NHS
South East Coast Ambulance Service
NHS Foundation Trust

Quality Account

2025/26

Saving Lives,
Serving Our Communities

Introduction

The Quality Account is a report on the quality of our services over the 2025/26 financial year. The quality of the services is measured by looking at:

- **Patient safety**
- **Effectiveness of patient care**
- **Patient feedback about care provided**

The report also provides information on improvements we have made over this period and provides an opportunity to share our successes with those that matter most, our patients.

The Quality Account is broken down into three parts:

- **Part 1** of the report contains a statement of quality from our Chief Executive.
- **Part 2** reports on our progress over 2025/26 and outlines our priorities for improvement for 2026/27. This section also details 'statements of assurance from the board' and 'reporting against core indicators'. These statements contain mandated wording to ensure we have provided a sufficient update on each aspect of the service provided over 2025/26.
- **Part 3** of the Quality Account is an opportunity to share other aspects of quality from across the Trust that have not already been discussed. This includes any other information relevant to the quality of health services provided or subcontracted during the reporting period.

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Quality Account
2025/26

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Part 1:

Statement of Quality from Our Chief Executive

Part 1: Statement of Quality from our Chief Executive

I am pleased to introduce our Quality Account for 2025/26. This year's report is underpinned by important independent assurance of the progress we have made.

Following inspections in September and November 2025, our Urgent and Emergency Care and Emergency Operations Centre services were both rated '*Good*' by the Care Quality Commission, with reports published in May 2026. These ratings provide clear external assurance that we are delivering safe, effective, caring and well-led services and reflect sustained improvement across the organisation.

This Quality Account builds on that assurance, setting out in more detail the progress we have made over the past year and our priorities as we continue to strengthen the quality, safety and responsiveness of care for patients across Kent, Surrey and Sussex.

This year has been about purposeful, sustainable progress, with a focus on embedding our five-year strategy, strengthening our clinical and organisational foundations and ensuring improvements are experienced consistently by both patients and our people.

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

Demand on urgent and emergency care across the NHS remains high and I want to recognise the professionalism, resilience and clinical excellence shown by our teams in the face of continued pressure. Patient safety and quality remain at the heart of everything they do.

A key area of development has been our clinical operating model. We have strengthened clinical leadership, management and supervision alongside more structured opportunities for reflection, feedback and learning. This has improved consistency in clinical decision-making, particularly in high-pressure environments.

We have also continued to develop our approach to virtual care, building on the strong foundations of our Unscheduled Care Navigation Hubs. Patient safety remains central, supported by clear clinical leadership and robust governance. This year we will evolve our virtual care model to ensure proactive remote clinical assessment is delivered to more patients by our skilled and well-supported clinicians, offering more timely access to the right care in the right place, and enabling effective system working.

Listening to patients and communities has been strengthened, with engagement increasingly shaping service design and improvement. We are working to ensure this is inclusive and accessible so a wider range of voices is heard.

Reducing health inequalities continues to underpin our work, with a focus this year on improving care for people with mental health needs and those requiring maternity care through clearer pathways, training and partnership working.

Our workforce remains fundamental. We have strengthened local leadership, improved support and created more opportunities for staff to be heard. While there is more to do, progress is encouraging.

Looking ahead, our priorities are clear: strengthening clinical quality and safety; improving access and responsiveness through virtual and alternative pathways; addressing health inequalities; investing in our workforce; and working collaboratively with NHS partners.

While pressures remain, we are building on strong foundations. What gives me confidence is the commitment of our people, delivering safe, high-quality and compassionate care every day.

The Board of Directors has reviewed this Quality Account and is assured that it provides an accurate and balanced reflection of the Trust's performance and priorities.

Jen Allan
Interim Chief Executive Officer

Care Quality Commission (CQC) Inspections: Significant Improvement in Quality of Care

One of the Trust's most significant achievements during 2025/26 was the publication of improved Care Quality Commission (CQC) inspection ratings for both our Emergency and Urgent Care service (Frontline Ambulance Operations) and our Emergency Operations Centre (EOC).

On 29 May 2026, the Care Quality Commission (CQC) published inspection reports for the Trust's Emergency and Urgent Care (Frontline Ambulance Operations) service and the Emergency Operations Centre (EOC). Both services were rated 'Good', marking a significant milestone in the Trust's multi-year improvement journey and providing independent assurance to patients and the public about the quality of care delivered.

The charts below illustrate the scale of progress made since 2022. At that time, both services were rated as 'Requires Improvement', with several domains including safety, effectiveness, and responsiveness identified as needing improvement. The most notable challenge was within leadership and governance, where the Emergency and Urgent Care service was rated "Inadequate" for well-led.

Following the inspections in late 2025, both services have demonstrated substantial improvement. The Emergency Operations Centre is now rated Good across all five domains: safe, effective, caring, responsive and well-led. Similarly, Emergency and Urgent Care (Field Operations) achieved Good in four domains, with the well-led domain rated Requires Improvement. This reflects the ongoing implementation of a strengthened governance framework during a period of organisational transition.

The improvement reflects a sustained and organisation-wide focus on quality, safety and culture. Inspectors highlighted a strong and open safety culture, with staff actively encouraged to raise concerns and share learning. The introduction of the Patient Safety Incident Response Framework (PSIRF) has supported a more consistent and structured approach to learning from incidents, helping to drive continuous improvement in patient care.

CQC findings also recognised the compassionate and patient-centred approach of staff. Patients consistently reported positive experiences, particularly noting professionalism, empathy and clear communication in often complex and distressing situations. This feedback reflects the commitment of frontline teams working under significant operational pressure.

A key area of progress identified across both services is improved partnership working. Staff now work more closely with other health and care organisations, supported by shared systems, integrated care pathways and multidisciplinary collaboration. Initiatives such as integrated care hubs and joint response models enable patients to be directed more quickly to the most appropriate care, improving outcomes and reducing delays.

While the Emergency and Urgent Care service continues to strengthen its leadership arrangements, significant progress has already been made. Since the inspection, the Trust has implemented a revised divisional governance structure as part of its Clinical Integrated Operating Model. This has improved oversight, accountability and alignment across teams. Although still maturing, there is a clear trajectory toward fully embedded and effective governance.

The Trust has moved from a position of recovery in 2022 to one of greater stability, stronger leadership and continuous improvement in 2025/26. For patients and the public, these findings provide reassurance that services are safe, effective and responsive, with caring staff and improving leadership supporting high-quality care now and into the future.

Emergency and Urgent Care

	August 2022			September 2025	
Overall Rating	***Requires Improvement***		→	***Good***	
Safe	Requires Improvement			Good	
Effective	Requires Improvement			Good	
Caring	Good			Good	
Responsive	Requires Improvement			Good	
Well-led	Inadequate			Requires Improvement	

Emergency Operations Centre

	June 2022			November 2025	
Overall Rating	***Requires Improvement***		→	***Good***	
Safe	Requires Improvement			Good	
Effective	Requires Improvement			Good	
Caring	Good			Good	
Responsive	Requires Improvement			Good	
Well-led	Requires Improvement			Good	

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Part 2:

Priorities for Improvement and Statements of Assurance from the Board

This section of the Quality Account is divided into two parts; the first sets out progress made against the priorities for 2025/26 and the second details the key areas of development for the next 12 months.

2.1 Quality Priorities for Improvement

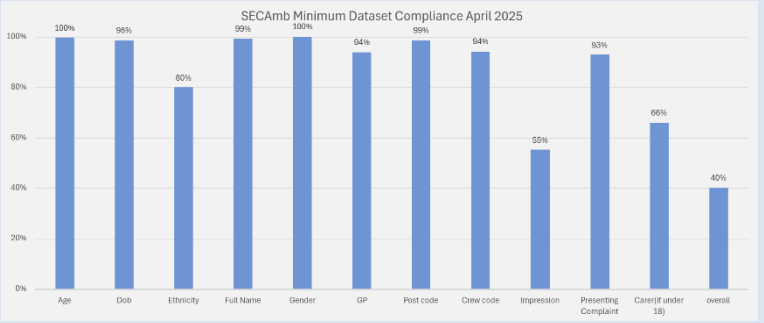
Looking back – report on the 2025/26 Quality Priorities

Two of the priorities identified in 2024/25 were planned as two-year priorities to allow for a more comprehensive and sustainable approach. This extended timeline enabled meaningful progress, with opportunity for ongoing evaluation, refinement, and integration into practice.

In 2025/26, the Trust continued work on these two-year priorities while also addressing a third one-year priority. The three priorities for 2025/26 were:

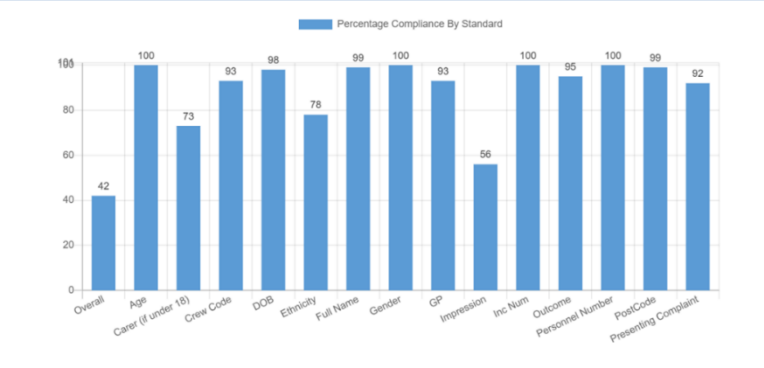
- **Priority 1** (Domain: Clinical Effectiveness) – Feedback to staff on Patient Care Records (PCR) (two-year priority)
- **Priority 2** (Domain: Patient Safety) – Framework for Staff Decision-Making and Documentation in Managing Suicidal Patients Declining Conveyance (one year priority)
- **Priority 3** (Domain: Patient Experience) – Health Inequalities (two-year priority)

Part 2: Priorities for Improvement and Statements of Assurance from the Board

Domain:	**Clinical Effectiveness**
Priority Title:	Feedback to staff on Patient Care Records (PCR)
Review of 2024/25 report	Patient Care Records (PCRs) are integral to safe and effective patient care, affording an opportunity to ensure smooth transition of care across the patients care journey. They also support the Trust in measuring effectiveness and development of our clinical care through audit. The quality of patient care records was variable as identified through central clinical audit in 2024, and there was no defined and consistent process that supported PCR review and feedback at a local level. Feedback to colleagues on the quality of PCR completion will support the supervision agenda aligned to the Trust's developing strategy, improve the quality of documentation, as a result promoting safe and effective patient care and support the Trust in measuring effectiveness and development of clinical care.
The aim for 2025/26	This was a two-year priority (2024-2026). The overall aim was to improve the quality of patient care record completion and support meaningful supervision to colleagues.
Our performance	During 2024/25: • A project plan for the delivery and oversight of the objectives was created, along with a project group. • The Trust's legacy Clinical Audit and Health Records Departments underwent a full restructure to create a single integrated Health Informatics Department, which ensured the capacity and capability to drive this priority forward. • A new digital software solution was tendered and procured for the processing of patient clinical records. The specification and system functionality has been significantly developed over the period, supported by joint monthly contract review meetings. • Engagement and floorwalking across the Trust's Operational Units (OUs) commenced during Q4 2024/25 to enable (a) the baselining of existing use of PCR data (b) to identify OU feedback approaches/mechanisms and (c) identify and define their local clinical data needs. During 2025/26: • The Critical Systems team ensured the timely configuration of the Trust's ePCR (electronic patient care record) requirements. • National Ambulance Data Set (ADS) fields were integrated into the Trust's ePCR platform, including new impression codes. • The Data Engineering Team ensured high quality data matching from ePCR and CAD (Computer Aided Dispatch) to ensure complete and accurate patient record keeping. • Operating Unit (OU) performance dashboards were developed and rolled out Trust wide. • Active Directory (AD) Groups were created and adopted. • A Minimum Data Set (MDS) for clinical record completion was developed and quality assured, supported by the dashboard monitoring of performance. • Changes to regional governance structure enabled the creation of Divisional Governance Groups with oversight of clinical performance. • Local OU data was shared via OU data screens and also via Viva • A Paper Records Task & Finish Group reviewed all paper clinical report forms and consolidated/removed those that could be integrated into the ePCR.
Did we achieve this priority	This workstream has been convoluted and challenging requiring multiple digital solutions and reconfigurations. At the end of 2025, data was benchmarked back to April 2025 where Trust wide performance was as follows. Analysis identified the largest gap was the documentation of impression codes (pending the transition from the documentation of crew condition codes): 

Part 2: Priorities for Improvement and Statements of Assurance from the Board

By March 2025, performance was as per the table below. Whilst it appears overall performance has remained static; the OU teams can now access and monitor this data which they had been unable to previously, presenting opportunity for further analysis and improvement.



In March 2026, a review of themes arising from the Trust's integrated patient safety data over the preceding 12 months was undertaken. While high-quality documentation remains essential for safe and effective patient care, documentation issues did not emerge as a significant contributory factor in patient safety incidents when compared with other areas of risk. This suggests that the improvements introduced through this priority have helped establish a stronger foundation for record keeping, and that further improvement can now be managed through business-as-usual processes while organisational focus is directed towards higher-risk patient safety priorities.

Actions to be carried forward to 2026/27

The project will now transition into business as usual (BAU):

- The digital developments will continue to be progressed
- AD Groups will be revised and updated following the recent Operational restructure to enable teams-based reporting and oversight
- ePCR developments will continue as planned in line with contractual requirements.
- Regional DGG oversight and performance management will continue at local levels, with central oversight continuing by the Health Informatics Department.
- A key PSIRP priority for 2026/27 is mental health. Record keeping is included in its sub themes, further enabling oversight and assurance during 2026/27.

Part 2: Priorities for Improvement and Statements of Assurance from the Board

Domain:	**Patient Safety**
Priority Title:	Framework for Staff Decision-Making and Documentation in Managing Suicidal Patients Declining Conveyance
Review of 2024/25 report	The interface between the Mental Health Act (1983) and Mental Capacity Act (2005) is a highly complex and challenging one, particularly when considering how best to support people who are in a mental health crisis and have expressed suicidal ideation or intent. There is no agreed national model that mandates the approach ambulance services should take when responding to patients who are experiencing suicidality, and neither the Mental Health Act (1983) or Mental Capacity Act (2005) provides an explicit approach. When considering the SECAmb response, there is an absence of local guidance for practitioners and no explicit policy framework. Through informal engagement with frontline staff, and insights from various patient safety events and coronial processes, it is recognised that there are opportunities to provide clear guidance to frontline staff to enable appropriate decision making and documentation in cases where patients are experiencing suicidality.
The aim for 2025/26	To improve the experience of patients who are in a mental health crisis and experiencing suicidality. To improve the advice and guidance available to frontline staff to support them in making safe, well documented decisions when they are responding to patients who are experiencing suicidality. To work with partners in Surrey, Kent and Sussex to further inform and develop shared decision-making pathways.
Our performance	During 2025/26, SECAmb made substantial progress toward improving decision-making and documentation when managing patients experiencing suicidality who decline conveyance. The work has moved from initial development to clear, measurable system change across Surrey, Sussex and (to a lesser degree so far) Kent. New Mental Capacity Assessment (MCA) & Suicidality Guidance was developed, approved by the Professional Practice Group, and uploaded to JRCALC (Joint Royal Colleges Ambulance Liaison Committee) for frontline access. JRCALC is a platform for clinical guidelines to support clinical staff with best practices to ensure high quality patient care. This guidance provides step-by-step support on assessing capacity, managing risk, involving partner organisations, safety planning and clear expectations on documentation. Strengthened Local Mental Health Pathways: County-specific pathway guides were created and distributed. All mental health pathways on Service Finder were updated; outdated versions removed. Significant increase in Single Point of Contact (SPOC) utilisation, Kent progress remains limited due to unavailable data, but this has been highlighted as a priority for 2026. Launch of Mental Health Data Dashboard: Phase 1 completed; high-level demand, incident profiles, on-scene times. Phase 2 underway; detail on Mental Capacity Act (MCA) module use, SPOC use, Electronic Patient Care Record (EPCR) documentation quality. Insights already influencing improvement activity and system risk identification. Training & Workforce Development: Mental health, suicidality, decision-making and mental capacity now embedded into: Trainee Associate Ambulance Practitioner (TAAP), Transition to Practice (TTP), Newly Qualified Practitioner (NQP) programmes and key skills 2026/27 curriculum. Mental Health team provided direct support, ad hoc teaching, and case-based feedback. National Leadership: SECAmb is co-leading the new national working group on suicidality & MCA, bringing together all ambulance trusts to develop sector-wide approached. Local Mental Capacity Summits: Surrey summit held with cross-sector representation; Kent and Sussex planned in early 2026.
Did we achieve this priority	Impact on patients: Patients experiencing suicidality who decline conveyance are now more likely to receive a structured mental capacity assessment, a documented safety plan, and access to specialist mental health support. This helps ensure decisions about their care are made lawfully and consistently, that their wishes are appropriately respected where they have capacity, and that they are not left without appropriate follow-up care and support. The success of the 2025/26 priority came from multiple aligned workstreams, all delivered as part of the broader Mental Health Models of Care programme.

	Staff Feedback Directly Informed the Model of Care and Guidance, through informal engagement sessions, local leadership meetings, station visits, and case reviews. Frontline clinicians shared clear, consistent concerns about the challenges they faced when managing suicidal or high-risk mental health incidents. They told us: • Mental health SPOC lines were often not answered or difficult to reach. • Other services sometimes placed undue pressure on ambulance crews to force conveyance, even where capacity and safety had been appropriately assessed. • Navigating the Mental Capacity Act, mental health law, safety planning, and documentation expectations was confusing without clear guidance. • More training in mental health, suicidality, capacity and communication was required. Real Case Reviews Drove Practice Improvements: Throughout the year, the Mental Health Team reviewed numerous mental health and suicidality incidents and provided personalised feedback to the crews involved. Learning from these real cases allowed SECAmb to identify: • Poorly understood pathways. • Documentation gaps. • Missed opportunities for SPOC involvement. • Inconsistencies in safety planning. • Variation in MCA assessment practice. These insights shaped the enhancements to EPCR prompts, and the development of the Mental Health Dashboard (Phase 1 and 2) as well as the guidance documents that were being produced. The case reviews created a robust learning loop where incidents informed change resulting in continuous improvement. Clear, Practical Clinical Tools: New MCA & Suicidality guidance directly addresses frontline needs, specifically focusing on how to complete a capacity assessment and safety planning. Making the guidance accessible via JRCALC and embedding prompts in EPCR ensured it reached crews consistently. Improving Collaborative Decision Making: 24/7 mental health professional lines in all counties give clinicians real-time specialist advice. Crews are now consistently encouraged to discuss cases with SPOC and work jointly on safety plans. Feedback from crews shows this has changed practice culture, one staff member said: “I feel much more supported with Mental Health patients… we’ve avoided the Emergency Department and freed up ambulances.” Strengthening System Interfaces: SECAmb worked with each mental health trust to improve; responsiveness, pathway clarity and handover processes. Sussex’s Rapid Response / Blue Light Line model is a standout example of system change with a significant increase in improvements to patient experience. Use of Data to Drive Focus: The data dashboard allowed SECAmb to identify, A rise in mental health demand (notably Sussex), increases in Hear & Treat rates as well as high rates of patients left at home following self-harm/suicidality presentations (“see & treat” with no onward referral), highlighting the need for robust safety planning and MCA clarity. Embedding Training: A full training needs analysis generated a comprehensive curriculum for 2026+ with focus on; mental capacity, suicide response, safe discharge, improved documentation, trauma-informed practice and the police interface
Actions to be carried forward to 2026/27	Next year’s commitments are as follows: Complete Kent Pathway Development: • Improve access and responsiveness of Kent’s 836 line. The 836 is the single point of access line for use by Police and ambulance in Kent. It is there to offer advice for Police and ambulance when they are on scene with a patient suffering with mental health illness. It is run by Kent and Medway Mental Health Trust. • Increase SPOC utilisation to levels seen in Surrey & Sussex. • Ensure pathway posters, training and engagement mirror improvements in other counties. Implement Phase 2 of the Mental Health Dashboard: • Add enhanced metrics such as use of MCA module. • Enable real-time monitoring of quality and variation. Finalise and Roll Out New Condition Codes: • Complete simplification of existing codes into accessible categories. • Provide definitions and training for new condition codes. • Monitor impact on data quality and audit capability.

