NHS
East of England
Ambulance Service
NHS Trust

Annual Report and Annual Governance Statement

2018/19

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#WeAreEEAST

Contents

1. Welcome from the Chair

As we conclude another year of providing great care to our patients and local communities, I must start by thanking our staff and volunteers for their passion, leadership and commitment to our patients.

This has been a year of improvement and change as we responded to our CQC report, risk summit and the Deloittes governance review. Our staff and volunteers have played a critical role in that improvement journey as we adapt to the increasing numbers of people who are presenting when extremely sick. I was able to see those improvements in action over Christmas and the New Year as I visited our people in stations and hospitals across Bedfordshire and Hertfordshire, where better planning, increased staffing and compassionate care were evident to see. Little wonder that the CQC recognised the care our staff and volunteers provide to patients as 'outstanding'.

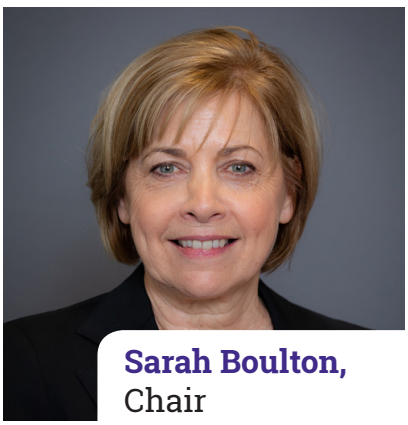
There is still plenty of work to do to improve and embed quality at the heart of our improvement journey. Our fully trained and qualified quality improvement team have travelled to stations across the region to support the implementation of staff-generated ideas and initiatives, and will continue that work through our quality improvement cafes. We have been working with our partners, Transformation Nous, to support cultural change by introducing safety huddles with the focus on improving quality of care. We have also invested further in our workforce, welcoming and training many new members of staff, and remain focused on this goal as there is still much more we need to do.

We have started to see the benefit of integrating our patient transport services within our 999 teams. We have significantly increased the size of our fleet of ambulances, involving our staff in designing and testing a new concept vehicle. And we have continued to extend our Make Ready capability through the addition of new estate facilities. The quality metrics we use to measure the care provided to patients show that we have improved on last year's performance, in particular by reducing the number of serious incidents and harm.

Dorothy Hosein joined our Trust as interim chief executive this year and has been at the heart of those many improvements. We also welcomed Marcus Bailey to the Board as interim chief operating officer and Ravi Mahendra as Audit Committee chair and non-executive director. Our thanks and good wishes go to our departing Board colleagues, Robert Morton as CEO, Kevin Brown as director of service delivery and Tony McClean as clinical non-executive director.

Over the next 12 months I fully expect our ambulance service to continue to build on the changes we have made this year to further improve our service and look forward to working with all our staff and volunteers to achieve this.

Sarah Boulton, Chair



Sarah Boulton,
Chair

2. Introducing EEAST

We serve around six million people in Bedfordshire, Hertfordshire, Essex, Norfolk, Suffolk and Cambridgeshire. Like the other ambulance NHS trusts in England, we provide a range of services, but are best known for the 999 emergency service. We employ more than 4,000 staff and have about 1,500 volunteers working with us.

Our dedicated and skilled staff and volunteers 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, while our quality services are engineered to meet each community's differing needs.

Due to the size of the area we serve, we work within six sustainability and transformation plan footprints. This year, we have worked hard to transform our operational structures to align with these business areas, which cover Bedford and Luton, Hertfordshire and West Essex, Cambridge and Peterborough, Norfolk and Waveney, Suffolk and North East Essex and Mid and South Essex.

In 2018/19 we dealt with more than one million 999 emergency calls which were answered and managed in our three ambulance operations centres (AOC) 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 its urgency. 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. Alternatively, we may carry out further clinical assessments over the phone for patients with minor conditions, with a clinician then offering them telephone advice or referral to their GP, pharmacist or local walk-in centre.

Resilience and specialist operations

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 Civil Contingencies Act (CCA) 2004 specifies that responders will be either category one (primary responders) or category two responders (supporting agencies). EEAST is a category one 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 assurance which NHS England provides to the Department of Health in relation to EPRR. The Trust Board ratified the EPRR annual return, prior to submission to NHS England.

The Trust also operates two hazardous area response teams (HART) and has a resilience and emergency planning department. This department 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 to ensure our patients receive the best possible care.

Not just an emergency service

As well as the 999 emergency ambulance service, we also provide a range of other services, including non-emergency patient transport services (PTS) and commercial services. These are described in more detail in the 'our services' section of this report.

We currently deliver PTS in Bedfordshire, Hertfordshire, Cambridgeshire and Peterborough, and parts of Essex. These services are essential for many patients receiving ongoing care, and we are proud to provide them for our communities.

We have worked hard this year to integrate PTS into our business units, bringing our staff together so that everyone is supported and so that every patient receives the right care for them, at the right place and at the right time.

3. Statement from Chief Executive

I am extremely proud of the outstanding care our staff, volunteers and community first responders (CFRs) have delivered to patients over the last year. Even when under extreme pressure and facing additional patient demand this winter, the care we provided was greatly improved by our intelligent planning, ability to embed learning from previous experience and the hard work of our staff.

Over the last few months, we have introduced a quality improvement plan to improve our performance in a number of key areas, including operational performance and recruitment and retention, in addition to specific initiatives in quality and operational domains. This programme has set the foundation for a cycle of continuous improvement to help us progress towards achieving the Trust's strategic objectives.

Earlier this year we launched our regional accountability committees, which enhance existing governance frameworks to improve integrated performance throughout the Trust. This ensures that the senior leaders and their teams are fully sighted of the issues, and have methodologies and robust plans for improvement in place which are fully aligned with the Trust's overall short or longer-term objectives.

We have worked hard this year to improve the way we engage with our staff. I have planned weekly visits across the region at different times to try and meet as many colleagues as possible, which has been an absolute pleasure. In recognition of the need to improve retention, I have personally spoken to any member of staff wishing to leave the organisation and will continue to honour this commitment. It is so very important that we retain as many of our staff as possible, which means that listening to and addressing their concerns is essential.

In recent months, we have rolled out safety huddles at our stations to give crews at the beginning and end of their shifts the opportunity to ask questions and receive information. Importantly, this also provides local teams with the chance to discuss their shift so that we can ensure we provide the best possible care to patients.

The safety huddles are part of our overall transformation programme, which has been designed to improve the care we provide to patients. It also aims to respond to what we have heard from our staff, and therefore includes actions to reduce hospital handover delays, late finishes for crews and other wellbeing issues.

This is an exciting time to be part of EEAST as we progress with our Make Ready programme. Some areas are already benefiting from a new or redesigned hub as part of the estate transformation which is running parallel to Make Ready. Our new vehicles, designed in partnership with staff, started arriving early this year and will make a significant difference to both our patients and crews.

A clinical focus and ethos will remain central to everything we do as we continue our improvement journey. We are committed to improving the service we provide to patients through robust methodologies and planning.

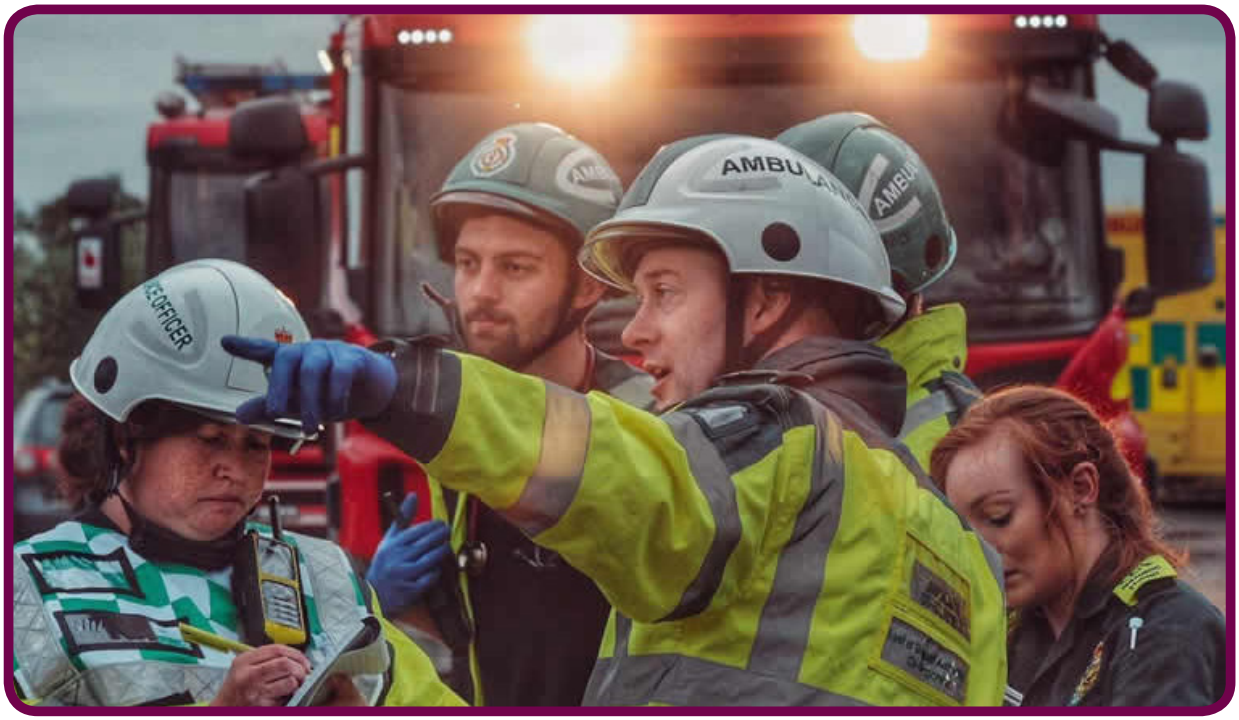
I will also continue to build on successful partnership working with the wider health economy to develop innovative alternate care pathways so that we can make sure every patient receives the most appropriate care.

Our staff are at the heart of EEAST. My team and I are fully committed to building on this year's improvements and engagement, and to continuing to make changes which will further boost their wellbeing and the experience they have when they come to work.

The dedication of our volunteers contributes towards the service we provide to patients and communities. In some cases, such as with CFRs, they enhance the speed with which life-saving treatment can be started. We would like to thank all of our volunteers for their ongoing dedication and commitment to the ambulance service, and for their positive impact on our patients and staff.

Dorothy Hosein, Chief Executive

Dorothy Hosein,
CEO



Major incident training exercise in West Norfolk

4. Our achievements

The following gives an outline of some of our achievements during the year:

- Five members of staff gained a nationally-recognised quality status as quality, service improvement and redesign (QSIR) teaching faculty associates.
- The Ministry of Defence awarded EEAST an employer recognition scheme gold award for showing outstanding support for armed forces staff.
- We secured capital investment to get ambulances cleaned and re-equipped through our Make Ready programme, so crews can get back into communities more quickly.
- A telemedicine platform was launched to help clinicians in east Suffolk and hospital consultants determine if a patient has had a stroke.
- Strategies for dementia care were spearheaded, and our Trust ended the year with more than 1,000 staff becoming dementia friends.
- Thousands of adults and children were trained in CPR through free events and commercial training around the region, including national restart a heart day.
- We improved safe and secure medicines management for clinicians.
- We planned more effectively for seasonal variations on service demand.
- Schemes run by our service and healthcare partners to keep patients at home following a 999 call were expanded to support more people.
- We introduced new cycle to work and lease car schemes for staff through salary sacrifice to add benefits for staff.
- We opened a joint station for Sudbury's fire and ambulance services.
- The Stanford/Corringham and Tilbury CFR group received the Queen's award for voluntary service, which is the highest accolade given to volunteer groups and recognises their outstanding work.
- Two call handlers who offered vital reassurance during difficult 999 calls were shortlisted for a national award.
- We issued wellbeing passports to more than 1,000 staff.
- We promoted 20 staff wellbeing initiatives, including our wellbeing bus.
- The clinical career pathway was launched to make it easier for our staff to progress their career through the Trust.
- We led the way with our work on freedom to speak up (FTSU), with two FTSU guardians in place.

5. Objectives for the year ahead

Over the last 12 months, we have been working to address significant challenges relating to performance, quality improvement, staff health and wellbeing and financial sustainability, alongside the recognition of historical underfunding and the capacity gap. Our top priority is providing high quality care to the public and, throughout all of the changes that have occurred, patients have been at the forefront of all of our actions.

Our ambition is to transform services to meet the requirements of the NHS Long Term Plan and Urgent and Emergency Care Review, with the significant aspects of change which is needed reflected in our annual operating plan. Following the 2018 independent service review report and the first year of transformation delivery, our 2019/20 annual operating plan reflects the continued level of pace and focus on improvement in order to deliver a safe and high-quality service to every patient. Our ongoing focus is the recruitment and retention of the clinical workforce, the establishment of robust efficiency schemes to maximise operational productivity, reduction in unwarranted variation in clinical practice and supporting the health and wellbeing of staff.

Our priorities for 2019/20 include:

Operational delivery

- Deliver safe, effective and compassionate care that promotes high quality health outcomes for patients in urgent and emergency care.
- Work towards the delivery of the ambulance response programme (ARP) performance standards.
- Deliver a challenging improvement programme, supported by Transformation Nous, focusing on improving operational productivity.

Our people

- Ensure robust plans are in place to attract, recruit, develop and retain the workforce with a focus on supporting the health and wellbeing of staff, whilst developing an integrated workforce which values the diversity of multi-professional groups across the Trust.
- Continually support the wellbeing of staff through education and promotion of a positive culture founded on the Trust values.
- Through local leadership and engagement, deliver the ‘Building Better Rotas’ project that will see the availability of resource matching that of demand to improve staff welfare and performance.

Clinical

- Progress from a Trust-wide Care Quality Commission rating of 'requires improvement' to 'good'.
- Increase patient engagement and using patient stories and experiences to help shape how services are delivered.
- Launch the EEAST clinical strategy, which puts the patient and clinician at the heart of the organisation.

Value for money

- Continue to introduce new initiatives, such as Make Ready, to improve our readiness and responsiveness.
- Deploy a new fleet of vehicles which are more efficient and economical to operate.
- Continue to develop non-emergency patient transport services across the east of England, aligned to system healthcare providers and supporting patient flow.
- Develop the digital capability and capacity to ensure key technology is identified and utilised effectively to support integrated services for staff and patients.

Our plan for 2019/20 reflects the scale of change required to continue to transform the Trust and enable us to deliver high quality, timely care to all of our patients. Whilst ambitious, we believe major transformation is achievable through careful planning, continuous monitoring and oversight through the governance processes established within the organisation.

Quality Account

Patients are at the heart of everything we do. Our standards are set to ensure that they receive the same high quality clinical care that we would want for our own family and friends, as well as positive clinical outcomes so that the person goes on to recover well.

To 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 2018/19 were set to help us reach the clinical quality standards we want, reach patients promptly and treat them effectively so they are satisfied with the service that they receive. In addition, our aim was also to gain their views through our patient survey programme and learn from any negative feedback, changing practice if necessary.

The Department of Health sets priorities, including timely response and care for stroke, cardiac arrest and heart attack patients. EEAST then identify targets set within three overarching priorities – patient safety, clinical effectiveness and patient experience.

For 2018/19, the locally defined priorities were:

Priority one: Patient safety	• Infection prevention and control – improvements within the vehicle deep cleaning target for all operational areas • Introduce a safety walkabout audit tool within patient transport services to align them with emergency and urgent care and the emergency operations centres.
Priority two: Clinical effectiveness	• Continue implementing the end of life care strategy • Recognition and management of acute coronary syndrome patients • Emergency care practitioner usage of antimicrobial drugs.
Priority three: Patient experience	• Monitor implementation of the dementia strategy, including the introduction of regular patient satisfaction surveys for people who have, or care for those that have, dementia following pilot surveys in 2016/17.

The Quality Account for 2019/20 will continue to focus on the core priorities which match the mandatory indicators for ambulance trusts set by the Department of Health. This includes areas defined within our soon-to-be launched clinical strategy and which take into account the recently-published NHS Long Term Plan, such as cardiovascular disease and stroke care.

Priority one: Patient safety	• Introduce a 'learning from incidents' policy • Deliver a compassionate and responsive service for dialysis patients through the patient transport service • Embed recommendations from the human factors / ergonomics project within the operational setting where possible
Priority two: Clinical effectiveness	• Implement clinical supervision • Increase the recognition of sepsis and neutropenic sepsis supported by the delivery of the sepsis care bundle to provide the highest standards of pre-hospital care • Produce a public health strategy in collaboration with Public Health England • Develop greater system intelligence through the use of public health data to inform population health management and the development of urgent and emergency care services and become key stakeholders in the development of population health management • Trial the stroke mobile unit in the Norwich and Ipswich areas • Launch the Trust's clinical strategy.

Priority three: Patient experience	• Obtain feedback from harder to reach groups of patients such as those with learning disabilities, dementia and younger people • Launch the learning disabilities and autism workplan • Improve experience and quality of care for people with learning disabilities / autism.

Outcomes for 2018/19 and further information for the priorities defined for 2019/20 can be found in our Quality Account, which is published at the end of June on the NHS uk website [Overview - East Of England Ambulance Service NHS Trust - NHS]

Staff engagement and project management teams working together

6. Our performance

i) Overview

In the following pages we have outlined our achievements against key areas of business delivery within the 2018/19 financial year. For ease, we have separated these into six key areas – operational performance, quality, safety and patient experience, workforce development, finance, strategy and transformation and our sustainability report.

Performance highlights include:

- We have delivered care to over 90% of our sickest patients within the 15-minute time standard.
- Working with our partners, we have significantly reduced the number of hospital handover delays so that more ambulances are available to attend to our patients.
- We have improved our call pick up times so that patients calling 999 are answered on average within three seconds.
- We have launched our quality improvement strategy and now have more than 20 staff trained in improvement methodologies to help us continue our improvement journey.
- We have reduced avoidable patient harm by almost 50%, meaning our patients are safer. We also recorded a 25% reduction in the number of complaints received within the year.
- We have achieved our target for ensuring our staff have received their statutory training, which includes safeguarding and information governance.
- Over 92% of our patients who responded to our friends and family test said they would be likely or extremely likely to recommend our service to others.
- We have recruited over 773 members of staff within the year, 584 of which are frontline staff who will be caring for patients.
- We have implemented two key software systems to support our staff – Evolve, our learning portal, and TRAC, our recruitment tool.
- We have launched two clinical apprenticeship pathways – our apprentice emergency medical technician and apprentice emergency care support worker programmes, and have enrolled 163 people across the two schemes.

There are also some key areas relating to performance where further work is needed:

- We will continue to focus on improving response times to all of our patients through continued recruitment and improving efficiency within operations, including further reduction in the number of hospital handover delays. This is in line with the plan agreed with our regulators and commissioners.
- We need to implement and embed a range of schemes to improve our reputation as an employer of choice so that staff stay with us for longer. This includes increasing engagement and talent management, as well as embedding a consistent leadership approach.

- We need to embed core management tasks which support staff into our business as usual, recognising that the winter period is historically a challenge for us. Ensuring staff have focussed time with their manager for compassionate conversations will support their development and improve the retention of our workforce.
- We need to continue to implement our dignity and respect campaign to further reduce the number of our staff who feel they have been bullied or harassed in the workplace.
- We need to continue to roll out our disability network, which began in March.

ii) Operational performance

All ambulance trusts in England have been measured under the ambulance response programme (ARP) since its introduction in 2017. We moved to ARP in October 2017, which means that 2018/19 has been the first full year we have been working towards these standards.

The table below provides detail on each of the main response categories and national standard, along with our performance over the year. As part of the agreement within the independent service review, EEAST was not expected to reach the national standards in 2018/19 since it was recognised that the workforce gap was too great to allow this level of performance. Therefore, 2018/19 was agreed as a transitional year in which an agreeable level of performance by quarter would be aspired to while staffing increased to the planned levels.

Compliance with national standards was expected from April 2019.

Category	Definition	National standard	EEAST performance (hh:mm:ss)
C1	Immediately life-threatening injuries and illnesses	Seven minutes mean response time	00:08:02
		15 minutes 90th centile response time	00:14:32
C1T	Immediately life-threatening injuries and illnesses where the patient is transported to hospital	Seven minutes mean response time	00:12:53
		15 minutes 90th centile response time	00:23:26
C2	Emergency	18 minutes mean response time	00:25:01
		40 minutes 90th centile response time	00:51:28
C3	Urgent calls and in some instances where patients may be treated in situ (e.g. their own home) or referred to a different pathway of care	120 minutes 90th centile response time	03:09:48
C4	Less urgent. In some instances, patients may be given advice over the phone or referred to another service, such as a GP or pharmacist	180 minutes 90th centile response time	03:31:39

As the table shows, we met the national standard for C1 90th percentile (the average time taken for nine out of 10 ambulances to arrive), with an end of year performance of 14 minutes and 32 seconds. However, our performance against all other categories did not meet the national standard, as expected through our commissioned position for the financial year.

In 2019/20 there is an expectation that our performance will reach national standards as a result of improvements in a number of areas, most notably:

- recruitment and growth of the clinical workforce;
- delivery of the Building Better Rotas project, designed to improve the ratio of double staffed ambulances over conventional fast response cars; and
- improved productivity of our vehicles to increase the number of patients we are able to see with the resources we have available.

