NHS
South East Coast Ambulance Service
NHS Foundation Trust

Annual Report and Accounts

1 April 2017 - 31 March 2018

Aspiring to be ***better today*** and even ***better tomorrow*** for our people and our patients

South East Coast Ambulance Service NHS Foundation Trust

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Presented to Parliament pursuant to Schedule 7,
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Chair's Introduction

I'd like to begin by thanking the previous Chair, Richard Foster, for his contribution to moving the Trust forward during his 12 months with the Trust.

Whilst the Council of Governors have started a selection and recruitment process for a new substantive Chairman, I am very pleased to be able to support the Trust as Interim Chair during this time. Having been a Non-Executive Director with SECAmb since 2012, Chaired the Trust's Finance & Investment Committee and been Deputy Chair for the last three years, I feel able to give my perspective on both the challenges and opportunities facing us.

2017/18 has undoubtedly been a challenging year for the Trust and for the NHS as a whole. We were inspected by the CQC in May 2017 and while the NHS 111 service received an overall good rating and all of our staff were rated as 'good' for caring, they did identify a number of areas of concern, resulting in an overall 'Inadequate' rating. You can read more details about their findings in the Annual Report. Consequently the Trust remained in Special Measures and we have undertaken a tremendous amount of work to address these findings together with other improvements we ourselves identified. Again you can read more details in the Annual Report. We have seen great progress in many areas and are keen to demonstrate this to the CQC when they undertake their next inspection but we also recognise that there is still much to do to achieve our vision.

In November of last year, the Trust moved to reporting 999 performance against new national Ambulance Response Programme (ARP) standards, as you will read in the Report. Since their introduction, we have performed well against Category 1 and 2 targets, the most seriously ill and injured patients, but less well in our response to Category 3 and 4 patients. These are often elderly patients, with complex clinical and unmet social needs, who may require a different type of response than a standard, emergency ambulance and we have been looking at how we can "do things differently", as we all recognise that this is an area where we must improve.

Jointly with our commissioners, we are undertaking an independently-led 'Demand & Capacity Review', to determine the level of resources and funding we require to respond to patients in an appropriate and timely way and to meet the new ARP standards. This work will conclude shortly but, even ahead of this, we are prioritising the resources we do have, to recruit additional staff and purchase extra emergency vehicles.

We have embarked on work to change the culture in our organisation. This is demanding work, given the largely dispersed nature of our workforce but we expect to start to see the impact of this, together with changes we are making to our management structure and operating model, over the next few months.

The Trust has continued it's Board Recruitment programme and I am very pleased that we have ended the year with a full Executive Team in place. I would also like to welcome three new Non-Executive Director colleagues who have joined during the year.

Despite the undoubted challenges facing the Trust, I continue to be impressed with the professionalism and dedication of our staff and would like to thank them, on behalf of the Trust Board, for their overwhelming commitment to providing excellent patient care.

Graham Colbert, Interim Chair

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Performance Report

Chief Executive's Statement

The purpose of the Overview is to give the user a short summary that provides them with sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

2017/18 was my first full year with the Trust, since joining SECAmb on 1 April 2017.

Looking back, it's been an extremely busy year – we have undoubtedly faced some significant challenges but I am also very proud of the progress we have made in a number of areas.

During the year, we saw a number of changes at Board level, as we continued to strengthen the leadership of the Trust. I am very pleased that we ended the year with a full Executive Team in place, as well as a number of new Non-Executive Director colleagues on the Board. I am confident that we now have the right mix of skills, experience and fresh ideas at a senior leadership level, to lead the Trust forwards.

One of my first tasks was to approve and launch our Health & Wellbeing Strategy, designed to create a healthy workplace where everyone feels their health & wellbeing is supported. Around the same time, in July 2017, I launched our new Trust Five-year Strategic Plan. Our focus in years one and two is on addressing the previous issues within the Trust and putting in place a right-sized operating model that develops our staff, improves our response and outcomes for patients and supports the priorities of the NHS across the South East region as a whole. We are well on our way to achieving this.

In September 2017 the Trust received the outcome of the inspection undertaken by the Care Quality Commission (CQC) in May 2017. Although we had started to make progress in some areas, following the previous inspection in May 2016, it had not advanced sufficiently for the CQC to see our progress since the previous inspection. This led to an 'Inadequate' rating overall and the Trust remaining in 'Special Measures'.

Since receiving the most recent report, we have continued implementing our plans and over the year have worked extremely hard to address the areas highlighted by the CQC as well as other areas identified through improved governance, systems and processes. By working together, we have seen notable improvements in many areas including medicines management, safeguarding and complaints during the year. We still have a great deal to do but I feel confident that we now have the right processes and structures in place to continue to make progress.

We are expecting a further inspection by the CQC at some point during the next few months, which will provide a good test of the progress we have made in improving the quality and governance of the services we provide.

Despite extremely hard work by everyone, especially our front-line staff, the Trust was not able to meet its 999 operational and performance targets during the year.

On 22 November 2017, we successfully moved to the new national Ambulance Response Performance (ARP) standards, which introduced four new categories of call. Since the move to ARP, I am pleased to report that the Trust has performed well overall in responding to Category 1 and 2 patients (the most seriously ill and injured patients) but less well in our response to our Category 3 & 4 patients.

Improving our response to these patients, who are often uninjured, elderly, with complex clinical and unmet social needs, requires a different type of response than a standard, emergency ambulance. We have already been working hard to look at how we can 'do things differently' to provide a better response to Category 3 and 4 patients and to work with system leaders to reduce unavailability of ambulances at hospital.

We are also looking at ways to improve our 999 call answering and this will continue to be a key area of focus for us during 2018/19.

Overall, our NHS 111 service performed well during the year against its key performance indicators, although the latter half of the year proved to be more challenging. We were very pleased that the CQC rated our NHS 111 service as 'good' overall following their inspection in May 2017, reflecting the hard work put in by the team to driving up the quality of the services provided during recent years.

One of our main areas of focus during 2018/19 will be to make the Trust a better place to work, where our staff and volunteers feel safe and supported to deliver the very best care to our patients. In January 2017, the Trust commissioned Professor Duncan Lewis to undertake an extensive and independent review into the culture of the organisation and we published his findings in full in August 2017.

This was a difficult time for many, as Professor Lewis' work identified that many staff were experiencing unacceptable behaviours at work from colleagues, including bullying and harassment. Similar themes were also reported by staff through the national NHS Staff Survey.

I, and the whole leadership team, take these findings extremely seriously. We are completely committed to eliminating the unacceptable behaviours identified previously and are establishing a new set of values and behaviours to underpin a culture that we all want to be part of. Work has already started on an extensive programme, which will touch every part of the Trust and help us to move forwards to build a very different workplace.

However, despite the challenges that the Trust has faced during the year, we have also seen some real successes.

During May and June 2017, we moved into our superb new facility in Crawley, which houses an impressive new Emergency Operations Centre for the west of our area, as a well as a single base, for the first time, for the majority of our support staff. At the same time, we invested in a new Computer Aided Dispatch system for our control room staff, which has significantly improved how we are able to manage our resources when responding to 999 calls.

In January 2018 we launched our new Wellbeing Hub, part of our Health and Wellbeing Strategy and a one-stop shop to help our staff access a range of support including mental and emotional wellbeing, Trauma Risk Management (TRiM), as well as physiotherapy referrals. The Hub has been well received by our staff since its launch and I look forward to seeing it grow and develop further.

I have been especially proud during the year of how well, as a Trust, we were able to respond to periods of significant demand, which caused real problems for many of our colleagues nationally in the wider NHS. Through careful planning and close focus, we continued to deliver a safe and responsive service to our patients during the Winter, despite periods of bad weather, high numbers of calls and real pressure in our regional NHS partner Trusts.

In a difficult financial environment, the Trust delivered a sound financial position at the end of the year. Making these savings and managing our resources carefully enables us to further invest as we move forwards, in quality & safety areas, recruiting additional staff, purchasing new vehicles and improving our facilities and equipment.

The Trust has started to introduce Quality Improvement (QI) methodology to assist in creating a learning culture and this is being supported through the QI Hub, safety huddles and QI notice-boards and posters. This is being complemented through human factors training which has been taking place throughout the year.

We have also been working hard with our commissioners for some months, through an independently-led 'Demand & Capacity

Chief Executive's Statement

Review', to determine the level of resources and funding we require to respond to patients in an appropriate and timely way; we are anticipating that this will conclude shortly, which will help to shape how we deliver services in the future.

In reflecting on the last year, I would like to take the opportunity to thank our trade union colleagues, as well as our Council of Governors, for the support and collaboration they have provided throughout the year. By working together, we have been able to respond promptly and make decisions, in partnership, that have benefited our patients and our staff.

I remain extremely proud of everyone who is part of SECAmb and who is committed, every day, to delivering the very best services possible to our patients, despite the challenges we face.

It is my job, and the job of the Board, to support our staff and volunteers in doing this as we move forwards and provide strong leadership and direction.

Daren Mochrie QAM, Chief Executive

Date: 25 May 2018

Performance Overview

South East Coast Ambulance Service NHS Foundation Trust (SECAmb) is part of the National Health Service (NHS).

It was formed in 2006 following the merger of the three former ambulance trusts in Kent, Surrey and Sussex and became a Foundation Trust on 1st March 2011.

We are led by a Trust Board, which is made up of an Independent Non-Executive Chair, Independent Non-Executive Directors and Executive Directors, including the Chief Executive.

As a Foundation Trust we have a Council of Governors, made up of 14 publically-elected governors, four staff-elected governors and six governors appointed from key partner organisations.

As a Trust, we:

- Receive and respond to 999 calls from members of the public
- Respond to urgent calls from healthcare professionals e.g. GPs
- Receive and response to NHS 111 calls from members of the public

We provide these services across the whole of the South East Coast region – Kent, Surrey, Sussex and parts of North East Hampshire and Berkshire (with the exception of the NHS 111 service).

We work closely with our main partners in the region – 22 Clinical Commissioning Groups (CCGs), 12 acute hospital trusts and four mental health and specialist trusts within the NHS, the Kent, Surrey and Sussex Air Ambulance and our 'blue light' partners – three police forces, four Fire & Rescue services and HM Coastguard.

During the year, we have developed and published our overarching Five-Year Strategic Plan for 2017-2022. This focuses on a continuous improvement approach to achieving our mission: "To deliver our aspiration of being better today and even better tomorrow for our people and our patients"

The next five years are focused on delivery of our four strategic themes, which are:

- Our people – supporting and developing our staff and volunteers
- Our patients - ensuring timely quality of care, in the right place by the right people
- Our enablers – fit for purpose technology, fleet and estates, underpinned by sustainable financial performance
- Our partners – working with health, 'blue lights' and education partners

These themes are translated into two-year objectives, which form the basis of delivery of our plan and which are delivered and monitored via five core work streams:

- Strategy
- Compliance
- Service Transformation and Delivery
- Sustainability
- Culture and Organisational Development

You can read more about how the Strategic Plan is being delivered throughout the Report.

Key risks and issues affecting the Trust

Many of the challenges faced by the Trust in recent years continued through 2017/18. There were a number of changes at Board level and, in May 2017, the CQC followed up its comprehensive inspection of the Trust's services from 2016 and identified a number of issues leading to an overall rating of Inadequate, as illustrated below

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency & urgent care	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate
Emergency operations centre (EOC)	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
NHS 111 service	Good	Good	Good	Good	Outstanding	Good
Overall	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate

On 23 June 2017, the CQC issued a Notice of Proposal, to impose a condition on the Trust's registration, pursuant to Section 12(5) (b) of the Health & Social Care Act 2008.

The conditions were:

1. By 22 September 2017 the registered provider must ensure they have a complete and accurate record of all 999 calls

2. By 22 September 2017 the registered provider must ensure that:

a. all medicines including controlled drugs and medical gases are stored securely in line with best practice and safe custody regulations, where applicable, in line with relevant licenses.

b. effective processes, including monitoring, are in place to ensure all medicines are stored within their recommended temperature ranges within buildings.

c. medicines are only administered or supplied by staff within the relevant medicines legislation and best practice, and appropriate records are kept.

In relation to the second condition, the Trust was asked to submit a Medicines Optimisation Plan by 22 July 2017, which it did. The CQC tested the evidence provided by the Trust, which demonstrated significant improvement in both areas and on 31 October 2017, removed both conditions.

Performance Overview

In July 2017 the Trust Board agreed SECAmb's new five-year strategy and strategic goals:

1. Our People	2. Our Patients	3. Our Enablers	4. Our Partners
We will respect, listen to and work with our staff and volunteers to provide development and support that enables them to provide consistent, quality care to our patients	We will develop and deliver an integrated clinical model that meets the needs of our communities whilst ensuring we provide consistent care which achieves our quality and performance standards	We will develop and deliver an efficient and sustainable service underpinned by fit for purpose technology, fleet and estate	We will work with our partners in STPs and blue light services to ensure that our patients receive the best possible care, in the right place, delivered by the right people

The strategy was developed following consultation with staff and other internal and external stakeholders, and was informed by the issues highlighted by the CQC during its inspection. Arising from the strategy the Trust established its Delivery Plan, with specific focus on years one and two.

The CQC reported its full findings in September 2017 and recommended that NHS Improvement continue to place the Trust in Special Measures. The Special Measures Programme consists of a range of interventions designed to support the Trust in achieving rapid improvement in the areas of concern identified by the CQC and to ensure that patients are receiving the high quality, safe care, they deserve from a responsive, well-led organisation.

Specific support measures were discussed at the Quality Summit held in October 2017. The Delivery Plan incorporated all the issues identified by the CQC (the 'must dos' and 'should dos') and the Board of Directors has closely monitored progress with the Plan at each of its meetings held in public.

During 2017 the Trust concluded three major projects. It moved to Nexus House in Crawley, it's new HQ and Emergency Operations Centre (EOC); moving from three EOCs to two, and installed a new computer aided dispatch (CAD) system. In addition, SECamb moved in November 2017 to the new national ambulance response programme (ARP).

Ambulance Trusts across the country have been challenged in meeting operational, clinical and financial performance targets during 2017/18, as has the wider NHS provider sector. There are several factors which are driving this, including how the NHS is working with a continuous growth in activity that is outstripping providers' capacity to deliver. SECAmb has continued to work closely with Clinical Commissioning Groups (CCGs) to ensure the right investment to meet demand. Specifically, a demand and capacity review was jointly commissioned in 2017 and is due to conclude in Q1 of 2017/18.

Increased handover delays at Accident & Emergency departments add to the challenge, resulting in a 999 response being unavailable in the community as ambulances are at hospitals waiting to handover patients. During the year, a system-wide Task & Finish Group was established to bring about improvement to this long-standing problem. While there continue to be delays, significant improvement is being made, most noticeably during the end of Q4.

The South East heath economy continues to be challenged. Of the trusts in the region, the majority are operating with significant financial deficits. 2016/17 was particularly challenging for SECAmb when it ended the year £7.1m in deficit. A stretching cost improvement programme was developed for 2017/18 and the Trust achieved its target of just over £15m. This helped the Trust to meet is £0.9m deficit control total.

In summary, the issues and challenges set out above will continue in to 2018/19. The Trust Board is focussed on ensuring continued improvement through the Delivery Plan to ensure a sound basis for delivering safe and effective services.

There are no material inconsistencies between the Annual Governance Statement, the corporate governance statement, the quality report, the annual report, and reports from the CQC.

Going concern statement

After making enquiries, the Directors have a reasonable expectation that the Trust will have access to adequate resources to continue in operational existence for the foreseeable future.

For this reason, the Directors continue to adopt the going concern basis in preparing the accounts.

Performance Analysis

999 Response Time performance

Within the last financial year, ambulance services within England have undertaken the most significant change to its categorisation of patients and response times in 40 years. This has included a change in the response time standards, and how the clock start and clock stop times are calculated, with a core focus of sending the right resource for the patient the first time, and removing the hidden wait for patients.

Further information on the new standards can be found here - https://www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/

As the new measures were introduced part way through the year (22 November 2017 in SECAmb), this performance analysis will provide both metrics, with Red 1 and 2 from the 1 April 2017 until 22 November 2017, and category 1 to 4 from the 22 November 2017 until 31 March 2018.

Red 1 and 2 performance

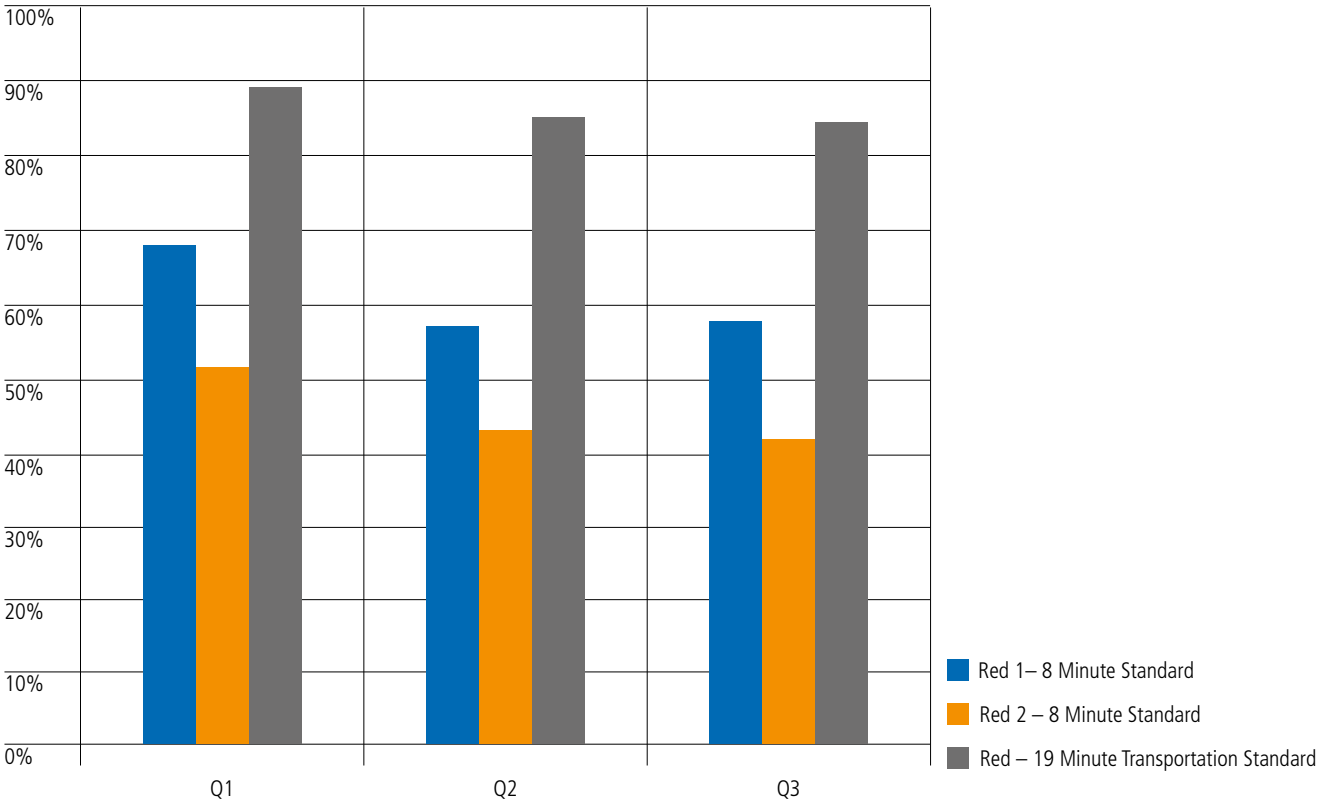
Red 1 – life-threatening conditions where speed of response may be critical in saving life or improving the outcome for the patient, for example – heart attack, trauma, serious bleeding – at least 75% of these patients should receive a response within eight minutes

Red 2 – other serious conditions – at least 75% of these patients should receive a response within eight minutes

Red 19 (A19) – 95% of all Red 1 and Red 2 patients should receive a response within 19 minutes

Achievement of targets – 2017/18	
Red 1 – 8 Minute Standard	60.97%
Red 2 – 8 Minute Standard	46.47%
Red 19 - Minute Transportation Standard	86.95%

SECAmb R1, R2 and R<19min Quaterly Response Performance and Year End 2017/2018 - National Target 75% and 95%



During 2017/18 on the Red 1 and 2 standards, the Trust failed to meet any of the nationally mandated response time targets. There are a number of factors that affected the Trust's ability to meet these targets, including:

- Continued pressure on acute services, resulting in significant ambulance delays at turnaround (arrival to clear), with a total of 68,783 vehicle hours lost over the 30 minute standard or the equivalent of 5,731 x 12 hour ambulance shifts
- Significant training requirements for the implementation of the new CAD system within EOC, and training for the implementation of ARP
- Recruitment and retention of Call Taking staff.

Ambulance Response Programme (ARP) Response Times

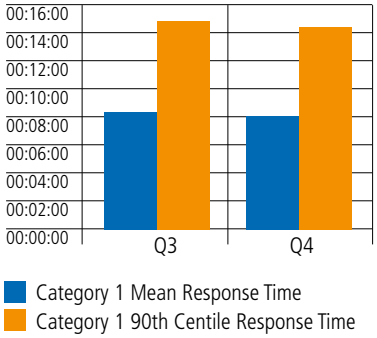
Category 1 – life threatening conditions where the speed of intervention may be critical to saving the life, or improving the outcome of a patient, for example cardiac arrest, choking or labour. On average patients should receive a response within seven minutes, with a 90th centile response time target of 15 minutes.

Category 2 – serious illness / injuries such as a heart attack, stroke or breathing difficulties – On average patients should receive a response within 18 minutes, and a 90th centile response time target of 40 minutes.

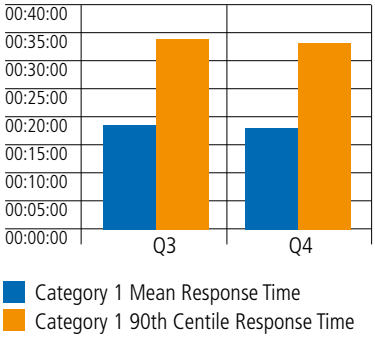
Category 3 – Urgent illness / injuries such as abdominal pain or limb injuries – a 90th centile response time target of 120 minutes (two hours).

Category 4 – Less urgent calls – a 90th centile response time target of 180 minutes.

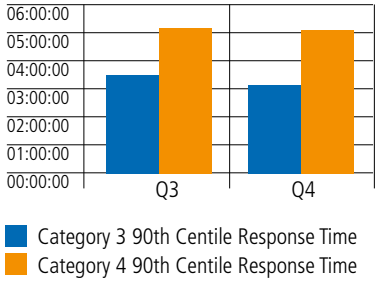
Category 1 Response Times by Quarter



Category 2 Response Times by Quarter



Category 3 + 4 90th Centile Response Times by Quarter



ARP Response Time Standards - 2017/18		
Response Time Measure	Target	Actual
Category 1 Mean Response Time	00:07:00	00:08:16
Category 1 90th Centile Response Time	00:15:00	00:14:52
Category 2 Mean Response Time	00:18:00	00:18:02
Category 2 90th Centile Response Time	00:40:00	00:33:46
Category 3 90th Centile Response Time	02:00:00	03:19:30
Category 4 90th Centile Response Time	03:00:00	05:12:36

Performance Analysis

Under the new ARP category measurements, the Trust met two of the national targets, and missed the Category 2 mean target by two seconds. With the new standards comes new challenges to meet the national response time targets. Some of these challenges include:

- A higher proportion of ambulances instead of response cars are required, in a time where all ambulance services will be facing the same challenge, leading to delays in being able to receive ambulances after purchase.
- A change of practice to ensure the right resource is sent to the patient, not the nearest available resource.

Overall SECAmb witnessed much lower than anticipated levels of activity, with only a 0.2% growth in commissioned activity levels compared to the previous year. To manage this activity, the Trust provided 3,144,563 hours of front-line staff.

In line with the initial Ambulance Quality Indicator (AQI) guidance, the Trust reports on a five-second call answer performance figure for 999 calls. The performance for 2017/18 ended at 61.7%, 16% lower than the previous year. This has been due to significant training requirements for the CAD system, alongside challenges with the recruitment and retention of call taking staff. An action plan is in place, with an agreed trajectory to improve this to 95% of calls answered in five seconds:

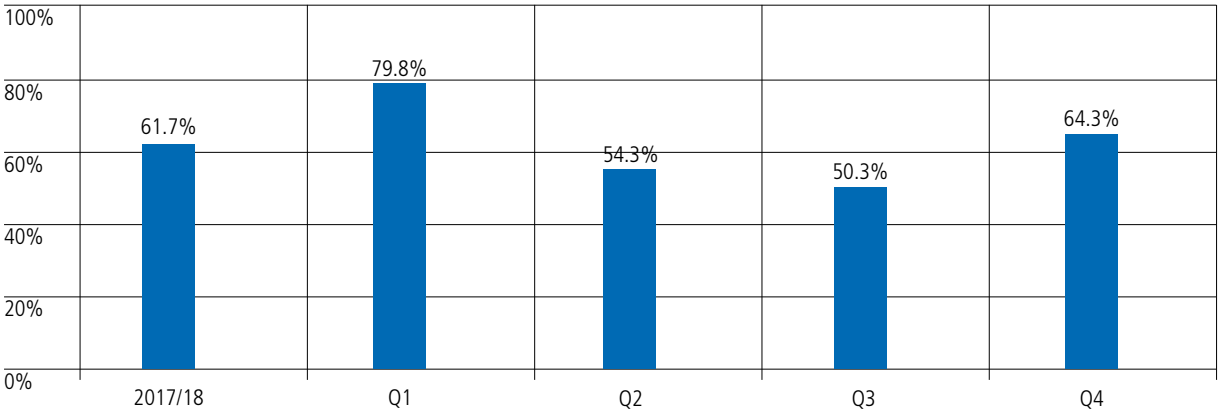
Hospital Handover Delays

A hospital turnaround is defined as the amount of time from when an ambulance arrives at hospital to when the ambulance crew book clear and are ready to respond to another emergency call. This is made up of a national standard of 15 minutes for patient handover to the hospital and a national standard of 15 minutes for the crew to prepare for the next call. The majority of the delays discussed below are due to the initial hospital hand over component of the turn-around.

During 2017/18, 288,091 out of 435,919 (66.1%) conveyances took 30 minutes or longer at our hospitals. This was a 4.5% increase on the previous year (61.6%)

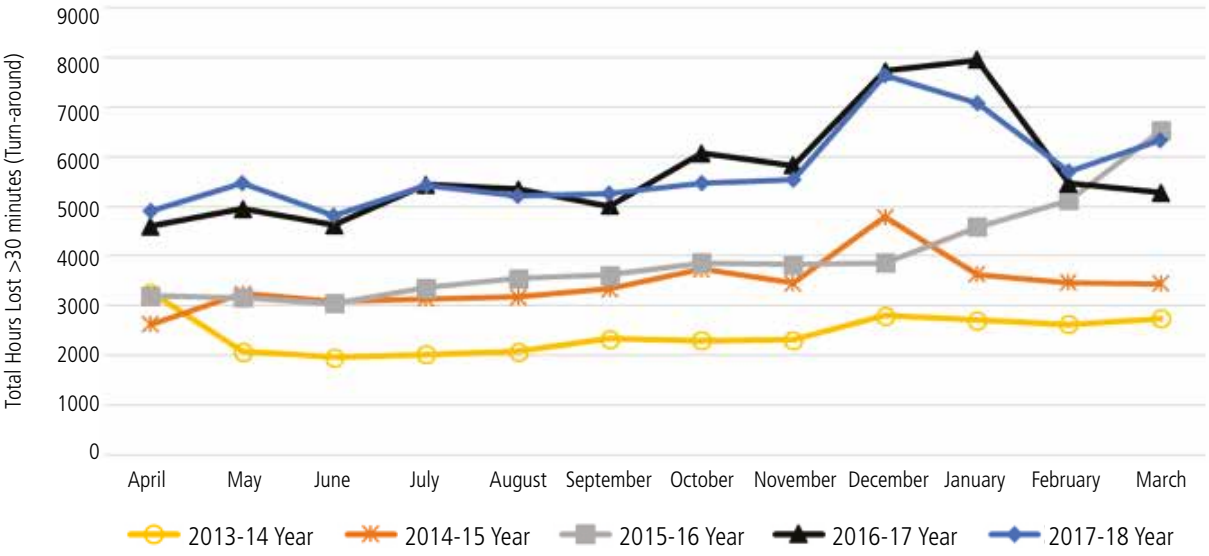
A total of 56,780 hours of our staff's time were lost due to hospital turnaround delays over the 30 minutes – equivalent to 2,365 x 12-hour ambulance shifts. This is a decrease in lost hours of 11, 446 (17 %) compared to last year, however this is a 94% increase (27, 529 hours) since 2013/14, the common baseline year.

% of 999 Calls Answered in 5 Seconds



To address this system wide problem, SECAmb has appointed a director to lead a programme of work, which is focused on achieving an overall and sustained improvement in hospital handover delays. A Steering Group has been established with the responsibility of driving the improvement needed. It is chaired by the Chief Executive of Royal Surrey County Hospital NHS Foundation Trust. Two operational groups (East and West) are also in place, each chaired by a Chief Operating Officer from an acute trust. Their remit is to deliver the improvement work required to reduce delays. The programme will run until the end of March 2019.

Hours lost to hospital turnaround delays



Kent Medway Surrey & Sussex (KMSS) NHS 111

SECAmb delivers the KMS 111 service in partnership with Care UK.

The KMSS 111 service started the financial year in a very positive fashion with its best performance against its contractual Key Performance Indicators (KPIs) across a public holiday period since the inception of the service over four years previously. The service was "green" for its principal measures on all four days of Easter 2017:

Date	Call Volume (incl IVR)	Answered in 60	Abandoned	Combined Clinical	AMB rate	ED rate	AHT (secs)
Friday, 30 March 2018	6135	98.5%	0.3%	91.9%	6.8%	5.1%	475
Saturday, 31 March 2018	6512	97.5%	0.4%	81.8%	6.9%	5.1%	478
Sunday, 1 April 2018	4967	98.8%	0.2%	80.1%	8.3%	5.4%	481
Monday, 2 April 2018	5181	98.2%	0.3%	94.1%	7.7%	5.5%	476

Performance Analysis

Having attained full service stability and then successfully delivering the service's Unified Recovery Plan (URP) whilst working in collaboration with Commissioners, KMSS 111 subsequently received a CQC inspection in May of 2017.

The service was able to demonstrate a real focus on quality and patient care for what remains very much a clinically-led service. In addition to being rated by the CQC as good overall and also for the Key Lines Of Enquiry (KLOE) of Safety, Responsiveness, Caring and Effective, KMSS 111 was also rated as outstanding for Leadership. This is a culmination of two years' planning to elevate standards and to put quality and patient care at the heart of everything that we aspire to achieve. The report ratings from the CQC represented a significant improvement on the previous inspection in May 2016:

Safe	Effective	Caring	Responsive	Well-led	Overall
Good	Good	Good	Good	Outstanding	Good

Building upon the success of 2016/17, KMSS 111 embarked upon an ambitious programme of pilots with four principal aims:

1) Increase the amount of cases of patients/ service users receiving an intervention from a clinician as they pass through the urgent care (111) system
2) Facilitate innovation and shared learning for clinical delivery operating models for the benefit of providers and Commissioners as we enter a period of procurement for new Clinical Advice Services (CAS) as part of NHS England's (NHSE) new template for the delivery of Integrated Urgent Care (IUC)
3) KMSS 111 to work in a more collaborative way across the urgent and emergency care network with Commissioners, NHSE and other providers
4) Extend the currently successful Clinician In-line Support (CIS) to ensure that the 999 service is protected with a more effective and consistent validation of non-emergency ambulances, especially as we enter a period of significant change in the emergency care system with the national introduction of the Ambulance Response Programme (ARP) in November 2017

Early in quarter one of 2017/18, the service undertook six Joint Clinical Pilots (JCPs) in conjunction with Commissioners and other stakeholders and these pilots were managed through a structured governance framework and facilitated through regular JCP working group meetings.

The main goals for these pilots was to:

- Increase the percentage of NHS 111 green non-emergency ambulances (Cat 3 and 4 via ARP) that receive validation prior to transfer to 999
- Introduce a mechanism whereby the service will start to pro-actively validate Emergency Department referrals
- Trial two distinctly different operating models facilitated by the splitting of calls through call routing in to defined telephone lines
- Develop mini-clinical hubs to initially trial the use of other healthcare professionals i.e. pharmacists and clinical navigators, to support integration with OOH and 999 services and reduce pressures on the wider system
- Focus on further training and support to enable a more informed and intelligent use of the Directory of Services (DoS), ensuring that where possible the opportunity to refer patients to services as an alternative to ED are fully maximised

Over 2017/18, the service was able to successfully deliver against these goals with the exception of the introduction of mini-clinical hubs, which has been deferred to 2018/19 because of the operational challenges and the need for the service to focus on core performance.

During the year, the 111 service has continued to be impacted by the levels of service offered by some GP Out of Hours (OOH) providers across the South East.

This tends to coincide with times of peak demand within 111, i.e. across public holidays and when the urgent care system is at its most vulnerable.

To address these issues, 111 has worked collaboratively with Commissioners and the OOHs providers to mitigate system risk through joint working. This is demonstrated by such actions as the revised GP OOHs escalation script, written in collaboration with a specific provider prior to Easter 2018, to manage the patient expectations of the service users accessing that provider via 111.

Whereas the service delivered a very strong first half of 2017/18, KMSS 111 became increasingly challenged operationally in the second half of the financial year. This is demonstrated by the operational KPIs of answer in 60 seconds and the rate of abandoned calls lagging behind the NHS England national average. This drop in performance is attributable to a number of factors including steeply elevated call volumes (winter-related), rota inequalities, sustained recruitment and retention issues and the impact of internal and external factors such as the introduction of ARP, NHS Pathways version 14, the JCP call-routing pilot and IT platform failures.

Given the learns from the delivery of the Unified Recovery Plan in 2016/17, the service has already managed to address many of the issues adversely impacting operational performance in 2018 and this can be demonstrated by a significantly better performance across Easter 2018 than expected.

In terms of sharing best practice and having a positive influence across the wider Trust, SECAmb members of the KMSS 111 Senior Leadership Team (SLT) have started integrating across the Trust's Operations Directorate and now play a key role in the clinical operations of our EOCs in addition to the Trust's focus on quality, audit and the patient experience.

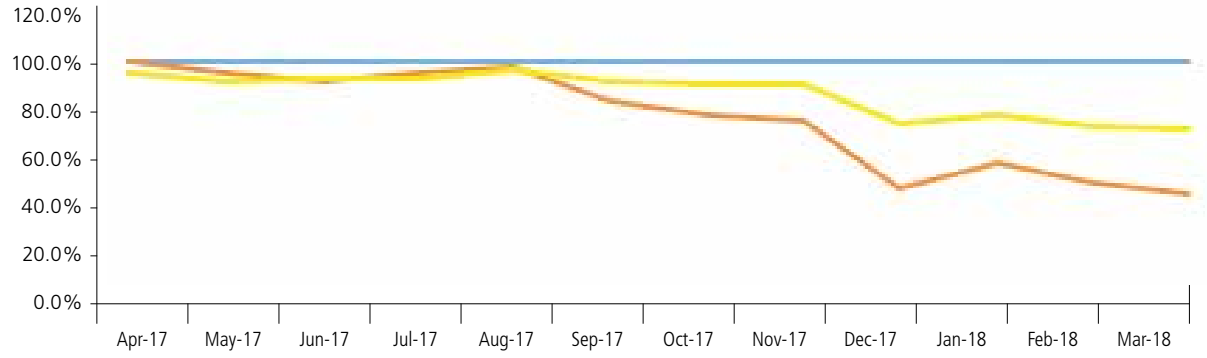
Aside from restoring operational effectiveness and maintaining clinical performance, 2017/18 also saw KMSS 111 realise sustained financial viability, a welcome change to the first years of this 111 contract.

KMSS 111 continues to have a positive impact on our Trust overall in terms of the clinical validation of non-emergency ambulances and also with regards to innovation (introduction of Clinical In-line Support (CIS) in the EOC), patient safety (the sharing of the 111 clinical navigation model), quality (the support with the delivery of the EOC NHS Pathways audit plan) and patient experience (better management of incident investigations and complaints).

Looking ahead to 2018/19, SECAmb will aim to build on the experience of successfully delivering a large 111 service with the potentially new smaller contracts for integrated urgent care being procured separately for Surrey, Sussex and Kent.

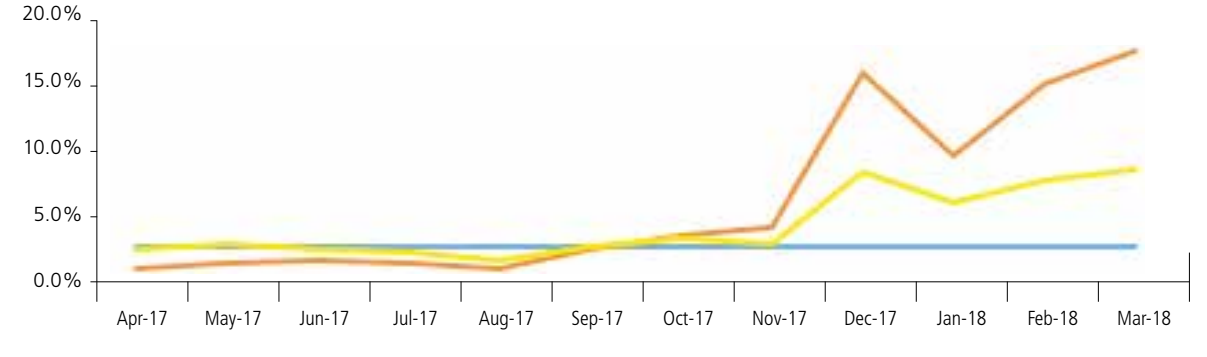
Performance Analysis

KMSS 111 "Answered in 60" KPI



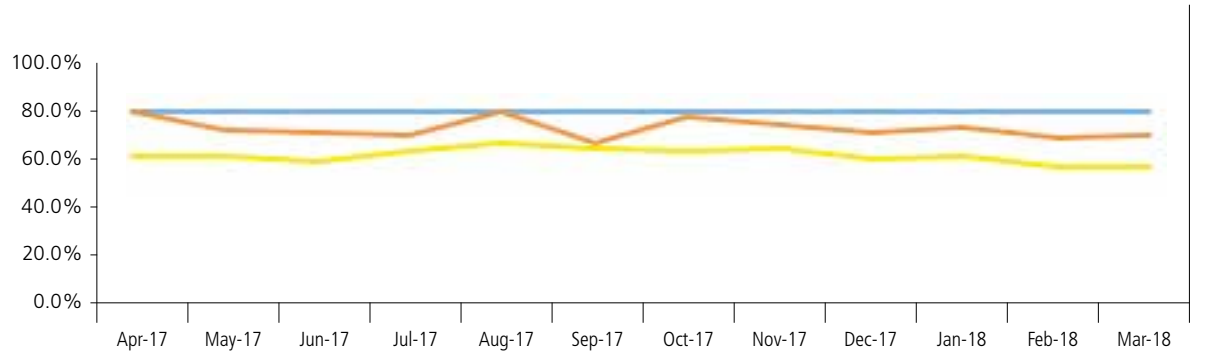
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Answered in 60 Contractual KPI	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
Answered in 60 Actual	95.5%	91.1%	88.4%	91.5%	93.5%	80.2%	75.3%	72.9%	47.9%	56.9%	49.2%	45.1%
Answered in 60 National	91.4%	88.9%	89.1%	89.7%	92.7%	88.3%	87.0%	87.4%	72.7%	75.2%	70.7%	70.2%

KMSS 111 Abandoned Call Rate



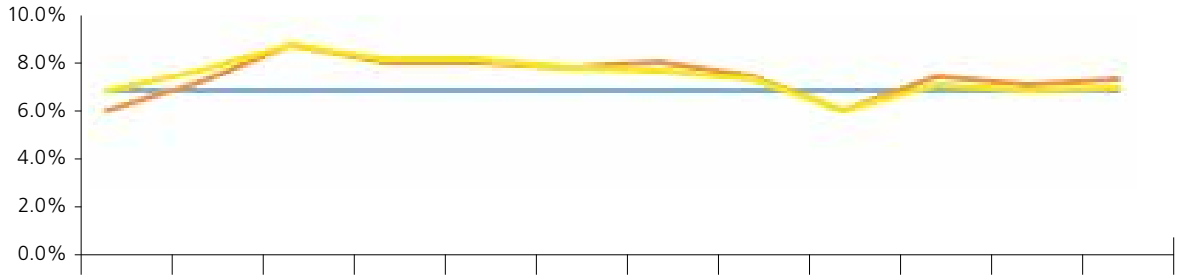
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Abandoned calls Contractual KPI	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Abandoned calls Actual	0.5%	1.0%	1.2%	1.1%	0.6%	2.0%	2.8%	3.6%	14.3%	8.4%	13.4%	15.7%
Abandoned calls National	1.9%	2.3%	2.0%	1.8%	1.2%	2.1%	2.7%	2.2%	7.2%	5.2%	6.6%	7.4%

KMSS 111 Combined Clinical KPI



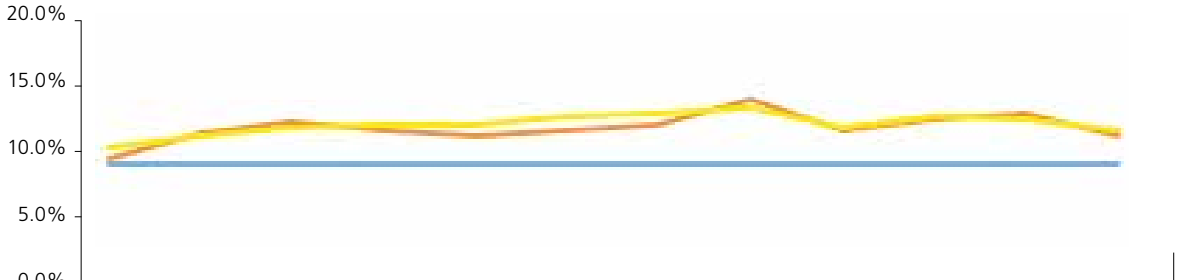
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Combined Clinical KPI Contractual KPI	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%
Combined Clinical KPI Actual	80.4%	74.0%	73.0%	71.8%	80.1%	69.5%	78.2%	75.3%	72.5%	74.7%	71.4%	71.9%
Combined Clinical KPI NaPonal	64.5%	63.9%	62.7%	65.9%	68.8%	67.2%	66.4%	66.8%	63.0%	64.4%	60.0%	60.7%

KMSS 111 A&E Referral Rate



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
A&E Referral Rate Contractual Target	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%	7.0%
A&E Referral Rate Actual	6.4%	7.2%	8.4%	7.9%	7.9%	7.7%	7.9%	7.4%	6.4%	7.5%	7.2%	7.3%
A&E Referral Rate National	7.1%	7.7%	8.5%	8.0%	8.0%	7.8%	7.7%	7.4%	6.4%	7.2%	7.1%	7.2%

KMSS 111 "999" Referral Rate



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
999 Referral Rate Contractual Target	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%
999 Referral Rate Actual	9.3%	10.6%	11.2%	10.7%	10.5%	10.8%	11.1%	12.4%	10.8%	11.4%	11.7%	10.5%
999 Referral Rate NaPonal	9.9%	10.5%	10.9%	11.1%	11.1%	11.6%	11.8%	12.0%	11.0%	11.5%	11.4%	10.8%

Performance Analysis

Clinical Performance

All ambulance services in England are required to report their clinical performance, through a set of Clinical Outcome Indicators, in the following areas:

Outcome from Stroke for ambulance patients:

- The percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face), potentially eligible for stroke thrombolysis, who arrive at a hyper-acute stroke centre within 60 minutes of emergency call
- The number of suspected stroke, or unresolved transient ischaemic attack, patients assessed face to face, who received an appropriate care bundle

Outcome from acute ST-elevation myocardial infarction (STEMI):

- The percentage of patients suffering a STEMI and who, following direct transfer to a centre capable of delivery primary percutaneous coronary intervention (PPCI), receive primary angioplasty within 150 minutes of emergency call
- The percentage of patients suffering a STEMI who receive an appropriate care bundle

Outcome from Cardiac Arrest – Return of Spontaneous Circulation (ROSC):

- ROSC at time of arrival at hospital (overall)
- ROSC at time of arrival at hospital (Utstein Comparator Group)

Outcome from cardiac arrest – survival to discharge:

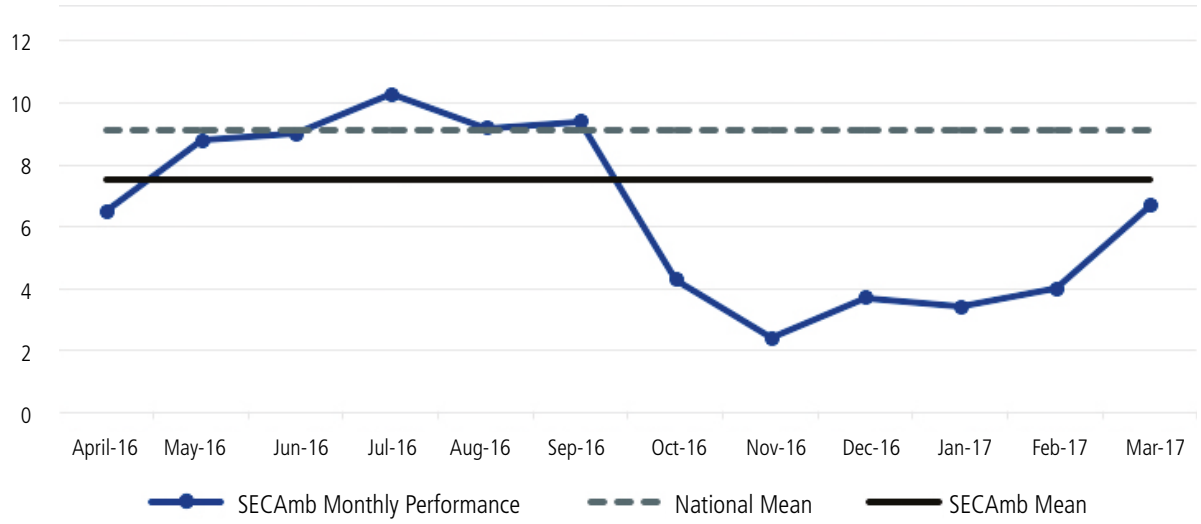
- Survival to discharge – overall survival rate
- urvival to discharge – Utstein

Comparator Group survival rate

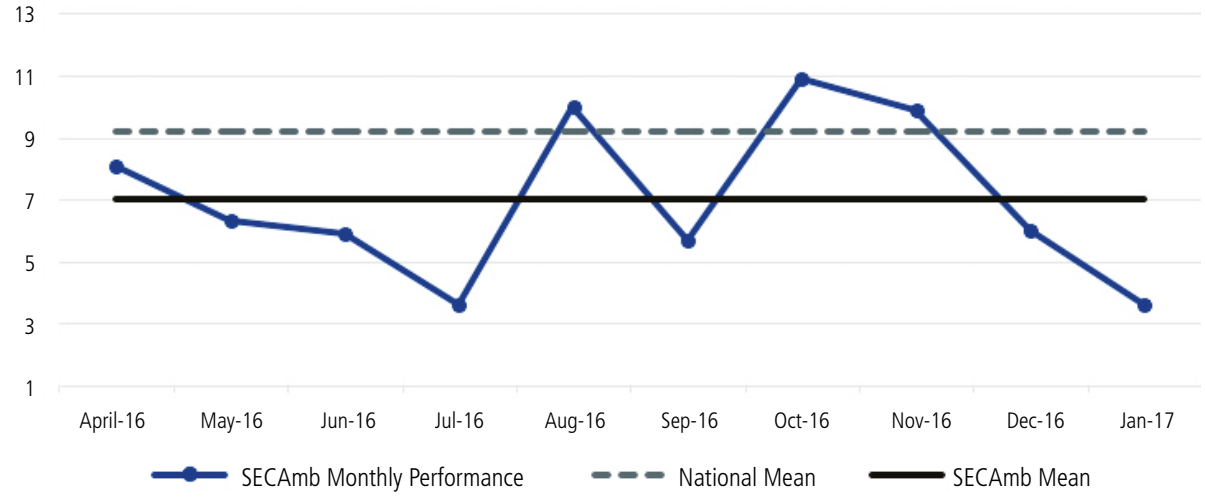
You can see our performance in each area in the graphs below, as well as comparison against the national mean of the other national ambulance trusts:

Outcome from cardiac arrest – survival to discharge:

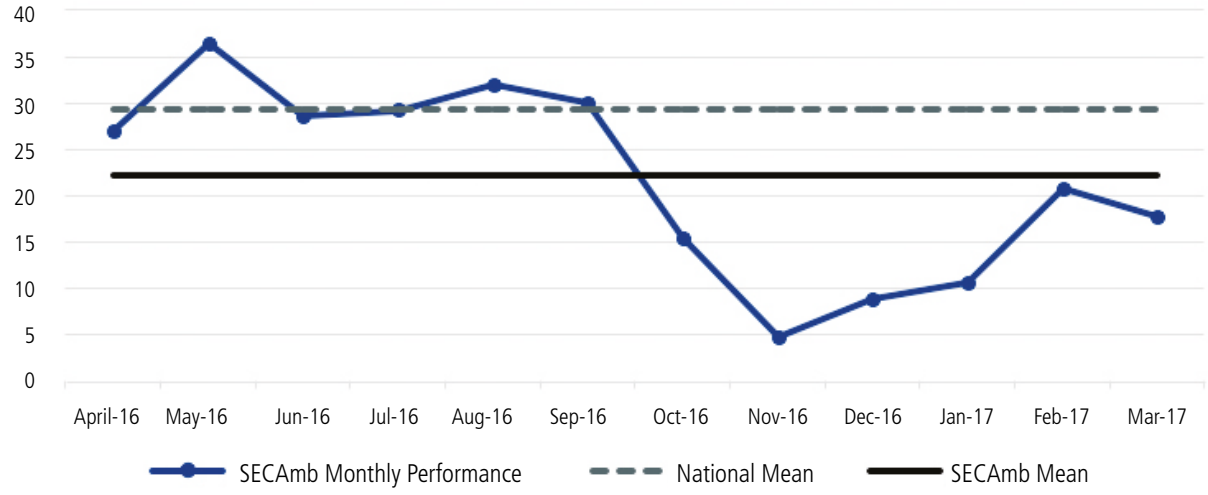
Percentage of cardiac arrest patients who survive to discharge (all patients) 2016/17:



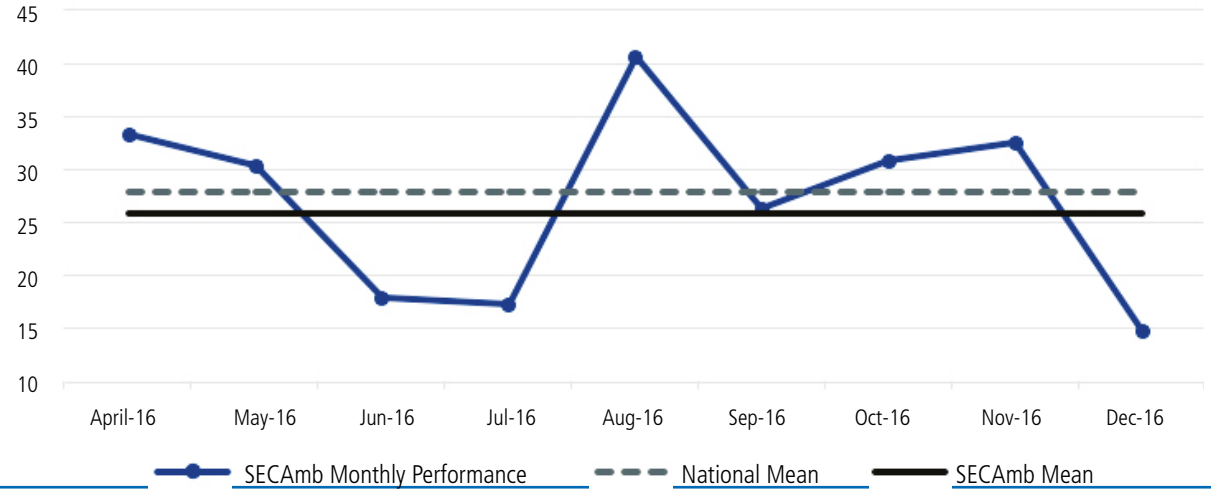
Percentage of cardiac arrest patients who survive to discharge (all patients) 2017/18:



Percentage of cardiac arrest patients who survive to discharge (Utstein) 2016/17:



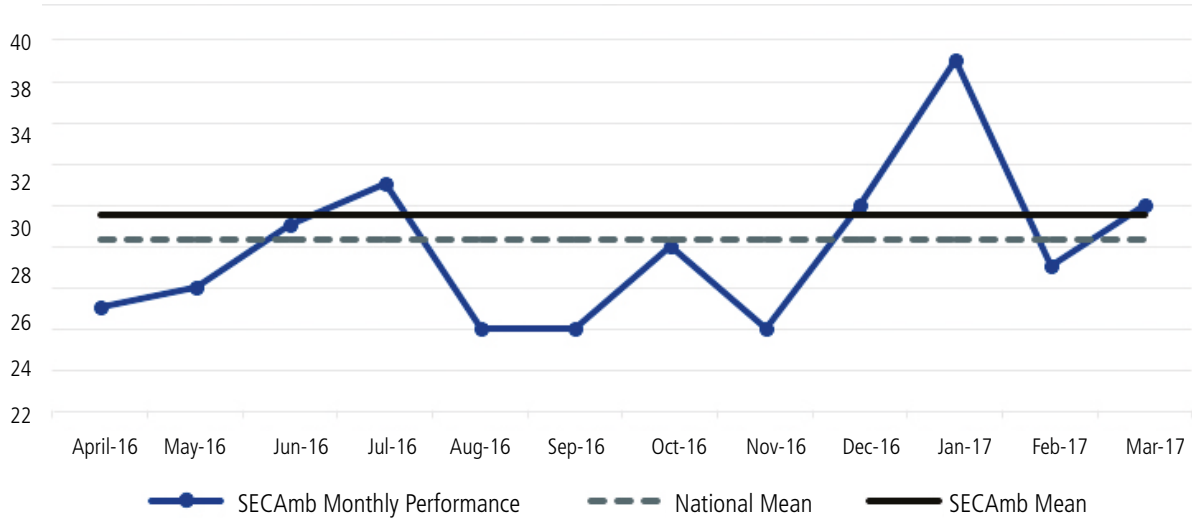
Percentage of cardiac arrest patients who survive to discharge (Utstein) 2017/18:



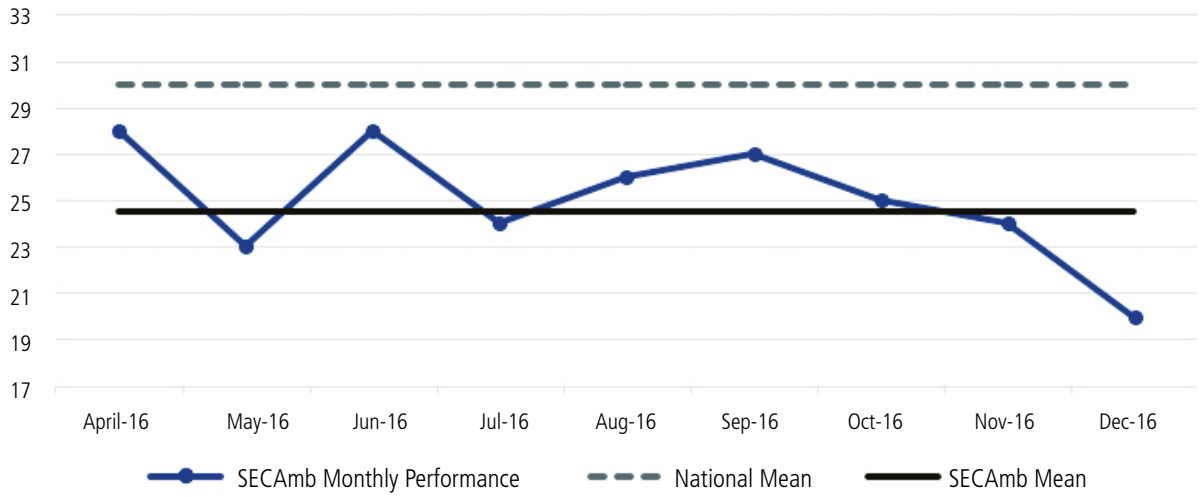
Performance Analysis

Outcome from Cardiac Arrest – ROSC

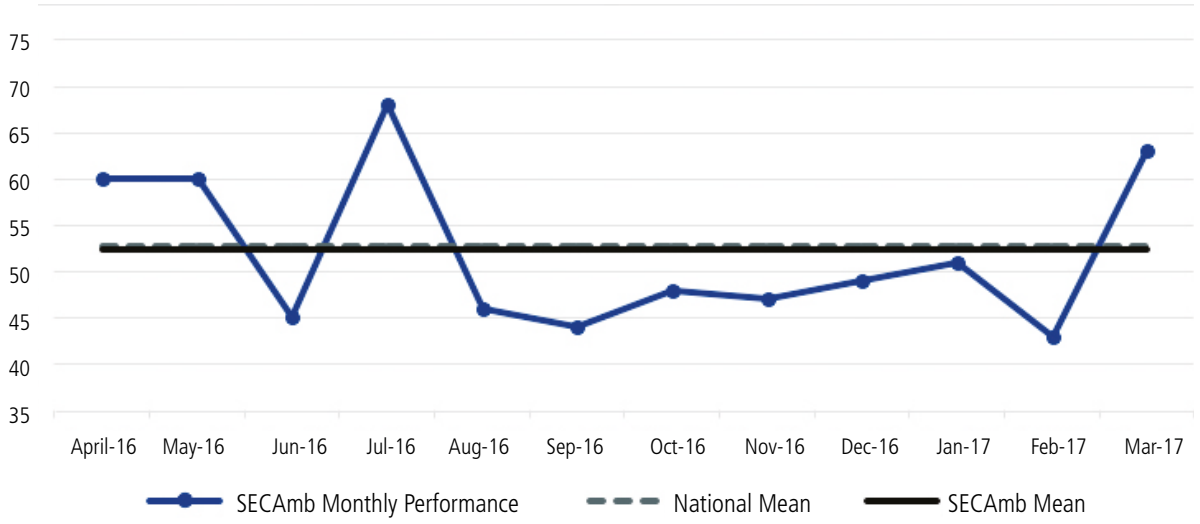
Percentage of cardiac arrest patients with ROSC at hospital (all patients) 2016/17:



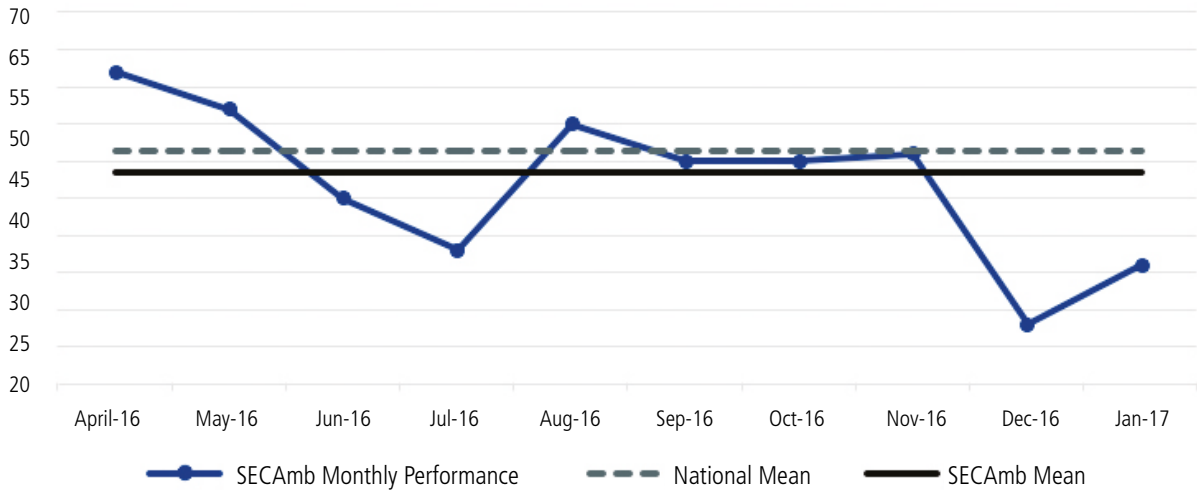
Percentage of cardiac arrest patients with ROSC at hospital (all patients) 2017/18:



Percentage of cardiac arrest patients with ROSC at hospital (Utstein) 2016/17:



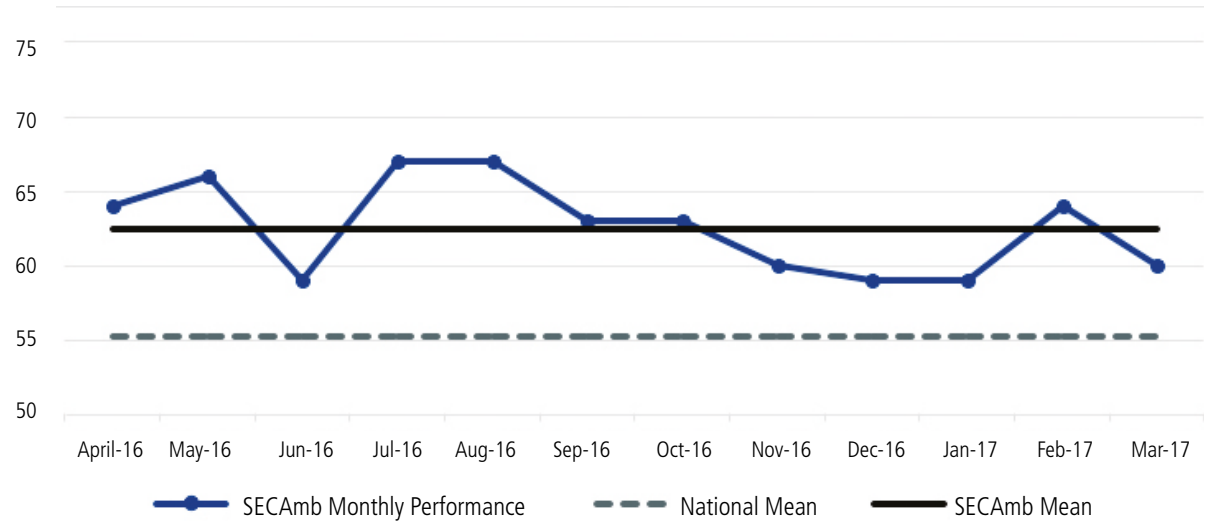
Percentage of cardiac arrest patients with ROSC at hospital (Utstein) 2017/18:



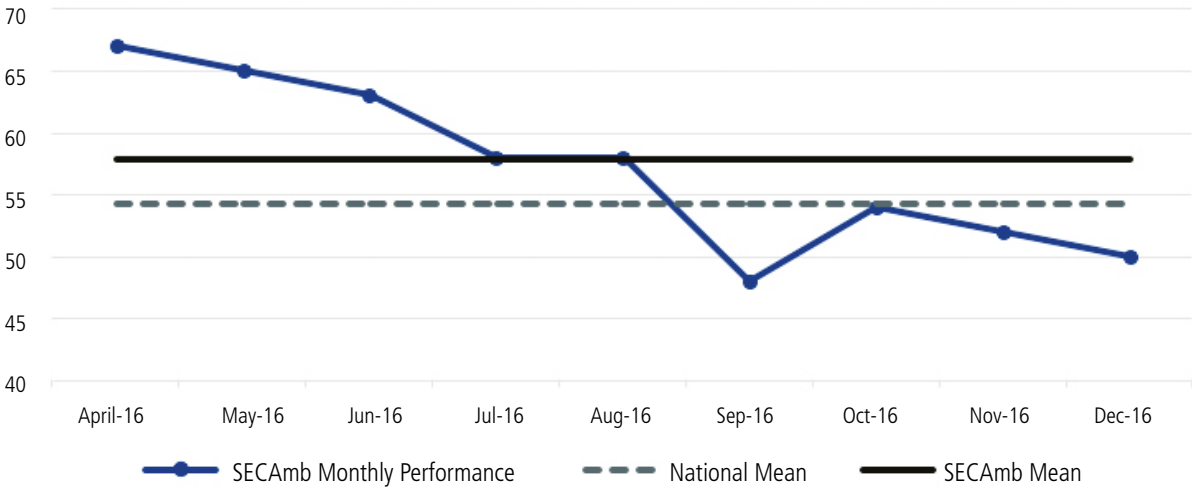
Performance Analysis

Outcome from Stroke

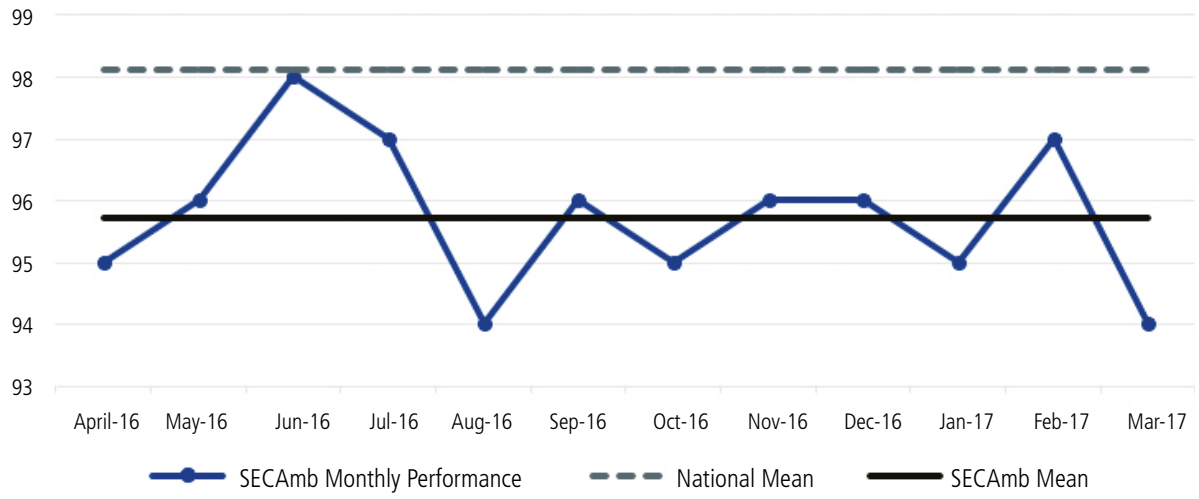
Percentage of stroke patients who arrived at a hyper-acute stroke centre within 60 minutes of their call 2016/17:



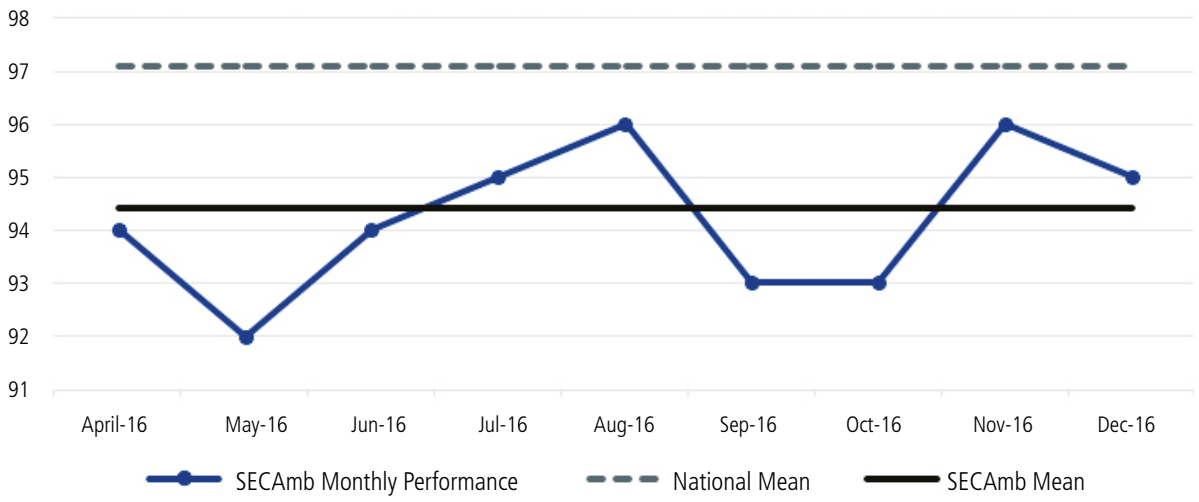
Percentage of stroke patients who arrived at a hyper-acute stroke centre within 60 minutes of their call 2017/18:



Percentage of stroke patients who received a full stroke diagnostic bundle 2016/17:



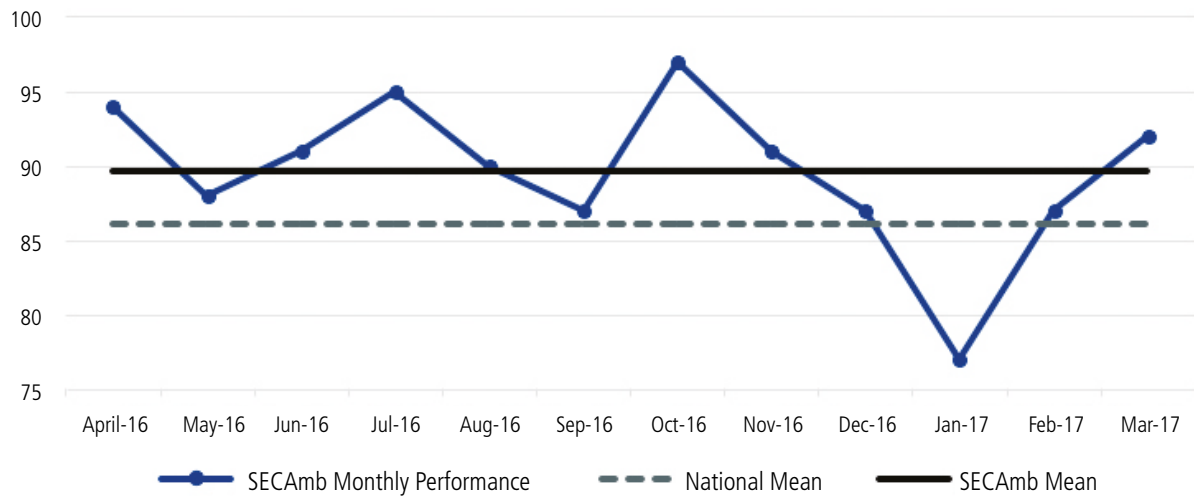
Percentage of stroke patients who received a full stroke diagnostic bundle 2017/18:



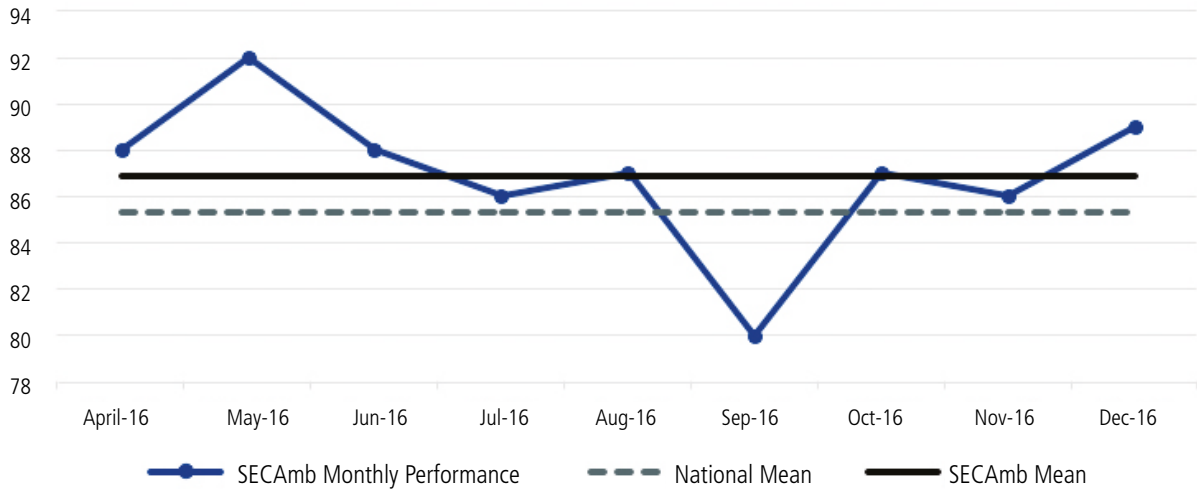
Performance Analysis

Outcome from STEMI

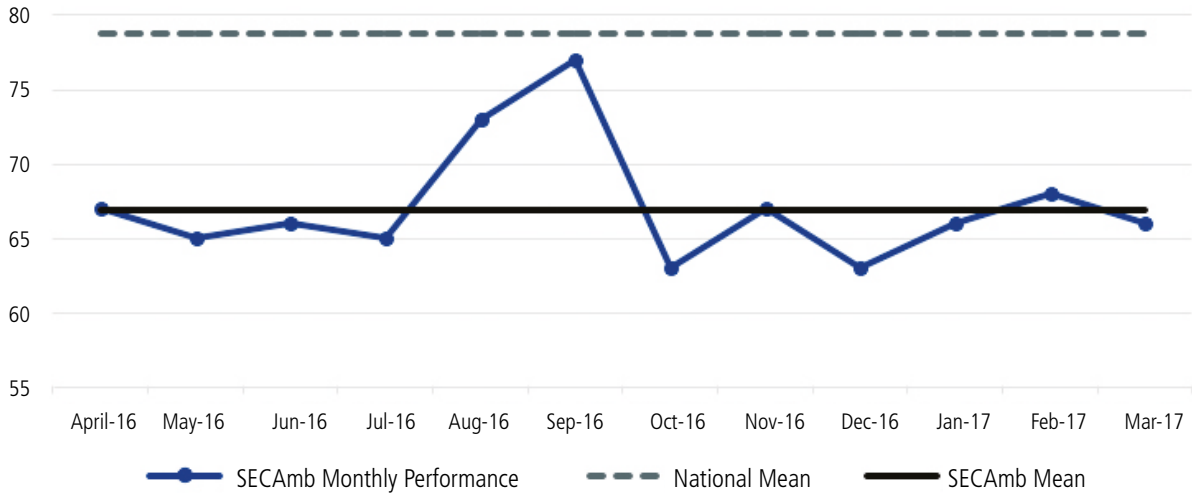
Percentage of STEMI patients who received angiography within 150min of their call 2016/17:



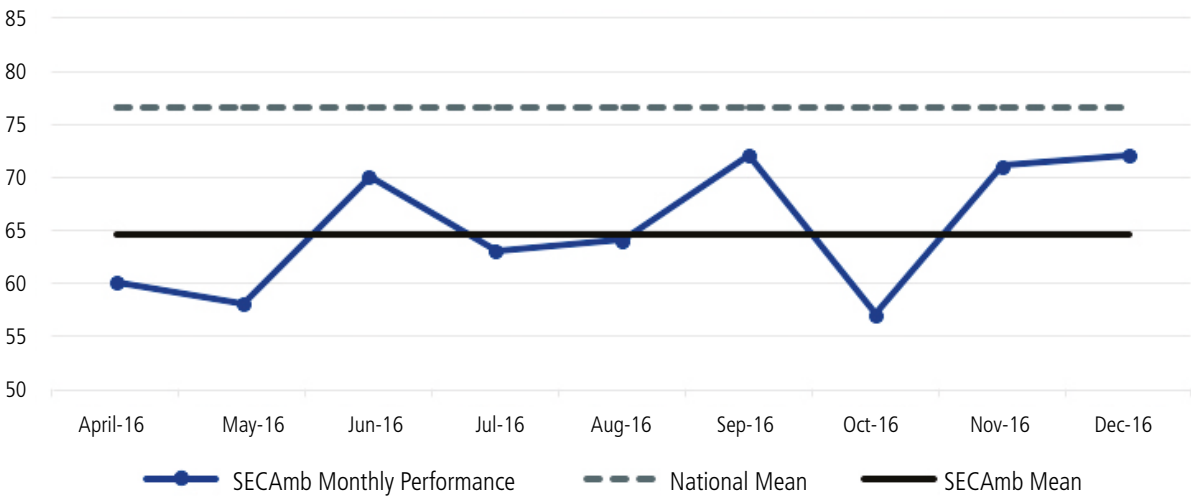
Percentage of STEMI patients who received angiography within 150min of their call 2017/18:



Percentage of STEMI patients who received a full bundle of care 2016/17:



Percentage of STEMI patients who received a full bundle of care 2017/18:



Performance Analysis

Financial Performance

Income and Expenditure Summary

This section of the report covers the Trust's financial performance for the year ended 31 March 2018. Audited annual accounts for the period are attached as an Appendix; they are also available for downloading from the Trust's website.

