70 YEARS OF THE NHS 1948 - 2018

NHS East of England Ambulance Service NHS Trust

Annual Report 2017/18

THISISEEAST

Innovative. Responsive. Excellent. Always community focused. Always patient driven.

Contents

1. Welcome from the Chair

My first thoughts as we conclude another year is to thank our staff and volunteers for their passion and leadership, and commitment to our patients. What demonstrated this in the best light was the response to the two heavy snowfalls we had in the region this Winter; people made sure that they got to jobs, even if they had to get to the person in need dragging all of their kit with them. It was amazing.

We are in the business of offering outstanding patient care. We are still seeing improvements to our services as we adapt to the increasing numbers of people who are presenting when extremely sick - more than 2,000 compliments to our teams during this year really does say it all for me. It is also encouraging that we have managed as one big team to hit a breakeven position financially, which will put us in good stead for the years to come.

There is still plenty of work to do to improve, and embed quality at the heart of that improvement. The culture of the organisation is changing, thanks to the Leadership Charter, the launch of the anti-bullying and harassment campaign and our continued efforts to promote good behaviours. It is great news that we have now secured a once in a generation increase in funding from 2018/19 and have signed a six year contract with regulators and commissioners. This step change will enable us to greatly expand our workforce and fleet capacity to ensure we have a truly sustainable service into the future.

I have also been able to see the passion in our equality agenda, and seen how we can make improvements. Some of the highlights in this area for me was the International Women's Day conference, hosted with police and fire in Essex. Seeing the re-start of a LGBT+ Network was also quite special and will be an apex for EEAST in furthering collective knowledge and learning in this area.

Whilst we have had to say a fond farewell to some of our executives and non-executive directors, we are continuing to attract high calibre individuals to join us in the future. I would like to thank Sandy Brown and Dr Mark Patten officially here for their stalwart efforts in leading us to strive for the highest quality care.

Over the next year, I fully expect the ambulance service to blossom even more. We have great opportunities with the new rules about advanced paramedics being able to prescribe, and attracting even more people who want to make a difference either on the ground or in the operations centres. I look forward to another good year.

2. Introducing the East of England Ambulance Service NHS Trust

We serve residents in, and visitors to, Bedfordshire, Hertfordshire, Essex, Norfolk, Suffolk and Cambridgeshire. Like the 10 other ambulance NHS Trusts in England, we provide a range of services, but are best known for the 999 emergency service and have been doing so since 2006. We have more than 4,000 staff and about 1,500 volunteers.

Our dedicated and skilled staff work 24 hours a day, 365 days a year, to make sure patients receive the best possible care. Our diverse area is spread over about 7,500 square miles, from Hemsby to Hemel Hempstead and Sawtry to Southend. It contains rural, coastal and urban areas and, and our quality services are engineered meet each community's differing needs. Within our region there are six STP 'footprints' covering:

- Cambridgeshire and Peterborough
- Norfolk and Waveney
- Suffolk and North East Essex
- Bedfordshire, Milton Keynes and Luton
- Hertfordshire and West Essex
- Mid and South Essex.

In 2017/18 we dealt with more than one million 999 emergency calls. All 999 emergency calls are answered and managed in our three emergency operations centres (EOC) at Bedford, Chelmsford and Norwich. The call handler records information about the nature of the patient's illness or injury to make sure they get the right kind of medical help.

Our call handlers use sophisticated software to put the patient's condition into a particular category, depending on how urgent it is. This is known as triaging, and allows us to make sure the most seriously ill patients can be prioritised and get the fastest response.

Once this key information is established, the response will be either an emergency ambulance dispatched on blue lights or another face-to-face response, such a rapid response vehicle, through to further clinical assessment over the phone for patients with minor conditions, which could be advice over the phone from a clinician or a referral to their GP, pharmacist or local walk-in centre.

Not just an emergency service
As well as providing the 999 emergency ambulance service, we also provide a range of other services, including provision of non-emergency patient transport services, and commercial services, which are described in more detail in the 'Our Services'.

The Trust also operates two hazardous area response teams (HART), and has a resilience and emergency planning department, which deals with all internal and external emergency planning, responds to significant/major incidents and, provides specialist advice to our command team. They work closely with blue light partners, critical care charities and community volunteers.

3. Statement from the Chief Executive

Reflecting on the past year, I have cause to be immensely proud of our commitment to the people we serve. Our people and volunteers have continued to deliver outstanding care for the people in the East of England.

There are some clear areas of progress for the Trust, including the implementation of the Ambulance Response Programme (ARP) last October. The ARP allows us to respond to patients based on clinical need and helps us get the right response to patients first time whether that be for see and treat, treat and convey or advice over the telephone. Under the new standards we will have more time to get to patients, except those Category 1 patients who really do need a very rapid response. This means that we will need to change how we operate and deploy our resources and importantly focus on more ambulance cover as we will need fewer rapid response vehicles (RRV) given the extra time we will have for most patients. This change is driving our efforts to improve our fleet, and we have secured new concept vehicles which are innovatively designed to be more efficient and improve both patient and staff experience.

Winter is always a time of heightened pressure on the NHS, and despite our planned additional resilience it was particularly challenging for us this year. A number of measures were implemented to mitigate the expected increase in workload, firstly more Ambulance crews were out on the roads and more clinical advisors were operating from the control rooms. Our Hospital Ambulance Liaison Officers (HALO) worked collaboratively with the newly introduced Patient Safety Intervention Teams (PSIT) at acute hospitals, a national first. Together, these teams released 5,000 ambulance staff hours back on to the road from hospital queues. We also encouraged people to help the NHS by looking after themselves when appropriate, reminding people when to use 999, and – when clinically appropriate – to use other services.

We came under the public and regulator spotlight in January and invited a system-wide conversation about some of the difficulties we had faced. This led to the region-wide implementation of a hospital handover protocol by regulators NHS England and NHS Improvement. Nationally, this has been recognised as good practice and together with our system partners, we have collectively improved this key issue affecting our ability to respond to patients in the community.

Feedback from staff, volunteers and patients led to efforts to improve our health and wellbeing services for staff, and develop and improve our culture. Our Trauma Risk Incident Management (TRiM) practitioners are just one part of a busy and engaging Health and Wellbeing hub we continue to improve and develop. We also ended the year with an idea for a pilot on reducing late finishes for patient-facing staff which we are looking forward to seeing the benefits of, although ultimately the solution lies in increasing our capacity. We have launched a recruitment campaign to grow our workforce by an additional 330 patient facing staff by 2020 and during 2018, are adopting a new approach to engaging with staff to build better rotas to help us improve the work life balance for our people and provide an improved service to our patients.

There is always more to do, and it continues to be a challenging but rewarding time to be part of an ambulance service. We are interlocked with the six NHS and social care areas in our footprint, aiming to integrate even further and by embedding quality improvement within every area of our Trust, we will continue to be at the forefront of high quality care for people in the east of England.

4. i) Our performance

Operational performance

Ambulance services have historically been measured on operational performance by an eight-minute response time to patients. The need for the service comes from 999 calls, from the 111 service or from healthcare professionals. In July 2017 NHS England, following a large study and pilot by three ambulance trusts nationally, announced that all English ambulance trusts were to progress to the Ambulance Response Programme (ARP), moving away from the decades-old national time-based targets. Our service implemented this significant change to call answering and categorisation in October.

The ARP introduced new target response times which reflect the approach of right resource, first time. In effect, this removes the 'fast car' model for all but life-threatening conditions where time is critical. Whilst the Trust has a funding gap to enable delivery of national standards and is impacted by other factors such as delayed handovers in emergency departments, patient safety remains a primary focus and we will continue to deploy a fast responder where we may not be able to reach the category 2 emergency call within the 90th centile standard or where clinical needs present. As we develop capacity, we will move fully to the new NHS England model.

There are four main categories of patient response, categories 1, 2, 3 and 4, which ambulance services use to identify the urgency of the patient's call.

Category	Description	Response time and target	
Category 1	Calls from people with life-threatening illnesses or injuries.	Mean average 90th percentile	7 minutes 15 minutes
Category 2	Emergency calls – serious illness or injury requiring and ambulance response	Mean average 90th percentile	18 minutes 40 minutes
Category 3	Urgent – less serious illness or injury but still requiring and ambulance response	90th percentile	120 minutes
Category 4	Less urgent calls	90th percentile	180 minutes

The Trust is not currently commissioned to achieve the national standards but as part of the 999 contract settlement for the next 6 years, has secured agreement on a programme of investment that should enable the Trust to deliver regional aggregate level performance from 2019/202o onwards. A working trajectory in line with investment and recruitment will see a positive and welcome journey to this.

Due to the change in national standards in October 2017, the Trust is reporting two sets of performance data. The following table is the pre-ARP data on the old performance standards Red 1 and 2 and Green 1-4 noting that the Trust was not commissioned to achieve national standards:

Category	Performance	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	AQIS
C1	Mean	0:08:24	0:08:40	0:09:11	0:08:35	0:08:41	0:08:47	A25
	90th %tile	0:15:10	0:15:47	0:16:41	0:15:25	0:15:37	0:15:40	A26
C2	Mean	0:22:44	0:24:28	0:32:04	0:29:12	0:26:54	0:27:27	A31
	90th %tile	0:45:14	0:49:09	1:05:06	1:00:50	0:56:02	0:56:23	A32
C3	90th %tile	2:29:32	3:00:00	4:40:34	3:22:54	3:07:36	3:29:15	A35
C4	90th %tile	3:08:48	3:52:56	5:14:02	3:52:10	4:01:05	4:02:38	A38

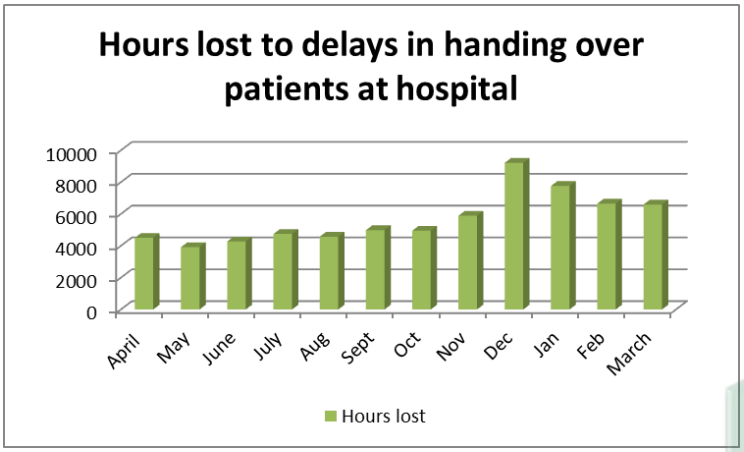
The table below is the post-ARP data (after the 18 October 2017), again noting that the Trust was not commissioned to meet national standards during the 2017/18 year:

Standard	Year to date position (at change of standards)
Red 1	70.53%
Red 2	59.27%
Green 1	49.68%
Green 2	41.67%
Green 3	53.57%
Green 4	71.84%

In the financial year to October 2017, the Trust met its commissioned standard of Red 1 (immediately life threatened calls) and moved itself to one of the best performing in this category nationally.

The Trust continued to experience significant loss of produced ambulance hours to delays in handing patients over to hospital care across the year. Some 96 per cent of all handovers exceeded the 15 minute standards, with 12 per cent (~26 thousand occasions) exceeding one hour. There were significant system-wide delays during the winter and particularly over the festive period.

To manage risk to patients in the community, the Trust developed Patient Safety Intervention Teams, a national first, that were deployed to hospitals to takeover care of patients who ambulances could not handover quickly. These teams cared for about 3,500 patients between November and March. The Trust is working with system partners to address hospital delay issues through A&E delivery boards, NHS Improvement and NHS England.

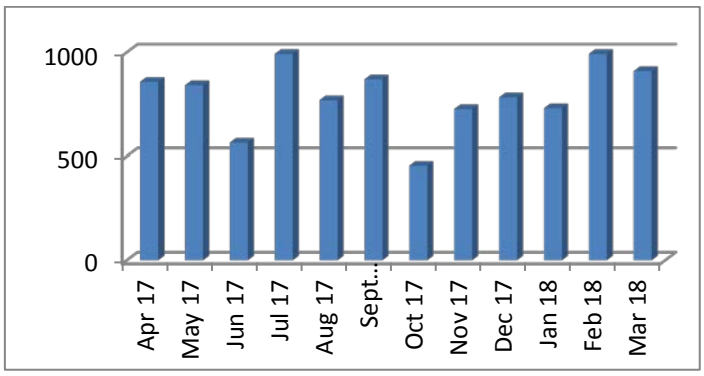


During the year, EEAST lost circa 69,000 hours in delays at hospitals. This equals approximately 6,000 12-hour ambulance shifts and resulted in an increase in response delays to patients.

Through an independent service review commissioned by NHS Improvement and NHS England, investment is identified and will form the basis of transformation plans over the next three years which will enable achievement of national standards and an efficient and sustainable operating model. The Trust continues to recruit to the student paramedic programme and also to vacant qualified posts.

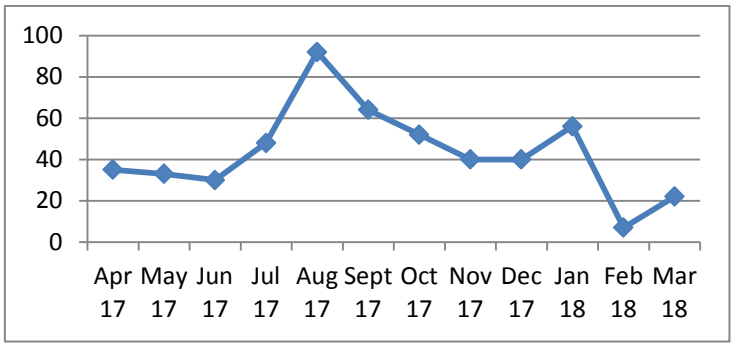
Resilience and Specialist Operations

The Hazardous Area Response Teams (HART) provided a strong and effective response to a major incident following a care home fire and were also deployed to support operations in Salisbury. The number of HART Team incidents attended across the year as follows:

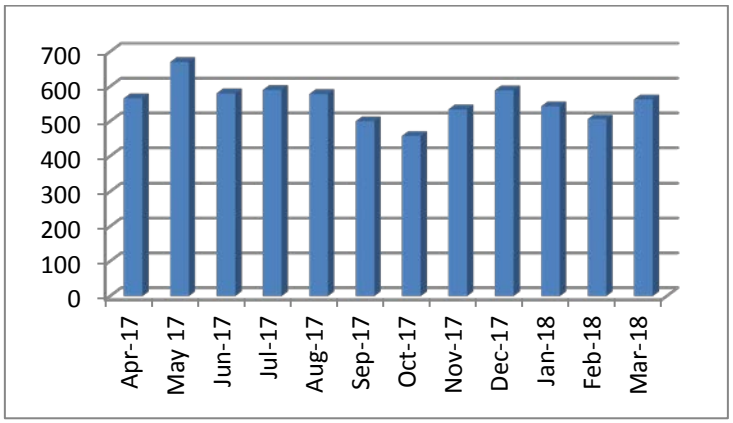


The Trust meets the specified requirement to provide 63 MTFA trained additional staff. There is a further training course planned for April 2018 to raise numbers to the aspiration of 100 in the team.

The key requirement is to ensure a full team of six is deployed for each HART team. Compliance with KPI availability requirements for the year as follows:



We continue to work closely with all our partners and stakeholders, which includes the three air ambulance charities and BASIC doctors. The number of Air Operations incidents attended across the year is as follows:



Emergency Preparedness, Resilience and Response (EPRR) – annual assurance
Under the NHS Constitution, all NHS funded services must ensure they have robust and well tested arrangements in place to respond to and recover from emergency situations.
The CCA 2004 specifies that responders will be either Category 1 (primary responders) or Category 2 responders (supporting agencies); EEAST is a Category 1 responder and therefore subject to the full set of Civil Protection Duties.

The minimum requirements which providers of NHS funded services must meet are set out in the current NHS England Core Standards for EPRR (core standards). These standards are in accordance with the CCA 2004 and the Health and Social Care Act 2012. The NHS Standard contract requires providers to comply with EPRR guidance and NHS England will ensure that NHS funded organisations are compliant as part of an annual assurance framework.

As part of an annual programme, NHS England seeks assurance on the preparedness of ambulance services in the form of a self-assessment against the NHS England EPRR core standards framework. This self-assessment informs the NHS England assurance provided to the Department of Health in relation to EPRR. The Trust board ratified the EPRR annual return, prior to submission to NHS England.

In October 2017 the Trust participated in a National Capabilities Audit and has an action plan in place to ensure focus on 100 per cent compliance.

Quality of Care

The Trust's overarching objective within the Quality and Safety Strategy relating to patient safety is 'to deliver harm free care to every patient, every time, everywhere'.

Five sub-objectives underpin this:

- **Honesty:** To be open, honest and transparent with staff, patients and stakeholders
- **Responsive:** To have a workforce to deliver services that is responsive to the needs of our communities
- **Support:** To establish a fit for purpose workforce, enabled through a mentoring and supervision framework
- **Safe:** To maintain and continually improve the quality care provided through the minimisation of risks, incidents, and complaints
- **Listens:** To ensure the patient's voice is the main driver for change and innovation.

To support meeting this objective successfully, the Trust is dedicated in continuing to reduce avoidable patient harm by 50 per cent, and is currently in the third year of its Quality and Safety Strategy to achieve this. At the point of implementing the strategy, 17 per cent of incidents related to patient safety involved a level of harm. This has reduced to 13 per cent with analysis of the final six months of the 2017/18 financial year to be done in quarter one of 2018/19. Through the strategy, the Trust focusses on 14 core areas designed to embed a safety culture, with the work undertaken demonstrating consistent improvement in 13 of these areas.

The NHS staff survey results further supports the improvements the Trust has made under the Quality and Safety Strategy, with a 5 per cent increase in staff believing they will be treated fairly if an incident occurs, and a 2 per cent improvement in staff confidence to report unsafe clinical practice. Work has not yet completed and focus remains on maximising learning opportunities through serious incident actions, the appraisal process, and ensuring staff have ample training opportunities.

Quality Strategy – quality improvement
The Trust is rapidly moving towards embedding quality improvement in all aspects of the service, with the intention to have a positive direct link and impact on developing the organisation's culture and high quality clinical care. We will need to build on the improvements already made and use lessons learnt to develop our progress and integrate this into patient-facing services.

Reduction of clinical variation is enabled through improved training, mentorship and supervision opportunities, with enhancements to the existing clinical variation and learning systems. Exploring options for learning apps and improved accessibility to e-learning will also be an aspect of the strategy. The Trust has already hosted its first Learning from Incidents events at the University of Suffolk, which was well attended with further dates planned to support the face-to-face element of our engagement strategy.

Establishing a quality improvement faculty via the quality, service improvement and redesign (QSIR) process is another ambition; staff delivering know and understand areas requiring improvement and the implementation of quality improvement methodologies will afford all staff with the opportunity to drive positive changes. Training of key roles is underway and 2018/19 will establish the Trust's quality improvement approach and the growth of the faculty.

The roll out of this programme in 2018/19 will rely on supporting the release of the faculty and our staff to undertake quality improvement methodology training. This will be managed through careful planning for gradual delivery over a two to three-year period, whilst collaborating with acute colleagues on the same programme to share faculty and staff. It is important that we do this in parallel with providing a safe and effective service for our patients.

The Quality Improvement Strategy for 2018/21 is in draft format and will be shared through engagement and consultation with staff and key stakeholders.

Quality indicators and priorities
The table below sets out the Trust's performance against its ACQIs for the financial year.

ACQI	Target 2017/18	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Avg YTD
ROSC at hospital (overall)	27.0%	28.8%	29.4%	25.5%	34.6%	35.3%	41.2%	35.8%	24.1%	28.7%	29.4%	26.6%	30.9%
		75/260	78/265	65/255	92/266	103/292	126/306	97/271	71/294	108/376	113/384	82/308	
ROSC at hospital (Utstein)	53.0%	59.3%	54.5%	66.7%	71.4%	57.5%	63.2%	78.3%	51.9%	54.2%	51.3%	51.4%	60.0%
		16/27	12/22	14/21	25/35	23/40	24/38	18/23	14/27	26/48	20/39	18/35	
Survival to discharge (overall)	7.0%	9.1%	6.6%	8.7%	13.1%	11.4%	11.4%	9.9%	6.9%	5.7%	6.0%	8.4%	8.8%
		23/252	17/257	21/241	33/252	32/280	33/289	26/262	20/288	21/371	23/381	26/308	
Survival to discharge (Utstein)	27.0%	32.0%	18.2%	42.1%	45.2%	27.0%	38.2%	36.4%	33.3%	18.8%	25.6%	29.7%	31.5%
		8/25	4/22	8/19	14/31	10/37	13/34	8/22	9/27	9/48	10/39	11/37	
PPCI <150**	95.0%	93.0%	92.6%	96.7%	86.7%	92.6%	89.1%	87.1%	87.5%	84.6%	85.7%	84.3%	89.1%
STEMI Care Bundle	86.0%	91.6%	93.4%	91.7%	90.6%	87.1%	91.4%	90.3%	93.5%	92.3%	87.8%	91.7%	91.0%
		131/143	141/151	110/120	135/149	122/140	138/151	121/134	115/123	108/117	144/164	111/121	
Stroke HASU <60	56.0%	52.2%	50.8%	49.3%	49.6%	51.9%	44.7%	38.8%	43.7%	28.3%	40.5%	46.1%	45.1%
		152/291	180/354	171/347	184/371	200/385	193/432	138/356	141/323	83/293	96/237	82/178	
Stroke Care Bundle	98.0%	99.3%	99.8%	100.0%	100.0%	99.6%	99.8%	99.8%	98.9%	99.3%	100.0%	99.2%	99.6%
		423/426	485/486	469/469	509/509	501/503	576/577	507/508	354/358	445/448	385/385	237/239	

The time-based targets for patients suffering a stroke (60 minutes for admission following receipt of the 999 call) and PPCI 150 remain challenging and the reconfiguration of the hyper acute stroke units (HASU) will require EEAST's close input to achieve the best outcome for patients.

The time-based targets have remained challenging for the Trust and work remains ongoing to support reducing on-scene times to a minimum where possible, thereby enabling patients to get to treatment centres earlier.

Work is also underway with the acute sector to better understand the survival-to-discharge potential, as this target is shared between the ambulance service and the acute hospital. Exploration is ongoing with Papworth Hospital regarding outcomes for patients and this will be widened throughout next year to other acute centres to support best practice and the sharing of learning.

Treatment of patients in cardiac arrest is the most serious form of emergency care and EEAST is focussed upon maximising the potential for patient survival. The Return of Spontaneous Circulation (ROSC) and Survival to Discharge targets remain challenging due to the relatively low numbers within this cohort of patients.

Within ARP, the focus of volunteer community first responders (CFRs) and deployment of defibrillators is targeted at the new Category 1 standard. Using the learning from ARP implementation, a longer-term plan of identifying new CFR schemes will be developed, alongside the continued use of community defibrillators. Defibrillators in the community will continue to be registered on the control room dispatch system in order that they can be deployed when an appropriate 999 call is received in the vicinity. Trials of new technology such as the GoodSam app are also planned for 2018/19 to continue to develop our response to patients in cardiac arrest.

The clinical audit plan remains focused on supporting quality account priorities with the additional areas for recognition of sepsis patients, emergency care practitioners (ECP) using antimicrobial drugs, recognition and treatment of acute coronary syndrome patients, quality of patient care records and the retrieval of submitted patient care records as a re-audit.
The themes suggested for next year's quality account priorities are currently in consultation with the public and stakeholders. The priorities suggested fit under the triumvirate of high-quality patient care - patient safety, clinical effectiveness and patient experience:

Priority 1	**Patient safety**	• Infection prevention and control – continuing improvements within the vehicle deep cleaning target for all operational areas • Improvements in results for the Safety Walkabout audit tool within patient transport services, in preparedness for a more combined approach the following year after completion of the restructure.
Priority 2	**Clinical effectiveness**	• Continuation in the implementation of an End of Life Care Strategy • Recognition and management of acute coronary syndrome patients • ECP usage of antimicrobial drugs.
Priority 3	**Patient experience**	• Monitoring of implementation of Dementia Strategy – bespoke user surveys.

Throughout clinical and quality improvements, there will be careful review of the impact of ARP on these initiatives to ensure they remain suitable. Amendments will be made where necessary during planning and review phases to support the longer term transformation and delivery against ambulance response standards.

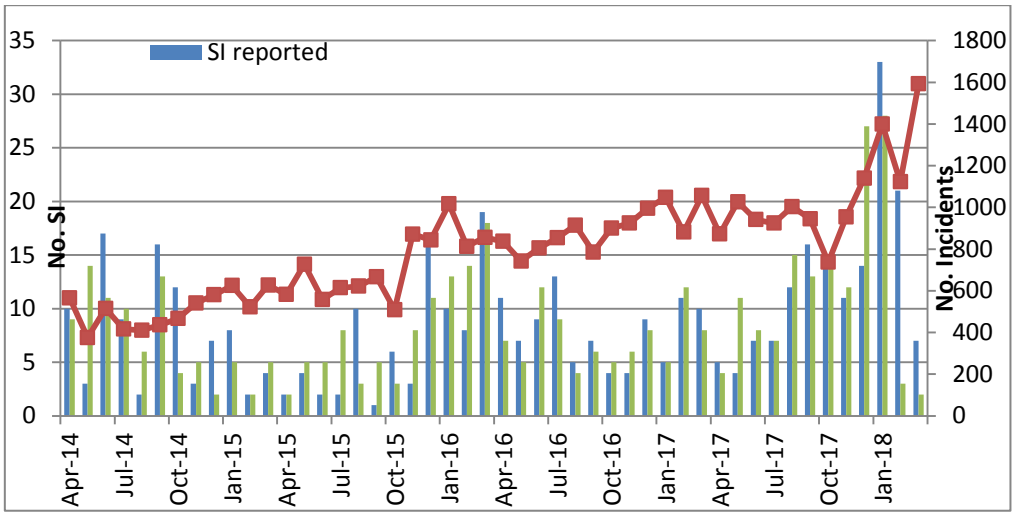
Patient safety

The Trust has robust patient safety processes that are well governed and effective, which have been scrutinised by regulators and deemed to be of high quality. As a result, the focus in 2018/19 will be improving the output of these processes; focussing upon learning and improving the pace with which learning is cascaded across the organisation and changes implemented.

During the year, the Trust has a sustained level of high reporting with low harm and has had no contractual never events. The total number of SIs reported in the 2017/18 financial year was 149, compared with 95 in previous year, a 57 per cent increase.

The Trust continues to have one of the highest levels of incident reporting nationally which indicates an open and transparent culture that promotes reporting across our workforce. Coupled with the ever decreasing levels of actual harm, indicates that the Trust is not just open and transparent but is committed to embedding the lessons learnt from reporting.

The following table shows the increase in reporting and also reflects a higher number of declared SIs. This is due to the Trust declaring 'near miss' incidents as an opportunity to learn, as outlined in the NHSE Serious Incident Framework which is highlighted as best practice:



These have included the 'near miss' category and accounted for 71% of those declared in line with the framework.

