



**South East Coast  
Ambulance Service**  
NHS Foundation Trust



**Trust Board Meeting to be held in public**

**5 February 2026**

**10.00-13.00**

**Redhill Suite, Banstead MRC**

**Agenda**

Item No.	Time	Item	Paper	Purpose	Board Lead
<b>Board Administration &amp; Governance</b>					
97/25	10.00	Welcome and Apologies for absence	-	-	MW
98/25	10.01	Declarations of interest	-	To Note	MW
99/25	10.02	Minutes of the previous meeting: 4 December 2025	Y	Decision	MW
100/25	10.03	Matters arising (Action log)	Y	Decision	PL
101/25	10.05	Chair's Report	Y	Information	MW
102/25	10.10	Shadow Board Feedback	Y	Information	KN
103/25	10.30	Chief Executive's Report	Y	Information	SW
<b>Strategy &amp; Performance</b>					
104/25	10.45	Board Story	-	Framing	JA
<b>Strategic Aim: We are a Sustainable Partner as Part of an Integrated NHS</b>					
105/25		Supporting Papers: a) Board Assurance Framework b) Integrated Quality Report c) Month 9 Finance Report			
106/25	11.00	Volunteering & Community Resilience Strategy & Business Case	Y	Decision	JA
107/25	11.15	Finance & Investment Committee Report	Y	Assurance	SO
108/25	11.20	Estates Strategy	Y	Decision	SB
109/25	11.30	Business Cases: a) DCA Replacement b) GRS Migration	Y	Decision	SB
	11.35	Break			
110/25	11.45	Medium Term Plan 2026-29	Y	Decision	SB
111/25	11.55	Integration Committee	Y	Decision	PL
<b>Strategic Aim: We Deliver High Quality Care</b>					
112/25		Supporting Papers:			

		a) Board Assurance Framework b) Integrated Quality Report			
113/25	12.05	Quality & Patient Safety Committee Report	Y	Assurance	LS
114/25	12.25	Chief Paramedic Report	Y	Information	JL
<b>Strategic Aim: Our People Enjoy Working at SECamb</b>					
115/25		Supporting Papers: a) Board Assurance Framework b) Integrated Quality Report			
116/25	12.35	People Committee Assurance Report	Y	Assurance	MP
<b>Closing</b>					
117/25	12.55	Any other business			MW
After the meeting is closed any questions received <sup>1</sup> from members of the public / observers of the meeting will be addressed.					

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



Trust Board Meeting

4 December 2025

**Banstead MRC**

Minutes of the meeting, which was held in public.

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**Present:**

Michael Whitehouse	(MW)	Chair
Simon Weldon	(SW)	Chief Executive
David Ruiz-Celada	(DR)	Chief Strategy Officer
Jacqueline Lindridge	(JL)	Chief Paramedic Officer
Jen Allan	(JA)	Chief Operating Officer
Karen Norman	(KN)	Senior Independent Director
Liz Sharp	(LS)	Deputy Chair
Margaret Dalziel	(MD)	Chief Nursing Officer / Deputy Chief Executive
Max Puller	(MP)	Independent Non-Executive Director
Nick Roberts	(NR)	Chief Digital & Information Officer
Paul Brocklehurst	(PB)	Independent Non-Executive Director
Richard Quirk	(RQ)	Acting Chief Medical Officer
Sarah Wainwright	(SWa)	Chief People Officer
Simon Bell	(SB)	Chief Finance Officer

**In attendance:**

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

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**79/25 Welcome and Apologies for absence**

MW welcomed members, and those in attendance and observing.

The following apologies were noted:

Howard Goodbourn	(HG)	Independent Non-Executive Director
Mojgan Sani	(MS)	Independent Non-Executive Director
Peter Schild	(PS)	Independent Non-Executive Director
Subo Shanmuganathan	(SS)	Independent Non-Executive Director
Suzanne O'Brien	(SO)	Independent Non-Executive Director

**80/25 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.

**81/25 Minutes of the meeting held in public 02.10.2025**

The minutes were approved as a true and accurate record.

**82/25 Action Log [10.01-10.32]**

The progress made with outstanding actions was noted as confirmed in the Action Log and completed actions will now be removed.

**83/25 Chair's Report [10.32–10.08]**

MW summarised his report, setting the scene for today's meeting, and explaining the schedule of focus and emphasis on Our People.

He then reflected on a recent NHSP conference, where there was an inspiring presentation from the Secretary of State and a series of presentations on AI. These provided examples of how we can make a difference to clinical care and the Board will have time in early 2026 to explore the opportunities for how we take forward AI at SECamb.

There were no questions.

**84/25 Audit & Risk Committee Report [10.08–10.28]**

In HG's and PS's absence MW summarised the output of the last meeting, reflecting on the positive assurance from the reviews, in particular the medicines audit which received substantial assurance.

**EPRR Annual Assurance**

Jen then spoke to the separate paper providing the outputs of the annual assurance review, celebrating the ongoing improvement in compliance with a Substantially Compliant outcome. She noted the work of Lucas and the team. The paper also includes our broader resilience work and how we are integrating this function more within front line operations. The Board agreed that this is a strong position for SECamb to be in.

MW was pleased to note the joint work with SCAS and Isle of Wight.

PB asked about culture and how we are measuring this. JA responded that we do have a focus on improving culture and the plan was reviewed at People Committee last week; there is a comprehensive set of metrics and measures to ensure we are improving. This has demonstrated improved engagement e.g. Staff Survey, appraisals etc. and a indicator of staff feeling able to participate. More EPRR metrics are planned for the IQR to ensure these are more embedded in business as usual.

PB asked about our ability to respond under the worst case scenario and whether we understand the implications. SW confirmed that the Manchester recommendations is a national issue and related to funding not yet secured. NHSE is conducting a rapid review through the national ambulance resilience unit of the current bids to a recommendation is due in Spring as to how we could go further. SW suggested therefore that we need to await outcome of this. In the meantime, we remain concerned as a sector about this and have put on record the board support for the NHSE review. We will seek an update in Spring about their intentions to fund the recommendations.

**Action**

EPRR - The Board to return in Q1 to the Manchester Recommendations and the output of the NHSE rapid review due to report in the Spring, related to how to fund the recommendations.

PB asked about business continuity planning as an area slightly behind. JA confirmed we are in a much better position than we were and have made progress on the business continuity arrangements through the supply chain.

JL asked about training and strategic commanders and whether we have enough people who have access to the Gold training. Also, related to emergency capability training and the shortage not all in our control, how

are we escalating this. JA responded that we have six people on strategic command with two acting up. We are reshaping the on call arrangements, to launch in Q1. JA confirmed that we have sufficient resilience for the moment. We have escalated the training shortage and new dates are now published so this is addressed in the short term. Discussions are ongoing with the southern ambulance collaboration to review the best way of delivering this training in the future.

KN reflected on the discussion at Shadow Board yesterday about training and the general policy about abstracting staff. SWa explained that the idea is to have agreed abstraction rates, so staff do it in work time; they are not expected to do it in their own time. JA added that it depends on what training it is. There is a lack of clarity on what is part of trust funded training with some variation in rules in some departments, also there is some disparity about the training needed for the trust and what people would like to do. JL clarified that for this type of training it is expected to be trust funded as key to the role.

SW commented that we have a strong training and education offer and a proud tradition of supporting career pathways. We commit significant investment on an annual basis. We do need to debate what we can reasonably expect colleagues do to in their own time as part of their own personal development and what the core offer is. The education strategy will prompt this debate.

#### **85/25 Shadow Board Feedback [10.28–10.35]**

KN provided feedback from the meeting this week with the Shadow Board. It considered EPRR as discussed and also WRES DES and the volunteer strategy.

There was some experimentation with how we structure meetings and members felt this last meeting was the most effective. The Shadow Board values input from officers who present papers and answer questions, there was good discussion which brought the papers to life. The specific feedback includes:

- Colleagues enjoyed learning about EPRR
- They welcomed the development of the volunteer strategy; here training one of the issues raised and also a desire to create non patient facing voluntary roles. There was a suggestion about how to strengthen links with schools and how we increase accessibility of PADs.
- Good discussion about WRES DES and the Shadow Board is struck by the impact of our people who experience violence and aggression at work and how we might think more critically about our own experiences, being more consciously observant.

The Board reflected on this acknowledging on the issue with PADs that their support with these inequalities will be really helpful.

MW asked Shadow Board members observing if they had anything to add; they did not, reflecting that it was a good summary of the discussion.

#### **86/25 Chief Executive's Report [10.35–11.00]**

SW highlighted specific areas from his report.

Winter

- He thanked staff for their efforts, noting the impact of flu this year.
- This morning there was an item on the radio about 200k A&E attendances between November and February last year that could've been dealt with elsewhere; many of which will have called us. Complaints about sore throats and itching skins etc. We have a responsibility to deploy our resources wisely and for the public to use services wisely.
- NHSE launches today the national campaign for Winter '24 hours not in A&E' Giving advice about other routes to seek medical advice.

- More locally, we looked at EMB yesterday the pattern of demand and at the end of November there was a significant increase. We are looking at a range of actions to augment support over winter. And how we work collaboratively with SCAS. Reviewing what is driving the demand and with the system what more we can do.
- Also, at EMB we reviewed flu vaccination; more to do but we are ahead of trajectory compared with the same point last year.

#### Other things

- October marked black history month, and SW attended a session with MACCA and is pleased to hear from the Inspire Network today.
- It is disability history month, and the DES data is showing positive progress; staff feeding back positively about the work we are doing to ensure reasonable adjustments.
- SW reflected on the charity going from strength to strength.

#### Future

- The Group model provides opportunity to recognise strengths in both organisations.
- SW paid tribute to MW for his leadership in taking this forward to benefit our population in the South of England.
- Planning round allocations have been released and the ambulance sector has got a good deal. SECAmb will deliver on our commitments to further our strategy. There are opportunities to do as much as we can together with SCAS.

MW agreed the strategy is really key and guiding all we do. He then opened to questions.

PB asked what we can do to help people make the right choices about using our services. SW responded that we all have a responsibility and are thinking about this.

LS highlighted that Shani, our Chief Pharmacist, is the first in the ambulance service to receive a fellowship and the transformation she has led in medicines management is commended. She provides strong clinical leadership and led much improvement. SW agreed.

KN asked about the collaboration with SCAS and the key challenges. SW outlined the key benefits and areas of focus. The challenges include sequencing the opportunities and acknowledging the cultural differences.

MW is incredibly grateful to the executive team for all they are doing, there is so much going on and is impressed with the agility and commitment being shown.

#### **87/25 Board Story [11.01-11.30]**

Amjad Nazir, Chair of Inspire joined. MD introduced him and asked him to reflect on the work of the Network. Amjad took the Board through the slides.

MW thanked him for the presentation and supports what he said about understanding different backgrounds/faiths. Particular concern is about abuse from patients, and MW asked Amjad if certain communities would consider ambulance a career choice. Amjad responded that many don't associate the ambulance with the NHS but rather the emergency services e.g. police and fire and so we need to raise awareness we are the NHS.

MW asked if the Network is getting the support needed. Amjad confirmed it is, and the current focus is on structure and growing membership; he encouraged other board members to attend from time to time.

MW referred to the WRES data and asked Amjad for his view. Amjad responded that he is positive we are stabilising and moving now in a better direction.

SWa thanked Amjad and all those connected to Inspire for their work. She reinforced the commitment of the executive to ensure support to the Network Chairs that was put in place recently to protect their time.

MP encouraged us to explore opportunities for intersectionality with other networks. And to consider perspectives of the Shadow Board. On the Crawley case study, he wondered how we connect to the volunteer strategy and new charity. He then asked about the positive journey with WRES, and if it feels different to network members. Amjad confirmed the feedback is showing the improvement is being felt.

DR was concerned to hear that blue light is a barrier to inclusion, suggesting we reflect on this.

KN reflected on the abuse to staff, and asked if we are content we have sufficient support to those who experience this.

SW drew together the themes from this discussion. Network are at their best when they connect to other parts of the organisation, to MP's point. The experience of community engagement is important and it is clear we have some green shoots, some of our communities are feeling less safe so invites consideration of what our role is in communicating messages in those communities.

MW agreed we need an open debate and is concerned about the experiences of some of our people; they need to come to work feeling safe. Noting the discussion later on the agenda, he asked we return to this more frequently as successful organisations are those who recruit from all parts of society.

Break 11.30 – 11.40

#### **88-91/25      Our People Enjoy Working at SECamb**

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.

#### **89-25      People Committee [11.40-11.47]**

MP summarised the output of the most recent meeting drawing attention to the need for further assurance on the education quality intervention, which is underpinned by a robust plan. The committee had a number of inter connected discussions about organisational change, recognising the critical nature of change and is content we are broadly on track. There was also assurance on the bandwidth both in terms of delivery of the changes and being part of it, linked to the BAF risks.

MW is conscious of the pace of change and the ability of the trust to assimilate this. SW confirmed that the executive is constantly returning to this and we have a PMO structure that reports to EMB where we consider if we are overloading. We did this very recently and for Q4 we are in the right place. It is not easy and we have deferred things e.g. Integrated Care team restructure so as not to overload.

MP acknowledged that this was one of the assurances we received about sensible prioritisation across a joined up executive.

SWa added that to support the change we spent much time in pre engagement via workshops with colleagues and TUs. Are Strategic People Partners are agents of change and support each of the divisions and corporate services.

MW asked the executive for any further response to the outputs of the committee and to highlight anything from the IQR.

SWa noted the work on TU relationships and establishing a new resolution policy; this will start to shift the change in culture to informal resolution to grievances. There has been good engagement with the GMB Union in particular, given the recent challenges, and the regional GMB attended our joint leadership meeting yesterday, which was really positive.

JC then highlighted some of the more informal indicators of engagement, for example our Christmas Stars campaign; we have already exceeded nominations we got last year. Our first ever carol concert 'celebrating life' is upcoming with 230 colleagues due to attend. This all points to a measure of engagement we haven't seen before. JC can't confirm the Staff Survey response rate yet but did say we have exceeded last year's response; every one of the operational areas exceeds 60% which is really significant given the changes this past year.

MW thanked JC, as this is really important to reflect on and it is a step change. He thanked TUs for coming together in more a collaborative way.

SW thanked Katherine and Declan (regional reps at GMB) for sharing and listening so openly to experiences in the spirit of working towards better partnership working. These are an important part of the first steps. The Recognition Agreement is next. SW also thanked our other recognised TUs for their support to create good conditions for partnership working.

#### **90-25 EDI / WRES DES [11.47-12.13]**

SWa introduced this item, reflecting on the integrated leadership within the executive and noting this is a full Board responsibility. She then introduced Jacqui Skeel, Deputy Director of People & OD, who took the Board through the reports.

Jacqui provided a summary of WRES and DES data and described what we have done and plan to do over the coming year. There was specific focus on slide 6 in both WRES and DES which illustrates the key findings, which are broadly positive with many upward trajectories. When you dig into the data there is more to do in areas such as career progression and recruitment.

Other improvements re comms and governance were noted by the Board.

MD added as network sponsor that in meetings with staff over this past year she has seen a significant shift in support and conversations being had through the EDI team. It is positive to hear that we will be looking at the anti racism framework. MD then invited the Board to reflect on all the good work and how we can better describe this improvement journey as the narrative is not consistent in reflecting the improvements demonstrated by the data.

RQ supports Enable and has seen this grow in terms of clarity of objectives; the key message from Enable is to encourage people to declare disabilities so we can ensure the right adjustments can be made to improve their experiences.

MW asked about our approach in relation to the data about bullying. SW responded that the percentage of staff experiencing bullying from patients forces us to think and he asked the Shadow Board for its help, to come back in February with its views on what more we might do in response. The trend here is not good and if we are to support staff then we need to be clear what zero tolerance actually means. We need to send a message to the public that we will not tolerate abuse. We definitely can be more assertive in this regard and

need to support staff and take decisive action against perpetrators. SW suggested that we should start to think of this as a never event, to avoid it becoming normalised.

**Action**

In the context of the WRES data and trends re staff experiencing violence and aggression by the public, the Shadow Board to reflect on what more the trust might do in response.

**91-25 Integrated Education Strategy [12.13-12.23]**

JL set out the approach to the development of this ambitious 5-year strategy, aiming to strengthen the development of our people. She outlined the five themes that underpin the strategy, reinforcing that we intend to live the strategy and ensure flexibility to take advantage of opportunities that might arise through collaboration with SCAS. The road map highlights the ambition.

MW thanked JL for this excellent work. He asked if we have tested it with our people. JL confirmed we have and there has been good feedback.

RQ reflected on the learning culture section and the good work to create a culture where people feel safe to raise incidents and speak up. The next stage is how we spread the learning.

SW acknowledged how much effort has gone into this. The learning point RQ made links directly to our digital enablement; the strategy relies on different sets of capabilities.

KN felt that this really is the life blood of the organisation and will help unlock our ambitions to becoming an innovative organisation and improving all practices. Conceptually it is all there and is looking forward to our delivery.

PB thanked JL for this; it is also a timely strategy as it fits into the work on the clinical model and long term workforce strategy. JL added that the training needs analysis will be key to this to ensure we look into the future to identify the skills needed.

The Board approved the strategy.

**92-93/25 We Deliver High Quality Care [12.23-12.36]**

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. She highlighted virtual care which is Red RAG rated due to H&T rates. The key risk relates to training delays and workforce capacity. The committee reflected on the speed we tried to introduce this, which meant we haven't been able to support clinicians undertake virtual assessment, but there is a plan in place. LS also highlighted the EOC risk (quality summit); several improvement actions have been completed and the committee will continue to track progress. CQC inspected these areas last week so will be interested on its feedback.

JA responded on virtual care agreeing that we have not delivered the outcomes. The slightly better news is that we are starting to see an increase in clinical productivity through different actions, so some green shoots. The new training plan aims to address the risk LS referred to which was agreed at EMB yesterday.

On EOC leadership JA confirmed we had a check and challenge review to supplement the existing action plan and there has also been positive early feedback from CQC.

MD explained she will confirm CQC feedback in part 2. They attended two days across Medway and Crawley EOC and listened to hundreds of calls. Our people enjoyed their visits and the broad feedback is positive with no significant issues to escalate.

PB noted how much the trust strategy is dependent on the delivery of virtual care and so asked if we believe we have a coordinated plan. SW responded that there is much work ongoing to develop a model for the upcoming year that addresses the issue of scale; scale seems to equal improvement and so we are working through how we approach this. SW added that even if scale happens it won't succeed unless we agree what can be delivered in the community to defray demand away from ambulances to another pathway. We know our urgent care centres are stuck at 20% acceptance. The assumptions we can rely on will be key part of our planning discussions.

**Action**

Focus at the Board in April on the emerging model for Virtual Care and the plan for the year ahead

**94-95/25 Sustainable Partnerships [12.36-12.55]**

The BAF & IQR, and M7 Finance Report informed the discussion and questions in this section of the agenda, which were framed against the assurance provided by the Finance & Investment Committee (FIC).

SB summarised the output of the most recent meeting of FIC noting the reduction in the financial plan BAF risk, given confidence in delivery.

There was a good presentation on driver safety demonstrating a reduction in collisions from the improvement actions in place.

Fire risk assessments is an emerging issue of concern and a deeper review via the H&S group will be considered early in Q4.

MW asked if there are any concerns that could knock us off course in achieving the year end breakeven plan. SB did not think so; we have a plan which is deliverable across money performance quality and people. We have done much work on plan b, for example the mitigations with the under delivery of efficiencies through vacancy freeze and delaying NQPs. There is therefore much confidence in delivery. We have also improved our underlying deficit, so this is about trying to balance money and safe and effective services. Lastly, SB assured the Board there is flexibility in the plan to respond to winter challenges.

MW asked if we will start the next financial year weaker or stronger. SB confirmed definitely stronger. There are areas we can be more productive / efficient, and so this is positive as there are things to go at to further improve the underlying deficit over coming years. There are many reasons to be optimistic but SB warned it will not be easy.

JA agreed we in a strong position as a trust and sector as we are empowered to shift from hospital to community. We need to think carefully about how we hold ourselves to account to become more efficient which means we need to take difficult decisions, not always having more. Our role is also to support the wider system in specific care pathways.

SW added that our control environment is better; our audit position is better; and the finance team restructure is complete. He agrees we are in a stronger place. We need to consider how well integrated our plan is between clinical workforce capital etc. Planning is better but there is more to do to improve

integration. SB agreed. There is further to go and we now have the ability to match rotas to demand which were less able to do 2-3 years ago. We also have more certainty on capital to support fleet planning, for example.

JL noted the review of driver safety reflecting the discussion at Board in February with Alice Clark's parents.

MW asked about collaboration with SCAS on the CAD. DR confirmed there is plan for a joint platform to be reviewed at the executive to executive in January.

**96/25            AOB**

None.

**There being no further business, the Chair closed the meeting at 12.56**

PL confirmed there have been no questions from the Public.

Signed as a true and accurate record by the Chair:

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Date

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DRAFT

## South East Coast Ambulance Service NHS FT Trust Bc

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	C
04.12.2025	84 25	EPRR - The Board to return in Q1 to the Manchester Recommendations and the output of the NHSE rapid review due to report in the Spring, related to how to fund the recommendations.	JA	Q1	Board	IP
04.12.2025	90 25	In the context of the WRES data and trends re staff experiencing violence and aggression by the public, the Shadow Board to reflect on what more the trust might do in response.	KN	05.02.2025	Board	C
04.12.2025	93 25	Focus at the Board in April on the emerging model for Virtual Care and the plan for the year ahead	JA	02.04.2026	Board	IP

### Key

	Not yet due
	Due
	Overdue
	Closed

# Board 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. On agenda
On agenda



<b>Item No</b>	101-25
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<b>Name of meeting</b>	Trust Board
<b>Date</b>	05.02.2026
<b>Name of paper</b>	Chair Board Report
<b>Report Author</b>	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.

This meeting has a specific focus on our strategic aim: *Sustainable partner*. I am really pleased to see the volunteering and community resilience strategy. We were clear when establishing our trust strategy that volunteers have a key role. The Board in June heard from Helen Vine, AACE, following her review of volunteering which has informed this new strategy, and I thank Jen Allen and Danny Dixon in particular for their leadership in this. I am grateful to Sarah Holmes, Community First Responder, who has agreed to attend to provide her insights as part of the Board Story.

There are many challenges ahead for the NHS and therefore SECAmb to ensure we remain sustainable. Against this context, the Board has been determined to ensure we become more efficient and productive and so will be supporting the Operating Plan for 2026-27, which will be compliant from a quality, performance and financial perspective. The final draft plan will be considered more fully in Part 2 ahead of submission on 14 February.

**Collaboration / Group Model**

One of the many benefits of closer collaboration with SCAS, as part of the Group Model, is to create more opportunities to improve productivity and ensure better value for money. There are five key areas of integration both Boards have agreed to focus on over the coming year. The new Integration Committee that the Board is asked to formally establish will support the Board's

assurance that we delivery against these commitments. This will be a committee in common with SCAS.

The searches for a new Group Chair and CEO are going well. The interviews for the Chair are scheduled for 9 February, and we will be able to say more shortly after this, via our Council of Governors. I thank the COG for its ongoing effort and support with this. The CEO search is scheduled to conclude in March.

## **Board Appointments**

This will be Max's and Howards' last formal Board meeting. Both have made significant contributions to the Board and will be missed.

As part of the Board's succession plan, the COG has been working to find equally impressive people to help maintain the achievements of Max and Howard – these are both in the final stages and we will be able to make a formal announcement in the next week or so.

## **Council of Governors**

The Board is accountable to the COG, who represent trust members and the wider public. The meeting just before Christmas was very constructive. It acknowledged the amount of progress that has been made and in the areas of greater challenge the key focus included:

- Virtual care strategic priority and the particular challenges in achieving the level of hear and treat we had expected.
- Linked to this, a gap in assurance related to a strategic workforce plan; the COG understood some of the reasons and asked for greater certainty on the approach and timeline.
- Group Model and the transition risks with the change in leadership.

The Non-Executive Directors were able to find the right balance between providing assurance to governors, and being clear where there remain risks and how they are supporting the executive to manage these. I reinforce the point that while SECamb is in a strong position with a really effective executive team, there are a range of risks the Board is aware of, many of which we will touch on at the Board meeting.



	Item No	102-25
Name of meeting	<b>Trust Board</b>	
Date	5 February 2026	
Name of paper	Shadow Board	
Lead	Karen Norman, Shadow Board Chair	
<p>This paper follows the discussion at the Trust Board in December when it asked for the Shadow Board's views on violence, aggression, harassment and abuse towards staff.</p> <p>The Shadow Board undertook focused engagement with subject matter experts, reviewed relevant Trust data and policies and considered lived experience from operational and call handling environments. This work was guided by three questions:</p> <ul style="list-style-type: none"> <li>▪ What "zero tolerance" should mean in a healthcare context.</li> <li>▪ Whether current arrangements provide sufficient protection and assurance for staff.</li> <li>▪ Where the Trust Board should most urgently focus its attention.</li> </ul> <p>While the Shadow Board recognised the positive work which is underway in violence prevention, for example SECAmb's increased compliance at 93% of the national Violence Prevention and Reduction standard, it also identified gaps in assurance. In particular, the current history marking system was consistently highlighted as an area for improvement. Underreporting of incidents is also likely, limiting organisational visibility and confidence.</p> <p>The Shadow Board does not believe the Trust Board can currently be fully assured that staff are adequately protected from violence and aggression. This paper sets out focused findings and practical recommendations aimed at strengthening staff safety and improving Board level assurance.</p> <p>The Trust Board is asked to note the Shadow Board's findings and consider the priority areas for further action.</p>		
Recommendation	For discussion	

## **Trust Board Paper: Violence and aggression towards Staff**

### **Purpose and context**

This paper is presented in response to a Chief Executive request at the December 2025 Trust Board meeting, where the Shadow Board was invited to share its views on how the Trust can continue to strengthen its approach to preventing and responding to violence, aggression, harassment and abuse directed towards staff.

The Shadow Board has considered this through an assurance and improvement lens. The purpose of the paper is not to present solutions but to provide insight into how current arrangements are supporting staff safety, where further assurance would be helpful and how SECamb could build on existing good practice.

Specifically, this paper:

- Sets out the question posed to the Shadow Board.
- Describes the activity undertaken to inform the Shadow Board's response.
- Summarises key themes and learning.
- Identifies areas where further assurance would strengthen staff confidence.
- Offers recommendations for the Board's consideration.

While the Shadow Board is not representative of the entire workforce, it brings together a diverse range of perspectives. Members are well placed to contribute informed insight drawn from lived experience, subject matter expertise and system level understanding across operational, contact centre and wider organisational contexts.

### **The question posed to the Shadow Board**

At the December 2025 Trust Board meeting, the Chief Executive asked the Shadow Board to consider:

*How should the Trust appropriately and effectively tackle violence, aggression, harassment and abuse towards staff?*

In doing so, the Shadow Board was invited to explore three key areas:

- What “zero tolerance” should realistically mean in a healthcare context
- Whether current approaches provide appropriate protection and reassurance for staff
- Where the Trust Board may wish to focus its attention to have the greatest impact

This framework shaped both the evidence gathered and the discussions that followed.

## **How the Shadow Board approached the task**

The Shadow Board undertook a series of structured activities designed to bring together evidence from policy, practice and lived experience.

## **Evidence review and engagement**

The Shadow Board reviewed relevant Trust policies, performance information and Board level papers relating to violence and aggression. Consideration was given to both frontline operational environments and call handling contexts, recognising that risk and experience can differ across roles.

Alongside this, the Shadow Board focused on understanding how systems and processes operate in day-to-day practice, as well as how they function.

## **Subject matter expert input**

The Shadow Board heard from several subject matter experts, each offering insight into different aspects of staff safety and violence prevention:

- **David Monk, Security Manager**, shared learning on violence prevention measures, body worn camera deployment and partnership working with the police.
- **Vikky Lewis, Clinical Operations Manager**, provided an overview of the history marking system and its role in identifying risk.
- **Andrew Gordon, Head of Mental Health**, discussed mental health pathways and interagency working.

These discussions supported open and constructive exploration of current arrangements, including opportunities for further development.

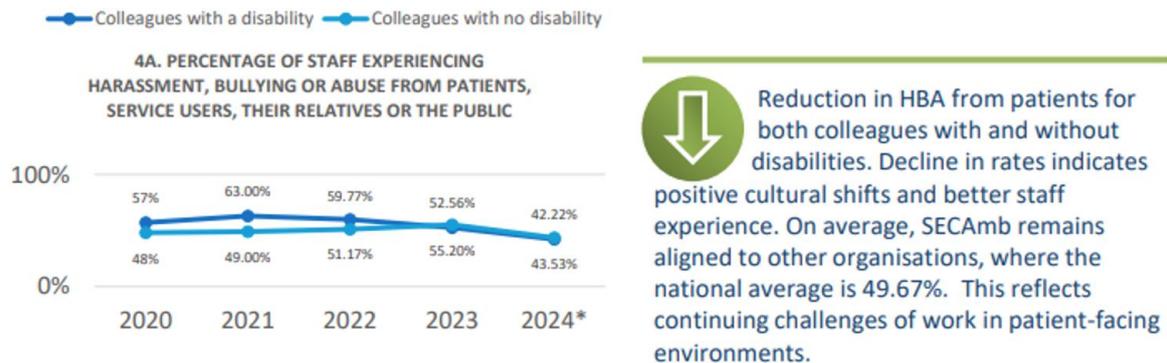
## **Shadow Board discussion**

A facilitated Shadow Board discussion brought together expert input with members' own experiences. The discussion explored staff confidence in reporting, the practical application of policies, interfaces between systems and how existing approaches are experienced by staff.

## Key themes and learning

### Scale of the issue and Board assurance

The Shadow Board noted that violence and abuse remain a reality for many healthcare workers. While there was a welcome downwards trend in 2024, the Shadow Board noted that over 42% of staff who responded to the NHS Staff Survey reported experiencing some form of abuse over the preceding 12-month period.



Source : David Monk's paper to People Committee, 29 January 2026

While incidents vary in severity, the Shadow Board agreed that all such experiences merit a clear organisational response and appropriate support for those affected.

Members reflected that incidents may go unreported, particularly where staff have become accustomed to challenging behaviour. This highlights the importance of continuing to promote the value and importance of reporting, and reassuring staff that they will be supported appropriately.

In the Shadow Board noted that elements of Violence and Aggression policies and procedures are currently overseen by three different Executives. Overall, the Shadow Board considered that there is an opportunity to strengthen Board level assurance by enhancing visibility of risk, controls and outcomes and bringing all elements together under a single Executive.

### History Marking: An opportunity for improvement

One of the most consistent themes related to the history marking system. Feedback from frontline experience and subject matter experts highlighted opportunities to further strengthen how risk information supports staff safety.

Areas identified for development included:

- Improved visibility where multiple risk factors are present (eg currently, only one marker can be shown on the MDT for operational crews).
- More detailed, actionable information provided to operational crews to support dynamic risk assessment.

- Standardised procedure to be followed by emergency operation centres (EOCs) and frontline staff when attending a patient with a known history of violence.
- Increase timeliness of marker application, through improvements to digital reporting processes.
- Reducing reliance on verbal relay (eg via AirWave radio) of critical safety information.
- The History Marking policy was first introduced 10 years ago and could benefit from a full review.

Importantly, these opportunities were openly acknowledged through expert input, reinforcing the Shadow Board’s view that there is shared understanding and an appetite for improvement. The Shadow Board considers this an area where focused and dedicated leadership from a member of the executive could deliver meaningful benefits for staff confidence and assurance.

### **Violence prevention: Building on strong foundations**

The Shadow Board welcomed the progress made in violence prevention, including improved alignment with national standards, expanded use of body worn video (BWV) and the delivery of conflict resolution training.

Members also identified opportunities to enhance the reach and impact of this work, including:

- Exploring regular refresher and tiered training approaches, particularly for newer staff.
- Considering how learning from BWV might be maximised within appropriate legal and governance frameworks – currently material from BWVs can only be shared with police to aid prosecution. It was noted that our call centres regularly review audio recordings of calls to aid learning and training.
- Developing a stronger evidence base to understand the key drivers of violence and aggression, supporting more targeted interventions and communications.

### **Mental health pathways, welfare checks and staff safety**

Discussions surfaced system-level challenges engaging with mental health services and other statutory partners. In some areas, attendance criteria mean specialist mental health teams (outside SECAMB) may be unable to respond when patients are intoxicated, distressed or have a history of violence, resulting in ambulance staff attending complex crises without specialist support. “Welfare checks” can be requested by external services with limited risk visibility for operational crews, increasing staff exposure to risk, as well as extending on-scene times.

The Shadow Board viewed this as a partnership opportunity to improve information sharing, clarify thresholds and shared responsibilities and ensure the right professional attends at the right time.

## **Conclusion**

The prevention and management of violence and aggression towards staff remains an important organisational focus. The Shadow Board recognises the positive progress already underway and the Trust Board's commitment to staff safety and wellbeing.

The evidence reviewed indicates clear opportunities to strengthen assurance through:

- Improved visibility of risk and outcomes.
- Targeted development of the history marking system.
- Enhanced capability and learning (including lawful BWV use cases).
- Clearer alignment of pathways at the interface with mental health and welfare responses and joint focus with partner agencies including police.

These areas present feasible, near-term improvements with focused leadership, partnership working and collective action.

## **Recommendations**

The Trust Board is asked to consider the following recommendations:

1. Bring all elements of Violence and Aggression together under one Executive to ensure appropriate focus and assurance.
2. Prioritise further development of the history marking system to support a more person-centred, detailed and timely approach to risk information recording and sharing.
3. Strengthen staff capability through refreshed and tiered conflict management training, particularly for newer colleagues, and continue engagement with our education partners on this topic.
4. Explore opportunities to support learning from body worn video footage within appropriate legal and governance controls.
5. Enhance reporting and feedback mechanisms so staff receive clear reassurance and support following incidents.
6. Agree a clear, practical definition of tolerance that supports consistent understanding, communication and action.
7. Work with partners to review mental health response and welfare pathways.
8. Improve risk information sharing, clarifying attendance criteria for mental health patients and reinforce shared responsibility so the right professional attends at the right time (eg a joint summit and work with mental health services and police).

# Violence and Aggression Towards Staff



South East Coast  
Ambulance Service  
NHS Foundation Trust



Shadow Board perspective

Philip Taylor, Paramedic

Hannah Sewell, Paramedic and Professional Standards Department

Anthony Walker-Banfield, Business Support Manager, 999 & 111

5th February 2026

# Purpose & Context



- Response to Chief Executive request
- Assurance and improvement lens
- Focus on staff protection and Board assurance



# The Question



*How should the Trust tackle violence, aggression,  
harassment and abuse towards staff?*

# Areas Explored



- Meaning of zero tolerance in healthcare
- Effectiveness of current protections and assurance
- Where Board focus has greatest impact



# Subject matter expert input



- Security and violence prevention
- History marking and risk identification
- Mental health pathways and partnership working



# Scale and assurance

- Nearly half of who responded to the NHS Staff Survey in 2024 reported abuse in 12 months
- Incidents vary: all require response and support
- Opportunity to strengthen Board-level assurance





# History Marking: opportunity

- Revise policy
- Improve visibility of multiple risks
- Provide clearer, actionable detail
- Increase timeliness of marker application and consistency of process
- Reduce reliance on verbal relay of risks



# Violence Prevention



## Current position

- Improved national standards compliance
- Expanded body worn camera use
- Conflict resolution training in place

## Future opportunities

- Tiered and refresher training
- Expanding use of body worn video footage
- Better evidence on drivers of violence



# Mental health and welfare pathways



- Complex interface with partner agencies
- Limited risk visibility for welfare checks
- Need for right professional, right time
- Mental Health model of care aiming to improve triage and appropriate access for patients



# Recommendations

- Bring all elements under a single Executive
- Develop and enhance the history marking system
- Strengthen staff capability
- Enable learning from body worn video footage
- Standardised procedures established for known violent patients
- Clarify Trust position on tolerance
- Review mental health and welfare pathway
- Improve risk information sharing among agencies



Item No	103-25
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Name of meeting	Trust Board
Date	5 February 2026
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 December 2025 and January 2026.
<b>A. Local Issues</b>	
2	<b>Bringing our Strategy to life</b> I would like to begin by thanking colleagues for delivering a strong performance through this winter period. While we remain in the grip of winter pressures, we are holding our position well and this is due to the sustained efforts of teams across the Trust and our system partners, whom I would also like to thank for their support.
3	Despite rising demand, performance through December and into early January has remained strong and represents a clear improvement on last winter. In December, Category 2 demand increased by 3%, yet the Category 2 mean response time improved by 3 minutes and 50 seconds. Category 1 response times also improved by 15 seconds, to 8 minutes 28 seconds, compared with 8 minutes 42 seconds in 2024. This was delivered alongside a 7.1% increase in Category 1 demand.
4	Virtual care has been a particular area of progress this winter. In December 2025, we saw this increase by 2.1% compared with last year. In line with our strategy, virtual care remains a clear focus for the Trust as we support patients safely through alternative pathways and protect frontline ambulance capacity for those requiring face-to-face care. My thanks to clinicians within the Trust and our partners for their continued focus and contribution to this progress.
5	In early January, the organisation operated at REAP Level 4 for a week. I would like to thank colleagues for their robust planning and clear leadership, ensuring services were maintained safely during a period of significant pressure.
6	Overall, while winter pressures remain a key focus, the organisation is in a stronger position than at the same point last year. And, despite being in one of our busiest periods operationally, I have been pleased to see the continuing strong focus on bringing our strategy to life through the ongoing delivery of a number of key programmes.

7	It's also been interesting to note the increasing intersectionality and overlap between strategic themes. Whilst this undoubtedly does add a level of complexity, it's also reassuring that there is synergy between areas and a level of cohesiveness that is moving us in the right direction.
8	A key area of focus that cuts across several areas of our strategy is increasing our virtual response and providing a differentiated physical response to our patients, which not only supports our strategic direction but also increases resilience and patient safety.
9	Ahead of the peak winter period, I was pleased that we were able to launch our 'Tortus' AI pilot to support clinicians working in our EOCs (see more below) and have been pleased to see the recent launch of the 'Virtual First' campaign, as well as work underway to improve the training and education available to virtual care clinicians.
10	We have also continued to move forwards with some of the key strategic enablers, including our new clinical operating model. During this period, we have concluded the operational leadership component of this programme, which although understandably unsettling for those involved, will set us up in the best way to progress with the model and the continuing evolution of our divisional structure.
11	Despite the challenging financial climate, we remain on track to deliver this year's plan and continue to make good progress on some key strategic investment choices. The procurement process to identify a new supplier for our defibrillator replacement programme – an important tool for our frontline clinicians – is almost complete and work to significantly improve our EOC, 111 and corporate facilities at Nexus House, Crawley continues at pace.
12	<p><b>Planning update</b></p> <p>Following the update in my last report on the national allocation of financial resources to the NHS, much work has been put in by teams across the Trust into our planning approach for the next financial year and we will be submitting our final plan in mid-February, following Board approval.</p>
13	<p>As required, the plan will be compliant with the national NHS Medium term Planning Framework in terms of:</p> <ul style="list-style-type: none"> <li>• improvement of Category 2 mean response to 18 minutes by 2028/29</li> <li>• achieving financial balance in each year</li> <li>• reducing the underlying deficit in three years</li> </ul>
14	These are stretching commitments for us to sign up to and achieving them will require us to move ahead at pace in delivering our strategy, including expanding our approach to virtual care, delivering the agreed 2026/27 efficiency programme with clear ownership, benefits tracking and contingency planning and increasing our use of emerging digital platforms.
15	<b>Executive Management Board</b>

	The Trust's Executive Management Board (EMB), which meets weekly, is a key part of the Trust's decision-making and governance processes.
16	<p>EMB consider a range of key issues during their meetings and important issues discussed during this period have included:</p> <ul style="list-style-type: none"> <li>• Preparations for and performance during the busy Christmas and new year period, recognising the significant pressures on the wider NHS system</li> <li>• Close review of our productivity and efficiency programme, as part of the wider planning process</li> <li>• The on-going collaboration with South Central Ambulance Service and reviewing progress in key areas, including digital and clinical operations, where teams are working together more closely</li> </ul>
17	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. Through these sessions, we have begun and are progressing the work to identify our key priorities for next year, ensuring that these are developed collaboratively.
18	<p><b>Meeting with GMB regional team</b></p> <p>On 3 December 2025, we were pleased to welcome Catherine Mathews and Declan MacIntyre from the regional team at the GMB union to one of our Joint Leadership Team meetings.</p>
19	In a first for the organisation, Catherine & Declan were able to share their perspectives on the challenges faced in the relationship between the GMB and the Trust, as well as listen to the experiences and views of our senior leaders.
20	The meeting was constructive, and I know attendees from both sides found it useful. It also marked an important step as we build new partnership arrangements with all our unions.
21	<p><b>Engagement</b></p> <p>I have been pleased to continue my programme of engagement with internal and external stakeholders during the past couple of months.</p>
22	Internally, my Connect with the Chief programme continued with a lively session at Tangmere on 20 January 2026, where it was good to hear directly from local colleagues on their challenges and issues. I have also met with both the Clinical Education and Critical Care Paramedic (CCP) teams during recent weeks, to hear about the issues that are important to them and how, as a leadership team, we can better support them.
23	Collaboration remains an important area of focus and a joint meeting with the SCAS Executive team on 14 January 2026, and a meeting of the CEOs and Chairs involved in the Southern Ambulance Services Collaboration (SASC) on 22 January 2026 continue to evolve these relationships.
24	Ensuring that SECAMB's perspective is shared nationally is an important part of my role. On 2 December 2025, I attend the NHS Providers Network meeting,

	which is an important strategic forum, and which provided a good opportunity to not only share our thoughts but also hear from NHS colleagues.
25	On 13 January 2026, I was pleased to host a visit to our Medway site from Ruth Rankine, Director of Primary Care and Neighbourhood Health and Ant Tucker, Senior Policy Lead for Community and Ambulance from the NHS Confederation and have the opportunity to discuss a range of issues with them including the collaboration with SCAS and the challenges we're facing currently, as well as opportunities on the horizon.
26	Ruth and Ant were also given a tour of the 111 and 999 Emergency Operations Centre, where they were able to see firsthand the levels of demand and complexity we face, and the ways in which our teams are constantly innovating and improving the quality of the services we provide.
27	<b>'Hearing Different Voices' – Shadow Board update</b> Our Shadow Board continues to go from strength to strength and have recently completed their fourth leaning module, which focused on finance. I understand that the session included a presentation from an external speaker, Lou Harris, the Finance Director of Crisis, on financial strategy, as well an update from Simon Bell on SECAMB's financial position.
28	Shadow Board members have also attended both the Finance Committee and the People Committee, supporting their broader organisational understanding.
29	I am pleased to hear that they are actively progressing my ask of them from our last Trust Board meeting around violence and aggression towards staff and very much look forward to hearing their findings and perspectives at the Board meeting.
30	I am also delighted to learn that we will hear the Shadow Board update directly from members at the Board meeting, rather than from the Chair on their behalf. This marks a real step forward in the growing confidence and maturity of the Shadow Board.
31	Finally, I am extremely pleased that we will be sharing the development of our Shadow Board at the national Ambulance Leadership Forum in March of this year, where sector colleagues will hear directly from Shadow Board members on their experiences so far, as well as from other colleagues on the benefits they feel the Shadow Board brings to the organization.
32	This is a fantastic opportunity for us to showcase our Shadow Board and highlight the positive impact it is making across a number of levels.
33	<b>Equality, Diversity &amp; Inclusion Awareness</b> I am pleased to report continuing strong momentum across our EDI agenda. With global tensions and intolerance never far from the news, I was encouraged to see our communications mark Hanukkah and Holocaust Memorial Day with a clear message of inclusion and opposition to antisemitism.

34	I am also pleased to see the practical support continuing through our staff networks, carers' cafés, neurodiversity sessions, leadership opportunities and work on a crisis pathway for veterans.
35	In parallel, NHS 111 has embedded a new EDI patient insight adjustment into routine reporting, enabling monthly analysis of patient experience by ethnicity so that emerging trends can be identified and acted upon earlier. It is also pleasing to note that this is already providing assurance that experience is tracking consistently across user groups.
36	<p><b>First ever 'Celebration of Life' service</b></p> <p>On 8 December 2025, the Trust held its first Celebration of Life service at St Nicholas Church, Sevenoaks, which brought together more than 200 patients, colleagues and local residents. Despite being unable to attend myself, I understand it was a great success.</p>
37	Patient Giles Phillips shared his story of surviving a life-threatening aortic dissection, before the audience of colleagues and patients - a powerful reminder of the difference our people make every day.
38	Our very own SECamb Choir – the Soundwaves Choir - gave its first live performance and pupils from Sevenoaks Prep School joined the congregation, strengthening our connection with the communities we serve. My thanks to all colleagues and partners who made the event so meaningful.
39	<p><b>Alice Clark honoured with national award</b></p> <p>I am very pleased to share that our colleague, the late Paramedic Alice Clark, has been recognised nationally with the Elizabeth Emblem, a national honour from His Majesty the King, for public servants who lose their lives in the line of duty.</p>
40	As you will be aware, Alice, tragically died in 2022 aged just 21. She was among 53 individuals recognised in the latest honours list, with her parents, Gill and Graeme to formally receive the award later this year, following an initial visit recently to Downing Street to meet the Chief Secretary to the Prime Minister.
41	Alice's compassion, courage and service continue to inspire us, and I know the Board will join me in recognising the significance of this honour for her family and for Alice.
42	<p><b>Brighton Marathon</b></p> <p>I would like to thank everyone who has donated or sent kind messages to support me in my fundraising for our SECamb Charity. Your support is helping me to stay motivated during the winter training period!</p>
43	As I continue my training programme ahead of the Marathon on 12 April, I remain absolutely committed to the challenge and continue to be motivated by the real dedication of SECamb staff and volunteers, alongside the big impact that I know charitable support can make for our patients, our communities and our staff.
<b>B. Regional Issues</b>	

44	<p><b>Collaboration with South Central Ambulance Service (SCAS)</b> Following the approval by the Board of our move to a Group model with SCAS, we are continuing to progress our collaboration programme by moving into the next phase of the transition.</p>
45	<p>The next key steps are the appointments of the Group Chair and Group CEO, which are progressing during February and March, and we will be making the appropriate announcements in due course.</p>
46	<p>We are working on our joint programme of work for the year ahead and we have continued to meet with our SCAS Executive colleagues to develop our emerging group priorities. We expect to be able to share those by the end of March as we move into the next financial year.</p>
47	<p>I am also pleased to report that we have been continuing to provide mutual support to our partners through the winter period to ensure we have a more resilient and safe service for patients overall, across our call-handling, physical response, and support services.</p>
48	<p><b>Artificial Intelligence (AI) Pilot in Emergency Operations Centres (EOCs)</b> I am pleased that our AI pilot, with ‘Tortus’ ambient voice transcription in our EOCs, is now underway. The new tool uses ambient voice transcription to listen to and digitally transcribe their conversations with patients, automatically transforming their spoken words into structured medical notes.</p>
49	<p>While the notes must then be checked and approved by the clinician, time spent writing up notes following the call is expected to reduce, meaning less time spent on administrative and enabling greater focus on patient care.</p>
50	<p>The pilot runs until February 2026 and sits alongside wider ambulance sector testing; we will evaluate impact on documentation quality, time saved and user experience before considering next steps.</p>
51	<p>This is a clear enabler for delivering our strategy and I’m sure the Board will be interested in its finding in due course.</p>
<b>C. National Issues</b>	
52	<p><b>BBC NHS Winter Pressures Coverage – Kent and Medway</b> I was proud to see our services featured as part of the BBC’s National NHS Winter Pressures Day on 22 January 2026. Coverage from East EOC highlighted the clinical decision making that supports safe triage during very high demand, with early January averaging over 3,000 calls per day.</p>
53	<p>The BBC also followed a full patient journey through our Ashford Unscheduled Care Navigation Hub, demonstrating how Hospital at Home and specialist input help avoid unnecessary admissions. At Medway Maritime Hospital, our ambulance handovers were showcased as among the strongest nationally, despite sustained daily increases.</p>

54	This is a testament to strong collaboration with our acute partners and the relentless efforts of our teams.
55	<p><b>NHS 111 National Campaign – ‘24 Hours Not in A&amp;E’</b></p> <p>I am also delighted that SECamb features prominently in NHS England’s new ‘24 Hours Not in A&amp;E’ campaign, which encourages the public to use the full range of urgent care options.</p>
56	Our own Natalie Randall, NHS 111 Paramedic and Clinical Advisor, plays a leading role in the film, illustrating how NHS 111, the NHS App, community pharmacies and GP services provide timely, appropriate care while easing pressure on emergency departments.
57	Natalie’s involvement reflects the calibre of our NHS 111 colleagues and their contribution to national resilience this winter.



South East Coast  
Ambulance Service  
NHS Foundation Trust



# Board Assurance Framework

2025/2026

February 2026



# Contents:

- + Our Strategy 2024 – 2029
- + How our Board Assurance Framework Works
- + We are a Sustainable Partner
  - Executive Assurance Summary
  - BAF Objectives in line with Strategy Plan
  - Progress Highlight Reports on Programmes
  - BAF Risks



# 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**



South East Coast Ambulance Service NHS Foundation Trust

**Saving Lives, Serving Our Communities**

**Our Trust Strategy 2024 - 2029**

South East Coast Ambulance Service NHS Foundation Trust

**Our Improvement Journey**

**COC Inspection June 2022**  
 In 2022 SECAmb was inspected by the COC and we were found to require improvements in board effectiveness and connectivity to frontline services, governance and culture. The quality of care provided for our people was deemed to be good.

**Trust Strategy 2017-2022**  
 Through the previous strategy cycle, the Trust delivered a number of key programmes, including a new Mobile Ready Centre at Bursfield and Brighton, and a multi-million pound centre at Medway housing 999, 111 and text operations.

**Having an impact through improvement**  
 We started an improvement journey which was focused on four core pillars:

- Delivering Quality Improvements
- Providing Responsive Care for our People
- Improving the Culture for our People
- Delivering sustainable services in partnership.

**Shaping our future together**  
 In 2023 the Board began the process to start shaping the new direction for the Trust. The principles for the development of the strategy were agreed with our Council of Governors and were based on delivering a clinically led strategy.

**Saving Lives & Serving Our Communities**  
 After extensive engagement, the new strategy was presented to the Trust Board in June 2024. This marks the start of a transformational journey that will build on the strengths and improvement achieved between 2022 and 2024, and will deliver a truly clinical model that will better serve the needs of our patients and communities in the future.

Since the start of our Improvement Journey, we have delivered significant improvements across all domains:

- Implemented trust-wide quality improvement methodologies to empower our people to drive change and drive patient safety by working with partners to keep patients safe while they wait for an ambulance response.
- Improved our culture and psychological safety for our people, having seen the biggest improvements nationally in freedom to speak up about issues in our staff survey, as well as improvements across every other domain.
- Improved the responsiveness of our services, delivering under 20 minutes for Category 2 response times against a 30 minute target.
- Established strong partnership working with our systems and other providers, including implementation of clinical alerts to improve decision making, patient safety, and system flow.

Our new service model will modernise how we care for our patients.

We will do this through:

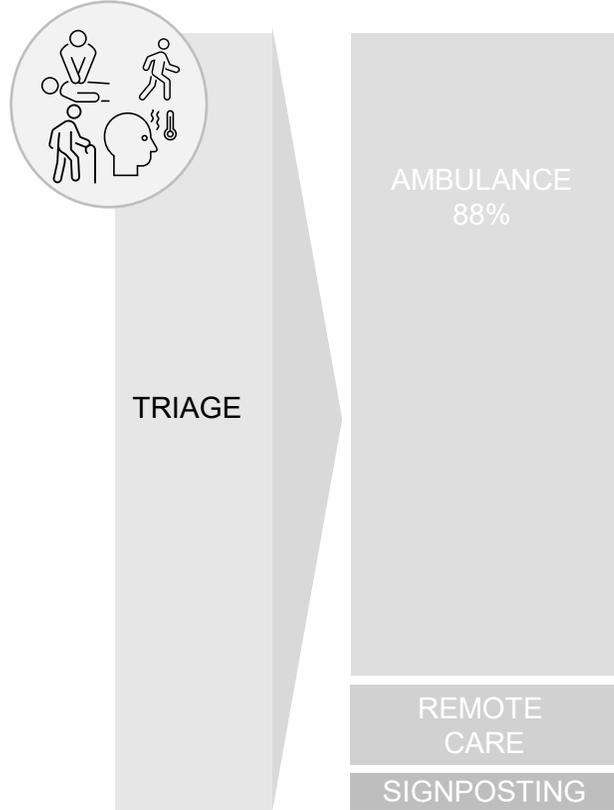
- Fast & accurate triage:** We will improve our triage with the support of artificial intelligence to ensure we apply and respond to severity patients who need a fast physical response.
- Faster dispatch of resources:** We will use digital solutions to optimise how we deploy our ambulances to ensure our emergency patients are seen quickly.
- Timely care for emergency patients:** We will support our people to deliver the highest possible quality of care and a fast response to our emergency patients.
- Virtual care for non-emergency patients:** For patients who have a non-emergency condition, they will receive a virtual video or audio assessment from a clinician. This clinical assessment will enable patients to be cared for directly or seamlessly referred to the most appropriate care provider.
- Connecting patients to the right care:** Following initial assessment, patients whose conditions do not require an ambulance will be seamlessly directed to appropriate health services or agencies. This ensures that every patient receives the right level of care, optimising resource use and patient outcomes.

We are transitioning from a predominantly ambulance-based response model to a more differentiated approach, where the type of response is tailored to the individual needs of the patient.

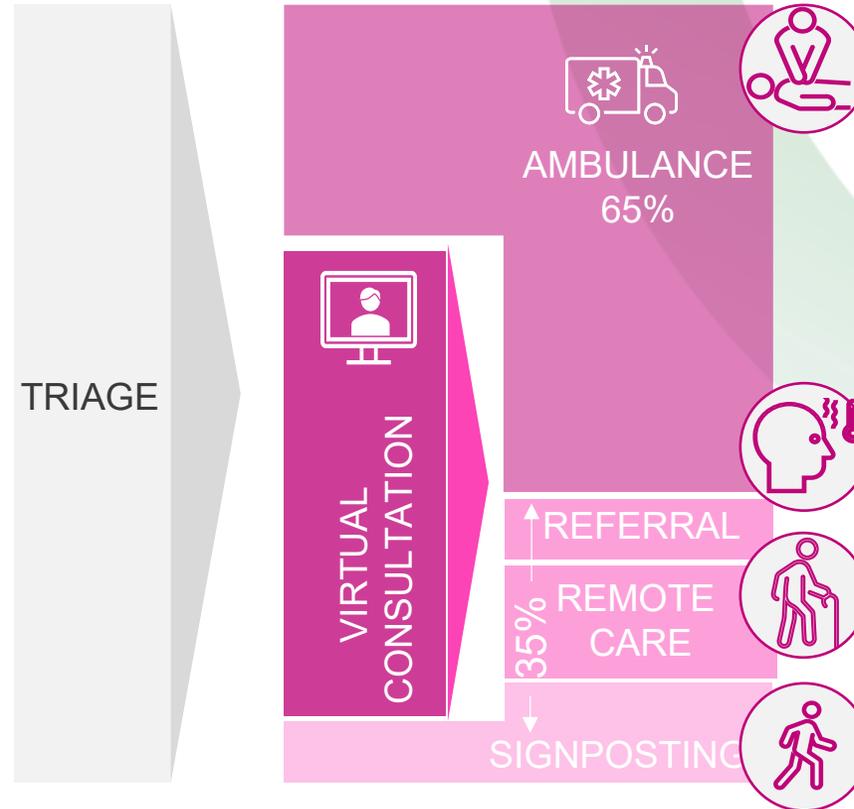
By ensuring we play a full part as a system partner, we can ensure that patients receive the most appropriate form of care for their condition, prevent unnecessary admissions to Emergency Departments and that care is provided in the community where possible.

# Our Strategy 2024-2029

**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.

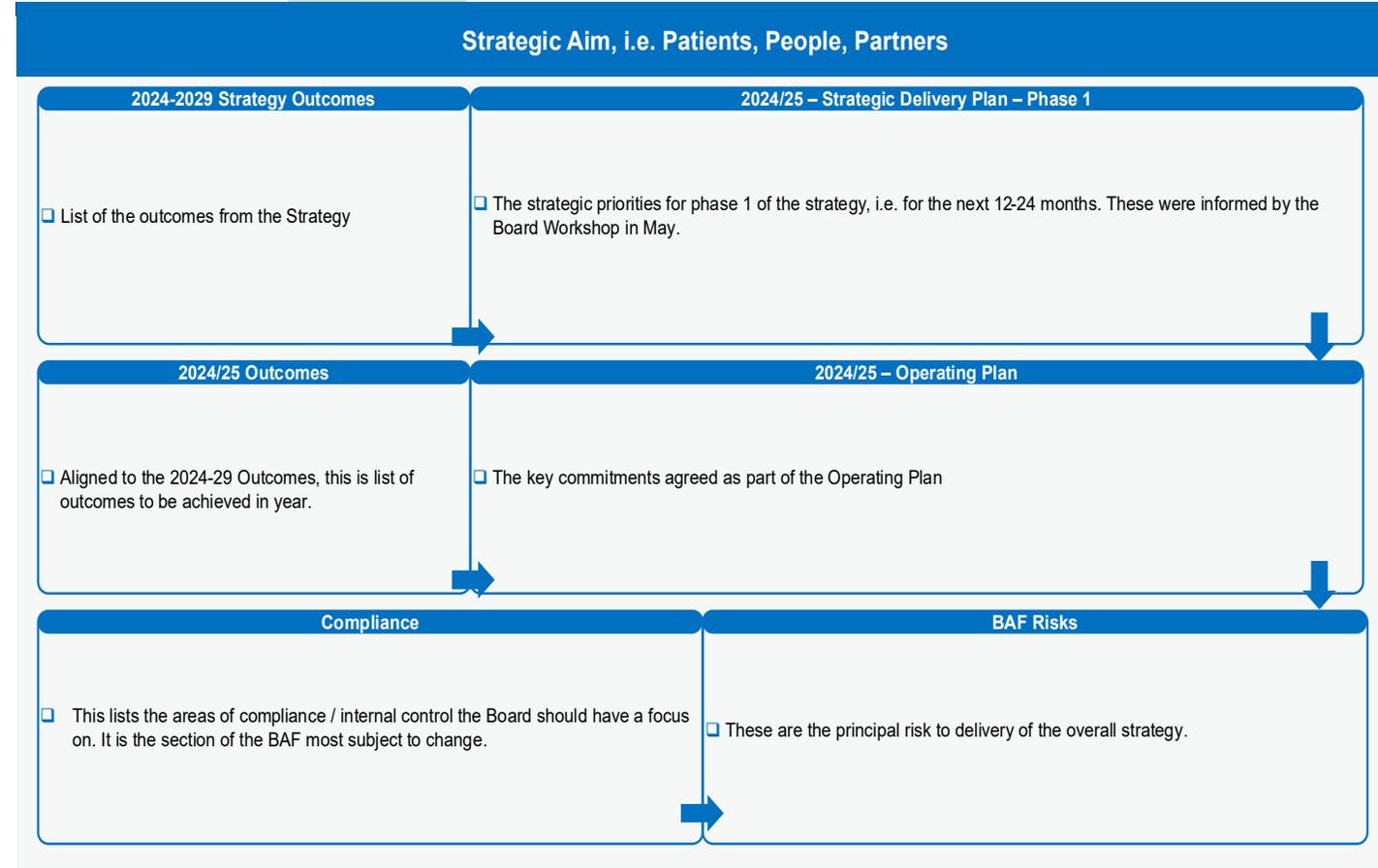


# How our Board Assurance Framework (BAF) Works



# 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



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

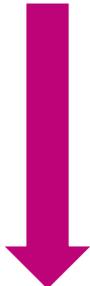
  

2024/25 – Operating Plan						BAF Risks			
Initiative	Sub-Initiative (if required)	Current RAG	Previous RAG	Oversight Committee	Date last reviewed at Committee	Risk Detail	Risk Score	Target Score	Owner
Operational performance plan						There is an ongoing, multi-year risk that the financial environment for the NHS prevents local commissioners from supporting our clinical strategy	20	04	SP&T
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					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
Deliver 2 Clinical QI priorities	Safety in the Waiting List IFTs								



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*



*Exception reporting will be provided as required following committee oversight*



*Each of our BAF Risks has a detailed risk page*

BAF Risk 537 – Funding			
<b>There is an ongoing, multi-year risk that the financial environment for the NHS prevents local commissioners from supporting our clinical strategy</b>			
<b>Controls, assurance and gaps</b>	Accountable Director	Strategic Planning and Transformation	
<b>Controls:</b> 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.	Committee	Finance and Investment Committee	
<b>Gaps in control:</b> 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.	Initial risk score	Consequence 5 X Likelihood 4 = 20	
<b>Positive sources of assurance:</b> 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 SEC&Amb 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.	Current Risk Score	Consequence 5 X Likelihood 4 = 20	
<b>Negative sources of assurance:</b> 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 SEC&Amb to financial sustainability.	Target risk score	Consequence 4 X Likelihood 1 = 04	
<b>Gaps in assurance:</b> 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.	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.

We are a sustainable partner as part of an integrated NHS



# We Are a Sustainable Partner

# We are a sustainable partner as part of an integrated NHS

## 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

- ❑ Health & 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 CW1 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 <b>digital initiatives</b> , 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	Jan 2026
	Deliver £10m efficiencies & eq. £10.5m productivity				SMG	No	FIC	Jan 2026
Implement H&S improvement plan to progress Trust to Level 4 of maturity by Q2				Chief Nursing Officer	EMB	No	PC	Jan 2026
Monitor System Led Productivity Schemes - improving alternatives to ED and reducing hospital handovers				Chief Operating Officer	SMG	No	FIC	Jan 2026
Deliver Strategic Estates Review	Creation of Joint 111/999 Centre			Chief Finance Officer	SMG	Yes	FIC	Jan 2026
	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	49 Nov 2025

## BAF Risks

Risk Detail	Risk Score	Target Score	Owner
<b>Collaboration:</b> 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
<b>Financial Plan:</b> 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
<b>System Productivity:</b> 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
<b>Cyber Resilience:</b> 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
<b>Digital Capacity, Capability &amp; Investment:</b> 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	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	Green	Green	Chief Nursing Officer	People Finance	Jan 2026 Jan 2025	<p>Overall, the committee has a reasonable level of assurance with our H&amp;S compliance. The internal H&amp;S review demonstrated that H&amp;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.</p> <p>The finance committee expressed some concern about fire safety (see Dec 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.</p>
Vehicle & Driver Safety / Driving Standards	Green	Green	Chief Strategy Officer	Finance	Nov 2025	As per the Dec committee report to Board, it is assured with the focus and progress being made to improve safety.
Data Security / Cyber Assurance Framework	Yellow	Yellow	CDIO	Audit & Risk	Nov 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.

