NHS

South Central Ambulance Service

NHS Foundation Trust

ANNUAL REPORT & ACCOUNTS 2017/18

SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST

ANNUAL REPORT & ACCOUNTS 2017/18

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

CONTENTS


AMBULANCE

WELCOME FROM CHAIR, LENA SAMUELS

My first year as Chair has been focused on developing our stakeholder relationships in support of our strategy and in response to the significant changes taking place in the way care is provided across the UK. With the emphasis on collaboration in order to provide a more effective and efficient service, I have spent time with commissioners and other health providers to give SCAS a voice at the earliest opportunity to help shape and define care from that first moment when a patient makes that essential call to 999, 111 or our Patient Transport Service.

As an ambulance service we recognise the pressure that colleagues in the acute sector are under and I have spent valuable time with hospitals in our area understanding how we can work together more effectively to reduce delays in access to care.

Our staff whether at the frontline, in the call centres or working in administration and management have been essential in providing the high quality of care that we aim to deliver every day. It has been a privilege to spend time with them gaining a better insight into what they do. It has allowed me to truly appreciate the dedication and care they demonstrate when dealing with people needing care, often under highly pressurised circumstances. They are well supported by volunteers such as community first responders who contribute an enormous amount of their personal time to provide care and to raise charitable funds; as well as by co-responders such as those from Hampshire Fire and Rescue Service.

South Central Ambulance Service is the mental health lead for the sector and I was delighted to co-chair the inaugural Global Paramedic Leadership Mental Health Summit hosted by the Association of Ambulance Chief Executives and which saw contributors from Canada, the US, Australia and New Zealand. In the coming year, SCAS will strengthen its support for the wellbeing of its staff who invariably deal with traumatic events, as well look to raise greater awareness of best mental health practice so colleagues across the sector, including ourselves can continuously improve the care we provide in this regard.

Underpinning our service are the values of the organisation: caring, professional, teamwork and innovation. Bringing these to life has been a key priority in ensuring that we provide a consistently high service and where there are short falls, to address these swiftly and productively. To this end, over the last year we have focused on refreshing those values by updating our organisational development strategy and by embedding the Trust's values in the appraisal process. We will continue to encourage all of our staff and volunteers to embed these values in their daily practice.

The leadership of the organisation is fundamental to this and we have successfully recruited new non-executive directors to fill the posts of those who sadly came to the end of their term of office. My thanks go to Alastair Mitchell-Baker who has been with SCAS since it achieved foundation trust status and to David Williams. Going forward the NED appraisal process and their development will similarly follow the values-based approach adopted for staff.

Our Council of Governors similarly has an important part to play in upholding the values of the organisation whilst undertaking the core elements of their role by providing governance oversight and acting as ambassadors out in the communities across the areas that we serve. During the year elections were held to fill both public and staff governor vacancies and we welcomed a number of new governors as well as Barry Lipscomb into the role of appointed Lead Governor. A special thanks goes to Robert Duggan who stood down from this role and who remains as a governor for a third term as well as to Hampshire governors Ray Rowsell, Andy Bartlett and Paul Carnell and staff governors Debbie Sengelow, Michele Foote and James Birdseye for their dedicated service as governors who completed their terms.

In order to stay at the forefront of excellence, it is our intention to carry out an external, independent well-led review of the Board in 2018/19. The review will help us to evolve and apply best practice to the way that we govern and manage, which in turn will have a positive impact on the standard of care we provide.

The challenge and opportunity for any organisation in the health sector is to find new ways to meet the increasing demand for healthcare that aligns to budgetary constraints. Innovation, collaboration and finding new ways of working will continue to be at the heart of our commitment to providing the best possible care for the people who need us. Having started the year on a mission to build stronger alliances with our partners, it is pleasing to see that we are actively played into shaping new models of care that put the patient and quality at its heart.

Lena Samuels

South Central Ambulance Service (SCAS)

3,300 staff

1,000 volunteers

25 governors

868 vehicles

13,957 public members

100+ sites

CQC rated **'Good'**

15.26% cardiac arrest survival to discharge from hospital

'Best in England'

£215.6m income

999 **111** **PTS**

24/7

Ambulance Response Programme

Integrated Urgent Care

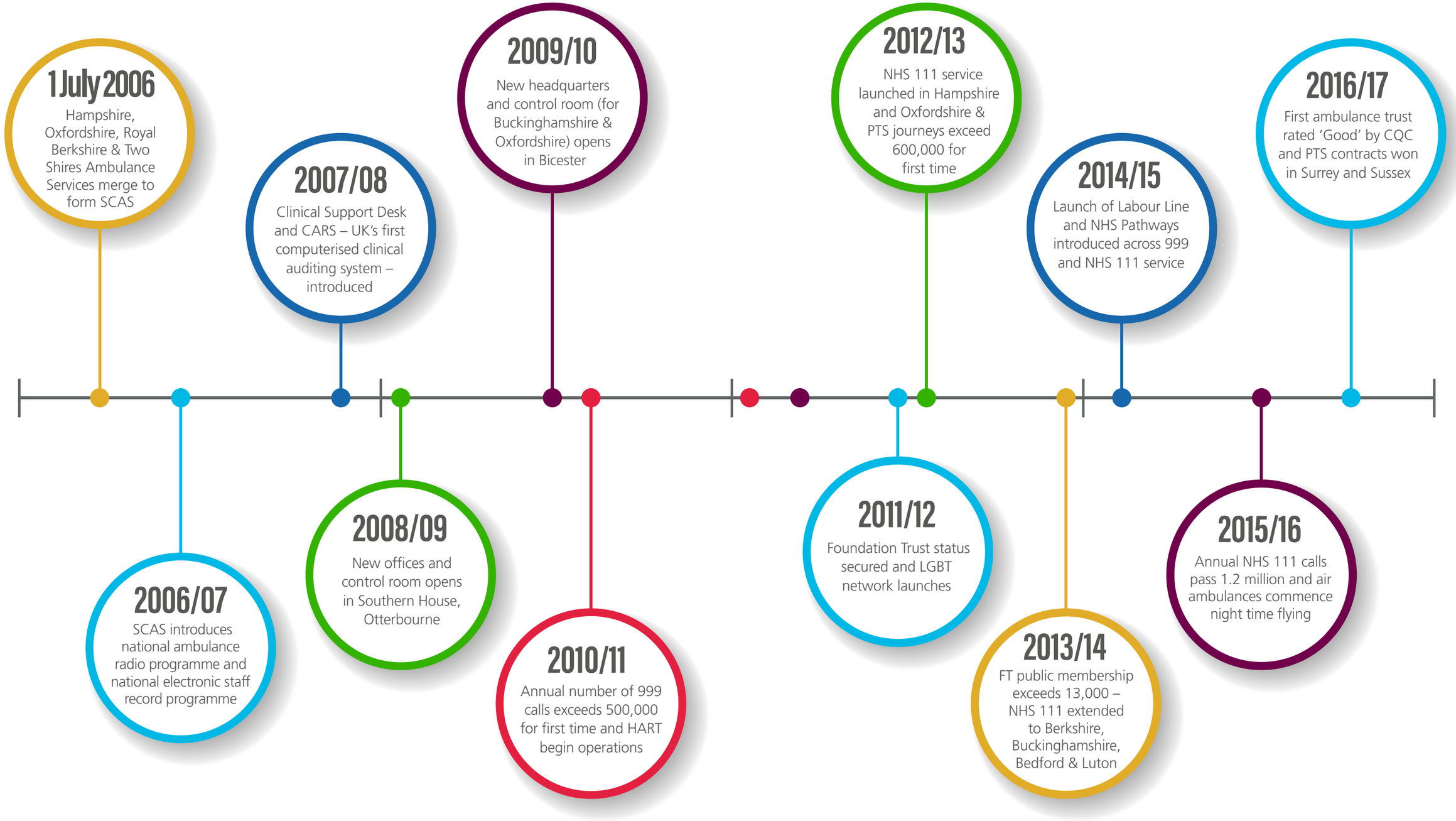
873,922 PTS journeys

567,217 emergency 999 incidents attended

1,200,000+ calls to NHS 111

PERFORMACE REPORT

This section includes the reflections of the Trust's Chief Executive on how the organisation has performed this year, a brief history of the Trust and the core services it provides, our mission, vision and areas of focus and how we aim to achieve them and the risks that could affect the Trust delivering its objectives.


1 July 2006
Hampshire, Oxfordshire, Royal Berkshire & Two Shires Ambulance Services merge to form SCAS
2006/07
SCAS introduces national ambulance radio programme and national electronic staff record programme
2007/08
Clinical Support Desk and CARS – UK's first computerised clinical auditing system – introduced
2008/09
New offices and control room opens in Southern House, Otterbourne
2009/10
New headquarters and control room (for Buckinghamshire & Oxfordshire) opens in Bicester
2010/11
Annual number of 999 calls exceeds 500,000 for first time and HART begin operations
2011/12
Foundation Trust status secured and LGBT network launches
2012/13
NHS 111 service launched in Hampshire and Oxfordshire & PTS journeys exceed 600,000 for first time
2013/14
FT public membership exceeds 13,000 – NHS 111 extended to Berkshire, Buckinghamshire, Bedford & Luton
2014/15
Launch of Labour Line and NHS Pathways introduced across 999 and NHS 111 service
2015/16
Annual NHS 111 calls pass 1.2 million and air ambulances commence night time flying
2016/17
First ambulance trust rated 'Good' by CQC and PTS contracts won in Surrey and Sussex

1. OVERVIEW OF PERFORMANCE

1.1 CHIEF EXECUTIVE'S FOREWORD

Thanks to the hard work and dedication of our staff and volunteers, SCAS is one of the country's leading ambulance services. The last 12 months has seen a great deal of progress, despite some considerable challenges, to achieving our ambition of becoming a world class service, enabling patients to get the right care, first time.

When I joined SCAS as the organisation's first Chief Executive in 2006, it was very much a traditional ambulance service: we attended emergency 999 incidents, assessed and treated patients at the scene and transported those requiring urgent medical attention to hospital. Fast forward 12 years and we now offer an integrated and innovative range of emergency, urgent and other healthcare services for the communities we serve.

Of course, over that time we have remained focused on prioritising those time critical patients suffering a life-threatening injury or illness to ensure they get the quickest response and best chance of survival. We have also, however, been able to develop a wider range of skills and now have greater access to information, so that we can treat more people at the scene of their emergency or in the comfort of their own homes, thus avoiding unnecessary and for our patients, sometimes anxious trips to hospital.

Our 999 staff working in our two clinical co-ordination centres and on the frontline, along with our volunteers and co-responder partners, faced some unprecedented challenges over the last 12 months. Pressure on hospital and social care services across our region mirrored those felt throughout the UK. The greatest impact of this demand on our own 999 service was the increase in handover delays experienced by our ambulance crews at A&Es; none of us want to see ambulance crews waiting sometimes many hours to be able to handover a patient. However, I have been heartened to hear from our patients and the many NHS partners I speak to, that despite such frustrations our staff have remained professional, caring and supportive in such circumstances.

I was delighted that this year we were able to not only retain the NHS 111 contract for the Thames Valley, but be trusted by our commissioners to begin the development of a new Integrated Urgent Care Service for the residents of Berkshire, Buckinghamshire and Oxfordshire. The new service builds on our existing experience and we can now help people access a wider range of clinical care through a single call, including dental, pharmacy and mental health services. The new Integrated Urgent Care service is a developmental service which allows for further innovations and changes to be introduced throughout the life of the contract including the use of text messaging and online symptom checkers.

SCAS is now the single largest NHS provider of non-emergency patient transport services (PTS) in the country following the contracts we won to provide such services in Surrey and Sussex going live at the very start of this financial year. Our PTS division has more than doubled in size in the last few years, and such rapid expansion has not been without its challenges, particularly in our newest regions.

The poor performance of the previous private sector provider in Sussex means it will take time to recover the quality and reputation of the service; but having recently spent time with the team in Sussex and been impressed with their knowledge, passion and expertise, I have no doubt that the improvements we are already seeing means we have the people in place to become the local provider and partner of choice.

The development, reorganisation and innovation of our own services mirror what is happening in the wider NHS and social care system. SCAS is a key partner across our region in a number of Sustainability and Transformation Partnerships (STPs) and Accountable Care Systems (ACSs). Such work is developing even closer relationships with our partners in hospitals, community health services, mental health services, social care organisations and local government. As these partnerships develop, there is more effective joint planning, services become more integrated and making the best use of available funding and resources locally, improves the overall health and wellbeing of the people we all serve.

For many patients we are the front door into the NHS – via our 999 or 111 services. As a result, demand on SCAS has increased exponentially over the last few years, driven by increasing frailty, an increasingly connected population through technology, a lack of access to other more appropriate services (or lack of awareness of how to access them), and the difficulties patients are increasingly finding in getting appointments with their GP (the other front door) when they want them. It is therefore essential that we are at the heart of plans to revolutionise old models of care, so that each patient is treated as a whole person, able to rapidly access the right, specialist services they need.

Because in the future we will play a more vital role for our patients and partners than ever before, it is therefore timely that SCAS published its new Five Year Strategy and Clinical Strategy towards the end of this financial year. These documents establish the roadmap on which our journey to a world class service will continue and more details about our plans can be found in the Quality Report section of this document.

As new services are launched, new technologies integrated and new processes embedded, our future success relies on what has made SCAS such a high performing organisation for many years. The professionalism, dedication, thoughtfulness and kindness of our staff and volunteers remains at the heart of everything we do and the firmest foundations we could have for our future success.

Will Hancock
Chief Executive

1.2 ABOUT US

South Central Ambulance Service NHS Foundation Trust provides a range of emergency, urgent care and non-emergency healthcare services, along with commercial logistics services. The Trust delivers most of these services to the populations of the South Central region – Berkshire, Buckinghamshire, Hampshire and Oxfordshire – as well as non-emergency patient transport services in Surrey and Sussex.

SCAS is a monopoly provider of 999 emergency ambulance services within the South Central region (as are all English ambulance trusts in their defined geographical areas); all other services the Trust delivers are tendered for on a competitive basis. With the expansion into Surrey and Sussex, we now serve a population of over seven million people across the six counties. We employ 3,300 staff who, together with over 1,000 volunteers, enable us to operate 24 hours a day, seven days a week.

What we do:

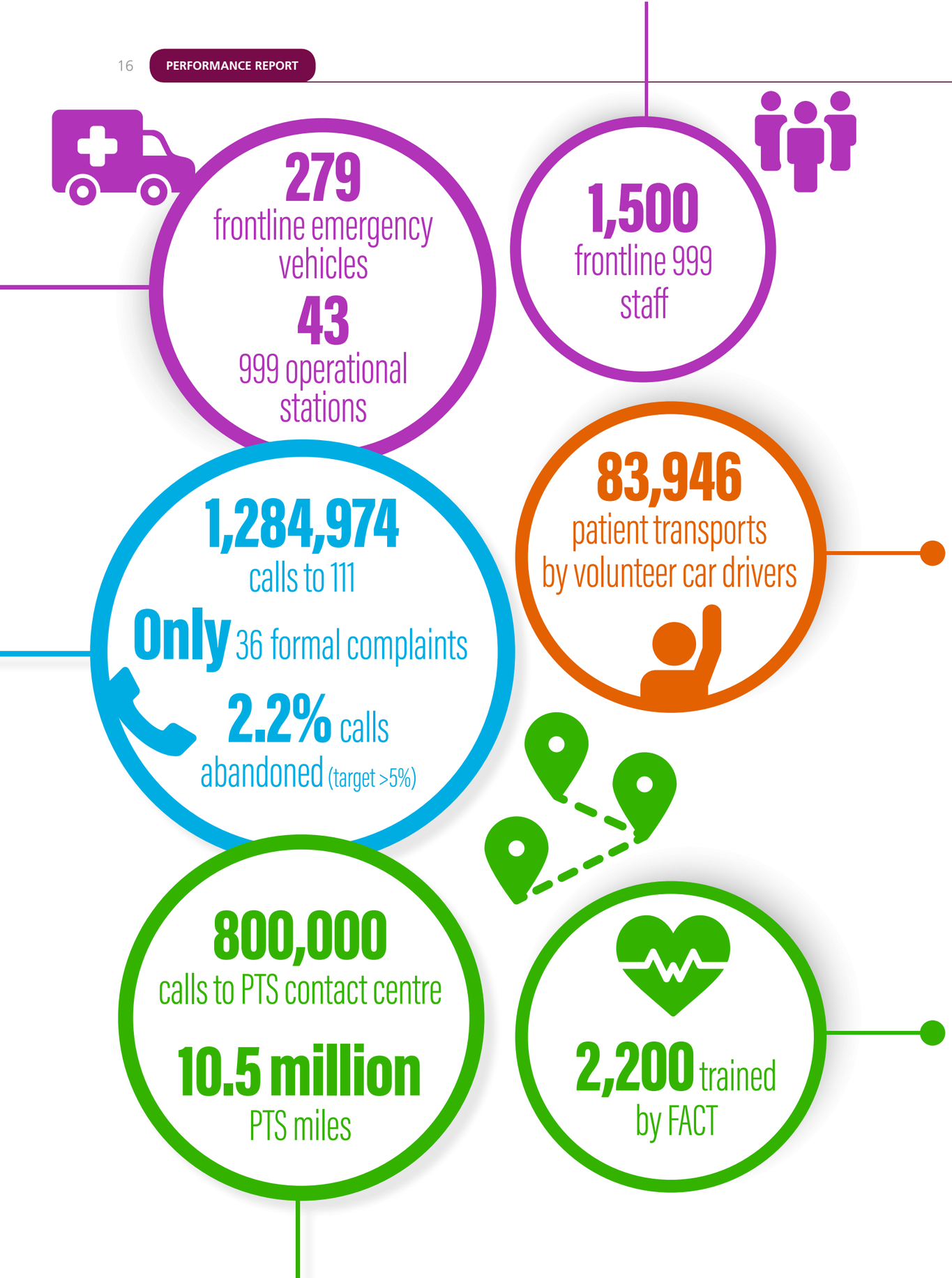
- Receive 999 calls in our clinical coordination centres in Bicester, Oxfordshire, and Otterbourne, Hampshire
- Respond to 999 calls by arranging the most appropriate resource from community first and co-responders, to rapid response vehicles, ambulances, air ambulances or a combination, and sometimes all, of these
- Provide the integrated urgent care service for the Thames Valley and NHS 111 service for Hampshire from our two clinical coordination centres
- Take eligible patients to and from their hospital appointments and treatments with our non-emergency patient transport service (PTS)
- Provide a commercial logistics service across Oxfordshire

Our vision

➔ Towards excellence - saving lives and enabling you to get the care you need

Our mission

➔ We are with you when you need us, providing help and professional mobile healthcare to you and your community



1.3 OUR STRATEGY

Our new five year strategy provides a roadmap for the development of our three major service lines to 2022:

- Mobile healthcare, including emergency response (999)
- Care coordination, including telephone assessment and signposting for 111 and 999
- Commercial services, including patient transport services (PTS)

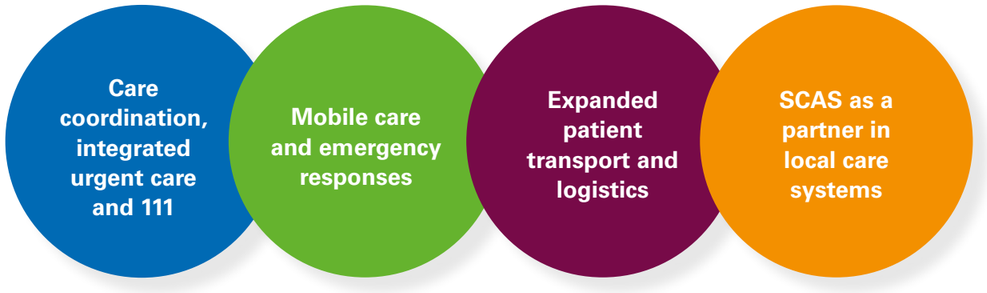
The last five years of modernisation across the NHS and social care have brought some significant changes in the way that our services are organised, accessed and delivered. Trends include:

- The provision of care through an increasing number of 'channels', including by telephone, video call and online and a rapid increase in the technology available to support this. Whilst some of these services support 'channel shift' allowing care to be provided in a different way, they are also used to provide additional capacity to cope with rising demand.
- The rapid consolidation of provider organisations and of commissioners, through mergers and acquisitions and other less formal partnerships, driven by the need to maintain quality whilst containing costs.
- The development of new organisational forms in the NHS, including the development of Accountable Care Systems bringing together commissioners and providers and new financial models.

Looking ahead, the key challenges facing SCAS are to improve the quality and effectiveness of patient care, and to support local systems in managing rising demand, within the context of tightening finances and increased competition. In particular, our strategic approach needs to reflect the following:

- Be mindful of the continued focus upon performance targets and quality of care, and ensure that we have plans in place to meet these expectations going forward. This should 'earn us the right' to take a leading role in any future changes which may arise through procurement opportunities, from the review of ambulance services and other national changes.
- SCAS will need to plot a careful course through the changing organisational structures. We cover a number of STP footprints, and our role within an ACS is less clear cut than it would be for many organisations. It is vital that we engage with this process and actively build alliances and partnerships, so that we can influence our own future.
- Anticipate and respond to the changing urgent care requirements, by developing and implementing our strategy for the creation of an Integrated Urgent Care Service.

Strategic themes



Since 2016, SCAS has been working with its local partners across our region's health and social care economies in the development and implementation of our four STP areas:

- Buckinghamshire, Oxfordshire & West Berkshire
- Hampshire & Isle of Wight
- Frimley
- Bedfordshire, Luton & Milton Keynes

As a result of our new PTS contracts, we are also now involved in both Surrey Heartlands and Sussex & East Surrey STPs. Whilst each STP reflects differing local priorities, they all share the following common themes:

- **Demand management:** Demand for health and care services is forecast to increase significantly due to demographic changes, and it is recognised that current service provision will not be able to cope fully with this demand. Each STP includes plans for improved prevention and increased self-care, together with redesigned and expanded primary and community care, intended to provide an alternative to hospital admission.
- **Primary, community and social care partners are grouping into 'hubs'** with the aim of offering better integrated services and extended hours, including evenings and weekend services
- **Digital and other technological developments** offer scope to find new ways to support people in their own homes.

These local priorities have several implications for SCAS, our strategy, objectives and organisational development:

- Enable patients to identify and access the care that they need first time
- Enable more people to stay safely in their own home or community
- Support efficient and effective patient flow around systems of care across 999, NHS 111 and PTS
- Align our services with the new hubs, potentially providing the technical infrastructure and clinical decision-making support required to deliver this new way of working

1.4 KEY ISSUES AND RISKS

The Trust has a robust risk management strategy which provides a basis for a well-managed risk assurance process to ensure safe services and an accurate record of risks. It is reviewed on an annual basis and approved by the Trust Board. It is published and made available to the public and stakeholders via the Trust's website.

The aims of this strategy are to:

- Integrate risk management into the Trust's culture and everyday management practice
- Clearly define the Trust's approach and commitment to risk management
- Raise staff awareness, knowledge and skills
- Document responsibilities and a structure for managing risk
- Ensure a coordinated, standard methodology is adopted by every directorate / department
- Encourage and support incident reporting in a 'fair blame' culture
- Ensure that the Trust Chief Executive and Trust Board are provided with evidence that risks are being appropriately identified, assessed, addressed and monitored
- Adopt an integrated approach to risk management, whether the risk relates to clinical, organisational, health and safety or financial risk, through the processes

In accordance with governance best practice and legislative requirements the Trust formally assesses and records all significant risks in a Corporate Risk Register and in the Board Assurance Framework. Risks are reviewed through the Risk, Assurance and Compliance Committee and the Audit Committee.

The Trust's aim is that the carrying out of suitable and sufficient risk assessments should become an integral part of everyday activity, becoming a pre-emptive approach to reducing accidents and adverse incidents rather than being reactive.

The Trust's principal risks have been identified as:

- Non achievement of NHS England Ambulance Response Programme standards
- Delays due to queuing at emergency departments, particularly at the Queen Alexandra Hospital in Portsmouth, impacting on patient care and safety
- Meeting compliance targets for statutory and mandatory training
- Delivery of the Surrey and Sussex non-emergency patient transport service contracts
- Achievement and realisation of annual cost improvements
- Managing sickness absence
- Compliance with the new General Data Protection Regulations
- Recruitment and retention of key clinical staff in 999 and 111 services

2. PERFORMANCE ANALYSIS

2.1 999 OPERATIONS

As well as responding to emergency 999 and urgent GP calls that you would expect from a traditional ambulance service, the expansion of our non-emergency NHS 111 and patient transport service means that SCAS now provides a much more integrated clinical assessment, sign-posting and advice service too.

We deliver our 999 services via an innovative and adaptive operating model which allows us to virtually split the 999 services across the Thames Valley & Hampshire. This model allows us then to further split our geography between 'nodes' which are:

- **Thames Valley**
  - North North – Milton Keynes
  - North East – Buckinghamshire
  - North West – Oxfordshire
  - North South – Berkshire

- **Hampshire**
  - South North – Basingstoke, Winchester and Eastleigh
  - South East – Portsmouth
  - South West – Southampton

Within Operations we have 43 stations where our fleet of over 279 specially equipped vehicles are located, and these are supported by established cover and standby points in areas of high demand, which allows us to deploy assets to patients in an effective and dynamic way.

To allow the dispatch of these assets we use a virtual Clinical Coordination Centre (CCC) split over two sites in Bicester and Otterbourne which allows us to dispatch via a virtual plan for call handling. This platform dispatches our clinical and specialist teams / departments 24 hours a day, 365 days a year.

To meet our demand, we have more than 1,500 paramedics, technicians and emergency care assistants on the road delivering excellent frontline care.

The way in which ambulance services are measured on their response to patients has changed. It was identified that the previous response time targets did not wholly meet the needs of patients. Therefore, a new set of national response standards have been developed with the aim of making sure the patients get the right response, first time.

Development and implementation of the Ambulance Response Programme (ARP) was supported by representatives from NHS England, ambulance services, the College of Paramedics, and the Association of Ambulance Chief Executives.

These changes are beneficial to patients and staff as making them prioritises the sickest patients, manages the demand peaks better and focuses on doing the right thing for patients.

What are the key benefits of ARP?

- Ensuring a timely response to patients with life-threatening conditions
- The most appropriate clinical resource is dispatched to meet the needs of patients based on presenting conditions, not simply the nearest, which means patients get to definitive care in a timelier fashion
- Fewer multiple dispatches = increased efficiency
- Reduction in diversion of resources
- Increases the ability to support patients through hear and treat, see and treat
- Having a transporting resource available for patients needing to be taken to a definitive place of care
- Improved patient experience

ARP was developed to address the complexities of time-based dispatch and move towards clinical prioritisation of patient needs, thereby reducing the rates of:

- Vehicle diversion
- Vehicle stand down
- Multiple vehicle allocation
- Long waits for less urgent calls

What does this mean for our patients?

- The sickest patients receive the fastest response
- Patients get the response they need first time, and in a timeframe that is appropriate for their condition
- Because resources are spread more equally amongst all patients the waiting times are reduced
- Patients living in rural areas receive a more equitable response

The new ARP processes support the dispatcher to allocate the most appropriate resource for each of type of incident in a timely way and without unnecessary over resourcing.

Performance against national ambulance service response targets 2017/18

1 March-30 October 2017

Red 1 Performance:	Red 2 Performance:	19 minute transportation:
73.9% (Target: 75.0%)	70.6% (Target: 75.0%)	94.2% (Target: 95.0%)

31 October 2017-31 March 2018

Category 1 - Mean	Category 1 - 90th Percentile	Category 2 - Mean	Category 2 - 90th Percentile
07:19 (Target: 07:00)	13:21 (Target: 15:00)	17:24 (Target: 18:00)	35:05 (Target: 40:00)

Cardiac arrest survival to leave hospital rates

Trust	2016-17		2017-18 YTD*
South Central	10.95%	South Central	15.26%
Isle of Wight	10.81%	Yorkshire	10.81%
Yorkshire	10.07%	West Midlands	9.91%
West Midlands	8.82%	Isle of Wight	9.47%
East of England	8.45%	North West	9.40%
North West	8.13%	East of England	9.03%
London	8.06%	North East	8.97%
South Western	7.80%	South Western	8.30%
East Midlands	7.44%	London	8.13%
North East	7.12%	East Midlands	7.80%
South East Coast	6.39%	South East Coast	7.43%
England average	8.43%	England average	9.18%

Source: NHS England, Ambulance Quality Indicators, Clinical Outcomes, published 10 May 2018

*April-December 2017

Furthermore, as an ambulance service we regularly work in close partnership with other blue light and emergency services in response to a wide range of incidents. As well as working together routinely, we also train together regularly in order that we can be prepared for emergency situations. The implementation of the Joint Emergency Services Interoperability Programme (JESIP) provides us with a framework to work closely with these other emergency services and responders.

Within the operations directorate in SCAS we have had another busy year with our continued focus on improved service delivery and patient care being at the heart of all we deliver and strive to achieve.

The single largest change that we as a Trust, and ambulance services nationally, have delivered was the implementation of ARP as described above. Since the implementation in October 2017, we have seen an improvement in our ability to respond to those patients who need us most, whilst also ensuring that we still give equitable care to all patient groups. With the implementation of ARP we are now reviewing our frontend model in terms of vehicle mix and rosters. We have established a project board to allow us to implement rosters that give us a patient centred approach to service delivery whilst we make sure our staff get an effective work-life balance.

We have also continued to maintain our focus on staff development and improvements within our teams as a more engaged and developed workforce delivers excellence. Therefore we have focused on our clinical workforce to upskill our paramedics to improve clinical ability and patient assessment whilst also reviewing our first line management tier (team leaders) to develop their managerial skills to allow them to better support their teams. We have also committed to recruit more specialist practitioners who will continue to enhance the care of those category three and four patients.

As SCAS is a top performing ambulance service with a capability to deliver care when called upon to do so, our Resilience and Specialist Operations (RSO) team has supported our colleagues nationally with their responses to terrorist incidents around the UK such as the Westminster Bridge, Manchester Arena, London Bridge terror attacks and the most recent Salisbury nerve agent attack. The Trust has been externally reviewed by the National Ambulance Resilience Unit (NARU), which identified us as a high performing RSO team. Since the review by NARU we have also invested in a new IT based system that allows us to deploy and mobilise our specialist staff in response to such incidents as well as giving us an ability to record and monitor our response.

This year has been a very busy year in terms of call volume and demand coupled with an ever increasing need to manage and work with our acute trusts to manage those hospitals that we have experienced excessive handover delays at; which impacts on our ability to respond to un-answered calls within our community. For example, at one of our acute trusts we lose on average circa 130 hours of ambulance cover a day as a result of handover delays at the hospital's emergency department; however we are working with them to improve this situation.

Finally we have continued to use innovation to deliver our service by working with partner agencies to target our responses to meet the ever changing needs of our patient groups. These initiatives include areas such as:

- **Frailty response initiatives** – We are working with an acute trust to develop a targeted response vehicle double crewed with an occupational therapist and paramedic to not only assess the patient who is frail and fallen from an acute perspective but also from an ongoing care need. This initiative has seen a marked improvement in reduced falls and acute admissions and has been recognised nationally as best practice.

- **Partnerships working with GPs** – This year we have further enhanced our partnership working with our colleagues in general practice. The main initiatives we are working on include GPs working within our clinical coordination centres (CCCs) to enhance the use of alternative pathways which patients can be referred to. We have also seen us increase our footprint in terms of the deployment of specialist paramedics (SPs) to work in primary care to help us manage our demand within the community before patients need to access the 999 systems.

- **New policies** – We have continued to review our policies and procedures to improve our working practices for our staff; one key one that we have reviewed is the meal break and end of shift policy. By reviewing this in partnership with internal stakeholders, to include HR and unions, we have been able to reduce the number of late jobs staff get whilst also improving our meal break compliance which both positively impact on staff welfare and health.

- **New services** – The launch of the Hyper Acute Stroke Unit at Milton Keynes University Hospital in October 2017, meant that local patients with suspected stroke were no longer taken to Luton and Dunstable University Hospital. Instead, they can now receive clot busting drugs more quickly in their local hospital within the crucial four hour window, resulting in faster recovery time and discharge back home.

2.2 INTEGRATED URGENT CARE AND NHS 111 SERVICE

In the last 12 months SCAS has continued to deliver the NHS 111 service to Hampshire, as well as launch the new Integrated Urgent Care service for the Thames Valley. This new service builds on the previous NHS 111 foundations and provides access for patients in Berkshire, Buckinghamshire and Oxfordshire to a wider range of clinical care - still through a single call to 111 - including dental, pharmacy and mental health services.

The new Integrated Urgent Care service for the Thames Valley was launched on 5 September 2017; SCAS led a collaboration of NHS providers (Berkshire Healthcare NHS Foundation Trust, Oxford Health NHS Foundation Trust and Buckinghamshire Healthcare NHS Trust) with the intention to close more 111 calls in the patient journey earlier in order to "consult and complete" with the patient rather than the previous NHS 111 model of "signpost and refer".

As part of the new Thames Valley Integrated Urgent Care (IUC) service we have extended our call centre technology into one of the partners in the alliance – Berkshire Healthcare NHS Foundation Trust – to ensure seamless delivery across our virtual network. Callers dialling 111 with complex clinical needs, who require review, referral to acute or other specialties can now be passed to a dedicated GP clinician based in Berkshire Healthcare's Wokingham hub who is working with our service. With our call centre telephones on desks in the Wokingham hub, the GP appears as a virtual extension on our network. We are able to see the GP on our call centre wallboards and telephony system as if they were sat in the same room as the rest of our clinical resource.

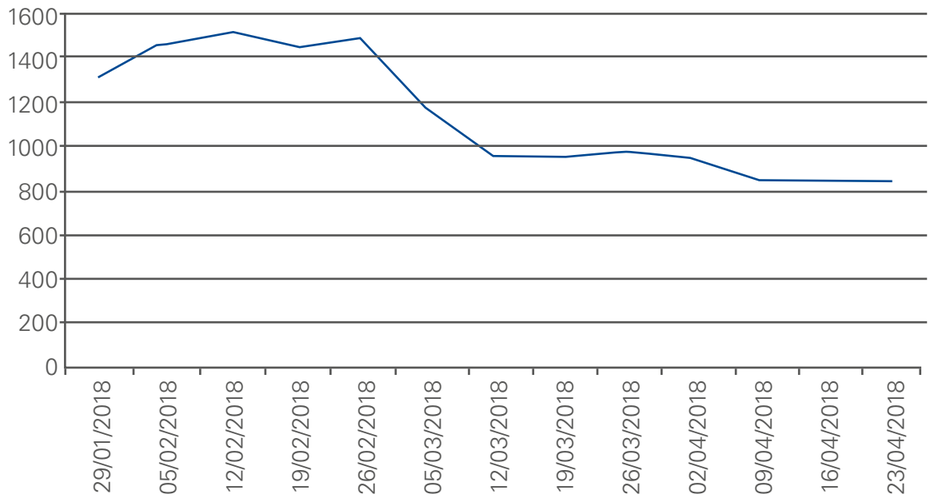
Five GPs currently provide input into the IUC service from the Wokingham hub, and we aim to utilise their additional skills and experience to provide enhanced clinical support to NHS 111 clinicians, as well as enhancing the support given to the following patient groups:

- Patients under five years of age
- Patients over 85 years of age
- Elderly and frail patients
- Complex clinical calls

The NHS 111 service at a national level is under pressure and inconsistent, and it has been a challenging 12 months for SCAS too. A considerable amount of work has been undertaken this year to address some long-standing difficulties that impact on the Trust's ability to meet all its key performance targets, most notably recruitment of call handlers and clinicians and improvement of sickness absence. That said, the Trust has a robust recruitment plan in place to try and mitigate staffing issues. As our experience in delivering the service builds year-on-year, we have a greater depth and breadth of knowledge of patient needs and historical call trends. However, and this year in particular, we have seen significant variabilities in demand, and when peak demand reaches levels of calls that are beyond our capacity, this places pressure on our service performance.

In the last quarter of 2017/18, we implemented a clinical validation process for all Category 3 and 4 ambulance dispositions by our 111/IUC clinicians. Under ARP, Category 3 and 4 calls are triaged as 'urgent' and 'less urgent', requiring an ambulance response within two and three hours respectively. This development is part of the IUC and the results are very encouraging; we have seen a significant reduction in our Category 3 and 4 dispositions to the ambulance service. For those that have been revalidated by a clinician, we have seen better outcomes in sign posting the patient to an appropriate outcome such as primary care or other local services.

111 to 999 Category 3 and 4



We acknowledge that across our 111 service call answer performance (percentage of calls answered within 60 seconds) remains below the 95% target, but when compared to other NHS 111 providers our performance is amongst the highest. In other key targets, the service is doing well; our call abandonment rate is low at just over 2%, we consistently transfer 111 callers to clinicians above our target of 30% of calls month-on-month and we have a low transfer to our 999 service of just over 10%. In addition, over the 2017/18 financial year the service received over 1.2 million calls but only 36 formal complaints, 165 informal concerns and 320 pieces of healthcare professional feedback. Such feedback provides valuable learning to help us improve our service.

Total calls offered
1,284,974

Total calls answered
1,193,215

Calls answered within 60 seconds
84.8%
(Target: 95%)

Calls abandoned
2.2%
(Target >5%)

Referrals to 999
124,055

Transfers to clinicians
425,294

2.3 COMMERCIAL DIVISION

The Commercial Division includes the following services:

- Patient Transport Services (PTS), which provides non-emergency patient transport over a large and expanding catchment area. Within PTS we operate a number of contracts across our core geographical area, and during the year mobilised new contracts across Surrey and Sussex
- The Logistics Service, which provides logistics support across Oxfordshire
- Call booking service/contact centre management for all PTS and logistics contracts
- First Aid and Clinical Training (FACT) for external companies and individuals

PTS activity for 2017/18 saw us deliver in excess of one million patient movements covering 10.5 million miles. Within our logistics contracts we have moved several million items covering around one million miles. The contact centres have answered nearly 800,000 calls during the year, and we trained over 2,200 individuals through our FACT business.

Patient Transport Service (PTS)

Since the commencement of our new PTS contracts we employ over 1,000 staff within the Commercial Division, supported by a large cohort of private providers utilised in Sussex which has a different operational model to that of our core PTS business. We currently use approximately 350 vehicles within the Commercial Division.

SCAS operates a service model which is designed to meet the diverse needs of patients, healthcare professionals (HCPs) and other stakeholders. It builds on our expertise in healthcare delivery and draws on our knowledge and experience, built up over 40 years, of providing patient-centric safe services that fully support the wider urgent and planned care system.

All our contracts have strict eligibility criteria to ensure transport is only utilised where there is an appropriate need. For patients deemed ineligible after assessment we will use our Directory of Alternative Transport (DAT) to signpost them to alternative travel options, including local travel cost schemes. This proven escalation process ensures that all eligibility criteria are applied correctly and patients' needs are met whether they are eligible or not.

We continue to benefit from the commitment of a fantastic cohort of volunteer car drivers, able to support walking patients eligible for non-emergency PTS transport. In the last 12 months, this amazing team has carried out 83,946 patient transports – around 9% of total PTS activity this year. The efforts of those in the Commercial Division who manage the team of volunteers, along with the volunteers themselves acting as ambassadors and taking part in recruitment activities, has allowed us to grow the team at the end of March 2018 to 191 active volunteer drivers (from 97 at the end of March 2017).

New contracts

On 1 April 2017 SCAS went live with two new contracts across Surrey and Sussex; through the mobilisation SCAS bought in 250 new team members through the TUPE process.

The Surrey contract is a five year agreement and is our only PTS contract that does not include renal transport, which is covered under a separate agreement. The contract also has a requirement for us to work collaboratively with community transport providers.

In Sussex, we have a three year agreement, which we took over as a step in provider following significant patient and public discontent with the quality and performance of the service. The short term mobilisation timeframe was extremely challenging, however the service is now stabilised. A recent Healthwatch survey carried out online and in face-to-face interviews, reported 85% of patients were either 'satisfied' or 'very satisfied' with the service.

Maintaining high standards

We are an ISO 9001:2015 accredited organisation and govern the service through our robust corporate and clinical assurance frameworks. SCAS is CQC regulated and ratings for the SCAS PTS are summarised below.

PTS overall rating	●	**Good**
Safe	●	**Good**
Effective	●	**Requires improvement**
Caring	●	**Outstanding**
Responsive	●	**Good**
Well-led?	●	**Good**

CQC ratings for SCAS PTS, September 2016

The CQC identified some areas for improvement within PTS, notably in terms of incident reporting and response; staff appraisal and inconsistent performance against target times for the arrival and collection of patients following hospital outpatient appointments or discharge. The CQC noted that:

"Care was outstanding in patient transport services where patients reported well developed supportive and caring and trusted relationships particularly regular users, such as renal or mental health patients. Patients appreciated this personal approach and the respect shown by staff for their social and emotional needs."

Service delivery

Our fleet utilises a full GPS tracking system using our Cleric system, supported by smartphone technology. This platform is used as the primary method of communication between our contact centre and road-based staff, as well as providing real-time performance data.

Our Fleet is continuously tracked via GPS with data including position and speed, with information continuously transmitted via systems to our contact centres. Vehicle location information is then recorded in real-time into our patient transport booking system, Cleric. This allows us to track our vehicles and patients, enabling us to monitor the service as it is being delivered, and to react to any unforeseen circumstances, resulting in both a caring and timely service.

All aspects of a patient's journey are logged on the smartphones and transmitted to the contact centre: this enables us to establish key timings for the patient journey, such as pick up or drop off to enable accurate measures of the KPI achievement.

Contact centre performance

SCAS provides a call handling, coordination and management service offering HCPs and patients round-the-clock access to our PTS online and telephony booking systems, seven days a week. We operate a virtual telephony platform across three contact centres based in Otterbourne, Bicester and Dorking. We also have two other contact centres in Sussex.

Following mobilisation of our new Surrey and Sussex contracts, achieving our call answer performance KPIs was challenging, largely due to limited call volume data available to us during contract mobilisation.

During the year we have seen mixed performance across some of our individual contracts. We acknowledge that across our contact centres, our call answer performance (percentage of calls answered within 60 seconds) remains below the 95% target.

However, towards the latter part of 2017/18, our contact centres have seen an improving picture for call answer performance. This is due to more reliable data now being available for expected call volumes relating to the new contracts and an ongoing recruitment campaign to ensure we have sufficient resources to deliver a high quality service.

Our contact centres are also responsible for the dispatching of crews to our patients on the day; this fundamental part of the PTS business sits at the heart of delivering our operational KPIs. This has been challenging, particularly in the early part of the year due to a high level of dispatcher vacancies, however this vacancy level has dropped throughout 2017/18 with a focused recruitment campaign.

PTS performance

All PTS SCAS contracts have key performance indicators (KPIs) which are essential for the contracting authorities to verify that the service we provide is effective, well-run and represents value for money. Within some of our contracts, some KPIs attract CQUIN payments to support achievement and some attract penalties for non-attainment.

The main KPIs across the PTS contracts are; patient arrival and patient collection, and time on vehicle. These are split out by patient category, namely renal patients (where applicable), outpatients, transfers / discharges and other. These are then further split by the booking time, whether it is a pre-planned booking or an on the day booking. Our KPIs vary across all of the contracts in terms of the timeframe we have to achieve performance against KPIs and the percentage target for each KPI.

Overall for 2017/18 we have seen a mixed performance picture, and in particular our Hampshire and Surrey contracts, in achieving a number of KPIs. Ongoing work is being undertaken to establish the correct level of resource hours required against demand and performance by area.

Across the Thames Valley throughout the year we have seen improving performance across most contract KPIs. We have worked collaboratively with our commissioners and system partners over the last 12 months to ensure we continue to maintain this strong focus, with particular focus on renal patients and to support our partners in earlier planning for on the day discharges.

There continues to be challenges with on the day bookings, which still remain very high and continue to impact daily operations as well as increase pressure on the dispatchers. There are ongoing discussions with CCGs across all contracts to establish a more sustainable way forward. Due to a lack of patient flow management in some of the acute hospitals, this resulted in our hospital liaison officers supporting operations and supporting with the movements of some complex discharges; this then impacts on the outpatient KPIs due to diverting resources to support discharges.

SCAS PTS continues to have significant recruitment activity across all areas. Although our retention appears low, this is because PTS is seen as the first step for a career within the ambulance service. This results in our staff moving on as part a well-trodden career development path into our frontline 999 service and other roles. Although this is a positive feature for the organisation providing clear career progression for new staff coming into the Trust, it provides operational challenges to our PTS management teams to be able to have sufficient in-house resources to deliver the service.

First Aid & Clinical Training

Within the Commercial Division we have for many years operated a commercial training business. This was responsible for delivering a range of clinical and non-clinical training courses for businesses and individuals mainly across the South Central region. Following a strategic review of our Commercial Division this year, particularly with respect to the external commercial environment where we have seen increased competition and a downward trend in course fees, the decision was made to cease the business from 28 February 2018, as it was no longer seen as core business within the division. Staff within the service were redeployed to our corporate education and training teams.

Logistics

Within our logistics business we service two contracts across Oxfordshire. Over the year we have transported millions of items including mail, specimens, blood samples, medical records and pharmacy and podiatry equipment. Within the logistics service we have approximately 40 vehicles and 45 staff members.

