South East Coast Ambulance Service NHS
NHS Foundation Trust

Annual Report and Accounts

1 April 2011 – 31 March 2012

Your service, your call

South East Coast Ambulance Service NHS Foundation Trust

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

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.

For more information

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Director's report

This section is designed to provide a fair and balanced review of the Trust's business during 2011/12.

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Our people – this provides information on our staff, highlighting the different roles within the organisation and detailed breakdowns on our workforce profile. It also contains information on how the Trust is run, both in terms of the Trust Board and the Council of Governors.

Our patients – this section provides information on patient experience and also identifies key clinical developments that the Trust is undertaking to improve the service we provide to our patients.

Our performance – this covers how the Trust has performed against key performance targets, including operational, clinical and financial performance. It also sets out our compliance with assessments by key regulators, including the Care Quality Commission and Monitor and discusses our performance against the sustainability and equality agendas.

Our partners – this section details how we work together with our key stakeholders, including those who commission our services and the wide range of volunteers who support us. It also contains information on our FT membership and sets out our plans moving forwards to improve engagement with all partners.

Our priorities – here we look at the key priorities that the Trust has focussed on during 2011/12 and areas that we will continue to work on during the coming year.

Our plans – this section provides information on the key service developments that the Trust is undertaking in order to improve patient care and experience, as well as improve efficiency.

Our processes – in this section, we provide information about the various processes that underpin and support the delivery of our core services.

Chairman's Introduction

Welcome to the 2011/12 report, which covers our first full year as a Foundation Trust and which I am pleased to introduce as the new Chairman of the Trust. As you will see throughout the report, the SECAmb team has delivered excellent performance during the year and further strengthened its capability.

The Board has had a busy year as it met the challenges of driving SECAmb forward in a tough external environment. The Trust strategy continues to serve us well, but given the extent of change within the health service we are already advanced in a strategy review.

There are a number of changes to Board membership. On the executive front, James Kennedy joined us in October 2011 as Director of Finance, and has brought with him a financial rigour and commercial astuteness. Sue Harris our Director of Strategy, Planning and Partnerships will shortly be leaving the Trust for a new role as Director of Service Delivery in the Welsh Ambulance Services. Sue has made a big contribution to both SECAmb and the Board and she has our best wishes for the future.

As regards the Non-Executive Directors, following approval by the Council of Governors, Christine Barwell and John Jackson have had their terms of office extended; we are pleased that we will continue to have their knowledge, expertise and commitment. Isobel Simpson will be leaving the Board in July 2012, and I would like to thank her for all she has done for the Trust. With Isobel's departure and having reviewed the tenures of the Non-Sxecutives, we expect to appoint two new Non-Executive Directors in the first half of 2012/13.

In addition, I'd also like to thank Mike Harris, for his input as Interim Chairman during the first part of the year, and for the part he played in supporting SECAmb in becoming one of the first ambulance Foundation Trusts nationally.

The Council of Governors can look back on its first full year with pride. It has exercised its statutory duties, including my own

appointment and setting the remuneration of our Non-Executive Directors. I believe the Council is exercising appropriately its role of holding the Board to account. It has contributed to the Trust's development, providing good input to the annual plan, the Inclusion Strategy and the Quality Account. The Council also provided strong support for the Board's increased attention to staff engagement. A number of the governors have been very active in promoting SECAmb to the public; as a consequence, combined with management support, the growth in membership is on track with our plan. I am very grateful to all members of the Council who have dedicated their time to support the Trust and play such an important role in the Trust's governance arrangements.

Looking forwards to 2012/13, we must maintain high patient care while covering an up-lift in demand with no increase in funding. Not easy, but I am confident that we have the leadership and staff, able and committed, to meet the challenge.

Tony Thorne, Chairman

Chief Executive's Report

Our first full year as a Foundation Trust has seen us successfully deliver against our performance targets, both annually, and on a more challenging quarterly basis. Our staff have not only responded to more emergency calls than ever before but have also reached more of these patients more quickly than previously.

I am very proud that we were one of the highest performing ambulance trusts nationally in relation to response-time targets. We will be working hard to maintain this excellent level of service through 2012/13, with a key focus being on working with other health-care providers to address issues relating to hospital handover and turnaround.

In addition to response time performance, we have also delivered an extremely high level of clinical treatment and care to our patients. Clinical performance is of high importance to me personally, and to the Board; as articulated in our vision, we strive to match and exceed international excellence. It is fantastic therefore that we have consistently been in the top two to three ambulance services on the main key clinical performance indicators measured nationally. I hope you will see lots of evidence of this commitment throughout the report.

Playing a key role in the wider health system, we worked hard to increase the numbers of patients handled through 'Hear and Treat' and 'See and Treat' capability, finding the right pathways for patients without having to take them to hospital. Being unable to match patients to a pathway more appropriate than hospital A&E departments has been a frustration for staff for a long time, therefore making progress on this has been important both for patients and staff. A key part of improvement in this area has been the introduction in 2011/12 of the NHS Pathways system within our Emergency Dispatch Centres; this has enabled us to improve our initial triaging and subsequent provision of care to all of our patients.