<h1>Digital Portfolio Context</h1> <p>Strategic overview for Portfolio</p>	<b>Exec. Sponsor:</b>	Nick Roberts
	<b>PM:</b>	Reeta Hosein
	<b>Last updated:</b>	19 <sup>th</sup> Sept 2025 – reviewed 21st Jan 26

## 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

## Programme Summary for Executive Management Board

Exec. Sponsor:	Nick Roberts
PM:	Reeta Hosein
Last updated:	19/01/26

**Headline Summary:**  
 This report has been reviewed and updated post presentation to EMB on the 7th January. The Digital Transformation Work Programme remains on track, with all major streams progressing according to plan and the overall portfolio status rated green. Key approvals since last update Infrastructure and GRS Business cases at BCRG and EMB. No material exceptions or delivery risks have been identified at this stage, and the programme continues to operate within its approved financial boundaries.

Programme Status	Previous RAG	Current RAG	Impact on Outcomes
			The pending digital restructure may negatively affect productivity and hinder progress.

Programme Headlines	Risks	Critical Milestones												
<p><b>Tortus:</b> There were initially mixed views about the product's accuracy. However, this has since been resolved by conducting a review of a call from one of the users who had raised concerns - showed that the user had misremembered the conversation, while TORTUS had recorded it correctly.</p> <p><b>Data Engineer PM:</b> A number of interviews have been scheduled with the view to support the Data and AI workstream.</p> <p><b>Data Engineer: Privilege Access Management (PAM):</b> Communications were issued on 30/12/2025, and critical users have been onboarded. Non-critical users will be added as required, with a defined process in place to manage onboarding. Now focusing on any outstanding issues, communication with vendors,</p>	<table border="1"> <thead> <tr> <th>Risk</th> <th>C</th> <th>T</th> <th>Control</th> </tr> </thead> <tbody> <tr> <td> <b>Cyber Resilience – ID 544</b>            There is a risk that a major cyber security incident exploits existing system vulnerabilities         </td> <td style="background-color: red; color: white; text-align: center;">16</td> <td style="background-color: yellow; text-align: center;">12</td> <td>Comprehensive cyber maturity assessment begun to define further interventions to reduce risk; target will only be met once all measures are complete.</td> </tr> <tr> <td> <b>Digital Capacity, Capability &amp; Investment – ID I650</b>            There is a risk that the organisation cannot facilitate necessary digital development and integration         </td> <td style="background-color: yellow; text-align: center;">12</td> <td style="background-color: yellow; text-align: center;">8</td> <td>Ongoing refinement of the Digital Programme ensures effective resource planning.. External expertise is engaged as needed, with business cases approved to support delivery.</td> </tr> </tbody> </table>	Risk	C	T	Control	<b>Cyber Resilience – ID 544</b> There is a risk that a major cyber security incident exploits existing system vulnerabilities	16	12	Comprehensive cyber maturity assessment begun to define further interventions to reduce risk; target will only be met once all measures are complete.	<b>Digital Capacity, Capability &amp; Investment – ID I650</b> There is a risk that the organisation cannot facilitate necessary digital development and integration	12	8	Ongoing refinement of the Digital Programme ensures effective resource planning.. External expertise is engaged as needed, with business cases approved to support delivery.	<ul style="list-style-type: none"> <li>Infrastructure &amp; GRS business cases reviewed at (BCRG – Dec 25 &amp; EMB Jan 26).</li> <li>GRS Cloud requires Trust Board for approval due to value 5th February 26.</li> <li>A Data Architect has been appointed to Support Data &amp; AI Workstream - 19th January 2026..</li> <li>GPConnect Cleric development is scheduled for completion in January, With testing to follow prior to implementation.</li> <li>Cyber Security Submission of the Cyber Security Operations Centre (CSOC)/Security Information and Event Monitoring (SIEM) Service Business Case for SASC Approval by end of January 2026.</li> <li>Completion of the Cyber Security Maturity Assessment by end of January 2026.</li> </ul>
Risk	C	T	Control											
<b>Cyber Resilience – ID 544</b> There is a risk that a major cyber security incident exploits existing system vulnerabilities	16	12	Comprehensive cyber maturity assessment begun to define further interventions to reduce risk; target will only be met once all measures are complete.											
<b>Digital Capacity, Capability &amp; Investment – ID I650</b> There is a risk that the organisation cannot facilitate necessary digital development and integration	12	8	Ongoing refinement of the Digital Programme ensures effective resource planning.. External expertise is engaged as needed, with business cases approved to support delivery.											

Key developments since last report	Board Oversight	Board Decisions								
<p><b>Business Cases:</b> Infrastructure and GRS – went through the BCRG and EMB. GRS Cloud approved at EMB – to Trust Board for approval due to value.</p> <p><b>GPConnect (NCRS)-</b> Option 1 – Multi-Factor Authentication (MS Authenticator) has been agreed and approved by Nick Roberts and Jen Allan.</p> <p><b>Capital Expenditure:</b> Ongoing collaboration with Finance to ensure greater assurance on budget versus actual spend, along with forecasting through to the end of the financial year. Report reviewed at FIC 22nd January 26.</p>	<p>We maintain close collaboration with Finance to track invoices, monitor payments, and address outstanding amounts, ensuring accurate reconciliation and strong financial governance. Capital expenditure is on track to spend fully.</p> <p>The Digital Senior Leadership team review high-level risks regularly to confirm that controls and mitigations are in place, tracked, and adjusted as needed to safeguard delivery and compliance.</p>	<table border="1"> <tr> <td>Alert</td> <td></td> </tr> <tr> <td>Advise</td> <td></td> </tr> <tr> <td>Approve</td> <td>Infrastructure and GRS Business Cases</td> </tr> <tr> <td>EMB Outcome</td> <td>Take the GRS Business case to Trust Board for approval to the value. Next update: GPConnect &amp; Tortus</td> </tr> </table>	Alert		Advise		Approve	Infrastructure and GRS Business Cases	EMB Outcome	Take the GRS Business case to Trust Board for approval to the value. Next update: GPConnect & Tortus
Alert										
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Approve	Infrastructure and GRS Business Cases									
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<b>Collaboration &amp; Partnerships Portfolio – Executive Summary</b>	<b>Exec. Sponsor:</b>	David Ruiz-Celada
	<b>PM:</b>	Claire Webster
	<b>Last updated:</b>	January 2026

**Headline Summary:**  
The Collaboration and Partnerships Programme continues to make good progress and is rated Green on the RAG status. The programme has entered the Transition Phase and to ensure successful execution during the phase, adequate funding and resourcing are critical. This includes targeted investment and robust planning to maintain leadership stability across the Trusts. Time-critical investment decisions must be made within the required opportunity windows to avoid delays and realisation of programme outcomes.

<b>Programme Outcomes</b>	<b>Previous RAG</b>	<b>Current RAG</b>
Enhanced patient outcomes through collaboration to ensure high-performing, sustainable services in the short, medium and long-term.	Green	Green

<b>Programme Headlines</b>	<b>Risk</b>	<b>C</b>	<b>T</b>	<b>Control</b>	<b>Critical Milestones</b>
<p><b>Leadership Recruitment:</b> The recruitment process has commenced for the Group Chair and Group CEO position. Chair process will complete by mid-February and CEO process by mid-March.</p> <p><b>26/27 Joint Planning Areas:</b> Working with commissioners, both Chief Executive Officers have agreed a core set of joint planning priorities to begin delivering early benefits of the new group model from 26/27. The overarching aim of these joint planning areas is to start the journey of aligning key foundations such as digital infrastructure and our clinical operating models. With the South Central and South East Ambulance Group aim of creating a safer, more sustainable ambulance service for the South East, one that delivers better care for patients and better support for our people.</p> <p><b>Governance Assurance:</b> An operating model has been designed to provide clarity, accountability, and momentum during the transition period. Clear escalation pathways ensure Board oversight whilst enabling executive agility on time-sensitive decisions. Regular reviews built in to adjust approach as transition progresses and requirements evolve.</p>	<p><b>Planning 26/27:</b> There is a risk that the providers do not put in place joint plans for 26/27 and start reflecting benefits realisation of the group during leadership transition</p>	20	16	<p>1. Committee in common established for oversight and assurance.</p> <p>2. CEO commitment to joint planning areas</p>	<ul style="list-style-type: none"> <li>Committee in Common to be established and terms of reference approved by each Trust – January</li> <li>Key joint planning areas proposal approvals at Committee in Common, covering strategic intent, principles, scope, resource requirements and recommended option for agreement – February</li> <li>Leadership Recruitment Outcomes – February &amp; March</li> <li>Joint Senior Leadership planning sessions – awareness of Trusts priorities and BAF for FY26/27 and alignment of joint areas - March</li> </ul>
	<p><b>Delivery &amp; Performance:</b> There is a risk of distraction from in-year plan delivery, performance recovery, and current operational priorities due to leadership attention being diverted to transition activities.</p>	20	16	<p>1. Align Executive objectives to collaboration priorities</p> <p>2. Calibrate transition activities against existing organisational priorities through 26/27 planning, aligned to BAF and Tier 1 priorities</p> <p>3. Maintain existing operational governance structures during transition</p>	

<b>Key developments since last report</b>	<b>Board Oversight</b>	<b>Board Decisions</b>
<ul style="list-style-type: none"> <li>Joint Strategic Lead extension approved by CEOs</li> <li>Key proposals Digital and Clinical Model developed and presented to Joint Executives with agreed recommendation to go to Committee in Common</li> <li>Transition phase governance and oversight model developed</li> </ul>	Continued and sustained progress towards integration is required for the programme to realise the benefits outlined in the Outline Business Case. The Committee in Common will provide strategic oversight, decision-making authority, and resource allocation for joint programmes of work, ensuring timely progression of critical initiatives where timeline imperatives and/or investment decisions could impact the benefits realisation window. <sup>53</sup>	

# Board Highlight Report – Multi-Year Plan

SRO/Executive Lead

Simon Bell

Key	
Completed	<span style="color: blue;">◆</span>
On Track	<span style="color: green;">◆</span>
At Risk	<span style="color: orange;">◆</span>
Delayed	<span style="color: red;">◆</span>

## Progress Report Against Milestones:

### Key achievements against milestone

- Basic medium-term financial model already in place, as commissioned as part of 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
<b>Risk:</b> Development 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.
<b>Risk:</b> Resources to undertake development and quality assurance is not available.		6	6		Additional development resource has been acquired.
<b>Risk:</b> 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. <span style="color: blue;">◆</span>  Initial multi-year plan T&F group meeting with SECamb/SCAS. <span style="color: blue;">◆</span>	Draft multi-year plan presented to execs. <span style="color: green;">◆</span> <span style="color: green;">◆</span>  'Live' multi-year plan presented to execs. <span style="color: green;">◆</span>	Multi-year plan used as basis for '26/27 Operational Planning' & 'Case for Change'.  'Live' multi-year plan presented to execs. <span style="color: green;">◆</span>	'Live' multi-year plan presented to execs. <span style="color: green;">◆</span>	

# 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:** Executive Committee in Common is established, as well as a Board Committee in Common. 5 Areas of collaboration for 26/27 to be included into the Trust’s plans have been agreed with the ICBs. Joint Appointments Committees in place for Group CEO and Group Chair appointments. Joint strategic commissioning group in place to coordinate the joint plans with the single pan-ICB commissioner

**Gaps in control:** Joint resourcing for 26/27 plans will require joint agreement through Q4 ahead of 1 April 2026, benefits mapping dependant on joint Tier 1 mandates.

**Positive sources of assurance:** Outline business case approved on 8 October by joint Boards. Joint communications plans and microsite launched. Interviews scheduled for CEO and Chair appointment. Extension of the joint strategic lead.

**Negative sources of assurance:** Financial plans not aligned in 26/27, integration team to be put in place by 1 April. No additional funding identified to support integration.

**Gaps in assurance:** Environment of uncertainty as ICBs submit their consolidation plans; limited visibility of ICB commissioning consolidation timelines.

<b>Accountable Director</b>	<b>Chief Strategy Officer</b>
<b>Committee</b>	<b>Trust Board</b>
<b>Initial risk score</b>	<b>Consequence 4 X Likelihood 3 = 12</b>
<b>Current Risk Score</b>	<b>Consequence 4 X Likelihood 3 = 12</b> 
<b>Target risk score</b>	<b>Consequence 4 X Likelihood 2 = 8</b>
<b>Risk treatment</b>	<b>Treat</b>
<b>Target date</b>	<b>Q4 2025/26</b>

<b>Mitigating Actions planned/ underway</b>	<b>Executive Lead</b>	<b>Due Date</b>	<b>Progress</b>
Development of joint Tier 1 mandates for SCAS and SECamb Boards to approve at respective Board in April 2026	Joint Strategic Lead	April 2026	New action*
Establish integration team capacity to deliver joint programmes around agreed 26/27 priorities	Joint Strategic Lead	April 2026	New action*
Appointments process for CEO and Chair on-going	Chief People Officers	April 2026	New action*

# 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 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., 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., 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, Process of identifying downside risk mitigation in place and operating.

**Gaps in control:** 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, 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., Month 9 year to date is on plan and forecast outturn is still at breakeven in line with plan.

**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.

<b>Accountable Director</b>	<b>Chief Finance Officer</b>
<b>Committee</b>	<b>Finance and Investment Committee</b>
<b>Initial risk score</b>	<b>Consequence 4 X Likelihood 3 = 12</b>
<b>Current Risk Score</b>	<b>Consequence 4 X Likelihood 2 = 08</b> 
<b>Target risk score</b>	<b>Consequence 3 X Likelihood 2 = 06</b>
<b>Risk treatment</b>	<b>Treat</b>
<b>Target date</b>	<b>Q4 2025/26</b>

<b>Mitigating Actions planned/ underway</b>	<b>Executive Lead</b>	<b>Due Date</b>	<b>Progress</b>
Q2 Review	SB	15th October 2025	Completed

# 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)**

## 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. Targeted recruitment has addressed critical gaps to ensure delivery objectives are met.

**Gaps in control:** There is currently a skills gap which is currently under review and will be addressed during the Digital restructure in May 2026.

**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:** None identified

**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**

**Q2 2026/27**

Mitigating Actions planned/ underway	Executive Lead	Due Date	Progress
Restructure of Digital Directorate	CDIO	Q2 2026/27	The Digital Workforce Restructure business case due to come to EMB March 2026 and schedule as part of Corporate Services Phase 5
Business cases to support delivery of digital strategy	HOD	Q4 2025/26	Business cases are in various stages of approval, Products/GRS, Infrastructure. Data & AI & Gartner Business case have been approved. The remainder will be presented in February 2026
JD Evaluation	CDIO	Q4 2025/26	JDs have been completed are now in current review, as per corporate services 5 timeline, this linked to Workforce restructure Business case (Workstream 2) – revised date February 2026
Governance	CDIO/HOD	57 Q3 2025/26	Completed capital plans are managed through DTB (Digital Transformation Board).

# 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

<b>Accountable Director</b>	<b>Chief Strategy Officer</b>
<b>Committee</b>	<b>Finance and Investment Committee</b>
<b>Initial risk score</b>	<b>Consequence 4 X Likelihood 4 = 16</b>
<b>Current Risk Score</b>	<b>Consequence 3 X Likelihood 4 = 12</b> 
<b>Target risk score</b>	<b>Consequence 3 X Likelihood 2 = 06</b>
<b>Risk treatment</b>	<b>Treat</b>
<b>Target date</b>	<b>Q4 2025/26</b>

<b>Mitigating Actions planned/ underway</b>	<b>Executive Lead</b>	<b>Due Date</b>	<b>Progress</b>
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 delivering
Establish regular monitoring of handover times and community response acceptance rates via CRM	Chief Operations Officer	June 2025 58	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



South East Coast  
Ambulance Service  
NHS Foundation Trust



# Integrated Quality Report

## Trust Board February 2026

Data up to and including December 2025





## What?

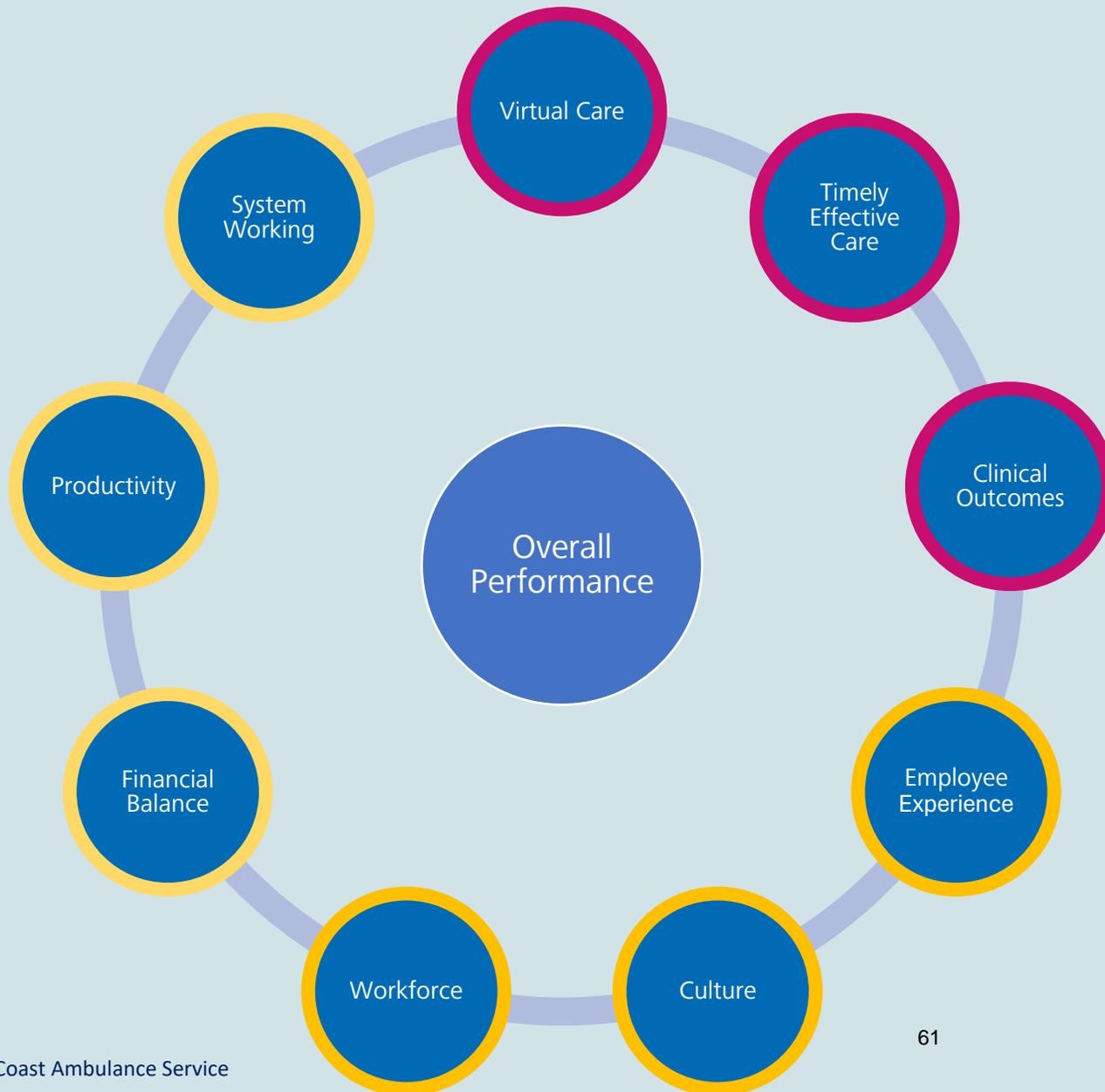
December C2 mean performance was at 28:25 against a plan of 27:23 but remains on trajectory YTD against the revised plan (acknowledging that system productivity has not been delivered). This was against a backdrop of significantly increased activity in December and driven by ongoing variation in the delivery of internal productivity improvements, although handover times remained stable despite demand. Our quality of care indicators remain strong, including our highest ever PGD compliance, and continued robust delivery of cardiac outcomes and care bundles. There remains a need to improve call handling audit compliance and times on scene. Progress continues across key workforce and culture priorities, with turnover remaining at its lowest rolling rate in several years (13.3%). Metrics show a mixed but improving position, with high employee relations and collective grievance volumes offset by improved case progression and zero cases exceeding 24 months; sickness has risen seasonally while appraisal rates have improved with increased focus. There are considerable organisational changes ongoing, which are being supported actively by the OD team and local leaders. The Trust's month 9 year to date and forecast revenue financial position is in line with plan, recognising that CIP delivery is focused in Q4.

## So What?

We continue to deliver sustainable performance in line with plan although there are risks relating to increased demand level over winter combined with increased sickness levels of our staff. There is further work to do in relation to improving productivity, though there are encouraging shifts in the virtual care call triage output. People indicators suggest a culture of improving stability and leadership capability, although risks remain due to the volume of organisational change and the ongoing need to improve key metrics such as appraisal and mandatory training rates to support staff development and skills to provide high quality care. An overarching strategic plan is in place to improve the capability and capacity of EOC staff and is being regularly reviewed and overseen by senior leaders, while we are working through AACE to escalate national concerns in relation to EOLC services as well as improving our own pathways and skills. We are continuing to support SCAS with mutual aid and doing additional workshop jobs to support their fleet, with continual review of our fleet position to ensure we balance responsiveness to our patients with safe care in the SCAS area. The Trust's stable financial position provides a good basis for medium term planning.

## What Next?

We continue to manage the winter resilience plan proactively to respond to these challenges, for example optimising vaccination rates and managing absence closely in line with our escalation levels. Further work will be undertaken on alternative pathways to ED including SDEC and Frailty, aligned to our Models of Care programme. The completion of the operational support re-structure in Q4 will improve fleet capacity for the year ahead from 1 April, and further clinical and operational productivity plans are being worked up to support future year planning, which will require both a strong base and further improvements in productivity, while continuing to deliver significant financial savings. For our people, we will work to embed newly agreed and streamlined workforce relations policies while embedding our OD plans for the coming year to continue to support development of our new Organisational operating model. HI objectives for 2025-2027 were discussed at QPSC in January and will be brought for final approval to QPSC in April following completion of the newly developed HI Maturity Matrix to identify key areas for improvement.



## BAF outcomes 25/26

- ❑ Category 2 Mean <25 minutes average for the full year
- ❑ Call Answer 5 seconds average for the full year
- ❑ Hear & Treat 18% average for 25/26 / 19.7% by the 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
  - ❑ Job cycle time (JCT)
  - ❑ Responses per incident (RPI)

- ❑ Improve staff reporting they feel safer in speaking up: statistically improved from 54% (23/24 survey)
- ❑ Our staff recommend SECamb as a 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

- ❑ Deliver a financial plan
- ❑ Handover delay mean of 18 minutes
- ❑ Increase Urgent Community Response (UCR) acceptance rate of 60-80%
- ❑ Reduce Vehicle Off Road rate (VOR): 11-12%
- ❑ Achieve over 90% compliance for Make Ready

## 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

Overall Rating

## CQC Rating

**Requires Improvement**

Safe	Requires Improvement	<span style="color: orange;">●</span>
Effective	Requires Improvement	<span style="color: orange;">●</span>
Caring	Good	<span style="color: green;">●</span>
Responsive	Requires Improvement	<span style="color: orange;">●</span>
Well-led	Inadequate	<span style="color: red;">●</span>

## 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



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

				Special cause variation where <b>UP</b> is neither improvement nor concern.
				Special cause variation where <b>DOWN</b> 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.



We are a sustainable partner as part of an integrated NHS



# Sustainable Partner

## What?

December C2 mean performance was at 28:25 against a plan of 27:23 but remains on trajectory YTD against the revised plan (acknowledging that system productivity has not been delivered). This was against a backdrop of significantly increased activity in December and driven by ongoing variation in the delivery of internal productivity improvements. Hospital handover times and VOR rates remained stable despite demand challenges, while there was improvement in virtual care call triage rates albeit not to target level. There remain low levels of use of alternatives to ED for our conveyed patients.

Winter resilience actions taken in December resulted in a reduction of VOR in Surrey to 12%, the trust-wide position remaining on average between 15 and 16%. This has resulted in improved availability, as well as supporting mutual aid requests from SCAS. MAN Vehicles are in commissioning and expected to start to become operational from February. The Trust's month 9 year to date and forecast revenue financial position is in line with plan, recognising that CIP delivery is focused in Q4.

## So What?

We continue to deliver sustainable performance in line with plan although there are risks relating to increased demand level over winter combined with increased sickness levels of our staff. There is further work to do in relation to improving productivity, though there are encouraging shifts in the virtual care call triage output.

We are continuing to support SCAS with mutual aid through January, and doing additional workshop jobs to support their fleet. We are reviewing our fleet position to ensure we take appropriate balance of risk and patient safety. Additional overtime is offered to fleet to support the tactical reduction in VOR, inclusive of moving technicians around the divisions to support peaks in demand where needed. The Trust's stable financial position provides a good basis for medium term planning.

## What Next?

We continue to manage the winter resilience plan proactively to respond to these challenges, for example optimising vaccination rates and managing absence closely in line with our escalation levels. Further work will be undertaken on alternative pathways to ED including SDEC and Frailty, aligned to our Models of Care programme. A robust operational productivity plan is being overseen to continue to impact on call triage output and therefore H&T rates, looking forward to next year's planning process which will require both a strong base and further improvements in productivity, while continuing to deliver significant financial savings.

The completion of the operational support re-structure in Q4 will improve fleet capacity for the year ahead from 1 April, and the new fleet is expected to support a reduction in VOR further in 26/27 to under 14%. 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. New vehicles are in commissioning and will start to become operational from February.

We will continue to develop our Digital metrics and anticipate including broader resilience metrics in the IQR in 2026/27.

### Variation

#### Special Cause Improvement



0%  
0



8%  
2

#### Common Cause



52%  
13

#### Special Cause Concern



4%  
1



12%  
3

### Assurance

#### Pass



8%  
2

#### Hit and Miss



12%  
3

#### Fail



12%  
3

#### No Target



68%  
17

### Productivity

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	% of DCA vehicles off road (VOR)	Dec-25	15.7%	10%	16.2%		
Board	Number of RTCs per 10k miles travelled	Dec-25	0.7		0.7		
Board	Handover Time Mean	Dec-25	00:18:37	00:17:30	00:18:51		
Board	Hear & Treat per Clinical Hour	Dec-25	0.4		0.4		
Board	See & Convey to ED %	Dec-25	50.7%		52.1%		
Board	See & Convey to Non-ED %	Dec-25	2.3%		2.6%		
Board	UCR Acceptance %	Dec-25	12.3%	60%	18.6%		
Supporting	111 to 999 Referrals (Calls Triaged) %	Dec-25	6.5%	13%	6.4%		
Supporting	% of SRV vehicles off road (VOR)	Dec-25	3.8%		3.1%		
Supporting	Critical Vehicle Failure Rate (CVFR)	Dec-25	87		93.9		
Supporting	999 Operational Abstraction Rate %	Dec-25	31%	31.7%	24.7%		
Supporting	Hear & Treat Recontact within 48 Hours %	Dec-25	2.3%		2.1%		
Supporting	Handovers > 45 Minutes %	Dec-25	4.4%	0%	4.4%		
Supporting	Number of Hours Lost at Hospital Handover	Dec-25	3332.6	2879.37	3183.9		

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	Dec-25	33		34.3		
Board	Manual Handling Incidents	Dec-25	31		27.5		
Board	Violence and Aggression Incidents (Number of Victims - Staff)	Dec-25	119		117.4		
Board	Organisational Risks Outstanding Review %	Dec-25	17.9%	30%	29.6%		
Supporting	Number of RIDDOR Reports	Dec-25	15		10.6		
Supporting	Compliance with Conflict Resolution Training	Dec-25	44%	85%	62.2%		
Supporting	Compliance with Face-to-Face Manual Handling Training	Dec-25	73.2%	85%	73.7%		

### Finance

Type	Metric	Latest	Value	Target	Mean
Board	Surplus/Deficit (£000s) Month	Dec-25	326	-29.6	16
Supporting	Agency Spend (£000s) Month	Dec-25	-111.8	-161	-227.5
Supporting	Capital Expenditure (£000s) YTD	Dec-25	11096	30534	7030.1

### Efficiency

Type	Metric	Latest	Value	Target	Mean
Board	Cost Improvement Plan (CIP) (£000s) Month	Dec-25	804		1301.6
Board	Cost Improvement Plans (CIPs) (£000s) YTD	Dec-25	4658	6761	8340.9

Pending metric: Cost per Call - Data not not available to BI/Not currently collected



### Variation

#### Special Cause Improvement



#### Common Cause



#### Special Cause Concern



### Assurance

#### Pass



#### Hit and Miss



#### Fail



#### No Target



### Resilience

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
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*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
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*Pending metric: Driver Safety Standard Metric - Needs to be defined*

### Digital

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
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Board	Count of P1 Incidents	Nov-25	0		0.1		
Board	Count of Cyber Incidents	Nov-25	3		6.4		



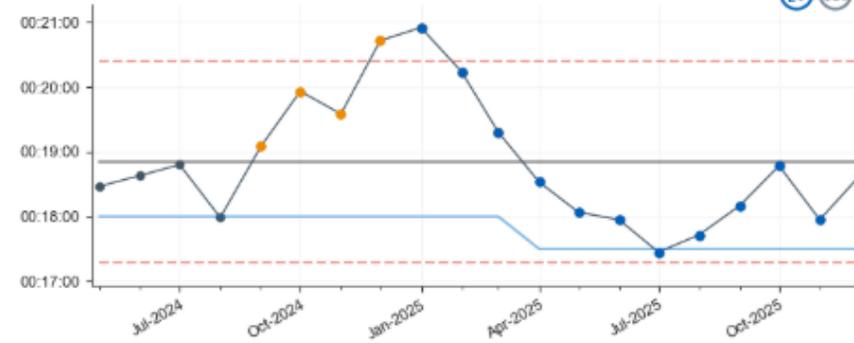
**% of DCA vehicles off road (VOR)**



**FL-4**

Dept: Fleet  
Metric Type: Board  
Latest: 15.7%  
Target: 10%  
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

**Handover Time Mean**



**999-39**

Dept: Operations 999  
Metric Type: Board  
Latest: 00:18:37  
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.

**Number of RTCs per 10k miles travelled**



**FL-2**

Dept: Fleet  
Metric Type: Board  
Latest: 0.7  
---  
Common cause variation, no significant change.

**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?**  
Handover time mean deteriorated slightly in December from November.

**So what?**  
Hours lost to hospital handover showed an approximate 20% increase compared to previous month (allowing for the 30 days in November and 31 days in December). This was not unexpected as Acute Trusts experienced significant pressures with capacity during December. Handover to clear (wrap-up) continues to show positive results, returning an average of 12min 50sec for December.

**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.

**% of DCA Vehicles off road (VOR)**

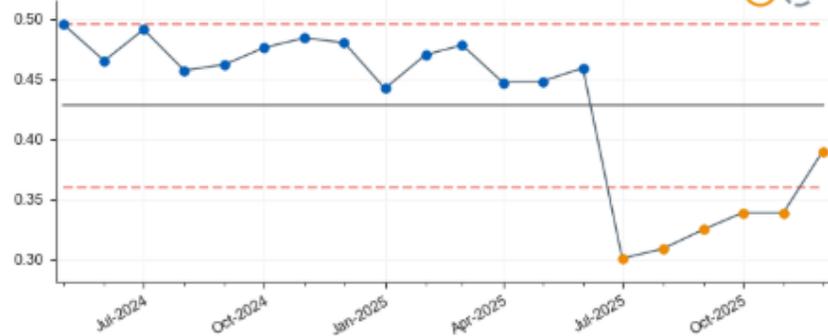
**What?**  
Current DCA VOR rate at 15.7%. Surrey division saw a reduction down to 12% during December as a result of additional actions taken through overtime to support winter resilience actions.

**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 February 2026.

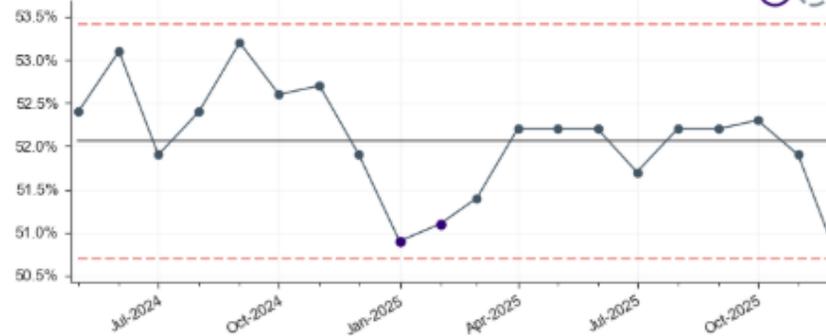


**Hear & Treat per Clinical Hour**



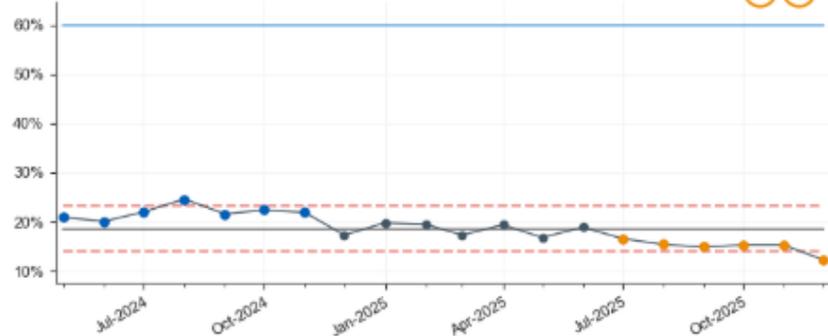
**999-41**  
Dept: Operations 999  
Metric Type: Board  
Latest: 0.4  
---  
Special cause of a concerning nature where the measure is significantly LOWER.

**See & Convey to ED %**



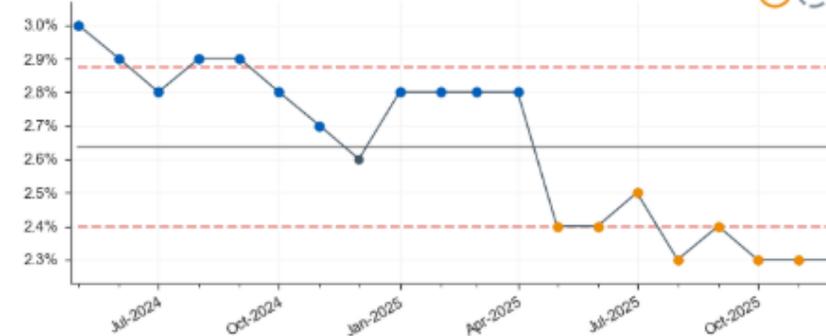
**999-9**  
Dept: Operations 999  
Metric Type: Board  
Latest: 50.7%  
---  
Special cause variation where DOWN is neither improvement or concern

**UCR Acceptance %**



**999-40**  
Dept: Operations 999  
Metric Type: Board  
Latest: 12.3%  
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.

**See & Convey to Non-ED %**



**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 to 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 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 16.6% for the month of December, the best month of 25/26, with 4.0% attributable to EMA activity. 10% of eligible C2 incidents underwent a clinical assessment as part of C2 streaming, with 16% downgraded to a C3/4 disposition and a significantly higher 50% downgraded to a non-ambulance disposition. Overall, the number of cases subject to C2 Streaming increased month on month, as did the positive outcomes. The Trust is still using an 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 a 10 week targeted programme (Virtual First), which will be launched mid-January and will run until the end of the financial year. A new C2 Streaming model is being developed in conjunction with NHS E, and is due to be implemented in early Jan 26.

**UCR Acceptance Rate**

**What?** In December, **12.31%** of incidents (**188** of **1,527**) referred via the UCR portal were accepted – a significant decrease from November's **17.72%** and well below the **60% target**. Although the **number of accepted incidents increased slightly** (Nov: 177 → Dec: 188), this did not keep pace with the additional **528 incidents** passed to UCR in December. The increased demand outstripped provider capacity, resulting in the lower overall acceptance rate.

**So What?** Acceptance rates remain significantly lower than required. December was the first month with minimal variation across providers, with all citing **capacity constraints (26.66%)** as their primary reason for declining referrals. There was also an increase in cases **not clinically reviewed at all**, reflected by a higher **auto-reject rate (42.94%)**.

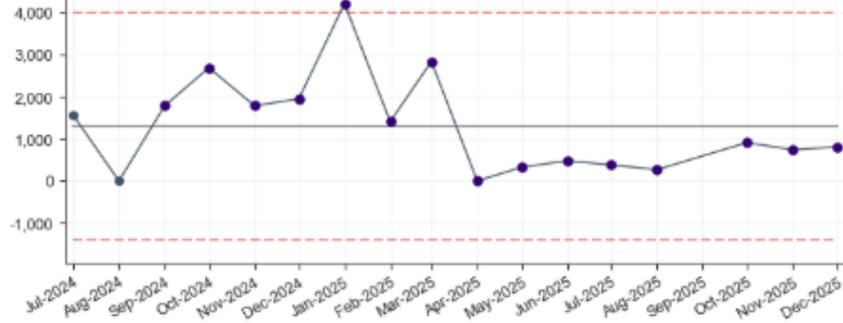
Acceptance continues to be highest within the first two hours of service opening, when SECAmb is one of multiple organisations simultaneously requesting UCR support.

**What Next?** Following positive discussions with KCHFT, their UCR teams are prepared to onboard to the portal in West Kent once the Christmas IT freeze lifts. A Go/No-Go decision to review outstanding go-live actions is scheduled for **23/01/26**.

Looking ahead, there may be value in reviewing the current 30-minute clinical review window. Extending this to a 1-hour risk assessment period could support teams who struggle to complete safe clinical review within the existing timeframe, potentially improving uptake.



**Cost Improvement Plan (CIP) (£000s) Month**



F-4

Dept: Finance

Metric Type: Board

Latest: 804

---

**Cost Improvement Plans (CIPS) YTD**

● Value ● Forecast



F-13

Dept: Finance

Metric Type: Board

Latest: 4658

Target: 6761

**What?**

For the nine months ending December 2025, the Trust is £2.1m or a third short of the £6.8m efficiency target. Year-to-date recurrent savings remained the same as last month, being 50-50 and forecasting to further improve to 59% by the end of the financial year.

**So what?**

The Trust is forecasting to achieve 76% or £7,537k of the planned target of £10,000k, resulting in a shortfall of £2,463k. The Trust (through Executive Management Board) has an agreed plan to address this projected gap and to deliver the agreed financial plan.

**What next?**

The Trust is focusing on the delivery of the current schemes and the development of future year's efficiency schemes through Executive Director and Quality Impact Assessment (QIA) approval.

**What?**

The present fully validated risk-adjusted forecast gap remains £2.5m, against the £10.0m target. The reliance on recurrent savings is gradually increasing and forecast to be 59% by the end of March 2026.

**So what?**

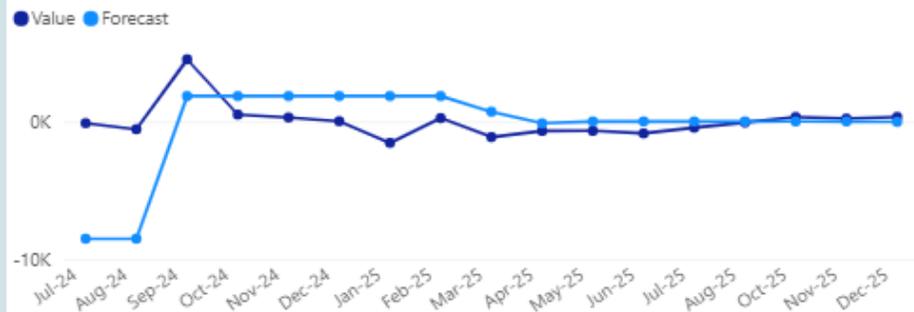
The Trust is focusing on delivering existing schemes and further developing future year's efficiency schemes.

**What next?**

The Trust has agreed action plans to mitigate the risk of under delivery that include vacancy freeze, tighter control of overtime, delay in recruiting newly qualified paramedics, accelerating progress with increasing call handling and other operational KPIs. The Board has agreed to fill any remaining gap with non-recurrent budget underspends and balance sheet provisions.

The Trust has identified recurrent efficiency schemes for the next financial year and has submitted a compliant plan on 17 December 2025. The Trust will carry on focusing on continuous improvement to reduce its running cost whilst maximising its output and carries on improving the quality of care it is providing.

Surplus/Deficit (£000s) Month



F-6
Dept: Finance
Metric Type: Board
Latest: 326
Target: -29.6

**What?**

The Trust is reporting a £2.0m deficit for the 9 months to December 2025, this is as planned. Forecast outturn continues at break even in line with plan.

**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 £30.7m as at 31st December 2025.



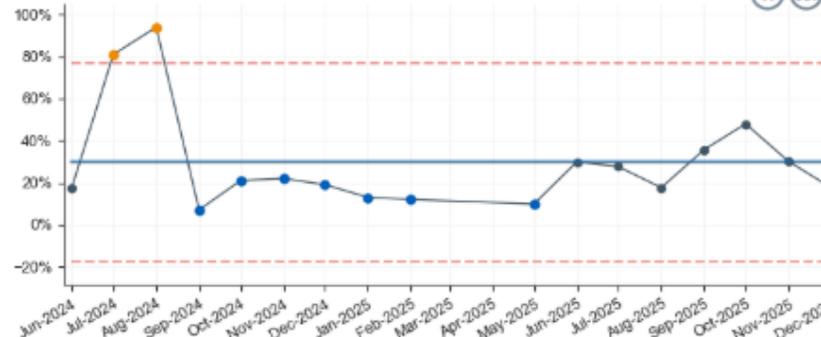
**Health & Safety Incidents**



**QS-20**

Dept: Quality & Safety  
Metric Type: Board  
Latest: 33  
---  
Common cause variation, no significant change.

**Organisational Risks Outstanding Review %**



**QS-24**

Dept: Quality & Safety  
Metric Type: Board  
Latest: 17.9%  
Target: 30%  
Common cause variation, no significant change. This process will not consistently hit or miss the target.

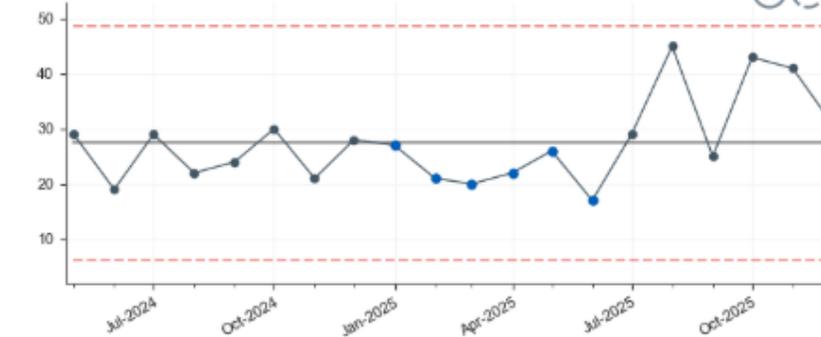
**Violence and Aggression Incidents (Number of Victims - Staff)**



**QS-13**

Dept: Quality & Safety  
Metric Type: Board  
Latest: 119  
---  
Common cause variation, no significant change.

**Manual Handling Incidents**



**QS-22**

Dept: Quality & Safety  
Metric Type: Board  
Latest: 31  
---  
Common cause variation, no significant change.

**What?**

- Overall, Health & Safety incidents decreased from **111 to 97** (↓12.6%) in Q3.
- Near-miss reporting also reduced during the quarter.

**So What?**

- The reduction indicates improved safety performance across operations.
- Lower near-miss reporting may reduce visibility of emerging hazards and limit proactive prevention opportunities.

**What next?**

- Maintain current Health & Safety controls and prevention activity.
- Reinforce and encourage near miss reporting to strengthen proactive risk management and prevent future incidents.

**What?**

- Violence & Aggression incidents decreased by **3.6%** (**370** → **361**) in Q3.
- Q3 2025 showed a more consistent monthly profile (**125 | 123 | 113**) with reduced volatility.

**So What?**

- The reduction indicates improving control and stability in managing V&A risk.
- A more consistent profile suggests fewer extreme spikes compared to Q3 2024.

**What next?**

- Maintain current V&A prevention and management controls.
- Continue targeted monitoring of trends and hotspots to support early intervention.
- Continue post-incident support and learning to sustain the downward trend.

**Manual Handling Incidents**

**What?**

- Manual Handling incidents increased by **32.0%** (**75** → **99**) in Q3.
- The increase was most prominent in November.

**So What?**

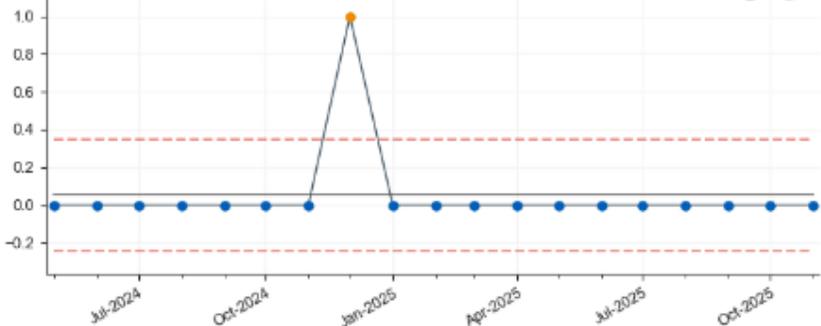
- The increase indicates a heightened MSK risk and a need for continued focus on prevention activity.
- The completed Manual Handling / MSK deep dive has provided clear learning to guide improvement priorities.

**What next?**

- Deep dive findings have been used to set key objectives for the MSK Injury Reduction Working Group.



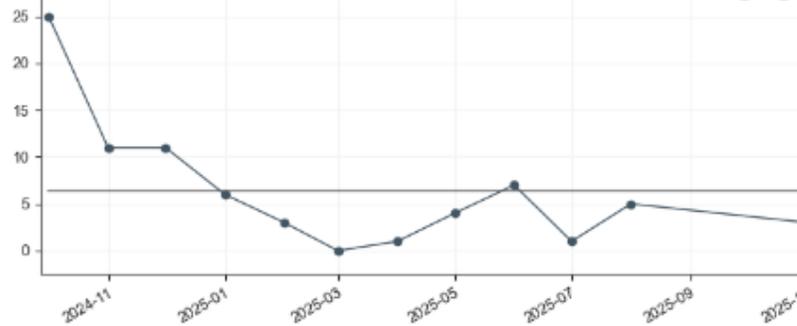
Count of P1 Incidents



IT-7

Dept: Digital  
Metric Type: Board  
Latest: 0  
---  
Special cause of an improving nature where the measure is significantly LOWER.

Count of Cyber Incidents



IT-8

Dept: Digital  
Metric Type: Board  
Latest: 3  
---  
Special cause or common cause cannot be given as there are an insufficient number of points.

**What?**

The chart shows one P1 incidents in the last 18 months (Dec 2024), 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?**

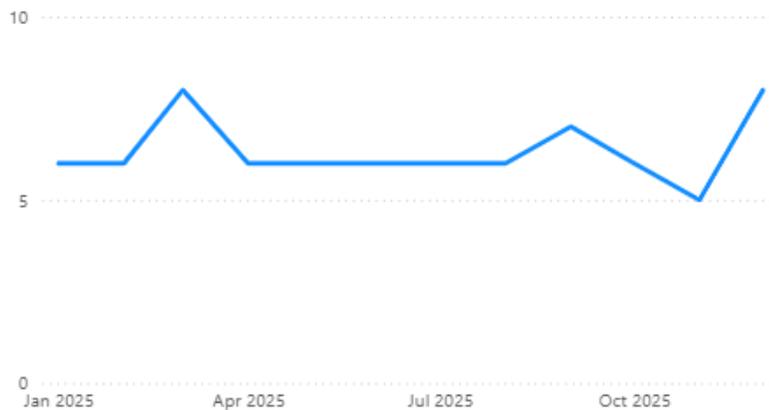
The downward trend is positive, but cyber threats remain persistent. Current controls are effective, but vigilance is essential given the evolving threat landscape.

**What next?**

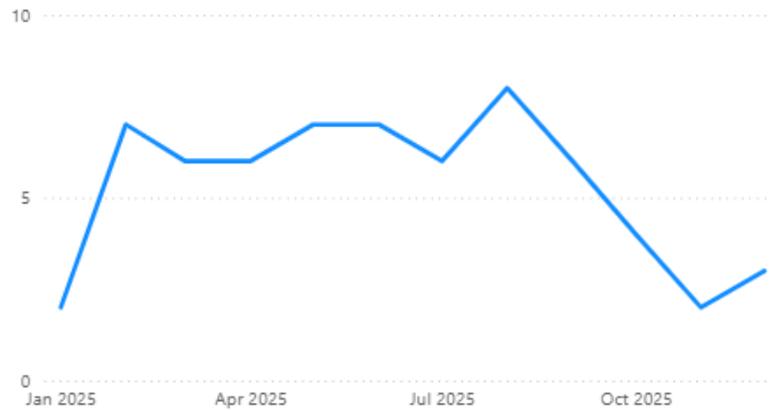
- Advance initiatives under the Digital Transformation Programme, including:
  - Collaboration with SASC on a joint Cyber Security Operations Centre (CSOC).
  - Deployment of a new SIEM tool for enhanced threat detection and response.
- Maintain continuous monitoring and rapid incident management.



**SecAmb Mean C1 Response Time Rank**



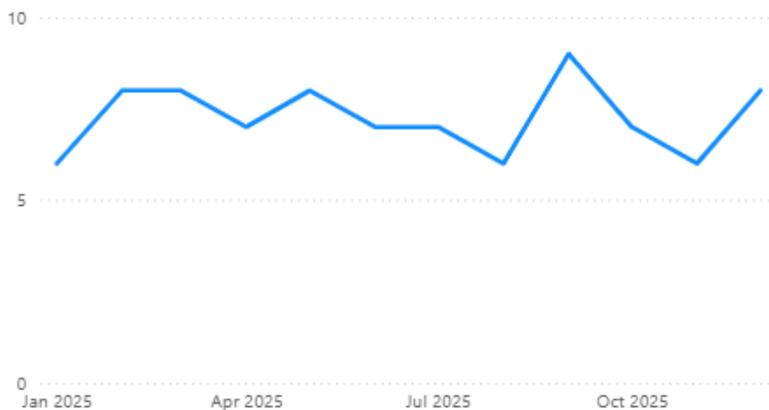
**SecAmb Mean C2 Response Time Rank**



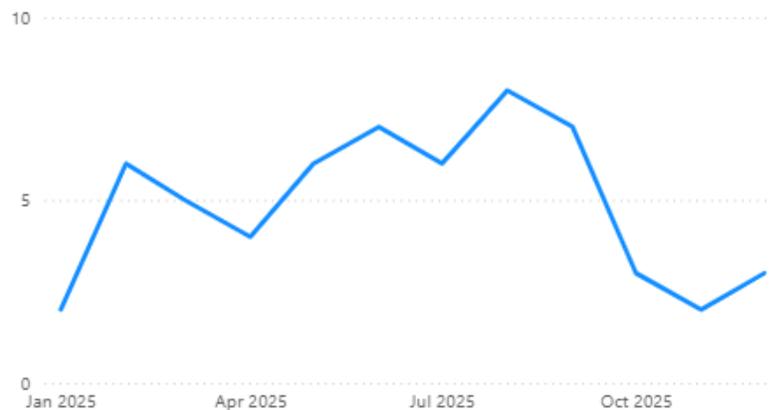
**SecAmb 90th Centile C3 Response Time Rank**



**SecAmb 90th Centile C1 Response Time Rank**



**SecAmb 90th Centile C2 Response Time Rank**



**SecAmb 90th Centile C4 Response Time Rank**

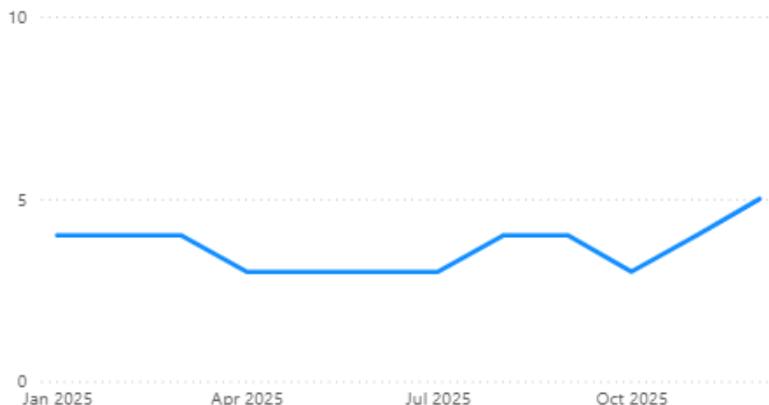


**Summary:**

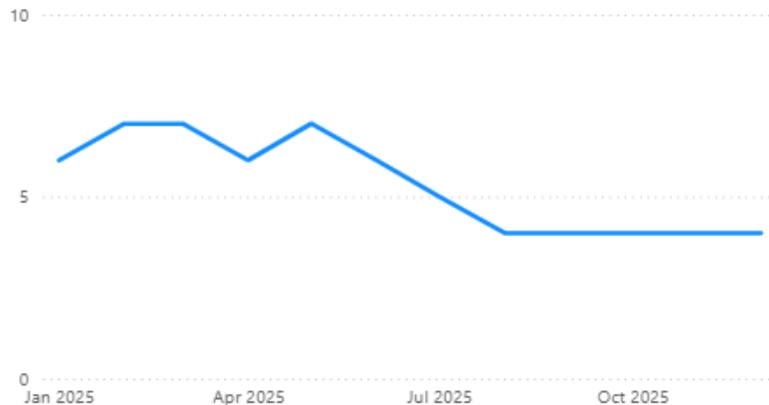
•Overall SECamb continues to benchmark broadly in the middle of the range of English NHS Ambulance Trusts for response times. All Trusts are being challenged to improve their C2 mean in the coming year in line with NHSE guidance.



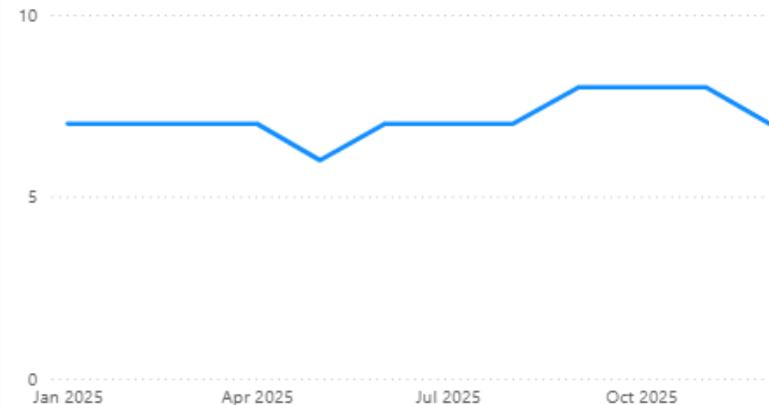
SecAmb Mean Call Answer Time Rank



SecAmb Hear & Treat % Rank



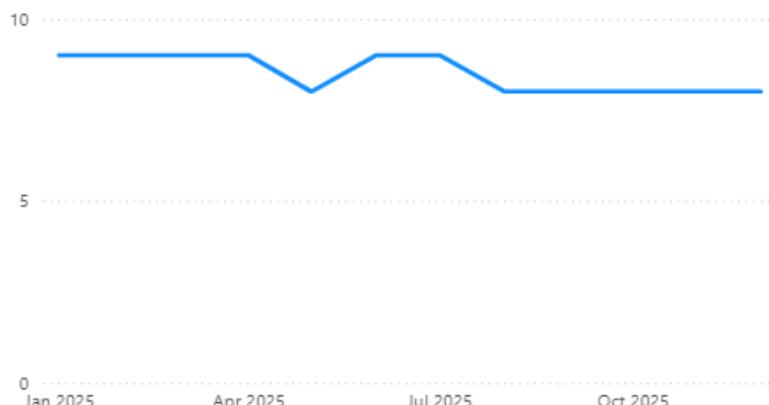
SecAmb See & Treat % Rank



SecAmb 90th Centile Call Answer Time Rank



SecAmb See & Convey % (ED) Rank



SecAmb See & Convey (Non-ED) Rank



**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



<b>AQI A7</b>	All incidents – the count of all incidents in the period
<b>AQI A53</b>	Incidents with transport to ED
<b>AQI A54</b>	Incidents without transport to ED
<b>AAP</b>	Associate Ambulance Practitioner
<b>A&amp;E</b>	Accident & Emergency Department
<b>AQI</b>	Ambulance Quality Indicator
<b>ARP</b>	Ambulance Response Programme
<b>AVG</b>	Average
<b>BAU</b>	Business as Usual
<b>CAD</b>	Computer Aided Despatch
<b>Cat</b>	Category (999 call acuity 1-4)
<b>CAS</b>	Clinical Assessment Service
<b>CCN</b>	CAS Clinical Navigator
<b>CD</b>	Controlled Drug
<b>CFR</b>	Community First Responder
<b>CPR</b>	Cardiopulmonary resuscitation
<b>CQC</b>	Care Quality Commission
<b>CQUIN</b>	Commissioning for Quality & Innovation
<b>Datix</b>	Our incident and risk reporting software
<b>DCA</b>	Double Crew Ambulance
<b>DBS</b>	Disclosure and Barring Service
<b>DNACPR</b>	Do Not Attempt CPR
<b>ECAL</b>	Emergency Clinical Advice Line
<b>ECSW</b>	Emergency Care Support Worker
<b>ED</b>	Emergency Department
<b>EMA</b>	Emergency Medical Advisor
<b>EMB</b>	Executive Management Board
<b>EOC</b>	Emergency Operations Centre
<b>ePCR</b>	Electronic Patient Care Record
<b>ER</b>	Employee Relations

<b>F2F</b>	Face to Face
<b>FFR</b>	Fire First Responder
<b>FMT</b>	Financial Model Template
<b>FTSU</b>	Freedom to Speak Up
<b>HA</b>	Health Advisor
<b>HCP</b>	Healthcare Professional
<b>HR</b>	Human Resources
<b>HRBP</b>	Human Resources Business Partner
<b>ICS</b>	Integrated Care System
<b>IG</b>	Information Governance
<b>Incidents</b>	See AQI A7
<b>IUC</b>	Integrated Urgent Care
<b>JCT</b>	Job Cycle Time
<b>JRC</b>	Just and Restorative Culture
<b>KMS</b>	Kent, Medway & Sussex
<b>LCL</b>	Lower Control Limited
<b>MSK</b>	Musculoskeletal conditions
<b>NEAS</b>	Northeast Ambulance Service
<b>NHSE/I</b>	NHS England / Improvement
<b>OD</b>	Organisational Development
<b>Omnicell</b>	Secure storage facility for medicines
<b>OTL</b>	Operational Team Leader
<b>OU</b>	Operating Unit
<b>OUM</b>	Operating Unit Manager
<b>PAD</b>	Public Access Defibrillator
<b>PAP</b>	Private Ambulance Provider
<b>PE</b>	Patient Experience
<b>POP</b>	Performance Optimisation Plan
<b>PPG</b>	Practice Plus Group
<b>PSC</b>	Patient Safety Caller
<b>SRV</b>	Single Response Vehicle

Item No	105-25
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Name of meeting	Trust Board
Date	5 February 2026
Name of paper	M09 (December 2025) Financial Performance
Executive sponsor	Simon Bell – Chief Finance Officer
Authors names and roles	Judit Friedl (Deputy Chief Finance Officer) Graham Petts (Head of Finance, Planning, Reporting and Systems), Rachel Murphy (Head of Finance – Cash, Projects, Business, and Investments)

This report provides the year-to-date (YTD) financial performance of the Trust.

As of month 9, the Trust is reporting a favourable variance of £7k compared to the planned deficit of £2,014k. The Trust forecasts achieving its financial breakeven plan and our C2 mean performance trajectory.

The Trust has achieved £4,658k (69%) of the planned £6,761k in efficiencies YTD. This amounts to 46% of the overall savings target, leaving 54% still to be achieved over the next three months. The Trust is forecasting to achieve 76% of the planned target of £10,000k, resulting in a shortfall of £2,463k. The Trust (through Executive Management Board) has an agreed plan to address this projected gap and to deliver the agreed financial plan.

YTD Capital expenditure £10,865k is £3,777k below plan, that is caused by the slippage in the DCA delivery schedule and Digital programme. The Trust is forecasting to spend its full capital allocation by the end of the year.

In December 2025 cash receipts exceeded payments by £2,329k which has increased the closing cash balance to £30,667k, which is £1,907k above plan. The key driver for the variance against plan is the timing of capital purchases.

**Note:** Tables are subject to rounding differences (+/- £1k).

Recommendations, decisions, or actions sought	The Committee is asked to note the following:  a) The financial performance for year to December 2025 (M09) of the 2025/26 financial year.
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Does this paper, or the subject of this paper, require an equality analysis ('EA')? (EAs are required for all strategies, policies, procedures, guidelines, plans, and business cases).	N/A
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**2025/26**

**Finance Report to the Board of Directors  
9 Months to 31 December 2025**

## Executive Summary

The Trust reported a £2,007k deficit for the 9 months to December 2025 (YTD), £7k better than planned.

Note: Tables are subject to rounding differences (+/- £1k).

