South East Coast Ambulance Service
NHS Foundation Trust

Trust Board Meeting to be held in public

4 December 2025

10.00-13.00

Redhill Suite, Banstead MRC

Agenda

Item No.	Time	Item	Paper	Purpose	Board Lead
Board Administration & Governance					
79/25	10.00	Welcome and Apologies for absence	-	-	MW
80/25	10.01	Declarations of interest	-	To Note	MW
81/25	10.02	Minutes of the previous meeting: 2 October 2025	Y	Decision	MW
82/25	10.03	Matters arising (Action log)	Y	Decision	PL
83/25	10.05	Chair's Report	Y	Information	MW
84/25	10.10	Audit & Risk Committee Report	Y	Assurance	PS
		EPRR Annual Assurance		Assurance	JA
85/25	10.25	Shadow Board Feedback	Verbal	Information	KN
86/25	10.40	Chief Executive's Report	Y	Information	SW
Strategy & Performance					
87/25	10.55	Board Story – Inspire Network	-	Framing	MD
Strategic Aim: Our People Enjoy Working at SECAmb					
88/25	Supporting Papers: a) Board Assurance Framework b) Integrated Quality Report				
89/25	11.05	People Committee Assurance Report	Y	Assurance	MP
90/25	11.20	EDI Priorities / WRES DES Data Insights	Y	Assurance	SWa
	11.40	Break			
91/25	11.50	Integrated Education Strategy	Y	Decision	JL
Strategic Aim: We Deliver High Quality Care					
92/25	Supporting Papers: a) Board Assurance Framework b) Integrated Quality Report				
93/25	12.05	Quality & Patient Safety Committee Report	Y	Assurance	LS
Strategic Aim: We are a Sustainable Partner as Part of an Integrated NHS					

94/25	Supporting Papers: a) Board Assurance Framework b) Integrated Quality Report c) Month 7 Finance Report				
95/25	12.35	Finance & Investment Committee Report	Y	Assurance	SO
Closing					
96/25	13.00	Any other business			MW

After the meeting is closed any questions received[1] from members of the public / observers of the meeting will be addressed.

[1] Only questions submitted at least 24 hours in advance of the Board meeting will be taken. Please see website for further details: Trust Board

South East Coast Ambulance Service
NHS Foundation Trust

Trust Board Meeting

2 October 2025

Nexus House, Crawley

Minutes of the meeting, which was held in public.

Present:

Michael Whitehouse	(MW)	Chair
Simon Weldon	(SW)	Chief Executive
David Ruiz-Celada	(DR)	Chief Strategy Officer
Jacqueline Lindridge	(JL)	Chief Paramedic Officer
Howard Goodbourn	(HG)	Independent Non-Executive Director
Jen Allan	(JA)	Chief Operating Officer
Liz Sharp	(LS)	Deputy Chair
Margaret Dalziel	(MD)	Chief Nursing Officer / Deputy Chief Executive
Max Puller	(MP)	Independent Non-Executive Director
Mojgan Sani	(MS)	Independent Non-Executive Director
Nick Roberts	NR)	Chief Digital & Information Officer
Paul Brocklehurst	(PB)	Independent Non-Executive Director
Peter Schild	(PS)	Independent Non-Executive Director
Richard Quirk	(RQ)	Acting Chief Medical Officer
Sarah Wainwright	(SWa)	Chief People Officer
Simon Bell	(SB)	Chief Finance Officer
Subo Shanmuganathan	(SS)	Independent Non-Executive Director
Suzanne O'Brien	(SO)	Independent Non-Executive Director

In attendance:

Peter Lee	(PL)	Director of Corporate Governance / Company Secretary
Janine Compton	(JC)	Director of Communications & Engagement

62/25 Welcome and Apologies for absence

MW welcomed members, and those in attendance and observing.

The following apologies were noted:

Karen Norman	(KN)	Senior Independent Director

63/25 Declarations of conflicts of interest

The Trust maintains a register of directors' interests, set out in the paper. No additional declarations were made in relation to agenda items.

64/25 Minutes of the meeting held in public 07.08.2025

The minutes were approved as a true and accurate record.

65/25 Action Log [10.32-10.32]
The progress made with outstanding actions was noted as confirmed in the Action Log and completed actions will now be removed.

66/25 Chair's Report [10.32–10.38]
MW summarised his report, setting the scene for today's meeting, and explaining the schedule of focus and emphasis on quality patient care, specifically models of care and the steps being taken to ensure a safe winter.

MW acknowledged Steve Lennox's contribution to our improvement journey.

There were no questions.

67/25 Audit & Risk Committee Report [10.38–10.50]
HG summarised the output of the last meeting as set out in his report, reinforcing the We Will Statements and mid-year self-assessment. Despite the positive number of Moderate Assurance reviews the committees continues to be curious to ensure continuous improvement. The IT review provided limited assurance related to the outstanding actions, which are now covered by the new digital delivery plan.

MW asked about Internal Audit and reference to the sexual safety survey and when we will know we are really making a difference. SWa is the executive lead and explained the role of the Steering Group now in place with a range of workshops planned to accelerate our response; the priorities reviewed at People Committee; and using staff stories to respond to concerns. She acknowledged this is an ongoing challenge but there is focus to build a different culture. MP added that when we look at the impact of the Plan we will need to take a holistic view and so at audit committee we asked for BDO to undertake a deeper dive next year to ensure we really do achieve the outcomes we need.

The Board then explored in the context of cyber risk, whether we are doing all we can heading into Winter. NR responded that we have made additional interventions to improve the position including with our capability and capacity. And with SACS we are working on further capability. We recognise our limitations in avoiding an attack and so the focus is to ensure robust processes that will recover quickly.

MW reflected that overall, there is good assurance from the work of this committee.

68/25 Shadow Board Feedback [10.50–10.58]
MP provided feedback from the meeting this week with the Shadow Board focussing on Models of Care and Winter Plan. The Shadow Board is pleased to see its feedback last time reflected in the CEO report this month. MP then took the papers considered in turn.

<u>Winter Plan</u>
There was a presentation from James Pavey which helped to explain the collaboration to ensure winter readiness. Some questions and challenge including the availability of PPE.

<u>Models of Care</u>
This helped to get into a key strategic priority and the feedback was about how we evolve the clinical scope of practice and how we influence Universities to ensure new skills of the future are in place. Also, how we use data to influence our work.

Education Strategy – hot topic

The Shadow Board welcomed the opportunity to provide input at this early stage of the thinking – it supported the approach for a holistic strategy that includes corporate and non-clinical people. Plus providing time for staff training.

In summary, MP commented that while it is still early days, there is good commitment and curiosity, and members are finding their voices.

MW asked the Shadow Board members observing if they would like to add anything. They did not other than to confirm the summary from MP was good. MW reflected that we are the only trust to organise a Shadow Board in this way and is supportive of way it is progressing.

69/25 Chief Executive's Report [10.58–11.18]

SW highlighted specific areas from his report. He attended a national leaders event recently and the three clear asks are; delivery of the money (NHS exists the first half of the year in a good place financially but we need to build on this); ensure robust plans for Winter (there is a need for Board assurance as per the paper later on the agenda); and linked to Winter, the third area is vaccination.

Restart heart day is coming up later this month and something we can all do is sign up to Good Sam. The executive had a training session on CPR and will all be signing up.

SW drew attention to FTSU week 13-17 October and the theme this year is 'follow up with action'. To that end, we have a desire to have FTUS champions within our new divisions to help embed a culture of local conversations.

Awards are this month too and for the first time we will be presenting a long service medal to EOC staff. This acknowledges their critical contribution. SW thanked them for all they do; they are the first person people speak to at often the most scary times of their lives.

The Charity launched this morning and SW thanked the High Sheriffs for their support. We talked in April about areas where we have less public access defibs and the charity will help address this very issue.

Lastly, SW added his thanks to Steve Lennox who has provided invaluable support to him and members of the Board.

MW thanked SW and the executive team for all the efforts, with so much to do. He then open to questions.

HG asked about the NOF league tables and the metrics which appear to be fairly random. For example, it does not include cardiac survival rates or any patient experience metrics. Despite coming out reasonably well in 4th place it does seem random. SW responded that we did have this discussion at the national leaders event and there is a genuine desire to make information more publicly available. This is not the first time the NHS has had league tables. When comparing in this way there will be limitations. The metrics have been carefully considered and while not what we would have chosen they do support some of the right conversations. Commissioners are separately looking to commission against clinical outcomes and SW expects the metrics to evolve, accepting we needed to start somewhere.

On the staff survey the Board noted that at the end of week 3 we at over 40% response rate indicating a good level of engagement. Double what it was this time last year.

MS referred to the 10 year plan and neighbourhood models. She asked for more information about the challenges identified by the ambulance service. SW explained that he represents the sector on the national

neighbourhood health group. There are two main challenges, the first is restoring confidence in neighbourhood services more generally. There are too many calls to 999 as few viable alternatives. Secondly, there is much ambition, but it will be how we scale quickly enough so people don't feel this is just another set of words; 43 pilot sites is a good start but will need to scale to every community. Lastly, this needs to reflect the differences e.g. urban v rural.

MS noted that October is also black history month, which the Board acknowledged.

70-73/25 We Deliver High Quality Care [11.18-12.58]
The BAF and IQR informed the discussion and questions in this section of the agenda, which were framed against the assurance provided by the Quality Committee.

LS summarised the output of the most recent meeting of the **Quality & Patient Safety Committee** outlining the areas covered under the different headings of Alert, Assure and Advise.

MW acknowledged the work of the quality leads in driving the agenda. He then asked the Board to turn to the specific papers:

Models of Care
RQ introduced three clinical colleagues to join him for this item – Imogen Baldock; Vicky Lewis; Dan Cody. He reminded the Board of the 11 models of care to support delivery of the trust strategy. Today there will be an overview of the three focussed areas and the progress we have made since April.

<u>End of Life Care</u>
Imogen talked through the slides in the pack. The new dashboard is helping to gain better data insights, e.g. most calls are between 9-11am potentially linked to unavailability in primary care. 78% see and treat and the plan is to completely reverse this. She gave an example from a call just this morning where a family member called as they did not know where else to seek help, which highlights a key issue. There is a focus too on the high number of resus for people with a DNR in place.

MW thanked Imogen for the clarity on the work being done.

SO asked about the need to track this particularly in the context of an ageing population. She commended how we are translating data into insights and asked that we also track interventions that lead to results.

HG asked about next steps and the work to engage ICSs. There are some good ideas coming out and he wondered how we spread this across our patch. Imogen responded by explaining the discussions ongoing with system partners, using our data and insights. Conversations are at an early stage, but it is encouraging to work through the scale of the problem. HG attended a committee in common in Sussex where he raised a need to ensure advanced care plans and having these available.

MD stated a need to keep in mind the divisional governance groups and their connections into the system where we can influence. There is only so much systems can focus on and currently end of life care isn't one. So, it is about us reinforcing the issues with data.

NR commented on care records and some of the things we are doing, including approving the roll out of GP connect across whole region. Also, rolling out Kent and Medway care record as a pilot. We intend to then roll out wider and this will give us direct access to end of life care records.

MW asked DR and SB about the new commissioning model and availability of funding. DR have the example of providing data to show impact, otherwise it won't be seen. MW asked if commissioners would recognise this as a specific service. DR responded that this is largely un-commissioned work. Therefore the question is what our role need to be to contribute to UEC across the region.

MW thanked Imogen again and is assured by the quality of work.

Fallers

Vicky Lewis talked to the slides on this model of care and areas we are working on, linking to winter resilience.

MW asked how far are we from this being a mature core offering, i.e. the trajectory. Vicky responded that key skills training is helping and longer term it is about access to the right services that are more appropriate. RQ added that the ambulance sector hasn't really tackled this; AACE launched a falls framework this year. The most important thing is to stop people laying on floor for too long, making their health worse. There is not one solution as many services are commissioned to respond to people who fall. Where we need to respond we do generally do so quickly. RQ felt we are at the start of the process.

MW reflected that much depends on commissioners understanding and public awareness. RQ responded, the public awareness of people who fall over is very low. We need to adapt our response as it is not always about an ambulance being sent. He felt that public awareness is more tricky to resolve.

SW added that ambulance services are commissioned in a fairly reductive way, e.g. time bound standards. The opportunity with a single strategic commissioner will be to influence as DR mentioned. C1-4 hides a wide range of clinical conditions requiring differentiated response. SW confirmed that we will use this presentation to inform national discussions re neighbourhood health.

Cardiac Care

Dan Cody then outlined work in this model of care, related to patients where speed of response is critical. He reinforced the link to the trust strategy in responding differently to ensure when people need an ambulance there is one available immediately. This is about saving lives and relates to bystander CPR / PADs / CFRs. And the health inequalities referred to earlier.

SO asked about the inequalities highlighted and in light of divisional structure how this will help get us in to communities to deal with these inequalities. SW responded, in short, yes. As the model matures he will expect divisions to identify specific areas of greatest need. SO asked about the role of the charity too and SW agreed this is one of the charity's missions to make PADs more available and to attract volunteers.

JA added, the divisional framework is a delivery vehicle to localise our response, and she described the inventions and how NED alignment can support the specific divisions.

MW felt that the CFRs point is really well made and asked if we can we tap in through AACE and others to understand how they have approached ensuring CFRs from less well served communities. Dan outlined some of the learning that is available and the link to work of community resilience volunteers strategy.

MW summarised that this provides good assurance we are being proactive.

[BREAK 12.30-12.40]

Winter Plan

JA made a few overall remarks from the Plan, which is a refreshed process and good to note it has been a more focussed approach; including the assurance statements and check list to support this assurance. The regional winter plan check and challenge was in early September, which was helpful to compare and contrast and to network to help relationships that will be important in our collaboration over winter. The Plan is part of our broader resilience framework and so is a live plan that our divisions will keep under constant review. JA outlined the specific areas of focus including our internal oversight of demand management and productivity.

JA then referred in the document to where we show how we have considered all the check list items, reinforcing the ongoing challenges and risks.

MW confirmed the Board responsibility to be assured as reasonably as we can. This comes recommended by EMB, and he asked each of the NEDs for their specific view, noting the review by the finance committee, which SO outlined.

- HG felt that this is the best winter plan he has seen, and it comes in good time. His only residual concern is our undertaking of the work at Nexus House at the start of winter. He appreciates how much work there has been to prepare but is still a concern.

- MP has no concerns, but reflected from the Shadow Board meeting one element of caution related to communication of it as one item on the check list relates to cancellation of annual leave; does this mean staff leave might be cancelled?

- PS has no concerns.

- LS did have some concerns re hear and treat and spent time with JA to discuss these. She gained assurance there is adequate resilience in the plan to respond if levels are not achieved.

- PB went through this in the Resilience sub-committee, and the main feedback was how we get people to understand it.

- SS asked about how we engage partners.

- MS asked about target for vaccination.

JA then responded:

- The target for vaccination (flu only as COVID only for specific groups) is 5% extra. So, 78.6%.
- There is no plan to offer RSV vaccinations but on the list is how we respond to a RSV outbreak, illustrating the fact this is a live document.
- The Plan is comprehensive but doesn't apply to all so we will cascade the right parts to the right people, so as to not confuse colleagues.
- In terms of annual leave, our REAP already includes this in high levels of escalation, so we need to strike the balance between not setting hares running and being clear this is an option to consider if the need arises, albeit unlikely.
- H&T – the Plan protects patients over winter so long as the H&T rate continues as it is currently. And to improve performance we need to increase this to meet performance obligations; there is a live discussion on how we shift improved rates through a range of measures.
- JA is not concerned about the timing of Nexus House as mitigations are in place, but these will of course be continually monitored.

The Board approved the Winter Plan, acknowledging it will continue to be a live document.

74-75/25 Sustainable Partnerships [12.58-13.15]
The BAF & IQR informed the discussion and questions in this section of the agenda, which were framed against the assurance provided by the Finance & Investment Committee (FIC).

SO summarised the output of the most recent meeting reflecting on how constructive the meeting was with good quality papers. The committee does not underestimate the financial challenges but is assured by a robust a plan as we could reasonably expect.

On cyber risk, this cannot be understated, and we need to be very aware of the controls in place to ensure awareness and as NR mentioned how we respond should an attack happen.

SO then reflected on the strategic aims and the tension to deliver quality for our people and ensure sustainability. This is a big ask and commended the executive team on how they are meeting these challenges, noting the link to good use of resources and quality patient care.

SB added that positioning the finances is really important. There is a change in the performance regime from NHSE with much more monthly focus on our financial position. In particular, how we address the underlying deficit and how we get to the end of the year at a breakeven position.

MW stated that part of financial deal this year is achieving C2 mean, which secures the additional £10m. There was some risk to this earlier in the year and asked if this is now resolved. SB responded that we are as confident as we can be this will be achieved. He is not flagging any specific risk, confirming the C2 target is now 27mins linked to the system productivity gap, which the region accepts.

MW asked if there are any funding concerns re digital strategy delivery. NR confident this is seen as a priority, and we have allocated capital funding to support this. It is going through the business case process currently to define the investment and expected benefits. SB agreed with this.

SS asked about the impact of the under delivery of efficiencies on the breakeven position. SB responded that the plan is always skewed to the backend of the year – we have a robust quarterly review process all the actions from Q1 are being taken. Nothing to report that puts the overall financial plan at risk.

SW came back to digital and the expectation to collaborate. The upcoming meeting with the SACS Board will confirm where we invest in the same things. While we will still need to invest locally we will also need to watch the interface between local and national.

On efficiencies, as we head in to the planning round, SW explained there is a different exam question e.g. how we become sustainable / reduce the underlying deficit. When we sign off the plan in December the expectation is to have a route map to recurrent balance. This will bring in questions about the collaboration with SCAS and work with commissioners.

76-77/25 Our People Enjoy Working at SECAmb [13.15-13.25]
The BAF & IQR informed the discussion and questions in this section of the agenda, which were framed against the assurance provided by the People Committee.

MP summarised the output of the most recent meeting of the **People Committee**. There was a good review of risk and the IQR and we sought greater clarity and assurance on the areas of the IQR set out in the report.

SWa referred to the people services restructure and the ability to ensure the right capacity to deal with challenges re ER cases / grievances. We are at 90% capacity now and the transition team is in place to support the new model. This will help accelerate resolution of legacy issues. A new role is in place to support TU relations, and there is much work on core people policies with the aim by Q4 to agree these in collaboration with TUs.

SWa noted this is black history month explaining we have podcasts which our staff networks have developed. There is also the first leadership conference on 30 October related to compassionate leadership where 200 leaders will come together to have time and space to reflect on the journey ahead.

JL confirmed that our response to NHSE education quality intervention is on track to. There was a positive meeting in July agreement we are taking the right actions. This includes some ambitious, but NHSE is pleased with our plans and our intent on making sustainable change.

SW added that we are now at a stage where we need to move away from a top down view of the world and get a more localised conversation. He also highlighted the leadership conference and the important link to the earlier discussion about education for all colleagues.

78/25 AOB
None.

MW reflected that he hopes the public would recognise the seriousness the Board takes its responsibilities. Good progress is being demonstrated showing the value of our courage in taking forward some of our strategic priorities. High standards of integrity shown too, and kindness. He thanked everyone for all they do.

There being no further business, the Chair closed the meeting at 13.25.

PL confirmed there have been no questions from the Public.

Signed as a true and accurate record by the Chair: _____

Date _____

Meeting Date	Agenda item	Action Point	Owner	Target Completion Date	Report to:	Status: (C, IP)
05.06.2025	32 25	The People & Quality Committees to oversee the development of the new Volunteer Strategy, which will then come to Board in December for approval.	JA	05.02.2026	Board	IP
07.08.2025	52 25	Finance Committee to receive assurance on the plan and timing of the six business cases related to the digital plan.	NR	27.11.2025	FIC	C

Key

- Not yet due
- Due
- Overdue
- Closed

ɔard Action Log

Comments / Update
The strategy has been reviewed by the quality and people committees (Nov) and following further review and the development of an associated business case, the strategy will come to the Feb Board for approval.
As set out in the committee report, it is assured with progress against the plan.

South East Coast Ambulance Service
NHS Foundation Trust

		Item No	83-25
Name of meeting	Trust Board		
Date	04.12.2025		
Name of paper	Chair Board Report		
Report Author	Michael Whitehouse, Chair		

Introduction & Board Meeting Overview

Meetings of the Board are framed by the Board Assurance Framework (BAF), against the three strategic aims:

We deliver high quality patient care

Our people enjoy working at SECAmb

We are a sustainable partner as part of an integrated NHS

The BAF helps to ensure ongoing Board oversight of the delivery of our strategic priorities; in year planning commitments; and areas of compliance. It provides the Board with clarity on progress against the organisational objectives and the main risks to their achievement, thereby informing the Assurance Cycle.

This meeting has a specific focus on our strategic aim: *Our People* with discussions on the WRES DES data insights and progress against our EDI priorities, and a new integrated education strategy.

One of our aims this year has been to hear different voices, and we will look forward to considering once more the views of the Shadow Board.

Board Development

It was a privilege to welcome Professor Michael West who was the keynote speaker at our first Leadership Conference, held last month. Prof. West first met with the Board to explore the evidence linking trust and Board performance, practicing compassionate, inclusive, and collective leadership. The Board was then joined by almost 200 colleagues from across the Trust, where we collectively discussed the challenges and how we can lead in more courageous and compassionate ways to ensure the continued delivery of high-quality, compassionate care for patients. It was a very thought-provoking session. We intend to run this conference on an annual basis.

Aligned to this, the Board is engaging with an external expert to support how we continue to ensure a more inclusive organisation. This will be a focus in Q4 and will build on some of the progress we are making, as reflected in the EDI / WRES DES paper on the agenda.

Collaboration

I thank our Board colleagues from South Central Ambulance Service for the really constructive meeting with had in October, where we agreed the outline business case, that brings both organisations closer together for the benefit of our populations.

We have agreed to form a Group Model, the structure of which is yet to be defined, with the first step being to establish joint leadership arrangements. The search for a Group Chair and Group CEO is due to start shortly. The plan is to make both appointments by April 2026.

This collaboration has the opportunity to achieve many benefits and as a Board we are fully committed to it.

Engagements

My engagements in the past month included representing SECAmb at the annual NHS Providers Conference in Manchester at which the Secretary of State gave the keynote address. I was particularly impressed by the presentations on AI and the case examples where this is delivering advances in healthcare.

I attended the monthly meetings of Chairs in Surrey and Kent and the monthly update provided by NHS England.

And I was pleased to support Simon Weldon in hosting a successful visit by Daniel Elkeles, CEO of NHS Providers to our Make Ready Centre and 111/999 at Medway.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	84/25

Name of meeting	Trust Board
Date	04.12.2025
Name of paper	Audit & Risk Committee Assurance Report – 20 November 2025
Author	Peter Schild, Independent Non-Executive Director

INTRODUCTION

This assurance report provides an overview of the most recent meeting on 20 November 2025 and is one of the key sources that the Board relies on to inform its level of assurance. It is set out in the following way:

- **Alert**: issues that requires the Board's specific attention and/or intervention
- **Assure**: where the committee is assured
- **Advise**: items for the Board's information

At the start of each meeting the committee asks the Chairs of the other committees to confirm if they have identified any significant internal control issues. There are currently none, although the quality committee noted its ongoing review of the risk identified in EOC, which the Board is aware that led to the quality summit earlier in the year, and the ongoing assurance the people committee is requiring related to our approach to sexual safety.

ALERT

Emergency Preparedness Resilience Response (EPRR)
The committee considered the outcome of the EPRR Annual Assurance assessment, which will be presented to Board. This is a really positive news story in how we have over the past 12-18 months strengthen our controls for EPRR. This is the first time we have been assessed as Substantially Compliant since 2019. The recommendations from 'Manchester Arena' are to be incorporated into the national core standards for next year.

There are a number of opportunities this opens and as part of the group model the executive will be establishing joint priorities to operate in more joined up way with SCAS.

Lastly, the committee reflected that only 18 months ago this was an area of significant concern, so it is really encouraging to see this level of sustained improvement.

Constitution
The committee supported the proposal to make two amendments to the Constitution, which is recommended to the Board (part 2). Subject to its decision this will then be presented to the Council of Governors, as changes to the Constitution require the approval of both the Board and COG.

ASSURE

Internal Audit
The Internal Audit plan is progressing well. To-date there have been no 'below the line' audit reviews and no high-risk recommendations; this demonstrates an effective internal control environment.

At this meeting two final reviews were received:

1. Station Visits (focus on medicines management) – this provided Substantial Assurance, having identified a number of positive things in place both in terms of the design and implementation of controls. The committee congratulated the executive for this progress and acknowledged the positive impact made by Shani Corb, Chief Pharmacist.
2. Financial Systems (Budgetary Control) – another positive outcome with Substantial Assurance for the design and Moderate Assurance for the effectiveness of controls, which recognises the further improvement needed with budget setting.

At the next meeting in March we will receive a draft Annual Head of Internal Audit Opinion, and based on the findings from the Internal Audit Plan to-date, the committee is hopeful of another positive outcome.

Risk Management
The Committee remains assured with the arrangements in place to support effective risk management. As reflected in the related reports to the Board, there is good risk reporting into the other board committees, helping ensuring visibility of the key risks.

In terms of compliance, the committee noted the recent decline in the number of risks overdue review, and so the committee will test at its next meeting the extent to which this is becoming a trend.

Policy Management
As with EPRR, policy management was another area 18-24 months ago that the Board had significant concerns about. It was identified in the 2023 Annual Governance Statement as a Significant Internal Control Issue and an Internal Audit that year provided 'minimal assurance'. This led a redesign of the controls, and this has supported sustained improvement in the effective management where we typically run at around 90% compliance (policies in date).

Maintaining compliance requires the effort of a number of colleagues and in the next 12 months 90 policies and procedures are scheduled for review. To mitigate the related risk, there is a comprehensive plan to ensure this level of review is achieved.

Counter Fraud

The Committee received an update on counter fraud activity, with good progress being made against the workplan. The committee continues to be assured that the Trust is responding appropriately to evolving fraud risks. In response to an interesting discussion about colleagues who have secondary employment (common across the sector), the committee will review in March how this is being managed, in particular to ensure the ongoing wellbeing of our people.

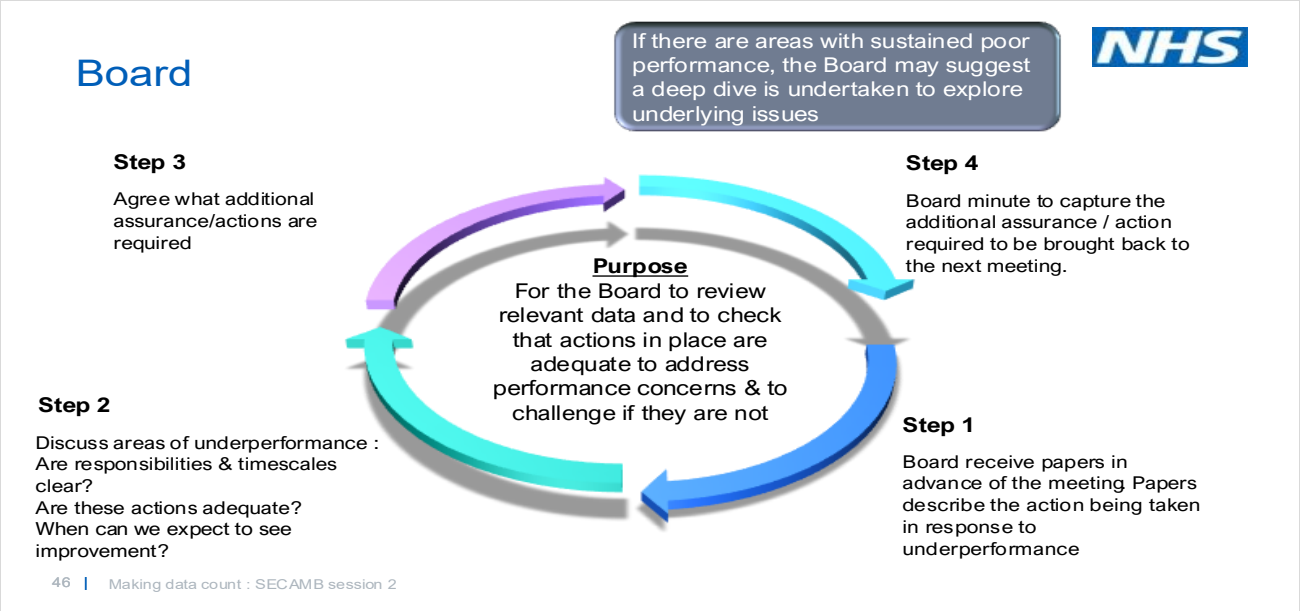
ADVISE

Integrated Quality Report

The Chief Operating Officer set out the ongoing plan to improve the IQR, which the committee supported. The Board will see these changes in the versions between now and April 2026.

Recommendation

The Board is asked to use the information within this report to inform its overall view of assurance and where gaps are identified to seek further assurance from the executive in line with the Assurance Cycle



South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	84-25

Name of meeting	Trust Board
Date	4 December 2025
Name of paper	2025 NHS EPRR Core Standards and Interoperability Standards Assurance update
Responsible Manager	Jen Allen, Chief Operating Officer and Accountable Emergency Officer (AEO)
Author	Lucas Hawkes-Frost, Divisional Director of Resilience and Specialist Operations

As an NHS Trust and provider of national capability programs, SECAmb is required to undergo an annual assurance and review process around the NHS EPRR Core Standards and NHS Interoperability Standards. These standards and the review processes around them are a fundamental part of the governance system for assuring capability, planning, and readiness in an auditable, consistent way internally, locally, regionally, and nationally.

In 2025, SECAmb undertook the annual review and assurance process in collaboration and concert with South Central Ambulance Service (SCAS) and the Isle of Wight (IoW).

Building on the progress made in 2024, SECAmb provided assurance around outstanding workplan items as well as identifying a range of areas within both the Core and Interoperable standards where further work will continue, SECAmb has agreed a final position of 'Substantially Compliant', improving on the position from the previous cycle.

Standards assurance processes are taking place presently, in conjunction with ICB and NHSE colleagues. Final approval of SECAmb's 2025 assurance results will take place on the 18th of November at the Local Health Resilience Partnership Executive group.

EMB reviewed this at is meeting on 5 November and commended the achievement to obtain substantial compliance.

Recommendations, decisions or actions sought	For information and assurance on behalf of the AEO.

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Audit Committee Update – 2025 EPRR Core and Interoperable Standards

Lucas Hawkes-Frost

November 2025

Headlines - Resilience and Specialist Operations

- Substantial structural and personnel changes this year
- Specialist Ops Culture plan continues separately
- Division still forming as part of clinical ops model reforms
- Significant development in Resilience functions including alignment of Resilience managers to Divisions
- Particular focus on ‘resilient organisation’ efforts and divisional resilience
- Community Resilience to join Division in Quarter 4
- Significant collaboration ongoing with SCAS

Oversight and Scrutiny

Group	Chair / Lead	Purpose
Resilience Sub-Committee	NED / Paul Brocklehurst	Non-exec assurance of progress against R&SO recovery process
Resilience Oversight Group + Exercising and Learning Sub-Group	Divisional Director for Resilience and Specialist Operations + Head of Resilience	Pan-SECAmb scrutiny and challenge of resilience functions and assurance against standards. Connection to organisational learning and QMS.
NHSE / ICB Assurance	Andy Wapling (NHSE) / Mark Twomey (Surrey Heartlands ICB)	Assurance against national standards and Civil Contingencies obligations.
External Quality Assurance	NHS ECU (NARU)	Assure alignment of training / operational delivery with National interoperable capability specifications (October 2025)
Divisional Governance Group	Clinical Lead for Spec Ops	Provide scrutiny and assurance around quality, clinical governance, safety and clinical practice via QCGG
Local Resilience Forums (x4), Local Health Resilience Partership (LHRP)	Various	Resilience planning and assurance across wider community under CCA 2004 and to assure health resilience regionally. LHRP Assurance 18/11/25.

NHS ECU Quality Assurance Feedback

“Can I please extend a huge thanks to Viv as our lead instructor, but also to Steve, Piers and the learners for being so welcoming, inclusive and open throughout the day.

I noted many carefully considered, positive examples of good teaching practice, which resulted in an exceptionally high standard of learner performance during the final teaching sessions of the day.

There was also a very clear desire and culture amongst all of your instructors to constantly improve their training provision, to give their learners the best experiences possible; as such, it was a genuine pleasure to spend time with everyone yesterday.”

Manchester Arena - Status update

- Substantial progress against recommendations
- Various recs expected to be reflected in revised national standards
- AACE escalation re Recs 105-107. Recs not progressed owing to central funding (or as part of national initiatives, etc)*
- Indications of intent to review funding business cases submitted 2+ years ago
- SECAmb continues to report via MAROG and NEPRRG
- Various internal progress – Body Worn Video

Manchester Arena Inquiry Recommendations– key updates from 2024

Theme	Identified Gap	Implications	Mitigation / Plan / RAG
Ability to respond to 'Reasonable Worst Case Scenario' incidents according to National Security Risk Assessment (Business Case outlined need for +40 additional DCA units)	No funding provision outlined from NHSE re Manchester arena recs.	Complexities of attending and resourcing a major emergency. Definitions against RWCS are broad and require national cooperation around developing capabilities in conjunction with NRCT (NARU), etc.	• This risk is common across all emergency services. • LRF risk systems to identify threats • SECAmb NILO role and cohort expanded dramatically • Business case and funding outline with NHSE • SORT and HART uplift
Compliance with suggested HART full scope of practice	Previous SECAmb position that these functions have been provided via CCP and medical resources.	Potential for limited clinical intervention in 'hot zone' working, particularly advanced analgesia	• SECAmb involved in development of national specifications • HART Scope enhancement a central aspect of HART Culture plan • Spec Ops Governance model established.
Engagement with private events and allocation of Event Liaison Officer roles	Requirements on private event organisers sit outside SECAmb purview	Potential vulnerability to under-resourced public event.	• SECAmb provides advice and participates as part of TCG/SCG/SAG processes for events.
Progression of body worn cameras for those in command roles	Specific focus within Saunders report on value and importance of recorded evidence to inform subsequent analysis.	Manchester Inquiry identified that recorded decision making improved the quality of logging at Manchester Arena.	• SECAmb first nationally to implement BWV for commanders with live stream • BWV now in place

2024/2025 – National Standards Lookback (Core / Interoperability)

South East Coast Ambulance Service NHS Foundation Trust

- Substantial Progress against 2023/24
- Focus on 3rd-party business continuity assurance
- Substantial push on JESIP commander compliance
- ICB assessment positive with clear workplan agreed
- **First 'Substantially Compliant' for SECAmb since 2019**

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	9	2	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	10	1	0
Hazmat/CBRN	1	1	0	0
CBRN Support to acute Trusts	7	6	1	0
Total	58	54	4	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Cyber Security	11	9	2	0
Total	11	9	2	0

Interoperable capabilities	Total standards applicable	Fully compliant	Partially compliant	Non compliant
HART	32	30	2	0
SORT	40	40	0	0
MassCas	14	14	0	0
C2	36	36	0	0
JESIP	13	11	2	0
Total	135	131	4	0

Update – Partially Assured **Core** Standards (24/5)

NHS South East Coast Ambulance Service NHS Foundation Trust

Standard	Identified Gap	Implications	Mitigation / Plan / RAG	Update / Outcome
(13) The organisation has arrangements in place to respond to a new and emerging pandemic	Pandemic plan in draft	Agreed plan not yet in place.	Plan to be implemented within Q4. Plan in late stage of development, existing IPC procedures in place	Complete and implemented. Exercise Concilllium (12/11/15) to test and refine.
(17) The organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	HQ building work currently in planning.	Risk of unauthorised access to EOC, HQ.	Trust security existing arrangements in place, ie pass codes on ID cards, etc.	Agreed and compliant as part of 2025/6 assurance process.
(53) The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Supplier BC review and assessment not completed prior to assessment.	Supplier BC under review. Potential for interruption to supply / service.	Workplan for completion in line with Yorkshire model by January, 2025 (must be complete Aug, 25). Further engagement required from procurement to continue analysis of contracting and contractor resilience.	Complete and implemented. BC assessment process now integrated as part of contract management.
(70) Following each formal review of the capability within a designated hospital, copies of all reports must be retained by the NHS Ambulance Trust for at least 10 years.	SECAmb does not hold files older than 2021.	Standard not reflective of previous practice.	Engagement with National Team around amendment to standard. Evaluation of external sources of evidence, ie hospitals	Current practice highly effective and well evaluated. Awaiting revised standards publication.

26

Update – Partially Assured **Interoperability** Standards (24/5)

Standard	Identified Gap	Implications	Mitigation / Plan	Update / Outcome
H8 - Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times (24/7)	Staffing challenges for HART identified in HART improvement plan.	Potential non-compliance with national interoperability standards	HART improvement plan. Recruitment and training plans in place with appropriate recurrent funding for HART uplift to teams of 7 FY 24/25 and then teams of 8 for FY 25/26.	HART improvement plan continues. Gatwick site now fully established. HART Team leaders positions filled, HART Training manager recruited, HART/SORT OUM recruited. Ashford specific recruitment ongoing as well as wider attendance management focus. 8 paramedic vacancies to fill. Remain partial until filled.
H30 -Ensure that all HART equipment is maintained according to applicable standards (abridged).	Current system vulnerable to error owing to lack of access control. Interim process in place	Equipment currently tracked and maintained, however reporting a challenge on a system level and full access for all users presents accuracy challenges.	Procedure updated. Reviewing suitability of D4H based on systems access and reporting capabilities. Exploring Fleetman and other systems.	Highly reliable and robust process in place for asset management and maintenance. Equipment Support Techs x 2 now in place.
J8 - All staff required to perform a command role must have attended a one day, JESIP approved, interoperability command course.	Standard requires that all commanders have attended JESIP each 3 years.	If not addressed, cohorts of commanders will become non-authorised	Further dates for revalidation to be planned from Jan 2025, monthly revalidation sessions to be held with multi-agency partners. Further awaiting guidance from JESIP to set the standards for 2025/26 which will guide planning.	All relevant staff expected to be compliant by January 2026. Self-assessed as partially compliant until completed.
J9 - All those who perform a command role should annually refresh their awareness of JESIP principles (abridged)	Engagement with some aspects limited across the organisation.	As above	As above	Complete and assured.

2025/26 Compliance

Overall assessment:	Substantially compliant
Interoperable capabilities:	Substantially compliant

- Further progress around core standards assurance. 2 standards partial (vs 4 in 2024/5)
- 3 Interoperable standards partial (vs 4 in 2024/5)
- JESIP commander compliance substantially improved.
- ICB assessment undertaken in conjunction with SCAS and IoW for first time very positive with clear workplan agreed
- **Improved 'Substantially Compliant' position.**

Interoperable capabilities	Total standards applicable	Fully compliant	Partially compliant	Non compliant
HART	32	31	1	0
SORT	40	39	1	0
MassCas	14	14	0	0
C2	36	36	0	0
JESIP	13	12	1	0
Total	135	132	3	0

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	9	2	0
Hazmat/CBRN	1	1	0	0
CBRN Support to acute Trusts	7	6	0	1
Total	58	55	2	1

25/26 Action Plan

NHS South East Coast Ambulance Service NHS Foundation Trust

Standard	Identified Gap	Implications	Mitigation / Plan	Progress Update and Current RAG
47 – Business Continuity Plans – The organisation has BCPs for the management of incidents. These should detail how it will respond, recover and management its services during disruptions.	7 BCPs are currently beyond review date, with programme underway to complete these reviews and bring back to compliance, anticipated to be completed in next 3 months..	Reduced confidence in BC Capability Increased Vulnerability Audit and Assurance Deficiency Reputational Risk	A formal programme is underway to review and update these BCPs. Improved tracking mechanisms are needed to prevent future lapses including the input from all directorates. The EPRR team are conducted a comprehensive review of how it manages Business Continuity over the next 12 months and this sits on the risk register.	7 Plans remain out of date. These have been chased with Directorates. Urgent revisions are underway with most, if not all of these. Deadline to be provided with escalation to Executive Sponsor if not met.
48 – BC Testing and Exercising – A procedure is in place whereby testing and exercising of BC plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from incidents.	SECAmb has a procedure which supports the testing but in principle, a significant portion of our BC Plans haven't been tested in the last 12 months nor can we evidence the ones that have.	Reduced confidence in BC Capability Increased Vulnerability Audit and Assurance Deficiency Reputational Risk	Over the next 12 months, all BCLPs should have been tested and this test recorded.	Development of systems and processes underpinning BC ongoing. BC a key aspect of SCAS collaboration. Evaluating the potential for joint procurement of BC software solution. Testing and embedding insights and lessons important as an organisational priority in work planning.
S5 – SORT Establishment. Trusts should have 35 SORT staff on duty between the hours of 06:00 and 02:00 daily.	SORT is currently over-delivering against national standards, challenges remain in sustaining adequate coverage during late evening periods. These challenges are primarily due to complexities within trust rotas and local station-level agreements.	Service Delivery Risk Governance and Assurance Risk	Once the proposed changes to rota and scheduling practices are implemented, SECAmb will achieve full compliance with evening SORT coverage requirements. An action card has been issued to the Scheduling Team to initiate these adjustments	Spec Ops leadership developing real-time data reporting to support accurate repoirting. Actions underway with Regional Directors to ensure cover balance regionally and to meet core standards. Rota and selection change processes underway. To remain partial until assured.

25/26 Action Plan

Standard	Identified Gap	Implications	Mitigation / Plan	Progress Update and Current RAG
(70) Following each formal review of the capability within a designated hospital, copies of all reports must be retained by the NHS Ambulance Trust for at least 10 years.	SECAmb does not hold files older than 2019.	Standard not reflective of previous practice.	Surrey Heartlands engaging with National Team around amendment to standard.	Unchanged position. Raised by Surrey Heartlands to NHSE however without resolution, will remain on the action plan until 2029.
J8 - All staff required to perform a command role must have attended a one day, JESIP approved, interoperability command course.	Standard requires that all commanders have attended JESIP each 3 years.	If not addressed, cohorts of commanders will become non-authorised	JESIP revalidation is continuing each month in Kent and Sussex with partners from the LRFs. With new commanders being recruited at all levels (Operational, Tactical & Strategic) this will be an ongoing piece of work to reach 100% compliance.	All relevant staff expected to be compliant by January 2026. Self-assessed as partially compliant until completed.
H8 - Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times (24/7)	Staffing challenges for HART identified in HART improvement plan.	Potential non-compliance with national interoperability standards	HART improvement plan. Recruitment and training plans in place with appropriate recurrent funding for HART uplift to teams of 7 FY 24/25 and then teams of 8 for FY 25/26.	HART improvement plan continues. Gatwick site now fully established. HART Team leaders positions filled, HART Training manager recruited, HART/SORT OUM recruited. Ashford specific recruitment ongoing as well as wider attendance management focus. 8 paramedic vacancies to fill. Remain partial until filled.

Metrics, Command Assurance

- HART / SORT / Resilience metrics to be reported as part of wider IQR process
- HART performance metrics to reflect training compliance and operational output
- Command compliance (right) on track and improving (ECU training shortage)
- Focus on balanced representation of operational and organisational measures and indicators of delivery / progress

Operational

NARU Operational Command

Command Level	Completed	Head Count	% Compliance
Operational Commander	159	181	87.85%
Tactical Advisor/NILO	5	5	100.00%
Tactical Advisor/NILO for EPRR	10	10	100.00%
Total	**174**	**196**	**88.78%**

Strategic

MAGIC

Command Level	Completed	Head Count	% Compliance
Strategic Commander	4	4	100.00%
Tactical Advisor/NILO	2	5	40.00%
Tactical Advisor/NILO for EPRR	6	10	60.00%
Total	**12**	**19**	**63.16%**

Tactical

NARU Tactical Command

Command Level	Completed	Head Count	% Compliance
Tactical Advisor/NILO	5	5	100.00%
Tactical Advisor/NILO for EPRR	9	10	90.00%
Tactical Commander (Field)	36	40	90.00%
Total	**50**	**55**	**90.91%**

Command training assurance

South East Coast Ambulance Service NHS Foundation Trust

JESIP (All)

Command Level	Completed	Head Count	% Compliance
Operational Commander	142	181	78.45%
Strategic Commander	1	4	25.00%
Tactical Advisor/NILO	5	5	100.00%
Tactical Advisor/NILO for EPRR	10	10	100.00%
Tactical Commander (Field)	38	40	95.00%
Total	**196**	**240**	**81.67%**

- Intent to develop command training in collaboration with SCAS and potentially other partners
- Strategic cohort expanding
- JESIP compliance a focus, planned until January and expect to achieve compliance
- HART - All disciplines at both sites are at least 95% compliant which is very high

Challenges

All Ambulance Services awaiting next steps re Manchester Arena business cases, etc – escalated nationally

Funding complexities and delays around Mass-Casualty Vehicles – escalated nationally

Chemical Protective Suit procurement remains a Trust obligation – escalated nationally

ECU training constraints and limitations around Command Training – escalated nationally

Considerable changes in NHS ICB structure, unclear implications for large trusts like SECAmb – dialogue continues

Conclusions

- High degree of confidence in progress around Core / Interoperability standards assurance
- High confidence in ongoing delivery of Manchester Arena recs with continued monitoring across NHS Ambulance sector
- Limited progress on some recommendations directed nationally / those contemplated with business case – but internal progress made in many areas.
- High confidence re alignment with LRF areas and solid relationships / exercising relationship
- SCAS collaboration continues with focus on command, specialist ops training, and future strategic collaboration opportunities.
- opportunity to work with ICSs on resilience functions and assurance across the region in future as ICS structures change

South East Coast Ambulance Service
NHS Foundation Trust

Item No	86-25

Name of meeting	Trust Board
Date	4 December 2025
Name of paper	Chief Executive's Report

1	This report provides a summary of the Trust's key activities and the local, regional, and national issues of note in relation to the Trust during October and November 2025.
	A. Local Issues
2	**Delivery of our Strategy** I have been pleased to see continuing evidence during this period of the work underway throughout the Trust to progress our five-year strategy and ensure we are delivering the very best care for our patients.
3	In the digital sphere, we have continued to see good progress with delivering our Digital Transformation Programme, with better use of data through delivery of operational dashboards and staff-accessible individual productivity analysis, improved resilience for our Emergency Operations Centres, and progress against key delivery streams of Data, Cyber, and Infrastructure.
4	This remains an area of focus, both locally and nationally, with a shift from analogue to digital systems one of the key pillars of the NHS 10 Year Plan.
5	I have also been pleased to see continuing progress made in improving our People Services – another key area of focus in our strategy – with tangible progress made through a wide range of appointments to the new team structure and the go live of enabling tools, including the new Employee Relations (ER) dashboard.
6	On 24 October, I was pleased to host a 'Big Conversation' together with David Ruiz-Celada, focused on our strategy and alignment with the NHS's 10-year plan.
7	It was fantastic to be joined by more than 120 colleagues, and we were able to reflect on the progress made since the launch of the Trust's strategy in July 2024 and how our strategy aligns with national priorities.
8	During the session, we highlighted the importance of revisiting the strategy and ensuring it remains relevant in light of national changes as well as important updates on some of the key deliverables within our strategy including virtual care hubs, divisional structures and digital enablement.

9	It was great to hear honest reflections shared by colleagues, with many acknowledging the positive direction of travel while raising concerns about the pace of change and the need for better support and training.
10	I am very clear that we need to continue to work hard to involve our people in the delivery of our strategy and ensuring it stay relevant.
11	**Executive Management Board** The Trust's Executive Management Board (EMB), which meets weekly, is a key part of the Trust's decision-making and governance processes.
12	EMB consider a range of key issues during their meetings and important issues discussed during this period have included:
13	• Our approach to Planning for 2026/27, recognising the challenging financial position facing the NHS as a whole • The on-going collaboration with South Central Ambulance Service and key areas where teams can start to work together more closely • The development of a number of key enabling strategies, including Volunteer and Community Resilience, Education and Charity
14	EMB also continues to hold meetings each month as a joint session with the Trust's Senior Management Group and also with a wider senior leadership group. These sessions are extremely useful in ensuring that, as a wider leadership team, we are consistently prioritising the right issues.
15	**Engagement** During recent weeks, I have continued our programme of engagement events, including a 'Big Conversation, on 24 October focussed on how we are delivering our strategy (as described above) and a 'Connect with the Chief' visit to Brighton MRC on 7 October. As always, these engagement events are both enjoyable and informative, providing a valuable opportunity to listen and interact with our people.
16	On 15 October, I was pleased to hold an engagement session at Banstead Make Ready Centre with our Fleet & Logistics team. It was a great opportunity to hear from the team about the particular issues and challenges they face, recognising that the vital work they do is usually behind the scenes.
17	On 4 November, I was pleased to welcome Daniel Elkeles, Chief Executive of NHS Providers and former CEO of London Ambulance Service to Medway MRC, together with our Chair, Michael Whitehouse.
18	It was a pleasure to be able to showcase the great facilities we have there with three key service areas of our business - field operations, 999 control room and 111 contact centre - all under one roof.
19	**'Hearing Different Voices' – Shadow Board update** I am pleased that our Shadow Board continues to go from strength to strength and that the feedback from Shadow Board members remains extremely positive about

	both the learning opportunities it provides for them as individuals, as well as enabling them to support a more inclusive organisational culture.
20	They are now in their third cycle, following the launch in Spring 2025, and are increasingly finding their voice and considering how they can maximise their influence over decision-making and development as we move forwards. I look forward to continuing to work with them closely and welcoming their expanded input into the Board.
21	**Equality, Diversity & Inclusion Awareness** Over recent months, we've continued to strengthen our commitment to equality, diversity and inclusion.
22	In October, we marked Black History Month a series of activities including special session at Medway provided by Everett Henry, Senior Consultant at the Medway African and Caribbean Association (MACA). I also had the pleasure of interviewing Amjad Nazir, Head of Health, Safety and Security and Chair of the Inspire Network. Amjad shared his lived experiences and highlighted the importance of representation and outreach to Black and Minority Ethnic communities as part of my Chats with the Chief series. This conversation reinforced our ambition to close the gap between our workforce diversity and the communities we serve.
23	We are currently supporting Disability History Month, which runs until 20 December. Activities include a programme, led by the Enable Network, focusing on this year's theme, "Disability, Life and Death." Events include a Lunchtime Masterclass on reasonable adjustments and Access to Work, alongside resources such as Enable's Handy Guide to support conversations about workplace accessibility. Our executive sponsor, Richard Quirk, has called on colleagues to share disability and caring responsibilities to help unlock support.
24	Finally, I'm very proud to share the news that Polegate's Steph Meech has been elected Deputy Chair of the National Ambulance LGBT+ Network, reflecting SECAmb's leadership in promoting inclusion across the sector.
25	**Remembrance ambulances** It was good to see colleagues once again proudly supporting a large number of Remembrance events this year, laying close to 100 wreaths at services across our region.
26	I was also pleased that, for the eighth year running, a number of our ambulances were wrapped with a specially designed Remembrance livery.
27	The design, featured on 12 of our ambulances, stemmed from suggestions from our Armed Forces Network and includes features including a Spitfire, marking its 90th anniversary and VJ Day, which commemorated its 80th anniversary this year.
28	We have close links with the Armed Forces with a number of colleagues who have served or continue to serve as reservists. This strong link and our commitment to supporting colleagues was recognised with the Trust receiving the prestigious Employment Recognition Scheme Gold Award earlier this year.

29	**Celebrating Success** In October 2025, I was delighted to attend the second of this year's 'Celebrating Success' events which recognise the success of learners from across our education and development pathways.
30	The October event, held at Lingfield Park in Surrey, expanded the celebration to encompass our growing portfolio of advanced education, including MSc and Postgraduate Diploma programmes in critical care and advanced practice. Once again, Special Awards also acknowledged outstanding achievement across a range of areas.
31	These events continue to demonstrate the critical role of education in workforce development and retention, while celebrating the professionalism and dedication of colleagues.
32	Planning is now underway for the next Celebrating Success event scheduled for April 2026.
	B. Regional Issues
33	**SECAmb Charity update** I am pleased to report that our Charity continues to grow well, with progress across governance, fundraising and operations. The new financial tracking system, insurance work and independent examination planning are underway, and the draft strategy has now been completed and formally signed off by CFC and EMB.
34	We have also received the first two tranches of the £142,000 Community Resilience grant, and work has begun on the NHS Charities Together wellbeing fund bid.
35	Public visibility is increasing through the launch of the external website and more proactive communications. Fundraising continues to broaden, with steady 'in memory' support, early regular givers and increased community activity, alongside preparations for major challenge events including my participation in aid of the Charity in the Brighton Marathon!
36	**Celebration of Life Carol Service** Preparations are well underway for our first ever Celebration of Life Carol Service, taking place on 8 December 2025, where we will honour patients whose lives were saved by our teams and recognise the extraordinary work of our staff.
37	We have contacted a number of patients who proactively expressed a wish to thank the teams involved in their care, to invite them to the event as well as the staff associated with their incidents—including responding crews, volunteers, call handlers and dispatch colleagues.
38	The service will be held at St Nicholas Church, Sevenoaks, a site with long-standing ties to SECAmb and Reverend Angus—whose own life was saved by SECAmb colleagues in 2011—will lead the service. The evening programme includes performances from the SECAmb Choir, personal stories from patients, and communal carols designed to foster connection and reflection.

39	I am very much looking forward to attending, deepening our bond with our communities and highlighting the compassion and professionalism of our staff.
40	**Leadership Conference and Leadership Framework Launch** Earlier this month, we brought together more than 130 leaders for a half-day development event focused on shaping the future of leadership at SECAmb.
41	One highlight was the launch of our draft Leadership Framework, which sets out six core qualities: Compassion, Inclusion, Accountability, Curiosity, Integrity and Collaboration. This framework is designed to empower colleagues at all levels to lead confidently and support our strategy.
42	I was especially pleased that we were joined on the day by Professor Michael West, who delivered an inspiring keynote on the impact of compassionate leadership on patient care and staff wellbeing. His insights reinforced the importance of engagement and teamwork and how learning from NHS Staff Survey data can drive cultural improvement.
43	Breakout sessions tackled key challenges, generating ideas that will feed into our next Big Conversation. As I mentioned in the session, I am committed to continuing these discussions and embedding compassion in how we lead the organisation.
44	**Collaboration with South Central Ambulance Service (SCAS)** On 29 October 2025, we announced the creation of the South Central and South East Ambulance Group, bringing SECAmb and SCAS together into the first ambulance group in the country.
45	The new group model marks a proactive move to strengthen patient care, ensure sustainable services, and build a more resilient ambulance system across the region. By working together more closely, the two services will be better placed to share expertise and resources, harness innovation, and invest in improvements that directly benefit patients.
46	Through the new group model, both Trusts will continue to operate independently, retaining the flexibility to meet the specific needs of their local communities, while collaborating on key priorities such as digital innovation, clinical best practice, and workforce development.
47	To strengthen alignment and ensure shared priorities are delivered effectively, the Group will introduce a shared leadership model, with a single Chief Executive and Chair supporting both Trusts. This will enable greater strategic coordination while maintaining each organisation's local accountability and identity.
48	**SECAmb Stars Awards** Our annual SECAmb Stars Awards, which sees us gather to celebrate the long service and special achievements of staff, volunteers and the public at events in Kent, Surrey and Sussex were, once again, a huge success.

49	I was extremely proud to attend each event as we paid tribute to those who have dedicated their lives to helping others and hear some amazing stories of the skill and care delivered across our region.
50	This year saw us present King's Long Service and Good Conduct Medals to our Emergency Operations Centre (EOC) colleagues for the first time since eligibility criteria was changed. I welcome this change which recognises the vital role our EOC teams play in delivering frontline care.
51	In another first, we introduced a new award honouring the life of Professor Douglas Chamberlain who died earlier this year. Well done to Operating Unit Manager, Dave Hawkins who picked up the award for his passionate work and commitment to improving cardiac arrest survival rates.
52	Well done also to Paramedic, Courtney Dent, who proudly received the Alice Clark Award, presented each year to a newly-qualified paramedic in memory of our colleague Alice who tragically lost her life in service in 2022.
53	Thank you and well done to all our award winners who represent just a fraction of the incredible care delivered across our region.
54	**Development of Volunteering & Community Resilience Strategy** I was pleased to read recently the external review of the Volunteer Emergency Responder (VER) scheme, carried out by BDO as part of their audit work with the Trust. The review provides a clear and independent look at how the scheme has been working, what it has achieved, and where there are opportunities to strengthen our approach.
55	The findings and recommendations will directly inform the development of the new Volunteering and Community Resilience Strategy. This Strategy will set out how we build an intentional and sustainable model for volunteer involvement in emergency response. It will also help ensure we have a consistent approach across the organisation, aligned with our wider aims for patient care, community engagement and operational resilience.
56	In the meantime, the VER scheme will continue in its existing form until the end of the financial year, allowing for the new overarching Strategy to be approved and launched, at which point we will be able to start to transition to a new model, incorporating key elements from the current pilot version of the scheme.
57	We want to extend a genuine thank you to everyone who supported the evaluation, whether through interviews, data, or insight from lived experience. Your contributions have been invaluable, and we are keen to continue to work with you all as we develop the new Strategy.
58	We also want to recognise and thank all our volunteers for their ongoing commitment to the Trust and the communities we serve. Your dedication continues to make a real difference every day, and we look forward to continuing to work alongside you as we develop a sustainable volunteering service which saves lives and serves the community.

	C. National Issues
59	**Financial allocation** In the past couple of weeks, we have seen the national allocation of financial resources to integrated care boards (ICBs) – the way through which individual NHS Trusts receive their funding.
60	Although the overall financial position remains challenging, we were pleased to see some clarity for the ambulance sector as part of the overall position, including confirmation of new recurrent funding as part of our baseline (linked to strong response time performance) and the enablement of discussions directly with the national team, rather than this being devolved via local structures.
61	We have already begun to consider the implications for us as part of our planning process, recognising that the financial position for the NHS as a whole remains challenging.
62	**National recognition for Chief Pharmacist** I am pleased to share that our Chief Pharmacist, Shani Corb, has been awarded a Fellowship of the Royal Pharmaceutical Society (RPS).
63	Shani is the first pharmacist within any UK ambulance service to receive this distinction, and as well as a real personal achievement for her, it also represents a significant milestone for the profession and for our organisation.
64	An RPS Fellowship is one of the highest honours available within pharmacy and is awarded only to individuals who have demonstrated exceptional professional distinction. Fewer than 700 pharmacists nationwide have ever achieved Fellowship status and Shani's inclusion in this cohort is a clear reflection of her leadership, expertise, and influence across the sector.
65	Shani has played a pivotal role in strengthening and advancing pharmacy practice within SECAmb with a particular focus on improving patient care, enhancing clinical governance, and raising professional standards across the ambulance service.
66	Congratulations to Shani on this historic and well-deserved achievement. Her success reflects the calibre of our clinical leadership and supports our continued commitment to high standards of care and innovation across the Trust.
67	**NHS Staff Survey 2025** The 2025 Staff Survey period closed on 28 November, following an 11-week period during which staff could share their views.
68	Although we are not yet able to confirm the final response rate, as this is subject to final confirmation by the survey provider, it looks likely that we have exceeded last year's response rate of 67%.

69	Please may I pass on my thanks to all those who took the time to share their views via the survey.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Board Assurance Framework

2025/2026

December

Contents:

Our Strategy 2024-2029

- **Our Vision:** To transform patient care by delivering prompt, standardised emergency responses while enhancing care navigation with seamless, accessible virtual services for non-emergency patients

- **Our Purpose:**

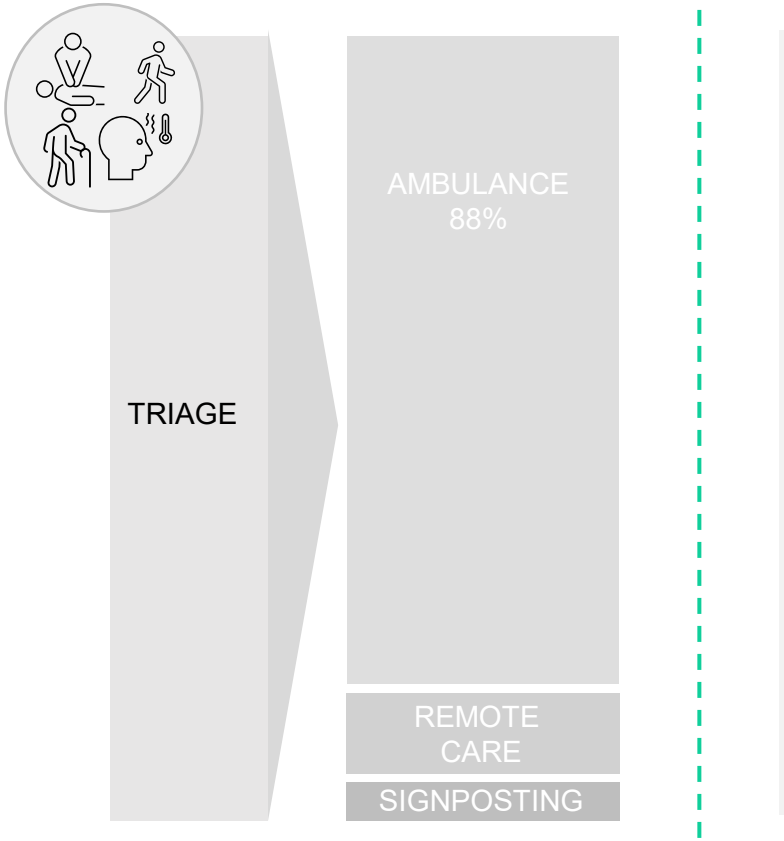
Saving Lives,

Serving Our Communities

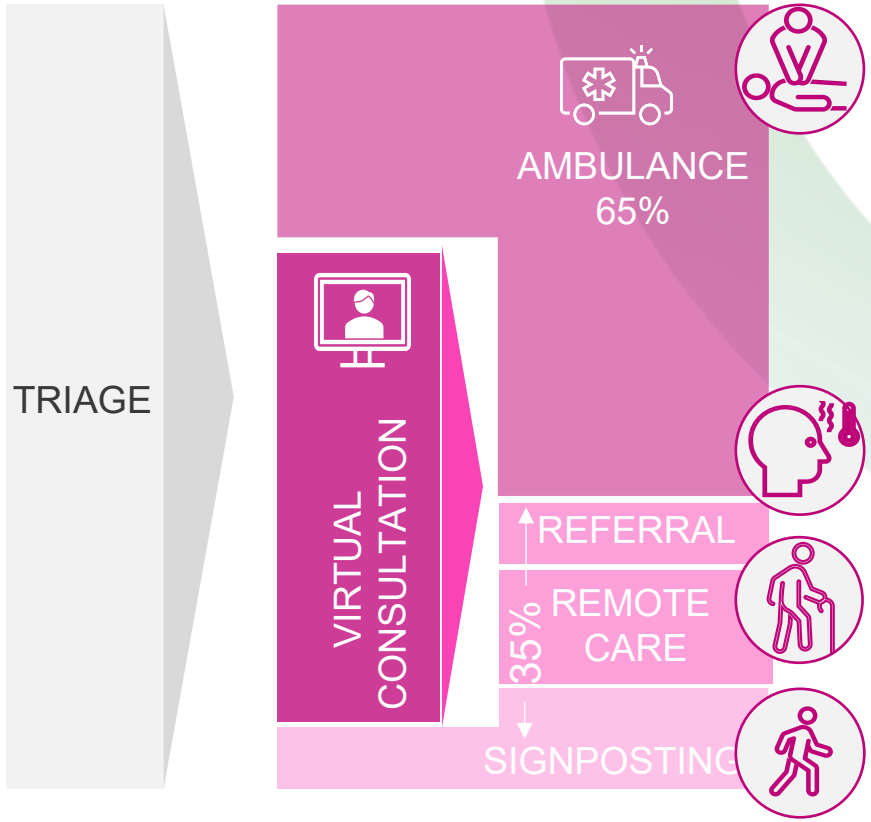
Our Strategy 2024-2029

NHS South East Coast Ambulance Service NHS Foundation Trust

NOW: We have the same response for most of our patients - we send an ambulance.



FUTURE: We will provide a different response according to patient need.



Timely care for emergency patients:

Resources will be refocused to provide a better and faster response to our emergency patients.

Virtual care for non-emergency patients:

Patient needs are thoroughly assessed by a senior clinician remotely. This clinical assessment will enable patients to be cared for directly or referred to the most appropriate care provider.

Connecting other patients with the right care, if they don't need us:

If, once assessed, the patient's needs do not require a SECAmb response, they will be signposted to an appropriate agency or service.