Our financial performance through the year has been strong. We met demanding financial targets in a very difficult economic climate and this enables us to continue to invest for the future in areas such as the paramedic education programme, the upgrading of the IT, the introduction of pathways and the opening of two 'Make Ready' centres. In addition, the Trust succeeded in meeting a challenging Cost Improvement Programme target, and putting in place robust measures for continuing cost improvements in 2012/13 and beyond.

2011/12 has been a successful year for the Trust in relation to our growth and development, winning the Patient Transport Service contract in Sussex (which went live on 1 April 2012) and in submitting bids for the Surrey and Kent contracts. We were delighted to hear in May 2012 that our Surrey bid was successful. In addition, the Trust submitted a credible bid, in partnership with Harmoni (an Out of Hours provider) for the provision of 111 services across the South East Coast region, the outcome of which will be determined in early summer 2012.

The Trust puts patient care at the top of its' priorities but this is only achieved through the capability and commitment of our staff. The attention to patients is demonstrated every day and is reflected in the many messages of thanks received from patients and families. It was also recognised by the Care Quality Commission, after its unannounced visit and inspection in the fourth quarter of 2011/12. Their report gave SECAmb a high rating across a range of issues, but included specific reference to the staffs' good understanding of procedures and their attention to patients.

Looking ahead to 2012/13, the Board are focussed on addressing issues regarding staff satisfaction and engagement; the annual staff survey has reinforced concerns in relation to staff perceptions of working in the organisation, and this is an issue that I, and the Board, take very seriously. The Board is implementing a series of initiatives targeted at improving matters for staff and I hope we will see real changes during the coming year.

I am pleased that we have been joined during the year by Tony Thorne as our new Chairman. He brings useful experience and a different perspective, which I know will be really valuable moving forwards.

Despite the challenges ahead, the coming year promises to be an exciting one for SECAmb. Not only do we see the Olympics coming to our region but also significant opportunities in terms of potential expansion in patient transport and 111 services. I am confident that our staff and the Trust as a whole are up to the challenge!

Paul Sutton, Chief Executive

At a glance…

"We will match and exceed international excellence through embracing innovation and putting the patient at the heart of everything we do."

Who we are

South East Coast Ambulance Service NHS Foundation Trust 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 1 March 2011.

We respond to 999 calls from the public, urgent calls from healthcare professionals and in Kent and Sussex we provide non-emergency patient transport services (pre-booked patient journeys to and from healthcare facilities).

We are led by a Trust Board, which is made up of a Non-Executive Chairman, 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 eight governors appointed from key partner organisations.

- SECAmb provides ambulance services to over 4.5 million people living in Kent, Surrey, Sussex and parts of Hampshire. We are one of 11 ambulance trusts in England.
- SECAmb delivers its service from:
  - Two regional offices at Lewes and Coxheath and the Trust HQ at Banstead. Each of these sites also houses an Emergency Dispatch Centre (EDC) where 999 calls are received, clinical advice provided and emergency vehicles dispatched
  - Five Make Ready Centres
  - 47 Ambulance Stations
  - 44 Ambulance Community Response Posts
- SECAmb employs 3,135 staff, including 2,005 clinicians in front-line roles
- SECAmb utilises a fleet of 552 vehicles, comprising:

  - 250 A&E ambulances
  - 100 response cars
  - 14 4x4 vehicles
  - Three Bariatric ambulances (used to transport patients with complex needs)
  - Four Neo-natal ambulances
  - 20 Hazardous Area Response Team (HART) vehicles
  - 11 Chemical Biological Radiological Nuclear (CBRN) vehicles
  - 150 Patient Transport Services (PTS) vehicles
- During 2011/12, we received £170m of income and spent £10.9m of this on capital spend, including the commencement of the HART facilities at Gatwick. We also delivered savings of £11.2m through our ambitious Cost Improvement Programme, allowing us to deliver improved services for lower cost.

- During 2011/12 we:
  - Received 688,714 emergency calls of which 38% were categorised as immediately life-threatening (Category A emergency calls)
  - Reached 195,700 of these patients within eight minutes (77.61%)
  - Our Patient Transport Service teams undertook 401,097 journeys

Our people

SECAmb employs 3,135 staff, 85% of whom are in direct contact with patients, either face to face or over the phone. Equally as important are the 454 staff, employed in support roles – fleet, infection control, finance, IT – and many others, as it is these staff who enable our clinicians to have the right tools and skills needed to provide care to patients.

This section provides a detailed breakdown on our staff, their job roles and training, as well as information on how we communicate and engage with our staff and recognise their achievements each year.