	Year to December 2025			Forecast to March 2026		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Income	268,833	269,978	1,145	358,376	360,013	1,637
Expenditure	(270,848)	(272,683)	(1,835)	(358,378)	(360,711)	(2,333)
Profit on Sale of Assets	0	668	668	0	668	668
<b>Trust Surplus / (Deficit)</b>	<b>(2,015)</b>	<b>(2,037)</b>	<b>(22)</b>	<b>(2)</b>	<b>(30)</b>	<b>(28)</b>
<i>Reporting adjustments:</i>						
Remove Impact of Donated Assets	1	1	0	2	1	(1)
Remove Impact of Impairments	0	29	29	0	29	29
<b>Reported Surplus / (Deficit)*</b>	<b>(2,014)</b>	<b>(2,007)</b>	<b>7</b>	<b>0</b>	<b>0</b>	<b>0</b>
Efficiency Programme (cash releasing)	6,761	4,658	(2,103)	10,000	10,000	0
Cash	28,760	30,667	1,907	30,427	30,489	62
Capital Expenditure	14,642	12,888	1,754	30,534	30,534	0

\*Reported Surplus / (Deficit) represents what the Trust is held to account for by the ICB/NHSE

## Year to December 2025 (YTD)

- For the 9 months to December 2025, the Trust's financial position is £7k better than planned.
- The overall financial performance contains adverse and favourable variances across directorates. Positive variances in Strategic Planning & Transformation, Medical, Quality & Nursing (Q&N), Finance, Paramedical and Digital areas are offsetting some financial pressures, including overspending in Operations, the CEO office, and People Services.
- The Trust's agreed 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 nine, the Trust has achieved £4,658k, almost half the of the efficiency savings required, half of which was delivered recurrently. 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 forecasted gap stands at £2,463k, with risk-adjusted schemes totalling £7,537k against a £10,000k. The Trust has put agreed mitigations plans in place, including delays in recruitment and recruitment freeze that will ensure the delivery of the agreed financial plan.
- As of 31 December 2025, the cash balance was £30,667k and is £1,907k above plan. This is due to delays in the capital spend.
- YTD Capital expenditure £10,865k is £3,777k below plan, that is caused by the slippage in the DCA delivery schedule and Digital programme The Trust is forecasting to spend its full capital allocation by the end of the year.

## 1. Income

	Year to December 2025			Forecast to March 2025		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
999 Income	241,774	242,247	473	322,366	322,800	434
111 Income	22,000	22,278	278	29,333	29,613	280
Education Income	2,611	2,618	7	3,434	3,732	298
Other Income	2,448	2,835	387	3,243	3,868	625
<b>Total Income</b>	<b>268,833</b>	<b>269,978</b>	<b>1,145</b>	<b>358,376</b>	<b>360,013</b>	<b>1,637</b>

- 999 income is £473k above plan, this is from the receipt of additional capacity funding for 2024/25 being received in this financial year.
- 111 income is £278k better than plan, following the release of the income provision provided against the 2024/25 contract for convergence. Commissioners have now confirmed convergence will not be applied to the contract value and the provision is no longer required.
- Education income is £7k 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 £387k favourable compared to plan, due to sales of obsolete equipment, and increased medical provision at events.

## 2. Directorate Expenditure

The key year to date performance drivers (adverse and favourable variances) are as follows.

- Operations, including field operations (£1,466k adverse) and NHS 111 (£131k favourable) services have a combined adverse variance of (£1,335k). In field operations this is driven by over establishment in two divisions (Kent and Surrey) and CIP not delivered. The controls to better manage overtime and overall pay cost delivered savings until the end of last month, however an increase in overtime in December was required as the Trust entered REAP3 then REAP4 that contributes to the adverse variance. For NHS 111 services the division is reliant on agency and overtime to ensure the safe delivery of the services, which cost is offset by lower non-pay cost. The Trust has agreed a new contract with IC24, the Trust's main subcontractor which will help the directorate to deliver cost in line with budget. The adverse variance is forecast to decrease to (£858k) by the end of the year.
- The Chief Executive Office has an adverse variance of (£503k that is driven by the unfunded head of charity role, executive support, and senior coaching that are agreed cost pressures and won't be mitigated. The adverse variance is forecast to increase to (£571k) by the end of the year.

- The People services directorate as an adverse variance of (£297k). The adverse variance is forecast to increase to £499k by the end of the year. This reflects the agreed investment for transitional support for the directorate which is funded from reserves.
- The above adverse variances are offset by budgetary underspend and CIP delivery in the other directorates. Key favourable variances include lower than planned fuel, maintenance and lease car contracts costs, resulting from strengthened controls and policy changes in Strategic Planning & Transformation. This was further supported by vacancies across directorates, reflecting the impact of the vacancy freeze and recruitment delays.

### 3. 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. The cash-releasing efficiency target does not negatively impact performance or the quality and safety of patients.
- As at month 9, ending December 2025, the Trust is reporting savings of £4,658k, which is 69% of the planned target of £6,761k. The delivery of this is underpinned by 57 fully validated schemes with a risk adjusted, full year forecast value of £7,537k.
- The Trust is forecasting to achieve 76% or £7,537k of the planned target of £10,000k, resulting in a shortfall of £2,463k. The Trust (through Executive Management Board) has an agreed plan to address this projected gap and to deliver the agreed financial plan.
- Directorates are focusing on delivering the schemes agreed to be a priority to enable required savings to be realised. These include rescheduling and phasing of newly qualified paramedics training and delaying their recruitment, utilising existing workforce differently to increase capacity for delivering patient care, enhanced vacancy control and vacancy freeze through the weekly recruitment panel for roles not delivering frontline care as well as running cost reduction across directorates (i.e.: fuel, medical consumables).
- Regular updates on progress are provided to the SMG, Joint Leadership Team, and the Finance and Investment Committee.

## Summary of YTD Efficiency Delivery

Efficiency Delivery	Year to December 2025			Forecast to March 2025		
	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance
Discretionary Non Pay	318	281	(38)	500	456	(44)
Estates and Facilities optimisation	64	0	(64)	96	0	(96)
Fleet - Fuel: Bunkered Fuel & Price Differential	289	425	136	385	622	237
Fleet - Other Efficiencies	0	189	189	0	383	383
Income generation	169	135	(34)	246	262	16
Digital Productivity	323	121	(203)	577	175	(402)
Medicines Management - Consumables	45	0	(45)	60	0	(60)
Medicines Management - Drugs	29	63	34	40	100	60
Medicines Management - Equipment	80	214	134	100	306	206
Operations Efficiencies	2,828	1,238	(1,591)	3,949	2,381	(1,567)
Optimisation in establishment - clinical	175	248	73	175	268	93
Optimisation in establishment - non clinical	686	1,215	529	986	1,730	744
Process review	55	81	26	76	158	82
Policy review	750	56	(694)	1,200	56	(1,144)
Service Redesign	118	5	(113)	157	8	(149)
Procurement contracts review	469	215	(254)	929	452	(477)
Supply Chain review	0	25	25	0	76	76
Travel and subsistence	82	37	(46)	144	46	(98)
Uniform review	279	110	(169)	381	147	(234)
<b>Total Cash Releasing Efficiency</b>	<b>6,761</b>	<b>4,658</b>	<b>(2,103)</b>	<b>10,000</b>	<b>7,626</b>	<b>(2,374)</b>
<i>of which:</i>						
Recurrent	4,557	2,357	(2,200)	6,996	4,533	(2,463)
Non-Recurrent	2,204	2,301	97	3,004	3,093	89

#### 4. Statement of Financial Position and Cash

	Year to December 2025			Forecast to March 2026		
	£000	£000	£000	£000	£000	£000
	Nov-25	Movt	Dec-25	Plan	Actual	Variance
<b>Non-Current Assets</b>						
Property, Plant and Equipment	98,962	5,056	104,018	115,554	118,815	3,261
Intangible Assets	1,361	(63)	1,298	915	1,108	193
Trade and Other Receivables	47	0	47	0	47	47
<b>Total Non-Current Assets</b>	<b>100,370</b>	<b>4,993</b>	<b>105,363</b>	<b>116,469</b>	<b>119,970</b>	<b>3,501</b>
<b>Current Assets</b>						
Inventories	3,771	(503)	3,268	3,088	3,171	83
Trade and Other Receivables	13,950	(3,564)	10,386	6,636	9,354	2,718
Asset Held for Sale	1,373	(357)	1,016	1,373	1,016	(357)
Other Current Assets	0	0	0	0	0	0
Cash and Cash Equivalents	28,338	2,329	30,667	30,427	30,489	62
<b>Total Current Assets</b>	<b>47,432</b>	<b>(2,095)</b>	<b>45,337</b>	<b>41,524</b>	<b>44,030</b>	<b>2,506</b>
<b>Current Liabilities</b>						
Trade and Other Payables	(36,967)	(23)	(36,990)	(37,227)	(35,689)	1,538
Provisions for Liabilities and Charges	(18,907)	277	(18,630)	(11,448)	(15,130)	(3,682)
Borrowings	(5,435)	113	(5,322)	(4,511)	(5,322)	(811)
<b>Total Current Liabilities</b>	<b>(61,309)</b>	<b>367</b>	<b>(60,942)</b>	<b>(53,186)</b>	<b>(56,141)</b>	<b>(2,955)</b>
<b>Total Assets Less Current Liabilities</b>	<b>86,493</b>	<b>3,265</b>	<b>89,758</b>	<b>104,807</b>	<b>107,859</b>	<b>3,052</b>
<b>Non-Current Liabilities</b>						
Provisions for Liabilities and Charges	(7,519)	0	(7,519)	(11,520)	(7,519)	4,001
Borrowings	(17,592)	(718)	(18,310)	(17,526)	(20,644)	(3,118)
<b>Total Non-Current Liabilities</b>	<b>(25,111)</b>	<b>(718)</b>	<b>(25,829)</b>	<b>(29,046)</b>	<b>(28,163)</b>	<b>883</b>
<b>Total Assets Employed</b>	<b>61,382</b>	<b>2,547</b>	<b>63,929</b>	<b>75,761</b>	<b>79,696</b>	<b>3,935</b>
<b>Financed By Taxpayers Equity:</b>						
Public dividend capital	109,889	0	109,889	121,022	123,649	2,627
Revaluation reserve	5,413	2,221	7,634	5,176	7,634	2,458
Donated asset reserve	0	0	0	0	0	0
Income and expenditure reserve	(53,920)	326	(53,594)	(50,437)	(51,587)	(1,150)
<b>Total Tax Payers' Equity</b>	<b>61,382</b>	<b>2,547</b>	<b>63,929</b>	<b>75,761</b>	<b>79,696</b>	<b>3,935</b>

- Non-Current Assets increased by £4,993k in the month arising mainly from £4,252k additions and revaluation of £2,194k less £27k disposals and depreciation of £1,426k.
- Movement within Trade and other receivables is a decrease of £3,564k, reduction in trade receivables from the payment of the ACCTS invoice, and reduction in accrued income from the payment of the ambulance growth funding.
- As of 31 December 2025, the cash balance was £30,667k an increase of £2,329k, mainly driven by the receipt of the second tranche of ambulance growth funding less payment of capital invoices.
- Trade and other payables increased slightly in the month, payments of capital invoices, is offset by the deferral of the final 3 months of the ambulance growth funding.

- Borrowings increased by £605k overall, arising from £1,482k of new lease additions, less £33k of lease terminations and £844k of payments.
- There has been no change to Public divided capital (PDC) that is used for funding non-current asset purchases, the forecast contains the capital funding for ambulance purchases.
- Revaluation reserve has increase by £2,221k following the building revaluation in December 2025.

• **Cash Flow:**

STATEMENT OF CASH FLOWS	MTH	YTD	Plan (YTD)	Var (YTD)
	£000	£000	£000	£000
<b>Cash flows from operating activities</b>	(288)	(2,376)	(1,214)	(1,162)
<i>Non-cash or non-operating income and expense:</i>				
Depreciation & Amortisation	1,426	13,272	13,950	(678)
Impairments and reversals	29	29	0	29
(Increase)/decrease in receivables	3,564	4,192	(617)	4,809
(Increase)/decrease in inventories	503	(573)	(94)	(479)
Change in AHFS	357	357	0	357
(Increase)/decrease in other assets	0	0	0	0
Increase/(decrease) in trade and other payables	(2,064)	(2,999)	433	(3,432)
Increase/(decrease) in other liabilities	2,087	2,008	0	2,008
Increase/(decrease) in provisions	(277)	(555)	(2,811)	2,256
<b>Net cash generated from / (used in) operations</b>	<b>5,337</b>	<b>13,355</b>	<b>9,647</b>	<b>3,708</b>
Interest received	116	1,070	450	620
Interest paid	(59)	(391)	(441)	50
(Increase)/decrease in property, plant and equipment	(4,227)	(11,226)	(15,687)	4,461
Proceeds from sales of property, plant and equipment	669	668	0	668
Purchase of Other LT Investments	0	0	0	0
Other Assets	0	0	0	0
<b>Net cash generated from/(used in) investing activities</b>	<b>(3,501)</b>	<b>(9,879)</b>	<b>(15,678)</b>	<b>5,799</b>
Increase/(decrease) in borrowings	605	(828)	(159)	(669)
Public dividend capital received/(repaid)?	0	0	2,000	(2,000)
PDC dividend (paid)/refunded	(112)	(1,008)	(810)	(198)
<b>Net cash generated from/(used in) financing activities</b>	<b>493</b>	<b>(1,836)</b>	<b>1,031</b>	<b>(2,867)</b>
Increase/(decrease) in cash and cash equivalents	2,329	1,640	(5,000)	6,640
Cash and cash equivalents at start of period	28,338	29,027	33,760	(4,733)
<b>Cash and cash equivalents at end of period</b>	<b>30,667</b>	<b>30,667</b>	<b>28,760</b>	<b>1,907</b>

- 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 slightly for the number of invoices paid to achieve the target in both number and value:

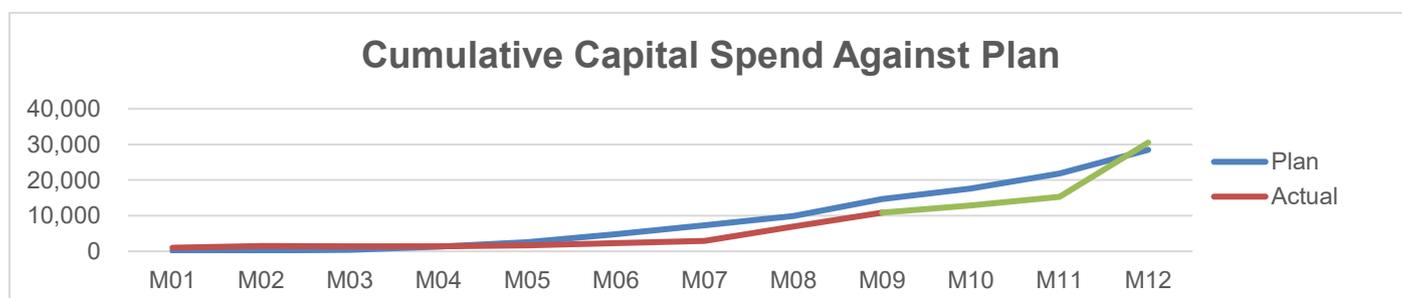
<b>Better Payments Practice Code (BPPC)</b>		<b>Year to December 2025</b>	
		<b>No.</b>	<b>£000</b>
Total bills paid in the year		12,076	72,361
Total bills paid within target		11,477	69,066
<b>Percentage of bills paid within target</b>		<b>95.0%</b>	<b>95.4%</b>

## 5. Capital

- The in-month capital spend is £4,045k. The in-month actual is £827k lower compared to the plan of £4,698k, this is due to the delay in delivery of DCAs and slippage in the Digital programme.

	<b>In Month DDecember 2025</b>			<b>Year to December 2025</b>			<b>Forecast to March 2026</b>		
	£000	£000	£000	£000	£000	£000	£000	£000	£000
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
Estates	470	2,316	(1,846)	3,530	3,068	462	5,747	7,011	(1,264)
Strategic Estates	0	8	(8)	0	(604)	604	0	(604)	604
IT	916	50	866	2,398	949	1,449	5,400	4,082	1,318
Fleet	3,112	1,497	1,615	8,014	4,289	3,725	15,475	14,318	1,157
Specialist Ops	200	0	200	700	2,326	(1,626)	3,538	4,364	(826)
Medical	0	0	0	0	839	(839)	374	1,364	(990)
<b>Total Capital Plan</b>	<b>4,698</b>	<b>3,871</b>	<b>827</b>	<b>14,642</b>	<b>10,865</b>	<b>3,777</b>	<b>30,534</b>	<b>30,534</b>	<b>(0)</b>

- The YTD spend is £10,865k, which is £3,777k less than the plan of £14,642k. This is due to the delay in the delivery of DCAs and the slippage in the Digital programme., the spend is now starting to catch up with the plan.
- The Trust is forecasting to spend its full capital allocation by the end of the year.



## 6. Risks and Opportunities

Table – Risk with rating

RISK DASHBOARD (JAN 2026)		
ID	RISK	NT RISK
522	There is a risk that the Trust is not capturing renewals and extensions, and contracts are expiring without sufficient time to strategize appropriately. In addition, lack of contract oversight is resulting in a failure to realise anticipated value and worth contracts.	9
487	Nexus House - Compliance with Health & Safety regulations and the Equality Act 2010	12
587	Paddock Wood Medical Distribution Centre Refurbishment (leaking roof)	12
655	There is a risk that the capacity and capability of the Trust's Estates Team is not sufficient to support the needs of the organisation in its current operating and control environment	9
637	There is a risk that the trust under-commits its allocated capital programme (CDEL/ROU) for 25/26 as a result of not identifying sufficient programmes of work and/or programmes	9
638	There is a risk that the Trust is subject to fraud resulting in financial loss	9
639	There is a risk that a failure to correct historic pay issues (in relation to ECSW, TAAPs pay and Section 2) could have a negative impact on our people.	12
40BAF	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.	8
641	There is a risk that the design and operation of financial controls is ineffective and results in poor value for money	9
642	There is a risk that the capacity and capability of the Trust's Finance Team is not sufficient to support the needs of the organisation in its current operation and control environment.	9

- 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.



Item No	106-25
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Name of meeting	<b>Trust Board</b>
Date	5 February 2026
Name of paper	Volunteering and Community Resilience Strategy and Business Case
Executive sponsor	Jen Allan, Chief Operating Officer
Author name and role	Danny Dixon, Head of Community Resilience
<p>This paper presents the Trust's proposed Volunteering and Community Resilience Strategy 2026-30, and accompanying business case to support implementation, for Board approval.</p> <p>The strategy responds to the Trust's desire to develop and build on existing valued volunteering activity to support our overall clinical strategy, as well as to deliver the recommendations of the AACE Review (led by Helen Vine) of our current volunteering function received by Board in June 2025.</p> <p>Following the review, extensive stakeholder engagement has taken place, internally and externally, including separate volunteer and staff focus groups, discussion at the Trust's public engagement forum, socialisation at management and governance subgroups, engagement with the National Ambulance Volunteer Responder Leadership Group, and direct conversations with key stakeholders. This led to the collaborative development of an overarching strategic aim, four strategic objectives with associated deliverables, and a set of principles through which the strategy would be delivered.</p> <p>Further development and endorsement has taken place via Joe Crook, the AACE National Volunteer Lead, to ensure alignment with the national volunteering strategy, and Helen Vine, to verify that the proposed new strategy sufficiently addresses the recommendations of her earlier review. In addition, the Trust has externally evaluated the Emergency Responder trial and incorporated the findings and recommendations into the strategy.</p> <p>Throughout November these were shared and discussed for feedback and refinement with Ops SLT, QPSC, EMB, People committee and the Shadow Board. Subsequently, the full draft strategy and the associated business case to fund implementation and delivery have been reviewed and endorsed through Business Case Group, EMB, Finance Committee and People Committee.</p> <p>Key aspects of strategy</p> <ul style="list-style-type: none"> <li>- Supports the Trust clinically-led strategy and outcomes, with a model which will save lives and serve the community.</li> <li>- Proposes an increase in resourcing and structure to support a minimum 50% increase in the number of active volunteers, supported by developments to function and delivery.</li> <li>- Specific volunteer roles to address community engagement and education, supporting the principles of the NHS 10-year plan.</li> <li>- Developing a 'whole of society' approach to resilience, where the Trust and our communities work in partnership through the work of our volunteers.</li> </ul>	

- Delivering a sustainable volunteering service which is based on demand, rather than supply, and prioritises impact over activity.

Page 11 of the draft document summarises the expected success indicators for the strategy, and presents a vision of the volunteering service in 2030.

Priorities for the strategy and for our volunteer work have been identified, including addressing health inequalities, integrating volunteering and the GoodSAM programme, enhancing support processes for volunteering and improving our data capture, analysis and benchmarking around the impact of volunteering to ensure data-driven decision making. We also want to prioritise developing the scope of what our volunteers can do at SECAMB into new areas, ensuring they fully meet the needs of our communities based on evidence and avoiding inequality.

People Committee noted and valued the quality and ambition of the strategy and endorsed its progression to Board. The need to integrate volunteering with our front line services through the Divisions and the strong and specific focus on using volunteers to enhance services and address health inequalities was emphasised. The committee also noted that assurance on the development of clear governance and standards for volunteering, and the need for a robust and timely evaluation of progress in delivering the strategy, should be embedded within the implementation plan in line with the strategy's aims.

We would like to take the opportunity to thank all our volunteers who commit time to supporting the Trust and our patients, and without whom this strategy could not be successfully delivered. We also thank all those who have contributed to the development of the strategy in any way.

Which strategic risk(s) does this relate to?	410 – Impact of the cessation of external charitable funding for the volunteer management team.
Recommendation	<p>The Board is asked to:</p> <ul style="list-style-type: none"> <li>- Formally receive and approve the Volunteering and Community Resilience Strategy</li> <li>- Approve the business case for implementation</li> </ul>



South East Coast  
Ambulance Service  
NHS Foundation Trust



# Volunteering and Community Resilience

## Strategy

2026 - 2030



“You cannot get through a single day without having made an impact on the world around you. What you do makes a difference and you have to decide what kind of a difference you want to make”

Jane Goodall, 1934 – 2025



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Saving Lives,  
Serving Our Communities

# Strategic context

The South East Coast Ambulance Service (SECAMB, 2024) Trust Strategy 2024–2029 – “Saving Lives, Serving Our Communities” sets out the Trust’s vision for the next five years: to transform patient care, improve outcomes, and strengthen its role within an integrated health system. The strategy recognises growing demand and the need for change to ensure long-term sustainability. Guided by the values of Kindness, Courage and Integrity, SECAMB’s purpose is to deliver high-quality, timely care for those in critical need while enhancing community-based and virtual care for patients with lower acuity conditions.

The strategy is built around three overarching aims. First, to deliver high-quality patient care by improving triage, differentiating patient needs, and providing timely emergency and virtual care — with clear outcome targets including a 5% increase in cardiac arrest survival rates, reduced treatment times for acute presentations, and fewer unnecessary conveyances to emergency departments. Second, to ensure SECAMB is a rewarding place to work, fostering an inclusive, compassionate culture and providing clear development pathways for all staff. Third, to be a sustainable partner within an integrated National Health Service (NHS), using data and digital innovation to improve efficiency, and promoting care in the community.

The Trust strategy aligns with the NHS 10 Year Plan (UK Government, 2025) which highlights three national strategic shifts, moving healthcare from hospital to community, treatment to prevention, and analogue to digital. Each of these require increased integration with local communities to deliver meaningful change

This strategy provides the foundation for the Volunteering and Community Resilience Strategy, recognising volunteers as an integral part of SECAMB’s delivery model. By aligning volunteering activity with the Trust’s strategic priorities — such as improving cardiac arrest survival, reducing health inequalities, and enhancing community-based care — SECAMB aims to strengthen local resilience, empower communities, and extend its reach beyond traditional service models. Volunteers will continue to play a vital role in helping SECAMB save lives and serve communities across Kent, Surrey, Sussex, and North East Hampshire.



1. We deliver **high quality patient care**



2. Our people **enjoy working** at SECAMB



3. We will be a **sustainable partner** as part of an integrated NHS

# Definitions

## Volunteering

Volunteering refers to the provision of time, skills, and commitment by individuals who freely give their time and expertise to support the Trust. Volunteers are an unpaid yet professional workforce, contributing to both clinical and non-clinical activities that enhance – rather than replace – the work of employed colleagues.



## Community

Community is understood in its broadest sense, encompassing not only the geographical regions across the Trust’s areas of operation, but also the diverse networks, cultural and faith groups, social collectives, and communities of shared experience or interest within them. Communities have unique and differing needs, strengths and capacities, and harnessing these by empowering people to take an active role in local health and wellbeing is intrinsic to improving health outcome and reducing health inequalities.



## Resilience

Resilience, in this context, refers to the collective capacity of individuals, communities and systems to prepare for, respond to, and recover from challenges (both on an individual and wider social basis). Advancing risk profiles, coupled with stretched resourcing in national services, have created a resilience gap, which requires a national shift in service provision from a “we will save you” mentality to a whole of society approach to resilience (Shaw and McClelland, 2025). Bridging the resilience gap is fundamental to strengthening community and organisational responses to adversity, leading to more effective and efficient preparedness and response.



# Our vision

Our vision demonstrates how we will support South East Coast Ambulance with delivering the Trust Strategy, recognising that volunteers are a resource who enhance and enrich, rather than bolster or subsidise, existing service delivery.

**Our vision is to provide a sustainable volunteering service which saves lives and serves the community.**

This serves as a 'guiding star' to ensure that activity, decisions, and objectives remain focused on a single goal which will provide a positive impact on our communities.

# Our aims

Our aims demonstrate how the Volunteering and Community Resilience function will enhance delivery of the Trust Strategy, and support delivery of the clinical operating model. They align to the three arms of the Trust strategy: our patients, our people and our partners.

Our overall aim is to enhance the delivery of the Trust strategy and support the clinical operating model.

Volunteering and Community Resilience Strategy



**1. We deliver high quality patient care**

We will...

- Focus volunteer responses where geographically required and clinically beneficial.
- Minimise the impact of health inequalities using data-driven decision making.



**2. Our people enjoy working at SECAmb**

- Enhance a positive and compassionate working environment for *all* colleagues.
- Support efficient service delivery with initiatives which enable and empower colleagues.



**3. We will be a sustainable partner as part of an integrated NHS**

- Represent the Trust and wider healthcare system within local communities.
- Embed health promotion and sickness prevention to create resilience communities.

# Our principles

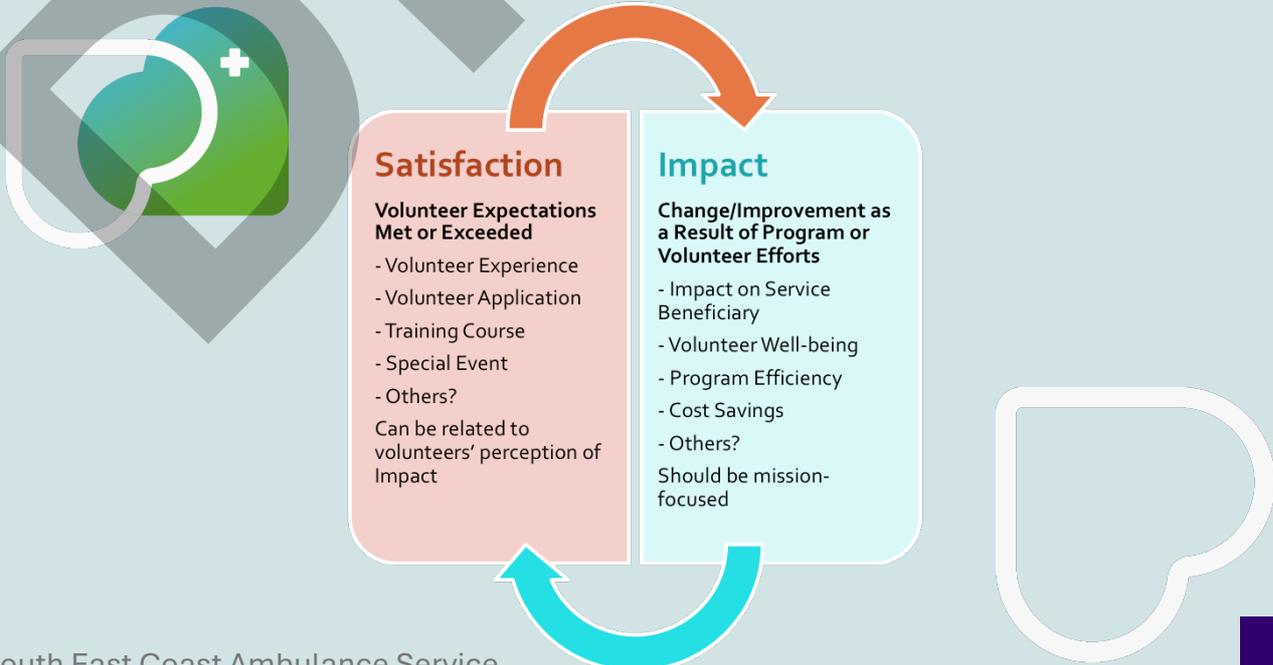
In delivering a strategy, it is important to distinguish between principles and preferences. Principles are the non-negotiable foundations that define what we stand for and guide how we operate – they reflect our purposes, values, and standards. Preferences, by contrast, describe how we might choose to deliver these principles in practice, and allow for flexibility and adaptability to meet the needs of different individuals, communities, and circumstances. In essence, principles provide the “what and why” that must remain consistent, while preferences describe the “how” – the approaches and methods that evolve as the organisation, its people, and its communities do.

By balancing principles with preferences, we can ensure that we provide a safe and governed service whilst allowing for meaningful autonomy to meet the needs of the local community.

## Balancing satisfaction and impact

Maintaining a motivated volunteer workforce is essential to successful delivery of the strategy, and this means achieving the balance between volunteer satisfaction and the impact of their actions. When volunteers feel valued, supported, and fulfilled, they are more likely to remain engaged and committed to their roles. However, volunteering within an ambulance service must also deliver measurable benefits for patients, communities, and the organisation. This means aligning volunteer activity with the Trust’s strategic priorities, ensuring that time and effort translate into improved outcomes and resilience.

Volunteering and Community Resilience Strategy



# Principles

## FLEXIBILITY

Volunteering roles and expectations will be designed to ensure adaptability in how they can be applied, to ensure that the principles and impact remain consistent, but the methodology for delivering that impact can vary depending on volunteer needs and preferences, and regional requirements. This will ensure an inclusive and diverse volunteering service which is adaptable to local community needs whilst ensuring a safe and governed approach.

## TRANSPARENCY

Ensuring the 'volunteer voice' is heard and represented throughout the Trust, with clear two-way feedback. Ensure expectations are clearly articulated, communicated, and supported.

## SUSTAINABILITY

Volunteering opportunities will be sustainable, both for volunteers and the Trust, promoting zero-cost volunteering and showing respect for volunteer time, whilst ensuring sufficient return on investment and maintaining financial efficiency.

## INTEGRATION

Ensuring volunteers are fully integrated into the Trust's operational delivery model, with strong links to Operating Unit leadership teams, clinical and corporate colleagues, Integrated Care and contact centres, and enabling functions within the Trust. Volunteers should also be integrated within their local communities and thereby offer a positive interface between the Trust and the communities we serve.

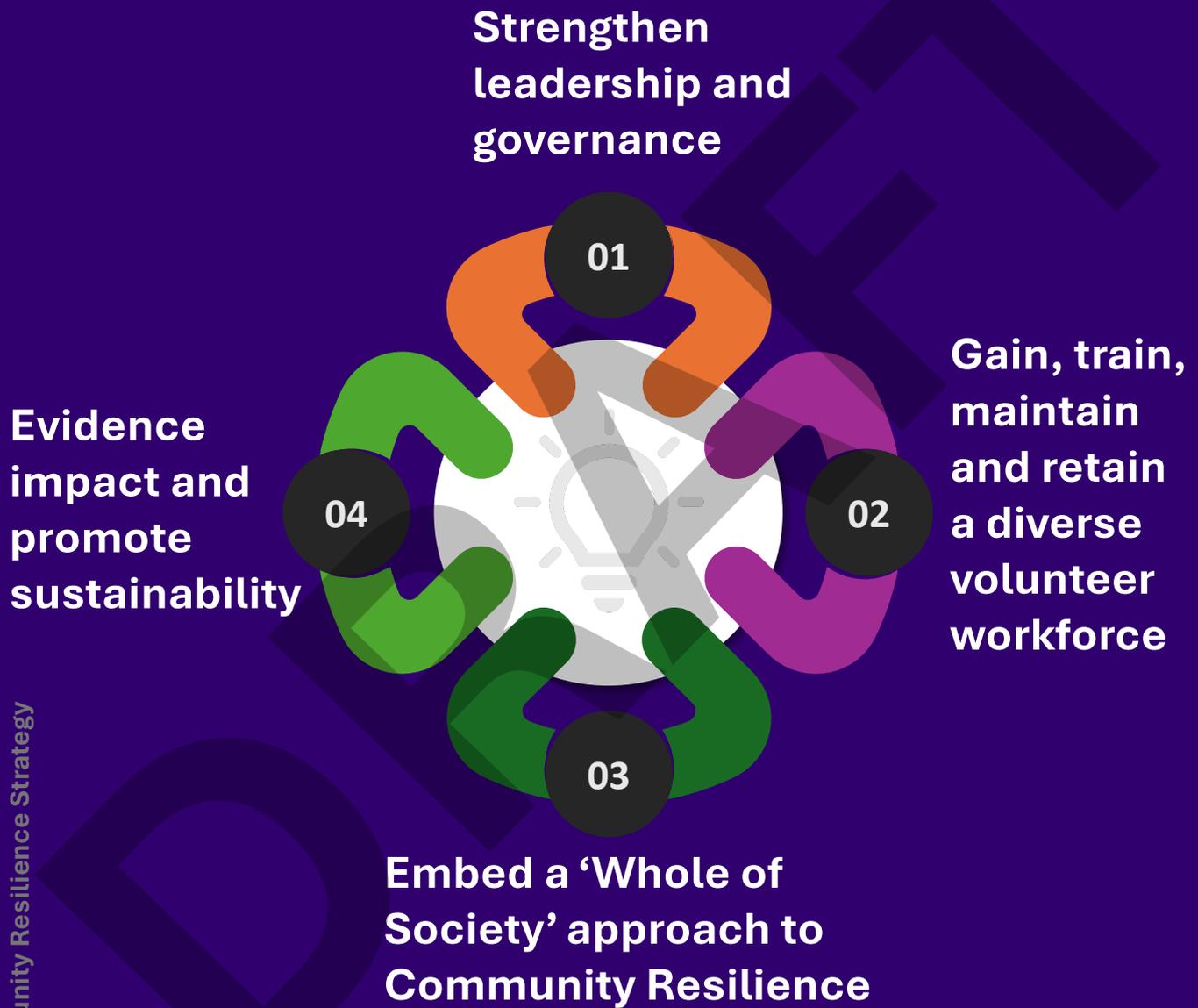
## IMPROVEMENT

Fostering a culture of continuous improvement where localised community needs can be identified, evaluated, and supported consistently and effectively. Projects delivered utilising quality improvement methodology.

## IMPACT

Decisions will be data-driven to ensure maximum impact, allowing for clear evidence of the impact of time volunteered, and ensuring an appropriate balance between volunteer expectations and Trust requirements.

# Objectives



# Objectives summary

## Objective 1: Strengthen leadership and governance.

1. We will establish a Volunteering and Community Resilience Department which fully aligns with the Trust's Clinical Operating model.
2. We will develop leadership opportunities for volunteers which align with the Department.
3. We will embed volunteering oversight within SECAMB's Board governance, with biannual reporting on volunteer metrics and impact.
4. We will encourage volunteer representation within all key governance forums.

## Objective 2: Gain, train, maintain and retain a diverse volunteer workforce.

1. We will identify specific community-based volunteer roles based on organisational need, with clear descriptions, training requirements, and expectations.
2. We will offer a modular training framework, to allow volunteers to move between roles more easily, ensure that training is appropriate to role, and that flexibility is provided to meet organisational need.
3. We will offer flexibility and variation in deployment models to meet individual volunteer, local community, and organisational needs.
4. We will establish a Volunteer-to-Career and a Career-to-Volunteer pathway, removing barriers between paid and voluntary roles.

## Objective 3: Embed a 'whole of society' approach to Community Resilience.

1. We will embed the chain of survival within communities, leading to increased survival from out-of-hospital cardiac arrest.
2. We will reduce the impact of falls on patients, the ambulance service, and the wider healthcare system.
3. We will develop meaningful partnerships with existing groups and organisations (charitable, public and private sector) to support delivery of key elements of our strategy.
4. We will implement the AACE EPRR Volunteer Framework.

## Objective 4: Evidence impact and promote sustainability.

1. We will continue to develop and review the scope of practice for our patient-facing volunteers based on identified needs and patient impact.
2. We will ensure effective use of public and charitable funds by maximising equipment utilisation and reducing unwarranted variation.
3. We will digitalise the volunteering infrastructure in a safe, secure, cost-effective, user-friendly way.
4. We will align and unify the financial operating model of all volunteer-led units with the SECAMB Charity.

# Success indicators summary

	2026	2027	2028	2029
<b>Objective one:</b> Leadership + governance	<p>Sustainable funding settlement in place to deliver strategy, with substantive leadership team in place.</p> <p>Impact reporting for internal and external stakeholders.</p>	<p>Volunteering and Community Resilience fully embedded within divisional and local leadership teams.</p> <p>Volunteer leadership training and development framework in place (aligned to Education strategy).</p>	<p>AACE Leadership Maturity Matrix rating increased to “thriving”.</p> <p>All Trust governance groups to have volunteer representation built into Terms of Reference.</p>	<p>All Operating Units have appointed Volunteer Leaders with succession planning in place.</p>
<b>Objective two:</b> Volunteer workforce	<p>Introduction of new community-based volunteer roles.</p> <p>Divisional Educators in post and aligned with Integrated Education.</p> <p>Trust volunteers preferred applicants for all vacancies.</p>	<p>Volunteer recruitment locally-led and data matched to demand profile, with positive action to improve representation.</p> <p>Emergency response capability available within each Division.</p>	<p>Volunteer training fully embedded within Trust’s Integrated Education Strategy.</p> <p>Peer supervision programme standardised for new and existing volunteers.</p>	<p>Volunteering population reflects the diversity of the SECAMB footprint.</p> <p>50% increase in number of volunteers targeted to areas of demand with reduction of inactive volunteers to less than 10%.</p>
<b>Objective three:</b> Community resilience	<p>All known cardiac arrest volunteer responders receive follow up.</p> <p>Delivery of the Falls and Frailty model of care.</p> <p>Fully embed the RC(UK) Quality Standards for Training in the Community.</p>	<p>All non-clinical Trust staff trained in CPR with at least 50% registered with GoodSAM.</p> <p>Role of SECAMB volunteers included within the Trust Incident Response Plan for major incidents.</p>	<p>Over 10% of the South East population ‘Resus Ready’ with no significant variation between areas.</p> <p>20% of cardiac arrests will have a defibrillator applied before an ambulance arrives.</p>	<p>Meaningful reduction in health inequalities for out-of-hospital cardiac arrest within the South East.</p> <p>Community Falls model fully embedded with Falls Rescue Kits sited and trained volunteers.</p>
<b>Objective four:</b> Impact + sustainability	<p>Pentrox available to all CFRs (subject to pilot evaluation).</p> <p>Clear guidance and toolkit provided to volunteers to encourage financial stewardship and income generation.</p>	<p>An ePCR solution will be in use by all patient-facing volunteer responders.</p> <p>All segregated funds depleted and all income generation into SECAMB Charity.</p>	<p>All equipment resources will be asset tracked with clear utilisation and return-on-investment metrics to support future purchase decision making.</p>	<p>Majority of capital costs for delivering volunteer activity met by SECAMB Charity, with volunteer-led income generation matching expenditure.</p>

# Objective 1:

## Strengthen leadership and governance

**We will establish a Volunteering and Community Resilience Department which fully aligns with the Trust's clinical operating model.**

This will ensure direct support for volunteers within all areas of the organisation and provide clear lines of reporting from volunteer to senior leadership, whilst ensuring that volunteers remain fully integrated to the Operating Units in which they are based. It will promote true integration with other departments within the Trust (for example Education, Patient Engagement, Integrated Care, Wellbeing) and uphold two-way collaboration in the delivery of all enabling strategies. Fundamental to this

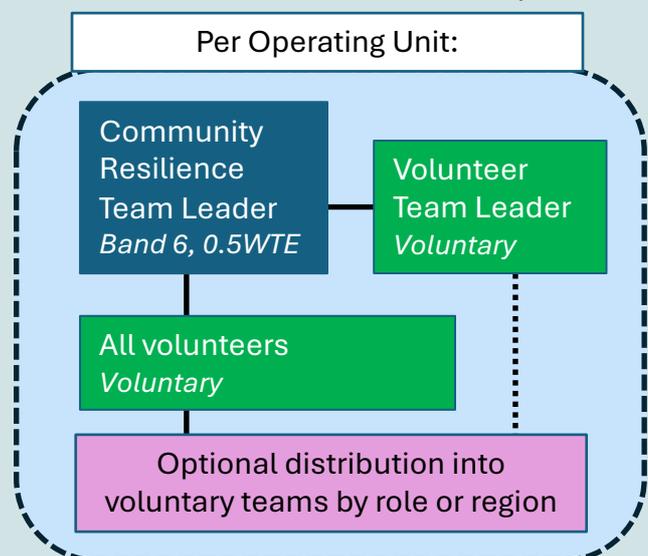
objective will be securing sustainable funding for the core volunteer infrastructure, recognising the importance of a stable leadership team whilst recognising that charitable funding can continue to be used to deliver additional projects. Alignment and integration will allow for effective and efficient administration and reporting, whilst recognising that volunteering activity will cross all areas of the Trust (including contact centres).

**We will develop leadership opportunities for volunteers which align with the Volunteering and Community Resilience Department.**

Volunteer-led leadership roles will be developed to integrate and enhance the function of the paid leadership team, allowing for meaningful autonomy within volunteer teams whilst maintaining the principles of the department and Trust. This will include a transparent selection process, recognise previous experience, and provide development opportunities.

Volunteers bring a range of different skills, knowledge and experiences which are incidental to their role, and we will seek to deliver mutual benefits by aligning these to specific portfolio and project lead opportunities to allow for meaningful local autonomy with central oversight from the Volunteering and Community Resilience Department.

Each Operating Unit will have a consistent support team which integrates paid and volunteer roles with local leadership teams:



# Objective 1:

## Strengthen leadership and governance

**We will embed Volunteering oversight within SECAmb's Board governance, with biannual reporting on volunteer metrics and impact.**

To demonstrate and monitor the impact of volunteering within SECAmb, the Trust will establish clear and measurable metrics that reflect the contribution of volunteers across all areas of activity. These metrics will be integrated into a Power BI dashboard, providing real-time access to data for key stakeholders and enabling informed, evidence-based decision-making. Performance against these

metrics, alongside progress in delivering the volunteering strategic plan, will be reported to the Trust Board on a biannual basis. In addition, SECAmb will ensure full compliance with all mandated and recommended national reporting requirements, including those set by NHS England (NHSE) and the Association of Ambulance Chief Executives (AACE).

**We will encourage volunteer representation within all key governance forums.**

SECAmb will establish a Volunteer Forum to represent the collective voice of volunteers, ensuring that all areas of the volunteer workforce are included and heard, and following the 'Volunteer Voice' guidance published by AACE (2025). Representatives from the Forum will be embedded within key Trust Governance Groups to strengthen collaboration, transparency, and shared decision-making

between volunteers and staff. Additionally, volunteer involvement will be introduced into Trust staff induction programmes—through roles such as Community Ambassadors and Community Educators—to promote early awareness and understanding of volunteering within SECAmb and to foster a culture of mutual respect and partnership from the outset of staff careers.

The Volunteer Voice will be welcomed and encouraged at Trust groups and subgroups, for example the Trust shadow board, to encourage consideration of differing insights.



# Objective 1:

## Strengthen leadership and governance

**Success Indicators**



1. We will establish a Volunteering and Community Resilience Department which fully aligns with the Trust’s Clinical Operating model.
2. We will develop leadership opportunities for volunteers which align with the Department.
3. We will embed volunteering oversight within SECAmb’s Board governance, with biannual reporting on volunteer metrics and impact.
4. We will encourage volunteer representation within all key governance forums.

2026

2027

2028

2029

**By mid 2026**

Sustainable funding settlement in place to deliver the strategy, with substantive leadership team in place.

Impact reporting in place for Trust Board, AACE and NHSE.

**By end 2027**

Volunteering and Community Resilience fully embedded with divisional and local leadership teams.

Volunteer leadership training and development framework in place (aligned to Education strategy).

**By end 2028**

AACE Leadership Maturity Matrix rating increased to “thriving”.

All Trust governance groups and subgroups to have volunteer representation built into Terms of Reference.

**By end 2029**

All Operating Units have appointed Volunteer Leaders with succession planning in place.

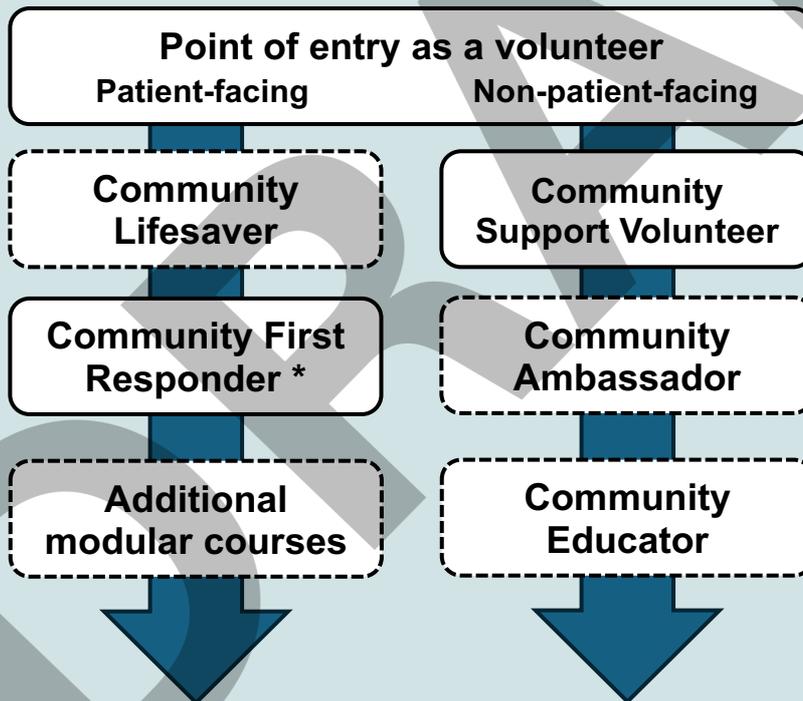
Volunteering and Community Resilience Strategy

# Objective 2:

## Gain, train, maintain, and retain a diverse volunteer workforce

**We will identify specific community-based volunteer roles based on organisational need, with clear descriptions, training requirements and expectations.**

Roles will include both patient-facing and non-patient-facing opportunities, recognising the variety of interests and skills held by our existing and potential volunteers. There will be an opportunity for progression from entry-level roles to more advanced positions, ensuring that the ability and availability of volunteers can be matched to the complexity and investment requirements of the roles offered – this will also allow for volunteers to move into other roles with reduced requirements as their circumstances change.



-----  
Indicates a new role.

\* The CFR title acts as an overarching role descriptor for a range of current defined roles such as Community Falls Team and Emergency Responder.

Each role will have a clear role description which identifies the purpose of the role, the relevant competencies required, the training requirements (both initial and maintenance training) and the expectation (including recommended hours). Roles will be designed on a modular basis to encourage volunteers to undertake more than one role where there is a desire and benefit to doing so.



## Case Study:

# HartslagNu (translates to ‘Heart Rate Now’)

The Netherlands is a densely populated, diverse nation in North East Europe, which runs a national civilian based call system for resuscitation called HartslagNu (in English, Heart Rate Now). The goal of HarslugNu is to increase the survival chances of those who suffer out-of-hospital cardiac arrest by embedding secure and sustainable CPR and AED citizen assistance throughout the Netherlands. They are the first country in the world with a national resuscitation network of civilian caregivers, and the impact of this is significant.



The 2024 Annual Report from HartSlagNu (2024) allows for comparison with key information from the SECamb (2025) Out of Hospital Cardiac Arrest report for a similar period and demonstrates a stark contrast of our current engagement with the community when supporting survival from cardiac arrest.

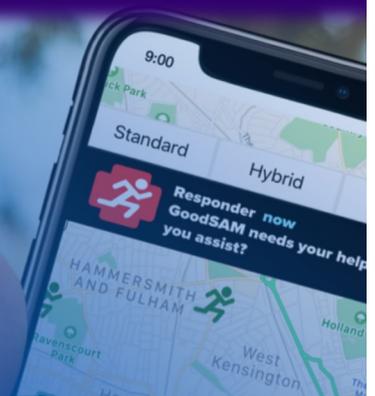


	Netherlands	SECamb
Number of cardiac arrests	12,726	9,065
Citizen responder alerted	99.9% 	9% 
Resuscitation started by bystander	79.2% 	77% 
Public Access Defibrillator used by citizen responder	61.2% 	9.5% 
Shock delivered by Public Access Defibrillator	42.5% 	45% 

This shows two key areas of focus where introducing the Community Lifesaver role, and enhancing our community-based response to cardiac arrest, can have a significant positive impact on patient care and survival from out-of-hospital cardiac arrest.

## Together we can save more lives

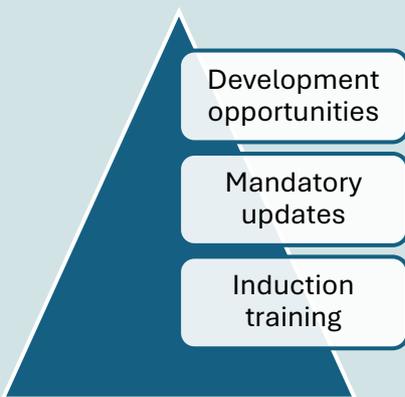
To find out more about our community response to cardiac arrest, including learning CPR and joining GoodSAM: <https://www.secamb.nhs.uk/cpr>



# Objective 2:

## Gain, train, maintain, and retain a diverse volunteer workforce

**We will offer a modular training framework, to allow volunteers to move between roles more easily, ensure that training remains appropriate to role, and that flexibility is provided to meet organisational need.**



All training will be provided on a tiered basis, ensuring that every volunteer is trained in the core knowledge and skills to deliver their role effectively (both initial induction training and ongoing maintenance of competency). Minimum training requirements will be built into role descriptions for internal and external transparency.

Where possible training will be delivered on a local or divisional level, minimising excess travel requirements and encouraging local integration and collaboration – including with paid colleagues.

A flexible approach to training will ensure the unique needs of volunteers are met, such as courses delivered in evenings and at weekends, split over multiple days where necessary.

Peer supervision (mentoring) will become embedded within our operational model, both for new and experienced volunteers, allowing for initial support and ongoing development. This will enhance the consolidation of theory into practice for new volunteers, improve confidence, provide governance and enhance patient and volunteer safety.

Development opportunities will include Continuous Professional Development (CPD) courses to support with improving confidence, and additional standardised modules to provide a quality-assured and governed approach to extra competences for the volunteer role undertaken.



# Objective 2:

## Gain, train, maintain, and retain a diverse volunteer workforce

**We will offer flexibility and variation in deployment models to meet individual volunteer, local community, and organisational needs.**

For patient facing volunteers, we will promote flexibility at each stage of the care episode:

### Standby

Current: volunteers work from their own home or workplace.  
Future: options for volunteers to work from a range of locations, including Trust sites, fixed areas of high demand / low resources, or mobilising to areas of intermitted peaks in activity (“standby”).

### Dispatch

Current: volunteers contacted to offer potentially suitable incidents to attend.  
Future: volunteers automatically dispatched based on pre-determined criteria where impact likely to be greatest (retain ability to decline attendance, gathering data on reasons).

### Mobilisation

Current: volunteers utilise their own car to respond.  
Future: we will utilise a range of methods for getting to scene depending on local need, including own cars, specialist volunteer vehicles, bicycles, and existing liveried Trust vehicles (including emergency response where trained).

### On scene

Current: volunteers work to a fixed and consistent scope of practice.  
Future: modular courses to be developed which enhance the volunteer activity where there is an evidenced local need to improve patient outcomes or experience.



# Case Study: Cycle Response Units

Frank Doel is a volunteer Community First Responder with the Trust and is also employed as a technician. He is passionate about improving local response times to patients in his community, and in conjunction with SECAmb's Innovators Den has launched a trial to use e-bikes to get to patients, particularly during peak times when local roads become very congested, hindering access for both volunteers and ambulances. Part of our new strategy involves identifying novel ways for volunteer responders to reach patients in a safe and timely manner to provide high quality care and improve patient experience.



The Manhood Peninsula is located at the southernmost tip of West Sussex, and is a semi-rural area known for its distinctive geography. Home to around 25,000 residents, the area experiences a significant rise in population during the summer months as visitors are drawn to its popular beaches, nature reserves, and coastal attractions. This seasonal influx places additional pressure on local infrastructure, particularly the limited road network, as access to the peninsula is restricted to a few key routes that cross narrow causeways - which makes responding to emergency calls in a timely manner more challenging particularly for volunteers travelling in their own cars.

The logical solution is to consider other forms of transport, with e-bikes being particularly well suited - they can travel safely both on and off-road, can safely bypass traffic whilst riding within the requirements of the Highway Code, and



can carry sufficient equipment (including an AED, oxygen and patient assessment devices) to provide an interim response until an ambulance arrives.

A pilot scheme has been launched for nine months to evaluate how effective this approach is to patient care, and following this any learning will be adopted into our volunteer response model moving forwards. As well as offering an improved patient response and experience, additional benefits include a more environmentally friendly way to reach patients which reduces our Trust carbon footprint, and providing opportunities for a broader range of volunteers who are unable to drive.



# Objective 2:

## Gain, train, maintain, and retain a diverse volunteer workforce

**We will establish a Volunteer-to-Career and a Career-to-Volunteer pathway, removing barriers between paid and voluntary roles.**

Our paid staff and volunteers work side-by-side, serving their communities. Integrating volunteer teams into the local operating units will enhance this collaboration, and will also increase the opportunities for individuals to move between volunteer and paid roles depending on their individual motivation and interests, and opportunities available.



Volunteers are motivated by a variety of reasons, and for some a volunteer role offers the opportunity to explore a career within the ambulance service whilst maintaining job security elsewhere. Where a volunteer applies for a paid role in the Trust, they have increased organisational knowledge, transferrable skills, and a demonstrable alignment to the Trust values making them an ideal applicant. Providing volunteers with the development and support to access careers in healthcare brings benefits both to the individual and the wider healthcare system.

Many paid staff are interested in volunteering opportunities, for a variety of reasons:

- Opportunity to do something different to their primary role
- Desire to 'give back' and support their local community
- Leaving the Trust for a new role but wish to maintain experience in ambulance setting
- Retiring but seeking a way to stay in touch with former colleagues

Irrespective of the reasons, ensuring these colleagues are supported, their activities are safe and governed, and their voluntary contribution is recognised provides benefits to the individual and Trust.



# Case Study:

## Critical Care to Colleague Care

Geoff Fitch has recently retired from his role as a Critical Care Paramedic (CCP) with the Trust, but was keen to continue supporting his colleagues and so has taken on a role as a Community Support Volunteer.

I have recently retired from the Trust after 24 years' service, and having held a range of different clinical roles I have most recently been working as a Critical Care Paramedic. Through this, I have come into contact with the welfare van and the volunteers who support it, and have seen first hand what a benefit to staff it is and how it can help to boost morale.

As I was preparing to end my service, I made enquiries about volunteering and after a discussion with the Community Resilience Team was given all the information I needed to get involved.

I felt that I wanted to give just a little back to the colleagues I had worked with and help to 'spread the love' a little. I am acutely aware, from my own personal experience, how this resource can help

your day, particularly if you have just dealt with a difficult job. Seeing a friendly face with a hot drink whilst preparing to deal with the next patient can make a big difference, and I knew that my experiences would allow me to provide a confidential and non-threatening listening ear for anyone who may need to offload with someone who can relate to their situation.

From a personal perspective, becoming a Community Support Volunteer gives me a great opportunity to stay in contact with former colleagues and keep up with the direction of the Trust, as well as knowing that I am still contributing to the work of the service (albeit in a different way). It has also helped ease the transition into retirement for me!



# Objective 2:

## Gain, train, maintain and retain a diverse volunteer workforce

### Success Indicators



1. We will identify specific community-based volunteer roles based on organisational need, with clear descriptions, training requirements, and expectations.
2. We will offer a modular training framework, to allow volunteers to move between roles more easily, ensure that training is appropriate to role, and that flexibility is provided to meet organisational need.
3. We will offer flexibility and variation in deployment models to meet individual volunteer, local community, and organisational needs.
4. We will establish a Volunteer-to-Career and a Career-to-Volunteer pathway, removing barriers between paid and voluntary roles.

2026

2027

2028

2029

### By end 2026

Introduction of new Community-based volunteer roles.

Divisional Community Resilience Educators in post (aligned with integrated Education team) and annual training plan published.

Trust volunteers will be preferential applicants for all vacancies.

### By end 2027

Volunteer recruitment locally-led and data-matched to demand profile of area, with positive action to improve representation.

Emergency response capability available within each Division.

### By end 2028

Volunteer training fully embedded within Trust's Integrated Education Strategy.

Peer supervision programme standardised for new and existing volunteers.

### By end 2029

Volunteering population reflects the diversity of the SEC Amb footprint.

50% increase in number of volunteers targeted to areas of demand with reduction of inactive volunteers to less than 10%.

# Objective 3:

## Embed a 'whole of society' approach to Community Resilience

**We will embed the chain of survival within communities, leading to increased survival from out-of-hospital cardiac arrest.**

The Resuscitation Council UK (RCUK) Guidelines 2025, based on the work of the International Liaison Committee on Resuscitation (ILCOR), further emphasise the importance of the chain of survival, which should be seen as best practice for ensuring meaningful survival from out-of-hospital cardiac arrest. Systems Saving Lives (RCUK, 2025) advocates for community-based initiatives to promote the implementation of CPR, from the age of 4 and up. It also identifies the importance of healthcare systems embedding a first responder programme with the focus on reducing time to first chest compression and defibrillator shock delivery.

### Community Ambassadors

Health promotion to prevent cardiac arrest  
Survivor engagement and bystander support  
Promoting Public Access Defibrillators (PAD)

### Community Educators

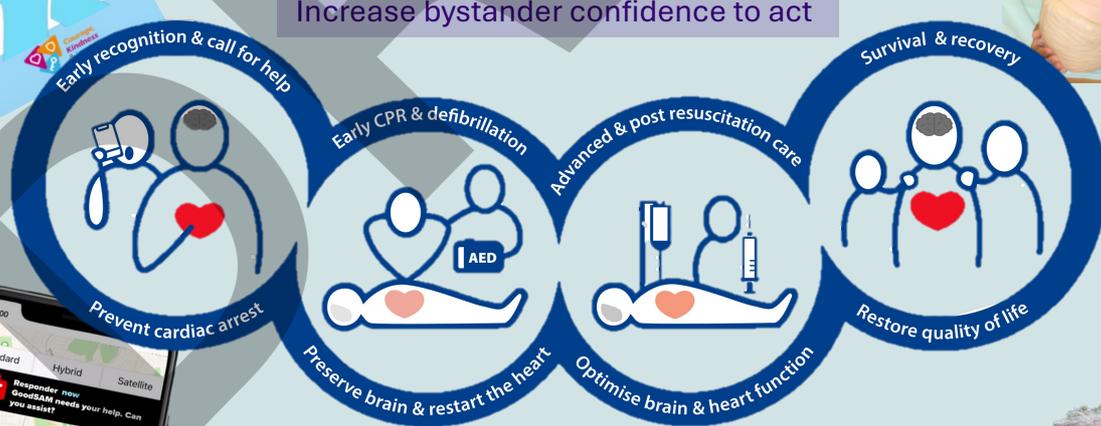
Improving high-quality bystander CPR  
Increase bystander confidence to act

### Community Lifesavers

Ensuring rapid hands-on-chest in community  
PAD site guardians and improved PAD to scene

### Community First Responders

Supporting clinicians to deliver high quality care



Volunteering and Community Resilience Strategy

# Case Study:

## Public Access Defibrillators

Phil Williams is a Paramedic who works for SECamb and lives in a rural area. He was keen to ensure a Public Access Defibrillator (PAD) was available should his neighbours need it. Supporting our people in similar communities to obtain and maintain PADs to improve survival from out-of-hospital cardiac arrest is a key focus of the new strategy.

I live in a very rural area and from experience I know that it could take time for an ambulance to reach us in an emergency. I wouldn't want to be waiting for a defibrillator should it be that serious and with all the neighbours joking that I was going to be the second person they call (after an ambulance) I thought we had better have one available!

To explore options, I contacted a local charity, as well as our parish council, and while everyone was supportive it seemed funding was the main barrier. Everybody wanted to give me further people to contact and in the end I was going round in circles so, as a community, we decided to raise the money ourselves. I set up a small charity so we could claim Gift Aid and boost our fundraising, and once we had raised enough we purchased a defibrillator and cabinet directly from a supplier. It's now installed on the back of my garage and accessible to everyone. The local Community First Responder (CFR) team

were brilliant and ran a training session that walked everyone through what to do in an emergency and even came with a training version of the defib. There were a lot of nerves when the defib was first installed but that training was invaluable, and everyone came away buzzing!

My advice to anyone thinking about installing a defibrillator would be to carefully consider the location as it needs to be safe, visible, and ideally have access to a power supply. The parish councils are a good place to start, although my local one already had the coverage they wanted and in the end we found it was surprisingly easy to raise the money required ourselves. Setting up the charity was hard work but worth the effort in the end and we couldn't be prouder of our community defib and the reassurance it gives us that, should the worst happen, we have the tools and knowledge to give somebody the best chance of survival!

The Resuscitation Council (UK) produce a free guide on Public Access Defibrillators for Communities, available here:  
<https://bit.ly/AEDguide>



# Objective 3:

## Embed a ‘whole of society’ approach to Community Resilience

**We will reduce the impact of falls on patients, the ambulance service, and the wider healthcare system.**

Falls represent a significant impact on society, both for the individuals affected and within health and social care systems. A third of people over 65 will experience a fall at home every year, and this often heralds the onset of functional decline. Around three quarters of the cost of supporting falls is in the community and embedding our volunteer response to this as a community response is key. The Association of Ambulance Chief Executives (AACE, 2025) Falls Governance Framework sets out five key domains, all of which will be supported by this strategy and aligned with the Falls and Frailty Model of Care.