NHS
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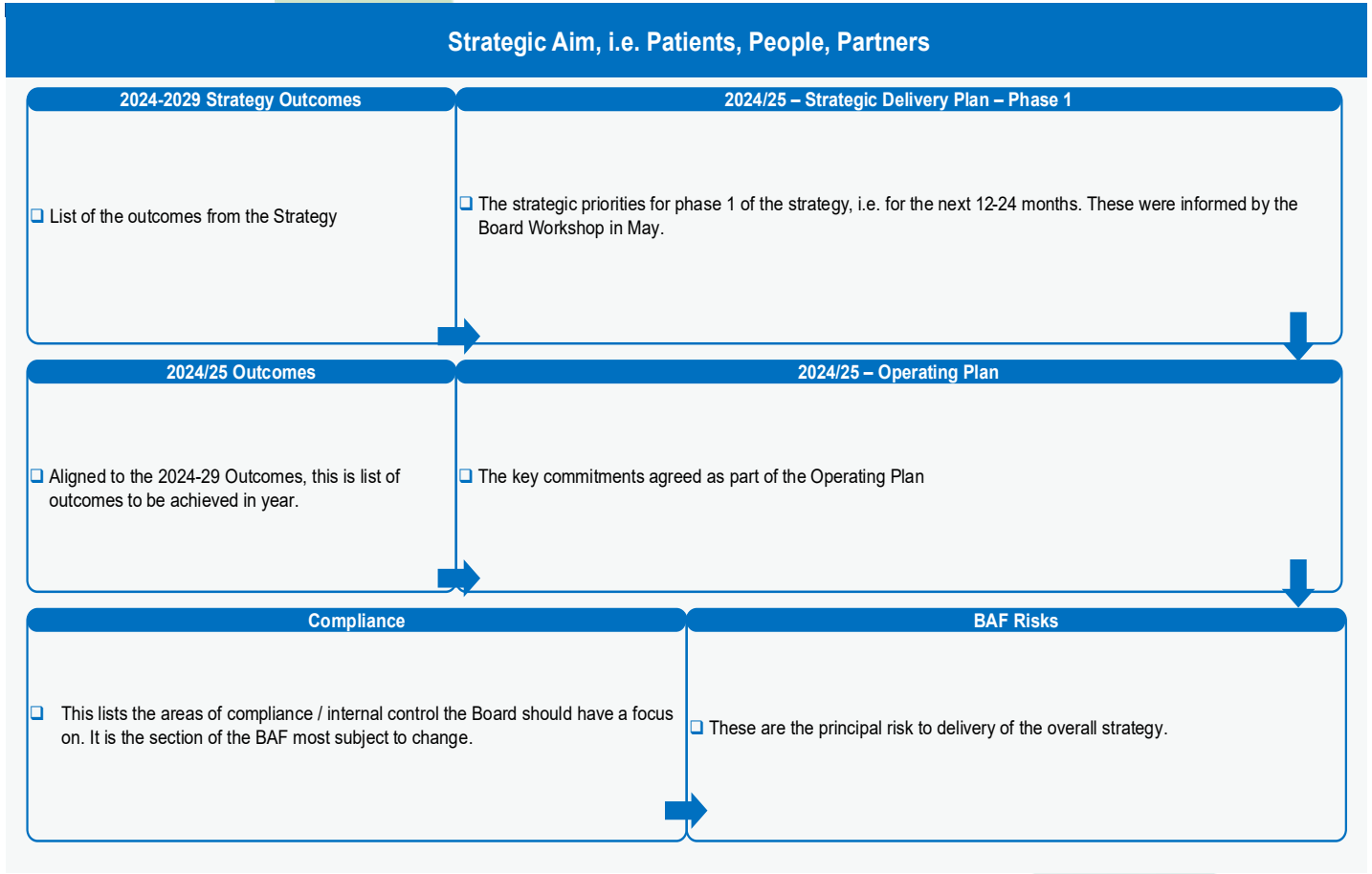
How our Board Assurance Framework (BAF) Works

Our BAF:

- The BAF is designed to bring together in a single place all the relevant information to help the Board assess progress against its strategic vision and the principal risks to delivery. This will support the Board's assurance on both the longer-term vision and in-year delivery.
- **Strategic Priorities** – this sets out the key priorities for the coming 12-24 months that will help set the foundations for delivery of the overall strategic vision.
- **Operating Plan** – this section of the BAF includes the key commitments the Board has made for the current financial year.
- **Compliance** – these are the internal control issues that are either most critical, or where the Board has greatest concern; they may therefore change over the course of the year subject to the level of the Board's assurance.



How our BAF reflects our Strategy :

- The Trust's priorities are aligned with three strategic aims, which help frame each meeting agenda of the Trust Board.
- Taken together with the related risks and sections of the IQR, The BAF provides the Board with the data and information to help inform its level of assurance in meeting the agreed aims:

Delivering High Quality Care

We are committed to delivering high quality care, ensuring every patient receives the best possible treatment and onward health management.

Our People Enjoy Working at SECAmb

We strive to make SECAmb a great place to work by promoting a supportive and rewarding work environment where all team members feel valued and motivated.

We are a Sustainable Partner

We are committed to being a sustainable partner within an integrated NHS, focusing on practices that enhance system integration and promote long-term resilience and efficiency.

Reporting Templates

South East Coast Ambulance Service NHS Foundation Trust

We deliver high quality patient care

2024/25 – Strategic Transformation Plan – Phase 1

Project	Milestone	Baseline Target	Forecast Target	Current RAG	Previous RAG	Executive Lead	Oversight Committee
Unscheduled Care Navigation Hub – Design & Implementation	Define scope of hub models agreed by ICBs	June 2024				Director of Operations	Quality & Patient Safety
	Implement first new hub	October 2024					
	Evaluation to inform future scope of virtual care	March 2025					
Clinical models of Care – Design and Agreement with ICBs	Scope determined with ICBs	Q2				Chief Medical Officer	Quality & Patient Safety
Patient Experience & Engagement	Enabling strategy for 2025 – 2035 developed	End of Q3				Director of Quality / Chief Nurse	Quality & Patient Safety

2024/25 – Operating Plan

Initiative	Sub-Initiative (if required)	Current RAG	Previous RAG	Oversight Committee	Date last reviewed at Committee
Operational performance plan					
Deliver the three Quality Account Priorities	Post-discharge reviews				
	Reduction in Health Inequalities				
	Patient Care Records Review Implementation				
Expand number of volunteers by 150					
Implementation of 80% of NHSE PSRIF Standards/Principles					
Deliver 2 Clinical QI priorities	Safety in the Waiting List				
	IFTs				

BAF Risks

Risk Detail	Risk Score	Target Score	Owner
There is an ongoing, multi-year risk that the financial environment for the NHS prevents local commissioners from supporting our clinical strategy	20	04	SP&T
There is a risk that, as a consequence of the NHS funding environment we have insufficient levels of leadership capacity to deliver our strategy and/or that our leadership structure does not allow for effective strategic delivery.	12	08	CEO

Exception reporting will be provided as required following committee oversight

Board Highlight Report –

Progress Report Against Milestones:	SRO / Executive Lead:	Previous RAG	Current RAG
Key achievements against milestone			
Upcoming activities and milestones	Risks & Issues:	Score	Mitigation
Escalation to Board of Directors			

Q1 (Apr-Jun 24)	Q2 (Jul-Sep 24)	Q3 (Oct-Dec 24)	Q4 (Jan-Mar 25)
◆ ◆	◆ ◆ ◆	◆ ◆	◆

Each of our strategic delivery programs will receive a Board-Level highlight report at every meeting

BAF Risk 537 – Funding

There is an ongoing, multi-year risk that the financial environment for the NHS prevents local commissioners from supporting our clinical strategy

Controls, assurance and gaps

Controls: we have the vision and a strategy which has been signed off by the Board. There is an agreed financial plan, with enhanced financial controls to be implemented. Our partners have signed up to the vision, however the available funding has not yet allowed them to commit to delivery.

Gaps in control: there is no agreement in place with commissioners for the 2024/25 financial year. No agreed multi-year plan with associated funding to support implementing our clinical model.

Positive sources of assurance: ICB clinical plans and strategy delivery plans refer to our strategy e.g.: Surrey Heartlands, shared delivery plan for Sussex. Strategic Commissioning group set up as formal governance route between SECAmb and ICB partners to develop a multi-year plan. NHSE through RSP has an expectation that we will develop this multi-year plan as part of our exit criteria. Our strategic delivery plan derives from our Strategy and is reflected in the BAF for 2024/25.

Negative sources of assurance: This year we are planning for a £16.5 million deficit. Current plans for ICBs do not support a multi-year funding arrangement to get SECAmb to financial sustainability.

Gaps in assurance: The Board has not yet seen the plan between June 2024 and December 2024 to develop the multi-year plan to exit RSP. There is a significant challenge in coordinating and aligning the multiple stakeholders involved in developing the multi-year plan, given the complexity and scale of the work. The Board has not yet seen the recommendations from the Southeast Ambulance Commissioning review or how the recommendations will affect the ability to deliver the multi-year plan.

Accountable Director	Strategic Planning and Transformation
Committee	Finance and Investment Committee
Initial risk score	Consequence 5 X Likelihood 4 = 20
Current Risk Score	Consequence 5 X Likelihood 4 = 20
Target risk score	Consequence 4 X Likelihood 1 = 04
Risk treatment	Treat
Target date	Q4 2024/25

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
We are developing a multi-year plan to exit RSP in collaboration with ICB partners and our region	SP&T, CFO	Q3 2024	The work is due to commence at the end of June, once the year one funding round is resolved.

Each of our BAF Risks has a detailed risk page

Our People Enjoy Working at SECAmb

Our people enjoy working at SECAmb

1	Tier 1
2	Tier 2
QI	QI
Directorate objective	Directorate objective

2024-2029 Strategy Outcomes

- Deliver career development opportunities for all staff across the Trust – 70% staff surveyed agree
- Our staff recommend SECAmb as place to work – over 60% staff surveyed agree
- Reduce staff turnover to 10%
- Our Trust is an open and inclusive place to work - demonstrate improvements in workforce race and disability standards indicators

2025/26 – Strategic Transformation Plan

- **Organisational Operating Model Programme** 1
  - Implement corporate restructure (including Hybrid Working Practices) going live **by end Q3**
  - Transition to Clinical Divisions **by end Q2** and undertake Clinical Operating Model design by end of Q4
- **People Services Improvement Programme** 1
  - Embed People Services new structures to enable effective support, with 90% staff in post by end of Q2
  - Develop Case for Change for optimising Recruitment and Service Centre by end of Q3
  - Enhance ER processes to ensure fair, timely case resolutions with strengthened staff confidence in ER services by end of Q4
  - Develop capability and professional practice of People Services
- **Long-term Workforce Plan Definition**
  - Scope to be developed by Q3 following the development of Models of Care

2025/26 - Outcomes

- Improve staff reporting they feel safer in speaking up – statistically improved from 54% (23/24 survey)
- Our staff recommend SECAmb as place to work – statistically improved from 44% (23/24 survey)
- 85% appraisal completion rate
- Reduce sickness absence to 5.8%
- Resolve ER cases more quickly to reduce the formal caseload over time, even as new cases are opened.

2025/26 – Operating Plan

- Full implementation of Resilience (Wellbeing) Strategy **by Q4**
- Implement Shadow Board **in Q1**
- Embed Trust Values & associated Behaviour Framework **by Q4**
- Refresh of the professional standards function by **end of Q2**
- Development of Integrated Education Strategy, informed by the EQI **by end of Q3**
- Establish the approach to volunteers

Compliance

- Equality Act / Integrated EDI Improvement Plan
- Sexual Safety Charter Commitments
- Education
- Statutory & Mandatory Training & Appraisals

BAF Risks

- **Culture and Staff welfare:** There is a risk that we will not achieve the culture and staff welfare improvements identified in our strategy.
- **People Function:** There is a risk that without an effective People function, we impact our ability to deliver parts of our Strategy.
- **Workforce capacity & capability:** There is a risk that the Trust will be unable to transition from physical to virtual care long-term, due to the absence of a sustainable workforce model with a clearly identified clinical skills mix.
- **Organisational Change:** There is a risk that the significant volume of change has an adverse impact on staff, leading to productivity and efficiency changes remaining unrealised.

Our people enjoy working at SECAmb

2025/26 – Strategic Transformation Plan

Programme	Milestone	Baseline Target	Forecast Target	Programme Manager	EMB / SMG	PMO	Executive Lead	Oversight Committee
Organisational Operating Model	Implement corporate restructure (including Hybrid Working Practices)	Q3	Q3	Vic Cole	EMB	Yes	Chief People Officer	People Committee
	Implement transition to first phase of Clinical Divisional Model	Q2	Q2		EMB	Yes	Chief Operating Officer	People Committee
	Complete design of second phase of Clinical Divisional Model	Q4	Q4					
People Services Improvement	Embed People Services new structures to enable effective support	Q3	Q3	Roxana Oldershaw	EMB	Yes	Chief People Officer	People Committee
	Develop Case for Change for optimising Recruitment and Service Centre	Q4	Q4					
	Enhance ER processes to ensure fair, timely case resolutions	Q4	Q4					
	Develop Capability and Professional Practice of People Services	Q4	Q4					
Workforce Plan	Scope to be developed following the development of Models of Care	Q3	Q3		EMB		Chief People Officer	People

2025/26 – Operating Plan

Initiative	Sub-Initiative (if required)	Current RAG	Previous RAG	Executive Lead	EMB / SMG	PMO	Oversight Committee	Date last reviewed @ Committee
Full implementation of Wellbeing Strategy				Chief Nursing Officer	EMB	No	People Committee	July 25
Implement Shadow Board				Director of Communications/ Chief People Officer	EMB	No	People Committee	May 25
Launch new Values & Behaviours Framework				Chief People Officer	EMB	No	People Committee	
Refresh of Professional Standards Function				Chief Paramedic Officer	SMG	No	Quality Committee	
Development of Integrated Education Strategy				Chief Paramedic Officer	EMB	No	People/ Quality Committee	

BAF Risks

Risk Detail	Risk Score	Target Score	Owner
Culture and Staff welfare: There is a risk that we will not achieve the culture and staff welfare improvements identified in our strategy.	12 →	08	CPeO
People Function: There is a risk that without an effective People function, we impact our ability to deliver parts of our Strategy.	12 →	08	CPeO
Workforce capacity & capability: There is a risk that the Trust will be unable to transition from physical to virtual care long-term, due to the absence of a sustainable workforce model with a clearly identified clinical skills mix.	12 →	08	CPeO
Organisational Change: There is a risk that the significant volume of change has an adverse impact on staff, leading to productivity and efficiency changes remaining unrealised	12 ↓	08	CPeO

Our people enjoy working at SECAmb

2025/26 – Compliance & Assurance

Compliance Initiative	Current RAG	Previous RAG	Executive Lead	Oversight Committee	Date of Last / Scheduled Review at Committee	Committee Feedback
Equality Act / EDI Plan			Chief People Officer	People	Nov 2025	EDI has been a focus at the Board Development sessions in 2025, and four priority areas have been agreed. Progress against these priorities was considered by the People committee in September and are due to come to Board in December alongside the WRES DES data insights.
Meet our Sexual Safety Charter commitments			Chief Nursing Officer	People	July 2025	Review of progress at People Committee in July 25 and plan agreed with timelines
Education			Chief Paramedic Officer	People	Nov 2025	As reported to the Board previously the committee was assured with the level of grip demonstrated by the executive, following the NHSE Education Quality Review. In Sept. QPSC assessed the evidence in place to demonstrate compliance against the recommendations and was assured and the new integrated education strategy (on the Board agenda for approval) is a welcomed step forward.
Statutory & Mandatory Training & Appraisals			Chief Paramedic Officer	People	Sept 2025	Last review of progress at the People Committee was in Sept with good progress with stat and man but lower than target on appraisals – via the IQR the committee noted in November that the trajectory is improving and will seek further assurance at its next meeting in January.

People Services Improvement Programme

Executive Summary

Exec. Sponsor:	Sarah Wainwright
PM:	Roxy Oldershaw
Last updated:	21 November 2025

Current position (Linked to outcomes)

O1: Enhanced service responsiveness

- The People Relations BI dashboard is transitioning into BAU following recent updates. The dashboard now includes an executive view, enabling senior leaders to access real-time data on grievances, disciplinary cases, and sickness. This improvement strengthens accountability and enables data-driven interventions across the Trust.
- Embedding new ways of working continues across all People Services teams, supported by structured engagement activities (Strategic People Partners Away Day, People Services Away Day, and monthly team sessions). These are reinforcing collective ownership and consistent leadership alignment.

O2: Operational efficiency

- Collaboration with SCAS has been reinstated to progress the shared payroll service. SCAS is leading the joint procurement process, with the business case and tender framework in alignment.
- ESR training for Recruitment and Payroll teams has been completed, with a taskforce now resolving legacy data issues. Completion is expected in the coming weeks and will improve data accuracy across reporting.
- The e-expenses, overpayments and underpayments policies have been submitted to JPF for approval. Once implemented, they are expected to reduce reporting errors and improve payroll accuracy.

O3: Strategic People Services partnership

- All priority policies have been submitted to JPF for approval. A supporting communications and training plan is in design, ensuring managers are confident in applying and embedding policy changes.
- The Sexual Safety oversight group continues to drive development of the “raising a concern” approach. This aims to encourage staff to speak up, provide clear support pathways, and ensure consistent and compassionate handling of concerns.

O4: Professional development and capability

- A skills analysis is underway to inform development plans across the People Services team. This will guide targeted investment in capability, aligned with Trust priorities.
- The business case for the People Services restructure is in development (targeting Q4 approval, Q1 2026 launch), focusing on building sustainable capacity in Recruitment, OD, and EDI to support both strategic and operational delivery.

Impact & Assurance

- Senior People Partners are actively supporting divisional and corporate restructures, improving responsiveness and consistency of advice. Early feedback points to improved responsiveness
- Policy development and implementation planning continue at pace, with Clinical Education engaged to co-deliver the training plan, providing assurance that policy rollout will be effectively supported.
- The relaunched BI dashboard is improving case visibility, demonstrating tangible progress towards a more responsive service model.

Decision and next steps

- Define timeline for the Recruitment, Service Centre, OD and EDI BC
- Confirm training plan with Clinical Education by end of Q3
- Approve dissemination tools (policy summaries, FAQs, templates)
- Decision on Capsticks proposal for more robust debt recovery process

Headline Assurance

- The Steering Group has noted increased visibility of People Services and feel positive about the SPPs supporting the culture change
- There is consensus that some programme elements are ready to transition into BAU, which will enable the programme to shift focus to transformational changes - a 6-month review is underway to identify key focus areas for both PSIP and BAU
- The People Forum governance structure will enable effective dependency management with the corporate restructure. It is essential that all affected PS functions remain informed and engaged in the org change process.
- Stakeholder engagement in the Sexual Safety workstream remains high, evidenced by strong attendance and feedback in recent sessions.
- Delivery is steady and governance is strong, overall impact is still embedding
- Dependencies with the corporate restructure and BAU pressures present moderate risk to capacity and pace. Active Mitigations: dedicated SPP oversight, structured governance, phased implementation planning.
- Likely to change to Green next quarter, subject to visible impact of policy rollout and dashboard usage informing OD, EDI and ER interventions

Status:	Under control
Ask of this forum:	Note progress

People Services Improvement Programme

Controls & Exceptions

Exec. Sponsor:	Sarah Wainwright
PM:	Roxy Oldershaw
Last updated:	21 November 2025

Change Control - Decision Requests

Proposed change	Type (T/C/Q/S)	Approval sought	Driver	Impact on delivery/assurance
N/A				

Dependencies (material only)	Owner	Due	Status	Risk if delayed	Mitigation
Corporate + Clinical Restructure Sequencing	Chief People Officer	Ongoing	On track	Misalignment of change processes; increased pressure on teams	EMB approval secured (05 Nov). Wraparound governance in place. Dependency reinforces need for EMB endorsement of PSIP alignment with corporate restructure.
SCAS Collaboration	Chief Strategy Officer	Ongoing	On track	Minor misalignment in planning future roles and responsibilities with new provider	Payroll co-tendering aligned; forward planning underway

Milestone Exceptions	Date	Exception	Impact on delivery/assurance	Recovery & new forecast
ESR Healthcheck complete	22/11/2025	Delayed	Data accuracy and system being used efficiently	Minor delays mitigated; no material risk to programme outcomes
JPF Policy approval	28/11/2025	On Track	Enables policy dissemination and capability building	N/A
Policy Dissemination and training plan confirmed	28/11/2025	On track	Supports manager confidence and consistent policy application	N/A
Review Sexual Safety Panel	01/12/2025	On Track	Supports assurance on culture & welfare	N/A
People Services Business Case	31/12/2025	On Track	Supports assurance on developing capacity and capability within the People Service function	N/A

EMB outcome, inc. decision requests (post-meeting)**:**	[To be completed after EMB]
People Committee outcome (post-meeting):	[To be completed after Committee meeting]

BAF Risks

- BAF Risk 539 - Culture and Staff Welfare
- BAF Risk 603 - People Function
- BAF Risk 649 - Organisational Change

Clinical Operating Model Programme - Executive Summary

Exec. Sponsor:	Jennifer Allan
PM:	Victoria Cole
Last updated:	27/11/25

Programme Outcomes	Prev RAG	Curr RAG	Impact on outcomes
• **Outcome 1** - Enhanced clinical governance and accountability through established Clinical Divisions structure • **Outcome 2 -** Optimised clinical service delivery through implemented Clinical Operating Model design • **Outcome 3** - Strengthened divisional leadership capability and team effectiveness through targeted OD interventions • **Outcome 4** - Improved pathways and service delivery integration across each ICS			• There is no material change to the programme's intended outcomes this period. Progress continues across all four areas, with the Clinical Divisions structure progressing as planned and operational elements expected to be substantively in place by the end of Q4. • Clinical service delivery optimisation continues, with the Field Ops structure now confirmed and ACL reporting lines agreed, providing a stable basis for alignment with the clinical strategy. • Outcome 3 is supported by OD's work to support leadership development and TED tools and timely delivery remains key to embedding new leadership teams.. • Early improvements in cross-programme collaboration and operational alignment support future service integration across ICSs, with fuller benefits expected as the new structures embed in 2026. • Changes to sequencing may affect timing (delivery by end Q4), but they do not impact the achievement of the intended outcomes.

Headline Key Performance Indicators (KPI) - These indicators are being used as proxies at this stage, as several of the programme's full KPIs will not be measurable until after organisational change is fully implemented. Current engagement levels, structure development and organisational alignment continue to provide confidence in delivery progress.

KPI	IQR or local	Latest (period)	Target	Trend	So what?
% of operational and clinical roles defined in new structure	Local	22% (Field Ops complete. Scheduling and Integrated Care under development)	100%	↓	The reduction from 33% reflects a scope change following the decision to further review clinical leadership roles to ensure alignment with the evolving clinical strategy. This slows role-definition work but strengthens the foundation for the final structure.
% of positive feedback from staff on engagement process	Local	N/A	>75% +ve	N/A	Strong interim engagement observed across Scheduling, IC and Ops Support; constructive feedback indicates good programme understanding. (Formal measurement due via NPS survey (currently under review - proposal to Steering Group to confirm timing given ongoing consultation activity). Measurable end of Q4 post the Div Review.
Alignment of operational areas to ICB boundaries)	Local	100% completed	100%	→	Completed alignment supports improved collaboration and future service integration across ICSs.

Top 3 Risks (BAF/Corporate only)

Description	ID	Current	Target	Trend	Control effectiveness & next steps
There is a risk that existing ER sensitivities across Scheduling and Integrated Care may result in increased sickness, grievances or resistance to organisational change processes, which may reduce staff capacity, affect engagement quality and slow programme delivery.	729	12	6	N/A – New risk	HR-supported ER plan. Early union engagement. Monitor absence/casework patterns. Wellbeing check-ins.
There is a risk the clinical operating model consultation for Scheduling will coincide with winter pressures and for consultation to fall throughout December, which will increase wellbeing concerns/sickness or grievances and potentially weaken operational delivery.	699	12	6	N/A - New risk	Operational Leads engaged to ensure effective planning for capacity and readiness. Timeline extended to account for reduced capacity to undertake consultation meetings across Christmas period when annual leave levels are higher.
There is a risk that the requirement of key staff in delivering change while maintaining critical services leads to pressure on BAU operations that causes service disruption if not carefully managed.	698	8	6	→	Engagement has confirmed understandable staff anxiety as expected during organisational change. However, no significant impact on service delivery or capacity has been identified at this stage. Wellbeing and workload continue to be monitored through weekly touchpoints as consultation progresses across Field Ops and Scheduling.

Clinical Operating Model Programme - Controls & Exceptions

Exec. Sponsor:	Jennifer Allan
PM:	Victoria Cole
Last updated:	27/11/25

Change Control - Decision Requests

Proposed change	Type	Approval sought	Driver	Impact on delivery/assurance
Pause to the development and implementation of the Integrated Care operating model (Nov 2025 - Apr 2026).	Approved prog scope and timeline change	None – endorsed by EMB since last highlight report (26/11)	Alignment with Field Ops, Virtual Care, and SCAS collaboration timelines	• Q4/Q1 plan re-baselined across Clin Op Model • Interim actions progressing: SDM reporting lines, Dispatch redesign, substantiate leadership posts • Prog timeline and interdependencies updated to reflect the IC pause
Implement the approved Field Ops model (four posts), with further work required on Advanced Practice and APP/CCP leadership arrangements.	Approved prog change / structural confirmation	None – endorsed by EMB since last highlight report. (26/11)	Confirm the agreed Field Operations structure following consultation closure, including finalised reporting lines whilst remaining agile given wider changes (e.g. Group model)	• Field Ops workstream moves from design into phased implementation for the four agreed posts. • Removal of the proposed Head of Ops (Advanced & Specialist Practice) role and confirmed ACL reporting to Div Clin Dir / Consultant Paramedic strengthens structural clarity. • Prog timeline and interdependencies updated to reflect the approved model and outstanding clinical design areas

Dependencies (material only)	Owner	Due	Status	Risk if delayed	Mitigation
OD Intervention programme	Dawn Chilcott	31 Jan 2026	OD are engaging an external provider to deliver a leadership programme and progressing a TED development tool to support embedding new divisional and operational leadership teams.	Delay in confirming or mobilising OD support could hinder Outcome 3 by slowing the development and embedding of divisional leadership capability and team effectiveness.	• Continue joint planning with HR/OD to confirm scope and delivery timelines • Align leadership development activity with SRO and divisional governance work • Ensure OD inputs are incorporated into Q4/Q1 planning to maintain progress against Outcome 3
IC Quality Summit & linkage to IC culture review	Jen Allan	31 Oct 2025	Review completed. Outcomes considered and will continue to be considered in IC model development.	Weak assurance on quality/culture improvements. Misalignment with IC operating model.	• Incorporate outputs from the Quality Summit into the Integrated Care Clinical Operating Model design and OD plan. Findings reviewed alongside Culture Review outputs to ensure they directly inform the IC model development.
SCAS Collaboration	Jen Allan	Ongoing	SCAS/SECAmb Group model development is progressing, with emerging requirements for aligned leadership and operational structures across both orgs.	Misalignment between IC leadership model and the Group model. Risk structural decisions made in isolation must be reworked.	• Pause IC model implementation for 6 months. Continue with development as group model develops • Ensure IC options explicitly incorporate Group model requirements
Virtual Care Model Programme	Jen Allan	Ongoing	Virtual Care model development is progressing with developments impacting Integrated Care Operating Model design.	Misalignment with the Virtual Care model could result in the IC Operating Model being designed on incomplete assumptions, requiring rework.	• Pause IC model implementation until Q1 26/27. Continue with development as group model develops • Dependency management will be coordinated through the PMO, with the Virtual Care PM and COM PM working jointly to identify, track and manage interdependencies.

Milestone Exceptions	Date	Impact on delivery/assurance	Recovery & new forecast
IC Operating Model proposal will not be submitted to EMB on 17 Dec due to the pause in programme timelines. Development work has been halted and re-phased accordingly.	17.12.25	Assurance and approval activities are delayed by 6 months. Required design work, engagement, governance products, and interdependency alignment cannot be completed to the standard required within the original timeframe.	Revised EMB submission date to be reset for mid-2026 following re-planning (indicative: June/July 2026). Updated development timelines and dependencies will be re-baselined in Q4.
Clinical Leadership structure cannot be fully implemented in Q4 due to outstanding alignment across Field Ops, IC, the DCD role and dependencies with the Virtual Care and Group models.	30.03.26	Clinical Leadership structure remains interim. Key clinical and operational assumptions can't be finalised.	Redesign will continue in sync with the developing Virtual Care model and Group Model requirements, with implementation rescheduled post-Q4 (timeline to be re-baselined).

BAF Risk 539 – Culture and Staff Welfare

There is a risk that we will not achieve the culture and staff welfare improvements identified in our strategy

Contributory factors, causes and dependencies: Scale of organisational change across an extended period; ER Casework backlog is high; legacy of inconsistent ER case management; variation in understanding and application of HR policy, and gaps in embedding the sexual safety charter

Controls, assurance and gaps

Controls: Mediation Programme planned to move under People Services BAU in Q1. Embedding management training in key people policies. Ongoing enhancement of ER processes and guidance. OD interventions underway to support divisional leadership teams and embed new structures. Trust Values and Behaviour Framework embedded through Awards programme and Engagement strategy. Leadership Conference held October 30th. Wellbeing Strategy approved with work commenced on developing an options analysis for future model. External providers commissioned to support complex case management and mediation. Priority policies submitted for approval.

Gaps in control: OD interventions not yet fully implemented across all teams. Wellbeing Strategy implementation plan still in development. ER backlog remains high with variable experience of ER processes. Capacity for sustained improvement actions across all directorates remains stretched. Workforce engagement on hybrid working and wellbeing options still in progress. Trust Values and Behaviour Framework embedding activities underway; full framework not yet approved.

Positive sources of assurance: Staff survey responses remain positive across all themes. Participation in engagement events remains high, including recent Awards programme and Leadership Conference. Positive results within Mediation Programme. Wellbeing Strategy approved and options analysis underway.

Negative sources of assurance: Grant Reviews (2022 and 2023) and Hunter Healthcare diagnostics report (2024) both identified risks in relation to SECAmb's management of ER cases. The number of formal cases remains high, and work is ongoing to address moving towards a culture of informal resolution. NHSE continued oversight of Culture and Leadership elements under RSP.

Gaps in assurance: Limited evidence of sustained improvements across all directorates. Ongoing staff feedback indicates variable experience of ER processes and inconsistent support.

Accountable Director	**Chief People Office**
Committee	**People Committee**
Initial risk score	**Consequence 4 X Likelihood 4 = 16**
Current Risk Score	**Consequence 4 X Likelihood 3 = 12** ⇨
Target risk score	**Consequence 4 X Likelihood 2 = 8**
Risk treatment	**Treat**
Target date	**Q4 2025/26**

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
OD Interventions	Chief People Officer	Q4 25/26	OD interventions underway to support divisional leadership teams and embedding new structures. Leadership engagement activities delivered including divisional sessions and targeted support.
Embed Trust Values & Behaviour Framework	Director of Communications & Engagement	Q3 25/26	Awards programme and Engagement strategy delivered. Leadership Conference held 30 October. Framework embedding activities underway but full framework not yet approved.
Refresh Wellbeing Strategy implementation plan	Chief Quality & Nursing	Q4 25/26	A working group focusing on the implementation of the 5 pillars of the Wellbeing Strategy is underway. Progress on delivery of the plans will be monitored at the People, Culture and Wellbeing Group (membership includes representatives from People Services, Q&N and Mental Health)

BAF Risk 603 – People Function

There is a risk that without an effective People function, we impact our ability to deliver parts of our Strategy

Contributory factors, causes and dependencies: Scale of organisational change, continuing into 25/26; ER Casework backlog still high.

Accountable Director	Chief People Officer
Committee	People Committee
Initial risk score	Consequence 4 X Likelihood 5 = 20
Current Risk Score	Consequence 4 X Likelihood 3 = 12 ⇨
Target risk score	Consequence 4 X Likelihood 2 = 8
Risk treatment	Treat
Target date	Q4 2025/26

Controls, assurance and gaps

Controls: People Services Improvement Programme (Tier 1) in delivery stage. Transition team in place. New People Services operating model in place and staff appointed, structure designed to support both centralised and decentralised working. Initial corporate restructure phase 1 now complete. Phase 2 restructure to focus on optimising Recruitment and the Service Centre, OD and EDI. CIPD and Professional mapping underway for managers and the ER teams, with other teams to follow early next year. Opportunities for collaboration with SCAS underway. Whole Trust restructure coordinated to align corporate functions with divisional model for improved local support. Sequencing of department restructures agreed and aligned to People Services capacity.

Gaps in control: Two-phase restructure is ongoing. Current vacancies in People Services reduce capacity to support whole Trust restructures. Delays in case resolution until new structures embedded and teams are fully staffed.

Positive sources of assurance: Tier 1 programme progress continues to be tracked across various governance forums including Steering Group, People Committee forum, EMB and Trust Board through RAG. SMG similarly monitors Tier Two projects. Whole Trust restructure planned so that corporate departments are managed concurrently.

Negative sources of assurance: Review by Hunter Healthcare stated that there was a need for immediate improvement in the function and identified some high-risk areas. Concerns raised around ER process consistency and staff confidence in outcomes.

Gaps in assurance: None identified

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Delivery of People Services Improvement Programme	Chief People Officer	Q4 2025/26	Programme delivery underway
People Services Restructure	Chief People Officer	Q2 2025/26	Recruitment and appointments complete, with new staff in key post
NHS Fair Recruitment framework implemented	Chief People Officer	Q3 2025/26	Scoping work being undertaken as part of the collaboration opportunities.

BAF Risk 648 - Workforce Capacity & Capability

There is a risk that the Trust will be unable to transition from physical to virtual care long-term, due to the absence of a sustainable workforce model with a clearly identified clinical skills mix.

- **Contributory factors, causes and dependencies: Operational pressures to meet Category 2 mean response times and Hear & Treat targets. In-year contractual obligations linked to financial performance.**

Accountable Director	**Chief People Officer**
Committee	**People Committee**
Initial risk score	**Consequence 4 X Likelihood 5 = 20**
Current Risk Score	**Consequence 4 X Likelihood 3 = 12** ➡
Target risk score	**Consequence 4 X Likelihood 2 = 08**
Risk treatment	**Treat**
Target date	**Q4 2026/27**

Controls, assurance and gaps

Controls: 2025/26 workforce plan completed and embedded in financial planning programme. Collaboration with system partners to explore opportunities for increasing workforce capacity. Workforce planning now being aligned with NHS 2026/27 planning guidance and financial envelope. Initial scoping for long-term sustainable workforce model completed. Outputs from two Virtual Care Summits incorporated into PMO governance and workforce design. Senior resource assigned to support workforce transformation. Workforce analytics and scenario modelling being used for modelling clinical skills mix. Clinical leadership engagement embedded through summits and steering groups. Weekly planning meeting underway.

Gaps in control: Skills mapping and gap analysis for virtual care roles not yet completed. No in-year workforce plan aligned to transformation objectives. Current capacity and capability gaps are likely to impact productivity and service delivery. Long-term workforce model still in development. Workforce transformation not yet embedded within strategic planning or committee annual cycles.

Positive sources of assurance: Virtual Care Programme oversight through BAF. Effective programme management and governance structures and cadence of meetings across programmes of work reporting to steering groups. Two Virtual Care Summits completed; third (Workforce focus) scheduled for December.

Negative sources of assurance: Strategic misalignment with commissioning intentions and NHS Long-Term Plan.

Gaps in assurance: Long-term workforce planning not yet integrated into committee annual plans

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Development of a 2026/27 workforce plan	Chief People Officer	Q4 2025/26	Underway as part of financial planning and efficiency programme, aligned to NHS national guidance
Development of a long-term sustainable workforce model	Chief People Officer	Q4 2025/26	3rd summit scheduled in December 2025: Incorporate summit outputs into workforce plan, including skills mapping and gap analysis for virtual care roles
Align workforce plan with NHS Long-Term Workforce Plan and Model Hospital benchmarks	Chief People Officer	Q4 2025/26	Weekly planning group has consolidated NHS planning guidance, Model Hospital benchmarks, and workforce data. The group is actively updating the workforce model to incorporate these benchmarks and financial assumptions, ensuring alignment with national priorities and virtual care requirements.

BAF Risk 649 – Organisational Change

There is a risk that the significant volume of change has an adverse impact on staff, leading to productivity and efficiency changes remaining unrealised

Contributory factors, causes and dependencies: Scale of organisational change across two phases; change fatigue and uncertainty.

Controls, assurance and gaps

Controls: Tier 1 programmes in place to manage change including Clinical Operating Model and Corporate Operating Model. Phase 1 corporate restructures complete and embedded. Revised Phase 2 plan for corporate services signed off by EMB to reduce scope of changes. Sequencing of Phase 2 underway with clear milestones. Phase 3 Business Case under development. Staggered approach to address limited capacity and to utilise learning from each stage. Clinical Operations restructure progressing to plan. OD plan under review and hybrid working practices scoped; Nexus House refurbishment underway. Communications plan in place and being delivered to support clarity and engagement. Staff survey leadership visits and staff feedback indicate overall engagement remains high and positive. Regular staff briefings and feedback mechanisms in place to continue to monitor understanding and support engagement.

Gaps in control: Line management roles and new structures not fully stabilised. Divisional structures still embedding which delays full integration. OD plan and hybrid working practices not yet fully implemented. Capacity to support OD and change management is stretched. Future workforce implications of Phase 2 changes not fully modelled. Staggered approach to divisional restructures is delaying full implementation of change.

Positive sources of assurance: Regular staff engagement through consultation processes. Impact Assessments undertaken as part of restructure process. Established governance structures with clear programme milestones and delivery plans and escalation of risks. Despite the scale of change, productivity has not significantly declined.

Negative sources of assurance: Staff feedback indicating change fatigue and lack of clarity on future roles. Uncertainty around hybrid working requirements and timelines. Organisational change policy requires review. Efficiencies and productivity gains expected from restructures have not yet been fully realised.

Gaps in assurance: Limited evidence of sustained improvement in productivity and efficiency.

Accountable Director	**Chief People Officer**
Committee	**People Committee**
Initial risk score	**Consequence 4 Likelihood 4 = 16**
Current Risk Score	**Consequence 4 Likelihood 3 = 12** Previously 16 ⇩
Target risk score	**Consequence 4 Likelihood 2 = 8**
Risk treatment	**Treat**
Target date	**Q4 2025/26**

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Delivery of restructure has clear plan and end date	Chief People Officer	Q4 2025/26	Phase 1 corporate restructures complete and embedded. Revised Phase 2 plan signed off by EMB and sequencing underway aligned to available resources. Phase 3 BC due 17 Dec
Ongoing communications plan in relation to organisational changes	Director of Communications & Engagement	Q4 2025/26	Implementation of plan underway. Staff survey currently open with evidence of completion rates at least similar to previous years.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Integrated Quality Report

Trust Board December 2025

Data up to and including October 2025

What

The Trust has been placed in National Oversight Framework segment 2 and ranked 6th in the Ambulance Trust league table as of November 2025. The new NOF score reflects a range of high level metrics such as operational performance (C2 mean), workforce experience (staff survey scores) and finance (delivery of plan) along with a self assessment process for the Board, which is currently in progress.
October saw a slight deterioration in C2 mean, and there are ongoing significant challenges in increasing the H&T rate related to under-delivery of improvements in the clinical calls per hour rate and difficulty fully resourcing and training the required clinical roles. Incident Cycle Time improvements have continued; call answer rates remain robust and support has been offered to SCAS and YAS to improve their call answer times within our established capacity. The EOC audit position has improved slightly following the Quality Summit. There was continued good cardiac outcome performance, although there is variation in Duty of Candour and Complaints timeliness, and in IPC compliance. The Trust received a CQC visit to its UEC (Field Operations) services during September and to its EOC services in November and there were no patient safety issues identified and positive early feedback. ER case numbers remain high although signs of improvement have been seen in higher numbers of cases being closed; turnover is stable and the trust remains over-established. The staff survey is in progress with significant numbers of staff responding, indicating improved engagement, although appraisal rates are below target. Financial performance is in line with plan and is forecast to break-even. NHSE has confirmed the Trust has earned the second half of the £10.2million performance fund and this has been reflected in an improved risk score in BAF (risk 640). The Trust has received notification of allocations as part of National guidance and work is underway to achieve a compliant draft plan submission for the deadline of 17th December.

So What

A revised performance plan acknowledging the impact of non-delivery of system productivity and of C2 streaming (formerly called segmentation) on C2 mean performance has been agreed with NHSE. Against this revised plan, the Trust is on track for C2 mean performance. However, further work is needed to ensure we manage winter demand and likely resourcing challenges; a comprehensive winter resilience plan has been created and continues to be refined. A deep dive into clinical productivity was undertaken in early September with clear actions defined to address the identified challenges and improve H&T performance. The Unscheduled Care Navigation Hubs are being supported across all operating units to deliver consistent clinical advice to crews and adjustments to the C2 streaming process have been made to reduce impact on the C2 mean, in line with discussions with NHSE. The Models of Care programme continues to address its focus areas and we are looking to embed further improvements in Incident Cycle Time to support response to patients, as well as optimise vehicle availability in line with resources. Actions are in place to address IPC compliance, increase appraisal rates and continue to enhance audit and outcome compliance. Following improvements to the People directorate structure and resourcing, the impact on ER caseloads, timeliness, and more strategic workforce planning has started to be seen. The financial position continues in line with plan. Information on allocations has been received and based on the information received and the proposed national management of future growth funding, this is expected to enable the Trust to submit a draft plan which is compliant with financial and performance requirements (break-even and C2 25 minute average).

What Next

Winter planning assurance to Board against the NHSE winter checklist was completed in October and the winter plans embedded within the divisional resilience framework to ensure continued oversight. We are also engaging through the divisional structure with ICS and acute/community partners to support timely handover of care at hospitals and improved use of alternative pathways. Internally, there is continued focus on the H&T rate, improved resources at the front line (including through reducing sickness and ensuring a high flu vaccination rate), and enhanced response to patients who fall. New fleet comes on line during Q4 and there are actions in progress to mitigate this slight delay to planned delivery timelines; improvements to the vehicle management process will also be worked up to support this. The leadership team continue to oversee improvements in our relationship with TU colleagues and optimise opportunities to improve ER processes and address the cost of employment. Alongside this we will be focusing on appraisal rates, including enhancing the digital systems, and staff survey response rates. Continued strong staff engagement is needed to support ongoing significant changes to our operating model and work with our people to help address the impact of both financial constraint and system instability. Work is underway and will continue until final plan submission in February 2026 to develop triangulated performance, workforce, capital and revenue plans that meet required short and medium term expectations for Ambulance trusts..

Overall, the Trust is in a robust position in regards to performance, quality, workforce engagement and financial sustainability. However, continued collective effort to address demand, productivity and system challenges will be needed through the remainder of this year and beyond as we work both as a system partner and in our group collaboration to make best use of limited resources to provide excellent emergency and urgent care for patients across our region.

NHS Oversight Framework

Segment - 2 – Above average

Access to services

1 – High performing

Sub-domain	Description	Metric Score	Rank
Urgent and emergency care	Category 2 Mean	1.00	6 out of 10

Effectiveness and experience

4 – Low performing

Sub-domain	Description	Metric Score	Rank
Effective out of hospital care	% of patients conveyed to ED	3.40	9 out of 10
Patient experience	Staff survey advocacy score	2.00	4 out of 10

Finance and productivity

2 – Above average

Sub-domain	Description	Metric Score	Rank
Finance	Combined finance	1.00	
Finance	Planned surplus/deficit	1.00	2 out of 10
Finance	Variance year-to-date vs plan	1.00	7 out of 10
Productivity	Relative difference in costs	2.39	7 out of 10

Patient Safety

3 – Below average

Sub-domain	Description	Metric Score	Rank
Patient safety	Staff survey – raising concerns	2.67	6 out of 10

People and workforce

3 – Below average

Sub-domain	Description	Metric Score	Rank
Retention and culture	Staff survey – engagement theme	2.00	4 out of 10
Retention and culture	Sickness absence rate	3.81	4 out of 10

CQC Rating

Overall Rating: **Requires Improvement**

Safe	Requires Improvement
Effective	Requires Improvement
Caring	Good
Responsive	Requires Improvement
Well-led	Inadequate

DSPT Status

Approaching standards

Staff Survey Results – 2024

People Promise Theme	SECAmb 2024	SECAmb 2023	National Avg	Best Result
Compassionate and inclusive	6.92	6.70	6.84	7.01
Recognised and rewarded	5.50	6.20	5.25	5.62
We have a voice that counts	5.98	5.90	5.98	6.13
Safe and healthy	5.73	5.80	5.65	5.84
Always learning	5.02	5.60	4.98	5.18
Work flexibly	5.48	5.50	5.45	5.96
We are a team	6.43	5.30	6.25	6.70
Staff Engagement	6.06	5.20	6.01	6.22
Morale	5.88	4.70	5.63	5.88

Icon Descriptions

Integrated Quality Report

	P	?	F	
H	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of an improving nature where the measure is significantly **HIGHER**. Assurance cannot be given as a target has not been provided.
L	Special cause of an improving nature where the measure is significantly **LOWER**. This process is capable and will consistently **PASS** the target.	Special cause of an improving nature where the measure is significantly **LOWER**. This process will not consistently **HIT OR MISS** the target. This occurs when the target lies between process limits.	Special cause of an improving nature where the measure is significantly **LOWER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of an improving nature where the measure is significantly **LOWER**. Assurance cannot be given as a target has not been provided.
	Common cause variation, no significant change. This process is capable and will consistently **PASS** the target.	Common cause variation, no significant change. This process will not consistently **HIT OR MISS** the target. This occurs when target lies between process limits.	Common cause variation, no significant change. This process is not capable. It will **FAIL** to meet target without process redesign.	Common cause variation, no significant change. Assurance cannot be given as a target has not been provided.
H	Special cause of a concerning nature where the measure is significantly **HIGHER**. The process is capable and will consistently **PASS** the target.	Special cause of a concerning nature where the measure is significantly **HIGHER**. This process will not consistently **HIT OR MISS** the target. This occurs when the target lies between process limits.	Special cause of a concerning nature where the measure is significantly **HIGHER**. This process is not capable. It will **FAIL** the target without process redesign.	Special cause of a concerning nature where the measure is significantly **HIGHER**. Assurance cannot be given as a target has not been provided.
L	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.
				Special cause or common cause cannot be given as there are an insufficient number of points. Assurance cannot be given as a target has not been provided.

NHS Performance Assessment Framework 2025/26

The NHS Performance Assessment Framework sets out how success and areas for improvement will be identified, and how organisations will be rated.
Metrics with this icon are part of this framework.

South East Coast Ambulance Service NHS Foundation Trust

People

What?

This month's data shows early signs of improvement in employee relations and cultural indicators. Grievance and sexual safety case closures have improved, with 17 individual grievances and 4 sexual safety cases resolved. The overall caseload remains significant at 162 cases, including 19 collective grievances and 11 live sexual safety cases. Long-standing sexual safety cases continue, with some exceeding 12 months due to complexity and police involvement. Turnover remains stable for the fifth consecutive month, with 55 leavers in October. Sickness absence is 7.3%, above the 5.8% target. Statutory and mandatory training compliance exceeds 85%, while appraisal completion remains low at 71.5%.

So what?

Overall, the trajectory is positive in terms of case resolution and cultural transformation. The uplift in case closures signals that structural changes within People Services and strengthened oversight are beginning to deliver impact, easing pressure on formal processes and improving staff experience. Long-standing sexual safety cases remain a concern, but governance through the Oversight Group, the increased capacity within People Services, and refreshed policy ensures renewed focus and consistency. Turnover stability is encouraging, although it is acknowledged that ongoing organisational change and restructuring are having an influence. Sickness absence remains above threshold; controls are in place, including divisional Strategic People Partners and operational reviews, but the trend warrants close monitoring. On development, statutory and mandatory training compliance continues to exceed the target, providing assurance on regulatory readiness. While appraisal completion remains low limiting confidence in staff development and engagement, there is an upward improvement due to targeted interventions such as ESR walkthroughs, appraisal skills workshops, and executive oversight are underway to address this gap.

What next?

The next phase will focus on embedding ER improvements and strengthening sexual safety case handling through policy implementation, oversight, and learning reviews. Improving appraisal compliance remains a priority, supported by targeted interventions and manager capability building. Monitoring turnover and sickness trends will continue, with analysis planned to assess the impact of restructures and inform workforce planning. The NHS Staff Survey remains open, with completion rates tracking previous years and its outcomes will inform further cultural and engagement priorities.

Variation

Special Cause Improvement			Common Cause		Special Cause Concern		
11%	16%		58%		11%	0%	
2	3		11		2	0	

Assurance

Pass	Hit and Miss	Fail	No Target
5%	63%	16%	16%
1	12	3	3

Culture

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	Collective Grievances Open	Oct-25	2	1	1.4		
Board	Count of Grievances Closed	Oct-25	8	3	14.6		
Board	Count of Sexual Safety / Sexual Misconduct Cases	Oct-25	1	3	4.1		
Board	Individual Grievances Open	Oct-25	6	5	13.2		
Supporting	Bullying & Harrassment Internal	Oct-25	1	2	2.3		
Supporting	Disciplinary Cases	Oct-25	11	3	9.5		
Supporting	Mean Suspension Duration (Days)	Oct-25	188	70	163.8		
Supporting	Freedom to Speak up: Cases Opened in Month	Oct-25	13	3	9.9		
Supporting	Freedom to Speak Up: Total Open Cases	Oct-25	19		21		

Pending metric: Improved Speaking Up Metric - Needs to be defined

Workforce

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	Annual Rolling Turnover Rate	Oct-25	12.7%	15%	15.4%		
Board	Sickness Absence %	Oct-25	7.3%	5%	6.5%		
Board	Turnover Rate %	Oct-25	0.9%	0.8%	1.1%		
Supporting	Number of Staff WTE (Excl bank and agency)	Oct-25	4640	4579.26	4573.7		
Supporting	Vacancy Rate %	Oct-25	4.4%	5%	1.1%		

Employee Experience

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Supporting	% of Meal Breaks Outside of Window	Oct-25	48.4%		48.3%		
Supporting	% of Meal Breaks Taken	Oct-25	98.3%	98%	98.3%		
Supporting	999 Frontline Late Finishes/Over-Runs %	Oct-25	43.9%	45%	42.9%		

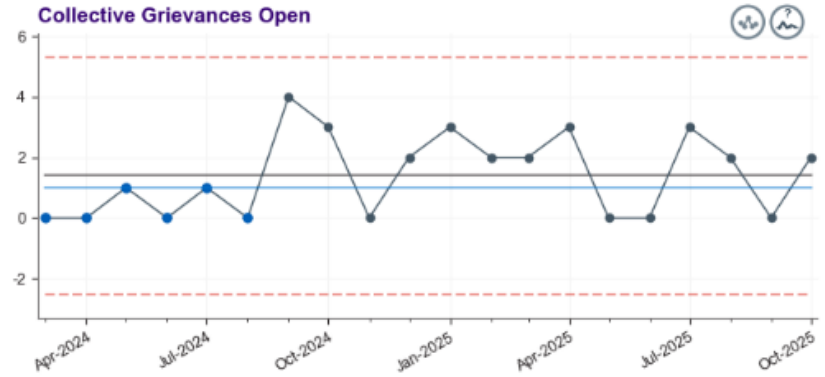
Pending metric: WRES/WDES - Needs to be defined

Pending metric: Improved Recommend as Place to Work Metric - Needs to be defined

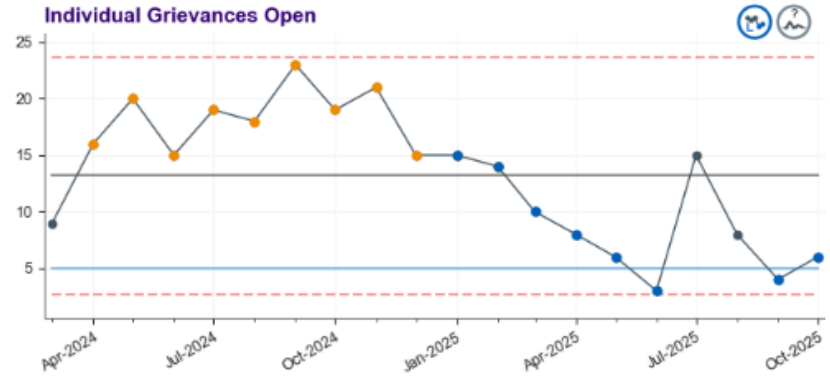
Employee Development

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	Appraisals Rolling Year %	Oct-25	70.5%	85%	64.2%		
Board	Statutory & Mandatory Training CSTF Rolling Year %	Oct-25	88.5%		84.9%		

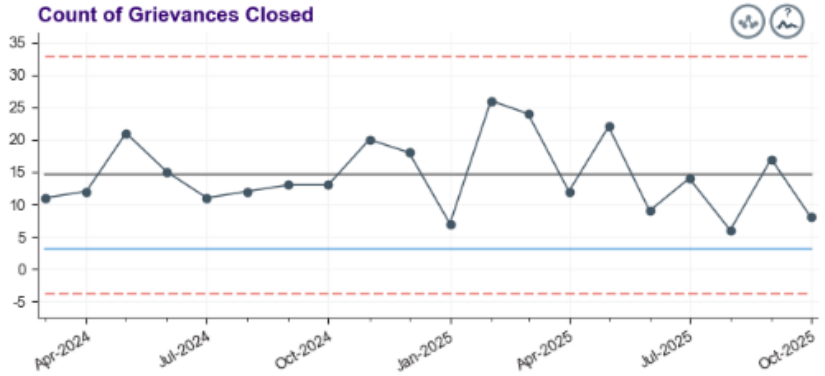
Pending metric: Education - Needs to be defined



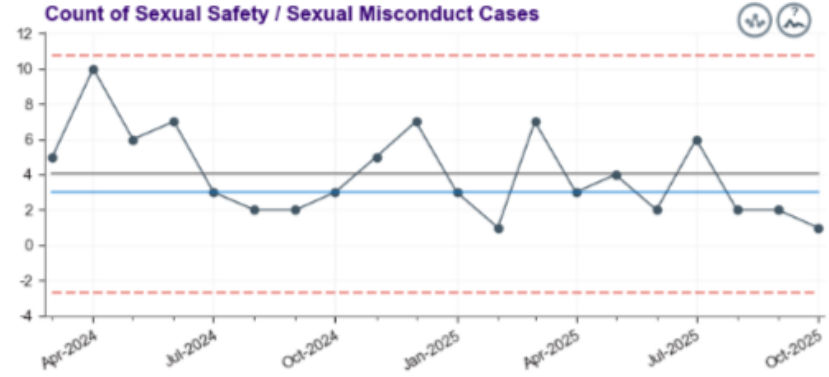
WF-11
Dept: Workforce HR
Metric Type: Board
Latest: 2
Target: 1
Common cause variation, no significant change. This process will not consistently hit or miss the target.



WF-10
Dept: Workforce HR
Metric Type: Board
Latest: 6
Target: 5
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.



WF-42
Dept: Workforce HR
Metric Type: Board
Latest: 8
Target: 3
Common cause variation, no significant change. This process will not consistently hit or miss the target.



WF-41
Dept: Workforce HR
Metric Type: Board
Latest: 1
Target: 3
Common cause variation, no significant change. This process will not consistently hit or miss the target.

What?
In October, 2 new collective grievances were raised. The total number of open collective cases is now 19, including the Trust-wide issues such as Section 2 and lease car concerns. 2 collective grievances closed. Furthermore, 17 individual grievances were closed in Septembe[VD2]a further 5 closed in October.

So What?
The closure rate demonstrates a tangible improvement in how we manage cases: our processes are becoming[VD1] more efficient, and leadership is more consistently engaged in driving timely resolutions. As a result, cases are moving more quickly, and colleagues are receiving more timely and higher quality, consistent outcomes.

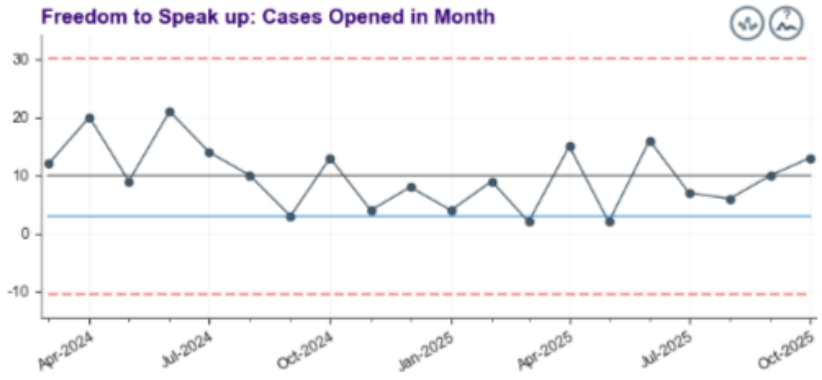
What Next?
- Grievance and Disciplinary policies are currently under review to strengthen early an[VD3]mal resolution pathways - to be discussed for approval at JPF on 28 November 2025, ahead of implementation in Q4 25/26.
- Negotiations have resumed regarding the collective grievance on pay.

What?
At month-end there were 11 live sexual safety cases, a net decrease of 1 compared with the previous month. 1 new case was opened, and 1 case was closed. Cases closed during the month took an average of 167 days to resolve, while open cases have been active for an average of 114 days. 30% of open cases are over 12 months old and remain a focus area for resolution.

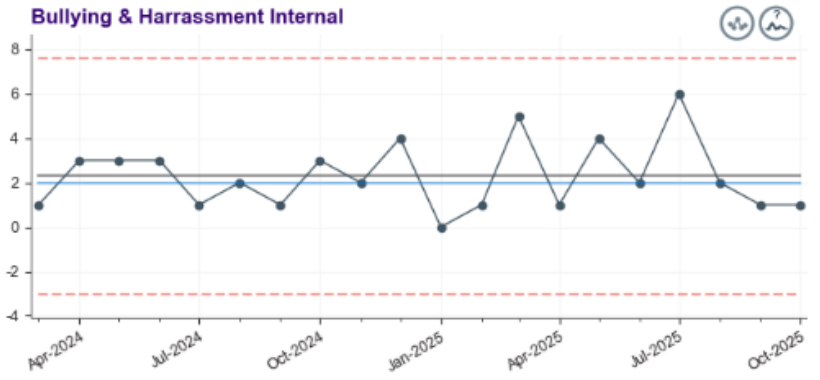
So what?
The reduction in live cases and increase in closures this month is a positive development, suggesting progress in managing the caseload. However, the presence of long-standing cases, some over a year old, remains a concern and highlights the need for continued focus on timely resolution and system responsiveness.

The Trust's commitment to strengthening its approach is reflected in the work of the Sexual Safety Oversight Group, which has now hosted two workshops aimed at reviewing processes, refreshing training, and addressing gaps in recognition and response. These efforts are essential to ensuring that colleagues feel safe, supported, and confident in the Trust's handling of these sensitive matters.

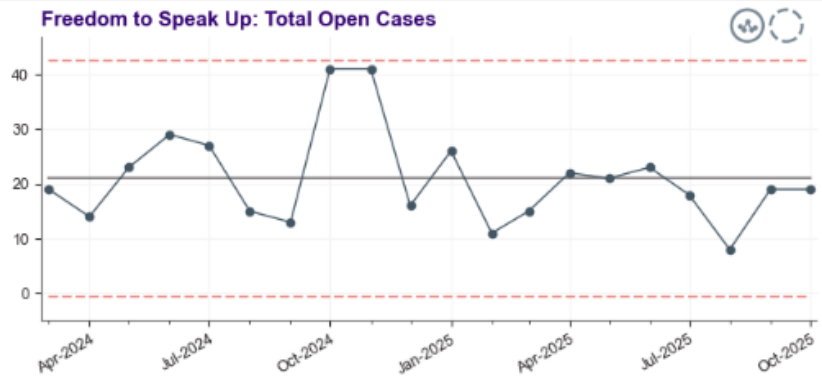
What Next?
- Refreshed Sexual Safety policy to be agreed at JPF on 28 November.
- Ongoing panel reviews are being carried out to capture learning and strengthen future case handling.
- The Sexual Safety Oversight Group will continue its workshops series
- Further work is underway to reduce the time cases remain open, with particular attention to those exceeding 12 months, ensuring a timely and appropriate resolution remains a priority



QS-27
Dept: Quality & Safety
Metric Type: Supporting
Latest: 13
Target: 3
Common cause variation, no significant change. This process will not consistently hit or miss the target.

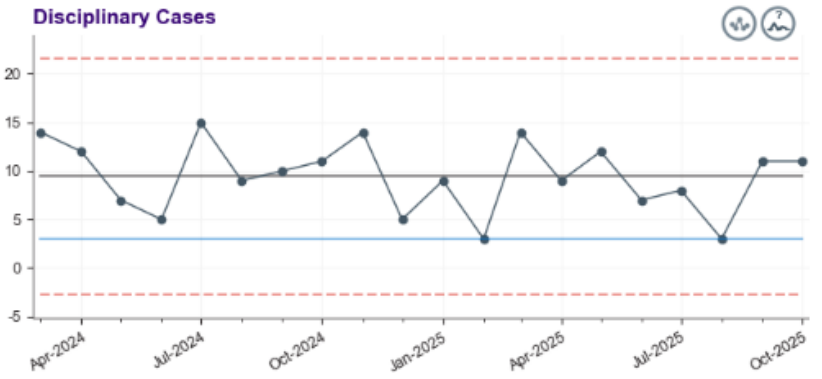


WF-12
Dept: Workforce HR
Metric Type: Supporting
Latest: 1
Target: 2
Common cause variation, no significant change. This process will not consistently hit or miss the target.



QS-27
Dept: Quality & Safety
Metric Type: Supporting
Latest: 19

Common cause variation, no significant change.



WF-9
Dept: Workforce HR
Metric Type: Supporting
Latest: 11
Target: 3
Common cause variation, no significant change. This process will not consistently hit or miss the target.

What?
IIn October, 19 concerns were raised to FTSU. Of these, 6 were submitted anonymously, and no cases of detriment were reported. Nine concerns have already been closed, with one remaining open. Integrated care (EOC/111) accounted for the largest proportion of concerns raised, followed by Tangmere, Gatwick and Brighton, which each represented around 10.5% of the total.

So what?
Leadership and relationships/Behaviours were the most prominent local themes, while worker safety and wellbeing continued to be the key national theme. The concentration of concerns within integrated care suggests ongoing challenges in this area, and the spread of issues across areas highlights need for local visibility and support.

What next?
The FTSU team will maintain engagement in integrated care. We will also continue to work closely with managers in other identified areas to promote a culture of open communication and early resolution. Efforts will remain focussed on wellbeing, leadership and relationship themes, supporting to staff to feel heard, supported and confident to speak up.

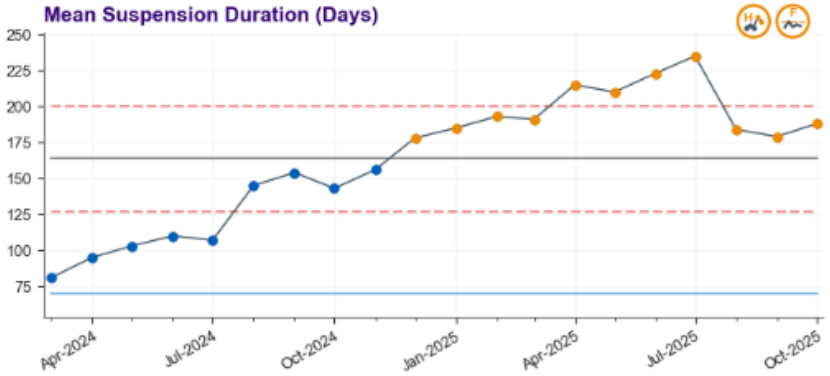
What?
In October, 1 new bullying and harassment case was raised, 2 were closed. The number of live disciplinary cases is currently 58, with 12 new disciplinaries opened and 6 closed.

So what?
Although only one new bullying and harassment case was raised in October, these cases continue to be highly complex and resource -intensive. Now that Strategic People Partners have begun analysing case data, early insights show that delays are most common in cases requiring multiple stakeholder inputs or where initial fact-finding is incomplete. This is helping to pinpoint specific teams and processes where additional support or intervention is needed.

The volume of disciplinary cases remains high at 58, with 12 new cases opened this month- twice as many as were closed. This imbalance indicates increasing pressure on capacity, process bottlenecks, and potential cultural challenges that may need addressing.

What next?

- Updated investigation training will be introduced to support consistent and timely resolution of disciplinary cases.
- Case volumes, resolution times, and emerging themes will continue to be monitored by Strategic People Partners to ensure appropriate action is taken.

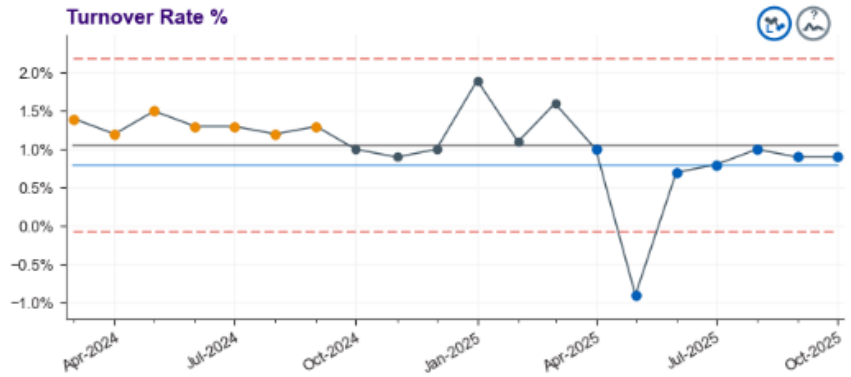


WF-47
Dept: Workforce HR
Metric Type: Supporting
Latest: 188
Target: 70
Special cause of a concerning nature where the measure is significantly HIGHER. This process is not capable. It will FAIL the target without process redesign.

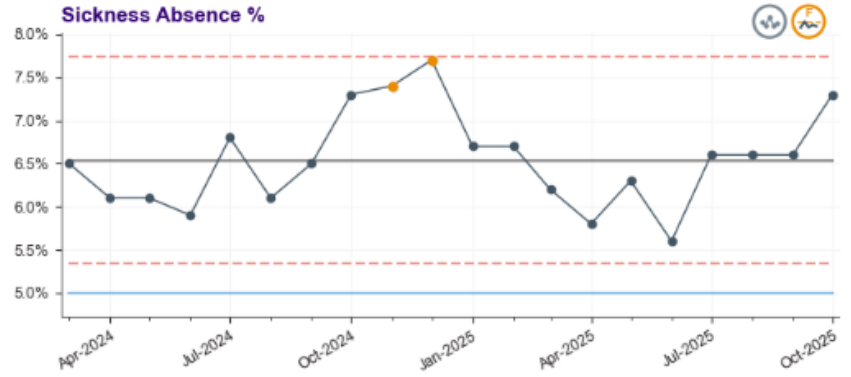
What?
There are currently 17 live suspensions across the organisation with an average suspension time of 180 days (compared to 189 days average across a rolling 12-month period). 4 suspensions were started during October, with 3 suspensions ending, resulting in a net increase of 1. 18% of active suspensions were over 12 months old (down by 1.1 percentage points vs the previous month).
There are 2 Restrictions of Practice in place.

So what?
Suspensions have been steadily increasing, signalling ongoing and increasing risk to the Trust. 18% of active suspensions are over 12 months old, a slight decrease on last month.