Transformation

On 29 June 2017, the proposed Commercial Business Strategy (2017-2022) was presented to the Board for approval. The strategy sets out a vision for:

- A modernised and expanded service
- Staff supported and developed to continue building the service towards profitable growth
- Delivering high quality patient care
- Becoming the provider and employer of choice for modern and innovative Patient Transport Services

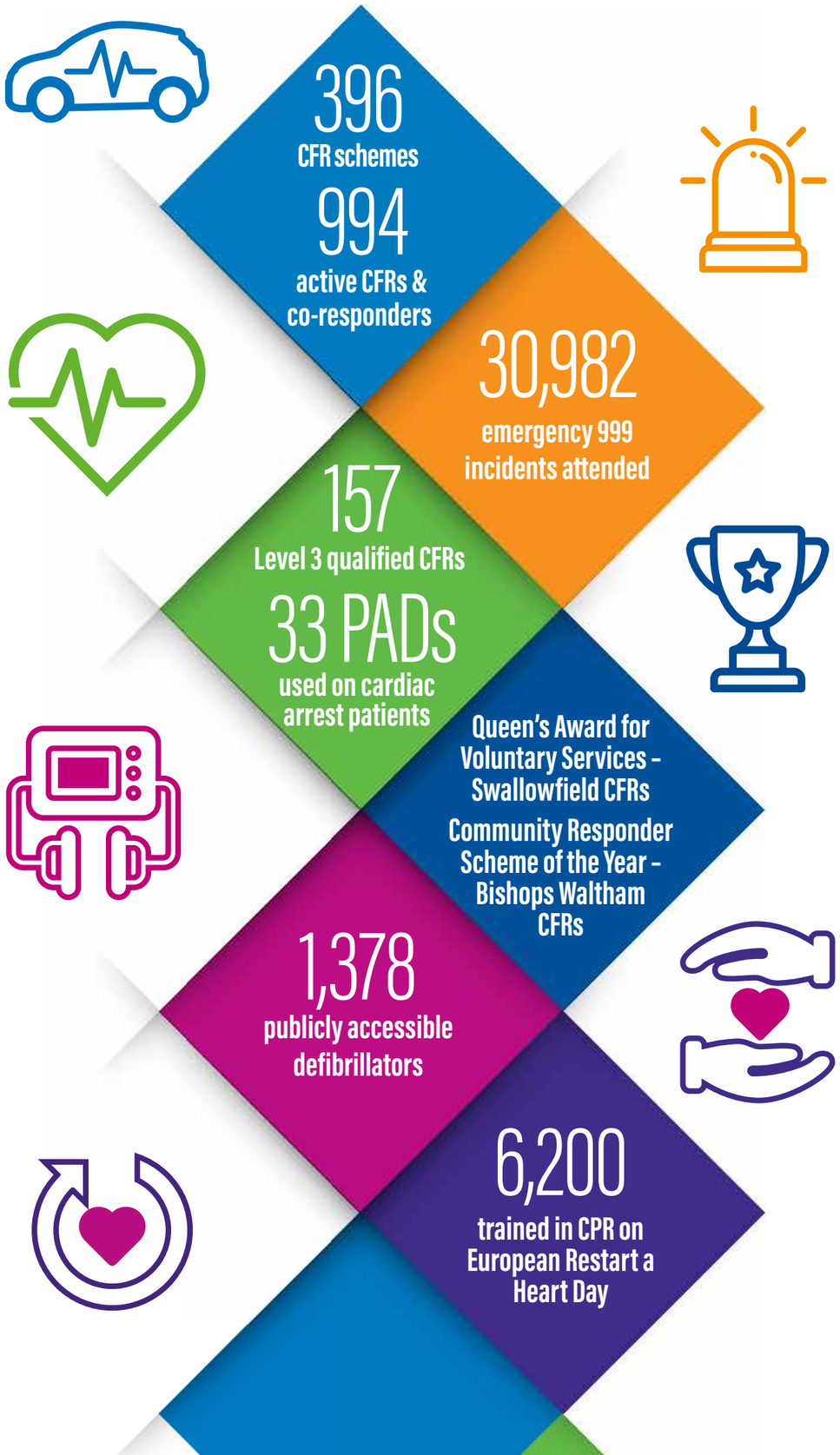
Approval was given to the strategy, and one of the objectives of the paper was to undertake a full commercial organisational transformation. This was identified to necessitate the better oversight and management of services within the recently expanded geography, but also to create a 'blueprint' for a modular structure that can be copied and applied to any new business expansion as it emerges.

Additionally, the expanded Commercial Division has grown so significantly that it now requires investment in, and improvement and modernisation of, the infrastructure that supports the day to day business activities.

Significant work has begun, and is ongoing with an end to end review of processes and procedures to ensure these meet the needs of the future business, and where possible supported effectively with existing or future technologies. The recent award of GDE status to the Trust presents an ideal opportunity to accelerate some of the innovation required to further optimise the service, and drive greater efficiencies for the future.

Further investment will have a positive impact on staff within the Commercial Division. It will be supported by a positive engagement campaign whereby staff have already been involved in the ongoing process redesign work, and they view this as a positive opportunity to reduce and eliminate frustrations they have already identified.

Additionally, a programme of development and training will be tailored to support staff working in new positions or in changed roles to help ensure that individuals are clear about their new roles, understand the background and rationale for the changes, and are properly equipped to deliver excellent patient care. The transformation consultation process will commence on 1 May 2018.



2.4 COMMUNITY RESILIENCE

SCAS continues to excel in providing healthcare and other services for the communities we serve. The Trust has further committed to investing in our local areas to help build a better, more resilient society and we achieve this by continuing to invest in the local communities through recruiting, training and developing a diverse team of community based volunteers who work side by side with our frontline staff to deliver care in medical emergencies.

SCAS has 396 community first response schemes and there are now 994 active community first responders (CFRs) and co-responders (an increase from 943 last year) who respond either within a three mile radius of their location or deploy themselves to cover an area of SCAS where our clinical coordination centres need them. Together, our CFRs and co-responders from the military, police and fire and rescue services have attended nearly 31,000 emergency 999 incidents for the Trust in 2017/18.

Community first responders	19,546
Fire co-responders	6,898
Military and police co-responders	4,538
Total	**30,982**

These volunteers have been trained to respond to specific life-threatening emergencies where patients may be suffering from a cardiac arrest, heart attack, breathing difficulties or a stroke. The ability of our CFRs and co-responders to be able to be at a patient's side to commence life-saving treatment, often within a few minutes prior to our first ambulance response arriving, makes a positive contribution and impact on the results the Trust has achieved this year in terms of some key Ambulance Quality Indicators, such as Return of Spontaneous Circulation (ROSC), stroke care and out-of-hospital cardiac arrest survival to discharge.

This year we have continued the rollout, commenced in 2016/17, of the Level 3 Certificate in Ambulance First Response; there are two pathways for the qualification – one for community first responders and one for co-responders. At the end of the financial year 2017/18, we had 157 CFRs who had achieved this national qualification.

SCAS conducted a successful pilot with 21 CFR schemes in Buckinghamshire, Berkshire and South East Hampshire to respond to non-injury falls. On average, SCAS receives around 180 calls a day relating to a patient who has fallen – that's over 65,000 calls a year. The CFRs involved in the pilot were sent to appropriate calls which had been assessed by paramedics or nurses on the Clinical Support Desk (CSD) within SCAS' Clinical Coordination Centres, and identified as a patient who was non-injured and only had a requirement for moving and handling. The pilot also involved CFRs attending silent alarm calls from care lines, where we need to respond but not necessarily with an emergency ambulance.

From 1 May to 25 June 2017, CFRs attended 57 non-injury falls incidents and only 11 of those patients needed to be conveyed to hospital; over the same period CFRs attended 137 concern for welfare incidents and only 21 of those patients needed to be conveyed to hospital. Previously, all the incidents attended would have seen a rapid response vehicle or ambulance sent to the patient as the first response. Such was the success of the pilot, that the scheme was approved by the SCAS Board in February 2018 to be rolled out across all 48 CFR schemes that have a dedicated response vehicle. Elderly and frail patients who may have been at risk of having a long wait for an emergency ambulance response for a non-injury fall, will now be able to be seen more quickly by our volunteer responders and helped off the floor. This is particularly beneficial not just because it ensures more ambulances and rapid response cars are available for patients suffering life-threatening emergencies, but also because it is proven that morbidity increases every hour that a frail and elderly patient is left on the floor without medical intervention.

The dedication and commitment of all our volunteer CFRs across SCAS was epitomised by Wokingham CFR, David Pickard, who chalked up his 1,000th call out in July 2017, the Swallowfield scheme being honoured with the Queen's Award for Voluntary Services (the highest award a voluntary group can receive in the UK), Bishop's Waltham Community First Responders crowned as 'Community Responder Scheme of the Year' at the UK Heart Safe Awards on 3 November 2017, and Bransgore Scheme Co-ordinator, Mike Jukes, receiving the Exceptional Volunteer Award at the Ambulance Leadership Forum 2018.

The last 12 months has seen a new responding partnership developed with the Hampshire Police Special Constabulary. This exciting new initiative is believed to be the first such scheme in the country; six special constables were trained by SCAS to develop and enhance the standard emergency first aid training they receive from Hampshire Police. The six constables went live towards the end of April 2017 and logon as available to SCAS whilst carrying out their normal duties. Operating in North Hampshire, the constables have been assigned to 101 category one and two emergency incidents (life-threatening and serious emergencies) and have achieved an average response time of less than five minutes.

In December 2017, Amanda Cundy, Co Responder Training and Liaison Officer (Armed Forces) and Military Champion at SCAS, along with some of our amazing Military Co Responders, attended the 10th Annual Military Awards, affectionately known as The Millies.

From thousands of entries, SCAS' Military Co Responders were shortlisted in the Hero At Home (Unit) category. The team's nomination highlighted how they had attended 5,626 incidents and undertaken an impressive 2,496 volunteering shifts between September 2016 and August 2017. This included being part of the emergency team at the scene of four cardiac arrest incidents where the patient had started breathing by the time they arrived at hospital. And all this was achieved on top of their day jobs in the Armed Forces.

The awards commenced with a reception at 10 Downing Street, hosted by the Secretary of State for Defence, Gavin Williamson, followed by a glamourous evening event at the Banqueting Hall in Whitehall, attended by a large number of VIPs and celebrities.

Our CFRs and community resilience team continue to focus on growing the number of publicly accessible defibrillators (PADs) installed in the South Central region, as well as training members of the public in how to perform cardiopulmonary resuscitation (CPR) or chest compressions, and how to use a defibrillator.

At the end of March 2018, there were 1,378 PADs in Berkshire, Buckinghamshire, Hampshire and Oxfordshire, and these had been assigned to 90 cardiac arrest emergencies and used on 33 patients. Once again, SCAS supported European Restart a Heart Day in October 2017, training over 6,200 local students and members of the public in life-saving skills. SCAS' Save a Life App, which was developed to be capable of providing a national database of all defibrillators, has now been extended to include its first non-South Central area with its adoption by Yorkshire Ambulance Service.

South Central Ambulance Charity

2017-18 has been a good year for South Central Ambulance Charity with income increasing both from our CFR-led fundraising activity and other, newer fundraising initiatives we have introduced. During the year we were supported by many individuals, companies and trusts who enable us to continue providing much needed support to our volunteers and our frontline staff in SCAS.

The year started with a substantial and very-well received grant from the Office of Civil Society as part of their Q Volunteering programme. The Charity was awarded £150,000 to develop new digital technology to support patients experiencing non-injury falls as well as to recruit further volunteers to support fundraising, administration and to join our CFR programme. The non-injury falls project trialled new technology in three parts of our region with our CFRs attending calls and receiving live video link with our clinical support desk to ensure the welfare and appropriate care for the patient. This meant that in those areas, patients received attention from our trained responders much quicker than previously. Due to the success of the project, the programme will be rolled out across the SCAS footprint in 2017-18 with a further grant from Q Volunteering to enable a further 200 CFRs to receive the necessary training to deliver this work.

Once again many individuals have supported the Charity by taking on challenges and organising events to raise funds ranging from running the Brighton and London Marathons to taking on the three peaks challenge to hiking from John O'Groats to Land's End. We are enormously grateful to them all. The number of individuals now playing the lottery in support of our Charity has increased and our recycling activity across Hampshire has raised £20,000 this year.

The level of individual donations from generous supporters has exceeded our expectations by over 100% with over £45,000 being generously given to the Charity by grateful patients, families and others who want to support our work. We must not forget those who at difficult personal times choose to support South Central Ambulance Charity by leaving a legacy or requesting donations in memory of a loved one. These gifts are a testament to the work our staff and volunteers do every day and by supporting us in this way families can know that our services will continue to be there for others when it is needed.

This year many of our CFR schemes have successfully applied for grants from the Co-op, Waitrose, Tesco and Asda among others. The continued support of these stores for charities is incredibly important in our local communities and has helped to fund important equipment and training for our CFRs. Other companies such as De Vere Wokefield, Ascot Racecourse, Liberty Global and the Chiltern American Women's Club and the support of the many Rotary Clubs, Freemasons, Lions Clubs and other community groups, continues to ensure our volunteers can carry on their life saving work across the SCAS region. Our CFRs continue to support our fundraising efforts with a wide variety of events and activities in their local communities which raise funds and ensure the ongoing success of our CFR programme.

As we continue to grow our Charity and fund new programmes and projects across SCAS so it becomes harder to thank everyone, but without this support, we would not be able to maintain our volunteer CFR programme and ensure they have the kit and vehicles they need to respond to emergencies. We would not be able to continue increasing the number of public access defibrillators out in our communities that help save lives and we would not be able to provide refurbished facilities within some of our ambulance stations which help support the welfare of our staff. There are many more projects and pieces of equipment that we would like to introduce for the benefit of all our patients so we look forward another year of fundraising and support for SCAS.

Thank you.

2.5 SUSTAINABILITY

The Trust will be undertaking a major overhaul of its Sustainable Development Plan in 2018/19. Unfortunately the Trust's Green Coordinator left the organisation in 2017/18 and has not yet been replaced. The Trust remains an active member of the Green Environmental Ambulance Network (GREAN) and will continue to play an active part in the local health sustainability working groups. These groups allow the Trust to keep up to date with the latest initiatives and engage in joint projects that will allow the Trust to lower its carbon emissions.

The Trust has an overseeing Green Committee that meets three times a year and monitors progress against strategy. The Committee is chaired by the Director of Finance, who is also the Board Sponsor, and comprises all of the main functional heads. The new Green Coordinator will undertake regular site visits identifying any areas of improvement from an environmental perspective.

Some of the initiatives that continue to have direct impact in the reduction of our carbon footprint include:

- ➔ All new ambulance vehicles meet Euro 6 standards using less fuel
- ➔ Introduction of Microsoft Office 365 which, along with video conferencing, will enable Trust staff to spend less time on travelling
- ➔ Introduction of e-expenses which will reduce paper usage and provide better visibility in relation to the nature of business travel
- ➔ Further approval of tranches of Cycle to Work schemes
- ➔ Lease car policy that limits vehicles to 100 CO2 g/km emissions

The Trust continues to work towards the Department of Health and Social Care initiative to reduce its CO2 emissions. Increased CO2 emissions in the table below are a reflection of higher demand on the Trust's 999 service and increased levels of PTS business, which result in greater vehicle usage.

Function	2016-17	2017/18
	Actual CO^2	Forecast CO^2
Fleet	11509	13215
Estates Related	3250	3273
Total	**14579**	**16488**

ACCOUNTABILITY REPORT

3. DIRECTOR'S REPORT

3.1 EXECUTIVE DIRECTORS 2017/18

Will Hancock
Chief Executive

In June 2006 I led the merger of the four ambulance services covering Hampshire, Oxfordshire, Berkshire and Buckinghamshire, becoming the first Chief Executive of the newly formed South Central Ambulance Service. In March 2012 the organisation achieved Foundation Trust status. In addition to my responsibilities with SCAS I lead nationally for the ambulance services in England on Finance, Mental Health Issues and Procurement & Outsourcing.

James Underhay
Deputy Chief Executive

I have held a number of senior operational and commercial roles in both the private and not for profit sectors, including at British Airways, KPMG and Turning Point, the UK's largest social enterprise providing health and social care services. I joined SCAS in 2012 as Director of Commercial Services, becoming the Trust's Deputy Chief Executive last financial year. I lead the growth of the organisation within the emerging competitive environment, to develop and deliver new services, which are integrated within our health economy. I also have operational responsibility for the effective and efficient delivery of all the Trust's non-emergency services, including our Patient Transport Service, and Healthcare Logistics Service, with particular emphasis on performance management, financial and contractual requirements.

Philip Astle
Chief Operating Officer

Following a 30-year Military career, retiring as a Colonel, I held a number of senior operational and leadership roles in both the public and private sectors. These have included director roles at Border Force, London Organising Committee of the Olympic and Paralympic Games, Chief Operating Officer at Her Majesty's Passport Office and Vice President of Menzies Aviation plc. I joined SCAS in March 2016 and lead the major operations of the organisation; our 999 and NHS 111 services. My role is to ensure that the Trust meets its core non-clinical operational objectives, complying with statutory and legal requirements, without sacrificing clinical standards, patient care and financial imperatives.

John Black
Medical Director

Since January 2000 I have worked as a Consultant in Emergency Medicine at Oxford University Hospitals NHS Foundation Trust and was appointed to the SCAS Trust Board in 2010 as Medical Director, having previously joined SCAS in 2007 as Divisional Medical Director for Oxfordshire and Buckinghamshire. My role is to support the strategic clinical direction of the Trust as well as to provide expert clinical advice to the Board and, together with the Director for Patient Care and Service Transformation, to provide assurance on the standards of clinical care delivered. I am also a member of the National Ambulance Service Medical Director's Group, and a member of the Army Reserve (Defence Medical Services).

Charles Porter
Director of Finance

Prior to joining SCAS in February 2007, I held a range of senior finance roles in the private sector, in the manufacturing, property and construction industries, including at BPB and John Laing. I also worked in practice for Price Waterhouse Coopers. I am primarily responsible for ensuring that SCAS has financial management and control systems in place which are fully compliant with the statutory instruments and guidelines. This ensures that we can monitor our financial performance and take decisions as the internal and external environment changes.

Professor Helen Young*
Director of Patient Care and Service Transformation

I have been an Executive Director of Nursing for over 15 years working at a number of trusts including Oxford University Hospital NHS Trust and Kings College Hospital NHS Foundation Trust. Prior to joining SCAS I was on the Board of Birmingham Women's and Children's Hospital NHS Foundation Trust. I also spent six years as Executive Clinical Director and Chief Nurse at NHS Direct shaping and developing the first clinical telephone assessment and virtual patient care services in the country. My role at SCAS is primarily responsible for ensuring the safe provision of high-quality, patient focused care, ensuring ongoing and consistent patient safety and quality standards and adherence to clinical controls and improvement in patient outcomes.

*(from 1 September 2017)
Deirdre Thompson (1 April-31 May 2017)
Jane Campbell (Acting) (1 June-31 August 2017)

Melanie Saunders
Director of Human Resources and Organisational Development

I started my career in HR during 1993, joining Oxfordshire Ambulance NHS Trust in 1996 and was appointed Director of HR & Governance in 2002. Following the establishment of SCAS in 2006, I secured the role of Assistant Director of HR (Operations) for the new Trust. I was appointed to the Board as Director of Human Resources & Organisational Development in April 2016. My role is to ensure that the Trust meets its strategic and operational aims by providing effective leadership, developing and delivering a successful Workforce, Education and Organisational Development Strategy.

3.2 NON-EXECUTIVE DIRECTORS 2017/18

Lena Samuels (Chair)

I started my career as a lecturer in further and higher education, and managed a training centre in London for young people at risk of exclusion. I currently run a company providing communications and training internationally in leadership, human rights and child protection on behalf of organisations such as the British High Commission, the National Crime Agency, CORAM, Bramshill Policing Advisers, UNICEF and UN Women. My healthcare sector experience includes non-executive director roles with University Hospital Southampton NHS Foundation Trust and Isle of Wight NHS Trust, as well as a Lay Advisor with Wessex Deanery.

Alastair Mitchell-Baker

I am a founding Director of Tricordant Limited, an organisational consultancy started in 2005 which specialises in whole systems organisation design and development, and have worked with numerous NHS, public sector, international NGOs, charities and commercial clients. I previously worked for 15 years in senior roles in the NHS, including as Chief Executive of a mental health and community trust and an executive director of a large acute hospital.

Sumit Biswas

Since 2004 I have worked as a consultant specialising in transformation, and programme and business change design and implementation. Prior to this I held director positions at Vodafone UK, Telewest and Thorn Rental. I was a non-executive director for NHS Oxfordshire Primary Care Trust (2006-2013) and have lived in Oxfordshire for 25 years.

Dr Ilona Blue

I have worked in the Civil Service for 15 years at the Home Office, Department for Work and Pensions, HM Treasury and am currently Deputy Director in Group Finance at the Department of Transport. Before joining the Civil Service, I undertook public health research. From March 2009 to October 2011, I was a non-executive director of South Central Strategic Health Authority.

Les Broude

I am a Chartered Accountant by background and spent 20 years with the Mars Group before moving to a senior executive role with Barclays Bank. Prior to joining SCAS, I was a non-executive director for Buckinghamshire Healthcare NHS Trust and Chairman of the Audit Committee. I am a Trustee for the Royal Hospital for Neuro-disability in Putney and Chair of the Audit Committee. I also coach CEOs of charities and social enterprises in leadership and personal development.

Nigel Chapman

I have had a long career as both CEO and Chair of major public sector organisations. In a senior managerial career in the BBC of over 20 years, I was in charge of English regional television and local radio, before moving to run the BBC World Service as its Director from 2004-2009. I am also a Trustee of Shelter UK, and Chair of NACRO (the National Association for the Care and Resettlement of Offenders).

Mike Hawker

I am a Chartered Accountant and after initially working in finance, moved into general management. I was the managing director of a start-up business, the merchandise director of a major home shopping business, and then the chief executive of several home shopping businesses owned respectively by British, French and German shareholders. I have been involved in new business development and in major change and rationalisation programmes. I have served as a non-executive director in a range of private and public organisations. Currently I am a Trustee/Director at the Shaw Trust and a member of the Audit and Risk Committee of the British Army.

Professor David Williams

I am a Professor of Global Oral Health at Bart's and The London School of Medicine and Dentistry, Queen Mary University of London. Previously I was Dean of the Faculty of Medicine, Health and Life Sciences and Professor of Pathology at the University of Southampton between 2004-10 and then Vice Provost between 2010-11. I was also a non-executive director of University Hospital Southampton NHS Foundation Trust.

It is the responsibility of the Board of Directors to prepare the Annual Report and Accounts, and they consider the Annual Report and Accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

3.3 BOARD OF DIRECTORS

The Trust's Board of Directors (the "Board") held six Board meetings in public between 1 April 2017 and 31 March 2018. The agendas, papers, presentations, and minutes of Board meetings are available on the Trust's website.

http://www.scas.nhs.uk/about-scas/our-board/board-meetings/

Decisions taken by the Board and delegated to management

The Board has overall and collective responsibility for the exercising of the powers and the performance of the Trust, and its duties include to:

- Provide effective and proactive leadership of the Trust
- Ensure compliance with the provider license, constitution, mandatory guidance issued by NHS Improvement, and other relevant statutory obligations
- Set the Trust's strategic aims at least annually, taking into consideration the views of the Council of Governors, ensuring that the necessary resources are in place for the Trust to meet its main priorities and objectives
- Ensure the quality and safety of healthcare services for patients, education, training and research delivered by the Trust, applying the relevant principles and standards of clinical governance
- Ensure that the Trust exercises its functions effectively, efficiently and economically, including in relation to service delivery
- Set the Trust's visions, values and standards of conduct and ensure that its obligations to patients and other key stakeholders are delivered

All Board members (executive and non-executive) have joint responsibility for decisions of the Board and share the same liability. All members also have responsibility to constructively challenge the decisions of the Board and help develop proposals on priorities, risk mitigation, values, standards and strategy.

The Board delegates certain powers to its sub-committees (not including executive powers unless expressly authorised). The executive team is responsible for the day-to-day running of the organisation and implementing decisions taken at a strategic level by the Board.

Board of Directors balance

The Board continually reviews its composition to ensure that it reflects the skills and competencies required to enable the Trust to fulfil its obligations.

The Board started 2017/18 with seven non-executive directors (NEDs), including the Chair, and seven executive directors, including the Chief Executive. Until 31 January 2018 the Chair had a second / casting vote for any decisions requiring a vote of the Board of Directors.

A new non-executive director, Les Broude, joined the Board on 1 February 2018 meaning the Board ended the year with eight non-executive directors, including the Chair, and seven executive directors, including the Chief Executive. All fifteen members had voting rights.

Lena Samuels, who was appointed as a non-executive director on 1 January 2017, assumed the Chair position on 1 April 2017 as planned.

On 1 April 2018, and again as planned linked to succession planning arrangements, Alastair Mitchell-Baker and Professor David Williams left the Trust and were replaced by Priya Singh and Anne Stebbing as new non-executive directors. Sumit Biswas has become Deputy Chair and Ilona Blue the Senior Independent Director.

During 2017/18, Deirdre Thompson left her position of Director of Patient Care (31 May 2017), with Jane Campbell formally acted up to the role prior to Professor Helen Young joining the Trust on 1 September 2017.

Board of Directors performance evaluation and review

The Board reviews its functioning and performance on an ongoing basis throughout the year. In line with the current 'well-led' regulatory guidance, an external and independent review of the Board also takes place every three to five years; the last review took place in 2014, and on current plans, and factoring in recent changes to the composition of the Board, the next review will be carried out in 2018.

During 2017/18 there have been a number of reviews with direct implications for the Board, including:

- The Trust, as with all other NHS providers, is assessed on an ongoing basis by NHS Improvement as part of its Single Oversight Framework regulatory approach. The reviews consider the following five elements:
    - operational performance
    - financial performance
    - quality of care
    - strategic change
    - leadership and improvement capability

  SCAS has been assessed throughout 2017/18 as being a segment 1 (maximum autonomy) provider, the best possible category.
- The Council of Governors' Nominations Committee, supported by the Chair, Director of Human Resources and Organisational Development and Company Secretary, have reviewed the non-executive director arm of the Board as part of a formal succession planning process. This considered, in particular, the skills and expertise required going forward and resulted in the appointment of Priya Singh and Anne Stebbing as new non-executive directors for the Trust with effect from 1 April 2018

In addition, to the processes outlined above, the Board has a systematic approach to assessing its collective performance including through the performance appraisal system. The 2017/18 appraisals of the Chair and non-executive directors included comprehensive feedback from the Trust's governors through a survey approach.

Reviews of the effectiveness of the key Board committees (e.g. Audit, Quality and Safety, Charitable Funds, and Remuneration) are also undertaken annually and presented to the Board (each May).

Governance

The Board uses the NHS Foundation Trust Code of Governance as best practice advice to improve governance practices across the Trust. Furthermore, the effectiveness of the Trust's governance arrangements is regularly assessed, including through internal audit.

The Trust was compliant with all aspects of the Code of Governance during 2017/18, with one exception. As mentioned previously, for a period of 2017/18 the Trust did not have an excess of non-executive directors over executive directors. This was as a result of reviewing the composition of the non-executive director element of the Board, and the skills required, linked to the recruitment exercise that took place in the second half of 2017. The appointment of the new non-executive director in February 2018 addressed this issue of non-compliance.

The Trust was compliant with its Constitution at all times during 2017/18.

The Board operates within a comprehensive structure and with robust reporting arrangements, which facilitates good information flows between the Board of Directors, various committees, and the Council of Governors.

The Trust maintains a register of Board members interests, gifts and hospitality, and this is presented on an annual basis at one of the Trust's Board meetings in public. Board members are also asked to declare any new interests at each meeting of the Board, or highlight any existing interest that might be relevant to the discussions at that meeting.

http://www.scas.nhs.uk/wp-content/uploads/Board-members-register-of-interests.pdf

The Board continues to apply the Fit and Proper Person Requirement regulations, satisfying itself that all current and newly appointed Board members fulfil the requirements. At each Board meeting in public, Board members are asked to declare whether there are any new factors which may impact on their ability to be regarded as 'fit and proper'.

Non-Executive Directors

Non-executive directors (NEDs) are members of the Board of Directors. They are not involved in the day to day running of the business, but are instead guardians of the governance process and monitor the executive activity as well as contributing to the development of strategy. They have four specific areas of responsibility – strategy, performance, risk and people – and should provide independent views on resources, appointments and standards of conduct. They are appointed by the Council of Governors, generally for terms of office lasting three years. Governors can also re-appoint NEDs and remove them if there are concerns about their performance or conduct. A policy is in place for the appointment / reappointment / removal of NEDs.

Non-executive directors have a particular duty to ensure appropriate challenge is made, and that the Board acts in the best interests of the public. They should:

- Bring independence, external skills and perspectives, and challenge strategy development
- Scrutinise the performance of, and hold to account, the executive management in meeting agreed objectives, receive adequate information, and monitor the reporting of performance
- Satisfy themselves as to the integrity of financial, clinical and other information, and that financial and clinical quality controls and systems of risk management and governance are robust and implemented
- Be responsible for determining appropriate levels of remuneration of executive directors and have a prime role in appointing, and where necessary removing, executive directors, and in succession planning

The Chair is one of the non-executive directors and is personally responsible for the leadership of the Board of Directors and the Council of Governors, ensuring their effectiveness on all aspects of their role and setting their agenda.

During 2017/18 the Trust had eight serving and voting non-executive directors, all of whom are independent:

NED	Date appointed to FT Board	Current term of office	Term
Lena Samuels (Chair)	1 January 2017	31 March 2020	First
Alastair Mitchell-Baker (Vice-Chair / Senior Independent Director)	1 March 2012	31 March 2018	Final
Sumit Biswas	1 July 2016	30 June 2019	First
Ilona Blue	1 March 2012	31 December 2019	Third
Les Broude	1 February 2018	31 January 2021	First
Nigel Chapman	1 March 2016	28 February 2019	First
Mike Hawker	1 January 2014	31 December 2019	Second
Professor David Williams	1 March 2012	31 March 2018	Final

Details of each non-executive director, including any declared interests, can be seen on the Trust's website at **http://www.scas.nhs.uk/about-scas/our-board/**

Executive Directors

The executive directors are responsible for the day-to-day running of the organisation, and the Chief Executive, as Accounting Officer, is responsible for ensuring that the organisation works in accordance with national policy and public service values, and maintains proper financial stewardship. The Chief Executive is directly accountable to the Board for ensuring that its decisions are implemented.

At the end of the 2017/18 financial year there were seven voting executive directors on the Trust Board:

Executive Director	Position
Will Hancock	Chief Executive
James Underhay	Deputy Chief Executive (Director of Strategy, Business Development, Communications and Engagement)
Philip Astle	Chief Operating Officer
John Black	Medical Director
Charles Porter	Director of Finance
Professor Helen Young	Director of Patient Care and Service Transformation
Melanie Saunders	Director of Human Resources and Organisational Development

Details of each executive director, including any declared interests, can be seen on the Trust's website at **http://www.scas.nhs.uk/about-scas/our-board/**

Board committees

The Board has four committees: Audit, Quality and Safety, Remuneration, and Charitable Funds.

The Audit and Quality and Safety Committees jointly oversee governance, quality and risk within the organisation and provide assurance to the Board.

The Audit Committee also seeks assurance that financial reporting and internal control principles are applied. Its members at the end of 2017/18 were Mike Hawker (Chair), Sumit Biswas, Ilona Blue, Professor David Williams and Les Broude, and five meetings were held during 2017/18.

The main focus of the Quality and Safety Committee is to enhance Board oversight of quality performance, and probe quality and care issues. Its members at the end of 2017/18 were Professor David Williams (Chair), Alastair Mitchell-Baker, Nigel Chapman and Sumit Biswas, and four meetings were held during 2017/18. Anne Stebbing will chair the committee from 1 April 2018.

The Remuneration Committee is responsible for ensuring that a policy and process for the appointment, remuneration and terms of service, and performance review and appraisal, of the Chief Executive, executive directors and senior managers are in place. Its members at the end of 2017/18 were Alastair Mitchell-Baker (Chair), Lena Samuels and Ilona Blue, and four meetings were held during 2017/18. Sumit Biswas will chair the committee from 1 April 2018.

The Charitable Funds Committee acts with delegated authority from the Board (the corporate trustee) to ensure that the South Central Ambulance Charity operates with appropriate governance. Its members at the end of 2017/18 were Nigel Chapman (Chair), Lena Samuels, Mike Hawker and Les Broude. Six meetings were held during 2017/18.

Attendance at meetings during 2017/18

The attendance at meetings during 2017/18 of those who have served on the Board, and reflecting their membership of the various committees, is as follows:

Name	Trust Board	Audit Committee	Quality and Safety Committee	Remuneration Committee	Charitable Funds Committee
Total meetings	6	5	4	4	6
NON-EXECUTIVE DIRECTORS					
Lena Samuels	6	N/A	N/A	4	6
Alastair Mitchell-Baker	5	N/A	2	4	N/A
Sumit Biswas	6	5	3	N/A	N/A
Ilona Blue	6	4	N/A	3	N/A
Les Broude	1/1	0/0	N/A	N/A	0/0
Nigel Chapman	6	N/A	3	N/A	6
Mike Hawker	6	5	N/A	N/A	5
Professor David Williams	5	5	4	N/A	N/A

Name	Trust Board	Audit Committee	Quality and Safety Committee	Remuneration Committee	Charitable Funds Committee
Total meetings	6	5	4	4	6
EXECUTIVE DIRECTORS					
Will Hancock	5	N/A	N/A	4	N/A
James Underhay	5	N/A	N/A	N/A	5
Philip Astle	5	5	3	N/A	N/A
John Black	5	0/0	N/A	N/A	0/0
Jane Campbell	2/2	N/A	1/1	N/A	N/A
Charles Porter	5	5	N/A	N/A	N/A
Melanie Saunders	6	N/A	N/A	4	N/A
Deirdre Thompson	0/0	N/A	0/0	N/A	N/A
Professor Helen Young	4/4	N/A	1/3	N/A	N/A

The table includes attendance by the Executive Director at Board Committees for which they are the Lead Director.

4. COUNCIL OF GOVERNORS

The Trust's Council of Governors (CoG) plays an essential role in the governance of South Central Ambulance Service NHS Foundation Trust (SCAS), providing a forum through which the Board of Directors is accountable to the local community.

The Trust's Constitution, reflecting relevant legislation, sets out the key requirements in respect of the functioning of the CoG. This includes its general functions, which are to:

- Hold the non-executive directors (NEDs) individually and collectively to account for the performance of the Board of Directors
- Represent the interests of the members of the Trust as a whole and the interests of the public

SCAS became a Foundation Trust on 1 March 2012; the period 1 April 2017 to 31 March 2018 represented the sixth full year of working for the SCAS CoG.

MEMBERSHIP AND MEETINGS

Membership of the CoG

The CoG is chaired by the Trust Chair, and has a full composition of 26 governors as follows:

- 15 elected public governors across four constituencies (Berkshire, Buckinghamshire, Hampshire and Oxfordshire)
- five elected staff governors
- three appointed local authority partner governors
- two appointed clinical commissioning group partner governors
- one appointed partner governor (the air ambulance charities)

The CoG elects a Lead Governor; Barry Lipscomb served in this position throughout 2017/18.

The CoG started the year with 23 governors in place. The three vacancies at this point related to the Buckinghamshire public governor constituency (two vacancies) and the patient transport service staff governor constituency.

The CoG ended the year with 25 governors in place and therefore one vacancy (local authority partner constituency).

There were a number of changes to the composition of the CoG during the year, including as a result of the Autumn 2017 public and staff governor elections. At these elections, four governors were re-elected and 10 governors were elected for the first time.

Details about each governor, including biographies and declared interests, can be seen on the Trust's website at:

https://www.scas.nhs.uk/about-scas/council-of-governors/meet-our-governors/

Formal meetings of the CoG

Five formal meetings of the CoG were held during 2017/18: in April 2017, July 2017, October 2017, November 2017, and January 2018. Four of the five meetings were held in public, and in accordance with the Trust's Constitution (i.e. fully quorate).

The additional meeting, in November 2017, was a confidential meeting in private to consider the recommended appointment of three new NEDs (the minutes of this meeting were presented at the subsequent meeting in public in January 2018).

All five meetings were chaired by the Trust Chair, and were well attended by Board members, including NEDs.

Details of all CoG meetings in public can be found at:

https://www.scas.nhs.uk/about-scas/council-of-governors/council-of-governors-meetings/

The table on page 68-69 reports on the attendance of governors at formal meetings of the CoG. This is also reported in the Trust's Annual Report, as a specific requirement of the ***NHS Foundation Trust Reporting Manual.***

Other meetings of the CoG

The CoG has two formal sub-committees; the Nominations Committee, and the Membership and Engagement Committee. Details of their meetings and work programmes are explained below.

Two joint CoG and Board working meetings were held during the year; in June 2017, to consider member and public engagement, and in February 2018, to obtain the views of the governors on the Trust's strategy in respect of local integrated care systems.

DUTIES AND FUNCTIONS

Delivery of specific statutory duties

The governors have a range of specific statutory duties; all of the statutory duties relevant to 2017/18 were satisfactorily discharged.

Duty		Comments
Receive annual accounts, auditor's report and annual report	✓	Received annual accounts and reports at the July 2017 meeting.
Appoint and, if appropriate, remove the external auditor	✓	The CoG approved a new external audit appointment in 2017/18 (Grant Thornton), supported by the work of a governor task and finish group.
Directors must have regard to governors' views when preparing the forward plan	✓	The CoG and Board hold an annual joint strategy workshop at which the Trust's future plans are discussed. Governors were part of a major refresh of the Trust's strategy, which took place during 2017/18. The annual strategy workshop on 7 February looked at SCAS' role in integrated care systems.
Appoint and, if appropriate, remove the Chair	N/A	In 2016/17 the CoG approved the appointment of a new Chair, which came into effect on 1 April 2017. Governors were extensively involved in the 2017/18 appraisal of the Chair.
Appoint and, if appropriate, remove the other non-executive directors (NEDs)	✓	During 2017/18, and following a process led by the CoG, three new NEDs were appointed (one started on 1 February 2018 and the other two on 1 April 2018). Governors were extensively involved in the 2017/18 appraisal of the NEDs.
Decide remuneration and terms of conditions for Chair and other NEDs	✓	During 2017/18 the CoG accepted a recommendation from the Nominations Committee that the remuneration level for the NED who chairs the Charitable Funds Committee be increased from £12k to £15k.
Approve appointment of Chief Executive	N/A	No new appointment was made in 2017/18.
Approve significant transactions	N/A	No significant transactions required approval in 2017/18.
Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution	N/A	No such applications occurred in 2017/18.
Decide whether the Trust's non-NHS work would significantly interfere with its 'principle purpose'	N/A	This was not required during 2017/18.
Approve amendments to the Constitution	N/A	No constitutional amendments were proposed during 2017/18.

Delivery of other duties and functions of the CoG

There are general duties for the governors in relation to holding the Board of Directors to account for the performance of the Trust via the NEDs, and in representing the interests of the members and the public.

A range of mechanisms are in place to support the governors with their holding to account role, including (but not exclusive to):

- All formal meetings of the CoG include an update from the Chief Executive on key strategic issues and operational performance, with an opportunity for governors to ask questions. The format of CoG meetings is such that governors can hear from the NEDs how they seek assurance and hold the executive directors to account for improving the performance of the Trust, and ask questions about this.
- Six Board meetings in public are held each year, and governor attendance at these has been strongly promoted. Governors are able to ask questions at the meetings, with the responses recorded in detail in the Board minutes
- The Trust ensures that the governors receive the papers for Board meetings one week ahead of the meeting, and the minutes on a timely basis subsequent to the meeting having taken place
- Governors have been invited to 'buddy up' with one of the Trust's NEDs to help develop their understanding of how the NEDs seek assurance over the day-to-day running of the organisation
- Governors have a detailed involvement in the appraisal of the Chair and NEDs
- Information is regularly circulated by the Company Secretariat to keep governors up-to-date on key Trust issues, developments, and performance with any questions and comments being responded to as appropriate.

During 2017/18, most of the Trust's governors in post at the end of the year had attended at least one of the Board meetings in public.

The work of the Membership and Engagement Committee has been key to the governors' other general duty of representing the interests of the members and the public. During the course of the year, governors have attended a range of membership recruitment and engagement events, and used other opportunities to meet with Trust members and members of the public to ascertain their views on the Trust.

In March 2018, a number of governors participated in a focus group meeting with representatives from the Care Quality Commission, and there is likely to be further engagement between the CQC and the CoG in 2018/19 as part of the regulatory approach.

CoG SUB COMMITTEES

Nominations Committee

One of two formal sub-committees, the Nominations Committee is chaired by the Trust Chair and has four other governor members (the Lead Governor and one governor each from the categories of local authority, staff and public).

The Nominations Committee has met, or held teleconferences, formally on four occasions during 2017/18; meeting attendance levels can be seen at page 68-69.

During the year, and with delegated authority from the CoG, the Nominations Committee has performed a range of tasks including:

- Overseeing an extensive and competitive recruitment process for the successful appointment of three new NEDs
- Developing processes for the 2017/18 Chair and NED appraisals

In addition to the four formal meetings or teleconferences, a number of the committee members were involved in supplementary activities such as long-listing, short-listing and interviewing for the NED vacancies.

Membership and Engagement Committee

The CoG already has an established Membership and Engagement Committee, whose main role is to recommend strategies to the CoG for the recruitment of, and engagement with, Trust members.

The Membership and Engagement Committee ended the year with six members, comprising five public governors, and one appointed partner governor.

The Membership and Engagement Committee has met on four occasions during 2017/18; meeting attendance levels can be seen at page 68-69.

During the year, the Membership and Engagement Committee has:

- Overseen development of the 2017-19 Membership and Public Engagement Strategy
- Agreed a Foundation Trust Membership Plan for 2017/18, and monitored progress throughout the year
- Contributed to the development of the Trust's annual member satisfaction and patient care survey
- Considered how governors can support the work of the SCA Charity

GOVERNOR SUPPORT, TRAINING AND DEVELOPMENT

The Trust has a formal duty to ensure that governors are equipped with the skills and knowledge they require to undertake their role; during the course of the year the Trust has supported governors in this respect. In addition to the mechanisms outlined to support the general duties of governors, the Trust has:

- Provided a comprehensive and tailored induction programme for all new governors
- Provided opportunities for governors to develop their understanding of the work of the Trust and its NEDs, including visits to the call centres, crew ride-outs, and attendance at Board committee meetings (a new initiative)
- Provided access to relevant external training as provided by NHS Improvement and NHS Providers (for instance, NED recruitment training for governors on the Nominations Committee; events aimed at lead governors)
- Arranged internal training and briefing sessions from time to time in accordance with governor needs, including equality and diversity training
- Issued regular briefings and bulletins on SCAS and the wider NHS

The governors approved a 'Governor Development Plan' at the CoG meeting in January 2018; this will consider further requirements in terms of support and training.

CONTACTING A GOVERNOR

The governors act as your voice. If you wish to raise an issue or have any ideas or suggestions you can contact your governor to relay these to the Trust. If you know who the public, staff or nominated governor who represents your particular constituency is then please contact the Membership Office who will pass on your query to them. If you do not know who your representative is, the membership office will also help you to identify the appropriate person.

Write to:

FREEPOST Communications – membership
South Central Ambulance Service NHS Foundation Trust
Freepost RSJY-USUX-GKBE
7-8 Talisman Business Centre
Talisman Road
Bicester
Oxfordshire
OX26 6HR

Or email getinvolved@scas.nhs.uk

Members of the Board of Directors can be contacted using the same details above.

CONCLUSIONS AND PRIORITIES FOR 2018/19

Conclusions

The CoG has overseen some major achievements during 2017/18 and helped contribute to the overall success of the Trust. It has appointed three new NEDs and effectively delivered all of the relevant statutory duties.

It is considered that the CoG has a good working relationship with the Board of Directors, and directors regularly attend CoG meetings to answer questions, participate in discussions, and help the governors deliver their statutory duties. In turn, the Trust has benefitted from the perspectives brought by a diverse group of governors, and this has been demonstrated in recent years by the governors' input to strategy discussions and CQC inspection processes.

Priorities for 2018/19

The CoG has identified the following priorities for 2018/19:

- Contributing to the development of the Trust's future strategic priorities and forward plans, in a complex and challenging environment and with a strong focus on local systems working together
- Given the challenges faced by the NHS, continuing the strong focus that the governors have in terms of holding the Board to account, via the NEDs, for the performance of the Trust
- Reflecting a continually growing membership that now stands at over 17,000 (public and staff), further developing arrangements for engaging with the Trust's membership and ensuring that the interests of members are suitably represented and that their views are brought to the attention of the Trust
- Continuing to review the effectiveness of the CoG to ensure that the governors are appropriately supported to deliver their roles, that value is added where appropriate, and the functioning of the CoG is delivered in the most cost effective way

Attendance at meetings for all governors who served during 2017/18[1]

Governor	Constituency	Current term of office	Formal CoG meetings[2]	Membership and Engagement Committee	Nominations Committee (exc. teleconferences)
Paul Ader	Public – Oxfordshire	1/3/2017 – 28/2/2020	5/5	4/4	N/A
Andy Bartlett	Public – Hampshire	1/3/2018 – 28/2/2021	4/5	N/A	N/A
James Birdseye[3]	Staff – 999 North	1/3/2015 – 28/2/2018	3/5	N/A	N/A
David Burbage[4]	Partner – Local Authority	1/10/2014 – 30/9/2017	0/2	N/A	N/A
Paul Carnell[5]	Public – Hampshire	1/3/2015 – 28/2/2018	4/5	N/A	N/A
Sabrina Chetcuti	Partner – CCG	1/7/2016 – 30/6/2019	5/5	N/A	N/A
David Chilvers	Partner – CCG	1/7/2016 – 30/6/2019	1/5	N/A	N/A
Jeanette Clifford	Partner – Local Authority	1/10/2017 – 30/9/2020	2/3	N/A	N/A
Richard Coates	Public – Hampshire	1/3/2017 – 28/2/2020	5/5	N/A	N/A
Bob Crocker	Public – Buckinghamshire	1/3/2018 – 28/2/2021	N/A	N/A	N/A
Emma Crozier	Staff – PTS	1/3/2018 – 28/2/2021	N/A	N/A	N/A
Mark Davis	Public – Berkshire	1/3/2017 – 28/2/2020	3/5	3/3	N/A
Bernadette Devine	Public – Buckinghamshire	1/3/2018 – 28/2/2021	N/A	N/A	N/A
Lynne Dove-Dixon	Staff – Corporate/support	1/3/2018 – 28/2/2021	N/A	N/A	N/A
David Drew	Partner – Charity	1/10/2017 – 30/9/2020	3/3	2/2	N/A
Bob Duggan	Public – Buckinghamshire	1/3/2018 – 28/2/2021	4/5	4/4	4/4
Jim Dunderdale	Staff – Contact centres	1/3/2018 – 28/2/2021	N/A	N/A	N/A
Frank Epstein	Public – Berkshire	1/3/2017 – 28/2/2020	4/5	N/A	N/A
Michele Foote[6]	Staff – Contact centres	1/3/2015 – 28/2/2018	3/5	N/A	N/A
Mike Fox-Davies[7]	Public – Oxfordshire	1/3/2017 – 28/2/2020	1/1	N/A	N/A
Colin Godbold	Public – Berkshire	1/3/2018 – 28/2/2021	4/5	N/A	N/A
Stephen Haynes	Public – Oxfordshire	1/3/2018 – 28/2/2021	N/A	N/A	N/A
Keith House	Partner – Local Authority	1/3/2018 – 28/2/2021	2/5	N/A	4/4
Joyce Hutchinson[8]	Public – Oxfordshire	1/3/2017 – 28/2/2020	1/2	N/A	N/A
Loretta Light	Public – Oxfordshire	1/3/2018 – 28/2/2021	N/A	N/A	N/A
Barry Lipscomb	Public – Hampshire/Lead	1/3/2017 – 28/2/2020	4/5	3/4	4/4
David Luckett MBE	Public – Hampshire	1/3/2017 – 28/2/2020	2/5	2/2	N/A
Charles McGill MBE	Public – Hampshire	1/3/2018 – 28/2/2021	N/A	N/A	N/A
Kate Moss	Staff – 999 North	1/3/2018 – 28/2/2021	N/A	N/A	N/A
Tony Nicholson	Public – Hampshire	1/3/2018 – 28/2/2021	N/A	N/A	N/A
David Palmer	Staff – 999 South	1/3/2018 – 28/2/2021	4/5	N/A	4/4
Ray Rowsell[9]	Public – Hampshire	1/3/2015 – 28/2/2018	4/5	N/A	N/A
Debbie Sengelow[10]	Staff – Corporate/support	1/3/2015 – 28/2/2018	4/5	N/A	N/A
Sue Thomas[11]	Partner – Charity	1/10/2014 – 30/9/2017	1/2	3/3	N/A
Jan Warwick[12]	Partner – Local Authority	1/3/2015 – 28/2/2018	1/1	0/1	N/A

[1] This is a full record of the governors who served during 2017/18. Those highlighted in bold were in post at the end of the 2017/18 year (i.e. on 31 March 2018)

[2] Meetings on 3 April 2017, 18 July 2017, 4 October 2017, 30 November 2017 (NED appointments), and 11 January 2018

[3] Did not seek re-election when term of office expired on 28 February 2018

[4] Did not seek re-appointment when term of office expired on 30 September 2017

[5] Was not re-elected and term of office expired on 28 February 2018

[6] Did not seek re-election when term of office expired on 28 February 2018

[7] Resigned on 2 June 2017 (term of office was until 28 February 2020)

[8] Resigned on 23 August 2017 (term of office was until 28 February 2020)

[9] Was not re-elected and term of office expired on 28 February 2018

[10] Did not seek re-election when term of office expired on 28 February 2018

[11] Was not re-appointed when term of office expired on 30 September 2017 as representation switched from Thames Valley to Hampshire & IoW Air Ambulance Charity

[12] Resigned on 20 June 2017 (term of office was until 28 February 2018)

5. MEMBERSHIP AND PUBLIC ENGAGEMENT

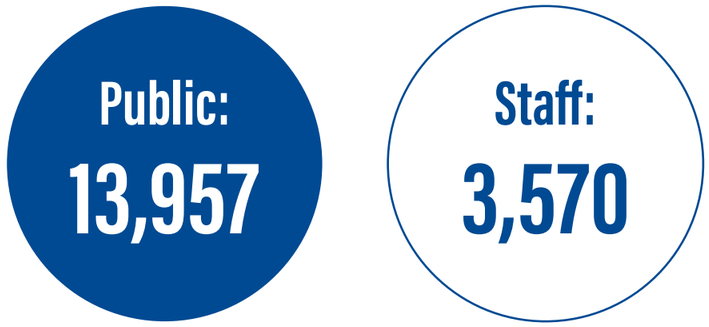
In March 2018, SCAS celebrated its sixth year as a Foundation Trust. The Trust's membership has grown and developed and continues to be an asset for the organisation in ensuring that the voices of our communities are heard and reflected in how SCAS is run.