Our people…how we work as a Foundation Trust

This section provides information on our staff, highlighting the different roles within the organisation and detailed breakdowns on our workforce profile. It also contains information on how the Trust is governed, both in terms of the Trust Board and the Council of Governors.

The Board of Directors

The Board of Directors is 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 Non-Executive Directors.

The Executive Directors manage the day to day running of the Trust, while the Chair and 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.

Non-Executive Directors are appointed by the Council of Governors, who also set their remuneration and terms and conditions of office. The appointment of the Chief Executive is by the Non-Executive Directors, subject to ratification by the Council of Governors.

In line with our Constitution, the Trust Board includes the Chairman, seven Non-Executive Directors, the Chief Executive and six Executive Directors. One of the Non-Executive Director posts is currently vacant.

The full time Executive Directors have extensive experience as NHS Directors and the Board is satisfied that its balance of knowledge, skills and experience is appropriate to the work of the Board.

The Board has reviewed and confirmed the independence of all the Non-Executive Directors who served during the year, none of whom have declared any significant conflicts of interest.

The Trust Board is supported by six standing committees, each dealing with a specialist area. These are:

- Appointments and Remuneration Committee
- Audit Committee
- Finance and Business Development Committee
- Risk Management and Clinical Governance Committee
- Workforce Development Committee
- Nominations Committee (whilst accountable to the Trust Board, the Nominations Committee is responsible for making recommendations to the Council of Governors. For more information, please see below).

Board performance is reviewed via the Board Development Programme, which is currently being revised. Each Committee submits an annual report to the Board, which outlines its performance in fulfilling its terms of reference

Register of Directors' interests

The Board of Directors are required to declare other company directorships and significant interests in organisations which may conflict with their Board responsibilities. A register of Directors' interests is updated annually and is available on request.

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Non-Executive Directors

[Terms of office shown in brackets]

1. Tony Thorne – Chairman
[1 September 2011 to 31 August 2014]

Tony chairs the Board of Directors, as well as the Council of Governors. Tony was Chief Executive of DS Smith PLC, the international packaging and office products group, from 2001 until his retirement from the Board in May 2010.

Previously President of the Swedish Group SCA's corrugated packaging business, Tony spent the early part of his career with Shell International, working throughout the world in senior management roles, including strategic planning and as President of the Shell companies in Mexico.

Tony is a member of the Trust Board and the Appointments and Remuneration Committee.*

Declared interests - Non-Executive Director with Drax Group plc; senior advisor with Newton

2. Mike Harris – Interim Chairman
[to 30 September 2011]

Prior to joining SECAmb as Interim Chair in October 2010, Mike was previously Chair of NHS West Sussex and prior to this gained over 25 years' experience at Board level in a range of industrial companies. Mike was also Chairman of two private companies and is a magistrate sitting on the North Sussex Bench.

Mike was a member of the Trust Board and the Appointments and Remuneration Committee.*

Declared interests - Non-Executive Chair, Stewart Signs Ltd; Non-Executive Director, Mid-Sussex GP Commissioning Group; Magistrate, North Sussex

3. Christine Barwell

[1 July 2006 to 30 June 2013]

Christine was formerly Chairman of Mid Sussex Primary Care Trust. Christine has undertaken a wide range of community involvement work with Age Concern, Social Services and the Children's Commissioner, as well as with voluntary groups and charities.

In March 2012, the Council of Governors approved a one year re-appointment, to take effect from 1 July 2012.

Christine is a member of the Trust Board, the Appointments and Remuneration Committee*, the Audit Committee, Chair of the Risk Management and Clinical Governance Committee and a member of the Workforce Development Committee.

Declared interests - none

4. Tim Howe

[28 January 2010 to 30 September 2014]

Tim has varied experience working in 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 the East Surrey Community Mediation Service. Tim is the Board's Senior Independent Director (SID).

Tim is a member of the Trust Board, the Appointment and Remuneration Committee, the Audit Committee and the Workforce Development Committee.

Declared interests - Director of Komoka Ltd; Director of Human Resource Centre; Sister works for SECAmb within PTS

5. John Jackson

[1 June 2007 to 28 February 2015]

John was previously the Chief Executive of Cable and Wireless SpA, Italy, and has held a series of operations, sales and general management roles in British Gas, Mercury Communications and Cable and Wireless. John has a wealth of experience at board level in the public and private sector and now runs his own international management consultancy company. John is the chair of the Finance & Business Development Committee.

Following his initial term of office, John was re-appointed from 1 March 2012 for three years.

John is a member of the Trust Board, the Appointments and Remuneration Committee*, the Audit Committee, Chair of the Finance and Business Development

Committee and a member of the Workforce Development Committee.

Declared interests - Director of Sunny Spells Ltd

6. Nigel Penny

[1 July 2006 to 30 June 2013]

Nigel has more than 20 years' financial management experience with Shell International. In past roles, he has concentrated on strategic planning and business performance appraisal and has a proven track record in change initiation and implementation. Nigel is the Deputy Chairman of the Trust.

