transparency displayed by the Trust while undertaking the investigation.
- The PSII found that there were issues within the Trust's call handling processes, with a lack of understanding around escalation routes available to the call handling team.
- Following completion of the PSII several recommendations were made.



From patient story to system Improvement

- The Task and Finish Group highlighted key challenges for both patients and staff in identifying a dominant symptom.
- This helped us understand where our systems, processes and culture were creating challenges for our people.

The review identified:

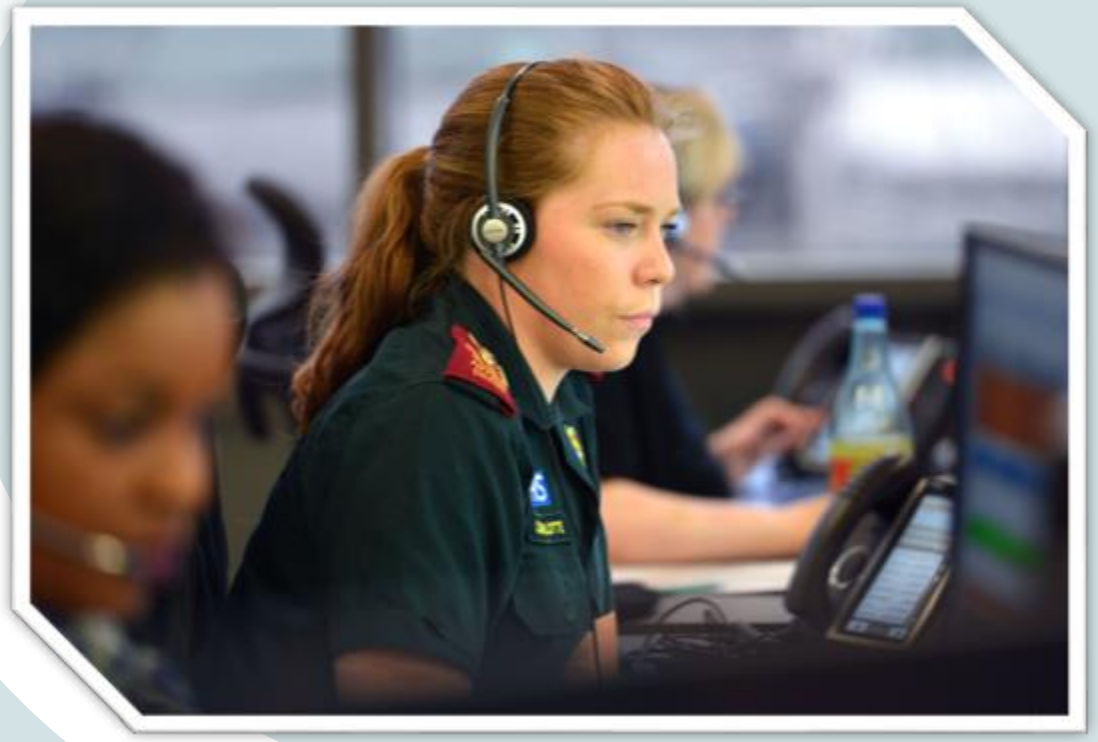
- Patient with multiple symptoms can be at increased risk.
- Staff need greater support to escalate concerns.
- The system needed to enable safer decisions.

Turning learning into action: early impact

- The Intelligent Clinical Queue (ICQ) has moved clinical allocation from a manual “pull” model to a risk-based “push” model.
- Higher-risk calls are prioritised first, supporting more timely clinical assessment.
- EOC learning has informed the wider Virtual Care / Field Ops rollout from 6 July 2026.
- Early operational feedback suggests improved focus on the oldest and highest-priority calls awaiting review.
- Alongside digital improvements such as ICQ, a Trust-wide implementation programme is now underway to embed the Multiple Symptoms learning into everyday call handling practice through communications, training, audit and decision-support tools.



Alignment to our Future Virtual Care Model



- Further development of the **Intelligent Clinical Queue** will enable:
  - Automated identification of high-risk calls
  - Routing of complex calls to the appropriate clinician based on skills mapping
  - Load balancing between queues to ensure timely response
  - Ability to push complex calls to more senior clinicians.
- **Tiered Multi-disciplinary team** with access to appropriate inline support.
- Increased collaboration and sharing of learning & knowledge between traditional ‘field operation hubs’ and ‘Integrated Care’ roles through the **creation of one virtual care service.**

Supporting Oliver's legacy moving forward

- This work has demonstrated the value of combining patient experience with staff insight and improvement methodology to identify and address patient safety risks.
- We are exploring the development of an e-learning module focused on recognising and responding to patients presenting with multiple symptoms.
- All learning has been fed into the development of our Future Virtual Care model.
- Oliver's story continues to remind us that every patient experience provides an opportunity to learn, improve and design safer systems for the future.

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SECAmb would like to formally thank Oliver's family for sharing Oliver's story with us and helping us to learn from this incredibly sad event.

Upward Report of the Finance & Performance Committee

Date Meeting met **25 September 2026**
Chair of Meeting **Peter Schild, Non-Executive Director**
Reporting to **Trust Board**

Items	Issue	Action Owner	Action
Points for escalation			
Joint CAD, NHS111 and ePCR Replacement Programme Full Business Case	The Committee reviewed the Full Business Case for the Joint CAD, NHS111 and ePCR Replacement Programme and endorsed Option 2B, utilising Crown Hosting infrastructure and a fully managed service solution. Members received assurance regarding the strategic benefits, system resilience and alignment with wider SCAS-SECAmb collaboration. The Committee noted emerging risks relating to supplier infrastructure cost increases and requested a future report on cyber disaster recovery arrangements. The business case is recommended to Trust Board for approval.	CE	Board approval required. Cyber disaster recovery business case to be developed and presented by March 2027.
Southern House Lease Renewal	The Committee considered the proposal to surrender the existing Southern House lease and enter into a new ten-year lease with a five-year tenant break clause. Members recognised the strategic importance of the site whilst balancing future organisational flexibility. The proposal is recommended to Trust Board for approval.	JBe	Board approval required.

Ambulance Services Contract 2026/27 and Thames Valley NHS111 Contract 2026/27	The Committee reviewed the contracts and supported approval, recognising the importance of contract security, particularly the award of the five-year plus five-year Thames Valley NHS111 contract.	MA / JBe	Board approval required.
Business Matters			
Operational Performance and CAT2 Recovery	The Committee received an update on performance against national ambulance standards and reviewed progress against the CAT2 recovery trajectory. Members challenged the sustainability of improvement plans, workforce availability, use of overtime and private provider support, and the impact of hospital handover delays. Assurance was provided that recovery actions continue to be closely monitored through weekly operational oversight and NHS England scrutiny arrangements.	MA	Continue monitoring delivery of recovery plans and provide updates through FPC.
Month 5 Finance Report	The Committee reviewed the Month 5 financial position and noted the Trust remained on plan and forecast to achieve break-even at year end. Members sought assurance regarding delivery of recurrent savings, operational pressures and financial recovery risks. Enhanced reporting on CIP delivery and associated risks will be developed.	JBe	Continue monitoring financial performance and delivery of savings plans.
Capital Plan Refresh	The Committee reviewed the refreshed capital programme and associated risks. Members discussed future capital pressures relating to CAD replacement, estate development and operational requirements, whilst noting successful receipt of external estate safety funding. Assurance was provided regarding prioritisation and governance arrangements.	JBe	Continue development of the capital programme and funding strategy.
Fleet Update	Members received an update on fleet performance and welcomed improvements in vehicle availability and reductions in vehicles off road.	LF	Develop a consolidated fleet

	Discussion focused on future requirements for electric vehicle charging infrastructure, estate capacity and associated investment needs.		and infrastructure plan for future Committee review.
Contracts Register	The Committee reviewed the contracts register and noted continuing improvements in contract management, governance and oversight arrangements. Members were assured that key contract risks were being proactively managed and monitored.	BM	Ongoing monitoring and reporting through established governance processes.
Areas of concern and / or Risks			
Operational Resilience and Winter Preparedness	The Committee remains concerned regarding sustainability of performance recovery during the winter period, given workforce pressures, hospital handover delays and continued reliance on additional operational capacity.	MA	Continue oversight through operational recovery reporting and regular performance reviews.
Financial Recovery Risks	Whilst the Trust remains forecast to achieve break-even, delivery is dependent upon achievement of savings plans, operational assumptions and external funding support. Members requested continued monitoring of financial risks and mitigations.	JBe	Ongoing scrutiny through FPC and Financial Recovery Group.
Estates and Infrastructure Capacity	Growing operational demand, fleet expansion and future electrification requirements continue to create pressure on estate capacity and supporting infrastructure.	LF / JBe /DH	Develop infrastructure requirements and investment plans.

CAD Programme Affordability and Delivery	The Committee noted ongoing affordability, implementation and supplier cost risks associated with the CAD Programme and requested continued oversight through programme governance arrangements.	CE	Continue monitoring programme risks and provide regular updates to Committee.
Best Practice and / or Excellence			
Fleet Improvement Programme	The Committee recognised the significant improvements achieved in fleet availability and vehicle-off-road performance, reflecting sustained effort by the fleet team.	N/A	N/A
Financial Management	Delivery of the planned financial position for five consecutive months was acknowledged, demonstrating effective financial control and management.	N/A	N/A
Contract Governance	Members noted the continued maturation of contract governance arrangements, resulting in improved visibility, compliance and risk management.	N/A	N/A
External Funding Success	The Committee welcomed the successful securing of sustainability and estate safety funding, supporting delivery of strategic and operational priorities.	N/A	N/A

Trust Board of Directors Meeting in Public 05 November 2026

Title	**Q2 Transformation Plan Report**
Report Author	**Caroline Morris, Director of Transformation**
Executive Owner	**Danny Hariram, Chief People Officer / Deputy Chief Executive**
Agenda Item	**9**
Governance Pathway: Previous	• Executive Management Committee • Highlight reports created by each programme workstream, signed off by SROs and reported to Transformation Oversight Group for review and challenge
Governance Pathway Next Steps	• Board for Assurance

1. Purpose

This document reports end of quarter two (Q2) of the 2026/27 SCAS Transformation Plan. This is the longer version of the report including the individual programme highlight reports and operational programmes. We have taken the opportunity to reflect on the last six months and highlight areas of achievement and notable progress.

This summary should be read alongside the attached highlight reports for each of the programmes of work.

2. Executive Summary

At Month six, programmes are largely reporting amber status. Teams have achieved progress against foundational and enabling activity, but programmes, particularly those focused on front line activities and digital have experienced schedule slippage, capacity constraints, workforce pressures, or dependency-related delays. Most issues appear recoverable within the year, though a small number of programmes have requested formal re-baselining as they have identified that they will not achieve their original year-end ambitions.

Given the financial position and the need to make significant progress against the operations recovery programme, we have taken the opportunity to realign what capacity we have to those front-line programmes likely to give us the biggest benefit in year.

Across the first six months of the programmes key achievements include:

Clinical Effectiveness	• GoodSAM text messaging pilot is underway in the call centres enabling us to communicate with patients who are waiting a long time. This is intended to reduce repeat callers reducing pressure on call handling. • New processes to share clinical teams across 999/111 is supporting 999 call handling at times of significant pressure. • Approval to expand Specialist Paramedic capacity, has been secured, which will support alternative deployment models in the future increasing see and treat opportunities. • Personal Issue of Controlled Drugs (PCID) rollout has been completed across frontline Resource Centres ensuring that SCAS is compliant with Home Office Regulation. • Using a quality improvement approach, we are recording a significant reduction in number of Lost Unit Hours meaning our staff are more available to respond to patient demand. • Testing of a Clinical Supervision approach using a quality improvement technique is underway in one sector. Once tested this will be rolled out improving the experience of our staff and supporting the improvement in clinical standards across the front line. • Joint SCAS/SECAMB Advanced Practice review underway. This enabling work will support future decisions about the skill mix of the workforce.
Digital Transformation	• Business Case signed off enabling the CAD programme to move into delivery phase providing the foundation for the next generation of digital platforms which will improve our opportunities to deliver improved patient care. • Completed cyber maturity assessments architecture reviews and strengthened cyber governance to improve digital safety for our organisation.
People and Culture	• Strengthened culture and leadership through Leadership Symposium supporting managers and leaders across the organisation in developing their knowledge and skills to better support their staff. • Strengthened understanding of future education requirements through benchmarking, gap analysis, CPD review activity and workforce planning work linked to the

	wider education review to address efficiencies and moving to a fit for the future delivery of education services. • Delivered improvements in employee wellbeing, for example reducing payroll errors, getting it right first time. • Reduced the time to hire by on average two weeks since the beginning of the year. Staff are arriving in post more quickly supporting delivery of key targets.
Enabling Services	• Digital checklist in development alongside fleet optimisation aimed at enhancing productivity and ensuring vehicles are increasingly available where and when needed. • Land Searches have commenced for the Make Ready Hub in Oxfordshire, following national funding. When delivered the Hub will improve operational performance in Oxford, with a modern fit for purpose base for staff. • Grant funding has been secured to progress EV charging infrastructure and mobile charging capability across the estate taking us close to our Net Zero commitments.
Partnerships and Sustainability	• Maintained financial performance, with a strong cash position, successful completion of ICB contract negotiations. • Established the foundations of the Ambulance Group model with the commencement of substantive leadership and agreement on joint programmes of work.

Month 6 Highlight Report by Exception

Clinical Effectiveness

Operational pressures across urgent and emergency care, particularly workforce capacity, remain the principal delivery risk. Strongest performance continues to be seen in Clinical Supervision, Patient Safety and Medicines Optimisation.

- Virtual Care: Performance remains below plan, although Dispatch Response Ratio is consistently ahead of target. Confidence remains that Hear & Treat will reach 20% by Q4, but recovery of the <10 second call-answer target is unlikely. 111 SLA performance is expected to remain below target.
- Pathways of Care: Mobilisation has been slower than anticipated, however See & Treat performance is ahead of plan.
- Medicines Optimisation: Rollout of Personal Issue of Controlled Drugs has been completed across Resource Centres. Track and Trace milestones require re-phasing considering financial constraints this year.

- Time to Care: Recruitment challenges delayed delivery, however improvements are now emerging in Lost Unit Hours and elements of Task Time.
- Patient Safety and Clinical Supervision: Milestones are on track with strong delivery confidence.
- Clinical Workforce: Advanced practice development has slipped but remains achievable.

Digital Transformation

Significant progress has been made in Computer Aided Dispatch System (CAD), Microsoft 365 benefits realisation and cyber maturity. Some programmes require re-baselining due to capacity and technical dependencies.

- Blue Light Platforms (CAD/Electronic Patient Care Record): The programme is moving into delivery phase. The key challenge remains affordability and associated cyber resilience investment.
- Nightingale: Business case approval for the Data Warehouse has delayed delivery, moving some benefits and costs from 2026/27 into 2027/28.
- Watson AI: Progress continues on governance and infrastructure, but milestone slippage requires programme rephasing with benefits likely to accrue later than planned.
- Cyber (Shield 24/7): Discovery and maturity assessment are progressing well, with future delivery dependent on funding and specialist capacity.

Enabling Services

Most benefits are expected in the second half of the year. Delivery risks are largely external rather than programme related.

- Estates Modernisation: Progress slowed due to challenges identifying and securing land for the Make Ready Hub. National funding has been secured.
- Fleet Modernisation: Vehicle growth remains behind plan due to supplier constraints, while work to reduce vehicle off-road rates continues. Fleet availability has improved.
- Sustainability: The programme has secured £964k external funding to support upgrades to electricity infrastructure, EV charging and solar panels. It remains forecast for year-end delivery despite delays related to infrastructure and legal dependencies.

People and Culture

Programmes milestones remain deliverable, although the Education programme requires rebasing.

- Building Trust Together: Three of four of Quarter two milestones were achieved. Staff engagement indicators deteriorated during the period but remained above the baseline position of quarter four in the pulse survey following sustained operational pressures and impacted by the heatwave following qualitative feedback from the pulse survey.

- Education Modernisation: Foundational activity has progressed. Original timescales are no longer achievable, and formal re-baselining is required.
- People Services: Improvement activity is beginning to demonstrate impact, and delivery remains on track with a reduction in payroll issues and reducing backlog in long term sickness and employee relation cases.
- Recruitment Optimisation: One of the strongest-performing programmes, with time-to-hire exceeding target and milestones achieved, which will support candidates joining earlier increasing workforce capacity more quickly in the contact centre.

Sustainability and Partnerships

The Trust is delivering its financial plan at Month six, but risks remain around year-end.

- Collaboration and Partnerships: Planned milestones have been achieved, and work is progressing to establish a clearer medium-term benefits framework.
- Financial Sustainability: The organisation remains on plan at Month six; however, delivery is being supported by non-recurrent savings, rather than recurring Cost improvement plan (CIP) delivery. Emerging cost pressures and operational performance requirements present ongoing risks.

3. Key Risks

- Clinical Effectiveness: workforce shortages, rising demand and the scale of improvement required to deliver Category two recovery create significant delivery risk.
- Digital Transformation: funding pressures, technical dependencies and programme capacity constraints are delaying benefit realisation and require re-baselining.
- Enabling Services: delivery remains dependent on external factors, particularly land acquisition, utilities infrastructure and specialist capacity.
- People and Culture: staff engagement measures have deteriorated, and Education Modernisation requires a revised scope and timetable.
- Financial Sustainability: reliance on non-recurrent savings, inflationary pressures and investment required to improve performance present risks to year-end delivery.

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

The Board is asked to take assurance from the progress made.

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

Attached: Q2 Heat Map and Detailed Highlight Reports

NHS
South Central Ambulance Service
NHS Foundation Trust

Transformation Plan 26/27

M6 Highlight Report

Month 6 High level Progress Report

	Alert	Advise	Assure
Clinical Effectiveness	Active recruitment and sickness management continue to support rising 111 demand, however KPI performance is significantly off track. SPOA funding in Hampshire has been withdrawn. C2 deployment is delayed by a challenge regarding availability of data and impact on patient safety.	The ICC SOP refresh is nearing completion. Rota reviews are underway in ICC the outcome of which will be supported by improving process pilots and stronger cross-team support. Morphine removal has reached 280 (around 50%) vehicles despite resourcing constraints.	CSD recruitment is progressing to plan with staffing increasing to 90 WTE in October and a further 13 WTE in the pipeline. Additional capacity is helping recover programme delivery. Medicines optimisation remains on track, with increasing confidence in delivery.
Digital Transformation	CAD programme milestones are being re-baselined following business case approval, with mobilisation underway and additional resource required to support development of the regional operating model. Limited PM capacity continues to impact delivery, with some milestones expected to move into FY27/28.	A separate business case is needed to address Cyber Disaster Recovery risk within the CAD programme. Resource constraints continue to impact delivery, while infrastructure, AI and NLP initiatives progress, subject to dependencies.	Financial pressures have reduced, and while infrastructure, data and AI initiatives continue to progress, delivery remains dependent on recruitment, supplier availability, technical decisions and external dependencies.
Enabling Services	Fleet growth remains below plan due to ongoing vehicle supply delays, reducing expected winter resilience and impacting the timely delivery of planned fleet capacity.	Make Ready Hub milestones require re-baselining following delays to the Early Fees Application and land acquisition, while Jaama and associated digital fleet applications are progressing to support process improvements and recover earlier delays.	Make Ready hub planning and fleet transformation activities are progressing, with land acquisition milestones being re-baselined, backlog maintenance reduction on track, and improvements underway across fleet processes, systems, forecasting and VOR performance.

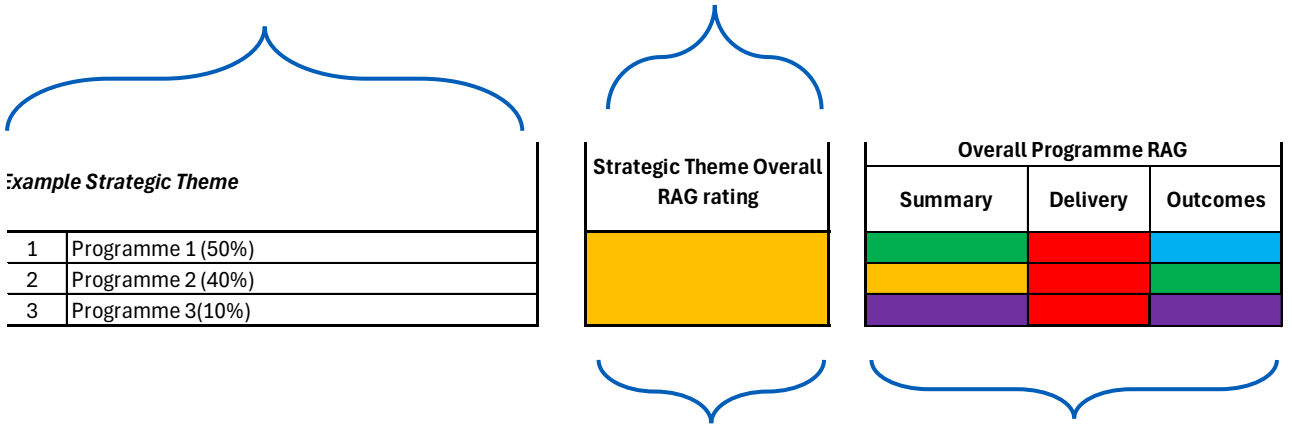
Month 6 – High level Progress Report Cont

	Alert	Advise	Assure
People & Culture	There have been delays in delivering against the sexual safety, strategy and education workstreams due to recent capacity constraints. While staff engagement improvements, leadership initiatives and ICC integration continue to progress, Q2 data indicates KPIs not met but improvements when compared to baseline Q4 position.	Diversity, leadership and education initiatives are progressing, with key milestones delivered and reviews underway..	Values & Behaviours and workforce development initiatives continue to progress, with reflection week completed, leadership training underway, strengthened culture governance in place, and CPD delivery improving despite remaining slightly below target.
Partnership & Sustainability	Break-even forecast remains at risk from rising costs and delivery of the £1.6m recovery plan. Collaboration-related costs continue to create short-term financial pressure.	**Group Strategy:** A Benefits framework and strategy refresh needed to support group model development and prioritisation. **CIP:** On plan, but reliant on non-recurrent savings. **Capital:** Fleet and estates risks may impact delivery; slippage is being managed.	**Group Development:** Workstream plans completed; governance strengthened. **Financials:** YTD performance, cash position and CIP remain on plan. **Contracts:** ICB negotiations have been completed with a positive outcome.

How the Heat Map works

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.



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

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

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 Plan Delivery and Outcomes achieved In this case plan deliver is materially off track, however outcomes are being achieved in two of the three programmes

Q2 Tier 1 RAG Heat Map

	Current Reporting Period: Month 6					Previous Reporting Period: Month 5				
		Strategic Theme Overall RAG rating	Overall Programme RAG			Strategic Theme Overall RAG rating	Overall Programme RAG		
Clinical Effectiveness			Summary	Plan Delivery	Outcomes		Summary	Plan Delivery	Outcomes
1	Virtual Care (25%)								
2	Pathways of Care (25%)								
3	Medicines Optimisation (25%)								
4	Time to Care (25%)								
Digital Transformation			Summary	Delivery	Outcomes		Summary	Delivery	Outcomes
1	Bluelight Platforms 2.0 (50%)								
2	Nightingale - data driven organisation (40%)								
3	Watson AI (10%)								
Enabling Services			Summary	Delivery	Outcomes		Summary	Delivery	Outcomes
1	Fleet optimisation (60%)								
2	Estates Modernisation (40%)								
People and Culture			Summary	Delivery	Outcomes		Summary	Delivery	Outcomes
1	Building Trust Together (75%)								
2	Education Modernisation (25%)								
Partnerships and Sustainability			Summary	Delivery	Outcomes		Summary	Delivery	Outcomes
1	Financial Sustainability (80%)								
2	Collaboration and Partnerships (20)								

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

Note: reporting is based on Year to date. It is not an assessment of year end position

NHS
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Fit for the Future
Model Highlight Reports
Tier 1 and 2

Key to understanding the reports:

Report Area	Nomenclature	Meaning
Quarters	Q1,2,3,4	Quarters of the financial year (from 01 April 2026 to 31 March 2027)
RAG rating	Blue: Green: Amber : Red :	Programme Completed and embedded Programme on track to complete as expected Programme off track but progressing – recovery actions required Programme off track / not progressing
Metrics table	Top Metric Other metrics T: A:	The headline metric reported in the Board Papers (shown in bold) Monitoring metrics for use to understand more detailed delivery of the programme Target (numeric) Actual (numeric) Expected completion of task (non-numeric) Task achieved (non-numeric)
Milestones	✓ ✖ Background colour	For current and future milestones: On track; Late; can be recovered; Late; cannot be recovered For historical milestones: ✓ Completed on time; ✓ Missed but completed late; ✖ Missed and not completed

Programme Name: Virtual Care (01/09/26 – 30/09/26)	Executive Sponsor: Senior Responsible Officer: Programme Manager:	Mark Ainsworth Ruth Page Emma Manaton

Programme benefits / Objective	Continually improve the ability of the organisation to provide the right care, first time: by increasing clinical capacity, modernising dispatch, and improving job roles. Work with Secamb to develop joint principles and outcome measures for virtual care, with a view to capitalising on the strengths of both organisations.

Alert

- CSD: Recruitment is ongoing. 6 WTE are due to commence in October; 90 WTE will then be in place. In addition, a further 13 WTE are in the pipeline.
- SPOA developments in the south are still under discussion following a change of funding approach from commissioners.

Advise

- Hear and Treat rates are improving as we move into Q3, and we expect to achieve 20% in year
- Refreshed SOPs are near completion, with the remainder going through Clinical Governance.
- Call Taking: 111: 12.6% more demand than Q2 2025-26. Active recruitment and training ongoing. Sickness being actively managed.

Assure

- CSD rota review commenced
- Review of pilot to streamline pre triage processes to reduce cognitive load and reduce AHT in review
- Reducing duplicate calls via GoodSAM Text messaging pilot underway
- 9s to 1s cross team support in times of high demand being strengthened further, to release as many benefits as possible.

Ask of this forum / action:	N/A

Quarterly Milestones

Q1		Q2		Q3		Q4	
New clinical and deployment structures in place (& structure & learning shared with SECAMB)	✓	Delivery of revised SOPs to reduce cognitive load on staff (inc. collaboration with SECAMB)	x	Analyse impact of the Pre Sieve Trial and implement benefits		Delivery of CAT 1 auto-divert improvements	
Implement a Team Leader Training Programme to standardise practice	✓	Deliver CSD recruitment to 99.0 WTE to contribute to improved performance	x	Deliver CSD rota cover benefits to cover rota gaps and improve performance		Full implementation of Attend Incident to improve multi agency working (SECAMB support)	
Dispatch workshop to finalise modernisation action plan for the year	✓	Tactical Performance Manager role fully functional and 24/7	✓	Workforce Management Tool – procurement process complete (in collaboration with SECAMB)		Maximise use of GoodSAM across all areas to improve patient experience and outcomes	
Recruitment and retention action plan published	✓	Development of an alternative SPOA delivery model	x	Analyse the impact of NLP in 111 & review benefit realisation (timelines nationally dependent)		Following evidence review, go/no go decision on Incident Command Desk	

Overall Programme RAG

Programme Status	• H&T and Call answer performance remain below target. • Restructure: new roles continue to be embedded. • New starters are commencing within CSD to ease some of the staffing pressures. • Sickness remains a challenge in call taking.
Impact on Outcomes	↔ Rag status remains at amber due to under performance.
Delivery Confidence	↔ CSD staffing: 6 WTE commencing in October. A further 13 WTE in the pipeline. Call taking staffing in 111 and 999 remains behind requirements to meet demand. Work is ongoing to address this.

Risks / Concerns

Work is ongoing to achieve targets, supported by detailed improvement plans. However, performance continues to be affected by variables, including staff turnover, sickness absence, increased demand and financial constraints, all of which are being systematically tackled.

Key Metrics

	Q1		Q2		Q3		Q4	
	T	A	T	A	T	A	T	A
Hear and Treat	20%	17.5 %	20%	16.8 %	20%		20%	
999 mean call answer	<10 secs	12 secs	<10 secs	19 secs	<10 secs		<10 secs	
111 call answer	81.2 %	74.0 5%	95.8 %	55.3 %	90.5 %		98.9 %	
Dispatch response ratio	1.12	1.09	1.11	1.09	1.11		1.10	

Programme Name: Pathways of Care (01/09/26 – 30/09/26)	Executive Sponsor: Senior Responsible Officer: Programme Manager:	Duncan Robertson Dan Holliday / Michaela Morris
Programme benefits / Objective	To improve quality and patient experience by aligning SCAS and SECAmb pathways, increasing utilisation and standardising specialist care access to ensure patients receive the right care first time while reducing unnecessary conveyance and health inequalities.	

Alert	Advise	Assure
There are no matters requiring immediate action at this time	The pilot to trial deployment of Specialist Paramedics to C2 cases is delayed with further discussions underway about the information required to mobilise safely.	Additional capacity in place and work is underway to bring Group Level work back on track. Joint pathways team workshop session held at Group Senior Teams meeting on 14.09.2026. Outputs discussed at Aligned Clinical Model Steering Group and outputs to be built into options appraisal.

Ask of this forum / action:

Quarterly Milestones

Q1		Q2		Q3		Q4	
Joint Pathways of Care Plan agreed SCAS & SECAmb	×	Align SCAS and SECAmb pathways	×	Joint SCAS and SECAmb pathways of care team proposal complete		Consultation commenced for joint team if required.	
Agree Business Case to increase SP numbers	✓	Review SP C2 deployment trial	×	Agree and implement exemplar pathways across both Trusts		Yr 1 outcome report and Yr 2 pathways of care plan shared with commissioners.	
C2 deployment trials with SPs	×	Complete baseline assessment of Tertiary and Specialist pathways	✓				

Overall Programme RAG

Programme Status		The programme continues to progress in line with its mobilisation phase; however C2 SP deployment is not able to commence without robust live dashboard in place.
Impact on Outcomes	↔	Impact on outcomes RAG remains green as impact can be recovered by required timescales.
Delivery Confidence	↔	Delivery confidence RAG continues to be green as limited progress against some milestones can be recovered during Q2.

Risks / Concerns

- IF secondary and community providers do not engage THEN alternative pathways may be inaccessible. Risk escalated via Aligned Clinical Model Steering Group with action to be taken by Executive.
- IF operational pressures increase THEN capacity may be reduced within 999 Operations. Minimal deliverables are planned for Q3 to allow for seasonal increase in demand whilst limiting impact on programme.
- IF we are unable to report accurately end point dispositions THEN the accuracy of a data led decisions is hindered.

Key Metrics

	Q1		Q2		Q3		Q4	
	T	A	T	A	T	A	T	A
See & Treat	29	31.8	29	32.8	29%		29%	
See & Treat to Non-ED	4	4%	4	3.8	4%		4%	

Medicines Optimisation Programme: (01/09/26 – 30/09/26)

Executive Sponsor:	**Duncan Robertson**
Senior Responsible Officer:	**Jo Williams**
Programme Manager:	**Dai Tamplin**

Programme benefits / Objective

Changing our ways of working to ensure better regulatory compliance, greater efficiency of medicines distribution and accountability and safe and secure medicines infrastructure.

Alert

Electronic Track and Trace (ETT) business case planned for submission in Nov 26. Milestones require re-baselining via Pharmacy Programme Board and Transformation Oversight Group (TOG) as they now cannot be met. Delivery of ETT procurement still planned for completion within FY 26/27.

Advise

Vehicle-based morphine removal in progress with 280 vehicles cleared. Progress has slowed due to non-availability of suitable alternative duties registrants, but alternative options are being scoped to maintain momentum.

Assure

No change to Personal Issue Controlled Drugs (PICD) roll-out status but Q2 metrics met with all RCs now using PICD process. HART/ACCT/BASICS have not yet transitioned but expected complete by mid-Q3 (delay due to requirement for specialist equipment).

Safe and Secure Handling of Medicines (SSHM) Procurement work is progressing. Phase 2 delivery confidence is increasing for delivery in FY26/27.

Ask of this forum / action: Nothing for escalation currently.

Quarterly Milestones

Q1		Q2		Q3		Q4	
Complete roll-out of PICD across whole Trust area {Frontline RCs).	✓	Complete roll-out of PICD to specialists (HART/ACCT/BASICS).	×	Electronic Track and Trace full procurement process started.		Electronic Track and Trace procurement completed.	
		Electronic Track and Trace Business Case approval granted.	×	Electronic Track and Trace Pilot completed.		SSHM Phase 2 works complete.	
		Electronic Track and Trace Pilot implemented.	×	SSHM Procurement complete.			
		SSHM Phase 2 Business Case approved.	✓	SSHM Phase 2 works underway.			

Overall Programme RAG

Programme Status		All frontline RCs have now moved to PICD model. SSHM confidence of delivery within FY26/27 increasing. ETT milestones require re-baselining.
Impact on Outcomes	↓	PICD process now bedding-in across frontline RCs. Delay to specialist area impacts compliance until complete.
Delivery Confidence	→	Although re-baselining required for ETT delivery, confidence remains that procurement can be completed as per financial planning within FY26/27.

Risks / Concerns

- PICD makes vehicle-based morphine redundant. Registrants still have access to vehicle CD safes. Work is underway to remove vehicle-based morphine but risk of diversion remains until complete.
- Without resolution of Hythe RC's future, HOCDL compliance cannot be achieved as building infrastructure cannot achieve security requirements.
- SSHM Phase 2 delivery timelines are tight: financial risk if not completed in-year.

Key Metrics

	Q1		Q2		Q3		Q4	
	T	A	T	A	T	A	T	A
PICD Roll-out Complete (Baseline 8%)	80 %	**92 %**	95 %	**96 %**	100 %		100 %	

Programme Name: Time to Care (01/09/26 – 30/09/26)

Executive Sponsor:	**Mark Ainsworth**
Senior Responsible Officer:	**Michaela Morris**
Programme Manager:	

Programme benefits / Objective

To improve productivity, performance and staff engagement through a locally led, data-driven Quality Improvement approach that empowers teams to redesign workflows, reduce variation and release clinical capacity sustainably.

Alert

There are no matters requiring immediate escalation at this time

Advise

This programme of work is fundamental to the Category 2 Recovery Plan which is built on QI principles.

Assure

Quality Improvement Facilitator position appointed to and post holder to commence from 05.10.2026.

Funding secured for Lean Six Sigma Course with QI leads nominated to complete training

Renewed milestone plan to be developed during October and output reflected within October highlight report

We have seen a material reduction in Lost Unit Hours and an improvement in task time.

Ask of this forum / action:

Quarterly Milestones

Q1		Q2		Q3		Q4	
Appoint new QI facilitator.	✓	QI Champions training complete.	✗	Internal QI training plan scoped		27/28 QI plan agreed.	
Complete data review into 'lost hours'	✓	QI Peer network in place.	✗				
Identify named QI lead per sector	✓	At least three QI cycles per sector (1 per month) focussed on job cycle time and/or reduction in lost hours.	✗				
Operations QI Group in place.	✗						

Overall Programme RAG

Programme Status		The programme RAG has been reduced from Red to Amber due to the appointment to the QI role.
Impact on Outcomes	↔	The programme will not deliver the full outcomes due to the delays in recruitment and inability to delivery full year impact.
Delivery Confidence	↑	Delivery confidence RAG has improved from Amber to Green due to the appointment to the QI role

Risks / Concerns

- IF operational pressures increase THEN capacity may be reduced within 999 Operations. Mitigation: Minimal deliverables are planned for Q3 to allow for seasonal increase in demand whilst limiting impact on programme.
- IF we are unable to recruit to the QI Facilitator role THEN we will not have capacity within transformation team to support programme. Mitigation: Secondment advert is clear to evidence organisational investment and training and development for the role.

Key Metrics

	Q1		Q2		Q3		Q4	
	T	A	T	A	T	A	T	A
Cat 2 Performance		00:33 :00		00:30 :35			27:30	
Task Time (exc handover reduction)	01:45 :41	01:34 :40	01:45 :41	01:34 :26	01:45 :41		01:45 :41	
Lost Hours (10% Reduction)	13,893		27,678		41,518		55,357	

Programme Name: Patient Safety & Experience (01/09/26 – 30/09/26)

Executive Sponsor: Helen Young
Senior Responsible Officer: Sue Hayes
Programme Manager: Emma Manaton

Programme benefits / Objective

Alert

Nothing of note.

Advise

Lower than planned PSIRF training completion rates due to heatwave and competing priorities. SCAS has been selected as the pilot site for the new NHSE PSIRF training, plan to use this pilot to mop up missed training.

New digital SMS patient experience survey approved for procurement will be a small advance in 'live' data to assess impact.

Assure

Achieved milestones as per the plan.

Already on track for Q3, ahead of plan with the Experience of Care Framework and Maternity & Neonatal.

Gap analysis for Maternity will support the models of care work in the Pathways programme.

Ask of this forum / action: Review support for a new clinical dashboard to enable monitoring of impact.

Overall Programme RAG

Programme Status		Programme is running to plan but now we need to audit the impact and effectiveness of the workstreams which is a challenge without a data dashboard.
Impact on Outcomes	↔	Not able to measure impact until the audit in Q4.
Delivery Confidence	↔	Confident in delivery assuming all the training still goes ahead going into winter pressures.

Risks / Concerns

- Difficult to measure impact of the work without a quality dashboard, not able to progress the dashboard due to data warehouse.

Quarterly Milestones

Q1		Q2		Q3		Q4	
Deliver PSIRF Lite training to reps	✓	Deliver module 2: Engaging Patient, Family & Staff training to reps	✓	Deliver module 3: After Action Review (AAR) training to service line reps.		Audit frequency, quality and timeliness of AARs undertaken within service lines.	
Complete gap analysis of Experience of Care Framework	✓	Begin implementation of Experience of Care improvement plan	✓	Improvement in≥ 2 key Experience of Care metrics		Evaluate Experience of Care outcomes and evaluation report complete.	
Priority themes and est. baseline metrics	✓	Launch maternity & neonatal steering group and workplan agreed.	✓	Deliver against steering group work plan		Complete thematic review on maternity and neonatal services. Review signed off and ≥3 themes identified	
Design a Maternity Services Steering Group, meeting schedule established.	✓						

Key Metrics

	Q1		Q2		Q3		Q4	
	T	A	T	A	T	A	T	A
% of staff trained in PSIRF modules	Module 1: 90%	84.9	Module 2: 90%	70	Module 3: 90%		Module 4: 90%	
Experience of Care – completion rate of actions (35)	10	20	20	33	30		35	

Programme Name: Clinical Supervision (01/09/26 – 30/09/26)	Executive Sponsor: Senior Responsible Officer: Programme Manager:	Duncan Robertson Michaela Morris
Programme benefits / Objective	A formalised Clinical Supervision Framework is a key enabler of a safe, resilient, and sustainable workforce, directly supporting organisational priorities for quality, patient safety, and workforce retention.	

Alert	Advise	Assure
There are no matters requiring immediate action at this time	Data reporting milestone has not been achieved due to the need to refine the clinical supervision recording and extraction process. This ongoing review has been included within PDSA Cycle 3.	Trial of Level 7 Clinical Supervision module for CTE's confirmed and commenced Sept. One day supervision training also completed

Ask of this forum / action:

Quarterly Milestones

Q1		Q2		Q3		Q4	
Steering Group and Task and Finish Group established	✓	Pilot site launched end of Q2	✓	Review of pilot, learning identified and roll out plans amended if required		Review of pilot, learning identified and roll out plans amended if required	
Clinical Supervision Framework ratified (live / working document)	✓	Educational requirements identified and plans in place to address skills gaps of workforce in place	✓	Roll out plan for other organisational functions developed		Roll out across 999 Operational sector commences.	
		Data reporting and specification to be agreed	×	Framework updated and ratified (if required)			

Overall Programme RAG		
Programme Status	The programme continues to progress in line with its mobilisation and design phase, with governance, and pilot now established	
Impact on Outcomes	↔	Programme remains Green as per previous reporting period.
Delivery Confidence	↔	Programme remains Green as per previous reporting period.

Risks / Concerns

- IF operational pressures increase THEN capacity may be reduced within 999 Operations. Minimal deliverables will be planned for Q3 to allow for seasonal increase in demand whilst limiting impact on programme
- IF Clinical Team Educator vacancies are not filled THEN there will not be capacity or equity of access to clinical supervision across each sector

Key Metrics

	Q1		Q2		Q3		Q4	
	T	A	T	A	T	A	T	A
PDSA Cycles (1 & 2) completed	0	0	2	2	0		0	
PDSA Cycles (3 & 4) completed	0	0	0	0	2		0	
Clinical Supervision active in sectors	0	0	1	1	1		6	

Programme Name: Clinical Workforce (01/09/26 – 30/09/26)	Executive Sponsor: Senior Responsible Officer: Programme Manager:	Duncan Robertson Michaela Morris

Programme benefits / Objective	Implement a consistent, South East–aligned Advanced Clinical Practice (ACP) model across the Soth Central and South East Coast Group. Aligned to national frameworks, the model will strengthen advanced clinical capability, improve workforce sustainability, and deliver improved patient outcomes through timely, senior clinical decision-making.

Alert	Advise	Assure
There are no matters requiring immediate action at this time	As per last highlight report the business case was not ratified by the end of Q2, but will be complete the ratification process during early Q3.	Joint principles for Aligned Clinical Model agreed at Aligned Clinical Steering Group following stakeholder consultation by joint senior leaders during 14 during meeting.

Ask of this forum / action:	

Quarterly Milestones

Q1		Q2		Q3		Q4	
Terms of reference and funding agreed for SCAS and SECAmb Advanced practice review.	✓	Board endorsed business case by the end of Sept 2026.	×	Development and agreement of shared principles with SECAmb future SE Aligned Clinical Model	✓	External HEE funding secured for 6wte Advanced Care Practitioners	
Framework for business case agreed	✓			Advanced care Workforce Planning for year 2 / 3 of multi year plan		Completion of joint SCAS and SECAmb Advanced practice review.	
Gap analysis against HEE framework completed	✓			Education and education support plan agreed for 27/28			

Overall Programme RAG		
Programme Status		The programme continues to progress in line with its mobilisation and design phase.
Impact on Outcomes	↔	Programme remains Green as per previous reporting period
Delivery Confidence	↔	Programme remains Green as per previous reporting period

Risks / Concerns

- IF workforce business cases are not approved THEN we will not commence with our new staffing model. Mitigations: Multi stakeholder business case Task and Finish Group to be established
- IF we are not able to secure advanced care supervisors THEN we will not be able to implement advanced care practitioners. Mitigation scoping of support from Strategic Partners (SECAmb and IOW) who have clinical supervisors within workforce to support trainees.

Key Metrics

	Q1		Q2		Q3		Q4	
	T	A	T	A	T	A	T	A
6 wte Trainee Advanced Care Practitioners appointed	0	0	0	0	0		6	

Estates Modernisation Programme: (01/09/26 – 30/09/26)

Executive Sponsor:	**Danny Hariram**
Senior Responsible Officer:	**Mark Finch**
Programme Manager:	**Dai Tamplin**

Programme benefits / Objective

Develop the strategic case for change across the Trust and Group model, improve working conditions, enhance Patient Safety through better compliance and develop the Make Ready Hub

Alert

Nothing for escalation currently.

Advise

MRH Early Fees Application meeting scheduled with NHSE early Oct 26.

Milestone for identification and securing of suitable land for MRH not achieved as originally planned. To be re-baselined as requiring due date of 31 mar 27 through TOG. This will have a direct impact on % Estates Plan Delivered metric as several works will not deliver until late H2 (incl. MRH milestones).

Assure

Make Ready Hub (MRH) statement of requirement developed. Land searches commenced (milestone will require re-baselining: not due until Mar 27).

Specialist Project Manager recruitment live and internal .

Reduction in backlog maintenance on track with funding allocated, work scoped and specifications issued. A number of contracts under direct award with other tenders either live, or to be issued shortly.

Ask of this forum / action: Nothing currently required.

Quarterly Milestones

Q1		Q2		Q3		Q4	
Trust Board approves Estates Plan 26/27	✓	Establish programme of work for Make Ready Hub	✓	Scope and commission Group Joint Strategic Estates Review		RIBA Stage 4 designs complete for Make Ready Hub	
Secure national funding for Make Ready Hub	✓	Submit Early Fees Application for Make Ready Hub				Submit planning application for Make Ready Hub	
Agree Capital Estates Plan work plan for year	✓	Identify and secure suitable land for Make Ready Hub	★ →				

Overall Programme RAG

Programme Status		MRH programme of work progressing. Securing of suitable land to be re-baselined to FY-end. Contracts in process of being let to progress backlog maintenance.
Impact on Outcomes	↔	Majority of progress to be made in H2. No significant concerns at this time.
Delivery Confidence	↔	Delivery confidence remains high, subject to identification of suitable land for MRH development.

Risks / Concerns

- Insufficient staff resource may impact on the development of the programme of work for the Make Ready Hub project. SRO and Transformation Team working to establish specialised PM support.

Key Metrics

	Q1		Q2		Q3		Q4	
	T	A	T	A	T	A	T	A
% Estates Plan Delivered	15%	10%	30%	10%	60%		> 80%	
% Reduction in Backlog Maintenance	+/- 0%	0%	+/- 0%	0%	+/- 0%		+/- 0%	

Fleet Efficiency Programme: (01/09/26 – 30/09/26)

Executive Sponsor: Jon Bell
Senior Responsible Officer: Lemuel Freezer / Jason Watson
Programme Manager: Dai Tamplin

Programme benefits / Objective

Achieve clear visibility and control of fleet operations, enabling evidence-based decision making and delivery of prioritised improvements, while establishing a strong, low-risk foundation for future transformation.

Alert

Fleet growth remains below plan, impacting the anticipated increase in winter resilience. A significant vehicle order remains delayed due to manufacturer supply constraints, at the converter, preventing planned vehicle deliveries from commencing despite orders being scheduled to commence earlier this year (April).

Advise

The initial DPIA assessment for the Jaama application has been completed, with the first draft due this month. Development of the My Driver, My Technician and My Vehicle applications is progressing to support the digitisation of workshop and VCU processes while recovering time lost through earlier delays.

Assure

The process mapping initiative is underway, with priority fleet processes identified and the operating framework approved. Data and system mapping activities will progress in parallel to support development of the fleet schema.

For the Anaplan project user requirements gathering is progressing at pace, with data architecture design and source data alignment now underway.

To support VOR reduction, mobile technician capacity is being increased from 3 to 6 and the geographical coverage is being expanded.

Ask of this forum / action: Nothing currently required.

Quarterly Milestones

Q1		Q2		Q3		Q4	
Fleet Portfolio Consolidated	✓	Programme workshops held across SCFS	✓	Anaplan discovery/requirements gathering initiated		VCU Lean Pilot Initiated	
Fleet Programme Initiated	✓	High level Data Schema initiated	✓	API feed established from the Trust data warehouse		Planning, scheduling and predictive capability defined	
Digital Checklist and application rollouts in VCU		Fleet Management Optimisation project initiated	✓	Centralised data repository route agreed		Process mapping and data schema completed across SCFS	
		SoP Standardisation and Process mapping projects initiated	✓	Anaplan discovery/requirements gathering initiated		VCU Lean Pilot outcomes evaluated	

Overall Programme RAG

Programme Status

Programme mobilisation is progressing as planned. Initial delays to selected workstreams have been mitigated, with governance established and discovery activity underway across the Data, Process Mapping and Anaplan workstreams.

Impact on Outcomes	↔	Digital checklist deployment remains dependent on completion of the Jaama DPIA; progress has resumed following removal of key blockers
Delivery Confidence	↔	Confidence in programme delivery remains high. Core mobilisation activities have been completed, governance is established and workstreams are progressing into discovery and design phases.

Risks / Concerns

- Resource availability remains constrained as programme delivery is balanced alongside operational priorities. Process simplification and digitisation opportunities are being progressed to support capacity release.
- Delivery of digital capabilities remains dependent on close partnership working between SCFS and Trust Digital Teams.

Key Metrics

	Q1		Q2		Q3		Q4	
	T	A	T	A	T	A	T	A
Fleet Size Variance (Planned/Actual) at Q-end	+/- 0%	-8%	+/- 0%	-6%	+ 10%		+ 10%	
Average Vehicle Availability (DCA)	60%	90%	60%	110 %	60%		60%	
Average VOR (Mechanical)	26.0 %	21.6 %	23.5 %	21.6 %	21.0 %		18.5 %	

Environmental Sustainability: (01/09/26 – 30/09/26)

Executive Sponsor:	**Jon Bell**
Senior Responsible Officer:	**Jonathan Guppy**
Programme Manager:	**Dai Tamplin**

Programme benefits / Objective

Furthering the environmental agenda of SCAS to realise sustainability compliance with national targets, enhancing organisational reputation, delivering value for money and real-time cost saving

Alert

Reliance solely on grant funding capital to deliver essential electrical infrastructure presents a risk to Trust ability to deliver necessary upgrades to operate an electric fleet or power new air conditioning systems.

Briefing paper on "Operational & Financial Risk Associated with DNO Electrical Capacity" has been discussed and approved by Net Zero Committee 10/09/26, next steps for EMC. It discusses this risk in detail and identifies mitigations.

Advise

3rd party legal issues delaying completion of Basingstoke & Kidlington DNO upgrades close to being resolved. Additional EV chargers from £204k NCAS grant will be installed at same time.

Stoke Mandeville DNO upgrade requires consent of hospital and nearby ASDA to commence works; agreed in principle, awaiting paperwork to sign, solicitors are being chased.

6 out of 7 sites for GB Energy solar PV require roof repairs. Roof and solar projects are being combined. Constellia contract delays are impacting prelims, risking further delays.

Assure

National Chargepoint Accelerator Scheme (NCAS) £204k project is on track for completion within grant terms / year end.

GB Energy Solar PV £760k project on track to be delivered by year end.

DNO upgrades in progress but off-plan at Basingstoke, Kidlington and Stoke Mandeville. For completion by year-end.

Aylesbury Workshops EV charging installation – physical works complete, awaiting commissioning and documents..