Deliver Full Mental Health Training Programme:

- Launch Key Skills 2026/27 mental health content.
- Deliver additional courses (MCA, suicidality, documentation) across EOC, 111 and frontline.
- Include scenario-based and virtual assessment training.

Continue Local Mental Capacity Summits:

- Deliver Kent and Sussex summits.
- Produce system-wide recommendations report based on learning from all three counties.

Ongoing Improvement of SPOC Responsiveness

- Work with partners to monitor responsiveness.
- Expand EOC-to-SPOC direct connectivity.

Continue Embedding the New Guidance in Practice

- Ongoing refreshers, posters, engagement with operational teams and case reviews.
- Audit use of MCA guidance.

Strengthen Patient and Lived Experience Involvement

- Expand service-user engagement during the development of the Mental Health Models of Care.
- Build a specific focus on patients with repeated suicidality and those frequently left at home.

Domain:	Patient Experience
Priority Title:	Health Inequalities
Review of 2024/25 report	Health inequalities refer to the unfair and avoidable differences in health outcomes between different population groups, often driven by the conditions in which people are born, live, work, and age (The King's Fund, 2020). Around 80% of health inequalities stem from these wider determinants, which influence an individual's ability to access healthy choices and healthcare services equitably. To address these disparities, Core20PLUS5 is a national NHS England framework designed to guide action on reducing healthcare inequalities at both national and system levels. This approach identifies a target population – the "Core20PLUS" – and highlights five priority clinical areas requiring accelerated improvement. These five focus areas exist separately for adults and children. Governance for these priorities is overseen by national programmes, with national and regional teams working collaboratively to coordinate activity across local health systems and drive progress towards national health equity goals.
The aim for 2025/26	This is a two-year programme which is structured in two phases, focusing on patients with maternity needs and/or severe mental illness. The aim is to enhance clinical care and outcomes by reducing health inequalities.
Our performance	As part of our commitment to reducing health inequalities, we have actively engaged in a range of initiatives: • We are members of the national Ambulance Health Inequalities Group, collaborating on best practices and shared learning. • Our lead for health inequalities is actively engaged with ICB and regional networks, ensuring cross-system collaboration and securing support to advance our work as we establish baseline data. • A clear problem statement and hypothesis have been developed in collaboration with key stakeholders. • We continue to work closely with regional public health boards, staff, and other professional groups to drive progress in this area. • Through the national Ambulance Health Inequalities Group, we are identifying and connecting with others working on similar priorities. • We have developed our own health inequalities mapping tool, which enables us to map, and subsequently track, all the health inequalities work that is happening across the Trust. This mapping is in the final stages.

	• Once the mapping is completed, we will set our priorities for the next 2 years. • We have included health inequalities in all the models of care, ensuring greater equity of access.
Did we achieve this priority	In 2025/26, we built on our progress from the previous year and completed the following: **Maternity Survey Expansion:** The survey was rolled out more widely and the results of the survey were reviewed. • Survey results have informed key skills for 2026/27. • New Trust maternity leaflet developed specifically for tourists, migrants, refugees and asylum-seeking women, providing information on how to access emergency ambulance care and highlighting that this care is free of charge. • Maternity training delivered for EOC staff, both clinical and non-clinical. • The associated key skills programme has increased clinician confidence in administering appropriate analgesia during pregnancy or potential pregnancy, helping to improve pain management, patient experience and the quality of care provided to pregnant patients. **Mental Health Priority Briefing:** A briefing paper was submitted to the patient safety group which provided: • A summary of historical work on mental health and physical health checks • A review of recent data and key findings • A validated and visualised dataset to deepen our understanding of health inequalities in these priority areas.
Actions to be carried forward to 2026/27	• **Key skills delivery** • **Ethnicity Data Collection work:** Adapt the NHS data sheet to make it fit for an ambulance service. • **Complete the Trust-wide health inequalities mapping:** This will allow us to commit to new priorities. • **Continue to work with system partners to reduce health inequalities** within **our region.** **Note:** these have all developed from the Quality Account priority however, they were not planned as part of the original actions.

Looking forward – report on the 2026/27 Quality Priorities

The process of identifying the Quality Account priorities for 2026/27 was robust, inclusive and evidence informed. It drew on multiple sources, including patient and public feedback, staff insight, patient safety incident data, performance metrics, health inequalities information, and alignment with the Trust's strategic objectives.

Engagement with internal and external stakeholders was central to this process. Staff, patients, and public representatives contributed through surveys, focus groups, and engagement sessions, while operational, clinical, and corporate leads provided insight through meetings and written feedback to ensure everyone could participate. The priorities were reviewed at the Patient Safety and Experience Group (PSEG) in December 2025 and at the Quality and Patient Safety Committee (QPSC) in January 2026, ensuring alignment with organisational strategy, national requirements, and patient safety considerations.

Following this process, the Trust has identified the following three Quality Account priorities for 2026/27, each aligned to a primary domain:

- **Patient Safety – Resilient Organisation**
  Building organisational resilience across workforce, operations, leadership, and system partnerships to ensure the Trust can anticipate, adapt, respond, and recover while maintaining safe, high-quality care.
- **Clinical Effectiveness – Falls: Level 1 Response**
  Focusing on timely, compassionate care for patients experiencing falls, reducing harm from prolonged "long lies," improving staff deployment, and strengthening system-wide pathways to support safe alternatives to unnecessary conveyances.
- **Patient Experience – Patient Safety Partners (PSPs)**
  Embedding patient and public voices in governance, improvement, and safety initiatives through the introduction of Patient Safety Partners. This will strengthen co-production, transparency, and learning from patient experience.

These priorities have been selected to target areas of greatest impact for patients and communities, support continuous improvement, and address known risks and themes identified through patient feedback and safety intelligence. They build on the Trust's existing programmes while introducing new initiatives where gaps have been identified.

The table overleaf provides further detail on each priority, including aims, delivery plans, and expected measures of success.

Part 2: Priorities for Improvement and Statements of Assurance from the Board

Domain:	**Patient Safety**
Priority Title:	Resilient Organisation
Why is this a priority?	Organisational resilience is not solely about emergency planning or business continuity; it is about the Trust's collective ability to anticipate, adapt, respond and recover while continuing to deliver safe, high-quality care. True resilience spans workforce wellbeing and capability, operational robustness, leadership behaviours, system collaboration and community partnerships. It requires shared ownership across the whole organisation rather than residing within a single team or function. By making Resilient Organisation a Quality Account priority, the Trust signals that resilience is a strategic, cultural and operational objective - integral to safety, performance and sustainability - and that it will be developed as a whole-Trust endeavour, supported by Quality and organisational development expertise.
Aims and objectives	• Develop a shared organisational definition of resilience across the Trust • Strengthen workforce resilience, including wellbeing, capability and adaptive leadership • Identify and mitigate single points of operational and system vulnerability • Embed business continuity principles within routine governance and improvement activity • Strengthen collaboration with South Central Ambulance Service (SCAS) and wider system partners • Develop community and volunteer resilience links where appropriate • Develop a business case for a dedicated Business Continuity/Resilience Lead
How will we achieve this?	• Co-design the resilience framework with operational, clinical, corporate and Quality teams to ensure whole-Trust ownership • Integrate resilience into governance and QI programmes • Conduct diagnostic assessments and develop mitigation plans • Collaborate with SCAS for shared learning • Engage frontline staff in early problem-solving • Promote resilience culture via Organisational Development (OD) and Comms • Develop proposal for Business Continuity/Resilience Lead

How will we know if we have achieved the quality measure?	• Baseline mapping of organisational vulnerabilities and mitigation plans completed
	• Evidence of early problem identification and resolution
	• Improved staff confidence and understanding of resilience roles (captured via staff surveys)
	• Business Continuity/Resilience Lead case proposal:
	  ○ The need for a dedicated role to oversee business continuity from a system and subject matter expert perspective.
	  ○ Joint procurement of an appropriate business continuity management system.

Domain:	Clinical Effectiveness
Priority Title:	**Falls: Level 1 Response**
Why is this a priority?	Falls among older adults contribute significantly to morbidity and mortality. Delays in response increase risks of hypothermia, dehydration, pressure injuries, and loss of confidence in care. Making Level 1 Falls Response a priority sharpens focus, ensures accountability and demonstrates our commitment to vulnerable patients.
Aims and objectives	• Reduce harm associated with long waits following a fall (e.g., long lies, pressure injuries, dehydration) • Improve patient and carer experience through faster, compassionate care and clear communication • Support staff with improved deployment models • Strengthen system-wide care by reducing unnecessary Emergency Department (ED) conveyances and enabling safe community alternatives
How will we achieve this?	• Implement the AACE Falls Response Framework, using alternative responder models • Optimise use of Community First Responders (CFRs) where appropriate and aligned to operational policy, with a focus on reducing long lies • Collaborate with system partners to develop shared pathways • Deliver targeted staff training • Monitor operational data and gather patient/carer feedback for continuous improvement

How will we know if we have achieved the quality measure?	• Establish baseline for average response time to Level 1 Falls calls (Q1 2026/27)
	• Reduce mean time on floor for patients who have fallen, measured from time of call to arrival of the first responder on scene. Baseline to be established in the initial review, with target reduction confirmed thereafter.
	• Increase appropriate use of alternative responder models, measured by:
	  ○ Percentage of falls-related calls attended by a volunteer responder (e.g., CFR)
	  ○ Number and proportion of falls calls resulting in non-conveyance following volunteer responder attendance
	• Reduction in proportion of patients experiencing prolonged “long lies” (as defined by >1 hour on floor, where recorded)
	• Reduction in avoidable Emergency Department conveyances where safe alternative pathways are available
	• Positive patient and carer feedback regarding timeliness and communication.

Part 2: Priorities for Improvement and Statements of Assurance from the Board

Domain:	Patient Experience
Priority Title:	**Patient Safety Partners**
Why is this a priority?	Patient and public involvement is central to delivering safe, high-quality, and compassionate care. The introduction of Patient Safety Partners (PSPs) aligns with NHS England's Patient Safety Partner Framework and SECAmb's Patient and Public Engagement Strategy. By embedding PSPs within our governance and improvement structures, we will strengthen the voice of patients and the public in safety and quality decision-making. This priority also supports our commitment to transparency, co-production, and continuous learning from patient experience. Our review of current engagement opportunities identified the need for a structured pathway that allows people to participate meaningfully at different levels, from sharing experiences to shaping governance. The hybrid PSP model tailor's involvement to the level of engagement and responsibility. Some roles will be voluntary, for those contributing through specific projects or sharing experiences, while other roles will be paid, reflecting higher responsibility, sustained involvement, or participation in governance forums. This approach ensures inclusivity, progression, and appropriate recognition for all PSPs according to their contribution.
Aims and objectives	• Recruit and onboard 2-3 PSPs by the end of 2026/27 • Embed PSPs in governance and improvement forums • Develop pathways for progression and training • Ensure appropriate support, remuneration and evaluation of impact
How will we achieve this?	• Finalise hybrid PSP role framework aligned with NHS England PSP roles • Develop recruitment, induction, and mentorship programmes • Deliver communications and recruitment campaigns • Embed PSPs in governance and QI activities
How will we know if we have achieved the quality measure?	• 2-3 PSPs active in governance by 2026/27 • Cohort reflects community diversity • Evidence of influence on safety/quality improvements • Positive feedback from PSPs and staff

2.2 Statements of Assurance from the Board

This section of the quality report includes a series of statements of assurance from the Trust Board on particular points of the service, set out by the 'detailed requirements' document provided by NHS England and NHS Improvement. The exact form of each of these statements, as specified by the quality accounts regulations, is laid out below with full details included.

Prescribed information	Form of statement
The number of different types of relevant health services provided or subcontracted by the provider during the reporting period, as determined in accordance with the categorisation of services: (a) specified under the contracts, agreements or arrangements under which those services are provided or (b) in the case of an NHS body providing services other than under a contract, agreement or arrangements, adopted by the provider.	**Provided and/or sub-contracted services** During 2025/26 the South East Coast Ambulance Service NHS Foundation Trust provided and/or subcontracted three relevant health services: 999 Accident and Emergency Services, NHS111 Integrated Urgent Care (IUC) and the Adult Critical Care Transport Service.
The number of relevant health services identified under entry 1 in relation to which the provider has reviewed all data available to it on the quality of care provided during the reporting period.	The South East Coast Ambulance Service NHS Foundation Trust has reviewed all the data available to them on the quality of care in three of these relevant health services.
The percentage that the income generated by the relevant health services reviewed by the provider, as identified under entry 1.1, represents of the total income for the provider for the reporting period under all contracts, agreements and arrangements held by the provider for the provision of, or subcontracting of, relevant health services.	The income generated by the relevant health services reviewed in 2025/26 represents 92% of the total income generated from the provision of relevant health services by the South East Coast Ambulance Service NHS Foundation Trust for 2025/26.
The number of national clinical audits (a) and national confidential enquiries (b) which collected data during the reporting period, and which covered the relevant health services that the provider provides or subcontracts.	**Clinical Audit** During 2025/26 ten national clinical audits and nil national confidential enquiries covered relevant health services that South East Coast Ambulance Service NHS Foundation Trust provides.
The number, as a percentage, of national clinical audits and national confidential enquiries, identified under entry 2, that the provider participated in during the reporting period.	During that period South East Coast Ambulance Service NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.
A list of the national clinical audits and national confidential enquiries identified under entry 2 that the provider was eligible to participate in.	The national clinical audits and national confidential enquiries that South East Coast Ambulance Service NHS Foundation Trust was eligible to participate in during 2025/26 are as follows: All audits are completed and submitted in accordance with national requirements, with 100% of submission deadlines met. In addition to national reporting, all audits are conducted monthly for internal audit reporting purposes, except for the Falls audit, which is carried out quarterly, and the End of Life Care audit, which is a non-recurring audit as of the time of reporting. 1. Return of Spontaneous Circulation (ROSC) at Hospital (All patients) 2. ROSC at Hospital (Utstein) 3. Post ROSC Care Bundle 4. Survival to 30 days (All patients) 5. Survival to 30 days (Utstein) 6. STEMI Care Bundle 7. STEMI Timeliness 8. Stroke Timeliness

	9. Falls Care Bundle 10. End of Life Care Audit
A list of the national clinical audits and national confidential enquiries, identified under entry 2.1, that the provider participated in.	The national clinical audits and national confidential enquiries that South East Coast Ambulance Service NHS Foundation Trust participated in during 2025/26 are as follows: 1. Return of Spontaneous Circulation (ROSC) at Hospital (All patients) 2. ROSC at Hospital (Utstein) 3. Post ROSC Care Bundle 4. Survival to 30 days (All patients) 5. Survival to 30 days (Utstein) 6. STEMI Care Bundle 7. STEMI Timeliness 8. Stroke Timeliness 9. Falls Care Bundle 10. End of Life Care Audit
A list of each national clinical audit and national confidential enquiry that the provider participated in, and which data collection was completed during the reporting period, alongside the number of cases submitted to each audit, as a percentage of the number required by the terms of the audit or enquiry.	The national clinical audits and national confidential enquiries that South East Coast Ambulance Service NHS Foundation Trust participated in, and for which data collection was completed during 2025/26, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. All audits are completed and submitted in accordance with national quality requirements, with 100% of submission deadlines met. In addition to national reporting, all audits are conducted monthly for internal audit reporting purposes, except for the Falls audit, which is carried out quarterly, and the End of Life Care audit, which is a non-recurring audit: 1. Return of Spontaneous Circulation (ROSC) at Hospital (All patients) – 100% 2. ROSC at Hospital (Utstein) – 100% 3. Post ROSC Care Bundle – 100% 4. Survival to 30 days (All patients) – 100% 5. Survival to 30 days (Utstein) -100% 6. STEMI Care Bundle – 100% 7. STEMI Timeliness – 100% 8. Stroke Timeliness -100% 9. Falls Care Bundle – 100% 10. End of Life Care Audit – 100%
The number of national clinical audit reports published during the reporting period that were reviewed by the provider during the reporting period.	The reports of 10 national clinical audits were reviewed by the provider in 2025/26, and South East Coast Ambulance Service NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. 1. The Trust actively engages with the National Audit Technical Guidance Committee along with Yorkshire Ambulance Service, London Ambulance Service and South West Ambulance Service. In 25/26 a new End of Life Care audit was developed. The Trust also participated in discussions regarding possible new national audits in Care of the Newborn. We have also changed the national STEMI care bundle standards. 2. Frequent, in-person feedback between the Health Informatics Leads and Operational Managers continues. This includes representing the team at divisional group meetings. 3. The Health Informatics Team developed an audit dashboard and Newsletter that is sent to all Operating Units so they can identify any non-compliant incidents and/or trends in non-compliance.