The Trust is committed to continue to:

- ➔ Engage with its public and staff Foundation Trust members
- ➔ Provide opportunities for governors to communicate with members and the public as a whole and understand their views
- ➔ Improve diversity in its membership representation

SCAS FT members

SCAS has a total membership of 17,527 people as of 31 March 2018, broken down as follows:



Staff constituency

Any SCAS staff member with a permanent contract or a fixed term contract of 12 months or longer is able to become a member of the Trust. Staff who join the Trust are automatically opted into membership and advised how they can opt out if they wish.

Public constituency

Members of the public aged 14 and over are eligible to become public members of the Trust if they live in the area (or have a connection with) where SCAS provides services (Buckinghamshire, Berkshire, Oxfordshire and Hampshire).

The public membership breakdown by category on 31 March 2018 is shown below.

Age	**13,957**
14-16	30
17-21	305
22+	12,914
Not stated	708
Age 22+	**12,914**
22-29	1,751
30-39	2,148
40-49	2,480
50-59	2,274
60-74	2,799
75+	1,462
Gender	**13,957**
Unspecified	22
Male	5,699
Female	8,236
Ethnicity	**13,957**
Asian	553
Black	268
Mixed	189
Other	2,017
White	10,930
Acorn Socio-Economic Category	**13,957**
Affluent Achievers	4,073
Rising Prosperity	1,588
Comfortable Communities	3,695
Financially Stretched	2,814
Urban Adversity	1,574
Not Private Households	168
Not Available	45

Public engagement

The Trust uses various types of engagement activities to ensure that it meets its duty to involve and consult with patients and the public in the way it develops and designs services.

Throughout the year SCAS representatives attended several events where they met with members of the public and provided information about the Trust's services and listened to their views.

Events included various large ones such as *Pride* days; *Hayling Island 999 Emergency Services Day*; *Buckinghamshire County Show*, near Aylesbury and the *Royal Berkshire Show* in Newbury.

The Trust also held community engagement roadshows in shopping centres and market squares across its coverage area together with recruitment open days at its call centres, charity events, talks at career job fairs, schools and various organisations.

Furthermore SCAS undertook regular patient surveys such as the annual members and patients surveys together with public consultations at its county forums. More details are listed below.

Consultation and partnership work with the public, local groups and organisations

In 2017/18 SCAS undertook the following consultations with FT members, members of the public and organisations:

CQC research – SCAS FT members in Oxfordshire, Berkshire and Buckinghamshire were invited to take part in a research conducted by Picker, on the CQC's behalf, which involved testing a questionnaire about people's experience of staying in hospital. The results of this research will be available in late 2018.

Focus group in Milton Keynes – SCAS FT members together with the members of the Trust's Bucks and MK Community Engagement Forum residing in the Milton Keynes area were invited to partake in a SCAS and Open University project which involved pulling together a research question around elderly care and the complexity of decision-making when managing older patients, looking at both the clinicians and carers experiences.

SCAS held three focus groups at the Open University in Milton Keynes and the results of these sessions will now help the SCAS research team and OU to look at a more focused research question.

Dementia - Developing a research project with our communities, with the University of Portsmouth – SCAS FT members, together with the Trust's Hampshire Community Engagement Forum members, members of the public and representatives of local organisations were invited to take part at the first face-to-face meeting with regard to involving the public with the University of Portsmouth with a research project on dementia. The aforementioned session was held at the SCAS Hampshire Community Engagement Forum in June 2017 and the results helped SCAS and the University of Portsmouth to progress further with this research (see copy of minutes from the CEF at http://www.scas.nhs.uk/wp-content/uploads/SCAS-HANTS-CEF-MINUTES-21-June-2017-1.pdf)

SCAS Patient Experience Policy – SCAS Community Engagement Forum members were invited to give their comments on the Trust's Patient Experience Policy.

SCAS partnership work with Slough Borough Council – In 2017 the Trust entered into partnership with Slough Borough Council with regard to SCAS referring patients to Solutions4Health (S4H), one of the Council's health providers. S4H offers a great service to the community for support with general health problems which can lead to serious illnesses, such as cardio wellness, smoking cessation, diet and physical activity support. This partnership will help the Trust to work towards a healthier community and preventative care.

SCAS 100 Virtual Club – As the amount of involvement requests from many different organisations increases, there are progressively fewer people willing to participate in face-to-face engagement and this is common in most NHS trusts and organisations. To overcome this issue, in January 2018 SCAS launched the 100 Virtual Club with the aim of appealing to 'armchair activists', i.e. people who are happy to be kept informed or participate in convenience activism (e.g. responding to surveys or consultations issued by the Trust) without having to attend meetings/events.

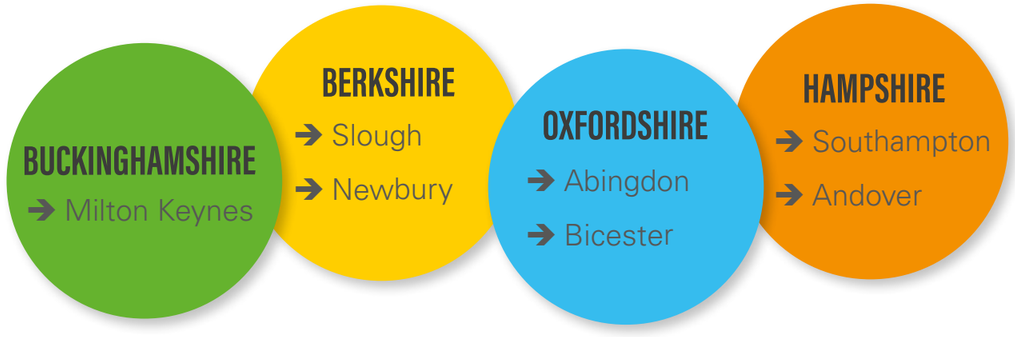
The club has 52 members and it will be involved in providing input into surveys, consultations, ideas on cost savings, working with other organisations, improving our services, and other areas where members can have an influence.

Healthwatch Thames Valley intelligence sharing meeting with SCAS – beginning in 2017 SCAS has a representation at these meetings.

Community Engagement Forums

The involvement of patients, public and stakeholders in the work of the Trust via the community engagement forums (CEFs) has brought several improvements to the planning, quality and delivery of services as listed in the previous examples.

In 2017 SCAS held its biannual CEFs in the following locations:



The forum minutes are available on the Trust's website at

http://www.scas.nhs.uk/get-involved/foundation-trust/scas-community-engagement-forums/

Surveys

SCAS regularly gathers online and face-to-face views of patients about the care they have recently received.

Membership satisfaction and patient care survey

The fifth annual membership survey was undertaken in June 2017 over a four week period. It was sent via *Foundation Times*, the Trust's membership newsletter to all Foundation Trust public members who have supplied the Trust with an email address.

For the third year running SCAS invited GP surgeries across its four counties to pass on the Trust's request to complete the survey to their patient participation groups (PPGs) so they could tell SCAS about their experience of care they receive from the Trust.

For the first time it was also emailed to other stakeholders such as Healthwatch groups and councils and also promoted via social media.

In total SCAS received 543 responses and the results were presented in full to the Board and the Membership and Engagement Committee (see SCAS report at **http://www.scas.nhs.uk/get-involved/foundation-trust/patient-experience-survey/**)

Quick surveys - emergency and non-emergency services including NHS 111

Throughout the year SCAS offers service users the opportunity to complete a quick survey either on line at **http://www.scas.nhs.uk/get-involved/foundation-trust/patient-experience-survey/** or face-to-face at the Trust's community engagement roadshows and other events. In 2017/18 SCAS collated nearly 250 responses.

Engagement with young people

The Trust uses various types of engagement activities with young people. These are as follows:

- ➔ Giving talks at colleges, secondary schools and universities
- ➔ Attending college careers fairs
- ➔ Providing CPR demos to secondary schools and colleges as part of *Restart a Heart Day* and also as solo initiatives
- ➔ Working with EBP South (Education, Business Partnership South), a charity which offers career inspiration, preparation and experience to young people by providing a single point of contact for schools to engage with businesses and businesses to engage with over 53 secondary schools in Hampshire
- ➔ Delivering the recently formed *SCAS Young Ambulance Citizens Programme.* This has been developed to support students who are interested in a career in healthcare and is delivered by the education department
- ➔ Undertaking public consultations at the Trust's county forums where young people are invited to participate (one of SCAS' recent forums was held at Newbury College)
- ➔ Carrying out e-surveys in secondary schools and colleges
- ➔ Inviting young FT members and young people to:
    - o join SCAS 100 Virtual Club
    - o take part in educational videos for the Trust's soon to be launched scasyouth website and *The Buzz* e-newsletter

Engagement with children

SCAS has a mascot named 999 Ted who plays a leading role attending local events and school visits.

The Trust is the only ambulance trust in England to have a website dedicated entirely to children's education (**www.scaskids.co.uk**). The site was created to provide easy advice and information for children, parents, teachers and group leaders. It was also designed to help ensure young people can stay healthy, safe and know what to do in an emergency and 999 Ted is a prevalent feature.

Two of the website's videos

- ➔ *Dial 999 for emergency* (**https://www.youtube.com/watch?v=HWCOF5Fm0tY**)
- ➔ *What's in an ambulance* (**https://www.youtube.com/watch?v=XAuWnu4QbMk**)

have received nearly 105,000 and 2.4m views respectively since their launch in 2016.

In 2017/18 SCAS continued to educate children in schools, scout clubs and various school fairs with live demonstrations and via its scaskids website, together with the site's 999 Ted activity packs.

Engagement with BME groups

In 2017/18 SCAS continued to engage with existing and new BME stakeholders with the aim of increasing the level of participation with these groups.

The activities include the following:

- ➔ Holding a presentation about the Trust's membership and governor election at an event organised by the Milton Keynes Equality Council to representatives of various local BME groups
- ➔ Holding a presentation about the Trust's membership and governor election at a Working in partnership event organised by SCAS at North Harbour Resource Centre where various key SCAS stakeholders were in attendance, including the Chairs of Portsmouth Multicultural Group and Portsmouth Central Masjid
- ➔ Attending the Oxford Carnival
- ➔ Attending the YMCA Celebrate! event in Slough

6. STAFF REPORT

6.1 OUR WORKFORCE

During 2017/18 SCAS employed a total of 785 new employees across the Trust.

The ongoing development of our workforce and the recruitment of additional resources within our 999 frontline services continued to be a key challenge for SCAS during 2017/18. Over the past 12 months, SCAS has welcomed a total of 200 new 999 frontline recruits, whilst 44 staff took up development opportunities to join the frontline. The Trust has continued to recruit paramedics both from abroad and within the UK to meet increasing demand for our emergency services. Attrition amongst 999 frontline services as at 31 March 2018 stands at 14.89%; the vacancy rate in 999 is currently at 15%.

Category	FTE Total
999 Frontline	1535.69
EOC	281.96
NHS 111	204.57
Operational Support Services	193.37
Patient Transport Services	742.88
Commercial Logistics	25.88
Corporate Support Services	316.24
Grand Total	**3300.59**

The following tables show a breakdown of the Trust's workforce by age, ethnicity and gender, as well as disability information, for 2016/17 and 2017/18 respectively.

	31 March 2017			31 March 2018		
Ethnic Group	**Headcount**	**%**	**FTE**	**Headcount**	**%**	**FTE**
A White – British	2839	85.2	2598.23	2870	80.4	2661.70
B White – Irish	21	0.6	20.35	24	0.7	21.79
C White - Any other White background	144	4.3	136.35	162	4.5	152.64
C3 White Unspecified	8	0.2	7.61	7	0.2	7.00
CA White English	31	0.9	29.83	28	0.8	26.83
CB White Scottish	1	0.0	1.00	1	0.0	1.00
CC White Welsh	2	0.1	1.80	2	0.1	1.80
CD White Cornish	2	0.1	1.51	1	0.0	0.51
CK White Italian	1	0.0	1.00	1	0.0	1.00
CP White Polish	6	0.2	6.00	4	0.1	4.00
CY White Other European	2	0.1	2.00	3	0.1	3.00
D Mixed - White & Black Caribbean	7	0.2	6.02	12	0.3	10.96
E Mixed - White & Black African	5	0.2	4.12	3	0.1	3.00
F Mixed - White & Asian	8	0.2	8.00	9	0.3	9.00
G Mixed - Any other mixed background	8	0.2	8.00	13	0.4	12.90
GD Mixed - Chinese & White	1	0.0	1.00	1	0.0	1.00
H Asian or Asian British – Indian	15	0.5	12.77	14	0.4	12.61
J Asian or Asian British – Pakistani	6	0.2	5.12	5	0.1	4.71
K Asian or Asian British – Bangladeshi	2	0.1	1.80	1	0.0	1.00
L Asian or Asian British - Any other Asian background	10	0.3	8.63	16	0.4	14.88
LH Asian British	1	0.0	1.00	1	0.0	1.00
LK Asian Unspecified	1	0.0	1.00	1	0.0	1.00
M Black or Black British – Caribbean	12	0.4	10.97	9	0.3	8.73
N Black or Black British – African	14	0.4	11.95	20	0.6	17.29
P Black or Black British - Any other Black background	1	0.0	0.27	0	0.0	0.00
R Chinese	3	0.1	2.32	4	0.1	3.32
S Any Other Ethnic Group	3	0.1	2.80	5	0.1	4.60
SE Other Specified	1	0.0	0.92	1	0.0	0.92
Unspecified	7	0.2	7.00	195	5.5	180.24
Z Not Stated	171	5.1	146.66	155	4.3	132.51
Grand Total	**3,333**	**100.0**	**3046.02**	**3,568**	**100.0**	**3300.59**

	31 March 2017			31 March 2018		
Age Band	**Headcount**	**%**	**FTE**	**Headcount**	**%**	**FTE**
<20	15	0.5	13.92	10	0.28	10.00
20-25	397	11.9	373.77	371	10.4	360.10
26-30	473	14.2	444.67	530	14.8	501.61
31-35	360	10.8	331.12	399	11.2	367.29
36-40	404	12.1	351.43	384	10.7	342.06
41-45	466	14.0	417.26	476	13.4	429.76
46-50	410	12.3	374.09	452	12.6	418.10
51-55	392	11.8	367.90	445	12.5	417.04
56-60	262	7.9	243.44	318	8.9	299.29
61-65	109	3.3	94.71	142	4.0	125.36
66-70	31	0.9	24.60	30	0.8	23.81
71+	14	0.4	9.13	11	0.3	6.18
	3,333	**100.00**	**3046.02**	**3,568**	**100.00**	**3300.59**

	31 March 2017			31 March 2018		
Gender	**Headcount**	**%**	**FTE**	**Headcount**	**%**	**FTE**
Female	1,658	49.7	1440.0	1,763	49.4	1562.7
Male	1,675	50.3	1606.1	1,805	50.6	1737.9
Grand Total	**3,333**	**100.0**	**3046.02**	**3,333**	**100.0**	**3300.59**

Within the Trust, SCAS defines senior managers as members of the Board. The gender split of the Board of Directors is detailed on page 48-51.

	31 March 2017			31 March 2018		
Disability Flag	**Headcount**	**%**	**FTE**	**Headcount**	**%**	**FTE**
No	2,623	78.7	2406.54	2,711	76.0	2526.97
Not Declared	540	16.2	484.60	480	13.5	428.75
Unspecified	15	0.5	13.91	217	6.1	200.24
Yes	155	4.7	140.97	160	4.5	144.63
Grand Total	**3,333**	**100.0**	**3046.02**	**3,568**	**100.0**	**3300.59**

FTE = full-time equivalent

Sickness absence

The overall sickness rate for the Trust for 2017/18 was 6.3% (6.04% in 2016/17) which equated to 14.7 days lost per person (13.6 days lot in 2016/17). Note that the latest available sickness rate data at the time of publication covers the 12-month period from Jan-Dec 2017, and is therefore compared against the 12-month period of Jan-Dec 2016.

During 2018/19 the Trust will be focusing on our health and wellbeing agenda, striving to improve attendance rates across all core areas, this will include a review of policies and working practices, including our absence policy, shift patterns and health and wellbeing services we provide, and ensuring our re-shaped appraisal process which uses a values-based approach, is embedded across the organisation.

6.2 STAFF COSTS

	Group			
			2017/18	2016/17
	Permanent	**Other**	**Total**	**Total**
	£000	**£000**	**£000**	**£000**
Salaries and wages	103,807	366	**104,173**	91,138
Social security costs	10,047	-	**10,047**	8,906
Apprenticeship levy	499	-	**499**	-
Employer's contributions to NHS pensions	12,988	-	**12,988**	11,615
Pension cost - other	-	-	**-**	-
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	-
Temporary staff	-	2,640	**2,640**	3,776
NHS charitable funds staff	-	-	**-**	-
Total gross staff costs	**127,341**	**3,006**	**130,347**	**115,435**
Recoveries in respect of seconded staff	-	-	**-**	165
Total staff costs	**127,341**	**3,006**	**130,347**	**115,600**
Of which				
Costs capitalised as part of assets	-	-	-	-

Average number of employees (WTE basis)	Group			
			2017/18	2016/17
	Permanent	**Other**	**Total**	**Total**
	Number	**Number**	**Number**	**Number**
Medical and dental	-	-	**-**	-
Ambulance staff	1,780	10	**1,790**	1,738
Administration and estates	1,057	19	**1,076**	884
Healthcare assistants and other support staff	379	9	**388**	362
Nursing, midwifery and health visiting staff	76	5	**81**	86
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	-	-	**-**	-
Healthcare science staff	-	-	**-**	-
Social care staff	-	-	**-**	-
Other	-	-	**-**	39
Total average numbers	**3,292**	**44**	**3,336**	**3,108**

Expenditure on consultancy was £223k (2016/17: £198k) which was mainly attributed to

Turnaround projects (see Note 5.1 in the Annual Accounts, page 229).

Reporting of compensation schemes

The Group had nil compensation packages in 2017/18 (2016/17: six cases at a total cost of £55,000).

The Group had no other non-compulsory departure costs in 2017/18 (2016/17: nil).

Payments to past senior managers

The Group had no payments to past senior managers in 2017/18 (2016/17: nil).

Payments for loss of office

The Group had no payments loss of office in 2017/18 (2016/17: nil).

6.3 STAFF POLICIES AND ACTIONS

The Trust's Recruitment Policy and the use of NHS Jobs ensure that a full and fair consideration is given to applications made by disabled persons, having regard to their particular aptitudes and abilities. The Trust is committed to ensuring equality of opportunity. This policy along with the Rehabilitation, Temporary / Permanent Redeployment Programme would be utilised when looking at development opportunities or promotion for disabled employees.

The policies that would be applied for continuing the employment of and for arranging appropriate training for employees who have become disabled persons are the Trust's Sickness Management Policy which covers both short-term and long-term absence. Following an internal audit, this policy is being reviewed with a view to ensure that staff are appropriately supported and that there are clear steps in the process for effectively managing staff absence.

The Rehabilitation, Temporary / Permanent Redeployment Programme – Management Framework, which was updated in October 2017, also outlines the process to enable staff to get back as soon as practically possible. By seeking to rehabilitate individuals back into the workplace sooner, individuals are able to gradually work up to optimum fitness prior to undertaking full contractual duties, thus improving morale and reducing the likelihood of feelings of isolation and personal stress.

Employees are regularly communicated with locally through team meetings and Trust-wide via Hot News and the weekly Staff Matters email bulletin. This weekly bulletin contains information about news items, individual or team achievements, regular topics of interest to staff along with regular health and wellbeing advice and information.

The Chief Executive regularly communicates via email to all staff particularly thanking them for their continued good work and linking this in with the Trust's values and strategies. The Trust strategy is also available to all staff on the intranet.

Staff and / or their representatives are consulted with regularly. This could be carried out locally for a specific restructure or change. Employees are also consulted on new policies that are produced or when there is a significant change to an existing policy. Operational and HR policies are also discussed at Policy Review Groups which are attended by representatives from management and staff side representatives. There are three partnership forums for our three main service delivery areas, which are a consultation forum between management and staff side representatives which discuss local and service side issues. The Joint Negotiation and Consultative Committee meet every six weeks and is the Trust's formal negotiation and collective bargaining forum with our recognised unions.

In addition to this there is the Bright Ideas email box which encourages all staff to submit innovative ideas to enhance their work life and / or improve the patient's experience or improve the efficiency or effectiveness of the services we deliver.

Staff are encouraged to complete the annual NHS staff survey as the Trust considers staff feedback is important. Each service area or department produces an action plan from the outcome of the feedback for their area and these then provide the data for the Trust action plan.

Of the Trust Council of Governors, two are staff governors and they can be contacted by any member of staff at any time. They also regularly hold 'clinics' on the main sites when staff are invited to go and visit them if they have anything they wish to discuss.

There is also the Trust's Whistleblowing Policy with a non-executive lead and this provides staff with an appropriate means of raising any concerns.

HR policies are reviewed throughout the year by the HR Policy Review Group which is a partnership of representatives from HR, management and our recognised unions. Policies that have been reviewed during 2017/18 include:

- Additional Employment Policy
- Annual Leave Policy
- Equal Opportunities Policy
- Flexible Working Policy
- Grievance Policy
- Rehabilitation, Temporary & Permanent Redeployment Programme
- Secondment Policy

The terms of reference for the Policy Review Groups which are attended by representatives from management and staff side representatives are being reviewed jointly with staff side to agree uniform roles, responsibilities and objectives to help improve the quality and efficiency of the policy review process.

The appraisal process and documentation has also been updated to reflect a more effective and engaging procedure. This is currently being rolled out across the Trust and to date the feedback has been very positive.

The Trust is currently taking a more proactive approach on increasing and encouraging attendance throughout the Trust. A recent internal audit on sickness management has been carried out and the recommendations from it are being implemented throughout the Trust by means of an action plan and focused pieces of work within services.

The Trust takes a proactive approach on the health and wellbeing of staff, including weekly tips for staff, health and wellbeing road shows across the Trust's many sites, notice boards in all sites and health and wellbeing champions as a first point of contact to assist in employees in getting the right assistance for their particular issue. The Trust has TRiM (trauma risk management) fully embedded into its attendance management procedures and is considering other systems such as STRaW (Stress Resilience at Work), and MECC (Making Every Contact Count). The Trust will continue to explore any assistance programmes that enhance the good physical and mental health of our employees.

Local staff recognition is recognised through 'job well done' postcards to encourage staff engagement and various other engagement systems are being explored.

The Trust is working in partnership to review our existing trade union recognition agreement during 2018/19. In the period since the existing agreement was written the NHS economy, the healthcare sector, the range of services managed by SCAS and the demands and expectations of core services has changed considerably.

The objective of the review is to work jointly with our recognised TU partners to agree and produce a dynamic new TU Recognition Agreement. The new agreement will reflect the new healthcare environment that reflects the existing SCAS business model and values which is robust and able to support the partnership in implementing future strategy.

The Trust has worked closely with our staff side partners to ensure compliance of the 2017 Trade Union Act regulations in respect of deduction of union subscriptions via payroll and TU facility time publication regulations.

A SLA in respect of the deduction of TU contributions has been agreed and implemented with Unison; with Unite and GMB agreements completed but not implemented, as they are subject to a national agreement which is pending subject to ratification of the regulations. The TU facilities time publication data has been generated from SCAS records and information supplied by staff side. The information will be included in the SCAS annual report and published annually on the SCAS website. HR working with the GRS team have agreed and implemented a new reporting system to monitor TU abstractions and activity on a monthly basis which will be shared with staff side.

Countering fraud

The Trust has a responsibility to ensure that public money is spent appropriately. SCAS has policies in place to counter fraud and corruption; these include Standing Financial Instructions, a Detection and Prevention of Fraud and Corruption Policy and an Anti-Bribery Policy.

The Trust receives its anti-fraud service from TIAA Ltd. An annual work plan is developed to meet the requirements of the NHS Protect Anti-Fraud Strategy and this is shared with the Trust's Audit Committee along with the Annual Report on counter fraud activities.

There have been no significant fraud issues or threats in the year affecting the Trust. The Trust's Local Counter Fraud Specialist continues to work closely with the Trust in making them aware of risk areas to the Trust so that the Trust can make arrangements to reduce that risk.

6.4 ANNUAL NHS STAFF SURVEY

Feedback from our staff is welcomed and valued within SCAS; we encourage all staff to share their opinions through our annual staff surveys and friends and family test. As a result of previous feedback from staff surveys a number of actions have been implemented, including improvements in staff health and wellbeing and team leadership development.

During quarter 3 of 2017/18, all staff (including those on maternity leave) were invited to participate in the annual NHS staff survey. The Trust achieved a final overall response rate of 61%; the highest return rate of all ambulance trusts and the largest number of responses since SCAS was formed in 2006.

Key Findings

A total of 88 questions were asked in the staff survey. Compared to our 2016 results, SCAS is:

- ➔ Significantly better on 11 questions
- ➔ Significantly worse on 0 questions
- ➔ No significant difference on 77 questions

In comparison to other 'picker' ambulance trusts, SCAS compares:

- ➔ Significantly better than average on 51 questions
- ➔ Significantly worse than average on three questions
- ➔ Scores are average on 34 questions

The 2017 results indicate a continuing improvement on the last two annual survey results, demonstrating that the Trust's ongoing organisation development agenda is continuing to benefit staff and their working lives. Our top 10 improvements since 2016 are detailed within the table below.

Survey Question	2016 (%)	2017 (%)	% change since 2016
Disability: SCAS made adequate adjustments to enable me to work	66	74	8
Had mandatory training in the last 12 months	84	90	6
Senior managers act on staff feedback	21	27	6
Immediate manager can be counted upon to help me with difficult tasks	71	76	5
Organisation takes action to ensure errors are not repeated	56	61	5
Staff given feedback about changes made in response to reported errors	50	54	4
Had appraisal / KSF review in last 12 months	76	80	4
Supported by manager to receive training, learning or development	47	51	4
Feedback from patients / service users is used to make informed decisions	36	40	4
Enough staff at organisation to do my job properly	18	22	4

The Trust scores significantly lower than average (compared to 'picker' ambulance trusts) on three questions as outlined in the table below and whilst they are lower than the 'picker' average, all three show an improvement on last year's results.

SIGNIFICANTLY WORSE THAN AMBULANCE SECTOR AVERAGE SCORES **			
QUESTION	2017 AVE PICKER AMB %	SCAS 2017	SCAS 2016
Enough staff at organisation to do my job properly	26%	22%	18%
Had mandatory training in the last 12 months	92%	90%	86%
Had appraisal / KSF review in last 12 months	83%	80%	76%

**Average ambulance refers to the seven ambulance trusts that use Picker as their staff survey provider

Areas of least satisfaction

Survey Question	2016 (%)	2017 (%)	% change since 2016
Not put myself under pressure to come to work when not feeling well enough	9	9	0
Satisfied with level of pay	23	21	-2
Appraisal / review definitely helped me improve how I do my job	19	21	2
Enough staff at organisation to do my job properly	18	22	4
Appraisal / performance review definitely left feeling work is valued	25	25	0
Senior managers act on staff feedback	23	27	4
Organisation definitely takes positive action on health and wellbeing	26	27	1
Don't work any additional paid hours per week for this organisation, over and above contracted hours	28	28	0
Communication between senior management and staff is effective	28	30	2

Having analysed the results, during 2018/19 SCAS will continue to focus on the following key areas:

- Organisational and leadership development
- Appraisals
- Statutory and mandatory training
- Staff health and wellbeing
- Team leadership development

Action plans following 2017 results

All teams are actively participating in workshops, developed with senior managers, to help them to understand their results whilst highlighting how positive results in the staff survey positively correlate with other HR statistics such as improved attrition, lower sickness and higher appraisal compliance. These in turn result in improved patient care. Team leaders and managers have been asked at a local level to analyse their results, publicise their successes and work with their teams to put in place plans to continue to improve areas of least satisfaction, whilst also striving to continue to improve all areas of the survey.

Local action plans will be reviewed by the executive team during the year and the steps individual departments are taking will be publicised in Trust communications on a regular basis.

6.5 DIVERSITY AND INCLUSION

Disability Confident Scheme

Disability Confident is a scheme from the Department of Work and Pensions (DWP) which has replaced the Two Ticks symbol. It was relaunched in 2016 and all NHS England Trusts have been encouraged to join the scheme. There are three levels:

- Disability Confident Committed
- Disability Confident Employer
- Disability Confident Leader

SCAS is currently level 1, Disability Confident Committed. In achieving level 1 SCAS has demonstrated that it will:

- Interview all disabled applicants who meet the minimum criteria for a job vacancy and consider them on their abilities, provide reasonable adjustments where necessary (pre-interview and post-employment offer)
- Ensure that there is a mechanism in place to discuss, at any time with disabled employees, what both parties can do to make sure disabled employees can develop and use their abilities
- Make every effort when employees become disabled to make sure they stay in employment
- Take action to ensure that all employees develop the appropriate levels of disability awareness needed to make sure these commitments work
- Review these commitments each year and assess what has been achieved.

NHS England, Disability Rights UK and NHS Employers have led work with a range of stakeholders, including the Strategic and Technical Advisory Group members, to develop the Workforce Disability Equality Standard (WDES).

The WDES sets out a series of metrics, which require NHS organisations to report annually on disability equality and to produce an action plan to address differences between disabled and non-disabled staff.

The draft WDES metrics were piloted between late October and November 2017 and the WDES metrics have been shared with NHS England's Equality and Disability Council (EDC). NHS England is now reaching the final stages of engagement before the publication of the final WDES metrics in autumn 2018.

SCAS is a member of the Strategic and Technical Advisory Group and was one of the pilot trusts for the WDES.

Equality Delivery System 2

SCAS has completed a four-year Equality Delivery System 2 (EDS2) cycle (2016-20) designed by the Equality & Diversity Council to support NHS commissioners and providers to deliver better outcomes for patients and communities and better working environments for staff, which are personal, fair and diverse. The EDS2 will help SCAS to achieve compliance with its Public Sector Equality Duty in a way that also helps us deliver on the NHS Constitution (2010) and the CQC's Essential Standards of Quality and Safety (2010).

In its last CQC inspection, SCAS was rated overall as 'Good', including rating the Trust as 'Good' in the well-led domain. The report highlighted positives across all five Key Lines of Enquiry (KLOE) and assessed SCAS as 'Outstanding' for equality and diversity. The report found that "the Trust had evaluated its equality delivery system (EDS2) uniquely, using community groups to do so. The EDS2 aims to improve patient outcomes, access to services, a representative and supportive workforce and inclusive leadership. The Trust continues to take action to reduce all forms of unlawful discrimination. SCAS was able to demonstrate that it is an organisation that adheres to the broad principles of the CQC KLOEs:

- Staff are positive about working for the Trust and recognised the value of their service
- Providing safe, caring, responsive and well-led services
- Diverse Board that reflects a diverse workforce and therefore decision making that considers diversity
- Monitors the diversity of its users and reassures itself with accurate data that the needs are all met

Workforce Race Equality Standards

In July 2014, the NHS Equality and Diversity Council proposed a national Workforce Race Equality Standard to tackle the lack of black and minority ethnic (BME) representation at senior levels in the NHS, and to galvanise cultural and organisational change.

The Workforce Race Equality Standard (WRES), underpinned by commissioning and regulatory action, is aimed at helping address the treatment of BME staff including adverse outcomes throughout recruitment and promotion, access to non-mandatory training and over-representation in disciplinary procedures, bullying and harassment.

There are nine indicators: four are specifically related to workforce data and four are based on the national NHS staff survey indicators. The latter highlights any differences between the experience and treatment of white staff and black and ethnic minority staff in the NHS, with a view to closing the gaps highlighted by those metrics. The final metric requires SCAS to ensure that the Board is broadly representative of its workforce. SCAS has now published its Board approved 2017-18 WRES report/action plan and its equality and diversity working group and steering group are now working to deliver on the actions.

Indicator 2

Analysis of applications, shortlisting and appointments for this reporting period ending July 2017 shows positive improvements. The relatively likelihood of white applicants being appointed by comparison with the previous report now indicates white applicants are 1.32 times more likely to be appointed. In 2015 the first WRES analysis showed white applicants were three times more likely to be appointed.

Indicator 9

The SCAS Board has, over the last 12 months, increased its representation of voting BME members so that the Board's composition now more closely reflects the ethnicity of the population the Trust serves.

7. REGULATORY RATING

Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- ➔ Quality of care
- ➔ Finance and use of resources
- ➔ Operational performance
- ➔ Strategic change
- ➔ Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where 4 reflects providers receiving the most support, and 1 reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found in breach or suspected breach of its licence.

Segmentation

South Central Ambulance NHS Foundation Trust has been placed in segment 1 reflecting the performance and financial challenges that the Trust has faced. The Trust continues to be one of the best performing ambulance services achieving a 'Good' CQC rating. This segmentation information is the Trust's position as at 31 March 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHS improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from 1 to 4 where 1 reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Use of Resource Metric Risk Rating 2017/18				
Measure	**Q1**	**Q2**	**Q3**	**Q4**
Capital Service Capacity Rating	3	2	2	2
Liquidity Rating	1	1	1	1
I and E Margin Rating	3	3	3	2
I and E Margin Variance Rating	1	1	1	1
Agency Rating	1	1	1	1
Overall	2	2	2	1
Where 1= highest acheivement				

8. ANNUAL GOVERNANCE STATEMENT

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of South Central Ambulance Service NHS Foundation 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 South Central Ambulance Service NHS Foundation 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 Foundation Trust Accounting 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 South Central Ambulance Service NHS Foundation Trust (SCAS), 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 SCAS for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Risk Management Strategy comprehensively sets out arrangements in respect of the accountability for risk management in SCAS.

Leadership

As Chief Executive and Accounting Officer I have overall accountability for ensuring that the organisation has effective risk management systems in place. I have delegated specific areas of risk management activity to each of the executive directors; for example, as follows:

- The Director of Patient Care and Service Transformation has day-to-day responsibility for managing the strategic development and implementation of organisational risk management, clinical effectiveness and clinical governance. This includes acting as the designated lead for a range of responsibilities such as health and safety, security management, and infection prevention and control
- The Medical Director has responsibility for the management and development of clinical standards
- The Director of Finance has responsibility for financial risk management and, in the role of Senior Information Risk Owner, for risks relating to information
- The Chief Operating Officer has responsibility for managing the strategic development and implementation of clinical and non-clinical risk management (operational risks) associated with the provision of emergency ambulance services, NHS 111 and fleet management, as well as being the lead for emergency planning and business continuity activities
- The Director of Strategy, Business Development, Communications and Engagement has responsibility for managing the risks associated with the provision of non-emergency ambulance services, including patient transport services
- The Board, with overall responsibility for governance, considers the risks faced by the Trust on a regular basis. For example, it receives the Board Assurance Framework at each public Board meeting
- The Quality and Safety Committee, with delegated authority from the Board, monitors and reviews the Trust's clinical governance arrangements
- The Audit Committee, also with delegated authority from the Board, receives the Board Assurance Framework and strategic risk register at every meeting, with the purpose of seeking assurance that effective risk management practice is in place
- The Executive Team, underpinned by the work of its various sub-committees, receives and reviews updates from all directorates relating to risk management, as well as the Trust's Board Assurance Framework and strategic risk register
- The Executive Team has also established a Risk, Assurance and Compliance Committee. This committee, comprising the executive directors of the Trust and the Company Secretary, carries out a deep-dive review of the Trust's biggest risks and ensures that appropriate mechanisms are in place to provide assurance over the management of those risks

Training

- Officers involved in leading the Trust's risk management processes (e.g. Head of Risk and Security Management, Clinical and Non Clinical Risk Managers) are suitably qualified and experienced governance and risk management professionals. A wide range of training has been delivered to staff to enable them to manage identified clinical and non-clinical risks effectively. This training has been informed by a detailed training needs analysis based on external training requirements outlined by NHS Resolution and the CQC, in addition to training needs identified internally by the Trust. Our corporate induction training programme for new staff covers health and safety, awareness of risk, and incident reporting.

- The Trust has a very positive culture of incident reporting. The team structure in place enables immediate raising of concerns with on duty team supervisors who are able to directly support the reporting of incidents and the actual investigation, and can apply actions to mitigate. Incidents are monitored and reviewed at different levels of the organisation, including by a Serious Incidents Requiring Investigation Review (SIRI) Group, to ensure trends and patterns are identified and responded to where appropriate.

The risk and control framework

Strategy

The Trust has a comprehensive Risk Management Strategy which is reviewed periodically (e.g. annually), and updated where required. It was last reviewed in March 2018, and a number of minor amendments are due to be presented to the Board for approval in due course.

The key elements of our strategy are to:

- Integrate risk management into the Trust's culture and everyday management practice by clearly defining the Trust's approach and commitment to risk management, by raising staff awareness, and building knowledge and skills

- Provide clearly documented responsibilities and structure for managing risk to ensure a coordinated, standard methodology is adopted by every directorate / department

- Encourage and support incident reporting in a culture to ensure that the Chief Executive and Board are provided with evidence that risks are being appropriately identified, assessed, addressed and monitored

- Adopt an integrated approach to risk management, whether the risk relates to clinical, organisational, health and safety or financial risk, through the processes and structures detailed in the Trust's Risk Management Strategy

- Accept that whilst the provision of healthcare is not risk free, the Trust will aim to minimise the adverse effects of any risks through management of risk via the Quality and Safety Committee and Audit Committee both of which are sub-committees of the Board

Identification of risk

A range of tools are used to identify and control risks, including:

- The monthly Integrated Performance Report, including SIRIs

- Review of adverse incidents and accident reports

- Quarterly reviews of claims and complaints

- Workforce engagement and leadership walk-rounds

- Annual fire safety inspections

- Health and safety risk assessments

- Review of performance against the NHS Resolution Risk Management Standards

- Self-assessments against the Care Quality Commission essential standards of quality and safety

The risks are identified through careful triangulation of the themes across the above reporting mechanisms, recognising issues that affect patient safety, treatment and experience as the most reliable indicators. The intention is to identify risks through a balance of top-down and bottom-up processes.

The Board undertook a major strategy refresh process during 2017/18 and as part of this process – for example, through SWOT and PESTLE analysis tools – considered some of the biggest strategic risks facing the Trust.

The Board also plans to hold a risk workshop during 2018/19, and this will cover mechanisms for identifying potential future risks (e.g. horizon scanning).

Appetite for risk

The Trust has documented its appetite for risk in a 'Risk Appetite Statement', due to be revisited by the Board in the next few months. In doing so, it is acknowledged that delivery of healthcare and, in particular, the provision of ambulance services, will always involve a degree of risk (potentially heightened during periods of demand and change management). However, the Trust is fully committed to taking all necessary actions to ensure that risk is both minimised and mitigated. We adopt a positive approach to risk management and are particularly cautious on matters affecting our reputation.

Equally, it is considered that risk is a component of change and improvement, and therefore the Trust does not expect or consider the absence of risk as a necessarily positive position, as all change involves risk in order to adapt and improve.

The Trust has the greatest risk appetite in pursuit of innovation and challenging current working practices to improve patient care, access to services and reputational risk in terms of its willingness to take opportunities where positive gains can be realised, within the constraints of the regulatory environment.

Quality governance arrangements

The key elements of our quality governance arrangements are set out in the periodic self-assessments we undertake against the Monitor Quality Governance Framework, and report to the Board. We are either compliant (mostly) or partly compliant for all elements. Performance information is key to ensuring delivery of quality, and we have rigorous processes in place to ensure the quality of performance data. These include internal checking mechanisms, internal and external audit reviews, and a comprehensive review of the monthly Integrated Performance Report by the Executive Team prior to being presented to the Board.

Key strategic risks

We have a range of key strategic risks, which we have identified and are proactively managing. The Board considers the Board Assurance Framework (BAF) at every Board meeting in public, and at the final meeting of 2017/18 (in March 2018) the submitted BAF had seven red risks.

The red rated risks related to the following categories:

- ➔ Handover delays due to queueing at emergency departments, in particular Portsmouth
- ➔ Surrey non-emergency Patient Transport Service (PTS) contract delivery (key performance indicators)
- ➔ Sussex PTS contract delivery (key performance indicators) and private provider compliance requirements regarding infection control, incident reporting and safeguarding referrals
- ➔ Delivery of the national Ambulance Response Programme (ARP) targets
- ➔ Achievement and realisation of cost improvements
- ➔ Meeting statutory and mandatory training requirements
- ➔ Managing sickness absence

Mitigating actions are in place for all of the risks reported in the BAF where these are under the control of the Trust.

NHS Foundation Trust licence condition 4 – FT Governance

The Trust undertakes periodic reviews of its position against all of the conditions contained within its provider licence, and reports to the Board accordingly. No risks have been identified in 2017/18.

In terms of condition 4 – FT governance, the Trust has undertaken a number of steps during 2017/18 to identify any potential risks. These include carrying out a high-level review of the Trust's corporate governance arrangements against the Code of Governance, including a review of the Board's sub-committees and non-executive director responsibilities (a number of changes have been made).

Involvement of public stakeholders

Public stakeholders are involved in the management of risks which impact on them through the work of the governors, public meetings of the Board, and our attendance at Health Overview and Scrutiny Committee meetings. Our engagement with our stakeholders produces an additional layer of scrutiny and challenge from broad representative areas of our population groups and therefore enables SCAS to remain grounded and responsive to the communities we serve.

Compliance with CQC registration requirements

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). The last CQC inspection of SCAS took place in May 2016, and the Trust was rated as 'Good'. Since then the Trust has focused on implementing action plans to address the 'must do' and 'should do' recommendations made by the CQC.

Compliance with NHS Pension Scheme Regulations

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

Compliance with equality, diversity and human rights legislation

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Equality impact assessments are integrated into the core business of the Trust, and reports on the Trust's position in relation to equality and diversity are regularly considered by the Board in public.

Compliance with Climate Change Adaptation reporting to meet the requirements under the Climate Change Act

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

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

There are a number of key processes in place to ensure that resources are used economically, efficiently and effectively, which include:

- The Board has regularly reviewed the economy, efficiency and effectiveness of resources through the regular performance management reports (the Integrated Performance Report, finance reports, and quality and safety reports) considered at each meeting
- Savings targets are set annually in the form of cost improvement programmes, and the Trust has a very strong track record in terms of delivering annual savings targets. In 2017/18 £6,690k of the original budget was achieved, equating to 99.3%. Robust arrangements are in place to ensure that cost improvement programmes in no way compromise the quality of services
- The Trust's bi-weekly Executive Performance Review meetings are designed to review performance against key financial, operational, clinical and workforce targets as agreed at the start of the year
- The Trust routinely carries out benchmarking reviews of its performance and efficiency levels with other NHS bodies. Most recently this has included through the Ambulance Response Programme sector performance reports issued by NHS England, and NHS wide corporate benchmarking data produced by NHS Improvement. SCAS also benchmarks sickness and recruitment and retention rates
- The Board receives regular reports on the performance of the estate against a set of key performance indicators. These have been developed to report on criteria such as the physical condition, statutory compliance, functional stability, efficient utilisation and energy performance of the estate
- The Trust has in place governance and financial policies which include standing financial instructions, standing orders and a scheme of delegation. These policies prescribe the Trust's policy for the effective procurement of goods and services within the Trust
- An annual programme of internal audits, monitored closely by the Audit Committee, allows further assurance to be given to the Board on the use of its resources

Information governance

Information governance and data security risks are identified through the use of the NHS Connecting for Health Information Governance Toolkit. Risks are recorded in the risk register and managed via specific action plans which are subject to regular review by the Trust's Information Governance Steering Group. The Trust has carried out a self-assessment against the 2017/18 Information Governance Toolkit, achieving an overall score of 79%. This compares with a score of 74% in 2016/17.