Nigel is a member of the Trust Board, the Appointments and Remuneration Committee, Chair of the Audit Committee and a member of the Risk Management and Clinical Governance Committee.

Declared interests - Chairman of Trustees, Phyllis Tuckwell Hospice, Farnham

7. Dr Isobel Simpson

[1 July 2008 to 30 June 2012]

Isobel has extensive experience of working with leadership teams and boards in major companies including BT, Shell and BP. She had a distinguished career in corporate planning and served as head of strategic planning for BT Global Service. Prior to this she was senior corporate planner for Shell Chemicals International.

Isobel is a member of the Trust Board, the Appointments and Remuneration Committee, the Audit Committee, the Finance and Business Development Committee and Chair of the Workforce Development Committee.

Declared interests - none

8. Trevor Willington

[28 January 2010 to 27 January 2014]

Trevor has extensive experience working in the public sector. Most recently he was Strategic Director - Resources and Director of Finance at Elmbridge Borough Council, with responsibility for financial management, audit, local taxation, information communications and technology, legal, estates and property services. He is a member of the Surrey Parent Partnership Steering Group, providing services and advice for parents and carers of young people with special needs, and has been both a trustee and governor of an independent school and college for children and young adults with learning disabilities.

Trevor is a member of the Trust Board, the Audit Committee, Chair of the Appointments and Remuneration Committee, a member of the Finance and Business Development Committee and the Risk Management and Clinical Governance Committee.

Declared interests - Non-Executive Director of Orbit South Housing Association (to November 2011); Member of Surrey Parent Partnership Steering Group

Executive Directors

9. Paul Sutton – Chief Executive

Paul has been Chief Executive since 2006 and prior to this was Chief Executive of Sussex Ambulance Service. He joined the ambulance service in 1990 and is a qualified paramedic. Paul has adopted an innovative approach to improving ambulance services in England, with a desire to emulate and exceed international best practice.

Paul is a member of the Trust Board and the Appointments and Remuneration Committee*.

Declared interests - none

* For any decisions relating to the appointment or removal of the Executive Directors, membership of the Appointments and Remuneration Committee consists of the Chairman, the Chief Executive and all Non-Executive Directors of the Trust as required under Schedule 7 of the National Health Service Act 2006. For all other matters, Committee membership is as shown.

10. James Kennedy - Director of Finance [from 17 October 2011]

Prior to James' appointment in 2011, he spent ten years with Thermo Fisher Scientific, a US corporation. In that time he fulfilled various financial and operational roles in the UK and Switzerland. James is a member of the Institute of Chartered Accountants of Scotland and qualified with Ernst & Young's London office.

James is a member of the Trust Board and of the Finance and Business Development Committee.

Declared interests – none

11. Robert Bell – Acting Director of Finance [15 April 2011 to 16 October 2011]

Robert has been qualified as a Chartered Accountant for more than twenty years and worked in the commercial sector prior to joining the NHS. Within the NHS, he has experience in the community, mental health, acute and primary care sectors.

Robert was a member of the Trust Board and of the Finance and Business Development Committee

Declared interests - none

12. Colin Perry – Interim Director of Finance [to 14 April 2011]

Colin was formerly a director at Royal Bournemouth and Christchurch Hospitals NHS Foundation Trusts, including director of finance and IT and acting chief executive and operating officer. Colin previously worked in the water industry, local government and the private sector.

Colin was a member of the Trust Board and of the Finance and Business Development Committee

Declared interests – Director of Management Solutions – Healthcare Ltd.; Governor for Anglo European College of Chiropractic

13. Dr Jane Pateman – Medical Director

Jane is a consultant anaesthetist at Brighton and Sussex University Hospital NHS Trust, and formerly associate postgraduate dean at the London Deanery. She has wide experience in education and managerial posts in clinical medicine and is a specialist in the areas of cardiac resuscitation and major trauma.

Jane is a member of the Trust Board and the Risk Management and Clinical Governance Committee.

Declared interests – Consultant Anaesthetist, Brighton and Sussex University Hospitals NHS Trust

14. Sue Harris – Director of Strategy, Planning & Partnerships

Sue has a wide and varied range of NHS operational and strategic experience in emergency care. She has had an extensive NHS career spanning community, mental health, acute and ambulance service sectors.

Sue is a member of the Trust Board and the Finance and Business Development Committee.

Declared interests - none

15. Professor Andy Newton – Director of Clinical Operations/ Consultant Paramedic

Andy was formerly Clinical Director for Sussex Ambulance Service NHS Trust and took on a similar role when SECAmb formed, assuming the Director of Clinical Operations in April 2011. He has extensive experience in the ambulance service and educational sectors, holding a visiting professorship at the University of Surrey. In September 2005 he was appointed as the first consultant paramedic in the country and remains active in both clinical work and research today. He is a Fellow and the Chairman, the College of Paramedics.

