REPORT OF: THE JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE (JHOSC):

South Central Ambulance Service CQC Improvement Journey

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Report to:
- Paul Jefferies (SCAS Divisional Director for Thames Valley)
- Andrew Battye (SCAS Head of Operations for Oxfordshire)

INTRODUCTION AND OVERVIEW

1. The Joint Health and Overview Scrutiny Committee considered a report with an update on the South Central Ambulance Service (SCAS). Particular attention was paid to the Trust's Care Quality Commission (CQC) improvement journey.

2. The Committee would like to thank Paul Jefferies (SCAS Divisional Director for Thames Valley) and Andrew Battye (SCAS Head of Operations for Oxfordshire) for attending the meeting and answering questions from the Committee.

3. The topic of the ambulance service and its journey in addressing concerns raised by the CQC is of significant interest and concern to the JHOSC given that it has a constitutional remit over health and healthcare services as a whole, and this includes the initiatives taken by SCAS to improve its services in ways that adhere to CQC standards.

4. Upon commissioning the report for this item, some of the insights the Committee sought to receive were as follows:

   - Confirmation of whether any regulatory conditions, warning notices, or external oversight arrangements remain in place and what is required to exit them.

   - The overall structure of the CQC improvement programme, including key workstreams and priorities.

   - How learning from inspections and assurance visits is translated into operational change rather than standalone action plans.

   - Performance indicators that demonstrate whether changes are actually improving patient experience and safety (for example response performance, call handling, handover delays, and medicines management where highlighted by CQC).

   - How SCAS assures itself that improvements are sustained, not just short-term compliance responses.

- What is the current strategy for meeting demand without the need for private providers.

- Progress on staff recruitment, retention, training and appraisal, including whether staff feel supported to deliver high-quality care.

- Actions taken to strengthen speaking-up culture, leadership visibility and staff engagement.

- How staff wellbeing is being protected in the context of operational pressures.

- How improvement depends on, or is constrained by, system-wide factors such as hospital handover delays; and what joint work is taking place with ICBs and acute trusts in Oxfordshire to address these issues.

SUMMARY

5. During the 11 June 2026 meeting, the Committee discussed which issues identified by inspection remained most significant. The Divisional Director for Thames Valley explained that one of the main areas of ongoing work was medicines management, which had been identified by the CQC as requiring improvement in relation to storage, documentation and process reliability. The Trust had significantly developed its pharmacy team and had invested in a new site to support improved “make ready” processes and safer medicines management.

6. The Committee revisited its earlier recommendations on internal assurance, audit and governance. The Divisional Director for Thames Valley explained that the Trust had introduced a Performance Management Accountability Framework, under which each divisional director was required to provide formal monthly assurance to the executive team through internal scrutiny arrangements. For Thames Valley, this covered Oxfordshire, Buckinghamshire and Berkshire, each with sector leadership beneath him, including a Head of Operations and a Clinical Operations Manager. He explained that scrutiny included appraisal completion, personal development plans, statutory and mandatory training, and operational quality indicators such as hand hygiene, vehicle cleanliness and medicines management.

7. The Committee explored the Trust’s implementation of the Patient Safety Incident Response Framework. Members asked what had changed in practice since its introduction, what recurrent risks had been identified, what actions had followed, and what evidence existed that those actions had reduced harm. The Head of Operations for Oxfordshire explained that the principal initial change had been in the training and support given to staff and team leaders in understanding the new process for handling patient safety incidents. Patient safety incidents from the previous day were now reviewed every day by the patient safety team in order to identify harm or emerging concerns, and that

there was now a much stronger culture of looking proactively for patient safety issues rather than reacting only after serious incidents had occurred.

8. The Committee examined the growing problem of violence and aggression towards staff. Members referred to similar concerns raised by Oxford University Hospitals NHS Foundation Trust (OUH) and asked whether the ambulance service was facing the same trend. The Head of Operations for Oxfordshire said that regrettably it was, and that the issue had not gone away but had worsened nationally and locally. He described the difficulty of distinguishing between aggression driven by illness and aggression that was deliberate, but stressed that no staff member deserved such abuse.

9. The discussion focused on workforce, particularly the report's statement that financial pressures and service realignment had led to a mismatch between clinical and non-clinical staff. The Head of Operations for Oxfordshire explained that the clinical workforce referred primarily to registered paramedics, while the non-clinical or clinical support workforce included Associate Ambulance Practitioners and Emergency Care Assistants.

10. The Committee scrutinised the Trust's 'Freedom to Speak Up' culture and psychological safety, and asked whether the increase in concerns being recorded indicated a genuinely safer speaking-up culture or continuing unresolved cultural problems. The Head of Operations for Oxfordshire acknowledged that it felt paradoxical to see rising numbers of concerns as positive, but said the increase suggested staff were becoming more comfortable raising issues. The organisation had invested heavily in the Freedom to Speak Up process, including local station-based champions, precisely so that staff did not have to raise issues only through line management and could speak to peers instead. The challenge was not only encouraging staff to speak up but also "listening up" and then following through, because if nothing changed the reporting would stop.