The Trust's financial performance improved significantly in 2017/18. The plan for the year submitted to the Regulator was for a deficit of £1.0m, compared to the adjusted deficit of £7.1m (excluding impairments) incurred in 2016/17. The planned deficit of £1.0m was also the 'control total' against which the Regulator measures the Trust's financial performance.

The underlying performance, excluding late adjustments to Sustainability Transformation Fund (STF) and CQUIN (quality initiative) income delivered the anticipated control total. The overall Trust performance of £1.3m surplus, after those adjustments, exceeded the projected deficit for the year by £2.3m. The Trust continued its progress towards financial balance by further improving financial controls and governance.

The table below is a summary of income and expenditure for the year compared with plan and the prior year.

Income and Expenditure Summary

	Year Ending 31 March			
	2018			2017
	Plan	Actual	Variance	Actual
	£m	£m	£m	£m
Income	224.4	214.1	(10.3)	205.4
Operating Expenses	212.6	200.3	12.3	201.4
EBITDA[1]	11.8	13.8	2.0	4.0
Interest, depreciation, and dividend	13.3	12.4	(0.9)	11.9
(Loss)/gain on sale of assets	0.5	(0.1)	(0.6)	0.8
Impairment	0.0	0.0	0.0	29.5
Retained surplus/ (deficit)	**(1.0)**	**1.3**	**2.3**	**(36.6)**
Add back impairment	0.0	0.0	0.0	29.5
Adjusted surplus/ (deficit)	**(1.0)**	**1.3**	**2.3**	**(7.1)**

1. Earnings Before Interest, Taxes, Depreciation and Amortisation

Performance Analysis

The underlying financial position of the Trust continues to present a challenge moving into 2018/19. The Trust maintains a robust cost improvement programme to develop the balance between income and expenditure.

A major demand and capacity review is being undertaken with a view to identifying an appropriate strategy for rectifying this imbalance.

Income

Income was up by 4.3% compared to the prior year. The activity relating to the provision of the core 999 service increased slightly by 0.2%, but commissioners provided the full contract value, including growth, releasing £7.8m to meet the increase in frontline hours to support the implementation of the Ambulance Response Programme. Further funding of £2.0m was received to support the additional costs relating to ambulance diverts arising from service reconfiguration at the East Kent Hospitals Trust; additional CQUIN funding provided £2.1m; Sustainability and Transformation Funding, including a bonus for achieving the control total, contributed £2.7m; and £1.7m of central funding was made available to implement the nationally-agreed re-banding of Paramedics. These sources were partly offset by the loss of income relating to the Patient Transport Service in Surrey.

The financial performance of our NHS 111 contract for South East Coast, delivered in conjunction with our partner, Care UK, again provided a small return. The service posted a slight surplus for the second year in 2017/18. The present two-year contract extension for Surrey, Sussex and Kent (excluding East Kent) continues until March 2019. Negotiations are currently under way with a view to a potential extension beyond 2018/19. The Trust has been involved in the 111 retendering across the region with the bid for Sussex already submitted and Surrey due in May 2018.

Expenses

Operating expenses decreased by 0.5% (£1.1m). This is driven by a combination of an increase in provisions for dilapidation and for payments of overtime, partly offset by the cost reduction associated with the loss of the PTS Surrey contract and the impact of non-recurrent costs incurred last year to support the Unified Recovery Plan.

Interest, depreciation and dividend increased by £0.4m. There was an increase in depreciation and amortisation of £1.4m due to the amortisation of the Trust's Electronic Patient Clinical Record project. This was partly offset by a reduction in the Public Dividend Capital dividend paid of £0.9m due to the reduced asset base after the valuation exercise at the 31 March 2017.

Capital Expenditure

Capital spend in the period was £7.8m compared to the planned level of £15.8m. The variation is because vehicle replacement of £8.3m, planned as a finance lease, was procured through an operating lease. The investments in the year included vehicle fleet for the 999 service, including medical equipment, improvement to the resilience of our IT systems, replacement Telephony and Voice Recorder, a new Informatics System and the investment in strategic estate priorities. The Trust expects to continue to make significant capital investments in the next five years in line with our planned capital programme. This includes more ambulances, both replacement and additional vehicles, investment in the estate in the form of new Make Ready Centres to replace ambulance stations, and improvements in the functionality and resilience of our operations centres.

Performance Analysis

Cash

The Trust's cash balance at 31 March 2018 was £22.9m against a plan of £5.5m. The cash balance has increased by £9.9m over the year, in part due to the reduction in cash spent on capital schemes compared to 2016/17. The working capital loan from the Department of Health was repaid in full during the year.

Cost Improvement Programme (CIP)

The Trust achieved £15.5m of CIP savings in 2017/18 against the planned target of £15.1m. This covered a range of schemes, of which recurrent schemes represented 55% of the total. The CIP governance framework and processes introduced during the year are fully functioning in the business and have received approval from Internal Audit. The Trust will continue to focus on key areas of improved operational efficiency. New schemes are being developed for 2018/19, with a delivery target of £11.4m.

Counter Fraud and Corruption

SECAmb is committed to maintaining an honest, open and transparent environment that seeks to eliminate any risk of fraud and bribery relating to our employees, contractors and suppliers. We have a counter fraud team that works closely with our executive team and Audit Committee to instil an anti-fraud and anti-bribery culture through all aspects of the organisation.

All new staff receive counter fraud awareness during corporate induction sessions and regular up-dates and reminders are provided to all staff during the year. The counter fraud team work closely with our internal auditors, and independently, to undertake proactive reviews to detect potential areas for fraud and work to reduce this risk though the training of staff and ensuring effective controls are implemented.

Staff are provided several routes in which to refer suspicious activity to the counter fraud team or freedom to speak up guardian, and all matters raised are investigated thoroughly.

Internal Audit Performance

The Trust has an active internal audit program, which is overseen by the Audit Committee. The programme covers both financial and non-financial controls on a risk basis. A programme of work is agreed, but some flexibility is retained to respond to any concerns that might arise during the year. The programme this year has included patient clinical records, complaints, incident management, information governance and safeguarding.

Accounting Policies

The accounting policies for the Trust are set out in the Annual Accounts.

Accounting policies for pensions and other retirement benefits are set out in note 1.7 to the accounts and details of senior employees' remuneration can be found in the Remuneration Report.

The number of, and average additional pension liabilities for, individuals who retired early on ill-health grounds during the year can be found in note 10.4 to the accounts

Capital Structure

SECAmb' s capital structure is typical of NHS Foundation Trusts. The Treasury provides capital finance in the form of Public Dividend Capital. Annual dividends are payable on the Public Dividend Capital at a rate of 3.5% of average relevant net assets. The Trust has reserves relating to income and expenditure surpluses and revaluations on fixed assets.

Audit Committee

The Audit Committee is the committee of the Board of Directors through which

the Board gains assurance that effective governance arrangements are in place.

The Audit Committee independently reviews, monitors and reports to the Board on the attainment of effective control systems and financial reporting processes. In particular, the Committee's work focuses on the framework of risk, control and related assurances that underpin the delivery of the Trust's objectives.

The Audit Committee receives and considers reports from Internal Audit, External Audit and the Local Counter Fraud Specialist.

The Audit Committee membership in respect of the period ended 31 March 2018 was:

- Angela Smith, Non-Executive Director (Chair)
- Al Rymer, Non-Executive Director
- Graham Colbert, Non-Executive Director

The Director of Finance, Director of Strategy & Business Development, Local Counter Fraud Specialist and Internal Audit and External Audit regularly attend the meetings of the Audit Committee.

The Audit Committee did not identify any significant issues in relation to the financial statements, operations and compliance as presented to the Committee on 21 May 2018.

Further information regarding the work of the Audit Committee and areas of scrutiny can be found in the Annual Governance Statement

The Audit Committee provides a written report to the Board confirming that it has complied with its terms of reference each year. The Audit Committee undertakes an assessment of its effectiveness at the end of each meeting.

The Trust tendered external audit services during the financial year and the contract with the former external auditor for the Trust, Grant Thornton UKLLP, expired in October 2017. The new external auditor for the Trust, KPMG LLP was appointed in November 2017 on a three-year contract. The fees payable to the auditor for statutory audit in respect of the period was £68,070. The external auditors also provided specialist advice to the Trust regarding appropriate revisions to the governance and risk management structures and the operation of the assurance framework in relation to concerns identified by the Care Quality Commission inspection of the Trust in September 2016. This incurred additional charges of £38,400 in the period.

Progress against key projects

Building on the work undertaken during 2016/17, the Trust continued to develop and expand its Programme Management Office (PMO) during the year, to support the delivery of the Trust's key areas of work.

The PMO was previously focused on the delivery of the Unified Recovery Plan which set out the recovery trajectory for the Trust but, as described in the Performance Report above, the Five Year Strategic Plan (2017 – 2022) was developed during the year, to build on this work and ensure that the Trust continues to improve quality for patients, deliver improved performance and to meet financial targets.

As part of the refreshed governance structure put in place to support the delivery of this important work, four Steering Groups were established during the year, overseen by the PMO and each led by an Executive Director:

- Compliance Steering Group (focusing on the CQC Must and Should Dos)
- Service Transformation & Delivery Steering Group (ARP Demand and Capacity, National Ambulance Resilience Unit, Hear and Treat, Hospital Handover)
- Culture and Organisational Development Steering Group (Culture Programme)
- Sustainability Steering Group led by an Executive Sponsor (Estates, Cost Improvement Programme and Digital)

The PMO continues to monitor overall progress for delivery against each project and reports regularly to the Executive Management Board and monthly to the Trust Board. It also provides specific support to the Task & Finish groups established as part of the Trust's response to the CQC's findings – you can read more about this elsewhere in the Report.

Key projects forming part of the Strategic Plan include:

New HQ/EOC

Following many months of work, the Trust began to move into its new facility at Manor Royal in Crawley during May and June 2017. The new building, leased from Surrey County Council, houses an impressive new Emergency Operations Centre (EOC) for the west of our area, as a well as a single base, for the first time, for the majority of our support staff. The move was completed in September 2017, when the last staff from Banstead EOC moved into Crawley.

The Trust previously operated EOCs at its previous HQ site in Banstead in Surrey and at its regional offices in Lewes, East Sussex and Coxheath, Kent.

As part of the move, the Trust closed the Lewes and Banstead EOCs, integrating staff from these sites into the new EOC at Crawley. This provides greater capacity than the Trust has ever had previously, as well as increased opportunities to provide a greater range of clinical care in the EOCs.

Computer Aided Dispatch (CAD) system

To coincide with the creation of the new EOC at Crawley, the Trust also invested significantly in a new Computer Aided Dispatch (CAD) system.

The CAD is the system used to record all data related to 999 and urgent requests for ambulance assistance requested of the Trust and is primarily used by EOC staff to assess, prioritise and, if necessary, dispatch ambulance crews to 999 calls.

Following an extensive testing and training process, which saw more than 500 staff trained on the new system, the Trust's Coxheath EOC in Kent began using the new system on 5 July 2017.

It was then rolled out to the new EOC at Crawley once it became operational and by September 2017, all staff were using the new system.

Feedback from staff on the new system has been very positive since it went live, including improved reliability and performance and ease and speed of use.

Building a better workplace

As described in the Performance Report above, during the year the Trust embarked on an ambitious programme, designed to promote an inclusive, supportive and respectful culture, built on values and behaviours developed by, and with, staff. This is a key area of focus for the Trust.

These values and behaviours will help improve the way we work together, enhance our environment and also have a positive impact on the care we provide to our patients, service users and partner organisations.

The programme has been developed to specifically address challenges identified by staff through the NHS Staff Survey, by the Care Quality Commission through their recent inspections of the Trust and through the report produced by Professor Duncan Lewis into the culture of the Trust, published in August 2017.

In compiling his report, Professor Lewis gained the views of more than 2,000 SECAmb staff and the findings highlighted serious issues, including bullying and harassment and inappropriate behaviours, as well as cultural issues.

Work to deliver the 18-month programme has already begun during the year and will continue into 2018/19. Detailed work plans cover each of the following areas:

- Culture Change
- Effective Leadership and Management
- Staff Engagement
- Inclusion and Wellbeing
- Clinical Education

Activities undertaken during the year include:

- Engaging our staff in refreshing Trust values and developing "signature" behaviours – approved by Board in January 2018
- Re-launching the Staff Engagement Forum with local engagement champions
- Re-launching the quarterly Pulse Surveys with a "you said, we did" response – this has seen increasing return rates per quarter
- Reviewing all our policies, recruitment and leadership programmes to ensure alignment with values
- Developing 360 degree feedback for managers

Sustainability & Environmental Report

Environmental Policy Statement

South East Coast Ambulance Service NHS Foundation Trust (SECAmb) is committed to minimising the environmental impacts of our service. Our commitment is to ensure compliance with environmental legislation and the prevention of pollution through appropriate risk control consistent with maintaining an exceptional service to our patients.

Our Sustainable Development Management Plan runs from 2017 to 2020.

Progress to deliver the Plan began in 2016/17 but has slowed in 2017/18 as the Trust has focused on other priorities; this has resulted in a number of actions being deferred to 2018/19.

Progress to date against our aims is set out in the table below:

Key Themes	Objectives	Outcomes
Operations	1. Analyse mileage associated with so-called 'Standby' manoeuvres and develop plan to reduce this 2. Vehicle procurement / replacement to take in to account developments in technology i.e. non-diesel based transport and based on a standard specification for most cost effective sustainable and low carbon options 3. Develop forecast plan and strategy for Operational Equipment and identify low carbon options 4. Develop investment plan to provide charging facilities at ACRP's to support move to greater numbers of operational electric vehicles with extended range	1. Not completed 2. Fleet Strategy drafted and hybrids project to report 3. Deferred to 2018/19 4. Deferred to 2018/19
Travel and transport	1. Facilitate the widespread take up of Skype for Business 2. Implement site specific travel plans at all new sites 3. Develop meaningful flexible working policy 4. Develop Pool car network using electric vehicles 5. Promote walking and cycling to work as part of staff health and wellbeing	1. Achieved 2. Achieved 3. Deferred to 2018/19 4. New HQ complete with charging ports for electric vehicles 5. Begun in new estate: day on sustainable travel options (including subsidised electric vehicle purchase) held at HQ in 2017

Key Themes	Objectives	Outcomes
Estate	1. Review energy performance of existing estate and plan energy efficiency interventions, i.e., air source heat pumps instead of gas, to mitigate impact on climate change 2. Apply Environmental Design specification to each new build 3. Implement Waste Management and Recycling Policy 4. Correct drainage non compliance 5. Oversee achievement of overall carbon reduction target	1. Some Salix funding has been obtained 2. New HQ meets Crown Estate specification for fit out 3. Started 4. Not completed 5. In process
Procurement	1. Identify Top 10 procurement items and produce plan to reduce carbon or find lower carbon alternatives 2. Low carbon and sustainability checklist applied to all purchases 3. Only FSC certified wood products and Woodland Trust paper 4. Cease use of consumables i.e., white and blue roll in kitchens and toilets and move to Leonardo only 5. Pharmaceuticals management follows the guidance produced by the SDU	1. Deferred to 2018/19 2. Deferred to 2018/19 3. Deferred to 2018/19 4. In process 5. Deferred to 2018/19
Corporate Social Responsibility (CSR)	1. Implement Climate Change Adaptation strategy 2. The organisation's resources are used to benefit rather than damage local and global social, economic and environmental conditions; i.e., deploy only non-diesel vehicles in urban areas where Air Quality is poor 3. The Trust uses its purchasing power to procure goods and services which support the principles of sustainable development i.e., furniture, timber goods, paper, IT equipment etc. from environmentally responsible suppliers and producers	1. Analysis of MRCs required to show carbon and energy savings and CCA strategy subsequently requires review 2. Deferred to 2018/19 3. Procurement plan requires review

Performance Analysis

Social, community and human rights issues

Volunteers

The Trust is fortunate to enjoy fantastic support from a large number of volunteers who support the work of the Trust and our staff in a number of different ways.

You can read about the work of some of our volunteers below and about others in the Directors Report.

Community First Responders (CFRs)

SECAmb currently has 549 Community First Responders (CFRs) spread across Kent, Surrey and Sussex.

Direct management of volunteers has moved to the Trust's 10 Operating Units with Operational Team Leaders overseeing the management, recruitment, training and support of this volunteer group. A comprehensive five-day training programme has been introduced. Many of the clinical components of this course follow the learning methodology for Emergency Care Support Workers. More interactive online training content is being created for volunteers, including modules on using tympanic thermometers and medicines management.

The Trust has been working towards achieving the national Investing in Volunteers accreditation. Formal feedback is pending but the application provided the opportunity to create a strong infrastructure for volunteers to continue to flourish. Alongside the new Community First Responder Policy, a Complaints, Issues and Concerns Process for CFRs and CFR Handbook have been created. There are increased opportunities for volunteers to provide feedback as well. An exit interview has been introduced for volunteers who leave and a series of engagement meetings planned and advertised for the financial year.

Public Access Defibrillators (PADs)

There are over 3,100 PAD sites within SECAmb's area, with over half of them available 24/7. The Trust is continuing to support the establishment of PAD sites, by providing advice and guidance to individuals, local companies, organisations and parish councils. Developing relationships with local communities, promoting the importance of PAD sites and encouraging local responsibility and ownership for these devices are key to improving survival rates from out of hospital cardiac arrests. Community First Responders have a vital role in this work, offering their time to familiarise members of the public on using a defibrillator, and demonstrating CPR techniques. 35 Community First Responders and three Fire and Rescue Services supported the Trust during Restart-A-Heart in October 2017. Together we were able to deliver CPR and defibrillator familiarisation sessions to almost 17,000 school children.

Chaplains

Our network of Chaplains continue to provide invaluable support to our staff, right across the region, with local Chaplains working closely with their allocated stations. The 24- hour alerting/call-out system enables both staff and volunteers to access support whenever they need it. The Chaplains also continue to attend many meetings and functions to support the wider work of the Trust.

There are currently 30 Chaplains. Recruitment for an additional 10 Chaplains will enable all Trust premises to have at least one Chaplain attached. Whilst the Chaplaincy is non-denominational, there is a commitment for the Chaplaincy to represent all major religious groups.

Important events after year end

Resignation of Chairman

On 18 April 2018, the Trust announced that the Chairman, Richard Foster, had decided to step down from the role with immediate effect, on health grounds.

On 27 April 2018, the Council of Governors confirmed Graham Colbert as Interim Chair, ahead of a recruitment and selection process taking place.

Daren Mochrie QAM, Chief Executive

Date: 25 May 2018

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Accountability Report

Directors' Report

The Board of Directors

The Board of Directors if responsible for all aspects of the performance of the Trust. All the powers of the Trust are exercised by the Board of Directors on its behalf. The Board of Directors is made up of both Executive and Independent Non-Executive Directors.

The Executive Directors manage the day to day running of the Trust, whilst the Chair and Independent Non-Executive Directors provide advice, particularly regarding setting the strategic direction for the organisation, scrutiny and challenge based on wide-ranging experience gained in other public and private sector bodies.

The Council of Governors holds the Independent Non-Executive Directors to account for the performance of the Board and represents the interests of members and the wider public. The Council has statutory duties, which include appointing or removing the Non-Executive Directors and setting their remuneration.

Independent Non-Executive Directors are appointed by the Council of Governors for three-year terms of office and may be reappointed for a second, three-year term of office. Independent Non-Executive Directors may, in exceptional circumstances, serve longer than six years but this should be subject to annual re-appointment. Serving more than six years (post authorisation as an FT) could be relevant to the determination of a Non-Executive Director's independence.

The Board has reviewed and confirmed the independence of all the Non-Executive Directors who served during the year. Non-Executive Directors' appointments can be terminated as set out in the Trust's constitution.

The appointment of the Chief Executive is by the Independent Non-Executive Directors, subject to ratification by the Council of Governors.

In 2017/18, the Trust Board as formally constituted included the Chair, six Independent Non-Executive Directors to January 2018 and nine Independent Non-Executive Directors for the remainder of the year, the Chief Executive and six Executive Directors.

Foundation Trusts have the autonomy to arrange their Boards as they see fit; subject to compliance with the Code of Governance which says there should be at least equal number of Executive and Non-Executive directors, excluding the Chair, and that the Board should not be too large and unwieldy. Changes to the Constitution no longer require the approval of NHS Improvement but must be agreed by both the Board of Directors and the Council of Governors.

In January, the Trust Board and Council approved amendments to the Constitution, primarily to remove the restriction on the maximum number of Non-Executive Directors. This was in order that the Trust was able to avail itself of additional Non-Executive expertise and oversight. In reviewing the Constitution, the Company Secretary took the opportunity to make some further relatively minor changes to clarify wording. During the process of this review, the Company Secretary noted the provision in the Constitution limiting Governors to two, three-year terms. This led to a realisation that the decision to amend this to a limit of three, three-year terms (nine years), which was made by the Board of Directors and Council of Governors in 2015, was not affected by the then Company Secretary. The revision therefore included this amendment.

During the year, there were a number of other changes to the membership of the Board, of which you can read more below.

There is extensive experience of the NHS within the current group of Executive Directors. Notwithstanding the changes experienced within

the Board membership in recent months, the Board is satisfied that overall there is a balance of knowledge, skills and experience that is appropriate to the requirements of the Trust.

The Council of Governors and the Board of Directors of SECAmb are committed to working in a spirit of co-operation for the success of the Trust. Every effort will be made to resolve disputes informally through the Chair, or, if this is not appropriate, through the Senior Independent Director.

In the event that the Council considers the Trust to have failed or to be failing to act in accordance with its Constitution or Chapter 5 of the NHS Act 2006, the Council would make the Board aware of the Council's concern and the Council and Board would then attempt to resolve the issue through discussion. This process would normally be led by the Lead Governor and the Chair. Where this fails, or where discussion through the Chair is inappropriate, the Senior Independent Director would act as an intermediary between the Council and the Board, with the objective to find a resolution.

As mentioned above, there have been a number of changes at Board level during the year.

On 1 April 2017, Daren Mochrie started with the Trust as the new Chief Executive.

Joe Garcia, who had been undertaking the role of Interim Director of Operations since joining the Trust on 5 December 2016, was appointed to the substantive role of Executive Director of Operations on 11 September 2017, following a selection and recruitment process.

During the year, Dr Fionna Moore continued in the role of Interim Medical Director, following her joining the Trust on 6 March 2017. At time of writing, the selection and recruitment process for the substantive Medical Director is underway.

Following the departure from the Trust on 31 March 2017 of Kath Start, the role of Interim Director of Nursing & Quality was undertaken by Emma Wadey until 1 June 2017 and by Steve Lennox until 31 March 2018. Following a selection and recruitment process, Bethan Haskins was appointed as the substantive Executive Director of Nursing & Quality and joined the Trust on 1 April 2018.

Jon Amos continued as Acting Director of Strategy & Business Development until 2 January 2018, when Steve Emerton joined the Trust in the substantive Executive role.

On 7 March 2018, Ed Griffin joined the Trust as the substantive Executive Director of HR & OD; up until this point, the role was covered on an interim basis by Steve Graham until 16 February 2018 and by Mark Power from 16 February until 6 March 2018.

On the Non-Executive side, Dr Tricia McGregor joined the Trust on 1 January 2018 as an Independent Non-Executive Director. Following the change to the Trust's Constitution, as described above, Laurie McMahon and Adrian Twyning both also joined the Trust on 7 February 2018 as Independent Non-Executive Directors.

The Trust Board is supported by seven standing Committees:

- Appointments & Remuneration Committee
- Audit Committee
- Charitable Funds Committee
- Finance and Investment Committee
- Quality and Patient Safety Committee
- Workforce and Wellbeing Committee
- Nominations Committee

Performance Evaluation

The Board meets in public at least 10 times a year, and meetings are well attended by members of staff, governors, external stakeholders and members of the public.

Every meeting is recorded so that stakeholders can listen to the discussions. These are available on the Trust website and typically there are hundreds dozens of hits on each recording.

Positive feedback is regularly received from observers, and this includes comments about the relevance of the issues received and the challenge demonstrated, particularly between the Independent Non-Executive Directors and the Executive Team.

During 2017/18, the Board oversaw the implementation of its new structure, based on the model and roles in a unitary Board, and the principles of good governance. Its four main committees - Audit, Quality, Workforce and Finance - report to the Board after each meeting, confirming the level of assurance it has received on the areas of scrutiny. Each committee is chaired by an independent non-executive director, and taking a risk-based approach scrutinises assurances that the system of internal control used to achieve objectives is well designed and operating effectively.

In addition, the Board also held development sessions, including on its specific duties around Health & Safety.

In conjunction with NHS Improvement, the Trust Board commissioned an external review of the Trust's governance. It found a number of areas of good practice, particularly with Board-level governance, but also a number of areas for development, which the Trust continues to take steps to address.

Better Payment Practice Code (BPPC)

The better Payment Practice Code requires the Trust to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is the later:

	Total invoices paid	Invoices paid on time	% of invoices paid within target	Total value paid £'000	Value paid on time £'000	% of invoices by value paid within target
2017/18	19,975	15,902	79.6%	72,430	55,510	76.6%
2016/17	26,994	21,099	78.2%	80,458	61,781	76.8%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice.

The Trust aims to support suppliers by paying in accordance with the policy. By the end of the financial year, the Trust's liquidity had recovered sufficiently that the Trust had fully repaid the Working Capital Facility of £6.2m drawn down in the prior financial year.

The 2017/18 Better Payment Practice Code percentages are below the target (95%) as a result of the Trust managing its cash flow to strict 30 day payment terms for all suppliers. This has meant an adverse impact upon this measure where suppliers are on shorter payment terms. As the liquidity of the Trust has recovered from it is the Trust's intention to focus on this area in the upcoming financial year.

Register of Directors' Interest

The Board of Directors are required to declare other company directorships and significant interests in organisations which may conflict with their Board responsibilities.

The register of Directors' interests is up-dated annually and is available on the Trust's website.

The interests of all Board members have been declared.

Board members (terms of office shown in brackets)

Richard Foster CBE – Chair

(From 31 March 2017)

Richard has held senior positions in the public and voluntary sectors and his career has seen him serve as Chair, CEO, Trustee, Executive Director and Non-Executive Director of a variety of large, complex, public, voluntary and private sector bodies. He was Chief Executive of the Crown Prosecution Service (CPS) between 2001 and 2007 and began his career at the Department of Employment in the 1970s. More recently, he has chaired the Criminal Cases Review Commission from 2008.

On 18 April 2018, the Trust announced that Richard had decided to step down from the role of Chair with immediate effect, on health grounds.

Declared interests – Chair of the Criminal Case Review Commission

Daren Mochrie – Chief Executive

(From 1 April 2017)

Daren has extensive experience of managing ambulance services in both rural and urban settings. Daren was the lead for ambulance provision in the 2014 Commonwealth Games in Glasgow, as well as being a specialist advisor with the Care Quality Commission (CQC), leading four previous CQC inspections of ambulance trusts in England.

Declared interests – Member of the College of Paramedics; Member of the Royal College of Surgeons Faculty of Pre Hospital Care; Paramedic registered with the Health Care Professions Council; Specialist Advisor to the Care Quality Commission

David Hammond – Executive Director of Finance and Corporate Services

(From 1 April 2016)

David has extensive experience in senior management positions within large and small corporate organisations in the UK and overseas. During recent years, David has led finance teams in Ambulance and Acute Hospital Trusts within the NHS.

Declared interests – None

Joe Garcia – Executive Director of Operations

(Interim Director of Operations from 5 December 2016; appointed to the substantive role of Executive Director of Operations on 11 September 2017)

Joe has over 20 years' experience in a number of operational and technical management roles in the ambulance service, most recently at East Midlands Ambulance Service.

Declared interests – None

Dr Fionna Moore – Interim Executive Medical Director

(From 6 March 2017)

Fionna has been an A&E Consultant for over 25 years and has a great deal of experience in the ambulance sector, having been Medical Director and then Chief Executive of the London Ambulance Service (LAS).

Declared interests – Medical Advisor LAS; Medical Director, Location Medical Services

Jon Amos – Acting Director of Strategy & Business Development

(From 31 May 2016 to 2 January 2018)

Jon is a qualified adult nurse and has experience across the health sector, having worked in resilience, project management, operational and relationship management roles in the health protection, acute, NHS 111 and ambulance sectors.

Declared interested – None

Steve Emerton – Executive Director of Strategy & Business Development

(From 2 January 2018)

Steve has a wealth of NHS experience, having previously been the Delivery Director for NHS England Specialised Commissioning. Prior to this, he was Director of Commissioning at North West Surrey Clinical Commissioning Group and also served as a British Army Nursing Officer between 1990 and 2004.

Declared interests – None

Steve Graham – Interim Director of HR

(From 1 August 2015 to 16 February 2018)

Steve joined the Trust in August 2015, having worked in HR in various private and public sector organisations for over 15 years.

Declared interests – None

Mark Power – Interim Director of HR

Mark joined the Trust on a consultancy basis, to support the broad HR agenda.

(From 16 February 2018 to 7 March 2018)

Declared interests – Not received

Ed Griffin – Executive Director of Human Resources & Organisation Development

Ed has extensive international HR experience and joined SECAmb from the British Council where he was Interim Global HR Director and was previously Head of HR. Prior to this he served as Group HR Director for international marketing group, CSM Sport & Entertainment.

(From 7 March 2018)

Declared interests - Lead editor of a Field Guide on Organisation Development, which is aimed at HR professionals, line managers and consultants. Has a financial interest in this as he receives royalty payments. Has an extensive network of external consultants from having worked as a consultant. If there are times one of this network is involved in tendering for work with SECAmb he will declare an interest. Occasionally buys and sells antiques.

Emma Wadey – Acting Chief Nurse/ Director of Quality & Patient Safety

(From 1 August 2016 to 1 June 2017)

Emma has worked in the NHS for over 20 years. She is a mental health nurse and has worked in a range of different roles, including community and in-patient services.

Declared interests – None

Steve Lennox - Acting Chief Nurse/ Director of Quality & Patient Safety

(From 1 June 2017 to 31 March 2018)

Steve joined the Board in June 2017 and is qualified nurse and mental health nurse. He has extensive experience in a variety of healthcare organisations and has previously worked as the Director of Nursing and Quality at London Ambulance Service. Most recently, Steve was part of the team working at Hounslow & Richmond Community Healthcare, helping the Trust to significantly improve its CQC rating.

Declared interests – None

Tim Howe - Non-Executive Director and Chair of Workforce and Wellbeing Committee (part year)

(From 28 January 2010 to 30 September 2018)

Tim has varied experience working the private sector as a senior Human Resources Executive. He was previously International Vice President, Human Resources at United International Pictures and Group Human Resources Director of the Rank Group Plc. Tim is a trained mediator and a former Chair of East Surrey Community Mediation Service.

Tim started on the Board prior to the Trust becoming an FT and was extended in post for a final year by the Council of Governors following a careful assessment of his independence and the value of continuity.

Declared interests - Director of Komoka Ltd HR Consultancy; Trustee Age UK (Sutton)

Adrian Twyning – Independent Non-Executive Director

(From 7 February 2018 to 6 February 2021)

Adrian's career has covered the energy, retail and health sectors. He is the Director of White Goods for DixonsCarphone Plc and was previously Head of UK Field Operations at Centrica Plc. Previous NHS experience includes Associate Director of Operations at Brighton and Sussex Hospitals NHS Trust and as Associate Director of Performance and Delivery at NHS East Coast Kent. He also served as Army Legal Officer for the British Army between 2006-2009 and as Solicitor and Associate with law firm, Taylor Wessing between 2001-2005

Declared interests – Employment with Dixons

Al Rymer – Independent Non-Executive Director

(From 29 January 2015 to 28 January 2021)

Al completed a full career in the Royal Navy in 2012. Leaving as a Read Admiral, he has since provided strategic management consultancy to UK and international clients. Throughout his career, he has gained a wide range of broad level experience in the public sector and partnerships with industry.

Declared interests – Director of Lune Consulting Ltd; Chair of Trustees of Church of England Soldiers, Sailors and Airmens Clubs – Charity welfare facilities for Armed Forces; Chairman and Director of Church of England Soldiers, Sailors and Airmens Housing Association – Charitable Sheltered Housing provision; President of Selsey RNLI Lifeboat Station – Lifesaving

Terry Parkin - Independent Non-Executive Director and Chair of Workforce and Wellbeing Committee (part year)

(From 1 September 2015 to 31 August 2018)

Terry's career led to senior posts in education and social care, as well as significant experience of volunteering. He has worked as a Chief Officer in two local authorities, leading portfolios covering services to both children and adults and including public health. He has a particular interest in children's mental wellbeing.

Declared interests – Managing Director of Monkmead Consulting Ltd; Chief Executive Officer of King's Academy Group; Member of Children's and Young Persons Disability Steering Group

Dr Angela Smith – Independent Non-Executive Director and Chair of Audit Committee

(From 1 February 2017 to 31 January 2020)

Whilst Angela's career was mostly focussed on the International Financial Services Sector, she spent some time as a Partner at KPMG and retired recently from a senior public sector role. Through her career, Angela has gained substantial Board and Committee experience, chairing several Finance and Risk Committees.

Declared interests – Independent Council Member at the University of Sussex; Chair and owner of GlobeRisk Ltd, a management consultancy business.

Tricia McGregor – Independent Non-Executive Director

(From 1 January 2018 to 31 December 2020)

Tricia is a speech and language therapist and a visiting professor in the School of Health Sciences at the University of Surrey. She is also an experienced board-level leader with some 30 years' experience in the healthcare, social enterprise and employee-owned sectors. Tricia also serves as a Non-Executive Director for the Kent, Surrey and Sussex Academic Health Science Network (AHSN) and was awarded an MBE in 2011 for services to social enterprise, while serving as Managing Director for CSH Surrey (formerly Central Surrey Health).

Declared interests – Non-Executive Director of KSS AHSN, supports and works with all health providers in KSS; Visiting Professor of University of Surrey, Trains Paramedics in SECAmb; Provision of Interim and Consultancy work of Tricia McGregor Ltd; and Interim Chief Executive Registrar at the General Chiropractic Council (the government regulator of chiropractors)

Graham Colbert – Independent Non-Executive Director, Deputy Chair and Chair of Finance & Investment Committee

(From 1 September 2012 to 31 August 2018)

Graham is Chief Financial Officer and Chief Operating Officer at Genomics England (a company set up by the Department of Health to carry out a programme of 100,000 whole genome sequences). He has extensive experience in growing businesses in both developed and emerging markets. Graham is a member of the Institute of Chartered Accountants in England and Wales. Graham was appointed Interim Chair by the Council of Governors shortly after year end.

Declared interests - Employed by Genomics England Ltd; Trustee of the British Lung Foundation

Lucy Bloem – Independent Non-Executive Director and Chair of the Quality and Patient Safety Committee

(From 1 September 2013 to 31 August 2019)

Lucy joined SECAmb having been a Partner at Deloitte Consulting since 2007; she is medically retired from Deloitte. With a business career spanning 20 years, Lucy brings a wealth of experience from different cultures and regulatory regimes. She has worked with some of the world's biggest companies, successfully delivering complex programmes and becoming a trusted advisor to many clients.

Declared interests – Deloitte Partner (medically retired)

Professor Laurie McMahon – Independent Non-Executive Director

(From 7 February 2018 to 6 February 2021)

Laurie spent much of the 1980s as a Senior Fellow at the King's Fund College. In 1989 he co-founded the Office for Public Management and co-founded and directed Realisation Collaborative, which specialises in helping large, multi-stakeholder organisations manage strategic change. He is also Honorary Visiting Professor in Strategy and Organisational Design at Cass Business School in London.

Declared interests – Director of the Realisation Collaborative, specialising in organisational development; Board member of The Horsebridge Arts and Community Centre, Whitstable and Trustee of The Collaborative Foundation, a charitable organisation aimed at improving public management.

Member		Director attendance at Board Meetings										
		27 April 2017	30 May 2017	29 June 2017	25 July 2017	29 September 2017	26 October 2017	29 November 2017	11 January 2018	25 January 2018	23 February 2018	27 March 2018
Richard Foster	Chair	-	x	x	-	x	x	x	x	x	x	x
Daren Mochrie	Chief Executive	x	x	x	x	x	x	x	x	x	x	x
Tim Howe	Independent Non-Executive Director	x	x	x	x	x	x	x	x	x	x	x
Graham Colbert	Independent Non-Executive Director	x	x	x	x	x	x	x	x	x	x	x
Lucy Bloem	Independent Non-Executive Director	x	x	x	x	x	-	x	x	x	x	x
Al Rymer	Independent Non-Executive Director	x	x	x	x	x	x	x	-	-	x	x
Terry Parkin	Independent Non-Executive Director	x	x	x	x	-	x	x	x	x	x	x
Angela Smith	Independent Non-Executive Director	x	x	x	-	x	x	x	x	x	x	x
Jon Amos	Acting Director of Strategy & Business Development	-	x	x	x	x	x	x				
Joe Garcia	Interim/Executive Director of Operations	x	x	x	x	x	x	x	x	x	x	x
Dr Fionna Moore	Interim Executive Medical Director	x	x	x	x	x	x	x	x	x	x	x
David Hammond	Executive Director of Finance & Corporate Services	x	x	x	x	-	-	x	x	-	x	x
Emma Wadey	Acting Chief Nurse/Director of Quality & Patient Safety	x	x									
Steve Lennox	Acting Chief Nurse/Director of Quality & Patient Safety			-	x	x	x	x	x	x	x	x
Steve Graham	Interim Director of HR	x	x	-	x	-	x	x	x	x		
Mark Power	Interim Director of HR										x	
Ed Griffin	Executive Director of HR & OD											x
Steve Emerton	Executive Director of Strategy & Business Development								x	x	x	x
Tricia McGregor	Independent Non-Executive Director								x	x	x	x
Adrian Twyning	Independent Non-Executive Director										x	-
Laurie McMahon	Independent Non-Executive Director										x	x

Key	
x	In attendance
-	Not in attendance
	Not in post

The Board also meets in confidential session, normally on the same date as the public Board meetings, to make decisions relating to items that need to be dealt with in confidence, usually because of commercial sensitivities. The Chair gives a brief overview of the issues discussed during the confidential session at the start of the public Board meeting and the agenda and minutes of confidential sessions of the Board are made available to the Council of Governors.

Member		Director attendance at Part 2 Board Meetings										
		27 April 2017	30 May 2017	29 June 2017	25 July 2017	29 September 2017	26 October 2017	29 November 2017	11 January 2018	25 January 2018	23 February 2018	27 March 2018
Richard Foster	Chair	-	x	x	-	x	x	x	x	x	x	x
Daren Mochrie	Chief Executive	x	x	x	x	x	x	x	x	x	x	x
Tim Howe	Independent Non-Executive Director	x	x	x	x	x	x	x	x	x	x	x
Graham Colbert	Independent Non-Executive Director	x	x	x	x	x	x	x	x	x	x	x
Lucy Bloem	Independent Non-Executive Director	x	x	x	x	x	-	x	x	x	x	x
Al Rymer	Independent Non-Executive Director	x	x	x	x	x	x	x	-	-	x	x
Terry Parkin	Independent Non-Executive Director	x	x	x	x	-	x	-	x	x	x	x
Angela Smith	Independent Non-Executive Director	x	x	x	-	x	x	x	x	x	x	x
Jon Amos	Acting Director of Strategy & Business Development	-	x	x	x	x	x	x				
Joe Garcia	Interim/Executive Director of Operations	x	x	x	x	x	x	x	x	x	x	x
Dr Fionna Moore	Interim Executive Medical Director	x	x	x	-	x	x	x	x	x	x	x
David Hammond	Executive Director of Finance & Corporate Services	x	x	x	x	-	-	x	x	-	x	x
Emma Wadey	Acting Chief Nurse/Director of Quality & Patient Safety	x	x									
Steve Lennox	Acting Chief Nurse/Director of Quality & Patient Safety			-	x	x	x	x	x	x	x	x
Steve Graham	Interim Director of HR	x	x	-	x	-	x	x	x	x		
Mark Power	Interim Director of HR										x	
Ed Griffin	Executive Director of HR & OD											x
Steve Emerton	Executive Director of Strategy & Business Development								x	x	x	x
Tricia McGregor	Independent Non-Executive Director								x	x	x	x
Adrian Twyning	Independent Non-Executive Director										x	-
Laurie McMahon	Independent Non-Executive Director										x	x

Board Committees

In order to exercise its duties, the Board is required to have a number of statutory Committees. NHS Improvement's Code of Governance sets out that the Board may opt to have one or two Nominations Committees and provides guidance on the structure for either option. SECAmb has elected to follow the model for two Nominations Committees – one which has responsibility for Executive Directors and one which has responsibility for Non-Executive Directors, including the Chair.

Appointments and Remuneration Committee (ARC)

The purpose of the Committee is to decide and report to the Board about appropriate remuneration and terms of service for the Chief Executive and Executive Directors employed by the Trust and other senior employees, having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements where appropriate. This fulfils the duties for the Nominations Committee for Executive Directors, as described above.

For any decisions relating to the appointment or removal of the Executive Directors, membership of the ARC of the Chair, the Chief Executive and all Independent Non-Executive Directors of the Trust is required under Schedule 7 of the National Health Service Act 2006. For all other matters, Committee membership is comprised exclusively of Independent Non-Executive Directors. All are eligible to attend but two must be present to be quorate.

Other individuals such as the Chief Executive and Director of Finance or external advisors may be invited to attend the Committee for specific agenda items or when issues relevant to their areas of responsibility are to be discussed.

Appointments & Remunerations Committee (ARC)		27 April 2017	30 May 2017	3 August 2017	26 October 2017	29 November 2017	23 February 2018
Richard Foster	Chairman	-	x	-	x	x	x
Daren Mochrie	Chief Executive	x	x	x	x	x	x
Lucy Bloem	Non-Executive Director	x	x	x	-	x	x
Tricia McGregor	Non-Executive Director						x
Adrian Twyning	Non-Executive Director						x
Al Rymer	Non-Executive Director	x	x	-	x	x	x
Tim Howe	Non-Executive Director	x	x	x	x	x	-
Angela Smith	Non-Executive Director	x	x	-	x	x	x
Laurie McMahon	Non-Executive Director						x
Graham Colbert	Non-Executive Director	x	x	-	x	x	x
Terry Parkin	Non-Executive Director	x	x	x	x	-	-

Key	
x	In attendance
-	Not in attendance
	Not in post

Audit Committee (AuC)

The purpose of the Committee is to provide the Trust with a means of independent and objective review of the internal controls over the following areas:

- Financial systems
- The information used by the Trust
- Assurance Framework systems
- Performance and Risk Management systems
- Compliance with law, guidance and codes of conduct

In undertaking such review, the Committee provides assurance to the Chief Executive and to the Board about fulfilment of the responsibility of the Trust's Accounting Officer, who under the terms of the National Health Service Act 2006 is responsible to Parliament by the Public Accounts Committee for the overall stewardship of the organisation and the use of its resources. In accordance with the NHS Foundation Trust Code of Governance, the Committee membership is comprised exclusively of Independent Non-Executive Directors. Three must be present to be quorate.

Audit Committee (AuC)		27 April 2017	30 May 2017	3 August 2017	26 October 2017	29 November 2017
Angela Smith	Independent Non-Executive Director/Chair	x	x	x	x	x
Tim Howe	Independent Non-Executive Director	x	x	x	x	x
Al Rymer	Independent Non-Executive Director	x	-	x	-	x
Graham Colbert	Independent Non-Executive Director	x	x	x	x	x

Key	
x	In attendance
-	Not in attendance
	Not in post

Charitable Funds Committee (CFC)

The purpose of the Committee is to make and monitor arrangements for the control and management of the Trust's charitable funds and to report through to the Trust Board.

The quorum necessary for transaction of business by the Committee is three members, including the Director of Finance or designate.

To minimise the amount of time spent attending Committee meetings, the Charitable Funds Committee meets immediately prior to the Audit Committee. The Charitable Funds Committee is required to meet a minimum of twice a year.

Charitable Funds Committee (CFC)		21 June 2017	4 December 2017
Angela Smith	Independent Non-Executive Director/Chair	x	x
Tim Howe	Independent Non-Executive Director	x	x
Lucy Bloem	Independent Non-Executive Director	-	x
Terry Parkin	Independent Non-Executive Director	-	x
David Hammond	Executive Director of Finance & Corporate Services	x	x

Key	
x	In attendance
-	Not in attendance
	Not in post

Finance and Investment Committee (FIC)

The purpose of the Committee is to acquire and scrutinise assurances that the Trust's system of internal controls relating to finance, corporate services and investments in future operational capability, are designed appropriately and operating effectively.

As a minimum, the Committee has three Independent Non-Executive Director members, appointed by the Board. The Committee also includes Executive members who shall number no more than the Non-Executives.

The quorum necessary for formal transaction of business by the Committee is two Independent Non-Executive Director members and one Executive member.

Finance & Investment Committee (FIC)		27 April 2017	30 May 2017	3 August 2017	26 October 2017	29 November 2017	23 February 2018
Graham Colbert	Independent Non-Executive Director/Chair	X	X	X	X	X	X
Lucy Bloem	Independent Non-Executive Director	X	X	X	X	X	X
Al Rymer	Independent Non-Executive Director	-	X	X	Not a FIC member	Not a FIC member	Not a FIC member
Tim Howe	Independent Non-Executive Director	Not a FIC member	Not a FIC member	Not a FIC member	Not a FIC member	Not a FIC member	X
David Hammond	Executive Director of Finance & Corporate Services	X	X	X	X	X	X
Joe Garcia	Interim/ Executive Director of Operations	X	X	-	X	-	X
Jon Amos	Acting Director of Strategy & Business Development	X	X	X	X		
Steve Emerton	Executive Director of Strategy & Business Development					X	-
Angela Smith	Independent Non-Executive Director	-	-	X	X	X	X

Key	
X	In attendance
-	Not in attendance
	Not in post

Quality and Patient Safety Committee (QPS)

The purpose of the Committee is to acquire and scrutinise assurances that the Trust's system of internal controls relating to quality governance (encompassing patient safety, clinical effectiveness and patient experience) are designed appropriately and operating effectively.

As a minimum, the QPS has three Independent Non-Executive Director members, appointed by the Board; it also includes Executive members who shall number no more that the Non-Executives. The Committee Terms of Reference specify that one of the Committee members shall have a clinical professional qualification and clinical experience.

The quorum necessary for formal transaction of business by the Committee is two Independent Non-Executive Director members.

Quality & Patient Safety Committee (QPS)		25 April 2017	22 May 2017	19 June 2017	20 July 2017	7 September 2017	20 October 2017	7 December 2017	23 January 2018	6 February 2018	8 March 2018
Lucy Bloem	Independent Non-Executive Director/Chair	x	x	x	x	x	x	x	x	x	x
Daren Mochrie	Chief Executive	-	x	-	x	x	x	x	-	-	x
Tim Howe	Independent Non-Executive Director	x	x	x	-	x	x	x	x	x	x
Terry Parkin	Independent Non-Executive Director	x	-	-	x	x	x	x	x	-	x
Fionna Moore	Medical Director	x	-	-	x	x	x	x	-	-	-
Emma Wadey	Interim Director of Quality and Safety	x	x								
Steve Lennox	Acting Director of Quality and Safety			x	x	-	-	x	x	x	x
Joe Garcia	Director of Operations	x	x	x	x	x	x	x	x	x	x
Tricia McGregor	Independent Non-Executive Director								Not a QPS member	x	x

Key	
x	In attendance
-	Not in attendance
	Not in post

Workforce and Wellbeing Committee (WWC)

The purpose of the Committee is to acquire and scrutinise assurances that the Trust's system of internal control relating to the workforce (encompassing resourcing, staff wellbeing and HR processes) are designed appropriately and operating effectively.

As a minimum, the Committee has three Independent Non-Executive Director members, appointed by the Board; it also includes Executive members who shall number no more than the Non-Executives.

The quorum necessary for formal transaction of business by the Committee is two Independent Non-Executive Director members and one Executive Director.

Workforce & Wellbeing Committee (WWC)		24 April 2017	25 May 2017	31 July 2017	20 October 2017	7 December 2017	8 March 2017
Tim Howe	Independent Non-Executive Director/Chair	x	x	x	x	x	x
Al Rymer	Independent Non-Executive Director	-	x	x	x	x	x
Terry Parkin	Independent Non-Executive Director	x	x	x	x	x	x
Steve Graham	Interim Director of HR	x	x	x	x	x	
Ed Griffin	Executive Director of HR & OD						x
Joe Garcia	Interim/ Executive Director of Operations	x	-	x	x	x	x

Key	
x	In attendance
-	Not in attendance
	Not in post

The Council of Governors

The Council is made up of Public Governors, Staff-Elected Governors and Appointed Governors from key partner organisations. Public Governors represent six constituencies across the area where SECAmb works (set out in the table below), and Staff-Elected Governors represent either operational (front-line) or non-operational staff. The Council elects a Lead Governor and a Deputy Lead Governor on an annual basis.

Statement from Lead Governor

The Council of Governors continued to be a critical friend to the Board of Directors as the Trust moved forward with its improvement programme during the year. We take every opportunity to fulfil our statutory duties to represent the interests of members and the public, and to hold the Non-Executives to account for the performance of the Board.

Having seen numerous changes on the Executive Team at Board level, Governors are increasingly heartened at the calibre and ethos of the Executive Directors now in post. At year-end the Executive Team is almost substantively complete and, save for the resignation of the Chair soon after year-end, we are coming close to achieving stability on the Board. It will be crucial to recruit well to the Chair position so we have the leadership we need.

There have been some very welcome additional Non-Executive Director (NED) appointments bringing much-needed organisational development, IT and clinical skills and experience to the Board, which should be very helpful with the work still ahead. The NEDs as a body seem to be working effectively and the revamped Board Committee structure highlights areas of risk to the Board and Council clearly and in a timely fashion.

Council meetings are becoming more effective in discussion with the NEDs, and Governors are finding that our questions to Trust managers between meetings are receiving much fuller and more frank responses: this bodes well for the general direction of travel.

We have been pleased with the CQC appraisal of the 111 service as good, and were proud of 999 staff who also achieved a CQC 'good' for caring for our patients. The numerous areas of serious deficit identified by the CQC were very much in the systems and processes put in place by the then leadership of the Trust. Governors also seek robust structures to protect patients and empower staff to deliver the best possible service. It is on these areas that Council puts its focus at our meetings and in our other interactions with the Trust.

The Trust remains challenged in a number of areas, not least operational performance, and while this is an issue nationally Governors will not stop seeking improvements for our locality. The introduction of the Ambulance Response Programme appears to have helped us get to the sickest people more quickly but Governors have been and will continue to be vocal in insisting on the importance of understanding the experience of our patients who wait the longest for our services, including those who sometimes experience long waits for their 999 call to be answered. The Trust is also finding it hard to recruit into some roles however the new HR Director appears to be getting to grips with this challenge quickly.

Governors have been involved, particularly the Staff Governors, in work to improve the culture of the organisation and remove the everyday blockages that staff experience that prevent SECAmb from being a more decent place to work. Our fantastic volunteers experience similar issues and more must be done to value and support both staff and volunteers to deliver vital services to patients. Governors look to the new HR Director to address these issues urgently (in conjunction with the Operations Director where appropriate) and will ask NEDs to focus on getting assurance that this work is moving apace. It is pleasing to see investment in cultural improvement work, and acknowledgement that this cannot be imposed on the organisation but must be owned by and embodied by all staff. We are seeing green shoots of improvement.

Financial challenges cannot be ignored and there has been some significant investment not undertaken this year, for example much-needed improvements to premises, while other investments, in our new HQ and Emergency Operations Centre and in a new and improved Computer Aided Despatch system for 999, have brought massive benefits. The Governors are pleased to see that the Trust now has a fleet replacement strategy in place and is beginning to replace older failing vehicles with more modern, fit for purpose units. This is important as our staff need access to the best possible equipment to be able to provide the continuing excellent levels of care safely.

We all know the NHS is strapped for cash and it's vital we make the right choices when we spend tax payers' money. We also need to work together better across the health and social care system, to remove the disincentives to work together when it can improve things for our patients and finances. Some Governors are very much involved in the emerging Sustainability and Transformation Partnerships (STPs) and are keeping a weather eye on their progress to ensure they are both effective and accountable to the public.

The Governors have continued to challenge the Executive on its volunteer strategy and use of this available resource. It is widely understood that front-line volunteers (Community First Responders) have been an under-utilised part of the Trust for some time and that the Trust hasn't made full use of a valuable resource. We have been pleased to note there are signs of investment in this area, whilst it is still early days, and that there is also the nationally recognised Investing in Volunteers programme, on which SECAmb is the National Ambulance Lead Trust. We will continue to scrutinise developments in this area, as we feel investment in volunteers will have a significant impact on our patients' outcomes.

There seems to be increasing recognition that Governors raise important issues that should be listened to and acted upon. The type of SECAmb where the Governors are listened to and respected will be the type of SECAmb where patients and staff receive the same basic courtesy and ultimately a good service and experience. This is the SECAmb we all strive for and that the South East deserves, and the Council will continue to support and challenge as the team also strive for this, under Daren's leadership.

There have been a number of changes in the Council and I thank those who have left during the year and welcome those who have joined.

Finally, I would like to thank all my fellow Governors for their hard work over the year, and recognise the efforts of Daren and his team, the rest of the Board, SECAmb's 999,111 and non-operational staff and all our volunteers. I sincerely hope their efforts continue to bear fruit in the year to come, and I know we in the Council will continue to do our best to represent the interests of the public and external stakeholders.

James Crawley, Lead Governor

Meet the Governors

Staff Governors

Non-operational

Alison Stebbings

(First term of office 1 March 2016 – 28 February 2019)

Alison is the Trust's Logistics Manager, supporting a team of 16 working across Sussex, Surrey and Kent. She is based at Worthing Ambulance Station in West Sussex.

- Governor Development Committee member
- Nominations Committee member
- Membership Development Committee member

Declared interests: None

Operational

Charlie Adler

(First term of office 1 March 2016 – 28 February 2019)

Charlie is a graduate Paramedic working out of Woking, Surrey. Prior to qualifying as a Paramedic Charlie served in the Army, with operational tours in Bosnia and Afghanistan.

- Deputy Lead Governor
- Membership Development Committee member

Declared interests: None

Nigel Coles

(First term of office 1 March 2016 – 28 February 2019)

Nigel is a Paramedic working out of Tongham Ambulance Station in Surrey. He has worked for SECAmb for 26 years.

- Membership Development Committee Deputy Chair

Declared interests: None

Nicholas Harrison

(First term of office 1 March 2017 – 28 February 2020)

Nick has worked for SECAmb as a Paramedic, Clinical Team Leader and now works as a Critical Care Paramedic (CCP) as well as working on the Critical Care Desk at Coxheath in Kent, providing trauma support to CCPs and road crews within SECAmb.

Declared interests: None

Public Governors

Brighton

Jean Gaston-Parry (Second term of office 21 June 2015 – 20 June 2018)

Jean's interest in SECAmb was sparked by the life-saving service she received on three occasions by ambulance crews. Jean is very involved in older people's issues in Sussex and has lots of links to groups in the local community.

- Nominations Committee member
- Membership Development Committee member
- Governor Development Committee member

Declared interests: None

Medway

Stuart Dane

(First term of office 1 March 2017 – 29 February 2020)

Stuart has been a volunteer in the Health and Social Care Sector with the British Red Cross for five years. He works part time with the Red Cross Ambulance Service supporting SECAmb through front line emergency ambulance work.

Declared interests: Red Cross ambulance crew (Emergency Care Support Worker).

East Sussex

Brian Rockell

(Third term of office 1 March 2017 – 28 February 2020)

Brian has represented the public in statutory roles to the Boards of Berkshire Ambulance Service, Sussex Ambulance Service and SECAmb. He Chaired the SECAmb Public and Patient Forum and has set up a Community First Responder group in his local area of Hastings. Brian has been very involved in helping develop the Trust's relationship with CFRs.

- Governor Development Committee member
- Membership Development Committee member
- Inclusion Hub Advisory Group member

Declared interests: None

Peter Gwilliam

(Second term of office 1 March 2016- 28 February 2019)

Peter worked for more than 20 years in the London Fire Brigade and currently volunteers with SECAmb as a Community First Responder. He is also a member of the Seaford Lifeguards.

Declared interests: None

Kent

James Crawley

(First term of office 1 March 2016 – 28 February 2019)

James is a Community First Responder for SECAmb in Sevenoaks, and he is also a Trustee of his local CFR scheme. James has previously served as an Officer in the Royal Navy and as a Special Sgt in the Metropolitan Police, he now works in Management Consultancy. Alongside volunteering for SECAmb James also volunteers for the British Red Cross as an Event First Aider Emergency Response and Trainer.

- Governor Development Committee Chair
- Nominations Committee member
- Membership Development Committee member
- Lead Governor

Declared interests: None

Dr Terry Collingwood

(First term of office 1 March 2017 - 23 January 2018)

Terry is a hospital-based doctor specialising in critical care. He resigned from his three-year term in January 2018 due to work commitments.

Declared interests: None

Roger Laxton

(First term of office 7 February 2018 – 29 February 2020)

Roger previously worked for SECAmb for 30 years and has extensive experience in the Trade Unions. Recently retired, Roger brings life skills in industrial relations which he hopes hold him in good stead for the role of Kent Governor. Roger is keen to see SECAmb return to being one of the most respected ambulance services in the country.

Declared interests: None

David Escudier

(First term of office 1 March 2017 - 29 February 2020)

David has worked alongside SECAmb for 20 years as an operational firefighter and more recently as a fire service co-responder and voluntary Community First Responder for SECAmb. He is currently a senior officer at Kent Fire and Rescue. David is also a Mind Blue Light Champion, which is where an employee or volunteer in the emergency services, takes action in the workplace to raise awareness of mental health problems.

Declared interests: None

Marguerite Beard-Gould

(Second term of office 1 March 2017 – 28 February 2020)

Marguerite has worked in the pharmaceutical sector for the past sixteen years, and while working in Canada, learned about the challenges faced bringing emergency responses to a large geographical area. She is a Parish Councillor in Walmer.

- Nominations Committee member
- Membership Development Committee member
- Governor Development Committee member
- Inclusion Hub Advisory Group member

Declared interests: None

Surrey

Mike Hill (Second term of office 1 March 2016 – 28 February 2019)

Mike's wife has been a patient of the Trust and they were part of a Trust Survivors event after she survived a heart attack in 2010. Mike brings varied experience from time in the RAF and senior management roles as well as this personal connection to the service.

- Chair of Membership Development Committee
- Governor Development Committee member
- Nominations Committee member

Declared interests: None

Dr Peter Beaumont

(First term of office 1 March 2016 – 13 March 2018)

Peter works as a Consultant in Critical Care Medicine and had to resign from his position as Governor in March 2018 due to work commitments. This position remains vacant and will be advertised in the 2019 elections.

Declared interests: Lead for patient transfers at South London Adult Critical Care Network.

Felicity Dennis (First term of office 1 March 2017 - 29 February 2020)

Felicity has lived and worked in Surrey for the past 30 years. She has worked in various parts of the NHS in Guilford, including the Royal Surrey County Hospital and Frimley Park Hospital. She has a particular interest in the implementation of new technologies in the National Health Service.

- Membership Development Committee member
- Governor Development Committee member
- Inclusion Hub Advisory Group member
- Patient Experience Group member

Declared interests: None

Gary Lavan

(First term of office 1 March 2017 - 29 February 2020)

Gary is a volunteer Community First Responder for SECAmb. He is a semi-retired professional, with senior management positions in the City over many years. His interest lies in how the strategic and operational goals of the Trust align with the needs of the Trust's staff and the public it serves.

- Patient Experience Group member

Declared interests: Gary's wife is a partner at Ernst and Young (auditors)

West Sussex

Geoff Lovell

(First term of office 1 March 2016 – 21 August 2018)

Living in Crawley, West Sussex, Geoff is passionate about the NHS and has experience in representative positions in the Trade Unions.

Geoff stood down from the Governor role in August 2017.

Declared interests: None

Reverend Francis Pole

(First term of office - 28 February 2019)

Francis has been a Chaplain for 25 years to the Police, and for 17 years with SECAmb. Chaplains are not staff members; all are volunteers. Francis is keen to champion the continued improvement of staff welfare and support at all levels throughout the Trust. Francis is in post for the remaining term of a previously-elected Governor who stood down from a position in West Sussex.

- Membership Development Committee member

Declared interests: None

Matt Alsbury-Morris

(First term of office 1 March 2017 - 28 February 2019)

Matt is a volunteer Community First Responder for SECAmb. He brings professional experience of working in blue chip organisations delivering transformation programmes and other voluntary work as a trustee.

Declared interests: None

Appointed Governors

Superintendent Diane Roskilly

(First term of office 17 September 2014 – 21 August 2017)

Superintendent Roskilly is the Trust's appointed governor from the police force. Di and Marian Trendell (see below) work with the Trust on providing services for patients with mental health needs. Di resigned from her Governor role in August 2017 due to commitments in a new role she had taken with the police. The Trust hopes to appoint another colleague to help continue and reinforce this partnership.

Declared interests: None

Michael Hewgill

(Second term of office 23 February 2015 – 22 February 2018)

Michael is the Programme Office Accountant at East Kent Hospitals University NHS Foundation Trust, one of the hospitals with which the Trust works closely in the region. Together with Dom Ford (see below) he brings the perspective of our acute hospital partners to the Council.

Declared interests: None

Dominic Ford

(First term of office 3 December 2014 – 21 August 2017)

Dominic Ford is Director of Corporate Affairs and Company Secretary at Brighton & Sussex University Hospitals. He resigned from his Governor position due to a new job in a different organisation.

Declared interests: None

Marian Trendell

(Third term of office 1 March 2017 – 28 February 2020)

Marian is the Head of Social Care for Specialist Service in Sussex Partnership NHS Foundation Trust; she has worked in a variety of roles in mental health, forensic services and safeguarding.

- Nominations Committee member

Declared interests: None

Graham Gibbens

(Second term of office 7 November 2016 – 6 November 2019)

Councillor Graham Gibbens is a Conservative Councillor on Kent County Council. Graham is the Cabinet Member for Adult Social Services and Public Health.

Declared interests: None

The Council has undertaken a number of statutory duties this year, which are outlined below.

The Council has held six formal meetings in public this year. The meetings were mainly held at the Trust Headquarters in Crawley, which is central to the patch and allows the best access for our members and the public, however our September meeting was held in Kent, prior to our Annual Members Meeting, which rotates around the patch. Council meetings are held on separate days from Board meetings, however many Governors attend the Board and Board members attend each Council meeting, including the Chief Executive.

The Trust has used interactive sessions between the Council and the Trust's Independent Non-Executive Directors (NEDs) this year to ensure communication and shared understanding between the Council and the NEDs, and to enable the Council of Governors to hold the NEDs to account for the performance of the Board of Directors. This year at least two NEDs were in attendance at each formal Council meeting and 'escalation reports' from Board Committees are presented by NEDs to alert Governors to any risk areas for the Trust.

The Council has a Membership Development Committee and a Governor Development Committee, and Governors also make up the majority of members of a Nominations Committee. Governors have also worked alongside the Trust's Audit Committee to appoint auditors in this financial year.

A summary of the function and activities of these Committees is outlined below.

Membership Development Committee (MDC)

The MDC is chaired by Mike Hill, Public Governor for Surrey. The MDC is open to all Governors to attend and membership fluctuates from meeting to meeting, with a core regular membership of around five Governors.

The remit of the Committee is to:

- Advise on and develop strategies for recruiting and retaining members to ensure Trust membership is made up of a good cross-section of the population
- Plan and deliver the Council's Annual Members Meeting
- Advise on and develop strategies for effective membership involvement and communications

The Committee met three times this year. Key areas of work have included: regular membership monitoring; planning and delivering the Trust's Annual Members Meeting and membership engagement 'Your Call' events in two counties; and advising on membership recruitment and engagement opportunities. You can read more about membership and public engagement in the Membership section of this report.

The MDC has worked to ensure that members' views and the views of the public are understood and communicated to the Board. Your Call meetings provided an opportunity for members, the public and our volunteers to meet Governors and Board members and directly share their views, as did our Annual Members Meeting, which was attended by over 100 stakeholders. Many Governors are plugged into their local communities including Patient Participation Groups and by attending Clinical Commissioning Group public meetings and feed back to the Chair and Non-Executives at Council meetings when relevant. Three members of the MDC are

permanent members of the Trust's Inclusion Hub Advisory Group, which is made up of FT members from across our patch. This enables them to hold interactive sessions with members to inform the views they feed back to Board members.

Nominations Committee (NomCom)

The NomCom is a Committee of the Board but the majority of members of the Committee are Governors. During the year, membership included one Appointed Governors, one Staff-Elected Governor and four Public Governors. The Senior Independent Director (Tim Howe, Non-Executive Director) and the Chair of the Trust are also members.

The remit of the Nominations Committee includes:

- To regularly review the structure, size and composition of Independent Non-Executive Director membership of the Board of Directors and make recommendations to the Council of Governors with regard to any changes;
- To be responsible for identifying and nominating, for the approval of the Council of Governors at a general meeting, candidates to fill non-executive director vacancies, including the Chair, as and when these arise;
- With the assistance of the Senior Independent Director, to make initial recommendations to the Council on the appropriate process for evaluating the Chair and to be involved in the Appraisal.
- To receive and consider advice on fair and appropriate remuneration and terms of office for Independent Non-Executive Directors.

The Committee has met formally on six occasions this year and has held additional meetings as necessary in order to undertake its statutory duty in recommending NED appointments, as outlined in the section on Statutory Duties below.

	Constituency/Role	13.04.17	06.07.17	12.10.17	23.11.17	30.11.17	08.02.18
Richard Foster	Chair	X	X	X	X	X	X
Tim Howe	Senior Independent Director and Non-Executive Director	X	X	X	X	X	X
Alison Stebbings	Staff – Non-Operational	X	X	X	X	X	X
Jean Gaston-Parry	Public – Brighton and Hove	X	X	X	X	X	X
Brian Rockell	Public – East Sussex (and Lead Governor)	X					
James Crawley	Public – Kent (and Lead Governor)		X	X	X	X	X
Mike Hill	Public - Surrey		X	X	-	X	X
Marguerite Beard-Gould	Public – Kent	X	X	X	X	X	X
Marian Trendell	Appointed	X	X	X	X	X	X

Key	
x	In attendance
-	Not in attendance
	Not in post

Governor Development Committee (GDC)

The GDC has met six times during the year. The GDC's membership fluctuates as all Governors are invited to attend, however there is a core regular membership of at least six Governors. The GDC is Chaired by the Lead Governor, and its remit is to:

- Advise on and develop strategies for ensuring Governors have the information and expertise needed to fulfil their role.
- Advise on and develop strategies for effective interaction between Governors and Trust staff.
- Propose agendas for Council meetings.

The GDC continues to regularly advise on the information, interaction and support needs of Governors, and has helped devise the annual Council effectiveness self-assessment survey.

Statutory Duties

Governors have undertaken a number of their statutory duties during the year, as set out below:

Appointment of three new Independent Non-Executive Directors

The Nominations Committee (NomCom) led a process to appoint a new Independent Non-Executive Director (NED) to the Trust with a clinical background. An extensive search and selection process, aided by Hunter Healthcare

recruitment agency, culminated in the appointment of Tricia McGregor by the Council on 30 November 2017 for a three-year term of office which commenced on 1 January 2018.

The NomCom also sought to appoint a NED with an organisational development background and followed a similar recruitment process. At its meeting of 29 January 2018, the Council appointed two NEDs with different types of organisational development experience, Adrian Twyning and Laurie McMahon, to three year terms of office, commencing 7 February 2018.

Reappointment of Non-Executive Directors

Tim Howe's second term of office came to an end on 28 September 2017 and, with advice from the Chair, the Council asked Tim to stay for an additional year as it was judged that he made an important contribution and maintained his independence. The Council met on 27 July 2017 to extend Tim's term of office for an additional year commencing 29 September 2017.

Al Rymer's first term of office ended on 31 August 2016. The Nominations Committee reviewed an appraisal of Al's performance from the Chair and considered that he maintained his independence, and recommended to the Council that Al be reappointed for a further three-year term of office. The Council met on 30 November 2017 and reappointed Al for a second term of office commencing 1 February 2018.

Appointment of an External Auditor to the Trust

A working group consisting of three Governors and two Independent Non-Executive Directors, was established, aided by the Trust's Audit Committee and senior finance and procurement staff, to undertake a procurement process to appoint external auditors to the Trust. The working group recommended the appointment of KPMG as the Trust's auditors to the Council at its meeting on 28 September 2017. The Council approved the appointment on a three-year contract.

Input to Annual Planning and Strategy Development

The Trust has worked with Governors to review and advise on its strategy and annual plans. Annual plans have revolved around achieving Care Quality Commission requirements, reviewing the Trust's governance and making improvements to the culture of the organisation. Interactive sessions involving Governors and NEDs and Governors and managers have been held to discuss priorities and plans.

Other Governor Engagement Activities

In addition, Governors have been involved in a number of Trust events over the year. These included opportunities to represent members' views and work alongside members on developing plans and strategies for the Trust.

Governors, working alongside public and staff FT members and other key stakeholders, helped to develop the Trust's Quality Account priorities for quality improvement in 2017/18 (see Quality Account).

Governors have continued to observe our frontline crews in action by spending time on our ambulances and in our Emergency Operations Centres, enabling Governors to understand more about the Trust's operation and meet and talk to our staff. Governors were also invited to attend our Awards ceremonies and received nominations in some categories.

Staff-Elected Governors have also undertaken specific work to understand their constituents' views using a number of methods, including by working as part of the Trust's Staff Engagement Forum (see the Membership section).

Appointments and Elections

There were no Governor elections held during the year. There were a number of changes to the Council, as follows:

Geoff Lovell, Public Governor for West Sussex, resigned from the Council on 21 August 2017. Rev Francis Pole, who received the next highest number of votes in the West Sussex constituency, was approached and we are pleased that he has taken on the remainder of Mr Lovell's role as a Governor until 28 February 2019. Dr Terry Collingwood, Public Governor for Kent resigned from the Council due to work commitments on 23 January 2018. His term of office was taken over by Roger Laxton until 28 February 2020. Dr Peter Beaumont, Public Governor for Surrey, resigned, also due to work commitments, on 13 March 2018. As elections are due to be held in this constituency within a year of his resignation, the post is being held open to fill in February 2019.