Andy is a member of the Trust Board, the Risk Management and Clinical Governance Committee and the Workforce Development Committee.

Declared interests – Chair and Executive, College of Paramedics; Visiting Professor, University of Surrey; Expert witness on behalf of NHS Scotland Legal Services

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16. Geraint Davies – Director of Commercial Services

Geraint has held senior positions within the NHS and related organisations for over 20 years, ranging from operational to strategic roles. He brings a breadth of knowledge and skills as well as his extensive experience of commissioning and service improvement and development.

Geraint is a member of the Trust Board, the Finance and Business Development Committee, the Risk Management and Clinical Governance Committee and the Workforce Development Committee.

Declared interests - none

17. Kath Start – Director of Workforce Development

Kath, a registered nurse and nursing tutor, has held a number of senior nursing and education roles throughout the NHS, including Head of Nursing at Kingston University and Deputy Dean at St George's, where she developed the first Paramedic Practitioner course.

Kath is a member of the Trust Board, the Risk Management and Clinical Governance Committee and the Workforce Development Committee.

Declared interests - none

Board Meetings

The Trust holds Board meetings in public on a bi-monthly basis. In the interim months, the Board holds a Business meeting.

Member	Attendance at Board Meetings held in public					
	2 June 11	28 July 11	28 Sept 11	28 Nov 11	30 Jan 12	28 Mar 12
Mike Harris *	x					
Tony Thorne**			x	x	x	x
Paul Sutton	x	x	x	x	x	x
Christine Barwell	x	x	x	x	x	x
Robert Bell ***	x	x	x			
Geraint Davies	x	x	x	x	x	x
Sue Harris	x	-	x	x	x	x
Tim Howe	x	x	x	x	x	x
John Jackson	x	x	-	x	x	x
James Kennedy****				x	x	x
Andy Newton	x	x	x	x	x	x
Jane Pateman	x	-	x	x	x	-
Nigel Penny	x	x	x	x	x	x
Colin Perry *****						
Isobel Simpson	x	-	x	x	x	-
Kath Start	x	x	x	x	-	x
Trevor Willington	x	x	x	x	x	x

* Interim Chairman to 30 September 2011
** Chairman from 1 September 2011
*** Acting Director of Finance from 15 April to 16 October 2011
**** Director of Finance from 17 October 2011
***** Interim Director of Finance to 14 April 2011

Member	Attendance at Board Business Meetings						
	27 Apr 11	28 Jun 11	9 Sept 11	28 Oct 11	30 Dec 11	20 Feb 12	28 Feb 12
Mike Harris *	x	x	-				
Tony Thorne**			x	x	x	x	x
Paul Sutton	x	x	x	x	x	x	x
Christine Barwell	x	x	x	x	-	-	-
Robert Bell ***	x	x	x				
Geraint Davies	-	x	x	x	x	x	x
Sue Harris	x	x	x	x	x	x	x
Tim Howe	x	x	x	x	-	x	x
John Jackson	x	x	x	x	x	x	x
James Kennedy****				x	x	x	x
Andy Newton	-	-	x	x	x	x	x
Jane Pateman	-	x	-	x	x	-	x
Nigel Penny	x	-	x	x	x	x	x
Colin Perry *****							
Isobel Simpson	x	x	x	x	-	x	x
Kath Start	-	x	-	x	x	x	x
Trevor Willington	-	x	x	x	x	x	x

* Interim Chairman to 30 September 2011
** Chairman from 1 September 2011
*** Acting Director of Finance from 15 April to 16 October 2011
**** Director of Finance from 17 October 2011
***** Interim Director of Finance to 14 April 2011

Board Committees

In order to exercise its duties, the Board is required to have a number of statutory Committees, including an Audit Committee, a Remuneration Committee and a Nominations Committee/s. The 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 nominations for Executive Directors and one which has responsibility for dealing with nominations for Non-Executive Directors, including the Chairman.

Appointments and Remuneration Committee

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 Appointments and Remuneration Committee consists of the Chairman, the Chief Executive and all Non-Executive Directors of the Trust as required under Schedule 7 of the National Health Service Act 2006. For all other matters, Committee membership is comprised exclusively of Non-Executive Directors. All are eligible to attend but two must be present to be quorate.

Other individuals such as the Chief Executive, Director of Finance and Director of Workforce Development 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.

Member	Meeting Date/Attendance								
	5 Apr 11	16 May 11	28 July 11	4 Aug 11	14 Sept 11	24 Oct 11	22 Nov 11	22 Dec 11	28 Feb 12
Trevor Willington (Chair)	x	x	x	x	x	x	x	x	x
Tim Howe	x	x	x	x	x	x	x	x	x
Nigel Penny	x	x	x	x	x	x	x	x	x
Isobel Simpson	x	x	-	x	-	x	x	x	x

Audit Committee

The purpose of the Committee is to provide the Trust with a means of independent and objective review of internal control over the following key 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 held 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 Non-Executive Directors. All are eligible to attend but two must be present to be quorate.