11. The Committee asked what the remaining causes of handover delay in Oxfordshire were and whether rising figures at the Horton General Hospital should be a concern. The Head of Operations for Oxfordshire replied that the main causes remained familiar system issues: acuity, seasonal or weather-related surges in demand, and the ability of acute hospitals to discharge patients safely into the community. The ambulance arrivals as having a "tsunami effect", with several vehicles often arriving in quick succession from different parts of the county, thereby creating episodic pressure in emergency departments.

KEY POINTS OF OBSERVATION:

12. This section highlights four key observations and points that the Committee has in relation to SCAS's CQC improvement journey. These four key points of observation have been used to determine the recommendations being made by the Committee which are outlined below:

For SCAS and the ICB to escalate the future pipeline issue with staff and challenges with non-availability of training placements: The Committee's recommendation that South Central Ambulance Service (SCAS) and the Integrated Care Board (ICB) should escalate concerns regarding the future workforce pipeline and the increasing challenges associated with the availability of training placements is a strategically important recommendation that goes beyond the immediate issues which often dominate discussions about ambulance performance. While ambulance response times, hospital handover delays and service demand are frequently the most visible indicators of system pressure, the ability of ambulance services to recruit, train and retain sufficient numbers of staff remains one of the most important determinants of long-term service sustainability. Without a reliable pipeline of future paramedics, technicians, emergency care assistants and clinical support staff, there is a significant risk that improvements achieved through SCAS's wider quality improvement programme could become increasingly difficult to sustain over time.

Evidence presented in the report by SCAS to the Committee demonstrates that this issue is already emerging. The report explained that financial pressures across the NHS had resulted in a recruitment freeze and that onboarding activity had become largely driven by establishment constraints rather than longer-term workforce planning. The report notes that SCAS is "acutely aware of the impact of not recruiting new graduates this year, particularly in relation to our engagement with students and our partnership with Oxford Brookes University." It further acknowledges that the current recruitment pause may create future difficulties because the organisation will eventually need to rebuild its candidate pipeline after a prolonged period of reduced intake. The report additionally highlights the loss of Patient Transport Services as reducing a valuable route through which staff historically progressed into Emergency Care Assistant roles and subsequently into registered clinical practice. These observations demonstrate that SCAS itself recognises the emergence of a workforce pipeline risk that extends beyond immediate staffing levels.

The significance of this issue lies in the nature of ambulance workforce development itself. Unlike some professions where new staff can be recruited and become productive relatively quickly, paramedic education requires a lengthy period of investment. Undergraduate paramedic programmes typically require three years of higher education followed by structured consolidation and preceptorship arrangements before staff become confident autonomous practitioners. Consequently, decisions taken today regarding recruitment, student support and placement provision may not be fully felt in workforce supply figures for several years. Once a gap emerges in the pipeline, it can take a prolonged period to rectify. This means that workforce planning in ambulance services must necessarily be proactive rather than reactive.

National workforce policy increasingly recognises the importance of this challenge. NHS England's Long Term Workforce Plan identifies workforce supply as one of the most significant risks facing the NHS and explicitly links future service sustainability to the expansion of education, training and placement opportunities. The Plan argues that workforce shortages have become one of the principal constraints on service improvement and states that increasing workforce numbers will require significant growth in student training opportunities, clinical placements and educator capacity[1]. The accompanying detailed workforce strategy further highlights that increasing recruitment alone will be insufficient if health systems are unable to provide the practical learning environments necessary to support expanding student cohorts[2].

This issue is particularly relevant for ambulance services because the scope of paramedic practice has evolved significantly over the last decade. Paramedics increasingly work not only within emergency response functions but also within primary care, urgent community response services, virtual wards, integrated neighbourhood teams and specialist practitioner roles. NHS England's Paramedics Workforce Programme recognises that the future workforce requires a broader clinical skillset and greater exposure to diverse care environments. This evolution has increased the importance of providing high-quality placements across multiple parts of the health and care system rather than relying solely upon traditional ambulance-based training experiences[3].

A particular concern is that increasing training places at universities does not automatically translate into future workforce growth. Students can only qualify if they are able to undertake supervised clinical placements. NHS England has repeatedly identified placement availability as one of the major barriers to workforce expansion across a range of clinical professions. Guidance produced through the national Allied Health Professions placement expansion programme highlights that placement capacity has historically acted as a limiting factor on workforce growth and that competition for placements has intensified as health systems seek to expand workforce supply[4].