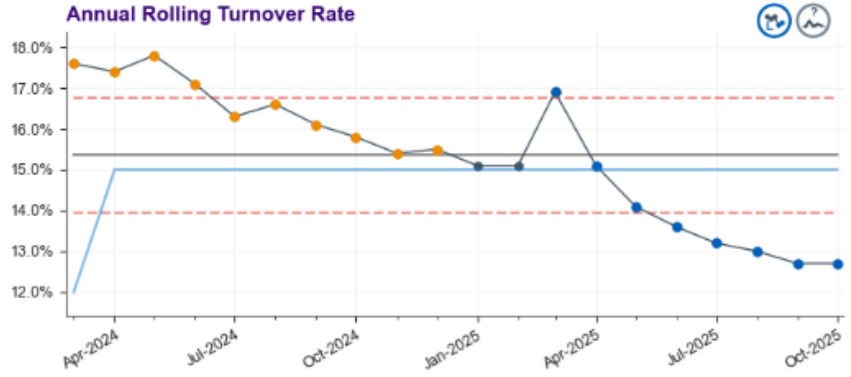
What Next?
- Continued weekly oversight by the Executive Team to ensure that delays are tracked and escalated where necessary.
- A dedicated effort by the People Relations team to focus on resolving suspension cases, working with external parties to ensure timely progress is being made.



WF-48
Dept: Workforce HR
Metric Type: Board
Latest: 0.9%
Target: 0.8%
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.



WF-49
Dept: Workforce HR
Metric Type: Board
Latest: 7.3%
Target: 5%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



WF-7
Dept: Workforce HR
Metric Type: Board
Latest: 12.7%
Target: 15%
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.

What?
In October, 55 staff left the organisation. 12 dismissals , 2 retirements, 2 redundancies, 2 end of FTC and 37 resignations.

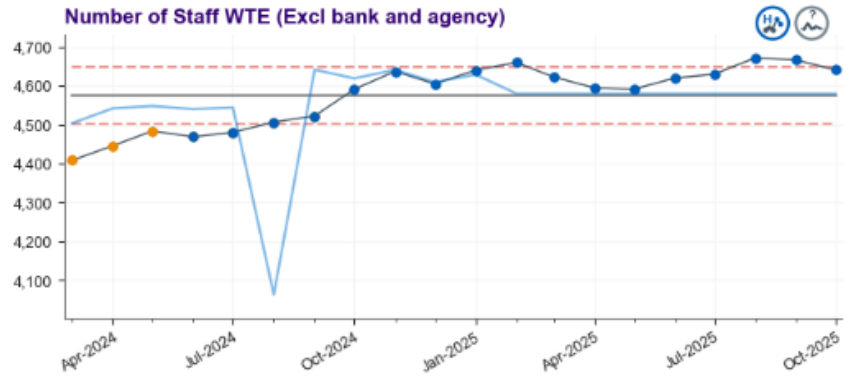
So What?
Turnover continues to trend positively, with rates well below target for a sustained period. This improvement suggests that recent retention efforts and organisational stability are having an impact. While this is encouraging, the process is not yet fully predictable, so ongoing monitoring is essential to ensure the gains are maintained and not driven by short-term factors.

What Next?
- Maintain focus on local action plans in higher-turnover areas to keep improvements on track.
- Review recent gains to understand underlying drivers and ensure they are sustainable.
- Continue monitoring and analysis to anticipate any impact from upcoming organisational restructures.

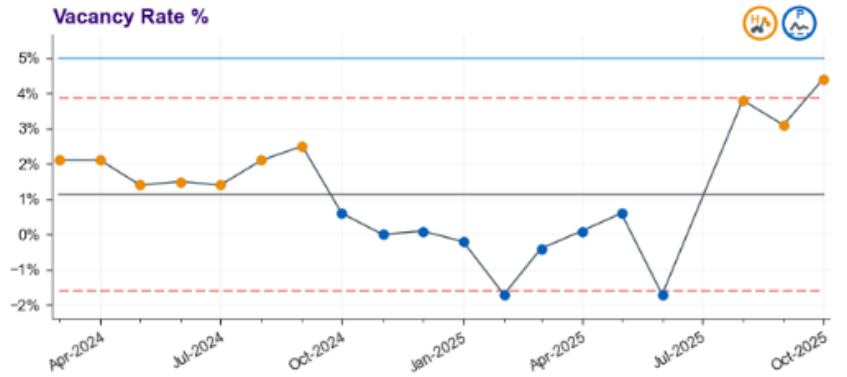
What?
Sickness absence is currently **7.3%**, with the rolling annual figure remaining above target at **around 7%**.

So What?
Sickness absence remains higher than target and shows no clear signs of improvement, despite recent fluctuations. The challenge is systemic rather than short-term, requiring sustained focus and redesign rather than incremental tweaks, and current plans to address absence are not expected to have significant impact in the short term.

What next?
- Strengthen attendance management through clearer policy and local accountability.
- Maintain quarterly leadership reviews to challenge progress and drive systemic change.
- Review wellbeing and support systems to tackle root causes of absence.



WF-1
Dept: Workforce HR
Metric Type: Supporting
Latest: 4640
Target: 4579.26
Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.



WF-4
Dept: Workforce HR
Metric Type: Supporting
Latest: 4.4%
Target: 5%
Special cause of a concerning nature where the measure is significantly HIGHER. Despite deterioration the process is capable and will consistently PASS the target.

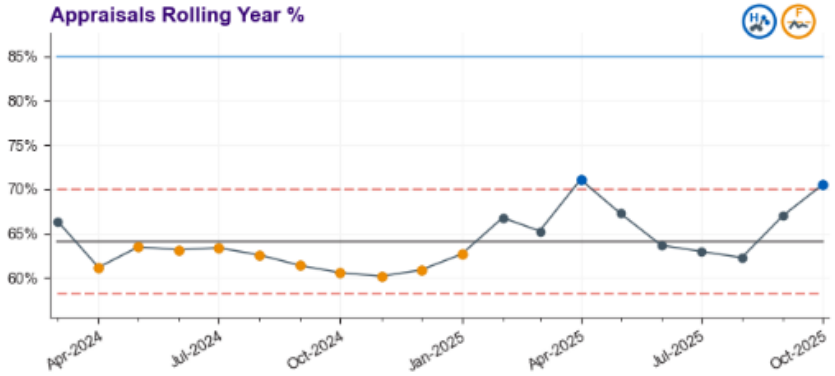
What?
Workforce WTE remains above the planned baseline at 4,640, reflecting stability. Vacancy rate has increased to 4.4%, partly due to positions being held open to support upcoming restructures.

So What?
The workforce position remains strong and aligned with strategic planning. The rise in vacancies is a deliberate choice to create flexibility for organisational change, not an indicator of risk. Service delivery and financial sustainability remain secure.

What Next?
- Workforce Planning Group maintains oversight to balance short-term staffing needs with restructure timelines.
- Progress long-term modelling to align workforce supply with transformation priorities and financial plans.
- Adjust recruitment activity to sustain optimal establishment while enabling restructure opportunities.
- Monitor the impact of the vacancy freeze and slower NQP recruitment to ensure service delivery remains unaffected.

People: Employee Development | Board Metrics

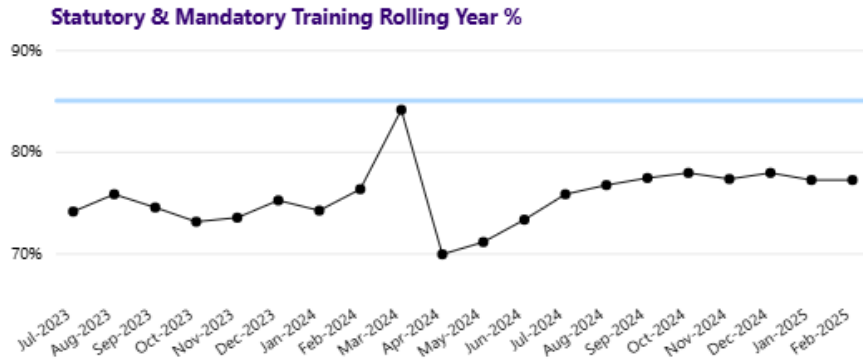
Integrated Quality Report



WF-40
Dept: Workforce HR
Metric Type: Board
Latest: 70.5%
Target: 85%
Special cause of an improving nature where the measure is significantly HIGHER. This process is still not capable. It will FAIL the target without process redesign.

WF-6
Dept: Workforce HR
Metric Type: Board
Latest: 88.5%

Special cause or common cause cannot be given as there are an insufficient number of points.



WF-6
Dept: Workforce HR
IP: People & Culture
Latest: 77.2%
Target: 85%
Special cause of an improving nature where the measure is significantly HIGHER. This process is still not capable. It will FAIL the target without process redesign.

What?
Current compliance rate is 71.5% within the Trust.

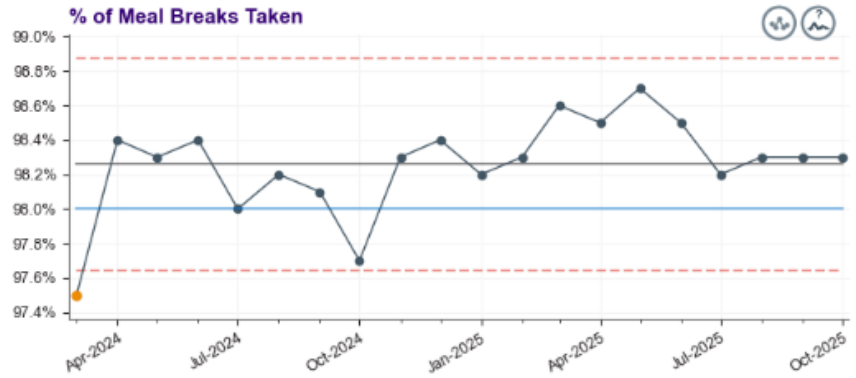
So what?
The data does show a increase in compliance; however, performance does still vary between directorates. Focused work continues to improve compliance in specific areas with regular checks made of their line managers to prioritise appraisal completion . To raise at divisional meetings for awareness and action. Weekly executive oversight will continue holding managers to account for non-compliance .

What next?
The L&D team have commenced the work having delivered several ESR walkthrough sessions via Microsoft Teams to support colleagues in correctly recording appraisals on ESR and improving compliance reporting. A new *Appraisal Skills Workshop* for managers is being designed and will be piloted in early December before becoming a business-as-usual offer. The session aims to build managers' confidence in holding meaningful, fair, and developmental appraisal conversations. We are also reviewing relevant NHS Elect and NHS Leadership Academy resources (e-learning, webinars, podcasts) to promote through internal channels such as the Weekly Bulletin, Viva Engage, and targeted communications. Additionally, we are collaborating with the CEO, Chairman, Executive Board, and their Executive Assistants to enable proxy access within ESR, allowing EAs to support the administration and accurate recording of appraisals to help drive compliance.

What?
Statutory and mandatory training compliance for the Core Skills Training Framework (CSTF) has remained above the 85% target for the fifth consecutive month. This demonstrates consistent Trust-wide engagement with nationally mandated learning requirements.

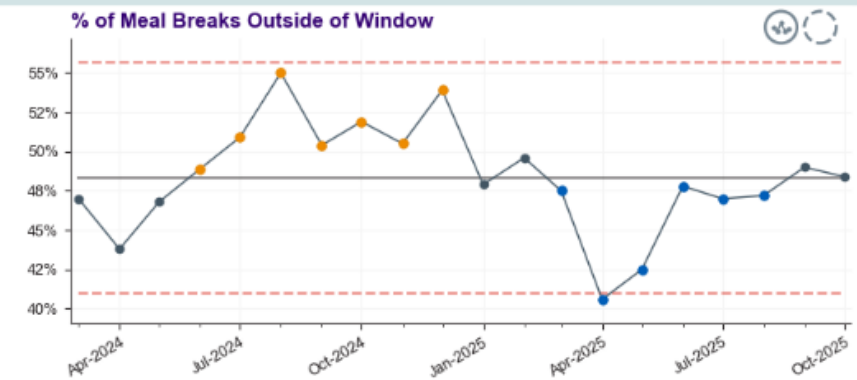
So what?
Sustained performance above the 85% target provides assurance that the workforce continues to meet national minimum compliance standards, reducing regulatory risk and supporting safe, high-quality care. It also indicates that the previous improvements to training access and reporting processes are now embedding. Maintaining this trajectory strengthens the Trust's position for external assurance processes and contributes directly to workforce readiness and organisational resilience.

What next?
Work has begun with the Data Analytics team to improve the accuracy and completeness of mandatory training capture. This is shown in the second graph which will now be reconfigured to capture all courses (data currently pending update).



999-27
Dept: Operations 999
Metric Type: Supporting
Latest: 98.3%
Target: 98%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

999-15
Dept: Operations 999
Metric Type: Supporting
Latest: 43.9%
Target: 45%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



999-28
Dept: Operations 999
Metric Type: Supporting
Latest: 48.4%

Common cause variation, no significant change.

What?
Slight improvement in mealbreaks taken outside of meal break window – but still over 40% of meal breaks taken outside of window.

So what?

Mealbreaks being out of window have a significant effect on trust finances with over £1 million pound paid out in compensation payments and a knock-on effect to Performance and out of service.

What next?
Mealbreak policy is currently under review with TUs and Staff to look for Opportunities to improve both patient and staff experience .Work with Dispatch to prioritise mealbreaks in the currently policy however policy allows for dispatch until out of window.

What?
Late Finishes remain high; this needs further analysis and benchmarking against other trusts which is being done as part of the southern collaborative work.

So what?
Continue to focus on dispatch decision making and end of shift crew protection being focused and balanced with staff and patient demand.

What next?
Reduction of over-runs remains focus of EOC and Field Ops teams.

Appendix 1: Glossary

Integrated Quality Report

AQI A7	All incidents – the count of all incidents in the period
AQI A53	Incidents with transport to ED
AQI A54	Incidents without transport to ED
AAP	Associate Ambulance Practitioner
A&E	Accident & Emergency Department
AQI	Ambulance Quality Indicator
ARP	Ambulance Response Programme
AVG	Average
BAU	Business as Usual
CAD	Computer Aided Despatch
Cat	Category (999 call acuity 1-4)
CAS	Clinical Assessment Service
CCN	CAS Clinical Navigator
CD	Controlled Drug
CFR	Community First Responder
CPR	Cardiopulmonary resuscitation
CQC	Care Quality Commission
CQUIN	Commissioning for Quality & Innovation
Datix	Our incident and risk reporting software
DCA	Double Crew Ambulance
DBS	Disclosure and Barring Service
DNACPR	Do Not Attempt CPR
ECAL	Emergency Clinical Advice Line
ECSW	Emergency Care Support Worker
ED	Emergency Department
EMA	Emergency Medical Advisor
EMB	Executive Management Board
EOC	Emergency Operations Centre
ePCR	Electronic Patient Care Record
ER	Employee Relations
F2F	Face to Face
FFR	Fire First Responder
FMT	Financial Model Template
FTSU	Freedom to Speak Up
HA	Health Advisor
HCP	Healthcare Professional
HR	Human Resources
HRBP	Human Resources Business Partner
ICS	Integrated Care System
IG	Information Governance
Incidents	See AQI A7
IUC	Integrated Urgent Care
JCT	Job Cycle Time
JRC	Just and Restorative Culture
KMS	Kent, Medway & Sussex
LCL	Lower Control Limited
MSK	Musculoskeletal conditions
NEAS	Northeast Ambulance Service
NHSE/I	NHS England / Improvement
OD	Organisational Development
Omnicell	Secure storage facility for medicines
OTL	Operational Team Leader
OU	Operating Unit
OUM	Operating Unit Manager
PAD	Public Access Defibrillator
PAP	Private Ambulance Provider
PE	Patient Experience
POP	Performance Optimisation Plan
PPG	Practice Plus Group
PSC	Patient Safety Caller
SRV	Single Response Vehicle

Agenda No	90-25

Name of meeting	Trust Board
Date	4th December 2025
Name of paper	EDI Quarterly Update
Executive sponsor	Sarah Wainwright – Chief People Officer
Author name and role	Jacqui Skeel – Deputy Director for People and OD Roxana Oldershaw – Project Manager Dawn Chilcott – Assistant Director of OD and Culture Carolanne L'etendrine – EDI Manager (Programme Lead)

There are two papers; the first provides an update against the four EDI priorities agreed by the Board in June 2025. The second relates to the insight from the latest annual WRES DES data.

EDI Priorities

Staff Networks

- A programme of events has been delivered, including Black History Month celebrations, Diwali recognition, Remembrance tributes, and the launch of Disability History Month.
- Network structure and governance continue to strengthen, with the Radius accreditation programme underway.
- Additional activity includes the launch of the Carers Café, promotion of carers passports, achievement of the Armed Forces Employer Recognition Scheme Gold Award, and development of a veteran's crisis pathway.

Inclusive Recruitment

- Community outreach events have engaged over 200 members of the public regarding career opportunities at the Trust.
- Work has commenced to explore progression routes from nursing into paramedic roles.
- Recruitment-focused initiatives to support achievement of Disability Confident Level 2 continue to progress.

Staff Development

- Recruitment for Cohort 2 of the Reverse Mentoring Programme is underway, alongside training of internal facilitators to ensure a sustainable long-term model.
- A Compassionate Leadership Conference, attended by more than 200 leaders, was successfully delivered.
- A new draft leadership framework has been developed and is progressing through review.

Data Insights

- The Trust met NHSE deadlines for publication of the WRES and WDES reports on the external website.

WRES DES Data

The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) are national frameworks to ensure NHS organisations monitor and improve equity in recruitment, career progression, disciplinary processes, and staff experience.

Key Findings

- Disabled and BME workforce representation has increased year-on-year since 2021, reflecting improved disclosure and recruitment outcomes. There is more work to do to improve diversity at all levels of the organisation as at present the data shows some disparity.
- Board-level diversity is not reported as representative of the total workforce, with no BME background or disability declared on ESR for any board members (as at 31 March 2025).
- While recruitment outcomes for disabled applicants have achieved parity, there is still more work to do for BME applicants who are currently 1.37 times less likely to be appointed from shortlisting than White applicants, although this is a considerable improvement form 2021 when the data showed they were 2.64 less likely.
- Capability and disciplinary outcomes show near parity across all staff groups, a very positive improvement since 2021 when BME staff were 2.64 more likely to enter formal disciplinary than their White colleagues and disabled colleagues were 2.90 times more likely to enter capability proceedings than non-disabled staff.
- Staff survey results show encouraging improvements in bullying, harassment, and career progression perceptions which are all positive indicators for culture improvement but indicators show there is still more work to do.

While compliance with national standards is essential, this data reflects SECAmb's culture and workforce reality. Progress is evident, but sustained action is needed to close the remaining gaps and ensure an inclusive, compassionate, and representative organisation.

Next Steps

- Following the publication last month the data will feed into NHSE's national benchmarking (results expected December 2025).
- Findings will inform targeted actions within our EDI Action Plan, aligned to the four focus areas: Staff Networks, Inclusive Recruitment, Staff Development, and Data Insights.
- Board Development session is being scheduled for Q4 to explore WRES/WDES and our strategic approach to EDI.

Recommendations, decisions or actions sought	For assurance / discussion

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Equality Diversity and Inclusion Highlight Report Q3

Executive Lead:- Sarah Wainwright

Senior Lead: Jacqui Skeel

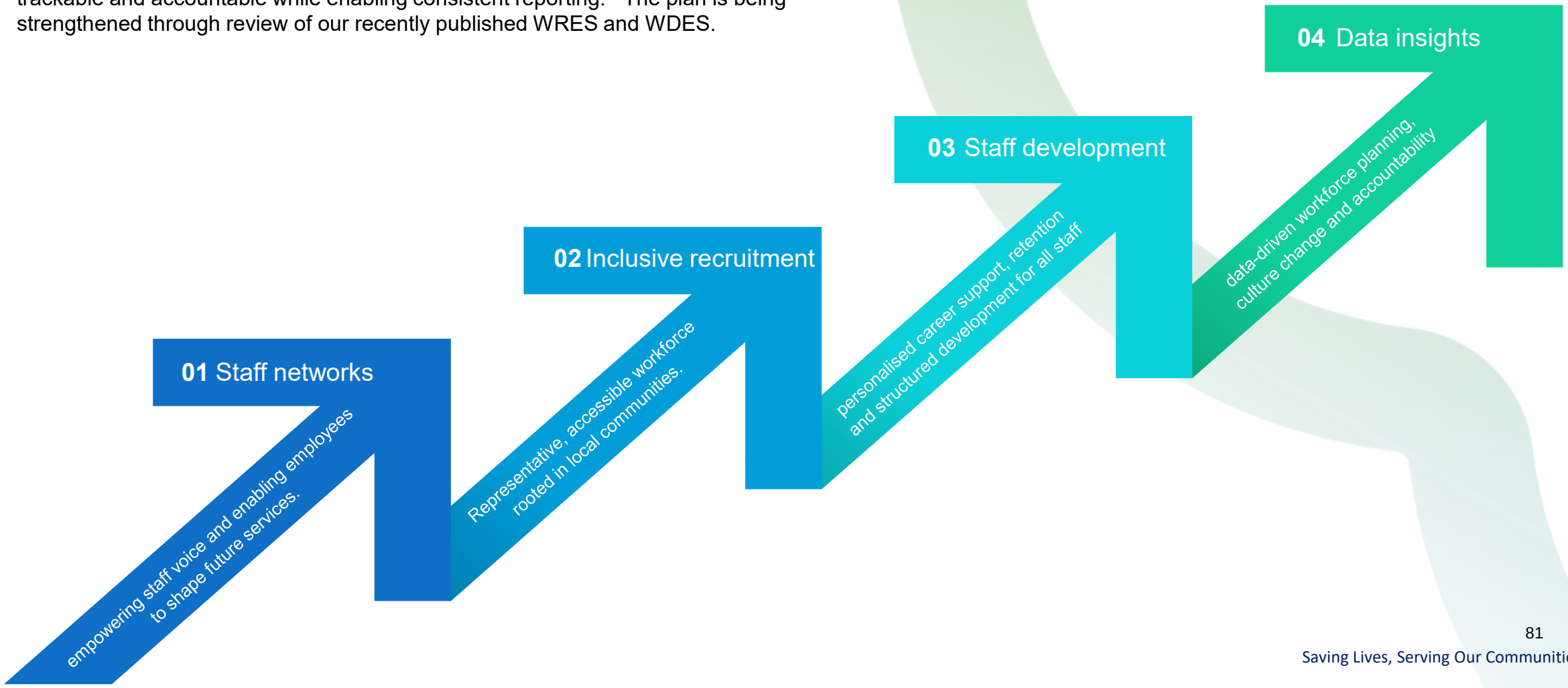
Last updated: 24th November 2025

Version 1.0

Executive Summary

Board Development days have created a strong platform for EDI, engaging over 50 senior leaders, network leads and People Services colleagues.

The EDI Action Plan is mapped to four focus areas making delivery coherent, trackable and accountable while enabling consistent reporting. The plan is being strengthened through review of our recently published WRES and WDES.



Highlight Report – EDI Plan – Q3 - Executive Summary

SRO / Executive Lead
Sarah Wainwright

Progress Highlights

STAFF NETWORKS

- Events: Black History Month celebrations, Diwali recognition, Remembrance tributes, and the launch of Disability History Month.
- Network structure and governance: Radius accreditation programme underway.
- Activity: Carers Café launched, promotion of carers passports, Armed forces Employer Recognition Scheme (ERS) gold award achieved, veteran's crisis pathway in development.

INCLUSIVE RECRUITMENT

- Community outreach events with engagement of over 200 members of public in relation to careers opportunities
- Work underway to explore nursing to paramedic progression routes
- Recruitment activity to support achievement of disability confident level 2 continued

STAFF DEVELOPMENT

- The reverse mentoring programme recruitment to cohort 2 currently underway and internal facilitators training to enable more sustainable approach
- Compassionate leadership conference held with over 200 leaders from across the organisation
- Development of new draft leadership framework

DATA INSIGHTS

- Publication of WRES/WDES onto Trust external website within NHSE deadline

Previous RAG	Current RAG	RAG Summary
		Objectives remain on track and the scope across the four focus areas is confirmed. Actions have been mapped against the EDI Action Plan, ensuring alignment and coherence. Timelines and milestones are clear, with progress already visible in networks, mentoring, and staff development. Governance through quarterly reporting provides assurance, though delivery would be strengthened with additional resourcing.

Risks	Initial	Current	Target	Mitigation
There is a risk of financial overspend if directorates approve reasonable adjustment requests without a consistent framework or central oversight. This could impact budgets and create inconsistency in the staff experience.	12	12	6	• The new Reasonable Adjustments Policy is due to go to JPF in November 2025 for final approval, reinforcing the centralised process and budget arrangements • Once launched, the policy will be actively communicated and embedded across directorates, with monitoring and escalation where approvals occur outside the process

WDES 2025

NHS
South East Coast Ambulance Service
NHS Foundation Trust

WORKFORCE DISABILITY EQUALITY STANDARD REPORT 2025

Version 3.0 – 15 Oct 2025

A message from our CEO

I am pleased to introduce this year's Workforce Disability Equality Standard (WDES) report, which reaffirms SECAmb's commitment to creating a workplace where equality, diversity, and inclusion are at the heart of everything we do. As an organisation serving a diverse population across the South-East, we recognise the importance of building a workforce that truly reflects and understands the communities we care for. This report offers an honest view of our progress, challenges, and the actions we are taking to ensure that every colleague, especially those with a disability, feels valued, respected, and supported.

This year we set out clear priority areas to guide our Trust-wide approach to Equality, Diversity and Inclusion (EDI). They were shaped through genuine engagement, including Board Development Days that brought together senior leaders, staff network chairs and colleagues from across the Trust.

From these conversations and lived experiences, four themes emerged: supporting and empowering our staff networks, strengthening inclusive recruitment, developing our staff, and improving our analytics and reporting. These priorities now form the foundation of our EDI delivery plan and reflect where we believe we can achieve the most meaningful and lasting change.

While we are encouraged by improvements, such as better access to reasonable adjustments and increased confidence in career progression, we recognise there is still more to do. Disabled colleagues continue to report lower levels of engagement and feeling valued and are more likely to experience bullying from peers or feel pressured to work when unwell. Reported representation at senior leadership and Board level also remains below that of the wider workforce.

We remain committed to addressing them with urgency and accountability. By continuing to listen, learn, and act, we aim to create an inclusive culture where every colleague can thrive and contribute fully to our shared purpose.

Simon Weldon
South-East Coast Ambulance NHS Trust

A MESSAGE FROM OUR ENABLE NETWORK

NHS
South East Coast Ambulance Service
NHS Foundation Trust

enABLE is our Disabilities, Neurodiversity and Carer Staff Network, created to bring people together, to shine a light on every experience, and to make sure that no one feels alone in their journey.

WDES helps SECAmb see how well we support colleagues with disabilities. It shows where we are doing well and where we need to improve.

What it means

- *WDES is about people, not just reports*
- *Everyone should have fair chances to learn, grow, and succeed*
- *We want a workplace where everyone is treated with dignity and respect*

Who it supports

- *Colleagues with physical or sensory disabilities*
- *Neurodiverse colleagues*
- *Colleagues with long-term health conditions*

Why it matters

- *When people feel valued, teamwork and care improve*
- *A workforce that reflects the community can give better care*

Sadie Ghinn-Morris & Mathew Allwright
Co-Chairs of SECAMb's enABLE Network

CONTENTS

Summary

Indicators

Conclusion

INTRODUCTION

The Workforce Disability Equality Standard (WDES) is a mandated, evidence based standard, required for all NHS organisations with over 250 staff. the WDES measures **the workplace experiences of disabled and non-disabled colleagues.** The purpose is to **identify inequalities**, **monitor progress** and **drive positive change in how organisations support disabled staff**.

WDES provides a year-on-year comparison against previous reporting periods and highlights where progress has been made, where disparities persist, and the actions we are taking through our Trust's EDI Action Plan.

As with previous years, this WDES analysis draws on two core datasets:

- Workforce data extracted from the **Electronic Staff Record** (ESR) as of 31 March 2025, including headcount by disability status, pay band, recruitment and capability processes

- Staff experience data from the **2024 NHS Staff Survey**, published in spring 2025, which captures the lived experiences of staff across areas such as bullying, harassment, discrimination, career progression and reasonable adjustments.

The two data sources together provide a balanced picture of both the structural and cultural aspects of disability equality within SECAmb.

Percentages are based on staff self-declaration of disability or long-term health condition. Staff who select “prefer not to say” are excluded from comparative calculations.

The WDES covers ten indicators, grouped into three broad areas:

- **Workforce composition and processes:** representation by pay band, recruitment, and capability outcomes
- **Staff experience:** perceptions of bullying/harassment, discrimination, career progression, presenteeism, feeling valued, reasonable adjustments and staff engagement
- **Leadership:** representation at Board level

WDES is integrated into SECAmb’s wider EDI plan, aligned to the EDI four focus areas:

- **Staff networks**: stronger enABLE leadership, clear objectives, and effective sponsorship
- **Inclusive recruitment**: fairer processes, improved progression pathways, and stronger senior representation
- **Staff development**: targeted programmes, including mentoring
- **Data insights:** the People Scorecard and Board oversight to track progress

KEYS & SYMBOLS & DEFINITIONS


Positive trend, evidence of improvement


Negative trend, area for improvement


No significant improvement/deterioration

KEY FINDINGS

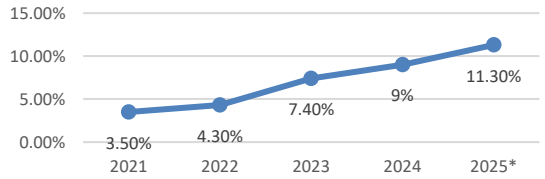
Data for indicators 1-3 and 10 are taken from the Employee Staff Record (ESR) and indicators 4 – 9 from National Staff Survey

South East Coast Ambulance Service NHS Foundation Trust

Colleagues with a disability | Colleagues with no disability | Overall organisation | *HBA = Harassment, Bullying or Abuse

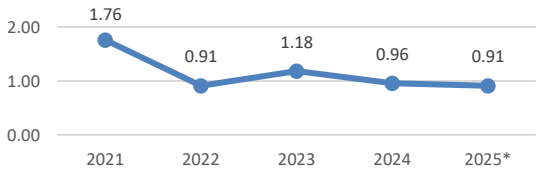
01 ↑

Workforce representation



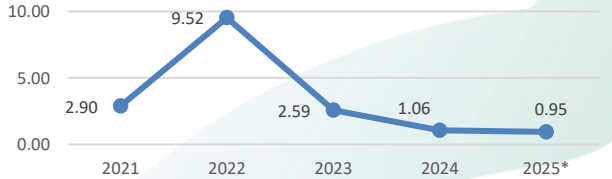
02 ↔

Relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting



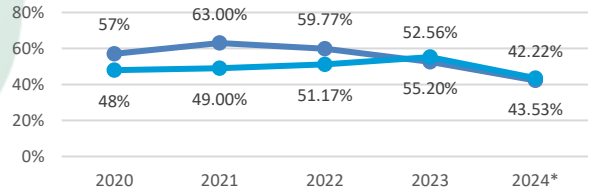
03 ↓

Relative likelihood of disabled staff entering formal capability proceedings compared to non-disabled staff



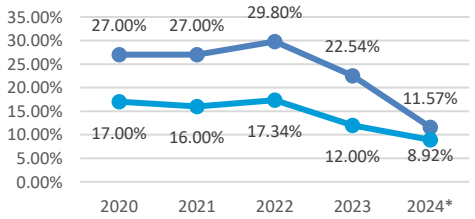
04A ↓

HBA* from public/patients



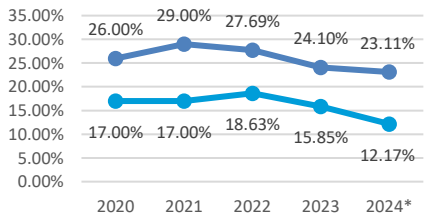
04B ↓

HBA from managers



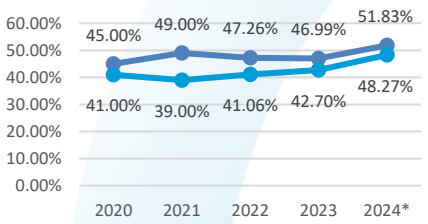
04C ↓

HBA from colleagues



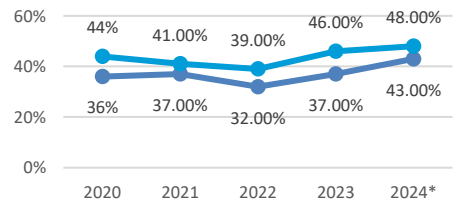
04D ↑

Reporting HBA



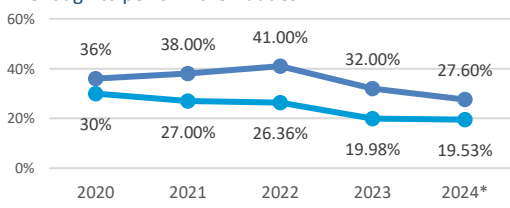
05 ↑

Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion



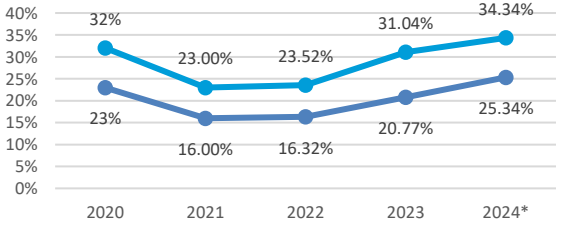
06 ↓

Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties



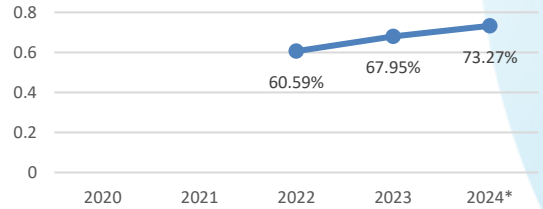
07 ↑

Percentage of staff satisfied with the extent to which their organisation values their work



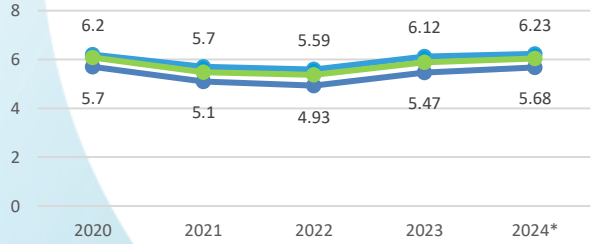
08 ↑

Percentage of staff with a long-lasting health condition or illness saying their employer has made reasonable adjustments to enable them to carry out their work



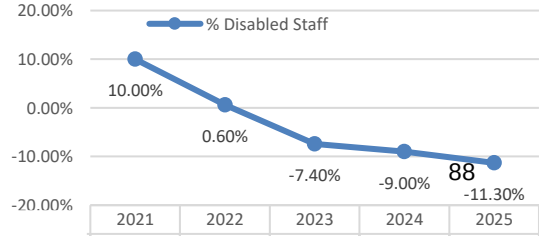
09 ↔

Staff engagement

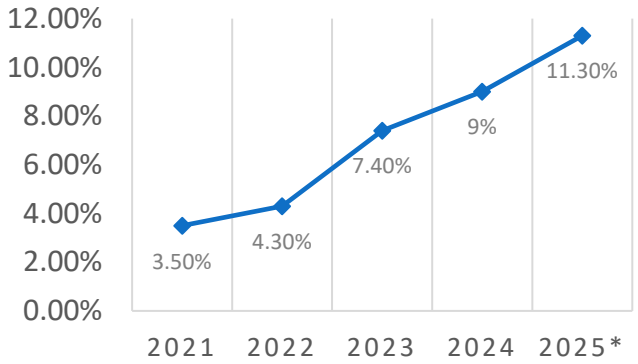


10 ↓

Board representation

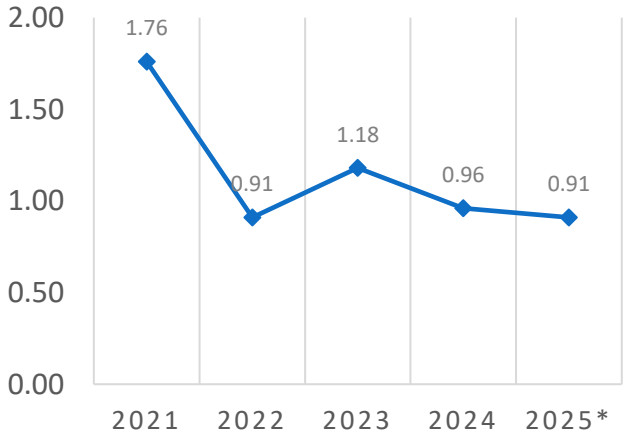


Indicator 1 | Disabled Staff Representation



Percentage of disabled staff in the last year, according to ESR declarations, has increased to 11.3% from 9% the previous year. This positive trend suggests greater disclosure confidence and/or improved recruitment and retention. Disclosure rates still vary, with around 4–5% non-disclosure, however SECAmb remains below the national average for non-disclosure, which was 14.3% in 2024.

Indicator 2 | Relative likelihood of disabled staff compared to non-disabled staff being appointed from shortlisting across all posts



This indicator compares the relative likelihood of disabled and non-disabled applicants being appointed after shortlisting. A ratio of 1.0 indicates equity, while indicators over 1.0 suggest non-disabled applicants are more likely to be shortlisted. In this case, the current indicator of 0.91 is close to equity, which has been the case since 2022 although a significant improvement compared to 2021, when disabled applicants were 1.76 times less likely to be appointed. The Trust is in line with national and regional benchmarks, reflecting improvements in inclusive recruitment processes.

**Workforce data (ESR) from 31 Mar 2025*

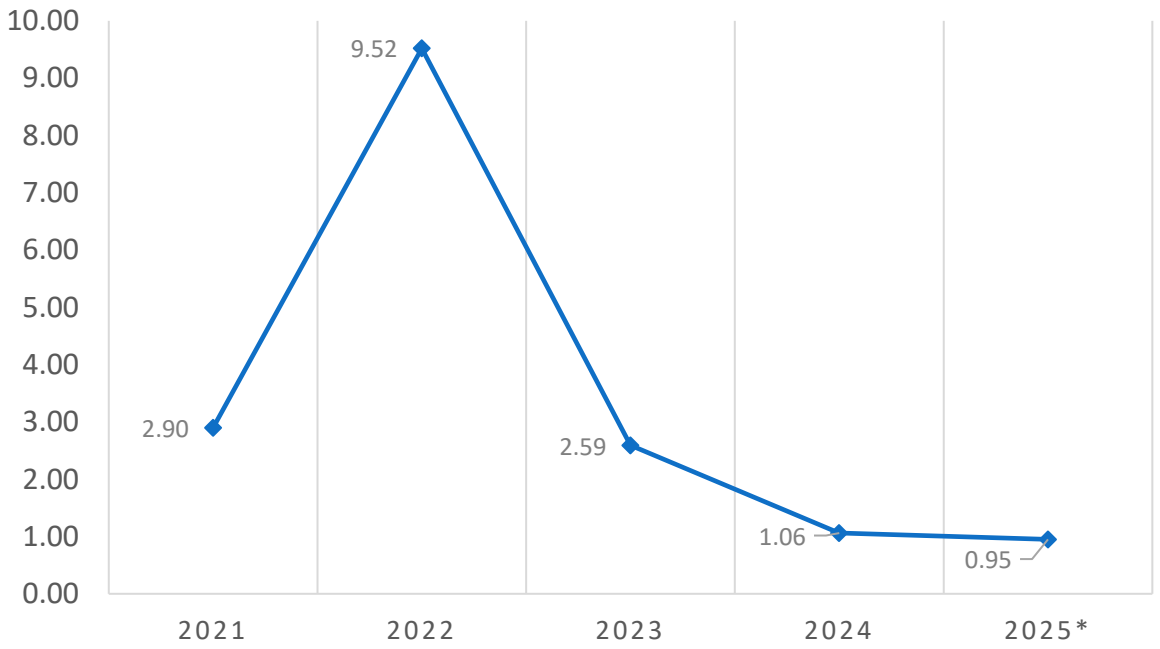
ACHIEVED TO DATE

- Disabled colleagues are now nearly as likely to be appointed as non-disabled peers, an 8% increase in representation since 2021
- The Trust has achieved Disability Confident Level 1, which means SECAmb has pledged inclusive practices, including guaranteed interviews for eligible disabled applicants and tailored support for employees with disabilities
- Reasonable Adjustments processes have been improved for both colleagues and line managers
- The enABLE network and Board development days have strengthened EDI awareness and engagement
- Equality Impact Assessment completion rates have improved, supporting more inclusive decision-making
- Recruitment team have received trained on implementing Reasonable Adjustments as part of the recruitment process

ACTIVITY PLANNED

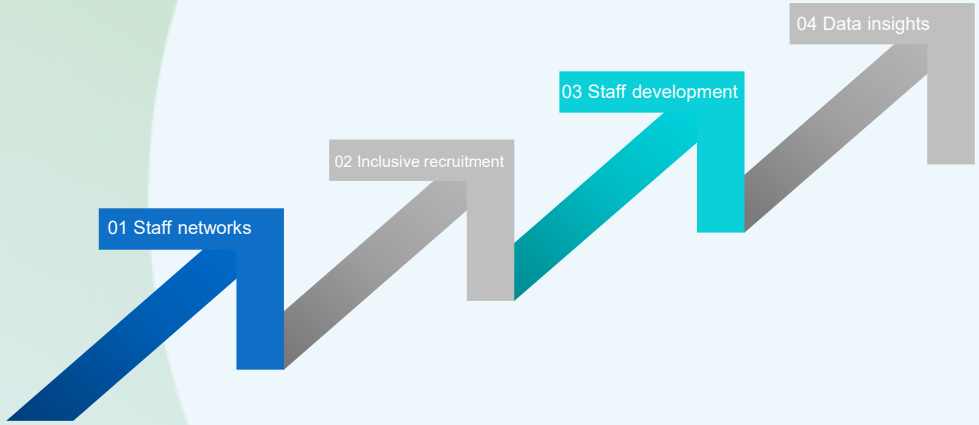
- To secure Disability Confident Level 2 by March 2026
- Reduce non-disclosure rates through awareness campaigns and staff network engagement
- Strengthened training for recruiting managers across divisions to include assessing candidates with declared disabilities
- Implement Reasonable Adjustments toolkit and Policy for line managers from November 2025 onwards
- Attend outreach career fair events in October 2025 to promote opportunities to local communities

Indicator 3 | Relative likelihood of disabled staff entering formal capability proceedings compared to non-disabled staff



This indicator measures the relative likelihood of disabled staff entering formal capability procedures (excluding ill-health) compared to non-disabled staff. There has been a significant improvement in the likelihood of disabled colleagues entering formal processes in 2025 (0.95) which represents almost parity with non-disabled colleagues.

**Workforce data from 31 Mar 2025*
A ratio of 1.0 indicates equity; higher values show disproportionate impact on disabled staff.



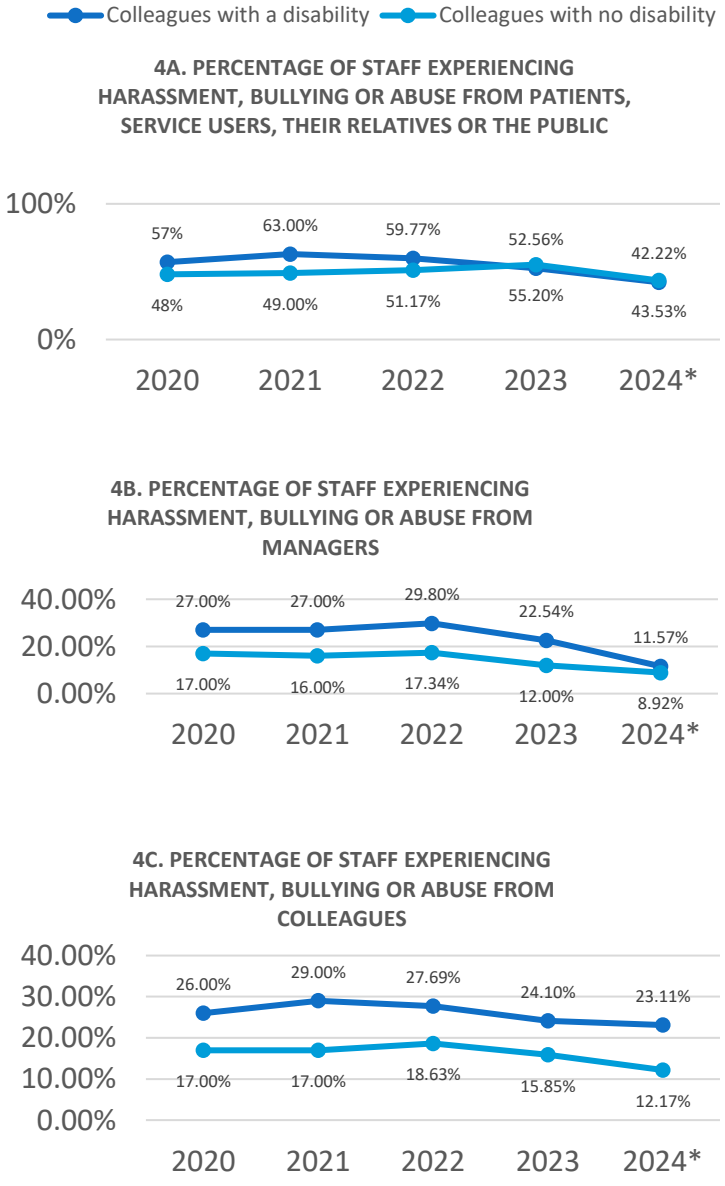
ACHIEVED TO DATE

- Achieved parity in likelihood of disabled or non-disabled staff entering capability proceedings
- Preventative support being used more proactively, e.g. improved reasonable adjustments process
- Enhanced support mechanism for colleagues through the Neurodiversity café, run by the Enable network

ACTIVITY PLANNED

- Review, gain approval for and launch refreshed Capability Policy due in Q4 2026
- Further implement ‘Beyond Bias’ training to line managers across divisions
- Continue to raise awareness of disabilities and long-term health conditions through staff network activities and divisional teams

Indicators 4A – 4C | Harassment, Bullying or Abuse (HBA)



Reduction in HBA from patients for both colleagues with and without disabilities. Decline in rates indicates positive cultural shifts and better staff experience. On average, SECAmb remains aligned to other organisations, where the national average is 49.67%. This reflects continuing challenges of work in patient-facing environments.

This indicator reflects workplace culture, management accountability and leadership behaviours. Disabled staff reporting bullying or harassment has significantly reduced from 30% in 2022 to 11.57% in 2024, however the data (see 4D) also shows that more colleagues with a disability are reporting HBA than those without .

This indicator highlights peer-to-peer culture and inclusivity within teams. Slight reduction since 2020, but disabled staff still report higher rates than peers. Steady decline indicates improved relationships and inclusive team dynamics, but still much work to be done.

**Staff Survey results published in 2025 (2024 survey)*

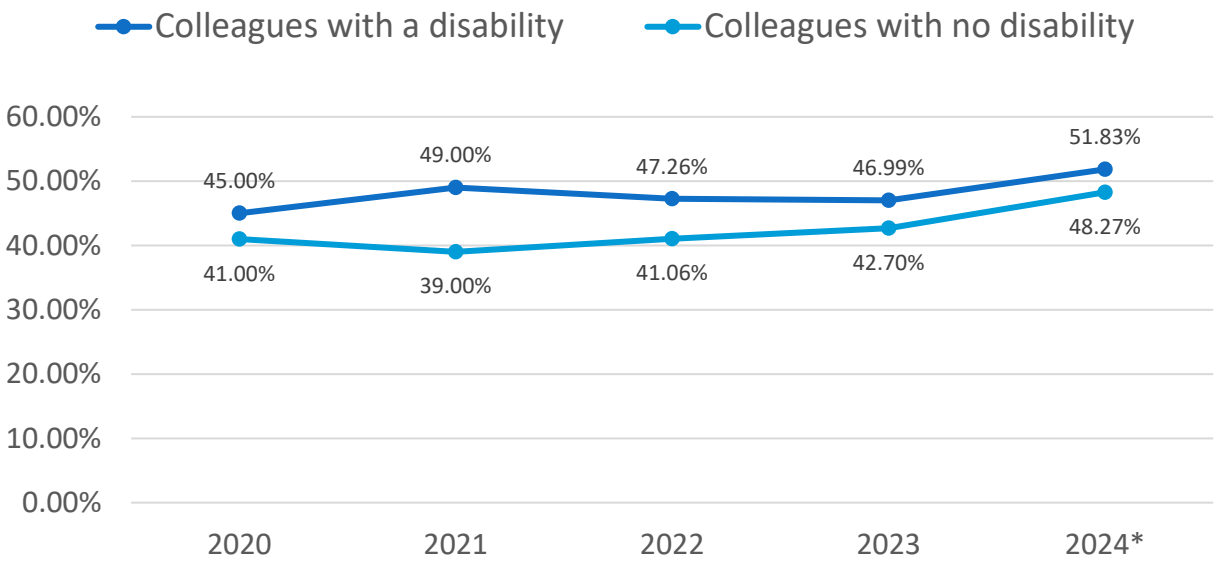
ACHIEVED TO DATE

- Increased use of body-worn cameras as part of our violence reduction initiatives
- Further implementation of leadership training programmes for staff at all levels to strengthen inclusive and compassionate leadership practices
- Staff safety initiatives (e.g., body-worn cameras, lone worker policies and procedures) introduced to reduce risks of HBA
- Active local engagement with the Assaults on Emergency Workers Act, led by the government and the NHS updated Violence Prevention Reduction Standards
- Collaboration with 'Operation Cavell', a joint workstream with Police, NHS Trusts and the Crown Prosecution Service tackling violence and aggression against staff
- Conflict resolution training introduced as part of key skills in April 2024, with excellent feedback. Training provides theory, breakaway techniques, and clinical restraint to help staff manage challenging behaviours. 86.34% colleagues completed the training as of 1 Oct 2025

ACTIVITY PLANNED

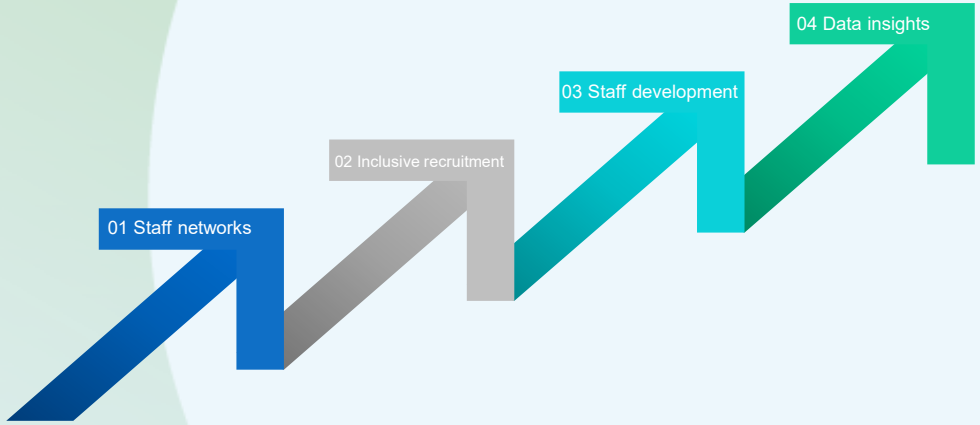
- Maintain focus on violence reduction initiatives and further embed inclusive and compassionate leadership training by refreshing the Trust's Leadership Framework and ensuring divisional teams have access to inclusive leadership development opportunities
- Explore targeted resilience and wellbeing support for disabled colleagues
- Strengthen escalation and feedback processes to ensure confidence in responses
- Co-design peer-led awareness campaigns with the enable staff network
- Enhance reporting feedback to demonstrate tangible outcomes when staff speak up
- Launch new Values & Behaviour Framework to embed Integrity, Kindness, and Courage, supporting inclusion and culture change across SECAmb.
- Continued collaboration between FTSU and Staff networks to bridge the gap for communities who are less likely to speak up

Indicator 4D |Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it



Increase in reporting reflects growing confidence in internal processes and support systems, suggesting enhanced awareness and trust in organisational response. However, with over half of those who responded to the survey indicating that they did not report incidents, there is still more work to do.

**Staff Survey results published in 2025 (2024 survey)*



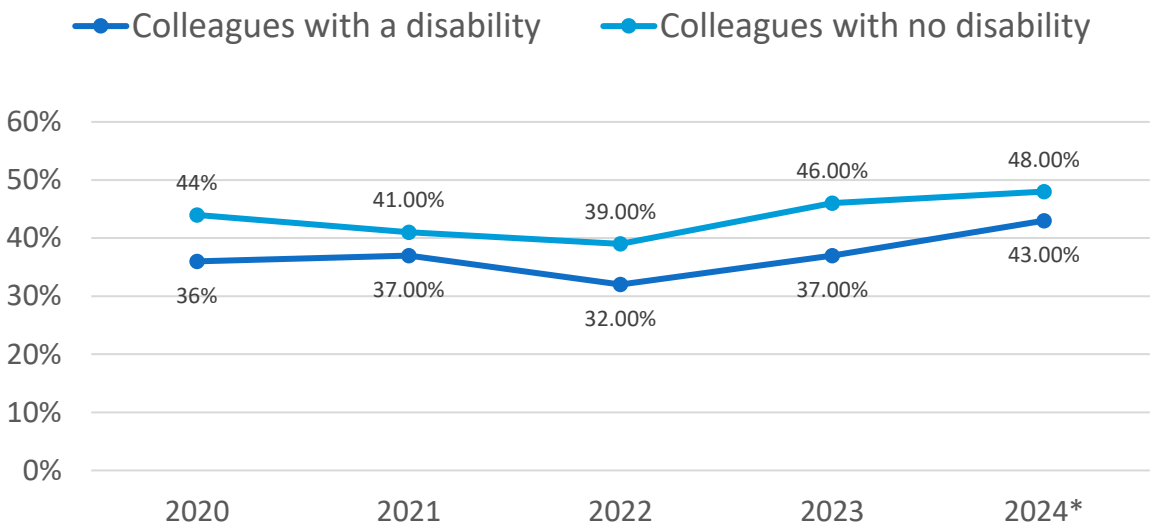
ACHIEVED TO DATE

- Improved visibility of reporting routes (e.g. FTSU)
- FTSU workshops delivered to 2nd and 3rd year university students
- Overview of the FTSU process and sexual safety training provided to Year 1 college students
- Engaged with staff networks to provide a brief overview and update on FTSU
- Sessions now incorporated at Induction and onboarding days to cover ways to speak up at the Trust

ACTIVITY PLANNED

- Expand awareness of informal and formal support options through trust-wide communications and engagement and at a local level in divisional and directorate teams
- Track trends via EDI dashboard and escalate longstanding issues with senior leaders as appropriate

Indicator 5 | Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion



This indicator reflects slightly increased confidence in equal opportunities. Both groups have experienced improvements since 2020 and the gap between groups has reduced. However, with only half of the staff that completed the survey indicating that they believe the organisation provides equal career progression there is still more work to do.

**Staff Survey results published in 2025 (2024 survey)*

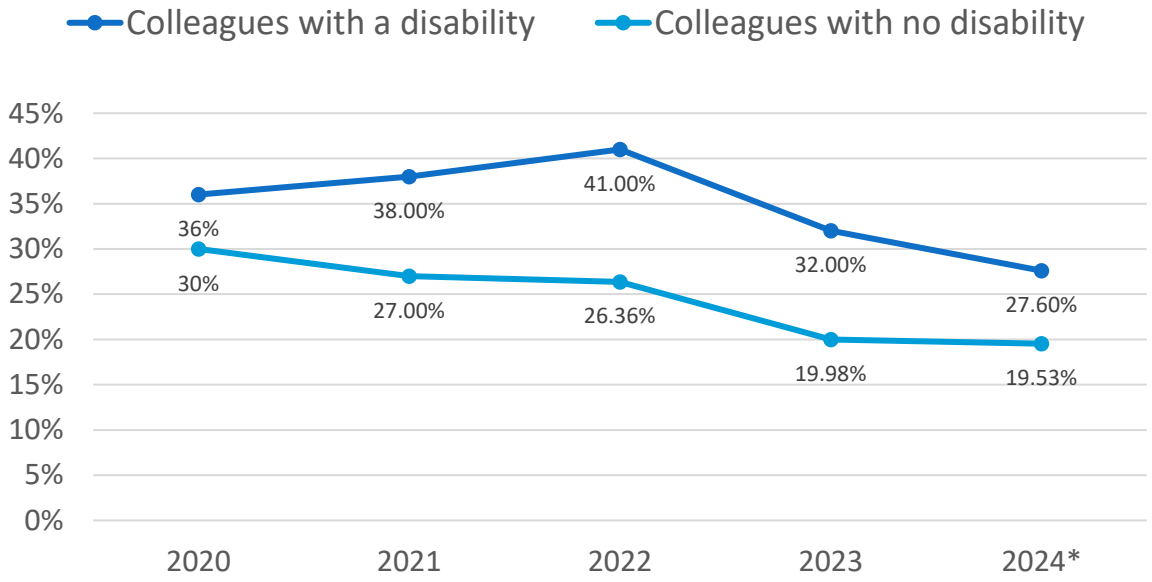
ACHIEVED TO DATE

- Access to Reverse Mentoring programme for colleagues who have disabilities (mentees supporting mentor with career progression advice)
- Training and Education panel implemented to support with access to the Training and Education Bursary application and budget for those staff with disabilities

ACTIVITY PLANNED

- Monitor progression data by disability status through the EDI dashboard and divisional reporting
- Future cohorts for Reverse Mentoring will be designed for wider accessibility, enabling colleagues from a broader range of staff groups to participate

Indicator 6 | Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties



This indicator measures the percentage of staff who feel pressured from their manager to attend work despite not feeling well enough. It reflects improved organisational culture and wellbeing. Disabled staff reporting pressure to come to work declined from 41% in 2021 to 27.6% in 2024 which is positive, but there is still much work to do to support staff wellbeing.

**Staff Survey results published in 2025 (2024 survey)*

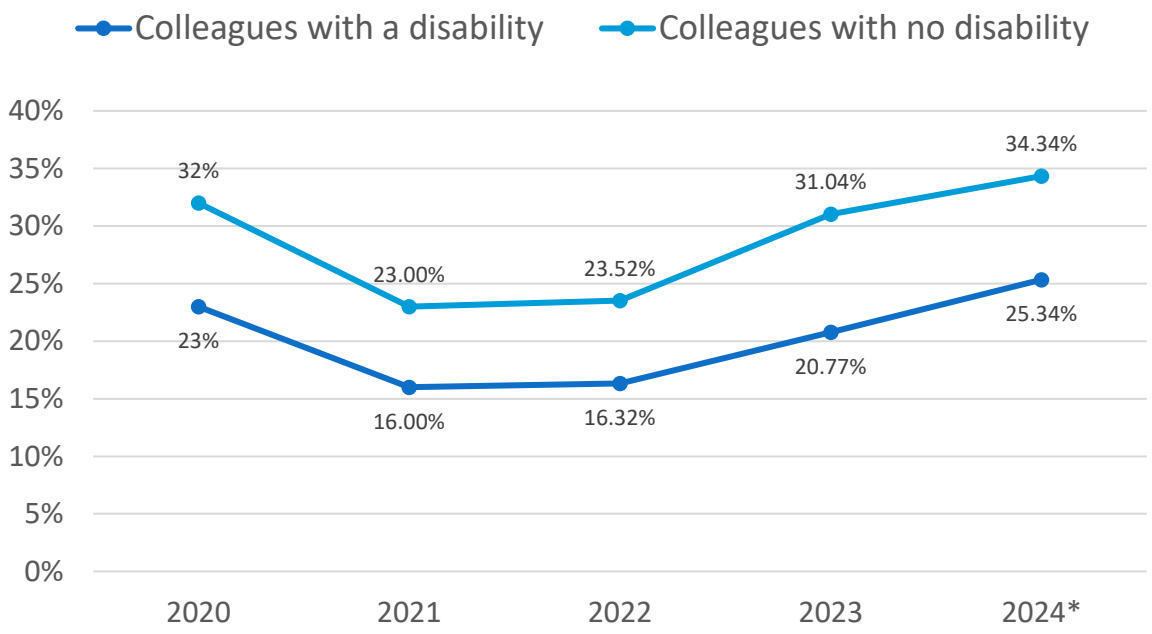
ACHIEVED TO DATE

- Wellbeing Strategy launched
- Reasonable adjustments monthly clinics launched to support line managers through the reasonable adjustments process
- 50+ wellbeing volunteers supporting the delivery of the Wellbeing agenda

ACTIVITY PLANNED

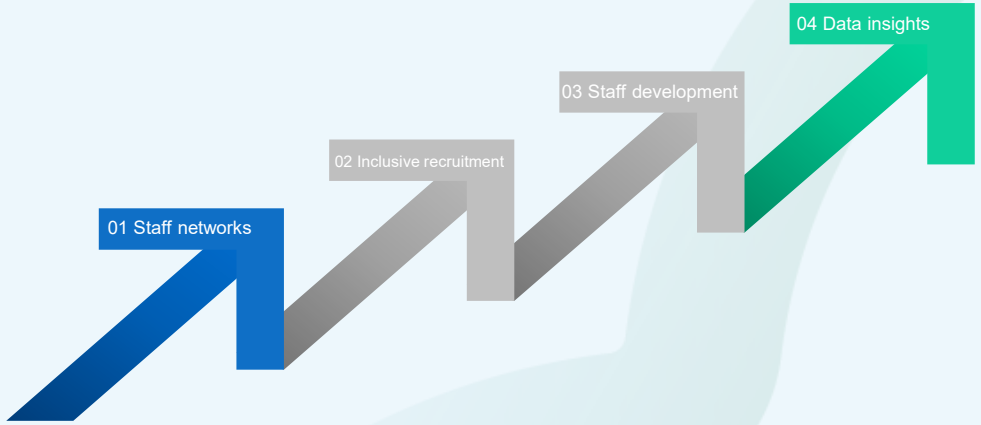
- Continue to promote a wellbeing centric culture through the implementation of the Wellbeing Strategy and further development of the wellbeing advocates role
- Strengthened Leadership and Management development provision to ensure compassionate and inclusive leadership practices across divisions
- Development and improved access of tools for line managers managing absence effectively. Launch of new policy Dec 2025
- Establishing a Wellbeing Forum to ensure that issues are addressed openly and transparently with clear lines of responsibility and accountability. This will be a forum where colleagues can discuss ideas about wellbeing, share their own lived experiences and work collectively on how to improve and prioritise wellbeing across the organisation
- The introduction of a Wellbeing Charter

Indicator 7 |Percentage of staff satisfied with the extent to which their organisation values their work



Improvement in feeling valued from colleagues with a disability reflects positive cultural change, though scores remain lower overall and compared to those without disability. Despite improvement, satisfaction levels still remain low, suggesting further work is needed to embed recognition and appreciation across teams.

**Staff Survey results published in 2025 (2024 survey)*



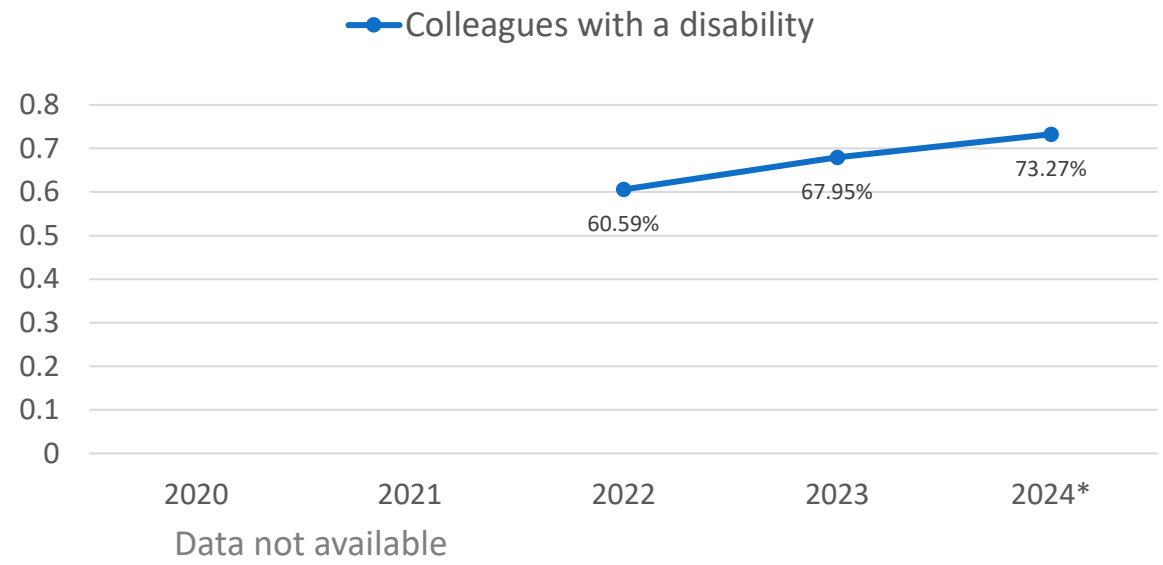
ACHIEVED TO DATE

- Recognition initiatives for all staff expanded across the Trust, with improved inclusion of diverse staff experiences
- Protected groups encouraged to participate in senior-level discussions as part of the newly launched Shadow Board
- Staff networks increasingly recognised as vehicles for staff voice and contribution
- A new Engagement Framework was launched in December 2024, offering multiple channels for staff to share their views and engage with senior leaders with over 1,500 colleagues (1/3 workforce) engaged face-to-face
- The Engagement Framework includes: Big Conversations, Shadow Board, NHS Staff Survey, NHS Pulse Survey, Local Engagement, Staff Networks, Connect with the Chief, Engage with the Execs and Town Halls

ACTIVITY PLANNED

- Formalise staff voices in decision-making forums, which will help with building belonging
- Track satisfaction of activity through staff survey and network feedback
- Continue to engage through the Engagement Framework to hear first hand from colleagues with lived experience

Indicator 8 | Percentage of staff with a long-lasting health condition or illness saying their employer has made reasonable adjustments to enable them to carry out their work



This indicator measures the percentage of disabled staff who state their employer has made reasonable adjustments to enable them to carry out their work and reflects compliance with equality legislation. This indicator started being tracked through the National Staff Survey in 2022 and is already showing significant improvement with an upward trajectory.