Member	Meeting Date/Attendance				
	3 May 11	1 June 11	9 Sept 11	9 Dec 11	9 Mar 12
Nigel Penny (Chair)	x	x	x	x	x
Christine Barwell	x	x	x	x	x
Tim Howe	x	x	x	x	x
John Jackson	x	x	x	x	x
Isobel Simpson	x	-	x	-	x
Trevor Willington	x	x	x	x	x

Finance and Business Development Committee

The purpose of the Committee is to review financial performance, business development and investment decisions of the Trust.

The quorum necessary for transaction of business by the Committee is three members, two of which must be Non-Executive Directors.

Member	Meeting Date/Attendance										
	18 April 11	18 May 11	16 June 11	15 July 11	16 Aug 11	18 Oct 11	16 Nov 11	16 Dec 11	18 Jan 12	14 Feb 12	21 Feb 12
John Jackson (Chair)	x	x	x	x	x	x	x	x	x	x	x
Isobel Simpson	x	x	-	x	x	-	x	x	–	x	x
Trevor Willington	-	x	x	x	-	x	x	x	x	x	x
Robert Bell*	x	x	x	x	-						
Geraint Davies	x	x	x	–	x	x	-	x	-	x	-
Sue Harris	-	x	x	x	x	x	x	-	x	x	-
James Kennedy**						x	x	x	x	-	x

* Acting Director of Finance from 15 April to 16 October 2011
** Director of Finance from 17 October 2011

Risk Management and Clinical Governance Committee

The Committee is responsible for ensuring that the Trust undertakes an integrated approach to the management of clinical governance and quality and all areas of risk. In fulfilling this responsibility the Committee will ensure that the Trust has an appropriate, up to date and co-ordinated range of systems, policies and procedures in place to manage all areas of risk and clinical governance. In so doing the Committee will ensure that risks are identified, assessed, evaluated and managed according to the Risk Management Policy and associated policies and procedures.

The quorum necessary for transaction of business by the Committee is three members, one of which must be a Non-Executive Director.

Member	Meeting Date/Attendance					
	4 May 11	29 July 11	12 Sept 11	10 Nov 11	2 Feb 12	12 Mar 12
Christine Barwell (Chair)	x	x	x	x	x	x
Nigel Penny	x	x	x	x	x	x
Trevor Willington	x	x	x	x	x	x
Geraint Davies	x	x	x	-	x	x
Andy Newton	x	-	-	-	x	x
Jane Pateman	x	-	-	-	x	x
Kath Start	x	x	-	x	-	-

Workforce Development Committee

The purpose of the Committee is to ensure compliance with the legislation relating to employment of staff, to provide assurance that work streams comply with the standards of external professional bodies, and to seek to promote best practice in these areas. The Committee will also ensure that the Trust's workforce has the capacity and capability to deliver the Trust's strategic vision through effective management, leadership and Board development, workforce planning and organisational development.

The quorum necessary for transaction of business by the Committee is three members, one of which must be a Non-Executive Director.

Member	Meeting Date/Attendance						
	19 Apr 11	20 May 11	10 June 11	26 Aug 11	12 Oct 11	12 Dec 11	10 Feb 12
Isobel Simpson (Chair)	x	x	x	x	x	-	x
Christine Barwell	-	x	x	x	x	x	x
Tim Howe	x	x	x	x	x	x	x
John Jackson	x	-	x	x	x	x	x
Kath Start	x	x	x	x	x	x	x
Andy Newton	-	-	x	x	x	x	x
Geraint Davies	-	x	-	x	x	x	x

Remuneration Report

As set out above, the remuneration and terms of service of the Executive Directors are agreed by the Appointments and Remuneration Committee. In addition, the Committee, together with the other Non-Executive Directors and the Chief Executive, makes decisions regarding the appointment of Executive Directors. All other managers, with the exception of the Programme Director (Estates) are covered by the national Agenda for Change arrangements.

The Chief Executive and all Executive Directors (except the Medical Director and the Director of Finance) have been appointed on the terms and conditions, including pay, for Very Senior Managers within the NHS. 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. 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.

Subject to subsequent implementation, during the year the Committee considered and agreed recommendations made for the remuneration of the Chief Executive and Executive Directors. It was also agreed that the use of pay scales should be discontinued and replaced by single pay points, and that bonuses would not be paid other than on rare occasions when authorisation by the Committee would be required.

Objectives for the Chief Executive are determined annually by the Trust Chairman and those for the Executive Directors by the Chief Executive, reflecting the strategic objectives agreed by the Board. Performance is reviewed at year end with the results reported to the Appointments and Remuneration Committee. The Trust does not apply performance related pay for Executive Directors or any other staff.