While we did not have contractual terms related to national standards in 2018/19, we did have terms related to the levels of ambulance cover the Trust provided. Known as patient-facing staff hours, levels were set each quarter to ensure that while performance times may not reach national standards, the levels of ambulance cover provided would meet an agreed level. We are pleased to say that we achieved each of these quarterly targets, as outlined in the table below:

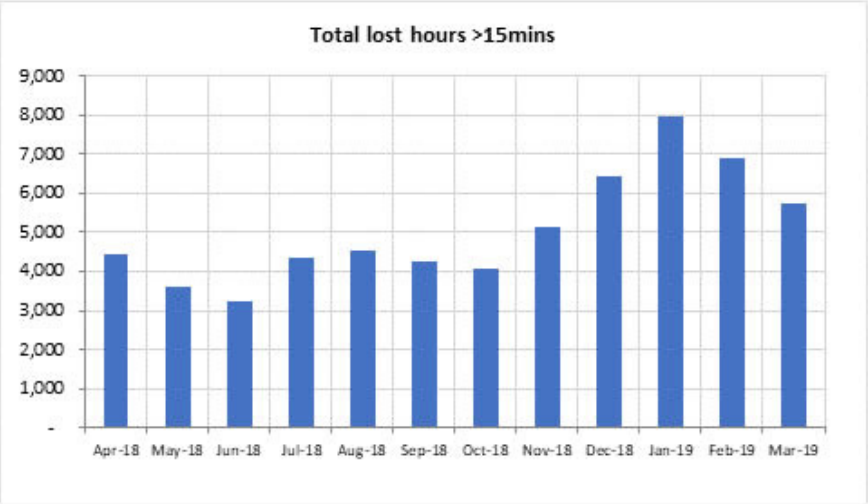
Weekly average gross patient facing staff hours		
2018/19	Target	Actual
Q1	84,656	84,732
Q2	85,603	86,702
Q3	86,817	92,754
Q4	89,293	94,473

Over recent years we have experienced a significant loss of ambulance hours available to respond to our patients as a result of delays in handing patients over to hospital care. Because of this, over the last year we have worked hard collaboratively with regulators, commissioners and our area's hospitals to make improvements and reduce handover delays so that our patients in the community are not waiting for an ambulance.

As a system, we have implemented the handover escalation protocol which helps all providers rapidly identify areas of concern and work together to resolve the barriers, reducing delays. As a result, there has been a marked improvement and reduction of handover delays this year, which has helped to improve patient safety and reduce the pressure across the system.

The chart below, however, highlights that in spite of the significant improvements made, we still lost an average of 5,000 ambulance hours per month due to handover delays, which equates to around 208 ambulance shifts. We will continue to work with our partners in the coming year to reduce this further so that we can respond faster to higher numbers of our patients.

Total lost hours > 15 mins



Ambulance operations centres (AOCs)

Staff in our AOCs receive all of our 999 calls, triaging our patients to make sure every one receives the right response for their condition. The time taken to answer a 999 call is an important indicator of our performance, as for our most unwell patients such as those in cardiac arrest, every second counts.

Call pick up improved significantly this year due to the hard work of our call handlers and focussed recruitment of staff to increase our shift cover, and is now at an average of just three seconds:

East of England Ambulance Service NHS Trust		Call answer times (seconds)			
		Mean	Median	95th centile	99th centile
2017-18	November	8	1	52	108
	December	14	1	83	150
	January	9	1	56	132
	February	7	1	40	100
	March	6	1	38	98
2018-19	April	3	1	6	51
	May	6	1	32	82
	June	7	1	46	104
	July	11	1	66	134
	August	6	1	30	93
	September	10	1	59	123
	October	7	1	47	102
	November	9	1	54	110
	December	3	1	7	52
2019	January	3	1	8	52
	February	4	1	15	63
	March	3	1	10	55

Table 1: Ambulance quality indicators: systems indicators (NHS England, 2019)

A number of our patients who call 999 do not need an ambulance, but instead need advice, guidance and signposting to other pathways. To do this, we have a team of clinicians in our enhanced clinical assessment and triage team (ECAT), who carry out 'hear and treat'.

On average, around 7% of all of our patients who call 999 can be managed safely through hear and treat. The table below shows our delivery of this essential service:

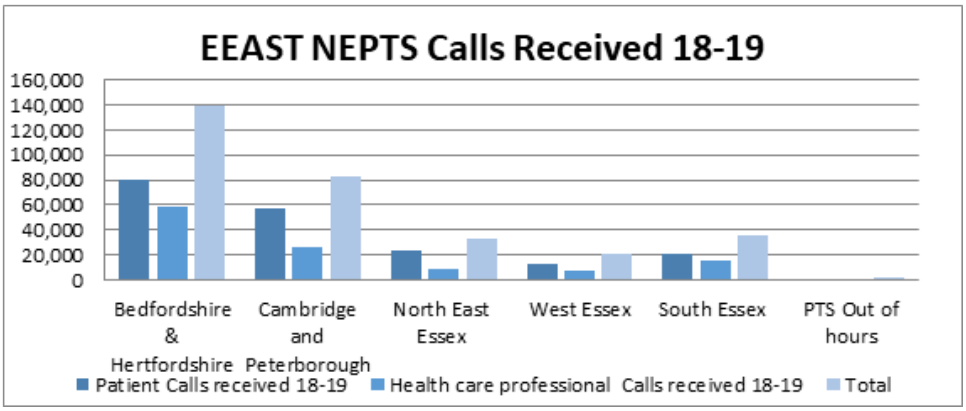
Month	ECAT hear and treat %
April 2018	6.18%
May 2018	7.62%
June 2018	7.89%
July 2018	7.64%
August 2018	6.95%
September 2018	6.56%
October 2018	6.34%
November 2018	6.51%
December 2018	7.0%
January 2019	7.39%
February 2019	6.92%
March 2019	7.03%

The national benchmark target for hear and treat is 7%, with the independent service review modelled target of 7.1%. Over the past year, we have remained within the top three trusts nationally for hear and treat performance, with some months being the best.

One of the emerging themes within ECAT is recruitment challenges, which are attributed to internal transfers to band six and band seven advanced practitioner programmes and external moves to primary care roles in GP surgeries. In response, we are developing a recruitment strategy which includes targeted media advertising, additional HR support and development of a recruitment brochure.

Patient transport services (PTS)

Non-emergency PTS – the transfer of patients to and from hospital appointments, or home following discharge from hospital – is an important component of every patient's care. PTS is commissioned separately to other parts of our services, and we currently hold five transport contracts, as well as a small out-of-hours element to help patients 24/7. Over the year, we helped more than 300,000 patients to get to or from the healthcare that they needed. A breakdown by area is below:

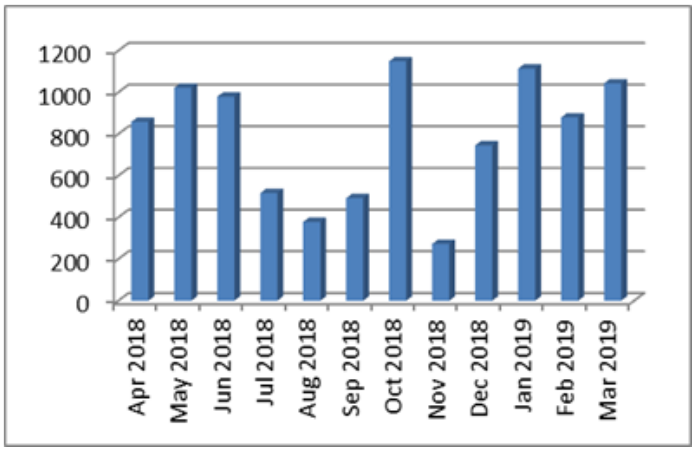


This year we have worked hard to integrate our PTS into our operational structure, and are now starting to feel the benefit of this closer working.

Hazardous area response teams

Hazardous area response teams (HART) provide specialist responses to significant, major or complex incidents. They are specially trained to deliver the best possible care in the most challenging situations whilst ensuring both they and their patients remain safe during their work. In addition to specialist operations, the teams can also respond to some of our 999 patients if they are available or are the closest clinicians when we receive the call.

Our hazardous area response teams attended more than 9,000 incidents over the year, which is consistent with 2017/18:

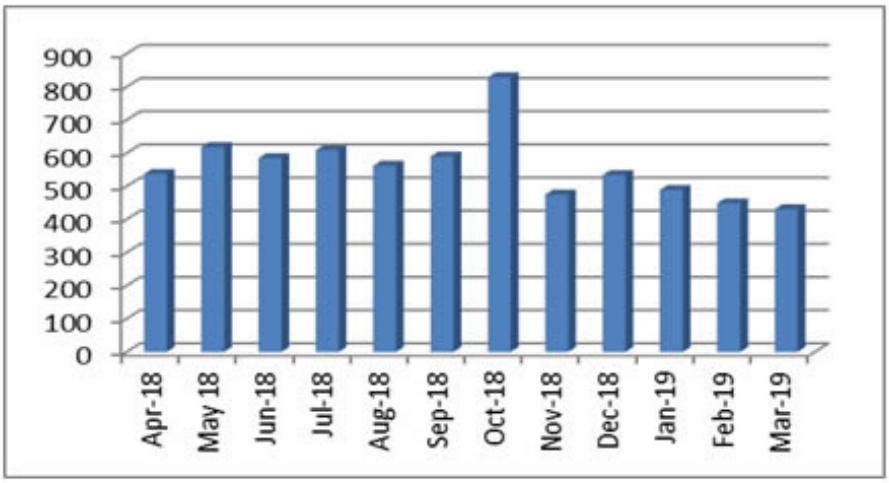


It is a key requirement to ensure a full team of six is deployed for each hazardous area response team. Compliance with availability requirements shows a total of 153 more shifts were fully covered this year, which is a 30% improvement compared with 2017/18.

We meet the specified requirement to provide 63 additional marauding terrorist firearms attack (MTFA) staff, who are specially trained to be able to respond to a firearms incident to support and deliver care to any potential patients. We started the year with 79 specially-trained staff, and have been working hard to increase that number to meet our aspiration of 100 MTFA trained staff. At April 2019, 88 of our staff were able to provide a response and support this type of incident.

In addition to the specialist responses we provide through HART and MTFA, the close joint working between ourselves and all our partners and stakeholders is a vital part of the care we provide to our patients. This collaboration includes the three air ambulance charities and BASIC (British Association for Immediate Care) doctors within our region.

The number of air operations incidents attended across the year is slightly higher than the previous year:



Air operations incidents attended in 2018/19

Commercial medical care service

The commercial medical care service (CMCS) provides paramedic-led ambulances for both event cover and dedicated medical transfers. The team operates primarily in Norfolk and Suffolk, but also travels across the region and sometimes further afield. Its aim is to raise funds for the Trust through commercial work whilst building resilience in EEAST by providing capacity and reducing pressure on emergency operations through delivery of frontline emergency care.

The events team has contracts to support Norwich City Football Club, providing emergency cover for players and the crowd. It also has a prestigious contract with The Jockey Club at Newmarket and Huntingdon racecourses, and provides support at Fakenham Racecourse. Other events covered include the Royal Norfolk Show, Tattersalls, Wymondham College Rugby, Sizewell and Cromer Carnival. In addition to event work, CMCS has supported patients by making numerous repatriation journeys for social services transfers, journeys to support private patients and repatriations on behalf of commissioners.

The events team uses four ambulances for its work and, during times of increased demand, has been used to support 999 operations in Norfolk. The 4x4 vehicles in the fleet were especially useful during the snowy weather in the winter. Further support has been provided to 999 operations through an urgent tier vehicle which provides paramedic-led resource to attend healthcare professional referrals and inter-hospital critical care transfers.

One call service

We ran the one call service and district nurse messaging until the end of September, when the contract transferred to the current provider. One call provided a single point of contact which allowed patients and health and social care professionals to get in touch with community services, including the rapid intervention team, district nurses, rehabilitation and enablement, community beds, palliative care and community matrons. As well as call handling, it also offered referrals management.

Single point of contact

The single point of contact (SPOC) has been established to make sure our staff are able to support patients to access the right care to meet their needs. SPOC is a 24/7 phone line which is available to all of our staff and includes the ability to refer patients to a range of different pathways, including diabetic or out-of-hours nursing.

The table below shows the number of times a SPOC pathway was used. Several changes were made to the pathways in March 2019, which means service utilisation may differ from previous months. These include the introduction of GP notification, removal of GP report and modification of the safeguarding and vulnerable persons' pathway.

Amongst the 100,000 times SPOC was used this year, almost 30,000 patients at risk of falls had their condition notified to a fall team, while nearly 2,000 patients were seen by the admission avoidance team so they could try to stay at home with their loved ones.

SPOC pathway	Total	Total % by pathway
Safeguarding / vulnerable persons	**52,317**	**50.51%**
Falls notifications	**29,698**	**28.67%**
GP report	**9,839**	**9.50%**
GP notification	**1,621**	**1.56%**
TIA notifications	**113**	**0.11%**
Herts admission avoidance response car	**1,968**	**1.90%**
Diabetic hypo	**1,891**	**1.83%**
Datix incidents	**6,136**	**5.92%**
Totals	**103,583**	

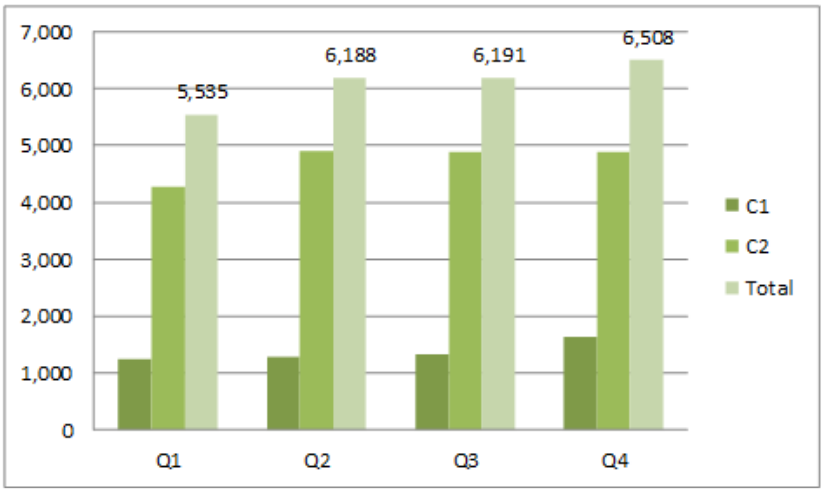
Community first responders

We are exceptionally fortunate to have a large cohort of more than 850 community first responders (CFRs) and 243 CFR volunteer groups. Trained and supported by us, our CFRs are members of the public who aim to reach patients with life-threatening conditions in their local communities within first few vital minutes, before the arrival of an ambulance crew. The community response team continues to target local areas to recruit more volunteers and establish new groups.

This year we have focussed on ensuring that our volunteers have a strong leadership and support model around them so that we work as closely together as possible for the benefit of our public. Our volunteer advisory forum and the CFR operational group are well embedded to support the daily leadership and activity of community response.

Our volunteer CFRs have made almost 430,000 hours of volunteer time available to help some of our sickest patients throughout the year. They have responded to a range of category one (C1) and category two (C2) calls, and have cared for almost 25,000 critically-ill patients. The graph shows a breakdown of calls attended by CFRs for each quarter:

Calls attended by community first responders by each quarter (2018/19)



The community response team also continues to support to the growing network of defibrillators across our region, working with businesses, sports facilities, community groups, parish councils and other organisations. These vital pieces of equipment help save the lives of people who go into cardiac arrest, in turn helping us deliver a better service to our patients.

Community first responder group completing their training

Co-responders

The Trust is supported by co-response schemes from external organisations, with 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), Honington (Suffolk) and Marham (Norfolk) and are trained to first response emergency care level three, which means they can respond to a wide range of incidents.

iii) Quality, safety and patient experience

Ambulance clinical quality indicators

Ambulance clinical quality indicators (ACQIs) look at quality of care and were introduced for all ambulance services in England in April 2011. They are ambulance-specific and provide consistent monitoring, and are a vital indicator of how well we maintain and improve the care patients receive.

Ambulance clinical quality indicators were originally set to measure how well we treat patients who are in cardiac arrest or experiencing a stroke or heart attack. Two additional indicators were introduced in 2018/19 – how we treat people who have a return of pulse after suffering a cardiac arrest (post-ROSC) and how we identify and treat patients who have sepsis.

Although no targets are set nationally, our commissioners set local thresholds and monitor our progress on a monthly basis.

The table below demonstrates the average level achieved for the year.

ACQI	Locally-set threshold 2018/19	Average
ROSC at hospital (overall)	27.0%	30.2%
ROSC at hospital (Utstein)	53.0%	58.4%
Survival to discharge (overall)	7.0%	10.8%
Survival to discharge (Utstein)	27.0%	36.1%
Post-ROSC care bundle	No threshold set	62.7%
PPCI <150**	95.0%	86.2%
STEMI care bundle	86.0%	91.4%
Stroke HASU <60	56.0%	41.2%
Stroke diagnostic bundle	98.0%	99.2%
Sepsis care bundle	No threshold set	81.5%

*** It should be noted that this outcome is based on 'unvalidated, preliminary data from the myocardial ischaemia national audit project (MINAP)'.*

Full information regarding our ACQIs and other clinical audits completed within the year can be found in our Quality Account at Overview - East Of England Ambulance Service NHS Trust - NHS

Quality improvement (QI)

We have recruited and developed a central quality improvement (QI) team to coordinate QI initiatives and are working towards an in-house faculty to deliver QI programmes. Five members of staff have qualified as quality, service improvement and redesign associates, while a further 20 staff are undertaking the one-day fundamental programme or working towards the college programme.

We have received just under 100 QI suggestions since October, and have active QI projects across the organisation. We give local teams the flexibility to choose what they work on before discussing how these align with directorate and Trust-wide priorities to ensure that QI is meaningful and beneficial for staff and service users.
Our quality improvement strategy informs the plan we have for delivering our commitment to provide a safe and effective healthcare service to all of our communities in the east of England by 2022. The strategy reflects our core values.

The three objectives of this strategy are to have:

- a sustainable process to embed QI in all aspects of our business
- a reduction of clinical variation
- an established QI faculty.

We are progressing well with the QI strategy and will continue to report on this in next year's annual report.

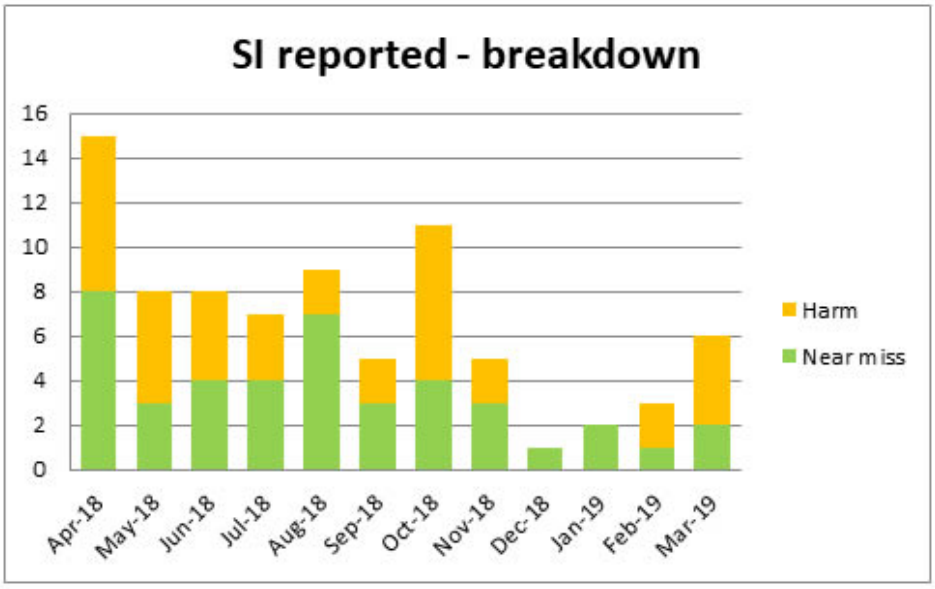
Patient safety

We have robust patient safety processes in place which are well governed and effective. They have also been scrutinised by regulators throughout this year and deemed to be of high quality.

We continue 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, this shows that we are not just open and transparent, but are also committed to embedding the lessons learnt from reporting.

We reported 80 serious incidents (SIs) in the 2018/19 financial year compared with 150 in 2017/18, representing a 47% decrease. Within this, the data shows a marked improvement in all measures, demonstrating a safer level of service delivery to our patients in the last 12 months. It meant that seven fewer patients experienced moderate or severe avoidable harm compared to the year before, while there were also 48 fewer cases where no harm occurred. There were no contractual never events during 2018/19.

A breakdown of SIs reported by month is:



We recorded a 75% reduction in SIs during the four-month period over the traditionally busy winter months. This came as a result of additional measures put in place throughout operations and with the patient safety team to ensure our patients remained safe during the period of high pressure.

Safety huddles

This year we have implemented a new initiative known as 'start of shift huddles' within the service delivery directorate.