The College of Paramedics has similarly emphasised the importance of placement capacity in determining future workforce sustainability. During the development of the profession's updated education framework, the College identified difficulties in securing sustainable placement opportunities across the wider health and care system as a significant national challenge. Increasing student numbers across multiple healthcare professions has generated growing competition for clinical

[1] https://www.england.nhs.uk/publication/nhs-long-term-workforce-plan/,
[2] https://www.england.nhs.uk/long-read/nhs-long-term-workforce-plan-2/,
[3] https://www.hee.nhs.uk/our-work/paramedics
[4] https://www.hee.nhs.uk/our-work/allied-health-professions/increase-capacity and https://www.hee.nhs.uk/our-work/allied-health-professions/increase-capacity/practice-placements-challenges-solutions

placements and increased pressure upon practitioners who serve as practice educators. The College has further highlighted concerns regarding the alignment between student numbers, placement opportunities and eventual employment pathways for newly qualified staff[5].

There are examples from elsewhere in England which illustrate the potential consequences of inadequate workforce pipeline planning. Several ambulance trusts experienced significant recruitment difficulties following the COVID-19 pandemic despite substantial growth in demand. The North East Ambulance Service, East of England Ambulance Service and South Western Ambulance Service all developed targeted workforce strategies to improve relationships with universities and increase placement opportunities after identifying risks associated with future workforce supply. Similarly, Health Education England's placement expansion work has drawn upon successful initiatives in regions such as Yorkshire and the Humber, where integrated approaches involving universities, ambulance trusts, community services and Integrated Care Systems were used to increase placement capacity and create sustainable learner pathways. Such examples demonstrate that workforce pipeline issues require coordinated system-wide action rather than relying upon individual organisations acting alone.

The academic literature strongly supports the Committee's concerns. Research published in journals including *BMC Health Services Research, Human Resources for Health* and the *International Journal of Practice-Based Learning in Health and Social Care* consistently identifies placement availability as one of the principal constraints upon healthcare workforce expansion. Studies have found that universities often possess capacity to educate larger numbers of students but are restricted by the availability of clinical learning environments and appropriately trained supervisors. Researchers have further highlighted a self-reinforcing cycle whereby workforce shortages reduce an organisation's ability to support students, which in turn contributes to future workforce shortages. This challenge has been identified across nursing, allied health professions and paramedic education[6].

The recommendation being made by the JHOSC also directly supports SCAS's wider CQC improvement journey. One of the concerns identified during previous inspections related to staff support, professional development and clinical oversight. Since then, SCAS has invested significantly in leadership development, staff wellbeing, Freedom to Speak Up processes, safeguarding capacity, patient safety improvement and cultural change. The report submitted to JHOSC details a substantial programme of organisational development designed to improve both staff experience and patient care. However, sustaining those

[5]https://collegeofparamedics.co.uk/COP/ProfessionalDevelopment/Developing%20a%20New%20Paramedic%20Curriculum.aspx,
[6] https://bmcmededuc.biomedcentral.com/articles/10.1186/s12909-022-03799-8

improvements ultimately depends upon having a sufficient supply of staff entering the organisation over the coming years. If workforce pipeline challenges are not addressed, future shortages could place renewed pressure upon supervision arrangements, training opportunities, staff wellbeing and service resilience.

Importantly, this challenge cannot be resolved by SCAS acting alone. The inclusion of the ICB within the recommendation is significant because Integrated Care Boards possess a system leadership role that extends beyond the boundaries of individual trusts. Training placements are provided across a wide range of organisations, including ambulance services, acute hospitals, community providers, mental health providers, primary care and voluntary sector partners. The ability to create sufficient placement opportunities therefore depends upon coordinated action across the entire health and care system. Integrated Care Boards are uniquely positioned to identify constraints, convene partners and advocate nationally where local barriers require intervention at regional or national level.

In essence, this recommendation made by the Committee is therefore both prudent and forward-looking. While SCAS currently benefits from comparatively favourable staffing levels within Oxfordshire, its own report identifies emerging risks relating to graduate recruitment, workforce succession planning and future placement availability. These risks have been recognised nationally through NHS workforce policy, by professional bodies such as the College of Paramedics and within academic research examining healthcare workforce sustainability. Escalating the workforce pipeline issue now represents a preventative intervention designed to protect future service resilience rather than a response to an immediate crisis. By drawing attention to workforce supply and placement capacity at this stage, the Committee is seeking to ensure that the considerable progress achieved through SCAS's improvement journey can be sustained, strengthened and built upon in the years ahead.

Recommendation 1: *For South Central Ambulance Service and the Thames Valley Integrated Care Board to escalate the future pipeline issue with staff and challenges with the non-availability of training placements.*

Strengthening public and patient involvement, and ensuring co-production forms part of shaping and monitoring SCAS's improvement journey: The Committee's recommendation that SCAS should strengthen opportunities for public and patient involvement and that co-production should form part of shaping and monitoring the Trust's improvement journey reflects an increasingly important principle within the modern healthcare improvement: sustainable organisational improvement is most effective when it is designed and monitored not only by professionals and regulators but also by the people who use services. While the CQC, NHS England and Trust Boards all have essential roles in assuring quality and safety, patients, carers and communities offer a

unique perspective on the real-world impact of services that cannot be replicated through performance metrics, inspections or governance processes alone.