Further information on the work of the Appointments and Remuneration Committee can be found above.

The Nominations Committee consists of four public-elected governors (including the Lead Governor), one staff-elected governor and two appointed governors, and is chaired by the Trust Chairman. This Committee makes recommendations to the Council of Governors regarding the appointment of Non-Executive Directors, as well as their remuneration and terms of service. In circumstances regarding the appointment or remuneration of the Chairman 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 Non-Executive Directors. This is done after receiving a recommendation from the Nominations Committee. In 2011/12, it was recognised that the granting of Foundation Status in March 2011 had changed the degree of

accountability and the time commitment of the NEDs. Therefore there was a thorough review of the new role and a comparison of the remuneration of the Non-Executive Directors within other Foundation Trusts. The Council agreed the new remuneration of £13,000 per annum for the Non-Executive Directors, with remuneration of £15,500 for the Chair of the Audit Committee and the Senior Independent Director. This was effective from 1 February 2012; a condition was that this level of remuneration would be set for two years and then reviewed, but only increased if staff are getting a general increase.

Further information on the work of the Nominations Committee can be found in the "Our People" section.

Paul Sutton, Chief Executive

Date: 29 May 2012

Remuneration table

Name and Title	Term of office	Year ended 31 March 2012			Month ended 31 March 2011		
		Salary (band of £5,000)	Benefits in kind (rounded to the nearest £100)	Employer Pension Contribution (rounded to the nearest £100)	Salary (band of £5,000)	Benefits in kind (rounded to the nearest £100)	Employer Pension Contribution (rounded to the nearest £100)
Chairman							
Mike Harris *Chairman*	*Contract ended 30.09.11*	15-20	-	0	0-5	-	0
Tony Thorne *Chairman*	*Appointed 01.09.11*	20-25	-	0	-	-	0
Non-Executive Directors							
Christine Barwell *Non-Executive Director*		5-10	-	0	0-5	-	0
Isobel Simpson *Non-Executive Director*		5-10	-	0	0-5	-	0
John Jackson *Non-Executive Director*		5-10	-	0	0-5	-	0
Nigel Penny *Non-Executive Director*		5-10	-	0	0-5	-	0
Trevor Willington *Non-Executive Director*		5-10	-	0	0-5	-	0
Tim Howe *Non-Executive Director*	*Appointed 01.03.11*	5-10	-	0	0-5	-	0
Chief Executive							
Paul Sutton *Chief Executive*		135-140	5,300	19,400	10-15	400	1,600
Executive Directors							
Andy Newton *Dir. of Clinical Operations*		85-90	3,200	12,400	5-10	100	1,000
Colin Perry *Interim Dir. of Finance*	*Contract ended 14.04.11*	10-15	1,600*	-	30-35	1,800*	-
James Kennedy *Director of Finance*	*Appointed 17.10.11*	55-60	-	8,200	-	-	-
Robert Bell *Acting Dir. of Finance*	*15.04.11 to 16.10.11*	80-85	-	11,200	-	-	-
Geraint Davies *Dir. of Commercial Services*		85-90	4,600	12,600	5-10	400	1,000
Kath Start *Dir. of Workforce Development*		85-90	5,200	12,600	5-10	500	1,000
Sue Harris *Dir. of Strategy, Planning & Partnerships*		90-95	4,200	12,600	5-10	300	1,100
Jane Pateman *Medical Director*		95-100	1,700	-	5-10	200	-

Pay Multiple

Band of Highest Paid Director's Total (£000) 135-140
Median Total Remuneration (£) 30,335
Remuneration Ratio 4.5

Benefits in Kind

* These figures relate to the provision of accommodation and subsistence to named individual
All other benefits-in-kind related 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

Pension entitlements

Name and Title	Year ended 31 March 2012						
	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 2011	Cash equivalent transfer 31 March 2012	Real increase in cash equivalent transfer value
Chief Executive							
Paul Sutton *Chief Executive*	0-2.5	5-7.5	30-35	95-100	376	458	71
Executive Directors							
Andy Newton *Dir. of Clinical Operations*	0-2.5	0-2.5	35-40	105-110	685	738	32
Geraint Davies *Dir. of Commercial Services*	0-2.5	0-2.5	25-30	75-80	377	449	61
Kath Start *Dir. of Workforce Development*	0-2.5	0-2.5	0-5	0	30	55	24
Sue Harris *Dir. of Strategy, Planning & Partnerships*	2.5-5.0	(10-12.5)	10-15	10-15	109	128	16
Robert Bell* *Acting Dir. of Finance*	5-7.5	17.5-20.0	5-10	15-20	0	105	105**
James Kennedy*** *Director of Finance*	0-2.5	0-2.5	0-5	0	0	9	9

* 15.04.11 to 16.10.11

** Please note that the Real increase in cash equivalent transfer value for Robert Bell refers to his cumulative NHS service and not only for 2011/12

*** Appointed 17.10.11

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 takes account of the increase in accrued pensions due to inflation, contributions paid by the employee (including the value of any benefits transferred from other pensions).