We thank Mr Lovell, Dr Collingwood and Dr Beaumont for their contributions and welcome Rev Pole and Mr Laxton to the Council.

Sincere thanks also to Dominic Ford, Appointed Governor from Brighton and Sussex University Hospitals, who moved on from his role and so stepped down as a Governor in August 2017.

Similarly, Chief Superintendent Di Roskilly left the Council on 29 September 2017 as she took on a new short-term role with the Police just prior to her retirement and felt she couldn't commit to the time that the Governor role required. We thank her for her input and commitment to the Council.

The Council has four Appointed Governor vacancies at year end: representing our University partners, the charitable sector, our 'blue light' emergency services partners and a fourth representing our acute hospital partners. Work is underway to fill these vacancies.

The table below sets out the terms of office, names and constituency of each Governor who has held office at any point in the last year. It also shows their attendance at public Council meetings, and their Committee membership.

		02.06.17	27.07.17	28.09.17 & AMM	30.11.17	29.01.18	29.03.18
Daren Mochrie	Chief Executive	x	x	x	-	x	x
Richard Foster	Chairman	x	x	x	-	x	x
Tim Howe	Independent Non-Executive Director	x	x	x	x	x	x
Al Rymer	Independent Non-Executive Director	-	-	x	x	-	-
Lucy Bloem	Independent Non-Executive Director	-	-	x	-	x	-
Terry Parkin	Independent Non-Executive Director	-	-	-	-	x	x
Graham Colbert	Independent Non-Executive Director	-	x	-	-	-	-
Tricia McGregor	Independent Non-Executive Director					-	x
Laurie McMahon	Independent Non-Executive Director						-
Adrian Twyning	Independent Non-Executive Director						x
Angela Smith	Independent Non-Executive Director			-	x	-	-
Jon Amos	Acting Director of Strategy & Business Development	-	-	-	x		
Steve Emerton	Director of Strategy & Business Development					-	-
David Hammond	Director of Finance & Corporate Services	-	-	-	x	-	-
Joe Garcia	Interim/Director of Operations	-	-	x	-	-	-
Fionna Moore	Medical Director	-	x	-	-	-	-
Steve Graham	Interim Director of HR & OD	-	-	-	-	-	
Ed Griffin	Director of HR & OD						-
Steve Lennox	Acting Chief Nurse/Director of Quality & Patient Safety	-	-	-	-	-	-

Key	
x	In attendance
-	Not in attendance
	Not in post

Improving our services and patient care

IBIS

SECAmb's Intelligence Based Information System (IBIS) has approximately 43,000 patients' care plans registered on the system. Across the South East region SECAmb work in collaboration with 48 partner organisations, 300 care teams, with over 1,300 health & social care professionals (including Community Nurses, Specialist Practitioners, Hospices, Mental Health Teams and Social Services) using IBIS to share patient care plans directly with SECAmb to support appropriate and tailored care in the event of a 999 call.

We also use IBIS internally within the Trust to hold certain patient records regarding frequent callers which are being supported by our Frequent Caller Team; Patient Specific Instructions for patients with complex care needs and electronic Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) documents. Our Safeguarding Team have access to IBIS to upload feedback received from Social Services, allowing information regarding vulnerable patients to be shared with attending SECAmb clinicians. Nationally, the Recommended Summary Plan for Emergency Care & Treatment (ReSPECT) tool is being implemented to support care for patients towards the end of life. Across the South East, SECAmb will receive ReSPECT documents into the Trust and upload onto IBIS, in-line with other patient records.

The average conveyance rate for patients with a care plan on IBIS is 36%. This is around 10-20% lower than the Trust's underlying managed conveyance rate. The South East population is around 4.5 million and therefore the 43,000 care plans make up almost 1% of the population. An increasing number of patients who access 999 help from SECAmb (approx. 6-8%) have a care plan available on IBIS. Having a care plan enables our clinicians to make better decisions for and with our patients because we understand more about their individual needs. IBIS also helps prevent inappropriate hospital admissions.

As part of preparations across the health and social care system for the new legislation aimed at protecting personal information, GDPR (General Data Protection Regulations), the IBIS Clinical Team have continued their work jointly with our partner organisations to continuously improving the quality of information stored on IBIS. We undertake regular audits to identify where improvements can be made in care plans and best practice guidelines developed to support community teams are well established.

We continue to encourage our operational clinicians who access patient care plans on IBIS to send feedback to the patient's care team to help further improve the quality of information being shared. By feeding back to the patients care team with specific gaps in information, the care plan can be rapidly updated, and be more effective should another 999 call be received for that patient. The development of the IBIS system that allows care plans to 'auto-retire' any patient record that has not been reviewed or updated within 12 months is now well established and ensures that the retaining of data is minimised. This has greatly improved the quality of patient records and patient safety. IBIS facilitates two-way communication between SECAmb and partner organisations. Over the last 12 months, the number of care plans on IBIS that have received a clinical review and closed with some clinical notes added (to update the patient's case manager for review and follow-up) continues to maintain around 90%.

During 2017 we developed IBIS to be accessed 'first party' by our clinicians on their Trust iPad tablet devices. Staff can now view and update a care record on IBIS by the patient's bedside, without needing to call a clinical colleague in the Emergency Operations Centre. Not only has this

improved timely access, the number of patient care plans being utilised by Trust clinicians has increased by five-times since development of IBIS on iPad.

Frequent Callers

Frequent callers are defined by the Frequent Caller National Network (FreCaNN) as a person

aged 18 or over who makes five or more emergency calls related to individual episodes of care in a month, or twelve or more emergency calls related to individual episodes of care in three months from a private dwelling.

Identifying and engaging with frequent callers to the emergency services is essential in order to support individuals who make multiple calls, and for whom 999 is not the most appropriate method of accessing healthcare. Our Frequent Caller Team work closely with patients' GPs and other health care professionals to get the patient the support they need, and this is turn can reduce the number of calls the patient makes. It also ensures that we can respond to these patients in a more focused way, often preventing the need to send an ambulance and providing care and advice over the telephone (hear & treat).

Our Frequent Caller system both informs and follows national best practice, and continues to have a positive impact on both the patient, who will no longer resort to relying on the ambulance service to address their unmet healthcare needs, and on the wider community by releasing ambulances to respond to more appropriate emergency calls.

Patients are identified using a unique database that draws data direct from the Trusts computer aided dispatch system to identify patients who meet the national criteria. The Frequent Caller Team review and process the information to ensure that the patients identified are managed based on their individual needs and profile – rather than simply the highest number of calls.

The frequent caller team also work to ensure that the patient is a frequent caller, rather than a 'repeat caller', which is a patient who has a sudden, unresolved health problem and makes multiple calls in a short period of time. Once these safety checks are completed, the patient is logged as a frequent caller and a letter is sent to their GP and also to the patient, encouraging them to engage with each other. These "stage one" letters have been developed in collaboration with patient and public involvement (PPI) representatives to ensure the letters are written in plain English and are appropriate in tone.

All frequent callers' cases are reviewed after four weeks. Where they continue to make a high number of 999 calls a local paramedic and/or team leader will visit the patient at home to undertake a 'stage 2' review. This review is aimed at establishing why the patient is making frequent calls and to ensure any unmet health or social care needs are identified. After the visit to the patient, the paramedic will compile a report and refer the patient to other agencies as appropriate. If another four weeks elapses and the patient continues to make regular 999 calls, stage 3 of the process is instigated.

Stage 3 is usually a multidisciplinary team (MDT) review where a range of professionals will work together to identify wider issues and a care plan: this might include Social Workers, Community Matrons, Falls Teams, Occupational Therapists and the patient's GP. If stage 3 is not successful, the process moves on to stage 4. This involves the patient's case being presented to the trust senior clinical leadership team for review. Sadly, some patients who reach stage 4 of the process do not have a clinical need, and their caller behaviour may be deemed vexatious. In these cases, and in order to minimise the number of calls received which in turn impact on our population who may be waiting for a response, we may need to take

legal action. This is very much a last resort, and only occurs once or twice per year on average.

There is also excellent progress being made with the Trust's "top ten" frequent callers. All four stages of the frequent caller process have now been used. Aside from the obvious benefits to our patients who have their needs identified and can be supported in the right way, the programme also improves the effectiveness and efficiency of our call takers and crews, who would otherwise be engaged responding to frequent callers. There are also financial savings, a single hospital admission costs on average £1,200 with an average conveyance cost to the Trust equating to a loss of - £65.00.

End of Life Care

End of life care (EOLC) continues to be a priority area for SECAmb and the ambulance sector across the UK. The Trust is actively involved with the EOLC agenda nationally and our EOLC Lead was central to the formation of the group which now sits within the AACE national group structure. The Trust can make a big difference to patient care by improving our response to patients at the end of their life, ensuring that we uphold their wishes, where these are known.

Our EOLC lead continues to provide support and training to staff to assist them in providing the best EOLC possible to our patients. This year, the EOLC Lead has completed a Darzi Fellowship in End of Life Care which has further strengthened our approach in the Trust as the wider health system. The SECAmb education package for staff has been rolled out to all staff, and has also been adopted by two other Trusts in the UK. The ongoing focus on EOLC continues, and includes making sure SECAmb is ready to access the new RESPECT tool being rolled out to health providers in the UK.

Incident Reporting

Serious Incidents

The number of Serious Incidents (SIs) reported in the year has increased to 103 from 54 in the previous year. The Serious Incident Group meets weekly to review all potential SIs identified through our Incident Reporting Software, Complaints received and from external concerns raised.

The Trust has implemented an improvement plan that includes SIs to ensure that there are robust systems and processes in place to enable us to investigate appropriately and that learning from these incidents is identified in an effective way to reduce future harm to patients.

The initial focus for the year was to decrease the backlog of SIs that were breaching the submission deadlines and good progress was made, reducing the backlog to four at the end of the financial year.

During the year, we have strictly implemented the requirement to ensure that all staff are trained in systems investigation (Root Cause Analysis) when they undertake an SI investigation. We have invested in training over 100 key staff in this method of investigation. We are implementing a robust process of sign off and evaluation of the final reports, ensuring that the quality of the investigations is monitored and identifying where there are areas for improvement.

New tools and templates are about to be launched across the organisation which will further assist in embedding appropriate investigation methodology. A new grade of incidents requiring an internal root cause analysis has been introduced for next year.

A new process has been implemented to ensure that the Trust is compliant with our Duty of Candour requirements. We have improved our compliance rate for serious incidents to 90 – 100% in the latter part of the year by introducing this. All other incidents of moderate harm and above that do not reach the threshold for a SI investigation

are currently being identified and reviewed in the weekly Serious Incident Group and Duty of Candour requirements will be monitored. The compliance rate for these incidents is currently lower as this process is still in its infancy.

To enable reporting trends, the Trust measures the Reporting Reason for Serious Incidents (SIs) rather than using the StEIS categories. This allows the Trust an improved picture of the causes of our Serious Incidents. StEIS categories (categories used for reporting by all NHS Trusts to enable comparison) in the SI Framework do not reflect ambulance service activity well. The following information has been collated from our SI management database and our incident reporting system (Datix).

Reporting Reason	Total
Delayed Dispatch / Attendance	43
Triage / Call management	15
Call Answer Delay	10
Treatment / Care	9
Child-related / Unexpected Child Death	6
Information Governance Breach	4
Non-Conveyance / Condition deteriorated	4
Other (Please state)*	4
Power / Systems failure	4
Patient / Third Party Injury	3
Delayed Back-up	2
OOH/111/GP Concerns	2
Staff Conduct	2
RTC/RTA	1

*Policies and procedures x 2; Equipment failure (vehicle); Vehicle fire

[Please note that an SI may have more than one reporting reason]

The focus for the coming year is to increase the quality of report writing to increase closure rates on first submission. We will ensure that appropriate monitoring processes for actions identified in investigations are in place and learning becomes embedded.

Infection Prevention and Control

Patient safety remains a top priority for the Trust and IPC is integral to maintaining this. The Trust has shown its commitment to IPC through the systems and processes implemented during 2017/18. The key achievements over the year include embedding IPC standards firmly from the Board to the Frontline – this has been achieved through a comprehensive communication plan, continued IPC education for all staff and joint working between IPC and Operational staff.

Effective infection prevention and control practice requires ownership at every level – from Board to Frontline. Success depends on creating a managed environment that minimises the risk of infection to patients, staff and the public and ensures compliance with relevant national and local standards, guidance and policies. A sustained approach to IPC can be achieved through personal accountability, skilled and competent staff, transparent and integrated working practices and clear management processes.

The Trust's Infection Prevention and Control Sub-Group (IPCSG) provides a forum for the co-ordination of any IPC related projects ensuring a consistent approach to IPC throughout the Trust. During 2017/18 the group met quarterly for the first three quarters of the year and then monthly for the last quarter to help support work on the IPC Improvement Plan. The IPCSG is responsible for providing assurance to the Clinical Practice Group (CPG) and upwards to the Quality and Patient Safety Committee (a sub-committee of the Board). It monitors compliance with the Health and Social Care Act 2008 via updates from all areas within SECAmb relating to the IPC audits for vehicles, premises and observed practice, and IPC training compliance is provided at each meeting.

This year we delivered Level 2 IPC training for all clinical staff and this was completed by way of a workbook with assessment paper up until September 2017. The workbook content was then transfer onto the new DICSOVER platform with additional hyperlinks, photos and animation added to enhance the learning for staff.

The IPC Team has produced audit tools to monitor both environmental cleanliness as well as compliance with IPC standards. The environmental audit tool has been developed in collaboration with the Estates Team and the contractors providing the service. These audits are completed on a monthly basis by the local management team or the IPC Champion and non-compliances identified with appropriate remedial actions generated.

The IPC team has developed its audit tools in line with guidance from the Department of Health and Public Health England. There are six different audit tools:

- Hand Hygiene Observed Practice
- Bare Below the Elbows Observed Practice
- Aseptic Non Touch Techniques Observed Practice
- A&E vehicle cleanliness
- Environmental cleanliness
- IPC Station compliance

In quarter two, the IPCT reviewed all of the audit tools used and have made changes to them in order to implement some of the learning outcomes that came out of the CQC inspection and Improvement Plan. A new weekly / monthly tracker / dashboard for audit completion and compliance was introduced and is now available on the Trust's iPads.

The schedule for audits has also been reviewed and in December 2017, the requirement for ten Hand Hygiene / Bare Below the Elbow audits per month was changed to te per week. IPC Champions and Operational Team Leaders are tasked with completing these audits and a new audit schedule was introduced in quarter four.

This year's flu vaccination programme once again improved on last year's compliance rate with 69.3% of frontline employees having the jab.

Safeguarding

Safeguarding is about protecting children, young people and adults at risk of harm. As part of a wider commitment by all health organisations to safeguard and promote the welfare of patients, the Trust encourages and supports staff to identify adults and children at risk in the community, who may be suffering harm from abuse or have unmet care needs.

The Safeguarding Department forms part of the Nursing & Quality Directorate and during 2017/18, the work of the team has been extremely focussed following recent CQC inspections. During the year, work has been undertaken to re-structure the team and increase the overall capacity.

The department has seen an increase in referral activity of 8% during the year, with a total of 11,272 referrals made. Every referral into the Department is scrutinised by the team and forwarded to the relevant social care team for either adults or children, where it is appropriate to do so.

The team has also seen an increase in other areas of activity, including acting as a point of contact for internal and external stakeholders and collating information pertaining to child deaths, including offering signposting to support services where needed.

Trust staff undertook a number of safeguarding-related training programmes during 2017/18. Support staff completed Level 2 child and adult e-learning, patient-facing frontline staff completed an e-learning course for the Mental Capacity Act and all paramedic staff were required to complete Level 3 safeguarding child training. The Trust also delivered face to face Level 3 child and adult training to operational managers and clinically-registered staff working in the Emergency Operations Centres and NHS 111.

It was agreed with the CCG that the Trust target for completion of safeguarding-related training would be 85% - the Trust exceeded this target reaching an overall complicate level of 98.04% at Level 3.

Care Quality Commission (CQC)

As reported in the Key Risks and Issues section within the Performance Report, in May 2017 the CQC carried out a comprehensive inspection of the Trust's services and identified a number of issues leading to an overall rating of Inadequate as illustrated below:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency & urgent care	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate
Emergency Operations Centre (EOC)	Inadequate	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
NHS 111 service	Good	Good	Good	Good	Outstanding	Good
Overall	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate

The CQC reported its full findings in September 2017 and recommended that NHS Improvement continue to place the Trust in Special Measures, which they agreed to do.

In their report, the CQC raised significant concerns around a number of areas, predominantly in the 'safety' domain including:

- Safeguarding
- Complaints
- Risk & Incident management
- Medicines Management
- 999 Call Recording
- EOC staffing

And in the 'well-led' domain including:

- Gaps relating to accountabilities within the Executive Team
- A number of interim post-holders on the Board
- Risk management processes not able to identify and escalate risks to the Board
- Bullying and harassment culture

In response, the Trust developed a detailed action plan to respond to the findings of the CQC, with eleven specific work-streams created, each supported by the Programme Management Office (PMO) and assigned a Project Lead and an Executive Lead.

Working with staff, we clearly set out what we were looking to achieve in each of the eleven areas:

The eleven key areas and what success will look like:

1. Incident Management

We will be able to identify all incidents on a single system and complete robust investigations to a good standard and within appropriate timescales. This will enable learning to be shared, ultimately improving patient safety.

2. Safeguarding

We will ensure that we have a robust safeguarding culture, embedded throughout the organisation, that ensures the safety of our patients and our staff. We will ensure that all staff are trained to the right level and a process is in place to ensure it remains this way.

3. Risk Management

We will be able to identify all risks onto a single system, which will function efficiently and will allow effective management of risks at all levels and learning. We will have the capability to ensure that those risks are mitigated where possible and that there is appropriate governance and scrutiny.

4. Clinical Records & Clinical Audit

We will ensure that all patient records are completed accurately and are fit for purpose, kept confidential and stored securely. We will have adequate resources available to undertake regular audits and robust monitoring of the services provided.

5. Staff Engagement

We will engage better with our staff by recruiting local staff champions, increasing the visibility of the Executive Team and by making better use of the Staff Survey results to drive local improvements.

6. Complaints

We will deal with complaints in a timely manner, to the satisfaction of the complainant, by utilising robust systems to manage, investigate, respond and learn from complaints.

7. Emergency Operations Centre (EOC)

We will ensure that there are sufficient numbers of clinicians working in our EOCs and that all staff follow new and up to date Operating Procedures. We will ensure that patients receive a consistent service, regardless of where or when their call is answered.

8. Performance Targets & Ambulance Quality Indicators (AQIs)

Through working with our local NHS partners, we will ensure we have the right resources in place to allow us to provide the most responsive service possible to our patients with improved clinical outcomes.

9. Medicines Management

We will store and utilise our medicines safely and securely, ensuring our staff are responsible for their own professional practice and ensuring we deliver safe care to our patients.

10. 999 Call Recording

The voice recording system will record all 999 calls and there will no longer be any instances where calls are missing from the system or not accessible by staff when needed.

11. Infection Prevention and Control (IPC)

We will embed IPC into every day practice and improving standards of environmental cleanliness, hand hygiene and uniform compliance. We will ensure our vehicles are clean therefore reducing the risk of infection to patients.

Delivery of improvements in each area was incorporated into the Trust's Delivery Plan. Monitoring of progress in each area was and continues to be closely monitored by the Executive Team and remains a key focus for the Trust during 2018/19.

Listening to patients and improving their experience

SECAmb has always been keen to listen to and learn from patients' experiences of our services, be they good or bad.

Complaints

The Trust's website contains information for patients on how to raise a complaint directly with the Patient Experience Team.

On receipt, the Trust's complaints are graded according to their apparent seriousness using a 'grading guide'; this is in order to help ensure that all complaints are investigated proportionately:

Level 1 complaints are simple concerns that can be resolved by the Patient Experience Team themselves, increasing in seriousness to level 4, which is the most serious and where the complaint has also been deemed to be a Serious Incident.

The majority of complaints received by the Trust are graded as level 2 and these are complaints that do not appear to be serious but do still require investigation by local operational managers to enable the Patient Experience Team to respond to them.

Level 3 and 4 complaints, i.e. complaints that are of a serious or complex nature, are responded to by the Chief Executive, with less complex complaints being managed to completion by the Patient Experience Team.

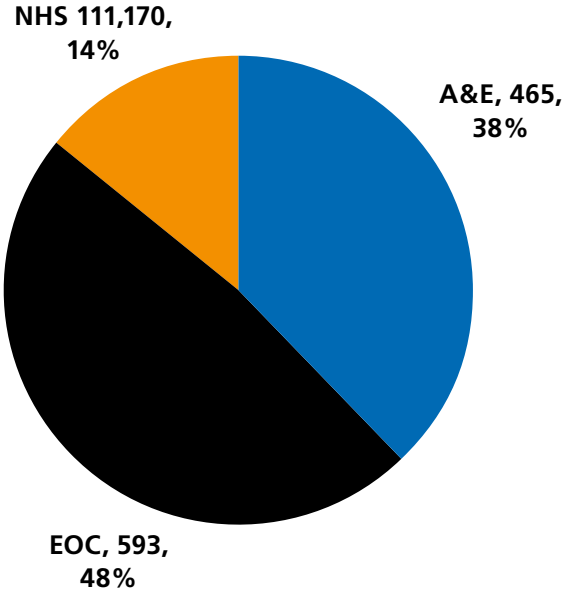
When a complaint is concluded, the investigating manager, with input from the Patient Experience Team where necessary, assesses whether the complaint should be upheld, partly upheld, not upheld or in some cases, unproven, based on the findings of their investigation.

Any complainant who is not satisfied with the outcome of a formal investigation into their complaint may take their concerns to the Parliamentary and Health Service Ombudsman for review. When the Ombudsman's office receives a complaint, they often contact the Patient Experience Team to establish whether there is anything further the Trust feels it could do to resolve the issues. If we believe there is, the Ombudsman will pass the complaint back to the Trust for further work.

In 2017/18, we were notified by the Ombudsman of 13 cases they wished to have more information about and/or investigate. Of these, two were partially upheld, two were not upheld and the remainder are still open.

During 2017/18, the Trust received 1,228 complaints – this is a slight reduction on the 1,262 complaints received during 2016/17. Of those complaints concluded at the time of writing, 70% were found to be upheld or partly upheld.

The break-down of complaints by operational area of the Trust is as below:



There has been a year on year reduction in complaints about NHS 111 and a significant decrease this year in the number of complaints about our A&E service.

However, there has been a disproportionate increase in EOC complaints, the majority of which are about delayed ambulance response and back-up.

The Trust's complaints response target is 25 working days. During 2017/18, approximately 61% of all complaints were responded to within the Trust's timescale, compared to 63% in 2016/17.

However, every week since the beginning of February, in excess of 91% of complaints have been concluded within timescale, with 98.2% and 97.7% concluded within timescale in February and March respectively and will be looking for this improvement to continue during 2018/19.

The Trust has significantly improved its approach and processes to identifying themes and learning from complaints, with further improvements to be made during 2018/19.

The main themes of complaints about the Trust's main field operations service are staff conduct (this includes conduct as well as driving) and patient care. As noted above, the main theme of complaints related to EOC is the timeliness of the response.

Depending on the nature of the complaints, a number of actions may be taken to mitigate against a recurrence of the complaint; these may include:

- Discussion of the complaint and its impact on both the complainant and the Trust's reputation
- Undertaking a reflective practice, where the member of staff reflects on the incident and produces a piece of written work to demonstrate their understanding of the impact of their actions and details how they will better handle such situations in future
- Taking part in a peer review, where the staff and some of their colleagues meet with their manager and/or the Learning and Development team to discuss the scenario and how it was handled, and what might have been done to avoid a negative outcome
- Attendance at an in-house customer care session, provided by the Learning and Development team
- Re-training and monitoring in the case of driving complaints.

In 2017/18, as in 2015/16, the mandatory two-day Key Skills course for field operations staff also included a Patient Experience session, which was developed by Learning and Development and the Head of Patient Experience. This was very well received and a further Patient Experience session will be planned for 2019/20.

Feedback from the NHS Choices and Patient Opinion website

NHS Choices can also be used by patients to leave feedback and this is monitored by the Patient Experience Team. At the end of 2017/18, there were 23 comments on NHS Choices giving the Trust a satisfaction rating of 4.5 stars. All postings had been responded to.

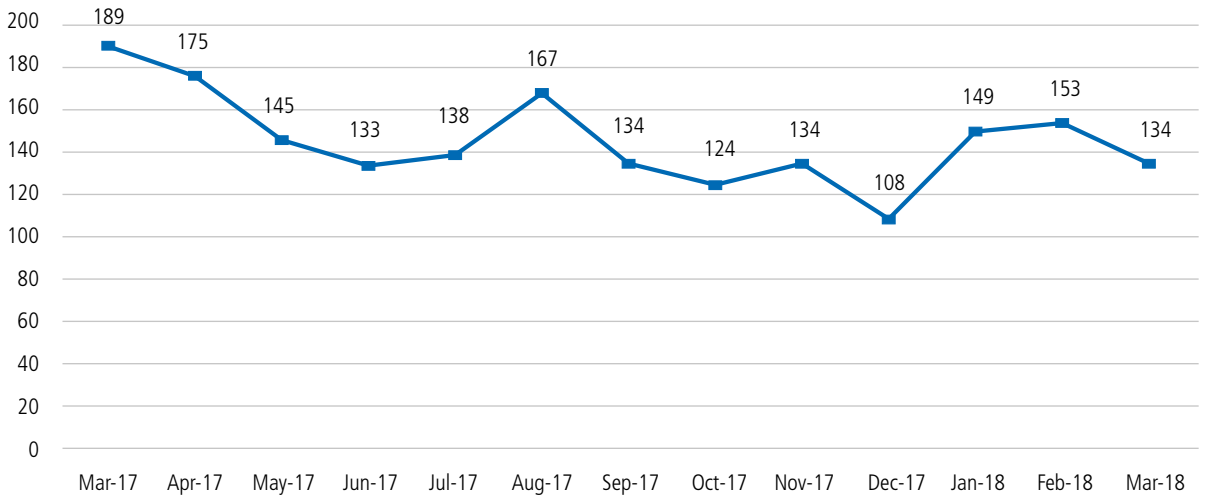
Compliments

The Trust also receives a high number of compliments (letters, calls, cards and emails) from patients and their families, thanking our staff for the work they do.

During 2017/18 the Trust received 1,688 compliments thanking our staff for the treatment and care they provide. This is a reduction against the 2,350 received in 2016/17. Overall the compliments we receive do provide a welcome boost for the staff.

The staff concerned receive a letter from the Chief Executive, thanking them for their dedication and for the care they provide to our patients.

The table below shows the number of compliments received during the year:



Sustainability and Transformation Partnerships (STPs)

SECAmb works with and relates to four STPs as follows:

- Kent and Medway
- Sussex and East Surrey
- Frimley Health
- Surrey Heartlands

They each have shared key drivers as follows:

- Financial sustainability
- Increased demand and complexity of need exceeding capacity
- Growth of population especially for those age over 65 years
- Lack of integrated care pathways and delivery
- Acute capacity demands in physical and mental health
- Unsustainable workforce
- Lack of progress in digital roadmap
- Improvements needed in urgent and emergency care

The Trust has been, and continues to work with each STP as a key partner on the common themes as follows:

Development of Consistent Core Services	Prevention / Health and Well being Primary Care Out of Hospital Care / Local Care Acute Care Urgent and Emergency Care Mental Health / parity of esteem
Enablers	Financial sustainability Digital footprint Workforce Estates

For our three main STPs, we are key members of the partnership boards and key fora within the governance of each STP covering the above key areas. We aim to develop this with Frimley Health also as we move forward.

The Trust work with STPs is focused on the following areas:

Acute reconfiguration – each STP is, or will be in the future, undertaking reconfiguration of varying elements of acute, urgent and emergency care. Although it is not yet clear what this will look like it is likely to include reconfiguration of key clinical services. SECAmb know from past experience, for example changes in locations of PPCI, Maternity, and Stroke, Paediatrics, General Surgery, Orthopaedics and Trauma care, that this will have a significant impact on the Trust operating model. The Trust is working with partners to ensure this is modelled into STP plans.

Urgent and Emergency Care – The Trust is engaged in this work for each area via the Urgent and Emergency care networks, and are modelling in changes as they develop.

Primary Care, Community Services and Clinical Hubs – a variety of locality models for better alignment of primary and community care are being proposed. The aim is to group all out of hospital services into single cohesive teams wrapped around groups of GP practices. The local teams known as communities of practice or similar titles vary in number by area. The development of local services is key to how the trust works with partners to deploy pathways for patients that avoid inappropriate conveyance to A&E.

The Trust is considering the balance of local and regional aspects of service delivery, the limitations regarding the volume of available workforce and where they need to be focused. SECAmb have been discussing with the system the potential risk of other organisations directly recruiting paramedics as this will further strain the available workforce and may cause clinical governance risks. As systems we are working to seek collaborative solutions rather than taking staff from each other.

Co-responding with Fire & Police

During the past year, the Trust has continued to participate in and build on collaborative opportunities with our 'blue light' partners. The Trust now sits as a partner on Collaborative Boards in Sussex and Kent; these Boards seek to identify new ways of collaborating in order to improve patient/ public experience and to improve efficiencies.

Co-responding training across the region with colleagues from Fire & Rescue Services has continued and whilst there has been a decline in responding in Surrey and West Sussex, due to an on-going industrial relations issue, in Kent the scheme has extended, to now include many retained Fire Stations. This is of benefit as these stations are often located in harder to reach, rural areas.

Joint initiatives that have been developed during the year include SECAmb calling the Fire and Rescue Service for assistance in gaining access to patients, rather than Police colleagues. This results in a faster response and significantly less damage to a patient's property when gaining entry.

A Joint Response Unit (JRU) pilot was also established in one Operating Unit in North Kent, becoming operational on 2 March 2018. This sees two Special Constables and a Paramedic working together on weekend evenings and Bank Holidays, providing a response to certain 999 calls where both a police and ambulance response is required.

In its first month of operation, the JRU attended more than 50 incidents and transported or escorted patients to hospital on 14 occasions. The Pilot will be formally evaluated after three months' operations, to look at effectiveness and, if successful, how it may be expanded.

Working with our local stakeholders

During what has been, at times, a challenging year, the Trust has worked hard to proactively maintain effective working relationships with our local stakeholders, including Members of Parliament (MPs), Health Scrutiny Committees and Police & Fire colleagues.

All local stakeholders receive regular up-dates from the Trust on key issues and developments.

The Trust is served by 44 MPs in our region, including representation from all four main political parties. Amongst local MPs are the current Secretary of State for Health, the Right Honourable Jeremy Hunt MP (Surrey South West) and the Chancellor of the Exchequer, the Right Honourable Philip Hammond MP (Runnymede & Weybridge).

The Trust's regional MPs receive detailed briefings on key issues and also often engage with the Chief Executive and Chair, face to face or via letter, on specific local or regional issues. During the year, the Chief Executive has had individual introductory sessions with many MPs and will continue to proactively engage with them during the coming year.

Within our area, the Trust is accountable to the following six Scrutiny Committees, covering the local government areas within our region:

- West Sussex
- Brighton & Hove
- East Sussex
- Kent
- Surrey
- Medway

During the year, the Trust has provided written up-dates as requested by Committee members and also appeared in person before each Committee to provide up-dates on key issues, including the CQC inspection and introduction of the new ARP performance standards.

The Trust also works closely at an operational level with four Police Forces (Kent, Surrey, Sussex & Hampshire) and five Fire and Rescue Services (Kent, Surrey, West Sussex, East Sussex & Hampshire). During the year, the Chief Executive has met with all the Chief Constables and Chief Fire Officers to discuss operational issues and opportunities for closer working. He has also had meetings with the Police Commissioners in the region.

Public and Patient involvement activities

Valuing difference

2017/18 has seen sustained progress in embedding equality, diversity and inclusion into core SECAmb business activity. We are particularly proud to have been awarded the Gold Standard Award for Equality at the Employers Network for Equality and Inclusion for the fourth year running.

SECAmb was an early adopter of the NHS Equality Delivery Scheme (EDS) introduced in 2012, prior to it becoming mandatory for all Trusts in April 2015. A full grading review of the EDS which involved our stakeholders was undertaken in March 2015 and follow up reviews have been undertaken annually in March. The 2018 review saw the recommendation that we continue to focus our energy on the single equality objective adopted in 2017, to continue improving representation within our workforce at all levels.

SECAmb published benchmarking data to fully comply with the requirements of the Workforce Race Equality Standard (WRES), mandatory for NHS organisations. Progress against the nine metrics is delivered via a comprehensive action plan, refreshed annually to ensure we continue to deliver meaningful improvements. In March 2018, a workshop facilitated by the Director of WRES Implementation NHS England was attended by members of the Board, Senior Managers and members of our Cultural Diversity network to embed accountability for continued progress against the metrics going forward.

The Trust has an Inclusion Working Group (IWG), comprising senior staff responsible for ensuring we meet our duties and responsibilities under the Equality Act 2010, Equality, Diversity & Human Rights legislation and codes of practice including NHS, Department of Health, and Equality and Human Rights Commission standards. Other members include representatives from our Inclusion Hub Advisory Group and staff networks. The group promotes, recognises and values the diverse nature of our communities, stakeholders and staff and in doing so, works to eliminate discrimination and make best efforts to provide equality of access to ensure the Trust meets the needs of patients and its staff.

The IWG is the mechanism for ensuring staff are made aware of their obligations and are provided with the necessary information and support to deliver on their areas of responsibility. It is responsible for providing assurance and governance to demonstrate that the organisation is meeting its duties and requirements on Equality and Diversity.

We are fully committed to meeting the General Equality Duty placed on all public bodies which states that public bodies must: "in the exercise of their functions, have due regard to the need to:

- Eliminate unlawful discrimination, harassment or victimisation and other conduct prohibited by the Act;
- Advance equality of opportunity between people who share a protected characteristic and those who do not;
- Foster good relations between people who share a protected characteristic and those who do not;

In addition, we have to comply with the following specific duties:

- Publish sufficient evidence to demonstrate compliance with the general duty
- Prepare and publish equality objectives

Further information regarding the above, our progress, plans and reports are available on our website on the pages accessible via the following link: http://www.secamb.nhs.uk/about_us/equality_and_human_rights.aspx

Alternatively, please contact Angela Rayner, Head of Inclusion & Wellbeing by email: angela.rayner@secamb.nhs.uk or Tel: 01737 364428,SMS/text: 07771 958085,

Inclusion

It is of paramount importance to SECAmb that we provide equitable and inclusive services to all patients and their carers, meeting and where possible, exceeding NHS requirements. We are committed to complying with equal opportunities legislation, equality duties and associated codes of practice for our staff. We aim to promote a culture that recognises respects and values diversity between individuals, and uses these differences to benefit the organisation and deliver a high quality service to all members of our community.

In 2011 we embarked on a process to introduce a new Inclusion Strategy to embed accountability for effective and timely involvement and engagement in the Trust's planning, service development and patient experience work. This was reviewed and refreshed in May 2016 and provides an effective approach, enabling our stakeholders to participate in ways that are right for them. It has enabled us to act on what we hear and feedback on what has changed as a result. If we are unable to act on what we hear we tell people why. As recommended in our original Inclusion Strategy we set up an Inclusion Hub Advisory Group (IHAG) who advise the Trust on effective engagement and involvement relevant to service design during both development and delivery of our services.

Working with a diverse membership in the IHAG provides us with insight at the start of our planning, and throughout development where relevant, which helps us get more things right, first time, more often. The IHAG is also able to raise issues with us and representatives from it sit on the Trust's Inclusion Working Group alongside senior managers, so that the IHAG's advice can be effectively incorporated into Trust activities. An early recommendation from the IHAG has led to the establishment of a virtual Equality Analysis (EA) Reference Group which provides staff with the ability to seek advice and guidance from a very diverse group of our members (patients and public) to ensure that we never knowingly discriminate or disadvantage any particular group. The EA reference group enables us to engage groups that we may otherwise struggle to involve, such as those who are housebound, carers etc.

Key achievements of the IHAG during 2017/18 include

- IHAG proposed a joint event with Governors in relation to the impact of Ambulance Response Programme. As part of this, their views informed the 999 messaging script and voicemail
- Involved in developing key messages for inclusion in the development of Trust five-year Strategy. Their feedback and involvement resulted in clear, inclusive messaging
- Participated in Quality Assurance Visits, carrying out inspections across the Trust, identifying good practice and gaps for improvement
- Involvement in the development of patient communications for the Frequent Callers process, in particular the drafting of patient communications
- Participated in a number of SECAmb working groups and sub groups and reported back on the outcomes e.g. History Marking sub group, Medicines Management Group, Patient Experience Group and Inclusion Working Group and going forward will also participate in Serious Incident deep dive sessions
- Participation at the Trust 2017 Quality Account meeting to assist in objective setting for the upcoming year. IHAG participants strongly recommended a review of the process to enable a more inclusive approach to determining future priorities
- Participated in focus groups during the process to recruit the substantive Executive Team and new Non – Executive Directors, ensuring the public/patient perspective were considered
- Defined the process for reviewing Trust Equality Objectives and took part in the review and adoption process of new Objectives.

In addition to the above, SECAmb continues to be committed to working collaboratively wherever possible. Both the Trust's Patient Experience Group and its Inclusion Hub Advisory Group include Healthwatch representatives in their membership, who have responsibility to actively engage with the community and encourage local people to share their opinions on the health and social care services that are available in their areas. Jointly we work together to ensure that mechanisms are in place to share information and respond to enquiries in an effective and timely way for the benefit of our population.

Our Members

SECAmb has a total membership of 13,118 people as of 31 March 2018. We have 9,769 public members and 3,349 staff members. Our public membership decreased by 582 over the year as only a small amount of member recruitment was undertaken due to a focus on engagement events for existing members. There was also the normal volume of members who moved out of the area or passed away.

Membership Eligibility

Public Constituency

Members of the public aged 16 and over are eligible to become public members of the Trust if they live in the area where SECAmb works. The public constituency is split into six areas by postcode and members are allocated a constituency area when they join depending on where they live. Members of the public can find out more or become a member by visiting our website:

http://www.secamb.nhs.uk/get_involved/membership_zone.aspx

Staff Constituency

Any SECAmb staff member with a 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 as per the constitution and advised how they can opt out if they wish.

Membership Breakdown

Public membership report

Index key:

Under-represented

Over-represented

Public constituency	Number of members	Population	Index
Age (years):			
0-16	18	978,542	**1**
17-21	127	278,82	**21**
22+	5,395	3,650,868	**69**
Ethnicity:			
White	8,684	4,302,671	**89**
Mixed	81	84,387	**42**
Asian	225	185,685	**53**
Black	102	51,929	**87**
Other	7	27,155	**13**
Socio-economic groupings*:			
AB	3,954	366,673	**105**
C1	3,878	459,537	**88**
C2	1,348	287,147	**100**
DE	1,107	275, 976	**108**
Gender analysis:			
Male	3,361	2,408,861	**66**
Female	4,835	2,499,373	**91**

* Classification of Household Reference Persons aged 16 to 64 by approximated social grade.

We monitor our representation in terms of disability, sexual orientation, and transgender although this is not required by our regulator.

The data of this report excludes:

- 4,996 public members with no dates of birth
- 1,430 members with no stated ethnicity
- 2254 members with no stated gender

We only have age data for a proportion of our public members, as the Trust did not begin to ask for members' dates of birth until late in 2010.

Membership Strategy, Engagement and Recruitment

Our membership strategy focuses on meaningful, quality engagement with a representative group of our members and regular, informative educational and health-related communication with all of our members. All members are invited to the Trust's Annual Members Meeting, which is reviewed below in more detail. The membership strategy is incorporated into the Trust's Inclusion Strategy, which aims to ensure staff, patients and the public (members and non-members) are involved and engaged appropriately in the Trust.

Membership engagement under the Inclusion Strategy is reported to the Board via the Inclusion Working Group and to the Council of Governors via the Council's Membership Development Committee. Governors are part of and can access the Inclusion Hub Advisory Group of public members and the Staff Engagement Forum (formally known as the Foundation Council) of staff members when they wish to discuss issues or hear views. Staff Governors are permanent members of the Staff Engagement Forum in order to regularly canvas the views of staff from across the Trust.

The Membership Development Committee has discussed and reviewed our strategies for membership recruitment and engagement during the year. Our public membership now represents 0.21% of the population. Although this percentage is low, our members provide a rich source of information and support to the Trust.

Constituency	Members	Population	Percentage of eligible population
Brighton & Hove	510	290,243	0.17%
East Sussex	17003	552,518	0.30%
Kent	3036	1,552,827	0.19%
Medway	642	282,059	0.22%
Surrey	2297	1,379,777	0.16%
West Sussex	1587	850,810	0.18%
Total	**10,536**	**4,908,234**	**0.21%**

The Trust has continued to focus on both staff and public FT member engagement and communications over the year. The Staff Engagement Forum consists of a group of staff engagement champions from across the Trust, and provides our Staff-Elected Governors with a forum in which to share information about the work of the Council of Governors and hear the views of their constituents. This two-way conversation goes some way to enable the Staff-Elected Governors to represent the interests of staff on the Council, and also provides a forum for the Trust to communicate and engage with staff on plans, priorities and issues, and for staff members to raise issues with the Trust but also to share areas of good practice more widely with colleagues.

During this year, the Staff Engagement Forum has, on behalf of the wider staff membership:

Reviewed the terms of reference for the forum including its purpose and membership. The SEF discussed how the new operational staff engagement champions could be brought into the SEF alongside existing members to ensure a joined-up approach and effective representation when discussing Trust-wide issues with a view to Trust-wide solutions.

- Discussed the importance of clear actions from the Trust in the follow-up to Professor Lewis' bullying and harassment report and made recommendations to the Trust in that regard.
- Fed back on staff perceptions and awareness of the Trust's five-year strategy and how it could be effectively promoted to staff.
- The SEF received a presentation on the launch of the Trusts new online learning platform.
- Took part in a healthy debate around an effective and timely delivery of the Trusts new culture/behaviour programme. The SEF offered their support in also being part of a planned 'Barometer group', which would meet to check the effectiveness of the work that was taking place.
- Provided feedback on posters advertising individual responsibility to report risk.
- Suggested questions for staff pulse surveys which are a temperature check for how staff are feeling about current progress in the Trust.

The Inclusion Hub Advisory Group (IHAG) of public members has similarly advised the Trust on many issues and engagement; you can read more about the work of the IHAG in the "Our People" section.

Annual Members Meeting

The Trust held its Annual Members Meeting (AMM) on 28 September 2017 in Kent. The AMM incorporated a showcase of SECAmb's services and service developments, with stalls at which members could talk to staff about the way we work and our future plans. The Governors were part of a 'Get Involved' stall, which showcased the work of the Council and all our other volunteers in the Trust alongside membership news. Members were able to speak with Governors on the stand at the event. In addition, we invited several community organisations to attend to promote their work and raise awareness among staff and public members. The AMM was held on the same day as our public Council meeting and good numbers of staff and public members attended the Council meeting as well as the AMM.

Governors and other SECAmb staff have also participated in member engagement events in different constituencies throughout the year. Member events were held in Surrey and West Sussex and included an overview of the Trusts services, volunteer roles including Community First Responders, clinical developments and specialist teams such as the Hazardous Area Response Team. At the events, Governors and staff took part in a question and answer session with members. Governors also took the opportunity to recruit members when appropriate, as the events were also open to the public.

Members have been invited to all public Council meetings during the year, through our membership newsletter and dates are also advertised on our website. Three issues of our membership newsletter, Your Call, have been sent to all public and staff members this year. The newsletter contains invitations to get involved with the Trust, spotlight articles on different staff within the ambulance service to help raise awareness of what we do and also career opportunities within the

Trust, and we regularly feature our volunteers and encourage members to get involved in this way. Our Staff-Elected Governors have used social media and internal publications to communicate with staff members about their work. Minutes from the Staff Engagement Forum have been shared on the Trust's intranet and outcomes from the meetings were fed back locally through staff engagement champions.

Contacting Governors and the Trust

Members who wish to contact the Trust can do so at any time using the following contact information. These contact details are printed on our Membership Form, members' newsletter, and on our website.

Membership Office

South East Coast Ambulance
Service NHS Foundation Trust
Nexus House
Gatwick Road
Crawley
RH10 9BG
Mobile: 07770 728250
Tel: 0300 123 0999
SMS/text: 07770 728250

The Membership Office will forward any contacts intended for Governors to the Governors.

To become a member, members of the public should complete a membership form which can be requested from the Membership Office using the details above or can be completed online at: https://secure.membra.co.uk/secambApplicationForm/

Statement as to disclosure to auditors

The Trust Board can certify that there is no relevant audit information of which the NHS Foundation Trust's auditor is unaware and that the Board of Directors', both individually and collectively, have taken all the steps required in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust's auditor is aware of that information.

Income Disclosures

South East Coast Ambulance Service NHS Foundation Trust confirms that income from the provision of goods and services for the purposes of the health service in England is greater than income from the provision of goods and services for any other purpose, in accordance with section 43 2(A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012). Income from the provision of goods and services for other purposes has had no detrimental effect on the provision of goods and services for the provision of health services.

Remuneration Report

Details of the membership and attendance at the Appointments and Remuneration Committee can be found in the Directors' report.

The appointment, remuneration and terms of service of the Executive Directors are agreed by the Appointments and Remuneration Committee.

Annual Statement on Remuneration

It was decided not to undertake a salary review for the Executive Directors in this financial year. However, the terms for the Executive Medical Director were amended in-year to increase from three days per week, to four. In addition, when appointing to the new post-holder, the Committee amended the terms of the Director of HR & OD, to make this an executive director position.

The remuneration of Executive Director posts may be reviewed individually in the light of changes in their responsibilities, in market factors, pay relativities or other relevant circumstances, and in comparison to the pay and conditions of other employees who are covered by Agenda for Change. While we do not directly consult employees locally about senior managers' remuneration, the Trust follows NHS England's Very Senior Manager pay framework. To ensure business continuity, where voluntary resignation may occur, the Chief Executive is required to give six months' notice (and other directors are required to give three months' notice) to the Trust.

Objectives for the Chief Executive are determined annually by the Trust Chair and those for the Executive Directors by the Chief Executive, reflecting the strategic objectives agreed by the Board. The Trust does not apply performance related pay for Executive Directors.

The Nominations Committee consists of four public-elected governors (including the Lead Governor), one staff-elected governor and one appointed governor, and is chaired by the Trust Chair. This Committee makes recommendations to the Council of Governors regarding the appointment and re-appointment of Independent Non-Executive Directors, as well as their remuneration and terms of service. In circumstances regarding the appointment or remuneration of the Chair of the Trust the Nominations Committee is chaired by the Senior Independent Director.

The Council of Governors is responsible for setting the remuneration and other terms and conditions of the Independent Non-Executive Directors. This is done after receiving a recommendation from the Nominations Committee. When considering remuneration, the Nominations Committee considers the Trust's ability to attract and retain Independent Non-Executive Directors of sufficient quality.

The Nominations Committee conduct a formal external review of the Chair's and other Independent Non-Executive Director's remuneration every three years and a desktop review annually. The Nominations Committee (NomCom) last commissioned an external review in April 2014. A desktop review was undertaken in the last financial year however the outcomes have not been presented to the Nominations Committee at the time of writing.

The NomCom received assurance from the Chair around NED performance during the year and the Committee discussed Non-Executive performance. The Committee and all Governors provided feedback to the Chair to aid his formal appraisals of each NED which are undertaken shortly after the end of the financial year. One NED's term of office was extended by one year and another was reappointed to a second term of office during the year, both following an appraisal by the Chair and discussion at the NomCom about their performance. Three new NEDs were recruited and appointed during the year.

Further information on the work of the Nominations Committee can be found in the Directors' report.

Directors	2017/18	2016/17	2015/16
Number of Directors	18	27	18
Number of Directors claiming expenses	15	16	13
Total claimed (£000)	16	22	23

Governors	2017/18	2016/17	2015/16
Number of Governors	25	23	25
Number of Governors claiming expenses	9	7	10
Total claimed (£00)	74	69	93

Renumeration Report

Salary and Pension Entitlements of Senior Managers - narrative explaining the changes in the leadership team during the year can be found in the introduction to the Directors' report. Any variation from the dates given in the Directors' report in terms of office and/or leaving dates are due to individual terms and conditions, including notice periods:

Name and Title	Term of Office	Year ended 31 March 2017				
		Salary (bands of £5,000)	Benefits in Kind Rounded to the nearest £100	Pensions related benefit (bands of £2,500)	Total (bands of £5,000)	
Chair						
Richard Foster		40-45	-	0	40-45	
Chief Executive						
Daren Mochrie	*from 01.04.17*	155-160	1,500	57.5-60	220-225	
Non Executive Directors						
Tim Howe		15-20	-	-	15-20	
Adrian Twyning	*from 07.02.18*	0-5	-	-	0-5	
Al Rymer		10-15	-	-	10-15	
Terry Parkin		10-15	-	-	10-15	
Angela Smith		15-20	-	-	15-20	
Tricia McGregor	*from 01.01.18*	0-5	-	-	0-5	
Graham Colbert		10-15	-	-	10-15	
Lucy Bloem (Crothers)		10-15	-	-	10-15	
Laurie McMahon	*from 07.02.18*	0-5	-	-	0-5	
Executive Directors						
David Hammond *Director of Finance & Corporate Services*		120-125	4,400	67.5-70	195-200	
Joe Garcia* *Interim/Director of Operations*	*Substantive from 11.09.17*	140-145	800	62.5-63	205-210	
Fionna Moore *Interim Medical Director*		135-140	3,100	-	135-140	
Jon Amos *Acting Director of Strategy & Business Development*	*To 02.01.8*	105-110	900	95-97.5	205-210	
Steve Emerton *Director of Strategy & Business Development*	*From 02.01.18*	25-30	-	12.5-13	35-40	
Steve Graham *Interim Director of HR*	*To 16.02.18*	150-155	-	-	150-155	
Mark Power *Interim Director of HR*	*From 16.02.18 to 07.03.18*	10-15	-	0	10-15	
Ed Griffin *Director of HR & OD*	*From 07.03.18*	5-10	-	0	5-10	
Emma Wadey** *Acting Chief Nurse/Director of Quality & Patient Safety*	*To 31.08.17*	55-60	-	-	55-60	
Steve Lennox *Acting Chief Nurse/Director of Quality & Patient Safety*	*To 31.03.18*	95-100	-	52.5-55	150-155	

	Year ended 31 March 2016			
	Salary (bands of £5,000)	Benefits in Kind Rounded to the nearest 100	Pensions related benefit (bands of £2,500)	Total (bands of £5,000)
	0	-	0	-
	0	-	0	-
	15-20	-	-	15-20
	0	-	-	0
	10-15	-	-	10-15
	10-15	-	-	10-15
	0-5	-	-	0-5
	0	-	-	0
	10-15	-	-	10-15
	10-15	-	-	10-15
	0	-	0	-
	105-110	5,500	77.5-80	190-195
	55-60	-	-	55-60
	10-15	700	-	10-15
	75-80	3,500	35-37.5	120-125
	0	-	0	-
	160-165	-	-	160-165
	0	-	0	-
	0	-	0	-
	65-70	-	-	65-70
	0	-	0	-

* The 2016/17 & 2017/18 salaries, up until 11 September 2017, was recharged from East Midlands Ambulance Service NHS Trust
**The 2016/17 & 2017/18 salaries for Emma Wadey were recharged from Sussex Partnership NHS Foundation Trust

Renumeration Report

Benefits in Kind
All Benefits-in-Kind relate to lease cars

Salary
Salary is the actual figure in the period excluding employers national insurance and superannuation contributions

Employer pension contribution
Employer pension contribution is the actual amount paid by the Trust towards director's pensions in the NHS defined benefit scheme.

Senior managers paid more than £150,000
The pay of all senior managers is commensurate with their position and in relation to the pay levels of equivalent positions in the local economy.

Fair pay multiple
Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in South East Coast Ambulance Service NHS Foundation Trust in the financial year 2017-18 was £155,000-£160,000 (2016-17, £160,000-£165,000). This was 5.3 times (2016-17, 5.5) the median remuneration of the workforce, which was £29,685 (2016-17, £29,363).

In 2017-18, Nil (2016-17, 2) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £1,000 to £225,000 (2016-17 £1,000-£252,000)

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Pay Multiple	2017/18	2016/17
Band of Highest Paid Director's Total (£000)	155-160	160-165
Median Total Remuneration (£)	29,685	29,363
Remuneration Ratio	5.3	5.5
Range of salaries for median remuneration	1-225	1-252

Name and Title	Term of Office						
	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 (bands of £5,000)	Lump sum at age 60 (bands of £5,000)	Cash equivalent Transfer 31 March 2017	Cash equivalent Transfer 31 March 2018	Real increase in case equivalent transfer value
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Chief Executive							
Daren Mochrie* ** *****	*2.5-5*	*-*	*0-5*	*-*	*n/a*	*28*	*n/a*
Executive Directors							
David Hammond *Director of Finance & Corporate Services*	*2.5-5*	*0*	*15-20*	*0*	*129*	*169*	*40*
Jon Amos *Acting Director of Strategy & Business Development (to 02.01.18)*	*2.5-5*	*0*	*10-15*	*0*	*64*	*105*	*41*
Steve Emerton** *Director of Strategy & Business Development (from 02.01.18)*	*0-2.5*	*0*	*5-10*	*0*	*n/a*	*64*	*n/a*
Steve Lennox** *Acting Chief Nurse/Director of Quality & Patient Safety (from 31.08.17)*	*2.5-5*	*0-2.5*	*30-35*	*100-105*	*n/a*	*698*	*n/a*
Joe Garcia** *Director of Operations*	*2.5-5*	*2.5-5*	*40-45*	*130-135*	*n/a*	*938*	*n/a*
Fionna Moore** *** *Medical Director*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*
Ed Griffin** **** *Director of HR & OD (from 07.03.18)*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*	*n/a*

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from other pensions).

** Figures received are for the current year only as the remainder of the pension is being transferred from NHS Pensions Scotland*

*** No comparable figures available for 2017 for the Chief Executive and marked Executive Directors as they were not directors at that time*

**** Fionna Moore is not in the NHS Pension Scheme*

***** No figures available for Ed Griffin as he joined in March 2018*

****** Figures received are for the current year only as the remainder of the pension is held by NHS Scotland*

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

Renumeration Report

Senior Managers' Remuneration Policy

Elements of Pay	Purpose and link to strategy	Operation	Maximum Opportunity	Performance Framework
Salary and Fees	To attract and retain high performing individuals, reflecting the market value of the role and experience of the individual Director	Reviewed by the Appointments and Remuneration Committee annually, taking into account the Government policy on salaries in the NHS, with regard to the bandings under Agenda for Change	Within the salary constraints on the NHS	Individual and business performance are considerations in setting base salaries
Benefits	Cars are provided to Directors based upon the operational requirements to travel on business	The Trust has the right to deliver benefits to Executive Directors based on their individual circumstances	The Appointments and Remuneration Committee reviews the level of benefits	N/A
Retirement benefits	To provide post-retirement benefits	Pensions are compliant with the rules of the NHS Pension Scheme	N/A	N/A
Long-term incentives	N/A	N/A	N/A	N/A

Notes

There are no provisions for the recovery of sums paid to senior managers or for withholding the payment of sums to senior managers. However, there are no bonus or incentive schemes currently in place for this group of employees.

Further information is set out in the Annual Statement on Remuneration (above).

Policy on payment for loss of office

The Trust would pay senior managers in line with their notice period of six months for the Chief Executive and three months for the other Executive Directors. Redundancy payments would be calculated as set out in the Agenda for Change Handbook.

Independent Non-Executive Director Remuneration Policy

Elements of Pay	Purpose and link to strategy	Operation	Maximum Opportunity	Performance Framework
Basic remuneration	To attract and retain individuals with the skills, experience and knowledge to contribute to an effective Board	The Nominations Committee is responsible for determining the fees for Non-Executive Directors, including the Chair	The fees are consistent with those of other NHS Trusts	N/A
Additional remuneration for specific NED roles	To provide a small amount of additional remuneration to the Chair of the Audit Committee and the Senior Independent Director to reflect the additional responsibilities of those roles	The Nominations Committee is responsible for determining the 'uplift' and the NEDs to whom this is applicable	N/A	N/A

Daren Mochrie, Chief Executive

Date: 25 May 2018

Staff Report

As at 31 March 2018, the breakdown of our staff between clinical and support roles was as follows:

89% of our workforce are directly engaged in providing care to patients.

Note – Please note differences throughout between Whole Time Equivalent (WTE) [job-related activity which covers a 37.5-hour working week; posts are measured in terms of fractions of WTEs] and Headcount [the actual number of people].

For the purposes of this report, dual roles have been counted twice in headcount figures for each of their part-time roles – this will explain the difference between the total WTE figure in the table below and the WTE figures reported in the workforce profile tables.

Staff Group	Permanent	Other	Agency	Whole Time Equivalent (WTE)
A&E	2115.52	14.00	4.00	2133.52
EOC	400.11	14.17	0.00	414.28
111	154.11	0.00	27.00	181.11
Support	342.66	36.47	33.00	412.13
TOTAL	**3012.41**	**64.63**	**64.00**	**3141.04**

The table below sets out the cost of Trust employees, broken down to distinguish permanent staff costs from other staff costs, for example sta The table below sets out the cost of Trust employees, broken down to distinguish permanent staff costs from other staff costs, for example staff on short-term contracts and the costs of agency/temporary staff. ff on short-term contracts and the costs of agency/temporary staff.

	2016-17			2015-16		
	Total	**Permanently employed**	**Other**	**Total**	**Permanently employed**	**Other**
Employee costs	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Salaries and wages	**106,334**	**105,617**	**717**	107,375	107,076	299
Social security costs	**10,562**	**10,562**	**0**	10,164	10,164	0
Employer contribution to NHS pension scheme*	**12,975**	**12,975**	**0**	12,870	12,870	0
Recoveries from DH Group bodies in respect of staff costs netted off expenditure	**(317)**	**(317)**	**0**	(321)	(321)	0
Costs capitalised as part of assets	**969**	**543**	**426**	593	593	0
Agency staff	**2,718**	**0**	**2,718**	6,346	0	6,346
Employee benefits expense	**133,241**	**129,380**	**3,861**	**137,027**	**130,382**	**6,645**

*The expected contribution to the pension plan for 2017/18 is £13,000k (2016/17 - £13,000k)

A&E (999) Workforce

Note – throughout the report, following Health Education England, NHS England and College of Paramedic guidelines, we will now use the term Specialist Paramedic (Urgent & Emergency Care) to describe the role formally known as Paramedic Practitioner/PP and Specialist Paramedic (Critical Care) to describe the role formally known as Critical Care Paramedic/CCP.

NHS Information Centre Occupational role	NHS Information Centre Occupational code	SECAmb equivalent roles
Manager	AOA	Team Leader; Operational Manager
Emergency Care Practitioners	AAA	Specialist Paramedic (Urgent & Emergency Care); Specialist Paramedic (Critical Care)
Ambulance Paramedic	ABA	Paramedic
Ambulance Technician	AEA	Ambulance Technician
Ambulance Personnel	A2	Associate Practitioner; Emergency Care Support Worker (ECSW)
Administration & Estates staff	G0-G3 (A-E)	Support staff
Support workers	H2S	Emergency Operations Centre (EOC) staff; NHS 111 staff

In line with reporting requirements, we have attempted to align the national definitions, as above, with job roles utilised within the Trust..

53% of the A&E workforce are Paramedics/Specialist Paramedics and 47% are Clinical Support Staff.

If a patient needs clinical advice or an emergency response, they can expect to come into contact with one or more of our clinicians, depending on their condition:

Emergency Care Support Workers – drive ambulances under emergency conditions and support the work of qualified ambulance technicians, associate practitioners and paramedics. We have 388 Emergency Care Support Workers (ECSWs).

Technicians/Associate Practitioners – respond to emergency calls, as well as a range of planned and unplanned non-emergency cases. They support Paramedics during the assessment, diagnosis and treatment of patients and during their journey to hospital. We have 599 staff in these roles.

The role of Associate Practitioner (APs) has been created to partially address the national shortage of paramedics, creating new development opportunities for staff and a new recruitment pathway. APs will initially be employed and practise as ECSWs, to enable them to acquire the requisite operational front-line skills to progress onto an accelerated paramedic degree programme. At the end of their first year, subject to negotiation with our partner Universities, individuals will undertake further internal training and their scope of practice will be increased, to enable them to be the lead clinician on a double-crewed ambulance, working with an ECSW, pending qualification as a registered paramedic.

Staff Report

Paramedics – respond to emergency calls and deal with complex, non-emergency hospital admissions, discharges and transfers. They work as part of a rapid response unit, usually with support from an ambulance technician or emergency care support worker. They meet people's need for immediate care or treatment. We have 847 paramedics, including those working as clinical managers.

Hazardous Area Response Teams – are comprised of front line clinical staff who have received additional training in order to be able to safely treat patients in challenging circumstances. We have 85 staff in these teams.

Specialist Paramedic – Urgent Care (Paramedic Practitioners) – are paramedics who have undergone additional education and training to equip them with greater patient assessment and management skills. They are able to diagnose a wide range of conditions and are skilled to treat many minor injuries and illnesses and are also able to "signpost" care – referring patients to specialists in the community such as GPs, community nurses or social care professionals. They can also refer patients to hospital specialists, thus avoiding the need to be seen in A&E first. We currently have 73 Specialist Paramedics (Urgent Care).

Specialist Paramedic – Critical Care (Critical Care Paramedics) – are paramedics who have undergone additional education and training to work in the critical care environment, both in the pre-hospital setting and by undertaking Intensive Care transfers between hospitals. Often working alongside doctors at the scene, they can treat patients suffering from critical illness or injury, providing intensive support and therapy ensuring the patient is taken rapidly and safely to a hospital that is able to treat their complex needs. Specialist Paramedics are able to assess and diagnose illness and injuries and treat patients using more powerful drugs and use equipment on scene that previously was only used in hospital. We currently have 55 Specialist Paramedics (Critical Care).

Operational Team Leaders – are first line paramedic managers, responsible for managing teams of up to eleven clinical staff. There are 149 employees working in this role.

Emergency Operating Centre Staff – 467 staff work in the Trust's Emergency Operations Centres in a variety of roles, including Emergency Medical Advisers, Dispatchers, Duty Dispatch Managers and Clinical Desk staff. These staff are responsible for receiving every one of the emergency calls made to the Trust, providing support and clinical advice to callers as needed and co-ordinating the most appropriate response to send to the patient.

NHS 111 staff – 202 staff work in the contact centre at Ashford. Further NHS 111 staff are employed by Care UK and work in the contact centre at Dorking. The majority of these staff are health advisors, who answer the NHS 111 calls and they are supported by nurses, paramedics and GPs who provide clinical advice.

Support staff – – our front line staff are supported by 484 non-clinical staff who work in areas including finance, human resources, service development and corporate affairs, information management and technology, education and training, estates, fleet and logistics services, contingency planning and resilience, clinical governance and communications.

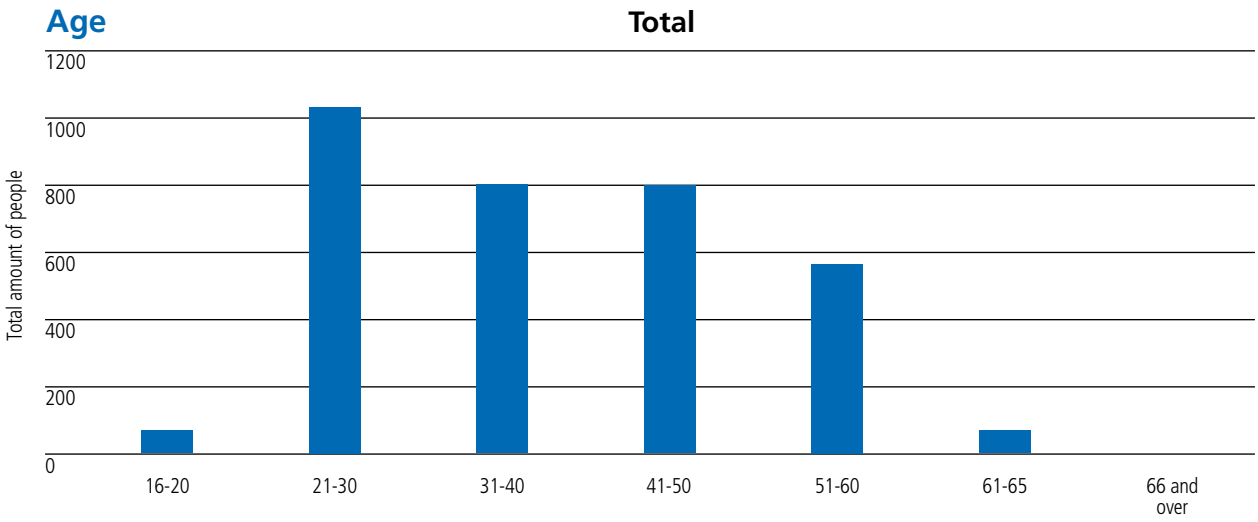
Workforce Profile

SECAmb values diversity, equal access for patients and equality of opportunity for staff. As an employer we will ensure that all our employees work in an environment which respects and includes everyone and is free from discrimination, harassment and unfair treatment.

A key tool to help us ensure that this is the case is workforce monitoring, whereby we collect relevant information on each staff member.

Age Band	Headcount
16-20	40
21-30	1,031
31-40	826
41-50	815
51-60	562
61-65	73
66 and over	2
TOTAL	**3349**

Age



Staff Report

Gender

In the workforce as a whole, the gender split has altered very little from the previous year (52% male and 48% female in 2016/17):

Gender	Headcount	Percent %
Female	1639	49%
Male	1710	51%
TOTAL	**3349**	**100%**

Gender – Directors	Headcount	Percent %
Female	4	29%
Male	10	71%
TOTAL	**14**	**100%**

Gender (Band 8a+)	Headcount	Percent %
Female	39	31%
Male	87	69%
TOTAL	**126**	**100%**

Gender – Band 8a+	Headcount		
	Female	Male	Total
Band 8 - Range A	17	40	57
Band 8 - Range B	9	23	32
Band 8 - Range C	5	6	11
Band 8 - Range D	2	2	4
Band 9	1	2	3
Non AfC	5	14	19
TOTAL	**39**	**87**	**126**

Race

The percentage of staff classified other than 'white British' has increased to 14% from last year's level of 12.10%.

Race	Headcount	Percent %
White - British	2896	86%
White - Irish	29	1%
White - Any other White background	135	4%
White Unspecified	7	0%
White English	3	0%
White Polish	9	0%
White Mixed	1	0%
White Other European	11	0%
Mixed - White & Black Caribbean	16	0%
Mixed - White & Black African	4	0%
Mixed - White & Asian	14	0%
Mixed - Any other mixed background	13	0%
Mixed - Black & White	1	0%
Mixed - Other/Unspecified	1	0%
Asian or Asian British - Indian	15	0%
Asian or Asian British - Pakistani	4	0%
Asian or Asian British - Bangladeshi	2	0%
Asian or Asian British - Any other Asian background	8	0%
Black or Black British - Caribbean	9	0%
Black or Black British - African	17	1%
Black or Black British - Any other Black background	1	0%
Black Nigerian	1	0%
Black British	1	0%
Black Unspecified	1	0%
Chinese	7	0%
Any Other Ethnic Group	12	0%
Unspecified	3	0%
Not Stated	128	4%
TOTAL	**3349**	**100%**

Staff Report

Disability

121 (3%) staff have declared themselves as having a disability:

Disability	Headcount	Percent %
Yes	118	4%
No	2396	72%
Prefer Not To Answer	835	25%
TOTAL	**3349**	**100%**

Again, this is an area which is under-reported, with 25% of staff preferring not to confirm whether or not they have a disability.

The Trust has taken specific steps to support people with disabilities and provides information and guidance related to declaring a disability, access to work funding, mental health and working with dyslexia. We take a proactive approach to ensure the individual needs of employees, ensuring reasonable adjustments are properly considered and implemented. The Trust is a member of the Disability Confident scheme and has a staff network to support people with disabilities.

Sexual orientation

20% of staff have not disclosed their sexual orientation:

Sexual orientation	Headcount	Percent %
Bisexual	39	1%
Gay	67	2%
Heterosexual	2573	77%
Lesbian	71	2%
I do not wish to disclose my sexual orientation	599	18%
TOTAL	**3349**	**100%**

Religion and belief

This area remains under reported, with 27% of staff having not stated their religion or belief:

Sexual orientation	Headcount	Percent %
Atheism	666	20%
Buddhism	13	0%
Christianity	1304	39%
Hinduism	6	0%
Islam	14	0%
Judaism	6	0%
Other	441	13%
Sikhism	3	0%
I do not wish to disclose my religion/belief	896	27%
TOTAL	**3349**	**100%**

Recruiting and retaining staff

Over the past year SECAmb has continued to make changes to our workforce structure, predominantly by re-banding Paramedics and Operational Team Leaders (OTLs) in line with national pay bandings. We have also re-structured parts of the Trust, such as Finance and continue to look at the support and operational functions to ensure they are structured in the most efficient way.

Our comprehensive assessment centre remains a major focus of our selection process, aimed at ensuring that we recruit the highest quality of staff, who are motivated to work for the Trust. We have re-designed the ECSW assessment centre and formulated management assessment centres based on the NHS Leadership model

Our use of the national NHS Jobs attraction and applicants' portal remains one of the methods used to encourage applications from all sectors of the community. The team deliver values-based recruitment referencing

compassionate care and NHS England's "6 C model" and our assessment process is now in line with the Key Skills framework.

We adhere to the NHS employment check standards, which ensures a fair, transparent and rigorous process.

We received 6,445 applications to our vacancies during the year via NHS Jobs, of which 4,720 were through our direct NHS Jobs adverts. We hired 496 'new to Trust' employees during the year; we received 376 applications from applicants who declared a disability, of which 31 were hired. There were two candidates recruited who preferred not to state whether or not they had disabilities.

We received 951 applications from BME candidates via NHS Jobs and hired 47 BME staff (although there were 22 candidates recruited who preferred not to state their ethnicity.)

At the end of the year, the Trust-wide vacancy rate is at 9.83%.

The Trust is investing in apprenticeships for Associate Ambulance Practitioners (AAPs), which will become our new route for in-service staff to progress to BSc Paramedic qualifications.

We currently have a recruitment drive for ECSWs and AAPs across the Trust and are aiming to recruit up to 300 operational staff by November 2018, to strengthen our workforce and enable us to meet demands over the winter period.

We are now recruiting Paramedics solely from the UK and this is a reflection of the great relationships that have been built with our partner universities. During the year we have seen a high turnover rate in our Emergency Operations Centres (EOCs), especially amongst Emergency Medical Advisors (EMAs). As well as recruitment, we are also focusing on EOC retention strategies to enable us to retain our staff and build an experienced workforce. We have developed a career progression plan for EMAs which should help with retention and career progression. We are also exploring the possibility of EMA Apprenticeships in both EOC and in NHS 111. Work continues to attract more Clinical Supervisors to work in the EOCs and in 111, including introducing a new Clinical Navigator role.

We have worked hard during the year to make permanent appointments to our Executive Team; at year-end, the only outstanding role to be recruited to substantively is Executive Medical Director. A key focus for this year will be to create a safe, effective and fit for purpose HR team.

Retention amongst clinical and operational staff remains challenging and Paramedic and Specialist Paramedic turnover remains a specific issue, as there is strong competition from Minor Injury Units, Emergency Departments, GP surgeries and other ambulance services for these clinicians. To counteract this, we are exploring rotational working, dual roles and refined job descriptions for clinicians and specialist paramedics.

However, looking at the Trust as a whole, the annual rolling turnover rate has remained relatively stable, if higher than desired, over the past year.

Month 2017/18	Rolling Annual Turnover %	Month 2016/17	Rolling Annual Turnover %
Apr-17	16.70%	Apr-16	16%
May-17	16.34%	May-16	16.8%
Jun-17	17.85%	Jun-16	16.7%
Jul-17	17.67%	Jul-16	16.9%
Aug-17	17.51%	Aug-16	16.9%
Sep-17	17.77%	Sep-16	16.3%
Oct-17	18.17%	Oct-16	16.1%
Nov-17	18.05%	Nov-16	16.5%
Dec-17	17.77%	Dec-16	16.9%
Jan-18	17.85%	Jan-17	16.9%
Feb-18	17.74%	Feb-17	16.6%
Mar-18	17.19%	Mar-17	16.7%

Staff Report

Sickness Absence

Sickness absence for the period 1 April 2017 to 31 March 2018 was 4.95%, a reduction of 0.13% compared with 5.08% in 2016/17.

Absence (WTE)	Total Days Lost
4.95%	64,510

The monthly breakdown for the period is:

Month	Rolling Annual Turnover %
April 2017	4.57%
May 2017	5.00%
June 2017	4.71%
July 2017	4.83%
August 2017	4.90%
September 2017	4.99%
October 2017	4.93%
November 2017	4.96%
December 2017	4.92%
January 2018	5.22%
February 2018	5.26%
March 2018	5.12%

Protecting staff

We strive to provide a safe environment for both our staff and the patients we treat. However, with the type of services that we provide, our staff may sustain injuries whilst treating or moving patients in various external environments. It is, sadly, also possible that staff may be the subject of directed aggressive behaviour or even violence from both service users and the public.

Work is continually developing to provide a safe and secure working environment as far as is reasonably practical given the inherent risks and nature of the work our staff undertake. There are several avenues the Trust utilises to raise awareness including inductions, articles, posters, talks with local Operating Unit management. There are also initiatives being developed regarding training requirements for de-escalation and conflict resolution/disengagement.