Our safety huddle concept is currently led by local management teams at the start of each duty period for patient-facing crews. They point out who is on duty, including management and AOC dispatch teams, and highlight key points for the shift, such as:

- resource escalation action plan (REAP) and current surge level, which shows the level of pressure we are facing at the time and the potential impact on the shift and our patients
- key local risks, such as hospital pressures
- factors that may impact on service delivery such as road closures, acute diverts or temporary closure of services
- clinical quality metrics such as reminder of care bundles and on scene times
- compliance issues to help ensure our staff have received all the necessary training.

Huddle boards have also been designed to help document and showcase the discussions to the wider staff group, with roll out across the whole service directorate due for completion in the coming weeks.

Learning from incidents

We are dedicated to ensuring that we learn from all of our incidents to prevent any further cases with the same cause from happening to another patient.

This year, we have successfully reduced the recurrence of cases where there has been an excessive delay in attending to patients, and have also embedded a new learning from incidents (LFI) project to translate this success into the range of clinical cases we see. So far, more than 151 clinicians, students and volunteers have taken part in the LFI workshops, which will be continued into the future.

Furthermore, we have introduced the role of patient safety integration lead to support both internal and external learning from cases as well as identifying when care has gone well and what we can learn from this.

Safeguarding

Over the past year, we have continued to build on the effective systems we have in place to safeguard children, young people and adults.

Safeguarding is a golden thread which runs throughout our organisation and affects all staff and volunteers. 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 ongoing compliance is regulated through the CQC, the fundamental standards of care and associated key lines of enquiry. It is reported through statutory safeguarding self-audits (Section 11 of the Children's Act (2004) for children and young people and the new adult audit which has been introduced in line with the Care Act (2014) requirements). External engagement with all 22 safeguarding boards in the region allows us to promote and highlight performance, challenges and initiatives that aim to keep all patients safe from harm.

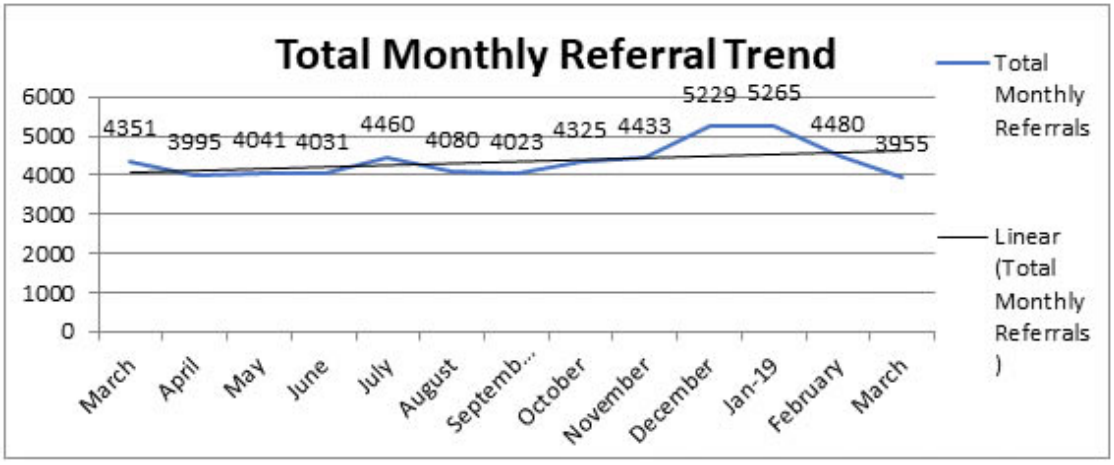
Our training is aligned to the Royal College of Paediatrics and Child Health's Safeguarding Children and Young People, and has focussed on a back to basics approach this year. The blended learning method was open to all patient-facing staff and volunteers and has been well-received and taken up, as shown by a marked increase in referrals from the previous year.

We also complete Prevent training, which is part of the Government's CONTEST counter-terrorism strategy to tackle radicalisation. At the end of March, we had exceeded the national training target of 85% at all levels, with 95.63% of staff completing basic awareness training (481/ 503 staff) and 97.8% meeting the next level, known as WRAP3.

Trust compliance with safeguarding level one and level two training reached 95% and 97% respectively at the end of the year, exceeding the improvement target of 90%. This demonstrates the level of focus and importance we place upon compliance with this essential component of the care we provide.

Level three multi-agency safeguarding training remained constant and at the required level, with 45 staff of differing grades trained and fully compliant across our footprint.

All safeguarding referrals are received via the SPOC system. The number has continued to increase year-on-year because of the increased awareness which has resulted from our high levels of compliance with safeguarding training.



Throughout the year, 42 requests for information were made for serious case reviews, serious adult reviews and domestic homicide reviews. This continues to lead to a number of recommendations to improve outcomes, not only in practitioner practice but within our safeguarding policies. In addition, our safeguarding team continue to receive positive feedback in relation to engagement and quality of the independent management reports they submit.

Other key achievements during the year included:

- Improving the quality and quantity of safeguarding referrals.
- Supporting level two safeguarding training for all patient-facing staff, including CFRs, fellow blue light responders (RAF and fire services), third sector ambulatory providers and the Trust Board. Training figures, including Prevent, have also been met.
- Completing successful internal audit reviews for safeguarding.

Our safeguarding priorities for the 2019/20 year will be:

- working with NHS Digital on 'Child Protection – Information Sharing' (CP-IS)
- continued regional and national engagement
- discussions around new training levels for paramedics and registered nurses.

The Care Quality Commission

The Care Quality Commission (CQC) is England's independent regulator of health and social care. It ensures that fundamental standards of quality and safety are met and sets out what good and outstanding care looks like. It encourages care services to meet those standards through inspections, ratings and published reports.

The CQC inspect organisations through five key lines of enquiry to determine whether we are:

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

The full report from the unannounced inspection which took place in April 2018 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. Overall, the Trust was rated as 'requires improvement'.

An inspection of our core service and a well-led inspection were carried out at the end of 2018/19 and completed at the beginning of May 2019. We are due to receive the draft report in June 2019 and will ensure that any learning and improvements identified are embedded through our integrated improvement process.

We will continue to monitor and track progression of the improvements we are making in response to our CQC actions at our quality roadshows, while also reviewing completed actions to ensure the improvements we put in place are sustainable.

Patient experience

We are committed to improving services we provide to our patients so they get the right care, in the right place, at the right time.

The patient experience team is responsible for coordinating all complaints, concerns, comments and compliments raised by patients, their families/carers and the public to make sure that any concerns are heard, investigated and action is taken to put things right.

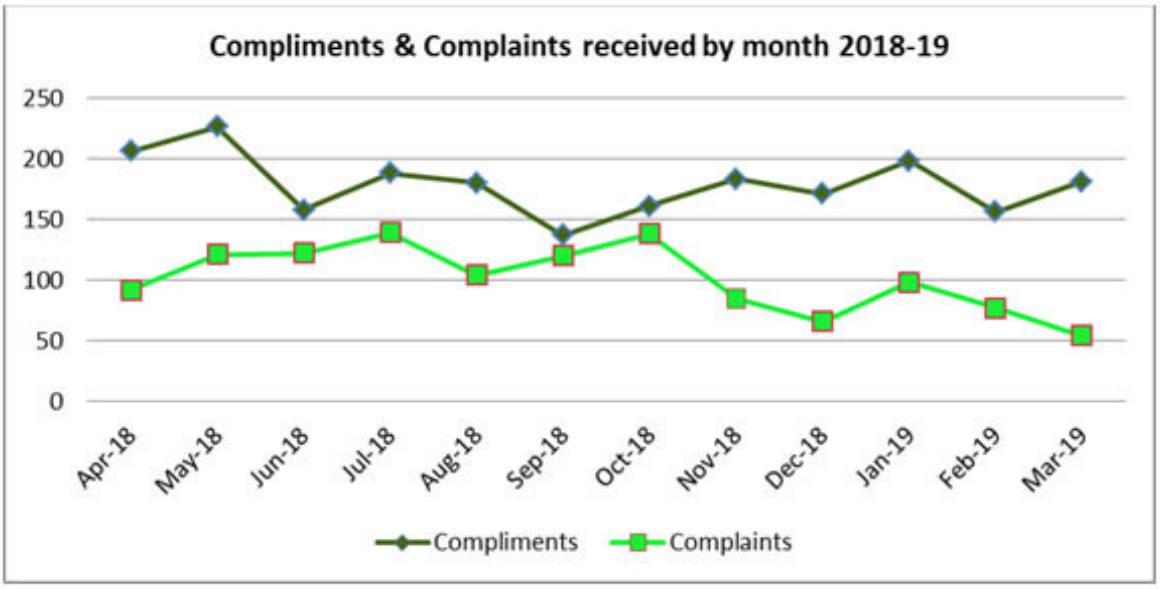
Anyone who would like to provide feedback about the Trust can email eoeasnt.feedback@nhs.net, call 0800 028 3382 or write to:

Patient experience department
East of England Ambulance Service NHS Trust
Hammond Road
Bedford
MK41 0RG.

We also receive feedback via social media channels, like Facebook, Twitter and Instagram, and through patient forums such as NHS Choices, Patient Opinion and our local Healthwatch boards.

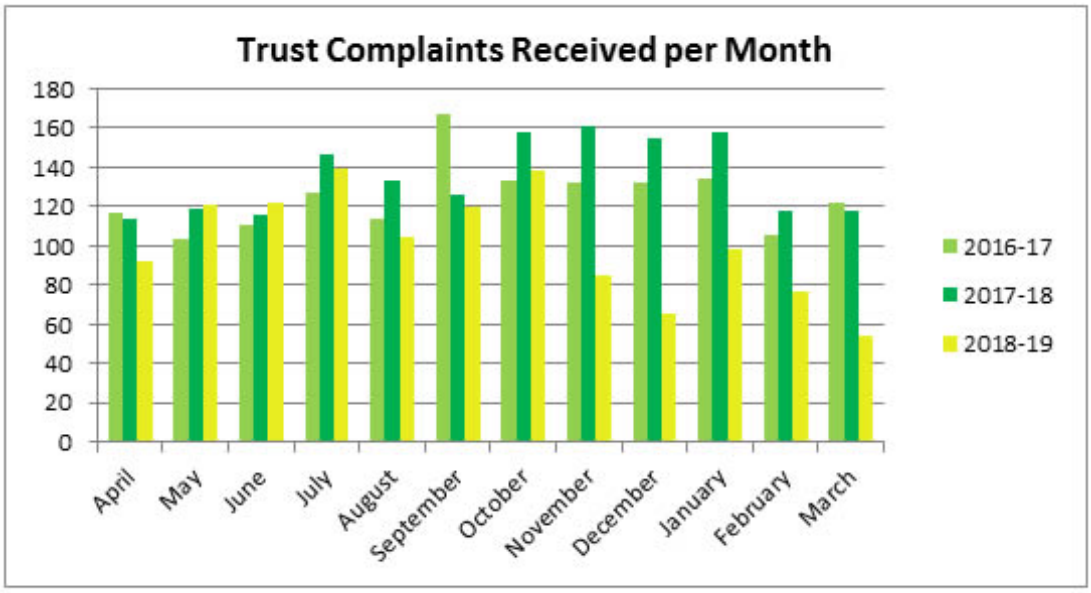
Compliments

We are proud to report that we continue to receive greater numbers of compliments from our patients and their families than complaints, giving testament to the outstanding care that our staff and volunteers provide. We consistently receive more than 150 compliments every month and often receive in excess of 200 "thank you" messages. We make sure that all compliments are passed to the staff involved in the care of the patient.



Complaints

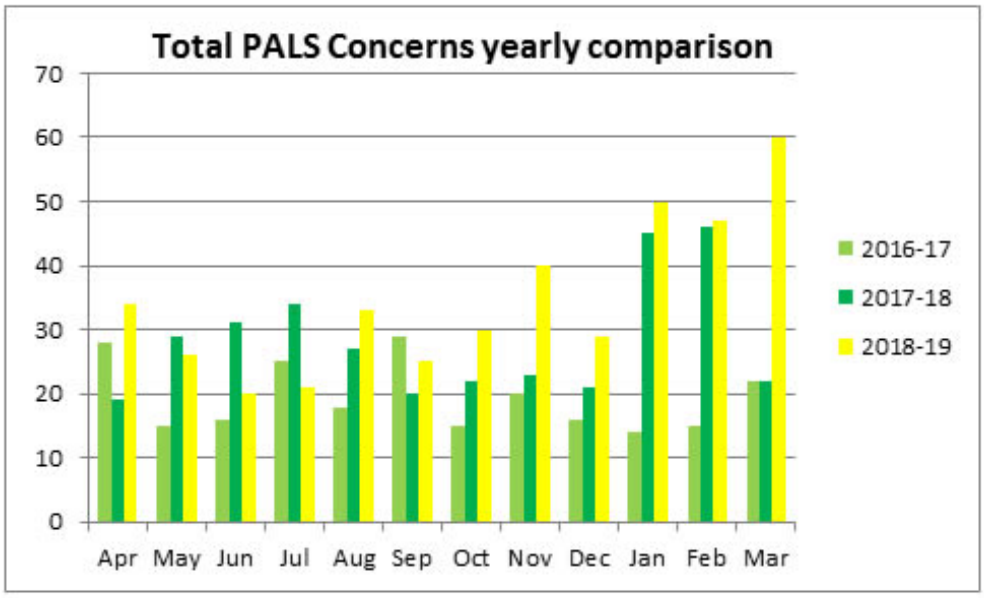
We received a total of 1,216 complaints in 2018/19, which was a 25% reduction on the 1,620 complaints received the previous year. Positively, this included a marked reduction in clinical assessment or treatment complaints and a halving of delay-related complaints. This trend is consistent with the reduction seen in serious incidents and demonstrates a safer service compared to the year before.



We meet our target of investigating and responding to all complaints within 25 working days unless express approval is received from the complainant. Of the complaints received during the year, more than 99% were acknowledged within three working days, which is in line with Local Authority, Social Services and National Health Service Complaints Regulations (2009).

Concerns and patient advice and liaison service (PALS) contacts

Concerns relate to any form of negative feedback which the individual has decided not to progress as a formal complaint. A written response is not necessarily required, and the issue may be resolved verbally. An increase in PALS queries is as a result of concerns and issues being resolved at the point of contact and not progressed to a formal complaint and investigation, thereby ensuring patients and relatives receive an immediate response.



On occasion, patients may contact the team with questions, to ask advice or be directed within the wider NHS or social care network. These comments are logged and responded to as required.

During 2018/19 we:

- received 415 contacts relating to negative concerns or feedback. This was an increase of 10% from 2017/18. All concerns were investigated and feedback provided;
- received 337 PALS contacts, which included comments, questions and other feedback. This was an increase of 63% from 2017/18; and
- managed 752 requests through the PALS team. This was an increase of 20% from 2017/18.

Cases referred to the ombudsman

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.

The number of cases referred by complainants to the ombudsman has halved this year. Six cases were referred and none upheld, which is a testament to the comprehensive complaints handling process we have in place and the open and honest approach we apply during any investigation.

Two cases for 2018/19 remain open with the ombudsman at the end of the year.

Friends and family test

The friends and family test (FFT) is a national NHS directive to obtain feedback about whether patients and staff would recommend the service to friends and family. It highlights areas of good practice as well as those where services could be improved, and provides real-time feedback so that swift action can be taken if necessary.

Results from the FFT provide a rich source of qualitative data and a greater understanding of patient experience of the service we provide. All 'see and treat' patients (patients treated at the scene) and patients using our PTS are given the opportunity to give feedback, with the results reported to NHS England and commissioners monthly.

The patient experience FFT results (April 2018 to March 2019) can be found below:

- See and treat – 98.0% of the 349 see and treat patients who responded to the survey would be either 'likely' or 'extremely likely' to recommend the service to friends and family who needed similar care.
- PTS – 90.9% of the 1871 PTS patients who responded to the survey said they would be either 'likely' or 'extremely likely' to recommend the service to friends and family.

Trust patient experience results	Friends and family test ('real-time')	
April 2018 to February 2019	**Quantity of patients**	**FFT performance ('real-time')**
'See and treat' emergency services	342/349	**98.00%**
PTS	1700/1871	**90.90%**
All services	2042/2220	**92.00%**

There are different approaches to data collection across ambulance trusts and the NHS as a whole. The FFT is intended to be a comparative measure between organisations, while also helping to ensure we gather regular and timely feedback from patients and that we act on the feedback we receive. As such, our goal is to increase the number of returns received from patients and to continue to review and act upon their comments. The approach and design of the FFT has recently been reviewed by NHS England and a project to develop it further has taken place over the past year.

Paramedic attending to a patient as part of the Stroke telemedicine pilot with ESNEFT

iv) Workforce

Freedom to speak up

We want to ensure that all of our staff are able to raise concerns and have them resolved. We have had two freedom to speak up (FTSU) guardians in post since the initiative launched in March 2017, who have supported 55 cases over the past two years. The guardians continue to work with staff in a number of the cases, with all those who have raised concerns saying they felt supported throughout the process.

Feedback on FTSU from external sources over the last 12 months has also been positive. The Deloitte review (2018) highlighted that: "The Trust is an early adopter of the FTSU guardian programme within the ambulance sector, and we observed a highly proactive approach to raising awareness of this across the organisation."

Our latest CQC report (2018) also provided good feedback, saying: "The Trust had FTSU guardians who were passionate about giving staff any support they needed to raise concerns and have them addressed. They told us that they were supported by the Board in their work and have developed excellent links with other guardians and the national guardian's office."

In addition to external reviews, the guardians have carried out a number of audits and regulator interviews with both NHS Improvement and our internal auditors. During these exercises, the process used and case management were scrutinised, with no concerns raised about the independent and respected process which our guardians have adopted and follow.

Our guardians have provided support to the national guardian group and regulators in understanding the way FTSU can be carried out in the ambulance sector. In March 2019, one of our guardians presented at the Ambulance Leadership Forum to help further embed the importance of FTSU and what it offers in improving the culture within the wider NHS.

Our future work focuses on increasing awareness of the raising concerns agenda by developing culture advocates and establishing a long term plan around the guardian role within the Trust and the wider ambulance sector.

Both guardians are fully supported by the Board and CEO to respectfully deal with any concerns raised through the FTSU process.

Workforce planning, recruitment and retention

We have made significant advancements in recruitment this year, reflected in the increased performance of the team. We processed 9,332 applications and recruited 773.58 whole time equivalent staff. Of these, 584 were frontline staff who will support the growth of the clinical workforce to ensure we provide a timely, high quality response to our patients.

We made significant changes to the recruitment process during quarter four, including introducing additional training courses and offering to meet C1 driving costs as an incentive to new recruits. We have also implemented a local recruitment model, partnering an operational and recruitment team lead, with these changes enabling an increased EEAST presence at recruitment events. The team have recently introduced TRAC and will continue with a transformation plan to enhance the customer service, performance and efficiency of the service.

Despite this high level of recruitment, our course fill rate did not hit our target and our turnover rate has been higher than anticipated at over 9% against a plan of 7%. As a result, our workforce growth has not met the in-year target required.

We set up a retention steering group in December 2018 to bring together workstreams aimed at supporting the retention of the workforce, ensuring integration and maximising available benefits. The workstreams represented include health and wellbeing, employee engagement, equality and diversity and dignity and respect, alongside the wider people and culture retention strategy.

There are a number of key activities in place to support the retention of staff, including a robust exit interview process which ensures we are aware of the reasons for staff leaving so that we can address them. The wellbeing team have also delivered several initiatives which are expected to help reduce the numbers of staff leaving the Trust.

Training and professional development

This year, we have begun to introduce a new learning management system called 'Evolve', which allows all staff access to their own training profile and compliance dashboard. There are four phases to the implementation over the coming year; phase one has enabled staff to access the statutory training requirements and their current compliance status. Phase two will add mandatory training and phase three continuing professional development, while phase four will make our compassionate conversations an online process.

Managers will have access to their team dashboard to enable monitoring and planning throughout the year.

Apprenticeship schemes

We launched our apprentice emergency medical technician (EMT) programme in September to provide a level four qualification for staff wishing to progress on a clinical pathway. A total of 129 staff have enrolled on the scheme to date.

The apprentice emergency care support worker (ECSW) programme is a new development which launched in March 2019 to support staff on the first steps of their career within the Trust. So far, 34 staff have enrolled.

Leadership programmes

We are committed to the ongoing development of both our current and aspiring leaders and run a number of programmes to support this aspiration. These include a two-day accredited ILM3 qualification which 41 staff have completed, as well as masterclasses to address the fundamentals of management such as managing sickness absence, recruitment and selection, supporting staff through change and managing disciplinary and grievances, which 110 staff have attended so far.

Our Trust-wide leadership programme has also been developed and will launch in 2019/20.

Engagement and communications

Our patient and public involvement and engagement team have focused on rolling out a strategy delivery plan this year. This has included increasing Community Engagement Group (CEG) membership across the region, with nearly 20 volunteers now acting as patient representatives and community ambassadors for our organisation. The strategy has also involved working more closely with Healthwatch organisations and other NHS patient and public involvement and engagement networks at a local and regional level, as well as engaging with the public.

To support this development, we have produced a charter for the CEG which ensures that individuals looking to work with us to improve services are not excluded and there is close partnership working.

The team visited 10 patients or carers who have used our ambulance service to get their feedback. These interviews have been filmed for quality review, with some used at public Board meetings to ensure that the voice of our patients is heard and considered throughout our business planning.