**Staff Survey results published in 2025 (2024 survey)*

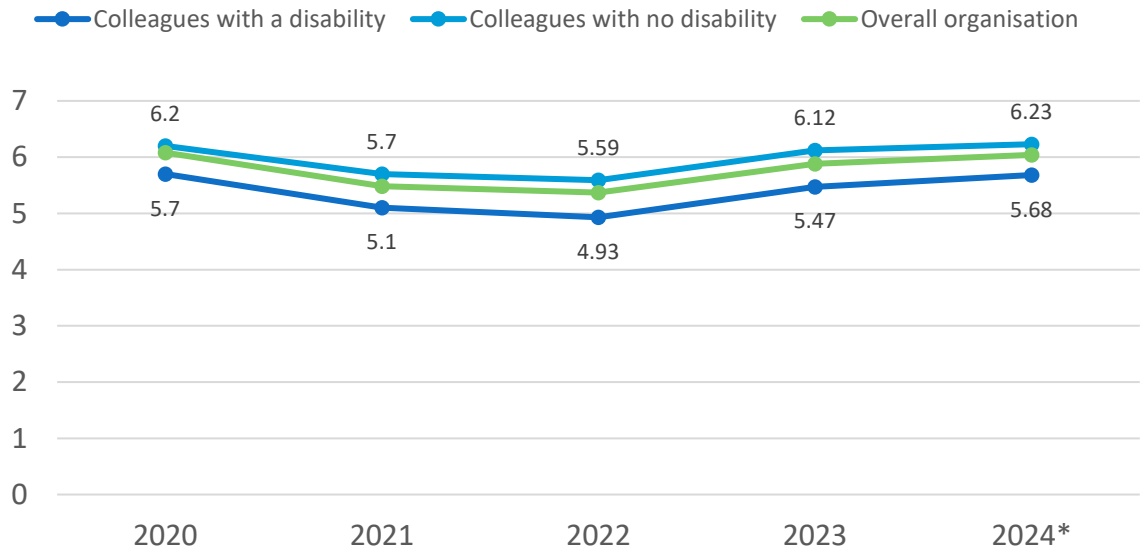
ACHIEVED TO DATE

- Significant improvement in provision and recording of adjustments
- Streamlined reasonable adjustments process and referral pathways
- Launched reasonable adjustments clinics for line managers and colleagues
- Since launching the improved process for requesting reasonable adjustments in early 2024, the Inclusion team have provided support for over 273 adjustment requests (note: staff may submit multiple adjustment requests)
- Locally managed reasonable adjustments passports have been used as a support tool by line managers since 2022

ACTIVITY PLANNED

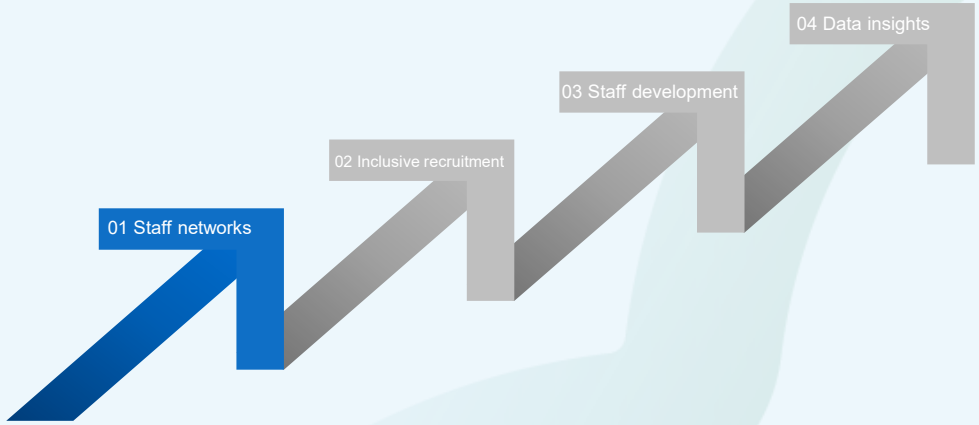
- Improve consistency and timelines of reasonable adjustments across all teams and divisions
- Gain approval from Joint Partnership Forum to launch Reasonable Adjustments Policy and support managers in applying policy.
- Monitor adjustments delivery via RA dashboard
- Improve reporting to capture the number of colleagues being supported with reasonable adjustments
- Launch an updated Managing Attendance Policy Q4 2025
- Beyond bias training to be further implemented across the Trust

Indicator 9 | Staff engagement score (0-10) (aggregated score calculated from nine specific questions grouped into three themes: motivation, involvement and advocacy)



This is an aggregated score (0-10) based on motivation, involvement and advocacy from the NHS staff survey. It reflects overall staff engagement. The staff engagement score for those who declared a disability has improved from 2022 to 2024, and the gap is smaller between disabled and non-disabled staff. The score for the overall organisation is 6.04 and comparable with neighbouring Ambulance Trusts.

**Staff Survey results published in 2025 (2024 survey)*



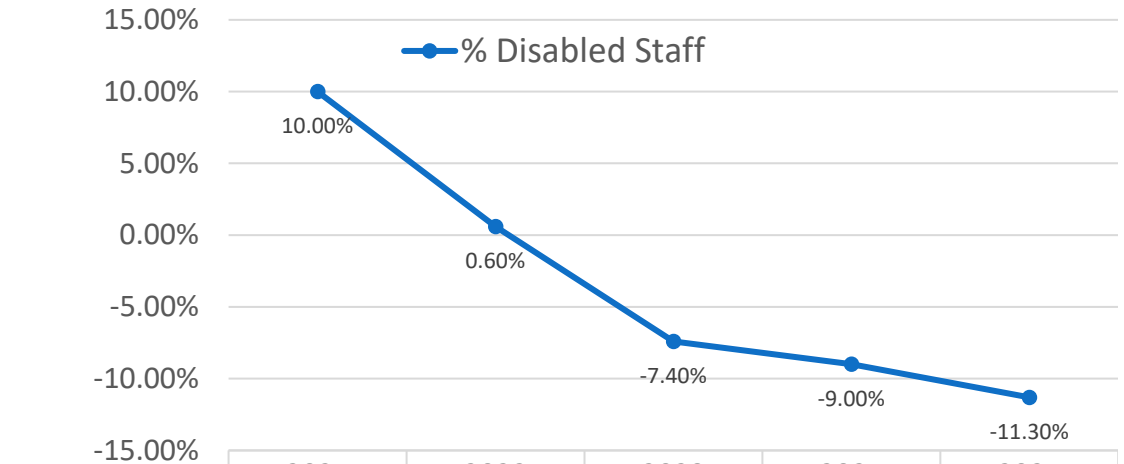
ACHIEVED TO DATE

- A new Engagement Framework launched, offering multiple channels for staff to share their views and engage with senior leaders
- The Engagement Framework covers: Big Conversations, Shadow Board, NHS Staff Survey, NHS Pulse Survey, Local Engagement, Staff Networks, Connect with the Chief, Engage with the Execs and Town Halls

ACTIVITY PLANNED

- Foster engagement through further embedding the Engagement Framework with involvement of staff networks and divisional teams
- Enhance communication of actions taken in response to staff feedback

Indicator 10 | Board representation



	2021	2022	2023	2024	2025
% Disabled Staff	10.00%	0.60%	-7.40%	-9.00%	-11.30%

This indicator measures whether the composition of the Board is proportionate to the workforce in terms of declared disability status. As at 31 March 2025, 11.3% of the workforce had recorded a disability on ESR, compared to 0% of the Trust Board (14 members reported no disability and one chose not to declare).
This creates a representation gap of 11.3 percentage points; meaning the Board currently has no disabled members.

While the wider workforce has seen steady year-on-year growth in disability disclosure and representation, this has not yet been mirrored at Board level. Closing the gap remains a key priority, with actions focused on inclusive succession planning, strengthening leadership pipelines, and embedding measurable EDI objectives for Board members. It is also important to encourage Board members to keep ESR data up to date and accurate.

ACHIEVED TO DATE

- Increased focus on Board-level EDI objectives, including reverse mentoring
- Executive and non-executive sponsors identified for all staff networks
- Board development days included lived experience contributions from staff with a disability with the support from Staff Networks.

ACTIVITY PLANNED

- Strengthened talent pipeline and succession planning for colleagues with a disability who aspire to develop into senior leadership roles
- Encourage Board Members and colleagues across the Trust to ensure ESR data is updated and accurately reported

Activities planned

Focus area	Next steps / activities planned	Linked WDES indicator(s)
1. Staff networks	• Further raise awareness of disabilities and long-term health conditions through staff networks • Co-design peer-led awareness campaigns with enable • Formalise staff voices in decision-making forums • Continued collaboration between FTSU and staff networks • Enhance communication of actions taken in response to staff feedback • Reduce non-disclosure rates through awareness campaigns and staff network engagement • Continued collaboration between FTSU and Staff networks to bridge the gap for communities who are less likely to speak up • Staff networks increasingly recognised as vehicles for staff voice and contribution • Continue to foster engagement through further embedding the Engagement Framework with involvement of staff networks	1, 3, 4, 7, 9, 10
2. Inclusive recruitment	• Secure Disability Confident Level 2 • Recruiting managers training to include module on assessing candidates with disabilities • Launch community outreach events (Oct 2025) • Roll out Beyond Bias training to line managers and all Directorates • Strengthen talent pipeline and succession planning for disabled colleagues aspiring to senior leadership • Encourage Board and wider Trust to update their ESR data • Access to Reverse Mentoring programme for colleagues who have disabilities (mentees supporting mentor with career progression advice)	1, 2, 5, 10

Activities planned

Focus area	Next steps / activities planned	Linked WDES indicator(s)
3. Staff development	• Roll out Reasonable Adjustments toolkit and policy for line managers (Nov 2025) • Review, gain approval for and launch refreshed Capability Policy due in Q4 2026. • Maintain focus on violence reduction initiatives and embed inclusive leadership training • Explore targeted resilience and wellbeing support for disabled colleagues • Launch new Values & Behaviour Framework (Jan/Feb 2026) • Encourage colleagues with disabilities to access reverse mentoring cohorts • Reverse Mentoring - future cohorts designed for wider accessibility • Promote a wellbeing-centric culture through further development of the wellbeing advocates. • Ensure line managers have tools, knowledge and confidence for managing absence supportively • Launch Updated Managing Attendance Policy (Dec 2025) • Expand awareness of informal and formal support options through trust-wide communications and engagement and at a local level in divisional and directorate teams relating to HBA • Gain approval from Joint Partnership Forum to launch Reasonable Adjustments Policy and support managers in applying policy • Launch an updated Managing Attendance Policy Q4 2025 • Beyond bias training to be further implemented across the Trust	2, 3, 4, 5, 6, 8
4. Data insights	• Reduce non-disclosure rates from 4–5% to <3% through campaigns and engagement • Strengthen escalation and feedback processes to ensure confidence in responses relating to HBA • Enhance reporting feedback loop to show tangible outcomes • Track trends via EDI dashboard and escalate long-standing issues • Monitor progression data by disability status • Track satisfaction of initiatives via staff survey and network feedback • Continue engaging staff through Engagement Framework • Monitor reasonable adjustments delivery and support to colleagues via EDI dashboard • Increased focus on Board-level EDI objectives, including reverse mentoring	1, 4, 5, 7, 8, 10

WRES 2025

NHS
South East Coast Ambulance Service
NHS Foundation Trust

WORKFORCE RACE EQUALITY STANDARD REPORT 2025

Version 5.0 – 17 Oct 2025

A message from our CEO

I am pleased to introduce this year's Workforce Race Equality Standard (WRES) report, which plays a vital role in helping SECAmb understand and address the disparities experienced by colleagues from Black and Minority Ethnic (BME) backgrounds. Creating a truly inclusive and equitable workplace is one of our highest priorities. We want every colleague to feel valued, supported, and able to thrive, and for our workforce to reflect the rich diversity of the communities we serve across the South-East.

This year's report shows encouraging progress in some areas, such as reductions in bullying and harassment for both BME and White colleagues, and increased confidence in career progression. For the first time, BME colleagues reported lower levels of harassment from other staff than White colleagues. However, challenges remain. BME colleagues continue to face disproportionate levels of discrimination from the public, and recruitment outcomes still favour White applicants, with a notable disparity in appointments from shortlisting. These inequities must be addressed with urgency and determination.

This year we set out clear priority areas to guide our Trust-wide approach to Equality, Diversity and Inclusion (EDI). They were shaped through genuine engagement, including Board Development Days that brought together senior leaders, staff network chairs and colleagues from across the Trust.

From these conversations and lived experiences, four themes emerged: supporting and empowering our staff networks, strengthening inclusive recruitment, developing our staff, and improving our analytics and reporting. These priorities now form the foundation of our EDI delivery plan and reflect where we believe we can achieve the most meaningful and lasting change.

These focus areas reflect where we believe we can make the greatest impact. We are committed to learning from lived experience, listening to our colleagues, and holding ourselves accountable as we work towards a workplace where every individual, regardless of background, feels respected, included, and able to reach their full potential.

Simon Weldon
South-East Coast Ambulance NHS Trust

A message from our Inspire Network

Inspire is SECAmb's Cultural Diversity and Faith network. We aim to promote equality of opportunity while creating a supportive network for all by discussing and promoting the interests of Black and Minority Ethnic (BME) and faith issues for all staff, students and volunteers alike.

The Workforce Race Equality Standard (WRES) is a vital tool in helping us measure, understand, and improve how we support colleagues from Black and Minority Ethnic (BME) backgrounds across SECAmb. Since its introduction in 2015, WRES has provided us with clear insights into where progress is being made and, just as importantly, where inequalities remain.

At its heart, WRES is about ensuring that every colleague has fair access to opportunities for development and career progression, while also being treated with respect and dignity in the workplace. It challenges us to look honestly at the data, listen to the lived experiences of our staff, and take meaningful action to address disparities.

As Chair of Inspire, I want to emphasise that WRES is about people. It represents our commitment to building a culture where everyone feels valued, included, and empowered to thrive. By standing firm in our dedication to equity and accountability, we can continue to create a stronger, fairer SECAmb for colleagues and the communities we serve.

Amjad Nazir
Chair Inspire Network

CONTENTS

NHS
South East Coast Ambulance Service
NHS Foundation Trust

INTRODUCTION

The Workforce Race Equality Standard (WRES) is a mandatory requirement for all NHS organisations with more than 250 staff. Its purpose is to identify and address disparities in the workplace experience of Black and Minority Ethnic (BME) colleagues compared with their White counterparts.

WRES provides a critical evidence base to measure progress against our EDI Action Plan, to hold ourselves accountable for change and to ensure we are building a workplace that is fair, inclusive and representative of the communities we serve.

As with previous years, this WRES analysis draws on two core datasets:

- Workforce data extracted from the **Electronic Staff Record** (ESR) as at 31 March 2025, including headcount by ethnicity, pay band, recruitment and disciplinary processes.

- Staff experience data from the 2024 **NHS Staff Survey**, published in spring 2025, which captures the lived experiences of staff across areas such as bullying, harassment, discrimination, and career progression.

The two data sources together provide a balanced picture of both the structural and cultural aspects of race equality within SECAmb.

Percentages are based on staff self-declaration.

The WRES covers nine indicators, grouped into three broad areas:

1. **Workforce composition and processes:** representation by pay band, recruitment, disciplinary outcomes and access to training.
2. **Staff experience:** perceptions of career progression, bullying/harassment and discrimination at work.
3. **Leadership:** representation at Board level.

WRES is integrated into SECAmb's wider EDI plan, aligned to the EDI four focus areas:

- **Staff networks**: stronger Inspire leadership, clear objectives, and effective sponsorship
- **Inclusive recruitment**: fairer processes, improved progression pathways, and stronger senior representation
- **Staff development**: targeted programmes, including the Ascend programme and mentoring
- **Data insights:** the People Scorecard and Board oversight to track progress

KEYS & SYMBOLS & DEFINITIONS

 Positive trend, evidence of improvement

 Negative trend, area for improvement

 No significant improvement/deterioration

KEY FINDINGS

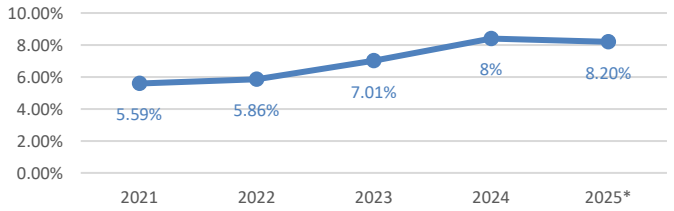
Data for indicators 1-3 and 9 are taken from the Employee Staff Record(ESR) Indicators 4 – 8 from National Staff Survey

South East Coast Ambulance Service NHS Foundation Trust

BME colleagues White colleagues *HBA = Harassment, Bullying or Abuse

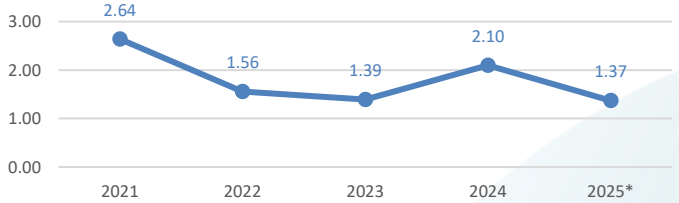
01

Workforce representation



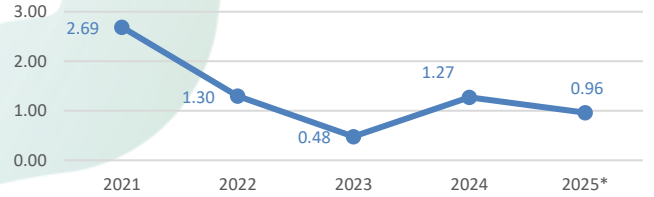
02

Relative likelihood of BME candidates compared to White candidates being appointed from shortlisting



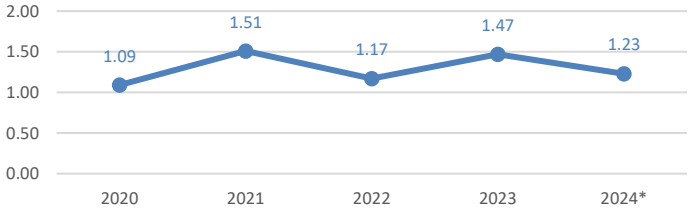
03

Relative likelihood of BME staff entering formal disciplinary proceedings compared to White staff



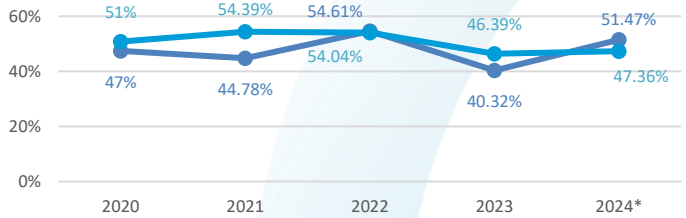
04

Relative likelihood of BME staff accessing non-mandatory training compared to white staff



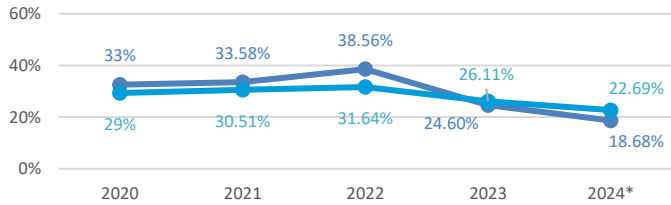
05

Percentage of staff experiencing HBA from patients



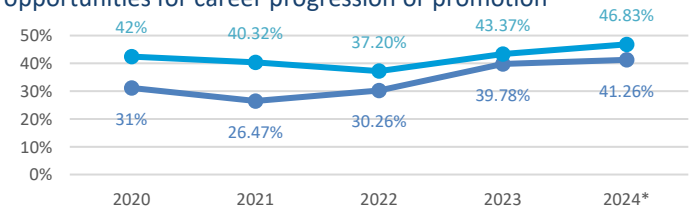
06

Percentage of staff experiencing HBA from staff



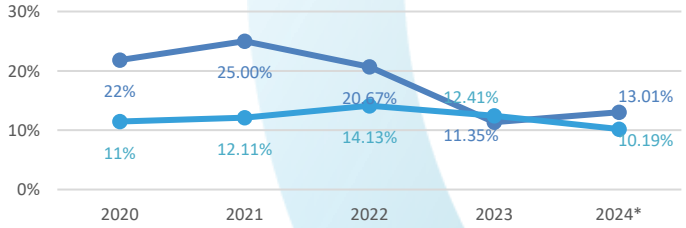
07

Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion



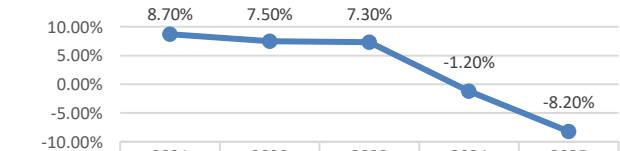
08

Percentage of staff experiencing discrimination



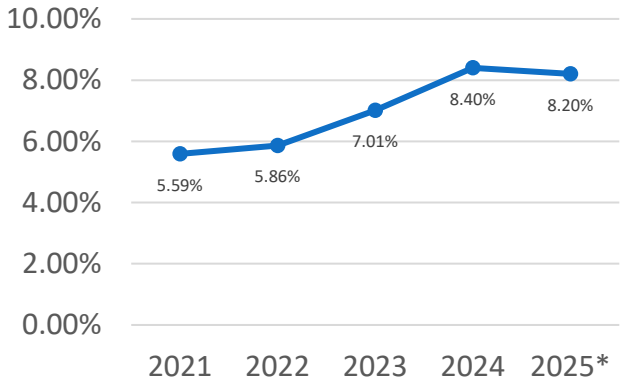
09

Board representation



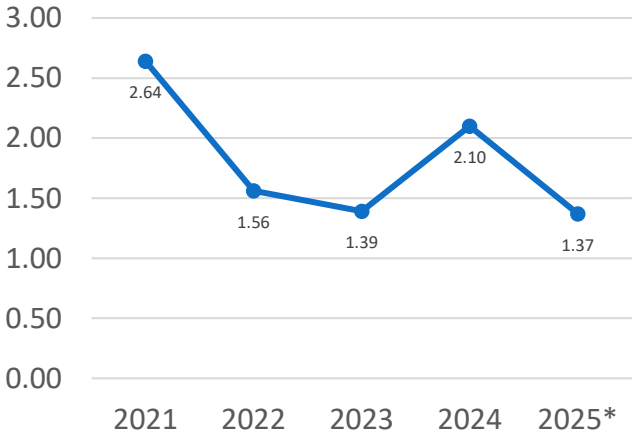
	2021	2022	2023	2024	2025
% BME Board	8.70%	7.50%	7.30%	-1.20%	-8.20%

Indicator 1 | Workforce representation



This indicator compares the proportion of BME staff across Agenda for Change (A4C) pay bands with the overall workforce. In 2025, **8.2% of SECAmb staff** identified as BME (down from 8.4% in 2024). BME staff are disproportionately located in **non-clinical roles at lower A4C pay bands (1–4)**. Representation steadily declines with seniority, creating a significant gap at leadership levels, with only one BME person at band 8C and above reported in post as of 31 March 2025.

Indicator 2 | Relative likelihood of BME candidates compared to White candidates being appointed from shortlisting



This indicator compares the relative likelihood of BME applicants being appointed compared with White applicants. A ratio of 1.0 indicates equity. White candidates are 1.37 times more likely to be appointed than BME candidates which, whilst this is an improvement from 2024, there is still much work to do to create an equal opportunity.

**Workforce data from 31 Mar 2025 and Staff Survey results published in 2025 (2024 survey)*

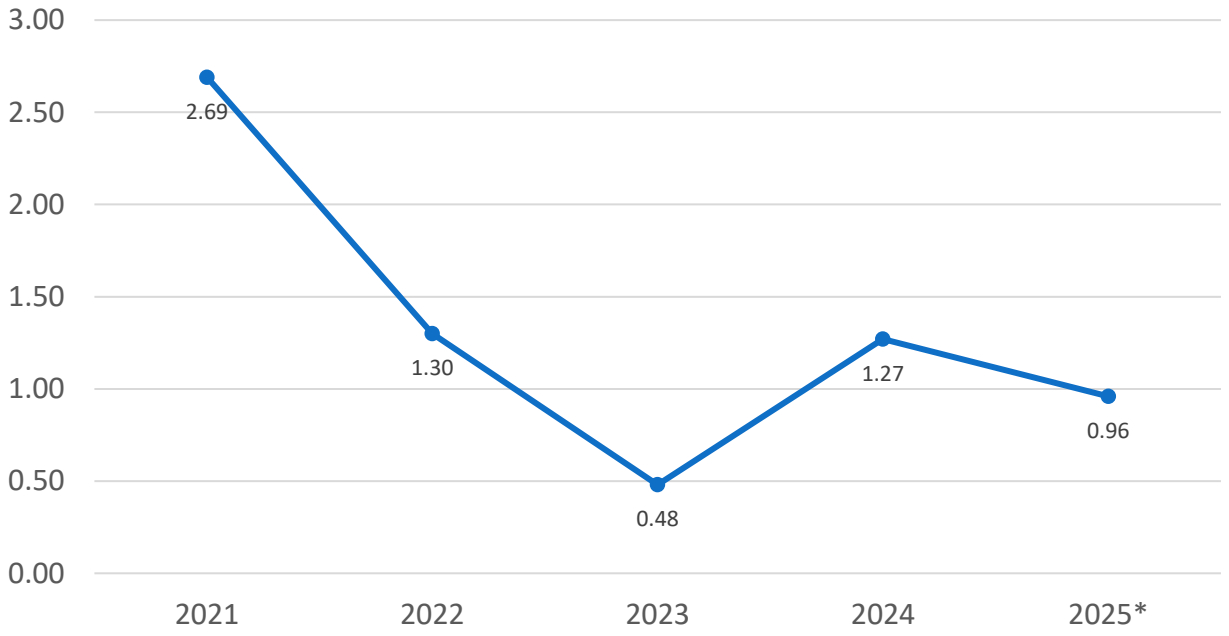
ACHIEVED TO DATE

- Overall number of BME colleagues has risen steadily, with BME colleagues well represented in non-clinical entry level roles, showing successes in recruitment campaigns
- Appointments ratios are moving in the right direction, with reduced disparity compared to earlier years
- Organisation's first ever Chief Paramedic Officer recruited to oversee education, training, and clinical supervision, working across the organisation to enhance patient care.
- Participation in College of Paramedic and Higher Education Institution (HEI) activity (e.g. conferences) focussing on race equality and increasing the representation of BME groups into the paramedic profession.

ACTIVITY PLANNED

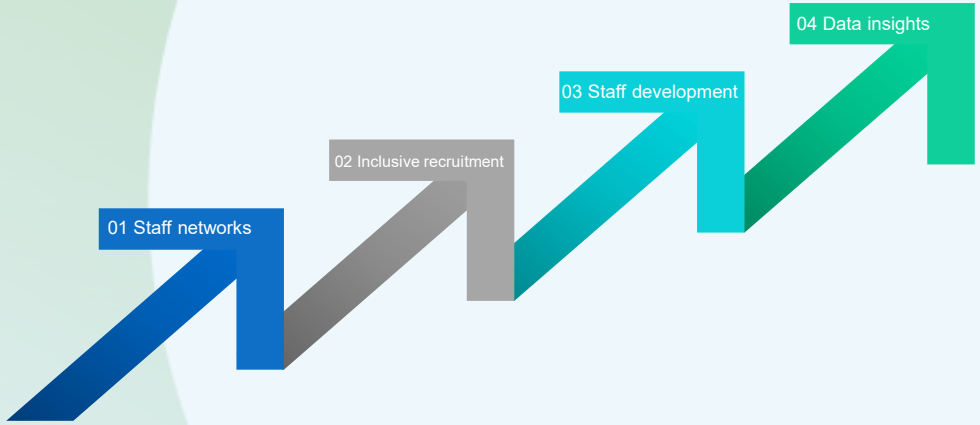
- Monitor breakdown of workforce distribution and recruitment across different directorates and action accordingly
- Implement Beyond Bias training to all directorates
- Strengthen approach to ensuring diverse recruitment panels
- Local engagement with higher education providers to help increase diversity in pipeline
- Train hiring managers in inclusive recruitment approaches across all divisions
- Three-day outreach careers event planned for October 2025
- Schedule summit with HEI partners, our Inspire network and College of Paramedics representatives to discuss local level initiatives to encourage more diverse applications to undergraduate paramedic programmes.

Indicator 3 | Relative likelihood of BME staff entering formal disciplinary proceedings compared to White staff



Compares the likelihood of BME staff entering formal disciplinary proceedings compared with White staff. A ratio of 1.0 indicates parity. In 2025, we have seen BME staff being slightly less likely than White staff to enter formal disciplinary proceedings, which is a vast improvement on 2021 data.

**Workforce data from 31 Mar 2025 and Staff Survey results published in 2025 (2024 survey). A ratio of 1.0 indicates equity; higher values show disproportionate impact on disabled staff.*



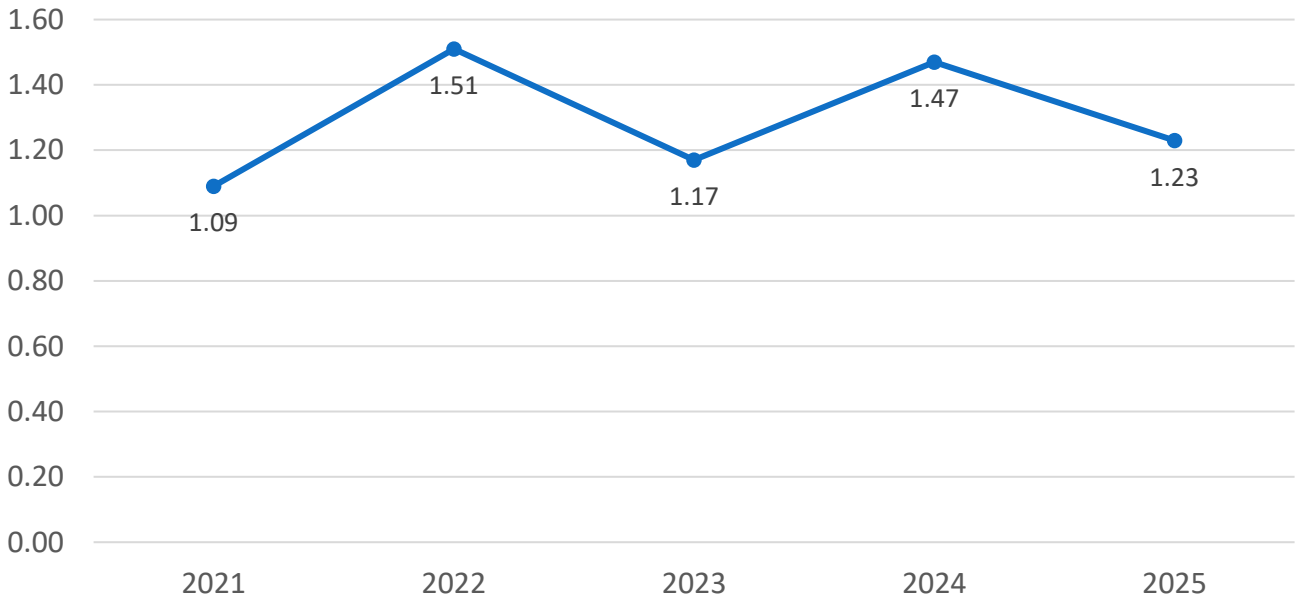
ACHIEVED TO DATE

- The embedding of early resolution and mediation service into the Trust in March 2025
- Ongoing support for managers in fair and consistent practice
- Beyond bias training delivered to senior leadership team of two directorates, Quality & Nursing and Strategy & Transformation

ACTIVITY PLANNED

- Maintain parity by continuing to use early resolution pathways, for example the Mediation Service. Transition the Mediation Service to the Employee Relations team by Q4 strengthening signposting to informal resolution as a clear option for colleagues facing conflict.
- Launch the Resolution Policy in December 2025 to support early resolution
- Regularly monitor and report disciplinary cases by ethnicity via EDI dashboard
- Engage with staff networks and divisional teams in reviewing trends and staff experiences to ensure confidence in fairness

Indicator 4 |Relative likelihood of BME staff accessing non-mandatory training compared to white staff



Measures the relative likelihood of BME staff reporting access to non-mandatory training, learning or CPD compared with White staff. A value of **1.0** = parity. In 2025, White staff were 1.23 times more like than BME staff to access non-mandatory training. Even though this is an improvement on the previous year, BME staff remain at a disadvantage for this indicator.

**Workforce data from 31 Mar 2025 and Staff Survey results published in 2025 (2024 survey). A ratio of 1.0 indicates equity; higher values show disproportionate impact on disabled staff.*

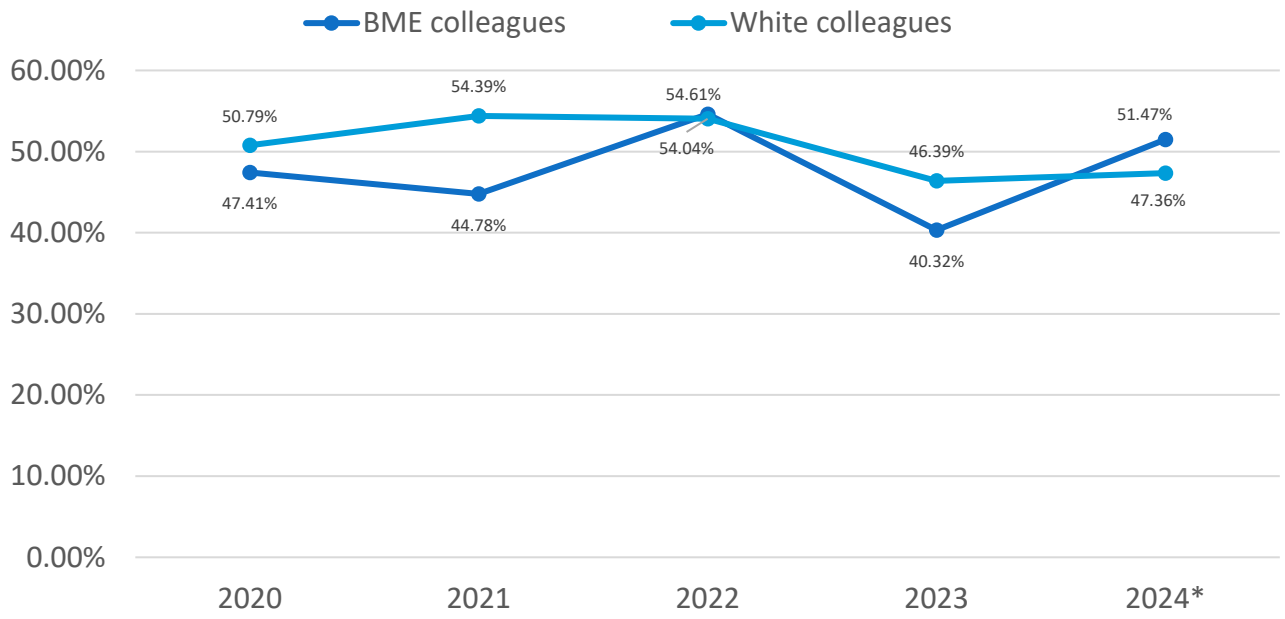
ACHIEVED TO DATE

- Targeted leadership programme (Ascend) is now in its 3rd and 4th cohorts, providing structured development specifically for BME colleagues
- Staff networks (e.g. Inspire) have actively promoted development offers and supported colleagues to access training
- First cohort of Reverse mentoring successfully delivered with the next cohort planned for late 2025
- Education representative now embedded within the Inspire Network to strengthen collaboration and inclusivity
- Training and Education panel implemented to support with how colleagues can access the Training and Education Bursary application and budget

ACTIVITY PLANNED

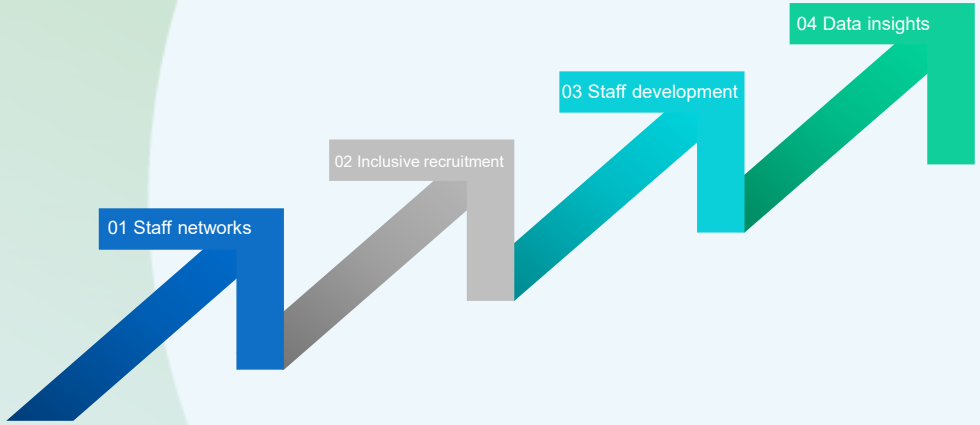
- Evaluate the impact of the first two cohorts of the Ascend programme on participants' career progression and feed lessons into wider leadership programmes
- Incorporate continuing professional development (CPD) access and outcomes into the EDI data dashboard for regular Board oversight
- Ongoing work to ensure the *Education* pages on *The Zone* reflect an inclusive and accessible approach for all colleagues
- Developing a new, integrated Education Strategy in collaboration with key stakeholders to ensure every professional group is represented and aligned to organisational priorities

Indicator 5 | Percentage of staff experiencing harassment, bullying or abuse from patients, service users, their relatives or the public



BME staff: 51.47% reported harassment, bullying or abuse (HBA). White staff: 47.36% reported HBA. This shows a 4.1 % point gap, with BME staff more likely to experience HBA. The data also shows a high overall prevalence across both groups (nearly half of staff who completed the survey reported being affected). While rates dropped in 2023, they rose again in 2024, with both groups reporting more incidents.

**Workforce data from 31 Mar 2025 and Staff Survey results published in 2025 (2024 survey). A ratio of 1.0 indicates equity; higher values show disproportionate impact on disabled staff.*



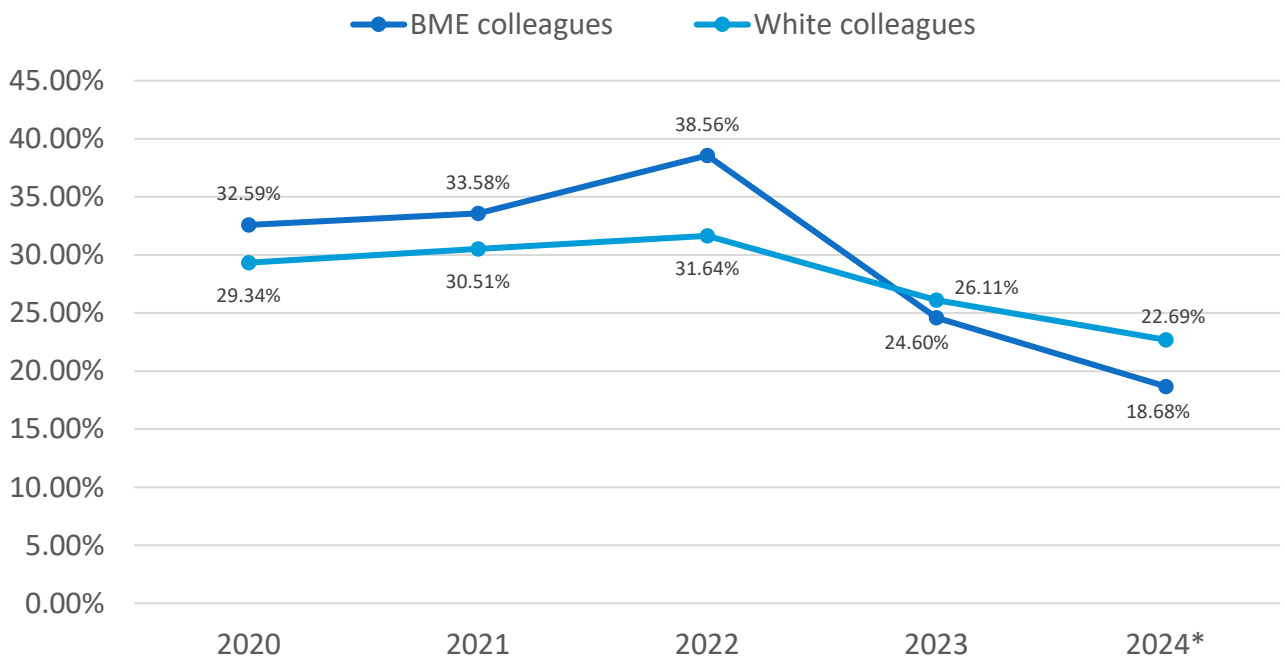
ACHIEVED TO DATE

- Staff safety initiatives (e.g., body-worn cameras, lone worker policies and procedures) introduced to reduce risks of abuse
- Active engagement with the Assaults on Emergency Workers Act, lead by the government and the NHS updated Violence Prevention Reduction Standards
- Collaboration with Operation Cavell, a joint workstream with Police, NHS Trusts and the Crown Prosecution Service tackling violence and aggression against staff
- Conflict resolution training introduced as part of key skills in April 2024, with excellent feedback. Training provides theory, breakaway techniques, and clinical restraint to help staff manage challenging behaviours. 86.34% colleagues completed the training as of Oct 2025

ACTIVITY PLANNED

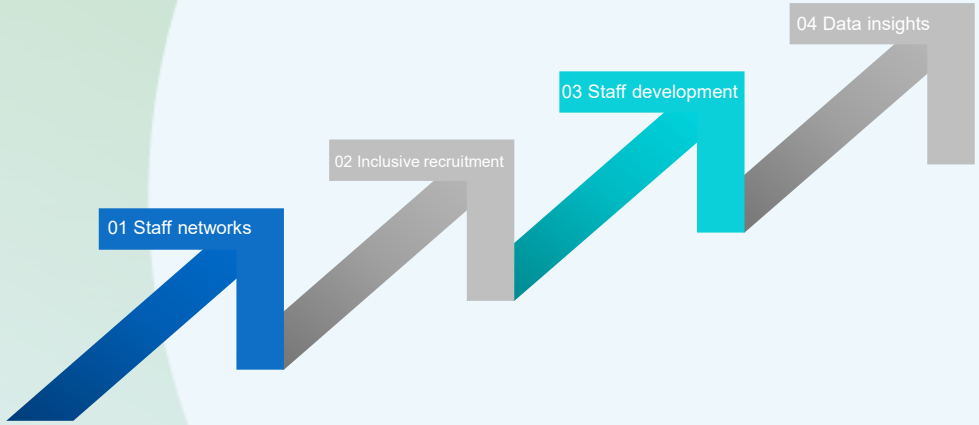
- Strengthen reporting and feedback mechanisms across divisions so staff feel confident incidents will be acted upon
- Track incident reporting and staff survey outcomes across divisions through the EDI dashboard
- Explore targeted resilience and wellbeing support for BME colleagues
- Continued collaboration between FTSU and staff networks to bridge the gap for communities who are less likely to speak up
- Maintain focus on violence reduction initiatives and embed inclusive leadership training

Indicator 6 | Percentage of staff experiencing harassment, bullying or abuse from staff



This is the first time since 2020 that BME staff reported lower levels of HBA from colleagues than White staff. The figures show an improvement for both groups.

**Workforce data from 31 Mar 2025 and Staff Survey results published in 2025 (2024 survey). A ratio of 1.0 indicates equity; higher values show disproportionate impact on disabled staff.*



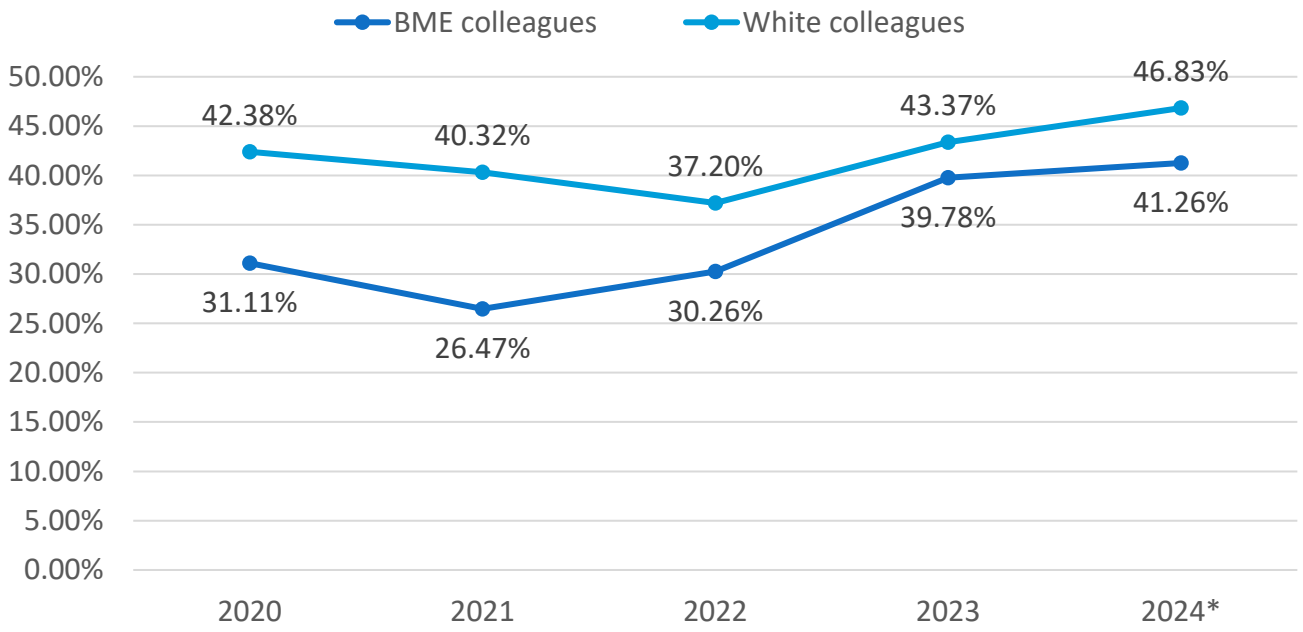
ACHIEVED TO DATE

- Consistent reduction in harassment from staff since 2022, showing positive cultural change
- Staff networks and Freedom to Speak Up Guardians providing safe spaces to raise issues
- Launched the Mediation Service in March 2025 to support conflict being resolved quicker and informally

ACTIVITY PLANNED

- Use staff networks and leadership programmes to model inclusive behaviours
- Deliver structured training sessions on the new Resolution Policy to all line managers ensuring they are confident in applying early resolution and mediation approaches in the first instance, from Q4.
- New Values and Behaviour Framework launching Q4 2026 to embed Integrity, Kindness and Courage, supporting inclusion and culture change across SECAmb

Indicator 7 | Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion



Compared with 2020, belief in equal opportunities has grown by around 10 percentage points for both groups, suggesting wider cultural improvements.

**Workforce data from 31 Mar 2025 and Staff Survey results published in 2025 (2024 survey)*

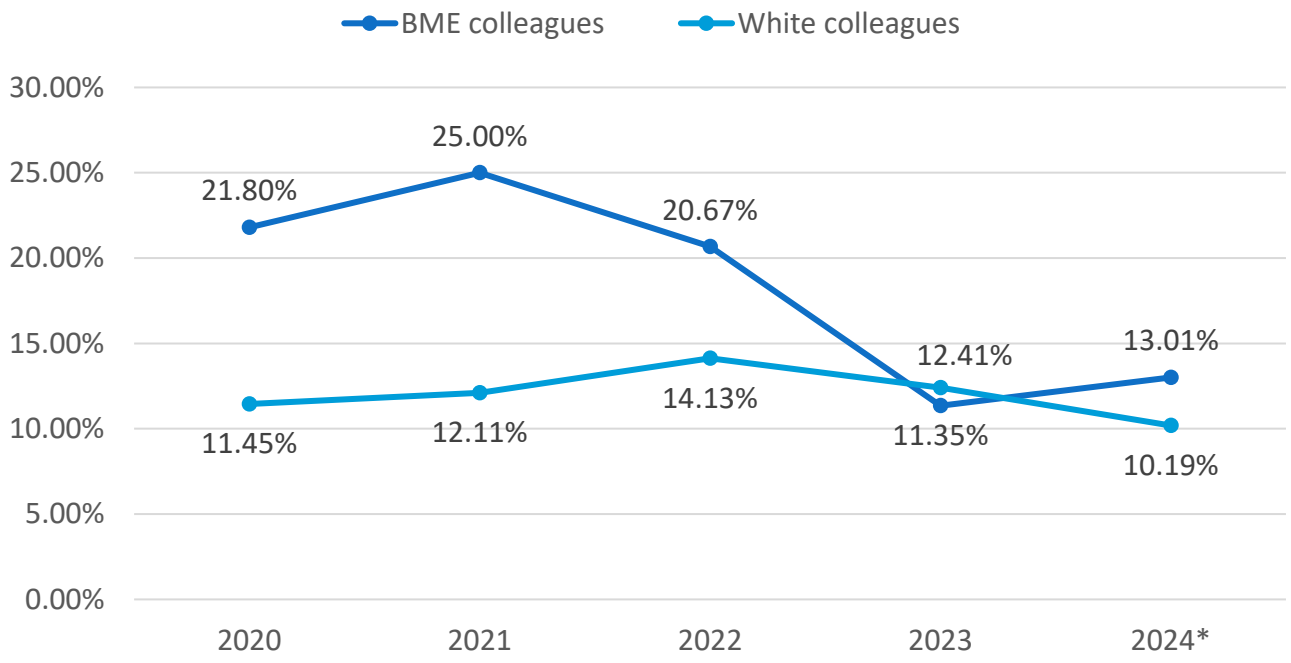
ACHIEVED TO DATE

- Ascend programme (now in its 3rd and 4th cohorts) provides targeted development and career support for BME staff
- Improved visibility of vacancies and development opportunities through internal comms

ACTIVITY PLANNED

- Track career outcomes of Ascend participants to evaluate impact on progression rates
- Maintain a centrally monitored pool of trained diverse staff for allocation to all Band 7+ recruitment and promotion panels
- Embed progression metrics into the EDI data dashboard and monitor across divisions
- Develop proposal for implementation of Beyond boundaries anti-racist framework, with Staff Network support

Indicator 8 | Percentage of staff experiencing discrimination at work from manager / team leader or other colleagues



Our data shows that BME staff are more likely to report discrimination. Whilst there is a gap in reporting, both groups' experiences of discrimination are significantly lower compared with 2020–2022 (when BME levels exceeded 20%).This suggests significant improvements in organisational culture.

**Staff Survey results published in 2025 (2024 survey)*

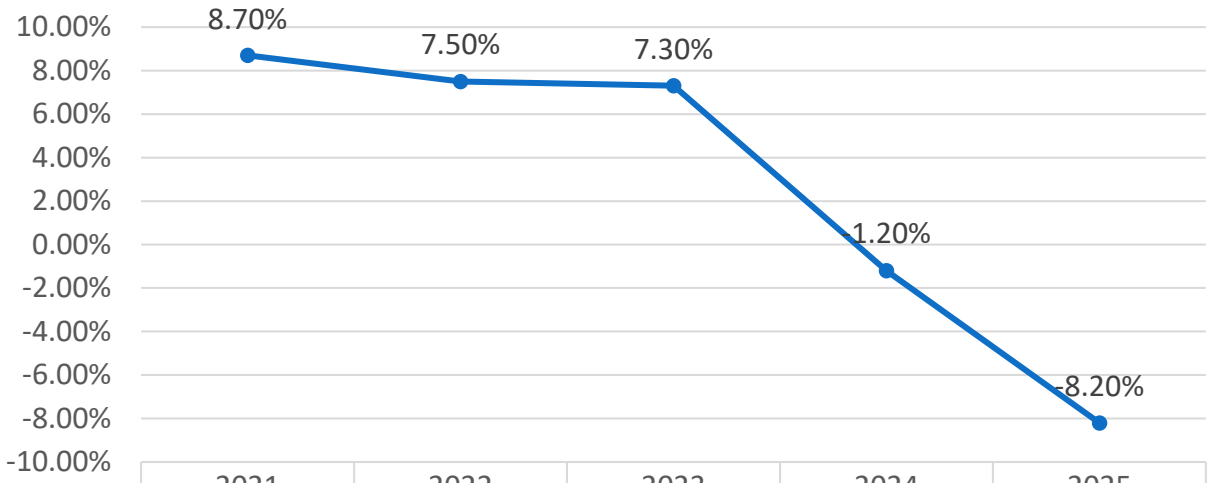
ACHIEVED TO DATE

- Reduction in reported discrimination among BME staff from 25% in 2021 to 13% in 2024
- Inclusive leadership modules threaded through several leadership development training packages

ACTIVITY PLANNED

- Strengthen manager accountability through clearer expectations, training and appraisal measures
- Embed data into the EDI data dashboard to monitor patterns at team and department level
- Strengthen escalation and feedback processes to ensure confidence in responses
- Co-design peer-led awareness campaigns with Inspire, include Staff Networks
- Launch new Values & Behaviour Framework (Jan/Feb 2026) to embed Integrity, Kindness, and Courage, supporting inclusion and culture change across SECAmb

Indicator 9 | Board representation



	2021	2022	2023	2024	2025
% BME Board	8.70%	7.50%	7.30%	-1.20%	-8.20%

This indicator compares the ethnic diversity of the Trust Board, as declared on ESR (both voting and non-voting members) with the ethnic profile of the overall workforce. It shows whether leadership is proportionate to the staff population.

As of 31 March 2025, 8.2% of the workforce had declared a BME background in ESR, compared with 0% of the Board. This creates a representation gap of 8.2 percentage points, meaning the Board currently does not reflect the diversity of the workforce.

From 2021–2023, Board representation was broadly proportionate to the workforce (around 7–9%). However, from 2024 this balance was lost, and by 2025 the gap had widened significantly.

ACHIEVED TO DATE

- Increased focus on Board-level EDI objectives, including reverse mentoring
- Executive and non-executive sponsors identified for all staff networks
- Board development days included lived experience contributions from BME staff

ACTIVITY PLANNED

- Strengthen talent pipeline and succession planning for BME colleagues aspiring to senior leadership
- Sustain reverse mentoring and active sponsorship by non-exec directors to model inclusive leadership

Conclusion and next steps

Focus area	Next steps / activities planned	Linked WDES indicator(s)
1. Staff networks	• Continue engaging with staff networks in reviewing trends and staff experiences • Continued collaboration between FTSU and staff networks to bridge the gap for underrepresented communities • Co-design peer-led awareness campaigns with Inspire • Sustain reverse mentoring and active sponsorship by non-exec directors to model inclusive leadership • Develop proposal for implementation of Beyond boundaries – anti-racist framework	1,3, 5, 6, 8,9
2. Inclusive recruitment	• Monitor workforce distribution and recruitment across directorates • Deliver Beyond Bias training to all directorates • Strengthen approach to ensuring diverse recruitment panels • Train all hiring managers in inclusive recruitment approaches • Develop engagement with higher education providers to increase diversity in pipeline • Three-day outreach careers event (Oct 2025) with follow-ups • Maintain centrally monitored pool of trained diverse staff for Band 7+ panels to strengthen diverse recruitment panels. • Develop proposal for implementation of Beyond boundaries – anti-racist framework • Engage with staff networks in reviewing trends and staff experiences to ensure confidence in fairness • Schedule summit with HEI partners, our Inspire network and College of Paramedics representatives to discuss local level initiatives to encourage more diverse applications to undergraduate paramedic programmes.	1, 2, 7,9

Conclusion and next steps

Focus area	Next steps / activities planned	Linked WDES indicator(s)
3. Staff development	• Evaluate the impact of Ascend programme cohorts on progression • Track career outcomes of Ascend participants • Incorporate CPD access and outcomes into EDI dashboard for Board oversight • Embed progression metrics into EDI dashboard • Strengthen talent pipeline and succession planning for BME colleagues aspiring to senior leadership • Maintain focus on violence reduction initiatives and embed inclusive leadership training • Explore targeted resilience and wellbeing support for BME colleagues • Strengthen manager accountability through clearer expectations, training and appraisal • Launch new Values & Behaviour Framework (Jan/Feb 2026) • Deliver structured training sessions on the new Resolution Policy to all line managers ensuring they are confident in applying early resolution and mediation approaches in the first instance, from Q4 • Maintain parity by continuing to use early resolution pathways, for example the Mediation Service. • Ongoing work to ensure the Education pages on The Zone reflect an inclusive and accessible approach • Developing a new, integrated Education Strategy in collaboration with key stakeholders to ensure every professional group is represented and aligned to organisational priorities • Explore targeted resilience and wellbeing support for BME colleagues • Strengthen reporting and feedback mechanisms so staff feel confident incidents of HBA will be acted upon • Explore targeted resilience and wellbeing support for BME colleagues	3,4, 5, 6, 7, 8, 9
4. Data insights	• Regularly monitor and report disciplinary cases by ethnicity via EDI dashboard • Incorporate progression and CPD metrics into EDI dashboard • Track incident reporting and survey outcomes via EDI dashboard • Embed progression metrics into the EDI data dashboard linked to career progresssion • Embed data into EDI dashboard to monitor trends at team/department level	1, 3, 4,5,7, 8

Agenda No	91-25

Name of meeting	Trust Board
Date	4 December 2025
Name of paper	Integrated Education, Training and Development Strategy
Executive sponsor	Jaqualine Lindridge, Chief Paramedic Officer
Author name and role	Jaqualine Lindridge, Chief Paramedic Officer

The Integrated Education, Training and Development Strategy is presented for Board approval.

This five-year strategy has been developed in collaboration with and been overseen by a cross-functional steering group with representation from across the Trust. It consists of five thematic workstreams:

- Learning culture and environment
- Quality management
- Digital and technological enablement
- Infrastructure and access
- Content and delivery

These five themes respond to the requirements identified by diagnostics and engagement with our learners and service leads. A detailed roadmap is contained within the strategy which will guide delivery of the strategy over the next five years.

At its meeting on 27 November, the People Committee supported this strategy, subject to some final amends that have been included related to more overt links to research and development, and with our collaboration with universities.

Recommendations, decisions or actions sought	For approval.

Does this paper, or the subject of this paper, require an equality impact analysis ('EIA')? (EIAs are required for all strategies, policies, procedures, guidelines, plans and business cases).	An EIA has been completed and approved for this strategy.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Integrated Education, Training & Development Strategy 2026-2031

Saving Lives,
Serving Our Communities

Foreword

I am delighted to introduce our **Integrated Education, Training and Development Strategy**, a comprehensive framework that recognises that our people are our greatest asset.

Every day, across our virtual and face-to-face clinical services, and throughout our corporate and support functions, our staff, students and volunteers demonstrate extraordinary dedication to the communities we serve. This strategy is our commitment to them – to **invest** in their skills, support their aspirations, and enable them to deliver the highest quality care and service.

The challenges facing healthcare services have never been greater. Rising demand, increasing clinical complexity, workforce pressures, and the rapid pace of technological and clinical advancement require us to think differently about how we develop our workforce. We cannot simply train people for the roles of today; we must **prepare** them for the healthcare landscape of tomorrow.

This integrated approach marks a significant shift in how we think about learning and development. This strategy brings coherence to our efforts across the Trust, recognising that whether someone answers a 111 call, dispatches an ambulance, treats a patient, manages our fleet, supports our finances, or leads a team, they are all essential to our **collective success**.

Our strategy is built on several key principles: that learning should be **accessible to all**, that development pathways should be **clear and equitable**, that we should grow our own talent whilst welcoming new perspectives, and that education should be seen not as a one-time event but as a **continuous journey** throughout every career.

We recognise the diverse starting points, experiences and aspirations across our workforce. From our volunteers giving their time so generously, to those taking their first steps in healthcare, to experienced clinicians and professionals – this strategy is designed to support **everyone's growth and development**.

I want to thank all of the staff, service users, learners, volunteers and academic partners who have contributed to the development of this document. Your insights have shaped a strategy that is genuinely **by our people, for our people**.

As we embark on this journey together, I am confident that our investment in education, training and development will not only enhance the care we provide to patients but will also make our service a place where people can **build rewarding, fulfilling careers** and feel valued for the contribution they make every single day.

Jaqualine Lindridge.

Chief Paramedic Officer.

Our Trust Strategy

Our Trust Strategy 2024–2029

Our Integrated Education, Training and Development (ETD) Strategy will enable the Trust to deliver its 2024–2029 Strategy, adapting to changes in how NHS ambulance services deliver care. Our purpose is *Saving Lives, Serving Our Communities* through three strategic aims: delivering high-quality patient care, ensuring our people enjoy working at SECAmb, and establishing ourselves as a sustainable partner in an integrated NHS.

The Trust is transforming from a predominantly ambulance-based response model to differentiated care tailored to individual patient need. The NHS 10-Year Plan positions ambulance services as lead coordinators of urgent and emergency care (UEC), and new regional commissioning from April 2026 emphasises collaboration with health partners.

This requires fundamental changes in how we develop our people, ensuring they have the skills to deliver safe, high-quality care for our patients and communities.

How ETD Enables Our Strategic Aims

For our patients, advanced triage training, supported by AI-enhanced decision-making, simulation and digital tools, will ensure our people can confidently determine appropriate patient pathways and will build capability in virtual consultation. This is essential to increasing alternatives to Emergency Department conveyance from 12% to 31% by 2029, so that more patients receive the right care in the right setting.

For our people, an integrated Learning Management System and enhanced leadership development will provide equitable access to learning, strengthen compassionate, inclusive leadership and support multiple development routes (including clinical, management, specialist and corporate), addressing current inequity and supporting our workforce targets.

For our partners, building capability to resolve care episodes outside hospital, refer seamlessly to alternatives, and apply data literacy, quality improvement, evidence-based practice and lean methodologies will drive productivity, support environmental targets and strengthen the Trust's role as a UEC partner. System leadership development and collaborative learning with partners will further equip our people to work effectively across our integrated care systems.

By investing in career pathways, equitable opportunities, supportive leadership and accessible learning, our ETD Strategy will give our workforce the skills, knowledge and confidence to deliver our Trust Strategy and the ambitions of the NHS 10-Year Plan.

Education, Training and Development at SECAmb

Within SECAmb, the three pillars of education, training, and development (ETD) should be seen as a system-wide function that supports our learner life cycle. We aim to empower staff and volunteers to support **continuous, lifelong learning**. We seek to enable our people to build foundational knowledge, acquire relevant skills, and evolve their careers.

Our **educational provision** covers all structured programmes that build foundational and advancing knowledge and focus on providing entry-level knowledge through to critical thinking. Our **training delivery** ensures that all staff and volunteers are equipped with the practical skills, technical competencies and knowledge required for safe and effective working, including mandatory and core skills training. Training offers targeted and practical learning designed to impart specific, role-related competencies. Our **development opportunities** focus on professional and personal growth, career progression, and leadership capability. It is inclusive for all to allow learners to build on what they already know and can do to reach their full potential. With a wide-ranging provision of ETD within the trust, our people have the opportunity to utilise contemporary, evidence-based knowledge to meet the needs of an evolving and diverse population.

Who this strategy is for

This strategy is for **everyone** who works, volunteers or studies with us at SECAmb.

We are all learners, and this **Integrated Education, Training and Development Strategy** aims to provide a roadmap to ensure that we all have access to the learning activities we need to thrive and deliver the best that we can for our service users, their carers and families. Whether you work for us, volunteer with us or are on placement with us this strategy is for you.

Our people are our greatest asset and education training and development (ETD) is for everyone, whether you work in one of our call centres, in a corporate team, at a make ready centre, on an ambulance or anywhere else!

This strategy presents a roadmap for how SECAmb will grow and integrate our learning offer to meet your development and career needs.

Our five strategic themes

Our ETD Strategy consists of **five inter-connected themes** which will be delivered over the next four to five years. As we enter into and develop the **South Central and South East Ambulance Group** we will consider collaboration and alignment at every stage of planning and delivery across all five of the following workstreams, whilst ensuring alignment with our Trust strategy.

Learning Culture and Environment

We will embed a culture of learning across the Trust, where we share and mobilise our knowledge as a centre of excellence where all our learners can grow and thrive.

- We will introduce **learning from excellence** to ensure that we learn from things which go well as well as from things which do not go as planned, scaling up from small scale pilot to spread this across the Trust
- We will support a culture of lifelong learning by investing in programmes of **learning and knowledge mobilisation events** accessible to learners at all levels in the trust, amplifying and building on our bright-spots
- We will implement the **safer learning environment charter** (SLEC) to improve learner experience and inform a manifesto to ensure all of our staff, volunteers and students absolutely thrive in a rich learning culture
- We will develop into a **centre of excellence** and form an Academy, acting as a recognised centre where-ever possible ensuring we deliver excellence in all our ETD activities. We will ensure that **research and innovation** sit at the heart of all we do, underpinning the delivery of evidence-based based practice both clinically and educationally.
- We will re-establish ourselves as **apprenticeship** provider with a clear roadmap for achieving this via registration with **Ofsted** or partnership arrangements, for example with a Higher Education Institute (HEI)

Quality Management

We will ensure sound quality governance and that we meet all regulatory requirements and develop a culture of continuous improvement in all aspects of education, training and development, wherever it is delivered in the Trust.

- We will build on our existing foundations to develop a **quality management system (QMS)** which incorporates education, learning and development on a Trust wide basis
- We will develop **organisational-level governance** encompassing curriculum development and quality assurance, unified learner feedback and evaluation systems and competency frameworks for facilitators across all ETD activities
- We will implement an integrated **ETD oversight framework** which will consolidate oversight of all ETD activities, policies and procedures across the Trust into a single framework
- We will develop annual **quality planning** rounds linked to trust-wide learning frameworks and training needs analyses
- We will ensure clear lines of **compliance** with regulatory requirements

Digital and Technological Enablement

We will ensure we keep pace with and meet our learners' needs in a modern way by ensuring that we provide the right digital and technological infrastructure to meet their andragogical needs.

- We will enhance our **technological infrastructure** to include simulation, virtual reality and artificial intelligence, both as trail blazers and where established evidence supports their use
- We will improve our **use of data** to ensure we make the best decisions we can as a responsive learning service by developing responsive dashboards to inform quality management where we will monitor how we meet the needs of all learners, including those with special educational needs
- We will develop **digital upskilling packages** to enable staff to make best use of digital tools and technology, such as AI, and ensure digital technology is fully accessible through equality impact assessment
- We will implement a new **learning management system** (LMS) to provide a modern and fit for purpose learning environment for a mobile workforce and enable blended learning opportunities to extend across the trust geography
- We will develop a trust-wide **digital repository** (knowledge management system) to act as a 'one stop shop' for knowledge, information and learning

Infrastructure and Access

We will develop the right infrastructure to meet our learners' needs and ensure that all of our staff, volunteers and students have equitable access to the ETD opportunities they need to grow and thrive

- We will optimise use of **apprenticeships** and accessible training methods (earn while you learn) across our geography, and take positive action to develop opportunities for under-represented groups
- We will develop **standards frameworks** for all areas, with personalised **career coaching and development plans** and skills escalators for **all staff**, taking individual learner needs into consideration
- We will address investment and resource gaps with a **comprehensive infrastructure review** and strategic plan for education facilities, equipment and staffing
- We will create an **equitable access framework** with a standardised CPD allocation that provides equitable access to development opportunities across **all staff** and responds to learners' needs using an **equality, diversity and inclusion** lens
- We will develop **Aspirant Programmes** for staff aspiring to develop their careers, introducing Chief Paramedic Fellowships and aspiring leader programmes which include internal and external learning which responds to developmental needs and builds organisational knowledge

Content and Delivery

We will create a culture where all ETD is high quality, engaging and responsive to the needs of our service users as well as our learners.