The Trust recognises it is still possible for violence and aggression to occur and in such instances promotes the reporting of incidents. The Trust takes violence and aggression against staff very seriously and will support any staff member who wishes to pursue action locally or by prosecution.

During the financial year 2017/18 the Trust recorded:

- 221 staff members being the victims of a physical assault
- 105* sanctions were applied either locally or by prosecution

*provisional figure, this may increase following final outcomes of cases from 2017/18 and communications concluded with e.g. Police/ Crown Prosecution Service (CPS)

Security Management has worked hard during the year to incorporate the additional requirements since the removal of NHS Protect from Security, now sitting under NHS England.

The number of physical assaults has remained at a fairly similar level with 221 reports of victims of physical assault opposed to 234 the previous financial year. Sanctions have also been maintained, with a provisional number of 105, compared to 104 for 2016/17. This number may increase however following the conclusion of communications relating to cases with the Police/CPS concluded in 2017/18.

Whilst the reduction in reported physical assaults is low, this is a significant step as it is the first reduction seen in the past five years. Additionally, the number of sanctions being maintained demonstrates the work between Security Management/Staff with the Police/ CPS.

Looking forward, significant initiatives are being considered including closer working

with the Police Forces within our region, additional considerations for those who are single responders and developments in policy around violence and aggression.

The Trust is working hard to develop a culture of safety and operates an integrated and open incident reporting system, enabling trend analyses to be reported through clinical and corporate governance routes.

The Central Health and Safety Working Group, comprising managers and trade union representatives, was previously meeting every three months, however during the year it was decided it should meet monthly, due to the large number of agenda items to be discussed. Moving forwards, it will be chaired by an Executive Director, to ensure it receives the appropriate level of focus.

Staff are encouraged to report adverse incidents as it assists in giving an accurate appraisal of the hazards which they face.

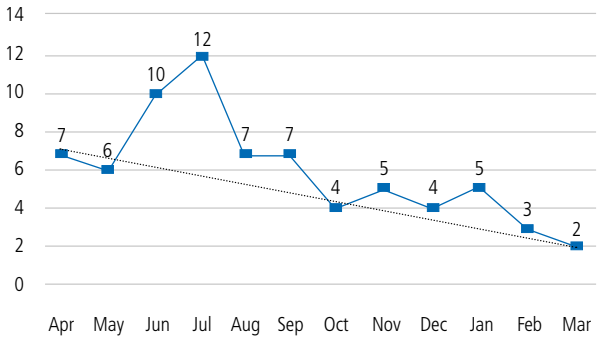
During the year over 1,250 Health & Safety-related incidents were recorded on our Datix system, which includes near miss and no harm events, manual handling incidents and violence and aggression towards our staff. The graphs below show the number of those incidents relating to manual handling, as well as those where RIDDOR applies (72).

All organisations are required to follow the legislation on RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) 1995. This requires the reporting of any absence from work of over seven days as a result of a work-related injury or illness (SECAmb uses the Datix system for this) and are required to be reported to the Health & Safety Executive (HSE) within 15 days of occurrence. Analysis of the RIDDOR data shows that the majority of staff absences over seven days were caused by lifting and handling injuries. Use of the carry chair is reported by staff on Datix as the most common cause. There was also an increase in the number of incidents reported for failures of the Mangar lifting cushion; moving forward, the Trust are looking to up-date this piece of equipment.

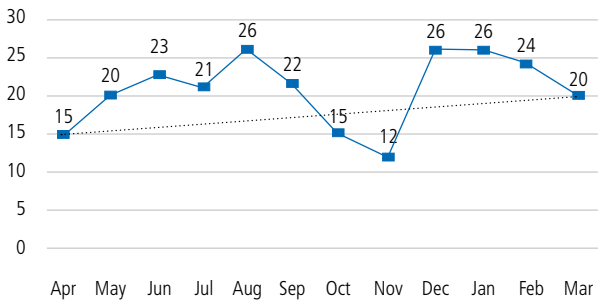
In 2017/18 only 23 of the 72 incidents where RIDDOR applied were reported within the 15-day timeframe. This was predominantly due to late reporting of incidents at a local level and a plan has been developed for 2018/19 to significantly improve this.

All manual handling incidents, including those where no or low harm were reported, are recorded on Datix; these are predominantly associated with moving patients using equipment and are not always avoidable.

RIDDOR Reported Month to Date 2017/18



Manual Handling Incidents Month to Date 2017/18



All muscular skeletal disorders (MSD) are referred to the Trust's Occupational Health provider, Optima Health, who collect aggregated data during the year. This has shown that the top three injury areas are lower back, shoulder and knee. The data also shows whether it was a new injury caused at work or not or if it is an existing injury exacerbated at work.

Analysis of the data collected during the year has led to the following actions being taken:

- A review of the equipment used to move and carry patients, including the carry chair and Mangar lifting cushion. This will lead to improved risk assessments and the introduction of new high-risk activity risk assessments
- The re-writing of the Trust's Bariatric Policy and associated procedures
- The creation of a new Moving & Handling Policy (currently in draft at time of writing) to replace the current Manual Handling Policy

However, it has been recognised during the year that this is an area where the Trust needs to make improvements. Plans for 2018/19 include:

- Enhancing the team by recruiting a Head of Health & Safety and a third Health & Safety manager with interviews planned for the end of May.
- Creating Area Health & Safety Groups to deal with local issues and share solutions
- Ensuring that Community First Responders (CFRs) are treated the same as our employed staff when it comes to minimising risk
- Reviewing all risk assessments for equipment and vehicles and creating a suite of risk assessments to address the more regular but challenging scenarios faced by staff
- Creating a new system for the inspection of trust sites and the recording of this information that it open and available to allow shared learning

Staff Friends & Family Test (FFT)

NHS England introduced the Friends and Family Test (FFT) to provide staff with the opportunity to feedback on their organisation by answering two questions:

- How likely are you to recommend SECAmb to friends and family if they needed care or treatment?
- How likely are you to recommend SECAmb to friends and family as a place to work?

The survey is a national NHS requirement.

At SECAmb, the uptake of the Staff FFT in 2016/17 dropped from 252 responses to 226 between Q1 and Q4.

To increase levels of participation, the Staff Engagement Advisors (SEAs) have taken responsibility for this test and have re-branded and incorporated the questions into the new quarterly Pulse Survey. The Survey is promoted via email communications, posters, social media and shared with staff through the network of Staff Engagement Champions.

In Q1 of 2017/18 there were 676 responses to the Pulse Survey, increasing to 754 in Q2. The Staff Engagement Advisors feedback to the wider Trust on the results, sharing positives and the areas for improvement using a "you said… we did" approach.

Staff Survey results

The NHS Staff Survey is undertaken annually and covers all staff who work for the NHS. It provides a valuable opportunity for staff to provide feedback, anonymously, on a number of important areas including the care provided by their Trust,

training, engagement and personal development.

The 2017/18 Survey was undertaken during the Autumn of 2017 by Quality Health, an independent organisation, on behalf of SECAmb and the results were published nationally on 6 March 2018.

Rather than just sending the survey to a sample of staff, SECAmb chose to send the survey to all eligible staff (3,349) and 44% completed and returned the survey questionnaire, a 4% increase on both 2016 and 2015.

Top ranking scores	Trust	National Ambulance Trust average	Trust Improvement or Deterioration
% of staff experiencing physical violence from staff in last 12 months	2%	2%	Improvement
% of staff reporting errors, near misses or incidents witnessed in the last month	84%	82%	No Change
% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	49%	48%	Improvement
Quality of appraisals	2.60	2.64	Improvement
Support from immediate managers	3.42	3.44	Improvement

Bottom ranking scores	Trust	National Ambulance Trust average	Trust Improvement or Deterioration
Staff recommendation of the organisation as a place to work or receive treatment	3.10	3.44	No Change
Staff satisfaction with resourcing and support	2.90	3.16	No Change
Staff satisfaction with the quality of work and care they are able to deliver	3.58	3.81	No Change
% of staff feeling unwell due to work related stress in the last 12 months	59%	48%	No Change
% of staff experiencing harassment, bullying or abuse from staff in last 12 months	41%	28%	No Change

Whilst the Trust saw improved feedback in some areas, overall the results were disappointing and highlight that the Trust is performing less well than other ambulance services.

During the year, the Trust had already begun a significant piece of work to improve the culture of the organisation, incorporating many individual areas including leadership development at all levels and introducing revised values and associated behaviours. Led by the Trust's Chief Executive, this work will continue at pace during 2018/19, with the full support, involvement and commitment of the whole senior team and this should contribute significantly to improved staff satisfaction moving forward.

Staff Report

Appraisals and Mandatory Training

In April 2017, the Trust launched a new performance management system, Actus, which allows staff and managers to record objectives, appraisals and performance on-line. The two-way system allows staff to evidence real-time issues, concerns and achievements in a single place, as well as recording learning and development.

Over 500 staff and line managers were trained on the system during the year and training will continue to be rolled out during 2018/19. Feedback from both staff and managers has been positive so far, as it allows both team member and manager to engage in the system and take ownership of their respective areas.

During 2017/18, 91.95% of objective setting and appraisal were recorded on the new system; this exceeded the expected target of 80% and was a significant improvement from 52% recorded on the manual system during 2016/17.

Moving forward, the Trust will continue to develop the capability of the Actus system, including embedding the values and behaviours that are key part of the culture programme.

Communicating and Engaging with staff

Meeting the challenges of communicating across a large and widely-distributed workforce, working diverse shift patterns is difficult but the Trust uses a range of different mechanisms to try to communicate effectively with staff.

Undertaking regular, face to face communication with front-line staff in particular is challenging, however during the year the Chief Executive has visited every Trust location to meet staff and a number of the Executive Team have undertaken 'surgeries' during the year, which have proved popular with staff.

Current mechanisms for communicating with staff include:

- All operational staff have been issued with individual issue iPADs during the year
- A weekly update from the Chief Executive to all staff, issued every Friday, focussing on the key issues affecting the Trust
- A weekly electronic staff bulletin, which contains key performance information, as well as 'beeline' messages, where staff pay tribute to their colleagues
- A quarterly staff magazine – SECAmb News – which is produced electronically as well as in hard copy
- Use of social media specifically for staff including a 'staff-only' Twitter account and the SECAmb Facebook Community, launched in December 2017 which already has over 1,600 members

The roll-out of the new operational management structure during the year has also presented improved opportunities for road staff to have closer contact with their Operational Team Leaders, leading to better local communication and engagement.

The introduction of the 'Teams' briefing process for operational staff has also enabled cascade briefing of key information in a timely way.

Staff Engagement is recognised as a key area for the Trust to focus on. Effective engagement leads to a more satisfied, motivated, involved and retained workforce which in turn will have a direct impact on the quality of patient care provided. The Trust has two substantive Staff Engagement Advisors (within Learning & OD) whose primary role is to advise on engagement practice and provide capacity to enable long-term, embedded change across SECAmb. The aim is for effective Staff Engagement to become the cultural norm across the organisation.

Over 2017/18 a detailed plan was developed, with some activities introduced or improved to achieve our aims.

Corporate Induction – the Corporate Induction has been re-branded and is now being managed and developed by the Staff Engagement Advisors. At the Corporate Induction, some guest speakers from the Trust are invited to meet the new starters, providing an insight of some key areas of the organisation and an overview of important information including Health & Safety, Duty of Candour, Fraud & Bribery (and more). In addition, the Chief Executive (or delegated member of the Exec) meet the staff for a question and answer session. The Corporate Induction is key to ensuring our new starters are certain that they have joined the right organisation and will continue to be reviewed and improved based on feedback and Trust developments.

Engagement Toolkit – an engagement toolkit has been developed to support local managers in their engagement activities with both staff and volunteers.

Local Staff Engagement Champions – the Trust now has a network of approximately 80 Staff Engagement Champions (SEC) who represent their local teams across the organisation. This number will continue to grow to ensure all areas of the Trust are represented. Each of the SEC has (or will) attend a workshop in which they learn the skills required to facilitate effective engagement forums in their local area, developing their agendas, managing their action logs, communication skills and social media training. The local forums are designed to allow staff to share their suggestions/ideas at a local level. The SEC will also be the link into the central Staff Engagement Forum, sharing best practice and raising issues which require discussion at an organisational level. The SEC feedback to their teams any information from the central forum or other engagement information via local forums, noticeboards or social media.

Staff Engagement Forum – the Staff Engagement Forum (SEF) has been improved and further utilised to maximise its effectiveness. The SEF is made up of a cross-section of staff including Staff Elected Governors, Non-Executives, Unions, operational staff, non-operational staff, a representative from the Executive team and the SEC. The SEF provides a forum for effective two-way communication and consultation on a range of subjects, with the opportunity to hear and share opinions from the variety of staff representatives and support the development and delivery of key messages to staff.

Pulse Survey – the Pulse Survey has been designed to provide a quarterly tool for staff feedback on the current big issues facing staff. The survey also acts as a temperature check for the annual NHS Staff Survey. The Friends and Family Test (FFT) are embedded within this, which has greatly increased the response rate for this test (an NHS England requirement).

Executive Engagement – the Executive Team is key to leading staff engagement. An Executive Engagement plan has been developed, and this will include activities such as Executive site visits and open forums, "walking in your shoes" - undertaking observer shifts and listening to calls in the EOC/111 – coffee mornings, Town Hall meetings and developing a social media presence. A member of the Executive Team now attends the Corporate Induction and Staff Engagement Forums.

Joint Partnership Forum (JPF)

The Joint Partnership Forum (JPF) is the body through which the Trust engages and consults with its recognised trade unions.

Staff Report

Within SECAmb, four trade unions are formally recognised:

- Unison
- GMB
- Unite
- RCN

The JPF meets regularly throughout the year and members includes representatives of each of the recognised unions, as well as attendees from all of the Trust Directorates, including the Chief Executive and other Directors as needed. It is chaired by the Director of HR & OD.

During the year, the JPF has been heavily involved in a number of key work-stream areas, including those highlighted below and close collaborative working has enabled real progress to be made in implementing these:

- Development of Trust Policies & Procedures – during the year, the JPF have been instrumental in helping to create a new approach to developing Policies & Procedures. This now sees every new Policy being formally discussed at the JPF at an early stage, as well as consultation with all staff
- Implementation of Band 6 for Paramedics– close working with the JPF was vital in ensuring that the Trust could successfully implement the nationally-agreed move to Band 6 for some Paramedics
- Unsocial Hours Procedure – The Trust and Unions worked together on this to provide a consistent platform for new rotas to be developed locally.

Off pay-roll engagements

Off pay-roll engagements are made following initial discussions between the Chief Executive and Chair, with Executive Directors consulted as appropriate. All appointments at this level are formally approved by the Appointments and Remuneration Committee.

Table 1: For all off-payroll engagements as of 31 March 2017, for more than £245 per day and that last longer than six months	Number of engagements
No. of existing engagements as of 31 March 2018	4
Of which:	
Number that have existed for less than one year at the time of reporting	3
Number that have existed for between one and two years at the time of reporting	1
Number that have existed for between two and three years at the time of reporting	1
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

Table 2: 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 engagements
Number of new engagements, or those that reached six months in duration between 1 April 2017 and 31 March 2018	17
Of which:	
Number assessed as within the scope of IR35	6
Number assessed as not within the scope of IR35	11
Number engaged directly (via PSC contracted to trust) and are on the Trust's payroll	3
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

Table 3: 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 engagements
Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility during the financial year	2
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility'. This should include both off-payroll and on-payroll engagements	26
In any cases where individuals are included within the first row to this table, please set out:	
Details of the exceptional circumstances that led to each of these engagements	Post 1. Interim Director of HR: The previous postholder was off due to ill-health during 2016-17 and left the Trust on 10 April 2017. The role needed to be covered until a substantive appointment could be made, and during this time it was crucial to maintain organisational and HR knowledge in a time of change. Post 2. Interim Director of HR: This post bridged the gap between the departure of post 1 above and the start date of a substantive Director of HR.
Details of the length of time each of these exceptional engagements lasted	Post 1: In post for 22 months. Post 2: In post less than one month.

Expenditure on consultancy

The total expenditure for 2017/18 was £704,000 and we engaged six consultancy firms.

Staff exit packages

There were fourteen exit packages paid in 2017/18 (six in 2016/17) at a total cost of £640,000 (£409,000 in 2016/17)

2017/18:

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Less than £10,000	1	0	1
£10,001-£25,000	6	0	6
£25,001-£50,000	4	0	4
£50,001-£100,000	1	0	1
£100,001-£150,000	0	0	0
£150,001-£200,000	2	0	2
Total number of exit packages by type	14	0	14
Total resource cost (£000)	**640**	**0**	**640**

2016/17:

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Less than £10,000	1	0	1
£10,001-£25,000	1	0	1
£25,001-£50,000	0	0	0
£50,001-£100,000	3	0	3
£100,001-£150,000	0	0	0
£150,001-£200,000	1	0	1
Total number of exit packages by type	6	0	0
Total resource cost (£000)	**409**	**0**	**409**

Other (non-compulsory) staff exit packages

There were no other (non-compulsory) staff exit packages agreed in 2017/18 (2016/17 – 0)

Disclosures

South East Coast Ambulance Service NHS Foundation Trust has applied the Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principle of the UK Corporate Governance Code issued in 2012.

Code Provision Section 2: Disclose	Requirement	Location of disclosure in 16/17 Annual Report
A.1.1	The schedule of matters reserved for the Board of Directors (BoD) should include a clear statement detailing the roles and responsibilities of the Council of Governors (CoG). This statement should also describe how any disagreements between the Council of Governors and the Board of Directors will be resolved. The Annual Report should include this schedule of matters or a summary statement of how the Board of Directors and the Council of Governors operate, including a summary of the types of decisions to be taken by each of the Boards and which are delegated to the executive management of the Board of Directors.	Directors' report
A.1.2	Identification of the Chair, Deputy Chair, CEO, SID, Chairperson and members of the Nominations, Audit and Remuneration Committees	Directors' report
A.5.3.	The Annual Report should identify the members of the CoG, constituency or organisation, date of election, duration of appointment and Lead Governor	Directors' report
FT ARM	The Annual Report should include a statement about the number of meetings of the Council of Governors and individual attendance by Governors and Directors	Directors' report
B.1.1	The BoD should identify in the Annual Report each NED it considers to be independent with reasons where necessary	Directors' report
B.1.4	The BoD should include in its Annual Report a description of each Directors skills etc. and make a clear statement about its own balance, completeness and appropriateness to the requirements of the FT.	Directors' report
FT ARM	The Annual Report should include a brief description of the length of appointments of the Non-Executive Directors, and how they may be terminated	Directors' report
B.2.10	A separate section of the Annual Report should describe the work of the Nominations Committee(s), including the process it has used in relation to Board appointments.	Directors' report
FT ARM	The disclosure in the Annual Report on the work of the Nominations Committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a Chair or Non-Executive Director	N/A
B.3.1	Chairman's other significant commitments should be included in Annual Report	Directors' report

Code Provision Section 2: Disclose	Requirement	Location of disclosure in 16/17 Annual Report
B.5.6	The Annual Report should include a statement as to how the views of members, Governors and the public have been canvassed and communicated to the Board	Directors' report
FT ARM	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151	N/A
B.6.1	The BoD should state in the annual report how performance evaluation of the Board, its Committees and its Directors, including the Chairman has been conducted	Directors' report
B.6.2	Where there has been external evaluation of the board and/or governance of the trust the external facilitator should be identified and a statement made as to whether they have any other connection with the Trust	Annual Governance Statement
C.1.1	Directors' responsibilities for preparing Annual Report and state that they consider them to be whole, fair and balanced etc. Directors should also explain their approach to quality governance.	Statement at end of the Accountability Report Annual Governance Statement
C.2.1	A Trust should disclose in the annual report: a) if it has an internal audit function; how the function and what role it performs; or b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes	Performance Report – financial performance section and Annual Governance Statement

Disclosures set out in the NHS Foundation Trust Code of Governance

Code Provision Section 2: Disclose	Requirement	Location of disclosure in 16/17 Annual Report
C.2.2	A Trust should disclose in the annual report: a) if it has an internal audit function; how the function and what role it performs; or b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Performance Report – financial performance section and Annual Governance Statement
C.3.5	If the Council of Governors' does not accept the Audit Committee's recommendation on the appointment, reappointment or removal of the external auditor, the Board of Directors should include in the annual report a statement from the Audit Committee explaining the recommendation and should set out reasons why the Council of Governors had taken a different position	N/A
C.3.9	A separate section of the Annual Report should describe the work of the Audit Committee in discharging its responsibilities. The report should include: the significant issues that the Committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	Annual Governance Statement
D.1.3	Where an NHS Foundation Trust releases an Executive Director, for example to serve as a Non-Executive Director elsewhere, the remuneration report should include a statement of whether or not the Director will retain such earnings.	Directors' report N/A
E.1.4	Contact procedures for members who wish to communicate with Governors and/or Directors should be made clearly available to members on the NHS Foundation Trust's website and in the Annual Report.	Directors' report

Code Provision Section 2: Disclose	Requirement	Location of disclosure in 16/17 Annual Report
E.1.5	The BoD should state in the Annual Report the steps they have taken to ensure that Board members, and particularly NEDs, develop an understanding of the views of Governors and members, for example through attendance at CoG meetings, face to face contact, surveys, consultations etc.	Directors' report
E.1.6	The Board of Directors should monitor how representative the NHS Foundation Trust's membership is and the level and effectiveness of membership engagement and report on this in the Annual Report.	Directors' report
E.1.6	The Board of Directors should monitor how representative the NHS Foundation Trust's membership is and the level and effectiveness of membership engagement and report on this in the Annual Report.	Directors' report
FT ARM	The Annual Report should include: a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; information on the number of members and the number of members in each constituency; and a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	Directors' report
FT ARM	The Annual Report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS Foundation Trust. As each NHS Foundation Trust must have registers of Governors' and Directors' interests which are available to the public, an alternative disclosure is for the Annual Report to simply state how members of the public can gain access to the registers instead of listing all the interests in the Annual Report.	Directors' report

The provisions in Section 6 below only require a disclosure in the Annual Report if the Trust has departed from the Code of Governance; in which case the disclosure should contain an explanation in each case where the Trust has departed from the Code of Governance, explaining the reasons for the departure and how the alternative arrangements continue to reflect the main principles of the Code of Governance.

We are not required to provide evidence of compliance in the Annual Report and in a number of cases the provision is not applicable or the circumstances described have not arisen.

Disclosures set out in the NHS Foundation Trust Code of Governance

Code Provision Section 6:	Requirement	Comply or Explain
A.1.4	The Board should ensure that adequate systems and processes are maintained to measure and monitor the NHS Foundation Trust's effectiveness, efficiency and economy as well as the quality of its health care delivery	Comply
A.1.5	The Board should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance	Comply
A.1.6	The Board should report on its approach to clinical governance.	Comply
A.1.7	The Chief Executive as the Accounting Officer should follow the procedure set out by Monitor for advising the Board and the Council and for recording and submitting objections to decisions.	Comply
A.1.8	The Board should establish the constitution and standards of conduct for the NHS Foundation Trust and its staff in accordance with NHS values and accepted standards of behaviour in public life	Comply
A.1.9	The Board should operate a code of conduct that builds on the values of the NHS Foundation Trust and reflect high standards of probity and responsibility.	Comply
A.1.10	The NHS Foundation Trust should arrange appropriate insurance to cover the risk of legal action against its directors.	Comply
A.3.1	The Chairperson should, on appointment by the Council, meet the independence criteria set out in B.1.1. A Chief Executive should not go on to be the Chairperson of the same NHS Foundation Trust.	Comply
A.4.1	In consultation with the Council, the Board should appoint one of the independent Non-Executive Directors to be the Senior Independent Director.	Comply
A.4.2	The Chairperson should hold meetings with the Non-Executive Directors without the Executives present.	Comply
A.4.3	Where Directors have concerns that cannot be resolved about the running of the NHS Foundation Trust or a proposed action, they should ensure that their concerns are recorded in the Board minutes.	Comply
A.5.1	The Council of Governors should meet sufficiently regularly to discharge its duties.	Comply
A.5.2	The Council of Governors should not be so large as to be unwieldy.	Comply
A.5.4	The roles and responsibilities of the Council of Governors should be set out in a written document.	Comply

Code Provision Section 6:	Requirement	Comply or Explain
A.5.5	The Chairperson is responsible for leadership of both the Board and the Council but the Governors also have a responsibility to make the arrangements work and should take the lead in inviting the Chief Executive to their meetings and inviting attendance by other Executives and Non-Executives, as appropriate.	Comply
A.5.6	The Council should establish a policy for engagement with the Board of Directors for those circumstances when they have concerns.	Comply
A.5.7	The Council should ensure its interaction and relationship with the Board of Directors is appropriate and effective.	Comply
A.5.8	The Council should only exercise its power to remove the Chairperson or any Non-Executive Directors after exhausting all means of engagement with the Board.	Comply
A.5.9	The Council should receive and consider other appropriate information required to enable it to discharge its duties.	Comply
B.1.2	At least half the Board, excluding the Chairperson, should comprise Non-Executive Directors determined by the Board to be independent.	Comply
B.1.3	No individual should hold, at the same time, positions of Director and Governor of any NHS Foundation Trust.	Comply
B.2.1	The Nominations Committee or Committees, with external advice as appropriate, are responsible for the identification and nomination of Executive and Non-Executive Directors.	Comply
B.2.2	Directors on the Board of Directors and Governors on the Council should meet the "fit and proper" persons test described in the provider licence.	Comply
B.2.3	The Nominations Committee(s) should regularly review the structure, size and composition of the Board and make recommendations for changes where appropriate.	Comply
B.2.4	The Chairperson or an independent Non-Executive Director should chair the Nominations Committee(s).	Comply
B.2.5	The Governors should agree with the Nominations Committee a clear process for the nomination of a new Chairperson and Non-Executive Directors.	Comply
B.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors.	Comply

Disclosures set out in the NHS Foundation Trust Code of Governance

Code Provision Section 6:	Requirement	Comply or Explain
B.2.7	When considering the appointment of non-executive directors, the council should take into account the views of the board and the nominations committee on the qualifications, skills and experience required for each position.	Comply
B.2.8	The annual report should describe the process followed by the council in relation to appointments of the chairperson and non-executive directors.	Comply
B.2.9	An independent external adviser should not be a member of or have a vote on the nominations committee(s).	Comply
B.3.3	The board should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity.	Comply
B.5.1	The board and the council governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.	Comply
B.5.2	The board and in particular non-executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis.	Comply
B.5.3	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors.	Comply
B.5.4	Committees should be provided with sufficient resources to undertake their duties.	Comply
B.6.3	The senior independent director should lead the performance evaluation of the chairperson.	Comply
B.6.4	The chairperson, with assistance of the board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as board members.	Comply
B.6.5	Led by the chairperson, the council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities.	Comply
B.6.6	There should be a clear policy and a fair process, agreed and adopted by the council, for the removal from the council of any governor who consistently and unjustifiability fails to attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties.	Comply

Code Provision Section 6:	Requirement	Comply or Explain
B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.	Comply
C.1.2	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary.	Comply
C.1.3	At least annually and in a timely manner, the board should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance.	Comply
C.1.4	The board should notify Monitor and the CoG without delay and consider whether it is in the public's interest to bring to the public's attention, any major new developments which may lead to a substantial change in financial wellbeing, healthcare delivery performance or reputation and standing of the FT.	Comply
C.3.1	The board should establish an audit committee composed of at least three members who are all independent non-executive directors.	Comply
C.3.3	The council should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors.	Comply
C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust.	Comply
C.3.7	When the council ends an external auditor's appointment in disputed circumstances, the chairperson should write to Monitor informing it of the reasons behind the decision.	Comply
C.3.8	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.	Comply
D.1.1	Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels.	Comply
D.1.2	Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles.	Comply

Disclosures set out in the NHS Foundation Trust Code of Governance

Code Provision Section 6:	Requirement	Comply or Explain
D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination.	Comply
D.2.2	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments.	Comply
D.2.3	The council should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.	Comply
E.1.2	The board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums.	Comply
E.1.3	The chairperson should ensure that the views of governors and members are communicated to the board as a whole.	Comply
E.2.1	The board should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate.	Comply
E.2.2	The board should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each.	Comply

NHS Improvement's 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:

1. Quality of care
2. Finance and use of resources
3. Operational performance
4. Strategic change
5. 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 to be in breach or suspected breach of its licence.

Segmentation

NHS Improvement has placed South East Coast Ambulance NHS Foundation Trust in segment 4 - special measures. The Trust has taken a number of steps to ensure improvement, all of which is set out in the Delivery Plan (see the Performance Report for more on the Plan).

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 the 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.

Area	Metric	2017/18 Q4 score	2016/17 Q4 score
Financial sustainability	Capital service capacity	2	4
	Liquidity	1	1
Financial efficiency	I&E Margin	2	4
Financial controls	Distance from financial plan	1	4
	Agency spend	1	4
Overall scoring		**1**	**3**

Statement of the Chief Executive's responsibilities as the Accounting Officer of South East Coast 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 Direction which require South East Coast 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 East Coast 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 and
- 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 outlines 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.

Daren Mochrie, Chief Executive

Date: 25 May 2018

Statement of Directors' responsibility for the report and accounts

The Board of Directors is responsible for preparing the Annual Report and Accounts. The Directors consider the Annual Report and accounts to be fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the Trust.

Annual Governance Statement

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the 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 the 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 Trust Accountable Officer Memorandum.

The purpose of the system of internal control

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

Capacity to handle risk

The Board of Directors has ultimate responsibility for ensuring that an effective risk management process is in place. The Board of Directors recognises that risk management is an integral part of good management practice and to be most effective should become part of the Trust's culture. The Board is therefore committed to ensuring that risk management forms an integral part of its philosophy, practice and planning rather than viewed or practised as a separate programme and that responsibility for implementation is accepted at all levels of the organisation. The provision of appropriate training is central to the achievement of this aim.

During the year, the Board has overseen an improvement plan designed to embed a culture of risk management and provide the tools to enable staff to manage and control risk. A substantial revision of the trust's risk management policy has been undertaken (to be introduced in Q1 of 2018/19) to provide a more robust framework for achieving the integration of risk management in the Trust's strategic aims and objectives. It encompasses our risk management process and sets out how we support and train staff to enable them to identify, evaluate and manage risk. In addition, there has been significant effort to improve the management governance structure to ensure management at all levels have the right focus on risk management.

Although I recognise more needs to be done to ensure better consistency, lessons learned and guidance on best practice is shared in many different ways including;

- Monthly Quality and Patient Safety Report
- Daily operational safety huddle conference calls including on call teams
- Weekly conference calls between the Improvement Hub and Operational Unit managers
- Dissemination of weekly Operating Unit Team Leader updates on key performance indicators
- Intensive support for live projects by the Improvement Hub
- Quality Assurance Visit team
- Redesign and simplification of Datix reporting for incidents

- Immediate feedback for staff who have reported incidents
- Production of Quality posters for safeguarding, compliments and complaints and clinical incidents
- Roll out of Quality Noticeboards at station/site level
- Trust wide newsletter, supported by a Clinical Newsletter (Reflections) and a Quality Newsletter
- Listen, Learn & Change regional conference 4th October 17
- Learning and Development programmes tailored to meet identified need

I am accountable for the leadership of risk within the Trust. I chair the Executive Management Board, which is responsible for ensuring the appropriate resource is available to manage risk. In particular, EMB oversees the strategic risks, including the risks identified with the Board Assurance Framework, seeking assurance that they are being adequately managed, and to seek assurance that services are being provided safely.

The established Board committee structure takes a risk-based approach, scrutinising assurances that the system of internal control used to achieve objectives is well designed and operating effectively. An independent non-executive director chairs each committee, and when assurance is not received, the committee asks management to respond by setting out the corrective action being taken. This is then monitored.

The **Executive Director Quality and Safety** is the executive lead for ensuring that overall risk and assurance processes are established and implemented, reporting to the Executive and Trust Board appropriately. This director is also responsible for providing assurance on patient care. The **Executive Medical Director** is responsible for providing assurance on all aspects of medical leadership (including the use of medicines) reporting to the Executive and Trust Board appropriately.

The **Executive Director of Finance and Corporate Services** has a specific role for leading the strategic development and implementation of financial risk management (including anti-fraud and bribery), which includes oversight of the Standing Financial Instructions.

The risk and control framework

The Risk Management Strategy and Policy sets out the framework and process by which the Trust implements control of risk. It describes what is meant by risk management and it defines the roles and responsibilities of staff, including the key accountable officers (some of which are referenced in the section above).

The risk management system of internal control aims to:

- Be embedded in the operation of the organisation and form part of its culture;
- Be capable of responding quickly to evolving risks; and
- Include procedures for reporting and escalating any significant control failings immediately to appropriate levels of management.

Risks are identified via a number of mechanisms and may be both proactive and reactive from a number of sources, for example; analysis of key performance indicators; change control processes; claims, incidents, serious incidents and complaints; risk assessment; information governance toolkit.

Once identified, risks are evaluated by analysis of the cause(s) and source(s) of the risk, their positive and negative consequences and the likelihood that those consequences will occur. Ideally, risk

evaluation should be an objective process and wherever possible should draw on independent evidence and valid quantitative data. In order to ensure consistency of risk quantification across the Trust a standardised set of descriptors and scoring matrices is used, based on the Australian/ New Zealand Standard AS/NZS 4360:2004.

Having identified and evaluated the risk, the controls and actions to be implemented are discussed, determined and recorded. Sometimes a decision will be taken to accept the risk, otherwise controls and actions are aimed at avoidance, transference, or reduction.

In light of the findings from the CQC inspection in May 2017, a number of actions and programmes were implemented to ensure compliance with the CQC registration requirements. This informed the Trust's new five-year strategy, which was agreed in July 2017. The Delivery Plan focusses on years 1-2 and has a number of work-streams, which report in to one of the following steering groups; strategy; compliance; transformation; culture and OD; and sustainability.

The steering groups meet at least monthly (compliance is weekly) and report progress and any risks on a weekly basis to the Executive.

The Trust Board monitors progress and risks to the Delivery Plan at each of its meetings and tests the assurances relating to specific improvement plans through its committees. Each committee is guided by an assurance purview map, which is based on the Trust's strategic goals; legal/ regulatory requirements; CQC key lines of enquiry; and the well-led framework. Committees tested throughout the year assurance against specific areas, prioritising the issues CQC set out following its inspection as 'must dos'.

As part of the governance arrangements related to being in special measures, the Trust also has meetings with NHS Improvement each month, to track progress against the Delivery Plan and consider key risks. A Single Oversight Group also meets monthly, this includes NHSI, NHSE, CCGs, Healthwatch and other stakeholders and, as well as seeking assurance, this Group helps to support us in our improvement journey. We also meet with CQC each month, with a scheduled series of deep dives.

The Trust has an annual programme that includes information governance training for all staff on the risks around data security and the appropriate handling of patient identifiable data. In addition to this, the Trust adheres to NHS and CESG best practice around IT Security in terms of managing user access, providing anti-virus & malware protection, email filtering, web filtering, network firewalls and data backup. These systems are constantly reviewed to ensure data is protected from outside attack.

The Trust's major risks during 2017/18 included;

Stability of the Executive

In the past two years, the Trust has experienced a high number of changes Executive level, and a number of interim directors. I joined as Chief Executive in April 2017 and the Board's Appointment & Remuneration Committee has worked through the year to implement its succession plan, successfully recruiting substantively to all bar one executive post. The final appointment is due to be made during Q1 of 2018/19.

Medicines Management

Significant issues were addressed during the first half of the year, following risks identified by the CQC that led to conditions being placed on the Trust's registration. A detailed medicines optimisation action plan was implemented, which demonstrated significant improvement. In September 2017, the CQC removed the conditions on our registration, on the basis of the evidence

we provided and the direct observations of our improved processes. We are working closely with an independent pharmacy advisor to support continued improvement and best practice.

Call Recording

There has been intermittent problems with our 999 call recording platform, resulting in some calls not recording and / or being readily available. The CQC imposed a condition on our registration to ensure we have a complete and accurate record of all 999 calls. In September 2017, the CQC removed this condition, on the basis of the evidence we provided. The Board of Directors approved a business case to replace the telephony and voice recording systems, due to be installed in Q1 of 2018/19.

Financial Position / Cost Improvement Programme (CIP)

Having ended 2016/17 £7.1m in deficit, the Trust began 2017/18 with a significant cost improvement challenge. The Board agreed a £15m cost improvement programme target, with the risks of each scheme considered through the quality impact assessment process. This process was carefully tested by the Board's Quality and Patient Safety Committee, ensuring no scheme with a significant adverse impact on quality was agreed.

Culture

The external review commissioned highlighted a significant issue with bullying and harassment. A range of actions were agreed with the engagement of staff, and the subsequent culture and OD programme aims to ensure address these issues. Linked to the Trust strategy the new values and behaviours framework is due to be launched in Q1 of 2018/19.

Recruitment & Retention

There has been significant issue with staff recruitment and retention, in particular within our EOC. A number of initiatives have been tested with some progress starting to be seen during the end of the year. This will remain one of the key risks for 2018/19.

The Board of Directors' committee structure, revised in 2016/17, continued to embed through 2017/18. Informed by the assurance purview map, board committees scrutinise the systems of internal control and through the monitoring of information tests their impact and how management ensures standards are improved and maintained.

An external governance review was commissioned during the year. The objectives were to:

- Benchmark the Trust governance structure to other ambulance service providers and a wider peer group of NHS providers
- Assess the design and content of papers to consider whether information is sufficient to enable informed decision making.
- Assess the risk management strategy to review the process for escalating risks from the front line to the Board promptly.

This review identified a number of areas of good practice, including:

- Meetings of the Board and its committees are well chaired and have a good balance of forward and backward looking information as well as the majority of the agendas are used for scrutiny and agreeing actions rather than for information.
- There is an appropriate governance structure in place to allow review of the key elements of performance at a Trust wide level. The governance structures are closely aligned with those used by the NHS providers used to benchmark the Trust against.
- There is a well-defined structure in place for the identification and escalation of risks. There are defined forums for the review of risks at different levels.

The review also identified a number of areas for development:

- A formal structure for monitoring and scrutinising local performance had not been fully established. While governance structures have been established for Operating Units it was not clear how these escalated to the Regions or how they were held to account by the Executive for the delivery of performance.
- Holistic performance information is not consistently available to enable analysis at a locality level.
- Insufficient information is included in the risk registers to enable detailed scrutiny of whether mitigations are appropriate

In response to these findings, the management governance structure was revised, in particular at divisional-level. There is now clearer lines of accountability with area governance reviews held monthly, where the executive hold operational areas to account for delivery of objectives.

In addition, improvements have been made to other reporting, such as the Delivery Plan; Integrated Performance Report; Quality & Safety Report; and the newly established Health and Safety Report, providing more timely and accurate information to enable better assessment of risk to compliance with the Trust's license.

As a foundation trust, we involve members, patients and the public in the development of our services. The Trust's Inclusion Strategy brings equality and diversity work, patient and public involvement and Foundation Trust membership engagement into a single strategy which ensures that our statutory and legislative duties are met.

As set out in the Inclusion Strategy, the Inclusion Hub Advisory Group is a diverse and representative group of members supported by the Trust's Inclusion Manager. It advises the Trust on:

- Appropriately involving and engaging with all those with an interest in our services;
- Ensuring that patients benefit from the best possible services, developed around their needs; and
- Providing relevant opportunities for staff to have meaningful input into service developments.

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

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.

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

The trust 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

The means by which the Trust aims to ensure economy, efficiency and effectiveness include;

- A robust pay and non-pay budgetary control system
- Financial and establishment controls
- Effective procurement
- Continuous programme of modernisation and quality and cost improvement

The Board of Directors performs an integral role in maintaining the system of internal control, supported by the work of its committees, internal and external audit and its regulators.

Each cost improvement plan (CIP) scheme is supported by an action plan, a quality impact assessment and appropriate metrics. Performance against these plans are monitored by the Executive and the Board of Directors.

The Trust's internal audit service provider is RSM. Detailed annual plans developed and approved by the Audit Committee at the start of each year taking into account the Trust's objectives and risks.

In accordance with the approved audit plan, a number of reviews were carried out during the year. These helped to identify some weaknesses in the control framework, which I would expect given where we are in our recovery. Management work with internal audit to develop plans to implement the agreed recommendations, within specified timescales. These are then tracked and overseen by the Audit Committee.

RSM were unable to provide any assurance following the audit of overpayments of salaries. Partial assurance and limited progress opinions were provided regarding the following systems reviewed;

- Budgetary control
- Incident management
- Complaints processes
- Staff records
- Risk Management

Information governance

The Trust has reported two incidents to the Information Commissioner's Office (ICO) during 2017/2018 both related to emails with incorrect attachments.

Incident 1 - ICO Security Notification Form completed 28th December 2017

In December 2017 an email was sent to a complainant, which erroneously included a response intended for another individual. This was reported internally to the IG Working Group, Trust SIRO and Caldicott Guardian and also externally to our regulatory body ICO and the Information Governance Toolkit. A review was completed and lessons shared.

Incident 2 - ICO Security Notification Form completed 1st February 2018 In January 2018 sent an email to a staff member and a referral form for another individual was incorrectly attached to the email. This referral form contained sensitive confidential information. The Information Governance Lead reviewed the incident and a team meeting was immediately facilitated, advice and guidance was provided to the staff involved, and a local action plan was discussed and implemented.

This breach was formally reported internally to the IG Working Group, Trust SIRO and Caldicott Guardian and also externally to our regulatory body ICO and the Information Governance Toolkit.

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.

Patient outcomes and experience are the benchmark of quality for any healthcare provider, and improving both of these is at the heart of SECAmb's purpose. In identifying and agreeing the Quality Report, measures are focused on improving outcomes and experience for patients; how this is to be done is described in the detail of each quality measure throughout the Quality Report.

As part of the annual process, Governors were invited to participate in a consultation event (alongside public members, staff and other stakeholders) to agree the Quality Report measures/objectives for the year. This took place in November 2017. Part 2 of the Quality Report gives details of the priorities for improvement and assurance statements from the Trust Board. The three priority areas agreed were:

1. **Improving outcomes from Out of Hospital Cardiac Arrests**
2. **Learning from Incidents, Complaintsand Safeguarding reviews**
3. **Patient facing staff adequately trained to manage safeguarding concerns and to report them appropriately**

The Trust is required to evaluate key processes and controls for managing and reporting against the mandatory indicators and to undertake sample testing of the data used to measure how well the Trust is doing against them – also called an audit. The findings of this audit are included within the Quality Report.

There were three priority areas for 2017/18:

Priority	Fully Achieved	Partially Achieved	Not Achieved
1. Learn from incidents and improve patient safety	√		
2. Patient and Family Involvement in Investigating Incidents.		√	
3. Improving Outcomes for Out of Hospital Cardiac Arrest.			√

Full details can be found within the Quality Report 2017/18.

Review of effectiveness

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

The Board and its committees have a significant role in reviewing the effectiveness of the system of internal control. The processes that have been applied in this regard include;

Board of Directors

The Board receives an update from me at each meeting on any significant issues that affect the trust, as well as considering the integrated performance report, which covers clinical safety; quality; performance; workforce and finance. The Board receives a written escalation report from each of its committees after every meeting.

Audit Committee

The Audit Committee is a standing committee of the Board of Directors. Its membership comprises of independent non-executive directors. It is responsible for overseeing overall risk management, losses and near misses, business continuity, information risks, financial risks, governance, internal audit, external audit and the local counter fraud and anti-bribery specialist.

The internal audit programme is risk based and generally focused on high-risk areas agreed between Internal Audit, Audit Committee and Management. The Audit Committee has flexibility to ask internal audit to review any urgent issue as they arise.

Audit Committee reviews the risks identified in the Board Assurance Framework (BAF), which includes controls and assurances (and any gaps) plus the mitigating action being taken. Through the year, the Trust has been developing its BAF risk report.

Quality & Patient Safety Committee

Chaired by an independent non-executive director, the Quality & Patient Safety Committee is also a standing committee of the Board of Directors. On behalf of the Board, it tests the design and effectiveness of the system of internal controls that relate to quality and patient safety. The committee has a key function in assessing the cost improvement programme (CIP) against the impact on quality.

During the year, this committee has prioritised the areas to scrutinise in order to test the design and effectiveness of the relevant parts of the overall system of risk management and internal control. Where the committee has identified weaknesses, it has asked management to provide assurance that corrective action is being taken respond. The areas the committee has asked for further assurance has included:

- Duty of Candour
- Patient Care Records
- Medical Equipment
- Complaints
- Hear & Treat
- Infection Prevention & Control

Clinical Audit

The Board lead for Clinical Audit is the Executive Medical Director who ensures sustained focus and attention to detail of clinical audit activity. The effectiveness of clinical audit has been a concern for a number of years. The team has experienced leadership challenges and, in 2017, a new Head of Clinical Audit was appointed. This coincided with the relocation of the team to the new Headquarters where colleagues are co-located with the Medical Directorate, providing greater support and oversight. For the first time in several years, the annual clinical audit plan was completed.

Internal Audit

Internal audit provides an independent and objective opinion on the degree to which risk

management, control and governance support the achievement of the Trust's objectives.

During 2017/18 the outcome of some audits identified issues as outlined earlier in this statement. As a consequence, the Head of internal audit opinion for 2017/18 is;

Annual Governance Statement

There are weaknesses in the framework of governance, risk management and control such that it could be, or could become, inadequate and ineffective.

Most particularly, these weaknesses related to the areas of Patient Clinical Records, Incident Management and Complaints, Staff Records and Risk Management. Our work has identified that further enhancements to the framework of risk management, governance and internal control are required to ensure that it is adequate and effective. Actions have been identified which the Trust has either implemented or is in the process of implementing to close these gaps. We have noted some areas where controls have improved since the previous year, most notably in the areas of Cost Improvement and Safeguarding. Controls have remained designed and operating effectively in core financial areas.

External Audit

External Audit report to the Trust on the findings from the audit work, in particular their review of the accounts and the Trust's economy, efficiency and effectiveness in its use of resources. During 2017/18 no significant issues were identified.

Conclusion

This year, particularly quarters 1 and 2, have been challenging for the Trust. Most significant were the conditions placed on our CQC registration in June 2017, relating to medicines governance and call recording. There has been significant effort in how we manage medicines at the Trust and I was pleased that the CQC were satisfied in September, when it tested the impact of our medicines optimisation plan.

While I am confident that there has been general improvement in many other areas, to ensure some controls have been well designed and operating effectively, there have been clear and significant instances where this did not apply, as set out within this annual governance statement.

I am aware of the areas we need to continue to make improvement, and I believe progress in quarters 3 and 4 is starting to address previous issues and that even greater progress will be made in developing our governance arrangements during 2018/19.

Daren Mochrie, Chief Executive

Date: 25 May 2018

South East Coast Ambulance Service
NHS Foundation Trust

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Appendix A

Quality Account & Quality Report 2017/18

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Introduction

Introduction to the Trust's 2017/18 Quality Account

The purpose of this document is to report on the quality of care provided by South East Coast Ambulance Service NHS Foundation Trust (SECAmb) during 2017/18.

Patients want to know they are receiving the very best quality of care. Consequently, providers of NHS healthcare are required to publish a quality account each year. These are required by the Health Act 2009 and the terms are set out in the National Health Service (Quality Accounts) Regulations 2010.

These quality reports help Trusts to improve public accountability for the quality of care they provide. The quality report incorporates all the requirements of the quality accounts regulations as well as some additional reporting requirements mandated by NHS Improvement.

NHS Foundation Trusts are also required to obtain external assurance on their quality reports. The Trust's auditors provide this assurance and it follows the framework set out by NHS Improvement. This scrutiny offers assurance to our patients on our performance reporting.

The format of the Quality Account is mandated. The regulations prescribe the three sections of the Quality Account that must appear in the following order:

- Part 1 – Statement on quality from the Chief Executive of the NHS Foundation Trust
- Part 2 – Priorities for improvement and statements of assurance from the Board. To include:
  - Priorities for improvement
  - Statements of assurance
  - Reporting against core indicators
- Part 3 – Other information; two annexes and links:
  - Annex 1 – Statements from external partners
  - Annex 2 – Statement of directors' responsibilities for the quality report
  - Links to supporting documents (additional information not mandated)

The quality account also contains a number of patient stories, all of which have been published by the Trust through the year.

For further information on the quality improvements the Trust is making, please refer to the Trust's website

www.secamb.nhs.uk

Patient Story 1 – Des

Cardiac arrest patient thanks ambulance team

24 April 2017

Des Crockford, now 50, collapsed at his Southwick home in the early hours of 30 May 2016. His daughters, Jade and Georgia, now 21 and 18, were woken by their dog, Brooke, who was restless, and while dealing with her, discovered their dad in bed making strange noises, unconscious and not breathing.

The pair acted quickly by dialling 999 and followed the instructions provided by the Emergency Medical Advisor. Jade, who is studying Medical Sciences at Exeter University and currently on placement at St George's Hospital in Tooting, began chest compressions in the minutes before the ambulance crews arrived.

Colin was first to arrive on scene with crew mate Charles. Together they continued Jade's CPR efforts and were able to restart Des's heart by delivering a shock with a defibrillator. "We were travelling on the Shoreham flyover on our way to another job when we were stood down to attend Des," said Colin. "It was close to the end of a 12-hour shift. Jade's actions were vital as they ensured we had a chance of saving her dad."

Colin and Charles were soon joined by Richard and Paramedic Practitioner Katie and the team set about stabilising Des.

However, with Des's room located in a loft

conversion with steep stairs, the team had to call for the assistance of East Sussex Fire and Rescue Service. This meant Des could be expertly lifted out of the loft window while still lying flat in order to not impact on his fluctuating blood pressure. With the complicated exit negotiated, Des was taken to Royal Sussex County Hospital with his daughters, and wife Michelle, who had rushed back from working nights, following behind.

Des's expert treatment continued in hospital and he was fitted with an internal defibrillator a little over a week later. Weeks of rehab and three months off work followed as he recovered. He has since returned to work as a civil servant and also to his love of cycling. "My recovery has gone very well," said Des. "I'm back at work and back cycling. I'm being sensible but physically I'm starting to feel as fit as I did before my cardiac arrest. Emotionally it's been hard on all of us and I can't imagine what Jade was thinking having to do CPR on me. It's a debt I'll never be able to repay. It's been hard but we've faced it all as a family and we're looking forward to going away on holiday soon. I'm really pleased we have been able to say thank you in person."

Jade, who is hoping to specialise in cardiology said: "I've been trained in CPR but obviously it was difficult and very different having to perform it on a member of your own family. I'm just so grateful for everything everyone did." Richard Crabb paid tribute to the quick thinking of the sisters and added: "All credit to the girls. Their actions made all the difference. It's great to see that Des has come full circle. His recovery is amazing. It was also great to see a patient in much better circumstances and on behalf of the whole team I wish him and family all the best for the future."

Part One

Part 1: Statement on quality from the chief executive of the South East Coast Ambulance Service NHS Foundation Trust

This has been my first year with the organisation. It has certainly been a challenging first twelve months and whilst we have faced some significant challenges, there have also been a number of successes and increased improvements, particularly in quarter 3 and 4 of the year. I feel proud to lead an organisation that has responded so well to these difficult challenges.

In May 2017, we began the move into our superb new facility in Crawley. This was not just an office move. The transfer involved moving two of our previous Emergency Operations Centres (EOC) – in Banstead and in Lewes – into a brand-new EOC covering the west of our region. This was a complex service change that had required detailed planning; it was carefully managed by the project team and I was very pleased with how smoothly it went.

In July 2017, we went live in our EOCs with a new Computer Aided Dispatch (CAD) system, used to record all data related to 999 and urgent requests for ambulance assistance and is primarily used by EOC staff to assess, prioritise and, if necessary, dispatch ambulance crews to 999 calls.

The move to the new CAD was complex and required a planned transition from old to new systems. Again, this required careful planning and management, but I was very pleased that it was a safe and seamless transition.

In the same month, I was very pleased when the Trust was awarded the 'Gold Standard' award, for the fourth year running, at the national Employers Network for Equality & Inclusion (ENEI) awards.

In August 2017, the Trust published a report, commissioned by the Chair, into the culture of the organisation. The report made difficult reading and was a clear message that we needed to embark on a substantial programme of change. Building on the ongoing work, a more comprehensive programme of work will be launched in the early part of 2018/19.

Following an unannounced inspection by the Care Quality Commission (CQC) in May 2017, we received notice that we needed to improve our medicines governance and the recording of our emergency calls. We immediately implemented a corrective action plan and on re-inspection in September, the notice was lifted.

In October 2017, the CQC published their Report following their inspection in May. Although I was pleased to see our staff rated as 'good' for caring and our NHS 111 service also receive a 'good' rating, overall the findings were disappointing, with an overall rating of 'inadequate'.

Since receiving the report, we have continued implementing our plans to improve the quality of the services we provide and, as a result, have already seen some significant improvements in our services.

We are creating a safer service for our patients and staff and have made significant improvements to the practice and governance of medicines. We have improved our ability to learn through incident reporting and have strengthened safeguarding by publishing a new safeguarding strategy with a supporting delivery plan.

We have also made improvements to the patient experience, by ensuring all complaints are responded to appropriately and in a timely way.

In November 2017, the Trust successfully moved to the new national Ambulance Response Programme (ARP) standards. This made significant changes to the way we categorise and respond to patients. It also improved

communication to patients, who now receive a clearer indication as to their waiting time.

Since the move to ARP, I am pleased that we have improved our response to our most seriously ill and injured patients (Categories 1 & 2); we know from patient feedback that timeliness is a key issue for them. However, we have performed less well in our response to Category 3 and 4 patients and need to 'do things differently' to provide these patients, who are often elderly, with a better response.

Despite making progress, we still have work to do. In December 2017, after listening to feedback from our staff, we launched our Learning from an Honest Mistakes Policy. Whilst our aim is to be a learning organisation, there are still a number of areas where we need to improve. We are working hard to be as effective as we can with the resources available to us, although recruitment challenges are at the heart of some of these initiatives. This is very much linked to the on-going demand and capacity review, being undertaken jointly with our commissioners. This work will determine the level of resources and funding we require moving forwards, to enable us to respond to our patients in an appropriate and timely way.

Many of the examples I have highlighted are discussed in detail within this Quality Account. Where possible, we have included a description of our achievement against the identified performance metrics.

I hope that you find the document provides a balanced picture and highlights both successes and challenges. Additionally, I hope the Quality Account gives you confidence that we take improving both safety and quality to be our most important ambitions.

Finally, I would like to acknowledge that this has been a particularly demanding year for our staff. Some areas, such as our Emergency Operations Centres, have seen significant challenges in recruitment, which inevitably puts additional demand on the staff who remain. With this in mind, I would like to thank our staff, on behalf of the Trust Board and our patients, for their continuing dedication and professionalism.

I can confirm that the Board of Directors has reviewed this Quality Account and can confirm that it is an accurate description of the Trust's quality and performance.

Daren Mochrie QAM , Chief Executive

Patient Story 2 – Daniel

Massive thank you for paramedic team

24 April 2017

10 May 2017 (published)

A Sussex man who fell from approximately 40 feet was delighted to meet two paramedics who were part of the team who responded to his neighbour's 999 call.

Just over two years ago, Daniel fell from the window four floors up in the early afternoon. "I really don't remember anything at all of the incident itself," said Daniel, "but it has been on my mind ever since to thank the medical people who came out to rescue me and now that I have recovered enough I wanted to thank them in person."

A neighbour saw Daniel's fall and raised the alarm rushing out to help him. An off duty doctor had just walked past and also stopped to help. Clinical Team Leader Liam McDine received a call that a man was unconscious. Liam, who reached the incident in less than two minutes after receiving the call said: "This is a job that I can distinctly remember from being first on scene. When I arrived I didn't know yet what had happened and to be confronted with a crowd around a seriously injured man was totally unexpected. It was immediately clear this was serious and that I needed urgent back-up." Several other ambulance crews were dispatched to attend, including the air ambulance service. SECAmb student paramedic Scott Fraser

said: "Daniel had suffered severe trauma and showed obvious injuries across his body. Air ambulance medics carried out further checks and treatment before Daniel was taken to Hospital.

It was found that Daniel had suffered a spinal cord injury from a broken back, multiple fractures to his left arm and wrist, and numerous fractured ribs. "I needed four weeks of rehabilitation to re-learn the smallest of things like walking and making a cup of tea," said Daniel. "But I have been so extremely lucky that I received immediate help from two members of the public, then the ambulance and air ambulance teams were with me so quickly and I did not have any internal organ damage." "I will have to live with the life-long consequences of the accident and I have learnt to accept that. I was a keen runner before but due to my injuries I'm no longer able to do that, so I've now taken up cycling which I'm really enjoying. I have learnt a lot about myself over the course of my recovery, and the whole journey has helped me refocus on what is important in life. I have realised that, over everything, what's most important is friends, family and unrelenting positivity. That's what's helped me come back to as normal a life as possible."

Daniel received the all clear last December. He's back to working all the hours he did before his accident. Both Scott and Liam were amazed to see their patient in such remarkably good health following the traumatic injuries they dealt with. Liam said: "We were just doing our job and somehow you get used to not knowing, not having feedback about your patients. It's great to see how well Daniel has recovered and how positive he is about everything." Scott added: "It's been fantastic to see him face-to-face and to know that our interventions made a difference and helped Daniel to get back to where he wants to be."

Part Two

Part 2: Priorities for improvement and statements of assurance from the board

This section of the Quality Account describes areas for improvement in the quality that the Trust intends to provide in 2018/19.

Introduction

This section identifies three priorities for improvement in 2018/19. The Trust board has agreed these priority areas and the rationale for identifying the three priorities is described, including the association with considered data, audit and reports.

An outline is also given on how the Trust intends to achieve the three priorities and how they will be monitored, measured and reported.

The section also includes progress made with the improvement priorities identified in the last Quality Account (2016/17), which includes the performance during the year against each priority.

Looking forward - the 2018/19 quality improvement priorities

Initial priority suggestions

An initial shortlist was created to support the Trust in identifying which improvements to prioritise.

The main driver for creating the shortlist was the Care Quality Commission Unannounced Inspection Report 2017. This report was an independent and comprehensive review of the Trust's services. It identified 17 areas that the Trust must address and 16 areas that the Trust should address.

The Trust agreed to draw the shortlist of quality improvement priorities from the 17 must do areas. To give an indication of priority within the 17 areas, the Trust also considered other information alongside the Inspection Report. This included any areas where the Trust was in potential breach of legislative requirements and a review of the clinical outcome data that the Trust held and any concerns from the Trust's external partners.

The final shortlist of proposed quality improvement areas was as follows:

Proposal Area 1. Development of Quality Improvement methodology within SECAmb

This suggestion directly arose from a Care Quality Commission Must Do: "The Trust must ensure that governance systems are effective and fit for purpose. This includes systems to assess, monitor and improve the quality and safety of services".

Additionally, as part of the Trust's improvement journey for a number of the domains following the CQC re-inspection, the Trust appreciated the need to have a single cohesive approach to improvement that all Trust employees understood and could engage with. This would also assist in making sustainable improvement across the organisation.

Proposal Area 2. Improving outcomes from out of hospital cardiac arrests

This suggestion directly arose from a Care Quality Commission Must Do: "The Trust must improve outcomes for patients who receive care and treatment". It had been selected as an improvement priority the preceding year and whilst work had been undertaken (reported later in this quality account) it was identified that further work could be done.

At the time of identifying the priority area, patient outcomes from out of hospital cardiac arrests were below the national average when compared to the other Ambulance Trusts in England. Additionally, the Trust's performance in this clinical outcome indicator had deteriorated over the past three years.

Priority Area 3. Learning from incidents, complaints and safeguarding reviews

This suggestion arose from a number of must

do actions from the Care Quality Commission Report. Within the report there is a recurrent theme that the Trust is not maximising the opportunity to learn from feedback.

Priority Area 4. Improving timeliness of completion of complaint responses to patients

This suggestion directly arose from a Care Quality Commission Must Do; "The Trust must ensure the systems and processes in place to manage, investigate and respond to complaints, and learn from complaints are robust".

Whilst the Trust does have some areas of complaint management that are well received, such as the patient story at Trust Board, the Board recognises that it was taking too long to address complaints and that there was an opportunity to improve the learning from complaint feedback.

Priority Area 5. Mandatory training on patient groups directions for all staff that administer medicines under the legal framework

Whilst patient group directions were not explicitly a Care Quality Commission Must Do, the area of medicine's management received a higher warning; a "Notice of Proposal to impose a condition on the Trust's registration for the regulated activity of treatment of disease, disorder or injury".

Considerable improvement work was already taking place but updating the patient group directions was proving difficult. This was identified as a priority area as there are legislative requirements within this area of practice.

Priority Area 6. Patient-facing staff adequately trained to manage safeguarding concerns and to report them appropriately

This suggestion directly arose from a Care Quality Commission Must Do: "The Trust must ensure all staff working with children, young people and/or their parents/carers and who could potentially contribute to assessing, planning, intervening and evaluating the needs of a child or young person and parenting capacity where there are safeguarding/child protection concerns receive an appropriate level of safeguarding training".

Additionally, this priority area has received considerable external attention and the area is regarded as a priority area for our commissioners.

Priority Area 7. 111/999 integration with enhanced clinical intervention and hear & treat

This was identified as part of the consultation with stakeholders and was raised by the 111 team.

Part Two

The selection process

A consultation and selection event was held with a range of invited stakeholders on Monday 27 November 2017. Representatives from the following groups attended: Council of Governors, Inclusion Hub Advisory Group (IHAG), Staff Engagement Forum, and Clinical Commissioning Groups, along with members of the Trust's senior management team and Trust Board.

Each of the seven priority areas had a sponsor and this individual gave a brief case for inclusion before answering arising questions.

At the end of the presentation, the participants voted on the priority area that they thought would make the biggest difference. The participants voted twice, initially as a group and then as individuals.

The following table illustrates how the participants voted.

Table 1: Voting Results

Quality Account Proposal	Group Vote	Individual vote
Clinical Effectiveness		
Development of Quality Improvement Methodology within SECAmb	0	4
Improving outcomes from Out- of-Hospital Cardiac Arrests (OHCA)	5	22
Patient Experience		
Learning from Incidents, Complaints and Safeguarding reviews	3	23
Improving timeliness of completion of complaint responses to patients	2	3
Patient Safety		
Mandatory Training on Patient Groups Directions (PGDs) for all staff that administer medicines under PGD legal framework	1	7
Patient-facing staff adequately trained to manage safeguarding concerns and to report them appropriately	3	14
111/999 integration with enhanced clinical intervention and hear & treat	2	14

Three priority areas were selected for 2018/19. These were as follows:

- **Improving outcomes from out-of-hospital cardiac arrests**
- **Learning from incidents, complaints and safeguarding reviews**
- **Patient-facing staff adequately trained to manage safeguarding concerns and to report them appropriately**

These were endorsed by the Executive Management Board on 7 March 2018 and the Trust Board on 27 March 2018.

Learning and reflection on the selection Process.

Feedback from some of the participants suggested there was minimal opportunity to suggest measures not presented by the Trust. This was not the intention. It appears that the Trust's plan of focussing on the CQC findings and presenting these up front had restricted innovative thinking.

This is important feedback. The participants all chose to attend the meeting and were keen to support the Trust on its improvement journey, and some felt the process disempowered them. Going forward the Trust will review how it can consider involving stakeholders in the initial selection of a long list of priority areas.

Planned action and the monitoring process

This section takes each of the three selected priorities and identifies the aim of the priorities and how the Trust intends to achieve an improvement. The section also identifies how the priorities will be monitored, measured and reported.

Priority Area 1. Improving outcomes from out-of-hospital cardiac arrests

The aim of this quality measure is to improve the return of spontaneous circulation in patients (knows as ROSC) and improve the survival to discharge of patients who have experienced a cardiac arrest (known as StD).

This was a priority for the previous year but on review of the data (which is reported extensively in this Quality Account) it was agreed to include this priority in the 2017/18 measures. The improvements will be achieved through the identification of cardiac arrest calls as soon as possible and by ensuring that appropriate dispatch of the correct resource is achieved with complete adherence to the Joint Royal College Ambulance Liaison Committee's guidelines.

The Trust will develop and implement a Trust-wide cardiac arrest strategy (either as a strategy in its own right or as part of the new clinical strategy), implement a structured "PITSTOP" model for all responding staff and provide clear and robust clinical guidelines.

The metrics for this will be:

- Return of spontaneous circulation
- Survival to discharge.

These established metrics are already subject to rigorous audit and validation.

These will form part of the quality metrics in 2018/19 reported within the monthly Quality & Safety Report and presented to Area Governance Meetings and to the Executive Board. The metrics will also be added to the Integrated Performance Report for Trust Board.

Priority Area 2. Learning from incidents, complaints and safeguarding reviews

The aim of this quality measure is to develop systems where staff are able to access information about errors or omissions, can demonstrate understanding, and where appropriate have improved their professional practice as a result.

This will be achieved through the better use of 'patient story' videos, which are shared with staff via the intranet to promote learning on a wider scale.

The Trust will produce a communications plan with clinical staff and the communications team. In addition, the teams will develop monthly case studies and information posters for publication on the Trust's website/local display boards and produce a repository on the intranet for access and reference for all staff.

A number of metrics are already in place, such as shared learning from complaints and sharing of incident feedback. Metrics will be further developed that will allow the Trust to maintain an overview of improved learning.

Monitoring of Trust-wide learning will be in the monthly Quality & Safety Report, discussed at relevant Area Governance Meetings, and disseminated as appropriate.

Priority Area 3. Patient-facing staff adequately trained to manage safeguarding concerns and to report them appropriately

The aim of this quality measure is to ensure our staff feel adequately trained and competent to manage a range of safeguarding issues.

This will be achieved by making safeguarding training a mandatory requirement for another year. Having trained over 85% of the clinical staff at Level 3 in 2017/18, the Trust will now develop a bespoke training package. This will further enhance competence, and awareness, in wider safeguarding issues.

The Trust will also develop a process that ensures safeguarding expertise has oversight of complaints and all allegations/incidents that have a potential safeguarding theme

This will be achieved through the delivery of the training and if possible the involvement of a service user to help personalise the training. The Trust's safeguarding dashboard will be strengthened so that trends become more apparent.

In addition, the Trust will ensure a process is in place to feed back to clinical staff on immediate actions taken following their safeguarding referrals.

The measure for assessing this will be the direct feedback of Trust staff when asked about safeguarding during the Trust's recently implemented Quality Assurance Visits. The Trust's ambition is that at least 90% of Trust staff when asked will articulate that they feel sufficiently trained, informed and supported to identify and report safeguarding concerns and know how to obtain assistance.

Monitoring of the improvement will be undertaken by the Trust's Safeguarding Sub-Group which forms part of the Trust's clinical governance structure. Additionally, information will be contained within the monthly Quality & Safety Report.

Monitoring

All three priority areas will be reported through the monthly Quality & Safety Report. During 2017/18 this report was created to be a single reference point for all quality and safety metrics. It will evolve further during 2018/19 and the report is reviewed by the Area Governance Meetings, the Executive Management Board and also the Clinical Commissioning Group.

Additional assurance is gained through quarterly and annual reports by the relevant corporate functions which are received by the Executive Board and the Trust's Quality & Patient Safety Committee (a sub-committee of the Trust Board).

All of the developed metrics for the above quality priorities will be reported in the appropriate reports.

Looking back; a review of the 2017/18 quality priorities

In last year's Quality Account the Trust identified the following three quality priorities;

- **Learn from incidents and improve patient safety**
- **Patient and family involvement in investigating incidents.**
- **Improving outcomes for out-of-hospital cardiac arrest.**

This section reports on the progress against the three identified priorities.

2017/18 Priority 1. Learn from incidents and improve patient safety

AIM:

Improve patient safety by reducing harm

MEASURE 1:

10% increase in near-miss reporting in quarter 4

MEASURE 2:

10% increase in low harm reporting in quarter 4

MEASURE 3:

Compliance with fundamental standards

STATUS:

Fully Achieved

Considerable work has been undertaken during the year to make improvements to incident reporting. A comprehensive Improvement Plan was developed and progress against actions were overseen weekly by members of the executive team.

Most notably the following have been undertaken:

- Face to face training by the DATIX™ incident reporting team has been introduced and is being rolled out across the organisation.
- The original incident reporting form has been re-designed to facilitate completion and a trial was undertaken in the Guildford area.
- A target of 20 days was agreed as an acceptable timeframe for an incident to be closed.
- A significant reduction in the number of incidents taking longer than 20 days.
- Implementing daily checks of all incidents by the incident team.

Part Two

Project goals

At the start of the project three goals were identified;

a) A 10% increase (with previous year comparison) in near-miss reporting by the end of 2017/18.

b) A 10% increase (with previous year comparison) in low harm reporting by the end of 2017/18.

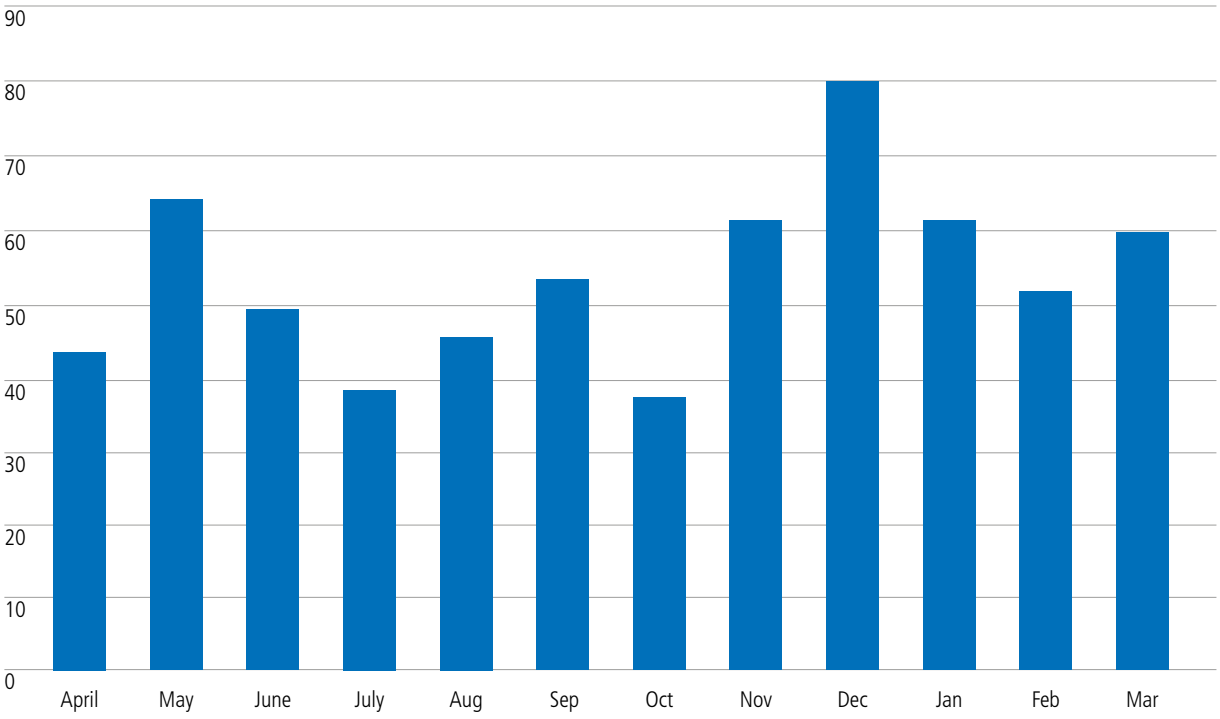
c) Compliance with the Care Quality Commission's fundamental standards.

There is a large amount of information within incidents that are graded as low harm or those graded as no harm and those that were averted (near miss). An organisation that is more aware of the value of incidents is more likely to report these lower graded incidents. Therefore, these goals were identified as an indication of the organisation's awareness.

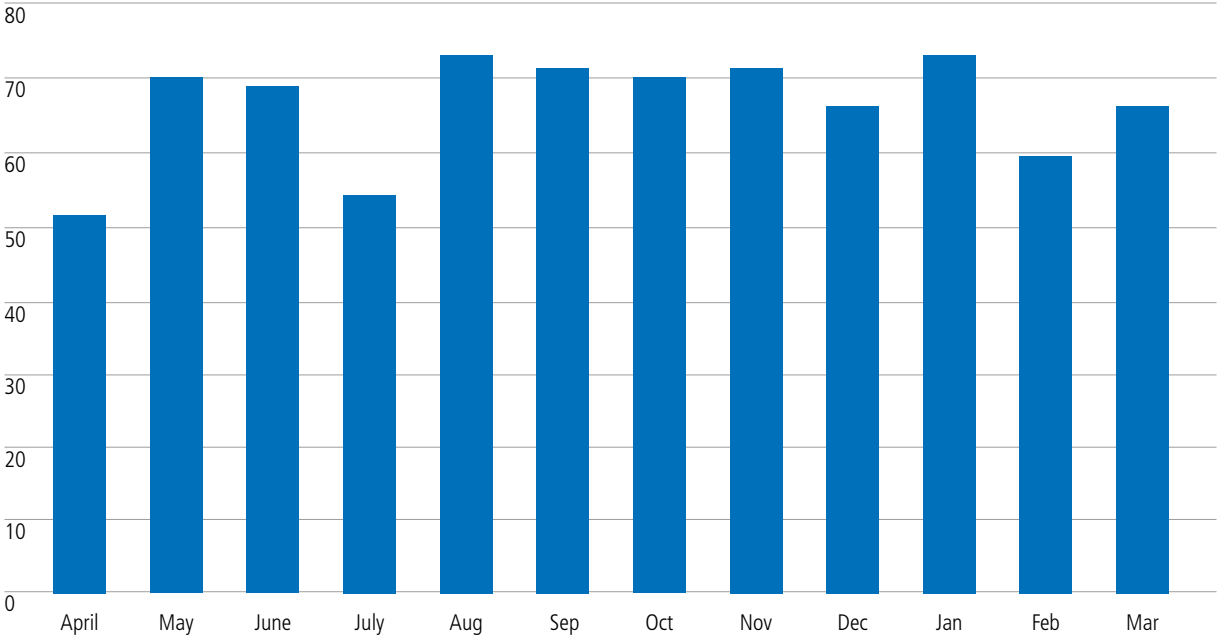
Progress

The following two graphs illustrate the improvements made in the Trust's effort to increase the reporting of near-miss incidents by 10% on the previous year.