There have been no reportable information security breaches during 2017/18. This compares with one during 2016/17 (involving the leaking of a high profile call audio recording), which resulted in a SIRI investigation that was closed during 2017/18 with appropriate learning taken.

Annual Quality Report

- 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. NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual.*

In preparing the Quality Report which is included within the Annual Report, the Trust's Directors have taken steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2017/18*
- The content of the Quality Report is not inconsistent with internal and external sources of information
- The officers accountable for the preparation of the Quality Report have the necessary skills and experience
- Appropriate processes have been used to develop and quality assure the Quality Report ensuring that it represents a balanced view of performance; this has included scrutiny by the Audit Committee and Quality and Safety Committee
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report are robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review

Review of effectiveness

As Accounting 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 Foundation Trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the content of the Quality Report attached to 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 and Safety Committee, and the Risk Assurance and Compliance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review during 2017/18 has also been informed by:

- Internal and external audit reports
- The Annual Audit / Management Letter
- The Head of Internal Audit Opinion/Annual Statement of Assurance
- Reports to the Board from the Audit Committee, Quality and Safety Committee, and Charitable Funds Committee
- Reviews of serious incidents requiring investigation and the associated learning from these
- Reports to the Executive Management Committee from its relevant sub-committees, as well as the work of the Risk, Assurance and Compliance Committee
- The monthly Integrated Performance Report, which covers clinical, operational, service development, financial and human resources
- Staff satisfaction surveys
- Care Quality Commission reports
- The Quality Accounts and Annual Report

There have been three particular key sources of assurance for me in 2017/18:

- Since May 2017 the regulator NHS Improvement has assessed the Trust as being a segment 1 provider under its *Single Oversight Framework* regulatory assessment. The assessment considers five key themes - quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability – and segment 1 is the best possible category that can be awarded
- We received an annual Head of Internal Audit Opinion for 2017/18 of "moderate assurance", defined as "generally a sound system of internal control designed to meet the Trust's objectives and that controls are being applied consistently"
- We have continued to make good progress in implementing action plans to address the 'must do' and 'should do' recommendations from the last CQC inspection (as validated by Internal Audit) when the Trust was awarded an overall 'Good' rating. In addition we have maintained an ongoing dialogue with the CQC and this has included quarterly 'keeping in touch' meetings and opportunities for the regulator to highlight any concerns (none)

Conclusion

My review confirms that South Central Ambulance Service NHS Foundation Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

No significant internal control issues have been identified in relation to the 2017/18 financial year, and this includes considering the examples presented by NHS Improvement in the Annual Reporting Manual.

Will Hancock
Chief Executive

24 May 2018

9. QUALITY REPORT

QUALITY REPORT

INCLUDING MANDATORY QUALITY ACCOUNTS

PART ONE

1.1 STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

Welcome to the SCAS Quality Report and Accounts 2017/18. This account gives an opportunity to really reflect on our achievements from last year and set further and new, focussed priorities for 2018/19.

The needs of our patients change over time as does our ability to meet those needs and improve our service. The rapid pace of change in the NHS and social care has continued over the last year as we modernise and transform all NHS services, and ambulance services are a key player and partner in that change programme. We are increasingly seen as the 'front door' of the NHS, often the first point of contact for a patient or a member of the public in need of help. We are therefore critical partners in the health and social care system to enable our patients to access the care that they need, providing assessment and advice and the right pathway and outcome for that person.

Providing high-quality, effective safe and responsive services within budget remains our highest focus. Many patients we are in contact with, whether in emergency care - 999, NHS 111 or non-emergency patient transport - have increasingly complex health and social care needs meaning we strive hard to work in partnership with our colleagues across boundaries to find the right place, signposts and service to offer treatment.

We face daily challenges in demand and expectation, as do other services and trusts in the healthcare sector and we must ensure our continued joined up working is developed and robust an outline some important examples below.

Our teams are constantly identifying learning from feedback and incidents, to ensure we take steps to improve and embed actions to minimise any harm and maximise our effectiveness.

I am also pleased to inform you through the Quality Account that SCAS updated and refreshed its clinical strategy this year. The strategy now better reflects the aggregation of learning we have developed and how the Trust's values (teamwork, professionalism, innovation, caring) are at the heart of the services we provide for patients. We have set out for each key clinical condition where we are now, what good looks like and how we are going to improve. This is deliberately designed so that patients, partners and stakeholders can engage and influence our services to help us to improve.

AMBULANCE RESPONSE PROGRAMME (ARP)

The biggest change for ambulance services and our patients and staff this year has been the introduction of the new ambulance response categories and the associated target times for all patients who call 999 across England. The four new categories have been robustly tested and will provide a standardised response time to all patients who call 999 for help. The standards are designed to ensure the most appropriate response (not the first or fastest) is sent to our patients. The benefits include early recognition of life-threatening conditions (including cardiac arrest, stroke and heart attacks) and increased patient safety as a result. The standards aim to reduce inefficiencies, releasing resources and improving the quality of care patients receive. The new operating model is also an enabler to support peoples' care out of hospital reducing the need to send ambulances to patients who do not need them and when appropriate supporting people to stay out of hospital.

Within the new categories we are analysing data on performance, benchmarking and long waits which include our continued focus on reducing ambulance delays of queueing at acute hospitals.

COMPLIANCE AND ASSURANCE

The CQC last inspected SCAS in May 2016 (report issued September 2016) but we continue to self-assess on the evidence and data we hold to provide the assurance we need to confirm compliance with the fundamental standards. SCAS has been involved in a number of Local System Reviews (LSRs) in the last year, which you can read about in Part 1 of this report.

GROWING SERVICES

SCAS expanded its commercial services in 2017/18 to include Surrey and Sussex patient transport services which extends our footprint significantly. We are working closely with commissioners and patient groups to make sure we meet the requirements of those who use these services. Our staff have responded exceptionally well to the challenge of delivering these new services.

INTEGRATED URGENT CARE (IUC)

The Integrated Urgent Care service went live in the Thames Valley area in September 2017. This is developing over a five year implementation plan with associated partners and providers of care to provide patients with less severe conditions easier access to urgent care clinical advice, on the phone and online.

Plans include rolling out enhanced triage across urgent care services, and potentially to urgent treatment centres, care homes and ambulance services. GP out of hours and NHS 111 services will increasingly be combined. By 2019, NHS 111 will be able to book people into urgent face to face appointments where this is needed.

As part of this transformation, NHS 111 is being enhanced so that patients access urgent care services that have been fully integrated.

Patients calling NHS 111 who need clinical input will be able in the future, to speak directly to a clinician who will seek to complete the assessment without the need to transfer the patient elsewhere. So it's an exciting time to be part of such innovation.

SUSTAINABILITY AND TRANSFORMATION PARTNERSHIPS (STPs)

The NHS and local councils are developing and implementing shared proposals to improve health and care in every part of England. Over the next few years, these represent the biggest national move to join up care in any major western country.

A collaborative approach is enabling local leaders to plan around the needs of whole areas, not just those of individual organisations. Proposals have been published for every part of England.

A small number of the partnerships are now evolving into integrated or 'accountable' care systems (ACSs) which SCAS is a part of. The proposals include practical changes to improve patients' lives. These include things that patients often tell the NHS they care about; like making it easier to see a GP, speeding up cancer diagnosis and offering help faster to people with mental ill-health concerns. They are bringing together the right groups of people to think about what fundamental local changes are needed in every part of England. Partnerships will be forums for shared decision-making, supplementing the role of individual boards and organisations.

Our teams are playing an important role in the development of STPs and ACSs in order to deliver high quality services based on need and streamlined integrated services. It is with a real sense of optimism we enter these partnerships for the future.

VALUES

With the launch of the new appraisal and the values based behavioural sets we are moving towards an organisational culture with a greater emphasis on appropriate behaviours and an expectation that our staff model these values and associated behaviours.

Our behavioural sets were developed by taking into account the views of staff across our organisation and they have been gradually introduced to groups of staff across the Trust. However, with the launch of the revised appraisal scheme we are taking the opportunity to re-launch the behavioural sets throughout all parts of the Trust. Our aim is to ensure that each employee receives, understands and models the behaviours associated to their role during their working lives.

There are seven role relevant behavioural value sets for our staff groups:

	SCAS Values-Based Behaviour Sets
1	The Executive Team
2	Corporate Managers
3	Managers
4	Corporate Staff
5	Team Leaders & Clinical Mentors
6	Frontline Patient Facing Staff
7	Frontline (Contact Centres) Staff

We are confident that the behavioural guidance contained within these sets will positively impact our culture by providing guidelines for how we will behave at work in accordance with our core values.

STAFF SURVEY

A total of 2,061 staff participated in the SCAS staff survey, giving us a response rate of 61%, again the highest return rate of all ambulance trusts. In comparison with other comparable ambulance trusts, SCAS was significantly better than average on 51 questions, and faired similarly to other trusts on 34 questions. There were only three questions where our results were not as favourable as other trusts.

Compared to other ambulance trusts we compare favourably on issues such as support from immediate management, communication between senior management and staff, staff confidence and security in reporting unsafe clinical practice, effective team working and fairness and effectiveness of procedures for reporting errors, near misses and incidents. I am proud of the great results that we have achieved.

While we are doing well, there is always room for improvement. SCAS strives to be a world class organisation and we want to build on our strengths making SCAS an 'Employer of Choice' through excellent people management, staff engagement and by empowering our staff to have a voice and feel listened too.

Looking after our patients is a people business and great care is delivered by great staff and volunteers. More than ever this year our committed, professional and caring staff across all services and locations including our dedicated volunteers, have made me very proud and honoured to lead our organisation every day.

This Quality Account has been prepared and written by South Central Ambulance Service NHS Foundation Trust under the National Health Service (Quality Accounts regulations) 2010 statutory instrument No 279. The Trust has reviewed all the data and information available on the quality of care that all the service arms provide on a daily basis. To the best of my knowledge the information in this document is accurate.

Will Hancock
Chief Executive

1.2 WHAT WE DO AND PROVIDE

South Central Ambulance Service NHS Foundation Trust (SCAS) is part of the National Health Service (NHS). SCAS was established on the 1 July 2006 following the merger of four ambulance trusts. On 1 March 2012, the Trust became a Foundation Trust.

3,300 STAFF	994 COMMUNITY & CO-RESPONDERS	868 VEHICLES	100+ SITES
1.2 MILLION+ CALLS TO NHS 111	565,000+ 999 INCIDENTS	800,000+ PTS JOURNEYS	POPULATION 7 MILLION

The Trust provides an emergency and urgent care service to respond to 999 calls, a NHS 111 / Integrated Urgent Care (IUC) telephone service for when medical help is needed, non-emergency patient transport services (PTS) and logistics and commercial services. The Trust also provides resilience and specialist operations offering medical care in hostile environments such as industrial accidents and natural disasters including a Hazardous Area Response Team (HART) based in Hampshire.

Services are delivered from the Trust's main headquarters in Bicester, Oxfordshire, and a regional office in Otterbourne, Hampshire. Each of these sites includes a clinical coordination centre (CCC) where 999, NHS 111 / IUC and PTS calls are received, clinical advice is provided and from where emergency vehicles are dispatched if needed.

South Central Ambulance Service NHS Foundation Trust covers the counties of Berkshire, Buckinghamshire, Hampshire, Oxfordshire and we are providers of PTS in Sussex and Surrey. This area has a residential population of over seven million.

The Trust works with air ambulance partners; Thames Valley Air Ambulance (TVAA) and Hampshire & Isle of Wight Air Ambulance (HIOWAA).

The Trust also offers the following services: first aid training to organisations and the public (discontinued February 2018), a commercial logistics collection and delivery service for our partners in the NHS, and community first responders (volunteers trained by SCAS to provide lifesaving treatment).

Non-emergency patient transport - Providing routine and non-emergency patient transport services

Clinical coordination centres - Facilitating delivery of the NHS 111 / IUC Health Helpline service and 999 and PTS calls

Mobile urgent healthcare - Providing 999 responses and care in a community setting

National Pandemic Flu service - SCAS hosts the National Pandemic Flu Service. It remains in dormancy at the present time. SCAS has regular meetings with the service leads and accredit all trainers for the national service. SCAS also carry out trainer re-validations around the country to ensure trainers remain compliant and competent.

What is quality and a Quality Account?

Quality accounts are mandatory annual statements as required by the NHS Act 2009, written for the public by all NHS organisations that provide healthcare.

The Quality Account is comprised of the three core and overlapping themes of quality:

THE THREE DIMENSIONS OF QUALITY

Regulation and compliance

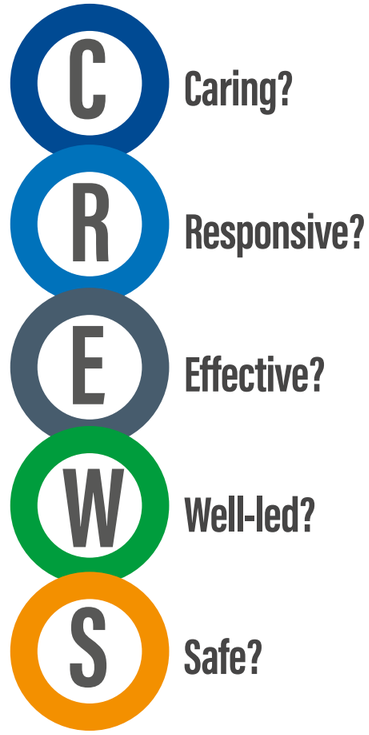
These Quality Accounts are aligned with the requirements and targets set by the NHS standard contract for ambulance services, the NHS England National Ambulance Indicators, the CQUIN (Commissioning for Quality and Innovation) payment framework and those of our regulators, NHS Improvement and the Care Quality Commission.

Care Quality Commission (CQC) and compliance with the fundamental standards

SCAS was last inspected and rated by the CQC in May 2016 and we received the formal report in September 2016. The Trust was pleased to receive a 'Good' rating which reflected the quality and safety of care received by our patients and the caring service delivered by our staff.

The CQC assessment - how does the CQC assess providers?

To get to the heart of patients' experiences of care, the CQC always ask the following five questions of every service and provider: they ask are we:



These five key questions are tested against the core services provided; the four core services tested in our last inspection (May 2016) were:

- ➔ Emergency operations centres (EOC); we now call these clinical coordination centres (CCC)
- ➔ Emergency and urgent care, 999
- ➔ Non-emergency patient transport services (PTS)
- ➔ NHS 111 telephone service

Each question and service is judged against the characteristics for *Outstanding, Good, Requires Improvement* and *Inadequate.* Each service is then rated following the judgements.

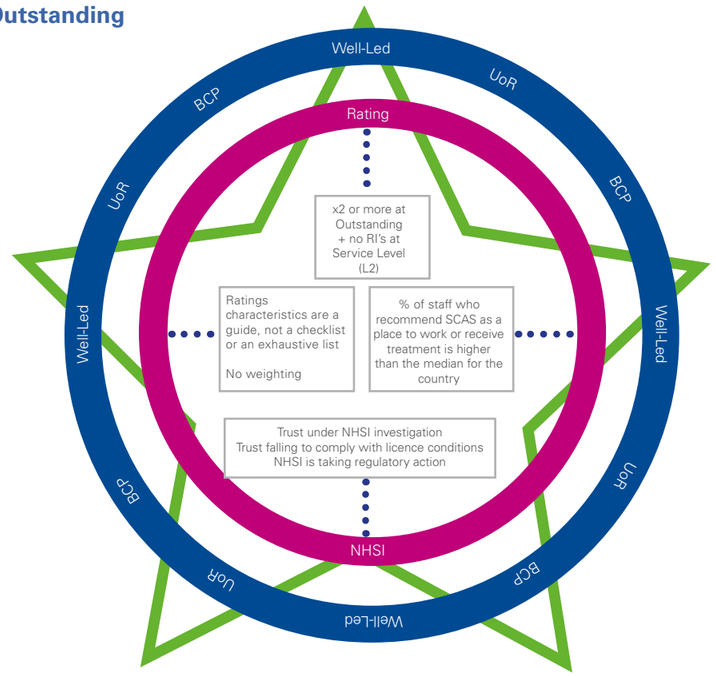
The Trust is then awarded an overall rating.

The table below shows the current SCAS rating.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency operations centre	Good	Good	Good	Good	Good	Good
Emergency and urgent care services	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Patient transport services	Requires improvement	Good	Outstanding	Good	Good	Good
NHS 111	Good	Requires improvement	Good	Good	Good	Good
Overall rating for the Trust	Good	Requires improvement	Good	Good	Good	Good

SCAS is still working to achieve "outstanding" in all our services. We have commenced initiatives to triangulate the many sources of information and data available in each service area and complete a self-assessment to present the current position indicating areas of good practice and areas for improvement.

Good to Outstanding



Local System Reviews (LSRs)

Over the past year, we have been participating in CQC LSRs across our footprint. LSRs have taken place in Bracknell Forest, Oxfordshire, East Sussex and Hampshire in 2018. Nationally 20 LSRs were announced in the first phase.

Summary of Local System Review process

- Requested by Secretaries of State for Health and Social Care and for Communities and Local Government (Sec 48 instruction)
- Reviews are based on local authority areas
- Review covers commissioners and providers
- Review focusses on people over 65
- Focus on Delayed Transfer of Care
- Focus on the interface between social care, primary, acute and community
- CQC team review six patient pathways:
    - two people who have received social services and avoided hospital admission
    - two people who attended the emergency department but were not admitted
    - two people who have had a hospital episode and completed a community or rehabilitation intervention

An online survey looks at relationships and how organisations work together.

The CQC has published an interim report based on the first six local system reviews. The interim report has identified that "those working within health and adult social care services are passionate about providing the best possible experience to the older people within their care". At this early stage these reviews have also identified that fragmentation is effecting care and choice is limited with confusion of who is coordinating care.

There are three key themes that the CQC identified as barriers to service integration:

- How providers and commissioners work together
- Capacity, market supply and workforce issues
- The need to look beyond delayed transfers of care in isolation to resolve the problems that local systems are facing

A full report following the 20 reviews is expected in 2018.

A full report from our last CQC inspection is available at **http://www.cqc.org.uk/provider/RYE**

Complaint management

We are sorry when we don't get it right for patients and their families and welcome their feedback. SCAS is aware that patients who complain need a speedy but thorough response. Our targets are to acknowledge receipt of a complaint within three days of receipt and to provide a response in 25 days. Sometimes a complaint is complex and we need to negotiate with the complainant to agree a reasonable timeframe to complete the investigation. However we have been reporting fluctuating performance in this area which we are trying to mitigate and address as a matter of priority. The volume of Patient Experience contacts has impacted on the timeliness of case closure. The percentage of formal complaints responded to within agreed timescales was:

Month	% Responded to within agreed timeframe
December 2017	75
January 2018	68
February 2018	80
March 2018	75

Patient Experience contacts received Trust-wide reduced in December 2017 (466) and January 2018 (523) from the peak we had seen in November 2017 (675).

We have mitigated the impact of the increased volumes with recruitment into the Patient Experience (PE) team. The PE team continues to deliver support and training sessions to investigating officers in all services across the Trust to drive up quality and focus on managing timeliness of responses to complaints, concerns and healthcare professional (HCP) feedback. The Head of PE is focussing on supporting contact centre staff with training in 'first time resolution' to ensure that concerns are dealt with to an appropriate standard at the earliest opportunity.

NHS ENGLAND AMBULANCE RESPONSE PROGRAMME (ARP)

Established in January 2015, the Ambulance Response Programme (ARP) aims to increase the operational efficiency of ambulance services whilst maintaining a clear focus on the clinical need of patients. SCAS joined the national programme to work on the potential changes to ambulance response standards in July 2015 and we implemented the new ARP national response standards on 31 October 2017.

Programme aims

The key aims of ARP are to improve response times to critically ill patients, ensuring that the best, high-quality, most appropriate response is provided for each patient first time. It is expected that the national programme will improve clinical outcomes for all patients presenting through the 999 system, with a generally reduced clinical risk throughout.

Key benefits of ARP:

- Ensuring a timely response to patients with life-threatening conditions
- The most appropriate clinical resource to meet the needs of patients based on presenting conditions, not simply the nearest
- Fewer multiple dispatches = increased efficiency
- Reduction in diversion of resources
- Increasing the ability to support patients through hear and treat and see and treat
- Having a transporting resource available for patients who need to be taken to a definitive place of care
- Improved patient experience
- Provides ambulance staff with greater role satisfaction – doing the 'right thing' for patients

New ARP response standards

Categories	National Standard	How long does the ambulance service have to make a decision?	What stops the clock?
Category 1	7 minutes mean response time 15 minutes 90th centile response time	The earliest of: ➔ The problem is identified ➔ An ambulance response is dispatched ➔ 30 seconds from the call being connected	The first ambulance service-dispatched emergency responder arrives at the scene of the incident (There is an additional Category 1 transport standard to ensure that these patients also receive early ambulance transportation)
Category 2	18 minutes mean response time 40 minutes 90th centile response time	The earliest of: ➔ The problem is identified ➔ An ambulance response is dispatched ➔ 240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport the first ambulance service-dispatched emergency responder arrives at the scene of the incident
Category 3	120 minutes 90th centile response time	The earliest of: ➔ The problem is identified ➔ An ambulance response is dispatched ➔ 240 seconds from the call being connected	If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock. If the patient does not need transport the first ambulance service-dispatched emergency responder arrives at the scene of the incident
Category 4	180 minutes 90th centile response time	The earliest of: ➔ The problem is identified ➔ An ambulance response is dispatched ➔ 240 seconds from the call being connected	Category 4T: If a patient is transported by an emergency vehicle, only the arrival of the transporting vehicle stops the clock.

Some key amendments and developments around the standards are being implemented

- ➔ Introduction of a standard Category 3 mean time of 60 minutes
- ➔ Inter-facility transfers
- ➔ Updated clinical care bundles
- ➔ Review of ambulance quality indicators
- ➔ Detailed analysis on the SCAS delivery model
- ➔ Development of an engagement and communications plan
- ➔ Redesign and revision of rosters with a detailed migration plan

Moving to business as usual

THAMES VALLEY INTEGRATED URGENT CARE (IUC) SERVICE

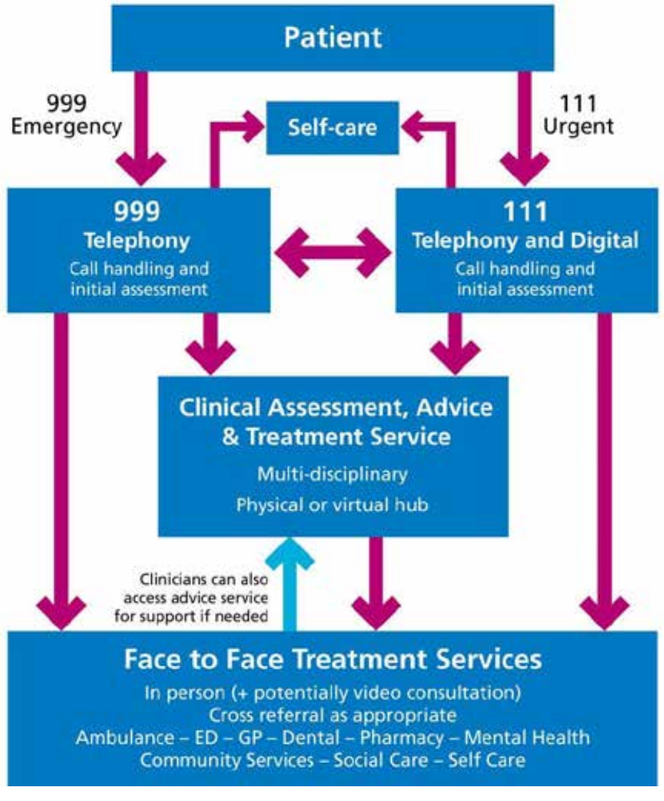
The new Thames Valley (Buckinghamshire, Oxfordshire and Berkshire) Integrated Urgent Care 111 service went live in September 2017. The service helps people access a wide range of clinical care through a single call, including dental, pharmacy and mental health services, ensuring patients get the right care, first time. We are providing this new service in collaboration with Berkshire Healthcare NHS Foundation Trust, Oxford Health NHS Foundation Trust and Buckinghamshire Healthcare NHS Trust.

Patients access IUC by calling 111, and a trained call handler assesses the person's needs. They are able to arrange for the patient to see or speak to a clinically trained healthcare professional, including GPs, where this is clinically appropriate.

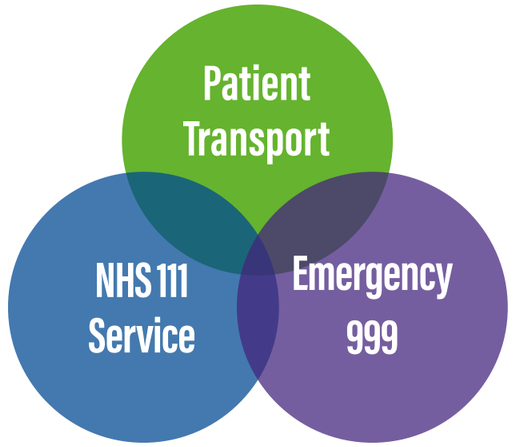
The service supports patient care across the region offering enhancements over the previous 111 service including:

- GP clinical leadership and triage within the service
- Dental nurse assessment
- Community psychiatric nursing and improved access to mental health crisis teams
- Paediatric specialists
- Pharmacists
- Tailored support to care and nursing homes
- Early intervention for under-fives, over 85s and end of life patients
- Direct booking of appointments in out-of-hours across Thames Valley
- Enhanced clinical assessment of emergency department and lower category ambulance response cases
- Improved support for self-care where clinically appropriate
- Improved transfer of patient information and access to care records

We are proud to be the leaders of this partnership that has been delivering real improvements in how the people of the Thames Valley access urgent care from the NHS.



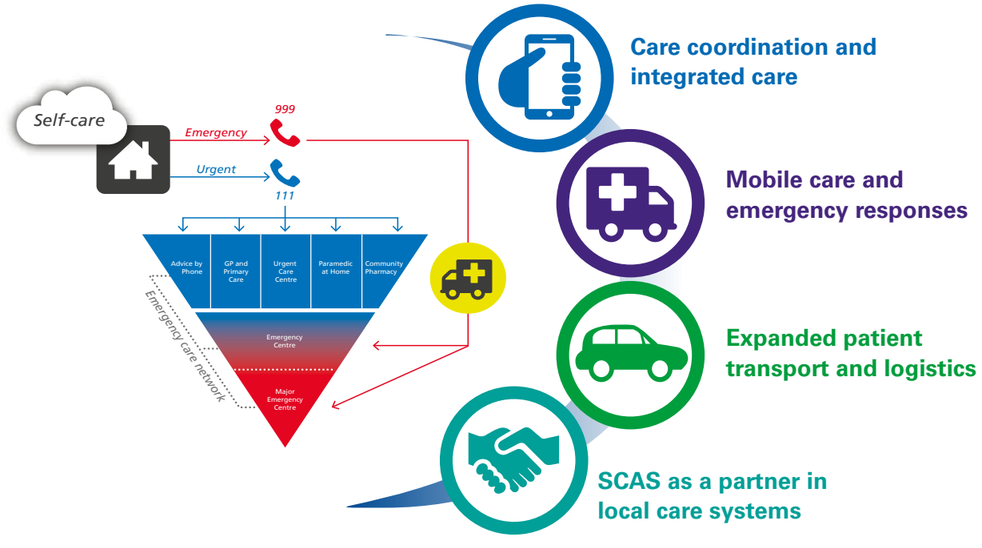
FIVE YEAR STRATEGY



As providers of NHS 111, 999 and non-emergency patient transport services, our strategic vision is one of integration:

- Enabling people to access right care, first time
- Saving lives and improving outcomes
- Supporting people in their own homes

Our strategic themes



Our progress so far

- ✓ Increased peoples' chance of survival
- ✓ Supported more people at home, assessing and treating them on the phone and at their home
- ✓ Won new contracts for patient transport services as well as retaining our existing business
- ✓ Recognised by Care Quality Commission as 'Good'
- ✓ Introduced specialist paramedic roles for critical care and urgent care, both to improve patient outcomes and to offer career development
- ✓ Performed well against a wide range of national benchmarks and standards
- ✓ Worked with partners in four different regions, contributing to each of the Sustainability & Transformation Plans on behalf of our sector

Rotating Specialist Paramedic Projects

We have been working with our local healthcare system partners over the past year to develop opportunities for our specialist paramedics to undertake 'portfolio' working across different healthcare settings. Such initiatives support demand and recruitment challenges across healthcare settings as well as clinical career development opportunities for these highly trained clinicians. We have been involved in supporting home visits in primary care within West Berkshire and have recently been named as a Health Education England pilot site for a joint working initiative within the Portsmouth area.

Mortality Review Group

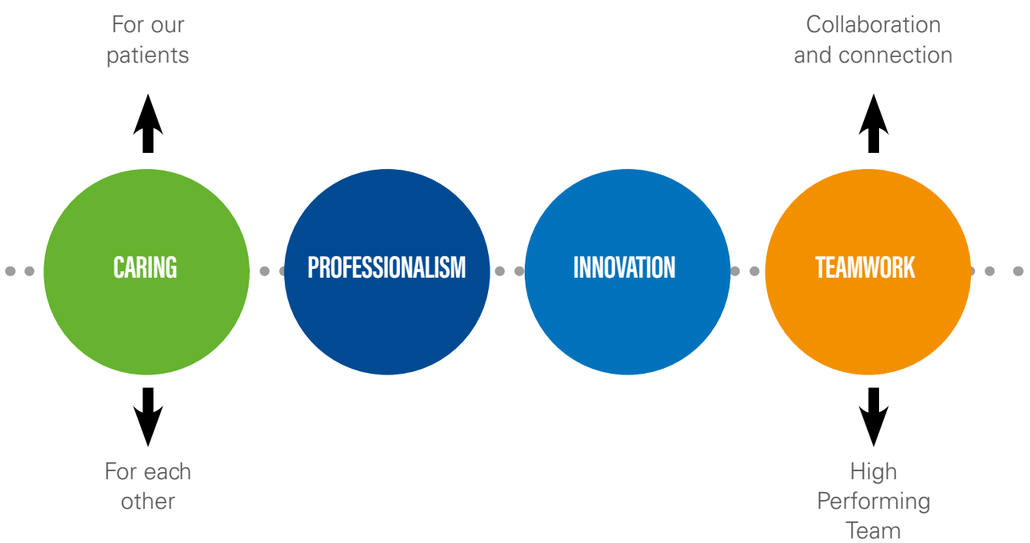
SCAS has instigated a mortality review group as preliminary work for ambulance services which outlined a framework for NHS trusts on learning from deaths, with the aim of reducing genuinely avoidable deaths. While the guidance was aimed at acute hospitals, over the past year we have been proactive in considering the data we collect to aid with this initiative. The group has been reviewing incidents in line with the guidance document to ensure any key learning and action points are identified and shared, and the group will continue to mature over the forthcoming year.

National Quality Board (2017) *National guidance on learning from deaths. A framework for NHS trusts and NHS foundation trusts on identifying, reporting, investigating and learning from deaths in care*. (First Edition). **www.england.nhs.uk**

New Values-Based Appraisal

SCAS has launched a new values-based appraisal approach based on our four key core values.

How we deliver our services



How we work with each other

Following last year's staff survey results highlighting we were not consistently providing a high quality appraisal experience, a thorough review was undertaken and changes have been made to our appraisal process.

The review:

- ➔ Listened to staff and managers across all departments – to find out what they value in their appraisal
- ➔ Assessed the appraisal documentation in line with best practice guidelines
- ➔ Considered best practice and processes in other organisations

As a result of the findings of this review we have launched a new values-based appraisal process, aligned to our core values of caring, professionalism, innovation and teamwork.

- ✓ **Self-assessment**

  The new appraisal paperwork includes a self-assessment section to allow staff to reflect and comment on their performance over the previous year.

- ✓ **Our values and behaviours**

  The paperwork facilitates a discussion around our core values and the behaviours we should be demonstrating at work in relation to these values.

- ✓ **Performance rating**

  The new process also includes a performance rating where the employee and manager can discuss and review performance.

- ✓ **Appraisal training**

  Appraisal training has also been reviewed and updated to focus on the essential skills and behaviour required to conduct effective appraisals.

2017 Staff Survey results

A total of 2,061 staff participated, giving us a response rate of 61%, the highest return rate of all ambulance trusts. The same 88 questions were used in both the 2016 and 2017 surveys. When compared with last year we made improvements in 11 questions, and for 77 questions the results were on a par with last year. In comparison with other 'picker' ambulance trusts, SCAS was significantly better than average on 51 questions and faired similarly to other trusts on 34 questions. There were only three questions where our results were not as favourable as other trusts.

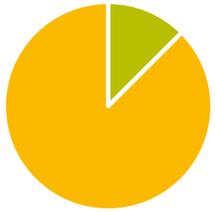
Compared to other ambulance trusts we compare favourably on issues such as support from immediate management, communication between senior management and staff, staff confidence and security in reporting unsafe clinical practice, effective team working and fairness and effectiveness of procedures for reporting errors, near misses and incidents. We are very proud of the great results that we have achieved.

Whilst we are doing well, there is always there is room for improvement. We strive to be a world class organisation and want to build on our strengths making SCAS an 'Employer of Choice' through excellent people management, staff engagement and by empowering our staff to have a voice and feel listened too.

These results will be used locally to form a series of pledges and action plans to make improvements to each department / area.

The key areas for 2018/19 are:

- ➔ Appraisal quality
- ➔ Staff training and development
- ➔ Health and wellbeing
- ➔ Team leadership development



A total of 88 questions were used in both the 2016 and 2017 surveys. Compared to the 2016 survey, your organisation is:

- Significantly BETTER on 11 question(s)
- Significantly WORSE on 0 question(s)
- The scores show no significant difference on 77 question(s)

In NSS17 a comparison can be drawn between your organisation and the Picker average on a total of 88 questions. Your organisation is:

- Significantly BETTER than average on 51 question(s)
- Significantly WORSE than average on 3 question(s)
- The scores were average on 34 question(s)

Engagement

Effective public engagement is a key element for providing excellent patient care and the Trust continued working with patients, the public, local organisations, partners and other stakeholders to keep on being seen as a service which is proud to be caring for the public.

SCAS has a public membership of nearly 14,000 people.

Members of its Foundation Trust, media organisations and feedback from patients, staff and governors continue to assist the Trust in creating an awareness of the service and also help to ensure demand is appropriate.

The Trust uses various types of engagement activities to ensure that it meets its duty to involve and consult with patients and the public in the way it develops and designs services.

Throughout the year SCAS representatives attended events where they met with members of the public and provided information about our services and listened to their views.

The Trust also held community engagement roadshows in shopping centres and market squares across its coverage area. Recruitment open days were held at its call centres, attendance at charity events, talks at career job fairs, schools and various organisations such as elderly groups and ethnic minority associations all provided opportunities for engagement.

Furthermore SCAS undertook regular patient surveys such as the annual members and patients' surveys together with public consultations at community engagement forums held in each of our four main counties.

In 2017/18 SCAS launched *SCAS 100 Virtual Club* as a way to appeal to *Armchair Activists* i.e. people who are happy to be kept informed or participate in convenience activism (e.g. responding to surveys or consultations issued by the Trust) without having to attend meetings/ events.

PART TWO

2.1 PRIORITIES FOR IMPROVEMENT 2017/18

In this section we review progress made since the publication of the 2016/17 Quality Report. Below is a table to show "at a glance" what progress and what we achieved from last year's priorities.

Priority	Achieved
To improve the recognition of sepsis in adults	Achieved
To complete a clinical governance review of the E&UC 999 service and implement recommendations	Achieved
To provide a consistent approach to medicines management which is compliant with regulatory standards	Partially achieved
To implement the workstreams in the national Sign up to Safety campaign to improve patient safety across all services	Achieved
To review and improve call abandonment for PTS, 999, 111 (two year priority)	On-going into second year
To improve and develop clinical assessments in CCC ensuring consistent methods and application across the services (three year priority)	On-going into second year
To continue to review FFT staff and patients with actions for improvement	Achieved
To learn from HCP feedback in all services (999, 111 and PTS)	Partially achieved
To ensure a service that is responsive to and listens and engages with feedback from all sources especially hard to reach groups	Achieved

PATIENT SAFETY

1A: TO IMPROVE THE RECOGNITION OF SEPSIS IN ADULTS

What we said we would do	What we have achieved
Review and reissue the sepsis tools throughout all SCAS areas and ensure staff understanding in all areas of business	We completed this and a NEWS score training package developed
Create a further sepsis campaign approach that aligns to the calendar of Trust-wide campaign events	Communications, clinical memos, Staff Matters and SCAScades have been issued and circulated throughout the year. The Consultant Pre-Hospital Care Practitioner has written a sepsis training session for team training days
Monitor the use of the tool through audit of adverse incident data and patient clinical records	A random sample audit of appropriate decisions based on NEWS is being undertaken in Q4. This data is described below. We are improving the ePR system to automatically calculate a NEWS score at the end of inputting the vital signs. This will show changing trends, such as a deteriorating (or improving) patient.
Continue to work with national groups and initiatives on sepsis awareness and training	The Consultant Pre-Hospital Care Practitioner is working with NHS England and all our acute partners to raise awareness and complete end to end reviews with acute hospitals and community care trusts. **Note:** This indicator was chosen by the Council of Governors for testing by our external auditors. The auditors tested the ePR data to support the achievement of this indicator. *Auditors compared the sample received from the Business Intelligence reports with what was recorded at the scene on the ePR system. For the 25 cases selected from 300, the time, date and NEWS Score for cases of sepsis in adults matched giving assurance that the patient outcome and pathway was correct.* *The audit identified that 100% of information recorded at the scene on CAD/ePR had fed through the SCAS systems, and was categorised correctly.*
Did we achieve this priority?	Achieved

1B: TO COMPLETE A CLINICAL GOVERNANCE REVIEW OF THE EMERGENCY AND URGENT CARE (E&UC) 999 SERVICE AND IMPLEMENT THE RECOMMENDATIONS

What we said we would do	What we have achieved
Set out terms of reference for a thorough and robust review of clinical governance in E&UC	This review was undertaken and completed in January 2018. The review affirmed that the Clinical Governance Leads in 999 had established an improved, integrated relationship and approach with frontline operations. Clinical governance is now embedded in the day to day 999 work evidenced by staff awareness of risks and how to escalate and mitigate them. Increased openness has led to clinical audits to improve patient care and consistently applied approaches.
Conduct the review methodically	In undertaking our review SCAS considered documentation and information from a number of sources including policies, committee meetings, procedures, interviews, observations and attendance at meetings, both internal and external.
Report on the review through the Patient Safety Group and to the Quality and Safety Committee	The report was reviewed by our Patient Safety Group in March 2018.
Ensure compliance with the CQC fundamental standards – report to Executive Management Committee and implement any recommendations	We achieved this by updating the Executive Management Committee fortnightly on our self-assessed compliance and activity with the CQC and in public through Board papers.
Did we achieve this priority?	Achieved

1C: TO ENSURE A CONSISTENT APPROACH TO MEDICINES MANAGEMENT PROCESSES WHICH ARE COMPLIANT WITH THE REGULATORY STANDARDS

What we said we would do	What we have achieved
Ensure actions from the CQC fundamental standards review are implemented	SCAS partially achieved this element as we recognise there is further work to do.
Utilise SCAScade regularly and effectively to communicate learning themes to staff from reflections on practice	Reflections and learning are regularly cascaded with real lived experiences of staff. "Ask Ed" continues in Staff Matters weekly to showcase commonly asked questions to our pharmacist.
Create and deliver a medicines campaign approach that aligns to the calendar of Trust-wide campaigns events	SCAS completed a campaign around medicines management and is further developing a specific medicines risk register monitored through our committee structure.
Identify any improvement actions for process and information issues and monitor through the medicines management group	SCAS has identified on-going improvement actions to ensure compliance and processes. These will be: ➔ Improving medicine audits with private providers ➔ Supporting medicines packing system ➔ Mitigating refrigerator power failures ➔ Auditing Patient Group Directions ➔ Conducting a health information advisor audit
Develop a standardised system and process for PGDs (Patient Group Directions)	SCAS has revised its sign-off system for Patient Group Directions ensuring a standard approach to governing medicines management for the staff who administer medicines. We have introduced an electronic sign-off record.
Did we achieve this priority?	Partially achieved

1D: TO IMPLEMENT THE WORKSTREAMS IN THE NATIONAL SIGN UP TO SAFETY CAMPAIGN TO IMPROVEMENT PATIENT SAFETY ACROSS ALL SERVICES

What we said we would do	What we have achieved
Review and reissue the pledges SCAS made as part of the Sign up to Safety campaign	Completed and updates have been provided to the Patient Safety Group.
Increase incident reporting each quarter by 1% above baseline	The total number of incidents reported between April 2017 and March 2018 was 6,237. The month with the highest number of reported incidents was May 2017 with 581 incidents. There has been an increase of 17% over the previous year. This is combination of clinical and non-clinical incidents.
As per indicator 1a audit the use of the sepsis tool	Please refer to Priority 1A
Encourage staff to share ideas for innovation through the Bright Ideas scheme and increase numbers submitted by five per year	The Bright Ideas innovation scheme was revived and actively promoted to staff via Staff Matters and Hot News. To date, 95 ideas have been submitted which is seven fewer than the previous year.
Ensure the workstreams are delivering and reported on in an aggregated way to Patient Safety Group identifying improvement plans	Our Quality and Safety Committee receives a quarterly aggregated learning report with quarterly action plans. An example would be the development of an app to assist with reducing medicines incidents. Secondly the issue of post-partum haemorrhage cards for maternity packs. Our aggregated learning report and actions are derived from a variety of intelligence sources including: incidents, complaints, feedback, plaudits, leadership walk-rounds, and clinical audits. To maximise learning we use a range of strategies which include (not exhaustive) face to face training, reflective practice, policy and directive reviews, newsletter articles and clinical memos.
Did we achieve this priority?	Achieved

CLINICAL EFFECTIVENESS

2A: TO DEMONSTRATE AN IMPROVEMENT IN CALL ABANDONMENT FOR PTS, 999 AND NHS 111 AND HEALTHCARE PROFESSIONALS (HCPs) (TWO-YEAR PRIORITY)

What we said we would do	Progress Year 1
Conduct a review of our call announcements on our HCP and patient facing lines to ensure that our online system is promoted – creating a baseline measure of callers that use online services.	Completed and baseline measure to be set in Q1 2018/19
We will review our call scripts to ensure that our staff promote pre-planned activity being placed via our online system.	Our PTS team do regular call audits to ensure scripting is followed and call durations are monitored.
Review our Patient Zone and release this functionality to the PTS contracts that this is not currently contractually bound to deliver.	The PTS is working towards an online booking system for all patients across all contracts in conjunction with our commissioners.
We will review our call announcements on our HCP and patient facing lines to ensure that our online system is promoted.	SCAS confirms that our call announcements on our telephone lines promote our online booking system. We developed two scripts in consultation with the telephony teams which were approved by commissioners.
Ensure an abandonment rate of below 1% in line with the national threshold.	Abandonment rate for 999 to end Dec 2017 – 0.43%, Jan 2018 – 0.42%, Feb 2018 – 0.59%, Mar 2018 – 0.57%
Did we achieve this priority?	Partially achieved

2B: TO EVALUATE AND DEVELOP CLINICAL ASSESSMENTS IN CALL CENTRES (CCCs) ENSURING CONSISTENT APPLICATION ACROSS THE SERVICES (THREE-YEAR PRIORITY)

What we said we would do	Progress Year 1
Implement the Green project (30 and 60 minute calls) for eight clinical conditions in Year 1	ARP was implemented in October 2017 and ambulance response times were categorised 1-4 meaning that the Green call project is now altered and we have worked to redefine long waits. We continue to monitor 60 minute responses under the "green project" against the clinical conditions identified.
Establish the baseline % of long waits for these Green calls and set an improvement target to commence in Year 2	A monthly group reviews long waits from each nodal area which now focus clearly on patient care, experience and safety rather than performance. Long wait thresholds use the 90th percentile as parameters for reviewing cases and through the reviews we are starting to see a reduction of harm levels. The team review the longest waits per category and these generally show low harm.
To further model the Green project after implementation and by end of 2017	This is live and is called the Accelerated Clinical Triage (ACT) process introduced post ARP in November 2017.
Ensure 80% of all eligible calls (green ambulance disposition) are transferred to an enhanced desk for further clinical assessment	The Green Code Service evaluation process is still running in both Emergency Operations Centres (EOCs) after the changes went live on 2 November 2017. The first evaluation of these results is planned for the end of January 2018 (after operating for a 3 month period). This will determine if any changes are required to the existing process to assist in improving our non-conveyance rates and to establish whether the initial expected benefits have been achieved. NHS 111 call indicator to be reported on in 2018/19. PTS do not conduct clinical assessments but do follow set eligibility questions for each of the contracts and again there is call auditing and reporting to all commissioners on the eligibility and statistics.
Evaluate the Live Link pilot and analyse the data to demonstrate an improvement in non-conveyance	The Live Link pilot is still in the test phase. SCAS has introduced the Live Link facility at 45 nursing homes in the SCAS region. SCAS introduced an algorithm for appropriate access to healthcare. We recognise that to improve consistency in the use of Live Link we need to re-energise this development.
Implement the NHS 111 online symptom checker in Year 1	At the time of writing this is currently with commissioners to procure a product of choice.
Did we achieve this priority?	Partially achieved