The recommendation is particularly relevant in the context of SCAS's ongoing improvement journey following its previous CQC ratings of "Requires Improvement". The report submitted to the Committee for this item demonstrates that SCAS has undertaken substantial work to address the concerns raised by regulators, including improvements in safeguarding, medicines management, patient safety, leadership development, staff wellbeing, Freedom to Speak Up processes and organisational culture. The Trust has also exited the NHS Recovery Support Programme, successfully had several undertakings removed and established extensive governance arrangements to monitor progress. These are significant achievements and indicate meaningful organisational commitment to improvement. However, much of the evidence presented focuses on internal measures of success, governance arrangements and organisational processes. While these are necessary elements of improvement, they do not alone demonstrate whether patients and communities experience those changes positively or whether services are evolving in ways that reflect the priorities of local people.

Co-production provides a mechanism through which this gap can be addressed. The term co-production refers to service users, carers and communities working in equal partnership with professionals to design, deliver and evaluate services. NHS England has increasingly promoted co-production as a core principle of healthcare transformation, arguing that healthcare services achieve better outcomes and greater public confidence when people are actively involved in decisions affecting them. NHS England's guidance on working in partnership with people and communities emphasises that involvement should move beyond consultation and towards meaningful collaboration in decision-making and service improvement[7].

This principle is particularly important for ambulance services. Unlike many NHS services, ambulance trusts interact with patients during some of the most stressful, urgent and vulnerable moments of their lives. Performance indicators such as response times, hospital handovers and non-conveyance rates are important, but they do not fully capture patient experience. For example, patients may judge the quality of care according to communication, reassurance, dignity, involvement in decision-making and confidence in clinical assessments. Carers may identify barriers affecting vulnerable individuals that are not visible through routine performance data. Communities may identify inequalities in access or outcomes that are not immediately apparent through organisational reporting. Public involvement therefore provides

[7] https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance

intelligence that complements traditional performance measures and supports more comprehensive improvement.

The argument for co-production is strongly supported by national policy. The Health and Care Act 2022 placed significant emphasis on involving patients and communities in the planning, commissioning and evaluation of health services. The legislation reinforced existing duties contained within Section 242 of the NHS Act 2006, requiring NHS organisations to involve service users in the planning and development of services. Guidance published by NHS England identifies engagement with communities as one of the fundamental components of system improvement and highlights the importance of co-production in developing effective and sustainable healthcare services[8].

Academic evidence similarly demonstrates the value of co-production in the healthcare improvement. A landmark review published in the *British Medical Journal* argued that healthcare systems achieve better outcomes when patients are treated as partners in improvement rather than passive recipients of care. The authors concluded that patient involvement improves service quality, strengthens safety cultures and leads to more effective service redesign[9]. Similarly, research published in *BMC Health Services Research* found that healthcare organisations using co-production approaches often experienced improvements in service quality, service responsiveness and organisational learning[10].

Further evidence comes from research undertaken by the National Institute for Health and Care Research (NIHR). The NIHR has consistently found that services designed with patients, rather than solely for patients, are more likely to identify unmet needs, reduce inequalities and achieve sustainable improvements. Their work on patient and public involvement highlights that lived experience provides a distinct type of expertise that complements professional knowledge[11].

Importantly, there are examples from elsewhere in the ambulance sector that demonstrate how public and patient involvement can strengthen organisational improvement. The London Ambulance Service established a Patient and Public Advisory Group which advises on strategic priorities, service redesign and equality initiatives. The Trust has reported that direct engagement with patients and carers has influenced decisions regarding accessibility, communication and experiences of urgent and emergency care[12].

Similarly, East Midlands Ambulance Service has developed a Patient Participation Group and community engagement structures that contribute to strategic planning and service evaluation. Through these

[8] at https://www.england.nhs.uk/publication/integrated-care-systems-design-framework/
[9] https://www.bmj.com/content/359/bmj.j3453
[10] https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-019-4247-6.
[11] NIHR Patient and Public Involvement Resources.
[12] https://www.londonambulance.nhs.uk/about-us/involving-patients-and-the-public

mechanisms, patients have provided feedback on service accessibility, communication standards and ambulance service experiences, helping shape organisational improvement activity[13].

North East Ambulance Service has also adopted extensive community engagement approaches, including engagement with seldom-heard groups, carers and voluntary sector organisations. This work recognises that ambulance services frequently interact with populations who may otherwise be underrepresented within traditional engagement processes, including people experiencing homelessness, individuals with learning disabilities and those living in rural communities[14].