Ask of this forum / action: Nothing currently required.

Quarterly Milestones

Q1		Q2		Q3		Q4	
Submit National Chargepoint Accelerator Scheme 26/27 bid	✓	*Complete DNO upgrades (Basingstoke, Kidlington, Stoke)*		Climate Change Adaptation Plan complete and approved		Ongoing grant applications through-year from Q2-Q4	
Submit GB Energy Solar PV bid	✓	Aylesbury Workshops EV Charging (incl. DLM) complete	✓	Sustainable Travel Plan complete and approved		Complete £204k NCAS EV charger project	
		£183k mobile EV chargers procured	✓			Complete £760k solar PV projects on 7 sites	

Overall Programme RAG

Programme Status		Q1 has progressed on-plan with positive inroads made for Q2 delivery milestones. External funding opportunities continue to be sought.
Impact on Outcomes	↔	£964k Grants awarded from Q1 bids. Projects will deliver tangible benefits and support compliance with Green Plan objectives.
Delivery Confidence	↔	Delivery confidence remains high at this time BUT may be impacted by grant award decisions, considering oversubscription challenges

Risks / Concerns

- Limited grant funding may impact the ability to deliver capital projects (e.g. DNO upgrades at 20 Resource Centres) essential for SCAS to deliver a sustainable fleet model and install air conditioning to avert future heat wave incidents.
- 3rd party legal wrangling over electrical supply easements and rights of access to enact repairs is causing considerable delays for DNO upgrade projects, despite the documentation being standard industry issue.

Key Metrics

	Q1		Q2		Q3		Q4	
	T	A	T	A	T	A	T	A
DNO Upgrades Completed	0	0	3	0	3		3	
No. of Solar Site Installs	4	4	5	4	5		12	
EV Chargepoint Installations	102	102	163	119	177		177	
Portable EV Chargers (Workshops)	0	0	0	0	7		7	

Programme Name: Blue Light Platforms 2.0 (01/09/26 – 30/09/26)

Executive Sponsor:	**Craig Ellis**
Senior Responsible Officer:	**Jason Somerville**
Programme Manager:	**Craig Robb**

Programme benefits / Objective

Improved Quality: Improve the safety and quality of service to patients by having a modern dispatch system through the implementation of new CAD and ePCR systems.

Alert

The programme brings a negative ROI based on the initial contract term, however will deliver efficiencies covering programme costs within 10 years compared to cost of remaining on incumbent systems.

A single shared CAD instance across the region has been agreed with operational and clinical colleagues. Most of the dependencies for this shared CAD are operational which require the Trusts to align processes & procedures.

This will require additional resource both programme and operational input to align the future operating model. Resources will need to be released and recruited to support this work

Advise

The recommended option in the FBC does not provide for Cyber Disaster Recovery, which has been deemed out of scope of this programme, and therefore leaves the region exposed to significant operational disruption if the system is lost for both 111 and 999 across SCAS, SECAmb and IWAS. A separate business case will be drafted to address this programme dependency.

The FBC was supported at Exec-to-Exec and is on and approved at Joint Trust Board on 1 October 2026.

Edge Switch Replacement

- Tranche 1 - 3 Pending Booker completion and 2 sites pushed into tranche 2.
- Tranche 2 BC in draft-aiming for FAMSG 26 then EMC

Assure

The revenue funding pressure has been reduced by taking lessons from SWAST CAD training, itself undergoing a transition from MIS CAD to Cleric scheduled October 2026. This has reduced the SCAS training commitment from 5 days to an average of 2.8 days per person, which varies by role and will be managed by the SCAS education team.

Revenue was reduced due clarification on the elements that qualified for VAT recovery. Capital requirement has been reduced from £3.5m to £2.3m. This was a reduction in programme resources.

Edge Switch Replacement T1

- 18 sites completed (22 Switches replaced)

Ask of this forum / action: To support the transition into the implementation phase of the CAD / ePCR programme

Overall Programme RAG

Programme Status		Programme remains under joint executive oversight. FBC identified funding gap which was acknowledged via appropriate governance routes. FBC will be submitted for Trust Board approvals on 1 Oct-26 with contracts signed soon after.
Impact on Outcomes	↔	Programme remains on track with no impact on expected outcomes.
Delivery Confidence	↔	Funding gap does not impact programme assurance but is critical to resolve to enable future delivery.

Risks / Concerns

Funding gaps may prevent delivery of a sustainable programme.

Not delivering Cyber DR leaves shared CAD services exposed to attack.

Service levels do not match resilience investment, limiting recourse.

Retained legacy systems may introduce unmanaged safety hazards.

Quarterly Milestones

Q1		Q2		Q3		Q4	
Gap Analysis and clarification document finalised	✓	Carry out and Complete Formal Tender Process	✓	Full Business Case Approval		Commence Mobilisation	
QI and EIA for CAD project completed	✓			Contract Award			
Finalise Specification	✓						

Key Metrics

	Q1		Q2		Q3		Q4	
	T	A	T	A	T	A	T	A
Contract Award	N	N	N	N	Y/N	-	Y/N	-
CAD mobilisation	0%	0%	0%	0%	0%	-	20%	-
Edge Switch Replacement	0	0	19	22	38	-	C	-
Distribution Switch Replacement	0	0	7	0	14	-	C	-

Programme Name: Nightingale (01/09/26 – 30/09/26)

Executive Sponsor:	**Craig Ellis**
Senior Responsible Officer:	**Mark Green**
Programme Manager:	**Craig Robb**
Project Manager	**NO PM RESOURCE**

Programme benefits / Objective

Improved Productivity & Effectiveness: Become a data-driven organisation through the delivery of a Data-Driven programme of work, new Datawarehouse and full implementation of Qlik Sense/IPR Analysis.

Alert

Programme milestones

- Milestones will be re-based following Data Warehouse business case approval at the end of Q2, with substantive mobilisation now commencing in Q3.
- Change control has been submitted to rebaseline milestones and KPI's for the deliverables in red

Advise

PM Recruitment

- Outstanding, existing programme / project management capacity is insufficient to provide the level of focus and coordination required for a multi-year programme.
- Technical work can progress, but overall programme management, administration and coordination remain constrained.

Assure

DW Business Case

- Approved at EMC 30.09.26. Technical approach to be defined.

Recruitment

- Commenced for key technical resource supporting Fabric, data architecture and data-source access
- Expected to be in place early Nov26.

SECAMB Collaboration

- Meeting planned for end of Oct26 – enabling progression of shared data model, learnings and data definitions

Ask of this forum / action: Support re-baselining of Nightingale milestones and resolution of PM resource requirement.

Overall Programme RAG

Programme Status		Programme mobilisation is progressing following Business Case approval, although confirmation of technical resources and completion of rebaselining remain key prerequisites to delivery
Impact on Outcomes	↔	Remains achievable; the later mobilisation point will affect delivery timescales, however re-baselining will align planned outcomes and milestones to a revised delivery profile.
Delivery Confidence	↔	Remains Amber: Delivery can now progress following business case approval, but confidence remains constrained until dedicated PM capacity is resolved and the revised programme baseline is agreed.

Risks / Concerns

Programme baseline – Issue

- Existing milestones are no longer aligned to the current delivery position, as substantive mobilisation has commenced later than originally planned following Data Warehouse business case approval.
- Next step: Rebaseline milestones and submit agreed amendments through TOG change control.

Quarterly Milestones (Year 1 of 3)

Q1		Q2		Q3		Q4	
Programme mobilisation & governance established		Data warehouse approach agreed – work commences		Organisational data model design completed		Delivery of Sub-Committee reporting capability	
Scope validation & stakeholder engagement		Data definitions complete with SECAmb (999/111 clinical, ESR and GRS)		Information literacy programme development		Deliver and complete SCAS data quality programme	
Data Platform (DW) design initiated with costed options appraisal	✓	Qlik visualisation environment proposal scoped		Delivery programme agreed with all directorates		Removal of shadow DA&I functions across SCAS	

Key Metrics

	Q1		Q2		Q3		Q4	
	T	A	T	A	T	A	T	A
% reduction in manual reporting	**B**	✓	0	0	**0**		**20-30%**	
% of Qlik dashboard utilisation	**0**	0	0	0	**0**		**40-50%**	
Data Quality improvement	**F**		0	0	**10-20%**		**20-30%**	

Programme Name: Watson AI
(01/09/26 – 30/09/26)

Executive Sponsor:	Craig Ellis
Senior Responsible Officer:	Craig Ellis
Programme Manager:	Not Assigned
Project Manager	Clair Ferguson/Olly Parsons

Programme benefits / Objective

Improved Productivity: Seek out opportunities where AI can enhance decision-making, support staff, and improve patient experience by running a set of pilots in 26/27.

Alert

Programme capacity

- Limited PM capacity continues to constrain wider Watson AI/QI delivery and has been a contributing factor to milestone slippage.
- As a result, a review is in progress to determine deliverables achievable in 26/27 and those that may need to be rebaselined into 27/28. Change control will follow.

Advise

Watson 1

- Rebuild remains paused pending an appropriate backup solution to avoid the risk of losing the environment again.
- Once backup arrangements are confirmed, technical resource can progress the remaining rebuild and model deployment activity.

AI Staff training Pilot

- NHS Pathways demo scheduled for 19 October to showcase development and progress achieved since the start of the year.
- Business case progressing for pilot planning/mobilisation (behind schedule)

111 NLP:

- Go live remains dependent on NHSE confirmation

Assure

Watson 2

- Supplier POs have been raised, approved and issued to the respective suppliers.
- Awaiting supplier availability to arrange a planning/kick-off session and agree the implementation approach and schedule.
- Technical delivery will progress following the planning session.

111 NLP

- Purchase order approved and issued to supplier; middleware development progressing. Internal testing process being drafted, Awaiting API credentials from Advanced before local testing can begin.

Ask of this forum / action:

Quarterly Milestones

Q1	Q2	Q3	Q4
Governance & Assurance Established	*AI Staff training Plan Agreed*	AI Staff training Pilot	AI Staff training Benefits Evaluation
AI Pilot Business Case Completed	Watson AI Agents Use Case Development	Watson AI Pilot agent 1 - Mobilised	AI Staff Training Scale up Recommendation
	Funding Approval Outcome		
Baseline Assessment & User Case Prioritised	Ai Staff training Pilot mobilised	111 NLP Benefits Realisation	Watson Year 2 Plan Defined
	111 NLP testing		

Overall Programme RAG

Programme Status	Progress continues on enabling activities; however milestone slippage has occurred within the AI Staff Training Pilot and Watson readiness activities due to capacity constraints and technical dependencies
Impact on Outcomes	↔ Remains Amber - Programme scope and intended benefits remain achievable, but some benefits are likely to be realised later than originally planned.
Delivery Confidence	↔ Remains Amber - Delivery requires additional or protected PM capacity.

Risks / Concerns

- **Programme capacity: IF** protected PM capacity is not secured, **THEN** wider programme milestones will continue to slip. ***Mitigation****: Confirm priorities/capacity and rebaseline affected milestones.*
- **Watson readiness: IF** technical readiness and resilience arrangements are delayed, **THEN** commissioning and subsequent AI activity may slip. ***Mitigation:*** *Complete discovery and supplier planning.*
- **111 NLP: IF** NHS England readiness and go-live confirmation are delayed, **THEN** implementation and Q3 benefits realisation may slip**. *Mitigation:*** *Complete local and end-to-end testing at the earliest opportunity and confirm the implementation timeline with NHS England.*

Key Metrics

	Q1		Q2		Q3		Q4	
	T	A	T	A	T	A	T	A
No of AI Pilots	0	0	1	0	2		3	

Programme Name: Shield 24/7

BAF link: Primary – SR3 / Trust risk 465

(01/09/26 – 30/09/26)

Executive Sponsor:	**Craig Ellis**
Senior Responsible Officer:	**Anita Lines**
Programme Manager:	**Not Assigned**
Project Manager	**NO PM RESOURCE**

Programme benefits / Objective

Increased Effectiveness: Deliver cyber security improvements to protect system safety, availability and core service continuity.

Alert

Programme Management Resource

- BC ready for FAMSG but submission is contingent on securing the FPP investment confirmation.
- Delivery of the wider improvement programme remains dependent on securing funding requirements. Delays or non-approval would impact the pace and scale of cyber resilience improvements.

Advise

Forensic service Business Case

- Approved at EMC 30.09.26.
- HR and Phoenix to progress activity planning, with Cyber involvement is no longer required.

Milestone additions

- Two additional milestones proposed to strengthen explicit alignment to BAF (SR3). Change control submitted for approval.

Assure

Cyber Architecture discovery: Discovery work completed. Cyber architecture report received and under review. Findings will support development of the Cyber Strategy and future programme planning.

Cyber Maturity Assessment: Assessment progressing as planned, evidence gathering continues with trust-wide engagement. Report anticipated mid-Oct26.

Entra ID Review: SCAS environment review completed. Report under review and expected to identify areas of strength alongside opportunities for improvement

Ask of this forum / action: **Note the continued dependency on funding approval and programme resource capacity**

Quarterly Milestones

Q1		Q2		Q3		Q4	
Discovery initiated	✓	*Discovery phase continues*	✓	Evidence of improvement required against maturity baseline		**ADD: approve strategy & roadmap (SR3)**	
				Delivery Cyber Strategy Plan		**ADD: Define SOC/SIEM model (SR3)**	
						Review Cyber plan for year 2 to year 4 activities	

Overall Programme RAG

Programme Status		Shield 24/7 discovery & maturity assessment activities continue to progress as planned. Outputs will inform development of the Trust's first Cyber strategy & future cyber resilience roadmap, while strengthening governance and assurance.
Impact on Outcomes	↔	**Remains Amber**. Benefits remain achievable. Discovery findings will help prioritise future investment and improvement activities. Longer-term outcomes remain dependent on securing funding & PM capacity.
Delivery Confidence	↔	**Remains Green**. Discovery, governance and assurance activities remain on track and continue to generate outputs required to develop the Trust Cyber Strategy and roadmap.

Risks / Concerns

IF FPP funding and PM capacity remain unsecured, **THEN** cyber improvements and secure Digital delivery may be delayed, prolonging risks to service continuity. ***Mitigation****: Continue funding escalation; progress the PM business case through FAMSG once confirmed.*

Key Metrics

	Q1		Q2		Q3		Q4	
	T	A	T	A	T	A	T	A
No of 'Denial of Service' Incidents	0	0	0	0	0		0	
Cyber maturity improvement Plan (Yr1 of 4)	30%	30%	60%	60%	100 %		100 %	

Programme Name: Caring with Digital

BAF Link: Primary – SR2/ Trust risk 467

(01/09/26 – 30/09/26)

Executive Sponsor:	**Craig Ellis**
Senior Responsible Officer:	**Steve Clarke**
Programme Manager:	**Not Assigned**
Project Manager	**Hanif Rahaman/Clair Ferguson**

Programme benefits / Objective

Safe patient care, improved productivity and a digitally capable workforce, enabled by secure, resilient and modern digital platforms

Alert

Safeguarding:

- Ageing APM infrastructure remains a key continuity/supportability risk pending migration to the replacement platform.

M365 Post Migration:

- 75 third-party applications/portals remain to be updated.

SQL optimisation:

- Position unchanged. NHSD_TRANS01 remains pending formal BAU handover; Proactis and Finance remain risk-accepted pending replacement.
- Capacity remains the key constraint.

Advise

M365 Post Migration:

- Remaining users are now managed through BAU.
- Support demand reduced, although not all additional tickets were M365-related, and inconsistent ticket recording limits detailed analysis.

Safeguarding:

- Reforecast required now that project plan is aligned to the supplier. CR submitted for UAT & deployment.
- Requirements, funding and delivery feasibility for GP Notifications, TIA and Falls Referrals remain under review. Programme scope and milestones will be updated through change control once confirmed.

Assure

M365 Migration:

- Core M365 migration completed successfully and transitioned to BAU.
- 234 of 309 applications/portals have migrated (76%), with residual activity progressing and lessons learned underway.

Safeguarding Progress:

- discovery and development kick-off complete. Internal and supplier project plans now aligned, providing an agreed basis for the revised UAT and deployment schedule.
- Funding route confirmed through the Clinical Directorate rather than Digital.
- Revised plan currently supports Q3 UAT

Ask of this forum / action: n/a

Quarterly Milestones

Q1	Q2	Q3	Q4
M365 Central Tenant Migration ✓	M365 applications implemented	Copilot Mobilisation	Copilot Rollout
SQL Estate optimisation	Safeguarding in UAT *(need to reforecast to Q3)*	Safeguarding deployment *(need to reforecast to Q4)*	TIA & Falls Referrals *(at risk)*
DocWorks Migration ✓		GP Notification of Attendance *(at risk)*	

Overall Programme RAG

Programme Status: Programme remains deliverable, with key Q2 progress achieved. Revised clinical sequencing, resource constraints and unresolved dependencies continue to require active management.

Impact on Outcomes ↕ **Remain Amber**: M365 has enabled future productivity benefits; clinical modernisation benefits will be realised later than planned.

Delivery Confidence ↔ **Remain Amber:** Completion of a key Q2 milestone supports delivery confidence, but this is offset by resource capacity constraints and outstanding confirmation of revised delivery plans.

Risks / Concerns

- **Safeguarding platform: IF** the ageing APM remains in use, **THEN** continuity and supportability risks remain. ***Mitigation:*** *Progress Q3 UAT and Q4 deployment and monitor.*
- **Clinical application scope**: **IF** GP notification and TIA/falls requirements and funding remain unresolved, **THEN** full modernisation may not complete in 2026/27. ***Mitigation:*** *Confirm scope/funding and rebaseline milestones and KPIs if required.*
- **M365 residual updates: IF** third-party applications and contacts are not updated before forwarding ends, **THEN** communications may be missed. ***Mitigation:*** *Complete outstanding updates and manage residual issues through BAU.*

Key Metrics

	Q1		Q2		Q3		Q4	
	T	A	T	A	T	A	T	A
% users migrated to M365	**Pilot**	Q2	100 %	**83 %**				
SQL server optimisation	**23**	7	-	19	-		-	
Copilot	**0**	0	0	0	0		100 %	
Clinical system application modernisation *(4 systems identified)*	**25%**	25%	50%	25%	75%		100 %	

Programme Name: Building Trust Together (01/09/26 – 30/09/26)	Executive Sponsor: Senior Responsible Officer: Programme Manager:	Danny Hariram Mehvish Shaffi-Ajibola Emma Manaton
Programme benefits / Objective	To create a safer, more inclusive and engaged workplace culture through strengthened leadership, improved behaviours and wellbeing support, meaningful staff engagement, high-quality conversations and delivery of key people and ED&I initiatives.	

Alert

Q2 Sexual Safety milestone and reporting metrics re delayed due to the temporary absence of lead subject matter expert. Timelines will be reviewed and progress will resume when capacity is restored.

Leadership symposium on 15th Oct has 60 staff attending with some Execs, providing an opportunity to discuss current issues and themes in an open style approach.

Missed targets around staff engagement and promotor score, mitigation actions include a new wider comms & engagement plan, local directorates will have a dedicated culture & leadership partner and stronger partnership with comms team with biweekly meetings.

Advise

The Q2 Unity in Diversity Conference milestone has been delivered. Feedback from attendees and stakeholders is currently being reviewed to identify learning opportunities and improvements.

A draft proposal for first-line leadership development is being developed

Aspiring Executive talent pipeline submitted as part of the regional succession planning return.

Planning for the Leadership Symposium has been completed, with delivery scheduled for 15 October

Assure

Values & Behaviours reflection week completed with a range of engagement and communications initiatives. The delivery group has now adopted a task-and-finish approach to complete the remaining embedding activities.

A new fortnightly Comms & Culture Coordination meeting has been established to strengthen planning and oversight of culture, engagement and communications activity.

Wolf we Feed training has started with the first line leaders: 16 attended on 29th Sep. Second session scheduled 12th October

Ask of this forum / action:	N/A

Quarterly Milestones

Q1		Q2		Q3		Q4	
Sexual Misconduct Policy finalised & approved.	✓	Multidisciplinary Sexual Safety triage & review process rolled out.	x	Sexual Safety Prevention plan submitted to NHSE - priorities agreed.		Local Sexual Safety action plans implemented across services.	
Refreshed Values & Behaviours formally approved & Trust-wide launch completed.	✓	Exec & Senior Leader Values & Behaviours engagement plan completed.	✓	Embedding Values across policies and recruitment processes underway.		V&B evaluation completed - refreshed materials and activities implemented.	
Senior Leadership Symposium successfully delivered.	✓	"Every Conversation Counts" toolkits launched with ongoing drop-in sessions established.	✓	Leadership capability strengthened through the 2nd Leadership Symposium.		PDR process aligned to the NHSE PDR framework.	
Culture Champion Network established & operational.	✓	Unity & Diversity Conference delivered.	✓	Values-based recognition launched through Each Person.		Disability Confident Leader self-assessment completed, with improvement plan agreed.	

Overall Programme RAG

Programme Status		Programme RAG remains Good progress made across leadership development, sucession planning and engagement with ¾ Q2 milestones delivered. Capacity pressure, has delayed progress of one Q2 milestones, requiring revised delivery timelines and recovery actions.
Impact on Outcomes	↔	Following a challenging summer period, including, extreme heat, operational pressures and organisational change, NQPS metrics have reduced below Q2 targets. Ongoing culture and engagement initiatives remain in place.
Delivery Confidence	↔	Most programme milestone remain achievable; capacity pressures and competing priorities continue to affect delivery timelines. Mitigations, revised delivery approaches and focused recovery delivery are underway to support delivery of Q2 & Q3 milestones.

Risks / Concerns

- Workforce (NQPS) metrics have fallen below expected levels, creating a risk that progress towards a safer, more inclusive and engaged workplace culture may not be realised at the pace required to achieve programme outcomes
- Capacity pressures across the programme may impact delivery of key milestones and progress towards a safer, more inclusive and engaged workplace culture. A new Culture and Leadership Partner has been onboarded to increase capacity, and deputy arrangements for Sexual Safety activity are being agreed to maintain delivery momentum.

Key Metrics

	Q1		Q2		Q3		Q4	
	T	A	T	A	T	A	T	A
Average time to Commission CoF (weeks)	8.9	11.2	6.5	TBC	5		3	
Time taken for Sexual Safety CoF (weeks)	13.5	13.1	10.5	TBC	9		8	
% Staff recommend SCAS as place to work	22.7	26.2	30.1	23.3	N/A	N/A	45.0	
NQPS employee engagement score	5	5.07	5.2 %	5.06 %	N/A	N/A	5.7 %	

Programme Name: Education Modernisation (01/09/26 – 30/9/26)	Executive Sponsor: Senior Responsible Officer: Programme Manager:	Danny Hariram Will Broughton Emma Manaton

Programme benefits / Objective	Deliver a modernised, integrated education service by aligning ICC and SCAS Education functions, strengthening capability through collaboration, benchmarking, and CPPD, and supporting workforce development, patient care, and safety through effective partnership working.

Alert

ICC integration complete for nonclinical, however clinical delayed, but now progressing.

Benchmarking and draft strategy incomplete whilst education review continues – need to be cognisant of SECAMB strategy and group approach.

Saving and efficiency work now a priority and impacting capacity, as forecast overspend of c.£400k and no clear large CIPS available.

3-year strategy by end of Q3 not achievable, working with workforce forecasting to understand education demand and deep dive into processes.

Advise

Education review by new Associate Director is ongoing, interim report provided to CPO and Deputy CPO. Final report due end of October.

CPD split is off track, meeting to review what offering and review feedback. New non-clinical CPD (based on TNA) due to be released Q3 which may improve this. CPD is done in own time so cannot make it mandatory so limited in how much we can affect this.

Course fill rate missed target but feel 73% is a positive number given the quarter of CI and REAP.

Assure

TNA work complete and panels are meeting to ratify CPD allocations based on the TNA (subject to NHSE approval in November). Internal training been identified and some implemented, some in development.

CPD places offered is up on Q1 but just misses the Q2 target, this is positive and confident will hit the total year target by end of year.

Ask of this forum / action:	To understand that the programme objective is at risk given the competing priority of a new department financial target and lack of workforce planning information and confirmed organisational priorities to inform education planning and enable creation of a draft strategy.

Quarterly Milestones

Q1		Q2		Q3		Q4	
Associate Director appointed.	✓	Priorities and operating model defined. Benchmarking, gap analysis, draft strategy and roadmap completed.	x	3-year strategy with KPIs finalised with executive approval.		Implementation of priority elements started and reporting framework established (with ICC integration).	
Complete education/TNA and cost/performance baselines (begin ICC integration).	✓	Quick wins delivered; early savings tracked (≥10% non-pay reduction)	x	Efficiency initiatives expanded; 3-year continuous improvement plan launched.		≥85% efficiency actions delivered; performance tracking embedded.	
Benchmarking against best practice completed; efficiency targets agreed.	x	Targeted CPD offer rolled out to wider staff groups	✓	CPD access expanded; uptake tracked and career pathways introduced.		≥85% workforce access achieved; CPD evaluated, refined and embedded	
Map provision, identify gaps, and define focussed CPD offer.	✓						

Overall Programme RAG

Programme Status	Programme RAG moved to RED, elements of the programme (strategic roadmap) are no longer achievable, suggest re-baseline these milestones. Work continues on benchmarking and will work closely with workforce lead to understand future education demand. Work on CPD offering is improved and close to target, but uptake out of control of the team, reviewing options
Impact on Outcomes	↓ Further cancellation of training and deployment of clinicians to operations impacting course fill rates. Challenges progressing the strategy and roadmap due to missing information.
Delivery Confidence	↓ Delivery confidence is low given the current position of the department and ongoing education review. Working on actions to address gaps in required information.

Risks / Concerns

- Ability to create education strategy impacted due to absence of workforce plan to inform education demand, collaboration with SECAMB still in initial stages and ICC integration was delayed. Working on action plan to address the gaps and look to re-baseline the strategic roadmap related milestones.
- Additional priorities for the department impacting capacity for the programme due to new significant financial pressure taking priority.
- Initial benchmarking review suggests need for deeper dive into what we currently deliver (how, why) as the emerging picture indicates a lack of readiness for modernisation and poor data to inform any approach to modernisation and/or transformation.

Key Metrics

	Q1		Q2		Q3		Q4	
	T	A	T	A	T	A	T	A
CPD coverage (available places across offer)	450	330	500	480	350		250	
CPD split (clinical / non-clinical)	65:35%	72:28	65:35%	77:23	65:35%		65:35%	
Course capacity fill rate (All courses)	75%	73%	78%	73%	80%		90%	
Maintain quality while delivering change: Learner Voice – 'overall I am satisfied with...	90%	95%	90%	90%	90%		90%	

Programme Name: People Services
(01/09/26 – 30/09/26)

Executive Sponsor: Danny Hariram
Senior Responsible Officer: Lynn Lane
Programme Manager: Emma Manaton

Programme benefits / Objective

Greater consistency and compliance, reduced payroll errors, improved staff wellbeing outcomes and service effectiveness. Deliver sustainable improvements across Employee Relations, Payroll and Wellbeing services to support a positive employee experience and operational excellence.

Alert

ER case dashboard delayed due to 365 migration, work restarted.

Q1 and Q2 ER case investigation targets missed, seconded 2 full-time investigators for 12-month pilot to reduce investigation time.

No progress with SECAmb on TRIM training, SECAmb have funded practitioners and sharing resources not yet agreed. However also concerns that unable to share resources due to GDPR. Mitigation is that we now have validated training TRIM licences to run our own training.

BC to move registration to Ops delayed as dealing with backlog first and want to review how SECAmb do these checks.

Advise

Manage Self Service phase 1 achieved (50% roll out), however activity has now slowed due to individual commencing maternity leave, roll out continues where capacity allows, may impact the level of savings in overpayments

DBS backlog work has been achieved; however, a process review is required to improve efficiency and cost savings.

Overpayments not hit target in £ but have seen a reduction in call case volume Q1 (131) and Q2 (101) (Q4 25/26 2qw 213). Majority of overpayment reasons are late leaver notifications. Re-reviewing processes. Underpayments have improved by more than 50%.

Assure

Joint tender work for payroll provider is ongoing, 3 bids have been received and currently under evaluation.

DBS backlog has been cleared.

Mental Health First Aiders have undertaken training and launched end of Sept. Ops leading the new network.

Occupational Health Tender on track.

Ask of this forum / action:

Quarterly Milestones

Q1		Q2		Q3		Q4	
Implement ER case dashboard	x	ITT Occupational Health out to tender	✓	ITT Occupational Health contract awarded		Begin implementation new OH service	
Proactive & prevention trauma support Mental Health First Aiders training	✓	Launch Mental Health First Aider Network	✓	Evaluate impact of Mental Health First Aider network and training.		Evaluation of TRIM Training, assess impact.	
Reduce DBS backlog. Submit BC to automate Pay steps	✓	TRIM training (SECAmb Collab)	x	Improve BI reporting from SBS portal		On board and begin payroll implementation.	
Payroll Invitation to tender (ITT)	✓	BC to move Registration checks to Ops,	x	Award Payroll contract			
		Manager Self Service roll out (phase 1)					
		Evaluate payroll tender submissions	✓				

Overall Programme RAG

Programme Status		Programme making good progress with majority of milestones achieved. Interventions in place to recover ER cases and new payroll manager having an impact.
Impact on Outcomes	↓	Not seeing the impact we expected in any KPIs. Added additional ER case investigators to the team and a new Collation of Facts Hub pilot, starting to see some improvements, confident will be seeing a difference by end of Q3.
Delivery Confidence	↔	Confident to catch up on missed milestones. New SCAS payroll manager now in post to hold SBS to account and access to the SBS data portal. Need to assess the impact of the 2 new investigators to reduce ER case times

Risks / Concerns

- Delays to MSS roll out due to capacity may impact our ability to achieve the reduction in overpayments we anticipated.
- Collaboration with SECAmb on TRIM is slow, if no agreement on sharing resources is reached, we will make little progress as we have already added the training we can within budget for SCAS staff. Investigate

Key Metrics

	Q1		Q2		Q3		Q4	
	T	A	T	A	T	A	T	A
ER case investigation time (calendar days)	48	63	46	73	44		42	
Time taken to resolve level 3 pay queries (days)	25		20		18		10-15	
Reduction in overpayment / underpayments (£000)	50	171	40	91	30		20	
Q4 25/26 (213 calls)		131 calls		101 calls				

Programme Name: Recruitment Optimisation (01/09/26 – 30/09/26)	Executive Sponsor: Senior Responsible Officer: Programme Manager:	Danny Hariram Lynn Lane Emma Manaton
Programme benefits / Objective	Deliver a skilled, diverse and sustainable workforce through streamlined, inclusive recruitment, stronger hiring manager accountability, reducing workforce gaps and costs.	

Alert	Advise	Assure
Best practice sharing with SECAmb was delayed, initial introduction call between heads of within the people teams has taken place. Next steps not yet agreed.	TRAC Training and guidance delivered but not done informally. Aim is to set up regular training sessions for hiring managers. Talent Pool established on TRAC system, but how we use this moving forward after the restructure needs to be reviewed.	Workplace adjustments passports and student learner agreements now in place with every new starter pack. Recruitment interview skills training has been updated to include more emphasis on bias with additional courses being planned to increase interviewers. Recruitment work with ICC is progressing. Ahead of plan on delivering the reduced time to hire.

Ask of this forum / action:

Quarterly Milestones

Q1		Q2		Q3		Q4	
Overhaul Shortlisting process (ICC)	✓	Increase no. 'Interview skills' trained managers, improve assessment process	✓	Review attraction strategy & brand		Job Evaluation centralised / controlled	
Hiring Manager experience survey and create action plan	✓	Vacancy control guidance & TRAC training	✓	Centralised JD repository complete		Joint Talent Pool SECAmb	
Review progression pathway	✓	Establish Talent Pool	✓	Align IWPs with internal jobs, clear career pathways		Disability confident Leader self-assessment analyse gaps, create plan	
Best practice sharing with SECAmb	x	Embed workplace adjustments passports, increase bias trained interviewers	✓				

Overall Programme RAG

Programme Status		Programme is on plan with a continuous improvement focus embedded across the team. Good progress has been made, however, stakeholder engagement dependencies can impact negatively.
Impact on Outcomes	↔	Achieving the reduction in time to hire ahead of target.
Delivery Confidence	↔	Confident in delivery for next quarter, collaboration with SECAmb slow to establish so group related items may be delayed

Risks / Concerns

- Pending increase in recruitment activity could impact team capacity to deliver improvements
- Uncertainty around the workforce plan vs establishment could impact delivery
- Recruitment team doing over an above hiring requirements. Hiring managers taking more accountability may lead to more frequent errors and potential poor staff experience.

Key Metrics

	Q1		Q2		Q3		Q4	
	T	A	T	A	T	A	T	A
Reduce Time to Hire (Weeks)	12	10	11	10	11		11	

Programme Name: Collaboration & Partnership (01/09/26 – 30/09/26)	Executive Sponsor: Senior Responsible Officer: Programme Manager:	Danny Hariram Caroline Morris Claire Webster
Programme benefits / Objective	To improve operational performance and organisational efficiency benefits through the creation of an Ambulance group model and through greater collaboration with neighbouring Ambulance Trusts	

Alert	Advise	Assure
• We have identified a series of costs of collaboration that highlight adverse short-term financial impacts as a result joint decision-making processes. These are being carefully monitored in conjunction with NHS England and our commissioners.	• A robust benefits framework building on the initial outline business case to support the next phase of group model development is required to support the group model development. • A strategy refresh across the group is to be started imminently to support prioritisation and focus on high impact activities given the scale of change required	• THe FBC for the CAD replacement has been approved in October and will now move forward. A delivery team is being assembled. • Plans on a Page for the six core workstreams previously agreed have been produced and are being socialised • The Group Model working group has been strengthened to include Chief Governance offices, communications and new chief Executive.

Ask of this forum / action:	None

Quarterly Milestones

Q1		Q2		Q3		Q4
Transitional governance in place including steering group	✓	New Chair starts	✓	New Chief Executive Starts	✓	
Interim CEOs appointed	✓			TBD		
Joint programmes of work signed off and established as programmes	✓					
				SEE CAD AND CLINICAL MODEL HIGLIGHT REPORTS FOR FURTHER KPIs		

Overall Programme RAG

Programme Status		Although milestones are being met, and programmes are progressing, there is a short-term cost of collaboration. A clearer benefits framework needs developing to assure on delivery of programme objectives over the medium term
Impact on Outcomes	↓	Further work is required to build a more robust benefits framework to support the delivery of the group model to demonstrate value.
Delivery Confidence	↔	Confidence in delivery of key workstreams remains high with a further detailed plans for remainder of the year in development.

Risks / Concerns

- If the speed of development of the group model fails to meet expectations of regional colleagues, there is a risk of a loss of confidence in leadership resulting in additional pressure and direction on the organisation at a time of financial and operational recovery.
- If senior leaders and staff are not meaningfully involved in the creation of the group model there is a risk of disengagement and poor staff morale making it harder to deliver quickly on a new organisational form.

Key Metrics

	Q1		Q2		Q3		Q4	
	T	A	T	A	T	A	T	A

See CAD and Clinical Model Highlight reports for KPIs

Programme Name: Financial Sustainability (01/09/26 – 30/09/26)	Executive Sponsor: Senior Responsible Officer: Programme Manager:	John Bell Spriha Dutt
Programme benefits / Objective	Achieve financial balance, strengthen multiyear planning processes and create continuous cycle, develop three-year productivity plan and deliver agreed capital and infrastructure plan.	

Alert

- The Trust has submitted a break-even forecast to the region. However, there remain significant risks associated with an increased expenditure run rate in the second half of the year. The forecast includes the £1.6m recovery plan to support improvements in Category 2 performance, together with delayed cost pressures relating to digital and other corporate areas. These assumptions will need to be kept under review, with the impact reassessed and mitigations identified to maintain delivery of a break-even position by year end.

Advise

- Monthly meetings are taking place with Directorate leads to review CIP delivery and develop the 2027/28 CIP programme. A mix of short and longer-term opportunities has been identified and is being progressed..
- CIP is on plan, although reliance on non-recurrent schemes continues to support delivery of the financial target. Focus remains on securing recurrent benefits and managing scheme slippage.
- Capital plan faces some significant risks, particularly across fleet and estates. Potential slippage is being managed through internal brokerage of schemes across financial years.

Assure

- The Trust's YTD M5 financial position is on plan against target.
- The Trust continues to maintain a healthy cash position, ahead of plan.
- The Trust now has a fully identified CIP plan, with ~90% of the schemes fully developed.
- All contract negotiations (excl. PTS) with ICBs have been completed with a favourable outcome for the Trust.

Quarterly Milestones

Q1		Q2		Q3		Q4	
Complete review of planning progress		*Undertake formal 6-month review*		Commence formal planning process		Conclude next iteration of 3-year plan	
Implement innovation process	✓	Revise planning model		Set up CIP planning process for 27/28 and beyond		Complete CIP Plan prior to year-end	
Fully work up CIP programme	✓	Review of innovation process		Ensure CIP programme on track		Ensure CIP programme on track	
		Ensure CIP programme on track					

Overall Programme RAG

Programme Status		On plan, with risks around emerging cost pressures that will need to be mitigated to ensure delivery against financial plan.
Impact on Outcomes	↓	Additional expenditure has been incurred to support operational performance during periods of increased demand due to heatwave conditions
Delivery Confidence	↔	Delivery confidence is Amber. Delivery is contingent on progress with mitigative actions to manage current risks.

Risks / Concerns

- There is a risk of inflationary pressure, particularly from unbudgeted fuel price increases. The full-year impact of £1.2m is expected at current rates. This remains dependent on the evolving geopolitical situation.
- There are costs associated with maintaining business continuity during heatwave and winter periods, which create further financial pressure. The Trust will also need to incur further spend to restore Cat 2 performance.

Key Metrics

	Q1		Q2 (YTD M5)		Q3		Q4	
	T	A	T	A	T	A	T	A
Cash Management	34.2 m	37.1 m	37.8 m	44.0 m				
Delivery against budget	£16k deficit	£12k deficit	£55k deficit	£54k deficit				
Capital Plan Delivered (incl. disposals)	£0.1 m	£0.5 m	£0.0 m	£1.4 m				

Programme Name: CIP Delivery (01/09/26 – 30/09/26)

Executive Sponsor:	**Jon Bell**	
Senior Responsible Officer:	**Spriha Dutt**	
Programme Manager:		

Programme benefits / Objective

Deliver in-year financial recovery plan and ongoing development of recurrent productivity and efficiency schemes to ensure Trust's financial sustainability.

Alert

- The programme's performance up to YTD M5 is £42k ahead of plan. While temporary measures have helped to mitigate shortfall in the short term, delivery on recurrent schemes must return to plan to ensure the Trust achieves its financial target.

Advise

- Delivery of the full CIP programme remains essential if the Trust is to achieve its financial plan. While a number of schemes have been identified, several carry a high risk of non-delivery or only partial delivery, with limited evidence of actions or improvements in place. Significant work is therefore required at pace to further develop, validate and implement these schemes to maximise delivery in H2 and mitigate the risk of a shortfall against the CIP target.

Assure

- The CIP plan has been fully identified with the gap against the £19.7m programme value closed
- All schemes are backed by passports, with relevant schemes going through the Quality Impact Assessment process.

Ask of this forum / action:

Quarterly Milestones

Q1	Q2	Q3	Q4
Complete CIP identification and delivery passports	Commence CIP identification for 27/28	Confirm CIP requirement as part of planning process	Develop CIP Passports for 27/28
Q1 Delivery	Q2 Delivery	Q3 Delivery	Q4 Delivery

Overall Programme RAG

Programme Status		On plan, with further identification of schemes required to provide headroom to manage against slippage and create a reinvestment pot for 'invest-to-save' initiatives.
Impact on Outcomes	↓	N/A
Delivery Confidence	↔	Delivery confidence RAG continues to be green with the CIP plan fully developed and delivery passports submitted.

Risks / Concerns

- There are potential risks associated with further cost pressures that are being identified or approved. While this does not change the current risk rating, it may increase the scope of the programme, requiring the rapid identification of additional schemes to manage the financial position effectively.

Key Metrics

	Q1		Q2 (YTD M5)		Q3		Q4	
	T	A	T	A	T	A	T	A
% of CIP plan delivered	21%	21%	37%	38%	71%		100%	

Trust Board of Directors Meeting in Public 5 November 2026	
Title	Integrated Performance Report – Month 6
Report Author	Tina Lewis - Head of Performance & Planning
Executive Owner	Stuart Rees – Interim Managing Director
Agenda Item	10
Governance Pathway	Executive Management Committee 19th October 2026 Finance & Performance Committee
Governance Pathway Next Steps	None – report is for the Trust Board

1. Purpose

To provide a consolidated and triangulated view of Trust performance across quality, people, operational performance and finance quadrant, using a combination of NHS Oversight Framework (NOF) metrics and locally determined metrics that relate to delivery of the commitments set out in the Operating Plan 2026/27 and aligned to the Fit for the Future Transformation Programme where applicable. The data in this report relates to September 2026.

2. Executive Summary

The 4 quadrants of Trust performance are inextricably linked, and underperformance in one area may be caused by or may impact performance in another(s). The purpose of this report is to provide a triangulated view of Trust performance.

The Trust remains in segment 4 of the NHS Oversight Framework (NOF) and is ranked 10/10 in the sector from a NOF perspective. As a consequence of sustained operational pressure impacting Category 2 (Cat2) response times and 999 call answer performance, the Trust remains under close monitoring at regional and national level. The Cat2 Recovery Plan that was approved by the Trust Board, with additional investment to recover performance, continues to be closely monitored both internally and externally.

Whilst there is additional commentary within the Integrated Performance Report (IPR) in appendix 2, the key metrics of concern to bring to the attention of the Trust Board are:

- Category 1 and 2 performance
- Hear and Treat
- Call answer time in 999 and 111
- Patient Harm
- Sickness absence

2.1 Key Performance Summary

Table 1 provides a summary of latest position against key metrics across quality, people, performance and finance, which contribute to our NOF score and segmentation, along with

our provider capability rating. Additional metrics across all 4 areas are included within the IPR (appendix 2) to provide a richer picture of performance.

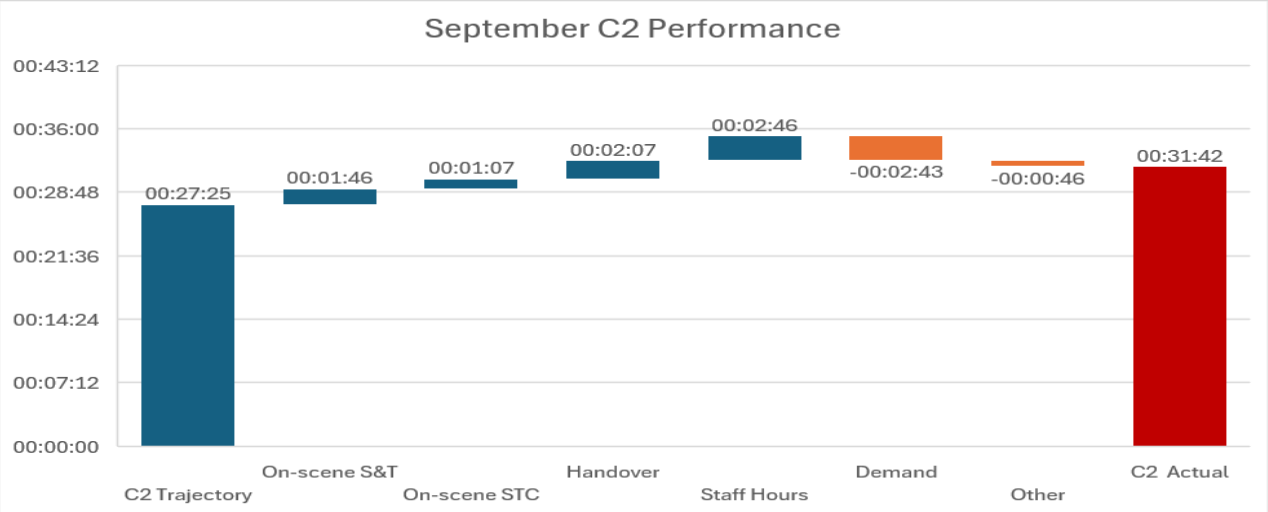
The key metrics in table 1 will be refined for the next iteration of this report to include additional quality metrics, which will provide a balanced view of the impact of operational performance on service quality. Existing quality metrics within the IPR are, however, subject to commentary in the context of wider performance considerations in section 3.3 of this report.

Table 1:

Priority	Measure	Target	Current	Last Year	RAG	Trend	Appendix/ Report	BAF Risk	Committee
NOF	NOF Score	2.5	2.82	2.89	RED	→	NOF		Board/EMC
NOF	NOF Segment	3	4	4	RED	↓	NOF		Board/EMC
Performance	Cat 1 Mean (mins)	7	8.41	8.29	RED	→	IPR	SR1	F&P
Performance	Cat 2 Mean (mins)	27.5	31.42	30.02	RED	↑	NOF / IPR	SR1	F&P
Performance	999 Answer (secs)	10	21	8	RED	→	NOF / IPR	SR1	F&P
Performance	Hear & Treat %	20	17.1	17.3	RED	↑	IPR	SR1	F&P
Performance	See & Treat %	29	32.9	30.6	GREEN	→	IPR	SR1	F&P
Performance	111 Call Answer %	95	45.5		RED	↓	IPR	SR1	F&P
Quality	Patient Harm %	10	10.35		RED	↑	NOF	SR1	Quality
Quality	NHS Raise Concerns	6	5.68		GREEN	→	NOF	SR1	People
People	NHS Advocacy Score	6	5.54		GREEN	→	NOF	SR6	People
People	NHS Engagement	6	5.6		GREEN	→	NOF	SR6	People
People	Sickness %	6.2	7.1		RED	→	NOF / IPR	SR6	People
People	Flu Vaccination %	75	50.3		AMBER	→	NOF	SR6	People
People	NHS Staff Standards		6.58		RED		NOF	SR6	People
People	Sexual Safety Collation of Facts (wks)	8	13.1	13.8	AMBER	↓	Transformation	SR6	Board/EMC
Finance	Variance to Plan %	0	0.01	0.39	RED	↑	NOF / Finance	SR7	F&P
Finance	Planned Surplus/Deficit %	-0.4	-0.4	-0.82	GREEN	↑	Finance	SR7	F&P
Finance	CIP delivery (£k)	9,021	9,366		GREEN	→	Finance	SR7	F&P
Finance	Productivity Index	100	95.02	95.02	AMBER	→	Finance	SR7	F&P

Chart 2 highlights the key drivers impacting delivery of Cat2 performance

Chart 2: September 2026 – Category 2 Performance Waterfall



3. Understanding Performance Impact

3.1 Operational Performance

Whilst demand is below the level set out in the Operating Plan, the performance benefit is being offset by the inability to fill rotas that provide the required number of hours on the road. As part of the investment approved by the Trust Board to support Cat2 improvement, additional Private Provider hours will come on stream during November, which will provide additional on the road resource and will free up crews to respond to Cat1 and Cat2 calls. Furthermore, additional overtime, which was agreed as part of the Improvement Plan, is not being taken up to the level anticipated or required, although this is gradually increasing.

Shortfalls in the Clinical Support Desk (CSD) workforce required to operate an effective Hear & Treat service continue to impact performance, which is 17.1% against a target of 20% (IPR ref OP8). Hear & Treat is pivotal service in terms of managing demand, which in turn improves our ability to respond to Cat2 calls. From a quality perspective, maximizing Hear & Treat means that patients are managed in the most appropriate setting; this not only provides a better experience but positively contributes to the system overall in that unnecessary conveyances to hospital are avoided. However, as the workforce numbers improve, we are starting to see a positive upward trend in performance.

Although this is not reported within the IPR, Task Time, which is the time that crews spend on scene with a patient and at hospital, remains above plan, with challenges more evident in Thames Valley. Whilst an element of this is due to variation in crew practice that is being addressed internally via quality improvement methodology, performance is also impacted by the availability and capacity of alternative pathways across our geography.

In many cases, it is quicker to convey a patient to hospital than to access alternative pathways, but this is not in the best interests of patients or our acute partners and is counter to the left shift approach outlined in the 10-Year Plan. The Chief Paramedic Officer is working with SECAmb to understand and influence the development and commissioning of pathways across both geographies as part of the workstream that is underway to develop a shared Clinical Operating Model, as we progress to the establishment of the Group Model.

3.2 People

A further contributing factor to the ability to meet the required number of hours on the road and adequately staff the Integrated Contact Centre to enable 999 (OP6) and 111 call (OP16) answering targets to be met, is continuing and persistently high levels of sickness absence. Sickness absence in month 6 is 7.1% against a target of 6.2% (IPR P7) but we are aware that sickness rates are continuing to increase.

This is partly driven by the anticipated onset of seasonal illnesses which are circulating in the wider community, but we are also aware that stress-related illness is increasing, driven by sustained operational pressures and additional pressure on staff when covering for colleagues who are absent from work. Whilst the Ambulance Sector has historically and continues to be an outlier in the NHS in terms of sickness absence, the Trust is currently

the worst performing ambulance trust and the position as we enter month 10 continues to deteriorate.

Robust management of sickness absences is key to improving our performance and the Attendance Management Policy has been refreshed and launched in October, with a package of training in place for managers. Whilst this is the correct action to take to sustainably improve sickness absence and support staff to return to work, immediate improvement is not expected as operational pressures have diverted Team Leaders from management activity to allow them to undertake clinical shifts. A reduction in management time and capacity is likely to impact on the implementation of the policy and impede performance improvement in the short term.

Closely linked to sickness absence is the launch of the Fu Vaccination campaign which is currently amber rated. Flu vaccinations are being offered across the breadth of our geography and uptake continues to be monitored closely by the Executive Team.

