Public Board Meeting 16.09.2026

Wednesday 16 September 2026, 09:30 - 12:30

Agenda

09:30 - 10:00
30 min

1. Opening Administration

1.1. Welcome

Trust Chair

1.2. Apologies for Absence

Trust Chair

1.3. Declarations of Interest

Trust Chair

1.4. Patient Story

Discussion *Chief People Officer*

Patient Story Report.pdf (3 pages)

1.5. Trust Chair Report

Trust Chair

Trust Chair Report.pdf (3 pages)

1.6. CEO Report

Chief Executive Officer

CEO Board Report.pdf (8 pages)

1.7. Minutes of Previous Meeting

Trust Chair

Draft Public Board Minutes 10.06.2026.pdf (15 pages)

1.8. Matters Arising and Action Tracker

All

Public Board Action Tracker 16.09.2026.pdf (1 pages)

10:00 - 10:40
40 min

2. Patients and Partnerships

2.1. Board Assurance Framework Summary

Chief Paramedic and Director of Quality, Medical Director, Chief Operating Officer, Director of Strategic Partnerships and Governance

Board Assurance Framework.pdf (5 pages)

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2.2. Integrated Performance Report – Patient and Partnerships

Chief Paramedic and Director of Quality, Medical Director, Chief Operating Officer, Director of Strategic Partnerships and Governance

- Coversheet - IPR.pdf (3 pages)
- Patients - Performance 2.pdf (21 pages)
- Patients - Clinical.pdf (13 pages)

2.3. Winter Plan

- Winter Plan 2026-27 - Public.pdf (3 pages)
- Winter Planning Review Outcome 28.08.26 - Public.pdf (11 pages)

2.4. Quality Governance Committee Assurance Report

Committee Chair

- QGC Report to Board 24.06.2026.pdf (4 pages)

2.5. Performance Committee Assurance Report

Committee Chair

- Performance Committee report to Board Sept 26.pdf (4 pages)

10:40 - 10:50
10 min

Break

10:50 - 11:40
50 min

3. People

3.1. Board Assurance Framework Summary

Chief People Officer

3.2. Integrated Performance Report - People

Chief People Officer

- IPR - People.pdf (9 pages)

3.3. Freedom to Speak Up Report

FTSU Guardians

- FTSU Report.pdf (4 pages)
- Board Report EEAST Aug 26 Final.pdf (10 pages)
- 16 09 2026 East of England case data comparison 25.26 (003) (1).pdf (2 pages)

3.4. WRES and WDES Submission and Action Plan

Chief People Officer

- WRES and WDES Coversheet.pdf (3 pages)
- WRES WDES Trust Board 9Sept26.pdf (14 pages)
- WDES Annual Report 2025-26 Jul26.pdf (27 pages)

3.5. Gender Pay Gap Reporting

Chief People Officer

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- Coversheet - Gender Pay Gap Report.pdf (4 pages)
- Gender Pay Gap Report 2026.pdf (7 pages)

3.6. Remuneration Committee Assurance Report

Committee Chair

Remuneration Committee Assurance Report 20.07.2026.pdf (2 pages)

3.7. People Committee Assurance Report

Committee Chair

People Committee Assurance Report 22.07.2026.pdf (3 pages)

11:40 - 12:05
25 min

4. Productivity

4.1. Board Assurance Framework Summary

Chief Finance Officer, Director of Digital Innovation

4.2. Integrated Performance Report - Productivity

Chief Finance Officer, Director of Digital Innovation

IPR - Finance.pdf (9 pages)

4.3. Annual External Audit Management Letter

Chief Finance Officer

Coversheet - External Independant Auditor's Annual Report 2026.pdf (2 pages)
East of England Ambulance Service Trust - Auditors Annual Report 25-26 Final.pdf (24 pages)

4.4. Audit Committee Assurance Report

Committee Chair

Audit Committee July 2026 Report to Board.pdf (5 pages)

4.5. Finance and Sustainability Committee Assurance Report

Committee Chair

FAS Report to Board 07.07.2026.pdf (3 pages)

12:05 - 12:15
10 min

5. Governance

5.1. Provider Capability Assessment Submission 2026

Decision *Director of Strategic Transformation and Governance*

Provider Capability Assessment - Coversheet.pdf (3 pages)
Appendix 1 - Provider Capability Assessment.pdf (21 pages)

12:15 - 12:20
5 min

6. Closing Administration

6.1. Questions from the Public

Trust Chair

6.2. Reflection on Meeting

Director of Strategic Partnerships and Governance

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6.3. Date of Next Meeting: Wednesday 11 November 2026 (09.30 – 12:30)

12:20 - 12:30
10 min

7. Corporate Trustee

7.1. Minutes of Previous Meeting

Trust Chair

- Corporate Trustee Minutes 10.06.2026.pdf (2 pages)

7.2. Charity Policy Approvals

- Coversheet - Charity Policies.pdf (2 pages)

7.2.1. Complaints Procedure

- Complaints procedure v1.pdf (13 pages)

7.2.2. Investment Policy

- Investment Policy v1.pdf (13 pages)

7.2.3. Reserves Policy

- Reserves Policy v1.pdf (12 pages)

7.2.4. Risk Management Policy

- Risk Management Policy v1.pdf (12 pages)

7.2.5. Cash Handling Policy

- Charity Cash Handling Policy v1.pdf (15 pages)

7.3. Charitable Funds Committee Assurance Report

Committee Chair

- CFC Escalation Report 03.09.2026.pdf (3 pages)
- DRAFT terms of reference for Charitable Funds Committee.pdf (8 pages)

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Meeting:	Trust Board – Public Meeting	**Date:**	16.09.2026
Report Title:	Patient Story – Hear and Treat – Ambulance no send		
Agenda Item:	PUB26/09/1.4		
Author(s):	Victoria Boyce, Patient and Public Engagement Manager		
Lead Director:	Simon Chase, Chief Paramedic / AHP and Executive Director of Quality		

Purpose:	Decision Approval		Discussion Review	**X**	Information Noting	
Assurance:	Limited		Reasonable	**X**	Substantial	

Link to CQC domain:		**Link to EEAST's Strategic Missions:**	
Caring	**X**	Patient Mission	**X**
Responsive	**X**	Partnership Mission	
Effective	**X**	People Mission	
Well Led		Productivity Mission	
Safe	**X**		

Link to Strategic Risk:									
SR1	**X**	SR3		SR5		SR7		SR9	
SR2	**X**	SR4	**X**	SR6		SR8		SR10	

Equality Impact Assessment Undertaken: YES		**NO**	**X**

Previously considered by:

This patient story has not been previously viewed by the Board.
Consent has been received from the patient to share her experience with the Trust Board.

Executive Summary:

What?

The patient story describes the experience of Susan, who initially contacted NHS 111 during a significant episode of acute illness associated with severe suspected norovirus and dehydration. Susan lives with Functional Neurological Disorder (FND), which affects her ability to swallow safely, and resides with her daughter who has Stage V kidney disease and is clinically vulnerable to infection.

Following assessment by NHS 111, a request for a Category 3 ambulance response was made to the Trust.

However, during a period of exceptional system pressure, the case was clinically reviewed through the Trust's Hear and Treat/clinical review process and a decision was made that an ambulance response would not be dispatched. Susan was subsequently advised to seek alternative healthcare support and, if necessary, make her own way to hospital.

The patient's subsequent complaint highlighted the significant impact this decision had on her and her family. Susan felt that her individual circumstances, particularly the implications of her FND and her daughter's clinical vulnerability, had not been fully understood or considered. She also

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described feeling that the communication of the decision was delivered too quickly and did not provide sufficient opportunity to explain her concerns or seek clarification.

The Trust undertook a comprehensive investigation which found that the clinical decision-making process was consistent with established operational protocols in place during a period of severe demand, when ambulance resources were being prioritised for patients at immediate risk to life.

The investigation found no evidence that the decision itself was clinically unsafe based on the information available to clinicians at the time.

However, it did identify that the communication, by the Hear and Treat function, of the decision fell below the standard expected by the Trust. The call handling and clinical intervention approach did not sufficiently support a two-way conversation that would have enabled the patient's family to fully express their concerns or provide additional contextual information.

Importantly, the patient's participation in a Discovery Interview provided valuable insight into the lived experience of receiving a Hear and Treat outcome during periods of extreme operational pressure. The Board is asked to recognise and thank Susan for her openness, honesty and willingness to share her experience to support service learning and improvement.

So What?

This case demonstrates both the value and the challenge of modern ambulance service Hear and Treat models.

Telephone assessment, clinical triage and Hear and Treat pathways are now an established and evidence-based component of urgent and emergency care. They enable ambulance services to safely manage many patients without dispatching an ambulance, ensuring that scarce emergency resources remain available for patients experiencing immediately life-threatening conditions.

These models are supported by clinical governance frameworks, nationally recognised triage systems and senior clinical oversight. They are critical in maintaining patient safety across the wider population during periods of exceptional demand but also will be a developing and increasing method of care delivery linked to the Trusts' Patient plan that was recently launched to the public.

Highlighting this case at Trust Board, aims to provide assurance that clinical decision-making processes were applied appropriately and that the service sought to balance the needs of an individual patient against the wider requirement to maintain emergency responses for patients at greatest risk of serious harm or death.

However, the case also highlights an equally important aspect of safe care: effective communication.

Safe clinical decisions can only be fully effective when they are accompanied by clear, compassionate and patient-centred communication. When patients and families do not feel heard, understood or able to contribute additional information, confidence in clinical decisions can be undermined regardless of whether those decisions are clinically appropriate.

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The patient's feedback reinforces the importance of ensuring that staff communicate decisions in a manner that promotes understanding, allows questions to be raised and provides opportunities for

additional information to be shared where circumstances may influence the most appropriate care pathway.

This learning aligns directly with the Trust's commitments to delivering care that is Safe, Effective, Responsive and Caring, while supporting system sustainability through clinically led telephone assessment and Hear and Treat pathways.

What Next?

The Trust has already provided individualised feedback and learning to the member of staff involved, focusing on communication style, pacing of conversations and techniques to ensure patients and families have opportunities to raise concerns and provide additional context.

Further organisational learning will continue to emphasise:

- The importance of high-quality clinical communication when advising patients of ambulance "no send" decisions.
- Creating opportunities for patients and carers to explain barriers to self-care or self-conveyance.
- Reinforcing escalation pathways where additional clinical review may be required.
- Ongoing review of patient experience themes arising from Hear and Treat and clinical triage complaints.
- Continued assurance through established clinical governance, patient experience and quality oversight processes.

The Trust extends its sincere thanks to Susan for participating in the Discovery Interview and helping us better understand the human impact of our decisions during periods of significant operational pressure. Her experience has provided valuable insight that will support ongoing improvements to both patient experience and communication practices across the organisation.

Action Required by the Board:

The Board is asked to:

- Note the patient story and associated learning.
- Take reasonable assurance that Hear and Treat and clinical review processes remain safe, clinically governed and effective methods of managing emergency demand while preserving ambulance responses for patients with immediate life-threatening conditions.
- Recognise the importance of compassionate communication and shared decision-making in maintaining patient confidence and experience.
- Thank the patient for her participation in the Discovery Interview and for contributing to organisational learning and quality improvement.

How does this report link with EEAST's vision, purpose and values?

https://www.eastamb.nhs.uk/about-us/our-corporate-strategy

This links with EEAST patient mission by being able to provide high-quality urgent and emergency care that is fair, responsive and focused on patient need.

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Meeting:	Public Board	**Date:**	16.09.2026
Report Title:	Trust Chairs report		
Agenda Item:	PUB26/09/1.5		
Author(s):	Julie Thallon, Interim Trust Chair		
Lead Director:	Julie Thallon, Interim Trust Chair		

Purpose:	Decision Approval		Discussion Review		Information Noting	**X**
Assurance:	Limited		Reasonable		Substantial	

Link to CQC domain:		**Link to EEAST's Strategic Missions:**	
Caring	**X**	Patient Mission	**X**
Responsive	**X**	Partnership Mission	**X**
Effective	**X**	People Mission	**X**
Well Led	**X**	Productivity Mission	**X**
Safe	**X**		

Link to Strategic Risk:									
SR1	X	SR3	X	SR5	X	SR7	X	SR9	X
SR2	X	SR4	X	SR6	X	SR8	X	SR10	X

Equality Impact Assessment Undertaken: YES		**NO**	

Previously considered by:

N/A

Executive Summary:

What?

This report is to update the Board on chair and non-executive activities since the last Board. It will identify:

- Key areas of Board focus since the last report
- Non-executive Director additional activities providing wider assurance and board visibility
- Key activities for the chair since the last report

So What?

This report demonstrates non-executive commitment and engagement across the trust and the various ways in which assurance is sought. The board sub-committees provide separate reports into board and so this reflects the other activities, and the variety of activities engaged in. It also reflects where non-executive focus is applied to support the trust to achieve its organisational objectives.

What Next?

Board focus:

As we come out of a very hot summer where we have seen record levels of activity the trust is now fully engaged in winter planning. Much work both internally and with partners is underway. Our focus currently is 2-fold:

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- ensuring that we have the most robust arrangements to provide a safe and good quality service to our patients as we move into winter.
- ensuring that we have the most robust arrangements to support our staff and enable them to work safely, use their full range of competencies and enable them to deliver a service they can be proud of.

We fully expect this to be a very challenging period for the trust with activity levels already higher than we've experienced previously. We are working with partners and NHSE to put in place the necessary arrangements to ensure that systems are working well together to provide the best and most appropriate service to our patients. Performance remains challenging for the trust as we move into the coming months and every effort will be made to maintain performance levels through the improvements in productivity and operations that we have achieved to date.

We are currently undertaking a review of our organisational culture to better understand the environment and challenges that our people work in. We have also recently been inspected by the CQC in a routine unannounced visit. Both these processes will provide us with valuable information for us to improve the working lives of our people.

Non-Exec activities:

Catherine Glickman – met with the HWE team and 1:1 meetings with executive directors.
Victoria Corbishley – meetings regarding the Trust Charity.

We are currently recruiting a new non-executive director to our board and chair of our People Committee. We hope to make an announcement soon about an appointment.

Chair activities:
As the interim Chair I have been spending time over the period since the June meeting, meeting with colleagues internally and externally. I have met with chairs from ICBs, trusts and NHS England and more meetings booked. These developing relationships will be crucial as we proceed with delivering our strategy but also more immediately with our management of winter.

I have met with all the Staff Networks except one now and will be feeding my reflections back to Executive colleagues about my reflections from those discussions. They all provide a valuable service to colleagues across the trust and their input to the board and I'm keen to ensure we maximise that contribution.

I have also visited the Emergency Operations Centres in Norwich and Chelmsford and spent time talking to colleagues which is always informative and interesting.

George Lynn
It is with great sadness that I report the death of one of our non-executive colleagues, George Lynn. George was a member of our board for 3 years and his quiet, thoughtful and expert experience provided a unique contribution that we all valued greatly. We miss him and extend our deepest condolences to his family.

Action Required by the Board:

Kingsmill Esther (NHS) 1019102626-5-5141

To note and discuss.
How does this report link with EEAST's vision, purpose and values? *https://www.eastamb.nhs.uk/about-us/our-corporate-strategy*

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Meeting:	Public Board	**Date:**	16.09.2026
Report Title:	Chief Executive Update		
Agenda Item:	PUB26/09/1.6		
Author(s):	Liz Cunnell, Chief of Staff		
Lead Director:	Neill Moloney, Chief Executive		

Purpose:	Decision Approval		Discussion Review	x	Information Noting	
Assurance:	Limited		Reasonable		Substantial	

Link to CQC domain:		**Link to EEAST's Strategic Missions:**	
Caring	x	Patient Mission	x
Responsive	x	Partnership Mission	x
Effective	x	People Mission	x
Well Led	x	Productivity Mission	x
Safe	x		

Link to Strategic Risk:									
SR1		SR3		SR5		SR7		SR9	
SR2		SR4		SR6		SR8		SR10	

Equality Impact Assessment Undertaken: YES		**NO**	

Previously considered by:

Executive Summary:

What?

The Chief Executive's report highlights continued organisational focus on improving patient care, workforce wellbeing, culture and stakeholder engagement across the Trust. Key areas include:

- Operational performance has improved through an 8% increase in double-staffed ambulance hours, supported by additional overtime and commissioned resources.
- Category 1 and Category 2 response times improved in July compared with June, with Category 1 performance at 8m 49s and Category 2 performance at 34m 51s.
- Emergency Operations Centres maintained excellent call answering performance, averaging 2.7 seconds despite handling more than 100,000 emergency contacts in July. Hear and Treat performance achieved target at 17.94%.
- Vehicle availability continued to improve, with vehicle off road levels reducing to 15.87% as new fleet vehicles entered service.
- The Trust underwent a Care Quality Commission (CQC) inspection in July 2026 and remains within the active inspection period.
- Significant focus has been placed on staff wellbeing, including the launch of Perkbox and further initiatives to support staff health and resilience.
- The independent culture review continues, with findings expected in October 2026.

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The report celebrates numerous staff achievements, national awards and recognition events, including Stars of EEAST, King's Birthday Honours recipients, and EEAST becoming the first UK organisation to achieve the British Dyslexia Association Gold Dyslexia Friendly Workplace Quality Mark.

So What?

The report provides assurance that progress is being made against all four strategic missions while maintaining a strong focus on operational delivery, regulatory compliance and organisational culture.

Key implications for the Board are:

- Increased frontline staffing hours, improved response times and reduced fleet downtime demonstrate positive operational improvements ahead of the winter period, although demand pressures remain significant.
- Strong EOC performance and achievement of Hear and Treat targets indicate continued effectiveness in managing increasing patient demand and reducing avoidable ambulance dispatches.
- The ongoing CQC assessment represents a significant regulatory milestone, and the Trust must maintain focus on evidencing improvements and responding promptly to any additional requests.
- The independent culture review provides an important opportunity to identify and address cultural issues, strengthen staff experience and support long-term organisational improvement.
- Investment in staff wellbeing, recognition and inclusion supports workforce retention, engagement and organisational resilience during a period of sustained operational pressure.
- High profile external recognition, awards and partnership activity continue to strengthen the Trust's reputation and demonstrate leadership within the ambulance sector.

Overall, the report indicates positive progress across operational, people and partnership priorities, while highlighting the need to maintain momentum on performance improvement, culture and regulatory assurance.

What Next?

- Maintain enhanced Patient Facing Staff Hours and operational resilience measures to support performance through periods of increasing demand and winter pressures.
- Continue to monitor and improve Category 1 and Category 2 response times, EOC performance and fleet availability through regular performance reporting and operational oversight.
- Support and coordinate ongoing engagement with the CQC until the inspection process concludes and findings are published.
- Receive the outcome of the independent culture review in October 2026 and develop a Trust-wide action plan to address recommendations and drive cultural improvement.
- Continue implementation and evaluation of wellbeing initiatives, including Perkbox, to support staff health, recruitment and retention.
- Maintain regular CEO engagement with staff, volunteers and partners to ensure visibility, strengthen relationships and support delivery of the Trust's strategic objectives.

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- Progress against these priorities will be monitored through Executive Leadership Team oversight, performance reporting and future CEO updates to the Board.

Action Required by the Board:

To review and discuss the CEO report.

How does this report link with EEAST's vision, purpose and values?

https://www.eastamb.nhs.uk/about-us/our-corporate-strategy

As discussed above all workstreams and areas of work align with our corporate strategy.

Personal Reflection:

July and August have often provided an opportunity for our staff to have some much-needed rest in advance of the Autumn and Winter pressure. We have improved the processes for booking leave and increased the allocation of leave following feedback from staff, enabling more of our teams to take some time off.

The really warm weather during this time will have been welcomed by some holiday makers to the East of England and we often do experience an increase in demand at this time, particularly near the coast. Extreme temperatures will also increase pressure on the health sector and this was demonstrated throughout the summer with increased activity compared with last year. We thank all our teams who have worked incredibly hard over this period.

This month I have had the opportunity to celebrate 999 Emergency Services day on 9th September. It was a great opportunity to reflect on the strength of our relationship with blue light colleagues and the excellent work we have completed in collaboration with the fire service, the police and other blue light partners. These include but are not exclusive to the Bedford train incident, the Dunwich Heath fire and all the day-to-day incidents which form part of our everyday roles. On the day I visited our teams in Ipswich and Bury but also took the opportunity to meet with Fire and Police colleagues in Suffolk to thank them for their hard work and commitment. I really appreciated the warm welcome I received from everyone.

A huge thank you to everyone responding to 999 calls across our region and for the contribution to our patients and communities. It's good to take the opportunity to celebrate the great work we do together as a 999 team.

Organisational Performance

The Trust continues work to strengthen patient care and service delivery, supported by an increase in Patient Facing Staff Hours (PFSH). On average we have increased Double Staffed Ambulance hours by 8% each week, compared with last year. This has been necessary due to an increase in demand of over 6% compared to last year.

In July C2 performance was 34 minutes and 51 seconds, and Category 1 performance was 8 minutes and 49 seconds. Performance in each of these categories was better than June 2026,

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although behind our plan for this year. Hospital Handover delays were longer than their plan with an average handover of 35 minutes and 44 seconds in August 2026 and 33 minutes year to date.

Our Emergency Operational Control (EOC) rooms have maintained excellent call pick up performance in June and July with an average call answer time of 2.7 seconds. This is despite dealing with over 100,000 emergency contacts in the month of July. Our Hear and Treat rate is currently 17.94% which meets our target for the month.

Operational support colleagues continue to work hard to reduce the number of vehicles off road, and in July numbers reduced further to 15.87%. We now have many of our new vehicles operational, and this makes a huge contribution to the service we deliver to patients.

Regulatory update

Care Quality Commission (CQC

The CQC inspected EEAST as part of their assessment programme on the 21, 22 and 23 July 2026. Whilst the Trust awaits the report for factual accuracy, we remain in the active inspection period with the potential for more data requests and or on site visits.

During the unannounced inspection, the inspection team visited a number of stations, emergency operations centres, completed ride outs with our crews and spoke to many of our staff across all counties within the East of England footprint. The report from this recent visit will be released along with the report from the 2024 inspection. The date of publication is yet to be confirmed by the CQC.

Stars of EEAST

The Stars of EEAST awards event was held on the 10th September, and was a great opportunity to celebrate the incredible work of our people. We received 456 nominations showcasing the remarkable achievements of our people and teams.

I would like to thank everyone who took the time to nominate a staff member and offer a huge congratulations to our winners. Our communications team work really hard to ensure that the evening is really special for all the nominations and winners. A big thank you for all their hard work.

Wellbeing Update

The Trust has recently launched access to Perkbox, an employee assistance programme which provides a range of wellbeing support in an easy to access format. Perkbox is available for all our staff and volunteers and offers 24/7 confidential support. It also provides GP and physiotherapy support to assist our people to stay at work and deliver a service to patients.

The wellbeing of our staff is a top priority and this initiative has received strong support from our staff.

Independent Culture Review

In April we launched an independent cultural review lead by Nazir Afzal OBE and Rise Associates in our Norfolk and Waveney and Bedfordshire and Luton sectors. In July the review team also visited staff in Peterborough and Stevenage. The lessons we learn from the review will be applied across the whole organisation.

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The report will be available in early October and will be presented to the Board in October. This will include recommendations and be supported by a clear action plan.

Engagement

Sadly, since my last report we have lost a number of our colleagues.

George Lynn



We are sorry to share the sad news of George Lynn's passing. George served as a non-executive director at EEAST from June 2023 to April 2026, bringing a wealth of experience and knowledge. George was a Fellow of the Institute of Chartered Accountants.

He was a passionate and committed member of our Trust Board and will be greatly missed by us all.

David Shea

It is with great sadness that I share the news of the sudden passing of David Shea.



David joined the clinical engineering team in May and, despite being with us for only a short time, he made a meaningful and lasting impression on everyone who had the privilege of working alongside him.

His enthusiasm, positivity, and genuine kindness were evident from the moment he joined the team.

Prior to joining the clinical engineering team David worked as a frontline clinician after a long career in the RAF.

Our thoughts and deepest condolences are with David's family, friends, and colleagues during this difficult time.

Jess McKee



It is with great sadness that we must confirm that our colleague Jess McKee has passed away.

Jess, 28, died following a fire at her home in Thetford in the early hours of Saturday, 22 August 2026.

Jess was an emergency medical technician and was set to qualify as a paramedic in January.

Jess was a hugely popular and friendly colleague, known for being kind and committed to patient care. Her passing has been devastating for her colleagues, family and friends – she will be greatly missed by all at EEAST.

Celebrations

Peterborough paramedic named University of Cumbria "Apprentice of the Year"

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Hard work, determination and a passion for patient care have earned a newly qualified paramedic based in Peterborough the title of Apprentice of the Year from the University of Cumbria's Institute of Health.



Jade Ford received the prestigious award at a graduation ceremony in July after completing the University's Paramedic Degree Apprenticeship with first-class honours.

The award celebrates Jade's exceptional commitment, academic excellence and dedication throughout her studies, during which she balanced the demands of frontline ambulance work with university learning.

Jade was selected from a highly competitive field of healthcare students at the University of Cumbria, one of the UK's leading providers of paramedic degree apprenticeships. Huge congratulations from us all to Jade.

Gold Dyslexia Friendly Workplace award

EEAST has become the first organisation in the UK to be awarded the British Dyslexia Association's Gold Dyslexia Friendly Workplace Quality Mark.

The prestigious award recognises EEAST's commitment to creating an inclusive workplace where neurodivergent staff and volunteers are supported to thrive and achieve their full potential.



The achievement marks the latest milestone in the Trust's commitment to supporting staff with dyslexia and other neurodivergent conditions. EEAST was awarded the Bronze Quality Mark in 2023, the Silver Quality Mark in 2024 and the Inclusive Employer Award later the same year before progressing to the gold standard.

More than 600 neurodivergent staff and volunteers have received specialist support through the Trust's dedicated service, led by Specialist Lecturer Practitioners Justin Honey-Jones and Emily Watton.

EEAST supports staff with a wide range of neurodivergent conditions, including dyslexia, autism, ADHD, dyspraxia, dyscalculia, Tourette's syndrome and visual stress.

EEAST's pioneering work in supporting neurodivergent staff has been widely shared across the NHS and emergency services, helping to shape best practice nationally.

The Gold Quality Mark was presented at EEAST's headquarters in Melbourn by Liz Green OBE MStJ DL on behalf of His Majesty's Lord-Lieutenant of Hertfordshire.

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King's Birthday Honours recognise two outstanding EEAST clinicians

We are proud to share that two EEAST colleagues have been recognised in The King's Birthday Honours List 2026 for their exceptional contributions to patient care and the ambulance profession.

Deputy Chief Paramedic awarded British Empire Medal



Deputy Chief Paramedic Paul Gates has been awarded the British Empire Medal (BEM) for his significant contribution to improving pre-hospital emergency care across Essex and nationally.

At EEAST, Paul leads on clinical practice, professional standards, patient safety and patient experience, helping ensure we deliver the highest quality care for our patients.

Alongside his role within the Trust, Paul has made a major impact through his long-standing work with the British Association for Immediate Care (BASICS). He is currently Vice-Chair nationally, as well as Co-Founder and Chairman of BASICS Essex.

Paul joined BASICS in 2004 and, while working full-time, completed the Advanced Pre-Hospital Care Course and Diploma in Immediate Medical Care in 2005, becoming one of a small number of paramedics at the time to pass at the first attempt. He later played a key role in bringing together Essex's two BASICS schemes to form BASICS Essex in 2010, creating a stronger and more sustainable service.

BASICS supports volunteer doctors, paramedics and other healthcare professionals to deliver urgent care to seriously ill or injured patients at scene. In 2025, BASICS Essex volunteers responded to more than 350 critical incidents across the county, working alongside statutory emergency services, including EEAST teams.

King's Ambulance Service Medal for advanced paramedic

Advanced Paramedic Liam Sagi has been awarded the King's Ambulance Service Medal (KAM) for his outstanding contribution to emergency care, particularly his work to improve cardiac arrest survival rates across the UK.

Liam is the National Strategic Lead for Out-of-Hospital Cardiac Arrest at the Association of Ambulance Chief Executives (AACE). He also works as an Advanced Paramedic in Critical Care with both EEAST and East Anglian Air Ambulance (EAAA).

He treats some of the most seriously ill and injured patients, while also helping to shape national approaches to care. He is particularly passionate about improving survival from cardiac arrest, focusing on strengthening the entire chain of survival – from bystander response through to post-resuscitation care.

Liam has played a key role in introducing live video support for 999 callers during out-of-hospital cardiac arrest – a UK-first approach developed at EEAST. The system allows bystanders to be guided in real time to deliver CPR and use a defibrillator, providing critical early intervention before crews arrive.

He began his ambulance career in London in 2011, moving to the East of England in 2014. After completing a master's degree in Emergency and Resuscitation Medicine, he qualified as an Advanced Paramedic in Critical Care. He now works across air ambulance bases in Cambridge and Norwich, EEAST's Emergency Operations Centre, and East Suffolk's advanced paramedic response vehicle.

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Alongside his clinical and national roles, Liam volunteers with Suffolk Accident Rescue Service (SARS), responding from home to serious incidents, and has contributed to research and innovation in areas including traumatic brain injury and cardiac arrest. In 2021, he was named Air Ambulance UK Critical Care Practitioner of the Year.

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EAST OF ENGLAND AMBULANCE SERVICE NHS TRUST
MINUTES OF THE MEETING OF THE BOARD OF DIRECTORS,
HELD IN PUBLIC ON WEDNESDAY 10 JUNE 2026 (09:30-12:30)
at EEAST, MELBOURN HEADQUARTERS, SG8 6NA

Present:			
Members	Julie Thallon	Interim Trust Chair	TC
	Catherine Glickman	Non-Executive Director	NED-CG
	Chris Brook	Non-Executive Director	NED-CB
	Darren Meads	Chief Operating Officer	COO
	Dr Hein Scheffer	Director of Strategy, Transformation and Governance	DoSTG
	Marika Stephenson	Chief People Officer	CPO
	Neill Moloney	Chief Executive Officer	CEO
	Sian Clark	Director of Digital Innovation	DDI
	Dr Simon Walsh	Medical Director	MD
	Steven Course	Chief Finance Officer	CFO
	Susan Wilkinson	Non-Executive Director	NED-SW
	Victoria Corbishley	Non-Executive Director	NED-VC
In attendance			
	Danielle Marshall	The Guardian Service *(PUB26/06/4.4 only)*	FTSUG-DM
	Kimberley Gillingham	The Guardian Service *(PUB26/06/4.4 only)*	FTSUG-KG
	Jacquie Pamphilon	The Guardian Service (PUB26/06/4.4 *only*)	FTSUG-JP
	Julie Young	Interim Company Secretary	CS
	John Newman	CEG Representative	CEGR
	Luke Roberts Andeou	Sector Clinical Lead (**PUB26/06/1.4 only)**	SCL
	Paul Gates	Deputy Chief Paramedic	CP
	Tom Bennett	Head of Communications	HoC
Administration	Esther Kingsmill	Head of Corporate Governance	HoCG

PUBLIC SESSION (Disclosable)	
PUB26/06/1.1	**Welcome**
1.1.1	*The meeting commenced at 09:30*
1.1.2	Julie Thallon, Interim Trust Chair (TC) welcomed those present to the Public Board meeting of the East of England Ambulance Service NHS Trust (EEAST). She advised that any questions that had been received from the public would be addressed at the end of the meeting.
PUB26/06/1.2	**Apologies for Absence**
1.2.1	Apologies were received from: • Simon Chase, Chief Paramedic and Director of Quality

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	• Omid Shiraji, Associate Non-Executive Director
PUB26/06/1.3	**Declarations of Interest**
1.3.1	There were no new declarations of interest received.
PUB26/06/1.4	**Patient Story**
1.4.1	Luke Roberts Andreou, Sector Clinical Lead (SCL) joined the meeting to present on the out of hospital cardiac arrest pilot: • The primary function of the pilot was to improve outcomes for patients experiencing a cardiac arrest, before the ambulance response arrived. • The Trust had been operating predominantly as an audio function for cardiac arrests, but countries in Europe and New Guinea had utilised video to improve the quality of CPR – there was evidence that both survivability and neurological outcomes were improved in areas where this was the practice. • The pilot was funded for four days per week, 12 hours per day in areas in which cardiac arrests were considered statistically more likely. • Over the six-month period, there were a total of 80 shifts undertaken by advanced paramedics, interrogating 3445 calls. • In 2025/26 the Trust reported one of the highest rates of survival from cardiac arrest, so although there were no specific metrics to demonstrate the programme success yet, this provided an initial indicator of the effectiveness of the change. • Aftercare support had recently been introduced for bystanders who may attend or undertake CPR of a patient in cardiac arrest. • 457 improvements had been delivered in the quality of CPR provided as a result of the video pilot.
1.4.2	The Public Board heard the story of three bystanders who had been first on scene at a cardiac arrest and had received support from the pilot programme. The bystanders all reflected positively on the support provided which helped to direct them when delivering CPR, and the aftercare provided.
1.4.3	Non-Executive Director, Susan Wilkinson (NED-SW) reflected on the improvements in outcomes, but noted that on occasion ambulances would not be able to attend before the bystanders were exhausted giving CPR, which was very physically taxing. The SCL advised that in East of England there was an agreement with the police service to attend cardiac arrests provided they were not actively attending another scene, which helped to contribute to a swifter response. There were also alerts via GoodSam to those with CPR training in the event of a cardiac arrest in the community. A national framework for GoodSam was being developed which would be area specific to ensure the deployment of individuals strategically. Moving forward, there were intentions to support CPR training in schools which was being expanded.
1.4.4	The Chief Executive Officer, Neill Moloney (CEO) commended the programme and extended his thanks to those involved in the delivery. He advised that although the pilot was extended for a further 12-month period, this was to collate the evidence to support on a more ongoing basis.

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1.4.5	Non-Executive Director, Chris Brook (NED-CB) reflected on how this played into the strategy ambition to deliver the right care at the right time. He was keen to consider how technology could better support the cardiac arrest desk to ensure this could be delivered sustainably.
1.4.6	Dr Simon Walsh, Medical Director (MD) extended his thanks to the cardiac arrest attendees for sharing their experience. He acknowledged the support they had received both during and following the event. For ambulance clinicians it was also helpful to receive this support, as the average paramedic would attend a limited number of cardiac arrests annually and guidance from someone who had recent experience was a benefit.
1.4.7	Sian Clark, Director of Digital Innovation (DDI) suggested this be built into the digital roadmap.
1.4.8	The Public Board resolved to extend its thanks to the bystanders and SCL and commended the scheme.
PUB26/06/1.5	**Trust Chair and Non-Executive Director's Report**
1.5.1	The TC presented the Trust Chair report on behalf of Mrunal Sisodia, who had concluded his term as Chair on 31.05.2026: • She reflected on the continuous performance improvements delivered, these were testament to the hard work of all of the staff working at EEAST under challenging circumstances. • There was confidence that improvements to staff welfare and experience would continue to be delivered. As part of this, there would be a focus on addressing the root cause of issues associated with sexual safety, to ensure a safe and inclusive environment for all staff. • New ICB system footprints had been implemented, the Trust would continue to engage with system partners to support regional activity including the implementation of Ho45 protocols. • NED-GL had now left EEAST, the TC extended her thanks to George for the wisdom provided during his time working with the Trust. • The TC welcomed Non-Executive Director, Victoria Corbishley (NED-VC) in her new role as Non-Executive Director..
1.5.2	The Public Board resolved to note the update.
PUB26/06/1.6	**Chief Executive Officer's Report**
1.6.1	The CEO presented the CEO report: • There had been a sustained improvement in performance, with some areas performing the best they had for a considerable period of time. • Despite the improvements, the service had come under exceptional pressure during the warmer weather, which demonstrated the fragility of the service, and raised particular challenges associated with hospital handover delays. • Call pick up times continued to improve, with EEAST performing amongst the best ambulance services in the previous week. • The CQC had advised of their intention to reinspect EEAST in the near future, as a result, both the 2024 and 2026 reports would be released together.

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	• The patient plan had been published and received positive media coverage. There were three key areas; right care, first time; providing advice at the right point of contact; and ensuring patients were navigated to the right care as quickly as possible. Work was being undertaken to improve the community pathways so that where hospital attendance was not required care could be provided by the right provider much closer to home. • A culture review of EEAST had commenced with a focus on delivering cultural transformation – this would report to the Board meeting in September. Data received from staff surveys and the FTSU provided a clear indication that although progress had been made there was more work to do to address some of the embedded cultural issues.
1.6.2	The Public Board resolved to note the update provided.
PUB26/06/1.7	**Minutes of Previous Meeting**
1.7.1	The minutes from the meeting on 08.04.2026 were approved subject to the below amendments. • 2.1.6 – Release the paramedics (not the patient from the home) • 2.5.1 – although this was complicated (not contributed to) • 2.1.4 –reflective OF more difficult cases • 5.1.1 – Year end position submitted to NHSE
PUB26/06/1.8	**Matters Arising and Action Tracker**
1.8.1	The action tracker was reviewed and updated.
1.8.2	The following actions were resolved for closure: • AC26/05/4.2.1 • PER26/05/5.2.1 • PUB26/02/2.1.6 • PUB25/07/12.1.9
PUB26/06/2.0	**PATIENTS**
PUB26/06/2.1	**Board Assurance Framework (BAF) Summary – SR1 and SR2**
2.1.1	Dr Hein Scheffer, Director of Strategy, Transformation and Governance (DoSTG) advised that discussions were held to align the risk registers with the IPR. There had been a 30% reduction in risks, and overdue actions had improved by 69%. The BAF remained a work in progress to align to the metrics and strategy delivery. Most risks remained stable. A workshop was being planned to align operational risks with Board level risks to better articulate the elements required to reduce and mitigate risks over time. This would strengthen Board confidence, improve transparency and ensure the BAF was a more effective tool for governance and assurance.
2.1.2	The TC was pleased to note the progress being made. She acknowledged that at times it would not be appropriate for scores to reduce dependent on the risk appetite, but it was essential to ensure there were the right mitigations and actions in place and she enquired when it might be appropriate to reduce risk scores. The DoSTG advised that

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	he would expect at least three consecutive months of sustainable improvement before a risk score was reduced. The CEO suggested that the assessment should be of the level of confidence that the actions being taken were the right actions to effectively mitigate the risk.
2.1.3	NED-SW suggested future amendments to the BAF incorporate the trajectory for a score reduction to ensure this could be tracked effectively. The DoSTG advised that for the supporting risks this could be demonstrated but the overarching risks would not change significantly during this period. **ACTION: Board Assurance Framework to be updated to include a trajectory for risk score reduction.** **Lead: CS**
2.1.4	The MD presented the update on SR2: Quality Governance - *Failure to meet performance targets leading to harm and poor outcomes:* • The score remained unchanged at 9. Successful mitigations had been implemented which were demonstrated through the reduction in patient safety incidents, but there were also factors outside of the Trusts control, namely handover delays. This meant there remained an increased pressure on resources and a reduction in available resources resulting in a challenge to respond in a timely manner. • Complaints and compliments continued to demonstrate common cause variation. The Trust was below target for complaint closure within the allocated timeframes. There had been concerted efforts through the Accountability forums to hold areas to account for complaint closure which was showing incremental improvement. • There was a significant improvement in the number of patient safety incidents reported, but overall reporting continued to increase providing assurance that reporting requirements were being adhered to. The number of harm incidents reported had reduced to 1 in 78,000 patient contacts, in the context of continued reporting. • There had only been one harm incident reported from a patient safety incident review since January 2026, compared to six incidents reported in the same time frame the previous year. • Since the non-conveyance policy was introduced, there had been a 50% reduction in non-conveyance incidents. • There were 0 delay harm incidents declared as moderate to severe harm, there were two incidents declared no to low harm. • All out of hospital cardiac arrest metrics showed common cause variation – survival to discharge overall and Utstein group were above the national average.
2.1.5	Darren Meads, Chief Operating Officer (COO) presented on SR1: Demand and Capacity - Failure to match capacity to demand impacting response times which had reduced to 16 but remained above the risk appetite: • There were two issues preventing a further reduction in risk – increasing activity which was exceeding the current operational plan, and compliance with the national plan for ambulance handover delays. • The consequential ability to respond to patients as a result of these pressures was compounded.

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	• Work was being supported with the regional NHSE team and via a bi-monthly COO meeting with representatives from both ambulance services and acute trusts to collaborate to address these pressures. • There was a trial at two acute hospitals to interlink with call before you convey following a successful trial over winter in which both providers worked together to limit conveyances and enact Ho45. • It was critical these plans were implemented effectively over the summer period, prior to peak winter pressures. • Call answer performance remained amongst the best across ambulance services and had been sustained consecutively for a considerable period. The COO extended his thanks to staff for their support to deliver this position. • The total incident count demonstrated that April 2026 was one of the busiest months on record, following on from the busiest March on record. • There would be a variation in hear and treat performance. As the total activity for the Trust increased, the denominator for hear and treat decreased due to the ability to mobilise staff to manage this increasing demand. Clinical advice capacity would be matched to forecast hear and treat activity in preparation for Winter 2026.
2.1.6	NED-SW enquired how the response from preventing future deaths recommendations was triangulated in learning. The DCP confirmed the patient safety team would pick up learning from deaths.
2.1.7	The CEO reflected that April demand had exceeded Christmas peak demand, the improved performance delivered over this period despite increasing demand was testament to the scale of the improvements delivered. The MD reflected that some performance improvements were being seen already, with the current trajectory it was anticipated that by the end of Q2 performance would be maintained above 80%.
2.1.8	NED-CB reflected on the evolving measures. He was keen to understand how assurance would be provided that patients were referred to the right alternative form of care. The COO advised that the final element was to link the decision to refer to another provider with the patient outcome which was not yet available across the NHS. The CEO acknowledged that systemic feedback was limited despite the breadth of pathways the ambulance service operated across. The only way this could be achieved was through a shared patient care record. The DCP reflected on how this shared care record would support crews to receive feedback on the patient outcomes, helping to close the feedback loop.
2.1.9	The TC reflected on the range of interventions and approaches and challenged how effective the Trust was in communicating these alternative models of care with the public. She suggested the understanding amongst the general public about what the ambulance service actually did was limited. There was a general perception amongst the public that they would receive an ambulance response, when the reality was managing some patients in the community could provide better outcomes for appropriate patients.
2.1.10	The Public Board resolved to acknowledge the improving position for performance within the context of increasing pressures.
PUB26/06/2.2	**Integrated Performance Report**

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2.2.1	The Integrated Performance Report and Board Assurance Framework were considered together due to the inter connectivities associated.
PUB26/06/2.3	**Quality Account**
2.3.1	The DCP presented the Quality Account for approval. This was a regulatory requirement for publication by 30.06.2026. The draft had been considered and approved by the Quality Governance Committee and was recommended to Board for approval.
2.3.2	The Public Board resolved to approve the Quality Account.
PUB26/06/2.4	**Community Engagement Group Report**
2.4.1	John Newman, Community Engagement Group Representative (CEGR) presented the report: • The three strategic priorities for youth engagement and recruitment, patient representation and bystander engagement continued as priorities. • Engagement had been integrated more extensively and comprehensively than it had ever been historically. For instance, at the People Committee the CEG representative was invited to contact the chair in advance which demonstrated a positive improvement in pro-active engagement. • The integration of the CEG in all aspects of the Trusts function was notable.
2.4.2	The TC reflected that engagement with the CEG at an operational level was more limited and suggested consideration was required of how to raise the profile of the CEG to ensure this engagement was being received. **ACTION: Consider how the profile of the CEG can be raised across the Trust to raise awareness of their role and duties at operational level.** **Lead: HoC**
2.4.3	The DoSTG noted the risks and challenges listed volunteer capacity as one of the challenges. He noted that the Trust had one of the largest volunteer groups and requested clarity on the nature of the risk. The CEGR clarified that although there were a large number of volunteers this was across a number of roles, in terms of community engagement, representation was more limited and raised capacity pressures.
2.4.4	The DDI suggested the digital innovation team could support some of the digital engagement requirements and agreed to make contact with the CEG in relation to this.
2.4.5	The Chief Finance officer, Steven Course (CFO) reflected on how the approach could be tailored to improve engagement in areas which were more deprived and may not be as open to this engagement. The CEG suggested the additional publicity would support this. There was an increasing focus on youth engagement but expanding this further required consideration.
2.4.6	The Public Board resolved to note the update provided.
PUB26/06/3.0	**PARTNERSHIP**

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PUB26/06/3.1	**Board Assurance Framework – SR6**
3.1.1	The DoSTG presented on SR6: Partnership Working - *Ineffective partnership working impacting patient flow and outcomes:* • The score was above the risk appetite, but stable at 9. • If EEAST did not work closely with partners across integrated care boards and other sectors, then performance targets may not be met and patients may be inappropriately conveyed to emergency departments, resulting in sub-optimal patient outcomes. • PTS contracts were performing well delivering a £132,000 positive contribution in month one, £14,000 above forecast. • Access to the stack during April had 3,400 incidents, with an eighty-five percent acceptance rate and a 47% closure rate. • A six-weekly system meeting with the respective directors of strategy across the new system footprint had been established which provided a forum to share best practice. • First responder utilisation was 12.26%, contributing approximately 16 seconds to C1 performance.
3.1.2	NED-CG reflected on the first responder report received at the last Performance Committee which was starting to show missed opportunities for first responders, reflecting an almost 10% additional opportunity for first responder utilisation. She also requested further information on auto allocation. The COO confirmed that auto allocation enabled the computer to digitally take over the allocation of resources – this was utilised across ambulance services but was not utilised for volunteers. It was suggested that to improve volunteer utilisation for the longer standing volunteers and for the groups that were actively coordinated, the potential for automatic allocation be considered for C1 calls. This would be tested from mid July 2026. He reflected that the time to dispatch a CFR remained consistent at 2.5 minutes which he was confident in.
3.1.3	The CEO was pleased to note the developing relationships with ICBs but enquired what the impacts were on the approach with NHSE. The DoSTG emphasised that NHSE would remain a key partner, although they were changing form within the Department of Health. ICBs were working differently and had lost some of their infrastructure driving a change in how this relationship and engagement was undertaken within the resource availability. The current six weekly meeting approach enabled a review of the respective strategies and how this enabled hospitals and the impact on the wider system.
3.1.4	The Public Board resolved to note the Trust's approach to building relationships within the changing system.
PUB26/06/3.2	**Integrated Performance Report**
3.2.1	The Integrated Performance Report and Board Assurance Framework were considered together due to the inter connectivities associated.
PUB26/06/4.0	**PEOPLE**
PUB26/06/4.1	**Board Assurance Framework – SR7, SR8 and SR9**

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4.1.1	The CPO presented on SR7: workforce sustainability - *Inadequate workforce planning leading to skills gaps*, SR8: staff retention - *Failure to retain staff leading to shortages and quality impact* and SR9: *Organisational Development - Ineffective OD support impacting culture and change*: • SR7 had improved from a residual score of 20 to 9. • SR8 was reporting above the risk appetite, at 12. • SR9 was reporting above the risk appetite at 12. • There were some successes in localised campaigns in hear and treat and Herts and West Essex which had experienced recruitment challenges. • The business plan, workforce plan and patient plan would be aligned to reflect the future direction for the Trust. • Staff turnover was 8% in January 2026 but given CEP, QCIP and the closure of Bedford EOC it was expected this level would remain elevated. • Time to hire improved to four weeks in April 2026, compared to the average of seven weeks. • The employee relations case load remained elevated causing an increase in case closure timescales. • In December 2025, 54 staff were suspended, largely associated with sexual safety cases. • Sickness had reduced from 9.73% in December 2025 to 7.14% in April 2026. The year end target was 7.2%. The focus was on managing long term and short term sick and preventative measures. The two largest drivers for sickness were Mental health and musculoskeletal.
4.1.2	NED-SW enquired whether there was a trajectory for when these initiatives might begin to deliver an improvement. The CPO confirmed there was feedback received through the big conversation which demonstrated the improvements delivered. It was also recognised that the NHS was a naturally high pressure, challenging environment which would be reflected in staff wellbeing measures.
4.1.3	The CFO was pleased to note the increasing number of women in the workforce but noted this was often in lower banded roles. He enquired whether there was confidence women were being supported into more senior positions. The CPO confirmed this was a focus, with time to lead there was a concerted effort to increase female representation at a senior level which was showing benefits although there was always further work required. Succession planning had been undertaken at executive level with a focus on aspiring women within the organisation for mentorship and support. There was a commitment to two leadership development programmes for diverse colleagues to move into leadership roles and an aspiring women programme.
4.1.4	The DoSTG noted there had been significant work to realise cultural change, but the ER case load remained high. He enquired at what point this curve was expected to flatten and reduce. The CPO advised that following the sexual safety campaign there was research which indicated that the sexual safety cases were forecast to reduce by September 2026, however she did not anticipate this would now happen as the culture review may reignite the number of staff coming forward. Overall case numbers were exceptionally high which was challenging to manage for both people services, managers and unions. It was considered positive that leadership development and a proportion of ER cases were disciplinary which demonstrated people were being actively held to account.

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4.1.5	NED-CG suggested she would not necessarily consider a reducing ER case load as a positive, as this indicated staff were confident to raise this with management and it was being actively dealt with. The focus should instead be on reducing the severity of cases and how these were resolved.
4.1.6	The Public Board resolved to note the update provided.
PUB26/06/4.2	**Integrated Performance Report**
4.2.1	The Integrated Performance Report and Board Assurance Framework were considered together due to the inter connectivities associated.
PUB26/06/4.3	**Modern Slavery Statement**
4.3.1	The CPO presented the modern slavery statement: • Historically the Trust held a local modern slavery statement. • New guidance recommended use of the NHS national modern slavery statement. • The Board was asked to approve the use of the NHS modern slavery statement on an ongoing basis.
4.3.2	The Public Board resolved to approve the adoption of the NHS modern slavery statement.
PUB26/06/4.4	**Freedom to Speak Up Report**
4.4.1	Dani Marshall, FTSU Guardian (FTSUG-DM) presented the report: • 232 concerns were raised by staff in 2025/26. • The three most common themes were systems and processes, behaviours and relationships and management issues. • 3 cases were related directly to patient safety, but they were recorded under other themes and had the potential to indirectly impact on the quality of patient care. • Norfolk and Waveney reported the most new cases over the period. • One staff member reported that they felt they had suffered detriment from speaking up, which they felt meant colleagues did not treat them in the same way, but the staff member opted not to escalate this.
4.4.2	The TC reflected on the overlap in themes and categories. The FTSUG-DM confirmed there were often overlaps in themes, particularly in systems and processes, management behaviours and relationships. This could be broken down further if required.
4.4.3	The TC was concerned to note the statement regarding the perpetrator returning to work where the victim was, which may deter individuals from speaking up. The CPO advised that this was dependent on the case. If an individual had undergone a disciplinary process and had a sanction they would return to work, and it would be challenging for them to return in a different areas but this was assessed on a case by case basis dependent on the circumstances.
4.4.4	The DoSTG enquired what could be done better to improve staff confidence in raising cases directly with line managers. The FTSUG-DM advised that where possible staff

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	were encouraged to raise issues directly with line managers or someone they felt they could trust within the organisation. She agreed to take the action away to consider how this could be improved. **ACTION: Consider how to better encourage staff raising FTSU concerns to raise these cases internally with line managers.** **Lead: FTSU**
4.4.5	The DoSTG enquired how the FTSUG linked in with the respective member of the executive team responsible for the operational area, to expedite case resolution. The FTSUG-DM confirmed that where the staff member provided permission this would be raised with the relevant executive team member as the case occurred. On a more generic basis themes could be reviewed by areas to provide a more overarching view.
4.4.6	The COO highlighted the opportunity to use the FTSU to build a healthier, more professional relationship between the Trust and staff. The FTSUG-DM confirmed there was already positive engagement between the service and Trust. In relation to collaborative working staff would be encouraged to report this internally, but building this Trust was a phased approach which was demonstrated through outcomes. There was a plan to reintroduce FTSU champions within the Trust which would be a collaborative approach and would help to rebuild the link between the Trust and staff raising concerns.
4.4.7	NED-SW noted there remained a high number of concerns raised by Norfolk and Waveney She continued to be concerned that 45% of individuals raised concerns anonymously which demonstrated they did not feel psychologically safe to raise these concerns internally. The CPO advised that Norfolk and Waveney was the largest sector, so be default would have a higher level of cases, but there was also a disproportionately higher level of cases. The area was being specifically supported by the culture review. Kym Gillingham, FTSU Guardian (FTSU-KG) acknowledged the number of cases was high, which she was pleased to note demonstrated confidence in raising concerns. In terms of staff not feeling confident to disclose their names, this was often dependent on the individual and probing into this may not be appropriate and could deter staff from contacting the service. It may be that staff unwilling to disclose their details had experienced detriment in the past or were concerned they would be labelled as a problem particularly where restructures were taking place. The focus was on ensuring staff felt comfortable to raise concerns, regardless of whether this was done anonymously or not. The CPO noted there had been a high level of changing leadership in Norfolk and Waveney which may also affect case levels.
4.4.8	The CPO enquired whether outcomes following case closure were measured. This would help to understand whether something was materially changed as a result of the concern, or whether this was about individual communication. FTSUG-KG advised that when staff reported a concern this was often based on their individual perception and was recorded based on the staff members perception. Some information could be provided on the outcome, but this was not detailed to maintain the staff members confidentiality.
4.4.9	The CEO suggested there should be a summary of the satisfaction of those raising concerns with the process from start to finish.

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4.4.10	NED-CB enquired what the maturity was of EEAST in embedding FTSU compared to other organisations. Jacquie Pamphilon, FTSU Guardian (FTSUG-KG) suggested that although it was difficult to compare across sectors a comparative could be undertaken of a similar sized organisation to assess this position. She was pleased to note most concerns were responded to quickly which provided assurance that FTSU was being embedded within the organisation. Themes across organisations were often similar. **ACTION: Provide a comparative of case levels and themes between EEAST and a size comparable organisation.** **Lead: FTSU**
4.4.11	The Public Board resolved to extend thanks to the FTSU for the work undertaken during the period, and request future reporting provide greater clarity on case outcomes, sector comparisons and ideas to enhance how safe staff feel to report concerns outside of the FTSU process.
PUB26/06/4.5	**People Committee Assurance Report**
4.5.1	NED-CG presented the People Committee Assurance Report: • There had been focussed work on long term sickness, in particular capability, which had contributed to the improvement in the sickness position. • Filling vacancies was a focus, with HWE fully staffed; in the EOCs, call handlers and dispatchers were on track, but it was proving harder to recruit senior call handler and CAS roles. • Project 5 was being restarted with a new approach, utilising external expertise to facilitate co-design whilst upskilling internal staff members to undertake this in future. Rota redesign would be managed on a sector-by-sector basis, with the management rota managed separately. • Rolling hours and holiday bookings remained outstanding. The CPO confirmed that a collaborative meeting was held which included staff, managers and unions to discuss the resolution. There were some areas of immediate agreement, the Trust had committed to come back to this group in August 2026 to review the success of the immediate initiatives implemented (increased leave allowance, enabled booking of leave 18 months in advance – increased from 12 months, enabled rest days to be registered as leave to ensure these were secure in the event that staff lines were changed). • There had been positive activity from the All Women's EEAST network to consider more inclusive unions and activity around baby loss awareness. • Work from the multi faith network had focussed on a celebration of Eid, sessions with speakers on religious diversity and on global and national tensions.
4.5.2	The Public Board resolved to note the update provided.
PUB26/06/5.0	**PRODUCTIVITY**
PUB26/06/5.1	**Board Assurance Framework Summary – SR3, SR4, SR5 and SR10**
5.1.1	The CFO presented the update on SR3: Estate - *Estate infrastructure not sufficient to deliver safe, high-quality care*, and SR4: Finance - *Failure to achieve financial sustainability and cost improvements:*

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	• The inherent risk for SR3 was 16. • The inherent risk for SR4 was 12. • The future focus was on disaggregation of block contracts. • Delivery of the QCIP had performed well in 2025/26 but there was not yet assurance on the planning in place to deliver efficiencies in 2026/27, although the M1 target for QCIPs was delivered. • Concern remained regarding the availability of capital to deliver planned and preventative maintenance. • Further work was required to define the sustainability risk. • There was confidence that the Trust would deliver a financial balance position. • The Trust had performed well against the planned surplus of £486k in M1, with actual delivery exceeding £600k. • There was a small overspend in pay associated with operational delivery. • There was an underspend in non-pay expenditure. • There remained an overspend in operational support fleet. • There was a risk posed by fuel and energy prices which were increasing and may affect the financial plan. There was a current risk of approx. £800k but non-recurrent mitigation was being considered to offset this. • The cash position was strong.
5.1.2	The DDI presented on the cyber risks: • Cyber security had stabilised at a risk score of 12 which was appropriate within the environmental context. One key action under this was submission of the Data Security Protection Toolkit which was a standard for all NHS organisations to comply with. This had been combined with the NHS cyber assessment framework which the Trust was on target to achieve. The areas outstanding from the previous year would be achieved. There were some gaps, which the Trust had bid for funding to support. 44 out of 47 outcomes were classified as 'met'. • A letter had been received from NHSE and the Head of Cyber Security to ensure cyber security measures were sufficiently robust within the context of the country. This would include new recommendations and assessments for cyber security. • SR10 was linked with the modernisation of systems and processes to respond to demand. An assessment was underway on the capacity to deliver. The digital roadmap was being developed to provide transparency on the volume of work and requests and shifting into a roadmap which supported these outcomes. Business cases would then be developed to provided investment to support delivery in innovation.
5.1.3	The Public Board resolved to note the risks associated with delivery, particularly Estates maintenance and digital innovation.
PUB26/06/5.2	**Integrated Performance Report**
5.2.1	The Integrated Performance Report and Board Assurance Framework were considered together due to the inter connectivities associated.
PUB26/06/5.3	**Data Security and Protection Toolkit Submission**

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	The Trust had met the expected standard in 44 of 47 outcomes, with minimal gaps associated with the Data Security and Protection Toolkit. The final submission was on track to complete by 30.06.2026.
5.3.2	The Public Board resolved to acknowledge the submission of the data security protection toolkit.
PUB26/06/5.4	**Audit Committee Assurance Report**
5.4.1	NED-VC presented the Audit Committee Assurance Report: • The Audit Committee had received the annual report from internal audit and counter fraud. • The forecast was a green rating for counter fraud. • Internal audit had finalised a report on fleet management and cost improvement. Fleet management had received limited assurance; recommendations were noted and would be monitored through the Committee. • The Standing Orders, Scheme of Delegation, Reservation of Powers were approved by the Committee. • The Committee noted the use of the Trust seal.
5.4.2	The Public Board resolved to acknowledge the escalation of the fleet report, which would be monitored through the Audit Committee.
PUB26/06/5.5	**Performance Committee Assurance Report**
5.5.1	NED-CG presented the Performance Committee Assurance Report: • There were six recommendations arising from the review of winter planning. The Committee fully supported the recommendations. • The Committee recognised the impact on staff from handover delays and recommended sharing with staff the actions being taken to address this, even when improvements had not yet been realised. • Discussions were progressing well with London Ambulance Service on integrated urgent care, a memorandum of understanding was underway. • An update was received on PTS. Good progress had been made in the last year.
5.5.2	The Public Board resolved to note the update.
PUB26/06/5.6	**Finance and Sustainability Committee Assurance Report**
5.6.1	NED-CB presented the update from the finance and sustainability committee: • He confirmed the Finance and Sustainability Committee had focussed on the financial position and how this impacted the risks and digital position.
5.6.2	The Public Board resolved to note the update provided.
PUB26/06/6.0	**CLOSING ADMINISTRATION**
PUB26/06/6.1	**Reflection on the Meeting**
6.1.1	The CPO provided the reflection on the meeting: • The patient story had provided the opportunity to reflect and hear how bystanders were supported through a cardiac arrest event.

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Kingsmill, Esther 19/03/2026 16:57:41

	• Further work was required on the Board Assurance Framework. It was agreed that stability in the improved position was required before a score reduction could be considered. • There was lots of positive news to reflect on patient outcomes, patient care, improved C2 performance within the context of rising demand etc. • However, there remained challenges to address particularly around complaints management, hospital handovers and FTSU.
PUB26/06/6.2	**Any Other Business**
6.2.1	There was no other business and the meeting closed at 12:30.
PUB26/06/6.3	**Questions from the Public**
6.3.1	There were no questions received from the Public.
PUB26/06/6.4	**Date of Next Meeting: Wednesday 16 September 2026 (09:30 – 12:30)**

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In Public Trust Board - Action Tracker for the meeting on 16.09.2026						
Ref	**Source (meeting / date / agenda item / title)**	**Action**	**Lead**	**Due Date**	**Status / Update**	**Proposed to Open/Close**
2.1.3	Public Board, 10.06.2026, PUB26/06/2.1.3, Board Assurance Framework	Board Assurance Framework to be updated to include a trajectory for risk score reduction.	CS	10.02.2027	16.09.2026: This will be picked up in the review of the BAF Framework that will be led by the new Company Secretary, to be finalised by the end of December 2026 **Item not yet due**	O
2.4.2	Public Board, 10.06.2026, PUB26/06/2.4.2, CEG Report	Consider how the profile of the CEG can be raised across the Trust to promote awareness of their role and duties at operational level.	HoC	16.09.2026	An article was published on East24 to highlight the role of the CEG **Proposed for Closure**	C
4.4.4	Public Board, 10.06.2026, PUB26/06/4.4.4, FTSU Report	Consider how to better encourage staff raising FTSU concerns to raise these cases internally with line managers.	FTSU		This is included in the What next section – we are trialling a training and engagement package in Beds and Luton to encourage the ethos of FTSU. Staff will be encouraged to utilise their managers and if not our independent service. **Proposed for Closure**	C
4.4.10	Public Board, 10.06.2026, PUB26/06/4.4.10, FTSU Report	Provide a comparative of case levels and themes between EEAST and a size comparable organisation.	FTSU		The comparison data is included in the data comparison report and analysed in the Board paper where the number of cases per 1000 is identified. **Proposed for Closure**	C
Business Delegated to Public Board from Committees/Private Board						
3.3.2	*Referral to Public Board* Private Board, 10.06.2026, PB26/06/3.3.2, Patient Plan Communications Update	Patient story at Public Board to focus on somebody successfully treated through hear and treat.	CP-DoQ	16.09.2026	PUB26/09/1.4 **Proposed for Closure**	C
2.1.1	*Referred to Public Board* Private Board, 06.05.2026, PB26/05/2.1.1, Transformation Portfolio Board Update	The Private Board requested an update on EOC staff redeployment and redundancies report to the Public Board.	CPO	10.03.2027	Closure of the call handling function is 30.11.2026 and dispatch end of 31.03.2027 - final position to be confirmed in March 2027 following conclusion of both elements. **Item not yet due.**	O
Business Delegated to Committees/Private Board						
4.4.3	*Referred to People Committee* Public Board, 08.04.2026, PUB26/04/4.4.4, FTSU Report	Report to People Committee with a breakdown of the time to appointment following all health and wellbeing referrals, broken down by cause.	CPO	22.07.2026	June 2026 Performance: June 2026 achieved the lowest average wait time of 8.6 days from referral to first appointment. Yearly Trend Comparison: Waiting times peaked in May at 17.1 days but improved by nearly 50% in June. Operational Improvements: Increased appointment capacity and improved triage contributed to reduced waiting times. Data Limitation: Referral causes are not available in data, limiting detailed waiting time analysis. **Closed at People Committee: 22.07.2026**	C
Actions from Board Development/Service Visits						

Kingsmill,Esther
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Meeting:	Public Board	**Date:**	16.09.2026
Report Title:	Board Assurance Framework Update Summary Report		
Agenda Item:	PUB26/09/2.1		
Author(s):	Julie Young, Interim Company Secretary/ Edward Bradshaw, Company Secretary		
Lead Director:	Dr Hein Scheffer, Director of Strategic Partnerships and Governance		

Purpose:	Decision Approval		Discussion Review	**X**	Information Noting	
Assurance:	Limited		Reasonable	**X**	Substantial	

Link to CQC domain:		**Link to EEAST's Strategic Missions:**	
Caring	**X**	Patient Mission	**X**
Responsive	**X**	Partnership Mission	**X**
Effective	**X**	People Mission	**X**
Well Led	**X**	Productivity Mission	**X**
Safe	**X**		

Link to Strategic Risk:									
SR1	**X**	SR3	**X**	SR5	**X**	SR7	**X**	SR9	**X**
SR2	**X**	SR4	**X**	SR6	**X**	SR8	**X**	SR10	**X**

Equality Impact Assessment Undertaken: YES		**NO**	**X**

Previously considered by:

The Board Assurance Framework (BAF) has been reviewed and updated by individual executive directors and collectively at Executive Leadership Team on 8th September 2026.