DOMAIN	
<b>1 Prevention</b>	Community Ambassadors supporting local events with falls prevention awareness and signposting to local services.
<b>2 Supporting community resilience</b>	Community Educators delivering courses to empower members of the public and their relatives to manage falls.
<b>3 Assessment and remote care</b>	Community First Responders liaising with Trust clinicians to provide a remote clinical consultation promoting virtual care.
<b>4 Falls response</b>	Community First Responders as an initial response to minimise the risk and impact of post-falls complications.
<b>5 Avoiding further harm</b>	Raising local awareness, creating an efficient ambulance response by supporting locally earlier in the patient journey.

Volunteering and Community Resilience Strategy



Exploring alternative response models to falls in the community.

# Objective 3:

## Embed a ‘whole of society’ approach to Community Resilience

**We will develop meaningful partnerships with existing groups and organisations (charitable, public and private sector) to support delivery of key elements of our strategy.**

In order to create meaningful change within communities which extends beyond the primary impact of our volunteers, it will be essential to develop meaningful partnership with other agencies. This aligns with the NHS strategic plan for co-

locating health, local authority, and voluntary sector to ensure community needs are met holistically. Although this applies to all volunteer roles, there are three key areas where this can demonstrate particular impact.

### Community Lifesavers

There are many organisations which have a large, mobile workforce who could infrequently be briefly redeployed from their primary role to attend a cardiac arrest with minimal impact on their employer – examples include other blue light agencies (whilst engaged on routine work), postal workers and delivery drivers, council workers, security personnel, and rail staff. By working with organisations to provide training and agree any limitations (such as only responding within their own working environment), GoodSAM technology can ensure cardiac arrest victims get hands-on-chest as rapidly as possible, leading to greater survival.

### Community Educators

As well as providing community education, we can focus on providing quality assured training materials, train-the-trainer courses, and ongoing peer support so that our Educators have an exponential impact, ensuring sustainability for the training provided and minimising costs of delivery both for the Trust and receiving organisations. This also offers the opportunity for supporting call reduction through community education, for example by increasing awareness of other healthcare services.

### Community First Responders

Embedding volunteers within local Operating Units (OU) with local oversight allows for the creation of additional, self-contained teams under the governance of that OU – particularly in areas where there is a defined need or potentially delayed response. Examples include university campuses, prisons, and large shopping precincts. There is also the opportunity for collaboration with other volunteer groups to support a shared goal, such as Volunteer Search and Rescue teams, military reserve units, and community support groups .

# Objective 3:

## Embed a ‘whole of society’ approach to Community Resilience

**We will implement the ACE Emergency Preparedness, Resilience and Response (EPRR) Volunteer Framework, ensuring volunteers can support the Trust effectively during major incidents.**

SECamb will adopt and implement the ACE EPRR Volunteer Framework to ensure that volunteers are appropriately trained, equipped, and integrated to support the Trust during major incidents and periods of heightened demand. A Volunteer Skills Matrix Tool will be developed to identify and record the skills, experience, and availability of volunteers who may be suitable for EPRR deployment. In addition, a Volunteer EPRR Deployment Action Card will be introduced to provide clear, role-specific guidance during activation.

Opportunities will be explored for volunteers to take on functional roles within the command support structure, ensuring support for command staff without negatively impacting on operational availability (NARU, 2013).

Volunteers will also be actively involved in EPRR exercises and simulations, enhancing their readiness while supporting the learning, confidence, and resilience of both clinical and command staff during emergency response situations.

Consideration will be given to how volunteers can best support the Trust during unanticipated extreme events, significant disruptions, and Business Continuity Incidents (learning from the rapid evolution and adaptation demonstrated during the coronavirus-19 pandemic).

Opportunities will be identified for local collaboration within communities during adverse incidents, recognising that increased risk also brings increased motivation to volunteer to enhance community resilience (Cabinet Office, 2025).



# Objective 3:

## Embed a ‘whole of society’ approach to Community Resilience

### Success Indicators



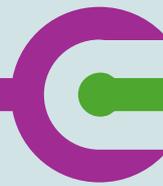
1. We will embed the chain of survival within communities, leading to increased survival from out-of-hospital cardiac arrest.
2. We will reduce the impact of falls on patients, the ambulance service, and the wider healthcare system.
3. We will develop meaningful partnerships with existing groups and organisations (charitable, public and private sector) to support delivery of key elements of our strategy.
4. We will implement the AACE Emergency Preparedness, Resilience and Response (EPRR) Volunteer Framework.

2026

2027

2028

2029



### By end 2026

### By end 2027

### By end 2028

### By end 2029

All known cardiac arrest volunteer responders receive follow up to provide thanks, signpost for support, and gather feedback.

All non-clinical Trust staff trained in CPR with at least 50% registered with GoodSAM.

Over 10% of the South East population to be ‘Resus Ready’ (2) with no significant variation between areas.

There will be a meaningful reduction in health inequalities for out-of-hospital cardiac arrest.

Delivery of the Falls and Frailty Model of Care.

The role of SECAmb volunteers will be included within the Trust Incident Response Plan for major incidents.

20% of out-of-hospital cardiac arrests will have a defibrillator applied before an ambulance arrives.

Community Falls model fully embedded with Community Falls Rescue Kits sited and trained volunteers.

Fully embed the RC(UK) Quality Standards for CPR and AED Training in the Community (1).

(1) RC(UK) Quality Standards: <https://www.resus.org.uk/library/quality-standards-cpr>

(2) RC(UK) ResusReady Map: <https://www.resus.org.uk/about-us/get-involved/resusready/resusready-map>

Find out more about our community CPR initiatives here:  
<https://www.secamb.nhs.uk/cpr>

# Objective 4:

## Evidence impact and promote sustainability

**We will continue to develop and review the scope of practice for our patient-facing volunteers based on identified need and patient impact.**

SECamb will maintain a dynamic and evidence-based approach to defining the authorised interventions for patient-facing volunteers, ensuring it remains aligned with patient need, clinical governance, and measurable impact on outcomes and experience. At the same time, interventions that are infrequently used or demonstrate limited clinical benefit will be reviewed, with consideration given to reducing or removing them from the standard skillset.

Scope of practice may vary between Community First Responders (CFRs) depending on individual competence, confidence, and experience, ensuring safety and quality of care. A modular

approach (uniquely possible with volunteer responders due to the model of augmentation rather than replacement of commissioned clinical responses) will allow for pre-defined groups of volunteers to align to local needs.

Deployment and scope will be strategically aligned to incidents where volunteers can deliver the greatest benefit to patients, and the Trust will explore opportunities for volunteers to support lower acuity cases through a physical presence that complements remote clinical consultations - enhancing virtual care provision, supporting accurate triage, and optimising patient flow.

Specific variations to the skillset of volunteer responders currently anticipated include:

### Analgesia

The provision of methoxyflurane (Pentrox) to Community First Responders (pending results of a successful trial period) to manage patients in pain earlier and thereby improve the patient experience.



### ePCR

Providing CFRs with an electronic Patient Clinical Record (ePCR) solution will support accurate record keeping, reduce the risk associated with paper records, and allow volunteers to record patient details saving time for later arriving clinicians.



# Objective 4:

## Evidence impact and promote sustainability

**We will ensure effective use of public and charitable funds by maximising equipment utilisation and reducing unwarranted variation.**

SECamb will ensure that all public and charitable funds invested in volunteering deliver maximum value and impact through efficient, standardised, and evidence-based use of resources, while utilising the charity to grow regional funding and community support for CFRs through a symbiotic approach.

Multi-purpose vehicles will be utilised wherever possible, equipped to support a range of functions including welfare provision, Community First Responder (CFR) deployment, public and community engagement, and logistical support.

Vehicles and volunteers can also be deployed to support other Trust business needs and charitable aims, including vaccination clinics, information sharing, and educational campaigns.



A robust approach to asset tracking and management will be developed in collaboration with the Trust logistics function to monitor utilisation, maintain accountability, and inform future investment decisions. Equipment purchasing will be standardised across all volunteer units to ensure consistency, maximise economies of scale, and reduce training requirements.

The distribution of equipment will be proportionate to volunteer activity levels, allowing lower-activity volunteers to continue to contribute meaningfully while ensuring that high-demand resources are used effectively.



Uniforms will also be standardised to meet the operational requirements of each volunteer role, providing a cost-effective and professional identity that reinforces the visibility and impact of volunteers as distinct but integrated colleagues.

# Objective 4:

## Evidence impact and promote sustainability

**We will seek to digitalise the volunteering infrastructure in a safe, secure, cost-effective and user-friendly way.**

Recognising the increasingly digital world in which we operate, SECAmb will deliver on the NHS 10-Year Plan's strategic shift from analogue to digital by modernising the volunteering infrastructure to improve efficiency, safety, and accessibility. The focus will be on ensuring systems are fit for purpose for volunteers and providing targeted support and training for those who are not digitally fluent to enhance ICT functional skills. Systems will be selected on the basis of functional need, with a balance between volunteer needs and integration with the wider Trust.

Digital platforms will be integrated wherever possible to maintain cost efficiency, reduce duplication, and minimise administrative burden—distinguishing between operational systems such as NMA and Responder+, and administrative systems such as Assemble and Selenity.

A clear digital communication strategy will also be developed and implemented, ensuring that messages are appropriately

categorised as essential, time-limited, or general information. This approach will prioritise user experience, allow for flexibility in how volunteers engage with content, and ensure clarity and consistency while avoiding unnecessary duplication.

The principle of flexibility will be adopted where possible, ensuring that volunteers can utilise their preferred approach to access the information they need, with clear delineation between information which needs to be shared in a timely manner, and information which can be made available to access at a volunteer's convenience. Solutions will be selected due to suitability for a mobile workforce.

Digital systems will also be used to allow information to be filtered by relevance, in particular allowing for localised working (for example supporting volunteers with identifying where peaks in demand exist locally).



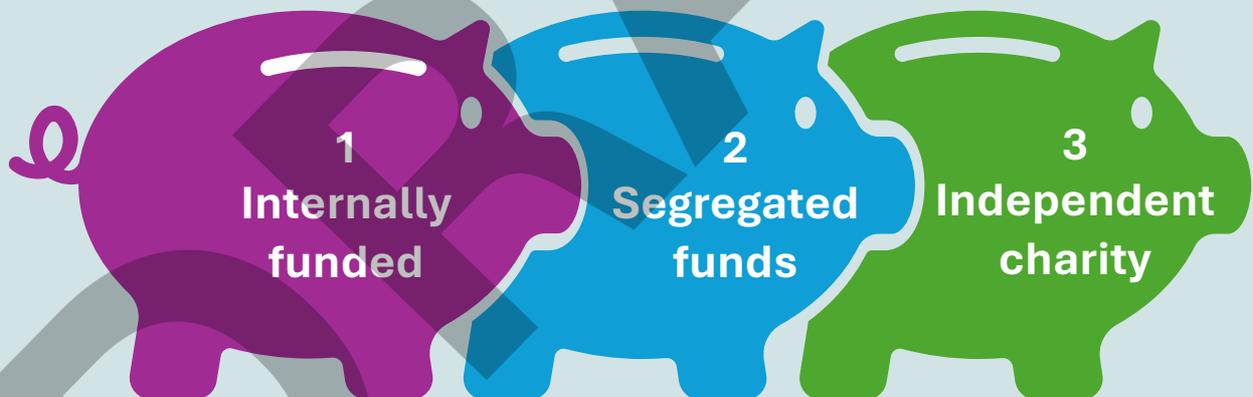
# Objective 4:

## Evidence impact and promote sustainability

**We will align and unify the financial operating model of all volunteer-led units with the SECAMB Charity.**

SECAMB will deliver a 'shift left' in the funding model for all Trust Volunteer Units, ensuring that essential operational costs are centrally supported while applications for additional expenditure are reviewed through an agreed governance process. No new independent charities will be established, and charitable giving will instead be embedded within volunteering activity with all fundraising and donations directed to the SECAMB Charity. A no detriment approach will be taken for existing independent charities, recognising

and supporting them unless they choose to transition towards a centralised model, while managing any potential conflicts of interest with care. These groups will be offered guidance in fund management and encouraged to contribute to shared, centralised resources that support communities facing local fundraising barriers. This approach will ensure that funding for volunteer schemes is equitable, accessible, and designed to avoid reinforcing health inequalities across the communities that SECAMB serves.



Units hold no separate funds, all operating costs are met by the Trust, and any fundraising activity supports the SECAMB charity.

Operating costs are fully funded by the Trust, but units hold segregated funds within Trust accounts for buying 'value added' items.

Unit has registered as an independent charity (with a unique charity number) and is subject to the relevant legislation and governance.

**SHIFT LEFT:** aim to align all units as internally funded.  
*(no new segregated funding or independent charities)*

Volunteering and Community Resilience Strategy



To donate to our SECAMB Charity, please visit our charity website:  
<https://www.secamb.nhs.uk/charity>

# Objective 4:

## Evidence impact and promote sustainability

### Success Indicators



1. We will continue to develop and review the scope of practice for our patient-facing volunteers based on identified needs and patient impact.
2. We will ensure effective use of public and charitable funds by maximising equipment utilisation and reducing unwarranted variation.
3. We will digitalise the volunteering infrastructure in a safe, secure, cost-effective, user-friendly way.
4. We will align and unify the financial operating model of all volunteer-led units with the SECamb Charity.

2026

2027

2028

2029

### By end 2026

Pentrox will be available to all Community First Responders (subject to successful pilot evaluation).

Clear guidance and toolkit provided to volunteers to encourage financial stewardship and income generation for SECamb Charity.

### By end 2027

An ePCR solution will be in use by all volunteer responders.

All segregated funds depleted through planned expenditure supporting community activity, and all income generation into SECamb Charity.

### By end 2028

All equipment and resources will be asset tracked with clear utilisation and return-on-investment metrics to support future purchase decision making.

### By end 2029

Majority of additional costs for delivering volunteer activity met by SECamb Charity, with volunteer-led income generation matching expenditure.

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The Trust recognises and is grateful for the support of all those who have contributed to the development of this strategy, including our volunteers, staff and members of the public.

RAFT



Saving Lives,  
Serving Our Communities

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## BUSINESS CASE TEMPLATE

### VOLUNTEERING AND COMMUNITY RESILIENCE STRATEGY

**22 January 2026**

**Author(s):** Danny Dixon, Head of Community Resilience

**Executive Lead:** Jennifer Allan, Chief Operating Officer

**Directorate:** Operations (Resilience and Specialist Operations)

**Business Case Ref:** BC-2526-022

**Version:** 0.9

**Date of approved summary QIA:** 15 January 2026

**Final Decision:**

Date proposal reviewed	By	Decision made

## **Document Control:**

### **Version Control:**

<i>Please record all key changes made to the document and how these have been approved (either person or committee)</i>				
Version	Date	Author and title	Summary of key changes	Approval by
V0.4	30/12/25	Danny Dixon		
V0.5	09/01/26	Danny Dixon	Amend to Trust template	
0.6	13/01/26	Mark Higgingson	Finance updates	
0.7	14/01/26	Rachel Murphy	Further updates	
0.8	14/01/26	Danny Dixon	Updates following JA feedback	
0.9	22/01/26	Danny Dixon	Updates following Business Case Group, EMB and Finance Committee	

### **Review and Approvals log:**

<i>Please ensure you log (in chronological order) all reviews and approvals to show the audit trail for support for your proposal</i>			
Version shared	Person and title or Committee	Date reviewed	Recommendation
	Managers of affected departments ( <i>state individual managers</i> )		
V0.5	Executive Sponsor	13/01/26	Approved to go forward to BCG
0.8	Business Case Group	19/01/26	Approved to go forward to EMB
0.8	Executive Management Board (EMB)	21/01/26	Approved to go forward to FIC
0.8	Finance and Investment Committee (FIC)	22/01/26	Approved to go forward to Board
0.9	Trust Board		

## 1. Proposal Overview

*Provide a summary of the whole case and include a brief background of the relevant area, proposal aim, current state, business need, all options considered and why they have been discounted and the preferred Solution. State the whole life cost.*

### Background

South East Coast Ambulance Service has an established and committed cadre of volunteers, who choose to give up their time freely to serve their communities. They are supported by a small but passionate team who are subject matter experts and have worked hard to deliver an evolution in volunteering.

A new Volunteering and Community Resilience Strategy, which builds upon the work and experience of both volunteers and the department, has been collaboratively developed over the past six months. It incorporates learning from the experience of the department to date, evaluation of various trials and pilots which have taken place within the Trust (some of which have continued to operate without specific funding to support), and best practice from ambulance volunteer schemes and other NHS volunteering across the country.

Delivery of this strategy requires an adequate funding settlement to provide the infrastructure necessary to support the continued provision of an effective volunteering service within the Trust. This business case details that settlement and highlights the benefits and positive impact the service will have on our patients, our people and our community partners.

### Aim

Through this business case, the new strategy will deliver the overarching vision of providing a sustainable volunteering service which saves lives and serves the community. This will align with the Trust's overall strategic aim and three primary objectives as follows:

Aligning to the overall Trust strategy, we will enhance delivery of the Trust Strategy and support the clinical operating model. This recognises that volunteering provides a model which enhances and enriches the Trust's models of care, rather than subsidising or bolstering them.

In delivering high quality patient care, we will:

- Focus volunteer responses where geographically required and clinically beneficial.
- Minimise the impact of health inequalities using data-driven decision making.

To ensure our people enjoy working at SECAmb, we will:

- Enhance a positive and compassionate working environment for *all* colleagues.
- Support efficient service delivery with initiatives which enable and empower colleagues.

In being a sustainable partner as part of an integrated NHS, we will:

- Represent the Trust and wider healthcare system within local communities.
- Embed health promotion and sickness prevention to create resilient communities.

### Current State

The Community Resilience department currently supports around 500 volunteers located across the Trust's geographical footprint. The majority of these are in patient-facing roles (specifically Community First Responders, including a subset of Emergency Responders

as part of a concluding pilot project), with a smaller number of non-patient-facing support volunteers. There are also volunteers elsewhere in the Trust which are outside the department but are peripherally supported (such as chaplains). Volunteers are fairly evenly spread between the 14 Operating Units.

Volunteers are directly managed by two Whole Time Equivalent (WTE) band 6 Community Resilience Leads, who in turn are managed by two WTE band 7 Community Resilience Managers. There is support from two WTE band 4 Administrators and one 0.5WTE band 4 Education Facilitator. Intermittent increase in support has historically been provided through charitable funding, but this is inconsistent and no further funding is currently anticipated. The current structure is shown in Appendix A.

There is limited integration with the remainder of the Trust, either at an operational (service delivery) level or from a management (service development) perspective.

As identified in the AACE led strategic review: “The current leadership infrastructure does not provide sufficient capacity and stability to support volunteers appropriately. Funding is temporary, changes of personnel frequent, in part due to the lack of certainty for these postholders, and this impacts on the experience of staff and volunteers and limits the impact volunteering can have.”

### **Business Need**

Healthcare across the UK is delivered in a context of rising demand and constrained resources. Ambulance services, in particular, face increasing call volumes, greater clinical complexity, and sustained operational pressures. Meeting these challenges requires novel and sustainable approaches that expand capacity, improve patient outcomes, and make best use of community assets.

SECAmb currently benefits from a dedicated workforce of around 500 volunteers delivering a range of clinical and non-clinical roles, including community first responders, chaplains, welfare volunteers, and governors. However, a comprehensive strategic review undertaken by the Association of Ambulance Chief Executives (AACE) in 2025 found that the existing infrastructure supporting volunteering was inadequate and unsustainable. The review identified a lack of stable leadership, inconsistent funding, fragmented data collection, and variable volunteer experience across the region. These weaknesses limit the impact and potential of volunteering within SECAmb and risk undermining volunteer satisfaction, retention, and patient benefit.

The current volunteering model has evolved organically over time, shaped by immediate operational needs and volunteer interests rather than strategic design. Much of the leadership and coordination is funded through temporary or charitable means, creating uncertainty for staff and inconsistency in volunteer support. While the Trust benefits from significant goodwill and local fundraising, this patchwork approach perpetuates inequality between communities—those with strong local fundraising capacity enjoy more robust volunteer schemes than those in less affluent areas.

The AACE review concluded that without stable, core-funded infrastructure, SECAmb cannot sustain its current level of volunteer activity. The Trust faces a critical decision: either reduce volunteer activity to match the available resources or invest in a sustainable model that aligns resources with activity levels and maximises strategic impact. The latter option provides an opportunity not only to maintain but to enhance volunteer contribution, ensuring that it is fully aligned to areas of greatest need and strategic value—such as improving cardiac arrest survival, reducing conveyances and supporting virtual care, and embedding community resilience within the Trust’s operating model.

The Trust is developing a five-year *Volunteering and Community Resilience Strategy* which sets out a structured, measurable approach to embedding volunteers across the organisation. This business case is therefore both complementary and foundational—the successful delivery of the strategy is contingent on the funding and infrastructure proposed within this case. The combined ambition is to create a sustainable, evidence-led model that strengthens leadership, standardises processes, and positions volunteering as a key enabler of SECamb’s operational and strategic objectives.

Whereas volunteering has historically been reactive, the new strategy provides the opportunity to transition to a purposeful, data-driven and outcomes-focused model. Volunteer activity will be planned, resourced, and evaluated to ensure measurable impact across three domains: patient outcomes (‘our patients’), staff wellbeing (‘our people’), and community resilience (‘our partners’).

## Options

In developing this business case, three delivery options have been considered to determine the most effective, affordable and strategically aligned approach to supporting volunteering and community resilience within the Trust (see visual structures in appendix A).

### Option One – Do Nothing

Under this option, the Trust would continue with the current level of substantive funding and maintain the existing infrastructure of the Community Resilience Department. This would necessitate a significant reduction in activity, as current resources are insufficient to sustain both existing services and the ambitions of the proposed *Volunteering and Community Resilience Strategy*.

Delivery would therefore be restricted to the “*Our Patients*” component of the strategy, with all activity aligned to the “*Our People*” and “*Our Partners*” strands ceasing. This reduction would likely have a negative impact on volunteer satisfaction and limit opportunities for wider engagement, collaboration, and innovation.

Additionally, this option would result in the loss of three roles currently funded through charitable income: one **Community Resilience Lead (Band 6)** post ending on **31 March 2026**, and two **Community Resuscitation Officer (Band 5)** posts ending in **April 2027**. The resultant capacity gap would further reduce the department’s ability to sustain current levels of volunteer support and coordination.

While financially neutral in the short term, this option is operationally and strategically unsustainable, and would not meet the requirements of either the Trust Strategy (*Saving Lives, Serving Our Communities 2024–2029*) or the AACE Strategic Review recommendations.

### Option Two – AACE Strategic Review Model

This option proposes expanding the size of the department to align with existing volunteer activity, implementing the structure recommended through the 2025 AACE Strategic Review. This model fulfils the national expectations of an Ambulance Volunteering Support Team, and provides sufficient resources and leadership capacity to deliver the *Volunteering and Community Resilience Strategy* in full.

The proposed structure includes capacity for seven-day operational cover with a 24/7 on-call function, providing a high degree of resilience and responsiveness. However, since the

completion of the AACE review, SECAMB's operational structure has evolved to a divisional model, and this proposed configuration does not fully align with that structure.

While this option represents a comprehensive response to the review's recommendations, it may not optimise integration with divisional leadership teams or deliver the same level of efficiency and local accountability achievable under a model aligned to the current operating framework.

#### **Option Three – Recommended Option: Divisional Model Integration**

This preferred option proposes increasing the size and capacity of the Community Resilience Department in line with SECAMB's new divisional clinical operating model. It builds upon the recommendations of the AACE review but reconfigures delivery around greater local integration, efficiency, and impact.

Under this approach, volunteer leadership and support functions would be embedded within the divisional and operating unit structures, promoting stronger relationships between volunteers and local clinical, operational, and support teams. This integration will enable a demand- and impact-driven approach to volunteering, ensuring activity is targeted where it can deliver the greatest benefit to patients, staff, and communities.

The proposed structure provides for full delivery of the *Volunteering and Community Resilience Strategy*, ensuring that all existing volunteer roles are supported while introducing new mechanisms for measuring impact and aligning resources with outcomes. It offers improved value for money by focusing the majority of work within social hours, with unsocial hours delivered on an "as required" basis to maintain flexibility and financial efficiency.

This option also includes the transition of volunteers to using the electronic Patient Clinical Record (ePCR) platform used by all other patient-facing colleagues within the Trust (currently they utilise the paper-based system which was previously in use and is now reserved as a backup in case of system failure).

This model delivers the best balance of strategic alignment, operational integration, sustainability, and cost-effectiveness, and is therefore the recommended option.

#### **Option Four – Divisional Model Integration without ePCR**

This final option provides the full infrastructure proposed by option three, but without the inclusion of ePCR. This would necessitate acceptance that patient-facing volunteers would continue to use the paper-based PCR (with the associated risks) either permanently, or temporarily until an alternative funding solution could be identified.

#### **Preferred Option**

The remainder of this business case will therefore focus on **Option Three – the Divisional Model Integration approach**, as the most viable, sustainable, and strategically aligned solution for the future of volunteering and community resilience at SECAMB. The business case seeks a funding settlement to secure the posts needed to provide this structure, as well as capital costs to support volunteers utilising the electronic Patient Clinical Record (ePCR) platform used elsewhere within the Trust.

#### **Whole Life Cost**

The BC is requesting a capital value of £340,787, an increase in annual revenue budgets of £349,347 for 2026/27, resulting in a total operating expenditure increase over 5 years of £1,986,733.

## 2. Strategic Case

*a) What will happen if we do not support the proposal? Is it a must do i.e. due to a regulatory requirement? Please highlight if this relates to a risk on the Corporate Risk Register*

The South East Coast Ambulance Service NHS Foundation Trust (SECAmb) exists to save lives and serve our communities. This purpose underpins the Trust Strategy *Saving Lives, Serving Our Communities 2024–2029*, which sets a clear vision for delivering high-quality care, ensuring our people enjoy working at SECAmb, and being a sustainable partner within an integrated NHS system. Volunteers already play a crucial role in achieving these aims, contributing thousands of hours each year to support patients, communities, and colleagues. The Trust Strategy explicitly recognises volunteers as an *integral part of our delivery model*, emphasising the need to embed their contribution within the Trust’s clinical and operational frameworks.

This business case seeks to ensure a sufficient funding settlement to ensure the infrastructure is in place to deliver the proposed strategy, through funding sufficient substantive posts within the Community Resilience department to oversee and deliver the identified aims and objectives. Without this support, there will be inadequate resources to deliver the strategy in its current draft, requiring a substantial rewrite which focuses purely on the objectives aligning to one area of the Trust strategy only (in other words, focusing on maintaining current patient-facing activity rather than increasing activity and delivering the remaining objectives). As well as delaying implementation, this is likely to have a significant negative impact on volunteers within the Trust who would be expected to cease any activity which is not currently funded – specifically activity such as community engagement and education, support for colleague welfare, and supporting community-based projects to increase survival from out-of-hospital cardiac arrest.

This relates to risk ID 410 on the Trust Risk Register: Impact of the Cessation of external charitable funding for the volunteer management team.

*b) How does the proposal fit with the Trust’s current strategies and Trust Objectives?*

This business case aligns directly with the Trust’s long-term vision and with national NHS objectives, including the NHS Long Term Plan and the AACE Volunteering Framework, which highlight the growing importance of community-based, preventative, and volunteer-supported care models in building resilience and addressing health inequalities. It funds delivery of the new Volunteering and Community Resilience Strategy which identifies the provision of a sustainable volunteering service which enhances delivery of the Trust strategy.

## 3. Economic Case

*a) What options have been considered? Please provide a high-level summary narrative of the options.*

<i>Options</i>	<i>Brief description</i>	<i>Benefits</i>	<i>Risks</i>
Option 1 - Do Nothing	Continue with current department size and structure.	No increase in funding requirement.	Externally reviewed as insufficient for level of activity, therefore will lead to reduction in activity and resultant

			negative impact. Also significant risk of reduced volunteer motivation further reducing impact.
Option 2	Restructure department to align with recommendations of AACE strategic review.	Directly matched to level of activity currently in place, provision of 24/7 support for volunteers.	Does not directly align with Trust's current operational structure (which has changed since external review). Cost of unsocial hours and on-call provision not required to deliver efficient and effective service.
Option 3 (preferred option)	Restructure department to incorporate recommendation of strategic review and fully align with Trust Divisional Operating model, with funding to digitalise Patient Clinical Records (ePCR) for volunteers.	Allows for full integration of a sustainable volunteering service aligned to the Trust Divisional Operating Model. Allows for integration with local leadership teams ensuring the new strategy can be delivered consistently across the Trust but allowing for localised variation and focus depending on specific needs of the area. Aligns volunteers with the Trust's approved and existing ePCR platform to manage the risk associated with continued use of paper records and achieve the digital strategy.	Requires restructure of the Community Resilience department through the Organisational Change process, which introduces short term risks relating to colleague wellbeing and motivation / output.
Option 4	Restructure department to incorporate recommendation of strategic review and fully align with Trust Divisional Operating model only – no funding for ePCR.	As for option 3, but without the benefits relating to digitalising patient records.	Continued risks associated with use of paper-based clinical records, either permanently or temporarily until an alternative funding source is identified.

#### **4. Preferred Option (all sections from now refer to the preferred option)**

*a) Please expand upon the preferred option, by providing full details of the proposal and provide rationale for why this will be the best way forward. Include consideration to strategic fit, deliverability and, ease of implementation. What resources are needed; will it affect any other departments. What is the proposals impact on the environment and sustainability.*

The funding requested in this business case is primarily to provide the staffing for the restructure of the Volunteering and Community Resilience Department (currently known as the Community Resilience Department) to provide a sustainable and effective department which integrates with the wider operational structure of the Trust and can deliver an effective volunteering service (with the associated benefits that this would bring). The secondary funding element is to provide patient facing volunteers with the Trust's approved and existing ePCR platform – this is discussed later in this section.

The additional posts created will be:

**1 additional Community Resilience Manager (band 7) – to give a total of 3**

This would align a Community Resilience Manager with each of the three operational divisions (Kent, Surrey and Sussex), allowing for greater oversight and integration at a divisional level. This ensures that as divisions adapt to meet the unique needs of their areas, the volunteering service in the area can support this and ensure the strategy is delivered in a meaningful way. It also allows for greater oversight at Divisional Management Groups and by Divisional Directors of how volunteers are supporting service provision within their area. They will also represent the Trust at externally for community-focused partnerships which are frequently county-based, for example with Local Resilience Forums, Community Partnership Forums, Blue Light Collaboration, etc.

**5 additional Community Resilience Team Leaders (band 6) – to give a total of 7**

The Community Resilience Team Leaders (currently Community Resilience Leads) act as a first line manager and point of support to volunteers, and will become based within each Operating Unit (0.5WTE per OU). This allows a degree of flexibility in personnel (for example, an appointee may be full time supporting two OUs, or part time supporting one OU), but crucially allows for meaningful autonomy within the OU, aligned with the OU leadership team, to fully integrate volunteers with paid staff. This also allows for different volunteering roles to be prioritised depending on the needs of the area, and allows for best practice to be shared between OUs whilst seeking quality improvement opportunities.

**1 additional Educator (band 4) – to give a total of 1.5**

Nominally this provides 0.5WTE educator per division. Alongside support from bank staff to support peaks in educational delivery, this will ensure sufficient time to meet the induction training, annual mandatory updates and assessments, and professional development needs of all the volunteers within the division. It will also allow for Trust-wide collaboration where required for delivery of courses and educational governance (for example to facilitate larger courses, or where trainer and assessor roles need to be differentiated). It allows for greater integration with the Trust's Education team to continue with collaborative delivery (for example with Conflict Resolution and Manual Handling), and further reducing any divide between paid colleagues and volunteers. It also offers cost saving opportunities through reduced reliance on bank staff to support course delivery, and provides a future potential for income generation (either to the Trust through offering spaces on courses, or to the charity through community-based donations).

**Efficiencies**

As part of the restructure, reductions will be made to offset the cost of additional staff as follows:

- 1 fewer Administrator (band 4) – to give a total of 1.
- Reduced utilisation of bank tutors to deliver courses.
- Reduction in unsocial hours (USH) payments – posts will be predominantly social with USH on an ad-hoc basis only where needed.
- Reduction in on call supplements (including recall to duty) – increased emphasis on dealing with support needs in hours, with out of hours requests dealt with through integration with Operating Units (who have 24/7 management availability).

## ePCR implementation

As part of the delivery of the new strategy, it is intended to transition Volunteer Responders to the Trust's ePCR platform (Cleric), which aligns with both NHS Digital recommendations and the Trust's strategic direction. This will resolve a number of outstanding risks relating to the current use of paper-based records, including assurance of records being returned to the Health Informatics team in a timely manner, security of paper records once completed but prior to submission, and timely recording of interventions for awareness of subsequent treating clinicians (both ambulance in an in-hospital).

There are two primary options for transitioning Volunteer Responders to ePCR – either introducing the full ePCR platform through an issued iPad, or developing an 'ePCR lite' platform aimed at volunteers and other first responders. The latter is the preferred option, and is anticipated to be more cost effective than providing the full ePCR platform, however cannot be fully costed until the strategy has been approved. Therefore, the business case has been costed on the known costs of the full ePCR platform, recognising that if the preferred option of developing ePCR-lite is more cost effective as anticipated, then this will be the approach taken.

*b) How will you measure the benefits of the preferred option? What Key performance indicators (KPIs) will you use? Please note that proposals will be rejected if there is no benefits realisation plan*

The strategy identifies four primary objectives that collectively deliver the required transformation:

1. **Strengthen leadership and governance** – Establish a stable and professional leadership infrastructure for volunteering that mirrors the Trust's divisional operating model and ensures volunteers are appropriately supported, valued, and visible across all levels of the organisation.
2. **Gain, train, maintain, and retain a diverse volunteer workforce** – Attract and develop volunteers who reflect the communities SECAMB serves, ensuring inclusive access to opportunities and robust training pathways that sustain motivation and competence.
3. **Embed a 'whole-of-society' approach to community resilience** – Build partnerships and education programmes that empower local communities to prevent ill health, respond to emergencies, and support vulnerable people.
4. **Evidence impact and promote sustainability** – Implement consistent data collection and evaluation frameworks to demonstrate the contribution of volunteers to patient outcomes, operational efficiency, and value for money.

Supporting this business case will enable SECAMB to deliver a fully integrated, sustainable, and evidence-based volunteer function that directly contributes to the Trust's strategic aims. The expected outcomes include:

- Improved patient outcomes through faster first response and increased bystander CPR rates.
- Enhanced staff wellbeing and retention through improved volunteer-led welfare and support initiatives.

- Reduced health inequalities by expanding access to volunteering and public education in underrepresented communities.
- Strengthened partnerships across the voluntary, community, and emergency sectors, supporting the NHS's integrated care objectives.
- Demonstrable value for money through data-led impact measurement and improved efficiency in service delivery.

The benefits of delivering the new strategy can also be identified through the key deliverables, linked to each of the strategic objectives, which can be seen in Appendix B.

No.	Benefit Description	Indicator and how is it recorded	Current and Target Measure and Change	Financial Saving if applicable	Timescale	Assumptions
1	Increased survival from cardiac arrest	Cardiac Arrest survival in annual report	For 2023/24 the Trust reported 11.5% survival. The current Trust strategy is to increase this by 5%.	N/A (although reduced C1 mean has positive financial impact).	5 years	Alongside other programmes of work through Cardiac Arrest Outcomes Improvement group.
2	Improved call response times	C2 mean	Improvement in C2 mean by 30 seconds attributable to volunteers.	£650K/year	Per year	Minimum change based on no increase in volunteer numbers – as volunteer numbers increase benefit increases in linear fashion.
3	Improved patient experience	Time to treat metrics for specific cases (e.g. analgesia, assist up from floor).		N/A	Ongoing	
4	Reduced ambulance attendance (increased virtual care)	% of incidents dealt with as 'see and treat' without requiring SECamb resource on scene, positively impacting C2 mean.	Improvement in C2 mean by 15 seconds attributable to volunteers.	£325K/year	Per year	Minimum change based on no increase in volunteer numbers – as volunteer numbers increase benefit increases in linear fashion.
5	Efficiencies through volunteer ePCR completion	Average Job Cycle Time (JCT)	Reduction in JCT by one minute resulting in 2 second	£44K/year Additional potential for cost	Per year	Scalable benefit – as volunteer numbers increase,

			improvement in C2 mean.	efficiencies through reduced working time required to process paper records.		benefit increases in a linear fashion.
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Additional information on benefits realisation:

### **Relating benefits to financial efficiencies**

Every one minute improvement in C2 mean requires an additional 22 WTE of field operations staff which equates to an additional £1.3 million spend. Therefore every second of improvement in C2 mean equates to around £21.8 thousand in costs potentially avoided.

#### **1 – Increased survival from cardiac arrest**

In their current form, through the use of Community First Responders (CFR), volunteers directly contribute to an improved C1 response time. Data from 1 December 2024 to 30 November 2025 shows that CFRs contributed a 7 second improvement in overall C1 mean. However, when looking at this from a patient impact perspective, the impact is more significant. In 2024, CFRs attended over 3,000 C1 calls and the average time between the CFR arriving and the next clinical resource arriving on scene was 6 minutes and 24 seconds. For patients in cardiac arrest, every minute of delay in defibrillation reduces the probability of survival to hospital discharge by around 10%. Therefore, for any of those patients in cardiac arrest attended to by a CFR who survived, it is more likely than not that this was due to the presence of the CFR. The benefits of this are scalable – the more CFRs we are able to train and deploy, the more likely our patients are to survive an out of hospital cardiac arrest. This will be enhanced by targeted recruitment to ensure CFRs are placed in areas of greatest need – particularly rural areas and communities which have traditionally been harder to reach, thereby supporting a reduction in health inequality.

Complementary to this is the development of a second patient-facing role – the Community Lifesaver role. This role is targeted specifically at supporting patients in cardiac arrest, and therefore has significantly lower training and equipment costs, allowing for deployment of a higher volume of people. It is also likely to appeal to different individuals than the established CFR role (for example due to reduced availability, motivation, or confidence to respond) and allows for an introduction to the Volunteer Responder roles available with the potential for progression to a CFR role in the future. The Community Lifesaver role allows for a reduction in the time from 999 call to ‘hands on chest’ (CPR), which is associated with higher survival outcomes. The most recent SECamb Cardiac Arrest Report 2023-2024 shows that roughly three quarters (77%) of out of hospital cardiac arrests received bystander CPR, with a mean time of three minutes and 22 seconds to start. More importantly, the Community Lifesaver role will increase the quality of CPR provided at an earlier stage, which again is shown to significantly increase survival, through a network of qualified and quality assured individuals to provide high-quality CPR.

Lastly, although harder to measure, improvements in cardiac arrest survival will be seen through the non-patient-facing volunteer roles. Despite the importance of CPR and defibrillation, the Resuscitation Council UK (RCUK) highlight that a third of UK adults have never undertaken CPR training, and nearly two thirds state they are not confident enough to use a Public Access Defibrillator (which does not require training to use). Through the

Community Ambassador and Community Educator roles, we will be able to improve local understanding of the risks associated with sudden cardiac arrest, the actions to take should this occur, and the training and confidence to undertake CPR and utilise a defibrillator until further help arrives. These are all highlighted by RCUK as vital elements to improve out of hospital cardiac arrest survival.

It is important to note that the benefits seen will be delivered through two complementary approaches which this business case supports – firstly a restructure in the way that current volunteers are supported and deployed, ensuring volunteer responses are focused on areas of greatest impact, and secondly an increase in the number of volunteers in areas where there is an identified demand. Either of these could be delivered in isolation but would require the same level of infrastructure and support to do so, and therefore by undertaking both approaches simultaneously the benefits can be linearly scaled, delivering increasing benefits as the number of volunteers increases.

## **2 – improved call response times (particularly C2 mean); 4 – Reduced ambulance attendance**

Volunteer Responders already provide an evidenced positive impact on Trust response times, which is relatively linear and scalable (in other words, as the number of volunteers increases, the realised benefits increase similarly). This can be measured through the impact on the mean response times, as well as the impact to the response times for individual patients. Data from 1 December 2024 to 30 November 2025 showed that during this impact volunteers contributed a 7 second improvement to the Trust's C1 mean. Increasing the number of volunteers would increase the improvement, and this will be further augmented by focusing volunteer recruitment on areas which currently provide the greatest response time challenges.

For individual cases, the Community First Responder (CFR) model by definition places a resource embedded within local communities, which has a specific positive impact on areas of rurality where response times are more likely to be increased due to remote locations and greater distances from SECamb sites and acute Trusts. Taking a data-driven approach to this also allows for the Trust to focus on reducing health inequalities in areas of social deprivation.

Furthermore, by focusing volunteer responses to specific types of calls where the greatest benefit can be evidenced, the Trust can reduce the number of physical ambulance responses which need to be dispatched. This in turn ensures ambulances are available for other incidents and reduces the C2 mean. A specific example is deploying volunteers to non- and minor-injury falls, a concept which has been demonstrated through the Falls, Frailty and Older People Model of Care. In the past 12 months (1 December 2024 to 30 November 2025) the Trust responded to 86,566 incidents. If Volunteer Responders attend and support a non-conveyance with the support of virtual care clinicians (therefore avoiding the need for an additional SECamb resource to attend) in 5% of these cases (4,328 incidents), this would provide a 35 second improvement to the Trust's C2 mean. Currently, volunteers have responded to over 1,000 incidents within this time frame, with over half resulting in a non-conveyance (albeit until now this has required a secondary SECamb resource to attend).

Expanding this approach to Concern for Welfare calls provides similar scalable benefits. Between 1 December 2024 and 30 November 2025, the Trust responded to 12,030 concerns for welfare incidents and committed a total of 16,381 resource hours to these incidents, averaging 1 hour and 21 minutes per incident. If Volunteer Responders can attend 10% of these incidents annually, equating to 1,203 incidents in the year or 3.3 incidents per day, and manage these with the support of virtual care clinicians it would

release 1,638 resource hours annually, and support a circa 11 second improvement to the C2 mean.

This approach can also be used for other types of calls which result in a non-conveyance. CFRs attended 6,550 non-conveyed incidents in the past 12 months. If the Trust is able to utilise its virtual care capacity to support a non-conveyance virtually without the need for a physical SECamb response this could improve our C2 mean. Avoiding a DCA on 10% of these incidents annually (655) would equate to a 6 second improvement on the Trusts C2 mean. It should be noted that currently volunteers are not specifically deployed to incidents likely to result in a non-conveyance – actively identifying these calls for a volunteer response could potentially enhance this improvement.

### **3 – Improved patient experience**

Patient experience improvements can be seen through two main outputs of the new strategy. The first is through continuing to improve response times. Details of how CFRs support an improvement in mean response times are included earlier in this section and not repeated here, however it is also worth noting that even where a CFR response does not directly impact the mean response times (for example when responding to a C2/C3 call which subsequently requires conveyance to hospital), they do provide a benefit to patient experience by providing early assessment (with escalation where appropriate), reassurance and life-saving care prior to subsequent ambulance arrival.

An equally significant improvement in patient experience is seen by training and equipping volunteers to better support patients and provide the care required without requiring a subsequent ambulance attendance. An example of this is CFRs providing a response to patients who have fallen with no or minor injuries who wouldn't otherwise require an ambulance response, however do need support with getting off the floor (either using coaching techniques, physical assistance, or lifting equipment). As well as the benefit of reducing ambulance deployments and subsequent impact on mean response times (discussed earlier), during 2024 where a patient had fallen and a CFR was available locally, they arrived on scene roughly an hour before subsequent ambulance crews, allowing for earlier assessment, reassurance, and intervention. Given that the National Institute for Health and Care Excellence (NICE) highlight that post-falls complications can develop in as little as 30 minutes following a fall, and the risk of hospital conveyance increases by around 10% for every hour a patient remains untreated on the floor, the investment in Volunteer Responders provides benefits not just for SECamb but also the wider healthcare system, and most significantly for each patient.

### **5 – Efficiencies through volunteer ePCR completion**

Part of the Volunteer and Community Resilience Strategy is to support efficiencies in service delivery, for example through the completion of electronic Patient Clinical Records (ePCR). Currently CFRs complete a paper version of a Patient Clinical Record (PCR) and pass the completed version to ambulance crews to return at end of shift. Although this should capture the key information required by the Trust, it is inefficient (resulting in data duplication and a poorer patient experience) and has limited assurance regarding records being returned correctly, which is captured in the Trust Risk Register (risk ID 478). Implementing ePCR for CFRs would resolve these concerns, but adds a further benefit that capturing information in a single ePCR which can be continued by an attending ambulance crew (rather than an ePCR having to be started from new and information from a paper PCR transcribed onto this) means the time spent by subsequent ambulance crews completing the ePCR can be reduced, thereby reducing the Job Cycle Time (JCT) for that crew. Currently CFRs attend around 3% of all Trust incidents that receive a response. If completing an ePCR reduces the Job Cycle Time by as little as one minute for crews on

incidents they attend, this would equate to a two second C2 mean improvement. Time savings can be achieved both through the CFR completing some elements (particularly data such as demographics, address, next of kin details, which don't change during patient care episode) of the ePCR prior to the crew arrival or remaining on scene to support crew with ePCR completion thereby expediting conveyance to hospital where required.

Whilst this demonstrates the efficiency benefits, there are other equally important benefits to providing CFRs with ePCR – specifically, an improvement in Information Governance and security of records, a more timely approach to clinical records being available, better continuity of care for patients as they move through their journey from Volunteer Responder to ambulance crew to hospital, greater consistency in the approach taken by Trust responders, full alignment with existing Trust ePCR processes, improved data quality, and better integration between the Trust paid and volunteer workforce. It is also important to note that fully adopting electronic patient records is a key component of the NHS Digital Agenda and 10-year workforce plan.

*c) When will the post project evaluation be completed?*

Throughout the lifecycle of the proposed strategy, the usual governance structure of the Trust will ensure clear oversight of delivery, performance, and benefits realisation.

Strategic oversight will be provided through existing Trust governance forums, with regular reporting on:

- Progress against agreed milestones
- Risks and issues requiring escalation
- Delivery of agreed benefits and outcomes

Benefits realisation will be managed and reviewed through the defined deliverables identified within the Volunteering and Community Resilience Strategy.

Monitoring will take place during implementation of each individual element of the strategy or project, and will include stage reviews at key milestones, enabling corrective action where required. A post-implementation evaluation will be undertaken once each development is fully embedded, assessing effectiveness, sustainability, and return on investment.

**5. Financial Case - Analysis and Affordability (of preferred option)**

*Please include VAT, where not claimable, within all costs stated.*

*a) Whole life costs of the preferred option (Please specify what this spend is related to) Net Cost/(Savings). All possible costs should be included, a list of costs that you should consider is included at appendix B.*

	Year 1 (26/27)	Year 2 (27/28)	Year 3 (28/29)	Year 4 (29/30)	Year 5 (30/31)	Total
<b>Capital</b>						
Laptop (£960 each)	8,640					8,640
Mobile phone - Standard (£85 each)	255					255
Mobile phone - Samsung (£396 each) - 6 & 7's	2,772					2,772
Monitor (£180 each)	1,620					1,620
500 volunteers each receiving ipad for Epcr	327,500					327,500
<b>Total Capital</b>	<b>340,787</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>340,787</b>
<b>Operating Expenditure</b>						
500 software licenses		60,000	60,000	60,000	60,000	240,000
<b>Additional Staff</b>						
Community Resilience Manager (band 7) - 1WTE	67,923	67,923	67,923	67,923	67,923	339,613
Community Resilience Team Leaders (band 6) - 5WTE	297,294	297,294	297,294	297,294	297,294	1,486,471
Educators (band 4) - 1.0WTE	40,250	40,250	40,250	40,250	40,250	201,248
Reduction in Staff						
Administrator (band 4) - 1WTE	(38,531)	(38,531)	(38,531)	(38,531)	(38,531)	(192,653)
Reduction in Bank Tutors	(17,589)	(17,589)	(17,589)	(17,589)	(17,589)	(87,945)
<b>Total Operating Expenditure</b>	<b>349,347</b>	<b>409,347</b>	<b>409,347</b>	<b>409,347</b>	<b>409,347</b>	<b>1,986,733</b>

*b) Impact on the Trusts Statement of Comprehensive Income (please specify what this spend is related to and if operating or non-operating) Net Cost/(Savings)*

	Year 1 (26/27)	Year 2 (27/28)	Year 3 (28/29)	Year 4 (29/30)	Year 5 (30/31)	Total
<b>Total Operating Expenditure</b>	<b>349,347</b>	<b>409,347</b>	<b>409,347</b>	<b>409,347</b>	<b>409,347</b>	<b>1,986,733</b>
<b>Non-Operating Expenditure</b>						
Depreciation	68,157	68,157	68,157	68,157	68,157	340,787
PDC Dividend)	11,832	11,832	11,223	11,023	10,823	56,733
<b>Total Non-Operating Expenditure</b>	<b>79,989</b>	<b>79,989</b>	<b>79,380</b>	<b>79,180</b>	<b>78,980</b>	<b>397,520</b>
<b>Net Impact on I&amp;E</b>	<b>429,336</b>	<b>489,336</b>	<b>488,727</b>	<b>488,527</b>	<b>488,327</b>	<b>2,384,253</b>

*c) Impact on the Trusts Cash Flow*

	Year 1 (26/27)	Year 2 (27/28)	Year 3 (28/29)	Year 4 (29/30)	Year 5 (30/31)	Total
<b>Operating Expenditure</b>						
Capital Costs	340,787	0	0	0	0	340,787
<b>Net Operating Expenditure</b>	<b>349,347</b>	<b>409,347</b>	<b>409,347</b>	<b>409,347</b>	<b>409,347</b>	<b>1,986,733</b>
PDC Dividend)	11,832	11,832	11,223	11,023	10,823	56,733
<b>Impact on Cashflow</b>	<b>701,966</b>	<b>421,179</b>	<b>420,570</b>	<b>420,370</b>	<b>420,170</b>	<b>2,384,253</b>

*d) What is the required funding source*

The capital can be funded from the current IT hardware capital budget. There is no funding suggested for the increase in operating expenditure.

**The above has been confirmed by:**

MARK HIGGINSON

*f) Please include narrative of workings of costs, savings and all financial and activity assumptions*

Please see embedded below the costing spread sheet.



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ables%20-%20Final9

## 6. Quality Impact assessment (of preferred option)

*Please embed the signed summary Quality Impact Assessment (QIA) below. The guidance and template can be found on the zone.*

Approved on 14/01/26



QIA%20-%20Volunt  
eering%20and%20C



QIA Approval  
Confirmation QIR-65

## 7. Equality Analysis (of preferred option)

*Please embed the completed equality analysis below. The guidance and template can be found on the zone.*

Approved on 13/01/26



EIA%20-%20Volunt  
eering%20and%20C

## 8. Risk Assessment (of preferred option)

*Please ensure you undertake a thorough assessment of the risks associated with implementing the proposal and mitigating actions (using the Trust Risk Management Approach). Include the top five here*

Risk Description	Mitigation	Likelihood (1-5)	Consequence (1-5)	Owner
Insufficient funding or delayed funding approval.	Business case is aligned to the approval of the new strategy	3	4	Head of Community Resilience
Capacity constraints during transition to new structures, recognising that further pressures will be placed on an already under-resourced team as part of the	Short term risk which will be fully resolved once completed. Phased approach to strategy delivery with most new activities	4	2	Head of Community Resilience

organisational change process.	commencing after restructure complete.			
Resistance to change from staff or volunteers, affecting efficacy and impact of new ways of working.	Strategy collaboratively developed with significant stakeholder engagement. New volunteering roles increase the range and breadth of opportunity.	2	3	Community Resilience Team
Data quality and availability challenges due to capacity pressures in data analytics and Business Intelligence team.	Utilising existing / available data in the short term until new dashboard can be developed. Working collaboratively with the BI team to ensure correct data is available from the outset, thereby minimising time commitments to change.	3	3	BI team
External pressures such as workforce availability and cost-of-living impacts on volunteering, which might negatively affect volunteer availability and willingness.	The new integrated structure for volunteering within SECAMB provides greater variability in opportunities, and can be supported at a more granular local level, allowing for specific areas of risk to be managed as they arise before they cause a negative impact on service delivery.	2	2	Community Resilience Team
Inability to deliver benefits intended either within the timeframes prescribed or at all, for example due to difficulties in recruitment or delays in governance approval for new ways of working.	Mitigated through collaborative approach of strategy development to ensure it aligns with Trust strategy, stakeholder requirements, and volunteer motivations. Delays may defer benefits realisation but not prevent them.	2	4	Head of Community Resilience

### 9. Commercial Case (of preferred option)

a) *Commercial detail. Explain how you intend to deliver the proposal? Did you go through a tender process, acquire supplier quotes, who is the preferred supplier and what selection process did you go through.*

No separate tender or competitive procurement exercise is required to deliver this proposal. The funding requested relates to two discrete elements, both of which will be delivered through established Trust arrangements.

Firstly, the staffing element will be delivered through the Trust's existing organisational and workforce processes. This will be managed via the Trust's Organisational Change process, with any new or amended posts recruited in line with the Trust's safer recruitment procedures. These roles are substantive Trust posts and will be subject to the same governance, approval, and assurance processes as other comparable roles across the organisation.

Secondly, the digital element relates to the extension of the Trust's existing electronic Patient Clinical Record (ePCR) platform to patient-facing volunteers. This will utilise the Trust's current ePCR supplier and contractual arrangements (Cleric), with no requirement for a new procurement or tender exercise. Should the Trust undertake a future re-procurement of the ePCR platform, volunteers will be considered as existing users within that process to ensure continuity and alignment with the Trust's digital strategy.

## **10. Management Case (of preferred option)**

*a) Project management detail. How will you track implementation, what governance group will the proposal report to during implementation and where does that group report into? What reports will be produced, what will they cover and how often will they be produced?*

Delivery of the strategy will be overseen through established Trust governance and programme management arrangements, ensuring clear accountability, appropriate assurance, and effective tracking of progress and benefits realisation. Overall accountability for implementation will sit with the Chief Operating Officer as Executive Sponsor, delegated to the Divisional Director for Resilience and Specialist Operations, supported by the Head of Community Resilience as the senior responsible manager for delivery.

Implementation will be managed as a defined programme of work rather than a standalone project, recognising that the proposal primarily comprises organisational change, workforce expansion, and controlled digital enablement. The departmental restructure will be managed through the Organisational Change Policy and Procedure, including development of a clear consultation document as required by the Procedure following approval of this business case. This will set out key milestones including the nature of the change (with reasons), expected timelines, new and revised evaluated job descriptions, and the Equality Impact Assessment. Progress against milestones, risks, issues, and dependencies will be tracked during this process supported by the relevant People Partners.

Operational oversight during implementation and delivery of the new strategy will be provided through the Volunteering and Community Resilience Management Group, chaired by the Head of Community Resilience and attended by departmental members with relevant stakeholders and guests attending by invite. This group will meet monthly and will be responsible for monitoring delivery, managing risks, resolving issues, and ensuring alignment with wider Trust priorities. Integration with the operational divisions will be achieved through delegated attendance at the relevant Divisional Management Groups by Community Resilience Managers, and operational (service) delivery will be overseen by the Community Resilience Team Leaders working within each operating Unit. The

Volunteering and Community Resilience department will report into the Resilience Oversight group, with escalation and interaction with other where required.

A post-implementation review will be undertaken at an agreed point following full implementation, expected within 6–12 months. This will assess delivery against the original objectives of the business case, confirm benefits realisation, identify learning, and inform any further refinement or scaling of the Volunteering and Community Resilience model.

*b) Include a high-level implementation plan and key milestones and dates? This must be included otherwise the proposal will be rejected*

<b>Milestone</b>	<b>[Planned] Start date</b>	<b>[Expected] Completion date</b>
Board steer on approach and options to define scope of strategy	June 2025	June 2025
Collaborative engagement to co-develop strategic objectives and deliverables (see section 11 for details).	July 2025	September 2025
Review and approval of strategy overview and intended business case (see section 11 for details).	October 2025	December 2025
Business case development and approval to define costs and agree funding settlement to enable strategy delivery.	December 2025	[February 2026]
Approval of Business Case.	[January 2026]	[February 2026]
Pre-consultation stage of Organisational Change process	[February 2026]	[March 2026]
Formal consultation period of Organisational Change process (30 days).	[1 April 2026]	[30 April 2026]
New structures in place for existing colleagues		[1 May 2026]
Recruitment and deployment of new posts.	[May 2026]	[August 2026]
Ongoing delivery of new Volunteering and Community Resilience Strategy, reviewed as per published milestones and deliverables within the strategy document.	[April 2026]	[2030]

## **11. Stakeholder engagement/consultation (of preferred option)**

*a) Does the proposal require/have commissioner, STP or other external support? If yes, provide evidence of discussions*

The proposed investment in volunteering and community resilience directly supports the ambitions of the NHS 10-Year Plan, the Urgent and Emergency Care (UEC) Plan, and the 2025/26 Ambulance Commissioning Guidelines. Together, these set a clear direction for healthcare delivery across England, emphasising prevention, community empowerment, and partnership-based models of care.

The NHS 10-Year Plan introduces three strategic shifts for health services:

- **From hospital to community** – prioritising local, preventative, and home-based care.
- **From analogue to digital** – embedding digital innovation and connectivity to improve patient access and efficiency, and increasing the focus on virtual care.
- **From cure to prevention** – investing in early intervention and health promotion to reduce avoidable demand on acute services.

Within this context, the Plan places significant emphasis on building community resilience, recognising that while volunteering provides a cost-effective means of supporting commissioned services, it requires sustained investment to deliver effectively. Volunteers play a vital role in bridging the gap between clinical care and community wellbeing, providing an essential human connection that enhances both patient outcomes and population health.

The Plan also introduces the concept of Neighbourhood Health Centres, co-locating NHS, local authority, and voluntary sector services to create integrated, place-based systems of care. These centres explicitly highlight the importance of supporting community resilience and encourage partnership working across organisational boundaries — with volunteers recognised as key enablers of collaboration and innovation.

The community-centric approach is embedded throughout the NHS Long Term Plan. One example is the move to shift recruitment away from international sources towards community-based recruitment, ensuring local people are supported into healthcare careers. This direction aligns directly with the proposed volunteer-to-career pathway which is a core component of the *Volunteering and Community Resilience Strategy*, and aims to provide accessible entry routes into the NHS for those motivated to serve their communities whilst reducing the costs of recruiting and onboarding new staff.

Furthermore, the Plan sets a strong mandate to end health inequalities and ensure local communities have a meaningful voice in the planning and delivery of care. It advocates for a holistic approach to health and wellbeing, recognising that non-clinical factors such as employment, education, and financial stability significantly influence health outcomes. The *Volunteering and Community Resilience Strategy* supports these ambitions by:

- Using data to identify and prioritise areas where volunteering can have the greatest impact.
- Introducing a Community Ambassador role to strengthen partnerships between the Trust, local authorities, and community organisations.
- Promoting a “*whole of society*” approach to resilience, enabling communities to take an active role in improving their own health outcomes.

It should also be noted that volunteering itself delivers measurable health and wellbeing benefits for participants — providing purpose, social connection, and improved mental health, all of which contribute to a healthier and more engaged population.

For ambulance services, the Urgent and Emergency Care (UEC) Plan is a key area of focus and reform. The Plan highlights the urgent need to reduce ambulance waiting times, particularly for Category 2 patients, and to improve the flow of patients through the system. Research conducted by King’s College London has demonstrated that Community First Responders (CFRs) make a measurable contribution to reducing

Category 2 waiting times, as well as improving outcomes for cardiac arrest and other time-critical conditions.

The UEC Plan also supports a shift towards paramedic-led, home-based care, reducing avoidable conveyances to hospital. Expanding the ambulance volunteer network provides an effective mechanism to support this shift. By gathering early information and “on-scene intelligence,” volunteers can enable remote, clinician-led consultations that facilitate timely decision-making and safe care closer to home. This model enhances patient experience, reduces unnecessary admissions, and ensures that ambulances are available for those in greatest need.

The Ambulance Commissioning Guidelines for 2025/26 further reinforce this direction of travel, advocating for enhanced utilisation of Community First Responders, particularly in reducing avoidable conveyance. CFRs are identified as a critical resource in delivering efficient, community-based responses that improve outcomes while reducing system pressures.

By aligning with these national frameworks, the *Volunteering and Community Resilience Strategy* and this associated business case ensure that SECAMB remains at the forefront of innovation within the ambulance sector — delivering a modern, sustainable, and community-embedded model of care that meets both local needs and national expectations.

*b) Does the proposal have a requirement for consultation (staff/union/JPF/public)? If yes, what consideration have you given to enacting this? How have affected staff groups been engaged and how have their responses been taken into account.*

Internally, the proposed strategy which this business case supports has been collaboratively developed through engagement with key stakeholders including enabling departments, volunteers, the current community resilience team, operational (paid) colleagues, and public and patient engagement forums. This has taken place through agenda items at formal meetings, open engagement forums, informal individual discussions and a digital feedback platform (Padlet).