Graph 1. Incident reporting (near-miss) in 2016/17



Graph 2. Incident reporting (near-miss) in 2017/18

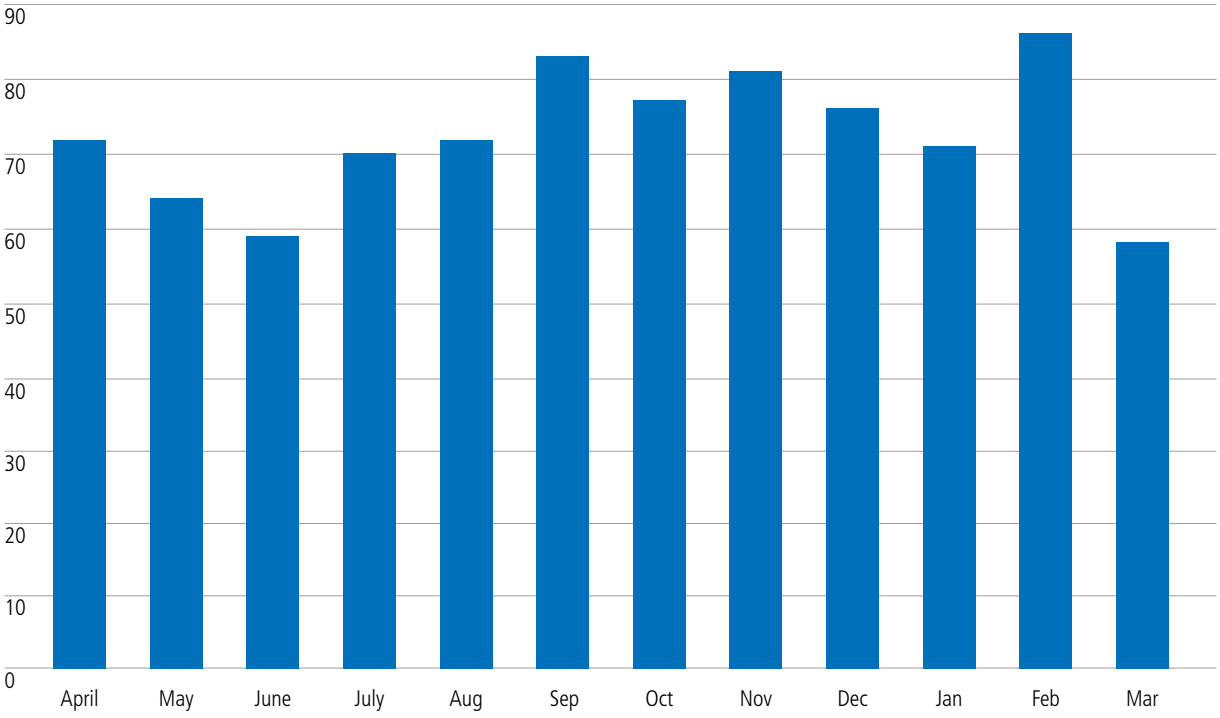


Graph 1 illustrates the month on month reporting for all incidents regarded as a "near miss" during 2016/17. The total number for the year was 644.

Graph 2 illustrates the same "near-miss" field but for the following financial year (the year of the improvement priority). The total number for the year is 794, an improvement of 23%.

The following two graphs (Graph 3 & Graph 4) illustrate the improvements made in the Trust's effort to increase the reporting of "low harm" by 10% on the previous year.

Graph 3. Incident reporting (low-harm) in 2016/17



Graph 3 illustrates the month on month reporting for all incidents regarded as "low harm" during 2016/17. The total number for the year was 869.

Graph 4 illustrates the same "low harm" field but for the following financial year (the year of the improvement priority). The total number for the year was 931, an improvement of 7.1%.

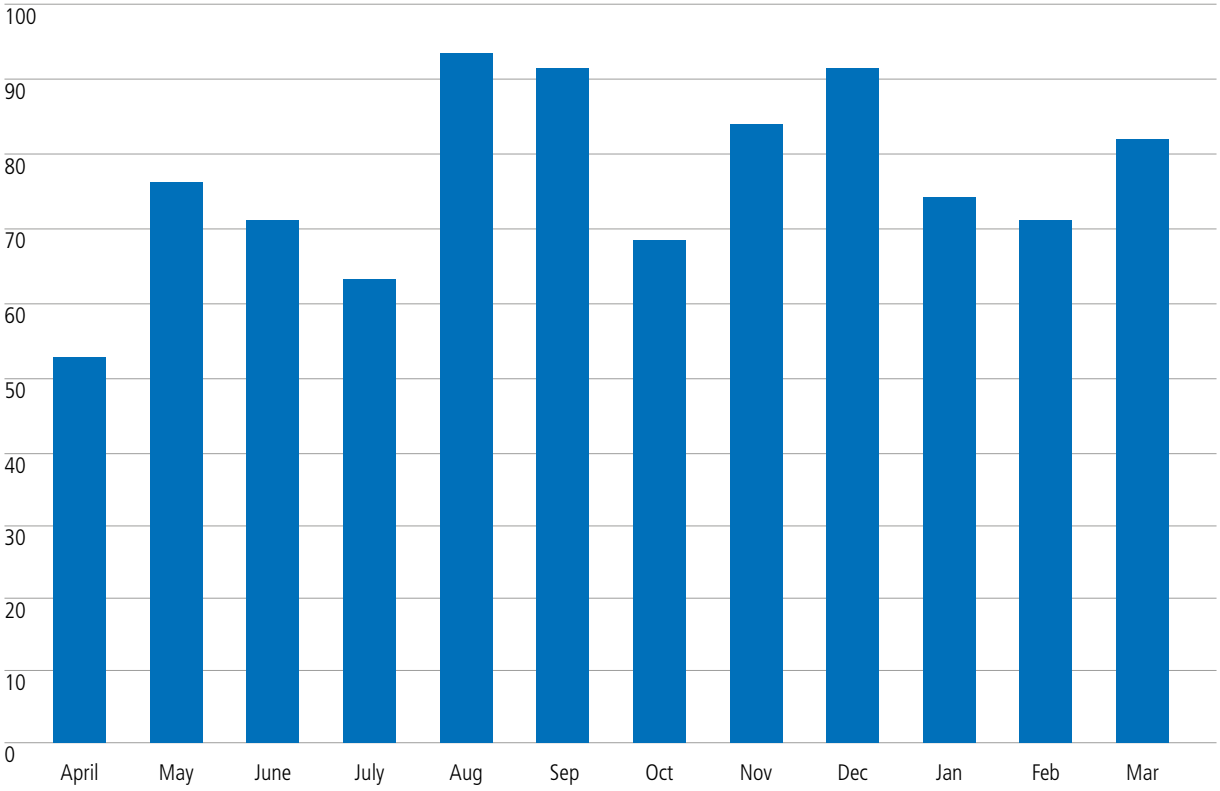
Achievement of this last aim is not within target. However, as part of the improvement work the Trust also aimed to increase the number of "no-harm" incidents, but this was not identified as a specific target in the 2016/17 Quality Account. When taking into consideration all three levels of harm (no-harm, low-harm and near miss), the Trust has improved reporting by 27%. Therefore, this aim is considered to be achieved.

The third goal was "Compliance with the Care Quality Commission's fundamental standards". This is a challenging goal to quantatively measure as there are 13 standards that are regarded as "fundamental" by the Care Quality Commission that have a number of sub sections.

These fundamental standards are the Care Quality Commission's response to the Francis Report (2013), which made a number of recommendations about basic standards that should be met by organisations that provide health and social care services. The report recommended the introduction of new Fundamental Standards below which care should never fall, covering those basic things that everyone agrees are important.

The Trust has undertaken a review of the year's annual incident reporting to identify areas where the Trust may not have been compliant with the Fundamental Standards of Care.

Graph 4. Incident reporting (low-harm) in 2017/18

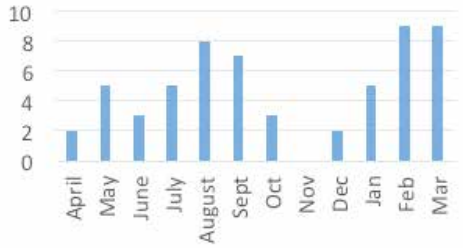


The following table (Table 2) identifies the 13 Fundamental Standards and provides an overview of each of the 13 standards.

The table identifies that there have been areas where an individual patient or service user may not have received all of the standards of care that they should have expected. This does not necessarily mean that there has been a systematic failure to deliver that standard.

In addition, whilst the Trust has significantly increased incident reporting it is also possible that not every breach in failure to deliver a fundamental standard of care is captured. In fact, Table 2 suggests the Trust has further work to do in raising awareness of these standards across the organisation. However, it is a positive change that the Trust has oversight of breaches and is now reporting these breaches within its incident reporting system.

Table 2 CQC Fundamental Standards of Care

Fundamental Standard	Overview (from incident reporting)
Person-centred care You must have care or treatment that is tailored to you and meets your needs and preferences.	No incidents on Datix
Dignity & Respect You must be treated with dignity and respect at all times while you're receiving care and treatment. This includes making sure: • You have privacy when you need and want it. • Everybody is treated as equals. • You're given any support you need to help you remain independent and involved in your local community.	No incidents on Datix
Consent You (or anybody legally acting on your behalf) must give your consent before any care or treatment is given to you.	No incidents on Datix
Safety You must not be given unsafe care or treatment or be put at risk of harm that could be avoided. Providers must assess the risks to your health and safety during any care or treatment and make sure their staff have the qualifications, competence, skills and experience to keep you safe.	
Safeguarding from abuse You must not suffer any form of abuse or improper treatment while receiving care. This includes: Neglect Degrading treatment Unnecessary or disproportionate restraint Inappropriate limits on your freedom.	Multiple safeguard entries on Datix but none specific to concerns identified regarding the Trust's provision of care.

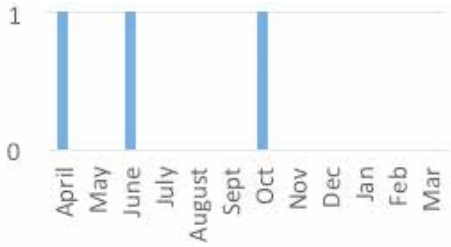
Food and Drink You must have enough to eat and drink to keep you in good health while you receive care and treatment.	No incidents on Datix
Premises & Equipment The places where you receive care and treatment and the equipment used in it must be clean, suitable and looked after properly. The equipment used in your care and treatment must also be secure and used properly.	This is now linked to safe care and treatment. There are multiple entries for missing equipment and the malfunction of equipment.
Complaints You must be able to complain about your care and treatment. The provider of your care must have a system in place so they can handle and respond to your complaint. They must investigate it thoroughly and take action if problems are identified.	No incidents on Datix
Good Governance The provider of your care must have plans that ensure they can meet these standards. They must have effective governance and systems to check on the quality and safety of care. These must help the service improve and reduce any risks to your health, safety and welfare.	
Staffing The provider of your care must have enough suitably qualified, competent and experienced staff to make sure they can meet these standards. Their staff must be given the support, training and supervision they need to help them do their job.	No incidents on Datix
Fit and Proper Staff The provider of your care must only employ people who can provide care and treatment appropriate to their role. They must have strong recruitment procedures in place and carry out relevant checks such as on applicants' criminal records and work history.	No incidents on Datix
Duty of Candour The provider of your care must be open and transparent with you about your care and treatment. Should something go wrong, they must tell you what has happened, provide support and apologise.	Reported elsewhere in this Quality Account.
Display of ratings The provider of your care must display their CQC rating in a place where you can see it. They must also include this information on their website and make our latest report on their service available to you.	Not reports on Datix.

Table 2 suggests there are areas where the Trust may have met the required standards and also identifies areas where the Trust needs to focus on making improvements. Additionally, the Trust needs to undertake additional work in raising awareness across the Trust of the Fundamental Standards and when to report breaches.

2017/18 Priority 2. Patient and family involvement in investigating incidents.

AIM:

To improve compliance with Duty of Candour requirements placed on the Trust following severe harm being caused to a patient

MEASURE 1:

Introduction of a process

MEASURE 2:

Upward trajectory of compliance with the Duty of Candour requirements across the year

STATUS:

Partially Achieved

Considerable work has been undertaken during the year to make improvements to the Trust's processes for involving patients and their family in the investigation of incidents. Most notably the following actions have been undertaken:

- Centralising the initial contact for informing patients/relatives that a serious incident has occurred (this process is known as Duty of Candour).
- Launched a training programme in root cause analysis for a variety of staff across the Trust.
- Introducing an experienced "buddy" to support newly-trained investigators.
- Developed a comprehensive Improvement Plan for incidents and serious incidents. This had weekly oversight by members of the Executive Team.
- Introduce three new roles to support the investigation of serious incidents and undertake Duty of Candour.

At the start of the project two goals were identified:

1) Introduction of a process to monitor and report the number of incidents meeting the Duty of Candour requirements.
2) Upward trajectory of compliance with the Duty of Candour requirements across the year, particularly with regard to timescales for informing patients that the Trust has caused them harm.

Progress

The Trust held a conference in October 2017 entitled "Listen, Learn, Change" where a variety of presentations enhanced the awareness and skills of over 100 delegates.

However, despite the conference and the extensive training delivered, the Trust has had significant challenges in meeting all its responsibilities to inform and involve relatives.

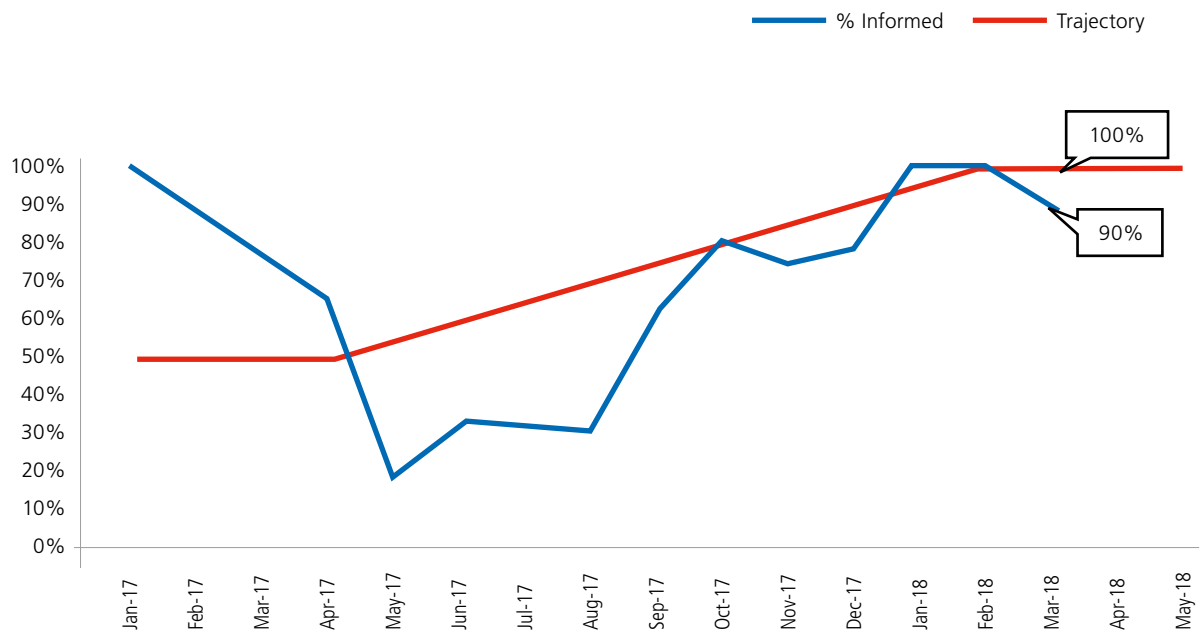
One of the challenges is the added complexity that the Trust may not be informed that an incident has occurred for several months after the Trust's involvement with the care of the patient. However, despite this challenge the Trust is determined to meet expectations in this area of care.

In order to make necessary improvements a project plan was developed. This plan identified two main groups of patients where there was a need to undertake Duty of Candour.

The first group consisted of the Trust's most serious incidents (SIs) and the second group consisted of those incidents that were not graded as serious but where moderate harm had been a consequence of the incident. The Trust identified the first group to be the initial priority.

The following graph illustrates month on month performance across the year for those groups where Duty of Candour had been undertaken for the incidents regarded as serious incidents.

Graph 5. Month on month reporting of Duty of Candour for serious incidents 2017-18



Information prior to January 2017 has not been included as the data was not being collected using the same methodology and confidence in the data is not high.

Graph 5 indicates that there was an initial decline in the Duty of Candour between January and August 2017. After a period of time, a steady improvement was made until 100% achievement in January 2018.

The initial decline was due to a significant backlog that occurred within the serious incident portfolio. The devolved model, where operational clinicians were required to make initial contact with patients, became unmanageable with this increasing backlog. As the year progressed, the model was gradually centralised and by the time compliance reached 100% the responsibility for Duty of Candour had been completely centralised.

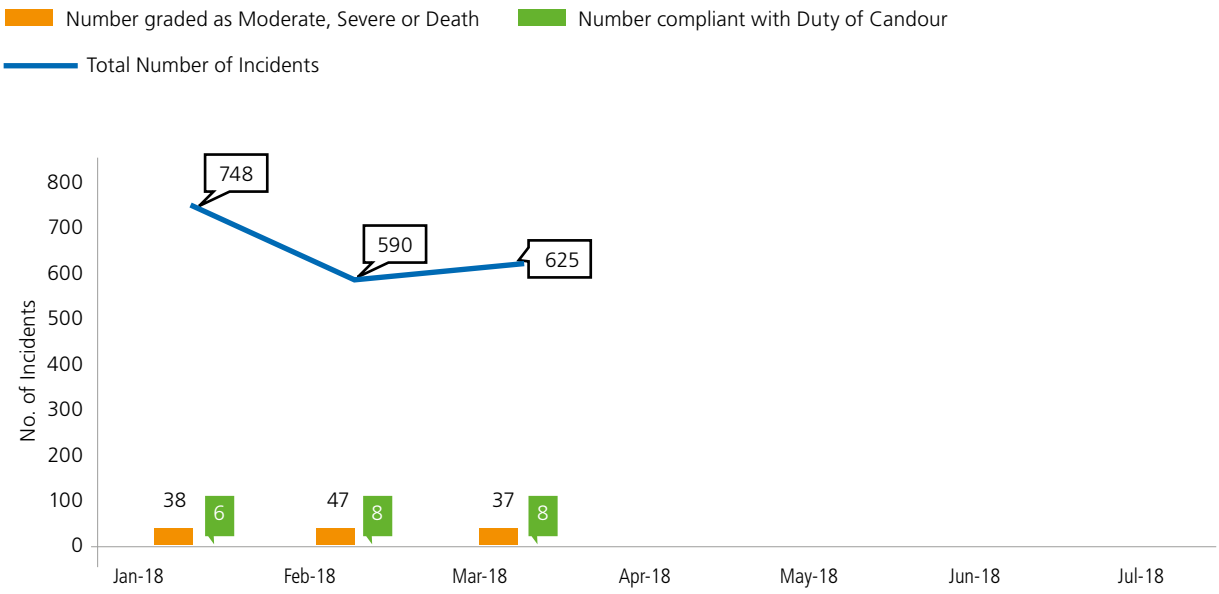
Graph 5 suggests that the Trust has been successful in meeting both of the identified goals for this priority.

However, this is only part of the picture. The Trust also has an obligation to inform patients who have experienced moderate harm or above. This was identified as group two in the improvement plan.

This was launched in quarter 4 of 2017/18. The following graph (Graph 6) illustrates month on month performance across the year for those groups where Duty of Candour had been undertaken for the incidents regarded as moderate harm or above.

Graph 6. Month on month reporting of Duty of Candour for moderate harm & above

Compliance with Duty of Candour (Moderate Harm and Above-excluding Serious Incidents)



On considering both graphs the Trust concludes that this priority has been partially achieved in meeting the goals associated with this quality priority.

Improving compliance with moderate harm and above is now a primary part of the Trust's continuing improvements.

2017/18 Priority 3. Improving outcomes for out-of-hospital cardiac arrest

AIM:

Early identification of cardiac arrest calls and appropriate dispatch in order to improve outcomes

MEASURE 1:

Improve return of spontaneous circulation rate

MEASURE 2:

Improve survival to discharge rate

STATUS:

Not Achieved

Considerable work has also been undertaken during the year to make improvements to the Trust's cardiac arrest outcomes. Most notably the following have been undertaken:

- In November 2017 new cardiac arrest guidelines were introduced for all staff. These were in line with the national guidance from the Resuscitation Council UK.
- Undertaking a programme of local roadshows targeted at the Trust's Operational Team Leaders. These included instruction on the interpretation of cardiac diagnostics and a discussion about the new guidelines.
- The Trust introduced monthly analysis of the cardiac arrest data produced for the Trust Board and for Trust staff.
- The introduction of dashboards down to an operating unit level that identify areas of best practice.

At the start of the project two goals were identified:

a) Analysis of the Survival to Discharge data through the national data sets.

b) Early recognition of cardiac arrest by implementing Nature of Call (NOC) and the Ambulance Response Programme (ARP).

Progress

In order to drive improvements an initial diagnostic was undertaken by the Trust's newly-appointed Paramedic Consultant in Cardiac Care. This led to a number of actions being put in place:

- Documentation was identified as a factor. At the time a number of patient records (13.8%) were not matched to the actual incident. As part of another improvement plan considerable effort has been made in improving this area.
- Building on the excellent practice of clinical audit feeding back to clinical staff on their cardiac diagnostics (ECG recording).
- Education was identified as a key element. An update on Resuscitation Guidelines, (incorporating the best practice guidelines from the Association of Ambulance Chief Executives (AACE)), was developed and has formed a template for training which will commence in April 2018.
- A project plan was developed to ensure all of the Trust's defibrillators were able to offer all necessary interventions.
- A review of the way the Trust allocates volunteers (community first responders) was also undertaken.

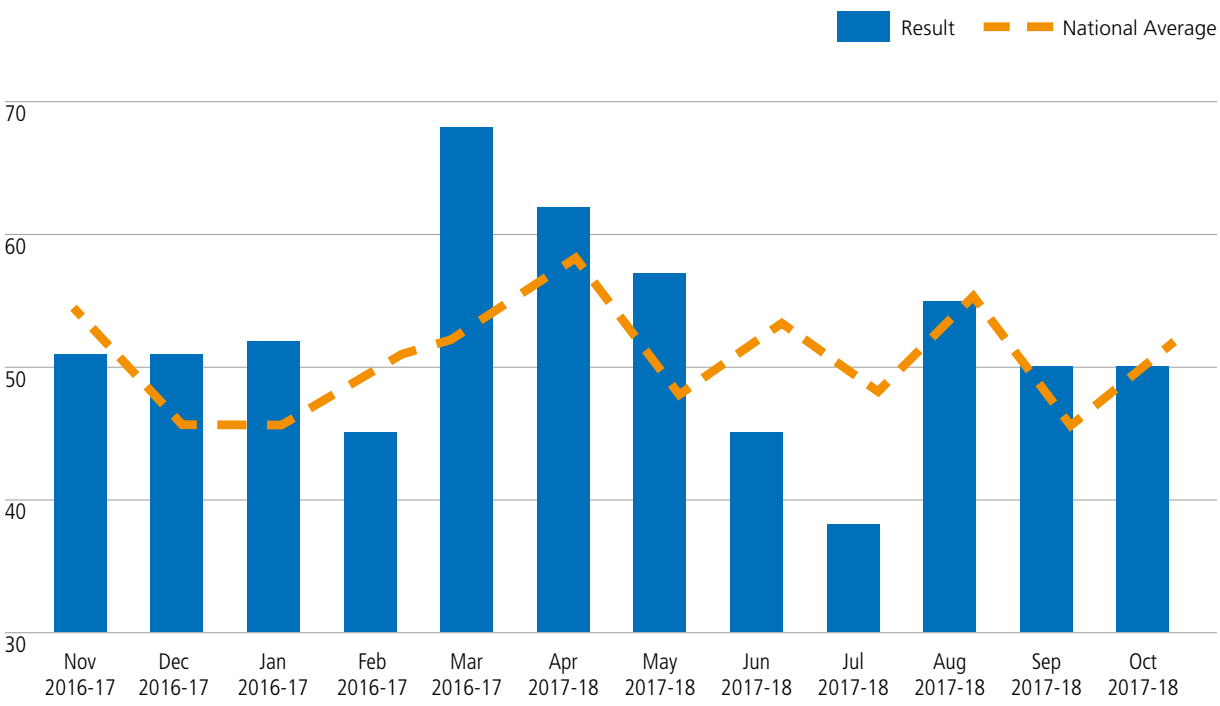
Part Two

In order to measure success the Trust identified two measures. Measure one was an improvement in the Return of Spontaneous Circulation data. Measure two was an improvement in the survival to discharge data.

The following two graphs (Graphs 7 and 8) illustrate the month on month performance across the year for those two measures. The information is presented for a 12-month period. The published data is significantly behind due to the validation process required prior to national publication.

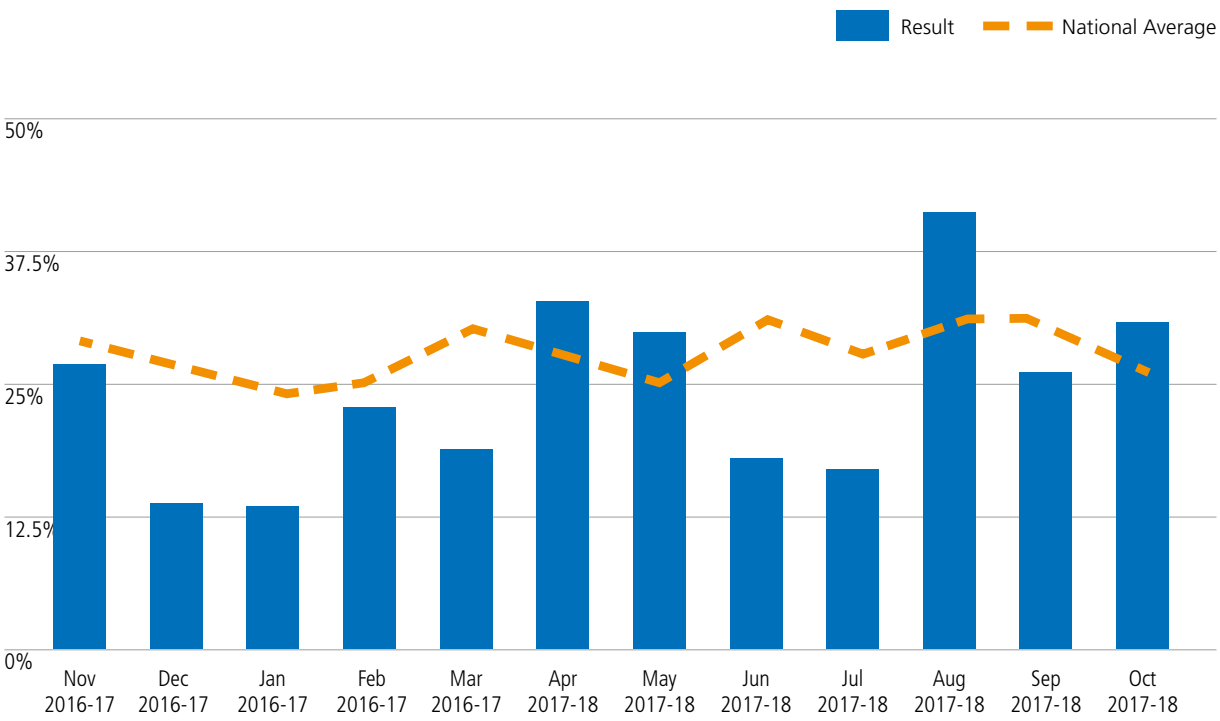
In section 2 of this Quality Account the indicators are re-presented as part of the Trust's measures for Clinical Effectiveness where the data is for the financial years 2016/17 and 2017/18. Section 2 also details some of the further improvements made during the year.

Graph 7. Month on month reporting of return of spontaneous circulation 2016/17[1]



[1] This is a measure of the number of patients who have suffered a cardiac arrest, but as a result of life-support started or continued by the ambulance service, had a pulse again by the time they arrived at hospital, and went on to be discharged from hospital.

Graph 8. Month on month reporting of survival to discharge 2016/17[2]



Both graphs reveal that the Trust has not made the sustained improvements that it anticipated. Therefore, this priority area has not been achieved.

Recognising the importance of this particular priority area the Trust has identified this as a priority area for 2018/19.

[2] This is a measure of the overall number of patients who were witnessed suffering a cardiac arrest and received life support started or continued by the ambulance service and treatment in hospital so they were successfully resuscitated, and where their initial heart rhythm allowed it to be shocked with a defibrillator, and survived.

Part Two

This following section of the Quality Account reports on the mandatory assurance statements.

Introduction

The various assurance statements are mandated by national reporting requirements for the annual Quality Account. The majority are simple statements of compliance or fact whilst others are more detailed descriptions of activity.

The published guidance mandates this section and is available via the following web link:

https://improvement.nhs.uk/resources/quality-accounts-requirements-201718/

Service provision

During 2017/2018 South East Coast Ambulance Services NHS Foundation Trust provided and/or sub-contracted two relevant health services.

- A&E Contract
- NHS 111 Contract

Data quality

South East Coast Ambulance Services NHS Foundation Trust has reviewed all the data available to it on the quality of care in both of these relevant health services.

Income

The income generated by the relevant health services reviewed in 2017/18 represents 95% of the total income generated from the provision of relevant health services by SECAmb for 2017/18.

Audit and enquiries (total)

During 2017/2018, ten national clinical audits and no national confidential enquiries covered relevant health services that SECAmb provides.

Audit & enquiries (participated)

During that period, SECAmb participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

Audit & enquiries (eligible)

The national clinical audits and national confidential enquiries that SECAmb was eligible to participate in during 2017-2018 are as follows:

- Cardiac Arrest – Return of Spontaneous Circulation (All Cases)
- Cardiac Arrest – Return of Spontaneous Circulation (Utstein Group)
- Cardiac Arrest - Survival to Discharge (All Cases)
- Cardiac Arrest – Survival to Discharge (Utstein Group)
- ST Elevation Myocardial Infarction (STEMI) – Delivery of Care Bundle
- ST Elevation Myocardial Infarction (STEMI) – Call to Hospital in 150 minutes
- Stroke – Delivery of Care Bundle
- Stroke – Call to Hospital in 60 minutes
- Out of Hospital Cardiac Arrest Outcomes (OHCAO) – Warwick Clinical Trials Unit
- Stroke – 'Act FAST' Campaign – Public Health England.

National audits (participated)

The national clinical audits and national confidential enquiries that SECAmb participated in during 2016-2017 are as follows:

- Cardiac Arrest – Return of Spontaneous Circulation (All Cases)
- Cardiac Arrest – Return of Spontaneous Circulation (Utstein Group)
- Cardiac Arrest - Survival to Discharge (All Cases)
- Cardiac Arrest – Survival to Discharge (Utstein Group)
- ST Elevation Myocardial Infarction (STEMI) – Delivery of Care Bundle
- ST Elevation Myocardial Infarction (STEMI) – Call to Hospital in 150 minutes
- Stroke – Delivery of Care Bundle
- Stroke – Call to Hospital in 60 minutes

- Out of Hospital Cardiac Arrest Outcomes (OHCAO) – Warwick Clinical Trials Unit
- Stroke – 'Act FAST' Campaign – Public Health England.

National audit (participated and number of cases)

The national clinical audits and national confidential enquiries that SECAmb participated in, and for which data collection was completed during 2017/18, are listed below alongside the number 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.

Cardiac Arrest – Return of Spontaneous Circulation at Hospital (All Cases)

Total: 2728 cases submitted.

737 confirmed ROSC at hospital

26.5% performance in this national audit*

Cardiac Arrest – Return of Spontaneous Circulation (Utstein Group)

Total: 374 cases submitted

193 confirmed ROSC at Hospital

51.6% performance in this national audit*

Cardiac Arrest - Survival to Discharge (All Cases)

Total: 2633 cases submitted

168 confirmed as Survival to Discharge

6.3% performance in this national audit*

Cardiac Arrest – Survival to Discharge (Utstein)*

Total: 350 cases submitted

90 confirmed as Survival to Discharge

25.7% performance in this national audit*

ST Elevation Myocardial Infarction (STEMI) – Delivery of Care Bundle

Total: 1243 cases submitted

805 confirmed as receiving full STEMI Care Bundle

64.8% performance in this national audit*

ST Elevation Myocardial Infarction (STEMI) – Call to Hospital in 150 minutes

Total: 1017 cases submitted

884 confirmed as arriving at hospital within 150 minutes of call

86.9% performance in this national audit*

Stroke – Delivery of Care Bundle

Total: 5322 cases submitted

5021 confirmed as receiving full Care Bundle

94.3% performance in this national audit*

Stroke – Call to Hospital in 60 minutes

Total: 4144 cases submitted

2457 confirmed as arriving at hospital within 60 minutes of call

59.2% performance in this national audit*

Out of Hospital Cardiac Arrest Outcomes (OHCAO)

Total: 1800 cases submitted

Stroke – Act FAST Campaign

Total: 32167 cases submitted

*Data collection for these indicators occurs three months in arrears, so the performance shown is for Q4 of 2016/2017 and Q1-3 of 2017/2018.

National audit (Improvements)

The reports of nine national clinical audits were reviewed by the provider in 2017/18 (a report is not produced for the 'Act Fast' Audit) and SECAmb intends to take the following actions to make improvements to the quality of healthcare provided:

Cardiac arrest

- The Trust has introduced a new resuscitation procedure that will drive high quality, evidence-based care for victims of cardiac arrest.
- The Trust has purchased additional mechanical CPR devices so that more victims of cardiac arrest receive continuous high quality CPR at the scene of a cardiac arrest and en route to hospital.
- Additional resuscitation training will be provided in the Trust's 2018-2019 annual mandatory training programme for clinical staff.
- The Clinical Audit team will expand the cardiac arrest data it collects in order to provide further evidence for improvement. (Measures to be considered include home/public place, call to first shock time, time taken to commence bystander CPR.)

ST elevation myocardial infarction (STEMI)

- Additional ECG training will be provided in the Trust's 2018/19 annual mandatory training programme for clinical staff to increase the accuracy and timeliness of STEMI diagnosis.
- Communications will be made to clinical staff to stress the importance of and the evidence base for completion of the STEMI care bundle.
- A programme of work to improve ambulance response times aims to improve the timeliness of arrival of definitive care for patients who are suffering a STEMI.
- A programme of work to promote good record keeping is expected to increase our evidence of high quality care in this area.

Stroke

- Communications will be made to clinical staff to stress the importance of and the evidence base for completion of the stroke care bundle.
- A programme of work to improve ambulance response times aims to improve the timeliness of arrival at definitive care for patients who are suffering a stroke.
- A programme of work to promote good record keeping is anticipated increase our evidence of high quality care in this area.

Local audit (improvements)

The provider reviewed the reports of nine local clinical audits in 2017/18 and SECAmb intends to take the following actions to make improvements in the quality of healthcare provided:

Management of presentations for mental health conditions

The Trust should:

- Combine the Risk of Suicide Assessment tool with the SECAmb Mental Health Risk Assessment tool.
- Review current key skills training to accommodate new assessment tool training.
- Consider the development of a mental health aide memoire for iPad use.
- Consider a separate drugs and alcohol audit independent of mental health audit, to build evidence for the development of crew condition coding.
- Update the SECAmb crew condition codes, as they do not reflect the range of mental health conditions that present to emergency medical services.
- Develop and disseminate a quick reference guide for patients cared for under Section 135 and 136 of the Mental Health Act.
- Consider undertaking an audit of use of the Mental Capacity Act.

Outcomes for older adults after falling

The Trust should:

- Increase the proportion of incidents where a full set of observations is recorded.
- Increase the proportion of falls incidents where a history of previous falls is taken and recorded.
- Increase awareness, amongst both clinicians and dispatchers, of the increased risk associated with falls to attempt to reduce response times.
- Consider the introduction of a dedicated falls response vehicle in each area, to respond solely to patients who have fallen.

Use of National Early Warning Scores (NEWS) in Red 1 calls

The Trust should:

- Include NEWS training in the key skills syllabus, using the SECAmb 'Discover' E-learning platform.
- Raise awareness of NEWS in the weekly bulletin by running alongside other clinical care bundle reminders.
- Include NEWS guidance on the intranet clinical guidance area.
- Re-audit after the other recommendations have been actioned.

Rocuronium administration by critical care paramedics (CCPs)

The Trust should:

- Carry out further audit of rocuronium administration.
- Add all administrations of rocuronium to CCPBase.
- Collect data on instances where patients have not been administered rocuronium through CCPBase and SECAmb CAD.
- Compare blood gas readings on admission of patients who have received Rocuronium to patients who did not experience prehospital paralysis, but went on to receive it within an hour of arrival at hospital.
- Complete patient follow-up and comparison to non-CCP managed ROSC patients in SECAmb.

Amiodarone infusion by critical care paramedics

The Trust should:

- Decide whether the administration of amiodarone by infusion should be ceased.
- Review the dataset that must be completed on the CCPBase and communicate this expectation to all CCPs.

Calcium chloride administration by critical care paramedics (CCPs)

The Trust should:

- Make a decision regarding the continued use of Calcium Chloride by CCPs for peri-arrest patients.
- Communicate the indications and use of the drug for cardiac arrest where there is very clear history of renal failure present.
- Undertake a review of the dataset that must be completed on the CCP Base and communicate this expectation to all CCPs.
- Undertake a re-audit to reassess whether compliance with the calcium chloride PGD has improved.

Identification and management of severe sepsis

The Trust should:

- Explore the rationale for pre-alert in patients where perfusion was not affected, with further educational needs considered if appropriate.
- Attempt to compare crew diagnosis of severe sepsis with final diagnosis at hospital.
- Explore and address factors affecting the delivery of the pre-hospital sepsis care bundle.

Record keeping

The Trust should:

- Agree and publish the standards expected when completing patient care records.
- Develop a suite of patient care records that are fit for purpose and user friendly.
- Implement a system for the audit and feedback of patient care records.
- Raise awareness of the benefits of good record keeping and the risks associated with poor record keeping.
- Build on the staff's intrinsic motivation for good record keeping.

Documentation accuracy

The Trust should:

- Introduce a consistent audit and feedback process.
- Raise awareness of the expected standards and the benefits that good documentation bring for the patient, the clinician and the Trust.
- Build motivators for staff to keep safe and effective clinical records.

Research

The number of patients receiving relevant health services provided or sub- contracted by SECAmb in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 0.

Conditional income

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

Further details of the agreed goals for 2018/19 and for the following 12- month period are available electronically at:

https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/ .

In 2017/18, SECAmb received £5,296k of income that was conditional on achieving quality improvement and innovation goals. For 2016/17, this value was £2,749K.

CQC registration

South East Coast Ambulance Service NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is "Inadequate".

The Care Quality Commission has taken enforcement action against South East Coast Ambulance Service NHS Foundation Trust during 2017/18 in relation to Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment by issuing a notice of proposal to impose conditions. The reasons for this were:

- By 22 September 2017 the registered provider must ensure they have a complete and accurate record of all 999 calls.
- By 22 September 2017 the registered provider must ensure that:

a) all medicines including controlled drugs and medical gases are stored securely in line with best practice and safe custody regulations, where applicable, in line with relevant licenses.

b) effective processes, including monitoring, are in place to ensure all medicines are stored within their recommended temperature ranges within buildings.

c) medicines are only administered or supplied by staff within the relevant medicines legislation and best practice, and appropriate records are kept.

The notice also required SECAmb to submit to the Care Quality Commission a copy of a medicines optimisation action plan by 22 July 2017. Then to ensure the medicines optimisation action plan was implemented by 22 September 2017 for all sites for completion of each action referred therein.

Following intensive improvement work and a re-inspection the Notice of Proposal was lifted in October 2017.

CQC reviews

South East Coast Ambulance Service NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Hospital episode statistics

SECAmb 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.

Information governance

SECAmb Information Governance Assessment Report overall score for 2017/18 was 73%.

Payment by results

SECAmb was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.

Data quality

SECAmb will be taking the following actions to improve data quality:

The Trust is continuing work to improve data quality; this began with the implementation of the new CAD system. Recent areas of progression include a sign-off process for internal and external reporting when reports receive adjustment; internally it receives author and senior analyst/performance manager sign-off. External reports require executive sign-off when a new change is enacted.

In addition, the new data warehouse structure is going through the final update stages to prepare for go-live.

To coincide with this, the Trust has also purchased a new reporting platform. This will enable faster report creation, an interactive user interface and for wide-scale sharing of data, improved data protection systems in place.

Mortality and morbidity

Acute Trusts have been mandated to report on patient deaths in some detail. This has not been extended to Ambulance Trusts in this reporting year. However, SECAmb believes it is important for the Trust to participate in this important initiative and has used the Acute Trust template to report on patient deaths.

Defining the number of deaths is difficult. Some of the Trust's patients may have died prior to arrival, such as a road traffic accident, or may have died on the way to hospital. The Trust has used the figures reported on the National Reporting and Learning System (NRLS) as the measure for this assurance statement.

During 2017-18, 18 of SECAmb's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

3 in the first quarter;

3 in the second quarter;

5 in the third quarter;

7 in the fourth quarter.

Case reviews

By 19 March 2018, no case record reviews and 15 investigations have been carried out in relation to the 18 deaths included in the above statement.

In 0 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

3 in the first quarter;

3 in the second quarter;

5 in the third quarter;

7 in the fourth quarter.

The Trust has used the definition of Case Review as defined by the Royal College of Physicians as a Structured Judgement review.https://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nmcrr-programme-resources

Part Two

Problems in the care provided

Zero cases, representing 0% of the patient deaths during the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

Zero cases representing 0% of the number of deaths which occurred in the quarter given in item "number of deaths" for the first quarter;

Zero cases representing 0% of the number of deaths which occurred in the quarter given in item "number of deaths" for the second quarter;

Zero cases representing 0% of the number of deaths which occurred in the quarter given in item "number of deaths" for the third quarter;

Zero cases representing 0% of the number of deaths which occurred in the quarter given in item "number of deaths" for the fourth quarter.

These numbers (18) have been drawn from the Trust's report to the National Reporting and Learning System (NRLS) by using the sub category of incident where care to a patient, including triage or treatment, but excluding delayed attendance.

However, the Trust has also undertaken 3 "Deep Dive Reviews" to review Serious Incidents and complaints around a potential theme. These reviews do not follow the Structured Judgement Review Case Note methodology as this is difficult to apply in the Ambulance setting. However, themes and learning are identified and escalated as appropriate.

Mortality and morbidity (Learning)

The Trust held three Deep Dive Reviews" during the year.

Quarter 1 deep dive

Theme: Paediatrics

Six Serious Incidents were identified and reviewed. Two potential themes were identified; 1) incorrect triage and 2) ambulance response not sent. The review group concluded that there needed to be a review of current staffing in the Emergency Operations Centre and the number of Clinical Supervisors. It was also agreed that for the under 1's a decision not to send an ambulance must have a clinical review and any child under 5 that is not conveyed should have additional safety advice.

Quarter 2 deep dive

Theme: Handover delay

The Trust Board requested this theme be considered. For the period 1 October 2016 to 30 September 2017 there had been no Serious Incidents reported with the reporting reason of hospital delay; neither were there any Serious Incidents reported with delayed attendance that cited hospital delays as a contributory factor.

Hospital delays greater than 45 minutes should be reported by the receiving hospital under the service-wide agreement.

Datix was also interrogated and in the preceding 12 months there were 43 incidents (not Serious Incidents) reported under this category.

Four other Serious Incidents were reviewed at the Deep Dive and these were regarding high demand and a lack of available resources.

The review group could draw no conclusions but acknowledged there was an under-reporting of handover delays.

Quarter 3 Deep Dive

Theme: Telephone triage (999 & 111)

19 Serious Incidents were reported in the previous 12 months and 12 investigations were completed and reviewed at the Deep Dive.

A theme in the triage undertaken at the 111 service relating to patients with cardiac problems was identified. This is being further reviewed at the time of completing the Quality Account.

Quarter 4 Deep Dive

Theme: To be decided

The Deep Dive for Quarter 4 had not taken place at the time of closing this Quality Account.

Mortality & Morbidity (actions)

A number of actions have arisen from the Deep Dives. These are:

- A significant change in service provision regarding the conveyance of children under one year old where the majority of calls are now conveyed to hospital for a second and specialist opinion.
- A review of staffing in EOC which identified the need to strengthen clinical oversight of the work in EOC.
- A new surge management policy is being introduced to assist in the management of high demand.
- A review of the welfare call procedure to ensure it correctly identified when to undertake such calls.

Mortality and morbidity (impact)

The learning and the subsequent actions have not been evaluated. However, a review of the impact of the conveyance change for the under 1s is planned.

Mortality and morbidity

Zero case record reviews and no investigations completed after March 2017 which related to deaths that took place before the start of the reporting period.

Mortality and morbidity (prior to 2017/18)

Zero cases representing 0% of the 11 reviewed patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the cases reported to the National Reporting and Learning Scheme.

Patient safety (NRLS)

1,149 patient safety incidents were reported to the National Reporting Learning Scheme in 2017/18 and 89 (7.7%) of such patient safety incidents resulted in severe harm or death.

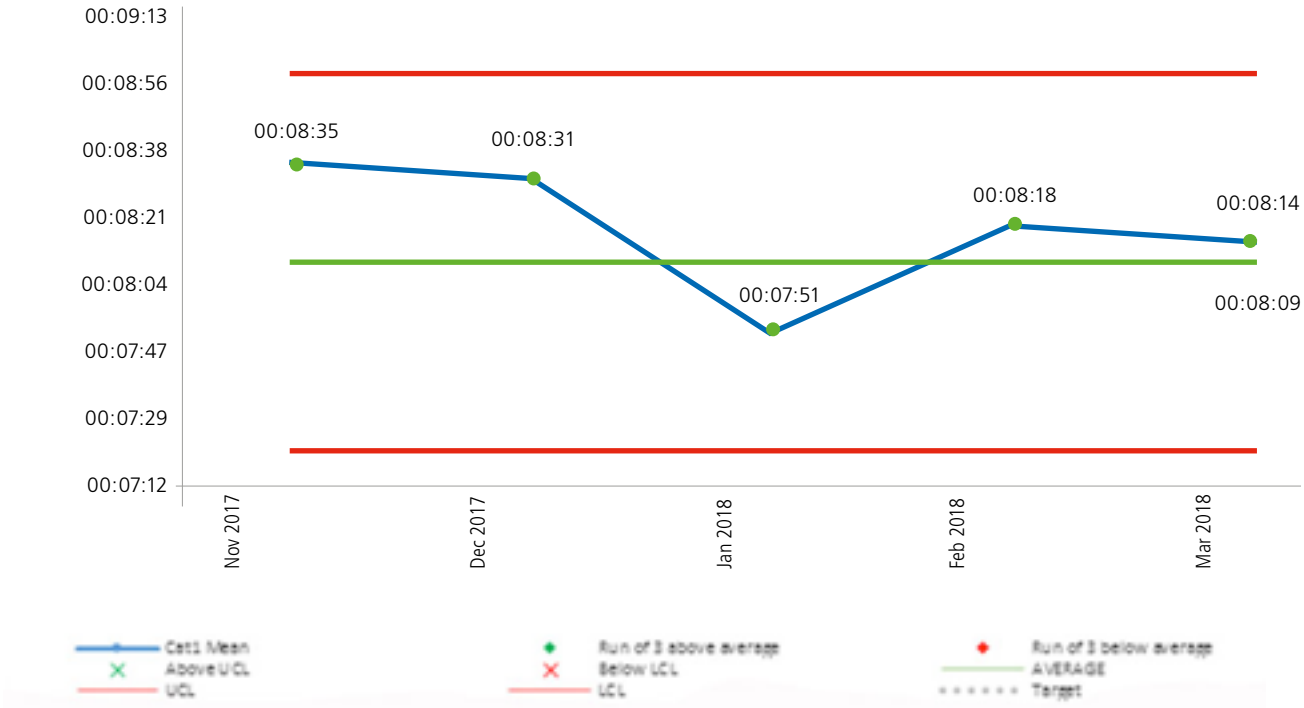
Part Two

Performance Cat 1

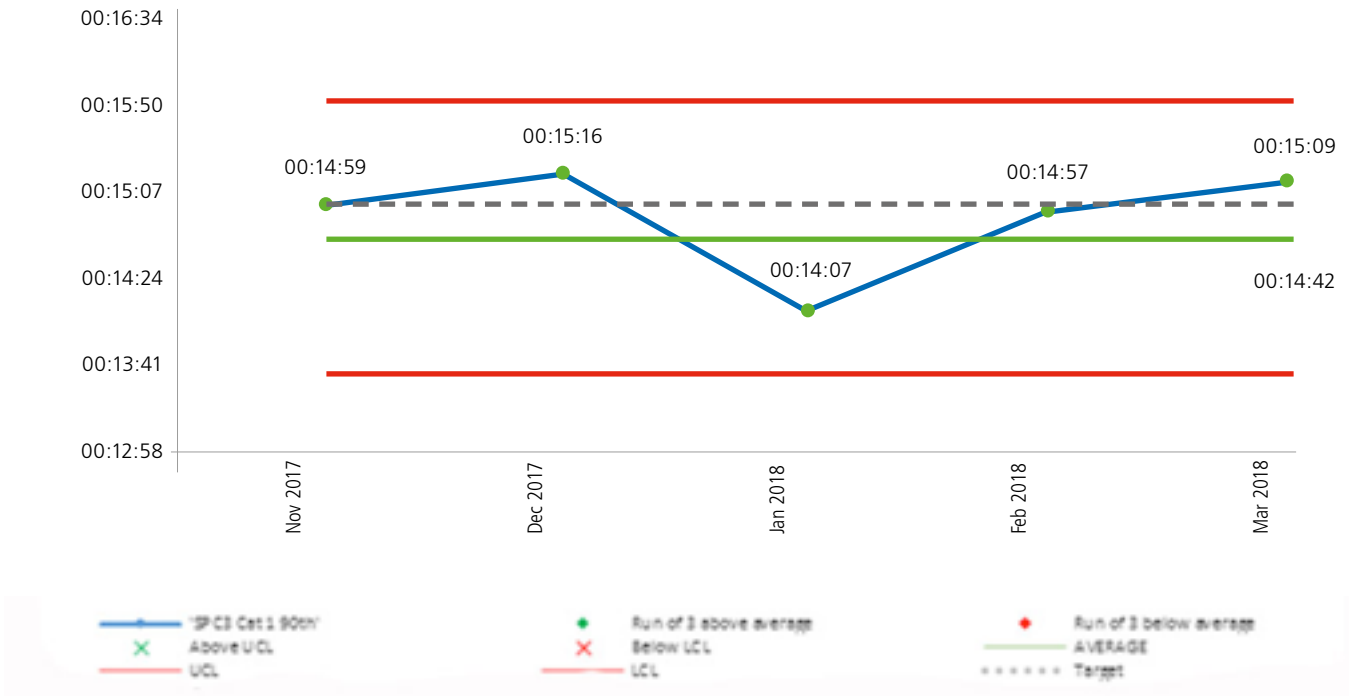
Category 1 is a mandated indicator. It is also reported within Section 3 where the measure shows performance against other ambulance services.

The Trust implemented the new Ambulance Response Programme (ARP) performance measures in November 2017 and the data is not comparable with previous years.

Graph 9. Category 1 mean response times 2017/18



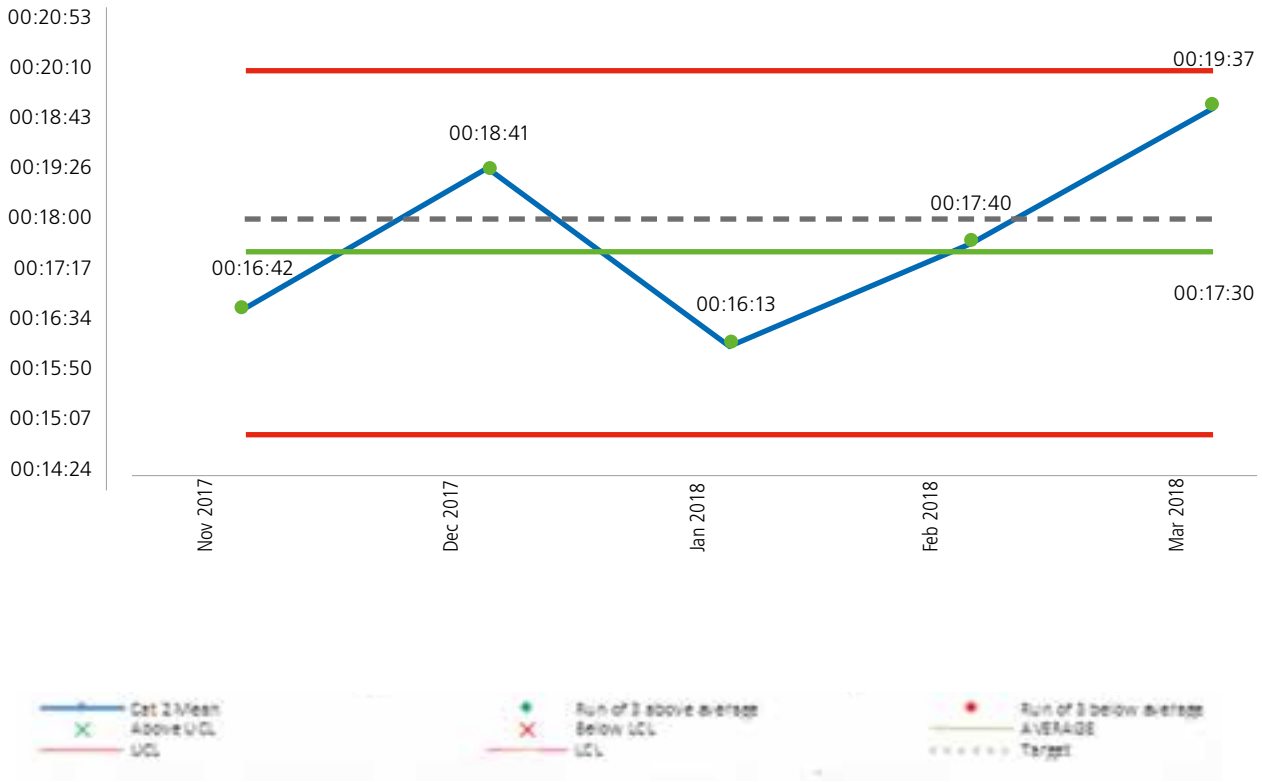
Graph 10. Category 1 90th centile response times 2017/18



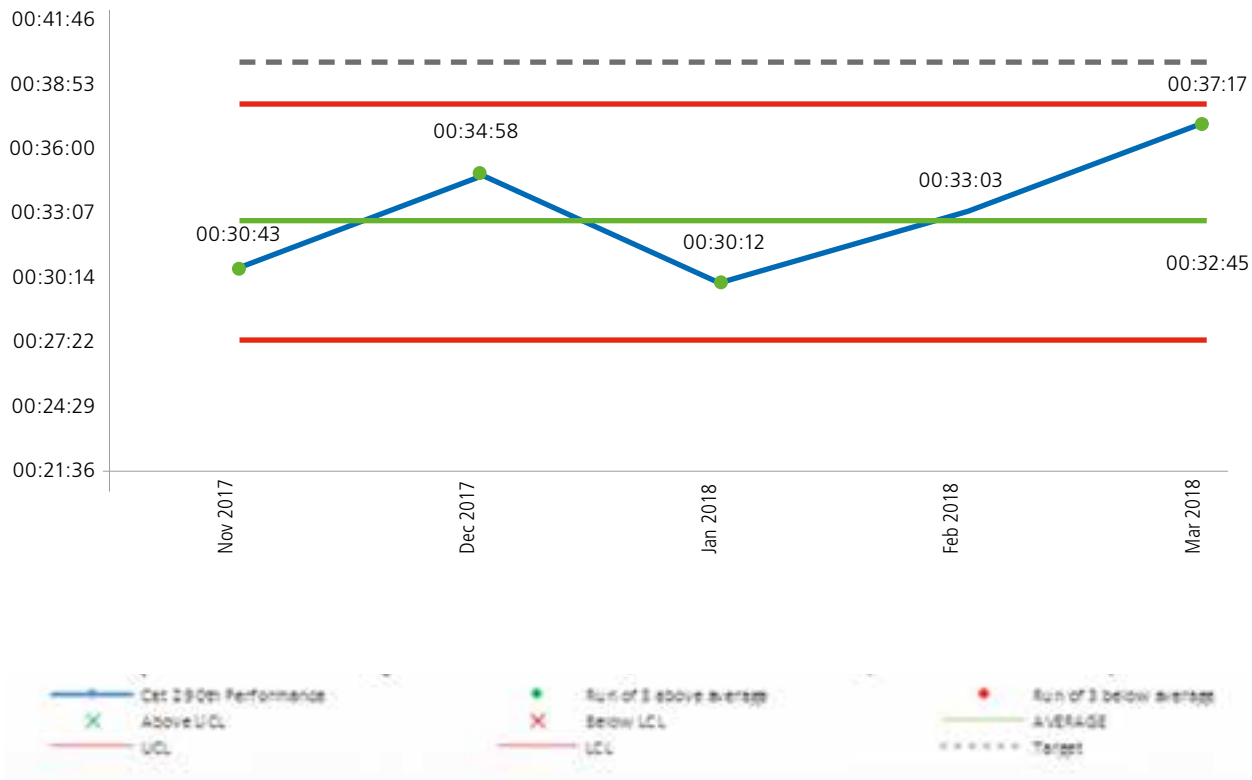
Performance Cat 2

Category 2 is a mandated indicator. It is also reported within Section 3 where the measure shows performance against other ambulance services.

Graph 11. Category 2 mean response times 2017/18



Graph 12. Category 2 90th centile response times 2017/18



SECAmb implemented the new ARP programme in November and has been supplying data since December 2017.

The data is published against two performance measures; mean response time (standard of 7 minutes) and 90th centiles (standard of 15 minutes).

Data Quality

South East Coast Ambulance NHS Foundation Trust considers that this data is as described for the following reasons:

- This indicator is part of the national reporting requirements. NHS England maintains the specification for the data that ambulance services collect, based upon user requirements and discussion with data providers. Provider groups include the National Ambulance Information Group (NAIG) for ambulance Systems Indicators (SI) data; and the National Ambulance Service Clinical Quality Group (NASCQG) for Clinical Outcomes (CO) data. NAIG and NASCQG represent the 11 Ambulance Services in England that provide and use the data.

Action being taken

South East Coast Ambulance Service NHS Foundation Trust has taken the following actions to improve this indicator, and the quality of its service:

- The Trust developed a comprehensive Improvement Plan for improving performance. This plan includes actions that aim to increase the Trust's capacity through recruitment initiatives, reducing absence and improving efficiency.
- The performance data is discussed each week with the Executive Management Team meetings and a number of actions arise as a result of that discussion.

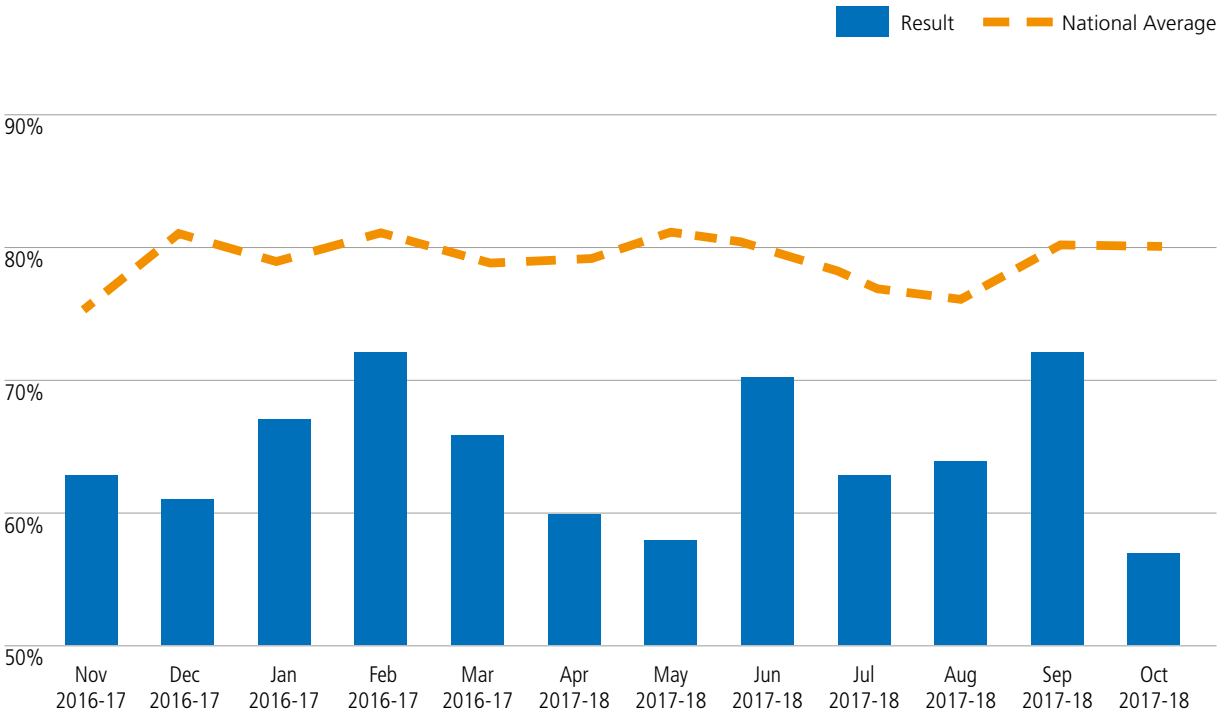
STEMI care

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.

In this section the performance is presented as a full 12 months across 2016-2017 but the data is re-presented in Section 3 across the two years with comparisons with other Trusts.

Graph 13. ST Elevation care bundle 2016/17

STEMI Care & Treatment 2016/17



Part Two

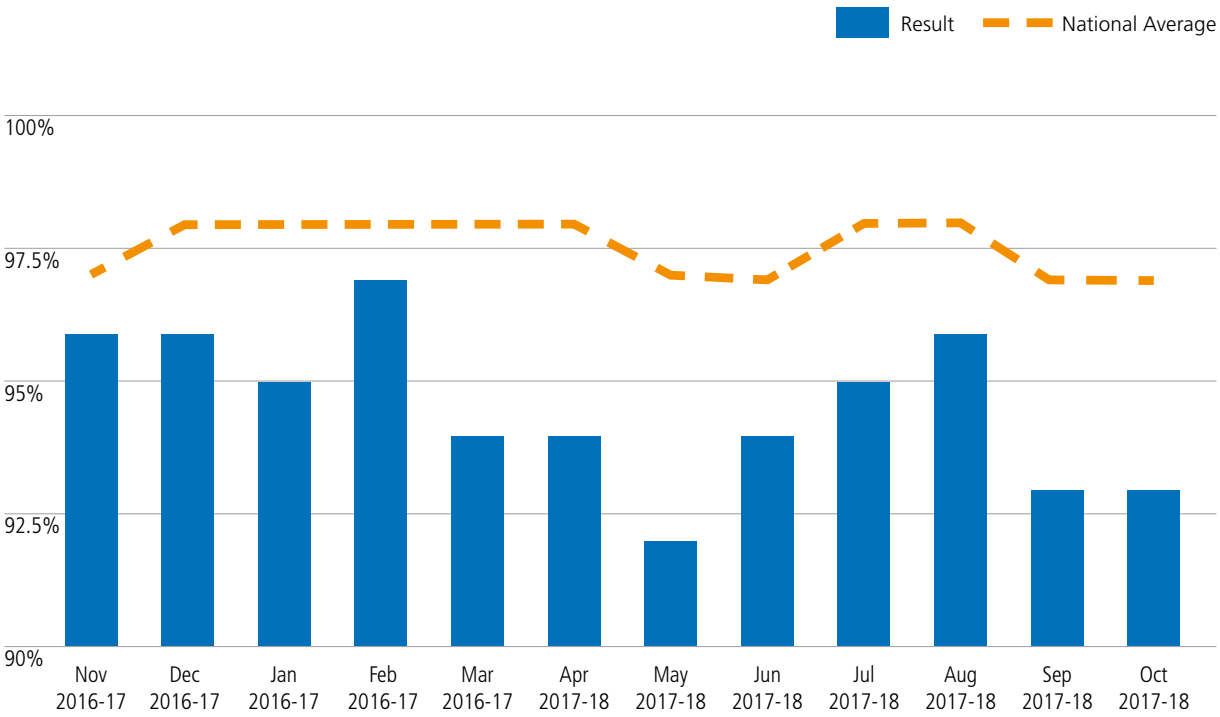
Stroke care

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

In this section the performance is presented as a full 12 months across 2016-2017 but the data is re-presented in Section 3 across the two years with comparisons with other Trusts.

Graph 14. Stroke Care Bundle 2016/17

Stroke Care & Treatment 2016/17



The South East Coast Ambulance NHS Foundation Trust considers that this data is as described for the following reasons;

- This indicator is part of the national reporting requirements. NHS England maintains the specification for the data that Ambulance Services collect, based upon user requirements and discussion with data providers. Provider groups include the National Ambulance Information Group (NAIG) for Ambulance Systems Indicators (SI) data; and the National Ambulance Service Clinical Quality Group (NASCQG) for Clinical Outcomes (CO) data. NAIG and NASCQG represent the eleven Ambulance Services in England who provide and use the data.

The South East Coast Ambulance NHS Foundation Trust has taken the following actions to improve this indicator, and the quality of its service by

- Developing an appropriate improvement Plan.
- The stroke data is also part of the monthly Quality Dashboard and is detailed down to a local level. This is discussed monthly by the Executive team and also at the Area Governance Meetings where local managers come together to discuss and action a number of issues.

Conclusion of Section 2

This section has identified the three quality priorities for 2018/19. These are:

- Improving outcomes from out-of-hospital cardiac arrests
- Learning from incidents, complaints and safeguarding reviews
- Patient-facing staff adequately trained to manage safeguarding concerns and to report them appropriately

These priorities have been identified through a consultation process with key stakeholders and agreed by the Trust Board.

One of the indicators has been taken forward from the previous year.

In addition, this section reported on progress made against the quality priorities identified for 2017/18. These were;

- Learn from incidents and improve patient safety
- Patient and family involvement in investigating incidents
- Improving outcomes for out-of-hospital cardiac arrest

In summary, whilst it is disappointing to note that the improvement priority for cardiac outcomes has been brought forward into 2018/19, the Trust has made progress on improving quality. The incident portfolio has achieved the improvement intended. The Trust will continue to build on this success as part of the overall Improvement plan.

In addition, whilst there is work to be done on Duty of candour, the Trust is now regulalrly fulfilling its fundamental obligations to inform patients and families when serious incidents have occurred.

The section also reported on a number of mandatory indicators, many of which have prescribed wording and phrasing.

Patient Story 2 – Daniel

Car accident survivor reunited with life-saving ambulance crews

23 June 2017

A Sussex man who suffered life-threatening injuries and spent six months in hospital after a serious car accident, has been reunited with the ambulance team who helped save his life.

Drew was travelling in his car on the A24 between Horsham and Dorking, when his vehicle left the road shortly after 6am on 9 September 2016. Luckily for mechanic and father Drew, a member of SECAmb control room staff, dispatcher Kate Nebbett, spotted his car in trees down an embankment on her way to work. Kate stopped to help, alerted her clinical colleagues and stayed to assist the medical team. Kate's actions for going above and beyond the call of duty were recognised at the Trust's annual staff awards earlier this year.

The first clinicians to arrive at the scene were Paramedic Rebekah Vonk and Associate Practitioner Heidi Gaskins after details had been gathered and support provided by Emergency Medical Advisor Laura Staplehurst. Rebekah and Heidi were backed by paramedics Julie Marchant and Johnathan Harrold before air ambulance team Mike Rose and Mark Salmon attended the scene by road. The crews worked together to provide emergency care to Drew before he was taken to Hospital in London.

The prognosis for Drew was uncertain and

he was kept in an induced coma for a month. Things weren't any more certain when he failed to gain consciousness when attempts were made to wake him from the induced coma. However, over time, and with expert hospital treatment, he made improvements and following a six-month hospital stay with intense rehab, he was able to return home.

Drew, who has had to teach himself to walk again due to a brain injury which affects his short term memory, was full of praise for everyone who helped him. He said: "I'm just so grateful to everyone for everything they did. You don't realise when you out and about quite how much the NHS does. It's been a real eye opener. I'm really pleased to have been able to meet everyone face-to-face to say thank you."

Drew's dad, Colin, a retired police officer, who now who works for SECAmb as an equipment officer at Banstead said: "As a former police officer I know how nice it is to have people let you know how thankful they are. I wanted to say a massive thank you from all of us. Everyone, from Kate who initially stopped and helped to the guys in the control room, from the crews who attended the scene to all the hospital teams - they all did a brilliant job."

Paramedic Rebekah added: "On behalf of the whole team it's been a real pleasure to meet Drew and Colin. It's essential in incidents such as this that everyone works together as a team and that's exactly what we did. We all wish Drew and his family all the very best for the future and for his continued recovery."

Part Three

Part 3: Other Information relevant to the quality of the Trust's health services

This section of the Quality Account describes the quality of the services provided through a set of indicators selected by the Trust Board in March 2018.

Introduction

NHS Foundation Trusts are mandated to use section 3 of the Quality Account to present an overview of quality across the Trust's services.

The indicators selected must include a range of measures across three domains. These are:

- At least three indicators for patient safety
- At least three indicators for clinical effectiveness
- At least three indicators for patient experience

There is also a fourth domain of indicators that are mandated by NHS Improvement.

Unfortunately, the national guidance on the 2017/18 Quality Account had not been published at the time of the Trust's Stakeholder meeting (Monday 27 November 2017). Therefore, there has been limited consultation on which indicators to include in the Quality Account. However, opportunity has been given for comments and contribution by stakeholders. The Trust's commissioners were written to, inviting comments, and other stakeholders were present at the Single Oversight Meeting on 16 March 2018 when the indicators were discussed. In addition, the indicators were presented to the Health Overview Scrutiny Committees at their regional meeting on 19 March 2018. They were finally agreed at a public Board meeting on 27 March 2018.

As a result of the discussions, two of the indicators selected for patient experience were changed.

Indicator Changes

In the 2016/17 Quality Account the following indicators were selected;

- Incident Reporting
- Medication Errors
- Asthma Care
- Febrile Convulsions
- Single Limb Fractures
- Mental Health
- Complaint volume
- Complaints outcome

Two of the indicators in the 2017/18 Quality Account remain the same (incident reporting and complaint volume). These have been re-selected as they are a good representation of safety (incidents) and patient experience (complaints).

The remaining indicators have been changed. This is for a number of reasons:

- The clinical indicators used in 2016/17 Mental Health, Asthma, Febrile Convulsions and Single Limb Fractures were not part of clinical audit in 2017/18 and therefore could not be selected.
- Medication errors was not selected as there was insufficient data at the start of the year and the intentional attempts to drive an increase in reporting makes comparison difficult. However, the subject area of medicines has been reselected.
- Complaint outcome was considered less helpful as an isolated indicator but the complaints measure has been considerably expanded on the previous year.

Data changes on previous year

The Quality Account guidance ask Trusts to report and explain any changes in data from the previous year. This section considers the data for the two indicators that have been reselected for 2017/18.

Incident reporting

The guidance suggests, where possible, that data be presented on a month by month basis. This has been undertaken for the 2017/18 Quality Account. However, the 2016/17 Quality Account reported aggregated data for the previous seven years, year by year. Therefore, comparisons with last year's published data are not possible. Therefore, the relevant 2016/17 data has been re-represented here for comparison month by month.

Complaint reporting

Again, the data has been presented monthly in this Quality Account whilst in the previous Quality Account the data was presented by service area rather than month by month.

This year some of the data has been removed from the 2016/17 data set (such as Patient Transport Services) as that service is no longer operated so is not useful for comparison purposes.

Comparisons

The Quality Account guidance invites Trusts to publish, where possible, comparative data. This Quality Account fulfils this requirement where data is available.

Patient safety indicators

Safety is the Trust's first priority. Over the past year the Medical Director and the Director of Nursing & Quality have developed a comprehensive monthly "Quality & Safety" report that contains an overview of the main indicators. This is discussed at the Executive Board, by Operating Unit Managers and with commissioners. During the course of the year it has evolved and is developing into a single source of information regarding the Trust's quality and safety performance.