Each year, the team, our CEGs and other staff attend various golden age fairs, winter warmer events, school and college career days and supermarkets. They also hold health awareness days and provide blood pressure checks and advice on general healthcare, while also covering some parts of recruitment and supporting staff who visit community groups. In the past year, there have been around 200 opportunities for public contact through these routes.

Engaging with the public on digital platforms has expanded in the past year, with an audience of more than 50,000 now following us on Facebook, Twitter, Instagram and LinkedIn. Publishing content on a near-daily basis about Trust priorities such as recruitment and clinical quality has raised the level of interaction we have with the hundreds of thousands of people who engage with these platforms.

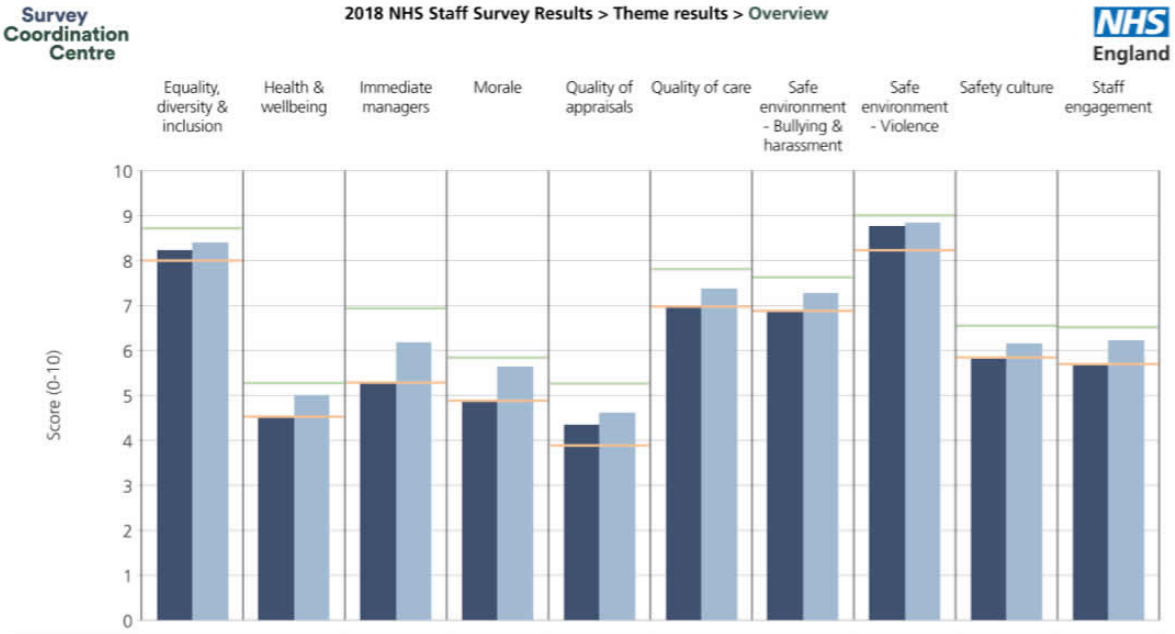
The NHS Staff Survey

The national NHS Staff Survey was carried out by Quality Health between September and December 2018 for 114 organisations, five of which were within the ambulance sector.

Questionnaires were sent to 4,649 of our staff and our response rate continued to increase year-on-year, with 1,794 questionnaires returned in 2018 – the equivalent of 38.6%. Results from the survey reflected similar themes as in 2017 and it is clear that more work needs to be done to improve staff morale and engagement:

- 80% of staff felt that they were encouraged to report errors, near misses and incidents, compared to 77% in 2017.
- When staff reported errors, they felt they were treated fairly (43% compared to 38% in 2017).
- Half of staff said they received feedback about changes made in response to errors, near misses and incidents compared to 48% in 2017.
- 80% of staff said they felt trusted to do their job compared to 81% in 2017.

- The majority of respondents (86%) felt their role made a difference to patients.
- 78% of staff felt the organisation took positive action on health and wellbeing, with 13% reporting feeling pressure from colleagues to come into work when unwell compared to 15% in 2017.
- 59% of staff reported feeling unwell as a result of work-related stress.
- Half of staff reported that they received positive support, encouragement and assistance from their line manager.
- 75% of respondents reported that their line managers had supported them in additional training and development opportunities.
- There was a decline in the number of respondents stating they had been bullied or harassed in the workplace, with 48% of respondents reporting this compared with 51% in 2017.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	8.7	5.3	6.9	5.8	5.3	7.8	7.6	9.0	6.5	6.5
Your org	8.2	4.5	5.3	4.9	4.3	7.0	6.9	8.8	5.8	5.7
Average	8.4	5.0	6.2	5.7	4.6	7.4	7.3	8.8	6.2	6.2
Worst	8.0	4.5	5.3	4.9	3.9	7.0	6.9	8.2	5.8	5.7
No. responses	1,740	1,767	1,766	1,736	727	1,587	1,759	1,755	1,741	1,792

Health and wellbeing

Our health and wellbeing strategy has progressed significantly this year, with access to all services within the wellbeing hub increasing. Over 45 wellbeing hub champions have been trained to ensure that any staff member is able to access advice and assistance quickly.

The aim of our wellbeing champions is to:

- support staff to become connected, motivated and self-aware of their own personal wellbeing and aware of how the Trust can support this;
- act as an empowered team who are proactive in helping colleagues with a wide range of issues and/or concerns;
- undertake self-reflection and to seek support where appropriate;
- encourage an open and safe place for discussion;
- build a compassionate and supportive environment for all staff to work in;
- assist with the retention of new staff; and
- provide feedback to the wellbeing hub outlining issues which might need wider attention.

The focus we have placed on health and wellbeing has resulted in over 1,100 staff members accessing the trauma response management system (TRiM) and 520 wellbeing hub referrals. We have also seen a significant increase in the proportion of staff taking up the flu vaccination this year, with 79.1% responding and 62.2% vaccinated.

Equality and diversity

Equality, diversity, inclusion and human rights are embedded throughout all of our aims, objectives and actions to address inequalities and promote diversity in healthcare and employment. A number of initiatives have been introduced to support our staff and managers over the past year, including:

- Our diversity and inclusion strategy 2018 – 2020, called Celebrating Diversity and Promoting Inclusion.
- The 'your disability and health' personalised record at EEAST.
- Our reasonable adjustment guide for staff and managers.
- The 'equality every day' document for managers and staff.
- The pilot rollout of the equality mapping crib sheet.
- The development of guidance and revised equality impact assessment proforma.

There has also been an increased level of engagement with staff, patients and communities which was reflected in the equality delivery system two public grading event that took place in Bedford in April 2018. We worked close with Healthwatch Bedford to promote the event, with attendees including a group of deaf students from Bedford College and British Sign Language interpreters, who supported the students so they could contribute to the grading discussions. We also published a survey on our website which people who were unable to attend the event could complete, which was also promoted by Healthwatch.

Following the event, members of the equality, diversity and inclusions team and a BSL-qualified paramedic were invited to Bedford College to meet deaf students and some students with learning disabilities. The work of the ambulance service was discussed, as well as when to call 999, before staff gave a demonstration of life-saving CPR skills.

Throughout the year, the team have been increasing engagement with staff by attending clinical briefing days and visiting ambulance stations to promote the staff networks available. They have also provided support and guidance on equality, diversity and inclusion matters to more than 150 staff via telephone or meetings and delivered two disability awareness sessions in March 2019, with further workshops scheduled throughout 2019.

The Equality, Diversity and Inclusion Steering Group is chaired by the Trust's chair and meets throughout the year to report on progress, raise any risks, identify and discuss ideas to promote equality and communicate changes to current and emerging standards.

Equality networks

There are several equality networks in place at EEAST:

- **All Women in EEAST (AWE)**, which is designed to support improved experience in the workplace with a focus on gender and the issues which impact women at work. AWE believe that by tackling gender inequality and discrimination, the Trust can be a better place to work and provide better patient care and experience to the communities we serve.

  The group is made up of a supportive network of women from across all areas of the Trust regardless of role, location or seniority, in turn enabling mentoring, coaching and informal support. It has also acted as a sounding board to help the Trust realise its aim of improving the representation of women in leadership roles to reflect the breakdown of the workforce and the communities we serve. The group is keen to support the health and wellbeing agenda for all staff with a focus on the specific wellbeing issues affecting women, and in 2018 considered how the Trust may support women through the menopause.

  AWE continues to represent EEAST at national events focusing on gender equality. During the year, the group also worked alongside fire and police colleagues to organise its second international women's day event, which was well attended by all services.

  The director of people and culture is AWE's sponsor on the Board.

- Since launching in April 2018, our **LGBT Network** and has attended several regional and national pride to promote the Trust and career opportunities with the service, while also engaging with the local community and demonstrating CPR skills. The group meets frequently, attends national ambulance LGBT network quarterly meetings and has a Facebook group to promote and discuss its work. Planning has begun to support a number of LGBT events in 2019/20.

  Nationally, our Trust is considered the most improved ambulance trust for promoting and supporting LGBT staff, and has received a gold star in recognition of this. We remain committed to supporting employees who identify as lesbian, gay, bisexual or transgender.

  The director of strategy and sustainability is the network's sponsor on the Board.

- Our **BME Network** launched in October 2018 and met several times during the remainder of the year, while also supporting the first national ambulance BME conference in October. A representative from EEAST has been nominated to attend national BME network meetings and will report updates to the network. A key area of focus for the group is the workforce race equality standard.

  The Trust chair is the network's sponsor on the Board.

- Our **Disability Network** launched in March 2019 and has been well-attended by staff in operational and support roles. Its first meeting focussed on scoping out the aspirations and intentions of the group, with work due to continue into the coming year.

  The medical director is the network's sponsor on the Board.

EEAST's LGBT+ Group at Brighton Pride

EEAST's Disability Network

AWE
all women in eeast

All Women in EEAST logo

v) Finance

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 2019, for which the Trust recorded a deficit of £2million.

During 2018/19, we invested in frontline services to help us progress towards the targets detailed in the independent service review. Funding from commissioners was put to effective use in serving patients, with the utmost priority placed on protecting their safety.

We faced financial challenges from the delivery of our PTS contract in Bedfordshire and Hertfordshire which was primarily caused by difficulties in recruiting staff. However, the Trust remains committed to the contract's successful delivery.

During the year, we improved our efficient use of frontline resources as a result of cost improvement workstreams based on reports by Lord Carter into NHS efficiency, including on unwarranted variations between ambulance services and work on local Trust initiatives. We delivered cost improvements of £5.8million (representing 2.1% of turnover), against the challenging target of £6.7million, building on our good record of delivering substantial savings over the last five years. However, momentum around our efficiency measures was curtailed by winter pressures, which led to the lower than target achievement.

Our expenditure on corporate support services pay remains significantly below the Carter target of 6% of turnover and, when benchmarked against other ambulance trusts, EEAST ranks amongst those with the lowest costs for this area of expenditure.

The Trust met its important financial targets in complying with its external financing limit and capital resource limit. We also worked closely with NHS Improvement throughout the year to monitor our financial performance and ensure all efforts to improve that performance were made.

As part of our multi-year capital plan to improve patient services through the roll out of Make Ready, £10.9million was invested into capital assets during the year. We also received £6.5million of STP funding which was used to purchase estate, fleet workshop equipment and technology assets. Of this total, £2.4million was spent on our estate, including work to provide workshop facilities at depots, while work also began on our new depot in Bury St Edmunds, Suffolk. A further £1million was invested in vehicles, including replacement vehicles for HART. The remaining £1million capital expenditure in year was largely on IM&T systems, hardware and infrastructure.

A further total of £18million of STP funding was awarded to the Trust for 2019/20 through to 2022/23. We are now progressing business cases to detail our infrastructure and capacity transformation plans for fleet, estates and the Make Ready service.

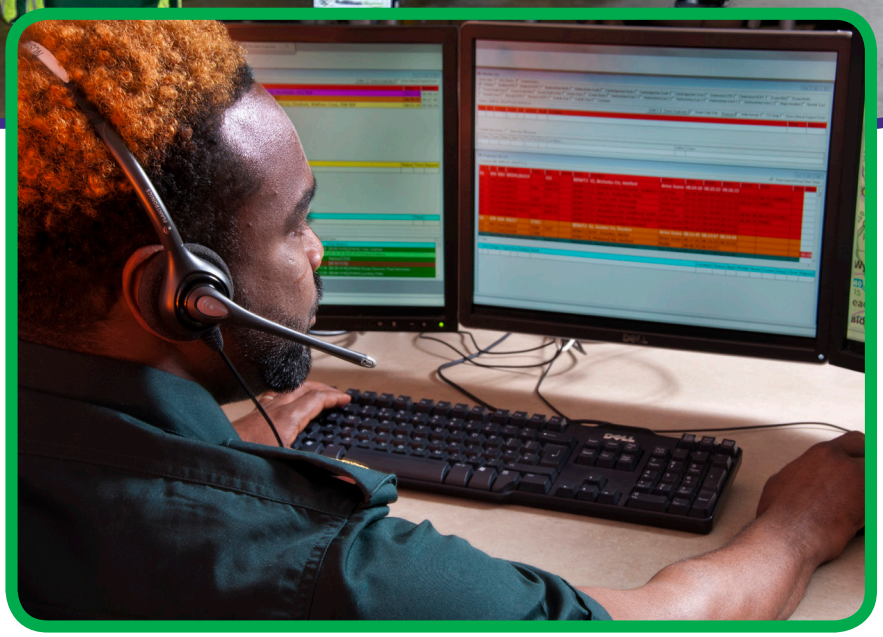
We delivered the first year of the six-year emergency services contract agreed with commissioners following the publication of the independent service review in 2018. This contract ensures significant further investment in the Trust to enable delivery of the ambulance response programme targets.

The plan has been set for 2019/20 for a deficit of £(1.0)million, which includes £2.2million from the provider sustainability fund. It also sets a challenging efficiency target of £10.5million for the year which, at 3.5% of turnover, is higher than the national requirement for NHS trusts.

Our Board will continue to monitor our financial position and key risks, which include significant financial risks around the delivery of the savings plans together with the production of target patient-facing hours over the year.

The full financial statements for the year ending 31st March 2019 are presented within the annual accounts.

EEAST's Make-ready team



EOC Dispatcher

vi) Strategy and transformation

During 2018/19, we have continued to make progress towards delivering our strategic objectives and vision and values through our improvement work. Early in 2018, we refined our core strategic objectives so that they focussed on delivering our overarching mission, which is to provide holistic, high quality clinical mobile healthcare at the time of need.

The strategic priorities set out to achieve this mission are as follows:

1. **Provide better care:** We will be resolute in delivering outstanding compassionate care to our patients.
2. **Value our people:** We will lead with compassion, engaging and developing our staff to provide outstanding safe and effective care.
3. **Improve performance:** We will be responsive to our patients' needs, improving to be a high performing Trust.
4. **Deliver value for money:** We will use the taxpayers' pound wisely to deliver maximum value for money from our services.

Underpinning these objectives are a suite of strategic priorities which illustrate the scale of transformational change we have committed to. Outlined below is the work which has taken place on the strategic objectives and priorities over the year:

1. Provide better care

We are committed to continuously improving so that all of our patients receive safe, high quality care, and launched our quality improvement strategy this year to help us achieve this goal. To drive the strategy, we have started work to set up a QI faculty to embed quality improvement methodologies throughout the Trust and enable all staff to find ways to continuously improve the service we provide to patients and partners. To date, we have trained 24 members of staff and are continuing our training programme throughout the next year.

Alongside this, we implemented our integrated improvement plan which encapsulates all of the improvements necessary across key areas so that we remain focussed on our priorities and can drive forward against all our objectives. This plan has already brought about improvements in all areas, including a reduction in avoidable harm, as well as improvements in medicines management and infection, prevention and control.

2. Value our people

Ensuring that our staff feel well supported and valued is one of our key priorities. We are working on improvements to make EEAST the employer of choice, ensuring we enable our staff to deliver the best service they can.

With the recognised capacity gap, it is essential that we continue to rapidly recruit 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 will also reduce the pressure currently on staff, as well as resolving issues with late finishes because there are insufficient staff to meet the demand.

Whilst we have recruited more clinicians than ever this year, the number of staff leaving has meant that our clinical workforce has not grown at the rate or to the level we need, demonstrating that real focus is required on both recruitment and retention of our workforce.

Our staff are pivotal to the success of our Trust and we know that looking after their health and wellbeing is essential. Because of this, we have continued to implement our health and wellbeing strategy, rolling out several schemes including the wellbeing passport, as well as training more than 45 wellbeing champions across the organisation.

The culture of our Trust is another key area of focus and our staff survey results for this year continue to demonstrate the need for improvement. We know that developing a consistent culture and set of behaviours across every level of the organisation is needed and that this will take time. We are continuing to roll out of the leadership strategy and its associated training programmes, as well as designing and implementing the clinical career progression pathway, so that our staff can see and understand their options for development and progression. This is supplemented by our compassionate conversation process, which enables managers and staff to have meaningful conversations about opportunities for career progression. So far, we have trained more than 450 managers in this process to ensure that staff receive the maximum benefit and can reach their full potential.

Benchmarking with other ambulance services has also shown us that we need to improve our employee relations. We have therefore launched a dignity and respect campaign, which seeks to resolve several themes and issues relating to staff relations to improve the way in which staff and managers are able to work together. This will continue during the coming year.

3. Improve performance

The overarching principle of our first strategic objective is that we must change the way we respond to 999 calls so that we can meet the needs of our patients in a timely fashion. 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, has resulted in the requirement for large-scale change.

During the past year, we have focussed on our operational structure to ensure the way in which we work is fully aligned to the wider NHS to maximise relationships and collaboration. An extensive consultation took place, with our final structure launched in quarter three. Since then, we have held listening events with a large range of staff so that we can ensure that the changes made are appropriate, embedded and have the desired effect to the quality of delivery.

As part of the new structure, six sector business units have been created. This has improved our forecasting and planning approach through more local ownership and planning, in turn making sure we are meeting the specific needs and demands of our population.

Alongside these changes, we have continued the work started in 2017/18 to review and rebuild our rotas, realigning existing resources wherever possible to increase the number of ambulances available to take patients to hospital. The consultation process on the building of the new rotas is taking place through the next financial year, with implementation in the autumn. The changes aim to help us attend to patients more quickly while also improving staff welfare by reducing the amount of late finishes and spoilt meal breaks our staff experience.

4. Deliver value for money

Within this strategic objective are a suite of five significant change programmes which will enable us to become a more efficient and effective organisation. Fleet, Make Ready, estates, Building Better Rotas and information technology are all fundamental to us becoming more economical, but each of these areas require investment to bring about savings.

The fleet programme involves significant transformation. We completed the final design of our future ambulance this year, as well as mapping out our new approach to the way our fleet will be maintained and repaired. Extensive consultation with our staff and union colleagues has taken place to make sure the final vehicle will meet the needs of our patients and staff, while the new vehicles will also bring the added benefit of significant savings and a reduction in our carbon emissions year on year. The vehicles will be rolled out in 2019/20.

We believe that implementing a full Make Ready system, where staff start their shift on a fully-kitted vehicle each and every time, will bring significant efficiency savings and enable clinicians to do their jobs more safely. Our Make Ready programme has continued throughout this year with the development of 10 sites, and will be rolled out further over the coming 12 months.

The size and scale of our Trust means we are dependent on technology, while we use many software systems and programmes to deliver our services. There is a clear need to further develop and invest in technologies to enable agile working, which will improve efficiency across the organisation. We have transferred to Office 365 this year, which will bring significant efficiencies throughout our support services, as will our move to e-enabled systems including our e-rostering and e-timesheets processes.

A lot of work has been put into the development of our information management and technology strategy this year, combined with an IT review to identify priority areas for focus. As a result, additional funding has been identified for the coming 12 months to further develop the technologies we use and support the delivery of the strategy. Aspects of this include replacing Toughbooks, which are currently used for electronic patient care records, with consideration given to personal issue devices.

Sustainability and transformation plan (STP) engagement

We are fully engaged with the six STP footprints within the east of England, each of which operates under a different set of agreed principles and governance arrangements. EEAST's 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 head of service delivery.

Working closely with STPs has led to innovation schemes being developed and expanded. The business and partnerships team and service delivery have worked closely together to enhance our offer to local systems. Some examples of collaborative working to date are as follows:

- In the Suffolk and North East Essex STP, we have introduced rapid intervention and early intervention vehicles to proactively manage demand in the community. We are members of the alliance established to implement the urgent treatment service across the north east Essex system. We have worked with the STP to ensure our case for Make Ready facilities in this area is included in the overall STP plans, while three of our proposed eight new-build facilities are in their area (Ipswich, Colchester and Bury St Edmunds).
- In Mid and South Essex STP, there is 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 faced some specific operational challenges with ambulance handovers. To support the system, we led the direction and delivery of improving patient care and patient outcomes, instigating and hosting a workshop with colleagues from NHS England and NHS Improvement, commissioners, all three acute trusts and all quality leads. There are also early intervention vehicle schemes within this STP area.
- Within Cambridgeshire and Peterborough, 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 well-established early intervention vehicles and care home schemes in operation across the Hertfordshire and West Essex STP which again support appropriate urgent and emergency care within the community and support the STP's demand management agenda.