Subsequent to informal engagement and collaboration, the proposals have been reviewed and supported through a number of formal governance groups including:

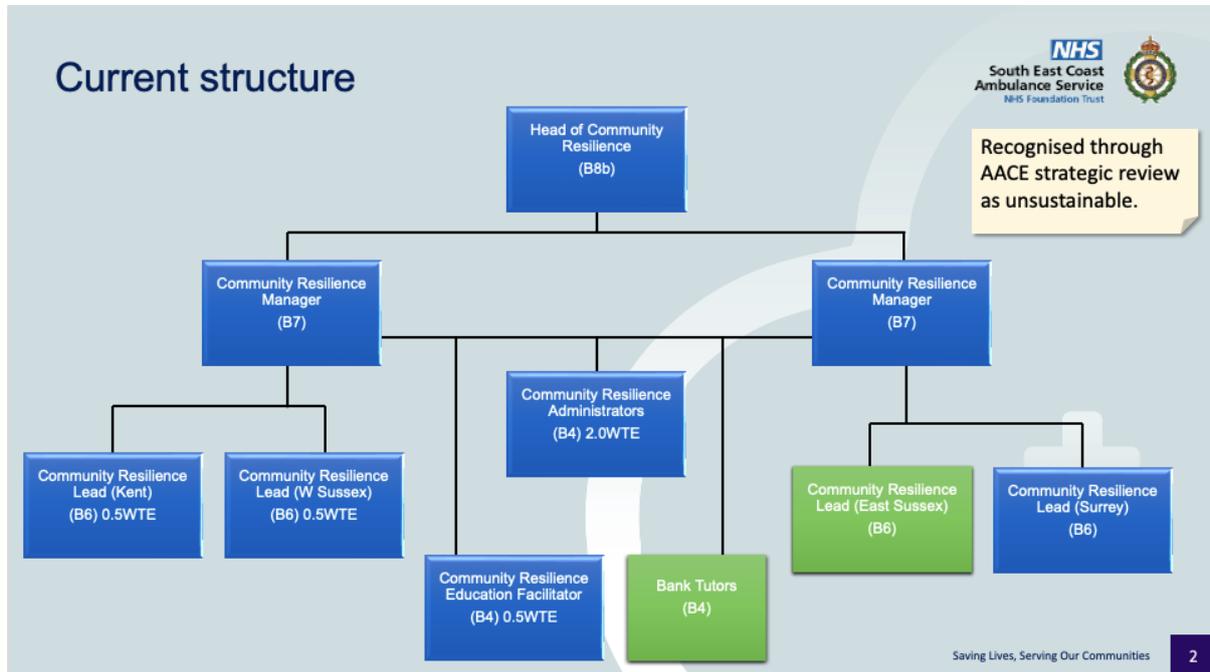
- Operations Senior Leadership Team
- Resilience Oversight Group
- Quality and Patient Safety Committee
- Executive Management Board
- People Committee
- Shadow board

Final approval will be requested through the Trust Board.

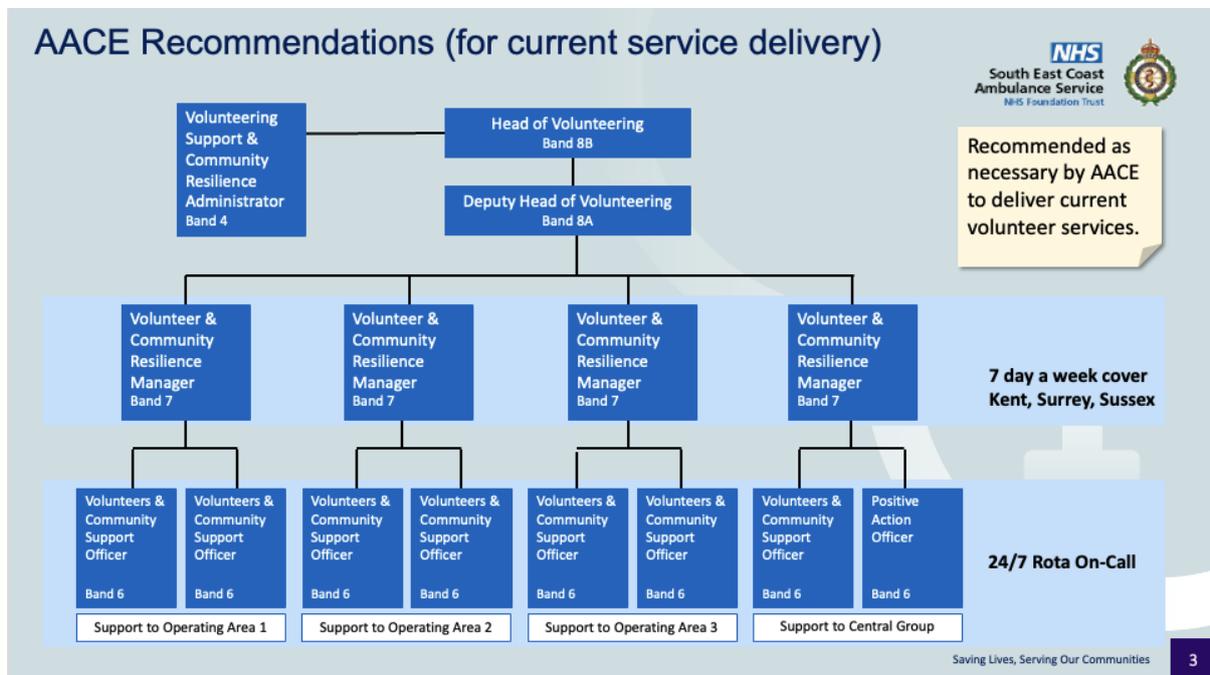
Following approval, further consultation will be required with staff and trade union representatives, supported by People Partners, through the Organisational Change process.

## Appendix A: team structures associated with options 1, 2 and 3

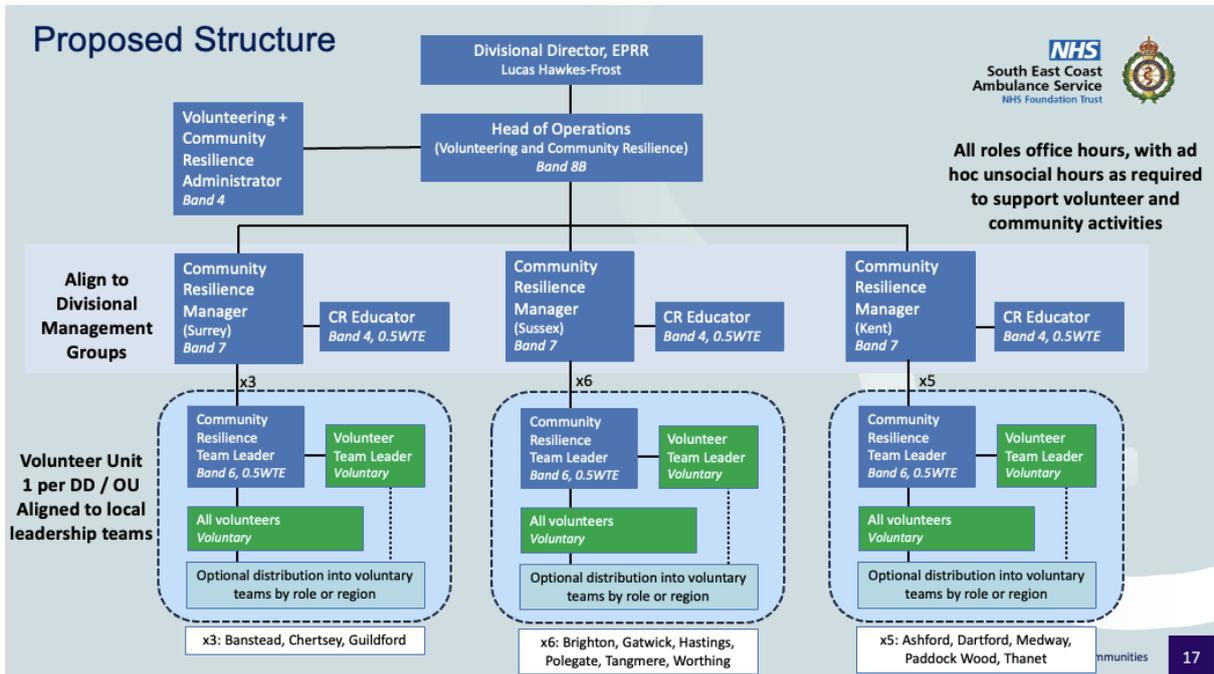
### Option 1 structure



### Option 2 structure



# Option 3 structure



## Appendix A: team structures associated with options 1, 2 and 3

The benefits of delivering the new strategy can be identified through the key deliverables, linked to each of the strategic objectives:

	2026	2027	2028	2029
<b>Objective one: Leadership and governance</b>	<p>Sustainable funding settlement in place to deliver strategy, with substantive leadership team in place.</p> <p>Impact reporting for internal and external stakeholders.</p>	<p>Volunteering and Community Resilience fully embedded within divisional and local leadership teams.</p> <p>Volunteer leadership training and development framework in place (aligned to Education strategy).</p>	<p>AACE Leadership Maturity Matrix rating increased to “thriving”.</p> <p>All Trust governance groups and subgroups to have volunteer representation built into Terms of Reference.</p>	<p>All Operating Units have appointed Volunteer Leaders with succession planning in place.</p>
<b>Objective two: Volunteer workforce</b>	<p>Introduction of new Community-based volunteer roles.</p> <p>Divisional Community Resilience Educators in post and aligned with Integrated Education team.</p> <p>Trust volunteers preferential applicants for all vacancies.</p>	<p>Volunteer recruitment locally-led and data matched to demand profile, with positive action to improve representation.</p> <p>Emergency response capability available within each Division.</p>	<p>Volunteer training fully embedded within Trust’s Integrated Education Strategy.</p> <p>Peer supervision programme standardised for new and existing volunteers.</p>	<p>Volunteering population reflects the diversity of the SECamb footprint.</p> <p>50% increase in number of volunteers targeted to areas of demand with reduction of inactive volunteers to less than 10%.</p>
<b>Objective three: Community resilience</b>	<p>All known cardiac arrest volunteer responders receive follow up to provide thanks, signpost for support, and gather feedback.</p> <p>Delivery of the Falls and Frailty model of care.</p> <p>Fully embed the RC(UK) Quality Standards for CPR and AED Training in the Community (1).</p>	<p>All non-clinical Trust staff trained in CPR with at least 50% registered with GoodSAM.</p> <p>Role of SECamb volunteers included within the Trust Incident Response Plan for major incidents.</p>	<p>Over 10% of the South East population to be ‘Resus Ready’ (2) with no significant variation between areas.</p> <p>20% of out-of-hospital cardiac arrests will have a defibrillator applied before an ambulance arrives.</p>	<p>Meaningful reduction in health inequalities for out-of-hospital cardiac arrest within the South East.</p> <p>Community Falls model fully embedded with Community Falls Rescue Kits sited and trained volunteers.</p>

<b>Objective four: Impact and sustainability</b>	Pentrox will be available to all Community First Responders (subject to successful pilot evaluation).  Clear guidance and toolkit provided to volunteers to encourage financial stewardship and income generation for SECAMB Charity.	An ePCR solution will be in use by all patient-facing volunteer responders.  No remaining funding in virtual accounts through planned expenditure supporting community activity and all income generation into SECAMB Charity.	All equipment resources will be asset tracked with clear utilisation and return-on-investment metrics to support future purchase decision making.	Majority of capital costs for delivering volunteer activity met by SECAMB Charity, with volunteer-led income generation matching expenditure.
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- (1) RCUK Quality Standards available at: <https://www.resus.org.uk/library/quality-standards-cpr>
- (2) RCUK ResusReady Map available at: <https://www.resus.org.uk/about-us/get-involved/resusready/resusready-map>



	Agenda No	108 - 25
Name of meeting	Trust Board	
Date	5 February 2026	
Name of paper	Estates and Facilities Management Strategy	
Executive Sponsor	Simon Bell, Chief Finance Officer	
Author	Andrew Froggatt, Interim Head of Estates and Facilities Management	
<p>This strategy has been developed following the discussion at the Board development session in September. It sets out the approach to delivering a safe, compliant, and cost-effective estate aligned with NHS standards, the and the NHS Net Zero Carbon objectives. Developed through extensive consultation across governance structures, this strategy addresses operational challenges, financial pressures, and sustainability goals while supporting the Trust's long-term priorities.</p> <p>It was reviewed in January by both EMB and FIC and is recommended for approval by the Board. A delivery plan is being developed, and the FIC will consider this at its next meeting in March 2026</p>		
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).		No.

# Estates and Facilities Management Strategy 2026-2030

Key document details			
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<b>Owner:</b>	Interim Head of Estates and Facilities Management	<b>Version no.:</b>	0.1
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<b>Ratified:</b>			

# SECamb Five Year Estates Strategy

Produced: December 2025

Period: January 2026 – December 2030

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## Purpose and Scope

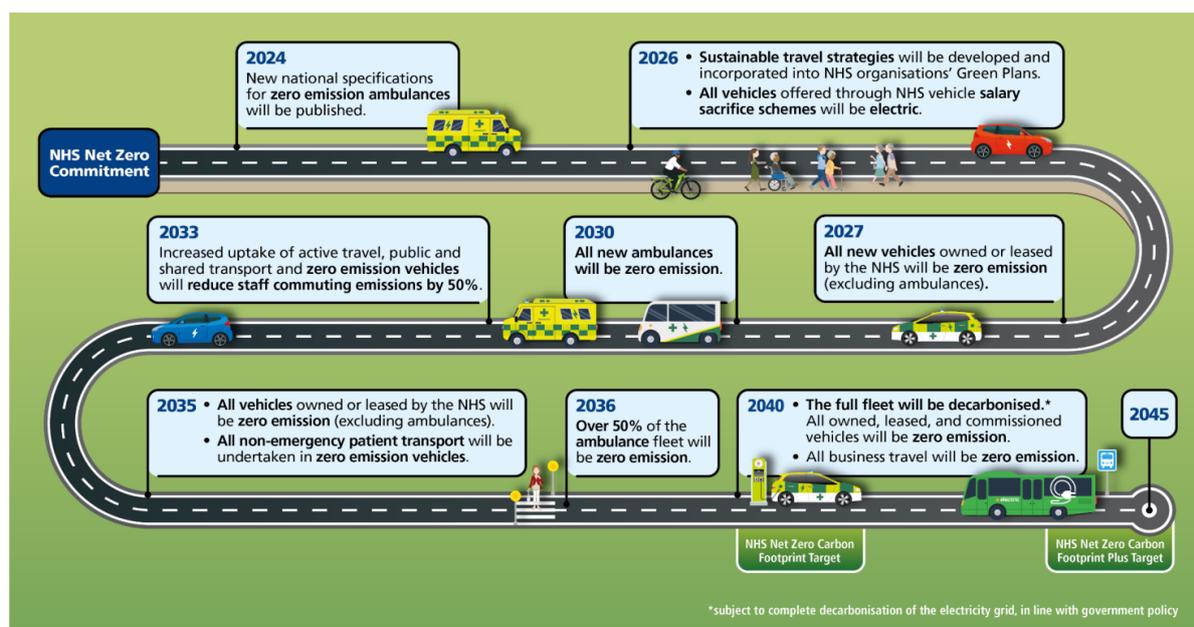
The Estates and Facilities Management Strategy comprise of three main elements.

1. Team strategy, developing the team who will deliver the strategy and keep the Estate safe and compliant.
2. Maintenance contract strategy. The current maintenance contract is due to end in June 2026, and this presents SECamb with a series of options which can provide cost benefits whilst increasing the level of care and customer service within the Estate.
3. Property strategy. A direction on several key elements that will drive the size, effectiveness and cost of the SECamb estate.

The 2026 – 2030 Estates Strategy is a complete bottom-up rewrite of the SECamb Estates Strategy which has gone through a large amount of consultation with various SECamb teams in its preparation. The content of the strategy has been discussed with all key governance structures to ensure this is “SECambs Estates Strategy” rather than an Estates led strategy.

One of the reasons for the complete rewrite is due to impact and changes on the Estate due to the rollout of an electric fleet. Early milestones on the roadmap to fleet Net Zero that fall into the period of his strategy are: -

- 2027 – All new vehicles procured except for ambulances must be fully electric
- 2030 – All new vehicles procured including ambulances must be fully electric.



## Executive Summary

The SECamb Five-Year Estates Strategy (2026–2030) sets out a comprehensive plan to deliver a safe, compliant, and cost-effective estate aligned with NHS standards, NHS Estate Code, the and the NHS Net Zero Carbon objectives. Developed through extensive consultation across governance structures, this strategy addresses operational challenges, financial pressures, and sustainability goals while supporting the Trust’s long-term priorities.

### Key Strategic Objectives:

- **Compliance & Governance:** Appointment of Duty Holders and deployment of a CAFM system to ensure statutory compliance and provide independent reporting.
- **Financial Efficiency:** In-house delivery of small works, improved contract management, and disposal of underused sites to achieve significant cost savings and revenue generation.
- **Operational Resilience:** Introduction of Building Custodians, hybrid maintenance contracts, and succession planning to strengthen service delivery.
- **Futureproofing for EV Rollout:** Development of an EV Blueprint to manage fire safety, parking, and charging infrastructure, supported by collaboration with NHS England.
- **Space & Asset Optimization:** Establishment of a Space Allocation Group (SAG) and CAFM integration to improve space governance and reduce estate size by up to 25%.
- **Sustainability Alignment:** Prioritisation of EV infrastructure and exploration of solar and battery storage solutions to support NHS Net Zero Carbon commitments.
- **Enhanced Engagement:** Improved communication through monthly updates, DMG attendance, and digital transparency via CAFM portals.

### Impact for SECamb:

- Improved compliance and assurance across the estate.
- Significant cost savings and operational efficiencies.
- Enhanced resilience and workforce capability.
- Strategic alignment with NHS sustainability and digital transformation goals.

**Recommendation:** The Board is asked to endorse the Estates Strategy and support investment in CAFM implementation, governance structures (including SAG), and capital prioritisation to ensure successful delivery.

## Team Strategy

The Estates and Facilities Management (EFM) team have evolved beyond recognition in the last ten years, though it is still some way short of where it needs to be to deliver a top quality, safe, cost effective and compliant Estates and Facilities service.

There are several issues that need to be addressed over the coming three to five years, which are: -

### Duty Holders

NHS Trusts need Duty Holders because they provide clear accountability for compliance with statutory and safety obligations across the estate. Healthcare environments are complex, and legislation such as the Health and Safety at Work Act, Pressure Systems Safety Regulations (PSSR), and HTMs (Health Technical Memoranda) require an identified person who holds ultimate responsibility for ensuring systems are safe and compliant. This role typically sits with the Chief Executive but can be delegated to senior executives for operational delivery.

Duty Holders <sup>1</sup>need to cover key compliance domains within NHS estates, often supported by Authorising Engineers (AEs) and Authorised Persons (APs) for technical oversight:

- **Water Safety (Legionella Control)** – HTM 04-01
- **Ventilation Systems** – HTM 03-01
- **Pressure Systems** – PSSR and HTM 08-08
- **Electrical Safety (Low Voltage & High Voltage)** – HTM 06 series
- **Medical Gas Pipeline Systems** – HTM 02-01
- **Fire Safety** – HTM 05 series
- **Decontamination Services** – HTM 01 series
- **Lift Safety and Maintenance**
- **Asbestos Management**

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<sup>1</sup> **NHS England Estates Technical Guidance:** Comprehensive guidance on Health Technical Memoranda (HTMs) and Health Building Notes (HBNs), covering statutory compliance for water safety, ventilation, electrical systems, and fire safety.

[Estates Technical Guidance – NHS England \[england.nhs.uk\]](https://www.england.nhs.uk/technical-guidance/)

**Estate Compliance Toolkit:** Highlights the importance of HTM compliance and the legal risks of non-compliance.

[Estate Compliance Toolkit – MIAA \[miaa.nhs.uk\]](https://www.miaa.nhs.uk/estate-compliance-toolkit/)

Work is underway within the EFM Team to identify which team members can appropriately be appointed into which duty holder posts, this will need to be followed by training and then appointment by an Authorising Engineer. Ideally this should be complete during 2026 to reduce this exposure.

## In-housing the Handy Person Service.

SECamb currently spend around £750k per annum with its maintenance contractor on small works. Around half of those requests do not require a high level of skills to address. Requests like hanging a notice board, unblocking a sink, fixing a door handle etc, often cost SECamb £300-500. SECamb could opt to bring in house the handy person function to undertake these requests, provide a better level of service, and make significant savings.

A suitable proposal would be to appoint three handy people, in vans with tools and basic materials plus two Building Custodians to look after Nexus House and Medway.

The likely cost of these appointments, tools, vehicles and materials would be around £200k and would likely enable savings on current spend of £150k.

If these handy people could also be mentored and receive training, then in a relatively short time they could undertake semi-skilled works and increase the saving further.

The appointment of these posts should be aligned with the start of the next iteration of the maintenance contract on the 1<sup>st</sup> of July 2026.

Another benefit of in-housing the handy person service is that it would start to address the Estates Technical Managers people management skills which is a current skills gap within the team. Addressing this gap would make the in housing the Estates Maintenance Contract a future possibility.

## Succession Planning

The Estates and Facilities Team is a relatively small team, currently just eight posts, so any leavers or absences in the team are hard to cover. Therefore, the team would benefit from a structured succession plan. The In-housing of the Handy Person service will provide some opportunities for succession planning with the new posts being potential future Technical Managers. Further to this, in-housing the whole maintenance service in the future will provide technical, management and administration succession options as there would be several TUPE posts that transfer into SECamb if the outsourced service was delivered in house.

## Estates and Facilities Management Team Key Skills

As well as the technical specialities of the duty holder requirements, there are several other key skills that should be addressed over the next three years. These skills will

enable Succession planning, in housing of the maintenance contract or the contract management of multiple specialist contracts rather than the one single maintenance contract.

### **CONTRACT MANAGEMENT SKILLS**

Currently the maintenance contract is a single contract with a single supplier. This supplier subcontracts most of the specialist/technical tasks to its own sub-contractors, which they mark up with a small margin. If the SECamb Estates and Facilities Team had the skill set to manage multiple specialist contractors, then a significant sum could be saved on the margin currently paid to the maintenance contractor by appointing these specialist sub-contractors directly.

The likely mark-up/handling fee applied by the maintenance contractor is unknown, but likely to be in the 10-15% area. This represents a potential future saving of a few hundred thousand pounds per annum if the EFM team could manage these specialist contracts directly.

### **FINANCE SKILLS**

Most of the members of the EFM Team have not historically been involved in budgeting or managing its own finances, though they all influence the spend and success of hitting the budget, or not.

Upskilling the EFM Team members finance skills will result in better management of Estates budgets. This work has begun by sharing finance results with the team monthly and by providing some basic finance workshops. This work should continue over the next three years to get a position where the EFM team are actively involved in budget setting and monthly reviews of the finances, at a Divisional level with the Estates Technical Managers.

### **FACILITIES MANAGEMENT**

The EFM Team see themselves as an Estates Team rather than an Estates and Facilities Team. The skill set of the Team is also strongly biased towards Estates and there is not a lot of Facilities Management knowledge within the team. The team would benefit from the Estates and Facilities Manager and at least one other member of the team gaining some basic level of facilities management knowledge over the next three years, such as by joining the Institute of Workplace and Facilities Management and by attending courses such as the NHS National Standards of Cleanliness.<sup>2</sup>

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<sup>2</sup> **National Standards of Healthcare Cleanliness 2025:** Mandatory for all healthcare settings, including ambulance facilities, ensuring consistent cleanliness and compliance.

[NHS England – National Standards of Healthcare Cleanliness 2025](#)

## MANAGEMENT

A common challenge in Estates and Facilities Management is that individuals often progress into supervisory or managerial roles based on technical expertise rather than leadership capability. While technical competence is essential, management roles require additional skills in areas such as people management, financial oversight, and strategic planning. Without targeted development, this transition can lead to gaps in performance and team effectiveness.

This has been evident within SECamb, and to address this, it is recommended that all staff progressing into leadership positions undertake structured management training aligned with NHS Leadership Academy frameworks and the *Healthcare Leadership Model*. Additionally, assigning mentors from outside the Estates function will provide broader organisational insight and support professional growth. These measures reflect best practice in NHS workforce development and comply with principles outlined in the *NHS People Plan*, which emphasises leadership capability and succession planning as key enablers of high-quality care and operational resilience.

### Building Custodians

SECamb currently has around 110 sites, which are managed by a small EFM Team. This means that key sites like Nexus House and Medway do not have a dedicated EFM presence. This lack of the presence is apparent particularly at Nexus House which feels unloved, untidy and uncared for. A dedicated Building Custodian could be provided to be the single point of contact for all EFM related issues, someone who would be responsible for keeping the site tidy and well maintained by undertaking basic repairs, setting up meeting rooms etc.

The Building Custodian post could be an Estates and Facilities Management apprentice and be funded with the savings by extracting small works from the current maintenance contract.

### CAFM System

A Computer-Aided Facilities Management (CAFM) <sup>3</sup>system is software system that is designed to help organisations to manage their buildings, assets, leases, space management and maintenance activities efficiently. Currently SECamb do not have a

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<sup>3</sup> CAFM systems improve efficiency, compliance, and cost control by centralizing asset and maintenance data, supporting statutory reporting, and enabling better decision-making.

[Role of CAFM in the NHS – TabsFM \[tabsfm.com\]](https://www.tabsfm.com)

Digitalization of estates management reduces compliance risks and operational costs.

[CAFM Systems Can Ease Estate Management – SWG UK \[swg.com\]](https://www.swg.com)

CAFM system so is unable to management this information centrally. This in turn means that the EFM Team cannot independently report upon our Estates compliance levels, which is currently done by providing the maintenance contractors compliance data.

The EFM Team has identified a cost effective CAFM system which should be deployed in the first half of 2026. This would enable the Trust to have a single location for the management of all sites, assets, projects, leases, space management, maintenance, compliance etc and more importantly to be able to report independently on its own compliance with a high level of assurance that isn't possible.

### Key Benefits

- **Centralized Data:** Stores all asset, maintenance, lease and compliance information in one place.
- **Cost Control:** Tracks spending, reduces downtime, and optimizes resource allocation.
- **Compliance Assurance:** Helps meet statutory and safety requirements with audit trails.
- **Space Management:** Monitors occupancy and optimizes space usage.
- **Reporting & Analytics:** Provides insights for better decision-making and performance tracking.
- **Mobile Access:** Enables engineers and staff to update jobs on-site in real time.

### Engagement

One of other directorates criticisms of Estates and Facilities is that it hasn't always engaged or communicated well. Departments have been clear that they would rather have bad news, than no news. Therefore, the EFM Team needs to proactively and consistently communicate its activity within the Trust. This has begun but must continue to evolve to meet the Trusts needs.

In 2025 the EFM Team has begun to: -

- Produce a monthly update, that can provide a consistent update to any meetings that EFM is part of.
- Attend the DMGs. Technical Managers should attend the divisional DMGs and the HoE should aim to attend each DMG at least three times each year.
- Attending other directorates meetings on request.

The engagement could continue to improve by: -

- Creating a portal from the CAFM system so that trust staff can follow up on the progress of their works or requests, check space usage details or check on Capital projects in their area.

## Maintenance Contract Strategy

At the time of writing in late 2025, the current maintenance contract is provided by a single supplier whose contract ends at the end of June 2026, with the next iteration of the contract due to commence on the 1<sup>st</sup> of July 2026.

There are issues with the current 2025 maintenance contract, which are: -

- It is provided by a single provider who sub-contract specialist elements of the contract and provide them to SECamb which would include an element of margin/mark up applied by the contractor.
- A single provider does not offer any resilience.
- The contract lacks the ability to sanction poor performance.

Several options had been considered for the next maintenance contract including retendering a like for like contract again, bringing the service in house, or a hybrid option broken down by geography and/or specialist services.

The Board opted to retender a variant of the Maintenance contract, which is: -

- Three lots, one per division. It was felt that three service providers would offer a level of resilience missing in the current contract.
- A more robust contract with appropriate KPIs and sanctions for poor service delivery.
- In house the handy person/small works element of the contract. <sup>4</sup>Around £750k a year is spent on small works, around half of which are requests that require little or no skill and could be undertaken by a handy person. Having a handy person in a van, with tools and materials in each division would likely cost under £200k per annum and enable savings upwards of £150k a year. The in-house service would also deliver a higher level of care and service that is currently missing.
- The inclusion of generators back into the EFM portfolio of assets to support from Digital where it has resided in recent years.

The fully hybrid and in house options both offered significant cost and savings benefits, but the belief is that the EFM team lacks some of the skills to make these options a success. However, with appropriate training and experience, both options could be serious considerations after the July 2026 contract comes to an end.

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<sup>4</sup> In-house maintenance can reduce reliance on costly outsourcing and improve service quality.  
[Cost Benefits Analysis of In-House vs Outsourced Maintenance](#)

## Properties Strategy

A review of the current ACRP sites, their cost and usage was undertaken and after review with several teams including Divisional Leadership, Dispatch, Make Ready etc then a list of sites proposed for disposal was produced and presented to the Board for approval. Some of the sites came with preconditions such as exploring suitable Blue Light collaboration opportunities. These sites were accepted by the Board, and the Board went further by challenging themselves and Estates to explore going further. Estates interpretation of this challenge has been that we will no longer automatically renew leases, but instead request Operations submit a case arguing why the renewal is operationally, strategically, financially beneficial and that there are no suitable collaboration or suitable roadside opportunities that would maintain current performance before considering renewal.

The usage of ACRPs is declining and is likely to continue further. The reasons being: -

1. The number of allocations made to crews whilst at ACRPs is declining, with the trend moving towards more roadside allocations or after immediately after dropping a patient off at a hospital. Patients are waiting for ambulances to become available rather than ambulances waiting for patients calls.
2. The increasing proportion of Hear and Treat will ultimately result in less dispatches of ambulances and more calls being dealt with by clinicians over the phone.
3. The deployment of Electric Ambulances will result in crews needing to take their breaks at hospital locations whilst their vehicles top up their charge or needing to return to a Make Ready Centre to charge or swap vehicles. Ultimately the deployment of EVs will further reduce the use of ACRPs.

Reducing the ACRP estate will be an ongoing balancing act of supporting SECAMbs financial challenges, whilst also ensuring it is done in a way to not impact operational performance.

## Disposals

### Proposed Disposals

The Board approved the disposal of the following sites.

- Staines, Caterham, Aldershot, Burgess Hill, Rye, Seaford, Faversham, Lydd (or New Romney) and Crowborough
- £81k in savings in 2026
- £230k pa there after
- Freehold sale revenue income of over £150k to be realised, probably by the end of 2026.

SECAMb Operations team are working with the Digital BI team to produce some new BI that would provide an additional level of intelligence around the potential disposals. This information may change the sites selected for potential disposal, but Ops commitment is to achieve the same financial targets.

### **POTENTIAL OTHER DISPOSALS**

NHS England are currently approaching several hospitals with Emergency Departments to explore the installation of EV Charge points for ambulances. If we can identify appropriate meal break points at the hospitals where EV Charge points can be installed, then we should be able to dispose of an equal number of ACRPs. The number of hospitals where ACRPs can be installed is unknown at this stage, but if we estimate this is five hospitals then we potentially could save the costs of the same number of ACRPs which could be in the region of £250k per annum from 2030 onwards, with some savings being realised before that.

Potential funding for a Guildford MRC will further enable the reduction of the ACRP Estate.

### **LEASE RENEWALS**

By not automatically renewing leases, an estimated further five sites could be disposed of from the ACRP Estate, providing potential savings of £250k per annum from 2030 onwards, with incremental savings of £50k in 2026, £100k in 2027, £150k in 2028 and £200k in 2029.

### **POTENTIAL REDUCTION OF 25% OF THE ESTATE OVER THE STRATEGIES PERIOD.**

There is a potential to reduce the size of the Estate over the coming five-year periods through the agreed disposals, not renewing leases and moving meal break/vehicle charge points to Emergency Departments. Through balancing financial ambition with operational performance this target is an achievable target

## **EV Blueprint**

The rollout of an electric vehicle infrastructure isn't just a fleet or operational challenge as it will also present several Estates related challenges. The Estate challenges include:

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<sup>5</sup> NHS England's EV charging strategy includes £8m funding for 1,200+ charge points across ambulance trusts, projected to save £130m over 25 years.

[NHS EV Charging Investment – NHS England \[england.nhs.uk\]](https://www.england.nhs.uk)

**Fire Safety.** There is little regulation around this area yet, only best practice guidance. The guidance suggests that we build in fire breaks between charging vehicles, particularly when they are on 120Kw+ fast chargers. This is largely due to the issue of electrical fires being difficult to extinguish and the high risk of spreading fire.

Other fire safety measures should also be considered such as ensuring that the vehicles charge on a concrete platform, battery temperatures are monitored through heat detection cameras and tanks of water with pumps/hoses are installed to help prevent the spread of an electrical fire.

**Parking.** We may need more parking spaces to accommodate ambulances if the fleet size increases and if we need to take fire safety measures such as allowing more space

#### **Charger Location.**

Again there is no legislation around the location of EV Charge points, though the Fire Brigade often quote not installing high power charge points within seven to ten meters from the perimeter of a building. It may not be possible to always follow this guidance due to the proximity of our sites to the perimeter of the building. However, this should be considered as we roll out our charge point infrastructure.

The installation of EV Charge Points within our buildings should be avoided where possible, due to the fire safety issue of being unable to extinguish an electrical fire and the fumes produced during an EV Vehicles fire, which include Hydrogen Fluoride, Carbon Monoxide, Hydrogen Chloride and Sulphur Dioxide.

#### **Changing Estate due to the recharging of electric vehicles.**

As we move towards a fully electric fleet the recharging of vehicles will be posed several problems. The turnaround time for an ambulance being made ready may increase due to the charge time of vehicles and this in turn may result in needing a larger fleet of vehicles, which in turn will require more parking spaces.

Vehicles may need to return to MRCs during the shift if their charge is depleted either to swap vehicles or fast charge. This issue can be reduced if we can identify locations to top up the electric vehicles charge during their shift. NHS England's Travel and Transport team anticipate that Ambulance Trusts will top up the electric ambulances charge at Emergency Departments either whilst dropping off a patient or immediately afterwards before making themselves available again. If these charge points were combined with a suitable location for the crews to take meal breaks whilst the vehicles top up their charge, then this could prove to be operationally beneficial as it would save time travelling to an ACRP/MRC to recharge and/or take a meal break.

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Collaboration with hospitals for EV charging supports operational efficiency and sustainability goals.  
[Emergency Services Times – EV Infrastructure \[emergencys...stimes.com\]](#)

## **EV Pilot Site and EV Vehicle Forum**

It was proposed to SMG that we should consider rolling out our initial allocation of Electric Ambulances (5 in Q1 of 2026) to a single site to that we can start to build our EV Blueprint in preparation for the rollout of further vehicles. SMG selected Banstead as the initial site to allocate the vehicles and EV Charge infrastructure.

One of the reasons Banstead was selected is that it is one of the few sites which does not need electrical infrastructure upgrade to accommodate the additional power requirements of charging an electric vehicle fleet.

An EV Rollout Forum has been created to oversee the rollout of EV's and to collaboratively work together to build the EV Blueprint from the lessons we learn from the rollout of our initial fleet at Banstead. The Board has requested that this forum feeds back to them periodically advising of the progress, challenges and findings from the trial.

The forums membership has representation from Banstead, Estates, Fleet, Operations and Trae Unions.

## **Storage**

Vacant space within SECAmb is largely unmanaged, which has resulted in areas being used inappropriately as ad-hoc workspaces or for storing equipment with no clear future use. This practice reduces operational efficiency, creates a shortage of suitable storage within the estate, and leads to additional expenditure on external storage solutions. Such inefficiencies conflict with the principles outlined in *NHS Estates and Facilities Management Standards* and the *NHS Premises Assurance Model (PAM)*, which emphasise effective utilisation of space to support patient care and organisational sustainability.

To address this, it is proposed that a Space Allocation Group (SAG) be established. This group would have responsibility for reviewing and approving the use of all vacant spaces across the estate, ensuring alignment with strategic priorities and compliance with NHS guidance such as *Health Technical Memorandum (HTM) 07-02: Sustainable Health and Social Care*. The SAG would work in conjunction with the Estates and Facilities Management (EFM) team to record all space allocations within the Computer-Aided Facilities Management (CAFM) system. By maintaining accurate, real-time data on space occupancy and utilisation, the CAFM system will enable proactive management, reduce inappropriate usage, and support scenario planning for future service models. This approach not only optimises estate capacity but also helps reduce unnecessary costs and supports the NHS Net Zero Carbon Delivery Plan by improving efficiency and reducing waste.

## Space Allocation Group

Decisions regarding the allocation and use of space must involve key stakeholders, including Estates, Health & Safety, Digital, and Operational teams, to ensure that any request is appropriate, safe, and aligned with organisational priorities. This approach reflects best practice outlined in the *NHS Premises Assurance Model (PAM)* and supports compliance with *Health Technical Memoranda (HTM)*, particularly those relating to safety and functionality of healthcare environments.

The establishment of a single Space Allocation Group (SAG) has been discussed in several forums as a mechanism to review and approve applications for space usage. To maximise efficiency and ensure timely decision-making, it is proposed that SAG discussions are incorporated into Divisional Management Group (DMG) meetings during weeks when key partners are present. This integrated approach ensures that space allocation decisions are made collaboratively, with full consideration of operational needs, digital infrastructure requirements, and health and safety compliance. Recording all approved allocations within the Computer-Aided Facilities Management (CAFM) system will provide transparency, maintain accurate utilisation data, and support strategic estate planning in line with NHS sustainability and efficiency objectives.

## Parking

There is a potential future challenge of a reduction in the availability of staff parking, which is largely associated with the rollout of an electric vehicle fleet. We have considered managing staff parking through methods such as issuing of parking permits or paying to park. However, the Board have been clear that neither of these options are appropriate and one of the things that the EV Forum should consider is how we manage parking fairly without the need to expand our car parks. Therefore, it is crucial to have staff/Trade Union representation on the EV Forum to understand these issues as they develop and to work on a colligate solutions in advance. One suggested area to investigate would be to promote that our car parks space availability is not guaranteed and to provide employees who cannot find parking with a list of local alternatives for the occasions that they are unable to park onsite. This colligate approach is successful in the Police and Fire Services.

## Capital Spend Priorities

Capital investment within the Estates and Facilities Management (EFM) team has historically been managed on an ad hoc basis, often prioritising projects based on urgency of requests rather than strategic need. This approach has sometimes resulted in funding being allocated to those who advocate most strongly, rather than to essential compliance or safety-related works.

Going forward, it is recommended that EFM Technical Managers are actively involved in the annual budget-setting process and in monthly financial reviews. This will ensure visibility of available capital funds and enable effective monitoring of project progress.

Capital prioritisation should align with NHS Estates and Facilities standards, focusing on statutory compliance, health and safety, and essential workplace improvements before discretionary or aesthetic projects. For example, areas currently used as office or clinical workspaces that lack adequate lighting, ventilation, heating, cooling, or air quality should be addressed as a priority. These issues directly impact staff wellbeing and operational efficiency and should take precedence over non-essential enhancements.

## Solar and Battery Backup Solutions

Solar energy has featured in previous NHS Estates and Facilities Management (EFM) strategies as part of the wider commitment to achieving Net Zero Carbon by 2040, in line with the NHS Long Term Plan and the Greener NHS programme. However, to date, significant progress on implementation has been limited.

Current priorities indicate that capital investment challenges associated with the transition to an Electric Vehicle (EV) fleet are taking precedence over solar deployment. Given these constraints, and unless dedicated funding streams for solar infrastructure become available, it is unlikely that a comprehensive rollout of solar solutions will occur within the next five years.

Considering this, it is recommended that large-scale solar implementation be deferred until funding opportunities arise. As an alternative, the EFM team could explore investment in battery storage systems. These systems can charge during off-peak hours when electricity tariffs are lower and discharge during peak periods when costs are higher. This approach offers potential financial benefits and provides resilience for the expanding EV fleet, supporting operational continuity and sustainability objectives.

## Alternative ACRP Options

### **Mobile ACRP**

There is a seasonal element to some of our ACRPs which makes them expensive in the periods where usage is low. The EFM Team should explore a mobile porta cabin style ACRP that could be deployed during events, peak times, etc. This may allow us to consider the closure of some ACRPs and offer the Trust with a more dynamic ACRP solution that even presents income generation opportunities.

## Collaboration<sup>6</sup>

SECamb is successfully collaborating with Kent Fire and Rescue Services and exploring collaboration with East Sussex Fire and Rescue Services for Operationally suitable and cost-effective alternatives to the classic ACRP solutions. Similar inroads should be explored with West Sussex and Surrey Fire and Rescue Services and maybe also Police Services over the next five years to enable SECamb to right size its estate whilst ensuring operational performance.

- Collaboration options such as alternative blue light ACRPs (Police and Fire Services)
- Co-location of Call Centres
- Co-location of key services such as training or vehicle depots

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<sup>6</sup> Joint estates strategies between emergency services improve efficiency and enable reinvestment into frontline services.

[Northamptonshire Police & Fire Estates Strategy \[northantsfire.gov.uk\]](http://northantsfire.gov.uk)

Government consultation promotes closer collaboration between ambulance, fire, and police services for better resource use.

[Enabling Closer Working Between Emergency Services – GOV.UK \[assets.pub...ice.gov.uk\]](https://assets.publishing.service.gov.uk)

# Summary

The SECamb Five-Year Estates Strategy (2026–2030) provides an achievable comprehensive roadmap to deliver a safe, compliant, and cost-effective estate aligned with NHS standards. It addresses operational challenges, financial pressures, and sustainability goals while supporting the Trust’s strategic priorities.

## 1. Improved Compliance and Governance

- Appointment of Duty Holders ensures statutory compliance across critical domains (HTMs for water, ventilation, electrical, fire safety, etc.).
- Deployment of a CAFM system provides centralized compliance tracking, independent reporting, and enhanced assurance.

## 2. Financial Efficiency and Cost Savings

- In-housing the handy person service could save £150k annually while improving service quality.
- Direct management of specialist contracts offers potential savings of hundreds of thousands in contractor mark-up fees.
- Disposal of underused ACRP sites and avoiding automatic lease renewals could save £230k per year and generate £150k+ in revenue from freehold sales.

## 3. Operational Resilience and Service Quality

- Hybrid maintenance contract structure (three divisional lots) adds resilience and performance accountability.
- Building Custodians improve on-site care and responsiveness at key locations.

## 4. Futureproofing for EV Rollout

- EV Blueprint addresses fire safety, parking, and charging infrastructure challenges.
- Collaboration with NHS England for hospital-based EV charging reduces reliance on costly ACRPs.

## 5. Enhanced Team Capability and Engagement

- Succession planning and skills development (contract management, finance, facilities management) strengthen the EFM team.
- CAFM portal and monthly updates improve transparency and engagement across directorates.

## 6. Space and Asset Optimization

- CAFM system enables efficient space management and supports the proposed Space Allocation Group (SAG) for governance.
- Potential to reduce estate size by 25% over five years without compromising operational performance.

#### 7. Sustainability Alignment

- Supports NHS Net Zero Carbon goals through EV infrastructure and future solar/battery solutions.
- Promotes collaboration with other blue-light services for shared facilities and cost efficiency.

#### Strategic Impact

Delivering this strategy will:

- Enhance compliance and safety across the estate.
- Achieve significant cost savings and revenue generation.
- Improve operational resilience and service quality.
- Support the Trust's sustainability commitments and NHS Net Zero Carbon objectives.

## Estates Strategy Appendix A

### Diverting Minor Works from the Maintenance Contract

Historically, SECamb has spent approximately **£750,000–£800,000 per annum** with our maintenance contractor on minor works. These are reactive costs above and beyond the annual fixed fee we pay for the service. Analysis indicates that around **50% of these tasks do not require a fully skilled tradesperson**, as they typically involve straightforward activities such as installing shelves, unblocking sinks, and other low-complexity jobs that could be completed by a semi-skilled handy person.

By reallocating these lower-skill tasks from the maintenance contractor to **SECamb-employed handy personnel**, we estimate a potential annual saving in the region of **£150,000–£200,000**. In addition to the financial benefit, this approach would deliver a significant service improvement across our estate. Regular on-site visits by in-house handy people would ensure timely completion of routine but important tasks, improving overall responsiveness and enhancing the quality of support provided to our sites by the Estates and Facilities team.

Item	Cost	Notes
Small Works Diverted from Maintenance Contractor (A)	£350k	This figure has the potential to increase as the handy people become skilled and take on more skilled works.
3 x Handy People (B)	£85k	3 x Band 3 @ £25k plus on costs
3 x Vehicles (C)	£36k	Est £7k per vehicle (Lease and maintenance) and £5k per vehicle for fuel.
Tools & Materials (D)	£30k	Initial tool kit would likely be £300 each plus ongoing annual replacements. (Est £1kpa)  Materials is the larger potential cost on this line.
Potential Saving A – B – C – D	£199k	

### Proposed Disposals

In the draft Estates Strategy a number of disposals were identified. Since the initial sharing of the draft strategy the Ops team have been working with the BI team on some new BI that would help inform on the performance impact of these disposals. Therefore, although we have a list of proposed disposals, the list may change based on the new BI being produced. However, the Ops team have committed to achieve the same financial targets if the list of proposed disposals were to be amended.

Some of the proposed disposals will need an alternate provision providing, but these are being explored with various collaboration partners such as Kent and East Sussex Fire and Rescue.

The proposed disposals are: -

### **Surrey**

Staines – Possible FRS option

Caterham – Can go. Low use. Crews don't like it.

Aldershot – Can go.

### **Sussex**

Haywards Heath OR Burgess Hill (Ops pref is to dispose of Haywards Heath).

Rye – we could potentially use East Sussex Fire & Recue (ESFRS) at Rye

Seaford – low usage – could cover with Newhaven or ESFRS

### **Kent**

Faversham – Explore Fire & Rescue option for meal breaks

Lydd or New Romney

Crowborough - Explore Fire & Rescue option for meal breaks

In 2026 we have the opportunity to close 6 of the 9 potential disposals, making a saving on rent, rates, cleaning, maintenance etc or £75 in year.

In 2027 we have the opportunity to close the remain 3 of the 9 bringing 2027 in year savings to £230k.

	Year 1		Year 2		Year 3	
Opportunity	Deliverable	£ benefit (saving-cost)*	Deliverable	£ benefit (saving-cost)*	Deliverable	£ benefit (saving-cost)*
Consolidation of ACRPs	Close 6 of the 9 identified sites	2026 - £82k	Close all of the 9 identified sites	2027 onwards - £230k pa	Close all of the 9 identified sites	2027 onwards - £230k pa
Procurement of Rydon contract	Inhouse Handy person service	£75k - 6 month benefit	Inhouse Handy person service	£150k pa	Inhouse Handy person service	£150k pa
EV recharging at EDs	Unlikely in 2026	£0	Est 2 ACRPs replaced with A&E Meal break/EV Charging points	£80k pa	Est 2 further ACRPs replaced with A&E Meal break/EV Charging points	£160k pa
SCAS/Fire Service collaboration	Preston Circus	£10k pa	ESFRS Vehicle Commissioning 1 additional FRS ACRP	£20k pa	1 additional FRS ACRP	£20k
<b>TOTAL</b>		<b>£167k</b>		<b>£480k</b>		<b>£560k</b>

Example Minor Works to be diverted from Maintenance Contract

Job Description	Site	Call Out Fee	Additional Hours	Hourly rate	Labour total	Sub-con cost	Material / Plant cost	Total Cost
CAT C -Add storage shelves to Sluice room	STROOD	£50.24	3	£41.87	£175.85	£0.00	£104.63	<b>£280.48</b>
CAT C - Light out in Kitchen	GRAVESEND	£50.24	0	£41.87	£50.24	£0.00	£0.00	<b>£50.24</b>
CAT C - Tighten door handle to crew room	GRAVESEND	£50.24	0	£41.87	£50.24	£0.00	£0.00	<b>£50.24</b>
CAT C - Rectify dorgard to OTL Office	SHEPPEY	£50.24	1	£41.87	£92.11	£0.00	£116.51	<b>£208.62</b>
CAT B- Blocked mens WC-Ground floor	WORTHING	£50.24	1	£41.87	£92.11	£0.00	£0.00	<b>£92.11</b>
FO From Ext Drainage Inspection WO - Blocked Drains	EASTGRINS	£0.00	0	£0.00	£0.00	£272.60	£0.00	<b>£272.60</b>
SV - Check temps again	CATERHAM	£50.24	2	£41.87	£133.98	£0.00	£0.00	<b>£133.98</b>
CAT C-Fill in drill / screw holes on wall	MEDWAYMRC	£50.24	2	£41.87	£133.98	£0.00	£21.51	<b>£155.49</b>
CAT C- Supply and install in event of fire poster	GRAVESEND	£50.24	1	£41.87	£92.11	£0.00	£16.13	<b>£108.24</b>
CAT A-Blocked ladies WC-Ground floor-no other	PADDOCKWOO	£50.24	0	£41.87	£50.24	£0.00	£0.00	<b>£50.24</b>
Repair Jet wash detergent barrel Wash Bay	TONGHAM	£0.00	0	£0.00	£0.00	£220.50	£0.00	<b>£220.50</b>
SV - To lag pipework and make good internal walls	NEWHAVENAS	£50.24	8	£41.87	£385.20	£0.00	£77.32	<b>£462.52</b>
SV - Remove pipework from loft and fill holes	NEWHAVENAS	£50.24	4	£41.87	£217.72	£0.00	£0.00	<b>£217.72</b>
SV - Remove pipework from loft	NEWHAVENAS	£50.24	3	£41.87	£175.85	£0.00	£0.00	<b>£175.85</b>
SV Assist - Remove pipework from loft	NEWHAVENAS	£54.24	3	£45.20	£189.84	£0.00	£0.00	<b>£189.84</b>
CAT C - repair 1 x light out - Shower	PADDOCKMRC	£54.24	0	£45.20	£54.24	£0.00	£7.05	<b>£61.29</b>
CAT C - repair 2 x lights out - Mens WC	PADDOCKMRC	£54.24	1	£45.20	£99.44	£0.00	£0.00	<b>£99.44</b>
CAT C - repair floor - Entrance	GODALMING	£50.24	0	£41.87	£50.24	£0.00	£0.00	<b>£50.24</b>
C - 7 clip frames to be put up	TUNBRIDGE	£50.24	1	£41.87	£92.11	£0.00	£0.00	<b>£92.11</b>
CAT B - Strip light out in Kitchen	TUNBRIDGE	£54.24	0	£45.20	£54.24	£0.00	£0.00	<b>£54.24</b>
CAT C - Put up clip frames - Entrance	TONBRIDGE	£50.24	0	£41.87	£50.24	£0.00	£4.79	<b>£55.03</b>
CAT C- Put up X7 clip frames	CROWBORO	£50.24	0	£41.87	£50.24	£0.00	£0.00	<b>£50.24</b>

These kind of unskilled tasks make up around 50% of the minor works that we currently allocate to the maintenance contractor, but which could easily be undertaken by our own unskilled inhouse handy people.



Agenda No	109-25
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Name of meeting	Trust Board
Date	5 February 2026
Name of paper	Business Case Group Report
Exec Lead	Chief Finance Officer
Author	Rachel Murphy - Business Case Group

The Business Case Group is established by the Executive Management Board to ensure robust assessment of business cases requiring EMB / Board approval.

It met in January to review the following business cases, which were later considered by EMB, ahead of the Finance & Investment Committee who recommends them for approval by the Board – see the separate FIC report.

Each case is summarised below

### Volunteering & Community Resilience

Whole Life Cost	Source of Funding
Total capital - £340,787 Total operating cost - £2,259,290	The capital can be funded from the current IT hardware capital budget.  £350k has been included in the operating expenditure plan for 2026/27 for this scheme. No additional funding is available.
Total Whole Life Saving - £2,600,077	
Revenue Impact (Operating and Non-Operating Costs)	
In year revenue impact (2025/26) - £NIL  Next year's revenue impact (2026/27) - £483,847	

#### Brief description of proposal

Restructure department to incorporate recommendation of strategic review and fully align with Trust Divisional Operating model, with funding to digitalise Patient Clinical Records (ePCR) for volunteers.

#### Recommendation

Following some work to reduce the annual operating expenditure to £350k, this case is recommended for approval, in line with the related Strategy.

#### Comments from BCG

Currently not enough staff to support the number of volunteers we have. An external review was done, and this BC incorporates the suggestions raised.

Will be using Charitable Funds to provide the equipment needed for the additional 500 volunteers.

Volunteers would rather not have an iPad, but some would have difficulty completing an ePCR on a phone. They are frustrated the number of different systems they must access, so best to keep it all in the right place.

This BC is in line with the strategy of the community resilience across all ambulance trusts.

## DCA Replacement

Whole Life Cost	Source of Funding
Total capital - £64,551,537 Total operating saving - £NIL  Total Whole Life Cost- £64,551,537	National cash-backed PDC funding is being made available, with the remainder of the spend each year having to be funded from the Trusts internal operating capital allocation.
Revenue Impact (Operating and Non-Operating Costs)	Total four-year PDC funding is £47,985,490, with the remainder of £16,566,047 being funded by the Trust.
In year revenue impact (2025/26) – N/A  Next year's revenue impact (2026/27) – 3,478,189	

### Brief description of proposal

Increase and smooth the number of DCAs replaced each year until the Trust reaches a recurrent consistent replacement plan, as per the below table.

	Year 0 (25/26)	Year 1 (26/27)	Year 2 (27/28)	Year 3 (28/29)	Total
MAN DCAs	60	47	35	18	160
Electric DCAs	10	20	36	52	118
<b>Total</b>	<b>70</b>	<b>67</b>	<b>71</b>	<b>70</b>	<b>278</b>

### Recommendation

For approval

### Comments from BCG

If we don't get the EV, we don't get that element of the funding.

We have funding in 2025/26 for EV chargers for three sites. We need to plan EV chargers going forward as some need UK power networks work to be undertaken. There is more funding for chargers coming in 2026/27. A separate BC will be done for EV chargers.

## GRS Migration BC

Whole Life Cost	Source of Funding
Total capital - £1,423,47 Total operating cost - NIL  Total Whole Life Cost- £1,423,47	Capital funding via the Digital Strategy
<b>Revenue Impact (Operating and Non-Operating Costs)</b>	
In year revenue impact (2025/26) – NIL  Next year's revenue impact (2026/27) – £516,008	

### Brief description of proposal

Migrate to GRS SaaS.

### Recommendation

Approval

### Comments from BCG

This is an essential migration that is compulsory for the Trust to implement and there are no viable alternatives.

This is being capitalised as a purchase of the licence, to save on revenue spend.

All other ambulance Trusts have already implemented the GRS cloud version. Several other Trusts have tried different systems, and they all fell through at implementation or procurement stage.



# BUSINESS CASE TEMPLATE

## DCA Replacement

11 December 2025

**Author(s):** Rob Martin

**Executive Lead:** David Ruiz-Celada

**Directorate:** Strategy and Transformation

**Business Case Ref:** BC-2526-021

**Version:** 2

**Date of approved summary QIA:**

**Final Decision:**

Date proposal reviewed	By	Decision made

## **Document Control:**

### **Version Control:**

*Please record all key changes made to the document and how these have been approved (either person or committee)*

Version	Date	Author and title	Summary of key changes	Approval by
1	10/12/25	Rob Martin	First Draft	
2	10/12/25	Rachel Murphy	Finance section	

### **Review and Approvals log:**

*Please ensure you log (in chronological order) all reviews and approvals to show the audit trail for support for your proposal*

Version shared	Person and title or Committee	Date reviewed	Recommendation	Rationale
	Business Case Group (BCG)			
	Executive Management Board (EMB)			
	Finance and Investment Committee (FIC)			
	Trust Board			

## 1. Proposal Overview

*Provide a summary of the whole case and include a brief background of the relevant area, proposal aim, current state, business need, all options considered and why they have been discounted and the preferred Solution. State the whole life cost.*

### **Background**

In April 2025 the Trust Board approved the NHSE short form business case for DCA acquisitions as part of the DCA Replacement Programme BC. This was to acquire 65 new replacement DCAs and 5 Fully electric DCAs as part of UEC funding and to decommission the oldest 65 vehicles on our Fleet. This confirmed the total number of DCAs required at the time would be 414. This BC also included the useful lives of DCAs as 7 years for a Mercedes Box Conversion and 5 years for the new Fiat van conversions or future NHSE proposal.

### **Aim**

To set up a recurrent consistent annual replacement programme for DCAs ensuring we can confirm build slots early to have consistency in builds, quality and value for money.

### **Current State**

The Trusts DCA replacements have been inconsistent across the last few financial years, the numbers delivered each year over the last few years, are listed below.

2017/18 - 0

2018/19 – 101 (two batches of replacement Mercedes, 43 and 42 and 16 additional Fiats)

2019/20 – 75 (25 additional Fiats and 50 replacement Mercedes)

2020/21 – 25 (25 additional Fiats)

2021/22 – 34 (batch of replacement Fiats)

2022/23 – 65 (batch of replacement Fiats)

2023/24 - 57 (Carter spec Fiats)

2024/25 – 57 (Carter spec Fiats)

2025/26 – 97 (27 MAN agreed in Trust capital plan and 65 MAN and 5 EDCAs as part of UEC funding)

This has resulted in an inconsistent annual cost, relating to depreciation, lease costs, fuel and maintenance as well as DCAs that are being used past their useful life.

### **Business Need**

To ensure that vehicle costs and the commissioning and de-commissioning workload is consistent from year to year the Trust needs to replace vehicles at the end of their useful life. The Trust currently has a mix of DCAs consisting of Mercedes Box conversions and Fiat Van conversions, which all have a different useful life. Currently a Mercedes Box has a 7-year replacement life cycle and a Fiat van conversion has a 5-year replacement life cycle. On a recurrent basis the Trust needs to end up with an annual consistent replacement plan of between 70-80 DCAs per year, This is based on a DCA Fleet of 441 vehicles replaced over a 7-year useful life based on current operational demand of 339 DCAs as of November 2025 and providing a relief rate across the Trust of 130% which has been a reduction from the original 138% relief required for make ready to run effectively when it was first introduced due to process and procedure improvements introduced by the Head of Make Ready.

### **Options**

Option 1 – Do Nothing - The non-replacement of DCAs is not a viable option.

Option 2 – Increase and smooth the number of DCAs replaced each year until the Trust reaches a recurrent consistent replacement plan of 70 - 80 DCAs per year.

## Preferred Option

Option 2 is the preferred option to order between 70 – 80 DCAs each financial year making use of allocated central funding for vehicles as set out in the table below as well as considering opportunities for ordering above this allocation using other capital if available.

This option allows us to ensure we can pre book build slots with vehicle converters and chassis suppliers ensuring continuity and best value for money. This option also allows us to off fleet older Mercedes DCAs past their current replacement life cycle and Fiat DCAs as soon as they reach their five-year replacement life cycle.

The number of DCAs being partially funded by NHSE over the next four years is in the table below. The Trust must purchase this number of vehicles in each year to be able to drawdown the funding.

	Year 0 (25/26)	Year 1 (26/27)	Year 2 (27/28)	Year 3 (28/29)	Total
MAN DCAs	60	47	35	18	160
Electric DCAs	10	20	36	52	118
<b>Total</b>	<b>70</b>	<b>67</b>	<b>71</b>	<b>70</b>	<b>278</b>

## Whole Life Cost

The total whole life capital cost being requested in this BC is outlined below, this will be part funded by cash-backed PDC funding from NHSE and partly funded from the Trusts internal operational capital allocation.

	Year 0 (25/26)	Year 1 (26/27)	Year 2 (27/28)	Year 3 (28/29)	Total
Capital Cost	16,134,973	15,506,436	16,521,583	16,388,545	64,551,537
NHSE PDC Funding	11,440,140	11,495,059	12,573,307	12,476,984	47,985,490
Internal Capital Allocation	4,694,833	4,011,377	3,948,276	3,911,561	16,566,047
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

## 2. Strategic Case

*a) What will happen if we do not support the proposal? Is it a must do i.e. due to a regulatory requirement? Please highlight if this relates to a risk on the Corporate Risk Register*

If DCAs are not replaced:

- The fleet would continue to age. Compared to new vehicles, old vehicles incur higher maintenance and fuel consumption costs and spend more time off road, putting pressure on delivery of frontline operations and requiring a larger Fleet maintenance workforce
- The Trust would not be making even the most basic contribution to environmental improvement by simply replacing old vehicles with more efficient new ones.

- Despite the perceived high level of staff discontent with the current Fiat DCA staff experience and satisfaction would be compromised. The ability to demonstrate to staff that the Trust is actively planning, and proactively replacing, the DCA fleet (whatever the model is going forward) in a timely fashion, demonstrates an investment in there's and patient welfare
- The Trust would be working at odds to Recommendation 5 in Lord Carter's Review, that NHS Improvement and the Ambulance Association of Chief Executives (AACE) drive rapid movement to a standard specification for new fleet across England and deliver significant improvements in the way fleet is managed.

Ambulance Trusts in England are now required, in the NHS Standard Contract (Service Condition 39.4) to ensure that all orders for new standard double-crewed emergency ambulance base vehicle and/or conversion comply with the National Ambulance Vehicle Specification and are in accordance with the National Ambulance Vehicle Supply Agreement (that is unless the Trust has written agreement from its Co-ordinating Commissioner, NHS England and NHS Improvement that these requirements need not apply).

The replacement of old vehicles with new, more fuel-efficient vehicles will allow the Trust to demonstrate its contribution to a 'Green NHS'. All NHS Trusts are now required, in the NHS Standard Contract 2020/21 (Service Condition 18.4), to have a Green Plan approved by its Governing Body:

"18.4 As part of its Green Plan the Provider must have in place clear, detailed plans as to how it will contribute towards a 'Green NHS' regarding NHS Long Term Plan commitments in relation to:

18.4.1 air pollution, and specifically how it will, take action to reduce air pollution from fleet vehicles, transitioning as quickly as reasonably practicable to the exclusive use of low and ultra-low emission vehicles.

The Trust has a Green Strategy fully supported at Board level and is aligned fully with the NHS direction of travel and timelines.

***b) How does the proposal fit with the Trust's current strategies and Trust Objectives?***

Vehicles are fundamental to the delivery of frontline Accident & Emergency (A&E) operations. The Trust must continually replace old vehicles with new ones.

The replacement of old vehicles with new complies with the Trust's own Green Plan strategy in the reduction of carbon emissions and its target to reduce emissions by 50% by 2030.

These new ULEZ compliant ICE DCA and BEV DCA vehicles show our commitment to driving down emissions where we know Fleet is the biggest contributor to these throughout the Trust.

**3. Economic Case**

***a) What options have been considered? Please provide a high-level summary narrative of the options.***

<i>Options</i>	<i>Brief description</i>	<i>Benefits</i>	<i>Risks</i>
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Option 1 - Do Nothing	Non replacement of DCAs.	Avoids additional expenditure to acquire new vehicles.	Vehicles and equipment continue to age, incurring increasing fuel consumption and maintenance costs, and time off road potentially threatening full deployment of operational hours.  Staff experience is compromised.  May compromise staff and patient safety.
Option 2 (preferred option)	Consistently replace 70-80 DCAs year on year based on allocated central funding available and any additional Trust capital investment opportunities	Reduces operating expenses – maintenance and fuel costs.  Improves patient and staff safety.  Improves staff experience.  Improves patient experience.  Avoids Trust reputational damage arising from malfunctioning vehicles, which can impact on clinical care.	May require additional capital and operating expenditure.