Compliance with Personal Development Reviews (PDRs) is 73.3% against a target of 95% (IPR ref P1). As alluded to above, operational pressures are impacting on the appraisal rates as management activity in operational services is being diverted to support improvement in Category 2 response times. As outlined in the IPR however, issues with the PDR app and recording PDRs have been identified and work is underway to resolve this and ensure that all PDR activity is captured and reported upon,

3.3 Quality

Patient Harm as a percentage of activity is above target and is rated red according to the NOF scoring. However, there are additional measures within the IPR relating to patient harm. Metric QS2 provides assurance that no Patient Safety Incident Investigations (PSIIs) were declared during September and QS3 indicates that the proportion of Patient Safety Incidents resulting in moderate/severe harm or death is decreasing. It should be noted however that Patient Safety incidents, due to their nature and the need for initial investigation before determining the most appropriate course of action, means that this can be a lagging indicator.

Hand Hygiene is an important element of ensuring the Trust meets its statutory duties around Infection Prevention and Control. There has been a decrease in the number of hand hygiene audits completed below target for the first time since June 2025. Operational pressures cannot be excluded as an underlying factor in the performance deterioration but due to the migration, audits are currently being completed om paper and vehicle audits, which are meeting targets (IPR ref QS8) are above target. The IPC team is maintaining a watching brief via the IPC Committee, which reports to the Quality & Safety Committee.

Whilst there is no target as such for complaints in terms of numbers, the SPC chart (IPR ref QS19) indicates that there has been no spike in complaints as a result of operational pressures, albeit complaints are a lagging indicator as they may not be received in the same month that the treatment or interaction complained of. Complaints from Healthcare Professionals have however increased during the month, largely due to inappropriate

referrals, particularly from one source. A meeting has been arranged to resolve these issues and reduce the number of complaints received.

Ambulance Care Quality Indicators (ACQIs) are also included within the IPR (ref QS10-18) but as these are subject to national reporting, processing and publication, the charts in the IPR reflect performance as at May 2026. It is not therefore possible to triangulate this data with wider performance indicators, as these relate to the month of September 2026.

3.4 Finance

Whilst the position at month 6 is in line with plan, there are concerns with regards to delivery of the Cost Improvement Programme (CIP) in the second half of the year, particularly in frontline operational services. The CIP also contains elements of non-recurrent savings, which even if delivered, will not address the underlying position and will therefore continue to impact in 2027/28.

Compounding the position further is the additional investment approved by the Board to support the Cat2 Recovery Plan. Whilst this investment was necessary and in the interests of patients, it has created additional CIP requirements.

However, failing to improve Cat2 performance and deliver on the commitments set out in the Operating Plan puts the growth funding that was agreed at the start of the financial year at risk, as receipt of this funding is contingent on delivering Cat2 performance. The funding is included within the financial plan and assumptions, and any reduction or loss will result in further deterioration in the Trust's year-end financial position and ability to meet the statutory duty to break even.

The long-term solution to the CIP challenge and financial sustainability is transformational activity as outlined in the Fit for the Future Plan and efficiency benefits arising out of the Group Model, but the impact of sustained operational pressures outlined in this report are equally impacting delivery of the transformational activity that is required. The Executive Team is actively re-prioritising delivery of the workstreams outlined in the plan to ensure that for the remainder of 2026/27, resources are directed towards delivering the commitments outlined in the Operating Plan.

3.5 Summary

Performance challenges continue to be driven by a common set of interconnected factors. Workforce shortages and high sickness absence are reducing operational hours, impacting 999 call-answering, Hear & Treat performance and Category 2 response times. These pressures are contributing to increased workload for remaining staff, reduced management capacity, deteriorating PDR compliance and risks to delivery of transformation programmes.

Whilst patient safety indicators remain broadly stable, continued vigilance is required to ensure sustained operational pressures do not result in deterioration in patient outcomes, staff wellbeing or financial sustainability. The Executive Team continues to monitor these

issues through a triangulated review of performance, quality, workforce and financial intelligence as outlined below.

Issue	Operational Impact	Quality Impact	People Impact	Financial Impact
Sickness	Fewer hours on road	Increased risk of delay	Increased workload pressure	Increased overtime/bank costs
EOC vacancies	Slower call answering	Delayed access to care	Increased stress	Bank/overtime spend
Hear & Treat shortfall	More ambulance dispatches	Reduced care in most appropriate setting	Clinical workload increase	Increased conveyance costs
Handover delays	Reduced ambulance availability	Increased patient waiting	Frustration and fatigue	Reduced productivity

4. Areas of Risk

The key areas of risk are highlighted in the first part of the executive summary with commentary in section 3 of this report but can be summarised as follows:

- Cat1, Cat2 and Call Answer performance and the consequent impact on delivery of the commitments set out in the Operating Plan 20206/27
- Establishment and sickness absence levels in frontline services and the ICCs, which are are impacting on operational performance and staff well-being
- Operational performance impacting on financial sustainability, with a risk to delivery of the financial plan and the statutory duty to break-even position

5. Link to Strategic Theme

The report links to all strategic themes.

6. Link to Board Assurance Framework Risk(s)

The report relates the current BAF risks**.**

7. Quality/Equality Impact Assessment

Not required for this report.

8. Recommendations

The Trust Board is asked to **DISCUSS** month 6 organisational performance, **NOTE** the impact of performance issues and the risks to delivery of the Operating Plan 2026/27 and

to seek further **ASSURANCE** on the actions being taken in response where required.

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

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Appendix 1 – Performance Scorecard – NOF Metrics

PERFORMANCE REVIEW - based on September 2026 data

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

QTR 1 26/27: SEGMENT 4 (Rank 10 ↓ score 2.82) - Capability Rating Amber / Red

					NHSE Oversight Framework (NOF)			Latest Performance - September 2026								
NOF	IPR	Group	Sub-Group	Metric	Previous NOF (QTR 4)	Current NOF (QTR 1)	Current Rank (QTR 1)	National Benchmark	IPR SPC Trend	SCAS Target	SCAS (All)	EOC	111	TV	Hants	Corporate
NOF 1	OP4	2B – Access	Urgent care	Mean response time to Category 2 calls	0:30:03	00:33:48	8/10 ↓	00:25:00	Expected / Random	00:27:30	00:31:42 ↑					
NOF 2	OP6	2B – Access	Urgent care	Mean 999 call response time		00:12:00	9/10	< 00:00:10	Declined / Fail	00:00:10	00:00:21 ↓					
NOF 3a	OP8	4 – Effectiveness	Outcomes	% incidents managed via hear-and-treat *		49.50%	4/10		Expected / Fail	20.0%	17.1% ↑					
NOF 3b	OP9	5 – Effectiveness	Outcomes	% incidents managed via see-and-treat *					Improving / Pass	29.0%	32.9% ↓					
NOF 4	P7	7 – People	People & culture	Sickness absence rate	7.80%	7.39%	4/10 ↓		Expected / Random	6.2%	7.1% ↑	7.01%	7.68%	7.35%	8.66%	4.21%
NOF 5		5 – Patient Safety	Safe outcomes	% safety incidents causing harm (% all PSI causing harm)	Contextual					<10%	10.35% ↑	0.7%	0.0%	3.3%	3.8%	0.5%
NOF 6		6 – Finance	Finance	Variance to plan year-to-date (£k)	0.39%	0.01%	8/10 ↓				0.01%					
NOF 7		3 – Experience	Experience	NHS Staff Survey advocacy rate	5.54	5.54	10/10 ↔				5.54					
NOF 8		5 – Patient Safety	Safe culture	NHS Staff Survey raising concerns sub-score	5.68	5.68	9/10 ↓				5.68					
NOF 9		7 – People	People & culture	NHS Staff Survey engagement theme score	5.60	5.60	9/10 ↔				5.60					
NOF 10		7 – People	People & culture	NHS Staff Standards score		6.58	9/10				6.58					
NOF 11		7 – People	People & culture	National Education and Training Survey satisfaction rate	75.23%	75.23%	8/10				75.23%					
NOF 12		7 – People	People & culture	Healthcare Worker Flu Vaccination Rate	50.3%	50.30%	6/10				50.3%					
NOF 13		6 – Finance	Finance	Planned surplus or deficit (k)	-0.82%	0.00%	2/10 ↑				0.00%					
NOF 14		6 – Finance	Productivity	Relative cost difference (National Cost Collection Index)	95.02%	95.02%	4/10 ↔	100%			95.02%					
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

Appendix 1 – Performance Scorecard – Finance

		M06 - September 2026			YTD		
		Plan	Actual	Variance	Plan	Actual	Variance
South 999	Financial Position: Surplus / (Deficit) £k	5,137	5,103	-34	30,694	30,072	-622
	Total efficiency savings £k	424	424	0	1,523	1,523	0
North 999	Financial Position: Surplus / (Deficit) £k	4,258	4,139	-119	24,697	24,704	7
	Total efficiency savings £k	424	424	0	1,523	1,523	0
EOC	Financial Position: Surplus / (Deficit) £k	2,497	2,440	57	14,915	13,829	1,086
	Total efficiency savings £k	177	177	0	1,078	1,078	0
111	Financial Position: Surplus / (Deficit) £k	134	268	135	1,176	1,782	606
	Total efficiency savings £k	46	46	0	206	206	0

Appendix 2 – Integrated Performance Report

The Integrated Performance Report (IPR) for September 2026 is provided as a separate attachment.

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Integrated Performance Report: Sep-26



Executive Summary

Operational Performance

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

Safety and Quality

People

NHS Executive Commentary - Operational Performance

Key Performance Headlines:

o (OP2) Category 2 mean response time was 31:42 against the target of 27:25. Demand was 2% below plan benefitting cat 2 by 2 mins 43, however operational staff hours were 2.5% (5,043) hours below plan impacting cat 2 by 2 mins 46. H&T also below plan leading to an additional 1,288 incidents receiving a response. Task Time in TV was 6% (6 min 14) above plan impacting cat 2 by 4 min 29 with 1 min 29 of this higher time caused by higher handover times.
o (OP6) 999 call answer has worsened to 21 seconds linked to high sickness levels in ICC.
o (OP8) H&T remains below the recovery target at 17%
o (OP16) 111 call answer has deteriorated for the 5th consecutive month to 45% linked to low workforce numbers. Recovery and recruitment plan in place.

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 and higher sickness levels.
o Private provider contract has not commenced and will be delayed to mid November
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 (OP13) Handover times remain above plan across TV and Hampshire with average handover at 3 minutes above plan and Hampshire are 1 minute 40 above plan. This impacts C2 2 minutes 7.

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 On boarding of new private provider by mid November
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:

o Recovery actions for cat 2 to recover YTD
o 111 and 999 call answer recovery action plan in place
o Increasing operational hours to recover YTD cat 2 performance
o H&T improvement plan to deliver revised recovery trajectory

Key Performance Headlines:

Patient safety performance remained stable during the reporting period, with common cause variation observed across key indicators. The proportion of reported incidents resulting in moderate harm, severe harm or death reduced to 1.2% of all incidents despite sustained operational pressures. No Patient Safety Incident Investigations were declared during September. Patient experience activity increased, with Healthcare Professional Concerns and Feedback remaining the most significant category of contact. Safeguarding and Prevent training compliance remained strong, providing assurance that statutory safeguarding responsibilities continue to be met.

Key Risks for Period:

IPC performance remains mixed, with QS6 below target and hand hygiene compliance continuing to require improvement. High vehicle utilisation remains a contributory factor affecting IPC performance. Healthcare Professional Concerns continue to identify inappropriate NHS 111 referrals as a recurring theme, creating potential impacts on patient experience and service efficiency. MCA training compliance has reduced whilst training content is updated to reflect legislative and policy requirements. The associated compliance risk remains captured within the corporate risk register and is subject to ongoing monitoring.
Risk to delivery o face to face resuscitation training compliance is emerging. Plans in place to mitigate.

Key Rolling Actions:

Targeted improvement activity has continued across patient safety, IPC and safeguarding. The Patient Safety Team has undertaken engagement activity to strengthen organisational learning and support safety culture development. Work is progressing with system partners to address concerns relating to inappropriate NHS 111 referrals and improve pathway allocation processes. IPC leads continue to support local teams to improve audit completion and hand hygiene compliance. Development of the revised MCA training programme remains on track, with implementation planned during the next financial year.

Forward View:

Priorities for the next reporting period will focus on improving IPC compliance, particularly hand hygiene performance and audit completion, whilst maintaining oversight of vehicle utilisation risks. Engagement with system partners will continue to address inappropriate NHS 111 referrals and optimise pathway utilisation. Implementation of the revised MCA training programme will support recovery of compliance levels and mitigation of associated risks. Quality, patient safety and safeguarding teams will maintain a focus on assurance, learning and continuous improvement to support safe, effective and person-centred care.

Executive Commentary - People

Key Performance Headlines:

The Month 6 Substantive workforce is 3,744 WTE and below the M5 planned total substantive workforce of 3,841 WTE by 98 WTE.
Staff turnover at 13.7%
In Month 6, Sickness was above the 6.2% target at 6.9%. Long-Term sickness is at 4.2% and Short-Term sickness at 2.8%. More accurate, less delayed recording, GRS sickness reporting is analysed to give greater insight.
PDR compliance data currently has a technical issue with PDR App completions not being included. Compliance without these is at 73% in Month 6, below 95% target. Communications has been sent to increase this and manual interventions will be taken while a solution is sought.
DBS- Trust at 98% against a 95% target

Key Risks for Period:

High sickness rates, particularly in Operational areas, remain high priority for SCAS with Regional oversight and recovery working groups making progress against key changes needed to improve and maintain business as usual work. Higher than targeted sickness levels present ongoing risk to operational resilience and staffing availability.

Key Rolling Actions:

Sickness action plan and reporting regionally as part of recovery plans. Sickness being monitored weekly, action groups and trajectories to reduce significantly in Operational areas in following months. An increased focus on reducing infection in winter period.
Continuous reviewing of workforce plans to ensure a changing turnover rate is reflected in establishment and recruitment assumptions

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.
Planning for financial year 27/28 with improved workforce planning submission and approach

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) .

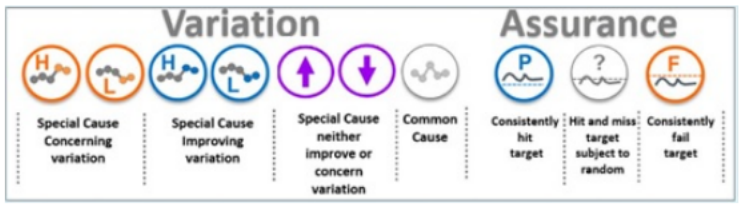
4) A run of 6 consecutive ascending or descending values (a trend).

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







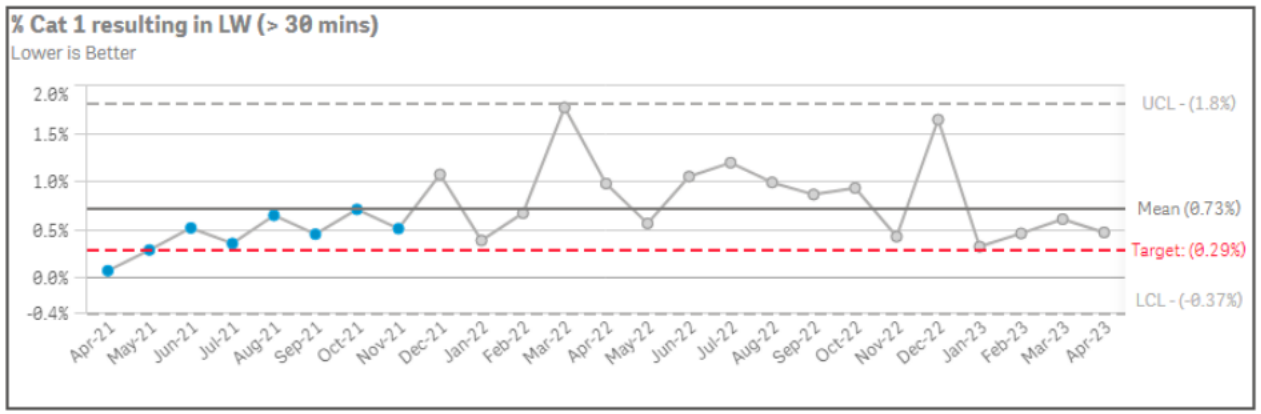
	Pass	Hit and Miss	Fail	No Target
	Special cause of an improving nature where the measure is significantly HIGHER.This process is capable and will consistently PASS the target.	Special cause of an improving nature where the measure is significantly HIGHER.This process will not consistently HIT OR MISS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

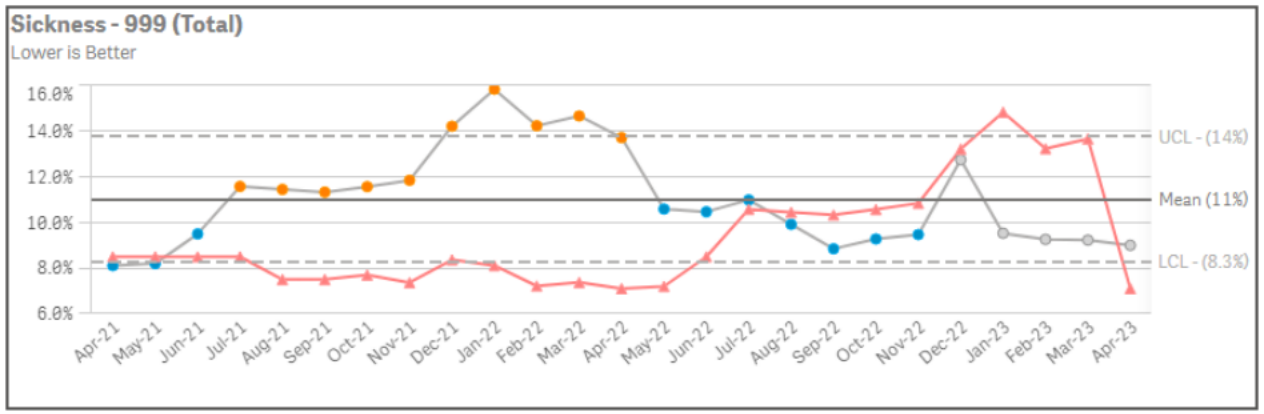
Assumptions:

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

September-26 Summary

Assurance →

Variance ↓

	Fail	Hit and Miss	Pass	No Target
H		111 Calls abandoned after 30 secs % 999 Mean Call Answer Time		
L	111 call answer in 120 Secs % Appraisals - Trust	Percentage of compliant Hand Hygiene audits Percentage of compliant Vehicle cleanliness audits ST&C (Non-ED 1&2) - SCAS	% DBS Compliance	
	% Arrival at hospital to handover <15mins % Vacancy 111 Call back < 20 min Average Hospital Handover Time - SCAS Cat 1 Mean SCAS Cat 3 90th %ile SCAS H&T - SCAS Meal Break Compliance - SCAS VOR - Total	24	Clear up Delays - SCAS Number of PSII declared in month Safeguarding Level 3	
L		Number of reported CD incidents – unaccounted for losses ST&C (ED 1&2) - SCAS	% Turnover Number of Complaints	
H			% Trust staff who are BAME % Trust staff who are declared disabled S&T - SCAS Safeguarding Adults Level 1	
↗				
↘				

Metrics:

Hit and Miss Common Cause Metrics:
% Long term sickness ; % Sickness in month ; 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 PSR declared in month ; Number of WTE ; Over-runs >30 mins - SCAS ; Overdue Datix incidents ; 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

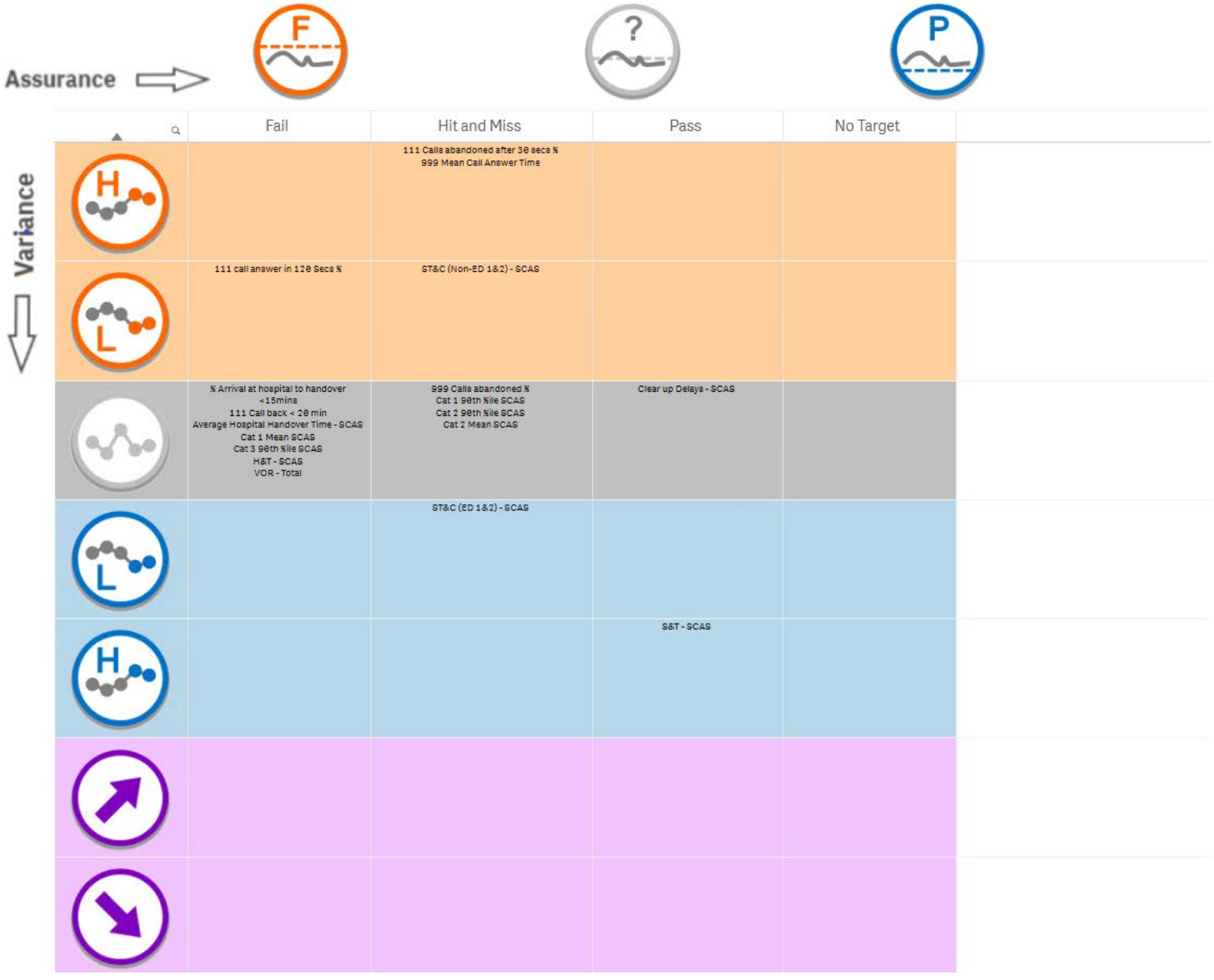
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Operational Performance

September-26 Summary

Metrics:



Variance \ Assurance	Fail	Hit and Miss	Pass	No Target
H		111 Calls abandoned after 30 secs % 999 Mean Call Answer Time		
L	111 call answer in 120 Secs %	ST&C (Non-ED 1&2) - SCAS		
	% Arrival at hospital to handover <15mins 111 Call back < 20 min Average Hospital Handover Time - SCAS Cat 1 Mean SCAS Cat 3 90th %ile SCAS H&T - SCAS VOR - Total	999 Calls abandoned % Cat 1 90th %ile SCAS Cat 2 90th %ile SCAS Cat 2 Mean SCAS	Clear up Delays - SCAS	
L		ST&C (ED 1&2) - SCAS		
H			S&T - SCAS	

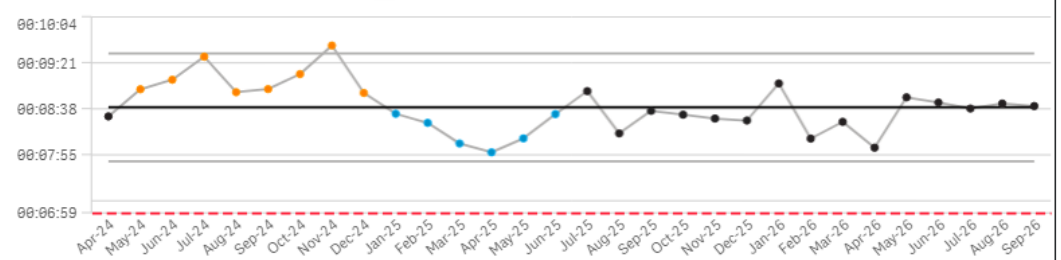
Operations - Response Times/Utilisation/Operations Centre

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Cat 1 Mean	Sep-26	00:08:41	00:07:00		F	00:08:40	00:07:49	00:09:31
Cat 1 90th %ile	Sep-26	00:16:05	00:15:00		?	00:15:46	00:14:21	00:17:10
Cat 2 Mean	Sep-26	00:31:42	00:27:30		?	00:30:00	00:18:38	00:41:22
Cat 2 90th %ile	Sep-26	01:00:07	00:40:00		?	00:59:49	00:38:28	01:21:10
Cat 3 90th %ile	Sep-26	05:12:03	02:00:00		F	05:49:32	02:17:30	09:21:34
% Vehicles off the road	Sep-26	37.7%	15.0%		F	40.2%	33.1%	47.3%
Average Handover Time	Sep-26	00:18:48	00:15:00		F	00:18:11	00:15:43	00:20:40
Handover < 15 mins	Sep-26	47.9%	60.0%		F	50.2%	44.1%	56.4%
Average Clear Up Time	Sep-26	00:13:09	00:15:00		P	00:13:26	00:13:07	00:13:46
% See and Treat	Sep-26	32.9%	29.0%	H	P	31.8%	30.5%	33.0%
See, Treat and Convey to ED	Sep-26	46.3%	47.0%	L	?	47.4%	46.0%	48.7%
See, Treat and Convey to Non-ED	Sep-26	3.7%	4.0%	L	?	3.9%	3.7%	4.2%
999 Call Answer	Sep-26	00:00:21	00:00:10	H	?	00:00:11	00:00:01	00:00:22
999 Call Abandonment Rate	Sep-26	2.2%	2.0%		?	1.6%	0.7%	2.6%
% Hear and Treat	Sep-26	17.1%	20.0%		F	17.4%	15.9%	19.0%
111 Call Answer	Sep-26	45.5%	95.0%	L	F	71.4%	49.7%	93.1%
111 Call Abandonment Rate	Sep-26	9.8%	3.0%	H	?	4.0%	0.1%	8.0%
111 Call Back Percentage	Sep-26	31.2%	90.0%		F	32.7%	23.8%	41.5%

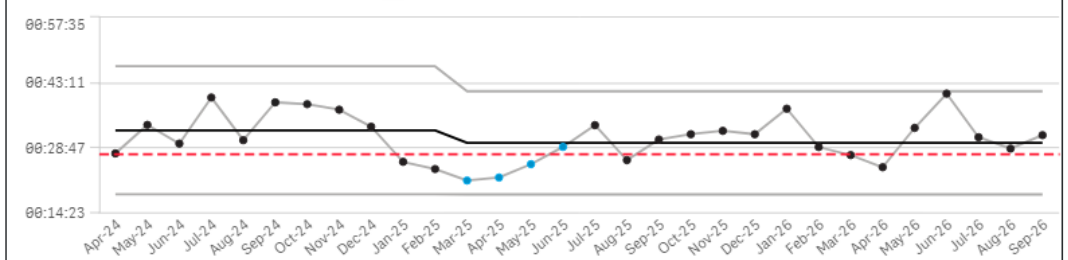
Operations - Response Times

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



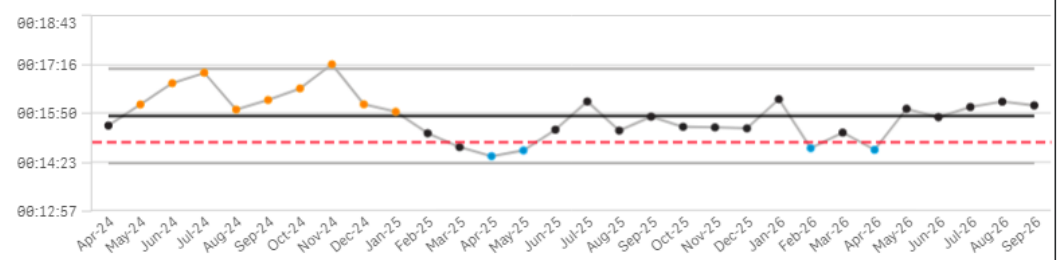
Variation	Assurance	Target	Latest
Expected	Fail	00:07:00	00:08:41

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



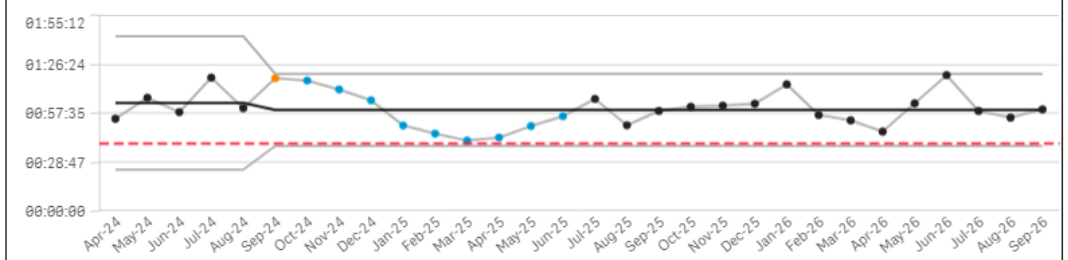
Variation	Assurance	Target	Latest
Expected	Random	00:27:30	00:31:42

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



Variation	Assurance	Target	Latest
Expected	Random	00:15:00	00:16:05

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



Variation	Assurance	Target	Latest
Expected	Random	00:40:00	01:00:07

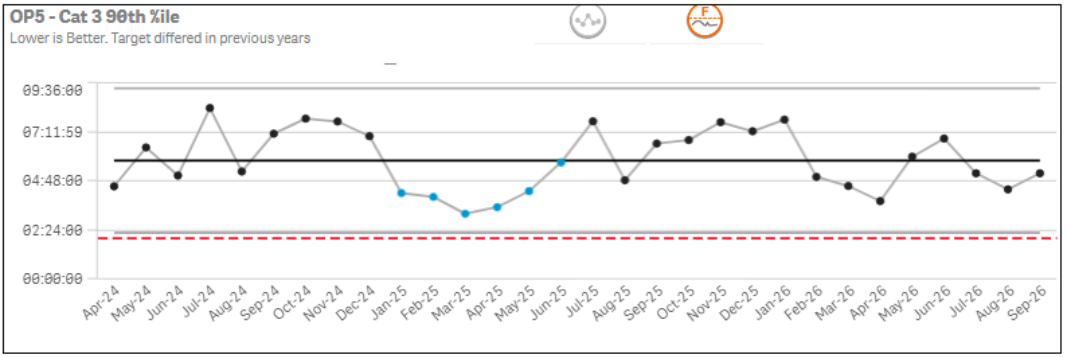
Understanding the Performance:

Cat 1 remained on the mean but Cat 2 increased, both remain above target. Throughout September demand was 2.0% below trajectory (898 incidents). Response demand impacted by below plan H&T driving an additional 1288 incident demand. Operational hours were 5043 hours below plan. Hospital delays improved but remained above plan adding 02:07 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.
Paper shared with NHSE seeking financial support to recruit up to 72 WTE ECAs
Progress tender to increase in Private Provider hours by 399 a week

Operations - Response Times



Variation

Expected

Assurance

Fail

Target

02:00:00

Latest

05:12:03

Understanding the Performance:

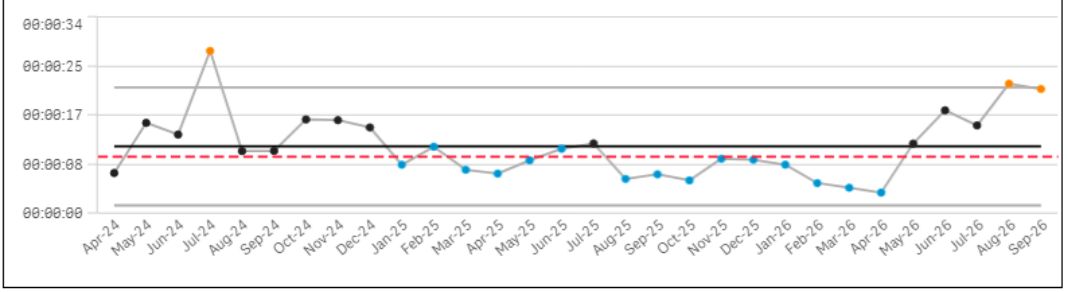
A decrease in performance, remaining above target. Throughout September demand was 2.0% below trajectory (898 incidents). Response demand impacted by below plan H&T driving an additional 1288 incident demand. Operational hours were 5043 hours below plan. Hospital delays improved but remained above plan adding 02:07 minutes to Cat.2 performance.

Actions (SMART):

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Paper shared with NHSE seeking financial support to recruit up to 72 WTE ECAs
Progress tender to increase in Private Provider hours by 399 a week

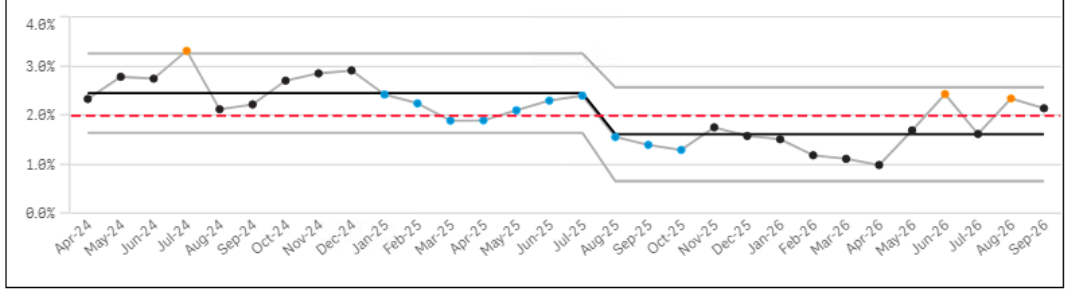
Operations - Operations Centre

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



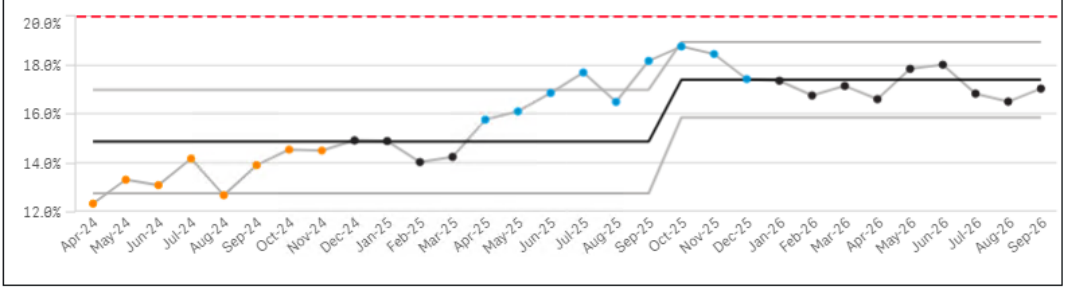
Variation	Declined
Assurance	Random
Target	00:00:10
Latest	00:00:21

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



Variation	Expected
Assurance	Random
Target	2.0%
Latest	2.2%

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



Variation	Expected
Assurance	Fail
Target	20.0%
Latest	17.1%

Understanding the Performance:

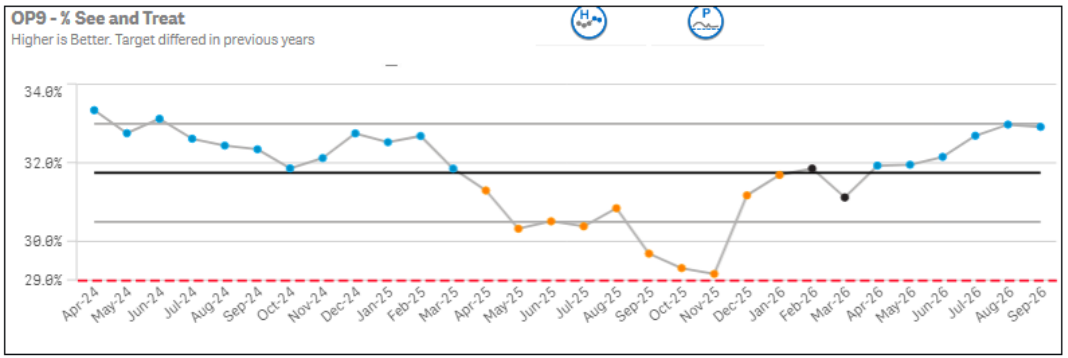
OP6 remains challenged at 21 seconds above control limits with a 90th percentile of 1 minute 23 seconds, correspondingly OP7 is also above target at 2.2%, reflecting the continued pressures on resourcing levels . Demand was 2.44% below forecast with duplicate call volume accounting for 20 - 23%. However, this reduction in demand has been insufficient to offset the impact of workforce shortfalls. Logged-in hours remain below plan, driven by a combination of vacancies and sickness absence, which continue to operate significantly above planned assumptions.

There are however early signs of improvement in OP8 which is improving on a daily level, for September was 17.1%, reflecting the impact of new starters joining the service and providing early signs of workforce recovery.

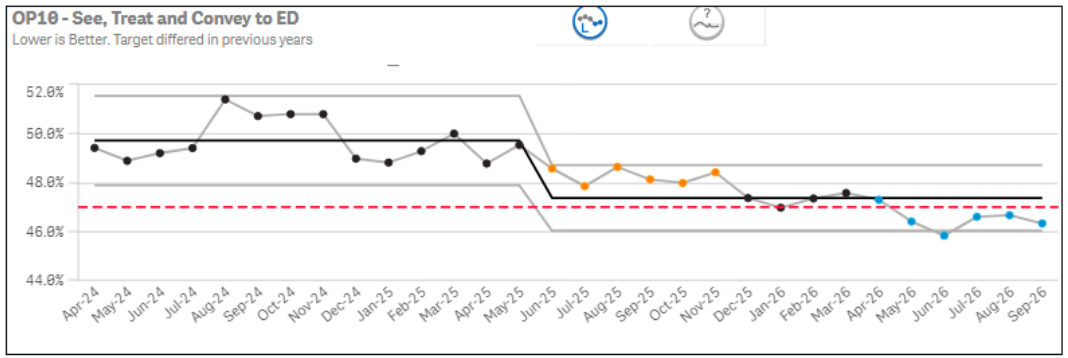
Actions (SMART):

Continue targeted recruitment into clinical and call handling vacancies to meet budget requirement, monitored through weekly operational recruitment meetings and monthly Integrated Workforce Planning Review.
Maintain weekly operational and HR attendance and wellbeing reviews, ensuring early and appropriate management of absence, with oversight through weekly Director meetings.
Strengthen room management arrangements through daily leadership ownership of performance by Call Taking Service Delivery Managers.
Further embed 111 clinical support process, with incentive approved for increased 111 clinical hours.

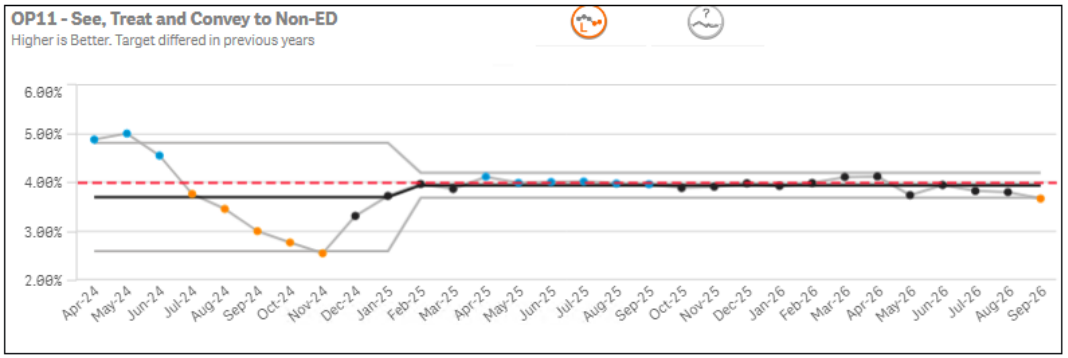
Operations - Utilisation



Variation	Improving
Assurance	Pass
Target	29.0%
Latest	32.9%



Variation	Improving
Assurance	Random
Target	47.0%
Latest	46.3%



Variation	Declined
Assurance	Random
Target	4.0%
Latest	3.7%

Understanding the Performance:

OP 9 - See and Treat - has now made 10 points above the target, accepting the target changed it is now above the previous target. OP10 - is also passing the target for the 5th consecutive month with the labels on the chart showing incorrectly. OP11 - Convey to Non Ed has shown a small drop in month but is tracking just below target and has done so so some time.

Actions (SMART):

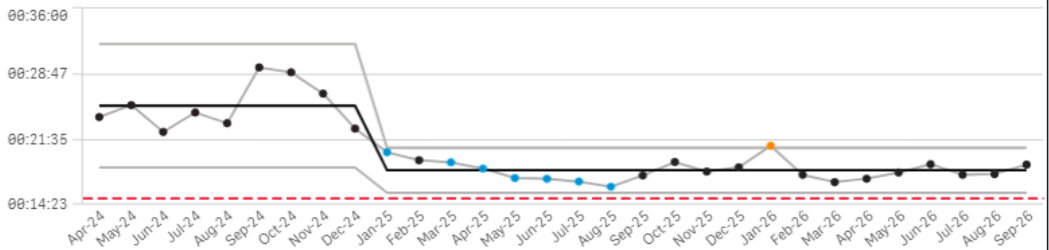
All measures are monitored through the performance review meetings and remain a focus with local teams. These are also monitored the NHS Region at the bi-weekly performance review meetings.

NHS

Operations - Utilisation

OP12 - Average Handover Time

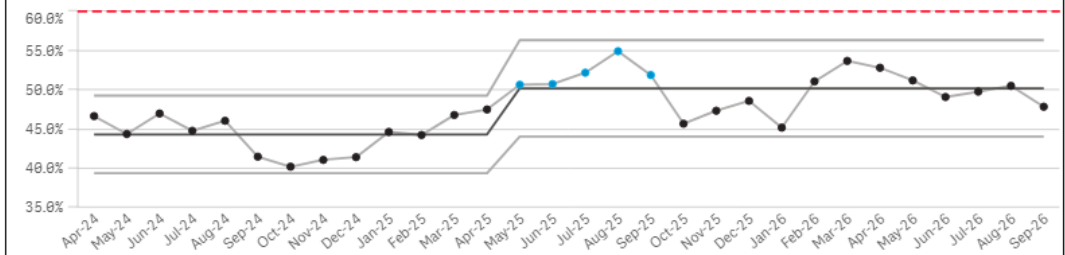
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Fail	00:15:00	00:18:48

OP13 - Handover < 15 mins

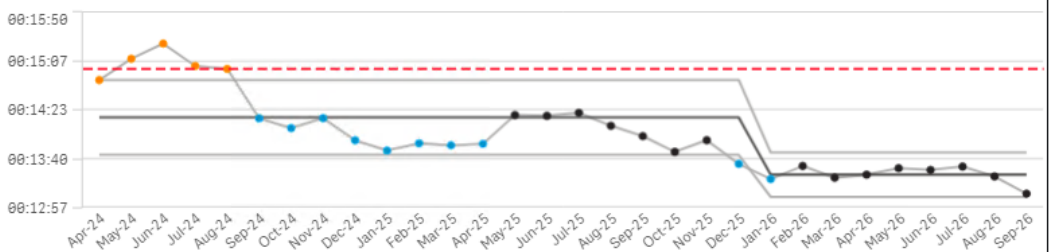
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Fail	60.0%	47.9%

OP14 - Average Clear Up Time

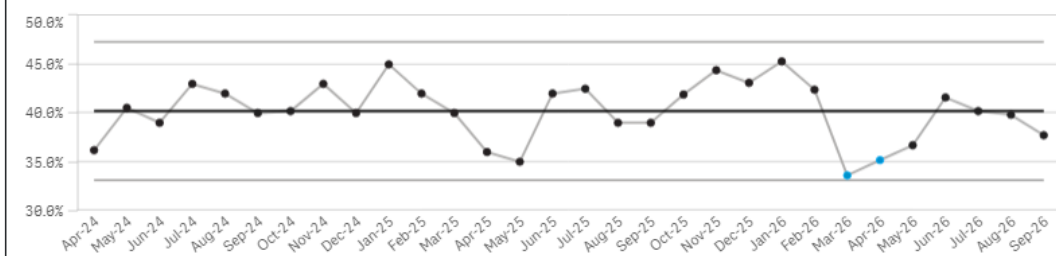
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Pass	00:15:00	00:13:09

OP15 - % Vehicles off the road

Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Fail	15.0%	37.7%

Understanding the Performance:

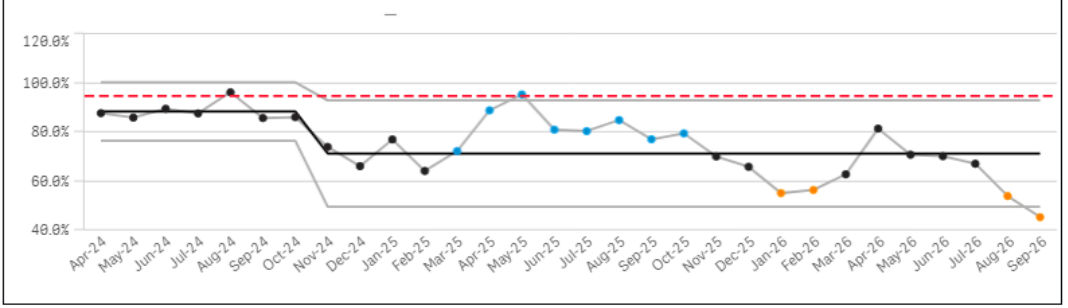
OP12 &13Handovers within 15mins and Average handover both deteriorated in September both with common cause variation but failing. OP14 remains strong with a further point of improvement in September. OP15 - VOR improving month on month with over 100% fleet availability to peak plan

Actions (SMART):

Handovers form a central element to the Performance/C2 recovery program - Each Head of Operation has specific plans with their acutes to deliver the agreed trajectories. This is reported through several internal governance meetings and is also bi-weekly at Regional level.

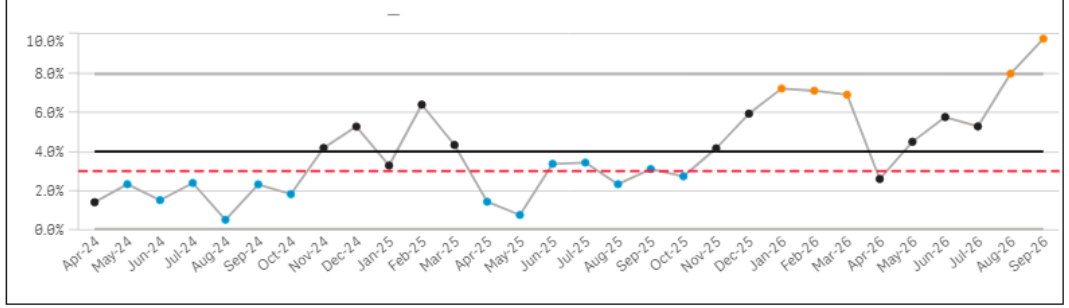
Operations - Operations Centre

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



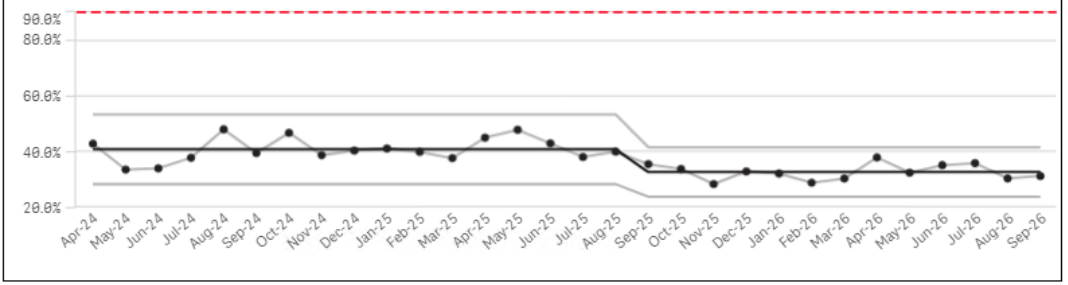
Variation	Assurance	Target	Latest
Declined	Fail	95.0%	45.5%

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



Variation	Assurance	Target	Latest
Declined	Random	3.0%	9.8%

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



Variation	Assurance	Target	Latest
Expected	Fail	90.0%	31.2%

Understanding the Performance:

NHS 111 demand remained significantly above plan, with calls offered 14.13% above forecast. While high abandonment levels are likely generating some repeat contact, the service answered 125,420 calls against a forecast of 125,747, demonstrating a strong operational focus on maximising answered calls despite workforce pressures. Performance continues to be constrained by staffing shortfalls, resulting in longer answer times and increased abandonment. 45.08% of calls were answered within 120 seconds, while the abandonment rate was 10.64%. Both measures remain above their upper control limits, indicating sustained variation from expected performance. Recruitment and workforce stabilisation remain key priorities to improve responsiveness and restore performance towards target levels.

Actions (SMART):

Deliver recruitment in line with the monthly budgeted establishment trajectory, reducing the gap between substantive workforce and budgeted WTE each month. Progress against the monthly establishment plan will be reviewed through weekly operational recruitment meetings, with weekly Director oversight of recruitment performance, vacancies, attrition and forecasted starters.
Reduce sickness absence through proactive attendance management and early intervention, with absence cases reviewed weekly at operational and HR attendance meetings, with weekly Director oversight.
Commence testing in October with NHS England for Natural Language Processing, which once introduced should support a reduction in average handling time.