Executive Summary:

What?

The BAF remains the central mechanism which enables EEAST's Board to identify, understand evaluate and oversee the principal risks to achieving its strategic objectives. As the Board is aware, each principal risk is owned and managed by a named Board committee.

Since the last Board Report in June 2026:

- The risk scores have improved for principal risks 4 (Finance), 7 (Workforce sustainability), 8 (Staff retention) and 9 (Organisational Development).
- Demand & Capacity remains the highest strategic risk to the Trust, at 16.
- Cyber security actions have largely been completed and reset, giving some confidence that the efficacy of the controls will increase over coming months.
- Estates and Digital programmes have updated milestones and governance arrangements to ensure more effective oversight of delivery.

Kingsmill Estate
10/09/2026 09:57:41

The latest full BAF can be found at **Appendix 1**.

So What?

SR1 Demand & Capacity – Risk Score 16
Updated with expanded controls, assurances and actions and a greater focus on workforce planning, winter resilience, productivity, handover improvement and Hear & Treat performance.

SR2 Quality Governance – Risk Score 9
Updated with performance leading measures and sub-measures included. Controls and assurances have also been strengthened in respect of the Clinical Governance Structure and staff competency.

SR3 Estates – Risk Score 12
Updated. Estates Plan deadline moved to October 2026 and EV infrastructure programme updated.

SR4 Finance – Risk Score 6
Risk reduced from **9 to 6**. New focus on financial forecasting, medium-term planning and delivery of financial balance.

SR5 Cyber Security – Risk Score 12
Cyber Plan, AI Policy and DSPT/CAF actions completed. New Cyber Security Review action introduced.

SR6 Partnership Working – Risk Score 9
The IUC tender has been paused. The implications of this will be considered in a deep dive on SR6 at the Performance Committee on 30 September.

SR7 Workforce Sustainability – Risk Score 6
Risk reduced from **9 to 6**. Significant refresh introducing People Plan, workforce planning maturity, recruitment pipelines and CAS workforce actions.

SR8 Staff Retention – Risk Score 8
Risk reduced from **12 to 8**. New actions include People Plan publication, wellbeing support, retention analysis and cultural improvement work.

SR9 Organisational Development – Risk Score 8
Risk reduced from **12 to 8**. Reframed around OD Transformation Plan Phase 2, staff culture, leadership and NHS Staff Standards.

SR10 Digital – Risk Score 12
Risk score unchanged. Digital roadmap, resource planning, target operating model and funding actions updated.

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What Next?
The BAF will continue to be updated monthly by executive directors and collectively at Executive Leadership Team meetings before being discussed at Board Committees. Since 1 July 2026, a more frequent structured 6-8-week cycle (previously a 10-week cycle) has been implemented as a standing element of the ELT agenda, with deep dives into each strategic risk. As part of the Governance Improvement Plan, the BAF framework will be reviewed, led by the new Company Secretary, which will include action trajectories. This work will be completed by the end of December 2026.
Action Required by the Board
The Board is asked to: i. Note the summary report **(Appendix 1)** ii. Note the reduction in risk scores in relation to SR4, SR7, SR8 and SR9. iii. Note the development of the BAF framework, by the end of December 2026
How does this report link with EEAST's vision, purpose and values? *https://www.eastamb.nhs.uk/about-us/our-corporate-strategy*
The Board Assurance Framework is the central mechanism that enables the Board to monitor the key risks to achievement of the Trusts Strategic Objectives.

Kingsmill,Esther
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Appendix 1: Summary of full BAF

Ref	Risk Area	Risk Description (summarised)/*Current Position*	Current Score	Trend	Risk Appetite
SR1	Demand & Capacity	If we do not match our capacity to the demand, we will not deliver an improvement in our response times.	**16**	→ Static	**6**
SR2	Quality Governance	If we fail to meet national and locally agreed performance targets due to not having the appropriate clinical or operational model may lead to avoidable harm to patients, adverse clinical outcomes and poor patient experience as well as potential failure to maintain regulatory compliance and confidence will be lost in delivering Trust strategic patient mission.	**9**	→ Static	**4**
SR3	Estates	If EEAST does not maintain appropriate estate infrastructure to support service delivery, then it may not have the right facilities and assets to deliver safe, high-quality care resulting in not attaining our safety, quality and compliance ambitions.	**12**	→ Static	**4**
SR4	Finance	If EEAST cannot achieve financial sustainability there is a risk to its ability to deliver high quality (safe and effective) services	**6**	Improved (from 9)	**12**
SR5	Cyber Security	If the Trust fails to prevent a Cyber Incident, then one or more Digital Systems will be compromised leading to operational, reputational, financial and patient impact.	**12**	→ Static	**9**
SR6	Partnership Working	If hospital handover delays are not reduced in line with EEAST 2026/27 trajectories and system partner recovery plans, then ambulance availability will remain constrained, resulting in risks to patients from prolonged response times.	**9**	→ Static	**4**
SR7	Workforce Sustainability	If EEAST does not have workforce plans that support recruitment then prospective staff may not choose to work at EEAST, resulting in associated skills deficit, reliance on temporary staffing, staff morale and our ability to provide high quality of care to our services users.	**6**	Improved (from 9)	**4**
SR8	Staff Retention	If EEAST does not effectively and efficiently manage a coherent staff retention strategy, then we will continue to effect staff and skills shortages in certain	**8**	Improved (from 12)	**4**

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Ref	Risk Area	Risk Description (summarised)/*Current Position*	Current Score	Trend	Risk Appetite
		professions resulting in associated skills deficit, impact on staff morale and our ability to provide high quality care to our services users.			
SR9	Organisational Development	If EEAST does not have in place effective OD support to address cultural development and management of change, then we may not achieve a positive impact, resulting in suboptimal outcomes for staff and patient care.	**8**	Improved (from 12)	**4**
SR10	Digital	If EEAST does not invest in, modernise, and integrate its digital systems, platforms, and infrastructure, then digital may be unable to deliver efficient, high-quality service, support innovation, or meet future service and partnership needs.	**12**	→ Static	**4**

Kingsmill,Esther
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Meeting:	Trust Board	**Date:**	16.09.2026
Report Title:	Integrated Performance report		
Agenda Item:	PUB26/09/2.2		
Author(s):	Emma Smith – Head of Information and Analytics		
Lead Director:	Steven Course – Chief Finance Officer		

Purpose:	Decision Approval		Discussion Review	**X**	Information Noting	**X**
Assurance:	Limited		Reasonable	X	Substantial	

Link to CQC domain:		**Link to EEAST's Strategic Missions:**	
Caring	**X**	Patient Mission	**X**
Responsive	**X**	Partnership Mission	**X**
Effective	**X**	People Mission	**X**
Well Led	**X**	Productivity Mission	**X**
Safe	**X**		

Link to Strategic Risk:									
SR1	**X**	SR3	**X**	SR5	**X**	SR7	**X**	SR9	**X**
SR2	**X**	SR4	X	SR6	**X**	SR8	**X**	SR10	X

Equality Impact Assessment Undertaken: YES	**X**	**NO**	

Previously considered by:

Executive Leadership Team

Executive Summary:

What?

The Integrated Performance Report (IPR) presents **July 2026** performance across the Trust, structured explicitly around the four Strategic Missions Patient, Partnership, People and Productivity. The reported metrics have been agreed with Executive Directors to ensure alignment between operational delivery and each Mission's strategic intent.

So What?

The report aims to provide the Board with:

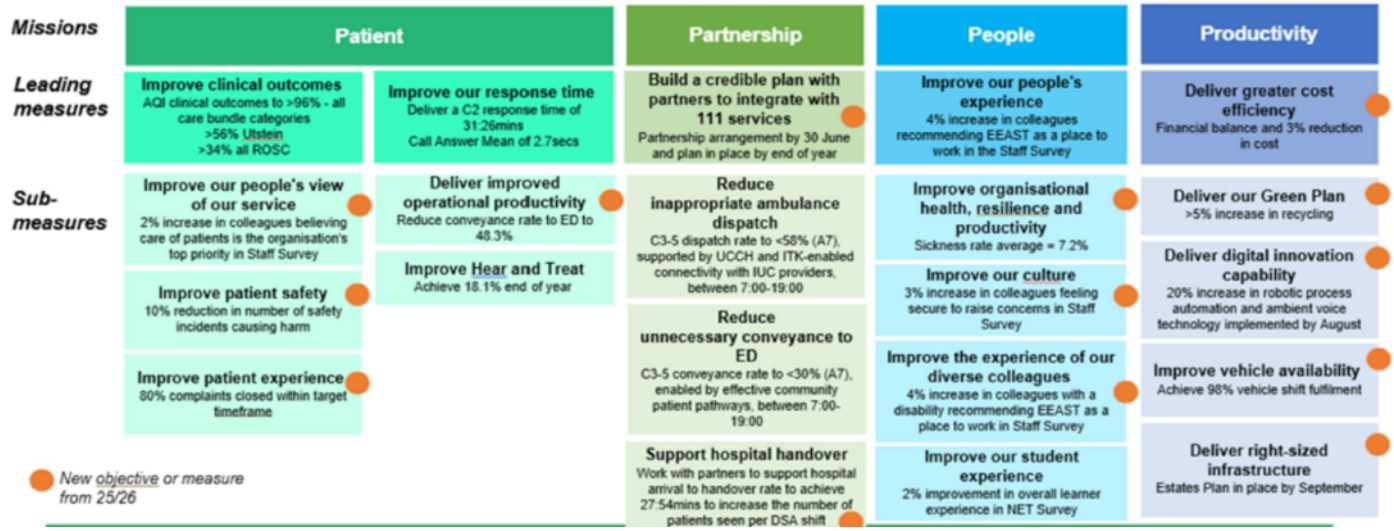
- Assurance regarding areas where performance is demonstrating sustained or improving delivery against the Strategic Missions.
- Early visibility of risk where performance is deteriorating or showing sustained variation outside expected limits.
- A clear differentiation between normal variation and special-cause change through the application of Statistical Process Control (SPC).

Additional IPR indicators are included within the appendix for information only, ensuring the Board's discussion remains focused on the strategically material metrics. Alongside the Strategic metrics any metrics that also are included in the NHSE National Oversight Framework are also included within the IPR for review.

Kirsty Fraser 09/09/2026 16:57:31

Strategic Objectives Summary

Strategic objectives 26/27



Strategic Metrics Summary July 2026/27

Strategic Indicator Metrics 2026/27

NHS East of England Ambulance Service NHS Trust
information@eastamb.nhs.uk

Strategy Section	Metric	Date	Value	Target	Assurance	Variation
Patient	Stemi Care Bundle	Apr 2026	93.9%	95%		
Patient	ROSC Care Bundle	May 2026	97.6%	95%		
Patient	ROSC - Utstein	Jun 2026	61%	55%		
Patient	ROSC - All	Jun 2026	34.2%	33%		
Patient	Falls in Older People - Discharged At Scene Care Bundle	Jun 2026	97%	95%		
Patient	Care of patients / service users is my organisations top priority	Apr 2026	51.1%	55.5%		
Patient	Declared Patient Safety events investigated under PSIRF	Jul 2026	1	4		
Patient	% of Complaints Closed in Compliant Timeframe	Jul 2026	61.22%	80%		
Patient	C2 Mean Response Time	Jul 2026	00:34:51	00:18:00		
Patient	Call Answer Mean (A3) (seconds)	Jul 2026	2.72	2.7		
Patient	See, Treat & Convey to ED %	Jul 2026	45.34%	48.3%		
Patient	Hear & Treat % (including A2S and PCT)	Jul 2026	17.94%	18.1%		
Partnership	C3-C5 Dispatch (Attendance) Rate % (% of A7) (7am - 8pm)	Jul 2026	54.76%	58%		
Partnership	C3-C5 Conveyance Rate % (% of A7) (7am - 8pm)	Jul 2026	26.67%	30%		
Partnership	Average Arrival to Handover Time	Jul 2026	00:32:37	00:15:00		
People	I would recommend my organisation as a place to work	Apr 2026	34%	42.3%		
People	Sickness Absence Rate %	Jul 2026	7.96%	7.2%		
People	Colleagues feeling secure to raise concerns	Oct 2025	49.3%	61%		
People	Colleagues with a disability recommending EEAST as a place to work	Oct 2025	32.5%	32.5%		
Productivity	Recycling Rate %	Jul 2026	28.78%	40%		
Productivity	Number of 999 CAD Patients Managed by Robotic Process Automation	Jul 2026	178	122		

What Next?

Board to note update to metric assignment within the IPR to align to executive directorate changes

Atkinson-Hill, Esther 10/09/2026 16:57:41

Metric	Moved from	Moved to

Access to Stack Completion Rate %	Partnerships	Patients - Performance
Total PTS Costs (£s)	Partnerships	Patients - Clinical
Community Response and Blue Light Collaboration to C1 Mean (seconds)	Partnerships	Patients - Clinical
Community Response and Blue Light Collaboration Utilisation %	Partnerships	Patients - Clinical

Action Required by the Board:

- To note areas demonstrating positive assurance against the Strategic Missions.
- To discuss areas of special cause deterioration or persistent under-performance.
- To discuss whether mitigating actions are effective and that risks to delivery of the Strategic Missions are being appropriately managed.

To note additional indicators in the appendix for contextual understanding, without detracting from the strategic focus.

How does this report link with EEAST's vision, purpose and values?

https://www.eastamb.nhs.uk/about-us/our-corporate-strategy

The IPR provides a link to the trust strategy, identifying key metrics to demonstrate changes that impact and influence outcomes.

Kingsmill,Esther
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NHS
East of England
Ambulance Service
NHS Trust

East of England Ambulance Service NHS Trust

Integrated Performance Report

August 2026 (July 2026 data)

#WeAre EEAST

Strategic objectives 26/27

NHS East of England Ambulance Service NHS Trust

Missions	Patient		Partnership	People	Productivity
Leading measures	**Improve clinical outcomes** AQI clinical outcomes to >96% - all care bundle categories >56% Utstein >34% all ROSC	**Improve our response time** Deliver a C2 response time of 31:26mins Call Answer Mean of 2.7secs	**Build a credible plan with partners to integrate with 111 services** Partnership arrangement by 30 June and plan in place by end of year	**Improve our people's experience** 4% increase in colleagues recommending EEAST as a place to work in the Staff Survey	**Deliver greater cost efficiency** Financial balance and 3% reduction in cost
Sub-measures	**Improve our people's view of our service** 2% increase in colleagues believing care of patients is the organisation's top priority in Staff Survey	**Deliver improved operational productivity** Reduce conveyance rate to ED to 48.3%	**Reduce inappropriate ambulance dispatch** C3-5 dispatch rate to <58% (A7), supported by UCCH and ITK-enabled connectivity with IUC providers, between 7:00-19:00	**Improve organisational health, resilience and productivity** Sickness rate average = 7.2%	**Deliver our Green Plan** >5% increase in recycling
	Improve patient safety 10% reduction in number of safety incidents causing harm	**Improve Hear and Treat** Achieve 18.1% end of year	**Reduce unnecessary conveyance to ED** C3-5 conveyance rate to <30% (A7), enabled by effective community patient pathways, between 7:00-19:00	**Improve our culture** 3% increase in colleagues feeling secure to raise concerns in Staff Survey	**Deliver digital innovation capability** 20% increase in robotic process automation and ambient voice technology implemented by August
	Improve patient experience 80% complaints closed within target timeframe		**Support hospital handover** Work with partners to support hospital arrival to handover rate to achieve 27:54mins to increase the number of patients seen per DSA shift	**Improve the experience of our diverse colleagues** 4% increase in colleagues with a disability recommending EEAST as a place to work in Staff Survey	**Improve vehicle availability** Achieve 98% vehicle shift fulfilment
				Improve our student experience 2% improvement in overall learner experience in NET Survey	**Deliver right-sized infrastructure** Estates Plan in place by September

New objective or measure from 25/26

Kingsmill Estates 10/09/2025 08:57:41

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#WeAre EEAST

Strategic Indicator Metrics 2026/27

NHS
East of England Ambulance Service
NHS Trust
information@eastamb.nhs.uk

Strategy Section	Metric	Date	Value	Target	Assurance	Variation
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Productivity	Number of 999 CAD Patients Managed by Robotic Process Automation	Jul 2026	178	122		

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NHS Trust
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Variance – Is the measure getting better/worse?	Assurance – Can the target be consistently achieved?			
	Consistently hit target	Target not consistently achieved or failed	Consistently fail target	No target set
Special Cause Improvement	**Excellent** Consistently achieving the target and metric is improving **Celebrate and Learn**	**Good** Target will not be consistently achieved but metric is improving **Celebrate and Understand**	**Concerning** Metric is improving, but target is consistently failing and won't be achieved without change **Celebrate but Take Action**	**Excellent** Metric is improving, no target has been set **Celebrate**
Common Cause	**Good** Consistently achieving the target and metric is not changing significantly **Celebrate and Understand**	**Average** Target will not be consistently achieved and metric not changing significantly **Investigate and Understand**	**Concerning** Metric not changing significantly, but target is consistently failing and won't be achieved without change **Investigate and Take Action**	**Average** Metric is not changing significantly and show levels of natural variation expected, not target has been set **Understand**
Special Cause Concern	**Concerning** Target is being achieved but metric is deteriorating **Investigate and Understand**	**Concerning** Metric not consistently achieved and metric is deteriorating **Investigate and Take Action**	**Very Concerning** Metric is deteriorating and target won't be achieved without change of process **Investigate and Take Action**	**Concerning** Metric is deteriorating, no target set **Investigate**

Kingsmill Esther
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Trust Strategy

Ideally every metric should be in one of these starred boxes, which indicate the metric is either currently passing its target or is currently improving ★

Assurance Grid (SPC Charts only)

NHS East of England Ambulance Service NHS Trust
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Data up to:

July 2026

Variance	Assurance: Consistently hit target (P)	Assurance: Inconsistently achieve or fail target (?)	Assurance: Consistently fail target (F)	Assurance: No target given
Special Cause - Improvement (L / H)	★	• % change in energy use compared to the same mon ★ in the previous year • C3-C5 Conveyance Rate % (% of A7) (7am - 8pm) • C3-C5 Dispatch (Attendance) Rate % (% of A7) (7am - 8pm) • Hear & Treat % (including A2S and PCT) • ROSC - Utstein • See, Treat & Convey to ED %	★	★
Common Cause	★	• % of Complaints Closed in Compliant Timeframe • Call Answer Mean (A3) (seconds) • Declared Patient Safety events investigated under PSIRF • I would recommend my organisation as a place to work • Number of 999 CAD Patients Managed by Robotic Process Automation • OOS as a % of Vehicle Hours • ROSC - All • ROSC Care Bundle • Sickness Absence Rate % • Stemi Care Bundle • Vehicle off Road % – All Emergency Operational Vehicles	• Average Arrival to Handover Time • C2 Mean Response Time • Recycling Rate %	
Special Cause - Concern (L / H)		• Care of patients / service users is my organisations top priority		

Please note that Efficiency Savings Full Year Plan (due to not being an SPC chart), the Falls In Older People - Discharged at Scene Care Bundle, Colleagues feeling secure to raise concerns and Colleagues with a disability recommending EEAST as a place to work (due to not having enough data points) are not included on this page.

Please note that where a National target for a metric exists, this is used for determining the assurance status rather than the local target being used.

Kingsmill Esther 10/09/2026 16:57:41

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East of England
Ambulance Service
NHS Trust
information@eastamb.nhs.uk

Patients - Performance

Director: Darren Meads

July 2026

Kingsmill Esther
10/09/2026 16:57:41

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Ideally every metric should be in one of these starred boxes, which indicate the metric is either currently passing its target or is currently improving ★

Assurance Grid (SPC Charts only)

Data Owner / Responsible Exec
Darren Meads

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Data up to:
July 2026

Variance	Assurance: Consistently hit target	Assurance: Inconsistently achieve or fail target	Assurance: Consistently fail target	Assurance: No target given
Special Cause - Improvement	★	• C3-C5 Conveyance Rate % (% of A7) (7am - 8pm) ★ • C3-C5 Conveyance Rate % (% of A7) (8pm - 7am) • C3-C5 Dispatch (Attendance) Rate % (% of A7) (7am - 8pm) • Hear & Treat % (including A2S and PCT) • See, Treat & Convey % • See, Treat & Convey to ED %	• Average On Scene Time - Conveyed ★ • C3-C5 Dispatch (Attendance) Rate % (% of A7) (8pm - 7am) • C4 90th PCTL Response Time • Total PTS Costs	• Average Number of Patients seen per DCA Shift ★ • C4 Incidents • C4 Mean Response Time • Multiple Assignment Ratio
Common Cause	• Average On Scene Time - Not Conveyed ★ • Daily Average Patient Facing Staff Hours (excludes PAS) • See & Treat %	• C1 90th PCTL Response Time • Call Answer Mean (A3) (seconds) • Call Pickup 95th Percentile (A5) • Community Response and Blue Light Collaboration Contribution to C1 mean (seconds) • OOS as a % of Vehicle Hours • Vehicle off Road % – All Emergency Operational Vehicles	• Access to Stack Completion Rate % • Average Arrival to Handover Time • Average Arrival to Handover Time - % Over 15 mins • C1 Mean Response Time • C2 90th PCTL Response Time • C2 Mean Response Time • C3 90th PCTL Response Time • C3 Mean Response Time	• C1 Incidents • C2 Incidents • C3 Incidents • Calls diverted in automatically (A124) • Calls diverted out automatically (A125) • Daily Average Calls (A1) • Daily Average Contacts (A0) • Incidents (A7)
Special Cause - Concern	• Average Handover to Clear Time	• Community Response and Blue Light Collaboration Utilisation %		

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Summary

Data up to: July 2026

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Calls & Incidents

Metric	Month	Value	Mean	Assurance	Variation
Daily Average Contacts (A0)	Jul 26	4278	4104.17		
Daily Average Calls (A1)	Jul 26	3233	3018.29		
Call Answer Mean (A3) (seconds)	Jul 26	2.72	1.9		
C1 Incidents	Jul 26	8649	8295.17		
C2 Incidents	Jul 26	45318	42833.58		
C3 Incidents	Jul 26	16536	16205.13		
C4 Incidents	Jul 26	367	445.29		
Incidents (A7)	Jul 26	88096	82538.2		
Hear & Treat % (including A2S and PCT)	Jul 26	17.94%	16.46%		
See & Treat %	Jul 26	33.87%	34.15%		
See, Treat & Convey to ED %	Jul 26	45.34%	47.15%		
See, Treat & Convey %	Jul 26	48.18%	50.11%		
C3-C5 Dispatch (Attendance) Rate % (% of A7) (7am - 8pm)	Jul 26	54.76%	62.07%		
C3-C5 Conveyance Rate % (% of A7) (7am - 8pm)	Jul 26	26.67%	31.62%		
Daily Average Patient Facing Staff Hours (excludes PAS)	Jul 26	12218.04	12601.98		
Average Number of Patients seen per DCA Shift	Jul 26	3.64	3.54		
Vehicle off Road % – All Emergency Operational Vehicles	Jul 26	16.25%	17.57%		
Call Pickup 95th Percentile (A5)	Jul 26	16	6.65		
Calls diverted in automatically (A124)	Jul 26	529	349.25		
Calls diverted out automatically (A125)	Jul 26	33	56.68		
Average On Scene Time - Conveyed	Jul 26	00:43:55	00:45:18		
Average On Scene Time - Not Conveyed	Jul 26	01:06:56	01:07:24		
OOS as a % of Vehicle Hours	Jul 26	5.66%	5.9%		
Multiple Assignment Ratio	Jul 26	1.15	1.16		

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Arrival to Handover & Handover to Clear

Metric	Month	Value	Mean	Assurance	Variation
Average Arrival to Handover Time	Jul 26	00:32:37	00:36:03		
Average Arrival to Handover Time - % Over 15 mins	Jul 26	70.99%	71.25%		
Average Handover to Clear Time	Jul 26	00:12:34	00:12:13		

C1

Metric	Month	Value	Mean	Assurance	Variation	YTD
C1 Incidents	Jul 26	8649	8295.17			
C1 Mean Response Time	Jul 26	00:08:49	00:08:37			00:08:31
C1 90th PCTL Response Time	Jul 26	00:16:35	00:16:09			00:16:03

C2

Metric	Month	Value	Mean	Assurance	Variation	YTD
C2 Incidents	Jul 26	45318	42833.58			
C2 Mean Response Time	Jul 26	00:34:51	00:34:50			00:32:24
C2 90th PCTL Response Time	Jul 26	01:13:22	01:13:07			01:07:55

C3

Metric	Month	Value	Mean	Assurance	Variation	YTD
C3 Incidents	Jul 26	16536	16205.13			
C3 Mean Response Time	Jul 26	01:59:04	01:53:44			01:41:27
C3 90th PCTL Response Time	Jul 26	04:40:10	04:28:43			04:00:08

C4

Metric	Month	Value	Mean	Assurance	Variation	YTD
C4 Incidents	Jul 26	367	445.29			
C4 Mean Response Time	Jul 26	02:17:53	02:35:57			02:02:35
C4 90th PCTL Response Time	Jul 26	05:10:25	06:21:08			04:45:59

Patients - Performance

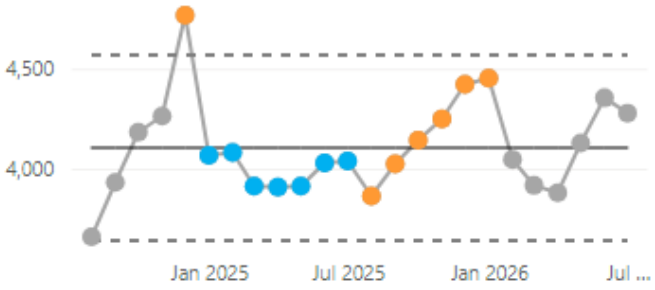
Call Volume

Data up to: July 2026

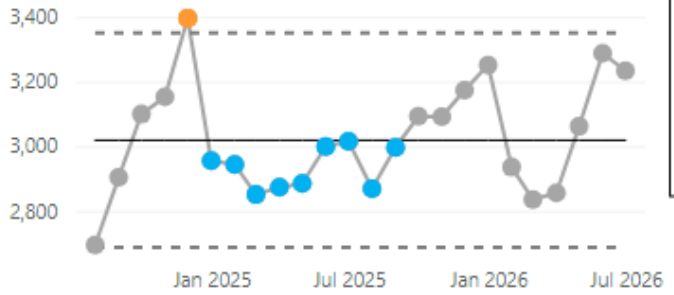
Data Owner / Responsible Exec
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Daily Average Contacts (A0): Trust



Daily Average Calls (A1): Trust



Metric	Month	Value	Mean	Assurance	Variation
Daily Average Calls (A1)	Jul 26	3233	3018.29		
Daily Average Contacts (A0)	Jul 26	4278	4104.17		

Intelligence Narrative	Operations Narrative
Daily Average Contacts (A0) metric shows common cause variation Daily Average Calls (A1) metric shows common cause variation Kingsmill Esther 10/09/2026 16:57:41	Overall call demand increased in July compared to the previous month. The average daily call volume (A0) was 4,278 which is an average of 3233 emergency (999) calls (A1) per day. Over the month, the EOC team responded to a total of 132,632 emergency contacts, of which 100,239 were public 999 calls connected by BT. In terms of overall call volumes, EEAST remains consistently among the five busiest Ambulance Services nationally.

Patients - Performance

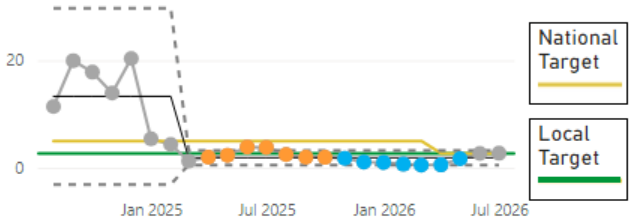
Call Pickup

Data up to: July 2026

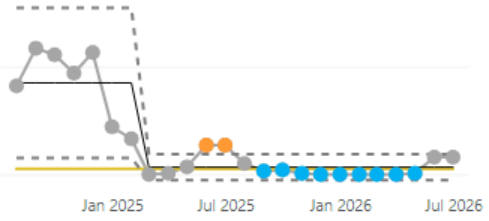
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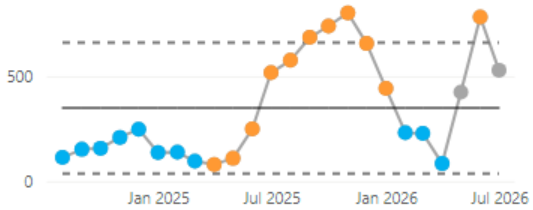
Call Answer Mean (A3) (seconds): **Strategy Metric**



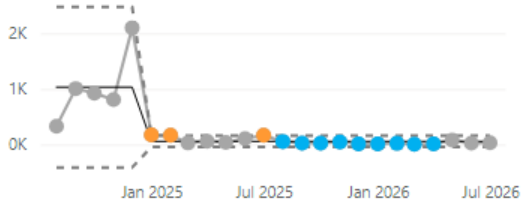
Call Pickup 95th Percentile (A5): Trust



Calls diverted in automatically (A124): Trust



Calls diverted out automatically (A125): Trust



Metric	Month	Value	Mean	Assurance	Variation
Call Answer Mean (A3) (seconds)	Jul 26	2.72	1.9		
Call Pickup 95th Percentile (A5)	Jul 26	16	6.65		
Calls diverted in automatically (A124)	Jul 26	529	349.25		
Calls diverted out automatically (A125)	Jul 26	33	56.68		

Intelligence Narrative

Call Answer Mean (A3) (seconds) metric shows common cause variation and the metric may hit it or miss target

Call Pickup 95th Percentile (A5) metric shows common cause variation and the metric may hit it or miss target

Calls diverted in automatically (A124) metric shows common cause variation

Calls diverted out automatically (A125) metric shows common cause variation

Operations Narrative

Both call answer mean and 95th percentile performance were consistent with the previous month. Mean call answer performance continued to deliver the national standard at 2.72 seconds however the mean 95th percentile (measure of longest waiting calls) was more challenged at 16 seconds which is outside of target. The EOC team are reviewing call handler productivity measures to plan a recovery and reduction of the 95th percentile time.

IRP activity saw 33 calls diverted out to other Ambulance Services. However, EEAST received 529 diverted calls into our EOC which reflects the system wide pressure and increased demand experienced across Ambulance Services.

In terms of call answering performance, EEAST continues to rank within the top five Ambulance Services nationally.

Kingsmill Esther
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Patients - Performance

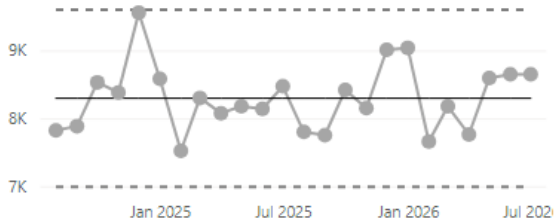
Incidents and Response Type

Data up to: July 2026

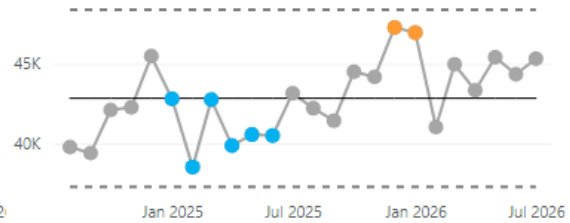
Data Owner / Responsible Exec
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C1 Incidents: Trust

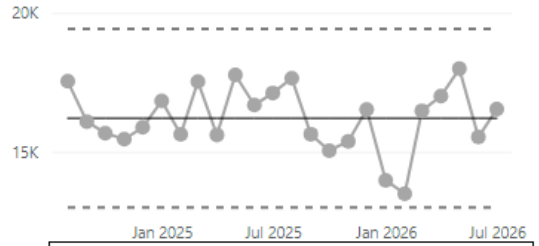


C2 Incidents: Trust

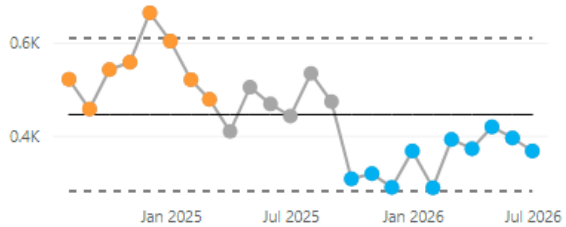


Metric	Month	Value	Mean	Assurance	Variation
C1 Incidents	Jul 26	8649	8295.17		
C2 Incidents	Jul 26	45318	42833.58		
C3 Incidents	Jul 26	16536	16205.13		
C4 Incidents	Jul 26	367	445.29		
Incidents (A7)	Jul 26	88096	82538.2		

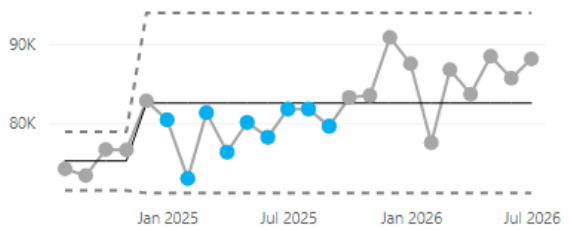
C3 Incidents: Trust



C4 Incidents: Trust



Incidents (A7): Trust



July 2026 Split

C1	12.20%
C2	63.95%
C3	23.33%
C4	0.52%

Please note: From October 2022, C3 Incidents includes C5 Incidents with a response on scene

Intelligence Narrative	Operations Narrative
C1 Incidents metric shows common cause variation C2 Incidents metric shows common cause variation C3 Incidents metric shows common cause variation C4 Incidents metric shows special cause variation of an improving nature Incidents (A7) metric shows common cause variation	EEAST responded to a total of 88,096 incidents (A7), an increase compared to the previous month. The overall category mix remained consistent with previous months. C2 incidents continued to account for most of the Trusts activity at 63.95%, showing a slight decrease on the previous month. C3 incidents also reduced to 22.33% as did C1 incidents to 12.20%. C4 incidents remained low at 0.52%.

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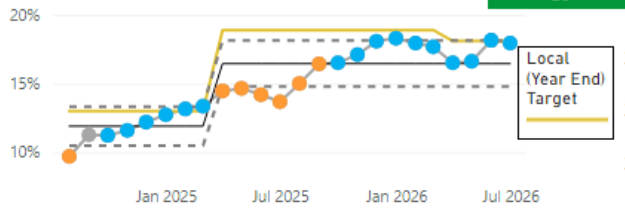
Hear & Treat, See & Treat and See, Treat & Convey

Data up to: July 2026

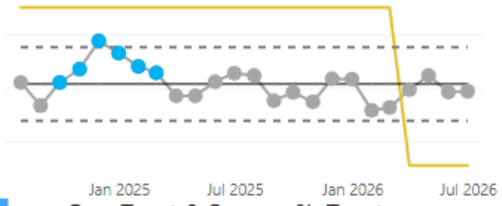
Data Owner / Responsible Exec
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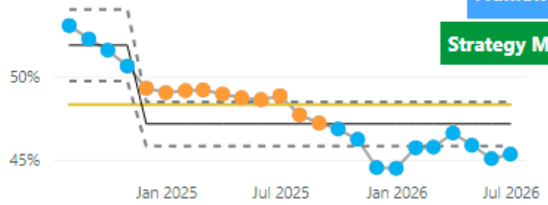
Hear & Treat % (Including A2S & PCT) **Strategy Metric**



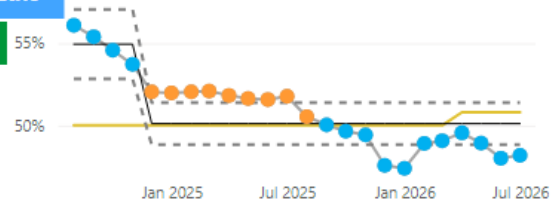
See & Treat %: Trust



See, Treat & Convey to ED %: Trust **NHS Oversight Framework Metric** **Strategy Metric**



See, Treat & Convey %: Trust



Metric	Month	Value	Mean	Assurance	Variation
Hear & Treat % (including A2S and PCT)	Jul 26	17.94%	16.46%		
See & Treat %	Jul 26	33.87%	34.15%		
See, Treat & Convey to ED %	Jul 26	45.34%	47.15%		
See, Treat & Convey %	Jul 26	48.18%	50.11%		

Intelligence Narrative	Operations Narrative
Hear & Treat % (including A2S and PCT) metric shows special cause variation of an improving nature, but the metric may hit it or miss target See & Treat % metric shows common cause variation and the metric will consistently hit its target See, Treat & Convey to ED % metric shows special cause variation of an improving nature, but the metric may hit it or miss target See, Treat & Convey % metric shows special cause variation of an improving nature, but the metric may hit it or miss target	15,805 calls reached a Hear and Treat (H&T) disposition which is 17.94% of total activity and delivered target. This is through CAS and UCCH management of calls. Improvement work continues with H&T delivery with includes productivity management of the CAS clinicians, clinical supervision strategy to improve conversion rate and continued improvements within the process to transfer calls to our 111 providers.

Kingsmill Esther
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Patients - Performance

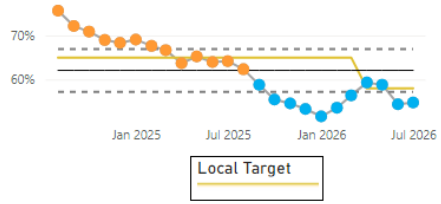
C3-C5 Dispatch and Conveyance Rates

Data up to: July 2026

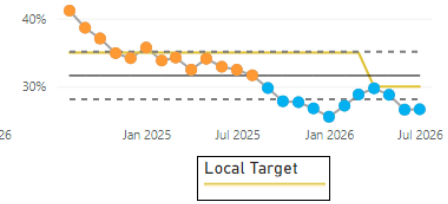
Data Owner / Responsible Exec
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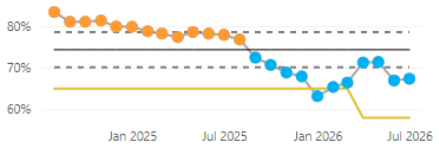
C3-C5 Dispatch (Attendance) Rate % (% of A7) (7am - 8pm) **Strategy Metric**



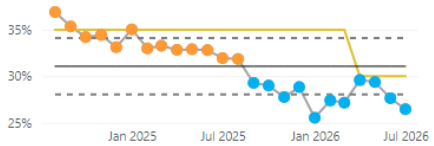
C3-C5 Conveyance Rate % (% of A7) (7am - 8pm) **Strategy Metric**



C3-C5 Dispatch (Attendance) Rate % (% of A7) (8pm - 7am)



C3-C5 Conveyance Rate % (% of A7) (8pm - 7am)



Metric	Month	Value	Mean	Assurance	Variation
C3-C5 Dispatch (Attendance) Rate % (% of A7) (7am - 8pm)	Jul 26	54.76%	62.07%		
C3-C5 Conveyance Rate % (% of A7) (7am - 8pm)	Jul 26	26.67%	31.62%		
C3-C5 Dispatch (Attendance) Rate % (% of A7) (8pm - 7am)	Jul 26	67.39%	74.34%		
C3-C5 Conveyance Rate % (% of A7) (8pm - 7am)	Jul 26	26.46%	31.07%		

Intelligence Narrative	Operations Narrative
C3-C5 Dispatch (Attendance) Rate % (% of A7) (7am - 8pm) metric shows special cause variation of an improving nature, but the metric may hit it or miss target C3-C5 Conveyance Rate % (% of A7) (7am - 8pm) metric shows special cause variation of an improving nature, but the metric may hit it or miss target C3-C5 Dispatch (Attendance) Rate % (% of A7) (8pm - 7am) metric shows special cause variation of an improving nature but the metric will consistently miss its target C3-C5 Conveyance Rate % (% of A7) (8pm - 7am) metric shows special cause variation of an improving nature, but the metric may hit it or miss target	Performance against the C3-C5 dispatch target continues to reflect both operational pressures as well as opportunities where an increase in pathway utilisation is required. Against a target of 65% dispatch in hours, performance was 54.76% and out of hours was 66.39%. Conveyance rates remained consistent with the previous months with C3–C5 conveyance at 26.67% in hours and 26.46% out of hours. EEAST will continue with work to focus on increasing the safe redirection of appropriate cases into alternative care pathways. Strengthened partnership working and more effective use of ITK transfers will reduce lower acuity daytime dispatch, enabling CAS clinicians to prioritise higher risk cases, improve Category 2 segmentation, and maintain capacity for the those with critical conditions.

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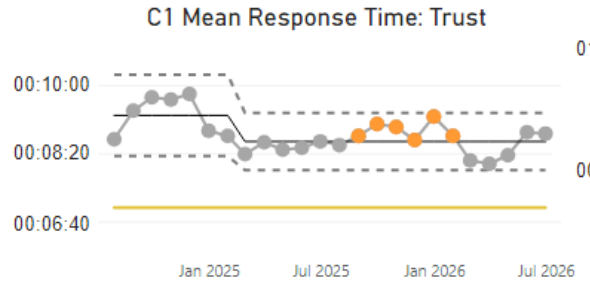
Patients - Performance

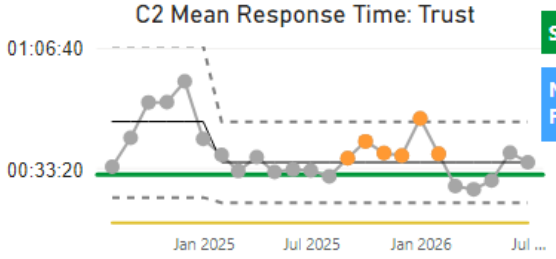
C1 / C2 Monthly Response Times

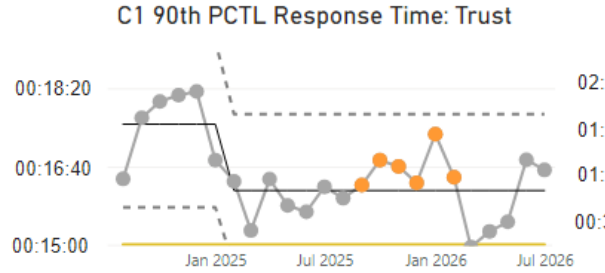
Data up to: July 2026

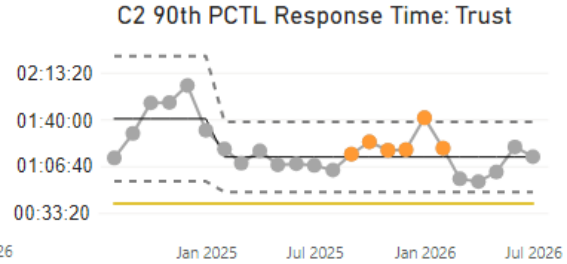
Data Owner / Responsible Exec
Darren Meads

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information@eastamb.nhs.uk









Strategy Metric

NHS Oversight Framework Metric

National Target

Local Target

Metric	Month	Value	Mean	Assurance	Variation
C1 Mean Response Time	Jul 26	00:08:49	00:08:37		
C2 Mean Response Time	Jul 26	00:34:51	00:34:50		
C1 90th PCTL Response Time	Jul 26	00:16:35	00:16:09		
C2 90th PCTL Response Time	Jul 26	01:13:22	01:13:07		

Intelligence Narrative

C1 Mean Response Time metric shows common cause variation and the metric will consistently miss its target

C2 Mean Response Time metric shows common cause variation and the metric will consistently miss its target

C1 90th PCTL Response Time metric shows common cause variation and the metric may hit it or miss target

C2 90th PCTL Response Time metric shows common cause variation and the metric will consistently miss its target

Operations Narrative

Response times for both Category 1 (C1) and Category 2 (C2) incidents have decreased slightly compared to the previous month. The average C1 response time was 00:08:49 and the average C2 response time was 00:34:51.

Actions underway: Operational productivity continues to be monitored through check and challenge forums and Power BI dashboards to maximise efficiencies, with targeted action on sickness absence supported by HR. Focus remains on maintaining Hear & Treat performance against plan and delivering the Vehicle Off Road reduction plan to maximise fleet availability.

Assurance: Operational response performance remains a priority for both the Clinical Operations Transformation Change Board and the Trust Portfolio Board. EEAST continues to work with ICB partners and NHS England to mitigate the impact of hospital handover delays on frontline delivery.

Kingsmill Esther
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Patients - Performance

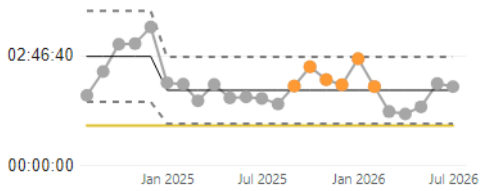
C3 / C4 Monthly Response Times

Data up to: July 2026

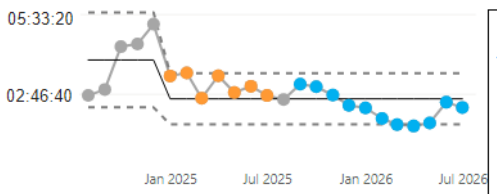
Data Owner / Responsible Exec
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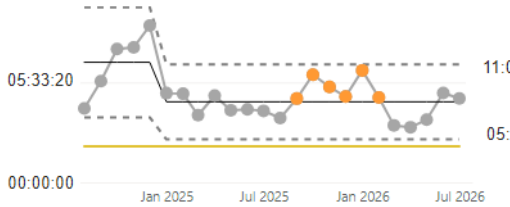
C3 Mean Response Time: Trust



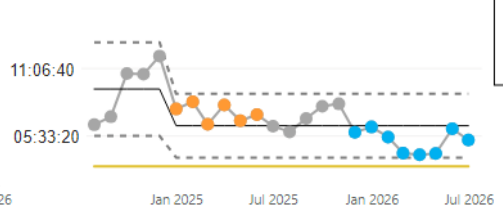
C4 Mean Response Time: Trust



C3 90th PCTL Response Time: Trust



C4 90th PCTL Response Time: Trust



Metric	Month	Value	Mean	Assurance	Variation
C3 Mean Response Time	Jul 26	01:59:04	01:53:44		
C4 Mean Response Time	Jul 26	02:17:53	02:35:57		
C3 90th PCTL Response Time	Jul 26	04:40:10	04:28:43		
C4 90th PCTL Response Time	Jul 26	05:10:25	06:21:08		

Intelligence Narrative

C3 Mean Response Time metric shows common cause variation and the metric will consistently miss its target

C4 Mean Response Time metric shows special cause variation of an improving nature

C3 90th PCTL Response Time metric shows common cause variation and the metric will consistently miss its target

C4 90th PCTL Response Time metric shows special cause variation of an improving nature but the metric will consistently miss its target

Operations Narrative

Response times for both Category 3 (C3) and Category 4 (C4) incidents have decreased slightly compared to the previous month. The average C3 response time was 01:59:04 and the average C4 response time was 02:17:53

Actions underway: Operational productivity continues to be monitored through check and challenge forums and Power BI dashboards to maximise efficiencies, with targeted action on sickness absence supported by HR. Focus remains on maintaining Hear & Treat performance against plan and delivering the Vehicle Off Road reduction plan to maximise fleet availability.

Assurance: Operational response performance remains a priority for both the Clinical Operations Transformation Change Board and the Trust Portfolio Board. EEAST continues to work with ICB partners and NHS England to mitigate the impact of hospital handover delays on frontline delivery.

Kingsmill Esther
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Patients - Performance

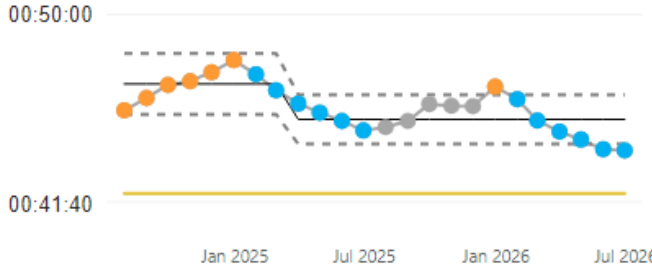
On Scene Times - Conveyed and Not Conveyed

Data up to: July 2026

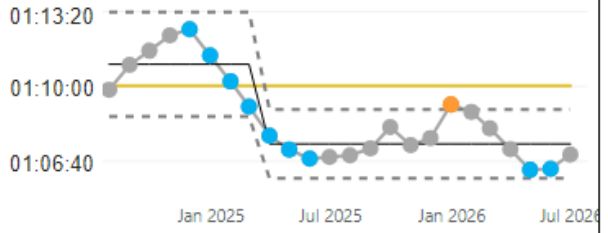
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Average On Scene Time - Conveyed: Trust



Average On Scene Time - Not Conveyed: Trust



Local Target

Metric	Month	Value	Mean	Assurance	Variation
Average On Scene Time - Conveyed	Jul 26	00:43:55	00:45:18		
Average On Scene Time - Not Conveyed	Jul 26	01:06:56	01:07:24		

Please note that the above two graphs are for all categories of incident

Intelligence Narrative

Average On Scene Time - Conveyed metric shows special cause variation of an improving nature but the metric will consistently miss its target

Average On Scene Time - Not Conveyed metric shows common cause variation and the metric will consistently hit its target

Operations Narrative

For conveyed patients, the average on scene time was consistent with previous months at 00:43:55. For non-conveyed patients, the average on scene time was 01:06:56.

Performance against this metric was in line with expected operational practice, with crews spending more time on scene to properly assess patients and make use of appropriate alternative care pathways. As a result, the Trust's overall conveyance rate stayed below the 62% target at 58.72%.

Actions: Work against agreed KPIs and minimum datasets for referrals and hub call answering continues. Improvement activity within Call Before You Convey remains focused on reducing call back times, with a five minute target in place and clear direction for crews to leave scene after 20 minutes where no response is received. Operational areas can also identify staff who have the best and OST-NC times to target more specific development opportunities.

Assurance: On scene time performance continues to be a key priority and is subject to regular oversight through local performance cells, the Trust Performance Board, and the Change Portfolio Board.

Kingsmill Esther
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Patients - Performance

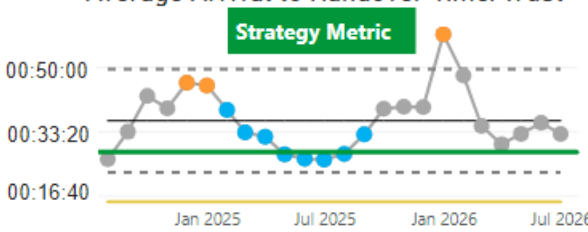
Handover

Data up to: July 2026

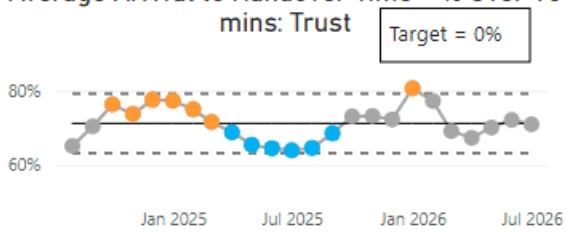
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Average Arrival to Handover Time: Trust

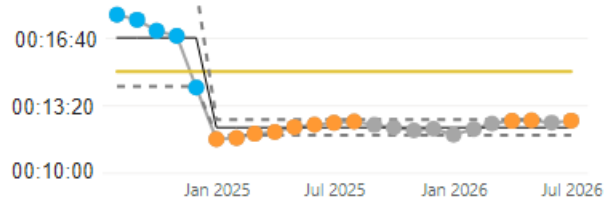


Average Arrival to Handover Time - % Over 15 mins: Trust



Please note the difference in y-axis scale between the chart above and below

Average Handover to Clear Time: Trust



Metric	Month	Value	Mean	Assurance	Variation
Average Arrival to Handover Time	Jul 26	00:32:37	00:36:03		
Average Arrival to Handover Time - % Over 15 mins	Jul 26	70.99%	71.25%		
Average Handover to Clear Time	Jul 26	00:12:34	00:12:13		

Please note that Auto Clear within 15 minutes was implemented on the 19th December 2024, this explains the drop in the Handover to Clear graphs

Intelligence Narrative

Average Arrival to Handover Time metric shows common cause variation and the metric will consistently miss its target

Average Arrival to Handover Time - % Over 15 mins metric shows common cause variation and the metric will consistently miss its target

Average Handover to Clear Time metric shows special cause variation of a concerning nature but the metric will consistently pass its target

Operational Narrative

Average Arrival to Handover (A2H) time was above target at 00:33:37 with the % of handovers exceeding 15 minutes at 70.99%. However both metrics show slight improvement compared with the previous month. Handover to Clear performance remains within the 15-minute target at 00:12:34.

Actions: EEAST continues to work closely with regional teams to meet NHSE expectations, including reducing average handover times. We are waiting for the expected agreed trajectories from the acute sites. Focus remains on reducing the volume of >15-minute handovers across all acute sites, with targeted support and escalation for hospitals experiencing the most significant delays. Local COO>COO scrutiny will continue.

Assurance: Overall assurance remains limited as many acute sites continue to face sustained and unprecedented operational pressures. While Handover to Clear times remain on target, the persistent upward trend in A2H times requires continued scrutiny and coordinated action to prevent further deterioration.

Kingsmill Esther
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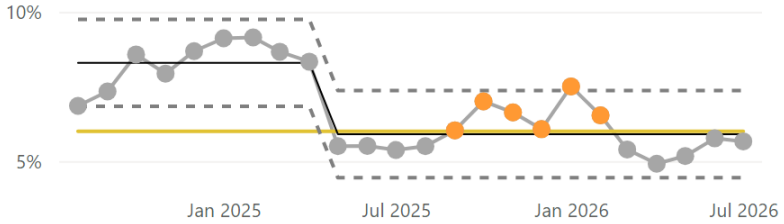
Patients - Performance

PFSH (Excluding PAS) and OOS

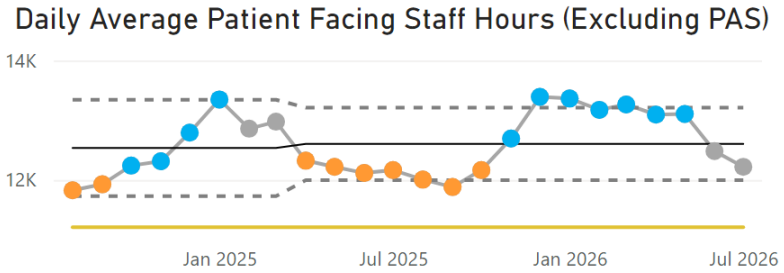
Data up to: July 2026

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Local Target



PFSH Minimum Floor Standard

Metric	Month	Value	Mean	Assurance	Variation
OOS as a % of Vehicle Hours	Jul 26	5.66%	5.9%		
Daily Average Patient Facing Staff Hours (excludes PAS)	Jul 26	12218.04	12601.98		

PFSH includes CRU, DSA, HCRT, ITV and RRV vehicle types only

Intelligence Narrative

OOS as a % of Vehicle Hours metric shows common cause variation and the metric may hit it or miss target

Daily Average Patient Facing Staff Hours (excludes PAS) metric shows common cause variation and the metric will consistently hit its target

Please note the use of the term 'Target' here refers to the Minimum Floor Standard for PFSH

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Operational Narrative

Patient facing hours continued to meet the targets set out in the NHSE plan. Additional PAS resources and overtime have been in place to support workforce, patient safety, increase operational capacity, and reinforce overall system resilience.

EEAST continues to report Out of Service (OOS) performance using both including and excluding cohorting metrics. This dual approach recognises that cohorting is a system level intervention outside EEAST's direct operational control and provides clearer distinction between internal operational performance and wider system pressures.

Overall, OOS performance was 5.76% which achieves the 6% target. When cohorting is excluded, OOS reduces further to 4.7%.

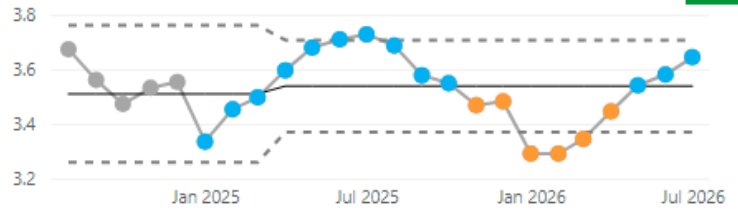
Patients - Performance
Average Number of Patients seen per DCA Shift & Multiple Assignment Ratio

Data up to: July 2026

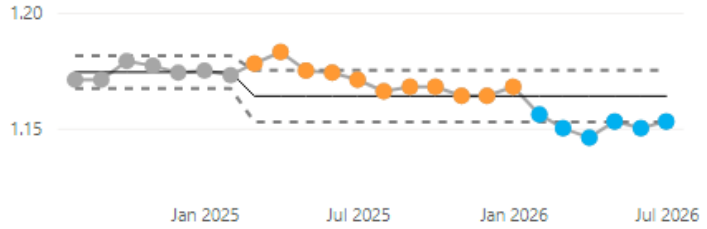
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Average Number of Patients seen per DCA Shift **Strategy Metric**



Multiple Assignment Ratio: Trust



Metric	Month	Value	Mean	Assurance	Variation
Average Number of Patients seen per DCA Shift	Jul 26	3.64	3.54		
Multiple Assignment Ratio	Jul 26	1.15	1.16		

Please note that Multiple Assignment Ratio includes all resources and Average Number of Patients seen per DCA shift only includes DSA, HCRT, SSA and URG vehicle types.

Intelligence Narrative	Sustainability Narrative
Average Number of Patients seen per DCA Shift metric shows special cause variation of an improving nature Multiple Assignment Ratio metric shows special cause variation of an improving nature	Patients per shift (PPS) has remained steady over the past 12 months and similar to the previous month's position. There's a clear seasonal trend, with PPS typically dipping over the winter period before improving again through the summer. This is largely due to increased pressure across the system in colder months, such as longer times on scene and delays at hospital handovers, which tend to impact PPS during periods of higher demand. Multiple Assignment Ratio (MAR) remains within target at 1.14 meaning that most incidents were attended by a single response. This helps to ensure resources are available to attend new incidents.

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Patients - Performance
Right Place, Right Time

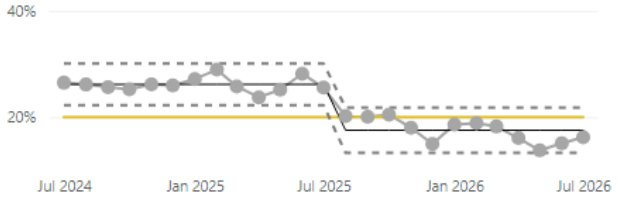
Data up to: July 2026

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Local Target

Vehicle Off Road % – All Emergency Operational Vehicles



Metric	Month	Value	Mean	Assurance	Variation
Vehicle off Road % – All Emergency Operational Vehicles	Jul 26	16.25%	17.57%		

Vehicle Shift Fulfilment % - Metric currently under discussion

Strategy Metric

Intelligence Narrative	**Operational Narrative**
Vehicle off Road % – All Emergency Operational Vehicles metric shows common cause variation and the metric may hit it or miss target	Performance against the overall average for all Vehicle Off Road (VOR) continues to remain within planned levels at 15.87% for DSA and an overall fleet VOR of 15.20%. This continues to be a result of the progress being made in ensuring a steady state supply of new vehicles. Enabling the rate of swapping out of the FIAT DSA to further increase. We have engaged with the convertor of the DSA's and have reached agreement for the high cost long lead time part to be held at the repairers location as a impress part. this will reduce accident VOR times for this repair. Responsibility for long term VOR has been reallocated back to the local workshop manager. They have the detail of the defects and now liaise with external suppliers when vehicles are taken externally for warranty or specialist repairs. This is showing benefit in the reduction of time vehicles are off site in 3rd party repairers.

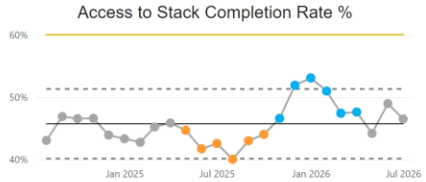
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Patients - Performance

System Involvement

Information as at: July 2026

Data Owner / Responsible Exec
Darren Meads



Metric	Month	Value	Mean	Assurance	Variation
Access to Stack Completion Rate %	Jul 26	46.51%	45.73%		

Intelligence Narrative	Integration Narrative
Access to Stack Completion Rate % metric shows common cause variation and the metric will consistently miss its target	3,568 incidents were passed to UCR teams in July 26 via Access to Stack (A2S). Of those, 2,827 (79.23%) were accepted by the Urgent Community Response (UCR) providers and 1,590 (44.56%) were completed by UCR teams with no ambulance response being required. The completion volume has decreased by 216 calls from June 26 and has decreased by 66 from July 2025. Sector totals (ordered by completion %) N&W - 918 passed, 753 accepted (82.03%) and 435 completed (47.39%) BLMK - 600 passed, 565 accepted (94.17%) and 265 completed (44.17%) MSE – 427 passed, 280 accepted (65.67%) and 187 completed (43.79%) SNEE - 955 passed, 829 accepted (86.81%) and 409 completed (42.83%) C&P - 404 passed, 356 accepted (88.12%) and 160 completed (39.60%) HWE - 647 passed, 481 accepted (74.34%) and 235 completed (36.32%) The highest single provider (only split in SNEE, HWE & N&W) is UCRS (ESNEFT) in SNEE with 425 passed and 216 completed (50.82%). The lowest is EIT in SNEE, with 204 passed and 62 completed (30.39%) EIT have followed REACT in adopting Centralised Triage as of 14/07, so this should see an expected improvement in completion and H&T rates and this was discussed with the West Suffolk Hospital COO and Deputy COO and a follow-up meeting with UCR managers is planned for 17/08.