Waveney Early Intervention Vehicle

vi) Sustainability report

We are committed to decarbonising our operations and promoting healthy, low carbon lifestyles. We will achieve this by continuing to work across five key areas:

- Reducing the environmental impact of our estate.
- Minimising the health and environmental impact of travel.
- Creating an ethical and resource-efficient supply chain.
- Empowering and motivating our staff, patients and community to make sustainable choices.
- Embedding sustainability in our corporate governance processes.

By taking such action, we expect to improve the wellbeing of our staff, reduce costs and support a sustainable environment.

Estates

We consider our environmental impact very seriously and continue to develop key strategies to reduce our carbon emissions. This includes rationalising current built assets and developing new and more energy efficient buildings, where both the construction and operation consider the environmental impact with the aim of providing operational efficiencies and reducing carbon emissions.

We are exploring ways to reduce waste by introducing recycling and strictly managing our waste streams. We are also working with a number of key suppliers to provide feedback on waste types, identify and explore new ways to reduce and manage waste and to ultimately recycle as much as possible.

Through the development of our Make Ready stations, we will reduce localised impact of vehicle cleaning, transportation costs and carbon emissions and provide continuity of service quality.

Fleet

In November 2016 we responded to a challenge from NHS England to reduce our vehicle costs by developing a new design of emergency ambulance. Our fleet transformation plan, which was approved by the Board and NHS England in March 2017, set out the scope to design an innovative vehicle which was lighter and more fuel-efficient/sustainable. Following extensive engagement with staff and Unison colleagues, we developed four prototype ambulances to help inform recommendations for our new concept emergency ambulance.

The new ambulances needed to be introduced by October 2018 to meet ambulance replacement needs and the growth requirements to deliver a safe service. As a result, we delivered a fast-paced design/build and evaluation programme to ensure the quality of the vehicle, evidence cost reduction and efficiency savings and – critically – to secure staff and Unison 'buy-in' throughout the process. By October, we had completed this programme and secured Board approval to enter a binding supply agreement with an ambulance convertor to deliver 485 new-style emergency ambulances over three years.

We are assured that our ambulance specification will satisfy the primary requirements of cost reduction/efficiency. As it is more than 200kg lighter than the national comparator, it will offer lower operating costs and improved sustainability over the full life cycle of the vehicle. Our specification also includes innovative patient and staff safety solutions which will promote higher user acceptance and return longer term cost reductions in relation to staff and patient safety.

Each new ambulance will produce eight fewer tonnes of carbon emissions each year, which equates to an anticipated overall saving of 1,126 tonnes based on 226 new vehicle deliveries phased throughout 2019/20. By the time our fleet transformation is complete in four years' time, we estimate our total CO2 emissions will be reduced by 3,982 tonnes per year.

We are committed to finding new, more sustainable ways to deliver operational services and will build on this success in the coming years to identify lighter, fit-for-purpose ambulances, ideally powered by electricity with an even lower plated weight of 3.5 tonnes. We will closely monitor market capability and influence the national ambulance fleet design agenda so that we can benefit from emerging, reliable technology solutions.

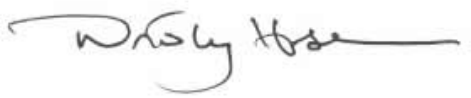
Procurement

We have introduced the supplier sustainability agreement to help us ensure that our suppliers understand that activity carried out with us or on our behalf must take into consideration economic, social and environmental impacts. The agreement now operates as a pass/fail element within all of our tenders, which means that suppliers which are unwilling to sign up are no longer awarded contracts. To date, all suppliers that have been awarded a tender and contract have signed the agreement, which covers five key areas of supply activity: labour, health and safety, environment, ethics and management systems.

The supplier sustainability agreement assures us that our suppliers are committed to upholding the human rights of workers, ensuring staff work in a safe environment, reducing their carbon footprint and becoming more a sustainable. It also ensures they operate ethically in the marketplace and have quality management systems in place to ensure compliance with applicable laws.

We still look for continuous improvements in all five areas of supply activity, collaborating with our suppliers to understand areas requiring change and identify actions. An example of the work undertaken has been through supplier engagement of private ambulance service providers, where we have introduced longer term contracts with suppliers so that zero-hour staff contract are reduced. Similarly, the award of our long-term vehicle conversion contract has also meant a reduction in zero hours contracts. These examples have enabled our suppliers to improve working conditions and reduce downtime and waste through better demand scheduling and planning, resulting in a lower conversion price for our contracts.

I confirm that this performance report complies with the reporting requirements.



Dorothy Hosein
Interim Chief Executive

7. Accountability report

i) Corporate governance report

In the following pages we have outlined our achievements against key areas of business delivery within the 2018/19 financial year. For ease, we have separated these into six key areas – operational performance, quality, safety and patient experience, workforce development, finance, strategy and transformation and our sustainability report.

The Trust Board

Directors' responsibilities

The Trust Board is made up of six non-executive directors, including the chair, who sit alongside five executive directors. The Board functions as the corporate decision-making body of the Trust. It is responsible for all strategic, operational and financial decision-making, but may delegate these powers to any of its sub-committees, as outlined in the terms of reference.

The executive directors who currently sit on the Board are the chief executive, director of finance and commissioning, director of people and culture, director of clinical quality and improvement and the medical director. The director of strategy and sustainability, acting chief operating officer and two associate non-executive directors are non-voting members of the Trust Board.

Appointment of directors

Consideration is given to the composition of the Board of Directors to ensure suitable experience, diversity, links with the local community and business acumen. The secretary of state for health and social care has delegated responsibility to NHSI to appoint to the role of Trust chair and non-executive director. NHSI takes responsibility for the appointment, removal and ongoing appraisal, support and mentoring of all non-executive directors. Generally, non-executive appointments are for a period of two years, with members eligible for reappointment for a maximum of ten years.

Non-executive director responsibilities include:

- helping to plan for the future growth and success of the organisation
- ensuring effective governance arrangements are in place and being adhered to
- holding the Board to account on matters of operational, financial and strategic delivery
- ensuring the Board operates in the best interest of the public

The chief executive and the executive directors are appointed via public advertisement.

Members of the Trust Board

i. Non-executive directors

Sarah Boulton
Chair of the Trust Board

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

	From	To
Appointed to the Board	10 March 2014	31 March 2016
Reappointed:	1 April 2016	31 March 2018
Reappointed:	1 April 2018	30 June 2019

Andrew Egerton-Smith MBE
Associate Non-Executive Director

Andrew qualified as a chartered surveyor in the 1960s and spent 30 years practising until his retirement in 1994. During the 1980s, he was 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. 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, Andrew 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 to 2012.

Andrew was awarded the MBE in the 2013 Queen's Birthday Honours.

	From	To
Associate term:	7 October 2013	6 October 2015
First term:	7 October 2015	6 October 2016
Second term:	7 October 2016	6 October 2017
Third term:	7 October 2017	6 October 2018
Fourth term:	7 October 2018	10 July 2019

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

Lizzy has gained extensive board experience in the private and public sector in both executive and non-executive roles, having in the past worked with NHS North East Essex Clinical Commissioning Group and the Central Arbitration Committee. She currently holds the position of HR director with the UK Border Force.

	From	To
Appointed to the Trust Board	15 January 2018	14 January 2020

Peter Kara
Non-Executive Director

A fellow of the Chartered Association of Certified Accountants, Peter joined EEAST in December 2013. He is a director of two private companies, and also provides financial investments and strategic planning advice to small and medium sized companies. He has been widely involved in voluntary sector in Milton Keynes since 1991, as well as with a national charity.

Peter was non-executive director with Milton Keynes Community NHS Trust from 1993 until its dissolution in 2000. He was also a non-executive director of Milton Keynes Primary Care Trust before its dissolution in April 2013, and has been a lay board member of Milton Keynes CCG and chaired its Audit, Finance and Remuneration Committee until the end of April 2019. 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 as chairman of both organisations.

	From	To
Appointed to the Trust Board	2 December 2013	6 June 2017
Reappointed:	7 June 2017	12 June 2019

Tom Spink
Non-Executive Director, Chair of Performance and Finance Committee

Tom has more than 17 years' experience operating at board level, nine of which have been with Aviva Insurance working in a global capacity. Having joined the company in 2009 as creditor and partnerships director, Tom went on to become CEO and general manager of its Turkish arm before moving to his current role as procurement director in 2013.

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

Alison Wigg
Associate Non-Executive Director

Alison has played a crucial role in global telecoms both in the UK and the US for the past 20 years, 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.

	From	To
Associate Term	15 January 2018	14 January 2019
Reappointed:	15 January 2019	14 January 2020

Ravi Mahendra
Non-Executive Director, Chair of Audit Committee

Ravi has over 18 years' experience operating within the financial sector, working with businesses such as AIG Genworth Financial and General Electric. His last executive role was as finance director for Global Insurer AIG, where he worked at board level to develop strategy and finance leadership across 90 countries.

	From	To
Appointed to the Trust Board	1 May 2018	30 April 2020

ii. Executive directors

Dorothy Hosein
Interim Chief Executive Officer
Appointed to the Board: November 2018 to date

Dorothy joined the Trust on 1st November. She has extensive experience as a senior healthcare leader along with private sector experience, Dorothy has delivered quality, performance and financial improvements at a range of hospitals, the most recent being Mid Essex Hospital (January – September 2018) and the Queen Elizabeth Hospital in King's Lynn, where she spent three years.

Wayne Bartlett-Syree
Director of Strategy and Sustainability
Appointed to the Board: July 2016 to date

Wayne started his career 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 become a senior nurse in critical care then moved into management, where he delivered 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.

Dr Tom Davis
Medical Director
Appointed to the Board: February 2018 to date

Tom joined the Trust in February 2016 as deputy medical director before taking on the acting medical director role in February 2018 and becoming the substantive medical director in June 2018. He qualified as a doctor in 2004 and worked in London and Bath before moving to Buckinghamshire to take up a training post in general practice. On completing his training in 2011, Tom became a partner GP before moving into a portfolio of clinical, management and training roles prior. He is also the named doctor for safeguarding at EEAST.

Kevin Smith
Director of Finance and Commissioning
Appointed to the Board: June 2014 – February 2016 as Acting Finance Director
March 2016 to date as 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 in the construction industry. He began his career at Great Yarmouth and Waveney Health Authority, then moved to 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.

Lindsey Stafford Scott
Director of People and Culture
Appointed to the Board: March 2016 to date

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, she has lived in the eastern region for four years. Lindsey's role involves continuing the development of effective partnerships and working with our staff to ensure a positive culture and working environment for everyone is built, regardless of their role or location.

Tracy Nicholls
Director of Clinical Quality and Improvement
Appointed to the Board: April to June 2018 as Acting Director of Clinical Quality and Improvement
June 2018 to date as Director of Clinical Quality and Improvement

Tracy has more than 20 years' experience in the ambulance service. Beginning her career with the service as a PTS carer, Tracy qualified as a paramedic in 1998 and has worked her way through many frontline operational management roles. She has also undertaken the NHS change leaders programme and the Athena programme, and mentors others through their development, quality improvement fellowships and quality improvement programmes.

She has been a proud career-long member of the College of Paramedics, taking the role of east of England trustee for five years. She is now its first female vice chair and was awarded a fellowship in 2016. Tracy represents the College of Paramedics at the UK Sepsis Trust meetings and has a passion for sepsis recognition and treatment within prehospital care.

Marcus Bailey
Acting Chief Operating Office
Appointed to the Board: March 2019 to date

Marcus has extensive experience within the ambulance sector, combing clinical and operational leadership roles. He took up the post of acting chief operating officer (COO) in February 2019. Professionally he is a paramedic and registered adult nurse who combines his leadership role with clinical practice.

Marcus joined the ambulance service in 1998 as a student ambulance technician and became a paramedic in 2002 before moving into education. He is currently completing a Florence Nightingale Scholarship focussing on leadership. His previous roles have included paramedic, nurse, general manager, clinical general manager, head of education and training and substantively as the deputy director (consultant paramedic).

Marcus' role focuses on ensuring our patients receive effective and high quality care. This is achieved through leading a team of clinicians and managers across the sectors in emergency operations, non-emergency operations and our ambulance operations centres. He also plays a significant leadership role within our volunteers, including our CFRs.

Executive departures in 2018/19

Robert Morton
Chief Executive Officer
Appointed to the Board: 24 August 2015 to 28 February 2019

Robert 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. He 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 volunteered as a CFR in Ireland and an intensive care paramedic in Australia.

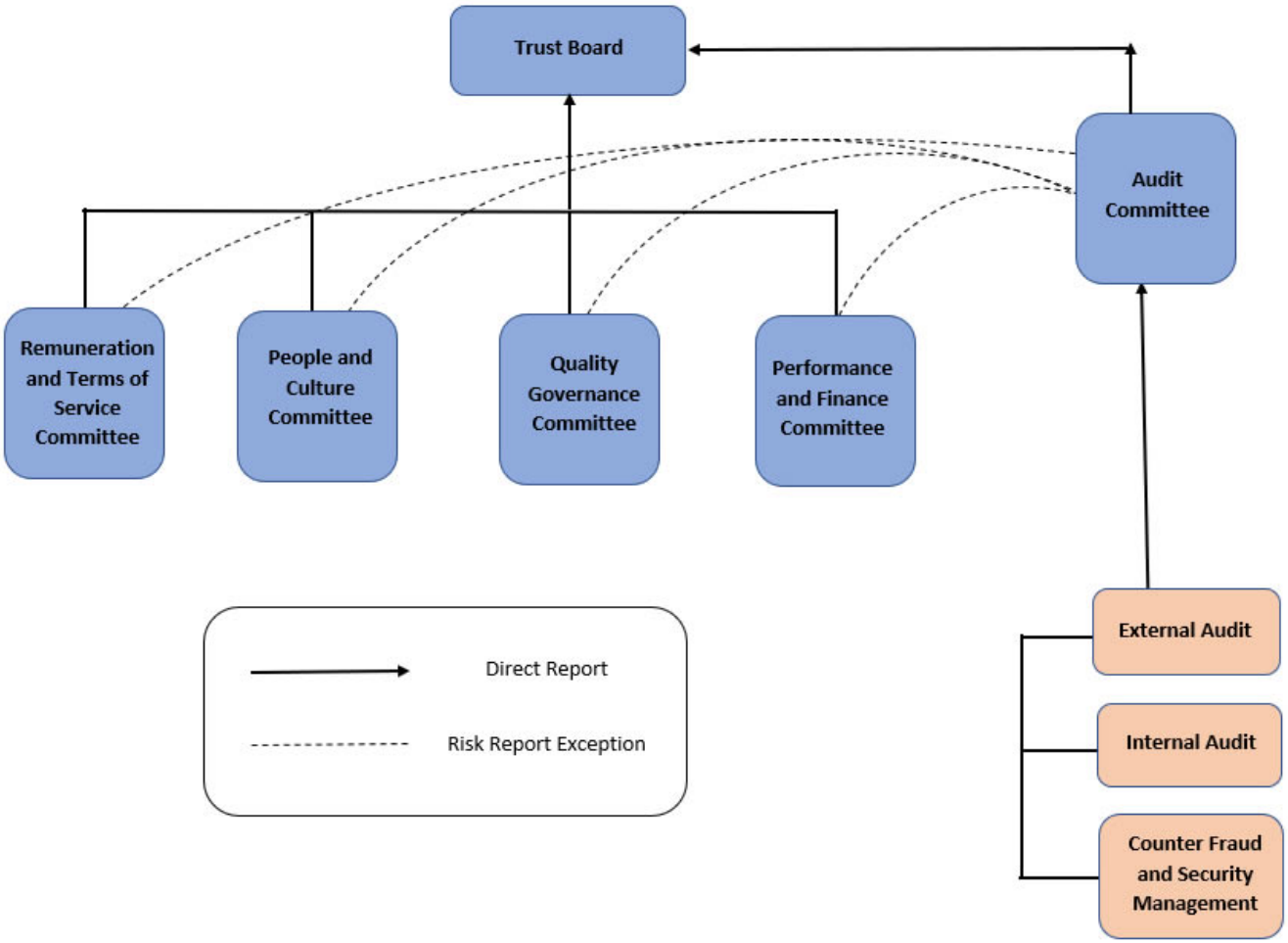
Kevin Brown
Director of Service Delivery
Appointed to the Board: 5 July 2016 to 29 March 2019

Kevin 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.

Kevin 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.

Trust Board subcommittees and their evaluation processes

In accordance with the Public Bodies (Admission to Meetings) Act 1960, the Board holds its meeting in public on a bi-monthly basis. The agenda and reports are published on the website and available ahead of the meeting. 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 formally on a yearly basis through an approved evaluation process. The Audit Committee uses the self-assessment questionnaire from the audit committee handbook. Both the Quality Governance Committee and Performance and Finance Committee also complete the self-evaluation on an annual basis.

The Audit Committee, Quality Governance Committee and Performance and Finance Committee carried out an annual review in March 2019. The terms of reference for each of the committees were reviewed at the same time, with revised membership and focus agreed. Development plans were also prepared to address the findings from the committee reviews.

Attendance at Trust Board and sub-committee meetings for 2018/19 was as follows:

Board Directors	Trust Board formal meetings Private	Public	Audit Committee	Performance and Finance Committee	People and Culture Committee	Quality Governance Committee	Remuneration and Terms of Service Committee
	Chair: Sarah Boulton		Chair: Ravi Mahendra	Chair: Tom Spink	Chair: Lizzy Firmin	Chair: Sarah Boulton	Chair: Lizzy Firmin
Sarah Boulton Chair	11/11	6/6			3/3	4/4	8/8
Peter Kara Non-Executive Director	11/11	6/6	5/5	5/5			
Andrew-Egerton-Smith Associate Non-Executive Director	9/11	5/6	4/5	4/5			
Lizzy Firmin Non-Executive Director	9/11	5/6			3/3	2/4	8/8
Tom Spink Non-Executive Director	11/11	6/6		5/5			
Alison Wigg Associate Non-Executive Director	10/11	5/6			3/3		7/8
Ravi Mahendra Non-Executive Director[1]	9/11	5/6	5/5			4/4	
Mike Burrows Non-Executive Director[2]	1/1	0/0					
Tony McLean Non-Executive Director	1/3	0/1			0/1	0/1	0/1

[1] Ravi Mahendra commenced in May 2018
[2] Mike Burrows left in April 2018

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

Directors' declaration of interest register 2018/19

Name and Position	Declaration of Interest	Declarations made	Resignation declared	Board Term of Office	
				From	To
Sarah Boulton	Director – Healthy Board Services Ltd			10/03/2014	31/03/2018
Trust Board Chair	Director – WMB Steele (2009) & Co Ltd	Mar-18		01/04/2018	31/04/2022
	Trustee to the NHS Providers Board as the representative for the Ambulance Services.	Jul-18			
Andrew Egerton-Smith Associate Non-executive Director	Honorary President – East Anglian Air Ambulance			07/10/2013	06/10/2018
Lizzy Firmin Non-Executive Director	Works for Waddington Brown, a supplier of the Trust Consultancy work for ESNEFT	Jul-18 May-19		15/01/2018	14/01/2020
Peter Kara	Mental Health Act Manager – Central & North West London NHS Foundation Trust	Jan-19		02/12/2013	01/06/2017
Non-executive Director	Lay Board Member – Milton Keynes Clinical Commissioning Group	Jan-19		02/06/2017	01/06/2019
Ravi Mahendra	Director - Savvy Circle Group Ltd	Apr-18			
Non-executive Director	Trustee - Rain Forest Foundation UK	May-19			
	Young Westminster Foundation	May-19			
	Audit Committee member, Goldsmiths University	Sep-18			
Tom Spink Non-executive Director	Director - Aviva Wife midwife at norfolk and Norwich Hospital	May-19 Mar-19		15/01/2018	14/01/2020
Alison Wigg Associate Non-Executive Director	Partner works for BT - Trust Supplier	Mar-19		15/01/2018	14/01/2019
Wayne Bartlett-Syree Director of Strategy and Sustainability	Wife is a nurse for NHS Blood and Transplants.	Mar-19		05/07/2016	
Marcus Bailey Acting Chief Operating Officer	Nil	Mar-19			
Kevin Brown Chief Operating Officer	Appointed as a Magistrate: North and East Hertfordshire Bench for a term of five years from	Jan-19		05/07/2016	
Dr Tom Davis	Director of TSD Heathcare Ltd	Mar-19		02/02/2018	
Medical Director	GP VTS Programme Director, Health Education England (Thames Valley)	Mar-19			
	Board member, Hertfordshire Independent Living Service (HILS, social enterprise)	Mar-19			
	Retainer of GP status at Wendover Health Centre	Mar-19			
	Wife is a consultant at the Milton Keynes University Hospital	Mar-19			
Robert Morton Chief Executive	Nil			24/08/2015	
Tracy Nicholls	Vice Chair and Trustee, College of Paramedics	Mar-19			
Director of Clincal Quality and Improvement	Company Secretary for dormant company, Challenge your Thinking;	Mar-19			
Kevin Smith Director of Finance and Commissioning	Nil	Mar-19		01/06/2014	
Dorothy Hosein Interim Chief Executive	Nil	Mar-19			
Lindsey Stafford-Scott Director of People and Culture	Nil			29/03/2016	

Statement of accounting/ accountable officer's responsibility

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 2019.

For the year ending 31st March 2019, the Trust is reporting a retained deficit of £2,071,000. This was behind the planned surplus target for the year.