	4. Thank You letters are shared with clinicians and Emergency Medical Advisors after their patient survives an Out-of-Hospital cardiac arrest. 5. The Health Informatics Team are expanding a trial with the Critical Care Paramedics to provide feedback to clinicians after a cardiac arrest. Following a successful trial, we aim to roll out across the Trust. 6. The Team continue to improve the Cardiac Arrest Annual Report, celebrating the Trust's high survival rate. 7. Improvement work on the Falls care bundle includes education around the difference between intrinsic and extrinsic falls.
	The reports of 15 local clinical audits were reviewed by the provider in 2025/26, and South East Coast Ambulance Service NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. 1. Audit data has been used to inform the Medicines Administration module on Key Skills training. 2. Audit highlighted trends across multiple audits in the quality of Worsening Care Advice and Safety Netting practices. Work continues with the Deputy Chief Medical Officer to provide further electronic discharge advice.
	3. Developed a training package for advanced clinicians on safe medicines management practices and documentation. 4. An audit of the management of patients with burns injuries was undertaken to assess whether staff were following clinical protocols and documenting care appropriately. The findings informed a staff bulletin and contributed to a review and update of the Trust's Photography and Video Policy, helping to strengthen guidance and support consistent practice across the organisation. 5. A change to the electronic record field so that clinicians can more accurately record the PGD they are using to administer medications. Additions to Key Skills Day four for the care of burns, documentation standards and Consent.
A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.5.	Improvement actions taken this year are: 1. The Trust actively engages with the National Audit Technical Guidance Committee along with Yorkshire Ambulance Service, London Ambulance Service and South West Ambulance Service. In 2024/25 a new falls audit was developed along with a recontact audit. The Trust also audits in respect of End-of-Life care and Care of the Newborn. Following a departmental restructure during 2024/25, frequent, in-person feedback between the Health Informatics Leads and Operational Managers continues. 2. The Health Informatics Team developed an audit dashboard and Newsletter that is sent to all Operating Units so they can identify any non-compliant incidents and/or trends in non-compliance.
The number of local clinical audit (a) reports that were reviewed by the provider during the reporting period.	
A description of the action the provider intends to take to improve the quality of healthcare following the review of reports identified under entry 2.7.	

	3. Thank You letters are shared with clinicians and Emergency Medical Advisors after their patient survives an Out-of-Hospital cardiac arrest. 4. The Health Informatics Team are co-ordinating a pilot with the Critical Care Paramedics to provide feedback to clinicians after a cardiac arrest. Following a successful trial, this is expanding to three sites with the aim to roll out across the Trust. 5. The Team continues to improve the Cardiac Arrest Annual Report, celebrating the Trust's highest ever survival rate. This year, the report was shared with external audiences via the Communications Dept. The reports of 25 local clinical audits were reviewed by the provider in 2024/25. This year, the annual plan focused on the quality of drug administration. Clinical Audit and Medicines Governance have worked closely this year to implement the following improvements: 1. Audit data has been used to inform the Medicines Administration module on Key Skills training. 2. A Patient Group Directions (PGDs) audit tracker has been developed to ensure audits are available during the review phase of a PGD. 3. Audit has improved the wording of PGDs such as removing contradictory exclusions/inclusions, changing sedation management plans and removing the ambiguous term "shocked" from post-ROSC (return of spontaneous circulation) PGDs. 4. Audit results highlighted the practice of seeking "Top Cover" to administer drugs outside of the PGD, leading to a reduction in non-compliance. 5. Audit highlighted that drug box labels were giving patients the wrong dosage information; the labels have now been changed. Audit highlighted trends across multiple audits in the quality of Worsening Care Advice and Safety Netting practices. Work continues with the Deputy Chief Medical Officer to provide further electronic discharge advice.
The number of patients receiving relevant health services provided or subcontracted by the provider during the reporting period that were recruited during that period to participate in research approved by a research ethics committee within the National Research Ethics Service.	**Research & Development** The number of patients receiving relevant health services provided or sub-contracted by South East Coast Ambulance Service NHS Foundation Trust in 2025/26 that were recruited during that period to participate in research approved by a research ethics committee was 344.
Whether or not a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals under the Commissioning for Quality and Innovation (CQUIN) payment framework agreed between the provider and any person or body they have entered into a contract, agreement or arrangement with for the provision of relevant health services. If a proportion of the provider's income during the reporting period was not conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, the reason for this.	**Commissioning for Quality & Innovation (CQUIN)** South East Coast Ambulance Service NHS Foundation Trust income in 2025/26 was not conditional on achieving quality improvement and innovation goals through the Commissioning for Quality and Innovation payment framework because as part of the 2025/26 revenue finance and contracting guidance CQUIN was paused by NHS England and providers were not required to payback any amounts.

If a proportion of the provider's income during the reporting period was conditional on achieving quality improvement and innovation goals through the CQUIN payment framework, where further details of the agreed goals for the reporting period and the following 12-month period can be obtained.	https://www.england.nhs.uk/long-read/revenue-finance-and-contracting-guidance-for-2025/26/
Whether or not the provider is required to register with CQC under Section 10 of the Health and Social Care Act 2008. If the provider is required to register with CQC: (a) whether at end of the reporting period the provider is: i. registered with CQC with no conditions attached to registration ii. registered with CQC with conditions attached to registration (b) if the provider's registration with CQC is subject to conditions, what those conditions are and (c) whether CQC has taken enforcement action against the provider during the reporting period.	**Care Quality Commission (CQC)** South East Coast Ambulance Service NHS Foundation Trust is required to register with the Care Quality Commission, and its current registration status is registered with CQC with no conditions attached to registration. The Care Quality Commission has not taken enforcement action against South East Coast Ambulance Service NHS Foundation Trust during 2025/26.
Whether or not the provider is subject to periodic reviews by the CQC under section 46 of the Health and Social Care Act 2008.	South East Coast Ambulance Service NHS Foundation Trust is subject to periodic reviews by the Care Quality Commission, and the last review took place in September 2025 and November 2025 for our Urgent and Emergency Care and Emergency Operations Centres services. The final reports of these reviews were published on 29 May 2026, and both services received a rating of Good.
	This represents significant progress from previous ratings and provides strong independent assurance that the Trust is delivering safe, effective, caring, responsive and well-led services, reflecting a sustained, organisation-wide improvement journey since 2022 that the Trust is very proud of.
Whether or not the provider has taken part in any special reviews or investigations by CQC under Section 48 of the Health and Social Care Act 2008 during the reporting period. If the provider has participated in a special review or investigation by the CQC (a) the subject matter of any review or investigation, (b) the conclusions or requirements reported by the CQC following any review or investigation, (c) the action the provider intends to take to address the conclusions or requirements reported by the CQC, and (d) any progress the provider has made in taking the action identified under paragraph (c) prior to the end of the reporting period.	South East Coast Ambulance Service NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period. This does not include routine Care Quality Commission inspections undertaken under Section 46 of the Health and Social Care Act 2008, details of which are provided above.
The provider's Information Governance Assessment Report overall score for the reporting period as a percentage and as a colour according to the IGT Grading scheme.	**Information Governance** The South East Coast NHS Foundation Trust Data Security and Protection Toolkit (DSPT) overall score for 2024/25 was Approaching Standards. **Publication history** **Status** — **Date Published** 2024-25 (version 7) - Approaching standards — 30 June 2025 The Trust submitted an improvement plan based on one requirement – Records Management. This has been approved and is currently being progressed.

	The South East Coast NHS Foundation Trust is currently working towards the DSPT for 2025/2026 submission which is due on the 30 June 2026.
Whether or not the provider was subject to the Payment by Results clinical coding audit at any time during the reporting period by the Audit Commission.	**Payment by Results (PbR)** South East Coast Ambulance Service NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2025/26 by the Audit Commission.
If the provider was subject to the Payment by Results clinical coding audit by the Audit Commission at any time during the reporting period, the error rates, as percentages, for clinical diagnosis coding and clinical treatment coding reported by the Audit Commission in any audit published in relation to the provider for the reporting period prior to publication of the relevant document by the provider.	
The action taken by the provider to improve data quality.	**Data Quality** How the Trust is improving quality, safety and system confidence The South East Coast Ambulance Service NHS Foundation Trust has taken the following actions to improve performance and provide assurance to system partners on the quality and safety of its services: ***Clinical oversight and patient safety*** A Clinical Safety Plan (CSP) is used to monitor demand and risk in the 999 system, supported by clear mitigating actions to maintain patient safety. 24/7 clinical navigation is embedded within the clinical stack, with Clinical Safety Navigators responsible for assessing risk and prioritising patients appropriately. Category 2 segmentation and C3/C4 clinical validation ensure patients receive timely clinical assessment and the most appropriate response within national timescales. Five Unscheduled Care Navigation Hubs bring together ambulance, community and acute clinicians to support shared decision-making, reduce avoidable ED conveyance and improve outcomes. ***Continuous improvement and learning*** Quality Improvement projects are in place to support keeping patients safe while waiting to improve inter-facility transfers The Trust applies PSIRF and Incident Review Groups to identify themes and trends from patient safety incidents, providing assurance that improvement actions are in place and risks are escalated appropriately. A strong culture of reporting incidents and risks is maintained across the organisation. ***System working and pathway optimisation*** The Trust works with system partners to optimise referrals to Urgent Community Response and other alternative pathways, ensuring patients are directed to the most appropriate service and system capacity is used effectively. Collaboration across the system supports shared understanding of pressures and coordinated responses to system-wide challenges impacting performance. ***Data, digital and system assurance*** Strengthened data governance arrangements provide clear ownership, agreed definitions and validation of quality and performance metrics prior to internal and system-level reporting.

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	A Data Governance Group provides oversight of data quality, standards and alignment with national guidance, supporting confidence in information shared with the ICB, NHSE and partners. A digital and analytics restructure, supported by the development of a modern data platform, is improving the timeliness, resilience and transparency of insight used to manage quality, patient safety and operational performance. The Trust works in close collaboration with national partners, commissioners and peer trusts to ensure data alignment, consistency of definitions and comparability of metrics across the system.

Learning from Deaths

Note on Data Coverage:

Please note that this report includes data for Quarters 1-3 of 2025/26 and Learning from Deaths (LfD) data from Quarter 4 of 2024/25. This reflects the usual time lag between when patient incidents occur and when full Structured Judgement Reviews (SJRs) are completed.

27.1	The number of its patients who have died during the reporting period, including a quarterly breakdown of the annual figure.	During 2025/26 6022 of South East Coast Ambulance Service NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 1890 in Q4 of 2024/25 1601 in Q1 of 2025/26 1476 in Q2 of 2025/26 1728 in Q3 of 2025/26
27.2	The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.	By 31 March 2026, 130 case record reviews and 27 investigations have been carried out. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 21 in Q4 of 2024/25 18 in Q1 of 2025/26 31 in Q2 of 2025/26 60 in Q3 of 2025/26
27.3	An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.	30 representing 23% of the patient deaths subject to record review during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of: 5 representing 24% for the first quarter; 7 representing 39% for the second quarter; 8 representing 26% for the third quarter; 10 representing 17% for the fourth quarter. These numbers have been estimated using the SJR outcome (Did SECAmb contribute to the death) that has been scored the following per quarter: - 1. Yes - 2. Likely - 3. Probably (>50%)
27.4	A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3.	The prevalent learning across these cases is not individual error, but system reliability: timely response, dynamic triage, effective escalation, and clear communication. Where care was prompt, coordinated, and clinically curious, outcomes, even when fatal, were appropriate and defensible. Where delay and uncertainty dominated, opportunities for survival, dignity, or comfort were lost.
27.5	A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4).	During this reporting period SECAmb has reviewed, and is revising, it's approach to clinical case reviews. Cases where a concern is raised are now systematically subject to clinical case review and outcomes are reviewed within a quality context to ensure appropriate quality processes are undertaken accordingly. SECAmb are also reviewing the data collation to ensure that all four areas required are being captured.
27.6	An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.	The work undertaken during the reporting period has led to a focus on the review of care when concerns have been raised; this has contributed to a rise in the percentage of cases where the outcome was deemed to have been contributed to by SECAmb. This reflects an improvement in process and maturation of approach to ensure meaningful utilisation of case reviews and corresponding quality processes, rather than a reduction in the quality care.

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27.7	The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 27.2 in the relevant document for that previous reporting period.	14 case record reviews and 2 investigations completed after 31/03/2025 which related to deaths which took place before the start of the reporting period.
27.8	An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.	Three representing 21% of the patient deaths subject to case record review before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. These numbers have been estimated using the SJR outcome (Did SECAmb contribute to the death) that has been scored the following per quarter: - 1. Yes - 2. Likely - 3. Probably (>50%)
27.9	A revised estimate of the number of deaths during the previous reporting period stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8.	10 representing 3.7% of the patient deaths during 2025/26 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3 Reporting against Core Indicators

The Ambulance Response Programme (ARP) provides performance targets for call answering and response times to a range of categories of call. These metrics are collated from all ambulance services nationally where the speed of response required is assigned according to clinical need and triage. It is worth noting that the national standard for the Category 2 mean within the Ambulance Quality Indicators (AQI) is 18 minutes.

The table below shows the overall performance against all ARP targets as well as call outcomes between 01 April 2024 and 31 March 2025

	Target		AQI		
Category	Mean	90th Centile	Incidents	Mean	90th Centile
C1	00:07:00	00:15:00	61157	00:08:24	00:15:29
C1T	00:19:00	00:30:00	37872	00:09:45	00:18:06
C2	00:18:00	00:40:00	409731	00:28:51	00:59:06
C3		02:00:00	158074	02:16:13	05:07:00
C4		03:00:00	7158	02:29:04	05:14:40
HCP 1 (C1)			966	00:10:21	00:18:28
HCP 2 (C2)			30435	00:26:15	00:52:25
HCP 3			13200	02:06:30	04:45:53
HCP 4			10574	02:47:14	06:45:42
IFT 1 (C1)			1034	00:10:00	00:19:45
IFT 2 (C2)			15785	00:27:51	00:58:58
IFT 3			6751	02:16:52	05:11:19
IFT 4			1510	02:47:56	06:55:28
HT	All Incidents		112307	14.4%	
ST	All Incidents		238329	30.6%	
SC	All Incidents		429009	55.0%	
Count of Incidents with a Response			667338		
Mean	999 Call Answer 00:05		913382	00:06	
90th centile	999 Call Answer 00:10			00:03	
95th centile				00:40	
99th centile				01:46	
Trust EOC 999 Abandoned Calls			1507	0.16%	
UHU	Calls Answered		1036160		

The table below shows the overall performance against all ARP targets as well as call outcomes between 01 April 2025 and 31 March 2026.

	Target		AQI		
Category	Mean	90th Centile	Incidents	Mean	90th Centile
C1	00:07:00	00:15:00	65332	00:08:17	00:15:22
C1T	00:19:00	00:30:00	40822	00:09:40	00:17:57
C2	00:18:00	00:40:00	406451	00:27:49	00:56:05
C3		02:00:00	168897	02:01:25	04:32:56
C4		03:00:00	7060	02:22:24	04:57:40
HCP 1 (C1)			1352	00:10:58	00:18:59
HCP 2 (C2)			31269	00:26:09	00:52:32
HCP 3			13030	02:23:24	05:37:18
HCP 4			10320	03:07:04	07:38:26
IFT 1 (C1)			1269	00:08:51	00:17:39
IFT 2 (C2)			16079	00:25:25	00:53:48
IFT 3			6965	02:18:31	05:29:51
IFT 4			1285	02:50:46	07:04:14
HT	All Incidents		128570	15.9%	
ST	All Incidents		241746	29.9%	
SC	All Incidents		437460	54.1%	
Count of Incidents with a Response			679206		
Mean	999 Call Answer 00:05		948711	00:04	
90th centile	999 Call Answer 00:10			00:04	
95th centile				00:17	
99th centile				01:24	
Trust EOC 999 Abandoned Calls			1264	0.13%	
UHU	Calls Answered		1070439		

***Response times sourced from publicly available AQI AmbSYS reporting - AmbSYS-Time-Series-to-20260430-QWZX3.xlsx*

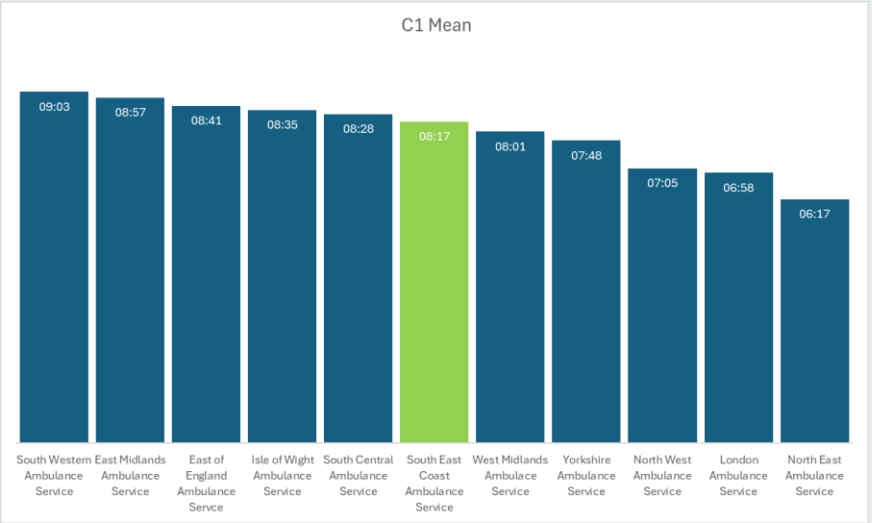
2024/25 vs 2025/26 Comparison

The table below outlines how the Trust's response times have changed from 2024/25 to 2025/26.

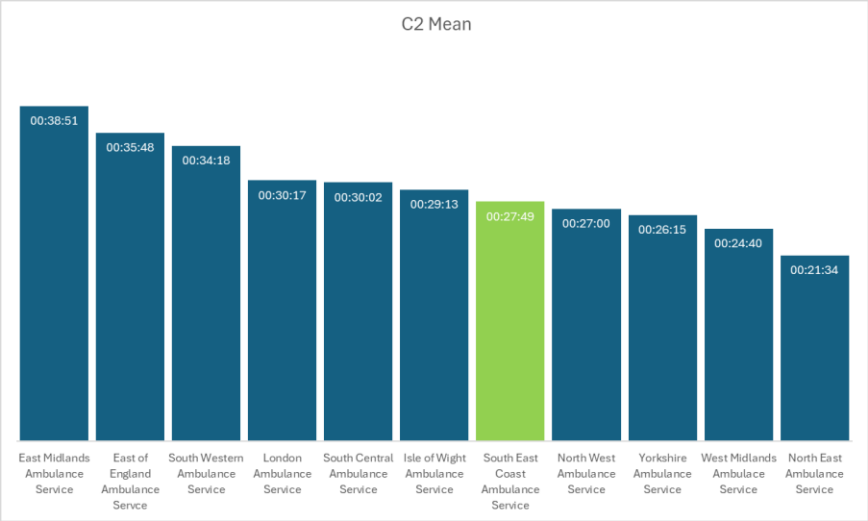
Metric (hh:mm:ss)	National Standard	2024/25	2025/26	Difference
Category 1 Mean	00:07:00	00:08:24	00:08:17	-00:00:07
Category 1 90th Centile	00:15:00	00:15:29	00:15:22	-00:00:07
Category 2 Mean	00:18:00	00:28:51	00:27:49	-00:01:02
Category 2 90th Centile	00:40:00	00:59:06	00:56:05	-00:03:01
Category 3 90th Centile	02:00:00	05:07:00	04:32:56	-00:34:04
Category 4 90th Centile	03:00:00	05:14:00	04:57:40	-00:16:20
Mean 999 Call Answer Time	00:00:05	00:00:06	00:00:04	-00:00:02
90th Centile Call Answer Time	00:00:10	00:00:03	00:00:04	+00:00:01

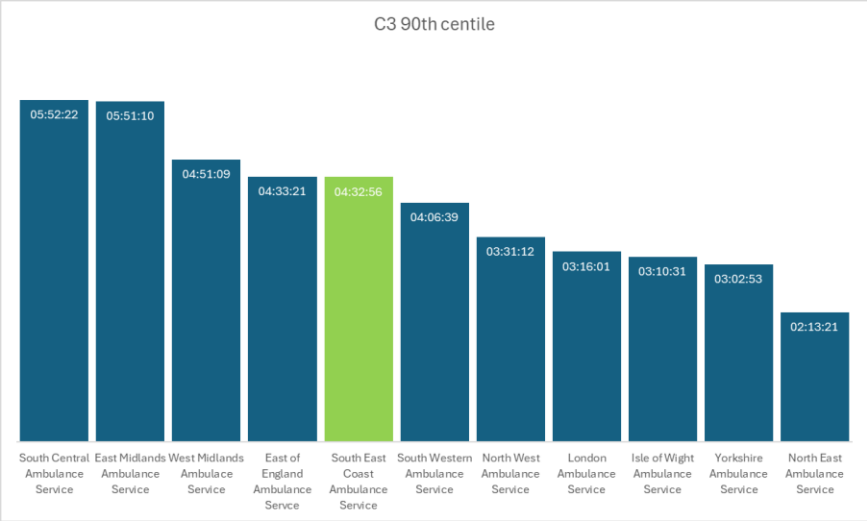
2025/26 National Comparison

The charts below and their associated tables show the comparison between the Trust's response times and peers across England for the 2025/26 financial year.