The recommendation being made by the Committee is also consistent with broader themes emerging from SCAS's own improvement work. The report submitted to the Committee describes extensive efforts to improve organisational culture, psychological safety and the ability of staff to raise concerns. SCAS highlights the strengthening of Freedom to Speak Up arrangements, the creation of champion networks and efforts to ensure that colleagues feel heard and valued. The Trust rightly recognises that listening to staff and responding to concerns are fundamental components of organisational improvement. The same principle logically extends to patients and communities. If listening to staff is essential for creating a learning organisation, listening to patients should be equally important for understanding whether services are meeting the needs of those who use them.

Co-production could also strengthen the monitoring of SCAS's improvement journey. Traditional organisational metrics often focus on what can be measured quantitatively, such as response times, staffing numbers, incident rates and compliance indicators. While these measures are important, they cannot fully explain whether improvements are translating into better experiences for patients and families. Involving patients, carers and community representatives in improvement oversight groups, quality committees or specific workstreams would allow the Trust to test whether improvements identified internally are producing meaningful external benefits. This would strengthen assurance for both regulators and local scrutiny bodies by demonstrating that progress is being validated not only by organisational self-assessment but also by those receiving services.

There is also a strong public accountability argument. Ambulance trusts are publicly funded organisations delivering services on behalf of local communities. Involving the public in shaping and scrutinising improvement programmes can strengthen transparency, trust and legitimacy. This is particularly important following periods of regulatory intervention or organisational challenge. International evidence suggests that organisations recovering from quality concerns often rebuild public confidence more effectively when service users are visibly involved in

[13] https://www.emas.nhs.uk/get-involved/patient-participation-group/.
[14] https://www.neas.nhs.uk/get-involved.aspx

monitoring progress and helping shape solutions. A comprehensive review published in *Health Expectations* found that meaningful patient involvement can improve trust, accountability and organisational legitimacy[15].

Ultimately, the Committee's recommendation reflects an increasingly accepted understanding that healthcare improvement should not be something that is done to patients but something that is done with patients. SCAS has demonstrated significant commitment to improving governance, culture, workforce development and patient safety, and these achievements should be recognised. However, the next stage of the improvement journey should ensure that patients, carers and communities play a more active role in shaping priorities, evaluating progress and identifying opportunities for further development. Strengthening public involvement and embedding co-production within the Trust's improvement programme would align with national NHS policy, academic evidence, and good practice from ambulance services across England. Most importantly, it would help ensure that improvements are judged not solely by organisational processes or regulatory assessments but by the experiences and outcomes of the people whom the service exists to serve.

Recommendation 2: *For the Ambulance Service to strengthen opportunities for public and patient involvement. It is recommended that there is coproduction as part of shaping and monitoring the Trust's improvement journey.*

To ensure that "speaking up" is not merely encouraged or measured per se, but to evidence that actions are followed up and lessons are learned around the themes emerging through "speaking up": The Committee's recommendation that SCAS should ensure that "speaking up" is not merely encouraged or measured, but that actions are demonstrably followed through and lessons are learned from the themes emerging through speaking up, reflects an important principle of effective organisational improvement. While encouraging staff to raise concerns is an essential component of a healthy organisational culture, evidence from healthcare regulation, national policy, organisational psychology and patient safety research consistently demonstrates that the true measure of a successful speaking-up culture is not how many concerns are raised, but what an organisation does with those concerns once they have been heard. A culture in which staff are actively encouraged to speak up but do not subsequently see meaningful action can ultimately become less safe than one where concerns are not raised at all, because repeated failures to respond may create cynicism, disengagement and loss of trust in leadership.

This recommendation is particularly relevant in the context of SCAS's ongoing Care Quality Commission (CQC) improvement journey. The

[15] https://onlinelibrary.wiley.com/doi/full/10.1111/hex.12640

report submitted to the Committee highlighted the substantial progress that the Trust has made since the CQC identified concerns relating to governance, leadership, clinical oversight and organisational culture. The report describes a significant programme of cultural improvement, including the development of a network of Freedom to Speak Up (FTSU) Champions, more than 800 conversations with staff, a 99% compliance rate for FTSU e-learning, and a 26% increase in concerns being recorded. The Trust states that these developments have improved its ability to "listen up" as well as encouraging colleagues to speak up. At the same time, however, the report acknowledges that there has been an increase in anonymous concerns and that significant themes continue to include bullying and harassment, behavioural concerns, psychological safety and sexual safety. The report further recognises that building a psychologically safe culture remains a continuing improvement priority rather than a completed task.

Importantly, during the Committee's discussion, the Head of Operations for Oxfordshire explicitly recognised that encouraging staff to raise concerns is only part of the challenge. He noted that the real challenge is "listening up" and ensuring that concerns result in meaningful follow-through, because if staff perceive that nothing changes, they will eventually stop reporting concerns. This observation goes to the heart of why the Committee made this recommendation. The success of Freedom to Speak Up arrangements cannot be judged purely by activity measures such as the number of champions trained, training compliance rates or the volume of concerns reported. Those indicators may show that mechanisms exist, but they do not demonstrate that the organisation is learning from concerns, addressing the issues identified, or improving outcomes for staff and patients.