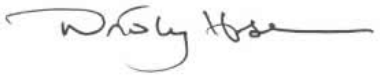
The Trust met the three important financial targets: cumulative breakeven, external financing limit and capital resource limit. Plans submitted to NHS Improvement were used for monitoring financial performance during the year.

Further details on the Trust's financial activities are given in section four of this report.

The full financial statements for the year ending 31st March 2019 are presented within this annual report.

Kevin Smith
Director of Finance and Commissioning

I can confirm that the accountability report, incorporating the corporate governance statement, the remuneration and staff report, annual governance statement, the annual financial statements and audit report have been prepared in adherence to the reporting framework.



Dorothy Hosein
Interim Chief Executive

ii) Annual governance statement 2018/19

Annual governance statement – East of England Ambulance Service NHS Trust

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 the 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 the East of England Ambulance Service NHS Trust for the year ended 31st March 2019 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. The chief executive officer retains overall responsibility for risk management, with the head of governance as the responsible manager. Risk management is a core component of the job descriptions, role and responsibility of senior managers throughout the Trust. The Trust Board undertakes mandatory training in terms of patient safety risk and risk management on an annual basis, with two focussed risk management sessions within this financial year, in addition to further 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 Trust has in place a Board-approved risk appetite, strategy and policy to facilitate risk management throughout the organisation.

Risk management training

The Trust has in place a risk management training approach to ensure that staff at all levels of the organisation are suitably equipped to manage risk in a way that is appropriate to their authority and duties.

The risk management training proposal is based upon four tiers of risk management training in order to reflect the way in which risk management is approached throughout the Trust. A summary of each of the tiers and what should be encompassed is outlined below:

Tier one: all staff

Risk management training for all staff is already embedded within existing training methodologies and has been for a number of years. Staff receive training via the corporate induction, as well as an annual refresher via the mandatory training requirements which are completed via e-learning. Compliance with this is monitored by the learning and development unit and has achieved 95% completion for the 2018/19 financial year.

Training at this level encompasses the recognition of risks, reporting of incidents and risks and the need for dynamic risk assessments.

Tier two: senior managers

This level of training is aimed at staff using our risk register software system and seeks to standardise the approach to risk management within teams, enabling managers to feel confident in the way in which they – and their teams – manage risks within business as usual. Tier two training is provided annually, via a three-hour risk management surgery for teams. The head of department and their management team responsible for managing their local risk register, plus any other staff they feel would support the process, are required to attend.

The training sessions cover:

- the risk management policy
- roles, responsibilities and accountability for risk management compliance
- risk identification, assessment
- development of effective controls
- establishing effective mitigating actions
- risk scoring methodology
- risk escalation and de-escalation
- documentation and risk software refresher training
- team risk register health check

Tier three: senior management team (formerly the Senior Leadership Board)

One Senior Leadership Board risk management workshop was held during 2018/19 to facilitate the implementation of the risk escalation process. Ongoing work is required in order to support the senior management team to deliver its responsibilities pertaining to risk management, which include:

- Provide a risk-focussed management process to deliver Trust objectives, ensuring risk management is the cornerstone of all business decisions undertaken by all Trust governance groups.
- Monitor key performance indicators at corporate and directorate levels and take improvement action when necessary.

- Identify, assess, manage and review risks through the corporate risk register, including the identification of corrective action. Identify risks requiring strategic oversight and scrutiny for escalation to the Board assurance framework.
- Risk monitoring, assurance and escalation.

Tier three training takes the form of one-half day risk management workshop per annum, focussed upon common areas for improvement identified through the tier two risk management surgeries. They also include:

- assurance and escalation
- risk appetite
- risk-based decision making and discussions, and their benefits to prioritisation
- risk assurance techniques

Tier four: Trust Board

The Trust Board receives an annual risk management training workshop to support continuous development of the way in which risk management is approached. It covers:

- review and determination of the strategic risks for the Trust
- consideration of the risk management approach and principles employed
- assurance and escalation of risks and their mitigating controls

Focus of tier four training in 2018/19 and into the 2019/20 financial year has and will continue to include methods to improve risk maturity levels across the organisation and the development and embedding of the Trust's risk appetite.

The risk and control framework

Risk management strategy and risk appetite

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.

In 2018/19, the Board established its risk appetite statement for the organisation, which over the coming months will help to ensure that assurance and monitoring is undertaken in line with our risk appetite, in addition to our strategic objectives.

The Board has overall responsibility for the management of risks that hinder achievement of the strategic objectives of the Trust. The Board has delegated the responsibility for managing the mitigation actions of the strategic risks to the Executive Leadership Board.

The Management Assurance Group oversees the day to day management of the risk management systems and processes and 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.

Escalation of risk is achieved through the well-established governance structures and processes, in line with the Trust's governance and assurance framework.

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 ongoing review and improvement:

- The 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 its 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, such as internal and external audit, CQC, NICE, etc.
- Compliance with statutory requirements – e.g. Health and Social Care Act 2010
- Monthly integrated performance report.
- Fire safety inspections and health and safety risk assessments.
- Reviews of the external environment.

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

Quality governance arrangements

EEAST has a robust set of quality governance arrangements in place, most of which are outlined within this report. Other aspects include:

- Committee and sub-group infrastructure to ensure all quality issues are monitored and addressed. This includes the Quality Governance Committee, Clinical Quality and Safety Group and its sub-groups which include safeguarding, medicines management, health and safety and infection, prevention and control.
- A full suite of policies and procedures to control quality systems and processes.
- Robust risk assessment and quality impact assessment processes.
- Data quality checks within the processes for publishing and using performance information – managed through a dedicated informatics team and include data keys and definitions.

Compliance with CQC registration requirements

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, ambulance operations centres and PTS. This was followed in late March 2018 by an announced well led inspection. These were both completed under the new methodology and the Trust given an overall rating of 'requires improvement', with 'outstanding' received for care.

As a result, the Trust established an integrated improvement plan to ensure focussed and sustainable improvements in the areas identified by the CQC in their inspection. The improvement plan aggregated the actions required with the recommendations also outlined within an external review of the Trust's governance arrangements, undertaken at the same time. The process includes weekly oversight of progress on actions, and triangulation of updates against key metrics as well as qualitative data from quality walkabouts and station visits, to gain assurance on progress. All Board members participate in the schedule of visits and overall assurance against CQC improvements is monitored through the Quality Governance Committee.

The Trust has been notified that the draft report will be completed and presented to the Trust mid-May 2019 for a matters of accuracy check. Any areas of improvement will be taken forward as part of the Trust's integrated improvement plan and finalised by the end of quarter one.

Data security risks

Data security risks are identified, assessed, managed and reported as per the Trust's risk management strategy and process. These are overseen by the Information Governance Group and the Trust's SIRO respectively. For oversight and monitoring purposes, the principal risks pertaining to data security, as well as the risk profile, are reported to and monitored by the relevant Trust Board committee.

Significant risks

The major risks identified within the 2018/19 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 and principal risks is as follows:

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

  This risk has continued to be challenging for the Trust to mitigate within the year due to the recognised capacity gap in the clinical workforce, combined with external pressures such as delays in hospital handover and the need to maximise our operational productivity. Ongoing growth of the clinical workforce is and continues to be a core mitigating action, and redesign and implementation of the new rotas to improve productivity continues into 2019/20. Significant clinical workforce recruitment has taken place, but the impact has been hindered as a result of a higher than anticipated level of attrition of the workforce. As a result, there is significant focus on recruitment and retention and the associated risks at Board and committee level moving into the 2019/20 financial year.

- **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 has continued to reduce over the year, and improvements have been seen within other areas including our ACQIs, infection, prevention and control compliance, reduction in complaints and serious incidents, and improvements in compliance with statutory and mandatory training. There have 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. As a result, the residual risk score for this risk has reduced over the course of the year, demonstrating effective mitigation. In 2019/20, we will focus on the ongoing implementation of the quality improvement strategy, as well as launch and delivery of the Trust's clinical strategy, which will ensure continued focus on our patient at all times.

- **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 establishment of the compassionate conversations process and associated training, implementation of the accountability committees and associated frameworks, and continued focus on leadership development and engagement via the chief executive and Board members. There has been continued positive working with the trade union to improve relations and establish a new, fit for purpose voluntary recognition agreement in order to maximise support for staff engagement and consultation. In 2018/19, our NHS Staff Survey results broadly remained the same, indicating the longer term continued focus which is required to mitigate this risk.

  Additionally, in June 2018 we received the report for our independent governance and well led review, which provided us with a clear set of recommendations to complete to strengthen our governance and leadership arrangements. These actions have been undertaken throughout the year to support mitigation of this risk and will continue to be embedded into the coming year. Further developments in 2019/20 will focus upon establishing and delivering the people and culture strategy and finalising key aspects such as talent management processes in order to futureproof 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).

  This risk has increased in score through the year due to the need to balance patient safety with delivery of financial targets. Decisions were taken collectively by the Board and the financial and patient safety risks were fully considered during the course of decision making. As a result, there is clear focus on mitigation of this risk moving into 2019/20 through stringent financial control measures, an ambitious and focussed cost improvement programme and targeted change work on the delivery of efficiencies. Good progress has been made on a number of our strategic efficiency schemes including our fleet transformation, estates strategy and implementation of Make Ready services, which is designed to reduce the time our clinicians spend stocking our ambulances to maximise their availability to treat patients.

- **Failure to maintain sound programme systems and governance processes to support transformation delivery** (risk that the Trust does not fully implement the improvements and transformation required).

  This risk has been mitigated well during 2018/19 through focussed development of key change drivers, including the integrated improvement plan and the accountability committee structures, both of which have demonstrated improvements in a range of metrics and indicators as a result. However, the challenges associated with making large scale, sustainable improvements whilst maintaining financial balance are significant, resulting in an increase in score at the start of the 2019/20 financial year due to the uncertainties associated with financial availability to enable the change required.

Governance compliance risks

The following provides a summary of the potential risks to compliance with the NHS Provider licence and the actions we have taken to mitigate these:

- A risk was identified regarding the application of corporate governance in the form of suitable oversight and accountability to deliver the improvements required to the service provided. Actions taken included the refresh and strengthening of the governance and assurance framework, as well as the addition of core governance forums such as the accountability committees, Improvement Programme Board and Management Assurance Group. These actions were in direct response to the governance review completed by Deloitte, and an internal audit on corporate governance has evidenced a much-improved position. These changes have significantly strengthened the appropriate principles, systems and standards of good governance in place.
- A risk of insufficient oversight at committee level was identified. This has been addressed through a full review of the committee schedule and an increase in the frequency of meetings, amendments to the terms of reference and agendas to ensure full coverage of all executive portfolios. The Board has a well-established committee structure with clear roles and responsibilities in place. The Trust's scheme of delegation and governance and assurance framework have been updated in year to ensure these remain fit for purpose. During 2018/19, the People and Culture Committee has been established to bring greater oversight to workforce, culture and wellbeing issues, with the focus in 2019/20 on ensuring the committee maximises its effectiveness.
- A risk of timeliness and quality of Board and committee oversight was identified, resulting in realignment of the frequency and meeting schedules of the Board and its committees to ensure enough opportunity for timely and effective scrutiny. Clear strategic goals and objectives are in place to support appropriate decision making regarding efficient and effective operations. The governance and assurance framework and scheme of delegation details clear oversight processes to ensure compliance with the applicable healthcare standards, evidenced via the Quality Governance Committee, Performance and Finance Committee and Clinical Quality and Safety Group. This has been further strengthened in-year through the implementation of the improvement plan, which focusses on continuous improvements in line with the core requirements and key lines of enquiry. Monthly financial performance is monitored by the Board and Performance and Finance Committee. Material risks are outlined within the BAF (strategic risks) and risk reports to each of the committees on the principal risks with the potential to impact upon achievement of our strategic goals. The integrated Board report and the full suite of routine reports to the Board and its sub-committees enable the Board to identify and respond to exceptions, issues and risks in a timely manner.

- There was a risk identified of the interdependency between performance, patient safety and financial balance which has given rise to the need for the Board to make choices in year to ensure and maximise patient safety that increased the Trust's financial challenge. The Trust has a full complement of executive directors with a heavy ratio of clinical executives, ensuring that quality of care and patient safety are considered fully within all decisions made. There is a comprehensive clinical governance system and process in place with clear oversight provided to the Board via the Quality Governance Committee

Embedding risk management

Risk management is embedded throughout key activities in the organisation. For example:

- All cost improvement programmes have a reviewed and approved quality impact assessment, where risks and mitigating actions are identified prior to the scheme being able to proceed. If deemed to have too great a risk to patients, staff or a range of other indicators, the scheme does not go ahead.
- All policies have an equality impact assessment undertaken prior to implementation.
- All core plans, such as the winter plan, potential for overtime incentives, surge plan or Board-level financial decisions, have a risk and impact assessment undertaken, to ensure a fully informed decision can be made.
- The Trust has in place a fully embedded incident reporting system for staff to report any adverse incident or near miss. An annual refresher on reporting is provided to all staff to ensure incidents are reported. The level of incidents and near misses reported demonstrates an open and honest reporting culture.
- Core groups all monitor the risks relevant to their terms of reference on a frequent basis.

Workforce strategies and staffing systems

To ensure that the Trust has sufficient workforce to meet demand and achieve patient-facing hours (PFSH) the Trust use a mix of substantive and bank staff, along with private ambulance providers (PAS) and agency.

In the medium term the Trust plan to increase substantive and bank staff and reduce PAS and agency so that care is provided by a consistent group of employees. An independent service review using activity data from previous years, and handover data from 2015/16 (the longest handover data of recent record), ensures demand keys are relevant.

The modelling returned a 38.5% relief factor to cover abstractions, sickness and annual leave. This concluded that the Trust needed to increase frontline staff by 333FTE to meet ARP standards. The ambitious recruitment plan to deliver this, led by the HR team and supported by local recruitment leads and move to a local recruitment model, supports the ability to plan the population of rotas and workforce numbers.

To maximise use of resources and support staff, a Trust-wide relief policy launched April 2019, with planners trained to ensure gaps are filled using Trust staff initially. The option of including relief in core rota lines allows flexibility for the Trust and a better work/life balance for staff.

PAS is planned proactively, filling a flexible gap and the Trust use own resource for additional requirements. Twelve-week planning was introduced to provide greater forward view of Trust resources.

The Trust has seen a maintained increase in the amount of PFSH over recent months, peaking over winter. This is monitored via weekly strategic forecasting and planning meetings.

Our workforce plan is monitored via the Executive Leadership Board, local accountability committees, the People and Culture Committee and the Trust Board. A new five-year people and culture strategy will launch in June 2019.

Register of interests

The Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by managing conflicts of interest in the NHS guidance.

Pension scheme

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 into 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.

UK climate projections

We have carried out risk assessments and put a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the adaptation reporting requirements are complied with.

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

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 Executive Leadership Board 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 the Quality Governance Committee 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 Audit Committee.

As part of their annual audit, our external auditors are required 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

This report details incidents reported to the Information Commissioner's Office (ICO) from the period of 1st April 2018 to 31st March 2019. During this period ,the Trust reported that 34 information governance incidents had occurred, as detailed in the table. The table also outlines the decision taken by the ICO, as all of these incidents were reported to them as per guidance.

On 25th May 2018 the reporting process changed to reflect the new regulations brought about by the implementation of the GDPR and DPA18. Incidents are no longer scored as level one and two but are graded according to a matrix supplied by NHS Digital. Incidents meeting the threshold for reporting (scoring four or above) are reported on the data security and protection toolkit (DSPT), previously known as the IG toolkit. The DSPT automatically notifies the ICO of any incidents which achieve an overall score of six or higher.

Incident	ICO decision
HR posted an employee's retirement due to ill health pack to the Trust's occupational health provider. The pack was posted to the correct address, marked for the attention of a specific employee and sent via track and trace service. The occupational health provider has never received the package.	No further action
A clinician has mislaid a paper copy of a patient care record within the receiving hospital. The record would have contained PID and special category data.	No further action
A member of staff has reported the loss of a patient care record. When leaving the hospital, the record was blown away on to the hospital roof, making it irretrievable.	No further action
The HR team are unable to locate or account for the whereabouts of a member of Trust staff's personnel file.	No further action
Members of Trust staff have reported being contacted by two motoring claim companies regarding accidents at work. Both companies have been made aware of a number of personal details.	No further action
A member of staff has reported that a former member of staff has continued to access Trust accounts since leaving the Trust.	Ongoing - TBC
PID and special category data (presenting condition) were shared with the attending crew and their manager as a compliment. These details were shared in the staff newsletter.	No further action
A member of Trust staff has been receiving sickness notifications via text message for staff that do not report to them.	No further action

Incident	ICO decision
When responding to a patient's relative, the email address was mis-typed, resulting in a response and call recordings being sent to the wrong email address. These were sent securely however the password was also sent to the same email address.	No further action
A patient care record could not be located. Based on the information entered into our audit tool, the missing record was in the possession of the medical records team. It is likely that the record is either still within the Trust's possession or has been securely destroyed.	No further action
An email intended for two named managers regarding issues the sender of the email was experiencing with the behaviour/attitude of two members of Trust staff (data subjects) was accidentally sent to an entire ambulance station.	No further action
A reporter and a photographer from an online news site accompanied an ambulance crew as observers. They have subsequently published photographs and special category data regarding patients on their news website. Both observers had signed paperwork regarding confidentiality and the sharing of these details no explicit consent was gained.	No further action
Whilst reviewing a statement of case the patient's details had not been redacted and the pack had been circulated to the member of staff and union representatives.	No further action
The patient transport service conveyed two patients home following hospital discharge. Patient one was given patient two's (data subject) mobile phone, medication and EDS.	No further action
Loss of personnel file.	No further action
An email from occupational health service informing us a member of staff had booked sick was forwarded on to a wider group of recipients and included the data subject's name.	No further action
A staff member sent details of personal and special category (including health information) relating to patients and 999 calls to their partner.	No further action
Missing patient care record.	No further action
After attending to a patient, the crew were unable to locate the patient care record.	No further action
At the receiving hospital there was a mix up over the patient's details and the hospital used the medical notes of the wrong patient to begin a care plan.	Ongoing - TBC
A trainee call handler was sent full personal details of another applicant in the post.	No further action
A patient care record for one patient has been left in the home of a subsequent patient.	No further action
A staff member's sickness record was emailed to them ahead of a formal meeting. Upon review, they discovered that the record also contained another staff member's sickness.	No further action
Emailed a response to a patient query to the wrong email address.	No further action

Incident	ICO decision
Emailed a response to a patient query to the wrong email address.	No further action
Crew lost an envelope containing two patient care records.	No further action
Member of staff requested to know who had allocated the next ambulance call. When the manager would not advise of this they accessed the system themselves.	No further action
A member of staff took photographs at the scene of an incident and shared them with an external party. They did not follow correct process or Trust policy when sharing images.	No further action
A member of EEAST staff reported that a video of him with a patient has been shared on Facebook. The patient is unidentifiable, the member of staff is identifiable from the footage.	No further action
An application pack for a voluntary role was sent in post to Trust and not received. Second pack sent and received but mislaid. Likely to have been misplaced on Trust premises.	No further action
Patient care record misplaced.	No further action
Patient care record for different patient left at patient's home.	No further action
Inappropriate access of relative's details.	No further action
Paramedic booking patient into hospital. Another patient overheard the address and advised he was the patient's father. The paramedic informed the patient's father that his daughter was in A&E and her diagnosis. The patient did not want her family to know.	No further action

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. We have 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 Committee, the Quality Governance Committee, the Performance and Finance Committee and the People and Culture Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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 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 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.

The Trust Board

Directors' responsibilities

The Trust Board is made up of non-executive directors (including associate non-executive directors) and executive directors that form a unitary body. It functions as a corporate decision-making body and should consist of six non-executive directors (including the chair) and five executive directors.

The 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, a director of clinical quality and improvement and a medical director. There is also a director of strategy and sustainability and an acting chief operating officer who are not voting members of the Board, and two associate non-executive directors who provide additional advice and expertise to the Board.

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 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 ongoing support through appraisal, mentoring and training. Terms of appointment are normally for periods of two years, with members eligible to be reappointed or to reapply 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 head of governance and is available to anyone who wishes to see it. This information is also published in the annual report and 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. It 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 2018/19, the 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 25th July. Eleven private sessions of the Board were held, seven of which were prior to the public meetings.

A number of workshop sessions were held during 2018/19 to allow the Board to forward plan and implement its Board development plan. These included safer recruitment, leadership and talent management, dignity and respect, counter fraud, GDPR and data protection, freedom to speak up, governance review, risk management, integrated performance reporting and well led. Membership attendance at the Board and sub-committee meetings is monitored throughout the year and is reported in the annual report.

As part of our sustainability and environmental programme, the Board continues to use Board Pad, which is a 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 sub-committee meetings.

Review of effectiveness of the Trust Board and sub-committees

The Board and its 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 carried out during 2018/19. Action plans have been 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 2019.