#### **4. Preferred Option (all sections from now refer to the preferred option)**

*a) Please expand upon the preferred option, by providing full details of the proposal and provide rationale for why this will be the best way forward. Include consideration to strategic fit, deliverability and, ease of implementation. What resources are needed; will it affect any other departments. What is the proposals impact on the environment and sustainability.*

Option 2 is the preferred option to have a reoccurring DCA replacement plan ensuring that all Trust DCAs are replaced on time and do not exceed its target replacement date.

Vehicles that continue to be in use past their planned replacement age are generally more expensive to maintain and become less reliable and spend more time off the road increasing the Trusts VOR rate.

A list of the current batches of DCAs that we have in operation and their replacement year is embedded at Appendix A. This has been used to work out a smoothing of DCA replacements over the next five years to get the Trust to a stable position of replacing a fifth of the fleet each year. The total fleet has currently been agreed at 441 DCAs, so a fifth of these is a replacement of 80 year, which gives a slight buffer for any vehicles requiring replacement prior to the end of their useful life.

A summary table of the replacement plan by year is below.

Over the next few years the fleet workforce resources will be enough to implement this plan, based on current directorate transformation plans.

The Trust is already working with the convertor to ensure that the national specification can be used for the next order of DCAs. The convertor that Secamb are currently working with is WAS, this is the same supplier that Secamb has used to convert its current MAN DCAs, so there is no issue with implementation.

All the equipment for the DCAs will be ordered via the existing arrangements, as per the Standard Load List (SLL).

This proposal does not change the impact on the environment, as the vehicles the Trust uses currently will not change. The Trust is working with NHSEI on the move to zero emission vehicles and is about to commission five environmentally friendly electric DCAs expected to arrive in March 2026. National DCA funding is specifically ringfenced for electric vehicles only.

*b) How will you measure the benefits of the preferred option? What Key performance indicators (KPIs) will you use? Please note that proposals will be rejected if there is no benefits realisation plan*

No.	Benefit Description	Indicator and how is it recorded	Current and Target Measure and Change	Financial Saving if applicable	Timescale	Assumptions
1	Reduction in Daily/Monthly VOR Rate	Recorded daily and on monthly IQR	Current VOR rate 16-17%. Target 14% with overall target of 5 years being reduced to 10%	Reduction in lost operational hours	2027/28 financial year	The newer vehicles are more reliable than those decommissioned
2	Reduction in Carbon Emissions	Recorded monthly through OSGG meeting		Fuel Saving	2027/28 financial year	Vehicles are more fuel efficient
3	Reduction in Critical Vehicle Failure / Breakdowns	Recorded monthly on Trust IQR report		Less running Costs and external recovery costs	2027/28 financial year	The newer vehicles are more reliable than those decommissioned

*c) When will the post project evaluation be completed?*

Data to inform KPIs 1, 2, 3 are already routinely collected.

KPIs 1, 2 and 3 are already captured in daily VOR reports (appendix C) and monthly Fleet IPR Well Led data submissions (Appendix D). These submissions will be closely monitored against set targets with exception reports being completed to explain why targets are not met.

## **5. Financial Case - Analysis and Affordability (of preferred option)**

*Please include VAT, where not claimable, within all costs stated.*

*a) Whole life costs of the preferred option (Please specify what this spend is related to) Net Cost/(Savings). All possible costs should be included, a list of costs that you should consider is included at appendix B.*

	Year 0 (25/26)	Year 1 (26/27)	Year 2 (27/28)	Year 3 (28/29)	Year 4 (29/30)	Year 5 (30/31)	Total
<b>Capital</b>							
MAN DCAs	13,778,228	10,792,945	8,037,299	4,133,468			36,741,940
Electric DCAs	2,356,745	4,713,491	8,484,284	12,255,076			27,809,596
<b>Total Capital</b>	<b>16,134,973</b>	<b>15,506,436</b>	<b>16,521,583</b>	<b>16,388,545</b>	<b>0</b>	<b>0</b>	<b>64,551,537</b>

*b) Impact on the Trusts Statement of Comprehensive Income (please specify what this spend is related to and if operating or non-operating) Net Cost/(Savings)*

	Year 0 (25/26)	Year 1 (26/27)	Year 2 (27/28)	Year 3 (28/29)	Year 4 (29/30)	Year 5 (30/31)	Total
Net Operating Expenditure	0	0	0	0	0	0	0
<b>Non-Operating Expenditure</b>							
Depreciation	0	2,689,162	5,273,568	8,027,165	10,758,589	10,758,589	37,507,075
PDC Dividend)	0	789,026	1,210,169	1,553,333	1,511,382	1,134,831	6,198,742
<b>Total Non-Operating Expenditure</b>	<b>0</b>	<b>3,478,189</b>	<b>6,483,737</b>	<b>9,580,499</b>	<b>12,269,972</b>	<b>11,893,421</b>	<b>43,705,817</b>
<b>Net Impact on I&amp;E</b>	<b>0</b>	<b>3,478,189</b>	<b>6,483,737</b>	<b>9,580,499</b>	<b>12,269,972</b>	<b>11,893,421</b>	<b>43,705,817</b>

*c) Impact on the Trusts Cash Flow*

	Year 0 (25/26)	Year 1 (26/27)	Year 2 (27/28)	Year 3 (28/29)	Year 4 (29/30)	Year 5 (30/31)	Total
<b>Operating Expenditure</b>							
Capital Costs	16,134,973	15,506,436	16,521,583	16,388,545	0	0	64,551,537
Net Operating Expenditure	0	0	0	0	0	0	0
PDC Received	(11,440,140)	(11,495,059)	(12,573,307)	(12,476,984)	0	0	(47,985,490)
PDC Dividend	0	789,026	1,210,169	1,553,333	1,511,382	1,134,831	6,198,742
<b>Impact on Cashflow</b>	<b>4,694,833</b>	<b>4,800,403</b>	<b>5,158,445</b>	<b>5,464,894</b>	<b>1,511,382</b>	<b>1,134,831</b>	<b>22,764,789</b>

*d) What is the required funding source*

National cash-backed PDC funding is being made available as per the below table, with the remainder of the spend each year having to be funded from the Trusts internal operating capital allocation.

	Year 0 (25/26)	Year 1 (26/27)	Year 2 (27/28)	Year 3 (28/29)	Total
<b>Capital Cost</b>	<b>16,134,973</b>	<b>15,506,436</b>	<b>16,521,583</b>	<b>16,388,545</b>	64,551,537
NHSE PDC Funding	11,440,140	11,495,059	12,573,307	12,476,984	47,985,490
Internal Capital Allocation	4,694,833	4,011,377	3,948,276	3,911,561	16,566,047
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

*The above has been confirmed by:*

Rachel Murphy

*f) Please include narrative of workings of costs, savings and all financial and activity assumptions*

All £ inclusive of VAT	2026/27	2027/28	2028/29	2029/30	Totals
Allocation per ICE DCA	£ 158,784	£ 165,135	£ 171,741	£ 178,610	
Expected number of ICE DCAs	60	47	35	18	<b>160</b>
Total ICE DCA Allocation	£ 9,527,040	£ 7,761,362	£ 6,010,927	£ 3,214,987	<b>£26,514,316</b>
Allocation per BEV DCA	£ 191,310	£ 186,685	£ 182,288	£ 178,115	
Expected number of BEV DCAs	10	20	36	52	<b>118</b>
Total BEV DCA Allocation	£ 1,913,100	£ 3,733,698	£ 6,562,380	£ 9,261,996	<b>£21,471,174</b>
Total funding allocation	£11,440,140	£11,495,059	£12,573,307	£12,476,984	<b>£47,985,490</b>

## 6. Quality Impact assessment (of preferred option)

Please embed the signed summary Quality Impact Assessment (QIA) below. The guidance and template can be found on the zone.

## 7. Equality Analysis (of preferred option)

Please embed the completed equality analysis below. The guidance and template can be found on the zone.

## 8. Risk Assessment (of preferred option)

Please ensure you undertake a thorough assessment of the risks associated with implementing the proposal and mitigating actions (using the Trust Risk Management Approach). Include the top five here

Risk Description	Mitigation	Likelihood (1-5)	Consequence (1-5)	Owner
Inability of the manufacturer (vehicles &/or equipment) to supply through the allocation of timely production slots.	Old owned DCAs will be kept running until the replacement vehicles are operational.	3 (Possible)	3 (Moderate)	Rob Martin
Inability of the converter to supply through the allocation of timely conversion slots.	Ensure slots are booked far enough in advance.	3 (Possible)	3 (Moderate)	Rob Martin

<p>The commissioning team are unable to cope with the rate of introduction of the new vehicles.</p>	<p>Phased receipt of vehicles from converter.</p> <p>Ensure the team is staffed appropriately: extra staff are included in this business case.</p> <p>Ensure that staff abstraction is carefully managed around workload peaks.</p> <p>Ensure that a robust programme is developed and managed (see 9d below).</p>	<p>2 (Unlikely)</p>	<p>3 (Moderate)</p>	<p>Rob Martin</p>

### 9. Commercial Case (of preferred option)

*a) Commercial detail. Explain how you intend to deliver the proposal? Did you go through a tender process, acquire supplier quotes, who is the preferred supplier and what selection process did you go through.*

All DCA purchases and conversions will be procured under the agreed national framework and contracts that have been set up and awarded by the NHSE procurement team.

Currently all national specification DCAs will be purchased direct from Manufacturer So MAN for the MAN Chassis and Ford for the EV chassis as per NHSE framework.

All DCA conversions for SECamb will be awarded to WAS who will convert all SECamb vehicles to the national specification under the NHSE framework agreements.

All the required vehicle medical and communications equipment will be purchased through the Trusts usual procurement routes.

### 10. Management Case (of preferred option)

*a) Project management detail. How will you track implementation, what governance group will the proposal report to during implementation and where does that group report into? What reports will be produced, what will they cover and how often will they be produced?*

Fleet Operations will be the lead on this project, with support from Clinical Operations, Logistics, Radio Engineers and Finance colleagues as required.

The process for commissioning the new DCAs will be affected through the Lewes Commissioning Centre.

The Commissioning Centre Manager will work closely with the Operational Support Desk and local centre managers to ensure a smooth process of distribution to Operating Units without impacting on operational demand or patient care. The current level of budgeted

Fleet staff as proposed in the current directorate restructure is expected to be sufficient to manage the commissioning of these vehicles, and the decommissioning of those they are replacing.

The Commissioning Centre Manager will be in regular contact with both the chassis and conversion suppliers to ensure that the builds are on track.

The Head of Fleet will provide overarching oversight that delivery is on time and on budget, and provide regular progress reports on delivery to:

- The Senior Management Group (SMG), which reports into the Executive Management Board (EMB).
- Fleet Divisional managers, to keep Divisional Operations managers informed of progress.
- 

***b) Include a high-level implementation plan and key milestones and dates? This must be included otherwise the proposal will be rejected***

Commissioning Financial Year	Number of DCAs To Commission	Commissioning Plan proposal											
		Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26
2026/27	60 - ICE												
	10 - BEV	Order								Order	Build Start	10	20
2027/28	47 - ICE	Jan-27	Feb-27	Mar-27	Apr-27	May-27	Jun-27	Jul-27	Aug-27	Sep-27	Oct-27	Nov-27	Dec-27
	20 - BEV	20	10	10		Build Start		20	20	Order (7)	10	10	
2028/29	35 - ICE	Jan-28	Feb-28	Mar-28	Apr-28	May-28	Jun-28	Jul-28	Aug-28	Sep-28	Oct-28	Nov-28	Dec-28
	36 - BEV					Build Start		20	15	Order (15)	15	6	
2029/30	18 - ICE	Jan-29	Feb-29	Mar-29	Apr-29	May-29	Jun-29	Jul-29	Aug-29	Sep-29	Oct-29	Nov-29	Dec-29
	52 - BEV					Build Start		18	15	15	15	7	

## 11. Stakeholder engagement/consultation (of preferred option)

***a) Does the proposal require/have commissioner, STP or other external support? If yes, provide evidence of discussions***

No, this proposal does not require any external engagement or approval, routine vehicle replacement is part of normal business.

***b) Does the proposal have a requirement for consultation (staff/union/JPF/public)? If yes, what consideration have you given to enacting this? How have affected staff groups been engaged and how have their responses been taken into account.***

No, Staff feedback is gathered on each new vehicle implementation and feedback is then used to improve the build where possible within the national specification and dependent on funding available. These considerations are tabled at vehicle user group meeting before a paper to SMG on any alterations that may have financial implications.



# BUSINESS CASE TEMPLATE

## GRS Migration to SaaS

10 December 2025

**Author(s):** Greg Walsh

**Executive Lead:** Nick Roberts

**Directorate:** Digital

**Business Case Ref:** BC-2526-020

**Version:** 2

**Date of approved summary QIA:**

**Final Decision:**

Date proposal reviewed	By	Decision made

## **Document Control:**

### **Version Control:**

*Please record all key changes made to the document and how these have been approved (either person or committee)*

Version	Date	Author and title	Summary of key changes	Approval by
1	10/12/25	Greg Walsh	First Draft	
2	10/12/25	Rachel Murphy	Finance Section	

### **Review and Approvals log:**

*Please ensure you log (in chronological order) all reviews and approvals to show the audit trail for support for your proposal*

Version shared	Person and title or Committee	Date reviewed	Recommendation	Rationale
	Business Case Group (BCG)			
	Executive Management Board (EMB)			

## 1. Proposal Overview

*Provide a summary of the whole case and include a brief background of the relevant area, proposal aim, current state, business need, all options considered and why they have been discounted and the preferred Solution. State the whole life cost.*

This business case seeks approval for South East Coast Ambulance Service NHS Foundation Trust (SECAmb) to migrate from its current on-premises Global Rostering System (GRS) to the modern, cloud-based Software as a Service (SaaS) GRS platform. The proposal directly supports SECAmb's digital transformation ambitions by modernising workforce management, improving staff experience, reducing operational inefficiency, and strengthening system resilience and cyber security. It also aligns with NHS England's broader aspiration to move ambulance services toward a more standardised, interoperable national GRS configuration.

### Background

SECAmb currently uses GRS to roster all operational and support staff. The system is supplied by Totalmobile, who acquired the original developer (Software Enterprises Ltd) in 2020. GRS is presently hosted entirely on-premises, requiring local infrastructure, specialist support, and manual maintenance. Totalmobile has confirmed that formal support for the on-premise version will cease by April 2026, after which only "best endeavours" assistance will be available. No further development, security patches, or performance enhancements will be provided.

This places SECAmb at a critical decision point: either migrate to the cloud-based GRS SaaS platform—the only supported future version—or attempt to procure an entirely new rostering product, despite there being no viable ambulance-specific alternative currently available.

### Aim

The aim of this proposal is to migrate SECAmb's rostering environment to the GRS SaaS platform by Q1 2026/27, ensuring continuity of service, access to ongoing vendor support, improved system functionality, and strengthened integration with ESR, CAD, payroll and HR systems. The project will also enhance SECAmb's ability to adopt automation, analytics and future roadmap improvements, including AI-assisted rostering.

### Current State

The current on-premises solution has several significant limitations:

- Restricted system integration: Only partial ESR connectivity exists (new starters and annual leave), with no automated transfer of absence, sickness or worked hours.
- Manual processes and spreadsheet dependency: Staff rely on workarounds for AL approvals, shift swaps, overtime claims, TOIL management and student rostering, increasing workload and error risk.
- Performance and reliability issues: Reporting is slow and prone to failure, contributing to inefficient planning and delays in producing operational insights.
- Inability to adopt new functionality: All innovation, enhancements and security improvements are focused exclusively on the SaaS version.

This fragmented digital landscape reduces efficiency, undermines data accuracy, and carries increasing cyber and operational risk.

## **Business Need**

Migration to GRS SaaS is essential to:

- Retain supported, secure workforce systems following the end of life of on-prem GRS.
- Improve interoperability with ESR, CAD, payroll and HR systems to reduce manual entry and data inconsistency.
- Strengthen cyber resilience through a secure, updated and fully managed cloud environment.
- Enable automation of key processes (annual leave, shift swaps, TOIL rules, student rostering), improving productivity and staff experience.
- Access the national GRS roadmap, ensuring SECamb remains aligned with the direction of other UK ambulance trusts.
- Support data-driven decision making through improved reporting, real-time analytics and reduced reliance on spreadsheets.

## **Options Considered**

### **Option 1 – Do Nothing (Rejected)**

Remain on unsupported software after April 2026. This is not viable due to serious risks relating to cyber security, service continuity, system stability, and compliance with NHS digital and cyber standards.

### **Option 2 – Migrate to GRS SaaS (Preferred Option)**

Provides ongoing vendor support, improved functionality, integration, automation, and long-term resilience. This is the only strategic, technically viable option.

### **Option 3 – Procure a New Electronic Rostering System (Rejected)**

Independent market reviews and experience across ambulance trusts show that no alternative system provides the capabilities required for the ambulance operating model. Procurement would introduce major cost, risk and delay with no assured outcome.

## **Preferred Option**

The preferred option is to migrate SECamb to the GRS SaaS platform. This solution:

- Ensures SECamb is protected from the cyber security risks inherent in using unsupported software, by delivering continuity of support and security beyond April 2026
- Delivers a modern, resilient and scalable cloud architecture.
- Supports integration with ESR, HR, payroll, CAD and other systems.
- Enables SECamb to benefit from national collaboration, shared roadmap development and potential licence-cost economies of scale.
- Reduces inefficiencies, manual processes, and payroll errors through improved automation and reporting.
- Aligns with the Trust's cloud-first, sustainability and digital transformation strategies.

## **Whole-Life Cost**

The total capital cost requested in this BC is £1,423,470.

## 2. Strategic Case

*a) What will happen if we do not support the proposal? Is it a must do i.e. due to a regulatory requirement? Please highlight if this relates to a risk on the Corporate Risk Register*

If SECAMB does not support this proposal, the organisation faces a high likelihood of operational disruption arising from the continued use of unsupported, end-of-life software. Once GRS on-premise enters “best endeavours only” support, the Trust will no longer receive security patches, defect fixes, or proactive maintenance, creating a significant and escalating cybersecurity vulnerability. This directly impacts BAF Risk #544 – Cyber Resilience, as operating a mission-critical Tier 1 system without vendor support increases the risk of system compromise, data breach, and non-compliance with national cyber standards.

In addition to cybersecurity concerns, the Trust would be unable to progress necessary interoperability with national workforce systems—such as ESR, CAD and emerging regional/national rostering initiatives—resulting in fragmented data, reduced reporting confidence, and ongoing inefficiencies for staff and managers. The organisation would also remain exposed to degraded system performance, increased manual workarounds, and a continued reliance on spreadsheets, all of which adversely affect rostering accuracy, payroll processing, and service delivery.

Migration to GRS SaaS supports SECAMB’s strategic objectives by strengthening cyber resilience, improving staff experience, enhancing productivity, reducing operational risk, and enabling the modern, data-driven workforce management capabilities required across ambulance services.

*b) How does the proposal fit with the Trust’s current strategies and Trust Objectives?*

The proposal aligns directly with SECAMB’s overarching Digital, People, Sustainability and Quality Improvement strategies, and supports multiple Trust-wide objectives:

- Cloud-first digital strategy.

Migrating to GRS SaaS is fully aligned with SECAMB’s cloud-first approach by replacing ageing, on-premise infrastructure with a secure, resilient, and scalable cloud platform.

This ensures the Trust can modernise core systems, reduce technical debt, and maintain compliance with national digital architecture principles.

- Enhanced cyber resilience and regulatory compliance

By adopting the supported SaaS platform, SECAMB strengthens its position against BAF Risk #544 (Cyber Resilience) and meets evolving NHS cyber standards. The SaaS environment provides continuous patching, monitored security, and fully managed updates—capabilities that cannot be delivered with unsupported on-prem systems.

- Improved staff experience and People Strategy alignment

A modern rostering platform reduces administrative burden, improves transparency of working patterns, streamlines annual leave and shift swaps, and reduces payroll errors.

These improvements contribute directly to staff wellbeing, retention, and the Trust’s ambition to create a positive, digitally enabled working environment.

- Increased productivity and operational efficiency

Automation of routine processes, enhanced reporting, and integration with ESR, CAD and HR systems support the Trust’s objectives to improve productivity, remove waste, and strengthen data-driven decision-making.

- Sustainability Strategy support

Transitioning to SaaS removes the need for local server hardware, associated cooling,

power consumption and on-site maintenance. This contributes to SECamb's environmental commitments by reducing carbon footprint, improving energy efficiency, and supporting the NHS Net Zero agenda.

- Alignment with regional and national NHS direction

The move positions SECamb to collaborate with neighbouring ambulance trusts and aligns with NHS England's ambition for greater standardisation of workforce systems across the ambulance sector—supporting interoperability, shared development, and future cost efficiencies.

### 3. Economic Case

*a) What options have been considered? Please provide a high-level summary narrative of the options.*

<i>Options</i>	<i>Brief description</i>	<i>Benefits</i>	<i>Risks</i>
Option 1 - Do Nothing	Continue using the unsupported on-premises GRS system	No additional cost	The system will not be supported and we will not be able to reliably be able to record and report on staff hours worked, Absactions (Annual leave, sickness and training) and ensure that staff are paid for additional hours worked and other supplementary payments
Option 2 (preferred option)	Migrate to GRS SaaS	While the GRS SaaS model will incur higher annual licence costs, these are offset by expected efficiencies through system consolidation, automation, and reduced infrastructure costs.	Totalmobile have successfully migrated several other ambulance Trust from on Prem to GRS SaaS with very limited issues.
Option 3	Procure a new electronic rostering solution	Not known	A number of trusts have undertaken market testing and have failed to come up with an alternative product that delivers what is being offered by GRS SaaS

### 4. Preferred Option *(all sections from now refer to the preferred option)*

*a) Please expand upon the preferred option, by providing full details of the proposal and provide rationale for why this will be the best way forward. Include consideration to strategic fit, deliverability and, ease of implementation. What resources are needed; will it affect any other departments. What is the proposals impact on the environment and sustainability.*

Migrating to GRS SaaS provides resilience, performance, security, and future-proofing. It replaces ageing infrastructure, removes reliance on spreadsheets, and provides interfaces with ESR, CAD and PAS/Bank systems. The system supports automation and AI-enhanced rostering.

There is significant potential for future collaboration with neighboring ambulance trusts, particularly SCAS and SAS (and potentially other GRS-using Trusts), to establish a single shared instance of the GRS SaaS platform. Totalmobile has confirmed that the SaaS commercial model offers tiered pricing based on user volumes, meaning that as the total number of users within a shared environment increases, the per-user license cost decreases.

If SECAMB were to align its migration with SCAS, SAS, or other ambulance services, this could enable the creation of a multi-Trust GRS tenancy with shared infrastructure, consistent configuration, and a unified roadmap. Not only would this support national NHS aims for standardisation, but it would also unlock economies of scale, where:

- A larger combined user base results in lower cost per user under the NHS ambulance framework pricing.
- Shared development, configuration, and support models reduce duplicated effort.
- A single code base enables faster roll-out of new functionality across all participating Trusts.
- Multi-Trust influence on the roadmap improves the likelihood of features being prioritised more quickly.

Early discussions with suppliers indicate that moving from a single-Trust licence volume to a multi-Trust aggregated user pool can produce material cost reductions over the lifetime of the contract. Therefore, SECAMB’s migration creates the opportunity to participate in a regional or national collaborative model, delivering:

- reduced license costs long-term,
- improved standardisation across ambulance services, and
- increased resilience and interoperability through a unified workforce management ecosystem.

*b) How will you measure the benefits of the preferred option? What Key performance indicators (KPIs) will you use? Please note that proposals will be rejected if there is no benefits realisation plan*

No.	Benefit Description	Indicator and how is it recorded	Current and Target Measure and Change	Financial Saving if applicable	Timescale	Assumptions
1	Improved rostering & workforce visibility	Shift changes; data quality	<b>Current:</b> High volume of late changes <b>Target:</b> 20–30% reduction	N/a	From go-live	Successful adoption
2	Integration with ESR, CAD, and HR systems.	Automated interfaces	<b>Current:</b> Manual re-entry required <b>Target:</b> 80–90% automation	N/a	Within 6 months of go-live	Interfaces delivered
3	Improved staff experience.	Survey scores; admin reduction	<b>Current:</b> Delayed AL approval; high queries <b>Target:</b> 25% fewer payroll queries	N/a	Ongoing post go-live	Consistent workflow use
4	System resilience	Uptime %; incidents	<b>Current:</b> Slow, occasional failures <b>Target:</b>	N/a	Ongoing	Total Mobile /Azure SLA

			99.95% uptime			
5						
<b>c) When will the post project evaluation be completed?</b>						
March 2027.						

## 5. Financial Case - Analysis and Affordability (of preferred option)

Please include VAT, where not claimable, within all costs stated.

a) Whole life costs of the preferred option (Please specify what this spend is related to) Net Cost/(Savings). All possible costs should be included, a list of costs that you should consider is included at appendix B.

	Year 0 (25/26)	Year 1 (26/27)	Year 2 (27/28)	Year 3 (28/29)	Total
<b>Capital</b>					
3 Year licence	1,303,470				1,303,470
Implementation Costs	120,000				120,000
<b>Total Capital</b>	<b>1,423,470</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,423,470</b>

b) Impact on the Trusts Statement of Comprehensive Income (please specify what this spend is related to and if operating or non-operating) Net Cost/(Savings)

	Year 0 (25/26)	Year 1 (26/27)	Year 2 (27/28)	Year 3 (28/29)	Total
Net Operating Expenditure	0	0	0	0	0
<b>Non-Operating Expenditure</b>					
Depreciation	0	474,490	474,490	474,490	1,423,470
PDC Dividend)	0	41,518	24,911	8,304	74,732
<b>Total Non-Operating Expenditure</b>	<b>0</b>	<b>516,008</b>	<b>499,401</b>	<b>482,794</b>	<b>1,498,202</b>
<b>Net Impact on I&amp;E</b>	<b>0</b>	<b>516,008</b>	<b>499,401</b>	<b>482,794</b>	<b>1,498,202</b>

c) Impact on the Trusts Cash Flow

	Year 0 (25/26)	Year 1 (26/27)	Year 2 (27/28)	Year 3 (28/29)	Total
<b>Operating Expenditure</b>					
Capital Costs	1,423,470	0	0	0	1,423,470
Net Operating Expenditure	0	0	0	0	0
PDC Dividend)	0	41,518	24,911	8,304	74,732
<b>Impact on Cashflow</b>	<b>1,423,470</b>	<b>41,518</b>	<b>24,911</b>	<b>8,304</b>	<b>1,498,202</b>

d) What is the required funding source

Capital funding via the Digital Strategy.

**The above has been confirmed by:**

Rachel Murphy

f) Please include narrative of workings of costs, savings and all financial and activity assumptions

	ex VAT	VAT	Total
GRS SaaS 3-year cost	£ 1,027,813	£ 205,563	<b>£ 1,233,376</b>
GRS Replica Database 3-year cost	£ 58,412	£ 11,682	<b>£ 70,094</b>

Migration fee	£ 100,000	£ 20,000	£ 120,000
<b>Total</b>	<b>£ 1,186,225</b>	<b>£ 237,245</b>	<b>£ 1,423,470</b>

This will be paid up front for the term of the contract.

### 6. Quality Impact assessment (of preferred option)

Please embed the signed summary Quality Impact Assessment (QIA) below. The guidance and template can be found on the zone.

[GRS BC QIA template 2025 \(002\)](#)

### 7. Equality Analysis (of preferred option)

Please embed the completed equality analysis below. The guidance and template can be found on the zone.

[GRS BC Equality Analysis Form](#)

### 8. Risk Assessment (of preferred option)

Please ensure you undertake a thorough assessment of the risks associated with implementing the proposal and mitigating actions (using the Trust Risk Management Approach). Include the top five here

Risk Description	Mitigation	Likelihood (1-5)	Consequence (1-5)	Owner
Failure to complete migration before support ends (April 2026).	Strong project governance and supplier engagement	3	4	

### 9. Commercial Case (of preferred option)

a) Commercial detail. Explain how you intend to deliver the proposal? Did you go through a tender process, acquire supplier quotes, who is the preferred supplier and what selection process did you go through.

SECAmb intends to deliver this proposal through the established NHS Framework Agreement for the Provision of an Ambulance Service Workforce Management Solution (SaaS), currently held by South Central Ambulance Service (SCAS). This framework has undergone a full and compliant NHS procurement process and provides a legally robust route for SECAmb to procure licencing, hosting, support, and associated migration services without the need for a further tender exercise.

Under this framework, Totalmobile is the approved supplier for the GRS SaaS solution.

The framework permits SECAMB to place a call-off order for:

- SaaS licence subscriptions
- Cloud hosting and support services
- The one-off migration and implementation fee
- Optional configuration and integration services

Using the SCAS framework ensures procurement transparency, compliance with the Public Contracts Regulations (PCR 2015), and consistency with the approach taken by other NHS ambulance trusts. This route offers several advantages:

- Assured value for money through nationally agreed pricing and tiered licence structures.
- Accelerated delivery, avoiding the time and resource burden of running a standalone tender.
- Standardised contractual terms, enabling alignment with regional and national digital ambitions.
- Reduced commercial risk, as the supplier has already been vetted for capability, technical competence, and financial stability.

Totalmobile is therefore the preferred supplier based on its exclusive position on the framework for GRS SaaS, its proven track record delivering migrations for other NHS ambulance services, and its ability to support SECAMB in achieving interoperability, resilience, and future system enhancements.

## 10. Management Case (of preferred option)

*a) Project management detail. How will you track implementation, what governance group will the proposal report to during implementation and where does that group report into? What reports will be produced, what will they cover and how often will they be produced?*

The GRS SaaS migration will be delivered using a structured PRINCE2 project management methodology, ensuring clear governance, controlled delivery, and effective risk and issue management throughout the programme lifecycle. The project will operate within SECAMB's established digital governance framework and will be overseen by a dedicated GRS SaaS Project Board.

*b) Include a high-level implementation plan and key milestones and dates? This must be included otherwise the proposal will be rejected*

- Q4 2025/26 – Initiate project and complete detailed planning.
- Q1 2026/27 – Begin data migration and testing.
- Q2 2026/27 – Go-live with GRS SaaS.
- Q3 2026/27 – Post-implementation review and benefits tracking.

## 11. Stakeholder engagement/consultation (of preferred option)

*a) Does the proposal require/have commissioner, STP or other external support? If yes, provide evidence of discussions*

No

*b) Does the proposal have a requirement for consultation (staff/union/JPF/public)? If yes, what consideration have you given to enacting this? How have affected staff groups been engaged and how have their responses been taken into account.*

Stakeholders impacted by this proposal include operational leaders, workforce planning teams, resourcing and scheduling teams, HR, ICT, payroll, ESR administration, finance, and wider staff groups who rely on GRS for rostering, annual leave, shift swaps, overtime claims and attendance management.

Engagement to date has included informal discussions, review of existing system pain points, contributions to the Collaborative Value Review, and participation in early user workshops. These insights have directly shaped the scope and priorities of the proposed migration.

The GRS SaaS solution has the same look and feels for the end users so there will be no need for training prior to the migration.



South East Coast  
Ambulance Service  
NHS Foundation Trust



# Medium-term plan: 2026-2029



# Medium-term plan 2026 - 2029

The Board is asked to endorse submission of the Trust's Final Medium-Term Plan to NHS England, confirming that it is compliant, credible and aligned to the Medium-Term Planning Framework and the Trust's Strategy.

The Plan is fully compliant with Medium-Term Planning Standards and commits to delivery of the NHS's core expectations over the three-year period:

- Achieve Category 2 mean response time of 18 minutes by 2028/29.
- Break-even financial position in each of the three years.
- Sustained removal of the underlying deficit by the end of the planning period.
- Supports the hospital-to-community and analogue-to-digital shifts set out in the 10 Year Health Plan.

We will achieve our plans by delivering the core components of our strategy; namely increasing our virtual response, with associated physical model reduction and differentiated responses.

# Medium-term plan 2026 - 2029



## Quality

- Cat 2 mean: 25mins mean - 26/27,  
23mins mean - 27/28,  
18mins mean - 28/29.
- Quality outcomes to be maintained.



## Finance

- Balanced plan for each of the 3 years.
- Recurrent CIP (4%) – pay and non-pay budget reductions.
- Underlying deficit movement from £9.6m FOT 25/26, reducing by 1% of income per year, until achieving recurrent breakeven at end 28/29.



## Productivity

- Increasing Hear & Treat remains the focus for improving Cat 2 response times (29% by 28/29).
- Reducing handover times to ED through use of alternatives (15mins by 28/29).
- Reducing abstraction rates through lower sickness levels (1% reduction each year).
- Reducing the time vehicles are off-road (2% in 26/27).



## Workforce

- Further alignment to agenda for change.
- Work with unions to resolve historic pay issues.
- Increased productivity in all areas, leading to reduced WTE overall.



## Years 2&3

- Continuing to increase Hear & Treat (requires system support e.g. access to pathways, trusted assessor)
- Implement new models of care and differentiated physical response,
- Embed rota review,
- Embed digital productivity,
- Corporate right-sizing,
- Alignment of future transformation within the Group Model.



# Next steps

- **Submission** of the plan on 12th February, including: the **5-year Integrated Plan**, 3-year **numerical templates** – finance, workforce, activity & performance, and the **Board Assurance** document, to NHS England.
- **Budgets** set net of efficiency targets by end March.
- Detailed **implementation plans** by end March.
- Finalisation of the **BAF** and Tier 1&2 programmes for Board endorsement in April.





South East Coast  
Ambulance Service  
NHS Foundation Trust



# Appendix



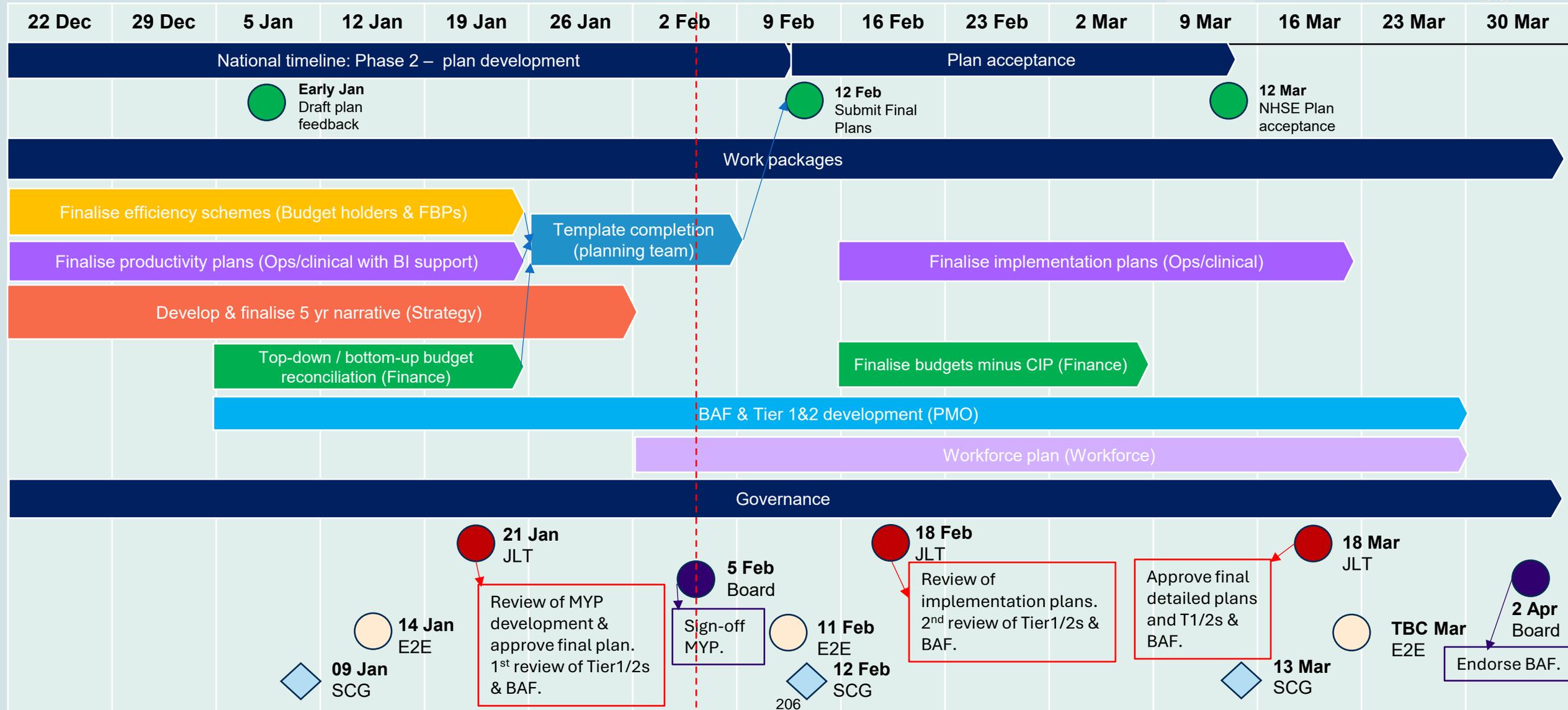
# Medium-term planning glidepath



South East Coast  
Ambulance Service  
NHS Foundation Trust



We are here





		Agenda No	111-25
<b>Name of meeting</b>	Trust Board		
<b>Date</b>	5 February 2026		
<b>Name of paper</b>	Integration Committee – Committee in Common Terms of Reference and Transition Operating Model		
<b>Responsible Executive</b>	Director of Corporate Governance		
<p>The Boards of both SECamb and SCAS have agreed six priorities for integration for the coming year.</p> <p>1. CAD/ePCR &amp; Digital Infrastructure   2. Clinical Model Development   3. Corporate Services Consolidation   4. Strategic Estates   5. Performance Improvement &amp; Patient Outcomes   6. Communications</p> <p>The executive management boards of both trusts will regularly meet in common to ensure joint planning priorities, resource allocation, programme oversight, and commissioner engagement.</p> <p>In order to ensure Board oversight both Boards are being asked to establish an Integration Committee which will meet in common. The TOR are enclosed. This committee will ensure strategic oversight and collective governance as part of the transition to the Group Model. It will support both Boards in progressing the integration priorities for 2026/27 and laying the groundwork for long-term Group-wide transformation.</p>			
<b>Recommendations, decisions, or actions sought</b>	<p>The Board is asked to establish an Integration Committee in line with the Terms of Reference enclosed. Noting that the Board of SCAS is being asked to do the same (on 5 February).</p> <p>The committee is anticipated to operate for approximately 6-9 months, with a formal review in Q3 by the Group Chair and Group CEO.</p>		

## South East Coast Ambulance Service NHS Foundation Trust

### Integration Committee - Terms of Reference

#### 1 Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Integration Committee. It will meet at the same time as the Integration Committee of South Central Ambulance Service NHS Foundation Trusts, as a 'Committee in Common'.

#### 2 PURPOSE

- 2.1 The primary responsibility of the Committee in Common is to oversee the delivery of the benefits set out in the Group Model Outline Business Case (OBC) and ensure a cohesive plan is developed into our 26/27 and medium-term plans.
- 2.2 The Committee in Common will provide strategic oversight, to ensure robust decision-making and resource allocation for the agreed joint programmes of work, ensuring timely progression of critical initiatives where timeline imperatives and/or investment decisions could impact the benefits realisation window.

#### 3 STRATEGIC CONTEXT

- 3.1 On 8 October 2025, the Boards of South Central Ambulance Service NHS Foundation Trust (SCAS) and South East Coast Ambulance Service NHS Foundation Trust (SECamb) approved an Outline Business Case to establish a South Central and South East Ambulance Group.
- 3.2 On 10 November 2025, the Trusts received a commissioning intent letter that set out expectations for joint planning between the two organisations to start delivering benefits of the group from 26/27. In response to commissioning intentions, both organisations agreed to establishing a Board Committee to meet in common, as the primary Board governance mechanism for joint planning and delivery during the transition and early integration period. This approach recognises that while the two organisations remain separate legal entities, a collaborative approach is essential to begin delivering the benefits of a Group model as outlined in the approved Business Case.
- 3.3 The Committee in Common is established to accelerate progress on joint planning areas that require early decision-making. This proactive approach is to maximise benefits realisation and prevent missed opportunities arising from external timelines or funding windows. These joint planning areas form the core set of priorities that will create a cohesive foundation, enabling the future Group Chair and CEO to build upon a well aligned and strategic plan.
- 3.4 The Committee in Common will be reviewed once the Group CEO is in post, which is expected in Autumn 2026 and more substantive Group governance structures are established.
- 3.5 The effectiveness of the Committee in Common will be assessed externally by the joint Strategic Commissioning Group (SCG), hosted by the SE single strategic commissioner, and internally by the respective Boards as they oversee and approve plans for 26/27 ensuring alignment with the commitments set out in the OBC.

## 4 INTEGRATION PRINCIPLES

- 4.1 The aim of the Committee in Common is to initiate integration through joint decision-making for 2026/27 and medium-term planning supporting the delivery of benefits outlined in the OBC.
- 4.2 Ensuring time-critical decisions are taken promptly to avoid missed opportunities and that investment decisions are made with appropriate pace to maximise benefits realisation.
- 4.3 Ensuring joint planning areas are adequately resourced and that joint plans are in place for Board approval as part of the 2026/27 planning process.

## 5 PRIMARY OBJECTIVES

- 5.1 Provide oversight for **Joint Planning Areas** for 2026/27 as set out to commissioners in the response to the commissioning intent letter received on 10 November 2025.

Joint Planning Area	Expected outcome in 26/27
Joint CAD/ePCR and digital infrastructure	<p>A joint CAD/ePCR programme will be put in place, development of a single specification for CAD 999/111/ePCR will be developed and suitably taken through a procurement process, to be implemented in 2027/28.</p> <p>Enabling digital infrastructure will also be aligned as required to ensure we achieve the aim of migrating to a common overall platform.</p>
Joint Clinical Model	<p>Development of a single ambulance clinical model proposition, aligned to both providers' strategies, and the 10-year plan ambitions to support a shift into the community.</p> <p>This agreed common model will be fundamental to underpinning the C2 trajectories, patient outcomes, workforce plans, and medium-term financials. We do not expect these to be aligned in 26/27, but the common model sufficiently understood to reflect any changes from 27/28 planning onwards.</p>
Corporate Services Consolidation	We expect a degree of corporate and support functions to consolidate through 26/27. These are yet untested and may not realise benefits until 27/28 given the complexities associated with coordinating this type of re-structuring across two organisations during transition
Strategic Estates	With consolidation of our systems and clinical models, there exists significant opportunity to align our strategic estates and achieve a leaner overall footprint. The focus will be to have a cohesive plan that enables rationalising call centres across the south-east such that we don't miss out on key opportunities that may present to us with key leases terminating through 2028.
Performance Improvement and Patient Outcomes (Operations)	Each organisation will develop its own plans and trajectories to meet a C2 Mean of 25 minutes on average through 26/27 in line with planning guidance. We will be aligning productivity assumptions such

<p>planning and medium term planning)</p>	<p>that each plan can be tested against the other and no opportunities for improvement are missed (i.e. across H&amp;T, Job Cycle Time, etc.)</p> <p>As part of the medium-term planning, we expect to develop a common narrative and build on the joint clinical model to describe how we return to an 18-minute C2 constitutional standard in an equitable way across the whole of the South-East.</p> <p>In the development of our trajectories, we will expect to work closely with the pan-ICB strategic commissioner on defining a clear and consistent approach to pathway improvement, and in particular establishing joint improvement in outcomes for patients who fall, are frail, or living with older age.</p>
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- 5.2 Oversee the development and delivery of joint **communications plans** for internal and external stakeholders, ensuring and consistent narrative, with a strong focus on the delivery of the clinical benefits.
- 5.3 **Other Functional Collaboration**, as outlined in appendix 1, will continue through existing channels. Issues requiring joint decision that cannot be resolved by individual executive leads will be escalated to the Committee in Common by exception.
- 5.4 **Oversee risks profile and mitigation actions** in place as identified by Boards and through regional QIA

## 6 ACCOUNTABILITY AND DELEGATED AUTHORITY

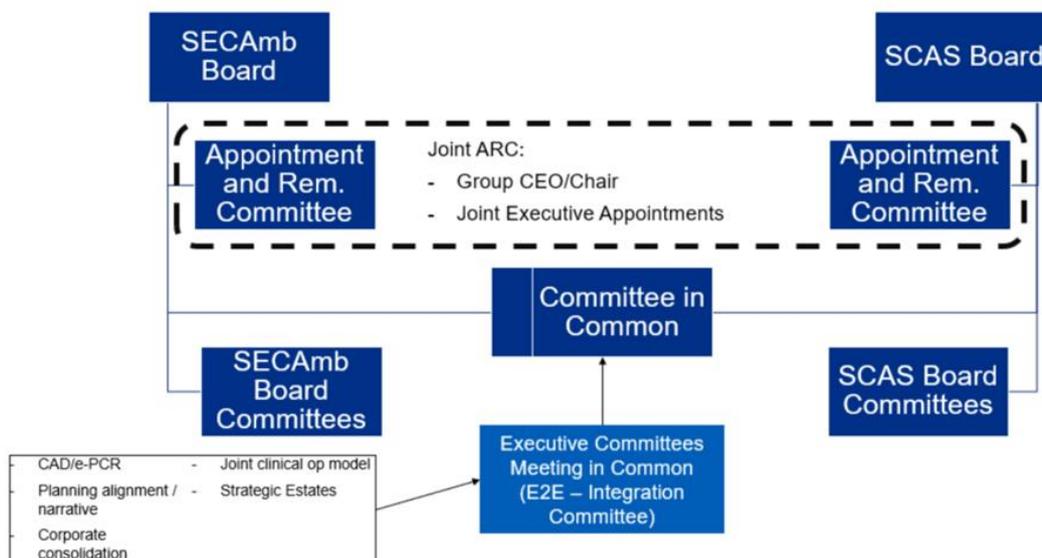
### 6.1 Delegated Authority

The Committee in Common is authorised by the Board in accordance with these Terms of Reference. It is empowered to act as a Committee in Common, reducing duplication and enabling streamlined decision making across both organisations.

### 6.2 Reporting Lines

The Committee in Common will seek assurance from the work of the Executive Integration Committee and will report progress / assurance to the Trust Board.

### Joint Governance and Oversight



### 6.3 Decision-Making Authority

The Committee in Common has authority to:

- Allocate resources and funding in line with each organisation's SFIs and SO.
- Approve programme mandates, scope, timelines and business cases
- Approve procurement strategies and supplier selection for joint programmes (subject to appropriate governance processes and thresholds)
- Make any other decisions that require joint decision-making as identified and escalated for the Functional Collaboration areas

The Committee in Common does **not** have authority to:

- Commit either Trust to expenditure beyond agreed integration budget envelopes without approval in accordance with the SFIs
- Make decisions that would materially alter the strategic direction agreed in the Outline Business Case
- Make structural or organisational changes to Executive teams or reporting lines (reserved to ARC)
- Alter existing contractual commitments or service delivery models without appropriate Board approval
- Make decisions that would compromise operational performance or patient safety
- Override individual Trust Board decisions on matters within their statutory responsibilities

### 6.4 Conflict Resolution

Conflicts that cannot be resolved by the Committee in Common would be taken to the individual Boards for discussion and resolution would be sought through the Chairs or Group Chair once appointed.

## 7 MEMBERSHIP

**7.1** The Committee in Common will be chaired by one of the Non-Executive Directors. They will agree co-chairing arrangements with the Chair of the SCAS Integration Committee

**7.2** Core members of the Committee in Common

- Three NEDs (including the Committee Chair)
- CEO
- Two Executive Directors
- Joint Strategic Lead

**7.3** Briefed deputies are welcome where the Executive member cannot attend.

**7.4 Additional Attendees**

In addition to the members, the following individuals shall regularly attend meetings:

- Director of Corporate Governance
- Programme Senior Responsible Owners where they are leading key programmes and providing SME or operational input to ensure alignment.
- PMO leads for both organisations to provide clear visibility of progress against the plans, development of agreed mandates, and ensure cohesive development of upward assurance reports for Boards and Commissioners.

**7.5 Administration and Secretariat**

The Director of Corporate Governance is responsible for ensuring appropriate administrative support is provided to the Committee in Common. The support provided by the person(s) identified by the Director of

Corporate Governance will include the planning of meetings, setting agendas, collating and circulating papers, taking minutes of meetings, and maintaining records of attendance for reporting in the Trust's Annual Report

As a minimum, papers will be shared 3 working days in advance, and will include collaboration programme-level RAID, and highlight reports for each agreed joint planning area.

Where joint decisions are required, these will be clearly outlined.

An action log will be kept and managed outside the meeting to ensure time is used effectively.

An agenda-type will be as follows

- Welcome, minutes of previous meeting, action log by exception
- Approval of new programme mandates (for the initial meetings)
- Progress update for approved programmes
- Communication plan review and look-forward
- Key risks for escalation

## 8 MEETING ARRANGEMENTS

### 8.1 Frequency

- The Committee in Common will meet bi-monthly commencing February 2026.
- Additional extraordinary meetings may be convened by the Chair where time-critical decisions are required between scheduled meetings.

### 8.2 Quorum

The meeting will be quorate with at least three members, as follows

- The Chair, or a nominated deputy
- At least one Executive Director
- At least one NED

## 9 REVIEW AND DISSOLUTION

**9.1** These Terms of Reference will be reviewed **quarterly** to ensure they remain fit for purpose as the transition progresses and requirements evolve.

The Committee in Common is anticipated to operate for 6-9 months, with formal dissolution or refresh expected by September/October 2026 following a review by the Group Chair and CEO.

## 10 SUCCESS MEASURES

**10.1** The Committee in Common will be considered successful if:

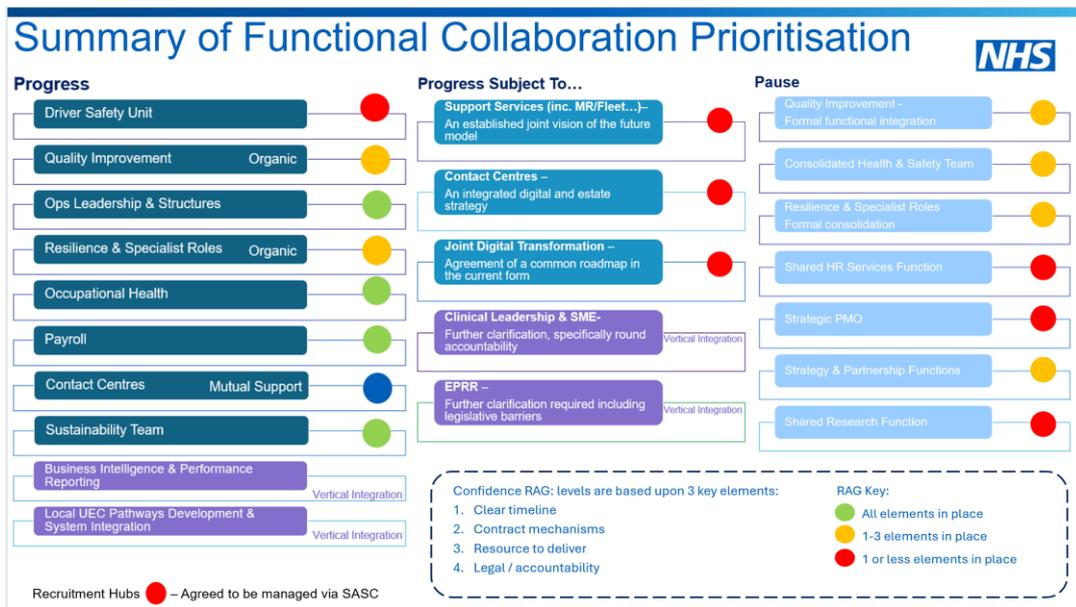
- All joint planning areas demonstrate measurable progress against agreed 2026/27 outcomes
- Time-critical investment decisions are made within the required opportunity windows
- Benefits realisation remains on track for delivery in 2027/28 and beyond
- Operational performance and patient safety are maintained or improved throughout transition

- Resources are deployed efficiently across joint programmes, supported by a clear cohesive plan reflected in the Board Assurance Frameworks. This plan should outline individual organisational priorities alongside joint programmes of work.

## APPROVAL AND VERSION CONTROL

Date	Version	Approved By	Status	Changes
05/02/2026	1.0	Trust Board	Final	tbc

## Appendix 1



We deliver high quality patient care



# Board Assurance Framework Delivering High Quality Patient Care

# Contents:



## + Delivering High Quality Patient Care

- BAF Objectives in line with Strategy Plan
- Progress Highlight Reports on Key Programmes
- BAF Risks

# 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 (Reversible 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	January 2026
Set out Health Inequalities objectives for 25-27				Chief Nursing Officer	SMG	No	QPSC	January 2026
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	January 2026
	ePCR			Chief Nursing Officer	SMG	No	QPSC	January 2026
	Framework for patients with Suicidal ideations/intent			Chief Nursing Officer	SMG	No	QPSC	January 2026
Patient Monitoring Replacement	Commence the replacement scheme by Q4			Chief Medical Officer	SMG	Yes	QPSC	January 2026
	Design future replacement programme by Q4						QPSC	January 2026
Deliver improved clinical productivity through our QI priorities	IFTs			Chief Nursing Officer	SMG	No	QPSC	N/A
	EOC Clinical Audit			Chief Nursing Officer	SMG	No	QPSC	N/A

## BAF Risks

Risk Detail	Risk Score	Target Score	Owner
<b>Delivery of our Trust Strategy:</b> 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
<b>Internal Productivity Improvements:</b> 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	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	Green	Green	Chief Operating Officer	Audit & Risk Trust Board	Nov 2025 Dec 2025	Commissioners have agreed the Trust's self assessment of substantially assured against the relevant measures. The final assessment confirming this was reviewed by the Board in December.
Medicines Management & CDs	Green	Green	<i>Chief Medical Officer</i>	Quality	Nov 2025	Positive assurance from both the CD Accountable Officer annual report and the medicines Internal Audit review, which confirmed Substantial Assurance.
PSIRF	Green	Green	<i>Chief Nursing Officer</i>	Quality	Sept 2025	2024-25 Implemented PSIRF Principles / Standards – compliance is over 90% as reported to QPSC in Sept. In Q3 IA is due to test the effectiveness of PSIRF including how learning is captured and shared.

<h1>Virtual Care Programme - Executive Summary</h1>	<b>Exec. Sponsor:</b>	Jen Allan
	<b>PM:</b>	Kate Mackney
	<b>Last updated:</b>	23 <sup>rd</sup> January 2026

Programme Outcomes	Previous RAG	Current RAG	Impact on outcomes
<ul style="list-style-type: none"> <li><b>We will</b> design the Target Operating Model to Deliver Virtual Care</li> <li><b>We will provide early and effective triage of patient need:</b> Increase Hear &amp; Treat outcomes to 19.7% by end Mar 26</li> </ul>	Red	Yellow	The Virtual Care Programme has entered the design phase and is on track, with effective engagement, workshops, and deliverables progressing as planned. Clinical productivity schemes, alongside the Virtual Care narrative, are contributing to an improving trend in Hear and Treat performance, which is being further enabled through the programme's design activity. A clear plan is in place to deliver the target operating model.

## Headline Key Performance Indicators (KPI)

KPI	IQR or local	Latest (period)	Target	Trend	So what?
Hear & Treat %	IQR	16.6% (Dec 25)	19.5%	Hear & Treat remains in an improving trend closer to and sometimes above the target. The number of incidents receiving clinical validation remain very high with several weeks above the upper control limit	Enhanced clinical productivity and efficiency are key enablers of improved Hear and Treat performance within the core business-as-usual model. The Virtual Care programme supports this ambition through design workshops that are shaping the target operating model, ultimately creating the capability to deliver a greater volume of virtual consultations and Hear and Treat outcomes where appropriate.
Incidents Triaged with H&T Outcome %	IQR	38.91% (Dec 25)	35%	Incidents with a Hear & Treat outcome following clinical triage is in special cause variation with an improving trend	Training and education plans are in place to support improved clinical decision-making when undertaking virtual consultations. The Virtual Care Programme will build on and further scope these plans through the design of the target operating model.

## Top 3 Risks (BAF/Corporate only)

Description	Type/ ID	Current	Target	Trend	Control effectiveness & next step
<b>Delivery of our Trust Strategy:</b> 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	↔	<ul style="list-style-type: none"> <li>VC &amp; MoC programmes to lead with a clear, co-designed vision that integrates population health, digital innovation, and workforce transformation to realise the future mode</li> </ul>
<b>Workforce Feasibility Uncertainty</b> During design, assumptions on skills, capacity & training needs may prove unrealistic, affecting design & model	Prog	16	12	↔	<ul style="list-style-type: none"> <li>Demand-led capacity assumptions</li> <li>Competency-based model</li> <li>Highlight pre-conditions in scenarios.</li> </ul>
<b>Stakeholder Divergence</b> Different partners may hold conflicting views on the virtual care model, slowing design decisions & creating fragmented assumptions	Prog	16	12	↔	<ul style="list-style-type: none"> <li>Strutured stakeholder panels for design</li> <li>Clear issue logs</li> <li>Decision escalation path to Executive Sponsor</li> </ul>

## Assurance

<b>Headline assurance:</b>	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.	<b>Status:</b>	Under control
		<b>Ask of this forum:</b>	Note

<b>Virtual Care Programme - Controls &amp; Decisions</b>	<b>Exec. Sponsor:</b>	Jen Allan
	<b>PM:</b>	Kate Mackney
	<b>Last updated:</b>	23 <sup>rd</sup> January 2026

**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
<b>Secamb/SCAS Group Model alignment is required to ensure there is not conflict with group decisions</b>	COO	Q1	In Progress	Decisions would create misalignment, redesign, delay to transition& weakened assurance	Explicitly documenting dependencies & hold points aligned to decision gates for alignment

Milestone Exceptions	Date	Exception	Impact on delivery/assurance	Recovery & new forecast
<b>Gateway 1:</b> Completion of design scope & exclusions, governance cadence, expected outputs, design methods & assurance approach	Jan 26	Achieved	Achievement of this milestone has established clear scope, governance, assurance processes and stakeholder engagement, providing a stable foundation for co-design activity, reducing delivery risk, and strengthening executive and clinical assurance for subsequent gateways	N/A
<b>Completion of current state validation:</b> Process, workforce, digital, governance as this underpins all future state design decisions	Jan 26	On Track	If delayed or incomplete, future state design would be based on an unstable & potentially inaccurate baseline, limiting the early identification of clinical safety risks, weakening evidence required & having a high impact on the quality & credibility of the emerging TOM, with direct consequences for the delivery on the future design workshops	N/A
<b>Future Design Workshop Completion:</b> Based on the four components of the Patient Journey this is core design output of the phase	Feb 26	On Track	Any delay would result in an incomplete Target Operating Model, unclear role delineation across EOC, CAHs & wider operations, & an inability to finalise performance & safety measures, directly impacting this critical path milestone & leaving EMB insufficiently prepared for decision making	N/A
<b>Gateway 2:</b> Provides executive scrutiny of the emerging TOM, early clinical assurance & confirmation of risks, dependencies & gaps	Feb 26	On Track	If delayed or weak, this highly sensitive milestone would undermine executive confidence in the emerging model, reduce time for refinement & impact assessment, compress clinical & quality assurance activity & significantly increase the risk of challenge at Board	N/A
<b>Completion of Impact Assessments:</b> QIA/EQIA mandatory for clinical quality assurance, equity considerations, Board & External scrutiny	Mar 26	On Track	Any delay would risk deferring Board submission due to late identified assurance gaps, increase the potential for regulatory challenge, & reduce confidence from QPSC & HQC Steering Group, with slippage against other non-negotiable assurance requirement	N/A
Gateway 3: Final design review & board readiness, clinical quality review complete, TOM & scenarios finalised & EMB endorsement to submission to Board	Mar 26	On Track	Any delay to this critical end point would cause Board decision making to slip, delay the transition into implementation, erode programme momentum & credibility & increase pressure to accept residual risk & weaken overall delivery assurance	N/A

<b>EMB outcome, inc. decision requests (post-meeting):</b>	EMB acknowledges the learning from the first 6 months which are not starting to show some positive impact on H&T performance. It has set the strategic direction for VC with the outcome of the modelling to established in Q4.	<b>BAF Risks</b>
<b>Relevant Board Committee outcome (post-meeting):</b>	Focus of QPSC in January was on the strategic modelling / design of the clinical assessment hubs across the region, and ensuring the executive achieve the right balance between the here and now (increasing H&T) and ensuring people get the right support and information. This will come from the design work in Q1	

Models of Care Programme - Executive Summary							Exec. Sponsor:		Richard Quirk		
							PM:		Katie Spendiff		
							Last updated:		22.01.26		
Programme Outcomes							Previous RAG	Current RAG	Impact on outcomes		
<ul style="list-style-type: none"> <li>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.</li> <li>Patients with Urgent Care lower acuity Category 2, 3 &amp; 4 responses (Type B patients) will receive a timely virtual response from the correct speciality who will meet their ongoing needs.</li> </ul>							Amber	Amber	Overall outcome status remains amber but is trending towards green, with positive assurance across the majority of KPIs. Completion of BI dashboard Level 1 and 2 metrics across all 11 MOCs has accelerated progress in most areas.		
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%	13.2% (Sept 25)	Green	13.2% (Sept 2025) currently over performing and seeing common cause variation for year to date. The programme initiatives are keeping performance steady with monthly mean above target for 5 out of the 6 months recorded to date.				
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 39m (C3) 1 hour 43m (C4) (Dec 25)	Amber	There is a clear improving trend in Category 3 mean response times, with the majority of performance now consistently below the long-term average. Targeted utilisation of CFRs on falls-related incidents, alongside active engagement on how they can best support this patient cohort, is underway and is expected to further strengthen performance against this KPI. Care home interventions that are reducing calls will free up resource to attend C3 & C4 calls contributing to the significant improving trend.				
Ambulance attendance to Non-Injury Falls calls	Falls, Frailty & Older People	Local	10%	11.7%	11.3% (Dec 25)	Amber	Just 0.4% shy of reaching target in December. In January 2026 we anticipate seeing increased CFR dispatch, reduced ambulance dispatch and growth in See & Treat activity with only a CFR on scene (virtual consultation) since the new process went live on 22 December 2025.				
Reduction in 999 calls from residential and care homes with interventions in place	Falls, Frailty & Older People	Local	644 calls per month	580 calls per month	593 calls (Dec 25)	Amber	593 calls (Dec 2025) however, month-on-month monitoring shows early positive impact, with 999 calls from intervention care and nursing homes reducing by 13.3% in November and 19.3% in December 2025 compared with the same months in 2024.				
Percentage of crews spending more than 3 hours on scene with patients at End of Life	End of Life Care, Palliative & Dying	Local	TRUST – 5.3%	4.8%	TRUST – 6.1% (Dec 25) 221	Red	Performance across all three counties remains stable and within expected common cause variation. During Year 1, the primary focus was on building staff confidence and competence; this will need to continue into Year 2 to further reduce on-scene times. Additionally, the Year 2 focus on reducing non-commissioned activity is expected to have a positive impact on this KPI.				