The national Freedom to Speak Up framework itself supports this interpretation. The original *Freedom to Speak Up Review*, led by Sir Robert Francis QC and published in 2015, argued that organisations should not simply focus on creating channels for reporting concerns but should actively demonstrate that concerns lead to visible change. The review stressed that staff must have confidence that raising concerns will result in action and that organisations should routinely communicate the lessons learned and improvements made following concerns being raised. The report warned that where employees see little evidence of organisational response, confidence in speaking-up systems rapidly deteriorates[16].

Subsequent NHS England guidance has reinforced this position. The National Guardian's Office, which oversees Freedom to Speak Up arrangements across the NHS, repeatedly emphasises that organisations should move beyond measuring speaking-up activity and instead demonstrate organisational learning. Its guidance highlights that boards should ask not merely how many concerns have been raised, but

[16]https://webarchive.nationalarchives.gov.uk/ukgwa/20150218150343/http://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf

what themes are emerging, what actions have been taken, whether those actions have improved culture and whether staff can see evidence of change. The National Guardian's Office stresses that visible learning and feedback are essential components of maintaining trust in speaking-up processes[17].

The Committee's recommendation is also strongly supported by patient safety literature. Modern patient safety thinking increasingly recognises that healthcare organisations are complex adaptive systems in which frontline staff often identify risks long before those risks become visible through formal performance metrics or serious incidents. Professor Amy Edmondson's influential work on psychological safety, published in journals such as *Administrative Science Quarterly* and subsequently developed through her book The Fearless Organization, demonstrates that high-performing organisations are characterised not simply by people speaking up, but by leaders responding constructively to concerns. Edmondson found that organisations learn most effectively when staff feel safe to identify problems and when leaders treat concerns as opportunities for improvement rather than criticism[18].

Similarly, research published in *BMJ Quality & Safety* has consistently shown that effective incident reporting and speaking-up systems depend on visible organisational learning. Studies have demonstrated that staff are significantly more likely to report concerns when they believe that reporting leads to meaningful action, whereas under-reporting becomes more common when employees perceive that concerns disappear into bureaucratic processes without producing tangible change[19].

The themes identified within SCAS's own report submitted to the Committee further strengthen the Committee's argument. The Trust reports that bullying, harassment, psychological safety and sexual safety remain among the most significant categories of concerns being raised by staff. These are not isolated operational issues but indicators of underlying organisational culture. The existence of recurring themes means that the organisation now possesses valuable intelligence about where cultural challenges remain. The key question therefore becomes whether those themes are informing systemic interventions. It is not enough to know that concerns relate to bullying or psychological safety; the organisation must be able to demonstrate how information from those concerns is influencing leadership development, workforce policies, investigations, behavioural expectations, performance management and organisational culture programmes.

There are noteworthy examples elsewhere in the NHS where organisations have attempted to embed this learning approach. Mersey Care NHS Foundation Trust, often recognised nationally for its work on psychological safety and organisational learning, publishes examples

[17] https://nationalguardian.org.uk/.
[18] https://www.hbs.edu/faculty/Pages/profile.aspx?facId=6451
[19] available through https://qualitysafety.bmj.com

showing how staff concerns have resulted in specific policy changes, leadership interventions and service improvements. Rather than reporting only the number of concerns raised, the Trust focuses on demonstrating what changed because staff spoke up[20].

Similarly, University Hospitals Birmingham NHS Foundation Trust has sought to strengthen confidence in Freedom to Speak Up arrangements through regular "You Said, We Did" reporting. This approach explicitly links themes raised by staff to actions implemented by the organisation and aims to ensure that employees can observe the practical consequences of speaking up. Such approaches help convert speaking-up activity into organisational learning and reinforce trust in reporting mechanisms[21].

The recommendation being made by the Committee is especially important because SCAS is moving from a period of regulatory recovery into a phase of longer-term organisational maturity. The report submitted to the Committee for this item notes that the Trust has now exited the NHS Recovery Support Programme and has had several undertakings removed. These are significant achievements. However, the Trust itself acknowledges that further improvement is required and that the Board remains focused on continuing the improvement journey. Sustained improvement depends upon developing learning systems capable of identifying and responding to emerging risks before they become major problems. Freedom to Speak Up represents one of the most powerful sources of organisational intelligence available to any healthcare provider. Staff are uniquely positioned to identify barriers to safe care, weaknesses in governance, leadership challenges and cultural concerns. The value of FTSU therefore lies not in the act of speaking up itself but in the organisation's ability to convert that information into improvement.