Process reviews and expanding the methodologies for learning to occur will be first and foremost to ensure rapid action is taken following a patient safety event. Steps have already been taken for dissemination of learning including the implementation of Jim's Legacy, the establishment of a procedure for gaining emergency access to properties to deliver emergency care to patients and the Trust intends to expand the level of learning from incidents. Furthermore, we will be establishing more intelligent analysis techniques that will allow EEAST to evaluate the effectiveness of actions, to ensure a positive change in practice or identify a need for further learning.

Within quarter four of 2017/18 a mortality review process, which is undertaken within all acute trusts, has been trialled. Whilst not mandated for the ambulance sector, the trial demonstrated a high number of opportunities for learning from these case reviews and consequently EEAST will explore the development of an ambulance process for mortality reviews, in order that every patient contact provides an opportunity for change and improvement.

The Trust will continue to work more with patients by involving them in the quality and Duty of Candour processes. The Trust recognises that involving patients in any investigation is critical to ensuring meaningful outcomes and learning opportunities.

Our commitment to delivering outstanding care remains imperative to the Trust vision and with continued focus from learning and the application of quality improvement methodologies to support staff innovation. Our ambition is to continue to provide that outstanding care to the patients within our communities.

Financial Performance

This Annual Report has been prepared to reflect the activities and financial position of the East of England Ambulance Service NHS Trust for the year ending 31 March, 2018.

2017-18 saw the Trust recover from a significant deficit of almost £10m the previous year to post a surplus of £3,376,000, therefore delivering a better position than our breakeven plan for the year.

Whilst this achievement was partly due to welcome additional funding from Commissioners, the Trust also improved its efficient use of front-line resources, in particular through the adoption of a 'Cost Control Model', which enabled operational managers to utilise overtime, agency and private ambulance provision to optimum effect.

Through the use of this model and other efficiency measures, the Trust was also able to fully deliver its cost improvement target of £6.2m (representing 2.3% of turnover) and has achieved over £37m in savings over the last five years. The Trust's expenditure on Corporate Support Services pay remains below the Carter Target of 6% of turnover and when benchmarked against similar costs for other ambulance trusts, EEAST ranks amongst the lowest costs.

A significant factor within the surplus was the reversal of impairments of fixed assets arising from the revaluation of land and buildings totalling £2,305,000. The Trust also benefitted from receipt of the CQUIN Risk Reserve of £976,000 which was released in March 2018.

The Trust also met the other important financial targets in complying with its External Financing Limit and Capital Resource Limit. The Trust worked closely with NHS Improvement to monitor its financial performance and ensure all actions to improve the financial performance were taken.

Almost £6.7m was invested into capital assets during the year. Of this over £2.7m was spent on our estate, including works to provide new depots, with Stevenage opened this year and work commencing in Ipswich. A further £2.0m was invested in vehicles and medical equipment including some replacement vehicles for our HART team. The remaining

£2.0m capital expenditure in year was largely on IM&T systems, hardware and infrastructure.

The Trust was pleased to agree the 2018-19 Emergency Services Contract with CCG Commissioners following the publication of the Independent Service Review. This contract ensures significant further investment in the Trust to enable delivery of the Ambulance Response Programme targets in 2019-20. However the agreement still leaves us with a challenging efficiency target of £6.7m for the year, which at 2.5% of turnover is higher than the national requirement for NHS trusts.

The Board will continue to monitor our financial position and key risks; the most significant financial risks being the delivery of the savings plans and the production of target patient facing hours over the year.

The full financial statements for the year ending 31 March, 2018, are presented within the Annual Accounts.

Strategic Performance

Over the course of the 2017/18 financial year, the Trust has made significant progress regarding its vision and values through progression against the strategic objectives and continued collaboration and involvement with STPs across our region.

In 2017 the Trust developed five core strategic objectives to focus upon until 2019, with the overarching mission to provide a safe and effective healthcare service to all of our communities in the East of England. The strategic priorities set out to achieve this mission are as follows:

1. Putting into place a new responsive operating model to deliver sustainable performance and improved outcomes for patients
2. Maintaining the focus on delivering excellent high quality care to patients
3. Ensuring we have a patient-focussed and engaged workforce
4. Delivering innovative solutions to ensure we are an efficient, effective and economic service
5. Playing our part in the urgent and emergency care system by being community focussed in delivering the five-year forward view

Underpinning these five priorities are a suite of 18 strategic priorities, which outline the scale of transformational change the Trust has committed to completing over the next two years, which are linked to four national drivers; the Single Oversight Framework, the Ambulance Improvement Urgent and Emergency Care Network and AACE.

Outlined below is the work undertaken on the strategic objectives and priorities over the first year, which will be continued in the 2018/19 financial year.

1. Putting into place a new responsive operating model to deliver sustainable performance and improved outcomes for patient

The overarching principle of the first strategic objective is that to meet the needs of our patients in a timely fashion, and the Trust must change the way it responds to the 999 calls it receives; historical operating models with a focus upon rapid response vehicles, combined with an operational structure that no longer aligns to the wider healthcare system due to the introduction of STPs resulted in the requirement for large-scale change.

Forecasting and planning is an essential component of the ambulance service to ensure we deliver care in the right place at the right time. Enhancements to our forecasting have been embedded, along with the procurement of additional software to support stronger planning abilities in the next financial year.

To do this, significant changes were required across all aspects of the organisation when the delivery model changed to ARP, most notably within the Emergency Operations Centres (EOCs) and information management and technology functions, as the way in which calls were taken, triaged and reported completely changed.

Alongside these changes, there was operational focus upon realigning the existing resources wherever possible to increase the number of ambulances available to take patients to hospital. This has established the framework for the work to be undertaken in 2018/19 to build better rotas and recruit more than 400 additional clinicians, to ensure we attend to all patients in a timely manner.

With ARP now embedded within operational delivery, there is now the requirement to focus upon the leadership structure itself to ensure the way in which we undertake operational business is well aligned to the wider NHS community to maximise relationships and collaboration. Significant work is already taking place within STPs through an interim operational structure but the planning for a permanent realignment is underway, with consultation on the changes commencing in early 2018, with implementation by quarter three.

2. Maintaining the focus on delivering excellent high-quality care to patients

The Trust is focussed upon ensuring patients receive safe, high quality care. To do this, the Quality and Safety Strategy outlines the core areas of improvement with the aim of reducing avoidable harm and strengthening the quality of treatment delivered. The three-year strategy has come to its conclusion with significant improvements across 17 core safety domains, and we are currently developing the Quality Improvement Strategy as the next phase of this journey.

Alongside this, a highly detailed improvement plan was developed following a Care Quality Commission (CQC) inspection in 2016, designed to reduce variation in practice across the Trust and improve the way in which we deliver our service so we move from an organisation requiring improvement, to one that is good. The improvement plan has been published and monitored through the website and resulted in large scale improvements in all areas, including medicines management and infection, prevention and control. The CQC Inspection completed its follow up inspection in quarter four 2017/18 and we are awaiting the results. However, work to continuously improve is ongoing.

The reduction of unwanted variation is also a core priority for the Trust, not just clinically but including variations in equipment and processes. The Trust is involved in standardisation of equipment wherever possible through the Carter and Ambulance Improvement Programme schemes, as well as looking internally through clinical variation, reflective practice and learning to improve the care our staff afford our patients.

In the coming year we will be focussing upon the establishment of a quality improvement faculty to embed quality improvement methodologies throughout the organisation and enable all staff to find ways to continuously improve the service we provide to patients and partners.

3. Ensuring we have a patient-focussed and engaged workforce

The Trust is committed to supporting staff, ensuring we enable them to deliver the best service they can. To achieve this, our aims have been threefold; recruit the right number and type of staff, establish robust health and wellbeing processes, and work to ensure the culture within the organisation embodies the vision and values established.

With the recognised capacity gap, it is essential the Trust undertakes the rapid recruitment of a significant number of clinicians to ensure we deliver timely care to patients. Not only will this improve the experience and safety of our patients, but it will reduce the pressure currently on staff, as well as resolve the existing issues with late finishes staff are experiencing because there are insufficient staff to meet the demand.

Completion of the independent service review in 2017/18 has determined the level of recruitment required and the People and Culture directorate has undergone a review of systems and processes in year to maximise efficiency for recruitment at scale in the years ahead. The workforce plan has been developed and delivery has commenced, with a recruitment trajectory in situ for each grade of clinician. Recruitment and training of our increased clinical workforce will continue over the next three years, to deliver the right workforce.

Our staff are pivotal to the success of this organisation and as such we recognise looking after the health and wellbeing of staff is essential. In 2017/18 significant work was undertaken

through the implementation of a wellbeing hub, working as a one-stop shop for staff to access a full suite of support services. The work on health and wellbeing continues into 2018/19 through the wellbeing strategy.

The culture of our organisation is the third area of focus within this strategic objective and staff survey results demonstrated the need for improvement. The Trust recognises that to change a culture takes time and as such, recognised the need to ensure this priority was approached in the correct way. As a result, an independent culture survey was commissioned and undertaken and a significant number of actions have been taken within the 2017/18 financial year as a result. Most notably, we have implemented a Leadership Strategy and Charter, designed to change the way in which all members of staff approach communication with one another and the core principles we will embody as a member of the East of England Ambulance Service.

Leadership training programmes have been established and will continue, in order to ensure staff are treated in the right way that is supportive of the Trust's vision and its values. The next stages within the cultural piece focus upon compassionate leadership, reviewing the appraisal process and establishing a performance framework that will support retention and development of staff.

4. Delivering innovative solutions to ensure we are an efficient, effective and economic service

Within this strategic objective are a suite of five significant change programmes that act as enablers to delivering a more efficient and effective organisation Fleet, make ready and estates, and information technology are fundamental to supporting the Trust to be more economic but require investment to bring about savings.

The fleet programme involves significant transformation, both in terms of the development of the future ambulance and replacement of the fleet, as well as the review and changes to the way in which our fleet are managed for maintenance and repair. The 2017/18 period has predominantly been a year of consultation and planning, with the development of four concept vehicles for staff to determine the best for the future implementation of the new fleet, which will take place in 2019.

The Trust recognises implementation of a full make ready system (the concept whereby staff commence their shift on a fully kitted vehicle, each and every time) brings significant efficiency savings and enables clinicians to do their jobs more safely. Make ready is in situ in some areas through the commencement of the programme, and further work is being undertaken in line with the estates strategy to roll out make ready sites across the Trust.

The size and scale of the organisation means we are technology dependent, with many software systems and programmes in use that are essential to delivering business. There is a clear need to develop and invest in technologies further to enable agile working, which will bring efficiencies across the entire organisation. Aspects of this include the replacement of Toughbooks currently used for electronic patient care records, with consideration given to personal issue devices. Transfer to Office 365 will bring significant efficiencies throughout the support services, as will progression to e-enabled systems such as e-rostering and e-timesheets. The Information Management and Technology strategy has been developed and is currently under consultation and work will continue through the next two years.

Underpinning this strategic objective is the principle of enabling the organisation to continuously deliver efficiency programmes, ensuring the way in which we use public money is maximised to ensure there is value in everything we do. Establishment of the Improving Value programme in 2018/19 will support a shift in how we go about identification and implementation of efficiency schemes and projects to better deliver the service we provide.

5. Playing our part in the urgent and emergency care system by being community focussed in delivering the five-year forward view (FYFV)

The FYFV proposes that, across the NHS, urgent and emergency care services will need to be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services and consequently the achievement of this will need to be system-wide. Therefore, the link into STPs is clear. The following provides an update on progress to date.

STP Engagement

The Trust's STP engagement is fully embedded across the six STP footprints within the east of England region. Each STP operates under a different set of agreed principles and governance arrangements and EEAST representation has been established in every STP through consistent attendance at key meetings and working groups associated with urgent and emergency care. The STPs have begun to mature and the formation of delivery groups has led to more requests and input from EEAST, which are managed by each sector head.

Working closely with STPs has led to innovation schemes being developed and expanded. Business development and service delivery have worked closely together to hone our offer to systems and develop a brochure of services that not only showcases the evidence on the effectiveness of these schemes but ensures consistency in messaging of the various innovative models we have to offer as a service. This brochure is in the final stages of development. Some examples of collaborative working to date are as follows:

- We have worked with Suffolk and North-East Essex STP on a paramedic rotation programme, and to ensure our case for make ready facilities in this area is included in the overall STP plans. Three of our proposed eight new-build facilities are in their area (Ipswich, Colchester and Bury St Edmunds).
- In Mid and South Essex STP, an expert group to support changes to the way healthcare is delivered across the three hospital sites within the footprint.
- During the winter period, the Norfolk and Waveney STP area faced some specific operational challenges with ambulance handovers. To support the system, the Trust led the direction and delivery of improving patient care and patient outcomes, instigating and hosting a workshop with colleagues from NHS England and Improvement, commissioners, all three acute trusts, and all quality leads.
- At Cambridgeshire and Peterborough CCG we are members of key meetings including health and care executive, STP programme board, urgent care delivery and interoperability board. Our input into these meetings supports the STP in its intention to become an integrated care service within the next three years.
- Across Bedfordshire, Luton and Milton Keynes STP we collaborate on the delivery of a mental health street triage vehicle.
- There are early intervention vehicles in operation across the Hertfordshire and West Essex STP.

Sustainability Report

In the Sustainability Development Action Plan (SDMP) we have set commitments to decarbonise our operations and promote healthy, low carbon lifestyles. We will achieve this by continuing to work across five key areas:

- Estate: reducing the environmental impact of our estate.
- Fleet operations: minimising the health and environmental impact of travel.
- Procurement: creating an ethical and resource efficient supply chain.
- Culture-informing, empowering and motivating our staff, patients and community to make sustainable choices.
- Governance: embedding sustainability in our corporate governance processes.

By taking such action, we expect to improve the well-being of our people, reduce costs and support a sustainable environment.

Estate

The Trust has started its long journey of transforming its estate in line with the Estates Transformation Plan. This year we opened new sites in Chelmsford, Stevenage and Letchworth and are focussed on establishing and securing capital for implementation of the Estates Strategy. Environmental impacts of our carbon footprint from lighting, heating and water continue to be focus areas for carbon reduction with the planned development of a carbon management plan which will set out the Trust's desire for establishing itself as an exemplar ambulance trust in the context of carbon reductions.

We are examining options together with suppliers for electric charging points to be located at strategic locations to accommodate the Trust's growing propagation of both fully electric and hybrid vehicles, and have begun to roll out the bulk storage of Adblu and palletised deliveries to reduce vehicle journeys across our estate and to reduce the need for staff to handle heavy containers of chemicals used to reduce carbon emissions.

We are tendering waste management services, which will embed a new approach to how waste is streamed to reduce the amount of waste going to incineration. The new tender will deliver bulk waste recycling at stations rather than landfill and safe removal of fleet engineering parts. The Trust continues to promote 'reuse' rather than purchase wherever possible.

Fleet operations

The Fleet team has continued to explore ways to provide vehicles that are environmentally cleaner and financially more sustainable. In our routine vehicle replacement programme for 2017/18 we have introduced 46 new Euro 6 standard vehicles replacing the older, less fuel efficient and higher carbon producing vehicles.

The following new vehicles have been introduced that meet the above standard:

- 10 Mercedes Benz ambulances
- 4 Fiat Ducato Trial ambulances
- 20 Peugeot Boxer patient transport vehicles
- 12 HART vehicles

A major focus has been preparing the Trust to move from high cost and high carbon-producing emergency ambulances to a different vehicle platform that performs more economically and is more carbon friendly. The existing Mercedes Benz coach built ambulance is based upon a 5-tonne chassis and will deliver approximately 14-16 mpg with a carbon footprint of 264 CO2 g/km.

We have developed four evaluation vehicles we are currently being tested by operational staff that are based upon a much lighter vehicle (4.2 tonnes) with a much higher mpg and lower carbon output. The base vehicle being tested is a Fiat Ducato, which can deliver 22 mpg with a carbon output of 153 CO2 g/km. Currently, the Fiat Ducato is the only commercial vehicle of this weight range that can deliver operational requirements, but we continue to explore developments within the commercial vehicle market within this weight range.

The Trust's fleet transformation plan clearly establishes the intention to shift to a lighter, interoperable ambulance that can deliver an appropriate operational and clinical environment, but offer the benefits of economy and sustainability. The fleet team will review the evaluation findings and develop a vehicle specification that meets the above objectives with the procurement process anticipated to commence within the late summer/autumn of 2018.

The groundwork delivered in 2017/18 will establish a rolling programme of carbon reduction with 485 vehicles identified to be procured within the next five years. The estimated overall carbon reduction based upon the existing emergency ambulance fleet is four million tonnes with achievement of this target phased by the ambulance replacement plan.

We are in the process on reducing the rapid response vehicle (RRV) fleet over the next two years. With a reduction of 116 vehicles planned and a replacement of the 74 remaining vehicles with newer more carbon efficient models. The estimated carbon reduction from this would be 800,000 tonnes.

We have taken the opportunity to explore the feasibility of new hybrid technology within an operational setting. A trial of the BMW i3 has been undertaken in some operational areas with extremely positive feedback. The vehicle performed well within a response-based context and whilst the trial was only a short period we experienced no mechanical or technical issues. We will continue to investigate opportunities to test the performance of this technology and evaluate other marques to enable a comparative assessment of benefits and costs.

We have reviewed the level of carbon emissions permissible within the lease car fleet and benchmarked against a range of public sector providers to demonstrate we are ambitious in our intention to minimise the carbon impact of our corporate car fleet on our environment. We will continue to review carbon emission thresholds and continue to reduce them as advances in technology enable cleaner, greener and operationally effective, reliable vehicles.

Procurement

We have introduced a supplier sustainability agreement that is utilised in OJEU tenders to support and develop sustainable and ethical practices within its supply chain. The aim of the agreement is to assist in/enable us to:

- Ensure the Trust contributes and delivers sustainable healthcare
- Ensures suppliers meet modern ethical standards and are working in a sustainable way
- Stimulate innovation to help deliver developments which are sustainable in our supply chain
- Meet stakeholder expectations and support our commissioners own sustainability strategies, policies and principles.

The supplier sustainability agreement covers five key areas of supply activity:

1. Labour
2. Health and safety
3. Environment
4. Ethics
5. Management systems

All tenders are evaluated on the basis of long term value for money, using whole-life costing evaluations and sustainability will be a factor in all OJEU tenders ensuring sustainability considerations are factored into all our major buying decisions.

The agreement will form part of the wider sustainable procurement policy currently being developed by the procurement team and due to be considered by the environment sustainability group later in the year.

Culture informing
The environment sustainability group aims to determine sustainability champions to highlight sustainability within the Trust. Staff have challenged the Trust to think of sustainable alternatives to plastic cutlery, plastic milk cartons and spoons and this has encouraged the Trust to examine the products in use:

- Packaging: action has been taken by Trust stores staff to call suppliers that deliver over packaged goods to reduce packaging.
- Location: where possible local sources of supply are being determined and used.
- Essential: The Trust continues to question each requisition. Do we need the item or can we live without it?
- Alternative: Is there a more sustainable alternative?
- End of life: Can it be donate? Is it durable and easy to recycle?

The Trust is due to begin to implement voice and video conferencing equipment starting in its headquarters next financial year. This demonstrates the Trust's commitment to find innovative ways to reduce carbon emissions through a reduction in journeys and to enhance staff wellbeing through a reduction in unnecessary travel.

Governance
The sustainability steering group has been renamed the environment sustainability group Lead by the Director of Strategy and Sustainability, the group has new terms of reference and a new determination to deliver on sustainability commitments through its quarterly meetings and action plans, and will produce for further consideration by the Trust Board a Sustainable Development Strategy for 2018-2023, providing a vision for a sustainable health and care system that considers the triple bottom line; finance, social and environmental factors.

Embedding sustainable development into management and governance processes is essential to deliver high quality healthcare. The Trust recognises this requires boards, managers, clinicians, nurses and many other staff groups to champion sustainability at the highest level.

ii) Our Achievements

The Trust is very proud both of its people and the service it provides, and achieved many achievements both in the workplace and further afield.

November's celebration ceremony at Anglia Ruskin University's Faculty of Medical Science in Chelmsford, Essex, welcomed more than 400 staff, volunteers, families and friends and distinguished guests and partners. The event consisted of a Celebration of Learning to recognise the professional development and achievements of staff followed by a Celebration of Special Contribution, which recognised staff with long service and those who had delivered excellence across a number of categories, including outstanding contribution awards of CEO commendations and special contribution awards for those going above and beyond the call of duty either through their work, or patient care.

The Ambulance Leadership Forum awards in March saw Rebecca Dawson, the Trust's Community Collaboration Administrator, receive an outstanding service award in the Administration Category. Rebecca was praised for putting her heart and soul into her role with the Community Collaboration Team and supporting the Volunteer Advisory Forum. She has also been instrumental in leading the Trust's volunteer recognition badges, designed to acknowledge 5, 10, 15 and 20 years' service of the Trust's volunteers, including community first responders, voluntary car drivers and Community Engagement Group members.

New awards schemes have been launched to further recognise the achievements of Emergency Operations Centre staff. The Stork Award pin badges are given to a call handler for assisting with the delivery of a baby, as well as platinum awards for staff who have achieved 300 high compliance audits – a quality measurement in the standards of handling 999 calls. The Discharged Alive badges, which will be awarded to call handlers, dispatchers and team leaders who have played their part in a cardiac arrest patient's chain of survival.

A pilot project between the Trust, Cambridge University Hospitals NHS Foundation Trust, Princess Alexandra Hospital in Harlow, Essex,, and East of England NHS Procurement Hub to reduce waste by standardising the use of medical products was shortlisted for a national award and won an 'Improving value through innovation' award from the Health Care Supplies Association (HCSA).

In 2017/18, EEAST continued to innovate and focus on system support and providing help and care where it is best provided:

- Early intervention vehicles focused on primary care and comprise a multi-disciplinary team of a paramedic or emergency medical technician and an occupational therapist, working together to support the patient staying at home where possible and providing them with both health and social care input at the point of contact.

- Mental Health Street Triage involved a multi-agency response model supporting a patient in crisis without an emergency department attendance.

- Increasing clinical support with telephone advice and supporting patients with self-care or into more appropriate care pathways. Over the last decade, however, the services have previously remained organised around an 8-minute response time target.

We continue to work with a number of clinical commissioning groups (CCGs) to develop early intervention schemes focussed on supporting patients to stay at home. An example is the introduction of 'Just in Case' medication for terminally ill patients, enabling them to be able to stay at home rather than taking them to hospital. This forms part of the End of Life Care Strategy, enabling

those nearing the end of their life to be treated in line with their own wishes and allowing them to die in their place of choice.

Through signing up and creating an action plan with the Dementia Action Alliance, we have also worked with the Alzheimer's Society and community-based groups, which include a number of dementia patients and their families, to look at how we can provide support and improve access to our services. This has included setting up a number of pop-up events and also their involvement in the design of the new ambulance.

During 2017/18 the Trust also recruited more than 520 participants (patients and Trust staff) into eight high quality research studies approved by a Research Ethics Committee, all of which were National Institute for Health Research (NIHR) Portfolio pieces of work. This is detailed further in the Trust's Quality Account for 2017-18.

The Trust released a short video to highlight who we are, the communities we serve, the priorities of the Trust, the struggles we have and most importantly, the people that do all of this. A huge array of staff from across the region were involved in the making of the video, and a British Sign Language version has also been released.

2017/18 also saw the official opening of two new ambulance hubs, in Stevenage and Chelmsford, which both provide better facilities and a better base to respond to patients.

iii) The Year Ahead

It is no overestimation to say that 2018/19 will be, and will precede a period of great transformation leading to further improvements for patient services. This section notes some of the significant work planned, and milestones to reach.

We will be realising the effect of £11.5m more funding into our service delivery this year – in reality, more people on the frontline and more fleet to help everyone respond to patients. Whilst it will take upwards of five years to translate funding increases during 2018-20 into improvement to services for patients and staff wellbeing, our Trust is working hard now to ensure we see tangible benefits soon.

One of the consequences of the Ambulance Response Programme implementation in October 2017 was to build better rotas for those staff who respond patients face-to-face. Changing rotas is never a piece of work to be taken lightly or done without staff consultation and engagement - in July we have launched the working parties with staff representatives across the region to start building rotas their colleagues then vote on. To be able to introduce rotas which ensure safe and appropriate responses to patients and balances with the needs of our diverse staff base, designed by the staff themselves, will be a major milestone for EEAST in 2018/19.

A major piece of work this year will be the new Quality Strategy, taking our quality agenda work through to 2022. The Quality Improvement team are taking a methodical approach with the strategy – by the time this annual report was published, the Quality Strategy draft had just gone through weeks of stakeholder consultation including involving staff and volunteers. Once the strategy has been finessed and signed off, it will be launched later this year and we looking forward to reporting some of the tangible outcomes of the ideas and innovations that come from it.

Our innovations in Fleet work continue into 2018/19 with the transformation programme for ambulances. The team responsible have tirelessly ensured that staff around the region have had the chance to test out models and related equipment, take on board their feedback, and finesse the

choices on what EEAST procures. We should see the fruit of their labours in June 2019 when the first new fleet start to roll out. The Estates Strategy is also informing the work needed for the next new hub in Ipswich, Suffolk. At the time of the annual report being published, EEAST is making good inroads in finding a suitable location and engaging staff in its development.

For all staff, they will see a difference this year in how their learning, development, and wellbeing is formally captured. The 'Compassionate Conversations' appraisal process will help continue to embed to embed the Trust values and the Leadership Strategy by equipping leaders will a simple, user-friendly process to support them to have effective working relationships with their teams. The new process actively encourages regular one-ones as part of having on-going conversations, and encourages engagement with each other and discussions of the things that matter. The positive consequences will be felt right across the Trust, and the benefits to our responses to patients and delivering services insurmountable.

The service delivery directorate in 2018/19 will focus on management structure alignment to substantiate arrangements around STP alignment, operating efficiency and effectiveness and non-emergency patient transport service integration.

5. Our patients

Caring for patients

Patients are at the heart of the ambulance service's purpose. Our standards are set to ensure high clinical quality, care given to a patient that we would want for our own family and friends, and positive clinical outcomes so that person goes on to recover well.

To help support this, every NHS Trust has a Quality Account which reflects on the progress made during the previous year and identifies priorities for the coming year. Our priorities for 2017/18 were set to help us reach the clinical quality standard we want, reach patients promptly and treat them effectively so they are satisfied with the service they receive from staff, as well as to gain their views through our patient survey programme and to learn and change practice determined from any negative feedback received. The Quality Account is published at the end of each June on the NHS Choices website.

Responding to patients' needs

Work with the rest of the community-focused health economy to progress the urgent and emergency care agenda is demonstrable by some of the work that the Trust has been involved in, such as the 'Just in Case' medication for terminally ill patients, the work with Dementia Action Alliance and the Alzheimer's Society, which were referred to earlier in the 'Our Achievements'.

Priorities for 2017/18

The Department of Health (DH) sets priorities including timely response and care for stroke, cardiac arrest and heart attack patients. From these, the Trust identifies targets set within three overarching priorities; patient safety, clinical effectiveness and patient experience. It includes matters such as learning from serious incidents and ensuring staff receive feedback from any incidents they have reported, implementing the Duty of Candour as well as continuing a priority set within the previous year in regard to the recognition of sepsis in the pre-hospital setting.