NHS

NHS
South Central
Ambulance Service
NHS Foundation Trust

Quality and Safety

Quality & Safety – Core Measures Matrix

September-26 Summary

Assurance →

Variance ↓

	Fail	Hit and Miss	Pass	No Target
H				
L		Percentage of compliant Hand Hygiene audits Percentage of compliant Vehicle cleanliness audits		1
		14	Number of PSII declared in month Safeguarding Level 3	
L		Number of reported CD incidents – unaccounted for losses	Number of Complaints	
H			Safeguarding Adults Level 1	
↗				
↘				

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 PSR declared in month ; Overdue Datix incidents ; 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

NHS 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	Sep-26	26.7	30.7			28	22.5	33.6
Monthly PSII	Sep-26	0	3			0.5	-1.27	2.27
Monthy PSILR	Sep-26	0	9			8.57	-8.95	26.1
Overdue Datix Incidents	Sep-26	0.888	1.02			0.826	-0.854	2.51
CD unaccounted for losses	Sep-26		2			1.2	-2.69	5.09
Level 1 Safeguarding	Sep-26	98.0%	95%			96.8%	95.6%	97.9%
Level 3 Safeguarding	Sep-26	96.6%	90%			97.5%	95.5%	99.5%
Complaints	Sep-26	0	2.53			0.774	-0.184	1.73
Compliments	Sep-26	8.13	0		n/a	12.9	5.44	20.3
Hand Hygiene Audits Completed	Sep-26	185	261			302	25.6	577
Hand Hygiene Audits % Compliance	Sep-26	58.4%	95%			85.8%	66.3%	105.3%
Vehicle Audits Completed	Sep-26	198	167			195	29.4	361
Vehicle Audits % Compliance	Sep-26	75.8%	90%			83.3%	60.1%	106.5%

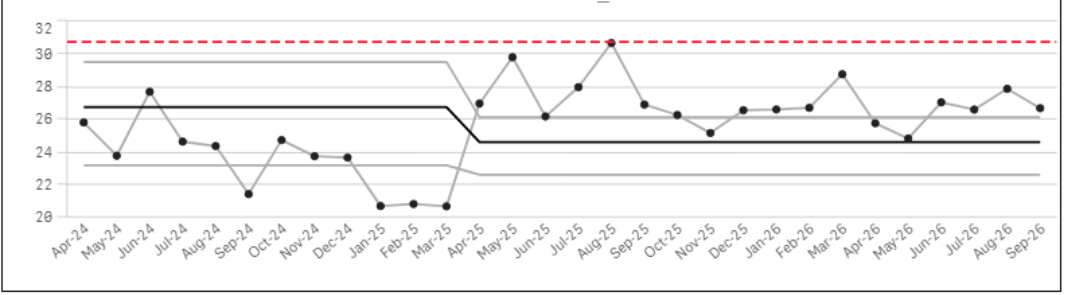
NHS Quality Safety– Ambulance Quality Indicators (AQIs)

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
STEMI Call to angiography - Mean	May-26	02:21:00	02:30:00			02:17:57	01:52:25	02:43:29
STEMI - Call to angiography 90th Centile	May-26	03:45:00	03:20:00			03:20:39	01:53:11	04:48:06
Stroke Call to Hospital Arrival Time Mean	May-26	01:36:00	01:30:00			01:35:27	01:17:28	01:53:26
Stroke Call to Hospital Arrival Time Median	May-26	01:21:00	01:20:00			01:22:16	01:09:30	01:35:02
Stroke Call to Hospital Arrival Time 90th Centile	May-26	02:19:00	02:30:00			02:21:55	01:51:35	02:52:14
Return of Spontaneous Circulation All	May-26	26.3%	25.8%			26.5%	19.0%	34.1%
Return of Spontaneous Circulation Utstein	May-26	54.2%	48.4%			53.3%	19.8%	86.8%
Cardiac Arrest 30 Day Survival - All	May-26	8.6%	8.9%			9.3%	3.3%	15.4%
Cardiac Arrest 30 Day Survival - Utstein group	May-26	20.8%	20.6%			31.2%	1.6%	60.9%

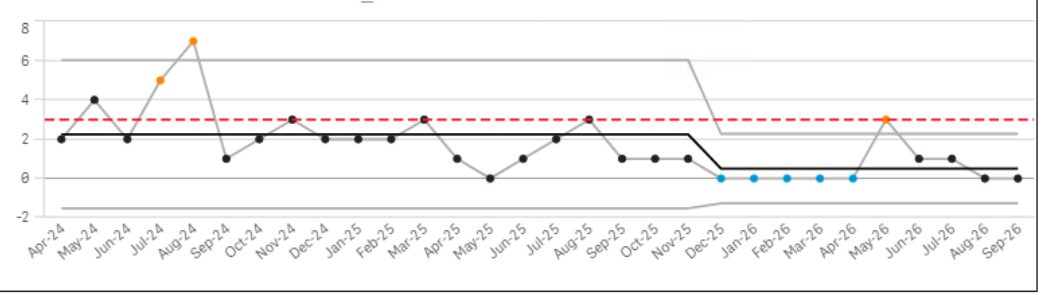
Quality & Safety – PSIRF

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



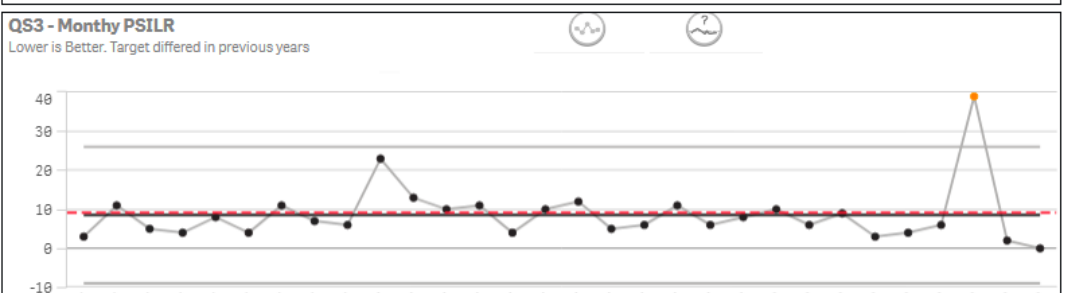
Variation	Assurance	Target	Latest
Expected	Random	30.7	26.7

QS2 - Monthly PSII
. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Pass	3	0

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



Variation	Assurance	Target	Latest
Expected	Random	9	0

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.
This represents common cause variation. The proportion of Patient Safety Incidents (PSIs) resulting in moderate or severe harm, or death, decreased to 1.2% of all reported PSIs, despite an increase in CAT2 and CAT3 response times (OP2 & OP5).

QS2 – No PSII were declared in September 2026.

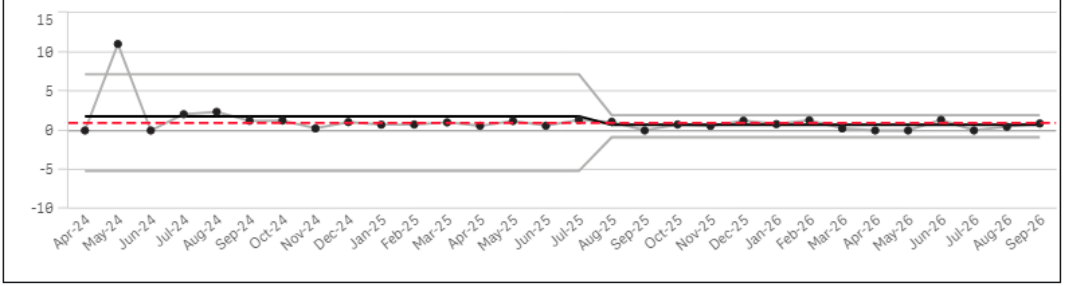
Actions (SMART):

QS3 – The patient safety team presented at the annual Volunteers Conference to understand how learning from patient safety incidents can be shared with volunteers and also to gain valuable feedback from the volunteer workforce to help develop patient safety in SCAS.

Quality & Safety – PSIRF

QS4 - Overdue Datix Incidents per 10,000 Interactions

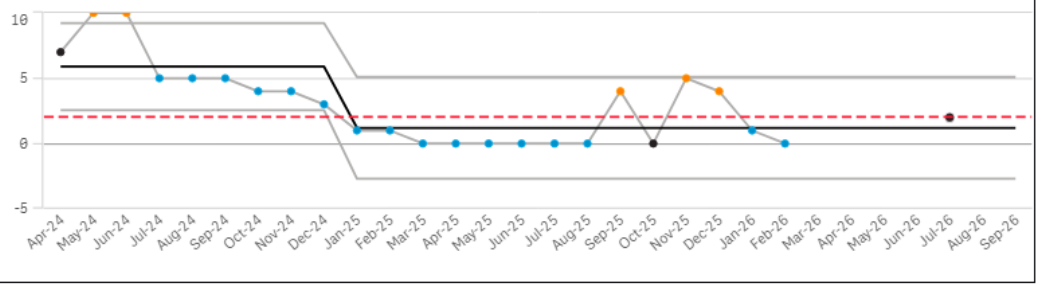
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	1.02	0.888

QS5 - CD unaccounted for losses

Lower is Better. Target differed in previous years



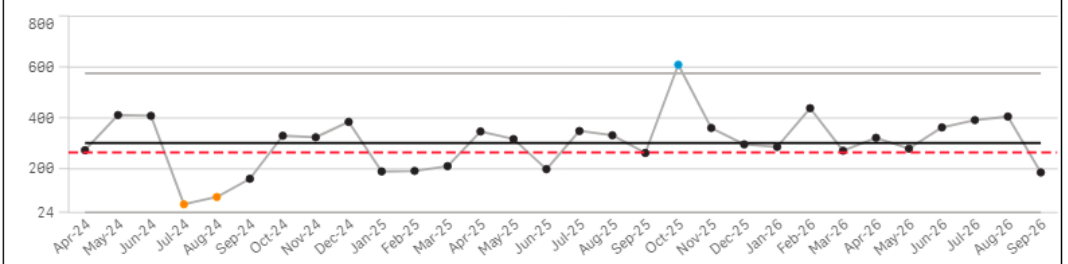
Variation	Assurance	Target	Latest
Improving	Random	2	

Understanding the Performance:

Actions (SMART):

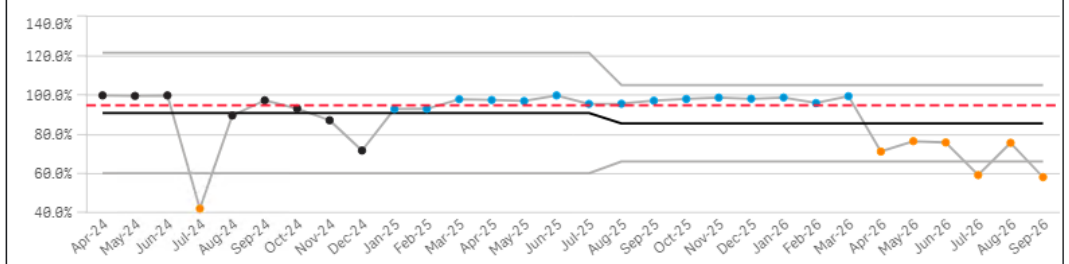
Quality & Safety - Audits

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



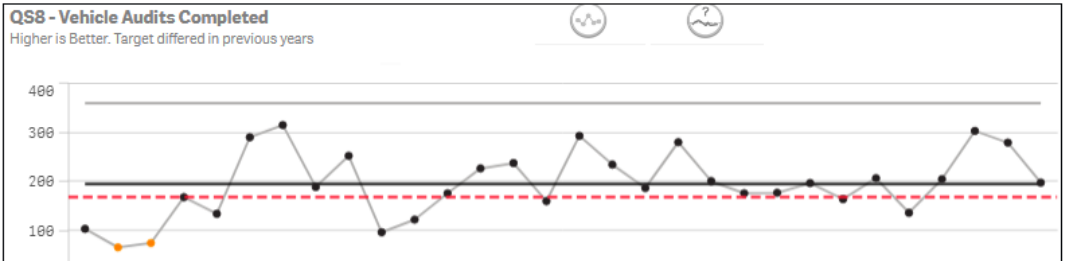
Variation	Assurance	Target	Latest
Expected	Random	261	185

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



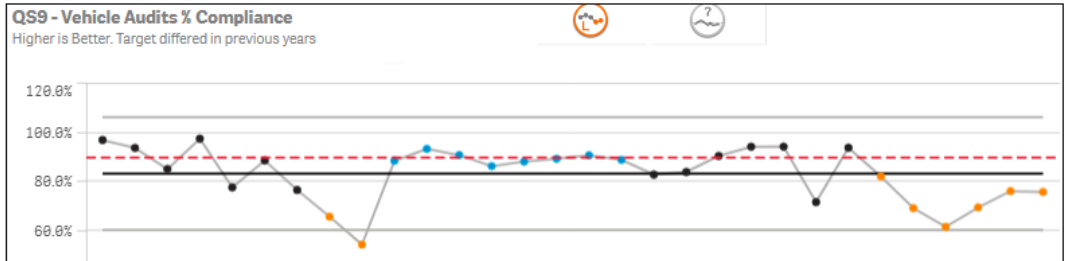
Variation	Assurance	Target	Latest
Declined	Random	95%	58.4%

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



Variation	Assurance	Target	Latest
Expected	Random	167	198

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



Variation	Assurance	Target	Latest
Declined	Random	90%	75.8%

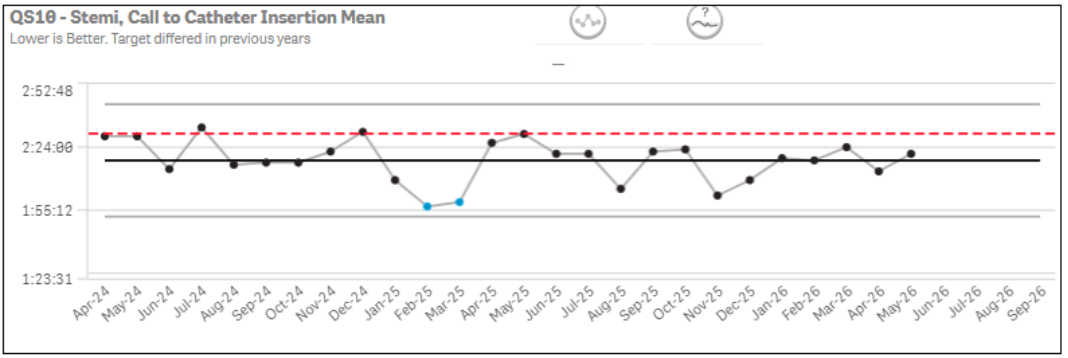
Understanding the Performance:

QS6 below target number of audits QS8 above target number. Due to system migration audits are currently on paper and vehicle audits appear to have been prioritised. QS7 Hand hygiene compliance remains below standard due to lower scores for the moisturiser and alcohol hand rub questions. QS9 vehicle utilisation remains high

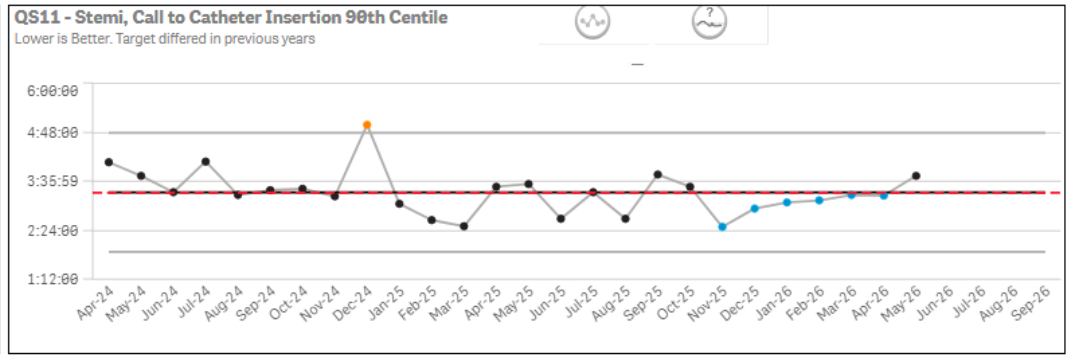
Actions (SMART):

Further communication with teams on hand hygiene audit completion. Return to audits being completed directly into the system once system updates are completed. IPC week 18 - 24 October - Global theme Generations of Infection Prevention: Past.Present.Protected

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



Variation	Expected
Assurance	Random
Target	02:30:00
Latest	02:21:00



Variation	Expected
Assurance	Random
Target	03:20:00
Latest	03:45:00

Understanding the Performance:

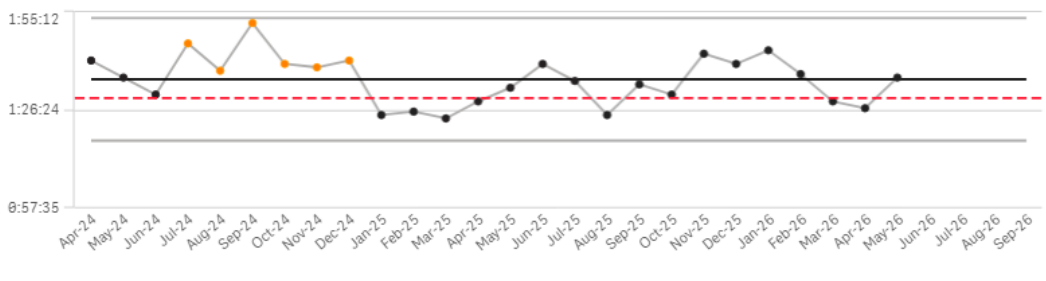
STEMI Mean (QS10) shows common cause variation and is below the target (4th of 11 reporting services).
STEMI 90th (QS11) shows common cause variation and is above the target (9th of 11).
Each of the charts is a system-based performance measure that reflects the whole cycle from point of call to time to insertion of the intervention and therefore includes time taken in hospital following ambulance arrival.
The chart represents data up until May 2026, with 63 recorded cases.

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).

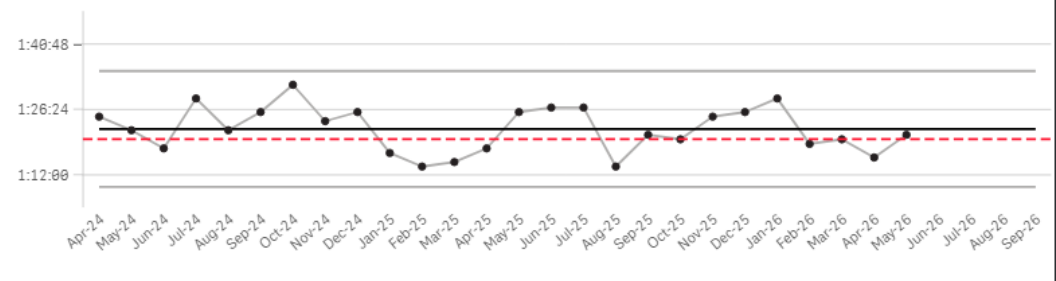
Quality & Safety – AQIs – Stroke - Chief Paramedic Officer

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



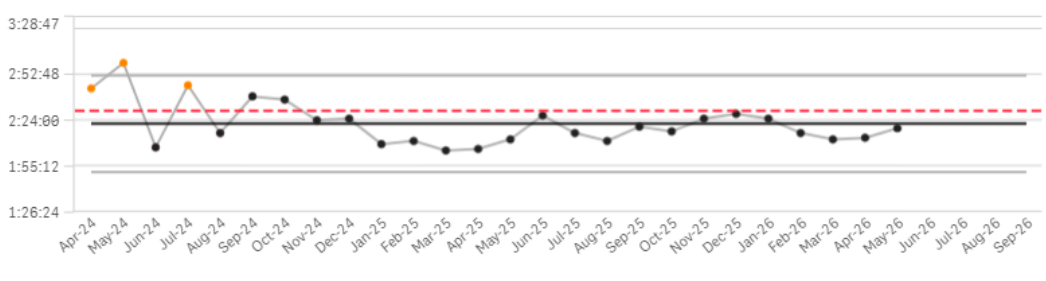
Variation	Assurance	Target	Latest
Expected	Random	01:30:00	01:36:00

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



Variation	Assurance	Target	Latest
Expected	Random	01:20:00	01:21:00

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



Variation	Assurance	Target	Latest
Expected	Random	02:30:00	02:19:00

Understanding the Performance:

Stroke Mean (QS12) shows common cause variation and is above the target (9th of 11 reporting services).
Stroke Median (QS13) shows common cause variation and is at the target (8th).
Stroke 90th (QS14) shows common cause variation and is below the target (6th) .

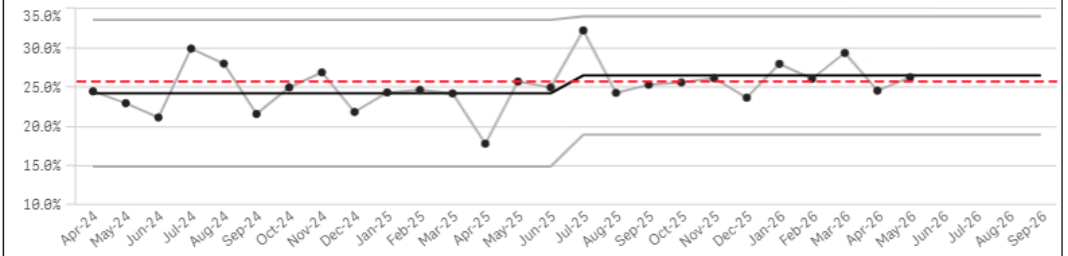
Each of the charts is a performance based measure and as such is reliant on the Trust's ability to identify a suitable resource, the time taken to get to scene and the ability of the Trust clinician to recognise a Stroke and provide the required care, the time spent on scene and the time spent travelling to the hospital site.
The data presented here represents May 2026 incidents covering 329 cases.

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).

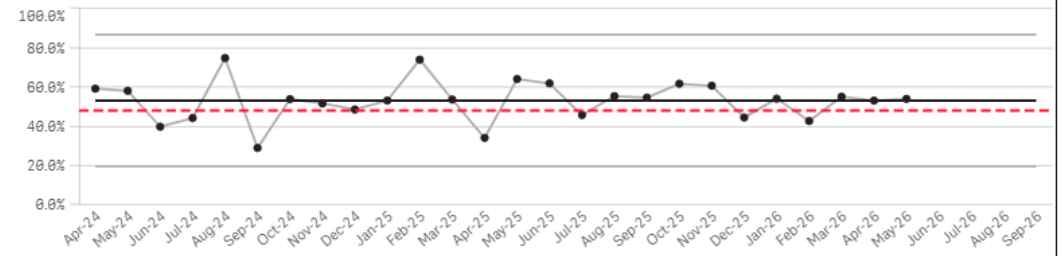
Quality & Safety – AQIs – Cardiac Arrest - Chief Paramedic Officer

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



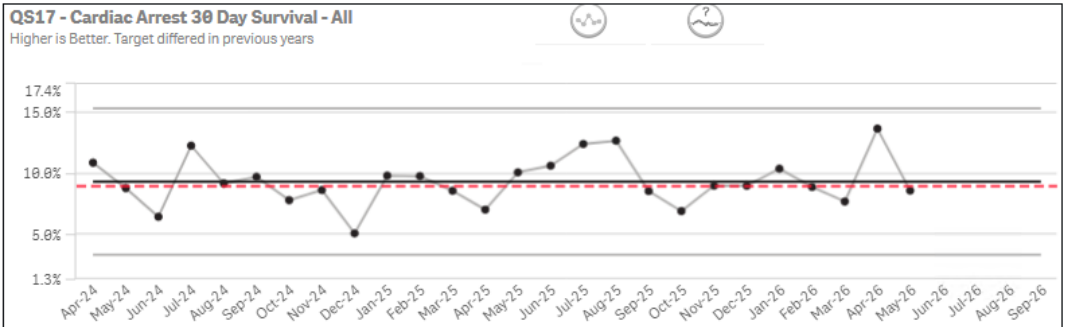
Variation	Assurance	Target	Latest
Expected	Random	25.8%	26.3%

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



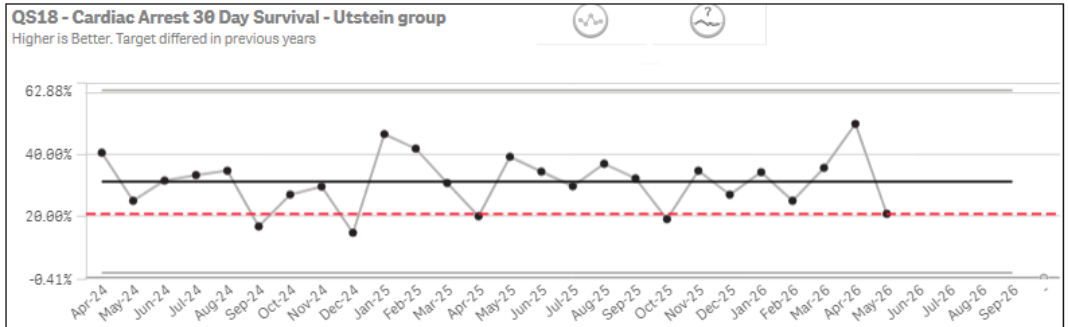
Variation	Assurance	Target	Latest
Expected	Random	48.4%	54.2%

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



Variation	Assurance	Target	Latest
Expected	Random	8.9%	8.6%

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



Variation	Assurance	Target	Latest
Expected	Random	20.6%	20.8%

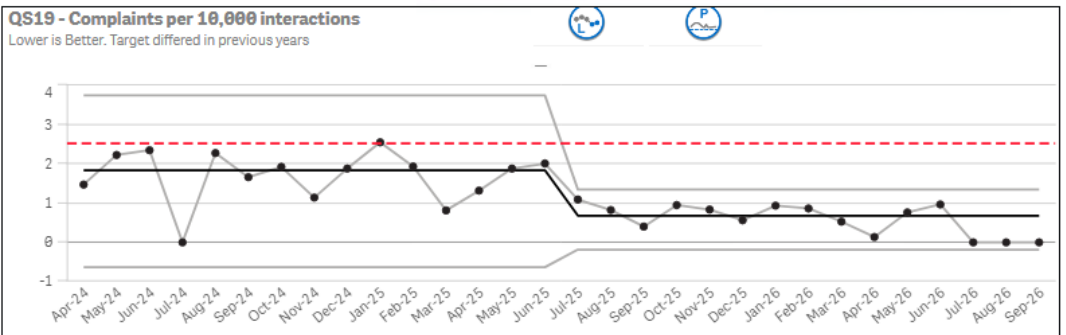
Understanding the Performance:
ROSC all (QS15) shows common cause variation, above the target (9th of 11 reporting services).
ROSC Utstein (QS16) shows common cause variation, above the target (7th)
Cardiac Arrest Survival All (QS17) shows common cause variation above the target (7th)
Cardiac Arrest survival Utstein (QS18) shows common cause variation at the target (10th)
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 May 2026 with 175 attempted resuscitations.

Actions (SMART):

Continuous focus of call answer times (OP6)
Continuous focus on Category 1 response times (OP1)
Continue to maximise vehicle availability to respond by reducing handover delays at Emergency Departments (OP 12 OP13 & OP14).
To have 95% of Trust clinical staff to have completed their annual mandatory training, both online and face to face for resuscitation, by the end of March 2027.

Quality & Safety – Safeguarding and Patient Experience

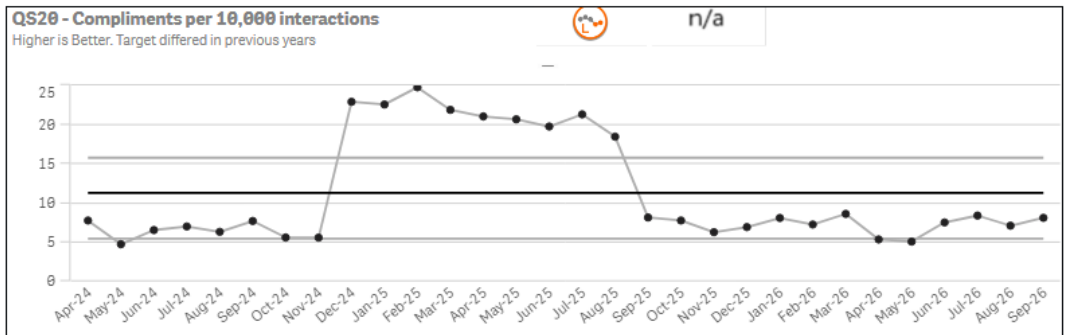
QS19 - Complaints per 10,000 interactions
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Improving	Pass	2.53	0.00

QS20 - Compliments per 10,000 interactions
Higher is Better. Target differed in previous years

n/a



Variation	Assurance	Target	Latest
Declined	-	-	8.13

Understanding the Performance:

QS20 – HCPF has increased from 109 to 127 representing 38% of all patient experience contacts; 119 compliments, 36% of all patient experience contacts, were received for the same period.
Themes are continued concerns regarding inappropriate referrals to services in 111.

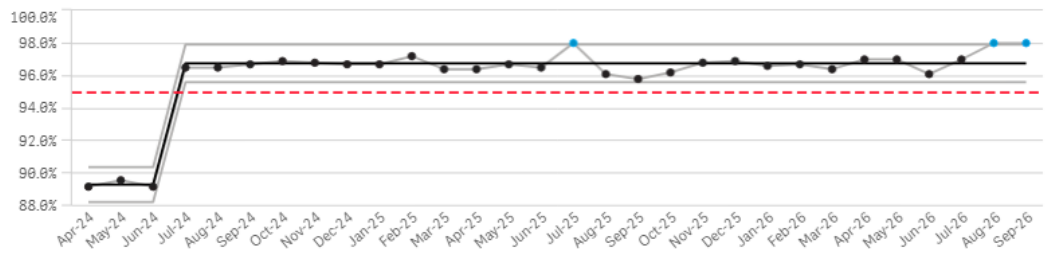
Actions (SMART):

QS20 – 111: A meeting is to be arranged with Gosport MIU to review concerns regarding inappropriate referrals and the current DoS configuration relating to SD/SG dispositions. The aim is to improve pathway suitability, strengthen system understanding, and reduce the number of HCPF submissions associated with inappropriate referrals.

Quality & Safety – Safeguarding and Patient Experience

QS21 - Level 1 Safeguarding

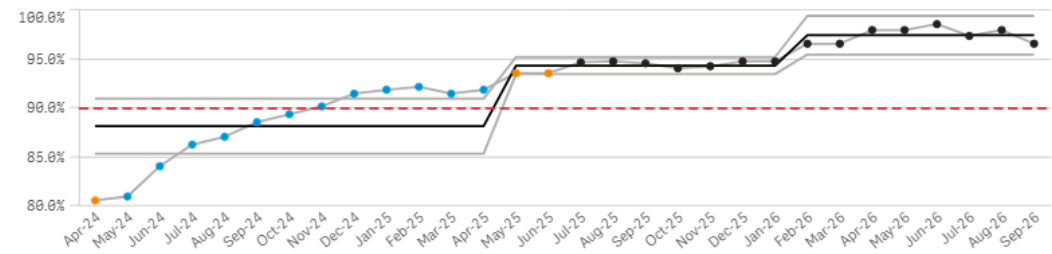
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Improving	Pass	95%	98.0%

QS22 - Level 3 Safeguarding

Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Pass	90%	96.6%

Understanding the Performance:

Actions (SMART):

NHS

NHS
South Central
Ambulance Service
NHS Foundation Trust

People

September-26

Summary

Metrics:

Assurance →

Variance ↓

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

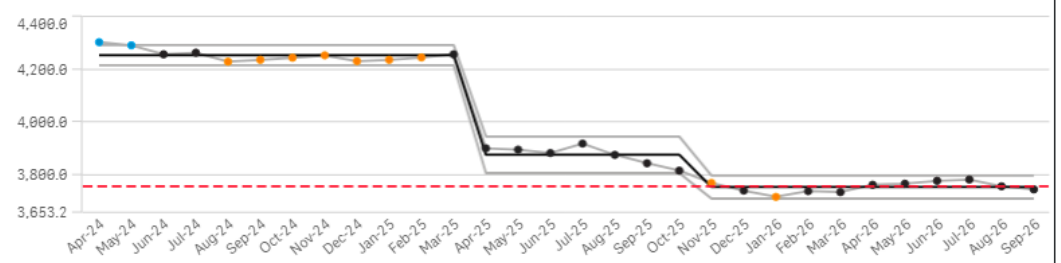
People - WTE, Availability, Staff Compliance, Staff Welfare

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

KPI	Latest Month	Measure	Target	Variation	Assurance	Mean	Lower Process Limit	Upper Process Limit
Number of WTE	Sep-26	3,744	3,753			3752.2	3708.4	3795.9
% Turnover	Sep-26	13.7%	17.70%	L	P	14.8%	13.9%	15.8%
% Vacancy	Sep-26		0.20%		F	2.1%	0.5%	3.8%
Time to hire	Sep-26	90	70			75.2	29.5	120.9
% Trust staff who are BAME	Sep-26	9.6%	8.86%	H	P	9.3%	8.9%	9.6%
% Trust staff who are declared disabled	Sep-26	12.7%	9.54%	H	P	12.1%	11.6%	12.6%
% Sickness in month	Sep-26	7.1%	6.20%			6.8%	5.9%	7.6%
Short term sickness	Sep-26	2.9%	2.70%			3.0%	2.0%	4.0%
% Long term sickness	Sep-26	4.2%	3.50%			4.0%	2.6%	5.4%
% DBS Compliance	Sep-26	98.0%	95.00%	L	P	98.1%	97.3%	98.9%
Appraisals - Trust	Sep-26	73.3%	95.00%	L	F	84.2%	79.4%	89.1%
FTSU Cases	Sep-26			L	n/a	18.2	3.8	32.7
Stat and Mand Compliance	Sep-26	99.8%	95.00%	–	P	-	-	-
Meal Break Compliance - SCAS	Sep-26	72.2%	85%		F	73.0%	63.7%	82.3%
Over-runs >30 mins - SCAS	Sep-26	15.8%	15%			15.5%	12.5%	18.4%

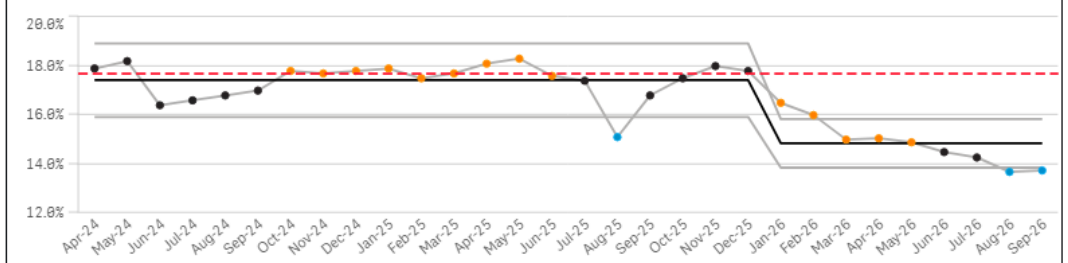
People - Workforce/WTE

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



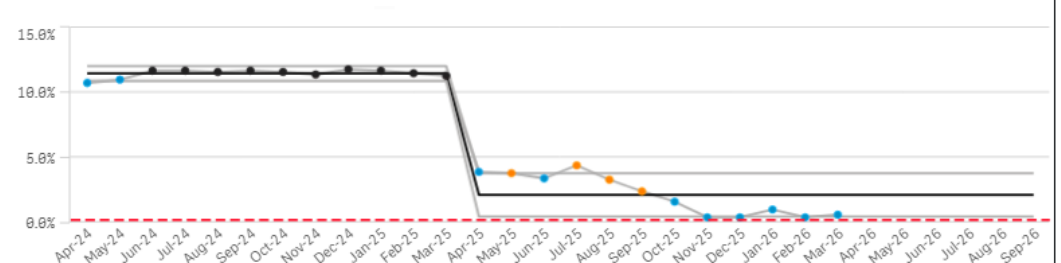
Variation	Expected
Assurance	Random
Target	3,753.15
Latest	3743.6

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



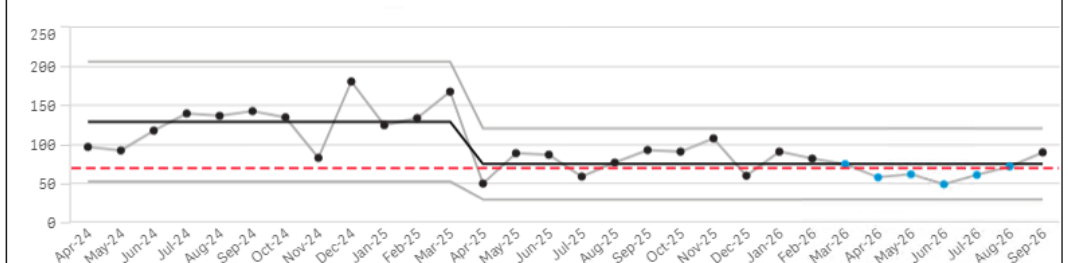
Variation	Improving
Assurance	Pass
Target	17.70%
Latest	13.7%

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



Variation	Expected
Assurance	Fail
Target	0.2%
Latest	

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



Variation	Expected
Assurance	Random
Target	7.0
Latest	90.0

Understanding the Performance:

P1: WTE is 3,744, below the monthly 3,841 WTE planned target but above the end of year target of 3753
P2: Turnover is 13.7%, below the 17.7% target and static since last month
P4 Time to Hire: 90 calendar days overall, 33 days from offer to ready.

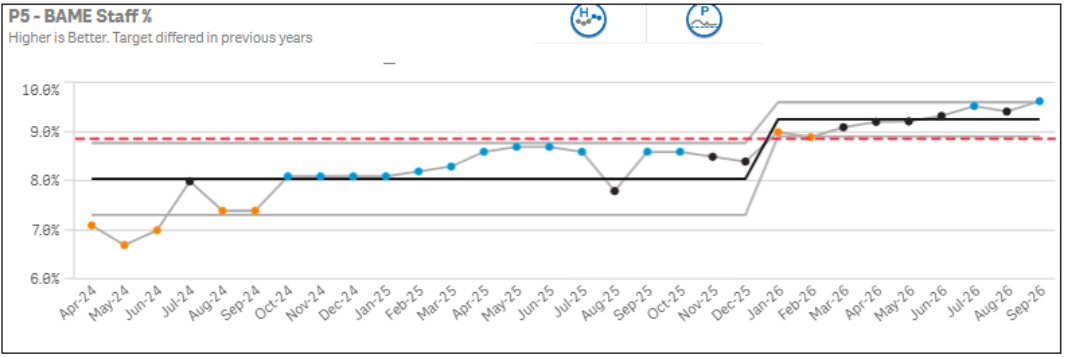
Actions (SMART):

P1: Monthly IWP meetings for the main workforce plan include close control and monitoring of attrition
P2: Changing turnover rate is shown in workforce planning groups to allow re-evaluation of recruitment assumptions
P4 Time to Hire: Delays in ICC due to pre-booked holidays and delays in completion of risk assessments, approval of additional employment and DBS outcomes to ensure full compliance before starting. Delays are out of the scope of Recruitment impact.

People - Workforce/Availability

P5 - BAME Staff %

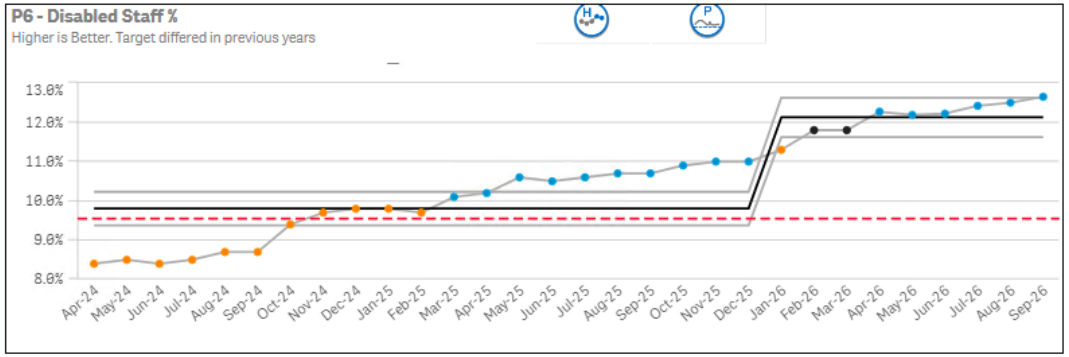
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Improving	Pass	8.9%	9.6%

P6 - Disabled Staff %

Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Improving	Pass	9.5%	12.7%

Understanding the Performance:

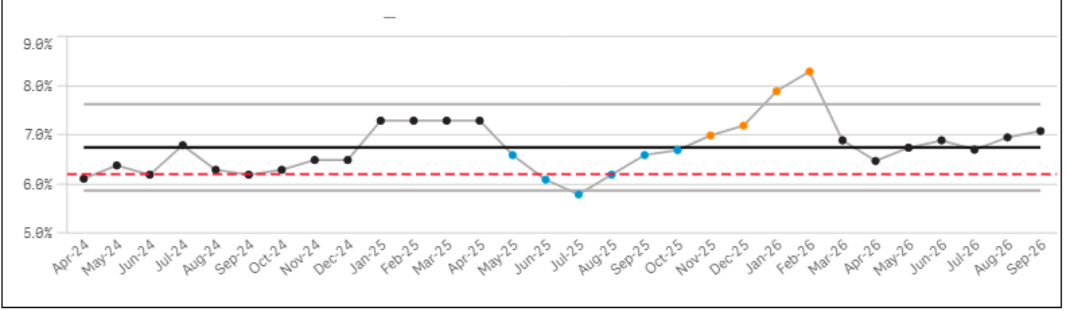
P5: BAME representation is 9.6%, above the 8.9% target and improving.

P6: Disabled staff representation is 12.6%, above the 9.54% target and improving.

Actions (SMART):

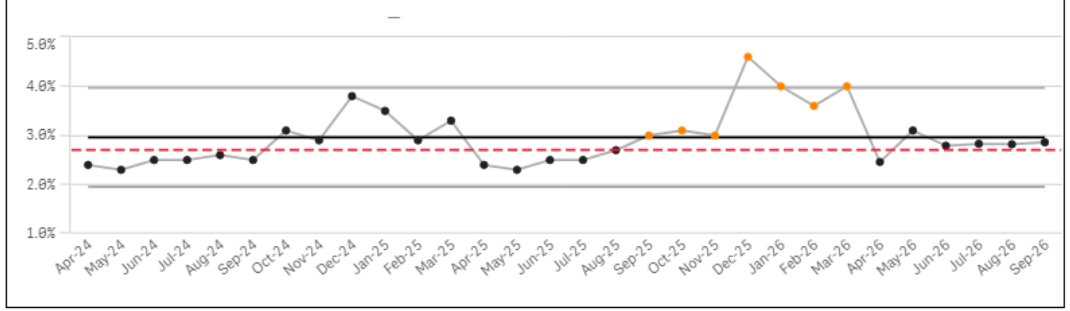
People - Workforce/Sickness

P7 - Monthly Sickness
Lower is Better. Target differed in previous years



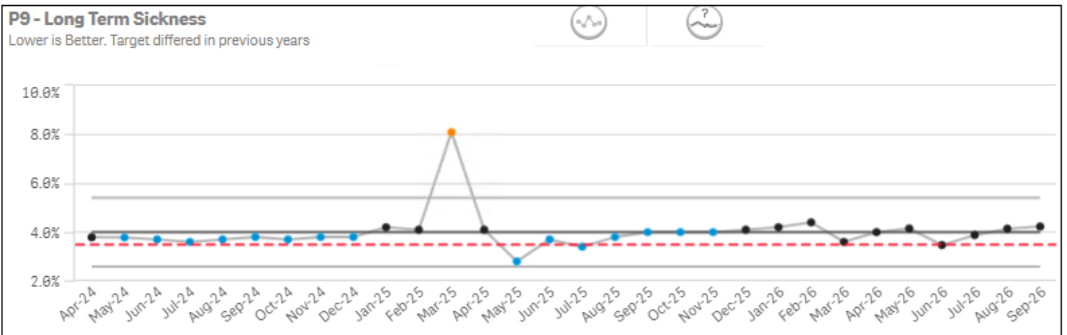
Variation	Assurance	Target	Latest
Expected	Random	6.2%	7.1%

P8 - Short term sickness
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	2.7%	2.9%

P9 - Long Term Sickness
Lower is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Expected	Random	3.5%	4.2%

Understanding the Performance:

P7: Monthly sickness is 6.9%, 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.
P9: Long-term sickness is 4.2%, above the 3.50% target and risen since previous month.

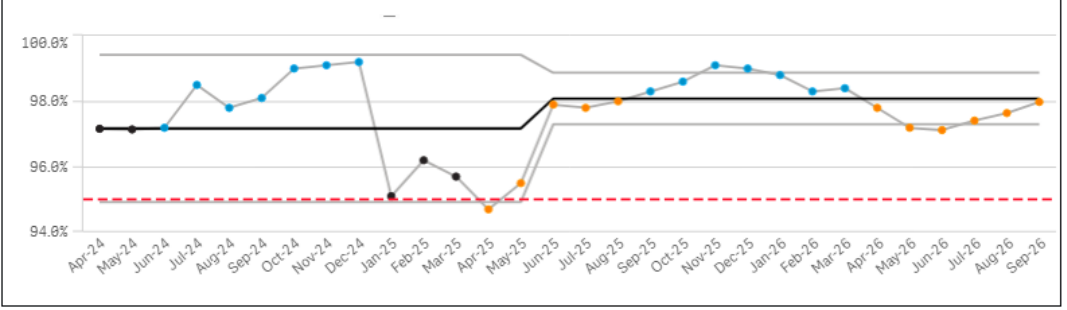
Actions (SMART):

We have recently seen an increase in COVID-19 being recorded as a reason for sickness absence. As we approach the winter respiratory illness season, a reminder has been issued from IPC and Health and Wellbeing teams to colleagues of the current guidance and the simple steps we can all take to help reduce the spread of infection and protect our workforce and patients.
The 2026/2027 Flu Campaign commenced on the 1st October, clinic dates have been announced, various peer to peer vaccination clinics will be taking place across the footprint, as well as linking with HIOW NHS Trust for clinic availability. 60% reporting is the target to achieve.

People – Workforce/Staff Compliance

P10 - DBS Compliance

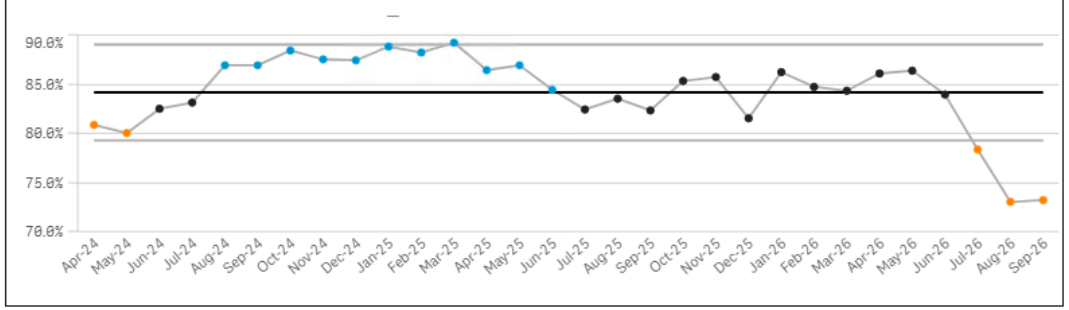
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Declined	Pass	95.0%	98.0%

P11 - Staff Appraisal Target

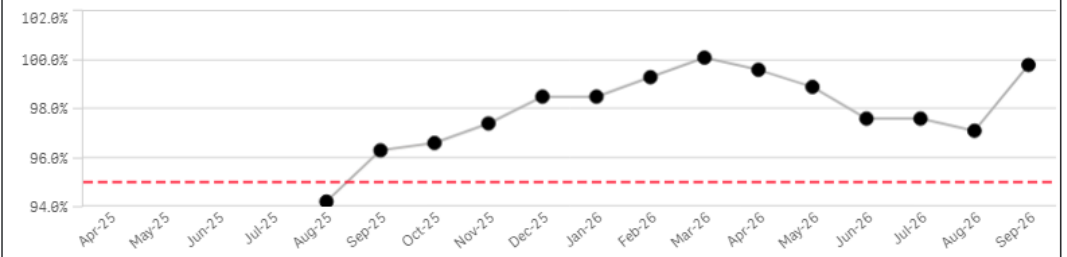
Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
Declined	Fail	95.0%	73.3%

P12 - Stat and Man Training Compliance

Higher is Better. Target differed in previous years



Variation	Assurance	Target	Latest
	Pass	95.0%	99.8%

Understanding the Performance:

P10: DBS compliance is 98%, above the 95% target.

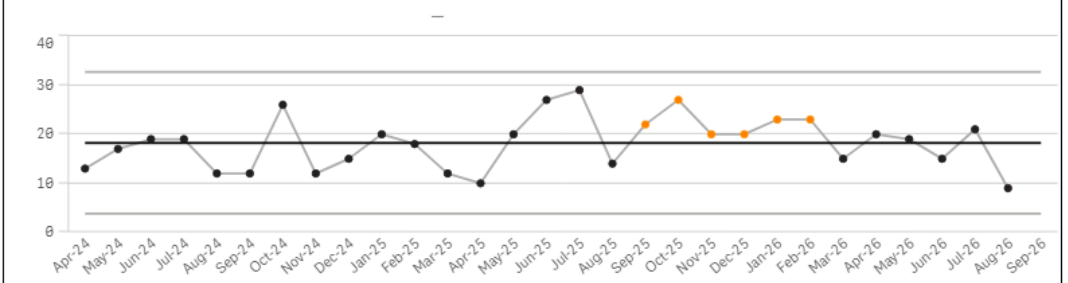
P11: Appraisal completion reporting has a technical issue with PDR App inputs. Compliance with just ESR input is 73%, below the 95% target.

Actions (SMART):

P11: Manual intervention will be taken to resolve the technical issue. Communication has been sent to managers and staff through various communications channels asking for all PDR's to be uploaded to ESR until the issue is resolved.