- We will strengthen **needs analysis** (TNA) and look into the future to ensure our ETD programmes keep pace with patient, volunteer and staff needs, focusing on the skills and competencies need to deliver our strategy, publishing this annually
- We will develop a comprehensive **leadership and management development framework** to support our staff as they develop their careers, which will include leadership programmes and modular managerial skills and develop **role specific programmes** where needed
- We will become more financially self-sufficient by **commercialising** our education and training offers

Our roadmap to delivery of our ETD strategy

We will deliver our strategic intentions in phases over the next four to five years according to the following roadmap:

Short term (1 to 2 years)

Theme	Goal	Action	KPI
Learning culture and environment	Implement the SLEC for learners across the whole Trust	Adopt all SLEC principles Trust governance and establish a cycle of annual re-evaluation of SLEC compliance using updated maturity matrices and learner feedback.	Formal Trust adoption of the SLEC Compliance reports to Education, Training & Development Group
Learning culture and environment	Ensure we learn from excellence	Design and implement a learning from excellence framework which encompasses the whole organisation, including mechanisms for spreading shared learning using a Plan Do Study Act (PDSA) approach	PDSA model at pilot sites Progress reports to Organisational Learning group LfE Dashboard development and monitoring
Learning culture and environment	Learning and knowledge mobilisation events	Develop a coordinated programme of annual events, including trust wide, divisional and corporate options	Business case prepared, approved and implemented Delivery plan in place
Quality Management	Develop Trust level ETD governance	Design an ETD Quality Management System for Trust wide education, training and development governance, which includes curriculum development, quality assurance, stakeholder feedback and evaluation.	Model designed and approved. Implementation plan agreed, and monitored by Education, Training and Development Group New KPIs developed and monitored

Theme	Goal	Action	KPI
Quality Management	Develop Trust level ETD governance	Complete a systematic review and evaluation of all ETD.	Evaluations reported to Education, Training & Development Group Learner satisfaction survey results Quality assurance reviews
Quality Management	ETD Oversight framework	Develop an integrated oversight & policy framework with clear lines of compliance with regulatory requirements	Approval of revised policy Approval of oversight framework Monitoring of KPIs at Education, Training & Development Group
Quality Management	Annual Quality Planning Rounds	Develop unified learner and stakeholder feedback process and evaluation framework to ensure ETD meets their needs.	Approval of framework Learner feedback KPIs reported and monitored
Quality Management	Annual Quality Planning Rounds	Design revised TNA to ensure that the learning needs of our people are met and translated into the Trust ETD Prospectus	Annual publication of TNA and Trust ETD prospectus Monitoring of delivery at Education, Training & Development Group
Quality Management	ETD Oversight framework	Develop an integrated oversight & policy framework with clear lines of compliance with regulatory requirements	Approval of revised policy Approval of oversight framework Monitoring of KPIs at Education, Training & Development Group

Theme	Goal	Action	KPI
Digital	Develop user capability in using digital infrastructure	Develop a prospectus of education, training and development opportunities which enable our learners to develop their computer skills, become more data literate, learn how to make best use of AI and use our software packages to their best advantage.	Development of digital prospectus Learner experience and uptake KPIs
Digital	Improved Learning Management System	Ensure learners have access to a single, integrated LMS interface which is user friendly and based on sound andragogical principles.	Implementation of LMS Learner experience survey results
Digital	Make more effective use of connected data	Develop ETD dashboards as enablers to quality management and planning at an enterprise level, and to supervision and appraisal at the individual level to enable meaningful personal development planning.	Development of ETD dashboards Linked PDR/ Appraisal KPIs Monitoring of delivery at Education, Training & Development Group
Infrastructure and access	Infrastructure review	Review educational facilities, equipment and digital infrastructure across the Trust, including in specialist areas such as HART, and develop a longer-term investment plan based on sound andragogy	Business case prepared, approved and implemented Improvement in learner satisfaction
Infrastructure and access	Improve equity of access to ETD across all learner groups.	Develop equitable access and sponsorship for study framework, which enables all of our learners to access education, training and development which meets their needs	Approve access framework, along with relevant policy and procedure Monitor access and uptake KPIs across all learner groups, including those with protected characteristics

Infrastructure and access	Improve equity of access to ETD across all learner groups.	Map staff and volunteer careers and roles to inform and highlight opportunities career growth	Publish career maps on rolling cycle
Infrastructure and access	Optimise apprenticeships	Undertake opportunity analysis for apprenticeship use and connect results with TNA and appraisal/ PDR outputs. Develop an expanded access offer for apprenticeships in a range of areas, including clinical, managerial, corporate and support services.	Publication of opportunity analysis Publication of prospectus Monitor access and uptake KPIs across all learner groups, including those with protected characteristics
Content and delivery	Strengthen our training needs analysis	Redesign the training needs analysis methodology, taking into account the needs of individual learners, our service users and strategic requirements. Using the results to inform our ETD activities and publishing the results annually, as part of our quality planning cycle.	Approval of a revised methodology Annual TNA publication Monitor stakeholder experience KPIs
Content and delivery	Leadership development framework	Bring the leadership development framework to life in ETG activities.	Publish revised prospectus based on leadership development framework Monitor access and uptake KPIs across all learner groups
Content and delivery	Develop a business enterprise function	Scope and plan commercialised ETD provision, with the intention of developing a subsidiary company with the ability to income-generate to offset the cost of education, training and development provision for our learners	Business case prepared, approved and implemented

Medium term (2 to 4 years)

Theme	Goal	Action	KPI
Learning culture and environment	Become and be recognised as a centre of excellence	Design Academy model which responds to the needs of our learners and facilitates commercialisation	Model approved Delivery plan in place
Learning culture and environment	Become and be recognised as a centre of excellence	Design and implement accreditation framework for all relevant topic and specialty areas	Framework approved Delivery plan in place Accreditation KPIs reported and monitored
Quality Management	ETD Oversight framework	Develop and implement competency framework for facilitators with GRS/ ESR profiling to ensure all learners have access to appropriately skilled facilitators	Approval of framework Monitoring of KPIs at Education, Training & Development Group
Digital	Accessing modern digital and technological infrastructure	Scope and develop an access plan for a digitally enabled ETD infrastructure, considering both options for on-site facilities and collaboration with partners.	Development of use and business cases for AI, 3D printing, broadcast and augmented reality Delivery and training plans for implementation Stakeholder experience and uptake KPIs

Theme	Goal	Action	KPI
Digital	New digital knowledge repository	Develop a new, fully searchable knowledge repository to act as front-door for knowledge mobilisation	Implementation of repository Repository access KPIs
Infrastructure and access	Develop standards frameworks across all functions and specialisms	Design cross-functional standards frameworks for all relevant functions, including clinical, operational and corporate functions.	Development of framework Monitoring of framework compliance KPIs
Infrastructure and access	Infrastructure review	Develop a plan for increased visibility and staff engagement with library and knowledge services	LKS development plan LKS metrics reported through ETD Group
Infrastructure and access	Equitable access framework	Widen the prospectus of activities to better respond to all our learners' needs, levelling up across professional groups	Publish revised prospectus Monitor access and uptake KPIs across all learner groups, including those with protected characteristics

Theme	Goal	Action	KPI
Infrastructure and access	Aspirant and fellowship programmes	Undertake a gap analysis of career maps and design a series of aspirant and fellowship programmes to meet the needs our staff and volunteers	Aspirant programme take up KPIs Fellowship experience KPIs
Content and delivery	Deliver commercial ETG activities	Launch commercial arm of SECAmb Academy	Monitor access and uptake KPIs Report on income generation offset via ETDG

Long term (4 to 5+ years)

Theme	Goal	Action	KPI
Learning culture and environment	Become and be recognised as a centre of excellence	Re-establish apprenticeship provision by either reopening as an Ofsted registered provider or partnering with a HEI. Establish readiness to apply for University Trust status	Business case prepared and approved Delivery plan in place

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Board Assurance Framework

2025/2026

December

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Delivering High Quality Patient Care

We deliver high quality patient care

1	Tier 1
2	Tier 2
	QI
	Directorate objective

2024-2029 Strategy Outcomes

- ❑ Deliver virtual consultation for 55% of our patients
- ❑ Answer 999 calls within 5 seconds
- ❑ Deliver national standards for C1 and C2 mean and 90th
- ❑ Improve outcomes for patients with cardiac arrest and stroke
- ❑ Reduce health inequalities

2025/26 – Strategic Transformation Plan

- ❑ Models of Care 1
  - 3 Focus Models of Care (Reversible Cardiac Arrest, Palliative and End of Life Care, Falls, Frailty and Older People) to be delivered within 25/26
  - Produce a three-year delivery plan for the 11 Models of Care
- ❑ Delivering Improved Virtual Care / Integration 1
  - Evaluation to inform future scope of virtual care commences April 2025
  - Design future model to inform Virtual Care, including integration of 111/PC
  - Establish commissioning implications of evaluation outcomes and inform multi-year commissioning framework

2025/26 Outcomes

- ❑ C2 Mean <25 mins average for the full year
- ❑ Call Answer 5 secs average for the full year
- ❑ H&T Average for 25/26 of 18% / 19.4% by end of Q4
- ❑ Cardiac Arrest outcomes – improve survival to 11.5%
- ❑ Internal productivity
  - ❑ Reduce the volume of unnecessary calls from our highest calling Nursing/Residential Homes by 1%
  - ❑ Job Cycle Time (JCT)
  - ❑ Resources Per Incident (RPI)

2025/26 – Operating Plan

- ❑ Operational Performance Plan – continuous monitoring through the IQR
- ❑ Set out Health Inequalities objectives for 2025-2027 by Q4
- ❑ Develop Quality Assurance Blueprint, including design of station accreditation complete by Q4
- ❑ Deliver the three Quality Account priorities by Q4
- ❑ Patient Monitoring replacement scheme by Q4 & design future model for replacements 2
- ❑ Deliver improved clinical productivity through our QI priorities by Q4
  - IFTs
  - EOC Clinical Audit

Compliance

- ❑ EPRR assurance
- ❑ Medicines Management & Controlled Drugs
- ❑ PSIRF Compliance to standards

BAF Risks

- ❑ **Delivery of our Trust Strategy:** There is a risk that we are unable to deliver our Trust strategy due to insufficient organisational maturity and capability, particularly in the virtual care space, resulting in poorer patient outcomes.
- ❑ **Internal Productivity Improvements:** There is a risk that we are unable to deliver planned internal productivity improvements while maintaining patient outcomes as a result of insufficient or unfulfilled changes to service delivery processes or models of care, resulting in unrealised operational performance or financial sustainability.

We deliver high quality patient care

2025/26– Strategic Transformation Plan

Programme	Milestone	Baseline Target	Forecast Target	Programme Manager	EMB / SMG	PMO	Executive Lead	Oversight Committee
Virtual Care Programme	Evaluation to inform future scope of virtual care	Q1	Q1	Kate Mackney	EMB	Yes	Chief Operating Officer	Quality & Patient Safety
	Design future model to inform Virtual Care, including integration of 111/PC	Q3	Q3					
	Establish commissioning implications of evaluation outcomes and inform multi-year commissioning framework	Q4	Q4					
Models of Care	Design 3 year delivery plan for MoC and obtain agreement with system partners	Q1	Q1	Katie Spendiff	EMB	Yes	Chief Medical Officer	Quality & Patient Safety
	Deliver 3 Focus Models of Care (Reversable Cardiac Arrest, Palliative and End of Life Care, Falls & Frailty and Older People) within 25/26	Q4	Q4					

2025/26 – Operating Plan

Initiative	Sub-Initiative (if required)	Current RAG	Previous RAG	Executive Lead	EMB / SMG	PMO	Oversight Committee	Date Last Reviewed @ Committee
Operational Performance Plan				Chief Operating Officer	SMG	No	FIC	
Set out Health Inequalities objectives for 25-27				Chief Nursing Officer	SMG	No	QPSC	
Develop Quality Assurance Blueprint			N/A	Chief Nursing Officer	SMG	No	QPSC	
Deliver the three Quality Account Priorities	Health Inequalities Year 2: 1) Maternity 2) MH			Chief Nursing Officer	SMG	No	QPSC	10/04/2025
	ePCR			Chief Nursing Officer	SMG	No	QPSC	10/04/2025
	Framework for patients with Suicidal ideations/intent			Chief Nursing Officer	SMG	No	QPSC	N/A
Patient Monitoring Replacement	Commence the replacement scheme by Q4			Chief Medical Officer	SMG	Yes	QPSC	11/09/2025
	Design future replacement programme by Q4						QPSC	11/09/2025
Deliver improved clinical productivity through our QI priorities	IFTs			Chief Nursing Officer	SMG	No	QPSC	
	EOC Clinical Audit			Chief Nursing Officer	SMG	No	QPSC	N/A

BAF Risks

Risk Detail	Risk Score	Target Score	Owner
Delivery of our Trust Strategy: There is a risk that we are unable to deliver our Trust strategy due to insufficient organisational maturity and capability, particularly in the virtual care space, resulting in poorer patient outcomes.	09 →	06	CSO
Internal Productivity Improvements: There is a risk that we are unable to deliver planned internal productivity improvements while maintaining patient outcomes as a result of insufficient or unfulfilled changes to service delivery processes or models of care, resulting in unrealised operational performance or financial sustainability.	16 →	08 136	COO

We deliver high quality patient care

2025/26– Compliance & Assurance

Compliance Initiative	Current RAG	Previous RAG	Executive Lead	Oversight Committee	Date of Last / Scheduled Review at Committee	Committee Feedback
EPRR assurance			Chief Operating Officer	Audit & Risk	Nov 2025	The outcome of the annual assessment is substantial assurance, which is a significant improvement and the first time this level of assurance has been achieved since 2019.
Medicines Management & CDs			*Chief Medical Officer*	Quality & Audit & Risk	Nov 2025	Substantial Assurance Internal Audit and strong assurance from the Accountable Officer for Controlled Drugs annual report
PSIRF			*Chief Nursing Officer*	Quality	Sept 2025	2024-25 Implemented PSIRF Principles / Standards – compliance is over 90% as reported to QPSC in Sept. IA is due to test the effectiveness of PSIRF including how learning is captured and shared, which will be reported to both quality and audit committees in Q4.

Virtual Care Programme - Executive Summary

Exec. Sponsor:	Jen Allan
PM:	Kate Mackney
Last updated:	25th November 2025

Programme Outcomes	Previous RAG	Current RAG	Impact on outcomes
• **We will provide early and effective triage of patient need:** Increase Hear & Treat outcomes to 19.7% by end Mar 26			There is considerable risk to achieving the year-end H&T target; despite strong engagement through summits, the scale of change required may be underestimated. Rating remains Red until a clearer improvement trajectory is evident.

Headline Key Performance Indicators (KPI)

KPI	IQR or local	Latest (period)	Target	Trend	So what?
Hear & Treat %	IQR	15.1% (Oct 25)	18.1%	Hear & Treat performance remains static below the October target and the year end trajectory of 19.7%, despite interventions.	Drive clarity and momentum through summits and workshops to define the Model, Process, Workforce, and Digital enablers. Decisive action and accelerated progress on the future virtual care model are essential to meet strategic objectives and deliver improved patient outcomes.
C2 Response	IQR	00:28:11 (Oct 25)	00:26:46	C2 Response Time is in common cause variation with no significant change	Without scaling virtual care effectively, the system will continue to rely on physical dispatch for cases that could be managed virtually. This limits capacity for genuine emergencies, undermines the strategic aim of reducing unnecessary conveyance, and risks eroding progress on patient safety and flow.

Top 3 Risks (BAF/Corporate only)

Description	Type/ ID	Current	Target	Trend	Control effectiveness & next step
Delivery of our Trust Strategy: There is a risk that we are unable to deliver our Trust strategy due to insufficient organisational maturity and capability, particularly in the virtual care space, resulting in poorer patient outcomes.	BAF/537	9	6	⟺	• VC & MoC programmes to lead with a clear, co-designed vision that integrates population health, digital innovation, and workforce transformation to realise the future mode
Workforce: There is a risk that both programmes will face challenges in recruiting, training, and retaining a skilled workforce. This includes capacity constraints, gaps in workforce planning expertise, and the impact of resource reallocation (e.g. from 111 to 999). These issues may delay delivery, reduce quality, and undermine staff confidence	Prog/688	12	8	⟺	• Establish a joint workforce planning group across both programmes. • Prioritise training and succession planning. • Use flexible staffing models and external support where needed. • Monitor workforce metrics and adjust plans dynamically
Organisational Change & Internal Stakeholder Engagement: There is a risk that poor internal communication and misalignment on programme delivery and organisational changes could lead to resistance, reduced morale, and delays.	Prog/728	9	6	↑	• Partial control from initial programme comms for Model of Care. Now need to focus on delivery of: • 1. Internal comms plan with comms team support / Regular updates and Q&A sessions. • 2. Change management plans including feedback loops and escalation routes. • 3. Phased implementation – being worked on via summits in Dec and Jan.

Assurance

Headline assurance:	The Virtual Care Programme is a critical enabler for system transformation, but outcome delivery risk is high. Model design, process mapping, workforce planning and digital enablers will all outline the requirements to mitigate this risk; however the programme will require decisive action and accelerated decision making from the board to meet the strategic objectives and improve patient outcomes and system flow.	**Status:**	Under control
		Ask of this forum:	Note

Virtual Care Programme - Controls & Decisions

Exec. Sponsor:	Jen Allan
PM:	Kate Mackney
Last updated:	25th November 2025

Change Control - Decision Requests

Proposed change	Type (T/C/Q/S)	Approval sought	Driver	Impact on delivery/assurance
N/A				

Dependencies (material only)	Owner	Due	Status	Risk if delayed	Mitigation
Digital Integration: Future model outputs will define digital requirements to support delivery. Cross-representation between the Virtual Care Steering Group and the Digital Transformation Board ensures alignment of scope, accountability, and timelines, reducing risk of fragmented delivery	CDIO	Dec 25	In Progress	Inability to progress to the future model and deliver the strategy, impacting transformation timelines and virtual care optimisation at scale	Define clear ownership of deliverables between Virtual Care governance and the Digital Programme. Escalate at VC summits if scope or accountability remains unclear.

Milestone Exceptions	Date	Exception	Impact on delivery/assurance	Recovery & new forecast
Virtual Clinical Assessment Summit: Part 1 Model	Nov 25	Completed	Provides clarity on future clinical model, reducing strategic ambiguity and enabling workforce/digital planning. No negative impact.	N/A
Virtual Clinical Assessment Summit: Part 2 Process	Nov 25	Completed	Process design reviewed, ensuring operational alignment and governance readiness. No negative impact.	N/A
Virtual Clinical Assessment Summit: Part 3 Workforce	Dec 25	On Track	Delay would stall workforce capability development, impacting ability to deliver safe, consistent virtual care and meet H&T targets. Assurance risk: High if not delivered on time.	Q3
Virtual Clinical Assessment Summit: Part 4 Digital	Dec 25	On Track	Delay would block digital integration, preventing scale-up of virtual care and risking fragmented delivery. Assurance risk: Critical for transformation milestones and KPI achievement.	Q3

EMB outcome, inc. decision requests (post-meeting)**:**	
Relevant Board Committee outcome (post-meeting):	

BAF Risks

- BAF Risk 537 - Delivery of our Trust Strategy
- BAF Risk 646 - Internal Productivity Improvement
- BAF Risk 647 - System Productivity
- BAF Risk 648 - Workforce Capacity & Capability

Models of Care Programme - Executive Summary

Exec. Sponsor:	Richard Quirk
PM:	Katie Spendiff
Last updated:	28.11.25

Programme Outcomes

• Patients requiring emergency Category 1 and high-acuity Category 2 responses (Type A patients) will receive a timely physical response from a paramedic crewed ambulance whose roles are designed to meet their needs.
• Patients with urgent care lower acuity Category 2, 3 & 4 responses (Type B patients) will receive a timely virtual response from the correct speciality who will meet their ongoing needs.

Previous RAG	Current RAG	Impact on outcomes
		Data gaps and limited capacity keep this at **amber**. Efficiency initiatives are expected to show impact in **late Q3–Q4**

Headline Key Performance Indicators (KPI)

KPI	MOC	IQR or local	Baseline	Target	current	Trend	So what?
Cardiac Arrest Survival Rate (All)	Reversible Cardiac Arrest	BAF	11.5%	12.5%	11% (July 25)		Survival to 30 Day performance will plateau until response times improve; reaching patients faster is critical. In Q4 we should see some positive impact on this data from the appointment of the Resus Officers. Looking at last years data vs this years – performance appears more consistent in terms of survival by month.
Response time to patients who have fallen	Falls, Frailty & Older People	Local	1 hour 47m (C3 mean) 1 hour 51m (C4 mean)	1 hour 35m (C3) 1 hour 39m (C4)	1 hour 30m (C3) 1 hour 39m (C4) (Oct 25)		Since January, the C3 mean has significantly improved with all points reporting below the long-term average in an improving trend. C4 is showing a similar pattern with an improving trend with most points falling below the average.
Ambulance attendance to Non-Injury Falls calls	Falls, Frailty & Older People	Local	TBC	TBC	TBC		Current state: Community First Responders (CFRs) attend promptly when available and are automatically backed up by an ambulance. They clear the scene after consulting an Advanced Paramedic Practitioner (APP). While this ensures patient safety, it often leads to unnecessary ambulance dispatch and inefficient resource utilisation. Upcoming Change: A new virtual triage process will launch as a pilot in late Q3/early Q4. This will allow CFRs to connect with a remote clinician at the patient's side, reducing unnecessary ambulance deployments. Expected Impact: The pilot will support a shift from "see and treat" to "hear and treat" where no clinical resource is on scene. We anticipate increased CFR dispatch, reduced ambulance dispatch and growth in Hear & Treat activity Awaiting SPC charts.
999 calls from high frequency	Falls, Frailty & Older People	Local	TBC	TBC	TBC		Focus is on reducing 999 calls from care / nursing homes with interventions in place by 10 % in Yr 1' – specificity was needed to

Top 3 Risks (BAF/Corporate only)

Description	Type / ID	Current	Target	Trend	Control effectiveness & next steps
Workforce: There is a risk that both programmes will face challenges in recruiting, training, and retaining a skilled workforce. This includes capacity constraints, gaps in workforce planning expertise, and the impact of resource reallocation (e.g. from 111 to 999). These issues may delay delivery, reduce quality, and undermine staff confidence	Prog/688	12	8	↓	• Reduced from 16 to 12 because the group agreed that while recruitment and training challenges remain, several mitigating actions are now in place: • An outline workforce plan had been developed (under existing task via Jo Turl & Tina I) and reconciliation work was beginning, which would provide further insights into staffing needs and gaps. The group had already committed to prioritising training, using flexible staffing models, and monitoring workforce metrics. The likelihood of impact was reassessed as lower, with the score adjusted to Likelihood 3, Consequence 4. This reflects improved confidence in managing the risk, though it remains a key area of focus.
System alignment to our strategy: There is a risk that external systems are initiating change and pathways that don't align to our own strategic deliverables.	Prog/711	6	3	↔	• Continued engagement on our strategic deliverables with system partners and ICBs • Mapping of contract deliverables with Strategy Partnership Managers • Risk to be reviewed at December steering group in light of recent changes in ICB landscape.
Organisational Change & Internal Stakeholder Engagement: There is a risk that poor internal communication and misalignment on programme delivery and organisational changes could lead to resistance, reduced morale, and delays.	Prog/TBA	9	6	↑	• Partial control from initial programme comms for Model of Care. Now need to focus on delivery of: • 1. Internal comms plan with comms team support / Regular updates and Q&A sessions. • 2. Change management plans including feedback loops and escalation routes. • 3. Phased implementation – being worked on via summits in Dec and Jan.

Assurance

Current programme assurance and impact:

Falls, Frailty and Older people
Two key workstreams have been identified as high-impact levers for releasing operational resource and improving system efficiency: Care Homes Initiative and the Community First Responder Optimisation for Falls Calls.

Care Homes Initiative: This workstream has demonstrated potential to reduce operational demand and improve C2 mean performance through the Paddock Wood trial, which took six months to yield measurable outcomes, and has laid the foundation for broader implementation. Success is contingent on Advanced Paramedic Practitioners (APPs) feeling empowered and supported by leadership to deliver this work and maintain engagement with the care homes over Winter. It is proposed that senior leaders visibly endorse and communicate support for this initiative, reinforcing its strategic importance and enabling APPs to act with confidence. We anticipate movement in performance metrics from late Q3 into Q4 subject to consistent engagement and delivery.

Status: Under control / Needs intervention

CFR Optimisation for Falls Calls:
A new process which brings in virtual consultation triage for CFRs with falls patients is planned to go live via a pilot and supporting bulletin in late Q3/ early Q4. This will enable CFRs to connect with a remote clinician at the patient's side which aims to reduce any unnecessary dispatch of an ambulance. The second component is the approval of the Volunteering and Community Resilience Strategy and associated business case in December 2025, which will enable the development of new volunteer roles. These roles are designed to be high-impact and low-maintenance, improving performance and reducing unnecessary resource allocation through better utilisation, training, and support of volunteers.

Status: Under control / Needs intervention

Reversible Cardiac Arrest
A mid-year priority review was undertaken to assess which workstreams are likely to deliver the greatest impact on survival outcomes – this requires consistent strong clinical leadership to ensure delivery. Grip is needed on the delivery of the priority Cleric updates over the next few weeks for GoodSam and delivery of the revised SOP to facilitate full implementation and release benefits. Volunteer strategy coming to Board in December proposes includes a new "high volume, low maintenance" volunteer role via GoodSAM, focused on community cardiac arrest response. With EOC representation now secured, the 'Improving Early Identification of Cardiac Arrest' workstream is being scoped in November and recommendation due on next steps. 2 x B5 Resus Officers have been appointed likely to start early Janaury.These roles will lead an 18-month project focused on community engagement and education to improve bystander CPR and PAD use.

Status: Under control / Needs intervention

End of Life Care
The programme is progressing across several strategic workstreams aimed at improving quality, reviewing non-commissioned activity data, and enhancing staff capability albeit there is some restricted capacity to deliver this at pace. Confidence and competence among staff is being strengthened through the deployment of EOLC advocates across operational units, a EOLC session in Q3 key skills, further CPD delivery, and a Trust-wide training needs assessment. This contributes to delivering on the KPI by 31st March 2026 of 'Percentage of crews spending more than 3 hours on scene with patients at End of Life to reduce by 10%'. The work for the Year 1 KPI on 'reducing commissioned activity by 10%' is underway and is focussed on evidencing the scale of the issue to system partners and commissioners – we are working with BI on this as the data sourcing is complex. We will then be able to robustly challenge what we respond to going into Year 2 and develop an implementation plan for the changes. Full KPI benefits will not be achieved in Year 1 due to a phased approach. Year 1 focuses on building staff confidence in managing these patients and gathering data to support proposals to commissioners and partners, which is progressing as planned

Status: Under control / Needs intervention

Decision and next steps:

- BI prioritisation for remaining MOC dashboards and reporting requirements.
- Leadership communication to APPs regarding Care Homes initiative.
- Strategy approval and resourcing for volunteer role expansion (4th December 25).
- Monitoring of impact metrics and operational hours saved for care home work.

Decision / Endorse / Note by XXX

Models of Care Programme - Controls & Decisions

Exec. Sponsor:	Richard Quirk
PM:	Katie Spendiff
Last updated:	27.11.25

Change Control - Decision Requests

Proposed change	Type (T/C/Q/S)	Approval sought	Driver	Impact on delivery/assurance
Benefits from reducing non-commissioned activity by 10% will start in Year 2. Year 1 focuses on building evidence for the change and presenting it to system partners and the ICB in Q3–Q4.	Time	Phase delivery of the KPI 'reduce non-commissioned activity by 10%' as follows: Year 1: Share evidence supporting proposed changes with stakeholders. Year 2: Develop a transition plan to say no to un-commissioned activity.	Limited capacity in EOLC: We will begin challenging non-commissioned activity immediately with system partners, while enabling structures—governance, reporting, and pathway redesign—will be developed in Year 2 to embed and sustain the approach. This phased strategy balances early action with long-term resilience.	October/November engagement with system partners has set the foundation for challenging non-commissioned activity, with BI data pending to inform a robust Year 2 implementation plan.

Dependencies (material only)	MOC	Owner	Due	Status	Risk if delayed	Mitigation
Appointment of Resus Officers	Reversible Cardiac Arrest	Danny Dixon	Q3 25/26		Delay to commencing some of the quality improvement and public education work related to the Rev CA MOC.	• Work plan in development for these roles so they are good to go on commencement in late Q3. • Appointments made so status updated to Green.
National Care Record System	End of Life Care, Palliative & Dying	Richard Quirk	Q3 25/26		The planned roll out of GP Connect does not allow frontline staff to view full care plans for EOLC patients limiting effectiveness of MOC roll out.	• CMO and CPaO on project steering group to advocate for agreed approach not having negative impact in this area. • EoLC lead being kept appraised and highlighting clinical impact of decision making to Exec Sponsor of Digital programme.
Cleric system work for GoodSam	Reversible Cardiac Arrest	Dan Cody	Q3 25/26		Poor end user experience due to issues with effective deployment to calls. Potentially disengaging new users before they have even had the opportunity to be deployed. Key enabler for the delivery of the Volunteer Strategy as new volunteer roles mobilised using this.	• Workstream Lead seeking timeline for delivery of prioritised five high-impact items for early delivery to significantly improve operational efficiency and user experience. • SOP being drafted to support implementation and liaison with SCAS to standardise this between the two Trusts.
Volunteer Strategy & accompanying business case	Falls, Frailty & Older People Reversible Cardiac Arrest	Danny Dixon	Q3 25/26		Delay to commencing some deliverables in the Rev CA MOC & Falls, Frailty & Older People MOC. There is a ceiling regarding improvements that can be made if the funding is not approved.	• New Volunteering and Community Resilience strategy drafted and engagement now in progress. • On track to go to Trust Board December 2025. • Focussing on improving current processes in alignment with strategic intent.

Milestone Exceptions	Date	Exception	Impact on delivery/assurance	Recovery & new forecast
Completion of EIA, QIA & DPIA as needed and finalised drafts for top three focus MOCs.	30 Sept 2025	Delayed	Minimal impact as this is a revision to what was approved for the strategy publication.	January 2026. Submission of finalised MOC documents and Group A & B joint QIA, EIA to be submitted to PPG or newly established Clinical Effectiveness Group when meeting cadence established. Aim is to bring 3 focus MOC docs to Board in January 2026.
MOC Dashboards fully operational	31st Dec 2025	Delayed	Significant outstanding MOC data and dashboards requests sitting with the BI Team. These are required to bring the MoCs up to date, monitor improvements and for reporting on to Board. It is now impacting our ability to deliver our clinical strategy in a timely manner.	Oct 25: Sprint requested for outstanding MOC BI work. Risk materialised in November so moved to Issue log. Escalated to EMB on 05.11.25 - requests scoped and with BI. Prioritisation agreed and forecast for delivery from BI in progress.

EMB outcome inc. decision requests (post meeting):

[To be completed after EMB meeting by Corp Gov Team]

BAF Risks

BAF Risk 537 – Delivery of our Trust Strategy

There is a risk that we are unable to deliver our Trust strategy due to insufficient organisational maturity and capability, particularly in the virtual care space, resulting in poorer patient outcomes.

Contributory factors, causes and dependencies: Reliance on engagement with commissioners and partners to support strategic delivery, against a backdrop of considerable financial pressure.

Accountable Director	**Acting Chief Medical Officer**
Committee	**Quality and Patient Safety Committee**
Initial risk score	**Consequence 5 X Likelihood 5 = 25**
Current Risk Score	**Consequence 3 X Likelihood 3 = 9** ➡
Target risk score	**Consequence 3 X Likelihood 2 = 6**
Risk treatment	**Treat**
Target date	**Q4 2025/26**

Controls, assurance and gaps

Controls: Vision and strategy agreed at Board. Agreed organisational financial plan which prioritises strategic delivery. Multi-year plan developed. A fully functioning programme board providing leadership and governance. A workforce committed to the improvements needed. Learning from the virtual care provided by the navigation hubs. Clinical leads appointed to each of the 11 models of care workstreams. A full time programme manager overseeing delivery. Initial Business Intelligence support was secured, further required under new action. Workforce planning lead assigned. Evaluation to inform future scope of virtual care completed.

Gaps in control: Supporting workforce plans to build capability not yet live.

Positive sources of assurance: Robust monitoring of both strategic delivery and patient outcomes through BAF. Consultant Paramedic overseeing the clinical leadership of the 11 models of care. Programme board membership from each directorate overseeing delivery. Models of care debated within the Professional Practice group (PPG). External scrutiny via the Clinical Reference Group (CRG) at NHS England region. Blended Governance and oversight of the model of care and virtual care programmes.

Negative sources of assurance: Previous CQC inspection report describing sub standard care and the need to change. Past inclusion in the RSP programme due to past failings in the delivery of care need to influence future models. Patient feedback (particularly about long waits) need to be considered.

Gaps in assurance: Presentation of the year 2 plans. Operational planning is still required to ensure that clinical plans are deliverable. The joint clinical model with SCAS is yet to be developed.

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Workforce planning assumptions and needs document to inform workforce plan.	Acting Chief Medical Officer	Q3 2025/26	Consultant Paramedic and Transformation Director have compiled a high level planning assumptions document based on the MOC requirements. Alignment with central workforce planning group.
Agreement of VC operating model to be defined & integrated with MOC implementation.	Chief Operating Officer	Q4 2025/26	Summits arranged for Nov, Dec and Jan to move this forward. Proposed re-baselining of the VC programme to support this activity.
Sprint request for BI Support to deliver the remaining MOC work required to help inform the VC/MOC workforce planning and	Chief Digital Officer	Q3 2025/26	Request submitted for prioritisation to BI Review Group mid Nov. Outcome awaited.

BAF Risk 646 – Internal Productivity Improvements

There is a risk that we are unable to deliver planned internal productivity improvements while maintaining patient outcomes as a result of insufficient or unfulfilled changes to service delivery processes or models of care, resulting in unrealised operational performance or financial sustainability

Contributory factors, causes and dependencies:
Organisational culture and employee relations situation limiting ability to make change and set expectations
Risk averse re: clinical practice meaning low appetite to make productivity changes without significant assurance on safety, reducing potential pace of delivery

Accountable Director	**Chief Operating Officer**
Committee	**Finance and Investment Committee**
Initial risk score	**Consequence 4 X Likelihood 4 = 16**
Current Risk Score	**Consequence 4 X Likelihood 4 = 16** ⇨
Target risk score	**Consequence 4 X Likelihood 2 = 8**
Risk treatment	**Treat**
Target date	**Q4 2025/26**

Controls, assurance and gaps

Controls: Ongoing process to enhance ER processes and renegotiate policies prioritised within People BAF; Specific schemes and robust oversight of productivity scheme delivery through SMG and Quarterly review; detailed planning and QIA process to assure safe delivery; Support team incl senior coordinating role, finance and BI input for productivity and efficiency in place. Communications undertaken to highlight productivity requirements across all divisions and clinical staff, successful engagement with TUs.

Gaps in control: Ongoing process of Clinical Operating Model Design creating possible gaps in leadership or governance structures. Impact of People Services restructure and vacancies on ER and policy changes required. Competing priorities for leadership team may distract from focus on productivity schemes

Positive sources of assurance: Robust monitoring of both strategic delivery and outcomes through SMG, EMB and BAF. IQR reporting. Operational reporting. Finance reporting

Negative sources of assurance: Continued lack of increase in H&T rate and clinical call productivity in line with required levels

Gaps in assurance: Limited analytical and finance capability/capacity to define and monitor improvement trajectories, understand impact of productivity changes and ensure embedded / benefits realised.

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Design and delivery of three priority models of care	Chief Medical Officer	Q4 2025/26	These are all on track for delivery as planned. Reporting being developed
Ongoing work with SCAS and SASC to enhance productivity and efficiencies	Chief Strategy Officer	Q4 2025/26	CSO now joint strategic advisor for SCAS and SECAmb.
Ongoing series of workshops with TU colleagues to support implementation of Ts&Cs changes	Chief Operating Officer	Q4 2025/26	Successful engagement and delivery of first tranche of changes.
Escalation plan being put in place regarding H&T productivity, aligned with quality summit work and development of Hubs	Chief Operating Officer	Q3 2025/26	In progress. Executive summit meeting completed and field operations divisions, through OUMs, leading on productivity through hubs. Early improvement seen.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Integrated Quality Report

Trust Board December 2025

Data up to and including October 2025

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

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

NHS Performance Assessment Framework 2025/26

The NHS Performance Assessment Framework sets out how success and areas for improvement will be identified, and how organisations will be rated.
Metrics with this icon are part of this framework.

South East Coast Ambulance Service
NHS Foundation Trust

Quality Patient Care

What? So what? What next?

STEMI care bundle compliance is consistently above target demonstrating it is firmly embedded in practice.

You will note that Hear & Treat is significantly behind target and has not hit the expected trajectory for H1. There are five key elements in the mitigation plan to improve the virtual care response and H&T rates as set out in slide 11 informed by a deep dive that has been undertaken to understand the key drivers and blockers. We expect this to move the position closer to target.

Compliance with NHS Pathways audits is currently at 87.1% for clinicians and 81.4% for EMAs . The risk of the issues driving this non-compliance was raised to Board in June 2025, and a quality summit was held in August 2025 identifying six key enablers to improve this position by addressing root causes. Workstreams are now in place with the ambition to improve this position over the coming months. This has been shared with the Executive team, QPSC and to the CQC who were present at the Quality Summit. Additionally following the commencement of a Safety Improvement Specialist this month, the current QI project underway will be complemented by a human factors approach to strengthen the plan for improvement.

Hand hygiene compliance is currently 82.9% which is below the target of 90%. The IPC Team will be carrying out a Quality Improvement project during Q4 of the year, focusing on hand hygiene but also including all areas of IPC practice. This will include staff and leadership collaboration throughout the project and be monitored at the IPC Sub Group.

Complaints timeliness compliance for October was only 56%, the lowest since January 2023. This was primarily due to staff shortages in integrated care delay investigations into 111 and EOC complaints and exacerbated by leave and absence in the PALS teams. A complaint process mapping improvement session was undertaken in Nov 2025 that has informed a plan for improvement through change of practice and process. The expectation is to see improved performance over the next month.

The Trust underwent an CQC unannounced inspection on the 2/3 October 2025 of the Urgent & Emergency Care pathways (Field Ops), and of EOC across Medway and Crawley on 27 /28 November 2025. The initial high-level feedback from both inspections has been very positive, with no breaches identified, no patient safety concerns, and strong evidence of compassionate staff delivering our services. We await the first drafts of the report for factual accuracy to confirm the outputs.

Quality Patient Care Overview

South East Coast Ambulance Service NHS Foundation Trust

Integrated Quality Report

Variation

Special Cause Improvement		Common Cause		Special Cause Concern	
8%	12%	69%		0%	2%
4	6	36		0	1

Assurance

Pass	Hit and Miss	Fail	No Target
8%	46%	19%	27%
4	24	10	14

Clinical Effectiveness & Patient Outcomes

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	**Acute STEMI Care Bundle Outcome %	Sep-25	88.8%	64.7%	78%		
Board	**Cardiac Arrest - Post ROSC %	Jul-25	75.6%	76.8%	77%		
Board	**Cardiac ROSC ALL %	Jul-25	27.4%	23.8%	28.7%		
Board	**Cardiac ROSC Utstein %	Jul-25	39.1%	45.1%	52.2%		
Board	**Cardiac Survival ALL %	Jul-25	11%	11.5%	11.8%		
Board	**Cardiac Survival Utstein %	Jul-25	28.9%	25.6%	33%		
Board	Hear & Treat %	Oct-25	15.1%	18.1%	14.6%		
Board	See & Convey %	Oct-25	54.7%	55%	54.9%		
Board	See & Treat %	Oct-25	30%	35%	30.3%		
Supporting	Compliant NHS Pathways Audits (Clinical) %	Oct-25	87.1%	100%	84.2%		
Supporting	Compliant NHS Pathways Audits (EMA) %	Oct-25	81.4%	100%	81.5%		
Supporting	Required NHS Pathways Audits Completed (Clinical) %	Oct-25	103.1%	100%	102.3%		
Supporting	Required NHS Pathways Audits Completed (EMA) %	Oct-25	100.5%	100%	101.7%		
Supporting	A&E Dispositions %	Oct-25	5.7%	9%	7.3%		
Supporting	PGD Compliance %	Oct-25	96.7%	95%	92.8%		
Supporting	Health & Safety Training Compliance	Oct-25	95%	100%	95%		

Response Times

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	111 Average Speed to Answer	Oct-25	00:01:15	00:00:20	00:01:32		
Board	999 Call Answer Mean	Oct-25	00:00:03	00:00:05	00:00:05		
Board	999 Call Answer 90th Centile	Oct-25	00:00:02	00:00:10	00:00:05		
Board	Cat 1 Mean	Oct-25	00:08:24	00:07:00	00:08:21		
Board	Cat 1 90th Centile	Oct-25	00:15:42	00:15:00	00:15:28		
Board	Cat 2 Mean ★	Oct-25	00:28:11	00:26:46	00:28:34		
Board	Cat 2 90th Centile	Oct-25	00:57:06	00:40:00	00:58:02		
Supporting	Cat 3 90th Centile	Oct-25	04:47:47	02:00:00	04:53:34		
Supporting	Cat 4 90th Centile	Oct-25	05:07:41	03:00:00	05:10:21		
Supporting	Section 136 Mean Response Time	Oct-25	00:23:20	00:18:00	00:24:17		

Models of Care

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	% of 999 Calls from Nursing Homes	Oct-25	6%	8%	6%		
Board	Falls, Frailty & Older People: Cat 3 Mean Response Time	Oct-25	01:58:38	01:35:00	02:08:35		
Board	Falls, Frailty & Older People: Cat 4 Mean Response Time	Oct-25	01:51:34	01:39:00	02:02:31		
Board	Falls, Frailty & Older People: H&T % - Non-Injury Falls	Oct-25	9.5%	15%	9.8%		
Board	Falls, Fraility & Older People: CFR First on Scene % - Non-Injury Falls	Oct-25	4%	4.8%	5.9%		
Board	End of Life Care, Palliative & Dying: % of on Scene Times Over 3 Hours	Oct-25	3.9%	4.8%	4.8%		

Quality Patient Care Overview

South East Coast Ambulance Service NHS Foundation Trust

Integrated Quality Report

Variation

Special Cause Improvement			Common Cause		Special Cause Concern		
8%	12%		69%		0%	2%	
4	6		36		0	1	

Assurance

Pass	Hit and Miss	Fail	No Target
8%	38%	15%	38%
4	20	8	20

Productivity

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	% of 999 Calls Receiving Validation	Oct-25	19.9%		19.3%		
Board	CFR Backup Time (CFR First on Scene) Mean	Oct-25	00:19:11		00:19:11		
Board	Responses Per Incident	Oct-25	1.1	1.09	1.1		
Board	JCT Allocation to Clear All Mean	Oct-25	01:35:37	00:50:27	01:36:31		
Supporting	JCT Allocation to Clear at Hospital Mean	Oct-25	01:47:45	01:59:21	01:50:44		
Supporting	JCT Allocation to Clear at Scene Mean	Oct-25	01:19:18	01:30:42	01:17:30		

Patient Safety

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	% of PSI (Datix) Where Final Harm is Moderate or Above	Sep-25	1.9%		1.8%		
Board	Hand Hygiene Compliance %	Oct-25	82.9%	90%	84.7%		
Supporting	Duty of Candour Compliance %	Oct-25	100%	100%	89.4%		
Supporting	Harm Incidents per 1000 Incidents	Sep-25	2.8		3		
Supporting	Number of Medicines Incidents	Oct-25	212		169.3		
Supporting	Safe in Back Audits	Oct-25	12%		12%		

Demand

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Supporting	111 Calls Offered	Oct-25	96385		91385.5		
Supporting	999 Calls Answered	Oct-25	79806		74941.9		
Supporting	CFR Attendances	Oct-25	1768		1752.2		
Supporting	Incidents	Oct-25	68471		65213.2		

Patient Experience

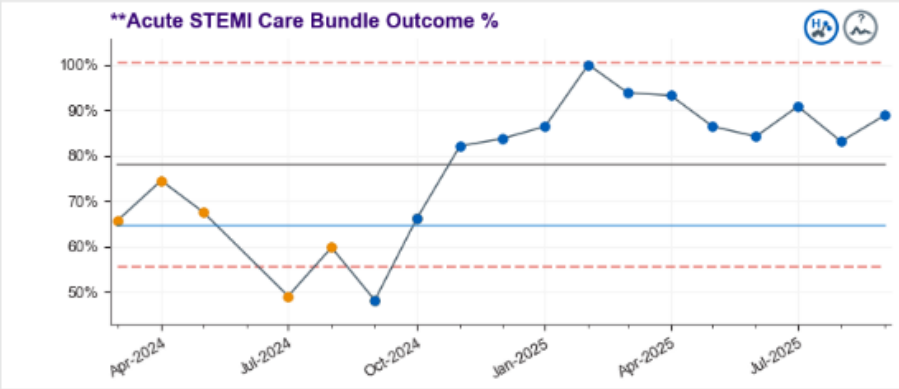
Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Supporting	Complaints Reporting Timeliness %	Oct-25	56%	95%	89.4%		
Board	Number of Complaints Received per 1000 Incidents Responded to (Patients)	Oct-25	0.6		0.5		
Supporting	Number of Complaints	Oct-25	55		69.1		

Health Inequalities

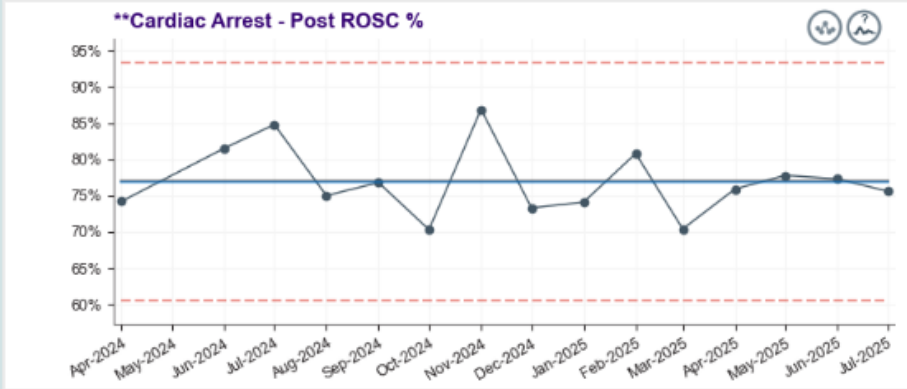
Type	Metric	Latest	Value	Target	Mean	Variation	Assurance

Pending metric: Reduce Health Inequalities - Needs to be defined

Pending metric: Ratio of CFRs (or Good SAM Responders) by Areas of Deprivation - Needs to be defined



M-5
Dept: Medical
Metric Type: Board
Latest: 88.8%
Target: 64.7%
Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.



M-11
Dept: Medical
Metric Type: Board
Latest: 75.6%
Target: 76.8%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

What?
STEMI care bundle compliance is 88.8%, remaining significantly above the 64.7% target. This represents sustained special cause improvement, with performance consistently high over the past year following the uplift seen from late 2024 onwards.

So what?
This ongoing high level of compliance demonstrates that the care bundle is firmly embedded in practice, ensuring patients with confirmed STEMI receive timely and appropriate interventions such as aspirin, GTN, pain monitoring, and analgesia. The sustained results suggest that improvement mechanisms and quality assurance processes are continuing to perform effectively.

What next?
JRCALC GTN changes are being implemented from December, these will be embedded into audit processes from January data. We will continue to monitor for stability and share learning from this sustained success across other clinical bundles. Maintain data quality assurance and clinician engagement to ensure this level of care delivery remains resilient through operational pressures and seasonal demand fluctuations.

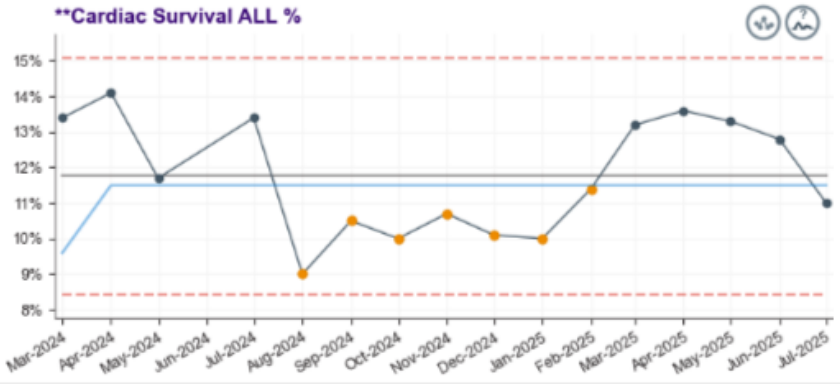
What?
Post-ROSC care bundle compliance is 75.6%, just below the 76.8% target. Performance has been stable over the past 12 months, showing common cause variation and no statistically significant change.

So what?
The steady compliance indicates that post-resuscitation care is being delivered reliably but has not yet advanced beyond the current plateau. This stability is reassuring but also highlights the opportunity to strengthen consistency further and build on the early positive findings from the CCP-led post-cardiac arrest feedback feasibility work.

What next?
Continue phased rollout of the CCP feedback model as resources allow, ensuring local teams are supported to embed the process effectively. Maintain close monitoring of post-ROSC compliance and outcome trends to assess the impact of wider implementation and identify opportunities for targeted support as the programme expands.

Quality Patient Care: Clinical Effectiveness & Patient Outcomes | Board Metrics

Integrated Quality Report



M-4

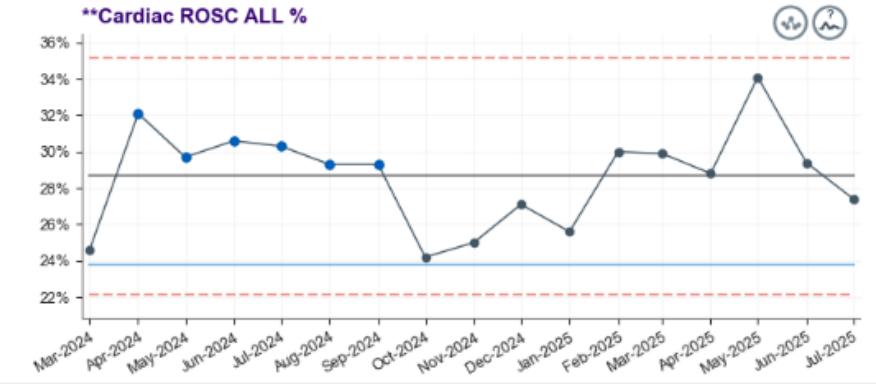
Dept: Medical

Metric Type: Board

Latest: 11%

Target: 11.5%

Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-2

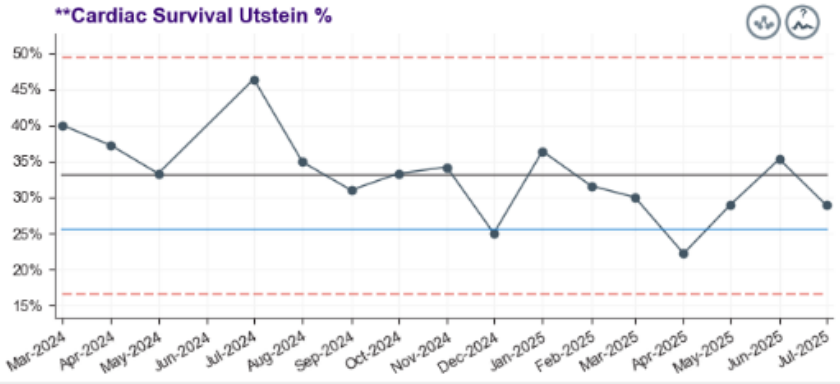
Dept: Medical

Metric Type: Board

Latest: 27.4%

Target: 23.8%

Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-3

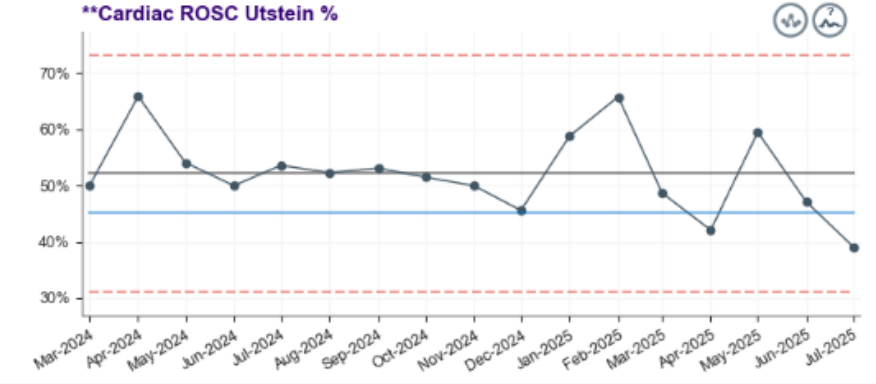
Dept: Medical

Metric Type: Board

Latest: 28.9%

Target: 25.6%

Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-1

Dept: Medical

Metric Type: Board

Latest: 39.1%

Target: 45.1%

Common cause variation, no significant change. This process will not consistently hit or miss the target.

What?
Overall cardiac survival is 11%, just below the 11.5% target, while Utstein survival is 28.9%, above the 25.6% target. Both measures continue to show common cause variation with no statistically significant change. Performance across both datasets remains stable, following a period of moderate fluctuation earlier in the year.

So what?
Overall cardiac survival is showing normal variation and the Utstein measure remains strong and above target, suggesting that the highest-quality care continues to be delivered for patients most expected to benefit from resuscitation. The stable performance across both cohorts demonstrates that system-wide cardiac arrest care remains robust. Encouragingly, the alignment between Utstein survival and broader outcomes continues to suggest that improvements in post-ROSC and in-hospital care are contributing positively to survivorship across a wider patient group.

What next?
Continue to monitor both measures to confirm sustained stability and to detect any early shifts in trend. Insights from post-ROSC feedback and survivorship research should be used to reinforce effective clinical practices and identify opportunities for targeted improvement. Ongoing collaboration between the Critical Care and Health Informatics teams will remain key to understanding the long-term patient impact and further refining quality improvement priorities.

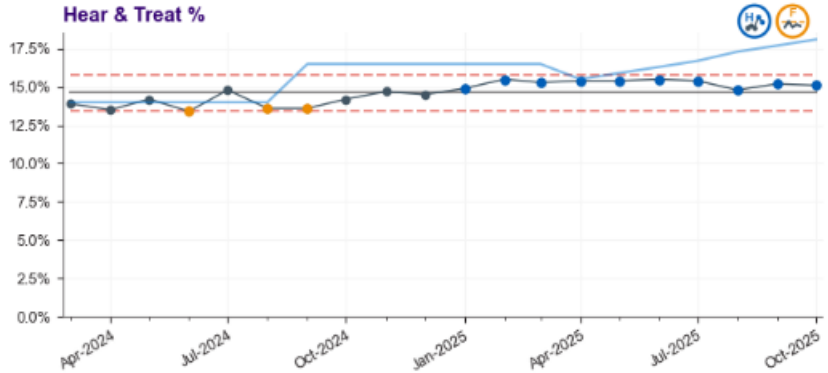
What?
ROSC for all cardiac arrest patients is 27.4%, above the 23.8% target, while ROSC for the Utstein cohort is 39.1%, below the 45.1% target. Both remain within common cause variation, showing no statistically significant change. Overall ROSC performance has stayed consistently above target, while Utstein ROSC continues to fluctuate and has shown a gradual downward trend since mid-2024.

So what?
The continued strong performance in overall ROSC suggests that resuscitation quality remains robust across a broad patient population, including those outside the benchmark Utstein group. However, the divergence between Utstein ROSC and survival observed in recent months persists - Utstein ROSC remains lower, yet Utstein survival remains above target. This pattern implies that while initial ROSC rates in Utstein cases may have softened, those achieving ROSC are surviving at higher rates, pointing to strengthened post-ROSC and in-hospital care.

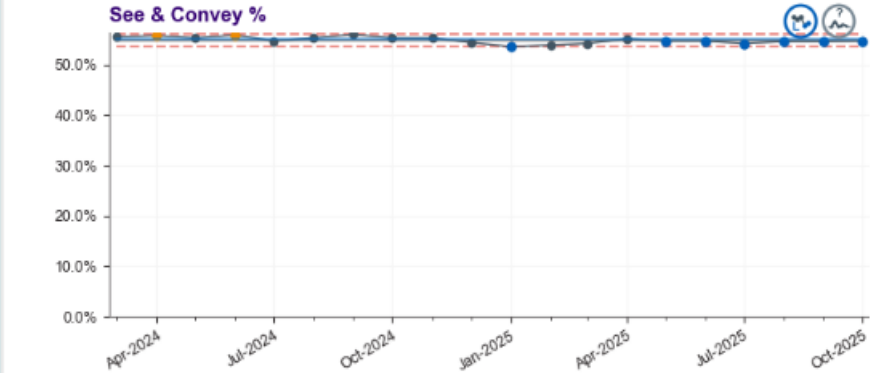
What next?
Maintain close observation of both ROSC measures to see whether this divergence persists or begins to realign. Use learning from the recently endorsed CCP-led post-cardiac arrest feedback process to reinforce early resuscitation consistency and strengthen the handover into post-ROSC care. Continued focus on data quality and pathway analysis will help identify factors contributing to survival gains and inform future quality improvement priorities.

Quality Patient Care: Clinical Effectiveness & Patient Outcomes | Board Metrics

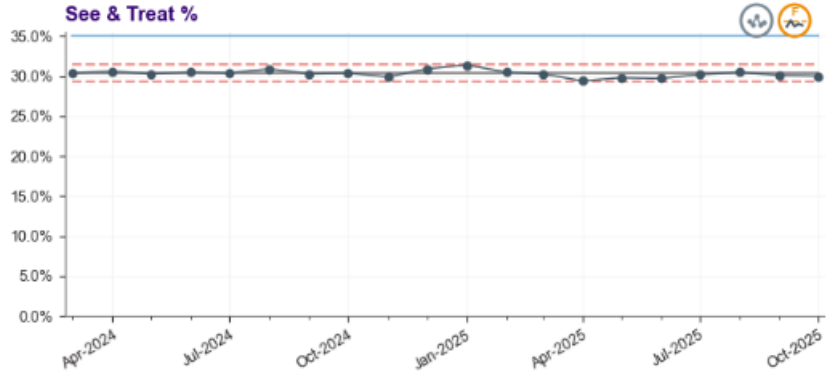
Integrated Quality Report



999-9
Dept: Operations 999
Metric Type: Board
Latest: 15.1%
Target: 18.1%
Special cause of an improving nature where the measure is significantly HIGHER. This process is still not capable. It will FAIL the target without process redesign.



999-9
Dept: Operations 999
Metric Type: Board
Latest: 54.7%
Target: 55%
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.



999-9
Dept: Operations 999
Metric Type: Board
Latest: 30%
Target: 35%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

See & Treat and See & Convey

What? See & Treat is 30%, whilst See & Convey remains stable at 54.7%

So what? It should be noted See & Convey % is directly related to the acuity of patients and availability of suitable alternative referral pathways.

What next?
Work continues with health system partners and SECAmb colleagues (cross-directorate), to make improvements to pathways, alongside enhancing utilisation of Hubs in the region to support reductions in avoidable ED conveyance.

Hear & Treat

What? Although virtual care is a key strategic goal for the Trust, SECAmb has been unable to implement the step change in Hear & Treat planned for 25/26, and is significantly behind the Trust's Hear & Treat target trajectory for H1 of 25/26. The Trust continues to use NHSE guidance to focus on key elements of virtual care, such as C3/C4 validation and C2 streaming, formerly called segmentation. However, there is real variability daily, linked to case acuity, clinician availability and critically clinician productivity, which adversely impacts the ability to deliver the target levels consistently.

So what? There are five key areas of focus to improve the effectiveness of virtual care and to increase Hear & Treat.

- Clinician capacity; the current substantive EOC clinician capacity is approximately 60% of requirement to achieve 100% C3/C4 clinical validation.
- Clinical productivity; the number of cases answered per clinician per hour whilst improving marginally to 1.4, is still behind the Trust target of 2.0 calls per hour.
- Clinicians managing the right cases at the right time; appropriate clinical navigation is required, with a focus on cases to optimise Hear & Treat outcomes i.e. C2 streaming vs. C3/C4 validation, and suitable case identification.
- Good utilisation of the Directory of Services (DoS) and alternative patient pathways e.g. UCR services; this remains at circa 20% acceptance rate, which is significantly behind the system target of 60%.
- Increased clinical effectiveness and outcomes identified alternative to ambulance dispatch; this is driven by clinical education to improve the confidence and competence of clinicians undertaking virtual care.

What next? The Trust has undertaken a rigorous Hear & Treat Deep Dive exercise, to review the current virtual care plan and actions, and to explore next steps to get virtual care back on track against the Trust's business Plan.

- A clear plan to increase clinician productivity in EOC and the Hubs has been created, with a live clinician productivity dashbaord, plan on a page guidance, support to help managers understand the metrics, and regular meetings and reports to maintain focus.
- The Trust has started a targeted piece of work to create a new virtual care model, with a draft proposal due for EMB before the end of Nov, following workshops and engagement events.
- A new C2 Streaming process is being developed, with implementation due before the end of Nov.
- A new "auto clinician allocation" process is being tested in the CAD, with a view to deployment in Dec to improve clinician utilisation in virtual care.

Quality Patient Care: Clinical Effectiveness & Patient Outcomes | Supporting Metrics

Integrated Quality Report

M-23

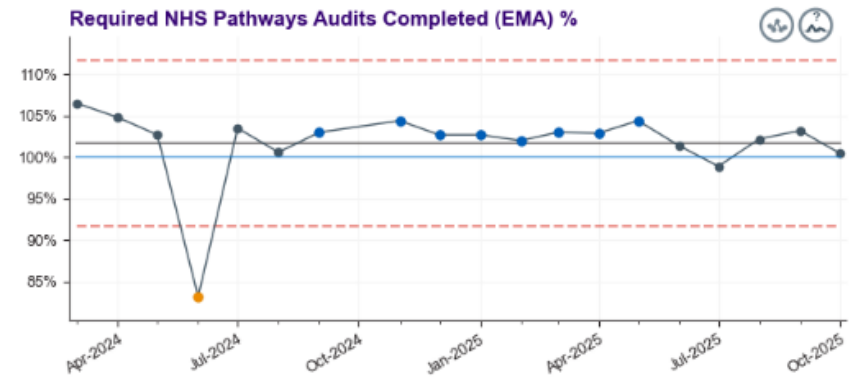
Dept: Nursing & Quality

Metric Type: Supporting

Latest: 103.1%

Target: 100%

Common cause variation, no significant change. This process will not consistently hit or miss the target.



M-21

Dept: Nursing & Quality

Metric Type: Supporting

Latest: 100.5%

Target: 100%

Common cause variation, no significant change. This process will not consistently hit or miss the target.

M-20

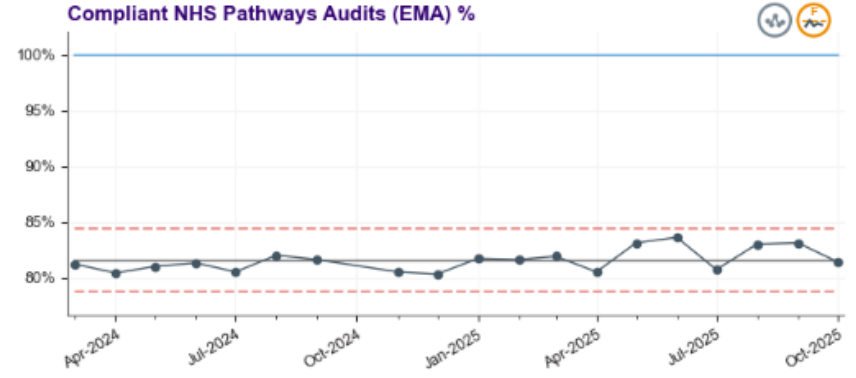
Dept: Nursing & Quality

Metric Type: Supporting

Latest: 87.1%

Target: 100%

Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



M-22

Dept: Nursing & Quality

Metric Type: Supporting

Latest: 81.4%

Target: 100%

Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

What? Required pathways audits continue to be completed to the expected 100% target. Any above target activity is because of additional audits retrospectively completed for investigation purposes. Call audit compliancy continues to be lower than target.

So what? Audits are being completed in a timely manner which means results can be fed back quickly, this ensures the feedback is as constructive as possible for the clinician. Low compliancy can lead to an inappropriate or unsafe disposition for the patient, and widespread low compliancy can be an early indicator of a wider issue in the workforce relating to recruitment, training, management or culture of the EOC clinical team.

What next?