To reflect the work needed to continue to meet patient needs, we will remain focussed on a number of core priorities which match the mandatory indicators for ambulance trusts set by the DH:

- Category 'A' ambulance response times: preventing people from dying prematurely (domain 1)
- Patients with a pre-hospital diagnosis of suspected ST elevation myocardial infarction who received an appropriate care bundle: preventing people from dying prematurely (domain 1), helping people to recover from episodes of ill health or following injury (domain 3)
- Suspected stroke patients assessed face to face who received the appropriate care bundle: preventing people from dying prematurely (domain 1), helping people to recover from episodes of ill health or following injury (domain 3)
- Percentage of staff who would recommend the provider to friends or family needing care: ensuring people have a positive experience of care (domain 4)
- Rate of patient safety incidents and percentage resulting in severe harm or death: treating and caring for people in a safe environment and protecting them from avoidable harm (domain 5).

Local targets set for 2017/18 will continue in to 2018/19 to ensure we improve on findings determined during the previous year, the exception being a priority around sepsis, as this has been proposed as an ambulance quality indicator for this year moving forwards. Information relating to these priorities is included in our Quality Account.

Safeguarding

We have continued to build on effective systems to safeguard children, young people and adults. Safeguarding is a golden thread of the organisation and affects all staff and volunteers associated with the Trust. It remains an essential part of our clinical governance and overall risk management strategy and is illustrated in our Declaration of Safeguarding Competence.

Demonstration of on-going compliance is regulated through the Care Quality Commission, the Fundamental Standards of Care and associated Key Lines of Enquiry, and reporting through the statutory safeguarding self-audits (Section 11 of the Children's Act (2004)) for children, young people and the new adult audit that has been introduced in line with the Care Act (2014) requirements.

External engagement with all 22 safeguarding boards in the region enables us to promote and highlight performance, challenges, and initiatives that aim to keep all patients safe from harm. Furthermore, Trust Board and senior leader commitment to safeguarding has strengthened; there is a named doctor for safeguarding who now completes the team along with our new safeguarding specialist practitioner for children and young people and a safeguarding specialist practitioner for adults.

Training is aligned to the Royal College of Paediatrics and Child Health: Safeguarding children and young people, and has focussed on a back to basics approach. The blended learning method was open to all patient-facing staff and volunteers and has been well received and taken up - evidenced by the marked increase in referrals from the previous year. Full details of the safeguarding training can be located in the Safeguarding Training Strategy that maps out the direction of learning and development for all staff groups and volunteers over the next five years. The Safeguarding Training Strategy 2016-2019 is available in the Policy Library on the Trust's website.

All staff are expected to complete Level 1 training. Trust Compliance YTD from April 2017 to the end of February 2018 shows 72.2 per cent of Trust employees have completed a refresher workbook with mandatory elements, which also includes completion of the non-clinical workbook (assessments, core training and induction).

All patient-facing staff and volunteers including community first responders and blue-light co-responders are expected to receive Level 2 training. For the financial year 2017/18, 87 per cent all appropriately identified Trust employees had completed the two day PU.

The number of safeguarding referrals has continued to increase year on year. In 2017/18, they reached 43,000 compared with 33,306 the previous year, with March 2018 seeing a new milestone of more than 4,000 referrals made in one month.

Total Trust safeguarding referrals increased by 30 per cent as at March 2018 compared to April 2017. An average of 26 per cent of referrals made, received feedback (sent to the clinician by e-mail) in 2017-2018, compared to 27 per cent the previous year. The top three categories of abuse reported via the Trust are:

1. Self-neglect
2. Neglect
3. Domestic abuse/violence

We saw an increase in requests for information, and received 1,265, a 15 per cent increase on 2016/2017. Also 26 requests for information were made for serious case reviews, serious adult reviews and domestic homicide reviews. This continues to lead to recommendations to improve outcomes not only in practitioner practice but within our safeguarding policies. In addition, the safeguarding team continue to receive positive praise in relation to engagement and quality of independent management reports submitted by the safeguarding team.

Our priorities focus on managing the increasing demand of training all staff at the appropriate level, meeting the statutory frameworks around safeguarding children, young people and adults, along with promoting the importance of that no patient should be left in a position of harm.

The Care Quality Commission

The Care Quality Commission (CQC), England's independent regulator of health and social care ensures fundamental standards of quality and safety are met, and sets out what good and outstanding care looks like. Then, through inspections, ratings and published reports, it encourages care services to meet those standards. The CQC inspect organisations through five Key Lines of Enquiry (KLoE) to determine whether:

- we are safe
- we are effective
- we are caring
- we are responsive to people's needs
- we are well led

The full inspection report from the April 2016 unannounced inspection can be found at http://cqc.org.uk/provider/RYC. We received a rating of 'Outstanding' for the Caring domain, and 'Requires improvement' for safe, effective, responsive and well-led, with an overall the Trust was rated overall as 'Requires Improvement' by the CQC.

An inspection of the Trust's core service and a well-led inspection were undertaken during 2017-18, completing at the end of April 2018. The draft report is due to the Trust in early May 2018 and an improvement plan will be developed from the final CQC report.

All improvement plans down to department level have been published, which were monitored and reviewed by the Chief Executive and Head of Quality Improvement.

Quality roadshows continue to monitor and track progression of CQC actions and also to review actions which are recorded as completed. The next phase of the quality roadshows will focus on changes made and to ensure they are sustainable.

Clinical Audit Programme

Part of the quality governance framework, the programme provides assurance that services are being delivered to patients at the required standard, to meet the dimensions of quality: patient safety, patient experience and clinical effectiveness.

It provides an essential view of the care we give in terms of the patient experience and the clinical outcome of the treatment provided to patients. Where audit and experience reports highlight standards being delivered below those expected, it serves as an early warning so that, where necessary, corrective action can be agreed and taken in a responsive way. The results enable us to share good practice along with benchmarking the Trust against other ambulance services nationally.

The results of audits and experience audits are used to review and develop training for our staff and examples, themes or trends have enabled us to identify areas that draw out the quality measures. All audits are presented to the clinical development and effectiveness group, which reports directly into the clinical quality and safety group

The audit and patient experience programme for 2017/18 focused on national, strategic and regulatory driven audit projects which related to the priorities set within the Quality Account agenda as well as those identified by local student paramedics as part of their quality improvement plans. Full details of all audits undertaken are included within our Quality Account, which will be published on the NHS Choices website on 30 June 2018.

Being able to gather a wide range of information ensures a focus on the key priorities or to identify areas to discuss with commissioners and other providers of care. The link with research produces an evidence base of patient need that allows a continued search for the delivery of clinical excellence.

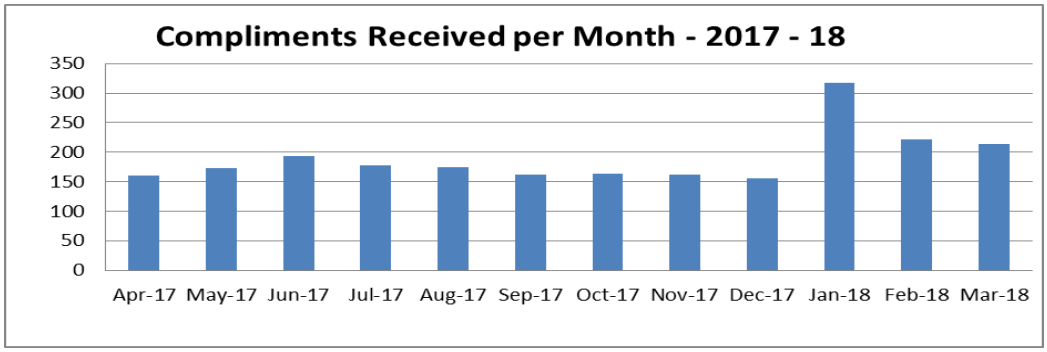
Compliments and Complaints

The Trust is committed to improving services to patients and to ensure that they get the right care, in the right place, at the right time.

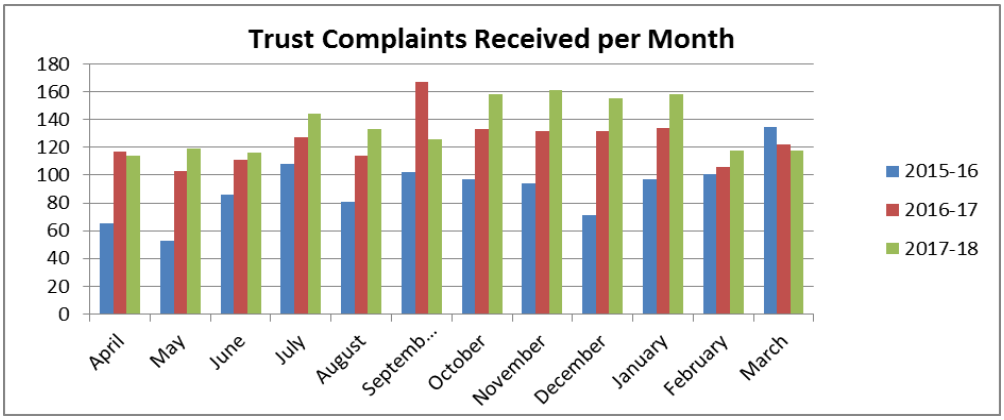
The patient experience team is responsible for co-ordinating all complaints, concerns, comments and compliments raised by patients, their families/carers and the public to ensure their concerns are heard, investigated and action is taken to put things right.

People who wish to provide feedback about the Trust can do so through a dedicated complaints e-mail address: eoeasnt.feedback@nhs.net, by phone: 0800 028 3382, in writing: Patient Experience Department, East of England Ambulance Service NHS Trust, Hammond Road, Bedford, MK41 0RG, via social media such as Facebook and Twitter and through patient forums such as NHS Choices, Patient Opinion and local Healthwatch boards.

Compliments
In 2017/18, more than 2,272 compliments were received; an average of 189 a month.



Complaints
In 2017/18, we received 1,620 complaints, an 8 per cent increase compared to 2016/17. Of those received, 60 per cent related to emergency services, 35 per cent to patient transport services and 4 per cent to commercial and corporate services. The total number of formal complaints received was 1,620.



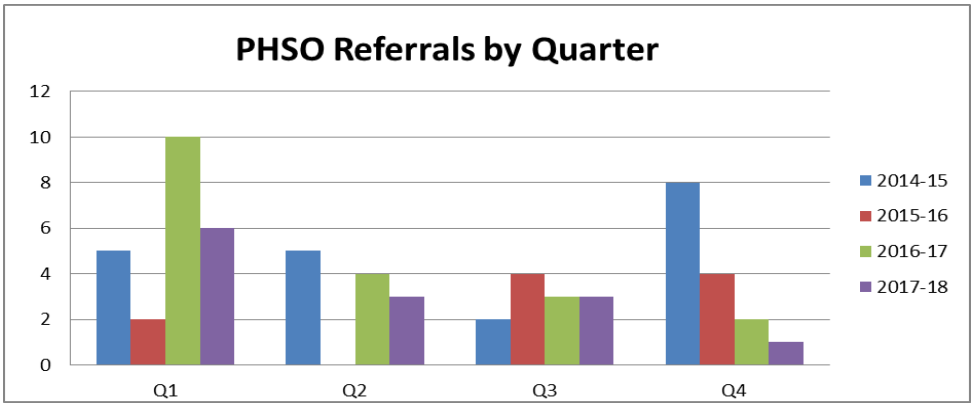
The Trust aims to investigate and respond to all complaints within 25 working days.

Of the complaints received in the year, 98.33 per cent were acknowledged within three working days, in-line with the local authority, Social Services and National Health Service Complaints Regulations (2009). Working with other NHS organisations is also embedded within the department and we worked on 87 joint complaints this year.

Complaints regarding clinical treatment and assessment, staff attitude and those relating to delay in response times have increased slightly since 2016/17. The Trust's priority is to continue to increase the number of patient facing compliments.

Although most complaints are resolved through our complaints process, complainants can refer their complaint to the Parliamentary and Health Services Ombudsman (PHSO) if they feel it has not been resolved. We received 13 referrals in 2017/18, a decrease from the 19 referrals in 2016/17.

The graph below shows the number of referrals the Trust has received from the PHSO per quarter.



Of those complaints investigated, only one complaint was upheld by the PHSO, demonstrating that the complaints handling process is both fair and proportionate, and resolving complaints to a satisfactory outcome in the majority of cases. The remaining closed complaints were not upheld, with the PHSO acknowledging the Trust's handling of each complaint did not require any further intervention or recommendations.

Looking forward
Quarterly peer review panels are held by the Community Engagement Group (CEG) to critically evaluate the current complaints process and their comments are appropriately actioned to improve the process for complainants.

Friends and Family Test (FFT)

The FFT is a national NHS directive and a method of obtaining feedback from patients and staff in relation to whether they would recommend the service to friends and family. The FFT is considered to be a continuous 'real-time' feedback loop between patients and the Trust, with patient feedback being available more quickly than traditional survey methods. Such a feedback loop not only highlights areas of good practice, but also areas for service improvement, which enables the Trust to take swift action if required.

The FFT question asks patients whether they would recommend the service they have used, and the responses received can provide the Trust with a greater understanding as to patients' experiences of the service.

The Trust is required to provide all see and treat emergency services (ES) patients (i.e. those we do not convey) and all PTS patients with the opportunity to provide feedback on the service received. The results to the FFT question are submitted to NHS England and the commissioners monthly.

The year-to-date FFT results are as follows:

- ES see and treat: Of the 418 responses received, 95.9 per cent of patients who answered the FFT question advised they would either be 'likely' or 'extremely likely' to recommend the service to friends and family if they needed similar care or treatment.
- PTS: Of the 1,536 responses received, 94.2 per cent of patients advised they would either be 'likely' or 'extremely likely' to provide a recommendation.

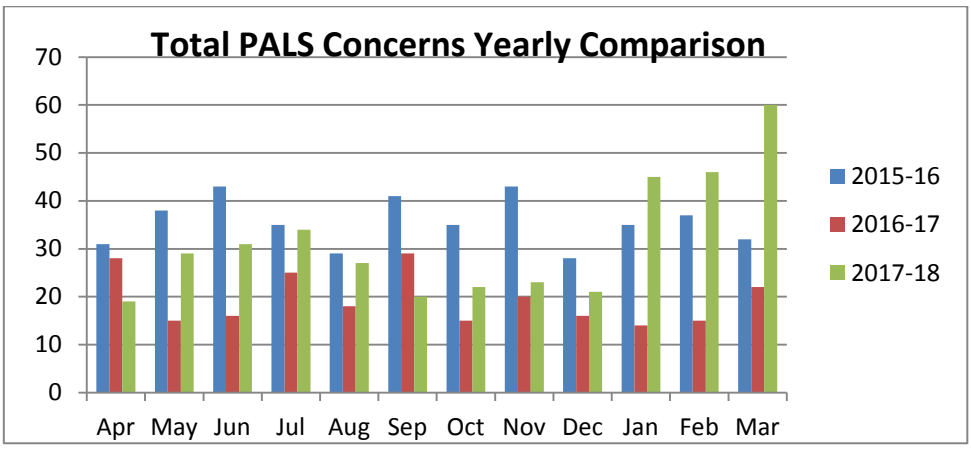
Trust patient experience results: April 2017 to February 2018	Friends and Family Test ('real-time')	
	Quantity of patients	FFT performance ('real-time')
'See & Treat' Emergency Services	401/418	**95.9%**
Patient Transport Services	1447/1536	**94.2%**
All Services	1848/1954	**94.6%**

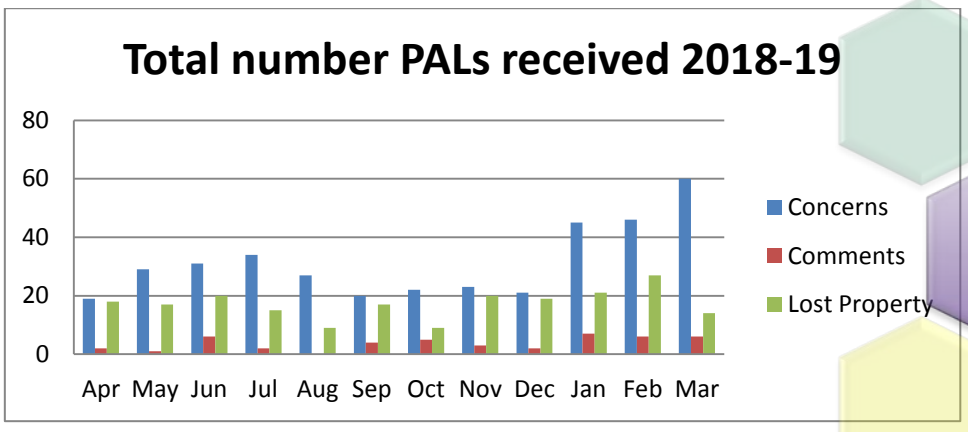
Our target for 2018/19 is to sustain the high level of patient satisfaction achieved in 2017/18.

Patient advice and Liaison Service (PALS)

The Patient Advice and Liaison Service (PALS) is responsible for recording a PALS enquiry (a question, comment or concern) or escalating the issue(s) to a formal complaint, as well as assisting patients and the public to locate lost property.

- 377 PALS contacts were received relating to negative concerns or feedback, an increase of 62 per cent from 233 received during 2016/17. These were all investigated and feedback provided, either verbally or in writing.
- 250 PALS contacts were received relating to comments, questions or other feedback, including requests about lost property; this is a slight decrease of 8 per cent from the numbers recorded during 2016/17.
- This makes a total of 627 PALS enquiries received, an increase of 23 per cent from 507 reported during 2016/17.





We are committed to using the feedback received through compliments, PALS comments and concerns to help drive improvements in service delivery. The themes and trends identified are linked with learning from other sources such as clinical audits, staff reported incidents, claims made by staff and patients and health and safety issues.

6. Our services

Patient Transport Services

The Patient Transport Service (PTS) is a lifeline for people who have scheduled appointments at hospitals, clinics or other healthcare units, but are unable to make their own way there.

The patient's journey starts with the patient transport clinical assessment and advice service. Patients and healthcare professionals call the advice line and are taken through the eligibility criteria that has been determined by the clinical commissioning groups. Those patients who are not medically eligible for PTS are directed to alternative services such as community transport schemes or voluntary services.

During 2017/18 the Trust handled more than 628,088 calls and completed 563,000 contracted journeys across Cambridgeshire, large areas of Essex, Suffolk, and Great Yarmouth and Waveney.

We also supported emergency cover in Bedfordshire and Hertfordshire due to the collapse of the previous provider, and supported commissioners with journeys which fall out of contract (ECR's). This year we undertook 8,082 non-contracted journeys.

Contracts for PTS are tender by CCGs and are a very competitive market. On 1 January 2018 the PTS contract for Bedfordshire and Hertfordshire went live. This is an unusual situation where a contract is being mobilised whilst being delivered. This contract provides 24-hour cover across four CCG areas. Unfortunately, when our contracts for Suffolk and Great Yarmouth and Waveney went out to tender, the Trust was not successful in these bids due to the financial envelope the commissioners required.

The PTS also complements our 999 emergency services and resilience team in the event of a major incident. This year we helped with the evacuation of patients at a nursing home fire in the Luton area.

Specialist vehicles are used to transport patients who are elderly, disabled, frail or with mobility or medical needs. Those patients who are mobile and able to sit comfortably in a standard saloon car may be taken to hospital by one of our volunteer drivers, known as the ambulance car service (ACS). The ACS supports the non-emergency service to deliver patient care within the region, by volunteering their time. This year, our volunteers made 106,657patient journeys.

We value the views of our patients, and satisfaction surveys conclude that satisfaction with PTS is extremely high, ranging between 90 per cent and 100 per cent, with patients saying that they would either be 'likely' or 'extremely likely' to recommend the service to a friend or a relative.

We have maintained our ISO accreditation and this year made the successful transition to the new ISO 9001:2015 standards in all areas; this is an auditable quality management system and is very valuable as a demonstration of the quality standards that we set for ourselves.

Commercial Medical Care Services

The Commercial Medical Care Service, (CMCS) provides paramedic lead ambulances for both event cover and dedicated medical transfers. Operating primarily in Norfolk and Suffolk, the team also travels across the region, and further afield.

The events team has contracts to support Norwich City Football Club, providing emergency cover for players and the crowd. The team has a prestigious contract with The Jockey Club at Newmarket and Huntingdon racecourses, and provides support at Fakenham Racecourse.

Other events covered include, for example, the Royal Norfolk Show and Cromer Carnival. In addition to event work, CMCS has supported patients by making numerous repatriation journeys for ill holiday makers returning to other CCG areas, transfers on behalf of social services and journeys to support private patients.

The events team has four ambulances that it uses for its work and in times of increased demand has been used to support local 999 operations in Norfolk. The 4x4 vehicles in fleet were especially useful during the snowy weather experienced in winter.

Further support has been provided to 999 operations through an urgent tier vehicle providing paramedic lead resource to attend health care professional referrals, inter hospital critical care transfers and as a first on scene to cardiac arrests.

The aim of CMCS is to raise funds for the Trust through commercial work, whilst building resilience in EEAST by providing capacity, reducing pressure on emergency operations through delivery of frontline emergency care.

Commercial Contact Centre

Our contact centre based in Norwich offers a 24-hour a day, year-round service to a large number of NHS and private sector customers, alongside providing a dedicated PTS booking and eligibility screening service for all of the Trust's PTS contracts. This includes North, South and West Essex, Bedfordshire and Hertfordshire, and Cambridge and Peterborough. It also operates PTS control overnight for the Bedfordshire and Hertfordshire PTS contract.

Commercial contracts include supporting GP surgeries throughout the east of England, message handling services for veterinary practices, fertility clinics, community nurses and solicitors. clients enjoy bespoke solutions that build on their organisational corporate social responsibility policies. The teams have great working relationships with stakeholders, who recognise the high-quality service provided. This is evident in the high retention of contracts, some of which have been contracted for more than 10 years.

The contact centre handled a total of 628,088 calls across all contracts in 2017/18.

OneCall and District Nurse Messaging

OneCall provides a single point of contact with call handling and referrals management for the community services including the rapid intervention team, district nurses, rehabilitation and enablement, community beds, palliative care, and community matrons. These are services provided by East London Foundation Trust (ELFT) with which we have an excellent relationship.

The service is for patients and community health and social care professionals and is integrated with our 999 system to enable ambulance crews to refer to services as required. Developments in this last year include the addition of Macmillan nursing and a more efficient dispatching process. An average of more than 6,200 calls was handled per month this year.

We provide a 24/7 support service to the community nurses who are able to access advice and support relating to case management and technical issues.

The following table sets out the number of referrals in each pathway during the year:

1Call Pathway	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Total	% by Pathway
District Nursing	3,810	4,453	4,492	4,432	4,304	4,195	4,357	4,340	4,292	4,405	3,751	4,338	**51,169**	**68.43%**
Rapid Intervention	298	355	390	408	372	357	378	351	412	404	367	378	**4,470**	**5.98%**
R&E / Physio / OT	1,426	1,484	1,502	1,422	1,454	1,324	1,383	1,427	1,074	1,523	1,406	1,497	**16,922**	**22.63%**
Community Bed	60	58	95	62	73	69	63	67	60	88	78	96	**869**	**1.16%**
Community Matron	29	28	39	29	34	34	40	45	34	35	27	41	**415**	**0.56%**
Macmillan	57	85	94	81	78	74	83	82	71	78	69	77	**929**	**1.24%**
Totals	**5,680**	**6,463**	**6,612**	**6,434**	**6,315**	**6,053**	**6,304**	**6,312**	**5,943**	**6,533**	**5,698**	**6,427**	**74,774**	
2016-17 Totals	6,021	6,443	6,701	6,280	6,555	6,302	6,481	6,459	6,274	6,430	5,919	6,758	76,623	
(increase on same period 2016-17)	-5.7%	0.3%	-1.3%	2.5%	-3.7%	-4.0%	-2.7%	-2.3%	-5.3%	1.6%	-3.7%	-4.9%	-2.4%	
2015-16 Totals	5,478	5,577	6,285	6,326	6,138	6,053	6,279	5,854	5,548	5,871	5,848	6,205	71,462	
(increase on same period 2015-16)	3.7%	15.9%	5.2%	1.7%	2.9%	0.0%	0.4%	7.8%	7.1%	11.3%	-2.6%	3.6%	4.6%	

Single Point of Contact

Single point of contact (SPOC) is an internal call handling service for all staff to make patient referrals to other organisations, as well as providing a telephone line for staff to raise incidents. It was set up in April 2009, and since its formation, SPOC usage has grown year on year and is now used for reporting:

- Safeguarding concerns for vulnerable adults and children
- Falls referrals
- GP report (relevant information the patient's own GP may need to know)
- Transient ischaemic attacks (or 'mini stroke')
- Hertfordshire admission avoidance response Car use
- Diabetic hypoglycaemia information
- Datix incidents

All services are managed through an Adastra system, specially designed with bespoke question templates for each pathway. These pathways not only provide a swift, efficient mechanism for staff to raise their concerns or fast track patients to specific services; they also have a positive impact on emergency 999 activities, reducing inappropriate repeat calls to the emergency service.

By the end of 2017/18, 94,235 referrals were made through SPOC. This represents an increase of 16.7 per cent against last year and a 58.5 per cent increase on 2015/16.

SPOC Pathway	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Total	Total % by Pathway
Safeguarding / Vulnerable Persons	3,340	3,520	3,476	3,616	3,512	3,267	3,597	3,605	3,635	3,884	3,643	4,351	**43,446**	**46.10%**
Falls Notifications	2,906	3,100	2,946	2,960	3,125	2,763	2,777	2,810	2,991	2,816	2,546	2,572	**34,312**	**36.41%**
GP Report	499	559	579	562	664	542	703	767	849	782	787	892	**8,185**	**8.69%**
TIA Notifications	4	8	9	17	12	6	11	9	13	11	8	7	**115**	**0.12%**
Abbey Pain Score	0	0	0	0	0	0	0	0	0	0	0	0	**0**	**0.00%**
Herts Admission Avoidance Response Car	87	93	95	90	79	95	112	75	75	74	50	65	**990**	**1.05%**
Diabetic Hypo	155	171	214	195	180	172	163	160	138	148	157	175	**2,028**	**2.15%**
Sudden Death *(Beds only)*	4												**4**	**0.00%**
Datix Incidents	390	460	419	418	401	374	390	390	432	453	396	631	**5,154**	**5.47%**
Totals	**7,385**	**7,911**	**7,738**	**7,858**	**7,973**	**7,219**	**7,753**	**7,816**	**8,133**	**8,168**	**7,587**	**8,693**	**94,234**	
(increase on same period 2016-17)	31.4%	32.6%	27.6%	25.0%	22.8%	13.7%	7.0%	7.7%	9.4%	8.8%	8.3%	15.9%	16.7%	
(increase on same period 2015-16)	69.3%	76.0%	73.9%	63.9%	59.6%	53.3%	51.9%	57.6%	52.2%	43.4%	49.4%	58.7%	58.5%	

Bedfordshire Out of Hours Call Handling

Providing a simple screening and triage service, calls are passed through a database to three different out of hours providers in Bedfordshire (Mdoc for west, Beddoc for north, and Care UK for south).