The Board's key activities during 2018/19 were:

- monitoring and gaining assurance on the risk management processes via the Board assurance framework;
- reviewing and approving the Trust's winter planning arrangements, receiving the Easter plan and approving the new REAP arrangements;
- receiving and approving annual reports for safeguarding, health and safety, medicines management 'controlled drugs', security management, infection prevention and control, gender pay gap and freedom to speak up;
- signing-off the annual report, including financial statements, annual governance statement and the annual quality report, the Trust's charitable funds financial statements and data security protection requirements;
- receiving the external governance review report and accepting and monitoring the recommendation implementation;
- receiving the 2018 CQC inspection report and approving the actions identified, monitoring completion via the newly established integrated improvement plan;
- agreeing the amended and improved governance arrangements, including the updated governance and assurance framework document and increased frequency of committee meetings;
- progressing and agreeing estate procurement in line with the estate strategy;
- agreeing a number of underpinning strategies including employee engagement, quality improvement and risk management; and
- agreeing to award a number of contracts including taxi services, ambulance procurement, HSCN, private ambulance provision and transformation work.

The Audit Committee

The Board has a fully-established Audit Committee made up of three designated members, appointed from the non-executive and associate non-executive directors. 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.

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, it 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 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. It 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 2018/19 included:

- reviewing the assurances as detailed in the BAF;
- 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 adequacy of relevant policies, legality issues and the codes of conduct;
- reviewing the policies and procedures related to standards of business conduct; and
- considering the Trust's compliance with emergency preparedness, resilience and response.

The Audit Committee completed all items included in its 2018/19 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.
- It is further positively assured through the establishment of the accountability committees and an assurance process from the Board sub-committees back to the Audit Committee on the principal risks reviewed by a sub-committee.
- 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. The committee was assured through the level of improvements demonstrated within the internal audit reports.

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 to check that it represents a balanced picture of the Trust's performance during 2018/19 and that the information it includes is reliable and accurate. The assessment will also ensure that data underpinning the measures of performance reported in the Quality Account was robust and reliable.

Ernst and Young LLP is the Trust's external auditor and independently audits the financial statements and the part of the remuneration report to be audited in accordance with relevant legal and regulatory requirements, such as the International Financial Reporting Standards. 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.

The Quality Governance Committee

The Trust Quality Governance Committee appoints its members from the non-executive directors and associate non-executive directors. Current membership consists of three non-executive directors.

The 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 CQC registration. The committee 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 and surveys, and seeks assurance on plans to address shortcomings. The committee's work 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 2018/19 included:

- Reviewing progress on the CQC action plans following the CQC report published in June 2018 and the quality improvement visits.
- Reviewing the clinical audit plan, the health and safety strategy, safeguarding strategies, infection prevention and control annual report and the annual safeguarding report.
- Reviewing serious incident reports, subsequent action plans and their progress.
- 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 the clinical strategic risk (SR2).
- Giving assurance on quality impact assessments for the 2018/19 cost improvement programme.
- Reviewing 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 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 is made up of two non-executive directors and an associate non-executive director. The chair of the 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 2018/19 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 2018/19 commissioning contract, budget delivery within 2018/19 and budget planning for 2019/20.
- Reviewing information systems and technology projects and the risks involved in delivering them.
- Monitoring the estates transformation project.
- Monitoring implementation and delivery of the Trust's improvement plan.

Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee is made up of three non-executive directors including the Trust chair and one associate non-executive director. It is responsible for advising on the appointment and/or dismissal of the executive directors. The committee is also responsible for approving their remuneration and terms of service and for monitoring their performance against delivery of organisational objectives. The chief executive is entitled to attend the committee and be consulted when the appointment and remuneration of the executive directors is being considered, but is excluded from meetings where their own position is discussed.

An appointment panel is convened for executive positions with representation of a non-executive director, chair, chief executive 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 met six times during the year and has been actively involved in:

- agreeing arrangements for the recruitment of the deputy chief executive;
- 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;
- reviewing issues relating to employment tribunal cases; and
- monitoring pay-related issues, including redundancy processes.

People and Culture Committee

The People and Culture Committee was formed in January 2018 to establish a clear assurance pathway for culture, people and workforce issues, which had previously been addressed by the other committees in the Trust Board structure. Its membership consists of three non-executive directors, including the chair of the Trust Board and one associate non-executive director.

The past year has focussed on initiation of the People and Culture Committee, which has met three times. Embedding the committee and ensuring its effectiveness continues as a key governance action in 2019/20.

Key activities during 2018/19 were as follows:

- Determining a clear schedule of work. The committee will meet quarterly with the option for two further meetings should this be required.
- Reviewing, monitoring and assessing the culture strategic risk, SR3, in addition to the principal recruitment and retention risk.
- Receiving, reviewing and monitoring strategies, including leadership, engagement, freedom to speak up.
- Recommending initiatives, such as the salary sacrifice scheme, to the Board.
- Reviewing processes, including support services capacity and bank contract processes.
- Monitoring progress against the workforce plan.

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 so 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 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 2018/19 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 30th June 2019.

Internal audit

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 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.

The head of internal audit opinion and annual internal audit programme

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:

- In respect of the design of the controls, an assurance opinion of substantial assurance was provided for seven out of the ten assurance audits.
- In respect of the operational effectiveness of the controls, an assurance opinion of moderate assurance was provided for all ten assurance audits.
- The Trust has specifically requested work relating to known areas of concern, new areas of risk and new approaches e.g. global rostering system and corporate governance.
- Management has responded positively to reports issued and action plans have been developed to address the recommendations raised.
- Implementation of recommendations has not always been undertaken within the original agreed timeframes e.g. IT disaster recovery, sickness and procurement. However, we have confirmed that 94% of recommendations due for implementation had been completed by the end 2018/19.

Whist the overall opinion remains one of moderate assurance, we have noted further improvement in controls since we gave limited assurance in 2016/17, and since 2017/18.

Our Annual report and head of internal audit opinion has been prepared based on the audit work carried out during the year. Whilst there are three reports currently in draft, these would not have any impact upon the overall annual opinions.

During 2018/19, the following reports have been issued. Seven received substantial assurance for design, and the remaining three moderate assurance. All received moderate assurance for operational effectiveness:

- safeguarding
- health and safety
- patient safety
- data security and protection toolkit
- training governance / ARP implementation
- fleet management
- CQC follow on
- corporate governance
- main financial systems

- operational performance
- business development
- global rostering system advisory review

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.

Actions taken to address internal control issues

The key challenges the Trust faced in 2018/19 were:

- Operational capacity to meet demand and performance requirements.
- Rate of the clinical workforce growth required and the level of attrition of staff – the Trust was not commissioned to meet the national standards within the financial year due to the recognised capacity gap and transformation required.
- Emergency department arrival to handover delays.
- Financial balance whilst undertaking the significant transformation required.

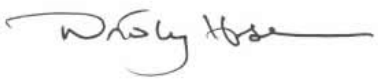
The Trust undertook several significant actions to mitigate these internal control issues which are outlined throughout this statement. However, a summary of key actions taken include:

- Workforce plan in situ for three years and progressing, with 584 whole time equivalent staff recruited to clinical roles.
- Retention programme implemented with a suite of underpinning projects and schemes to improve the retention rate, as 464 whole time equivalent staff left clinical roles. This work continues into 2019/20.
- Close partnership working with providers, regulators and commissioners including the implementation of the handover escalation protocol, with a marked improvement in handover delays as a result.
- Initiation of the Building Better Rotas project, which will progress through to autumn 2019 and will improve operational capacity and improve performance.
- Close review of the financial position and budgets, including strengthening of the oversight of the cost improvement plan to ensure that financial controls are maximised moving into 2019/20.

Conclusion

Based on the information above, no significant internal control issues have been identified. Recruitment and improvement in retention to meet the clinical workforce capacity gap remains the organisation's significant issue at the end of the financial year, with clear plans in place to continue to address this, as outlined above.

Signed



Interim Chief Executive
22nd May 2019

iii) Remuneration and staff report

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 it 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/she is excluded from meetings on their 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 2018/19:

- 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. 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 over the following pages 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.

Patient meet-ups:

King's Lynn crews (Mark Salter - Paramedic, Jemma Carnell - Associate Ambulance Practitioner, Shaun Reddy - Leading Operations Manager and Daniel Twite - Paramedic) with patient James Buckenham

Paramedic, Eloise Murphy and baby Charlie

Salary and Pension entitlements of senior managers - subject to audit

Salary and Allowances

Name	Title	2018-19						2017-18					
		(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 2019													
Sarah Boulton	Chair	35-40	Nil	Nil	Nil	Nil	35-40	35-40	Nil	Nil	Nil	Nil	35-40
Tom Spink	NED	5-10	Nil	Nil	Nil	Nil	5-10	0-5	Nil	Nil	Nil	Nil	0-5
Lizzie Firman	NED	5-10	Nil	Nil	Nil	Nil	5-10	0-5	Nil	Nil	Nil	Nil	0-5
Peter Kara	NED	5-10	Nil	Nil	Nil	Nil	5-10	5-10	Nil	Nil	Nil	Nil	5-10
Ravi Mahendra	NED	5-10	Nil	Nil	Nil	Nil	5-10	Nil	Nil	Nil	Nil	Nil	Nil
Andrew Egerton-Smith	Associate NED	0-5	Nil	Nil	Nil	Nil	0-5	5-10	200	Nil	Nil	Nil	5-10
Alison Wigg	Associate NED	5-10	Nil	Nil	Nil	Nil	5-10	0-5	Nil	Nil	Nil	Nil	0-5
Dorothy Hosein	Interim Chief Executive	65-70	1300	Nil	Nil	Nil	65-70	Nil	Nil	Nil	Nil	Nil	Nil
Wayne Bartlett-Syree	Director of Strategy and Sustainability	105-110	5300	Nil	Nil	35-37.5	145-150	100-105	5000	Nil	Nil	32.5-35	135-140
Dr Tom Davis	Medical Director	135-140	4500	Nil	Nil	62.5-65	200-205	20-25	5200	Nil	Nil	35-40	60-65
Tracy Nicholls	Director of Clinical Quality & Improvement **	95-100	1300	Nil	Nil	*	95-100	Nil	Nil	Nil	Nil	Nil	Nil
Marcus Bailey	Acting Chief Operating Officer **	15-20	0	Nil	Nil	*	15-20	Nil	Nil	Nil	Nil	Nil	Nil
Lindsey Stafford-Scott	Director of People & Culture	105-110	5800	Nil	Nil	25-27.5	135-140	100-105	9700	Nil	Nil	22.5-25	130-135
Kevin Smith	Director of Finance & Commissioning	115-120	5600	Nil	Nil	60-62.5	180-185	110-115	6500	Nil	Nil	27.5-30	145-150
Senior Managers who left the Trust Board in 2018-19													
Robert Morton	Chief Executive	140-145	1200	Nil	Nil	35-37.5	175-180	140-145	7300	Nil	Nil	32.5-35	185-190
Alexander Brown	Director of Nursing & Clinical Quality	5-10	Nil	Nil	Nil	0	5-10	115-120	6000	Nil	Nil	15-17.5	135-140
Kevin Brown	Director of Service Delivery	125-130	8100	Nil	Nil	100-102.5	230-235	100-105	8400	Nil	Nil	27.5-30	140-145
Mike Burrows	Associate NED	0-5	Nil	Nil	Nil	Nil	0-5	5-10	Nil	Nil	Nil	Nil	5-10
Tony McLean	NED	0-5	Nil	Nil	Nil	Nil	0-5	5-10	Nil	Nil	Nil	Nil	5-10

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.

* Pension information not available at the time of publication

** Where contract of employment were for the entire year but individuals were only a senior manager for part of the year it is the remuneration for the time as a senior manager which is shown.

The following senior managers served for part of the financial year 2018/19:

Dorothy Hosein	Appointed to Trust Board on 1st November 2018	Alexander (Sandy) Brown	Left the Trust Board on 2nd April 2018
Tracy Nicolls	Appointed to Trust Board on 14th June 2018	Mike Burrows	Left the Trust Board on 30th April 2018
Marcus Bailey	Appointed to Trust Board on 4th February 2019	Tony McLean	Left the Trust Board on 30th June 2018
Ravi Mahendra	Appointed to Trust Board on 1st May 2018	Kevin Brown	Left the Trust Board on 29th March 2018
		Robert Morton	Left the Trust Board on 28th February 2019

Signed on behalf of East of England Ambulance Service NHS Trust on 22 May 2019:

Sarah Boulton
Chair of Trust Board

Dorothy Hosein
Interim Chief Executive

Salary and Pension entitlements of senior managers - subject to audit

Pension Benefits 2018-19

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 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2018 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2019 £'000	Employer's contribution to stakeholder pension £'000
Chief Executive	Robert Morton	2.5-5	0	10-15	0	84	47	138	Nil
Director of Nursing & Clinical Quality	Alexander Brown	0	0	35-40	115-120	813	0	813	Nil
Director of Service Delivery	Kevin Brown	5-7.5	10-12.5	20-25	60-65	334	142	488	Nil
Director of Finance & Commissioning	Kevin Smith	2.5-5	2.5-5	50-55	85-90	681	145	846	Nil
Director of Strategy and Sustainability	Wayne Bartlett-Syree	2.5-5	0-2.5	20-25	50-55	279	77	365	Nil
Director of Clinical Quality & Improvement	Tracy Nicholls	*	*	30-35	90-95	*	*	715	Nil
Acting Chief Operating Officer	Marcus Bailey	*	*	*	*	*	*	*	*
Director of People & Culture	Lindsey Stafford-Scott	0-2.5	0	5-10	0	34	29	64	Nil
Medical Director	Dr Tom Davis	2.5-5	2.5-5	15-20	30-35	161	76	242	Nil

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

* Pension information not available at the time of publication

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

	2018-19	2017-18
Band of Highest Paid Director's Total Remuneration (Bands of £5,000) £'000	140-145	145-150
Median Total Remuneration £'s	30,326	29,510
Ratio	4.70	5.00

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 2017/18.

The banded remuneration of the highest-paid director in the organisation in the financial year 2018-19 was £140k-145k (2017-18 £145k-150k) . This banding is 4.70 times (2017-18 5.00 times) the median remuneration of the workforce, which was £30,326 (2017-18 £29,510).

In 2018-19 nil (2017-18 nil) permanent employees received remuneration in excess of the highest paid director however two specialist tempoaray contractors annulaised rates exceed the highest paid director's pay . Remuneration ranged from £7 to £222k (2017-18: £7 to £150k).

The change in the median salary value is attributable to the National Pay award ratified at NHS Staff Council on 27 June 2018, which has changed the composition of salaries, 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 2019. These agency costs are annualised based on the expenditure on that individual in the week ending 31st March 2019, less an agency commission fee of 5%.

Staff Report - subject to audit

Senior Managers

	Number Employed	
Pay Band	2018-19	2017-18
Executive Directors	8	7
Agenda for change Band 9	2	1
	10	8

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

	2018-19			2017-18
	Total Number	Permanently employed Number	Other Number	Total Number
Average Staff Numbers				
Medical and dental	1	1		1
Ambulance staff	2,301	2,244	57	2,143
Administration and estates	593	557	36	534
Healthcare assistants and other support staff	1,866	1,725	141	1,818
Nursing, midwifery and health visiting staff	16	16		18
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	-	-	-	-
Social Care Staff	3	2	1	2
Healthcare Science Staff	-	-	-	-
Other	-	-		2
TOTAL	4,780	4,545	235	4,518
Of the above - staff engaged on capital projects	0	0	0	0

Staff Costs

	2018-19			2017-18		
	Total £000s	Permanently employed £000s	Other £000s	Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	168,347	166,200	2,147	155,560	153,154	2,406
Social security costs	16,824	16,824	0	15,468	15,468	0
Apprenticeship Levy costs	802	802	0	744	744	0
Employer Contributions to NHS BSA - Pensions Division	19,871	19,871	0	19,022	19,022	0
Other pension costs	22	22	0	14	14	0
Termination benefits	387	387	0	5	5	0
Total employee benefits	206,253	204,106	2,147	190,813	188,407	2,406
Employee costs capitalised	0	0	0	0	0	0
Gross Employee Benefits excluding capitalised costs	206,253	204,106	2,147	190,813	188,407	2,406

Staff Composition

2018-19			2017-18		
Total	**Male**	**Female**	Total	Male	Female
4,896	**2,591**	**2,305**	4,840	2,640	2,200

Staff Sickness absence

	2018-19	2017-18
	Number	Number
Total Days Lost	62,688	57,574
Total Staff Years	4,527	4,376
Average working Days Lost	**13.8**	**13.2**

	2018-19	2017-18
	Number	Number
Number of persons retired early on ill health grounds	10	8
	£000s	£000s
Total additional pensions liabilities accrued in the year	850	612

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

2018-19	2017-18
£000s	**£000s**
493	428

East of England Ambulance NHS Trust
Annual Report 2018-19
Compensation and exit packages- subject to audit

Reporting of other compensation schemes - exit packages 2018-19

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								
£10,000 - £25,000								
£25,001 - £50,000								
£50,001 - £100,000	1	86,667	1	63,835		150,502		
£100,001 - £150,000	1	140,000				140,000		
£150,001 - £200,000	1	160,000				160,000		
>£200,000								
Total		**386,667**	**0**	**63,835**	**0**	**450,502**	**0**	**0**

Compulsory redundancies arise from the reorganisation of operational and corporate positions during the year. Other agreed departures relate solely to the payment of contractual notice agreed.

Reporting of other compensation schemes - exit packages 2017-18

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	1	5,111				5,111		
£10,001 - £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**

Other Exit Packages 2018-19

Other Exit packages - disclosures (Exclude Compulsory Redundancies)	Number of exit package agreements Number	Total Value of agreements £000s	2017/18 Number of exit package agreements Number	2017/18 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	1	64	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	**1**	**64**	**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.

Off-Payroll Engagements Note

Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2019	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 2018 and 31 March 2019, 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 2018 and 31 March 2019.	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

All existing off-payroll engagements have at some point been subject to a risk based assessment as to whether assurance needs to be sought that the individual is paying the right amount of tax and, where necessary, that assurance has been sought

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 2018 and 31 March 2019:

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.

8. Annual accounts and auditor's report

East of England Ambulance Service NHS Trust

Annual accounts for the year ended 31 March 2019

Contents page for the Annual Accounts

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;

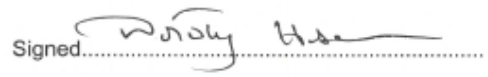
· value for money is achieved from the resources available to the trust;

· 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.



Dorothy Hosein
Interim Chief Executive Officer

22 May 2019

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;

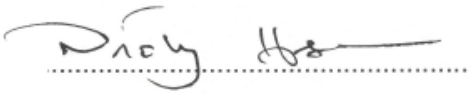
· make judgements and estimates which are reasonable and prudent;

· 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.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy



Dorothy Hosein

Interim Chief Executive Officer

22 May 2019

Kevin Smith

Director of Finance and Commissioning

22 May 2019

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 2019 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 34. 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 2018/19 HM Treasury's Financial Reporting Manual (the 2018/19 FReM) as contained in the Department of Health and Social Care Group Accounting Manual 2018/19 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 2019 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.

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 set out on pages 1 to 87, 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 2019.

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, 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 November 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 2019.

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.

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.

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

28 May 2019

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.

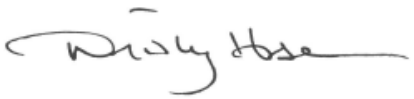
Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	2	277,026	262,306
Other operating income	3	4,714	4,623
Operating expenses	4, 6	(283,028)	(262,567)
Operating surplus/(deficit) from continuing operations		**(1,288)**	**4,362**
Finance income	9	100	16
Finance expenses	10	(17)	(15)
PDC dividends payable		(887)	(918)
Net finance costs		**(804)**	**(917)**
Other gains / (losses)	11	21	(69)
Surplus / (deficit) for the year		**(2,071)**	**3,376**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Revaluations	14	-	1,056
Total comprehensive income / (expense) for the period		**(2,071)**	**4,432**

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	12	490	540
Property, plant and equipment	13	55,680	50,461
Investment property	15	980	980
Total non-current assets		**57,150**	**51,981**
Current assets			
Inventories	17	1,371	1,054
Receivables	18	17,052	20,582
Cash and cash equivalents	19	16,587	9,144
Total current assets		**35,010**	**30,780**
Current liabilities			
Trade and other payables	20	(33,832)	(30,735)
Provisions	21	(3,971)	(2,100)
Total current liabilities		**(37,803)**	**(32,835)**
Total assets less current liabilities		**54,357**	**49,926**
Non-current liabilities			
Provisions	21	(5,486)	(5,614)
Total non-current liabilities		**(5,486)**	**(5,614)**
Total assets employed		**48,871**	**44,312**
Financed by			
Public dividend capital		71,461	64,831
Revaluation reserve		3,925	3,926
Other reserves		(1,413)	(1,413)
Income and expenditure reserve		(25,102)	(23,032)
Total taxpayers' equity		**48,871**	**44,312**

The notes on pages 14 to 56 form part of these accounts.



Dorothy Hosein
Interim Chief Executive Officer
22 May 2019

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**64,831**	**3,926**	**(1,413)**	**(23,032)**	**44,312**
Surplus/(deficit) for the year	-	-	-	(2,071)	**(2,071)**
Transfer to retained earnings on disposal of assets	-	(1)	-	1	**-**
Public dividend capital received	6,630	-	-	-	**6,630**
Taxpayers' equity at 31 March 2019	**71,461**	**3,925**	**(1,413)**	**(25,102)**	**48,871**

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

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£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**

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

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust. The deficit balance on this reserve substantially arose in 2009/10 as a result of asset valuation changes.