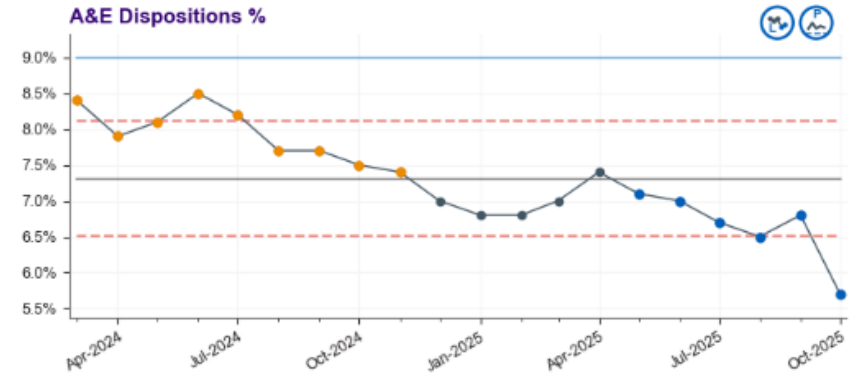
- An internal OD review has been undertaken that identified human factor impacts adversely impacting compliancy and gaps identified. This has fed into the QI project.
- A collaborative piece of work is currently underway jointly with the EOC and EOC Practice Development management teams to review and revise the NHS Pathways Audit Tool for a trial period, with the support of the NHSE team.
- The QI Project to address the identified gaps/actions that commenced May 2025, is now in the Define and Measure stage.
- A Quality Summit to identify further improvement actions was held in August 2025.
- The first phase of training for EOC colleagues on 'how to give' and 'how to receive feedback' is being progressed and the training team are exploring methods for future delivery
- Levelling training is continuing to be rolled out to EOC colleagues and a new tracker with support provided by ICB subject matter experts.
- Dashboards are being revised to closely monitor teams' performance at staff level as well as teams' level

What? Required pathways audit continue to be completed to the expected 100% target. Any above target activity is because of additional audits retrospectively completed for investigation purposes. Call audit compliancy continues to be lower than the 85% target.

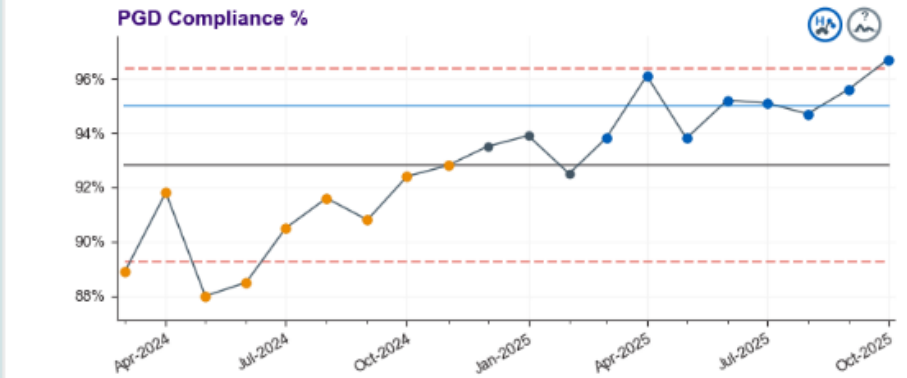
So what? Audits are being completed in a timely manner which means results can be fed back quickly, this ensures the feedback is as constructive as possible for the EMA. Low compliancy can lead to an inappropriate or unsafe disposition for the patient.

What next? A QI project is addressing the low compliancy for clinical calls. Once complete any transferable actions will be implemented for EMA auditing. In the meantime, EMA call compliancy will be monitored and locally initiated projects will continue such as:

- EOC Practice Developers are being assigned individual Team Leaders to work in partnership, the aim is to harbour closer working relationships.
- A deep dive into Cardiac Arrest Call Compliancy, using the registry to understand the factors when a patient survives and use the results to drive improvement.



111-5
Dept: Operations 111
Metric Type: Supporting
Latest: 5.7%
Target: 9%
Special cause of an improving nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target.



MM-8
Dept: Medicines Management
Metric Type: Supporting
Latest: 96.7%
Target: 95%
Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.

QS-39
Dept: Quality & Safety
Metric Type: Supporting
Latest: 95%
Target: 100%
Special cause or common cause cannot be given as there are an insufficient number of points.

111 Clinical Performance

What? During October KMS 111 had an ambulance referral rate of 6.7% (5,642 of ambulances sent of 83,822 triaged cases) and this was supported by C3/C4 ambulance validation rate of 43.4%,
Clinical assessment in the Clinical Assessment Service (CAS) of ED dispositions remains a key focus of the Trust. In October, 49.2% of all calls triaged were assessed by a clinician, in line with the NHS E national average.
The proportion of total calls initially given an ED disposition that received remote clinical intervention was 30.8%, indicative of sustained focus on protecting the wider health system. In addition, the proportion of cases identified by NHS E requiring clinical assessment via 111 First was 4,074 with 3,442 (85%) receiving a clinical intervention. Again, the Trust's 111 service delivered exceptional performance with regards to its ED referral rate, achieving 5.8% vs. a target of 9%, again being top of the national benchmarking table for this metric.

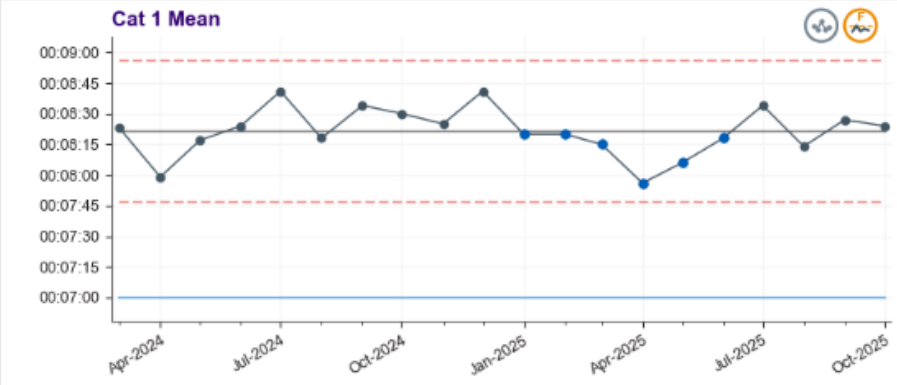
So what? The service continues to make a difference to not only our 999 service, but also the wider healthcare economy. The positive impact of the CAS and its clinical interventions is vital in reducing unheralded demand to EDs and facilitating appropriate care, optimising patient pathways.

What next? The service continues to stabilise following the change to the new sub-contractual operating model in H1. Following the transition to the new model, SECAmb is using the Service Delivery Improvement Plan (SDIP) to improve service effectiveness and efficiency. The Trust is also committed to undertaking a revised skills mapping exercise, to ensure the CAS clinical workforce is aligned to patient needs. This revised 111 workforce plan will be submitted to commissioners by the end of Q3

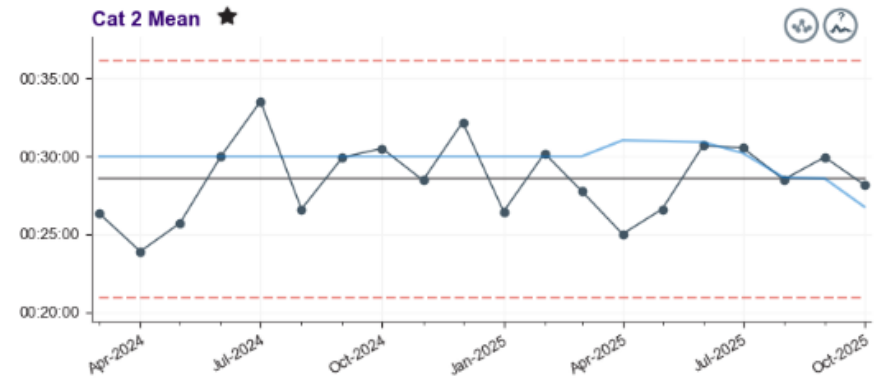
PGD compliance (MM-8)
What?
Our PGD compliance remains stable, considering fluctuations when updated or new PGDs are released for authorisation.

So what?
Training and compliance ensure that all healthcare professionals administer medicines under PGDs consistently, regardless of location or individual practice variations This is crucial for maintaining high-quality care.

What next?
Strengthened communication between the Medicines Team and operational staff aims to embed and sustain this excellent progress.

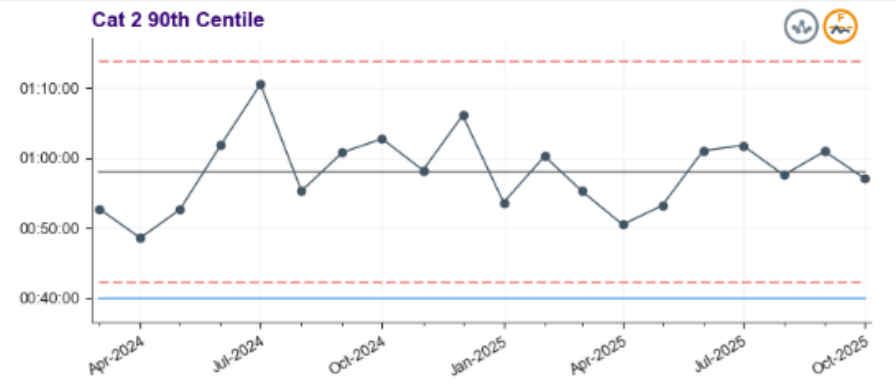


999-2
Dept: Operations 999
Metric Type: Board
Latest: 00:08:24
Target: 00:07:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



999-4
Dept: Operations 999
Metric Type: Board
Latest: 00:28:11
Target: 00:26:46
Common cause variation, no significant change. This process will not consistently hit or miss the target.

999-2
Dept: Operations 999
Metric Type: Board
Latest: 00:15:42
Target: 00:15:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.



999-4
Dept: Operations 999
Metric Type: Board
Latest: 00:57:06
Target: 00:40:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Cat 1 Performance

What? For the year-to-date C1 performance is 8.16 mins against an ARP target of 7 minutes

So what? C1 Mean performance improved by 3 seconds and was 8.24 in October and the variation remains within normal limits.

What next? Continuation of the Local Community Dispatch Model I(LCDM) is now BAU and does not appear to have had a detrimental impact upon C1 performance, this is being monitored regularly. Breakaway

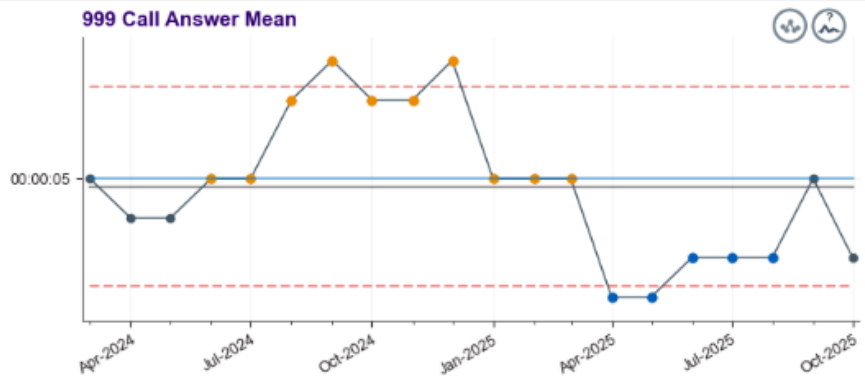
Cat 2 Performance

What? For the year-to-date C2 Mean for the YTD has reduced by 20 seconds and now stands at 28.16 and the there was a marked improvement in October reducing the time by 1.43 to 28.11.

So what? C2 Mean performance for October was 28.11, total hours abstracted fell from **216,877** in September to **202,893** in October, and the abstraction percentage also dipped from **34.32%** to **32.24%**.

What next? Continuing focus on delivery of the C2 mean with all OUM's across Operations. with regular prospective reviews of hours available on the road, monitoring abstractions – focused drive to manage sickness rates (both long and short term), along with targeted application of overtime where appropriate.AL

Other influencing factors have mitigated against worsening C2 performance, such as reduction in job cycle times, particularly crew handover to clear times following automation (auto-clear).

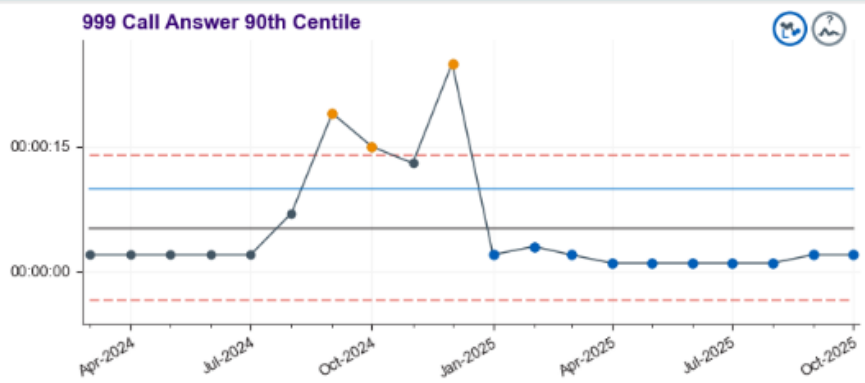


999-1
Dept: Operations 999
Metric Type: Board
Latest: 00:00:03
Target: 00:00:05

Common cause variation, no significant change. This process will not consistently hit or miss the target.

111-9
Dept: Operations 111
Metric Type: Board
Latest: 00:01:15
Target: 00:00:20

Special cause of an improving nature where the measure is significantly LOWER. This process is still not capable. It will FAIL the target without process redesign.



999-1
Dept: Operations 999
Metric Type: Board
Latest: 00:00:02
Target: 00:00:10

Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.

999 Call Handling Performance

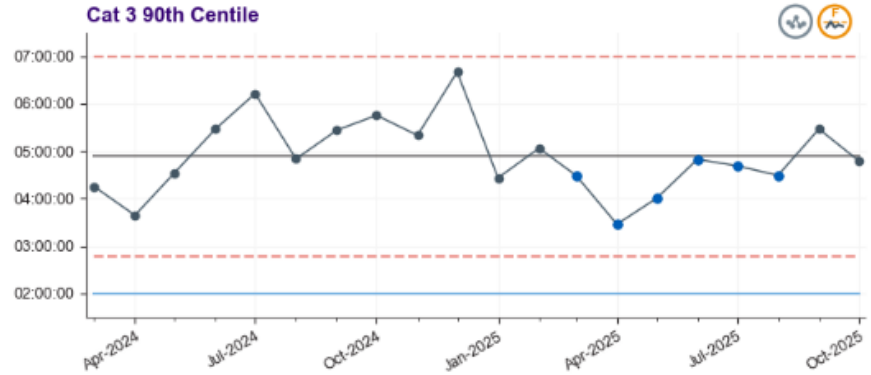
What? Performance in September saw the Trust comfortably meet the AQI target of 5 secs, for the tenth consecutive month, with a call answer mean of 3 secs. Activity in Octoberr was up on the previous month, with an average of more than 20K calls per week.
Following the decision by ten of the eleven English ambulance trusts to retain Intelligent Routing Platform (IRP), SECAmb has implemented a 999 resilience call overflow model, which facilitates the movement of calls between 999 services more easily, and SECAmb was able to answer a significant number of calls for SCAS and YAS, with no detriment to its own 999 call handling performance.
The current staffing position is 262 WTE call handlers (inc. Diamond Pods) live on the phones vs. a budget of 265 WTE, with 18 further in training or mentoring. This training has offset staff turnover through H1 and has ensured good service performance year to date.
Although sickness and abstraction increased during October in part because of the early onset of the cold/flu season, it remained within acceptable tolerance levels for the month.
So what? SECAmb's consistent delivery of 999 call answering means the long waits that patients experienced prior to and immediately after the move to the Medway contact centre in 2023 no longer occur. This means patients get a timelier ambulance response and it reduces the pressure on EMAs, and the inherent moral injury generated by elongated 999 call waits. It also has a positive impact on overall ARP performance, and enables SECAmb to help other ambulance trusts.
What next? Looking ahead, the service experienced a rise in attrition last month and overtime will be reviewed and targeted where needed. The EOC operations rota review is now fully in place with the updated EMA rota removing some of the peaks of over-staffing at times. Whilst SECAmb continues to deliver a high level of performance, it will continue to support other trusts, although this is reviewed weekly, especially with the Nexus House refit now causing a temporary relocation of EMAs in Crawley to the first floor.

111 Call Handling Performance

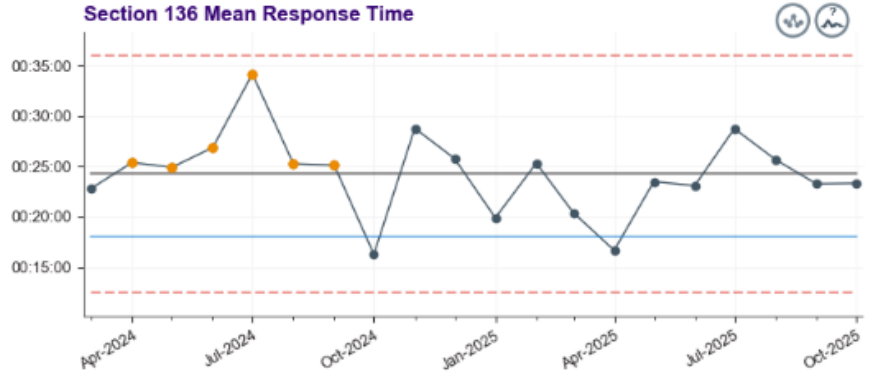
What? The 111-service transitioned to a revised operating model in H1, with a new sub-contractor operating configuration and contract in place. The Trust has also agreed a new 111 contract variation, which extends the current 111 service until the end of 26/27.

So what? The model has been embedded successfully with improved call handling metrics, with an October rate of abandoned calls of less than the 5.0% target, and an average speed to answer of 75 secs. Overall, the service's operational and clinical metrics have improved with a more equitable split of activity between SECAmb and its sub-contractor. The call splits (operationally and clinically) are reviewed monthly to maintain performance and to ensure contractual compliance.

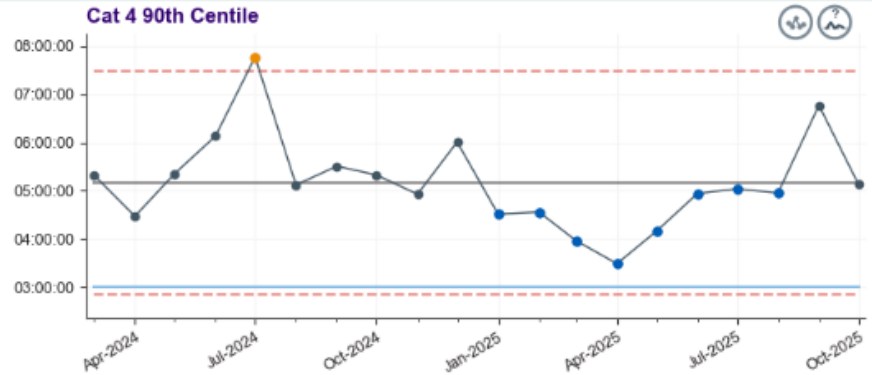
What next? The service is now in a period of stabilisation and is continuing to review to find efficiencies and optimise performance. Recruitment remains positive, with steady staffing levels resulting in the planned number of NHS Pathways (NHS P) courses per month being reduced in Q3.
"Hybrid" flexible working remains a key focus of the service, and currently there are more than 130 operations colleagues with a Hybrid 'kit'. Given the focus on increasing the number of bank GPs in the service, following the changes in operating model, the service is suspending increasing its number of non-clinical Hybrid workers in H2.
The Trust is submitting by the end of Q3 a revised 111 workforce model aligned to the new 111 CV



999-5
Dept: Operations 999
Metric Type: Supporting
Latest: 04:47:47
Target: 02:00:00
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



999-18
Dept: Operations 999
Metric Type: Supporting
Latest: 00:23:20
Target: 00:18:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.



999-6
Dept: Operations 999
Metric Type: Supporting
Latest: 05:07:41
Target: 03:00:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.

What? C3 response times are above target. This is caused in part because of demand exceeding resource, an inability to dispatch against non-emergency ambulances for significant periods of shifts (meal break policy), and with some known dispatch delays due to all C3 and C4s going into validation. These combined factors can create increased response times. C4 response times (very low numbers of activity) remain challenged due to volume of C2 and C3s which are prioritised and dispatched ahead of this call type.

So what? The Trust needs to optimise its resource, and take action within its control regarding factors such as handovers, on-scene times, out of service time etc. SECAmb also need to support the reduction in see and treat through hear and treat of C3 and C4 non-emergency ambulances.

What next? The Trust has introduced a suite of actions to improve grip on performance in its winter plan, with a designated manager overseeing key metrics to maintain focus and performance throughout the day. We will also continue to focus on C3 & C4 calls to ensure they have adequate clinical oversight, as they are a cohort of patients which is suitable for virtual care and potentially alternative care pathways.

What?
There is no significant change to S136 metric

So what?
Numbers are low and there is some variation in the metric

What next?
We continue to work in partnership with the Police to address the current issues through Right Person Right care Programme

Quality Patient Care: Productivity | Board Metrics

Integrated Quality Report

999-17

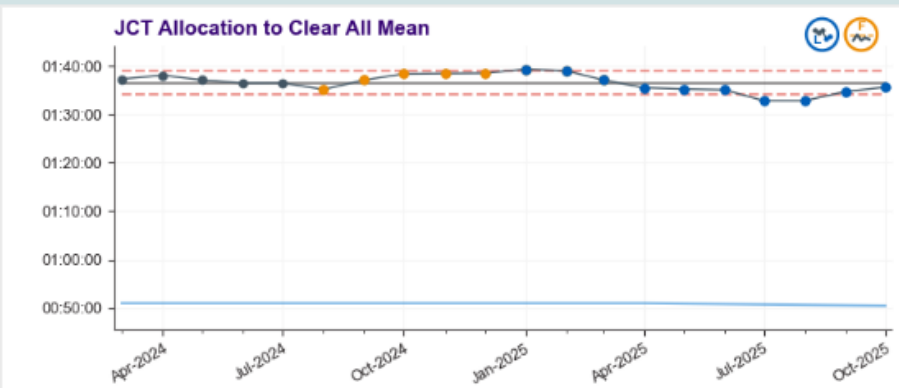
Dept: Operations 999

Metric Type: Board

Latest: 1.1

Target: 1.09

Common cause variation, no significant change. This process will not consistently hit or miss the target.



999-44

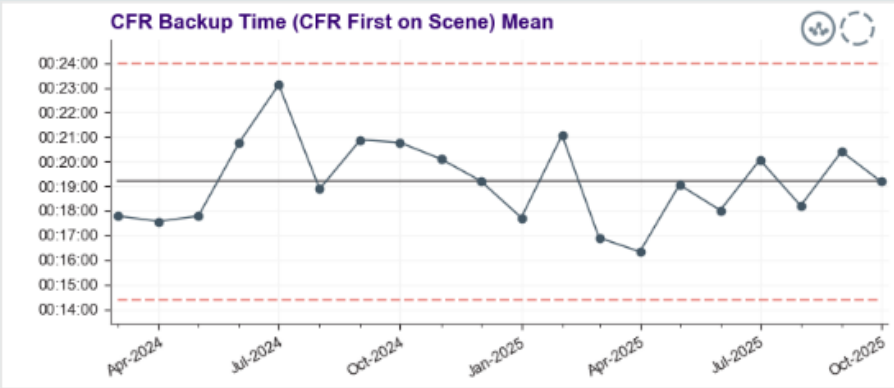
Dept: Operations 999

Metric Type: Board

Latest: 01:35:37

Target: 00:50:27

Special cause of an improving nature where the measure is significantly LOWER. This process is still not capable. It will FAIL the target without process redesign.



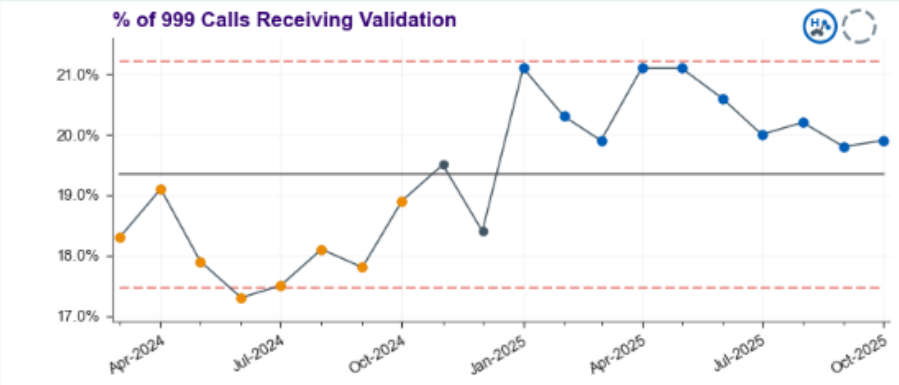
999-36

Dept: Operations 999

Metric Type: Board

Latest: 00:19:11

Common cause variation, no significant change.



999-34

Dept: Operations 999

Metric Type: Board

Latest: 19.9%

Special cause of an improving nature where the measure is significantly HIGHER.

Responses Per Incident (RPI)

What? RPI continues to be a key area of focus for the Trust, with RPI above the target, although continuing on an improving trajectory.

So what? This means the Trust is on average dispatching marginally more resource to each incident than planned, thereby adversely impacting ambulance availability elsewhere.

What next? A pilot began in Q1 to enable Critical Care Paramedics, supported by a Resource Dispatcher, to work on the critical care desk to prioritise C2 cases and where appropriate, ensure appropriate resource is dispatched according to the incident acuity and patient needs. This pilot has so far proved successful in H1 and will continue in H2, subject to evaluation. The Trust is also reviewing its dispatch policy, to ascertain whether it dispatches "excessive" resource for certain incidents.

JCT Allocation to Clear All Mean

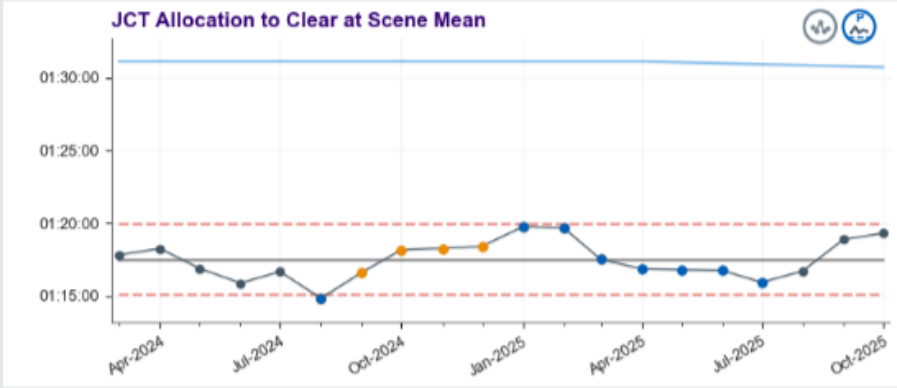
What? JCT Allocation to Clear remains above target with a slight improving trend from March 2025
So what? Local Community Dispatch Model (LCDM) has been piloted and demonstrates improvements to overall JCT due to lower travel time and mileage. A robust evaluation has been completed, and this is now part of our BAU plans.
What next? Continue with current operational actions.

% 999 Calls Receiving Validation

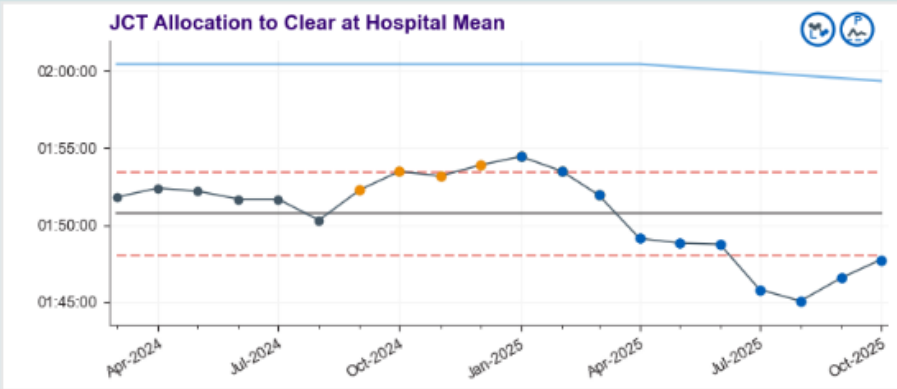
What? There is an improving trend and this is important, as it's aligned to the Trust strategy of clinically assessing cases pre ambulance dispatch, where safe and appropriate to do so.

So what? The Trust is increasing its virtual care capacity in the hubs, following NHS PaCCS training, with the new 50:50 UEC:VC rotas having gone live in July.

What next? The Trust's Delivering High Quality Patient Care program (formerly Virtual Care and Models of Care) will support this goal going forwards, as the clinical capacity, productivity, and capability of clinician intervention prior to ambulance dispatch increases.



999-11
Dept: Operations 999
Metric Type: Supporting
Latest: 01:19:18
Target: 01:30:42
Common cause variation, no significant change. This process is capable and will consistently PASS the target.



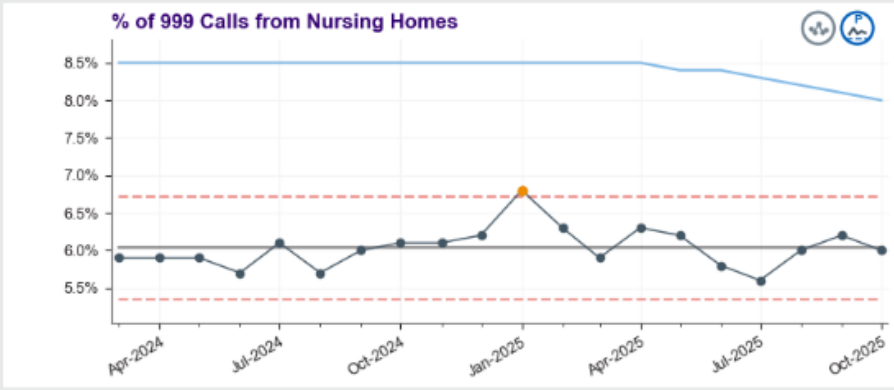
999-11
Dept: Operations 999
Metric Type: Supporting
Latest: 01:47:45
Target: 01:59:21
Special cause of an improving nature where the measure is significantly LOWER. This process is capable and will consistently PASS the target.

JCT Allocation to Clear at Scene and at Hospital.

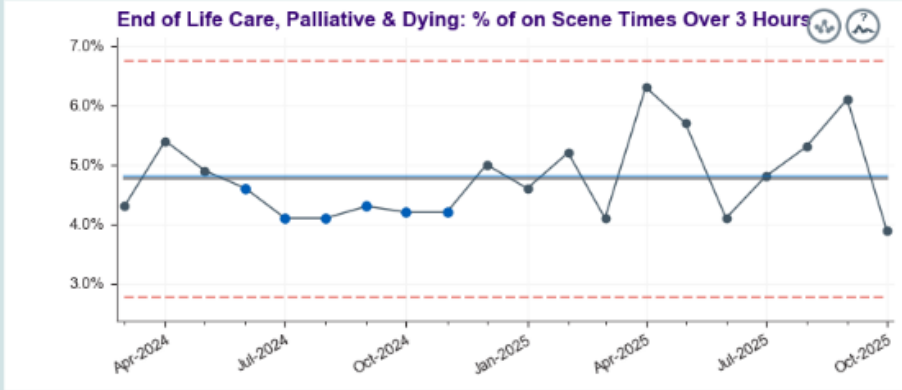
What?
Improved JCT clear at hospital has continued from April into August.

So what?
This improvement is driven by improvement in handovers at hospital and crew to clear automation.

What next?
Further improvements are intended to be realised as we focus on efficiency actions and working in partnerships with hospital colleagues. Handover to clear times are not likely to improve, as the auto-clear implementation has probably realised full potential for time saving already.



999-35
Dept: Operations 999
Metric Type: Board
Latest: 6%
Target: 8%
Common cause variation, no significant change. This process is capable and will consistently PASS the target.



QS-46
Dept: Quality & Safety
Metric Type: Board
Latest: 3.9%
Target: 4.8%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

What? - Percentage of 999 calls from nursing homes
This is new measure for this year as part of our productivity plans and follows a presentation that an Advanced Paramedic Practitioner gave to the Trust Board about a project they had led to educate care home staff on how to manage patients who deteriorated without the need to always call an ambulance.

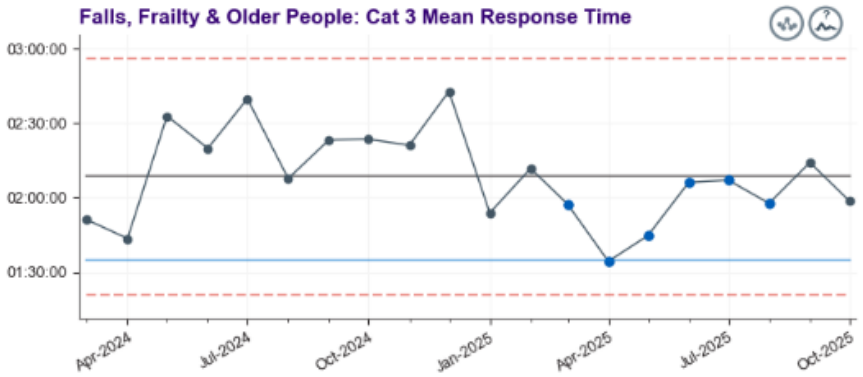
So what?
This APP has been commissioned to lead a project, Trust-wide, to work with the care homes who call 999 most frequently to support and educate them on what to call for help and when to manage the situation within the care facility.

What next?
We aim to reduce unnecessary calls from care homes by 10% over this year. No substantive change can be observed to date.

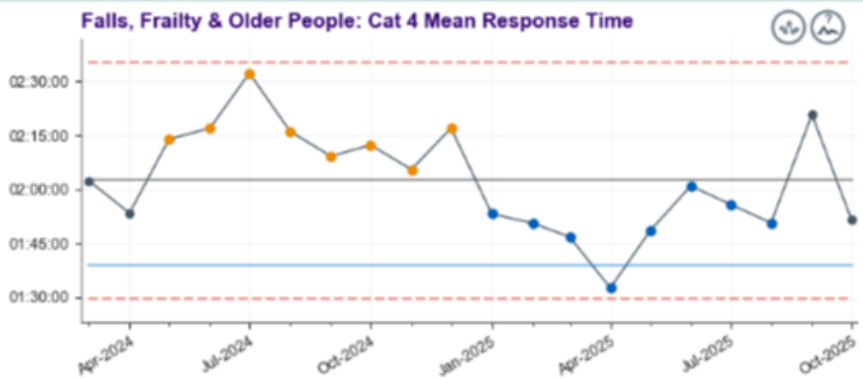
What?
Calls to patients with palliative care needs, or who are at end of life or actively dying, are associated with extended on scene times. There are multiple factors to consider, such as patients discharged without advance care plans or medicines, patient/carer anxiety, and limited fallback options. For crews on scene, there is variation is confidence to act, as well as audit evidence showing large numbers of phone calls being made by crews to advocate for patients.

So what?
Many of the incidents with the longest on scene times could be considered non-commissioned activity. Be addressing NCA, we can lower the aggregate on scene times.

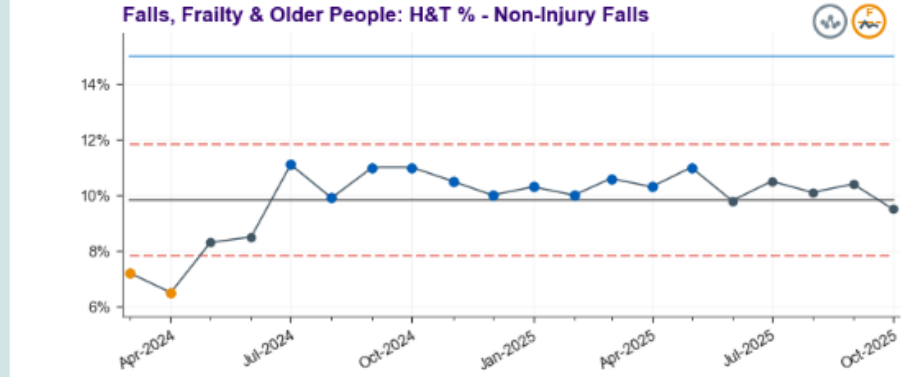
What next?
We will be working to define what is commissioned, non-commissioned, and potentially shared activity. Using recent published literature, linked to our MOC and audits, create focused support for staff to be more decisive at these incidents.



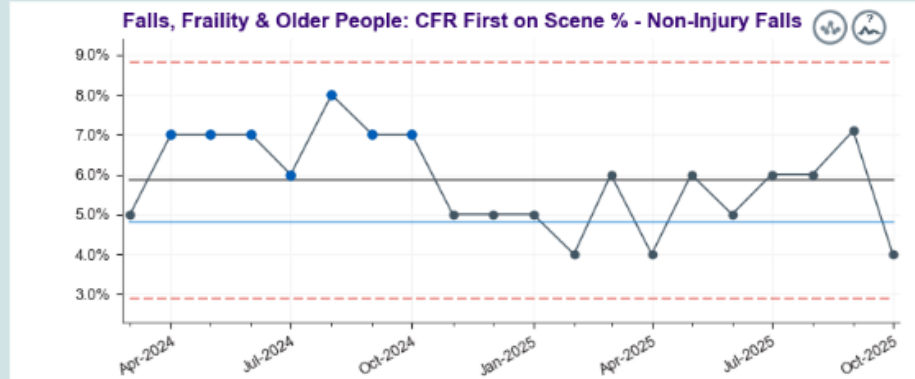
QS-42
Dept: Quality & Safety
Metric Type: Board
Latest: 01:58:38
Target: 01:35:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.



QS-43
Dept: Quality & Safety
Metric Type: Board
Latest: 01:51:34
Target: 01:39:00
Common cause variation, no significant change. This process will not consistently hit or miss the target.



QS-44
Dept: Quality & Safety
Metric Type: Board
Latest: 9.5%
Target: 15%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



QS-45
Dept: Quality & Safety
Metric Type: Board
Latest: 4%
Target: 4.8%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

What?
There has been improvement in C3 & C4 mean response time with the majority of points falling below the long-term average in a significant improving trend. (comparing 2024 data to this years data)

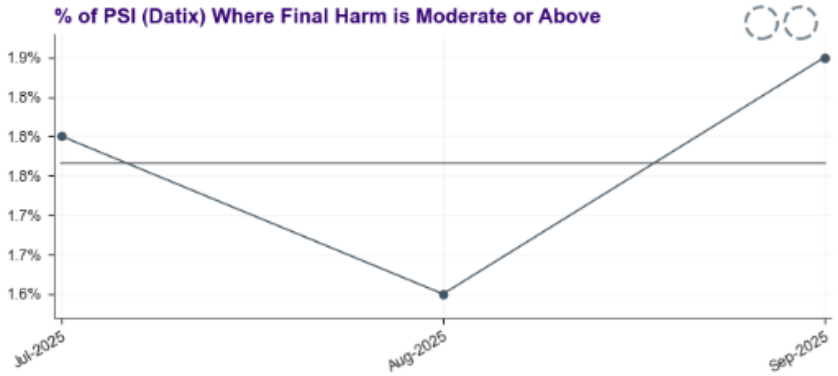
So what?
This means that our patients, who are stuck on the floor, will receive a quicker response and therefore reduce their risk of injury though a long-lie.

What next?
Continue to work with care homes, CFRs and virtual clinicians to ensure appropriate management of patients within this cohort.

What?
CFRs are being trained to attend non-injury falls, assist the patient off of the floor and check for any injuries. These calls will then be virtually consulted and completed via H&T, Onward referral or upgraded to an ambulance dispatch, where appropriate.

So what?
Pateints who have fallen, without any injury, need early assistance off of the floor to prevent injury from long-lie. By sending CFRs we will ensure our ambulances are available for patients with emergency care needs.

What next?
Continue to roll out the CFR training. Ensure that the process to dispatch CFRs is embedded within the EOC.



QS-37
Dept: Quality & Safety
Metric Type: Board
Latest: 1.9%

Special cause or common cause cannot be given as there are an insufficient number of points.

QS-7
Dept: Quality & Safety
Metric Type: Board
Latest: 82.9%
Target: 90%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

What? The percentage of patient safety incidents resulting in moderate, severe or fatal harm following investigation remain relatively small – 1.9% of all incidents in September 2025. All of these are scrutinised at the Divisional Incident Review Groups

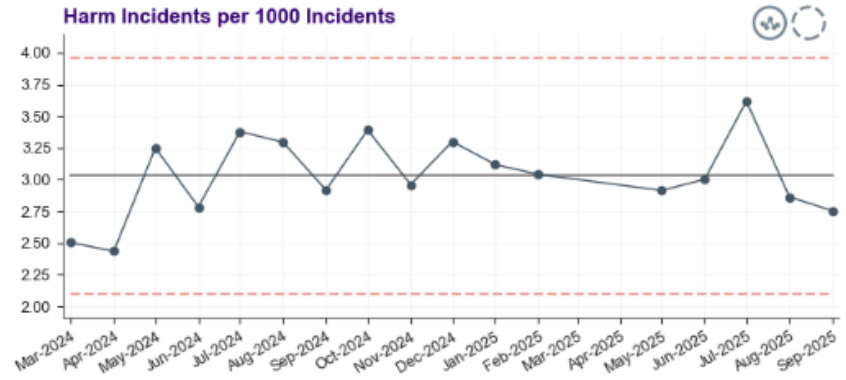
So What? Insufficient data points to establish SPC. Number of incidents closed each month ranges from 577 to 1900/month, averaging at 1200 incident closed per month.

What next? Establish baseline data and continue to monitor themes resulting in harm and articulate improvement plans through the introduction of improvement responses (improvements on a page).

What? Hand hygiene compliance is showing normal variation with no significant change but remains below the target of 90%.

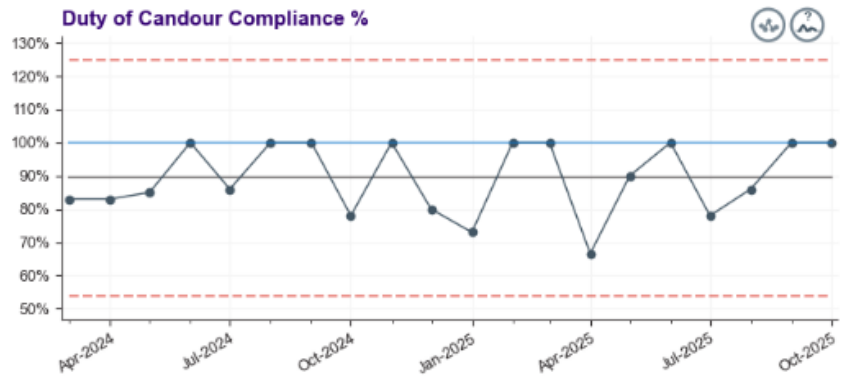
So What? The IPC Team share compliance levels with the Divisional Management Group along with the levels of infection related sickness absence. The team can see a direct link to non-compliance and higher levels of absence in some areas of the Trust. Local teams are now more focused on achieving the improvement required for both patient safety and staff absence.

What next? The IPC Team will be carrying out a Quality Improvement project during Q4 of the year, focusing on hand hygiene but also including all areas of IPC practice. This will include staff and leadership collaboration throughout the project and be monitored at the IPC Sub Group.

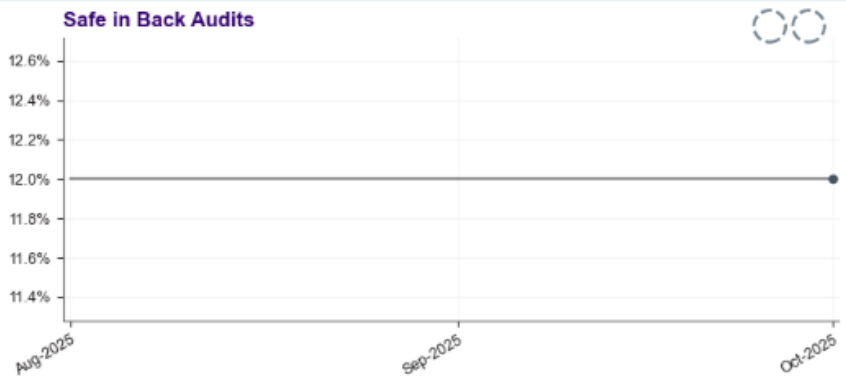


QS-29
Dept: Quality & Safety
Metric Type: Supporting
Latest: 2.8

Common cause variation, no significant change.



QS-3
Dept: Quality & Safety
Metric Type: Supporting
Latest: 100%
Target: 100%
Common cause variation, no significant change. This process will not consistently hit or miss the target.



QS-41
Dept: Quality & Safety
Metric Type: Supporting
Latest: 12%

Special cause or common cause cannot be given as there are an insufficient number of points.

MM-1
Dept: Medicines Management
Metric Type: Supporting
Latest: 212

Common cause variation, no significant change.

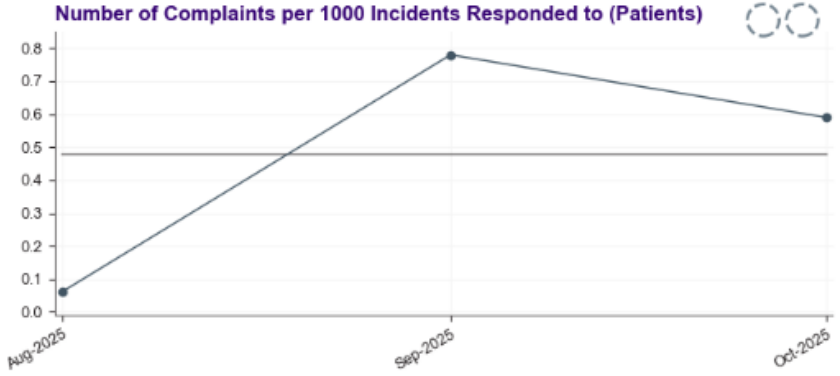
Harm per 1000 incidents
What? Common cause variation with no significant change. Whilst harm is a good indicator of how safe our services is; there is a focus under PSIRF to evidence ongoing safety improvements showcasing our drive to become safer. This is shown through our integrated patient safety report paper.
So What? The reduction in harm in 2024 coincides with the introduction of PSIRF and DCIQ. As such the data for this time may not be reliable and that 3.3 to 3.7 may be more realistic going forward based on most recent data.
What next? The Patient Safety framework is moving away from monitoring safety through harm although a focus on incidents triggering duty of candour might help us identify how safe our service is.

Duty of candour compliance
What? Our target is to undertake 100% of duty of candour within ten working days (a regulatory requirement).
So what? We do experience common cause variation each month. In general, this may be because we are unable to source contact details during this time-period or experience complex safeguarding challenges. I
What next? Weekly reporting at system-led Incident Review Groups to maintain this level of compliance and a focus on written improvement responses with training being rolled out to improve the quality of these duty of candour conversations.

Number of Medicines Incidents (MM-1)
What? Medicines incident reporting has increased slightly. This could be due to changes in Key Skills where there has been a focus on sharing medicines errors; emphasising the role of reporting medicines errors in terms of systems learning and improved patient safety.
So what? Individuals are encouraged to report medicines-related incidents to demonstrate transparency, integrity; supporting the identification of trends and subsequent learning, quality improvement and increased patient safety. It is important to note that although reporting of errors has increased, the levels of harm have not. This demonstrates a healthy reporting culture within the organisation.
What next? Reporting of medicines-related incidents continues to be encouraged and supports evidence of harm-free care. Themes are discussed at Medicines Governance Group for further action.

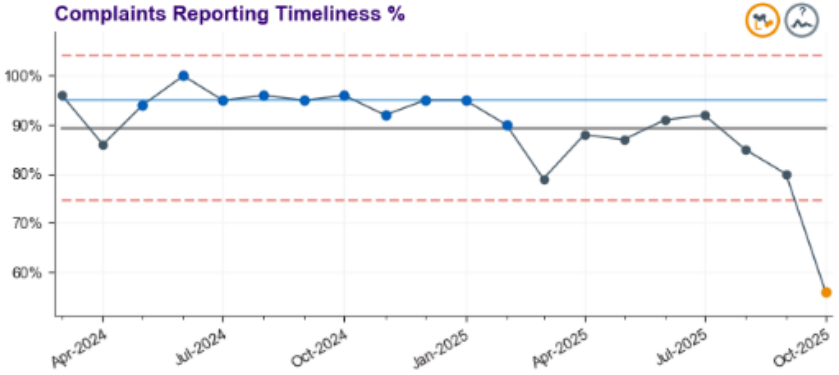
QS-5
Dept: Quality & Safety
Metric Type: Supporting
Latest: 55

Common cause variation, no significant change.



QS-38
Dept: Quality & Safety
Metric Type: Board
Latest: 0.6

Special cause or common cause cannot be given as there are an insufficient number of points.



QS-4
Dept: Quality & Safety
Metric Type: Supporting
Latest: 56%
Target: 95%
Special cause of a concerning nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.

What?
- The number of complaints received was within normal variation and continues to reduce since a peak in July 2025.
- Timeliness in responding to complaints is showing special cause variation of a deteriorating nature. Compliance for October was only 56%, the lowest since January 2023 (49%).

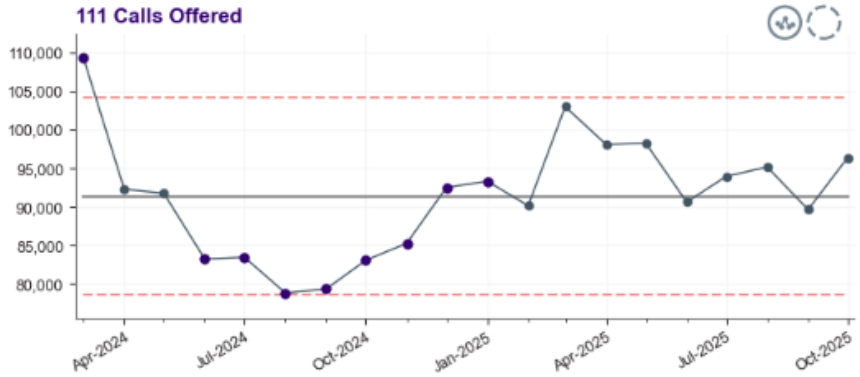
So what?
- This means that the Trust is not meeting our target of responding to 95% of complaints within the required timeframes (35 working days for level 2 complaints and 45 working days for level 3 complaints).
- There were several staff on pre-booked annual leave reducing staffing levels by a third throughout October
- Additionally, the Integrated Care team were a member of staff short delaying investigations into 111 and 999 complaints

What next?
- The Divisional Quality Leads met with the PALS Officers on 10 November to complete a Complaints Mapping Process and agree a date for them to commence working in their Divisional Structure.
- There were also several other processes agreed to reduce the level of administrative work completed by the PALS Officers releasing them to concentrate on their primary function of processing complaints and concerns received.

What?
- A new telephone system is to be introduced from 1 December 2025 meaning that callers will be able to talk to a member of staff rather than being put through to the answer phone service to await a call back.

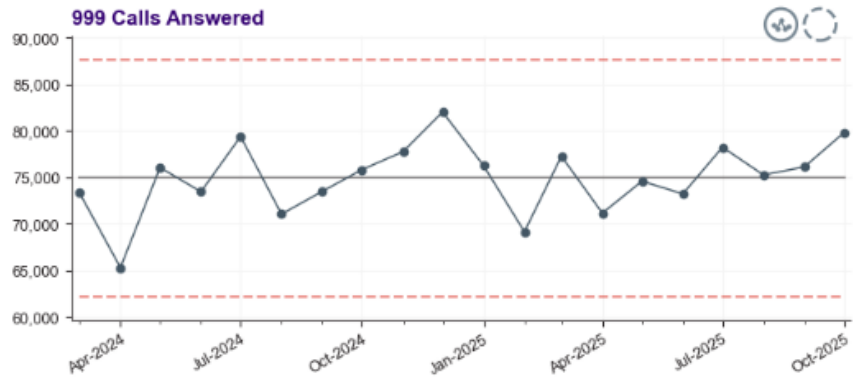
So what?
- The new system will allow calls to be directed to the appropriate staff member i.e., the Kent, Surrey or Sussex PALS Officer, the compliment processor and the Subject Access staff member.

What next?
- This will reduce the large number of call backs currently being completed.



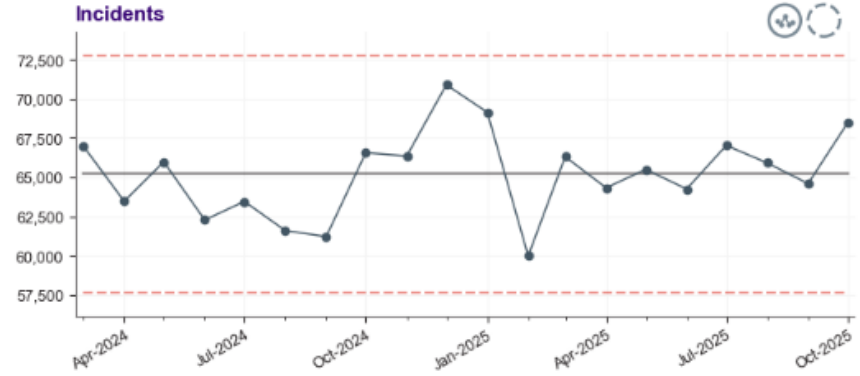
111-1
Dept: Operations 111
Metric Type: Supporting
Latest: 96385

Common cause variation, no significant change.



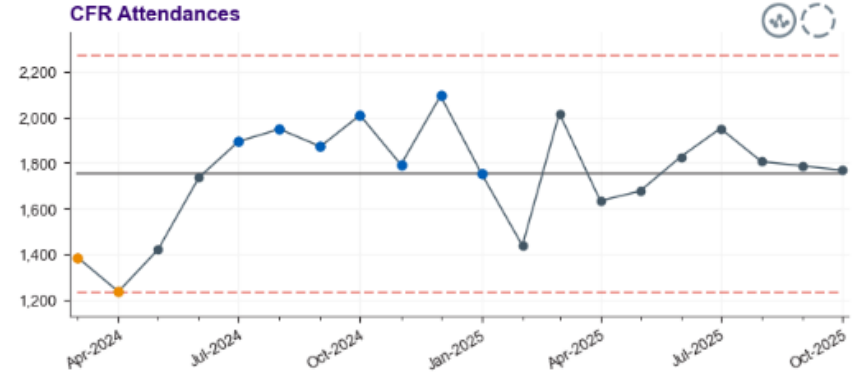
999-10
Dept: Operations 999
Metric Type: Supporting
Latest: 79806

Common cause variation, no significant change.



999-10
Dept: Operations 999
Metric Type: Supporting
Latest: 68471

Common cause variation, no significant change.



999-10
Dept: Operations 999
Metric Type: Supporting
Latest: 1768

Common cause variation, no significant change.

111 Calls
What? Although the underlying number of calls offered in 111 since January is trending downwards, there was another small rise in October. However, the actual number of calls answered and the average speed to answer are on an improving trajectory. The service continues to record an abandoned call rate below the contractual target of 5%.
So what? The 111 service does have a positive impact on our 999 service and other system service providers, including EDs and primary care.
What next? The 111 service has now entered a period stabilisation, following the change in operating model in Q1. It will continue reviewing opportunities to implement digital innovation and improve service efficiency and the patient care.

Incidents
What? The volume of incidents that the Trust has responded to has remained broadly level across the past 15 months, although there was a steep uptick in October.
So what? This has helped the Trust with regards to its planning, and scheduling appropriate resource to respond to patient demand, be that in contact centres or in field operations.
What next? The Trust is reviewing its current scheduling function as part of the organisational change process, with a view to optimising planning and forecasting going forward, to optimise performance.

999 Calls
What? The number of 999 calls answered remains broadly consistent however, the actual call handling performance and % of calls abandoned has significantly improved, with the Trust having achieved its 999-call answering mean and 90th centile targets every month so far this calendar year.
So what? Patients wait less time to have their 999 calls answered, meaning a timelier response and reducing the time before a call is passed on for clinical assessment or ambulance dispatch.
What next? The service is helping SCAS and YAS with their 999 call handling, and is facilitating this trough the IRP model.

CFR Attendances
What? Slight improving trend since April.
So What? Not a significant change
What Next? New appointment to lead role for volunteers from July and their focus will be to set out an improvement plan and implement. The Board has approved the AACE report on volunteering and plan to develop a strategy that will be presented to the Trust Board in December 2025. Review of the role of Emergency Responders complete and being reviewed as per Trust Governance processes.

Appendix 1: Glossary

Integrated Quality Report

AQI A7	All incidents – the count of all incidents in the period
AQI A53	Incidents with transport to ED
AQI A54	Incidents without transport to ED
AAP	Associate Ambulance Practitioner
A&E	Accident & Emergency Department
AQI	Ambulance Quality Indicator
ARP	Ambulance Response Programme
AVG	Average
BAU	Business as Usual
CAD	Computer Aided Despatch
Cat	Category (999 call acuity 1-4)
CAS	Clinical Assessment Service
CCN	CAS Clinical Navigator
CD	Controlled Drug
CFR	Community First Responder
CPR	Cardiopulmonary resuscitation
CQC	Care Quality Commission
CQUIN	Commissioning for Quality & Innovation
Datix	Our incident and risk reporting software
DCA	Double Crew Ambulance
DBS	Disclosure and Barring Service
DNACPR	Do Not Attempt CPR
ECAL	Emergency Clinical Advice Line
ECSW	Emergency Care Support Worker
ED	Emergency Department
EMA	Emergency Medical Advisor
EMB	Executive Management Board
EOC	Emergency Operations Centre
ePCR	Electronic Patient Care Record
ER	Employee Relations
F2F	Face to Face
FFR	Fire First Responder
FMT	Financial Model Template
FTSU	Freedom to Speak Up
HA	Health Advisor
HCP	Healthcare Professional
HR	Human Resources
HRBP	Human Resources Business Partner
ICS	Integrated Care System
IG	Information Governance
Incidents	See AQI A7
IUC	Integrated Urgent Care
JCT	Job Cycle Time
JRC	Just and Restorative Culture
KMS	Kent, Medway & Sussex
LCL	Lower Control Limited
MSK	Musculoskeletal conditions
NEAS	Northeast Ambulance Service
NHSE/I	NHS England / Improvement
OD	Organisational Development
Omnicell	Secure storage facility for medicines
OTL	Operational Team Leader
OU	Operating Unit
OUM	Operating Unit Manager
PAD	Public Access Defibrillator
PAP	Private Ambulance Provider
PE	Patient Experience
POP	Performance Optimisation Plan
PPG	Practice Plus Group
PSC	Patient Safety Caller
SRV	Single Response Vehicle

South East Coast Ambulance Service NHS Foundation Trust

Agenda No	93/25

Name of meeting	Trust Board
Date	4 December 2025
Name of paper	Quality & Patient Safety Committee Assurance Report – 13 November 2025
Author	Liz Sharp Independent Non-Executive Director – Committee Chair

INTRODUCTION

The Quality & Patient Safety Committee is guided by a cycle of business that algins with the Board Assurance Framework – strategic priorities; operating plan commitments; compliance; and risk.

This assurance report provides an overview of the most recent meeting on 13 November 2025, and is set out in the following way:

- **Alert**: issues that requires the Board's specific attention and/or intervention
- **Assure**: where the committee is assured
- **Advise**: items for the Board's information

ALERT

Strategic Priority: Virtual Care (Strategic Priority)
This key strategic priority continues to be RAG rated Red due to the targeted interventions not impacting the desired outcomes to increase in H&T. The key risks relate to training delays and workforce capacity. The committee acknowledges that we are not where we had hoped to be, but given the complexity is at least understandable. One of key actions relates to the training package, which the executive has a plan for; up to now this has largely focussed on using a clinical decision support systems rather than how to undertake virtual consultation. This is the gap that needs to be closed working with our university partners.

EOC Risk
There was a specific focus on this risk which led to the quality summit earlier in the year, linked to the issue with non-compliant call audits, inconsistent staff performance, insufficient training, and ineffective management of underperformance. Several improvement actions have been completed and the impact of these will be tracked by the committee, including via patient experience data.

ASSURE

Internal Audit – Station Visits (Medicines)
This audit concludes Substantial Assurance that our medicines management systems are well designed and effectively operated. Controls for storage, access, transport and monitoring of medicines are robust, though minor procedural and training consistency improvements are needed. The committee really welcomed this level of assurance and gave special mention to Shani Corb, Chief Pharmacist.

Annual Reports
CDAO Annual Report
The CDAO Annual Report 2024/25 provides assurance that SECAmb maintains robust governance and compliance in the safe management of controlled drugs. Across the 999 service, over 778,000 individual units of controlled drugs were issued with incidents remaining very low (0.12%, mainly minor such as breakages), supported by improved reporting and monitoring through Omnicell and Medicines Governance processes. The 111 service introduced strengthened prescribing procedures, including stricter quantity limits and processes to identify and manage drug-seeking behaviour, with prescribing data now routinely analysed and shared with commissioners. Key achievements include the refurbishment of the Medicines Distribution Centre, enhanced staff training and education, and improved external oversight through police liaison and CD Local Intelligence Networks. This report is an additional source of assurance demonstrating robust medicines management.

Health Informatic Clinical Audit & Health Records Annual Report
Good level of assurance too from this report, where there have been significant changes this year. The team was restructured to enable an outward facing audit function, building relationships with operational managers and other stakeholders through face-to-face visits. The team has also made significant strides by embracing technology to automate processes. These combined efforts have led to improved and efficient management of clinical performance data, the translation of this data into quality improvement initiatives taken directly to those that can enact the improvements.

Integrated Pt Safety Report
This is the quarterly report triangulating learning from incidents, complaints, claims, inquests, and patient experience feedback to identify key patient safety themes and improvement actions. This helps to demonstrate how the Trust continues to strengthen its learning culture under PSIRF, with steady improvement in Duty of Candour compliance (88%) and increased use of After-Action Reviews and multidisciplinary learning responses. Key developments include the introduction of the *Being Fair* tool to support staff post-incident, enhanced telemetry reliability through 4G LIFEPAK upgrades, and implementation of new mental health and suicidality training. The Patient Safety and Health Inequalities Framework has been published, aligning safety improvements with equity priorities.

In terms of issues identified, there are some recurring themes related to equipment reliability and EOC processes (linked to the identified Risk). Challenges persist in system partnership working and mental health patient care, particularly around capacity assessment and discharge-on-scene decisions. Patient involvement in learning responses is improving but remains inconsistent.

In response the executive has a focus on the following:

- Strengthen Duty of Candour quality through enhanced training.
- Implement real-time learning responses and structured partner MDT reviews.
- Improve equipment traceability and logistics processes.
- Finalise suicidality and mental capacity policy updates.
- Recruit Patient Safety Partners and a Safety Improvement Specialist to embed learning

ADVISE

Learning Framework
The committee reviewed a draft plan to develop and implement a trust level organisational learning framework. The framework is proposed to be based on the 4I Framework, a simple, evidence-based model which can be used to underpin the framework we develop at SECAmb. An organisational learning group has been established, which will ensure the systematic capture, triangulated analysis, and actioning of learning from all sources to continuously improve patient care, staff wellbeing, and operational effectiveness across the trust. Next steps include a current state assessment, development of governance framework, process design and communications architecture design. This design and development work will prepare for the implementation of a pilot test in Q4, ahead of wider scaling in 2025/26.

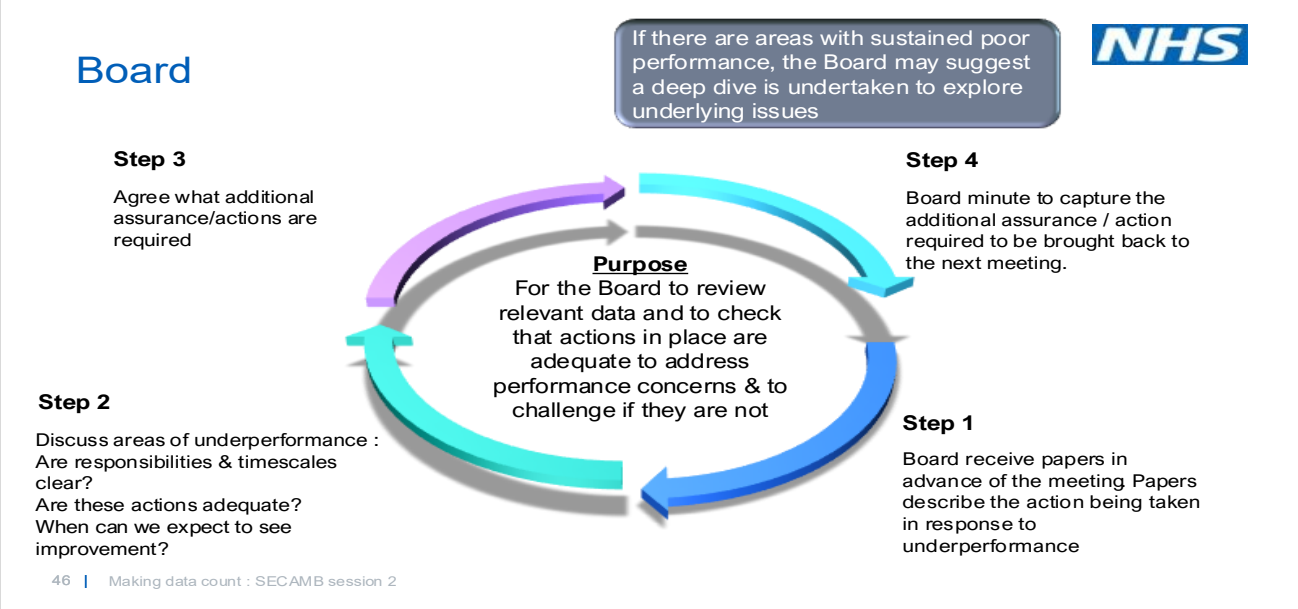
Quality Assurance Engagement Visits
The committee noted the new framework that has been consulted on across the organisation. This will include NEDs and external partners and the committee will monitor the outputs throughout the year.

Volunteer Strategy
The approach was reviewed to developing the strategy, particularly around ensuring a focus on clinical outcomes, alignment with the Trust strategy, and the national volunteering approaches. There has been a consultative process throughout the year to engage stakeholders, including volunteers, front line staff and leaders. The committee provided feedback to inform the preferred approach and associated investment. The final strategy is expected to come to Board in February.

IQR
A review of the proposed revised metrics was undertaken with good progress and much thought leading to the IQR becoming a stronger document. The committee reinforced the importance of ensuring robust narrative, pulling out the assurance it offers / risks etc.