This service has been delivered by the Bedford team since October 2006. However, Bedfordshire CCGs have now successfully re-procured the service and this element transferred to another provider at the end of March 2017 under the new title of 'integrated urgent care service'.

Driver Training

The driver training unit (DTU) continues to be an approved centre to deliver FutureQuals emergency response driving and non-emergency ambulance driving awards.

Around 70 members of staff were trained for PTS and in excess of 250 staff members were trained in emergency response driving. Numerous other staff were assessed or given refresher training when joining the Trust from other organisations and already holding a driving award. Several people were trained as high speed driving assessors in an ongoing programme and several BASICS Doctors were also trained.

The DTU instructional team continues to maintain their accreditation as Driver and Vehicle Standards Agency approved driving instructors, LANTRA instructors, trained collision investigators and highly-qualified emergency response driver trainers. Many are further developing to conduct internal quality assurance. Three new developing tutors have joined the DTU team.

First Aid Training

The Commercial Training team, incorporated within the Training and Education directorate, is two years into the five-year plan focussed firmly on supporting the mission of the Trust by delivering financial surplus that will be reinvested to help improve patient outcomes and, through training and engagement, increase public awareness of emergency aid and 999 protocols'.

The team has extensive training operations across the region, from clinical D13 police firearms training to life support courses with Norfolk and Suffolk Foundation Trust along with other training (businesses, GP surgeries, dentists and schools). The people trained are then ready and able to assist in an emergency. Last year the team celebrated its 100,000th person trained.

The team has moved into offices in Hellesdon, Norwich, with an adjacent training room, which means the team can now offer open courses to the public.

The team is also winning new business with, among others, Manchester Airport Group (at Stansted Airport), Construction Industry Training Board, Herts Care Provider Association, Bedford Estates and Tendring Careline, and works with the community partnership team and automated external defibrillators (AED) manufacturers to promote the provision of AEDs and lifesaving training across the region, and the surplus is ploughed back into the frontline service.

The team is qualified in internal quality assurance and is assessed throughout the year to maintain training standards and compliance.

Growth plans in progress include recruiting to the team to support growing training demands, including the establishment of a bank training team to improve resilience and allow for more flexible expansion, and developing new products and customers.

7. Our people

Workforce planning, recruitment and retention

Recruitment was a critical focus for the Trust in 2017/18, and we continued to work towards meeting our clinical establishment with a focus on the recruitment of Student paramedics.

Figures for staff training in 2017/18 are tabled below:

Clinical grade	Numbers starting in 17/18
Intermediate ambulance practitioner	47
Associate ambulance practitioner	55
Student paramedic (Year 1) External Internal	88 82
Student paramedic (Year 2)	202
Graduate paramedic	116
Direct entry staff	59

As a Trust we expanded routes to market by running targeted recruitment campaigns for hard to recruit areas. These involved local recruitment advertising on buses and bus shelters, use of local press, building closer links with colleges and increased targeted use of social media. These campaigns saw much success and moving forward, it is our intention to build on this and further raise awareness of the organisation and promote vacancies.

In addition to A&E, recruitment in EOCs has also been a key focus for the Trust. The call handler profession typically has relatively high turnover rates.

In order to support with this, we worked to build resilience into the recruitment screening and emergency call handler training to ensure individuals we employ are a good fit for the organisation and fully understand the nature and scope of the role.

Our retention strategies in 2017/18 have focused on wellbeing interventions to support the mental health of the workforce. As with most emergency providers we experienced increasing demand and this coupled with the nature of the role has meant it has been paramount that we support our staff holistically so they are able to perform to the best of their ability are feel happy at work.

We therefore expanded the health and wellbeing team and held seminars across the trust to address mental health issues such as suicide prevention, launched a wellbeing bus that travels across the region to support all staff with any physical, emotional, social and psychological issues, and launched the Wellbeing Hub. . We also collaborated with other blue light services to provide training and development for both staff and managers in supporting with mental health and wellbeing in the workplace.

To aid with retention, we started to explore rotational programmes within the wider healthcare sector as we are mindful that paramedics are increasingly in demand from other healthcare providers (i.e. GP surgeries and acute care Trusts). We are working with our STP and wider sector colleagues to put schemes in place to support with this a pilot for rotational secondments has been established with Colchester Hospital University Foundation Trust. A cohort of specialist paramedics have been recruited onto Masters level programmes with partner universities to develop a cadre of paramedics with advanced skills in primary care, we will evaluate this over the coming year.

The review recommended an increase in staffing levels to enable the organisation to deliver safe and effective ambulance services, and will enable the Trust to increase the number of frontline staff by a further 333 whole time equivalent over the next three years.

In line with this, the Trust has developed a three-year workforce plan supported by a rota review and fleet and estates transformations to ensure resources appropriately match to patient demand. The A&E FTE 'staff in post' trajectories are set out below:

2016/17 average in post	2017/18 current in post	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20
c. 2600	2785	2930	2973	3060	3033	3066	3146	3166	3118

The implementation of the independent service review will mean the Trust will need to reconfigure the skill mix of the workforce as it moves to a paramedic-led model of care.

Training and Professional Development

Abstraction for frontline clinical staff continues to be a challenge due to sustained high demand. The professional update cycle remains at 18 months, with a plan to revert to a 12-month cycle in 2018/19. The online learning platform has been enhanced and a wide range of new materials added as part of the blended approach to learning and development.

The uptake and completion of statutory and mandatory training has increased with the move to online content, which is web-enabled and can be accessed remotely. A major review of the frequency and role specific content is underway. The introduction of a new learning management system and adoption of national content will enable the Trust to recognise learning from other NHS organisations and give a detailed breakdown of compliance by individual staff member, role or locality.
The learning and development and occupational development (OD) teams are reviewing the training plan for 2017/18 with a view to developing a more varied blended learning approach utilising new technologies, to support wider access of learning and development opportunities.

Leadership and management

The OD team continues to develop and deliver a range of leadership and management programmes in response to training needs identified by the Trust. This year, the OD team developed a blended learning approach; a mixture of e-learning modules, short courses, workshops and access to a range of leadership offers such as those from the NHS leadership academy and an in-house middle manager programme.

The internal programme has now supported six cohorts of band 6/7 leaders across clinical and non-clinical directorates. The programme is ILM accredited leading to a level 3 certificate on completion.

We continue to engage in the Mary Seacole Programme, and a collaborative 999 blue light leadership programme following a successful pilot in 2017. We are commencing the NHS Employers Leading Healthy Workplace programme developing a cohort of internal trainers to allow roll out across all teams.

Leadership continues to be highlighted as the most important factor in staff health and wellbeing in the recent staff survey and the Trust continues to implement the leadership development strategy launched in 2017. The focus this year has been compassionate and inclusive leadership supporting the new appraisal process that is predicated on compassionate conversations, values, development and performance.

A range of OD initiatives are in development to continue culture change including, talent management with open and transparent succession planning and promotion processes, systems leadership and the development of quality improvement skills.

The induction process is being refreshed with a focused approach for new managers and leaders to support their transition into role. We are working with an organisational psychologist to evaluate the interventions and measure impact on culture change and staff engagement.

Staff engagement and Involvement

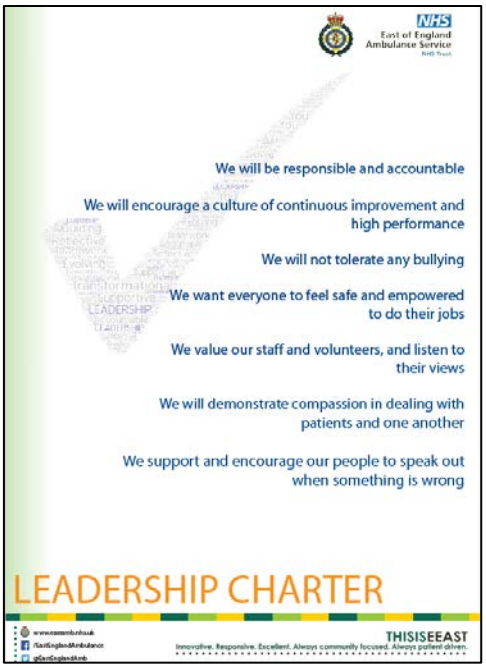
We continued to build on our staff engagement agenda in 2017/18. Our people told us they valued increased visibility of our executive team and the opportunity to speak directly with senior leaders in the organisation. To that end Chief Executive Robert Morton and other Executives held a number of listening events at locations across the region to meet directly with staff and listen to their ideas, experiences and concerns first hand.

Our people are fundamental to ensuring we can deliver on the expectations of those we serve, and therefore it has been a priority to ensure that compassionate leadership was the defining factor to support the organisation in achieving its aims. In-line with this, the Trust's leadership strategy was launched and set out how we identify and develop our leaders across all areas of the organisation and enhance the health, wellbeing and engagement of our staff. The aim of the Leadership Strategy is to ensure that:

'Our organisation will be led by compassionate, accountable and inclusive leaders across the whole organisation supporting delivery of safe and effective healthcare services.'

It clearly outlines the need to develop effective leadership at all levels of the organisation to support the achievement of the Trust's vision to provide a safe and effective healthcare service to all of the communities in region.

Alongside the launch of the Leadership Strategy was the Trust's Leadership Charter, which we have made visible on all channels and at all Trust sites.



Clinical briefings
To support the focus on staff development and engagement the Trust held a two-day clinical briefing event at Newmarket Racecourse for both staff and volunteers. These sessions celebrated clinical excellence and development.

With a 'back to basics' theme, the lectures focussed on important clinical areas like the science behind resuscitation, a deep dive analysis of the East of England Trauma Network, as well as learning from other ambulance providers like Wales and London ambulance services.

Talks and workshops were led by some of the country's leading experts in pre-hospital care, including Dr. Ron Daniels from the UK Sepsis Trust, Dave Halliwell, who founded Lifecast Body Simulation, and Aimee Yarrington, a paramedic and midwife.

Between the lectures there was the opportunity to look at the latest tools available and all members of staff also had the opportunity to receive a free flu jab, with the Trust's executive team leading the way and having their jabs ready for winter.

Special interest groups
As part of our commitment to inclusion, the Trust has set up a number of networking groups for underrepresented areas of the organisation, to provide a forum for networking opportunities, mentoring pathways and support personal and professional development, and the opportunity to explore more in depth the issues underrepresented groups face at work and what can be done to break down barriers. These are as follows:

- AWE: All Women East for women across the Trust
- LGBT: For lesbian, gay, bisexual, transgender and gender-fluid colleagues
- BME: for black and minority ethnic members of staff
- Disability Network: for colleagues with disabilities

The groups aim to inspire all attendee's to be the best they can be and the positive impact will no doubt be felt across the whole organisation.

The AWE group recently took part in a **#pressforprogress** event at Chelmsford City Racecourse which was a joint eastern regional International Women's Day conference on 8 March. The event was attended by a number of our blue light colleagues, including those from Essex Police, Essex County Fire and Rescue Service and Kent Police, and hosted key speakers from these organisations, who shared their experiences, and also celebrated achievements of women in the emergency services.

Staff survey
The 2017 staff survey results were broadly the same as 2016. The results remained unchanged in all areas except for two, which saw our results improve in relation to staff feeling we have fair and effective procedures for reporting errors, near misses and incidents and the percentage of staff who received an appraisal in the last 12 months. These results are encouraging, however, we do note that some of our scores are behind those of our ambulance sector colleagues and will work to address these areas moving forwards.

Our top five ranking scores are detailed below:

Survey finding	Trust score	Average Ambulance Trusts
Effective use of patient / service user feedback	3.30	3.24
% of staff experiencing discrimination at work in the last 12 months	18%	19%
% of staff satisfied with opportunities for flexible working patterns	35%	34%
% of staff experiencing harassment, bullying, or abuse from patients relatives or the public in the last 12 months	47%	48%
% of staff working extra hours	85%	85%

Data presented in % scores i.e. % of staff giving a particular response to a question or by scale summary scores where the minimum score is 1 and maximum is 5

Our bottom five ranking scores are detailed below:

Survey finding	Trust score	Average Ambulance Trusts
Support from immediate managers	3.31	3.44
Staff confidence and security in reporting unsafe clinical practice	3.34	3.49
Staff satisfaction with resourcing and support	3.02	3.16
Recognition and value of staff by managers and the organisation	2.91	3.01
Quality of appraisals	2.52	2.65

Data presented in % scores i.e. % of staff giving a particular response to a question or by scale summary scores where the minimum score is 1 and maximum is 5

These scores triangulate with findings from the Trust's previously undertaken cultural audit which further helped us to understand the key issues facing our people. Much work has already been undertaken to address areas for improvement which includes new leadership development approaches, revised appraisal process, the launch of FTSU guardians, and the development of our equality and diversity strategy.

We have noted from the staff survey that our bottom five scores are linked to our staff' interaction with their immediate line manager or other senior leaders within the organisation and we will work to embed our leadership strategy which will support targeted interventions to address these issues.

Dignity at Work
Ensuring staff work in an environment free from violence, abuse and harassment is of critical importance to our organisation and to support with this in we launched a campaign aimed at raising awareness of the right to dignity at work.

Through the cultural audit we identified that violence and aggression towards staff from patients or members of the public has a negative impact on our staff, with the survey revealing that more than 75 per cent of the respondents said they received verbal abuse regularly or every shift.

The **#dontchoosetoabuse** campaign was born as a consequence, which was hugely successful. The campaign was backed by TV presenter Jeremy Kyle, and launched publically to raise public awareness of the issue. Staff also worked with the communications team to share their experiences, with many also joining the movement on social medial using the **#dontchoosetoabuse** hashtag.

Health and Wellbeing

The Wellbeing Hub, established in 2017, is now gaining more recognition and momentum and handling growing numbers of enquiries and referrals each month. The wellbeing team supports staff, and recognises the importance and influence of good wellbeing on retention, absence, and morale of our people.

The hub offers a completely confidential one-stop shop for health and wellbeing, offering all staff and managers the opportunity to gain support and guidance, or signposting to a wide variety of services all relating to their wellbeing. Sometimes it purely offers the listening ear that might be needed at that time.

It will be moving into a new, fit-for-purpose home in Melbourn very soon and, although already well established, the Wellbeing Hub will be formally 'opened'.

The team will be extending their services during 2018 to include drop-in sessions around the Trust. The wellbeing bus will travel throughout the region engaging staff and promoting personal responsibility for health, as well as publicising the established wellbeing services. The small, satellite wellbeing office will also remain in Bedford where the Hub originated.

In the coming year, the Trust will be launching a team of Wellbeing Hub champions (still to be formally named) to provide peer to peer support around the three main call centres in Bedford, Chelmsford and Norwich. This team will be trained in spotting any basic signs of distress, and will encourage people to access the Wellbeing Hub for more support where appropriate. This model will be expanded to other areas of the Trust later in the year.

The Trauma Response Management system (TRiM) continues to thrive, with further training taking our team of practitioners to 200 across the Trust. We are developing a programme for ensuring staff wellbeing both during and after any major incident that might occur, and are looking at how we can specifically look after the needs of armed forces veterans who join our service.

The wellbeing strategy continues to focus on the recognition of the need for balance in the three elements of holistic wellbeing; psychological (including mental, emotional, spiritual), social (relational) and physical. Mental health and musculoskeletal remain the highest causes of sickness absence within the Trust and we are continuing to focus our resources in supporting staff with these issues, continually looking at new research, new options and new ideas for improvement.

The Trust's philosophy is that holistic wellbeing is an essential part of the foundation of any organisation. The model of integrated wellbeing (where both person and organisation need to have all aspects of physical, social and psychological wellbeing in sync to thrive) has been developed to provide both a healthy, inclusive culture, and an engaged, proactive workforce who look after themselves and each other. Closer working relationships are being forged with many other teams both within and without the Trust to ensure our goals of providing better services and best practice at all times are met.

Equality, Diversity and Inclusion

Equality, diversity, inclusion and human rights encompass all of the Trust's aims, objectives and actions addressing inequalities and promoting diversity in healthcare and employment.

2017/18 was a progressive year for equality, diversity and inclusion within the Trust. During this period, with support from Health Education England funding, some ground-breaking work took place to assist the Trust in engaging with the hard to reach and emerging communities in two of the most diverse areas in the Trust's areas of operation, Bedford and Luton.

A community ambassador engagement programme was introduced to aid the Trust in trying to fully understand and create a platform for members of the diverse communities to engage with the service.

The Trust demonstrates its commitment to Equality, Diversity and Inclusion for all by meeting the Public Sector Equality Duty (PSED). The Trust's equality, diversity and inclusion steering group oversees compliance with equality, diversity and human rights legislation, and is chaired by the Chair of the Trust Board. Action plans are reviewed and updated on a regular basis and further monitored by the steering group. The Trust Board reviews and monitors this work through its committees. Action plans accompanying each element are reviewed and updated on a regular basis and further monitored by the steering group.

Volunteers

The dedication of all our volunteers contributes towards the service we provide to patients and communities. In some cases, such as with community first responders (CFR), they enhance the speed that life-saving treatment can be started. We would like to thank all volunteers for their ongoing dedication and commitment to the ambulance service and for their positive impact on our patients and staff. The voluntary advisory forum (VAF) continued to meet and develop in 2017/18 and is a shared forum for volunteers to share information between volunteers and the Trust and to identify shared opportunities for learning and resource.

Community first responders

A CFR is a volunteer trained and supported by the ambulance service to attend emergency calls in the area where they live or work. Their aim is to reach a potentially life-threatening emergency in the first vital minutes before the ambulance crew arrives.

More than 870 CFRs in more than 240 groups play a vital role in saving lives in their community. They often reach a patient in minutes to start life-saving treatment whilst the ambulance is on its way and as an example can therefore have a specific impact on cardiac arrest.

In 2017, the implementation of ARP and associated ambulance quality indicators (AQIs) meant a change to how 999 calls are categorised and dispatched to. It also affects how the contribution of CFRs is measured in terms of performance. Despite this, the Trust has maintained the philosophy of deployment of CFRs to a range of calls across both the new Category 1 and Category 2 standards. Since the implementation of ARP in October, CFRs have attended more than 2,000 calls per month, peaking at almost 2,500 in December, which coincides with the peak of winter activity.
Led by the community collaboration team and supported by the VAF and CFR operational representatives, the volunteers also promote the role of the CFR and inform and educate people on the importance of basic life support and defibrillation and also on the role CFRs play. Many support the service and partner charities with training in basic life support (CPR). In addition, the team provides support to the growing network of defibrillators across our region, working with businesses, sports facilities, community groups, parish councils and others in their communities. These vital pieces of equipment help save the lives of people who go into cardiac arrest, and help deliver a better service to our patients.

Co-responders

We are supported by co-response schemes from external organisations, the main two being the RAF and fire services. The three established RAF co-responder schemes provide specific times of cover via dedicated vehicles from Henlow (Bedfordshire), Honnington (Suffolk) and Marham (Norfolk). They are trained to FREC 3 Level and as such respond to a wider range of incidents.

An ongoing pilot with fire and rescue services across the six counties continued in the first part of 2017/18 with fire co-responders providing a response to patients in cardiac arrest and providing early defibrillation and CPR. Unfortunately, this was not continued following the trial as business as usual on the same scale with only a limited number of sites remaining on a volunteer basis.

Q-Volunteering
Funded by the Department of Media, Culture and Sport, the Trust is a local lead for Q-Volunteering in Health and Social Care. In partnership with community and voluntary organisations, the Trust recruited 100 volunteers to work alongside publicly funded health and social care providers to help improve the health and well-being of the hard to reach communities. The Q-Volunteers are being recruited from diverse communities and those covered by the nine protected characteristics as defined in the Equality Act 2010 – in particular representing race, age, religion/faith, disability and sexual orientation.

8. The Trust Board

Directors' responsibilities
The Trust Board comprises non-executive directors, including associate non-executive directors, and executive directors that form a unitary body. The Trust Board functions as a corporate decision-making body and should consist of six non-executive directors including the Chair, and five executive directors.

The Trust Board currently consists of a Chair and five other non-executive directors, the Chief Executive, Director of Finance and Commissioning, Director of People and Culture, acting Director of Clinical Quality and Improvement, and Acting Medical Director. There is also the Director of Strategy and Sustainability and Director of Service Delivery who are not voting members of the Board, and three associate non-executive directors, who provide additional advice and expertise to the Board.

The Medical Director submitted his resignation notice on 10 November 2017 and left the Trust on 1 February 2018. The Director of Nursing and Clinical Quality retired from the Trust in April 2018. The terms of office of two non-executive directors also came to an end on 14 January 2018 and two new non-executive directors were appointed on 15 January 2018.

Appointment of Board directors
Due consideration is given to the composition of the Board in terms of the protected characteristic groups in the Equality Act 2010. Each Board member is appointed for their experience, business acumen and links with the local community. The Secretary of State for Health and Social Care has the power to make the appointments of the Chair and non-executive directors but has delegated this role to NHSI. As a result, NHSI is responsible on behalf of the Secretary of State for their appointment and removal and for on-going support through appraisal, mentoring and training. Terms of appointment are normally for periods of two years, with members eligible to be re-appointed or to re-apply up to a maximum of ten years. The non-executive directors' responsibilities include:

- Helping to plan for the future growth and success of the organisation.
- Making sure the management team meets its performance targets.
- Ensuring that finances are properly managed with accurate information.
- Helping the Board ensure it is working in the public interest.

The Chief Executive and the executive directors are appointed via public advertisement.

The Trust Board

i) Non-Executive and Associate Non-Executive Directors

Sarah Boulton
Chair of the Trust Board

Sarah Boulton has worked at NHS Board level for many years, chairing a number of NHS organisations, as chair of NHS Midlands and East Strategic Health Authority. Her background is in business and finance, working as a business and management lecturer and as a management consultant advising on strategy, change and Board development.

	From	To
Appointed to the Trust Board:	10 March 2014	31 March 2016
Re-appointed:	1 April 2016	31 March 2018
Re-appointed:	1 April 2018	31 March 2022

Mike Burrows
Associate Non-Executive Director, Chair of Audit Committee

Mike was in practice as a chartered accountant with KPMG and then Grant Thornton. Mike's main client-facing role was in audit and business advice but he also held various leadership positions. Since retiring in 2008, Mike has held a variety of non-executive and trustee roles including within the NHS, social landlord, economic development partnership, scientific research institute, a school academy, a theatre, an offshore wind farm services company and the FE/Skills Sector.

Within the NHS Mike was Audit Chair of the East of England Strategic Health Authority and then Chair of Hinchingbrooke Hospital during the period when its management was subject to a private sector franchise. Apart from the ambulance service, Mike's main current role is as Chair of the newly formed East Coast College which is based in Great Yarmouth and Lowestoft.

	From	To
Appointed to the Trust Board (Associate term):	1 May 2017	30 April 2018

Sheila Childerhouse
Non-Executive Director

Sheila joined us in July 2013 with a wide breadth of experience within the public, health and voluntary sectors. She has served for various local and regional health bodies since 1984 in non-executive and chair roles, including interim Chair of The Queen Elizabeth Hospital King's Lynn NHS Trust in 2005 and Chair of the national NHS Confederation Rural Sub Group from 2004 to 2012. Sheila was Chair of NHS Norfolk and Waveney and Deputy Chair of the East of England Development Agency. Sheila left the Trust Board on 14 January 2018.

	From	To
Appointed to the Trust Board (interim term):	15 July 2013	14 January 2014
Appointed to the Trust Board (first term):	15 January 2014	14 January 2018

Andrew Egerton-Smith MBE

Associate Non-Executive Director

Andrew qualified as a chartered surveyor in the 1960s and spent 30 years practising in the eastern counties until his retirement in 1994. During the 1980s, he was closely involved as a Trustee of Garden House Hospice in Letchworth, which was established in 1985 as one of the first hospice charities working in partnership with the NHS, and he remained a Trustee until 1998 when he was appointed Chairman of East Anglian Ambulance NHS Trust, a position which he held until 2006.

In 2000 he was one of the trustees involved in establishing the East Anglian Air Ambulance charity and was Chairman until December 2015. He is much involved in his own property activities and has been a Board member of various organisations including Flagship Housing from which he retired in 2013 and as deputy chairman of NHS Norfolk from 2006-2012. Andrew was awarded the MBE in the 2013 Queen's Birthday Honours.

	From	To
Appointed to the Trust Board (Associate term):	7 October 2013	6 October 2015
Extended to:		7 October 2018

Lizzy Firmin

Non-Executive Director, Chair of People and Culture Committee and Remuneration and Terms of Service Committee

Lizzy has extensive board experience gained in the private and public sector in both executive and non-executive roles having in the past worked with the North East Essex Clinical Commissioning Group (NHS) and the Central Arbitration Committee. Currently holding the position of HR Director with the UK Border Force, Lizzy is looking forward to meeting the people who make up the Trust.

	From	To
Appointed to the Trust Board (first term):	15 January 2018	14 January 2020

Peter Kara

Non-Executive Director, Chair of Performance and Finance Committee

A Fellow of the Chartered Association of Certified Accountants, Peter joined us in December 2013. He is a director of two private companies, and also provides financial investments to small and medium sized companies, together with strategic planning advice.

He has had a wide range of involvement in the voluntary sector in Milton Keynes since 1991 and with a national charity. He was Non-Executive Director to the Milton Keynes Community NHS Trust from 1993 until its dissolution in 2000. Peter was previously a Non-Executive Director of the Milton Keynes Primary Care Trust before its dissolution in April 2013, and is a Lay Board member of the Milton Keynes CCG and chairs its Audit, Finance and Remuneration committees. He has lived in Milton Keynes since 1980 and served as a trustee of the Milton Keynes Community Foundation and a director of its subsidiary, MK Community Properties Limited, having served terms as chairman of both organisations.

	From	To
Appointed to the Trust Board (first term):	2 December 2013	6 June 2017
Re-appointed:	7 June 2017	6 June 2019

Tony McLean

Non-Executive Director

Tony began his career in nursing and trained as a general nurse, psychiatric nurse and health visitor before moving into general management and eventually becoming a NHS trust CEO, managing community mental health and learning disability trusts in the South and East Anglia. He then moved into the independent sector and has run a number of other large healthcare businesses across the UK and Scotland.

	From	To
Appointed to the Trust Board (first term):	1 April 2015	31 March 2017
Re-appointed:	1 April 2017	31 March 2019

Valerie Morton

Non-Executive Director, Chair of Remuneration and Terms of Service Committee

Valerie has more than 35 years' experience in the voluntary sector specifically in fundraising and management. She has held senior positions at Help the Aged, NSPCC and RNIB. Valerie set up her own third sector consultancy business 15 years ago and she is currently a trustee of Central YMCA and of the Julia Norris Almshouse Trust.

She was a non-executive director at Bedfordshire Heartlands Primary Care Trust from 2001 to 2006, East of England Strategic Health Authority from 2006 to 2011 and Midland and East Cluster SHA from 2011 to 2013. She has been awarded the honour of Fellow of the Institute of Fundraising, is the author of the best-selling fundraising textbook Corporate Fundraising and is a regular columnist in Third Sector magazine. She left the Trust Board on 14 January 2018.