Kingsmill Esther
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Patients - Clinical

Director: Simon Chase

July 2026

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The following slides relate to clinical and safety metrics and whilst reported separately, it's important to recognise the relationship, influence and alignment to the operational performance.

The Clinical team is comprised of a number of specialised areas including Safety and Risk, Patient Experience, Safeguarding, Compliance, Claims, Inquests and Standards, Infection, Prevention and Control and Quality Improvement. All areas are contributors to the slide pack.'

Patients - Clinical

Ideally every metric should be in one of these starred boxes, which indicate the metric is either currently passing its target or is currently improving ★

Assurance Grid (SPC Charts only)

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Data up to:
July 2026

Variance	Assurance: Consistently hit target (P)	Inconsistently achieve or fail target (?)	Consistently fail target (F)	No target given
Special Cause - Improvement (L, H)	• % of Incidents that are Moderate,Severe or Fatal Harm ★ • Statutory/Mandatory Training (11 CSTF topics) %	• ROSC - Utstein ★	★	★
Common Cause	• Complaints per 10000 Patient Interactions ★ • IG Training Compliance % • Number of Incidents per 10000 Patient Interactions • Patient Safety Incident Reviews (PSIRs) per 10000 Patient Interactions	• % of Complaints Closed in Compliant Timeframe • Declared Patient Safety events investigated under PSIRF • ROSC - All • ROSC Care Bundle • Stemi Care Bundle • Survival to Discharge All - 30 Day Survival • Survival to Discharge Utstein - 30 Day Survival		• Compliments per 10000 Patient Interactions • Number of Prevention of Future Death (PFDs)/Regulation 28 reports received in month • Resus face to face element (Adult/Paediatric/Neonatal) % • STEMI Timeliness - 90th centile time from call to catheter insertion for angiography • STEMI Timeliness - Mean average time from call to catheter insertion for angiography • Stroke Timeliness - 90th centile time from call to hospital arrival • Stroke Timeliness - Mean average time from call to hospital arrival • Stroke Timeliness - Median average time from call to hospital arrival
Special Cause - Concern (L, H)				

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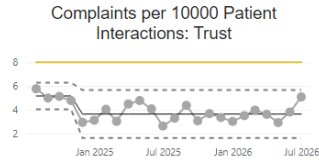
Please note that Falls in Older People - Discharged at Scene Care Bundle will not appear on the above grid until it has a sufficient amount of data points to be an SPC chart. Additionally, Number of Preventing Future Deaths (PFDs)/ Regulation 28 Reports is a bar chart so will also not show.

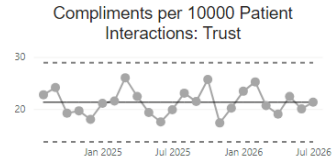
Patients - Clinical

Complaints & Compliments

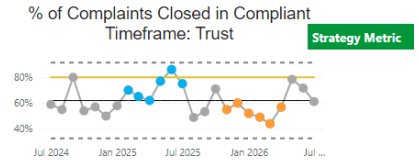
Data up to: July 2026

Data Owner / Responsible Exec
Simon Chase





Metric	Month	Value	Mean	Assurance	Variation
Complaints per 10000 Patient Interactions	Jul 26	5.08	3.65		
Compliments per 10000 Patient Interactions	Jul 26	21.32	21.3		
% of Complaints Closed in Compliant Timeframe	Jul 26	61.22%	61.98%		



Intelligence Narrative	Clinical Narrative
Complaints per 10000 Patient Interactions metric shows common cause variation and the metric will consistently hit its target Compliments per 10000 Patient Interactions metric shows common cause variation % of Complaints Closed in Compliant Timeframe metric shows common cause variation and the metric may hit it or miss target	Complaint activity increased during July, with 76 complaints received. This represents a 35.7% increase compared with June 2026 (56 complaints) and is above the rolling 12-month average of 53 complaints per month. July's complaint rate equates to 5.08 complaints per 10,000 patient contacts, compared with the SPC mean of 3.65. Whilst above this average, complaint activity remains within expected variation. The Trust received 319 compliments during July, equating to 21.3 compliments per 10,000 patient contacts and remaining consistent with the long-term average. Positive feedback continues to significantly outweigh complaint volumes, reflecting the professionalism, kindness and care demonstrated by Trust staff. During July, the most common UEC and EOC complaint themes continued to relate to clinical assessment and treatment (32.7%), staff attitude (23.6%) and communication/call handling (21.8%). Despite operational pressures, only three complaints relating to delays (5.5%) were received. 18 PTS complaints were received during July, slightly above the rolling 12-month average of 16 complaints per month. Complaint themes predominantly related to transport and driving concerns (61.1%), followed by delays (27.8%). No PTS attitude-related complaints were received during the month, representing an improvement compared with June (6) and the annual monthly average. Complaint themes continue to be monitored closely following PTS contract changes, journey capping arrangements and the introduction of new vehicles, which are expected to support ongoing improvements in service delivery and patient experience. Compliance and Governance Complaint closure compliance reduced during July to 61.2%. Whilst lower than June's performance, compliance remains broadly in line with the long-term average (62.0%) and above levels reported during Q4, indicating that recent improvements have largely been sustained. The reduction in closure compliance is largely attributable to temporary capacity pressures within the Patient Experience Team rather than delays in local investigations. This has primarily been associated with the induction and training of two newly appointed Patient Experience Co-ordinators, together with annual leave commitments during the summer period. The Patient Experience Co-ordinators are nearing completion of their training programme and are gradually taking on larger and more complex caseloads. This is expected to strengthen team capacity and support improvements in complaint closure performance from October 2026. Currently, 14 of 110 local investigations (12.7%) exceed the 35/40-day local investigation timeframe, with six of these investigations within Operations and six within PTS. Although the number of overdue investigations has increased since June, the proportion remains low overall and the majority continue to be completed within the required timeframe. Performance is monitored through established governance arrangements, with overdue investigations escalated where appropriate. The introduction of additional performance metrics within the Accountability Dashboard has strengthened visibility of complaint and investigation performance and supports clearer identification of where delays occur within the complaint pathway. Overall open complaint compliance remains strong, with 98.2% of cases currently within the required 55/65-day compliance timeframe, providing assurance that complaints are being actively managed and progressed through the process in a timely manner. Actions • Continue oversight of overdue local investigations through established governance arrangements, including PSEG, QRAG, OSDG, QGC and Accountability. • Maintain engagement with Heads of Operations and PTS managers to continue to improve local investigation compliance. • Support the continued development of newly appointed Patient Experience Co-ordinators as they transition to managing their own caseloads, whilst monitoring the impact on complaint closure compliance. • Embed improvements identified through the complaints process review to reduce delays across the complaint pathway. • Monitor PTS complaint themes and trends to evaluate the impact of contract changes, journey capping arrangements and the introduction of new vehicles. Impact • Complaint activity remains within expected SPC variation despite an increase in overall complaint volumes during July. • 98.2% of open complaints remain within the required 55/65-day compliance timeframe, demonstrating that complaints continue to progress within expected timescales. • The introduction of additional performance metrics within the Accountability Dashboard has strengthened visibility of complaint and investigation performance and supports clearer identification of delays within the complaint's pathway. • Positive feedback continues to significantly outweigh complaint volumes, providing ongoing assurance regarding patient experience and the quality of care received. • As newly appointed Patient Experience Co-ordinators gain experience and take on larger caseloads, team capacity continues to increase, supporting future improvements in complaint handling performance.

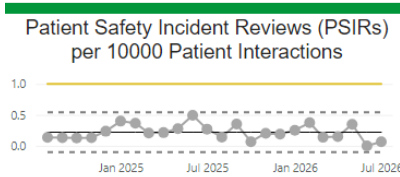
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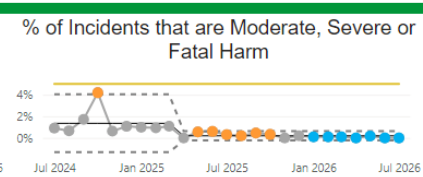
Patients - Clinical

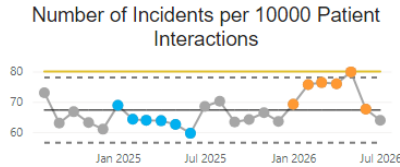
Patient Safety

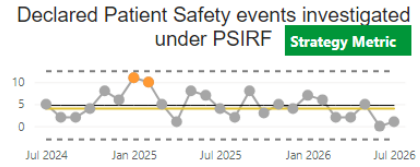
Data up to: July 2026

Data Owner / Responsible Exec
Simon Chase









Metric	Month	Value	Mean	Assurance	Variation
Patient Safety Incident Reviews (PSIRs) per 10000 Patient Interactions	Jul 26	0.07	0.22		
% of Incidents that are Moderate,Severe or Fatal Harm	Jul 26	0%	0.19%		
Number of Incidents per 10000 Patient Interactions	Jul 26	63.84	67.24		
Declared Patient Safety events investigated under PSIRF	Jul 26	1	4.72		

Intelligence Narrative

Patient Safety Incident Reviews (PSIRs) per 10000 Patient Interactions metric shows common cause variation and the metric will consistently hit its target

% of Incidents that are Moderate,Severe or Fatal Harm metric shows special cause variation of an improving nature and the metric will consistently pass its target

Number of Incidents per 10000 Patient Interactions metric shows common cause variation and the metric will consistently hit its target

Declared Patient Safety events investigated under PSIRF metric shows common cause variation and the metric may hit it or miss target

Clinical Narrative

The number of incidents reported in July 2026 was 955, a decrease from the 988 in June, reporting remains consistent with no special cause for concern. For the third consecutive month there was Zero delay incidents deemed to have caused harm.
Despite the number of incidents discussed at Incident Review panel being in line with previous data, there were zero patient safety events declared via the incident review panel, this is the second consecutive month of reporting zero.

The total number of SJR's completed for Q1 of 2026/27 is 175, this has exceeded the compliance figure of 40 per month (120 per quarter). The Q2 to date total is 80 completed SJR's. The LFD workstream is supported by staff in the patient safety team on alternate working duties. Learning and excellence themes are reported into PSEG on a quarterly basis. The more SJR's completed allows for learning and excellence themes to be highlighted which has a positive impact on patient care.

Duty of Candour is undertaken in a way that demonstrates both our candour and empathy for those involved or their relatives. When contact can not be established, this causes a delay in discharging DOC, for all instances, a get in touch letter is sent to patients or relatives to try and establish contact as soon as possible.

The Team continue to engage with frontline staff in liaison with other teams from the Clinical Directorate. Patient Safety, Datix and AAR training is being delivered out to operational staff on a regular basis.

Timely review of incidents is imperative to avoid incidents of a similar nature reoccurring. There has been an increase in the number of overdue incidents across the region, this has been escalated to PSEG & CRG and is being monitored to ensure it does not become a special cause for concern sustained. The number of overdue incidents in July was 890 across the trust, this is an increase from the 750 and 770 reported in May and June of 2026. Escalations are reported to OSDG monthly by the HoPS as a standing agenda item, they are also reported to the relevant EOC governance groups by the EOC PSS

Action:
A new After Action Review (AAR) template has been produced to support more efficient review processes as well as streamlining the documentation of AAR's. As part of this , specific training sessions have been delivered during July for AAR trained staff to embed the new template. Additional AAR training for those not already trained will continue to be offered to managers in operations and EOC throughout the year. The aim to standardise the incident review process by incorporating AAR's is reliant on local teams within sector attending the patient safety team AAR & Datix training.

Peer review of the Resuscitation decision making PSII is underway, positive feedback is evident so far. This remais on track to be published in Q2 of 2026
LFD data for ambulance attendances to Code 9 calls with DNAR's in place was presented to the regional quality and safeguarding group in July, this is to raise awareness of this identified theme of 999 calls for deceased patients requesting we attend to complete ROLE despite other community providers, i.e. 111 & GP providers having the autonomy to do this. Reporting to the group to maintain oversight will occur on a quarterly basis.

Impact:
Zero harm events deemed moderate , severe or fatal harm have been recorded for june 2026, one declared in July 2026 , in comparison with he same time period of ast year , the number of declared patient safety events was 11
The number of non conveyance events causing harm to patients has reduced since the publication of the Non Conveyance PSII. The look back of incident data indicates a 50% reduction in non conveyance harm events in the last 24 months.
The number of missed STEMI incidents has reduced since the publication of the Cardiac PSII in both frequency & patient harm , there has been zero missed STEMI incidents causing moderate, severe or fatal harm to patients since June 2024.
The publication of the Patient Injury PSII has positively impacted the frequency of incidents and harm caused to patients following the adoption of the proposed safety actions. The patient safety team will lead a review on incident data to further evidence the improvements made since the publication of the PSII

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Patients - Clinical
Ambulance Quality Indicators - Clinical
Care Bundles - Cardiac Arrest Metrics

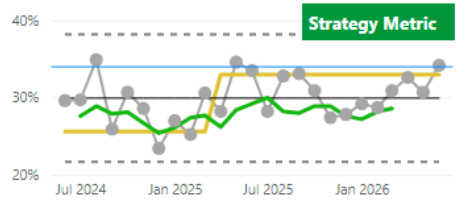
Please note the data on these Care Bundles pages will be more than 1 month behind unlike the rest of the pages in this reports due to when the data is available

Data up to: July 2026

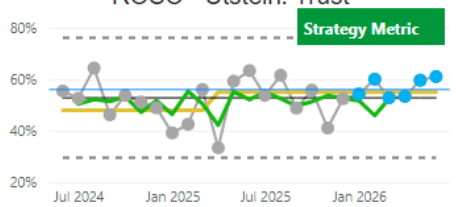
Data Owner / Responsible Exec
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ROSC - All: Trust



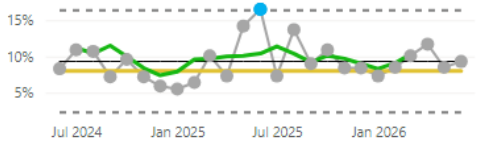
ROSC - Utstein: Trust



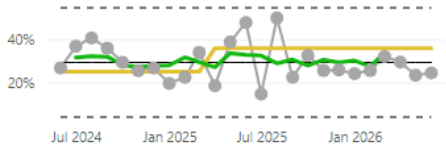
National Averages | Commissioner Set Target | Local Target

Metric	Month	Value	Mean	Assurance	Variation
ROSC - All	Jun 26	34.2%	29.94%		
ROSC - Utstein	Jun 26	61%	52.79%		
Survival to Discharge All - 30 Day Survival	Jun 26	9.3%	9.32%		
Survival to Discharge Utstein - 30 Day Survival	Jun 26	24.4%	29.33%		
ROSC Care Bundle	May 26	97.6%	96.53%		

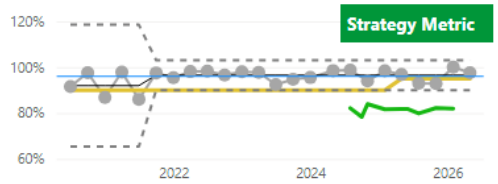
Survival to Discharge All - 30 Day Survival: Trust



Survival to Discharge Utstein - 30 Day Survival: Trust



ROSC Care Bundle: Trust



Definitions of the metrics on this page may be found at the end of the Clinical Section

Intelligence Narrative

ROSC - All metric shows common cause variation and the metric may hit it or miss target

ROSC - Utstein metric shows special cause variation of an improving nature, but the metric may hit it or miss target

Survival to Discharge All - 30 Day Survival metric shows common cause variation and the metric may hit it or miss target

Survival to Discharge Utstein - 30 Day Survival metric shows common cause variation and the metric may hit it or miss target

ROSC Care Bundle metric shows common cause variation and the metric may hit it or miss target

Clinical Narrative

Summary – 3 of the cardiac arrest (ROSC Overall, ROSC Utstein & Survival To Discharge - 30 days) outcome indicators for June 26 increased in performance when compared to May 2026, reflecting the end of the spring period . As previously reported, due to the extended timeline for the publication of national averages, it is difficult to benchmark more recent months, however when compared to published data for previous months (up to March 2026), EEAST is performing above the national average (28.6%) for ROSC Overall = (30.9%), (currently 2nd Best Performing Trust), ROSC Utstein (52.8%) National = 52.4%, 5th Best Performing Trust, STD Overall (6th Best Performing Trust at 10.1%) and STD Utstein (7th Best Performing Trust at 32.1%) and no special cause for concern. The Trust met 3 of its own 'stretch' targets for these outcomes and met 3 of the Commissioner set thresholds.The latest National comparable month for the quarterly Post ROSC Care Bundle (Feb 2026) demonstrates that EEAST, achieving 100%, and still continues to perform well above the trending national average (81.9%) with EEAST being the Best Performing out of the 11 UK Ambulance Trusts, demonstrating the consistent high level of care being delivered, meeting above the 90% commissioner threshold but not meeting the local threshold of 95%.

Actions – The Local Clinical Managers and Supervisors continue to actively work with the Clinical Audit Manager to engage with and support crews. Monthly outcomes with recommended actions are also disseminated to help continue to improve metrics. Ongoing monitoring of Trust performance against national data continues, however due to the time lag in the publication of national data, true comparisons within current months are not able to be made.

The cardiac arrest desk to support bystander CPR prior to EMS arrival was launched on 01 June 2026 and is now fully manned (7/7 Day Shifts by Advanced Paramedic Practicitioners in Urgent and Critical Care expertise only for frontline staff and Public Video Support prior to EMS arrival to improve Patient Survival Outcomes. Since the first OHCA video call in September 2026, 5102 cases have been listened to. This optimises early recognition and treatment of OHCA, with video being used in 400 cases to help understand what is going on at the scene prior to ambulance arrival. Across these 400 video calls, 753 individual improvements have been made to the delivery of CPR and public access defibrillation prior to EEAST arrival on scene. These improvements range from the Essential Clinical Skills training is focusing on good cardiac arrest and serious conditions management to raise the profile of ACQI improvement.

The Critical Care Desk (CCD) has 24/7 cover to also support crew decision making. A further refocus on ECS re care bundles to all operational staff has been undertaken to help stregthen our performance.

Impact - Improvements in response times highlights the link to improving the ROSC outcomes (both for all patients and UTSTEIN patients). The launch of the cardiac arrest desk and continued CCD Desk support should further impact on outcomes for cardiac arrest, this will continue to be monitored over future months to determine the effectiveness of this initiative.

It should be noted that the cohort for the post-ROSC patient group is very small which can sway the compliance level achieved. Survival to discharge is dependent on treatment and decisions taken by the relevant acute organisation as well as EEAST's timely response.

Assurance offered remains reasonable with no special cause for concern - Although the Trust is currently performing in line with the national average, sustained improvements in ROSC are needed to provide sustained assurance.

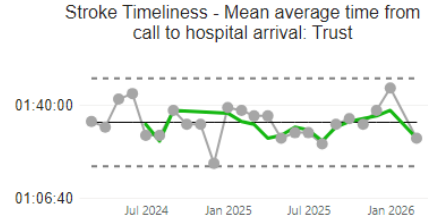
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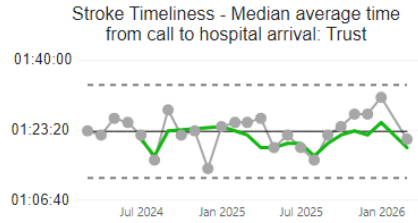
Patients - Clinical Ambulance Quality Indicators - Clinical Care Bundles - Stroke

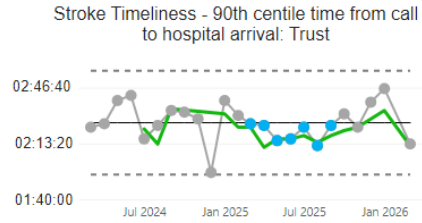
Please note the data on these Care Bundles pages will be more than 1 month behind unlike the rest of the pages in this reports due to when the data is available

Data up to: July 2026

Data Owner / Responsible Exec: Simon Chase







National Averages

Metric	Month	Value	Mean	Assurance	Variation
Stroke Timeliness - Mean average time from call to hospital arrival	Mar 26	01:28:00	01:33:42		
Stroke Timeliness - Median average time from call to hospital arrival	Mar 26	01:21:00	01:22:53		
Stroke Timeliness - 90th centile time from call to hospital arrival	Mar 26	02:13:00	02:25:42		

Intelligence Narrative

Stroke Timeliness - Mean average time from call to hospital arrival metric shows common cause variation

Stroke Timeliness - Median average time from call to hospital arrival metric shows common cause variation

Stroke Timeliness - 90th centile time from call to hospital arrival metric shows common cause variation

Clinical Narrative

Summary - Stroke timeliness - The graphs above demonstrate that EEAST fell slightly short (by 1 & 2 minutes) for the Median & 90th Centile time from call to hospital arrival for March 26 compared to the national published averages and met the Mean Average of 01:28, however there is a significant time-lag in publication of the national and EEAST data for these outcomes (4-months). Therefore, any improvements in category 2 response times are difficult to understand for recent months for these indicators but for March 26 EEAST was the 6th Best Performing Trust and no special cause for concern.

Actions - Actions relating to improving category 2 response times and on scene times are identified within our strategic objectives, this has become more focused following the receipt of a Section 64 (Reg 17) notice issued by the Care Quality Commission in January 2025 however New figures show that last month (April 26)EEAST is seeing our strongest response time performance in nearly five years. Category 2 response times are the fastest since 2021, and Category 1 performance is also improving.

Impact - The focus on reducing handover delays and the time spent on scene appears to be having a positive impact on the call to arrival at hospital times and should continue to influence further improvements over the coming months. However, it is difficult to determine whether this is in line with a national trend due to the unavailability of recent national data.
Each LAM Area have dedicated an LCM to monitor Time Spent On Scene working with staff as well as EOC Monitoring supporting staff with prompt clinical decision making.

The stoke video trial, where clinicians on scene have the availability to video-call consultants, still continues, which although can result in a slightly longer on scene time, it results in inappropriate hospital conveyances. A trial in West Suffolk is looking at impact on moving to a 24/7 model to be launced in 2026.Across the region, arrival-to-imaging times for confirmed stroke patients have fallen from 50 minutes to 15 minutes, with Luton and Dunstable Hospital reducing this to just three minutes. Faster access to specialist care is linked to lower mortality, reduced disability and shorter hospital stays. Up to 30 per cent of Stroke Video Triage patients are admitted directly from scanning to a Hyper Acute Stroke Unit (HASU), where they receive intensive care during the first 72 hours following a stroke.Earlier this year, The Trust was named a regional champion in the NHS Excellence Awards for its Stroke Video Triage service.

Assurance offered remains reasonable - Although the Trust is currently performing in line with the national average, job 'cycle' times need to continue to improve to provide sustained high assurance.February 2026 SSNAP AmbCO data items is missing from the Thu 9 July 26 & 13th Aug 26 National publications,due to SNNAP National Database, technical issues that have been onging for the last 2 weeks. Once fixed data can be added and the Feb Stroke Timelienss Data will be added and published at a later date.

Kingsmill Esther
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Patients - Clinical Ambulance Quality Indicators - Clinical Care Bundles - Stemi

Please note the data on these Care Bundles pages will be more than 1 month behind unlike the rest of the pages in this reports due to when the data is available

Data up to: July 2026

Data Owner / Responsible Exec
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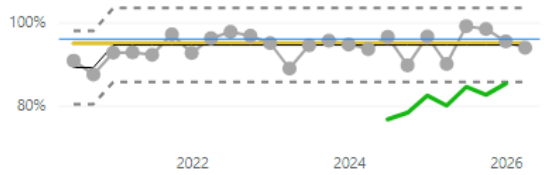
National Averages

Commissioner Set Target

Local Target

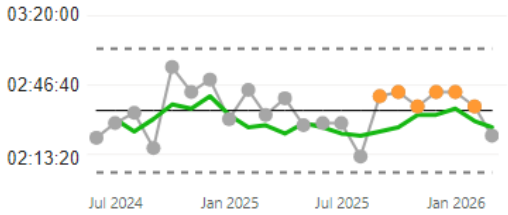
Stemi Care Bundle: Trust

Strategy Metric

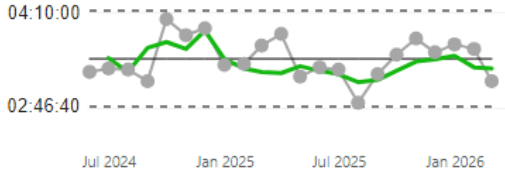


Metric	Month	Value	Mean	Assurance	Variation
Stemi Care Bundle	Apr 26	93.9%	94.55%		
STEMI Timeliness - Mean average time from call to catheter insertion for angiography	Mar 26	02:22:00	02:34:05		
STEMI Timeliness - 90th centile time from call to catheter insertion for angiography	Mar 26	03:10:00	03:29:27		

STEMI Timeliness - Mean average time from call to catheter insertion for angiography: Trust



STEMI Timeliness - 90th centile time from call to catheter insertion for angiography: Trust



Intelligence Narrative

Stemi Care Bundle metric shows common cause variation and the metric may hit it or miss target

STEMI Timeliness - Mean average time from call to catheter insertion for angiography metric shows common cause variation

STEMI Timeliness - 90th centile time from call to catheter insertion for angiography metric shows common cause variation

Clinical Narrative

Summary - STEMI timeliness – As per the stroke timelines for ACQI, EEAST has continued to submit data relating to the overall job cycle time for STEMI patients. When compared to the latest published comparable data (March 26), EEAST performance greatly increased (02:22 & 03:10),compared to the National Average for the Mean (02:26) and the 90th Centile (03:21), within the reporting month but remains no special cuase for concern.

STEMI Care Bundle –EEAST showed a slight decrease in performance 93.9% (1.5%) for this outcome and did not meet the commissioner or local threshold targets, (95%). The Trust continues to perform well above the national average.The latest comparable month for the quarterly STEMI Care Bundle (Jan 26) demonstrates that EEAST, achieving 95.4%, still continues to perform well above the trending national average (Jan 26) of 85.3% and demonstrates the consistent high level of care being delivered, meeting the commissioner threshold of 95% and surpassing the local target of 95%.
Actions - Actions relating to improving category 2 response times and on scene times are identified within our strategic objectives for the year and as per stroke response times, this has become more focused following the receipt of a Section 64 (Reg 17) notice issued by the Care Quality Commission in January 2025, however New figures show that last month (May 26) EEAST is seeing our strongest response time performance in nearly five years. Category 2 response times are the fastest since 2021, and Category 1 performance is also improving and our Quality Account 2025/26 showed that 999 calls were answered in two seconds on average.

Identified improvements required relating to the STEMI Care Bundle regarding pain management, continue to be shared with operational teams to enable feedback to the individual clinicians concerned and is a new focus on current ECS delivery.
10:10 posters have been refreshed and published on EAST24 to promote the importance of time-sensitive patients with regards to time spent on scene.
Impact – Despite the focus on improving category 2 response times and the time spent on scene the call to catheter insertion for angiography has shown an increasing trend during the last three reporting periods and is a focus to ensure not becoming a special cause for concern. Reasonable assurance remains with no special cause for concern.

Kingsmill Esther
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Patients - Clinical Ambulance Quality Indicators - Clinical Care Bundles - Falls

Please note the data on these Care Bundles pages will be more than 1 month behind unlike the rest of the pages in this reports due to when the data is available

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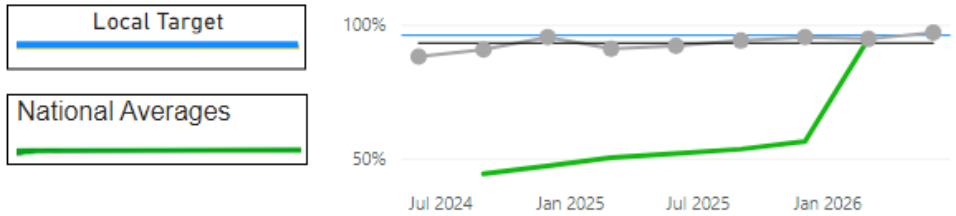
July 2026

Data Owner / Responsible Exec
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Falls in Older People - Discharged At Scene Care Bundle: Trust

Strategy Metric



Metric	Month	Value	Mean	Assurance	Variation
Falls in Older People - Discharged At Scene Care Bundle	Jun 26	97%	93.1%		

Intelligence Narrative

Due to the limited data currently available, it is difficult to assess, however the Trust's current position demonstrates this trending as a common cause of improvement which consistently performs well. Assurance is high EEAST = 94.7% compared to National Average = 57.9%. EEAST continues to be the Best Performing Trust since introduction 2 years ago.

Clinical Narrative

Summary - Publication for the 7th national data period (March 2026) demonstrates that the Trust, achieving a compliance level of 94.%, was yet again the highest performing Trust achieving 36.8% above the national average (57.9%) with compliance rates for ambulance trusts ranging from 19%. Outcomes for the 8th reporting period (June 2026) demonstrates that EEAST achieved 97%. This will be compared against the national average for this month when the data is published in Jan 2027.

Actions - A number of actions have already been taken including; podcasts and guidance documents for staff, implementation of the care bundle within the ePCR software. Results have also been shared with the sectors. Other ambulance trusts also expressed an interest in learning how we prepared for the introduction of this ACQI to enable learning for their own organisations.
There is no commissioner set threshold for this recently introduced ACQI, however the Trust has set a local target of 95% which has been met for June 26 (97%).

Impact - From the first year of reporting, it would appear that actions taken across the organisation prior to the national adoption of the care bundle have had a positive impact on compliance with the ACQI. This will continue to be monitored with a view to improving compliance to 95%.

Assurance (substantial-high) - assurance has been given due to the very high level of compliance for Older Adult Falls Care Bundle.

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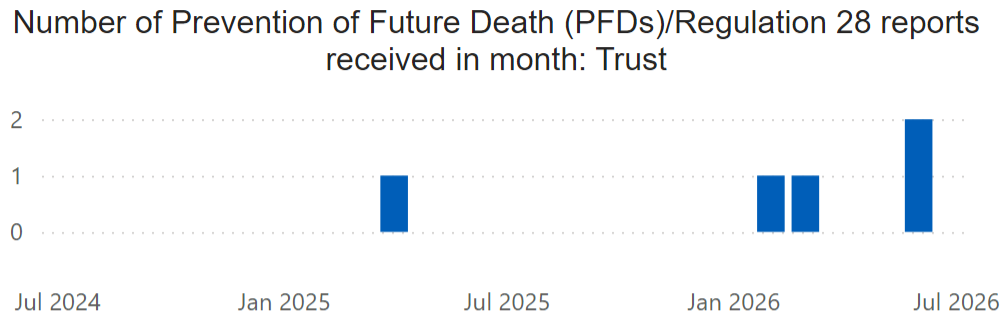
Patients - Clinical

Number of Prevention of Future Deaths (PFDs)/ Regulation 28 Reports

Data up to: July 2026

Data Owner / Responsible Exec
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Metric	Month	Value	Mean
Number of Prevention of Future Death (PFDs)/Regulation 28 reports received in month	Jul 26	0	0.2

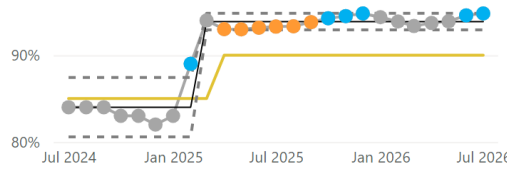
Clinical Narrative

EEAST currently has two open Prevention of Future Death reports and responses are in progress. One was in respect of a highly complex case and the concerns raised were around communication between ambulance service and other emergency services in line with JESIP; use of METHANE/ETHANE messaging; awareness in EOC of the different emergency services; and use of the JRCALC submersion tool. This response has been drafted and is awaiting final approval, the deadline is 12 August 2026.

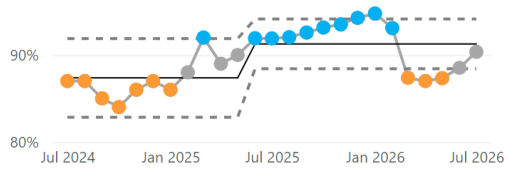
The other PFD is in relation to identifying patients in high-density areas, such as university campuses, and a delay in attending a Category 2 call. The deadline is 25 August 2026. Currently, there is no trend of increasing PFDs apart from a number increase (both of which were submitted by the same Coroner) and work is underway to communicate with Coroners for them to understand the work being undertaken to improve service delivery, including the annual Coroner's Briefing Session. The Trust take every PFD as a prority to learn and respond to within the timeframes provided and will work with all Coroners to improve care.

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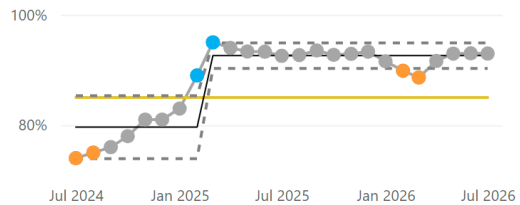
Statutory / Mandatory Training (11 CSTF topics) %



Resus face to face element Adult/Paediatric/Neonatal) %



IG Training Compliance %



Metric	Month	Value	Mean	Assurance	Variation
Statutory/Mandatory Training (11 CSTF topics) %	Jul 26	94.81%	93.87%		
Resus face to face element (Adult/Paediatric/Neonatal) %	Jul 26	90.36%	91.28%		
IG Training Compliance %	Jul 26	92.97%	92.59%		

Please note that Statutory / Mandatory Training % and IG Training Compliance % cover all staff including non-clinical staff

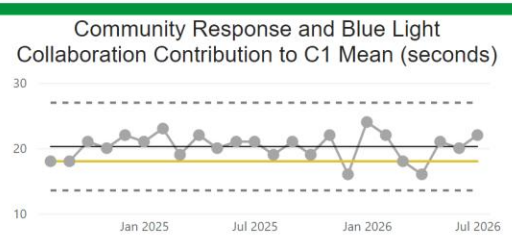
Intelligence Narrative	Clinical Education Narrative
Statutory/Mandatory Training (11 CSTF topics) % metric shows special cause variation of an improving nature and the metric will consistently pass its target Resus face to face element (Adult/Paediatric/Neonatal) % metric shows common cause variation IG Training Compliance % metric shows common cause variation and the metric will consistently hit its target	Statutory/Mandatory Training (11CSTF topics as a %) The trusts overall compliance has increased this month for the 11 CSTF topics to 94.81%. Reminders continue to be sent to staff currently out of date and those coming out of date have been sent for all e-learning topics and for face-to-face topics the Learning and Development team are working with the Locality Clinical Managers to ensure all sessions which have been planned are on OLM prior to session dates. LCM/SCL's receiving monthly compliance and trajectory information for Resus/Moving and Handling. Resus face to face element Adult/Paediatric/Neonatal)% Resus compliance has increased this month 90.36%, the Learning and Development Team continue working with the Locality Clinical Managers concerning planning of sessions and delegates to achieve and maintain resus compliance going forward. IG Training Compliance % Information Governance compliance this month is 92.97% the Learning and Development team have sent reminder emails to all staff that are currently out of date. Safeguarding Level 3 % Safeguarding Level 3 training compliance this month is 90.72% the L&D team have emailed all staff who are currently non-compliant with the face-to-face element of this learning dates of all sessions due to take place and are planning to contact Sector Management teams advising of staff that are not enrolled to attend a virtual session. All MAST remains above the 90% target and provides no special cuase for concern.

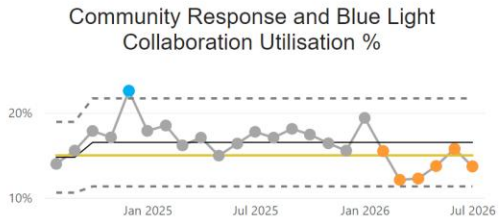
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Patients - Clinical
Volunteers

Information as at: July 2026

Data Owner / Responsible Exec
Simon Chase





Metric	Month	Value	Mean	Assurance	Variation
Community Response and Blue Light Collaboration Contribution to C1 mean (seconds)	Jul 26	00:00:22	00:00:20		
Community Response and Blue Light Collaboration Utilisation %	Jul 26	13.69%	16.52%		

CFR Utilization % shows what % of their Available Hours that CFRs are on assignments

Intelligence Narrative

Community Response and Blue Light Collaboration Contribution to C1 mean (seconds) metric shows common cause variation and the metric may hit it or miss target

Community Response and Blue Light Collaboration Utilisation % metric shows special cause variation of a concerning nature, but the metric may hit it or miss target

Integration Narrative

What: The data for the Community Response and Bluelight collaboration team is showing a slight decrease in utilisation of the resources (number of calls per hour of resource on duty), but an increase in the C1 performance contribution of these resources. The % of Trust C1 calls assigned to a volunteer resource remained above the KPI at 7.24%, with a good First on scene metric of 68.97% (just under the stretch target of 70%) whch has become a special cuase for concern in deterioiation.

Why: The continued focus within EOC demonstrates a good understanding of maintaining good volunteer utilisation, and maximise the utilisation of available volunteer resources to support patient care when experiencing times of high demand due to the seasonal changes. The utilisation measured by jobs per hour is not an accurate indicator due to some resources being in a very rural location, where demand is low but the importance of the cover is high. Through continuing to monitor calls within the geographic location of an on-duty volunteer resource and interrogating their appropriateness this indicates a more holistic view of the effective utilisation of resources. Using that data along with other metrics available within the volunteer workforce, identify the volunteer hours provision, allocation time and some patient outcomes around escalation of care and discharge on scene through the clinical advise line can demonstrate the impact of the volunteer resources on the patient experience. Often our volunteer resources are first on scene to our patients and good effective utilisation of these resources enables patients to have a positive experience of the service and support their pathway.

What next: The introduction of the auto deploy for volunteer resources will reduce the time to allocate volunteers to coded C1 calls, increasing the ability to make a clinical difference to patients quicker. As we expand to the C2 calls as well it will also start to reduce the human factors that impact on the number of missed opportunities that are seen within the volunteer workforce. It will require additional monitoring to ensure that opportunities that are not within an algo rhythm but are still beneficial from a patient care view are not missed from the personal review. Continued dialogue between EOC colleagues and the community response team to identify areas for learning and engagement to support our patients in the community. Continued work within communities to identify how best to maximise the volunteer opportunities within their community, and to ensure that they are engaged with the changes and the impact that has on their availability and call volume.

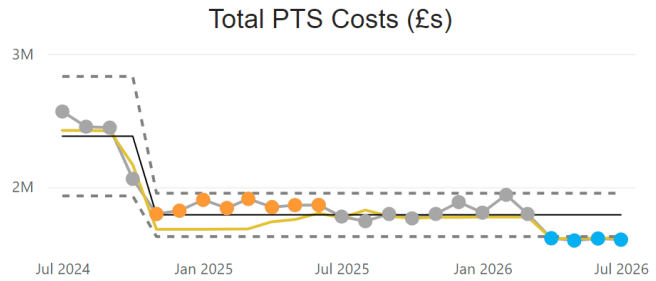
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Patients - Clinical
PTS

Information as at: Jul 26

Data Owner / Responsible Exec
Simon Chase

NHS East of England Ambulance Service NHS Trust
information@eastamb.nhs.uk



Metric	Month	Assurance	Variation	Value	Mean
Total PTS Costs	Jul 26			£1,604K	£1,790K

Please note that the amber line on this chart is the budget rather than a target

Intelligence Narrative

Total PTS Costs metric shows special cause variation of an improving nature but the metric will consistently miss its target

Integration Narrative

PTS has maintained a strong financial position during the first quarter of 2026/27, reporting an excess in contribution of £12k in Month 4. This brings the year to date contribution to £514k, which is £48k ahead of the planned budget position. Performance is broadly consistent across both the HWE and Bedfordshire & Luton contracts, with contributions split evenly between the two areas.

The positive variance continues to be driven primarily by lower than budgeted pay expenditure resulting from vacant posts across the contracts. In addition, tighter management controls around taxi utilisation and expenditure have enabled costs to remain within agreed contractual values, this is closely monitored with monthly budget line by line calls.

Whilst vacancies have contributed positively to the current financial position, this benefit is not sustainable in the longer term, however, recruitment is progressing. Vehicle lease costs continue to reflect a period of double running whilst the fleet replacement programme is completed – we expect the first delivery of vehicles from w/c 24th August.

The focus over the coming months will be on maintaining financial control whilst supporting operational resilience through recruitment and fleet modernisation activities. Key actions include:

- Continuing recruitment to vacant posts to ensure sustainable workforce capacity whilst closely monitoring the associated financial impact.
- Maintaining robust oversight of taxi expenditure
- Monitoring vehicle lease costs and planned efficiencies associated with the introduction of replacement vehicles
- Tracking contract level performance across HWE and BLMK to ensure financial performance remains aligned with service delivery requirements.

Based on current performance and forecasting assumptions, the service remains on track to achieve a positive year end contribution, subject to the impact of recruitment, fleet replacement costs and operational demand remaining in line with expectations.

Financial and performance oversight continues through:

- Contract Manager reviews (ODG)
- BLMK and HWE CQRM meetings
- Monthly budget forecasting and review meetings
- Performance Committee
- Accountability Review meetings
- KPI Review meetings
- Risk Register reviews

This governance framework provides ongoing assurance that financial performance, operational delivery and identified risks are regularly reviewed and managed through appropriate controls and escalation routes.

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The Utstein Style is an International set of criteria/guidelines for the uniform reporting of Out of Hospital Cardiac Arrest Cases attended by the EMS.

ROSC Overall = Total Number of ROSC (Return Of Spontaneous Circulation On Hospital Arrival) Cases Achieved Out of the Total Number of Cardiac Arrest Cases Attended by EMS.

ROSC Utstein = Total Number of ROSC (Return Of Spontaneous Circulation On Hospital Arrival) Cases Achieved Out of Total Number of Viable (Utstein Criteria) Cardiac Arrest Cases Attended by EMS.

Utstein Criteria / Comparator Group = Out of Hospital Cardiac Arrests where by:
- The Origin/ Aetiology is presumed Cardiac Only
- Arrest Bystander Witnessed
- Initial Rhythm On EMS Arrival is VF (Ventricular Fibrillation) or VT (Ventricular Tachycardia)

Survival To Discharge (30 Day Survival) = Total Number of Cases that Survive to be Discharged Home Alive or Transferred Out of Total Number of Cardiac Arrest Cases Attended by EMS.

Survival To Discharge Utstein (30 Day Survival) = Total Number of Cases that Survive To be Discharged Home Alive or Transferred Out of Total Number of Viable (Utstein Criteria)Cardiac Arrest Cases Attended by EMS.

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Meeting:	Trust Public Board	**Date:**	16/09/2026
Report Title:	Winter Plan 2026-2027		
Agenda Item:	PUB26/09/2.3		
Author(s):	Jon Moore - Deputy Chief of Clinical Operations Clare Kemman-Lane - Business Support Manager		
Lead Director:	Darren Meads - Chief Operating Officer		

Purpose:	Decision Approval	**X**	Discussion Review		Information Noting	
Assurance:	Limited		Reasonable	**X**	Substantial	

Link to CQC domain:		**Link to EEAST's Strategic Missions:**	
Caring	**X**	Patient Mission	**X**
Responsive	**X**	Partnership Mission	**X**
Effective	**X**	People Mission	
Well Led	**X**	Productivity Mission	**X**
Safe	**X**		

Link to Strategic Risk:									
SR1	**X**	SR3		SR5		SR7		SR9	
SR2	**X**	SR4	**X**	SR6	**X**	SR8		SR10	

Equality Impact Assessment Undertaken: YES	**X**	**NO**	

Previously considered by:

OSDG 20.08.26.
Winter Planning Group
Winter Planning Outline Business Case Review

Executive Summary:

What?

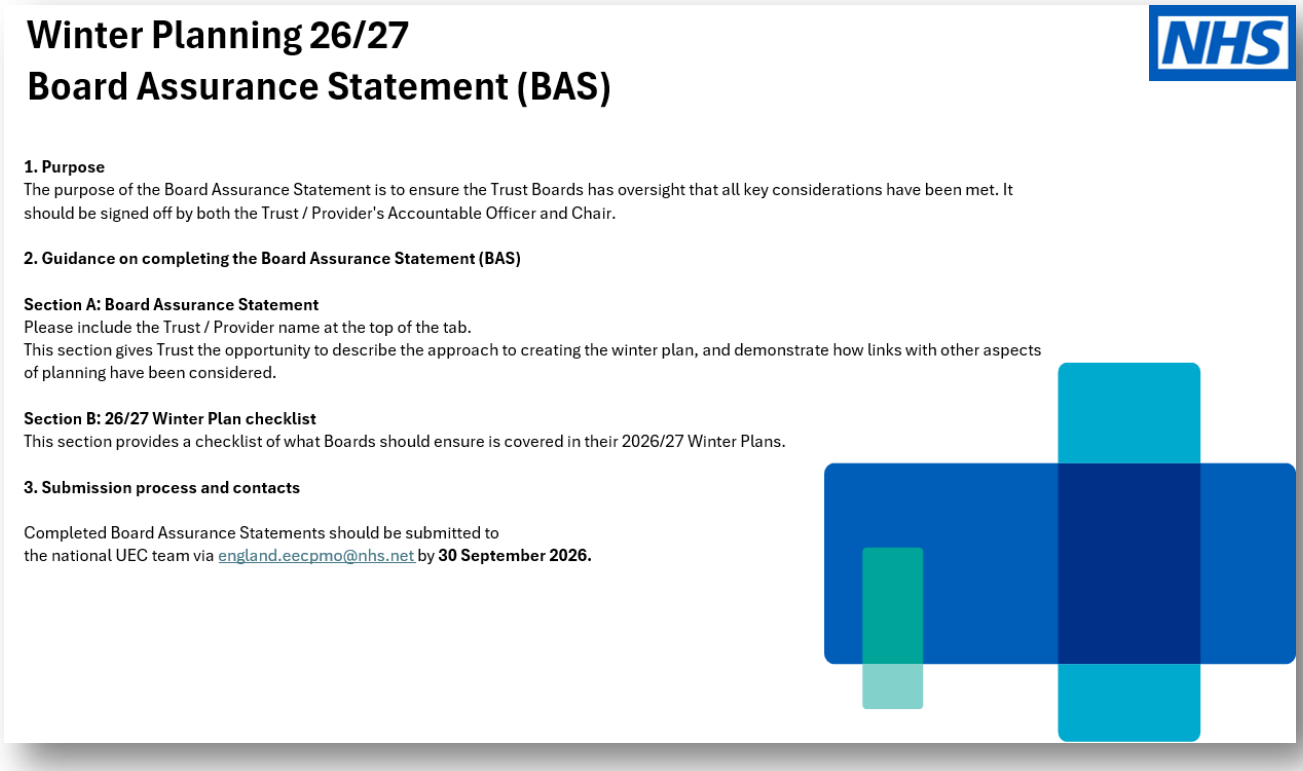
The purpose of the winter plan is to set out how we will maintain safe patient care during periods of increased winter demand by managing demand, staffing, patient flow, and system pressures.

The plan includes:

- Learning from Last Year
- Forecast Challenges Versus Current Business Plan
- Planned Mitigation
- Board Assurance Framework
- Outsourcing Validations Proposal

A completed and signed Board Assurance Statement (BAS) is required to be submitted to NHSE from all providers. The document asks for Board assurance on a number of areas related to winter planning. Our winter plan has used the BAS as the basis for our lines of preparedness.

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Winter Planning 26/27
Board Assurance Statement (BAS)

1. Purpose
The purpose of the Board Assurance Statement is to ensure the Trust Boards has oversight that all key considerations have been met. It should be signed off by both the Trust / Provider's Accountable Officer and Chair.

2. Guidance on completing the Board Assurance Statement (BAS)

Section A: Board Assurance Statement
Please include the Trust / Provider name at the top of the tab.
This section gives Trust the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 26/27 Winter Plan checklist
This section provides a checklist of what Boards should ensure is covered in their 2026/27 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2026.**

The BAS contains requirements that cannot reasonably be confirmed. This mirrors the issues in approving all areas last year. In 2025, the EEAST Board made additional notes that reflected the concerns with compliance to hospital handover trajectories. The same will be suggested this year.

2.1	The Board has considered key risks to quality and is assured that appropriate mitigations are in place for surge and extreme surge of winter pressures.	No	The current hospital handover trajectories remain above plan and are without reasonable further mitigation.
2.2	The Board is assured that workforce resilience assumptions have been reviewed and mitigation plans are in place for periods of increased demand.		
2.3	The Board has reviewed its Category 2 ambulance response time trajectory and is assured the Winter Plan will mitigate any risks to ensure delivery against the final 2026/27 trajectory	No	EEAST C2 plan is unlikely to deliver owing to YTD face-to-face responses are 5.3% above plan and Ambulance patient handovers are 6 minutes 26 seconds above plan, both of which will be having an impact on Category 2 performance

Planning Timeline:

- 19 August – Operational / Quality / Financial review of the draft winter & H&T increase plans.
- 25 August – Final plans completed (paper, plan, presentation, BAS).
- 1 September – ELT review.
- 8 September – 2nd ELT review (if required).
- 16 September - Private Board review.
- 7th October - ICB Board Assurance Statements submitted to NHSE (SNEE).

So What?

The BAS requires very detailed assessment of our operating plans and exceptional provisions for the winter period. Two notable risks require mitigation:

- **Higher-than-forecast demand** will adversely affect response times, patient flow and our resilience over the winter period.

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- Failure to deliver agreed **ambulance handover delay** trajectories will reduce DCA availability, which will impact EEAST's ability to achieve patient response times.

Two scenarios are presented:

What Next?

1. ELT is required to recommend Trust Board accept our winter plan and submit the Board Assurance Statement.

2. As part of our ELT review, further actions are required for debate:

£1.3m has been reallocated for the initial winter undertakings. These include:

1. Additional overtime provision 1,000 additional hrs/week.
2. PAS c.1,000 additional hrs/week.
3. Overtime incentive c.100 hrs/week hours (for the weeks of use which will be confirmed).

Action Required by the Board:

- Review and approve if appropriate the Winter Plan including recommendation of the BAS to Trust Board.

How does this report link with EEAST's vision, purpose and values?

https://www.eastamb.nhs.uk/about-us/our-corporate-strategy

The proposed programme supports EEAST's strategic ambition to provide the right care, first time, every time and Trust missions by:

- Improving patient access to appropriate clinical advice.
- Reducing unnecessary ambulance dispatches.
- Preserving frontline response capacity for high-acuity incidents.
- Supporting productivity and clinical effectiveness.
- Strengthening partnerships across urgent and integrated care systems.

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Winter Planning 2026



OPERATIONAL READINESS

- Robust winter plans and escalation arrangements
- Enhanced forecasting and risk monitoring
- 24/7 strategic oversight and coordination

PEOPLE AND WELLBEING

- Wellbeing support for all staff
- Appropriate rest and recovery
- Training and guidance for winter conditions

FLEET AND EQUIPMENT

- Winter vehicle checks and maintenance
- Essential equipment and consumables stocked
- Resilient transport in all conditions

SYSTEM AND PARTNERSHIP

- Working with NHS partners and local authorities
- Coordinated patient flow and handovers
- Shared situational awareness

COMMUNICATION AND ENGAGEMENT

- Clear public messaging on staying well this winter
- Timely updates for staff and partners
- Engaging with our communities

CONTINUOUS IMPROVEMENT

- Learning from experience
- Reviewing and adapting plans
- Building resilience for the future

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Introduction:

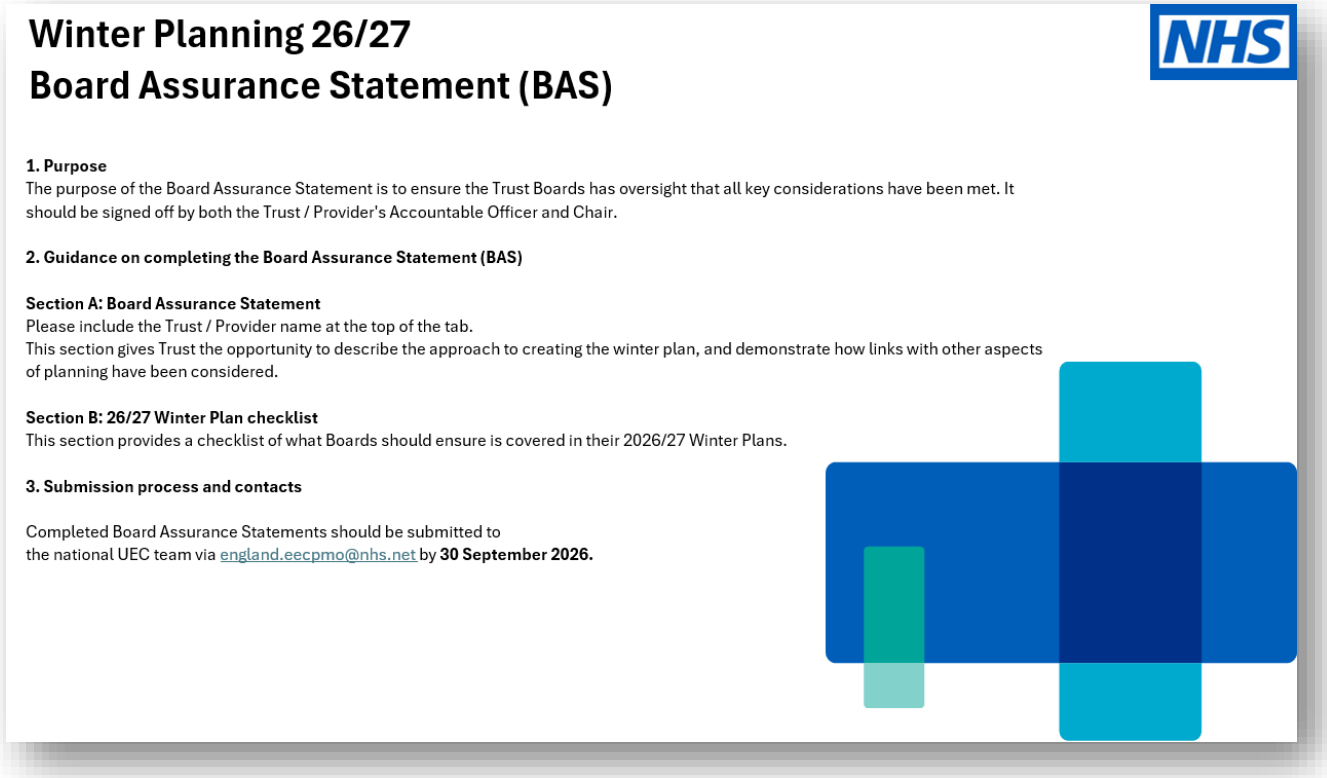
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Set out how we will maintain safe patient care during periods of increased winter demand by managing demand, staffing, patient flow, and system pressures.

1. Learning from Last Year
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Winter Planning 26/27
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NHS

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Winter Planning 2026:

This year's approach is split into two distinct Outline Business Cases.

Hear and Treat Expansion OBC

The purpose is to:

Present a plan that routinely increase H&T validations to 4,000 patients per week (+500 more patients per week).

It includes:

- Options for increasing validations (including the potential support from other NHS providers)
- Approach to Patient Safety
- Affordability
- Link to CSP Plan



Winter Plan 2026 OBC

The purpose is to:

Set out how we will maintain safe patient care during periods of increased winter demand by managing demand, staffing, patient flow, and system pressures.

It includes:

- Learning from 2025, and how these have influenced 2026's plan.
- Expected levels of demand (calls and incidents) and constraints (hospital delays, staff sickness).
- The planned mitigations for each and the accelerated mitigations for use in potential extremes.
- Demonstrated compliance with the Board Assurance Statement - NHS Ambulance Trusts Winter Plans 25-26 EEAST



Learning from Last Year & Actions Taken Forward

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Learning From Previous Years:

1 Structured Planning

- Earlier planning for Winter
- Align funding, recruitment and incentives to demand
- Cross directorate engagement

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2 Role Clarity & Capability

- Clearly defined scope of responsibilities for LOC Cells, HALO & TOC roles
- Training and preparedness of lead roles for winter processes

3 Improve System Working

- Strengthen partnership working through LOC/HALO
- Test escalation plans, reduction of handover delays
- Clear process and actions for escalations

4 Sustainability & Resilience

- Workforce plan delivery
- Out of hours resilience for escalation
- Capacity for prolonged incidents or escalation
- Appoint to winter roles to allow backfill

5 Staff Welfare

- Break compliance
- Mitigation for handover delays
- End of Shift support
- Prioritise Welfare Wagons and other support functions

6 Ops Reporting & Information Flow

- Reduce duplication
- User knowledge of available information
- Access to real time data on fleet

Actions From Previous Years:

1. **Structured Planning**
   - EEAST Winter Plan in line with NHSE timescale for production
   - Operational Plan in place for resourcing allocated to demand
   - Incentive schemes included in Winter Planning at outset

2. **Role Clarity and Capability**
   - Job Descriptions now in place for all winter-specific roles
   - Re-training & briefing sessions to be undertaken across TOC/LOC functions
   - HALO Job Description being updated August '26 with partner input
   - Exercising and testing of plans with partners to be undertaken

3. **Improved System Working**
   - EEAST Winter Plan will be shared with all partners earlier
   - LOC will specifically align to ICB SCC functions
   - Exercises to be undertaken with system partners
   - Internal escalation plans reviewed and updated

4. **Sustainability & Resilience**
   - Workforce Plans in place
   - Out of hours cover for winter increased with LOC function
   - Appointment to additional roles planned for Sept '26
   - Extreme weather briefing planned for Operational Teams

5. **Staff Welfare**
   - End of shift trial process commenced August '26
   - Grey fleet cars planned to support shift handover
   - Handover trajectories in plan for forecast delivery
   - Ambulance Improvement workstreams underway with partners to improve handovers
   - Winter rota planned for Welfare Wagons

6. **Ops Reporting & Information Flow**
   - Role clarity removing duplication between internal functions
   - Training and briefing to cover system information for all roles
   - System access provided to users from appointment
   - Additional data requirement need finalised Sept '26.

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2026 Undertakings:

Resource Levels

- Annual Leave reduction – 50% reduction during festive period.
- Reduction in training and abstractions .
- Overtime profile prioritised to winter months (5,500 hours per week).
- Resourcing planned against workforce forecast (currently on track).
- Advanced Practitioners working on DCAs shifts.
- Prioritising recourse from RRV to DCA provision.
- Additional overtime provision 1,000 additional hrs/week (compared to plan).
- PAS c.1,000 additional hrs/week.
- Overtime incentive c.100 hrs/week hours.

Welfare Arrangements

- Locality Operational Cells, driving operational performance and efficiency, out of hours resilience at weekend, handover delay escalation.
- Welfare Wagon rota coordinated locally via Hub Administrators.
- Grey fleet hire cars for start/finish events at hospitals.

Command & Control

- Festive Plan in review for key dates during winter and specific C&C arrangements.
- REAP principles adopted reduced meeting attendance to allow focus on frontline delivery and facilitate management hours of cover.

Technical Oversight Required:

- Critical Readiness Checklist:
  - Ops DCA levels
  - EOC CH & Dispatch levels
  - DTC / TOC cover
  - On-call C&C cover
  - Vehicle readiness/turnaround
  - Sector intelligence reviews
- IC / Divert real-time arrangements.
- Mutual aid request coordination.
- Call pick up / national IRP support coordination.
- Patient Safety Reviews Assessments.
- CSP / Clinical Cell Reviews.

Extremis Considerations

- Cancellation of all staff training.
- Implement Clinical Safety Plan level 4 as default.
- Mutual Aid requests.
- Reallocate APs from all other duties to delivery CAS/H&T.

Forecast challenges versus current business plan

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C2 Response Times:

- C2 mean response times are calculated from the total C2 response times / number of C2 on scene incidents. It is measured identically in each of the 10 English ambulance services.
- For all calls except C1, the patient response time (known as clock stop) is defined as the time the first conveying vehicle arrives. There are no exceptions to AQI compliance.
- If an RRV, AP, MHST, **or any other non-DCA resource** calls for conveying ambulance to take the patient to hospital, the clock stop time is taken **from the arrival of the DCA.**
- This intentionally discourages the use of resources to C2 patients that do not have the capability to convey patients, in the interests of patient safety, and is a key ARP principle.
- **DCA resources types are therefore the key provision of C2 performance**. The DCA hours are highly regulated by NHSE and formulate the key driver in our annual plan.

Clock stop – C2, C3, C4, Level 2-4 HCP, Level 2-4 IFT

If no patients are conveyed by an emergency vehicle (including incidents with non-emergency conveyance), the clock stops at the arrival of the first vehicle as defined in paragraphs i) to iii) in Clock stop – C1.

If the only resource to arrive on scene is a First Responder, where no other ambulance resource arrives on scene, and an EOC clinician confirms to the responder that conveyance is not necessary, the clock stop is the arrival of the First Responder.

Otherwise, the clock stops at the arrival of first vehicle of the type that conveys the patient. Examples:

- If two emergency ambulances arrive, and for logistical reasons the patient is conveyed in the second, the first will stop the clock;
- If the patient is conveyed in an emergency ambulance, arriving after an RRV, the clock stops at the emergency ambulance arrival, not the RRV;
- For Level 3 and Level 4 HCP incidents, if the only resource attending is an Urgent Tier vehicle, then that will stop the clock in the same way as an emergency vehicle.

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20250117 AmbSYS specification (published 17 January 2025)



- When a DSA arrives, the C2 time is taken from that point.
- When an RRV (of any type) arrives and undertakes see-and-treat , the C2 time is taken from that point.
- When successful hear-and-treat is undertaken, the C2 time is taken from call pick up to validation, plus navigation.
- When an RRV (of any type) arrives and subsequently calls for transport, the C2 time is taken from the arrival of the conveying ambulance. In most ambulance services this almost always results **in highly extended C2 response times**.

Current Plan Assumptions:

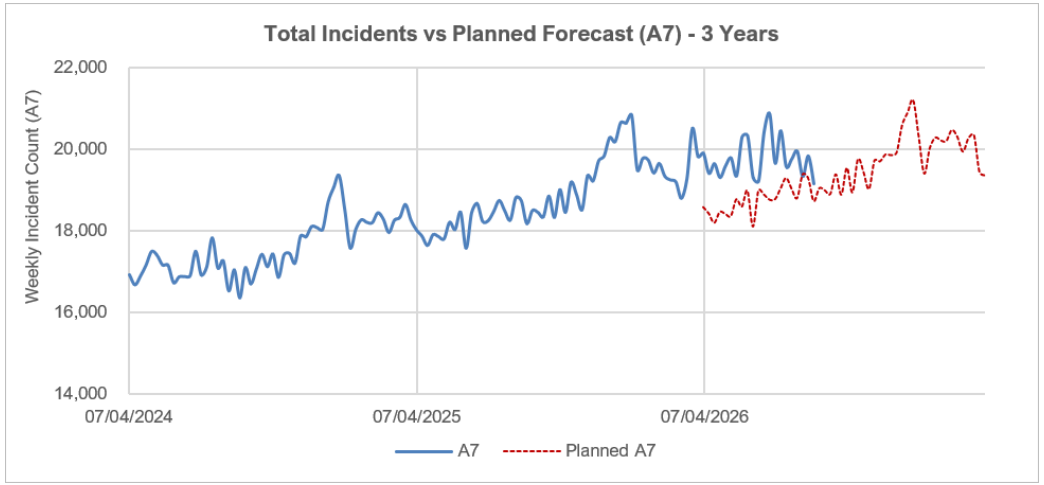
These undertakings represent the most impactful elements to C2 performance.

		Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Dec-26	Jan-27	Feb-27	Mar-27
Demand	Calls Answered (AQI A1)	25,141	26,036	27,008	26,522	26,235	27,714	28,366	28,980	29,256	29,259	28,484	28,357
	All Incidents (AQI A7)	**18,406**	**18,670**	**18,697**	**19,035**	**19,082**	**19,174**	**19,287**	**19,812**	**20,755**	**19,981**	**20,230**	**19,853**
	Cat 2 Incidents (AQI A10)	9,993	10,612	10,219	10,558	10,042	9,948	10,634	10,674	11,486	10,810	9,728	10,797
	Average Handover (AQI A142)	**00:27:10**	**00:26:58**	**00:25:33**	**00:25:27**	**00:24:45**	**00:27:22**	**00:28:28**	**00:28:34**	**00:32:30**	**00:34:30**	**00:28:52**	**00:25:57**
Capacity	DCA resource hours - Total	**43,852**	**43,236**	**41,078**	**40,773**	**40,789**	**41,350**	**43,589**	**45,118**	**48,417**	**48,381**	**45,811**	**46,487**
	DCA resource hours - Unavailable	8,103	7,721	7,450	7,341	7,333	7,596	8,712	8,765	9,717	9,481	8,968	9,030
	Average DCA Time per F2F Response not including HO	01:32:15	01:32:15	01:31:21	01:31:41	01:31:27	01:31:50	01:34:07	01:34:33	01:34:26	01:33:47	01:32:54	01:32:11
	DCA resource hours - Available	7,808	7,205	5,737	5,204	5,744	5,521	5,739	6,290	6,559	7,790	6,546	8,402
	% of DCA Hours Available	17.8	16.7	14.0	12.8	14.1	13.4	13.2	13.9	13.5	16.1	14.3	18.1
	Total PFSH	92,505	91,272	86,956	86,346	86,378	87,500	91,979	95,037	101,634	101,562	96,422	97,773
	Call handlers FTE (inc OT, bank etc)	273	263	262	264	257	255	258	251	219	215	216	223
	Clinicians in EOC FTE (inc OT, bank etc)	114	121	129	136	143	148	147	148	147	146	149	148
Activity Ratios	**Hear & Treat Rate (AQI A17/A7)**	**16.5%**	**16.5%**	**16.5%**	**17.2%**	**18.4%**	**18.8%**	**18.9%**	**18.9%**	**18.9%**	**18.9%**	**18.9%**	**18.9%**
	See & Treat Rate (A55/A7)	31.7%	31.7%	31.7%	31.5%	31.0%	30.9%	30.8%	30.8%	30.8%	30.8%	30.8%	30.8%
	Conveyance Rate (AQI A53+A54/A7)	51.8%	51.8%	51.8%	51.3%	50.6%	50.3%	50.3%	50.3%	50.3%	50.3%	50.3%	50.3%
	Call Pickup (A3)	1.0	1.3	1.4	1.3	1.0	1.8	2.3	2.6	9.8	4.5	3.8	3.0
	Cat 2 Mean (AQI A31) - NHSE Forecast	***00:28:29***	***00:29:28***	***00:32:15***	***00:33:42***	***00:32:05***	***00:32:59***	***00:33:14***	***00:32:12***	***00:32:45***	***00:30:00***	***00:31:50***	***00:28:20***

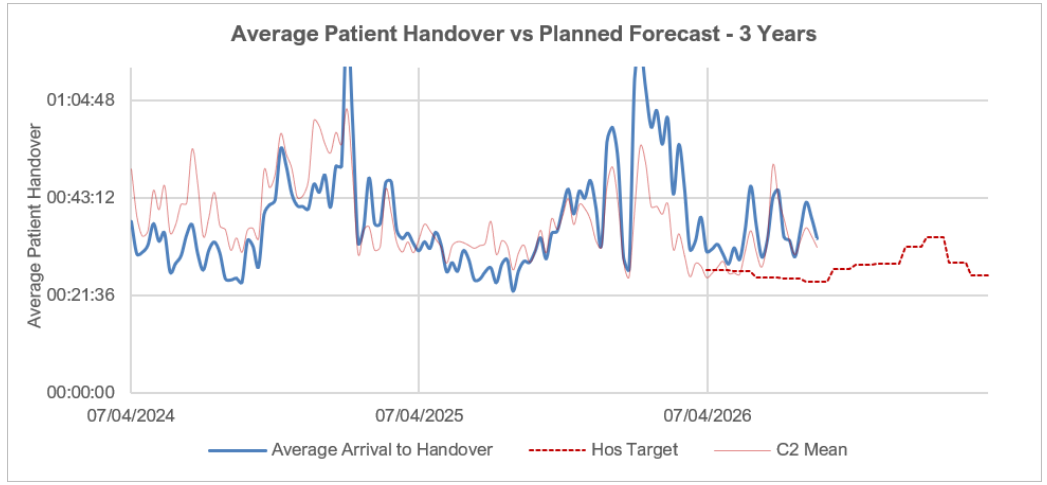
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Current Pre-Winter Position (August):

CAUSE

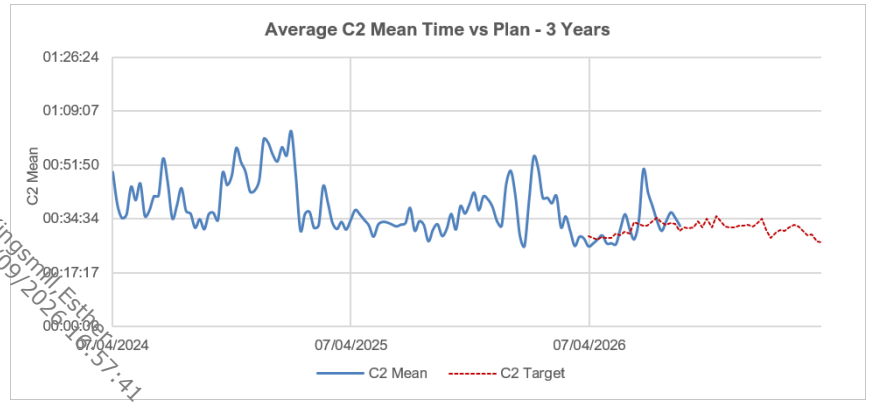


- Incident activity is c.**5.5% above plan** (8.5% above last year).
- On average this results in 1k more incidents managed each week above plan.
- Activity levels are driven in part by lost historic 'no-send' calls.



- Handover trajectories are currently running **00:09:00 mins above plan** in YTD.
- Q2 variance has increased to >**00:11:30** above plan for every patient.
- These times affect c.9,000 patient call cycles per week **requiring 150 more DCA shifts** each week to mitigate above plan.

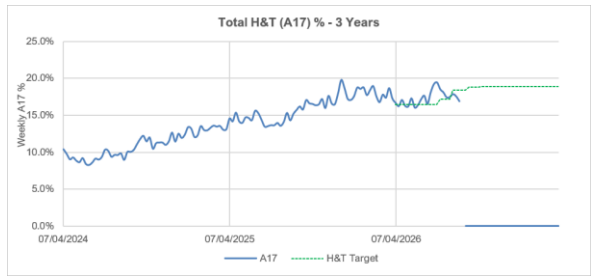
EFFECT

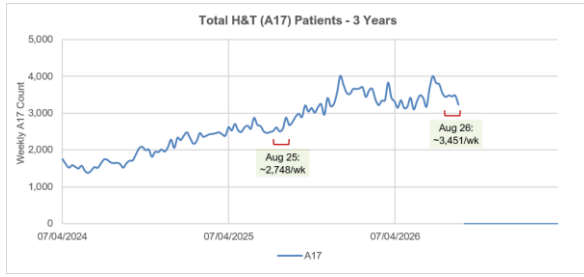


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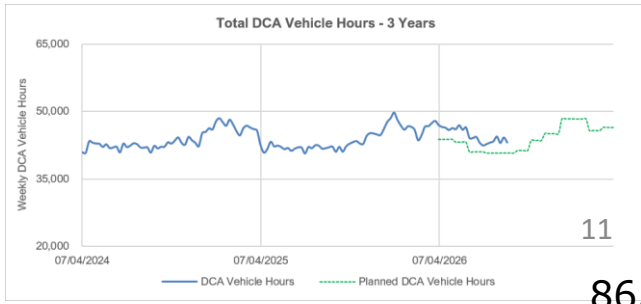
	Apr	May	Jun	Jul	Aug TD	*YTD*
C2 Target:	00:28:29	00:29:32	00:32:15	00:33:42	00:32:05	*00:31:26*
C2 Actual:	**00:27:21**	**00:29:47**	**00:37:33**	**00:34:51**	**00:34:19**	***00:32:43***
Difference:	*00:01:08*	*-00:00:05*	*-00:05:18*	*-00:01:09*	*-00:02:14*	*00:00:06*

RESPONSE





- In response, H&T numerators are exceeding plan by 1k patents per week, and DCA hours have been increased to consistently exceed targets in all areas.
- In Q2, DCA levels are the highest in the last 3-years and cannot be easily increased further.



Reporting To:	Trust Board	**Date:**	16.09.2026
Agenda Item:	PUB26/09/2.4		
Originating Meeting:	Quality Governance Committee	**Date:**	24.06.2026
Committee Chair:	Susan Wilkinson, Committee Chair		
Lead Director:	Simon Chase, Chief Paramedic and Director of Quality Simon Walsh, Medical Director		

Purpose:	Decision Approval		Discussion Review	x	Information Noting	

Link to CQC domain:		**Link to EEAST's Strategic Missions:**	
Caring	x	Patient Mission	x
Responsive	x	Partnership Mission	x
Effective	x	People Mission	
Well Led	x	Productivity Mission	
Safe	x		

Link to Strategic Risk:									
SR1 Demand & Capacity		SR3 Estates		SR5 Cyber Security		SR7 Workforce Sustainability		SR9 Organisational Development	
SR2 Quality Governance	x	SR4 Use of Resources		SR6 Partnership Working		SR8 Staff Retention		SR10 Digital	

Alert: Items requiring Board/ Committee Attention/ Action		
What?	**So What?**	**What Next?**
There are no areas for escalation.		

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Advise: Areas requiring ongoing monitoring		
What?	**So What?**	**What Next?**
Update and review/ discuss BAF SR2.	This sets the strategic direction and risk level / actions/ key controls for meeting national and locally agreed performance targets, providing appropriate clinical/ operational models. If we do not do this there will be a risk to patient safety, outcomes and experience. Level of assurance - Reasonable	Work is ongoing to review and clarify levels of strategic assurance, moving from reassurance. Governance structure is an evolving framework and relevant groups are now in place and functioning to underpin this framework. Further work to refine the framework is planned a board development in July.
Medicines management review/ annual report	If we do not have a robust medicines management plan then there is a risk to staff/ patient safety and potential regulatory penalties Level of assurance – Reasonable	Annual report completed and presented. Awaiting internal audit findings, further report will be provided for September meeting.
Clinical Audit annual report	Annual report 24/25 has been completed. Clinical audits provide oversight and assurance that our clinical activity is meeting requirements, action plans and gaps in assurance are identified. If this does not happen we are at risk of not being aware of gaps and potential safety issues. Level of assurance – Reasonable.	Risks identified and discussed – need to ensure ownership and capacity to support oversee and act on outcomes of audit.
Transformation Board Update	If we do not ensure oversight of transformation projects, we will be unaware of progression and potential inability to deliver programmes. Level of assurance – Reasonable	Received update on Advanced and Enhanced practice programmes. Advanced Critical care Paramedics programme now live and can deliver planned work. Enhanced practice programme continues to develop – to review at a future meeting.
HSSB Report	The HSSIB provide reports outlining learning and areas for improvement/ action for all organisations. If we fail to identify actions for EEAST then we may cause additional risk to patient and staff safety and regulatory penalties Level of assurance – Reasonable	EEAST have reviewed the report, specifically relating to maternity care. Ongoing work to meet requirements, some elements already meeting actions required. To continue to monitor.

Kingsmill Esther 10/09/2025 16:57:41

Assure: Areas of positive improvement		
What?	**So What?**	**What Next?**
Patient Voice Task and Finish Group	If we do not appropriately engage and listen to our service users there is a risk that our services will not deliver the expectations of patients/ communities. Level of assurance – Good	Close the task and finish group – continue to work with service users and capture health inequalities – AACE are involved.
PSIRF Review	The patient safety incident framework should identify learning, without assurance that the framework is robust, and that learning is identified and actioned there remains a risk to staff and patient safety. Level of assurance – Good	Psychological harm is now captured and articulated. To continue to deliver the framework.
Risks		
What?	**So What?**	**What Next?**
IQPR review; Complaints, Safeguarding level 3 and IPC KPIs, stroke metrics	If we do not meet our key performance indicators there is a risk that patient and staff experience and safety may be at risk. There is also a risk we will not meet regulatory compliance	Continue to monitor recent improvement in complaints closure to ensure sustainable. Continue to support staff relating to complaints citing staff attitude.

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	Level of assurance – Reasonable with exception of complaints closure and stroke metrics	Noted safeguarding level 3 compliance likely to reduce with roll out of training to all staff. IPC standards now incorporated, meeting requirements but continue to monitor Stroke metrics – noted delay in reporting but will bring back deep dive to future meeting.

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Reporting To:	Trust Board	**Date:**	16.09.2026
Agenda Item:	PUB26/09/2.5		
Originating Meeting:	Performance Committee	**Date:**	29.07.2026
Committee Chair:	Julie Thallon, Interim Trust Chair		
Lead Director:	Darren Meads, Chief Operating Officer Hein Scheffer, Director of Strategic Partnerships and Governance		

Purpose:	Decision Approval		Discussion Review	**x**	Information Noting	

Link to CQC domain:		**Link to EEAST's Strategic Missions:**	
Caring	**x**	Patient Mission	**x**
Responsive	**x**	Partnership Mission	**x**
Effective	**x**	People Mission	**x**
Well Led	**x**	Productivity Mission	**x**
Safe	**x**		

Link to Strategic Risk:

SR1 Demand & Capacity	**x**	SR3 Estates		SR5 Cyber Security		SR7 Workforce Sustainability		SR9 Organisational Development	
SR2 Quality Governance		SR4 Use of Resources		SR6 Partnership Working	**x**	SR8 Staff Retention		SR10 Digital	

Alert: Items requiring Board/ Committee Attention/ Action		
What?	**So What?**	**What Next?**
There are no areas for escalation.		

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Advise: Areas requiring ongoing monitoring		
What?	**So What?**	**What Next?**
Update and review/ discuss BAF SR1 & 6. Specifically, to decide whether to reduce the risk score for SR6.	This sets the strategic direction and risk level / actions/ key controls for meeting national and locally agreed performance targets and our partnership working. If we do not do this there will be a risk to the safe delivery of our services to patients and our partnership working will be undermined. Level of assurance - Reasonable	Work is ongoing to review and clarify levels of strategic assurance, moving from reassurance to assurance. Underpinning groups in place and functioning well. Further work required to align the BAF with the performance reporting and to ensure is it aligned to our strategic objectives. Committee members agreed to keep SR6 at the same score to reflect the ongoing concerns.
SR 1 Deep Dive	To ensure that the actions underpinning the mitigations for SR1 are the right ones and that they will derive the changes and improved performance we need. To highlight where the risk may not be being managed effectively and further actions are needed to provide assurance. Committee members agreed that the report provided very similar information to that in the BAF. Level of assurance - Reasonable	Consider how a deep dive paper in future could provide additional detail to underpin the BAF to provide better assurance.
Integrated Performance Report	To provide performance information to the Committee outlining areas of	Additional actions to be taken in preparation for winter and continued implementation of

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	improvement or deterioration. The trust will either hit or miss targets which impact on the safety and quality of care. Level of assurance – Reasonable.	productivity measures to ensure more effective operations. Continue work with partners to ensure system wide approach to management of patients.
Transformation Board Update	If we do not ensure oversight of transformation projects, we will be unaware of progression and potential inability to deliver programmes. Level of assurance – Reasonable	Work continues on the 111 tender development. Committee noted the work in progress with the EOC move, on time against plan. EOC transfer in November with Despatch moving in March 2027.Received update.
Hear & Treat Deep Dive	If we do not provide an effective H&T service, we will not be able to provide the most appropriate response to patients or meet our C2 target. Level of assurance - Good	Recruitment of 16 additional staff underway.
Partnership Update	If we do not work constructively with partners, we will not be able to provide a system wide responsive service to patients appropriate to their levels of need. Level of assurance – Reasonable.	Continue with regular meetings with trusts, ICBs and regulators. Consider further ways to encourage achievement of Hospital Handover target times working with partners to find solutions.
Management of High Intensity Users	If we do not manage high intensity users in the most sensitive and effective way the patients are in danger of not getting the correct care they need. Additionally trust resources are not used effectively and response times may deteriorate.	This report will be considered by the Quality Governance Committee in future

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	Level of assurance - Reasonable	

Assure: Areas of positive improvement		
What?	**So What?**	**What Next?**
Hear & Treat	If we do not provide an effective H&T service, we will not be able to provide the most appropriate response to patients or meet our C2 target.	Continue to deliver high levels of H&T to maximise the delivery of appropriate care to patients.
Closure of Bedford EOC and development of Chelmsford EOC	If the trust does not manage the transfer well there will be detriment to staff, impact on patients and potential reputational damage to the trust.	Continue with the very good work underway to deliver the change on plan.
Risks		
What?	**So What?**	**What Next?**
High levels of activity as we move into winter alongside high hospital handover delays.	If activity outstrips capacity and ambulance are unable to offload at hospital the trust will not be able to respond to calls in the community in a timely manner and patient harm may result	Continue refinement of the winter plan and work with partners to seek improvements in HHO delays. Work with ICBs and NHSE to ensure a system wide approach to all patients.

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NHS
East of England
Ambulance Service
NHS Trust
information@eastamb.nhs.uk

People

Director: Marika Stephenson

July 2026

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People

Ideally every metric should be in one of these starred boxes, which indicate the metric is either currently passing its target or is currently improving ★

Assurance Grid (SPC Charts only)

Data Owner / Responsible Exec
Marika Stephenson

NHS East of England Ambulance Service NHS Trust
information@eastamb.nhs.uk

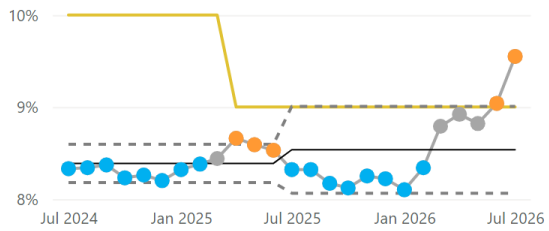
Data up to:
July 2026

Variance	Consistently hit target	Inconsistently achieve or fail target	Consistently fail target	No target given
Special Cause - Improvement	★	• % of ER Cases Out of Timescale (% that are ER Red Cases) ★ • Appraisals %	• BME Staff % ★ • Declared Disability %	• % of All Eligible Trust Staff who have completed the Leadership Development Framework ★
Common Cause	★	• Avg Working Days Suspended • I would recommend my organisation as a place to work • No of Staff on Suspension • OH - Average number of days between referral submission and first offered appointment • Sickness Absence Rate % • Time to Hire (Average Weeks)	• Employee Relation Live Cases • LGB Staff %	• Number of OH Cases • Sickness % - Anxiety/stress/depression/other psychiatric illnesses • Sickness % - Back problems & Other musculo-skeletal problems
Special Cause - Concern		• Care of patients / service users is my organisations top priority • Staff Turnover Rate %		

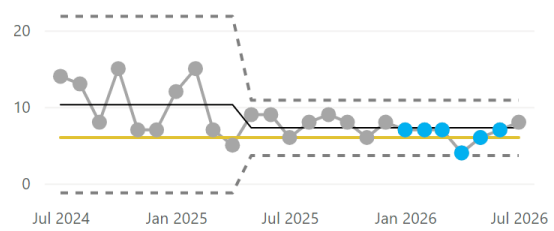
Please note the above table only includes metrics which are SPC charts

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Staff Turnover Rate %: Trust



Time to Hire (Average Weeks): Trust



Metric	Month	Value	Mean	Assurance	Variation
Staff Turnover Rate %	Jul 26	9.55%	8.54%		
Time to Hire (Average Weeks)	Jul 26	8	7.27		

Intelligence Narrative

Staff Turnover Rate % metric shows special cause variation of a concerning nature, but the metric may hit it or miss target

Time to Hire (Average Weeks) metric shows common cause variation and the metric may hit it or miss target

People Services & Culture Narrative

Updates since previous month: Staff turnover has continued to increase and is now operating above the previous average, with recent performance indicating a potential shift from the historic pattern that will require ongoing monitoring. Recruitment timeliness remains stable and continues to perform significantly below historical levels, supporting workforce supply despite a small increase from recent lows.

Current issues: The increase in turnover is occurring during a period of significant organisational change activity, including CEP, QCIP, the closure of Bedford EOC (early leave agreements) and other change programmes, which are heavily influencing workforce movement. When the planned attrition is deducted our overall turnover would be circa 8.74 % which falls in line with our target. Seasonal pressures and organisational change will continue to influence both turnover and recruitment performance over the coming months.

Key dependencies: Workforce stability remains dependent on effective delivery of organisational change programmes, targeted retention activity, successful recruitment pipeline conversion and continued leadership engagement to support employees through change. Maintaining current recruitment performance will be important to support all of the organisational change programmes that are in place especially the closure of Bedford EOC.

Future actions: Turnover and recruitment timeliness will continue to be monitored through established KPI and workforce planning governance arrangements to determine whether the recent increase in turnover represents a sustained shift. Targeted retention interventions will be implemented where required, with emerging workforce risks escalated and managed through workforce planning processes.

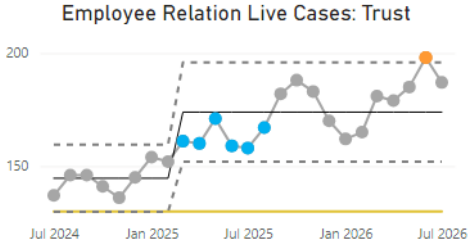
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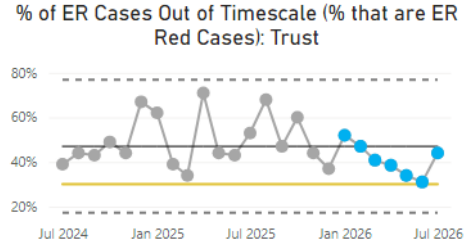
People
Employee Relations

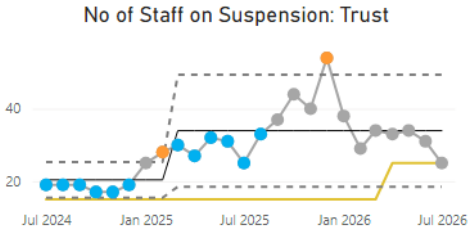
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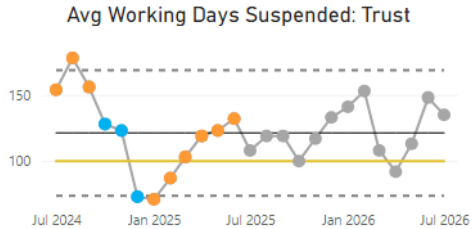
Data Owner / Responsible Exec
Marika Stephenson

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Metric	Month	Value	Mean	Assurance	Variation
Employee Relation Live Cases	Jul 26	187	173.88		
% of ER Cases Out of Timescale (% that are ER Red Cases)	Jul 26	44%	47.01%		
No of Staff on Suspension	Jul 26	25	33.94		
Avg Working Days Suspended	Jul 26	135	121.32		

Intelligence Narrative

Employee Relation Live Cases metric shows common cause variation and the metric will consistently miss its target

% of ER Cases Out of Timescale (% that are ER Red Cases) metric shows special cause variation of an improving nature, but the metric may hit it or miss target

No of Staff on Suspension metric shows common cause variation and the metric may hit it or miss target

Avg Working Days Suspended metric shows common cause variation and the metric may hit it or miss target

People Services & Culture Narrative

Updates since previous month: ER caseload remains elevated and continues to operate above the historical baseline. Following a sustained period of improvement in case timeliness during early 2026, the proportion of ER cases exceeding timescale has increased in the latest reporting period and will require ongoing monitoring. This is due to a focus on closing longer standing cases. Suspension levels have continued to reduce in recent months. The ER Transformation Programme continues to progress, with delivery focused on governance and recovery, suspension management, leadership accountability and staff experience.

Current issues: Demand for ER support remains high, with live caseloads continuing at levels above those historically experienced. The recent increase in cases exceeding timescale highlights the challenge of maintaining timely case progression whilst managing a large and complex caseload. Average suspension duration remains variable, reinforcing the need for continued focus on case progression, consistency and case management oversight.

Key dependencies: Successful delivery of the ER Transformation Programme, effective management engagement and accountability, robust governance and oversight arrangements, and alignment with wider policy development and Employment Rights Bill implementation activity.

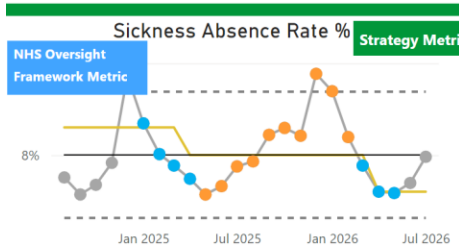
Future actions: The ER Transformation Programme will continue through the stabilisation phase to September 2026, focusing on embedding governance improvements, progressing recovery plans for aged cases, maintaining the revised Pre-ARM process and reinforcing alternatives to suspension. Performance against caseload, timeliness and suspension measures will continue to be monitored through established governance arrangements to ensure early intervention where performance deteriorates.

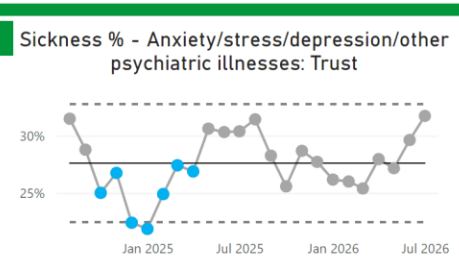
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People
Wellbeing - Sickness

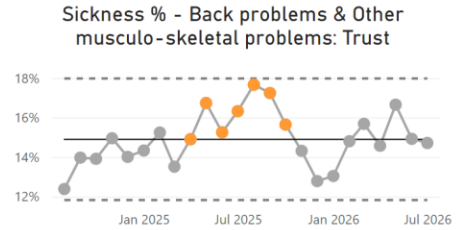
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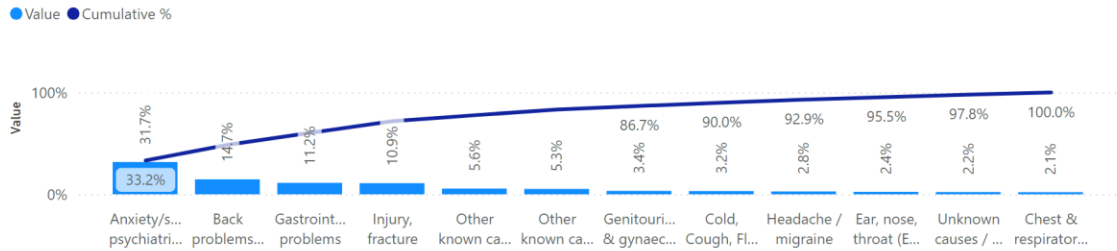
Data Owner / Responsible Exec
Marika Stephenson





Metric	Month	Value	Mean	Assurance	Variation
Sickness Absence Rate %	Jul 26	7.96%	8%		
Sickness % - Anxiety/stress/depression/other psychiatric illnesses	Jul 26	31.72%	27.59%		
Sickness % - Back problems & Other musculo-skeletal problems	Jul 26	14.71%	14.9%		





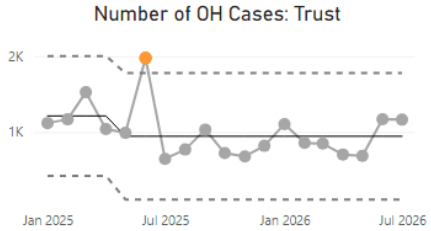
Intelligence Narrative	People Services & Culture Narrative
Sickness Absence Rate % metric shows common cause variation and the metric may hit it or miss target Sickness % - Anxiety/stress/depression/other psychiatric illnesses metric shows common cause variation	Updates since previous month: Overall sickness absence remains significantly below the peak levels experienced earlier in the year, although a small increase has been observed in the most recent reporting period following a period of sustained improvement. Long-term sickness reduction remains the strongest area of programme delivery, supported by strengthened attendance management arrangements, Occupational Health interventions and wellbeing support. Mental health and musculoskeletal conditions continue to be the largest contributors to sickness absence, accounting for almost half of all absence episodes combined. Current issues: Overall sickness remains above programme trajectory, with short-term sickness continuing to be the principal source of variation. Mental health-related absence has increased in recent months and remains the single largest cause of sickness absence. Further analysis is underway to better understand the underlying drivers of short-term absence, including the potential impact of operational demand, major and critical incidents, hot weather and major sporting events. Key dependencies: Delivery remains dependent on successful implementation of the revised Attendance Policy, sustained operational leadership accountability, effective Occupational Health support and targeted wellbeing interventions focused on mental health and musculoskeletal conditions. Future actions: Focus will remain on embedding the revised Attendance Policy, sustaining reductions in long-term sickness absence and completing enhanced analysis of short-term sickness drivers. Occupational Health and Wellbeing services will continue to deliver targeted interventions focused on mental health and musculoskeletal conditions, with progress and emerging risks monitored through established governance arrangements.

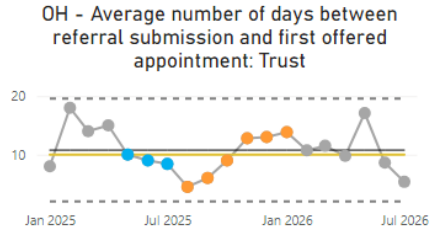
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People
Wellbeing - Support

Information as at: July 2026

Data Owner / Responsible Exec
Marika Stephenson





Metric	Month	Value	Mean	Assurance	Variation
Number of OH Cases	Jul 26	1163	943.13		
OH - Average number of days between referral submission and first offered appointment	Jul 26	5.35	10.77		

Please note the July 2026 figures for the Number of OH Cases metric do not include Counselling OH cases due to system issues.

Intelligence Narrative
Number of OH Cases metric shows common cause variation OH - Average number of days between referral submission and first offered appointment metric shows common cause variation and the metric may hit it or miss target

People Services & Culture Narrative

Updates since previous month: Occupational Health referral volumes remain stable within expected levels, with demand continuing to fluctuate in line with organisational need. Appointment waiting times have reduced significantly in recent months and are now operating below the historical average, demonstrating improved service responsiveness. Delivery of the Occupational Health and Wellbeing workplan remains on track, including THRIVE, TRiM, Mental Fitness training and Wellbeing Champion activity.

Current issues: Demand for Occupational Health support continues to fluctuate and mental health and musculoskeletal conditions remain the primary drivers of wellbeing service activity. Maintaining service responsiveness whilst managing changing referral volumes remains a key focus.

Key dependencies: Continued Occupational Health capacity, delivery of wellbeing programmes, progression of Workplace Adjustments activity and effective integration with attendance management and workforce wellbeing processes.

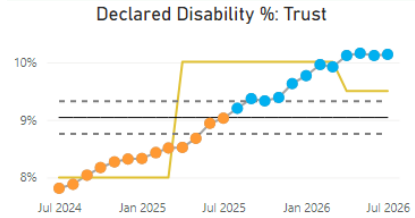
Future actions: Occupational Health and Wellbeing teams will continue targeted case review processes, increase engagement with Mental Fitness training and progress THRIVE, new Employee Assistance Programme, Workplace Adjustments and the Health & Wellbeing Passport programme. Service performance, referral demand and emerging risks will continue to be monitored through established governance arrangements to ensure improvements in appointment responsiveness are sustained.

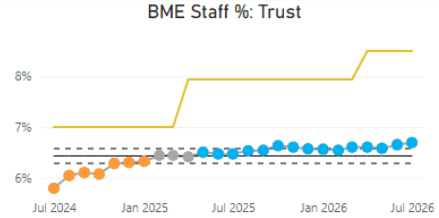
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People
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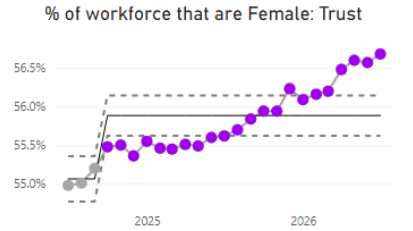
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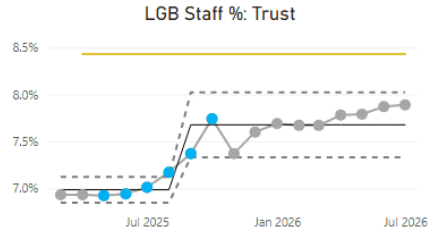
Data Owner / Responsible Exec
Marika Stephenson





Local Target





Metric	Month	Value	Mean	Assurance	Variation
Declared Disability %	Jul 26	10.14%	9.04%		
BME Staff %	Jul 26	6.69%	6.43%		
% of workforce that are Female	Jul 26	56.68%	55.88%		
LGB Staff %	Jul 26	7.89%	7.68%		

Intelligence Narrative

Declared Disability % metric shows special cause variation of an improving nature but the metric will consistently miss its target

BME Staff % metric shows special cause variation of an improving nature but the metric will consistently miss its target

% of workforce that are Female metric shows special cause variation of neither concerning nor improving variation

LGB Staff % metric shows common cause variation and the metric will consistently miss its target

People Services & Culture Narrative

Updates since previous month: Workforce representation indicators continue to demonstrate positive progress. Declared disability rates, female representation and LGBT declaration rates remain above their historical baselines and continue to show sustained improvement. BME representation has remained stable with a modest upward trend. WRES and WDES reporting continues to demonstrate improvements in workplace experience, workplace adjustments, engagement and perceptions of career opportunity.

Current issues: Recruitment inequality remains the most significant workforce equality risk; however, opportunities to improve representation through recruitment are currently constrained by reduced vacancy levels associated with CEP, QCIP and wider financial controls. Focus has therefore shifted towards retention, career development, succession planning and internal progression opportunities. Capability outcomes for disabled colleagues continue to require close monitoring, particularly in relation to attendance management processes. Individual cases are reviewed to identify any potential discrimination and ensure workplace adjustments and policy requirements are appropriately applied. Workplace adjustments remain a key area of focus to further improve colleague experience and consistency of application.

Key dependencies: Delivery of the WRES and WDES action plans, Cultural Transformation Programme, Workplace Adjustments programme and wider workforce retention, talent management and succession planning activity.

Future actions: Executive-sponsored EDI Task and Finish Groups will continue delivery of Education & Awareness, Workplace Experience and Workplace Adjustments priorities. This will be supported by ongoing implementation of the WRES and WDES action plans, progression of workplace adjustment improvements and continued monitoring of workforce equality outcomes throughout 2026/27.

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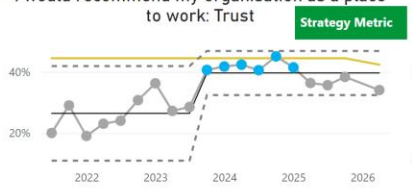
People

Staff Survey Questions

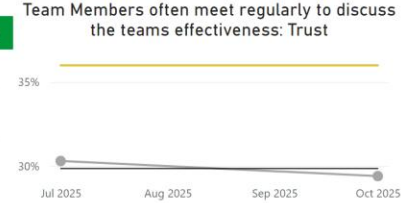
Information as at: July 2026

Data Owner / Responsible Exec
Marika Stephenson

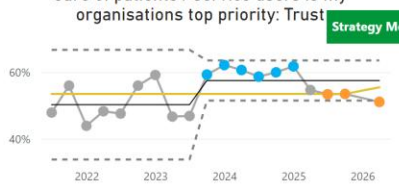
I would recommend my organisation as a place to work: Trust



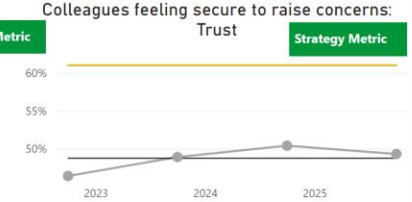
Team Members often meet regularly to discuss the teams effectiveness: Trust



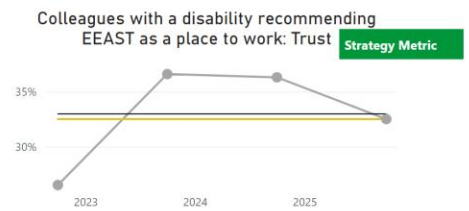
Care of patients / service users is my organisations top priority: Trust



Colleagues feeling secure to raise concerns: Trust



Colleagues with a disability recommending EEAST as a place to work: Trust



Local Target

Metric	Month	Value	Mean	Assurance	Variation
I would recommend my organisation as a place to work	Apr 26	34%	39.57%		
Team Members often meet regularly to discuss the teams effectiveness	Oct 25	29.4%	29.85%		
Care of patients / service users is my organisations top priority	Apr 26	51.1%	57.54%		
Colleagues feeling secure to raise concerns	Oct 25	49.3%	48.75%		
Colleagues with a disability recommending EEAST as a place to work	Oct 25	32.5%	32.98%		

Intelligence Narrative	People Services & Culture Narrative
I would recommend my organisation as a place to work metric shows common cause variation and the metric may hit it or miss target Care of patients / service users is my organisations top priority metric shows special cause variation of a concerning nature, but the metric may hit it or miss target	Updates since previous month: Staff engagement remains strong, supported by a range of established staff voice mechanisms, including the Staff Survey, Big Conversation, Staff Partnership Forum and Staff Networks. Staff participation remains high, with a Staff Survey response rate of 61% and more than 1,200 contributions through the Big Conversation. Key survey indicators continue to perform above historic baselines, demonstrating sustained improvements in workforce engagement and experience. Current issues: Whilst engagement indicators remain positive overall, staff feedback continues to consistently identify workload and capacity as the most significant factors affecting workforce experience. Some survey indicators have reduced from previous highs, reinforcing the need to maintain focus on workload management, leadership visibility and staff support. Feedback also highlights continued opportunities to strengthen speaking up, team effectiveness and inclusion. Key dependencies: Continued improvement is dependent on delivery of the Organisational Development Plan, Cultural Transformation Programme, leadership development activity and actions arising from staff feedback. Ongoing participation through staff voice mechanisms (including the NHS Staff Survey) remains essential to understanding workforce experience and measuring improvement. Future actions: Staff Survey, Big Conversation and Staff Partnership Forum themes will continue to be translated into organisational development, culture and workforce priorities, with particular focus on workload, leadership, inclusion, career development and psychological safety. Progress will be monitored through established staff engagement and organisational development governance arrangements.

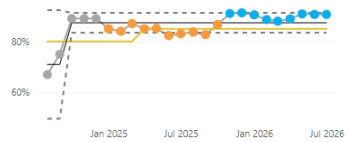
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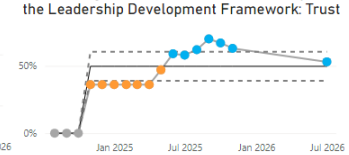
People

Leadership Development

Information as at: July 2026

Data Owner / Responsible Exec
Marika Stephenson





Metric	Month	Value	Mean	Assurance	Variation
Appraisals %	Jul 26	90.62%	87.35%		
% of All Eligible Trust Staff who have completed the Leadership Development Framework	Jul 26	53%	49.64%		

Intelligence Narrative	People Services & Culture Narrative
Appraisals % metric shows special cause variation of an improving nature, but the metric may hit it or miss target % of All Eligible Trust Staff who have completed the Leadership Development Framework metric shows special cause variation of an improving nature	Updates since previous month: Appraisal compliance remains consistently above the historical baseline and has been sustained at around 90% throughout the reporting period, demonstrating continued management focus on performance and development discussions. Leadership Development Framework completion continues to progress, with 83% completion across A&E and Operational Support cohorts and almost 50% completion within EOC cohorts, which commenced later in the reporting period. Current issues: Approximately 160 of the 1,350 leaders in scope have not yet engaged with the Leadership Development Framework, including new starters and leaders newly appointed to role. Completion of the People Essentials and Finance & Performance modules remains the primary constraint to overall completion rates. Key dependencies: Delivery of the Organisational Development Plan, Leadership Development Framework, Cultural Transformation Programme, continued management engagement, and data quality within ESR reporting systems. Future actions: Targeted engagement activity will continue for leaders who have not yet started the LDF programme, with a particular focus on support services and APOC cohorts. Efforts will also continue to improve completion of the People Essentials and Finance & Performance modules and enhance reporting through ongoing ESR data improvements.

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Meeting:	Public Board	**Date:**	16/09/2026
Report Title:	Freedom to Speak Up Report		
Agenda Item:	PUB26/09/3.3		
Author(s):	Liz Cunnell Chief of Staff Dani Marshall FTSU Guardian		
Lead Director:	Neill Moloney Chief Executive		

Purpose:	Decision Approval		Discussion Review	x	Information Noting	
Assurance:	Limited		Reasonable		Substantial	

Link to CQC domain:		**Link to EEAST's Strategic Missions:**	
Caring	x	Patient Mission	x
Responsive		Partnership Mission	
Effective		People Mission	x
Well Led	x	Productivity Mission	
Safe	x		

Link to Strategic Risk:									
SR1		SR3		SR5		SR7		SR9	
SR2		SR4		SR6		SR8		SR10	

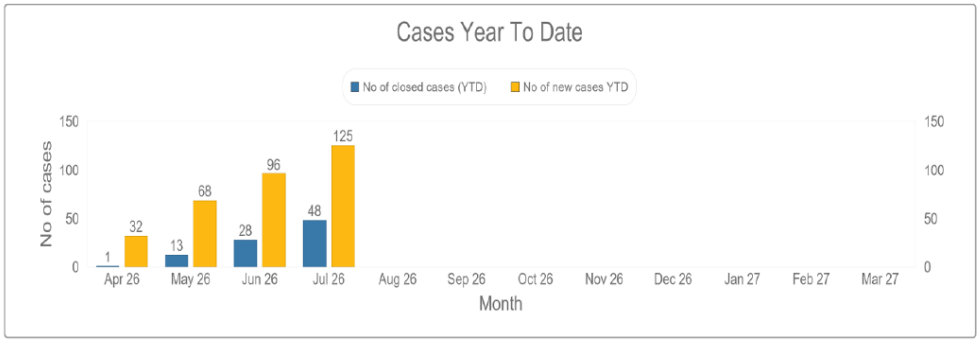
Equality Impact Assessment Undertaken: YES		**NO**	

Previously considered by:

Executive Summary:

What?

The number of cases reported to FTSU has increased by 95% from April - July 2025 to April - July 2026 (64 to 125).

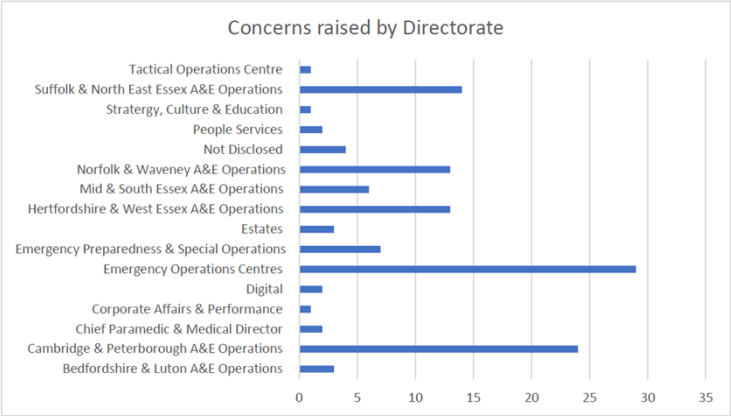


This large increase is positive and demonstrates that the visibility and engagement is having an impact. In our Emergency Operations Centres (EOC) Guardians have been supported by EOC staff to increase cases during visits. This is demonstrated in the chart below which shows a significant increase in case numbers in EOC. For context last year

Public Board – FTSU Report – September 2026

36 cases were raised in EOC throughout the whole year and have reached 24 in the first quarter in 2026.

Across the other operational sectors case numbers are consistent and all show an increase compared to last year. The exception is Beds and Luton where numbers remain very low and in fact zero cases have been raised in some months.



The themes for case work remain consistent and are shown in the table below.

Theme	Total	% of Concerns
A Patient and Service User Safety / Quality	1	0.8%
B Management Issue	20	16.0%
C System Process	68	54.4%
D Bullying and Harassment	3	2.4%
E Discrimination / Inequality	5	4.0%
F Behavioural / Relationship	23	18.4%
G Other	0	0.0%
H Worker Safety	4	3.2%
I Sexual Misconduct	1	0.8%
Total Concerns	**125**	**100%**

The report highlights that system and process includes the following sub themes:

- Recruitment and selection
- Operational process
- Sickness and medical issues
- Wellbeing concerns in relation to operational pressure
- Redeployment

In answer to an action raised at the previous Board meeting the Guardians have created a report which compares EEAST data with other Ambulance Trusts and NHS organisations of a similar size. The report is attached with the paper. The key areas to emphasise are the high number of cases EEAST records compared to other Trusts.

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For ease the following chart shows the approximate number per 1000 staff for each Trust and EEAST has the second highest. A strong indication the Trust is cultivating a culture in which staff feel safe to speak up :

Ambulance Trust	Approx. Staff	Per 1000 staff
Ambulance Service 5	~8,000	15
Ambulance Service 4	~7,000	23
Ambulance Service 8	~7,500	13
Ambulance Service 6	~6,700	17
Ambulance Service 7	~5,000	22
Ambulance Service 1	~4,800	53
East of England Ambulance Service	~6,000	38
Ambulance Service 3	~5,000	40
Ambulance Service 9	~3,500	9
Ambulance Service 2	~7,000	32

The other key areas to highlight are the number of anonymous concerns and the number of cases which have an element of inappropriate attitude and behaviours. Nationally compared to other Trusts we have the lowest number of cases which remain anonymous. This is positive in terms of the confidence our people have in the process and demonstrates a lack of fear of retribution for speaking up.

EEAST has the highest number of cases with an element of inappropriate attitudes and behaviours but this is most likely linked to the work we have been doing to encourage staff to report inappropriate behaviours.

So What?

As discussed above the data demonstrates that although case numbers are improving, more is required to increase speaking up in the Beds and Luton area. Plans are in place for focused communication and training to address this area specifically. The low numbers is a risk as there is the potential that staff fear reprisal or we are not aware of local issues and concerns. This is being mitigated by the additional plan to provide training and engagement in the area. The independent cultural review team have also included this area and therefore will assist in finding resolutions.

The overall increase in case numbers indicates that the engagement from the Guardians is effective and determines the areas which require more focus.

The Chief People Officer and Chief Operating Officer meet with the Guardians bi weekly to discuss themes and record actions. Recommendations are discussed and agreed and barriers to progress unpicked at Executive level. This increased awareness assists Directors with future planning and discussions with heads of department.

What Next?

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A focused programme of engagement and training is being planned in Beds and Luton. This will include each staff member receiving face to face training on FTSU. This will include the benefits, process and protection afforded to those who choose this entirely independent process. Importantly through encouraging the ethos of speaking up the training will also encourage staff to raise concerns with their line managers. Staff will be stood down to attend a short but targeted training session held on station by the Guardian Service team. This is being monitored by the COO during bi weekly meetings and updates will be shared through ELT.

The cloud system and screens on station are being utilised to advertise a booking service for the Guardians. This ensures that visits to station are productive and optimise the time the Guardians are visible. The Guardians are using posters and postcards to ensure staff know how to reach them and we will soon have key rings on every Trust vehicle sharing contact information. Case numbers are monitored by the Chief of Staff and Chief Executive. Last month concerns were raised to the GSL management team about the case numbers in Beds and Luton and the workload of Guardians. GSL are committed to maintaining visibility and engagement and have committed additional resources to support in operational areas. These are Guardians working for GSL who are working within the same governance framework.

The recommendations from this report will be addressed at the monthly task and finish group with the Chief of Staff and an update provided with the next report.

Action Required by the Board:

The Board are asked to review the report.

How does this report link with EEAST's vision, purpose and values?

https://www.eastamb.nhs.uk/about-us/our-corporate-strategy

This report links to our four missions as part of the Trust vision and our values.

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East of England Ambulance Service NHS Trust

The Guardian Service
Here to listen

1st April 2026- 31st July 2026

Circulation: **Liz Cunnell – Chief of Staff**

Prepared by: Kym Gillingham & Dani Marshall

Guardian
The Guardian Service Ltd.

Date: 13th August 2026

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1. Executive summary

The Guardian Service Limited (GSL) began providing the Freedom to Speak Up Service for the East of England Ambulance Service (EEAST) on the 5th August 2024.

Between the period of 1st April 2026 and 31st July 2026, 125 concerns were raised by staff members. This number has increased and is over half the number of concerns that were taken in the last complete financial year.

The majority of staff who continue to choose to use the GSL felt that they hadn't received impartial support from the Trust or they had raised the concern previously and felt they had not been listened to.

Concerns received are recorded by GSL against specific themes which are Management Issues, System & Process, Bullying & Harassment, Discrimination & Inequality, Behaviour & relationship, Patient Safety/Quality, Worker Safety and Sexual Misconduct.

The three most common themes for new cases were System & Process (68), Behaviour & Relationships (23) and Management Issues (20).

The top two job groups raising concerns were Allied Health Professionals (66) and Additional Clinical Services (27).

Over the past four months 1 concern specifically relating to Patient Safety has been raised. This was raised and dealt with, within the RAG protocol timeframe and formal proceedings were instigated.

Emergency Operations Centres were the directorate with the highest number of concerns. The total number of concerns across the sites are 29 with 16 at Chelmsford, 12 in Norwich and 1 from Bedford. The increase in concern from this directorate could be due to the increased visibility of the FTSU Guardians. To note, there are 3 concerns of racial discrimination within the Chelmsford EOC. This is currently under investigation.

The Guardians have received soft intelligence making them aware of issues relating to Luton and Bedfordshire and that staff members do not want to speak to the Freedom to speak up Guardians. There is a sense of trust lacking in the confidentiality due to past experiences.

There are several recommendations detailed at the end of this report that the Trust is asked to consider.

2. Background to Freedom to Speak Up

Following the Francis Inquiry[1] 2013 and 2015, the NHS launched 'Freedom to Speak Up' (FTSU). The aim of this initiative was to foster an open and responsive environment and culture throughout the

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[1] https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

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NHS enabling staff to feel confident to speak up when things go or may go wrong; a key element to ensure a safe and effective working environment.

3. The Guardian Service

The Guardian Service Limited (GSL) is an independent and confidential staff liaison service. It was established in 2013 by the National NHS Patient Champion in response to The Francis Report. The Guardian Service provides staff with an independent, confidential 24/7 service to raise concerns, worries or risks in their workplace. It covers patient care and safety, whistleblowing, bullying, harassment, and work grievances. This needs to come out. The Guardian Service is advertised throughout EEAST as an independent organisation. This encourages staff to speak up freely and without fear of reprisal. Freedom to Speak Up is part of the well led agenda of the CQC inspection regime. The Guardian Service supports the East of England Ambulance Service Trust's Board to promote and comply with the NGO national reporting requirements.

The GSL was implemented in the East of England Ambulance Service (EEAST) on the 5th August 2024.

Communication and marketing have been achieved by meeting with senior staff members, joining team meetings, site visits, the Intranet and the distribution of flyers and posters across the organisation. All new staff will become aware of the Guardian Service when undertaking the organisational induction programme.

4. Access and Independence

Being available and responsive to staff are key factors in the operation of the service. Many staff members, when speaking to a Guardian, have emphasised that a deciding factor in their decision to speak up and contacting GSL was that the Guardians are not EEAST employees and are external to the Trust.

5. Categorisation of Calls and Agreed Escalation Timescales

The following timescales have been agreed and form part of the Service Level Agreement.

Call Type	Description	Agreed Escalation Timescales
Red	Includes patient and staff safety, safeguarding, danger to an individual including self-harm.	Response required within 12 hours
Amber	Includes bullying, harassment, and staff safety.	Response required within 48 hours
Green	General grievances e.g. a change in work conditions.	Response required within 72 hours
White	No discernible risk to organisation.	No organisational response required

For this date period, all escalated cases were responded to within the agreed RAG protocols.

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Open cases are continually monitored, and regular contact is maintained by the Guardian with members of staff who have raised a concern to establish where ongoing support continues to be required. This can be via follow up phone calls and/or face to face meetings with staff who are in a situation where they feel they cannot escalate an issue for fear of reprisal. Guardians will also maintain contact until the situation is resolved or the staff member is satisfied that no further action

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is required. Where there is a particular complex case, setbacks or avoidable delays in the progress of cases that have been escalated, these would be raised with the organisational lead for the Guardian Service at regular monthly meetings.

Escalated cases are cases which are referred to an appropriate manager, at the request of the employee, to ensure that appropriate action can be taken. Not all employees want their manager to know they have contacted the GSL, and sometimes after a conversation with the Guardian they feel empowered to progress the matter themselves .There are circumstances where cases are escalated at a later date by the Guardian. A staff member may take time to consider options and decide a course of action that is right for them. A Guardian will keep a case open and continue to support staff in such cases. In a few situations contact with the Guardian is not maintained by the staff member.

6. Purpose of the paper

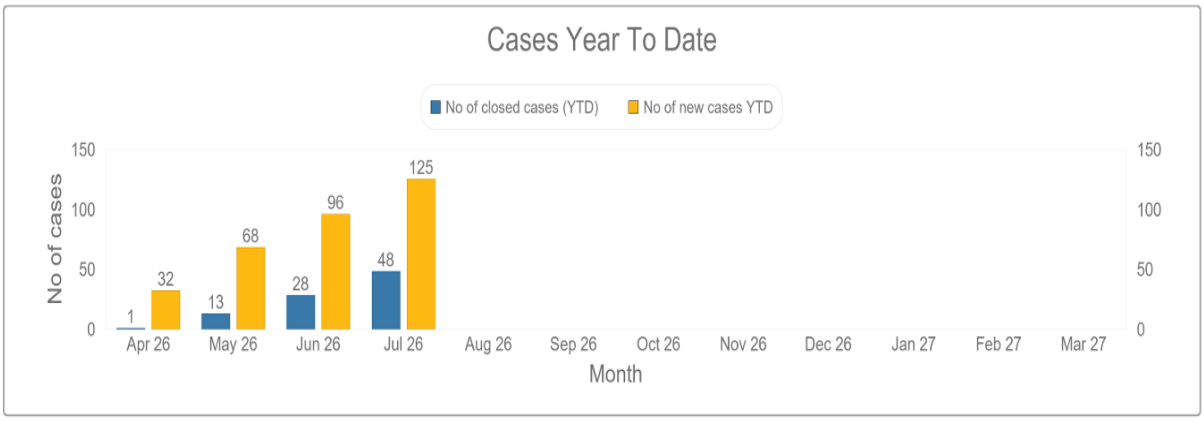
The purpose of this paper is to detail the progress and development of the Speak Up service within EEAST and to identify learning from the themes arising from the cases received by the Freedom to Speak Up Guardians.

This report provides an overview of themes and issues raised through the Guardian Service from 1st April 2026 to 31st July 2026. The report also sets out some learning points and makes recommendations for consideration.

The report follows national guidance on the content FTSU Guardians should include when reporting to their Board which include Assessment of cases, Action taken to improve speaking-up culture and Recommendations.

7. Number of concerns raised

Between 1st April 2026 – 31st July 2026, 125 concerns were raised to The Guardian Service.

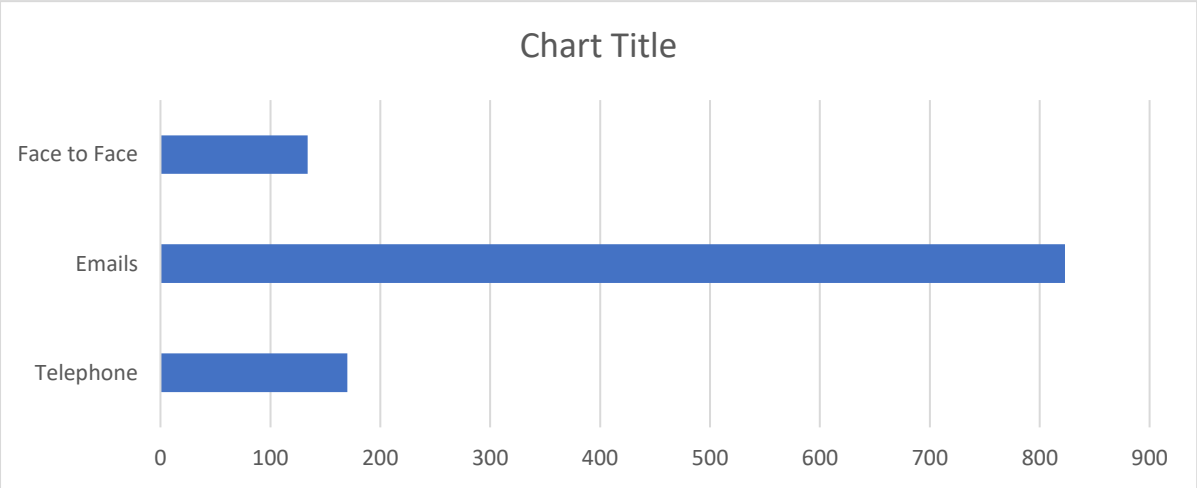


Since the service went live within East of England Ambulance Trust, case related activity has doubled. Monthly calls, emails and face-to-face concern meetings have increased.

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Between 1st April 2026 and 31st July 2026, the Guardians have replied to 823 emails, taken 170 phone calls and met staff members 134 times to discuss concerns. Over the past 4 months, the average number of monthly concerns raised is 31.



By the 31st of July 2026, 77 cases remained open and 48 have been closed. This data indicates concerns are taking longer to close. This could be due to the complexity of the concerns.

Open cases are continually monitored, and regular contact is maintained by the Guardians. Where there are a particular complex case, setbacks or avoidable delays in the progress of cases that have been escalated, these would be discussed with the Chief of Staff at regular monthly meetings.

Cases are escalated to the most appropriate person in the Trust, after a discussion with the staff member it is decided who would hear their concern. Guardians always encourage the staff member to escalate to their manager in the first instance; however, this may not always be the most appropriate action for them. If this is the case, the Guardians can support them to escalate higher.

51% of staff members preferred to keep their concern confidential and for the Guardians not to escalate to the trust. 25% of staff members were happy for their concern to be escalated with their name. The remaining 24% wished to raise their concerns anonymously or without using their name

8. Themes

Concerns raised are broken down into the following categories;

Theme	Total
A Patient and Service User Safety / Quality	1
B Management Issue	20
C System Process	68
D Bullying and Harassment	3
E Discrimination / Inequality	5
F Behavioural / Relationship	23

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G Other	0
H Worker Safety	4
I Sexual Misconduct	1
Total Concerns	**125**

9. Assessment of Themes

The three highest themes recorded are Systems and Process, Behaviour and relationship and Management issues. Below is a breakdown of these themes to demonstrate the type of concerns that are raised:

System & Process

The Trust has received 68 primary concerns relating to the systems and process theme, this data has been further analysed and outlined below. This is the theme with the highest number of concerns.

The categories within Systems and Process are:

- **Recruitment and Selection Process Concerns**
  (including secondments and apprenticeships, including the LOM/HALOM roles)
- **Non-Adherence to Operational Processes and Employee Wellbeing Requirements**
  (including reasonable adjustments for Neuro diversity and other individual needs)
- **Sickness and Medical Issues concerns,** relating to staff member feeling at a disadvantage and being redeployed in their eyes unfairly due to medical reasons that are no fault of their own.
- Operational process concerns include wellbeing concerns and is listed as the highest area.
- Recruitment Concerns includes concerns raised on redeployment, and thoughts from staff members that the following have been unfairly progressed - Secondments, Apprenticeship and Talent pool recruitment.
- Overall, staff members feel there is a lack of support and clear communication when following processes and procedures also when speaking up internally they have said they are left feeling unheard, dismissed and not understood.

Behavioural / Relationship

23 concerns were reported in relation to this theme. Examples as described by staff:

- Managers from various levels of seniority displaying unprofessional behaviours.
- Perceived Inappropriate and unprofessional conduct and discussions/comments by colleagues. (subjects including Racism, sexism and sexualised comments)
- Rude and belittling behaviours
- Open social media posts by staff members with tones, comments and attempted jokes on domestic violence, sexual misconduct and racism.