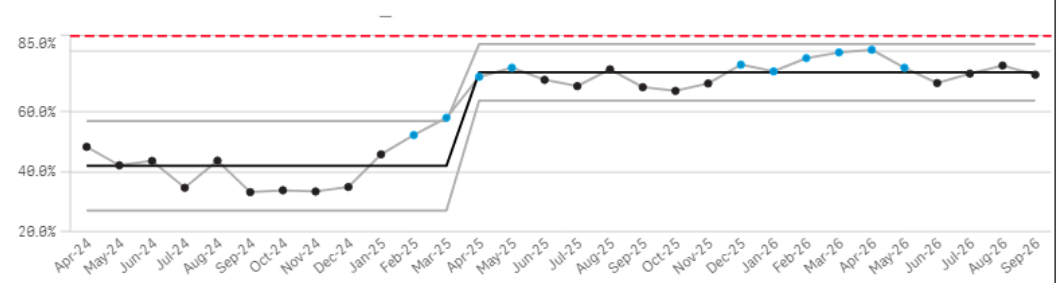
People - Workforce/Staff Welfare

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



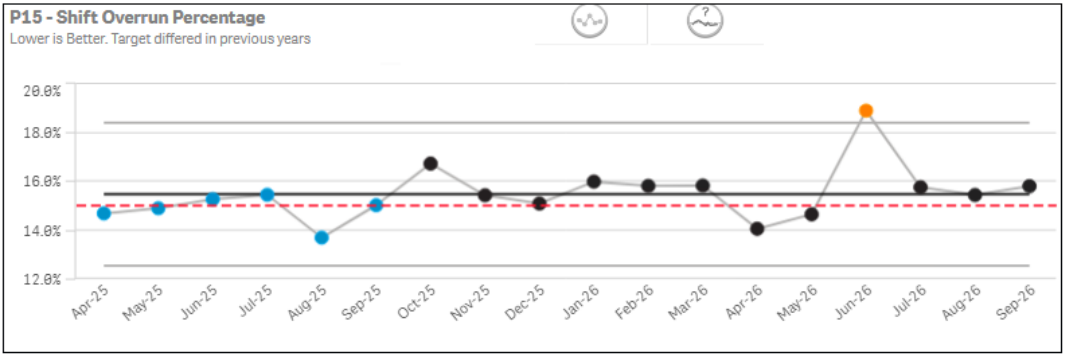
Variation	Assurance	Target	Latest
Improving	-	-	

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



Variation	Assurance	Target	Latest
Expected	Fail	85%	72.2%

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



Variation	Assurance	Target	Latest
Expected	Random	15%	15.8%

Understanding the Performance:

P14 &P15 have largely tracked against previous performance and without changes to policy it is felt that this is the current pattern

Actions (SMART):

Further modelling work undertaken with Omda to be able to put together revised policies that support the delivery of these policies. Discussions this week with Union colleagues has give a clear steer to next steps, a last modelling exercise and then staff engagement. Both policies will see significant changes to allocation improving compliance and improving patient experience.

NHS
South Central Ambulance Service
NHS Foundation Trust

Trust Board of Directors Meeting in Public 5 November 2026	
Report title	Month 6 Financial Performance
Agenda item	11
Report executive owner	Jon Bell, Interim Chief Finance Officer
Report author	Spriha Dutt, Deputy Chief Finance Officer
Governance Pathway: Previous consideration	Finance and Performance Committee
Governance Pathway: Next steps	N/A

1. Purpose

The paper is a report to the Board on the financial performance of the Trust for the year to 30th September 2026.

2. Executive Summary

Income & Expenditure (I&E)

The Month 6 position is on plan, with a £5k favourable variance in-month and £6k 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, emerging pressures would result in a forecast year-end deficit of £3m without further mitigating actions.

Capital

Capital expenditure in Month 6 was £2.9m against a planned position of £15.2m, reflecting slippage in the estates and fleet programmes. Trust's capital position at Month 6 is underspent by £12.3m. Capital expenditure of £2.9m reflects lower-than-planned spend on estates and fleet programmes, with underspends of £7.6m on core capital, £7.5m on PDC-funded schemes and £10.9m on IFRS 16 budgets. These are largely offset by £13.7m 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 Sept was £42.9m, which is £6.7m ahead of plan due to slippage in the capital programme. In month, the Trust generated a net cash outflow of £1.1m.

Key Performance Indicators

	Actual	Plan	Variance
Surplus / (Deficit) In-month (£'000)	50	45	5
Pay Costs In-Month (excl. agency) (£'000)	18,795	18,183	-612
Agency Costs - in month (£'000)	114	78	-36
Capital Spend - YTD (£'000)	2,902	15,252	-12,350
Closing Cash Position (£m)	42.9	36.2	6.7

3. Areas of Risk

See report

4. Link to Strategic Theme

Partnerships and Sustainability

5. Link to Board Assurance Framework Risk(s)

SR7 Sustainability

6. Quality/Equality Impact Assessment

Not Applicable

7. Recommendations

The Board is asked to:

- The Board is asked to note the M6 Financial performance and current risks to delivering the FY plan.

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

1. Background / Introduction

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

Income and Expenditure (I&E)

In Month 6, the Trust's I&E position is an adjusted surplus of £50k, which is a £5k favourable variance to plan. YTD, the position is an adjusted deficit of £4k, £6k favourable to plan

	Month 6			YTD - Month 6			FY 26/27
	Actual	Budget	Variance	Actual	Budget	Variance	Budget
	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s	£'000s
Income from patient care activities	27,614	27,451	163	165,034	164,708	326	329,416
Other income	167	236	(70)	1,300	1,419	(119)	2,837
Deficit Support Funding	-	-	-	-	-	-	-
Income Total	**27,781**	**27,688**	**93**	**166,334**	**166,126**	**208**	**332,253**
Substantive	18,574	17,847	(727)	110,053	106,882	(3,171)	213,918
Bank	221	336	115	1,430	2,015	585	4,040
Agency	114	78	(36)	827	609	(218)	697
Pay Total	**18,909**	**18,261**	**(648)**	**112,309**	**109,506**	**(2,803)**	**218,655**
Non Pay	**7,833**	**8,221**	**388**	**47,987**	**48,823**	**836**	**99,843**
Contingency	110	360	250	1,584	3,044	1,461	4,063
Injury Benefit	17	17	0	100	102	2	204
Depreciation	1,631	1,531	(100)	8,953	9,380	427	20,233
IFRS16 Interest	113	115	2	640	719	79	1,845
IFRS16 Credits	(866)	(865)	1	(5,166)	(5,458)	(292)	(12,634)
Financing Costs	11	49	37	137	292	156	585
P&L on disposal	23	5	(18)	92	36	(56)	70
Other Total	**1,040**	**1,212**	**173**	**6,339**	**8,115**	**1,776**	**14,367**
Surplus/(Deficit)	**(0)**	**(6)**	**6**	**(301)**	**(317)**	**16**	**(612)**
System Reporting Adj	**50**	**51**	**(1)**	**297**	**308**	**(11)**	**615**
Surplus/(deficit) adjusted	**50**	**45**	**5**	**(4)**	**(10)**	**6**	**3**

The Trust remains on plan year to date; however, there are significant risks to the financial position in the second half of the year arising from anticipated cost pressures. Sustained focus on cost control, productivity and delivery of savings plans will be essential to maintain financial sustainability.

In the year to Month 6, 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 significant increase in Cat 2 response times. There is a risk of further costs to manage winter pressures 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. 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

Pay	Month			Year to Date		
	Actual £000's	Plan £000's	Variance £000's	Actual £000's	Plan £000's	Variance £000's
Substantive	18,574	17,847	(727)	110,053	106,882	(3,171)
Bank	221	336	115	1,430	2,015	585
Agency	114	78	(36)	827	609	(218)
Total Pay	**18,909**	**18,261**	**(648)**	**112,309**	**109,506**	**(2,803)**

Substantive Pay Costs:

- Total pay expenditure for the month was £18.9m against a budget of £18.3m, resulting in an overspend of £0.6m. This variance is primarily attributable to the non-delivery of recurrent CIP savings within pay.
- Overtime for the month was £0.44m against a budget of £0.43m, resulting in a small deficit of £0.01m. The YTD deficit is £66k
- Third Party Providers (inc. Taxi and Volunteer drivers) in month spend is 0.7m which is £0.06m favourable against budget. The YTD spend is at £4.4m, with a favourable variance of £91k against budget.

Agency Costs:

- Agency costs totalled £114k, exceeding the plan by £36k.
- The spend above plan was driven by Fleet Mechanics in SCFS. There have been plans in place to reduce this spend from Q2 onwards are currently delivering

Bank Costs:

- Bank costs totalled £221k, under budget by £115k.
- The underspend is due to a lower uptake of bank shifts across service lines

Pay CIPs Risk:

A recurrent CIP gap on pay is being mitigated by non-recurrent vacancy savings (YTD £1.8m) and other contingencies in non-pay. 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 costs with SECAMB - £141k
- Payroll Accuracy £20k

Non- Pay Costs

Non-pay expenditure is reporting a favourable variance of £0.4m against budget. 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 will need to monitor operational and financial risks throughout the year, including workforce, fleet, and non-pay pressures, alongside risks associated with strategic and multi-year planning. Any financial risks will need to be mitigated through additional cost savings.

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

Workforce expenditure will continue to be closely monitored, with corporate recruitment controls, including vacancy freezes, 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 continues to operate within a challenging funding and affordability environment, with the available funding envelope requiring the Trust to deliver significant efficiencies alongside the operational requirements and performance expectations.

The Trust has a total CIP plan of £19.7m. 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 £12.2m (62%) recurrent delivery and £7.4m (38%) non-recurrent delivery. However, the actual YTD performance is 49% recurrent and 51% non-recurrent, with temporary measures, including vacancy freeze, offsetting under-delivery of other schemes.

In-month delivery was £1.9m (9% of the full-year plan).

In-month, 999 delivered £1m 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 £53k of savings which is mostly non-recurrent, reflecting temporary vacancies within the department.

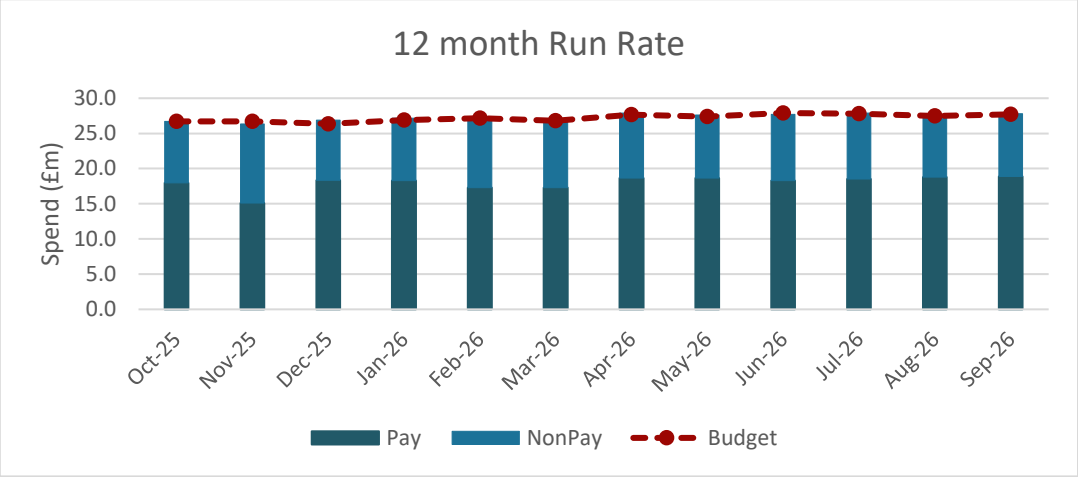
Fleet delivered £97k however is currently £623k under-delivering against its CIP YTD. The position is forecast to have a £1.2m gap by year end.

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. Procurement continue to not achieve against their target.

CIP is forecast to breakeven. This includes a £1m deficit within Fleet, offset by £0.4m forecast delivery in 999 ICC and £1m forecasted within the Central line. However, no schemes have currently been identified to support the Central delivery, representing a £1m delivery risk.

Run Rate

The 12-month run rate demonstrates the movement in pay and non-pay expenditure against budget between Aug 25 and Sep 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 6 is underspent by £12.3m. Capital expenditure of £2.9m reflects lower-than-planned spend on estates and fleet programmes, with underspends of £7.6m on core capital, £7.5m on PDC-funded schemes and £10.9m on IFRS 16 budgets. These are largely offset by £13.7m 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 were 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 that were being coach built by AEV are now being coach built by WAS. It is expected that there will be slippage in this cohort of 12 DCA's into 2027/28 (£1.2m).
- **2026/27 DCA Cohort (MAN units):** The 26/27 DCA cohort of 70 MAN DCA's are being coachbuilt by AEV. 20 units have slipped into 27/28 (£2m) with the remaining 50 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 £3.6m of underspend at M6. Spend is expected to pick up in Qtr3 following agreement of the Estates Safety Funding with NHSE.

- **Southern House Lease:** The lease extension for Southern House has been agreed by SCAS Board. This has created a £2.2m pressure on the 26/27 capital budget. The slippage from the 26/27 AEV DCA cohort has been re-allocated to negate this pressure.
- **27/28 Capital Budget:** The slippage in the two DCA cohorts (£3.2m) will impact the 27/28 capital budget. The five year capital plan is under review to mitigate this slippage and to produce a balanced budget for 27/28 and 28/29.

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.

		Year to Date			Forecast		
	£m	Actual	Plan	Variance	Actual	Plan	Variance
Estates	Internal CDEL	1.5	2.8	(1.3)	4.0	4.0	0.0
	PDC	0.0	3.3	(3.3)	9.3	9.3	0.0
	Disposal	(1.4)	(2.1)	0.7	(2.1)	(2.1)	0.0
	IFRS16	0.6	0.4	0.2	0.4	0.4	0.0
	Total	**0.7**	**4.4**	**(3.6)**	**11.6**	**11.6**	**0.0**
Digital	Internal CDEL	0.1	1.0	(0.9)	3.9	3.9	0.0
	Total	**0.1**	**1.0**	**(0.9)**	**3.9**	**3.9**	**0.0**
Fleet (DCA)	Internal CDEL	1.2	5.7	(4.5)	11.3	11.3	0.0
	PDC	0.2	4.5	(4.3)	6.2	6.2	0.0
	Disposal	(1.5)	(14.1)	12.6	(28.9)	(28.9)	0.0
	IFRS16	1.4	12.5	(11.1)	25.6	25.6	0.0
	Total	**1.4**	**8.6**	**(7.2)**	**14.3**	**14.3**	**0.0**
Fleet (Non-DCA)	Internal CDEL	0.6	1.2	(0.6)	2.1	2.1	0.0
	Disposal	(2.2)	(2.6)	0.4	(3.9)	(3.9)	0.0
	IFRS16	2.0	2.0	0.0	3.2	3.2	0.0
	Total	**0.4**	**0.6**	**(0.2)**	**1.4**	**1.4**	**0.0**
Other (Operations, Ops Support, Education,	Internal CDEL	0.2	0.7	(0.4)	0.9	0.9	0.0
	Total	**0.2**	**0.7**	**(0.4)**	**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		3.7	11.3	(7.6)	22.3	22.3	0.0
PDC Total		0.2	7.8	(7.5)	15.5	15.5	0.0
Disposal Total		(5.1)	(18.8)	13.7	(35.0)	(35.0)	0.0
IFRS16 Total		4.0	14.9	(10.9)	29.3	29.3	0.0
Total		**2.9**	**15.2**	**(12.3)**	**32.0**	**32.0**	**0.0**

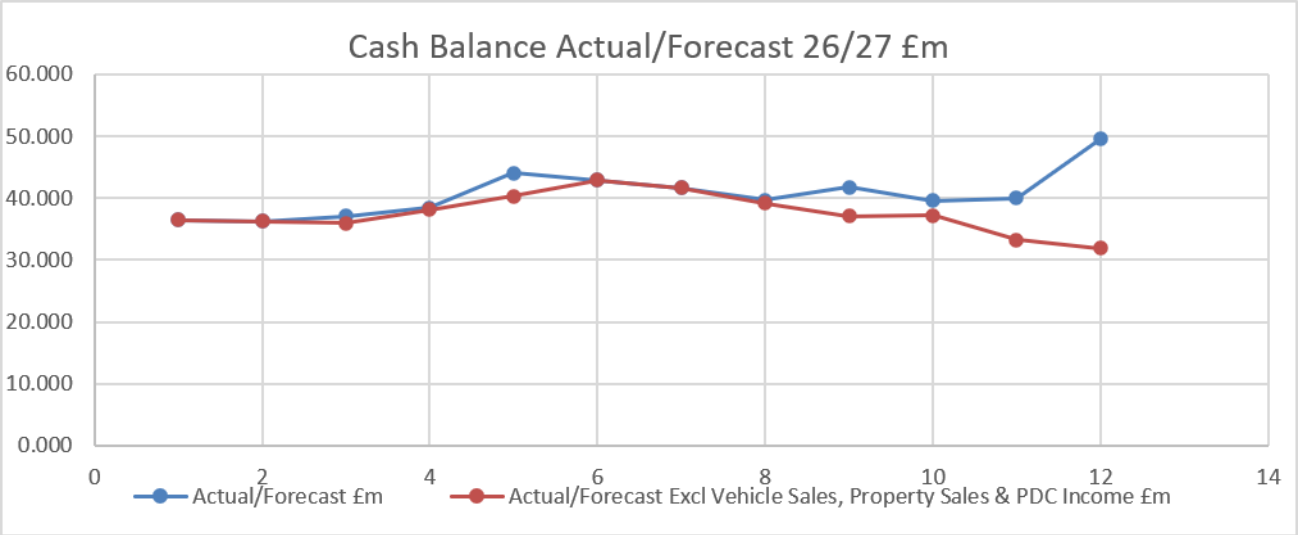
Cash

The Trust's cash balance at the end of Sept was £42.9m, which is £6.7m 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 outflow of £1.1m due mostly to the payments of £1m PDC and £1.6m of capital spend.

2026/27	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Income £m	28.3	27.4	29.0	30.2	33.0	28.3	28.8	28.7	32.8	30.9	35.4	46.6
Expenditure £m	(36.0)	(27.6)	(28.2)	(28.7)	(27.4)	(29.4)	(30.0)	(30.6)	(30.8)	(33.1)	(34.9)	(37.0)
Net Inflow/(Outflow) £m	(7.7)	(0.2)	0.8	1.4	5.6	(1.1)	(1.2)	(1.9)	2.0	(2.1)	0.4	9.5
Cash Balance £m	36.5	36.3	37.1	38.5	44.0	42.9	41.7	39.7	41.7	39.6	40.0	49.6
Cash Lowest Point	36.0	34.0	34.1	33.9	36.7	37.5						

The lowest point of cash in the month was £37.5m which is an increase from last month of £0.8m.

There was a net cash outflow in Month 6 of £1.1m.



Included within the March forecast is an expectation of receiving £15.9m of disposal proceeds for vehicles sold as part of sale/leaseback arrangements. There is also an expectation of receiving £1m for the disposal of the Chalfont property. These items are a risk to the cash flow, should these sales not deliver as expected the underlying cash balance for March would be on budget at £32.7m, this £32.7m cash position is the forecast that has been reported to the ICB.

The 90-day debtor increased to £0.232m in Sept (£0.319m in Aug). This represents 26.52% (33.88% in Aug) of the total debtor balance. The percentage debtors has decreased due to the overall debt balance decreasing.

Overdue debts include; Airwave Solutions £5k, Aurobindo Emergency Medical Services £81k, FedBucks Limited £29k, London Ambulance Service £76k, Newcastle Upon Tyne Hospitals NHS Foundation Trust £2k 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 6.

	Month 6 - YTD BPPC			
-	Number	%age	Value	%age
NHS	392	95.9%	£3,334,067	98.2%
Non-NHS	6,191	93.7%	£77,112,958	99.1%
Total	**6,583**	**93.8%**	**£80,447,026**	**99.1%**
Target		95.0%		95.0%
Variance		**-1.2%**		**4.1%**

2. Risks

- The Trust continues to work within a challenging financial context, where available resources are under sustained pressure to support service delivery and performance expectations.
- 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.

3. Next steps

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

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

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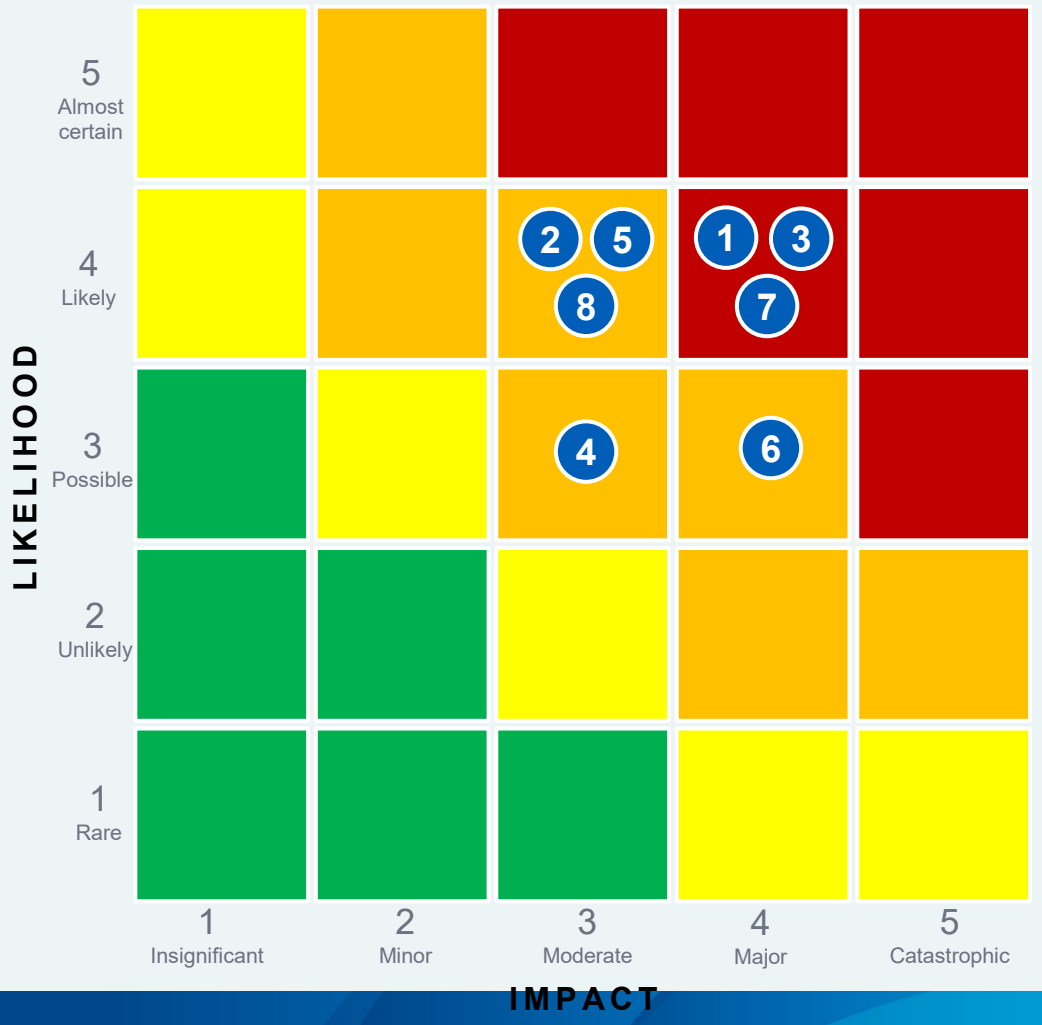
2026 – 2027
Board Assurance Framework

October 2026

Strategic Risk Heat Map

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: November 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

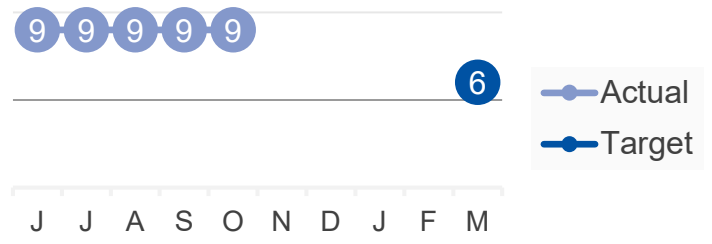
MITIGATING ACTIONS — DEADLINE

✓	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



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: **October 2026** · Next review: **November 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
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

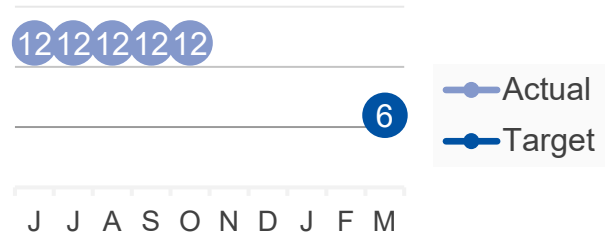
MITIGATING ACTIONS

- ✓ 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: **October 2026** · Next review: **November 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: Oct **2026** · Next review: Nov **2026**

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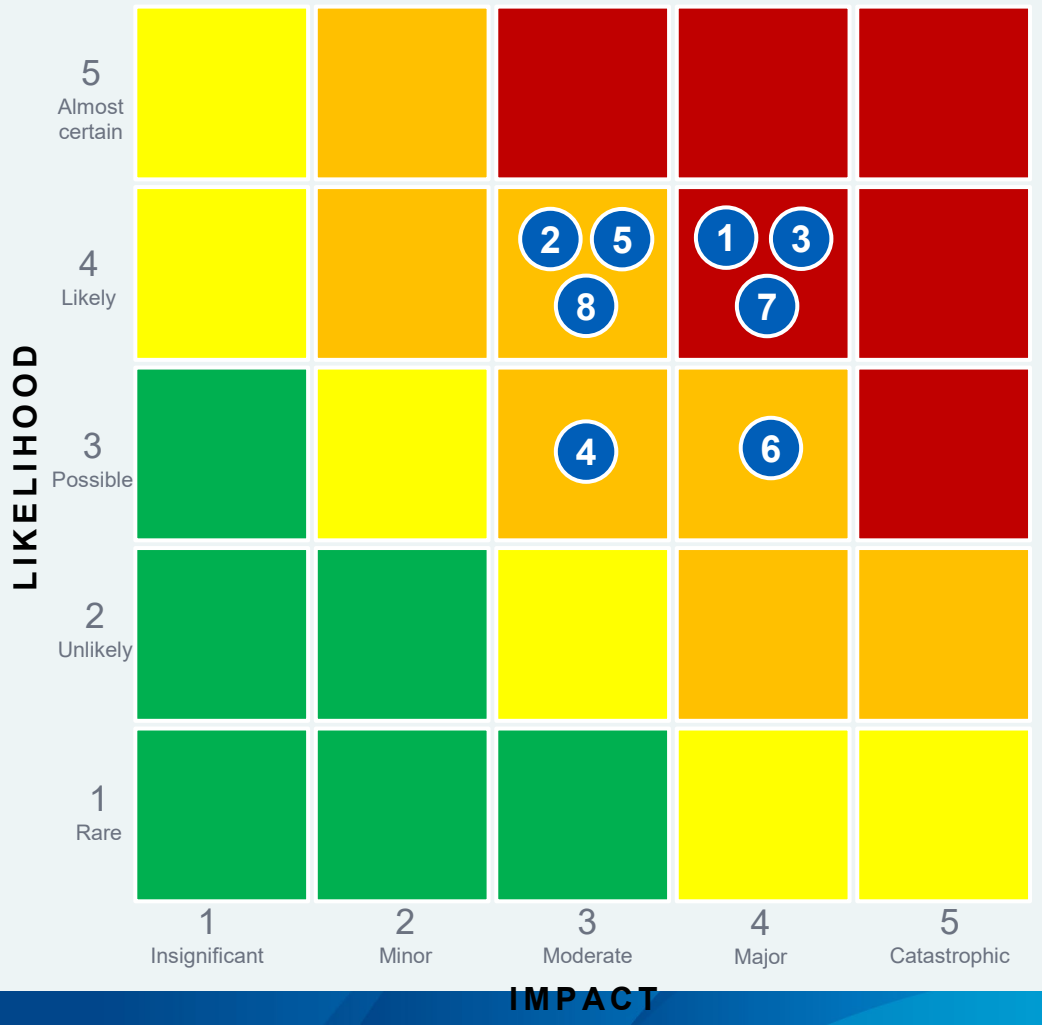
2026 – 2027 Board Assurance Framework – Digital Transformation

October 2026

Strategic Risk Heat Map

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	⟺
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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: November 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: **October 2026** · Next review: **November 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: **October 2026** · Next review: **November 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

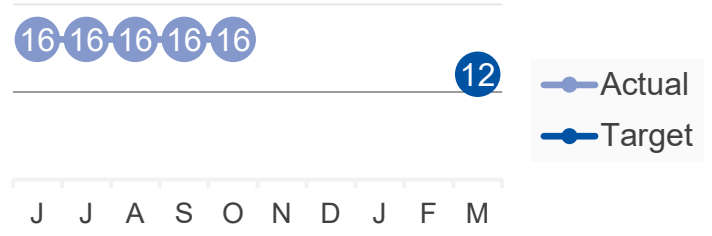
MITIGATING ACTIONS — DEADLINE

✓	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: **October 2026** · Next review: **November 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: **October 2026** · Next review: **November 2026**

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NHS Foundation Trust

Upward Report of the Quality & Safety Committee

Date Meeting met **28th September 2026**
Chair of Meeting **Katie Kapernaros, Non-Executive Director**
Reporting to **Trust Board**

Items	Issue	Owner	Action
Points for escalation			
Clinical Directorate Top 4 risks	Confirmation was given that the Trust is now in receipt of its Controlled Drugs licence. Processes are in place to ensure this is renewed in advance of expiry and an inspection against the licence conditions is anticipated in the summer of 2027.		Business as usual governance and oversight
Key issues and / or Business matters to raise			
Maternity & Neonatal Safety Improvement	Assurance was provided around the governance in place to oversee improvements in the maternity pathway following national reports into maternity care. The committee receives updates via the Upward Report, but a progress update was requested in January 2026	N/A	Part of the committee workplan
Clinical Directorate Top 4 risks	The committee received a verbal update on the quality impact of the Heatwaves; assurance was provided that all duty of candour letters had been provided to affected patients/families. It was agreed that a Patient Story would be presented to Board relating to the Heatwave and impact on operational demand/response.	BM	Patient Story and Heatwave Debrief Report on the agenda for the November board meeting.

Digital Safeguarding Referral System	The timeframe for the implementation of the new system was provided with assurance that delivery was on track. In the interim, manual checks remain in place to ensure that all referrals are submitted in line with the process. A peer review is also being commissioned with the output being reported to a future QSC meeting. It was also agreed that the committee would receive a quarterly report relating to Safeguarding activity to supplement the upward report.	HY	Quarterly report on Safeguarding to be presented to QSC.
Patient Safety Report	The committee received the Patient Safety Report and noted that it is scheduled for consideration by the Trust Board as part of the Board agenda.	N/A	
Director of Infection Prevention & Control Annual Report	The committee received the Director of Infection Prevention & Control Annual Report and noted that it is scheduled for consideration by the Trust Board as part of the Board agenda.	N/A	
Areas of concern and / or Risks			
Integrated Performance Report	Quality and safety related KPIs were received and discussed. The need for a clinical quality dashboard was emphasised to quality performance to be understood and assured. It was noted however that the build could not take place until the Data Warehouse is implemented and the timescales are therefore circa 9 months. The rationale was noted but committee members expressed concern as this is a gap in the trust's quality governance mechanism and therefore a risk. Interim solutions using the BI Team are under development in mitigation.	N/A	Committee will maintain a watching brief.
Items for information and / or awareness			
Patient Safety			
Best Practice and / or Excellence			
N/A			
Policies for approval			
None			

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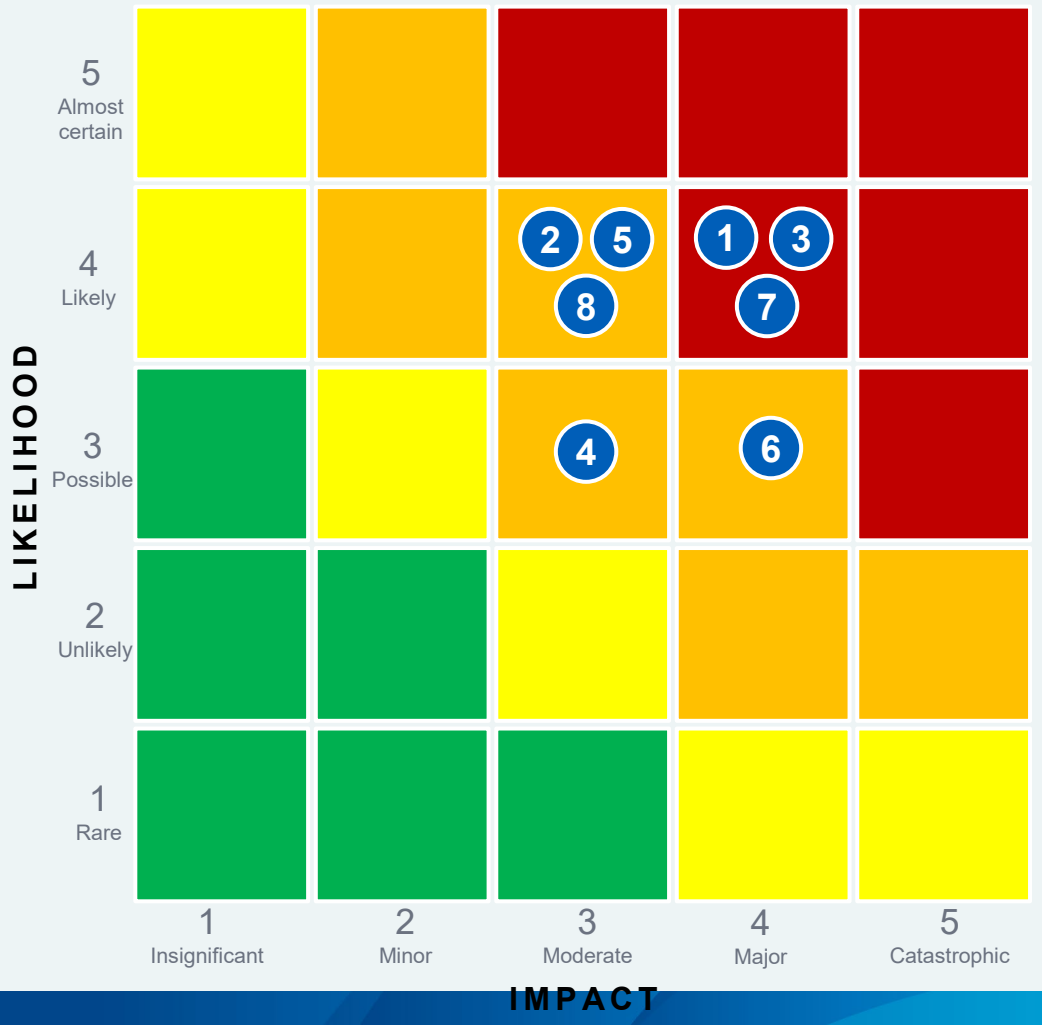
2026 – 2027 Board Assurance Framework – Clinical Effectiveness

October 2026

Strategic Risk Heat Map

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: November 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 Deployment 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)
- ✓ Daily strategic review of service delivery chaired by strategic commander.
- ✓ 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

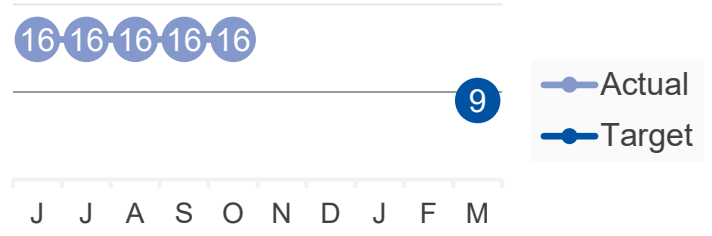
MITIGATING ACTIONS — DEADLINE

✓	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
- Not seeing the required increase in operational hours from OT and Bank.
- Delays with private provider recruitment

RISK MOVEMENT



Risk movement since last BAF: **Static** · Last reviewed: **October 2026** · Next review: **November 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 remains stable
- ✓ Cat 2 recovery programme team now in place with dedicated programme support and QI lead appointed
- ✓ 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 delivering cat 2 or call answer YTD
- ✗ 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
- ✗ Estates infrastructure unable to support growing fleet and staff requirements to meet demand

ASSURANCE SUMMARY

- Continuing challenge deliver operational hours with low uptake of OT and bank staff.
- Delays with private provider procurement
- 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: **October 2026** · Next review: **November 2026**

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Trust Board of Directors Meeting in Public 05 November 2026

Title	**Thirlwall Report Briefing Document**
Report Author	**Laura Mathias – Assistant Director Patient Safety** **Sarah Thompson – Interim Head of Safeguarding and Professional Standards and Allegation Lead**
Executive Owner	**Helen Young Executive Chief Nurse**
Agenda Item	**16**
Governance Pathway: Previous	Executive Management Committee Patient Safety & Experience Group
Governance Pathway Next Steps	Trust Board

1. Purpose

This report reviews the findings of the Thirlwall Inquiry, established following the conviction of former neonatal nurse Lucy Letby, and considers their relevance to ambulance services, with particular focus on organisational culture, safeguarding, patient safety, workforce governance and Freedom to Speak Up (FTSU) arrangements.

The Inquiry highlighted that serious harm resulted not solely from the actions of an individual, but also from failures within organisational systems to recognise, escalate and respond effectively to emerging concerns. A key lesson is the need for patient safety, safeguarding, workforce governance, complaints management, speaking up arrangements and organisational learning processes to function as a cohesive and integrated assurance framework.

SCAS has established governance arrangements across these domains; however, the review has identified opportunities to strengthen the systematic identification, collation and triangulation of intelligence from multiple sources to support the earlier recognition of potential risks relating to individual staff members and clinicians.

To support this work, a multidisciplinary Task and Finish Group, chaired by the Interim Head of Safeguarding, will be established with representation from key stakeholders across the Trust. The group will undertake a detailed gap analysis, develop a comprehensive action plan and propose a governance framework to provide ongoing oversight, assurance and monitoring of implementation.

The review has identified several opportunities to further enhance existing arrangements. In particular, strengthening the ability to bring together workforce, safeguarding, patient safety, complaints and speaking up intelligence will improve organisational awareness of emerging themes and support earlier intervention where concerns arise.

The Inquiry's central finding was that serious harm occurred not only because of the actions of one individual, but because multiple organisational safeguards failed to identify, connect and act upon warning signs. Despite concerns being raised and information being available through a range of governance mechanisms, opportunities to intervene and mitigate risk were missed. This reinforces the importance of robust oversight, professional curiosity, effective escalation processes and the timely triangulation of intelligence to protect patients and support a culture of safety.

The inquiry made **17 recommendations** in total, which are outlined in (**Appendix 1**). Of these, **4 recommendations** are relevant to the ambulance service, (3,4,9,13)

2. Areas of Risk

The following recommendations from the Thirlwall Inquiry have been identified as applicable to ambulance services and will form the basis of a detailed gap analysis and implementation plan. A multidisciplinary Task and Finish Group will oversee this work and provide assurance through established governance arrangements.

- **Recommendation 3: Bereavement Care**

The Inquiry recommends the national implementation of the National Bereavement Care Pathway for neonatal death by August 2027.

Whilst the recommendation is focused on neonatal services, it reinforces the wider importance of compassionate engagement with bereaved families, consistent communication, and ensuring that learning from patient safety incidents is identified and acted upon. SCAS will review existing arrangements relating to family engagement, support following significant incidents, and organisational learning to ensure alignment with the principles underpinning best practice bereavement care.

- **Recommendation 4: Safeguarding and Contracts of Employment**

The Inquiry recommends that all NHS organisations provide safeguarding training appropriate to role and responsibility, including for Board members and Non-Executive Directors. Training should specifically address the recognition, escalation and management of concerns where deliberate harm by a healthcare professional is suspected.

In addition, NHS employment contracts are expected to include an explicit requirement for staff to comply with safeguarding guidance and any future Suspicion of Deliberate Harm Protocol.

SCAS has established safeguarding arrangements, including mandatory safeguarding training and Board-level oversight. However, the Inquiry highlights the need to strengthen awareness of deliberate harm, professional curiosity, escalation pathways and the role of safeguarding in managing concerns relating to healthcare professionals. A review of safeguarding policies, training programmes and employment documentation will therefore be undertaken as part of the Trust's response.

- **Recommendation 9: Suspicion of Deliberate Harm Protocol and Guidance**

The Inquiry recommends the introduction of a national Suspicion of Deliberate Harm Protocol, setting out the actions required when concerns are raised that a healthcare professional may have intentionally harmed a patient.

Although national guidance is awaited, the recommendation reinforces the importance of clear escalation routes, timely investigation, robust safeguarding arrangements and prompt action where concerns arise. SCAS will review existing governance, safeguarding, disciplinary and professional standards processes to ensure they support the early identification, escalation and management of concerns relating to potential deliberate harm and will embed the national protocol on publication.

- **Recommendation 13: NHS Manager Accountability**

The Inquiry recommends strengthening managerial accountability through the introduction of an individual duty of candour for managers, alongside enhanced expectations regarding professional conduct and leadership.

SCAS supports the principles of openness, transparency and accountability and recognises the importance of leaders creating environments where concerns can be raised and acted upon appropriately. The recommendations provide an opportunity to review managerial responsibilities, leadership development arrangements and governance processes to ensure that patient safety remains the overriding priority in all decision-making.

Overall Assessment

The relevant recommendations collectively reinforce the importance of an organisational culture that prioritises patient safety, encourages professional curiosity, supports staff to speak up, and enables intelligence from multiple sources to be effectively triangulated and acted upon. While SCAS has maturing governance arrangements in place, the review has identified opportunities to strengthen the integration of patient safety, safeguarding, workforce, complaints and Freedom to Speak Up intelligence to support earlier identification and escalation of emerging risks.

3. Link to Strategic Theme

Clinical Effectiveness

4. Link to Board Assurance Framework Risk(s)

SR1 Quality Performance and Patient Outcomes

5. Quality/Equality Impact Assessment

Not required

7. Recommendations

A multidisciplinary Thirlwall Inquiry Task and Finish Group will be established, chaired by the Interim Head of Safeguarding and Professional Standards, with representation from Patient Safety, Safeguarding, People Services, Freedom to Speak Up, Professional Practice, Quality Governance and Information teams. The group will:

1. Undertake a comprehensive gap analysis against all relevant Thirlwall recommendations.
2. Review existing mechanisms for identifying, escalating and investigating concerns relating to deliberate harm.
3. Develop a framework for triangulating patient safety, safeguarding, complaints, workforce, disciplinary and Freedom to Speak Up intelligence at individual staff member level.
4. Review safeguarding, disciplinary, allegations management and professional standards policies to ensure patient safety remains the overriding consideration.
5. Incorporate deliberate harm and professional curiosity scenarios within safeguarding, leadership and Board development programmes.

6. Review bereavement care arrangements and align relevant processes to the National Bereavement Care Pathway principles.
7. Establish clear escalation thresholds, executive oversight arrangements and assurance reporting for concerns involving potential deliberate harm.
8. Produce a Trust-wide implementation plan with measurable milestones, owners and completion dates.

Progress will be monitored through Patient Safety & Experience Group, with quarterly assurance reporting to Executive Management Committee and Trust Board.

The Board is asked to:

- Note the findings of the Thirlwall Inquiry and their relevance to SCAS.
- Take assurance from the current safeguarding, patient safety and speaking up arrangements.
- Support the establishment of a multidisciplinary Task and Finish Group to oversee implementation.
- Endorse the development of an organisational action plan and assurance framework focused on strengthening the triangulation of intelligence, management of deliberate harm concerns and implementation of relevant Inquiry recommendations.
- Receive a progress update and detailed action plan within six months.

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

Appendix 1– Thirlwall Recommendations

Recommendation Area	Recommendation
1 Baby monitors	Install baby monitors (live-streaming cot/incubator cameras) in all neonatal units, with nationally managed funding and implementation by March 2027.
2 Insulin security	Restrict insulin access through digital controls and access logs; install CCTV covering insulin storage areas; mandate compliance with GIRFT insulin testing and reporting guidance.
3 Bereavement care	Implement the National Bereavement Care Pathway for neonatal deaths across all Trusts by August 2027.
4 Safeguarding	Provide safeguarding training to all staff and Board members and include safeguarding responsibilities and deliberate harm procedures within employment contracts.
5 Digital systems	Deliver interoperable NHS digital systems enabling single-entry, shared neonatal and maternity records with real-time monitoring.
6 Mortality oversight	Strengthen monitoring of neonatal and child deaths through Board-level oversight and escalation processes for concerning trends.
7 Neonatal reporting	Appoint a trained neonatal data reporting lead in every hospital and ensure regular Board reporting of alerts, investigations and actions.
8 SUDIC process	Clarify and strengthen the application of the SUDIC process for babies who die unexpectedly in hospital.
9 Deliberate harm protocol	Introduce a national Suspicion of Deliberate Harm Protocol with clear escalation, safeguarding involvement and police notification requirements.
10 Independent investigations	Establish a national panel of independent clinical and managerial experts to review emerging concerns about patient harm.
11 Medical examiner system	Standardise neonatal death reviews, improve safeguarding enquiries, increase neonatal specialist input and review funding arrangements.
12 Pathology workforce	Increase paediatric and perinatal pathology training places to meet workforce requirements by 2033.

Recommendation Area	Recommendation
13 NHS manager accountability	Introduce manager barring arrangements, strengthen controls on movement between Trusts, introduce an individual duty of candour and reinforce a patients-first management code.
14 CQC inspections	Increase unannounced inspections, include practising clinicians in inspection teams and strengthen focus on patient safety and effectiveness.
15 CQC oversight	Introduce regular independent scrutiny of CQC performance through the Health and Social Care Committee.
16 Whistleblowing	Transfer the National Guardian's Office functions to the Parliamentary and Health Service Ombudsman with enhanced investigative powers.
17 Recommendation tracking	Give the National Audit Office responsibility for auditing implementation of NHS statutory inquiry recommendations.

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Trust Board of Directors Meeting in Public 5 November 2026

Title	**Quarter 1 Report on Learning from Patient Safety**
Report Authors	**Laura Mathias, Assistant Director of Patient Safety** **Melanie Whitfield, Patient Safety Specialist** **Dawn Chase, Patient Safety Specialist**
Executive Owner	**Professor Helen Young, Chief Nursing Officer**
Agenda Item	**17**
Governance Pathway: Previous	Quality & Safety Committee Patient Safety & Experience Group
Governance Pathway Next Steps	NA

1.0 Introduction and purpose

This report provides a high-level overview of patient safety activity and learning during Q1 2026/27. It brings together insights from safety incident reporting, patient experience, staff feedback, legal cases, coronial matters, safeguarding, and Learning from Deaths. These sources have been triangulated to identify key risks and inform the actions taken to reduce patient harm. The report is presented to provide assurance on the organisation's patient safety performance and ongoing improvement work.

In summary
A total of 1,255 patient safety incidents were reported during the period, with most resulting in low or no harm. Fifty-two incidents (5.2%) were assessed as causing moderate harm or above. Although the overall number of incidents is consistent with Quarter 1 of 2025/26, there has been a notable increase in the level of harm reported. This rise is largely attributable to the recently declared major and critical incidents.

The main areas of risk are:

- Delays in ambulance response times (Recorded on Risk Register No 82).
- Clinical Risk Assessment and Escalation
- Communication and Multi-Agency Decision Making

Actions taken to mitigate the risks identified in sections below and include:

- Cluster PSII[1] declared which is being undertaken as phase 2 of the corporate response to the critical incident and major incident.

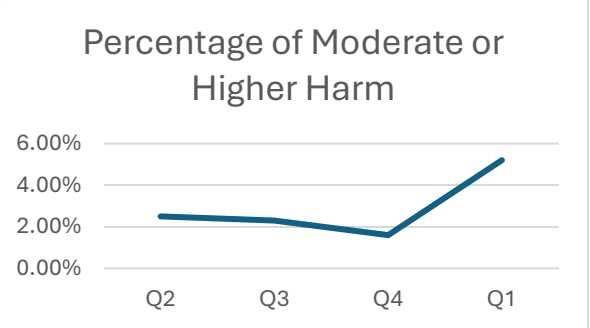
2.0 Q1 Patient Safety Performance

Incident Reporting

1,255 Patient Safety Incidents (PSIs) reported via Datix
↔ *Stable and consistent with Q1–Q4 2025-2026*

Harm Profile 5.2% moderate harm or above
Higher than previous quarters
Lower is better (monitored via SPC charts in Trust-wide IPR)





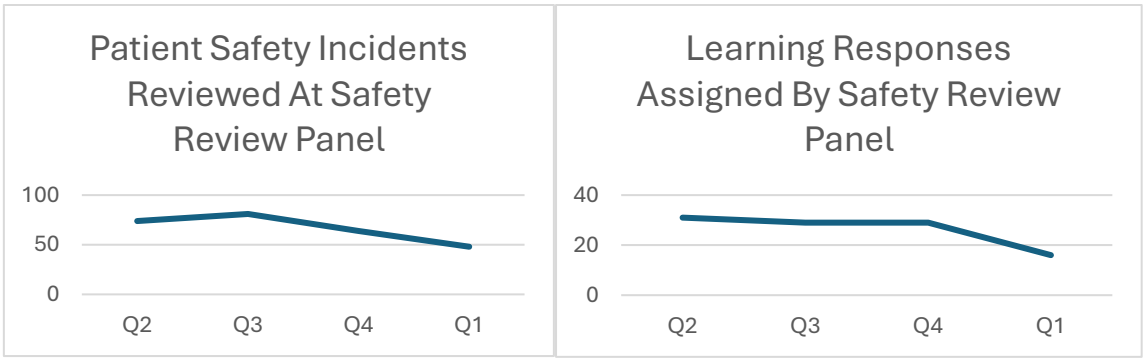
Learning Responses

48 PSIs escalated to **Safety Review Panel**
⬇️ *Down from 64 in Q4*

16 Learning Responses assigned

- **14** with patient harm identified
- **2** with **no harm**, but with opportunity for learning and improvement identified

[1] Under PSIRF, a cluster PSII examines a group of similar patient safety incidents together to identify recurring themes, system factors and opportunities for improvement, rather than investigating each incident in isolation.