Ultimately, the Committee's recommendation reflects a mature and evidence-based understanding of organisational culture. SCAS has clearly invested substantial effort in encouraging staff to speak up through champion networks, training programmes, leadership development initiatives and cultural improvement work. Those achievements should be recognised. However, the next stage of the Trust's cultural development should focus on demonstrating the impact of Freedom to Speak Up activity. This means evidencing how concerns are analysed, how themes are identified, how actions are implemented, how lessons are shared across the organisation and how leaders can demonstrate that staff voices directly influence change. Such an approach would align with the recommendations of the Francis Review, the expectations of the National Guardian's Office, NHS policy on organisational learning, and a substantial body of academic research on psychological safety and patient safety. Most importantly, it would help ensure that speaking up becomes not merely a measure of

[20] https://www.merseycare.nhs.uk/
[21] https://www.uhb.nhs.uk/

organisational activity, but a mechanism for continuous learning, safer care and lasting cultural improvement.

Recommendation 3: *For the Trust to ensure that "speaking up" is not merely encouraged or measured per se, but to evidence that actions are followed up and lessons are learned around the themes emerging through "speaking up".*

To support staff wellbeing and develop clear, measurable and transparent outcomes frameworks to demonstrate success in supporting staff and tackling burnout: The Committee's recommendation that SCAS should continue to support staff wellbeing and develop clear, measurable and transparent outcomes frameworks to demonstrate success in supporting staff and tackling burnout reflects a growing recognition across the NHS that staff wellbeing is not merely a workforce issue but a fundamental component of patient safety, service quality and organisational sustainability. The Committee welcomed the extensive work undertaken by SCAS as part of its CQC improvement journey and recognised the significant investment that has been made in culture change, staff support and organisational development. However, the Committee considered that it is no longer sufficient simply to demonstrate that wellbeing initiatives are being implemented. There must also be clear evidence that these initiatives are delivering measurable improvements in staff experience, reducing burnout and ultimately contributing to safer and more sustainable services.

The report submitted by SCAS to the Committee demonstrates that considerable progress has been made in strengthening support for staff. The Trust reported major developments across its Freedom to Speak Up arrangements, leadership development programmes, mental health support services, Occupational Health provision and organisational culture improvement work. The report notes that SCAS has strengthened its Freedom to Speak Up network, achieved 99% compliance with associated training, introduced culture champions, established leadership forums, implemented new leadership development programmes and secured a £250,000 wellbeing grant to strengthen support for learners and new recruits. The Trust has also expanded Mental Health First Aid provision, strengthened Trauma Risk Management support, developed a suicide prevention steering group and invested in programmes designed to create psychologically safe working environments. The Committee recognised these initiatives as positive and welcomed the continued commitment shown by the organisation towards staff wellbeing.

However, the report simultaneously highlights why continued attention is required. SCAS acknowledges that, despite progress in some areas, results from the NHS Staff Survey demonstrated that morale and burnout scores remained below the national average and that both organisational trust and staff engagement had declined. The Trust explicitly identified reducing the gap between local trust and organisational trust as a continuing challenge. These findings are significant because they

suggest that while substantial effort is being invested in wellbeing initiatives, the impact of these interventions cannot yet be viewed as fully realised. The Committee therefore concluded that the next stage of the improvement journey should focus not only upon delivering wellbeing initiatives but also upon demonstrating whether those initiatives are achieving their intended outcomes.

This recommendation being made by the JHOSC is consistent with wider national policy. NHS England's People Promise recognises staff wellbeing as a strategic priority and emphasises that NHS organisations should create environments where staff feel safe, supported, valued and able to thrive. The People Promise explicitly links staff wellbeing to patient experience, staff retention, productivity and quality of care. NHS England further argues that wellbeing programmes should be supported by robust metrics and meaningful evaluation rather than focusing solely on activity measures such as attendance at training or participation in wellbeing events[22].

The evidence linking staff wellbeing to patient outcomes is now substantial. One of the most influential reviews in this area was undertaken by Professor Michael West and Dame Denise Coia for NHS England, published as *Caring for Doctors, Caring for Patients*. The review concluded that the wellbeing of healthcare staff directly influences the quality and safety of patient care and argued that organisations have a responsibility to create environments in which staff can flourish. The review found that staff experiencing burnout are more likely to demonstrate reduced engagement, increased sickness absence, lower job satisfaction and a greater likelihood of making mistakes[23].

Academic research provides further support for the Committee's recommendation. A major systematic review published in *The Lancet* identified burnout among healthcare professionals as a significant threat to patient safety, workforce retention and organisational effectiveness. The study found consistent associations between burnout and higher rates of patient safety incidents, reduced professionalism and poorer quality of care[24]. Similarly, research published in *BMJ Open* found that ambulance staff experience some of the highest levels of occupational stress within the NHS due to exposure to trauma, shift working, high workloads and emotionally demanding situations. This research highlighted the importance of organisational support mechanisms in reducing burnout and promoting resilience[25].