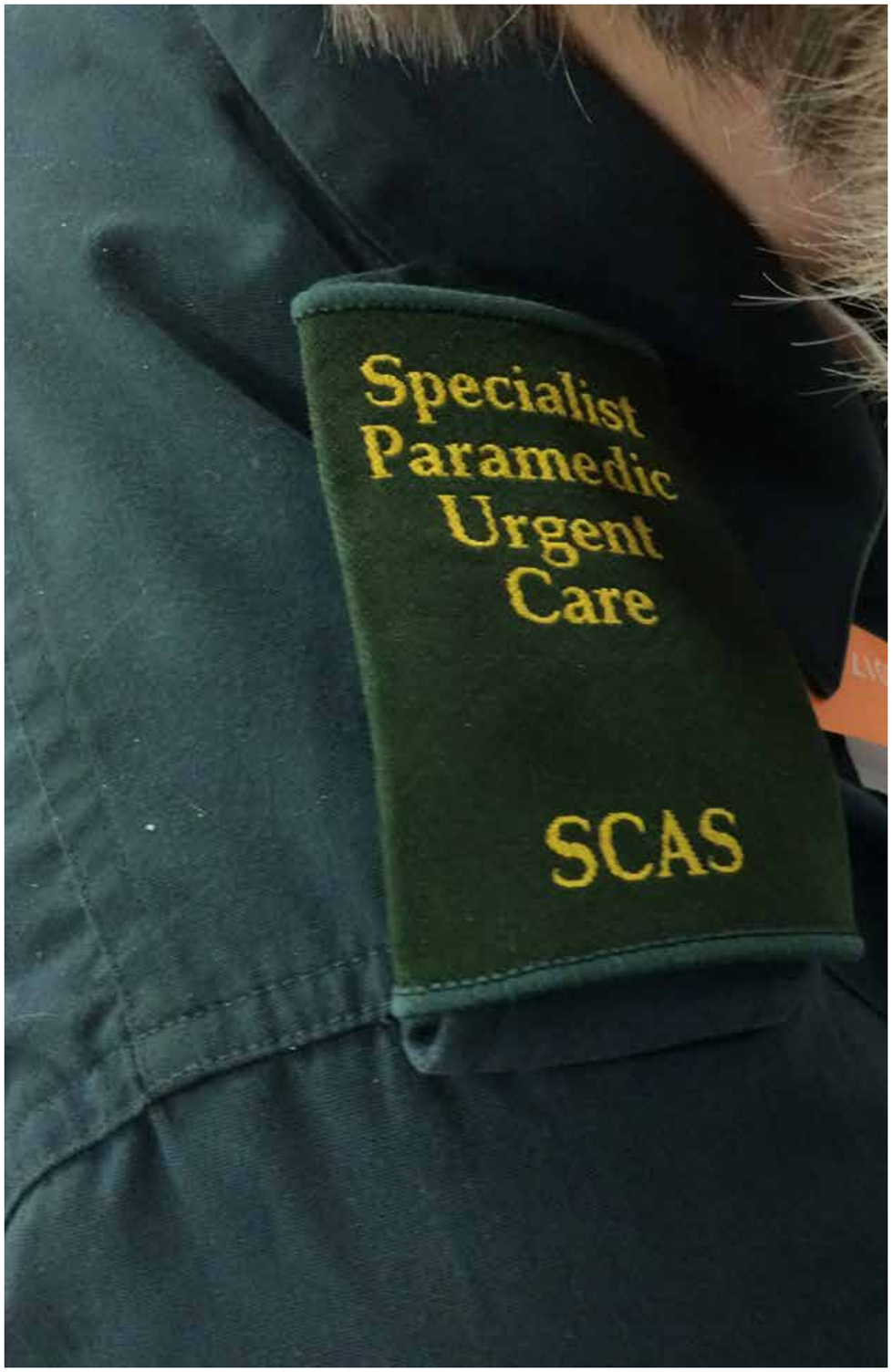
PATIENT EXPERIENCE

3A: TO REPORT ON THE FRIENDS AND FAMILY TEST (FFT), STAFF AND PATIENTS, AND ACTIVELY DEMONSTRATE THAT WE SEEK FEEDBACK AND ACT ON RESULTS

What we said we would do	What we have achieved
Refresh the response cards and methods for FFT surveys for patients in the first half of the year and report on numbers of responses, themes and learning	SCAS has revised and reissued the FFT response card. We decided to have one Friends and Family Test card to be used in PTS and a second card for see and treat patients. They contain the minimum data set as required in the national guidance. One poster has been produced to be displayed in vehicles in all areas of the Trust to invite patients to share their feedback. The new cards arrived with the Trust in the first week of May 2017 and were distributed to PTS and to 999 Operations via the Make Ready Team. Patient surveys were updated to have the FFT question as the first survey question. NHSE Insight and Feedback team, who oversee the national programme, has already made some changes since its introduction to tackle specific issues. They are now ready to undertake a fuller review of some aspects of it to maximise its use for driving local improvement: whether the question could be better worded, whether there are better ways to time feedback in maternity and A&E services, and how / when data should be published nationally.
Utilise and improve the range of ways we seek feedback	The current patient survey that can be completed online has been made more prominent on the SCAS website and feedback is also welcomed via the Patient Zone online portal in PTS.
Report on the findings and implement any improvements based on responses	Findings and improvements are evidenced through our quarterly Patient Experience Review Group. As an example some of our older fleet in PTS was replaced with newer vehicles. SCAS can now report that the FFT question regarding vehicles has increased to a higher positive level in Hampshire. In Surrey as a result of patients' feedback on delays, SCAS has introduced daily performance reviews and an auto planning system.
Increase the response rate from the baseline in 2016/17	This remains a challenge nationally however SCAS has refreshed campaigns for increasing responses.
Did we achieve this priority?	Achieved

3B: TO EVIDENCE LEARNING FROM HEALTHCARE PROFESSIONAL (HCP) FEEDBACK IN ALL SERVICES (NHS 111, PTS AND 999)

What we said we would do	What we have achieved
Ensure the process used to review and respond to feedback is robust and facilitates aggregated learning practices	In 2017/18 the Trust Board Experience Group received regular updates on HCP feedback. The Quality and Safety Committee received quarterly aggregated learning reports including feedback, complaints, concerns and compliments. As we interface with a large range of partners we encourage other professionals to feedback to us in order to learn and improve. We now have a robust system using Datix for receiving and auditing all feedback across our services. The Patient Experience Team has undertaken a programme of training sessions across all services which has included clear advice on the importance of capturing feedback from our HCP colleagues, along with support and guidance on conducting an investigation and responding in a timely way with a quality response.
Engage with our HCP partners to ensure they are aware of and able to access our feedback processes across all areas of service provision giving assurance that feedback will be dealt with in a timely way	SCAS service areas meet regularly with our HCP partners; an example would be our PTS managers meeting monthly with the hospital liaison officers to build close working relationships and provision for open feedback reciprocally. The Clinical Governance Leads for 999 and the Head of Patient Experience also met with patient safety and experience teams at Queen Alexandra Hospital, Southampton General Hospital, Basingstoke and North Hampshire Hospital and Solent NHS Trust to ensure they are aware of and able to access our feedback processes.
Include the new partners in Surrey and Sussex PTS services in all governance reports as a quality indicator	Completed as evidenced in all our public governance reports.
Report widely on feedback themes, trends and actions taken	Our Trust Board receives regular reporting on HCP feedback activity.
Develop a trajectory for consistently responding on time (30 days) – improve by 10 per month	A deep-dive analysis of HCP feedback in PTS was undertaken in Q3 – this included reviewing 20 cases in the Thames Valley region and identifying root causes. An action plan for improvement was presented in March 2018 to our Patient Experience and Quality and Safety groups. The root causes identified were: *Resource levels - resources available to meet demand* *Planning - planned work to resources available* *Communication - perceived lack of communication to patients and departments to advise of delays* *Managing expectations - HCPs unsure of the PTS service commissioned* It was considered that the action plan should be implemented across all SCAS PTS contracts as the same root causes are the same in each contract. ***Actions to date:*** Analyse resourcing issues - rota reviews in both contact centre and operations completed and lines are now full in the contact centre, operations ongoing recruitment is being conducted Identify if renal dispatch requires alteration - new renal coordinator now in place to make these changes Identify the HCP feedback responses and analyse that the learning that has taken place. Ensure response times are met with HCP feedback - generic responses have been written and will be reviewed on a monthly basis **Actions going forward:** **Resource levels - meetings with hospitals scheduled with regards to on the day bookings as on the day discharge activity is high** **Planning - monthly re-assessment and monitoring of pre-planned journeys and ensure they are achievable.** **Communication - new Standard Operating Procedure (SOP) to be drafted regarding exceptions for deallocation and the SOP recirculated.** **Trajectory for improvement being developed.** As a result of our improved processes and guidance shared across the Trust, the volume of HCP feedback recorded by the Trust increased by 52% from March 2017 to November 2017. This has allowed us to have a much more comprehensive and clear picture of the impact of our services on wider NHS HCP services.
Did we achieve this priority?	Partially achieved



3C: TO DEVELOP SYSTEMS THAT ENGAGE AND SEEK FEEDBACK FROM HARD TO REACH GROUPS

What we said we would do	What we have achieved
Conduct focus groups across the SCAS footprint to engage harder to reach groups	Patient Transport Services in Sussex have been surveying renal and cancer patients. A programme of Trust-wide planned community engagement forums and roadshows took place in 2017/18. Representatives from groups as diverse as Dementia Action Alliance, Southampton Alzheimers Society, Parability, Radian Lifelink, Eastleigh Southern Parishes Older Peoples Forum, PPGs for several GP surgeries, Oxfordshire Association of Care Providers, North Oxfordshire Locality Forum, Health & Social Care students from Newbury College, Mayor of Newbury, Oxfam Exploration, Milton Keynes Equality Council, WhyWeight Milton Keynes, Compass (young peoples' substance misuse service), Global Outreach Foundation and also Friends of the Caribbean Charity have attended our forums to raise questions and share their views. Representatives of Healthwatch groups across the SCAS footprint also regularly attend our forums along with several SCAS governors.
Work closely with CCGs to ensure management of wider engagement	A programme of Trust-wide community engagement forums and roadshows took place in 2017/18 and these were well attended by representatives from a diverse range of community groups including Healthwatch.
Develop feedback mechanisms through patient forums	Trust staff have been invited to attend future Healthwatch public engagement events in Berkshire and will be attending events run by local community groups.
Feedback the information through our Patient Experience Review Group (PERG)	SCAS staff have attended several Sussex PTS patient forums and will continue to do so as this is a valuable source of feedback and promotes open and honest dialogue.
Did we achieve this priority?	Achieved

2.2 STATEMENT OF ASSURANCE FROM THE BOARD

1. During 2017/18 South Central Ambulance Service NHS Foundation Trust (SCAS) provided and/or sub contracted three relevant health services:

- Emergency 999 ambulance service
- Non-emergency patient transport service
- NHS 111 telephone advice service

1.1 SCAS has reviewed all the data available to it on the quality of care in these three relevant health services. Along with qualitative data, the Board has sought assurance from a variety of sources:

- Patient surveys
- Friends and family
- Staff surveys
- Narrative from complaints and feedback and their resolution
- HCP feedback
- Patient stories at public Board meetings
- Root cause analysis of incidents and identified leaning
- Internal audit reports
- External reviews of quality including the CQC and commissioner visits
- Leadership walk-rounds and actions
- Committee meetings and upward reports
- Staff meetings
- Quality impact assessments of cost savings projects
- Quality and safety papers to the Board

1.2 The income generated by the relevant health services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by SCAS for 2017/18.

2. During 2017/18, eight national clinical audits and nil national confidential enquiries covered relevant health services that SCAS provides.

2.1 During 2017/18, SCAS participated in 100% national clinical audits and 0% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

2.2 The national clinical audits and national confidential enquires that SCAS was eligible to participate in during 2017/18 were as follows:

- Acute Myocardial Infarction and other Acute Coronary Syndrome (MINAP)
- Ambulance Service Clinical Quality Indicator Stroke Care Bundle
- Ambulance Service Clinical Quality Indicator Cardiac Arrest (ROSC) Rates (and separate witnessed arrest ROSC rates)
- Ambulance Service Clinical Quality Indicator Cardiac Arrest Survival to Discharge (STD) Rates (and separate witnessed arrest STD rates)
- Ambulance Service Clinical Quality Indicator ST Elevation Myocardial Infarction Care Bundle
- Ambulance Service Clinical Quality Indicator Primary Percutaneous Coronary Intervention (pPCI) call to Balloon within 150 minutes
- Warwick Clinical Trials Unit Out of Hospital Cardiac Arrest Outcomes
- NASMeD Use of Adrenaline in Asthma

2.3 The national clinical audits and national confidential enquires that SCAS participated in during 2017/18 were as follows:

- Acute Myocardial Infarction and other Acute Coronary Syndrome (MINAP)
- Ambulance Service Clinical Quality Indicator Stroke Care Bundle
- Ambulance Service Clinical Quality Indicator Cardiac Arrest (ROSC) Rates (and separate witnessed arrest ROSC rates)
- Ambulance Service Clinical Quality Indicator Cardiac Arrest Survival to Discharge (STD) Rates (and separate witnessed arrest STD rates)
- Ambulance Service Clinical Quality Indicator ST Elevation Myocardial Infarction Care Bundle
- Ambulance Service Clinical Quality Indicator Primary Percutaneous Coronary Intervention (pPCI) call to Balloon within 150 minutes
- Warwick Clinical Trials Unit Out of Hospital Cardiac Arrest Outcomes
- NASMeD Use of Adrenaline in Asthma

2.4 The national clinical audits and national confidential enquiries that SCAS participated in, and for which data collection was completed during 2017/18, are listed below alongside the numbers of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National clinical audit	Number of cases	% submitted
Acute Myocardial Infarction and other Acute Coronary Syndrome (MINAP)	1,107 April 2017 to February 2018	100%
Ambulance Service Clinical Quality Indicator Stroke Care Bundle	5,779 April 2017 to February 2018	100%
Ambulance Service Clinical Quality Indicator Cardiac Arrest ROSC Rates (and separate witnessed arrest ROSC rates)	137 April 2017 to February 2018	100%
Ambulance Service Clinical Quality Indicator Cardiac Arrest Survival to Discharge (STD) Rates (and separate witnessed arrest STD rates)	91 April 2017 to February 2018	100%
Ambulance Service Clinical Quality Indicator ST Elevation Myocardial Infarction Care Bundle	603 April 2017 to February 2018	100%
Ambulance Service Clinical Quality Indicator Primary Percutaneous Coronary Intervention (pPCI) call to Balloon within 150 minutes	568 April 2017 to February 2018	100%
Warwick Clinical Trials Unit Out of Hospital Cardiac Arrest Outcomes	1,855 April 2017 to February 2018	100%
NASMeD Use of Adrenaline in Asthma	67 January 2017 to December 2017	100%

2.5 and 2.6 The reports of eight national clinical audits were reviewed in 2017/18 and SCAS intends to take the following actions to improve the quality of healthcare provided:

- ➔ Consider the implications of the Paramedic 2 trial research outcomes and the implications this may have for the treatment of cardiac arrest in the pre-hospital setting
- ➔ Monitor ARP response to Category 1 patients presenting with cardiac arrest, stroke or STEMI
- ➔ Engage nationally once confirmation of the new post-ARP Ambulance Care Quality Indicators are released
- ➔ Continue monthly internal audit of 50 cases for what was the NCPI groupings, such as asthma, falls, hypoglycaemia and lower limb fractures

2.7 and 2.8 The reports of 12 local clinical audits were reviewed in 2017/18 and SCAS intends to take the following actions to improve the quality of healthcare provided:

- ➔ Improve compliance with recording peak flow measures including a compliance screen to ensure clinicians add the required elements for treating patients with an exacerbation of asthma
- ➔ Improve the recording of pre- and post-blood glucose monitoring with a review of guidelines
- ➔ Improvements to our electronic clinical records system to introduce a compliance element for appropriate medication for patients with febrile convulsions
- ➔ SCAS will be testing a requirement for clinical staff to record limb immobilisation for fractures 100% of the time and reiterating this in our education programmes
- ➔ Introduction of a Falls Working Group led by Clinical Governance Leads
- ➔ Maintain monthly reviews of all private providers including a random audit of patient records
- ➔ Monthly Long Wait Review Group auditing a range of cases per category per nodal area

3. The number of patients receiving relevant health services provided or sub contracted by SCAS in 2017/18 that were recruited to participate in research, approved by a research ethics committee was 743.

Conference presentations and publications demonstrate our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

Our engagement with clinical research also demonstrates the Trust's commitment to testing and offering the latest medical treatment and techniques. The areas of engagement are outlined below.

Publications

2018

- Deakin CD. The Chain of Survival: Not all links are equal. *Resuscitation* 2018 In press.

- Deakin CD, Potter R, Sidebottom D. Can rescuers accurately deliver subtle changes to chest compression depth if recommended by future guidelines? *Resuscitation* 2018; 124; 58–62.

- Eaton G, Renshaw J, Gregory P, Kilner T. Can the British Heart Foundation PocketCPR application improve the performance of chest compressions during bystander resuscitation: A randomised crossover manikin study. *Health Informatics Journal 2018;* 24(1):14-23.

- Eaton G, Brown S, Raitt J. HEMS dispatch: A Systematic Review. *Trauma 2018;* 20(1):3-10.

-Fleming S, Philips S, Pritchard N, Perkins L, Smpons K, Inkster H, **Best D.** Teams that work together should train together: PHONE999 course. *British Journal of Midwifery 2018.*

- Mahtani K, **Eaton G**, Catterall M, Ridley A. (2018) Setting the scene for paramedics in general practice: What can we expect? *PeerJ Preprints6:e*15934v1 [online] **https://doi.org/10.7287/peerj.preprints.15934v1**

- Pocock H, Jadzinski P, Taylor-Jones C, King P, England E, Fogg C (2018) A clinical audit of the electronic data capture of dementia in ambulance service patient records. *British Paramedic Journal* 2018; 2 (4), 10-18.

2017

- Brooks B, **Deakin CD**. Exothermic warming blankets: a case of full thickness burns and the relationship between oxygen concentration and ensuing heat generation. *Emergency Medicine Journal* 2017 In press.

- Chen Ji, Lall R, Quinn T, Kaye C, Haywood K, Horton J, **Deakin CD, Pocock H,** Carson A, Smyth M, Rees N, Kyee Han, Byers S, Brace-McDonnell S, Gates S, Perkins GD. Post-admission outcomes of participants in the PARAMEDIC trial: a cluster randomised trial of mechanical or manual chest compressions. *Resuscitation* 2017 doi: 10.1016/j.resuscitation.2017.06.026.

- Deakin CD. Reply to: Hatton SJ. Identification of adult cardiac arrest using NHS Pathways. *Heart* 2017. In press.

- Deakin CD, England S, Diffey D, Maconochie I. Can ambulance telephone triage using NHS Pathways accurately identify paediatric cardiac arrest? *Resuscitation* 2017: 116: 109-112.

- Eaton G, Raitt J, Browns S, Parsons V. How appropriate are the data produced by NHS Pathways for identifying suitable cases for involvement of enhanced care teams? *British Paramedic Journal 2017;* 2(3): 16–23.

- Eaton G. Taking healthcare to the community: the evolving role of paramedics. *Journal of Paramedic Practice 2017;* 9(5): 190-191.

- Gates S, Lall R, Quinn T, **Deakin CD,** Cooke MW, Horton J, Lamb SE, Slowther AM, Woollard M, Carson A, Smyth M, Wilson K, Parcell G, Rosser A, Whitfield R, Williams A, Jones R, **Pocock H**, **Brock N, Black JJ,** Wright J, Han K, Shaw G, Blair L, Marti J, Hulme C, McCabe C, Nikolova S, Ferreira Z, Perkins GD. Prehospital randomised assessment of a mechanical compression device in out-of-hospital cardiac arrest (PARAMEDIC): a pragmatic, cluster randomised trial and economic evaluation. *Health Technol Assess.* 2017 Mar; 21(11): 1-176. doi: 10.3310/hta21110.

- Hanson S, **Hanson A,** Aldington D. (2017) Pain Priorities in Pre-Hospital Care. *Anaesthesia and Intensive Care Medicine 2017*, 18, 8, 380 – 382.

- Marti J, Hulme C, Ferreira Z, Nikolova S, Lall R, Kay C, Smyth M, Kelly C, Quinn T, Gates S, **Deakin CD,** Perkins GD. The cost-effectiveness of a mechanical compression device in out of hospital cardiac arrest. *Resuscitation* 2017; 117: 1-7 .

- Mildenhall, J. Putting ambulance staff psychological wellbeing on the academic agenda. *Paramedic Insight (College of Paramedics) 2017.* 9.

- Raitt J, Norris-Cervetto E, Hawksley O. A report of two years of pre-hospital blood transfusions by Thames Valley Air Ambulance. *Trauma* April 24, 2017 Online publication ahead of print **http://journals.sagepub.com/doi/full/10.1177/1460408617706388**

- Renshaw J, **Eaton G,** Gregory P, Kilner T. The BHF PocketCPR smartphone application: 'Staying alive' with bystander CPR. *Resuscitation 2017; 1*18: e3-e4. 10.1016/j.resuscitation.2017.08.232

- Sidebottom D, **Hodgetts G, Deakin CD.** A shocking picture: automated external defibrillators are poorly signposted in the community. Congress of the European Resuscitation Council in Freiburg, Germany September 2017. *Resuscitation* 2017 **https://doi.org/10.1016/j.resuscitation.2017.08.148.**

- Sidebottom D, Potter R, **Deakin CD** Can rescuers accurately deliver subtle changes to chest compression depth if recommended by future guidelines? Congress of the European Resuscitation Council in Freiburg, Germany September 2017. *Resuscitation* 2017 In press.

Presentations

- Best D. Pre-Hospital Obstetric and Neonatal Emergency. *Annual Neonatal Simulation Conference. Southampton, September 2017.*

- Best D. Pre-Hospital Obstetric and Neonatal Emergency. *Thames Valley Strategic Clinical Network / Oxford Academic Health Science Conference. Oxford, November 2017.*

- Deakin CD. Management of refractory ventricular fibrillation. *Kent, Surrey & Sussex Air Ambulance Clinical Governance Day. Redhill, March 2017.*

- Deakin CD. Adrenaline – friend or foe? *Kent, Surrey & Sussex Air Ambulance Clinical Governance Day. Redhill, March 2017.*

- Deakin CD.. Adrenaline – friend or foe? *Kent, HEMS Conference. University of Surrey. September 2017.*

- Deakin CD. Telephone CPR: How to guide bystanders and colleagues. *2nd European Paediatric Resuscitation and Emergency Medicine conference. Ghent, Belgium. May 2017.*

- Deakin CD. Cardiac trauma – from roadside to operating theatre. *EACTS Academy Course, Fundamentals in Cardiac Surgery: Part II. Windsor, June 2017.*

- Deakin CD. Controversies in Advanced Life Support *European Resuscitation Council. Resuscitation 2017-Society Saving Lives. Freiburg, Germany. September 2017.*

- Deakin CD. Is sudden death so sudden? *European Resuscitation Council. Resuscitation 2017-Society Saving Lives. Freiburg, Germany. September 2017.*

- Deakin CD. Quality Monitoring of Dispatch CPR. *Resuscitation Science Symposium. Scientific Sessions 2017. American Heart Association. Anaheim, California, U.S.A. November 2017.*

- Dearman J. Prehospital blood transfusion – a review of two years of red cell use by Thames Valley Air Ambulance. *Celebrating Trauma Research in the Thames Valley conference. Reading, February 2018.*

- Eaton G. HEMS Dispatch – A Review. *College of Paramedics National Conference. Solihull. May 2017.*

- Hawkes N, Wetenhall S, Maskery N, Raitt J. A review of one year of night flying. *Thames Valley & Hampshire and Isle of Wight Air Ambulances' Clinical Governance Day, July 2017.*

- Kaye R, Alden T, Raitt J. Improving identification of trauma cases at dispatch. *Thames Valley & Hampshire and Isle of Wight Air Ambulances' Clinical Governance Day, July 2017.*

- Masud S. Head injury management in PHEM. *Head injury symposium, Boyes Turner Injury Law Firm. Reading.*

- Masud S. The year ahead in PHEM. *TVAA Volunteers Conference. Thame , October 2017.*

- Masud S. TVAA Innovations in PHEM clinical care. *TVAA Symposium. 2017.*

- McPherson D. Point of care blood testing (POCbT) for patients >65 presenting with acute frailty syndromes. *Health Education England Thames Valley 'The Power of Partnerships' Event. Oxford, March 2018.*

- Meadham J, Knott H, Raitt J. How good is TVAA job documentation? *Thames Valley & Hampshire and Isle of Wight Air Ambulances' Clinical Governance Day, March 2017.*

- Mildenhall J. Psychological distress in emergency workers. *'This is My Hand' Emergency Services Mental Health Charity Conference, Newbury. May 2017.*

- Mildenhall J. Paramedics' Experiences of Traumatic Incidents & Post-Incident Support. *National Paramedic Conference 2017, College of Paramedics, Solihull. May 2017.*

- Mildenhall J. Coping with Distressing Incidents as an Emergency Responder. *Life Connections Conference, Aylesbury, Buckinghamshire. March, 2018.*

- Mildenhall J. Coping with Distressing Incidents as an Emergency Responder. *Pre-Hospital Care Conference. University of West of England, Bristol. 2018.*

- Pocock H. Research in pre-hospital emergency medicine: challenges of the PARAMEDIC 2 Trial. *National Pre-Hospital Emergency Medicine Conference. Oxford, November 2017.*

- Raitt J, Norris D, Hawksley O. A review of two years of blood use. *Thames Valley & Hampshire and Isle of Wight Air Ambulances' Clinical Governance Day, January 2017.*

- Spence C. Improving identification of trauma cases at dispatch. *Celebrating Trauma Research in the Thames Valley Conference. Reading, February 2018.*

- Spence C. Using key performance indicators to drive quality improvement in pre-hosptial emergency anaesthesia: the Thames Valley Air Ambulance approach. *Celebrating Trauma Research in the Thames Valley Conference. Reading, February 2018.*

Poster presentations

- Eaton G, Raitt J, Brown S (2017) How appropriate is the data produced by NHS pathways at identifying suitable cases for HEMS involvement? *CAHPR Spring Conference, Oxford 2018; Thames Valley Research Network, Reading 2017; Trauma Care Conference, Staffordshire 2017; College of Paramedics National Conference, Solihull 2017.*

- Raitt J, Norris E, Hawksley O. Pre-hospital blood transfusion - a review of two years of red cell use by Thames Valley Air Ambulance. *Trauma Care Conference, Staffordshire 2017.*

- Raitt J, Mayne L, Masud S, Staves J. Pre-hospital blood transfusion - practical solutions to common problems. *Trauma Care Conference, Staffordshire 2017.*

- Letchford K, Raitt J. The whole team approach. Enhanced training for all ambulance staff by HEMS paramedics. *Trauma Care Conference, Staffordshire 2017.*

- Raitt J, Hugnell J, Masud S. Using key performance indicators to drive quality improvement in pre-hospital emergency anaesthesia: the Thames Valley Air Ambulance approach. *Annual Scientific Meeting PHEC Faculty of PHEC, RCS Ed. Solihull 2017.*

Presentation prizes

- Council for Allied Health Professions Research (CAHPR) Public Health Research Award Winner 2017. Renshaw, J., **Eaton, G.**, Gregory, P., Kilner, T. *"The BHF Pocket CPR smartphone application: 'Staying alive' with bystander CPR."*

- Runner up prize for best poster presentation at conference: **Raitt J, Hugnell J, Masud S.** Using key performance indicators to drive quality improvement in pre-hospital emergency anaesthesia: the Thames Valley Air Ambulance approach. *Annual Scientific Meeting PHEC Faculty of PHEC, RCS Ed. Solihull 2017.*

4. A proportion of the Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between SCAS and any person or body the Trust entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

4.1 and 4.2 Further details of the agreed goals for 2017/18 and for the following 12-month period include:

➔ Health and wellbeing (including flu vaccinations)

➔ Improving dementia training in PTS

➔ Audit and actions for reducing manual handling incidents in PTS

➔ Year 2 of Live Link developments for appropriate access to healthcare

➔ Year 2 of non-conveyance improvements

5. SCAS is required to register with the Care Quality Commission (CQC) and its current registration status is without conditions in all fundamental standards.

5.1 The CQC has not taken enforcement action against SCAS during 2017/18.

6. Removed from the legislation by the 2011 amendments.

7. and 7.1 SCAS has not participated in any special reviews or investigations by the CQC during the reporting period.

8. and 8.1 SCAS did not submit records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

9. The Trust's Information Governance Assessment Report overall score for 2017/18 was 79% and was graded green from the IGT Grading scheme.

10. and 10.1 The Trust was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.

11. SCAS will be taking the following actions to improve data quality:

- ➔ Integrated Performance Report review and revision – includes all finance, operational, service and quality data
- ➔ Patient records analysed and audited and ePR improvements
- ➔ Clinical audit plan
- ➔ Review and implementation of actions from internal audit reports to Audit Committee
- ➔ Corporate Risk Register and Board Assurance Framework reviews and escalation process from local risk registers to ensure data quality concerns are addressed

2.3 REPORTING AGAINST NHS IMPROVEMENT CORE INDICATORS

Set by NHS Improvement (NHSI), mandated indicators are intended to strengthen the reporting processes and create a comparable set of targets across all UK ambulance trusts. The mandated core quality indicators are outlined.

The percentage of Category A telephone calls (Red 1 and Red 2 calls) resulting in an emergency response by the Trust at the scene of the emergency within eight minutes of receipt of that call during the reporting period.

Red 1 (1 April -30 October 2017)	**Red 2 (1 April-30 October 2017)**
73.9%	70.6%
Category 1 (31 October 2017-31 March 2018)	**Category 2 (31 October 2017-31 March 2018)**
C1 07:19 (mean) C1 13:21 (90th percentile) C1T 11:45 (mean)	C2 17:24 (mean) C2 35:05 (90th percentile)
Previous years' data (Red 1)	Previous years' data (Red 2)
2016/17 – 73.3% 2015/16 – 71.9% 2014/15 – 75.0%	2016/17 – 73.1% 2015/16 – 72.7% 2014/15 – 74.5%

South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons; CAD system has robust fall back plans, ARP standards measured and reported nationally, the Trust has a robust data quality process for ensuring performance reporting is benchmarked, and that data is scrutinised internally by the executive directors and Board and by commissioners.

SCAS intends to take the following actions to improve this indicator and so the quality of its services, by continually analysing the ARP data and continuing to model our staff rotas and fleet availability to meet the category requirements. Through the Integrated Performance Report to Trust Board there will be clear visibility of the data and our actions. SCAS will continue to input into the national group and workstreams and audit long waits.

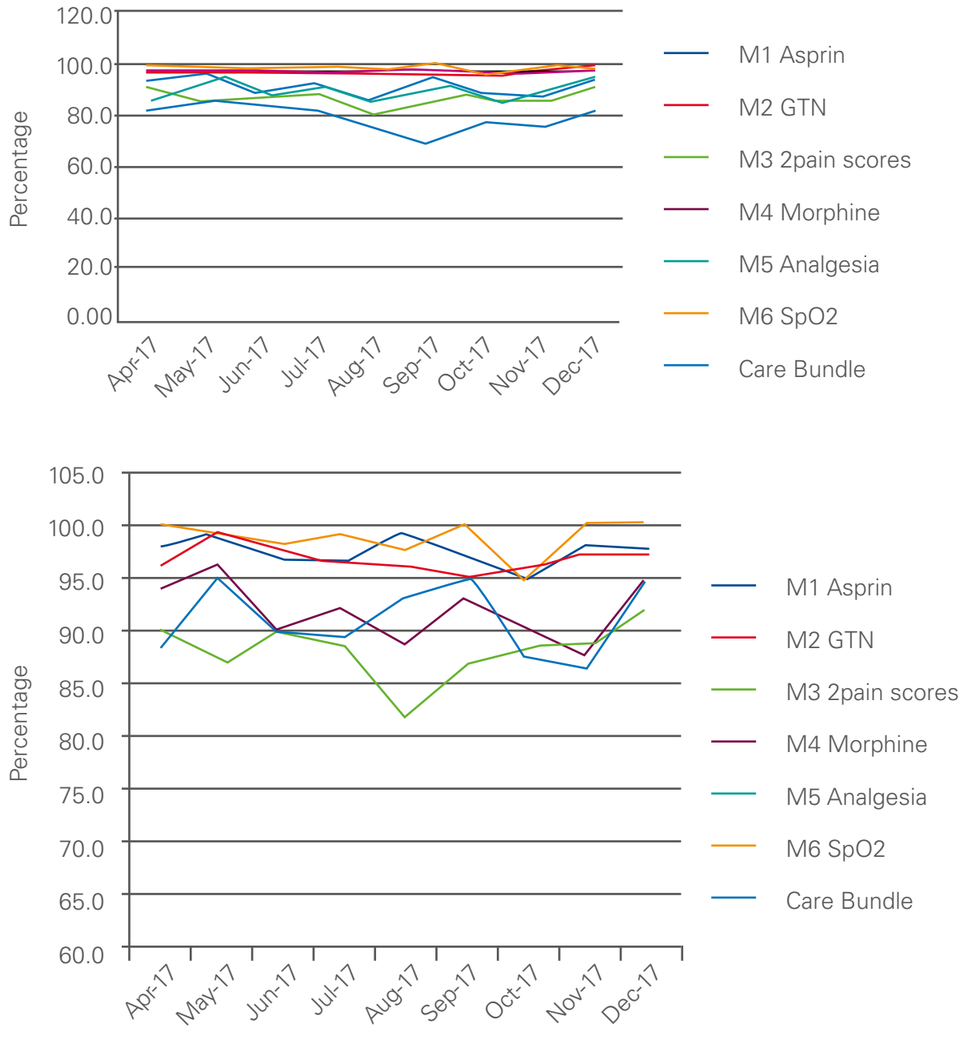
The percentage of Category A telephone calls resulting in an ambulance response by the Trust at the scene of the emergency within 19 minutes of receipt of that call during the reporting period (up to the introduction of the ARP standards at the end of October 2017).

Red 19 (1 April-30 October 2017)	**94.2%**
Previous years' data	94.7% - 2016/17 94.4% - 2015/16 95.5% - 2014/15

STEMI Care Bundle Performance

The percentage of patients with a pre-existing diagnosis of suspected ST elevation myocardial infarction who received an appropriate care bundle from the Trust during the reporting period.

STEMI Care Bundle



NOTE: This is YTD data in line with national reporting validation processes.

In 2016/17 compliance was 73.8%.

Stroke Care Bundle Performance

The percentage of patients with suspected stroke assessed face to face who received an appropriate care bundle from the Trust during the reporting period.

Stroke Care Bundle

NOTE: This is YTD data in line with national reporting validation processes.

In 2016/17 compliance was 98.7%

South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons; electronic patient record data and analysis, report and data for national reporting requirements, Board reports, external contract reports, and Integrated Performance Report.

SCAS intends to take the following actions to improve these indicators, and so the quality of its services, by utilising data collected from the electronic patient record system and analysing that data as per national reporting requirements. SCAS has an internal clinical audit programme and conducts deep dives where necessary (reporting to the Quality and Safety Committee and Clinical Review Group). SCAS is continuing to input into the national work on revising the ambulance quality indicators.

Ambulance Clinical Quality Indicators YTD Apr to November 2016/17 against national average (YTD)

Clinical Quality Indicator	Lower	Upper	Difference	National Average	South Central	Greater or lower than Average
STEMI - Care	58.33%	90.65%	32.32%	77.99%	72.31%	▼
Stroke - Care	94.37%	99.64%	5.27%	97.63%	98.59%	▲

Ambulance Clinical Quality Indicators YTD Apr to October 2017/18 against national average (YTD)

Clinical Quality Indicator	Lower	Upper	Difference	National Average	South Central	Greater or lower than Average
STEMI - Care	63.16%	91.81%	28.65%	76.53%	79.79%	▲
Stroke - Care	94.00%	99.77%	5.77%	97.12%	98.92%	▲

The percentage of staff employed by, or under contract to, SCAS during the reporting period who would recommend the Trust as a provider of care to their family or friends.

		Your Trust in 2017	Average (median) for ambulance trusts	Your Trust in 2016	Your Trust in 2015
Q21a	"Care of patients / service users is my organisation's top priority"	60%	59%	58%	49%
Q21b	"My organisation acts on concerns raised by patients / service users"	67%	62%	66%	60%
Q21c	"I would recommend my organisation as a place of work"	51%	47%	49%	39%
Q21d	"If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"	74%	70%	72%	63%
KF1	Staff recommendation of the organisation as a place to work or receive treatment (Q21a, 21 c-d)	3.56	3.44	3.51	3.27

South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons; FFT responses by rotating staff group requests, website feedback, robust analysis at the internal group of Patient Experience and through external contractual reports to commissioners.

SCAS intends to take the following actions to improve this and so the quality of its services by relaunching the new FFT postcards, making the website function easier to use and reporting to the Patient Experience Review Group on themes and learning.

The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

	2014/15	2015/16	2016/17	2017/18
Number of incidents	570	447	282	129
Number and % severe harm / death	52 (9.1%)	21 (4.7%)	13 (4.6%)	1 (0.8%)

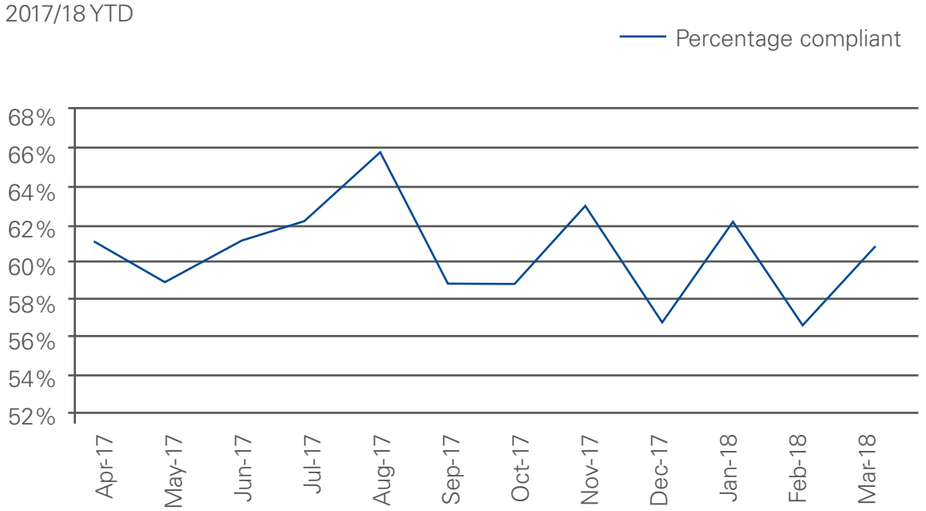
Notes:
Rate is not calculated for ambulance services and national benchmark is not yet available.
SCAS process revised with NRLS – reporting figures accurately checked.

South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons; Datix reports, minutes of the Datix Review Group, Board reports and scrutiny of data at the incident reporting group, and NRLS confirmation.
SCAS intends to take the following actions to improve this indicator and so the quality of its services by refresher training for staff on Datix, reviewing numbers, severity and themes of incidents at the Patient Safety Group, Trust Board scrutiny, aggregated learning reports, staff survey of Datix use with actions, campaign of awareness around incident reporting, and easy guide reissued to staff on incident reporting.

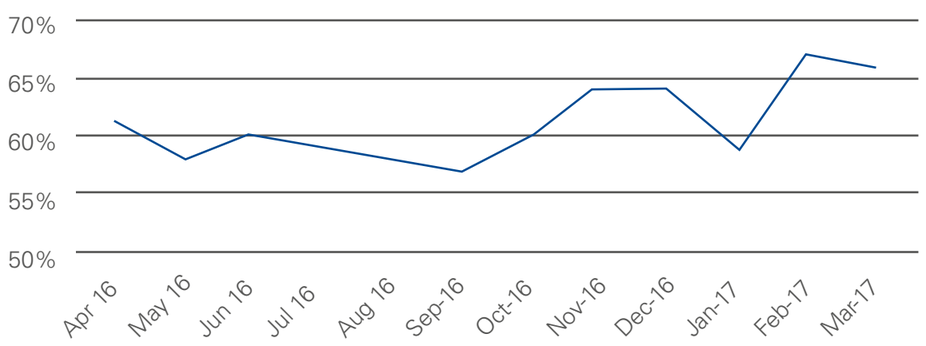
NHSI issued further detailed guidance for Quality Reports in February 2018. Below is information on those elements now required for ambulance trusts to report on.

Stroke 60 Performance

2017/18 YTD

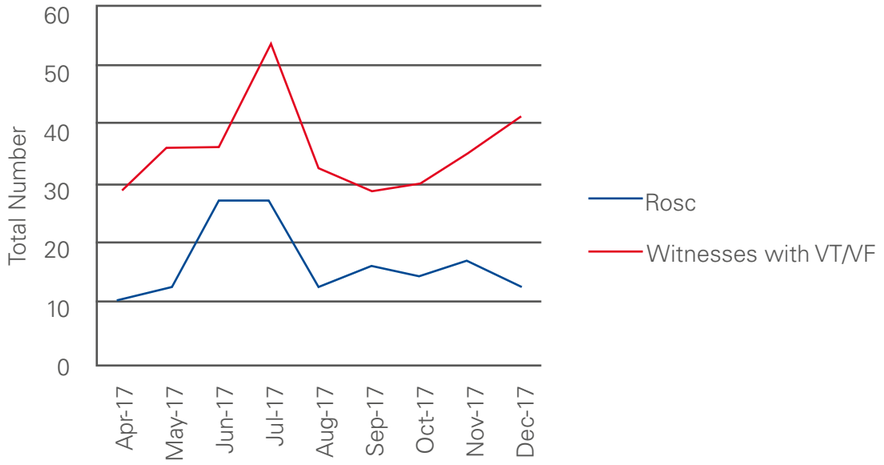


2016/17



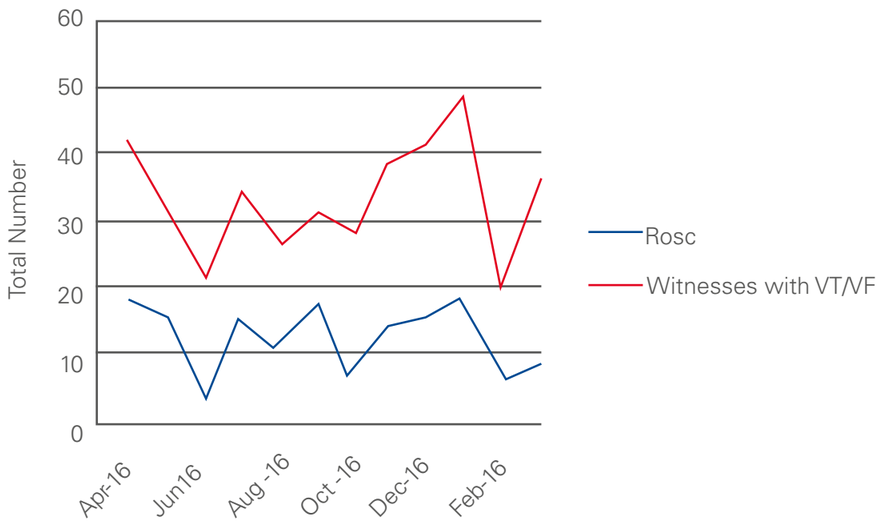
Return of Spontaneous Circulation (ROSC)* Performance

2017/18 YTD



2016/17

Return of Spontaneous Circulation in witnessed cardiac arrests 2016/17



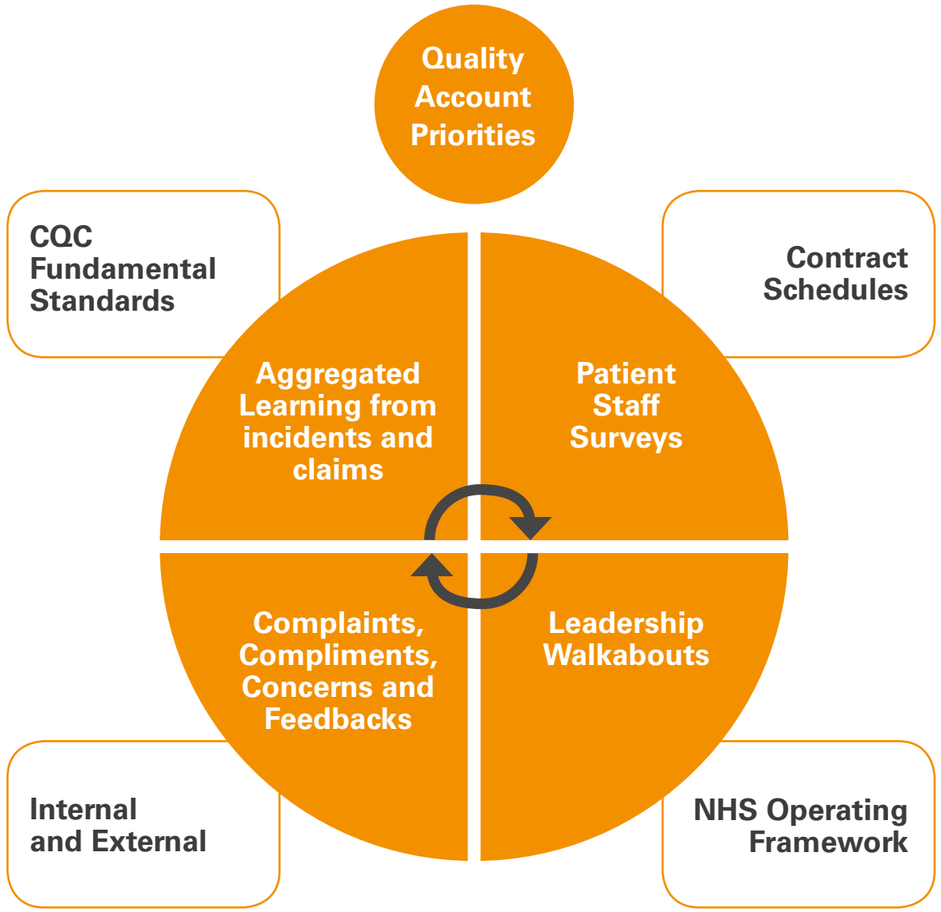
*Note: where the arrest was bystander witnessed and the initial rhythm was ventricular fibrillation (VF) or ventricular tachycardia (VT)

PART THREE

3.1 CHOOSING AND PRIORITISING QUALITY IMPROVEMENT INITIATIVES 2018/19

In this part of the report we will outline a number of areas where we have identified quality improvements for the coming year. They have been developed in partnership and demonstrate a commitment to improve care in a measureable way where there is room for improvement. Two of our priorities have been extended over more than one year.

Priorities are identified through scrutiny of a wealth of information collated through robust operational and engagement practices which are shared at Board level through our governance structure.