Actions & Follow-up

0 Outstanding **patient safety actions**
↔ *Stable and consistent with Q4 2025-2026*

Key Takeaway
High reporting rates maintained, harm levels remain low, fewer cases require escalation, and learning continues to be embedded with minimal outstanding actions.

3.0 Main risks identified from the patient safety data sources:

3.1 Delays in ambulance response times (Recorded on Risk Register No 82).

The most prevalent and highest-impact risk this quarter (44 cases). Delays (particularly Category 3 and Category 2) contributed to:

- Deterioration prior to crew arrival.
- Patients found deceased following prolonged waits.
- Reduced opportunity to provide timely interventions.

These delays can be linked to:

- Sustained system pressure (Enhanced Patient Safety Procedure)
- Insufficient operational capacity
- High vehicle downtime (Vehicle Off Road)
- Extreme weather conditions experienced during Q1

3.2 Patient Safety Actions

- Critical Incident declared in June 2026 in response to delays. This was upgraded to a Major Incident response due to extreme weather conditions and worsening performance leading to patient harm.
- Live clinical dashboard created and shared with incident leads to enable real time monitoring of patient harm and to inform the incident command cell.

South Central Ambulance Service NHS Foundation Trust - Official

- Amended Duty of Candour process agreed with executives and lead commissioner owing to the volume of statutory duties required.
- Cluster PSII declared which is being undertaken as phase 2 of the corporate response to the critical incident and major incident.
- Directorate Business Continuity Plan tested and will be updated in September 2026.
- Directorate Major Incident Action Card developed and tested in September 2026.

3.3 Clinical Risk Assessment and Escalation

Learning has highlighted challenges in assessing complex presentations, recognising deterioration, determining capacity and making timely escalations across both ICC and operational services.

- Challenges undertaking clinical assessment and risk stratification where information is limited, patients are non-engaging, or presentations are evolving, across both ICC and operational settings.
- Opportunities to improve recognition of clinical risk and deterioration across repeat-contact presentations and younger patients.
- Opportunities to strengthen use of available escalation routes and senior clinical support when managing complex or high-risk presentations.
- Questions regarding the appropriateness of triage and disposition outcomes for some higher-risk patients.

3.4 Patient Safety Actions

- Reinforced use of senior clinical support services, including the Clinical Validation Line, to support decision making and reduce the risk of decisions being made in isolation.
- Providing targeted education across ICC and EUC services, including risk recognition, deterioration, cognitive bias, and escalation processes.
- Facilitating reflective learning, staff development and structured learning discussions following incidents and reviews.

3.5 Communication and Multi-Agency Decision Making

Learning has identified opportunities to improve information sharing and collaborative decision making within SCAS. Actions have focused on improving handover processes, strengthening interagency working and sharing learning through established governance and learning frameworks.

- Communication gaps identified both within SCAS between ICC and operational services.
- Critical information not always being effectively transferred between teams, services, and partner organisations.

3.6 Patient Safety Actions

- Strengthening handover and information-sharing processes between ICC teams and operational staff.
- Improving escalation, allocation, and stand-down processes to support safe decision making and effective communication.
- Sharing learning through the Patient Safety Hub, organisational learning processes, and wider governance structures.

4.0 Action Updates from Q4 Paper

- Revised meal break and end of shift policy pilot commenced in November 2025 for 6 months, to increase staff availability. Data from the pilot to be triangulated against patient safety data to ensure patient benefits are realised. Outcome and recommendations to be reported to EMC and Quality & Safety Committee in June 2026 by Divisional Director of Operations and Assistant Director of Patient Safety. **Operational performance benefits and patient related improvements proved difficult to evidence. A partner company has been instructed to conduct complex modelling work to fully understand the impact.**
- The patient safety team to use the Parapass platform to share learning and monitor numbers of staff completing Continual Professional Development elements related to learning responses. This is now business as usual.
- Maintain ongoing engagement with partners where cross[OBJ]organisational Learning responses are underway, ensuring agreed actions are progressed. Patient Safety Managers, Q1, 2026/27. **There is an agreed MOU in place across both BOB and HIOW ICS.'**

5.0 Patient Experience & Engagement

The Patient Experience Team is progressing a business case through internal governance channels to upgrade patient surveys, including the Friends and Family Test, to a digital platform.

The business case was conditionally approved at Business Sub-Committee in June 2026 and has been re-submitted for final approval in September 2026.

Once approved, the digitalisation of surveys is anticipated to increase survey returns alongside improving “real-time” feedback to the Trust and a year-on-year cost saving against current postal surveys.

The appointment of a new Patient and Public Engagement Facilitator in June 2026 presents an opportunity to further develop the Trust's approach to patient and public engagement. The role will support the enhancement of patient experience, increase the reach of engagement activity, and ensure a wider and more representative patient demographic is included in shaping service development.

6.0 Triangulating Themes from Patient Experience and Health Care Professional Contacts:

6.1 Healthcare professionals continue to report incidents where SCAS NHS111 and 999 has offered inappropriate care pathways.

6.2 Patient Safety Actions

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

6.3 Delays in attendance across Emergency & Urgent Care and Non-Emergency Patient Transport Services associated with the Critical & Major Incident.

6.4 Patient Safety Actions

See section 3.2.

7.0 Learning from Deaths

Themes identified in the Learning from Deaths Group align with issues covered in the Patient Safety Incident Response Plan 2 and include:

Stage 2 review identified cases where further investigation or action was required.

- 1 case – Delayed response.
- 1 case – Clinical care concern. Additional care could have been given before moving patient.
- 1 case – Oxygen not given by Primary Care Paramedic; unsure if oxygen is routinely taken to home visits.
- 2 cases of excellent care were identified.

7.2 Patient Safety Actions

- The delayed response case was reviewed under the Patient Safety Incident Review (PSIR) for delays; multiple routes were attempted to identify a next of kin to discharge a statutory Duty of Candour, but none could be found.
- The clinical concern case was identified as individual learning and was managed locally.
- The case involving external learning was referred to the primary care provider for consideration.
- The learning from deaths review provides assurance that care quality remains high, with no deaths attributed to care failings. Isolated clinical decision-making concerns have been identified and addressed through feedback and governance processes.

8.0 Claims & Concerns Raised by Coroner's this Quarter include:

8.1 Application of Right Care, Right Person

One area of focus from HM Coroner this quarter include the understanding of how to apply Right Care Right Person between SCAS and local police forces.

Assistant Director of ICC - Resource and Deployment is liaising with both police forces to agree a joint process.

8.2 Response delays

In section 8.2 of the previous report, the Board were advised that the Chief Executive Officer and Executive Director of Operations had agreed to the legal services team adding our commissioned response times to the evidence the Trust provides to HM Coroner for instances where we have not achieved ARP targets. This has resulted in a Prevention of Future Deaths (PFD) report being issued to the Secretary of State for Health raising concerns that ambulance services are not commissioned to provide a response in line with the ARP timeframes.

8.3 National Learning from Regulation 28

As part of national learning from PFD reports sent to other ambulance services, the Trust is reviewing how we respond to multi agency incidents including where they are related to possible drowning.

The Assistant Director of Operations, Resilience and Specialist Ops and the ICC Quality Team have been tasked to conduct this review and will be asked to provide the results of this by 31 September 2026.

9.0 Duty of Candour (DoC)

There have been no breaches of Duty of Candour this quarter, and compliance remains consistently strong.

Quarterly audits, reviewed by the Patient Safety & Experience Group, continue to demonstrate sustained compliance with the 10-day internal benchmark, with no deviations reported this quarter.

10. Risk Register

New risks added in Q1: None

Risks closed in Q1: None

11. Link to Strategic Theme

Clinical Effectiveness

12. Link to Board Assurance Framework Risk(s)

SR14 - Quality Performance

13. Quality/Equality Impact Assessment

Quality and Equality Impact Assessments have been considered and no QIAs are required for any patient safety activity contained in this report currently. However, any future changes to policy, service delivery, or staffing arising from this work will be reassessed.

14. Recommendations

The Board is asked to:

- Note the report

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

Appendix One – Current Patient Safety Incident Response Plan 2 PSIRP2) Local Priorities

Category	Patient Safety Incident	Required response	Learning from excellence
Patient care and treatment	Non conveyance to hospital in		Trust-wide patient safety improvement plan.

	cases of declared chest pain where acute coronary syndrome cannot be excluded.	Learning response and duty of candour requirement to be agreed at SRP	*Clinical Services Policy and Procedure (CSPP) 7: Care Policy Pathway and Procedures*
	Inappropriate discharge on first attendance	Learning response and duty of candour requirement to be agreed at SRP	Trust-wide patient safety improvement plan. *Clinical Services Policy and Procedure (CSPP) 7: Care Policy Pathway and Procedures*
	Failure to convey patients STEMI, Fast Positive, Major Trauma, Abdominal Aortic Aneurysm to appropriate facilities and within national target time frames:	Learning response and duty of candour requirement to be agreed at SRP	Trust-wide patient safety improvement plan.
Medicine management	Incorrect administration of life saving medication e.g. adrenaline for anaphylaxis, diazepam.	Learning response and duty of candour requirement to be agreed at SRP PSII where there has been a failure to administer a medication in line with BNF and JRCALC guidance.	Trust-wide patient safety improvement plan.
Mental Health Care	Failure to follow appropriate care pathway (MHA / MCA)	Learning response and duty of candour requirement to be agreed at SRP Learning response to be agreed at SRP	Trust-wide patient safety improvement plan.



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SCAS Learning Snapshot

Description:
Attendance to a patient presenting with neurological symptoms. No pre alert given to receiving ED who raised concerns.

What happened:
Attendance to a patient presenting with neurological symptoms. No pre alert given to receiving ED who raised concerns.
20yom who had been drinking previous night. Call to 999 service reaching a Cat 2 disposition possible stroke. No delay in time to scene. Patient was unable to effectively communicate, had vomited, left arm and leg weakness. Working impression alcohol poisoning/spiked
Conveyed under normal road speeds with no pre alert.
Patient had an AVM and intracerebral bleed.

- Producing white phlegm
- Scratches on upper back

Why did it happen?
Focused on history of drinking
Neurological symptom present but potential bias due to history
Young normally fit adult male
No pre alert-delay in treatment

What have we learnt?

- Clinicians need to maintain a broad differential diagnosis and avoid diagnostic anchoring.
- The recognition and escalation of neurological red flags, such as weakness, vomiting, severe headache, and reduced communication are time critical and require prompt recognition, documented assessment, and escalation.
- Explore professional curiosity supporting differential diagnoses.
- Awareness of pre-alert pathways

What did we do well?
Initial SWARM to explore learning opportunities and reflect upon incident.

Actions:

- Support the clinicians and crew members with reflective discussions to highlight the importance of maintaining a broad and open clinical approach, particularly when assessing patients with undifferentiated or overlapping symptoms.
- Complete an accredited mentoring course to strengthen skills in coaching, reflective practice, and support of students.

SCAS Learning Snapshot

Description:
Three attendances to a patient presenting with seizure symptoms.

What happened:
Attendance (1) to a patient presenting as Cat 2 possible seizure/blood loss/breathing difficulties. No response on attending and crew stood down.
Attendance (2) for pt who had had a seizure and there was blood on the floor. Cat 3 disposition. Crew (2) at scene. No answer from pt's door and as triage reached a Cat 3 just after crew arrival, stood down and reallocated to Cat 2.
Call reviewed by CSD-no response.
Attendance (3) on arrival P1 back up requested by CFR as pt unresponsive, possibly post ictal. Two further witnessed seizures. Conveyed under emergency conditions with a pre alert.

Why did it happen?
Initial call from SECAMB with minimal information and location/ITK failure. Pt was a 21yof in a university residence. Difficulty with access.
Patient deteriorated during the initial call, potential subconscious framing of a "student halls call" bias.
Breakdown in process and communication between crew who was at scene and EOC with regards to the stand down procedure.
Delay in initial attendance was influenced by rising demand on the service.

What have we learnt?
- Strengthen NHS Pathways early exit and deterioration training.
- Improve critical information transfer at triage and dispatch.
- Clarify non-contact and stand-down escalation procedures with collaborative working between Emergency Coordination Centre and Emergency and Urgent Care directorates.
- Address fatigue, bias awareness, and system strain.
- Embed environmental intelligence for complex residential settings.

Actions:
- Complete targeted training on recognising risk in complex 999 calls, including a module on cognitive bias and its impact on decision-making in emergency call handling
- Improve the accuracy and completeness of information sharing by using a structured handover approach to ensure key clinical details are consistently communicated between teams and systems.

  Use a structured decision-making approach utilising early escalation, team discussion, and risk assessment in unclear, non-contact scenarios. Introduction and clear escalation process with Tactical Performance Managers to balance risk before standing crews down.
- Improve the accuracy and completeness of CAD and electronic patient record documentation to ensure key clinical details are clearly recorded and shared with crews with ongoing development of staff
- Individual reflection and development of crews on scene with regards to assessing clinical risk/having professional curiosity prior to being stood down.

South Central Ambulance Service NHS Foundation Trust - Official

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Trust Board of Directors Meeting in Public 5 November 2026

Title	**Director of Infection Prevention and Control Annual Report 2025-2026**
Report Author	**Siobhan Fensom - IPC Lead**
Executive Owner	**Helen Young - Chief Nurse and Executive Director of Patient Care**
Agenda Item	**18**
Governance Pathway: Previous	Infection prevention and control group – August 2026 Quality and Safety Committee – September 2026
Governance Pathway Next Steps	NA

1. Purpose

The purpose of this report is to provide assurance to the board that effective infection prevention and control systems are in place, to review IPC performance during the reporting period, identify areas of risk and improvement, and outline priorities for the forthcoming year.

2. Executive Summary

During the reporting year, the Infection Prevention and Control (IPC) team continued to support the delivery of safe, high-quality care through surveillance, assurance, and education.

Key achievements:

- A revised and comprehensive Audit Schedule including a level 3 Subject Matter Expert (SME).
- Advancement of IPC A-Z Infectious Disease onto electronic platforms with a collaborative review.
- A new revised embedded Decontamination Policy with associated Standard Operating Procedures (SOP) and IPC Manual.
- Standards of cleanliness for Buildings and Vehicles improved and sustained.
- A CQC Inspection that noted the improvement within IPC.
- Commencement of a Quality Improvement Project to introduce non time critical stock into pouches.
- Comprehensive review and deep dive completed into all needlestick and sharps related incidents.

Ongoing collaboration with clinical and operational teams has helped foster a strong culture of infection prevention, ensuring patients, staff, and visitors remain protected. The team remains committed to continuous improvement and delivering effective IPC practices across all services.

3. Areas of Risk

NA

4. Link to Strategic Theme

Clinical Effectiveness

5. Link to Board Assurance Framework Risk(s)

SR14 - Quality Performance

6. Quality/Equality Impact Assessment

EIA not required.

7. Recommendations

- Receive a report/paper and take assurance from it

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

South Central Ambulance Service NHS Foundation Trust - Official

Director of Infection Prevention and Control
Annual Report 2025-2026

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

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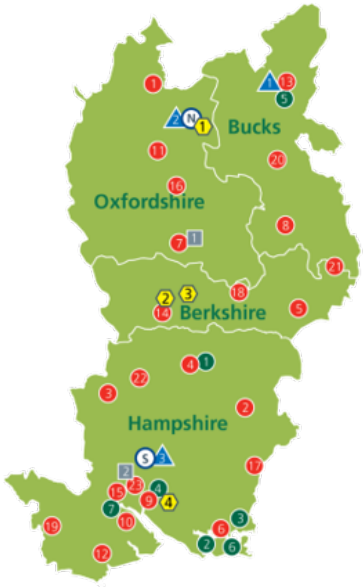
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1. Overview

South Central Ambulance Service NHS Foundation Trust (SCAS) is part of the National Health Service (NHS). SCAS is one of 10 ambulance services in England.

We provide 111 and 999 services for a population of 4.4 million across the counties of Berkshire, Buckinghamshire, Hampshire and Oxfordshire. We also run Patient Transport Services in Hampshire and Milton Keynes.

There is one Non-Emergency Patient Transport Service (NEPTS) Contact Centre and seven NEPTS bases, and there are 23 Ambulance Resource Centres. The Trust delivers care in the community which means the Trust supports patients at home and in their local area.



Headquarters
N. Northern House, Bicester
S. Southern House, Otterbourne

Patient Transport Service
1. Basingstoke
2. Gosport
3. Havant
4. Hightown
5. Milton Keynes Blue Light Hub
6. Portsmouth
7. Totton

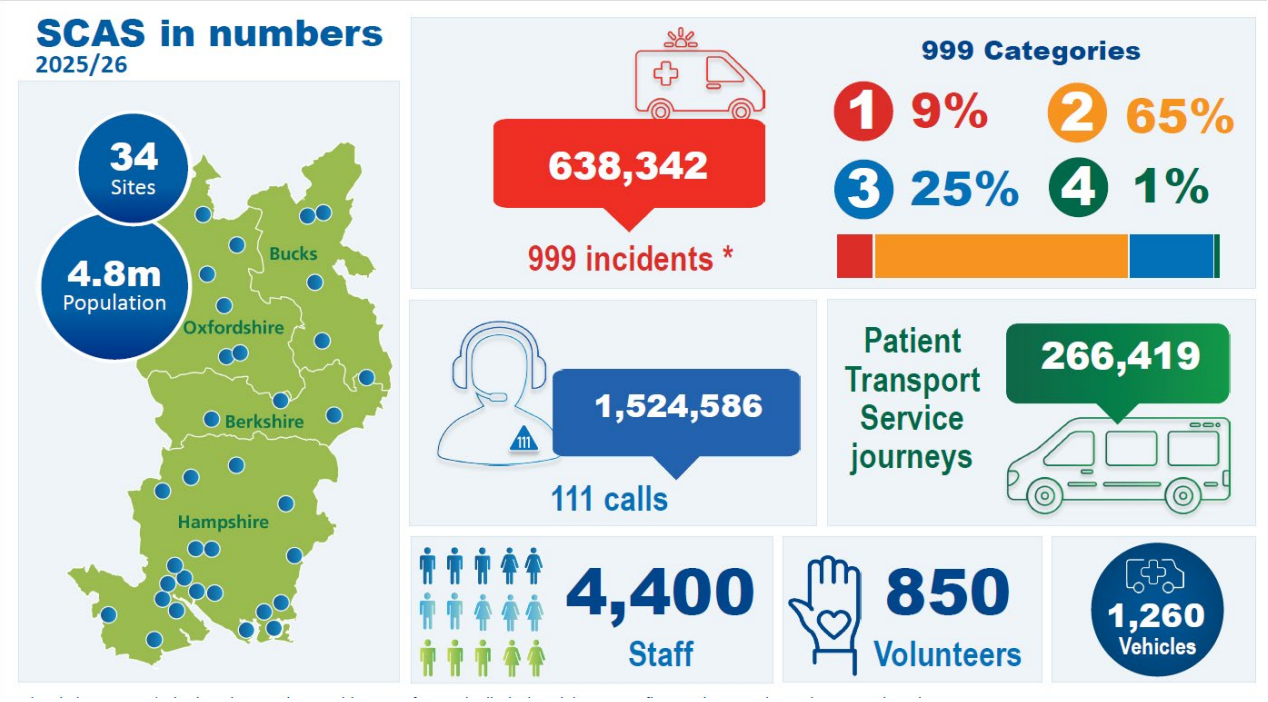
Contact Centres
1. Milton Keynes (111)
2. Northern House (111, 999)
3. Southern House (111, 999, PTS)

Education Centres
1. Bicester (Unit 2)
2. Newbury (Bone Lane)
3. Thatcham
4. Whiteley

Fleet Workshops
1. Milton Park
2. Nursling

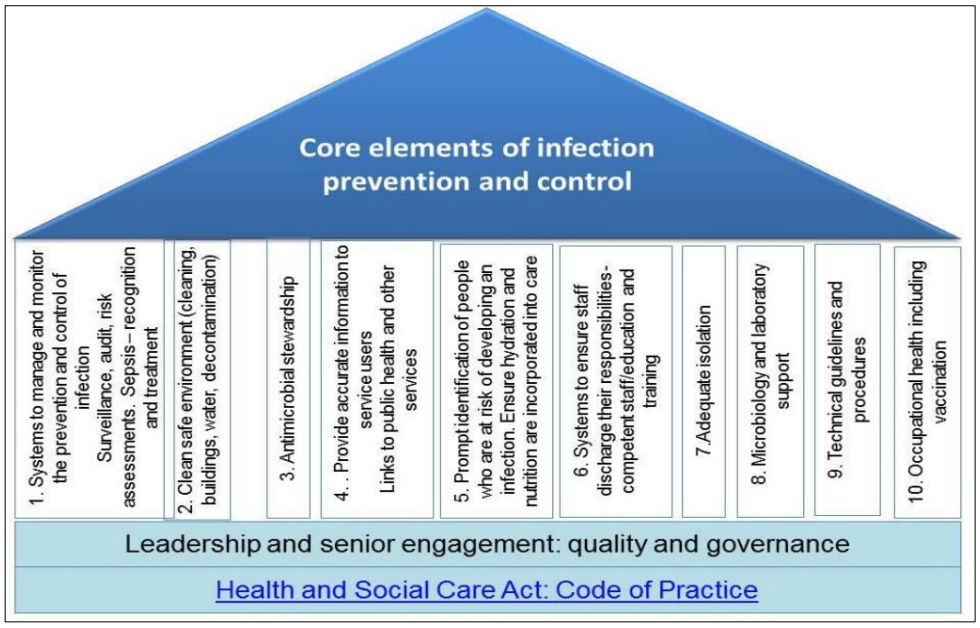
Resource Centres
1. Adderbury
2. Alton
3. Andover
4. Basingstoke
5. Bracknell
6. Cosham, Northarbour
7. Didcot
8. High Wycombe
9. Hightown
10. Hythe
11. Kidlington
12. Lymington
13. Milton Keynes Blue Light Hub
14. Newbury
15. Nursling
16. Oxford City
17. Petersfield
18. Reading
19. Ringwood
20. Stoke Mandeville
21. Wexham Park
22. Whitchurch
23. Winchester & Eastleigh

South Central Ambulance Service Summary in numbers:



Executive summary

The Trust is committed to the prevention and control of infection, minimising the risks and impact of healthcare associated infections for patients, staff and the organisation overall. The Health and Social Care Act 2008, Code of Practice on the Prevention and Control of Infections and related guidance updated 2022, states that *good infection prevention (including cleanliness) is essential to ensure that people who use health and social care services receive safe and effective care. Effective prevention and control of infection must be part of everyday practice and be applied consistently by everyone*. This approach is implemented across all SCAS services.



Within SCAS, the Trust Board is accountable for ensuring that there are effective Infection Prevention and Control (IPC) arrangements within the Trust. Please see Appendices 1 and 2 for IPC structures and team structure.

The Trust receives support from the occupational health service, Optima Health, who provide services to SCAS to aid managing all aspects of staff health and report and advise on occupation-related health compliance.

Compliance with the Health and Social Care Act requires NHS organisations to receive microbiology support for the IPC function. From 2025-2026 SCAS has had a Service Level Agreement (SLA) with our acute partner organisation Oxford University Hospital (OUH) to provide this service.

For 2025-2026 SCAS IPC is regulated by Hampshire and Isle of Wight Integrated Care Board, Legislation, the CQC, the Department of Health and NHS England (NHSE). Cleanliness standards are monitored against national cleaning standards and monitored through the Trust IPC Group and governance framework. Standards are related to policy, procedures, and outcomes, and include the provision of high-quality facilities and standards of practice. The Trust has taken measures to ensure that our policies and processes adhere to the requirements and performance outlined by the following:

- CQC, Fundamental Standards
- The National Infection Prevention and Control Manual for England
- National Cleaning Standards for Healthcare (2025)
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2015 (updated 2022)
- Health and Safety Executive advisory committee on dangerous pathogens
- NICE Guidelines

- EPIC 3 - National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England
- Standard infection control precautions: national hand hygiene and personal protective equipment policy (2019)

Compliance with relevant national and local standards, guidance and policies supports effective infection prevention and control practice Trust-wide. Success depends on personal accountability, skilled and competent staff, transparent and integrated working practices, and clear management processes. IPC practice is integrated into each new employee's induction and is continued throughout their SCAS career with additional e-learning.

Introduction

The annual report provides information and evidence of the Trust's ongoing commitment to IPC, embedding these key principles and practices throughout the organisation. The report identifies the significant improvement the Trust has made within infection prevention and control in all areas of the organisation. This report is the annual report from the Director of Infection Prevention and Control (DIPC).

It provides assurance of the progress made against the Health and Social Care Act 2008: *Code of Practice for the prevention and control of infection* (2022) and related guidance and the Care Quality Commission (CQC) standards over the last twelve months. The updated annual work programme for 2025-2026 provides an overview of the priorities for the upcoming year and is attached to this report (Appendix 4).

At the end of the year 2025-2026, SCAS declared compliance in IPC practices. Where IPC non-compliance is demonstrated action plans, recommendations and timeframes are given to service lines to address IPC issues.

The table below details the 10 Criterion required for compliance with the Health and Social care Act and the actions, policies, and education in place to ensure these criterions are met.

	Criterion	Achieved through:
1.	Systems to manage and monitor the prevention and control of infection.	Annual Plan, Annual Report, Risk Assessments, Audit Requirements, Training, Policy and Procedures
2.	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	Audit programme and completion of action plans generated if non-compliance is reported and actioned. Audit assurance programme requires development

3.	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	Use of area specific antimicrobial resistance (AMR) prescribing guidelines
4.	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion	Intranet, Policy and Procedures Hospital pre-alert
5.	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	Infection status recorded on booking of all NEPTS transfers, risk of infection identified through Emergency Operations Centre dispatch and information given to response crews.
6.	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	IPC Trust intranet page Communications plan through 'Hot News', Staff Matters and clinical memos per service requirements
7.	Provide or secure adequate isolation facilities	Process of NEPTS booking allows cohort and isolation of patients with infectious disease. E & UC single patient transfer only
8.	Secure adequate access to laboratory support as appropriate	Microbiology Support SLA provided by Oxford University Hospital (OUH)
9.	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections	SCAS IPC Policy Manual. Updated 2025, A-Z Disease specific Guidelines- Updated 2025.
10.	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection	Occupational Health services provided by Optima Health.

Assurance and Governance

Robust processes are in place within SCAS in relation to IPC including environmental and vehicle cleanliness. The following internal and external processes are in place:

- An online audit system (Audit Online) focusing on Observational Hand Hygiene, Vehicle and Building Cleanliness Audits. Compliance data from SCAS-specific systems is imported to Audit Online on a weekly basis to ensure staff, vehicle and building data is accurate. The Audit Schedule consists of three levels, level 1 being provider led, Level 2 being operational colleagues, and Level 3 being Subject Matter Expert (SME) and Compliance-led.
- Reporting of Audit results and Key Performance Indicator (KPI) performance through monthly contracts meetings, monthly Clinical Governance meetings and quarterly IPC Group.
- IPC Group meets on a quarterly basis and provides oversight for compliance and completeness of the IPC Annual Work Plan and the IPC Board Assurance Framework (BAF). The IPC Group upwardly reports to the Trust's Quality and Safety Committee.
- Upward escalation from IPC Group to Quality and Safety Committee through to Board.
- KPI monitoring, action planning, and improvement planning completed by IPC and wider Compliance and Governance Lead.
- Datix incident reporting system to capture patient safety events and non-patient incidents including needlestick injuries, exposure to body fluids and infectious diseases is utilised within SCAS. The Trust promotes an open reporting culture and encourages all staff to report all incidents and near misses.
- Quarterly reporting from Datix system to Health Safety and Risk group.

2. Annual Plan Review

A programme of work was outlined for 2025-2026 in the form of an annual plan. The annual plan has been reviewed and updates provided as Appendix 4.

3. Achievements

Significant achievements were made in the 2025-2026 financial year detailed below:

- A revised and comprehensive Audit Schedule including a level 3 Subject Matter Expert (SME).
- Advancement of IPC A-Z Infectious Disease onto electronic platforms with a collaborative review.
- A new revised embedded Decontamination Policy with associated Standard Operating Procedures (SOP) and IPC Manual.
- Standards of cleanliness for Buildings and Vehicles improved and sustained.
- A CQC Inspection that noted the improvement within IPC.
- Commencement of a Quality Improvement Project to introduce non time critical stock into pouches.
- Comprehensive review and deep dive completed into all needlestick and sharps related incidents.

4. Infection Prevention and Control Compliance Audits

Maintaining clean clinical and working environments alongside excellent hand hygiene practices are key to the safety of our patients and staff. IPC Level 2 compliance audits are carried out by Team Leaders and Clinical Team Educators at their local stations. This audit programme encompasses vehicle, building and observational hand hygiene audits to ensure IPC standards are being met both within our environments and through good hand hygiene practices.

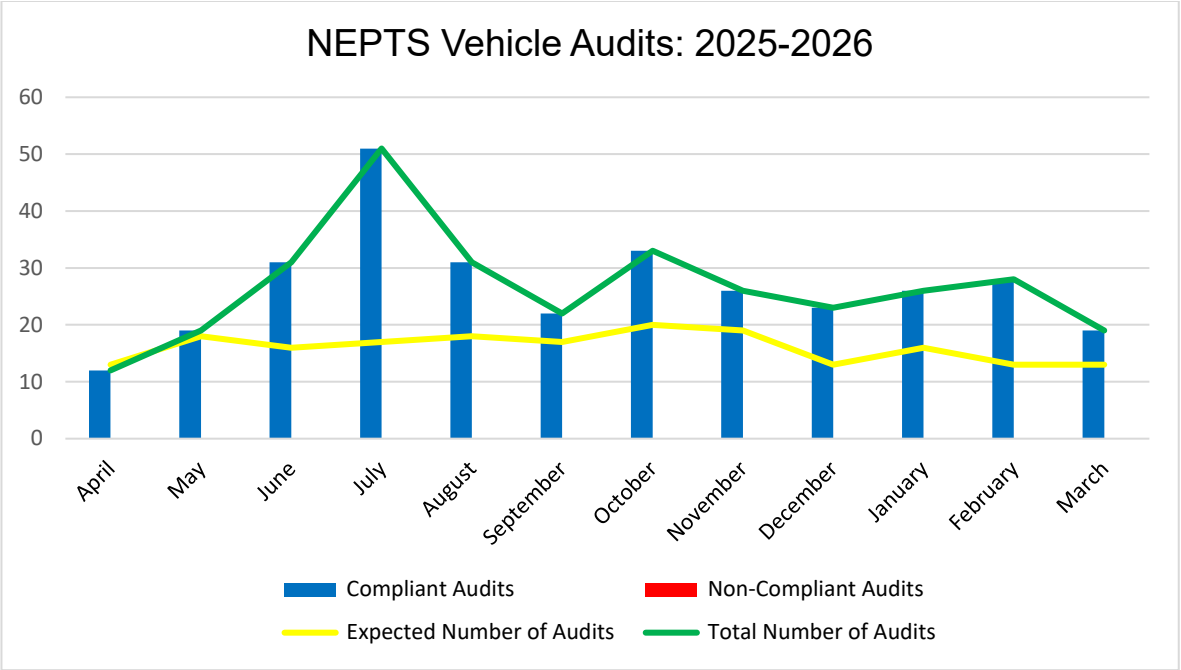
Level 2 Audit Schedules can be noted in Appendix 3.

4.1 Vehicles

Graph 1 below details the number of both compliant and non-compliant audits for the 2025-2026 period. The yellow line shows the number of required audits each month to ensure the number of vehicles audited reach the required number.

The IPC team have monitored the level of audits completed each month, and where the minimum level has not been achieved, communication with Team Leaders and Senior Operations Managers has occurred to ensure the audits are conducted. Monthly variations occur due to operational demand within the division and availability of vehicles for audit, this also as does not account for the vehicles off the road (VOR) and service activity.

Non-Emergency Patient Transport Services

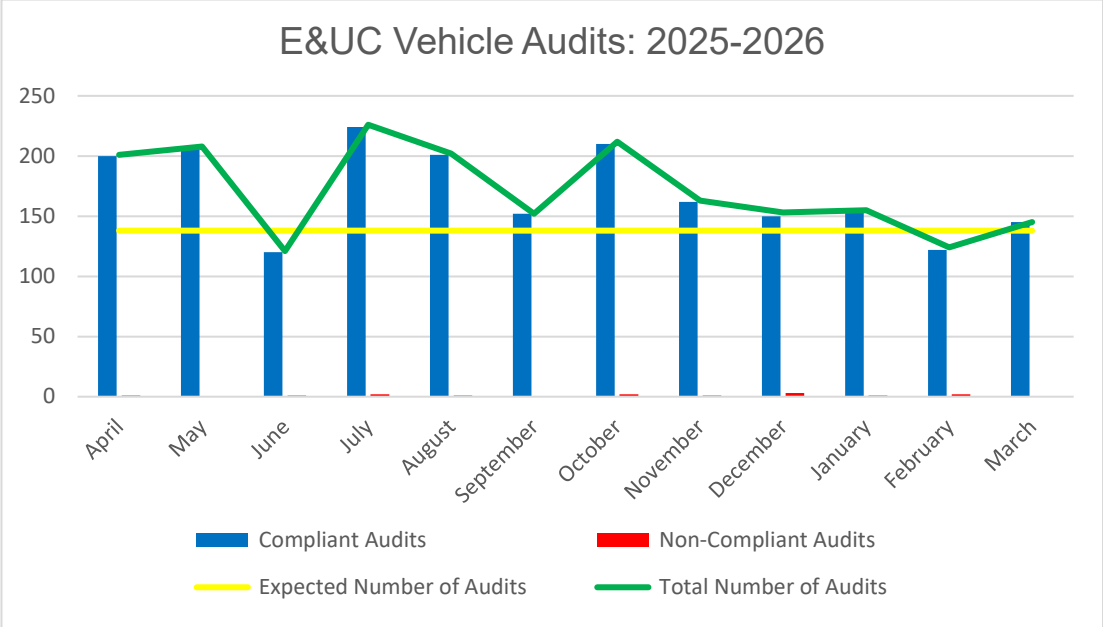


Graph 1

NEPTS vehicles remain as a functional risk category (FR5) within the National Cleanliness Standards and thus requires a compliance target of 80%.

In 2025-2026 a total of 193 audits were expected to be completed in the year, however 321 were completed. Of the 321 audits completed 100% achieved compliance of a target above 80% with 0% achieving non-compliance.

Emergency and Urgent Care Services (E & UC)



Graph 2

E & UC vehicles are in Functional Risk group (FR3) of the National Cleanliness standards – with a cleanliness compliance target of 90% and an increased audit frequency to bi-monthly as per national cleaning standards (2025).

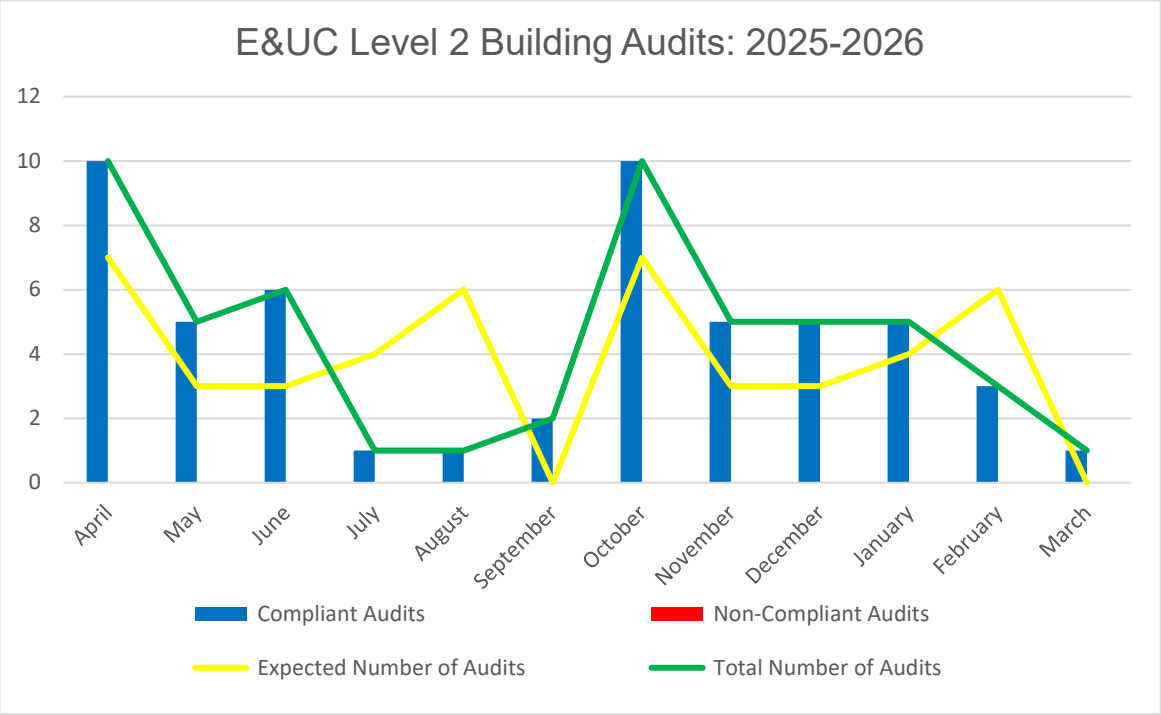
SCAS currently has an active Double Crewed Ambulance (DCA) fleet of 350. This figure can fluctuate during the year if a vehicle requires significant repair work and is Vehicle off Road (VOR). To remain compliant with DCA vehicles receiving a bi-annual audit in 2025-2026 a total of 1656 audits were expected to be completed. The Trust achieved 2062 audits, therefore 125% completed.

Of the audits completed, 99.3% achieved compliance with 0.7% non-compliant. It is noted the 99.3% that achieved compliance are above the target of 90% set against the National Cleanliness Standards. Any areas of non-compliance are rectified immediately prior to the vehicle returning to operational use. This is monitored using action plans and through communication with the Operational Support Desk (OSD).

4.2 Buildings

All buildings require bi-annual audits and should reach a compliance score of 80% (Functional Risk Group 5, FR5) in line with National Cleaning Standards. The lower

required compliance rate is reflective of these buildings not being clinical environments that provide patient care. No buildings within SCAS treat patients within them. However, the focus of attention is the areas that are utilised to supply and clean all vehicles as this is deemed the clinical environment. SCAS aims to achieve higher compliance rates across its sites to maintain a clean and functioning environment given this clinical element. Graphs 3 and 4 below detail the number of audits completed per service against target and the overall compliance against audit.

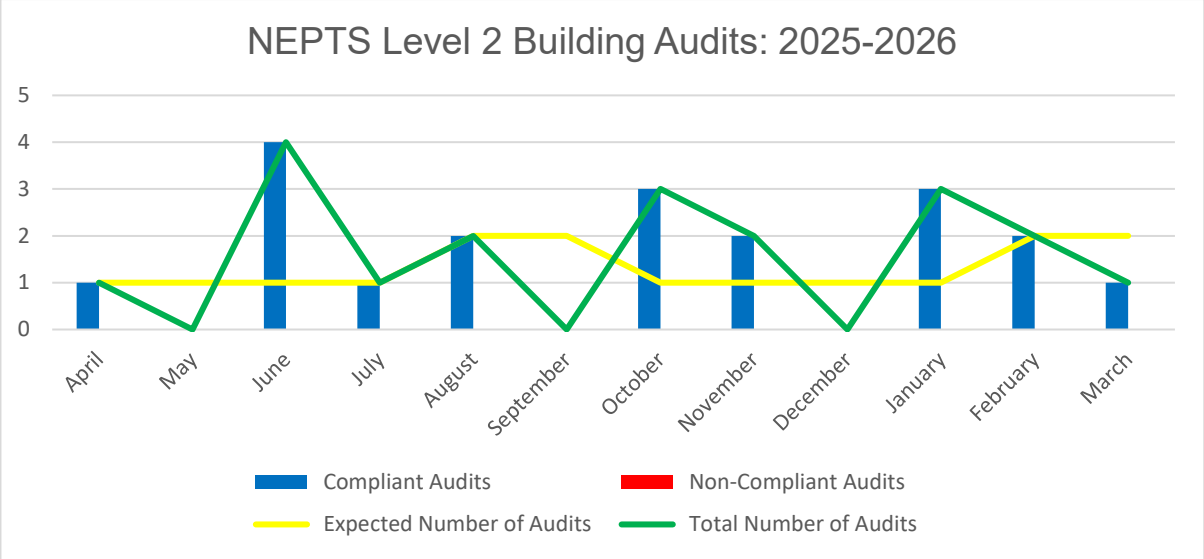


Graph 3

Within E & UC it can be seen the buildings have achieved the required number of audits. The expected total of audits should be 48 and 54 have been completed. It can be noted of the total audits completed they achieved a compliance rate of 100% of audits being over the required standard of 80%.

Where non-compliance with an audit was found the issue was rectified immediately where possible, for example immediate decontamination required, and actions documented through contracts meetings and Clinical Governance meetings.

Audits continue to be monitored and highlight when there are improvements to be made to allow compliance with IPC standards such as the identified improvement in Make Ready spaces.



Graph 4

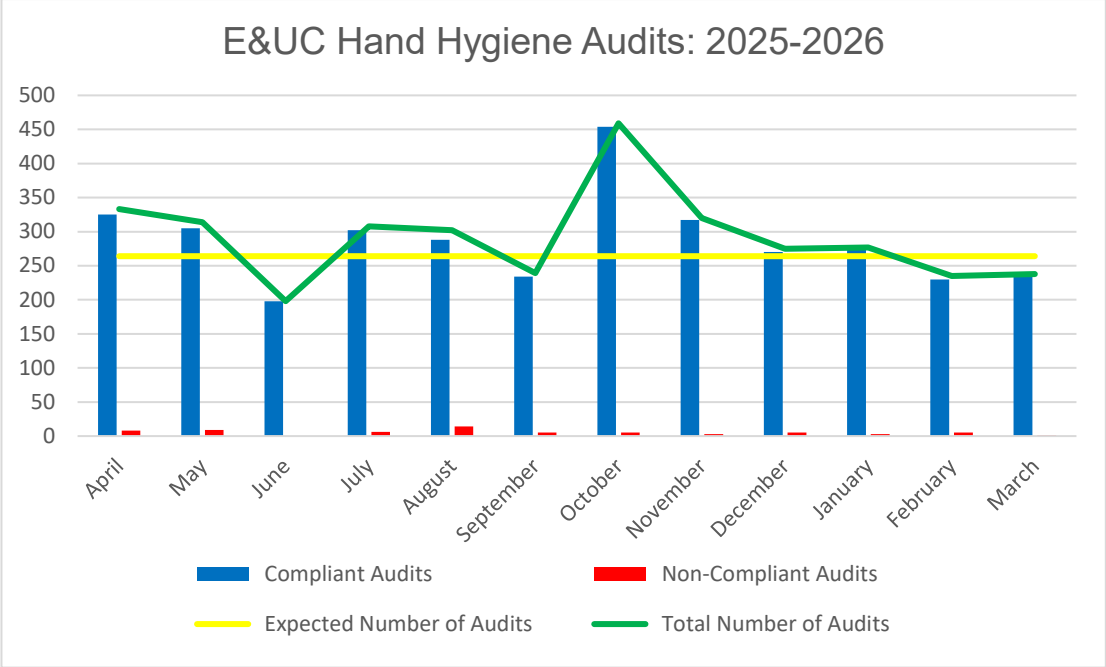
Within SCAS there are combined sites for NEPTS and E & UC with NEPTS also having their own satellite stations.

Within NEPTS a total of 14 audits were expected to be completed. A 136% completion rate was achieved with 19 audits completed. Of the 136% of audits completed 100% were compliant, achieving over the required standard of 80%. As with E & UC, audits continue to be monitored, and improvement plans developed to improve IPC standards.

4.3 Hand Hygiene Audits

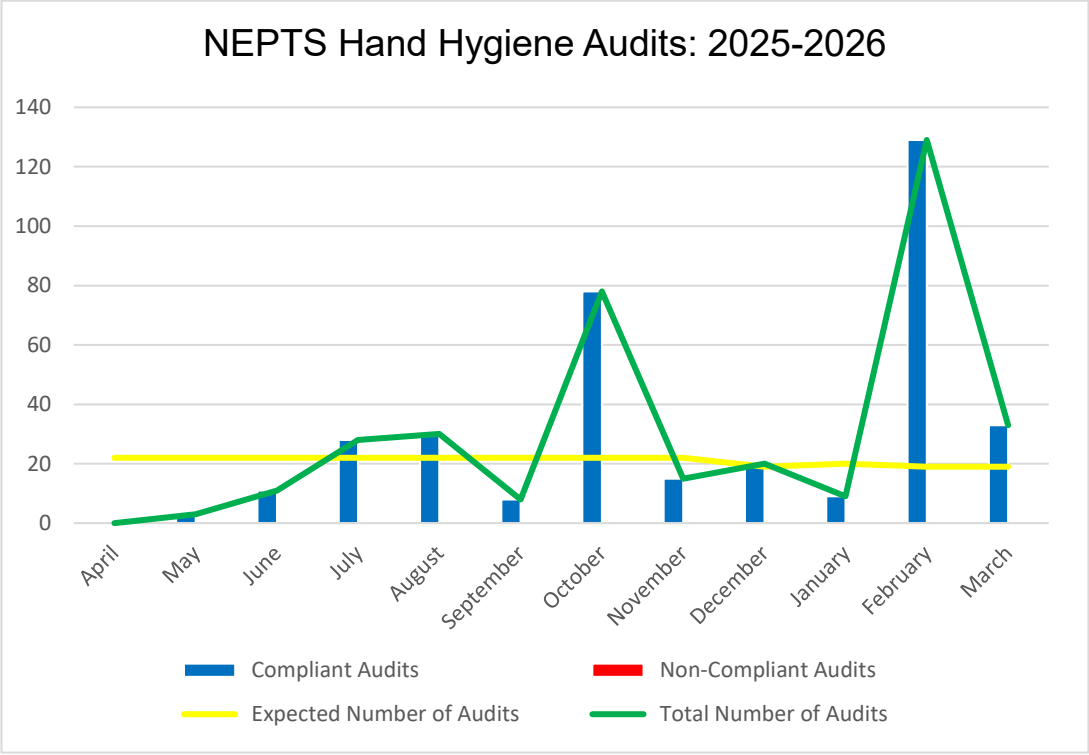
SCAS employs more than 4,380 clinical and non-clinical staff and all are responsible for complying with good IPC practices. It remains imperative that all staff adopt and adhere to IPC practices to protect themselves, their patients, and their colleagues. To ensure compliance with good hand hygiene practice staff who are in patient-facing roles and encounter patients, or work within the environment where patients are seen are audited on an annual basis via a discussion audit and anonymous observational audits are completed out in the field by the Clinical Team Educators and Team Leaders to significantly increase the number of audits completed to provide assurance in compliance with meticulous hand hygiene.

Below Graph 5 details E & UC activity and compliance. This shows that of the expected number of audits (3168), 110% were completed (3498 audits). Of these 98% were compliant.



Graph 5

Below is the activity for NEPTS hand hygiene audits. Of the expected 253 audits required, 143% were completed, a total of 362 audits. Of the audits completed 100% achieved compliance. NEPTS will continue with the audit schedule; the IPC team will share compliance at Clinical Governance meetings and actions agreed.



Graph 6

Audit Data Summary Table:

	Q1-Q4 22-23	Q1-Q4 23-24	Q1-Q4 24-25	Q1-Q4 25-26
Number of Vehicle Audits Required	828	1593	2351	1849
Number of Audits Achieved	614	734	1835	2383
% of Audits completed	74%	46%	78%	128%
Required % score for compliance	90	90	90	90
Achieved compliance score	95%	94%	91%	99%
Number of Building Audits Required	255	131	82	62
Number of Audits Achieved	201	227	127	73
% of Audits completed	79%	173%	155%	118%
Required % score for compliance	80	80	80	80
Achieved compliance score	77%	90%	94%	100%
Number of Hand Hygiene Audits Required	2146	6150	3954	3421
Number of Audits completed	2116	1371	2405	3862
% of Audits completed		22%	61%	113%
Achieved compliance Score	100%	99.6%	91%	98%

4.4 IPC Assurance Audits - Level 3 Audit Assurance Programme

The assurance programme is embedded in the SCAS footprint, encompassing NEPTS and E & UC services. The timescales and audit schedule are set out in Appendix 3. The audits are completed by the IPC team, with reports sent to operational management, and action plans created to ensure compliance remains and quality improves.

Level 3 audits completed in 2025-2026 with compliance rates listed in brackets	Total audits completed	Compliant audits	Non-compliant audits
Buildings (>80%)	34	33	1
Vehicles – E & UC (>90%)	148	51	97
Vehicles – NEPTS (>80%)	2	1	1
Hand Hygiene Observations – E & UC (100%)	215	183	32
Hand Hygiene Observations – NEPTS (100%)	5	3	2

The table above includes only Level 3 audits completed by IPC and provides a greater level of assurance as completed by subject matter experts.

Work is being undertaken to ensure that the IPC team captures a greater number of NEPTS vehicles and hand hygiene observations.

5. Focused Workstreams

5.1 CQC Inspection

The CQC conducted an inspection of SCAS on 6-8th May 2025, with the report published 11th December 2025. The report notes that the Trust has improved IPC practices, but the following improvements could be made:

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

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

CQC improvements: Compliance with dating and labelling sharps bins. Audits lacked some consistency in their completion to ensure consistency moving forward. IPC level 2 training below required threshold at the time of inspection at 88%, to increase level 2 training to 95% or above.

A Well-Led inspection took place 27-29th January 2026 with the report still outstanding at the time of writing the report.