The three areas reported under safety are:

- Incident Reporting
- 999 Call Recording
- Medicines Management

Part Three

Incident reporting

REASON CHOSEN:
Incident management is considered a key element of managing safety and a marker of a safety culture. In addition, the Trust has undertaken considerable improvement work in this area

DATA SOURCE:
Electronic database (Datix)

CONFIDENCE IN THE DATA:
(INDICATED IN BOLD):
Low, **Medium**, High

This year the Trust identified incident reporting as one of the measures of patient safety.

The Trust is embarking on a large cultural change programme. Part of this change is to become more transparent and acknowledge the learning within errors and near misses. It is recognised that an organisation that is developing a true safety culture will have a high level of incident reporting. This is because staff will be keen to register a wide range of incidents where learning can lead to real improvements.

Therefore, in 2017/18 the Trust set an ambitious target to increase overall incident reporting by 20%. This target has been exceeded (as illustrated in graphs 15 and 16).

However, in order to achieve this the Trust had to ensure incident reporting was valued and that staff were aware that incident reports were scrutinised and brought about real change. Over the course of the year the monthly Quality & Safety Report identified the top themes within incident reporting and described the changes that resulted from the reporting. Additionally, learning is now summarised in a monthly poster on incidents which is circulated for display at all stations.

The Trust had to significantly improve the time frame associated with the identification, investigation and closing of an incident. Again, the Trust set an ambitious time scale to ensure at least 75% of incidents were closed within the allocated time. This is on track to be achieved.

Finally, a programme of training was introduced across the Trust. This was to raise awareness of incident reporting and to improve the quality of the information within the actual incident report. In 2017/18 the Trust trained 253 members of staff on incident reporting.

Learning

Examples of change that has resulted from incident management include the following:

Life Pack (defibrillator) incidents

In August 2017 it was apparent that there was an increase in the number of incidents being reported that were related to the Trust's defibrillators. These were initially regarding the life of the battery charge. A drive to ensure all vehicles had the most up-to-date model available in the Trust was introduced, together with the replacement of all batteries older than four years. This reduced the number of incidents regarding battery failure.

However, a new issue arose in quarter three where 61 incidents were reported regarding the connector pad from the ECG leads to the patient. As a result a new and more robust connector was purchased which has significantly reduced the number of incidents.

Medication Incidents

The Trust has undertaken a significant amount of work regarding medicines management and this is detailed later in this section. However, medicines management was identified as an area that required rapid improvement by the Care Quality Commission.

The resulting focus paid to medicines management allowed the staff to become more aware of the need to report any type of medication issue as an incident. This increase has been attributed to this heightened awareness and an increasing understanding that medicines management is a professional issue and any failings are potential breaches in safety.

In quarter two, the period when the Trust commenced its improvement programme, there were 295 medication incidents being reported, which compares to 414 medication incidents in quarter three and 431 in quarter four.

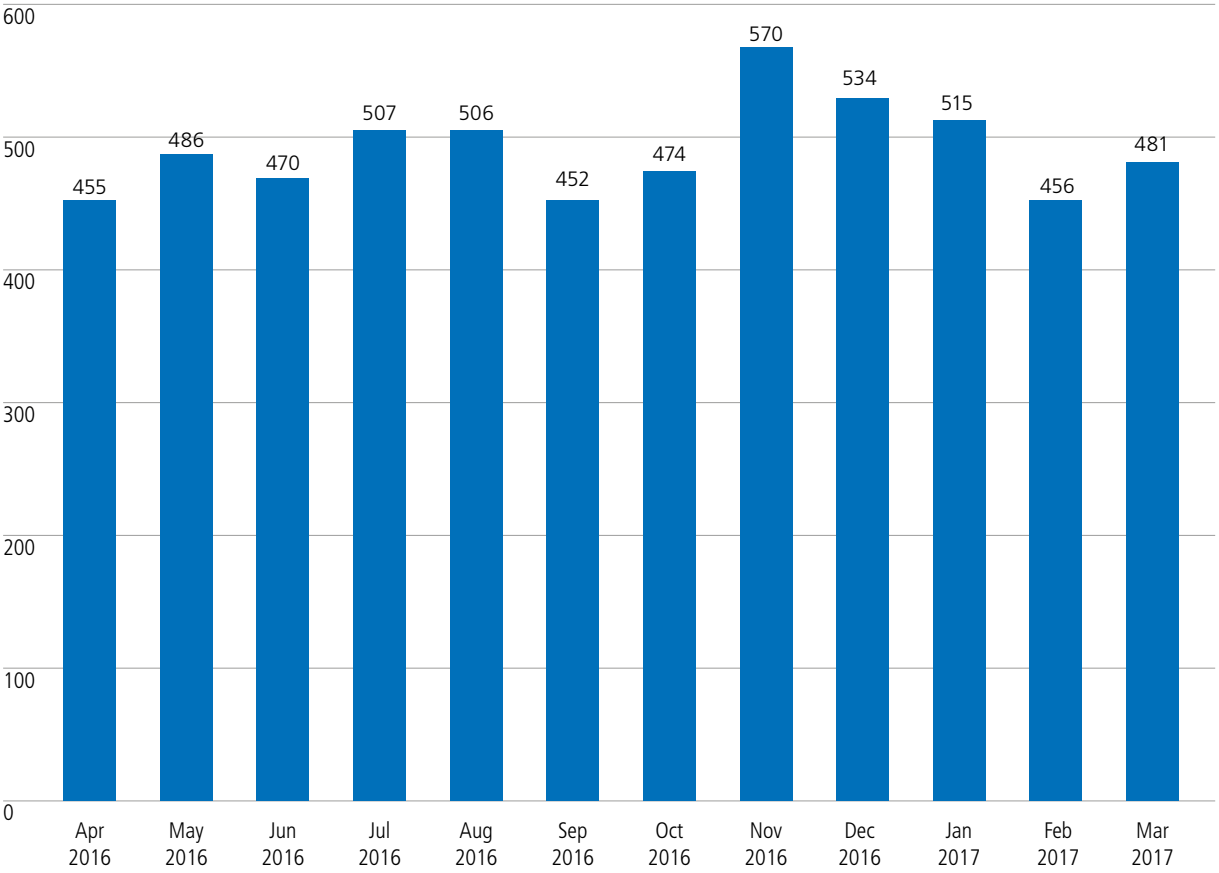
One of the most frequently reported incidents was the breaking of ampoules of controlled drugs. Consequently, a new storage system was introduced and this led to a significant reduction.

The number of reported incidents

The following graphs represent the number of incidents reported in 2016/17 (graph 12) and the number of incidents reported in 2017/18 (graph 13).

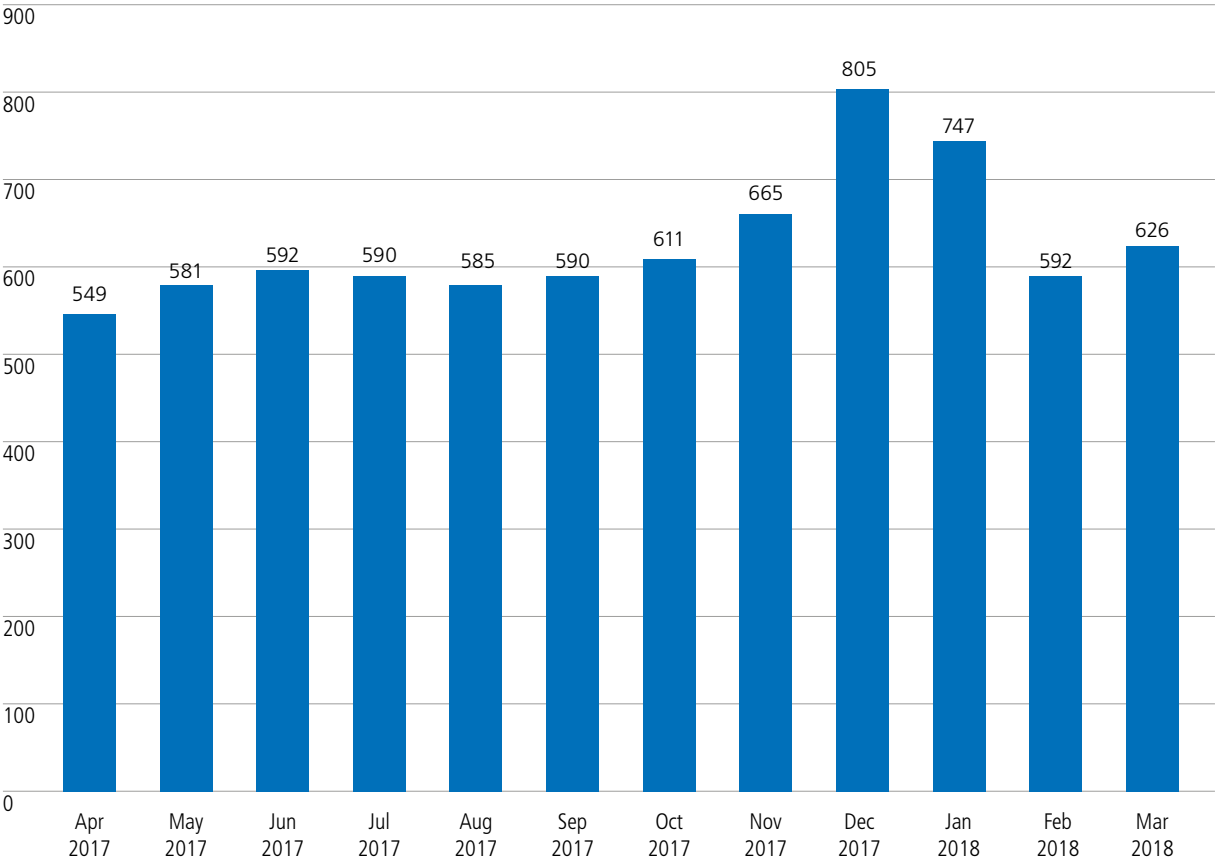
Graph 15. Incident reporting 2016/17

Number of incidents Reported April 2016 - March 2017



Graph 16. Incident reporting 2017/18

Number of incidents Reported April 2017 - March 2018



It is clear that the Trust has considerably improved incident reporting across the organisation. The percentage growth is 27.5% which is a considerable achievement and one which the Trust is proud of.

However, it is clearly not enough to simply report the incident. The organisation also has a responsibility to use incident analysis as a way of learning and making improvements.

Consequently, an innovative communication mechanism was developed that clearly communicates the data and main themes arising from a monthly analysis. This information is detailed every month in a poster format and circulated to all stations for display as part of the quality and safety metrics. This is supported by a more detailed case study which others can also learn from.

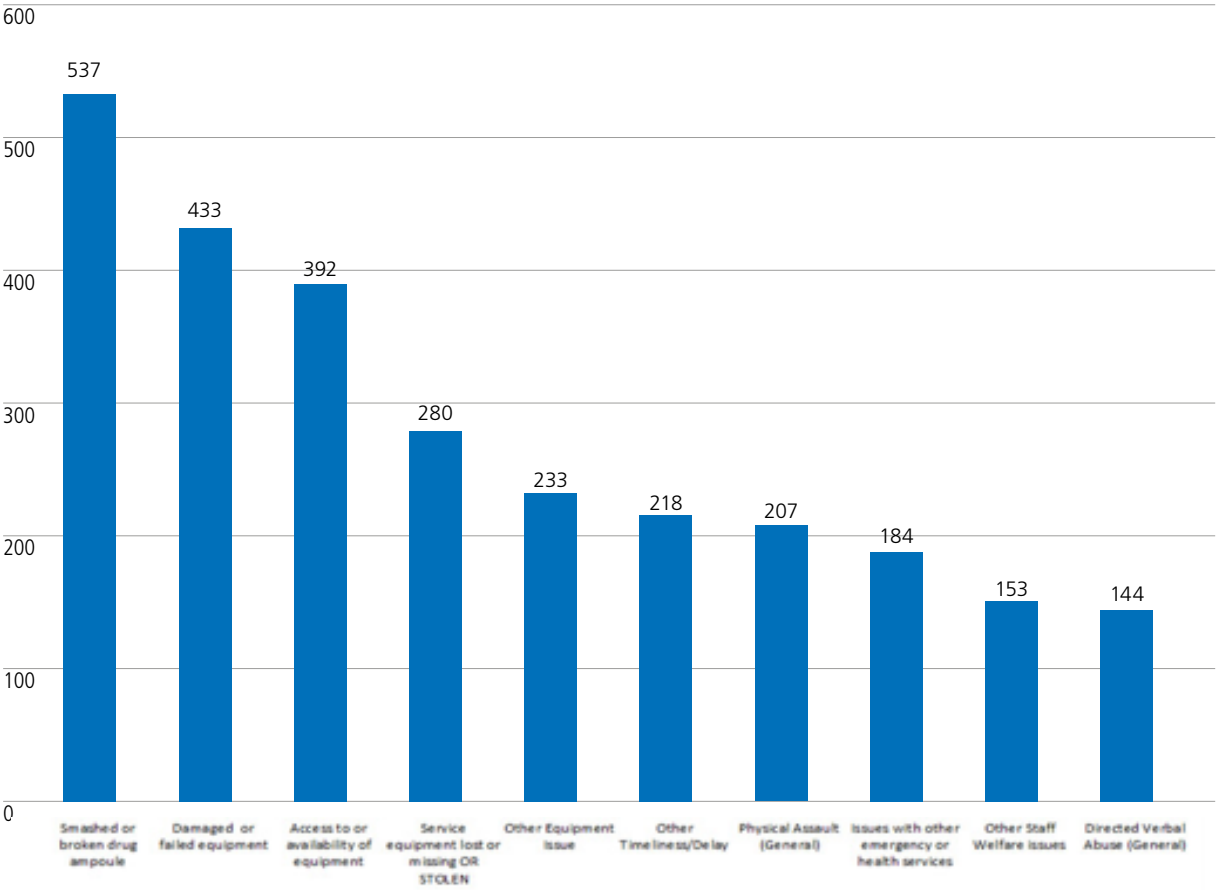
Themes and learning

The themes have been varied and there appears to be a relationship in reporting with the awareness raising undertaken across the Trust, such as medication incidents.

The following two graphs illustrate the main themes across 2016/17 (graph 17) and the main themes across 2017/18 (graph 18).

Graph 17. Incident themes 2016/17

Top 10 Sub Category of Incidents Reported April 2016 - March 2017



Graph 18. Incident themes 2017/18

Top 10 Sub Category of Incidents Reported April 2017 - March 2018

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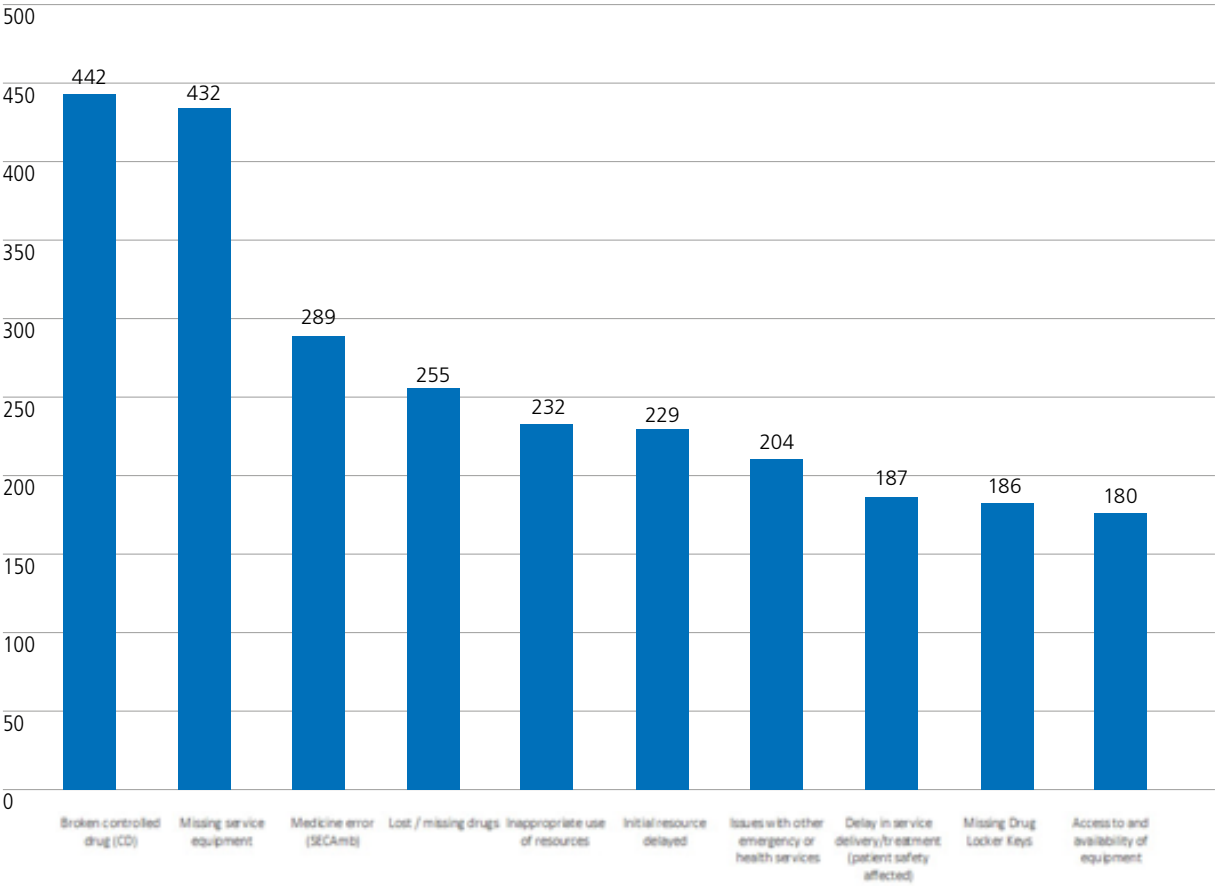


Data definition and comparisons

There are no specific national data definition for incidents. Each NHS Trust is able to guide staff via local policy and procedures, which makes comparisons between different ambulance providers difficult.

However, incidents reported to the National Learning Reporting System (NRLS) are guided by a national definition. This is:

"A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care".

The six monthly published report by NHS Improvement provides comparative data by provider Trusts. The full report can be accessed via the NHS Improvement website;

https://improvement.nhs.uk/resources/monthly-data-patient-safety-incident-reports/

However, the following table (table 3) is represented for comparison purposes in the Quality Account.

NRLS has also changed to monthly publications of incident data. This has allowed Trusts to scrutinize their data more effectively.

The Trust has had some difficulty in initially capturing and then uploading NRLS data due to complexities in the Datix set up. This initially meant that only a small part of the data was sent to NRLS.

However, this was resolved in July 2017 and since this time all data has been uploaded to NRLS and the backlog of data was uploaded at the end of Q3 2017. The Trust is now uploading data on a weekly basis from newly-reported incidents.

On average, from April 2017 to August 2017, the Trust uploaded 35 incidents on average per month. From September 2017 to January 2018, the Trust uploaded on average 175 incidents per month.

The London Ambulance Service NHS Trust reported the most incidents to NRLS between April 1-September 30 2017 and South Central Ambulance Service NHS Foundation Trust reported 60. It is difficult to draw comparisons as this is not converted into a rate based on population but the data does not give cause for concerns for SECAmb.

Table 3. NRLS Reporting (Organisational level data for the first 10 months) April 17 – January 18

Organisation name	Number of incidents occurring
SOUTH WESTERN AMBULANCE SERVICE NHS FOUNDATION TRUST	**2,371**
LONDON AMBULANCE SERVICE NHS TRUST	**2,313**
NORTH EAST AMBULANCE SERVICE NHS FOUNDATION TRUST	**1,614**
YORKSHIRE AMBULANCE SERVICE NHS TRUST	**1,572**
SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST	**1,046**
NORTH WEST AMBULANCE SERVICE NHS TRUST	**891**
EAST OF ENGLAND AMBULANCE SERVICE NHS TRUST	**758**
WEST MIDLANDS AMBULANCE SERVICE NHS FOUNDATION TRUST	**630**
EAST MIDLANDS AMBULANCE SERVICE NHS TRUST	**541**
SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST	**126**
All Ambulance trusts	**11,862**

Part Three

Data quality

The data is drawn from the Trust's electronic database, Datix. The data presented in this Quality Account has been compiled from a report that was pulled from the system twice in order to ensure accuracy. The data has then been evaluated by the Datix Manager and the Head of Risk to check for consistency and abnormalities.

The incident data is regularly presented and is featured in the monthly quality & safety report which is presented to the Executive Team, Commissioners and Area Governance Meetings.

The NRLS data in table 3 is produced by NHS Improvement.

999 Call Recording

REASON CHOSEN:

999 call recording is a key element of the Trust's clinical documentation and is consequently a fundamental element of patient safety. This was a key failing identified by the care Quality Commission in 2017.

DATA SOURCE:

Electronic database.

CONFIDENCE IN THE DATA:

(INDICATED IN BOLD):

Low, Medium, **High**

This year the Trust identified 999 call recording as one of the measures of patient safety.

Call recording was identified by the Care Quality Commission as a significant failure which resulted in a "Notice of Proposal" in 2017. This was rapidly corrected and as a result the notice was lifted in September 2017.

However, the infrastructure that is required to undertake 999 call recording requires investment and whilst this has been authorised by the Trust Board there is a time lag between business case, approval, procurement and implementation. Consequently, a monitoring system has been put into place which gives oversight of any failings in the Trust's ability to record 999 calls.

999 Call auditing process

The monitoring system is a weekly audit of compliance. The Trust's Compliance Steering Group maintains a weekly overview of the audit results and if there are any failings escalates these issues to the Executive Management Board.

Table 4 illustrates that the recording issues are being actively managed.

Since October there have only been two cases identified through the audit process.

Date	Number of Missing Calls	Number of Calls Audited	Number of Partial Recordings	Number with Static in Recording	Number of Conjoined Recordings	Number of Transferred calls not recorded
19-09-17	30	408	67	91	0	0
2-10-17	9	2622	1	60	0	0
13-10-17	18	2402	14	105	0	0
20-10-17	0	2473	0	0	0	0
27-10-17	0	2252	0	0	44	0
10-11-17	0	2547	0	0	0	0
17-11-17	0	2603	0	0	0	1
23-11-17	0	2576	0	0	0	0
05-01-18	0	1555	0	0	0	0
26-01-18	1	1408	0	0	0	0
02-02-18	1	2064	0	0	0	0
09-02-18	0	2416	0	0	0	0
02-03-18	0	400	0	0	0	0
23-03-18	0	799	0	0	0	0

Data definition and comparisons

There are no data definitions and comparisons are not possible.

Data quality

The Trust's Computer Aided Dispatch system (CAD) is used as the baseline for the audit. It contains records for every call made into the control room and also out of the room to the Trust's clinical staff. Also captured are the subsequent calls made into the control room (patient or a clinician ringing a patient back).

The data is located by members of the audit team where each call selected for audit is traced back. To date the Trust has audited over 20,000 voice records since commencing the audit.

There is a high confidence in the quality of the data.

Part Three

Medicines management

REASON CHOSEN:
Medicines Management is a key element to keeping staff and patients safe. This was a key failing identified by the care Quality Commission in 2017

DATA SOURCE:
Manually audited

CONFIDENCE IN THE DATA:
(INDICATED IN BOLD):
Low, Medium, **High**

Over the past year the Trust has placed a considerable emphasis on the need to improve medicines management. For the summer months of 2017 this was the Trust's primary focus on improving safety.

The care Quality commission report was useful in the way that it assisted the Trust to prioritise and take rapid action. The Care Quality Commission's immediate conclusions were that the Trust was significantly failing in this area of practice which resulted in a "Notice of Proposal" in 2017. This was rapidly corrected and as a result, the notice was lifted in October 2017 following a re-inspection the month previously.

Improvements

A number of work streams were implemented via the creation of a new Improvement Plan. These included;

- The recruitment of a Chief Pharmacist.
- Controlled Drugs Accountable Officer (CDAO) appointed and medicines safety officer (MSO) appointed.
- Recruitment into an expanded medicines governance team.
- Training for staff through workshops and facilitated discussions.
- Training for the new standard operating procedures.
- The creation of a system of audit and assurance to monitor compliance against standards.
- A complete review of the suite of policies and procedures that guide medicines management
- A revision of the Trust's Patient Group Directions (an agreement that permits some staff to administer medications in the absence of a prescription).
- New medicines storage for staff carrying medicines on their person.
- A revision of drug security and the locking of medicines and medical gases.
- Commissioning an external review into medicines management.
- Development of a medicines optimisation strategy.
- Introduction of a system to monitor temperature recordings of medicines storage conditions.
- Review of the use of medicines within the clinical training team.
- Development of performance metrics for monitoring.
- Undertook training for the Controlled Drugs Accountable Officer (CDAO).

The Trust implemented a wide range of metrics that are thoroughly audited in order to ensure compliance. Operational Team Leaders are required to audit medicines compliance on a weekly basis. Operating Unit Managers are required to undertake monthly audits and the Chief Pharmacist leads quarterly audits.

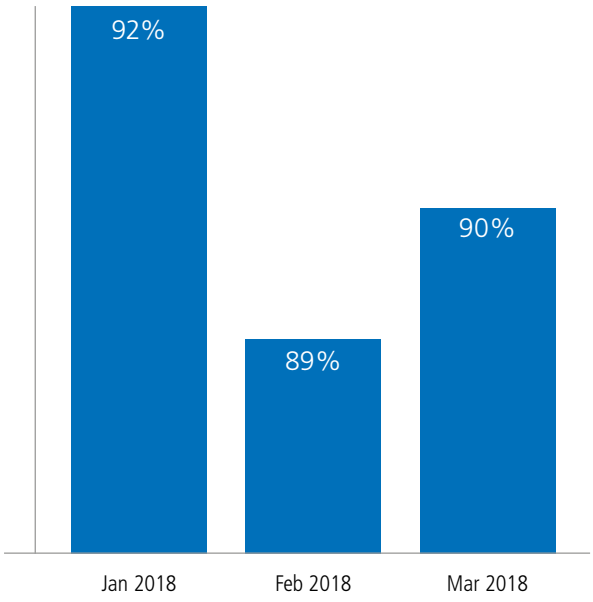
These are supplemented by ad hoc site checks and also additional checks form part of station assurance visits that are coordinated across the service.

Compliance with Medicines Standards

The graph below illustrates the compliance with the monthly audits. These were only introduced in January 2018. No further data is available.

Graph 19. Compliance with Medicine Standards 2017/18

% Compliance with Medicines Standards



As the medicines standards and subsequent audits were only introduced in late 2017 the Trust is unable to provide data for the whole year and for the previous year.

When an area reports a breach in compliance, relevant actions are identified and implementation of the actions is monitored. In addition, the central team track any identified themes and plans are developed to rectify corporate issues. For example, through analysis it was identified that there was a problem with the tagging of medicines pouches (the tagging allows quick identification as to the status of the contents). Appropriate changes were identified and have been implemented. The intended improvements are currently being observed and monitored.

Data definition and comparisons

There are no data definitions and comparisons are not possible.

Data quality

The improvement plan has delivered considerable improvement to the management of medicines. There is a high level of confidence in the data as the audits are undertaken in three different time frames, weekly, monthly and quarterly, by different people and the results are compared and discussed by the senior management team.

Clinical effectiveness indicators

The nature of the emergency and urgent care service means that patients are under the care of the Trust for a limited time and many more professionals are often involved with the care of the patient. So evaluating the effectiveness of the ambulance intervention is challenging as there are fewer metrics that solely measure the care and treatment given by the ambulance service.

Nevertheless, the Trust has identified three indicators for clinical effectiveness.

Part Three

Clinical audit programme

REASON CHOSEN:

Clinical audit is a vital component of the Trust's evaluation work. Through audit the Trust can examine how effective it has been. In previous years the Trust has had difficulty fully delivering the audit programme and identified this as an area of quality improvement

Clinical audit was identified by the Care Quality Commission as an area that required immediate attention

DATA SOURCE:

Various sources

CONFIDENCE IN THE DATA:

(INDICATED IN BOLD):

Low, Medium, **High**

Each year the Trust creates a clinical audit programme. The programme includes a range of locally identified audits and the nationally mandated ambulance clinical quality indicators.

Documentation

As the majority of the audits are document based, the Trust's clinicians are required to maintain a high standard of documentation. Therefore, sitting alongside the audit programme is an improvement plan aimed at improving clinical documentation.

The health records team are a vital part of this process and are responsible for the timely scanning and indexing of all paper-based patient care records. This ensures the data is available for the audit process.

Considerable work has been undertaken to improve this process and whilst some challenges remain there has been improvement.

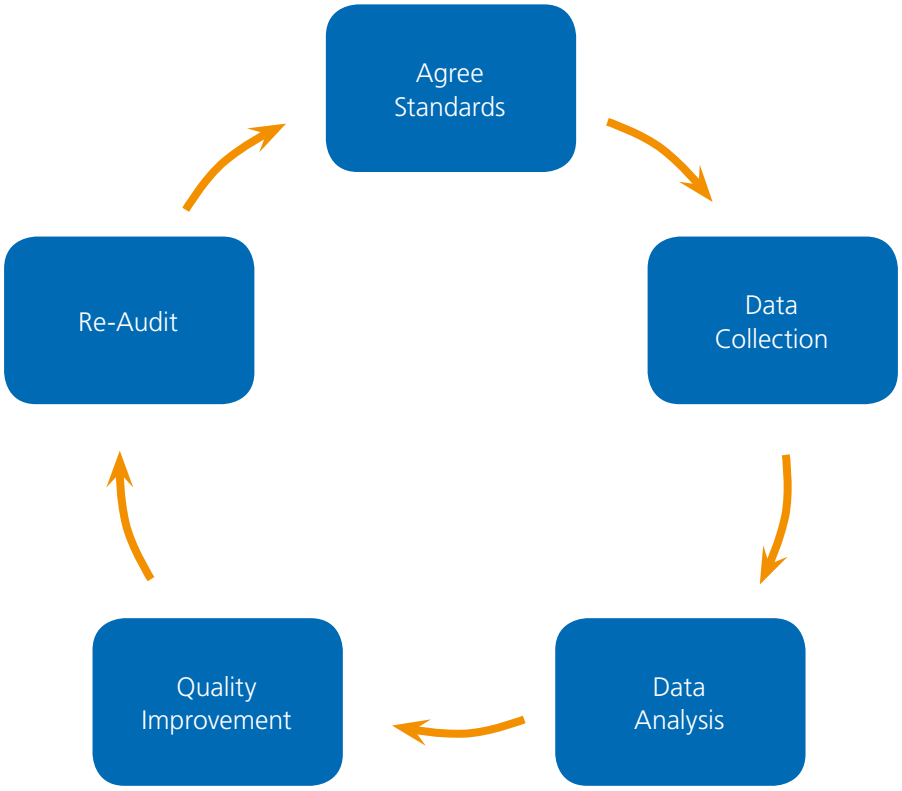
Additionally, the Trust has improved the accuracy of documentation. In July 2017, the start of the improvement journey, the Trust had a compliance rate of 28% for all documentation containing all the relevant data. By the end of March the compliance rate was 51%.

Clinical audit

NHS Trusts have a statutory and mandatory requirement to have well-designed clinical audit and improvement systems in place, in order to provide safe and effective care to the population they provide for.

Clinical audit is the quality improvement cycle that SECAmb uses to measure the quality of care delivered against agreed and proven standards, and to produce improvements by bringing practice into line with these standards.

Fig 1: Improvement Cycle



The Clinical Audit Team have defined high quality care as being:

Safe – avoiding injuries to service users from the care that is intended to help them.

Timely – reducing waits and sometimes harmful delays for both those who receive and those who give care.

Efficient – avoiding waste, including waste of equipment, supplies, ideas and energy.

Equitable - providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, sexuality, geographic location and socio-economic status.

Effective – providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit.

Person-centred – providing care that is respectful of and responsive to individual service user preferences, needs and values and ensuring that patient values guide all clinical decisions

During the year the Trust produced an improvement action plan, which included appointing the Clinical Audit Support Centre to undertake a review of the clinical audit function.

The clinical audit programme

The 2017/18 clinical audit programme comprised of 13 locally identified clinical audits. The list of all 13 audits is given in Table 5. This is the first year in three years that all of the audits will have been fully completed (graph 20). This is a significant achievement for the organisation.

In addition, the audit team are required to audit the following national requirements:

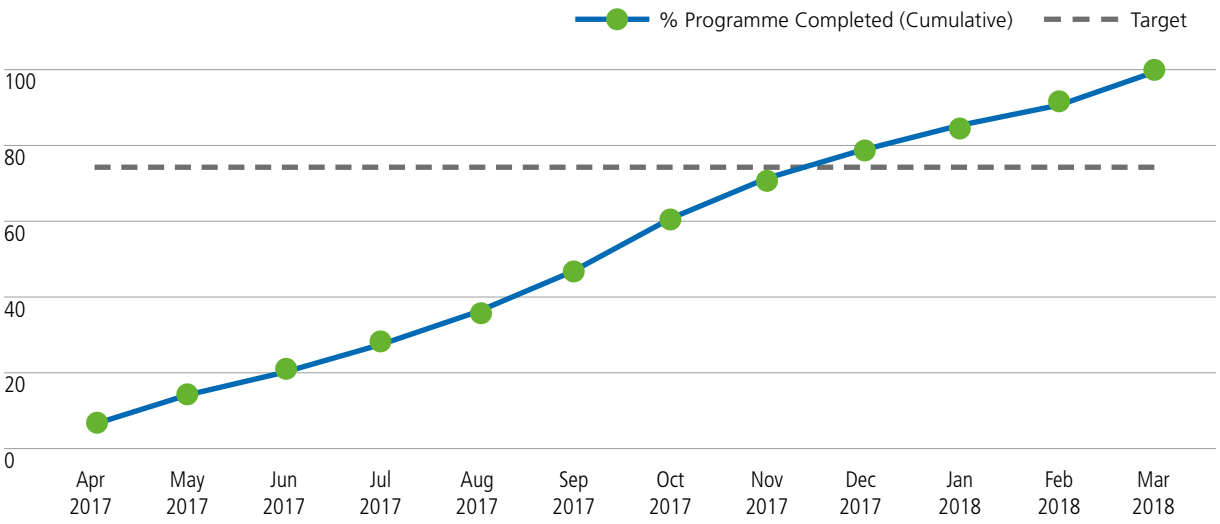
- Stroke Care
- STEMI Care
- Stroke arrival at hospital within 60 minutes.
- STEMI and treatment received within 150 minutes
- Cardiac arrest survival
- Return of Spontaneous Circulation (ROSC)

Whilst the achievements within the audit programme are significant for the Trust there remains further work. There needs to be a more active role in monitoring improvements and for identifying accountability for incorporating audit results into clinical practice.

The Trust's clinical audit group will be instrumental in driving the recommendations and outcomes from clinical audit.

Audit Area
Fractured neck of femur
Patient risk assessment in mental health conditions
Condition coding, incident categorisation and documentation for mental health
Management of mental health conditions
Correct diagnosis of non-conveyed chest pain
Falls - patient outcome
Falls – referrals
Early warning scoring
Adherence to guidance for Rocuronium
Patient outcome for Rocuronium
Head injury management
Sepsis management
Amiodarone use

Graph 20. Compliance with clinical audit programme across 2017/18



Data definition and comparisons

There is no data definition and comparisons are not possible.

Data quality

The data used to populate graph 17 is of low volume and has been manually counted a number of times.

The Head of Clinical Audit maintains an oversight of all the data and reports this weekly to the Trust's Compliance Steering Group. There is a high confidence in the data.

Cardiac arrest survival

REASON CHOSEN:
One of the most important clinical outcome measures for patients

DATA SOURCE:
Clinical Records

CONFIDENCE IN THE DATA:
(INDICATED IN BOLD):
Low, Medium, **High**

Cardiac arrest survival is also one of the mandated indicators for clinical audit.

Ambulance services in the whole of England attempt resuscitation in nearly 30,000 people suffering out-of-hospital cardiac arrest every year.

Approximately eight percent of people in whom resuscitation is attempted survive to the point of hospital discharge.

The presence of a clinician significantly improves response to, and outcome from, a cardiac arrest, as the clinician on scene can begin the correct advanced life support at the earliest opportunity.

However, the indicator is a measure of more than just the ambulance intervention. It is a whole system measure. Survival can be increased significantly by the early use of cardiopulmonary resuscitation (CPR) and automated external defibrillators (AEDs) either by members of the public or the ambulance service.

The chances of survival are time-dependent; the longer the attempted resuscitation is delayed, the worse the outcome. In patients with a shockable heart rhythm, there is approximately a 10% reduction in survival for every minute's delay in providing defibrillation .

There are two measures for evaluating the outcome of this indicator. The first is the overall number of patients suffering a cardiac arrest but as a result of life-support started or continued by the ambulance service, and treatment in hospital, they were successfully resuscitated and survived to discharge at hospital. The second measure is known as the Utstein group. This is an internationally-recognised method of calculating out-of-hospital cardiac arrest survival rates and focuses on a sub-group of patients who have the best chance of a successful resuscitation. The calculation takes into account the number of patients discharged alive from hospital who had resuscitation attempted following a cardiac arrest of presumed cardiac aetiology, and who also had their arrest witnessed by a bystander and an initial cardiac rhythm of ventricular fibrillation or ventricular tachycardia.

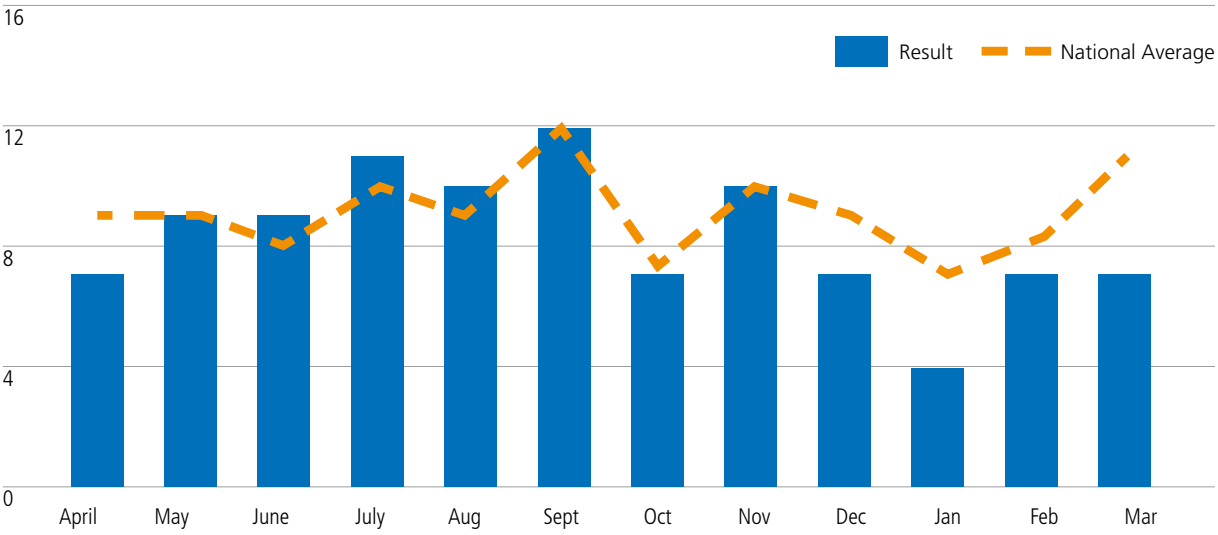
The Utstein group is regarded as the best of the two measures as it more accurately measures the care and treatment given to those patients most likely to survive.

The Utstein measure has already been provided in section 2 of the Quality Account but is reproduced again here for convenience.

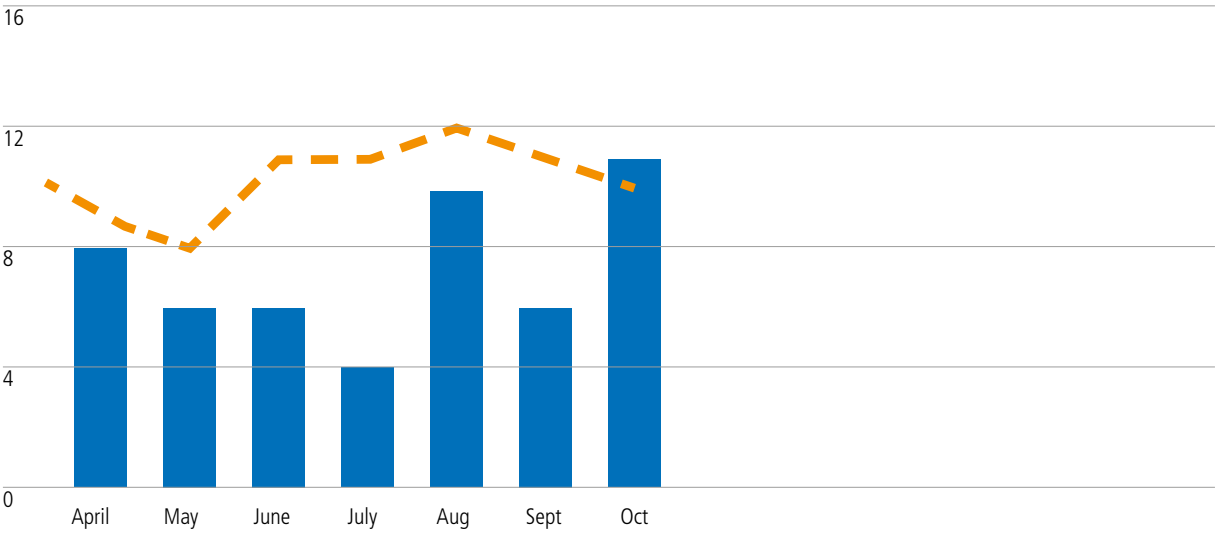
The following graphs show the Trust's performance across the last two years.

[4]Taken from Resuscitation to Recovery. A National Framework to Improve Care of People with Out of Hospital Cardiac Arrest in England. March 2017.

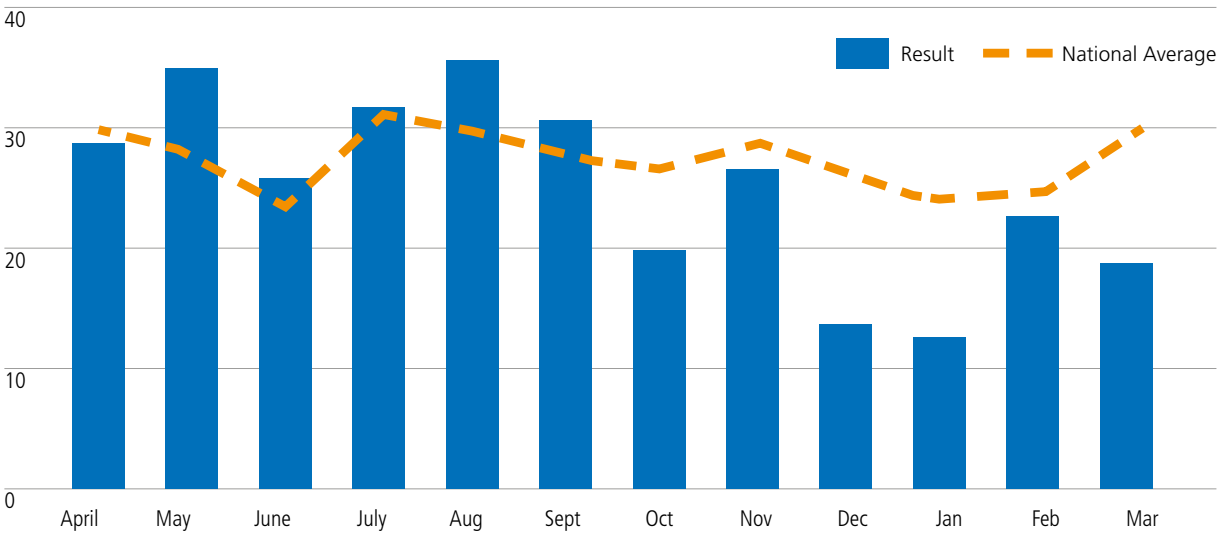
Graph 21. Survival to discharge following cardiac arrest (All) 2016/17



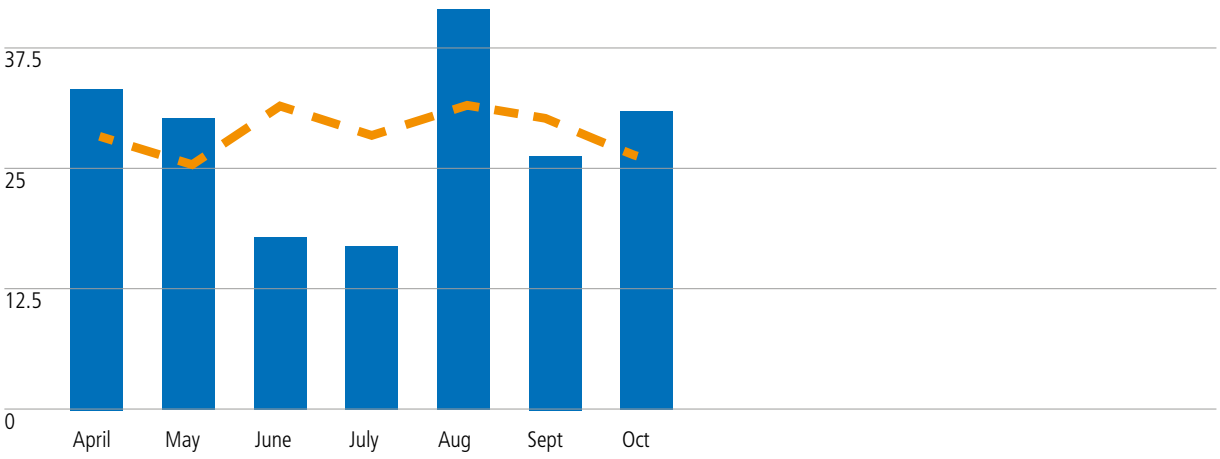
Graph 22. Survival to discharge following cardiac arrest (All) 2017/18



Graph 23. Survival to discharge following cardiac arrest (Utstein) 2016/17



Graph 24. Survival to discharge following cardiac arrest (Utstein) 2017/18



Part Three

Work undertaken

Survival from cardiac arrest is a key area of focus for the Trust. The clinical audit team collate and analyse the Trust's data on the number of cardiac arrests we attend, the number of patients that have a 'return of spontaneous circulation' (have a heartbeat) when they arrive at hospital, and how many patients survive to be discharged from hospital. This data and analysis drives improvement across the Trust.

Early recognition:

- In order to reduce the time taken to respond to a cardiac arrest when somebody calls 999, we have introduced three 'pre-triage' questions. These questions are asked before taking any location details or before detailed triage begins and allow us to get help to our most unwell patients first.
- SECAmb once again took part in 'Restart a Heart Day'; which is a designated yearly day of action across Europe with the aim to teach vital life-saving cardiopulmonary resuscitation (CPR) skills to as many people as possible. We doubled our efforts from 2016 and trained 16,800 people to recognise cardiac arrest and buy time by delivering bystander CPR.

Early CPR:

- Our Emergency Medical Advisors (EMAs), who answer 999 calls, deliver instructions on how to deliver CPR when a patient is in cardiac arrest. The quicker CPR commences, the greater the patient's chance of survival. We have begun to collect data on how quickly this telephone guided CPR commences. Monitoring this data helps us to benchmark and identify opportunities for improvement.
- A programme of work has updated and strengthened the training provided to our community first responders (CFRs). CFRs are volunteer members of a local community who are trained to respond to emergency calls in conjunction with SECAmb. As they respond in the local areas where they live and work, they are able to attend the scene quickly and commence CPR to increase the patient's chances of survival. The changes to the training programme will enhance the skills of the group and facilitate improved patient care. Further recruitment of CFRs will commence in 2018/2019.
- The Trust has purchased additional mechanical CPR devices so that more victims of cardiac arrest receive continuous, high-quality CPR at the scene of a cardiac arrest and en route to hospital.

Early defibrillation:

- The Trust database of Public Access Defibrillators (PADs) currently holds around 3,000 records. We continuously receive additional entries for the database. When a 999 call for a cardiac arrest is received and there is a public access defibrillator in a close proximity, the caller is given instructions on how to access the defibrillator and how to use it. This allows early defibrillation to take place and increases the patient's chance of survival.

Post-resuscitation care:

- A new resuscitation procedure has been introduced in the Trust, which provides more clarity on the safe and effective management of patients after a successful resuscitation.
- Additional resuscitation training will be provided in the Trust's 2018-2019 annual mandatory training programme for clinical staff. This will include content on advanced life support skills and effective post resuscitation care.

Data definition and comparisons

The national definition for cardiac arrest survival is:

- This is a measure of the overall number of patients suffering a cardiac arrest, but as a result of life-support started or continued by the ambulance service, and treatment in hospital, they were successfully resuscitated and survived.

The national definition for Cardiac Arrest Survival (Utstein) is;

- This is a measure of the overall number of patients who were witnessed suffering a cardiac arrest and received life support started or continued by the ambulance service and treatment in hospital so they were successfully resuscitated, and where their initial heart rhythm allowed it to be shocked with a defibrillator, and survived.

The data is not currently published across a whole year as the data validation means data is published three months behind collection. However, it is possible to compare rates for the last published month; October 2017. For the "all group" the national average is 10% and SECAmb's performance is 11%. The highest performing Trust was South Central Ambulance Service NHS Foundation Trust at 17%, and the lowest performing Trust was South Western Ambulance Service NHS Foundation Trust at 6%.

For the "Utstein group" the national average is 27% and SECAMbs performance is 31%. The highest performing Trust was Yorkshire Ambulance NHS Service NHS Trust at 43% and the lowest performing Trust was South Western Ambulance Service NHS Foundation Trust and London Ambulance Service NHS Trust at 18%.

Data quality

This indicator is part of the national reporting requirements. NHS England maintains the specification for the data that ambulance services collect, based upon user requirements and discussion with data providers. Provider groups include the National Ambulance Information Group (NAIG) for Ambulance Systems Indicators (SI) data; and the National Ambulance Service Clinical Quality Group (NASCQG) for Clinical Outcomes (CO) data. NAIG and NASCQG represent the 11 ambulance services in England that provide and use the data.

However, the patient numbers are very low within the Utstein group which makes comparisons across time and other providers more difficult.

Part Three

Return of spontaneous circulation

REASON CHOSEN:
One of the most important clinical outcome measures for patients

DATA SOURCE:
Clinical Records

CONFIDENCE IN THE DATA:
(INDICATED IN BOLD):
Low, Medium, **High**

Cardiac return of spontaneous circulation is one of the mandated indicators for clinical audit. However, unlike survival to discharge it measures the intervention undertaken by the ambulance service.

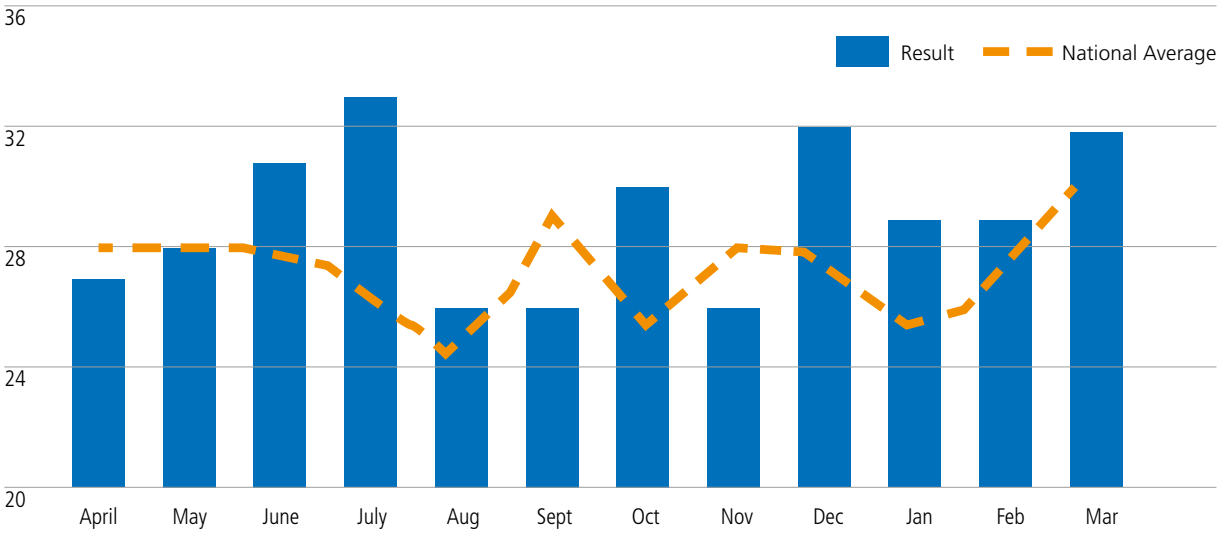
In the UK, call handlers answering 999 calls generally have no medical training and read triage questions from a screen. They are however extensively trained to use the software that guides the assessment of the patient. The system is designed to be precise and identify the medical condition or complaint as soon as possible. Too much flexibility or ambiguity during the assessment can cause a delay starting dispatcher assisted CPR.

The dispatcher-assisted CPR allows the most important intervention to be given to the patient as soon as possible. Our call handlers are a vital part in our ability to get care and treatment rapidly to the patient.

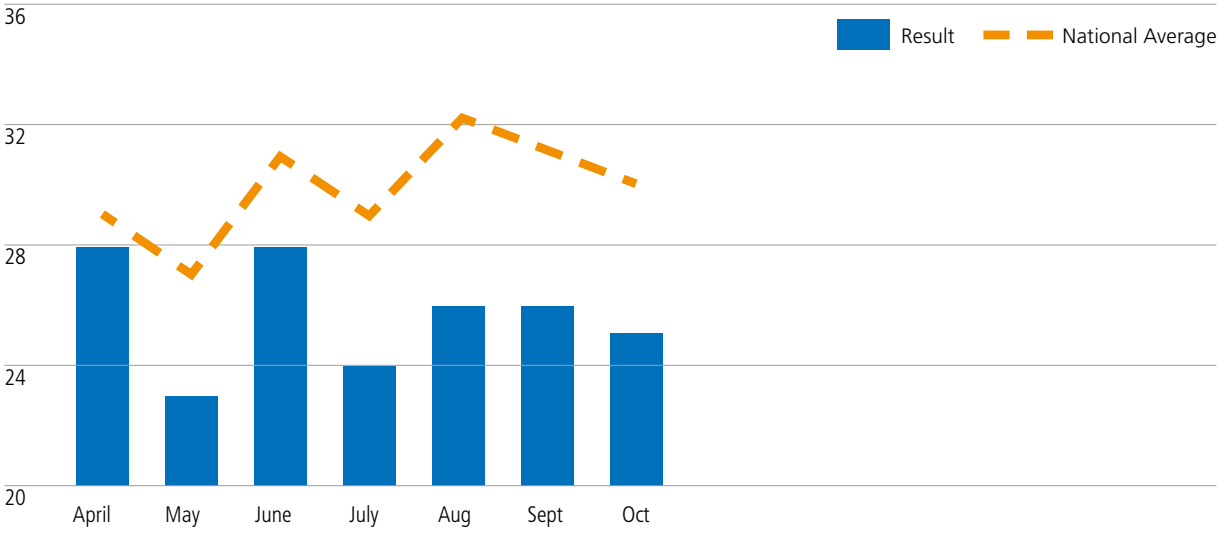
Clearly once an ambulance clinician arrives on scene they can either commence, if not already started, or continue the CPR. Therefore, it is vital that the Trust's clinicians remain current and competent with this intervention.

Consequently, the Trust requires the clinical staff to retrain regularly.

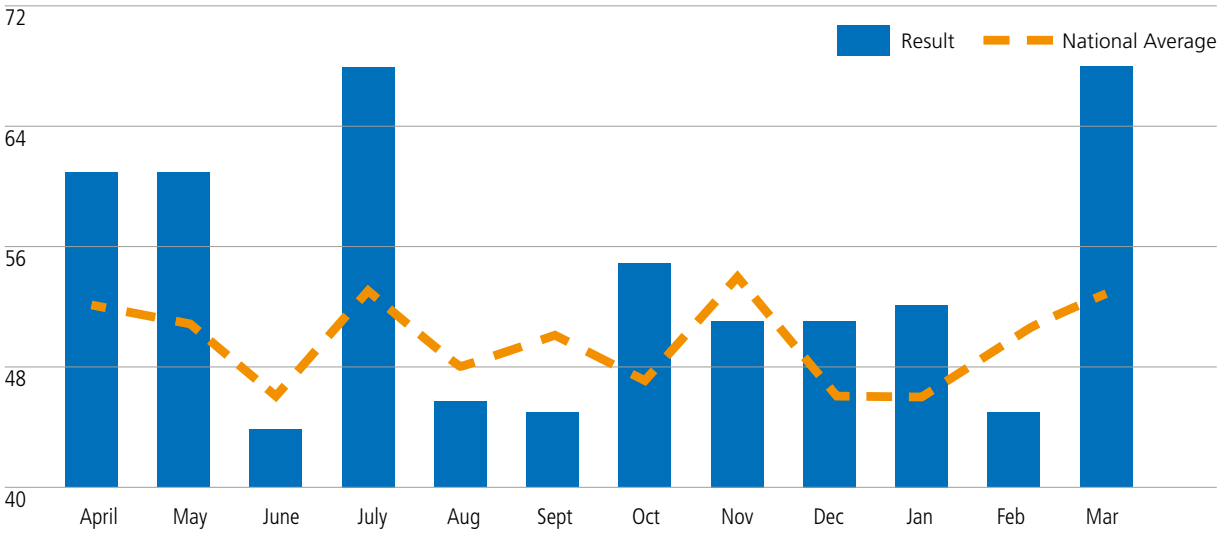
Graph 25. Return of spontaneous circulation (All) 2016/17



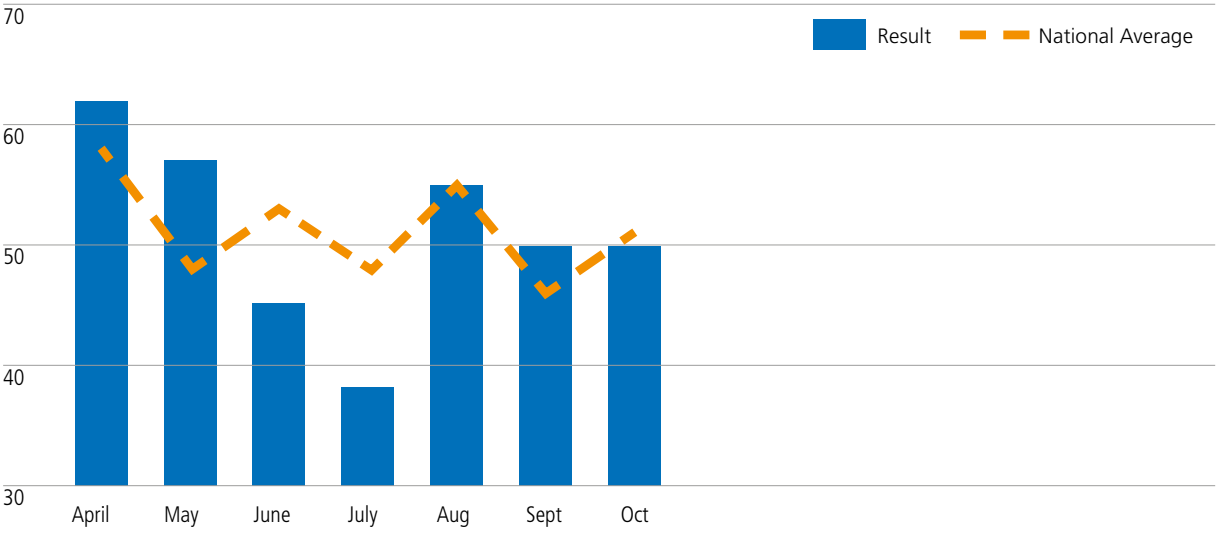
Graph 26. Return of spontaneous circulation (All) 2017/18



Graph 27. Return of spontaneous circulation (Utstein) 2016/17



Graph 28. Return of spontaneous circulation (Utstein) 2017/18



Data definition and comparisons

The national definition for ROSC is;

- This is a measure of the number of patients who have suffered a cardiac arrest, but as a result of life-support started or continued by the ambulance service, had a pulse again by the time they arrived at hospital.

The national definition ROSC (Utstein) is;

- This is a measure of the number of patients who have suffered a cardiac arrest, but as a result of life-support started or continued by the ambulance service, had a pulse again by the time they arrived at hospital, and went on to be discharged from hospital.

The data is not currently published across a whole year as the data validation means data is published three months behind collection. However, it is possible to compare rates for the last published month; October 2017. For the "all group" the national average is 29% and SECAmb's performance is 25%. The highest performing Trust was South Central Ambulance Service NHS Foundation Trust at 37% and the lowest performing Trust was Isle of Wight NHS Trust at 21%.

For the "Utstein group" the national average is 51% and SECAmb's performance is 50%. The highest performing Trust was East of England Ambulance Service NHS Trust at 75% and the lowest performing Trust was Isle of Wight NHS Trust 0%.

Data quality

This indicator is part of the national reporting requirements. NHS England maintains the specification for the data that ambulance services collect, based upon user requirements and discussion with data providers. Provider groups include the National Ambulance Information Group (NAIG) for Ambulance Systems Indicators (SI) data; and the National Ambulance Service Clinical Quality Group (NASCQG) for Clinical Outcomes (CO) data. NAIG and NASCQG represent the 11 ambulance services in England who provide and use the data.

Patient experience indicators

Patient experience is the third domain of indicators where Foundation Trusts are required to publish information.

Patients are generally within the ambulance service's care for a short length of time and this can make evaluation more difficult. Nevertheless, the Trust takes patient experience seriously and draws upon the complaints and compliments that the Trust receives as the main indication of patient satisfaction. Each month either a complaint or a compliment is selected for presentation and discussion at the Trust Board.

REASON CHOSEN:
One of the most important measures for patient experience

DATA SOURCE:
Complaint Letters & Datix

CONFIDENCE IN THE DATA:
(INDICATED IN BOLD):
Low, Medium, **High**

The Trust identified complaints management as one of the areas requiring improvement. A comprehensive improvement plan was developed and monitored weekly by members of the Trust's executive team.

Three objectives were identified;

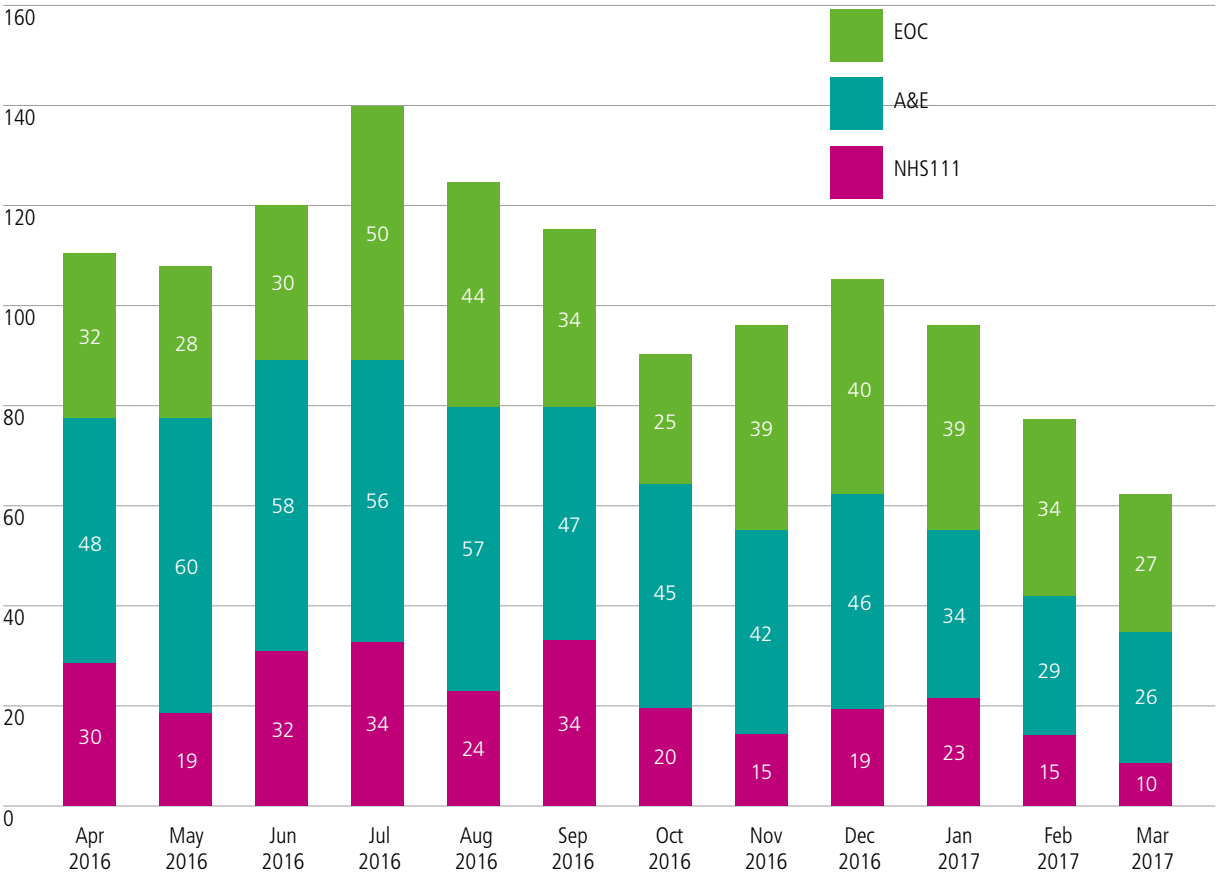
- Objective 1: By 31/03/2018 80% of complaints are being concluded within 25 working days.
- Objective 2: By 31/01/18 be able to provide evidence of learning from at least 95% of complaints.
- Objective 3: By 31/03/2018 80% the Trust will have improved the sharing of learning from complaints and will be able to evidence this.

All of the objectives were achieve to the plan and within timescales. This has made a significant difference to the profile of complaints across the organisation.

Graphs 29 and 30 illustrate the volume of complaints across 2016/17 and 2017/18.

Part Three

Graph 29.Number of complaints 2016/17

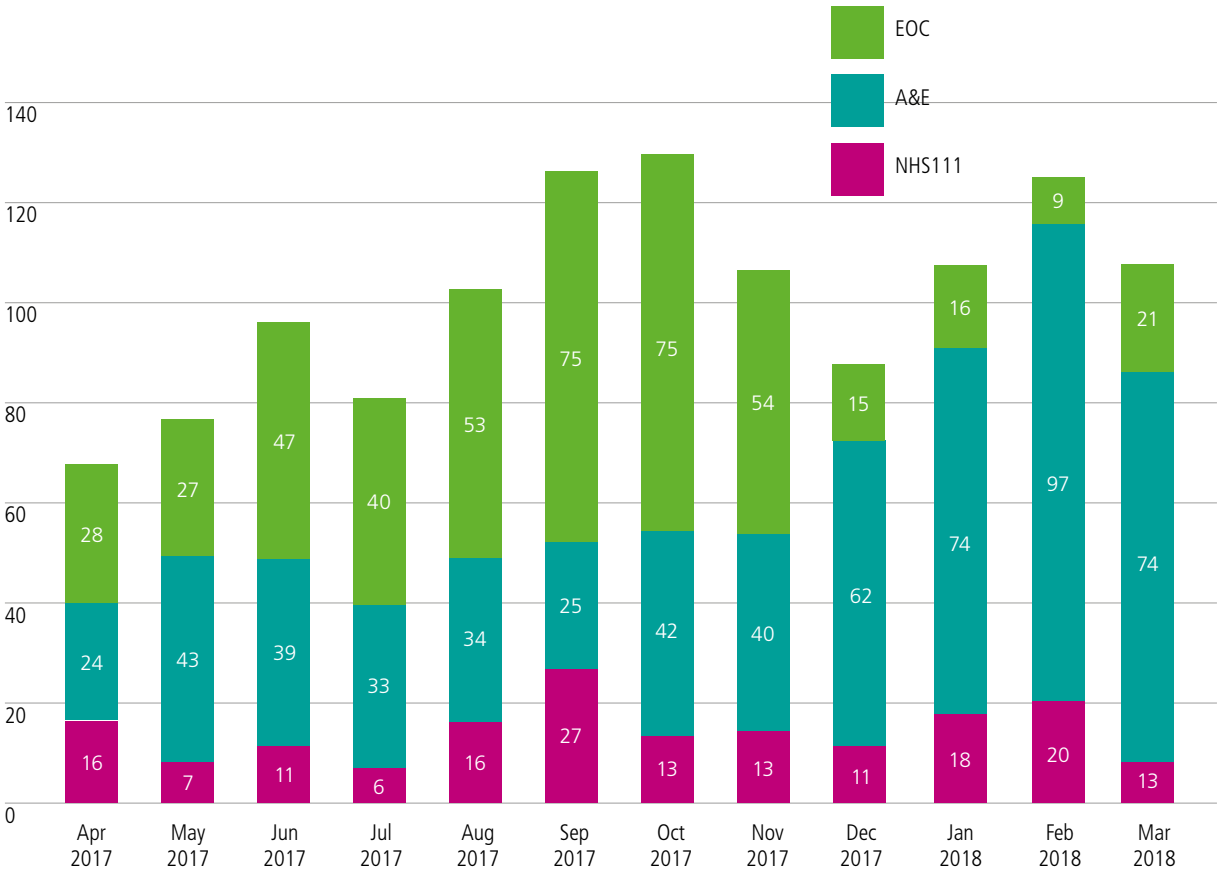


Complaint Numbers

Overall the Trust has received a similar number of complaints as the previous year. The Trust did experience a fall as the new Ambulance Response Programme was implemented, as this introduced a new element where patients were informed approximately how long they may wait for an ambulance. This seemed to manage expectations and appeared to be well received by patients. This will be monitored by the team to see if this is sustained.

However, this year has seen a rise in the number of complaints about 999 call answering. There is a direct relationship with call answering performance, which has been more challenged this year than the previous year.

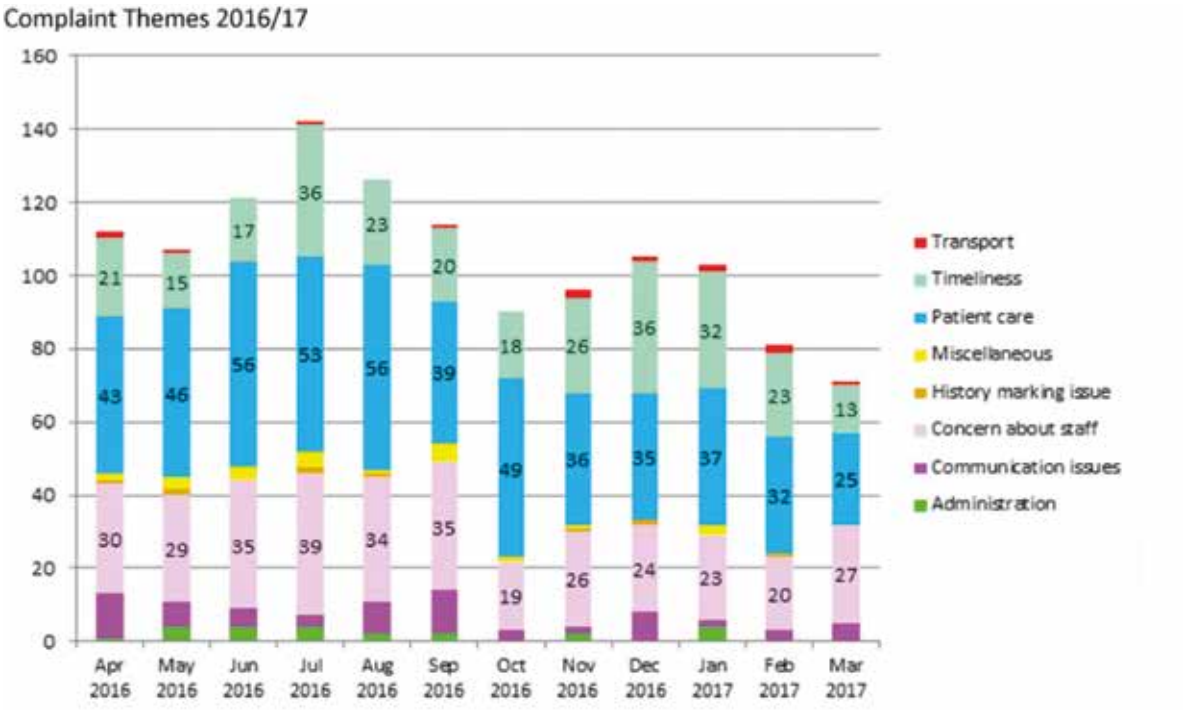
Graph 30. Number of complaints 2017/18



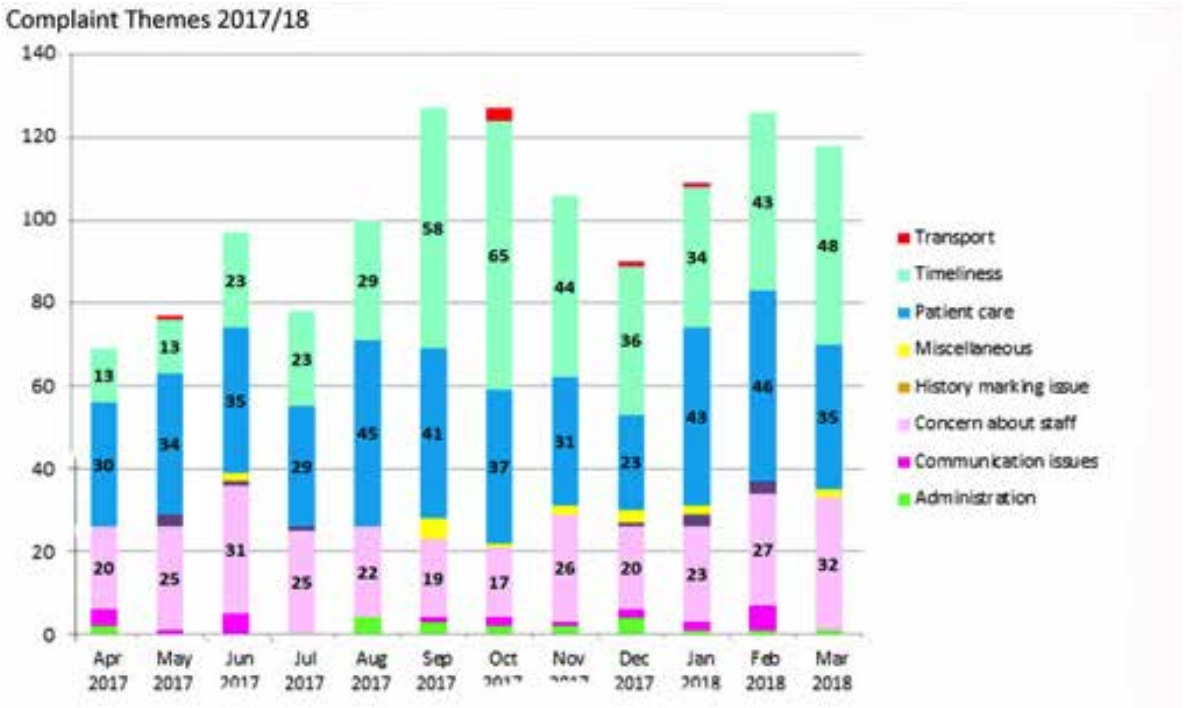
Complaint themes

The following graph (graph 31) illustrates the themes of complaints.