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- Inappropriate comments and discussion within Emergency Operation Centre's where patients could potentially hear
- Staff member reporting detriment from speaking up.
- Staff shouting / swearing at each other

Management Issue

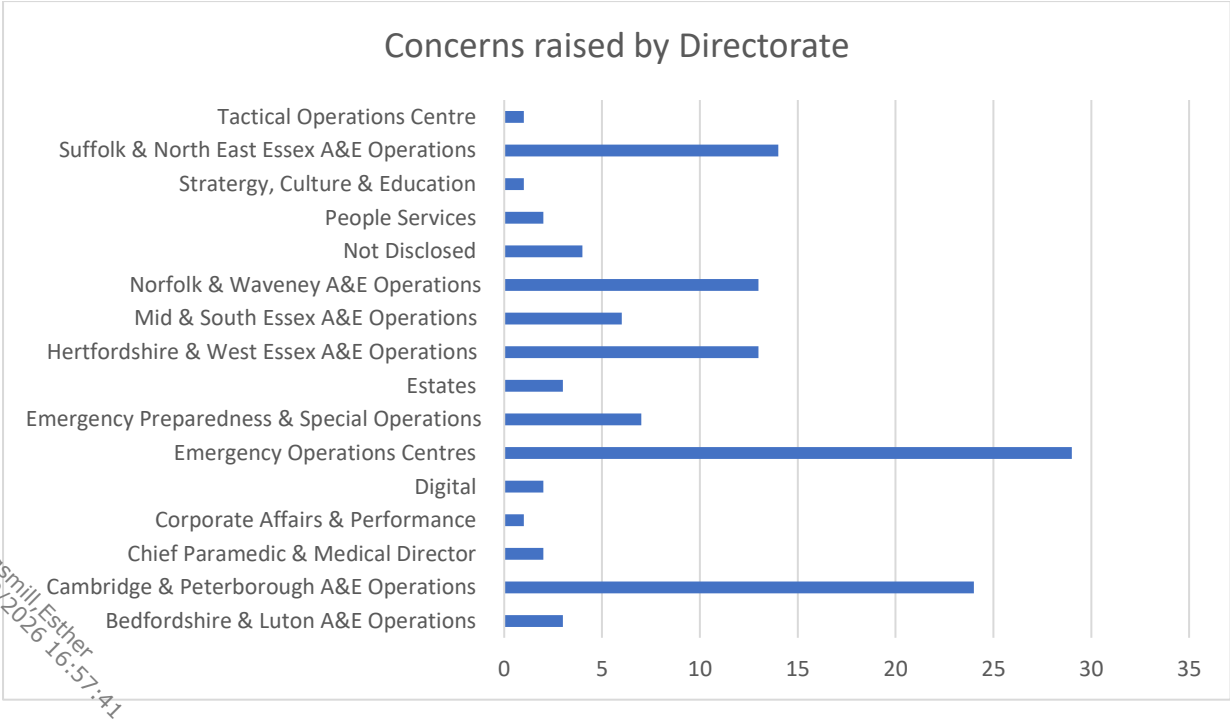
20 concerns were raised in relation to this theme. Examples as described by staff:

- Managers displaying bullying and inappropriate behaviors towards staff members
- Managers displaying dishonest behaviors / discrimination
- Lack of support from managers following operational staff
- Managers treating staff differently following a concern being raised
- Managers not dealing with issues and concerns raised directly to them.
- Managers breaching staff confidentiality and inappropriately sharing information with others
- Managers dismissing Occupational Health reports
- Managers not addressing bad behaviors displayed by others in their presence.
- Managers discouraging staff members from speaking to FTSU Guardians and alleged surveillance on staff members who do.
- Unprofessional behavior displayed Infront of patients at Cardiac arrest.

Recently there have been 3 concerns of racial discrimination within Chelmsford EOC. These concerns are being investigated by the trust, but this does highlight the strong feeling of inappropriate racially motivated behaviors that are unacceptable.

10. Statistical Graphs

Concerns raised by Directorate



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11. Comments & Recommendations

- Due to increased demand for information and visibility of the FTSU Guardians. It is felt that targeted and highly advertised marketing approaches might be appropriate. If the Marketing team links in with the Guardians to work together on how best to highlight visibility and other ways in which to speak up, this could reinstate trust and confidence in the confidentiality of the FTSU service in certain directorates.
- Unconscious Bias/ Micro aggression/ By Stander training or refreshers – This kind of training or refreshers can highlight how treating each other with kindness, thinking before speaking and intervention where appropriate can have a positive impact on supporting each other in the workplace. With the racial discrimination concerns, sometimes people act unconsciously and refreshing staff members on this could contribute to the reduction in bad behaviour.

- Schwartz Rounds/ Reverse Mentoring – Both group conversations and reverse mentoring can be impactful to appreciate and understand the trust staff members. All staff members attending Shwartz rounds can feel heard and have a sense of sharing and educating colleagues of all levels. By conducting Schwartz rounds throughout the year, you can align this with certain topics and awareness months. With the reverse mentoring, this is a way in which to learn from those in different departments with different ideas and perspectives. For example, this is a great way to appreciate how black staff member feel when faced with racial discrimination. These could be hosted by senior leaders and non-executives.

- Standards review –It can sometimes be hard to see the wood for the trees. A review of Policies and procedures of the trust could provide a report and different perspective as well as highlighting areas of change or improvements. This would be done by GSL's central office functions so as not to detract from the BAU. This service would be an addition to what is currently contracted and so would be at an additional cost.

- Sharing of FTSU Themes with LAM/LOM's – By HOCO's sharing how staff members feel with their teams could help managers understand that their own behaviors are having an impact on the wider teams they manage. This could be set out as a section on a team meeting agenda or to be discussed within appraisals and 121 sessions. The trust can share the FTSU reports and data with operational leaders so that they can look to challenge and improve at a middle management level.

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- As per our last report, the Guardians suggest further training and understanding around the neuro divergent workforce. More adults within the UK are being diagnosed as neuro divergent and so empathy and a level of understand as to how complex and different each staff member lives would benefit the workforce.

- The Guardians continue to encourage the trust to use and share the reflection and planning tool. This guide has 3 stages and is designed to help you identify strengths in yourself, your leadership team and your organisation. This should be used alongside Freedom to speak up and promoting the Guardian Service.

    - The FTSU Guardian encourages the Trust to embed Speaking up further by making it mandatory for all staff to complete the 'Freedom to Speak Up in Healthcare' modules - *Speak Up*, *Listen Up* and *Follow Up*, introduced by the NGO.
    - ***Speak Up*** covers what speaking up is and why it matters. It helps staff understand how they can speak up and what to expect.
    - **Listen Up** focuses on listening to concerns and understanding the barriers to speaking up. It helps Managers to understand what speaking up is and how they should respond when someone speaks up to them.
    - **Follow Up** was developed for senior leaders throughout healthcare – including executive and non-executive directors, lay members and governors. The module aims to promote a consistent and effective Freedom to Speak Up culture across the system, which enables workers to speak up and be confident they will be listened to and action taken.

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East of England case data comparison 25/26

East of England Ambulance Service NHS Trust is a Guardian Service client. The data presented here is drawn from national FTSU case data submissions for 25/26 reporting year and is intended to support contextual comparison. While we can verify the accuracy and consistency of the data submitted through our Guardian Service reporting processes, each ambulance trust is responsible for its own local data collection and submission approach. Differences in organisational context, reporting culture, awareness of FTSU routes, and local recording practices may influence the figures reported. For this reason, comparisons should be viewed as indicative rather than definitive and used to support discussion and reflection rather than as a direct measure of performance between organisations.

- **Ambulance trust case comparison**

Ambulance Trust	Total Cases	No. cases raised Anonymously	No. cases with an element of Patient Safety	No. cases with an element of Worker Safety	No. cases with an element of Bullying/ harassment	No. cases with an element of Inappropriate attitudes & behaviours
Ambulance Service 1	254	34	9	98	83	51
East of England Ambulance Service NHS Trust	230	13	10	23	16	127
Ambulance Service 2	226	40	21	65	29	50
Ambulance Service 3	200	40	33	98	12	64
Ambulance Service 4	159	74	29	93	15	70
Ambulance Service 5	118	18	2	50	7	62
Ambulance Service 6	114	12	15	88	20	33
Ambulance Service 7	111	32	16	84	33	23
Ambulance Service 8	98	38	21	6	14	53
Ambulance Service 9	32	16	7	21	2	18

Average quarterly case comparison

Metric	East of England	Other Ambulance NHS Trusts Avg.	Vs Average
Avg Cases/Quarter	58	40	↑ Above
Avg Anonymous/Quarter	3	9	↓ Below
Avg Patient Safety/Quarter	3	5	↓ Below
Avg Worker Safety/Quarter	6	19	↓ Below
Avg Bullying/Quarter	4	7	↓ Below

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Avg Inappropriate/Quarter	32	13	↑ Above
Avg Disadvantageous/Quarter	0	1	↓ Below

Ambulance NHS Trust case comparison key findings:

1. **EEAST reports the second highest total case volume** among the 10 ambulance trusts shown, with 230 cases reported for 2025/26.
2. **Inappropriate attitudes and behaviours is the most prominent theme for EEAST**, accounting for 127 cases and sitting above the levels reported by the other ambulance trusts shown.
3. **Anonymous reporting is comparatively lower for EEAST**, with 13 anonymous cases, representing 5.7% of total cases.
4. **Worker safety cases are lower than several comparator ambulance trusts**, with 23 cases reported by EEAST.
5. **EEAST has a higher average case volume per quarter** than the other ambulance trusts average shown, with 58 cases per quarter compared with 40.

- **Medium-sized NHS trust workforce comparison: NHS Trusts with 5,000 to 10,000 workers**

Metric	East of England No. cases	Medium-sized trust average No. cases	vs Average
Total Cases	230	156	↑ Above
Anonymous Cases	13	19	↓ Below
Patient Safety Cases	10	29	↓ Below
Worker Safety Cases	23	66	↓ Below
Bullying/Harassment	16	26	↓ Below
Inappropriate Attitudes	127	65	↑ Above

Medium-sized NHS Trust workforce comparison key findings:

1. **EEAST reports above-average total case volume compared with medium-sized NHS Trusts**, with 230 cases compared with a medium-sized trust average of 156 cases.
2. **Inappropriate attitudes and behaviours is the only theme where EEAST is above the medium-sized Trust average**, whilst other themes are all below the average shown.

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Meeting:	Public Board	**Date:**	16.09.2026
Report Title:	WRES & WDES 2025/26 Submission & 2026/27 Action Plan		
Agenda Item:	PUB26/09/3.4		
Author(s):	Amanda Marsh & Tiffani Galiza, Associate Inclusivity Business Partners		
Lead Director:	Marika Stephenson, Chief People Officer & Deputy CEO		

Purpose:	Decision Approval	**X**	Discussion Review		Information Noting	
Assurance:	Limited		Reasonable		Substantial	X

Link to CQC domain:		**Link to EEAST's Strategic Missions:**	
Caring		Patient Mission	**X**
Responsive		Partnership Mission	
Effective		People Mission	**X**
Well Led	**X**	Productivity Mission	
Safe	**X**		

Link to Strategic Risk:									
SR1		SR3		SR5		SR7	**X**	SR9	
SR2		SR4		SR6		SR8	**X**	SR10	

Equality Impact Assessment Undertaken:			
YES		**NO**	**X**

Previously considered by:

The WDES Annual Report and the proposed WRES and WDES Action Plans have been considered by the Executive EDI Task and Finish Groups covering:

- Education and Cultural Awareness
- Workplace Experience
- Workplace Adjustments

The report and action plans have also been informed by engagement with the Disability Support Network (DSN), REaCH Network and the Executive Leadership Team.

These papers were presented to and approved by the People Committee on 22 July and are now submitted to the Board for final approval.

Executive Summary:

What?

The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) are nationally mandated NHS frameworks that support organisations to identify, monitor and address workforce inequalities. They provide an evidence-based assessment of workforce representation, recruitment, career progression, workplace experience, organisational culture and inclusion. The attached report presents the Trust's 2025/26 WDES outcomes and associated WRES findings and seeks approval of the 2026/27 WRES and WDES Action Plans.

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During 2025/26, the Trust has made positive progress across several workforce equality measures. Improvements have been achieved in workplace adjustments, staff engagement, perceptions of career progression and experiences of bullying, harassment and abuse. Positive movement has also been seen in disciplinary outcomes for ethnically diverse colleagues and in disability workforce representation.

This progress has been supported through a range of initiatives, including the ESR Disability Declaration Campaign, Leadership Development Framework, Cultural Inclusion Ambassador Programme, Time to Listen engagement activity, Disability and Neurodiversity Survey, workplace adjustment improvements and enhanced Freedom to Speak Up promotion and activity. In addition, the Executive Team has approved the implementation of a Cultural Transformation Programme and procurement activity is underway for a Trust-wide Neurodiversity Training Programme.

Despite these improvements, several areas of inequality remain. Recruitment inequality continues to represent the most significant area of concern within WRES. Disabled colleagues remain disproportionately represented within formal capability processes, confidence to report bullying, harassment and abuse has remained largely unchanged and representation of diverse groups at senior leadership level remains below the Trust's ambition. The proposed 2026/27 WRES and WDES Action Plans have been developed to address these identified priorities and improve equality outcomes across the workforce.

So What?

The findings demonstrate that, whilst good progress is being made, workforce inequalities continue to present organisational, workforce and cultural risks. Persistent inequalities can negatively affect colleague engagement, wellbeing, retention, career development opportunities and confidence in organisational processes. They may also impact the Trust's ability to attract, retain and develop a diverse workforce and create an inclusive environment in which all colleagues can thrive.

The most significant risks identified through the WRES and WDES data relate to recruitment outcomes for ethnically diverse applicants, disproportionality within formal capability processes for disabled colleagues, ongoing reports of discrimination, bullying and harassment, static reporting confidence and under-representation of diverse groups within senior leadership. Failure to address these issues could adversely affect organisational culture, psychological safety, workforce sustainability, succession planning and delivery of the Trust's People Plan.

Failure to improve recruitment and representation outcomes may impact workforce diversity and succession planning. Persistent workplace experience inequalities may adversely affect organisational culture and psychological safety, whilst failure to improve workplace adjustments and capability outcomes may negatively affect the experience of disabled colleagues. Organisational change and operational pressures may also impact delivery of improvement activities.

The report provides assurance that these risks have been identified, reviewed and prioritised through the Trust's EDI governance arrangements. The proposed Action Plans provide a targeted and evidence-based response to the areas of greatest concern and align with the People Plan, Executive EDI Priorities and wider workforce improvement objectives.

What Next?

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The proposed 2026/27 WRES and WDES Action Plans focus on the areas where inequality remains most pronounced and where targeted action is likely to have the greatest impact. Priority areas include:

- Improving recruitment outcomes for ethnically diverse applicants.
- Increasing representation of diverse groups at leadership and senior management levels.
- Reducing disproportionality within formal capability processes.
- Improving workplace experience and reducing experiences of discrimination, bullying and harassment.
- Increasing confidence to report concerns and inappropriate behaviours.
- Strengthening workplace adjustment processes and improving the experience of disabled colleagues.
- Delivering the Cultural Transformation Programme and Trust-wide Neurodiversity Training Programme.

Delivery will be supported through Executive-sponsored EDI Task and Finish Groups and aligned to the Trust's People Plan and Executive EDI Priorities. Progress will be monitored through established People and EDI governance arrangements, with ongoing oversight provided through the People Committee and Executive Leadership Team to ensure delivery against agreed objectives throughout 2026/27.

Approval of the Action Plans will ensure continued focus on the workforce equality risks identified through WRES and WDES and support delivery of the People Plan, Executive EDI Priorities and wider workforce improvement objectives.

Action Required by the Board:

The Trust Board is asked to:

- Approve the WDES 2025/26 Annual Report.
- Approve the WDES 2026/27 Action Plan.
- Approve the WRES 2026/27 Action Plan.
- Support Executive ownership and delivery of the identified priorities through the People Plan and Equality, Diversity and Inclusion Improvement Programme.

How does this report link with EEAST's vision, purpose and values?

https://www.eastamb.nhs.uk/about-us/our-corporate-strategy

The report supports delivery of the Trust's ambition to be an exceptional place to work, volunteer and learn by improving workforce experience, inclusion, leadership capability and colleague wellbeing. The proposed actions support the Trust values of Excellence, Respect and Accountability and contribute to creating a safe, inclusive and supportive working environment for all colleagues. The report also supports delivery of the People Mission through improving colleague experience, increasing confidence to raise concerns and strengthening equality, diversity and inclusion across the workforce.

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East of England Ambulance Service NHS Trust

Workforce Equality Standards (WRES & WDES)

2025/26 Outcomes, Key Risks and 2026/27 Priorities

Trust Board: 9 September 2026



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Workforce Equality Standards (WRES & WDES)

East of England Ambulance Service NHS Trust

Purpose

1. Review 2025/26 WRES and WDES outcomes.
2. Highlight key workforce equality risks.
3. Present 2026/27 priorities and targets.
4. Demonstrate alignment to the People Plan and EDI priorities.

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Approval Requested

Approve WDES Annual Report.

+ Approve WRES Action Plan.

+ Approve WDES Action Plan.

Strategic Context

East of England Ambulance Service NHS Trust

People Plan

- **Fixing the Fundamentals:** Simpler people processes, Better workplace adjustments & Improved wellbeing and support.
- **Making EEAST a Great Place to Work, Learn and Volunteer:** Inclusive leadership, Better workplace experience & Improved staff engagement.
- **Building the Workforce of the Future:** Diverse workforce, Clear career pathways & Strong succession planning.

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EDI Priorities

- **Priority 1:** Education and Cultural Awareness
- **Priority 2:** Workplace Experience
- **Priority 3:** Workplace Adjustments
- These priorities provide the delivery mechanism for addressing workforce inequalities identified through WRES, WDES and Staff Survey data.

Patient Plan

- **Right Care First Time:** Better navigation and clinical advice.
- **Faster Emergency Care:** Faster response for the sickest patients.
- **More Care Closer to Home:** Supporting appropriate care outside hospital.
- **Outcome:** Better patient outcomes through a skilled, supported and inclusive workforce.

The WRES and WDES Action Plans support delivery of the People Plan, while helping create the workforce capability, experience and inclusion required to deliver the Patient Plan.

Workforce Equality Dashboard: Current Dashboard

NHS East of England Ambulance Service NHS Trust

Workforce Theme	WRES	WDES	Position
Recruitment			High Risk
Capability & Performance			Requires Improvement
Staff Experience			Strong Improvement
Safety & Inclusion			Positive Improvement
Representation			Improving

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Recruitment inequality remains the Trust's highest workforce equality risk, whilst staff experience, engagement, workplace adjustments and representation show encouraging improvement. Capability outcomes for disabled colleagues remain a key area requiring focused intervention.

WDES Summary 2025/26

East of England Ambulance Service NHS Trust

WDES Metric	2024/25	2025/26	Movement	Status
1a. Disabled colleagues in Bands 1-7 compared with overall workforce	8.3%	9.75%	▲1.45%	
1b. Disabled colleagues in Bands 8–9 & VSM compared with overall workforce	13.69%	14.45%	▲ 0.76%	
Overall disability	8.51%	9.93%	▲ 1.42%	
2. Recruitment outcomes – likelihood of appointment following shortlisting (non-disabled vs disabled applicants)	0.72x	0.88x	▲ Movement towards parity	
3. Capability outcomes – likelihood of entering a formal capability process (disabled vs non-disabled colleagues)	2.11x	1.86x	Improved but remains disproportionate	
4a. Harassment, bullying or abuse from patients	45%	29.7%	▼ 15.3%	
4b. Harassment, bullying or abuse from managers	22.3%	13.6%	▼ 8.7%	
4c. Harassment, bullying or abuse from colleagues	28.6%	22.9%	▼ 5.7%	
4d. Reporting confidence – colleagues experiencing bullying, harassment or abuse who reported it/ had it reported on their behalf	54.9%	54.9%	No change	

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WDES Summary 2025/26

East of England Ambulance Service NHS Trust

WDES Metric	2024/25	2025/26	Movement	Status
5. Career progression – colleagues believing the Trust provides equal opportunities for promotion and development	42.9%	48.6%	▲ 5.7%	
6. Pressure to attend work when unwell	38.2%	25.6%	▼ 12.6%	
7. Staff feel valued	23.5%	34.4%	▲ 10.9%	
8. Adequate workplace adjustments	65%	74.9%	▲ 9.9%	
9a. Staff engagement score	5.5	6.3	▲ 0.8	
9b. Disabled staff voice heard	Yes	Yes	Maintained	
10a. Voting Board members declaring disability	1	1	No change	
10b. Executive Board members declaring disability	1	2	Improved	

Assurance

Positive progress across most indicators; continued focus required on capability outcomes, reporting confidence and representation.

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WRES Summary 2025/26

NHS
East of England Ambulance Service
NHS Trust

WRES Metric	2024/25	2025/26	Movement	Status
1a. Representation in Bands 1–7	6.46%	6.67%	▲ 0.21%	
1b. Representation in Bands 8–9 & VSM	4.94%	4.3%	▼ 0.64%	
Overall workforce representation	6.4%	6.58%	▲ 0.18%	
2. Recruitment outcomes (appointment from shortlisting)	1.61x	3.29x	▼ Deteriorated (1.68x)	
3. Formal disciplinary outcomes	1.44x	0.82x	▼ Improved	
4. Access to learning and development opportunities	1.47x	1.07X	▼ Improved	
5. Harassment, bullying or abuse from patients/public	32.5%	29.2%	▼ 3.3%	
6. Harassment, bullying or abuse from staff	27.5%	23.4%	▼ 4.1%	
7. Equal opportunities for career progression and promotion	42.2%	49.7%	▲ 7.5%	
8. Discrimination from managers or colleagues	16.8%	13.9%	▼ 2.9%	

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WRES Summary 2025/26

East of England Ambulance Service NHS Trust

WRES Metric	2024/25	2025/26	Movement	Status
9a. Board voting membership representation	16.67%	33.33%	▲ Improved	
9b. Board non-voting membership representation	0%	25%	▲ Improved	
9c. Executive Board representation	25%	40%	▲ Improved	
9d. Non-Executive Board representation	20%	9.09%	▼ Deteriorated	

Assurance

Positive progress is evident across workforce experience, development opportunities and disciplinary outcomes. Recruitment disparities and under-representation at senior levels remain the most significant workforce equality risks and will be a key focus of the 2026/27 Action Plan.

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What the Data is Telling Us

NHS East of England Ambulance Service NHS Trust

Progress

- Harassment reducing.
- Better workplace adjustments.
- Improved engagement.
- Improved perceptions of opportunity
- Reduced disciplinary inequalities.

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Areas Requiring Action

- Recruitment inequality.
- Leadership diversity.
- Capability inequality due to sickness related dismissals.
- Confidence to raise concerns.
- Workforce representation – limited recruitment due to CEP & QCIP restraints.

Key Activity Delivered During 2025/26

NHS East of England Ambulance Service NHS Trust

Workforce Experience & Culture

- Heart of EEAST recognition platform launched
- Time to Listen programme established
- Big Conversations engagement programme
- Staff Networks Conference and events week
- FTSU support and visibility increased

Leadership & Inclusion

- Board EDI development session completed
- Leadership Development Framework rollout continued
- Cultural Inclusion Ambassador programme expanded
- Cultural Intelligence facilitator training delivered

Disability Inclusion & Workplace Adjustments

- ESR Disability Declaration Campaign
- Disability & Neurodiversity Survey completed
- Workplace Adjustments improvement programme initiated
- Neurodiversity training procurement commenced

Recruitment & Career Development

- Recruitment support sessions delivered
- Application support resources introduced
- CIA involvement in recruitment and formal processes

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These activities have contributed to improvements seen across workplace adjustments, engagement, harassment indicators and perceptions of career opportunity

WDES 2026/27 Improvement Priorities, Targets & Success Measures

NHS East of England Ambulance Service NHS Trust

The priorities below reflect the specific areas identified within the 2026/27 WRES and WDES Action Plans. Delivery is supported through the People Plan, Executive EDI Priorities and associated Task and Finish Groups.

Priority Area	Current Position	2026/27 Target	Key Actions Underway	Current Status	Key Interdependencies
Workforce representation	9.93% disability declaration	11.4%	ESR Declaration Campaign; Cultural Awareness & Intelligence Training; Neurodiversity Training; Cultural Inclusion Ambassadors	In progress	Recruitment, succession planning, talent management, colleagues updating ESR records
Recruitment outcomes	0.88x likelihood ratio	Towards parity (1.0+)	Continued monitoring through People Committee; Cultural Inclusion Ambassadors on panels	In progress	Recruitment team, hiring managers, CIA capacity
Capability outcomes	1.86x likelihood ratio	Reduce to 1.5x (dependant on impact of	Increase CIA presence on hearings; Cultural Awareness & Intelligence Training; Neurodiversity Training	In progress	ER processes, manager capability, workplace adjustments
Reporting confidence	54.9%	Increase to 60%	FTSU support; improved communication of outcomes; cultural awareness activity	In progress	FTSU, leadership visibility, communications
Workplace adjustments	74.9% positive experience	Increase to 80%	Workplace Adjustments TAFG; process redesign; neurodiversity training; manager education; estates review	TAFG established; work underway	Occupational Health, Estates, Procurement, line managers
Board & Executive representation	Baseline position	+1.5% (depending on vacancies)	ESR declaration activity; leadership development; inclusive recruitment actions	In progress	Succession planning, executive recruitment

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WRES 2026/27 Improvement Priorities, Targets & Success Measures

NHS East of England Ambulance Service NHS Trust

The priorities below reflect the specific areas identified within the 2026/27 WRES and WDES Action Plans. Delivery is supported through the People Plan, Executive EDI Priorities and associated Task and Finish Groups.

Priority Area	Current Position	2026/27 Target	Key Actions Underway	Current Status	Key Interdependencies
Workforce representation	6.58%	8.08%	ESR declaration activity; Cultural Awareness Training; Cultural Inclusion Ambassadors; leadership development programmes	In progress	Recruitment, career pathways, succession planning
Recruitment outcomes	3.29x likelihood ratio	1.61x	Recruitment support sessions; CIA involvement; Cultural Transformation Programme; Inclusive Leadership Development	Significant Improvement Required	Recruitment Team, hiring managers, leadership accountability
Harassment, Bullying & Abuse from Staff	23.4%	19.4%	Workplace Experience Task & Finish Group; speaking-up activity; staff engagement initiatives	In progress	Local leadership, FTSU, Communications
Discrimination from Managers or Colleagues	13.9%	10.9%	Cultural Transformation Programme; Inclusive Leadership Development; EDI Education Programme. Cultural Transformation Programme approved by Executive Team and implementation planning underway	In progress	Leadership behaviours, staff networks, organisational culture
Board & Executive representation	Baseline position	+1.5% (depending on vacancies)	Development pathways for aspiring ethnically diverse leaders; succession planning; People Plan actions	In progress	Talent management, succession planning, recruitment

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Key Improvement Actions 2026/27

East of England Ambulance Service NHS Trust

Inclusive Leadership & Education

- Cultural Transformation Programme approved by Executive Team.
- Mandatory programme for managers (Team Leader and above).
- Cultural Awareness and Intelligence Training.
- Neurodiversity Training Programme in procurement.
- Enhanced Practice Educator and Leadership Development activity.
- **Status: Implementation planning underway. Launch expected during 2026/27.**

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Workplace Experience

- Workplace Experience Task & Finish Group.
- Let's Talk programme development.
- Speaking Up culture initiatives.
- Staff Network engagement.
- Cultural Transformation Programme.
- Sexual Safety and inclusion learning activity.
- **Status: In progress.**

Workplace Adjustments

- Workplace Adjustments Task & Finish Group.
- Neurodiversity training procurement.
- Specialist training for: Occupational Health, ER Case Team, Learning & Development and Leadership Development Teams
- Reasonable Adjustment process improvements.
- **Status: Procurement and design phase.**

Risks & Assurance Summary

NHS East of England Ambulance Service NHS Trust

Key Risks	Assurance
🔴 Recruitment inequality remains significant & is limited by CEP & QCIP	Action plans developed from WRES, WDES and Staff Survey data
🔴 Capability disproportionality remains for disabled colleagues, impacted by sickness related dismissals	Aligned to People Plan, Patient Plan and EDI Priorities
🟠 Disability representation at senior leadership and Board level remains below overall workforce representation and opportunities for improvement are dependent on vacancies, succession planning and declaration rates	Supported through three Executive-sponsored Task & Finish Groups
🟠 Workplace experience inequalities persist	Cultural Transformation Programme approved
🟠 Organisational change may impact delivery pace	Regular People Committee oversight and reporting established

Summary

Positive progress has been achieved across workplace experience, engagement, career opportunities, workplace adjustments and workforce representation. Recruitment inequality, capability outcomes and confidence to report concerns remain the most significant workforce equality risks. Representation at senior leadership and Board level continues to require sustained focus.

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East of England Ambulance Service NHS Trust

NHS Workforce Disability Equality Standard (WDES) Annual Report

Inclusivity Team

Report Period: Apr-2025 to Mar-26
Date of Report: 07 July 2026

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10/09/2026 16:55:21

1. Introduction

The Workforce Disability Equality Standard (WDES) was introduced on 1 April 2019 to support NHS organisations in understanding and improving the experiences of disabled colleagues. The WDES comprises ten national measures that enable organisations to compare the experiences and outcomes of disabled and non-disabled staff, identify areas of inequality and develop targeted improvement plans. The Standard is mandated through the NHS Standard Contract and was commissioned by the Equality and Diversity Council (EDC).

EEAST's 2025/26 WDES Action Plan was developed by the Inclusivity Team in partnership with the Disability Support Network (DSN). The priorities and actions were informed by analysis of workforce data, NHS Staff Survey findings, and feedback gathered through disability and neurodiversity surveys undertaken by McKenzie LLP on behalf of the Trust. The action plan was reviewed through the Trust's governance framework and approved by the appropriate committees and boards before publication on both the Trust intranet and external website.

The Trust continues to work collaboratively with system partners and Integrated Care Boards (ICBs) to share learning and promote good practice. Following recent system changes, EEAST's primary point of engagement is through the Norfolk and Suffolk Integrated Care Board.

The WDES Action Plan forms part of the Trust's broader commitment to creating an inclusive workplace and delivering the objectives set out within the People Plan and People Mission. The actions focus on improving colleague experience, access to workplace adjustments, confidence to raise concerns, and equality of opportunity. In doing so, they contribute to the development of a workforce that feels valued, supported and empowered to deliver high-quality patient care. Delivery of the action plan is aligned to the Trust's Executive Equality, Diversity and Inclusion priorities of Education and Cultural Awareness, Workplace Experience, and Workplace Adjustments.

2. Executive Summary

2.1 Overview

The 2025/26 Workforce Disability Equality Standard (WDES) results demonstrate continued progress in improving the experience of disabled colleagues across EEAST. The Trust has maintained its focus on identifying and reducing workforce inequalities through analysis of workforce data, staff survey findings, employee engagement activity and feedback from disabled colleagues.

Four of the five priority objectives identified within the 2025/26 WDES Action Plan were achieved or exceeded. Significant improvements were recorded in workplace adjustments, career progression, organisational value and experiences of bullying, harassment and abuse. Disability workforce representation also increased during the reporting period.

Whilst the overall direction of travel is positive, some inequalities remain. Disabled colleagues continue to be disproportionately represented within formal capability processes, confidence to report concerns has remained unchanged, and representation at senior leadership and Board level requires further improvement.

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2.2 Priority Metrics and Outcomes

Five priority metrics were identified for focused improvement during 2025/26 following review of workforce data, NHS Staff Survey results, previous action plan performance, and findings from disability and neurodiversity surveys.

Metric	Target	Outcome
Metric 3: Relative likelihood of disabled staff entering a formal capability process	Reduce from 2.11 to 1.5 times more likely	Improved to 1.86 times more likely, but target not achieved
Metric 4a(i): Experience of bullying, harassment or abuse from patients	Reduce from 45.0% to 43.0%	Reduced to 29.7%, target exceeded
Metric 5: Equal opportunities for career progression and promotion	Increase from 42.9% to 44.0%	Increased to 48.6%, target exceeded
Metric 7: Staff satisfied that the organisation values their work	Increase from 23.5% to 24.5%	Increased to 34.4%, target exceeded
Metric 8: Adequacy of workplace adjustments	Increase from 65.0% to 68.0%	Increased to 74.9%, target exceeded

2.3 Key Areas of Progress

The Trust has recorded encouraging improvements across several workforce equality indicators during 2025/26, including:

- Reduced experiences of bullying, harassment and abuse from patients, managers and colleagues.
- Improved perceptions of equal opportunities for career progression and promotion.
- Increased satisfaction that the organisation values employees' contributions.
- Improved experiences of workplace adjustments.
- Reduced pressure to attend work when unwell.
- Increased workforce disability representation from 8.51% to 9.93%.

These improvements indicate that actions delivered through the WDES Action Plan and wider Equality, Diversity and Inclusion programme are having a positive impact on colleague experience.

2.4 Strategic Delivery During 2025/26

A number of initiatives were implemented during the reporting period to support improvements in workforce equality and inclusion, including:

- ESR Disability Declaration Campaign.
- Leadership Development Framework and Cultural Intelligence training.
- Equality Impact Assessment training.
- Recruitment support sessions and applicant guidance resources.
- Expansion of the Cultural Inclusion Ambassador programme.
- Staff Networks Conference Week.
- Heart of EEAST recognition platform.
- Time to Listen engagement programme.

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- Freedom to Speak Up promotion and independent Guardian support.
- Disability and Neurodiversity Survey.

2.5 Challenges and Risks

Despite the progress achieved, several workforce equality challenges remain.

Capability Outcomes

Disabled colleagues remain 1.86 times more likely than non-disabled colleagues to enter a formal capability process. Whilst this represents an improvement on the previous year, the measure continues to be influenced by attendance management activity and ill-health capability cases associated with the Trust's Attendance Improvement Programme. Further analysis is required to understand the extent of this impact and identify opportunities to reduce the disparity.

Reporting Confidence

Experiences of bullying, harassment and abuse have reduced significantly during the reporting period. However, confidence to report incidents has remained unchanged at 54.9%.

This distinction is important:

- Experiences of bullying, harassment and abuse have improved.
- Confidence to report incidents has not improved.

Increasing confidence to raise concerns will remain a priority during 2026/27.

Workforce and Leadership Representation

Workforce disability representation has increased; however, representation within senior leadership and Board roles remains limited and further progress is required to ensure leadership more closely reflects the wider workforce.

Organisational Change

The Corporate Efficiencies Programme and estate review activity undertaken during the year have had an impact on colleague morale. The longer-term effects on workforce demographics and colleague experience remain under review.

2.6 Looking Ahead

The 2025/26 WDES results demonstrate measurable progress across most workforce equality indicators, with four of the five priority objectives achieved.

The 2026/27 WDES Action Plan will focus on areas where inequalities remain most pronounced:

- Workforce representation.
- Capability outcomes.
- Confidence to report concerns.
- Workplace adjustments.
- Board and leadership representation.

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These priorities align with the Trust's People Plan, People Mission and Executive Equality, Diversity and Inclusion priorities of Education and Cultural Awareness, Workplace Experience and Workplace Adjustments.

3. WDES Progress in 2025/26

3.1 Overview

The 2025/26 WDES results demonstrate positive progress across the majority of indicators, with notable improvements in workforce representation, workplace adjustments, career development, staff engagement and experiences of bullying, harassment and abuse. Four of the five priority objectives identified in the 2025/26 Action Plan were achieved or exceeded. However, challenges remain in relation to capability outcomes, reporting confidence and senior-level representation.

The Disability Support Network (DSN) continues to play a key role in supporting disabled colleagues, providing a forum for sharing experiences, identifying concerns and contributing to organisational improvement activity. The Network works closely with the Inclusivity Team and Trust leadership to ensure that the voices of disabled colleagues continue to inform decision-making.

3.2 Workforce Representation (Metric 1)

The proportion of staff declaring a disability increased during 2025/26 from 8.51% to 9.93%, representing an increase of 108 colleagues. Representation within senior pay bands also increased slightly, with the number of disabled colleagues in Bands 8-9 and VSM positions rising from 36 to 37.

Workforce Representation Summary

Indicator	2024/25	2025/26	Variance
Disabled workforce representation	8.51%	9.93%	+1.42%
Disabled staff headcount	561	669	+108
Disabled staff in Bands 8-9 & VSM	36	37	+1
Undeclared / Unknown disability status	1,742	1,846	+104

Source: ESR Workforce Data

Whilst progress has been achieved, the number of employees who have not declared their disability status remains high. Improving declaration rates remains important to ensuring that workforce data accurately reflects the diversity of the organisation and enables targeted support where required.

3.3 Recruitment Outcomes (Metric 2)

Recruitment outcomes remained positive for disabled applicants during 2025/26. The relative likelihood score increased from 0.72 to 0.88, indicating movement towards greater parity between disabled and non-disabled applicants following shortlisting

A score of 1.0 indicates that disabled and non-disabled applicants are equally likely to be appointed following shortlisting. Whilst disabled applicants continue to be more likely to secure appointment than non-disabled applicants, the movement towards 1.0 demonstrates greater parity in recruitment outcomes.

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Recruitment Metric	2024/25	2025/26	Variance

Relative likelihood of non-disabled applicants being appointed compared to disabled applicants	0.72	0.88	+0.16 Closer to parity

Key contributors to this improvement include:

- Increased promotion of disability declaration through the ESR campaign.
- Recruitment support resources and application guidance.
- Continued involvement of Cultural Inclusion Ambassadors in recruitment processes.
- Improved awareness of inclusive recruitment practices.

3.4 Capability Outcomes (Metric 3)

The relative likelihood of disabled staff entering a formal capability process improved during the reporting period, reducing from 2.11 times more likely to 1.86 times more likely than non-disabled colleagues. Although this represents progress, the target of 1.5 was not achieved and the measure remains a significant area of concern.

Capability Metric	2024/25	2025/26	Variance
Relative likelihood of disabled staff entering a capability process	2.11	1.86	-0.25

The relative likelihood of disabled staff entering a formal capability process improved during the reporting period, reducing from 2.11 times more likely to 1.86 times more likely than non-disabled colleagues. Although this represents positive progress, the target of 1.5 was not achieved and the measure remains an area requiring continued focus.

It is important to recognise that this metric includes both performance-related and ill-health capability cases. During 2025/26, the Trust continued to implement the Attendance Improvement Programme, which resulted in a greater focus on attendance management and a number of ill-health related dismissals. As disabled colleagues are more likely to have underlying health conditions requiring workplace support and attendance management interventions, this activity is likely to have influenced the metric and contributed to the continued disparity.

Whilst this context should be considered when interpreting the results, disabled colleagues nevertheless remain disproportionately represented within formal capability processes. Further analysis will therefore be undertaken during 2026/27 to better understand the underlying drivers, distinguish between performance and ill-health related cases, and identify opportunities to reduce inequality in outcomes whilst maintaining appropriate attendance and performance management arrangements.

3.5 Bullying, Harassment and Abuse (Metrics 4a and 4b)

Experiences of Bullying, Harassment and Abuse (Metric 4a)

The Trust recorded substantial improvements across all three measures relating to experiences of bullying, harassment and abuse.

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Source of Experience	2024/25	2025/26	Variance
Patients and service users	45.0%	29.7%	-15.3%
Managers	22.3%	13.6%	-8.7%

Colleagues	28.6%	22.9%	-5.7%

These results demonstrate a significant reduction in the proportion of disabled staff experiencing bullying, harassment or abuse during the reporting period. Whilst the direction of travel is positive, disabled colleagues remain more likely than non-disabled colleagues to report negative workplace experiences and further improvement remains necessary.

Reporting Confidence (Metric 4b)

Whilst experiences of bullying, harassment and abuse have improved, confidence to report incidents has remained unchanged.

Reporting Confidence	2024/25	2025/26	Variance
Staff reporting incidents of bullying, harassment or abuse	54.9%	54.9%	No change

This distinction is important. Fewer disabled colleagues are reporting negative experiences, but there has been no improvement in confidence to report concerns when they occur. This will remain a priority for action during 2026/27.

3.6 Career Progression and Promotion (Metric 5)

Positive perceptions regarding career progression opportunities improved significantly during the reporting period.

Indicator	2024/25	2025/26	Variance
Disabled staff believing EEAST provides equal opportunities for career progression and promotion	42.9%	48.6%	+5.7%

The increase suggests that initiatives aimed at leadership development, career support and inclusive recruitment are having a positive impact on colleague perceptions and opportunities.

3.7 Attendance Pressure (Metric 6)

The percentage of disabled colleagues reporting pressure from managers to attend work when unwell reduced significantly.

Indicator	2024/25	2025/26	Variance
Pressure to attend work when unwell	38.2%	25.6%	-12.6%

This reduction represents one of the most significant improvements within the WDES results and is indicative of a more supportive approach to colleague wellbeing.

3.8 Feeling Valued at Work (Metric 7)

Disabled colleagues reported increased satisfaction with the extent to which the organisation values their work.

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Indicator	2024/25	2025/26	Variance
Staff satisfied the organisation values their work	23.5%	34.4%	+10.9%

This positive movement aligns with wider engagement and recognition activity introduced during the year, including Heart of EEAST, Time to Listen and wider staff engagement initiatives.

3.9 Workplace Adjustments (Metric 8)

Experiences of workplace adjustments improved substantially and exceeded the Trust's target.

Indicator	2024/25	2025/26	Variance
Disabled staff reporting adequate workplace adjustments	65.0%	74.9%	+9.9%

This improvement reflects continued focus on workplace adjustment processes, wellbeing support, policy development and broader awareness of disability inclusion across the organisation. Workplace adjustments remain a strategic priority for EEAST.

3.10 Staff Engagement and Staff Voice (Metrics 9a and 9b)

Staff engagement scores improved significantly during 2025/26.

Indicator	2024/25	2025/26	Variance
Staff engagement score	5.5	6.3	+0.8

The Trust continues to support staff voice through:

- Disability Support Network activity.
- Disability and Neurodiversity Survey.
- Big Conversations.
- Time to Listen engagement programme.
- Staff Networks Conference Week.
- Executive Question and Answer sessions.
- Freedom to Speak Up services.
- Cultural Inclusion Ambassador network.

The Trust is therefore able to confirm that action has been taken to facilitate the voices of disabled colleagues being heard throughout the organisation.

3.11 Board Representation (Metric 10)

Representation of disabled colleagues at Board level remains an area requiring continued focus.

Measure	2024/25	2025/26	Variance
Voting Board Members with declared disability	1	1	No change
Executive Board Members with declared disability	1	2	+1

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Whilst Executive representation has improved, voting Board representation remains unchanged. The reduction in overall Board size during the reporting period should also be considered when interpreting these results. Improving disability declaration within senior leadership remains a priority. Whilst opportunities to improve Board representation are dependent upon vacancies and recruitment activity, the Trust will continue to promote inclusive leadership and encourage declaration at senior levels.

4. Key Activity Delivered During 2025/26

The initiatives outlined below have supported improvements across WDES outcomes during 2025/26 and have informed the priorities identified within the 2026/27 Action Plan.

4.1 Workforce Experience and Culture

Significant investment was made in colleague engagement and cultural improvement during the reporting period.

Key activity included:

- Launch of the Time to Listen engagement programme, providing opportunities for Executive Directors and senior leaders to meet directly with colleagues across Trust locations.
- Delivery of EEAST's first Staff Networks Conference Week, bringing together speakers, workshops and events focused on inclusion and diversity.
- Launch of the Heart of EEAST colleague recognition platform.
- Continued promotion of Freedom to Speak Up services, including independent Guardian support.
- Ongoing delivery of employee engagement activity through Big Conversations and other listening exercises.

These initiatives have contributed to improved engagement scores, increased feelings of being valued and greater opportunities for colleagues to influence decision-making.

4.2 Leadership and Inclusion

The Trust continued to strengthen leadership capability and inclusive decision-making throughout 2025/26.

Key developments included:

- Continued roll-out of the Leadership Development Framework.
- Delivery of Equality, Diversity and Inclusion and Cultural Intelligence learning modules.
- Board development activity focused on Equality, Diversity and Inclusion and organisational culture.
- Delivery of Equality Impact Assessment training to support more consistent and effective assessment of organisational change.
- Training of a cohort of Cultural Intelligence facilitators through an external provider.

These activities have contributed to the Trust's wider cultural transformation agenda and support the development of inclusive leadership behaviours across the organisation.

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4.3 Disability Inclusion and Workplace Adjustments

Improving the experience of disabled colleagues remained a key area of focus throughout the year.

Key initiatives included:

- Continuation of the ESR Disability Declaration Campaign.
- Delivery of a Trust-wide Disability and Neurodiversity Survey.
- Ongoing development of workplace adjustment policies, guidance and support arrangements.
- Introduction and promotion of Health and Wellbeing Passport arrangements.
- Progression of procurement activity for a Trust-wide Neurodiversity Training Programme.
- Continued partnership working with the Disability Support Network and National Ambulance Disability Network.

These activities have contributed to improved confidence in workplace adjustments and increased disability declaration rates.

4.4 Recruitment and Career Development

Activity during the year continued to focus on reducing barriers and improving access to career opportunities.

Key activity included:

- Development of recruitment support resources and applicant guidance materials.
- Delivery of application support sessions for prospective applicants and staff.
- Continued use of Cultural Inclusion Ambassadors within recruitment and employee relations processes.
- Ongoing delivery of career development opportunities through the Leadership Development Framework and wider learning offer.
- Expansion of the Cultural Inclusion Ambassador programme, increasing representation and support available across the organisation.

The Trust believes these activities have contributed to improved perceptions of career progression and the positive recruitment outcomes reported within the WDES metrics.

5. Conclusion and Next Steps (2026/27)

5.1 Overall Assessment

The 2025/26 Workforce Disability Equality Standard (WDES) results demonstrate that EEAST has continued to make positive progress in improving the experiences and outcomes of disabled colleagues. Four of the five priority objectives identified within the 2025/26 Action Plan were achieved or exceeded, with notable improvements in workplace adjustments, perceptions of career progression, staff feeling valued by the organisation, staff engagement, and experiences of bullying, harassment and abuse. Workforce representation has also improved, with disability declaration rates increasing from 8.51% to 9.93% during the reporting period.

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The progress achieved reflects the significant investment made in inclusion, engagement and organisational culture throughout the year. Initiatives such as the ESR Disability

Declaration Campaign, Leadership Development Framework, Cultural Inclusion Ambassador Programme, Staff Networks Conference Week, Heart of EEAST, Time to Listen and the Disability and Neurodiversity Survey have all contributed to creating a more inclusive and supportive working environment for colleagues.

However, despite this encouraging progress, the data demonstrates that inequalities remain. Disabled colleagues continue to be disproportionately represented within formal capability processes and confidence to report bullying, harassment and abuse has remained unchanged. Whilst representation has improved across the wider workforce, progress within leadership and Board-level representation remains limited. These areas require continued focus to ensure that improvements are sustained and that workforce experiences become more equitable across the organisation.

The Trust also recognises that 2025/26 has been a year of significant organisational change. The Corporate Efficiencies Programme, Attendance Improvement Programme and estate review activity have all had an impact on workforce experience and morale. These wider organisational factors should be considered when interpreting the year's results and understanding the challenges associated with some of the metrics.

5.2 Priority Areas for 2026/27

Analysis of WDES data, NHS Staff Survey findings, employee engagement activity, Disability Support Network feedback and the Disability and Neurodiversity Survey has informed the development of the 2026/27 Action Plan. The Trust's priority focus areas are outlined below.

Workforce Representation

Continue to improve disability workforce representation across all staff groups, whilst increasing disability declaration rates and promoting greater representation within senior leadership positions. Building confidence in disability declaration and improving data quality will remain an important area of focus.

Capability Outcomes

Further investigate and address the factors contributing to disabled colleagues being disproportionately represented within formal capability processes. Particular attention will be given to understanding the relationship between attendance management activity, ill-health capability cases and WDES outcomes to ensure that interventions are evidence-based and proportionate.

Confidence to Report Concerns

Whilst experiences of bullying, harassment and abuse have improved, reporting confidence remains unchanged. Work will continue to strengthen psychological safety, promote Freedom to Speak Up services, improve understanding of reporting routes and increase confidence that concerns will be addressed appropriately.

Workplace Adjustments

Improving access to workplace adjustments remains a key organisational priority. The Trust will continue to review its policies, processes and manager capability to ensure that disabled colleagues are able to access timely and effective support that enables them to

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thrive at work. The introduction of a Trust-wide Neurodiversity Training Programme will support this objective.

Leadership and Board Representation

Whilst opportunities to improve Board representation are dependent on vacancies and appointment processes, the Trust will continue to encourage disability declaration at senior levels and ensure that recruitment, succession planning and leadership development processes support greater inclusion and representation wherever possible.

Recruitment outcomes will continue to be monitored to ensure progress towards greater parity between disabled and non-disabled applicants.

5.3 Delivery Priorities for 2026/27

The delivery of the 2026/27 WDES Action Plan will support the Trust's wider Equality, Diversity and Inclusion priorities:

- Improve the education of the workforce and managers on bias and cultural awareness.
- Improve the workplace experiences of diverse colleagues.
- Improve access to and use of workplace adjustments.

To support these objectives, key activity planned for 2026/27 includes:

- Relaunch of the ESR Disability Declaration Campaign.
- Delivery of Neurodiversity Awareness and Neurodiversity Manager Training.
- Continued roll-out of the Leadership Development Framework.
- Expansion of the Cultural Inclusion Ambassador Programme.
- Continued promotion of Freedom to Speak Up services.
- Further development of workplace adjustment resources and support.
- Ongoing engagement through Time to Listen, Staff Networks and colleague feedback mechanisms.
- Delivery of actions arising from the Disability and Neurodiversity Survey findings.

5.4 Monitoring and Governance

Progress against the WDES Action Plan will continue to be monitored through the Trust's established governance arrangements, including regular review through People Committee, Equality, Diversity and Inclusion governance structures, and engagement with the Disability Support Network. The WDES Action Plan will remain a standing agenda item within the Disability Support Network to ensure that disabled colleagues continue to influence organisational priorities and hold the Trust accountable for delivery.

The Trust remains committed to creating a workplace where all colleagues feel valued, included and able to achieve their full potential. By maintaining a clear focus on workforce equality, listening to colleague experiences and acting on the evidence available, EEAST aims to achieve meaningful and sustainable improvements in disability inclusion during 2026/27 and beyond.

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Appendix 1 – WDES Metric Report 2025/26

Metric 1: Percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including executive board members) compared with the percentage of staff in the overall workforce.

Overall Figures for 2024/25:

ALL STAFF 31/3/2025	Disabled H/C	Non-disabled H/C	Unknown H/C	Total
AfC Bands 1-7	525	4121	1683	6329
AfC Bands 8-9 & VSM	36	168	59	263
All Staff Total	**561**	**4289**	**1742**	**6592**

As at 31 Mar 2025	Disabled %	Non-disabled %	Unknown/Null %
AfC Band 2	4.35	71.74	23.91
AfC Band 3	9.97	67.18	22.86
AfC Band 4	9.68	71.68	18.64
AfC Band 5	7.61	61.01	31.38
AfC Band 6	7.08	63.63	29.30
AfC Band 7	8.28	65.18	26.53
AfC Band 8a	16.10	64.41	19.49
AfC Band 8b	13.89	63.89	22.22
AfC Band 8c	9.76	58.54	31.71
AfC Band 8d	5.26	68.42	26.32
AfC Band 9	16.67	83.33	0
VSM	14.29	57.14	28.57
All Staff Total	**8.51%**	**65.06%**	**26.43%**

Overall Figures for 2025/26:

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ALL STAFF 31/3/2026	Disabled H/C	Non-disabled H/C	Unknown H/C	Total
AfC Bands 1-7	632	4061	1786	6479
AfC Bands 8-9 & VSM	37	159	60	256
All Staff Total	**669**	**4220**	**1846**	**6735**

As at 31 Mar 2026	Disabled %	Non-disabled %	Unknown/Null %
AfC Band 2	6.93	61.39	31.68
AfC Band 3	11.56	60.25	28.19
AfC Band 4	12.59	73.96	13.45
AfC Band 5	7.59	56.44	35.96
AfC Band 6	8.95	64.13	26.91
AfC Band 7	10.78	65.73	23.49
AfC Band 8a	15.93	63.72	20.35
AfC Band 8b	14.08	59.15	26.76
AfC Band 8c	14.29	61.90	23.81
AfC Band 8d	6.25	75.00	18.75
AfC Band 9	0.00	100.00	0.00
VSM	18.18	36.36	45.45
All Staff Total	**9.93**	**62.66**	**27.41**

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Summary:

Year end	Disabled	Non-Disabled	Unknown/Null	Total
As at 31/3/25	561	4289	1742	6592
As at 31/3/26	669	4220	1846	6735
Afc 8-9 & VSM as at 31/3/25	36	168	59	263
Afc 8-9 & VSM as at 31/3/26	37	159	60	256

(Data source: ESR (Electronic Staff Record)

Workforce disability representation increased from 8.51% to 9.93% during 2025/26. The number of disabled colleagues employed by the Trust increased from 561 to 669. Disability declaration rates continue to improve, although the number of staff whose status remains unknown remains significant.

Metric 2: Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.

Reporting Year 2024/2025	Disabled	Non- disabled	Unknown	Total
Sum of Shortlisted	880	4426	132	5438
Sum of Appointed	104	375	416	895

Relative likelihood of shortlisted to appointment	
Disabled	**0.12**
Non-disabled	**0.08**
Relative likelihood of **Non-disabled** candidates being appointed from shortlisting compared to **Disabled** candidates.	**0.72 times greater**

Reporting Year 2025/2026	Disabled	Non-disabled	Unknown	Total
Sum of Shortlisted	340	1592	98	2030

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Sum of Appointed	66	273	14	353

Relative likelihood of shortlisted to appointment	
Disabled	**0.19**
Non-disabled	**0.17**
Relative likelihood of **Non-disabled** candidates being appointed from shortlisting compared to **Disabled** candidates.	**0.88 times greater**

Note: Likelihood below 1 indicates non-disabled people are less likely to be appointed from shortlisting compared to Disabled applicates (likelihood of 1 = equally likely). A score of 1.0 represents parity between disabled and non-disabled applicants. The movement from 0.72 to 0.88 indicates recruitment outcomes are moving closer towards parity.

Metric 3: Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

2024/2025	Disabled	Non-disabled	Unknown/Null
All Staff	561	4289	1742
ALL Capability Cases (Perf & Ill Health)	4	21	13
Of which Ground of Ill Health	1	6	6
Of which Grounds of Performance	3	15	7

Likelihood of **Disabled** staff entering the capability process	**0.007130**
Likelihood of **non-disabled** staff entering the capability process	**0.003381**

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Relative Likelihood of **Disabled** staff entering the capability process compared to **non-disabled** staff	**2.11 times**

2025/2026	Disabled	Non-disabled	Unknown/Null
All Staff	669	4220	1846
ALL Capability Cases (Perf & Ill Health)	10	22	5
Of which Ground of Ill Health	3	3	3
Of which Grounds of Perf	7	19	2

Likelihood of **Disabled** staff entering the capability process	**0.007474**
Likelihood of **non-disabled** staff entering the capability process	**0.004028**
Relative Likelihood of **Disabled** staff entering the capability process compared to **non-disabled** staff	**1.86**

The capability metric includes both performance-related and ill-health capability cases. During 2025/26, attendance management activity and subsequent ill-health dismissals are likely to have influenced the results and should be considered when interpreting the data.

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Metric 4a: Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse.

WDES Metric	Mar 26 Disabled	Mar 26 non-disabled	Mar 25 Disabled	Mar 25 non-disabled
4a I - Patients & Service users	29.7%	33.4%	45%	37.4%
4a II – Managers	13.6 %	7.4%	22.3%	11.8%
4a III – Other Colleagues	22.9%	14.8%	28.6%	18%

Metric 4b: Percentage of Disabled staff compared to non-disabled staff saying the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

Mar 26 Disabled	Mar 26 non-disabled	Mar 25 Disabled	Mar 25 non-disabled
54.9%	54.9%	54.9%	52.5%

Whilst experiences of bullying, harassment and abuse reduced during the reporting period (Metric 4a), reporting confidence remained unchanged at 54.9%.

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Metrics 5 – 9a

WDES Metric	Data from Annual Staff Survey	Mar 2026 Disabled	Mar 2026 Non-disabled	Mar 2025 Disabled	Mar 2025 Non-disabled
5	% of staff believing that the Trust provides equal opportunities for career progression or promotion. (Q15)	48.6%	55.7%	42.9%	46.9%
6	% of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. (Q 11e)	25.6%	17.5%	38.2%	26.2%
7	% staff saying that they are satisfied with the extent to which their organisation values their work. (Q4b)	34.4%	46.1%	23.5%	30.1%
8	% of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. (Q28b)	74.9%	n/a	65.%	n/a
9a	The staff engagement score for Disabled staff, compared to non-Disabled staff. The overall engagement score for the organisation. 5.8%	6.3	6.9	5.5	6.1

Metric 9b: Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No): **YES**

During 2025/26, disabled colleagues were able to contribute feedback and influence decision-making through a range of engagement mechanisms, including the Disability Support Network, Disability and Neurodiversity Survey, Big Conversations, Time to Listen, Staff Networks Conference Week, Executive Question and Answer sessions, Freedom to Speak Up services and the Cultural Inclusion Ambassador programme. These activities have informed the Trust's Equality, Diversity and Inclusion priorities and the development of the 2026/27 WDES Action Plan.

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Outcome from facilitating Disabled staff voices to be heard:

In June 2025 EEAST held their inaugural Staff Networks Conference/Events week: a variety of workshops and webinars were run for staff to attend and join on-line. The sessions were all recorded so staff could re-watch or watch them at a more convenient time. These events were organised by our staff networks.

Key sessions that were delivered that staff engaged with and also gave our Disabled colleagues a forum to discuss challenges and raise awareness were: “The Power of Neurodiverse Thinking” and an informative tutorial on “Understanding Reasonable Adjustments”. The points raised at these sessions and feedback given have fed into the business case for Neurodiversity Training.

We are currently progressing though a rigorous procurement process to source an appropriate provider to meet our training requirements.

One of EEAST’S key EDI 2026 priorities is “improve the access and use of workplace adjustments”.

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Metric 10: Percentage difference between the organisation’s board voting membership and its organisation’s overall workforce

Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated:

- By voting membership of the Board.
- By Executive membership of the Board. The Trust Board does (voting and non-voting).

As at 31/3/2026	Disabled	Non Disabled	Unknown/null	Total
EXEC	2 (25%)	3 (37.50%)	3 (37.50%)	8
NON EXEC	0	6 (100%)	0	6
TOTAL	**2**	**9**	**3**	**14**
VOTING	1 (10%)	6 (60%)	3 (30%)	10
NON-VOTING	1 (25%)	0	3 (75%)	4
TOTAL	**2**	**6**	**6**	**14**
As at 31/3/2025	**Disabled**	**Non Disabled**	**Unknown/null**	**Total**
EXEC	1 (14.29%)	4 (57.14%)	2 (28.57%)	7
NON EXEC	1 (11.11%)	7 (77.78%)	1 (11.11%)	9
TOTAL	**2**	**11**	**3**	**16**
VOTING	1 (9.09%)	8 (72.73%)	2 (18.18%)	11
NON-VOTING	1 (20%)	3 (60%)	1 (20%)	5
TOTAL	**2**	**11**	**3**	**16**

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Appendix 2 – WDES Action Plan 2026/27

The 2026/27 WDES Action Plan has been developed following analysis of WDES performance data, NHS Staff Survey findings, disability and neurodiversity survey feedback, employee engagement activity and feedback from the Disability Support Network. The actions align to the Trust's strategic objectives, People Plan and Executive Equality, Diversity and Inclusion priorities.

EDI Priorities:

1. Improve the education of the workforce and managers on bias and cultural awareness.
2. Improve the poor workplace experiences of diverse colleagues.
3. Improve the access and use of workplace adjustments.

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Metric	Objective	Action	Delivery Date	Leads/Stakeholders	Inclusivity Plan priority area

1 **Priority Metric**	Percentage of staff in each of the AfC Bands 1-9 and VSM (including Executive Board Members) compared with the percentage of staff in the overall workforce. **11.4% disability declaration**	• ESR Declaration campaign. • Bias & cultural awareness training (focus on appraisals & recruitment) • Cultural Inclusion Ambassador's (CIA's) • Cultural Awareness & Intelligence Training • Develop and rollout neurodiversity training	31/03/2027 31/03/2027 31/12/2027 2026-2027	People Services Communications & Engagement	Strategic Objective (People 1 & 4). EDI Priorities 1&2
2	Relative likelihood of non-disabled candidates being appointed from shortlisting compared to Disabled candidates.	*EEAST will continue to monitor this objective and report quarterly to People Committee.*		People Services Communications & Engagement	
3 **Priority Metric**	Relative likelihood of disabled staff compared to non-disabled staff entering the formal capability process. **Reduce from 1.86 times more likely to 1.5 times more likely. Continue to reduce the disparity in capability outcomes between disabled and non-disabled colleagues and improve understanding of the impact of attendance management and ill-health capability cases.**	• Increase the presence of Cultural Inclusion Agents (CIAs) at disciplinary and capability panels. • Cultural Awareness & Intelligence Training • Improve the education of the workforce and managers on bias and cultural awareness • Develop and rollout neurodiversity training	31/03/2027 31/12/2027 2026-2027	People Services	Strategic Objective (People 1, 3 & 4). EDI Priorities 1, 2 & 3
Metric	**Objective**	**Action**	**Delivery Date**	**Leads/Stakeholders**	**Inclusivity Plan priority area**

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4	Percentage of disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from (i. patients, ii. managers, or iii. other colleagues) in the last 12 months.	*EEAST will continue to monitor this objective and report quarterly to People Committee*		Information Analytics Corporate Governance Health, Safety & Security	
4d **Priority Metric**	Percentage of disabled staff compared to non-disabled staff who reported they had experienced harassment, bullying or abuse at work. **Increase from 54.9% to 60%**	• Improve the education of the workforce and managers on bias and cultural awareness • Freedom To Speak Up Guardians (staff support & reporting of themes). • Improved communication of outcomes	31/03/2027 31/03/2027	People Services Communication and Engagement Health, Safety & Security	Strategic Objective (People 2, 3 & 5). EDI Priorities 1& 2
5	Percentage of disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	*EEAST will continue to monitor this objective and report quarterly to People Committee*		Communication and Engagement People Services	
6	Percentage of disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	*EEAST will continue to monitor this objective and report quarterly to People Committee.*		People Services Communication and Engagement	

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Metric	Objective	Action	Delivery Date	Leads/Stakeholders	Inclusivity Plan priority area
7	Percentage of disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	*EEAST will continue to monitor this objective and report quarterly to People Committee*		People Services Communication and Engagement	
8 **Priority Metric**	Percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. **Increase from 74.9% to 80%**	•Improve the access & use for workplace adjustments •Audit of Estates and facilities to identify potential barriers or issues with accessibility for all staff •Develop and rollout neurodiversity training •Cultural Awareness & Intelligence Training •Improve the education of the workforce and managers on bias and cultural awareness •Equip managers to identify and address bias in their appraisal and recruitment decisions	31/03/2027 2026 - 2027 31/12/2027	People Services Communications & Engagement Finance/Procurement & Estates	Strategic Objective (People)1, 2, 4 & 5. EDI Priorities 1& 3
9a	The staff engagement score for disabled staff compared to non-disabled staff.	*EEAST will continue to monitor this objective and report quarterly to People Committee.*		People Services Information Analytics Corporate Governance	

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				Health, Safety & Security	
Metric	**Objective**	**Action**	**Delivery Date**	**Leads/Stakeholders**	**Inclusivity Plan priority area**
9b	Has your Trust taken action to facilitate the voices of disabled people in your organisation to be heard?	*EEAST will continue to monitor this objective and report quarterly to People Committee.*		People Services Communications & Engagement	
10 **Priority Metric**	Percentage difference between the organisation's Board voting membership and its overall workforce disaggregated by: A) Voting membership of the Board. B) B) Executive membership of the Board. **Workforce increase by 1.5% (depending on vacancies) Improve disability declaration and representation at Executive and Board level where opportunities arise through vacancies, recruitment and succession planning activity.**	• ESR Declaration campaign. • Bias & cultural awareness training (focus on appraisals & recruitment) • Cultural Inclusion Ambassador's (CIA's) • Cultural Awareness & Intelligence Training • Develop and rollout neurodiversity training	31/03/2027 31/03/2027 31/12/2027 2026 - 2027	People Services Communications & Engagement	Strategic Objective 1 & 4. EDI Priorities 1&2

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Meeting:	Public Board	**Date:**	16.09.2026
Report Title:	Gender Pay Gap Report Action Plan 2025 - 2026		
Agenda Item:	PUB26/09/3.5		
Author(s):	Celia Oke, Inclusivity Manager Belinder Virk, Associate Inclusivity Business Partner		
Lead Director:	Marika Stephenson, Chief People Officer & Deputy CEO		

Purpose:	Decision Approval		Discussion Review		Information Noting	**X**
Assurance:	Limited		Reasonable	X	Substantial	

Link to CQC domain:		**Link to EEAST's Strategic Missions:**	
Caring		Patient Mission	**X**
Responsive		Partnership Mission	
Effective		People Mission	
Well Led	**X**	Productivity Mission	**X**
Safe	**X**		

Link to Strategic Risk:								
SR1		SR3		SR5		SR7		SR9	
SR2		SR4		SR6		SR8	**X**	SR10	

Equality Impact Assessment Undertaken: YES		**NO**	

Previously considered by:

People Committee

Executive Summary:

What?