	From	To
Appointed to the Trust Board (Associate term):	2 December 2013	14 January 2014
Appointed to the Trust Board:	15 January 2014	14 January 2018

Dean Parker

Non-Executive Director, Chair of Audit Committee

Dean joined us in December 2013. He qualified as an accountant with the Audit Commission and is a member of the Chartered Institute of Public Finance and Accountancy.

Dean has more than 20 years' professional experience and expertise in audit, financial reporting, risk management and corporate governance. In addition to his Board role, Dean was a Non-Executive Director, and Chair of the Audit Committee at the Office of the Public Guardian. He was also the Independent Chair of the Electoral Commission Audit Committee and an Independent Member of the Audit and Risk Assurance Committee of the Equality and Human Rights Commission.

Previously, he was a Financial Audit Director at the National Audit Office, leading projects at the Department of Health, Monitor, the National Institute for Health and Clinical Excellence, the Health Protection Agency and the Department for Business Innovation and Skills.

	From	To
Appointed to the Trust Board (first term):	2 December 2013	1 December 2016
Reappointed:	2 December 2016	1 December 2018
Left the Trust Board:	14 January 2018	

Tom Spink

Non-Executive Director

Tom has more than 17 years extensive experience operating at board level, and nine of these have been with Aviva Insurance working in a global capacity. Having joined the company in 2009 as Creditor and Partnerships Director, Tom then went on to become CEO and General Manager of the Turkish arm of the insurance company in 2012 before going on to his current role as Procurement Director in 2013. Tom now joins the Trust with a real eagerness to make a change.

	From	To
Appointed to the Trust Board (first term):	15 January 2018	14 January 2020

Alison Wigg

Associate Non-Executive Director

Alison has for the past 20 years played a crucial role in global telecoms both in the UK and the US, helping large multinationals expand their internal networks in up to 170 countries around the world. She is currently a General Manager with British Telecom (BT) where she has been a board member for the past six years working on the strategy of BT's global network. Alison is keen to bring her technological background into her new role at the Trust.

	From	To
Appointed to the Trust Board (Associate term):	15 January 2018	14 January 2019

ii) Executive Directors

Robert Morton

Chief Executive

Robert Morton was appointed in August 2015. He began his ambulance career more than 27 years ago at the National Ambulance Service in Ireland, where he worked his way from the frontline to become chief executive, then became the CEO of the South Australian Ambulance Service before heading back across the globe to join EEAST. Robert is an HCPC-registered paramedic and has volunteered as a community first responder in Ireland and an Intensive Care Paramedic in Australia.

Appointed to the Trust Board:	August 2015 to date

Wayne Bartlett-Syree

Director of Strategy and Sustainability

Wayne started as a nurse auxiliary at Bedford South Wing Hospital in 1998, before training as a nurse at the Queen's Medical Centre in Nottingham. After qualifying, he progressed to becoming a senior nurse in critical care, and then moved into management, delivering a range of service improvement programmes, before leading urgent and emergency care reform in Coventry and Warwickshire and the West Midlands. More recently, Wayne was a member of the national team for specialised commissioning at NHS England, where he led the strategic planning function.

Appointed to the Trust Board:	July 2016 to date

Kevin Brown

Director of Service Delivery

Kevin has always lived in the east of England, and has nearly 20 years' experience in the ambulance service. He spent his first 10 years as a paramedic in the Beds and Herts Ambulance and Paramedic Service, before moving onto the police service and eventually into commercial healthcare, where he specialised in critical care.

He worked for London Ambulance Service for nine years as an experienced strategic commander when, amongst other achievements, he led the planning and delivery of the ambulance response for one of the London 2012 Olympic Games zones.

Appointed to the Trust Board:	July 2016 to date

Sandy Brown

Director of Nursing and Clinical Quality

Sandy has worked within NHS boards in Scotland and England in a career spanning more than 25 years, including a foundation trust. He has experience at executive level with the acute and ambulance sector, and worked within an integrated Board covering a wide range of services including mental health.

Sandy's roles have included general management, Director of Nursing, and Nurse Director incorporating the Director of Operations duties. He has also developed clinical pathways, working with clinical teams to improve patient care and experiences. Sandy was one of the first Nurse Consultants in the country and specialised in critical care. He has a degree in Clinical Practice (nursing) and an MA in Health Research. He has completed a Florence Nightingale Institute Scholarship and the Kings Fund Leadership Programme.

Appointed to the Trust Board:	February 2015
Retired from the Trust:	1 April 2018

Dr Tom Davis

Acting Medical Director

Dr Tom was appointed as the Deputy Medical Director and joined the Trust in February 2016 before taking on the Acting Medical Director role in February 2018. He qualified as a doctor in 2004 and worked in London and Bath as a junior doctor before moving to Buckinghamshire to take up a training post in General Practice. On completing his training in 2011 he became a Partner GP before moving into a portfolio of clinical, management and training roles prior to joining the Trust in 2016. He is also the Named Doctor for Safeguarding within the Trust.

Appointed to the Trust Board:	2 February 2018 to date

Dr. Mark Patten

Medical Director

Dr. Mark has worked in the medical field for nearly 30 years, both in the NHS and as a Royal Navy reservist. He has worked at the Luton & Dunstable NHS Foundation Trust for 18 years, starting in the critical care field as a consultant anaesthetist and clinical lead. He then became clinical director of theatres, anaesthesia and critical care, before spending three years as the medical director.

Appointed to the Trust Board:	July 2016
Resigned from the Trust	1 February 2018

Kevin Smith

Director of Finance and Commissioning

Kevin has more than 20 years' experience in NHS finance, working in the acute, community, mental health and ambulance sectors as well as experience in the construction industry.
He began his career at Great Yarmouth and Waveney Health Authority, then the James Paget Hospital and Norfolk Mental Health, before joining the East Anglian Ambulance Service NHS Trust in 2005. Following the merger of ambulance services in 2006, Kevin was appointed as Deputy Director of Finance for EEAST, continuing in this role until appointed as Acting Director of Finance in June 2014 to February 2016.

Appointed to the Trust Board (as Acting Finance Director):	June 2014 to February 2016
Director of Finance and Commissioning:	March 2016 to date

Lindsey Stafford Scott

Director of People and Culture

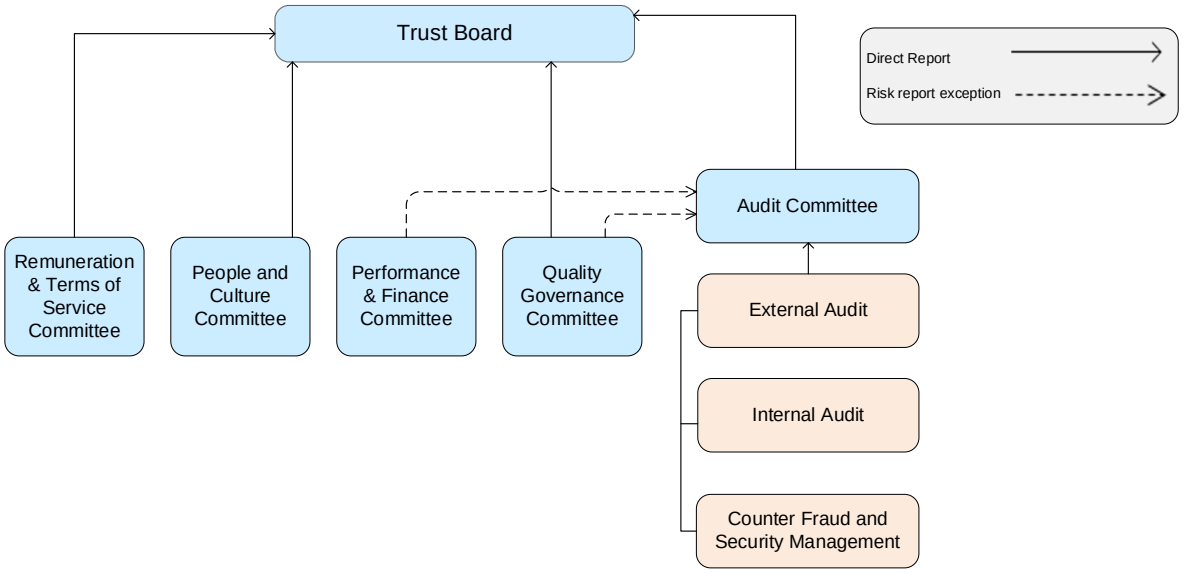
Lindsey has held a range of senior HR roles in public sector organisations including the probation service, education, social housing, Greater Manchester Police and the Essex Fire and Rescue Service. Originally from Lancashire, Lindsey has lived in the eastern region for four years.

Her role involves continuing the development of effective partnerships, and working with our people to ensure a positive culture and working environment for everyone is built, regardless of their role or location.

Appointed to the Trust Board:	March 2016 to date

Trust Board subcommittees and their evaluation processes

In accordance with the Public Bodies (Admission to Meetings) Act 1960, the Board holds its meetings in public. The Board has powers to delegate and make arrangements to exercise any of its functions through a committee, sub-committee or joint committee. The relationship of these is shown in the diagram below:



Review of effectiveness of the Board and sub-committees

The Board and sub-committees review their effectiveness informally on a regular basis and formally once a year through the Board's approved evaluation process. The Audit Committee utilises the self-assessment questionnaire from the Audit Committee Handbook. Both QGC and P&FC also undertake the self-evaluation on an annual basis.

The findings the self-assessments this year resulted in action plans and revised terms of reference for each of the committees. These were approved by the Trust Board in March 2018. The Board will also review and build its effectiveness, particularly reflecting the set of visions and values and the action plans from the cultural audit in the coming financial year.

Attendance at Trust Board and sub-committee meetings for 2017-18 is summarised in the table below:

BOARD DIRECTORS	Trust Board Formal Meetings Private	Public	Audit Committee	Performance & Finance Committee	Quality Governance Committee	Remuneration & TOS Committee
	Chair – Sarah Boulton		Chair – Dean Parker [Mike Burrows from May 2017]	Chair – Peter Kara	Chair – Tony McLean	Chair – Valerie Morton [Lizzy Firmin from February 2018]
Sarah Boulton Chair	10/11	6/6				4/4
Mike Burrows Associate Non-Executive Director	10/11	6/6	5/5	5/5		
Sheila Childerhouse [1] Non-Executive Director	7/8	4/4			3/4	2/3
Andrew Egerton-Smith Associate Non-Executive Director	10/11	6/6	4/5	4/5		
Lizzy Firmin [2] Non-Executive Director	3/3	3/3			0/1	1/1
Peter Kara Non-Executive Director	10/11	6/6	5/5	5/5		
Tony McLean Non-Executive Director	10/11	6/6			4/5	2/4
Valerie Morton [1] Non-Executive Director	8/8	4/4			3/3	
Dean Parker [1] Non-Executive Director	0/1	0/1	2/2	0/2		
Tom Spink [2] Non-Executive Director	2/3	1/2		0/0	0/1	
Alison Wigg [2] Associate Non-Executive Director	3/3	2/2				1/1

Values shown are number of attendances against number of meetings during the year. Where there is no entry this means the director is not a member of that committee.

[1].Sheila Childerhouse, Dean Parker and Valerie Morton left the Board on 14 January 2018.

[2] Lizzy Firmin, Tom Spink and Alison Wigg joined the Trust Board on 15 January 2018

Director's Declaration of Interests register 2017-18

Name and Position	Declaration of Interest	Declaration made	Resignation declared	Board Term of Office	
				From	To
Sarah Boulton Trust Board Chair	Director – Healthy Board Services Ltd Director – WMB Steele (2009) & Co Ltd	 Mar-18		10/03/2014	31/03/2018
Mike Burrows Associate Non-Executive Director	Chair of East Coast College (formerly Governor and Audit Chair of Great Yarmouth College & Chair designate of East Coast College: colleges have merged) Trustee and Chair of Finance for Sheringham Little Theatre Chair of NALEP Growing Business Fund Approvals Panel Member of Eastern Agri-Tech Programme Delivery Board Son is a consultant at Norfolk and Norwich NHS Foundation Trust	Mar-18		15/05/2017	30/04/2018
Sheila Childerhouse Non-Executive Director	Partner – T&D Childerhouse Self-employed as partner in T&D Childerhouse Self-employed executive coach Trustee – Keystone – Keystone Development Trust Trustee – Burrell Museum Trustee – East Anglian Children's Hospice Associate – Julie Oliver Associates Chair – Anglian Community Enterprise Appointed as Chair of the West Suffolk NHS Foundation Trust , as from 1 January 2018	 Oct-17		15/07/2013 15/01/2014	14/01/2014 14/01/2018
Andrew Egerton-Smith Associate Non-Executive Director	Honorary President – East Anglian Air Ambulance			07/10/2013	06/10/2018
Lizzy Firmin Non-Executive Director	Nil			15/01/2018	14/01/2020

Director's Declaration of Interests register 2017-18

Name and Position	Declaration of Interest	Declaration made	Resignation declared	Board Term of Office	
				From	To
Peter Kara Non-Executive Director	Mental Health Act Manager – Central & North West London NHS Foundation Trust			02/12/2013	01/06/2017
	Lay Board Member – Milton Keynes Clinical Commissioning Group			02/06/2017	01/06/2019
Tony McLean Non-Executive Director	Executive Chairman – Cumbric Care Limited			01/04/2015	31/03/17
	Executive Chairman - Byron Court Care Home Limited			01/04/2017	31/03/19
	Executive Chairman – Mother Redcaps Care Home Limited				
	Executive Chairman – Barrisle Care Home Limited				
	Executive Chairman – Rivington Park Care Home Limited				
	Executive Chairman – Blair House Care Home Limited				
	Executive Chairman – Victoria Care Home (Burnley) Limited				
	Executive Chairman – Newco Southport Limited				
	Chairman and Director - Allington Healthcare Limited				
	Managing Director of Mclean and Mclean Consultants Ltd				
	Director of Cumbric Community Care Ltd	Mar-18			
	Cumbric Community Solutions Ltd (10587257)	Mar-18			
	Wife is Chief Nurse for Ipswich and East Suffolk CCG and West Suffolk CCG				
	Wife is on secondment to NHSE Midlands and Eastern Region	Mar-18			
Valerie Morton Non-Executive Director	Proprietor of Valerie Morton Fundraising & Consultancy – some clients may be health related charities. Currently no conflicts to disclose.			02/12/2013	14/01/2014
	Undertaking consultancy work for The Ambulance Staff Charity (TASC)			15/01/2014	14/01/2018

Director's Declaration of Interests register 2017-18

Name and Position	Declaration of Interest	Declaration made	Resignation declared	Board Term of Office	
				From	To
Dean Parker Non-executive Director	Wife is the Chief Officer at the following Clinical Commissioning Groups – Westminster, Ealing, Hounslow, Kensington and Chelsea, Hammersmith and Fulham and was previously the Chief Finance Officer at the same groups. Chair of the Electoral Commission Audit Committee Non-Executive Director of the Office of the Public Guardian			02/12/2013	15/01/2018
Tom Spink Non-Executive Director	Nil			15/01/2018	14/01/2020
Alison Wigg Associate Non-Executive Director	Nil			15/01/2018	14/01/2019
Wayne Bartlett-Syree Director of Strategy and Sustainability	Wife is a nurse for NHS Blood and Transplants.			05/07/2016	
Kevin Brown Director of Service Delivery	Nil			05/07/2016	
Sandy Brown Director of Nursing and Clinical Quality	Member – Lord Carter National Clinical Reference Board Member – Eastern Academic Health Scientists Network Patient Safety Collaborative	 Apr-17		23/02/2015	
Dr Tom Davis Acting Medical Director	Director of TSD Healthcare Ltd GP VTS Programme Director, Health Education England (Thames Valley) Board member, Hertfordshire Independent Living Service (HILS, social enterprise) Wife is a consultant at the Milton Keynes University Hospital	Mar-18 Mar-18 Mar-18 Mar-18		02/02/2018	
Robert Morton Chief Executive	Nil			24/08/2015	
Dr Mark Patten Medical Director	Part-time consultant at Luton and Dunstable Hospital Wife is a part-time GP – Everest House Hemel Hempstead			06/07/2016	01/02/2018

Director's Declaration of Interests register 2017-18

Name and Position	Declaration of Interest	Declaration made	Resignation declared	Board Term of Office	
				From	To
Kevin Smith Director of Finance and Commissioning	Wife is an employee of the Trust, working as part of the Commercial Services Team.	May-17		01/06/2014	
Lindsey Stafford-Scott Director of People and Culture	Nil			29/03/2016	

9. Accountability Report

i) Financial Report

This Annual Report has been prepared to reflect the activities and financial position of the East of England Ambulance Service NHS Trust for the year ending 31st March, 2018.

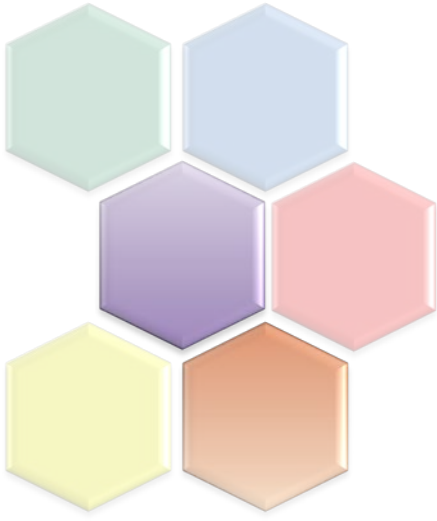
The Trust met the three important financial targets: Breakeven, External Financing Limit and Capital Resource Limit. Plans submitted to NHS Improvement were used for monitoring our financial performance during the year.

For the year ending 31 March 2018, the Trust is reporting a retained surplus of £3,376,000. This was ahead of the planned breakeven target for the year. Of this surplus, £2,305,000 was due to the reversal of impairments of fixed assets arising from the revaluation of land and buildings.

Further details on the Trust's financial activities are given in Section 4 of this Report above.

The full financial statements for the year ending 31 March 2018 are presented within this Annual Report.

Kevin Smith
Director of Finance and Commissioning



Remuneration Report

Trust Board Remuneration Committee

The Remuneration Committee is responsible for advising on the appointment and/or dismissal of executive directors and directors the approval of their remuneration and terms of service, and for the monitoring of their performance against delivery of organisational objectives. Membership is drawn from the non-executive directors and has four members including the Chair. The Chief Executive is entitled to attend the committee and be consulted with when the appointment and remuneration of the executive directors is being considered. He is excluded from meetings on his own position.

All appointments are by public advertisement, and external assessors are part of the recruitment process.

Remuneration and performance conditions

The remuneration of the Chair and the non-executive directors is decided by the Secretary of State. The time commitment required is approximately three days per week for chairs and two-and-a-half days per month for non-executive directors.

To determine an executive director's salary level, the Remuneration Committee used one or more of the following independent benchmarking comparative data during 2016/17:

- Hay Group
- NHS Foundation Trust Network
- NHS ambulance services
- NHS Providers Survey.

Our policy on remuneration of senior managers fully reflects the national guidance issued by the Department of Health. The performance of senior managers is assessed by performance against objectives. Executive directors have permanent employment contracts with termination periods of six months. The exception to this policy is by agreement of the Remuneration Committee.

Reporting of other compensation schemes – exit packages

There are no special contractual compensation provisions for early termination of executive director's contracts. Early termination by reason of redundancy is subject to normal NHS terms and conditions of service handbook or, for those older than the minimum retirement age, early termination by reason of redundancy or 'in the interests of the efficiency of the service' is in accordance with the NHS Pension Scheme. Staff above the minimum retirement age who themselves request termination by reason of early retirement are subject to the normal provisions of the NHS Pension Scheme.

Detailed below are the remuneration, salary and pension entitlements of the senior managers. These disclosures have been audited.

Salary and pension entitlement of the Board

The Chief Executive has determined that senior managers are those people in senior positions having authority or responsibility for directing or controlling our major activities. This means those who influence the decisions of the entity as a whole rather that the decisions of the individual directorates or departments.

Detailed below are the remuneration, salary and pension entitlements of the senior managers. These disclosures have been audited.

Staff Report

This reports staff numbers, staff composition, sickness absence data, expenditure on consultancy and exit packages.

Salary and Pension entitlements of senior managers - subject to audit

Salary and Allowances

Name	Title	2017-18						2016-17					
		(a)	(b)	(c)	(d)	(e)	(f)	(a)	(b)	(c)	(d)	(e)	(f)
		Salary (bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (a to e) (bands of £5.000)	Salary (bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (a to e) (bands of £5.000)
Senior Managers in post at 31 March 2018													
Sarah Boulton	Chair	35-40	Nil	Nil	Nil	Nil	35-40	35-40	Nil	Nil	Nil	Nil	35-40
Tom Spink	NED	0-5	Nil	Nil	Nil	Nil	0-5	n/a	n/a	n/a	n/a	n/a	n/a
Lizzie Firman	NED	0-5	Nil	Nil	Nil	Nil	0-5	n/a	n/a	n/a	n/a	n/a	n/a
Tony McLean	NED	5-10	Nil	Nil	Nil	Nil	5-10	5-10	Nil	Nil	Nil	Nil	5-10
Peter Kara	NED	5-10	Nil	Nil	Nil	Nil	5-10	5-10	Nil	Nil	Nil	Nil	5-10
Andrew Egerton-Smith	Associate NED	5-10	200	Nil	Nil	Nil	5-10	5-10	Nil	Nil	Nil	Nil	5-10
Mike Burrows	Associate NED	5-10	Nil	Nil	Nil	Nil	5-10	n/a	n/a	n/a	n/a	n/a	n/a
Alison Wigg	Associate NED	0-5	Nil	Nil	Nil	Nil	0-5	n/a	n/a	n/a	n/a	n/a	n/a
Robert Morton	Chief Executive	140-145	7300	Nil	Nil	32.5-35	185-190	140-145	5100	Nil	Nil	30-32.5	180-185
Alexander Brown	Director of Nursing & Clinical Quality	115-120	6000	Nil	Nil	15-17.5	135-140	110-115	6400	Nil	Nil	47.5-50	165-170
Kevin Brown	Director of Service Delivery	100-105	8400	Nil	Nil	27.5-30	140-145	75-80	5600	Nil	Nil	72.5-75	155-160
Wayne Bartlett-Syree	Director of Strategy and Sustainability	100-105	5000	Nil	Nil	32.5-35	135-140	75-80	6000	Nil	Nil	67.5-70	145-150
Dr Tom Davis	Acting Medical Director	20-25	5200	Nil	Nil	35-40	60-65	n/a	n/a	n/a	n/a	n/a	n/a
Lindsey Stafford-Scott	Director of People & Culture	100-105	9700	Nil	Nil	22.5-25	130-135	100-105	5600	Nil	Nil	22.5-25	130-135
Kevin Smith	Director of Finance & Commissioning	110-115	6500	Nil	Nil	27.5-30	145-150	110-115	6000	Nil	Nil	122.5-125	240-245
Senior Managers who left the Trust Board in 2017-18													
Sheila Childerhouse	NED	0-5	Nil	Nil	Nil	Nil	0-5	5-10	Nil	Nil	Nil	Nil	5-10
Valerie Morton	NED	0-5	Nil	Nil	Nil	Nil	0-5	5-10	Nil	Nil	Nil	Nil	5-10
Dean Parker	NED	0-5	Nil	Nil	Nil	Nil	0-5	5-10	Nil	Nil	Nil	Nil	5-10
Dr Mark Patten	Medical Director	45-50	4400	Nil	Nil	Nil	50-55	40-45	200	Nil	Nil	35-37.5	75-80

The Benefit in kind is included in the "Expense payments (taxable)" column and relates to car benefit charge or use of other assets benefit for emergency response vehicles.

The following senior managers served for part of the financial year 2017/18:

Dr Tom Davies	Appointed to Trust Board 2nd February 2018	Lizzie Firmin	Appointed to Trust Board 15th January 2018	Sheila Childerhouse	Left the Trust Board on 14th January 2018
Mike Burrows	Appointed to Trust Board 1st May 2017	Dean Parker	Left the Trust Board on 15th January 2018	Dr Mark Patten	Left the Trust Board on 1st February 2018
Alison Wigg	Appointed to Trust Board 15th January 2018	Valerie Morton	Left the Trust Board on 14th January 2018		

Signed on behalf of East of England Ambulance Service NHS Trust on 23 May 2018:

Sarah Boulton
Chair of Trust Board

Robert Morton
Chief Executive

Salary and Pension entitlements of senior managers - subject to audit

Pension Benefits 2017-18

The following pension benefits have accrued for those senior managers directly employed by the Trust.

Title	Name	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2017 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2018 £'000	Employer's contribution to stakeholder pension £'000
Chief Executive	Robert Morton	2.5-5	0	5-10	0	49	34	84	Nil
Director of Nursing & Clinical Quality	Alexander Brown	0-2.5	2.5-5	35-40	115-120	734	72	813	Nil
Director of Service Delivery	Kevin Brown	0-2.5	5-7.5	15-20	45-50	277	54	334	Nil
Director of Finance & Commissioning	Kevin Smith	0-2.5	0-2.5	45-50	80-85	613	62	681	Nil
Director of Strategy and Sustainability	Wayne Bartlett-Syree	0-2.5	0-2.5	20-25	45-50	236	41	279	Nil
Medical Director	Dr Mark Patten	0-2.5	0	45-50	115-120	800	13	824	Nil
Director of People & Culture	Lindsey Stafford-Scott	0-2.5	0	0-5	0	16	17	34	Nil
Acting Medical Director	Dr Tom Davis	0-2.5	0-2.5	10-15	25-30	133	4	161	Nil

As Non-Executive members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive members.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schames (Transfer Values) Regulations 2008.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, the value of any benefits transferred from another scheme or arrangement, and uses common market valuation factors for the start and end of the period.

Fair Pay Disclosures - subject to audit

	2017-18	2016-17
Band of Highest Paid Director's Total Remuneration (Bands of £5,000) £'000	145-150	140-145
Median Total Remuneration £'s	29,510	28,560
Ratio	5.00	5.03

NHS Trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisations' workforce. There is no change to the highest paid director compared to 2016/17.

The banded remuneration of the highest-paid director in the organisation in the financial year 2017-18 was £145k-150k (2016-17 £140k-145k) . This banding is 5.00 times (2016-17 5.03 times) the median remuneration of the workforce, which was £29,510 (2016-17 £28,560).

In 2017-18 nil (2016-17 nil) employees received remuneration in excess of the highest paid director. Remuneration ranged from £7 to £150k (2016-17: £7 to £145k).

The change in the median salary value is attributable to the National Pay award of 1% and the annual increment drift of staff pay as salaries move up the pay scale annually.

Total remuneration includes salary, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cost equivalent transfer values of pensions.

Agency and Consultancy staff are included on the basis of those occupying a vacant post as at 31st March 2018. These agency costs are annualised based on the expenditure on that individual in the week ending 31st March 2018, less an agency commission fee of 5%.