Graph 31. Complaint themes 2016/17

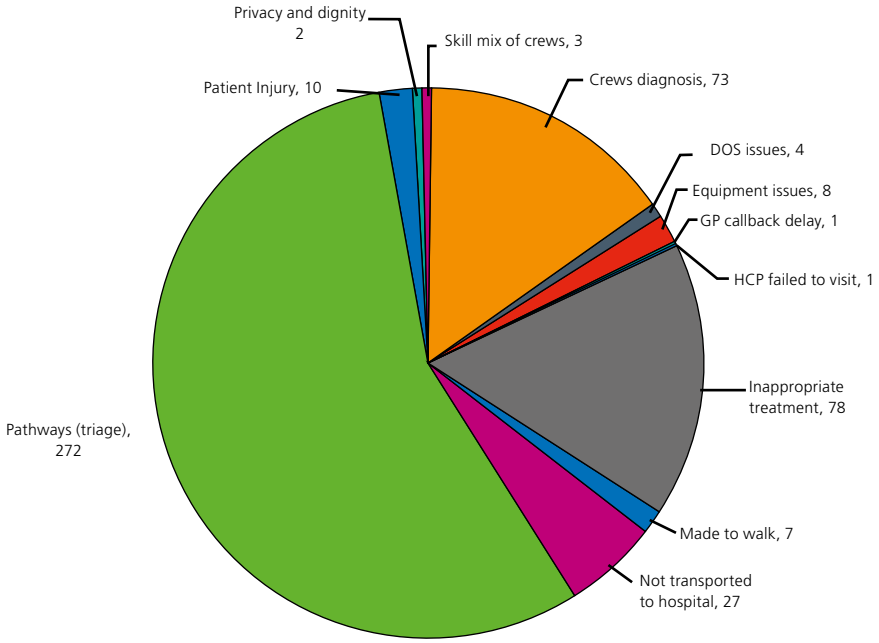


Graph 32. Complaint themes 2017/18



The most common theme this year has been 'patient care', with 429 complaints received. This includes care provided to patients by our ambulance crews, as well as the clinical triage of 999 and NHS111 calls.

Graph 33. Complaint themes



Complaints classed as 'inappropriate treatment included the following:

- Poor manual handling x 5
- Lack of alert (ASHICE) passed/patient not blue-lighted to hospital x 4
- Poor wound care
- Patient taken to wrong treatment centre
- Too much time taken to decide which hospital to convey patient to

Complaints about 'crew diagnosis' are often about the Trust's clinicians not listening to patients or carers and appearing to be dismissive of patients' conditions, and conveying them to hospital reluctantly when it was in fact warranted.

Sometimes they cross over with complaints about patients not being conveyed, where crews believe the patient's symptoms do not warrant conveyance to hospital but it is later found that the patient's condition was more serious than first thought and the patient is conveyed by a second ambulance or by their family. These include patients who have fallen, have abdominal pain, head injuries and fractures.

Complaint response

As previously discussed; the Trust has placed a focus on improving the response times of complaints.

As a result, a weekly report is now produced and circulated to the senior management and leadership teams. This report tracks the response and highlights any responses that could take longer than the 25 day target.

The following graph illustrates the considerable improvement the Trust has made across all areas of the service. By year end all services were meeting the target of responding to at least 80% of complaints within a 25 day target.

Graph 34. Complaint response times 2017/18

Complaint Responses Completed Within 25 Days 2017/18

Learning from complaints

The Trust is very keen to learn from complaints and to be able to demonstrate and share the resultant learning across the organisation.

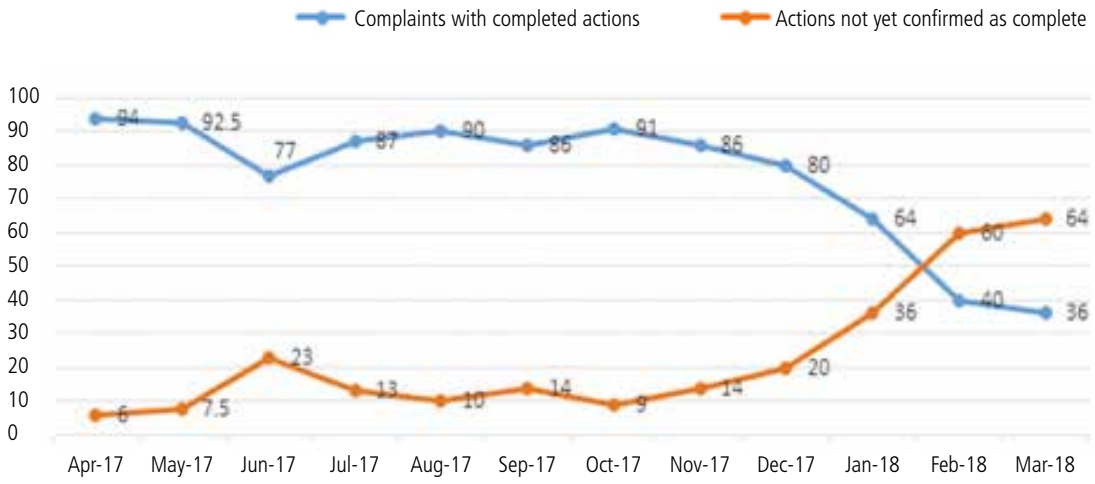
Whenever a complaint is even partly upheld, the investigating manager is expected to make recommendations for actions to mitigate a recurrence of the issue that occurred and to generate learning from what has happened. The Trust now has a system to track the implementation of all such actions, and the chart below (Chart 35) shows the percentage of complaints for which actions have been completed and those for which we are still awaiting confirmation.

Sharing learning

The Trust has recently developed 'Quality posters', which are produced monthly and displayed at all stations and make ready centres. The posters show complaints statistics by operating unit area as well as trust-wide, include a case study showing the outcome of and learning from a complaint, and also provide details of a recent 'compliment' received, ie a letter, email or telephone call expressing thanks for the service provided by our staff, which helps to provide balance. A shared learning discussion group has recently been established to consider different methods for sharing learning, recognising that everyone learns differently and that a variety of mechanisms is needed in order to engage as many of our staff as possible.

Graph 35. Implementation of learning

Actions Completed 2017/18



Data definition and comparisons

There is no national definition of a complaint. But generally most Trusts are guided by NHS England's definition:

- A complaint or concern is an expression of dissatisfaction about an act, omission or decision, either verbal or written, and whether justified or not, which requires a response.

However, there are no published figures that reliably compare the rates of complaints across ambulance services as inevitably the local variations on the above definition creates difficulty in making comparisons.

Data quality

Every complaint received by the Trust is registered on the Trust's electronic risk management system, Datix, by the Trust's own Patient Experience Team. A 'step by step' guide to processing complaints has been developed and is regularly updated by the Patient Experience Team to ensure that all members are recording data in a consistent way.

Datix is widely used throughout the NHS and provides a secure platform for holding data in accordance with data protection regulations.

More locally there are some data concerns regarding the 2017 data for the number of complaints as the Trust piloted a change in definition (which was not ultimately adopted) and as a result altered the Datix parameters. This reduces the confidence in the whole year's data.

Compliments

REASON CHOSEN:
The Trust receives a high proportion of compliments and these are a valuable source for evaluating patient experience.

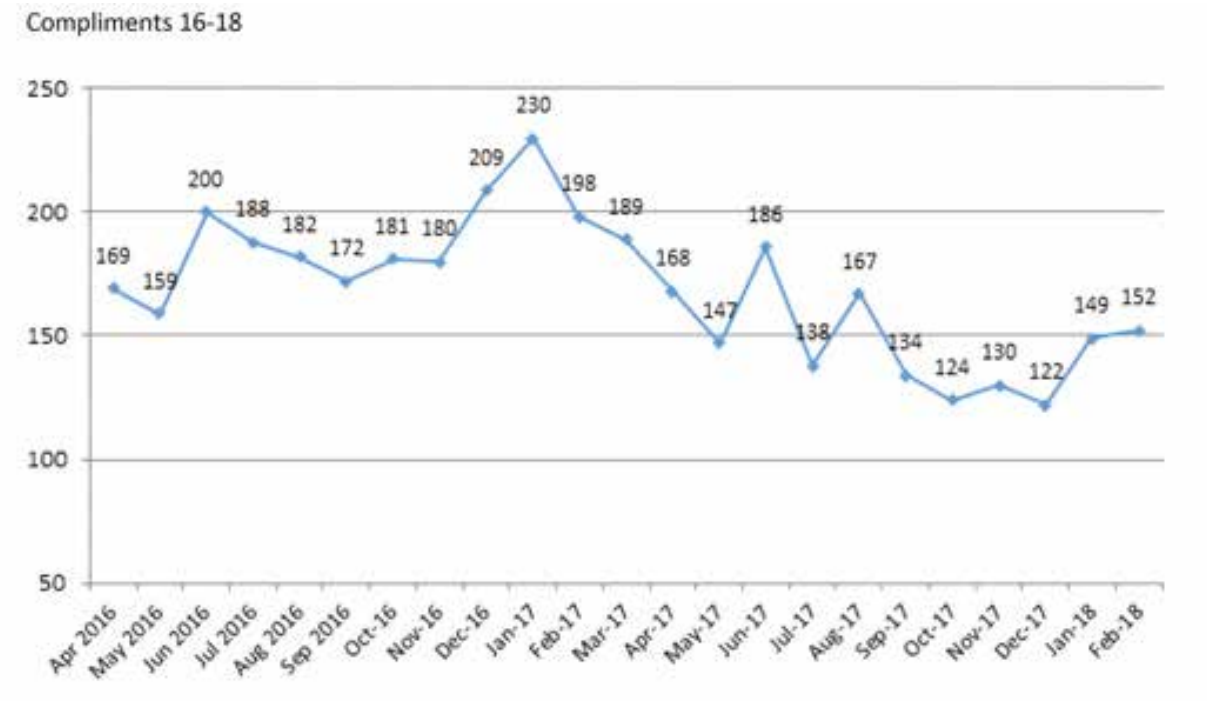
DATA SOURCE:
Complaint Letters & Datix

CONFIDENCE IN THE DATA:
(INDICATED IN BOLD):
Low, Medium, **High**

Each year SECAmb receives an increasing number of "compliments", ie letters, calls, cards and emails, thanking our staff for the work they do. Compliments are recorded on SECAmb's Datix database, alongside complaints, ensuring both positive and negative feedback is captured and reported. The staff concerned receive a letter from SECAmb's Chief Executive, thanking them for their dedication and for the care they provide to our patients. Examples of compliments are provided on the following pages.

The following graph (graph 36) shows that the number of compliments being received has steadily reduced over recent months.

Graph 34. Complaint response times 2017/18



Part Three

Below are examples of recent compliments.

A&E Operations

Compliment received recently from the manager of a nursing home

Last Thursday around 16.30 an ambulance arrived for a gentleman who resides here. He is renowned for being non-compliant which is especially dangerous since he has diabetes and declines all treatment.

The entire crew were fabulous but I must mention Sophie who was one of the three crew who attended to the client, and I want to let you know that she was absolutely outstanding. She remained calm while persuading the gentleman to go into hospital. Knowing the client as I do, it was an amazing result to see him setting off to hospital.

I understand that Sophie is in training and I want to register our appreciation on behalf of the client who is now back with us again.

Well done to all concerned, and a letter of thanks will be arriving to Sophie and her crew mates soon.

111 Service

Compliment received from a 111 service user

Last night I spoke to a gentleman, 111 health advisor @ 18:15 01/12/2017 and whom also called me back at 19:16. I was also passed to a paramedic. May I just say how thankful I am to both the healthcare advisor and paramedic. They got me the help I so desperately needed, stayed with me on the line to make sure I was okay. They kept me talking, and most of all waited until the ambulance arrived.

They are a real asset to the 111 service and the NHS as a whole. The bad press that 111 has received certainly doesn't resemble anything to how last night was handled. I overdosed on two medications, I was freezing cold, and lonely and they got me to safety. I was frightened.

Also the ambulance crew who came to my aid are also a real asset. I was worried how I would be judged for taking an overdose, and definitely felt I was a burden. Please can they be thanked, as well. I hope all four people involved last night will be personally identified and thanked on behalf of me and given a good pat on the back.

A&E Emergency Operations Centre (Call Centre)

Compliment received from a 111 service user

I called 999 on 29th June 2017 at 0726. The situation was that my partner was in labour. We we're told by the hospital by mistake to wait at home until her contractions were stronger although her previous history should've meant her to go in immediately. As the labour progressed so fast, I had no option but to call 999 as I would not have made the drive to hospital in time.

Basically, the 999 operator I spoke to was fantastic. She spoke me through what to do whilst we awaited the arrival of the ambulance. At no point did I expect what happened next... With the help of the operator, I delivered my own child before the ambulance arrived. He was born at 0746 and the ambulance arrived at 0755.

The reason for my email is because I feel yet again the need to express my gratitude to the NHS service. (My first child was also a dramatic birth which left his mother in a critical condition. She made a full recovery with the help of the fantastic team at Pembury hospital.)

I ask please that this email reaches the operator that I spoke to that day. Without her, I could not have done what I did. People keep calling me a hero, but I tell them that the real hero was the 999 operator that took my call that day. Attached is a picture of my son Joshua, born weighing 9lb, delivered by myself and the amazing 999 operator that took my call. From the bottom of my heart, I thank you, and what you do.

The Trust has recently developed a comprehensive communication system with station based staff. Information posters are a part of this process. These show complaints statistics by operating unit area as well as trust-wide, include a case study showing the outcome of and learning from a complaint. Importantly the posters also provide details of a recent 'compliment' received. This helps to provide balance and reminds staff of how valued they are by our patients, their families and carers.

Data definition and comparisons

There is no national definition of a compliment and comparison data is currently not available.

Data quality

Every compliment received by the Trust is registered on the Trust's electronic risk management system, Datix, by the Trust's dedicated Compliments Administrator.

Datix is widely used throughout the NHS and provides a secure platform for holding data in accordance with data protection regulations.

111 Patient survey

REASON CHOSEN:
The Trust undertakes a planned patient experience survey for patients using the 111 service

DATA SOURCE:
Feedback responses

CONFIDENCE IN THE DATA:
(INDICATED IN BOLD):
Low, Medium, **High**

NHS 111 is a national telephone service. SECAmb provides the service for Kent, Surrey and Sussex, working in partnership with Care UK. The service aims to make it easier for people to access healthcare services when they need medical help fast, but not in life-threatening situations

Patients who use the Trust's 111 service are invited to participate in a feedback survey based on text messaging.

There are six questions asked. The following table illustrates the six questions with the % of positive responses for 2017/18.

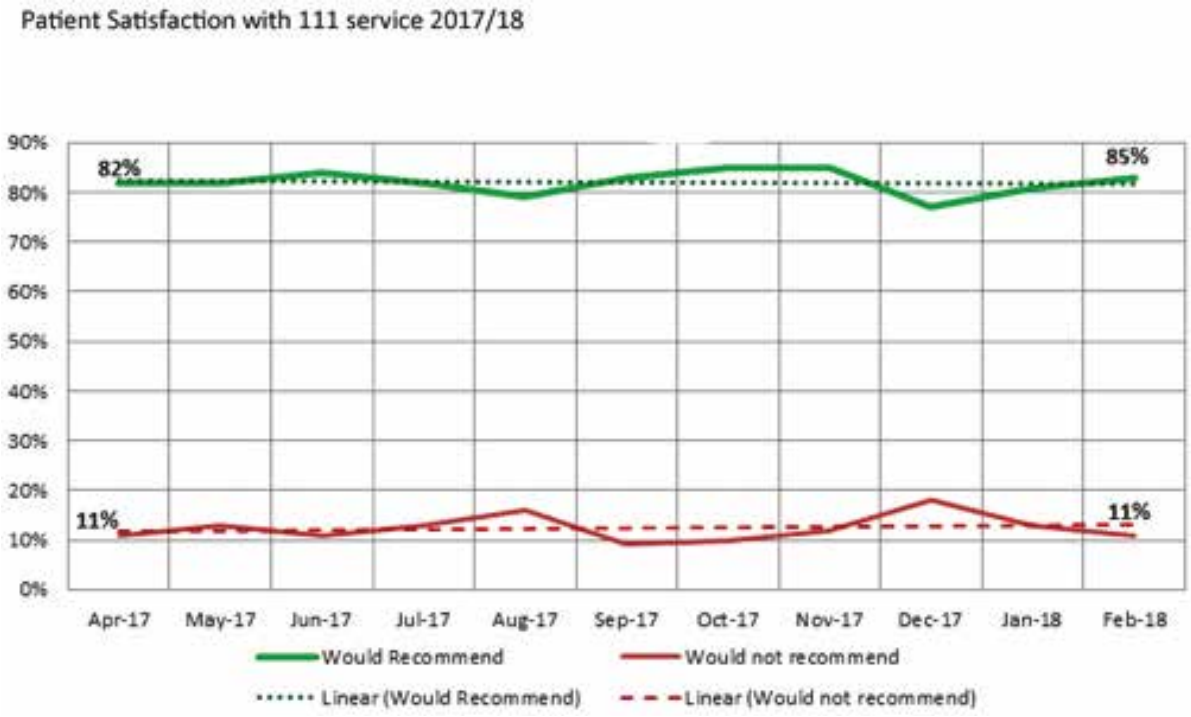
Question	
How likely are you to recommend this service to friends and family?	81%
Throughout my consultation I felt the 111 advisors listened carefully to what I had to say	85%
I feel I was treated with respect throughout my consultation	87%
Did you follow the advice of the 111 service	93%
Seven days after your call to 111 how was your problem?	60%
How satisfied overall are you with 111	81%

Table 6. Satisfaction Questions (111 service)

Graph 37 illustrates the overall satisfaction with the 111 Service for the current financial year, based on whether the caller would recommend the service. The graph shows that overall satisfaction has increased from 82% to 85% with the level of dissatisfaction remaining at 11%.

The satisfaction rating score has increased from 71% to 74% since April '17.

Graph 37. Patient satisfaction with the Trust's 111 service



Data definition and comparisons

There is no national definition of a compliment and comparison data is currently not available.

Data quality

The data is collected centrally by CareUK and then distributed to the appropriate services. It is included within the NHS111 monthly Patient Experience Bulletin which is distributed to all NHS111 staff. This provides assurance to staff that, despite the pressures of the service, patients are happy with their overall experience of using the 111 service. Being provided with this information helps encourage staff and instils a sense of pride in the service provided.

The data is also communicated to the 111 service's lead commissioners within the monthly Clinical Governance Report. This provides the CCGs with a quality assurance measure, which can be easily evaluated.

The results of the survey also link into the complaints and incidents from which shared learning is distributed to promote improvements to the service.

Part Three

Mandatory reporting indicators

This final domain reports on the mandatory indicators that have been prescribed by NHS Improvement for NHS Ambulance Trusts that are also Foundation Trusts.

The first two relate to the new Ambulance Response Programme (ARP). This was fully implemented in the ambulance service during 2017 after extensive trials that started in 2015.

The Ambulance Response Programme

The reason for the change falls within three areas:

- Ambulances services have fundamentally changed, but for the past four decades the service has remained organised around an eight-minute response time target.
- Half of all calls are now resolved by paramedics without the need to take patients to hospital, and for specialist care the focus of the ambulance service is increasingly on getting patients to the right hospital rather than simply the nearest. The current standards do not support this.
- The current standards have meant that ambulance services have been overly focussed on hitting the targets, but sometimes in a "wasteful and illogical manner".

Consequently, the response profile was reviewed and following a trial period was implemented Ambulance Trust by Ambulance Trust until all services were delivering the new Ambulance Response Programme.

The following changes were made to ambulance response standards:

- All Ambulance Trusts now have additional time to determine the most appropriate response to all calls (except the most serious category 1 999 calls). This allows Ambulance Trusts additional time (up to 180 seconds more) to decide on the most appropriate resource required. In addition to this three pre-triage questions have been added to ensure that new 'category 1' calls are dealt with in less time (30 seconds).
- Introduction of new target response standards. Ambulances will now be expected to reach the most seriously ill patients in an average of seven minutes. New times are also introduced to cover every single patient, not just those in immediate need. This is intended to improve performance management of these waits (classed as "green") by introducing mean and 90th centile measures.
- Amending "stop the clock" definitions. The rules are being changed around what "stops the clock" means so targets are met based on patient need. This means that the clock will only stop when the most appropriate response arrives on scene, rather than the first.
- Introducing condition-specific measures. This is to track the time from the 999 call to hospital treatment for heart attacks and strokes. By 2022, we will expect that 90% of eligible heart attack patients will receive treatment within 150 minutes. Nine out of ten stroke patients should also receive appropriate management within 180 minutes.

The new standards were introduced by SECAmb on 22 November 2017. The categories are shown in Table 7.

Category	Response	Average response time
Category 1	For calls to people with immediately life-threatening and time critical injuries and illnesses.	These will be responded to in a mean average time of seven minutes and at least 9 out of 10 times before 15 minutes.
Category 2	For emergency calls. Stroke patients will fall into this category and will get to hospital or a specialist stroke unit quicker because we can send the most appropriate vehicle first time.	These will be responded to in a mean average time of 18 minutes and at least 9 out of 10 times before 40 minutes.
Category 3	for urgent calls. In some instances, patients in this category may be treated by ambulance staff in their own home. These types of calls will be responded to at least 9 out of 10 times before 120 minutes	These types of calls will be responded to at least 9 out of 10 times before 120 minutes.
Category 4	for less urgent calls. In some instances, patients may be given advice over the telephone or referred to another service such as a GP or pharmacist.	These less urgent calls will be responded to at least 9 out of 10 times before 180 minutes

Category 1 Call

REASON CHOSEN:

Category 1 is a mandatory measure for reporting

DATA SOURCE:

NHS England

CONFIDENCE IN THE DATA:

(INDICATED IN BOLD):

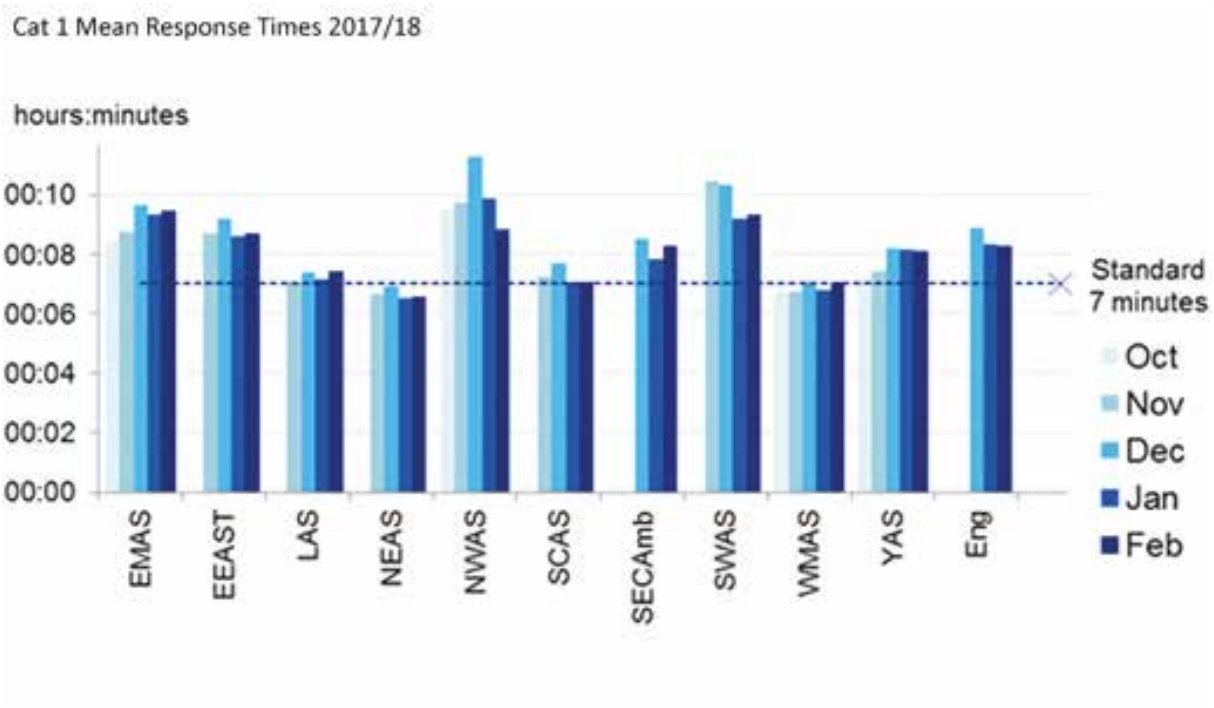
Low, Medium, **High**

Category 1 is part of the new Ambulance Response Programme. The intent is to ensure that Category 1 incidents are identified and responded to as quickly as possible with resources appropriate to the patient's needs. Across the whole ambulance sector Category 1 comprises around 8% of incidents and covers a wider range of conditions than the former Red 1 category. There have been some changes to the definition which makes comparison with the former Red 1 category meaningless. For example, the attendance of a bystander with a defibrillator is no longer regarded as a response. However, a Health Care Professional (HCP) on scene with a Category 1 patient, who has access to a defibrillator, is regarded as an appropriate response.

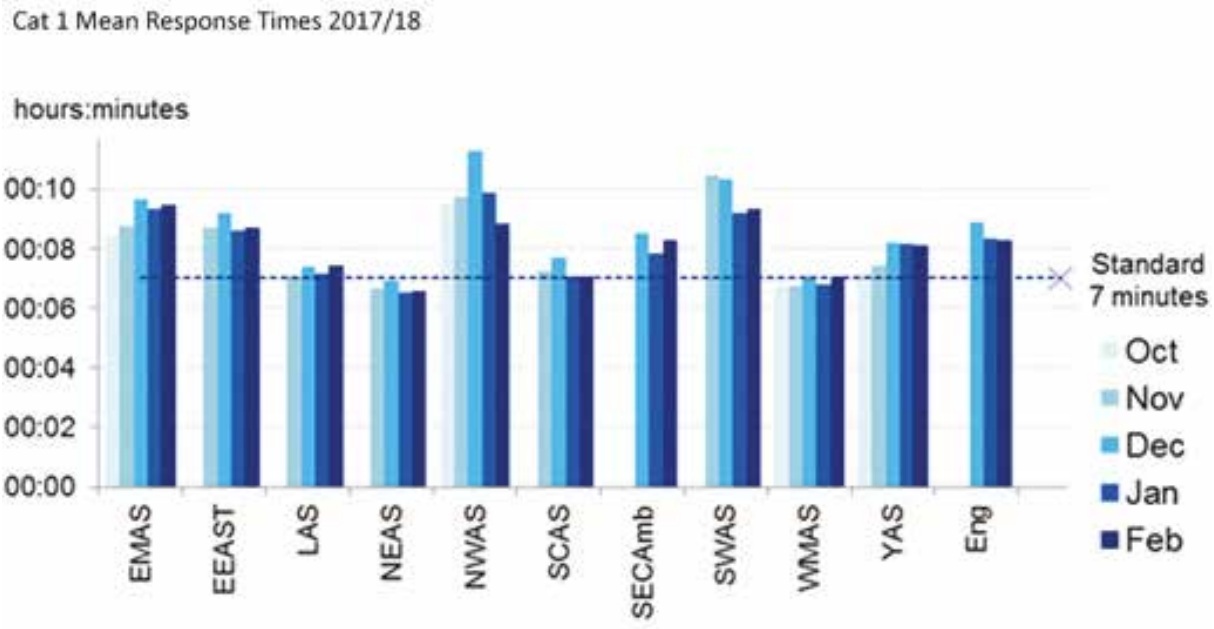
The standards associated with category 1 are:

- Mean response time of seven minutes
- 90th Centile responded to within 15 minutes

Graph 38. Category 1 mean response time



Graph 39. 90th centile response time



The Trust has performed well for both of the associated category 1 measures. The Trust is not consistently compliant with the mean response time but compares well with other Ambulance Trusts. However, for the 90th centile the Trust is within the 15 minute target.

Data definition and comparisons

Data definition is given at the introduction of this section and the graphs illustrate comparisons.

Data quality

South East Coast Ambulance NHS Foundation Trust considers that this data is as described for the following reasons:

- This indicator is part of the national reporting requirements. NHS England maintains the specification for the data that Ambulance Services collect, based upon user requirements and discussion with data providers. Provider groups include the National Ambulance Information Group (NAIG) for Ambulance Systems Indicators (SI) data; and the National Ambulance Service Clinical Quality Group (NASCQG) for Clinical Outcomes (CO) data. NAIG and NASCQG represent the eleven Ambulance Services in England who provide and use the data.

Action being taken

South East Coast Ambulance NHS Foundation Trust has taken the following actions to improve this indicator, and the quality of its service by:

- The Trust developed a comprehensive Improvement Plan for improving performance. This plan includes actions that aim to increase the Trust's capacity through recruitment initiatives, reducing absence and improving efficiency.
- The performance data is discussed each week with the Executive Team and a number of actions arise as a result of that discussion.

Category 2 Call

REASON CHOSEN:
Category 2 is a mandatory measure for reporting

DATA SOURCE:
NHS England

CONFIDENCE IN THE DATA:
(INDICATED IN BOLD):
Low, Medium, **High**

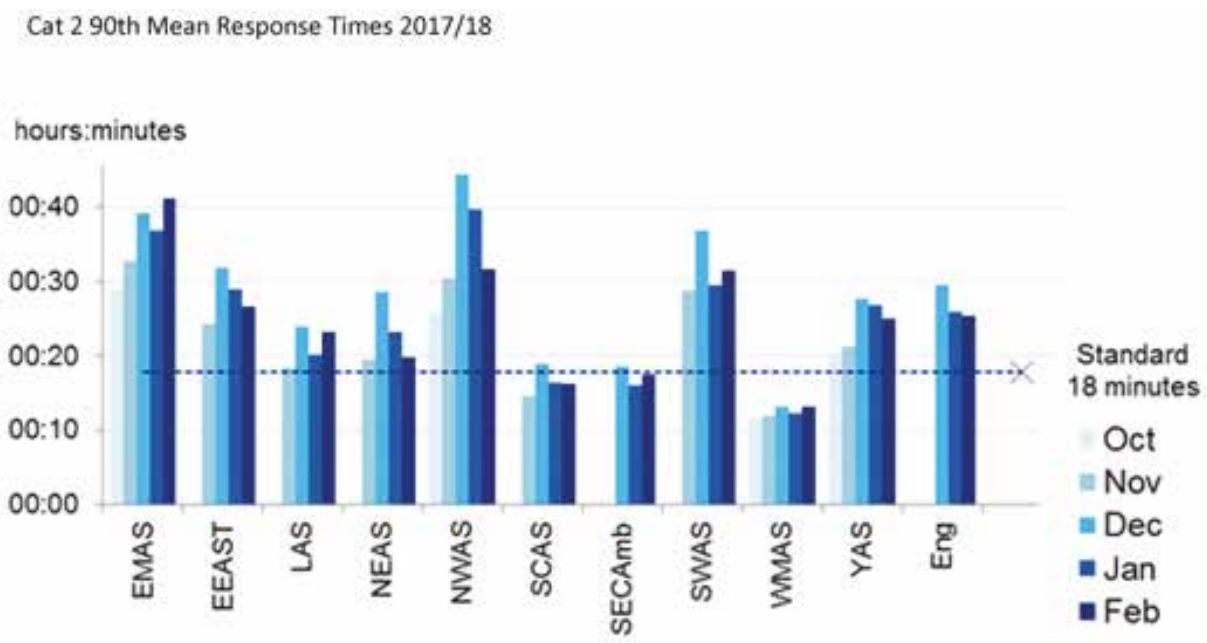
Category 2 is also part of the new Ambulance Response Programme.

The intent is to ensure that patients in the remaining categories who require transportation receive a conveying resource in a timeframe appropriate to their clinical needs.

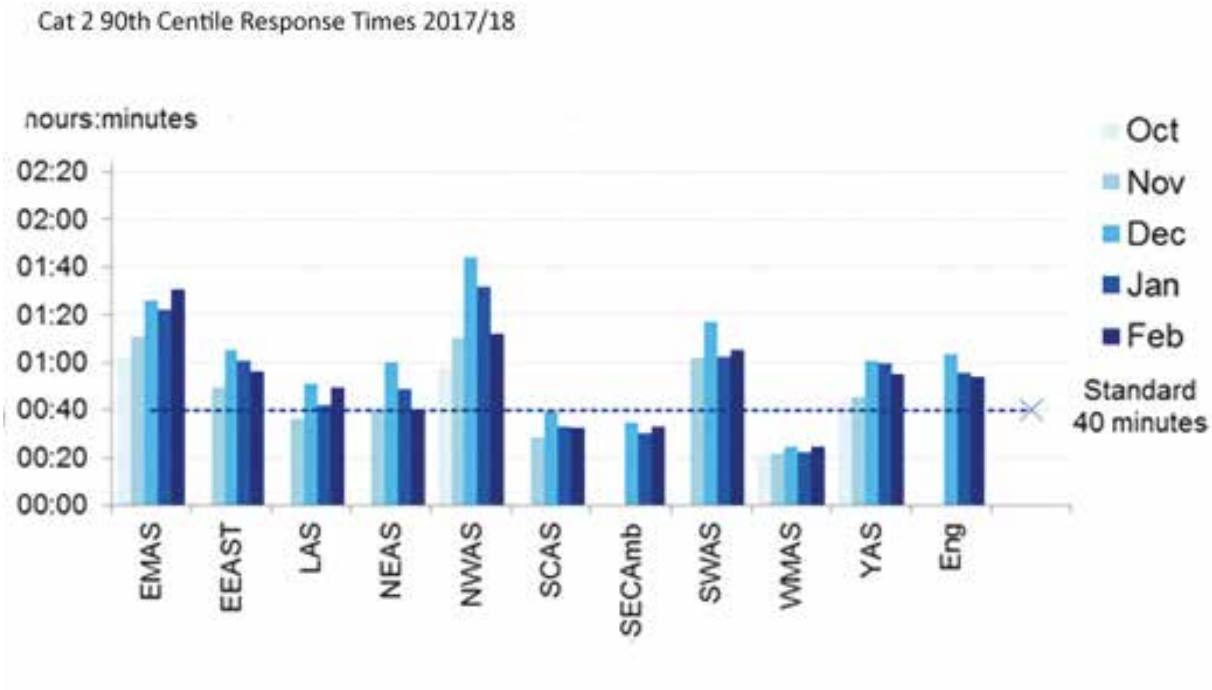
The standards associated with category 2 are:

- Mean response time of 18 minutes
- 90th Centile responded to within 40 minutes

Graph 40. Category 2 mean response times 2017/18



Graph 41. Category 2 90th centile response times 2017/18



The Trust has performed well for both of the associated Category 2 measures. The Trust is not consistently compliant with the mean response time but again compares well with other ambulance Trusts. However, for the 90th centile the Trust is within the 40-minute target.

Data definition and comparisons

Data definition is given at the introduction of this section and the graphs illustrate comparisons.

Data quality

SECAmb considers that this data is as described for the following reasons;

- NHS England maintains the specification for the data that ambulance services collect, based upon user requirements and discussion with data providers. Provider groups include the National Ambulance Information Group (NAIG) for Ambulance Systems Indicators (SI) data; and the National Ambulance Service Clinical Quality Group (NASCQG) for Clinical Outcomes (CO) data. NAIG and NASCQG represent the 11 ambulance services in England that provide and use the data.

Action being taken

SECAmb has taken the following actions to improve this indicator, and the quality of its service:

- The Trust has a comprehensive Improvement Plan for improving performance. This plan includes actions that aim to increase the Trust's capacity through recruitment initiatives, reducing absence and improving efficiency.
- The performance data is discussed each week with the Executive Team and a number of actions arise as a result of that discussion.

Category 3 Call

REASON CHOSEN:
Category 3 is a mandatory measure for reporting

DATA SOURCE:
NHS England

CONFIDENCE IN THE DATA:
(INDICATED IN BOLD):
Low, Medium, **High**

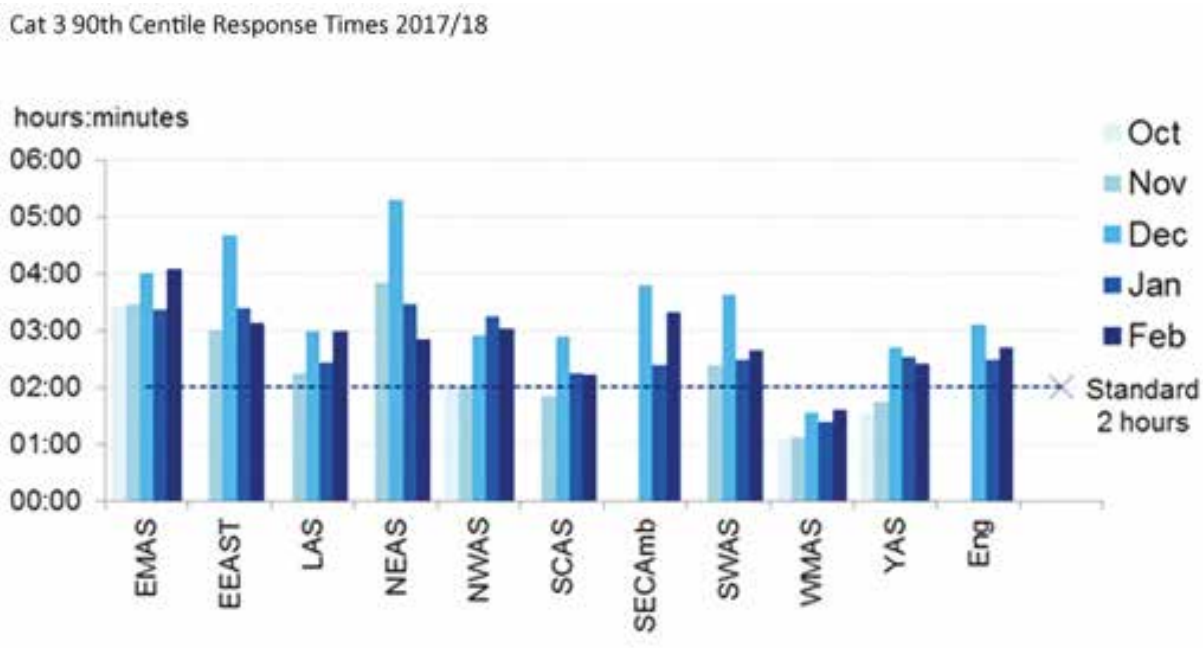
Category 3 is also part of the new Ambulance Response Programme.

The intent is to ensure that patients in the remaining categories who require transportation receive a conveying resource in a timeframe appropriate to their clinical needs.

The standard associated with category 3 is:

- 90th Centile responded to within 120 minutes

Graph 42. Category 3 90th centile response times 2017/18



The Trust has performed less well for the associated Category 3 measures. The Trust is not consistently compliant with the 90th centile standard.

Data Definition and Comparisons

Data definition is given at the introduction of this section and the graphs illustrate comparisons.

Data quality

South East Coast Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons:

- This indicator is part of the national reporting requirements. NHS England maintains the specification for the data that ambulance services collect, based upon user requirements and discussion with data providers. Provider groups include the National Ambulance Information Group (NAIG) for Ambulance Systems Indicators (SI) data; and the National Ambulance Service Clinical Quality Group (NASCQG) for Clinical Outcomes (CO) data. NAIG and NASCQG represent the 11 ambulance services in England that provide and use the data.

Action being taken

South East Coast Ambulance Service NHS Foundation Trust has taken the following actions to improve this indicator, and the quality of its service by:

- The Trust developed a comprehensive Improvement Plan for improving performance. This plan includes actions that aim to increase the Trust's capacity through recruitment initiatives, reducing absence and improving efficiency.
- The performance data is discussed each week with the Executive Team and a number of actions arise as a result of that discussion.

Category 4 Call

REASON CHOSEN:
Category 4 is a mandatory measure for reporting

DATA SOURCE:
NHS England

CONFIDENCE IN THE DATA:
(INDICATED IN BOLD):
Low, Medium, **High**

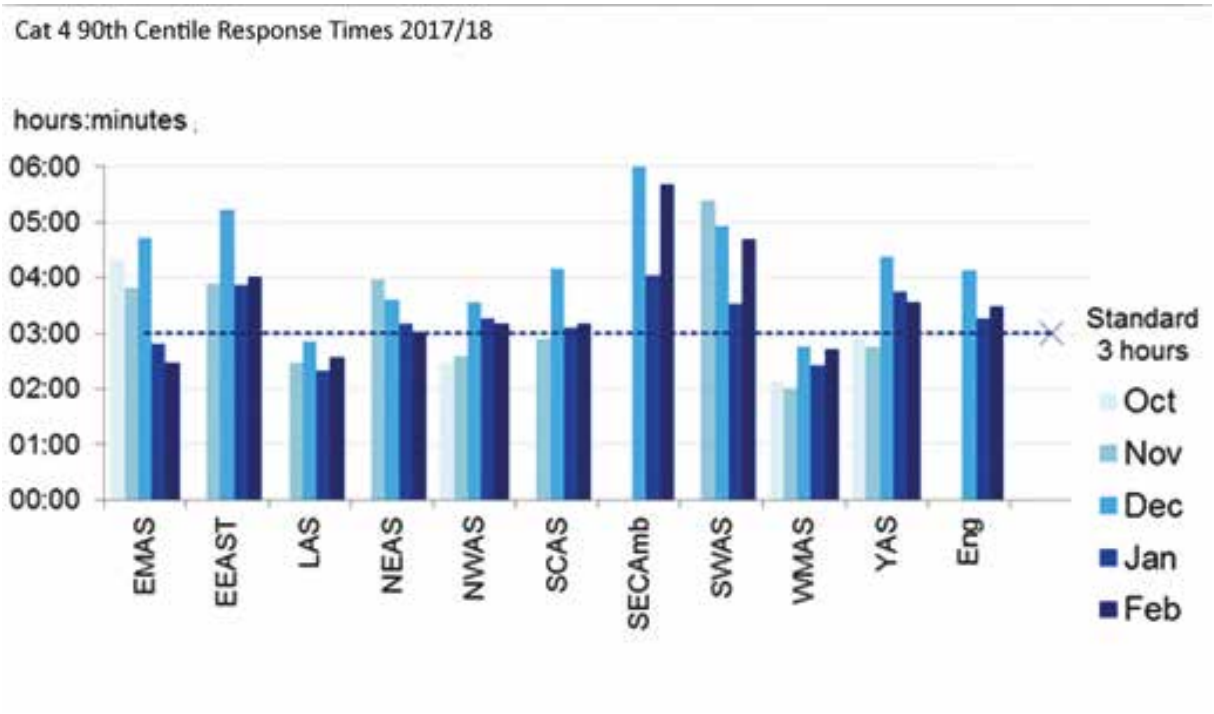
Category 4 is also part of the new Ambulance Response Programme.

The intent is to ensure that patients in the remaining categories who require transportation receive a conveying resource in a timeframe appropriate to their clinical needs.

The standard associated with category 4 is:

- 90th Centile responded to within 180 minutes

Graph 43. Category 3 90th centile response times 2017/18



The Trust has performed less well for the associated Category 4 measures. The Trust is not consistently compliant with the 90th centile standard.

Data definition and comparisons

Data definition is given at the introduction of this section and the graphs illustrate comparisons.

Data quality

SECAmb considers that this data is as described for the following reasons;

- This indicator is part of the national reporting requirements. NHS England maintains the specification for the data that Ambulance Services collect, based upon user requirements and discussion with data providers. Provider groups include the National Ambulance Information Group (NAIG) for Ambulance Systems Indicators (SI) data; and the National Ambulance Service Clinical Quality Group (NASCQG) for Clinical Outcomes (CO) data. NAIG and NASCQG represent the 11 ambulance services in England who provide and use the data.

Action being taken

SECAmb has taken the following actions to improve this indicator, and the quality of its service:

- The Trust developed a comprehensive Improvement Plan for improving performance. This plan includes actions that aim to increase the Trust's capacity through recruitment initiatives, reducing absence and improving efficiency.
- The performance data is discussed each week with the Executive Team and a number of actions arise as a result of that discussion.

Performance Summary

The Trust is mandated to report the final end of year position against category 1 and category 2. Table 8 reports this for the mean response time and the 90th centile against the target position.

However, whilst not mandated, the Trust has published the year-end position for Category 1-4 as it recognises a delay to any patient could be regarded as poor service quality to the individual patient and family affected.

Table 8. Year End Response Times

Response Time Measure		Target	Actual
Category 1	Mean Response Time	00:07:00	00:08:16
Category 1	90th Centile Response Time	00:15:00	00:14:52
Category 2	Mean Response Time	00:18:00	00:18:02
Category 2	90th Centile Response Time	00:40:00	00:33:46
Category 3	90th Centile Response Time	02:00:00	03:19:30
Category 3	90th Centile Response Time	03:00:00	05:12:36

Stroke 60 minutes

REASON CHOSEN:
Stroke 60 minutes is a mandatory measure for reporting

DATA SOURCE:
NHS England

CONFIDENCE IN THE DATA:
(INDICATED IN BOLD):
Low, Medium, **High**

Stroke 60 minutes is a time standard. The FAST procedure helps assess whether someone has suffered a stroke. It consists of the following elements:

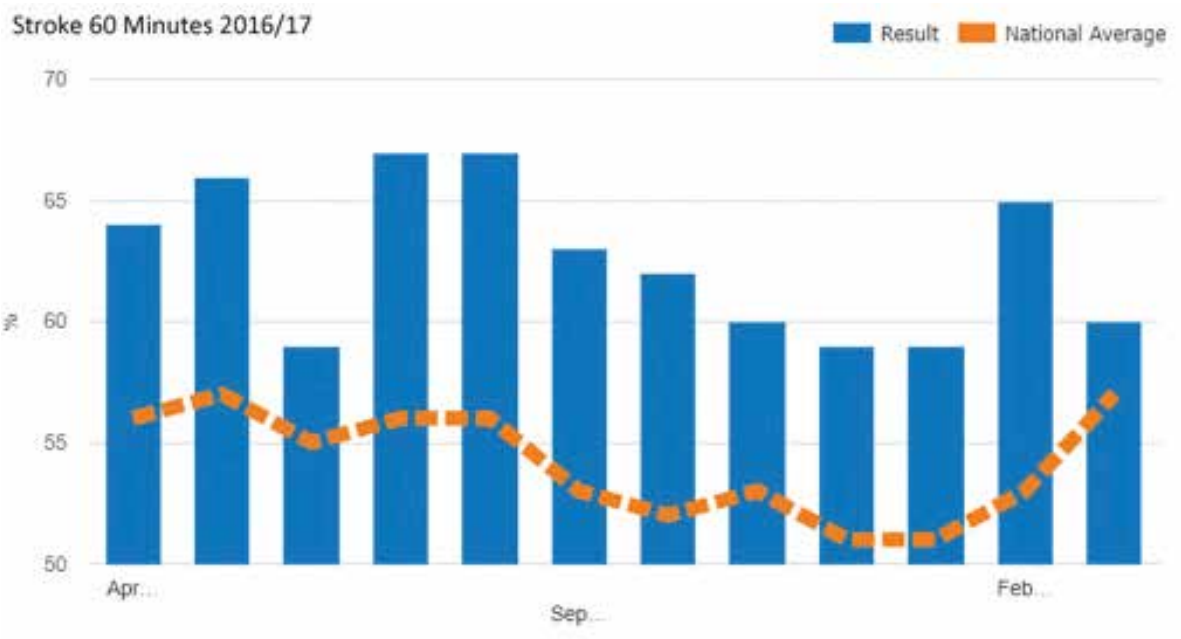
- Facial weakness: can the person smile? Has their mouth or eye drooped?
- Arm weakness: can the person raise both arms?
- Speech problems: can the person speak clearly and understand what you say?
- Time to call 999 for an ambulance if you spot any one of these signs.

Of FAST positive patients in England, assessed face to face, and potentially eligible for stroke thrombolysis (within agreed local guidelines) the standard asks Trusts to measure time taken to arrive at an hyperacute stroke unit within 60 minutes of an emergency call connecting to the ambulance service.

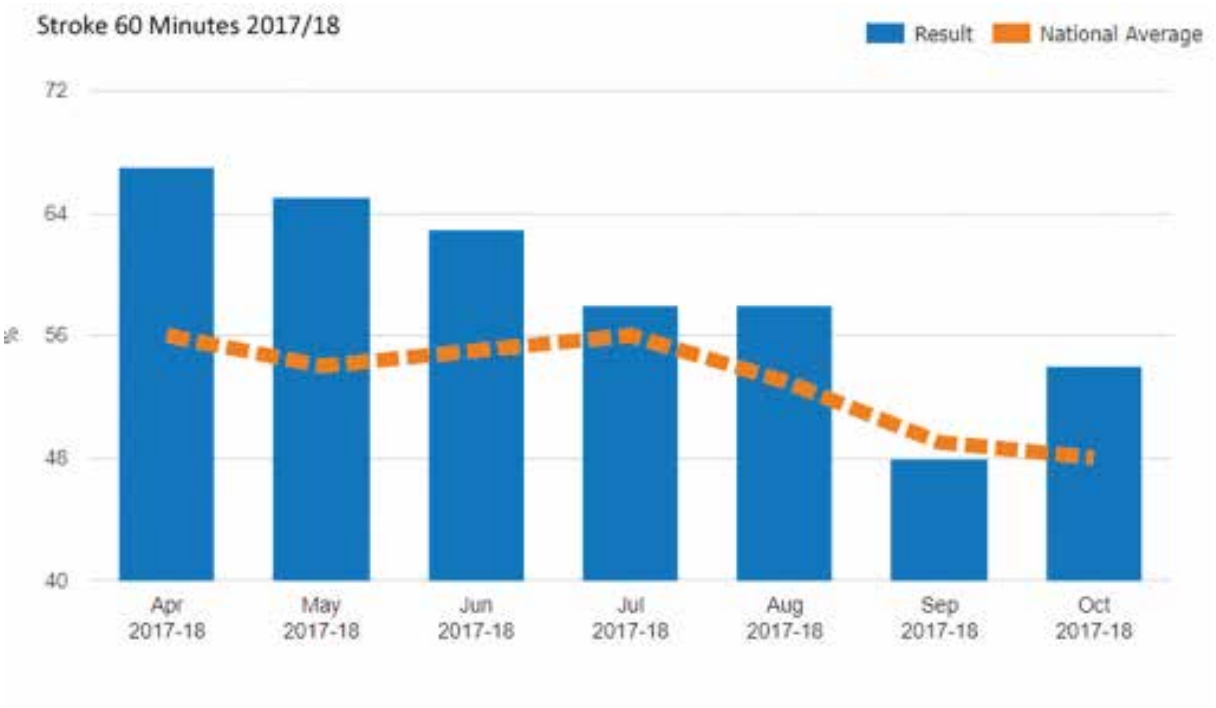
There is no specific % standard associated with Stroke Care 60. However, Trusts are asked to publish their percentage compliance. Monthly figures are reported in graphs 44 and 45. Overall year-end figures are:

- April-March 2016/17 is 62.4%
- April-October 2017/18 is 59.5%

Graph 44. Stroke 60 minute times 2016/17



Graph 45. Stroke 60 minute times 2017/18



The Trust has performed well for the conveyance of FAST positive patients in England, assessed face to face and potentially eligible for stroke thrombolysis conveyed to a hyper-acute stroke unit in 60 minutes.

Data definition and comparisons

The national definition for Stroke 60 is;.

- Patients who have suffered a confirmed stroke can be eligible for treatment with a clot-busting drug. This is called stroke thrombolysis. This graph is a measure of the percentage of patients that arrived at a thrombolysis centre within 60 minutes of their 999 call.

The data is not currently published across a whole year as the data validation means data is published three months behind collection. However, it is possible to compare rates for the last published month of October 2017. The national average is 48% and SECAmb's performance is 54%.

The highest performing Trust was South Central Ambulance Service NHS Foundation Trust at 61% and the lowest performing Trust was South Western Ambulance Service NHS Foundation Trust at 33%.

Data quality

South East Coast Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons;

- This indicator is part of the national reporting requirements. NHS England maintains the specification for the data that Ambulance Services collect, based upon user requirements and discussion with data providers. Provider groups include the National Ambulance Information Group (NAIG) for Ambulance Systems Indicators (SI) data; and the National Ambulance Service Clinical Quality Group (NASCQG) for Clinical Outcomes (CO) data. NAIG and NASCQG

represent the 11 ambulance services in England who provide and use the data.

Action being taken

South East Coast Ambulance Service NHS Foundation Trust has taken the following actions to improve this indicator, and the quality of its service:

- The Trust developed a comprehensive Improvement Plan for improving performance. This plan includes actions that aim to increase the Trust's capacity through recruitment initiatives, reducing absence and improving efficiency.
- The performance data is discussed each week with the Executive Team and a number of actions arise as a result of that discussion.

ROSC

REASON CHOSEN:
ROSC is a mandatory measure for reporting

DATA SOURCE:
NHS England

CONFIDENCE IN THE DATA:
(INDICATED IN BOLD):
Low, Medium, **High**

ROSC has been reported in detail earlier in this section. However, Trusts are asked to publish their percentage compliance. Monthly figures are reported in graphs 25-28. Overall year end figures are:

- April-March 2016/17 is 27.9%
- April-October 2017/18 is 25.6%

Conclusion to section 3.

Section 3 has reported on key safety and quality metrics, all of which were selected by the Trust Board, after inviting key stakeholders to comment on the selection.

On the whole, the overall improvement picture shows a positive change. Section 3 reports on 14 indicators and when RAG rated against Green = improvement, Amber = same, Red = deterioration, then Ten indicators are suggesting improvements, three are the same and one is a deterioration. This is summarised in Table 9.

Indicator	RAG
Incident Reporting	
999 Call Recording	
Medicines Management	
Clinical Audit	
Survival to Discharge	
ROSC	
Complaints	
Compliments	
111 Patient Survey	
Category 1	
Category 2	
Category 3	
Category 4	
Stroke 60 Minutes	

Table 9. Summary of indicators

Stroke care has been rated Green, as SECAmb fares well against other services given the current availability of resources.

Contact Us.

If on reading this Quality Account there are any further questions then please do contact the Trust directly on one of the following:

E mail enquiries@secamb.nhs.uk

Mail **Trust headquarters**
SECAmb
Nexus House,
4 Gatwick Road,
Crawley
RH10 9BG

Tel: 0300 123 0999

Patient Story – John

Cardiac arrest patient thanks ambulance team

24 April 2017

Excellent life-saving treatment saw a retired GP make a stunning recovery from a cardiac arrest to walk his daughter down the aisle at her wedding just 12 days later.

Dr John, his wife and daughter, made an emotional visit to the local Ambulance Station to thank the staff who helped save his life when he collapsed suddenly. The visit provided John and his family with a chance to thank the crews in person and fill in a few of the blanks from the day.

The last thing John remembers is enjoying a Sunday cycle ride on his own in Guildford before waking up in the Hospital's cardiac suite. "I couldn't understand why I was there," he said. "I hadn't had any of the classic symptoms of any heart problems and actually felt very well but fate was on my side that day." Luckily for John a passing driver saw him fall and immediately called 999 where SECAmb Emergency Medical Advisor Hayley took the call who quickly provided instructions and gathered the necessary information from the scene.

A second stroke of good fortune was the arrival of bystander Craig, a highly-trained helicopter medic with the United Nations from Wales, who was in the town to visit the university. Craig, who only came across John because he chose to ignore his vehicle's sat nav instructions, was giving excellent cardio pulmonary resuscitation (CPR) when the first SECAmb crews arrived at the scene. The vital early CPR kept John alive to allow the ambulance team of paramedic Adam, associate practitioner Sam; recently arrived Australian paramedic Ellen and response car paramedic Sam to administer a shock which restarted his heart.

They were quickly backed up critical care

paramedics Kenny and Nathan, who sedated John for the journey, where he was quickly given stents to open a completely-blocked coronary artery. The team was also well supported throughout by Operational Team Leader Lesley.

"It was a traumatic time for us," said John's wife Jane, who usually would have been out riding with John. "The first we heard of what had happened was when the police called round. They were tremendous rushing us to the hospital to be with John but also we were right in the middle of preparing for Helen's wedding with my one son already on a flight over from Australia. "But John made a quite amazing recovery and was in hospital just five days. He was then well enough to walk Helen down the aisle, although I am quite sure who was supporting who.

John, a former cardiac registrar, who retired as a family GP five years ago, is now back on his bike and even back working part time with very little neural deficit other than memory loss from the day. "It was just wonderful to be able to meet these amazing people today," he said.

Annex 1

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

This section details the feedback received from commissioners, local Healthwatch organisations, overview and scrutiny committees and other stakeholders.

Introduction

The guidance for Quality Accounts states that Trusts must provide a copy of the draft Quality Account to the clinical commissioning group which has responsibility for the largest number of people to whom the Trust has provided relevant health services during the reporting period for comment prior to publication and should include any comments made in its published report.

In addition, NHS foundation Trusts must also send draft copies of their Quality Account to their local Healthwatch organisation and overview and scrutiny committee (OSC) for comment before publication, and should include any comments made in their final published report.

The commissioners have a legal obligation to review and comment, while local Healthwatch organisations and OSCs will be offered the opportunity to comment on a voluntary basis

The Trust submitted the draft Quality Account to the following stakeholders;

- 9 HealthWatch organisations
- Trust Commissioners
- 7 Health Overview & Scrutiny Committees
- All Governors

The following feedback has been received.

Commissioners

Kent, Surrey and Sussex Clinical Commissioning Groups

The Trust's draft Quality Accounts document was sent to Clinical Commissioning Groups (CCGs) for consultation and comment. The CCGs have a responsibility to review the Quality Accounts of the Trust each year, using the Department of Health's Quality Accounts checklist tool to ascertain whether all of the required elements are included within the document.

The CCG confirms that the Quality Account has been developed in line with the national requirements with most of the required areas identified however some gaps were noted in particular on CQUINs and the CQC ratings grid therefore the CCG are unable to confirm that inclusion of all information is accurate.

Of the 2017/18 priority updates included, it is confirmed that this is an accurate reflection of achievement and gives clear articulation to the outcomes and what did/didn't work well. It is unfortunate that not all priorities were achieved, of the three priorities set, one was fully achieved, one partially achieved and one not achieved. For one priority this has been reconfirmed as continuing for 2018/19. It is acknowledged that the Patient safety indicators are well-articulated however, due to lack of benchmarking in the majority of the indicators; it is difficult to ascertain how the trust has compared against other Ambulance services. The CCG expect the trust to remain committed and continue to focus on improving in this area and anticipate focussed prioritising and monitoring is incorporated to ensure achievement is attained in 2018/19.

It is positive to note that the trust recognise and acknowledge its areas where improvement is required and the Quality Account is an open

and honest report on the challenges the trust is facing and areas it is required to improve in particular the transition of the Computer Aided Dispatch System. It is also encouraging to see that the report recognises and values the staff within the trust, in particular through the patient stories throughout the report.

The Trust has clearly outlined three priorities for 2018/19 of which the CCG agree are pertinent areas to drive forward improvements in patient care and largely based upon recommendations from the CQC inspections. It is also positive to see that patients and stakeholders feedback has also been taken into account. The CCG are committed to supporting the trust in achieving against the priorities set and it is an expectation that the trust regularly report updates against the Quality Account priorities to provide ongoing assurance that they are on track to be achieved or where there is a deviation that this is reconsidered in the priority requirement.

In conclusion, the report identifies that providing a safe and effective service whilst maintaining patient's quality of care and safety is a high priority for the Trust and that this is only achieved and supported by an effective and committed workforce. The trust recognises many improvements required and its ability in achieving a sustainable quality service which can only be supported by delivery of a well led Executive Team that provides a substantive workforce with clear direction and vision.

The CCG thanks the Trust for the opportunity to comment on this document and looks forward to further strengthening the relationships with the Trust through closer joint working in the future.

Healthwatch

Healthwatch Kent is the independent champion for the views of patients and social care users in Kent. Our role is to help patients and the public get the best out of their local Health and Social Care services.

For several years now, local Healthwatch across the country have been asked to read, digest and comment on the Quality Accounts which are produced by every NHS Provider (excluding primary care and Continuing Healthcare providers).

SECAmb obviously covers a large geographical area spanning several local Healthwatch. We have agreed together that Healthwatch West Sussex will take the lead on behalf of the South East Healthwatches. This means that unlike other NHS Trusts in Kent, we do not have a direct working relationship with SECAmb.

This Quality Account clearly reflects the difficult year faced by the ambulance trust and their staff and communicates some of the changes that have been made as a result. We welcomed the comment that improvements have been shared and celebrated with staff. We would like to see a copy of the monthly posters being used to summarise learning from incidents.

We felt that the data within the report was clearly presented and we welcomed the honesty where they have criticised their own performance.

Looking ahead we would like to see a culture of patient engagement develop within the Trust to ensure they are hearing from their patients and engaging with the communities that they serve. We would be very happy to work with the Trust on this.

One of our priorities for the year is to explore the experience of homeless patients following a discharge from hospital. We would very much like to work with SECAMb on this project.

Annexe 1

Healthwatch – West Sussex

I will be asking our Board to take the same status with Quality Accounts as we took last year as these are long documents, constrained by the format and not really written for patients and the public

Response to South East Coast Ambulance Trust (SECAmb) Quality Account on behalf of Medway Council's Health and Adult Social Care Overview and Scrutiny Committee

Representatives of SECAmb have attended the Committee three times during 2017-18, in June and October 2017 and in January 2018

June 2017 Meeting

Questions and points raised by the Committee were responded to as follows:

Mental health provision: A mental health nurse specialist had been appointed who would review services for patients with mental health needs. This would include considering whether increased specialist provision was required in operation centres. In response to a Member question, it was confirmed that there had not previously been a mental nurse health specialist post.

Partnership Working: Work was taking place with the police and other partners to ensure a seamless response to calls. Call handling processes were being reviewed to ensure good levels of service. Work was also taking place across the healthcare system in relation to home care packages.

Rollout of IPads: Comprehensive training would be provided for staff being provided IPads. Rollout was due to have taken place by 31 March but had been delayed to July. This delay had been partly to ensure the quality of training provided. The rollout of electronic record keeping would enable records to be shared more quickly and easily, including with general practitioners.

Financial challenges: In relation to the £15 million savings requirement for the Trust, robust plans were in place to enable achievement of this. Work would take place with commissioners to ensure that control totals were met. Quality Impact Assessments would be undertaken to ensure that quality was balanced with the need to make savings. In response to a Member question, it was confirmed that £15million amounted to 10% of the SECAmb budget.

Emergency ambulances and medical cars: It was considered that an increased ratio of ambulances compared to medical cars was needed as cars did not have the ability to transport patients to hospital. It was also acknowledged that not every call required an advanced support vehicle to attend. It was anticipated that the integration of 111 and 999 provision would enable calls to be triaged more effectively.

Staffing: In response to Member concerns that demand led rotas could lead to undue pressure being placed on staff, it was confirmed that close working was undertaken with frontline staff. Shift overruns had been reduced and an increasing number of staff were able to take a break during their shift. Directors had been encouraged to work with frontline staff to get their ideas for areas of improvement.

Bullying: A Committee Member raised concerns about the prevalence of staff bullying at SECAmb. It was acknowledged that this was an issue and that there needed to be a cultural shift with senior staff being given the right leadership skills. It was anticipated that the aforementioned in-depth study would help this work to be taken forward.

Winter Pressures: In relation to concerns that persons who had no medical need for an emergency ambulance were increasing pressure on the system, the SECAmb Chief Executive said that winter pressures were often related to alcohol consumption. Partnership working

was exploring how this could be managed. A number of frequent caller leads were working with operational unit managers and call centres to look at how repeat calling could be managed. It was noted that there were some patients who had requested an ambulance on hundreds of occasions. The possibility of charging repeat callers was a national policy issue and was therefore not something that SECAmb could consider currently.

October 2017 Committee Meeting

Questions and points raised by the Committee were responded to as follows:

CQC inspection rating: In response to Member concerns about the inadequate inspection rating and lack of progress made, the Regional Operations Manager advised that additional staff were needed to meet demand. The staffing level for paramedics and ambulance staff was adequate with the Trust being in a better position than a number of other trusts. Adequately staffing call centres was more of a challenge as this was a difficult job that was not well paid, with equivalent work elsewhere tending to be better paid. It was not possible to increase the pay for these roles as salaries had to be in accordance with the NHS pay framework. It had been agreed to recruit more staff than required into these roles to allow for turnover and staff subsequently moving into other roles. Adequate numbers of clinicians were needed within the call centres to analyse calls and determine how urgent a response would be required.

A new computer aided dispatch system had been implemented during 2017. This had replaced an old, unreliable system. The transition to the new system had been smooth and had been welcomed by staff. It had been challenging to train control room staff given that the control room had to remain operational. A national Ambulance Response Programme was due to go live on 22 November. This would enable calls to be prioritised more effectively. An update on this would be included in the next report provided to the Committee.

With regards to medicines management, a significant amount of work had taken place since the May CQC inspection. Operational staff had been issued with IPads and supervisors were now able to carry out daily audits of medicines. Compliance was now amongst the best of any ambulance trust.

Ambulance Response Times: A Member shared a concern in relation to ambulance response times. The case of a child who had fallen over and hit his head was highlighted. It had taken over three hours and multiple calls for a medical car to arrive. The paramedic had not been made aware of the child's heart condition, which should have resulted in a priority response.

Another Committee Member highlighted a recent personal experience when they had injured themselves and called 111. The ambulance staff had not been informed by 111 staff of the seriousness of the case and had considered that the call should have received a 999 response.

The Regional Operations Manager agreed that the case highlighted in relation to the injured child could not be defended. It was suggested that both incidents be formally reported so that they could be fully investigated. A number of factors affected ambulance response times. This included ambulances having to wait at hospitals until the hospital was able to remove the patient from the vehicle. The Ambulance Response Programme would help to ensure sufficient capacity in the system through call responses being prioritised more effectively. Calls received went through a triage system which should determine the seriousness of the case and ensure a time appropriate response.

Medway Data: In response to a Member request it was agreed that data specific to Medway would be provided in the next report to the Committee.

Annexe 1

Other concerns raised by the CQC: A Member considered that while there were some positives arising from the inspection, such as being good for caring and frontline staff generally being very good at their jobs, there were significant failings with regards to appraisals, staff communication and engagement and the culture of bullying present at the Trust. It was extremely worrying that the executive team had been found not to have sufficient understanding of risk in relation to call recording failures. Medicines management and storage of clinical records were also serious concerns identified.

The SECAmb representative said that the Lewis report into bullying at the Trust had been voluntarily commissioned. The executive team was largely new to the organisation and did not comprise the people who could be held accountable for previous organisational culture. The executive team were making significant changes. The CQC had recognised that there had already been a cultural change although a lot more progress was required. In relation to medicines management the recent visit had found that the issues identified by the May inspection had been significantly addressed. Regular staff workshops were being held with the executive team becoming increasingly accessible and engaging with staff.

Bullying at the Trust and workplace environment: A Member felt that publication of the Lewis report had been a brave step. The report showed that there were serious issues to address and that staff had been treated very badly. It was questioned whether the perpetrators of bullying and harassment had been disciplined and also what was being done to improve working relationships and reduce staff turnover.

Another Committee Member highlighted other staff related issues facing the Trust. This included staff feeling that they had unmanageable workloads and impossible deadlines, which was likely to result in significant staff turnover.

The Regional Operations Manager said that the first step taken had been to get the Lewis report produced to fully set out the problems. The second step was to engage with staff, which was a significant piece of ongoing work. Feedback was being analysed which would inform the next steps. It was important to create an organisational atmosphere that made people want to work for SECAmb. Ensuring effective leadership and that supervisors led by example was a key part of this. A culture where staff felt supported and able to report poor behaviour needed to be created. Disciplinary action had been taken in relation to some individuals responsible for unacceptable behaviour and there was no tolerance of such behaviour.

Stroke and Vascular Service Reconfigurations: A Member was concerned that the proposed reconfiguration of stroke and vascular services in Kent and Medway was based upon ambulance response times to transport patients to hospital. Without reliable response times, it would be difficult to effectively design and deliver services based upon a smaller number of centres of excellence.

The Committee heard that the future configuration of services would be based upon providing the best possible treatment to patients and that transporting patients to centres of excellence would result in more effective outcomes than taking them to the nearest hospital. It was acknowledged that there needed to be effective prioritisation of calls to ensure an ambulance response within required timescales.

Varied working practices – In response to a Member who had heard that meal breaks and other working practices could vary between operational areas, the Operations Manager advised that all staff were entitled to a standard length meal break and that work was taking place to ensure that staff were always able to take such a break and to reduce avoidable shift overruns.

Attendance at Committee: Committee Members expressed disappointment that no one from the executive team had been able to attend the meeting. The Operations Manager advised that the Chief Executive had been unavailable and that he would pass on the concerns raised

January 2018 Committee Meeting

Members of the Committee asked a number of questions which were responded to as follows:

Ambulance Response Times Performance data – In response to Member questions about why a data table in the report was based on percentages while another was based on response times and concerns about some of the response times, the Committee was informed that the Trust was working to ensure that there were the resources available to meet demand, particularly for non life threatening patients, where performance was currently the most challenging. The data tables were based upon national reporting requirements. Percentages had now been replaced by times, as specified by national reporting standards. It was confirmed that the times stated were average response times. Data was also captured for the 90th percentile in order to show the longest response times more clearly. Concerns were raised that some response times outside Medway were being missed by a significant margin. It was agreed that guidance for staff in relation to the Ambulance Response Programme would be circulated to the Committee.

Delays in ambulance crews being able to handover patients to hospital staff were a challenge across the UK. Locally, a Handover Director had been appointed to work with the healthcare system to help address this. The equivalent of 10 ambulances a day were lost in the SECAmb service area due to handover delays. It was recognised that there was a need to ensure that patients were not being taken to hospital unnecessarily and also that paramedic time was not taken by cases that did not require paramedic response. A comprehensive demand and capacity review was being undertaken which would be a key step towards improving response times.

Appointment of Executive Team – There had only been one substantive director in post when the Chief Executive had been appointed in April 2017. Appointment of a new team was almost complete with the new Director of Nursing and Quality due to be announced in the next week. This would complete the executive team. The Medical Director post was currently a fixed term contract which was likely to be made permanent.

Bullying and Harassment – The Freedom to Speak Up and Speak Up in Confidence schemes were available for staff who had concerns in relation to bullying and harassment. Externally, Professor Duncan Lewis could be contacted with concerns. A variety of engagement was being undertaken with staff to understand what was working well and it was anticipated that the NHS annual staff survey results, due to be published in February 2018, would show improved satisfaction amongst SECAmb staff. The Chief Executive operated an open door policy for staff to suggest improvements and senior staff were involved in a programme of meetings and visits to engage with staff to look at organisational culture. Based upon his engagement with staff, the Chief Executive considered that the culture of the Trust was improving. A Member requested specific figures for the number of staff who had had disciplinary or legal action taken against them due to bullying or harassment. Figures were not provided during the meeting, but the Committee was advised that some staff had left as a result. The Chief Executive considered that bullying had been addressed as far as possible, but it was not possible to eradicate it completely from a large organisation.

Recruitment – Recruitment remained challenging with most ambulance trusts struggling to recruit paramedics. It was now a graduate occupation and the workforce was much more mobile.

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Paramedics were being lost to other organisations, such as in the primary care sector and emergency departments. It was acknowledged that more needed to be done to support retention of paramedics and also of 999 call handlers.

Planning for Hyper Acute Stroke Provision – It was confirmed that the ambulance service was fully engaged in the proposed reconfiguration of hyper acute and acute stroke service provision in Kent and Medway.

Engagement Activity – The Chief Executive apologised that he had been unable to attend the November meeting of the Committee. Engagement with the Committee was important but it was challenging to attend every meeting requested due to the large area that SECAmb covered. The Chief Executive undertook to make attendance at future meetings a priority.

Private Ambulances – SECAmb did currently make use of private ambulance contractors. It was hoped that this could be reduced and would be considered as part of the Demand and Capacity Review and other strategic planning.