Category 1 Mean *National Standard: 7 minutes*	**2025/26**
North East Ambulance Service	00:06:17
London Ambulance Service	00:06:58
North West Ambulance Service	00:07:05
Yorkshire Ambulance Service	00:07:48
West Midlands Ambulance Service	00:08:01
South East Coast Ambulance Service	**00:08:17**
South Central Ambulance Service	00:08:28
Isle of Wight Ambulance Service	00:08:35
East of England Ambulance Service	00:08:41
East Midlands Ambulance Service	00:08:57
South Western Ambulance Service	00:09:03





Category 2 Mean *National Standard: 18 minutes*	**2025/26**
North East Ambulance Service	00:21:34
West Midlands Ambulance Service	00:24:40
Yorkshire Ambulance Service	00:26:15
North West Ambulance Service	00:27:00
South East Coast Ambulance Service	**00:27:49**
Isle of Wight Ambulance Service	00:29:13
South Central Ambulance Service	00:30:02
London Ambulance Service	00:30:17
South Western Ambulance Service	00:34:16
East of England Ambulance Service	00:35:48
East Midlands Ambulance Service	00:38:51

Category 3 90th Centile *National Standard: 2 hours*	**2025/26**
North East Ambulance Service	02:13:21
Yorkshire Ambulance Service	03:02:53
Isle of Wight Ambulance Service	03:10:31
London Ambulance Service	03:16:01
North West Ambulance Service	03:31:12
South Western Ambulance Service	04:06:39
South East Coast Ambulance Service	**04:32:56**
East of England Ambulance Service	04:33:21
West Midlands Ambulance Service	04:51:09
East Midlands Ambulance Service	05:51:10
South Central Ambulance Service	05:52:22

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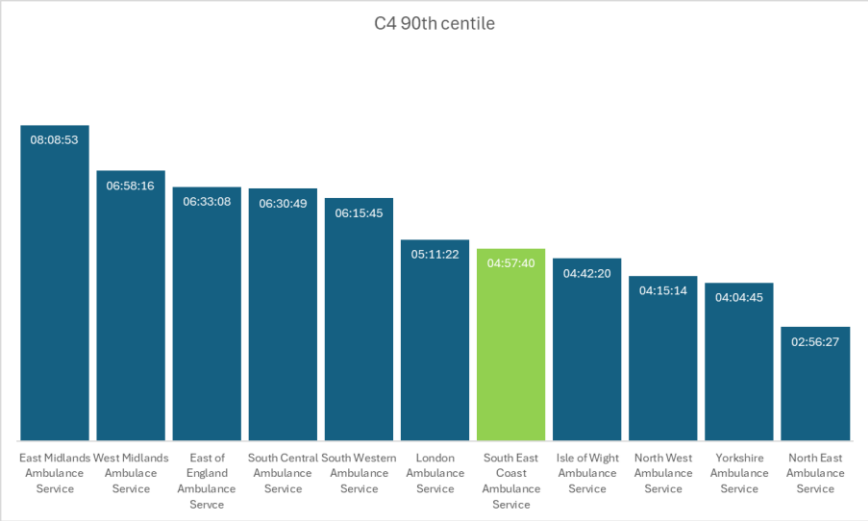


Category 4 90th Centile *National Standard: 3 hours*	**2025/26**
North East Ambulance Service	02:56:27
Yorkshire Ambulance Service	04:04:45
North West Ambulance Service	04:15:14
Isle of Wight Ambulance Service	04:42:20
South East Coast Ambulance Service	**04:57:40**
London Ambulance Service	05:11:22
South Western Ambulance Service	06:15:45
South Central Ambulance Service	06:30:49
East of England Ambulance Service	06:33:08
West Midlands Ambulance Service	06:58:16
East Midlands Ambulance Service	08:08:53

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

- National guidance and definitions for Ambulance Quality Indicators (AQI) submissions to NHS digital when producing category performance information.
- This information is published every month by NHS England.
- This information is reported to the Board of Directors monthly in the integrated Quality and Performance report.
- The data is routinely validated to ensure consistency against the AQI standards.
- Annual external audits have previously confirmed that the C2 mean is being correctly reported against AQI standards and definitions

The South East Coast Ambulance Service NHS Foundation Trust has taken the following actions to improve these indicators, and so the quality of its services, by:

- The Trust strengthened Hear & Treat delivery during 2025/26 through a focused programme to improve clinical productivity, consistency and performance within the Emergency Operations Centre (EOC), supported by enhanced business intelligence, clearer productivity expectations, and structured performance management.
- A targeted improvement approach was implemented for clinicians not meeting Key Performance Indicators (KPIs), with all staff on structured improvement pathways demonstrating measurable performance gains, reflecting effective leadership oversight and workforce development.
- Hear & Treat performance improved across the year, with sustained increases in both overall delivery and individual clinician productivity, reducing variability and demonstrating a more consistent performance profile compared to previous years.
- The virtual care model demonstrated system resilience during periods of atypical demand, including increased lower-acuity call volumes, where patients were safely managed through remote clinical assessment, reducing unnecessary ambulance dispatch.
- Improvement in Hear & Treat outcomes was driven primarily through workforce optimisation, including increased clinical hours and onboarding of operational clinicians into virtual roles, alongside growing clinician confidence in risk management, patient negotiation, and appropriate disposition.

- The Trust has introduced a new Service Delivery Manager (SDM) role to provide 24/7 Trust-wide oversight of operational demand, risk, patient flow and system pressures. The role strengthens tactical leadership, supports faster decision-making, and improves alignment of resource deployment across EOC, 111, field operations and specialist teams.
- The SDM model is designed to complement and support local leadership, reducing duplication, improving communication, and enabling more effective resolution of operational bottlenecks, particularly during periods of escalation and system pressure.
- Early implementation has focused on comprehensive induction and training, ensuring SDMs are equipped to manage complex operational challenges and work collaboratively with divisional teams, supporting coordinated escalation, investigation oversight, and system-wide situational awareness.
- The Trust continued to explore digital and Artificial Intelligence (AI)-supported decision tools to enhance clinical assessment and navigation, with early indications of potential to support earlier risk identification, improved information flow, and increased clinical productivity.
- Increased collaboration between EOC and operational services supported the expansion of virtual care delivery, with renewed focus on onboarding operational clinicians into Hear & Treat roles, strengthening integration and supporting future scalability.
- Workforce capacity remained the key constraint to further Hear & Treat expansion, with actions underway to increase trained clinical hours through enhanced training capacity, revised educational approaches and continued workforce development.
- These improvements form a critical component of the Trust's strategy to increase Hear & Treat rates, improve patient experience, optimise ambulance utilisation, and maintain performance against Category 2 response standards while ensuring patient safety.

ST elevation myocardial infarction (STEMI)

A STEMI occurs when a coronary artery becomes blocked by a blood clot, causing the heart muscle supplied by the artery to die. It belongs to a group of heart conditions known as acute coronary syndromes.

The table below demonstrates the percentage of patients with a pre-existing diagnosis of ST elevation myocardial infarction who received an appropriate care bundle from the Trust during the reporting period. The care bundle includes administration of aspirin, glyceryl trinitrate (GTN), analgesia (pain relief) and the recording of two pain scores. This data is published quarterly by NHS England - in January 2026 GTN administration was removed as a standard in the care bundle.

2024/25 data:

Month	SECAmb Monthly STEMI Care Bundle Compliance	SECAmb Annual Mean Compliance	National YTD Mean Compliance	Highest Monthly National Compliance	Lowest Monthly National Compliance
Apr-24	74.51%	79.35%	78.22%	96.2%	56.8%
May-24	*	79.35%	78.22%		
Jun-24	*	79.35%	78.22%		
Jul-24	75.00%	79.35%	78.22%	96.5%	48.6%
Aug-24	82.03%	79.35%	78.22%		
Sep-24	60.55%	79.35%	78.22%		
Oct-24	67.50%	79.35%	78.22%	95.6%	57.8%
Nov-24	80.00%	79.35%	78.22%		
Dec-24	83.70%	79.35%	78.22%		
Jan-25	86.40%	79.35%	82.6%	97.2%	63.0%
Feb-25	88.37%	79.35%	82.6%		
Mar-25	93.75%	79.35%	82.6%		

**STEMI care bundle cases total from 10 months due to restructure in early 2024. National months (April and July) prioritised and submitted.*

2025/26 data:

Month	SECAmb Monthly STEMI Care Bundle Compliance	SECAmb Annual Mean Compliance	National Annual Mean Compliance	Highest Monthly National Compliance	Lowest Monthly National Compliance
Mar-25	93.75%	79.35%	78.22%		
Apr-25	93.20%	89.1%	82.6%	95.3%	49.2%
May-25	86.40%	89.1%	82.6%		
Jun-25	84.20%	89.1%	82.6%		
Jul-25	90.80%	89.1%	82.6%	98.4%	63.8%
Aug-25	83.10%	89.1%	82.6%		
Sep-25	88.80%	89.1%	82.6%		
Oct-25	87.30%	89.1%	82.6%	98.4%	63.0%
Nov-25	86.10%	89.1%	82.6%		
Dec-25	91.10%	89.1%	82.6%		
Jan-26	95.50%	89.1%		Yet to be published	Yet to be published
Feb-26	94.00%	89.1%			
Mar-26					

Data Quality

The South East Coast Ambulance Service NHS Foundation Trust (SECAmb) considers that this data is as described because both paper and electronic care records are included in the audit sample.

Actions being taken

The South East Coast Ambulance Service NHS Foundation Trust has taken the following actions to improve this number, and so the quality of its services, by:

- A deep dive into the reason for non-compliance found that the most common areas of non-compliance continue to be the administration of analgesia and the documentation of two pain scores. This part of the care package needs to be balanced against the need to keep on scene times short.
- Joint Royal Colleges Ambulance Liaison Committee (JRCALC) to review Acute Coronary Syndrome (ACS) national guidelines to simplify analgesia guidance.
- Operational Unit (OU) level data on STEMI is being circulated to OUs and feedback to OUs is now in action, already showing a positive impact on compliance numbers as demonstrated from July 2024 onwards.
- Performance has improved further to operational engagement and more audit feedback; STEMI compliance remains highly performing.

The annual data set, at the time of writing this report, is incomplete as NHS England submissions are three months in arrears. Therefore, full analysis and interpretation cannot be completed until all data is validated. It is expected that the full data set will be available by the end of July 2026, which will then require validation, analysis and reporting. This is in-line with national targets.

End of Life Audit

In May 2024, National Ambulance Service Medical Directors Group (NASMeD) and NHS England approved the introduction of an annual programme of national clinical audits, to replace the Stroke diagnostic bundle Ambulance Clinical Quality Indicator (ACQI).

The second national audit, for 2025/26, would look at End of Life Care patients and be based upon the standards agreed by the National Technical Subgroup in collaboration with the Ambulance End of Life Care Leads.

Members of the National Ambulance Service Clinical Quality Group (NASCQG) agreed to select the month of January 2026, and all patients coded as End-of-Life Care were in the sample. A maximum of 300 incidents were audited, examining the clinical assessment, interventions, shared decision-making to support non-conveyance and symptom relief provided to these patients. It was agreed that the London Ambulance Service Trust would support the data collection and analysis. 300 cases were identified by SECAmb, they were audited against the national standards by the Health Informatics Team and submitted as per the national schedule. At the time of writing, the results are still being analysed by the London Ambulance Service, the draft report is expected in June 2026.

Falls

This table demonstrates the percentage of patients aged 65 and over who have had a fall from less than two meters, who received an appropriate care bundle. This data is published quarterly by NHS England.

2024/25 data:

Month	SECAmb Monthly Falls Care Bundle Compliance	SECAmb Annual Mean Compliance	National Annual Mean Compliance	Highest Monthly National Compliance	Lowest Monthly National Compliance
Mar-24					
Apr-24					
May-24					
Jun-24	33.0%	39.3%	44.9%	88.0%	17.7%
Jul-24					
Aug-24					
Sep-24	40.7%	39.3%	44.9%	90.7%	20.3%
Oct-24					
Nov-24					
Dec-24	44.3%	39.3%	44.9%	95.3%	16.0%
Jan-25					
Feb-25					
Mar- 25	41.6%	39.3%	44.9%	91%	19.6%

2025/26 data:

Month	SECAmb Monthly Falls Care Bundle Compliance	SECAmb Annual Mean Compliance	National Annual Mean Compliance	Highest Monthly National Compliance	Lowest Monthly National Compliance
Mar-25					
Apr-25					
May-25					
Jun-25	43.0%	43.7%	52.3%	92%	20.3%
Jul-25					
Aug-25					
Sep-25	46.3%	43.7%	52.3%	94%	21%
Oct-25					
Nov-25					
Dec-25	41.3%	43.7%	52.3%	Not yet published	Not yet published
Jan-26					
Feb-26					

Data Quality

The South East Coast Ambulance Service NHS Foundation Trust considers that this data is as described because both paper and electronic care records are included in the audit sample.

Improvement activities for this audit are relatively new as it is a new audit. We have seen a steady improvement in compliance over the year, and the Health Informatics Team will continue to concentrate on this audit for the 2026/27 year.

Actions being taken

The South East Coast Ambulance Service NHS Foundation Trust has implemented the following actions to enhance compliance with the Falls Care Bundle and improve overall service quality:

- Providing feedback to Operating Units with guidance on the standards requiring improvement and actively working to address areas that fall below compliance trends.

- Adding care elements to the Health Informatics Newsletter.
- Providing information about AQIs as part of the Key Skills Curriculum.
- A deep dive into the reasons for non-compliance suggest that there is a lack of understanding about the difference between intrinsic and extrinsic factors. This has been addressed as part of Key Skills and via an infographic disseminated across the Trust and during operational visits.
- SECAmb have been given permission by the National Group to amend the standards to reflect local falls protocols, a local falls guide will be developed this year, with approvals from National and Local governance channels.

Return of Spontaneous Circulation (ROSC) after cardiac arrest

This table demonstrates the percentage of patients, where return of spontaneous circulation (ROSC) was achieved following a cardiac arrest, who received an appropriate care bundle. This data is published quarterly by NHS England.

2024/25 data:

Month	SECAmb Monthly ROSC Care Bundle Compliance	SECAmb YTD Mean Compliance	National YTD Mean Compliance	Highest Monthly National Compliance	Lowest Monthly National Compliance
Mar-24	*73.56%*	*72.80%*	*77.06%*		
Apr-24	71.91%	77.3%	83.69%		
May-24	84.15%	77.3%	83.69%	98.5%	66.7%
Jun-24	81.48%	77.3%	83.69%		
Jul-24	86.17%	77.3%	83.69%		
Aug-24	75.26%	77.3%	83.69%	100.0%	70.8%
Sep-24	76.83%	77.3%	83.69%		
Oct-24	70.33%	77.3%	83.69%		
Nov-24	86.90%	77.3%	83.69%	94.8%	60.0%
Dec-24	73.33%	77.3%	83.69%		
Jan-25	74.1%	77.3%	83.69%		
Feb-25	80.8%	77.3%	83.69%	98.3%	70.3%

2025/26 data:

Month	SECAmb Monthly ROSC Care Bundle Compliance	SECAmb YTD Mean Compliance	National YTD Mean Compliance	Highest Monthly National Compliance	Lowest Monthly National Compliance
Mar-25	*69.4*	*77%*	*83.69%*		
Apr-25	75.9%	77%	81.1		
May-25	77.7%	77%	81.1	100%	67.8%
Jun-25	77.3%	77%	81.1		
Jul-25	75.6%	77%	81.1		
Aug-25	76.7%	77%	81.1	93.8%	40.9%
Sep-25	72.9%	77%	81.1		
Oct-25	78.4%	77%	81.1		
Nov-25	81.4%	77%	81.1	Not yet published	Not yet published
Dec-25	*				
Jan-26	*				
Feb-26	*				

**Cardiac arrest audit data runs 3 months in arrears, SECAmb continue to meet all national auditing deadlines.*

Data Quality

The South East Coast Ambulance Service NHS Foundation Trust (SECAmb) considers that this data is as described because both paper and electronic care records are included in the audit sample.