Top 3 Risks (BAF/Corporate only)					
Description	Type / ID	Current	Target	Trend	Control effectiveness & next steps
<b>Workforce:</b> 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	↔	<ul style="list-style-type: none"> <li>No changes since last report.</li> <li>An outline workforce plan had been developed (under existing task via Jo Turl &amp; Tina I) and reconciliation work underway to provide further insights into staffing needs and gaps.</li> <li>The programme had already committed to prioritising training, using flexible staffing models, and monitoring workforce metrics</li> </ul>
<b>System alignment to our strategy:</b> 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	↔	<ul style="list-style-type: none"> <li>Continued engagement on our strategic deliverables with system partners and ICBs</li> <li>Mapping of contract deliverables with Strategy Partnership Managers</li> <li>Risk to be reviewed at January steering group in light of recent changes in ICB landscape.</li> </ul>
<b>Organisational Change &amp; Internal Stakeholder Engagement:</b> 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	↔	<ul style="list-style-type: none"> <li>Partial control from initial programme comms for Model of Care. Now need to focus on delivery of:               <ol style="list-style-type: none"> <li>Internal comms plan with comms team support / Regular updates and Q&amp;A sessions.</li> <li>Change management plans including feedback loops and escalation routes.</li> <li>Phased implementation – being worked on via summits in Dec and Jan.</li> </ol> </li> </ul>
Assurance					
<b>Current programme assurance and impact:</b>	<ul style="list-style-type: none"> <li>Programme continues to deliver against its strategic objectives, with progress visible across the focus area MOCs, data quality and our responsiveness to patients. Dependencies with the Virtual Care Design Phase Programme are aligned, with joint governance in place to facilitate safe and timely organisational change.</li> <li>Year 1 V1 delivery of the three focus-area MOC documents and the six Group B MOC documents is on track to achieve clinical approval by 31 March 2026.</li> <li>The Virtual Care design phase work and subsequent programme will be a key enabler for the strategic delivery of all our Models of Care as outlined in the Trust's strategy. Accelerating the Virtual Care design phase in Q4 enables tighter alignment between creation of our Year 2 MOC delivery objectives and the design and rollout of the Trust's virtual care offering.</li> </ul>				<b>Status:</b> <b>Under control /</b> Needs intervention
<b>Decision and next steps:</b>	<ul style="list-style-type: none"> <li>For noting only.</li> </ul>				Decision / Endorse / <b>Note</b> by XXX

<b>Models of Care Programme - Controls &amp; Decisions</b>	<b>Exec. Sponsor:</b>	Richard Quirk
	<b>PM:</b>	Katie Spendiff
	<b>Last updated:</b>	22.01.26

**Change Control - Decision Requests**

Proposed change	Type (T/C/Q/S)	Approval sought	Driver	Impact on delivery/assurance
Reversible Cardiac Arrest MOC Year 1 V1 PPG approval delayed to March 2026 to include Annual Cardiac Arrest retrospective data.	Time	For noting.	Annual reporting timelines.	Being actively managed within agreed tolerances.

Dependencies (material only)	MOC	Owner	Due	Status	Risk if delayed	Mitigation
Cleric system work for GoodSAM	Reversible Cardiac Arrest	Dan Cody	Q3 25/26		Suboptimal end-user experience arising from ineffective deployment to calls risks disengaging new users before they are operational. Addressing this is critical, as effective deployment is a key enabler of the Volunteer Strategy, underpinning the mobilisation of new volunteer roles.	<ul style="list-style-type: none"> <li>Delayed to Q4 25/26 due to winter systems freeze and external factors.</li> <li>Drafting of the GoodSAM clinical bulletin is underway, with final functionality expected to go live in the coming weeks (as of 21 Jan 26).</li> <li>SOP being drafted to support implementation and liaison with SCAS to standardise this between the two Trusts.</li> </ul>
Volunteer Strategy & accompanying business case	Falls, Frailty & Older People Reversible Cardiac Arrest	Danny Dixon	Q4 25/26		Delays to some of the benefit realisation within the Rev CA MOC and the Falls, Frailty and Older People MOC. Without approval of funding to scale the approach, there is a clear ceiling on the level of improvement that can be achieved.	<ul style="list-style-type: none"> <li>The Volunteering and Community Resilience Strategy has been drafted and socialised, with early engagement completed with Executive and Business Case approval stakeholders. Submission of the Business Case and strategy has been rescheduled from Trust Board December 2025 to February 2026 to allow continued focus on strengthening existing processes and ensuring alignment with strategic intent.</li> </ul>
National Care Record System	End of Life Care, Palliative & Dying	Richard Quirk	Q1 26/27		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.	<ul style="list-style-type: none"> <li>New forecasted delivery for NCRS is by end of Q1 26/27</li> <li>CMO and CPaO on project steering group to advocate for agreed approach not having negative impact in this area.</li> <li>EoLC lead being kept apprised and highlighting clinical impact of decision</li> </ul>

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. Being actively managed within agreed tolerances.	January 2026. Submitted EOLC, Falls, and Medical and Illness MOC to PPG and approved. EIA approved. Awaiting confirmation of QIA. March 2026: Reversible Cardiac Arrest MOC Year 1 V1 PPG approval delayed to March 2026 to include Annual Cardiac Arrest retrospective data. On track to bring 3 focus Y1 V1 MOC docs to Board by end of Q4.

<b>EMB outcome, inc. decision requests (post-meeting):</b>	EMB is reasonably content with progress. It has reinforced and pushing harder to realise the digital enablement opportunities, such as GP connect (EOLC) and use of volunteers (fallers), which links to the volunteering strategy.	<b>BAF Risks</b>
		<ul style="list-style-type: none"> <li>BAF 537 - Delivery of our Trust Strategy, BAF 646 - Internal Productivity Improvements, BAF 647 - System Productivity, BAF 648 - Workforce Capacity &amp; Capability.</li> </ul>

<b>Relevant Board Committee outcome (post-meeting):</b>	QPSC believes good progress is being made with now deeper insights into the different models of care and the key drivers and interdependencies. There is more we can do to ensure greater system
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# 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.

## 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. Business Intelligence support was secured. Workforce planning lead assigned. Virtual Care strategic planning being developed through a series of workshops.

**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:** A Trust workforce plan is being developed. Operational planning is still required to ensure that clinical plans are deliverable. The joint clinical model with SCAS is yet to be developed.

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

<b>Mitigating Actions planned/ underway</b>	<b>Executive Lead</b>	<b>Due Date</b>	<b>Progress</b>
Workforce planning assumptions and plan for Trust.	Director of HR and OD	Q4 2025/26	Workforce planning agreed as an executive priority for delivery of the strategy. EMB providing oversight of the Workforce plan.
Agreement of VC operating model to be defined & integrated with MOC implementation.	Chief Operating Officer	Q4 2025/26	Design phased launch Q4 25/26. Current state discussions around digital, workforce & governance have produced a matrix of information to support Future Model Design Workshops which will produce outputs for EMB/Board submission of the TOM
Sprint request for BI Support to deliver the remaining MOC work required to help inform the VC/MOC workforce planning and implementation plans.	Chief Digital Officer	Q4 2025/26	Last remaining Models of Care receiving BI support to achieve dashboards for each Model.

# 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

**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. Ongoing focused management conversations to support productivity and delivery in EOC and Hubs.

**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:** Slow 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. Responsibility for H&T leadership sits across portfolios

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

<b>Mitigating Actions planned/ underway</b>	<b>Executive Lead</b>	<b>Due Date</b>	<b>Progress</b>
Design and delivery of three priority models of care	Chief Medical Officer	Q4 2025/26	These are all on track for delivery as planned.
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. Further workshop in Feb.
Implementation of escalation actions incl new C2 streaming process, Auto-allocation of calls, and "Virtual First" comms campaign	Chief Operating Officer	Q4 <sup>225</sup> 2025/26	In progress. C2 streaming and Virtual First campaign launched in January

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### What?

ST Elevation Myocardial Infarction (STEMI) care bundle compliance has been consistently above 80% for the last 12 months, demonstrating delivery of the care bundle is now firmly embedded in practice. Our survival to 30 days (all cause) was reported as 13.2% for September. Although Hear & Treat is significantly behind the expected target an improving picture has been seen over the past 3.5 months, with December 2025 delivering 16.6% and currently sitting at 16.7% for January 2026. Call audit compliance for both clinical and non-clinical staff continues to be lower than the 85% target. Low compliancy can lead to an inappropriate or unsafe disposition for the patient. Overall, patient experience processes are stable, harm levels remain low (1.6% of all Datix incidents are moderate harm or above and 2.7 harm incidents occur per 1000 patient interactions), and learning is being generated from complaints. The number of PEQs remains very low, which limits the organisation's ability to learn proactively. Flu vaccinations rates are positive but not yet at a level that provides optimal protection for patients or staff (In November 2025, 59.1% of staff had been vaccinated against flu. Currently, this is over 67%). Data gaps limit the Board's ability to fully assure itself on hand hygiene performance and rectification work is taking place on this. Manual handling incidents did increase in Q3 but continue to show normal variation over time. Training compliance is too low to provide full assurance. This month we have achieved the highest Patient Group Direction (PGD) compliance of 97.5%. This figure indicates the level of Paramedic training in the use of medicines which can be administered under a PGD. Each paramedic must take a test to demonstrate their understanding of the medicine and how it should be used. This high figure is as a result of focussed partnership work between the medicines team and operational managers.

### So What?

Delivery of the return of spontaneous circulation (ROSC) care bundle remains under the target level. Low compliancy can lead to an inappropriate or unsafe disposition for the patient. The number of PEQs remains very low, which limits the organisation's ability to learn proactively. Data gaps limit the Board's ability to fully assure itself on hand hygiene performance and rectification work is taking place on this. Training compliance is too low to provide full assurance. Improving training uptake is a key action to reduce the risk of future incidents and strengthen staff safety alongside reviewing other possible improvement interventions including wearable AI devices to support safe posture and movement. We are escalating the concerns the ambulance sector as a whole is having around the increase in volume and length of time on scene we have with patients at the End of Life, where other more suitable services should be caring for these patients. All ambulance services are seeing an increase in complex end of life calls and AACE through NASMED are escalating to NHSE and commissioners about the current gaps in community provision for End of Life care patients.

### What Next?

The Critical Care Paramedic and Health Informatics teams are progressively expanding the resuscitation feedback programme and are including this as this spreads across the Trust. Over the coming months we anticipate the delivery towards the target to improve as key processes to support increasing clinical hours and virtual assessments are delivered within both our Integrated care and divisional teams. An overarching strategic plan is in place to improve the capability and capacity of EOC staff and is being regularly reviewed and overseen by senior leaders. Improvements are planned to send the PEQ via SMS to a selection of patients following contact with our service to increase this. Rectification work is taking place on hand hygiene data gaps. Improving training uptake is a key action to reduce the risk of future incidents and strengthen staff safety alongside reviewing other possible improvement interventions including wearable AI devices to support safe posture and movement. HI objectives for 2025-2027 were discussed at QPSC in January and will be brought for final approval to QPSC in April following completion of the newly developed HI Maturity Matrix to identify key areas for improvement. In the meantime we are up-skilling our staff in this complex clinical area via additional training on Key Skills days.



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

				Special cause variation where <b>UP</b> is neither improvement nor concern.
				Special cause variation where <b>DOWN</b> 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.





## Variation

### Special Cause Improvement



### Common Cause



### Special Cause Concern



## Assurance

### Pass



### Hit and Miss



### Fail



### No Target



## Clinical Effectiveness & Patient Outcomes

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	**Acute STEMI Care Bundle Outcome %	Oct-25	87.3%	79.4%	79.4%		
Board	**Cardiac Arrest - Post ROSC %	Sep-25	78.4%	83%	77.2%		
Board	**Cardiac ROSC ALL %	Sep-25	31.9%	28.4%	29%		
Board	**Cardiac ROSC Utstein %	Sep-25	48%	53.9%	51.9%		
Board	**Cardiac Survival ALL %	Sep-25	13.2%	11.4%	11.8%		
Board	**Cardiac Survival Utstein %	Sep-25	32%	34.1%	32.5%		
Board	Compliant NHS Pathways Audits (Clinical) %	Dec-25	76.8%	100%	83.6%		
Board	Compliant NHS Pathways Audits (EMA) %	Dec-25	83%	100%	81.7%		
Board	Hear & Treat %	Dec-25	16.6%	19%	14.9%		
Board	See & Convey %	Dec-25	53%	55%	54.7%		
Board	See & Treat %	Dec-25	30.3%	35%	30.3%		
Supporting	A&E Dispositions %	Dec-25	5.2%	9%	7.1%		
Supporting	PGD Compliance %	Dec-25	97.5%	95%	93.5%		
Supporting	Health & Safety Training Compliance	Dec-25	95.3%	100%	95.2%		
Supporting	Compliance with Audit Feedback Within Timeframe	Dec-25	95%	100%	95%		
Supporting	Falls Care Bundle Compliance	Sep-25	46.5%	46.6%	44%		
Supporting	Mean Average Time from Call to Catheter Insertion (STEMI)	Aug-25	00:02:27	00:02:31	00:02:23		
Supporting	90th Centile Time from Call to Catheter Insertion (STEMI)	Aug-25	00:03:34	00:03:27	00:03:16		
Supporting	Mean Average Time from Call to Arrival at Hospital (Stroke)	Aug-25	00:01:30	00:01:27	00:01:28		
Supporting	Median Time from Call to Arrival at Hospital (Stroke)	Aug-25	00:01:18	00:01:18	00:01:17		
Supporting	90th Centile Time from Call to Arrival at Hospital (Stroke)	Aug-25	00:02:13	00:02:14	00:02:12		

## Response Times

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	111 Average Speed to Answer	Dec-25	00:03:18	00:00:20	00:01:22		
Board	999 Call Answer Mean	Dec-25	00:00:08	00:00:05	00:00:05		
Board	999 Call Answer 90th Centile	Dec-25	00:00:22	00:00:10	00:00:06		
Board	Cat 1 Mean	Dec-25	00:08:27	00:07:00	00:08:22		
Board	Cat 1 90th Centile	Dec-25	00:15:38	00:15:00	00:15:29		
Board	Cat 2 Mean ★	Dec-25	00:28:23	00:27:25	00:28:46		
Board	Cat 2 90th Centile	Dec-25	00:57:23	00:40:00	00:58:28		
Supporting	Cat 3 90th Centile	Dec-25	05:06:44	02:00:00	04:57:59		
Supporting	Cat 4 90th Centile	Dec-25	05:50:30	03:00:00	05:11:56		
Supporting	Section 136 Mean Response Time	Dec-25	00:25:44	00:18:00	00:24:19		

## Models of Care

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	% of 999 Calls from Nursing Homes	Dec-25	6.1%	7.9%	6.1%		
Board	Falls, Frailty & Older People: Cat 3 Mean Response Time	Dec-25	01:43:38	01:35:00	02:08:50		
Board	Falls, Frailty & Older People: Cat 4 Mean Response Time	Dec-25	01:37:59	01:39:00	02:00:41		
Board	Falls, Frailty & Older People: H&T % - Non-Injury Falls	Dec-25	11.2%	15%	10.2%		
Board	Falls, Frailty & Older People: CFR First on Scene % - Non-Injury Falls	Dec-25	7.4%	4.8%	6%		
Board	End of Life Care, Palliative & Dying: % of on Scene Times Over 3 Hours	Dec-25	4.9%	4.8%	4.8%		

### Variation

#### Special Cause Improvement



#### Common Cause



#### Special Cause Concern



### Assurance

#### Pass



#### Hit and Miss



#### Fail



#### No Target



### Productivity

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	% of 999 Calls Receiving Validation	Dec-25	20.3%		19.5%		
Board	CFR Backup Time (CFR First on Scene) Mean	Dec-25	00:18:37		00:19:19		
Board	Responses Per Incident	Dec-25	1.1	1.09	1.1		
Board	JCT Allocation to Clear All Mean	Dec-25	01:35:30	00:50:16	01:36:16		
Supporting	JCT Allocation to Clear at Hospital Mean	Dec-25	01:47:05	01:58:59	01:50:13		
Supporting	JCT Allocation to Clear at Scene Mean	Dec-25	01:20:26	01:30:34	01:17:40		

### Demand

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Supporting	111 Calls Offered	Dec-25	119869		92270.9		
Supporting	999 Calls Answered	Dec-25	85223		76133.5		
Supporting	CFR Attendances	Dec-25	2121	2000	1826		
Supporting	Incidents	Dec-25	72923		65759.6		

### Health Inequalities

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
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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

### Patient Safety

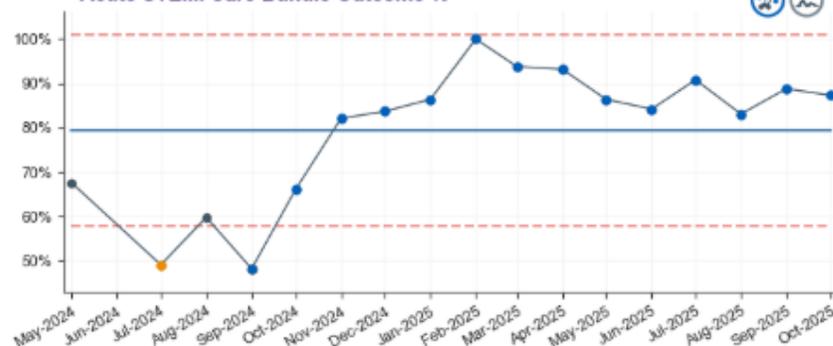
Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	Harm Incidents per 1000 Incidents	Dec-25	2.7	2.85	3.1		
Board	% of PSI (Datix) Where Final Harm is Moderate or Above	Dec-25	1.6%	1.7%	1.7%		
Supporting	Duty of Candour Compliance %	Dec-25	86%	100%	90%		
Supporting	Number of Medicines Incidents	Dec-25	212		173.3		
Supporting	Hand Hygiene Compliance %	Dec-25		90%			
Supporting	Safe in Back Audits	Dec-25	70%		28.7%		
Supporting	Number of Learning Responses Commissioned	Dec-25	10		5		
Supporting	Number of Level 4 Safeguarding Referrals Made	Dec-25	300		298.5		

### Patient Experience

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	Number of Complaints Received per 1000 Incidents Responded to (Patients)	Dec-25	1	0.49	0.6		
Board	Number of Compliments Received per 1000 Incidents	Dec-25	2	1.82	2		
Board	% of Patients Who Express Satisfaction With Our Service	Dec-25	84.2%	95%	90.7%		
Supporting	Complaints Reporting Timeliness %	Dec-25	95%	95%	89.1%		
Supporting	Complaints That Have Resulted In Learning For The Trust %	Dec-25	37%	95%	42%		
Supporting	No. of PEQs Received Across the Trust Per Month Per 1000 Incidents in 999	Dec-25	1.3		1.1		



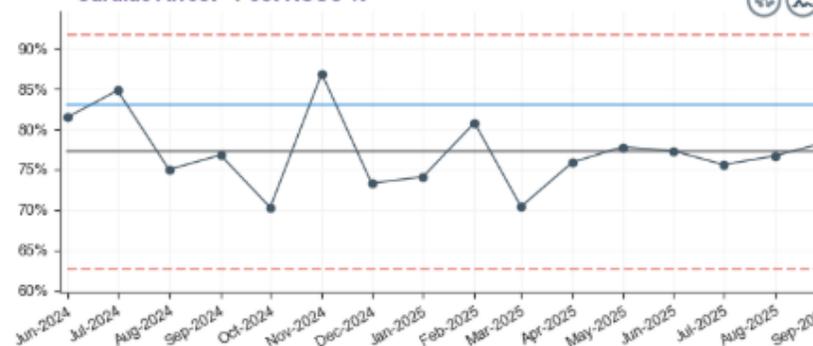
**\*\*Acute STEMI Care Bundle Outcome %**



M-5

Dept: Medical  
Metric Type: Board  
Latest: 87.3%  
Target: 79.4%  
Special cause of an improving nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.

**\*\*Cardiac Arrest - Post ROSC %**



M-11

Dept: Medical  
Metric Type: Board  
Latest: 78.4%  
Target: 83%  
Common cause variation, no significant change. This process will not consistently hit or miss the target.

**What?**

STEMI care bundle compliance is 87.3%, remaining well above the 79.4% target. Performance continues to demonstrate sustained special-cause improvement, with compliance consistently maintained at a high level since late 2024 with normal month-to-month variation.

**So what?**

This sustained performance indicates that the STEMI care bundle is firmly embedded in routine clinical practice. Patients with confirmed STEMI continue to reliably receive key interventions, including aspirin and GTN administration, pain assessment, and appropriate analgesia. The stability of this measure suggests that both clinical delivery and audit processes remain robust and resilient to operational pressures.

**What next?**

Maintain focus on preserving this level of compliance through ongoing quality assurance and clinical engagement. Continue to share learning from the STEMI pathway to inform improvement approaches in other time-critical care bundles, ensuring that gains achieved remain protected and transferable across the wider system. Planned updates to the STEMI care bundle, reflecting evolving clinical guidance, will be implemented in a controlled way, with continued monitoring to ensure sustained compliance and outcome stability.

**What?**

Post-ROSC care bundle compliance is 78.4%, below the 83% target. Performance continues to show common cause variation with no statistically significant change over time. Recent months show some fluctuation but remain within the established range for this measure. Patient survival continues to perform well.

**So what?**

While this metric provides assurance around consistency of post-resuscitation processes, it is important to note that there is currently no direct evidence that compliance with this care bundle measure alone improves patient outcomes. As such, this indicator should be interpreted as a process measure rather than an outcome proxy. The primary focus for assessing impact remains the survival and neurological outcome measures, where recent data shows encouraging performance. Structured clinical oversight and case learning continue to support post-ROSC care delivery within the wider system.

**What next?**

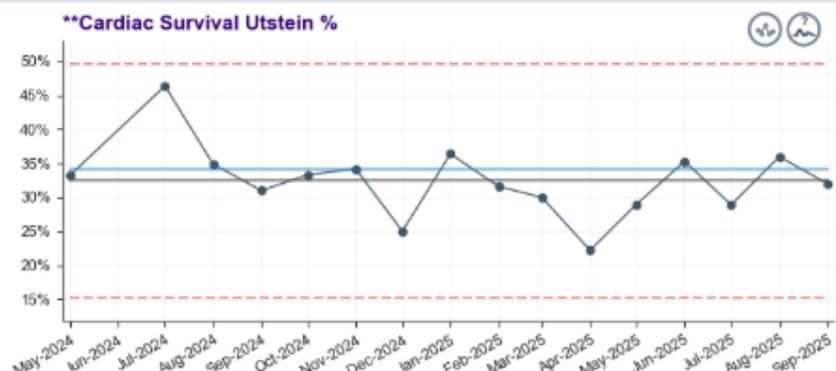
Continue phased rollout of the endorsed CCP-led post-cardiac arrest feedback approach, recognising that progress will be incremental while staffing capacity and competing workstreams are managed. Maintain routine monitoring of post-ROSC compliance for assurance purposes, while prioritising interpretation of survival and ROSC outcomes to guide future quality improvement focus.



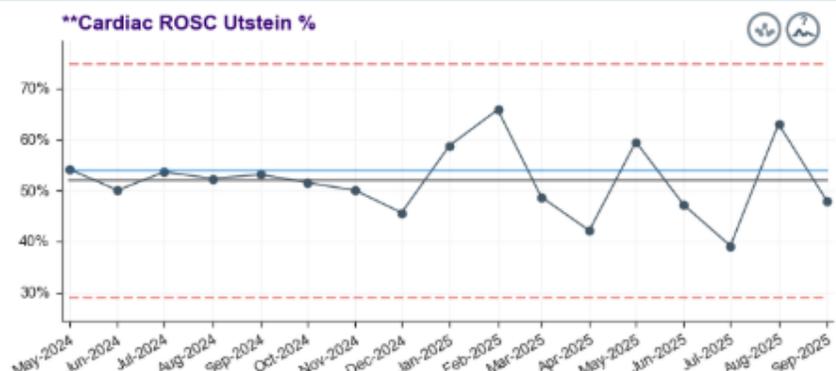
**M-4**  
Dept: Medical  
Metric Type: Board  
Latest: 13.2%  
Target: 11.4%  
Common cause variation, no significant change. This process will not consistently hit or miss the target.



**M-2**  
Dept: Medical  
Metric Type: Board  
Latest: 31.9%  
Target: 28.4%  
Common cause variation, no significant change. This process will not consistently hit or miss the target.



**M-3**  
Dept: Medical  
Metric Type: Board  
Latest: 32%  
Target: 34.1%  
Common cause variation, no significant change. This process will not consistently hit or miss the target.



**M-1**  
Dept: Medical  
Metric Type: Board  
Latest: 48%  
Target: 53.9%  
Common cause variation, no significant change. This process will not consistently hit or miss the target.

**What?**  
Overall cardiac survival is 13.2%, above the 11.4% target, while Utstein survival is 32%, slightly below the 34.1% target. Both measures continue to demonstrate common cause variation with no statistically significant change. Overall survival remains consistently above target, while Utstein survival shows month-to-month fluctuation around the target line.

**So what?**  
The sustained above-target performance in overall survival indicates a resilient cardiac arrest care pathway delivering positive outcomes across a broad patient population. The slightly lower Utstein figure this month reflects expected variability rather than deterioration, and should be interpreted alongside the consistently strong overall survival rate. Importantly, this pattern continues to suggest that gains later in the pathway - including post-ROSC and in-hospital care are contributing meaningfully to survivorship, even where early benchmark measures fluctuate.

**What next?**  
Continue to prioritise survival metrics as the primary indicators of pathway effectiveness, supported by ongoing monitoring of ROSC and post-ROSC process measures for assurance. Maintain focus on system-wide learning and clinical oversight to preserve stability in outcomes and identify opportunities for incremental improvement as longer-term trends emerge.

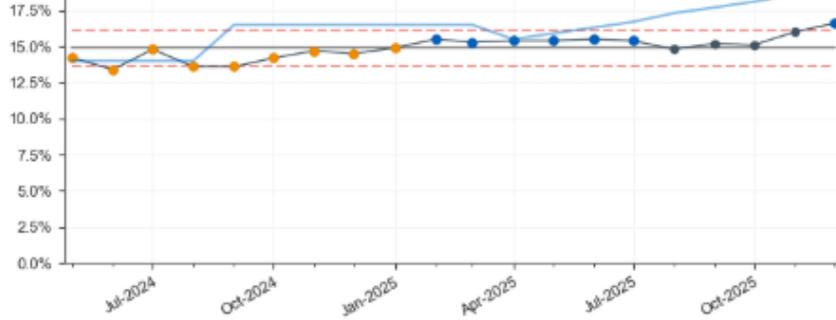
**What?**  
ROSC for all cardiac arrest patients is 31.9%, above the 28.4% target, while ROSC for the Utstein cohort is 48%, below the 53.9% target. Both measures continue to demonstrate common cause variation with no statistically significant change. Overall ROSC has strengthened in recent months and remains consistently above target, while Utstein ROSC shows expected fluctuation around the target line.

**So what?**  
The sustained above-target performance in overall ROSC indicates a resilient and effective early resuscitation response across a broad patient population. Month-to-month variability in the Utstein cohort is expected given smaller numbers and should be interpreted alongside the more stable and positive survival outcomes. As seen previously, divergence between ROSC and survival reinforces that early resuscitation success and longer-term outcomes do not always move in parallel, and that improvements later in the pathway can meaningfully influence survivorship even when ROSC rates fluctuate.

**What next?**  
Continue to use ROSC measures primarily as supporting process indicators, while prioritising survival outcomes as the key markers of pathway effectiveness. Ongoing monitoring across ROSC, post-ROSC care, and survival will help ensure a balanced view of performance and guide future quality improvement focus as longer-term trends become clearer.



**Hear & Treat %**



999-9

Dept: Operations 999

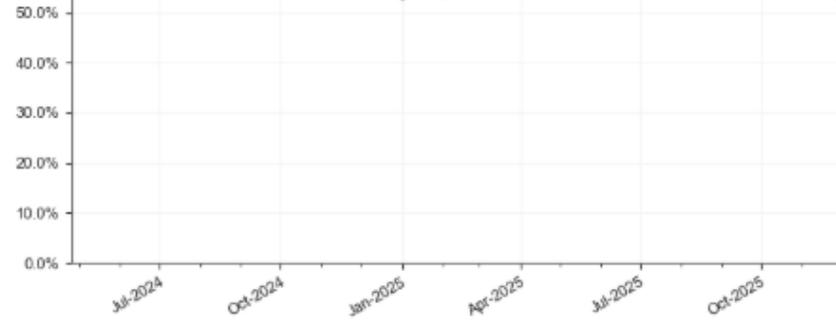
Metric Type: Board

Latest: 16.6%

Target: 19%

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.

**See & Convey %**



999-9

Dept: Operations 999

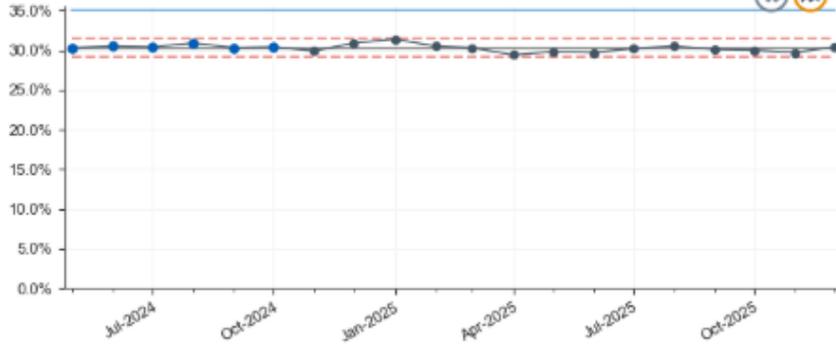
Metric Type: Board

Latest: 53%

Target: 55%

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

**See & Treat %**



999-9

Dept: Operations 999

Metric Type: Board

Latest: 30.4%

Target: 35%

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

**Hear & Treat**

**What?** Although the Trust's Hear & Treat improved last month, 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. The Trust continues to use NHSE guidance to focus on key elements of virtual care, such as C3/C4 validation and C2 streaming. However, there is real variability daily, linked to case acuity, clinician availability and critically clinician productivity, which influences the Trust's 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 – although the Trust has increased clinician capacity in the UCNHs, this has not offset the planned reduction in agency clinician usage.
- Clinical productivity; the number of cases answered per clinician per hour whilst improving marginally to 1.6, 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 less than 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?** Following the Trust's Hear & Treat Deep Dive exercise in Q2, the current virtual care plan and actions were reviewed and updated. The Trust has subsequently held multiple Virtual Care summits, the review how the Trust's current VC model is aligned to realising the Trust's strategy of increasing hear and treat, whilst reducing see and treat.

- A plan to increase clinician productivity in EOC and the Hubs is in place, with a live clinician productivity dashboard, 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 the draft proposal presented to EMB last month, following workshops and engagement events.
- A new C2 Streaming process has been developed, with implementation due in early January.
- A new "auto clinician allocation" process is being tested in the CAD, with a view to deployment in Jan to improve clinician utilisation in virtual care, which should improve clinician productivity.

**See & Treat and See & Convey**

**What?** Hear & Treat rate increased to 16.6% in December, See & Treat and See & Convey rates remain stable

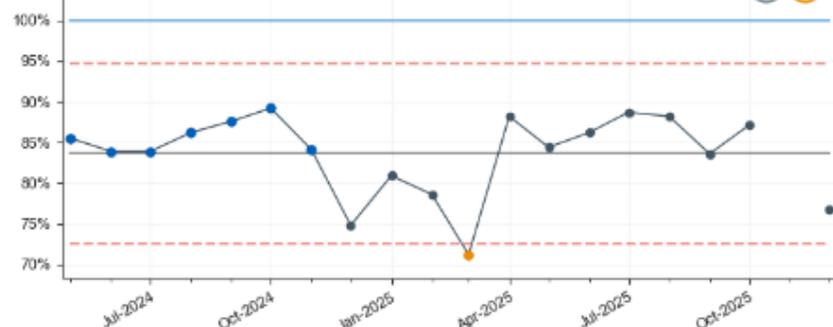
**So what?** It should be noted See & Convey % is directly related to the acuity of patients and availability of suitable alternative referral pathways.

**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 and increasing H&T rates. Further targeted promotion of H&T and Virtual care across operating units commences in January, with Operating Unit Managers taking the lead in increasing H&T % and productivity.



**Compliant NHS Pathways Audits (Clinical) %**



M-20

Dept: Nursing & Quality

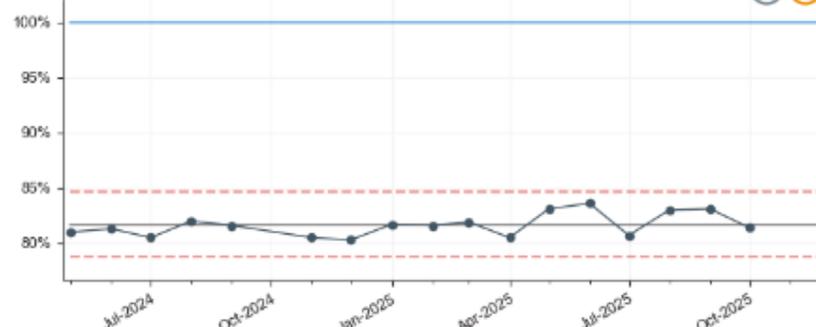
Metric Type: Board

Latest: 76.8%

Target: 100%

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

**Compliant NHS Pathways Audits (EMA) %**



M-22

Dept: Nursing & Quality

Metric Type: Board

Latest: 83%

Target: 100%

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

**What?** Call audit compliancy has sustained at previous levels following a dip in performance earlier in the year, this remains low compared to other ambulance services, there is no formal compliancy target.

**So what?** 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.
- 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' was delivered 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
- Feedback is being revised to ensure face-to-face delivery is focussed on clinicians with low compliancy.

**What?** Call audit compliancy continues to be lower than the 85% target.

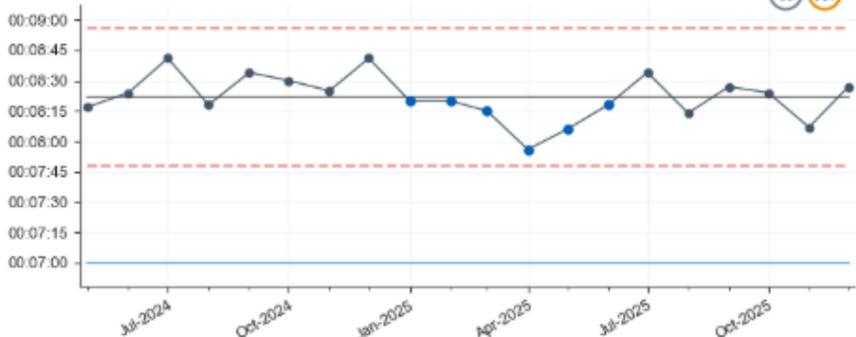
**So what?** Low compliancy can lead to an inappropriate or unsafe disposition for the patient, and widespread low compliancy can be an early indicator of a wider issue in the workforce relating to recruitment, training, management or culture of the EOC team.

**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.



Cat 1 Mean



999-2

Dept: Operations 999  
Metric Type: Board  
Latest: 00:08:27  
Target: 00:07:00  
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

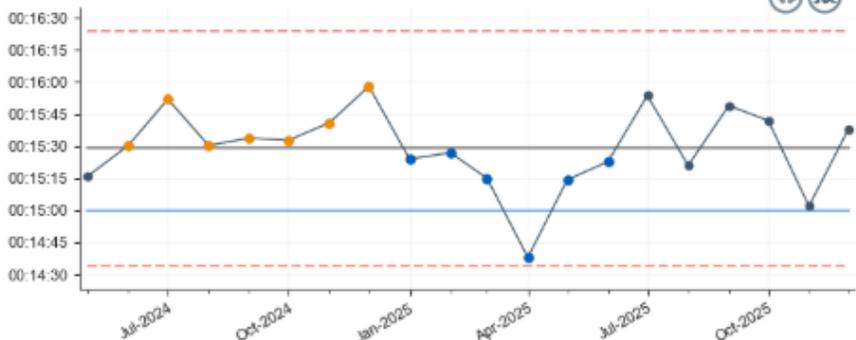
Cat 2 Mean ★



999-4

Dept: Operations 999  
Metric Type: Board  
Latest: 00:28:23  
Target: 00:27:25  
Common cause variation, no significant change. This process will not consistently hit or miss the target.

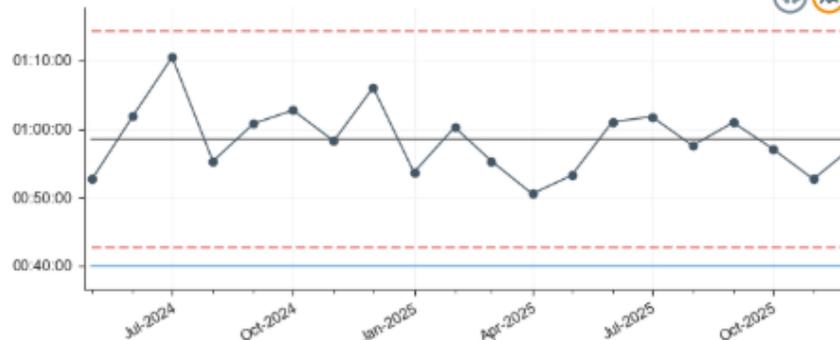
Cat 1 90th Centile



999-2

Dept: Operations 999  
Metric Type: Board  
Latest: 00:15:38  
Target: 00:15:00  
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Cat 2 90th Centile



999-4

Dept: Operations 999  
Metric Type: Board  
Latest: 00:57:23  
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 to 31<sup>st</sup> Dec C1 performance is 08:16 against an ARP target of 7 minutes

**So what?** C1 Mean performance and was 08:27 in December (17sec improvement from Nov), variation remains within normal limits.

**What next?** Continuation of the Local Community Dispatch Model (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 stands at 28.13 although in December's C2 mean 28:23 deteriorated slightly from November (t should be noted that in Dec 24 C2 mean was 32:13)

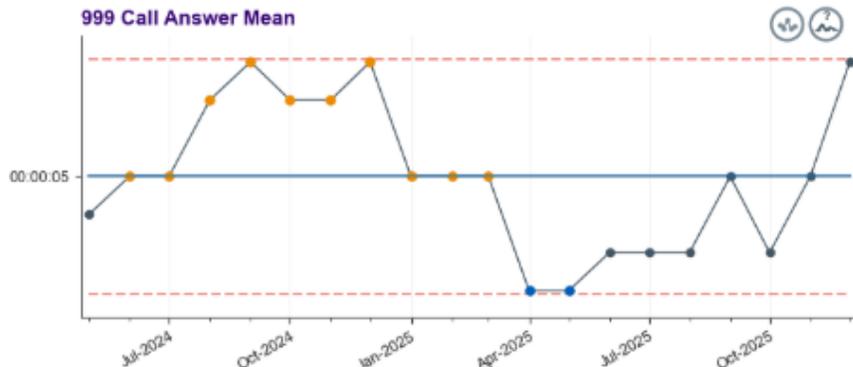
**So what?** C2 Mean performance for December was 28:23, field operational hours provided just under target (-1.4% against plan).

**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), although sickness absence rates were high through December in line with increasing incidents of colds/flu in the general population.

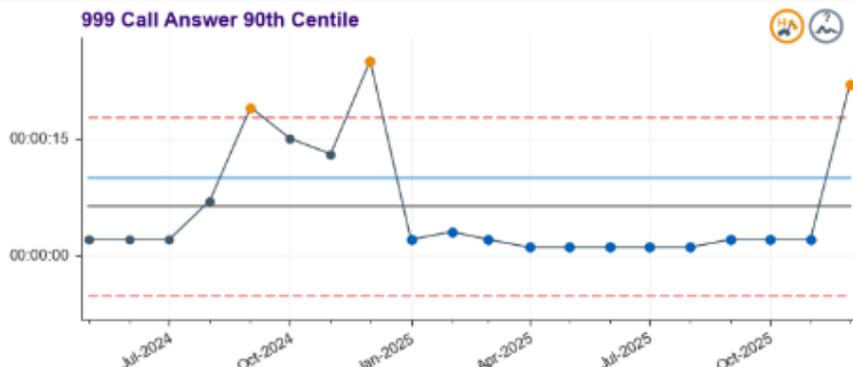


**999 Call Answer Mean**



**999-1**  
Dept: Operations 999  
Metric Type: Board  
Latest: 00:00:08  
Target: 00:00:05  
Common cause variation, no significant change. This process will not consistently hit or miss the target.

**999 Call Answer 90th Centile**



**999-1**  
Dept: Operations 999  
Metric Type: Board  
Latest: 00:00:22  
Target: 00:00:10  
Special cause of a concerning nature where the measure is significantly HIGHER. This process will not consistently hit or miss the target.

**111 Average Speed to Answer**



**111-9**  
Dept: Operations 111  
Metric Type: Board  
Latest: 00:03:18  
Target: 00:00:20  
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.

**999 Call Handling Performance**

**What?** Performance in December did not meet the AQI target of 5 secs, the first time in eleven months, with a call answer mean of 8 secs. Activity in December was again up on the previous month, averaging over 22K calls per week, peaking over 24K the first week of the month

SECamb continues to use its IRP 999 resilience call overflow model, which facilitates the movement of calls between 999 services more easily, to support SCAS and YAS, with their 999 call answering.

The current staffing position is 259.5 WTE call handlers (inc. Diamond Pods) live on the phones vs. a budget of 265 WTE, with 14.6 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 December in part because of the early onset of the cold/flu season,

**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, with fewer than planned new starters last month, 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. Increased seasonal activity in December saw the rate of abandoned calls exceed the 9% target, and the average speed to answer up to 198secs. 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.

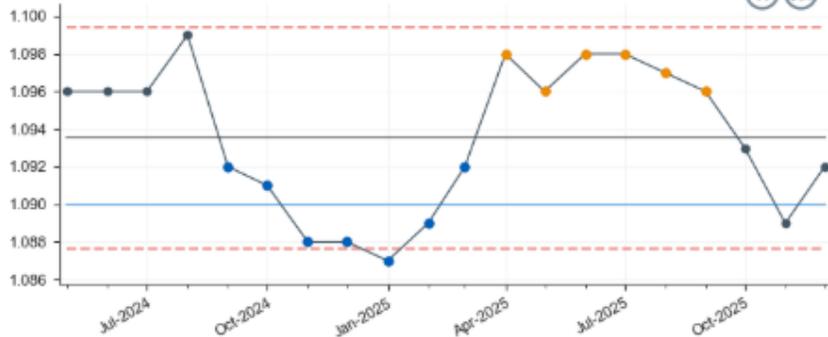
**What next?** The service is now in a period of stabilisation and is continuing to review to find efficiencies and optimise performance. Recruitment remains positive, with steady staffing levels resulting in the planned number of NHS Pathways (NHS P) courses per month being reduced in Q3.

"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 early Q4 a revised 111 workforce model aligned to the new 111 CV



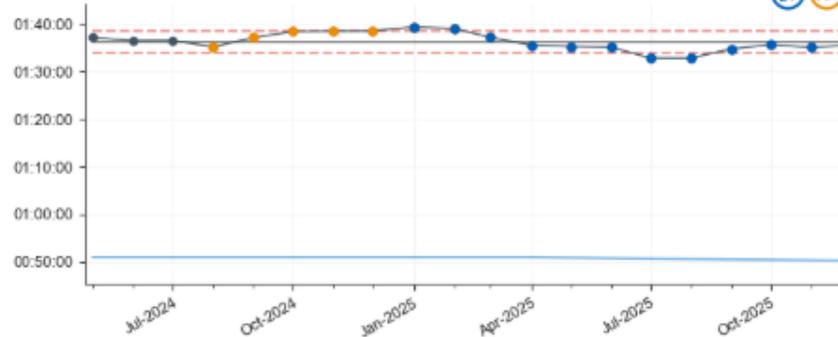
Responses Per Incident



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.

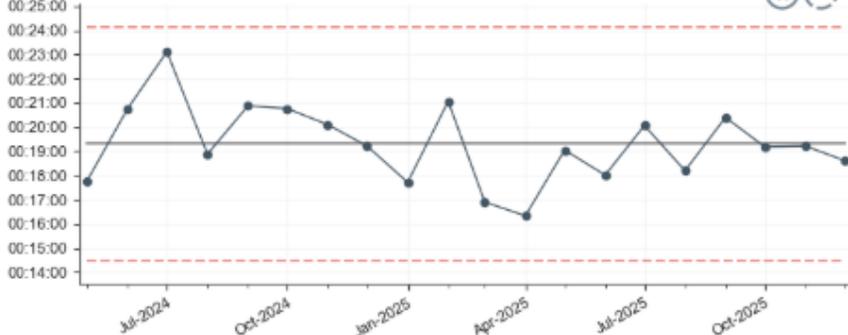
JCT Allocation to Clear All Mean



999-44

Dept: Operations 999  
Metric Type: Board  
Latest: 01:35:30  
Target: 00:50:16  
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.

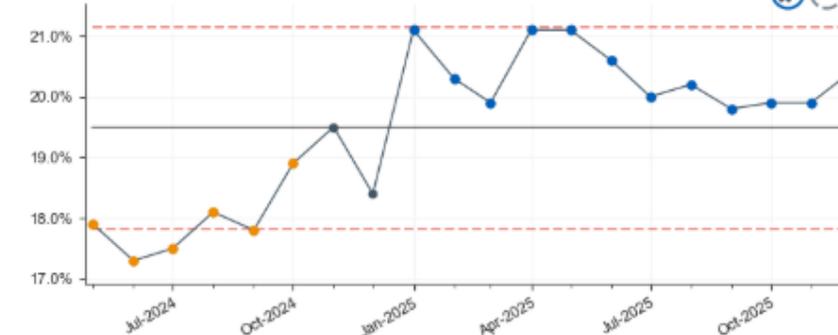
CFR Backup Time (CFR First on Scene) Mean



999-36

Dept: Operations 999  
Metric Type: Board  
Latest: 00:18:37  
---  
Common cause variation, no significant change.

% of 999 Calls Receiving Validation



999-34

Dept: Operations 999  
Metric Type: Board  
Latest: 20.4%  
---  
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 marginally above target following a consistent reduction in RPI month on month ytd.

**So what?** This means the Trust is on average dispatching marginally more resource to each incident than planned, thereby having an adverse impact on 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 subject to resource availability. The Trust is also reviewing its dispatch policy, to ascertain whether it dispatches "excessive" resource for specific 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 and ensure pro-active tactical commander focus and oversight.

% 999 Calls Receiving Validation

**What?** The % of calls validated is stable and improving, and this is important, as it's aligned to the Trust strategy of increasing virtual care and clinically assessing cases pre ambulance dispatch, where safe and appropriate to do so.  
**So what?** The more 999 cases SECamb clinically validates, the better the Hear & Treat rate and less ambulances are inappropriately dispatched, so the Trust can improve its responsiveness for CAT 1 and CAT 2 emergency ambulances.  
**What next?** The Trust has initiated a new programme, with a clear focus on virtual care. This is a timebound, critical piece of work aimed at designing what the model for delivering virtual care in SECamb will look like going forward, aligning it to the Trust's strategy.

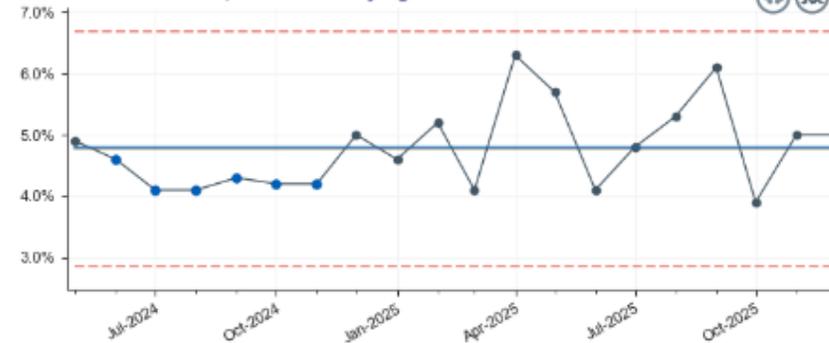


% of 999 Calls from Nursing Homes



**999-35**  
Dept: Operations 999  
Metric Type: Board  
Latest: 6.1%  
Target: 7.9%  
Common cause variation, no significant change. This process is capable and will consistently PASS the target.

End of Life Care, Palliative & Dying: % of on Scene Times Over 3 Hours



**QS-46**  
Dept: Quality & Safety  
Metric Type: Board  
Latest: 5%  
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?**

Reducing calls from Nursing Homes is part of a wider improvement project, overseen by divisional director and consultant paramedic, that also includes falls reduction and increasing use and scope of community first responders.

**What next?**

We aim to reduce unnecessary calls from care homes by 10% over this year. The data we are measuring here (percentage of calls from nursing homes) does not show the real terms decrease in inappropriate calls from the care homes/nursing homes where we are working to educate staff on the use of 999. In future iterations we will change this metric to clearly demonstrate the impact of this work on reducing unnecessary calls.

**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 in confidence to act, as well as audit evidence showing large numbers of phone calls being made by crews to advocate for patients.

**So what?**

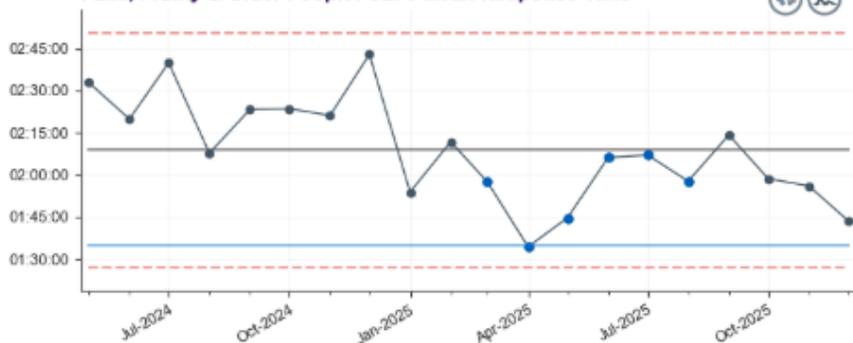
Many of the incidents with the longest on scene times could be considered non-commissioned activity. By addressing NCA, we can lower the aggregate on scene times.

**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.



Falls, Frailty & Older People: Cat 3 Mean Response Time



QS-42

Dept: Quality & Safety  
Metric Type: Board  
Latest: 01:43:38  
Target: 01:35:00  
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Falls, Frailty & Older People: H&T % - Non-Injury Falls



QS-44

Dept: Quality & Safety  
Metric Type: Board  
Latest: 11.3%  
Target: 15%  
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Falls, Frailty & Older People: Cat 4 Mean Response Time



QS-43

Dept: Quality & Safety  
Metric Type: Board  
Latest: 01:37:59  
Target: 01:39:00  
Common cause variation, no significant change. This process will not consistently hit or miss the target.

Falls, Frailty & Older People: CFR First on Scene % - Non-Injury Falls



QS-45

Dept: Quality & Safety  
Metric Type: Board  
Latest: 7.5%  
Target: 4.8%  
Common cause variation, no significant change. This process will not consistently hit or miss the target.

**What?**

There has been no deterioration in C3 & C4 mean response times for December.

**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?**

Increased % of CFRs first on-scene in December has remained stable from November. 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?**

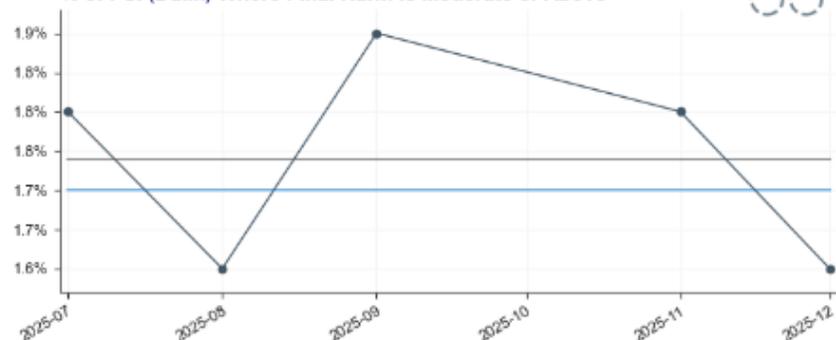
Patients who have fallen, without any injury, need early assistance off of the floor to prevent injury from long-lie. By sending CFRs we will ensure our ambulances are available for patients with emergency care needs.

**What next?**

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



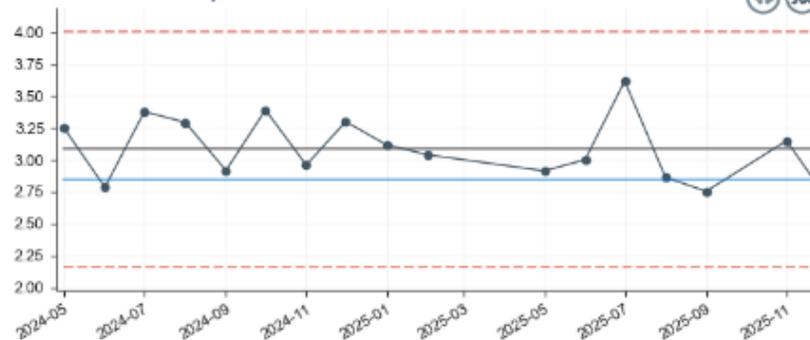
% of PSI (Datix) Where Final Harm is Moderate or Above



QS-37

Dept: Quality & Safety  
Metric Type: Board  
Latest: 1.6%  
Target: 1.7%  
Special cause or common cause cannot be given as there are an insufficient number of points.

Harm Incidents per 1000 Incidents



QS-29

Dept: Quality & Safety  
Metric Type: Board  
Latest: 2.7  
Target: 2.85  
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 – 1.6% of all incidents in December 2025. This is below the target of 1.7%. All of these are scrutinised at the Divisional Incident Review Groups.

**So What?** There are insufficient data points to establish an SPC. Number of incidents closed each month varies for several reasons – such as closure at PSEG/IRGs and operational pressures.

**What next?** Continue to monitor themes resulting in harm and articulate and implement improvement plans

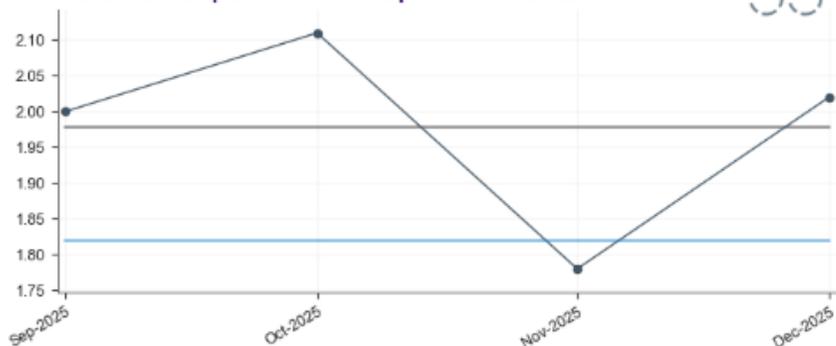
**What?** The number of incidents resulting in harm to patients per 1000 incidents across our 999 and 111 services was 2.7.

**So What?** The number of patients who came to harm for every 1000 incidents was 2.7, marginally exceeding the target of 2.8.

**What next?** The Incident Review Groups continue to monitor emerging themes, commission learning responses, implement safety changes and highlight risks to our teams. Further, we have undertaken recent analysis which identified new priority themes where there are opportunities to learn from incidents in 2025/26.



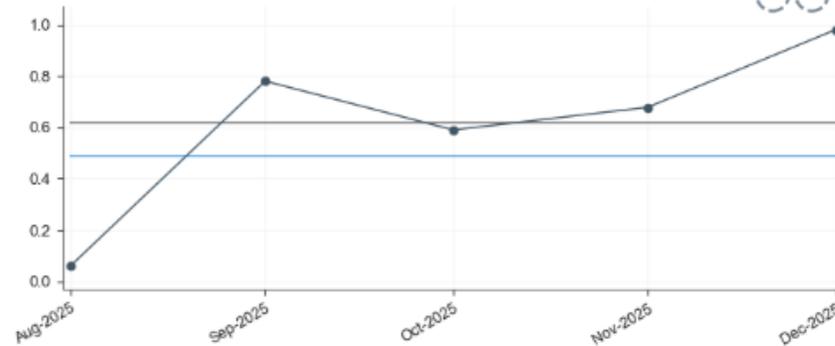
Number of Compliments Received per 1000 Incidents



QS-48

Dept: Quality & Safety  
Metric Type: Board  
Latest: 2  
Target: 1.82  
Special cause or common cause cannot be given as there are an insufficient number of points.

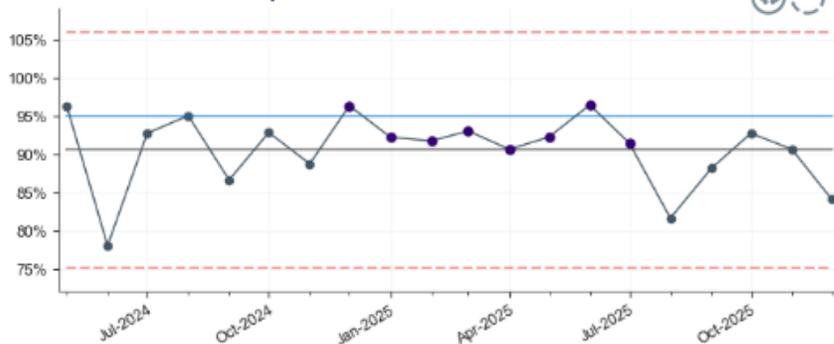
Number of Complaints per 1000 Incidents Responded to (Patients)



QS-38

Dept: Quality & Safety  
Metric Type: Board  
Latest: 1  
Target: 0.49  
Special cause or common cause cannot be given as there are an insufficient number of points.

% of Patients Who Express Satisfaction With Our Service



QS-61

Dept: Quality & Safety  
Metric Type: Board  
Latest: 84.2%  
Target: 95%  
Common cause variation, no significant change.

**What?**

1.8 compliments are received per every 1000 patient interactions the Trust has. This is nearly double the number of complaints the Trust receives per 1000 patient interactions. The percentage of patients who express satisfaction with our service continues to show normal variation.

**So what?**

This is a new metric on the IQR so will need to be monitored over time but suggests a high-quality service that supports accessibility in patient and public feedback. The data for the percentage of patients who express satisfaction with our service is from derived from Patient Experience Questionnaire (PEQ) data. This currently a small data set of approx. 100 PEQs per month so any variation should be treated with caution.

**What next?**

Continue to monitor metric on number of compliments received per 1000 incidents and progress plans to send PEQs to patients via SMS to ensure a robust data set for assessing patient satisfaction.

**What?**

In December, one complaint was received for every 1000 patient interactions. There are currently insufficient data points to determine whether this is an improving or deteriorating trend.

**So what?**

The Trust continues to receive nearly double the number of compliments compared to complaints and complaint numbers remain low.

**What next?**

The Quality & Safety Co-Ordinator has noticed an increase over the last year in re-opened complaints. A deep dive is currently taking place to understand the reasons for this and to identify improvement actions.



<b>AQI A7</b>	All incidents – the count of all incidents in the period
<b>AQI A53</b>	Incidents with transport to ED
<b>AQI A54</b>	Incidents without transport to ED
<b>AAP</b>	Associate Ambulance Practitioner
<b>A&amp;E</b>	Accident & Emergency Department
<b>AQI</b>	Ambulance Quality Indicator
<b>ARP</b>	Ambulance Response Programme
<b>AVG</b>	Average
<b>BAU</b>	Business as Usual
<b>CAD</b>	Computer Aided Despatch
<b>Cat</b>	Category (999 call acuity 1-4)
<b>CAS</b>	Clinical Assessment Service
<b>CCN</b>	CAS Clinical Navigator
<b>CD</b>	Controlled Drug
<b>CFR</b>	Community First Responder
<b>CPR</b>	Cardiopulmonary resuscitation
<b>CQC</b>	Care Quality Commission
<b>CQUIN</b>	Commissioning for Quality & Innovation
<b>Datix</b>	Our incident and risk reporting software
<b>DCA</b>	Double Crew Ambulance
<b>DBS</b>	Disclosure and Barring Service
<b>DNACPR</b>	Do Not Attempt CPR
<b>ECAL</b>	Emergency Clinical Advice Line
<b>ECSW</b>	Emergency Care Support Worker
<b>ED</b>	Emergency Department
<b>EMA</b>	Emergency Medical Advisor
<b>EMB</b>	Executive Management Board
<b>EOC</b>	Emergency Operations Centre
<b>ePCR</b>	Electronic Patient Care Record
<b>ER</b>	Employee Relations

<b>F2F</b>	Face to Face
<b>FFR</b>	Fire First Responder
<b>FMT</b>	Financial Model Template
<b>FTSU</b>	Freedom to Speak Up
<b>HA</b>	Health Advisor
<b>HCP</b>	Healthcare Professional
<b>HR</b>	Human Resources
<b>HRBP</b>	Human Resources Business Partner
<b>ICS</b>	Integrated Care System
<b>IG</b>	Information Governance
<b>Incidents</b>	See AQI A7
<b>IUC</b>	Integrated Urgent Care
<b>JCT</b>	Job Cycle Time
<b>JRC</b>	Just and Restorative Culture
<b>KMS</b>	Kent, Medway & Sussex
<b>LCL</b>	Lower Control Limited
<b>MSK</b>	Musculoskeletal conditions
<b>NEAS</b>	Northeast Ambulance Service
<b>NHSE/I</b>	NHS England / Improvement
<b>OD</b>	Organisational Development
<b>Omnicell</b>	Secure storage facility for medicines
<b>OTL</b>	Operational Team Leader
<b>OU</b>	Operating Unit
<b>OUM</b>	Operating Unit Manager
<b>PAD</b>	Public Access Defibrillator
<b>PAP</b>	Private Ambulance Provider
<b>PE</b>	Patient Experience
<b>POP</b>	Performance Optimisation Plan
<b>PPG</b>	Practice Plus Group
<b>PSC</b>	Patient Safety Caller
<b>SRV</b>	Single Response Vehicle



<b>Agenda No</b>	113/25
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<b>Name of meeting</b>	Trust Board
<b>Date</b>	5 February 2025
<b>Name of paper</b>	Quality & Patient Safety Committee Assurance Report – 8 January 2026
<b>Author</b>	Liz Sharp Independent Non-Executive Director – Committee Chair

**INTRODUCTION**

The Quality & Patient Safety 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 8 January 2026, 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**

**Provider Collaboratives updates – Pathways**  
A helpful summary of the achievements and challenges and activity across the different systems; UCR acceptance rate is in decline overall and an area for development and learning from SCAS who have more developed pathways. This aligns to the alignment of the clinical models that is ongoing and overseen by the new Integration Committee, which need to pick up how the system is driving pathways to ensure the ‘left shift’. There is a role for the new Group Model to help narrate and take a lead on how pathways need to be commissioned, to help the system thinking.