Recommendation

The Board is asked to use the information within this report to inform its overall view of assurance and where gaps are identified to seek further assurance from the executive in line with the Assurance Cycle



NHS
South East Coast Ambulance Service
NHS Foundation Trust

Board Assurance Framework

2025/2026

December

NHS
South East Coast Ambulance Service
NHS Foundation Trust

We Are a Sustainable Partner

We are a sustainable partner as part of an integrated NHS

Tier 1
Tier 2
QI
Directorate objective

2024-2029 Strategy Outcomes

- Breakeven / 8% reduction in cost base: £26m annually. Avoid 100m additional expenditure / growth
- Increase utilisation of alternatives to ED - 12 to 31%
- Reduce conveyance to ED - 54 to 39%
- Saving 150-200k bed days per year
- Reduce direct scope 1 CO2e emissions by 50%

2025/26 – Strategic Transformation Plan

- Advance **South-East Ambulance Transformation Programme** through 1
  - Progress functional priority areas (SCAS / SASC)
  - Develop Business Case (SCAS)
  - Deliver ICB-approved **multi-year plan** and refreshed **strategic commissioning framework** to support strategy delivery and sustainability, including break-even trajectory.
- Progress delivery of our **digital enablement** plans, presenting a detailed plan to the Board at the end of Q1 1

2025/26 Outcomes

- Deliver a financial plan
- Handover delay mean of 18 minutes
- Increase UCR acceptance rate to 60-80%
- Reduce Vehicle off Road Rate – 11-12%
- Achieve over 90% Compliance for Make Ready

2025/26 – Operating Plan

- Deliver **Financial Plan**
  - Meet CIP Plan of £23m (Efficiencies - £10m; Clinical productivity – eq. £10.5m)
- Deliver **strategic estates review** (inc. Trust HQ refurbishment - 111/999 Contact Centre & Corporate Floor) 2
- Implement H&S improvement plan to progress Trust to Level 4 of maturity by Q2 with clear milestones in place
- Complete **support services review**, including Make Ready model and vehicle provision 2
- Monitor **system-led productivity** schemes, improving alternatives to ED and reducing hospital handovers.
- Develop a Trust-wide Health & Safety improvement plan in Q1 for implementation by Q2

Compliance

- Heath & Safety
- Vehicle & Driver Safety / Driving Standards
- Data Security / Cyber Assurance Framework

BAF Risks

- **Collaboration:** There is a risk that the Trust does not drive collaboration, which will result in reduced strategic delivery and missed opportunities to integrate services and care pathways, reduce waste, and drive productivity to improve care.
- **Financial Plan:** There is a risk that the Trust fails to deliver a break-even finance plan, our Board, our people, our regulators and commissioners lose confidence in our organisation.
- **Cyber Resilience:** There is a risk that the organisation will not have sufficient resilience to withstand a cyber-attack, resulting in significant service disruption and/or patient harm.
- **Digital Capacity, Capability & Investment:** There is a risk that the organisation cannot facilitate necessary digital development and integration, due to insufficient capacity, capability and investment, resulting in impeded strategic delivery.
- **System Productivity**: There is a risk that without cross-system improvements in productivity, as a result of insufficient planning or resource allocation, in-year financial and operational outcomes will not be achieved.

We are a sustainable partner as part of an integrated NHS

2025/26 – Strategic Transformation Plan

Programme	Status	Baseline Target	Forecast Target	Programme Manager	EMB / SMG	PMO	Executive Lead	Oversight Committee
Collaboration & Partnerships	Progress functional priority areas (SCAS / SASC)	All year	All year	Claire Webster	EMB	Yes	Chief Strategy Officer	Finance & Investment
	Develop Business Case (SCAS)	Q3	Q3					
Multi-Year Plan	Deliver multi-year plan to support a break-even trajectory.	Dec-25	Dec-25	Jo Turl	EMB	No	Chief Finance Officer	Finance & Investment
Strategic Commissioning Framework	Work with ICB commissioning leads to deliver a refreshed strategic commissioning framework to support strategy delivery and sustainability, including break-even trajectory.	Mar-25	Mar-25	Claire Webster	EMB	No	Chief Strategy Officer	Finance & Investment
Digital Enablement	Implement priority **digital initiatives**, supporting overarching Trust Strategy	Q4	Q4	Reeta Hosein	EMB	Yes	Chief Digital Information Officer	Finance & Investment

2025/26 – Operating Plan

Initiative	Sub-Initiative (if required)	Current RAG	Previous RAG	Executive Lead	EMB / SMG	PMO	Oversight Committee	Date Last Reviewed @ Committee
Deliver Financial Plan	Meet CIP Plan of £20.5m			Chief Finance Officer	SMG	No	FIC	24/7/2025
	Deliver £10m efficiencies & eq. £10.5m productivity				SMG	No	FIC	24/7/2025
Implement H&S improvement plan to progress Trust to Level 4 of maturity by Q2				Chief Nursing Officer	EMB	No		
Monitor System Led Productivity Schemes - improving alternatives to ED and reducing hospital handovers				Chief Operating Officer	SMG	No	FIC	24/7/2025
Deliver Strategic Estates Review	Creation of Joint 111/999 Centre			Chief Finance Officer	SMG	Yes	FIC	N/A
	Redevelopment of Corporate HQ							
	Full Trust Estate Review					No	FIC	
Complete Support Services Review	Make Ready Service Model			Chief Strategy Officer	SMG	Yes	FIC	n/a
	Vehicle Provision				SMG	No	FIC	24/7/2025

BAF Risks

Risk Detail	Risk Score	Target Score	Owner
Collaboration: There is a risk that the trust does not drive collaboration, which will result in reduced strategic delivery and missed opportunities to integrate services and care pathways , reduce waste, and drive productivity to improve care.	12 →	08	CSO
Financial Plan: There is a risk that the Trust fails to deliver a break-even finance plan, our Board, our people, our regulators and commissioners lose confidence in our organisation.	08 ↓	06	CFO
System Productivity: There is a risk that without cross-system improvements in productivity, as a result of insufficient planning or resource allocation, in-year financial and operational outcomes will not be achieved	12 →	06	CSO
Cyber Resilience: There is a risk that the organisation will not have sufficient resilience to withstand a cyber-attack, resulting in significant service disruption and/or patient harm.	16 →	12	CDIO
Digital Capacity, Capability & Investment: There is a risk that the organisation cannot facilitate necessary digital development and integration, due to insufficient capacity, capability and investment, resulting in impeded strategic delivery.	12 →	08 175	CDIO

We are a sustainable partner as part of an integrated NHS

2025/26 – Compliance & Assurance

Compliance Initiative	Current RAG	Previous RAG	Executive Lead	Oversight Committee	Date of Last / Scheduled Review at Committee	Committee Feedback
Meet H&SE compliance requirements			Chief Nursing Officer	People Finance	July 2025 Nov 2025	Overall, the committee has a reasonable level of assurance with our H&S compliance. The internal H&S review demonstrated that H&S is largely viewed positively with good awareness of reporting mechanisms. However, areas of further improvement were identified, including training and managers being clearer on their responsibilities. The safety culture maturity assessment concluded level 3 of 5. The improvement plan aims to achieve level 5, over time, and the committee will review progress with the next review in Q4. The finance committee expressed some concern about fire safety (see board report) and is keeping close to this risk and the actions in place which aim to address all the key issues within the next three months. The committee felt this was a reasonable timeframe.
Vehicle & Driver Safety / Driving Standards		NA	Chief Strategy Officer	Finance	Nov 2025	As per the committee report to Board, it is assured with the focus and progress being made to improve safety.
Data Security / Cyber Assurance Framework			CDIO	Audit & Risk	July 2025	The annual Data Protection & Security Toolkit, based on the new Cyber Assurance Framework, submitted in June 2025 was largely compliant. However, there are some gaps in assurance related to the Cyber BAF Risk, with the related actions included in the Digital Strategy Implementation Plan approved by the Board in August.

Digital Portfolio Context

Strategic overview for Portfolio

Exec. Sponsor:	Nick Roberts
PM:	Reeta Hosein
Last updated:	19th Sept 2025

Year 1 Focus

The portfolio's overarching objective is to enable high-quality, patient-centred care through the delivery of safe, efficient, and future-ready digital services that empower both clinical teams and operational staff.

Overall, Vision:

- Every patient and team member safeguarded by secure, resilient digital foundations and infrastructure - By empowering people through protected data, reliable infrastructure, and trusted systems.
- Resilient networks and data powering care – By enabling seamless, uninterrupted care through robust digital infrastructure and secure information flow.
- Connected care through regional and national collaboration – By fostering integrated, digitally enabled partnerships to improve outcomes and reduce inequalities across communities and Trusts.

Our **six core digital focus areas** are:

1. Cyber Security & Assurance: Will strengthen our cyber posture by embedding 24/7 proactive monitoring and alerting, increasing cyber awareness through dedicated leadership and strengthening the security and management of our mobile devices.

2. Digital Workforce: Will create a digital workforce that can safely and securely create a robust digital architecture to support the ambitions of the Trust strategy and capitalise on the technology of tomorrow.

3. Data and Artificial Intelligence: Will create new data products to enable in year productivity improvements, whilst beginning the migration to a new data platform that can provide the necessary scalability and compute for broader self-service analytics and implementing M365 Co-Pilot.

4. Digital Infrastructure: Will modernise our network and Wi-Fi capabilities, increase the resilience of our data centre infrastructure, embed good change management practices to prevent future outages and improve the recovery time of our most critical systems.

5. Collaborative Initiatives: For our People and Partners: Will foster relationships through the SASC collaborative through new initiatives to trial AI systems within our EOC, and jointly co-lead on the creation of a cyber security operations centre.

6. Product Delivery: Will enable the migration of our core rostering platform to a more resilient and effective cloud solution, whilst delivering improvements to our operational capabilities through the MDVS solution.

Strategic Alignment & Anticipated Impact

The digital transformation programme underpins the Trust's strategy objectives by delivering secure, efficient, and future ready digital services that enhance patient care and staff experience. It equips teams with the right tools and training, modernises infrastructure, and fosters seamless regional collaboration and positioning SECAmb as a digitally enabled, sustainable leader within the integrated NHS system.

Our digital initiatives directly enable all seven Trusts strategic commitments, with Cyber Security underpinning all of these:

1. Early and effective Triage: Data & Artificial Intelligence

2. Providing standardised emergency care for our Patience: Digital Workforce

3. Virtual non-emergency services: Product Delivery

4. Creating an inclusive and compassionate environment: Collaborative Initiatives

5. Invest in our people's careers: Digital Workforce

6. Sustainable and productive organisation: Digital Infrastructure

7. Collaborate with our partners to establish are role as a UEC system leader: Collaborative Initiatives

Digital Transformation Portfolio - Executive Summary

Exec. Sponsor:	Nick Roberts
PM:	Reeta Hosein
Last updated:	31st October 2025

Portfolio Outcomes	Previous RAG	Current RAG	Impact on outcomes
• Empowering people through protected data, reliable infrastructure, and trusted systems • Enabling seamless, uninterrupted care through robust digital infrastructure and secure information flow • Fostering integrated, digitally enabled partnerships to improve outcomes and reduce inequalities across communities and Trusts			• Improved Confidence & engagement from staff, Reduced risk and data breech and Enhanced operational efficiencies. • Continuity of care, faster clinical decision making, more focus on care, improved patient safety. • Stronger collaboration, scalable innovations, better resource allocation.

Headline Key Performance Indicators (KPI)

KPI	IQR or local	Latest (period)	Target	Trend	So what?
Availability of Critical Applications (CAD/EPCR/Telephony)	Local	100%	99.9%	Sustaining	100% uptime has been maintained with no unplanned downtime/disruptions.
High Severity Cyber Alerts Actioned in 14 Days	Local	100%	95%	Improving	100% compliance YTD. Continue compliance with responding to high severity alerts.
% Of Incidents where the Shared Care Record was Accessed	Local	3.3%	TBD	Improving	Pilot currently limited to Paddock Wood. Once the benefits/impact has been analysed, access to GP Connect will be rolled out to all Operating Units which will increase the access rates.

Top 3 Risks (BAF/Corporate only)

Description	ID	Current	Target	Trend	Control effectiveness & next step
Cyber Security: There is a risk that a major cyber security incident exploits existing system vulnerabilities leading to data breaches, service disruption, and unauthorised access to sensitive information that causes reputational damage, regulatory non-compliance, and compromised patient data security	544	16	12	↔	Continue advancing the CSOC workstream and wider cyber security initiatives as strategic priorities within the Digital Transformation Programme. Regularly update the Board and EMB on progress, risks, and support needs. A comprehensive cyber maturity assessment and follow-up actions are essential to reduce risk, though some targets may only be met once all measures are complete.
Digital Capacity, Capability & Investment: There is a risk that the organisation cannot facilitate necessary digital development and integration, due to insufficient capacity, capability and investment, resulting in impeded strategic delivery	650	12	8	↔	Ongoing review and refinement of the Digital Programme ensures effective resource planning, targeted upskilling, and engagement of key personnel to deliver against scope. External expertise is engaged as needed, with business cases approved to support delivery.
Integration & Interoperability Challenges: There is a risk that new digital systems fail to integrate effectively with existing clinical applications (CAD, patient records, fleet management) leading to additional manual effort, data silos and workflow disruption that causes reduced operational efficiency, staff frustration, and inability to realise transformation benefits	707	12	6	↓	Trust Integration Engine procurement funded through Work Programme. Next steps are to establish market offerings, tender options and approval of the Data and AI business case. New Enterprise Architect is leading design principles with existing integration team. Cleric have confirmed they support the latest health integration standards enabling automation and improved recovery following any system failures.

Headline assurance:	The portfolio continues to progress within its financial boundaries. Operational delivery has progressed, with active projects advancing according to plan. Business cases are moving through the approval stages, and project managers are fully aligned with their respective initiatives, driving projects forward. Pilot programmes and discovery activities are underway, generating early insights to inform future phases. Close collaboration with Finance is ongoing to ensure the programme remains within budget.	**Status:**	**Under control** / Needs intervention
		Ask of this forum:	Decision / Endorse / **Note** by [*date*]

Digital Transformation Portfolio - Controls & Decisions

Exec. Sponsor:	Nick Roberts
PM:	Reeta Hosein
Last updated:	31st October 2025

Change Control - Decision Requests

Proposed change	Type (T/C/Q/S)	Approval sought	Driver	Impact on delivery/assurance
None	N/A	N/A	N/A	N/A

Dependencies (material only)	Owner	Due	Status	Risk if delayed	Mitigation
Regional Collaboration: Cyber security programme: CSOC implementation is dependent on business case approval through SASC and the shared SASC process timeline.	Chief Digital Information Officer	Mar-26	In Progress	Although funding and plans are in place, delays in the SASC process risk exposing the shared environment to cyber threats, regulatory breaches, and slower incident response.	Establish clear milestones with buffer time and phased implementation plans to minimize SASC delays. Deploy interim security measures while maintaining proactive SASC engagement and progress monitoring.
Technology Integration Successful integration with existing clinical systems without operational disruption	Head of Digital Delivery	Mar-26	In Progress	Legacy infrastructure constraints could derail transformation and benefits.	Conduct early technical assessments and interoperability mapping | Implement phased integration with rollback plans and sandbox testing | Engage clinical informatics teams to co-design workflows
TORTUS AI Proof of concept: London Ambulance Service LAS to provide current pilot plan and milestones and agreement that SECAmb participate in their pilot Objectives.	Chief Digital Information Officer	Nov 25	In Progress	There is no risk to SECAmb as we are aligned with LAS timelines and their availability.	Initial meeting set up on the 30th October with LAS and TORTUS to discuss current pilot state and opportunities for collaboration. Engage key operational teams to pilot and feedback within LAS timelines.
Integration Engine: The integration engine business case is dependent on the Data and AI stream, with funding and progress needing to be clearly communicated and split between separate business cases	Chief Digital Information Officer	Nov-25	In progress	Data and AI stream blockage, funding uncertainty from split business cases, cascading project delays, resource misallocation, and potential strategic timeline impact on overall transformation objectives	Expedite integration engine business case approval, clearly define funding and dependencies upfront, Maintain cross-project communication, and establish contingency timelines for dependent Data and AI initiatives.

Milestone Exceptions	Date	Exception	Impact on delivery/assurance	Recovery & new forecast
Cyber Maturity Assemssent	Q2	Postponed	Interim Head of Information Security & Business Continuity now in post to move this forward. No impact to the continued delivery of the Cyber Security and Assurance Programme.	Head of Information Security and Business Continuity met with M8 and has agreed the scope and received a proposal from them, which is under review. Target to complete end of December 25.

EMB outcome, inc. decision requests (post-meeting)**:**	[To be completed after EMB meeting]
Relevant Board Committee outcome (post-meeting):	[To be completed after Committee meeting]

BAF Risks

- BAF Risk 544 - Cyber Resilience
- BAF Risk 650 - Digital Capacity, Capability & Investment

Board Highlight Report – Collaboration & Partnerships

SRO/Delivery Lead

David Ruiz-Celada

Key
- Completed
- On Track
- At Risk
- Delayed

Progress Report Against Milestones:

Business Case Development: Progress continues across both clinical and financial model development.
The outline business case was presented and approved at the Joint Board on the 8th October. Within the formal Board in Common the Boards were asked to approve the OBC as per the recommendations in section 7.
Prior to the formal Board in Common, three facilitated workshop sessions were held –
Session 1 Ambition: Explored the scale of the ambition, asking the Boards to reflect on what it considers most compelling about this opportunity. There was good consensus about the benefits that could be realised. The key benefits emphasised the potential for innovation and best practice sharing, improved patient outcomes and experience through standardisation and coordinated commissioning, enhanced workforce development and retention opportunities, and greater operational efficiency through reduced duplication and shared services across the region.
Session 2 Risks: Focussed on the risks that will need managing, which were wide ranging. A broad spectrum of risks was surfaced, spanning governance, accountability, organisational culture, leadership focus, and delivery capacity. Through a dot-voting process, the most significant concerns were concentrated around the clarity of purpose, potential leadership distraction, and the complexity of governance arrangements.
Session 3 Next Steps: Reviewed the practical immediate next steps, through the lens of Patients, People, Finance, Partnerships:

- Patients: Co-develop a unified clinical vision focused on patient outcomes, drive innovation through digital care models, and improve service design by incorporating public feedback and lessons learned from past experiences.
- People: Clearly defining and communicating the Group concept, engaging staff through transparent communication, articulating the clinical case for change, and ensuring strong leadership and transition planning.
- Finance: aligning financial planning and investment strategies across both organisations, including rationalising accounts, validating the financial model, and securing innovation funding.
- Partnership: Strengthen commissioning and stakeholder relationships, clarifying investment and benefit phasing, and establishing robust transition governance.

Previous RAG	Current RAG	RAG Summary
		Following approval of the business case, the transition group has been setup to oversee the appointments process for Group CEO and Chair. The search will start at the end of November. Executives are working on joint plans for 26/27 planning.

Risks & Issues:	Initial	Current	Target	Mitigation
Risk: Capacity constraints - There is a risk that limited availability and competing priorities of Executive leaders, Subject Matter Experts (SMEs), and programme delivery resources across partner organisations may impact the timely development, alignment, and delivery of collaboration priorities. This could delay the progression of key workstreams, hinder decision-making, and reduce the effectiveness of the Provider Collaboration Programme.	16	12	8	Align joint executive objectives to collaboration priorities agreed via E2E and B2B. This will help ensure a balance of capacity and integration with the strategic direction and annual priorities. Existing programmes within each organisation are likely to align with these efforts. SME and Programme Management resources have been identified for key workstreams.
Risk: Funding Requirements - There is a risk that the necessary funding to support transitional arrangements or joint investments required for the successful implementation of collaboration priorities may not be secured in a timely or coordinated manner. This could delay progress, limit the scope of delivery, or reduce the effectiveness of the proposed changes.	16	16	8	Transitional funding requirements to be identified as part of the financial sustainability component of the business case. Some additional investment is recommended to support business case timelines. SME and programme support provided by both Trusts in a "goodwill" manner.
Risk: Strategic Commissioning - There is a risk that ongoing structural and functional changes within NHSE & ICBs may not align with the objectives, timing, or delivery model of the Provider Collaboration Programme. Variability and instability across the systems could strain efforts to coordinate effectively, potentially leading to delays, duplication, or misalignment.	16	12	6	Provider Executives and SHICB leads have established aligned programmes of work to co-design the changes in organisational structures and functions aligned to emerging commissioning model. However, the variability and instability in NHSE and ICB systems may strain these efforts.

Q1 (Apr-June 25)

- Discovery Phase Report
- Joint Executive
- Joint Board
- JSCC approval of BC workstreams & glidepath
- Develop clear narrative, 2 Stories, 1 Why?
- Micro-Site framework agreed

PHASE 2: Business Case Development

- Define benefits & opportunities
- Articulation of proposed future models
- Create functional initiative mandates

Q2 (Jul-Sep 25)

- ← Joint Executive →

PHASE 3: Implementation Road Map Development

- Implementation Planning
- Identify & agree transition resources
- Agree governance approach
- Milestone setting & success matrix

Q3 (Oct-Dec 25)

- Joint Board
- Micro-Site published
- FI progress checkpoint: value & benefit realisation

Q4 (Jan-Mar 26)

- Joint Executive
- Joint Board

Outcomes

- Enhance patient outcomes through collaboration to ensure high-performing, sustainable services in the short, medium, and long term

Board Highlight Report – Multi-Year Plan

SRO/Executive Lead
Simon Bell

Key
Completed
On Track
At Risk
Delayed

Progress Report Against Milestones:

Key achievements against milestone

- Basic medium-term financial model already in place, as commissioned as pat on 25/26 operational planning.
- Board to Board financial case for change discussion enables aligned multi-year planning with SCAS.
- Initial SECAmb/SCAS financial planning group held and assigned leads to T&F groups include the 'Multi-year plan' T&F group.

Upcoming activities and milestones

- Multi-year financial planning group to meet in first two weeks of June to agree a joint model and timeline of activities for next three months, which will enable delivery of a multi-year plan for both organisations. The plan will include the flexibility to turn on/off collaboration opportunities.

Escalation to Board of Directors – None

Previous RAG	Current RAG	RAG Summary

Risks & Issues:	Initial	Current	Target	Mitigation
Risk: Develpment could be delayed by working across two organisations	6	6		The model can be run with only one organisations data, therefore development can go ahead without delay.
Risk: Resources to undertake development and quality assurance is not available.	6	6		Additional development resource has been acquired.
Risk: The requirement for a multi-year plan from NHSE may require a differential approach, assumptions and/or timeline.	6	6		The model will be designed to be flexible to meet the needs of multiple audiences.

Q1 (Apr-June 25)	Q2 (Jul-Sep 25)	Q3 (Oct-Dec 25)	Q4 (Jan-Mar 26)	Outcomes
Initial financial planning meeting with SECAmb/ SCAS.	Draft multi-year plan presented to execs.	Multi-year plan used as basis for '26/27 Operational Planning' & 'Case for Change'.		
Initial multi-year plan T&F group meeting with SECAmb/SCAS.	'Live' multi-year plan presented to execs.	'Live' multi-year plan presented to execs.	'Live' multi-year plan presented to execs.	

BAF Risk 541 – Collaboration

There is a risk that the trust does not drive collaboration, which will result in reduced strategic delivery and missed opportunities to integrate services and care pathways , reduce waste, and drive productivity to improve care.

Contributory factors, causes and dependencies: increasing NHS financial constraints require providers to integrate and collaborate to provide consistent care, reduce waste, and drive productivity so investment can focus on front line patient care. CF Report recommended this workstream to kick off in 2024, with HIOW and SHICB working to establish single strategic commissioning function for 999/111 across Southeast. Success depends on alignment with partner organisations and ability to adapt to structural changes in regional healthcare landscape.

Controls, assurance and gaps

Controls: Joint Transition Group established, Commissioning intent letter sets out expectations for collaboration for the 2 providers for 26/27.

Gaps in control: Transitional leadership arrangement and governance need to be developed.

Positive sources of assurance: Outline business case approved on 8 October by joint Boards. Transition Group established. Communications plan launched.

Negative sources of assurance: Complex multi-partner environment with competing priorities; financial constraints across all partners; structural changes in commissioning creating uncertainty.

Gaps in assurance: Environment of uncertainty as ICBs submit their consolidation plans; limited visibility of ICB commissioning consolidation timelines.

Accountable Director	**Chief Strategy Officer**
Committee	**Trust Board**
Initial risk score	**Consequence 4 X Likelihood 3 = 12**
Current Risk Score	**Consequence 4 X Likelihood 3 = 12** ⇨
Target risk score	**Consequence 4 X Likelihood 2 = 8**
Risk treatment	**Treat**
Target date	**Q4 2025/26**

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Complete collaboration business case development with South Central Ambulance Service	Joint Strategic Lead	October 2025	Completed
Joint board meetings to review collaboration case and determine next steps	Joint Strategic Lead	May & October 2025	Completed
Complete divisional restructuring to align with local systems	Chief Operating Officer	September 2025	Progressing in alignment between SCAS and SECAmb
Maintain sector leadership roles and national group participation	Chief Executive Officer	Ongoing	2 executives chair national groups; CEO chairs Southern Collaborative
Establish Joint Strategic Commissioning Group	Chief Strategy Officer	July 2025	Completed

BAF Risk 640 – Financial Plan

There is a risk that the Trust fails to deliver a break-even finance plan, our Board, our people, our regulators and commissioners lose confidence in our organisation.

Contributory factors, causes and dependencies: Uncertainty given changes at ICB/ national level. See link to risk 647 System Productivity

Controls, assurance and gaps

Controls: Planning improvements: Planning for 25/26 incorporated substantial improvements over 24/25 information and controls and better integrated operational performance, ops support (fleet/make ready), workforce, and capital. Additional resource brought in to help integrate planning and, also prepare ten-year planning insight. Workforce: Omission of NQP training numbers from plan has created an affordability issue which will need further mitigation and incorporating as an improvement for 26/27 planning. Guidance clarification: NHSE has clarified guidance such that the H2 £5m performance funding is independent of the 2 minutes of C2 performance improvement dependent on system actions. Downside risk mitigation planning: Process of identifying downside risk mitigation in place and operating.

Gaps in control: System C2 Contribution: The C2 performance element of the plan relies on 2 minutes of time being contributed by the wider system including reduced handover delays and a more consistent UEC capacity/capability. No detailed plans have been supplied at the time of final plan submission. £5m of funding linked to achieving 25 min C2 mean is therefore at risk if the additional 2 minutes is not realised in the system. Budgeting errors: Omission of full NQP trainee numbers and TOIL budget in plans has created an additional cost pressure in the order of £1.3m in year.

Positive sources of assurance: Compliant plan submitted on 27th March. No negative feedback received/queries outstanding. 24/25 plan outcomes in line with plan across workforce, finance, and operational performance domains. Internal audit financial systems audit gives reasonable assurance. SECAmb and Lead ICB CEO have written to all ICB CEOs advising that if credible system plans to contribute to 2 minutes of C2 mean performance are not produced and realised then the Trust will invoice for the balance of £5m in order to offset the loss of the C2 related NHSE income and breakeven. Also, that ICBs need to fund £2m of additional 111 capacity which NHSE has been funding or else accept a performance deterioration. Clarification from NHSE that £5m performance funding associated with improvement in C2 trajectory can be earned providing Trust delivers its component of the improvement (to 27 minutes) independent of the 'system' 2 minute improvement. Oversight by NHSE at National, Regional, and local level continues on a monthly basis. Downside mitigation planning in place. This includes estate review coming to September Board development session. September Board Development session including accounting and estates overview complete. Q3 and three year plan will incorporate revised planning trajectories along with a refreshed view of underlying recurrent deficit. M6 Reporting and Bridge Analysis for NHSE reconfirms trajectory and plan to achieve planned breakeven from M6 position. £5.2m funding confirmed by NHSE as second half of £10.2m C2 performance funding. To be paid in November.

Negative sources of assurance:

Gaps in assurance: No detailed plans received and assured from ICBs at submission stage. No response to the CEO letter as yet received. No plans for system contribution for C2 performance yet received nor risk assessed. Under-delivery of recurrent CIP plans likely.

Accountable Director	**Chief Finance Officer**
Committee	**Finance and Investment Committee**
Initial risk score	**Consequence 4 X Likelihood 3 = 12**
Current Risk Score	**Consequence 4 X Likelihood 2 = 08** Previously 12 ⇩
Target risk score	**Consequence 3 X Likelihood 2 = 06**
Risk treatment	**Treat**
Target date	**Q4 2025/26**

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Q2 Review	SB	15th October 2025	Completed

BAF Risk 544 – Cyber Resilience

There is a risk that the organisation will not have sufficient resilience to withstand a cyber-attack, resulting in significant service disruption and/or patient harm.

Contributory factors, causes and dependencies:

Controls, assurance and gaps

REDCATED

Accountable Director	Chief Digital Information Officer
Committee	Finance and Investment Committee
Initial risk score	Consequence 4 X Likelihood 4 = 16
Current Risk Score	Consequence 4 X Likelihood 4 = 16 ⇨
Target risk score	Consequence 4 X Likelihood 3 = 12
Risk treatment	Treat
Target date	Q4 2025/26

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress

BAF Risk 650 - Digital Capacity, Capability & Investment

There is a risk that the organisation cannot facilitate necessary digital development and integration, due to insufficient capacity, capability and investment, resulting in impeded strategic delivery

Contributory factors, causes and dependencies: NHS funding environment. Partner/ wider NHS focus given ongoing changes at national and regional level may make investment more challenging. Integration with national programmes (i.e.: national care records programme)

Accountable Director	**Chief Digital Information Officer (CDIO)**
Committee	**Finance and Investment**
Initial risk score	**Consequence 4 X Likelihood 4 = 16**
Current Risk Score	**Consequence 4 X Likelihood 3 = 12** ⇨
Target risk score	**Consequence 4 X Likelihood 2 = 08**
Risk treatment	**Treat**
Target date	**Q4 2025/26**

Controls, assurance and gaps

Controls: Our approach included strengthening the business cases even further for the Digital Transformation Programme workstreams (1-6) with further rigorous analysis of the allocated budget vs the projected against the business cases. This measured approach ensured we have sufficient detail in our work programme to provide full assurance over expenditure and delivery plans for FY25/26, demonstrating our commitment to financial discipline and delivery excellence. Opportunities for collaboration with partners in the digital space. Ongoing Digital check and challenge with Executive team.

Gaps in control: There is currently a skills gap which is currently under review. Findings will inform the ongoing workforce restructure. In the interim, targeted recruitment will address critical gaps to ensure delivery objectives are met.

Positive sources of assurance: Strategic and operational delivery monitored through Audit and Risk Committee. Revised Digital Delivery resourcing has improved service engagement and project productivity.

Negative sources of assurance:

Gaps in assurance: Digital Transformation Programme to be presented to Trust Board on 7 August 2025.

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Restructure of Digital Directorate	CDIO	Q4 2025/26	The Digital Workforce Restructure business case due to come to EMB on 17 December and schedule as part of Corporate Services Phase 3
Business cases to support delivery of digital strategy	HOD	Q3 2025/26	Business cases are in various stages of approval, Data & AI / Gartner Business case have been approved. The remainder will be presented in December 2025
JD Evaluation	CDIO	Q3 2025/26	JDs have been completed are now in current review, as per corporate services 3 timeline, this linked to Workforce restructure Business case (Workstream 2) - on track.
Governance	CDIO/HOD	Q3 2025/26	Capital plans to support the Digital transformation programme have also been completed which will be controlled via various sub-groups now DTB (Digital Transformation Board)has been established.

BAF Risk 647 – System Productivity

There is a risk that without cross-system improvements in productivity, as a result of insufficient planning or resource allocation, in-year financial and operational outcomes will not be achieved

Contributory factors, causes and dependencies: National focus on improving NHS productivity following consecutive years of decline since COVID, combined with financial pressures limiting growth needed to cope with inflationary pressures. System productivity plans for 2025/26 require hospital handover times <18 minutes and urgent community response teams to accept 60% of referrals to meet C2 25 min.

Controls, assurance and gaps

Controls: Strategic commissioning group and contract review meetings with system partners; system partnership leads engaging directly with providers; operational teams restructuring to align with systems; regional teams reviewing system plans as part of new oversight framework. Successful outcomes from meetings to date

Gaps in control: System plans not delivering, UCR acceptance rate reduced from 20% to 15% this year

Positive sources of assurance: NHS England confirmed £10m funding will not be removed if targets missed due to reasons beyond our control; established governance structures and regional oversight framework. Most recent meeting re-stated commitment that SECAmb will not be penalised for non-delivery of system productivity.

Negative sources of assurance: System plans not yet received from 4 systems, YTD trends for UCR at M02 remain at 21% and Handover time trends remain above plan in 3 or 4 systems, with an upward trend

Gaps in assurance: No system plans delivering improvements

Accountable Director	**Chief Strategy Officer**
Committee	**Finance and Investment Committee**
Initial risk score	**Consequence 4 X Likelihood 4 = 16**
Current Risk Score	**Consequence 3 X Likelihood 4 = 12** ⇨
Target risk score	**Consequence 4 X Likelihood 2 = 08**
Risk treatment	**Treat**
Target date	**Q4 2025/26**

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Design and delivery of three priority models of care with input from system partners	Chief Medical Officer	Q4 2025/26	3 models of care priority areas progressed in 25/26
Secure submission of system productivity plans from all 4 systems (Kent, Surrey, Sussex, Frimley)	Chief Strategy Officer	June 2025	Not completed – plans not deliverying
Establish regular monitoring of handover times and community response acceptance rates via CRM	Chief Operations Officer	June 2025	Complete
Refocus system partnership work on alternatives to ED and	CSO / COO	Sep 2025	Agreement being enacted by SP&T with partnership managers; detailed plans for the work

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Integrated Quality Report

Trust Board December 2025

Data up to and including October 2025

Icon Descriptions

Integrated Quality Report

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

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

NHS Performance Assessment Framework 2025/26

The NHS Performance Assessment Framework sets out how success and areas for improvement will be identified, and how organisations will be rated.
Metrics with this icon are part of this framework.

NHS
South East Coast Ambulance Service
NHS Foundation Trust

Sustainable Partner

What?
The Trust has agreed a revised C2 mean plan acknowledging the impact of under-delivery of system productivity and C2 streaming (previous called segmentation). However, internal productivity metrics remain variable, with continued challenges in increasing clinical calls per hour, although offset by strong Hospital Handover performance and improved Incident Cycle time. Vehicle availability due to a combination of factors remains low, with our Vehicle of Road rate (VOR) above the target for the end of the year of 10%. An emerging challenge has been provision of hours due to more effective workforce deployment above the vehicle plan.

The number of manual handling incidents has increased (although still within normal variation). As such, the H&S team have undertaken a deep dive, identifying themes in moving and handling of high BMI patients and challenging environments. A number of improvement actions are currently in progress to support. The wellbeing strategy also indicates the move from a reactive MSK service (in terms of physio provision) to a proactive approach. This workstream has commenced and a proposed alternative model will come to EMB in Q4.

So What?
The Trust's month 7 year to date and forecast revenue financial position is in line with plan. NHSE has confirmed the Trust has earned the second half of the £10.2million performance fund and this has allowed the Trust to reduce the risk evaluation of BAF risk 640 as agreed by Novembers FIC.

The revised C2 mean performance plan means that the Trust is now in line with expected C2 performance. Vehicle availability is negatively impacting performance, in particular where more effective workforce deployment is increasing the demand on fleet, compounded by a higher level of VOR. Overall, we normally would expect to operate our fleet with about 38% resilience. This is currently down to abou 20% once the increased hours being scheduled and increased VOR are taken into account.

What Next?

System productivity work is supported through the new divisional structure and with a focus on strong local relationships supporting Winter resilience, including handover and pathways providing an alternative to ED. A deep dive on H&T productivity was undertaken and actions arising to address expectations, data, call selection and training and competencies are now in train. There is an operational plan in place to review sickness processes and share best practice between teams.

Operations Support and Operations are working closely together to ensure the plans through December and Q4 are aligned to deliver our trajectories to year-end. Since the beginning of November, we have implemented a "Ghost Callsign" for crews who don't have a vehicle available at the start of shift to log onto. This is a learning from SCAS colleagues, and we are using the new data alongside a review of the demand and capacity for fleet.

The new MAN DCA vehicles (92) and electric DCA Fords were expected from originally from Q3 25/26. Due to delays in conversion due to changes in pass-fail criteria for IVA tests (Individual Vehicle Assessments), there is some delay to the receipt of vehicles by about 2-3 weeks. We expect now vehicles from the middle of January at a rate of 3 to 4 a week.

Sustainable Partner Overview

NHS South East Coast Ambulance Service NHS Foundation Trust

Integrated Quality Report

Variation

Special Cause Improvement		Common Cause		Special Cause Concern	
0%	13%	57%		4%	13%
0	3	13		1	3

Assurance

Pass	Hit and Miss	Fail	No Target
9%	9%	13%	70%
2	2	3	16

Productivity

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	% of DCA vehicles off road (VOR)	Oct-25	14%	10%	16%		
Board	Number of RTCs per 10k miles travelled	Oct-25	0.8		0.7		
Board	Handover Time Mean	Oct-25	00:18:47	00:17:30	00:18:54		
Board	Hear & Treat per Clinical Hour	Oct-25	0.3		0.4		
Board	See & Convey to ED %	Oct-25	52.3%		52.2%		
Board	See & Convey to Non-ED %	Oct-25	2.3%		2.7%		
Board	UCR Acceptance %	Oct-25	15.3%	60%	19%		
Supporting	111 to 999 Referrals (Calls Triaged) %	Oct-25	6.7%	13%	6.4%		
Supporting	% of SRV vehicles off road (VOR)	Oct-25	5.7%		5%		
Supporting	Critical Vehicle Failure Rate (CVFR)	Oct-25	76		93.1		
Supporting	999 Operational Abstraction Rate %	Oct-25	30.7%	31.9%	23.7%		
Supporting	Hear & Treat Recontact within 48 Hours %	Oct-25	2.2%		2.1%		
Supporting	Handovers > 45 Minutes %	Oct-25	4.2%	0%	4.5%		
Supporting	Number of Hours Lost at Hospital Handover	Oct-25	3257.4		3199.3		

Pending metric: Make Ready Compliance % - Data not available to BI/Not currently collected

Pending metric: Rate of Admission from ED - Needs to be defined

Health & Safety

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	Health & Safety Incidents	Oct-25	35		34.6		
Board	Organisational Risks Outstanding Review %	Oct-25	48%	30%	29.1%		
Supporting	Number of RIDDOR Reports	Oct-25	13		9.7		
Supporting	Manual Handling Incidents	Oct-25	43		26.5		
Supporting	Violence and Aggression Incidents (Number of Victims - Staff)	Oct-25	108		119		

Finance

Type	Metric	Latest	Value	Target	Mean
Board	Surplus/Deficit (£000s) Month	Oct-25	320	1.4	-17.6
Supporting	Agency Spend (£000s) Month	Oct-25	-218.7	-161	-237.3
Supporting	Capital Expenditure (£000s) YTD	Oct-25	3181	28496	6746

Efficiency

Type	Metric	Latest	Value	Target	Mean
Board	Cost Improvement Plan (CIP) (£000s) Month	Oct-25	909		1372.1
Board	Cost Improvement Plans (CIPS) (£000s) YTD	Oct-25	3113	4669.66	8885.5

Pending metric: Cost per Call - Data not not available to BI/Not currently collected

Pending metric: Cost per Hour on the Road - Data not not available to BI/Not currently collected

Sustainable Partner Overview

Integrated Quality Report

Variation

Special Cause Improvement		Common Cause		Special Cause Concern			
0%	13%	57%		4%	13%		
0	3	13		1	3		

Assurance

Pass	Hit and Miss	Fail	No Target
9%	9%	13%	70%
2	2	3	16

Resilience

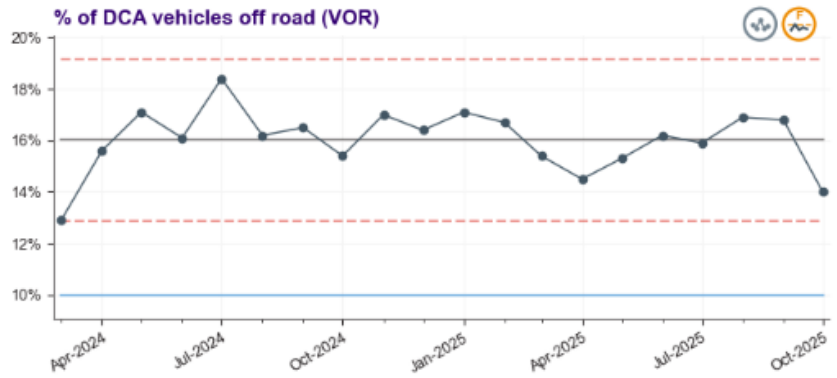
Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Pending metric: Data Security / Cyber Assurance - Needs to be defined							
Pending metric: EPRR Standards Compliance % - Needs to be defined							
Pending metric: Digital Capacity/Delivery - Needs to be defined							

Patient Safety

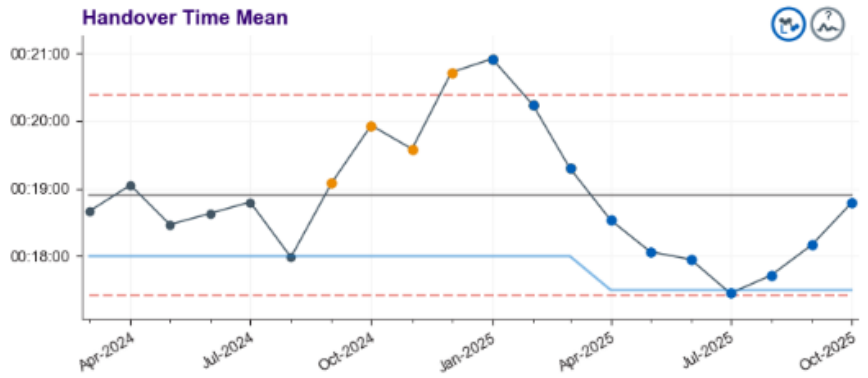
Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Pending metric: Driver Safety Standard Metric - Needs to be defined							

Digital

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	Count of P1 Incidents	Oct-25	0		0.2		
Board	Count of Cyber Incidents	Aug-25	5		6.7		



FL-4
Dept: Fleet
Metric Type: Board
Latest: 14%
Target: 10%
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.



999-39
Dept: Operations 999
Metric Type: Board
Latest: 00:18:47
Target: 00:17:30
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.

FL-2
Dept: Fleet
Metric Type: Board
Latest: 0.8

Common cause variation, no significant change.

% of DCA Vehicles off road (VOR)
What?
Current DCA VOR rate at 14%

So what?
Parts supply for FIAT DCA spares is still challenging with multiple parts still back ordered to Italy. This is the main driver of the increased VOR over the last 12 months along with aging fleet of Mercedes DCAs.

What next?
Due to the reliability of the Fiat product the Trust have now ordered 92 MAN box DCAs and 5 Electric Transit DCAs that will assist with reducing VOR Rates. The demonstrator DCA vehicle is now built and has arrived in Trust for staff feedback with the first vehicles of our orders expected to become operational by the Start of December 2025.

Number of RTCs per 10K miles travelled
What?
No significant change to RTCs per 10k travelled.

So what?
RTC's reduce vehicle availability and increase VOR, The repair times and costs to fix these vehicles post RTC is high having a negative impact on the Trust both operationally and financially.

What next?
The introduction of the driving standards review panel have seen improvements in learning and education to staff post RTC which will help drive reductions in RTCs and associated vehicle downtime and costs. We are working in collaboration with SCAS to adopt a new approach to driver safety, learning from their "points system", and expect to further develop this as the functional collaboration case evolves.

Hospital Handovers
What?
A slight deterioration in October from the previous month and times have increased for the last 4 months. Average handover time for October is 18.47 against a target of 17 minutes.

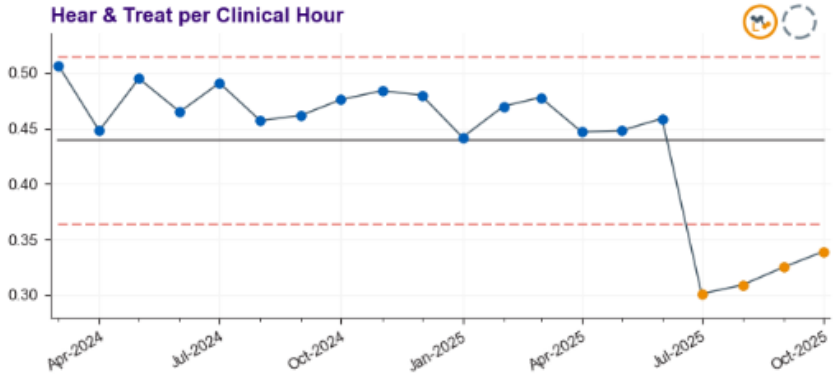
So what?
Likely cause of deterioration linked to pressures at acute trusts due to demand and along with challenges related to infection/prevention controls (Norovirus outbreaks and COVIID)

What next?
Continue to be an area of clinical operations with a focus with system partners to support meeting our C2 mean. we will be focusing on escalation of longer handovers and use of alternatives to ED such as SDEC.

Sustainable Partner: Productivity | Board Metrics

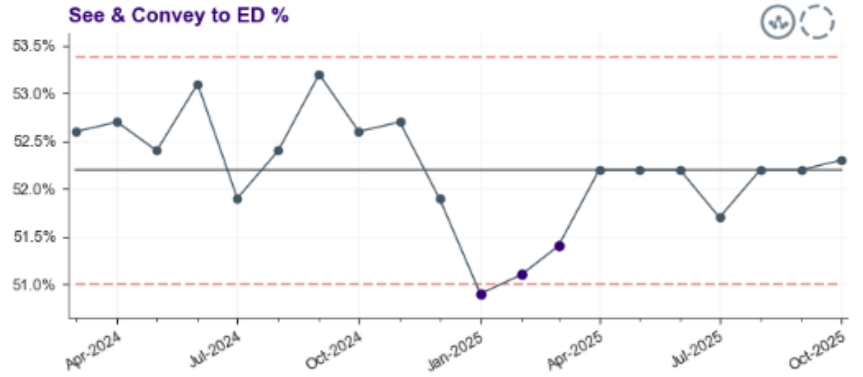
South East Coast Ambulance Service NHS Foundation Trust

Integrated Quality Report



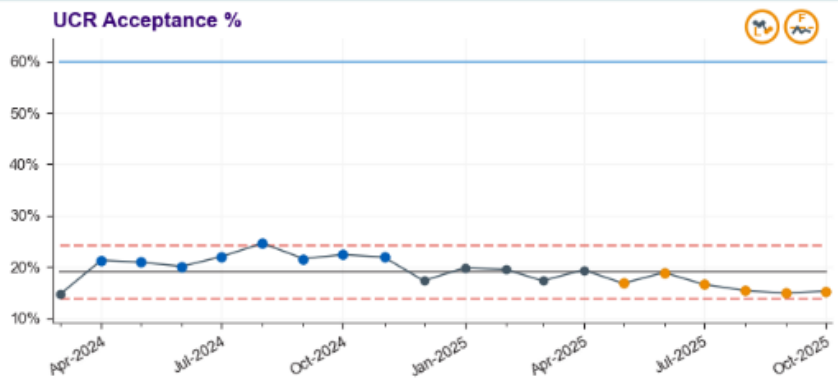
999-41
Dept: Operations 999
Metric Type: Board
Latest: 0.3

Special cause of a concerning nature where the measure is significantly LOWER.

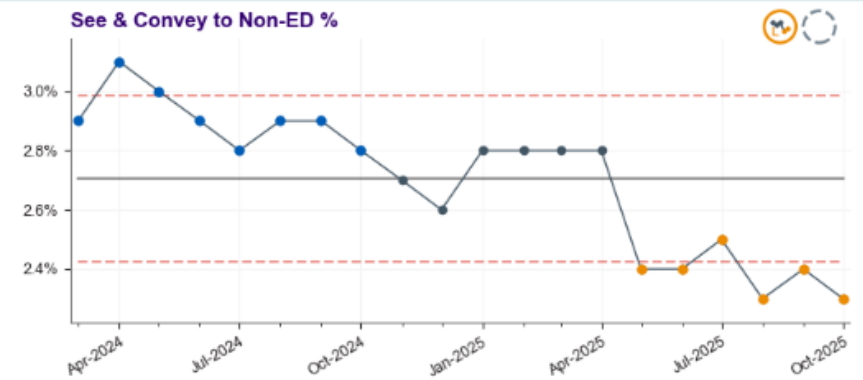


999-9
Dept: Operations 999
Metric Type: Board
Latest: 52.3%

Common cause variation, no significant change.



999-40
Dept: Operations 999
Metric Type: Board
Latest: 15.3%
Target: 60%
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.



999-9
Dept: Operations 999
Metric Type: Board
Latest: 2.3%

Special cause of a concerning nature where the measure is significantly LOWER.

Hear and Treat per Clinical Hour

What? A key focus for the Trust is to drive virtual clinician productivity as part of the Virtual Care Tier 1 programme (now called High Quality Care) is improve the Hear and Treat (H & T) generation per clinical hour provided, in addition to increasing the volume of H & T capacity via the dual training of paramedics to support clinical validation and assessments via C2 streaming and C3/C4 clinical validation in the Unscheduled Care Navigation Hubs. Although the overall Hear & Treat outcomes per hour is trending upwards in H2 of 25/26, it is still below target.

So what? The H & T finished at 15.2% for the month of October with 3.9% attributable to EMA activity. Only 8% of eligible C2 incidents underwent a clinical assessment as part of C2 streaming, with 17% downgraded to a C3/4 disposition and 36% downgraded to a non-ambulance disposition. Overall, the number of cases subject to C2 Streaming has decreased since August. This is because of the new interim C2 streaming model which SECAmb implemented to reduce the adverse impact that the NHS E process was having on C2 mean overall. There is real variability in H & T rates each day with different contributing factors to the higher levels which gives a challenge to being able to deliver the target levels consistently however, clinical productivity with respect to calls triaged per hour has increased.

What next? As part of the "high quality patient care" programme, it has been identified that clinicians undertaking virtual care need clinical education and further training, to enhance their skills and help them to become more competent and confident when undertaking virtual care. This will generate a higher degree of downgrades and increased H & T. There is also a focus on clinician productivity, which is being addressed via the Virtual Care delivery group, supported by an updated H&T action plan.

A new C2 Streaming model is being developed in conjunction with NHS E and is due to be implemented before the end of Q3.

UCR Acceptance Rate

What?

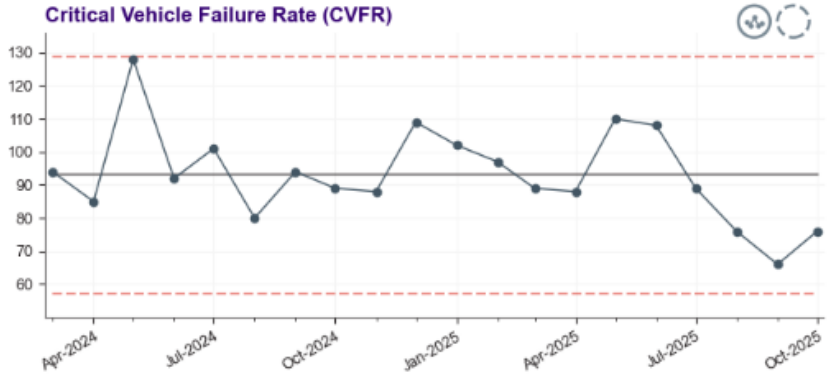
In October, **15.42%** of 882 incidents referred via the UCR portal were accepted (**n=137**), a slight increase from September but still far below the **60% target**. Most rejections were due to **no response (39%)**, **accepted but no capacity (27%)**, or **clinical inappropriateness (26%)**. Acceptance rates varied significantly across the region, from **50% in North West Surrey** to **1% in Hastings**.

So What?

Acceptance rates remain well below desired levels, with marked variation across geographies, indicating inequity in service access. Capacity constraints are the dominant barrier, limiting the benefit of increased referrals. Rejection patterns point to systemic issues—delayed responses, capacity shortfalls, and clinical misalignment between referral criteria and ground level UCR service scope.

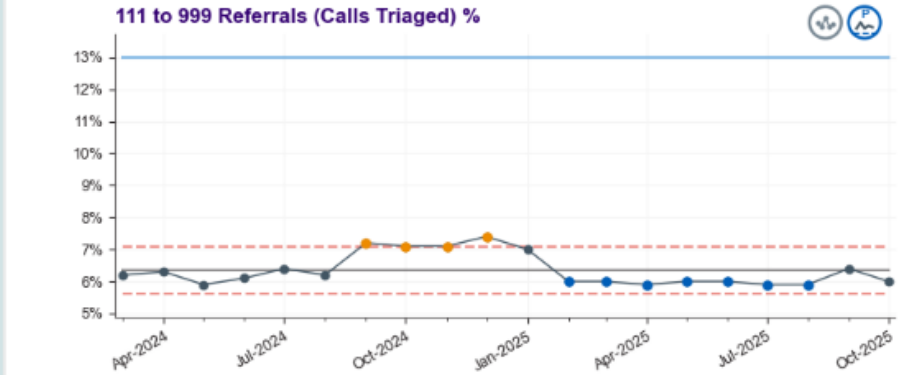
What Next?

Learning visits to WMAS and EEAST confirm that even mature services target ~40% acceptance. EEAST achieves **70% acceptance** but only **40% completion** due to case pass-back capability. Their model includes a **1-hour review for patient risk assessment**. All providers are live except **KCHFT**, which covers the largest geography; engagement efforts continue, with a meeting scheduled **W/C 12/11/2025** with the incoming Deputy Director of Community Services. System leaders are analysing trends in "accepted but no capacity" rejections and reductions in auto-rejects and clinically inappropriate referrals to inform redesign options.

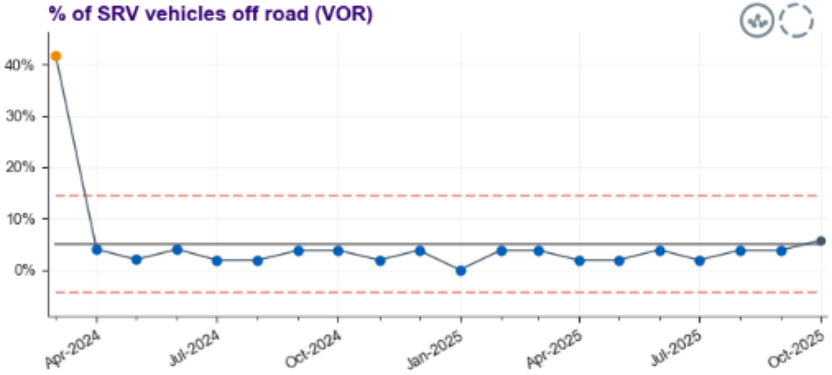


FL-12
Dept: Fleet
Metric Type: Supporting
Latest: 76

Common cause variation, no significant change.



111-4
Dept: Operations 111
Metric Type: Supporting
Latest: 6%
Target: 13%
Common cause variation, no significant change. This process is capable and will consistently PASS the target.



FL-5
Dept: Fleet
Metric Type: Supporting
Latest: 5.7%

Common cause variation, no significant change.

Critical Vehicle Failure Rate (CVFR)

What?
No significant change to critical vehicle failure rate in recent months

So what?
Current CVFR levels are mainly due to vehicle age and operational vehicles that are required to be used passed there agreed replacement life cycle due to the reliability of the Fiat product.

What next?
New DCAs are to start being delivered into the Trust for commissioning from the 25th November 2025 that will reduce average fleet age and improve vehicle reliability.

% of SRV vehicles off road (VOR)

SRV VOR % remains stable due to all vehicle being within their agreed replacement life cycle.

999-42

Dept: Operations 999

Metric Type: Supporting

Latest: 2.2%

Common cause variation, no significant change.

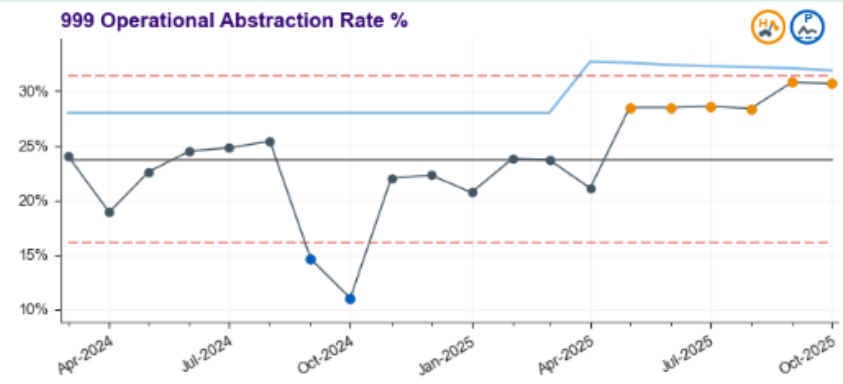
999-24

Dept: Operations 999

Metric Type: Supporting

Latest: 3257.4

Common cause variation, no significant change.



999-12

Dept: Operations 999

Metric Type: Supporting

Latest: 30.7%

Target: 31.9%

Special cause of a concerning nature where the measure is significantly HIGHER. Despite deterioration the process is capable and will consistently PASS the target.

999-39

Dept: Operations 999

Metric Type: Supporting

Latest: 4.2%

Target: 0%

Special cause of an improving nature where the measure is significantly LOWER. This process is still not capable. It will FAIL the target without process redesign.

Hear & Treat Recontact

What? Contact from patients who have received a Hear & Treat (H & T) outcome (alternative disposition to ambulance dispatch) increased slightly in October but remains relatively low.

So what? H & T recontact is a measure of clinical effectiveness and needs further analysis to evaluate risk and the impact of the H & T intervention.

What next? The Trust will be incorporating this metric in its new Virtual Care productivity dashboard, to ensure that the quality and impact of virtual care can be recorded and reviewed.

999 Operational abstraction

What: Total hours abstracted fell from **216,877** in September to **202,893** in October, and the abstraction percentage also dipped from **34.32%** to **32.24%**. The data reflects a decrease in annual leave during October.

So what?

YTD: abstraction levels show a seasonal pattern with a steady rise from spring into a prolonged peak running from July through to October. During this period, weekly abstracted hours consistently ran between 38,000 and 42,000 driven by high levels of annual leave. During this period, training such as key skills remained steady, however we also have a small but steady amount of both short and long-term sickness. This combination explains the higher abstraction percentage over the summer and early autumn.

There are several factors that combined to cause this increase: Implementation of a revised Key Skills programme with additional number of hours and delivery schedule weighted to months such as May June and July to reduce pressure on months with higher demand challenge. High annual leave rates as per policy upper limit. (Cont. in next narrative box)

999 Operation Abstraction cont.

What next?

Oversight of abstraction rates is undertaken by the Divisional Directors at the Divisional Management Meetings. Each Operating Unit Manager is required to report monthly on levels of abstraction to provide assurance that all staff absent from the workplace are appropriately supported and managers are following Trust policy consistently. Longer term work on updated Trust policies and procedures is ongoing with HR colleagues.

Hospital Handovers

What?

Hours lost to Hospital Handovers continue to improve, supported by the changes made to "auto clear" functionality at ED.

So what?

The number of hours lost due to handovers is improving as we continue to focus on this priority area with all system partners working collaboratively on an agree plan.

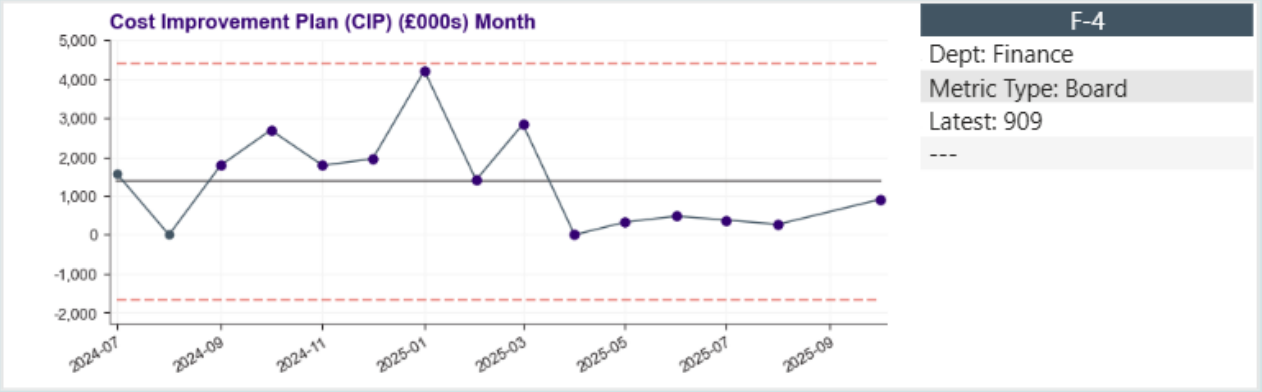
What Next?

We continue to focus on this with system partners as a key productivity scheme that will contribute to improvements in the C2 mean, including looking at escalation processes to avoid long handover times and using SDEC and UTC more effectively.

Sustainable Partner: Efficiency | Board Metrics

South East Coast Ambulance Service NHS Foundation Trust

Integrated Quality Report

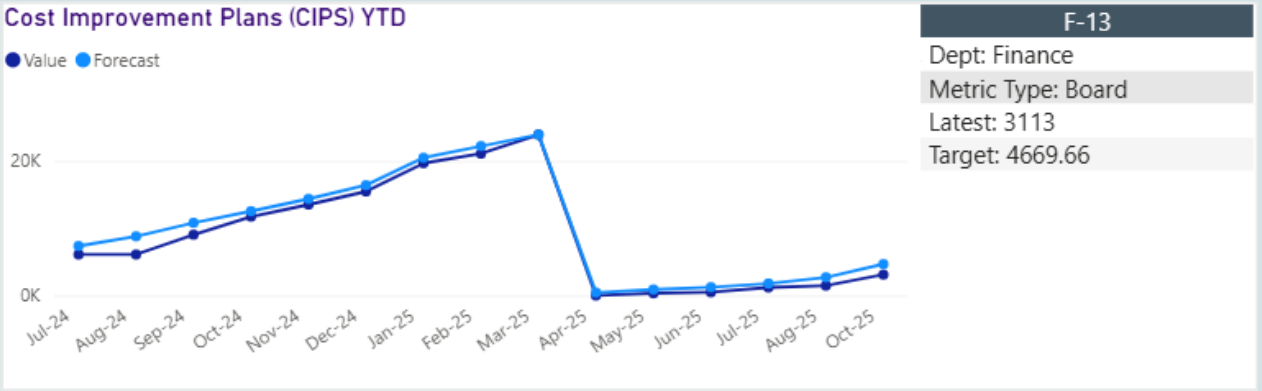


F-4

Dept: Finance

Metric Type: Board

Latest: 909



F-13

Dept: Finance

Metric Type: Board

Latest: 3113

Target: 4669.66

What?

For the seven months ending October 2025, we are £1.6m or a third short of our £4.7m efficiency target. Year-to-date recurrent savings have dropped to 40%, below our 63% target, leading to a rise in non-recurrent savings to 60%.

So what?

We need to achieve £6.9m of the £10.0m efficiency target in the next five months to reach breakeven and establish sustainable savings.

What next?

Expedite the development and financial validation for 17 schemes worth £1.9m and advance them through Executive Director and Quality Impact Assessment (QIA) approval to reach the delivery stage.
Develop outstanding initiatives from the August Joint Leadership Team (JLT) meeting.
Minimise risks and ensure budget compliance to meet efficiency targets.

What?

The present fully validated risk-adjusted forecast gap remains £2.4m, against the £10.0m target. The reliance on non-recurrent savings has reduced recurrent savings from 70% to 42%.

So what?

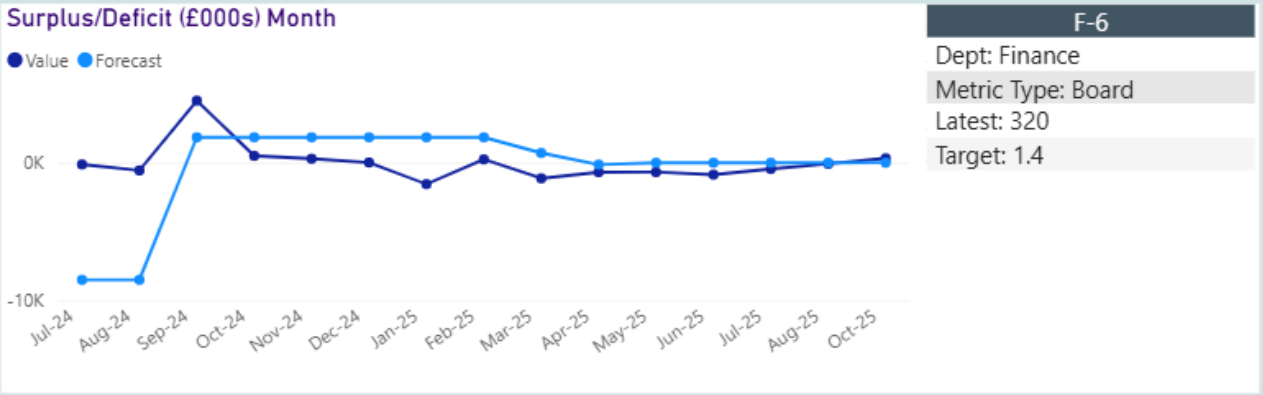
With initiatives below target, additional actions are needed to close the gap, especially since 69% of expected savings are in the second half of the year, which may face winter pressures.

What next?

To address this gap, we have implemented mitigation strategies, including the use of non-recurrent budget underspends and balance sheet flexibilities.
However, it is essential to identify initiatives for productivity and cost improvements to ensure sustainable progress over the next three years. We must comply with budget and efficiency targets while aiming to achieve a 3% surplus by 2028/29, as required by NHS providers.

Sustainable Partner: Finance | Board Metrics

Integrated Quality Report



What?
The Trust is reporting a £2.5m deficit for the 7 months to October 2025, this is as planned.

So what?
The deficit year to date position is in part due to the impact of CIP being planned more towards the second half of the year.

What next?
The Trust continues to monitor its performance and forecast position and is confident in meeting its financial plan for 2025/26

What?
For 2025/26 the Trust has again a break-even financial plan.
So what?
The Trust will not be receiving any deficit support funding to achieve this.
What next?
However, additional £10.2m ambulance growth funding has been allocated to enable the Trust to deliver a revised trajectory improvement in C2 mean to 28 minutes for 2025/26.

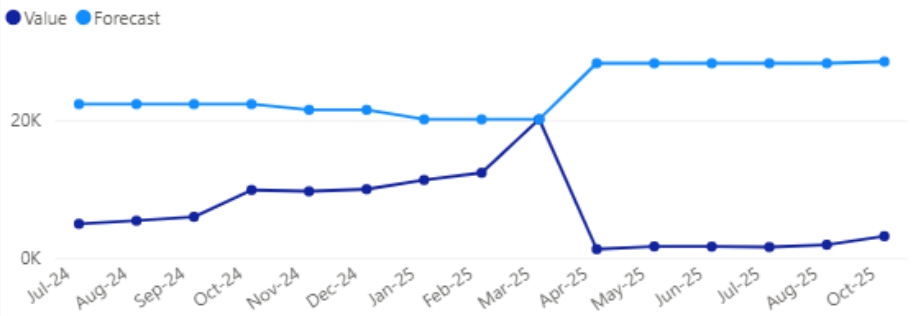
This plan is supported by the £22.6m efficiency target, £10.0m cash releasing (a shortfall as mentioned above) and £12.6m from productivity improvements helping it to meet its performance target.