Actions being taken

The South East Coast Ambulance Service NHS Foundation Trust has taken the following actions to improve this number, and so the quality of its services:

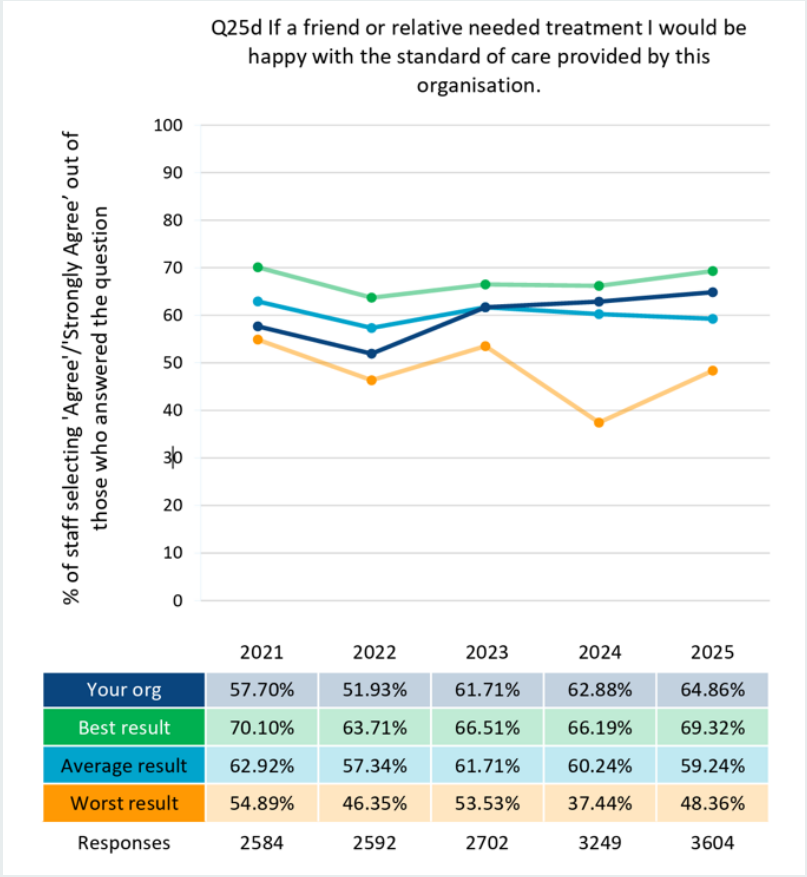
- The 2024/25 Annual Cardiac Arrest Report is due to be circulated in Q1 of 2026/27.
- The data shows that SECAmb's post ROSC care bundle remains below national averages. However, this is not affecting patient outcome indicators; ROSC at hospital performance remains 1% above national averages and patient survival remains over 2% above the national average. The reporting of the bundle requires clinicians to document the care they've provided. The figures show that ROSC and patient survival is stable, if not, improving and so it is likely that this dip in performance is due to lack of documentation rather than lack of clinical care. SECAmb is contributing to improvement work at national level, looking at the efficacy and limitation of the care bundle. The Trust has worked closely with the Cardiac Arrest Outcome Improvement Board and Operating Units to understand the barriers facing clinicians and will await national changes before implementing local improvement work.

The annual data set, at the time of writing this report, is incomplete as NHS England submissions are three months in arrears. Therefore, full analysis and interpretation cannot be completed until all data is validated. It is expected that the full data set will be available by the end of June 2025, which will then require validation, analysis and reporting. This is in-line with national targets.

Staff survey results

The percentage of staff employed by, or under contract to, the Trust during 2025/26 who would recommend the Trust as a provider of care to their family or friends was 64.89%. This is an improvement of nearly two per cent compared to 2024/25 and above the sector average score of 59.24%.

The graph below shows the organisation's score against the national average.



	2021	2022	2023	2024	2025
Your org	57.70%	51.93%	61.71%	62.88%	64.86%
Best result	70.10%	63.71%	66.51%	66.19%	69.32%
Average result	62.92%	57.34%	61.71%	60.24%	59.24%
Worst result	54.89%	46.35%	53.53%	37.44%	48.36%
Responses	2584	2592	2702	3249	3604

Data Quality

The South East Coast Ambulance Service NHS Foundation Trust considers that this percentage is as described for the following reasons:

- Survey is independently administered by an external body
- It is conducted confidentially and is anonymised
- The survey is scored and weighed to ensure consistent interpretation of results
- The survey is benchmarked and compared with the sector and with wider NHS organisations.

Actions being taken

The South East Coast Ambulance Service NHS Foundation Trust has taken / intends to take the following actions to improve this percentage, and so the quality of its services:

- Introduce a framework to ensure that Trust has assurance of acting on feedback provided by the survey
- Review the new clinical operational model brought in to provide greater local autonomy benefits staff
- Ensure that the staff survey results align on the delivery key strategic objectives set out in our five-year strategy
- Roll out wellbeing strategy that aims to improve work/life balance
- Roll out a values and behaviour framework
- Continue to deliver on its recognition framework.

Patient Safety Incidents

The number of Patient Safety Incidents (PSIs) reported within the Trust during 2025/26 was 4,475 and the number of such PSIs that resulted in severe harm or fatal outcomes was 51 (1.14%). The table below shows this data in comparison to 2023/24 and 2024/25.

While there was a total of 7,934 reported incidents affecting patients, only 4,475 of these met the definition of a Patient Safety Incident (PSI) under the Patient Safety Incident Response Framework (PSIRF).

PSIRF defines a PSI as an event that could have or did result in unintended or unexpected harm to one or more patients. Not all reported incidents meet this threshold; many involve no risk of harm, expected outcomes, or administrative issues that do not impact patient safety.

This distinction reflects the shift under PSIRF from counting all incidents to focusing on those that offer opportunities for compassionate, system-based learning to improve care and reduce future risk.

It should also be noted that national guidance relating to harm grading was updated during 2024/25 as part of the continued implementation of PSIRF. NHS England revised the definitions used to categorise patient harm, including replacing the term death with fatal. Under the revised guidance, a fatal outcome should be recorded where a patient has died and the reported incident may have contributed to that death at the time of reporting. These changes in classification and reporting practice may have influenced the number of incidents recorded as severe harm or fatal outcomes and should be considered when comparing data across reporting periods.

Reporting period	Number of Patient Safety Incidents reported in SECAmb	Number of Patient Safety Incidents that resulted in severe harm or death
2023/24	3,496	31 (0.9%)
2024/25	4,578	37 (0.8%)
2025/26	4,475	51 (1.14%)

Data Quality

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

- Monitoring of data reported on Datix
- Information from the Integrated Quality Report (IQR)
- Data reporting to the Learning from Patient Safety Events (LFPSE) service
- Ongoing review and refinement of incident classification in line with the Patient Safety Incident Response Framework (PSIRF), including the introduction of an initial assessment checklist to support consistent identification and recording of patient safety incidents.

Actions being taken

The South East Coast Ambulance Service NHS Foundation Trust has taken the following actions to improve this number, and so the quality of its services, by:

- Ongoing development and refinement of incident reporting processes, including improved classification, enhanced data quality, and timely closure of patient safety investigations.
- Rebuilding the Trust's patient safety incident reporting digital infrastructure to improve the reliability, usability, and quality of data used to support organisational learning.

Part 2: Priorities for Improvement and Statements of Assurance from the Board

- Embedding the Patient Safety Incident Response Framework (PSIRF) to support a proportionate, compassionate, and learning-focused approach to incident management.
- Commissioning learning responses through system-led incident review groups to strengthen shared learning and cross-system improvement.
- Appointment and development of Patient Safety Partner roles to strengthen patient voice, lived experience, and independent insight within patient safety governance structures.
- Refreshing complaints policies and processes to improve accessibility, responsiveness, and the use of patient feedback to inform safety improvement.
- Triangulating themes across incidents, complaints, claims, risks, and learning from deaths to identify recurring issues, strengthen organisational insight, and support continuous improvement.
- Reinforcing systems used to monitor the effectiveness, implementation, and sustainability of patient safety mitigations and improvement actions.
- Delivering additional investigator training to improve the quality, consistency, and impact of patient safety investigations and learning responses.
- Initiating a Trust-wide human factors awareness programme to strengthen understanding of system-based safety and support a culture of continuous learning.
- Maintaining compassionate engagement and involvement with patients, families, carers, and staff affected by patient safety incidents.

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NHS Foundation Trust

Part 3:

Other Information

Part 3 of the quality account is an opportunity to share other aspects of quality from across the Organisation that have not already been discussed. This includes any other information relevant to the quality of health services provided or subcontracted during the reporting period.

The information will be presented as a number of indicators within the following sections:

- **Freedom to Speak Up (FTSU)**
- **Patient Safety**
- **Clinical Effectiveness**
- **Patient Experience**

Freedom to Speak Up (FTSU)

At South East Coast Ambulance Service NHS Foundation Trust (SECAmb), the Freedom to Speak Up (FTSU) team operates independently to support and promote a culture where speaking up is recognised as a vital part of delivering safe, effective, and compassionate care. The team continues to play a key role in fostering an environment where all staff feel empowered and safe to raise concerns, confident that their voices will be heard and valued.

The FTSU Guardian maintains direct access to the Trust Board through regular engagement with the Chief Executive Officer and presents formal reports on a bi-annual basis. The service is led by the Chief Nursing Officer, with additional support from a designated Non-Executive Director, ensuring strong oversight and governance.

The FTSU team comprises a full-time Lead Guardian and two full-time Guardians. Together, they work in close collaboration with local leadership across the organisation, using data-driven insights to support continuous improvement and ensure barriers to speaking up are addressed and removed. A bespoke dashboard continues to support the monitoring of FTSU activity and trends, enabling targeted engagement with services to identify emerging themes and provide focused support.

Concerns raised to FTSU Team by Year/Quarter:

2021/22	Total FTSU Concerns	2022/23	Total FTSU Concerns	2023/24	Total FTSU Concerns	2024/25	Total FTSU Concerns	2025/26	Total FTSU Concerns
Q1	19	**Q1**	20	**Q1**	46	**Q1**	90	**Q1**	66
Q2	19	**Q2**	35	**Q2**	51	**Q2**	55	**Q2**	45
Q3	60	**Q3**	52	**Q3**	62	**Q3**	99	**Q3**	68
Q4	46	**Q4**	60	**Q4**	69	**Q4**	53	**Q4**	50
Total	**144**	**Total**	**167**	**Total**	**228**	**Total**	**297**	**Total**	**229**

During 2025/26, a total of 229 concerns were raised through the FTSU service. This represents a reduction compared to the previous reporting period. It is important to recognise that fluctuations in reporting volumes can reflect a range of factors, including increased confidence and capability within local leadership to address concerns early, as well as continued embedding of a 'speak up, listen up, follow up' culture across the organisation.

Rather than viewing reporting levels in isolation, the Trust continues to focus on the quality of concerns raised, the timeliness and effectiveness of responses, and the extent to which learning and improvement are achieved. The FTSU service remains a key safety net, providing an alternative route where staff do not feel able to raise concerns through other channels.

Staff can raise concerns through a range of accessible channels, including a dedicated team email, direct contact with a Guardian, an anonymous online form via the staff intranet, or in person. Information on how to contact the FTSU team continues to be widely promoted across the Trust through the intranet, workplace materials, and engagement activities, including participation in national FTSU awareness month.

The FTSU team continues to engage actively with staff at all levels, attending Trust sites, team meetings, university sessions, and local events to promote the importance of speaking up and to build trust and visibility. The service also contributes to wider organisational learning by triangulating FTSU data with information from serious incidents, HR metrics, and staff feedback, including NHS Staff Survey results and local engagement insights.

This approach supports early intervention and helps to identify and address cultural and systemic issues that may impact both staff experience and patient safety.

SECAmb continues to see sustained improvement in staff confidence to speak up, as evidenced through national NHS Staff Survey results over recent years. This reflects the ongoing commitment across the organisation to nurture an open, inclusive culture where all staff feel safe, supported, and heard.

3.1 Our Indicators

Patient Safety

Indicator 1: A Human Factors and Ergonomics Approach to Improving Safety in the Back of Ambulance

In 2025, the Trust launched the Safe in the Back programme to improve the safety of both patients and staff when travelling in the rear of an ambulance. This work was prompted by several safety incidents, including occasions where patients were not fully secured during transfer, and equipment moved unexpectedly during journeys. These incidents reflect a longstanding national concern across ambulance services about seatbelt use, equipment storage and the physical design of ambulance interiors.

To understand this risk differently, the Trust adopted a Human Factors and Ergonomics (HFE) approach. This method focuses on how real work happens in practice, known as *work-as-done*, rather than how tasks are imagined in policy. National evidence shows ambulance clinicians frequently adapt procedures to manage real-world conditions such as limited space, urgent clinical needs and unpredictable patient behaviours.

Using Walk-Through Talk-Through to Understand Real Work

To explore this further, the Trust conducted Walk-Through Talk-Through (WTTT) assessments with staff across three Operating Units. This is an HFE method where staff demonstrate tasks step-by-step while explaining what helps or hinders safe practice. It highlights issues that may not be visible in written policies, such as, the layout of equipment, physical reach and the challenges of working while vehicles are moving.

Staff consistently reported that they understood when restraints and seatbelts should be used, but environmental constraints made this difficult at times. Examples included trailing straps that caught on equipment, difficulty reaching patients while seated and secured, tangled cables from monitors, and inconsistent layouts between vehicles.

These findings showed that instances where restraints were not used were usually system-related, not due to staff attitudes. This insight aligns with national literature, which highlights a gap between *work-as-prescribed* and *work-as-done* in many safety-critical settings.

What Has Improved So Far

The Task & Finish Group reviewing these findings has delivered several early improvements:

- **System-level mitigations** have been introduced, including new solutions for securing gas cylinders to reduce reliance on improvised storage.
- **Seatbelt extenders** have been purchased to support the safe conveyance of larger patients.
- **A new, lighter defibrillator** with a stretcher-mounted control panel has been procured to reduce manual handling risks and equipment movement.
- **A communications campaign** focused on safe behaviours is being rolled out, shaped by behavioural insights from the HFE study.

Compliance data shows early signs of improvement. In 2024/25, 1,824 checks identified 52 cases of non-compliance (2.9%). In 2025/26 to date, 738 checks found 9 cases (1.2%). While fewer checks have taken place this year, the trend is positive, and a new dashboard is being developed to provide clearer oversight.

National Work

This work aligns with a national programme led by the Association of Ambulance Chief Executives (AACE), which have also identified inconsistent restraint use and design-related barriers to rear-compartment safety. The Trust is now an active member of the national Safe in the Back group, contributing local insights and learning.

Looking Ahead

Further work will include visual guides for patient restraints, simulation-based training and a technology trial of seatbelt alert systems in 2026.

By taking a Human Factors and Ergonomics approach, the Trust has gained a deeper understanding of the real-world factors that affect patient safety in ambulances. This has already led to meaningful improvements and is helping build a safer system for both patients and staff.

Indicator 2: Community First Responder (CFR) Dispatches to Cardiac Arrests

Community First Responders (CFRs) are a critical part of the early response to out-of-hospital cardiac arrest, providing rapid, life-saving interventions while ambulance resources are enroute. During 2024/25, we have continued to strengthen our approach to CFR dispatch, by increasing availability, improving activation processes, and maximising the proportion of cardiac arrests receiving an early community response.

In 2024/25, the Trust achieved its second highest ever cardiac arrest survival rate, with 11.4% of patients surviving to 30 days post-resuscitation, an improvement from 9.5% in 2022/23. This reflects the combined impact of early recognition, rapid response, and high-quality clinical care. CFRs play an important role within this “chain of survival,” particularly in delivering early cardiopulmonary resuscitation (CPR) and defibrillation.

The importance of early intervention is well established. Survival from cardiac arrest decreases by approximately 10% for every minute without CPR or defibrillation. By contrast, prompt action in the first few minutes can significantly improve outcomes. CFRs, as locally based volunteers, are often able to reach patients ahead of ambulance crews, particularly in rural areas or during periods of high demand, helping to reduce time to first intervention.

Over the past year, we have seen continued growth in CFR utilisation, despite the number of volunteers remaining relatively static, through system improvements and increased focus on the benefits of CFR mobilisation. Enhancements to dispatch processes have enabled more consistent and timelier mobilisation of CFRs to suspected cardiac arrests, ensuring they are deployed alongside statutory resources where appropriate. In addition, ongoing work to refine call triage and activation criteria has helped to improve the accuracy and timeliness of dispatch.

Moving forwards, the launch of a new Volunteering and Community Resilience Strategy will help to continue increasing the utilisation of community-based volunteers as a first response to cardiac arrests. In particular, we aim to target recruitment of volunteers to areas of highest need, in order to reduce the impact of health inequalities which means that currently patients in areas of social and economic deprivation experience poorer cardiac arrest outcomes. Targeted recruitment, alongside ongoing work to support public education in CPR, aims to increase both the likelihood and quality of CPR prior to ambulance arrival and in doing so save more lives.

We also plan to launch a new volunteer role, the Community Lifesaver, which specifically focuses on cardiac arrest survival. By minimising the time commitment required whilst providing focused and appropriate training and support, we aim to increase the number of volunteers available at any time to respond to cardiac arrests within each community.

Finally, we will continue to develop our processes to minimise delay in CFR dispatch, by identifying appropriate calls earlier, remove perceived or actual barriers to CFR mobilising, utilising technology to speed up the information flow to support rapid arrival at scene, and take a data-driven approach to the location of CFR recruitment to ensure sufficient numbers of volunteers in the highest risk areas. Feedback from CFRs and learning from incidents will continue to inform improvements in both operational practice and volunteer experience.

Indicator 3: Response Times to Patients who have Fallen

The aging population presents a significant healthcare challenge, with falls and frailty being major contributors to morbidity and mortality among older adults. Recognising this, the Trust has prioritised the development of a comprehensive plan to ensure that people who have fallen are responded to with the most appropriate resource, in the quickest timeframe. The aim is to address the unique needs of this patient demographic, ensuring timely and effective care delivery to improve outcomes and enhance quality of life.

Currently, the Trust manages a high volume of falls cases. Services are often reactive, leading to avoidable conveyances and hospital admissions. Many of these patients are already known to other local community health and social care providers.

By focusing on prevention, assessment, treatment and ongoing management of falls. We aim to:

- Promote **independence and dignity** for older adults.
- Enhance **triage, virtual consultations and alternative care pathways**.
- Strengthen **collaborative working across the integrated care system (ICS).**
- Reduce **unnecessary hospital conveyance**.
- Deliver **person-centred care** that addresses the **physical, cognitive and psychosocial aspects of aging.**

Part 3: Other Information

What Has Improved So Far and what do we need to do more of

The Falls Task & Finish Group[1] have been working hard to implement the following changes, based on best practice:

- **Reduction in ambulance attendance to non-injury falls calls –** We have worked with our telephone (virtual) clinicians to ensure early assessment by a registered clinician and streaming to the most appropriate falls service. We have increased our hear and treat [2]percentage by 0.8% for non-injury falls calls to 10.6%. We hope to continue seeing improvements.

- **Increase of utilisation of Community First Responders (CFRs) for non-injury falls calls –** We have continued to train our CFR colleagues in the assessment and management of non-injury falls. If they arrive first on scene, they can assist people up off the floor and arrange a virtual consultation by one of our clinicians. We have increased our incidents where a CFR is first on scene to 3.6%. As we continue with this training, we will see more incidents where a CFR is first on scene.

- **Reduction in long lies -** We have **r**educed our response times to patients who have fallen by 10% C3 & C4 mean.

National Work

This work aligns with a national programme led by the Association of Ambulance Chief Executives (AACE), which highlighted how Ambulance trusts should be responding to people who have fallen.

The overarching direction of travel in healthcare emphasises a shift towards person-centred, integrated and preventive care. National policies and guidelines provide strategic direction and priorities for healthcare organisations. These drivers emphasise:

- Proactive management of frailty and falls
- Collaboration across healthcare sectors
- Optimising resources to improve outcomes and experiences

Relevant Documents:

- NHS Long Term Plan (2019)
- National Institute for Health and Care Excellence (NICE) Guidelines:
- Integrated Care Systems (ICS) Framework
- Ageing Well: A National Service Framework for Older People (2001)
- Better Care Fund (BCF) Guidance
- Association of Ambulance Chief Executives Falls Response Guidance

[1] Task and finish group is a short-term working group set up to complete a specific piece of work or solve a particular problem.