The ambulance sector faces particular challenges that make staff wellbeing especially important. Ambulance clinicians routinely encounter traumatic incidents, death, serious injury, distressed families and highly

[22] https://www.england.nhs.uk/ournhspeople/online-version/lfaop/supporting-our-nhs-people/people-promise
[23] https://www.gmc-uk.org/-/media/documents/caring-for-doctors-caring-for-patients_pdf-80706341.pdf
[24] The Lancet: Interventions to Reduce Burnout Among Physicians
[25] https://bmjopen.bmj.com/content/12/3/e050965

pressured operational environments. They often work long shifts, experience unpredictable workloads and face the challenges associated with hospital handover delays and increasing demand. Research published in the *British Paramedic Journal* has shown that paramedics experience high rates of occupational stress, emotional exhaustion and psychological distress compared with many other professional groups[26].

Importantly, many NHS organisations have moved towards outcome-based wellbeing frameworks rather than relying solely on descriptions of wellbeing initiatives. For example, Northumbria Healthcare NHS Foundation Trust has developed a comprehensive workforce wellbeing strategy accompanied by quantitative measures relating to sickness absence, staff survey results, workforce retention and wellbeing service utilisation[27]. Similarly, Mersey Care NHS Foundation Trust has established a wellbeing framework that uses measurable indicators alongside qualitative feedback to assess whether wellbeing investments are genuinely improving staff experience[28].

Within the ambulance sector, London Ambulance Service has increasingly integrated workforce wellbeing metrics into its People Strategy, monitoring indicators such as sickness absence, retention, staff survey responses, psychological support uptake and workforce engagement measures. The rationale for this approach is that leadership teams require objective evidence to determine whether interventions are producing meaningful improvements rather than simply demonstrating activity[29].

The Committee's recommendation is therefore not a criticism of the work already undertaken by SCAS but rather reflects the view that the Trust has now reached a stage in its improvement journey where demonstrating impact is as important as demonstrating commitment. The report identifies a wide range of positive initiatives, including wellbeing conversations training, occupational health improvements, mental health support programmes, leadership development and culture change interventions. These initiatives should continue to be supported and expanded where necessary. However, the Committee considered that it should be possible to evidence whether those initiatives are leading to measurable improvements in areas such as sickness absence, turnover rates, retention, burnout indicators, NHS Staff Survey results, engagement scores, psychological safety measures and workforce stability. Such information would provide a more robust basis for understanding whether interventions are succeeding and would strengthen assurance for staff, regulators, governors and local scrutiny bodies.

[26] British Paramedic Journal: Occupational Stress and Paramedic Wellbeing
[27] https://www.northumbria.nhs.uk/about-us/our-strategy
[28] https://www.merseycare.nhs.uk/about-us/our-values-and-strategy
[29] https://www.londonambulance.nhs.uk/about-us/our-strategy

There is also an important transparency argument underpinning the recommendation. Healthcare organisations frequently report the activities they undertake to support wellbeing but comparatively few publish comprehensive assessments of whether those activities have improved outcomes. Transparent reporting of wellbeing measures can help strengthen trust between staff and leaders by demonstrating that wellbeing is being treated as an organisational outcome rather than a promotional initiative. It would also support learning across the wider NHS, enabling other organisations to understand which interventions are having the greatest impact.

Ultimately, the Committee concluded that staff wellbeing must remain central to SCAS's continued improvement journey. The evidence presented demonstrates that SCAS has invested significantly in supporting its workforce and has implemented a substantial programme of cultural and organisational development. Nevertheless, the persistence of concerns relating to morale, organisational trust and burnout demonstrates that this work remains unfinished. National policy, academic evidence and experience across the NHS all show that staff wellbeing is intrinsically linked to patient safety, workforce retention and organisational performance. The Committee therefore considered it appropriate to recommend that SCAS not only continues its investment in staff wellbeing but also develops clear, measurable and transparent outcomes frameworks capable of demonstrating whether those investments are delivering meaningful improvements for staff and, ultimately, for the patients they serve.

Recommendation 4: *To ensure that there is continued support for staff wellbeing. It is recommended that there are clear, measurable, and transparent outcomes frameworks to demonstrate success in supporting staff and in tackling burnout.*

Legal Implications

13. Health Scrutiny powers set out in the Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide:
  - Power to scrutinise health bodies and authorities in the local area
  - Power to require members or officers of local health bodies to provide information and to attend health scrutiny meetings to answer questions
  - Duty of NHS to consult scrutiny on major service changes and provide feedback n consultations.

14. Under s. 22 (1) Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 'A local authority may make reports and recommendations to a responsible person on any matter it has reviewed or scrutinised'.

15. The Health and Social Care Act 2012 and the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 provide that the Committee may require a response from the responsible person to

whom it has made the report or recommendation and that person must respond in writing within 28 days of the request.

Annex 1 – Scrutiny Response Pro Forma

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