In March 2026, EEAST published its annual Gender Pay Gap Report in accordance with statutory reporting requirements. This paper presents the findings for the reporting period 1 April 2025 to 31 March 2026 and outlines the actions being taken to address the underlying workforce factors contributing to the Trust's gender pay gap.

The Trust's gender pay gap is driven primarily by the distribution of women and men across pay bands and leadership levels rather than unequal pay for equal work. Women remain underrepresented within some senior and higher-paid roles, which continues to influence overall pay outcomes.

The proposed response combines immediate recruitment and progression controls with longer term action on leadership development, workforce support and accountable governance.

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This report focuses specifically on the hourly gender pay gap for the reporting period 1st April 2025 - 31 March 2026.

EEAST reports a persistent gender pay gap driven by the distribution of women across pay levels rather than unequal pay for the same role.

Women earn 97p for every £1 earned by men on median hourly pay. The mean gap exceeds the median gap, this suggests that the distribution of men and women in senior or specialist positions influences the overall gap.

Analysis identifies a range of workforce factors influencing the gender pay gap, including career progression, access to development opportunities, workforce retention and the impact of flexible working arrangements.

Findings

The Trust has seen a modest improvement in both median and mean gender pay gap measures compared with the previous reporting period.

Pay Gap Year	Women's median hourly pay	Women's mean average hourly pay
2025 to 2026	3.0% lower than men's	6.6% lower than men's
2024 to 2025	5.1% lower than men's	6.9% lower than men's

Whilst progress has been made, the data demonstrates that women continue to be underrepresented within higher-paid and senior roles, contributing to the overall gender pay gap. The Trust's Inclusivity plan is introducing initiatives to address underrepresentation and progression access for women in higher paid and senior roles.

The action plan prioritises recruitment decisions, leadership progression, flexible-working, and workforce support to address pay gap factors.

3%	6.6%	12 points
Median pay gap	**Mean pay gap**	**Representation gap**
Women earn 97p for each £1 earned by men	Average hourly pay difference	58.3% lowest quarter versus 46.3% highest quarter

The difference between the median pay gap (3.0%) and mean pay gap (6.6%) indicates that a relatively small number of higher-paid senior and specialist roles continue to have a disproportionate impact on overall pay outcomes. This reinforces the importance of targeted action to support progression, succession planning and representation at senior levels.

So What?

The Trust remains compliant with statutory reporting requirements; however, the findings highlight continuing workforce inequalities relating to representation, progression and career advancement.

Whilst the gender pay gap has reduced since the previous reporting period, women continue to be underrepresented within higher-paid and senior roles. Addressing this remains important to ensuring that organisational talent is fully utilised and that opportunities for career progression are fair and accessible.

Public Board Gender Pay Gap Report

Failure to address the underlying causes of the gender pay gap could have implications for leadership succession, workforce retention, colleague experience, organisational culture and EEAST's reputation as an inclusive employer. Continued action is therefore required to strengthen representation across senior roles, improve progression pathways and maintain workforce confidence in equitable employment practices.

What Next?

Delivery of the Gender Pay Gap Action Plan will continue through the Trust's Inclusivity Plan, with executive accountability provided through the Chief People Officer and oversight through established governance arrangements. The Trust will implement a programme of activity focused on addressing the workforce factors that contribute to the gender pay gap, particularly the underrepresentation of women within senior and higher-paid roles.

Key areas of focus include:

- Embedding equality, diversity and inclusion considerations within strategic workforce planning and organisational decision-making.
- Strengthening recruitment, talent management, succession planning and leadership development processes to support greater representation of women in senior and higher-paid roles.
- Improving transparency, consistency and accessibility of opportunities relating to recruitment, promotion, secondments, acting-up arrangements and career development.
- Supporting retention and career progression through flexible working arrangements, family-friendly policies, wellbeing initiatives and development opportunities.
- Continuing to monitor gender pay gap indicators alongside wider workforce metrics to identify trends, evaluate impact and inform targeted interventions.

Monitoring and Assurance

Progress against the Gender Pay Gap Action Plan will be monitored through the Trust's Inclusivity governance framework and reported through established workforce and people performance arrangements. Assurance will be provided through:

- Annual Gender Pay Gap reporting.
- Regular review of workforce metrics, including recruitment, progression, retention and representation by pay band and leadership level.
- Delivery monitoring through the Inclusivity Plan and associated action plans.
- Executive oversight by the Chief People Officer to ensure actions remain aligned to organisational priorities and deliver measurable improvement over time.

This approach will support the Trust's ambition to reduce the gender pay gap, strengthen representation at senior levels and ensure equitable access to career progression and development opportunities across the workforce.

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Action Required by the Board:

The Board is asked to:

1. Note the findings of the 2025-2026 Gender Pay Gap Report.
2. Take assurance that the Trust has met its statutory reporting obligations.
3. Take assurance that actions are in place to address the workforce factors contributing to the gender pay gap.
4. Endorse the continued delivery of the Gender Pay Gap Action Plan through the Trust's Inclusivity Plan.

How does this report link with EEAST's vision, purpose and values?

https://www.eastamb.nhs.uk/about-us/our-corporate-strategy

Addressing the gender pay gap supports EEAST's strategic commitment to being an inclusive, equitable and values-led organisation. By improving representation, progression opportunities and access to development, the Trust can strengthen leadership diversity, enhance workforce experience and maximise the contribution of talent across the organisation.

This work directly supports the People Plan and contributes to the delivery of a well-led, inclusive and high-performing organisation capable of attracting, retaining and developing a diverse workforce.

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East of England Ambulance Service NHS Trust

Gender Pay Gap Report

Inclusivity Team

Report Period: 1st April/2025 - 31st March/2026
Date of Report Produced: March/2026

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4 EEAST Gender Pay Gap Long -Term Actions....7

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1 Background

The gender pay Gap is the average difference between how much men and women are paid in EEAST. Gender pay gap legislation requires EEAST to publish statutory calculations every year showing how large the pay gap is between men and women.

1.1 The Gender Pay Gap indicators.

Three calculations have been published by EEAST to show:

i. Average gender pay gap as a mean average.
ii. Average gender pay gap as a median average.
iii. Proportion of men and women when divided into four groups (quartiles) ordered from lowest to highest pay.

NB: EEAST employees do not receive bonus pay, therefore calculations in relation to this are not required.

1.2 The Median Gender Pay Gap figure.

The **median** gender pay gap compares the hourly pay of the man and the woman who sit in the middle of their respective pay ranges when all employees are listed from lowest to highest paid.

This shows what a typical man and a typical woman earn.

The median is helpful because it is not affected by very high or very low pay, making it easier to understand everyday pay differences across the organisation. However, it may not fully reflect pay gaps that exist at the very highest or lowest pay levels.

1.3 The Mean Gender Pay Gap figure.

The **mean** gender pay gap looks at the average hourly pay of all men and all women across the organisation.

It is calculated by adding up everyone's hourly pay and dividing by the number of employees.

The mean gender pay gap gives an overall picture of pay differences, but it can be influenced by a small number of very high- or very low-paid roles. This means it can highlight imbalances in senior or specialist positions.

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2 Our Gender Pay Gap Data

This report looks specifically at the hourly gender pay gap for the reporting period 31st March 2025 - 31 March 2026.

Data is provided on:

- the average difference between men and women's hourly pay at EEAST.
- the percentage of men and women in the highest, middle and lowest pay groups/quartiles at EEAST.

2.1 Main gender pay gap figures

In this organisation:

- women earned 97p for every £1 that men earned (comparing median hourly pay)
- women made up 46.3% of employees in the highest paid quarter, and 58.3% of employees in the lowest paid quarter



- women's mean (average) hourly pay was 6.6% lower than men's

3 Pay Quarters

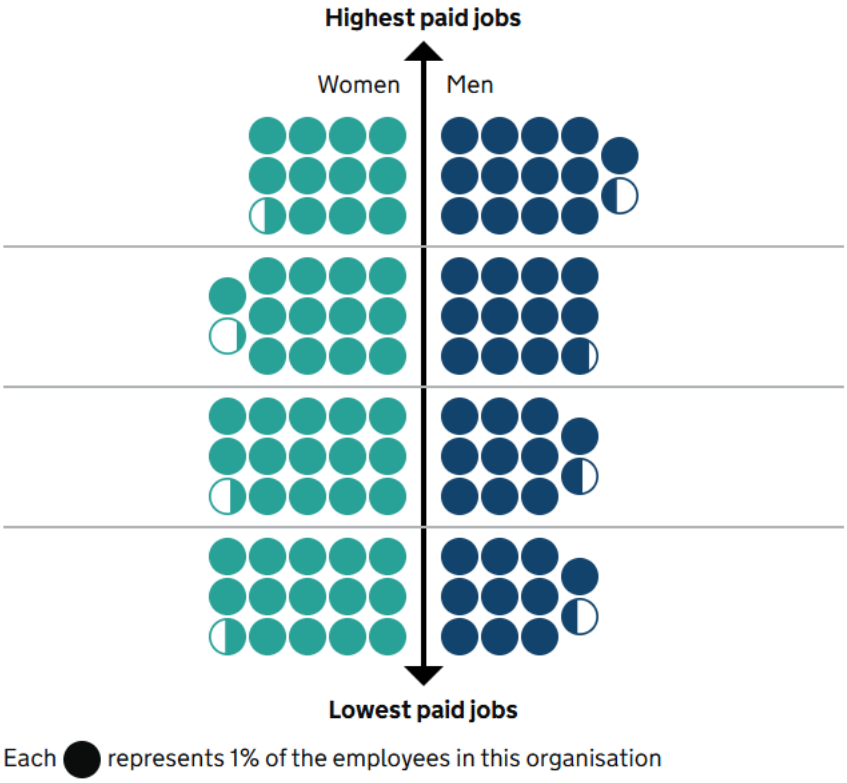
Pay quarters show how men and women are distributed across four equal-sized groups of jobs, ranked from the lowest paid to the highest paid. This

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helps us understand whether one gender is more likely to be concentrated in lower- or higher-paid roles within the organisation.

In EEAST, women made up:

- 46.3% of employees in the upper hourly pay quarter (highest paid jobs)
- 53.0% of employees in the upper middle hourly pay quarter
- 57.7% of employees in the lower middle hourly pay quarter
- 58.3% of employees in the lower hourly pay quarter (lowest paid jobs)



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This chart provides a numerical breakdown of the proportion of men and women in each pay quarter, helping to show where gender representation increases or decreases across pay bands.

Pay quarter		Women (%)	Men (%)	Total (%)
Upper hourly pay quarter (highest paid)	**Percentage in this pay quarter**	46.3	53.7	100
	Percentage of all employees	11.6	13.4	25
Upper middle hourly pay quarter	**Percentage in this pay quarter**	53.0	47.0	100
	Percentage of all employees	13.3	11.7	25
Lower middle pay quarter	**Percentage in this pay quarter**	57.7	42.3	100
	Percentage of all employees	14.4	10.6	25
Lower hourly pay quarter (lowest paid)	**Percentage in this pay quarter**	58.3	41.8	100
	Percentage of all employees	14.6	10.4	25
Totals		53.8	46.2	100

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4 EEAST Gender Pay Gap Long -Term Actions

Embed equality, diversity and inclusion into **all strategic decision-making**, aligned with EEAST's new organisational strategy and delivered through the **EEAST Inclusivity Plan**.
Strengthen workforce planning, recruitment, progression and talent development to support **inclusive career pathways**
Increase transparency and consistency across **pay, reward, promotion, secondments and acting-up opportunities**, ensuring fair access for all.
Support retention and progression through **flexible working, family-friendly policies and wellbeing initiatives**, reflecting national NHS and regional priorities.
Monitor gender pay gap data alongside wider workforce metrics to **inform evidence-based action and continuous improvement**.
Embed equality, diversity and inclusion into **all strategic decision-making**, aligned with EEAST's new organisational strategy and delivered through the **EEAST Inclusivity Plan**.

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Reporting To:	Trust Board	**Date:**	16.09.2026
Agenda Item:	PUB26/09/3.6		
Originating Meeting:	Remuneration Committee	**Date:**	03.06.2026 and 20.07.2026
Committee Chair:	Catherine Glickman, Committee Chair		
Lead Director:	Neill Moloney, Chief Executive Officer Marika Stephenson, Chief People Officer and Deputy CEO		

Purpose:	Decision Approval	x	Discussion Review	x	Information Noting	

Link to CQC domain:		**Link to EEAST's Strategic Missions:**	
Caring		Patient Mission	
Responsive		Partnership Mission	
Effective		People Mission	x
Well Led	x	Productivity Mission	
Safe			

Link to Strategic Risk:									
SR1 Demand & Capacity		SR3 Estates		SR5 Cyber Security		SR7 Workforce Sustainability		SR9 Organisational Development	x
SR2 Quality Governance		SR4 Use of Resources		SR6 Partnership Working		SR8 Staff Retention		SR10 Digital	

Alert: Items requiring Board/ Committee Attention/ Action		
What?	**So What?**	**What Next?**
There are no areas for escalation.		

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Advise: Areas requiring ongoing monitoring		
What?	**So What?**	**What Next?**
Presentation and approval of 26/27 Objectives for CEO and Executive Leadership team	Measurable and clear annual objectives ensure that Executive Directors are focussed on their part of delivery of EEAST's strategy and operation. Review across Executives' objectives ensures interdependencies are recognised and acknowledged.	The Committee provided commentary and feedback which will be shared with the individual Directors by the CEO, including focussing on a small number of key deliverables. Review of performance against the objectives will be reported at the year end.
Emergency Operations Centre (EOC) Reconfiguration– approval sought for redundancy payments for staff leaving Bedford EOC	Staff unable to be redeployed as a result of the closure of Bedford EOC will be paid redundancy as part of the approved business case.	Redundancy payments approved for those leaving as redundant in line with the handover timetable. The numbers of staff and redundancy costs will be monitored in Q3 and Q4.

Assure: Areas of positive improvement		
What?	**So What?**	**What Next?**
Not applicable		
Risks		
What?	**So What?**	**What Next?**
Not applicable		

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Reporting To:	Trust Board	**Date:**	16.09.2026
Agenda Item:	PUB26/09/3.7		
Originating Meeting:	People Committee	**Date:**	22.07.2026
Committee Chair:	Catherine Glickman, Committee Chair		
Lead Director:	Marika Stephenson, Chief People Officer and Deputy CEO		

Purpose:	Decision Approval		Discussion Review	**x**	Information Noting	**x**

Link to CQC domain:		**Link to EEAST's Strategic Missions:**	
Caring		Patient Mission	
Responsive		Partnership Mission	
Effective		People Mission	**x**
Well Led	**x**	Productivity Mission	
Safe			

Link to Strategic Risk:

SR1 Demand & Capacity		SR3 Estates		SR5 Cyber Security		SR7 Workforce Sustainability	**x**	SR9 Organisational Development	**x**
SR2 Quality Governance		SR4 Use of Resources		SR6 Partnership Working		SR8 Staff Retention	**x**	SR10 Digital	

Alert: Items requiring Board/ Committee Attention/ Action		
What?	**So What?**	**What Next?**
There are no areas for escalation.		

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Advise: Areas requiring ongoing monitoring		
What?	**So What?**	**What Next?**
Workforce planning – EOC in line with plan; A&E in line, with minor shortfalls in MSE and C&P. CAS Clinicians continue to be the most difficult role to recruit into.	The Trust is on track for the EOC reconfiguration and Chelmsford opening. Patient Facing Staff Hours (PFSH) are broadly meeting the required number, supported by targeted overtime: this remains under tight management.	The Committee to continue to monitor EOC recruitment and retention; a full report on Bedford EOC closure and Chelmsford opening will be presented in the Autumn. CAS Clinicians – continue the incentivisation plan for lateral moves, internal development and potential rotation through the roles.
ER Caseload high, with resolution of cases outside the targeted timescales.	The Trust is tackling issues of behaviour and discipline, resulting in higher case volumes, which is to be expected and supported: some improvement in case resolution in the last month.	Continued focus on caseload resolution, monitored and reported back to the Committee.

Assure: Areas of positive improvement		
What?	**So What?**	**What Next?**
Project 5: successful start to the co-design on the LOM/HALO/Team Leader role; co-design is the agreed approach to develop Team Based Working in the future.	First co-design project in the Trust: staff involvement and engagement strong. Concern about meeting timescales on decisions and implementation ahead of winter period.	Workshops to continue over summer, with target decision by end of August 2026 on LOM/HALO/Team Leader roles: this will be flexed to ensure there is sufficient time to gain support.
Retention of skills for the future, should the supply of Newly Qualified Paramedics (NQPs) change	Future shortage of qualified paramedics could result in a shortfall of qualified staff to staff the DSAs.	Support for recruitment of NQPs as they graduate to ensure we have sufficient skills over the next years.
Reduction of short and long term absence with appropriate support for staff to minimise sickness and support returning to work safely and healthily.	To maximise the PFSHs, the Trust is working with those who have been absent for a long time, and short term absences to reduce sickness overall. Long term sickness has	Continued tight management of absence and on return to work. Staff will have same day appointment GP access for themselves, their partners and children.

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	stabilised: focus now reducing short term sickness.	Continued development and training for staff and managers on improving attendance.
WRES and WDES: improvements in the recent staff survey results for race and disability	Workplace adjustments, staff engagement, perceptions of career progression, valued by organisation and experiences of bullying, harassment and abuse have improved. However recruitment inequalities and leadership diversity remain issues.	Focus groups have identified education and cultural awareness, workplace experience for diverse staff and workplace adjustments as priority areas for FY27. Key targets, including for recruitment, agreed in WRES and WDES 26/27. 2 leadership programmes – 1 focussed on women and one on ethnic minorities - planned for 26/27 to increase future leadership diversity.
Risks		
What?	**So What?**	**What Next?**
Improvement in the H&S statistics, with strong mandatory training completion (90%+) however staff survey results have not improved and near misses remain under-reported.	RIDDOR incidents remain elevated, particularly for slips, trips and falls, with musculoskeletal and mental health absences being the highest.	More work to understand how to improve staff experience of H&S, coupled with learning from other ambulance services.

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NHS
East of England
Ambulance Service
NHS Trust
information@eastamb.nhs.uk

Finance

Director: Steven Course

July 2026

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Finance
Income & Expenditure

Data up to: July 2026

Data Owner / Responsible Exec
Steven Course

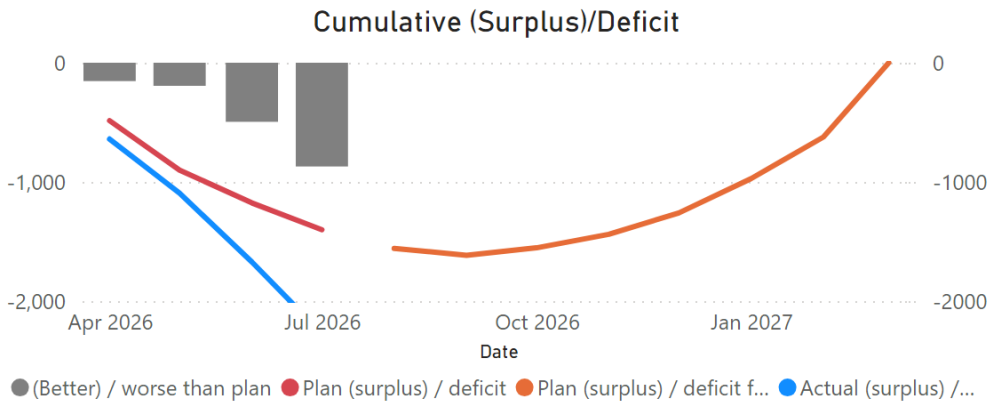
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Income and Expenditure £000's
July 2026

	PLAN YTD	ACTUAL YTD	VARIANCE YTD	PLAN FULL YEAR
INCOME	(170,903)	(170,642)	261	(514,190)
PAY	128,747	128,483	(264)	390,103
NON-PAY	40,755	39,888	(867)	124,087
(SURPLUS)/DEFICIT	(1,401)	(2,271)	(870)	0

The metrics on this page are in £000's

Local Target



Finance Narrative

At Month 04, July 2026, the YTD plan is for a surplus of £1,401k.

The actual YTD position is a surplus of £2,272k, favourable to plan by £870k.

Income lower than plan reflects low workshop income and reduced depreciation income, partly offset by strong interest income due to cash being ahead of plan.

Pay costs lower than plan is due to vacancies in many departments, partly offset by high levels of frontline overtime to support performance, with high incident levels being experienced.

Non-pay underspend includes Estates utilities and maintenance savings, low expenditure to date on clinical and driver training, and PAS expenditure lower than plan.

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Finance
Efficiency Savings

Data up to: July 2026

Data Owner / Responsible Exec
Steven Course

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The metrics on this page are in £000's

Efficiency Savings £'000s
July 2026

	PLAN YTD	ACTUAL YTD	VARIANCE YTD	PLAN FULL YEAR
TOTAL	4,901	4,972	71	15,000

Strategy Metric

Finance Narrative

At Month 04, £4,972k has been saved against a target of £4,901k. QCIP delivery is predominantly recurrent in nature, which is in line with the Trust's planning intentions.

The target for 2026-27 is £15,000k. At the end of July 2026 (Month 04), £13,742k of budget across the year has been allocated towards it. Other schemes are continuing but have not yet progressed to the point where the budget can be moved.

There is a level of risk in delivery of the remaining balance, with some plans still being developed, and fuel costs - which continue to be impacted by the situation in the Middle East - forming part of the plan. However, there is time for further action to be taken if required, so the current risk profile is low.

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Finance
Cash, Capex & BPPC

Data up to: July 2026

Data Owner / Responsible Exec
Steven Course

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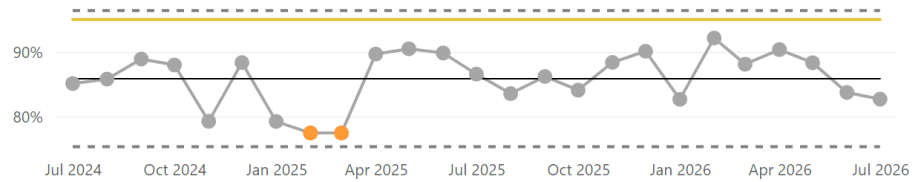
The metrics on this page are in £000's

Cash, Capex & BPPC Savings £000s
July 2026

	PLAN MONTH END	ACTUAL MONTH END	VARIANCE MONTH END	PLAN FULL YEAR
CASH	14,556	25,815	11,259	16,969
SALE AND LEASEBACK WORK IN PROGRESS	(0)	8,242	8,242	(0)
INVOICES PAID WITHIN 30 DAYS	95.00%	82.67%	-12.33%	95.00%

	PLAN YTD	ACTUAL YTD	VARIANCE YTD	PLAN FULL YEAR
OWNED CAPITAL	1,502	1,360	(142)	12,393
LEASED CAPITAL	13,117	7,771	(5,346)	29,028

Invoices paid within 30 days of receipt: Trust



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Intelligence Narrative	Finance Narrative
Invoices paid within 30 days of receipt metric shows common cause variation and the metric may hit it or miss target	Cash at 31 July 2026 is £25,815k against a plan of £14,556k, with contributions to this arising from the surplus year to date, and the plan's assumed lower level of cash coming into the new financial year. Capital expenditure is arising at a lower level than planned while schemes dependent on public dividend capital funding await confirmation of funding. The level of sale and leaseback work in progress will reduce across the year as ambulance conversions for fleet replacement complete and are bought into use. Invoice payments within 30 days remains below the 95% target, and frequently dipping below the 90% sector average. Improvement is focused on removing delays to the timely payments to high volume suppliers, and the resolution and recording of disputed invoices with suppliers.

Finance
Green Plan - Energy Consumption and CO2e Emissions

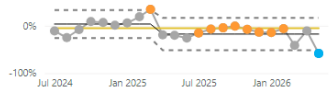
Data up to: July 2026

Data Owner / Responsible Exec
Steven Course

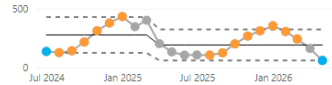
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Local Target

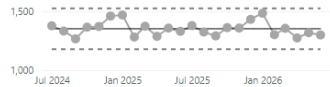
% change in energy use compared to the same month in the previous year



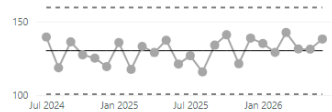
Energy (Electricity and Gas) tonnes CO2e emissions



Fleet (Trust-procured fuel) tonnes CO2e emissions



Anaesthetics (Entonox) tonnes CO2e emissions



Metric	Month	Value	Mean	Assurance	Variation
% change in energy use compared to the same month in the previous year	May 26	-58.45%	-17.52%		
Energy (Electricity and Gas) tonnes CO2e emissions	May 26	59.58	191.41		
Fleet (Trust-procured fuel) tonnes CO2e emissions	Jun 26	1297.44	1350.98		
Anaesthetics (Entonox) tonnes CO2e emissions	Jun 26	138.18	130.23		

Please note that the top two metrics on this page are reported 1 to 3 months behind the other data in this report

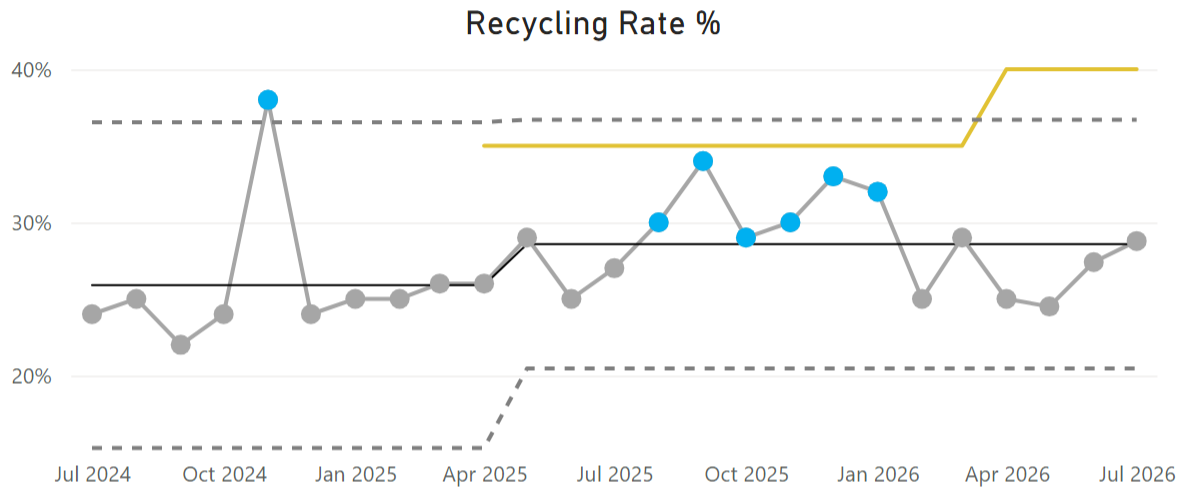
Intelligence Narrative	Sustainability Narrative
% change in energy use compared to the same month in the previous year metric shows special cause variation of an improving nature, but the metric may hit it or miss target Anaesthetics (Entonox) tonnes CO2e emissions metric shows common cause variation Energy (Electricity and Gas) tonnes CO2e emissions metric shows special cause variation of an improving nature Fleet (Trust-procured fuel) tonnes CO2e emissions metric shows common cause variation	Summary Utilities: Over the past reporting year (Jun 2025 – May 2026), the Trust recorded the following changes in utility consumption: Electricity: 6% decrease, Gas: 24% decrease, Water: 11% decrease. The bill validation process means that past consumption data is subject to change, at time of publishing the gas bills for May 2026 were still undergoing bill validation. We are investigating the reasons for these changes with assistance from our bill validation provider. Note: Water consumption figures are based on estimated meter readings. Energy (purchased electricity and natural gas): We have a strategic objective to reduce energy consumption by at least 5% over the 2026/27 financial year. In May 2026, we saw a 58% reduction in energy consumption compared with May 2025. For 2026/27 to date (M02) energy consumption reduced by 25% versus the same period in FY2025/26. Up to M02, we have seen a 36% reduction in gas consumption, primarily due to the bill validation delay and the heating switch off in late spring 2026, and a 13% reduction in purchased electricity showing the benefits of the solar PV and battery storage installations. Carbon emissions: • Long term targets: 5% reduction on 2019/20 baseline annually, total 47% reduction by 2028-2032 (Trust target 50% reduction by 2030) – NHS Carbon Footprint target is net zero emissions by 2040. • Annual targets: 30% reduction on baseline in 2025/26 and 35% in 2026/27. • Fleet (Trust-procured fuel): 2026/27 M03 (June) emissions were 2% lower than in 2025/26. Projected 2026/27 emissions show a 4.7% reduction over 2025/26, 26% reduction on baseline. DSA vehicle changes continue with Fiat being replaced with MAN and some Renault and Ford. • Energy (purchased electricity and natural gas): 2026/27 M03 (May) emissions were 55% lower than M02 in 2025/26. This is partly due to the gas bill validation, but as of April 2026 purchased electricity has lower emissions than natural gas due to the decarbonisation of the national grid. Year to date emissions were 33% below 2025/26. • Entonox (nitrous oxide): 2026/27 M03 (June) emissions are 3% higher than in 2025/26. Projected 2026/27 emissions show a 2% increase on 2025/26, 24% reduction on baseline emissions. Further work needed to reduce estimated 30% waste from Entonox consumption. Actions • The Sustainability Team has completed energy audits across all ambulance hubs and stations. Recommendations have been submitted to estate management for inclusion in future capital and revenue schemes. • The Sustainability Team has chased up with outstanding bills for sites including for the recently commissioned Ipswich Hub. • Ongoing bank holiday switch off campaigns. • Completed 5 of 10 workshops to develop the Trust's 2027-32 Green Plan. Infrastructure progress includes: • Estates submission to Great British Energy for grants for solar PV and battery storage totalling £1,395,106 was unsuccessful. We are investigating further funding streams. • The Trust is rolling out AC electric vehicle chargers across its estate. We are still in negotiation with acute hospitals and related potential partners in the East of England to install DC chargers outside A&E Departments for EEAST use. Following further assessments, we are unable to install DC chargers at Norfolk Community Health and Care NHS Trust (NCHC). Conversations with Peterborough City Hospital (PCH) and Norwich & Norfolk University Hospital (NNUH) continue. In addition, there is ongoing conversation with FirstBus to use their depot charging within their operational areas. Given the anticipated increase in electrical demand, quotations are currently being secured for electrical capacity upgrades at priority hub sites (Bury St Edmunds Hub, Peterborough, Chelmsford Lawnside, Stevenage and Longwater), these were chosen as they are potential locations for EV ambulance trials. • To mitigate increased electrical demand, the Trust is expanding its solar PV with battery storage portfolio and there are currently 12 new installations accessible remotely. We are seeing the benefits of these systems almost immediately, for example replacement systems at Hellesdon EOC, Luton and Welwyn Garden City are double the efficiency of old panels. Assurance KPI monitoring from energy audits, review of existing energy service contracts, payment of outstanding bills, re-audit of selected sites and solar PV capital projects will continue, with regular updates submitted to the ELT Committee. Detailed reviews and follow up actions will be undertaken as required.

Kingsmill Esther
10/09/2026 16:57:41

NHS East of England Ambulance Service NHS Trust
information@eastamb.nhs.uk

Strategy Metric

Local Target



Metric	Month	Value	Mean	Variation
Recycling Rate %	Jul 26	28.78%	28.58%	

Intelligence Narrative	Sustainability Narrative
Recycling Rate % metric shows common cause variation and the metric will consistently miss its target	A benchmarking exercise is being undertaken against other Ambulance Trusts to see how EEAST's recycling performance compares. Actions to be taken in the meantime:• Refreshed signage and posters on sites • Delivery of a waste management toolbox talk for the cleaning staff to ensure correct bags etc are used • Monthly comms to all sectors with their recycling figures, so they can include in their accountability sessions and ODG meetings • Development of a league table on the intranet, with top 10 and bottom 10 performing sites • Veolia have committed to doing monthly waste audits on our sites, to identify areas for improvement and engage with staff • Focus on the sites with the highest waste volumes for maximum impact (EOCs and hubs) • Re-engage the Green Champions to support locally • Develop a specific comms plan targeting the most common items places in wrong bins.

Kingshill Esther 10/09/2026 09:57:41

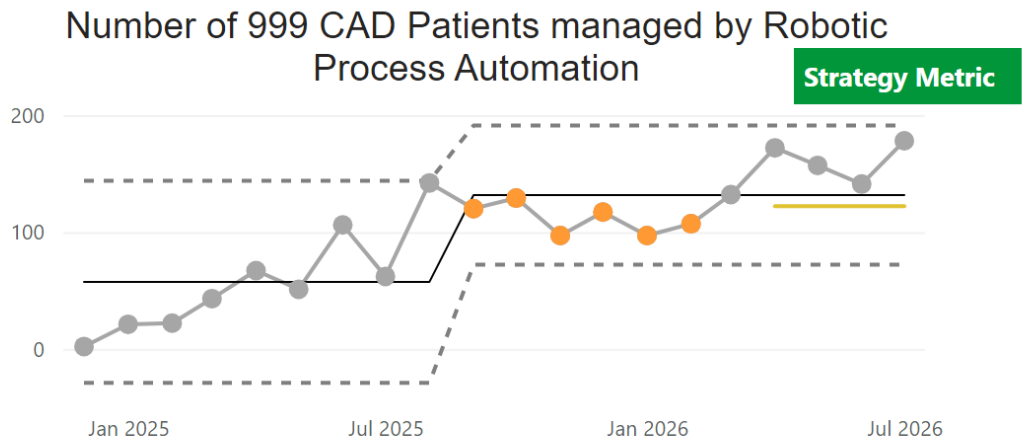
Finance

Number of 999 CAD Patients managed by Robotic Process Automation

Data up to: July 2026

Data Owner / Responsible Exec
Steven Course

NHS East of England Ambulance Service NHS Trust
information@eastamb.nhs.uk



Metric	Month	Value	Mean	Assurance	Variation
Number of 999 CAD Patients Managed by Robotic Process Automation	Jul 26	178	131.55		

Intelligence Narrative	Narrative
Number of 999 CAD Patients Managed by Robotic Process Automation metric shows common cause variation and the metric may hit it or miss target	178 patients were moved to A2S via the robotoic process automation (RPA) in July 2026, which is a decrease on the previous month. This is howevr above the 122 a month. The reduction is due to increase cover in the trust UCCH. RPA is currently being evaluated by NHS Health Innovation Network to inform the next steps of use within the trust. This evaluation is expected in August 2026. RPA is currently being scoped for use in other processes such as the ITK. RPA supports consistency in the direction of patients to alternative providers releasing ambulance capacity.

Public Trust Board 01/09/2026 Item 15.1

SPC Charts Explanation

NHS
East of England Ambulance Service
NHS Trust
information@eastamb.nhs.uk

Statistical process control

An SPC chart is a plot of data over time. It allows you to distinguish between common and special cause variation. It includes a mean and two process limits which are both used in the statistical interpretation of data.

To help you interpret the data a number of rules can be applied.

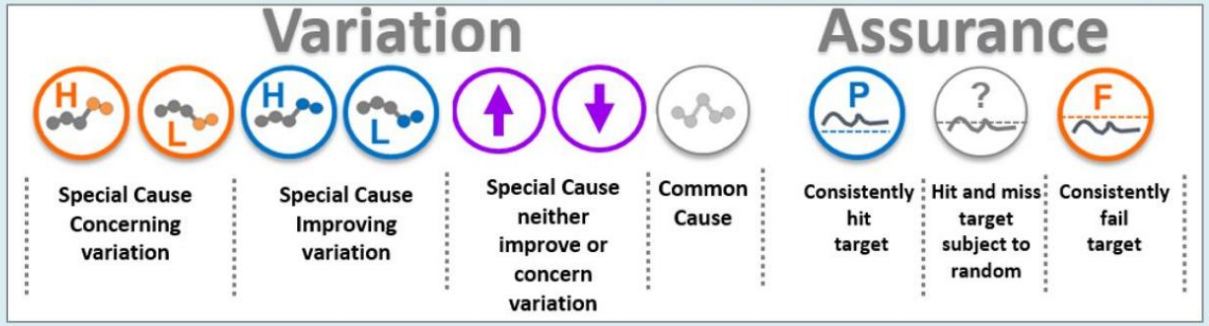
The rules

1) Any single point outside the process limits.
2) A run of 7 points above or below the mean (a shift), or a run of 7 points all consecutively ascending or descending (a trend).
3) 2 out of 3 points within 1 sigam of the upper or lower control limit
4) A large change in the moving range (greater that 3.27 * av moving range)

All these rules are aids to interpretation but still require intelligent examination of the data.
This tool highlights when a rule has been broken and highlights whether this is improvement or deterioration

If you change in your process and observe a persistent shift in your data, it may be appropriate to change the process limits. A process limit change can be added if the observed change is sustained for a longer period not just 7 points. You should try and find out the cause of the process change before recalculating the limits and annotate this on the chart. Be very cautions if you do not know what changed the process.

Icon key



Kingsmill Esther
10/09/2026 16:57:41

When SPC Charts are not suitable

There are instances where an SPC chart will not be the most suitable type of chart to use. These are:

1. Where you have a number of categories for a subject (i.e. Sickness reasons) and you want to see which of these is the biggest proportion of the total metric in question then a Pareto Chart is more suitable (see chart left below).

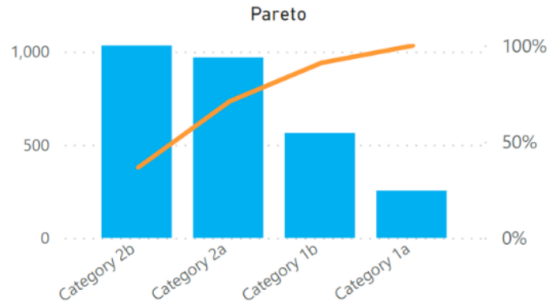
2. Where you don't have enough data points, a minimum of 14 are needed to be able to use an SPC Chart. Please note that this will always apply to any metric where you only want to show data within the current Financial Year.

3. Where the mean is below 1 AND there are not 5 different values in the data set e.g. 1,2,3,4,5; In other words, metrics of events which rarely happen are unsuitable.

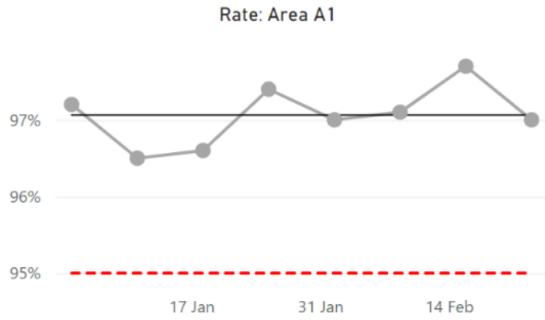
4. Where the metric is cumulative within the year i.e. Expenditure by Directorate

(Please note: This list is not definitive and is a work in progress)

Pareto chart
A Pareto chart shows which areas are the largest to focus attention where it will have the biggest impact. The areas are ranked in descending order with an increasing line chart overlaid, showing how the proportion of the largest X areas increases as more are added – that is, how big an impact focussing on the largest X areas will have.



Not enough data points?
An SPC chart requires enough data for a robust analysis. If there are too few data points (fewer than 14), the SPC elements are not displayed.



Kingsmill Esther
10/09/2026 16:57:41

Meeting:	Trust Board – Public Meeting	**Date:**	16.09.2026
Report Title:	External Auditor's Annual Management Letter		
Agenda Item:	PUB26/09/4.3		
Author(s):	Ed Davison, Head of Financial Governance and Compliance		
Lead Director:	Steven Course, Chief Finance Officer		

Purpose:	Decision Approval		Discussion Review		Information Noting	**x**
Assurance:	Limited		Reasonable		Substantial	x

Link to CQC domain:		**Link to EEAST's Strategic Missions:**	
Caring		Patient Mission	
Responsive		Partnership Mission	
Effective		People Mission	
Well Led	**x**	Productivity Mission	**x**
Safe			

Link to Strategic Risk:									
SR1		SR3		SR5		SR7		SR9	
SR2		SR4	x	SR6		SR8		SR10	

Equality Impact Assessment Undertaken: YES		**NO**	**x**

Previously considered by:

Audit and Risk Committee Meeting held on 22 July 2026

Executive Summary:

What?

The presented Auditor's Annual Report sets out the independent external auditor's key findings for the Financial Statements audit and their review of the Trust's arrangements for ensuring value for money, including the value for money commentary.

The following summarises the findings of the audit report:

Financial statements: The Independent Audit Opinion is Unqualified – The financial statements give a true and fair view of the financial position of the Trust as at 31 March 2026 and of its expenditure and income for the year then ended. The auditor's report was issued on 18 June 2026, being ahead of the 26 June NHS England deadline.

Parts of the remuneration report and staff report subject to audit: The Trust took up amendments to disclosures in the narrative, salary and pensions tables from the audit. No other matters were identified.

Kingsmill Issue
10/09/2026 15:54:41

Consistency of the other information published with the financial statement: Financial information in the Annual Report and published with the financial statements was consistent with the audited accounts.

Value for money: The auditors identified a significant weakness that impacted on two Value for Money criteria and therefore reported by exception on the Trust's Value for Money arrangements.

Consistency of the Annual Governance Statement: The auditors were satisfied that the Annual Governance Statement is consistent with their understanding of the Trust.

Referrals to the Secretary of State: There were no reasons to make a referral o the Secretary of State.

Public interest report and other auditor powers: There were no reasons for the auditors to use their auditor powers.

Reporting to the Trust on its consolidation schedules: The auditors concluded that the Trust's consolidation schedules agreed, within a £1,000,000 tolerance, or £300,000 tolerance for losses and special payments, gifts and contingent liability disclosures, to the audited financial statements.

Reporting to the National Audit Office (NAO) in line with group instructions: The auditors reported to the NAO in line with their group instructions.

Certificate: The auditors could not formally conclude the audit or issue an audit certificate until the NAO, as group auditor, confirmed that no further assurances were required from them as component auditors of the Trust.

So What?

The independent auditor's findings are included in the auditor's report to the Directors of the Trust contained within the Trust's Annual Report.

What Next?

The Auditor's Annual Report presented is to be published on the Trust website alongside the Trust's Annual Report.

Action Required by the Board:

The report contains recommendations to the Trust to resolve the Value for Money matter identified. With the key action being that the Trust continue to work closely with the Care Quality Commission (CQC) to conclude the inspection process and finalise the associated report.
It is anticipated that completion of this process will address the Value for Money matter identified and reported by the external auditors.

How does this report link with EEAST's vision, purpose and values?

https://www.eastamb.nhs.uk/about-us/our-corporate-strategy

The independent auditor's report provides assurance over the performance and position of the Trust, and its arrangements as reported in the Trust's Annual Report.

Kingsmill,Esther
10/09/2026 16:57:41

East of England Ambulance Service NHS Trust

Auditor's Annual Report

Year ending 31 March 2026

2 July 2026

Kingsmill Esther
10/09/2026 16:57:41

The better the question. The better the answer. The better the world works.

Shape the future with confidence



East of England Ambulance Service NHS Trust
Audit and Risk Committee
Whitting Way
Melbourn
Hertfordshire
SG8 6NA

2 July 2026

Dear Audit and Risk Committee Members

2025/26 Auditor's Annual Report

We are pleased to attach our Auditor's Annual Report, including the commentary on the Value for Money (VFM) arrangements for East of England Ambulance Service NHS Trust. This report and commentary explains the work we have undertaken during the year and highlights any significant weaknesses identified along with recommendations for improvement. The commentary covers our findings for audit year 2025/26.

This report is intended to draw to the attention of the Trust any relevant issues arising from our work. It is not intended for, and should not be used for, any other purpose.

We welcome the opportunity to discuss the contents of this report with you at the Audit and Risk Committee meeting on 22 July 2026.

E. Jackson

Elizabeth Jackson

For and on behalf of Ernst & Young LLP

Enc

Kingsmill Esther
10/09/2026 16:57:41

Contents

1 Executive Summary

2 Audit of Financial Statements

3 Value for Money Commentary

4 Appendices

Kingsfleet Limited 10/03/2025 16:16:41

The contents of this report are subject to the terms and conditions of our appointment as set out in our engagement letter.

This report is made solely to the **Audit and Risk Committee, Board of Directors and Management of East of England Ambulance Service NHS Trust**. Our work has been undertaken so that we might state to the **Audit and Risk Committee, Board of Directors and Management of East of England Ambulance Service NHS Trust** those matters we are required to state to them in this report and for no other purpose. To the fullest extent permitted by law we do not accept or assume responsibility to anyone other than the **Audit and Risk Committee, Board of Directors and Management of East of England Ambulance Service NHS Trust** for this report or for the opinions we have formed. It should not be provided to any third-party without our prior written consent.

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01 Executive Summary

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Executive Summary

Purpose

The purpose of the Auditor's Annual Report is to bring together all of the auditor's work over the year and the value for money commentary, including confirmation of the opinion given on the financial statements; and, by exception, reference to any reporting by the auditor using their powers under the Local Audit and Accountability Act 2014. As set out in the Code of Audit Practice 2024 (the 2024 Code) issued by the National Audit Office (NAO) and the accompanying Auditor Guidance Note 3 (AGN 03), this commentary aims to highlight to the Trust, and the wider public, relevant issues identified during our audit. It includes the recommendations arising from our current year's audit as well as a follow-up on recommendations issued in previous years. Additionally, it includes our assessment of whether previous recommendations have been satisfactorily implemented.

Responsibilities of the appointed auditor

We have undertaken our 2025/26 audit work in accordance with the Audit Plan that we presented to the Audit and Risk Committee on 25 February 2026. We have complied with the National Audit Office's (NAO) Code of Audit Practice 2025, other guidance issued by the NAO and International Standards on Auditing (UK).

As auditors we are responsible for:

Expressing an opinion on:

- The 2025/26 financial statements;
- The parts of the remuneration and staff report to be audited;
- The consistency of other information published with the financial statements, including the Annual Report; and
- Whether the consolidation schedules are consistent with the Trust's financial statements for the relevant reporting period.

Reporting by exception:

- If the Governance Statement does not comply with relevant guidance or is not consistent with our understanding of the Trust;
- To the Secretary of State for Health and Social Care and NHS England if we have concerns about the legality of transactions or decisions taken by the Trust;
- Any significant matters or written recommendations that are in the public interest; and
- If we identify a significant weakness in the Trust's arrangements in place to secure economy, efficiency and effectiveness in its use of resources.

Kingsman Esther
10/04/2026 16:51:41

Responsibilities of the Trust

The Trust is responsible for preparing and publishing its financial statements, Annual Report and Governance Statement. It is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

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Executive Summary

2025/26 conclusions

Financial statements	Unqualified – The financial statements give a true and fair view of the financial position of the Trust as at 31 March 2026 and of its expenditure and income for the year then ended. We issued our audit report on 18 June 2026.
Parts of the remuneration report and staff report subject to audit	Our work in this area identified amendments to the disclosures in the narrative, salary and pensions tables. These were corrected in the audited remuneration report. No other matters were identified.
Consistency of the other information published with the financial statement	Financial information in the Annual Report and published with the financial statements was consistent with the audited accounts.
Value for money (VFM)	We identified a significant weakness that impacted on two VFM criteria and therefore reported by exception on the Trust's VFM arrangements. We have included our VFM commentary in Section 03.
Consistency of the annual governance statement	We were satisfied that the annual governance statement was consistent with our understanding of the Trust.
Referrals to the Secretary of State	We had no reason to make a referral to the Secretary of State.
Public interest report and other auditor powers	We had no reason to use our auditor powers.

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10/09/2026 16:57:41

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Executive Summary

2025/26 conclusions (continued)

Reporting to the Trust on its consolidation schedules	We concluded that the Trust's consolidation schedules agreed, within a £1,000,000 tolerance, or £300,000 tolerance for losses and special payments, gifts and contingent liability disclosures, to the audited financial statements.
Reporting to the National Audit Office (NAO) in line with group instructions	We have reported to the NAO in line with their group instructions.
Certificate	We cannot formally conclude the audit and issue an audit certificate until the NAO, as group auditor, has confirmed that no further assurances will be required from us as component auditors of East of England Ambulance Service NHS Trust.

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10/09/2026 16:57:41

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Executive Summary

Value for money scope

Under the 2025 Code, we are required to consider whether the East of England Ambulance Service NH Trust has put in place 'proper arrangements' to secure economy, efficiency and effectiveness on its use of resources. The Code requires the auditor to design their work to provide them with sufficient assurance to enable them to report to the Trust a commentary against specified reporting criteria (see below) on the arrangements the Trust has in place to secure value for money through economic, efficient and effective use of its resources for the relevant period.

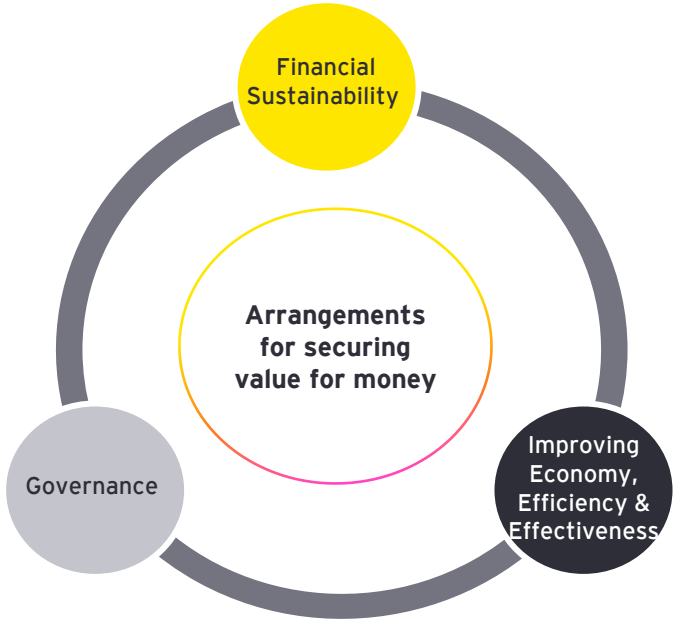
We do not issue a 'conclusion' or 'opinion', but where significant weaknesses are identified we will report by exception in the auditor's opinion on the financial statements.

The specified reporting criteria are:

- Financial sustainability - How the Trust plans and manages its resources to ensure it can continue to deliver its services.
- Governance - How the Trust ensures that it makes informed decisions and properly manages its risks.
- Improving economy, efficiency and effectiveness - How the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

In undertaking our procedures to understand the Trust's arrangements against the specified reporting criteria, we identify whether there are risks of significant weakness which require us to complete additional risk-based procedures. AGN 03 sets out considerations for auditors in completing and documenting their work and includes consideration of:

- Our cumulative audit knowledge and experience as your auditor;
- Reports from internal audit which may provide an indication of arrangements that are not operating effectively;
- Our review of Trust committee reports;
- Meetings with the key finance officers;
- Information from external sources; and
- Evaluation of associated documentation through our regular engagement with Trust management and the finance team.



Kingsfleet Esther 10/09/2025 16:07:41

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Executive Summary

Reporting

Our commentary for 2025/26 is set out in Section 03. The commentary on these pages summarises our understanding of the arrangements at the Trust based on our evaluation of the evidence obtained in relation to the three reporting criteria (see table below) throughout 2025/26. We include the associated recommendations we have agreed with the Trust in Appendix A and B.

In accordance with the 2025 Code, we are required to report a commentary against the three specified reporting criteria. The table below sets out the three reporting criteria, whether we identified a risk of significant weakness as part of our planning procedures, and whether, at the time of this report, we have concluded that there is a significant weakness in the body's arrangements.

Reporting criteria	Risks of significant weaknesses in arrangements identified?	Actual significant weaknesses in arrangements identified?
Financial sustainability: How the Trust plans and manages its resources to ensure it can continue to deliver its services	One significant risk identified	No significant weakness identified
Governance: How the Trust ensures that it makes informed decisions and properly manages its risks	One significant risk identified	Significant weaknesses identified in respect of the Care Quality Commission (CQC) inspection findings, including a Section 29A warning notice and a Section 64 letter issued to the Trust
Improving economy, efficiency and effectiveness: How the Trust uses information about its costs and performance to improve the way it manages and delivers its services	One significant risk identified	Significant weaknesses identified in respect of the Care Quality Commission (CQC) inspection findings, including a Section 29A warning notice and a Section 64 letter issued to the Trust

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10/09/2026 16:57:41

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Executive Summary

Independence

The FRC Ethical Standard requires that we provide details of all relationships between Ernst & Young (EY) and the Trust, and its members and senior management and its affiliates, including all services provided by us and our network to the Trust, its members and senior management and its affiliates, and other services provided to other known connected parties that we consider may reasonably be thought to bear on the our integrity or objectivity, including those that could compromise independence and the related safeguards that are in place and why they address the threats.

There are no relationships from 1 April 2025 to the date of this report, which we consider may reasonably be thought to bear on our independence and objectivity.

EY Transparency Report 2025

Ernst & Young (EY) has policies and procedures that instil professional values as part of firm culture and ensure that the highest standards of objectivity, independence and integrity are maintained.

Details of the key policies and processes in place within EY for maintaining objectivity and independence can be found in our annual Transparency Report which the firm is required to publish by law. The most recent version of this report is for the year end 30 June 2025:

EY UK 2025 Transparency Report | EY - UK

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10/09/2026 16:57:41

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02 Audit of Financial Statements

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10/09/2026 16:57:41

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Audit of Financial Statements

Key findings

The Annual Report and Accounts is an important tool for the Trust to show how it has used public money and how it can demonstrate its financial management and financial health.

On 18 June 2026, we issued an unqualified opinion on the financial statements. We reported our audit scope, risks identified and detailed findings to the 17 June 2026 Audit and Risk Committee meeting in our Audit Results Report. We outline below the key risk areas identified as part of our audit and our findings for each of these areas. While we did not identify any corrected misstatements, we reported five internal control recommendations and areas for improvement in the control environment within our Audit Results Report.

Financial statement risks

Significant risk	Conclusion
Misstatements due to fraud or error – Management override	We have not identified any instances of inappropriate judgements or estimates being applied. Our work did not identify any other transactions during our audit which appeared unusual or outside the Trust's normal course of business.
Misstatements due to fraud or error – Misclassification of expenditure - Capitalisation of revenue expenditure	We have completed our work in this area and have not identified any material misstatements or errors. We have however identified that during the year the Trust capitalised a total of £0.17 million of staff costs which were allocated to various projects. The Trust has not been able to provide sufficient evidence to support the accounting treatment of these costs in accordance with IAS 16 Property, Plant and Equipment. We have made a recommendation for a robust monitoring process in place to strengthen the evidence support appropriate capitalisation of these costs. We are satisfied that there was no indication of management override or fraud in this area.
Misstatements due to fraud or error – Accounts payable manual accruals	We did not identify any material weaknesses in controls or evidence of material management override concerning the accounts payable manual accruals. We have not identified any instances of inappropriate judgements or estimates being applied. Our work did not identify any misstatements.
Valuation of land and buildings	We did not identify any errors within our testing of this area. Our EY Real Estate (EYRE) team did identify that one asset (the Ipswich Ambulance Hub) should not be valued using existing use value (EUV) valuation methodology and instead should be valued at depreciated replacement cost (DRC). However, we have concluded that the immaterial difference, is a difference between EYRE's and the Trust's valuation estimation judgement and therefore is not a factual misstatement that required correcting in 2025/26.

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10/09/2026 16:57:41

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03 Value for Money Commentary

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10/09/2026 16:57:41

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Value for Money Commentary

Financial sustainability: How the Trust plans and manages its resources to ensure it can continue to deliver its services

No significant weakness identified

Risk of significant weakness - Financial planning for 2025/26 and cumulative breakeven position

For 2025/26, the Trust posted an adjusted surplus of £4.609 million. This has led to a:
- Breakeven duty cumulative position: £1.210 million surplus; and
- Cumulative breakeven position as a percentage of operating income: 0.2%.

The 'Statutory breakeven duty: a guide for NHS trusts' dated April 2018 sets out the requirement for NHS Trusts to meet the breakeven duty over a rolling three-year period. Although the Trust received an extension to this period to five years from NHS England and therefore did not breach this duty, as the Trust failed to cumulatively breakeven in 2024/25, we deemed financial planning for 2025/26 a significant risk of weakness in arrangements.

The Trust's achievement of the breakeven position planned for 2025/26:

The Trust received confirmation from NHS England during 2025/26 that they would receive deficit support funding for being a high-performing Trust. This funding was received in March 2026 and took the Trust out of their cumulative deficit. We obtained supporting evidence of this funding received during our 2025/26 audit and confirmed that this can be used against a deficit. As such, we are satisfied that the Trust has cleared their cumulative deficit and has met the breakeven duty. We therefore do not note any significant weakness in arrangements in relation to financial sustainability.

The Trust's arrangements for monitoring the financial position within the context of the local Integrated Care Systems they are part of:

The Trust is committed to improving relationships with system partners via the Fit for the Future Improvement Programme. The vehicle for this work is the Business and Partnerships Development Group, encompassing the integrated partnerships agenda, business development and commercial activity to create a coordinated and coherent ICS Partnerships Strategy, co-produced alongside stakeholders and commissioners. The Trust continues to make good progress on the Fit for the Future programme. These aim to improve performance of the Trust by focusing on leadership development, making better use of Trust's resources, supporting and empowering the workforce, and working closely with partners, particularly integrated care boards, as part of a system.

On 1 April 2026, the six Integrated Care Boards (ICBs) across the East of England merged into three. The Trust's new lead ICB for contracting is Norfolk & Suffolk ICB and the Trust is building relationships with the newly formed ICB.

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Value for Money Commentary

Financial sustainability: How the Trust plans and manages its resources to ensure it can continue to deliver its services (continued)

No significant weakness identified

We have also considered the financial planning approach for 2026/27, including the Cost Improvement Programme (CIP) target to ensure there are not any financial sustainability risks for 2026/27 that could put the Trust back into a deficit position.

The Chief Executive Officer is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan and a balanced budget. The CIP is developed ahead of the new financial year and in line with budget setting. All cost improvement programmes have a reviewed and approved quality impact assessment, where risks and mitigating actions are identified prior to the scheme being able to proceed. Equality impact is assessed for all policies implemented by the Trust. The Finance and Sustainability Committee scrutinises the Trust's CIP and reviews delivery of this programme which is supported by Quality Impact Assessments. A CIP of £14.956 million was achieved by the Trust in 2025/26 against a target of £14.9 million (over delivering by £0.056 million). The cost efficiency target for 2026/27 is planned at £15 million, with only 3% being non-recurrent in nature - £0.496 million out of £15 million. This is broadly in line with the targets set for 2025/26. The Trust also has monthly monitoring in place to assess how they are delivering against targets.

Conclusion: Based on the work performed, the Trust had proper arrangements in place in 2025/26 to enable it to plan and manage its resources to ensure that it can continue to deliver its services.

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Value for Money Commentary

Governance: How the Trust ensures that it makes informed decisions and properly manages its risks

Significant weakness identified

Overall governance arrangements

The Trust's Annual Governance Statement sets out the core governance arrangements that are in place for the year. The primary oversight in relation to making decisions and managing risk lies with the Trust Board, with some delegated responsibilities (such as financial management and risk management) to the Audit and Risk Committee and the Performance and Finance Committee. As set out in the constitution, the Trust Board has the overall duty to establish and maintain the strategic direction of the Trust. It agrees the vision, strategy and policy, and agrees a forward plan with clear objectives to deliver the organisation's purpose. It is accountable for governing the organisation and holds the Executive and its members to account for the delivery of strategy. It must also be risk-aware and receive assurance about progress against its corporate aims and objectives. We have not identified any issues in relation to the Trust Board meeting the requirements of the Constitution.

The Audit and Risk Committee monitors and provides scrutiny over the approved risk management framework to ensure that Trust policies, systems and processes are effective in the management of all risks within the Trust and escalating risk management issues appropriately. The Board Assurance Framework (BAF) outlines the material risks identified to the Trust's ability to achieve its strategic objectives, and the view of assurance across the Trust's risk environment. This is reviewed annually at each of the Board sub-committees to ensure alignment with any changes to revised risks and strategic objectives. Assurance concerns are escalated to the Audit and Risk Committee, and then to the Trust Board.

The Trust has appointed internal auditors to provide the Board with independent assurance of its internal control process. The Head of Internal Audit Opinion for 2025/26 concluded that the Trust has reasonable and effective risk management, control and governance processes in place. Internal Audit carried out seven reviews during the year to support the overall opinion with assurance ratings as follows: five reasonable and two limited.

The Trust's operational performance is monitored internally through its Integrated Performance Reporting (IPR), which reports on key performance areas including workforce, clinical and finance. The Trust's financial plans include reporting on these wider areas as part of its mechanisms for monitoring the achievement of targets for each of the key performance areas. If there are any significant financial pressures identified or areas of non-financial performance which are not in line with expectations, the Trust will ensure action is taken and the BAF updated to reflect the changing risk profile.

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Value for Money Commentary

Governance: How the Trust ensures that it makes informed decisions and properly manages its risks (continued)

Significant weakness identified

Risk of significant weakness - CQC inspection findings

The Care Quality Commission (CQC) carried out a focused inspection in November 2024 of the Trust's Emergency Operations Centre sites in Bedford, Chelmsford and Norwich. Following the inspection, the CQC issued a warning notice under Section 29A of the Health and Social Care Act 2008 on 23 January 2025 against the Trust for failing to meet service requirements on various areas.

The notice served was based on CQC's concerns over the following areas:
- The service did not ensure that staff kept up-to-date with their mandatory training.
- Waiting times for calls were below national standards which meant the service did not ensure people could access the service when they needed it.
- The service did not have enough staff to keep service users safe from avoidable harm and/or provide the right care and treatment.
- The service had cultural issues across the three Emergency Operations Centre sites and the Emergency and Urgent Care sites.
- Not all controlled medicine incidents were investigated, appropriate action taken and recorded to mitigate further risks or lessons identified to improve future practice.
- Ambulance station areas did not all adequately act on information about staff opinion of the service to develop and take actions for improvement.