We engage with our clinical commissioning groups and other external partners when defining our goals for quality improvement and we place high importance on the feedback we receive from patients and other healthcare professionals, through:

- Surveys – staff and patients
- Healthcare professional feedback
- Public feedback including complaints, concerns, compliments
- Serious incidents
- Adverse incidents
- CQC compliance actions
- Audits (internal and external)
- Committee reports
- Leadership walk-rounds
- Feedback from key stakeholders (Healthwatch, HOSCs, patient forums, commissioners)

Leadership walk-rounds by the executive and non-executive directors also provide intelligence to develop areas for improvement and helped to engage frontline and support staff in discussions and debates about our clinical and patient priorities.

Finally, as a Foundation Trust, we are fortunate to be able to draw on the input of our Council of Governors who provide a picture of the needs of the community which we serve.

Quality Priorities for 2018/19

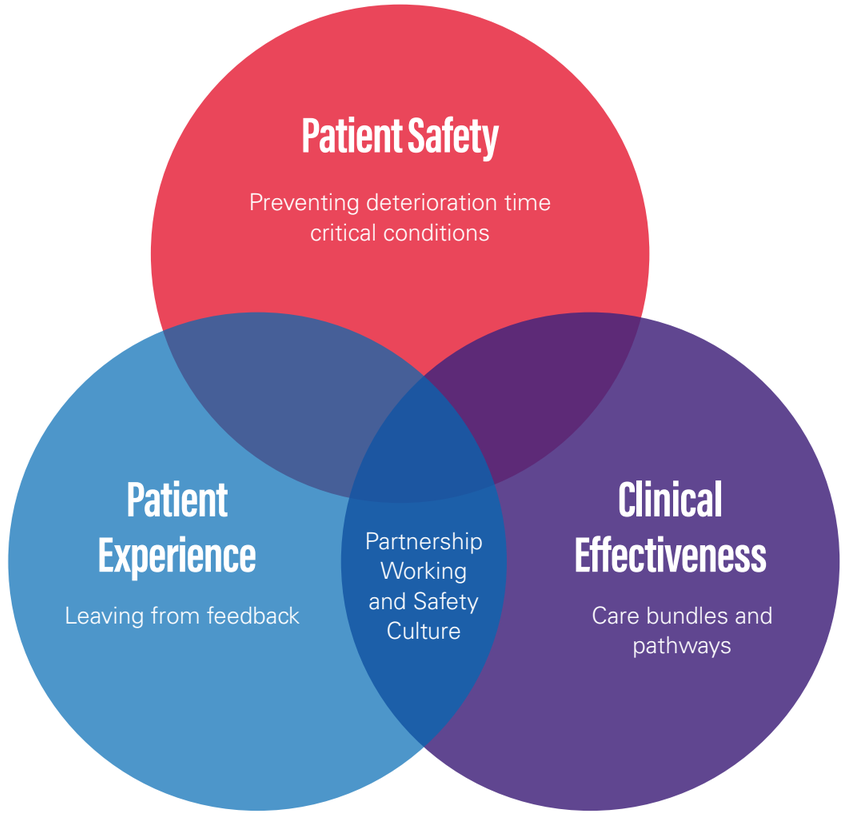
Following consultation with the Trust Board, our Council of Governors, Quality and Safety Committee, the senior leadership team and staff representation the following priorities have been approved and confirmed for the Quality Accounts.

Patient Safety	
1a	To implement and assess the effectiveness of the NEWS2 scoring system for sepsis care (identifying patients with sepsis early)
1b	To improve hand hygiene audit compliance (all services)
1c	To implement the new NICE Mental Capacity Act (MCA) guidance – improving awareness and parity

Clinical Effectiveness	
2a	To review and improve call abandonment for PTS (non-emergency Patient Transport Service), 999 and NHS 111 (two-year priority) ***continues***
2b	To increase clinical assessments in CCC (call centres) ensuring consistent methods and application across the services (three-year priority) ***continues***
2c	To improve long waits in the new ARP response categories

Patient Experience	
3a	To conduct a survey of patients using the 999 service highlighting improvement actions to be taken to improve patients experience of the service
3b	To improve the focus on improving staff health and wellbeing at work in relation to stress
3c	To improve end of life care in PTS across all contracts

Each of our priorities and our proposed initiatives for 2018/19 accounts, are described in detail on the following pages. They will be monitored through the quality improvement plans that are presented to the executive and senior management teams and the Quality and Safety Committee. External audit assurance is provided by Grant Thornton and through an internal audit programme.



Patient Safety

1a	To implement and assess the effectiveness of the NEWS2 scoring system for sepsis care (identifying patients with sepsis early)

Why have we chosen this indicator?

Sepsis is defined as a life-threatening organ dysfunction caused by a dysregulated host response to infection (surviving Sepsis Campaign 2016).

There are around 150,000 cases of sepsis every year in the UK, with approximately 44,000 deaths attributed to sepsis. Of patients admitted to intensive care from the Emergency Department, 80-90% will arrive by ambulance, so ambulance staff are very well placed to recognise sepsis cases.

Missed sepsis cases have been a theme in some SCAS SIRI investigations, and retrospective review of these cases show that many of these would have been identified had SCAS been using a sepsis recognition tool.

SCAS do have a sepsis recognition tool on their ePR devices for both paediatric and adult cases and this is the third year we have included a priority in the Quality Accounts to improve sepsis recognition. We are committed to improving further.

To achieve this we are going to:

- ➔ Conduct an ePR audit and review of sepsis cases Q1
- ➔ Introduce the ePR app on sepsis
- ➔ Conduct and complete a robust education programme
- ➔ Audit the use of NEWS2 and ongoing care (right disposition) from ePR
- ➔ Audit re-attendance in 48hrs

Board Sponsor

Medical Director

Implementation Lead

Consultant Pre-Hospital Practitioner

Patient Safety

1b	To improve hand hygiene audit compliance (all services)

Why have we chosen this indicator?

Prevention and control of infection is a fundamental part of keeping patients and staff safe. This indicator is to support staff to adopt best practice at all times in order to protect patients.

Reinforcing good practice regarding hand hygiene is ongoing as is the audit of compliance. SCAS want to demonstrate a commitment to emphasising the importance of good hand hygiene continuously across all services.

Effective hand decontamination – either by washing with soap and water or with an alcohol-based hand rub is recognised as crucial in reducing avoidable infection.

To achieve this we are going to:

- ➔ Increase hand hygiene compliance across all services Q2/3/4 from Q1 baseline
- ➔ Conduct a hand hygiene campaign in Q1 and Q3
- ➔ Monitor and report on hand hygiene rates per service
- ➔ Achieve 95% compliance

Board Sponsor

Director of Patient Care and Service Transformation

Implementation Lead

Infection Control Lead

Patient Safety

1c	To implement the new NICE Mental Capacity Act (MCA) guidance – improving awareness and parity

Why have we chosen this indicator?

The Mental Capacity Act 2005 (MCA) provides the legal framework for acting and making decisions on behalf of individuals (aged 16 years and over) who lack the mental capacity to make particular decisions for themselves. Everyone working with and / or caring for an adult who may lack capacity to make specific decisions must comply with the MCA. The same rules apply whether the decisions are life-changing events or everyday matters.

The underlying philosophy of the MCA is to ensure that any decision made, or action taken, on behalf of someone who lacks the capacity to do so for themselves, is made in their best interests. It sets out a legal framework of how to act and make decisions on behalf of people who lack capacity to make specific decisions for themselves. This includes the core five principles which underpin every intervention under the Act (relating to personal welfare, healthcare, and financial matters).

To support staff using the MCA, the National Institute for Health and Clinical Excellence (NICE) is due to publish a new guideline on the MCA (this is expected to be published in June 2018). As a 'registered stakeholder' SCAS has been fully involved with the development of this guideline, which has ensured that the - sometimes unique - requirements for ambulance staff (of all roles) have been represented in the consultation process.

Putting the guidance into practice will benefit all SCAS patient facing staff and ensure that we continue to provide good, evidence based care to patients who, for a variety of reasons, lack capacity to make decisions for themselves.

To achieve this we are going to:

- ➔ Conduct a staff survey to ascertain knowledge and appropriate use in Q1
- ➔ Identify any specific training needs
- ➔ Conduct a MCA campaign in Q3 aligned with mental health awareness
- ➔ Details of NICE MCA Guidelines will be included in all pertinent education sessions (relevant to role) and used to inform future audits and surveys

Board Sponsor

Director of Patient Care and Service Transformation

Implementation Lead

Clinical Lead – Mental Health and Learning Disability

Clinical Effectiveness

2a	To review and improve call abandonment for PTS (non-emergency Patient Transport Service), 999 and NHS 111 (two-year priority) ***continues***

Why have we chosen this indicator?

We have identified a two-year priority for demonstrating an improvement in call abandonment rates. We already have a robust integrated workforce plan in place to ensure workforce numbers are aligned to demand levels and budget but we need to continually review this. We have reviewed all call centre metrics and introduced standardised activity codes within the telephony platform across 999 and NHS 111 services to ensure call taker availability is robustly and fairly managed.

As we introduced a dynamic skills based routing process within NHS 111 to ensure calls are answered more efficiently to reduce call answer delays that lead to abandoned calls, we need to demonstrate a sustained rate of below 1% which is the national standard.

To improve the call abandonment rate in PTS we will continue to inform our callers via the call announcements of the information required to enable our call centre staff the ability to deal with the call efficiently.

To improve the call abandonment threshold we will ensure that our online system is encouraged through our call announcements and call script to enable our call handlers to be released to deal with complex and on the day activity. We know through our feedback from the public that call answering and messages are important to those calling us.

To achieve this we are going to:

- ➔ Conduct a review of our call announcements on our HCP and patient facing lines to ensure that our online system is promoted – creating a baseline measure of callers that use online services
- ➔ We will review our call scripts to ensure that our staff promote pre-planned activity being placed via our online system
- ➔ Review our Patient Zone and release this functionality to the PTS contracts that this is not currently contractually bound to deliver
- ➔ We will review our call announcements on our HCP and patient facing lines to ensure that our online system is promoted
- ➔ Ensure an abandonment rate of below 1% in line with the national threshold

Board Sponsor

Chief Operating Officer

Implementation Lead

Director of Clinical Coordination Centres

Clinical Effectiveness

2b	To increase clinical assessments in CCC (call centres) ensuring consistent methods and application across the services (three-year priority) ***continues***

Why have we chosen this indicator?

As outlined in Part 1 of this report we are working hard with national projects and local partners to ensure patients are given timely information and advice and are directed to the right resource to meet their needs. The national Integrated and Urgent Care review means that we are increasing our clinical interventions from 20-30% and have introduced a clinical advice line within the NHS 111 Call Centre that focusses on ambulance and emergency department dispositions that are transferred to a clinician.

We are currently exploring a pilot of NHS 111 online and are working with external providers of online symptom checkers to enable demand to be managed more effectively giving members of the public the ability to self-assess their symptoms. The plan is to operationalise this by the end of 2017. We have introduced a Live Link pilot in the 999 Call Centre. Patients in high intensity user care homes who dial 999 are assessed by a clinician who can see the patient via Skype for SCAS to manage demand more effectively. This is live with two care homes, one based in the Hampshire area and one in the Thames Valley area.

We have undertaken a demand analysis on low acuity green calls. We have identified eight low risk conditions that will be identified at the outset of the call and then immediately transferred to a clinician. This aims to continually improve our hear and treat rates and see and treat rates and increase ambulance vehicle availability. This has the real potential to improve patient experience. Ambulance dispositions from NHS 111 calls that require a Green time (i.e. 30 or 60 minutes) will be re-triaged by a clinician in the call centre to determine the pathway required. This may not mean a frontline ambulance to hospital but a different pathway for the patient such as a pharmacist or walk-in centre.

To achieve this we are going to:

- ➔ Y1: implement the Green project (30 and 60 minute calls) for eight clinical conditions
- ➔ Y2: establish the baseline % of long waits for green calls and set improvement target
- ➔ To further model the Green project after implementation and by end of 2017
- ➔ Ensure 80% of all eligible calls (green ambulance disposition) are transferred to an enhanced clinical advisor desk for further clinical assessment
- ➔ Evaluate Live Link pilot and analyse data to identify improvement in non-conveyance
- ➔ Implement the NHS 111 online symptom checker in Year 1

Board Sponsor

Chief Operating Officer

Implementation Lead

Director of Clinical Coordination Centres and Director of Commercial Services

Clinical Effectiveness

2c	To improve long waits in the new ARP response categories

Why have we chosen this indicator?

The Ambulance Response Programme (ARP) began in 2015 with some trusts piloting the new response times and clinical coding.

It is a programme across all ambulance services to improve response times, right resource first time, productivity and workforce development.

The new categories (rolled out in SCAS from 31 October 2017) prioritise the sickest patients better and reduce long waits by ensuring resources are distributed more appropriately based on need. It is therefore expected that long waits reduce.

The service should be more equitable and improve workload management.

Patient and staff experience should be enhanced too. Therefore SCAS has included reducing long waits in this year's quality priorities.

To achieve this we are going to:

- ➔ Ensure the long waits groups utilise an agreed definition of long waits under the ARP categories
- ➔ Review monthly long waits ensuring a detailed themed analysis is reported to Patient Safety Group and Quality and Safety Committee
- ➔ Implement learning and actions from long waits reviews through Patient Safety Group
- ➔ Report externally to commissioners with approved actions for improvements

Board Sponsor

Chief Operating Officer and Director of Patient Care and Service Transformation

Implementation Lead

Director of Operations

Patient Experience

3a	To conduct a survey of patients using the 999 service highlighting improvement actions to be taken to improve patients experience of the service

Why have we chosen this indicator?

We aim to improve our services from gaining feedback from service users as part of a triangulated approach to improve quality of care and experience.

Patient experience remains a fundamental measure of quality healthcare provision. Listening, recording and learning from feedback and patients insights can be a lever for implementing change to reflect needs.

We have robust survey plans for all our services and proactively seek feedback through a variety of sources.

Patients who require 999 services ae usually the sickest and in our care for relatively short periods of time before receiving ongoing treatment elsewhere. This makes asking for, and receiving feedback slightly more challenging.

However, SCAS recognises the importance of doing more to obtain the feedback through surveys of this patient group and we have included this to focus on capturing experience data that may help us improve.

To achieve this we are going to:

- ➔ Establish baseline in Q1 and set an improvement trajectory to increase respondents
- ➔ Use the data set to identify actions for learning
- ➔ Conduct a thematic analysis with actions for improvement Q4
- ➔ Report to Patient Experience Group and through external contract meetings

Board Sponsor

Director of Patient Care and Service Transformation

Implementation Lead

Head of Patient Experience

Patient Experience

3b	To improve the focus on improving staff health and wellbeing at work in relation to stress

Why have we chosen this indicator?

Without staff that are well and at work the NHS could not deliver quality and effective care to patients. We need to ensure that staff are provided with an environment and opportunities that encourage and enable them to lead healthy lives and make choices that support their wellbeing.

Effective partnership working between human resources, occupational health, health and safety and other services that support staff health is essential.

SCAS includes this priority to help combat stress, common sickness absence problems, mental health and improve emotional wellbeing in the workplace.

To achieve this we are going to:

- ➔ Use staff survey action plans to focus on stress reduction per service area
- ➔ Agree a reduction trajectory in Q1 for the year
- ➔ Report to Quality and Safety Committee identifying actions for improvement and any new initiatives

Board Sponsor

Director of Human Resources and Organisational Development

Implementation Lead

Assistant Director of Human Resources

Patient Experience

3c	To improve end of life care in PTS across all contracts

Why have we chosen this indicator?

End of life care is support for people who are in the last months or years of their life. People who are approaching the end of life are entitled to high-quality care, wherever they're being cared for.

Working with our healthcare partners and commissioners SCAS often transports patients at the end of their life in PTS to appointments and therefore want to ensure their care and needs are met to the highest standard. We need to get it right every time and therefore have chosen an indicator to ascertain how we can improve.

To achieve this we are going to:

- ➔ Undertake an analysis of incidents reported on end of life care in PTS Q1
- ➔ Create an action plan from this analysis to ensure that patients are not being referred to PTS inappropriately encouraging staff to report any issues
- ➔ Identify experience and contractual issues that require improvement in Q2
- ➔ Survey staff in Q3 to ascertain staff and patient experiences with improvement actions
- ➔ Ensure and report on appropriate use of PTS for transporting patients at the end of their life

Board Sponsor

Director of Patient Care and Service Transformation

Implementation Lead

Clinical Governance Leads - PTS

3.2 OTHER QUALITY IMPROVEMENTS AND INITIATIVES

Ministry of Defence Employer Recognition Scheme - Gold Award

SCAS is one of only two ambulance trusts in England to have received the Ministry of Defence's Employer Recognition Scheme Gold Award. The award is the Ministry's prestigious badge of honour for organisations who have demonstrated outstanding support for the Armed Forces community. SCAS supports veterans looking for a fulfilling second career and those members of staff serving as reservists in our Armed Forces. We were proud to accept this award from HRH Prince Henry of Wales and the Defence Secretary, Sir Michael Fallon at a ceremony at the Imperial War Museum in London on Monday 9 October 2017.

Launch of Step Into Health

Step Into Health is the first access pathway from the military into numerous career opportunities in the NHS. As a result of the excellent, trail blazing work we do with the Ministry of Defence, and our recruitment of military service leavers to the Trust, we were invited to meet The Duke of Cambridge, who opened the Step Into Health event in London. We spoke about the support we receive from staff, the veterans we employ and how staff throughout our service delivers high quality patient care.

Equality Awards 2017

Will Hancock (CEO) and Ludlow Johnson (Equality, Diversity and Inclusion Manager) received the Equality Award 2017, which celebrated those people who go above and beyond to make Milton Keynes a better place.

Will Hancock was nominated for showing great leadership amongst the South Central Ambulance workforce where employees can thrive in confidence. It's a type of leadership that demonstrates empathy, compassion and understanding that gives out a message to staff that they matter.

Ludlow Johnson was nominated for his leadership promoting and implementing Equality and Diversity principles and practice throughout the area covered by SCAS and nationally.

Mental Health

We have been conducting joint Mental Capacity Act (MCA) and safeguarding audits in PTS Sussex, developing a PTS pocket guidance on mental health and the mental health act.

SCAS has introduced some "bitesize" training sessions for NHS 111 and call centre staff to support the mental health education programme and we have begun with service users to produce short podcasts for NHS 111 staff.

Falls and Frailty Response Team

Since an original pilot in 2015/16, the project that sees collaboration between SCAS and the Royal Berkshire Hospital (RBH) has grown. The Falls and Frailty Response (FFR) initiative sees paramedics and occupational therapists working together to assess and support older patients to remain at home and reduce unnecessary conveyance to A&E.

The benefit of this service is that patients receive a full assessment, including point of care blood testing, at home and as well as an assessment their home environment, cognition and mobility. Equipment or signposting to other community support is also provided as required.

The service was nominated in the Royal Berkshire Hospital Staff Excellence Awards, in the Excellence in Partnership Awards, where it was Highly Commended. The service was also nominated in the SCAS Ambies, where it won the Partners & Stakeholders' Award for Innovation 2017.

ANNEX 1: STATEMENTS FROM COMMISSIONERS, HEALTHWATCH, OVERVIEW AND SCRUTINY COMMITTEES

Fareham and Gosport Clinical Commissioning Group (F&GCCG), as lead commissioner, and its associate commissioners of Southampton, Hampshire and Portsmouth (SHiP) welcomes the opportunity to participate in the governance "sign off" process for the 2017/18 Quality Account of South Central Ambulance Service NHS Foundation Trust (SCAS) for 999, non-emergency patient transport (NEPT) and the 111 Services.

Commissioner Introductory Statement

Commissioners are grateful for the opportunity to comment on the trust's annual quality account for 2017/18, which has been produced following new guidance being issued by NHS Improvement (NHSI) in January and February 2018. Commissioners wish to recognise the challenging system pressures that SCAS have experienced during the last 12 months and would like to take this opportunity to thank SCAS for their continued effort and support to our patients and the health and social care organisations that work within their geographical area. Commissioners also thank SCAS for their engagement across a number of local systems, with the development of system transformation partnerships (STPs).

Commissioner assessment summary

The quality account provides clear information on what SCAS do and what services they provide, together with identification of the geographical areas that services cover. There is clear information on what a quality account is.

SCAS have referenced their Care Quality Commission (CQC) inspection that took place in May 2016. Positive progress has been made against the plan and the quality account provides an opportunity for SCAS to identify the improvements these actions have made.

Commissioners note the input from SCAS into Local System Reviews (LSR) and look forward to receiving the full report of the 20 reviews. Commissioners have also noted the fluctuating performance within the Patient Experience (PE) Team through the year but recognise the mitigation that SCAS has put in place with additional recruitment to the team. Whilst SCAS work towards a 25 day timeframe for closing complaints, individual timeframes can be agreed with each complainant. Using this approach would allow SCAS the opportunity to appropriately agree more realistic timeframes with complainants during challenging times.

SCAS have referenced the implementation on 31st October 2017 of the NHS England Ambulance Response Programme (ARP) and the impact that this has had on response times and the definition of long waits. Commissioners were kept informed of the progress during monthly Contract Review Meetings (CRM) and have been advised that it will not be possible to compare performance from the implementation date with historical data. Following the successful implementation of ARP it is anticipated that further developments will take place in the coming year and it is positive to see that these have been referenced in the quality account. Historically rapid response vehicles (RRV) response times were included when

measuring performance. With the introduction of ARP, although these vehicles remain in place supporting our patients in more rural areas, their response times are no longer included when patients require conveying. The SCAS contract measures performance at aggregate and not by individual CCG performance, but it is helpful to have sight of this data.

The Thames Valley Integrated Urgent Care (IUC) service is noted. The report would have benefited from qualitative and quantitative data to support the statement 'delivering real improvements in how the people of Thames Valley access urgent care from the NHS'. An update on the outcomes from the high intensity user quality, innovation, productivity and prevention (QIPP) programme that has been in place in the SHiP locality could also have been included.

F&G and SEH CCGs are engaged in the development work with SCAS for the rotating specialist paramedic projects. Specialist paramedics have been in place for over two years now and this section provided an opportunity for SCAS to include examples of the benefits that this cohort of staff provide to patients in their own home and by working in the wider health system. SCAS may like to consider the role of the rotating paramedic in supporting their clinical advisor desks, which have experienced challenges in recruitment across services and geographical areas.

It is positive to see that SCAS have been proactive in the development of a mortality review group. The report would have been enriched by including examples of the outcomes from this group i.e. learning that has been identified and changes to practise that have been put in place. Commissioners hope that in the new contractual year they will be able to attend and see evidence of outcomes from these meetings.

SCAS should be congratulated on the response achievement for their staff survey at 61%, the highest return rate of all ambulance trusts. It is positive to note that improvements were made in 11 questions when compared to last year, and that they were significantly better than average for 55 of the 88 questions. Commissioners look forward to receiving the pledges and action plans being developed and, in particular, how they propose to make improvements for the 3 questions where they favoured less than when compared to other trusts. This section could have benefited by including the link to access the full outcomes of the survey online.

PART 1 – STATEMENT OF QUALITY FROM THE CHIEF EXECUTIVE

The Chief Executive Officer's quality statement includes recognition of the changing landscape for the provision of health and social care that is taking place at a rapid pace. It also recognises the daily challenges that the health and social care system experience. There is clear acknowledgement of the need to identify learning from feedback provided by other health/social care professionals, patients and incidents in order to minimise harm and maximise effectiveness within a challenging financial time for all providers.

Key areas of change taking place have been referenced including the change in ambulance response times, growing services, integrated urgent care (IUC) and sustainability and transformation partnerships (STP) that are being developed across the SHiP locality and nationally.

It is positive to see that in recognition of the learning and changes that are taking place the SCAS 5 year Clinical Strategy has been reviewed and refreshed; it would have been useful to see examples illustrating how SCAS have made the improvements that have led to positive outcomes e.g. 'increased people's chances of survival'. Additionally the report provides opportunity for SCAS to identify how they mitigated for concerns raised regarding changes to stroke services in the north of the SHiP footprint; to ensure that patients from that locality continued to receive the same level of performance and are improved in the longer term.

It is positive to see the changes that SCAS are making to their appraisal system, as challenges in compliance have been noted by commissioners during the year. By aligning their appraisal process to their values commissioners look forward to seeing an improvement in the retention of staff and positive impacts on the culture within their organisation. Improvements in the outcomes in this year's staff survey should be seen as a reflection of the positive work that has already taken place during 2017/18.

Finally it is positive to see the Chief Executive Officer's recognition of the level of care that the staff and volunteers from SCAS provide to patients in our locality.

PART 2 – PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

Looking back at the progress made

Throughout the year SCAS have continued to be engaged with the A&E Delivery Boards across the SHiP locality. The multi-agency delivery boards have been established to address the urgent and emergency care system-wide pressures and challenges that continue to be experienced.

SCAS outlined its priorities for 2017/18 and all Hampshire associate commissioners had the opportunity to review these. New NHSI guidance published in February 2018 indicates that updates on progress should include performance in 2017/18 and, where possible the performance in previous years.

Patient Safety

1a. To improve the recognition of sepsis in adults

It is positive to see that the review of 25 cases by SCAS auditors showed 100% compliance for the information being recorded at the scene on their computer aided dispatch (CAD) system and electronic patient record (EPR). Commissioners are keen to understand how this has impacted patient outcomes.

1b. To complete a clinical governance review of the Emergency and Urgent Care (E&UC) 999 service and implement the recommendations.

Commissioners recognise the work that has taken place for this priority. The quality account would have been enriched by including details of any key recommendations that were reported to the Executive Management Committee and how those recommendations improved quality and what measureable improvements were identified.

1c. To ensure a consistent approach to medicines management processes which are compliant with the regulatory standards

Following the identification of areas for improvement for medicines management during the May 2016 CQC visit, SCAS established a medicines management task and finish group. It is therefore useful to see the internal communication that is taking place to highlight learning from medication incidents. SCAS identify that this priority has been partially achieved and during 17/18 commissioners have been advised of the challenges that remain in completing actions. Although medicines management has not been identified as a priority for 2018/19 commissioners require assurance that this area of performance will continue to be an internal priority for SCAS and will continue to monitor the action plan and risk register that are already in place.

1d. To implement the work streams in the national 'Sign up to Safety' campaign to improve patient safety across all services.

Commissioners acknowledge the work that has taken place to implement the work streams, including the development of an app through the year to aid with reducing medicines incidents, together with the issuing of post-partum haemorrhage cards for maternity packs. This section of the report provided an opportunity for SCAS to detail examples of what 'Bright Ideas' scheme provided by staff have been developed and the corresponding outcomes, which may also improve the number of ideas that are submitted in 2018/19. Commissioners would also like to note the improvement in the content of their aggregated learning reports that have been shared during 17/18.

Clinical Effectiveness

2a. To demonstrate an improvement in call abandonment for non-emergency patient transport (NEPT), 999, NHS 111 and health care professionals (HCPs) (2 year priority)

It is positive to see that all recorded messages promote the on-line service. Commissioners recognise that this is a two year priority and across all 3 services and that the actions completed this year predominantly relate to the NEPT service. The report would have been enhanced by triangulating the work that has taken place with changes in HCP/patient behaviour e.g. whether themes and trends in feedback have changed or there has been an increase in the number of on-line bookings. It continues to be essential that each service (NEPT, 999 and 111) is clearly measured for improvement separately.

2b. To evaluate and develop clinical assessments in clinical coordination centres (CCC) ensuring consistent methods and application across the services (3 year priority)

Commissioners recognise the impact that the implementation of ARP has had on this priority. The report would have been enriched by evidencing the reduction in harm that SCAS note with both qualitative and quantitative data. Commissioners concur with SCAS that the audits and reports for those patients audited from the long waits group indicate that they are low risk patients who endure poor patient experience rather than harm. It would be interesting to know how SCAS plan to re-energise the Live Link work stream. Commissioners remain concerned about the aspiration for 80% of eligible green calls to be transferred for further clinical assessment in view of on-going workforce challenges.

Patient Experience

3a. To report on the Friends and Family Test (FFT), staff, patients and actively demonstrate that we seek feedback and act on results.

Commissioners are aware that SCAS, in collaboration with all national ambulance trusts, are in discussions with NHS England regarding the on-going challenges in obtaining this feedback from 999 service users. Although SCAS have articulated the work that they have done with the FFT response cards, the report would have been enriched by including the impact this had had on response rates for all 3 services, particularly as SCAS have advised that the priority has been achieved and yet there is recognition of the challenges in increasing responses. It is positive to see examples of how feedback has been used to make changes. Commissioners again highlight that an app may improve responses.

3b. To evidence learning from HCPs' feedback in all services (999, 111 and NEPTS)

Commissioners recognise that improved aggregated learning reports include feedback from HCPs, complaints, concerns, incidents, Quasar (commissioners reporting tool) and safeguarding. SCAS have been open and welcoming in supporting clinical visits from the CCGs and their employed clinicians. Commissioners have also been involved in provider to provider discussions that have identified changes to practice. It is positive to see evidence of how feedback has led to identifying root causes and corresponding action plans to improve patient outcomes and performance. Commissioners feel that there is an opportunity for providers/ commissioners to learn from feedback provided by SCAS and that future reporting could provide examples of this.

3c. To develop systems that engages and seeks feedback from hard to reach groups

It is positive to see the range of engagement events that have taken place. However, the report would have benefitted from recognising any explicit engagement events that have been arranged to target hard to reach groups, rather than more general forums where they may have attended. The report provides an opportunity for SCAS to detail any specific feedback from those groups and what learning and changes to practise have taken place as a direct result.

2.2 Statement of Assurances from the Board

Commissioners note the statements of assurance from the Board. It is positive to see the range of data that has been available on the quality of care provided. It is also positive to note 100% participation in national clinical audits and that 100% of the required cases were submitted. Commissioners acknowledge the publications and presentations that were recorded in 2017 and 2018 by SCAS staff and commend the Trust's engagement with clinical research.

Commissioners have yet to receive evidence for the 17/18 national CQUIN achievement, which is a proportion of SCAS' income.

2.3 Reporting against the NHSI core indicators

The NHSI Guidance published in February 2018 indicates that for data made available by NHS Digital, the numbers, percentages, values, scores or rates of each of the NHS foundations trust's indicators should be compared with:

➔ The national average for the same

➔ NHS Trusts and foundation trusts with the highest and lowest for the same.

Commissioners note that for indicators shown by SCAS the above information is not included for all indicators. It is positive, to see the improvement in STEMI care and that both STEMI and stroke care are above the national average.

Although commissioners are yet to see the staff survey results broken down by the 3 services that it delivers, and their geographical contract areas, SCAS should be recognised for their year on year improvement since 2015. The actions that have been identified in this section of the report have been recognised as having already been completed in section 2.1.3 above.

SCAS should be proud for the improvements that they have made in the reduction in the category of incidents for severe harm/death. This reduction has been supported by previous quality indicators focussing on Datix reporting. Work has also been undertaken by SCAS in reviewing the information they upload to NRLS to validate that the appropriate information is being recording correctly.

PART 3 – OTHER INFORMATION AND QUALITY PRIORITIES FOR 2018/19

3.1 SCAS outlined its priorities for 2018/19 and all Hampshire associate commissioners had the opportunity to review these. A written response with our comments on those initially identified, together with improvements and suggestions of alternative/additional areas of focus were shared with SCAS for consideration.

The NHSI guidance published in February 2018 in respect of the detailed requirements for quality reports 2017/18 identifies that for each priority the provider should identify how progress to achieve these priorities will be monitored and measured and how progress to achieve these priorities will be reported. It is vital for commissioners to be able to know if a priority has been delivered and therefore milestones and KPIs linked to each improvement programme must be clearly able to demonstrate this.

Patient Safety

1a. To implement and assess the effectiveness of the NEWS2 scoring system for sepsis care (identifying patients with sepsis early)

Commissioners concur with the SCAS proposal around the National Early Warning Score (NEWS)2 for identifying acutely ill patients. However, the priority should not be limited to those patients with sepsis. SCAS should also clearly identify which of their 3 services this priority relates to.

1b. To improve hand hygiene audit compliance (all services)

Commissioners do not believe that the priority is sufficiently stretching. Compliance with hand hygiene audits was identified during the 2016 CQC visit and commissioners would have anticipated that this would have been addressed as one of their 'should do actions'.

1c. To implement the new NICE Mental Capacity Act (MCA) guidance – improving awareness and parity.

Commissioners are supportive of the proposal. Commissioners are concerned however that SCAS have previously advised that all training is developed and set prior to the financial year commencing and therefore seek further information on when any training needs identified will be included within their training modules.

Clinical Effectiveness

2a. To review and improve call abandonment for PTS, 999 and 111 (continuation of 2 year priority)

On reviewing current data provided commissioners noted that all services are performing in line with targets and therefore believe that this priority is no longer stretching. Commissioners acknowledge that this was a 2 year priority but would have anticipated a change in focus ie; increase in on-line bookings for PTS, together with improvement in responding to the ETA line as this is a key theme in HCP feedback. Actions identified under 'what we will do' have been reported as completed in the update provided on last year's priorities. Commissioners believe that patients would benefit from a continued focus on warm transfer improvement rates and initiatives for the need for patients to keep repeating the same information.

2b. To increase clinical assessment in clinical call centres (CCC) ensuring consistent methods of application across the services (2nd year of 3 year priority)

Commissioners note a change in the description from last year from 'evaluate and develop clinical assessment' to 'Increase clinical assessment'. As we responded last year; how will this be measured and what quality outcomes are expected? What are SCAS ambitions in respect of this indicator? It would be good to understand the baseline and to have this separated for each service.

2c. To improve long waits in the new ARP response categories

SCAS have provided their rationale on why this priority was chosen but clarity is required on what SCAS are aiming to improve i.e. is it a reduction in waits, or an increase/ improvement in safety netting patients?

Patient Experience

3a. To conduct a survey of patients using the 999 service highlighting improvement actions to be taken to improve patients' experience of the service.

SCAS have provided their rationale for choosing this as a priority, which commissioners support. It would be beneficial to understand how SCAS are going to determine the baseline in view of the small number of returns that are being reported across ambulance trusts. SCAS have not identified when the survey will take place and until the survey is completed it is not possible to identify what improvements need to be set. Will the actions for improvement be around improving the response rate or improving patient outcomes? What are patients saying

already e.g.; through complaints, incidents, HCP feedback? Commissioners acknowledge the challenges in obtaining FFT and the ongoing national discussions but SCAS need to develop a robust and sustainable methodology for obtaining patient feedback from the 999 service going forward.

3b. To improve the focus on improving staff health and wellbeing at work in relation to stress.

Commissioners support the rationale and the proposal.

3c. To improve end of life care in PTS across all contracts.

Clarity is required on what this means; is it a more timely response? Commissioners would have expected this to cover the 999 service as well i.e. work focussed around advance care planning, ReSPECT etc. It would be beneficial to understand how this will be measured.

Commissioners also requested that SCAS consider safeguarding as a priority in view of ongoing commissioner concerns and medicines management in view of the challenges with traction on the action plan and risks identified in the medicines management risk register. During 17/18 commissioners have been aware of vacancies across all 3 services and staff attitude has been a recurring theme in complaints and concerns. Commissioners had therefore anticipated that SCAS would identify workforce as a priority.

3.2 Other quality improvements and initiatives

Commissioners acknowledge the information and updates provided in respect of other activities that have taken place to improve quality and congratulate SCAS on receiving the Armed Forces Covenant Gold Employer recognition award and the Equality Award in 2017.

Commissioners look forward to continued positive working relationships with South Central Ambulance NHS Foundation Trust as a valued health care partner who consistently seek ways to improve the outcome of patients in our locality.

Yours sincerely

Julia Barton
Director of Quality and Nursing
Fareham & Gosport and South Eastern Hampshire Clinical Commissioning Groups
2 May 2018

Statement from Buckinghamshire's Health and Adult Social Care Select Committee in response to South Central Ambulance Service's Annual Quality Report 2017/18

Buckinghamshire County Council's Health and Adult Social Care (HASC) Select Committee holds decision-makers to account for improving outcomes and services for the residents of Buckinghamshire. The Committee scrutinises issues in relation to NHS services, including how services are commissioned and the overall performance of the services.

In October, Members of the HASC visited the South Central Ambulance Service Control Centre at Bicester where they received a warm welcome from all the staff and enjoyed an interesting tour and presentation.

In our role as a "critical friend" to the Trust, we are pleased to have an opportunity to provide feedback on the Trust's Quality Report for 2017/18.

We watch with interest to see the potential positive impact of the new ambulance response categories and the Trust's journey in achieving the overall aims of reducing inefficiencies and improving patient quality of care.

We support and commend the Trust's approach to collaborative working across the health and social care sector and hope to see partnership working strengthen even more over the coming months as the deadline for health and social care integration approaches.

We would like to congratulate the Trust on its CQC rating of "Good" and commend the Trust on its drive and ambition to reach "Outstanding".

We make the following general comments on the report.

- The Trust recognises the challenges faced by providing services across a wider geographical area than the Buckinghamshire, Oxfordshire and Berkshire West STP footprint for the health and social care sector
- The need for extended training in the Mental Capacity legislation as the Select Committee is particularly interested in the development of mental health
- The list of publications and presentations is impressive, particularly around the effective signposting of community defibrillators
- The list of focus groups for Patient Experience "hard to reach" groups does not appear to extend to Buckinghamshire
- The category of "Effectiveness" in the CQC assessment is the least well achieved but recognise that one of the categories relates to NHS 111 which has recently been launched across Buckinghamshire, Oxfordshire and Berkshire so we would expect this to improve
- The three questions in the staff survey where the response were less favourable have not been stated in the report.

Achievements in Quality 2017/18

We note the particular successes in:

- Launching the new Thames Valley (Buckinghamshire, Oxfordshire and Berkshire) Integrated Urgent Care 111 service
- Developing opportunities for Specialist Paramedics to undertake 'portfolio' working across different healthcare settings
- Proactively setting-up a mortality review group, with the aim of reducing genuinely avoidable deaths
- Introducing a new "armchair activists" initiative to give patient views

- Early recognition of sepsis
- Launching a new values based appraisal approach across the Trust
- Receiving the Ministry of Defence Employer Recognition Scheme Gold Award

As our role is to ensure Buckinghamshire residents receive high quality services and a good patient experience, we welcome the Trust's approach to public engagement and hope their engagement activities continue over the coming months to ensure patients continue to be at the heart of what they do.

We feel the annual report demonstrates a high level of accountability. We welcome the Trust's open and transparent way of working with its partners and we look forward to hearing about the Trust's progress throughout the year.

Submitted by County Councillor Brian Roberts, Chairman of Buckinghamshire's Health & Adult Social Care Select Committee on behalf of the Committee.

3 May 2018

Commissioner Statement from NHS North West Surrey Clinical Commissioning Group (NWS CCG)

North West Surrey CCG (NWS CCG) welcomes the opportunity to comment on the South Central Ambulance Service (SCAS) Quality Account for 2017/18.

Having reviewed the draft Quality Account document for 2017/18, the CCG is satisfied that this gives an overall account and analysis of the quality of services along with appropriate evidence of the Trust's quality improvement progress. The detail is in line with the quality performance data supplied by SCAS during the year under the contract with NWS CCG.

From our review, the CCG believes the Quality Account is clearly set out and meets most of the mandated requirements. Some gaps were noted in relation to the achievement against the quality requirements from CQUINs. The requirement this year to report on Learning from Death reviews is included but again may be further enhanced if some detail on the learning and any changes from the process were also included.

Performance on last year's priorities is clearly summarised and where performance was not met further improvement actions are outlined in the report. At the time of receipt and review of the document some areas are not completed with up to date data therefore the CCG is unable to confirm that inclusion of all information is accurate.

Quality improvement priorities for 2017/18

The CCG is satisfied the priorities identified by the Trust comply with Quality Account requirements in relation to Patient Safety, Clinical Effectiveness and Patient Experience and provides a summary of progress against the 2017/18 quality priorities.

The CCG notes and agrees with the priorities agreed for 2018/19 and also the governance and engagement process that was undertaken to agree these.

NWS CCG would like to thank SCAS for sharing the draft Quality Account document and is satisfied it accurately reflects the quality priority work being undertaken by the Trust. As Commissioner we will continue to work together to ensure continuous improvement in the delivery of safe and effective services for patients.

Clare Stone
Executive Director for Quality, Surrey Heartlands CCGs
(Guildford and Waverley, North West Surrey and Surrey Downs CCGs)
3 May 2018

Healthwatch Milton Keynes response to SCAS Quality Accounts 2017/18

Healthwatch Milton Keynes would like to thank South Central Ambulance Service for inviting us to comment on their Quality Account 2017/18.

We felt that over all SCAS Quality Account reflects a positive attitude toward its patients, patient care and the importance of patients being involved in the way services are delivered and being heard when things go wrong.

We can see that some improvement has been made in the use of plain English, as a result of previous recommendations. However, poor use of grammar and punctuation in some sections of the document, as well as unexplained acronyms, means that it can be difficult to read.

The formatting was variable in quality. The contents page does not correspond to the document well and page numbering ends on page 54. The formatting is uneven in places, so headings are on different pages to the body of text that they relate to and tables are split over pages.

The Star overlaid with a circle diagram is not easily understandable as an illustration of where or how SCAS will achieve its intended ambition of increasing Care Quality Commission ratings from 'good' to 'outstanding'. We feel the public reader would benefit from this section being explained in plain English text, or a more reader-friendly diagram.

We found the ARP information interesting, but unfortunately there is no data or narrative to say how SCAS are performing against these standards and what this means for patient care.

The Trust covers a wide geographical area and other organisations that have to submit Quality Accounts provide an insight into performance etc., at a locality level e.g. Milton Keynes. This approach provides an understanding about whether the standards are being achieved for our resident population. As Milton Keynes Council is a Unitary Authority with the same local administrative responsibilities as a County Council, we believe it should be delineated on the map, and in the information provided, as a separate area.

Where the Quality Accounts report a less than satisfactory outcome (e.g. staff survey), these have been noted but not expanded on. To ensure transparency and reflect an organisational understanding regarding the quality of services currently provided, it is pertinent to outline quality issues, and provide comment on quality improvement plans.

The NHSi further requirement (e.g. Stroke 60) information does not provide any narrative to say whether there is a benchmark, whether SCAS are achieving against this, or how they are comparing to other Trusts if a target has not been set.

Moving forward, we feel that the 2018/19 priorities are well set out, well laid out and achievable and would urge South Central Ambulance Service to provide more detail in the 2018/19 Quality Account to help patients and the public understand service quality and improvement looks like in their unitary authority area.

Maxine Taffetani
Chief Executive Officer
Healthwatch Milton Keynes
4 May 2018

Milton Keynes Council Health and Adult Social Care Committee Quality Accounts Panel Report

Milton Keynes Council's Quality Accounts Panel commends South Central Ambulance Service (SCAS) NHS Foundation Trust for its Quality Account for the period 2017/18. Its production in keeping with a legal requirement reflects SCAS's continued effort to outline the quality of its services, and how stakeholders especially patients, and the public on a whole are incorporated into service planning and delivery. Particular praise is extended to SCAS for recognising the current and future impact of the Sustainable and Transformation Partnership (STP)/Accountable Care System (ACS) on healthcare services within the Bedfordshire, Luton and Milton Keynes areas, and the service planning and delivery being done against the background of the STP/ACS.

However the Panel is of the view that the Quality Account for 2017/18 is of equal quality to that produced in 2016/17 with no noticeable improvement. Additionally whereas SCAS's priorities for 2018/19 are clearly outlined and 2016/17, the priorities for 2017/18 are not equally and clearly outlined.

Further, although it is acknowledged that SCAS serves a wide geographical region across several local authority boundaries, the Quality Account would have benefitted from greater inclusion and use of specific local authority data, therefore making it easier to relate to by varied readers.

The Quality Account was somewhat difficult to read due to the layout of the document's structure, the table of contents needed to be better detailed, and the document's numbering was incomplete.

QUALITY ACCOUNT- COMMENDATIONS

The Panel is of the view that there are some things done by SCAS as reflected in the Quality Account that have to be especially commended:-

1. Chief Executive's Statement which acknowledges the fact that SCAS is often a "front door" and first point of contact for many members of the public with the NHS.
2. SCAS's contribution to development of the STP/ACS as outlined in the Chief Executive's Statement.
3. SCAS's support and involvement in home visits in primary care in West Berkshire. The Panel hopes this will be extended to Buckinghamshire and specifically Milton Keynes in the near future.
4. SCAS being named as a Health Education England Pilot Project.
5. SCAS's publications and presentations made over the 2017/18 period, in addition to prizes received over the same period. This for the Panel demonstrates that SCAS has not been content with merely providing a specific NHS service, but is determined to have a positive impact on the NHS community and health sector on whole.
6. SCAS's positive record with the Care Quality Commission (CQC) in **(i)** having a current registration that is without conditions in all fundamental standards, **(ii)** not being the subject of any CQC enforcement action, and **(iii)** not having to take part in any special CQC reviews or investigations during 2017/18.
7. SCAS's "Information Governance Assessment Report" score of 79% and being graded green from IGT Grading scheme.

Performance Indicators

The Panel also commends SCAS for particular actions taken to specifically address prior performance shortcomings including:-

1. The thorough review undertaken and changes made to the staff appraisal process.

In NHSi indicators associated with performance, the Panel is of the view that SCAS should be lauded for:-

2. Improvement in Red 1 (Oct 2017 – Mar 2018) to 73.9% from 73.3% in 2016/17.
3. SCAS's input into the national work on revising ambulance quality indicators.
4. SCAS's good performance in **(i)** STEMI- Care, having scored 79.79% which was an improvement on 72.31% achieved in 2016/17, and above the national average of 76.53% for 2017/18, and **(ii)** Stroke- Care, having scored 98.92% which was an improvement on 98.59% achieved in 2016/17, ands above the national average at 97.12% for 2017/18.
5. SCAS's performance in Q21a, Q21b, Q21c. Q21d, and KF1 having exceeded not only performance in previous years, but the average for ambulance trusts.
6. SCAS' performance in significantly reducing the number of patient safety incidents from 570 in 2014/15 to 123 in 2017/18 (up to 5 March 2018).

Other Information and Quality Priorities for 2018/19

The Panel also believes that the Quality Account shows clearly that the work and services of SCAS is having a positive and meaningful impact on the communities it serves.

This work which must be lauded is evidenced by:-

7. SCAS's care contribution to the United Kingdom's armed forces, and positive impact as seen from the *"Armed Forces Covenant Gold Employer recognition Scheme Gold Award"*, and the *"Launch of Step in to Health"*.

8. SCAS's commitment to equality in its service provision, and the winning of the *"Equality Awards"* by SCAS's CEO and Equality, Diversity and Inclusion Manager.