The Trusts cash position is £27.8m as at 31 OCtober 2025.

Sustainable Partner: Finance | Supporting Metrics

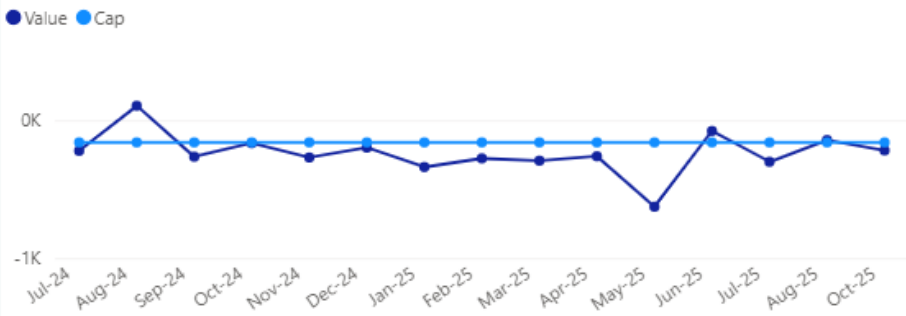
Integrated Quality Report

Capital Expenditure ($000s) YTD



F-14
Dept: Finance
Metric Type: Supporting
Latest: 3181
Target: 28496

Agency Spend (£000s) Month



F-8
Dept: Finance
Metric Type: Supporting
Latest: -218.7
Target: -161

What?
For the financial year 2024/25, the Trust incurred £20.1m of capital expenditure, this was £2.2m below plan, this underspend was agreed with its system partners.

So what?
The capital spend for 2024/25 covered improvements in Digital, Estates and Fleet (including Medical equipment).

What next?
For 2025/26 the Trust has a capital plan of £28.3m, this includes £10.7m for ambulance purchases and £0.8m for Estates that is supported by national capital funding.

For the year to October 2025, the Trust has spent £2.9m, this is £4.4m behind the plan of £7.3m. This underspend is caused by the sale of vehicles to a lease company that were purchased by the Trust last year and a delay in digital and fleet spend. This underspend will be caught up later in the year when the vehicles leases start and vehicles start to be delivered.

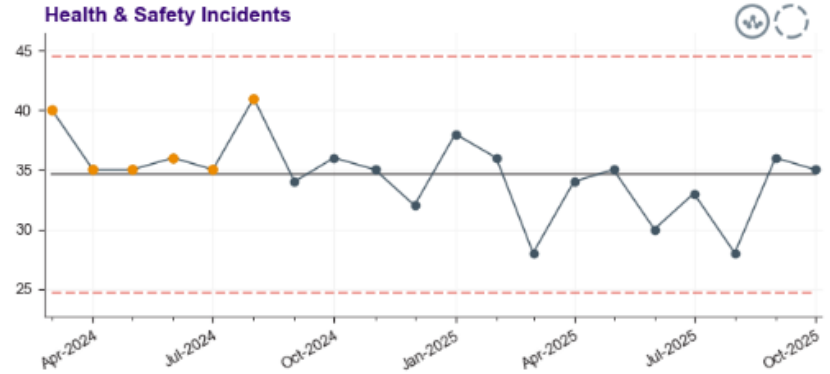
The Trust is confident in meeting its capital plan for 2025/26

What?
For the financial year 2024/25 the Trust spent £2.3m on the provision of third-party agency employees, this was £0.3m above plan.

So what?
This overspend was due to meet demand in both its 999 and 111 contact centres and to support productivity improvements within its 999 contact centre, supporting the improvement in C2 mean and improved C2 segmentation, these improvements were supported by additional funding.

What next?
For 2025/26 it has a plan to spend £2.0m, for the year to October 2025 the Trust has spent £1.7m, £0.5m above plan due to delays in its ability to recruit into permanent roles within its 999 and 111 contact centres.

The Trust continues to work towards reducing its reliance on temporary agency staff.



QS-20
Dept: Quality & Safety
Metric Type: Board
Latest: 35

Common cause variation, no significant change.

QS-24
Dept: Quality & Safety
Metric Type: Board
Latest: 48%
Target: 30%
Common cause variation, no significant change. This process will not consistently hit or miss the target.

What?
Health and Safety incidents for the reporting period are showing normal variation with no significant change.

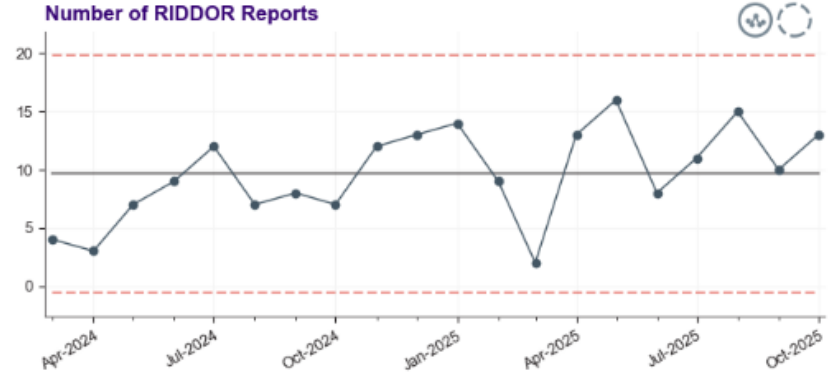
So what?
Whilst there is stability in the count of incidents for the reporting period, the recent introduction of IOSH Managing Safely training is expected to drive improved control assurance as the first line of defence and ultimately support the reduction in incidents.

What next?
- Continued role out of IOSH Managing Safely training
- Training gaps being shared within key skills
- Establishment of third line of defence assurance (BDO) t be planned for 26/27
- Benchmarking key metrics with other Ambulance Trusts to identify learning and drive improvement.
- RIDDOR learning reviews to strengthen preventative measures.

What? Risks are not always being updated on the system following review by the risk owner.

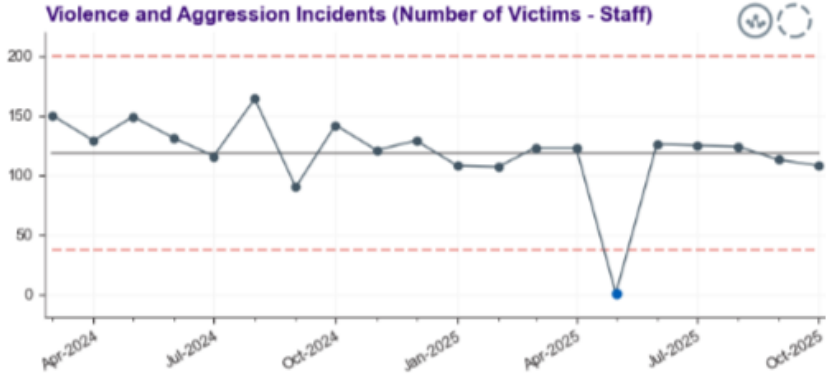
So What? The Risk Assurance Group has a specific focus on this aspect of compliance and following the meeting in November is confident this will improve. Many of these risks showing as overdue are in fact being discussed and the risk owners acknowledge the discipline needed to then take the final step in updating the system, DCIQ.

What next? Risk Assurance Group will continue its focus and by the end of Q4 look to reduce this target to 10%



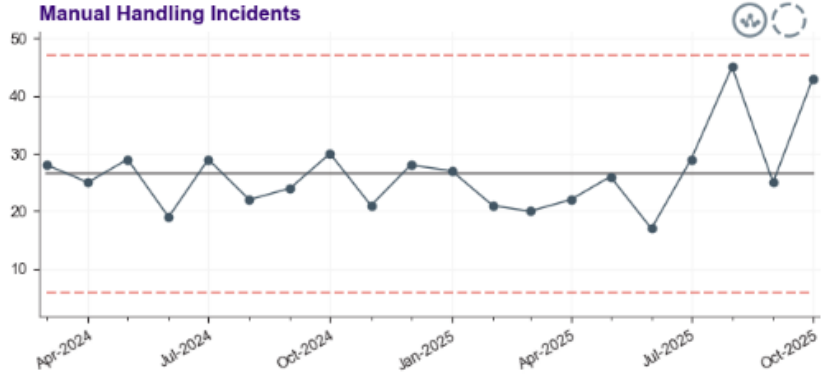
QS-9
Dept: Quality & Safety
Metric Type: Supporting
Latest: 13

Common cause variation, no significant change.



QS-13
Dept: Quality & Safety
Metric Type: Supporting
Latest: 108

Common cause variation, no significant change.



QS-22
Dept: Quality & Safety
Metric Type: Supporting
Latest: 43

Common cause variation, no significant change.

RIDDOR
What? 13 RIDDOR reports went to the HSE during the reporting period, with 54% of events relating to moving and handling of patients and significant loads with a moderate level of harm in 77% of reports. Three of these reports were submitted outside of the expected time frame.
So what? There has been improvement in the reporting RIDDOR incidents in timely manner. Common theme identified of moving and handling of high BMI patients and challenging environments.
What next? Please refer Metric QS 22 – Summary Manual Handling.

Violence & Aggression Incident Reporting
What? Reports of violence and abuse have seen a sustained reduction for 11 out of the last 13 months.
So what? Call handler incidents are the main reduction in incidents and assaults have remained stable at an average of 27 per month.

What next? As of 10/10/2025 ,2843 staff have received Conflict resolution training . Anticipated completion date for all road staff is still on track for the end Dec 2025. Training for CFR and new joiners is a priority.
113 Violence and Abuse incidents were reported in September 2025. And 108 were reported in October 2025. The average has dropped to 118 per month from a high of 134 so the data is not statistically significant.
Monitoring & Governance
The Trust maintains robust monitoring and triage processes for violence and abuse incidents:
- Incident data is reviewed at the monthly Violence Reduction Working Group at regional levels and by the Trust Health & Safety Working Group.
- The Trust remains 93% compliant with the new NHS Violence Reduction Standards. An external review is being undertaken in September / October 2025. This audit process is still ongoing.

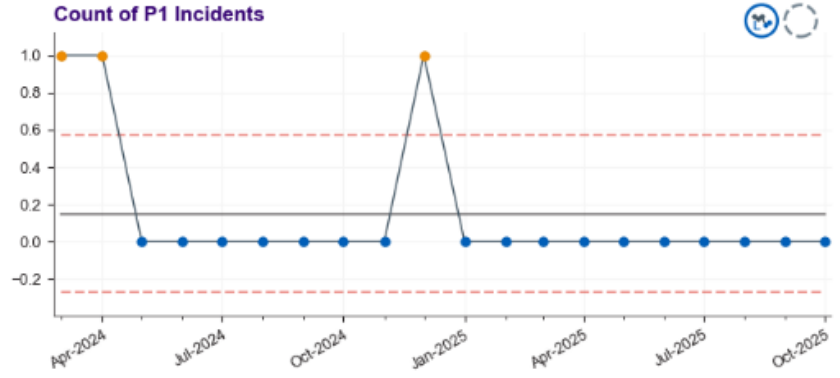
Key Initiatives for 2025
- Local violence risk assessment reviews
- Continued partnership working with relevant police forces. / Hate crime focus with Kent Police
- Review of call handler training in managing conflict

Manual Handling Incidents

What? Recent reporting months have seen a spike in such incidents, that is on the border of the upper control limit indicating a requirement of a deep dive.
So what? A deep dive has identified key themes in reported moving and handling adverse events:
- Moving and handling of High BMI patients
- Challenging patient extractions
- Carry of significant loads (Lifepak 15 and Primary Bags)

What next?
- NHSE funded E DCA's due late 2025 that have self-loading trolleys.
- Trust opportunity for moving to powered trolleys and carry chairs with future fleet.
- Key skills back to basics (TILE) now covered in Q2 25/26
- Bariatric Model provision - review underway
- Input to Clinical Education to further develop meaningful Dynamic Risk Assessments

Note: TILE is an acronym that aims to help you carry out a manual handling risk assessment. TILE prompts you to consider each essential area of the activity to improve health and safety. In terms of manual handling, the TILE acronym stands for Task, Individual, Load, and Environment:



IT-7
Dept: Digital
Metric Type: Board
Latest: 0

Special cause of an improving nature where the measure is significantly LOWER.

IT-8
Dept: Digital
Metric Type: Board
Latest: 5

Special cause or common cause cannot be given as there are an insufficient number of points.

What?
The chart shows three P1 incidents in the last 18 months (Mar 2024, Apr 2024 and Dec 2025), with no recent occurrences.

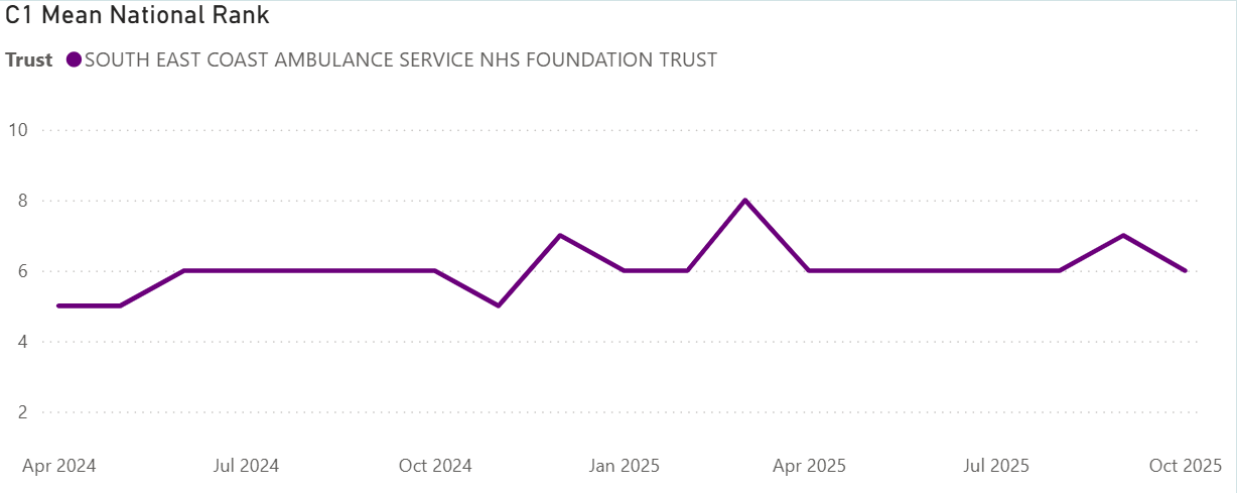
So what?
The absence of recent P1 incidents suggests the network remediation programme has been effective.
Cross-site resilience has improved, reducing operational risk and the likelihood of service disruption.

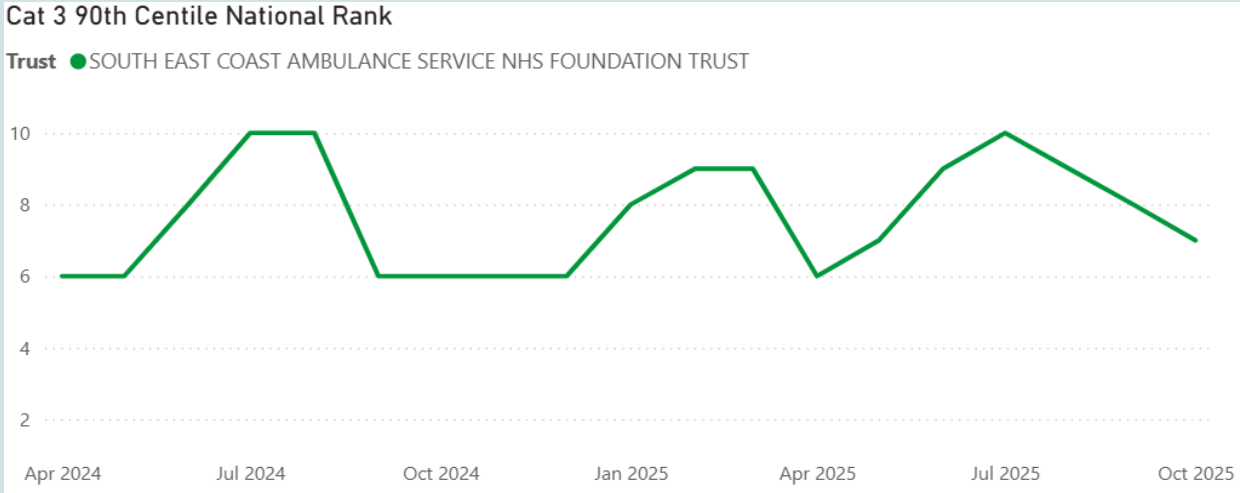
What next?
- Continue ongoing work to strengthen infrastructure and maintain resilience.
- Monitor systems proactively to prevent recurrence.
- Embed lessons learned into future digital resilience strategies.

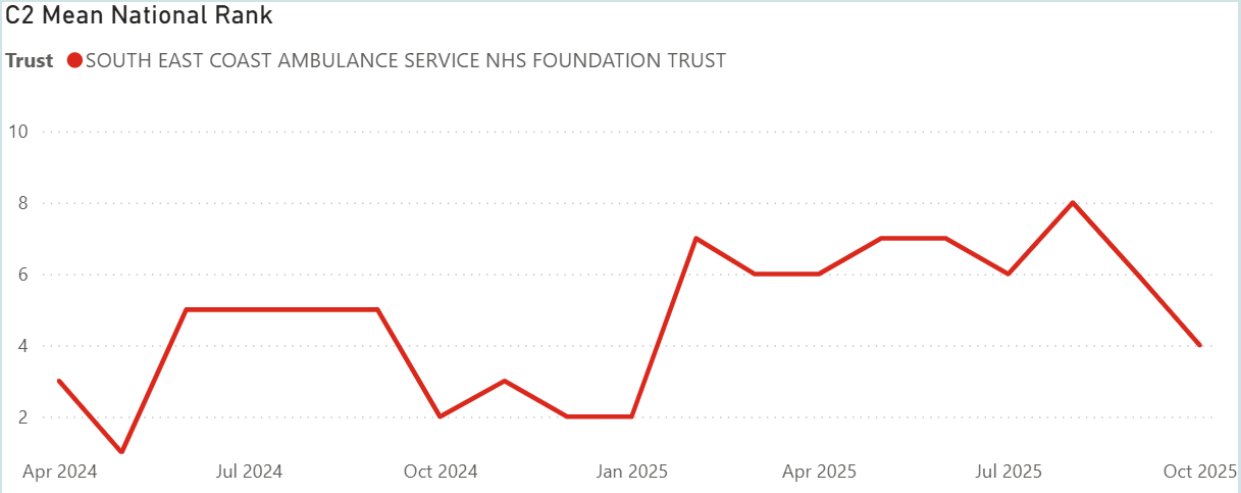
What?
Cyber incidents have reduced from 25 in Oct 2024 to 5 in Aug 2025, showing normal variation.
No special cause variation can be determined due to insufficient data points.

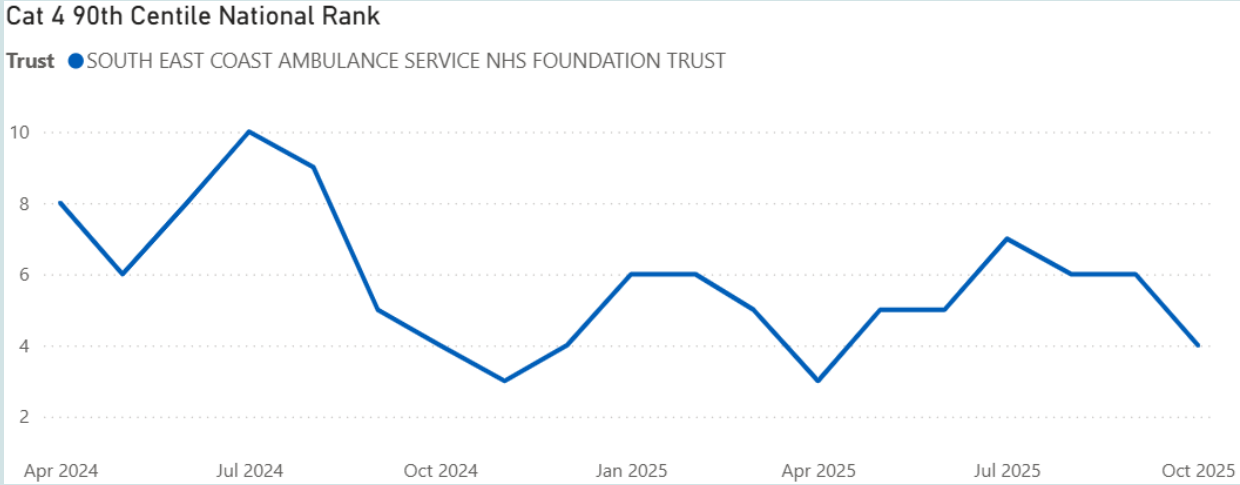
So what?
The downward trend is positive, but cyber threats remain persistent.
Current controls are effective, but vigilance is essential given the evolving threat landscape.

What next?
- Advance initiatives under the Digital Transformation Programme, including:
  - Collaboration with SASC on a joint Cyber Security Operations Centre (CSOC).
  - Deployment of a new SIEM tool for enhanced threat detection and response.
- Maintain continuous monitoring and rapid incident management.

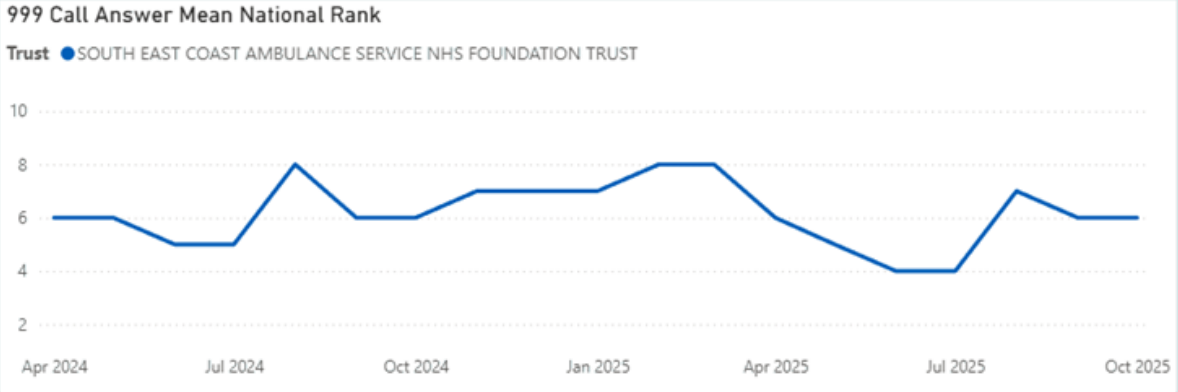


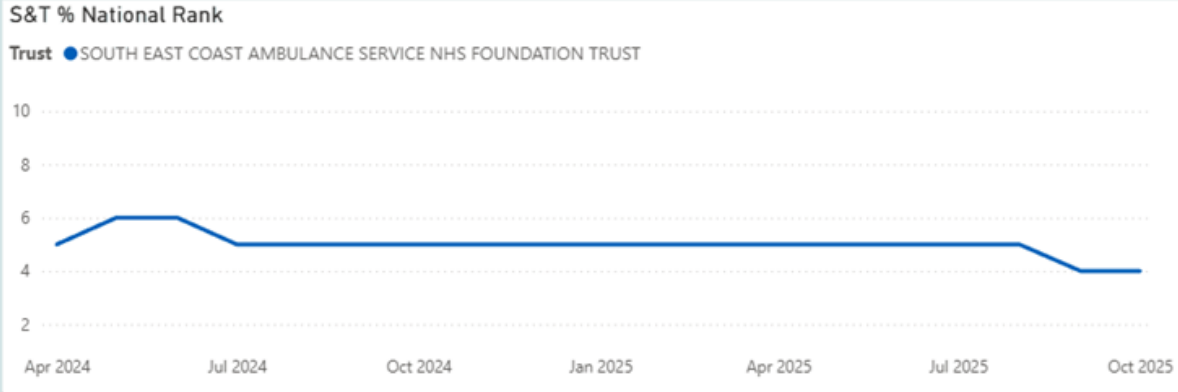


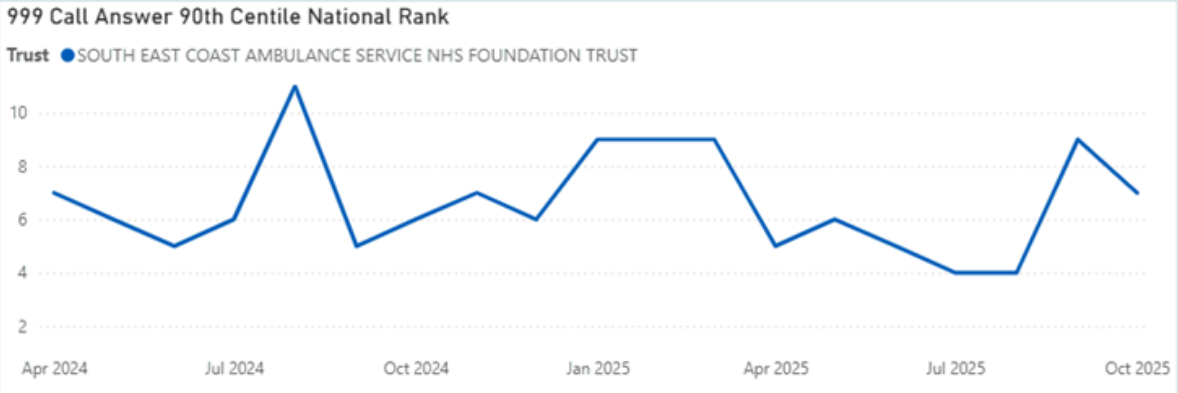


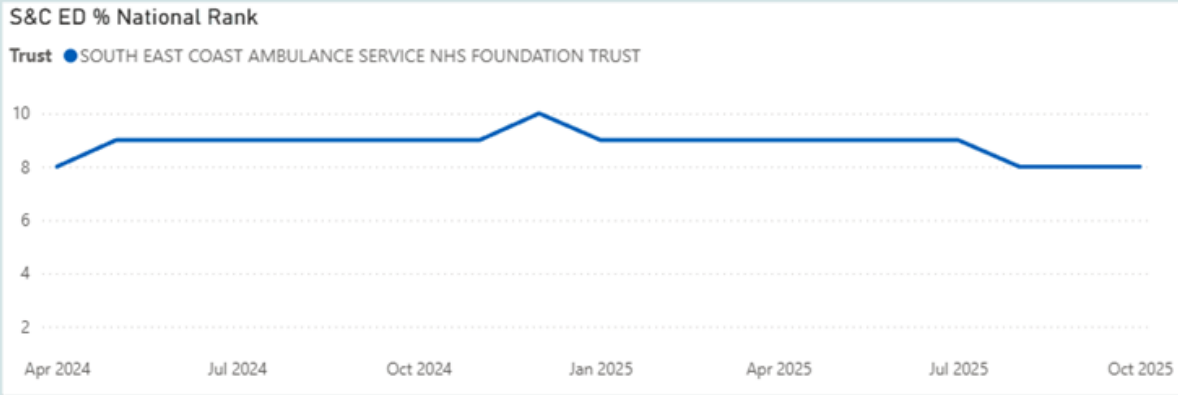


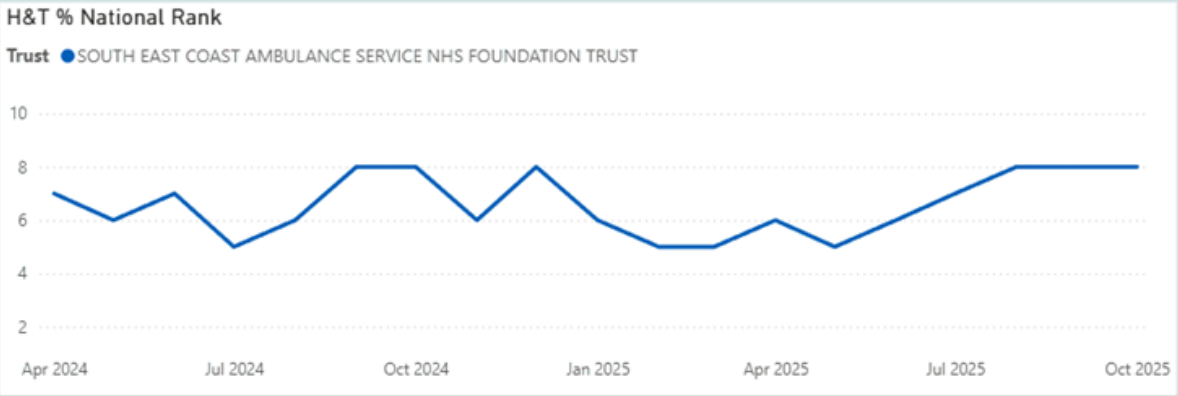
Summary:
•Overall SECAmb continues to benchmark broadly in the middle of the range of English NHS Ambulance Trusts for response times. All Trusts are being challenged to improve their C2 mean in the coming year in line with NHSE guidance.

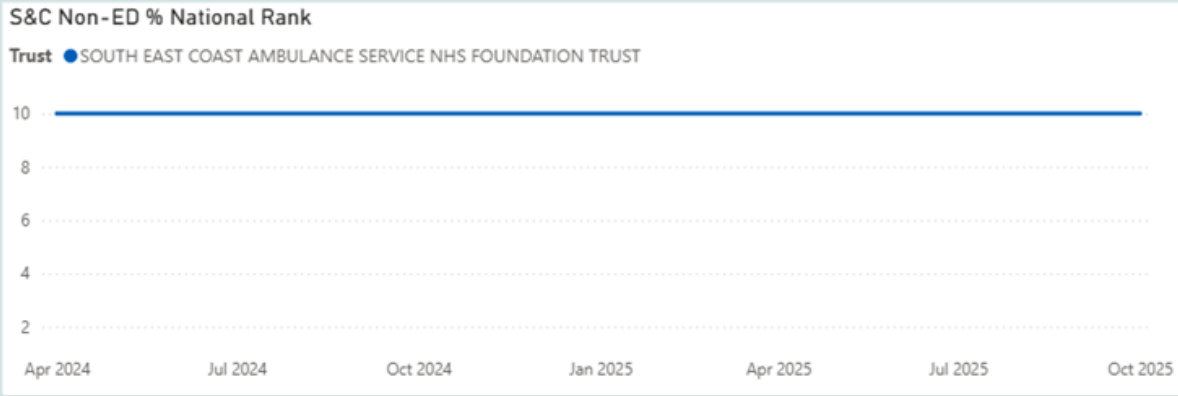












Summary:

•Secamb continues to benchmark well for 999 call answer times but has room for improvement in H&T rate, as noted in the report. We are also working to improve our S&C to non-ED settings in partnership with system providers

Appendix 1: Glossary

Integrated Quality Report

AQI A7	All incidents – the count of all incidents in the period
AQI A53	Incidents with transport to ED
AQI A54	Incidents without transport to ED
AAP	Associate Ambulance Practitioner
A&E	Accident & Emergency Department
AQI	Ambulance Quality Indicator
ARP	Ambulance Response Programme
AVG	Average
BAU	Business as Usual
CAD	Computer Aided Despatch
Cat	Category (999 call acuity 1-4)
CAS	Clinical Assessment Service
CCN	CAS Clinical Navigator
CD	Controlled Drug
CFR	Community First Responder
CPR	Cardiopulmonary resuscitation
CQC	Care Quality Commission
CQUIN	Commissioning for Quality & Innovation
Datix	Our incident and risk reporting software
DCA	Double Crew Ambulance
DBS	Disclosure and Barring Service
DNACPR	Do Not Attempt CPR
ECAL	Emergency Clinical Advice Line
ECSW	Emergency Care Support Worker
ED	Emergency Department
EMA	Emergency Medical Advisor
EMB	Executive Management Board
EOC	Emergency Operations Centre
ePCR	Electronic Patient Care Record
ER	Employee Relations
F2F	Face to Face
FFR	Fire First Responder
FMT	Financial Model Template
FTSU	Freedom to Speak Up
HA	Health Advisor
HCP	Healthcare Professional
HR	Human Resources
HRBP	Human Resources Business Partner
ICS	Integrated Care System
IG	Information Governance
Incidents	See AQI A7
IUC	Integrated Urgent Care
JCT	Job Cycle Time
JRC	Just and Restorative Culture
KMS	Kent, Medway & Sussex
LCL	Lower Control Limited
MSK	Musculoskeletal conditions
NEAS	Northeast Ambulance Service
NHSE/I	NHS England / Improvement
OD	Organisational Development
Omnicell	Secure storage facility for medicines
OTL	Operational Team Leader
OU	Operating Unit
OUM	Operating Unit Manager
PAD	Public Access Defibrillator
PAP	Private Ambulance Provider
PE	Patient Experience
POP	Performance Optimisation Plan
PPG	Practice Plus Group
PSC	Patient Safety Caller
SRV	Single Response Vehicle

Item No	94/25

Name of meeting	Trust Board
Date	4 December 2025
Name of paper	M07 (October 2025) Financial Performance
Executive sponsor	Simon Bell – Chief Finance Officer
Authors names and roles	Judit Friedl (Deputy Chief Finance Officer) Graham Petts (Head of Financial Planning and Reporting), Priscilla Ashun-Sarpy (Head of Financial Management), Rachel Murphy (Financial Manager - Projects, Business, and Investments)

This report provides the year-to-date (YTD) financial performance of the Trust.

As of month 7, the Trust is reporting a favourable variance of £7k compared to the planned deficit of £2,571k. The Trust forecasts achieving its financial breakeven plan and the planned C2 mean performance.

The Trust has achieved £3,113k (two-thirds) of the planned £4,670k in efficiencies YTD. This amounts to 31% of the overall savings target, leaving 69% still to be achieved over the next five months. We forecast achieving 76% of the planned target of £10,000k, resulting in a shortfall of £2,439k. We have implemented measures to address this projected gap.

Additionally, the YTD recurrent savings have decreased from 46% last month to 40%, against the plan of 63%. We expect these savings to remain below the anticipated full-year target of 70%, projecting a reduction to 42% due to an increase in non-recurrent schemes, such as vacancies.

YTD Capital expenditure £2,939k is £4,376k below plan, that is caused by the sale of vehicles to a lease company that were purchased by the Trust last year and which is causing a temporary underspend. The Trust is forecasting to spend its full capital allocation by the end of the year.

In October 2025 cash payments exceeded receipts by £1,542k which has decreased the cash balance to £27,797k from £29,340k in the previous month. The closing balance is £94k below plan. The key driver for the variance against plan is the timing of capital purchases offset by delays in the anticipated receipt of growth funding.

Note: Tables are subject to rounding differences (+/- £1k).

Recommendations, decisions, or actions sought	For information

2025/26

Finance Report to the Board of Directors

7 Months to 31 October 2025

Executive Summary

The Trust reported a £2,571k deficit for the 7 months to October 2025 (YTD), £7k better than planned.

Note: Tables are subject to rounding differences (+/- £1k).

	Year to October 2025			Forecast to March 2026		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	209,124	209,986	862	358,376	359,506	1,130
Expenditure	(211,703)	(212,574)	(871)	(358,378)	(359,520)	(1,142)
Profit on Sale of Assets	0	16	16	0	16	16
Trust Surplus / (Deficit)	**(2,579)**	**(2,572)**	**7**	**(2)**	**1**	**3**
Reporting adjustments:						
Remove Impact of Donated Assets	1	1	0	2	1	(1)
Reported Surplus / (Deficit)*	**(2,578)**	**(2,571)**	**7**	**0**	**2**	**2**

Efficiency Programme (cash releasing)	4,670	3,113	(1,557)	10,000	10,000	0
Cash	27,891	27,797	(94)	30,427	26,985	(3,442)
Capital Expenditure	7,315	2,939	4,376	28,496	28,496	0

*Reported Surplus / (Deficit) represents w hat the Trust is held to account for by the ICB/NHSE

Year to October 2025 (YTD)

- For the 7 months to October 2025, the Trust's financial position is £7k better than planned.

- The overall financial performance shows a mix of variances. Positive variances in Strategic Planning & Transformation, Medical, Quality & Nursing (Q&N), and Digital areas are offsetting some financial pressures, including overspending in Operations, the CEO office, and HR.

- The Trust's breakeven financial plan for 2025/26 depends on achieving a £10,000k cash-releasing efficiency target, representing 2.0% of operating expenditure.
    - As of month seven, the Trust has achieved £3,113k in efficiency savings, falling one-third short of the target. This represents 31% of the total efficiency program, meaning £6,887k (69%) in additional savings must be realised in the next five months.
    - The shortfall is primarily due to delays in advancing schemes and updates to terms and conditions and HR policies, along with the timing of process reviews.
    - The YTD recurrent schemes reduced to 40% of total savings (last month was 46%), 23% below the planned target of 63%. While non-recurrent savings make up 60%, exceeding the planned 40%.
    - The forecasted gap stands at £2,439k, with risk-adjusted schemes totalling £7,561k against a £10,000k. Recurrent savings have decreased from 44% to 42% compared to a planned 70%.

  - Although the program has an overall risk rating of amber, the Trust is committed to achieving the £10,000k target with mitigation strategies in place.

- As of 31 October 2025, the cash balance was £27,797k and is £94k below plan. Reduced capital spend is offset by delays in the anticipated receipt of growth funding.

- YTD Capital expenditure of £2,939k is £4,376k below plan, that is caused by the sale of vehicles to a lease company that were purchased by the Trust last year and which is causing a temporary underspend. The Trust is forecasting to spend its full capital allocation by the end of the year.

1. Income

	Year to October 2025			Forecast to March 2025		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
999 Income	188,047	188,510	463	322,366	322,829	463
111 Income	17,111	17,111	0	29,333	29,334	1
Education Income	2,049	2,067	18	3,434	3,644	210
Other Income	1,917	2,298	381	3,243	3,699	456
Total Income	**209,124**	**209,986**	**862**	**358,376**	**359,506**	**1,130**

- 999 income is £463k above plan, this is from the receipt of additional capacity funding for 2024/25 being received in this financial year.
- 111 income remains on plan.
- Education income is £18k above plan. Reduced expenditure for funded projects is offset by increased placement support funding based on the volume of placements being undertaken.
- Other income is £381k favourable compared to plan, due to sales of obsolete equipment, medical provision at events.

2. Expenditure

The table below shows the expenditure plan and outturn by directorate. The below is offset by the corresponding funding the Trust receives and is recognised under income.

Expenditure By Directorate*	Year to October 2025			Forecast to March 2025		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Chief Executive Office	(2,704)	(3,062)	(358)	(4,583)	(5,058)	(475)
Finance & Corporate Services	(9,612)	(9,547)	65	(16,765)	(16,646)	119
Quality and Safety	(3,656)	(3,435)	221	(6,182)	(6,070)	112
Medical	(7,807)	(7,184)	623	(13,597)	(13,175)	422
Operations	(121,479)	(122,198)	(719)	(207,820)	(207,983)	(164)
Operations - 111	(17,388)	(17,310)	78	(29,395)	(29,342)	53
Strategic Planning & Transformation	(17,044)	(16,267)	777	(28,756)	(28,654)	102
Human Resources	(3,252)	(3,453)	(201)	(5,446)	(5,981)	(535)
Digital	(7,685)	(7,525)	160	(13,095)	(12,970)	125
Paramedical	(4,282)	(4,179)	103	(7,953)	(8,071)	(118)
Total Directorate Expenditure	**(194,909)**	**(194,160)**	**749**	**(333,592)**	**(333,950)**	**(359)**
Depreciation	(10,494)	(10,427)	67	(19,397)	(18,106)	1,291
Impairments	0	0	0	0	0	0
Financing Costs	(623)	(104)	519	(1,067)	(770)	297
Corporate Expenditure	(5,678)	(7,883)	(2,204)	(4,321)	(6,695)	(2,374)
Total Expenditure	**(211,703)**	**(212,574)**	**(871)**	**(358,378)**	**(359,520)**	**(1,142)**
Profit on Sale of Assets	0	16	16	0	16	16
Total Trust Expenditure	**(211,703)**	**(212,558)**	**(855)**	**(358,378)**	**(359,504)**	**(1,126)**

*Excludes Income - Values subject to rounding

Year to Date performance against plan

- Total expenditure for the year to October 2025 was £212,574k, which is exceeding the plan by £871k.

- The overall net overspend is the result of a combination of favourable and unfavourable variances, outlined as follows:

- Overspending in Operations accounts for £719k of the total adverse variance. The main drivers of this overspend are as follows:
    - A significant portion of the overspend, amounting to £969k, is attributed to increased costs in Field Operations. This is largely attributable to 4% over establishment, producing an additional £1,122k in costs. Additionally, a £650k retrospective reallocation relating to eCal clinical hours back to Field Operations from the Emergency Operations Centre (EOC) has brought the EOC to breakeven following a review of PACCS costs. This is mitigated by a 33% reduction in overtime (£1,207k) and a 44% decrease in Time Off In Lieu (TOIL) payments (£483k). There are also underspends in non-pay costs, such as a £133k reduction in travel. However, delays in achieving operational efficiencies have led to a £2,083k shortfall in the cost improvement target, contributing to the overspend.
    - Offsetting some of these costs, we see an underspend in Specialist Operations, which stems from the timing of recruitment in HART (£211k) and delays in planned non-pay expenses, particularly the procurement of protective clothing due to stock shortages.

- The financial performance of our NHS 111 service continues to improve, currently showing a favourable variance of £78k. This is largely due to management's implementation of tight controls over increased staff costs, which currently exceed the plan by £681k. This overspend is mainly due to the reliance on clinical agency staff and overtime to ensure safe service delivery during the early part of the year. However, this is compensated by an underspend of £759k in non-pay costs, particularly the IC24 subcontract following the contract review.

- Further cost pressures include an additional £358k in expenditures in the CEO's office, primarily due to increased contributions towards external consultancy support for the Association of Ambulance Services and external facilitation for leadership development. Meanwhile, HR is overspending by £201k due to higher costs for external investigations and additional senior management support agreed upon to facilitate the transition.

- These overspends are partly offset by savings of £935k in support and back-office functions due to delayed recruitment during restructuring in the Medical, Quality & Nursing, Paramedical, and Finance & Corporate Services directorates. Additionally, there's a £777k net underspend in Strategy & Transformation, primarily from Fleet costs being £789k below plan, with fuel savings of £559k due to 5% more favourable fuel rate compared to the plan of £1.50. Furthermore, maintenance and lease car contracts are lower, resulting from strengthened controls and policy changes. Uniform expenses are also £268k below plan, following a review of stock levels, which is partially offset by unbudgeted transformation costs of £255k. Digital underspend of £160 has resulted in high-value contracts reviews being superseded by new contracts.

- Additionally, financing costs are £519k better than planned, thanks to a strong cash balance and favourable interest rates, along with lower depreciation costs of £67k, primarily due to the timing of leasing assets.

3. Workforce

- The following table shows the analysis of the movement in WTE by directorate and comparison to the monthly plan:

WTE By Directorate	Analysis to October 2025			Month of October 2025			Vacancies* - October 2025		
	Sep-25	Oct-25	Movt	Plan	Actual	Variance	Plan	Actual	Variance
Chief Executive Office	56.5	55.7	(0.8)	51.6	55.7	(4.1)	51.6	57.3	(5.7)
Finance	38.6	38.0	(0.6)	40.5	38.0	2.5	40.5	38.9	1.6
Quality and Safety	92.9	93.9	1.0	80.6	93.9	(13.3)	80.6	94.8	(14.2)
Medical	118.4	110.7	(7.7)	129.2	110.7	18.6	129.2	110.2	19.1
Operations	3,691.9	3,653.1	(38.8)	3,742.4	3,653.1	89.3	3,742.4	3,616.3	126.1
Operations - 111	385.6	366.5	(19.1)	420.1	366.5	53.7	420.1	378.8	41.3
Strategic Planning & Transformation	114.1	113.5	(0.6)	115.2	113.5	1.8	115.2	115.1	0.2
Human Resources	60.1	67.3	7.1	63.5	67.3	(3.8)	63.5	64.0	(0.5)
Digital	69.2	68.8	(0.3)	68.0	68.8	(0.8)	68.0	67.5	0.5
Paramedical	81.1	104.9	23.8	108.7	104.9	3.8	108.7	102.3	6.4
Total Whole Time Equivalent (WTE)	**4,708.3**	**4,672.3**	**(36.0)**	**4,819.9**	**4,672.3**	**147.6**	**4,819.9**	**4,645.1**	**174.9**

*Net Funded WTE less Contracted (ESR) WTE

- The Trust is 147.6 WTE below plan for October.

- Movements are mainly driven by overtime, including TOIL, provided in Operations to meet demand.

- Vacancies in operations are supported by overtime and bank.

4. Efficiency Programme

The Trust submitted a breakeven financial plan for 2025/26 predicated on the delivery of a £10,000k cash-releasing efficiency target, which represents 2.0% of operating expenditure. This does not negatively impact performance or the quality and safety of patients.

Summary of Schemes on the Pipeline Tracker

Scheme Category	Fully Validated	Validated	Scoped	Total Schemes	Proposed	Total
	£'000	£'000	£'000	£'000	£'000	£'000
Digital Productivity	206	-	-	206	-	206
Discretionary Non Pay	456	85	25	566	-	566
Estates and Facilities optimalisation	-	196	-	196	-	196
Fleet - Fuel: Bunkered Fuel & Price Differential	622	-	-	622	-	622
Fleet - Other Efficiencies	307	-	-	307	-	307
Income generation	296	-	-	296	-	296
Medicines Management - Drugs	100	-	-	100	-	100
Medicines Management - Equipment	306	-	-	306	-	306
Operations Efficiencies	2,598	-	-	2,598	-	2,598
Optimisation in establishment - clinical	268	-	299	567	-	567
Optimisation in establishment - non clinical	1,730	-	140	1,870	30	1,900
Policy review	56	-	657	713	200	913
Process review	158	-	-	158	-	158
Procurement contracts review	525	70	-	595	-	595
Service Redesign	5	100	-	105	50	155
Supply Chain review	76	-	-	76	-	76
Travel and subsistence	46	45	-	91	-	91
Uniform review	147	-	-	147	-	147
Grand Total - current month	**7,901**	**496**	**1,121**	**9,517**	**280**	**9,797**
Last month	7,901	496	1,151	9,510	280	9,790
Movement	**0**	**0**	**(30)**	**7**	**0**	**7**

- As indicated in the table above, for the YTD month 7, ending October 2025, there has hardly been any movement in the efficiency schemes. We are still reporting a total of 74 efficiency schemes (excluding split schemes) totalling £9,797k (98%) in the Pipeline Tracker. The current shortfall compared to the planned target of £10,000k is £203k (2%).

- 64 (86%) templates valued at £9,264k out of the 74 total schemes have been completed, with 10 schemes (14%) mounting to £534k, are still outstanding since last month.
- Out of the 74 schemes,
    - 57 schemes totalling £7,902k are fully validated and have progressed to the delivery phase.
    - 9 “validated” schemes worth £496k and 5 "scoped" schemes worth £1,121k remain pending executive approval and/or QIA review before they can move to the delivery phase.
    - Additionally, 3 proposed schemes valued at £280k are under development.

Summary of YTD Efficiency Delivery Summary

2025-26 Efficiency Delivery Summary by Category

Scheme Category	YTD M07 Plan	YTD M07 Actuals	Variance		Full Year (FY) Plan	FY Forecast - Risk Adjusted Fully Validated	Variance	
	Total	Total	Total		Total	Total	Total	
	£000	£000	£000		£000	£000	£000	
Digital Productivity	204	239	35	✓	577	539	(38)	✗
Discretionary Non Pay	228	189	(39)	✗	500	456	(44)	✗
Estates and Facilities optimalisation	43	0	(43)	✗	96	0	(96)	✗
Fleet - Fuel: Bunkered Fuel & Price Differential	225	322	97	✓	385	552	167	✓
Fleet - Other Efficiencies	0	141	141	✓	0	377	377	✓
Income generation	121	58	(62)	✗	246	296	50	✓
Medicines Management - Consumables	35	0	(35)	✗	60	0	(60)	✗
Medicines Management - Drugs	22	39	17	✓	40	100	60	✓
Medicines Management - Equipment	60	145	85	✓	100	306	206	✓
Operations Efficiencies	2,011	602	(1,409)	✗	3,949	2,591	(1,358)	✗
Optimisation in establishment - clinical	175	189	14	✓	175	189	14	✓
Optimisation in establishment - non clinical	486	877	391	✓	986	1,565	579	✓
Policy review	450	56	(394)	✗	1,200	56	(1,144)	✗
Process review	42	79	37	✓	76	158	82	✓
Procurement contracts review	229	24	(205)	✗	929	100	(829)	✗
Service Redesign	92	3	(88)	✗	157	8	(149)	✗
Supply Chain review	0	35	35	✓	0	76	76	✓
Travel and subsistence	37	31	(7)	✗	144	46	(98)	✗
Uniform review	211	82	(129)	✗	381	147	(234)	✗
	4,670	3,113	(1,557)		10,000	7,561	(2,439)	
Recurrent v non-recurrent split								
Recurrent	2,953	1,247	(1,706)	(58%)	6,996	3,200	(3,796)	(54%)
Non-recurrent	1,717	1,866	149	9%	3,004	4,362	1,358	45%
Total	**4,670**	**3,113**	**(1,557)**	**(33%)**	**10,000**	**7,561**	**(2,439)**	**(24%)**

- As indicated in the table above, the Trust is reporting savings of £3,113k, which is one-third, or £1,557k, of the planned target of £4,670k. This means the Trust needs to achieve £6,887k (69%) in savings over the next five months to reach the overall target of £10,000k.

- The shortfall is primarily due to a combination of factors. This includes the timing of progress in moving schemes to the delivery phase; currently, 10 templates worth £534k are still outstanding. Other contributing factors include delays in implementing process changes, service redesigns, and updates to HR policies and terms and conditions. These issues have resulted in an underachievement in operational efficiencies amounting to £1,409k, a policy review shortfall of £394k, and a shortfall in service redesign of £88k.

- Additionally, procurement contract reviews fell short of the plan by £205k, largely due to the timing of negotiations and market forces. The anticipated reductions in uniform costs also proved to be overly optimistic, resulting in a shortfall of £103k.

- These shortfalls are partially offset by overachievements in other initiatives, notably non-recurring vacancy factor savings of £405k, favourable fleet fuel rate efficiencies of £239k, and clinical supplies savings of £67k.

- The YTD recurrent schemes have decreased from 44% last month and now represent £1,247k (40%) of the YTD total savings, while the planned figure was 63%. Consequently, non-recurring savings have increased by 23% and now make up 60% of the total savings.

- The risk-adjusted fully validated forecast remains at £7,561k out of £7,901k in fully validated total schemes on the Pipeline Tracker. This is £2,439k (24%) below the planned target of £10,000k. Mitigation strategies are in place to close this gap, which includes exploring additional initiatives and utilising non-recurrent budget underspends and balance sheet flexibilities.

- Our reliance on a higher proportion of non-recurrent savings, particularly from the vacancy factor and newly qualified paramedics (NQP) schemes, has caused recurrent savings to decrease from 44% last month to 42%, compared to a planned target of 70%. As a result, non-recurrent savings have risen by 28% to 58%, surpassing the planned figure of 30%.

- The overall risk rating for the program is amber. Schemes are assessed based on their risk levels, considering factors such as achievability, dependencies related to policy changes, the timeliness of adjustments to processes, and contract reviews.

- Additionally, 69% of the schemes are scheduled for delivery in the second half of the year, which may create challenges due to operational pressures during the winter months. The planned distribution of these savings for the next five months is as follows: 11% in November, 10% in December, and 37% in the fourth quarter.

- The Trust remains committed to achieving the underlying efficiency target of £10,000k to reach a breakeven position.

- The Productivity and Efficiency Team, along with Finance Business Partners (FBPs), is collaborating with the SMG leads to:
    - Develop and accelerate the identified initiatives, including completion of the outstanding 10 templates and the schemes agreed schemes established by the Joint Leadership Team in August, through the Executive Director/QIA, and into the delivery phases.
    - Promote sustainable initiatives and explore new opportunities to minimise risks, ensuring that each directorate meets its assigned targets to address any shortfalls.

- Regular updates on progress are provided to the SMG, Joint Leadership Team, and the Finance and Investment Committee.

5. Statement of Financial Position and Cash

	Year to October 2025			Forecast to March 2026		
	£000	£000	£000	£000	£000	£000
	Sep-25	Movt	Oct-25	Plan	Actual	Variance
Non-Current Assets						
Property, Plant and Equipment	97,045	(772)	96,273	115,554	116,225	671
Intangible Assets	1,486	(62)	1,424	915	1,107	192
Trade and Other Receivables	47	0	47	0	47	47
Total Non-Current Assets	**98,578**	**(834)**	**97,744**	**116,469**	**117,379**	**910**
Current Assets						
Inventories	3,439	11	3,450	3,088	3,415	327
Trade and Other Receivables	11,575	1,157	12,732	6,636	10,380	3,744
Asset Held for Sale	1,373	0	1,373	1,373	1,373	0
Cash and Cash Equivalents	29,340	(1,543)	27,797	30,427	26,985	(3,442)
Total Current Assets	**45,727**	**(375)**	**45,352**	**41,524**	**42,153**	**629**
Current Liabilities						
Trade and Other Payables	(34,177)	1,500	(32,677)	(37,227)	(31,287)	5,940
Provisions for Liabilities and Charges	(18,907)	0	(18,907)	(11,448)	(18,907)	(7,459)
Borrowings	(4,901)	(545)	(5,446)	(4,511)	(5,446)	(935)
Total Current Liabilities	**(57,985)**	**955**	**(57,030)**	**(53,186)**	**(55,640)**	**(2,454)**
Total Assets Less Current Liabilities	**86,320**	**(254)**	**86,066**	**104,807**	**103,892**	**(915)**
Non-Current Liabilities						
Provisions for Liabilities and Charges	(7,612)	93	(7,519)	(11,520)	(7,519)	4,001
Borrowings	(17,855)	481	(17,374)	(17,526)	(20,905)	(3,379)
Total Non-Current Liabilities	**(25,467)**	**574**	**(24,893)**	**(29,046)**	**(28,424)**	**622**
Total Assets Employed	**60,853**	**320**	**61,173**	**75,761**	**75,468**	**(293)**
Financed By Taxpayers Equity:						
Public dividend capital	109,889	0	109,889	121,022	121,611	589
Revaluation reserve	5,413	0	5,413	5,176	5,413	237
Income and expenditure reserve	(54,449)	320	(54,129)	(50,437)	(51,556)	(1,119)
Total Tax Payers' Equity	**60,853**	**320**	**61,173**	**75,761**	**75,468**	**(293)**

- Non-Current Assets decreased by £834k in the month arising mainly from £654k additions less £53k disposals and depreciation of £1,435k.

- Movement within Trade and other receivables is an increase of £1,157 that is driven by expected receipt for the ambulance growth funding, expected in November.

- As of 31 October 2025, the cash balance was £27,797k and is £94k below plan. Reduced capital spend is offset by delays in the anticipated receipt of growth funding.

- Trade and other payables decreased by £1,500k, mainly due to the reduction in general expenditure accruals, linked to improve payments to suppliers.
- Borrowings decreased by £64k overall, arising from lease payments.

- There has been no change to Public divided capital (PDC) that is used for funding non-current asset purchases.

- **Cash Flow:**

STATEMENT OF CASH FLOWS	MTH	YTD	Plan (YTD)	Var (YTD)
	£000	£000	£000	£000
Cash flows from operating activities	284	(2,484)	(1,956)	(528)
Non-cash or non-operating income and expense:				
Depreciation & Amortisation	1,483	10,427	10,851	(424)
(Increase)/decrease in receivables	(1,157)	1,846	(1,028)	2,874
(Increase)/decrease in inventories	(12)	(756)	(31)	(725)
Increase/(decrease) in trade and other payables	(1,845)	(5,652)	(535)	(5,117)
Increase/(decrease) in other liabilities	347	349	0	349
Increase/(decrease) in provisions	(93)	(278)	(2,811)	2,533
Net cash generated from / (used in) operations	**(994)**	**3,452**	**4,490**	**(1,038)**
Interest received	119	830	350	480
Interest paid	(50)	(282)	(343)	61
(Increase)/decrease in property, plant and equipment	(649)	(2,954)	(8,126)	5,172
Proceeds from sales of property, plant and equipment	(34)	16	0	16
Net cash generated from/(used in) investing activities	**(613)**	**(2,391)**	**(8,119)**	**5,728**
Increase/(decrease) in borrowings	65	(1,639)	(1,610)	(29)
PDC dividend (paid)/refunded	0	(652)	(630)	(22)
Net cash generated from/(used in) financing activities	**65**	**(2,291)**	**(2,240)**	**(51)**
Increase/(decrease) in cash and cash equivalents	(1,542)	(1,230)	(5,869)	4,639
Cash and cash equivalents at start of period	29,340	29,027	33,760	(4,733)
Cash and cash equivalents at end of period	**27,797**	**27,797**	**27,891**	**(94)**

- The above table shows the movement of cash flow in the month (MTH) and year to date (YTD).

- Better Payments Practice Code (BPPC) is a key financial best practice for the NHS, aiming to ensure timely payment to suppliers to pay at least 95% of all undisputed invoices on time. The Trust has improved its BPPC to above this target for both volume and value:

Better Payments Practice Code (BPPC)	Year to October 2025	
	No.	£000
Total bills paid in the year	9,390	54,936
Total bills paid within target	8,937	52,251
Percentage of bills paid within target	**95.2%**	**95.1%**

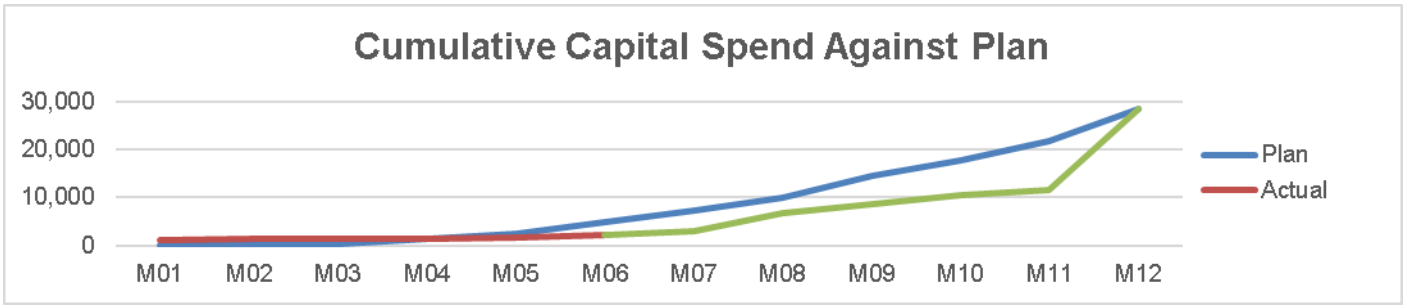
6. Capital

- The in-month capital spend is £645k. The in-month actual is £1,824k lower compared to the plan of £2,469k, mainly from delays in fleet purchases.

	In Month October 2025			Year to October 2025			Forecast to March 2026		
	£000	£000	£000	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
Original Plan									
Estates	600	50	550	2,050	494	1,556	3,800	3,800	0
Strategic Estates	0	39	(39)	0	(469)	469	0	(469)	469
IT	542	115	427	790	771	19	5,400	4,589	811
Fleet	17	362	(345)	1,415	1,372	43	1,500	2,629	(1,129)
Medical	0	0	0	0	839	(839)	374	1,364	(990)
Total Original Plan	**1,159**	**566**	**593**	**4,255**	**3,006**	**1,249**	**11,074**	**11,912**	**(838)**
PDC	**0**	**37**	**(37)**	**0**	**82**	**(82)**	**11,722**	**11,722**	**0**
CDEL Credit	**0**	**(45)**	**45**	**0**	**(2,164)**	**2,164**	**(1,400)**	**(4,014)**	**2,614**
Total Purchased Assets	**1,159**	**558**	**601**	**4,255**	**924**	**3,331**	**21,396**	**19,620**	**1,776**
Leased Assets									
Estates	20	34	(14)	380	(17)	397	900	837	63
Fleet	1,090	53	1,037	2,380	239	2,141	4,700	4,700	0
Specialist Ops	200	0	200	300	1,840	(1,540)	1,500	3,340	(1,840)
Total Leased Assets	**1,310**	**87**	**1,223**	**3,060**	**2,061**	**999**	**7,100**	**8,877**	**(1,777)**
Total Capital Plan	**2,469**	**645**	**1,824**	**7,315**	**2,985**	**4,330**	**28,496**	**28,496**	**(0)**

- The YTD spend is £2,885k, which is £4,330k less than the plan of £7,315k. This is due to the sale of vehicles to a lease company that were purchased by the Trust last year and which is causing a temporary underspend.

- The Trust is forecasting to spend its full capital allocation by the end of the year.



7. Risks and Opportunities

Table – Risk with rating

Risk ID	Risk Status	Risk Title	Current Rating
487	Active	Compliance with Health and Safety regulations and the Equality Act 2010	12
517	Active	Compliance with Procurement Regulations	9
587	Active	Paddock Wood Medical Distribution Centre Refurbishment (leaking roof)	9
639	Active	Legacy Pay Remediation	12
640	Active	Financial Plan	12
522	Active	Capturing accurate Procurement Contract Data	9
637	Active	Under committing capital resource	9
638	Active	Fraud	9
641	Active	Internal Controls	9
642	Active	Finance Team Capacity & Capability	9
524	Active	e-Procurement Platform	6
551	Active	Electric Vehicle Infastructure	6

- The table above shows those risks to achieving the finance department's objective that are linked to the organisation's ability to achieve its financial target.

- Potential opportunities for the year have been incorporated into the Trust's plan which mitigate risks identified.

South East Coast Ambulance Service
NHS Foundation Trust

Agenda No	95-25

Name of meeting	Trust Board
Date	4 December 2025
Name of paper	Finance & Investment Committee Assurance Report – 27 November 2025
Author	Suzanne O'Brien Independent Non-Executive Director – Committee Chair

INTRODUCTION

The Finance & Investment Committee is guided by a cycle of business that aligns with the Board Assurance Framework – strategic priorities; operating plan commitments; compliance; and risk. This assurance report provides an overview of the most recent meeting on 27 November 2025 and is one of the key sources that the Board relies on to inform its level of assurance. It is set out in the following way:

- **Assure**: where the committee is assured
- **Alert**: issues that requires the Board's specific attention and/or intervention
- **Advise**: items for the Board's information

ALERT

The committee reviewed the risk register and integrated quality report (IQR). As with the other committees the principal aim of this is to ensure the committee has good visibility of the key issues as part of its cycle of business. Overall, the committee remains assured with its alignment with the key risks.

Specifically, it considered and agreed the reduction of the **BAF Risk 640 (financial plan)** based on delivery of the plan to-date and confidence this will continue between now and year end, ~~following a bridge analysis~~. The committee noted this was despite being behind on the efficiency programme, which was likely to always be the case as discussed by the Board earlier in the year, but with the in-year mitigation being the associated non-recurrent measures that will close the gap, e.g. vacancy control.

Good assurance was also received on the risks related to the key estates project (Nexus House) and the committee has asked for this to be a standing assurance item through to completion.

The review of the IQR focussed on the metrics related to operational performance, in particular **H&T rates** where we have not made the progress in line with our trajectory. This is due to a combination of factors, such as recruitment and training.

Vehicle & Driver Safety / Driving Standards
The Board is asked to specifically note this, following the Board Story in February when the Board heard from the parents of Alice Clark who tragically died following a road traffic collision. The Board committed then to ensuring a focus on improving our driving safety standards.

There has been much work since then and the committee received a good level of assurance by the actions being taken including the support now in place for colleagues as part of the driver risk management system. The data shows the number of collisions recorded in 2025 is on a downward trajectory, and the lowest number since December 2023. Analysis is being done to analyse the times of day when collisions occur in order to help identify further opportunities of support and intervention.

The committee encouraged the executive to ensure the rich information available is disseminated more widely among colleagues.

ASSURE

Financial Performance Month 7 / Efficiencies & Productivity

At month 7 we are on track to deliver the breakeven financial plan. As stated earlier, delivering the efficiency programme is challenging but there is good confidence that the gap will be covered non recurrently. The Board is aware that this will add to the underlying deficit which will be picked up separately as part of the 3-year plan, to be discussed in Part 2.

Despite the plan being on track the committee explored some of the variances (overspends) and the finance team will review how this is presented from M8 to ensure clearer supporting narrative.

ADVISE

Estates Strategy

There was a helpful review of the draft estates strategy which will come to Board in February. There are three parts to the strategy – ensuring the team is fit for the future; approach to maintenance contracts; and our sites. The committee provided its feedback to inform the ongoing review including the need to understand the impact of our changed working relationship with SCAS. There are also some uncertainties to work through related to EV infrastructure. The Committee requested detailed business cases and a wider consultation with the other Directorates across SECAmb. It will undertake a further review in January.

Estates Performance / Business Case

The performance review undertaken confirmed good levels of statutory compliance, concluding low risk across the estate. However, the outcome of the review for Fire Risk Assessments concluded 'moderate risk', related to some outstanding risks surveys and work to correct some identified deficiencies with Fire Doors. There is an associated estates improvement business case that is recommended by the committee for Board approval (scheduled in part 2). This investment forms part of the overall capital plan agreed at the start of year.

The committee will keep close to this risk and the actions in place which aim to address all the key issues within the next three months. The committee felt this was a reasonable timeframe.

Digital Delivery

The Digital Transformation Work Programme (part of the BAF) is currently tracking green and progressing according to plan, including the work to strengthen our cyber maturity, which is a key BAF risk. The

committee welcomes the progress made, noting the importance of this to both improving patient outcomes and achieving financial sustainability.

Patient Monitoring (Defibs) Replacement Scheme
This is one of the priorities within the BAF and the procurement process and the potential devices are being clinically evaluated. The executive is confident this will be complete in time to purchase the required defibrillators by the end of the financial year as planned.

Recommendation
The Board is asked to use the information within this report to inform its overall view of assurance and where gaps are identified to seek further assurance from the executive in line with the Assurance Cycle