Following the report the IPC team continued to work on the below to ensure the IPC practice continues to be embedded:

- Transition audit programme to internal system, Qlik, to provide accurate data displayed on an accessible dashboard
- Continue to build action trackers to ensure all actions are tracked and monitored to ensure change is completed.
- Ensure waste is correctly labelled and segregated.

- Link Practitioner Programme to be further developed to ensure sustained and embedded.

5.2 IPC Policy and Procedures

The IPC Policy was fully reviewed, enhanced and became a Policy Manual to ensure parity with the National IPC Manual for England and combines all IPC SOPs making a comprehensive document that details IPC practices for all staff.

A comprehensive decontamination policy was developed, documenting all decontamination processes within the Trust and separately written SOPs for levels of cleaning of the Trust patient-facing vehicles.

A further amendment and collaborative review took place of the A-Z of Disease Specific Precautions in line with national guidance, and the new decontamination policy. The document has been digitalised on the Trust's internal communication platform, for ease of contact centre personnel and developed on the JRCALC app for timely access by frontline clinicians.

5.3 Hand Hygiene

The audit schedule has been reviewed, amended, and embedded. The completed audits provide assurance of improved compliance, and the area noted where there can be a reduction in compliance is where wrist watches are worn. The IPC team continue to work on adjusting the culture.

The SCAS IPC team took part in World Hand Hygiene Day on Friday 5th May 2025. A comprehensive campaign ran with resources published through internal communication channels.

During International Infection Prevention and Control Week October 15th - 21st 2025, the IPC team attended various sites throughout the SCAS footprint and met with a multitude of staff to refresh individual IPC fundamentals and ran a series of stories with interactions via the Trust's internal communication channels.

5.4 Vehicle Decontamination Specifications/ Churchill Partnership Working

Ongoing maintenance of a clean clinical environment remains key to keeping our patients and staff safe. Close partnership working has continued with Churchill, our vehicle Make Ready (MR) providers, to ensure vehicles are decontaminated effectively and to the correct standards as guided by the National Cleaning Standards 2025.

SCAS has provided guidance on required decontamination products and the correct levels of personal protective equipment (PPE) required by staff to complete decontaminations

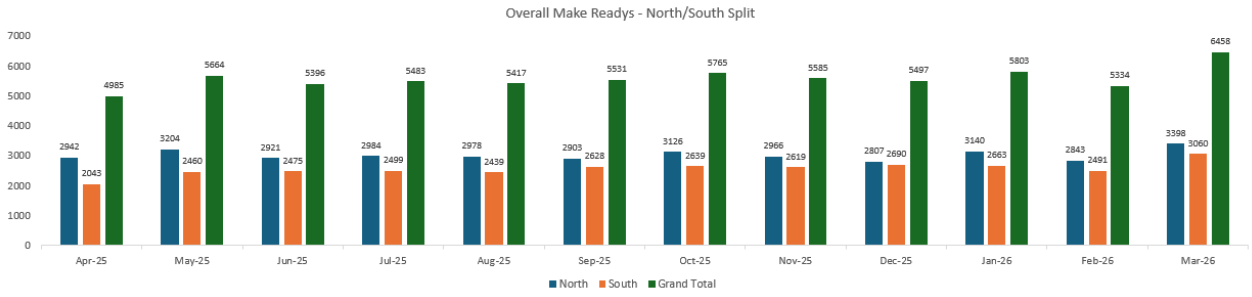
through sharing of standard operating procedures and the A-Z of Disease Specific Precautions.

Periodic cleans and 24 hour Make Ready services have been maintained at a high level throughout the last 12 months, with a robust system in place for booking vehicles for enhanced cleans due to an infectious disease when required.

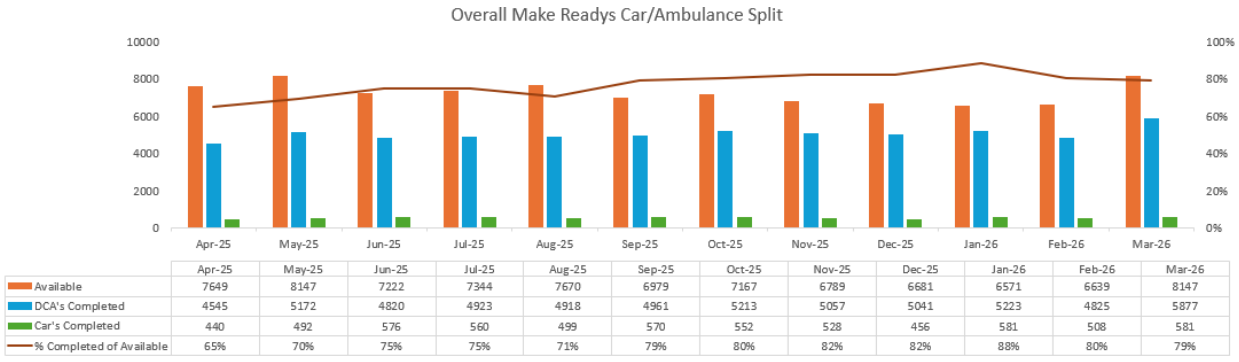
The requirements of specific decontamination post infectious disease are set out in the SCAS robust decontamination policy alongside the SCAS A-Z disease specific precautions, which our partners, Churchill, utilise to guide appropriate decontamination techniques.

Where vehicles have not been booked off-road for the periodic clean two weeks prior to their required date, and have missed their clean, due to operational demand, a recovery plan commences. This process ensures that vehicles do not exceed their allotted 6 weekly or 12 weekly periodic clean.

Graph 7 tables the number of completed Make Ready's (MR) for the Trust with a North and South split. Graph 8 details total number of MR with a breakdown of Dual Crewed Ambulances (DCA) and Rapid Response Vehicles (RRV).



Graph 7

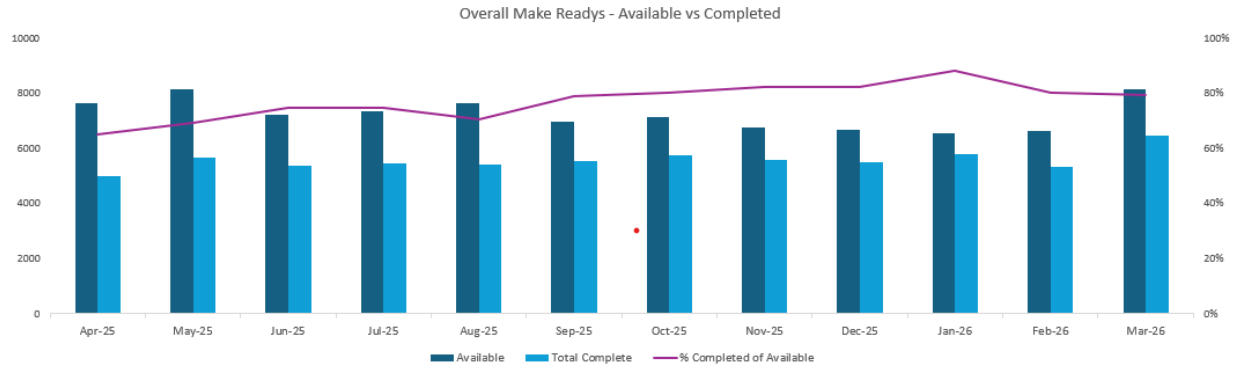


	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Available	7649	8147	7222	7344	7670	6979	7167	6789	6681	6571	6639	8147
DCA's Completed	4545	5172	4820	4923	4918	4961	5213	5057	5041	5223	4825	5877
Car's Completed	440	492	576	560	499	570	552	528	456	581	508	581
% Completed of Available	65%	70%	75%	75%	71%	79%	80%	82%	82%	88%	80%	79%

Graph 8

Graph 9 details the total number of MR completed versus those that were available. Strong progress continues across Make Ready, with SCAS recording its highest-ever number of daily Make Ready events. This uplift is being supported by record frontline DCA availability,

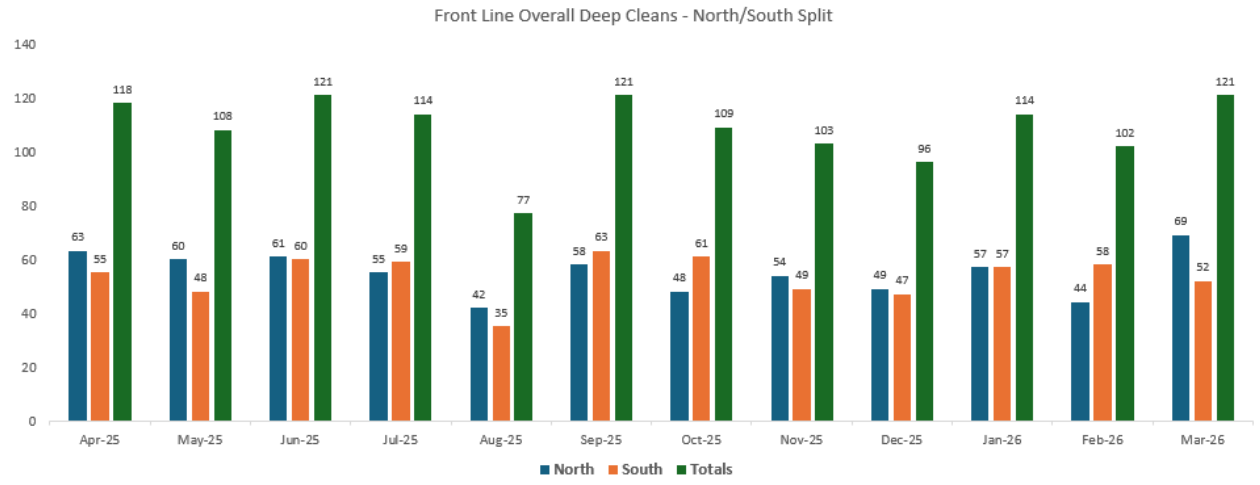
with the current variance largely driven by operational teams having more DCAs on station than originally planned. Future workstreams will focus on identifying opportunities to better align resource levels and further close this gap.



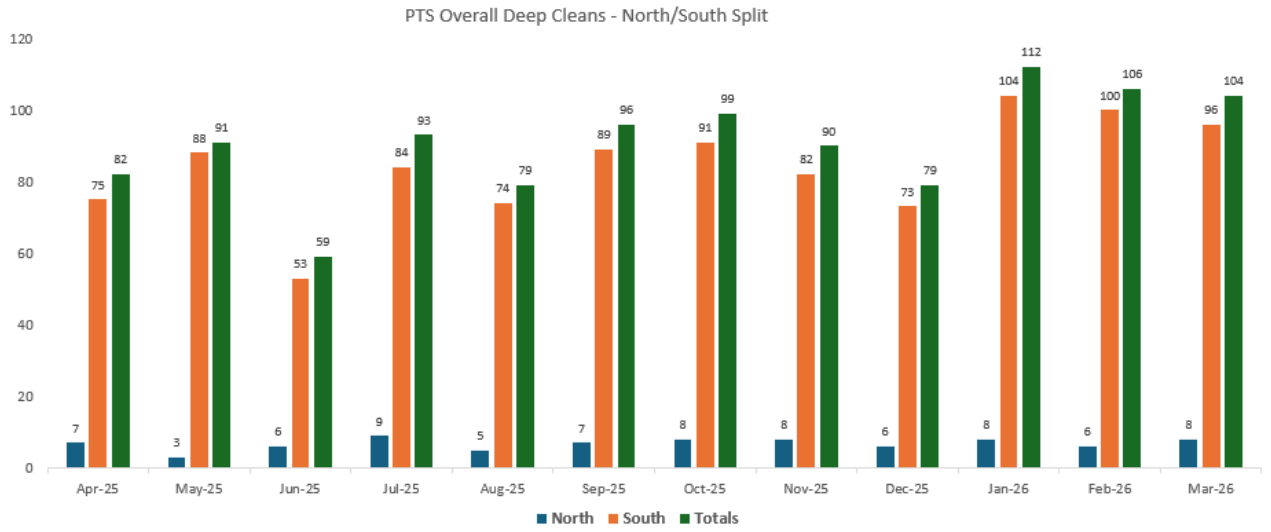
Graph 9

As noted above routine periodic cleans take place every 12 weeks for E & UC in addition to a 24 hour Make Ready and crews complete in-between patient cleans. NEPTS have a periodic clean every 6 weeks only.

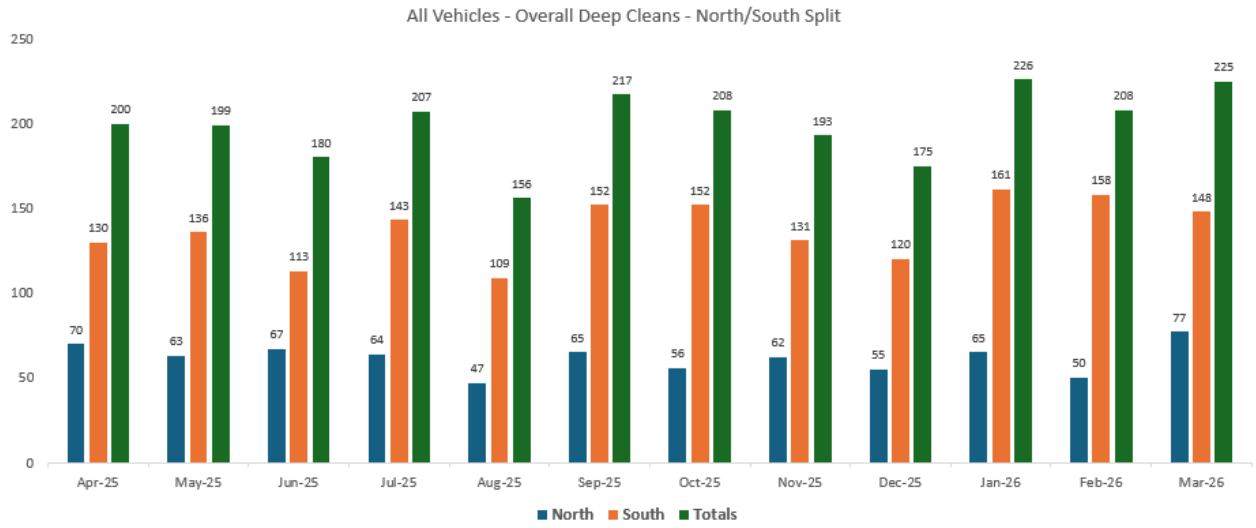
Below in Graphs 10 and 11, the totals for E & UC with a North South split, then for NEPTS with a North and South split are displayed and then graph 12 documenting the overall number of periodic cleans with a North South split. Noting fewer number of deep cleans within in the North as there are less sites that have periodic clean hubs.



Graph 10



Graph 11



Graph 12

5.5 Estates Cleaning Contract Bidvest Noonan

Contractors Bidvest Noonan conduct self-assessed audits, visiting every site monthly, audits are then forwarded, and are reviewed by the Estate Manager for compliance.

These audit results are included in the Bidvest monthly reporting and presented at a monthly meeting at which IPC is in attendance.

Work has begun to take place with Bidvest for the Trust to access the TASK platform to visualise audit scores, actions taken to rectify and any themes and trends to improve quality of cleaning services across site.
IPC and Estates are to implement star rating scores and complete efficacy audits in accordance with the Standards of Healthcare Cleanliness 2025 in the coming year.

5.6 Estates, Water Safety, Refurbishment and New Build Works

The IPC Lead continues to work closely with our Estates and Facilities Team during 2025-2026 where Stage 2 of the upgrade sluice programme progressed significantly.

Water Safety Assurance remains the responsibility of the Head of Estates and Compliance. This covers water risk assessments, with completion of remedial works actioned in priority order (Priority Classification can be available upon request).

Monthly water temperature testing takes place with summary reports sent to Compliance and Performance Estates Manager. If the same concern is recorded more than twice a Legionella test is triggered. Annual Legionella sampling was completed in July 2025.

Throughout the 2025-2026 period, the Estates team has undertaken a significant programme of works across the SCAS estate which has delivered direct and measurable improvements to infection prevention and control standards. These projects have focused on enhancing the cleanliness, resilience, and functionality of operational environments to better support frontline services and ensure compliance with healthcare estate standards. Improvements have included upgrades to clinical waste handling facilities, refurbishment of high-use operational areas, and replacement of ageing building infrastructure that posed risks to effective environmental control measures.

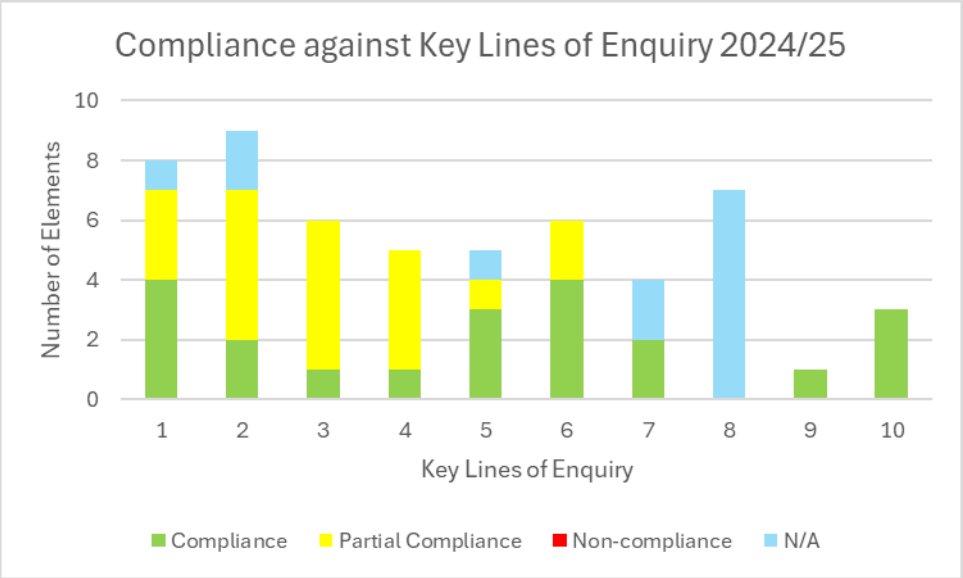
Key projects completed during the year include sluice installation and upgrade works at Whitchurch Resource Centre (RC), Ringwood RC, and Kidlington RC, providing improved facilities for the safe management and disposal of clinical waste and contaminated materials. Major roof replacement schemes were also delivered at Newbury, Gosport, and Stoke Mandeville, addressing longstanding water ingress risks and improving the integrity of the buildings to support hygienic conditions. In addition, the internal refurbishment at Didcot has modernised staff and operational spaces with improved finishes and layouts that support effective cleaning regimes. Several wash bay refurbishment projects have also been completed across the estate, enhancing vehicle cleaning capability and supporting robust decontamination processes for frontline ambulance operations.

The IPC team remain actively involved with future site development plans and their progress in collaboration with Estates and Facilities Team.

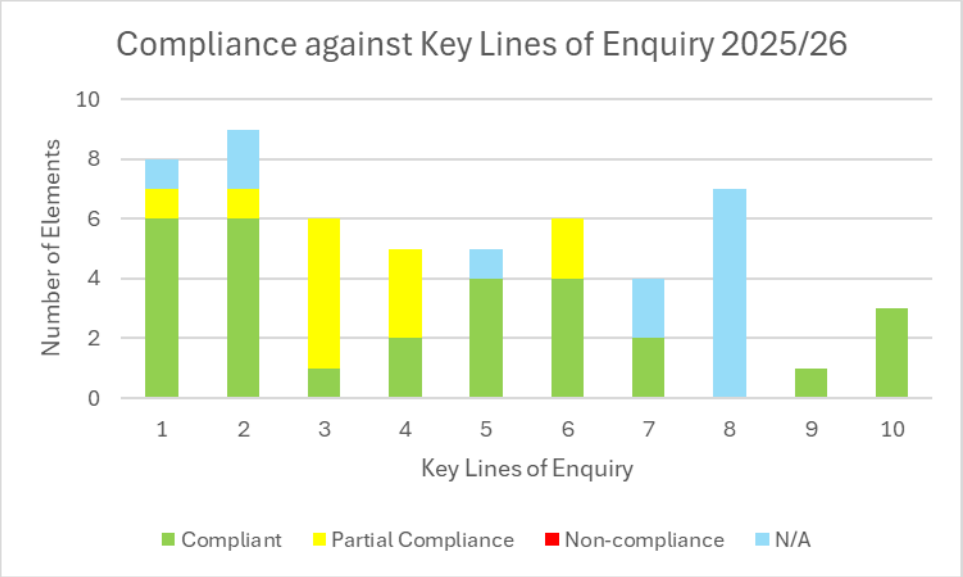
6. Board Assurance Framework.

Infection Prevention and Control board assurance framework – Key Lines of Enquiry

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users.
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4. Provide suitable accurate information on infections to patients/service users, visitors/carers and any person concerned with providing further support, care or treatment in a timely fashion.
5. Ensure early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.
6. Systems are in place to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7. Provide or secure adequate isolation precautions and facilities.
8. Provide secure and adequate access to laboratory/diagnostic support as appropriate.
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection.



Graph 13



Graph 14

In graph 13 it can be noted the areas on noncompliance for the end of the year 2024/25. Key improvements have been made, with increasing compliance over the year in Key Lines of Enquiry as noted in graph 14 for: Systems are in place to manage and monitor the prevention and control of infection, providing and maintaining a clean and appropriate environment in managed premises that facilitates the prevention and control of infections, and ensuring early identification of individuals who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others.

Outstanding areas of partial compliance are detailed in the annual workplan for 2026-2027.

7. Education

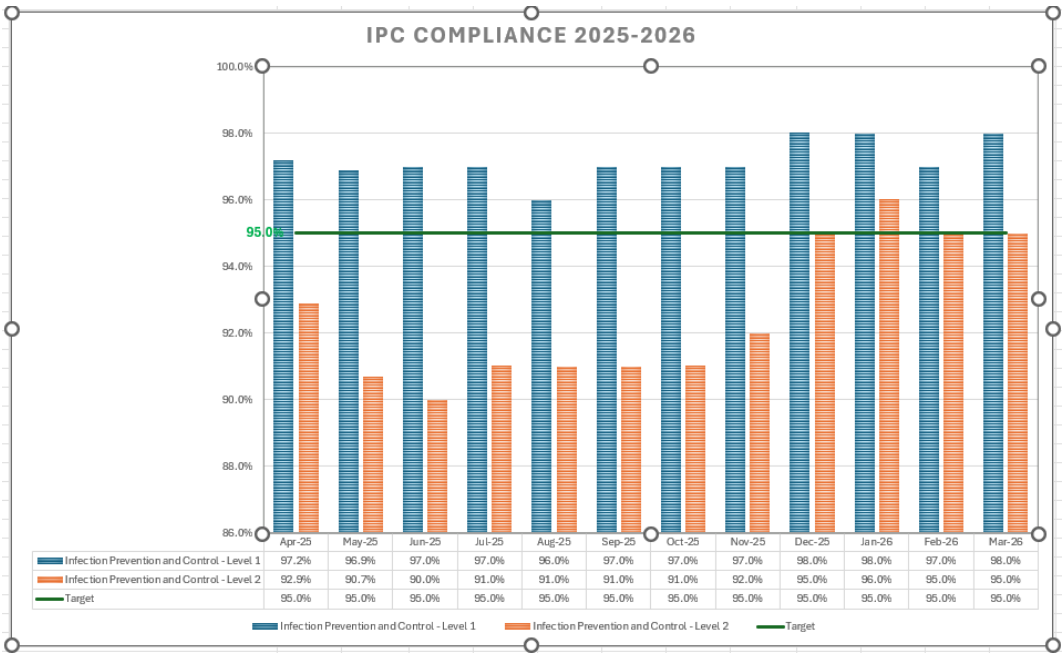
IPC training is included in the SCAS corporate induction provided to all new starters. Training covers IPC Level 1 and Level 2 training. The training packages have been tailored to the various job roles within SCAS and are delivered by the Education department. The content/material is reviewed to ensure compliance with Skills for Health Framework, linked to Health Education England, the National Cleaning Standards and complies with the requirements of the CQC Fundamental Standards and the Health and Social Care Act.

Employees remain up to date with IPC learning through mandatory e-learning modules.

Below Graph 15 shows Trust-wide compliance month on month for Level 1 and Level 2 training. Level 1 training has remained compliant with the 95% target.

Level 2 training remains separated from the overall figure to allow monitoring for compliance for clinical staff who require enhanced further IPC training in clinical roles.

Level 2 training has risen to the target compliance of 95% where robust measures were in place to address the shortfall earlier in the year. This included working with the Education team with action plans documented and monitored.



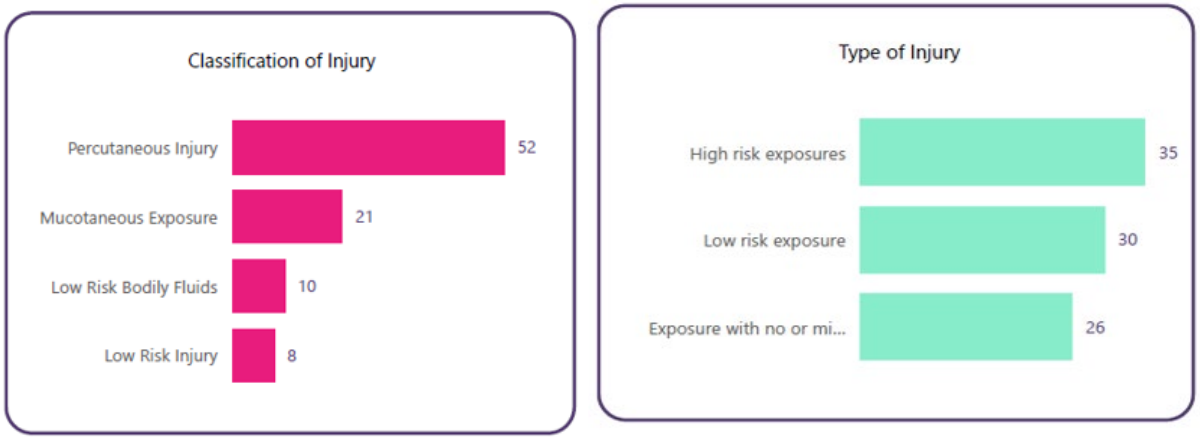
Graph 15

8. Staff Health

Optima Health was the awarded provider of SCAS Occupational Health Services. Broadly they cover the following:

- Telephone Support Services
- Online Portal
- Referrals from the Trust
- Attendance Management Advice and Assessments
- Attendance Management Reports
- Case Conferences
- Ill Health Retirement
- Pre-Appointment and Pre-Employment Checks
- Surveillance Services
- Fitness for Task and Safety Critical Work Services: Hearing Tests and Baseline Hearing Tests
- Immunisations, Vaccinations, Inoculations, Medications and Blood Tests.
- Health Screening Services
- Publicity and Promotion

In the past 12 months there have been 102 Blood Borne Virus Risk Assessments carried out. Of the 102 assessments the table below notes the classification of Injury:

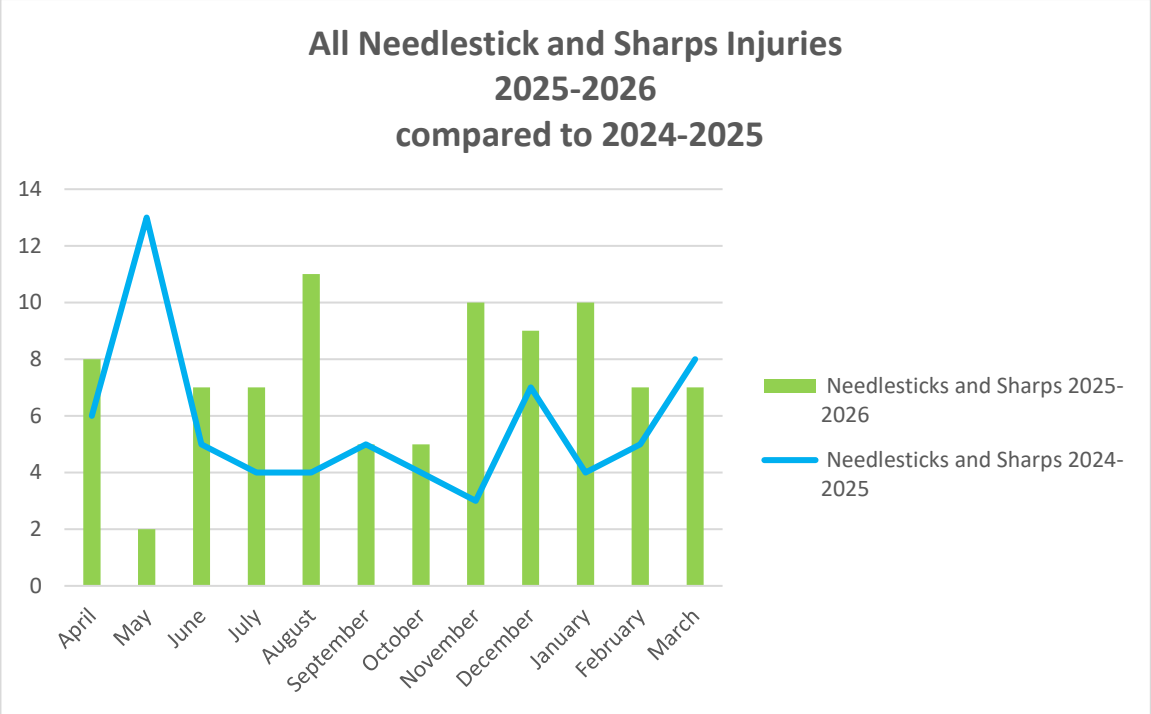


Graph 16

8.1 Needlestick and Sharps

The UK continues to follow European Union (EU) regulations (2010/32/EU) that all needlestick injuries are reported and investigated. Within SCAS, needlestick injuries are investigated by the local Team Leader, Optima Health, the Clinical Governance Team, and Infection Prevention and Control. All needlestick injuries are upwardly reported through the Health and Safety Risk Group.

Graph 17 details the number of needlestick and sharps injuries for the reporting period of 2025-2026.

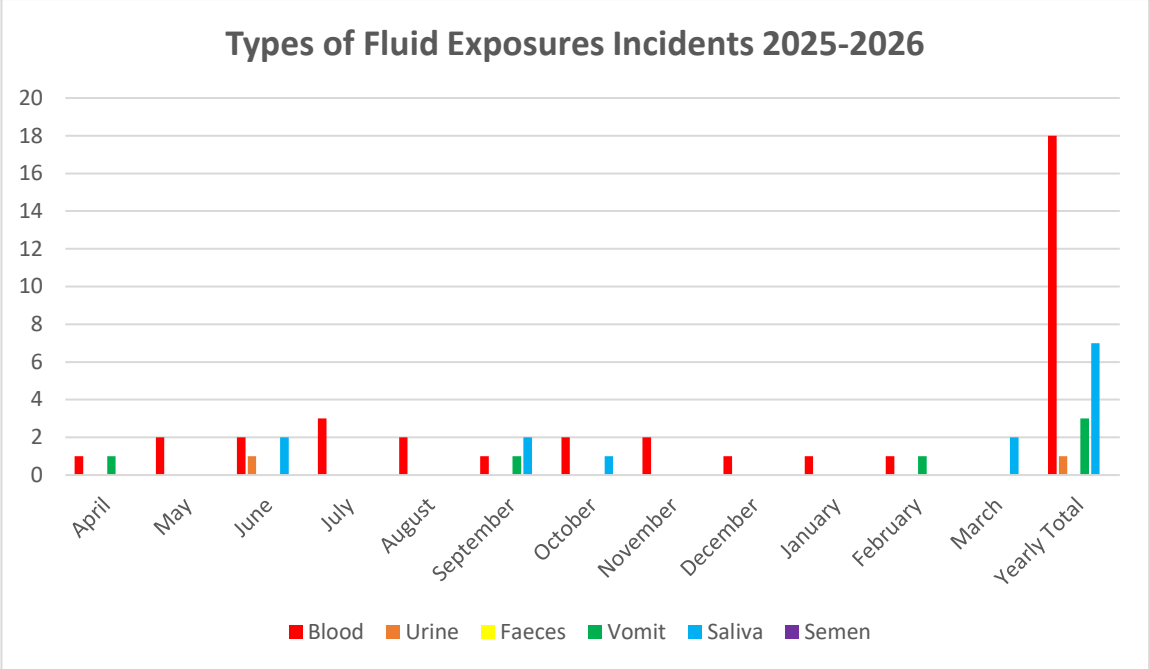


Graph 17

There has been an increase in incidents from 68 in 2024/2025 to 88 in 2025/2026. A further deep dive into the data was successfully completed showing recurring themes causing mechanism of injury. This surrounds safe disposal of sharps. Key messaging for the safe use of sharps has been embedded in face-to-face education, and internal education team to work with higher education institutes where cannulation is taught. Actions created from the deep dive will be monitored through IPCG and are due in the following year August 2026.

Exposure to blood/body fluid incidents

Graph 18 below highlights the total number of exposures to bodily fluids. From the total of 20 incidents reported in 2024-2025, there has been an increase of 9 incidents with the total for 2025-2026 being 29. The highest number of incidents reported via the Trust's Datix system is exposure to blood. These incidents are investigated, reviewed and learning ascertained.



Graph 18

8.2 Outbreaks

There were no identified outbreaks in 2025-2026.

8.3 Infectious Disease Adverse Incidents Notified to SCAS by UKHSA

Received notification of 20 Briefing Notes in 2025-2026. The following were listed as relevant to SCAS, and comprehensive communications and actions took place to address the notification.

2025/019 Pilgrims returning from the Hajj/Umrah: Middle East Respiratory Syndrome coronavirus (MERS-CoV) and invasive meningococcal disease (IMD)
2025/031 National Standard Measles Incident: Measles epidemiology and recommended control measures
2025/042 Influenza A(H3N2) early season activity in England: implications for clinical practice and laboratory referral
2025/45 Outbreak of Marburg virus disease in Ethiopia

2026/006 Increase in mpox (clades Ib and IIb) in England

8.4 Influenza Vaccination Campaign

The national flu immunisation programme is essential in protecting vulnerable people and supporting the resilience of the health and care system.

The overall uptake figure for 2024-2025 was 46% and the target for 2025-2026 was a 5% increase on the previous year.

SCAS carried out the flu vaccination campaign as a peer-to-peer vaccination programme via a number of SCAS flu clinic locations. As in previous years, staff could also be vaccinated via a Covid/flu hub, via their GP, or at a community pharmacy. All staff, including those who declined to be vaccinated, were expected to complete a flu vaccination record form.

Overall vaccine uptake in 2025-2026 for SCAS for eligible frontline staff was 52%.

Factors considered as challenges to achieving a greater uptake included:

- Accuracy of new national reporting platform – Federated Data Platform (FDP)
- Accuracy of ESR
- Late recruitment of a clinical lead/coordinator
- Vaccinator training on MS Teams and e-learning
- Change of requirements for transporting vaccines in staff cars
- Vaccinators competing demands

An issues log, which is collaboratively collated by the internal Seasonal Vaccination Team to highlight any lessons learnt, risks and issues, is reviewed, and performance monitored of the flu vaccination campaign annually to determine lessons learnt, identify areas of good practice, and suggest areas for improvement in future campaigns. This has been considered in the 2026-2027 planning.

<u>Benchmarking</u>

NHS trusts are required to submit data regarding vaccine uptake of eligible frontline staff.

The table below shows the overall percentage vaccine uptake from 1st September to 28th February reported in February 2025 and February 2026.

To note: the uptake listed for February 2025 was reported via Immform. This differs from the FDP uptake reporting which was first implemented for 2025-2026.

Ambulance Service	Vaccine uptake reported February 2025	Vaccine uptake reported via FDP February 2026
West Midlands Ambulance Service	62.6%	64.0%
East Midlands Ambulance Service	68.3%	62.6%
South East Coast Ambulance Service	73.7%	62.0%
South West Ambulance Service	42.9%	52.8%
South Central Ambulance Service	46.3%	52.0%
East of England Ambulance Service	No data	52.0%
Yorkshire Ambulance Service	No data	46.5%
North West Ambulance Service	42.5%	45.0%
North East Ambulance Service	No data	42.2%
London Ambulance Service	34.4%	40.9%
(Northern Ireland Ambulance Service)	No Data	24.4%

At the time of this report the planning for the 2026-2027 season has commenced.

9. IPC Annual Work Programme 2025-2026

The IPC Annual Work Programme can be viewed as a separate detailed document. The fundamental aim of the 2026-2027 IPC work programme will be to continue the promotion of sound Infection Prevention and Control practice in line with the Health and Social Care Act 2015.

IPC Annual Plan 2025-2026 elements update**:**
All areas of the work plan completed except for the areas below:

- Section 9 - To develop antimicrobial workstream in conjunction with Pharmacy. Not progressed due to capacity within Pharmacy and IPC.
- Section 11 - Embedding of Link Practitioners challenged due to operational availability. Strategy to be reviewed.
- Section 12 - Information available on external internet for patients/service users. Not progressed due to team capacity.

To facilitate this the IPC team will continue to positively engage with all staff, encourage ownership and provide a forum where good practice is shared. The focus for 2026-2027 will be:

- Ensure the Infection Prevention and Control Link Practitioner Programme is embedded within the organisation to facilitate sound two-way communication between the care setting and Infection Prevention and Control.

- To develop and enhance antimicrobial workstreams in collaboration with Pharmacy.

- Continue building IPC audits on Internal Business Intelligence Systems with visual dashboards noting audit cycles and areas of improvement.

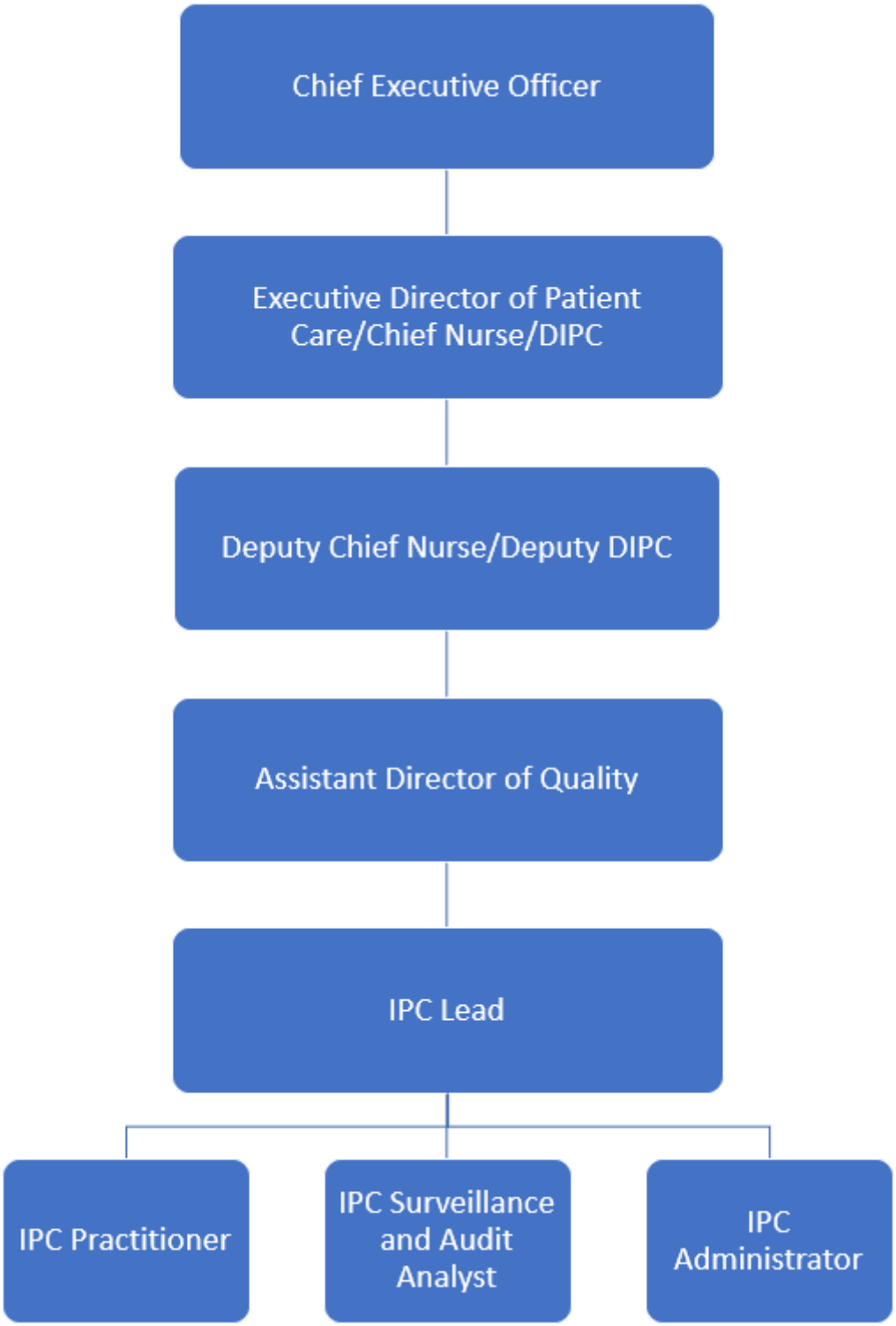
- Continue Quality Improvement Projects.

APPENDIX 1 - Infection Prevention and Control Structures

The Trust Board and the Director of Infection Prevention and Control (DIPC) have overall responsibility for patient safety and all infection prevention and control issues ensuring they are managed safely and appropriately. The DIPC sits on the Trust Board and Quality and Safety Committee.



IPC team Structure



APPENDIX 2 - Infection Prevention and Control Statement

The SCAS Trust Board - is committed to compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections (updated July 2015) and as amended to prevent and control Health Care Associated Infections (HCAI). The Code is presented under three headings which form the basic Code, and the Trust has pledged to undertake these duties by:

1. Management, organisation, and the environment

- Protect patients, staff, and others from HCAI.
- Put in place appropriate management systems to prevent and control infections.
- Assess the risks of acquiring an HCAI in the pre-hospital environment and take action to reduce or control these risks.
- Provide a clean and appropriate environment.
- Provide information on HCAI to patients and the public.
- Provide information when a patient moves from the care of one healthcare body to another.
- Always co-operate with other health care professionals
- Provide facilities to prevent or minimise the spread of HCAI.
- Acquire micro-biology and laboratory support.

2. Clinical care protocols:

- Have in place appropriate evidence-based core policies and protocols that are monitored and maintained to provide clear guidance on the prevention and control of HCAI in the Ambulance Service.

3. Health care workers:

- Ensure so far as is reasonably practicable that ambulance staff are free of and protected from exposure to communicable infections.
- Access to relevant occupational health services is provided to all staff.
- Ensure that all staff are educated in the prevention and control of HCAI.

APPENDIX 3 - Audit Schedules

E & UC Level 2 audit schedule



EUC Audit Schedule 2025-2026 Level 2 - F

PTS Level 2 audit schedule



PTS Audit Schedule 2025-2026 Level 2 - F

Level 3 audit schedule



Level 3 IPC Assurance Schedule

APPENDIX 4 - IPC Annual Work Plan for 2025-2026 and 2026-2027

IPC Annual Work Plan for 2025-2026



IPC Annual workplan 2025-26.p

IPC Annual Work Plan for 2026-2027



IPC Annual workplan 2026-27.p

Embedded appendices below

NHS
South Central
Ambulance Service
NHS Foundation Trust

Upward Report of the People & Culture Committee

Date Meeting met **21 September 2026**
Chair of Meeting **Harbhajan Brar, Non-Executive Director**
Reporting to **Trust Board**

Items	Issue	Owner	Action
Points for escalation			
Workforce Culture, Leadership and Staff Experience	Whilst positive progress was noted across leadership development, values and behaviors, learner safety and sexual safety programmes, the Committee remained concerned by the lack of improvement in key workforce indicators including sickness absence, Personal Development Reviews compliance and staff experience measures. The Committee emphasised the need to demonstrate the impact of people initiatives through measurable improvements in workforce outcomes and staff experience.	DH	Continue monitoring through Board Assurance Framework (BAF), Workforce Metrics and Staff Survey results.
Key issues and / or Business matters to raise			
Workforce Recruitment and Retention	Assurance was received that recruitment activity remained strong, particularly within Integrated Contact Centres, with significant progress made in recruiting substantive staff. However, turnover within contact centre roles remains high and continued focus is required on retention, onboarding and understanding reasons for attrition. The Committee requested further focus on exit interviews and retention activity.	DH	Standing item on Committee agenda.
Sickness Absence and Wellbeing	Sickness absence remains above target, particularly within operational services and EOC functions. Members discussed the relationship between	DH	Review factors contributing to

	workload pressures, wellbeing, mental health and retention. Assurance was received regarding trauma support services, mental health first aid provision and increasing utilisation of employee wellbeing support services.		elevated EOC sickness absence and report back to the Committee.
Employee Relations	The Committee noted progress in reducing the number of active Employee Relations cases following strengthened oversight and escalation arrangements. Members welcomed the reduction in case numbers but emphasised the importance of continuing to reduce investigation timescales and ensuring timely resolution.	LL	Standing item on Committee agenda.
Sexual Safety Framework	Significant progress was noted against delivery of the NHS Sexual Safety Framework, with all actions either completed or in progress. Members received assurance regarding implementation of the Sexual Safety Policy, strengthened governance arrangements and enhanced reporting mechanisms. The Committee thanked those involved in delivering the programme.	DR	Continued oversight through Sexual Safety Oversight Group and PACC.
Learner Safety Action Plan	Good progress was reported against the Learner Safety Action Plan, including establishment of learner safety leads, enhanced reporting arrangements and strengthened governance processes. Members discussed opportunities to incorporate learner experience within accreditation and assurance processes and noted the importance of maintaining organisational focus on learner	DH / DR	Explore incorporation of learner feedback within accreditation and assurance arrangements.
Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)	The Committee reviewed annual WRES and WDES reports. Positive progress was noted in representation and several workforce indicators; however, continued concerns remained regarding experiences of harassment, discrimination, workplace culture and access to opportunities. The Committee approved publication of both annual reports.	DRa	Reports to be published and action plans implemented.
Areas of concern and / or Risks			
Staff Engagement and Culture Risk	The Committee reviewed the Board Assurance Framework and acknowledged that staff engagement, wellbeing and workforce culture remain significant organisational risks. Whilst numerous improvement	DH	Ongoing monitoring through

	initiatives are underway, it was recognised that measurable improvement will take time and continued scrutiny will be required.		BAF and Staff Survey results.
Learner Safety	Learner safety remains the highest-rated People Directorate risk. Although substantial progress has been made, the Committee recognised that continued focus is required to embed improvements and sustain confidence in reporting arrangements.	DH / DR	Ongoing monitoring via Sexual Safety Oversight Group and PACC.
Items for information and / or awareness			
National People Agenda	The Committee received updates regarding implementation of the NHS People Portal, National Transforming People Services programme, joint payroll procurement arrangements with SECAmb and procurement of a new Occupational Health contract.	N/A	For information
Best Practice and / or Excellence			
Culture and Leadership Development	The Committee received assurance regarding progress within the Fit for the Future People & Culture workstream. Three cohorts of the NHS Elect leadership programme have now been delivered, alongside management development programmes and values-based leadership initiatives. Participation and feedback continue to improve and members welcomed the increasing focus on first-line manager development.	N/A	Programme continues.
Equality, Diversity and Inclusion	Positive progress was reported through the See Me First campaign, staff network development, Workplace Adjustment Passports, Unity and Diversity Conference, and wider implementation of Lord Mann recommendations.	N/A	Continued delivery through EDI action plans.
Policies / Reports for approval			
Workforce Race Equality Standard (WRES) Annual Report	Approved by the Committee for publication.	DRa	Publication by October 2026.

Workforce Disability Equality Standard (WDES) Annual Report	Approved by the Committee for publication.	DRa	Publication by October 2026.

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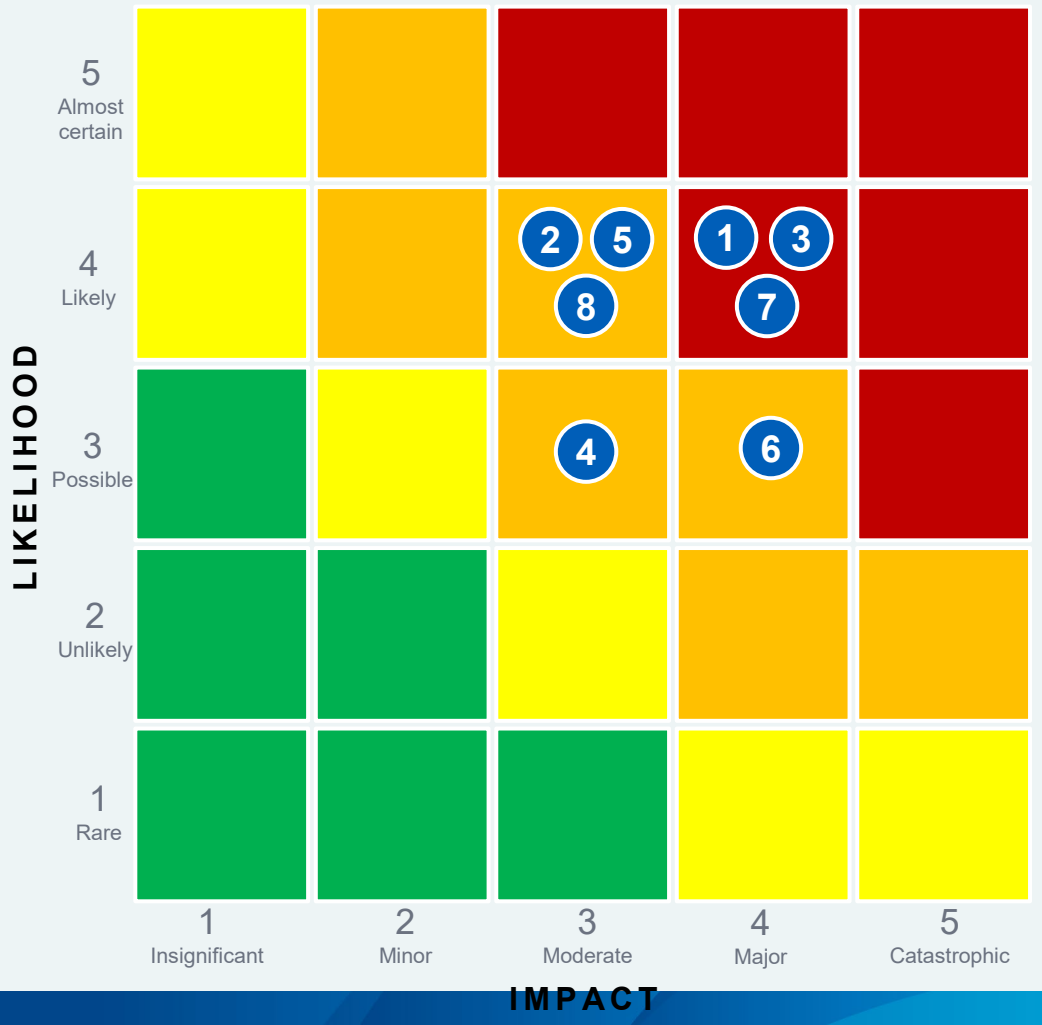
2026 – 2027 Board Assurance Framework – People & Culture

October 2026

Strategic Risk Heat Map

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: November 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**	**492 – Staff Safety** **493 – Sexual Safety**

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

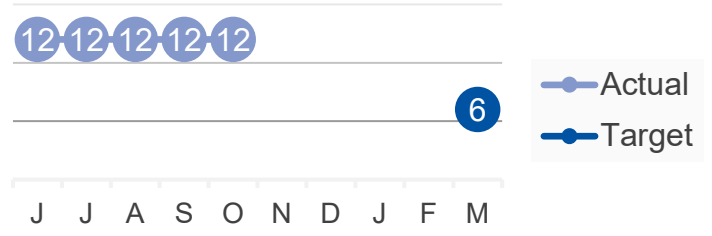
MITIGATING ACTIONS DEADLINE

✓	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: **October 2026** · Next review: **November 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.