Statement of Cash Flows

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(1,288)	4,362
Non-cash income and expense:			
Depreciation and amortisation	4.1	5,761	5,280
Net impairments	5	-	(1,586)
(Increase) / decrease in receivables and other assets		3,386	(1,245)
(Increase) / decrease in inventories		(317)	(59)
Increase / (decrease) in payables and other liabilties		(410)	5,622
Increase / (decrease) in provisions		1,727	1,338
Net cash generated from / (used in) operating activities		**8,859**	**13,712**
Cash flows from investing activities			
Interest received		100	16
Purchase of intangible assets		(58)	(540)
Purchase of property, plant, equipment and investment property		(7,365)	(7,349)
Sales of property, plant, equipment and investment property		20	36
Net cash generated from / (used in) investing activities		**(7,303)**	**(7,837)**
Cash flows from financing activities			
Public dividend capital received		6,630	140
Other interest		-	-
PDC dividend (paid) / refunded		(743)	(1,046)
Net cash generated from / (used in) financing activities		**5,887**	**(906)**
Increase / (decrease) in cash and cash equivalents		**7,443**	**4,969**
Cash and cash equivalents at 1 April - brought forward		**9,144**	**4,175**
Cash and cash equivalents at 31 March	19.1	**16,587**	**9,144**

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 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards (IFRS) 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 the 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, inventories and certain financial assets and financial liabilities.

Note 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 2019-20, not require any long term financial support to achieve a positive cashflow and be able to pay its creditors across 2019-20 as they fall due. Trust management expect these conditions to be met in 2019-20 and continue beyond that period for the foreseeable future.

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

Note 1.3.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.
Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

As per paragraph 121 of the Standard the Trust does not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less. The GAM does not require the Trust to disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

Note 1.3.2 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.
The Trust received central funding from the Department of Health and Social Care for the 2018/19 cost effect of the Agenda for Change (AfC) multi-year pay and contract reform deal. The funding is fully recognised as income in 2018/19 reflecting the consumption of benefit, and is disclosed in Note 2.1.

Note 1.3.3 Other 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 1.4 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 scheme is accounted for as though it is a defined contribution scheme.

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 1.5 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 1.6 Property, plant and equipment

Note 1.6.1 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 lives.

Note 1.6.2 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.

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured 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 with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values 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 on a modern equivalent asset basis.

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, borrowings costs. Assets are revalued and depreciation commences when the assets 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 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.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful 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’ cease 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 expenditure in "net impairments".

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 in "net impairments".

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 1.6.3 De-recognition

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 abandoned 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 useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.6.4 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 1.6.5 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful 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 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 1.7 Intangible assets

Note 1.7.1 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 1.7.2 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".

Amortisation

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

Note 1.7.3 Useful economic life of intangible assets

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

	Min life Years	Max life Years
Software licences	3	10

Note 1.8 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 1.9 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 1.10 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 1.11 Financial assets and financial liabilities

Note 1.11.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes 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 and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Note 1.11.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense.

The Trust has no financial assets or liabilities acquired principally for the purpose of selling in the short term (held for trading), or derivatives. as such the Trust has no financial assets or financial liabilities at fair value through income and expenditure. The Trust has no financial assets measured at fair value through other comprehensive income

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses have been determined from review of the agreements in place to collect the amounts due. The nature of the receivable assets held by the Trust means the main source of impairment arises from monies due from individuals. The Trust does not normally recognise expected credit losses in relation to other NHS bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.11.3 Derecognition

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

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

Note 1.12 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 1.12.1 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 charge 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 1.12.2 The trust as lessor

Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's 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 1.13 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 1.14 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 1.15 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 1.16 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 1.17 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 1.18 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 1.19 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.

Note 1.19.1 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 21.1. A discount rate of 0.29% (2017/18: 0.10%) 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 2019. The carrying value of the accrual is £2.9m within Note 20.1 under accruals.

Note 1.20 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

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

IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2020, 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

All income from patient care activities relates to contract income recognised in line with accounting policy 1.3.1

Note 2.1 Income from patient care activities (by nature)	2018/19	2017/18
	£000	£000
Ambulance services		
A & E income	245,752	231,298
Patient transport services income	21,185	23,292
Other income	6,949	7,716
Agenda for Change pay award central funding	3,140	-
Total income from activities	**277,026**	**262,306**

Note 2.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19	2017/18
	£000	£000
NHS England	651	598
Clinical commissioning groups	269,125	258,097
Department of Health and Social Care	3,236	-
Other NHS providers	1,129	1,158
NHS other	200	-
Local authorities	56	39
Non-NHS: private patients	-	-
Non-NHS: overseas patients (chargeable to patient)	-	-
Injury cost recovery scheme	696	725
Non NHS: other	1,933	1,689
Total income from activities	**277,026**	**262,306**

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

Note 3 Other operating income

	2018/19 £000	2017/18 £000
Other operating income from contracts with customers:		
Education and training (excluding notional apprenticeship levy income)	2,137	3,092
Provider sustainability / sustainability and transformation fund income (PSF / STF)	1,566	-
Other contract income	595	1,184
Other non-contract operating income		
Education and training - notional income from apprenticeship fund	-	-
Rental revenue from operating leases	416	347
Other non-contract income	-	-
Total other operating income	**4,714**	**4,623**

Note 4.1 Operating expenses

	2018/19	2017/18
	£000	£000
Staff and executive directors costs	205,866	190,813
Remuneration of non-executive directors	80	83
Supplies and services - clinical (excluding drugs costs)	4,552	7,206
Supplies and services - general	2,912	2,461
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	1,085	1,332
Inventories written down	-	5
Consultancy costs	493	428
Establishment	6,560	6,582
Premises	4,442	4,417
Transport (including patient travel)	25,421	19,706
Depreciation on property, plant and equipment	5,653	5,280
Amortisation on intangible assets	108	-
Net impairments	-	(1,586)
Movement in credit loss allowance: all other receivables and investments	85	(15)
Increase/(decrease) in other provisions	-	210
Change in provisions discount rate(s)	-	-
Audit fees payable to the external auditor		
audit services- statutory audit	73	69
other auditor remuneration (external auditor only)	-	-
Internal audit costs	74	95
Clinical negligence	1,469	1,111
Legal fees	809	894
Insurance	2,407	3,073
Research and development	-	-
Education and training	1,627	2,004
Rentals under operating leases	16,315	16,374
Early retirements	-	-
Redundancy	387	-
Losses, ex gratia & special payments	122	-
Other	2,488	2,025
Total	**283,028**	**262,567**

Note 4.2 Limitation on auditor's liability and Other auditor remuneration

The limitation on auditor's liability for external audit work is £2m (2017/18: £2m).
No "Other auditor remuneration" was paid to the external auditor.

Note 5 Impairment of assets

	2018/19 £000	2017/18 £000
Net impairments charged to operating surplus / deficit resulting from:		
Abandonment of assets in course of construction	-	719
Changes in market price	-	(2,305)
Total net impairments charged to operating surplus / deficit	**-**	**(1,586)**
Impairments charged to the revaluation reserve	-	-
Total net impairments	**-**	**(1,586)**

No impairments are recongised at 31 March 2019. 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

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	166,587	153,167
Social security costs	16,824	15,468
Apprenticeship levy	802	744
Employer's contributions to NHS pensions	19,871	19,022
Pension cost - other	22	14
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	-	5
Temporary staff (including agency)	2,147	2,393
Total staff costs	**206,253**	**190,813**
As split for operating expenditure note 4.1		
Staff and executive directors costs	205,866	190,813
Redundancy	387	-
Total	**206,253**	**190,813**

Note 6.1 Retirements due to ill-health

During 2018/19 there were 10 early retirements from the trust agreed on the grounds of ill-health (8 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £850k (£612k in 2017/18).

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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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 latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

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

	2018/19 £000	2017/18 £000
Operating lease revenue		
Minimum lease receipts	416	347
Contingent rent	-	-
Other	-	-
Total	**416**	**347**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease receipts due:		
- not later than one year;	181	586
- later than one year and not later than five years;	314	964
- later than five years.	61	136
Total	**556**	**1,686**

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.

	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	16,315	16,374
Contingent rents	-	-
Less sublease payments received	-	-
Total	**16,315**	**16,374**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	10,822	14,434
- later than one year and not later than five years;	9,820	16,087
- later than five years.	17,387	17,822
Total	**38,029**	**48,343**

Note 9 Finance income

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

	2018/19	2017/18
	£000	£000
Interest on bank accounts	100	16
Total finance income	**100**	**16**

Note 10.1 Finance expenditure

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

	2018/19	2017/18
	£000	£000
Interest expense:		
Interest on late payment of commercial debt	-	3
Total interest expense	**-**	**3**
Unwinding of discount on provisions	16	12
Other finance costs	1	-
Total finance costs	**17**	**15**

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

	2018/19	2017/18
	£000	£000
Amounts included within interest payable arising from claims under this legislation	-	3

Note 11 Other gains / (losses)

	2018/19	2017/18
	£000	£000
Gains on disposal of assets	21	-
Losses on disposal of assets	-	(169)
Total gains / (losses) on disposal of assets	**21**	**(169)**
Fair value gains / (losses) on investment properties	-	100
Total other gains / (losses)	**21**	**(69)**

Note 12.1 Intangible assets - 2018/19

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**572**	**572**
Additions	58	**58**
Valuation / gross cost at 31 March 2019	**630**	**630**
Amortisation at 1 April 2018 - brought forward	**32**	**32**
Provided during the year	108	**108**
Amortisation at 31 March 2019	**140**	**140**
Net book value at 31 March 2019	**490**	**490**
Net book value at 1 April 2018	**540**	**540**

Note 12.2 Intangible assets - 2017/18

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**32**	**32**
Prior period adjustments	**-**	**-**
Valuation / gross cost at 1 April 2017 - restated	**32**	**32**
Additions	540	**540**
Valuation / gross cost at 31 March 2018	**572**	**572**
Amortisation at 1 April 2017	**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	**-**	**-**

Note 13.1 Property, plant and equipment - 2018/19

	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 2018 - brought forward	**13,050**	**22,281**	**155**	**22,501**	**6,518**	**10,869**	**690**	**76,064**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Additions	2,255	368	5,971	474	964	840	-	**10,872**
Impairments	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	-	**-**
Reclassifications	-	-	(155)	155	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(2,541)	(109)	-	**(2,650)**
Valuation/gross cost at 31 March 2019	**15,305**	**22,649**	**5,971**	**23,130**	**4,941**	**11,600**	**690**	**84,286**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**2,070**	**-**	**11,230**	**4,587**	**7,207**	**509**	**25,603**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Provided during the year	-	1,304	-	2,533	465	1,311	40	**5,653**
Impairments	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(2,541)	(109)	-	**(2,650)**
Accumulated depreciation at 31 March 2019	**-**	**3,374**	**-**	**13,763**	**2,511**	**8,409**	**549**	**28,606**
Net book value at 31 March 2019	**15,305**	**19,275**	**5,971**	**9,367**	**2,430**	**3,191**	**141**	**55,680**
Net book value at 1 April 2018	**13,050**	**20,211**	**155**	**11,271**	**1,931**	**3,662**	**181**	**50,461**

Note 13.2 Property, plant and equipment - 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
Valuation / gross cost at 1 April 2017 - as previously stated	**12,346**	**19,244**	**3,431**	**24,226**	**4,640**	**9,327**	**707**	**73,921**
Prior period adjustments	-	-	-	-	-	-	-	**-**
Valuation / gross cost at 1 April 2017 - restated	**12,346**	**19,244**	**3,431**	**24,226**	**4,640**	**9,327**	**707**	**73,921**
Transfers by absorption	-	-	-	-	-	-	-	**-**
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	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	**-**
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 - as previously stated	**6**	**3,823**	**-**	**12,045**	**4,306**	**6,094**	**489**	**26,763**
Prior period adjustments	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2017 - restated	**6**	**3,823**	**-**	**12,045**	**4,306**	**6,094**	**489**	**26,763**
Transfers by absorption	-	-	-	-	-	-	-	**-**
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	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	**-**
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 13.3 Property, plant and equipment financing - 2018/19

	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 2019								
Owned - purchased	15,305	19,275	5,971	9,367	2,430	3,191	141	**55,680**
Finance leased	-	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	-	**-**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	-	**-**
Owned - donated	-	-	-	-	-	-	-	**-**
NBV total at 31 March 2019	**15,305**	**19,275**	**5,971**	**9,367**	**2,430**	**3,191**	**141**	**55,680**

Note 13.4 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**
Finance leased	-	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	-	**-**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	-	**-**
Owned - donated	-	-	-	-	-	-	-	**-**
NBV total at 31 March 2018	**13,050**	**20,211**	**155**	**11,271**	**1,931**	**3,662**	**181**	**50,461**

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 Trust has assessed that the fair value of land and buildings has not moved significantly from the 31 March 2018 revaluation, as such no revaluation has been performed at 31 March 2019.

Note 15.1 Investment Property

	2018/19	2017/18
	£000	£000
Carrying value at 1 April	**980**	**880**
Movement in fair value	-	100
Carrying value at 31 March	**980**	**980**

Note 15.2 Investment property income and expenses

	2018/19	2017/18
	£000	£000
Investment property income	145	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 supporting the operation of community first responder groups, and the welfare of staff and strategic priorities of the Trust.

Note 17 Inventories

	31 March 2019 £000	31 March 2018 £000
Drugs	63	28
Work In progress	-	-
Consumables	789	661
Energy	519	365
Other	-	-
Total inventories	**1,371**	**1,054**

Inventories recognised in expenses for the year were £6,824k (2017/18: £8,370k). Write-down of inventories recognised as expenses for the year were £0k (2017/18: £5k).

The carrying amount of any inventories pledged as security for liabilities is nil (2017/18: £nil).

Note 18.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	4,174	
Trade receivables*		8,569
Allowance for impaired contract receivables / assets*	-	
Allowance for other impaired receivables	(202)	(117)
Prepayments (non-PFI)	9,973	11,089
Interest receivable	-	-
PDC dividend receivable	138	282
VAT receivable	304	474
Other receivables	2,665	285
Total current trade and other receivables	**17,052**	**20,582**
Of which receivables from NHS and DHSC group bodies:		
Current	3,389	7,314
Non-current	-	-

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Other receivables includes £1.323m in respect of sale and lease back assets in the course of completion (2018:nil).

Note 18.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward		**117**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	0	-
New allowances arising	-	85
Changes in existing allowances	-	-
Reversals of allowances	-	-
Utilisation of allowances (write offs)	-	-
Changes arising following modification of cotractual cash flows	-	-
Allowances as at 31 Mar 2019	**0**	**202**

The majority of contract receivables are held with Clinical Commissioning Groups, as commissioners for patient care services, as Department of Health & Social Care entities these are not considered to expose the Trust to credit losses.

Note 18.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables
	£000
Allowances as at 1 Apr 2017	**132**
Amounts utilised	(15)
Unused amounts reversed	
Allowances as at 31 Mar 2018	**117**

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.

	2018/19 £000	2017/18 £000
At 1 April	**9,144**	**4,175**
Net change in year	7,443	4,969
At 31 March	**16,587**	**9,144**
Broken down into:		
Cash at commercial banks and in hand	47	24
Cash with the Government Banking Service	16,540	9,120
Total cash and cash equivalents as in SoFP	**16,587**	**9,144**
Bank overdrafts (GBS and commercial banks)	-	-
Total cash and cash equivalents as in SoCF	**16,587**	**9,144**

Note 20.1 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	9,863	10,134
Capital payables	5,194	1,687
Accruals	11,442	11,598
Receipts in advance (including payments on account)	-	38
Social security costs	4,590	4,537
Other payables	2,743	2,741
Total current trade and other payables	**33,832**	**30,735**
Of which other payables relate to pension contributions:	2,682	2,617
Of which payables from NHS and DHSC group bodies:		
Current	497	1,211
Non-current	-	-

Note 21.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits*	Legal claims	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2018	**380**	**5,427**	**170**	**1,737**	**7,714**
Change in the discount rate	-	-	-	-	**-**
Arising during the year	32	225	280	2,239	**2,776**
Utilised during the year	(83)	(281)	(112)	(545)	**(1,021)**
Reversed unused	(8)	-	(20)	-	**(28)**
Unwinding of discount	1	15	-	-	**16**
At 31 March 2019	**322**	**5,386**	**318**	**3,431**	**9,457**
Expected timing of cash flows:					
- not later than one year;	42	281	318	3,330	**3,971**
- later than one year and not later than five years;	170	1,117	-	101	**1,388**
- later than five years.	110	3,988	-	-	**4,098**
Total	**322**	**5,386**	**318**	**3,431**	**9,457**

Pensions - Early Departure Costs, and Pensions Injury benefits
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 21.2).

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 £3.1m, 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.

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within Pensions - Early Departure Costs:

Note 21.2 Clinical negligence liabilities

At 31 March 2019, £29,461k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of East of England Ambulance Service NHS Trust (31 March 2018: £24,000k).

Note 22 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims	(76)	(66)
Net value of contingent liabilities	**(76)**	**(66)**

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 2019 £000	31 March 2018 £000
Property, plant and equipment	3,075	1,178
Intangible assets	-	-
Total	**3,075**	**1,178**

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 2019 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 Commissioners, which are financed from resources voted annually by Parliament. Cash flow management is undertaken to plan the timing of financial obligations. The Trust funds its capital expenditure from funds obtained within its prudential external financing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 24.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	6,637	-	-	**6,637**
Cash and cash equivalents at bank and in hand	16,587	-	-	**16,587**
Total at 31 March 2019	**23,224**	**-**	**-**	**23,224**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	8,737	-	-	-	**8,737**
Cash and cash equivalents at bank and in hand	9,144	-	-	-	**9,144**
Total at 31 March 2018	**17,881**	**-**	**-**	**-**	**17,881**

Note 24.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Trade and other payables excluding non financial liabilities	26,560	-	**26,560**
Total at 31 March 2019	**26,560**	**-**	**26,560**

	Other financial liabilities	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Trade and other payables excluding non financial liabilities	23,541	-	**23,541**
Total at 31 March 2018	**23,541**	**-**	**23,541**

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 2019	31 March 2018
	£000	£000
In one year or less	26,560	23,541
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	**26,560**	**23,541**

Note 25 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	-	-
Fruitless payments	-	-	-	-
Bad debts and claims abandoned	-	-	-	-
Stores losses and damage to property	16	6	7	6
Total losses	**16**	**6**	**7**	**6**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	1	17
Ex-gratia payments	17	116	37	155
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**17**	**116**	**38**	**172**
Total losses and special payments	**33**	**122**	**45**	**178**
Compensation payments received		-		-

Note 26.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

First time application of this standard has had no material impact on the 1 April 2018 balances or transactions.

Note 26.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

First time application of this standard has had no material impact on the 1 April 2018 balances or transactions.

Note 27 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
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 28 Events after the reporting date

No events have been identified after the end of the reporting period which require adjustment or disclosure.

Note 29 Better Payment Practice code

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	42,860	116,865	39,114	106,313
Total non-NHS trade invoices paid within target	40,599	102,666	35,138	91,320
Percentage of non-NHS trade invoices paid within target	94.7%	87.9%	89.8%	85.9%
NHS Payables				
Total NHS trade invoices paid in the year	394	1,489	578	1,908
Total NHS trade invoices paid within target	344	1,226	409	1,249
Percentage of NHS trade invoices paid within target	87.3%	82.3%	70.8%	65.5%

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 30 External financing

The trust is given an external financing limit against which it is permitted to underspend:

	2018/19 £000	2017/18 £000
Cash flow financing	**(813)**	**(4,829)**
Other capital receipts		
External financing requirement	**(813)**	**(4,829)**
External financing limit (EFL)	5,698	507
Under / (over) spend against EFL	**6,511**	**5,336**

Note 31 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	10,930	6,689
Less: Disposals	-	(208)
Charge against Capital Resource Limit	**10,930**	**6,481**
Capital Resource Limit	11,946	6,841
Under / (over) spend against CRL	**1,016**	**360**

Note 32 Adjusted financial performance	2018/19	2017/18
Adjusted financial performance (control total basis):	**£000**	**£000**
Surplus / (deficit) for the period	(2,071)	3,376
Departmental expenditure limit	-	(2,305)
CQUIN risk reserve adjustment (2017/18 only)	-	(976)
Adjusted financial performance surplus / (deficit)	**(2,071)**	**95**

Note 33 Breakeven duty financial performance	2018/19	2017/18
	£000	**£000**
Adjusted financial performance surplus / (deficit) (control total basis)	(2,071)	95
Remove impairments scoring to Departmental Expenditure Limit	-	719
Remove CQUIN risk reserve adjustment	-	976
Breakeven duty financial performance surplus / (deficit)	**(2,071)**	**1,790**

Note 34 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		757	2,364	3,121	4,175	379	1,251	158	(9,989)	1,790	(2,071)
Breakeven duty cumulative position	1,745	2,502	4,866	7,987	12,162	12,541	13,792	13,950	3,961	5,751	3,680
Operating income		228,076	222,389	226,874	235,499	237,725	245,982	232,190	247,134	266,929	281,740
Cumulative breakeven position as a percentage of operating income		1.1%	2.2%	3.5%	5.2%	5.3%	5.6%	6.0%	1.6%	2.2%	1.3%

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.

#WeAreEEAST

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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