**Virtual Care**  
The committee focussed on the future strategic modelling of virtual care the outputs of the design work should emerge by the end of March 2026. This will inform how we will implement clinical assessment hubs across the region, while retaining the agility to the development of digital & AI.

The discussion explored the clinical competencies required for virtual care, and how the executive will manage these strategic changes with delivery of the here and now. Hear and treat continues to be current focus as part of the work on productivity. It remains stubbornly below target but there are some recent green shoots from the interventions.

As we develop the model there will be a need to assess the impact not just on performance but ensuring patients get the right care. Also important is the need to educate and support the public to access services in the right way, which links to the earlier discussion about pathways and the role of the wider system.

### **Models of Care**

The committee is happy with what has been achieved in the last year, and there are now deeper insights into the different models and the key drivers and interdependencies, which will support some of the decisions for phase 2.

Picking up the data in the IQR, there was a debate about on scene time for end of life care patients and the role of our system partners. Individual care plans continue to include reference to calling 999 with some homes laying off staff. The executive has good awareness of the issues and are working through how we mitigate some of the issues, for example via delayed sign posting.

In support of the executive the committee reinforced the need for the system to better understand the impact on us of the decisions on pathways. We could do even more to ensure this awareness as there is good evidence of how we are attending to some of these patient groups due to deficits in other parts of the system.

## **ASSURE**

### **Quality Account Priorities**

#### EPCR

This is a two-year priority for delivery between 2024 & 2026 with the overall aim to improve the quality of patient care record completion and support meaningful supervision to clinical colleagues. Good progress has been made with the outcomes.

#### Framework for Suicidal Patients

The key objectives of this priority is to improve the experience of patients experiencing suicidality and declining further care; improve the support and guidance available to staff making complex decisions on scene; and establish a shared, regionally consistent approach with partners.

Significant progress has been made with intensive work to improve the response to patients who are experiencing suicidality, especially in Surrey and Sussex, with similar work to be replicated in Kent before the end of the financial year. Data shows that ambulance crews are utilising locality single point of access mental health support services more and that the trend is improving.

## **ADVISE**

### **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 quarter's triangulated patient safety insights demonstrate meaningful progress in identifying, understanding, and addressing recurrent risks across our service. The themes highlighted the dead and dying pathway, HCP requests, medicines safety, and trauma which continues to require sustained focus, strengthened system learning, and consistent collaboration with partners.

There are positive developments in patient involvement, learning response closure, and safety improvement planning reflect a maturing safety culture, supported by clearer processes and growing engagement. Continued attention to embedding learning, improving compliance, and closing identified gaps will be essential to ensuring safer, more reliable care for all patients we serve.

On medicines concern was expressed about some of the incidents, noting that no harm has been caused. The committee asked for more assurance in the next report on how the executive ensure we are following up and monitoring.

### **Risk Report & IQR**

The risk report helps to ensure the committee has visibility of key risks, which also informs the cycle of business. While the report continues to improve in assisting the committee it has asked for more analysis and impact of controls. Especially the highest rated risks and those that are more long standing.

The review of the quality section of the IQR noted the position with hear and treat, which is picked up in the separate Virtual Care agenda item, and the time on scene data for end of life care, also picked up separately under Models of Care.

### **Health Inequalities Quality Account Objectives for 2025-27**

As a reminder there are two priorities, Maternity and Severe Mental Illness, as listed in the BAF. The discussion on these acknowledged the need for a wider understanding of health inequalities, and so it was good to learn about the maturity matrix tool developed to raise awareness and identify priorities for coming years. This includes:

- Planning a pan SECAmb mapping exercise – Health inequalities. Every 6 months raised awareness and inform local interventions. Then central analysis to identify trust wide priorities.
- Roll out the NHS ethnicity infographic/document to enable greater understanding of the rationale for capturing ethnicity data
- Consultants to include ethnicity findings in all areas of training including Key Skills 2026.
- Continue to look at all available interpreter services and their suitability to the ambulance service, along with EOC colleagues.

Given the breadth of health inequalities the committee explored if it would be best to focus on the areas more within the purview of the ambulance sector / core business. The executive will consider this when setting the objectives for the coming year.

### **Quality Account, PSIRP & QI Priorities for 2026-27**

The committee reviewed the proposed priorities for each of these three areas, in order to ensure they are considered in the round this year compared with previous years. The final priorities will come back in March.

#### Draft Quality Account Priorities (with primary domain)

##### *Patient Safety*

- Resilient Organisation
- Falls – Level 1 Response

*Clinical Effectiveness*

- Enhancing Virtual Consultations

*Patient Experience*

- Patient Safety Partners

PSIRF Priorities

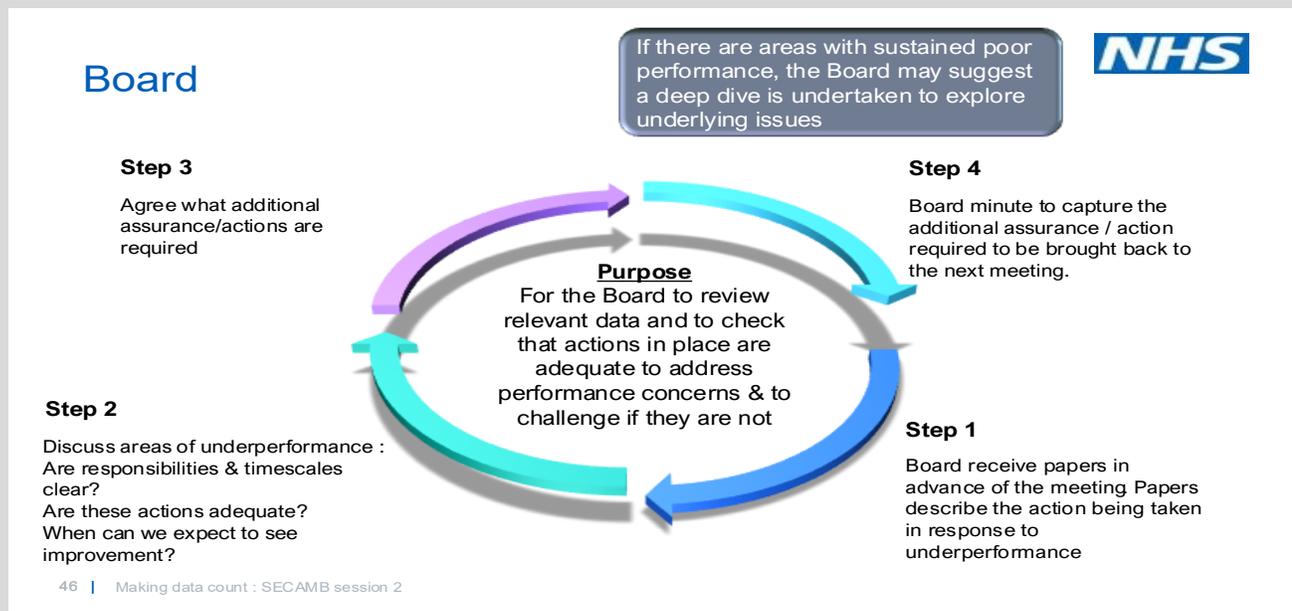
- Trauma
- Mental Health Emergencies

Quality Improvement Priority

- Review of Dispatch Operational Processes
- Falls – Level 1 Response (also a Quality Account priority)

**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





Agenda No	114-25
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Name of meeting	Trust Board
Date	5 February 2026
Name of paper	Chief Paramedic Officer's Report
Executive sponsor	Jaqualine Lindridge, Chief Paramedic Officer
Author name and role	Jaqualine Lindridge, Chief Paramedic Officer

This report provides SECAmb's Trust Board with a consolidated view of key issues, achievements, and workforce insights raised to the Chief Paramedic Officer across quarters two and three of 2025/26.

**Celebrating Professional Milestones**

The report opens by recognising the transition of the College of Paramedics to **Royal College** status on 1 January 2026—a significant moment for the paramedic profession and an important backdrop to developments within SECAmb's workforce.

**Clinical Practice**

Clinicians continue to express a strong commitment to delivering safe and effective care, illustrated by examples such as a recent critical care paramedic intervention in a paediatric cardiac arrest, where advanced management enabled safe stabilisation and transfer. The pilot enabling **Advanced Paramedic Practitioners with non-medical prescribing qualifications** to prescribe from the existing PGD formulary is showing early impact, with more than 100 prescriptions issued to date—reducing delays, enhancing holistic clinical decision-making, and improving patient experience. Further phases will assess training needs, governance, finances, and future adoption of electronic prescribing.

**Leadership & Management**

Engagement with Newly Qualified Paramedics on the Transition to Practice (TtP) programme continues to highlight the clinical enthusiasm and innovative ideas of early-career staff. Recent suggestions—ranging from improved ECG skin preparation to enhanced digital tools—are being taken forward via CPD snapshots, procurement pathways, or working groups.

**Education**

Efforts to strengthen the student-to-paramedic transition have shown clear benefits, particularly the part-time Emergency Care Support Worker scheme that supports students' development of confidence and core skills. Established clinicians have also reported significant improvements in the refreshed **key skills training** programme, following a review driven by learner feedback. We have additionally prioritised development for the **virtual care workforce**, launching a multi-phase training programme and a new learning hub, with bespoke virtual care key-skills training commencing in April 2026.

**Research & Development**



SECAmb staff have contributed extensively to national clinical guidance, including new JRCALC draft guidance and consensus statements. In Q2 and Q3, eight peer-reviewed research articles and several abstracts/ commentaries were published. Research activity includes innovations to improve medicines pouch design, informed by frontline clinician feedback collected through a novel app funded by the Trust's Innovators' Den initiative.

**Conclusion**

Across all four pillars of practice, staff continue to shape service development through ideas, feedback, innovation, and research. The report reflects a workforce deeply committed to patient safety, clinical effectiveness, and continuous improvement. Their contributions are helping SECAmb evolve its practice, strengthen clinical services, and enhance patient experience.

Recommendations, decisions or actions sought	That the Trust Board of Directors discuss and note the Chief Paramedic Officer's report for Q2 and Q3 2025/26.
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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).	Not at this stage
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## Clinical Practice

One of the most frequent subjects of discussion with clinicians across the Trust is the desire to provide the most effective and safe care that we can for our service users, and a desire to ensure that our care services develop to keep pace with patients' needs across the lifespan.

I'd like to highlight how our critical care paramedic scope of practice is responding to this with a notable recent case in which our critical care paramedics (CCPs) assisted in our response to a child in cardiac arrest. Our CCPs were able to provide specialist interventions, including advanced airway management, sedation and other post-resuscitative care ensuring a high-quality resuscitation and importantly stabilisation facilitating a successful transfer to hospital with the patient in a sustained stable condition.

In my last report, I highlighted feedback from our Advanced Paramedic Practitioners (APPs) about access to prescribing and we are now undertaking a pilot!

Several of our Advanced Paramedic Practitioners (Urgent & Emergency Care) have existing non-medical prescribing (NMP) qualifications that they use as part of a portfolio career. The pilot has been launched to explore the utility of NMP in the Trust. The scope of the pilot focusses on the medicines currently available in the Patient Group Direction (PGD) formulary for APPs, using their prescribing skills. Due to their nature, PGDs are necessarily limited in scope which can limit their use in practice. A prescriber can use their enhanced skill and knowledge to make more holistic decisions about treatment, and this means less patients experience delays in their care associated with the need for onward referral.

*"Prescribing by APPs is a significant step by the Trust - the data collected so far shows a very positive impact with more patients being treated first time."*

Consultant Paramedic

## Trust trials prescribing powers for Advanced Paramedics

A new three-month pilot launched on 1 November 2025 aims to reshape how patients are treated after a 999 call by exploring a prescribing model for Advanced Paramedic Practitioners (APPs).

To date, over 100 prescriptions have been issued where previously the patient would not have been able to commence indicated therapy at the time of the encounter.

The next phase of the pilot is to examine the feasibility of training further SECamb APPs and CCPs. This will test the

financial, educational and supervisory arrangements, as well as leadership, and governance. Following this, further phases will explore developing the formulary and testing electronic prescribing which will mean that patients can get their prescriptions dispensed at a pharmacy, potentially allowing us to reduce our medicines for supply stock holding.

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## Leadership and management

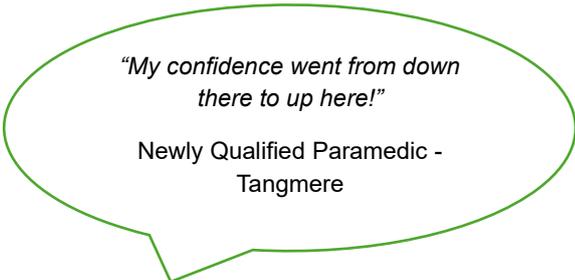
One of the highlights of my working week is when I get to meet new clinicians joining SECamb on their Transition to Practice (TtP) course. I recently heard from 26 Newly Qualified Paramedics at our training facility in Haywards Heath who are beginning their clinical careers with us. They presented several ideas to improve care for patients, including using better skin preparation to improve acquisition and interpretation of 12 lead ECGs, use of digital technology to help paramedic students to better prepare for arriving at the scene at emergency calls and to improve patient experience and infection control measures for vomiting patients. I was struck how grounded in patient-safety, clinical effectiveness and good experience these ideas were. One of the ideas will be made into a CPD snapshot to enable our wider clinical workforce to benefit from their learning and other ideas are being progressed into the Equipment Working Group for consideration.

A previous TtP group highlighted the lack of equity in the availability of gender specific toileting products for patient use, and this improvement is now being progressed via our testing and procurement channels.

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## Education

Our newly qualified paramedics undertake an important journey as they transition from students to qualified practitioners. In response to feedback on opportunities to improve this journey the Trust have supported paramedic students at our partner universities with the opportunity to undertake part-time work as an Emergency Care Support Worker during their studies.



*"My confidence went from down there to up here!"*

Newly Qualified Paramedic -  
Tangmere

As these students transition into newly qualified paramedics, we are pleased to note their feedback that this approach has had a positive impact on their development, and in particular aided their development of confidence in practice by enabling them to grow holistically as professionals with greater time in the ambulance clinical setting learning and practicing the basics of practice in the ambulance setting and environment.

*"Night and day – I actually look forward to it now!"*

Paramedic - Gatwick

Turning to our more established clinicians, we have noted feedback in relation to 'key skills' training, the theory and practical education programme which provides annual updates for all clinicians working in field operations, which suggested that improvement was needed. In response to this, the programme has been reviewed and the training needs analysis which

underpins this developed to incorporate greater learner feedback and our clinicians across the Trust are reporting that the key skills programme is much improved and providing training which more tailored to their needs. One participant described the change as 'night and day'. The education team continue to work on improving the key skills offer, and looking ahead to next year's programme will structure the programme with an increase in skills development.



We have heard clear feedback from our teams that a greater emphasis on development for virtual care is needed. In response to this, we are developing a multi-phase programme of work to improve the educational offer for clinicians working in the virtual care setting. This programme covers core system training, continuing professional development and holistic virtual consultation education. A new key skills programme bespoke for virtual care is being finalised, following a workshop in January to develop the content. Delivery of this will commence from April 2026. Earlier this year a new learning hub was launched via the Trust intranet, The Zone. This hub serves as a front door for virtual care learning and development, and provides access to a range of resources, including bite-sized learning, CPD and additional development opportunities.

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## Research and development

SECamb clinicians are proactive in contributing to service development and clinical practice, including the development of national clinical guidelines and consensus statements. Recently, our clinicians have contributed to the development of new draft Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidance on Falls and a consensus statement on critically ill or injured pregnant patients with the Faculty of Pre-Hospital Care.

Eight full research articles authored by staff in quarters two and three this year have been published in the peer reviewed academic press. Also, one full research article has been published from a study where SECamb was a study site. In addition, one staff research abstract, and two staff research comment articles have been published.

Access to medicines in clinical practice is an issue which has been raised by staff, with concerns arising from missing or damaged stock and the potential impact on patients. One of these papers, a research abstract, focussed on improving the way that medicines are packed into portable pouches for use by clinicians in field operations. The paper, co-authored by our Chief Pharmacist, reported qualitative feedback from frontline clinicians obtained via a novel application, which was developed with funding from our Innovators' Den initiative. The results of this study are enabling clinicians as users of the medicines pouches to influence the design of our equipment based on their experience of using medicines in our workplace as part of the pouch review programme.

Abstract citation ID: riaf093.102

(ID: 282) Qualitative review of medication pouches carried on ambulances within the South East using an open card sort methodology

Sarah Cook<sup>1</sup>, Shani Corb<sup>2</sup>,  
Connor Thompson-Poole<sup>1</sup>

<sup>1</sup>University of Brighton, Brighton, UK, <sup>2</sup>South East Coast Ambulance Service  
NHS Foundation Trust, Crawley, UK

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## Conclusion

This report highlights celebrations, improvement ideas and concerns through the lens of our paramedics and clinicians across all four of the pillars of practice which structure our work. The rich feedback received from our staff is used to influence and effect improvements in how we structure our practice and develop our clinical services at SECamb.

To conclude, I would like to thank all our staff for their hard work and contributions in ensuring we deliver high quality care to our patients.

Our people enjoy working at SECAmb



# Board Assurance Framework Our People Enjoy Working at SECAmb

# Contents:



## + Our People Enjoy Working at SECAMB

- BAF Objectives in line with Strategy Plan
- Progress Highlight Reports on Key Programmes
- BAF Risks

# Our people enjoy working at SECamb

1	Tier 1
2	Tier 2
	QI
	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

## BAF Risks

Initiative	Sub-Initiative (if required)	Current RAG	Previous RAG	Executive Lead	EMB / SMG	PMO	Oversight Committee	Date last reviewed @ Committee	Risk Detail	Risk Score	Target Score	Owner
Full implementation of Wellbeing Strategy		Green	Green	Chief Nursing Officer	EMB	No	People Committee	Nov 25	<b>Culture and Staff welfare:</b> There is a risk that we will not achieve the culture and staff welfare improvements identified in our strategy.	12 	08	CPeO
Implement Shadow Board		Green	Green	Director of Communications/ Chief People Officer	EMB	No	People Committee	Complete	<b>People Function:</b> There is a risk that without an effective People function, we impact our ability to deliver parts of our Strategy.	12 	08	CPeO
Launch new Values & Behaviours Framework		Green	Green	Chief People Officer	EMB	No	People Committee	Complete	<b>Workforce capacity &amp; capability:</b> 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
Refresh of Professional Standards Function		Green	Green	Chief Paramedic Officer	SMG	No	Quality Committee	Sept 25		12 	08	CPeO
Development of Integrated Education Strategy		Blue	Green	Chief Paramedic Officer	EMB	No	People/ Quality Committee	Complete	<b>Organisational Change:</b> 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	Yellow	Yellow	Chief People Officer	People Trust Board	Nov 2025 Dec 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 November, and by the Board in December. There is good assurance by the actions in place and progress made. A further board development session is scheduled for March 2026.
Meet our Sexual Safety Charter commitments	Green	Green	Chief Nursing Officer	People	Jan 2026	Good progress being made with agreed actions. The committee is aware that this is a multi-year and complex cultural issue to address that will take continued effort.
Education	Yellow	Yellow	Chief Paramedic Officer	People	Jan 2026	As reported to the Board in June, the committee was assured with the level of grip demonstrated by the executive, following the NHSE Education Quality Review. The committee assessed the evidence in place to demonstrate compliance against the recommendations and was assured prior to submission in Q3. Further assurance was sought by NHSE and the committee is overseeing this with an update scheduled next in March 2026.
Statutory & Mandatory Training & Appraisals	Yellow	Yellow	Chief Paramedic Officer	People	Jan 2026	Good progress with stat and man (achieving the 85% target) but lower than target on appraisals – the committee has sought further assurance on this.

People Services Improvement Programme (PSIP) Executive Summary				Exec. Sponsor:		Sarah Wainwright	
				PM:		Roxy Oldershaw	
				Last updated:		26 January 2026	
Programme Outcomes				Previous RAG	Current RAG	Impact on outcomes & Delivery Confidence	
<ul style="list-style-type: none"> <li><b>Enhanced service responsiveness:</b> People Services is a trusted, agile partner that enables effective service delivery across all divisions</li> <li><b>Operational efficiency:</b> Streamlined processes that maximise productivity/minimise administration</li> <li><b>Strategic People Services partnership:</b> Consistent, high-quality advice and collaboration</li> <li><b>Professional development and capability:</b> Highly skilled PS team driving continuous improvement</li> </ul>						<b>Impact on Outcomes:</b> Status remains stable, supported by strengthened Sexual Safety governance and streamlined policy and ER processes. BI dashboard implementation and embedding expected over next quarter.	
						<b>Delivery Confidence:</b> People Services activity continues to underpin safe delivery of organisational change, with Senior People Partners, Employee Relations, Org Development, Job Evaluations and Recruitment capacity aligned to the phased corporate restructure programme approach.	
Assurance							
<ul style="list-style-type: none"> <li>Programme continues to deliver against its strategic outcomes, with progress visible across case responsiveness, data quality and policy development.</li> <li>Dependencies with the Corporate Restructure Programme (CRP) aligned, with People Services capacity sequenced to support safe and timely organisational change.</li> </ul>							
Alert			Advise			Assure	
<ul style="list-style-type: none"> <li>Approval timelines for key policies remain a dependency, with the Wellbeing &amp; Attendance policy requiring rescheduling.</li> <li>Capacity within People Services continues to require close oversight to ensure critical organisational change activity is prioritised appropriately.</li> </ul>			<ul style="list-style-type: none"> <li>Further sequencing of People Services Phase 2 restructure will align with the wider Corporate Restructure Programme</li> <li>Decisions regarding ESR data alignment will be needed to strengthen reporting accuracy and ensure dashboards support the divisional model.</li> </ul>			<ul style="list-style-type: none"> <li>Divisional dashboards launching this quarter, enabling more consistent workforce oversight and strengthening local accountability</li> <li>Recruitment Hub development is advancing, supporting improved strategic workforce collaboration across the Trust.</li> </ul>	
Milestones for next reporting period			Impact on delivery			Mitigations	
Jan 2026 – Divisional dashboards launched			<ul style="list-style-type: none"> <li>Provide greater visibility and drive earlier intervention on case trends.</li> </ul>			<ul style="list-style-type: none"> <li>Teams are integrating dashboards into standard reviews to support consistent use</li> </ul>	
Mar 2026 – Priority policies published			<ul style="list-style-type: none"> <li>Strengthen decision-making and support consistent practice across divisions.</li> </ul>			<ul style="list-style-type: none"> <li>Policy pipeline monitored to ensure milestones remain on track</li> </ul>	
Mar 2026 – ER Training Package confirmed			<ul style="list-style-type: none"> <li>Enhance manager capability, supporting faster and more consistent case handling</li> </ul>			<ul style="list-style-type: none"> <li>Training plan designed to ensure alignment and manageable capacity</li> </ul>	
Status:	Under control					BAF Risks	
Ask of this forum:	259					<ul style="list-style-type: none"> <li>BAF Risk 539 - Culture and Staff Welfare</li> <li>BAF Risk 603 - People Function</li> </ul>	

Corporate Restructure Programme (CRP) Executive Summary				Exec. Sponsor:		Sarah Wainwright		
				PM:		Roxy Oldershaw		
				Last updated:		26 January 2026		
Programme Outcomes				Previous RAG	Current RAG	Impact on outcomes & Delivery Confidence		
<ul style="list-style-type: none"> <li><b>Strategic organisational alignment:</b> functions and teams configured to meet future needs and priorities</li> <li><b>Workforce capability optimisation:</b> clear roles following robust job evaluation, aligned with divisional model</li> <li><b>Change delivered with assurance and wellbeing:</b> restructures completed within budget and governance standards, with consistent engagement and wellbeing support</li> </ul>						<b>Impact on Outcomes</b> <ul style="list-style-type: none"> <li>Overall impact remains stable, with phased approach reducing organisational and capacity-related risks. Job evaluation approach agreed.</li> </ul>		
						<b>Delivery Confidence</b> <ul style="list-style-type: none"> <li>Delivery confidence is high, supported by clear governance and aligned timelines. Collaborative working with SPPs, TUs, Directorate Leads, and the Clinical PM ensures consultation readiness, sequencing, and interdependencies are well managed.</li> </ul>		
Assurance								
<ul style="list-style-type: none"> <li>An organisational change matrix exercise has informed a phased approach that balances organisational complexity, TU concerns, staff impact, PS capacity and financial constraints, including the 5% CIP integration into directorate plans. Governance is robust, SMG and EMB alignment and delivery structures in place to enable a streamlined and controlled implementation.</li> </ul>								
Alert		Advise				Assure		
<ul style="list-style-type: none"> <li><b>Programme sequencing</b> is being adjusted in response to key dependencies, with timings overseen through agreed governance processes.</li> <li><b>People Services</b> senior leadership changes may influence ability to support pace of change as planned</li> </ul>		<ul style="list-style-type: none"> <li><b>Ops Support consultation</b> closure marks a key Phase 2 milestone, with new structure on target to achieve 5% CIP</li> <li><b>External JE support</b> will be required, given the volume of new and updated role descriptions, particularly within Digital, to keep timelines achievable.</li> </ul>				<ul style="list-style-type: none"> <li><b>Governance arrangements</b> are robust, with strengthened oversight through SMG/EMB and structured sequencing informed by the organisational change matrix.</li> <li><b>Transparency and engagement</b> have improved, with regular TU meetings and directorate-level alignment reducing the risk of consultation delays.</li> </ul>		
Milestones for next reporting period		Impact on delivery				Mitigations		
28 Jan 26 – Org Change proposal approved		<ul style="list-style-type: none"> <li>Enables progression of Phase 3 and sets the baseline for sequencing Phases 4 and 5 activity</li> </ul>				<ul style="list-style-type: none"> <li>Clear governance route in place; sequencing aligned to capacity and risk</li> </ul>		
Feb 2026 – Phase 3 Business Case approved		<ul style="list-style-type: none"> <li>Confirms scope, resource demand and timelines and informs JE and recruitment planning</li> </ul>				<ul style="list-style-type: none"> <li>Early planning with JE and wider PS teams using org change matrix</li> </ul>		
Mar 2026 – Digital job description evaluations completed		<ul style="list-style-type: none"> <li>Critical dependency for starting Digital consultation; delays may shift Phase 4 timeline</li> </ul>				<ul style="list-style-type: none"> <li>External JE support secured; regular reviews with Digital Working Group to manage risks</li> </ul>		
Status:	Under control				260		BAF Risks	
Ask of this forum:	Note progress						<ul style="list-style-type: none"> <li>BAF Risk 649 - Organisational Change</li> </ul>	

<b>Clinical Operating Model Programme - Executive Summary</b>	<b>Exec. Sponsor:</b>	Jennifer Allan
	<b>PM:</b>	Victoria Cole
	<b>Last updated:</b>	23/01/26

<b>Programme Outcomes</b>	<b>Previous RAG</b>	<b>Current RAG</b>	<b>Impact on outcomes &amp; Delivery Confidence</b>
<ul style="list-style-type: none"> <li><b>Outcome 1</b> - Enhanced clinical governance and accountability through established Clinical Divisions structure</li> <li><b>Outcome 2</b> - Optimised clinical service delivery through implemented Clinical Operating Model design</li> <li><b>Outcome 3</b> - Strengthened divisional leadership capability and team effectiveness through targeted OD interventions</li> <li><b>Outcome 4</b> - Improved pathways and service delivery integration across each ICS</li> </ul>		→	<ul style="list-style-type: none"> <li>The programme remains aligned to the agreed Clinical Operating Model outcomes.</li> <li>Delivery confidence is amber as several initiatives remain in pre-consultation, consultation or early implementation phases, meaning full outcome impact cannot yet be assured.</li> <li>Governance arrangements remain in place and delivery is aligned to agreed KPIs, with benefits expected to be realised progressively as structures embed.</li> <li>A number of outcomes and benefits are expected to be delivered in the next financial year as part of the planned phased approach, with delivery sequencing extending beyond 2025/26 as originally anticipated.</li> </ul>

### Assurance

<b>Alert</b>	<b>Advise</b>	<b>Assure</b>
<ul style="list-style-type: none"> <li>There are no matters requiring escalation to the Board at this stage.</li> <li>Delivery confidence remains Amber, reflecting the various stages of implementation across a number of initiatives and the scale of organisational change underway</li> </ul>	<ul style="list-style-type: none"> <li>The programme continues to progress across its core workstreams, including divisional governance, clinical leadership structures and roles, scheduling and dispatch.</li> <li>Formal consultation activity is underway or planned in line with agreed organisational change processes.</li> <li>Dependencies with wider system programmes, including the SCAS Collaboration Model and Virtual Care Programme, are being actively managed, with IC redesign paused to avoid premature decision-making and mitigate the risk of misalignment.</li> <li>Costing and affordability work is underway for elements of the Clinical Operating Model implementation. This is being progressed in alignment with Trust financial planning assumptions.</li> </ul>	<ul style="list-style-type: none"> <li>The programme continues to operate within established governance and oversight arrangements, with regular review through the Steering Group and delivery forums.</li> <li>Risks and interdependencies are being actively managed through the PMO, with strengthened alignment across related programmes to support mitigation of complexity and sequencing risks.</li> <li>A refreshed communications approach has been implemented to support organisational change activity, including clearer, coordinated and more regular Organisation Operating Model programme messaging.</li> <li>Benefits are expected to be realised progressively as consultation concludes and new structures embed in line with the planned phased approach.</li> </ul>

**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.

<b>KPI</b>	<b>IQR or local</b>	<b>Latest (period)</b>	<b>Target</b>	<b>Trend</b>	<b>So what?</b>
% of operational and clinical roles defined in new structure	Local	36%	100%	↑	36% of roles now fully defined. Remainder in progress and on track to be fully defined by end Q1 26/27
% of positive feedback from staff on engagement process	Local	N/A	>75% +ve	N/A	Measure in development. Reporting approach by end Q4.
Improved collaboration (internal and external)	Local	N/A	>75% +ve	N/A	261 Being explored via external review. Findings expected end Q4

<b>Clinical Operating Model Programme – Risks &amp; Dependencies</b>	<b>Exec. Sponsor:</b>	Jennifer Allan
	<b>PM:</b>	Victoria Cole
	<b>Last updated:</b>	23/01/26

**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	→	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/January, which will increase wellbeing concerns/sickness or grievances and potentially weaken operational delivery.	699	8	6	↓	Consultation timelines adjusted to reflect winter pressures and reduced capacity. Ongoing engagement with operational leads to support planning, wellbeing and readiness ahead of consultation activity.
There is a risk that managing the complexity of the governance and stakeholders successfully makes maintaining timely decision-making and effective escalation of emerging issues difficult, leading to possible delays in delivery, misalignment across interdependent workstreams and the need for rework if risks or dependencies are not collectively addressed early.	730	12	6	→	Strengthened regular alignment with related programmes (Group Model, Virtual Care and Corporate Restructure) through additional touchpoints. IC redesign activity has been deliberately paused to avoid progressing decisions ahead of clarity on system-level models, reducing the risk of misalignment and rework. Continued PMO oversight at PMO fortnightly meetings with dependencies actively monitored.

Dependencies (material only)	Owner	Due	Status	Risk if delayed	Mitigation
OD Intervention programme	Dawn Chilcott	31 Jan 2026	OD 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.	<ul style="list-style-type: none"> <li>Continue joint planning with HR/OD to confirm scope and delivery timelines</li> <li>Align leadership development activity with SRO and divisional governance work</li> <li>Ensure OD inputs are incorporated into Q4/Q1 planning to maintain progress against Outcome 3</li> </ul>
SCAS Collaboration	Jen Allan	Ongoing	IC Operating Model redesign has been paused. The dependency will be reviewed in Q1, with a decision on whether to progress subject to the development and direction of the SCAS Collaboration Model.	Ongoing uncertainty regarding future SCAS collaboration arrangements may limit the ability to finalise IC clinical and operational structures and align fully with the divisional model.	<ul style="list-style-type: none"> <li>Maintain pause on IC redesign activity pending clarity on the SCAS Collaboration Model.</li> <li>PMO to monitor progress of SCAS model development and bring recommendations forward in Q1 to inform decision-making.</li> </ul>
Virtual Care Model Programme	Jen Allan	Ongoing	IC Operating Model redesign has been paused. The dependency will be reviewed in Q1, with a decision on whether to progress subject to the development and direction of the Virtual Care Model programme.	If Virtual Care model direction is not confirmed, IC operating model design may remain constrained, delaying finalisation of clinical and operational structures and increasing the risk of rework if progressed prematurely.	<ul style="list-style-type: none"> <li>Continue to pause IC redesign activity pending confirmation of the Virtual Care Model.</li> <li>PMO to maintain close alignment with the Virtual Care Programme and bring forward recommendations in Q1 to support informed decision-making on progression</li> </ul>

<b>EMB outcome, inc. decision requests (post-meeting):</b>	EMB is content with the progress being made. Much has been achieved in the past year. An external review of the divisional model will conclude in Q4 to inform the ongoing implementation and governance framework.	<b>BAF Risk</b>
<b>Relevant Board Committee:</b>	At the most recent meeting the focus was on the BAF risk (impact and management of	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.

# 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. Priority policies scheduled to go-live in Q4. Strengthened Sexual Safety governance, with revised reporting pathways, triage improvements and aligned processes following NHSE charter requirements

**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. 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.

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

<b>Mitigating Actions planned/ underway</b>	<b>Executive Lead</b>	<b>Due Date</b>	<b>Progress</b>
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 Nursing Officer	Q2 26/27 <sub>263</sub>	The proposed Wellbeing Strategy is progressing through the Trust's governance processes. Implementation of the new strategy is aligned with the timelines of all transformation and restructure activity coordinated by People's services

# 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 26/27; ER Casework backlog still high.

## Controls, assurance and gaps

**Controls:** People Services Improvement Programme (Tier 1) continues to provide structured oversight, with clear sequencing of priorities supporting organisational change delivery. New People Services operating model in place and staff appointed, structure designed to support both centralised and decentralised working. Phase 2 restructure focus on optimising Recruitment and the Service Centre, OD and EDI scheduled for autumn 2026. CIPD and Professional mapping underway for managers and the ER teams, with other teams to follow. Opportunities for collaboration with SCAS underway. People Services priorities continue to be sequenced to support the Corporate Restructure Programme, protecting capacity and enabling safe delivery of organisational change.

**Gaps in control:** People Services capacity remains stretched during ongoing organisational change and needs continued prioritisation. Full embedding of the new People Services operating model will take further time as structures and responsibilities mature.

**Positive sources of assurance:** Tier 1 programme progress continues to be tracked across various governance forums including People & Culture Forum, People Committee, EMB and Trust Board through RAG. Whole Trust restructure planned so that corporate departments are managed concurrently. Improved policy framework, with key policy approved and go-live scheduled for Q4, strengthening consistency in people management. External JE support in place to avoid bottlenecks

**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. Although ER processes have considerably improved over the last year, the ER case numbers are still high.

**Gaps in assurance:** Leadership transitions within the People Services function continue to impact stability; interim arrangements are in place, but full assurance will only be realised once the new structure is fully embedded

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

<b>Mitigating Actions planned/ underway</b>	<b>Executive Lead</b>	<b>Due Date</b>	<b>Progress</b>
Delivery of People Services Improvement Programme	Chief People Officer	Q4 2025/26	Programme delivery on track,
NHS Fair Recruitment framework implemented	Chief People Officer	Q3 2025/26	Progress made against the NHS Fair Recruitment Framework, with core elements already embedded (values-based recruitment, inclusive language in adverts, reasonable adjustments, structured assessment and diverse panels). Remaining components are being incorporated into the Recruitment Strategy due for launch in April 2026

# 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.

## 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

**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**

## 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 completed in December 2025: Further workshops scheduled across Jan/Feb to design future state, including skills and competency mapping to define plan to address gaps 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

# 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 multiple 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. 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. A Trust-wide organisational change prioritisation matrix is now in place, enabling safe sequencing of restructures based on risk, complexity, staff impact and People Services capacity

**Gaps in control:** Divisional structures still embedding which delays full integration. OD plan and hybrid working practices not yet fully implemented. Staggered approach to divisional restructures is delaying full implementation of change. People Services capacity remains constrained during high-volume change and requires ongoing prioritisation.

**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. Enhanced stakeholder engagement, including monthly TU meetings and directorate-level alignment, is now embedded to increase transparency and reduce consultation risk. External CSU job evaluation support secured to alleviate internal capacity constraints

**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. People Services capacity remains stretched during peak delivery and requires ongoing prioritisation.

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

<b>Mitigating Actions planned/ underway</b>	<b>Executive Lead</b>	<b>Due Date</b>	<b>Progress</b>
Delivery of restructure has clear plan and end date	Chief People Officer	Q4 2025/26	Revised Phase 2 plan signed off by EMB and sequencing underway aligned to available resources. Phase 3 BC under development in response to changed sequencing of organisational change
Ongoing communications plan in relation to organisational changes	Director of Comms & Engagement	Q4 2025/26	Implementation of plan underway. Staff survey complete and final results to be shared in coming months.

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# IQR Our People

### What?

Overall, workforce stability continues to strengthen despite ongoing organisational restructuring, with improvements in training, appraisals and turnover balanced against continuing sickness challenges and a high ER caseload. Progress continues across key workforce and culture priorities, with turnover remaining at its lowest rolling rate in several years (13.3%). Metrics show a mixed but improving position, with high employee relations and collective grievance volumes offset by improved case progression and zero cases exceeding 24 months. The reductions in long-running cases indicate better grip on complex cases and leadership engagement to resolve.

Fifteen concerns were submitted to the FTSU team in December. Workforce turnover has increased with sixty-four leavers bringing our rolling total to 13.3%, partially due to organisational restructures and resolution of a number of legacy ER cases. Sickness absence remains above target at 6.8%. Progress on core skills training framework compliance is now 85.5% for this reporting period, just above the 85% standard for the sixth consecutive month, and appraisal compliance rose to 79.3%. Operational indicators showed a slight rise in overruns and stable performance on meal breaks, with minor seasonal variation.

The Trust has made positive progress in EDI, with WRES and WDES reports showing strong five-year improvement, although Harassment, Bullying and Abuse remains a concern. Targeted action is underway to improve staff safety and wellbeing, including increased use of body-worn cameras and enhanced support for call-centre staff. EDI delivery continues across the four priority areas, with strengthened staff networks, improved reasonable adjustments processes and reverse mentoring and the Ascend programme. Alongside this the OD team are working closely with leaders to coordinate support for staff and their teams affected by restructuring across clinical and corporate areas.

### So What?

These indicators suggest a culture that is becoming more stable, with early signs of improving managerial capability and more effective informal resolution at earlier stages. The reduction in legacy cases and improved closure rates provide assurance that cases are being managed more pro-actively. Workforce turnover remains largely stable, and sickness absence continues to be slightly higher than expected at this time of year. At the same time, sustained improvement in mandatory training and rising appraisal completion rates that our leaders are engaging in core people-management responsibilities. This is crucial given the scale of organisational transformation underway. Operationally, consistent meal-break performance and manageable overruns indicate that, despite wider pressures, core staff wellbeing safeguards are holding, reducing the likelihood of further deterioration through the winter period. The Trust is demonstrating sustained improvement in staff inclusion, leadership capability and managing organisational change. However, HBA remains a risk to staff experience, engagement and retention if not addressed consistently. Strong alignment between EDI and OD activity is helping ensure change is delivered in an inclusive and people-centred way. Investment in managers, leadership pipelines and staff networks is strengthening resilience during a period of significant transformation.

### What Next?

The Trust will focus on embedding the new Resolution Policy and newly approved Managing Conduct Policy, strengthening case management consistency and continuing training on sexual safety and professional boundaries. Speak Up support will be expanded with the induction of new Champions. Workforce priorities include maintaining and refreshing local action plans in higher turnover areas, supporting managers with improved sickness management systems, and continuing leadership reviews focused on absence reduction. Workforce planning activity will continue to align staffing supply with organisational change. Learning and development actions include launching the new mandatory training dashboard and preparing for the transition to Microsoft Forms for appraisals. These represent the most material people-related risks during the restructuring period, and the Trust will strengthen its oversight and response by prioritising ER backlog reduction, enhanced sickness-management tools, and increased Speak Up engagement to stabilise cultural risk. Focused action will continue to reduce harassment, bullying and abuse, with further rollout of safety and wellbeing interventions. The Anti-Racism Framework and Disability Confident Level 2 will be implemented during 2026. Cohort two of reverse mentoring and the next Ascend leadership programme will launch, with evaluation of impact on progression and inclusion. The OD change programme will be delivered over the next 12 months, including piloting and refining the new "Mates to Managers" offer. Recommendations from culture, operating model and succession planning reviews will be implemented to strengthen leadership capability and organisational effectiveness.



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

				Special cause variation where <b>UP</b> is neither improvement nor concern.
				Special cause variation where <b>DOWN</b> 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.



### Variation

#### Special Cause Improvement



10%  
2



10%  
2

#### Common Cause



52%  
11

#### Special Cause Concern



10%  
2



0%  
0

### Assurance

#### Pass



5%  
1

#### Hit and Miss



62%  
13

#### Fail



14%  
3

#### No Target



19%  
4

### Culture

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	Collective Grievances Open	Dec-25	2	1	1.6		
Board	Count of Grievances Closed	Dec-25	7	3	14.1		
Board	Count of Sexual Safety / Sexual Misconduct Cases	Dec-25	1	3	3.6		
Board	Individual Grievances Open	Dec-25	5	5	12.7		
Board	Number of FTSU Concerns Raised	Dec-25	15	21.9	21.8		
Supporting	Bullying & Harrassment Internal	Dec-25	3	2	2.3		
Supporting	Disciplinary Cases	Dec-25	7	3	9.2		
Supporting	Mean Suspension Duration (Days)	Dec-25	203	70	174.1		

### Employee Experience

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Supporting	% of Meal Breaks Outside of Window	Dec-25	50.1%	43.4%	48.7%		
Supporting	% of Meal Breaks Taken	Dec-25	98.3%	98%	98.3%		
Supporting	999 Frontline Late Finishes/Over-Runs %	Dec-25	44.2%	45%	43%		

Pending metric: WRES/WDES - Needs to be defined

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

### Employee Development

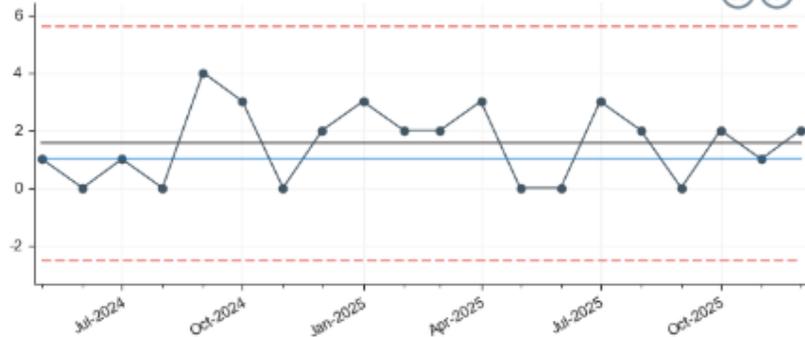
Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	Appraisals Rolling Year %	Dec-25	79.3%	85%	65.6%		
Board	Statutory & Mandatory Training CSTF Rolling Year %	Dec-25	85.5%		85.3%		

Pending metric: Education - Needs to be defined

### Workforce

Type	Metric	Latest	Value	Target	Mean	Variation	Assurance
Board	Annual Rolling Turnover Rate	Dec-25	13.3%	15%	14.9%		
Board	Sickness Absence %	Dec-25	7.7%	5%	6.6%		
Board	Turnover Rate %	Dec-25	1%	0.8%	1%		
Board	Frontline Staff Vaccinated Against Flu %	Dec-25	62.5%	80%	60.8%		
Supporting	Number of Staff WTE (Excl bank and agency)	Dec-25	4674.4	4579.26	4598.5		
Supporting	Vacancy Rate %	Dec-25	4.6%	5%	1.4%		
Supporting	Staff Sickness Absence Related to Respiratory Infections	Nov-25	0%	75%	0%		

Collective Grievances Open



WF-11

Dept: Workforce HR

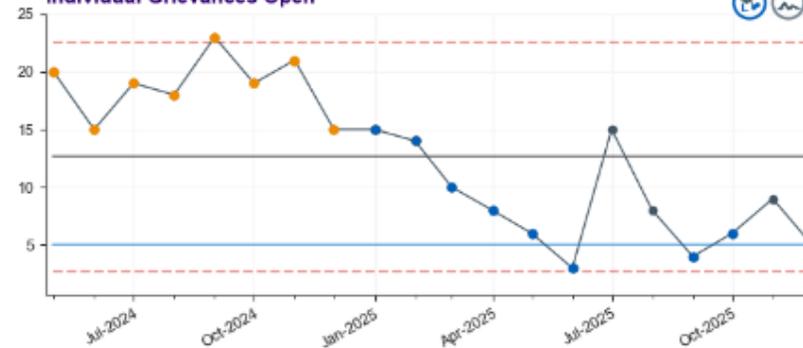
Metric Type: Board

Latest: 2

Target: 1

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

Individual Grievances Open



WF-10

Dept: Workforce HR

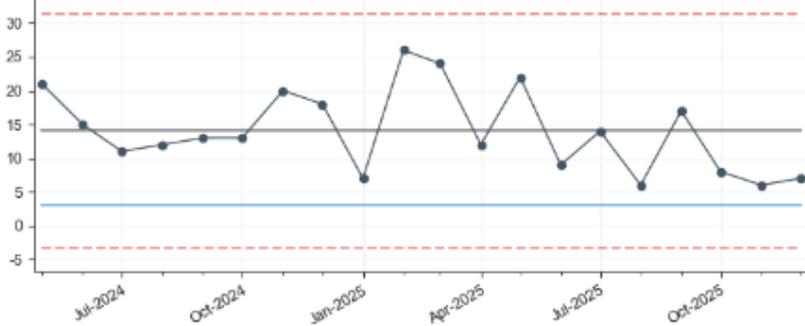
Metric Type: Board

Latest: 5

Target: 5

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

Count of Grievances Closed



WF-42

Dept: Workforce HR

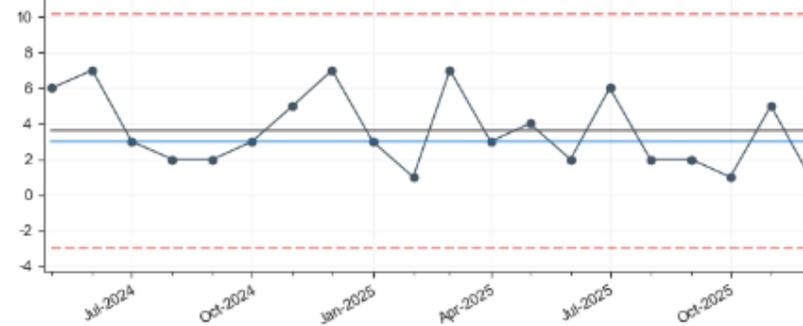
Metric Type: Board

Latest: 7

Target: 3

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

Count of Sexual Safety / Sexual Misconduct Cases



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 November, 2 new collective grievance were raised. The total number of open collective cases is now 18, including the Trust-wide issues such as Section 2 and lease car concerns. 8 cases were opened and 6 closed during November.

So What?

The closure rate demonstrates a tangible improvement in how we manage cases: our processes are becoming 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, higher quality and consistent outcomes.

What Next?

- New grievance policy (Resolution Policy) was approved at JPF in November
- Resolution policy training to commence in Dec/Jan to go live by end of February 26.
- Negotiations have resumed regarding the collective grievance on pay.

What?

At month-end (30 Nov 2025), there were 19 live cases, down by 1 compared with the previous month. On a 12-month rolling basis, completed cases took on average 164 days to close. Open cases had been open on average 178 days. 16% of open cases were over 12 months old (up by 5.8 percentage points vs the previous month) and 0% were over 24 months old (unchanged from the previous month). 1 case was opened, and 2 cases were closed within the month, resulting in a net decrease of 1.

So what?

Overall, the case load remains high as new cases continue to outpace closures, signalling growing pressure on capacity if the trend persists. Completed cases took an average of 163 days. 16% of open cases are over 12 months old but there are none over 24 months. There are, however, some positive signs regarding backlog: the proportion of cases over 12 months old has reduced, and no cases exceed 24 months, indicating progress in tackling older, higher-risk cases. The number of new grievances each month are on a downward trajectory, possibly demonstrating an improvement in manager capability, an improvement in overall culture, and better use of informal mediation routes.

What Next?

- Continue to deliver targeted training through Key Skills on sexual safety and understanding professional boundaries
- Review of policies to ensure learning from recent cases is embedded to enhance response to student concerns.

Number of FTSU Concerns Raised



QS-27

Dept: Quality & Safety

Metric Type: Board

Latest: 15

Target: 21.9

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

**What?**

In December 2025, 15 concerns were raised to the FTSU team, with 7 already closed. Five concerns were submitted anonymously (33%) and no cases of detriment were reported. Integrated care accounted for 5 concerns (33%), with the remainder distributed across other areas of the Trust.

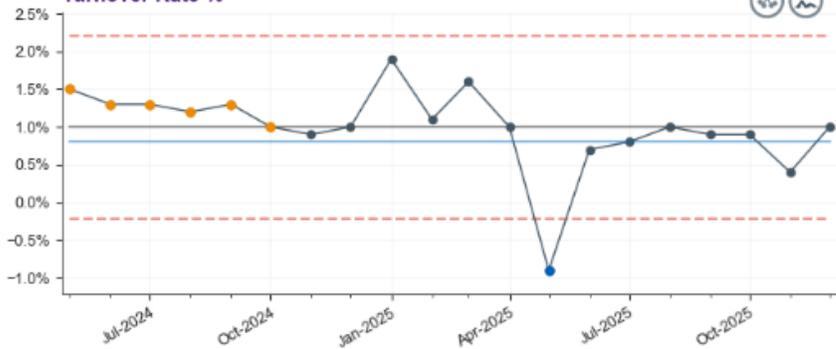
**So what?**

Worker safety and wellbeing was the predominant national theme, featuring in 9 of the 15 concerns (60%). The top three secondary local themes were leadership and relationships and behaviours, each with 5 concerns (33%), and system process with 3 concerns (20%). These figures continue to highlight staff concerns around wellbeing, leadership practices and organisational processes.

**What next?**

The newly appointed Speak Up Champions will be inducted in February, providing additional local support and visibility for staff wishing to raise concerns. The FTSU team will continue to monitor emerging trends and work with leaders across the organisation to address issues relating to wellbeing, leadership and processes, ensuring that staff feel safe, supported and encouraged to speak up.

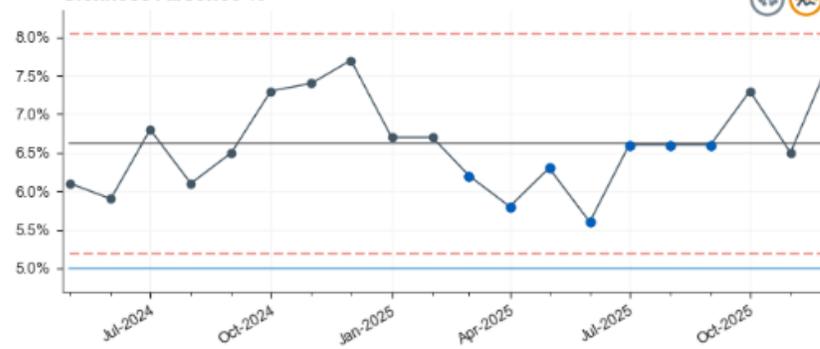
Turnover Rate %



WF-48

Dept: Workforce HR  
Metric Type: Board  
Latest: 1%  
Target: 0.8%  
Common cause variation, no significant change. This process will not consistently hit or miss the target.

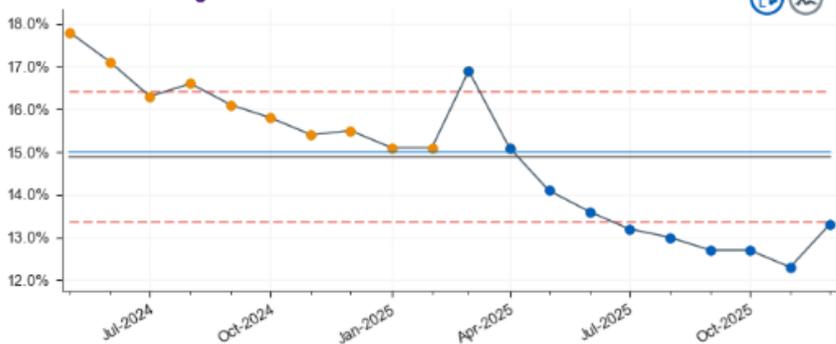
Sickness Absence %



WF-49

Dept: Workforce HR  
Metric Type: Board  
Latest: 7.7%  
Target: 5%  
Common cause variation, no significant change. This process is not capable. It will FAIL to meet target without process redesign.

Annual Rolling Turnover Rate



WF-7

Dept: Workforce HR  
Metric Type: Board  
Latest: 13.3%  
Target: 15%  
Special cause of an improving nature where the measure is significantly LOWER. This process will not consistently hit or miss the target.

Frontline Staff Vaccinated Against Flu %



WF-54

Dept: Workforce HR  
Metric Type: Board  
Latest: 62.5%  
Target: 80%  
Special cause or common cause cannot be given as there are an insufficient number of points.

**What?**

In December, 64 staff left the organisation, our highest number in nine months bringing our rolling percentage total to 13.3%. This is our highest rolling total for six months, recognising that we are deep into organisational restructures and have been able to close some long standing ER cases.

**So What?**

Turnover continues to trend positively overall, with rates below target for a sustained period. This improvement suggests that recent retention efforts and organisational stability are having an impact.

**What Next?**

- Maintain focus on local action plans in higher-turnover areas to keep improvements on track.
- Ensure local action plans are refreshed to maintain energy and focus.
- 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 **7.7%**, with the rolling annual figure remaining above target at **around 6.8%**.

**So What?**

Sickness absence remains higher than target but is within normal variation. 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. Seasonal trend is currently impacting short term absence, in particular in call centres.

**What next?**

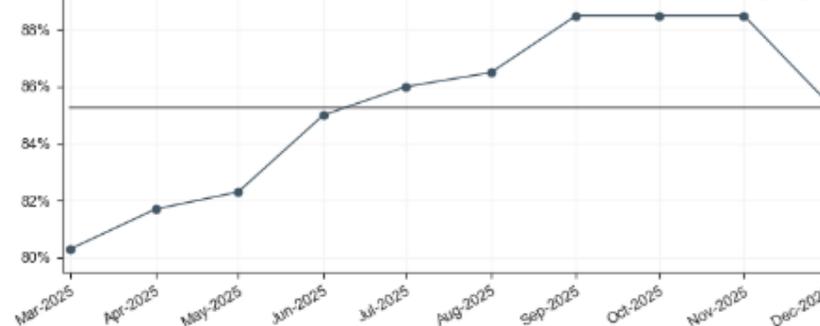
- Strengthen attendance management through development of new system to support managers to stay on top of day-to-day sickness absence management.
- Maintain quarterly leadership reviews to challenge progress and drive systemic change. The latest review is currently with Strategic People Partners ahead of going to SMG.
- Review wellbeing and support systems to tackle root causes of absence.

Appraisals Rolling Year %



**WF-40**  
 Dept: Workforce HR  
 Metric Type: Board  
 Latest: 79.3%  
 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.

Statutory & Mandatory Training CSTF Rolling Year %



**WF-6**  
 Dept: Workforce HR  
 Metric Type: Board  
 Latest: 85.5%  
 ---  
 Special cause or common cause cannot be given as there are an insufficient number of points.

**What?**  
Compliance has increased to 79.3% for this reporting month

**So what?**  
Overall appraisal compliance has continued to improve, demonstrating sustained organisational focus on appraisal completion. Despite this positive trend, variation across directorates remains, indicating that targeted support and clear, consistent processes are still required. The Appraisal Skills Workshop has now transitioned into a business-as-usual L&D offer, with dates actively being advertised, supporting managers to develop the skills and confidence needed to deliver high-quality, meaningful appraisal conversations. Ongoing 1-2-1 ESR support and the introduction of proxy access for Executive Assistants continue to reduce administrative barriers, improving the accuracy and timeliness of appraisal submissions for senior teams. Preparatory work is underway to support the forthcoming move to sole use of Microsoft Forms for appraisal completion, recognising the importance of clear guidance and effective communication ahead of launch.

**What next?**  
The move to sole use of Microsoft Forms for appraisal completion will be launched by mid-February. Ahead of this, the Appraisal Hub will be updated to reflect the new process, ensuring colleagues and managers can easily access clear, step-by-step guidance and supporting resources. Trust-wide communications will be issued to confirm the change, outline expectations, and signpost available support. A programme of drop-in sessions will be introduced to train and support colleagues and managers in using Microsoft Forms confidently and consistently. The Appraisal Skills Workshop will continue to run quarterly as part of the business-as-usual L&D offer, alongside tailored 1-2-1 ESR support and ongoing work with Executive Assistants to embed proxy access arrangements. Collectively, these actions aim to further improve compliance, reduce variation across directorates, and strengthen the quality and consistency of appraisal practice across the Trust.

**What?**  
Statutory and mandatory training compliance for the Core Skills Training Framework (CSTF) is 85.5%, just above the 85% target. This demonstrates consistent Trust-wide engagement with nationally mandated learning requirements. A new dashboard has been developed to improve visibility of training compliance and need and improve data quality.

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

**What next?**  
To launch the new full training dashboard to increase visibility of all Trust training courses and optimise uptake to role specific programmes. Demonstrations will now place of the new configured dashboard across all directorates.



<b>AQI A7</b>	All incidents – the count of all incidents in the period
<b>AQI A53</b>	Incidents with transport to ED
<b>AQI A54</b>	Incidents without transport to ED
<b>AAP</b>	Associate Ambulance Practitioner
<b>A&amp;E</b>	Accident & Emergency Department
<b>AQI</b>	Ambulance Quality Indicator
<b>ARP</b>	Ambulance Response Programme
<b>AVG</b>	Average
<b>BAU</b>	Business as Usual
<b>CAD</b>	Computer Aided Despatch
<b>Cat</b>	Category (999 call acuity 1-4)
<b>CAS</b>	Clinical Assessment Service
<b>CCN</b>	CAS Clinical Navigator
<b>CD</b>	Controlled Drug
<b>CFR</b>	Community First Responder
<b>CPR</b>	Cardiopulmonary resuscitation
<b>CQC</b>	Care Quality Commission
<b>CQUIN</b>	Commissioning for Quality & Innovation
<b>Datix</b>	Our incident and risk reporting software
<b>DCA</b>	Double Crew Ambulance
<b>DBS</b>	Disclosure and Barring Service
<b>DNACPR</b>	Do Not Attempt CPR
<b>ECAL</b>	Emergency Clinical Advice Line
<b>ECSW</b>	Emergency Care Support Worker
<b>ED</b>	Emergency Department
<b>EMA</b>	Emergency Medical Advisor
<b>EMB</b>	Executive Management Board
<b>EOC</b>	Emergency Operations Centre
<b>ePCR</b>	Electronic Patient Care Record
<b>ER</b>	Employee Relations

<b>F2F</b>	Face to Face
<b>FFR</b>	Fire First Responder
<b>FMT</b>	Financial Model Template
<b>FTSU</b>	Freedom to Speak Up
<b>HA</b>	Health Advisor
<b>HCP</b>	Healthcare Professional
<b>HR</b>	Human Resources
<b>HRBP</b>	Human Resources Business Partner
<b>ICS</b>	Integrated Care System
<b>IG</b>	Information Governance
<b>Incidents</b>	See AQI A7
<b>IUC</b>	Integrated Urgent Care
<b>JCT</b>	Job Cycle Time
<b>JRC</b>	Just and Restorative Culture
<b>KMS</b>	Kent, Medway & Sussex
<b>LCL</b>	Lower Control Limited
<b>MSK</b>	Musculoskeletal conditions
<b>NEAS</b>	Northeast Ambulance Service
<b>NHSE/I</b>	NHS England / Improvement
<b>OD</b>	Organisational Development
<b>Omnicell</b>	Secure storage facility for medicines
<b>OTL</b>	Operational Team Leader
<b>OU</b>	Operating Unit
<b>OUM</b>	Operating Unit Manager
<b>PAD</b>	Public Access Defibrillator
<b>PAP</b>	Private Ambulance Provider
<b>PE</b>	Patient Experience
<b>POP</b>	Performance Optimisation Plan
<b>PPG</b>	Practice Plus Group
<b>PSC</b>	Patient Safety Caller
<b>SRV</b>	Single Response Vehicle