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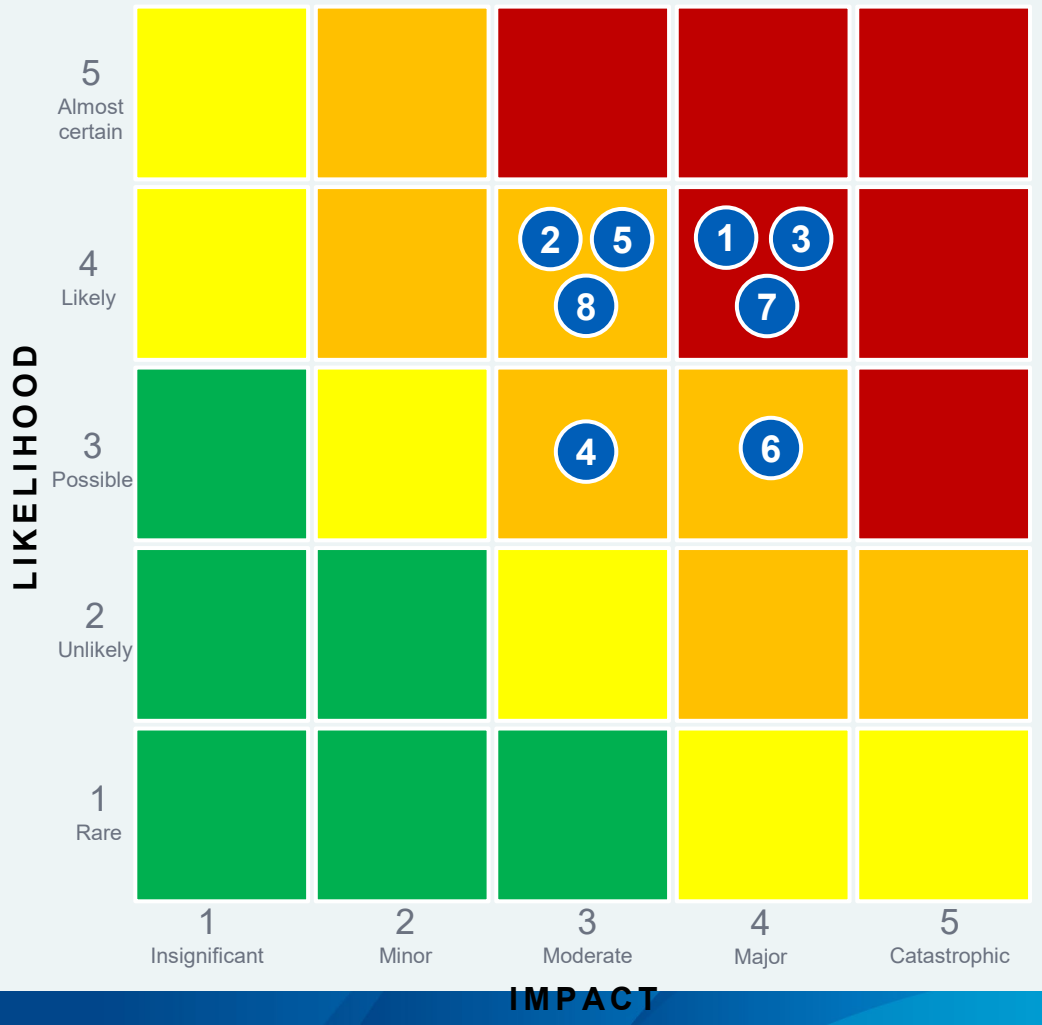
2026 – 2027
Board Assurance Framework

October 2026

Strategic Risk Heat Map

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: November 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

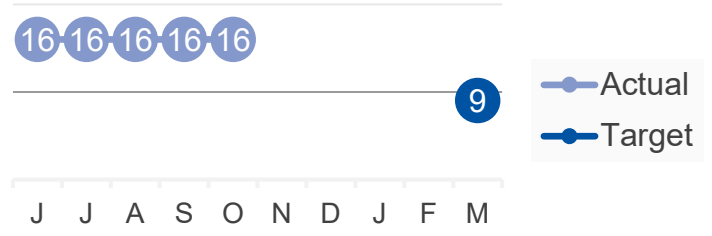
MITIGATING ACTIONS DEADLINE

✓	1. Financial Sustainability and Recovery Programme with bi-weekly oversight	Complete
✓	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 M6 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: **October 2026** · Next review: **November 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.

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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

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: **October 2026** · Next review: **November 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

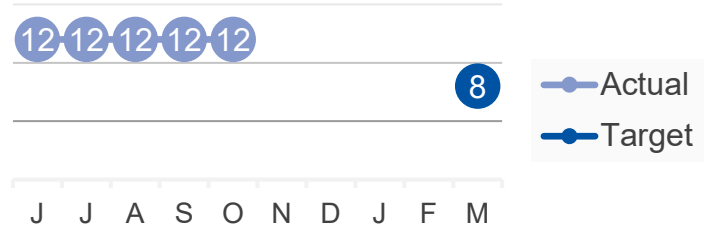
MITIGATING ACTIONS — DEADLINE

✓	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

- Joint risk going to Exec to Exec in November
- 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: **October 2026** · Next review: **November 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.

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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: **October 2026** · Next review: **November 2026**

Trust Board of Directors Meeting in Public 5 November 2026	
Title	Hampshire & Isle of Wight NHS Collective Commitment
Report Author	Becky Murray, Chief Governance Officer
Executive Owner	Simon Ashton, Chief Executive Officer
Agenda Item	22
Governance Pathway: Previous	None – paper is for the Board
Governance Pathway Next Steps	As above

1. Purpose

To present the collective commitment that leaders in the Hampshire & Isle of Wight NHS system have agreed as principles for system working.

2. Executive Summary

The Collective Commitment was developed following work undertaken by the Hampshire & Isle of Wight (HioW) Chairs and CEOs during the earlier part of the year. This work built on the good working relationships that already existed, which was recognised as a strong basis from which to build system-wide collaboration and deliver collective outcomes.

A key driver for this work was to develop a strong system leadership group, focused on a small number of shared priorities, with clear collective decision-making, which would lead to demonstrable improvement in outcomes for the population. This was against a backdrop of significant NHS reform, including the move towards strategic commissioning, neighbourhood health models, population health management, the "left shift" of care closer to home, and increasing expectations that providers work collaboratively to improve outcomes and value.

The principles outlined in the document align to the direction of travel we are pursuing through the establishment of the SCAS-SECAmb Group model and our wider system partnerships. In particular, the emphasis on population health, neighbourhood-based care, integrated urgent care pathways, prevention, reducing inequalities and delivering more care closer to home are all areas where ambulance services have an increasingly important strategic role.

The Collective Commitment represents a shared statement of intent and principles for working, which sets out how organisations across the system will work together, make decisions, manage differences and focus on the long-term needs of the population.

3. Areas of Risk

There are no specific areas of risk to highlight to the Trust Board.

4. Link to Strategic Theme

The agreement relates to our Partnerships & Sustainability and Clinical Effectiveness strategic themes.

5. Link to Board Assurance Framework Risk(s)

The report relates to:

- SR1 – quality performance and patient outcomes
- SR7 – sustainability
- SR8 – collaboration

6. Quality/Equality Impact Assessment

Not required for this report

7. Recommendations

The Board is asked to **NOTE** and **ENDORSE** the shared principles outlined in the Collective Commitment.

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

Hampshire and Isle of Wight NHS Collective Commitment

As Chairs and Chief Executives across Hampshire and Isle of Wight, we commit to working as one NHS system to improve the health and wellbeing of the people and communities we serve.

Our shared ambition is to improve healthy life expectancy, reduce health inequalities and ensure high-quality, sustainable services for current and future generations.

Recognising that no organisation can achieve these ambitions alone, together we will:

- Put the needs of our population before organisational interests.
- Work with openness, trust and transparency.
- Focus on collective solutions and delivery.
- Be ambitious, action-oriented and willing to innovate.
- Take collective responsibility and communicate a consistent narrative about our challenges, priorities and progress.
- Create the conditions for collaboration and success across our organisations.
- Improve patient experience by making services easier to access and navigate, particularly for people who face the greatest barriers to care.
- Improve care team experience by supporting and empowering our staff and volunteers and removing barriers that prevent them from delivering their best.
- Deliver best value by making the most effective use of our collective resources, improving productivity and reducing duplication.

Our shared priority: Home is Best

We will make *Home is Best* our shared strategic priority, recognising that long-term sustainability and improved outcomes require a fundamental shift in how care is delivered across Hampshire and Isle of Wight.

Working together with local authorities, primary care, the voluntary and community sector and other partners, we will increase our focus on prevention, early intervention and care delivered in people's homes and communities. By redesigning services around people's needs, we will reduce reliance on hospital-based care wherever possible, helping more people to live independently, remain connected to their communities and achieve better outcomes.

Our shared ambition is to create a system where more care is delivered in homes and communities, and where people experience seamless transitions between services. By working together across organisational boundaries, we will reduce unnecessary time spent in hospital and ensure people can return home as soon as they are ready, with the right support in place.

By signing this commitment, we pledge to hold ourselves and one another accountable for working in this way and for delivering better outcomes for the people of Hampshire and Isle of Wight.

Signature

NHS
Hampshire and Isle of Wight

Signature

NHS
South Central Ambulance Service
NHS Foundation Trust

Signature

NHS
Hampshire and Isle of Wight Healthcare
NHS Foundation Trust

Signature

NHS
Portsmouth Hospitals University
NHS Trust

Signature

NHS
Hampshire Hospitals
NHS Foundation Trust

Signature

NHS
University Hospital Southampton
NHS Foundation Trust

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Upward Report of the Audit Committee

Date Meeting met **10th September 2026**
Chair of Meeting **Mike McEnaney, Non-Executive Director**
Reporting to **Trust Board**

Items	Issue	Owner	Action
Points for escalation			
Internal Audit	Clinical Pathways Audit; a limited assurance report was received. Challenges with data were evident although assurance was provided that joint working with SECAmb on Clinical Pathways was part of the Clinical Model Workstream. Executives were asked to consider how to bring visibility of pathway utilisation into reporting given the impact on Cat2 performance.	BS	Raise at EMC
Internal Audit Follow Up	Extensions to completion of actions relating to Medicines Management were agreed. Deadlines in response to actions relating to Fleet were also extended as whilst progress is being made, this is a large-scale piece of work for which digital solutions are required. Whilst slippage is disappointing given performance in 2025/26, the requests for extensions were for valid reasons. Management were however reminded to set realistic deadlines when agreeing actions.	N/A	Routine monitoring at Audit Committee
Key issues and / or Business matters to raise			
Board Assurance Framework	The committee received the BAF for 2026/27 and welcomed the new format in terms of the ability to track progress over time.	N/A	N/A

Freedom to Speak Up and Health & Safety Annual Assurance Reports	The committee received a report detailing the leadership, governance and oversight arrangements in relation to Freedom to Speak Up and Health & Safety. The reports focused on the systems and processes as the assurance route for these two areas are overseen by the People & Culture Committee and Quality & Safety Committee respectively.	N/A	N/A
South Central Fleet Services Ltd Accounts	The Accounts were received following approval at the SCFS Board. A number of challenges were noted around the audit process in relation to timely provision of information. Executives are holding a post audit review meeting with external audit to discuss successes and learning that will be carried forward into the current financial year. Audit Committee will receive an update at the next meeting.	JBe	Report to be presented to the next Audit Committee meeting
Areas of concern and / or Risks			
Digital Capacity	The committee discussed the number of actions/projects across the trust for which digital solutions are required. This is an area of concern given resource constraints and clear prioritisation is required. Executives were asked to discuss this.	BM	Raise at EMC
Items for information and / or awareness			
None			
Best Practice and / or Excellence			
Single Tender Waivers and Contract Management	Good adherence continues with minimal single tender waivers	N/A	Routine monitoring at the Audit Committee
Policies for approval			
N/A			

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Trust Board of Directors Meeting in Public 5 November 2026

Title	**2026 EPRR Assurance Return**
Report Author	**Martin Blaker**
Executive Owner	**Mark Ainsworth**
Agenda Item	**24**
Governance Pathway: Previous	Presented to Executive Management Committee for sign off
Governance Pathway Next Steps	n/a

1. Purpose

The purpose of this report is to provide the Trust Board with an overview of the Trust's 2026 Emergency Preparedness, Resilience and Response (EPRR) Core Standards assurance submission to NHS England. The report outlines the Trust's compliance position, highlights the significant progress made since the previous reporting cycle, details the remaining areas of partial compliance and associated improvement actions, and provides assurance that arrangements are in place to achieve and sustain full compliance whilst continuing to deliver high-quality EPRR, Business Continuity, HART and Specialist Operations capabilities across the Trust.

2. Executive Summary

This overview forms part of our 2026 EPRR assurance return, submitted annually to NHS England. The process has been supported by a peer challenge facilitated by the ICB, alongside an internal appraisal led by the Head of EPRR, with input from the RSO team and other departments.

We are reporting a **Fully Compliant** rating, which is an improvement from last years Substantially compliant position. However, this year we have identified **4 areas of partial compliance**, compared to **15** in the previous cycle. This reduction reflects both the implementation of new processes and the hard work by the RSO team to deliver updated policy's and procedures. We have worked hard to address our areas requiring improvement with the establishment of a new structure which will enable us to implement the final parts of our improvement plan and our newly signed off structure.

We have a detailed action plan for the 4 areas identified as partial compliance which requires the implementation of the new RSO structure and also awaits the HART strategic

review with regards to the staffing levels and financial support for HART and SORT delivery.

Our **Business Continuity** program is still being used as an example of best practice, with both **IOW Ambulance Service** and **SECAMB** now implementing our approach within their own Trusts.

I would like to highlight that our partial compliance around HART staffing levels might not meet the 100% requirement, which is also a similar picture across the country, but I am happy to report that with the trust investment we have seen a compliance increase from 82% - 92%.

3. Areas of Risk

- Performance

Whilst the Trust is reporting an overall **Fully Compliant** position against the 2026 EPRR Core Standards, there remain a small number of areas of partial compliance that present an ongoing risk to performance if not addressed. The most significant risk relates to **HART staffing resilience and capability levels**, where compliance, although improved from 82% two years ago to 92% this year, this still remains below the national aspiration of 100%. Delivery of the remaining improvement actions is dependent upon the implementation of the new Resilience and Specialist Operations structure and the outcome of the HART Strategic Review, particularly in relation to workforce establishment and sustainable funding arrangements. Failure to fully implement these measures could impact the Trust's ability to achieve and maintain full compliance against future assurance requirements and may place additional pressure on specialist operational response capabilities during periods of heightened demand or major incidents. However, robust action plans are in place, and progress continues to be monitored through established governance arrangements.

Item	Description	Reason for partially compliant
H8 - HART	Six operational HART staff on duty	The unit has 1 vacancy and is recruiting from a pool. However the challenge to have 100% staff coverage every day for a full year has proven impossible since inception. Short notice sickness and injuries do occur. Having Teams of 8 to provide 6 has imporved. FYTD is 92.16% last year was 90.00%. Evidence H8 – it is worth noting this is a national issue and only one team in the country can

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		meet this standard due to extra funding.
H26 - HART	Capital depreciation and revenue replacement schemes	SCAS currently maintains a capital depreciation reserve of £1.4 million to support the replacement of HART fleet vehicles. However, depreciation funding arrangements are not currently in place for a number of other significant capital assets, including EDBA sets, PRPS equipment, GTS systems, radios, gas monitors, and Incident Ground Technology Kit. Historical information provided by ECU Inform indicates that the depreciation requirement should be approximately £1.9 million, with the additional £500,000 reflecting changes in equipment holdings and replacement costs. Despite this, there remains a discrepancy regarding the agreed depreciation value, and financial planning continues to be based on the £1.4 million figure. This creates a potential risk that future capital replacement requirements may not be fully funded. Which we are now experiencing in which is covered in our partial compliance for H29
H29 - HART	Fleet compliance with national specification	Whilst SCAS maintains a compliant HART fleet, Airbox technology is not currently available within our incident ground technology capability. Progression of this requirement has been constrained by the

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		unresolved £500,000 funding gap identified in H26. Addressing this shortfall would provide the investment necessary to deliver the required ground technology capability, reducing operational risk and supporting the ongoing development and resilience of the HART service.
H32 - HART	Capital estate provision	current SCAS HART accommodation is located on a shared site that is increasingly constrained by capacity limitations. Growth in both specialist equipment holdings and the HART vehicle fleet has resulted in the service outgrowing its existing facilities. This is creating operational challenges and reducing flexibility in the delivery of day-to-day activities. Furthermore, the current estate provision makes it increasingly difficult to comply fully with national HART standards and best practice relating to accommodation, equipment storage, vehicle management, training facilities, and operational readiness. A review of future estate requirements is therefore necessary to ensure the long-term sustainability and resilience of the HART capability.

4. Link to Strategic Theme

Enabling Services

5. Link to Board Assurance Framework Risk(s)

SR14 - Quality Performance

6. Quality/Equality Impact Assessment

A QIA is not required for this due to the strength of the return but each year this is reviewed against areas of the core standards that require a QIA assessment

7. Recommendations

- **Note** the contents of the 2026 EPRR Core Standards Assurance Return and the Trust's achievement of a **Fully Compliant** rating, representing an improvement from the previous year's **Substantially Compliant** position.
- **Recognise** the significant progress made in reducing areas of partial compliance from 15 to 5 through the implementation of improvement actions, revised policies and procedures, and the continued efforts of the Resilience and Specialist Operations teams.
- **Support** the delivery of the remaining improvement actions, including the implementation of the approved Resilience and Specialist Operations structure and the outcomes of the HART Strategic Review, to ensure sustainable compliance against future EPRR assurance requirements.
- **Take assurance** that robust action plans and governance arrangements are in place to address the remaining areas of partial compliance and to maintain the Trust's preparedness, resilience, and response capability.

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

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SCAS Board Meeting October 2026

2026 EPRR Assurance Summary

South Central Ambulance Service
NHS Foundation Trust

Current Position

Overall Status:

Fully Compliant

EPRR Standards Fully Compliant in 58/58

Interoperable Capabilities Fully compliant in 131/135

South Central Ambulance Service
NHS Foundation Trust

Comparison

- 2025

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	5	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	11	0	0
Command and control	2	2	0	0
Training and exercising	4	3	1	0
Response	5	5	0	0
Warning and informing	4	4	0	0
Cooperation	5	5	0	0
Business Continuity	11	9	2	0
Hazmat/CBRN	1	1	0	0
CBRN Support to acute Trusts	7	7	0	0
Total	58	54	4	0

Interoperable capabilities	Total standards applicable	Fully compliant	Partially compliant	Non compliant
HART	32	29	3	0
SORT	40	39	1	0
MassCas	14	12	2	0
C2	36	32	4	0
JESIP	13	12	1	0
Total	135	124	11	0

- 2026

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	11	0	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	5	5	0	0
Warning and informing	4	4	0	0
Cooperation	5	5	0	0
Business Continuity	11	11	0	0
Hazmat/CBRN	1	1	0	0
CBRN Support to acute Trusts	7	7	0	0
Total	58	58	0	0

Interoperable capabilities	Total standards applicable	Fully compliant	Partially compliant	Non compliant
HART	32	28	4	0
SORT	40	40	0	0
MassCas	14	14	0	0
C2	36	36	0	0
JESIP	13	13	0	0
Total	135	131	4	0

2025 SCAS reported a total of 15 partial compliant sections with 0 Non-compliment sections
2026 SCAS are reporting a total of 4 partial compliant sections with 0 Non-compliant sections.

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Areas of Partial Compliance- Interoperable Capabilities

H8	**HART**	**Six operational HART staff on duty**	Partially compliant	HART Manager to continue to monitor and establish an increase in core staffing levesl to provide 7x8 staffing
H26	**HART**	**Capital depreciation and revenue replacement schemes**	Partially compliant	With changes in the financial procurement procedures as well as changes in the Trust Financial Teams work is continually ongoing to identify all appropriate replacement schemes are present

H8 - The HART team have a current 6 on shift for 92% of shifts so far this year. A national review is due to look at the feasibility of this standard.

H26 – Ongoing work with Finance to identify the 500K gap in depreciation funding which ECU state should cover the equipment changes.

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Areas of Partial Compliance- Interoperable Capabilities

H29	**HART**	**Fleet compliance with national specification**	Partially compliant	Business case is being written for Airbox procurement following ECU SBAR
H32	**HART**	**Capital estate provision**	Partially compliant	SCAS HART building requires some action to ensure it is compliant with the estates specification. HART Manager is working with the Estates team to ensure HART is part of the Trust Estates Strategy. Business cases are due to be submitted this FY for some improvements to the Estate

H29 – This is linked to H26 Ongoing work with Finance to identify the 500K gap in depreciation funding which ECU state should cover the equipment changes.

H32 – Ongoing collaboration with Estates and the Compliance Team to develop a sustainable estate solution that supports current and future HART operational requirements and compliance with national standards.

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Highlights

- Through targeted workforce growth and ongoing improvements to HART rostering arrangements, compliance has increased from 80% two years ago to 92% currently. Whilst this represents significant progress, the national standard remains 100%. It is recognised nationally that achieving full compliance is challenging within the existing funding envelope.
- HART capital depreciation remains an area of concern, with current discussions with Finance identifying an approximate £500,000 funding gap. Until this issue is resolved, SCAS will be unable to fully deliver the incident ground technology requirements specified within the HART Core Standards.
- We continue to work collaboratively with Estates and the Compliance Team to progress the Capital Estates Scheme. However, until a viable alternative solution and associated funding allocation are identified and approved, the current estate limitations will remain and continue to impact compliance with national HART estate standards.

South Central Ambulance Service
NHS Foundation Trust

Highlights

- Through the continued commitment and hard work of the Resilience Team, the Trust has progressed from a Substantially compliant position to achieving fully compliant against the relevant standards.
- Significant improvements have been made in reducing the number of partially compliant areas from 15 to 4, with ongoing work focused on sustaining and further strengthening this level of performance.
- The Trust's Business Continuity (BC) programme is recognised as an area of national good practice. Our continued ambition and development place SCAS in a strong position to become a national leader in Business Continuity compliance and assurance.
- The continued implementation of the Resilience and Specialist Operations (RSO) restructure will strengthen our ability to maintain and enhance compliance going forward. The revised structure will improve team capacity and capability, supporting both the Resilience Team and the wider Trust in delivering Emergency Preparedness, Resilience and Response (EPRR) Core Standards effectively and sustainably.

Trust Board of Directors Meeting in Public 5 November 2026

Title	**Heatwave Major Incident Report**
Report Author	**Martin Blaker – Assistant Director of Operation (RSO)**
Executive Owner	**Mark Ainsworth**
Agenda Item	**25**
Governance Pathway: Previous	EPRR Delivery Group EMC FPC
Governance Pathway Next Steps	SCAS Board

1. Purpose

The purpose of this report is to provide assurance on the findings and recommendations arising from the independent After Action Review (AAR) of the South Central Ambulance Service (SCAS) response to the June 2026 extreme heatwave Major Incident. The report outlines the key lessons identified, highlights areas of good practice, and presents a programme of actions designed to strengthen organisational resilience, preparedness, command and control arrangements, staff welfare provision, business continuity, and operational response capabilities.

The report seeks to ensure that learning from this incident is embedded across the Trust and applied not only to future extreme weather events but also to any prolonged incident that generates sustained operational pressure. It also establishes the governance arrangements for monitoring delivery of the identified actions, providing assurance that SCAS continues to enhance its ability to anticipate, respond to, and recover from major incidents whilst maintaining safe and effective patient care.

2. Executive Summary

In June 2026, South Central Ambulance Service (SCAS) declared a Major Incident in response to a prolonged period of extreme heat and humidity, which generated sustained and unprecedented demand across operational, clinical, and support services. The incident presented significant challenges to service delivery, staff welfare, estate infrastructure, and organisational resilience, requiring a coordinated Trust-wide response over an extended period.

Following the incident, an independent After Action Review (AAR) was commissioned to provide an objective assessment of the Trust's response, identify areas of good practice, and highlight opportunities for improvement. The review has enabled SCAS to undertake a comprehensive evaluation of its preparedness, response arrangements, and recovery processes, ensuring that lessons are captured and embedded across the organisation.

Whilst the review focused on the heatwave response, many of the findings are equally applicable to any future event that results in sustained operational pressure or requires a coordinated SCAS-wide surge response.

The review identified 14 lessons and associated actions that will strengthen the Trust's resilience and improve its ability to respond to future extreme weather events and other prolonged incidents. The recommendations focus on several key themes including:

- **Improving preparedness and escalation arrangements** through the review of escalation triggers, enhanced extreme weather planning, and clearer criteria for the declaration of Critical and Major Incidents.
- **Strengthening command and control arrangements** by enhancing tactical resilience capacity, standardising governance structures and incident management processes, and improving communication of operational decision-making across the organisation.
- **Enhancing staff welfare provisions** during periods of extreme weather and heightened operational pressure, including arrangements for hydration, cooling, welfare monitoring, and support for frontline and support staff.
- **Improving business continuity and infrastructure resilience** through updated and accessible business continuity plans, enhanced estate resilience measures, and the introduction of environmental monitoring capabilities.
- **Increasing ICT and operational system resilience** through reviews of Computer Aided Dispatch (CAD) contingency arrangements, critical infrastructure dependencies, and measures to reduce the impact of future technology failures.
- **Developing enhanced surge demand management processes**, including mechanisms for the earlier deployment of NHS 111 clinical support within the Emergency Operations Centre during periods of exceptional demand.
- **Embedding organisational learning and assurance** through the testing and validation of improvements during future severe weather exercises, business continuity exercises, winter preparedness activities, and Major Incident training events.

The implementation of these recommendations will further strengthen SCAS's ability to anticipate, manage, and recover from prolonged periods of operational pressure whilst

maintaining safe and effective patient care. Action owners and implementation timescales have been assigned to each recommendation, with delivery ranging from October 2026 to January 2027.

Progress against the identified actions will be monitored through the EPRR Delivery Group, with regular updates provided through established governance structures. This will ensure that the lessons identified through the review are translated into meaningful organisational improvements and that the Trust continues to enhance its resilience, preparedness, and response capability in line with national expectations and best practice.

3. Areas of Risk

1. Organisational Preparedness and Escalation

There is a risk that future periods of sustained operational pressure may not be identified or escalated at the earliest opportunity due to inconsistent escalation triggers, unclear thresholds for Critical Incident and Major Incident declaration, or insufficient planning for extreme weather events.

2. Command and Control Resilience

There is a risk that command and control arrangements may become overstretched during prolonged incidents, resulting in reduced situational awareness, delayed decision-making, inconsistent governance, and ineffective communication across the Trust.

3. Staff Welfare and Workforce Resilience

Extended periods of extreme heat and high operational demand may adversely affect staff wellbeing, performance, and availability. Insufficient welfare arrangements could increase the risk of fatigue, heat-related illness, reduced productivity, and staff absence.

4. Business Continuity Arrangements

There is a risk that business continuity plans may not be sufficiently robust, accessible, or tested to support an effective response during prolonged incidents, leading to disruption of critical services and organisational functions.

5. Estate and Infrastructure Resilience

Extreme weather events may impact the functionality of Trust facilities and infrastructure. Inadequate environmental monitoring, cooling arrangements, or estate resilience measures could affect operational capability, staff welfare, and service delivery.

6. ICT and Critical Systems Failure

There is a risk that failures in critical technology systems, including Computer Aided Dispatch (CAD) and associated infrastructure, could significantly impact operational performance if appropriate contingency arrangements and resilience measures are not in place.

7. Surge Demand Management

During periods of exceptional demand, delays in implementing surge management measures or accessing additional clinical support may lead to increased patient waiting

times, reduced service performance, and heightened operational pressure across the Trust.

8. Organisational Learning and Assurance

There is a risk that lessons identified from the heatwave response are not fully embedded, tested, or monitored, resulting in repeated shortcomings during future incidents and reduced confidence in the Trust's preparedness arrangements.

9. Patient Safety and Quality of Care

The combination of sustained demand, environmental pressures, workforce fatigue, and system disruption creates a risk that patient safety, clinical effectiveness, and care quality could be adversely affected during future prolonged incidents.

EMC Risk Statement

Failure to implement the recommendations arising from the Heatwave Major Incident After Action Review could reduce the Trust's ability to effectively prepare for, respond to, and recover from future prolonged incidents. This may result in impacts to patient safety, staff welfare, operational performance, command and control effectiveness, business continuity, and organisational resilience.

4. Link to Strategic Theme

Clinical Effectiveness

5. Link to Board Assurance Framework Risk(s)

SR16 - Operating Model

6. Quality/Equality Impact Assessment

The recommendations contained within this report are expected to have a positive impact on patient safety, staff welfare, and organisational resilience. No adverse equality impacts have been identified at this stage. The actions arising from this review are being progressed through the Patient Safety Team and are being delivered in parallel with the Patient Safety Report relating to the same event.

7. Recommendations

1. **Review and Strengthen Escalation Processes**
    - Review existing escalation triggers and thresholds.
    - Develop clearer criteria for the declaration of Critical Incidents and Major Incidents.
    - Enhance planning arrangements for extreme weather events and other sustained pressure incidents.

2. **Improve Command and Control Arrangements**
    - Increase Tactical Commander resilience and availability during prolonged incidents.

- Standardise command structures, governance arrangements, and incident management processes.
- Improve communication and dissemination of operational decision-making across the Trust.

3. **Enhance Staff Welfare Measures**
   - Introduce strengthened welfare arrangements during periods of extreme heat and operational pressure.
   - Ensure access to hydration, cooling facilities, welfare monitoring, and staff support mechanisms.
   - Review staff welfare responsibilities within incident management structures.

4. **Strengthen Business Continuity Planning**
   - Review and update Business Continuity Plans across all departments.
   - Ensure plans are readily accessible and regularly tested.
   - Improve organisational understanding of business continuity processes and responsibilities.

5. **Improve Estate and Infrastructure Resilience**
   - Implement measures to mitigate the impact of extreme temperatures on Trust facilities.
   - Introduce environmental monitoring capabilities where appropriate.
   - Review cooling, ventilation, and wider estate resilience arrangements.

6. **Increase ICT and Operational System Resilience**
   - Review Computer Aided Dispatch (CAD) contingency arrangements.
   - Identify and address critical technology and infrastructure vulnerabilities.
   - Strengthen resilience measures to reduce the impact of future ICT failures.

7. **Develop Enhanced Surge Management Arrangements**
   - Improve mechanisms for managing exceptional demand.
   - Establish earlier deployment of NHS 111 clinical support into the Emergency Operations Centre during periods of sustained pressure.
   - Enhance processes for monitoring and managing demand escalation.

8. **Embed Organisational Learning**
   - Ensure lessons identified are incorporated into Trust policies, plans, and procedures.
   - Validate improvements through exercises, training, and testing activities.
   - Include recommendations within winter preparedness activities and future Major Incident exercises.

9. **Establish Governance and Assurance Arrangements**
   - Allocate clear ownership and implementation timescales for all actions.
   - Monitor progress through the EPRR Delivery Group.
   - Provide regular assurance updates through established governance structures to ensure completion and effectiveness.

Board Recommendation

The SCAS board are asked to note the findings of the independent Heatwave Major Incident After Action Review. The actions and recommendations will be monitored through the EPRR delivery group and EMC where required.

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

South Central Ambulance Service NHS Foundation Trust - Official

Overview of the June 2026 Heatwave Critical and Major Incident

During June 2026, South Central Ambulance Service (SCAS) experienced unprecedented operational pressures because of a prolonged period of extreme heat across the region. On the 22nd June 2026, the Met Office issued a Red Extreme Heat Warning covering the majority of the SCAS area for the 24th and 25th June, which was subsequently extended to include the 26th June. Concurrent Red Heat Health Alerts were also issued by the UK Health Security Agency (UKHSA).

As temperatures and system demand increased, SCAS experienced exceptional pressure across both its 999 and 111 services, with significant increases in call volumes and patient acuity. In response to the escalating situation, SCAS declared a Critical Incident at 12:17 on the 25th June 2026. Operational pressures continued to intensify, and following sustained demand and growing service impact, a Major Incident was declared at 21:26 on 26th June 2026. The Major Incident remained in place until it was stood down at 11:40 on 28th June 2026.

During the incident period, SCAS experienced its highest-ever number of calls waiting overnight on 25th June, resulting in significant delays to ambulance responses and considerable pressure on frontline crews and ICC staff. Patients experienced extended waiting times for assessment and treatment, and several incidents of patient harm were subsequently identified. Additional challenges arose when the SCAS data centre overheated overnight on 25th June, causing data reporting systems to become unavailable and affecting the performance of the CAD system. The wider NHS also experienced substantial disruption, particularly within Hampshire, where healthcare organisations reported increased patient acuity, excessive temperatures within hospital environments and failures of critical diagnostic infrastructure.

In recognition of the scale and impact of this, the incident was reviewed by the SCAS Safety Review Panel on 7th July 2026, which commissioned a Cluster Patient Safety Incident Investigation (PSII) to examine all relevant patient safety incidents occurring during the Critical and Major Incident period. It was agreed that the PSII would align with wider organisational lessons identified and improvement workstreams.

An initial review identified 34 incidents that met the criteria for the Duty of Candour process. Following further investigation and referrals from additional sources, including safeguarding and patient experience teams, the total number of cases increased to 39 incidents. Given the volume of cases and the sensitive nature of the circumstances, it was agreed that each incident would undergo an individual review,

with a personalised Duty of Candour response provided to patients or their next of kin.

To support organisational learning, a debrief was undertaken on 21st August 2026. The review considered the effectiveness of the response, challenges encountered during the incident, actions taken to maintain service delivery, and opportunities to strengthen resilience, surge capacity, business continuity arrangements and preparedness for future periods of extreme weather.

The June 2026 heatwave represented one of the most significant periods of operational pressure experienced by SCAS, highlighting the impact that extreme weather events can have on ambulance services, healthcare infrastructure and patient safety across the wider health and care system. The investigations and reviews undertaken have provided valuable insights and identified lessons to improve preparedness, response arrangements and system resilience for future extreme heat events.

Lessons identified

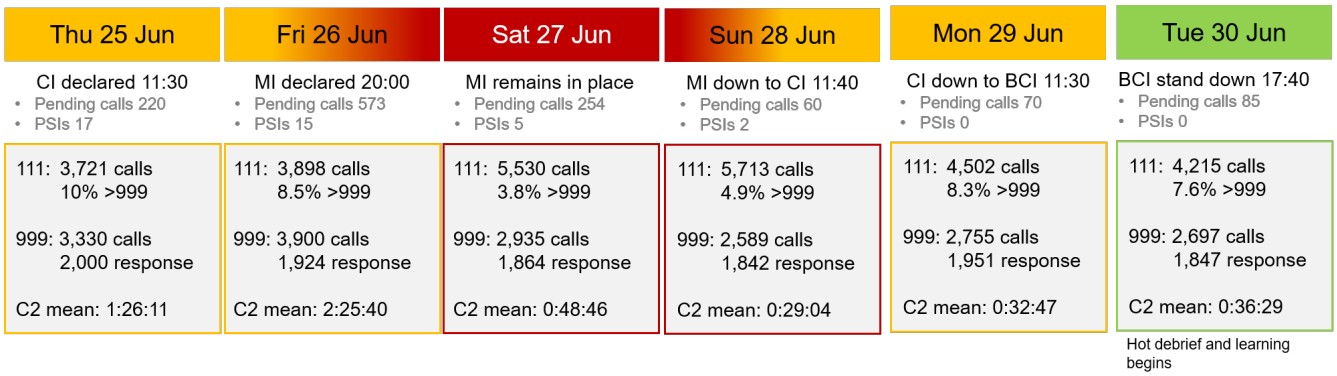
- **Earlier escalation and proactive planning:** Extreme heat should be recognised as a whole-system operational risk, with early escalation, proactive use of advance weather warnings, and implementation of preparedness measures before pressures become critical.
- **Strengthened command and control:** Prolonged incidents require scalable and sustainable command structures, clear role allocation, leadership rotation, and sufficient tactical and strategic capacity to avoid reliance on individual goodwill.
- **Staff welfare as an operational priority:** Robust and consistent welfare arrangements, including support outside normal weekday hours, are essential to protect staff from fatigue and maintain safe patient care during sustained incidents.
- **Improved communication and situational awareness:** Timely communications should provide clear context, rationale for decisions, and awareness of both internal and wider system pressures to support informed decision-making and staff engagement.
- **Greater business continuity preparedness:** Staff should be familiar with Business Continuity Plans and incident management arrangements, understand their responsibilities, and be confident in accessing plans during incidents.
- **Enhanced infrastructure and technology resilience:** Increased resilience is required across estates, cooling systems, vehicle fleets, data centres, CAD, and critical ICT systems, supported by robust contingency and recovery arrangements.

- **Innovative demand management approaches:** Early deployment of clinical support interventions, such as NHS 111 clinicians managing 999 demand, can significantly reduce operational pressure and improve patient flow.
- **Stronger patient and public communication:** Alternative methods of communicating with patients should be explored to reduce repeat calls and alleviate pressure on the EOC during periods of high demand.
- **Effective mutual aid arrangements:** Existing mutual aid processes should be reviewed to ensure timely and reliable support during prolonged, high-impact incidents.
- **Building resilience beyond staff goodwill:** While exceptional staff commitment was a key factor in maintaining performance, future resilience arrangements should be founded on sustainable systems, resources and processes rather than reliance on extraordinary individual effort.

Key Strengths and Good Practice

- **Strong Incident Management:** Rapid activation of Critical Incident and Major Incident command structures, supported by dedicated Incident Management Teams, improved coordination, oversight and decision-making.
- **Exceptional Staff Commitment:** Staff across the organisation demonstrated outstanding resilience, flexibility and professionalism, regularly going above and beyond to maintain patient care and service delivery during extreme pressures.
- **Effective Teamwork and Collaboration:** Strong cross-departmental working, particularly between Operations and Fleet, enabled rapid problem-solving and helped sustain operational capability.
- **Enhanced Operational Support:** Additional frontline resources were provided through overtime, managerial support, redeployment of corporate staff, increased clinical oversight in the EOC, and expanded fleet and mechanical support.
- **Clinical Innovation:** The deployment of NHS 111 clinicians to support 999 demand management significantly reduced outstanding calls and improved patient flow, demonstrating the value of early clinical intervention.
- **Improved Resilience Structures:** Enhanced command, control and communication arrangements, aligned to JESIP principles, strengthened situational awareness and organisational coordination compared to previous incidents.
- **Mutual Aid and Partnership Working:** Support from Yorkshire Ambulance Service, NHS partners, Local Resilience Forums and voluntary sector organisations enhanced resilience and helped manage sustained operational pressures.
- **Robust Risk Management:** Continuous review of operational risks, supported by effective service-wide communications, enabled a proactive and coordinated response throughout the incident.

Call data timeline



PSII review and Duty of Candour Summary

A significant element of the review focused on the Trust's Duty of Candour response during both the Critical Incident and Major Incident periods. **39 cases** were reviewed across Clinical Incidents and Patient Experience investigations. **Delays in ambulance response** were the dominant issue, with the overwhelming majority relating to **delayed arrival at scene**.

- Delayed arrival at scene (36)
- Delayed backup responses (3)

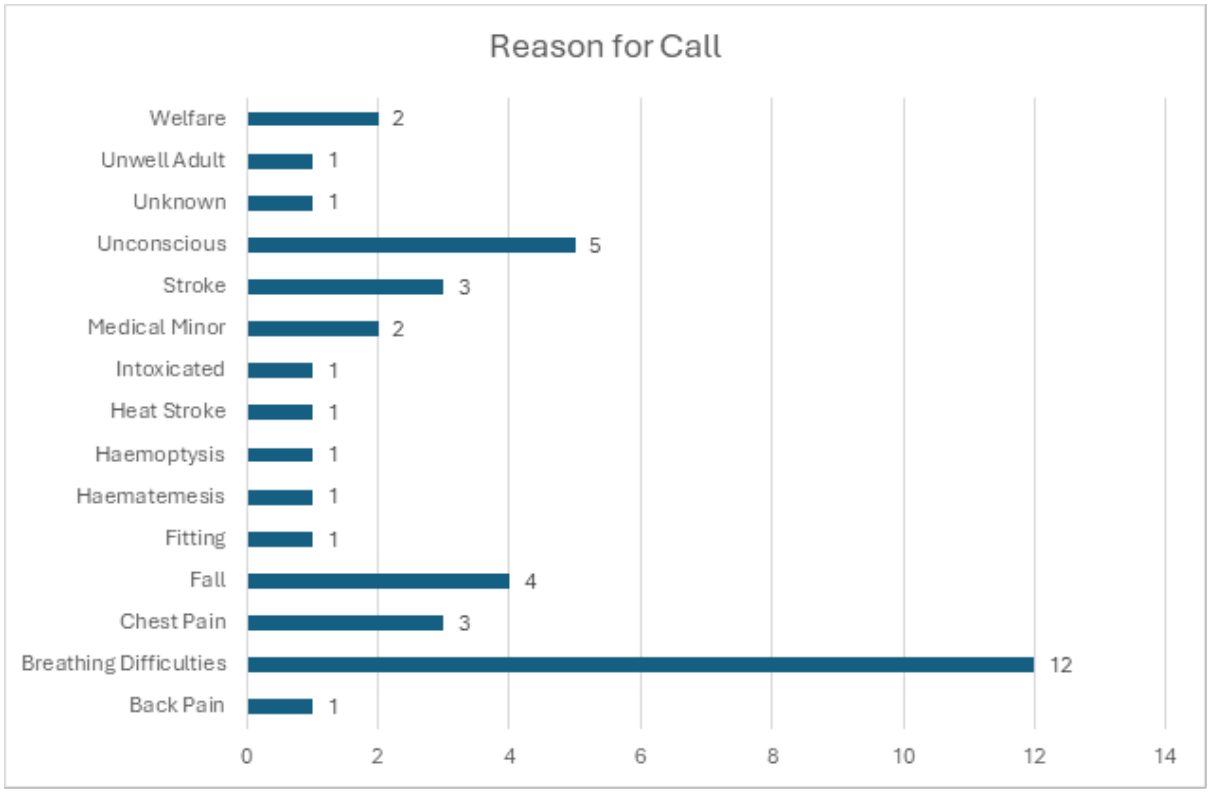
Patient Harm Recorded On Datix

- 21 cases **(53%)** death
- 9 cases **(23%)** severe harm
- 6 cases **(16%)** moderate harm
- 3 cases **(8%)** low or no harm

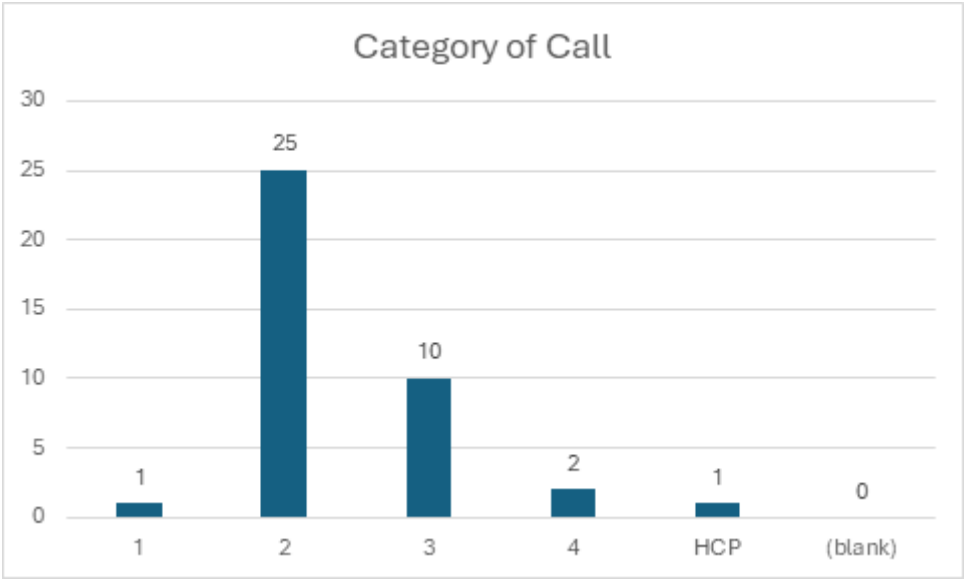
Combined, **30 of 39 cases (76%)** were associated with **severe harm or death**.

The most common presenting conditions were:

- Breathing difficulties (12)
- Unconscious patients (5)
- Falls (4)



Harm Occurred Across a Range of Initial Triage Categories



Escalation and Upgrading

41% cases were upgraded following initial triage, most often because of patient deterioration and repeat calls made to 999.

Duty of Candour letters were issued to those 39 cases as reported in the table below, demonstrating the Trust's commitment to openness, transparency and

compliance with statutory Duty of Candour requirements throughout the incident response and recovery process.

Period / Source	Cases Identified	Duty of Candour Outcome
Critical Incident (moderate harm or above)	28	All patients/next of kin notified.
Additional Patient Experience concerns (Critical Incident)	6	1 already included, 3 related to healthcare professional feedback (1 linked to an existing case), 2 new cases reviewed and DoC letters issued where required.
Major Incident cases meeting DoC threshold	6	All reviewed and managed under the Duty of Candour process.
Additional Patient Experience concerns (Major Incident)	**3**	**2 linked to existing cases, 1 new case received a DoC response.**
Safeguarding referral	1	Managed under Duty of Candour requirements.
Total Duty of Candour Letters Issued once duplicates removed)	**39**	**All affected patients or next of kin received notification.**

- For the **Major Incident period**, **6 incidents** were identified that met the threshold for Duty of Candour consideration.
- A further **3** Patient Experience concerns were received, **2** of which were linked to already identified cases.
- The remaining **1** case received a Duty of Candour response.
- An additional case was subsequently identified through the safeguarding processes and was also managed under Duty of Candour requirements.

Summary of Actions

No	Action
1	Review and revise escalation triggers for prolonged environmental and system pressure incidents
2	Develop a structured extreme heat preparedness checklist linked to Met Office and UKHSA warning levels
3	Review criteria and decision-making processes for Critical Incident and Major Incident declarations
4	Develop and implement an enhanced staff welfare plan for extreme weather events, including hydration, cooling and welfare monitoring arrangements
5	Review command and control structures for prolonged incidents and increase tactical resilience capacity where required
6	Standardise incident meeting structures, governance arrangements and battle rhythms for extended responses.
7	Ensure that response plans and training include consideration for commanders to provide greater operational context and rationale behind key decisions when communicating to staff
8	Ensure Business Continuity Plans are accessible, current and available to all relevant teams
9	Undertake a review of estate cooling infrastructure and implement identified resilience improvements, with a particular focus on staff welfare and operational effectiveness during heatwaves
10	Develop monitoring and alerting arrangements for temperatures within critical buildings, infrastructure and ICT environments.
11	Review data centre resilience arrangements, including cooling contingency plans and contractor activation processes. Ensure that the risk to data centre resilience is on the SCAS risk register at board level
12	Review CAD resilience, contingency arrangements and system dependencies to reduce the impact of future infrastructure failures.
13	Develop a formal process for early deployment of NHS 111 clinical support to the Emergency Operations Centre during periods of exceptional demand, to prevent call waiting volumes building beyond tolerable levels.
14	Exercise and test improvements identified through this debrief through future severe weather, business continuity and major incident exercises

Conclusion

Despite unprecedented operational pressures associated with the heatwave and system-wide demand, SCAS implemented extensive mitigation measures to maintain patient safety and service delivery, demonstrating significant organisational resilience and exceptional commitment from staff across the Trust.

The review identified several strengths, including effective incident management, partnership working and innovative approaches to managing demand, while also highlighting opportunities to further strengthen preparedness, communication, staff welfare, business continuity, and infrastructure resilience for future prolonged

incidents. Assurance was also provided through the comprehensive implementation of the Duty of Candour process, with all patients identified as having experienced harm receiving appropriate communication and follow-up.

It is therefore recommended that SCAS develops and implements a formal action plan arising from this debrief, with clear ownership, timescales and governance oversight, to enhance preparedness, resilience and response arrangements for extreme weather events and other periods of sustained system-wide pressure.