[2] Hear and treat means a patient receives clinical assessment, advice and/or onward referral over the phone, without an ambulance being dispatched or the patient being physically seen by a crew.

Clinical Effectiveness

Indicator 1: Cycle Response Unit Trial

As part of our commitment to improving response times and patient outcomes, we continue to explore innovative ways to support our Community First Responders (CFRs) in reaching patients quickly and safely.

During 2025 we have developed a Cycle Response Unit pilot through SECAmb's Innovators Den[3]. The initiative focuses on the use of electrically assisted bicycles (e-bikes) to respond to patients, particularly during periods of high demand when road congestion can delay traditional vehicle-based responses.

The pilot is based on the Manhood Peninsula in West Sussex, a semi-rural coastal area with a resident population of approximately 25,000. During the summer months, this population increases significantly due to tourism, placing additional strain on local infrastructure. Access to the peninsula is limited to a small number of routes, including narrow causeways, which can become heavily congested and present challenges for both ambulance crews and volunteer responders travelling by car.

The introduction of e-bikes offers a practical and innovative solution to these challenges. E-bikes enable CFRs to navigate traffic more efficiently, access areas that may be difficult to reach by car and respond more quickly to patients. Importantly, they can be used safely in line with the Highway Code and are equipped to carry essential clinical equipment, including an automated external defibrillator (AED), oxygen, and patient assessment tools. This allows CFRs to provide immediate, potentially life-saving care while awaiting the arrival of an ambulance resource.

A nine-month pilot scheme has been launched to evaluate the effectiveness of this approach. The evaluation will consider a range of factors, including response times, patient outcomes, volunteer experience, and operational feasibility. Learning from the pilot will inform future decisions about whether this model can be adopted more widely across the Trust.

In addition to improving response times and patient experience, the Cycle Response Unit also supports wider organisational objectives. The use of e-bikes represents a more environmentally sustainable mode of transport, contributing to a reduction in the Trust's carbon footprint. It also increases accessibility for volunteers, providing opportunities for individuals who may not be able to drive but are able to respond using a bicycle.

This pilot reflects our broader strategic ambition to develop innovative, flexible, and community-based approaches to care. By supporting CFRs with new and effective ways to reach patients, we aim to deliver faster interventions, improve outcomes, and enhance the overall experience for the communities we serve.

Indicator 2: Cardiac Arrest Feedback Pilot

When someone experiences a cardiac arrest, their heart stops beating and blood can no longer circulate around the body. It is the most serious medical emergency, and immediate, high-quality treatment is vital.

In England 2024/25, ambulance services attempted resuscitation in nearly 33,000 cases. At South East Coast Ambulance Service NHS Foundation Trust (SECAmb), clinicians attempted resuscitation for 2,839 patients. Survival from out-of-hospital cardiac arrest varies around the world, from less than 5% to more than 25%. In England, fewer than one in ten people survive for 30 days after their cardiac arrest. SECAmb currently has a survival rate of 11.4%, the second-highest of any ambulance service in the country.

While many factors influence survival, the quality and consistency of care delivered by clinicians plays a crucial role. For this reason, SECAmb has launched a Cardiac Arrest Feedback Trial to support crews and strengthen patient outcomes.

What the Trial Involves

The project provides clinicians with personalised feedback on key aspects of a resuscitation attempt, including:

- Initial rhythm
- CPR rate
- Proportion of time spent performing compressions
- Pauses during CPR
- How and when defibrillation was delivered
- Administration of cardiac arrest drugs

[3] **Innovators Den**: programme that aims to showcase innovative quality improvement ideas from staff. The event sees innovators pitching their project proposals to a panel of peers in a "Dragon's Den" style event. The panellists include colleagues from across the Trust - front line operational staff and managers, contact centre leaders, Information Technology (IT), Finance, Critical Care, Community responders and a patient representative.

The feedback is delivered via email from a local, senior clinician, with the opportunity for face-to-face follow-up if either side deem it necessary or specifically beneficial. The aim is to help crews reflect on what went well and identify opportunities to further improve the care they provide during the most critical moments.

Protecting Patient Information

Because this trial involves using patient data in a new way, SECAmb has put strict systems in place to ensure confidentiality. All processes have been reviewed and approved by our Information Governance team.

Where We Are Now

The trial began at one site in October 2024, and following a review in June 2025, it expanded to two more sites – covering Surrey, Sussex and Kent.

Feedback from clinicians has been extremely positive. Crews report that the process helps them sharpen their focus during the initial stages of patient care. Early data also suggests improvements in the consistency and quality of treatment provided, although it is too early to know whether this is directly increasing survival rates.

Our Next Steps

In 2026/27, SECAmb plans to expand the programme across the whole Trust. This will ensure that every clinician involved in a cardiac arrest can benefit from the same high-quality, supportive feedback – ultimately helping us continue to improve the care we deliver and give more patients the best chance of survival.

Indicator 3: Infection Prevention Control (IPC)

Infection Prevention and Control (IPC) remain a core priority in ensuring the delivery of safe, effective, and high-quality care. SECAmb's focus throughout the reporting period has been to strengthen clinical practice, reduce avoidable infections to both patients and staff, and embed evidence-based standards across all clinical environments.

The Trust has continued to implement national guidance, including the UK Health Security Agency (UKHSA) infection prevention standards, and the NHS England Board Assurance Framework for IPC. Regular audits have been integral to measuring clinical effectiveness. These include hand hygiene compliance, environmental / vehicle cleanliness, aseptic technique (procedures performed under sterile conditions), and personal protective equipment compliance. Audit outcomes are shared with local teams at the monthly Divisional Governance Group meetings and leadership teams can review their compliance levels live a dashboard on Power BI supporting awareness and continuous improvement.

To support clinical effectiveness, we continue to provide staff education through mandatory Level 1 and 2 IPC training. The Trust has also introduced a new role for High Consequence Infectious Disease (HCID) training that provides both internal and external expertise. The individual in this role works with our Hazardous Area Response Team (HART) colleagues to ensure compliance. Training uptake is good, with frontline teams demonstrating increased confidence in applying infection control principles in day-to-day practice.

Following the introduction of the IPC App last year the Trust has seen an increasing uptake in usage by staff. One recent example of good practice was the Kent meningitis outbreak where both staff and local managers made use of the app for checking information and feedback received from staff was that this was a helpful and quickly accessible resource supporting them in practice. The app has now received three national awards, and the Trust are in the process of sharing it with other ambulance services and community NHS Trust providers.

Collaboration has been central to progress and continuous improvement. IPC has worked closely with Integrated Care Boards and the team attend both regular IPC Forums and Post Infection Review meetings to support learning and ensure the highest infection control standards are maintained.

This year's flu vaccination programme was very successful and 68.7% of frontline staff were vaccinated. In early May 2026, the IPC team will undertake a look back and learning review meeting, adapting the programme as required for next year.

The IPC Team have been working on reinforcing our IPC Champions network and have introduced continuing professional development (CPD) to the role to help strengthen the Champions knowledge and understanding of in the ambulance environment enhancing capability and capacity in this area

Looking ahead, priorities for IPC include further development of clinical audit programmes, enhancing digital systems for real-time surveillance, and supporting teams to embed quality improvement methodologies within IPC practice. We remain committed to reducing variation, improving patient outcomes, and maintaining a proactive, evidence-based approach to infection prevention and control across all services.

Indicator 4: Ambient Voice Transcription Technology Pilot

During 2025/26, we piloted ambient voice transcription technology within our Emergency Operations Centre (EOC) to explore whether ambient voice technology could reduce clinicians' administrative workload and improve the consistency of clinical documentation. The system listens to clinical triage calls (under appropriate governance arrangements) and produces a transcription and draft clinical summary. Clinicians always review, edit, and remain fully responsible for the final record and all clinical decision-making. This work forms part of a wider collaboration with the London Ambulance Service (LAS) and South Western Ambulance Service (SWAST), with LAS leading the shared evaluation. SECAmb participated using telephony "airtime" provided by LAS at no cost during 2025/26.

We introduced the pilot on a small scale with appropriate safeguards in place to ensure it was implemented safely, staff were supported, and that we could gather evidence on its effectiveness. This included clinical safety assessments to identify and manage potential risks, alongside reviews of information governance and cyber security arrangements. A Data Protection Impact Assessment (DPIA) was also completed to ensure that patient information is handled securely and in line with legal requirements.

Initial engagement generated 16 expressions of interest. Of these, 13 clinicians were onboarded, and 8 were actively using the system at the point of reporting. A small number of users disengaged before becoming fully familiar with the end-to-end process, highlighting the importance of structured training and hands-on support when introducing new digital tools. Supplier usage data (February 2026) reported 21 users in total, with 1,514 consultations supported and 223.85 hours of audio processed.

As this is an early-stage pilot, findings are encouraging but not yet statistically conclusive. Early data suggests a learning curve followed by improved performance as users became more familiar with the system. In the most recent three-week period reported (mid-January to early February), triage productivity improved from 2.08 to 2.23 calls per hour, and average triage time reduced from 19 minutes 08 seconds to 17 minutes 41 seconds among active users.

We have proposed a time-limited extension of the pilot (up to three months) to strengthen the evidence base, focusing on evaluation rather than wider adoption. This would enable increased user participation, re-introduction of NHS Pathways users to address a current evidence gap, and a more structured evaluation framework supported by business intelligence and quality measures such as re-contact rates and escalation outcomes. Unlike the initial pilot phase, this extension would involve an agreed cost as part of the regional collaboration led by LAS. Any decision to proceed would remain subject to internal governance and assurance processes. In the longer term, should the evidence support further development, any future procurement would need to consider full integration with our Computer Aided Dispatch (CAD) system rather than operating as a standalone pilot.

Patient Experience

Indicator 1: Patient and Public Engagement Strategy – Year One Progress

Establishing the Foundations

The Patient and Public Engagement Strategy 2025–2029 sets out SECAmb's approach to strengthening patient and public involvement across service design, delivery, and improvement. Year 1 has focused on establishing the foundations required to embed engagement across the organisation and beginning to demonstrate early impact through structured feedback, co-design activity, and improved insight into patient experience.

Patient Experience Questionnaire

Throughout 2025/26, patient experience feedback continued to be captured through the Patient Experience Questionnaire (PEQ), alongside wider engagement activity. In Quarter 4, 311 PEQs were received across 999 call handling, telephone clinical advice, and ambulance care. Overall satisfaction remained high, particularly with those that received an ambulance response, with 95% of respondents reporting they were treated with dignity and respect and 94% reporting that care was appropriate and effective. Feedback highlighted consistently positive experiences of staff professionalism, communication, and compassionate care, alongside strong performance in call handling and clinical advice.

Patient Stories

A key development during Year 1 has been the strengthening of structured patient insight collection and use. Patient stories are now captured via a digital platform introduced in February 2026, enabling patients, families, and carers to share experiences directly with the Trust. These insights are being used to inform training, communication, and clinical education, including call handler training, sepsis and meningitis awareness, empathy workshops, and wider staff development.

Public Events

Engagement with patients and the public through community events supports education, listening, and relationship-building with local communities. During 2025/26, the Trust continued to participate in public events aimed at improving health literacy, promoting appropriate use of 999 services, supporting CPR awareness, and improving access to care.

These activities also supported recruitment and engagement with underrepresented communities.

A structured review of public events was undertaken between February and May 2025 through a Task and Finish Group. This identified the need for more consistent planning, clearer governance, improved tracking and evaluation, and strengthened clarity around roles and operational oversight, including abstraction.

In response, a revised standardised approach has been developed, introducing a phased planning process, strengthened governance, and a central tracking system. Public education remains the core purpose, with a focus on appropriate 999 use, CPR, defibrillator awareness, and wider health promotion.

A stakeholder engagement exercise also informed future planning, bringing together patients, staff, and voluntary sector partners to identify priority areas for 2026/27. This resulted in seven priority public engagement events being identified for 2026/27, with a focus on underrepresented communities and targeted public education.

The revised model includes strengthened evaluation, with post-event review processes to capture feedback and inform service development. Overall, 2025/26 represents a shift towards a more structured and strategically aligned approach to public engagement, providing a stronger foundation for 2026/27 delivery.

Patient Engagement Ambassadors

Patient Engagement Ambassadors (PEAs) support engagement activity across operational areas, championing key messages and feeding back local insight. By Year 1 end, 37 PEAs were recruited across 13 of 14 dispatch desk areas. PEAs contribute to co-design activity, including patient information materials and public education resources, embedding patient voice more directly within operational settings.

Collaboration

Partnership working has supported strategy delivery, including collaboration with other ambulance services and external organisations to share learning on engagement methods, digital tools, and patient involvement approaches. Internal engagement activity has also supported priority setting for 2026/27, ensuring alignment with quality, safety, and health inequalities priorities.

Inclusivity

Work has progressed to improve inclusivity in engagement activity. Analysis of PEQ responses has identified underrepresented groups, and targeted approaches are being developed, including accessible survey formats, community engagement activity, and collaboration with partners to improve reach into underserved populations.

Summary

Year 1 has established the foundations for a more structured and systematic approach to patient and public engagement across SECAmb. Early progress demonstrates improved insight collection, increased involvement activity, and greater use of patient experience data to inform learning and improvement. Year 2 will focus on embedding these approaches, expanding reach, and strengthening the use of patient insight in decision-making.

Indicator 2: Health Inequalities Maturity Matrix

'Health inequalities are avoidable, unfair and systematic differences in health between different groups of people'. The term can also be used to refer to the difference in the care people receive and the opportunities that they have to access healthcare. As such, health inequalities can result in differences in:

- Health status, for example, life expectancy
- Access to care / availability of given services
- Quality & experience of care, for example, patient satisfaction
- Behavioural risks to health, for example, smoking rates
- Wider determinants of health, for example, quality of housing.

We have developed a self-assessment tool to identify work that we are doing, across all departments that have a positive impact on health inequalities. This provides an opportunity to develop our trust health inequalities priorities.

The self-assessment mapping tool will allow services / teams to collaboratively:

- **Benchmark** where each service / team currently is in working towards tackling health inequalities
- **Identify strengths** and **areas for development**
- **Track progress** and **measure impact** over time
- Work with **local partners and stakeholders** to plan further action
- **Share best practice**.

HI mapping will be undertaken on a six-monthly basis at SECAmb to self-assess progress and the approach across multiple directorates / teams in working to reduce health inequalities, utilising a business-as-usual approach. Gaps identified will be supported by Specific, Measurable, Achievable, Realistic and Time-bound (SMART) local action plans overseen by the relevant management groups.

There are 4 categories that services / teams will self-assess their progress against, providing evidence for their decision. These are "early", "developing", "maturing" and "mature".

Progress is measured across 5 domains:

1. **Delivering services inclusively**
2. **Mitigating against 'digital exclusion'**
3. **Ensuring datasets are complete and timely**
4. **Supporting preventative programmes**
5. **Strengthening leadership and accountability.**

Indicator 3: Integration of Patient Stories into Trust Learning

At SECAmb, we recognise that patient, family, and carer experiences provide vital insight into the care we deliver. Over the past year, we have worked to embed patient and family experiences into our quality improvement and staff development initiatives, ensuring that feedback translates into meaningful change across our services.

One key strand of this work has been the co-design of an online form for patients, families, and carers to share their experiences directly with the Trust. Developed with accessibility and inclusivity in mind, the form enables individuals to provide reflections on both positive experiences and opportunities for improvement. Submissions will be systematically reviewed and shared internally, creating a structured approach to transforming feedback into action and informing ongoing service development.

In parallel, we have begun working closely with families whose experiences highlight opportunities for learning and improvement within urgent and emergency care. For example, we are collaborating with Suzie, whose son Oliver tragically passed away after contacting our service. Through sensitive and structured conversations, Suzie has shared her family's experience and perspective on the challenges families can face in urgent care settings, including recognition of meningitis and sepsis symptoms and the impact of communication during emergency calls.

These discussions have directly informed a number of improvement initiatives across the Trust. Learning themes identified include improving staff understanding of multiple concurrent symptoms, strengthening guidance on escalation to clinical or operational support, and embedding empathy and emotional intelligence within staff interactions. In response, SECAmb has worked with the Communications team to develop a standardised patient and family storyboard and infographic approach, enabling experiences and learning to be shared consistently and meaningfully across the organisation.

In addition, work is underway with the Education team to develop a dedicated patient and family experiences section within the Trust's staff training platform, Discover. This resource will support managers and educators to incorporate lived experiences into local training, reflective learning, and staff development activities. Patient journeys and family perspectives will also begin to feature within key skills sessions and workshops to strengthen compassionate, patient-centred practice and reinforce learning through real-life experiences.

The Trust is also exploring the development of an e-learning module focused on patient and family experiences and the learning arising from Oliver's and Suzie's experience. Subject to further development and agreement with the family, there are plans to share this work more widely with national colleagues to support broader system learning and improvement.

Oliver's and Suzie's experience complements the wider programme of patient and family experience work and demonstrates how lived experiences can shape both organisational culture and clinical practice. By integrating qualitative narratives alongside quantitative feedback, the Trust is able to develop a richer understanding of the patient experience and ensure that learning is embedded into day-to-day practice.

Through these initiatives, SECAmb demonstrates its commitment to placing patients and families at the heart of service development. By systematically capturing, analysing, and sharing lived experiences, and by transforming individual experiences into actionable learning, the Trust continues to improve patient safety, strengthen staff awareness, and promote compassionate, patient-centred care.

Indicator 4: Improving Communication for Deaf or hard of hearing Patients

During 2025/26, we have progressed plans to introduce Convo/SignLive on iPads to improve communication between frontline ambulance crews and patients who are deaf, hard of hearing or use British Sign Language (BSL).

This technology will provide on-demand access to qualified BSL interpreters via video relay. Using Trust-issued iPads, crews will be able to connect quickly to an interpreter, enabling real-time, two-way communication with patients at the scene. This is expected to support more accurate clinical assessment, improve patient understanding, and enable informed decision-making.

Currently, communication with deaf patients can be challenging and may rely on written notes, lip reading, or support from family members. These approaches can create barriers, increase the risk of misunderstanding, and impact patient experience. The proposed introduction of Convo/SignLive aims to address these challenges by providing a more reliable and inclusive communication method.

During the year, a full business case has been developed to support implementation, alongside completion of a Data Protection Impact Assessment (DPIA) to ensure patient information is handled securely and appropriately. These steps represent significant progress towards introducing the service safely and effectively.

Procurement for this resource has now been completed and steps are underway to roll this out to frontline crews, ensuring staff awareness to support adoption in practice.

This work aligns with the NHS Accessible Information Standard, which requires services to meet the communication needs of patients with disabilities. While national benchmarking data is limited, video relay interpreting services are recognised as best practice in improving accessibility for BSL users.

We anticipate that, once implemented, this initiative will improve patient safety, experience, and equity of access for deaf patients, ensuring they can communicate effectively with our services when they need us most.

Indicator 4: Patient Advice and Liaison Services (PALS)

The Trust welcomes feedback from patients, relatives and carers, including complaints. Complaints provide an important opportunity to understand where things have not met expectations, identify areas for improvement and make changes to improve patient experience and safety.