Staff Report - subject to audit

Senior Managers

	Number Employed	
Pay Band	**2017-18**	**2016-17**
Executive Directors	7	10
Agenda for change Band 9	1	0
	8	10

The number of Senior Managers listed above by pay band, include individuals who occupied a Senior Manager post for all or part of the financial year.

The Senior managers in this note are included within the Remuneration Note.

Staff Numbers

	2017-18			2016-17
	Total Number	**Permanently employed Number**	**Other Number**	Total Number
Average Staff Numbers				
Medical and dental	1	**1**	**-**	1
Ambulance staff	2,143	**2,085**	**58**	1,891
Administration and estates	534	**508**	**27**	482
Healthcare assistants and other support staff	1,818	**1,815**	**3**	1,886
Nursing, midwifery and health visiting staff	18	**18**	**-**	17
Nursing, midwifery and health visiting learners	-	**-**	**-**	-
Scientific, therapeutic and technical staff	-	**-**	**-**	-
Social Care Staff	2	**2**	**-**	-
Healthcare Science Staff	-	**-**	**-**	-
Other	2	**-**	**2**	3
TOTAL	**4,518**	**4,429**	**89**	**4,280**
Of the above - staff engaged on capital projects	**0**	0	0	0

Staff Costs

	2017-18			2016-17		
	Total £000s	**Permanently employed £000s**	**Other £000s**	Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	**155,560**	153,154	2,406	145,141	141,802	3,339
Social security costs	**15,468**	15,468	0	14,463	14,463	0
Apprenticeship Levy costs	**744**	744	0	0	0	0
Employer Contributions to NHS BSA - Pensions Division	**19,022**	19,022	0	17,518	17,518	0
Other pension costs	**14**	14	0	5	5	0
Termination benefits	**5**	5	0	119	119	0
Total employee benefits	**190,813**	**188,407**	**2,406**	177,246	173,907	3,339
Employee costs capitalised	**0**	0	0	0	0	0
Gross Employee Benefits excluding capitalised costs	**190,813**	**188,407**	**2,406**	177,246	173,907	3,339

Staff Composition

2017-18			2016-17		
Total	**Male**	**Female**	Total	Male	Female
4,840	**2,640**	**2,200**	4,581	2,536	2,045

Staff Sickness absence

	2017-18	2016-17
	Number	Number
Total Days Lost	57,574	54,179
Total Staff Years	4,376	4,149
Average working Days Lost	**13.2**	**13.1**

	2017-18	2016-17
	Number	Number
Number of persons retired early on ill health grounds	8	12
	£000s	£000s
Total additional pensions liabilities accrued in the year	612	1,084

Staff Policies applied during the year:

Disability Policy

The East of England Ambulance Service is committed to supporting all staff and recognises that staff with disabilities, or those who may be developing a disability, may require additional support to enable them to remain in the workplace. As well as being an NHS Employer of choice, the Trust is a 'two ticks' employer and has made a commitment not only to abide by the essential actions, but wherever operationally possible, to go beyond any statutory legal requirement to support staff who develop a disability to stay in the workplace.

Recruitment and Selection Policy

The Recruitment and Selection Policy supports the continuing the employment of, and for arranging appropriate training for, employees of the Trust who have become

Learning and Development Policy

The Learning and Development policy supports the training, career development and promotion of disabled persons employed by the Trust.

Expenditure on consultancy

2017-18	**2016-17**
£000s	**£000s**
428	75

East of England Ambulance NHS Trust

Annual Report 2017-18

Compensation and exit packages- subject to audit

Reporting of other compensation schemes - exit packages 2017-18

Exit package cost band (including any special payment element)	*Number of compulsory redundancies WHOLE NUMBERS ONLY	*Cost of compulsory redundancies £s	Number of other departures agreed WHOLE NUMBERS ONLY	Cost of other departures agreed £s	Total number of exit packages WHOLE NUMBERS ONLY	Total cost of exit packages £s	Number of departures where special payments have been made WHOLE NUMBERS ONLY	Cost of special payment element included in exit packages £s
Less than £10,000	1	5,111				5,111		
£10,000 - £25,000								
£25,001 - £50,000								
£50,001 - £100,000								
£100,001 - £150,000								
£150,001 - £200,000								
>£200,000								
Total	**1**	**5,111**	**0**	**0**	**0**	**5,111**	**0**	**0**

Reporting of other compensation schemes - exit packages 2016-17

Exit package cost band (including any special payment element)	*Number of compulsory redundancies Number	*Cost of compulsory redundancies £s	Number of other departures agreed Number	Cost of other departures agreed £s	Total number of exit packages Number	Total cost of exit packages £s	Number of departures where special payments have been made Number	Cost of special payment element included in exit packages £s
Less than £10,000								
£10,001 - £25,000								
£25,001 - £50,000								
£50,001 - £100,000								
£100,001 - £150,000	1	118,893			1	118,893		
£150,001 - £200,000					0	0		
>£200,000					0	0		
Total	**1**	**118,893**	**0**	**0**	**1**	**118,893**	**0**	**0**

Other Exit Packages 2017-18

Other Exit packages - disclosures (Exclude Compulsory Redundancies)	Number of exit package agreements Number	Total Value of agreements £000s	2016/17 Number of exit package agreements Number	2016/17 Total Value of agreements £000s
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non contractual payments requiring HMT approval *	0	0	0	0
Total	**0**	**0**	**0**	**0**
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

Note * this includes any non-contractual severance payment following judicial mediation and amounts relating to non-contractual payments in lieu of notice.

Details must be disclosed in the Trusts Annual Report and Accounts

Details should be consistent with related disclosures in (a) the Remuneration Report and (b) the losses & Special Payments note.

Off-Payroll Engagements Note

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2018	0
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between two and three years at the time of reporting	0
for between three and four years at the time of reporting	0
for four or more years at the time of reporting	0

Table 2: New Off-payroll engagements

all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018.	0
Of which, the number that have been:	0
assessed as caught by IR35	0
assessed as not caught by IR35	0
engaged directly (via PSC contracted to department) and are on the departmental payroll	0
engagements reassessed for consistency / assurance purposes during the year.	0
engagements that saw a change to IR35 status following the consistency review	0

Table 3: Off-payroll board member/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018:

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	0
Number of individuals that have been deemed “board members, and/or senior officers with significant financial responsibility” during the financial year. This figure includes both off-payroll and on-payroll engagements*	19

*All individuals who occupied a Board member position, for a period of time in the financial year, have been included in this figure.

NHS
East of England
Ambulance Service
NHS Trust

East of England Ambulance Service Trust

iii) Annual Governance Statement

2017-18

East of England Ambulance Service NHS Trust
Organisation Code: RYC
Annual Governance Statement 2017-18

Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Trust Accountable Officer Memorandum.*

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of East of England Ambulance Service NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in East of England Ambulance Service NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

Risk Leadership

The Board of Directors has overall responsibility for the management of risk within the Trust. In October 2017, the Director of Strategy and Sustainability took over from the Executive Director of Nursing and Clinical Quality as the nominated director with responsibility for risk management. The Head of Risk Management is the responsible manager. Risk management is a core component of the job descriptions of senior managers. The Trust Board undertakes mandatory training in terms of patient safety risk and risk management on an annual basis, and sessions focussing on other business areas as required. Staff are trained or equipped to manage risk in a way appropriate to their authority and duties.

The Risk and Control Framework

The Trust's combined Risk Management Strategy and Policy describes the risk management processes established to identify, assess and manage potential risks that may exist within the Trust. It outlines the principles that are applied to all Trust activities and services to ensure that any risks identified and analysed are suitably evaluated and treated, thereby mitigating any risks that could prevent the Trust from achieving its strategic objectives. It also supports the governance, assurance and escalation arrangements established within the Trust, and affords the Board a clear view of the risks associated with strategic delivery.

The Trust Board has overall responsibility for the management of risks that hinder achievement of the strategic objectives of the Trust. The Trust Board has delegated the responsibility for managing the mitigation actions of the strategic risks to the Executive Leadership Board (ELB). The Senior Leadership Board (SLB) oversees the day to day management of the risk management systems and processes. SLB has a risk management focussed remit, seeking to ensure that business as usual monitoring against key risks and objectives occurs, as well as utilising a risk-based approach to new business and decision-making. There is detailed scrutiny of the Trust's risks at an operational and strategic level.

All risk registers for the Trust are managed via an electronic database. The risk management software has also been upgraded in order to allow more intelligent monitoring of the risk profile of the organisation in the 2018/19 financial year.

Escalation of risk is achieved through the well-established governance structures and processes within the Trust. As a result of the latest internal audit recommendation for Corporate Governance, a governance and assurance framework was developed and is being implemented.

Identification and assessment of risk is a core business function within the Trust, with managers responsible for recognising and assessing risks to the delivery of their aspect of the service. The Trust has a risk management and Board assurance process that is both top-down and bottom-up, and subject to on-going review and improvement:

- The Trust Board will identify the strategic risks being faced by the Trust.
- Operational risks will be identified through operations and activities of the Trust in going about the achievement of the Trust's objectives.
- Electronic system of incident reporting via a web-based incident reporting system.
- Serious Incident Panel, for review of information from incidents, complaints, concerns and safeguarding issues to triangulate and identify trends and themes for risk assessment and mitigating action.
- Continual review of the Trust's performance in relation to external assessors and regulators, i.e. Internal and External Audit, CQC, NICE, etc.
- Compliance with Statutory Requirements – e.g. Health and Social Care Act 2008 (Code of Practice, December 2009), Equality Act 2010 public sector duties.
- Monthly Integrated Performance Report.
- Fire Safety inspections and Health and Safety risk assessments.
- Reviews of the external environment.

Once identified, a risk assessment is undertaken using standard risk management principles, focusing upon causes and effects and assessing the risk against impact and likelihood using the internationally recognised 5 by 5 matrix. Controls are then implemented and mitigating actions established to reduce the risk.

The major risks identified within the 2017/18 financial year have been monitored and acted upon by the Trust Board and sub-committees regularly through scrutiny of the BAF at Trust Board and sub-committee meetings.

A summary of the Trust's strategic risks is as follows:

- **Failure to deliver agreed contractual targets** (risk that the Trust cannot deliver a sustainable and responsive model in line with the commissioner performance contracts).

  This risk has been the most challenging for the Trust to mitigate within the year due to the recognised capacity and funding gap. Implementation of the new Ambulance

Response Programme standards has been a key action to support longer term delivery, and work in relation to utilisation of private ambulance resource, staff overtime and improved management of resources have helped to ensure stability in performance over the year, as well as an improvement in performance to the highest category of call. The Independent Service Review has outlined the financial and workforce levels required to deliver a service in line with the standards and a significant transformation programme focussing upon rota alignment, extensive recruitment and improvements in efficiencies will be taken throughout 2018/19 to support improvements and mitigation of this risk.

- **Failure to achieve continuous quality improvements and high quality care delivery** (risk that the challenges within the Trust result in a lack of focus upon safe care for patients and that avoidable harm occurs).

  The incidence of avoidable harm over the financial year has maintained its downward trend, demonstrating the outstanding levels of care provided to patients by our staff. There has been numerous risk mitigation controls put in place to maintain safety of patients who experience delays, through increasing the clinical presence within the control rooms, and embedding the surge plan. Redesign of the medicines management processes and implementation of the action plan established following the Trust's last CQC inspection in 2016 has also strengthened the management of the safety risk. The 2018/19 financial year will focus upon ensuring the transformation required occurs safely, as well as implementing a new Quality Strategy focussed upon embedding quality improvement methodologies and approaches throughout the organisation, in order to bring about continuous improvement and enable all staff to bring about positive change.

- **Failure to establish a culture of engagement and accountability that is patient focussed** (risk that the Trust becomes a poor employer due to poor relationships with staff).

  Significant work to mitigate this risk has been undertaken to date, including the development and completion of the Trust Cultural action plan, establishment and embedding of the Leadership Charter and Strategy, continuation of the suite of leadership training established in the last financial year and completing a review into areas for further development. There has been much focus on working with the trade union to improve relations and establish a new, fit for purpose voluntary recognition agreement in order to maximise the support for staff engagement and consultation; there has been some success and work continues into the new financial year as a priority. In the 2017/2018 year, the Trust saw improvement in the NHS Staff Survey results. Further developments in the 2018/19 year will focus upon establishment of a framework for accountability, development and talent management, in order to future proof the organisation and support staff progression.

- **Failure to deliver an efficient, effective and economic service** (risk that funding, systems and processes do not match the required pace of change for sustainable service delivery).

  There has been good mitigation of this risk over the financial year through strong financial management and cost control measures, in addition to involvement and robust discussions with the regulatory-commissioned Independent Service Review. The Trust have move from a deficit in 2016/2017 to positive variance outturn in 2017/2018. Implementation of the transformation systems and processes acting as enablers to the delivery of change over the coming year has been a key action, and the focus in the

2018/19 year will be on delivering aspects of the transformation portfolio, in line with the increase in the contract value.

- **Failure to maintain strategic relationships with national and local partners to deliver community focussed healthcare** (risk that the Trust, working with the regional healthcare economy, does not fully implement the commitments in the Five Year Forward View).

  This risk has been mitigated well through the 2017/18 year through focussed involvement and engagement with the STPs across the region, in addition to close partnership working with regulators, commissioners and other provider organisations. Steps have also been taken to mitigate this risk through development of the Trust's transformation plans. This risk has now evolved into the way in which the systems and governance functions of the transformation process will support delivery against the five year forward view through robust consultation and engagement on all of our priorities.

NHSI Single Oversight Framework

The Single Oversight Framework, published in September 2016, sets out the Segments under which each NHS Trust in England will be supported**.** From May 2017, NHS Trusts were required to self-certify that they can meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements. The aim of self-certification is for providers to carry out assurance that they are in compliance with the conditions.

The Trust Board regularly monitors the Trust's compliance and how the risk to compliance is mitigated.

The Trust was given an improved Single Oversight Framework rate by NHS Improvement in September 2017, moving up to level 2 from level 3, as a result of the progress made against quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability within the service.

Care Quality Commission (CQC)

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

In early March 2018, the Trust had an unannounced core service inspection, which covered Emergency and Urgent Care, Emergency operations centres and patient transport services. This was followed in late March 2018 by an announced Well Led inspection. These were both completed under the new methodology.

The Trust has been notified that the draft report will be completed and presented to the Trust mid-May 2018 for a matters of accuracy check. Any areas of improvement will be taken forward as part of the Trust's Integrated Improvement Plan will be finalised by the end of Quarter 1.

Compliance with NHS Pension Scheme Regulations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions, and payments in to the Scheme are in accordance with the

Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality, Diversity and Human Rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.
The Trust:

- ensures that its services are anti-discriminatory enabling equality of access and provision and meeting the legal requirements under the Equality Act 2010;
- demonstrates its commitment to Equality, Diversity and Inclusion for all by meeting the Public Sector Equality Duty (PSED);
- demonstrates 'Due Regard' in all aspects of its business to ensure it remains focussed on equality of outcome and equality of opportunity;
- uses the Equality Delivery System2 (EDS2) to ensure that service priorities are influenced and set by the health needs of all its local and regional communities through consultation, equality monitoring and partnership working.
- ensures compliance with WRES and the Accessible Information Standard.

Equality, Diversity, Inclusion and Human Rights encompass all of the Trust's aims, objectives and actions addressing inequalities and promoting diversity in healthcare and employment. The Trust's Equality, Diversity and Inclusion (EDI) Steering Group oversees compliance with Equality, Diversity and Human Rights legislation, and is chaired by the Chair of the Trust Board. Action plans are reviewed and updated on a regular basis and further monitored by the Steering Group. The Trust Board reviews and monitors this work through its Committees.

Key activities during 2017/18 included:

- With support from Cabinet Office Funding, ground-breaking work was undertaken to assist the Trust in engaging with the hard to reach and emerging communities as part of the Q Volunteering project
- A Community Ambassador's Engagement programme was introduced to aid the |Trust in trying to fully understand and create a platform for members of the diverse communities to engage with the service

Emergency preparedness and civil contingency requirements

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

In 2017/2018, NHSE undertook an audit of compliance against relevant standards which confirmed that the Trust's governance standards were good and fully compliant.

Review of economy, efficiency and effectiveness of the use of resource

The Trust has a range of processes to ensure that resources are used economically, efficiently and effectively. This includes clear and effective management and supervision

arrangements for staff and a system of devolved budget management. This incorporates reviews of finance and performance at budget manager, service director and overall Trust level.

This involves a system of reporting finance and performance to SLB, ELB and the Trust Board, supported by detailed performance and financial reporting to the Performance and Finance Committee. The Performance and Finance Committee also scrutinises the Trust's Cost Improvement Programme and reviews delivery of this programme together with monitoring that Quality Risk Assessments are carried out on all CIP schemes.

The Trust's Internal Auditors also play an important role in reviewing the economy, efficiency and effectiveness of the use of resources as part of their programme of audits throughout the year. All Reports issued by Internal Audit are reviewed by the Trust's Audit Committee.

Our external auditors, are required as part of their annual audit to satisfy themselves the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and report by exception if in their opinion the Trust has not.

Information Governance

Serious Incidents

During 2017/18 the Trust reported twenty six Serious Incidents related to data security or information governance. This is a significant increase compared to 2016/17, which is due to the improved reporting of information governance incidents and the increased awareness of these types of issues. Work is ongoing with the National Ambulance Information Governance Group around standardising this type of reporting.

All Serious Incidents have a full root cause investigation carried out with identified learning and recommendations. The Trust is in regular communication with the Information Commissioner's Office around these incidents and provides additional information and assurance where requested. A significant change has been made to the Trust's patient care record process including the use of pre-printed shift log envelopes. These are used by staff to store patient care records throughout their shift and for safe onward transfer to the clinical quality departments.

The table below shows the type of data security/information governance breaches reported by the Trust as Serious Incidents:

Type of incident	Number of Serious Incidents reported
Clinical record loss	10
Incorrect information shared/information shared with incorrect person	11
Inappropriate release of confidential information	2
Storage/retention of records issue	3

During 2017/18, the Trust continued to improve claims reporting and learning processes, with claims learning and actions now being monitored by the Health and Safety Committee to ensure completion and dissemination to other staff groups where appropriate. The Quality Governance Committee receives regular reports around high value claims and the Trust will be utilising the NHS Resolution scorecard in 2018/19 to monitor trends and themes across claims closely.

Information Governance Toolkit

The annual self-assessment against the Information Governance Toolkit was completed at the end of March. For 2017/18 the Trust has declared an overall 'satisfactory' rating level 2 on all applicable Toolkit requirements. Work has begun on the new Data Security and Protection Toolkit assertions, which will form the new reporting requirements for information governance for 2018/19.

Annual Quality Account

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

The Trust has a number of processes in place to ensure that data included within the Quality Account is accurate and provides a balanced view. These include:

- Clinical data and outcomes
    - Checked and verified by the Clinical Audit Manager (State Registered Paramedic) prior to submission to the national audit programmes
    - Monthly checks of the Department of Health statistical reports to ensure latest comparative data is included
    - Assurance through internal governance processes to Board Level via the Integrated Board Report
- Information Governance Toolkit
    - Assurance provided through Information Governance Group to Trust Board via the Audit Committee
- Regular scrutiny of processes and information through:
    - Quality Governance Committee
    - Clinical Commissioning Groups through contracting requirements
    - Information Management Group

Review of Effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Governance Framework of the Organisation

The Trust Board continues to adopt the National Leadership Council's principles as defined within The Healthy NHS Board Principles of Good Governance (2013). These are:

- Formulate strategy for the organisation.

- Ensure accountability by holding the organisation to account for the delivery of strategy and through seeking assurance that all systems of control are robust and reliable.
- Shape a positive culture for the Board and the organisation.

The Trust Board recognises the importance of the principles of good corporate governance and is committed to ensuring these are effective and efficient. This is implemented through key governance documents, policies and procedures of the Trust, including:

- The Trust's Standing Orders.
- The Reservation of Powers to the Trust Board and Scheme of Delegation.
- The Standing Financial Instructions.
- The Annual Operating Plan.
- Terms of reference of the sub-committees of the Trust Board.

The Trust has applied the principles of the relevant codes of corporate governance in the following manner:

- The Trust is led by a Board comprising Non-Executive and Executive Directors, which provides leadership within a framework of internal control whilst promoting innovation and vision, and challenge to any performance issues. The Trust Board monitors the effectiveness of the internal control systems and processes through clear accountability arrangements.
- Each Executive Director is held to account in relation to control systems and processes, monitoring methods and weaknesses within their Directorates during the year; cross checking evidence of compliance with statutory functions to ensure that the Trust remains legally compliant.
- Delegation of authority for executive management is to the Chief Executive, subject to monitoring and limitations as defined within the policies and procedures of the Trust, including Standing Financial Instructions and the Scheme of Delegation. The limitations require that any executive action taken in the course of business does not compromise the integrity and reputation of the Trust and takes account of any potential risks, health and safety, patient experience and finance issues while working with partner organisations.
- The Audit Committee is fully functioning, with a Chair with the requisite financial qualifications and experience.

Directors' Responsibilities

The Trust Board comprises the Non-Executive Directors (including Associate Non-Executive Directors) and Executive Directors that form a unitary body. The Trust Board functions as a corporate decision-making body and should consist of six Non-Executive Directors (including the Chair) and five Executive Directors.

The Trust Board currently consists of a Chair and five other Non-Executive Directors, the Chief Executive, a Director of Finance and Commissioning, a Director of People and Culture, an acting Director of Clinical Quality and Improvement, and an Acting Medical Director. There is also a Director of Strategy and Sustainability and a Director of Service Delivery who are not voting members of the Board, and three Associate Non-Executive Directors, who provide additional advice and expertise to the Board.

The Medical Director submitted his resignation notice on the 10 November 2017. The Director of Nursing and Clinical Quality retired from the Trust in April 2018. The terms of

Office of two Non-Executive Directors also came to an end on 14 January 2018 and two new Non-Executive Directors were appointed from 15 January 2018.

Appointment of Board Directors

Due consideration is given to the composition of the Board in terms of the protected characteristic groups in the Equality Act 2010. Each Board member is appointed for their experience, their business acumen and their links with the local community. The Secretary of State for Health and Social Care has the power to make the appointments of the Chair and Non-Executive Directors but has delegated this role to NHSI. As a result NHSI is responsible on behalf of the Secretary of State for their appointment and removal, and for on-going support through appraisal, mentoring and training. Terms of appointment are normally for periods of two years, with members eligible to be re-appointed or to re-apply up to a maximum of ten years. The Non-Executive Directors' responsibilities include:

- Helping to plan for the future growth and success of the organisation.
- Making sure that the management team meets its performance targets.
- Ensuring that finances are properly managed with accurate information.
- Helping the Board ensure it is working in the public interest.

The Chief Executive and the Executive Directors are appointed via public advertisement.

Register of Interests

At the time of their appointment, all Directors are asked to declare any interests on the Register of Directors' Interests. Board members are asked at each formal Board meeting to register any changes to their declarations and to confirm in writing on an annual basis that the declarations are accurate. The Register is maintained by the Trust Secretary and is available to anyone who wishes to see it. This information is also published in the Annual Report and Accounts and published on the Trust website.

Trust Board and Sub-Committee Meetings and Their Evaluation Processes

The Trust Board, in accordance with the Public Bodies (Admission to Meetings) Act 1960, holds its meetings in public. The Trust Board has powers to delegate and make arrangements to exercise any of its functions through a committee, sub-committee or joint committees. The Trust Board has five committees, namely, the Audit Committee, Remuneration and Terms of Service Committee, Quality Governance Committee, Performance and Finance Committee and the newly formed People and Culture Committee.

How the Trust Conducts its Board Meetings

The Trust has maintained its support of the Nolan principles for public life and has continued to make the majority of decisions at Board meetings held in public. During 2017/18 the Trust Board met each month, conducting a series of different meetings throughout the day. These included seven meetings in public, one of which was the Annual Public Meeting, which was held on 26 July 2017. Eleven private sessions of the Board were held; seven prior to the public meetings. Five workshop sessions were held during 2017/18 to allow the Board to forward plan and implement its Board development plan. These workshops included Leadership Strategy, Information Governance. Surge Plan, Safeguarding, Risk Management, Unconscious Bias and Wilful Blindness, Well Led, WRES 2 and Charitable Strategy review. Membership attendance at Trust Board and sub-committee meetings is monitored throughout the year and is reported in the Trust's Annual Report and Accounts.

As part of the sustainability and environmental programme, the Board continues to use BoardPad, the meeting and document collaboration solution that turns directors' devices into

highly secure digital board and meeting packs, which improved the efficiency and effectiveness of the board and subcommittee meetings.

Review of Effectiveness of the Trust Board and Sub-Committees

The Board and the sub-committees review their effectiveness informally on a regular basis and formally once a year through the Board's approved evaluation process.

Reviews of the effectiveness of the Board and its committees were undertaken during the 2017/18 financial year. Action plans were developed to improve the effectiveness of the Board based on the evaluation. Revised Terms of Reference for the committees were approved by the Trust Board in March 2018.

The Board's key activities during 2017/18 were:

- Launching the Leadership Strategy.
- Supporting the delivery of the actions emerging from the Zeal Cultural Review.
- Reviewing and approving the Surge Plan, reviewing the Trust's winter planning arrangements, and receiving the Easter Plan.
- Reviewing the outcome of the Independent Service review and progressing the Transformation Plan that has emerged from this.
- Monitoring the transition to the new Ambulance Response standards.
- Initiating and receiving assurance from a deep dive into the strategic risk pertaining to 'Failure to achieve continuous quality improvements and high quality care delivery' (SR2).
- Receiving and approving the following annual reports: Safeguarding, Health and Safety, Medicines Management 'Controlled Drugs', Security Management, Infection Prevention & Control.
- Undertaking a review of the Trust's partnership arrangements.
- Signing-off the Annual report [including Financial Statements, Annual Governance Statement, the Annual Quality Report], the Trust's Charitable Funds Financial Statements, IG Toolkit.
- Agreeing the Well-led assessment process and the scope of the external Governance Review.
- Agreeing the Governance and Assurance Framework document.
- Approving the Trust's Strategic Narrative and supporting the Trust's corporate video launch.
- Signing up to the Hertfordshire Health Concordat.
- Agreeing a number of underpinning strategies including Employee Engagement, Well-being, Health and Safety, Security Management, Risk Management, Treasury Management.
- Agreeing a number of underpinning policies, including Treasury Management and Standards of Business Conduct.
- Agreeing to award a number of contracts including Patient Transport Services, Medical Gas Contract, and the extension of the Payroll Contract.

Audit Committee

The Board has a fully-established Audit Committee comprising three designated Members, appointed from the Non-Executive and Associate Non-Executive Directors. The Chair of the Audit Committee has recent and relevant financial experience and is a qualified accountant. The Trust Chair usually attends Audit Committee meetings, although is not a member. The Audit Committee's primary role is to review the adequacy and effective operation of the organisation's overall internal control system.

In performing that role, the Committee's work predominantly focuses upon the framework of risks, controls and related assurances that underpin the delivery of the organisation's objectives (the Board Assurance Framework or 'BAF'). As a result, the Committee has a pivotal role to play in reviewing the Board's disclosure statements that flow from the organisation's assurance processes. These declarations are independently assessed by the Committee as part of the annual report and accounts sign-off process, and actions are recommended to the Trust Board. The Committee has responsibility for the review of the corporate risk register as well as oversight of the systems and processes in place to manage risk. The Committee reviews the BAF at every meeting and recommends new processes and formats for the BAF to enable better management of corporate risks and associated action plans.