QUALITY ACCOUNT- AREAS FOR IMPROVEMENT

Notwithstanding the above achievements, the Panel is disappointed that the Quality Account lacked adequate area specific information. There was for example little information which was specific to service provision in Milton Keynes. This shortcoming was similarly outlined by the Panel as regards SCAS's Quality Account for the 2016/17 period. The Panel also found the Quality Account to be "text heavy", and is of the view that it could have been made more reader friendly with greater use of graphical information.

More specifically, the Panel is of the view that the below are areas wherein there is scope for improvement in SCAS's services and delivery as outlined in the Quality Account:-

1. As four new ambulance response categories and associated target times have been introduced for 999 calls across England, the Quality Account would have benefited from a summary description of these categories. It is however not expected that the Quality Account would contain information as to how these new categories were robustly tested as it is accepted that this would be the purview of NHS England.

➔ **N.B.-** The Panel hopes that in SCAS determining the most appropriate response to a 999 call in keeping with new response categories, that this does not adversely impact response time. It should also be noted that information from a caller which is used to inform the most "appropriate response", can also be flawed.

2. The Quality Account highlights that SCAS extended its commercial services during the 2017/18 period. The Quality Account would have benefited from summary evidence and or assurance that this expansion has not adversely impacted or that there has been no trade off with the provision of non-commercial services.

3. The Quality Account's outline of "Integrated Urgent Care" in the Chief Executive's Statement is confusing and not reader friendly, and an explanation as to what constitutes a "commercial logistics collection and delivery service" would also aid readers.

4. The Quality Account although identifying areas wherein there is scope for improvement by SCAS, could have added value by informing if there was any service area prior regarded as good/outstanding in 2016/17 but now graded as requiring improvement by the CQC.

5. It is not clear within the priorities, where "engagement" fits, and whether any such fit is clearly understood as a key component within any priority. Although the Quality Account references a number of engagement activities undertaken by SCAS, it lacks adequate detail as regards such engagements for example dates of events, seniority of staff taking part in events, particular feedback received from such events.

6. In outlining achievements against priorities, SCAS's choice of words does not provide adequate clarity. Specifically, if "On-going into second year" means the priority was not achieved, then this should be clearly stated.

7. Whereas it is noted that SCAS did not submit records during 2017/18 to the Secondary Uses Service, the Quality Account would have provided greater value if an explanation for such failure had also been provided.

8. It is concerning that there was a decline to 70.6% in SCAS's performance in Red 2 for the 2018/19 period, compared to 73.1% achieved in 2016/17.

CONCLUSION

SCAS's Quality Account is disappointing in that although it has valuable information, and has not declined in quality to last year, it has also not improved in content quality. A lot of the identified shortcomings and recommendations previously made by the Panel as relates to the 2016/17 Quality Account, equally applies to the 2017/18 Quality Account. This is for example as relates to the indexing of the Quality Account, lack of local information, and lack of clear information as to how engagement/patient experience fits within the Quality Account priorities.

It is therefore hoped that for the 2018/19 Quality Account, improvements will be made to SCAS's Quality Account in light of this feedback from the Panel.

ANNEX 2: STATEMENT OF DIRECTORS' RESPONSIBILITIES

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

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- The content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2017 to March 2018
    - Papers relating to quality reported to the Board over the period April 2017 to March 2018
    - Feedback from commissioners dated 02/05/2018
    - Feedback from governors dated 11/01/2018
    - Feedback from local Healthwatch organisations dated 08/05/2018
    - Feedback from Overview and Scrutiny Committee dated 09/05/18
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 17/05/18
    - The national staff survey 06/03/18
    - The Head of Internal Audit's annual opinion of the Trust's control environment dated 19/04/2018
    - CQC inspection report dated 20/09/2016
- The Quality Report represents a balanced picture of the NHS foundation trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board, 24 May 2018

Will Hancock
Chief Executive

Lena Samuels
Chair

10. REPORT OF THE AUDIT COMMITTEE

The Audit Committee is a statutory committee of the Board comprising non-executive directors of the Trust, all of whom are considered independent. There were five meetings during 2017/18 and all of its members attended each of those meetings. Members of the Audit Committee were Mike Hawker (Chair), Ilona Blue, Professor David Williams and Sumit Biswas.

Other managers are regular attendees of the Audit Committee which includes the Director of Finance, Director of Patient Care and Service Transformation and the Company Secretary. Representatives of external audit, internal audit and the counter fraud team are also in regular attendance. Other managers also attend the Audit Committee on an irregular basis.

The Audit Committee's responsibilities include:

- Review the Trust's draft accounts and make recommendations with regard to their approval to the Board
- Provide assurance to the Board as to the effectiveness of internal controls and the risk management processes that underpin them
- Agree the annual plans for external audit, internal audit and counter fraud
- Make recommendations to the Council of Governors regarding the appointment of the external auditors

In discharging its responsibilities the Committee reviews, and takes account of the Board Assurance Framework, the Trust's Risk Registers and the work of other Board Committees such as the Quality and Safety Committee.

EXTERNAL AND INTERNAL AUDIT

The effectiveness of internal and external audit is reviewed on a regular basis by the Audit Committee. The Trust appointed Grant Thornton as its new external auditors, following a competitive tender process, for the 2017/18 financial statements for an initial period of three years with an option to extend for a further two years. Grant Thornton attend every Committee reporting on progress and developments that are likely to impact on the final accounts. Grant Thornton will be invited to attend Council of Governor meetings from time to time. Grant Thornton performed some non-audit work (value £10,000) relating to a quality audit on behalf of the Trust in 2017/18. The value of statutory audit work undertaken was £41,900 (compared to £43,000 in 2016/17). The fee for the audit of SCFS Ltd is additional and will be £5,000.

SIGNIFICANT ISSUES

At its meeting on 4 May 2018, the Audit Committee considered matters relating to the 2017/18 accounts which included the following:

Accounting for South Central Fleet Services Ltd

The Audit Committee was requested to note that the Trust Accounts included the results of South Central Fleet Services Ltd which is a wholly owned subsidiary of SCAS. The accounting statements included the results of the Group which include the Trust and the Company, and the results of the Trust excluding the Company.

NHS Direct Activities

Ongoing activities in relation to NHS Direct were discussed by the Committee and the accounting treatment of these activities was discussed by the Committee.

Analysis of Notes relating to Expenditure

The Committee discussed the increase in transport related expenditure. This was due to the big increases in expenditure on private providers for the Patient Transport Service (PTS) contracts in Surrey and Sussex. It was agreed that private provider expenditure for PTS should be reclassified from transport related expenditure to a new separate line within the operating expenses note.

Going Concern

The Committee discussed going concern and agreed that they could recommend to the Board that they could adopt the accounts on the basis that the Trust remained a going concern.

Mike Hawker
Audit Committee Chairman
24 May 2018

11. OPERATIONAL AND FINANCIAL REVIEW

The Group, which includes the results of the Trust and South Central Fleet Services Ltd reported a surplus in 2017/18 of £1.311m. This result included £2.2m in respect of the profit on disposal of land in Reading.

The NHSI measures the financial performance and sustainability of the Trust using the use of resource measure where the Trust was rated as a one which was the highest attainable rating.

Summary of Financial Performance

On Income and Expenditure the Group reported a continuing operations surplus of £1.2m for the year and a surplus of £1.3m after taking into account discontinued activities.

Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA) of £8.2m represented 3.8% of turnover which is £0.8m above last year.

Capital expenditure was £10.1m (£4.7m in 2016/17) with ambulances being the largest single item.

The year-end cash balance was £17.6m which was a decrease of £2.6m when compared to the previous year. The main decreases in cash were due to capital payments exceeding depreciation (£1.9m) and loan and dividend repayments (£3.0m) offset by working capital movements and the operating surplus of £2.3m.

It has been a financially challenging year but we still managed to achieve £6.7 million of cost improvements in 2017/18.

Total revenue income to meet pay and other day to day running costs reached £215.6m of which the majority was secured through various service level agreements with clinical care commissioning groups and hospital NHS trusts.

The accounts are stated in accordance with International Financial Reporting Standards. Total fixed assets (land, buildings and capital equipment) of the Trust were valued at £68.7m (£66.3m in 2017).

The Trust formed a subsidiary company (South Central Fleet Services Ltd) to provide fleet services which was incorporated in September 2015 and commenced trading on 1 November 2015. The results of the activities of the company are included in the group results with the company recording a deficit of £324k for the year ending 31 March 2018.

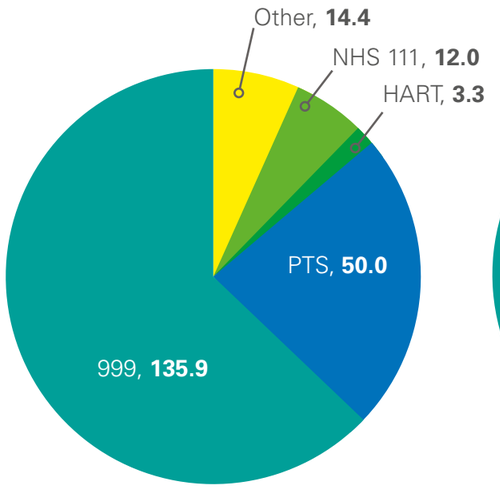
Analysis of Income

The Trust reported income of £215.6 million for the year end 31 March 2018 (2017: £183.7 million). The increase of over 17.0% was due to increased income arising from new Patient Transport Service contracts in the Surrey and Sussex areas.

The Trust's principal source of income is from local NHS commissioning contracts for the provision of the emergency service. This income totalled £135.9 million (£128.6 million in 2017) which represented 63.0% of the Trust turnover (2017: 70.0%).

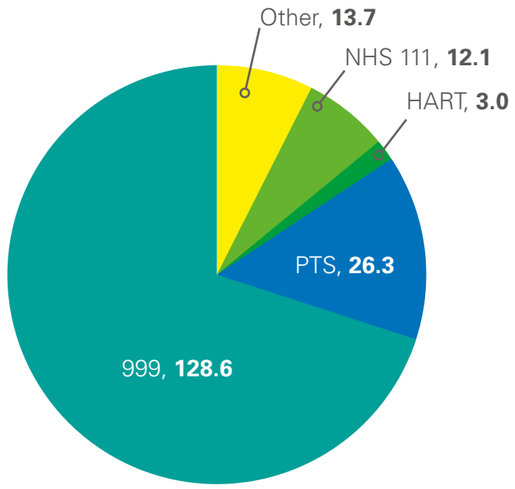
The Trust confirms that the NHS income it receives for the provision of healthcare exceeds its income receives for any other purpose in accordance with the requirements of the Health and Social Care Act 2012. The amount of income that the Trust received in this regard for 2017/18 was £205.9m representing 95.5% of total income.

Trust Income £m 2017/18



Total 215.6m

Trust Income £m 2016/17



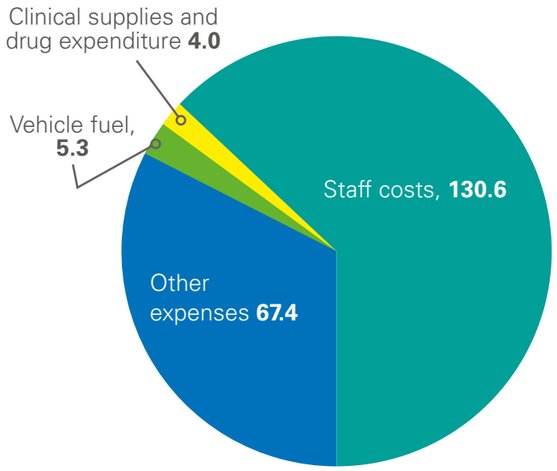
Total 183.7m

Analysis of operating expenditure

Total operating expenditure for the Group (excluding depreciation, amortisation and impairments) was £207.3 million for the year ended 31 March 2018 (2017: £176.3 million). The increase of 17.5% was mainly due to increased expenditure arising from the expansion of the non-emergency patient transport service into Surrey and Sussex.

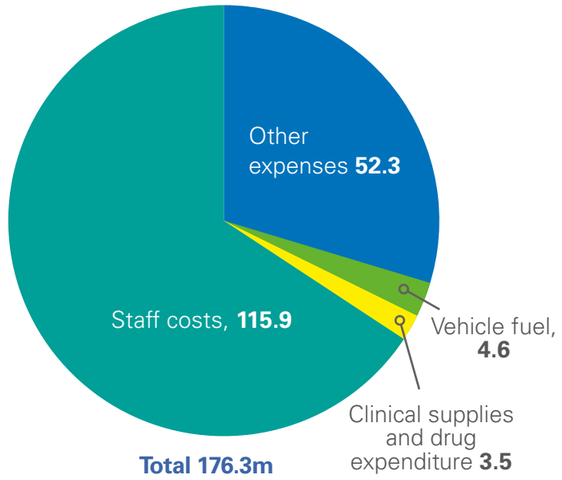
Staff costs represent 63.0% of total operating expenditure (2017: 65.7%). The increase in other expenditure is due to an increase in use of front line ambulance private providers relating to the new non-emergency contracts.

Trust Expenditure £m 2017/18



Total: £207.3m

Trust Expenditure £m 2016/17

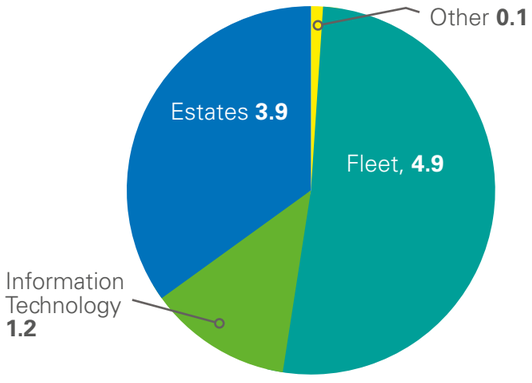


Total 176.3m

Capital Investment

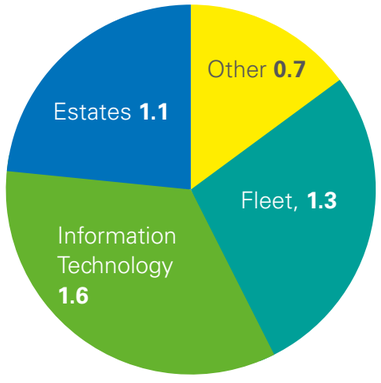
Investment in capital resources for 2017/18 was £10.1 million (2017: £4.7 million). This amount includes 999 ambulance replacements and the provision of two new training facilities in Bicester and Newbury rationalising and improving the current estate.

Capital investment £m 2017/18



Total: £10.1m

Capital investment £m 2016/17



Total: £4.7m

Internal Audit Function

The Trust's internal audit function for the past five years has been undertaken by BDO and they have been appointed for a further three years from 2018/19. BDO work to a pre-agreed internal audit plan which is signed off annually by the Audit Committee. They play an important role in the Trust's annual governance process providing assurance on the working of the Trust's internal controls through their Head of Internal Audit Opinion and liaising with other external agencies, including Grant Thornton, the Trust's appointed external auditor. Internal Audit has a standing invitation to all of the Trust's Audit Committees.

Going Concern

After making enquiries, the directors have a reasonable expectation that South Central Ambulance NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason they continue to adopt the going concern basis in preparing the accounts.

Disclosure of Information to the Auditors

So far as each of the directors is aware, there is no relevant audit information of which the South Central Ambulance NHS Foundation Trust's auditor is unaware.

Each director has taken all the steps that they ought to have taken to make themselves of any relevant audit information and to establish that South Central Ambulance NHS Foundation Trust's auditor is aware of that information.

Cost Allocation and Charging

South Central Ambulance Service NHS Foundation Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector information guidance.

12. REMUNERATION REPORT

ANNUAL STATEMENT FROM CHAIR OF REMUNERATION COMMITTEE

The Remuneration Committee regularly reviews the Remuneration Policy; the Committee is satisfied that the policy provides a framework for agreeing salaries and is consistent with the Monitor FT Code of Governance and the NHS Act 2006.

The Committee benchmarks against similar sized foundation trusts but must also take into account other factors when reviewing executive director pay, to ensure pay is proportionate and justifiable. These include the local employment market, being situated in a high cost area, and also competing with the London recruitment market. As a result, remuneration levels are set to be sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the Trust.

The Committee reviews performance of each director each year before any decision regarding remuneration is made. The Trust takes its responsibility in approving all salaries seriously and acts in accordance with its responsibilities towards protecting public money. The Trust only has one executive director on a higher salary than the Prime Minister; this is a result of the comprehensive review taking into account the scope of the role and the local labour market and to ensure comparability with the wider market for ambulance and other foundation trusts.

In accordance with the policy, the Committee undertook a review of salaries informed by a benchmarking report, and agreed that salaries of four of the executive directors remained within current market rates, the salary of the CEO was uplifted following a comprehensive review of the market rates, local benchmarking and taking into account the ongoing development of the Trust and its expansion of services into other geographical areas. The Committee also approved a recruitment and retention allowance to be allocated to the executive director (Director of Strategy, Business Development and Communications) nominated as Deputy Chief Executive. With the backing of the full non-executive membership of the Board, the Committee approved inflationary increase of 1% of salaries for the executive team and the three very senior managers (VSMs) from 1 April 2017. In accordance with the policy, the Committee had agreed in 2013, that 5% of executive salaries be available in 2017/18 for payment of non-consolidated bonuses where performance targets had been met in 2016/17. For consideration of a bonus to be paid, the Committee would first be assured that the Trust had met corporate targets; only then would the performance of individual directors be reviewed.

Having undertaken this review, the Committee approved non-consolidated bonuses to be paid to six of the executive directors and one of the VSMs in July 2017. In 2017, the Committee again agreed that no more than 5% of executive and VSM salaries be available in 2017/18 for payment of non-consolidated bonuses where performance targets had been met in 2017/18.

During 2017/18 no decisions were made regarding the loss of office of senior Trust staff resulting in severance payments.

The Remuneration and Nominations Committee met five times during 2016/17 and, in accordance with its terms of reference, considered and agreed the remuneration and terms of service of the Chief Executive and executive directors. Following the inclusion of Director of Sales, Operations and Development, Deputy Medical Director and Charities CEO during 2015/16, the committee also considered and reviewed the terms and conditions for these three VSM post.

Will Hancock
Chief Executive

24 May 2018

Remuneration Committee – Attendance List 2017/18

Date	Alastair Mitchell-Baker	Ilona Blue	Lena Samuels	Melanie Saunders	Will Hancock
29 June 2017 (meeting)	Yes	Yes	Yes	Yes	Yes
June 2017 (telephone conference)	Yes	Yes	Yes	Yes	N/A
26 October 2017	Yes	Yes	Yes	Yes	N/A
14 December 2017	Yes	Yes	Yes	Yes	Yes
1 March 2017 (telephone conference)	Yes	Via email	Yes	Yes	Yes

DIRECTORS SALARIES AND BENEFITS FOR THE YEAR ENDED 31 MARCH 2018

	2017/18					2016/17					
Name and Title	Salary (bands of £5,000) £000	Taxable benefits to the nearest £100 (Note 11)	Annual performance related bonuses in bands of £5,000	All pension related benefits (bands of £2,500)	Total in bands of £5,000	Salary (bands of £5,000) £000	Taxable benefits to the nearest £100	Annual performance related bonuses in bands of £5,000	All pension related benefits (bands of £2,500)	Total in bands of £5,000	
Lena Samuels (Chair)	35-40					0-5					Note 1
Alastair Mitchell-Baker (Non-Executive Director)	15-20					15-20					Note 2
Ilona Blue (Non-Executive Director)	0					0					
Les Broude (Non-Executive Director)	0-5					0					Note 3
Professor David Williams (Non-Executive Director)	15-20					15-20					Note 4
Mike Hawker (Non-Executive Director)	15-20					15-20					
Nigel Chapman (Non-Executive Director)	10-15					10-15					
Sumit Biswas (Non-Executive Director)	10-15					5-10					Note 5
William Hancock (Chief Executive)	175-180	59	5-10	130-132.5	320-325	155-160	53	5-10	42.5-45	210-215	Note 6
Deirdre Thompson (Director of Patient Care)	15-20		0-5		20-25	110 - 115		5-10	22.5-25	140-145	Note 6,7
Charles Porter (Director of Finance)	115-120		0-5	45-47.5	165-170	115-120		0-5	27.5-30	145-150	Note 6
Philip Astle (Chief Operating Officer)	120-125		0-5	30-32.5	150-155	120-125			32.5-35	150-155	Note 6
James Underhay (Director of Strategy and Business Development)	120-125	49	0-5	42-45	175-180	120-125	43	0-5	50-52.5	180-185	Note 6
Melanie Saunders (Director of Human Resources and Organisational Development	100-105	26	0-5	77.5-80	185-190	95-100	20		97.5-100	195-200	Note 6
John Black (Medical Director)	100-105	68			110-115	110-115	41			110-115	Note 8
Professor Helen Young (Director of Patient Care and Service Transformation)	65-70			65-70	135-140						Note 9
Jane Campbell (Acting Director of Patient Care)	25-30			n/a	25-30						Note 10
Mid Point Band of highest paid Director's Total	177.5					157.5					
Median Total Remuneration (£000)	24.9					24.88					
Highest Paid Director as a proportion of the median	7.13					6.33					

Notes

1 Lena Samuels became Chair of the Trust on 1 April 2017. Her remuneration for 2016/17 was as a Non-Executve Director from 1 January 2017

2 Alistair Mitchell-Baker left the Trust on 31 March 2018

3 Les Broude joined the Trust on 1 February 2018

4 Professor David Williams left the Trust on 31 March 2018

5 Sumit Biwas joined the Trust on 1 July 2016

6 William Hancock, Charles Porter, James Underhay, Philip Astle, Deirdre Thompson and Melanie Saunders were awarded an annual bonus based on individual performance

7 Deirdre Thompson left the Trust on 31 May 2017

8 Dr John Black is a recharge from the Oxford University Hospitals NHS Foundation Trust

9 Professor Helen Young joined the Trust on 1 September 2017. The pension benefit shown is the amount attributable to the Trust

10 Jane Campbell acted as Director of Patient Care from 17 May 2017 to 31 August 2017

11 Taxable benefits in all cases relate to the private use of allocated Trust vehicles

PENSIONS FOR THE YEAR ENDED 31 MARCH 2018

Name and Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2018 (bands of £5,000)	Lump sum at aged 60 related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2018	Cash Equivalent Transfer Value at 31 March 2017	Real Increase in Cash Equivalent Transfer Value 31 March 2018
	£000	£000	£000	£000	£000	£000	£000
Will Hancock (Chief Executive)	7.5-10	10-12.5	55-60	150-155	966	841	116
Professor Helen Young (Director of Patient Care and Service Transformation)	5-7.5	15-17.5	40-45	120-125	709	598	106
Charles Porter (Director of Finance)	2.5-5	0-2.5	15-20	35-40	308	255	51
Philip Astle (Chief Operating Officer)	0-2.5	0	0-5	0	59	28	30
James Underhay (Director of Strategy and Business Development)	2.5-5	0	15-20	0	241	192	47
Melanie Saunders (Director of Human Resources and Organisational Development	2.5-5	5-7.5	25-30	70-75	452	370	78

CASH EQUIVALENT TRANSFER VALUE

A Cash Equivalent Transfer Value (CETV) is the actuarially completed 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 pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme.

They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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, contributions paid by the employee (including 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.

Government Actuary Department (GAD) factors for the calculation of CETVs assume that benefits are indexed in line with CPI which is expected to be lower than RPI which was used previously and hence will tend to produce lower transfer values.

EXPENSES

Details of number and value of expenses claimed by governors and directors are detailed below:

	2017/18			2016/17		
	Total Number in Office	Total Number Receiving Expenses	Aggregate Sum of Expenses paid (£00)	Total Number in Office	Total Number Receiving Expenses	Aggregate Sum of Expenses paid (£00)
Governors	25	18	63	23	16	53
Directors	15	13	133	15	13	198

OFF-PAYROLL ENGAGEMENTS

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

No. of existing engagements as of 31 March 2018	0
Of which:	
Number that have existed for less than one year at the time of reporting	0
Number that have existed for between one and two years at the time of reporting	0
Number that have existed for between two and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0

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

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

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

Number of off-payroll engagements of Board members, and / or senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed 'Board members and / or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements	0

ANNUAL ACCOUNTS 2017/18

FOREWORD TO THE ACCOUNTS

South Central Ambulance Service NHS Foundation Trust

These accounts, for the year ended 31 March 2018, have been prepared by South Central Ambulance Service NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Will Hancock
Chief Executive
24 May 2018

STATEMENT OF COMPREHENSIVE INCOME

		Group		Trust	
		2017/18	2016/17	2017/18	2016/17
	Note	£000	£000	£000	£000
Operating income from patient care activities	3	207,044	175,315	207,044	175,315
Other operating income	4	8,443	8,403	8,482	8,155
Operating expenses	5	(215,015)	(183,884)	(214,730)	(183,644)
Operating surplus / (deficit) from continuing operations		**472**	**(166)**	**796**	**(174)**
Finance income	10	56	46	56	46
Finance expenses	11	(87)	(126)	(87)	(126)
PDC dividends payable		(1,549)	(1,627)	(1,549)	(1,627)
Net finance costs		**(1,580)**	**(1,707)**	**(1,580)**	**(1,707)**
Gains on disposal of non-current assets	12	2,288	169	2,288	156
Surplus / (deficit) for the year from continuing operations		**1,180**	**(1,704)**	**1,504**	**(1,725)**
Gain/ (loss) from absorption and discontinuance of operations	14	**131**	**2,405**	**131**	**2,405**
Surplus / (deficit) for the year		**1,311**	**701**	**1,635**	**680**
Total comprehensive income/ (expense) for the period		1,311	701	1,635	680

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2018

	Note	Group 31 March 2018 £000	Group 31 March 2017 £000	Trust 31 March 2018 £000	Trust 31 March 2017 £000
Non-current assets					
Intangible assets	15	3,373	3,694	3,365	3,677
Property, plant and equipment	16	65,322	62,588	57,247	58,843
Other investments / financial assets	20	-	-	7,836	2,841
Total non-current assets		**68,695**	**66,282**	**68,448**	**65,361**
Current assets					
Inventories	18	910	938	569	590
Trade and other receivables	19	15,936	12,074	15,269	11,895
Other investments / financial assets	20	-	-	1,300	300
Non-current assets for sale and assets in disposal groups	21	-	2,700	-	2,700
Cash and cash equivalents	22	17,632	20,272	17,529	19,921
Total current assets		**34,478**	**35,984**	**34,667**	**35,406**
Current liabilities					
Trade and other payables	23	(17,412)	(17,684)	(17,365)	(16,149)
Borrowings	24	(1,740)	(1,738)	(1,740)	(1,738)
Provisions	25	(4,468)	(2,821)	(4,097)	(2,821)
Total current liabilities		**(23,620)**	**(22,243)**	**(23,202)**	**(20,708)**
Total assets less current liabilities		**79,553**	**80,023**	**79,913**	**80,059**
Non-current liabilities					
Trade and other payables	23	(13)	(15)	(13)	(15)
Borrowings	24	(1,400)	(3,140)	(1,400)	(3,140)
Provisions	25	(5,753)	(6,117)	(5,753)	(6,117)
Total non-current liabilities		**(7,166)**	**(9,272)**	**(7,166)**	**(9,272)**
Total assets employed		**72,387**	**70,751**	**72,747**	**70,787**
Financed by					
Public dividend capital		58,199	57,874	58,199	57,874
Revaluation reserve		10,669	10,885	10,669	10,885
Other reserves		(350)	(350)	(350)	(350)
Income and expenditure reserve		3,869	2,342	4,229	2,378
Total taxpayers' equity		**72,387**	**70,751**	**72,747**	**70,787**

The financial statements on pages 205 to 209 were approved by the Board on 24 May 2018 and signed on its behalf by:

Will Hancock
Chief Executive
24 May 2018

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 31 MARCH 2018

Group	Public dividend capital £000	Revaluation reserve £000	Other reserves* £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**57,874**	**10,885**	**(350)**	**2,342**	**70,751**
Surplus/(deficit) for the year	-	-	-	1,311	**1,311**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(216)	-	216	-
Public dividend capital received	325	-	-	-	**325**
Taxpayers' and others' equity at 31 March 2018	**58,199**	**10,669**	**(350)**	**3,869**	**72,387**

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 31 MARCH 2017

Group	Public dividend capital £000	Revaluation reserve £000	Other reserves* £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2016 - brought forward	**57,874**	**10,998**	**(350)**	**1,528**	**70,050**
Surplus/(deficit) for the year	-	-	-	701	**701**
Transfer to retained earnings on disposal of assets	-	(113)	-	113	-
Public dividend capital received	-	-	-	-	-
Taxpayers' and others' equity at 31 March 2017	**57,874**	**10,885**	**(350)**	**2,342**	**70,751**

*Other reserves

This reflects a residual balance required in 2006 when the Trust was formed from ambulance predecessor trusts to balance opening net assets with taxpayers' equity.

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 31 MARCH 2018

Trust	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**57,874**	**10,885**	**(350)**	**2,378**	**70,787**
Surplus/(deficit) for the year	-	-	-	1,635	**1,635**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(216)	-	216	-
Other transfers between reserves	-	-	-	-	-
Public dividend capital received	325	-	-	-	**325**
Public dividend capital written off	-	-	-	-	-
Taxpayers' and others' equity at 31 March 2018	**58,199**	**10,669**	**(350)**	**4,229**	**72,747**

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 31 MARCH 2017

Trust	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2016 - brought forward	**57,874**	**10,998**	**(350)**	**1,585**	**70,107**
Surplus/(deficit) for the year	-	-	-	680	**680**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	-
Transfer to retained earnings on disposal of assets	-	(113)	-	113	-
Taxpayers' and others' equity at 31 March 2017	**57,874**	**10,885**	**(350)**	**2,378**	**70,787**

*Other reserves

This reflects a residual balance required in 2006 when the Trust was formed from ambulance predecessor trusts to balance opening net assets with taxpayers' equity.

STATEMENT OF CASH FLOWS

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Cash flows from operating activities				
Operating surplus / (deficit)	472	(166)	796	(174)
Non-cash income and expense:				
Depreciation and amortisation	7,706	7,613	7,301	7,302
(Increase) / decrease in receivables and other assets	(1,275)	(704)	(787)	(748)
(Increase) / decrease in inventories	28	93	21	94
Increase / (decrease) in payables and other liabilities	1,716	518	2,174	248
Increase / (decrease) in provisions	1,274	(3,752)	903	(3,752)
Net cash generated from / (used in) operating activities	**9,921**	**3,602**	**10,408**	**2,970**
Cash flows from investing activities				
Interest received	52	48	52	48
Purchase of intangible assets	(742)	(1,227)	(733)	(1,226)
Purchase of PPE and investment property	(11,347)	(1,667)	(5,600)	(1,501)
Sales of PPE and investment property	2,477	647	2,477	634
Net cash flows from / (used in) investing activities	**(9,560)**	**(2,199)**	**(3,804)**	**(2,045)**
Cash flows from financing activities				
Public dividend capital received	325	-	325	-
Movement on loans from DHSC	(1,738)	(1,738)	(1,738)	(1,738)
Other interest paid	(98)	(110)	(98)	(110)
PDC dividend (paid) / refunded	(1,621)	(1,614)	(1,621)	(1,614)
Financing cash flows of discontinued operations	131	2,405	131	2,405
Cash flows from (used in) other financing activities	-	-	(5,995)	300
Net cash flows from / (used in) financing activities	**(3,001)**	**(1,057)**	**(8,996)**	**(757)**
Increase / (decrease) in cash and cash equivalents	(2,640)	346	(2,392)	168
Cash and cash equivalents at 1 April	20,272	19,926	19,921	19,753
Cash and cash equivalents at 31 March	**17,632**	**20,272**	**17,529**	**19,921**

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES AND OTHER INFORMATION

1.1 BASIS OF PREPARATION

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts. Where the statements show Group, this includes the results for both the NHS Foundation Trust and its wholly owned subsidiary, i.e. South Central Fleet Services Ltd.

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.

GOING CONCERN

These accounts have been prepared on a "going concern" basis. This means that the Trust expects to operate into the future and that the Statement of Financial Position (SOFP) reflects the ongoing nature of the Trust's activities. The Trust Board of Directors has considered and declared that "after making enquiries, the Board of Directors has a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future". For this reason, they continue to adopt the going concern basis in preparing the accounts.

1.2 CONSOLIDATION

NHS Charitable Fund

South Central Ambulance Service NHS Foundation Trust is the Corporate Trustee to South Central Ambulance Service (SCAS) NHS Charity. South Central Ambulance Service NHS Foundation Trust has considered the materiality of the current annual value of transactions and as a result has not consolidated the charitable fund results into the Trust accounts.

The SCAS Charity had total assets of £719k as at 31 March 2018 (31 March 2017: £716k). During 2017/18 the Charity received income of £394k (2016/17: £538k) and incurred expenditure of £391k (2016/17: £348k). The results for 31 March 2018 are provisional and unaudited at this stage.

Other subsidiaries

On 5 September 2015 the Trust established a wholly owned subsidiary company 'South Central Fleet Services Ltd'. The accounts show results for the Group and the Trust. The company began trading on 1 November 2015 and provides a range of fleet services to the Trust. The Trust's investment in the company is £441,340 of share capital.

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year, except where a subsidiary's financial year end is before 1 January or after 1 July in which case the actual amounts for each month of the Trust's financial year are obtained from the subsidiary and consolidated.

Where subsidiaries accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

1.3 INCOME

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

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

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

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 schemes are not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

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

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

1.5 EXPENDITURE ON 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.

1.6 PROPERTY, PLANT AND EQUIPMENT

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 and the cost of the item can be measured reliably
- ➔ The item has a cost of at least £5,000, or collectively a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous disposal dates and are under single managerial control
- ➔ Items form part of the initial equipping and setting-up cost of a new building, irrespective of their individual or collective cost

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

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 fair value. Land and buildings, used for the Trust's services, or for administrative purposes, are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any impairment. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined as follows:

- ➔ Land and non-specialised buildings – market value for existing use
- ➔ Specialised buildings – depreciated replacement cost

An item of property, plant and equipment, which is surplus, with no plan to bring it back into use, is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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 economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment, which has been reclassified as 'held for sale', ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

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 income.

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

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

Impairments

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

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income 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.

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, i.e.:
    - Management is 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'
    - The actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it

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

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

Donated, government grant and other 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.

Useful economic lives of property, plant and equipment

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	20	70
Dwellings	20	70
Plant & machinery	5	15
Transport equipment	5	10
Information technology	3	5
Furniture & fittings	5	15

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

1.7 INTANGIBLE ASSETS

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, e.g., 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
- The Trust can measure reliably the expenses attributable to the asset during development

Software

Software which is integral to the operation of hardware, e.g. 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, e.g. application software, is capitalised as an intangible asset.

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. Revaluation 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 economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful economic life of intangible assets

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

	Min life Years	Max life Years
Purchased intangible assets – Software	3	5

1.8 REVENUE GOVERNMENT AND OTHER GRANTS

Government grants are grants from government bodies other than income from commissioners or NHS 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.

1.9 INVENTORIES

Inventories are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.10 FINANCIAL INSTRUMENTS AND FINANCIAL LIABILITIES

Recognition

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

De-recognition

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

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

Classification and measurement

Financial assets are categorised as loans and receivables.

Financial liabilities are categorised as other financial liabilities.

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

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables

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

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

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

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

Other financial liabilities

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

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

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

Impairment of financial assets

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

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

1.11 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.

The Trust as lessee

Finance leases

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

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

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

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease. 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.

1.12 CASH & 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 instruments that mature in three 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 South Central Ambulance Service NHS Foundation Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

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 26 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.

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 27 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 27, 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
- 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

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 payments 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.

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.

1.17 CORPORATION TAX

South Central Ambulance Service NHS Foundation Trust has determined that it has no corporation tax liability as the Trust's profit generated from non-operational income falls below the threshold amount of £50,000.

1.18 FOREIGN EXCHANGE

The functional and presentational currency of the Trust is sterling. A transaction, which is denominated in a foreign currency, is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- Monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March
- Non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction
- Non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise. Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.19 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*.

1.20 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 by 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 its 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.

1.21 EARLY ADOPTION OF STANDARDS, AMENDMENTS AND INTERPRETATIONS

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

1.22 STANDARDS, AMENDMENTS AND INTERPRETATIONS IN ISSUE BUT NOT YET EFFECTIVE OR ADOPTED

At the date of authorisation of these financial statements, the following Standards and Interpretations, which have not been applied in these financial statements, were in issue but not yet effective. IFRS 9 and IFRS 15 are applicable for financial years commencing after January 2018 but are not expected to impact upon the current or future accounts of the Trust. None of the remaining IFRS standards listed below are expected to impact on the Trust's financial statements except IFRS 16 which is applicable from 2018/19.

- IFRS 9 Financial Instruments
- IFRS 14 Regulatory Deferral Accounts
- IFRS 15 Revenue from Contracts with Customers
- IFRS 16 Leases
- IFRS 17 Insurance Contracts
- IFRIC 22 Foreign Currency Transactions and Advance Consideration
- IFRIC 23 Uncertainty over Income Tax Treatments

1.23 CRITICAL ACCOUNTING ESTIMATES AND JUDGEMENTS

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

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

Indexation has not been applied to any non-current assets as no material changes were reflected in any relevant price indices.

Information provided by NHS Resolution has been used to determine provisions required for potential employer liability claims and disclosure of clinical negligence liability.

The NHS Pensions Agency has provided information with regard to disclosure and calculation of ill health retirement liability.

Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

These valuations are judgemental and future events (such as a change in economic conditions) could cause these valuations to change. Non-current assets relating to land and buildings had a carrying value of £40.9m as at 31 March 2018 (31 March 2017: £38.4m). The Trust undertakes a full valuation exercise every five years. The last quinquennial exercise was undertaken in 2013/14.

2. OPERATING SEGMENTS

Each segment is reported separately in the monthly Board report. Emergency Services include the 999 service, NHS 111 call handling, Education and Training and the Hazardous Area Response Team. Non-Emergency Services include non-emergency Patient Transport Services (PTS), Logistic Services and Commercial Training Income. Direct costs include employee and non-employee costs (staff costs, drugs, medical equipment, vehicle costs, etc.). The Trust only reports contribution before overheads by service line reporting to the Trust Board at public Board meetings.

	Emergency Services	Non-Emergency Services	Total
	2017/18 £000	2017/18 £000	2017/18 £000
Income	163,285	52,202	215,487
Direct Costs	(129,283)	(47,721)	(177,004)
Contribution Operational Activities	**34,002**	**4,481**	**38,483**
Total Overheads			(30,304)
Depreciation and Amortisation			(7,707)
Total Costs Before Dividends and Interest			**(38,011)**
Operating Surplus(Deficit)			**472**

	Emergency Services	Non-Emergency Services	Total
	2016/17 £000	2016/17 £000	2016/17 £000
Income	154,847	28,624	183,471
Direct Costs	(124,905)	(25,555)	(150,460)
Contribution Operational Activities	**29,942**	**3,069**	**33,011**
Total Overheads			(25,564)
Depreciation and Amortisation			(7,613)
Total Costs Before Dividends and Interest			**(33,177)**
Operating Surplus(Deficit)			**(166)**

3. OPERATING INCOME FROM PATIENT CARE ACTIVITIES (GROUP)

3.1 INCOME FROM PATIENT CARE ACTIVITIES (BY NATURE)

	2017/18 £000	2016/17 £000
Ambulance services		
A&E income	155,049	148,058
Patient transport services income	50,046	26,328
Other income	1,949	929
Total income from activities	**207,044**	**175,315**

All income from patient care activities were derived from the Trust.

3.2 INCOME PATIENT CARE ACTIVITIES (BY SOURCE)

Income from patient care activities received from:	2017/18 £000	2016/17 £000
NHS England	287	454
Clinical commissioning groups	200,960	169,434
Other NHS providers	3,136	3,286
NHS other	338	380
Local authorities	28	23
NHS injury scheme	425	393
Non NHS: other	1,870	1,345
Total income from activities	**207,044**	**175,315**
Of which:		
Related to continuing operations	207,044	175,315

Injury cost recovery income is subject to a provision for impairment of receivables of 22.84% of all claims to reflect the percentage probability of not receiving the income. This is in line with the advice issued by the compensation recovery unit for 2017/18 as instructed by the GAM.

4. OTHER OPERATING INCOME (GROUP)

	2017/18 £000	2016/17 £000
Education and training	1,552	1,647
Non-patient care services to other bodies	1,813	1,601
Sustainability and transformation fund income	3.179	2,413
Income in respect of staff costs where accounted on gross basis	379	573
Other income*	1,651	2,169
Total other operating income	**8,574**	**8,403**
Of which:		
Related to continuing operations	8,443	8,403
Related to discontinued operations	131	-

*Other income includes £188k for commercial training (2016/17: £368k), £246k radio mast income (2016/17: £253k) and £318k private event income (2016/17: £351k).

4.1 INCOME FROM ACTIVITIES ARISING FROM COMMISSIONER REQUESTED SERVICES

The Trust no longer has activities that are deemed as arising from commissioner requested services (2016/17: £nil)

5.1 OPERATING EXPENSES (GROUP)

	2017/18 £000	2016/17 £000
Purchase of healthcare from NHS and DHSC bodies	255	-
Purchase of healthcare from non-NHS bodies – Accident & Emergency	13,141	16,579
Purchase of healthcare from non-NHS bodies – Patient Transport	16,270	5,291
Staff and executive director costs	130,347	115,600
Remuneration of non-executive directors	260	250
Supplies and services - clinical (excluding drug costs)	3,579	3,165
Supplies and services - general	1,195	1,061
Drug costs (drugs inventory consumed & purchase of non-inventory drugs)	393	381
Consultancy costs	223	198
Establishment	3,919	3,608
Premises	3,233	2,872
Information technology	3,735	2,871
Transport (including patient travel)	16,985	13,963
Depreciation on property, plant and equipment	6,643	6,677
Amortisation on intangible assets	1,063	936
Increase / (decrease) in provision for impairment of receivables	7	(227)
Audit fees payable to the external auditor;		
audit services - statutory audit	32	40
other auditor remuneration (external auditor only)	15	21
Internal audit costs	70	77
Clinical negligence	1,174	838
Legal fees	224	214
Insurance	1,089	1,364
Education and training	1,071	888
Rentals under operating leases	6,775	5,027
Hospitality	18	11
Other services, e.g. external payroll*	2,098	1,376
Other	1,201	803
Total	**215,015**	**183,884**
Of which:		
Related to continuing operations	215,015	183,884

*Other services includes £1,933k from 111 managed service contract (2016/17: £1,293k)

5.2 OTHER AUDITOR REMUNERATION (GROUP)

	2017/18 £000	2016/17 £000
All other assurance services	15	21
Total	**15**	**21**

5.3 LIMITATION ON AUDITOR'S LIABILITY (GROUP)

The limitation on auditor's liability for external audit work is £2m (2016/17: £1m)

6. IMPAIRMENT OF ASSETS (GROUP)

There were no impairments identified or reversals of previous impairments identified in relation to non-current assets.

7. EMPLOYEE BENEFITS (GROUP)

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	104,173	91,138
Social security costs	10,047	8,906
Apprenticeship levy	499	-
Employer's contributions to NHS pensions	12,988	11,615
Temporary staff (including agency)	2,640	3,776
Total gross staff costs	**130,347**	**115,435**
Recoveries in respect of seconded staff	-	165
Total staff costs	**130,347**	**115,600**

7.1 RETIREMENTS DUE TO ILL-HEALTH (GROUP)

During 2017/18 there were six early retirements from the Trust agreed on the grounds of ill-health (two in the year ended 31 March 2017). The estimated additional pension liability of these ill-health retirements is £300k (£184k in 2016/17).

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

Further details of directors' remuneration can be found in the remuneration report which is included in the Trust Annual Report 2017/18.

In the year ended 31 March 2018, six directors (2017: six) accrued benefits under a defined pension scheme.

During the year to 31 March 2018, the highest paid director was the Chief Executive who was paid a salary between £175k and £180k and was assessed as in receipt of benefit in kind of £5.9k.

8. PENSION COSTS

Past and present employees are covered by the provisions of the two NHS Pensions 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 the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

a) Accounting valuation

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

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, 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 the contribution rates payable by employees and employers.

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

c) National Employment Savings Trust (NEST)

The Pensions Act 2008 introduced new duties on employers in providing access to a workplace pension for all of its employees. The NHS Pension Scheme is not available to all employees and the Trust has provided access to a scheme for these employees which is operated by the National Employment Savings Trust (NEST). NEST is a defined contribution scheme where a minimum contribution is paid by the employer. South Central Ambulance Service NHS Foundation Trust currently contributes 5% of qualifying earnings to the scheme and employees contribute 5% of pensionable pay.

NEST levies a contribution charge of 1.8% and an annual management charge of 0.3% which is paid from the employer contributions. There are no separate employer charges levied by NEST and the Trust is not required to enter into a contract to utilise NEST qualifying pension schemes.

Staff who are recruited by South Central Fleet Services Ltd will be auto-enrolled into the NEST Pension Scheme.

9. OPERATING LEASES (GROUP)

9.1 SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST AS A LESSOR

The Group had no operating lease income in 2017/18 (2016/17: nil).

9.2 SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST AS A LESSEE

This note discloses costs and commitments incurred in operating lease arrangements where South Central Ambulance Service NHS Foundation Trust is the lessee.

	2017/18 £000	2016/17 £000
Operating lease expense		
Minimum lease payments	6,775	5,027
Less sublease payments received	-	-
Total	**6,775**	**5,027**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease payments due relating to building leases:		
- not later than one year;	2,396	1,551
- later than one year and not later than five years;	7,705	5,661
- later than five years.	11,356	10,487
Total	**21,457**	**17,699**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease payments due relating to other leases:		
- not later than one year;	2,778	1,825
- later than one year and not later than five years;	5,098	3,050
- later than five years.	-	-
Total	**7,876**	**4,875**

The figures in the table above are identical for both the Group and the Trust.

10. FINANCE INCOME (GROUP)

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

	2017/18 £000	2016/17 £000
Interest on bank accounts	56	46
Total	**56**	**46**

11.1 FINANCE EXPENDITURE (GROUP)

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

	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	78	117
Total interest expense	**78**	**117**
Unwinding of discount on provisions	9	9
Total finance costs	**87**	**126**

11.2 THE LATE PAYMENT OF COMMERCIAL DEBTS (INTEREST) ACT 1998 / PUBLIC CONTRACT REGULATIONS 2015

No interest payments were made by the Group in the reporting period.