The information below relates to the period 1 April 2025 to 31 March 2026 and is reported in line with Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009.

Total Complaints

During 2025/26, the Trust received 886 complaints. All complaints were reviewed and investigated through the Trust's complaints process.

Of these complaints:

- 240 (27%) were found to be justified.
- 198 (22%) were found to be partially justified.

The remaining complaints were either not upheld or did not identify any failings in the care or service provided.

Parliamentary and Health Service Ombudsman (PHSO)

Twelve complaints were referred to the Parliamentary and Health Service Ombudsman during the reporting period.

Following a review of the information provided by the Trust, six cases were not taken forward for investigation. Five cases remain under consideration by the Ombudsman and one case is currently subject to a formal investigation.

Main Themes of Complaints

The most common reasons for complaints remained consistent with previous years and accounted for 94% of all complaints received.

The main themes were:

- **Professional concerns (clinical)** – concerns relating to staff attitude, communication or clinical care (37%).
- **Emergency Operations Centre (EOC) and NHS 111 concerns** – concerns regarding the outcome of a clinical triage assessment (25%).
- **Dispatch delays** – delays in an ambulance arriving at the scene (12%).
- **Conveyance delays** – delays in transporting patients to hospital (11%).
- **Professional concerns (non-clinical)** – concerns such as driving standards and staff conduct (8%).

Learning from Complaints

Learning was identified in 375 complaints investigations (42%).

This included:

- Individual learning for members of staff in 342 cases.
- Wider organisational learning in 33 cases, where opportunities were identified to improve systems, processes or service delivery across the Trust.

The Trust is committed to ensuring that learning from complaints is shared appropriately and used to improve the quality and safety of services.

Service Improvements

Complaints continue to play an important role in driving service improvement.

One example during 2025/26 was the introduction of a revised process within our 111 and 999 call centres. Under this approach, patients presenting with multiple symptoms are escalated directly to a clinically trained NHS Pathways clinician for further assessment, rather than being managed solely through the standard triage process.

This change was informed by learning from patient feedback and complaints and aims to improve the assessment and management of patients with more complex presentations.

3.2 Mandatory Reporting Indicators

Ambulance Response Programme: Response Times

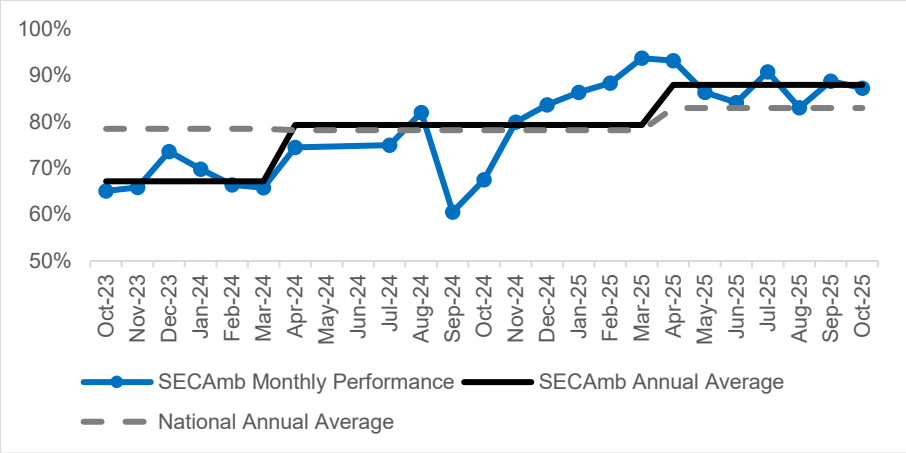
South East Coast Ambulance Service NHS Foundation Trust performance against the National Ambulance Response Programme (ARP) response times are reported in Part 2.3

National returns are submitted quarterly. Monthly monitoring is undertaken internally only, to facilitate operating unit oversight of performance.

ST Elevation Myocardial Infarction (STEMI)

The Trust aims to identify and measure its performance in 100% of the ST elevation myocardial infarctions (STEMI) cases that it attends. The Trust measures the quality of care provided to patients who present with a suspected STEMI by the proportion of patients who receive a bundle of care that is shown to improve outcomes for patients for this patient group.

Percentage of suspected STEMI patients who received the STEMI care bundle:



** STEMI care bundle cases over a 24-month period up to the most recent nationally published figures (correct as of 16/04/2026).*

The percentage of patients experiencing a STEMI who received a full bundle of care:

- The Trust saw sustained improvement in this care bundle, with compliance above national average.
- The diagnostic bundle includes administration of aspirin, glyceryl trinitrate (GTN), analgesia (pain relief) and the recording of two pain scores.
- The most common areas of non-compliance continue to be the administration of analgesia and the documentation of two pain scores.

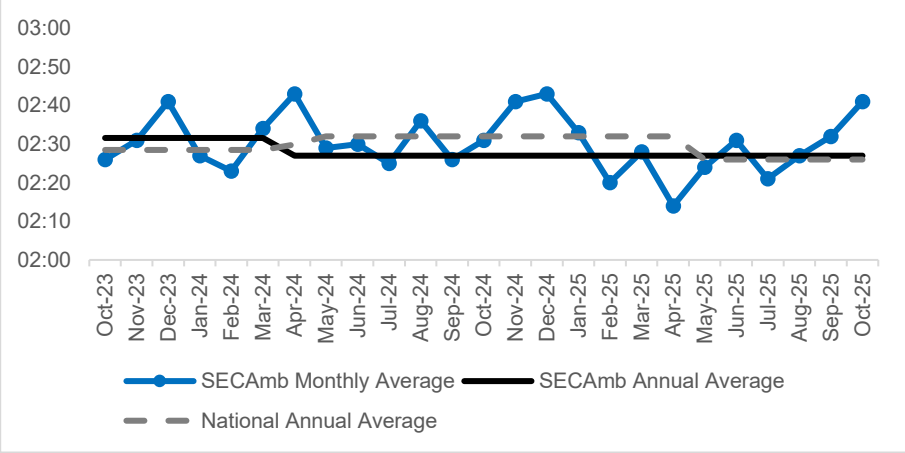
Improvement work focused on joint working partnerships with the OUs to drive improved compliance on analgesia and two pain scores.

National returns are submitted quarterly with submissions required in April, July, October, and January. Monthly monitoring is undertaken internally only, to facilitate operating unit oversight of performance.

ST Elevation Myocardial Infarction (STEMI) – Timeliness

The Trust also records the call to angiography time for patients presenting with a STEMI, this is compared as the mean and the 90th centile against other trusts.

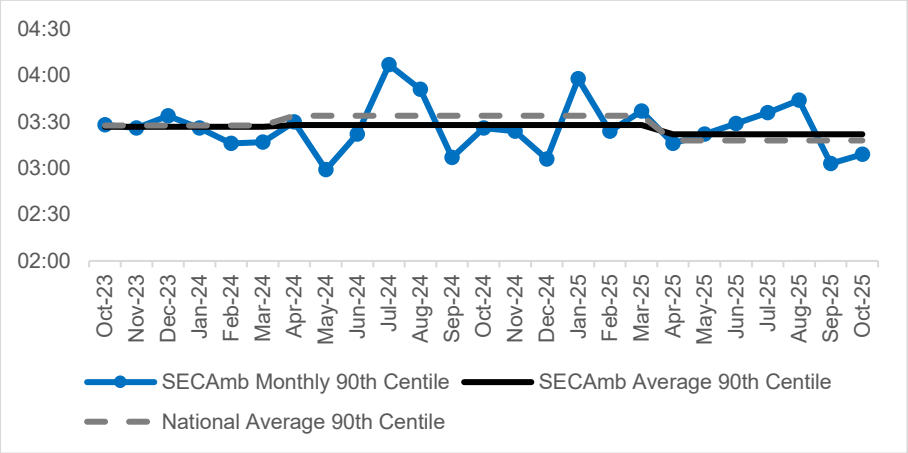
Mean time from call to angiography for patients with confirmed STEMI (hh:mm):



**STEMI timeliness figures over a 24-month period up to the most recent nationally published figures (correct as of 16/04/2026).*

Part 3: Other Information

90th centile time from call to angiography for patients with confirmed STEMI (hh:mm):



**STEMI timeliness figures over a 24-month period up to the most recent nationally published figures (correct as of 16/04/2026).*

The above graphs for STEMI timeliness indicators show expected levels of variance and a general drop in times year-on-year. A drop in this measure is a positive outcome as patients are receiving treatment faster.

- Trust STEMI mean performance has improved and is currently shorter than national averages.
- Trust STEMI 90th centile performance has improved and is broadly tracking national averages.

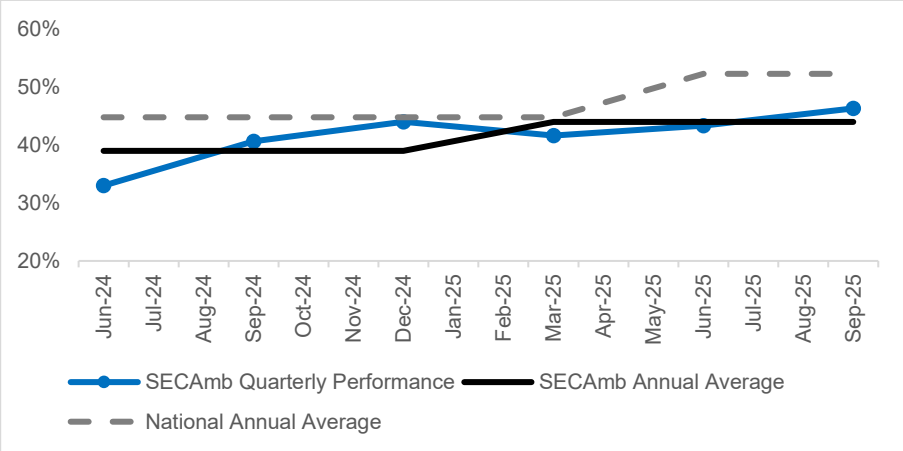
End of Life Care Audit – January 2026

In May 2024, National Ambulance Service Medical Directors Group (NASMeD) and NHS England approved the introduction of an annual programme of national clinical audits, to replace the Stroke diagnostic bundle Ambulance Clinical Quality Indicator (ACQI). The second national audit, for 2025/26, would look at End of Life Care patients and be based upon the standards agreed by the National Technical Subgroup in collaboration with the Ambulance End of Life Care Leads.

Members of the National Ambulance Service Clinical Quality Group (NASCQG) agreed to select the month of January 2026, and all patients coded as End-of-Life Care were in the sample. A maximum of 300 incidents were audited, examining the clinical assessment, interventions, shared decision-making to support non-conveyance and symptom relief provided to these patients. It was agreed that the London Ambulance Service Trust would support the data collection and analysis. 300 cases were identified by SECAmb, they were audited against the national standards by the Health Informatics Team and submitted as per the national schedule. At the time of writing, the results are still being analysed by the London Ambulance Service, the draft report is expected in June 2026.

Falls

The Trust measures the quality of care provided to older adults who have fallen and are not conveyed to hospital. The care standards include a thorough physical assessment and documentation of the history of the fall.

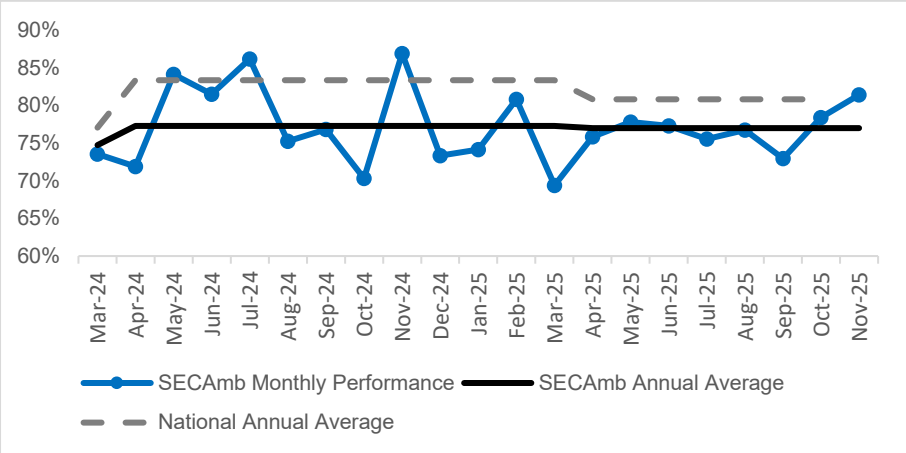


**Care bundle compliance over a 10-month period, from the start of data collection up to the most recent nationally published figures (correct as of 16/04/2026).*

The graph above shows that SECAmb is currently just below the national average but demonstrating improvement. This audit was introduced in 2024 and is still in its early stages of data collection. As the audit develops and more data becomes available for analysis, we expect to see significant improvements and refinement in performance.

Return of Spontaneous Circulation (ROSC) after cardiac arrest[4]

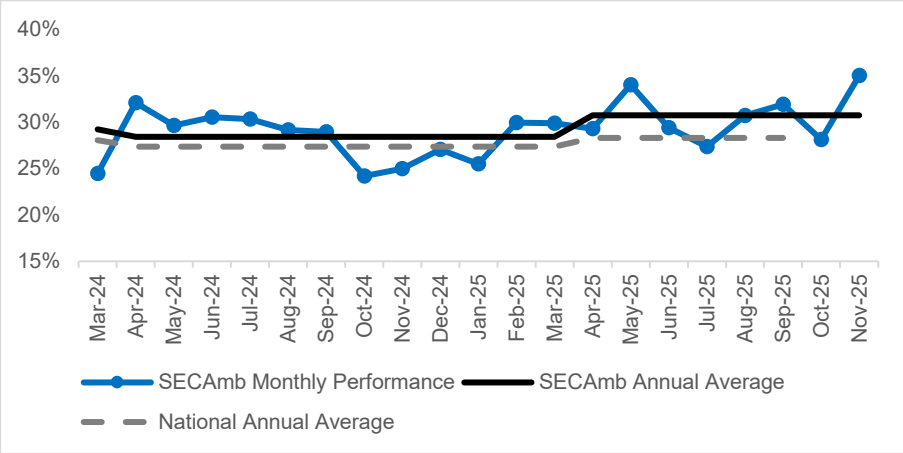
Percentage of patients where ROSC was achieved who, where applicable, received the post ROSC care bundle:



The data shows normal variation but remains under the national annual average. The reporting of the bundle requires clinicians to document the care they have provided. Given that ROSC and patient survival rates are improving, this decline is likely due to documentation challenges rather than a decrease in clinical care. SECAmb is contributing to national improvement efforts, assessing the effectiveness and limitations of the care bundle. We continue to collaborate with the Cardiac Arrest Outcome Improvement Board, individual skills feedback and Operating Units (OUs) to identify barriers faced by clinicians and will await national changes before implementing local improvement work.

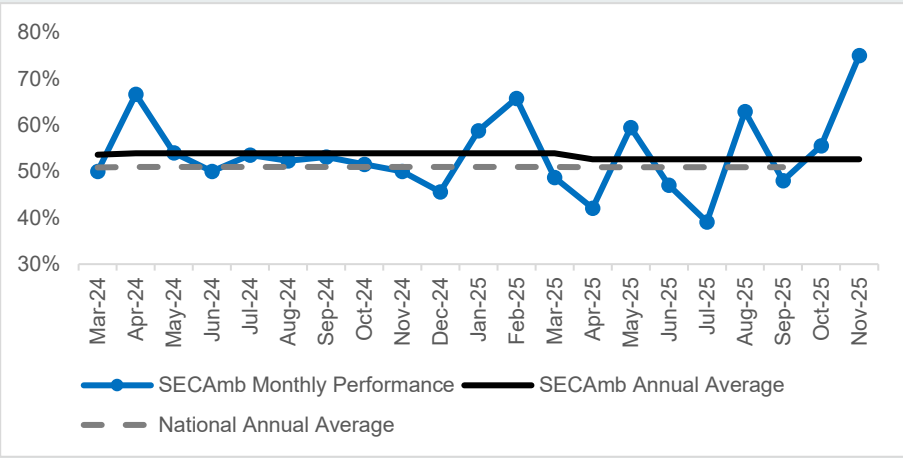
[4] All ROSC and survival figures are over a 21-month period up to the most recent nationally published figures (correct as of 16/04/2026).

ROSC at time of arrival at hospital (all patients):



A detailed Annual Cardiac Arrest Report was published for 2024/25 and was improved with graphic design enhancements. The data shows that SECAmb's ROSC at hospital performance has fluctuated but remained close to or above the national annual average for most of the year. The overall trend indicates stability and gentle improvement. This provides reassurance that compliance with the ROSC care bundle is likely impacted by documentation issues rather than a decline in clinical care.

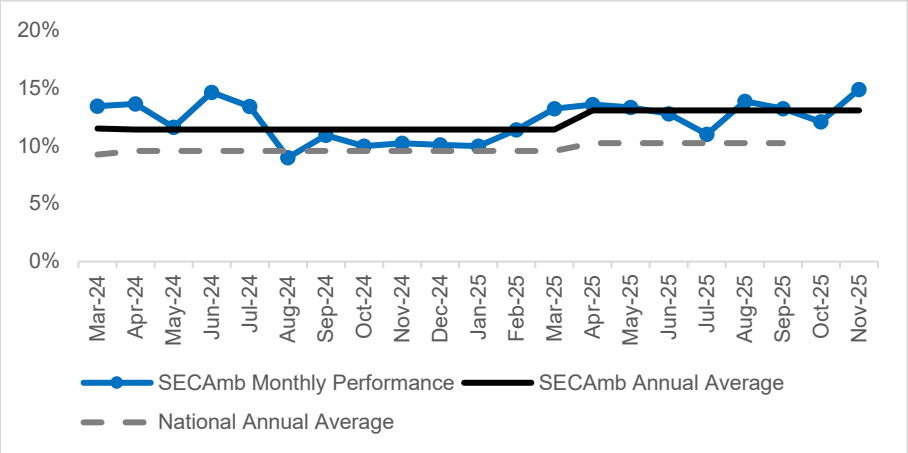
ROSC at time of arrival at hospital (Utstein Comparator Group):



Part 3: Other Information

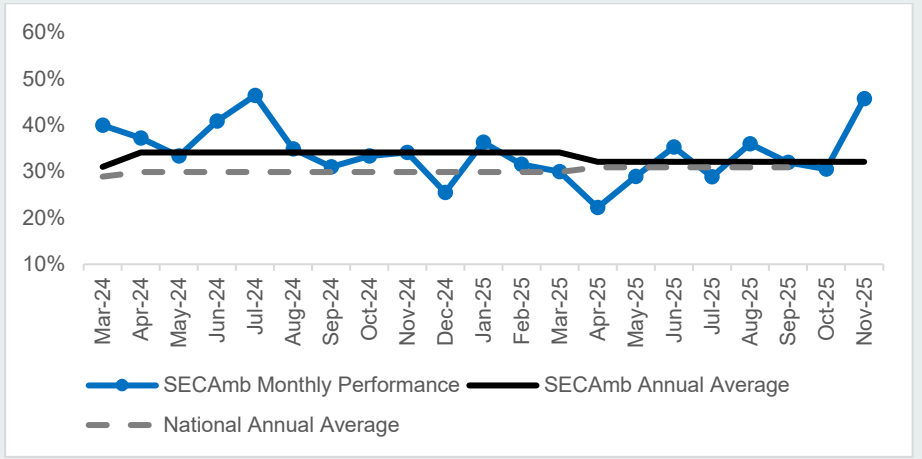
The ‘Utstein comparator group’ refers to patients who had a bystander-witnessed cardiac arrest, in a Ventricular Fibrillation / Ventricular Tachycardia (VF/VT) rhythm, and of cardiac origin. Therefore, a higher rate of ROSC would be expected. The data shows significant variation throughout the year, with a peak in November 2025. As this is a small subset, month-to-month variation is anticipated. However, overall performance remains within expected parameters and aligns with national trends, indicating ongoing improvement.