Along with the warning notice, on 27 January 2025, CQC issued a Section 64 letter identifying a breach of Regulation 17 and 12 of Health and Social Care Act 2008 during the inspection:
- Regulation 17 (Good Governance)
- Regulation 12 (Safe care and treatment)

The CQC found that the Trust's systems and processes failed to ensure compliance with the Regulations and identify issues that may have impacted people's safety. This indicated that people using the Trust's service did not consistently receive a standard of care and support that was safe and appropriate to their needs.

Findings:

As indicated in the Section 29A warning notice issued by CQC, the Trust was required to make significant improvements in the Emergency Operations Centre and Emergency and Urgent Care sites. If significant improvements were not demonstrated by that date, the CQC would consider recommending to the Secretary of State to appoint a special administrator to monitor the Trust's actions and progress in addressing the findings noted in their inspection, in the interests of the health service because of the serious failure.

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Value for Money Commentary

Governance: How the Trust ensures that it makes informed decisions and properly manages its risks (continued)

Significant weakness identified

Along with the warning notice, CQC issued a Section 64 letter identifying a breach of Regulation 17 and 12 of Health and Social Care Act 2008 during the inspection. There were specific concerns regarding the Trust's failure to adhere to the national standard for Category 2 (emergency situations requiring rapid assessment) response times, which is set at 30 minutes. Between October 2023 and October 2024, the service's response times fell short of the expected targets. The average response times varied, reaching 33 minutes and 38 seconds in August 2024 and 51 minutes and 32 seconds in October 2024, corresponding to 71.18% and 52.56% compliance, respectively. Since the CQC's last inspection in April and May 2022, where the Trust's Category 2 response times were falling far below the national standards expected, the CQC noted that the Trust have made some improvements. However, the changes implemented since the inspection in 2022 have not become embedded in the service and CQC were not assured that improvements will continue or be sustained.

The Trust developed an action plan, which was agreed with CQC, to address the issues noted. Regular meetings were held to discuss the Trust's progress on the action plan and improvements made as part of the monthly Rapid Quality Review. These meetings are attended by ICB Quality Leads, NHS England, and representatives from CQC. In addition, this is closely monitored through governance framework, including reporting to the Trust Board.

The CQC was due to publish their formal report outlining the November 2024 inspection findings during 2025/26. However, due to delays at the CQC this did not happen and it was agreed with the Trust that a new unannounced inspection would take place during 2026, and both reports would subsequently be released concurrently.

Whilst the Trust has made progress as demonstrated through its own internal reporting to the Trust Board, as the CQC are yet to lift the warning notice or publish their updated report we are unable to determine that this is not still a significant weakness in governance arrangements. As such, we will report by exception on this matter.

Conclusion: Based on the work performed, we have identified a significant weakness in the arrangements in relation to Governance. The Trust has plans in place, and continues to implement improvement actions, to address the findings from the focused inspection. Although the Trust has made good progress on the action plans, as acknowledged by CQC, there are still weaknesses in the arrangements as of 31 March 2026 as the warning notice remains in place and the Trust remains in breach of the Health and Social Care Act 2008. There remains evidence of a significant weakness in arrangements during 2025/26 that:

- **Could reasonably lead to significant impact on the quality and effectiveness of the service, and the body's reputation; and**
- **Identifies a failure to take action to address CQC findings and achieve planned progress on improvement plans to achieve exit criteria requirements.**

Recommendation: The Trust should continue to engage with the CQC and closely monitor its delivery of plan to ensure that sufficient change and improvements are being made.

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Value for Money Commentary

Improving economy, efficiency and effectiveness: How the Trust uses information about its costs and performance to improve the way it manages and delivers its services

Significant weakness identified

Overall improving economy, efficiency, and effectiveness arrangements

The Trust reports to each Board meeting on key performance areas including workforce, clinical and finance. The Trust's financial plans include reporting on these wider areas as part of its mechanisms for monitoring the achievement of targets for each of the key performance areas. Where the Trust identifies a risk to target achievement, it incorporates the resulting identified mitigating actions into the Board Assurance Framework, which enables it to identify the necessary financial resources required to implement the actions.

The Trust translates this into an annual operating plan, including the financial plans for enabling sustainable delivery of services. This forms the basis of monthly Trust Board reporting. The Trust has aligned its financial plans with its Corporate Strategy "Our Strategy, Our People, Our Trust" which is a key enabler of delivering its strategic plan, operational plans, statutory duties and to help deliver the NHS Long Term Plan ambition to place ambulance services at the heart of urgent and emergency care.

The Trust reports to each Board meeting on key performance areas including workforce, clinical and finance. The Trust's financial plans include reporting on these wider areas as part of its mechanisms for monitoring the achievement of targets for each of the key performance areas. Where the Trust identifies a risk to target achievement, it incorporates the resulting identified mitigating actions into the BAF, which enables it to identify the necessary financial resources required to implement the actions.

The Trust publishes an Annual Report and Quality Account that report on the Trust's Performance against objectives.

The Chief Finance Officer has responsibility for monitoring compliance with Public Contract Regulations 2015 and any relevant Public Procurement Policy Notice's, including publishing all Contracts above £25,000 on Contracts Finder. Compliance with procurement legislation is incorporated into the Trust's Standing Orders, Standing Financial Instructions and Procurement Strategy. These are available to staff members of the Trust via the intranet. The Trust Board has a standing item to review procurement Items for approval. The Procurement Strategy and contract waivers is reviewed and monitored by the Audit and Risk Committee.

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Value for Money Commentary

Improving economy, efficiency and effectiveness: How the Trust uses information about its costs and performance to improve the way it manages and delivers its services (continued)

Significant weakness identified

Our audit work on the Trust's patient care income identified that the main contract was not signed by the Trust until after year end. Further, the contract variation in place to account for the changes in contract values initially agreed was not signed by both parties. We have therefore made a control recommendation within our Audit Results Report in respect of this internal control weakness.

Risk of significant weakness - CQC inspection findings

The risk arising in relation to the Governance criteria also impacted on the Improving Economy, Efficiency and Effectiveness criteria. Full commentary on the CQC inspection findings is included on pages 17 and 18 of this report.

The CQC findings set out earlier in the report also impact in relation to this criteria as the Section 64 letter issued by CQC raised specific concerns regarding the Trust's failure to adhere to the national standard for Category 2 (emergency situations requiring rapid assessment) response times. Since the CQC's last inspection in April and May 2022, where the Trust's Category 2 response times were falling far below the national standards expected, the CQC noted that the Trust has made some improvements.

Conclusion: Based on the work performed, we have identified that there is a lack of effective performance measurement systems to track response times, along with the lack of continuous improvement in practices since the last CQC inspection, which indicate a significant weakness in the Trust's arrangements for improvement specifically in the improving economy, efficiency. In particular, how it evaluates the services it provides to assess performance and identify areas for improvement. We have raised a recommendation on these weaknesses identified as indicated in the Governance criteria, therefore we have not repeated the recommendation here.

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04 Appendices

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Appendix A – Recommendations

VFM recommendations from 2025/26

The table below sets out the recommendations arising from the value for money work for the year 2025/26.
All recommendations have been agreed by Management.

Issue	Recommendation	Management response
Governance Improving economy, efficiency and effectiveness	The Trust should continue to engage with the CQC and closely monitor its delivery of plan to ensure that sufficient change and improvements are being made.	The Trust attends monthly engagement meetings with the CQC and responds to any enquiries in line with their deadlines. As part of ongoing monitoring, senior leaders and members of the internal compliance team undertake onsite inspections to ensure improvements have been embedded and to prepare for any future inspections.

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Appendix B – Prior Year Recommendations

Recommendations brought forward from previous years

The table below sets out the recommendations arising from the value for money work in the prior year, 2024/25, and progress made in the current year.
All recommendations have been agreed by Management.

Issue	Recommendation	Progress made in 2025/26
Financial sustainability	The Trust needs to continue monitoring the budget and take appropriate action to mitigate any variances from budget. This includes monitoring implementation of the Cost Improvement Programme to ensure delivery of the £14.9 million target for 2025/26 is on track throughout the year.	As the Trust has now met their breakeven duty and are no longer in a cumulative deficit, we are satisfied the Trust have actioned this recommendation effectively and as such this is no longer a recommendation for 2025/26. Action is implemented and closed.
Governance	The Trust should continue to engage with the CQC and closely monitor its delivery of plan to ensure that sufficient change and improvements are being made.	The Trust has not had a CQC inspection nor received the final CQC report within 2025/26. This recommendation therefore carries forward for 2025/26.

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Reporting To:	Trust Board	**Date:**	16.09.2026
Agenda Item:	PUB26/09/4.4		
Originating Meeting:	Audit and Risk Committee	**Date:**	22.07.2026
Committee Chair:	Victoria Corbishley, Audit Committee Chair		
Lead Director:	Steven Course, Chief Finance Officer		

Purpose:	Decision Approval		Discussion Review	x	Information Noting	

Link to CQC domain:		**Link to EEAST's Strategic Missions:**	
Caring		Patient Mission	x
Responsive		Partnership Mission	x
Effective	x	People Mission	x
Well Led	x	Productivity Mission	x
Safe			

Link to Strategic Risk:

SR1 Demand & Capacity	x	SR3 Estates	x	SR5 Cyber Security	x	SR7 Workforce Sustainability	x	SR9 Organisational Development	x
SR2 Quality Governance	x	SR4 Use of Resources	x	SR6 Partnership Working	x	SR8 Staff Retention	x	SR10 Digital	x

Alert: Items requiring Board Attention/ Action		
What? *Summary of the issue and data to demonstrate. Include key performance metrics (with trend where possible)*	**So What?** *What does this mean for the Trust, including importance, impact and risk rating (if applicable), and mitigation*	**What Next?** *Describe the action to be taken (tactical/strategic) and how this will be monitored/assured including named responsible lead(s) and clear timescales.*
There are no areas for escalation		

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Advise: Areas requiring ongoing monitoring		
What? *Summary of the issue and data to demonstrate*	**So What?** *What does this mean for the Trust, including importance, impact and/or risk*	**What Next?** *Describe the action to be taken (tactical/strategic) and how this will be monitored/assured*
Tenders and waivers Six waivers were approved in quarter one which is broadly compliant with the annual target of no more than 24 waivers in the year. All waivers were assessed as reasonable. Three retrospective waivers were approved. These related to historical contractual arrangements where the level of contractual cover was not in place at the point payment was requested.	Waivers allow exceptions where competitive procurement is not practical, but they must be justified and monitored to maintain transparency, reduce financial risk and prevent inappropriate spending.	Regular monitoring continues
Counter fraud The counter fraud progress report reported the Trust had achieved a green rating in its annual functional Standard return to NHS Counter Fraud. There are 21 open cases reported of which nine are being progressed through Employee Relations processes	Any fraud diverts limited NHS funding away from patient care and essential services. Effective prevention, detection and investigation protect public money, strengthen accountability and maintain confidence in the NHS.	Regular monitoring continues
Internal Audit Good progress has been made against the Internal Audit plan during Q1.	Internal audit provides independent assurance that the Trust's governance,	Regular monitoring continues

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A revised monthly process has been introduced to follow up on management actions required to support timely completion of agreed actions.	risk management and internal controls are effective. It helps identify weaknesses, supports timely corrective action and gives the Board confidence that public resources are being managed properly.	
External Audit The Annual Report for 2025/26 was received and considered by the Committee. An unqualified audit opinion was noted. The committee reviewed progress made on four recommendations that were carried forward from the 2024/25 external audit, noting that some actions were reliant upon external factors and outside the direct control of the Trust.	External audit provides independent assurance that the Trust's financial statements are accurate and comply with relevant requirements. It supports transparency, strengthens public confidence and helps the Board identify financial or governance issues requiring action.	Regular monitoring continues

Assure: Areas of positive improvement		
What? *Summary of the issue and data to demonstrate*	**So What?** *What does this mean for the Trust, including importance, impact and/or risk*	**What Next?** *Describe the action to be taken (tactical/strategic) and how this will be monitored/assured*
Losses and Special Payments No losses or special payments were reported in Q1	Losses and special payments are public funds lost or paid outside normal business activity such as theft, damage, or overpayments.	Regular monitoring continues.

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	Monitoring them is important because it supports financial control, accountability and transparency, while helping the NHS identify weaknesses and prevent future losses.	
Strengthening risk management Since January 2026, work has continued across directorates to improve the description of risks and the appropriate mitigation and management arrangements. This has resulted in the number of risks reducing from 178 to 154.	Clearer risks and mitigations help readers identify where further action is needed and what residual risks remain, enabling better prioritisation of high-impact areas.	More work is needed on ensuring the quality of entries is consistently high with updated review dates and clear owners.
Security Management The annual security management report highlighted progress, including a more structured approach to violence prevention and stronger links with partner agencies.	Protecting our staff is essential because they work in unpredictable environments and may face violence, aggression or abuse while delivering care. Effective security measures help keep staff safe, support their wellbeing and enable them to focus on delivering timely, high quality patient care. Reasonable assurance is noted	The ongoing roll out of body worn cameras will continue and conflict management training is being refreshed.
Risks		
What? *Summary of the issue and data to demonstrate*	**So What?** *What does this mean for the Trust, including importance, impact and/or risk*	**What Next?** *Describe the action to be taken (tactical/strategic) and how this will be monitored/assured*
Cyber security Cyber threats continue to evolve rapidly and constant vigilance is required from everyone to protect the Trust. Mandatory	Patient care depends on reliable digital systems and the safe handling of sensitive information. A successful	Cyber risk will be raised at the group meeting of Southern Ambulance Services Collective (SASC) to share and learn from

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cyber training is in place (compliance) and the Trust achieved the 2025/26 Data Protection Security Toolkit (DPST) standard. The Cyber Assessment Framework (CAF) internal audit has been completed.	cyberattack could disrupt essential services, delay treatment and compromise patient data.	good practice. The group will consider whether a shared approach to cyber awareness and phishing simulations could improve efficiency.
Freedom of Information (FOI) compliance There has been a period of non-compliance with freedom of information requests. Performance was reported as 73% (average compliance for NHS Trusts was 82% in 2025) Initial steps to address the issue included expanding the disclosure log and signposting individuals to this in the expectation it will reduce the number of requests.	Compliance with Freedom of Information requests demonstrates transparency and helps maintain public trust in the NHS. Failure to respond accurately and within statutory timescales can lead to regulatory action, reputational damage and increased scrutiny.	A FoI improvement action plan has been developed and is scheduled for discussion at Executive Team in August 2026. The Committee requested the plan is circulated outside the meeting cycle when approved to maintain momentum on this issue. FoI compliance is also being monitored through the Information Governance Group.

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Reporting To:	Public Board	**Date:**	16.09.2026
Agenda Item:	PUB26/09/4.5		
Originating Meeting:	Finance and Sustainability Committee	**Date:**	07.07.2026
Committee Chair:	Chris Brook, Committee Chair		
Lead Director:	Steven Course, Chief Finance Officer		

Purpose:	Decision Approval		Discussion Review		Information Noting	**x**

Link to CQC domain:		**Link to EEAST's Strategic Missions:**	
Caring		Patient Mission	
Responsive		Partnership Mission	
Effective	**x**	People Mission	
Well Led	**x**	Productivity Mission	**x**
Safe			

Link to Strategic Risk:

SR1 Demand & Capacity		SR3 Estates	**X**	SR5 Cyber Security	**X**	SR7 Workforce Sustainability		SR9 Organisational Development	
SR2 Quality Governance		SR4 Use of Resources	**X**	SR6 Partnership Working		SR8 Staff Retention		SR10 Digital	**X**

Alert: Items requiring Board/ Committee Attention/ Action

What?	**So What?**	**What Next?**
Progress continues to refine the BAF process and ensure risks are clear and have both the controls and actions associated with each area.	Clarify the actual risk posed to the Trust for sustainability, including the impacts on patients, the Trusts reputation and potential enforcement.	The CFO will progress the Sustainability action with the Head of Estates.

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This committee was not clear on the actual risks associated with Sustainability and the ability of the Board to respond to core questions associated with Cyber Security from the National Security Centre.	Board Development session to be scheduled on Digital to improve the ability of the Board to articulate the position for cyber.	The Director of Digital Innovation will progress the action on Cyber.
Within the Transformation portfolio there has been a longstanding action associated with benefit tracking which has yet to be resolved.	The finance committee would like assurance that the Trust can articulate the benefits of each initiative and track them accordingly.	The Director of Digital Innovation will utilise the Strategy & Change Board meeting to discuss how we improve in this area.

Advise: Areas requiring ongoing monitoring		
What?	**So What?**	**What Next?**
There was an improved budget surplus at month 3, which was £1.6m favourable to plan. The QCIP has delivered £3.7m, with 85% delivered.	There is sufficient tracking of the budget with all areas being closely monitored with detailed rationale for over or under spend. The Trust has been shielded from Fuel price volatility because they had fixed prices in advance. This position is now ending and requires close monitoring. There is a long term HMRC case which presents a risk to EEAST based on how GP's were paid to provide out of hours coverage, with a full settlement cost of £2.7m.	The budget will continue to be managed and monitored on a business as usual basis. The finance teams will monitor the position on Fuel charges. Some initial ideas were discussed in the committee and will be completed if costs increase and additional budget is required – close monitoring is required. The Trust feel we have a strong case to challenge the HMRC costs – the CFO will progress

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Assure: Areas of positive improvement		
What?	**So What?**	**What Next?**
The Trust is obliged to submit a report to NHS England on our activity and unit costs associated with the type of service we provide to patients so that benchmarking can be undertaken across the different Ambulance Trusts.	In terms of activity, the Trust had observed a 1% increase year on year, equating to 17k extra incidents. Relatively high-cost incidents had increased 8% and low-cost incidents had reduced by 9% year on year. From a unit cost perspective. Hear & Treat: £87 (down 4% YoY) See & Treat: £437 (up 1%) See & Convey: £586 (up 4%) This study is important as it confirms the Trust's strategy to ensure that the right care is provided to the right patient first time with the right associated cost.	Await the benchmarking results for all Ambulance Trusts so that we can compare EEAST's results, understand the areas to improve and learn from best in class performers.
Risks		
What?	**So What?**	**What Next?**
Summarised in previous sections.		

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Meeting:	Public Board of Directors	**Date:**	16.09.2026
Report Title:	Provider Capability Assessment 2026		
Agenda Item:	PUB26/09/5.1		
Author(s):	Edward Bradshaw, Company Secretary		
Lead Director:	Dr Hein Scheffer, Director of Strategic Partnerships and Governance		

Purpose:	Decision Approval	**X**	Discussion Review		Information Noting	
Assurance:	Limited		Reasonable	**X**	Substantial	

Link to CQC domain:		**Link to EEAST's Strategic Missions:**	
Caring	**X**	Patient Mission	**X**
Responsive	**X**	Partnership Mission	**X**
Effective	**X**	People Mission	**X**
Well Led	**X**	Productivity Mission	**X**
Safe	**X**		

Link to Strategic Risk:									
SR1	**X**	SR3	**X**	SR5	**X**	SR7	**X**	SR9	**X**
SR2	**X**	SR4	**X**	SR6	**X**	SR8	**X**	SR10	**X**

Equality Impact Assessment Undertaken: YES		**NO**	**X**

Previously considered by:

Iterations of the draft Provider Capability Assessment were reviewed by the Executive Leadership Team (ELT) on 1 and 8 September 2026.

Executive Summary:

What?

NHS England's Provider Capability Assessment is used alongside segmentation to provide a more comprehensive understanding of the level of regulatory oversight and support appropriate for each trust. The Assessment Framework outlines the key expectations of trust boards of directors and fosters a constructive, transparent relationship between trusts and NHS England regional oversight teams, based on a principle of 'no surprises'.

Trust boards are required to complete an annual self-assessment of their organisation's capability across six domains that are aligned to NHS England's *Insightful Provider Board* guidance:

- Strategy, Leadership and Planning
- Quality of Care
- People and Culture
- Access and Delivery of Services
- Productivity and Value for Money
- Financial Performance and Oversight

To guide boards in their self-assessment, the Assessment Framework has several supporting 'capability statements' within each of the six domains, as well as some indicative evidence (set out in the annex of Appendix 1) that trusts should consider in arriving at their conclusions. Trusts are required to RAG-rate their capability in each of the six domains but are not asked to provide an overall rating.

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Once submissions are received, NHS England regional teams triangulate the Trust's self-assessment with other information sources to develop a holistic view of the Trust's capability and assign an overall rating in line with table 1 below.

This regulatory exercise was first undertaken in October 2025, and the Trust was assigned an overall Provider Capability rating of **Amber-red**.

Rating	Indicative characteristics
Green High confidence in management	• Strong track-record across management team • No concerns with board's grip, • No reputational issues, system partner/other third-party concerns
Amber-green Some minor issues that should be addressed	• No material concerns, but some areas may require a • watching brief and as yet are not affecting quality of care, • delivery of core services, finance or the wider reputation of • the NHS, **or** • Trust in 'probation' – no concerns but trust capability • recovering from previous concerns before final assurance.
Amber-red Material issue needs addressing or failure to address major issues over time	• Serious governance/capability issues in at least one • domain or capability statement and/or • Trust recovering from red-rating below, with serious issues still present but evidence of improvement and grip
Red Significant and persistent concerns	• Serious issues in multiple domains **and/or** • Serious ongoing issues in a single domain that • management has been unable to address sufficiently over time • In breach of governance licence condition or likely to be.

Table 1: Provider Assessment Criteria RAG ratings

So What?

The draft self-assessment has been developed and iterated at executive management level over recent weeks. In completing the self-assessment, management have had regard to the following considerations:

1) The extent to which we are meeting each capability statement
2) The availability of evidence for the systems and processes referenced in our self-assessment
3) The need to evidence the improvements made since the last submission in 2025.
4) How the Trust compares to the indicative aspects of capability in the Annex of Appendix 1, and whether the proposed ratings are consistent with this.

The Board should note that, when the Trust completed this exercise in October 2025 NHS England required it to state whether it 'confirmed', 'partially confirmed' or had 'not met' the capability statements in each of the six domains. In 2026 the exercise has changed and the Trust has been asked to give an indicative RAG rating for each of the domains. The current proposals are as follows:

Domain	2025	2026
Strategy, Leadership and Planning	Partially confirmed	Green
Quality of Care	Partially confirmed	Green
People and Culture	Partially confirmed	Amber-Green
Access and Delivery of Services	Partially confirmed	Amber-Green

Unclassified - Trust Confidential

Productivity and Value for Money	Partially confirmed	Green
Financial Performance and Oversight	Confirmed	Green

What Next?

The Trust's 2026 self-assessment is required to be approved, signed by the Chair and Chief Executive and submitted to NHS England by Friday 2 October 2026.

NHS England's regional oversight team will review the self-assessment and triangulate this with other information including the trust's recent operational history, track record of delivery and third-party intelligence and, based on its assessment across the domains, propose a capability rating for the Trust as per the table below.

Proposed ratings will be reviewed in late 2026 by a provider capability moderation panel of regional and national directors. Following ratification, oversight teams will discuss the capability rating with the NHS trust and consider, in the round, the principal challenges the organisation faces, prioritising issues and the actions needed – for example, monitor something more closely, request follow-up action(s), or refresh the capability rating to reflect concerns if necessary.

There remains an ongoing requirement to notify NHS England in-year if the Board becomes aware of a significant change to its ability to meet any of the self-assessment criteria.

Action required by the Board

The Board is asked to **review and approve** the Trust's Provider Capability Assessment (Appendix 1) for sign-off by the Trust Chair and Chief Executive and submission to NHS England by 2 October 2026.

How does this report link with EEAST's vision, purpose and values?
https://www.eastamb.nhs.uk/about-us/our-corporate-strategy

The Provider Capability Assessment framework aligns closely with the Trust's strategic missions and provides an external mechanism for assessing the effectiveness of the Trust's governance, leadership and organisational delivery arrangements.

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Provider Capability Self-Assessment Return 2026

East of England Ambulance Service NHS Trust

Providers should use the form and the supporting annex to rate themselves across each domain and, following Chair and CEO sign-off, submit to their regional oversight lead by **5pm Friday October 2**.

I. Strategy, leadership and planning

Capability statements	**Proposed domain rating**
	Green
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners	*Trust to insert commentary here. To include the board's views and evidence supporting its proposed rating, taking account of* ○ *the domain's capability statements* ○ *governance arrangements to oversee this area **and** their effectiveness to date* ○ *any areas where the board has identified concerns and/or development needs and actions planned or in place to address these.* ○ *any relevant developments since the 2025 exercise.* The Board is satisfied that the Trust has a **clear and measurable strategy** (accessible here) which aligns organisational priorities with the needs of patients, staff, system partners and the direction set out within the *Fit for the Future* NHS 10-Year Health Plan. The strategy supports delivery of the Trust's ambition to provide the right care, every time, rather than an ambulance by default. During 2025/26, the Trust approved and commenced implementation of its strategy, which runs from 2025 to 2030. The strategy has four distinct 'missions' (patients, people, productivity, partnerships). Delivery of each mission is underpinned by a clear strategic framework supported by annual objectives, delivery plans and performance measures. Strategic delivery is monitored by the Board's committees and regularly reported to the full Board. The Board Assurance Framework helps to log, manage and mitigate the principal risks to delivery of the Trust's strategy. The Trust is compliant with the conditions of its provider licence and is not currently in breach of its provider licence. On 1 December 2025 NHS England agreed to discontinue all regulatory undertakings in force at that time.
2. **If in breach of licence:** The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE	
3. The board has the skills and expertise to deliver its strategy in the context of the 10-Year Health Plan.	
4. The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	

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5. The trust has an effective cyber security strategy and uses digital technology to support organisational improvement	The Trust Board of Directors **has the skills, experience and governance arrangements** necessary to oversee delivery of the Strategy. Annual Board effectiveness reviews and Board appraisal processes, supplemented by skills audits, ensure the capacity and capability of the Board members is kept under regular review. All Board members meet the requirements of the 'Fit and Proper Persons' regulations. There is regular time set aside in the corporate calendar for Board development activities, and a refreshed development programme is being created to provide further assurance that capability remains aligned to organisational requirements. **The Trust Board is stable**, with all executive directors having been in post for at least 12 months and a handful – including the Chief Executive – for over two years. There are no current vacancies within the executive team and all executive director positions are filled by substantive postholders. **Executive and senior manager development, together with effective succession planning**, remains a key area of focus for the Trust. The Remuneration Committee oversees executive succession planning to ensure leadership continuity and to support the future composition of the Board, taking into account the Trust's strategic challenges, opportunities, and evolving capability requirements. Over the past 12 months there has been some natural and expected turnover in non-executive directors as their terms have come to an end. The Trust's Chair's term ended in May 2026 and **recruitment of a substantive successor Chair is due to commence in October 2026**. The Interim Chair, who was previously a non-executive director at the Trust, has been in the role since June 2026 and brings significant experience and a strong understanding of the organisation, ensuring continuity of leadership during this period. The Trust is also currently working with NHS England to recruit a successor to the Non-Executive Chair of the People Board Committee, as the current postholder will complete her tenure in December 2026. The Trust has typically held a number of associate non-executive director roles to facilitate succession planning for non-executives. Non-executive directors maintain close bilateral working relationships with the executive leads responsible for the areas in which they are most actively involved. In line with NHS England guidance the Trust has a number of non-executive director 'champion' roles; these are set out in the **Trust's Board Governance Assurance Framework** which is updated annually and approved by the Board. The Trust recognises that delivery of its strategic ambitions cannot be achieved in isolation and depends on **effective partnership working** across the wider health and care system. The Trust **continues to work collaboratively** with the Integrated Care Boards (ICBs), provider collaboratives, and acute providers across its footprint, and wider partners both locally and nationally, to improve urgent and emergency care pathways, support system resilience and deliver shared priorities.

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	Partnership working is evidenced through the Trust's comprehensive winter plan, urgent care coordination initiatives, hospital flow programmes and strategic planning aligned to system objectives. Individual members of the Trust Board – including both the Chair and Chief Executive – **regularly meet system partners** to discuss issues, risks, challenges and opportunities. Many of these meetings are ad hoc, in response to specific matters arising and as part of the collaborative arrangements described above. Relations across the system are good and well developed and there are open discussions about the challenges we collectively face. The Trust is exploring how it can more regularly host senior representatives of its key system partners as part of a refreshed Board development programme. Although the ICB landscape has recently changed and is still evolving, the Trust is increasingly positioning itself as a **system partner and enabler**, aligning its approach across the three ICBs within its footprint and supporting the development of more coordinated, **neighbourhood-based** models of care, in line with the ambitions set out in the 10-year health plan. The Trust has a **cyber security plan** that is based on the national NHS cyber risk profile. The Board regularly receives assurance reports regarding the effectiveness of its **cyber security, digital maturity and information governance** arrangements through its Finance and Sustainability and Audit and Risk committees. As a prominent strategic risk on the Trust's Board Assurance Framework, cyber security is actively managed and its status is reported to each bi-monthly full Board meeting. As at mid-September the risk score was static at 12; whilst this exceeds the tolerance of 9 in the Trust's risk appetite statement, it indicates the risk is generally being well-controlled. Digital transformation and technology-enabled improvement form an integral part of delivery planning and support organisational improvement, operational effectiveness and patient care. One channel for enabling this transformation is the Digital Improvement Group, which acts as a single portal for all digital requests. The Trust plans to review its governance arrangements around cyber security and digital to ensure these remain fit for purpose. This is likely to involve the establishment of an annual report to the Board from the Senior Information Risk Officer that would cover cyber security and information governance more broadly.

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II. Quality of care

Capability statements	Proposed domain rating
	Green
6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt). 7. The trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients 8. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	*Trust to insert commentary here. To include the board's views and evidence supporting its proposed rating, taking account of* ○ *the domain's capability statements* ○ *governance arrangements to oversee this area **and** their effectiveness to date* ○ *any areas where the board has identified concerns and/or development needs and actions planned or in place to address these.* ○ *any relevant developments since the 2025 exercise.* The Board is satisfied that the Trust has robust arrangements in place to monitor, assess and continuously improve the **quality and safety of care** provided across, patient safety, incidents, complaints and other key measures. The Trust's Quality Account 2025/26 (accessible here) provides details of the quality of the services provided to patients during that financial year. Quality of care is closely overseen at an executive level by the Quality Regulatory Assurance Group and at a Board level by the Quality Governance Committee. This Committee **provides assurance to the Board** on the efficacy of the Trust's quality governance arrangements and the delivery of safe, effective and compassionate care in line with the Trust's strategic objectives and statutory duties. Oversight is enabled by a comprehensive suite of clinical metrics in the Trust's Integrated Performance Report (IPR), and supplemented by patient safety incidents and reports, clinical audits, patient experience feedback, complaints, learning from events, and thematic quality reviews. During 2025/26, the Trust continued implementation of its Quality Improvement Programme, including actions arising from **Care Quality Commission (CQC) findings**. Through Rapid Quality Review meetings over the last 18 months, the Trust has monitored and reported improvements in appraisals, mandatory training, recruitment and performance that has enabled normal surveillance to return to quality apart from staff engagement and culture. The Board has maintained oversight of delivery through regular reporting and has received assurance regarding progress against agreed improvement actions, strengthened governance arrangements and improvements in quality monitoring processes.

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	The Trust had a recent monitoring inspection from Ofsted which shows **reasonable progress** has been made across all areas. This has provided assurance that our education model for our apprentices is providing a positive and safe experience. **Patient experience remains central** to governance and decision-making. Patient stories are routinely presented to the Board, and assurance is provided through Community Engagement Group reporting, Friends and Family Test feedback, complaints analysis and wider patient engagement activity. Established escalation routes ensure that emerging safety concerns are promptly reviewed and addressed at executive and Board level. Board directors, both executive and non-executive, **regularly visit locations where care is provided** to get views of staff and patients and triangulate this with the information they receive through reports and other data sources. Feedback from these visits is provided to relevant staff to enable improvements to be made. The **Patient Safety Incident Response Framework (PSIRF)** is in place at the Trust and is a key platform to maintain and improve the quality of care by promoting learning from patient safety incidents and enhance the culture of safety. The Trust has a **risk on its Board Assurance Framework** regarding the potential “avoidable harm to patients, adverse clinical outcomes and poor patient experience”. This risk is owned and actively managed on behalf of the Board by the Quality Governance Committee. As at mid-September the risk score was static at 9, with the Board confidence the risk was being managed effectively, although the score remained greater than the tolerance of 4 in the Trust’s risk appetite statement. The Board is satisfied that **quality governance arrangements are effective**, subject to ongoing review and refinement, and support an open and learning culture, while recognising that continuous improvement remains essential.

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III. People and culture

Capability statements	Proposed domain rating
	Amber-Green
9. Staff feedback is used to both improve the quality of care provided by the trust and monitor and improve staff experience 10. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels 11. Staff can express concerns in an open and constructive environment	*Trust to insert commentary here. To include the board's views and evidence supporting its proposed rating, taking account of* ○ *the domain's capability statements* ○ *governance arrangements to oversee this area **and** their effectiveness to date* ○ *any areas where the board has identified concerns and/or development needs and actions planned or in place to address these.* *any relevant developments since the 2025 exercise.* The Board's understanding of organisational culture and workforce experience is informed through multiple sources of evidence, including the Trust's *Big Conversation* engagement programme, NHS Staff Survey results, Freedom to Speak Up reporting, Time to Listen events, engagement with Unions, co-design, staff networks, workforce equality indicators, monthly Executive-led question and answer sessions and an independent cultural review commissioned by the Board. Taken together, these sources **provide a comprehensive and evidence-based assessment** of culture, staff experience and organisational behaviours, enabling the Board to identify areas of progress and those requiring further attention. The Board places considerable importance on the outcomes of the annual NHS Staff Survey and receives reports on the Survey results and the actions being taken in response. In the 2025 NHS Staff Survey results the Trust achieved a 61% response rate from substantive staff and 31.5% from Bank Staff; **this was the Trust's highest in over nine years** and both were above the average for participating ambulance trusts. Among the eight participating ambulance trusts, the Trust moved to fourth place for overall change in scores, having previously ranked as the most improved trust for three consecutive years. The Board noted that a key advocacy indicator (recommendation as a place to work) fell to 38%, a reduction of 7% from the previous year, and the Trust's work to address this, and other areas highlighted by the Survey, are overseen by the People Committee. The **evidence demonstrates that the Trust has continued to make meaningful progress** in strengthening organisational culture over recent years. Improvements have been seen in staff engagement, speaking up, inclusion, leadership visibility and the mechanisms available for staff to influence organisational decision-making. The Board has increased its focus on culture through initiatives such as the *Big Conversation* programme, enhanced engagement with staff networks and regular review of workforce and cultural indicators.

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	Working in partnership with its Staff Side, Trust management has established a **Staff Partnership Forum** to help foster good industrial relations, avoid misunderstandings and promote joint participation in all matters of common interest and concern on a genuine consultative and negotiating basis at Trust level. The Trust also has several **staff networks**, each of which is led by an executive and non-executive director. These networks provide a supportive and inclusive forum where employees with shared backgrounds, interests, or experiences can connect, amplify their voices, and create a direct link between colleagues and the Board to help inform decision-making and drive positive organisational change. The Board therefore recognises, however, that while significant progress has been made in improving culture, governance, inclusion and staff engagement, the **Trust's values and expected behaviours are not yet experienced consistently across all parts of the organisation.** Whilst many of the foundations for a positive culture are now in place, the Board remains concerned that fundamental behavioural change has not yet been fully embedded across the organisation. In recognition of this, an independent cultural review was commissioned to provide objective insight into the Trust's cultural maturity, identify underlying barriers to sustained behavioural change and inform the next phase of organisational development. The Board received an informal briefing on the emerging findings of this review on 24 September. **The Board receives regular assurance** via the People Committee, regarding workforce performance, NHS Staff Survey outcomes, workforce equality standards, staff wellbeing, learning and development, staff retention, sickness absence and employee relations activity. The Trust has maintained focus on **workforce capability** through workforce planning, leadership development, mandatory training compliance and professional development programmes. Following actions taken during 2026/27, **training compliance improved** with statutory and mandatory training rates increasing from 90.6% in July 2025 to 94.8% in July 2026. This remains subject to ongoing Board oversight. Annual appraisals are also in a stronger and more sustained position as these improved from 83.3% in July 2025 to 90.6% in July 2026. The appraisal process provides an opportunity for managers to review the skills of the staff they manage versus the requirements of the jobs they deliver, and to consider any further development needs that can be addressed either through the Trust's own learning and development programmes or through external means. Independent Freedom to Speak Up arrangements and enhanced approaches to respectful resolution provide assurance that staff **are able to raise concerns** in an open and constructive environment. Both executive management and the Board review speaking up trends

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	and receives assurance regarding associated actions, themes and outcomes. The Audit and Risk Board Committee is responsible for keeping under review the efficacy of the Freedom to Speak Up service and its ability to ensure concerns raised by staff are addressed. The Trust has **three people-related risks on its Board Assurance Framework** regarding workforce sustainability, staff retention and organisational development. The risks are owned and actively managed on behalf of the Board by the People Committee. As at mid-September the risk scores were, respectively, 6, 8, and 8, all against tolerance levels of 4. The Board is satisfied that effective arrangements are in place to understand workforce experience, develop workforce capability and respond to staff concerns, whilst recognising that embedding a consistently positive culture requires sustained leadership focus and continued organisational commitment.

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IV. Access and delivery of services

Capability statements	Proposed domain rating
	Amber-Green
12. Plans are in place to improve performance against the relevant access and waiting times standards 13. The trust can identify and address inequalities in access/waiting times to NHS services across its patients 14. Appropriate population health targets have been agreed with the ICB	*Trust to insert commentary here. To include the board's views and evidence supporting its proposed rating, taking account of* ○ *the domain's capability statements* ○ *governance arrangements to oversee this area **and** their effectiveness to date* ○ *any areas where the board has identified concerns and/or development needs and actions planned or in place to address these.* ○ *any relevant developments since the 2025 exercise.* The Trust Board recognises that operational performance remains challenging, driven by high demand for the Trust's services, but is satisfied that performance data shows evidence that the Trust has **credible plans in place to sustainably improve operational performance** and work with partners and the NHS England regional team towards restoring delivery against national standards. Performance is monitored through the information presented on the Trust's Integrated Performance Report which is regularly reviewed at both an executive and Board level, and is published on the Trust website for transparency. The Trust has continued implementation of its **Operational Performance Improvement Programme** and has maintained oversight of recommendations arising from external reviews and benchmarking activity. The Board maintains a **comprehensive understanding of the factors influencing operational performance** including system flow, hospital handover delays, workforce availability and demand pressures. Improvement activity continues to focus on ambulance response performance, patient flow, Emergency Operations Centre (EOC) effectiveness and system coordination. The Trust has a **risk on its Board Assurance Framework** regarding the potential failure to match capacity to demand, and the associated inability to improve response times. This risk is owned and actively managed on behalf of the Board by the Performance Committee. As at mid-September the risk was the highest-rated strategic risk on the BAF, at 16 versus a tolerance of 6. The Trust has strengthened its focus on **health inequalities and population** health through completion of a health inequalities self-assessment and development of a multi-year improvement programme aligned with population needs and system priorities. The Board receives assurance regarding progress and partnership working with **Integrated Care Boards and** other system organisations. The

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	Trust continues to work with partners to align population health ambitions and delivery priorities. The Board recognises that delivery of access standards remains impacted by wider system pressures but is satisfied that credible improvement plans are in place, are actively monitored and are delivering measurable progress.

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V. Productivity and value for money

Capability statements	Proposed domain rating
	Green
15. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	*Trust to insert commentary here. To include the board's views and evidence supporting its proposed rating, taking account of* o *the domain's capability statements* o *governance arrangements to oversee this area **and** their effectiveness to date* o *any areas where the board has identified concerns and/or development needs and actions planned or in place to address these.* o *any relevant developments since the 2025 exercise.* The Board is satisfied that **productivity improvement** forms a core component of organisational planning, performance management and resource allocation. The Trust routinely uses benchmarking data, operational metrics, external reviews and performance intelligence to understand productivity drivers and identify opportunities for improvement. Productivity is considered alongside quality, patient experience and workforce wellbeing to ensure that improvements are sustainable and support safe care delivery. During the year the Trust has continued to prioritise operational productivity measures, with the Board overseeing delivery of improvement programmes aimed at increasing operational efficiency, improving resource utilisation and maximising value from public funds. **Performance and productivity improvement plans** are regularly reviewed through Board committees and assurance reporting structures. Key achievements this year include improved response times across all categories, consistently meeting national 999 call answer targets, increased patient-facing staff hours during peak demand, and a growing proportion of patients safely supported without the need for ambulance dispatch. The Board is satisfied that it understands the key drivers of productivity and has appropriate mechanisms in place to identify, monitor and deliver improvement opportunities across the organisation.

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VI. Financial performance and oversight

Capability statements	Proposed domain rating
	Green
16. The trust has a robust financial governance framework and appropriate contract management arrangements 17. Financial risk is managed effectively, and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes 18. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	*Trust to insert commentary here. To include the board's views and evidence supporting its proposed rating, taking account of* ○ *the domain's capability statements* ○ *governance arrangements to oversee this area **and** their effectiveness to date* ○ *any areas where the board has identified concerns and/or development needs and actions planned or in place to address these.* ○ *any relevant developments since the 2025 exercise.* The Board is satisfied that **robust financial governance arrangements** are in place and operating effectively. **Regular oversight of the Trust's financial performance** is provided by the Board and particularly closely by its Finance and Sustainability Committee. The Audit and Risk Committee receives reports from internal and external auditors that enable it to take assurance around the robustness of the core financial systems in place and the accuracy of the financial information produced. The Board receives regular assurance regarding financial performance, efficiency delivery, financial risks and mitigation plans. The Trust continues to maintain a strong focus on financial sustainability, delivery of efficiency programmes and recurrent savings. Financial decisions are supported through **established governance processes** and quality impact assessments, ensuring that financial considerations do not adversely affect patient safety, quality of care or clinical outcomes. As part of the Board's focus on the Strategic Risks identified in the BAF, the Board routinely considers workforce, operational and financial information together to support effective decision-making and ensure that **underlying drivers of financial performance** are understood. Internal and external assurance reviews have provided confidence in the effectiveness of governance, risk management and control processes. The Trust has a **risk on its Board Assurance Framework** regarding financial sustainability. This risk is owned and actively managed on behalf of the Board by the Performance Committee. As at mid-September the risk was scored at 6, well within its tolerance level of 12. The Trust continues to **engage actively with system partners** regarding resource allocation, financial planning and delivery of

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	system objectives. The Board is satisfied that appropriate arrangements are in place to manage financial risk, support system sustainability and deliver value for taxpayers.

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Signed on behalf of the Board of Directors

Chair: Julie Thallon

Signature: _____ Date: _____

Signed on behalf of the Board of Directors

Chief Executive: Neill Moloney

Signature: _____ Date: _____

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Annex: Using a RAG-rating approach to derive the rating – guidance for providers

The table below sets out the approach providers should take to assess themselves across the six domains. Providers should set out, in their return template, a commentary covering the rationale behind each domain's rating, the evidence referenced in their return and improvements made since the last submission in 2025.

Note that regions will take their own views of capability across the board and will not have the level of detail that providers have – while the evidence here supports the rating it should not be considered automatic or algorithmic in every instance, rather it sets a general benchmark around different levels of capability taking account of the statements.

Leadership and strategy	
Overarching expectation: the trust's board is working well as a unit to oversee the provider and has effective relationships with system partners and stakeholders. The board demonstrates the skills to oversee the delivery of safe, sustainable services, plans effectively and receives the right information to oversee performance and plan delivery as well as monitoring internal and external risk factors.	
Capability statements	**Indicative evidence**
1. The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners 2. **If in breach:** The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE 3. The board has the skills and expertise to deliver its strategy in the context of the 10-Year Health Plan. 4. The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	*The following are indicative aspects of each level of capability but should not be seen as exhaustive* **Green** • Strategy is coherent, measurable, aligned with provider's objectives and system priorities. • **If in breach:** all undertakings being delivered; regulatory confidence restored and trust on track to compliance • Board has requisite range of skills; development plans active; succession plans in place; no vacancies > 3 months; no interims > 6 months. • Strong collaboration with local partners; joint planning; shared outcomes delivered. • Regular board reporting on cybersecurity matters, cyber built into Board Assurance Frameworks; digital strategy embedded. **Amber-Green** • Strategy mostly aligned with the provider's objectives but lacks depth or consistent delivery. • **If in breach:** On track to compliance with credible plans; minor slippage only. • Skills mostly adequate; some gaps recognised and being addressed.

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5. The trust has an effective cyber security strategy and uses digital technology to support improvement	• Good relationships with system partners but inconsistent joint delivery. • Cybersecurity is mostly well-managed, but some areas lack maturity or consistency. • Concerns from independent board governance reviews or CQC well-led findings in past 6 months that are in hand **Amber-Red** • Strategy unclear, outdated, or inconsistently applied. • **If in breach:** Behind trajectory on return to compliance; repeated slippage; weak assurance. • Significant capability gaps at board level; weak development; over-reliance on individuals. • CQC well-led 'requires improvement' • Patchy collaboration; strained relationships; siloed behaviour. • Outdated systems; weak cyber assurance; limited digital use. **Red** • No credible strategy; board direction fragmented. • **If in breach:** persistent non-compliance; enforcement actions escalating; board grip absent. • Board lacks a number of core skills; no development; unsafe capability. • CQC well-led 'Inadequate' • Board isolated; system relationships dysfunctional. • No credible cyber strategy; repeated material incidents.
Quality oversight	
Overarching expectation: the trust's board is set up for effective oversight of the quality of care it provides, monitoring safety, patient experience and using insights from third parties as appropriate. This is evidenced by robust information going to boards, a track record of high-quality care and an open, curious and enquiring approach on quality issues from executives and non-executives alike.	
Capability statements	**Indicative evidence**
6. The organisation has regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt).	*The following are indicative aspects of each level of capability but should not be seen as exhaustive* **Green** • Guidance is used effectively to drive improvements in quality of care. • Established quality governance arrangements in place; confidence in early warning systems; systems of triangulation identify issues before they become critical

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7. The trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients 8. Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	• Patient experience embedded in discussions around quality; concerns reach board quickly. **Amber-Green** • Mostly compliant with guidance and it is generally used to improve care; • Some gaps in the effectiveness of quality oversight e.g. escalation approaches or learning from close calls. Triangulation is used in places. • Systems in place to monitor patient experience but aren't always used consistently to escalate. **Amber-Red** • Guidance applied inconsistently • Board tends to be reactive to quality issues and actions to address issues are not consistently effective. • Limited insight into patient experience; slow escalation; weak or non-existent triangulation. **Red** • No regard for guidance; blind spots in safety and complaints. • Quality governance failing; evidence from third parties that serious risks are unmanaged. • No reliable patient experience monitoring.
People and culture	
Overarching expectation: the board has an accurate, evidence-based view of the trust's culture and improves the organisation as a place to work. This is evidenced by: staff input being collected, valued and used in board decisions; staff being able to speak up where they have concerns; and staff have access to training and other opportunities to carry out their roles as well as possible.	
Capability statements	**Indicative evidence**
9. Staff feedback is used to both improve the quality of care provided by the trust and monitor and improve staff experience 10. Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels 11. Staff can express concerns in an open and constructive environment	*The following are indicative aspects of each level of capability but should not be seen as exhaustive* **Green:** • Evidence that staff feedback drives improvement; strong culture indicated by high scores in staff survey, and Staff Standards measures. • Workforce plans credible; training embedded across the organisation; safe staffing levels in place and reviewed regularly. • Strong speaking-up culture. **Amber-Green** • Feedback collected but not consistently acted on. • Staff skills are mostly adequate but there may be gaps/insufficient depth in key areas. • Generally open culture; some pockets of concern in specific areas of the staff survey.

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	Amber-Red • Feedback intermittently collected or when reported is out of date; limited impact on care or management actions. • Persistent gaps in skill levels in key areas; weak/ineffective training; • Evidence that staff groups indicate fear of speaking up; insufficient insights at board level. • Persistently lowest quartile in NHS staff survey **Red** • Persistent lowest 10% in NHS staff survey • Staff feedback ignored; culture deteriorating. • Unsafe staffing; no development in staff. • Evidence of a toxic culture; concerns suppressed.
Access and delivery of services	
Overarching expectation: the board understands the drivers of delivery of core national access standards and uses this to optimise the trust's performance. The Board has extracted the maximum reasonable performance from the resources, workforce and authority available to it, and does all it can to mitigate the impact of external factors.	
Capability statements	**Indicative evidence**
12. Plans are in place to improve performance against the relevant access and waiting times standards 13. The trust can identify and address inequalities in access/waiting times to NHS services across its patients 14. Appropriate population health targets have been agreed with the ICB	*The following are indicative aspects of each level of capability but should not be seen as exhaustive* **Green** • Generally delivering on trajectory vs plans. • Clear knowledge/awareness of access and care levels across local geography and demographics in order to identify and address inequalities; can demonstrate measurable improvement. • Targets aligned with system partners; joint delivery plans in place where necessary (e.g. with provider collaborative partners). **Amber-Green** • Plans credible but inconsistent delivery. • Inequalities in access/care identified; actions underway but not yet fully addressing issues. • Targets aligned with system partners; joint delivery plans in place as necessary (e.g. provider collaborative) but not fully implemented or delivering desired outcomes. **Amber-Red**

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	• Under-delivery or deterioration in performance but board cannot demonstrate a credible plan to address it; • Underperforming local peers with no evidence of mitigating factors • Known variation in the quality of and access to services but little or no evidence of addressing them. • Limited engagement across system partners to deliver access standards. **Red** • Behind trajectory on multiple access measures with no credible plan to address. • No insights into inequalities by demographic. • No engagement with rest of system
Productivity and value for money	
Overarching expectation: the board understands how workforce, estate, asset utilisation, activity and provision of care interact at the trust to drive productivity. This is evidenced by a track record of improvements in productivity that are delivered within the wider context of quality of care and patient experience.	
Capability statement	**Indicative evidence**
15. Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	*The following are indicative aspects of each level of capability but should not be seen as exhaustive* **Green** • Board understands drivers of productivity and can use them to improve use of resources; provider in top 25% vs peers • Productivity improvements are discussed in the context of quality of care, patient experience and staff wellbeing **Amber-green** • Board has good insights and credible plans but has not fully extracted efficiencies • Performance vs peers flat/declining <12 months **Amber-red** • Board is aware of poor productivity and associated symptoms but has been unable to address them • Declining productivity vs peers >12 months **Red** • Board cannot explain the drivers behind poor productivity, quantify the upside or deliver improvement • Persistent bottom quartile in benchmarks vs peers

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Financial performance and oversight	
Overarching expectation: the trust's board demonstrates a good financial understanding and literacy, leads the forecasting and risk management process and has a track record of overseeing the delivery of financial plans and efficiencies and offers strong challenge and insight. There is effective triangulation of workforce, activity and finance in both forward planning and in-year oversight.	
Capability statements	**Indicative evidence**
16. The trust has a robust financial governance framework and appropriate contract management arrangements 17. Financial risk is managed effectively, and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes 18. The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	*The following are indicative aspects of each level of capability but should not be seen as exhaustive:* **Green** • Track record of delivering financial plans 'without surprises'; cost improvement programmes are generally delivered • Executives and Non-Executives understand the drivers of the trust's financial position and the board links finance discussions to quality of care, operational demand and workforce • Financial risks are reviewed regularly at board level; • Strong links between trust and system planning functions; supports system outturn. Impact of external factors outside the board's control are minimised **Amber-Green** • Occasionally off-plan, but generally returns to plan over time and by year-end • Cost improvement programs are delivered, but below forecast • Minimal reliance on one-off mitigations to hit plans **Amber-Red** • Understands headline numbers but struggles to explain or control how underlying drivers affect financial performance. • Unplanned reliance on agency/bank staff • Has recurring forecasting inaccuracies and missing planned performance – may rely on one-off mitigations to ameliorate under-performance • Shows weak linkage between workforce, activity levels, quality of care and financial performance. **Red** • Persistent plan under-delivery, with frequent unexplained in-year deterioration in performance vs plan, and little confidence in forecasts. Consistently misses savings targets. • Unplanned reliance on agency/bank staff

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	• Board cannot clearly articulate factors behind the organisation's financial position; weak board-level financial governance, poor scrutiny of financial information and the factors behind performance • Track record of reliance on external support, regulatory intervention or year-end bailouts; little connection with system partners on financial planning and investment.

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East of England Ambulance Service NHS Trust

CONFIRMED

MINUTES OF THE EAST OF ENGLAND AMBULANCE SERVICE NHS TRUST CORPORATE TRUSTEE MEETING HELD IN PUBLIC ON WEDNESDAY 10 JUNE 2026 at EEAST HEADQUARTERS, MELBOURN HQ, SG8 6NA

Present:			
Members	Julie Thallon	Interim Trust Chair	TC
	Catherine Glickman	Non-Executive Director	NED-CG
	Chris Brook	Non-Executive Director	NED-CB
	Darren Meads	Chief Operating Officer	COO
	Dr Hein Scheffer	Director of Strategy, Transformation and Governance	DoSTG
	Marika Stephenson	Chief People Officer	CPO
	Neill Moloney	Chief Executive Officer	CEO
	Sian Clark	Director of Digital Innovation	DDI
	Dr Simon Walsh	Medical Director	MD
	Steven Course	Chief Finance Officer	CFO
	Susan Wilkinson	Non-Executive Director	NED-SW
	Victoria Corbishley	Non-Executive Director	NED-VC
In attendance			
	Danielle Marshall	The Guardian Service *(PUB26/06/4.4 only)*	FTSUG-DM
	Kimberley Gillingham	The Guardian Service *(PUB26/06/4.4 only)*	FTSUG-KG
	Jacquie Pamphilon	The Guardian Service (PUB26/06/4.4 *only*)	FTSUG-JP
	Julie Young	Interim Company Secretary	CS
	John Newman	CEG Representative	CEGR
	Paul Gates	Deputy Chief Paramedic	CP
	Tom Bennett	Head of Communications	HoC
Administration	Esther Kingsmill	Head of Corporate Governance	HoCG

PUBLIC SESSION (Disclosable)	
The meeting commenced at 12:20	
PUB26/04/07	**CORPORATE TRUSTEE**
7.1	**Minutes of the Previous Meeting** The minutes of the meeting held on 08.04.2026 were approved as an accurate record.
7.2 7.2.1	**Charitable Funds Committee Assurance Report** Non-Executive Director and Committee Chair, Victoria Corbishley (NED-VC) presented the report: • It was highlighted how the charity had supported the video cardiac arrest pilot which was received as a Public Board story. • She reflected on whether the charity branding was being effectively communicated and how this branding could be better enhanced so people could understand the role, value and impact of the charity. • There was a reasonable level of unrestricted funds.

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	• The draft charity annual accounts were noted.
7.3	**Date of Next Meeting: Wednesday 16 September 2026.**

The meeting closed at 12:30

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Meeting:	Corporate Trustee	**Date:**	16/09/2026
Report Title:	Charity Policies for Approval		
Agenda Item:	CT26/09/7.2		
Author(s):	Ed Davison, Head of Financial Governance and Compliance		
Lead Director:	Steven Course, Chief Finance Officer		

Purpose:	Decision Approval	**X**	Discussion Review		Information Noting	
Assurance:	Limited		Reasonable		Substantial	X

Link to CQC domain:		**Link to EEAST's Strategic Missions:**	
Caring		Patient Mission	
Responsive		Partnership Mission	
Effective		People Mission	
Well Led		Productivity Mission	
Safe			

Link to Strategic Risk:									
SR1		SR3		SR5		SR7		SR9	
SR2		SR4		SR6		SR8		SR10	

Equality Impact Assessment Undertaken: YES		**NO**	
Previously considered by:			
Charitable Funds Committee			

Executive Summary:

What?

The attached policies have been reviewed by the Charitable Funds Committee and are presented to the Corporate Trustee for approval:

Investment Policy
Risk Management Policy
Reserves Policy
Charity Cash Handling Policy
Complaints Procedure

The policies form part of the Charity's governance framework and set out the arrangements for the management of charitable funds, investments, reserves, risk, cash handling and complaints.

The Charitable Funds Committee has scrutinised the policies and is satisfied that they provide an appropriate framework for the management and oversight of the Charity. The Committee therefore recommends their approval by the Corporate Trustee.

So What?

As Corporate Trustee, the Board is responsible for ensuring appropriate governance arrangements are in place to support the effective stewardship of charitable funds and compliance with relevant

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charity governance requirements. The policies provide a clear framework through which those responsibilities can be discharged.

The policies are being presented directly to the Corporate Trustee following consideration by the Charitable Funds Committee. This reflects the distinction between the Board's role as an NHS Trust Board and its separate role as Corporate Trustee of the Charity.

Presenting charity matters through the Charitable Funds Committee and then directly to the Corporate Trustee helps maintain clear accountability for trustee decisions and avoids potential ambiguity regarding whether decisions are being taken in the Board's NHS Trust capacity or its charity trustee capacity. It also strengthens the separation between Trust and Charity governance arrangements and ensures clear decision-making responsibility for charitable funds matters.

What Next?

Subject to approval, the policies will take effect immediately and will form part of the Charity's governance framework.

The Charitable Funds Committee will continue to oversee compliance with the policies through its delegated assurance role and will recommend any future amendments to the Corporate Trustee for approval.

Action Required by the Corporate Trustee:

The Corporate Trustee is asked to approve the:

Investment Policy;
Risk Management Policy;
Reserves Policy;
Charity Cash Handling Policy; and
Complaints Procedure.

as recommended by the Charitable Funds Committee.

How does this report link with EEAST's vision, purpose and values?

https://www.eastamb.nhs.uk/about-us/our-corporate-strategy

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Complaints Procedure

Document Reference	TBC
Document Status	Draft
Version:	V1.0

DOCUMENT CHANGE HISTORY		
Initiated by	**Date**	**Author (s)**
The requirement for the Trustee to adopt a complaints procedure	December 2024	Ed Davison, Head of Financial Governance and Compliance. Linda Gove, Head of Corporate Governance
Version	**Date**	**Comments**
V0.1	22 January 2025	Reviewed by Charitable Funds Committee and recommended to Board
V1.0	16 September 2026	Review for approval at Board

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Recommended at Date	Charitable Funds Committee 22 January 2025
Approved by Date	Trustee 16 September 2026
Valid Until Date	January 2028
Equality Analysis	Y
Linked procedural documents	N/A
Dissemination requirements	Charity stakeholders
Part of Trust's publication scheme	No

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The East of England Ambulance Service NHS Trust Charitable Funds Charity Complaints Procedure

1.0 Purpose

1.1 The East of England Ambulance Service NHS Trust Charitable Funds Charity is committed to working in an open and accountable manner that builds the trust and respect of all its stakeholders. The Charity wants to ensure the highest standards across all its activities.

1.2 This document sets out the Charity's process for dealing with complaints. It sets out the procedure to be followed by those wishing to make a complaint and explains how the Charity will respond.

1.3 This procedure covers complaints about any aspect of the Charity's work and reflects the Trustee commitment to the Fundraising Code and Fundraising Promise.

1.4 The Charity recognises that occasionally people may be dissatisfied or concerned about their interactions with the Charity, and it is anticipated that problems can be readily reconciled between the parties concerned. If not, the Charity will deal with complaints promptly, impartially, and in confidence.

1.5 Complaints related to the delivery of treatment and care by the NHS Trust (Corporate Trustee) are not covered by this policy. All such complaints must be made to the Trust using its own complaints policy and process.

2.0 Background

2.1 One way the Charity can continue to improve activity is by listening and responding to the views of stakeholders and responding to complaints and learning from the situation.

2.2 The Charity takes complaints seriously and treat them as an opportunity to develop and thanks people who take the time to help it improve.

2.3 Reasons for making a complaint might include:

- A failure of an activity, service or system which affects an individual or a group of people, causing inconvenience, upset or loss
- Marketing/fundraising collateral which is misleading, inaccurate or has caused upset or offence
- Personal contact with a staff member or representative of the Charity which was inaccurate or misleading or which has caused upset or offence.

The following would **not** be treated as complaints:

- A simple request for removal from the Charity's database
- A request for other data markers to be removed or corrected
- A change of contact details
- A comment or remark with no response expected/required

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2.4 The Charity will accept any complaint in good faith. However, complaints made on the basis of discrimination, or malicious or vexatious complaints will not be tolerated. In order to protect its representatives, the Charity will investigate such complaints in a manner so as to expose such malicious intent. This will not apply to genuine complainants.

3.0 People and Responsibilities

31. East of England Ambulance Service NHS Trust is the Corporate Trustee of the charity.

3.2 This procedure applies to all staff and agents of the Trustee who may find themselves required to receive, initially to respond to, investigate and/or resolve a complaint and ensure that learning is acted upon to avoid future complaints.

3.3 The Charity is committed to:

- Providing a fair complaints procedure which is clear and easy to use
- Publishing our complaints procedure so that people know how to make a complaint
- Ensuring all complaints are investigated in a timely manner
- Ensuring that complaints are, wherever possible, resolved quickly, fairly and effectively to build relationships
- Gathering information which helps us to improve what we do.

4.0 How to make a Complaint

4.1 We understand the importance of learning from peoples' experiences and welcome all feedback. When something has happened and you feel something should be done about it, you can support us by letting us know what the problem is as soon as possible.

4.2 We have a procedure so that your complaint can be looked into and you can be given a considered response. A complaint can be made to us in several ways.

By phone
By email
Online/social media
Face to face

4.3 Information we will need from you:

- Your full name, address and contact details e.g. phone number and email address
- The reason for your complaint
- What has happened and when
- How has it affected you
- What do think should be done to resolve the complaint
- Any evidence that you consider supports the complaint

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4.4 We are happy to receive a complaint through an advocate or representative, if they know the details relating to the case. If someone else writes the complaint on the

complainant's behalf the complainant should sign the complaint to confirm the content is accurate.

5.0 Recording Complaints

5.1 All complaints received are recorded in a Complaints Log which includes:

Date complaint received
Date of incident
Description of incident
Preferred method of contact
Nature/category of complaint
Investigation conclusion date
Outcomes, actions and/or learning

5.2 If an informal complaint is raised (i.e. verbally, bringing a matter to our attention but not wanting to make a formal complaint) we will respond verbally within seven working days either in a face-to-face meeting or phone conversation. This will be recorded for our records, but we will not give a written response.

5.3 A summary of the Complaints Log will be regularly reviewed by the Trustee to assess the nature and extent of complaints made in the period, how they are resolved, and to discuss any actions required to prevent similar incidents occurring in the future.

6.0 Stage 1

6.1 We will acknowledge your complaint within 5 working days of receipt. We will record your complaint and between us agree on the best way and time to get in contact with you.