12. OTHER GAINS / (LOSSES) (GROUP)

	2017/18	2016/17
	£000	£000
Gains on disposal of assets	2,288	169
Total gains / (losses) on disposal of assets	**2,288**	**169**

The above gain on disposal of assets includes £2,237k for the sale of the Battle site previously held in the assets held for sale.

13. CORPORATION TAX

The Trust has determined that it has no corporation tax liability from its subsidiary, South Central Fleet Services Ltd, in the qualifying period. The Trust does not have any other qualifying income from any of its other activities.

14. DISCONTINUED OPERATIONS (GROUP)

	2017/18	2016/17
	£000	£000
Movement in provisions for liabilities on discontinued operations	131	2,405
Total	**131**	**2,405**

The Trust is the appointed successor body to NHS Direct which ceased providing services on 31 March 2014.

15.1 INTANGIBLE ASSETS 2017/18 - GROUP

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**7,686**	**1,458**	**9,144**
Transfers by absorption	-	-	-
Additions	275	467	742
Reclassifications	618	(618)	-
Disposals / de-recognition	-	-	-
Valuation / gross cost at 31 March 2018	**8,579**	**1,307**	**9,886**
Amortisation at 1 April 2017 - brought forward	**5,450**	**-**	**5,450**
Transfers by absorption	-	-	-
Provided during the year	1,063	-	1,063
Disposals / de-recognition	-	-	-
Amortisation at 31 March 2018	**6,513**	**-**	**6,513**
Net book value at 31 March 2018	**2,066**	**1,307**	**3,373**
Net book value at 1 April 2017	**2,236**	**1,458**	**3,694**

15.2 INTANGIBLE ASSETS 2016/17 - GROUP

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**6,633**	**1,284**	**7,917**
Prior period adjustments	-	-	-
Valuation / gross cost at 1 April 2016 - restated	**6,633**	**1,284**	**7,917**
Additions	51	1,176	1,227
Reclassifications	1,002	(1,002)	-
Disposals / de-recognition	-	-	-
Valuation / gross cost at 31 March 2017	**7,686**	**1,458**	**9,144**
Amortisation at 1 April 2016 - as previously stated	**4,514**	**-**	**4,514**
Prior period adjustments	-	-	-
Amortisation at 1 April 2016 - restated	**4,514**	**-**	**4,514**
Provided during the year	936	-	936
Disposals / de-recognition	-	-	-
Amortisation at 31 March 2017	**5,450**	**-**	**5,450**
Net book value at 31 March 2017	**2,236**	**1,458**	**3,694**
Net book value at 1 April 2016	**2,119**	**1,284**	**3,403**

15.3 INTANGIBLE ASSETS 2017/18 - TRUST

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**7,563**	**1,458**	**9,021**
Additions	266	467	**733**
Reclassifications	618	(618)	-
Disposals / de-recognition	-	-	-
Valuation / gross cost at 31 March 2018	**8,447**	**1,307**	**9,754**
Amortisation at 1 April 2017 - brought forward	**5,344**	**-**	**5,344**
Provided during the year	1,045	-	1,045
Disposals / de-recognition	-	-	-
Amortisation at 31 March 2018	**6,389**	**-**	**6,389**
Net book value at 31 March 2018	**2,058**	**1,307**	**3,365**
Net book value at 1 April 2017	**2,219**	**1,458**	**3,677**

15.4 INTANGIBLE ASSETS 2016/17 - TRUST

	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2016 - brought forward	**6,511**	**1,284**	**7,795**
Additions	50	1,176	1,226
Reclassifications	1,002	(1,002)	-
Disposals / de-recognition	-	-	-
Valuation / gross cost at 31 March 2017	**7,563**	**1,458**	**9,021**
Amortisation at 1 April 2016 - brought forward	**4,425**	**-**	**4,425**
Provided during the year	919	-	919
Disposals / de-recognition	-	-	-
Amortisation at 31 March 2017	**5,344**	**-**	**5,344**
Net book value at 31 March 2017	**2,219**	**1,458**	**3,677**
Net book value at 1 April 2016	**2,086**	**1,284**	**3,370**

16.1 PROPERTY, PLANT AND EQUIPMENT 2017/18 - GROUP

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**9,139**	**36,678**	**-**	**3,364**	**13,769**	**40,137**	**7,884**	**1,436**	**112,407**
Additions	-	2,599	-	1,864	682	3,784	447	1	9,377
Reclassifications	-	1,302	-	(3,282)	610	1,180	190	-	-
Disposals / de-recognition	-	(30)	-	-	(683)	(1,729)	-	-	(2,442)
Valuation/gross cost at 31 March 2018	**9,139**	**40,549**	**-**	**1,946**	**14,378**	**43,372**	**8,521**	**1,437**	**119,342**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**7,385**	**-**	**-**	**9,186**	**26,321**	**6,003**	**924**	**49,819**
Provided during the year	-	1,473	-	-	1,208	2,958	909	95	6,643
Disposals/ de-recognition	-	(30)	-	-	(683)	(1,729)	-	-	(2,442)
Accumulated depreciation at 31 March 2018	**-**	**8,828**	**-**	**-**	**9,711**	**27,550**	**6,912**	**1,019**	**54,020**
Net book value at 31 March 2018	**9,139**	**31,721**	**-**	**1,946**	**4,667**	**15,822**	**1,609**	**418**	**65,322**
Net book value at 1 April 2017	**9,139**	**29,293**	**-**	**3,364**	**4,583**	**13,816**	**1,881**	**512**	**62,588**

For land and buildings the Trust uses a qualified professional valuer FRICS provided by Bomford Estates. They provide on an annual basis indices for use in valuing land and buildings. The Trust undertakes a full valuation exercise every five years. The last quinquennial exercise was undertaken in 2013/14.

16.2 PROPERTY, PLANT AND EQUIPMENT 2016/17 - GROUP

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 – brought forward	**9,203**	**36,422**	**161**	**1,599**	**13,882**	**43,043**	**6,935**	**1,408**	**112,673**
Additions	-	58	-	3,176	117	91	21	3	**3,466**
Reclassifications	-	178	-	(1,411)	-	280	928	25	**-**
Disposals / de-recognition	(64)	-	(161)	-	(230)	(3,227)	-	-	**(3,732)**
Valuation/gross cost at 31 March 2017	**9,139**	**36,678**	**-**	**3,364**	**13,769**	**40,137**	**7,884**	**1,436**	**112,407**
Accumulated depreciation at 1 April 2016 – brought forward	**-**	**5,985**	**13**	**-**	**8,199**	**26,543**	**5,068**	**860**	**46,668**
Provided during the year	-	1,400	6	-	1,217	3,055	935	64	**6,677**
Disposals / de-recognition	-	-	(19)	-	(230)	(3,277)	-	-	**(3,526)**
Accumulated depreciation at 31 March 2017	**-**	**7,385**	**-**	**-**	**9,186**	**26,321**	**6,003**	**924**	**49,819**
Net book value at 31 March 2017	**9,139**	**29,293**	**-**	**3,364**	**4,583**	**13,816**	**1,881**	**512**	**62,588**
Net book value at 1 April 2016	**9,203**	**30,457**	**148**	**1,599**	**5,683**	**16,500**	**1,867**	**548**	**66,005**

16.3 PROPERTY, PLANT AND EQUIPMENT FINANCING 2017/18 - GROUP

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	8,235	30,861	-	1,946	4,667	15,822	1,609	418	**63,558**
Owned - donated	904	860	-	-	-	-	-	-	**1,764**
NBV total at 31 March 2018	**9,139**	**31,721**	**-**	**1,946**	**4,667**	**15,822**	**1,609**	**418**	**65,322**

16.4 PROPERTY, PLANT AND EQUIPMENT FINANCING 2016/17 - GROUP

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017									
Owned - purchased	8,235	28,419	-	3,364	4,583	13,806	1,881	512	**60,800**
Owned - donated	904	874	-	-	-	10	-	-	**1,788**
NBV total at 31 March 2016	**9,139**	**29,293**	**-**	**3,364**	**4,583**	**13,816**	**1,881**	**512**	**62,588**

16.5 PROPERTY, PLANT AND EQUIPMENT 2017/18 - TRUST

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**9,139**	**36,678**	**-**	**2,091**	**13,061**	**37,639**	**7,884**	**1,436**	**107,928**
Additions	-	2,599	-	1,587	293	-	180	1	**4,660**
Reclassifications	-	1,302	-	(2,009)	517	-	190	-	**-**
Disposals / de-recognition	-	(30)	-	-	-	-	-	-	**(30)**
Valuation/gross cost at 31 March 2018	**9,139**	**40,549**	**-**	**1,669**	**13,871**	**37,639**	**8,254**	**1,437**	**112,558**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**7,385**	**-**	**-**	**8,702**	**26,071**	**6,003**	**924**	**49,085**
Provided during the year	-	1,473	-	-	1,168	2,611	909	95	**6,256**
Disposals / de-recognition	-	(30)	-	-	-	-	-	-	**(30)**
Accumulated depreciation at 31 March 2018	**-**	**8,828**	**-**	**-**	**9,870**	**28,682**	**6,912**	**1,019**	**55,311**
Net book value at 31 March 2018	**9,139**	**31,721**	**-**	**1,669**	**4,001**	**8,957**	**1,342**	**418**	**57,247**
Net book value at 1 April 2017	**9,139**	**29,293**	**-**	**2,091**	**4,359**	**11,568**	**1,881**	**512**	**58,843**

16.6 PROPERTY, PLANT AND EQUIPMENT 2016/17 - TRUST

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2016 - brought forward	**9,203**	**36,422**	**161**	**1,599**	**13,174**	**40,545**	**6,935**	**1,408**	**109,467**
Additions	-	58	-	1,903	117	91	21	3	**2,193**
Reclassifications	-	178	-	(1,411)	-	280	928	25	**-**
Disposals / de-recognition	(64)	-	(161)	-	(230)	(3,277)	-	-	**(3,732)**
Valuation/gross cost at 31 March 2017	**9,139**	**36,678**	**-**	**2,091**	**13,061**	**37,639**	**7,884**	**1,436**	**107,928**
Accumulated depreciation at 1 April 2016 - brought forward	**-**	**5,985**	**13**	**-**	**7,758**	**26,544**	**5,068**	**860**	**46,228**
Impairments	-	1,400	6	-	1,174	2,804	935	64	6,383
Disposals / de-recognition	-	-	(19)	-	(230)	(3,277)	-	-	(3,526)
Accumulated depreciation at 31 March 2017	**-**	**7,385**	**-**	**-**	**8,702**	**26,071**	**6,003**	**924**	**49,085**
Net book value at 31 March 2017	**9,139**	**29,293**	**-**	**2,091**	**4,359**	**11,568**	**1,881**	**512**	**58,843**
Net book value at 1 April 2016	**9,203**	**30,457**	**148**	**1,599**	**5,416**	**14,001**	**1,867**	**548**	**63,239**

16.7 PROPERTY, PLANT AND EQUIPMENT FINANCING 2017/18 - TRUST

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	8,235	30,861	-	1,669	4,001	8,957	1,342	418	55,483
Owned - donated	904	860	-	-	-	-	-	-	1,764
NBV total at 31 March 2018	**9,139**	**31,721**	**-**	**1,669**	**4,001**	**8,957**	**1,342**	**418**	**57,247**

16.8 PROPERTY, PLANT AND EQUIPMENT FINANCING 2016/17 - TRUST

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017									
Owned - purchased	8,235	28,419	-	2,091	4,359	11,558	1,881	512	57,055
Owned - donated	904	874	-	-	-	10	-	-	1,788
NBV total at 31 March 2017	**9,139**	**29,293**	**-**	**2,091**	**4,359**	**11,568**	**1,881**	**512**	**58,843**

17. INVESTMENTS IN SUBSIDIARIES

South Central Ambulance Service NHS Foundation Trust purchased 441,340 ordinary shares of £1 each in South Central Fleet Services Ltd.

This represents a 100% direct ownership of South Central Fleet Services Ltd which is incorporated in England and Wales. This subsidiary company is included in the consolidation.

18. INVENTORIES

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Consumables	771	797	430	449
Energy	139	141	139	141
Total inventories	**910**	**938**	**569**	**590**

Inventories recognised in expenses for the year were £28k (2016/17: £nil). Write-down of inventories recognised as expenses for the year were £57k (2016/17: £nil).

19. RECEIVABLES

19.1 TRADE RECEIVABLES AND OTHER RECEIVABLES

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Current				
Trade receivables	2,841	1,344	2,841	1,340
Capital receivables (including accrued capital related income)	2,511	-	2,511	-
Accrued income	5,267	5,653	5,267	5,653
Provision for impaired receivables	(349)	(342)	(349)	(342)
Prepayments (non-PFI)	3,204	3,060	3,165	3,036
Interest receivable	7	3	7	3
PDC dividend receivable	101	29	101	29
VAT receivable	803	456	499	475
Other receivables	1,551	1,871	1,227	1,701
Total current trade and other receivables	**15,936**	**12,074**	**15,269**	**11,895**
Of which receivables from NHS and DHSC group bodies:				
Current	7,039	5,961	7,039	5,961
Non-current	-	-	-	-

The Trust had no non-current trade or other receivables.

The majority of trade receivables are due from clinical commissioning groups, as commissioners for NHS patient care services. As clinical commissioning groups are funded by Government no credit scoring of them is considered necessary.

19.2 PROVISION FOR IMPAIRMENT OF RECEIVABLES

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
At 1 April as previously stated	**342**	**569**	**342**	**569**
Transfers by absorption	-	-	-	-
Increase / (decrease) in provision	7	(227)	7	(227)
Amounts utilised	-	-	-	-
Unused amounts reversed	-	-	-	-
At 31 March	**349**	**342**	**349**	**342**

The provision relates to £229k injury cost recovery (2016/17: £234k), £41k trade receivables (2016/17: £33k) and £79k overpaid salaries (2016/17: £75k)

19.3 CREDIT QUALITY OF FINANCIAL ASSETS

Group	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	**£000**	**£000**	**£000**	**£000**
0-30 days	-	-	-	-
30-60 Days	-	-	-	-
60-90 days	-	-	-	-
90-180 days	-	-	-	-
Over 180 days	349	-	342	-
Total	**349**	**-**	**342**	**-**
Ageing of non-impaired financial assets past their due date				
0-30 days	161	-	272	-
30-60 Days	9	-	15	-
60-90 days	14	-	(1)	-
90-180 days	3	-	6	-
Over 180 days	78	-	33	-
Total	**265**	**-**	**325**	**-**

The Trust's impaired receivables are identical to the Group figures stated above.

20. OTHER FINANCIAL ASSETS

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Non-current				
Share capital	-	-	441	441
Loan and receivables	-	-	7,395	2,400
Total other current assets	**-**	**-**	**7,836**	**2,841**
Current				
Loan and receivables	-	-	1,300	300
Total	**-**	**-**	**1,300**	**300**

Other financial assets represent five loans made to South Central Fleet Services Ltd to purchase ambulances. The Trust has made a total of five loans of £9,520k which range from 5-10 years, all attracting interest of 3.5%.

21. NON-CURRENT ASSETS FOR SALE AND ASSETS IN DISPOSAL GROUPS

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**2,700**	**2,950**	**2,700**	**2,950**
Assets sold in year	(2,700)	(250)	(2,700)	(250)
Impairment of assets held for sale	-	-	-	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**2,700**	**-**	**2,700**

The value above relates to the open market value estimate of the Battle site £2.7m which was sold during 2017/18.

22. CASH AND CASH EQUIVALENT 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.

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
At 1 April	**20,272**	**19,926**	**19,921**	**19,753**
Transfers by absorption	-	-	-	-
Net change in year	(2,640)	346	(2,392)	168
At 31 March	**17,632**	**20,272**	**17,529**	**19,921**
Broken down into:				
Cash at commercial banks and in hand	124	364	21	13
Cash with the Government Banking Service	17,508	19,908	17,508	19,908
Deposits with the National Loan Fund	-	-	-	-
Other current investments	-	-	-	-
Total cash and cash equivalents as in SoFP	**17,632**	**20,272**	**17,529**	**19,921**
Bank overdrafts (GBS and commercial banks)	-	-	-	-
Drawdown in committed facility	-	-	-	-
Total cash and cash equivalents as in SoCF	**17,632**	**20,272**	**17,529**	**19,921**

22.1 THIRD PARTY ASSETS

The Group held no third party assets as at 31 March 2018 (31 March 2017: nil).

23.1 TRADE AND OTHER PAYABLES

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Current				
Trade payables	1,036	2,892	1,036	2,722
Capital payables	591	2,561	511	1,451
Accruals	13,061	9,819	13,133	9,631
Social security costs	1,559	1,412	1,540	1,393
Other taxes payable	1,035	916	1,015	903
Accrued interest on loans	15	35	15	35
Other payables	115	49	115	14
Total current trade and other payables	**17,412**	**17,684**	**17,365**	**16,149**
Non-current				
Other payables	13	15	13	15
Total non-current trade and other payables	**13**	**15**	**13**	**15**
Of which payables from NHS and DHSC group bodies:				
Current	993	414	993	414
Non-current	-	-	-	-

Accruals include £1,737k outstanding pension contributions as at 31 March 2018 (31 March 2017: £1,591k).

23.2 EARLY RETIREMENTS IN NHS PAYABLES ABOVE

There were no early retirement payments in the above.

23.3 BETTER PAYMENT PRACTICE CODE

Measure of compliance	March 2018 Number	March 2018 £000	March 2017 Number	March 2017 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	43,739	123,470	43,392	82,843
Total non-NHS trade invoices paid within target	39,192	117,130	38,098	78,127
Percentage of non-NHS trade invoices paid within target	89.6%	94.9%	87.8%	94.3%
NHS Payables				
Total NHS trade invoices paid in the year	634	3,231	644	2,957
Total NHS trade invoices paid within target	584	3,147	576	2,648
Percentage of NHS trade invoices paid within target	92.1%	97.4%	89.4%	89.6%

The Trust will continue to try to pay invoices from its suppliers promptly and will strive to pay all valid invoices by the due date, or within 30 days of receipt of invoice in accordance with the Better Payment Practice Code.

24. BORROWINGS

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Current				
Loans from DHSC	1,740	1,738	1,740	1,738
Other loans	-	-	-	-
Total current borrowings	**1,740**	**1,738**	**1,740**	**1,738**
Non-current				
Loans from DHSC	1,400	3,140	1,400	3,140
Other loans	-	-	-	-
Total non-current borrowings	**1,400**	**3,140**	**1,400**	**3,140**

The Trust has one capital loan of £3,551k (payable over 10 years) taken out in 2008/09 at an interest rate of 4.28% and one of £7,000k (payable over five years) taken out in 2014/15 at an interest rate of 1.48%.

25.1 PROVISIONS FOR LIABILITIES AND CHARGES ANALYSIS (GROUP)

	Pensions - early departure costs	Legal claims	Re-structuring	Other*	Total
	£000	£000	£000	£000	£000
At 1 April 2017	**3,868**	**564**	**304**	**4,202**	**8,938**
Change in the discount rate	54	-	-	-	**54**
Arising during the year	195	74	338	2,831	**3,438**
Utilised during the year	(224)	(75)	(58)	(795)	**(1,152)**
Reversed unused	(276)	(275)	(100)	(415)	**(1,066)**
Unwinding of discount	9	-	-	-	**9**
At 31 March 2018	**3,626**	**288**	**484**	**5,823**	**10,221**
Expected timing of cash flows:					
- not later than one year;	221	288	484	3,475	**4,468**
- later than one year and not later than five years;	861	-	-	768	**1,629**
- later than five years.	2,544	-	-	1,580	**4,124**
Total	**3,626**	**288**	**484**	**5,823**	**10,221**

*Other provisions include £2,059k ongoing costs arising from the management of closure activities including the retention of clinical records, £1,456k staff related costs, £427k property dilapidations, £143k for lease car related costs, £128k for site contamination costs and £952k provision for credit notes.

25.2 PROVISIONS FOR LIABILITIES AND CHARGES ANALYSIS (TRUST)

	Pensions - early departure costs	Legal claims	Re-structuring	Other*	Total
	£000	£000	£000	£000	£000
At 1 April 2017	**3,868**	**564**	**304**	**4,202**	**8,938**
Transfers by absorption	-	-	-	-	**-**
Change in the discount rate	54	-	-	-	**54**
Arising during the year	195	74	-	2,798	**3,067**
Utilised during the year	(224)	(75)	(58)	(795)	**(1,152)**
Reversed unused	(276)	(275)	(100)	(415)	**(1,066)**
Unwinding of discount	9	-	-	-	**9**
At 31 March 2018	**3,626**	**288**	**146**	**5,790**	**9,850**
Expected timing of cash flows:					
- not later than one year;	221	288	146	3,442	4,097
- later than one year and not later than five years;	861	-	-	768	1,629
- later than five years.	2,544	-	-	1,580	4,124
Total	**3,626**	**288**	**146**	**5,790**	**9,850**

*Other provisions include £2,059k ongoing costs arising from the management of closure activities including the retention of clinical records, £1,456k staff related costs, £427k property dilapidations, £143k for lease car related costs, £128k for site contamination costs and £952k provision for credit notes.

26. CLINICAL NEGLIGENCE LIABILITIES

At 31 March 2018, £39,387k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of South Central Ambulance Service NHS Foundation Trust (31 March 2017: £35,542k).

27. CONTINGENT ASSETS AND LIABILITIES

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Value of contingent liabilities				
NHS Resolution legal claims	(70)	(83)	(70)	(83)
Other	-	-	-	-
Gross value of contingent liabilities	**(70)**	**(83)**	**(70)**	**(83)**
Amounts recoverable against liabilities	-	-	-	-
Net value of contingent liabilities	**(70)**	**(83)**	**(70)**	**(83)**
Net value of contingent assets	**-**	**-**	**-**	**-**

28. CONTRACTUAL CAPITAL COMMITMENTS

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Property, plant and equipment	112	2,031	112	2,031
Intangible assets	334	139	334	139
Total	**446**	**2,170**	**446**	**2,170**

29. FINANCIAL INSTRUMENTS

29.1 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 Trust has with clinical commissioning groups and the way those clinical commissioning groups are financed, the 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 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 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 therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust's borrowings are from Government, the borrowings are for 1-10 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.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note. The Trust's procurement process is robust and the Trust restricts prepayments to suppliers. The Trust is not exposed to significant liquidity risks.

29.2 CARRYING VALUES OF FINANCIAL ASSETS

Group	Loans and receivables	Available-for-sale	Total book value
	£000	£000	£000
Assets as per SoFP as at 31 March 2018			
Trade and other receivables with NHS and DHSC bodies excluding non-financial assets	6,938	-	**6,938**
Trade and other receivables with other bodies excluding non-financial assets	4,692	-	**4,692**
Cash and cash equivalents	17,632	-	**17,632**
Total at 31 March 2018	**29,262**	**-**	**29,262**

Note: The loans and receivables figure includes £2.5m due for the remaining capital proceeds for the Battle site sale. The Trust holds a legal charge over the land and buildings at the former Battle site as security against the capital receivable. The Battle site is being leased back to the Trust at a peppercorn rent.

Group	Loans and receivables	Available-for-sale	Total book value
	£000	£000	£000
Assets as per SoFP as at 31 March 2017			
Trade and other receivables with NHS and DHSC bodies excluding non-financial assets	5,232	-	**5,232**
Trade and other receivables with other bodies excluding non-financial assets	2,396	-	**2,396**
Cash and cash equivalents	20,272	-	**20,272**
Total at 31 March 2017	**27,900**	**-**	**27,900**

Trust	Loans and receivables	Available-for-sale	Total book value
	£000	£000	£000
Assets as per SoFP as at 31 March 2018			
Trade and other receivables with NHS and DHSC bodies excluding non-financial assets	6,938	-	**6,938**
Trade and other receivables with other bodies excluding non-financial assets	4,506	-	**4,506**
Other investments	441	-	**441**
Cash and cash equivalents	17,529	-	**17,529**
Total at 31 March 2018	**29,414**	**-**	**29,414**

Trust	Loans and receivables	Available-for-sale	Total book value
	£000	£000	£000
Assets as per SoFP as at 31 March 2018			
Trade and other receivables with NHS and DHSC bodies excluding non-financial assets	5,232	-	**5,232**
Trade and other receivables with other bodies excluding non-financial assets	2,270	-	**2,270**
Other investments	441	-	**441**
Cash and cash equivalents	19,921	-	**19,921**
Total at 31 March 2017	**27,864**	**-**	**27,864**

29.3 CARRYING VALUES OF FINANCIAL LIABILITIES

Group	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Borrowings excluding finance lease and PFI liabilities	3,140	-	**3,140**
Trade and other payables with NHS and DHSC bodies excluding non-financial liabilities	1,072	-	**1,072**
Trade and other payables with other bodies excluding non-financial liabilities	11,259	-	**11,259**
Other financial liabilities	-	-	**-**
Provisions under contract	3,690	-	**3,690**
Total at 31 March 2018	**19,161**	**-**	**19,161**

Group	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Borrowings excluding finance lease and PFI liabilities	4,878	-	**4,878**
Trade and other payables with NHS and DHSC bodies excluding non-financial liabilities	509	-	**509**
Trade and other payables with other bodies excluding non-financial liabilities	12,112	-	**12,112**
Provisions under contract	3,593	-	**3,593**
Total at 31 March 2018	**21,092**	**-**	**21,092**

Trust	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Borrowings excluding finance lease and PFI liabilities	3,140	-	**3,140**
Trade and other payables with NHS and DHSC bodies excluding non-financial liabilities	1,071	-	**1,071**
Trade and other payables with other bodies excluding non-financial liabilities	15,446	-	**15,446**
Provisions under contract	3,690	-	**3,690**
Total at 31 March 2018	**23,347**	**-**	**23,347**

Trust	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Borrowings excluding finance lease and PFI liabilities	4,878	-	**4,878**
Trade and other payables with NHS and DHSC bodies excluding non-financial liabilities	509	-	**509**
Trade and other payables with other bodies excluding non-financial liabilities	15,109	-	**15,109**
Provisions under contract	3,593	-	**3,593**
Total at 31 March 2018	**24,089**	**-**	**24,089**

29.4 FAIR VALUES OF FINANCIAL ASSETS AND LIABILITIES

The Group held no non-current financial assets as at 31 March 2018 (31 March 2017: nil).

The carrying amount of the following financial assets and liabilities is considered a reasonable approximation of fair value; cash and cash equivalents, trade and other receivables, trade and other payables.

29.5 MATURITY OF FINANCIAL LIABILITIES

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
In one year or less	15,475	15,550	19,661	18,547
In more than one year but not more than two years	1,729	2,052	1,729	2,052
In more than two years but not more than five years	411	1,985	411	1,985
In more than five years	1,546	1,505	1,546	1,505
Total	**19,161**	**21,092**	**23,347**	**24,089**

30. LOSSES AND SPECIAL PAYMENTS

Group and Trust	2017/18 Total number of cases Number	2017/18 Total value of cases £000	2016/17 Total number of cases Number	2016/17 Total value of cases £000
Losses				
Cash losses	-	-	-	-
Bad debts and claims abandoned	-	-	1	63
Stores losses and damage to property	101	283	113	392
Total losses	**101**	**283**	**114**	**455**
Special payments				
Ex-gratia payments	-	-	2	1
Total special payments	**-**	**-**	**2**	**1**
Total losses and special payments	**101**	**283**	**116**	**456**

All losses are derived from the Trust.

Note: all losses and special payments are on an accruals basis but exclude provision for future losses.

31. PRIOR PERIOD ADJUSTMENTS

There were no prior period adjustments.

32. EVENTS AFTER THE REPORTING DATE

There were no events after the reporting date.

33. RELATED PARTIES

During the year none of the Board members or members of the key management staff or parties related to them has undertaken any material transactions with South Central Ambulance Service NHS Foundation Trust.

The Department of Health and Social Care is regarded as a related party. During the year South Central Ambulance Service NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

Health Education England
Oxford University Hospital NHS Foundation Trust
Buckinghamshire Healthcare NHS Trust
NHS Oxfordshire CCG
NHS West Hampshire CCG
NHS Aylesbury Vale CCG
NHS Chiltern CCG
NHS Southampton CCG
NHS Milton Keynes CCG
NHS Fareham & Gosport CCG
NHS Portsmouth CCG
NHS South Eastern Hampshire CCG
NHS Slough CCG
NHS North Hampshire CCG
NHS South Reading CCG
NHS Windsor, Ascot & Maidenhead CCG
NHS Wokingham CCG
NHS Bracknell & Ascot CCG
NHS Newbury & District CCG
NHS North & West Reading CCG
NHS North West Surrey CCG
NHS North East Hampshire & Farnham CCG
NHS High Weald Lewes Havens CCG
NHS Brighton & Hove
NHS Hastings & Rother CCG
NHS Coastal West Sussex CCG
NHS Crawley CCG
NHS Horsham & Mid Sussex CCG
NHS Eastbourne, Hailsham & Seaford CCG

South Central Ambulance Service NHS Foundation Trust entered into the following transactions during the year with its wholly owned subsidiary, South Central Fleet Services Ltd.

Payments to South Central Fleet Services Ltd £6.444m (2016/17: £5.009m)

Receipts from South Central Fleet Services Ltd £0.579m (2016/17: £0.552m)

Amounts owed to South Central Fleet Services Ltd as at 31 March 2018 £0.366m (2016/17: £0.128m)

Amounts owed from South Central Fleet Services Ltd as at 31 March 2018 £nil (2016/17: £nil)

During the period South Central Ambulance Service NHS Foundation Trust had charitable funds of £0.7m (2016/17: £0.7m).

ACCOUNTING OFFICER'S STATEMENT OF RESPONSIBILITIES

Statement of the Chief Executive's responsibilities as the Accounting Officer of South Central Ambulance Service NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS foundation trust.

The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require South Central Ambulance Service

NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions.

The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of South Central Ambulance Service NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- Prepare the financial statements on a going concern basis

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act.

The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Signed

Will Hancock, Chief Executive

Date: 24 May 2018

INDEPENDENT PRACTITIONER'S LIMITED ASSURANCE REPORT TO THE COUNCIL OF GOVERNORS OF SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of South Central Ambulance Service NHS Foundation Trust to perform an independent limited assurance engagement in respect of South Central Ambulance Service NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and additional supporting guidance in the 'Detailed requirements for quality reports 2017/18' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- Category 1 (C1) – Life-threatening calls – the mean average response time across all incidents coded as C1 that received a response on scene; and
- Category 2 (C2) – Emergency calls – the mean average response time across all incidents coded as C2 that received a response on scene.

We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance and the six dimensions of data quality set out in the "Detailed requirements for external assurance for quality reports 2017/18'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2017 to 25 May 2018;
- papers relating to quality reported to the Board over the period 1 April 2017 to 25 May 2018;
- feedback from commissioners dated 2 May 2018;
- feedback from governors dated 11 January 2018;
- feedback from local Healthwatch organisations dated 8 May 2018;
- feedback from the Overview and Scrutiny Committee dated 9 May 2018;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, dated 17 May 2018;
- the national staff survey dated 6 March 2018;
- the Care Quality Commission inspection report dated 20 September 2016; and
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 19 April 2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of South Central Ambulance Service NHS Foundation Trust as a body, to assist the Council of Governors in reporting South Central Ambulance Service NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and South Central Ambulance Service NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by South Central Ambulance Service NHS Foundation Trust.

Our audit work on the financial statements of South Central Ambulance Service NHS Foundation Trust is carried out in accordance with our statutory obligations. This engagement will not be treated as having any effect on our separate duties and responsibilities as South Central Ambulance Service NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to South Central Ambulance Service NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to South Central Ambulance Service NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose.

Our audits of South Central Ambulance Service NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than South Central Ambulance Service NHS Foundation Trust and South Central Ambulance Service NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

Grant Thornton UK LLP
Chartered Accountants
30 Finsbury Square
London
EC2A 1AG
25 May 2018

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

OPINION

Our opinion on the financial statements is unmodified

We have audited the financial statements of South Central Ambulance Service NHS Foundation Trust (the 'Trust') and its subsidiary (the 'group') for the year ended 31 March 2018. The financial statements comprise the Trust and group Statements of Comprehensive Income, Statements of Financial Position, Statements of Changes in Equity, Statements of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and the NHS foundation trust annual reporting manual 2017/18.

In our opinion the financial statements:

- give a true and fair view of the financial position of the group and of the Trust as at 31 March 2018 and of the group's expenditure and income and the Trust's expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2017/18; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

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. We are independent of the group and 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 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.

Who we are reporting to

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors 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 Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Conclusions relating to going concern

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

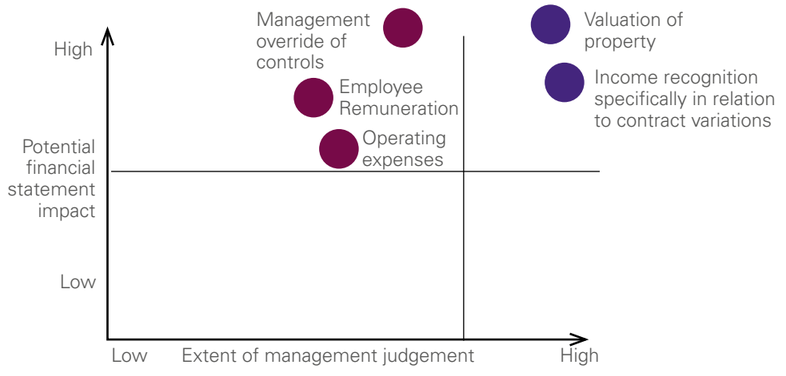
- the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the group's or 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.

Overview of our audit approach

- Overall materiality: £4,303,000, which represents 2% of the group's gross operating expenses.
- Key audit matters were identified as:
    - Income recognition, specifically in relation to contact variations
    - Valuation of property
- We performed a full scope audit of South Central Ambulance Service NHS Foundation Trust and targeted procedures of its non-significant component South Central Fleet Services Limited.

Key audit matters

The graph below depicts the audit risks identified and their relative significance based on the extent of the financial statement impact and the extent of management judgement.



Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current year and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those that had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key Audit Matter – Trust and Group	How the matter was addressed in the audit – Trust and Group
Risk 1 - Income recognition, specifically in relation to contract variations Approximately 96% of the Trust and group income is from patient care activities and contracts with NHS commissioners. These contracts include the rates for and level of patient care activity to be undertaken by the Trust. The Trust recognises patient care activity income based on the completion of these activities. Patient care activities provided that are additional to those incorporated in these contracts (contract variations) are subject to verification and agreement by commissioners. As such, there is a risk that income is recognised in the financial statements for these additional services that is not subsequently agreed to by the commissioners. We therefore identified the occurrence and accuracy of income recognition in relation to contract variations as a significant risk, which was one of the most significant assessed risks of material misstatement.	Our audit work included, but was not restricted to: ➔ Evaluation of the group's accounting policy for recognition of income from patient care contract variations for compliance with the Department of Health and Social Care (DHSC) Group Accounting Manual 2017/18 ➔ Gaining an understanding of the group's processes and procedures for accounting for income from patient care contract variations, covering 999, non-emergency patient transport services (PTS) and NHS 111 services, and evaluation of the design of the associated controls; ➔ Analysing the Trust's key contracts with commissioners for 999, PTS and NHS 111 income, to gain an understanding of what constituted core contract income (which was outside the scope of the identified risk), and which elements constituted income from patient care contract variations (which were within the scope of the identified risk); ➔ Agreeing a sample of income from patient care contract variations to supporting evidence, including information from third parties confirming the values; and ➔ Analysing the year-end expenditure amounts disclosed by other NHS organisations for consistency with those reflected as income in the Trust and group's financial statements. The group's accounting policy on income recognition is shown in note 1.3 to the financial statements and related disclosures are included in note 3. **Key observations** We obtained sufficient audit evidence to conclude that: ➔ The Trust and group's accounting policy for recognition of income from patient care complies with the DHSC Group Accounting Manual 2017/18 and has been properly applied; and ➔ income from patient care contract variations, including that accrued for at year-end, is not materially misstated.

Key Audit Matter – Trust and Group	How the matter was addressed in the audit – Trust and Group
Risk 2 - Valuation of property The Trust revalues its land and buildings on a quinquennial basis, with the last full revaluation being performed as at 31 March 2014. A desktop revaluation was carried out in 2017/18 to ensure that the carrying value of land and buildings was not materially different from fair value. This represents a significant estimate by management in the financial statements, which requires the use of an external valuations expert. The Trust elected not to update the carrying values of assets in their financial statements as a result of the desktop valuation exercise performed. We therefore identified the valuation of property, plant and equipment as a significant risk, which was one of the most significant assessed risks of material misstatement.	Our audit work included, but was not restricted to: ➔ Evaluating management's processes for the calculation of the estimate, the instructions issued to the valuation expert, and the scope of their work; ➔ Obtaining and challenging evidence for the assumptions made by management in relation to the valuation of its land and buildings; ➔ Assessing the competence, capabilities and objectivity of management's valuation expert; ➔ Discussing with the valuer the basis on which the valuation was carried out and challenging key assumptions used by the valuer; ➔ Evaluating the information used by the valuer to ensure it was complete, accurate and consistent with our understanding; and ➔ Evaluating the judgement made by management not to adjust the valuation of land and buildings held in the financial statements, and assessing how they have satisfied themselves that these valuations are not materially different from current value. The group's accounting policy on valuation of property, plant and equipment is shown in note 1.6.2 to the financial statements and related disclosures are included in note 16. **Key observations** We obtained sufficient audit assurance to conclude that: ➔ the basis of the valuation exercise performed by the external valuer was appropriate and the assumptions and processes used by management in determining the estimate were reasonable; ➔ the decision made by management not to adjust the values of land and buildings assets in the financial statements on the basis of this valuation exercise has not led to a material misstatement.

Our application of materiality

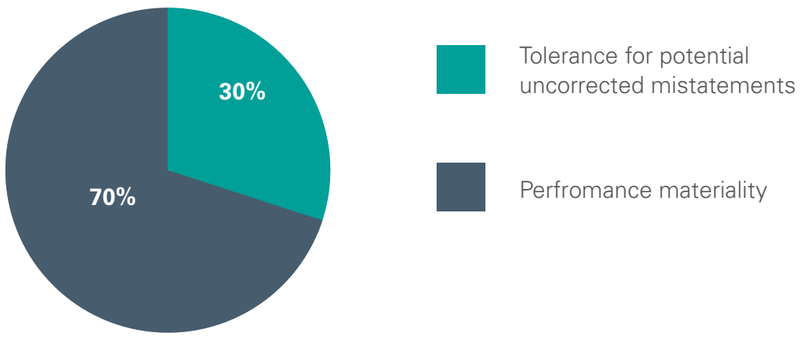
We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

Materiality was determined as follows:

Materiality Measure	Group	Trust
Financial statements as a whole	£4,303,000 which is 2% of the group's gross operating expenses. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how the group has expended its revenue and other funding.	£4,295,000 which is 2% of the Trust's gross operating expenses. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how the Trust has expended its revenue and other funding.
Performance materiality used to drive the extent of our testing	70% of financial statement materiality	70% of financial statement materiality
Communication of misstatements to the Audit Committee	£215,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.	£215,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

The graph below illustrates how performance materiality interacts with our overall materiality and the tolerance for potential uncorrected misstatements.

Overall materiality - group and Trust



An overview of the scope of our audit

Our audit approach was a risk-based approach founded on a thorough understanding of the group's business, its environment and risk profile, and in particular included:

- Evaluation of identified components to assess the significance of each component and to determine the planned audit response based on a measure of materiality and significance of the component as a percentage of the group's total assets, income and expenditure. A full scope, targeted or analytical approach was taken for each component based on their relative materiality to the group and our assessment of audit risk;
- Performing full scope audit procedures on South Central Ambulance Service NHS Foundation Trust. This entity represents 99.96% of the group's income and 99.94% of its total assets.
- Gaining an understanding of, and evaluating, the group's internal control environment, including its financial and IT systems and controls; and
- Performing targeted audit procedures on the intra-group income and debt of non-significant component, South Central Fleet Services Ltd., and testing any significant balances which were consolidated into the Group Statement of Financial Position or Statement of Comprehensive Income.

For the significant components, testing undertaken covered 99.91% of income, 99.96% of expenditure and 99.24% of net assets.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our 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 of the group and Trust obtained in the course of our work, including that gained through work in relation to the Trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resources, 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 this other information, we are required to report that fact.

We have nothing to report in this regard.

In this context, we also have nothing to report in regard to our responsibility to specifically address the following items in the other information, and to report as uncorrected material misstatements of the other information where we conclude that those items meet the following conditions:

- Fair, balanced and understandable set out on page 57, in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance – the statement given by the directors that they consider the Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the group and Trust's performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit; or

- Audit Committee reporting set out on page 197, in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance – the section describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee is materially inconsistent with our knowledge obtained in the audit.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice), we are required to consider whether the Annual Governance Statement does not meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2017/18. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Our opinion on other matters required by the Code of Audit Practice is unmodified

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2017/18 and the requirements of the National Health Service Act 2006; and

- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice we are required to report to you if:

- we have reported a matter in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or

- we have referred a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters**.**

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accounting Officer's responsibilities, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2017/18, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the group's and 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 group or the Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the group or the Trust.

The Audit Committee is Those Charged with Governance.

Auditor's responsibilities 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 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: **www.frc.org.uk/auditorsresponsibilities.** This description forms part of our auditor's report.

REPORT ON THE LEGAL AND REGULATORY REQUIREMENTS – CONCLUSION ON THE TRUST'S ARRANGEMENTS FOR SECURING ECONOMY, EFFICIENCY AND EFFECTIVENESS IN ITS USE OF RESOURCES

Matter on which we are required to report by exception - Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if, in our opinion we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

We have nothing to report in respect of the above matter.

Responsibilities of the Accounting Officer

The Accounting Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. 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.

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 in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

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 be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

REPORT ON THE LEGAL AND REGULATORY REQUIREMENTS – CERTIFICATE

We certify that we have completed the audit of the financial statements of South Central Ambulance Service NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Paul Grady
Engagement Lead
for and on behalf of Grant Thornton UK LLP
30 Finsbury Square
London
EC2A 1AG
25 May 2018

GLOSSARY

A&E	Accident & Emergency
Acorn	Consumer classification that segments the UK population by analysing demographic data, social factors, population and consumer behaviour
ACS	Accountable Care System
ACT	Accelerated Clinical Triage
AED	Automated External Defibrillator
ARP	Ambulance Response Programme
BAF	Board Assurance Framework
BBC	British Broadcasting Corporation
BME	Black and Minority Ethnic
CAD	Computer Aided Despatch
CARS	Clinical Audit Record System
CCC	Clinical Coordination Centre
CCG	Clinical Commissioning Group
CEF	Community Engagement Forum
CEO	Chief Executive Officer
CETV	Cash Equivalent Transfer Value
CFR	Community First Responder
Cleric	Patient Transport Service booking system
CO2	Carbon Dioxide
CoG	Council of Governors
CPI	Consumer Prices Index
CPR	Cardiopulmonary Resuscitation
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CSD	Clinical Support Desk
DAT	Directory of Alternative Transport
DHSC	Department of Health and Social Care
DWP	Department of Work and Pensions
E&UC	Emergency & Urgent Care
EBITDA	Earnings Before Interest, Tax, Depreciation and Amortisation
EBP	Education Business Partnership
ED	Emergency Department
EDC	Equality and Disability Council
EDS	Equality Delivery System
EOC	Emergency Operations Centre
ePR	Electronic Patient Record
FACT	First Aid and Clinical Training
FFT	Friends and Family Test
FReM	Financial Reporting Manual
FT	Foundation Trust
GAD	Government Actuary Department
GAM	Group Accounting Manual
GBS	Government Banking Services
GDE	Global Digital Exemplar
GMB	General trade union
GP	General Practitioner
GPS	Global Positioning System
GREAN	Green Environmental Ambulance Network
HCP	Healthcare Professional
HIOWAA	Hampshire and Isle of Wight Air Ambulance
HOSC	Health Overview and Scrutiny Committee
IAS	International Accounting Standard
IFRIC	International Financial Reporting Interpretations Committee
IFRS	International Financial Reporting Standards
ISO	International Organisation for Standardisation
IoW	Isle of Wight
IT	Information Technology
IUC	Integrated Urgent Care
JESIP	Joint Emergency Services Interoperability Programme
KLOE	Key Lines of Enquiry
KPI	Key Performance Indicator
LA	Local Authority
LGBT	Lesbian Gay Bisexual and Trans
LSR	Local System Review
MCA	Mental Capacity Act
MECC	Making Every Contact Count
MINAP	Myocardial Ischaemia National Audit Project
NARU	National Ambulance Response Unit
NASMeD	National Association of Medical Directors
NED	Non Executive Director
NEST	National Employment Savings Trust
NEWS	National Early Warning Score
NGO	Non-Governmental Organisation
NHS	National Health Service
NHSE	NHS England
NHSI	NHS Improvement
NICE	National Institute of Clinical Excellence
NLF	National Loans Fund
OU	Open University
PAD	Publically Accessible Defibrillator
PDC	Public Dividend Capital
PE	Patient Experience
PERG	Patient Experience Review Group
PESTLE	Political, Economic, Social, Technological, Legal and Environmental
PFI	Private Finance Initiative
PGD	Patient Group Directions
PPCI	Primary Percutaneous Coronary Intervention
PPE	Property, Plant and Equipment
PPG	Patient Participation Group
PTS	Patient Transport Service
ROSC	Return of Spontaneous Circulation
RPI	Retail Prices Index
RSO	Resilience and Specialist Operations
S4H	Solutions4Health
SCAC	South Central Ambulance Charity
SCAS	South Central Ambulance Service NHS Foundation Trust
SCFS	South Central Fleet Services Ltd
SIRI	Serious Incident Requiring Investigation
SLA	Service Level Agreement
SoFP	Statement of Financial Position
SOP	Standard Operating Procedure
SP	Specialist Paramedic
STD	Survival To Discharge
STEMI	ST Elevation Myocardial Infarction (Heart Attack)
STP	Sustainability & Transformation Partnership
STRaW	Stress Resilience at Work
SWOT	Strengths, Weaknesses, Opportunities and Threats
TRiM	Trauma Risk Management
TU	Trade Union
TVAA	Thames Valley Air Ambulance
TVP	Thames Valley Police
UKCIP	UK Climate Impacts Programme
VAT	Value Added Tax
VF	Ventricular Fibrillation
VHF	Very High Frequency
VSM	Very Senior Manager
VT	Ventricular Tachycardia
WDES	Workforce Disability Equality Standard
WTE	Whole Time Equivalent
YMCA	Young Men's Christian Association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