The Committee also provides assurance to the Board on compliance with relevant regulatory, legal and code of conduct requirements. The Committee reviews the arrangement by which the Trust's staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control. The Committee's aim is to ensure that arrangements are in place for an independent investigation of such matters and for appropriate follow-up action through Internal Audit or the Counter Fraud Service. It maintains appropriate relationships with the organisation's auditors, both internal and external, as well as the Counter Fraud Specialist and Security Management.

Key activities during the course of 2017/18 included:

- Reviewing the assurances as detailed in the Board Assurance Framework.
- Reviewing in detail the Annual Accounts for the Trust and its Charitable Fund, and considering the Annual Governance Report
- Reviewing in detail the Trust's Standing Orders, Standing Financial Instructions, Scheme of Delegation and Reservation of Powers to the Trust Board.
- Monitoring the delivery of an agreed programme of internal audit reviews, considering the findings of those reviews and monitoring the timely and effective implementation of agreed recommendations.
- Reviewing the recommendations and action plans arising from audits with a limited assurance rating.
- Monitoring internal financial control matters, such as safeguarding of assets, the maintenance of proper accounting records and the reliability of financial information.
- Reviewing the assurances as detailed in the Board Assurance Framework
- Reviewing the adequacy of relevant policies, legality issues and the Codes of Conduct.
- Reviewing the policies and procedures related to Standards of Business Conduct.
- Considering the Trust's compliance with EPRR.

The Audit Committee completed all items included in its 2017/18 plan, and reported to the Trust Board that:

- In its view and taking into account the impact on Board composition and Board committee functions, the Trust had maintained an adequate system of governance, risk management and internal control across the whole of the Trust's activities (clinical and non-clinical), that supported the achievement of the Trust's objectives.
- There was an effective internal audit function, including Counter Fraud Services, established by management that met mandatory NHS internal audit standards and provided appropriate independent assurance.

Financial reports were complete and accurate, as reflected in the External Auditor's report to those charged with Governance. The audit opinion confirms that the accounts give a 'true

and fair view' of the state of the Trust's income and expenditure for the year and that they were properly prepared in accordance with the accounting policies relevant to the NHS in England.

The Quality Account will be reviewed by the Quality Governance Committee, and the internal auditors will carry out an independent assessment before submission to check whether this represents a balanced picture of the Trust's performance during 2017/18 and that the information reported therein was reliable and accurate, there were proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls were subject to review to confirm that they were working effectively in practice. The assessment will also check to ensure that data underpinning the measures of performance reported in the Quality Account was robust and reliable, conformed to specified data quality standards and prescribed definitions, and was subject to appropriate scrutiny and review. Checks will also be made to ensure that the Quality Account has been prepared in accordance with Department of Health guidance.

As the Trust's external auditor, Ernst and Young LLP independently audits the financial statements and the part of the remuneration report to be audited in accordance with relevant legal and regulatory requirements i.e. the International Financial Reporting Standards (IFRS). The Trust ensures that the external auditors' independence is not compromised by work outside the audit code by having an agreed protocol for non-audit work. Non-audit work may be performed by the Trust's external auditors where the Audit Committee's approved procedure is followed. This ensures that all such work is properly considered and the auditors' objectivity and independence is safeguarded. No non-audit services were undertaken during the reporting period. The statutory audit fee for 2017/18 audit work is estimated to be £57,600.

Quality Governance Committee

The Trust Board's Quality Governance Committee (QGC) appoints its members from the Non-Executive Directors and Associate Non-Executive Directors. Current membership consists of three Non-Executive Directors. The Chair of the QGC has a clinical background. The Trust Chair also usually attends meetings, but is not a member.

The Quality Governance Committee is accountable to the Trust Board for assurance on quality, clinical governance frameworks, internal controls and related assurances which underpin the Trust achieving its strategic objectives. It plays a pivotal role in the assurance processes linked to the Quality Account and compliance linked with Care Quality Commission (CQC) Registration. QGC sets out to scrutinise patient safety performance, clinical performance, agree the clinical audit programme, review clinical audit findings and monitor plans to address deviation from expected clinical performance. It also reviews patient experience feedback (such as complaints, surveys, etc.) and seeks assurance on plans to address shortcomings. QGC's work plan also includes scrutiny of the CQC standards, principally on patient safety and clinical performance and a review of the performance of the Trust's clinical risk management, health and safety regimes and equality, diversity and inclusion requirements.

Key activities during the course of 2017/18 included:

- Reviewing progress on the CQC inspection action plans following the CQC report published in August 2016 and the quality improvement visits.
- Reviewing the Clinical Audit Plan, the Health and Safety Strategy, Safeguarding Strategies, IPC Annual report, the Annual Safeguarding Report.
- Reviewing serious incident reports, subsequent action plans and progress made with these plans.

- Closely monitoring the incidents backlog to improve performance.
- Monitoring performance against ACQIs.
- Monitoring the strategic risks relevant to the Committee and instigating a review of strategic risk Failure to achieve continuous quality improvements and high quality care delivery (SR2).
- Monitoring the Surge Plan.
- Reviewing and monitoring actions plan in relation to the NHS Protect Audit, the HEE Quality Framework and Saville-Lampard review.
- Giving assurance on quality impact assessments for the 2017/18 cost improvement programme.
- Reviewing NHSI Infection Prevention and Control reports, monitoring progress on the resulting action plans, and approving procedural changes.
- Monitoring the Medicines Management Controlled Drugs action plan.
- Receiving and reviewing update reports in relation to Equality, Diversity and Inclusion, Claims and Litigation cases, the Trust's policies and procedures, patient experience and education and training.
- Maintaining an overview and monitoring performance of PTS.

Performance and Finance Committee

The Performance and Finance Committee membership comprises of four members; two Non-Executive Directors and two Associate Non-Executive Directors. The Chair of the Trust Board also attends the meetings, but is not a member. The Committee assists the Board in seeking assurance that the Trust is running to plan in relation to operational and financial performance.

Key activities during the course of 2017/18 included:

- Reviewing the Cost Improvement Programme (CIP).
- Continuing engagement in the Financial Improvement Programme (FIP).
- Reviewing operational performance against targets, remedial action plans and trajectories.
- Monitoring the strategic risks relevant to the Committee.
- Reviewing and monitoring the 2017/18 commissioning contract and budget planning for 2018/19.
- Reviewing information systems and technology projects and the risks involved in delivering them.
- Monitoring the Estates Transformation Project.
- Reviewing workforce performance and monitoring progress on training and education programmes

Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee comprises three Non-Executive Directors including the Trust Chair and one Associate Non-Executive Director. The Committee is responsible for advising on the appointment and/or dismissal of the Executive Directors. The Committee is also responsible for the approval of their remuneration and terms of service and for the monitoring of their performance against delivery of organisational objectives. The Chief Executive is entitled to attend the Committee and be consulted upon when the appointment and remuneration of the Executive Directors is being considered. The Chief Executive is excluded from meetings where his own position is discussed.

An appointment panel is convened for Executive positions with representation of a NED, Chair, CEO and external panel member, usually from NHSI. The Committee oversees the

appointment process in terms of agreeing the role specification, recruitment campaign, salaries, and terms and conditions of service. All substantive, permanent appointments are by public advertisement, and external assessors are included as part of the recruitment process.

The Remuneration and Terms of Service Committee has met six times during the year and has been actively involved in the following:

- Agreeing arrangements for the recruitment of a Director of Clinical Quality and Improvement and a Medical Director
- Considering the annual appraisal outcome of the Chief Executive and Executive Board members.
- Setting of the Chief Executive's objectives.
- Reviewing Executive Directors' remuneration, in-line with Regulatory guidance.
- Reviewing the Business Travel Policy and Director's lease car scheme.
- Approving the Executive On Call arrangements.
- Reviewing issues relating to employment tribunal cases.

People and Culture Committee

The People and Culture Committee is a newly formed Committee. Its membership consists of three Non-Executive Directors, including the Chair of the Trust Board and one Associate Non-Executive Director.

The Trust Board agreed to the introduction of this committee in January 2018, which has been formed to specifically focus on people and cultural issues, which have ordinarily been addressed by the other Committees in the Trust Board structure.

Clinical Audit

Clinical Audit forms part of the quality governance framework and provides assurance that services are being delivered to patients at the required standard, in order that the Trust meets the dimensions of quality: patient safety, patient experience and clinical effectiveness.

It provides an essential view of the care the Trust gives in terms of the patient experience and the clinical outcome of the treatment provided to patients. Where audit and experience reports highlight standards being delivered below those expected, it serves as an early warning so that, where necessary, corrective action can be agreed and taken in a responsive way. The results enable the Trust to share good practice along, and benchmark itself against other ambulance services nationally.

The results of audits and experience audits are used to review and develop training for staff, and examples, themes and trends have enabled the Trust to identify areas that draw out the quality measures.

The Clinical Audit and Patient Experience programmes for 2017/18 focused on national, strategic and regulatory driven audit projects that related to the priorities set within the Quality Account agenda. Full details of all audits undertaken are included within our Quality Account which will be published on the NHS Choices website on 30 June 2018.

The Head of Internal Audit Opinion and Annual Internal Audit Programme

The Head of Internal Audit provides an opinion on the overall arrangements for gaining assurance through the BAF and on the controls reviewed as part of the internal audit work. In addition, the Trust Board is advised by auditors and assessors providing an opinion on the adequacy and effectiveness of risk management, governance and control processes, service

delivery, financial management and control, human resources, operational and other review levels.

Opinion
The Head of Internal Audit has provided 'Moderate Assurance' that there is a sound system of internal control, designed to meet the Trust's objectives, and that controls are being applied consistently. In forming this view, Internal Auditors have taken into account that:

- The Trust has performed broadly in line with budget and the underlying financial performance is a surplus. We were able to provide substantial assurance on budgetary control effectiveness.

- The Trust's record in implementing audit recommendations has improved over the past two years, with Implementation rates at 83%. There is room for further improvement but we have closed all except one 2015/16 legacy recommendation. In addition, three out of the four remaining legacy recommendations have been implemented.

- Management are proactive in discussing plans to address the risks identified in audits.

- For the majority of audits we have provided substantial or moderate assurance, including key audits such as corporate governance, operational performance, budgetary control and main financial systems. Whilst we have given limited (or part limited) assurance in some areas, including recruitment and retention, project management and procurement, management has already taken action to address the findings.

Overall, we have noted an improvement in controls since 2016/17, when we gave limited assurance and this is a very positive performance. The basis for forming the opinion is as follows:

- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes.

- An assessment of the range of individual opinions arising from risk based audits audit assignments contained within the internal audit plan for the year. This assessment has taken account of the relative materiality of the audit areas and management's progress in addressing control weaknesses identified.

- The improved financial position of the Trust during 2017-18.

During 2017/18, the following five internal audits were awarded an assurance rating of 'limited assurance':

- Complaints and incidents
- Recruitment and retention
- Project management
- Cyber Security
- Procurement

Actions have been agreed based on the recommendations from these audit reports and the implementation of these actions is being followed up by the Audit Committee.

Counter Fraud

The Trust is fully committed to preventing fraud or bribery within the organisation and will take action against those identified to have committed fraud against the East of England Ambulance Service NHS Trust.

The Trust takes a positive stance in countering fraud against the organisation and the NHS in general and actively seeks to ensure that an appropriate, yet proportionate response is taken to allegations of fraud and bribery. Where appropriate, sanctions and redress are sought.

The Counter Fraud Specialist (CFS) reports to the Director of Finance and Commissioning and attend Audit Committee meetings to report on the work undertaken. The CFS has during the past year undertaken counter fraud awareness work ensuring that counter fraud is integrated at station level and cascaded by managers to local staff. The CFS has also ensured that a programme of fraud awareness material has been published to staff via the Trust intranet.

Throughout the past financial year, work has continued in accordance with the agreed counter fraud work plan, which was agreed at the beginning of the year. This incorporates action across the four areas as set out in the Standards for Providers 2016/2017: Fraud, Bribery and Corruption, as directed by NHS Protect, namely 'Inform and involve', 'Prevent and Deter', 'Hold to Account' and 'Strategic Governance'.

Significant Issues

The key challenges the Trust faced in 2017/18 were:

- Implementation of the NHS England Ambulance Response Programme (ARP).
- Operational capacity to meet demand and performance requirements.
- Emergency department arrival to handover delays.
- Impact of system wide pressures during winter.

The national ARP was mandated to the Trust in July 2017 and was implemented in part by October 2017. This saw a significant change in the way that calls were categorised and a shift from the time based standards. Full implementation will require transformational change and commissioner investment.

The Trust was not commissioned to meet the previous national standards and remains un-commissioned to achieve the new ones. Through an independent service review led by NHS Improvement and NHS England, efficiency and investment is identified and will form the basis of transformation plans over the next three years. There will be significant recruitment requirements to build to a positon that enables national standards to be met.

The Trust continued to experience significant loss of produced capacity across the year and worked with system partners in trying to reduce these. 96% of all handovers exceeded the 15 minute standards, with 12% (~26 thousand occasions) exceeding one hour. So significant was this issue that the Trust put further mitigation into the winter period to support the system, but experienced serious delays across the festive period leading to concerns on patient safety in the community.

Risk Summit

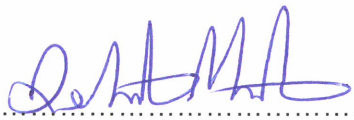
In response to recent concerns raised by a whistle blower about the Trust a Risk Summit was held on 30 January 2018. Co-hosted by NHS Improvement and NHS England, the summit was attended by representatives from the East of England Ambulance Service Trust (EEAST), its lead commissioner Ipswich and East Suffolk Clinical Commissioning Group, the Care Quality Commission, Healthwatch Suffolk, Norfolk and Norwich University Hospitals

NHS Foundation Trust, Mid Essex Hospital Services NHS Trust, Queen Elizabeth NHS Foundation Trust and Health Education England.

The Risk Summit identified a number of actions some of these actions are for the Trust and some for the wider NHS, specifically to improve hospital handover delays which were identified as having a significant impact on the Trust's ability to respond to patients in the community.

Conclusion

I can confirm that no significant internal control issues have been identified in 2017- 18

Signed:  .....Date:23 May 2018

Robert Morton
Chief Executive

NHS
East of England
Ambulance Service
NHS Trust

East of England Ambulance Service Trust

iv) Annual Accounts for the year ended 31 March 2018

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Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum.* These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the trust;
- the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; and
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Robert Morton
Chief Executive

23 May 2018

Statement of Directors' responsibilities in respect of the Accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, the directors are required to:

· apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;

· make judgements and estimates which are reasonable and prudent;

· state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

Robert Morton,
Chief Executive

23 May 2018

Kevin Smith,
Director Finance and Commissioning

23 May 2018

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF EAST OF ENGLAND AMBULANCE SERVICE NHS TRUST

Opinion

We have audited the financial statements of East of England Ambulance Service NHS Trust for the year ended 31 March 2018 under the Local Audit and Accountability Act 2014. The financial statements comprise the Trust Statement of Comprehensive Income, the Trust Statement of Financial Position, the Trust Statement of Changes in Taxpayers' Equity, the Trust Statement of Cash Flows and the related notes 1 to 33. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2017-18 HM Treasury's Financial Reporting Manual (the 2017-18 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2017/18 and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to the National Health Service in England (the Accounts Direction).

In our opinion the financial statements:

- give a true and fair view of the financial position of East of England Ambulance Service NHS Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with the National Health Service Act 2006 and the Accounts Directions issued thereunder.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report below. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and the Comptroller and Auditor General's (C&AG) AGN01 and we have fulfilled our other ethical responsibilities in accordance with these requirements.
We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Use of our report

This report is made solely to the Board of Directors of East of England Ambulance Service NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014 and for no other purpose. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's 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 Directors, for our audit work, for this report, or for the opinions we have formed.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the directors use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or

- the directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in this report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on other matters prescribed by the Health Services Act 2006

In our opinion the part of the Remuneration and Staff Report to be audited has been properly prepared in accordance with the Health Services Act 2006 and the Accounts Directions issued thereunder.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the NHS Improvement's guidance; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014; or
- we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

We have nothing to report in these respects.

Responsibilities of the Directors and Accountable Officer

As explained more fully in the Statement of Directors' Responsibilities in respect of the Accounts, set out on page 3, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. In preparing the financial statements, the Accountable Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accountable Officer either intends to cease operations, or have no realistic alternative but to do so.

As explained in the statement of the Chief Executive's responsibilities on page 2, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibility for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at https://www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in August 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Certificate

We certify that we have completed the audit of the accounts of East of England Ambulance Service NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Janet Dawson
Ernst & Young LLP

Janet Dawson (Key Audit Partner)
Ernst & Young LLP (Local Auditor)
London

Date 25th May 2018

The maintenance and integrity of the East of England Ambulance Service NHS Trust web site is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the web site. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	2	262,306	242,313
Other operating income	3	4,623	4,821
Operating expenses	4, 6	(262,567)	(255,627)
Operating surplus/(deficit) from continuing operations		**4,362**	**(8,493)**
Finance income	9	16	29
Finance expenses	10	(15)	(12)
PDC dividends payable		(918)	(1,071)
Net finance costs		**(917)**	**(1,054)**
Other gains / (losses)	11	(69)	(442)
Surplus / (deficit) for the year		**3,376**	**(9,989)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	14	1,056	1,060
Total comprehensive income / (expense) for the period		**4,432**	**(8,929)**

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	12	540	-
Property, plant and equipment	13	50,461	47,158
Investment property	15	980	880
Total non-current assets		**51,981**	**48,038**
Current assets			
Inventories	17	1,054	995
Trade and other receivables	18	20,582	19,209
Cash and cash equivalents	19	9,144	4,175
Total current assets		**30,780**	**24,379**
Current liabilities			
Trade and other payables	20	(30,735)	(26,313)
Provisions	21	(2,100)	(680)
Total current liabilities		**(32,835)**	**(26,993)**
Total assets less current liabilities		**49,926**	**45,424**
Non-current liabilities			
Provisions	21	(5,614)	(5,684)
Total non-current liabilities		**(5,614)**	**(5,684)**
Total assets employed		**44,312**	**39,740**
Financed by			
Public dividend capital		64,831	64,691
Revaluation reserve		3,926	2,874
Other reserves		(1,413)	(1,413)
Income and expenditure reserve		(23,032)	(26,412)
Total taxpayers' equity		**44,312**	**39,740**

The following notes on pages 14 to 55 form part of these accounts.

Robert Morton
Chief Executive
23 May 2018

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2018

	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2017 - brought forward	**64,691**	**2,874**	**(1,413)**	**(26,412)**	**39,740**
Surplus/(deficit) for the year	-	-	-	3,376	**3,376**
Revaluations	-	1,056	-	-	**1,056**
Transfer to retained earnings on disposal of assets	-	(4)	-	4	**-**
Public dividend capital received	140	-	-	-	**140**
Taxpayers' equity at 31 March 2018	**64,831**	**3,926**	**(1,413)**	**(23,032)**	**44,312**

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**64,591**	**1,831**	**(1,413)**	**(16,440)**	**48,569**
Prior period adjustment	-	-	-	-	**-**
Taxpayers' equity at 1 April 2016 - restated	**64,591**	**1,831**	**(1,413)**	**(16,440)**	**48,569**
Surplus/(deficit) for the year	-	-	-	(9,989)	**(9,989)**
Other transfers between reserves	-	(17)	-	17	**-**
Revaluations	-	1,060	-	-	**1,060**
Public dividend capital received	100	-	-	-	**100**
Taxpayers' equity at 31 March 2017	**64,691**	**2,874**	**(1,413)**	**(26,412)**	**39,740**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Other reserves
The Trust's originating capital on 1 July 2006 was set equal to the aggregate of the predecessor Trusts closing net assets as at 30 June 2006. However, the calculation of the originating capital included predecessor Trusts' donated assets and government grant reserves. The 'other reserves' of £1,413,000 has been established at 31 July 2008 to account for this omission

Retained earnings reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		4,362	(8,493)
Non-cash income and expense:			
Depreciation and amortisation	4.1	5,280	5,300
Net impairments	5	(1,586)	-
(Increase) / decrease in receivables and other assets		(1,245)	158
(Increase) / decrease in inventories		(59)	310
Increase / (decrease) in payables and other liabilties		5,622	(3,356)
Increase / (decrease) in provisions		1,338	169
Other movements in operating cash flows		-	-
Net cash generated from / (used in) operating activities		**13,712**	**(5,912)**
Cash flows from investing activities			
Interest received		16	29
Purchase of intangible assets		(540)	-
Purchase of property, plant, equipment and investment property		(7,349)	(6,499)
Sales of property, plant, equipment and investment property		36	667
Net cash generated from / (used in) investing activities		**(7,837)**	**(5,803)**
Cash flows from financing activities			
Public dividend capital received		140	100
Other interest paid		-	-
PDC dividend (paid) / refunded		(1,046)	(1,225)
Cash flows from (used in) other financing activities		-	-
Net cash generated from / (used in) financing activities		**(906)**	**(1,125)**
Increase / (decrease) in cash and cash equivalents		**4,969**	**(12,840)**
Cash and cash equivalents at 1 April - brought forward		**4,175**	**17,015**
Cash and cash equivalents at 31 March	19.1	**9,144**	**4,175**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

The financial statements are presented in sterling and all values rounded to the nearest thousand pounds (£000) unless otherwise indicated. The functional currency of the Trust is sterling and all transactions including those with overseas suppliers are undertaken in sterling amounts.

The East of England Ambulance Service NHS Trust Charitable Funds' Trust Deed established the East of England Ambulance Service NHS Trust as corporate Trustee. The Trust does not consider this charity fund Charity Registration Number 1047987, is material therefore this has not been consolidated in the results of the Trust.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets and certain financial assets and financial liabilities.

Note 1.1.2 Going concern

These accounts have been prepared on a going concern basis. This is based on the expectation that the Trust will be able to maintain a positive cashflow across 2018-19, not require any long term financial support to achieve a positive cashflow and be able to pay its creditors across 2018-19 as they fall due. Trust management expect these conditions to be met in 2018-19 and continue beyond that period for the foreseeable future.

All the operations of the Trust are considered to be continuing operations.

Note 1.2 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Leases classification

Determining whether a lease agreement is a finance lease or an operating lease requires judgement as to whether the agreement transfers substantially all the risks and rewards of ownership to the Trust. Judgement is required on various aspects that include, but are not limited to, the fair value of the leased asset, the economic life of the leased asset, whether or not to include renewal options in the lease term, and determining an appropriate discount rate to calculate the present value of the minimum lease payments. Classification as a finance lease means the asset is recognised in the statement of financial position as property, plant, and equipment, whereas for an operating lease no such asset is recognised. The Trust has exercised its judgement on the appropriate classification of property and equipment leases, and has determined all lease arrangements are operating leases.

Notes to the Accounts

Note 1.2.1 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Asset Valuations

All land and buildings are restated to fair value by way of professional valuations. Annually an independent Chartered Surveyor reviews the values of the land, non specialised assets and market values, to identify if a full revaluation is required. If it is deemed that market values do not warrant revaluation over the long term a full revaluation will be provided at least every five years.

Useful economic lifes of assets: The reported amounts for depreciation of property, plant and equipment and amortisation of non-current intangible assets can be materially affected by the judgements exercised in determining their estimated economic lives. The estimated economic lives are disclosed in note 1.7.5 and the carrying values of property, plant and equipment and intangible assets in notes 13 and 12 respectively. Assessing the appropriateness of useful life estimates requires the Trust to consider a number of factors such as the physical condition of the asset, expected period of use of the asset by the Trust, and expected disposal proceeds from the future sale of the asset. An incorrect estimate of the useful life or residual value will affect the depreciable amount of an asset, therefore affecting the depreciation expense recognised in the surplus or deficit and the asset's carrying amount. The Trust minimises the risk of this estimation uncertainty by:

- Physical inspection of assets
- Asset-replacement programmes
- Analysis of prior asset sales.

The Trust has not made significant changes to past assumptions concerning useful lives and residual values.

Provisions

Provisions are made for liabilities that are uncertain in amount. These include provisions for the cost of pensions relating to other staff, legal claims, restructuring and other provisions. Calculations of these provisions are based on estimated cash flows relating to these costs, discounted at an appropriate rate where significant. The costs and timings of cash flows relating to these liabilities are based on management estimates supported by external advisors. The carrying values of provisions are shown in Note 21. A discount rate of 0.10% (2016/17: 0.24%) has been used to estimate the present value of provisions.

Annual Leave Accrual

The accrual is based on management's estimation of untaken leave as at 31 March 2018. The carrying value of the accrual is £2.0m within Note 20 under accruals.

Notes to the Accounts

Note 1.4 Income

Patient care activities income:
Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services. At the year end, the trust accrues income relating to activity delivered in that year to ensure recognition in the correct accounting and reporting period.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

The NHS trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual.

Other operating income:
The Trust operate other income generating schemes, including the provision of education and training services. Income in respect of these non-patient care activities are recognised when the performance of the agreed upon service is delievered measured at the fair value of the consideration receivable.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.7.2 Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.
Assets that are held for their service potential and are in use (either as operational assets used to deliver either front line services or back office functions) are measured subsequently at their current value in existing use. For non-specialised assets, current value in existing use is interpreted as market value in existing use which is defined in the Royal Institution of Chartered Surveyors (RICS) Red Book as Existing Use Value (EUV).
Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.
Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
● Land and non-specialised buildings – market value for existing use.
● Specialised buildings – depreciated replacement cost, modern equivalent asset basis.
HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.
Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.
IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Note 1.7 Property, plant and equipment continued

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenses as a reversal of impairment.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the *GAM* , impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 Derecognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7 Property, plant and equipment continued

Note 1.7.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment. The Trust has no donated or grant funded assets.

Note 1.7.5 Useful economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	10	60
Plant & machinery	5	20
Transport equipment	5	7
Information technology	5	10
Furniture & fittings	5	20

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Note 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the trust intends to complete the asset and sell or use it
• the trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
• the trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Note 1.8.2 Measurement continued

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic lives of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	**Max life Years**
Software licences	3	10

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 1.10 Investment properties

Investment properties are measured at fair value. Changes in fair value are recognised as gains or losses in income/expenditure.

Only those assets which are held solely to generate a commercial return are considered to be investment properties. Where an asset is held, in part, for support service delivery objectives, then it is considered to be an item of property, plant and equipment. Properties occupied by employees, whether or not they pay rent at market rates, are not classified as investment properties.

Note 1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as "fair value through income and expenditure", loans and receivables or "available-for-sale financial assets".

Financial liabilities are classified as "fair value through income and expenditure" or as "other financial liabilities".

Financial assets and financial liabilities at "fair value through income and expenditure"

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges, although the Trust hold no derivative financial instruments.

Note 1.12 Financial instruments and financial liabilities continued

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the Statement of Financial Position date, the trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly or through the use of a bad debt provision. Receivables are impaired initially through the bad debt provision and written off against the carrying receivable amount only when irrecoverablity is confirmed. Other financial assets impairments are recognised directly when the evidence of impairment is identified.