General Comments:

- The Committee is extremely concerned that the May 2017 CQC inspection had found SECAmb to be inadequate overall and that there had not been enough progress made since the previous inspection to enable a better outcome. In particular, the Committee remains concerned in relation to ambulance response times, hospital handover delays, bullying and harassment at SECAmb and the Trust's financial situation.
- The Committee recognises that some progress had been made and notes that previously issued improvement notices in relation to medicines management and 999 call recording had been lifted. The Committee also welcomes the Improvement Plan put in place by SECAmb in order to address the concerns raised by the CQC.
- The Committee has supported the Sub-Group, established by the South East Regional Health Scrutiny Network to undertake scrutiny of SECAmb and to support its improvement journey. However, the Committee does not consider that this is a replacement for scrutiny by individual health scrutiny committees. The Committee looks forward to SECAmb attending the Committee once again in August 2018 and subsequently during 2018/19.
- The Committee relies on Healthwatch Medway, which is a non-voting committee member, to feed back patient views and experiences.

This response to the Quality Account has been submitted by officers, in consultation with the Committee Chairman, Vice-Chairman and Opposition Spokesperson, under delegation from the Medway Health and Adult Social Care Overview and Scrutiny Committee.

Overview Scrutiny Committee

Joint Statement from South East Coast Health Overview and Scrutiny Committees (Brighton and Hove Health Overview and Scrutiny Committee (HOSC), East Sussex HOSC, Kent HOSC, Medway Health and Adult Social Care Scrutiny Committee, Surrey Wellbeing and Health Scrutiny Board and West Sussex Health and Adult Social Care Select Committee)

Introduction

It is clear from the Quality Account, and from the HOSCs' own scrutiny, that 2017/18 has been another challenging year for the Trust. Demand for services has continued to increase and it is clear that the Trust's capacity has been stretched, which has impacted on performance. Alongside these ongoing operational pressures the Trust has been implementing a number of major change programmes and undergoing significant change at senior management level, all of which inevitably impacts upon capacity. However, there is now evidence of significant improvement in key areas, increased stability and strengthened leadership across the organisation.

Engagement

During 2017/18 the six HOSCs within SECAmb's area have continued to operate a joint liaison meeting in order to monitor collectively the implementation of the Trust's quality improvement plan. The Trust's commitment to these meetings has overall been positive, in particular the senior representation at meetings, including the consistent attendance of the Trust's new Chief Executive. This level of engagement, and the Chief Executive's openness about the challenges faced by the Trust, is welcomed by HOSCs.

The HOSCs also welcome the Trust's well-established process for engaging a range of stakeholders in the identification of quality improvement priorities for inclusion in the Quality Account – HOSCs were also invited to participate in this process.

Performance and Quality

HOSCs have focused joint scrutiny over the past year on the Trust's ongoing response to the findings of Care Quality Commission (CQC) inspections, as well as performance and quality measures. It is disappointing that SECAmb continues to be rated 'inadequate' by the CQC and remains in special measures. However, more detailed scrutiny has revealed significant progress in key areas highlighted by CQC such as incident reporting, medicines management and complaints handling. HOSCs also note the positive CQC rating for the 'caring' domain which reflects the commitment of front-line staff. HOSCs have been assured that the Trust is working to a comprehensive plan for addressing CQC recommendations and that this is integrated with wider Trust development and improvement work. It should be expected that this work will translate into improved CQC ratings at future inspections.

SECAmb has provided some evidence of improvements during 2017/18 with regards to response times, staffing, and organisational culture, but it is recognised that more work is needed in these areas. In particular, HOSCs have noted SECAmb's variable performance in delivering against response time targets for its highest priority calls in 2017/18 and the concerning findings of an independent review into the organisational culture. The Trust's staff survey results in 2017 remained disappointing and HOSCs wish to see more progress with the work to improve staff engagement and experience.

The transition to the Ambulance Response Programme standards in November 2017 provides a good foundation for further performance improvement but the HOSCs would like to see the Trust delivering in accordance with national targets for response times on lower priority category 3 and 4 calls. HOSCs have, however, seen welcome evidence of the Trust taking a strategic approach to improving response times across all categories through initiatives such as conducting a demand

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and capacity review with commissioners as well as developing a Surge Management Plan to manage periods of peak demand in an agreed way.

HOSCs have ongoing concerns about the impact of delays in the handover of patients at hospital A&E departments. The considerable number of hours lost to handover delays inevitably impacts on SECAmb's performance and therefore on the Trust's ability to provide a timely response to other calls. HOSCs have scrutinised this issue during the past year but it continues to be a cause of concern requiring ongoing local and national focus.

2017/18 Quality Priorities

HOSCs welcome the progress made, particularly in relation to incident reporting. However, it is clear that further work is needed on both duty of candour compliance and, in particular, improving outcomes for out of hospital cardiac arrest.

2018/19 Quality Priorities

The HOSCs support the continued inclusion of out of hospital cardiac arrest outcomes, and the development of a Trust-wide Cardiac Arrest Strategy, given the need for further improvement in this area. In terms of learning from incidents, complaints and safeguarding reviews HOSCs would expect to see evidence of direct feedback to those involved in specific incidents as well as general communication to staff. In relation to safeguarding training HOSCs agree this is of critical importance and support the priority being given to this area.

HOSCs look forward to working with the Trust to monitor progress on the priority areas, and overall performance, over the coming year.

Trust Governors

I thought it read well and is a fair representation of the trusts quality improvement work over the past year

Felicity Dennis
Public Governor for Surrey and NE Hants

Southeast Coast Ambulance Service
NHS Foundation Trust

Patient Story – Steve

Cardiac arrest survivor reunited with lifesavers

26 September 2017

Steve collapsed and went into cardiac arrest on 26 June. He met with ambulance crews and club staff to thank all those involved in helping to save his life on Sunday 24 September.

The quick thinking and actions of Steve's training partner, Matt Carter, and club staff, saw Steve receive immediate life-saving CPR and a shock with a defibrillator in the moments before SECAmb clinician Phil Parrish arrived at the scene.

Phil was joined by colleagues and the air ambulance service as the resuscitation continued and the team worked together to stabilise Steve before he was taken to Hospital where he received emergency treatment to fit two stents.

"The first thing I remember is waking up the next morning in hospital with friends telling me what had happened," said Steve. "At first I didn't believe a word of it. It was just incredible what everyone did. I'm so grateful. From the first moments and treatment I received from the staff to the ambulance crews and my treatment at hospital. Every breath I take now is a bonus."

Phil Parrish added: "It was great for everyone to meet Steve, obviously in far better circumstances. The action of everyone at the scene prior to our arrival was vital in giving him the best chance of survival and shows how important it is that people take the opportunity to learn CPR. On behalf of all my colleagues I'd like to wish him all the best for the future."

Annex 2

Annex 2: Statement of directors' responsibilities for the quality report

The quality report must include a statement of directors' responsibilities. This is presented in this section and the words and form are mandated.:.

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 11/05/18.
  - Feedback from the governors was not received.
  - Feedback from local Healthwatch organisations dated 09/04/2018.
  - Feedback from Overview and Scrutiny Committee dated 04/05/18 and 08/05/18.
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 26/04/18.
  - Ambulance Trusts do not participate in the national patient survey programme so have been unable to include this perspective.
  - The [latest] national staff survey 06/03/2018.
  - The Head of Internal Audit's annual opinion of the Trust's control environment received 21/05/18.
  - CQC inspection report dated 05/10/2017.
- The Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered
- The performance information reported in the Quality Account is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, 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 Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- The Quality Account 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 Account.

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

By order of the board

30 May 2017 ..... **Date**

..... **Chair**

30 May 2017 ..... **Date**

..... **Chief Executive**

Patient Story – Rob

Family reunited with ambulance team as children praised for quick thinking

7 March 2017

A Brighton family was able to spend Christmas together thanks to their children raising the alarm when their dad collapsed at home in cardiac arrest.

Sisters Lilly-May, nine, and Miya-Rose, six, were instructed to find their dad's phone by older brother Grant, 14, when dad, Rob, collapsed at the family's then home in Eastbourne.

The trio have been praised for their swift actions on a November morning last year and received commendation certificates when the family and ambulance team were reunited at School in Brighton, where the girls are pupils.

The siblings worked together and contacted their mum Debbie who in turn dialled 999 as she rushed home from a shopping trip with a friend in a taxi. Debbie remained calm as she explained the situation and was soon home where she and her friend followed advice over the phone and commenced CPR.

Control room staff, including Dispatcher, Jo Smith, ensured help was quick to arrive with ambulance crew Paramedic Matthew and Emergency Care Support Worker, Aaron first on scene. They were joined by Paramedic Sarah and Student Paramedic Scott. Eastbourne Community First Responder Gordon arrived moments before Critical Care Paramedics Alan and Phil completed the team.

The team were on scene for two hours carrying out a complex resuscitation before Rob was stable enough to be taken to Hospital where he received further life-saving treatment.

Critical Care Paramedic Alan said: "I'm delighted that Rob has gone on to make such a good recovery and the family got to spend Christmas together. Lilly-May, Miya-Rose and Grant all stayed remarkably calm and worked together to arrange the help Rob desperately needed. Debbie and Rob should be very proud of them all. Debbie and her friend also did a great job in providing early CPR which is vital. Rob's recovery is thanks to a chain of survival that included excellent call taking and dispatching, early by-stander CPR and advanced life support, including several enhanced interventions we were able to provide as CCPs, and of course expert care in hospital."

Debbie said: "The girls are so young so they could have just frozen but they stayed calm and worked with Grant really well to let me know what was going on. We're very proud and so grateful to everyone for what they did to help Rob. We were able to have a good Christmas and Rob is generally on the mend. It's lovely that we've been able to meet with everyone and that the children's actions have been recognised in this way."

Rob added: "Without the dedication, professionalism and sheer determination to save my life I wouldn't be here. The work of paramedics, doctors and everyone involved in giving life back, when all seems lost, is what makes all medical professionals the backbone of life and survival. They give people the chance to live again."

Supplementary Information:

This section contains various links to documents references within this Quality Account.

Annual Complaints Report 2017-18

http://www.secamb.nhs.uk/about_us/document_library.aspx

CQC Inspection Report 2017

http://www.cqc.org.uk/sites/default/files/new_reports/AAAG5730.pdf

NRLS Comparative Data

https://improvement.nhs.uk/resources/monthly-data-patient-safety-incident-reports/

Quality Account 2016/17

https://www.nhs.uk/Services/Trusts/Overview/DefaultView.aspx?id=29240

Staff Survey 2017

http://www.secamb.nhs.uk/about_us/our_performance/national_nhs_staff_survey.aspx

NHS
South East Coast Ambulance Service
NHS Foundation Trust

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Appendix B

Accounts 2017/18

STATEMENT OF CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

The National Health Service Act 2006 (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 East Coast Ambulance 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 East Coast Ambulance Service NHS Foundation Trust and of its income and expenditure, items of other comprehensive income 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 the NHS Foundation Trust Annual Reporting 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;
- assess the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

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 them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and 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. The accounting officer is also responsible for ensuring that the use of public funds complies with the relevant legislation, delegated authorities and guidance.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Daren Mochrie, Chief Executive
25 May 2018

FOREWORD TO THE ACCOUNTS OF SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

The accounts have been prepared in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.

Daren Mochrie, Chief Executive
25 May 2018

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

Report on the Audit of the Financial Statements

Report on the Audit of the Financial Statements

1. Our opinion is unmodified

We have audited the financial statements of South East Coast Ambulance Service NHS Foundation Trust ("the Trust") for the year ended 31 March 2018, which comprise of statement of comprehensive income, statement of financial position, statement of changes in taxpayers' equity, statement of cash flows and the related notes, including the accounting policies in Note 1.

In our opinion:

- the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended; and
- the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2017/18 and the Department of Health Group Accounting Manual 2017/18.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Overview

Materiality:	**£4.5m**
financial statements as a whole	2% of total revenue

Risks of material mistatement

Recurring Risks	Recognition of NHS Income
	Valuation of Land and Buildings
	Valuation and Existence of Receivables

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS AND BOARD OF DIRECTORS OF SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which 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.

Recognition of NHS Income

NHS Income (£206.7 million; 2016/17: £201.8 million)

The Risk

Income 2017/18

- Of the Trust's reported total income of £206.7 million, £204.9 million (2016/17,£197.9 million) came from commissioners (Clinical Commissioning Groups (CCGs) and NHS England). CCGs and NHS England make up 98% of the Trust's income. The majority of this income is contracted on an annual basis, and usually actual achievement is based on completing the planned level of activity and achieving key performance indicators (KPIs).

However, a contract variation between the Trust and its CCGs meant that income is fully awarded irrespective of activity, but is still conditional on the achievement of certain KPIs.

In 2017/18, the Trust recognised Sustainability and Transformation Funding from NHS Improvement. This was received subject to achievement of defined financial and operational targets on a quarterly basis.

An agreement of balances exercise is undertaken between all NHS bodies to agree the value of transactions during the year and the amounts owed at the year end. 'Mismatch' reports are available setting out discrepancies between the submitted balances from each party in transactions and variances over £300,000 are required to be reported to the National Audit Office to inform the audit of the Department of Health consolidated accounts

Our response

Our procedures included:

Test of details: We undertook the following tests of details

- We assessed the outcome of the agreement of balances exercise with CCGs and other NHS bodies. Where there were mismatches we challenged Trust's assessment of the level of income they were entitled to and the receipts that could be collected. In doing so we examined supporting correspondence for any formal disputes or arbitration for consistency with the accounting treatment within the financial statements;
- We inspected contract variations and assessed that they were appropriately signed and that the agreed billing was in line with the contracts. The variations signed during the year retrospectively converted the contracts from being activity based to being fixed rate, as such we assessed the balance recorded to agree that only the SLA per the original agreement is

recorded, i.e. there are no accruals, receivables, or payables raised for activity; We assessed the Trust's reporting and accounting for STF income recognised in the financial statements to the letter received from NHS Improvement informing the Trust of its allocation; and

- We assessed that contracts had been agreed for 2017/18 and that billing was in line with the agreed contracts.

Valuation of Land and Buildings

(£35.3million; 2016/17: £30.6 million)

The Risk

Subjective valuation:

Land and buildings are required to be held at fair value. Assets which are held for their service potential and are in use should be measured at their current value in existing use. In accordance with the adaptation of IAS16 this is interpreted as market value for non- specialised assets and as market value in existing use for specialised assets.

Market value in existing use is interpreted as the modern equivalent asset value, being the cost of constructing an equivalent asset at today's cost. Trusts may determine that an equivalent asset would be constructed at a different site or make assumptions about the amount of space required. These should be realistic assumptions about the location and size of site required.

It is also necessary to consider whether there is any indication of impairment. Impairment could occur as a result of loss of market value due to conditions in the market or due to deterioration in the value in use of the asset, either because of its condition or because of obsolescence.

The Trust completes full valuations every five years, within interim desktop exercises in some intervening years.

The Trust did not complete a valuation during 2017/18.

South East Coast Ambulance Service NHS Foundation Trust's considered an indexation factor to assess the impact of estimated current market value by using the Investment Property (IPD) sector all Property Industrial Index for all buildings.

Our response

Our procedures included:

- **Control environment:** We critically assessed the design and implementation of the controls in place at the Trust to identify impairments.
- **Methodology choice:** Buildings We challenged Trust's basis for the valuation of land and buildings for the year ended 31 March 2018
- **Accuracy of assumptions**: We compared the valuation of buildings to other industry indices considering the nature and location of the asset, whether the land is built upon, and its location.
- **Methodology choice:** We challenged the Trust's assessments of impairment.
- **Tests of details:** We assessed that the Trust' considered the complete estate when revaluing including disposals and additions in year.

Valuation and Existence of NHS and Non-NHS Receivables

(£11.9 million; 2016/17: £15.5 million)

The Risk

Subjective estimate:

At 31 March 2018 the Trust had total receivables of £11.9 million. The Trust is required to make a number of estimates in determining the final receivables balance, due to the nature of activity recording and elements of its income being contingent on the achievement of performance targets.

Of the total £11.9 million, £7.4 million relates to NHS receivables and accrued income and £4.6 million relates to non-NHS receivables and accrued income.

The Trust participates in the agreement of balances exercise at the end of the year as part of which, it is required to agree with each of its counterparties within the Department of Health boundary.

Our response

Our procedures included:

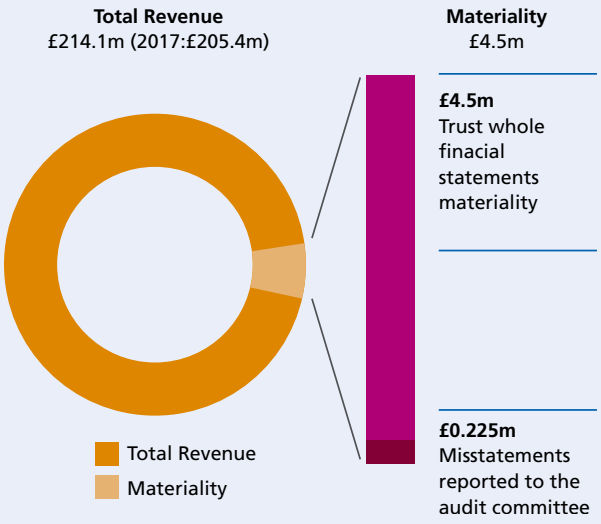
- **Test of details:** We undertook the following tests of details
- We assessed the outcome of the agreement of balances exercise with CCGs and other NHS providers. Where there were mismatches we challenged the Trust's assessment of the level of income they were entitled to and the receipts that could be collected. In doing so we examined supporting correspondence for any formal disputes or arbitration for consistency with the accounting treatment within the financial statements;
- We assessed that trade and other receivables to post year-end cash receipts and other documentation to assess whether they were posted on the correct period for the correct amount;
- **Control operation:** We tested the design and implementation of controls to monitor receivables balances for old items and control in place to authorise impairments and write-offs of non- NHS balances;
- **Methodology choice and implementation:** We considered the basis upon which credit provisions have been made. We tested the assumptions taking into account both past performance and circumstances specific to the financial year end.

3. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £4.5 million, determined with reference to a benchmark of total revenue (of which it represents approximately 2%).

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.225 million, in addition to other identified misstatements that warranted reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was all performed at the Trust's headquarters in Gatwick.



4. We have nothing to report on going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements.

5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Corporate Governance disclosures

We are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy; or the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or
- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6. Respective Responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 157 of the annual report, the Accounting Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the

intention to dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

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 our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not 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 the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters.

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.
- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

We have nothing to report in respect of our work on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

Subject to the matters outlined in the basis for adverse conclusion paragraph below, we are unable to satisfy ourselves that the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for adverse conclusion

During 2015 the Trust was found to be in breach of its provider license and an action plan was developed in response to address concerns relating to governance, performance and patient safety.

In September 2016 the CQC published its inspection report which rated the Trust as overall 'inadequate'. Concerns were raised in relation to safety, leadership, accountability and staffing levels. The Trust was placed into special measures.

A re-inspection by the CQC during 2017/18 noted some progress and improvements however the Trust continues to be rated 'inadequate' and under special measures.

These issues led us to consider there to be a significant risk related to proper arrangements for informed decision making.

The Trust has failed to meet performance targets during the year and is continuing to work on its Delivery Plan which has workstreams across the following areas:

- Service Transformation & Delivery;
- Sustainability;
- Compliance; and
- Culture & Organisational Development

The Trust is making progress and improvements are being made however there remain risks and actions required in relation to ambulance response times, medicines management, medical devices, hospital handover and embedding governance arrangements.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources.

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

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 the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources.

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local. Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risks identified during our risk assessment related to concerns over proper arrangements for informed decision making. We have set out our findings from this work on the next page.

Significant Risk	Description	Work Carried out and judgements
Informed decision making	The Trust's received an adverse VFM conclusion in the prior year. This was largely driven by the findings from the CQC inspection undertaken September 2016. The CQC rated the Trust as 'inadequate' overall. Particular areas of concern were: that the Trust was assessed as not "safe", mainly due to inefficient reporting, accountability and staffing levels; • that the Trust was not 'well-led, due to ill-defined roles and responsibilities, a lack of outcome measurement and a culture of bullying/harassment. The Trust was then placed into special measures with regular oversight from both the CQC and NHSI. The Trust also had missed key national performance indicators during the past year. The Trust developed an action plan which was incorporated into the wider recovery workstreams that had been set up after Monitor (NHSI) published in November 2015 that the Trust as in breach of its license conditions and was charged with actions to address concerns relating to decision making, governance and patient safety.	**Our work included:** We considered the Trust's Delivery Plan and the processes to report against progress and to address adverse performance against planned actions in relation to CQC and NHSI findings; . • We considered the findings in the CQC report of the re-inspection published in July • We reviewed evidence of the improvements made in year as well as those areas that remain a key area of concern; and • We considered arrangements put in place to improve decision making and the actions taken in response to the regulatory intervention that is it current subject to.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

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 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and the further matters we are required to state to them in accordance with the terms agreed with the Trust and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of South East Coast Ambulance Service NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Fleur Nieboer
for and on behalf of KPMG LLP (Statutory Auditor)
Chartered Accountants
15 Canada Square, Canary Wharf, London E14 5GL
25 May 2018

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2018

	NOTE	Year ended 31 March 2018	Year ended 31 March 2017
		£000	£000
Revenue			
Revenue from patient care activities	5	**208,069**	201,960
Other operating revenue	5.1	**6,059**	3,416
Operating expenses	8	**(211,197)**	(240,323)
Operating (deficit)/surplus		**2,931**	(34,947)
Finance costs:			
Investment revenue	13	**42**	28
Finance costs	14	**(223)**	(271)
Public dividend capital dividends payable	14	**(1,315)**	(2,235)
(Deficit)/surplus for the financial period		**1,435**	(37,425)
Gains/(losses) of disposal of non-current assets		**(137)**	850
Retained (deficit)/surplus for the period		**1,298**	(36,575)
Other comprehensive income			
Impairments and reversals	15	**0**	(7,981)
Gains on revaluations	15	**0**	0
Total comprehensive income for the period		**1,298**	(44,556)

The notes on pages 274 to 309 form part of these accounts.

Reported NHS financial performance position [Adjusted retained (deficit)/surplus]

Retained surplus for the year	**1,298**	(36,575)
Reported NHS financial performance position [Adjusted retained (deficit)/surplus]	**1,298**	(36,575)

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2018

	NOTE	Year ended 31 March 2018	Year ended 31 March 2017
		£000	£000
Non-current assets			
Property, plant and equipment	15	**59,920**	63,579
Intangible assets	16	**1,229**	634
Total non-current assets		**61,149**	64,213
Current assets			
Inventories	19	**1,776**	1,441
Trade and other receivables	20	**11,927**	15,506
Non-current assets held for sale	22	**2,296**	3,745
Cash and cash equivalents	21	**22,892**	13,036
Total current assets		**38,891**	33,728
Total assets		**100,040**	97,941
Current liabilities			
Trade and other payables	23	**(26,292)**	(23,561)
Other liabilities	23	**(22)**	(12)
Borrowings	24	**(204)**	(197)
Provisions	26	**(5,817)**	(3,592)
Total current liabilities		**(32,335)**	(27,362)
Net current assets/(liabilities)		**6,556**	6,366
Total assets less current liabilities		**67,705**	70,579
Non-current liabilities			
Borrowings	24	**(1,542)**	(7,907)
Provisions	26	**(7,603)**	(6,135)
Total non-current liabilities		**(9,145)**	(14,042)
Total assets employed		**58,560**	56,537
Financed by taxpayers' equity:			
Public dividend capital		**80,249**	79,524
Retained earnings		**(24,978)**	(26,396)
Revaluation reserve		**3,289**	3,409
Total taxpayers' equity		**58,560**	56,537

The financial statements on pages 274 to 309 were approved by the Board on 25 May 2018 and signed on its behalf by:

Signed: ..... (Chief Executive) Date: 25 May 2018

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

FOR THE YEAR ENDED	31 March 2018				31 March 2017			
	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Total	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April	79,524	(26,396)	3,409	56,537	79,524	9,517	12,052	101,093
Transfer from reval reserve to I&E reserve for impairments arising from consumption of economic benefits	0	120	(120)	0	0	662	(662)	0
(Deficit)/surplus for the year	0	1,298	0	1,298	0	(36,575)	0	(36,575)
Impairments	0	0	0	0	0	0	(7,981)	(7,981)
Public Dividend Capital received	**725**	**0**	**0**	**725**	0	0	0	0
Balance at 31 March	**80,249**	**(24,978)**	**3,289**	**58,560**	79,524	(26,396)	3,409	56,537

INFORMATION ON RESERVES

Public dividend capital

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

Revaluation reserve

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

Retained earnings reserve

The balance of this reserve is the accumulated surpluses and deficits of the NHS foundation trust.

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2018

	NOTE	**Year ended 31 March 2018**	Year ended 31 March 2017
		£000	£000
Cash flows from operating activities			
Operating (deficit)/surplus		**2,931**	(34,947)
Depreciation and amortisation	8,15,16	**10,825**	9,433
Impairments and reversals	17	**34**	29,501
(Increase)/decrease in inventories	19.1	**(335)**	67
(Increase)/decrease in trade and other receivables	20.1	**3,119**	(160)
Increase/(decrease) in trade and other payables	23	**781**	4,524
Increase/(decrease) in other current liabilities	23.1	**10**	(236)
Increase/(decrease) in provisions	26	**3,681**	555
Other movements in operating cash flows		**71**	0
Net cash inflow/(outflow) from operating activities		**21,117**	8,737
Cash flows from investing activities			
Interest received	13	**42**	28
(Payments) for property, plant and equipment		**(5,084)**	(16,564)
Proceeds from disposal of plant, property and equipment		**1,348**	2,767
(Payments) for intangible assets		**(814)**	(189)
Net cash inflow/(outflow) from investing activities		**(4,508)**	(13,958)
Net cash inflow/(outflow) before financing		**16,609**	(5,221)
Cash flows from financing activities			
Public dividend capital received		**725**	0
PDC dividend paid	1.25	**(855)**	(2,956)
Loans (repaid)/received	24	**(6,163)**	6,163
Interest on obligations under finance leases	14	**(99)**	(175)
Interest paid	14	**(110)**	(33)
Other loans repaid		**(8)**	(6)
Capital element of finance leases		**(187)**	(793)
Cash flows from (used in) other financing activities		**(56)**	0
Net cash inflow/(outflow) from financing activities		**(6,753)**	2,200
Net increase/(decrease) in cash and cash equivalents		**9,856**	(3,021)
Cash and cash equivalents (and bank overdrafts) at the beginning of the financial period		**13,036**	16,057
Cash and cash equivalents (and bank overdrafts) at the end of the financial period	21	**22,892**	13,036

1. Accounting policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2017/18 issued by the Department of Health. The accounting policies contained in that manual follow IFRS and HM Treasury's FReM to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

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.

The following standards have been issued by the IASB but have not yet been adopted by the Foundation Trust Annual Reporting Manual:

- IFRS 9 "Financial Instruments": Application required for accounting periods beginning on or after the 1 January 2018 but not yet adopted by FReM.
- IFRS 14 "Regulatory Deferral Accounts": not yet EU endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DH group bodies.
- IFRS 15 "Revenue from contracts with customers": Application required for accounting periods beginning on or after the 1 January 2018 but not yet adopted by FReM.
- IFRS 16 "Leases": Application required for accounting periods beginning on or after the 1 January 2019 but not yet adopted by FReM.
- IFRS 17 "Insurance Contracts": Application required for accounting periods beginning on or after the 1 January 2021 but not yet adopted by FReM.
- IFRIC 22 "Foreign currency Transactions and Advance Consideration": Application required for accounting periods beginning on or after the 1 January 2018.
- IFRIC 23 "Uncertainty over Income Tax and Treatments": Application required for accounting periods beginning on or after the 1 January 2019.

The DH Group Accounting Manual does not require these standards to be applied in 2017-18.

Going Concern

These accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

After making enquiries, the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. The Trust provided NHSI with its updated 2018/19 Plan in March 2018 reflecting the agreed control total deficit and the Trust had been granted a working capital facility of £15m by NHSI to enable it to meet any temporary cash flow problems which has not been required at 31 March 2018. For these reasons the Directors continue to adopt the going concern basis in preparing the accounts.

1.1 Critical accounting judgements and key sources of estimation uncertainty

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 only affects that period, or in the period of revision and future periods if the revision affects both current and future periods.

1.2 Critical judgments in applying accounting policies

The following are the critical judgements, apart from those involving estimates, that management has made in the process of applying the Trust's accounting policies and which have the most significant effect on the amounts recognised in the financial statements.

Charitable Funds - see Note 1.4
Consolidation below NHS 111 - see Note 1.27 Joint Operations below

1.3 Key sources of estimation uncertainty

The following are the key sources of estimation uncertainty which may cause a material adjustment to assets and liabilities in the next financial year.

Asset Valuations

All land and buildings are revalued to fair value. Details of these revaluations are shown in Note 1.9.

The reported amounts for depreciation of property, plant and equipment and amortisation of non-current intangible assets can be materially affected by the judgements exercised in determining their estimated economic lives. Details of economic lives and carrying values of assets can be found in notes 15 and 16.

Provisions

Provisions are made for liabilities that are uncertain in amount. The costs and timings of cash flows relating to these liabilities are based on management estimates supported by external advisors. Details of this can be found in note 1.16; the carrying values of provisions are shown in note 26.

1.4 Consolidation

Charitable Funds

The Trust is the corporate trustee of the linked charity, the South East Coast Ambulance Service Charitable Fund. The Trust has assessed its relationship under IFRS 10 and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund. However the charitable fund's transactions are immaterial in the context of the group and therefore transactions have not been consolidated. Details of the transactions with the charity are included in the related party transactions note.

1.5 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. 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.

Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.6 Expenditure on employee benefits

Short term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from the 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.

1.7 Pension costs

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

The scheme is subject to a full actuarial valuation every four years and accounting valuation every year.

1.8 Expenditure on other goods and services

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

1.9 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 will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- 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 purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building or unit, 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, the components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

All property, plant and equipment are measured initially at cost, representing the cost 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 subsequently measured 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 current value at the date of revaluation, less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and buildings – market value for existing use
- Leasehold improvements - depreciated replacement cost
- Assets held for sale - lower of carrying amount and current value less costs to sell

It is Trust accounting policy to re-value its owned land and buildings at least every five years. The land and buildings were last re-valued by the District Valuer as at 31 March 2015. The Trust considered it appropriate to commission a further revaluation exercise from Montagu Evans as at 31 March 2017 to confirm that the estate is correctly valued. Montagu Evans advised that the Existing Use Value (EUV) method of valuation is more appropriate to this Trust than the Depreciated Replacement Cost method previously in use on the basis that EUV applies to non-specialised assets that are owner occupied. These form the majority of the Trust's assets. Land and buildings owned by the Trust were therefore revalued on this basis. For the year ended 31 March 2018 a desktop review was carried out to review the valuation of these owned buildings and management deemed that no adjustment was required.

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 set out above. The carrying amount of the part replaced is derecognised. 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.

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'.

1.10 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only when 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 and is at least £5,000.

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

Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred.

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 fair value. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.

1.11 Donated assets

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

The donated assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.12 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period

over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

In accordance with the Group Accounting Manual impairments that arise from a clear consumption of economic benefits or 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 arising from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are 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.

1.13 De-recognition

Assets intended for disposal are classified 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.

  a) management are committed to a plan to sell the asset;

  b) an active programme has begun to find a buyer and complete the sale;

  c) the asset is being actively marketed at a reasonable price;

  d) the sale is expected to be completed within 12 months of the date of the classification as 'Held for Sale';

  and

  e) the actions needed to complete the planned sale 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", after which depreciation ceases to be charged. Assets are derecognised when all material sale contract conditions are met.

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

1.14 Leases

Finance leases

Where substantially all the 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.

All other leases are classified as operating leases.

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, discounted using the interest rate implicit in the lease, with a matching liability for the lease obligation to the lessor. The assets and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. 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.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.15 Inventory

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the First in First Out (FIFO) method.

1.16 Cash and Cash Equivalents

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

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

1.17 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation of uncertain timing or amount as a result of a past event, it is probable that the Trust will be required to settle the obligation and a reliable estimate can be made of the amount of the obligation. The amount recognised in the Statement of Financial Position is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates for general provisions, except for early retirement and injury benefit provisions which both use the HM Treasury's post employment benefit discount rate of 0.1% (2016-17: 0.24%) in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

1.18 Clinical negligence costs

NHS Resolution (NHSR) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSR which in return settles all

clinical negligence claims. The contribution is charged to expenditure. Although the NHSR is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSR on behalf of the Trust is disclosed at Note 26 (Provisions) but is not recognised in the Trust's accounts.

1.19 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 the NHS Litigation Authority and, in return, receives assistance with the cost 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.

1.20 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is not recognised in the Trust accounts but is disclosed in Note 27.1 (Contingent liabilities) unless the possibility of a transfer of economic benefit is remote.

1.21 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.

1.22 Corporation tax

The Trust has determined that it has no Corporation Tax liability as its commercial activities provides less than £50,000 profit.

1.23 Foreign currency

The functional and presentational currency of the Trust is sterling. The Trust has no material transactions or assets and liabilities denominated in a foreign currency.

Recognition

Financial assets and financial liabilities which arise from the 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 that, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above.

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 the risks and rewards of ownership.

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

Classification and measurement

Financial assets and financial liabilities are initially recognised at fair value, net of transaction costs.

Financial assets are classified as loans and receivables. Financial liabilities are classified as other financial liabilities. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

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. After initial recognition at fair value, net of transaction costs, they are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, where appropriate, a shorter period, to the net carrying amount of the financial asset.

Impairment of financial assets

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and losses recognised 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 through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

Other financial liabilities

The Trust's other financial liabilities comprise: payables, finance lease obligations and provisions under contract. After initial recognition, at fair value, net of transaction costs, they are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, where appropriate, a shorter period, to the net carrying amount of the financial liability.

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

Interest on other 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.

1.25 Public Dividend Capital (PDC) and PDC dividend

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 Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as PDC dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation 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 Service (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 (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 of the audit of the annual accounts.

1.25 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However, the losses and special payments note (Note 31) is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provision for future losses.

1.27 Joint operations - Accounting for the NHS 111 service

The NHS 111 service is a national telephone service whose aim is to make it easier for the public to access healthcare services when urgent medical help is required but not in life-threatening, emergency situations. From March 2013, the Trust has provided the 111 service in Kent, Surrey and Sussex working in partnership with an independent provider of urgent care services in England, the Care UK Group.

The Trust holds the head contract to provide the service but the contractual arrangement between the Trust and the Care UK Group is such that the service is subject to joint control. Strategic, financial and operating decisions relating to the service require the consent of both parties.

Both parties use their own property, plant and equipment and carry their own inventories. In addition, both parties incur their own expenses and liabilities and raise their own finance, which represents their own obligations. In addition the Care UK Group provide the Trust with a Managed IT service via Amicus, which is also part of the Care UK Group.

The activities of the service are undertaken by the Trust's employees alongside the Trust's similar activities of patient services. The Trust includes within its financial statements its share of the assets, liabilities and expenses. No separate joint entity exists.

Therefore under International Accounting Standard IFRS 11, the contractual arrangement for the NHS 111 service is a joint operation. IFRS 11 recognises two forms of Joint Arrangements, namely Joint Operations and Joint Ventures. The Trust's arrangement falls under the definition of a Joint Operation as no separate entity exists and both parties are responsible and account for their own assets.

2. Pooled budget

The Trust has no pooled budget arrangements.

3. Operating segments

The segments identified and reported are Patient Services and Commercial Activities. Commercial Activities are external training, private ambulance services and third party fleet maintenance that are offered by the Trust. All other actives are reported under Patient Services (including Clinical Commissioning Group revenue).

	Patient Services		Commercial Activities		Total	
	2017-18	2016-17	**2017-18**	2016-17	**2017-18**	2016-17
	£000	£000	**£000**	£000	**£000**	£000
Income	**213,850**	205,135	**278**	241	**214,128**	205,376
(Deficit)/surplus before interest	**2,939**	(34,916)	**(8)**	(31)	**2,931**	(34,947)

4. Income generation activities

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. The following provides details of income generation activities where the full cost was not exceeding £1m or was otherwise material.

	2017-18	2016-17
	£000	£000
Income	**278**	241
Full cost	**286**	272
Deficit	**(8)**	(31)

5. Revenue from patient care activities

	2017-18	2016-17
	£000	£000
NHS Trusts	-	5
NHS England	940	2,338
Clinical Commissioning Groups	204,881	197,894
Foundation Trusts	19	15
Local Authorities	53	37
NHS other	690	1,250
Income generation	278	241
Non-NHS:		
Business with other Whole of Government bodies		
Injury costs recovery	627	671
Other	581	(491)
	208,069	201,960

* Included in the Revenue from Clinical Commissioning Groups of £204,881k (2016-17: £197,834k) is £13,548k (2016-17: £14,100k) relating to the NHS 111 service, the contract for which is in the Trust's name. The reimbursement of the income attributable to the Trust's joint venture partner, Care UK Group, of £6,774k (2016-17 restated: £7,050k) is shown under "Purchase of Healthcare from non NHS bodies" see note 8.

5.1 Other operating revenue

	2017-18	2016-17
	£000	£000
Education, training and research	2,647	2,849
Charitable and other contributions to expenditure	-	13
Sustainability and transformation fund (STF)	2,695	-
Non-patient care services to other bodies	67	65
Other revenue	492	330
Secondment income	158	159
	6,059	3,416

6. Revenue by classification

	2017-18	2016-17
	£000	£000
A & E income	192,630	179,767
Other NHS clinical income	147	4,831
Other non-protected clinical income	15,292	17,362
Other operating income	6,059	3,416
	214,128	205,376

Of total revenue from patient care activities, £204,020k (2016-17: £199,315k) is from Commissioner Requested Services and £10,108k (2016-17: £6,061k) is from non-Commissioner Requested Services.

7. Revenue

Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.

8. Operating expenses

	2017-18 £000	2016-17 £000
Purchase of healthcare from non NHS bodies*	**18,384**	18,226
Employee Expenses - Non-executive Directors	**142**	150
Employee Expenses - Staff	**130,130**	136,198
Drug costs	**1,397**	1,601
Supplies and services - clinical (excluding drug costs)	**4,411**	4,525
Supplies and services - general	**1,785**	1,806
Establishment	**5,359**	5,710
Research and development	**0**	7
Transport	**14,108**	14,135
Premises	**13,240**	12,919
Increase/(decrease) in bad debt provision	**126**	21
Increase in other provisions	**3,792**	743
Depreciation on property, plant and equipment	**8,571**	9,256
Amortisation on intangible assets	**2,254**	177
Impairments/(reversals) of property, plant and equipment	**34**	29,497
impairments/(reversals) of intangible assets	**0**	4
Audit fees :		
Audit services - statutory audit**	**60**	55
Other Services audit assurance related services	**8**	0
Other auditors remuneration	**38**	0
Internal audit services	**103**	139
Other services	**365**	161
Clinical negligence	**1,576**	1,471
Legal fees	**430**	546
Consultancy costs	**830**	798
Training, courses and conferences	**2,880**	1,771
Insurance	**101**	91
Redundancy	**348**	236
Losses, ex gratia & special payments	**639**	47
Other	**86**	33
TOTAL	**211,197**	240,323

* The reimbursement of the Trusts 111 joint venture partnership of £6,774k (2016-17 restated: £7,050k) is shown under Purchase of Healthcare from non NHS bodies.

** In 2017/18 audit fees for statutory audit and audit related assurance services (Quality Accounts), excluding VAT, were £50k and £7k respectively (2016-17 No split provided by previous auditors).

9. Operating leases

9.1 As lessee

Operating leases relate to the leasing of land and buildings, vehicles and other minor operating items.

There are no contingent rents, terms of renewal of purchase options or escalation clauses and there are no specific restrictions imposed by the lease arrangements.

Payments recognised as an expense

	2017-18 £000	2016-17 £000
Minimum lease payments	**1,785**	2,273
	1,785	2,273

Total future minimum lease payments

	2017-18 £000	2016-17 £000
Payable:		
Not later than one year	**2,453**	1,962
Between one and five years	**6,276**	3,614
After five years	**15,518**	4,942
Total	**24,247**	10,518

Total future sublease payments expected to be received: £nil (2016-17: £nil)

10. Employee costs and numbers

10.1 Employee costs

	2017-18			2016-17		
	Total	**Permanently employed**	**Other**	Total	Permanently employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	**106,334**	**105,617**	**717**	107,375	107,076	299
Social security costs	**10,562**	**10,562**	**0**	10,164	10,164	0
Employer contributions to NHS pension scheme *	**12,975**	**12,975**	**0**	12,870	12,870	0
Recoveries from DH Group bodies in respect of staff cost netted off expenditure	**(317)**	**(317)**	**0**	(321)	(321)	0
Costs capitalised as part of assets	**969**	**543**	**426**	593	593	0
Agency staff	**2,718**	**0**	**2,718**	6,346	0	6,346
Employee benefits expense	**133,241**	**129,380**	**3,861**	137,027	130,382	6,645

* The expected contribution to the pension plan for 2017-18 is £13,000k (2016-17: £13,000k)

10.2 Average number of people employed

	2017-18			2016-17		
	Total	**Permanently employed**	**Other**	Total	Permanently employed	Other
	Number	Number	Number	Number	Number	Number
Ambulance staff	**2,442**	**2,410**	**32**	2,506	2,477	29
Administration and estates	**1,061**	**1,008**	**53**	1,139	988	151
Healthcare assistants and other support staff	**9**	**9**	**0**	113	113	0
Total	**3,512**	**3,427**	**85**	3,758	3,578	180

Of the above		
Number of whole time equivalent staff engaged on capital projects	8	9

10.3 Staff sickness absence

	2017-18	2016-17
	Number	Number
Total days lost	**36,057**	38,167
Total staff years	**3,105**	3,170
Average working days lost	**11.6**	12.0

Data provided by Department of Health for 12 months period January to December 2017.

10.4 Retirements due to ill-health

During 2017-18 there were 4 (2016-17: 7) early retirements from the Trust agreed on the grounds of ill-health at an additional cost of £177,000 (2016-17: £531,000) to the NHS Pension Scheme.

10.5 Staff exit packages

There were 14 exit packages paid in 2017-18 (2016-17: 6) at a total cost of £640k (2016-17: £409k)

	2017-2018			2016-2017		
Exit package cost band (including any special payment element)	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	Number	**Number**	**Number**	Number	Number	Number
Less than £10,000	**1**	**0**	**1**	1	0	1
£10,001-£25,000	**6**	**0**	**6**	1	0	1
£25,001-£50,000	**4**	**0**	**4**	0	0	0
£50,001-£100,000	**1**	**0**	**1**	3	0	3
£100,001 - £150,000	**0**	**0**	**0**	0	0	0
£150,001 - £200,000	**2**		**2**	1	0	1
Total number of exit packages by type	**14**	**0**	**14**	6	0	6
Total resource cost (£000)	**640**	**0**	**640**	409	0	409

10.6 Other (non-compulsory) staff exit packages

There were no other (non-compulsory) staff exit packages agreed in 2017-18 (2016-17: nil) at a cost of £nil (2016-17: £nil) as shown below:

	2017-18		2016-17	
Exit packages: other (non-compulsory) departure payments	**Payments Agreed Number**	**Total value of agreements £'000**	Payments Agreed Number	Total value of agreements £'000
	0	0	**0**	**0**
Voluntary redundancies including early retirement contractual costs	**0**	**0**	0	0
Mutually agreed resignations (MARS) contractual costs	**0**	**0**	0	0
Early retirements in the efficiency of the service contractual costs	**0**	**0**	0	0
Contractual payments in lieu of notice	**0**	**0**	0	0
Exit payments following Employment Tribunals or court orders	**0**	**0**	0	0
Non-contractual payments requiring HMT approval *	**0**	**0**	0	0
Total	**0**	**0**	0	0
of which: non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	**0**	**0**	0	0

* Includes any non-contractual severance payment made following judicial mediation, and none relating to non-contractual payments in lieu of notice.

10.7 Pension costs

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

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

Accounting Valuation

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

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

Full actuarial (funding) valuation

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

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

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared.

The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required

11. Directors' Remuneration

The aggregate amounts payable to directors were:

	2017-18 £000	2016-17 £000
Salary	**1,439**	1,682
Taxable benefits	**12**	30
Employer's pension contributions	**79**	136
Total	**1,530**	1,848

Further details of directors' remuneration can be found in the remuneration report.

12. Better Payment Practice Code

12.1 Better Payment Practice Code – measure of compliance

	2017-18		2016-17	
	Number	£000	Number	£000
Total Non-NHS trade invoices paid in the period	**19,675**	**70,411**	26,732	79,078
Total Non-NHS trade invoices paid within target	**15,693**	**54,260**	20,905	60,562
Percentage of Non-NHS trade invoices paid within target	**80%**	**77%**	78%	77%
Total NHS trade invoices paid in the period	**300**	**2,019**	262	1,380
Total NHS trade invoices paid within target	**209**	**1,250**	194	1,219
Percentage of NHS trade invoices paid within target	**70%**	**62%**	74%	88%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice.

The 2017-18 Better Payment Practice Code percentages are below the target (95%) as a result of the Trust managing its cash flow to strict 30 day payment terms for all suppliers. This has meant an adverse impact upon this measure where suppliers are on shorter payment terms.

12.2 Late Payment of Commercial Debts (Interest) Act 1998

There were no material payments made as a result of late payment of Commercial Debts (2016-17: £nil)

13. Investment revenue

	2017-18 £000	2016-17 £000
Interest revenue:		
Bank accounts	**42**	28
Total	**42**	28

14. Finance costs

	2017-18 £000	2016-17 £000
Interest on loans and overdrafts	**110**	31
Interest on obligations under finance leases	**99**	175
Unwinding of discount	**12**	63
Other	**2**	2
Total interest expense	**223**	271

15. Property, plant and equipment

2017-18	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017	6,149	25,755	9,851	12,598	57,199	9,730	338	121,620
Transfers by absorption	0	0	0	0	0	0	0	0
Additions purchased	0	0	7,034	0	0	0	0	7,034
Additions leased	0	0	0	0	0	0	0	0
Additions donated	0	0	0	0	0	0	0	0
Impairments charged to operating expenses	0	0	0	0	0	0	0	0
Impairments charged to the revaluation reserve	0	0	0	0	0	0	0	0
Reversal of Impairments	0	0	0	0	0	0	0	0
Reclassifications	0	5,918	(11,791)	84	1,077	2,443	0	(2,269)
Revaluations	0	0	0	0	0	0	0	0
Transferred to disposal group as asset held for sale	0	0	0	0	615	0	0	615
Disposals	(150)	(499)	(69)	0	(8,124)	(717)	0	(9,559)
At 31 March 2018	**5,999**	**31,174**	**5,025**	**12,682**	**50,767**	**11,456**	**338**	**117,441**
Depreciation at 1 April 2017	0	1,348	0	9,269	39,401	7,685	338	58,041
Provided during the year	0	925	0	1,065	5,240	1,341	0	8,571
Impairments charged to operating expenses	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0
Revaluation surpluses	0	0	0	0	0	0	0	0
Transferred to disposal group as asset held for sale	0	0	0	0	0	0	0	0
Disposals	0	(430)	0	0	(7,944)	(717)	0	(9,091)
Depreciation at 31 March 2018	**0**	**1,843**	**0**	**10,334**	**36,697**	**8,309**	**338**	**57,521**
Net book value								
Purchased	5,859	27,859	5,025	2,348	13,176	3,147	0	57,414
Donated	140	199	0	0	117	0	0	456
Finance leased	0	1,273	0	0	777	0	0	2,050
Total at 31 March 2018	**5,999**	**29,331**	**5,025**	**2,348**	**14,070**	**3,147**	**0**	**59,920**
Asset financing								
Owned	5,999	28,058	5,025	2,348	13,293	3,147	0	57,870
Finance leased	0	1,273	0	0	777	0	0	2,050
Total 31 March 2018	**5,999**	**29,331**	**5,025**	**2,348**	**14,070**	**3,147**	**0**	**59,920**

15. Property, plant and equipment (cont.)

2016-17	Land	Buildings excluding dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2016	18,723	34,282	20,283	11,830	57,693	9,220	338	152,369
Transfers by absorption	0	0	0	0	0	0	0	0
Additions purchased	0	0	16,044	0	0	0	0	16,044
Additions leased	0	0	0	0	0	0	0	0
Assets purchased from cash donations	0	0	0	0	0	0	0	0
Impairments charged to operating expenses	(10,424)	(20,936)	0	0	(3,006)	(284)	0	(34,650)
Impairments charged to the revaluation reserve	(2,113)	(5,868)	0	0	0	0	0	(7,981)
Reversal of Impairments	0	0	0	0	0	0	0	0
Reclassifications	625	19,193	(26,476)	768	4,495	794	0	(601)
Revaluations	0	0	0	0	0	0	0	0
Transferred to disposal group as asset held for sale	(662)	(264)	0	0	(1,445)	0	0	(2,371)
Disposals	0	(652)	0	0	(538)	0	0	(1,190)
At 31 March 2017	**6,149**	**25,755**	**9,851**	**12,598**	**57,199**	9,730	338	121,620
Depreciation at 1 April 2016	0	2,852	0	8,215	36,359	7,359	338	55,123
Provided during the year	0	1,573	0	1,177	5,974	532	0	9,256
Impairments	0	(2,456)	0	0	(2,491)	(206)	0	(5,153)
Reclassifications	0	0	0	(123)	0	0	0	(123)
Revaluation surpluses	0	0	0	0	0	0	0	0
Transferred to disposal group as asset held for sale	0	(22)	0	0	0	0	0	(22)
Disposals	0	(599)	0	0	(441)	0	0	(1,040)
Depreciation at 31 March 2017	**0**	**1,348**	**0**	**9,269**	**39,401**	**7,685**	**338**	**58,041**
Asset financing	5,848	20,391	9,851	3,329	16,235	2,045	0	57,699
Owned	301	713	0	0	141	0	0	1,155
Finance leased	0	3,303	0	0	1,422	0	0	4,725
Total 31 March 2017	**6,149**	**24,407**	**9,851**	**3,329**	**17,798**	**2,045**	**0**	**63,579**

15. Property, plant and equipment (cont.)

There were no assets donated in the year.

All land and buildings were valued by Montagu Evans as at 31 March 2017 to reflect their Existing Use Value (EUV) method of valuation. The Trust has reviewed an indexation factor in 2018 to assess the impact of estimated current market value by using the Investment Property Databank (IPD) sector All Property Industrial Index for all buildings. The Trust has deemed that no adjustment is required.

Further to the valuation exercise in 2017 Montagu Evans have undertaken a review of existing freehold buildings and their estimated remaining useful lives. The impact of which has been to extend the lives of certain assets to beyond the previously stated maximum life of 50 years to some buildings being depreciated by up to 75 years.

All other non-current assets are capitalised at historic cost depreciated over their remaining useful lives on a straight line basis.

The Trust uses depreciated historical cost as a fair value proxy in respect of assets with short useful lives and low values, namely plant and machinery, transport equipment, Information Technology and furniture & fittings.

The economic lives of fixed assets range from:

	Min Life Years	Max Life Years
Buildings excluding dwellings	3	75
Plant & Machinery	5	7
Transport & Equipment	3	7
Information Technology	1	5
Furniture & Fittings	10	10

16. Intangible assets

2017-18	Computer software – purchased	Computer software – (internally generated)	Licences and trademarks	Patents	Development expenditure (internally generated)	Total
	£000	£000	£000	£000	£000	£000
Gross cost at 1 April 2017	**2,097**	**0**	**0**	**0**	**0**	**2,097**
Additions purchased	**814**	**0**	**0**	**0**	**0**	**814**
Additions donated	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**2,269**	**0**	**0**	**0**	**0**	**2,269**
Revaluation / indexation	**0**	**0**	**0**	**0**	**0**	**0**
Transferred to disposal group as asset held for sale	**0**	**0**	**0**	**0**	**0**	**0**
Impairments charged to operating expenses	**0**	**0**	**0**	**0**	**0**	**0**
Reversals of impairments	**0**	**0**	**0**	**0**	**0**	**0**
Disposals	**(1,607)**	**0**	**0**	**0**	**0**	**(1,607)**
Gross cost at 31 March 2018	**3,573**	**0**	**0**	**0**	**0**	**3,573**
Amortisation at 1 April 2017	**1,463**	**0**	**0**	**0**	**0**	**1,463**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications as held for sale	**0**	**0**	**0**	**0**	**0**	**0**
Disposals	**(1,373)**	**0**	**0**	**0**	**0**	**(1,373)**
Revaluation	**0**	**0**	**0**	**0**	**0**	**0**
Impairments charged to operating expenses	**0**	**0**	**0**	**0**	**0**	**0**
Reversal of impairments	**0**	**0**	**0**	**0**	**0**	**0**
Charged during the year	**2,254**	**0**	**0**	**0**	**0**	**2,254**
Amortisation at 31 March 2018	**2,344**	**0**	**0**	**0**	**0**	**2,344**
Net book value						
Purchased	**1,229**	**0**	**0**	**0**	**0**	**1,229**
Donated	**0**	**0**	**0**	**0**	**0**	**0**
Government granted	**0**	**0**	**0**	**0**	**0**	**0**
Total at 31 March 2018	**1,229**	**0**	**0**	**0**	**0**	**1,229**

16. Intangible assets (cont.)

2016-17	Computer software – purchased	Computer software – (internally generated)	Licences and trademarks	Patents	Development expenditure (internally generated)	Total
	£000	£000	£000	£000	£000	£000
Gross cost at 1st April 2015	**1,322**					**1,322**
Additions - purchased	**189**	**0**	**0**	**0**	**0**	**189**
Additions - donated	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**601**	**0**	**0**	**0**	**0**	**601**
Reclassified as held for sale	**0**	**0**	**0**	**0**	**0**	**0**
Revaluation / Indexation	**0**	**0**	**0**	**0**	**0**	**0**
Transferred to disposal group as asset held for sale	**0**	**0**	**0**	**0**	**0**	**0**
Impairments	**0**	**0**	**0**	**0**	**0**	**0**
Impairments charged to operating expenses	**(15)**	**0**	**0**	**0**	**0**	**(15)**
Reversals of impairments	**0**	**0**	**0**	**0**	**0**	**0**
Disposals	**0**	**0**	**0**	**0**	**0**	**0**
Gross cost at 31 March 2017	**2,097**	**0**	**0**	**0**	**0**	**2,097**
Amortisation at 1st April 2015	**1,174**	**0**	**0**	**0**	**0**	**1,174**
Impairments	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**123**	**0**	**0**	**0**	**0**	**123**
Disposals	**0**	**0**	**0**	**0**	**0**	**0**
Revaluation	**0**	**0**	**0**	**0**	**0**	**0**
Impairments charged to operating expenses	**(11)**	**0**	**0**	**0**	**0**	**(11)**
Reversal of impairments	**0**	**0**	**0**	**0**	**0**	**0**
Transferred to disposal group as asset held for sale	**0**	**0**	**0**	**0**	**0**	**0**
Charged during the year	**177**	**0**	**0**	**0**	**0**	**177**
Amortisation at 31 March 2017	**1,463**	**0**	**0**	**0**	**0**	**1,463**
Net book value						
Purchased	**634**	**0**	**0**	**0**	**0**	**634**
Leased	**0**	**0**	**0**	**0**	**0**	**0**
Donated	**0**	**0**	**0**	**0**	**0**	**0**
Total at 31 March 2017	**634**	**0**	**0**	**0**	**0**	**634**

16.1 Amortisation rate of intangible assets

Software - 5 years

17 Impairments and reversals

17.1 Analysis of impairments and reversals recognised in 2016-17

	31 March 2018 Total £000	31 March 2017 Total £000
Property, Plant and Equipment impairments and reversals taken to Statement of Comprehensive Income (SoCI)		
Loss or damage resulting from normal operations	0	593
Over-specification of assets	0	0
Abandonment of assets in the course of construction	0	0
Total charged to Departmental Expenditure Limit	0	593
Unforeseen obsolescence	0	0
Loss as a result of catastrophe	0	0
Other	0	0
Changes in market price	0	28,904
Total charged to Annually Managed Expenditure	0	28,904
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve		
Loss or damage resulting from normal operations	0	0
Over-specification of assets	0	0
Abandonment of assets in the course of construction	0	0
Unforeseen obsolescence	0	0
Loss as a result of catastrophe	0	0
Other	0	0
Changes in market price	0	7,981
Total impairments for PPE charged **to reserves**	0	7,981
Total Impairments of Property, Plant and Equipment	0	37,478
Intangible assets impairments and reversals charged to SoCI		-
Loss or damage resulting from normal operations	0	4
Over-specification of assets	0	0
Abandonment of assets in the course of construction	0	0
Total charged to Departmental Expenditure Limit	0	4
Total Impairments of Intangibles	0	4
Non-current assets held for sale charged to SoCI	0	0
Loss or damage resulting from normal operations	0	0
Total charged to Departmental Expenditure Limit	0	0
Changes in market price	34	0
Other	0	0
Total charged to Annually Managed Expenditure	34	0
Financial Assets impairments and reversals charged to the Revaluation Reserve	0	0
Loss or damage resulting from normal operations	0	0
Loss as a result of catastrophe	0	0
Other	0	0
TOTAL impairments for Financial Assets charged to reserves	0	0
Total Impairments of Financial Assets	34	0

17.2 Impairment of assets

	31 March 2018 Total £000	31 March 2017 Total £000
Impairments charged to operating deficit	**34**	29,501
Impairments charged to the revaluation reserve	**0**	7,981
Total impairments	**34**	37,482

Following the revaluation exercise carried out at 31 March 2017 no formal revaluation exercise has been undertaken at this financial year end. The above impairment relates to a property held for disposal impaired to its anticipated disposal value.

17.1 Analysis of impairments and reversals recognised in 2016-17 (cont.)

	31 March 2018 £000	31 March 2017 £000
Non-current assets held for sale - impairments and reversals charged to SoCI.	**0**	0
Total impairments of non-current assets held for sale	**0**	0
Total Investment Property impairments charged to SoCI	**0**	0
Total Impairments charged to Revaluation Reserve	**0**	0
Total Impairments charged to SoCI - Departmental Expenditure Limits	**0**	0
Total Impairments charged/(credited) to SoCI - Annually Managed Expenditure	**34**	29,501
Overall Total Impairments	**34**	29,501
		0
Of which: Impairment on revaluation to "modern equivalent asset" basis	**0**	593
TOTAL DONATED/GOVERNMENT GRANTED ASSET IMPAIRMENTS	**0**	0

17.2 Property, plant and equipment

The charge of £34k (2016-17: £29,501k) results from the revaluation of an asset held for sale based upon latest anticipated valuation.

17.3 Non-current assets held for sale

Please see Note 22.2 (Non-current assets held for sale) for details.

18. Capital Commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2018	31 March 2017
	£000	£000
Property, plant and equipment	**1,191**	1,907
Total	**1,191**	1,907

The principle commitment relates to the Trust's Make Ready Centre capital developments.

19. Inventories

19.1 Inventories by category

	31 March 2018	31 March 2017
	£000	£000
Drugs	**2**	64
Consumables	**1,461**	1,139
Fuel	**313**	238
Total	**1,776**	1,441

19.2 Inventories recognised in expenses

	31 March 2018	31 March 2017
	£000	£000
Inventories recognised as an expense in the period	**335**	(67)
Write-down of inventories	**0**	0
Reversal of write-downs that reduced the expense	**0**	0
Total inventories recognised in the period	**335**	(67)

20. Trade and other receivables

20.1 Trade and other receivables by category

	Current 31 March 2018 £000	Non-current 31 March 2018 £000	Current 31 March 2017 £000	Non-current 31 March 2017 £000
Trade receivables NHS	**3,755**	**0**	3,470	0
Trade receivables Other	**243**	**0**	949	0
Provision for impaired receivables	**(613)**	**0**	(487)	0
Prepayments	**2,771**	**0**	4,467	0
Accrued income	**3,365**	**0**	4,692	0
PDC Receivable	**255**	**0**	715	0
Other receivables	**2,151**	**0**	1,700	0
Total	**11,927**	**0**	15,506	0

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

20.2 Receivables past their due date but not impaired

	31 March 2018 £000	31 March 2017 £000
By up to three months	**1,116**	2,177
By three to six months	**130**	287
By more than six months	**836**	1,160
Total	**2,082**	3,624

21. Cash and cash equivalents

	31 March 2018 £000	31 March 2017 £000
Opening Balance	**13,036**	16,057
Net change in year	**9,856**	(3,021)
Closing Balance	**22,892**	13,036
Made up of:		
Cash with Government banking services	**22,870**	13,013
Commercial banks and cash in hand	**22**	23
Cash and cash equivalents as in statement of financial position	**22,892**	13,036
Cash and cash equivalents as in statement of cash flows	**22,892**	13,036

22. Non-current assets held for sale

22.1 Non-current assets held for sale

	Land	Buildings, excl dwelling	Dwellings	Other property, plant and equipment	Intangible assets	Total
	£000	£000	£000	£000	£000	£000
Balance at 1 April 2017	**1,262**	**1,038**	**0**	**1,445**	**0**	**3,745**
Plus assets classified as held for sale in the year	**0**	**0**	**0**	**0**	**0**	**0**
Less assets sold in the year	**0**	**0**	**0**	**(800)**	**0**	**(800)**
Less impairments of assets held for sale	**0**	**(34)**	**0**	**0**	**0**	**(34)**
Plus reversal of impairment of assets held for sale	**0**	**0**	**0**	**0**	**0**	**0**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	**0**	**0**	**0**	**(615)**	**0**	**(615)**
Balance at 31 March 2018	**1,262**	**1,004**	**0**	**30**	**0**	**2,296**
Balance at 1 April 2016	1,372	1,791	0	0	0	3,163
Plus assets classified as held for sale in the year	662	242	0	1,445	0	2,349
Less assets sold in the year	(772)	(995)	0	0	0	(1,767)
Less impairments of assets held for sale	0	0	0	0	0	0
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0
Balance at 31 March 2017	1,262	1,038	0	1,445	0	3,745

22.2 Non-current assets held for sale - Make Ready Centres & Patient Transport Service Vehicles

As a result of the Trust's programme of transferring Operations to Make Ready Centres, during 2011-12 the Board approved the marketing of ambulance stations for sale relating to the Make Ready Centres.

Where the Trust is actively marketing properties asset values are transferred to Assets Held for Sale. There are 5 ambulance stations in Assets Held for Sale; these are Eastbourne, Dover, Herne Bay, Knaphill and Pulborough with a combined asset value of £2,260,000 (2016-17: £2,300,000). There are a further 4 properties awaiting agreement to market; these are properties at Crawley, Littlehampton, Pulborough and Newhaven, the asset values of which are included within Non Current Assets.

The expected disposal date of the remaining ambulance stations is prior to 31st March 2019.

As of 31 March 2018 the Trust had 2 vehicles with a combined value of £30,000 that were held for sale as a result of its exit from the Patient Transport Service in 2017. These vehicles are expected to be sold by 31 March 2019.

23. Trade and other payables

	Current 31 March 2018 £000	Non-current 31 March 2018 £000	Current 31 March 2017 £000	Non-current 31 March 2017 £000
Trade payables - capital	**2,828**	**0**	878	0
NHS trade payables	**762**	**0**	576	0
Other trade payables	**6,143**	**0**	7,260	0
Taxes payable	**4,447**	**0**	4,350	0
Other payables	**207**	**0**	1,013	0
Accruals	**11,905**	**0**	9,484	0
PDC payable	**0**	**0**	0	0
Total	**26,292**	**0**	23,561	0

23.1. Other liabilities

	Current 31 March 2018 £000	Non-current 31 March 2018 £000	Current 31 March 2017 £000	Non-current 31 March 2017 £000
Deferred grants income	**0**	**0**	0	0
Other deferred income	**22**	**0**	12	0
Deferred PFI credits	**0**	**0**	0	0
Lease incentives	**0**		0	0
Net pension scheme liability	**0**		0	0
Total	**22**		12	0

24. Borrowings

	Current 31 March 2018 £000	Non-current 31 March 2018 £000	Current 31 March 2017 £000	Non-current 31 March 2017 £000
Other Loans	**8**	**11**	8	19
Obligations under finance leases	**196**	**1,531**	189	1,725
Working capital loans from Department of Health	**0**	**0**	0	6,163
Total	**204**	**1,542**	197	7,907

25. Finance lease obligations

The Trust leases 20 single response vehicles on a five year commercial lease arrangement.

In addition the Trust leases the Paddock Wood Make Ready Centre buildings on a 30 year commercial lease arrangement.

Amounts payable under finance leases:

	Minimum lease payments 31 March 2018 £000	**Present value of minimum lease payments 31 March 2018 £000**	Minimum lease payments 31 March 2017 £000	Present value of minimum lease payments 31 March 2017 £000
Within one year	**263**	**196**	263	189
Between one and five years	**576**	**358**	749	511
After five years	**1,613**	**1,173**	1,703	1,214
Less future finance charges	**(725)**	**0**	(801)	0
Value of minimum lease payments	**1,727**	**1,727**	1,914	1,914

Included in:		
Current borrowings	**196**	189
Non-current borrowings	**1,531**	1,725
	1,727	1,914

Future sublease payments expected to be received total £nil (2016-17: £nil).
Contingent rents recognised as an expense £nil (2016-17: £nil).

26. Provisions

	Current 31 March 2018 £000	Non-current 31 March 2018 £000	Current 31 March 2017 £000	Non-current 31 March 2017 £000
Pensions relating to staff	**376**	**4,497**	351	4,785
Legal claims	**1,401**	**0**	926	0
Other	**4,040**	**3,106**	2,315	1,350
Total	**5,817**	**7,603**	3,592	6,135

	Pensions relating to other staff £000	Legal claims £000	Other £000	Total £000
At 1 April 2016	4,611	756	3,742	9,109
Change in the discount rate	592	0	0	592
Arising during the year	221	170	563	954
Utilised during the year	(351)	0	(91)	(442)
Reversed unused	0	0	(549)	(549)
Unwinding of discount	63	0	0	63
At 31 March 2016	5,136	926	3,665	9,727
At 1 April 2017	**5,136**	**926**	**3,665**	**9,727**
Change in the discount rate	**64**	**0**	**0**	**64**
Arising during the year	**63**	**475**	**4,077**	**4,615**
Utilised during the year	**(402)**	**0**	**(182)**	**(584)**
Reversed unused	**0**	**0**	**(414)**	**(414)**
Unwinding of discount	**12**	**0**	**0**	**12**
At 31 March 2018	**4,873**	**1,401**	**7,146**	**13,420**
Expected timing of cash flows:				
Within one year	**376**	**1,401**	**4,040**	**5,817**
Between one and five years	**1,500**	**0**	**1,825**	**3,325**
After five years	**2,997**	**0**	**1,281**	**4,278**

Other provisions include dilapidations of leasehold premises, anticipated health compensation claims, holiday pay and pre-1985 banked leave.

The pension provision of £4,873k represents the Trust's pension liability for pre-1995 reorganisations (31 March 2017: £5,136k).

Legal claims are the member provision for personal injury claims being handled by the NHS Resolution.

A further £4,605k is included in the provisions of the NHS Resolution at 31 March 2018 (not in these accounts) in respect of clinical negligence liabilities of the NHS Trust (2016-17: £15,331k).

27. Contingencies

27.1 Contingent liabilities

	2017-18	2016-17
	£000	£000
Legal claims	**404**	694
Total	**404**	694

The contingent liability for legal claims is based on information from NHS Resolution and relates to other legal claims shown in Note 27. NHS Resolution provides a probability for the success of each claim which is included in Provisions. The difference between this probability and 100% of each claim is included in contingent liabilities.

27.2 Contingent assets

The Trust has no contingent assets.

28. Related party transactions

During the year none of the Department of Health Ministers, Trust Board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Trust apart from those listed below:

- Dr Angela Smith, Non Executive Director and Chair of the Audit Committee, is an Independent Council Member at the University of Sussex from whom the Trust received £22k income and £22k receivable for services provided.
- Ms Tricia McGregor, Independent Non Executive Director, is a Non Executive Director at Kent Surrey Sussex Academic Health Science Network from whom the Trust received £2k receivable for services provided.

The Department of Health is regarded as a related party. During the year the 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.

In addition, the Trust has had a number of transactions with other government departments and other central and local government bodies.

The Trust has received revenue payments of £nil (2016-17: £154k) from the South East Coast Ambulance Service Charitable Fund, the Trustee for which is the South East Coast Ambulance Service NHS Foundation Trust. The Trust has charged the Charity £11k (2016-17: £11k) for administration and associated costs and £nil (2015-16: £nil) representing other charges for the financial year 2017-18.

The Trust has not consolidated the Charitable Fund (see note 1.4), although related party transactions with the Charitable Fund are included within these accounts.

29. 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 service provider relationship that the Trust has with Clinical Commissioning Groups (CCG's) and the way those CCG's 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's financial assets and liabilities are generated by day-to-day operational activities rather than by the change in 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 auditor.

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 minimal exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows for capital expenditure, subject to affordability. The borrowings are in line with the life of the associated assets, and interest is charged at a commercial rate. The Trust aims to ensure that it has low exposure to interest rate fluctuations by fixing rates for the life of the borrowing where possible. The Trust has low exposure to interest rate risk and currently has 20 support vehicles on a 5 year fixed rate finance lease. Similarly, the Trust has the building element of the Paddock Wood Make Ready Centre on a fixed rate 30 year finance lease.

Credit risk

As 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 20.1.

Liquidity risk

The Trust's operating costs are incurred under contracts with CCG's, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from cash reserves, borrowings and Public Dividend Capital. The Trust is not exposed to significant liquidity risks.

29.1 Financial assets

	Loans and receivables	
	31 March 2018	31 March 2017
	£000	£000
Receivables	**8,693**	10,037
Cash at bank and in hand	**22,892**	13,036
Total at 31 March 2018	**31,585**	23,073

29.2 Financial liabilities

	31 March 2018	31 March 2017
	£000	£000
Payables	**21,845**	19,211
Finance lease obligations	**1,727**	1,914
Other borrowings	**19**	6,190
Provisions under contract	**7,146**	3,665
Total at 31 March 2016	**30,737**	30,980

29.3 Fair values

There is no difference between the carrying amount and the fair values of financial instruments.

29.4 Derivative financial instruments

In accordance with IAS39, the Trust has reviewed its contracts for embedded derivatives against the requirements set out in the standard. As a result of the review the Trust has deemed there are no embedded derivatives that require recognition in the financial statements.

30. Losses and special payments

The total number of losses and special payments cases and their total value is as follows:

	Total Value of Cases 2017-18	**Total Number of Cases 2017-18**	Total Value of Cases 2016-17	Total Number of Cases 2016-17
	£000		£000	
Losses				
Cash losses	**86**	**96**	0	0
Fruitless payments	**0**	**0**	0	0
Bad debts	**0**	**0**	0	0
Stores losses	**5**	**18**	0	0
Damage to buildings and property	**721**	**1,730**	557	1,794
Other damage to buildings and property	**0**	**0**	0	0
Special payments				
Extra-contractual payments	**0**	**0**	0	0
Extra-statutory payments	**0**	**0**	0	0
Compensation payments	**0**	**0**	0	0
Special severance payments	**0**	**0**	0	0
Ex-gratia payments	**84**	**14**	82	16
Total losses and special payments	**896**	**1,858**	639	1,810

The amounts are reported on an accruals basis but exclude provisions for future losses.

31. Auditor liability limitation agreement

The Trust's contract with its external auditor, as set out in the engagement letter, provides for a maximum aggregate auditor's liability of £500k.

32. Events after the reporting period

There are no post balance sheet events.

For more information

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NHS Foundation Trust

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INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of South East Coast Ambulance Service NHS Foundation Trust to perform an independent assurance engagement in respect of South East Coast Ambulance Service NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following two national priority indicators (the indicators):

- Category 1 (C1) – Life-threatening calls
- Category 2 (C2) – Emergency calls

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

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* 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* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2017/18* ('the Guidance'); 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 and the six dimensions of data quality set out in the *Detailed Requirements for external assurance for quality reports for foundation trusts 2017/18.*

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual 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 and papers for the period April 2017 to May 2018;
- papers relating to quality reported to the board over the period April 2017 to May 2018;
- feedback from commissioners, dated 11 May 2018;
- feedback from governors, dated 02 May 2018;
- feedback from local Healthwatch organisations, dated 09 April 2018;
- feedback from Overview and Scrutiny Committee, dated 04 May 2018 and 08 May 2018;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national staff survey, dated 06 March 2018;
- Care Quality Commission Inspection, dated 05 October 2017];

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST ON THE QUALITY REPORT

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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* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2017/18* ('the Guidance'); 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 and the six dimensions of data quality set out in the *Detailed Requirements for external assurance for quality reports for foundation trusts 2017/18.*

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual 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 and papers for the period April 2017 to May 2018;
- papers relating to quality reported to the board over the period April 2017 to May 2018;
- feedback from commissioners, dated 11 May 2018;
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- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national staff survey, dated 06 March 2018;
- Care Quality Commission Inspection, dated 05 October 2017];

- the 2017/18 Head of Internal Audit's annual opinion over the trust's control environment, dated 21 May 2018; and
- any other information included in our review.

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.

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 East Coast Ambulance Service NHS Foundation Trust as a body, to assist the Council of Governors in reporting the 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 indicator. 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 East Coast 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 indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual 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 which 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* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by South East Coast Ambulance Service NHS Foundation Trust.

Conclusion

Based on the results of our procedures, 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 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
15 Canada Square, London

25 May 2018