Survival to 30 days (Sto30) after cardiac arrest (all patients):



Performance in this element has remained above the national average. A detailed Annual Cardiac Arrest Report was published in 2024/25, highlighting significant improvements in design and structure. Ongoing improvement work continues to be coordinated by the Cardiac Arrest Outcome Improvement Programme Board.

Survival to 30 days (Sto30) after cardiac arrest (Utstein Comparator Group):



The ‘Utstein comparator group’ refers to patients who had a bystander witnessed cardiac arrest, in a VF/VT rhythm and cardiac in origin. Therefore, a higher rate of ROSC would be expected.

- Due to the nature of the group being reported there is a higher probability of survival.
- Performance for the year remains within the normal national variables for this indicator. There is liable to be a degree of fluctuation due to the small number of incidents eligible for inclusion in this element.

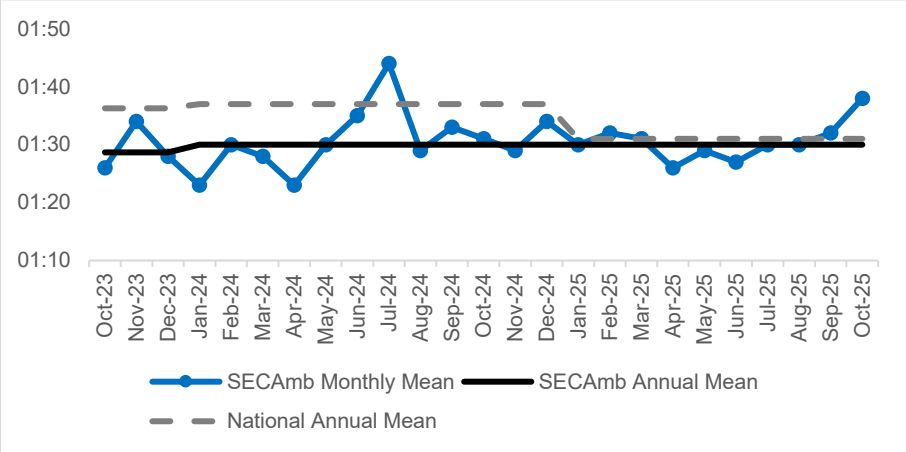
Stroke Timeliness[5]

The Trust also records the call to hospital door time for patients presenting with a stroke, this is compared as the mean and the 90th centile against other trusts.

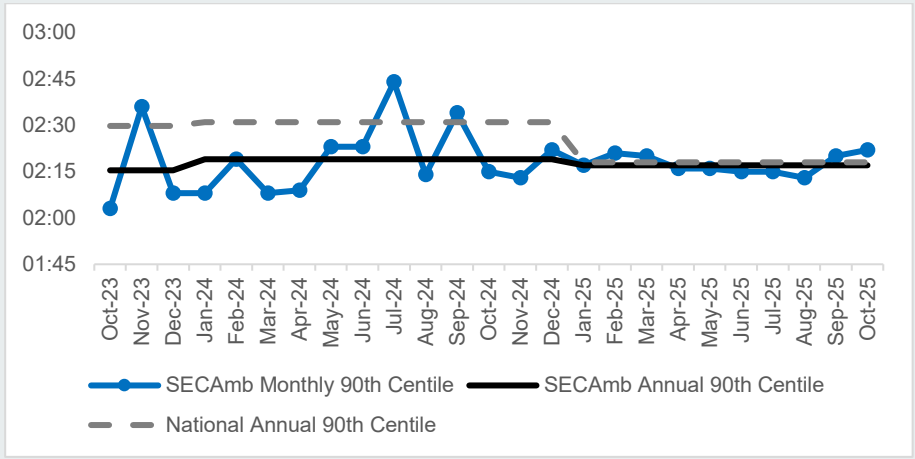
The below graphs for Stroke timeliness indicators show expected levels of variance and stability or a small drop in times year-on-year. A drop in this measure is a positive outcome as patients are receiving treatment faster.

- Trust Stroke mean performance has been stable and is currently tracking national averages.
- Trust Stroke 90th centile performance has improved slightly and is broadly tracking national averages which have also dropped.

Mean average time from call to arrival at hospital (hh:mm):



Time from call to arrival at hospital 90th centile (hh:mm):



[5] Stroke timeliness figures over a 24-month period up to the most recent nationally published figures (correct as of 16/04/2026).

NHS
South East Coast Ambulance Service
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Annex 1:

Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

We thank our external stakeholders for taking the time to review the Quality Account in its various stages of development. We have noted all suggestions for improvements. Where possible, these have been incorporated into the final version of the Quality Account. If we have been unable to do this, we have documented all improvements for consideration in next year's Quality Account, supporting our journey of continuous improvement.

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Joint Commissioner Statement from NHS Surrey Heartlands ICS on behalf of Kent, Medway, Sussex, Surrey Heartlands and Frimley (Surrey) regions

NHS Surrey and Sussex Integrated Care Board (ICB), as commissioner for South East Coast Ambulance Service NHS Foundation Trust (SECAmb), welcomes the opportunity to provide a statement on the Trust's 2025/26 Quality Account.

We acknowledge SECAmb's continued engagement with commissioners throughout the year and confirm that the draft Quality Account has been shared within the agreed timeframe. We are satisfied that the report reflects the information presented through contract, quality and performance assurance processes and provides an open and comprehensive account of progress, challenges and priorities.

During 2025/26, SECAmb has continued to demonstrate measurable progress in strengthening governance, safety oversight and learning systems. We particularly recognise the continued embedding of the Patient Safety Incident Response Framework (PSIRF), the development of system-level approaches to learning from incidents and deaths, and the increased use of data, thematic analysis and case review to inform improvement activity. The Quality Account appropriately reflects both areas of improvement and those requiring further development, including variation in performance and data maturity.

We also recognise the significant milestone achieved during the year, with SECAmb stepping down from locally enhanced oversight arrangements. This reflects improved confidence in the Trust's governance, leadership grip and ability to identify and manage risk. As commissioners, we welcome this progress while being clear that sustained improvement depends on continued openness, transparency and early escalation of emerging issues. Maintaining strong relationships, psychological safety and timely intelligence sharing will remain essential to ensuring risks are identified early and addressed collaboratively.

The Quality Priorities identified for 2026/27 align well with known system risks and opportunities, particularly the focus on organisational resilience, falls response and the strengthening of patient and public voice through Patient Safety Partners. Delivery of these priorities will require continued partnership working across the system to ensure meaningful and sustained improvements for patients and communities.

We look forward to continuing our constructive working relationship with SECAmb through established quality and contract governance arrangements, supporting a culture of learning, improvement and mutual accountability. As commissioners, NHS Surrey and Sussex ICB remains committed to providing appropriate oversight while working in partnership with the Trust to ensure high-quality, safe and equitable urgent and emergency care for the populations we serve.

Healthwatch Surrey

Thank you for the opportunity to comment on the South East Coast Ambulance (SECAmb) 2025 -26 Quality Account. Over the past year, we have maintained a collaborative working relationship with SECAmb. We have continued to share the voice of local people in the form of themes arising from our collection of insight and our project work; and we have raised any cases of particular concern. We look forward to continuing this relationship.

At Healthwatch Surrey, we are committed to obtaining the views of Surrey residents about their needs and experience of local health and social care services. In order to make these views known, we have consulted with our volunteers to provide comments on the Quality Account and have incorporated their comments and reflections.

We are pleased to see the continued emphasis on patient experience since last year, including the introduction of a digital platform that enables patients to share their feedback more easily. We welcome this development and look forward to seeing how these valuable insights continue to inform and enhance SECAmb's services in the future.

Healthwatch Surrey will continue to gather experiences from service users and share these with SECAmb to ensure people are given a voice to shape, improve and get the best from local health and care services. As an independent statutory body, we are always happy to help SECAmb access lived experiences that can inform service development for improved patient outcomes.

Healthwatch Sussex

Healthwatch welcomes the opportunity to review the Quality Accounts but cannot comment on the full content, much of which is outside of our remit. Healthwatch values the ongoing partnership working we have with SECAMB, including sharing our insight, asking questions and escalating concerns on behalf of patients and service users. We also monitor Trust activity through local and national performance indicators.

It is paramount that NHS bodies clearly communicate how they've captured patient experiences, what they've heard and how they've used this to support change and improvement in satisfaction and health outcomes. This will become even more essential if government plans to abolish Healthwatch and the independent role and scrutiny we provide is implemented. NHS organisations must ensure they develop and publish engagement plans and use their Quality Accounts to describe what steps they have taken and what difference this has made.

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Medway Council Health Oversight and Scrutiny Committee

Thank you for providing Medway Council with the opportunity to comment on South East Coast Ambulance Service NHS Foundation Trust's Quality Account for 2025/26.

Medway Council recognises the considerable efforts made by the Trust to maintain high standards of care over the past year, while continuing to respond to significant and sustained demand across urgent and emergency care services within the NHS. We acknowledge the ongoing system pressures and commend the commitment shown by staff and leadership in delivering care under these challenging circumstances.

Medway Council is particularly pleased to see the Trust's focus on improving patient experience for individuals in mental health crisis, including efforts to better support those experiencing suicidality. Improving mental health, emotional wellbeing and resilience for residents is set out as a key priority within Medway's Joint Local Health and Wellbeing Strategy 2024-2028, and we would therefore welcome opportunities for engagement and collaboration in this area. We note that future work would benefit from strengthened patient involvement in line with the Trust's Patient and Public Engagement Strategy, and we would encourage more explicit articulation of how lived experience has directly shaped this work in future Quality Accounts.

Medway Council also welcomes the Trust's ongoing commitment to reducing health inequalities, which is a core principle underpinning our health and wellbeing agenda. Medway's Joint Health and Wellbeing Strategy highlights the need for more effective service provision to meet the needs of vulnerable and disadvantaged communities, and we are pleased to see this reflected as a priority within the Trust's work. We would support continued focus in this area and encourage further partnership working to deliver meaningful improvements for those most at risk of poor health outcomes.

Medway Council is pleased to see overall progress against the 2025/26 quality priorities and supports the continuation of actions into 2026/27. In reviewing the core performance indicators, we acknowledge the consistent performance in call answering and response times when compared with 2024/25. It is however noted that there are discrepancies in the reported Category 4 90th centile response times, with differing values presented across the 2025/26 overall performance table, the year-on-year comparison table, and the 2025/26 national comparison graph. There are further discrepancies in Category 3 90th centile response times between the data tables and the 2025/26 national comparison graph. We would welcome clarification on these data points to support transparency and confidence in future performance reporting.

Note in response to statement from Medway Council Health Oversight and Scrutiny Committee:

Following a review of the ambulance response time data included within this report, a discrepancy was identified in the figures originally presented. The data has since been checked against the official figures published by NHS England and the relevant section of the Quality Account has been updated to reflect the corrected information.

Quality Account
2025/26

South East Coast Ambulance Service
NHS Foundation Trust

Annex 2:

Statement of directors' responsibilities for the quality report

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

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

NHS England has issued guidance to NHS Foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support data quality for the preparation of the Quality Report.

In preparing the Quality Report, the Directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance. As no updated guidance has been issued for the current reporting period, the most recent available version has been used.
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period 1 April 2025 to 31 March 2026.
  - Papers relating to quality reported to the Board over the period 1 April 2025 to 31 March 2026.
  - Feedback from commissioners.
  - Feedback from local Healthwatch organisations.
  - Feedback from Overview and Scrutiny Committees.
  - The Trust's complaints data reported in line with Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009.
  - The most recent national staff survey results.
  - The most recent Care Quality Commission (CQC) inspection report.
- The Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered.
- The performance information reported in the Quality Report is reliable and accurate.
- There are appropriate internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, and is subject to appropriate scrutiny and review.
- The Quality Report has been prepared in accordance with NHS England's Annual Reporting Manual and supporting guidance, including the Quality Accounts Regulations.

The Trust adopts the Audit Commission's six key characteristics of data quality: accuracy, validity, reliability, timeliness, relevance and completeness. Assurance is obtained through routine systems and processes that validate and maintain the quality of data held within the Trust's Computer Aided Dispatch (CAD) system, in accordance with Trust policies and procedures.

The Trust has continued to invest in its Business Intelligence function and reporting capabilities through the Microsoft Power BI platform, supporting the provision of accurate and timely information to both internal and external stakeholders. In addition, work is underway to implement a new data platform which will further strengthen data quality processes, governance arrangements and reporting across the organisation.

Additional Note:

By order of the board

Chairman 

Date: 25/06/2026

Chief Executive 

Date: 25/06/2026

South East Coast Ambulance Service
NHS Foundation Trust

Glossary

Glossary

Acronym	Term	Definition
AACE	Association of Ambulance Chief Executives	National body representing UK ambulance chief executives
AARs	After Action Reviews	Structured reviews conducted after incidents to identify learning
ACQI	Ambulance Clinical Quality Indicator	National clinical quality measures for ambulance services
ACS	Acute Coronary Syndrome	A range of conditions caused by reduced blood flow to the heart
ADS	Ambulance Data Set	National dataset for ambulance activity and outcomes
AED	Automated External Defibrillator	Device used to deliver a shock to restore heart rhythm
APP	Advanced Paramedic Practitioner	Experienced paramedic with extended clinical scope
AQI	Ambulance Quality Indicators	National performance and quality metrics for ambulance services
ARP	Ambulance Response Programme	National framework for categorising and measuring ambulance response times
BI	Business Intelligence	Data analysis and reporting function supporting decision-making
BSL	British Sign Language	Language used by Deaf people in the UK
C1-C4	Category 1-4	Ambulance call categories based on clinical urgency
CAD	Computer Aided Dispatch	System used to manage and dispatch emergency resources
CFR	Community First Responder	Trained volunteer who responds to medical emergencies
CQC	Care Quality Commission	Independent regulator of health and social care in England
CPD	Continuing Professional Development	Ongoing learning and development for staff
CPR	Cardiopulmonary Resuscitation	Life-saving technique used during cardiac arrest
CQUIN	Commissioning for Quality and Innovation	Payment framework linking funding to quality improvements
CSN	Clinical Safety Navigator	Role supporting clinical safety processes
CSP	Clinical Safety Plan	Plan outlining safety controls for clinical systems
DMAIC	Define, Measure, Analyse, Improve, Control	Quality improvement methodology
DPIA	Data Protection Impact Assessment	Assessment of data protection risks
DSPT	Data Security and Protection Toolkit	NHS framework for cyber and data security compliance
ECAL	Emergency Care Advice Line	Clinical advice service for urgent care decision-making
ED	Emergency Department	Hospital department for emergency care
EOC	Emergency Operations Centre	Control centre for ambulance call handling and dispatch
ePCR	Electronic Patient Care Record	Digital record of patient care provided by clinicians
FTSU	Freedom to Speak Up	NHS programme supporting staff to raise concerns safely
GTN	Glyceryl Trinitrate	Medication used to treat cardiac conditions
HART	Hazardous Area Response Team	Specialist ambulance team responding to high-risk incidents
HCID	High Consequence Infectious Disease	Highly infectious and severe disease requiring specialist response
HFE	Human Factors and Ergonomics	Study of system design and human interaction to improve safety
HOSC	Health Overview and Scrutiny Committee	Local authority committee reviewing health services

Glossary

ICS	Integrated Care System	Partnership of NHS organisations and local authorities
ICB	Integrated Care Board	NHS organisation responsible for commissioning services locally
IPC	Infection Prevention and Control	Measures to prevent spread of infection in healthcare settings
IUC	Integrated Urgent Care	Services providing urgent medical advice and care outside hospital
JRCALC	Joint Royal Colleges Ambulance Liaison Committee	Clinical guideline body for UK ambulance services
LAS	London Ambulance Service	NHS ambulance service covering London
MDT	Multidisciplinary Team	Group of professionals from different disciplines working together
NASCQG	National Ambulance Service Clinical Quality Group	National group overseeing clinical quality standards
NASMeD	National Ambulance Service Medical Directors Group	Group of UK ambulance medical directors
NHS	National Health Service	Publicly funded healthcare system in the UK
NICE	National Institute for Health and Care Excellence	Organisation producing clinical guidance
OU	Operational Unit	Local operational division within the Trust
PALS	Patient Advice and Liaison Service	An NHS service that provides information, advice, and support to patients, and helps resolve concerns about healthcare services
PEA	Patient Engagement Ambassador	Staff supporting patient engagement activity
PEQ	Patient Experience Questionnaire	Tool for collecting patient feedback
PDR	Post Discharge Review	Review of patient care after discharge from service
PGD	Patient Group Direction	Protocol allowing non-prescribers to supply/administer medicines
PSII	Patient Safety Incident Investigation	Structured investigation into patient safety incidents
PSIRF	Patient Safety Incident Response Framework	NHS framework for managing and learning from incidents
PSOG	Patient Safety Oversight Group	Governance group overseeing patient safety activity
QI	Quality Improvement	Systematic approach to improving healthcare quality
ROSC	Return of Spontaneous Circulation	Restoration of heartbeat after cardiac arrest
S&T	See and Treat	Clinical model where patients are treated without conveyance
SECAmb	South East Coast Ambulance Service NHS Foundation Trust	Regional NHS ambulance service
SI	Serious Incident	Significant safety incident requiring investigation
STEMI	ST-Elevation Myocardial Infarction	Severe type of heart attack caused by coronary blockage
Sto30	Survival to 30 Days	Survival outcome measure following cardiac arrest
SWAST	South Western Ambulance Service Trust	NHS ambulance service covering South West England
UKHSA	UK Health Security Agency	National public health protection agency
UCR	Urgent Community Response	Service providing rapid community-based urgent care
UEC	Urgent and Emergency Care	Healthcare services for urgent and emergency conditions
VF	Ventricular Fibrillation	Life-threatening heart rhythm causing cardiac arrest
VT	Ventricular Tachycardia	Abnormally fast heart rhythm that can lead to cardiac arrest
WTTT	Walk Through Talk Through	Human Factors method to study real-world work processes

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Serving Our Communities

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