Embedded derivatives
Derivatives which are embedded in other contracts but which are not "closely-related" to those contracts are separated-out from those contracts and measured at fair value with changes in value recognised as income or expense. The Trust has applied judgement in reviewing contracts and considers there are no embedded derivatives which require seperate recognition or presentation.

Note 1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.13.1 The trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.13.2 The trust as lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the trust net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trusts' net investment outstanding in respect of the leases.

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.14 Provisions

The trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the trust is disclosed at note 21.2 but is not recognised in the trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 22 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 22, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.17 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.20 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.21 Standards, amendments and interpretations in issue but not yet effective or early adopted

HM Treasury publishes the Financial Reporting Manual (FReM), on which the GAM is based. The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and IFRS 16 being for implementation in 2019-20.

● IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
Minimal change is expected from the adoption of IFRS 9 in 2018/19.

● IFRS 15 Revenue from Contracts with Customers - Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
Minimal change is expected from the adoption of IFRS 15 in 2018/19.

● IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
A qualitative assessment of the change on adoption has been performed which indicates a significant change to the gross assets and liabilities of the Trust is expected from the recognition of "right to use assets" and "lease liabilities" in the statement of financial position. The classification of expendtiure will change from "lease expense" to a charge to "depreciate the right of use asset" and "interest charge" from the present valuing of the lease liability over time. The timing of expenditure recognition is expected to change as a result of this, going from an even straight line recognition of operating lease expense, to an increased overall charge in the initial years of the lease which decreases over the years of the lease as the lease liability and consequential interest charge decrease. It is expected that operating leases held by the Trust will continue to meet the definition of leases. IFRS 16 offers a range of transitional arrangements and it is expected that FReM interpretation will set the approach to be taken by the Trust.

Note 2 Operating income from patient care activities

Note 2.1 Income from patient care activities (by nature)	2017/18 £000	2016/17 £000
Ambulance services		
A & E income	231,298	216,419
Patient transport services income	23,292	19,116
Other income	7,716	6,778
Total income from activities	**262,306**	**242,313**

Note 2.2 Income from patient care activities (by source)		
Income from patient care activities received from:	**2017/18 £000**	**2016/17 £000**
NHS England	598	920
Clinical commissioning groups	258,097	237,509
Department of Health and Social Care	-	-
Other NHS providers	1,158	2,033
NHS other	-	10
Local authorities	39	37
NHS injury scheme	725	727
Non NHS: other	1,689	1,077
Total income from activities	**262,306**	**242,313**

The Trust has only one reporting segment which is the provision of Ambulance response and transportation services.

Note 3 Other operating income

	2017/18 £000	2016/17 £000
Education and training	3,092	3,550
Rental revenue from operating leases	347	339
Other income	1,184	932
Total other operating income	**4,623**	**4,821**

Note 4.1 Operating expenses

	2017/18 £000	2016/17 £000
Staff and executive directors costs	190,813	177,246
Remuneration of non-executive directors	83	78
Supplies and services - clinical (excluding drugs costs)	7,206	4,628
Supplies and services - general	2,461	2,241
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	1,332	1,413
Inventories written down	5	108
Consultancy costs	428	75
Establishment	6,582	5,883
Premises	4,417	3,960
Transport (including patient travel)	19,706	29,110
Depreciation on property, plant and equipment	5,280	5,300
Amortisation on intangible assets	-	-
Net impairments (analysed in note 12)	(1,586)	-
Increase/(decrease) in provision for impairment of receivables	(15)	22
Increase/(decrease) in other provisions	210	-
Change in provisions discount rate(s)	-	728
Audit fees payable to the external auditor		
audit services- statutory audit	69	82
other auditor remuneration (external auditor only)	-	-
Internal audit costs	95	82
Clinical negligence	1,111	797
Legal fees	894	501
Insurance	3,073	2,609
Research and development	-	-
Education and training	2,004	2,531
Rentals under operating leases	16,374	15,980
Early retirements	-	-
Redundancy	-	-
Losses, ex gratia & special payments	-	-
Other	2,025	2,253
Total	**262,567**	**255,627**

The 2016/17 operating expenditure analysis has been recalculated with the effect that: drugs costs have been split from the supplies and service - clinical, cost line. Establishment, premises and transport costs have been reduced as a result of a separate line item analysis of rentals under operating leases.

Note 4.2 Limitation on auditor's liability

There is a £2 million limitation on auditor's liability for external audit work carried out for the financial year 2017/18.

Note 5 Impairment of assets

	2017/18 £000	2016/17 £000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	-
Abandonment of assets in course of construction	719	-
Changes in market price as a result of revaluation - impairment/(reversal)	(2,305)	-
Total net impairments charged to operating surplus / deficit	**(1,586)**	**-**
Impairments charged to the revaluation reserve	-	-
Total net impairments	**(1,586)**	**-**

As a result of the 31 March 2018 revaluation of property, plant and equipment a net gain is recognised in the surplus/decifit arising from the reversal of previous revaluation changes charged through the surplus/ deficit. Revaluation gains not reversing previous impairments have been taken to the revaluation reserve through other comprehensive income.

Note 6 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	153,167	141,802
Social security costs	15,468	14,463
Apprenticeship levy	744	-
Employer's contributions to NHS pensions	19,022	17,518
Pension cost - other	14	5
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	5	119
Temporary staff (including agency)	2,393	3,339
Total gross staff costs	**190,813**	**177,246**
Recoveries in respect of seconded staff	**-**	-
Total staff costs	**190,813**	**177,246**
Of which		
Costs capitalised as part of assets	-	-

Note 6.1 Retirements due to ill-health

During 2017/18 there were 8 early retirements from the trust agreed on the grounds of ill-health (12 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £612k (£1,084k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 7 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2018 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Note 8 Operating leases

Note 8.1 East of England Ambulance Service NHS Trust as a lessor

This note discloses income generated in operating lease agreements where East of England Ambulance Service NHS Trust is the lessor.The Trust leases office space within some of its properties

	2017/18	2016/17
	£000	£000
Operating lease revenue		
Minimum lease receipts	347	339
Total	**347**	**339**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease receipts due:		
- not later than one year;	586	218
- later than one year and not later than five years;	964	418
- later than five years.	136	75
Total	**1,686**	**711**

Note 8.2 East of England Ambulance Service NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where East of England Ambulance Service NHS Trust is the lessee.

Leases are primarily for the leasing of land and buildings and leased vehicles.

	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	16,374	15,980
Contingent rents	-	-
Less sublease payments received	-	-
Total	**16,374**	**15,980**

31 March 2018	Total	Buildings	Other
	£000	£000	£000
Future minimum lease payments due:			
- not later than one year;	14,434	1,190	13,244
- later than one year and not later than five years;	16,087	4,251	11,836
- later than five years.	17,822	17,822	-
Total	**48,343**	**23,263**	**25,080**

31 March 2017	Total	Buildings	Other
	£000	£000	£000
Future minimum lease payments due:			
- not later than one year;	14,069	1,467	12,602
- later than one year and not later than five years;	24,600	4,351	20,249
- later than five years.	18,808	18,808	-
Total	**57,477**	**24,626**	**32,851**

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Note 9 Finance income

Finance income represents interest received on assets and investments in the period.

	2017/18	2016/17
	£000	£000
Interest on bank accounts	16	29
Other finance income	-	-
Total	**16**	**29**

Note 10.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017/18	2016/17
	£000	£000
Interest expense:		
Interest on late payment of commercial debt	3	-
Total interest expense	**3**	**-**
Unwinding of discount on provisions	12	12
Other finance costs	-	-
Total finance costs	**15**	**12**

Note 10.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2017/18	2016/17
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	3	-

Note 11 Other gains / (losses)

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	-	-
Losses on disposal of assets	(169)	(442)
Total gains / (losses) on disposal of assets	(169)	(442)
Fair value gains / (losses) on investment properties	100	-
Fair value gains / (losses) on financial assets / investments	-	-
Fair value gains / (losses) on financial liabilities	-	-
Total other gains / (losses)	**(69)**	**(442)**

Note 12.1 Intangible assets - 2017/18

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**32**	**32**
Additions	540	540
Gross cost at 31 March 2018	**572**	**572**
Amortisation at 1 April 2017 - brought forward	**32**	**32**
Amortisation at 31 March 2018	**32**	**32**
Net book value at 31 March 2018	**540**	**540**
Net book value at 1 April 2017	**-**	**-**

No asset purchases are financed by leases (2017: nil).
No revaluation reserve is held for intangible assets (2017: nil).

Note 12.2 Intangible assets - 2016/17

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	32	32
Valuation / gross cost at 1 April 2016 - restated	32	32
Valuation / gross cost at 31 March 2017	32	32
Amortisation at 1 April 2016 - as previously stated	32	32
Amortisation at 1 April 2016 - restated	32	32
Amortisation at 31 March 2017	32	32
Net book value at 31 March 2017	-	-
Net book value at 1 April 2016	-	-

Note 13.1 Property, plant and equipment - 2017/18

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2017 - brought forward	**12,346**	**19,244**	**3,431**	**24,226**	**4,640**	**9,327**	**707**	**73,921**
Additions	1,109	1,251	156	1,486	409	1,738	-	**6,149**
Impairments	-	-	(719)	-	-	-	-	**(719)**
Reversals of impairments	-	(255)	-	-	-	-	-	**(255)**
Revaluations	(405)	1,250	-	-	-	-	-	**845**
Reclassifications	-	791	(2,713)	419	1,469	34	-	**-**
Disposals / derecognition	-	-	-	(3,630)	-	(230)	(17)	**(3,877)**
Valuation/gross cost at 31 March 2018	**13,050**	**22,281**	**155**	**22,501**	**6,518**	**10,869**	**690**	**76,064**
Accumulated depreciation at 1 April 2017 - brought forward	**6**	**3,823**	**-**	**12,045**	**4,306**	**6,094**	**489**	**26,763**
Provided during the year	**-**	**1,012**	**-**	**2,609**	**281**	**1,342**	**36**	**5,280**
Impairments	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	(2,560)	-	-	-	-	-	**(2,560)**
Revaluations	(6)	(205)	-	-	-	-	-	**(211)**
Reclassifications	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	(3,424)	-	(229)	(16)	**(3,669)**
Accumulated depreciation at 31 March 2018	**-**	**2,070**	**-**	**11,230**	**4,587**	**7,207**	**509**	**25,603**
Net book value at 31 March 2018	**13,050**	**20,211**	**155**	**11,271**	**1,931**	**3,662**	**181**	**50,461**
Net book value at 1 April 2017	**12,340**	**15,421**	**3,431**	**12,181**	**334**	**3,233**	**218**	**47,158**

Note 13.2 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**12,062**	**17,705**	**751**	**25,449**	**4,366**	**10,071**	**659**	**71,063**
Prior period adjustments	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2016 - restated	**12,062**	**17,705**	**751**	**25,449**	**4,366**	**10,071**	**659**	**71,063**
Additions	516	887	2,712	491	274	1,848	63	**6,791**
Impairments	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	**-**
Revaluations	284	776	-	-	-	-	-	**1,060**
Reclassifications	-	32	(32)	-	-	-	-	**-**
Disposals / derecognition	(516)	(156)	-	(1,714)	-	(2,592)	(15)	**(4,993)**
Valuation/gross cost at 31 March 2017	**12,346**	**19,244**	**3,431**	**24,226**	**4,640**	**9,327**	**707**	**73,921**
Accumulated depreciation at 1 April 2016 - as previously stated	**5**	**2,895**	**-**	**10,839**	**4,191**	**6,944**	**474**	**25,348**
Prior period adjustments	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2016 - restated	**5**	**2,895**	**-**	**10,839**	**4,191**	**6,944**	**474**	**25,348**
Transfers by absorption	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Provided during the year	**1**	**957**	**-**	**2,821**	**115**	**1,376**	**30**	**5,300**
Impairments	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	**-**
Disposals/ derecognition	-	(29)	-	(1,615)	-	(2,226)	(15)	**(3,885)**
Accumulated depreciation at 31 March 2017	**6**	**3,823**	**-**	**12,045**	**4,306**	**6,094**	**489**	**26,763**
Net book value at 31 March 2017	**12,340**	**15,421**	**3,431**	**12,181**	**334**	**3,233**	**218**	**47,158**
Net book value at 1 April 2016	**12,057**	**14,810**	**751**	**14,610**	**175**	**3,127**	**185**	**45,715**

Note 13.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	13,050	20,211	155	11,271	1,931	3,662	181	**50,461**
NBV total at 31 March 2018	**13,050**	**20,211**	**155**	**11,271**	**1,931**	**3,662**	**181**	**50,461**

Note 13.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017								
Owned - purchased	12,340	15,421	3,431	12,181	334	3,233	218	**47,158**
NBV total at 31 March 2017	**12,340**	**15,421**	**3,431**	**12,181**	**334**	**3,233**	**218**	**47,158**

Note 14 Revaluations of property, plant and equipment

The Trust revalue the asset classes of Land, and Buildings (excluding dwellings).

Land and Buildings were re-valued as at 31 March 2018 by Montagu Evans LLP an Independent Chartered Surveyor. The valuation has been prepared in accordance with the RICS Valuation Standards, insofar as these terms are consistent with the requirement of HM Treasury, the National Services and the Department of Health and Social Care. The market value by reference to observable rental values and rental yields was used in arriving at fair value for the operational assets subject to the additional special assumptions that:
a) no adjustment has been made on the grounds of a hypothetical "flooding of the market" if a number of properties were to be marketed simultaneously;
b) in the respect of the Market Value of non-operational asset only the NHS is assumed not to be in the market for the property interest;
c) regard has been had to appropriate lotting to achieve the best price.
The revaluation model set out in IAS 16 was applied to value the capital assets to fair value.

No significant changes in accounting estimates for useful economic life or valuation methodology were made in the preparation of the 31 March 2018 valuation as compared with previous valuations.
The revaluation increase reversing previous impairments is shown in note 5.

Note 15.1 Investment Property

	2017/18	2016/17
	£000	£000
Carrying value at 1 April - brought forward	**880**	**880**
Movement in fair value	100	-
Carrying value at 31 March	**980**	**880**

Note 15.2 Investment property income and expenses

	2017/18	2016/17
	£000	£000
Direct operating expense arising from investment property which generated rental income in the period	-	-
Direct operating expense arising from investment property which did not generate rental income in the period	-	-
Total investment property expenses	**-**	**-**
Investment property income	73	73

Note 16 Disclosure of interests in other entities

The East of England Ambulance Service NHS Trust Charitable Funds' Trust Deed established the East of England Ambulance Service NHS Trust as corporate Trustee. The Trust does not consider this charity fund Charity Registration Number 1047987, is material therefore this has not been consolidated in the results of the Trust. The charitable funds supports the provision of healthcare to the population including supporing the operation of community first responder groups, and the welfare of staff and strategic priorities of the Trust.

Note 17 Inventories

	31 March 2018 £000	31 March 2017 £000
Drugs	28	22
Consumables	661	641
Energy	365	332
Total inventories	**1,054**	**995**
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £8,370k (2016/17: £7,665k). Write-down of inventories recognised as expenses for the year were £5k (2016/17: £108k).

The carrying amount of any inventories pledged as security for liabilities is nil (2016/17: £nil).

Note 18.1 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	8,569	6,474
Accrued income	-	59
Provision for impaired receivables	(117)	(132)
Prepayments (non-PFI)	11,089	11,502
Interest receivable	-	-
PDC dividend receivable	282	154
VAT receivable	474	899
Other receivables	285	253
Total current trade and other receivables	**20,582**	**19,209**
Of which receivables from NHS and DHSC group bodies:		
Current	7,314	6,194
Non-current	-	-

Note 18.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**132**	**138**
Increase in provision	(15)	22
Amounts utilised	-	(28)
Unused amounts reversed	-	-
At 31 March	**117**	**132**

Receivables that were 90 days old were reviewed and considered on an individual basis as to whether the amounts were recoverable.

Note 18.3 Credit quality of financial assets

	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	**£000**	**£000**	**£000**	**£000**
0 - 30 days	-	-	-	-
30-60 Days	-	-	-	-
60-90 days	-	-	-	-
90- 180 days	-	-	-	-
Over 180 days	117	-	132	-
Total	**117**	**-**	**132**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	-	-	-	-
30-60 Days	-	-	-	-
60-90 days	888	-	1,323	-
90- 180 days	40	-	167	-
Over 180 days	358	-	30	-
Total	**1,286**	**-**	**1,520**	**-**

The great majority of trade is with Clinical Commissioning Groups, as commissioners for NHS patient care services. As Clinical Commissioning Groups are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

Note 19.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2017/18	2016/17
	£000	£000
At 1 April	**4,175**	**17,015**
Net change in year	4,969	(12,840)
At 31 March	**9,144**	**4,175**
Broken down into:		
Cash at commercial banks and in hand	24	46
Cash with the Government Banking Service	9,120	4,129
Total cash and cash equivalents as in SoFP	**9,144**	**4,175**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**9,144**	**4,175**

The trust holds no cash and cash equivalents which relate to monies held on behalf of patients or other parties.

Note 20.1 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	10,134	8,427
Capital payables	1,687	2,887
Accruals	11,598	8,639
Receipts in advance (including payments on account)	38	-
Social security costs	4,537	3,660
Deferred income	-	184
Other payables	2,741	2,516
Total current trade and other payables	**30,735**	**26,313**
Of which payables from NHS and DHSC group bodies:		
Current	1,211	692
Non-current	-	-

The payables note above includes amounts in relation to Pension contributions as set out below:

	31 March 2018 £000	31 March 2017 £000
Outstanding pension contributions	2,617	2,387

Note 21.1 Provisions for liabilities and charges analysis

	Pensions - early departure costs	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2017	**5,833**	**266**	**265**	**6,364**
Change in the discount rate	-	-	-	**-**
Arising during the year	-	115	1,501	**1,616**
Utilised during the year	-	(112)	(29)	**(141)**
Reversed unused	(38)	(99)	-	**(137)**
Unwinding of discount	12	-	-	**12**
At 31 March 2018	**5,807**	**170**	**1,737**	**7,714**
Expected timing of cash flows:				
- not later than one year;	313	170	1,617	**2,100**
- later than one year and not later than five years;	1,251	-	102	**1,353**
- later than five years.	4,243	-	18	**4,261**
Total	**5,807**	**170**	**1,737**	**7,714**

Pensions - Early Departure Costs:
These provisions relate to payments to the NHS Pension Agency for Early Retirements and Injury Benefit Awards and are based on amounts paid by the NHS Pensions Agency and average life expectancy for the individuals concerned. As these amounts are known with reasonable certainty there is no related balance in contingent liabilities.

Legal Claims:
The legal provision is for claims made against the Trust by employees and members of the public. Due to the nature of these provisions there is considerable uncertainty concerning when the provisions are likely to be realised. These claims also give rise to a contingent liability (see Note 22).

Other Provisions:
Arising during the year are provision balances for estimated annual leave costs and outstanding VAT assessments. The estimated annual leave provision arises from recent employment tribunal findings that overtime costs effect annual leave payments to be made to staff. Review of overtime worked and the period of possible claims derive an estimate of £0.93m, expected to be settled in the coming year but uncertain in take up.
Included within other provisions are Terms and Conditions of employment for Whitley Council ambulance staff changed in 1986 in respect of annual leave entitlement. The move from accrued to current leave entitlement resulted in the "freezing" of accrued leave to be paid at a future date on resignation/retirement from the Ambulance Service, at current rates of pay. A provision has been made for the estimated value of discharging this entitlement when staff leave the service.

Note 21.2 Clinical negligence liabilities

At 31 March 2018, £24,000k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of East of England Ambulance Service NHS Trust (31 March 2017: £29,610k).

Note 22 Contingent assets and liabilities

	31 March 2018 £000	31 March 2017 £000
Value of contingent liabilities		
NHS Resolution legal claims	(66)	(116)
Net value of contingent assets	-	-

HMRC have notified the Trust that they challenge our treatment of the employment status of GPs paid by the Trust for working in the Out of Hours Service prior to the end of that service in 2015. The Trust believe the treatment is correct and are disputing the HMRC position. An outflow of resources to settle the disputed position is not considered likely.

Note 23 Contractual capital commitments

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	1,178	1,184
Intangible assets	-	-
Total	**1,178**	**1,184**

Note 24 Financial instruments

Note 24.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with Commissioners and the way those Commissioners are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust has few overseas suppliers and invoices and terms of trade are in sterling. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust currently holds no borrowings. To raise borrowings, the Trust would borrow from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with primary care Trusts, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 24.2 Carrying values of financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity at	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2018					
Trade and other receivables excluding non financial assets	8,737	-	-	-	**8,737**
Other investments / financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	9,144	-	-	-	**9,144**
Total at 31 March 2018	**17,881**	**-**	**-**	**-**	**17,881**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Embedded derivatives	-	-	-	-	**-**
Trade and other receivables excluding non financial assets	6,595	-	-	-	**6,595**
Other investments / financial assets	-	-	-	-	**-**
Cash and cash equivalents at bank and in hand	4,175	-	-	-	**4,175**
Total at 31 March 2017	**10,770**	**-**	**-**	**-**	**10,770**

Note 24.3 Carrying value of financial liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Trade and other payables excluding non financial liabilities	23,541	-	**23,541**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2018	**23,541**	**-**	**23,541**

Note 24.3 Carrying value of financial liabilities continued

	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Trade and other payables excluding non financial liabilities	17,532	-	**17,532**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2017	**17,532**	**-**	**17,532**

Note 24.4 Fair values of financial assets and liabilities

Book value (carrying value) is a reasonable approximation of fair value.

Note 24.5 Maturity of financial liabilities

	31 March 2018	31 March 2017
	£000	£000
In one year or less	23,541	17,532
In more than one year but not more than two years	-	-
In more than two years but not more than five years	-	-
In more than five years	-	-
Total	**23,541**	**17,532**

Note 25 Losses and special payments

	2017/18		2016/17	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	-	-	-	-
Fruitless payments	-	-	12	4
Bad debts and claims abandoned	-	-	-	-
Stores losses and damage to property	7	6	9	1
Total losses	**7**	**6**	**21**	**5**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	1	17	-	-
Ex-gratia payments	37	155	18	22
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**38**	**172**	**18**	**22**
Total losses and special payments	**45**	**178**	**39**	**27**
Compensation payments received		-		-

Note 26 Related parties

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with East of England Ambulance Service NHS Trust.

The Department of Health and Social Care is the parent department and is regarded as a related party. During the year East of England Ambulance Service NHS Trust has had a significant number of material transactions with the Department, NHS England and with other entities for which the Department is regarded as the parent Department. For example :

Basildon & Brentwood Clinical Commissioning Group (CCG), Bedfordshire CCG, Cambridgeshire & Peterborough CCG, Castle Point & Rochford CCG, East & North Hertfordshire CCG, Great Yarmouth & Waveney CCG, Herts Valley CCG, Ipswich & East Suffolk CCG, Luton CCG, Mid Essex CCG, North East Essex CCG, North Norfolk CCG, Norwich CCG, Southend CCG, South Norfolk CCG, Thurrock CCG, West Essex CCG, West Norfolk CCG, West Suffolk CCG.

NHS Resolutions (formerly NHS Litigation Authority)
NHS Business Services Authority
NHS Supply Chain
NHS Pensions
Health Education England

In addition the Trust has had a number of material transactions with other government departments and other central and local government bodies.
The requirement to disclose the compensation paid to management, expense allowances and similar items paid in the ordinary course of the trust's operations will be satisfied by the disclosures made in the notes to the accounts and in the Remuneration Report.
The Trust provides administrative and management services to the Trust's related Charitable Fund totalling £400. All members of the Trust Board act on behalf of the Trust in its capacity as the Trustee of the Charitable Trust.

Note 27 Events after the reporting date

No events have been identified after the end of the reporting period which require adjustment or disclosure.

Note 28 Better Payment Practice code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	39,114	106,313	43,428	73,751
Total non-NHS trade invoices paid within target	35,138	91,320	36,288	52,509
target	89.83%	85.90%	83.56%	71.20%
NHS Payables				
Total NHS trade invoices paid in the year	578	1,908	605	1,993
Total NHS trade invoices paid within target	409	1,249	442	1,404
Percentage of NHS trade invoices paid within target	70.76%	65.46%	73.06%	70.45%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 29 External financing

The trust is given an external financing limit against which it is permitted to underspend:

	2017/18 £000	2016/17 £000
Cash flow financing	(4,829)	12,940
External financing requirement	**(4,829)**	**12,940**
External financing limit (EFL)	507	14,465
Under / (over) spend against EFL	5,336	1,525

Note 30 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	6,689	6,792
Less: Disposals	(208)	(1,109)
Charge against Capital Resource Limit	6,481	5,683
Capital Resource Limit	6,841	5,978
Under / (over) spend against CRL	360	295

Note 31 Adjusted financial performance	2017/18 £000
Surplus/(deficit) for the period/year	3,376
Add back all I&E impairments/(reversals)	(1,586)
Surplus/(deficit) before impairments and transfers	1,790
Retain impact of Departmental Expenditure Limit I&E	(719)
CQUIN Risk Reserve adjustment	(976)
Adjusted financial performance surplus/(deficit)	95

Note 32 Breakeven duty financial performance

	2017/18
	£000
Adjusted financial performance surplus / (deficit) (control total basis)	95
Remove impairments scoring to Departmental Expenditure Limit	719
Remove CQUIN risk reserve adjustment	976
Breakeven duty financial performance surplus / (deficit)	1,790

Note 33 Breakeven duty rolling assessment

	2006/07-2008/09 £000	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000
Operating income	*	228,076	222,389	226,874	235,499	237,725	245,982	232,190	247,134	266,929
Breakeven duty in-year financial performance	*	757	2,364	3,121	4,175	379	1,251	158	(9,989)	1,790
In-year breakeven position as a percentage of operating income	*	0.33%	1.06%	1.38%	1.77%	0.16%	0.51%	0.07%	(4.04%)	0.67%
Breakeven duty cumulative position	1,745	2,502	4,866	7,987	12,162	12,541	13,792	13,950	3,961	5,751
Cumulative breakeven position as a percentage of operating income	*	1.10%	2.19%	3.52%	5.16%	5.28%	5.61%	6.01%	1.60%	2.15%

Breakeven duty assessment

NHS Improvement has provided guidance that the first year for consideration for the breakeven duty should be 2009/10. * Periods prior to 2009-10 have been consolidated to provide the cumulative breakeven position. The Trust is subject to a three year period for recovery of any deficit incurred.

The application of breakeven duty means that if a cumulative surplus or deficit is reported (greater than a materiality threshold of 0.5% of operating income), it should be recovered within the subsequent two financial years.

Thank you for reading this annual report. If you have any comments or feedback about the service EEAST provides to you or your family, please contact:

East of England Ambulance Service NHS Trust (EEAST)
Patient Experience Team
Hammond Road
Bedford
MK41 0RG

Freephone: 0800 028 3382 or 01234 243320. Phone lines are open between 10am and 4pm Monday to Friday.

Email: eoeasnt.feedback@nhs.net

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