6.2 During this period, we may ask you to provide further information if this is required. The complaint will be investigated by a relevant person (and not by any person named or involved in the complaint.) The outcome response will be approved by the relevant manage.

6.3 Our response will include facts that we have been able to establish through our investigation. During the investigation we will talk to all parties and any witnesses to any incident. We will outline whether the complaint to be justified any proposals to address upheld concerns. We will always make an apology where that is appropriate.

6.4 We would anticipate that this will resolve the issue satisfactorily. If the complainant gets in touch because they are not content with this outcome then the complaint will be escalated to Stage 2.

7.0 Stage 2

7.1 The Chief Finance Officer of the Trustee will review all correspondence and will decide whether or not to uphold the response of the Charity.

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If the complaint is not upheld will assign a lead for the investigation and ensure that all complaints are dealt with impartially and promptly. We endeavour to respond fully

within 20 working days of our acknowledgement. If we believe it will take longer due to the nature of the complaint, we will let you know.

8.0 Stage 3

8.1 If you are dissatisfied with the outcome of the investigation, you may seek an appeal to the Chair of the Trustee's Charitable Funds Committee. Your appeal must be received within 10 Working days from the date of the outcome letter. The decision at this stage is final.

9.0 What can you do if you are still dissatisfied

9.1 We hope that we can respond to the issues raised in your complaint in an appropriate way. We are keen to learn from the way in which we manage all complaints to try and develop and improve our services.

9.2 If you are unhappy about our response or feel that we have not answered the points that you have raised, you should in the first instance refer them back us, so that all appropriate attempts can be made to resolve them.

If you are still dissatisfied, you can contact the following organisations.

10.0 Fundraising Regulator

10.1 The Fundraising Regulator consider complaints about charitable fundraising where these cannot be resolved by the organisations themselves.

Example the Fundraising regulator may investigate:

- The charity has made misleading or excessive requests for donations
- The charity has been disrespectful or treated you unfairly when seeking donations
- The charity is not transparent or open about the relationship it has with a third party
- The charity has failed to respect your wishes related to fundraising
- The charity has not dealt appropriately with a complaint you have made about fundraising

10.2 Fundraising Regulator can be contacted:

by email: complaints@fundraisingregulator.org.uk

by post: Fundraising Regulator, Eagle House, 167 City Road, London, EC1V 1AW.

By phone: call 0300 999 3407 to record a message with the details and a member of the team will call back

By website: https://www.fundraisingregulator.org.uk/complaints/make-complaint

11.0 Charity Commission

11.1 The Commission is the independent regulator of charities. Its job as regulator is to ensure that charities are accountable, well run and meet their legal obligations. Its

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work means that the public can be confident about giving their support to charities and beneficiaries can have confidence about the services they receive.

11.2 The Commission has a specific online form for reporting serious issues. The form allows it to consider the issues more quickly than by other means. Even where you phone or write to report concerns the Commission will ask you to fill in the online form. When completing the form, make sure you have all the information you need to hand so it can be sent to the Commission all together.

By website: https://www.gov.uk/government/publications/complaints-about-charities/complaints-about-charities

Examples of complaints the Charity Commission may investigate:

- The charity is not doing what it claims to do.
- The charity is losing money.
- The charity is harming people.
- The charity is being used for personal profit or gain.
- The charity is involved in illegal activity.

11.3 As well as informing the Commission you should:

- report suspected fraud connected to a charity using the Action Fraud online reporting service or call 0300 123 2040

- inform the police if you believe there is criminal activity within a charity; if you have already informed the police before notifying the Commission please provide it with the crime reference number, the police officer and police station dealing with your complaint

12.0 Information Commissioner's Office

12.1 Complaints about how personal information has been managed, processed, collected or stored which have not been satisfactorily resolved with the charity may be investigated by the Information Commissioner's Office.
Information Commissioner's Office can be contacted

By phone: call the helpline on 0303 123 1113.

By website: https://ico.org.uk/make-a-complaint/

13.0 Review

13.1 This complaints procedure will be reviewed by the Charitable Funds Committee at least every three years unless an earlier review is required.

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Appendix A

Monitoring Table

What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
Effectiveness of the internal control system including the system for the management of risk	Trustee	Review and scrutiny	At least one each quarter	Risk Register and Risk appetite	Via the Charitable Funds Committee	Charitable Funds Committee	Charitable Funds Committee

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Appendix B

Equality Impact Assessment

EIA Cover Sheet	
Name of process/policy	Risk Management Policy
Is the process new or existing? If existing, state policy reference number	New
Person responsible for process/policy	Kate Lott – Head of Charity
Directorate and department/section	Integration directorate
Name of assessment lead or EIA assessment team members	Ed Davison – Head of Financial Governance and Compliance
Has consultation taken place? Was consultation internal or external? (please state below):	Internal consultation and review of the Charity by the Charitable Funds Committee

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The assessment is being made on:	Guidelines: x Written policy involving staff and patients: x Strategy: Changes in practice: Department changes: Project plan: Action plan: Other (please state) Charitable Funds Procedure

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Equality Analysis
What is the aim of the policy/procedure/practice/event? This Policy sets out the principles, processes and procedures to ensure the Trustee, can demonstrate effective management of charitable funds and how it fulfils its responsibilities
Who does the policy/procedure/practice/event impact on? No EIA impact identified
Who is responsible for monitoring the policy/procedure/practice/event? Charitable Funds Committee
What information is currently available on the impact of this policy/procedure/practice/event? The policy does not adversely impact any of the equality groups and is applicable to all staff regardless of gender, race, orientation, religion or marital status
Do you need more guidance before you can make an assessment about this policy/procedure/ practice/event? No
Do you have any examples that show that this policy/procedure/practice/event is having a positive impact on any of the following protected characteristics? If yes, please provide evidence/examples: No
Are there any concerns that this policy/procedure/practice/event could have a negative impact on any of the following characteristics? If so, please provide evidence/examples: No
Action Plan/Plans - SMART N/A
Evaluation Monitoring Plan/how will this be monitored? Who: Charitable Funds Committee

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How: Reporting of concerns via committee members and managers in their reporting to committee.
By: Quarterly meetings of the committee
Reported to: Charitable Funds Committee

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Investment Policy

Document Reference	TBC
Document Status	Draft
Version:	V1.0

DOCUMENT CHANGE HISTORY		
Initiated by	**Date**	**Author (s)**
The requirement for the Trustee to adopt an investment policy	December 2024	Ed Davison, Head of Financial Governance and Compliance
Version	**Date**	**Comments**
V0.1	22 January 2025	Reviewed by Charitable Funds Committee and recommended to Board
V1.0	16 September 2026	Review for approval at Board

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Recommended at Date	Charitable Funds Committee 22 January 2025
Approved by Date	Trustee 16 September 2026
Valid Until Date	January 2028
Equality Analysis	Y
Linked procedural documents	N/a
Dissemination requirements	Charity stakeholders
Part of Trust's publication scheme	No

The Corporate Trustee has made every effort to ensure this policy does not have the effect of unlawful discrimination on the grounds of the protected characteristics of: age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity. The Corporate Trustee will not tolerate unfair discrimination on the basis of spent criminal convictions, Trade Union membership or non-membership. In addition, the Corporate Trustee will have due regard to advancing equality of opportunity between people from different groups and foster good relations between people from different groups.

This Policy can be provided in alternative formats.

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East of England Ambulance Service NHS Trust Charitable Funds Charity Investment Policy

1.0 Purpose and Background

1.1 The Board of East of England Ambulance NHS Trust (EEAST) acts as the Corporate Trustee (Trustee) of the East of England Ambulance Service NHS Trust Charitable Funds Charity (the Charity) registered with the Charities Commission for England and Wales (Registered charity number 1047987).

1.2 This policy ensures that the Trustee complies with the requirement of the Charities Code of Governance and other legislation to have a written investment policy.

1.3 This Policy sets out the principles, processes and procedures to ensure the Trustee, can demonstrate effective management of charitable funds and how it fulfils its responsibilities.

1.4 This policy sets out the Trustees' requirements in relation to the type of investments it wishes to make, the risks it is willing to take, investment income requirements and review requirements.

2.0 Duties - Trustee

2.1 The Trustee has overall responsibility for this policy and to ensure that control measures can be implemented to ensure the effective management of Charity fund investments.

2.2 The Trustee has a duty to ensure that donations to the Charity are spent in accordance with the donors' wishes. Where the funds remain unspent, the Trustee has a duty to ensure that they obtain the best possible return on those funds. The Trustee should have regard to the level of risk inherent in the investment decisions made.

2.3 The Trustee should periodically review the investment strategy, monitor investment activities against policy and regularly review the performance of the funds.

2.4 The Trustee when exercising its power of investment under the general power of investment will consider the need for any diversity to reduce the impact of any loss of investment.

2.5 The Trustee will ensure that all investments are ethically and environmentally sound and support the purpose of the Charity even if the investment might provide a lower rate of return than an alternative investment.

3.0 Duties - Charitable Funds Committee

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3.1 The Charitable Funds Committee has delegated responsibility for reviewing and monitoring compliance with this policy.

4.0 Duties - Individuals

4.1 The Trustee's Head of Financial Governance and Compliance will provide reports to the Charitable Funds Committee to enable it to monitor the investments, how they are held and maintained at the levels agreed, reporting any issues to the Trustee.

4.2 All employees of EEAST who deal with charitable funds are responsible for following this policy and must always ensure compliance with it.

5.0 Investment

5.1 The accumulation of funds is not the objective of the Charity, and the investment strategy should demonstrate this. Funds will be required to be held as short-term monies or working capital, with the remainder constituting funds available for investment, which subject to this policy, being invested.

5.2 Sufficient funds will be held in cash deposits to meet the day-to-day cashflow needs, immediate funding requirements and to pay out agreed projects and other short-term commitments made but not yet paid. Consideration of the anticipated timing of cash outflows from free reserves, designated funds and restricted funds is required to determine this cash deposits requirement.

5.3 Remaining funds which include excess free reserves as well as restricted and designated funds not expected to be utilised within 12 months will be invested to achieve returns which will be utilised to meet charitable objectives.

5.4 The financial objective is to maintain the real value of investment over the long-term and at the same time generate a stable and sustainable income to support expenditure on charitable projects.

5.5 Cash balances should be deposited with reputable institutions with high credit ratings.

5.6 Principles to be applied to all investment decisions include:

- To receive interest and/or dividends from the investments as income to the Charity and utilise it as such.
- To reinvest capital gains in line with the investment principles above.
- To take normal charitable expenditure from ongoing donations and interest from investments that is surplus to administrative expenditure.
- Cash for the Charity's needs can be generated from both income and from cashing in the capital growth.

6.0 Risk – control and mitigation

6.1 The Trustee understands that risk assessment is part of the investment process decision making and will consider the appropriate level of risk that it will accept. The Trustee must be satisfied that the overall level of risk is appropriate for the Charity.

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6.1.1 Capital Risk

- loss of capital: the main risk for the Charity arising directly from investments is that it could lose capital and/or investment income as the value of investments change.
- volatility risk: this is the existence of variability in the price of an asset; some asset types are more volatile than others, which needs to be taken into account when selecting an investment and considering its place in the overall investment portfolio. A diverse portfolio can mitigate volatility risk.

6.1.2 **Liquidity Risk**

To manage liquidity risk the Trustee recognises some asset classes are more suitable as short-term investments and others are better for the medium or long term. The Trustee will consider the time frame for investing and the characteristics of differing types of investments when making investment decisions.

6.1.3 **Market Risk**

The Trustee will ensure it is aware of the risks of potential investment strategies by seeking guidance to understand the level of risk associated with an investment strategy, balanced with the potential gains.

The adopted risk profile will be assessed in the current economic climate as striking a balance between investment and market risks, in order to generate a return and to mitigate risks such as inflation.

6.1.4 **Risk mitigations**

The Trustee will mitigate capital risks by ensuring funds are only invested in credit worthy, reputable institutions. Investments that are speculative in nature are prohibited.
The Trustee will mitigate liquidity risk by ensuring any investment is able to be returned to cash deposits with at most 12 months' time lead.
The Trustee will mitigate market risk through the avoidance of equity investments being placed with exposure to undiversified holdings in companies.

7.0 Investment Preference

7.1 Government banking service

The Charity due to its relationship with the NHS Trust as Corporate Trustee is able to access the Government Banking Service customer arrangements including the holding of an interest earning account on the interest rate of the National Loan Fund (minus HM Treasury's margin).

The holding of investment funds alongside working capital within a Government Banking Service account represents a high level of capital security and liquidity, along with no additional transactional or management costs which would reduce the total return.

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7.2 Short Term Deposit

Where the total return on a 3, 6 or 12 month term investment is supported by the cashflow forecast requirements of the Charity, and the total return as assessed by

the income/growth from the rate of return, less transactional and management costs, achieves a greater total return, taking into account risk, than the Government Banking Service.

8.0 Equities Investment and Restrictions

8.1 Equity investment currently represents the least preferred method due to the increased Capital, Liquidity and Market Risk. If the Trustee determines funds can be invested in equities following the risk criteria above, the Trustee will utilise professional investment managers to support the active implementation of its investment policy and review their performance at least annually, when it is agreed this is required. The costs of utilising a professional investment manager are required to be considered when assessing the total return from equity investment.

8.2 The Trustee acknowledges the general principle that the power of investment has to be used to further the purposes of the Charity, and that those purposes will normally be best served by seeking the maximum return consistent with commercial prudence; Harries (Bishop of Oxford) v Church Commissioners [1992] 1 WLR 1241 (the 'Bishop of Oxford' case). In particular the Trustee is not free to take a moral position on behalf of and at the expense of the Charity.

8.3 Having considered the three situations where an ethical restriction is permitted, namely:

- cases where investment in a particular type of business would conflict with the aims of the Charity
- investments which might hamper the work of the Charity, either by making potential beneficiaries unwilling to be helped because of the source of the charity's money, or by alienating supporters
- investments judged to be inappropriate on moral grounds, provided excluding them would not involve a risk of significant financial detriment.

8.4 The Trustee will consider the following investment restrictions important, as they maybe in conflict with the Charity's objectives as outlined above:

- Arms: no direct investment in companies involved in the manufacture of chemical or biological weapons, cluster or landmines and related systems or components and the production of nuclear weapons. These are judged to be likely to prove damaging, directly or indirectly, to the purposes, reputation or public support of the charity

- Tobacco: no direct investment in companies involved with the manufacture, distribution, retail, licensing or supply of tobacco products. Tobacco being injurious to health and thereby creating an additional burden on NHS resources which is at conflict with the aims of the Charity.

- Alcohol: no direct investment in companies involved with the manufacture, distribution, retail, licensing or supply of alcohol products.

- The Trustee expects to conduct screening for investment in companies in relation to modern slavery.

Kingsmill,Esther
10/09/2026 16:57:41

9.0 Policy Review

9.1 This policy will be reviewed by the Charitable Funds Committee at least every three years unless an earlier review is required as part of the on-going cyclical review of all Charity policies.

Kingsmill,Esther
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Appendix A

Monitoring Table

What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
Control measures can be implemented to ensure the effective management of Charity fund investments	Trustee	Review and scrutiny	At least one each quarter	Policy and compliance	Via the Charitable Funds Committee	Charitable Funds Committee	Charitable Funds Committee
Review the investment strategy, monitor investment activities against policy and regularly review the performance of the funds	Trustee	Review and scrutiny	At least one each quarter	Policy and compliance	Via the Charitable Funds Committee	Charitable Funds Committee	Charitable Funds Committee

Kingsmill,Esther
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Appendix B

Equality Impact Assessment

EIA Cover Sheet	
Name of process/policy	Investment Policy
Is the process new or existing? If existing, state policy reference number	New
Person responsible for process/policy	Kate Lott – Head of Charity
Directorate and department/section	Integration directorate
Name of assessment lead or EIA assessment team members	Ed Davison – Head of Financial Governance and Compliance
Has consultation taken place? Was consultation internal or external? (please state below):	Internal consultation and review of the Charity by the Charitable Funds Committee

Kingsmill,Esther
10/09/2026 16:57:41

The assessment is being made on:	Guidelines: x Written policy involving staff and patients: x Strategy: Changes in practice: Department changes: Project plan: Action plan: Other (please state) Charitable Funds Policy

Kingsmill,Esther
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Equality Analysis
What is the aim of the policy/procedure/practice/event? This Policy sets out the principles, processes and procedures to ensure the Trustee, can demonstrate effective management of charitable funds and how it fulfils its responsibilities
Who does the policy/procedure/practice/event impact on? No EIA impact identified
Who is responsible for monitoring the policy/procedure/practice/event? Charitable Funds Committee
What information is currently available on the impact of this policy/procedure/practice/event? The policy does not adversely impact any of the equality groups and is applicable to all staff regardless of gender, race, orientation, religion or marital status
Do you need more guidance before you can make an assessment about this policy/procedure/ practice/event? No
Do you have any examples that show that this policy/procedure/practice/event is having a positive impact on any of the following protected characteristics? If yes, please provide evidence/examples: No
Are there any concerns that this policy/procedure/practice/event could have a negative impact on any of the following characteristics? If so, please provide evidence/examples: No
Action Plan/Plans - SMART N/A
Evaluation Monitoring Plan/how will this be monitored? Who: Charitable Funds Committee

Kingsmill Exner
10/09/2015 16:57:41

How: Reporting of concerns via committee members and managers in their reporting to committee. By: Quarterly meetings of the committee Reported to: Charitable Funds Committee

Kingsmill,Esther
10/09/2026 16:57:41

Reserves Policy

Document Reference	TBC
Document Status	Draft
Version:	V1.0

DOCUMENT CHANGE HISTORY		
Initiated by	**Date**	**Author (s)**
The requirement for the Trustee to adopt a reserves policy	December 2024	Ed Davison, Head of Financial Governance and Compliance
Version	**Date**	**Comments**
V0.1	22 January 2025	Reviewed by Charitable Funds Committee and recommended to Board
V1.0	16 September 2026	Review for approval at Board

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10/09/2026 16:57:41

Recommended at Date	Charitable Funds Committee 22 January 2025
Approved by Date	Trustee 16 September 2026
Valid Until Date	January 2028
Equality Analysis	Y
Linked procedural documents	N/A
Dissemination requirements	Charity stakeholders
Part of Trust's publication scheme	No

The Corporate Trustee has made every effort to ensure this policy does not have the effect of unlawful discrimination on the grounds of the protected characteristics of: age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity. The Corporate Trustee will not tolerate unfair discrimination on the basis of spent criminal convictions, Trade Union membership or non-membership. In addition, the Corporate Trustee will have due regard to advancing equality of opportunity between people from different groups and foster good relations between people from different groups.

This Policy can be provided in alternative formats.

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7.0	Reasons to hold Reserves	6
8.0	Setting agreed level of Reserves	6
9.0	Maintaining agreed level of Reserves	6
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East of England Ambulance Service NHS Trust Charitable Funds Charity Reserves Policy

1.0 Purpose and Background

1.1 The Board of East of England Ambulance NHS Trust (EEAST) acts as the Corporate Trustee (Trustee) of the East of England Ambulance Service NHS Trust Charitable Funds Charity (the Charity) registered with the Charities Commission for England and Wales (Registered charity number 1047987).

1.2 This policy ensures that the Trustee complies with the requirement of the Charities Code of Governance and other legislation to have a written reserves policy.

1.3 This Policy sets out the principles, processes and procedures to ensure the Trustee, can demonstrate effective management of charitable funds and how it fulfils its responsibilities.

2.0 Definitions

Charity Reserves	Funds available to be spent at the Trustee's discretion in furtherance of the Charity's objectives that have not been committed for a specific purpose. Reserves exclude restricted funds and assets that can only be realised through the disposal of fixed assets. These funds are classified as "free" reserves.
Unrestricted Funds (not designated)	Funds that may be used at the Trustee's discretion to support the Charity's objectives. The Charity's unrestricted and undesignated fund is known as the General Fund. These funds are classified as "free" reserves.
Designated Funds (unrestricted)	Funds that the Trustee has earmarked from unrestricted funds for a specific future purpose, project or commitment. Designated funds remain unrestricted because the designation is an internal administrative decision and may be amended or removed by the Trustee. However, designated funds are not normally treated as "free" reserves where they have been allocated to identified commitments.
Restricted Funds	Funds which are subject to specific trusts e.g. terms of will, funds raised by campaign for a specific purpose – not free
Endowment Funds	Funds which are to be held as capital and only the income generated can be expended – not free

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3.0 Duties - Trustee

3.1 The Trustee has overall responsibility for this policy and to ensure that control measures can be implemented to ensure the effective management of Charity funds.

3.2 The Trustee has a responsibility for ensuring the Charity has an appropriate level of reserves, (to achieve and maintain) and for regular review of the level.

4.0 Duties - Charitable Funds Committee

4.1 The Charitable Funds Committee has delegated responsibility for reviewing and monitoring compliance with this policy.

4.2 The Charitable Funds Committee will review this policy at least on an annual basis, and as required, to ensure that levels reflect the activities of the Charity.

4.3 The Charitable Funds Committee will review the balances held in funds, to determine whether funds are being expended in line with the policy, where it is felt that funds are not assisting in the achievement of the Charity's objectives, the Charitable Funds Committee may agree to release those funds into the generally available funds for reallocation.

4.4 Where the generally available reserves are excessive, the Charitable Funds Committee shall consider bids to best utilise the resources.

5.0 Duties – Delegated

5.1 The Trust's Finance team will maintain accurate records of reserves and provide reports to the Charitable Funds Committee to enable it to monitor the funds to ensure reserves and investments are held and maintained at the levels agreed, reporting any issues to the Trustee.

5.2 The Head of Charity will advise on the commitments of the Charity, and the utilisation of restricted and designated funds.

5.3 All employees of EEAST who deal with charitable funds are responsible for following this policy and must always ensure compliance with it.

6.0 Reserves

6.1 Reserves are part of the Charity's unrestricted income funds that are freely available to spend on any of the Charity's purposes.

6.2 The Trustee is under a legal duty to apply charity funds within a reasonable time of receiving them. In setting an appropriate level of reserves the Trustee should consider the Charity's financial circumstances and other relevant factors. Including:

- Fund working capital – including fundraising, support and on costs.
- Fund unexpected expenditure, e.g. when projects overrun, or unplanned events occur.
- Fund shortfall in income, when income does not reach expected levels.
- Balance between short-term spending and long-term sustainability.

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7.0 Reasons to hold reserves

7.1 The Trustee considers it necessary to retain reserves over the longer term to:

- Reduce the impact of risks from the external environment should the levels of income reduce significantly that the Charity cannot meet its obligations.
- Continue the programme of support to Charity strategic objectives.
- Hold sufficient reserves to ensure the Charity can cover its ongoing operational costs to process outstanding commitments.
- Meet the cost of closure or transfer of the charity's affairs should the need ever arise.

8.0 Setting agreed level of Reserves

8.1 The Trustee recognises the importance of deciding an appropriate level of reserves as part of active financial management and forward financial planning. Failure to do this may result in reserves which are either:

- Higher than necessary which would limit the amount that could be spent on charitable activities and therefore potential benefits the Charity can provided to staff, patients and communities
- Too low, creating a risk to the Charity's ability to carry on activities in the future, especially in the event of financial difficulties or unforeseen events.

8.2 The minimum level of the reserves held by the Charity should be above £150,000 which is greater than one year's operational costs and estimated annual commitments.

8.3 Reserves are made up of cash held at the bank in order for the Charity to meet its day-to-day cashflow requirements.

8.4 Reserves held above the minimum level will be considered for utilisation to fund projects to further the objectives of the Charity, subject to assessment of the best use of funds and the mitigations of risks to financial sustainability.

9.0 Maintaining agreed level of Reserves

9.1 The Trustee will apply an understanding of the below to ensure appropriate levels are maintained:

- The nature and amounts of all types of funds held by the Charity, including the availability and potential uses of any designated and restricted funds.
- The reliability, sustainability and diversity of current and expected future income streams.
- Current and expected future expenditure patterns and the degree to which the Charity is committed to the expenditure.
- Any future needs, opportunities, commitments or risks, where future income alone is unlikely to be able to meet anticipated costs.
- The potential consequences for the Charity of not being able to meet any future needs, opportunities or commitments.

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- Designated funds will only be created and held for appropriate and clearly defined purposes and will be monitored to ensure spending takes place within reasonable timescales.

10.0 Monitoring and Review of Reserves

10.1 The Trustee should continuously monitor reserve levels against target as part of the regular finance and budgetary reporting.

10.2 Any significant variances of reserves from the target level, and the reasons for them, will be reported to the Trustee.

10.3 The Trustee will consider whether significant differences are due to a short-term situation or a longer-term issue. The Trustee will be advised:

- When reserves are drawn on so that it can understand the reasons and can consider the corrective action that can be taken.
- When reserve levels rise significantly above target to understand the circumstance which may require a broader review of finances and reserves.
- Where any designated fund expenditure has not taken place as planned or expected and establish if the designation is required.

11.0 Policy Review

11.1 This policy will be reviewed by the Charitable Funds Committee at least every three years unless an earlier review is required as part of the on-going cyclical review of all Charity policies.

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Appendix A

Monitoring Table

What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
Control measures can be implemented to ensure the effective management of Charity fund investments	Trustee	Review and scrutiny	At least one each quarter	Policy and compliance	Via the Charitable Funds Committee	Charitable Funds Committee	Charitable Funds Committee
Ensuring the Charity has an appropriate level of reserves, (to achieve and maintain) and for regular review of the level	Trustee	Review and scrutiny	At least one each quarter	Policy and compliance	Via the Charitable Funds Committee	Charitable Funds Committee	Charitable Funds Committee

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Appendix B

Equality Impact Assessment

EIA Cover Sheet	
Name of process/policy	Risk Management Policy
Is the process new or existing? If existing, state policy reference number	New
Person responsible for process/policy	Kate Lott – Head of Charity
Directorate and department/section	Integration directorate
Name of assessment lead or EIA assessment team members	Ed Davison – Head of Financial Governance and Compliance
Has consultation taken place? Was consultation internal or external? (please state below):	Internal consultation and review of the Charity by the Charitable Funds Committee

Kingsmill,Esther
10/09/2026 16:57:41

The assessment is being made on:	Guidelines: x Written policy involving staff and patients: x Strategy: Changes in practice: Department changes: Project plan: Action plan: Other (please state) Charitable Funds Policy

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10/09/2026 16:57:41

Equality Analysis
What is the aim of the policy/procedure/practice/event? This Policy sets out the principles, processes and procedures to ensure the Trustee, can demonstrate effective management of charitable funds and how it fulfils its responsibilities
Who does the policy/procedure/practice/event impact on? No EIA impact identified
Who is responsible for monitoring the policy/procedure/practice/event? Charitable Funds Committee
What information is currently available on the impact of this policy/procedure/practice/event? The policy does not adversely impact any of the equality groups and is applicable to all staff regardless of gender, race, orientation, religion or marital status
Do you need more guidance before you can make an assessment about this policy/procedure/ practice/event? No
Do you have any examples that show that this policy/procedure/practice/event is having a positive impact on any of the following protected characteristics? If yes, please provide evidence/examples: No
Are there any concerns that this policy/procedure/practice/event could have a negative impact on any of the following characteristics? If so, please provide evidence/examples: No
Action Plan/Plans - SMART N/A
Evaluation Monitoring Plan/how will this be monitored? Who: Charitable Funds Committee

Kingsmill Exner
10/09/2016 16:57:41

How: Reporting of concerns via committee members and managers in their reporting to committee. By: Quarterly meetings of the committee Reported to: Charitable Funds Committee

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Risk Management Policy

Document Reference	TBC
Document Status	Draft
Version:	V1.0

DOCUMENT CHANGE HISTORY		
Initiated by	**Date**	**Author (s)**
The requirement for the Trustee to adopt a risk management policy	December 2024	Ed Davison, Head of Financial Governance and Compliance
Version	**Date**	**Comments**
V0.1	22 January 2025	Reviewed by Charitable Funds Committee and recommended to Board
V1.0	16 September 2026	Review for approval at Board

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Recommended at Date	Charitable Funds Committee 22 January 2025
Approved by Date	Trustee 16 September 2026
Valid Until Date	January 2028
Equality Analysis	Y
Linked procedural documents	N/A
Dissemination requirements	Charity stakeholders
Part of Trust's publication scheme	No

The Corporate Trustee has made every effort to ensure this policy does not have the effect of unlawful discrimination on the grounds of the protected characteristics of: age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity. The Corporate Trustee will not tolerate unfair discrimination on the basis of spent criminal convictions, Trade Union membership or non-membership. In addition, the Corporate Trustee will have due regard to advancing equality of opportunity between people from different groups and foster good relations between people from different groups.

This Policy can be provided in alternative formats.

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5.0	Risk Identification, Evaluation and the Risk Register	6
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East of England Ambulance Service NHS Trust Charitable Funds Charity Risk Management Policy

1.0 Purpose and Background

1.1 The East of England Ambulance Service NHS Trust Charitable Funds Charity (the Charity) acknowledges that efficient and effective management of risk is important in achieving its business objectives. This policy reflects its commitment to sound risk management principles and practices.

The Charity's risk management objectives are to:

- Integrate risk management into the culture of the organisation
- Manage risk in accordance with best practice
- Consider legal compliance as an absolute minimum
- Anticipate and respond quickly to social, environmental and legislative change
- Prevent injury, damage or loss and reduce the cost of risk events
- Raise awareness of the need for risk management

1.2 This policy outlines the basic principles and strategies that the Charity applies to help manage its risks through ensuring significant risks are identified, known, managed and monitored, enabling the Corporate Trustee and those working on its behalf to:

- make informed decisions about how to respond to these risks and take timely action
- make the most of opportunities and develop them with the confidence that any risks will be managed
- improve forward and strategic planning
- achieve the Charity's aims more successfully

1.3 By law, where the Charity's Annual Report and Accounts are required to be audited, the Corporate Trustee must make a risk management statement in the Annual Report confirming that consideration has been given to the major risks to which the Charity is exposed and be satisfied that systems or procedures are established to manage those risks.

1.4 The Charity acknowledges the value of a risk management statement and an open and frank statement of major risks and how they are managed in demonstrating its commitment to good governance. This Policy is designed to enable the Charity to make a risk management statement whether required by law or not, for example when an independent examination is required rather than an audit.

1.5 The statement should include:

- an acknowledgement of the Corporate Trustee's responsibility
- an overview of the risk identification process
- an indication that major risks identified have been reviewed or assessed
- confirmation that control systems have been established to manage those risks
- a description of the current key strategic risks faced
- how each risk is managed or mitigated

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- that these risks and other identified risks relating to the Charity are analysed in a formal risk register which includes controls and actions to mitigate the risks.

2.0 Definitions

2.1 Risk is defined as uncertainty surrounding events and their outcomes that may have a significant impact on any area of the Charity's operations. Risk is an everyday part of charitable activity, either from potential threats or from failing to realise opportunities, and managing it effectively is essential if the Corporate Trustee is to achieve its key objectives and safeguard the Charity's assets.

2.2 Risk assessment is a qualitative and quantitative evaluation of the nature and magnitude of risk to the Charity's objectives. The evaluation is based upon known or theoretical vulnerabilities and threats, as well as the likelihood of the threats being realised and the potential impact on the Charity.

2.3 Risk management is the process of evaluating and responding to risks to the Charity's business for the purpose of reducing those risks to acceptable levels. Risk management is inclusive of the risk assessment process and uses the results of risk assessments to make decisions on the acceptance of risks or on taking action to reduce those risks.

2.4 Major risks are those risks that have a major impact and a probable or highly probable likelihood of occurring. If they occurred, they would have a major impact on some or all of the following areas of the Charity's business:

- governance
- operations
- finances
- environmental or external factors such as public opinion or relationship with funders
- a charity's compliance with law or regulation

3.0 Duties and Responsibilities

3.1 **The Corporate Trustee** will determine the risk appetite and set the culture of risk management within the Charity. The Corporate Trustee will have ultimate responsibility for risk management including major decisions affecting the risk profile or exposure. The Corporate Trustee will receive minutes from the Charitable Funds Committee to monitor the management of important risks facing the Charity.

3.2 **The Charitable Funds Committee** will act under delegated authority of the Corporate Trustee to provide an independent and objective view of the arrangements for the management of risk. It will report to the Corporate Trustee on internal controls and alert them to any emerging issues. It will oversee independent examination and /or audit and review recommendations and advise the Corporate Trustee on the effectiveness of the internal control system including the system for the management of risk. It will satisfy itself that risks are appropriately owned and that risk owners are actively managing their risks with the appropriate controls in place and working effectively. It will monitor and critically review the management of important risks and the maintenance of the risk register to ensure they are fit for

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purpose. It will be responsible for reviewing the Risk Management Statement for the Annual Report and Accounts.

3.3 **The Charitable Funds Committee** of the Corporate Trustee will have responsibility for the identification and management of risks that threaten the achievement of business objectives within their areas of competence. They will consider the quality and timeliness of information provided on key risks and escalate any risks to the Corporate Board which have a high residual score, which do not appear to be being managed, or where assurances are either not available or not received.

3.4 **The Chief Finance Officer** is responsible for supporting the Corporate Trustee and its Committees in the identification and assessment of major risks. They will ensure that controls are implemented and provide regular reports on the status of risks and their controls. They are responsible for encouraging good risk management practices and a positive attitude towards the control of risk amongst all levels of staff.

3.5 **The Head of Charity and Staff** of the Corporate Trustee with responsibility for the day-to-day operation of the Charity are responsible for controlling risk when carrying out their duties, for following policies and procedures set by the Corporate Trustee designed to mitigate risk, and for providing such information as the Corporate Trustee or Charitable Funds Committees may require in fulfilling their responsibilities under this Policy.

4.0 Risk Appetite

4.1 The level of risk associated with the attainment of Charity objectives is reviewed by, and referenced to, the risk appetite accepted by the Corporate Trustee. This provides oversight and consistency in the level of risk taken. The Trustee has determined its risk appetite in the following key areas:

4.1.1 **Organisational risk** - The Charity recognises that it works in a changing environment where its governance arrangements and organisational structure will need to evolve over time. It will accept some risks in these circumstances to ensure it is positioned to optimum advantage providing any change does not impact on its core sustainability.

4.1.2 **Developmental risk** - The Charity accepts a degree of risk that is part and parcel of its willingness to support innovation, facilitate change and to evolve its support for the benefit of NHS patients and the wider public. These risks will be monitored as grants are awarded and projects are completed.

4.1.3 **Reputational risk** - The Charity has a very low risk appetite for actions and decisions which may damage our reputation. It therefore puts a strong emphasis on rigorous processes to be followed in its financial dealings, and when engaging third parties.

5.0 Risk Identification, Evaluation and the Risk Register

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5.1 Identifying risks is the first step in building the Charity's risk profile, which is followed by the risk analysis and risk evaluation. The process of identifying and defining risks

establishes a common understanding and therefore better capability to respond as appropriate.

5.2 When identifying and defining risks the following guidelines will be considered:

- risks will be related to the Charity's business plan objectives
- risks will be identified at a level where a specific impact can be identified and a specific action or actions to address the risk can be identified
- care will be taken to avoid stating impacts which may arise as being risks themselves, and to avoid stating risks which do not impact on business plan objectives
- equally, care will be taken to avoid defining risks with statements which are simply the converse of objectives.

5.3 There are several mechanisms that should be considered when identifying risks, such as: questionnaires, workshops, audit reports, and SWOT/PESTLE analysis.

5.4 For each risk identified in each area an analysis is undertaken of:

- the factors that may cause the risk to occur
- the controls that are in place to mitigate the likelihood or impact of the risk
- an action plan for further management of the risk

5.5 A consensus evaluation for each risk is made of the likelihood of the risk occurring on a scale 1-5 (rare to almost certain) and the severity of the impact if the risk were to occur, also on a scale 1-5 (insignificant to catastrophic). The product of these two scores is the risk rating (ranging from 1 to 25), where scores of 1-6 are low, 7-14 are moderate, and those scoring 15 or above are the major risks.

5.6 The list of risks, risk ratings, control measures and action plans are the recorded on the Risk Register for the Charity. Risks are also assigned ownership so that operational and oversight responsibility is easily identifiable in every case.

5.7 The Risk Register should be kept under constant review by senior management to enable the Corporate Trustee and Committees to formally review and reconsider risks as follows:

- risk rating - up to 6 – annually
- risk rating - 7 to 14 – 6 monthly
- risk rating – 15+ – quarterly
- the possibility of new risks to be considered at every review point

6.0 Policy Review

6.1 This policy will be reviewed by the Charitable Funds Committee at least every three years unless an earlier review is required as part of the on-going cyclical review of all Charity policies.

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Appendix A

Monitoring Table

What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
Effectiveness of the internal control system including the system for the management of risk	Trustee	Review and scrutiny	At least one each quarter	Risk Register and Risk appetite	Via the Charitable Funds Committee	Charitable Funds Committee	Charitable Funds Committee

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10/09/2026 16:57:41

Appendix B

Equality Impact Assessment

EIA Cover Sheet	
Name of process/policy	Risk Management Policy
Is the process new or existing? If existing, state policy reference number	New
Person responsible for process/policy	Kate Lott – Head of Charity
Directorate and department/section	Integration directorate
Name of assessment lead or EIA assessment team members	Ed Davison – Head of Financial Governance and Compliance
Has consultation taken place? Was consultation internal or external? (please state below):	Internal consultation and review of the Charity by the Charitable Funds Committee

Kingsmill,Esther
10/09/2026 16:57:41

The assessment is being made on:	Guidelines: x Written policy involving staff and patients: x Strategy: Changes in practice: Department changes: Project plan: Action plan: Other (please state) Charitable Funds Policy

Kingsmill,Esther
10/09/2026 16:57:41

Equality Analysis
What is the aim of the policy/procedure/practice/event? This Policy sets out the principles, processes and procedures to ensure the Trustee, can demonstrate effective management of charitable funds and how it fulfils its responsibilities
Who does the policy/procedure/practice/event impact on? No EIA impact identified
Who is responsible for monitoring the policy/procedure/practice/event? Charitable Funds Committee
What information is currently available on the impact of this policy/procedure/practice/event? The policy does not adversely impact any of the equality groups and is applicable to all staff regardless of gender, race, orientation, religion or marital status
Do you need more guidance before you can make an assessment about this policy/procedure/ practice/event? No
Do you have any examples that show that this policy/procedure/practice/event is having a positive impact on any of the following protected characteristics? If yes, please provide evidence/examples: No
Are there any concerns that this policy/procedure/practice/event could have a negative impact on any of the following characteristics? If so, please provide evidence/examples: No
Action Plan/Plans - SMART N/A
Evaluation Monitoring Plan/how will this be monitored? Who: Charitable Funds Committee

Kingsmill Bethel
10/09/2026 16:57:41

How: Reporting of concerns via committee members and managers in their reporting to committee. By: Quarterly meetings of the committee Reported to: Charitable Funds Committee

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Charity Cash Handling Policy

Document Reference	TBC
Document Status	Draft
Version:	V1.0

DOCUMENT CHANGE HISTORY		
Initiated by	**Date**	**Author (s)**
The requirement for the Trustee to adopt a cash handling policy	April 2026	Kate Lott, Head of Charity
Version	**Date**	**Comments**
V0.1	14 May 2026	Reviewed by Charitable Funds Committee and recommended to Board
V1.0	16 September 2026	Review for approval at Board

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10/09/2026 16:57:41

Recommended at Date	Charitable Funds Committee 14 May 2026
Approved by Date	Trustee 16 September 2026
Valid Until Date	May 2029
Equality Analysis	Y
Linked procedural documents	N/A
Dissemination requirements	Charity stakeholders
Part of Trust's publication scheme	No

The Corporate Trustee has made every effort to ensure this policy does not have the effect of unlawful discrimination on the grounds of the protected characteristics of: age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity. The Corporate Trustee will not tolerate unfair discrimination on the basis of spent criminal convictions, Trade Union membership or non-membership. In addition, the Corporate Trustee will have due regard to advancing equality of opportunity between people from different groups and foster good relations between people from different groups.

This Policy can be provided in alternative formats.

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East of England Ambulance Service NHS Trust Charitable Funds Charity Cash Handling Policy

1. INTRODUCTION

1.1 This document sets out the Cash Handling Policy for the East of England Ambulance Service NHS Trust Charitable Funds (East of England Ambulance Charity / EEAS Charity)

1.2 This policy forms part of the financial policies for East of England Ambulance Service NHS Trust (EEAST) as Corporate Trustee for EEAS Charity.

1.3 The purpose of this policy is to:

- set out how cash and cash equivalents will be handled safely and securely
- set out the audit procedures surrounding cash and cash equivalents
- demonstrate controls to prevent fraud and money laundering

1.4 This policy is in line with the Charities Act 2011, its amending act, the Charities Act 2022 and the good practice code from the Fundraising Regulator.

- The charities act 2022 is available at https://www.legislation.gov.uk/ukpga/2022/6/contents
- The Charities Act 2011 is available at https://www.legislation.gov.uk/ukpga/2011/25/contents
- The Fundraising code of practice is available at https://www.fundraisingregulator.org.uk/code

1.5 Linked policies

- EEAST Finance policies
- EEAST Anti-fraud & anti-money laundering policy
- EEAST Standards of Business Conduct

1.6 Definition of terms applicable to this policy:

- Cash in this policy refers to notes, coins, cheques and gift vouchers with a cash value. It also refers to donations taken by card/contactless means in person.
- Unrestricted funds – income received by the Charity which has no restriction or expectation for use for a specific purpose can be made up of donations, charitable activities and unrestricted grants.
- Restricted funds – income received by or committed by the Charity for a specific purpose and cannot be used for any other purpose.
- Designated funds – unrestricted funds allocated to specific charitable objects but can be removed and transferred back to unrestricted funds. Where funding is designated and this creates a binding expectation that those funds will be available, this needs to be a restricted fund.

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1.7 Policy review - this policy should be reviewed every two years unless new legislation or best practice guidance is issued or there are significant changes to the way the Charity operates.

2 THE POLICY

2.1 General principles.

2.1.1 Any member of EEAST Trust/Charity staff or Volunteers may be given responsibility for collecting cash on behalf of the charity.

2.1.2 Cash handling may occur in one or more of the following common situations (this list is not exhaustive):

- Donations received by post or to EEAST sites
- Event/bucket collections
- Donations given in thanks for free training sessions
- Gaming fees for a raffle
- EEAS Charity collection tins or other collections

2.1.3 Any person responsible for Charity cash must ensure that it is safe and secure until banked or received by EEAS Charity.

2.1.4 Cash (notes/coin) should never be sent by post or via internal mail unless in extenuating circumstances.

2.1.5 Unless authorised by EEAS Charity, no Staff member/Volunteer should bank EEAS Charity monies into a personal bank account and then transfer the funds.

2.1.6 Staff and Volunteers must ensure that wherever possible cash is not counted or displayed in general view of the public.

2.1.7 Any person acting on behalf of the charity, where they may reasonably be expected to have to handle and hold cash regularly should familiarise themselves with the charity cash handling policy and banking and acknowledgement processes.

2.1.8 Where any person has collected and is holding cash as a representative of EEAS Charity and the value is over £500, EEAS Charity must be notified immediately to facilitate priority processing.

2.1.9 Where practical donors should be given a receipt for the collection of cash, where a follow up acknowledgement is required, the receipt should state ‘uncounted’ if the value of the donation needs verified.

2.1.10 Where possible cash should always be counted and prepared for banking by two people.

2.1.11 The safety and security of our staff and volunteers is paramount, anyone collecting/holding cash on behalf of EEAS Charity should familiarise themselves with this policy, the banking and acknowledgement process and the safety

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procedures in appendix 1 to follow if confronted with a threatening situation pertaining to charity cash.

2.1.12 The charity's preferred approach is to operate on a cash-free basis wherever reasonably practicable to minimise risk and support strong financial governance and transparency.

2.2 Donations received by post or dropped at EEAST HQ

2.2.1 The charity team should be notified of all cash donations.

2.2.2 Where donations are dropped off in person at an EEAST site, these should be put in a sealed envelope/bag, the donor details written and emailed to the charity at charitablefunds@eastamb.nhs.uk, copying in line manager.

2.2.3 All donations should logged on Expected Charity Income - Donations and Grants – Fill in form

2.2.4 The charity team will contact the recipient to arrange collection / paying in for processing. Paying in slips can be obtained from the charity charitablefunds@eastamb.nhs.uk or CFR@eastamb.nhs.uk

2.2.5 The charity team log cash on receipt in the cash register document.

2.3 Donations received from the public to EEAST staff and EEAST Stations/Sites

2.3.1 A reminder that EEAST Staff are not permitted to accept gifts of cash/cash equivalents of any value (see EEAST standards of Business Conduct Policy for more details). However, it is recognised that this is not always avoidable. EEAS Charity must be notified to arrange collection / paying in for banking.

2.3.2 Where the donation is for a specific purpose (restricted or designated fund) or the donor requires an acknowledgement, the person receiving the donation should take contact details to pass onto EEAS Charity.

2.4 Event / Bucket collections

2.4.1 Monies should always be collected in a EEAS Charity branded collection tin/bucket. Even at busy events a person should always be overseeing the charity stand, or the tin/bucket should be secured if the stand needs to be left unattended.

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2.4.2 Receipts should be given if asked for.

2.4.3 Where the tin/bucket needs emptied throughout the event or at the end, this should be done out of view of the public, emptied into a secure cash bag, sealed and stored securely out of view in a locked vehicle.

2.4.4 Where donations have been made via a charity card/contactless device, the donor has the right to ask for a receipt. The facility to email or text this receipt should be utilised via the machine or a paper receipt given. Where the value of the donation is £50 or more the donor must be offered the option for a receipt.

2.5 Donations given in thanks for training

2.5.1 Often when staff/volunteers deliver a free CPR/AED or other training session to the public, the group may offer to make a voluntary donation to EEASC Charity (EEAST Heart).

2.5.2 Where possible groups should be directed to the charity website, EEAST Heart just giving page or to email the charity directly to make their donation. Where this is not possible and the person accepts a cash donation, notify EEAS Charity for details on how to securely process the donation.

2.5.3 Note that cheques should be made payable to **East of England Ambulance Service Charity**.

2.6 Gaming fees

2.6.1 EEAS Charity does not hold a gambling licence. The Charity can only undertake incidental lottery/raffle type activities to raise funds.
Guidance on incidental lotteries / raffles can be found on the gambling commission: How to run a fundraiser with lotteries or raffles at events

2.6.2 EEASC Charity has no responsibility for non-profit gambling activities undertaken by a supporter hosting an 'in aid of' activity.

2.7 EEAS Charity collection tins

2.7.1 Monies should always be collected in a EEAS Charity branded collection tin/bucket with a security seal.

2.7.2 Collection tins are individually numbered and should be recorded with the venue that is hosting the tin and the named guardian responsible for the tin.

2.7.3 Collection/ banking arrangements will be made on an individual basis with each tin guardian. Where this is a EEAST Trust site, the Charity will endeavour to collect and bank the monies (or make local arrangement) but with public sites the guardian will have permission to either count and bank directly into the Charity bank account with a paying in slip or personally bank and transfer funds with written correspondence to the charity detailing, when and where the money was collected (e.g. date, location, amount).

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3 POLICY REVIEW:

This policy will be reviewed by the Charitable Funds Committee at least every three years unless an earlier review is required as part of the on-going cyclical review of all Charity policies.

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APPENDIX A

East of England Ambulance Service Charity Cash Handling

Personal safety and security principles

Your own safety and security is paramount and always takes precedent.

If you collect and/or hold cash on behalf of EEAS Charity, please familiarise yourself with these principles.

Collecting cash

1. If you are collecting cash on behalf of EEAS Charity at a public site, you must have your EEAST ID with you
2. If you regularly collect cash, ensure to vary your days/times of collection
3. Park in a well-lit area as close to the venue as possible
4. When collecting cash, where possible, empty the tin/bucket if applicable into a sealable cash bag and write the date/venue of collection

Storing cash

1. Never store collection tins/buckets/cash bags (empty or otherwise) on display to the public either at home or in a vehicle
2. If you have collected cash and the value is £500 or over you must notify EEAS Charity charitablefunds@eastamb.nhs.uk or Tel. 01603 422731 immediately for priority processing.
3. Do not disclose that you collect or store cash.

Banking cash

1. Do not complete banking on a regular schedule – vary days and times where possible.
2. Use a suitable carrier for banking – not see through or draws attention as a cash bag.

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3. Park in well-lit secure areas as close to the bank as possible, if banking a substantial amount of cash/coin £500 or more, contact the charity beforehand.
4. Paying in slips can be obtained from the charity charitablefunds@eastamb.nhs.uk or CFR@eastamb.nhs.uk
5. Log donations on Expected Charity Income - Donations and Grants – Fill in form

In the event of a robbery

1. Stay calm
2. Obey their instructions
3. Comply with all demands and surrender any cash quickly and without argument or struggle
4. Try and take note of details of the robber(s): height, build, clothing, voice, facial features, distinguishing marks
5. Call the police immediately afterwards and follow their instructions
6. Contact EEAST Charity or line manager

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Appendix B

Monitoring Table

What	Who	How	Frequency	Evidence	Reporting arrangements	Acting on recommendations	Change in practice and lessons to be shared
Control measures can be implemented to ensure the effective management of Charity fund investments	Trustee	Review and scrutiny	At least one each quarter	Policy and compliance	Via the Charitable Funds Committee	Charitable Funds Committee	Charitable Funds Committee

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Appendix C

Equality Impact Assessment

EIA Cover Sheet	
Name of process/policy	Risk Management Policy
Is the process new or existing? If existing, state policy reference number	New
Person responsible for process/policy	Kate Lott – Head of Charity
Directorate and department/section	Integration directorate
Name of assessment lead or EIA assessment team members	Ed Davison – Head of Financial Governance and Compliance
Has consultation taken place? Was consultation internal or external? (please state below):	Internal consultation and review of the Charity by the Charitable Funds Committee

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The assessment is being made on:	Guidelines: x Written policy involving staff and patients: x Strategy: Changes in practice: Department changes: Project plan: Action plan: Other (please state) Charitable Funds Policy

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Equality Analysis
What is the aim of the policy/procedure/practice/event? This Policy sets out the principles, processes and procedures to ensure the Trustee, can demonstrate effective management of charitable funds and how it fulfils its responsibilities
Who does the policy/procedure/practice/event impact on? No EIA impact identified
Who is responsible for monitoring the policy/procedure/practice/event? Charitable Funds Committee
What information is currently available on the impact of this policy/procedure/practice/event? The policy does not adversely impact any of the equality groups and is applicable to all staff regardless of gender, race, orientation, religion or marital status
Do you need more guidance before you can make an assessment about this policy/procedure/ practice/event? No
Do you have any examples that show that this policy/procedure/practice/event is having a positive impact on any of the following protected characteristics? If yes, please provide evidence/examples: No
Are there any concerns that this policy/procedure/practice/event could have a negative impact on any of the following characteristics? If so, please provide evidence/examples: No
Action Plan/Plans - SMART N/A
Evaluation Monitoring Plan/how will this be monitored? Who: Charitable Funds Committee

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How: Reporting of concerns via committee members and managers in their reporting to committee. By: Quarterly meetings of the committee Reported to: Charitable Funds Committee

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Reporting To:	Corporate Trustee	**Date:**	16.09.2026
Agenda Item:	CT26/09/7.3		
Originating Meeting:	Charitable Funds Committee	**Date:**	03.09.2026
Committee Chair:	Chris Brook, Acting Committee Chair		
Lead Director:	Steven Course, Chief Finance Officer		

Purpose:	Decision Approval	**X**	Discussion Review		Information Noting	**x**

Link to CQC domain:		**Link to EEAST's Strategic Missions:**	
Caring	**x**	Patient Mission	**x**
Responsive		Partnership Mission	**x**
Effective		People Mission	**x**
Well Led		Productivity Mission	
Safe			

Link to Strategic Risk:									
SR1 Demand & Capacity		SR3 Estates		SR5 Cyber Security		SR7 Workforce Sustainability		SR9 Organisational Development	
SR2 Quality Governance		SR4 Use of Resources		SR6 Partnership Working		SR8 Staff Retention		SR10 Digital	

Alert: Items requiring Board/ Committee Attention/ Action		
What?	**So What?**	**What Next?**
The Committee reviewed the contribution of Community First Responders following significant Charity investment in vehicles and equipment.	CFR volunteers responded to 7% of C1 calls and were first on scene in 70% of those cases, arriving on average six minutes before ambulance crews. For the highest-priority calls, earlier attendance	As the CFR model expands, closer alignment with Operations is required to ensure the resource is deployed effectively, targeted to areas of greatest need, and supported by appropriate oversight.

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	can materially improve outcomes for critically ill patients.	
The charity also reviewed their terms of reference for the year ahead.	The charitable funds committee recommended the Terms of Reference to the Corporate Trustee for approval	Corporate Trustee to approve the CFC Terms of Reference

Advise: Areas requiring ongoing monitoring		
What?	**So What?**	**What Next?**
Financial performance for the first four months of the year was in line with expectations, with income of £159k and expenditure of £224k. The general fund balance stood at £323k, with total fund balances of £1.5m.	The Charity continues to hold an appropriate level of unrestricted reserves to support running costs and discretionary projects. Revised banking arrangements generated £19k in interest, demonstrating improved fiscal management.	Recruitment is underway for a dedicated fundraising lead. This role is critical to delivering the new strategy, strengthening income generation and supporting the Charity's long term sustainability.

Assure: Areas of positive improvement		
What?	**So What?**	**What Next?**
The Charity has developed a three-year strategy, which has been reviewed by the executive team and in principle they are supportive of the future direction.	The strategy demonstrates clear alignment between Charity activity and the Trust's missions. It also improves visibility of the Charity's impact, helping donors and prospective donors understand the benefits delivered	The Charity team has been asked to set out its funding goals and hurdle rates clearly, providing assurance on the Charity's future strategic direction.

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	through their contributions. It also focuses the team on sustainable income streams.	
Charity communications continues to perform well, with a wealth of positive media coverage.	The Charity benchmarks well against other Ambulance Trusts – earlier surveys also suggested good brand awareness. A positive platform to build from.	Strengthen the link between media / social media posts and the ability for someone to donate.
Risks		
What?	**So What?**	**What Next?**
-		

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East of England Ambulance Service NHS Trust

Terms of Reference – Charitable Funds Committee 2026-2027

Document Reference	To be assigned by Corporate Records Manager
Document Status	Draft
Version:	0.1

DOCUMENT CHANGE HISTORY		
Initiated by	**Date**	**Author(s)**
Annual Review	February 2026	Esther Kingsmill, Deputy Head of Corporate Governance

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Document Owner	Company Secretary~~Governance Improvement Specialist~~
Recommended at Date	Charitable Funds Committee
Approved at Date	Corporate Trustee
Valid Until Date	March 2027
Linked Policy Documents	Standing Orders Reservation of Powers Scheme of Delegation Other Committee Terms of Reference Standing Financial Instructions Board Governance Assurance Framework Risk Management Policy
Dissemination requirements	Cascade to Board members and Senior Leaders and forms part of Board level induction pack
Part of Trust's publication scheme	Yes

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Charitable Funds Committee

Draft Terms of Reference

East of England Ambulance Service NHS Trust

1. Constitution

1.1 The East of England Ambulance Service NHS Trust Charitable Funds Charity is registered with the Charities Commission for England and Wales (Registered charity number 1047987) and operates to raise funds to support the staff, volunteers, and local communities of the east of England, strengthening the provision of outstanding care to patients.

1.2 The charity exists as a result of donations, support from fundraising activities, legacy giving, and opportunities from grant programmes. The work of the charity enhances that of the Trust and is intended to be beyond that ordinarily afforded by the NHS.

1.3 The East of England Ambulance Service NHS Trust Board is appointed to act as the Corporate Trustee of the East of England Ambulance Service NHS Trust Charitable Funds Charity.

1.4 The Corporate Trustee is the sole Trustee, and it acts through the Trust Board of Directors. Individual directors act as 'agents' of the Trustee and are not individual trustees. The Corporate Trustee is legally responsible for all the charity's activities.

1.5 The Corporate Trustee hereby resolves to establish a Committee of the Trustee to be known as the Charitable Funds Committee (The Committee). The Committee is a non-executive Committee and has no executive powers, other than those specifically delegated in these Terms of Reference. As an assurance Committee it may only make recommendations to the Corporate Trustee. The Committee may establish, subject to Trustee approval, sub-groups to execute the delegated powers within these Terms of Reference.

2. Purpose

2.1 The Charitable Funds Committee provides the Corporate Trustee with a means of assurance regarding the administration of the Charity in accordance with applicable legislation.

2.2 The Trust Board is regarded as having responsibility for exercising the functions of the Trustee. The Trust Board delegates these functions to the Committee, within any limits set out in these Terms of Reference.

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3. Authority

3.1 The Committee is authorised by the Corporate Trustee to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee.

3.2 The Committee is authorised by the Corporate Trustee to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

3.3 The Committee is authorised by the Corporate Trustee to liaise, as necessary, with other sub-committees of the Board and chairs of the formal sub-committees have a responsibility for ensuring that the Charitable Funds Committee and the Corporate Trustee are advised of any risks or potential conflicts.

4. Duties and Responsibilities

4.1 To monitor the application of all charitable funds in accordance with the Charities Acts, external guidance and applicable legislation and to ensure that decisions on the use or investment of such funds are compliant with the explicit conditions or purpose of each donation or bequest.

4.2 To assure on the investment of charitable funds with regards to existing and subsequent legislation, strategy, policy and guidance. Including the monitoring and performance of the investment/reserve portfolio.

4.3 Ensure that funds are correctly allocated as restricted, unrestricted or designated and accounted for accordingly. Further, that donation and investment income and loss are attributed appropriately.

4.4 Overseeing the development and implementation of a charity strategy including governance, plans and key risks on behalf of the Corporate Trustee.

4.5 To review business cases relating to ~~major~~ investment decisions and to recommend investment or otherwise.

4.6 Ensure that there is an appropriate system of control over income and expenditure, and that robust governance arrangements are in place.

4.7 To receive and review the charitable funds income and expenditure accounts together with any other supporting information.

4.8 To support charity brand development and to ensure funds are appropriately publicised and recognised.

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4.9 To review and recommend approval to the Corporate Trustee, via the Audit Committee of the charity Annual Report and Accounts for submission to the Charity Commission.

4.10 To ensure compliance with EEAST's Standing Financial Instructions and Scheme of Delegation as applicable to charities, and to gain assurance that they are appropriately interpreted for charitable funds.

4.11 Ensure that the investment/reserve policy approved by the Corporate Trustee is implemented and that sufficient funds are kept readily available to meet planned requirements.

4.12 To receive and scrutinise all audit reports on charitable funds and recommend action to the Corporate Trustee.

4.13 To establish and monitor policies and procedures to ensure the effective day to day management of charitable funds.

4.14 Oversee the formulation and delivery of policies for fundraising activities and for the use of charitable funds.

4.15 Ensure compliance with charity law and all relevant related legislation

4.16 To approve fundraising between £5,001 and £300k following recommendation by the Head of Department or Chief Finance Officer.

4.17 To make a recommendation to the Corporate Trustee on any fundraising exceeding £300k.

5. Membership

5.1 The Committee membership shall be appointed by the Corporate Trustee from amongst its voting members and shall consist of not less than three designated Members, (at least one non-executive and one executive director) and including the Chief Finance Officer.

5.2 The Corporate Trustee shall appoint the Chair of the Committee from amongst the Non-Executive Directors.

5.3 In the absence of the Committee Chair, the remaining members present shall elect one of themselves to chair the meeting.

6. Attendees

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6.1 In addition to the Non-Executive Director members/ chair, and the Chief Finance Officer, attendees at Committee meetings will include:

- Head of Communications
- Head of Community Response
- Head of Wellbeing
- Head of Charity

6.2 Any voting Corporate Trustee director may attend any meeting.

6.3 An appropriate finance representative will be invited to attend

6.4 Additional members of Trust staff or external stakeholders will be invited as and when required to support the workings of the meeting

6.4 The Chair of the Board (as Corporate Trustee) shall not be a member of the Committee but may attend meetings.

6.5 Members should aim to attend every meeting and should attend a minimum of 75% of meetings held in each financial year. Where a member is unable to attend a meeting, they should notify the Committee chair or Secretary of the Committee in advance.

6.6 Any member of the Committee may participate by means of telephone conferencing, video conferencing or similar communications equipment whereby all persons participating in the meeting can hear each other, and participation in the meeting in this manner shall be deemed to constitute presence in person at such meeting.

7. Quorum

7.1 The quorum necessary for the transaction of business is two members. (At least one non-executive, one executive director with a finance representative being also present). A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of its authorities and powers.

8. Frequency of Meetings

8.1 Meetings shall be held as necessary, but not less than four times a year.

8.2 Extraordinary meetings will be held as necessary at the discretion of the Corporate Trustee or Committee Chair.

9. Administration

9.1 The minutes of all meetings of the Committee may be formally recorded to aid in the production of written minutes and the recording will be deleted in line with Trust guidance.

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9.2 All meetings will be formal and minuted. Minutes of the meeting will be available no more than 10 business days following the meeting. Minutes of

the meeting will be recorded formally and ratified by the Committee at its next meeting.

9.3 Meeting papers will be circulated to members a minimum of three business days prior to the meeting.

9.4 A record will be kept of the schedule of business and matters and issues to be carried forward.

10. Reporting and Monitoring Arrangements

10.1 The Chair of the Committee will provide a Chair's report to the next available Corporate Trustee meeting drawing to its attention any issues or risks that require disclosure to the full Board or require executive action. A copy of the approved minutes from the previous meeting will also be provided to the Corporate Trustee for information.

10.2 The Chair of the Committee shall draw the attention of the Corporate Trustee, to any formal recommendations by the Committee, the requirements for action to implement these, any resource implications and the timescale considered appropriate by the Committee for implementation.

10.3 EEAST's annual report shall include a section describing the work of the Committee in discharging its responsibilities.

10.4 The Committee will undertake an annual review of its performance effectiveness against its duties in order to evaluate its achievements and will report on its findings annually to the Corporate Trustee.

10.5 The Committee will report once a year to the Audit Committee on the following areas for assurance:

- Annual Report and Accounts
- Annual Plan, strategy and key objectives

10.6 The Chair of the Board (as Corporate Trustee) will receive a copy of all meeting papers and will attend at least one meeting per annum for monitoring and assurance purposes.

10.7 The Terms of Reference of the Committee shall be reviewed by the Corporate Trustee, at least annually.

11. Conduct of Business

11.1 The Chair will be responsible for ensuring that the Committee conducts its business in accordance with the Trust's Standards of Business Conduct, Conflicts of Interest Policy and other relevant policies.

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11.2 Members must declare any conflicts of interest at the start of each meeting. The Chair will decide how these will be managed and ensure they are recorded in the minutes.

11.3 Papers should be concise, analytical and clearly identify the risk and assurance implications of the issues presented, including BAF/CRR references where applicable.

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