Council of Governors

The Council of Governors of an NHS Foundation Trust consists of elected NHS Foundation Trust members and appointed individuals or representatives from other key stakeholders. The Chairman of the Board of Directors is also the Chairman of the Council. In line with the NHS Foundation Trust Code of Governance, we are required to have a Lead Governor. Their role is to facilitate direct communication between Monitor and the Council if required. In SECAmb, this person also acts as a key link between the Chairman and the Council of Governors.

Monitor is the independent regulator of NHS foundation trusts and was established in January 2004 to authorise and regulate NHS foundation trusts. It is independent of central government and directly accountable to Parliament.

In order to support the Council of Governors in fulfilling their statutory duties, they are supported by a number of Committees and Working Groups:

- Nominations Committee
- Membership Development Committee
- Governor Development Working Group
- Audit Working Group

Tony Thorne – Chairman
[September 2011 to August 2014]

See profile above

Mike Harris – Interim Chairman
[October 2010 to September 2011]

See profile above

Public Elected Governors

Alison Arnold (West Sussex)
[1 March 2011 to 28 February 2014]

Alison is also a staff governor at Surrey and Borders Partnership NHS Foundation Trust, where she was previously Lead Governor; Alison's interest in the NHS stems from her previous career as a nurse.

Alison is a member of the Nominations Committee.

Declared interests - none

Margaret Bridges (Kent)
[24 August 2011 to 23 August 2013]

Margaret previously worked for SECAmb as Health and Wellbeing Manager; she is also a qualified nurse, and has worked in the NHS for 37 years.

Following elections held in 2011 to fill the vacant governor position in Kent, Margaret joined the Council in August 2011.

Margaret is a member of the Governor Development Working Group.

Declared interests - none

Marjory Broughton (Surrey)
[1 March 2011 to 28 February 2014]

Marjory was previously a member of Bromley Community Health Council, and has an extensive experience of governance in the NHS.

Marjory is a member of the Nominations Committee.

Declared interests - none

Ted Coleman (West Sussex)
[1 March 2011 to 28 February 2013]

Ted is a Community First Responder in Billingshurst; his career background is in the insurance industry, and he is a magistrate.

Ted is a member of the Audit Working Group and the Governor Development Working Group.

Declared interests - none

Terry Daubney (Surrey)
[1 March 2011 to 28 February 2014]

Terry retired in 2008, after completing over 38 years in the ambulance service in a variety of roles.

Terry is a member of the Governor Development Working Group.

Declared interests - none

Ken Davies (Kent) and Lead Governor
[1 March 2011 to 28 February 2014]

Ken retired from working for SECAmb in 2010 after over 37 years of service as an ambulance technician.

Ken is a member of the Nominations Committee.

Declared interests - none

Maggie Fenton (Kent)
[1 March 2011 to 28 February 2014]

Maggie is a teacher; she is also a qualified nurse, and used to work at Westminster Hospital.

Maggie is a member of the Membership Development Committee.

Declared interests - none

Colin Hall (Medway)
[1 March 2011 to 28 February 2014]

Colin has over 15 years operational experience in the ambulance service, having worked in both Surrey and Kent.

Colin is a member of the Membership Development Committee and has also provided input from a governor's perspective to the review of the Make Ready Programme that was undertaken in 2012.

Declared interests - none

Paul Jordan (Surrey)
[1 March 2011 to 28 February 2013]

Paul is a Director of the Surrey Coalition of Disabled People, and until recently, was the Secretary for the Surrey & Sussex region of the MS Society.

Paul is a member of the Membership Development Committee.

Declared interests - none

Robin Kenworthy (Kent)
[1 March 2011 to 28 February 2013]

Robin has experience through his career in Health & Safety and Facilities Management. He has over 15 years' experience with patient representation in different forums.

Robin is a member of the Membership Development Committee and Governor

Development Working Group.

Declared interests - none

Gloria Parks (Brighton & Hove)
[1 March 2011 to 25 March 2012]

Gloria has held a number of administrative roles in the NHS during her working life. Prior to becoming a governor, Gloria was involved with SECAmb as a member of the Public Opinion Group.

Gloria resigned from the Council of Governors on 25 March 2012; at the date of writing, elections are underway to appoint to the vacant governor position in Brighton & Hove.

Declared interests - none

Tony Prince (East Sussex)
[1 March 2011 to 9 September 2011]

Tony is a volunteer Community First Responder; in his career he was involved in hospital services design consultancy.

Tony resigned from the Council in September 2011.

Declared interests - none

Brian Rockell (East Sussex)
[1 March 2011 to 28 February 2014]

Brian is a Director of St John's Ambulance Service, and has represented the public in statutory roles to the Board of Berkshire Ambulance Service, Sussex Ambulance Service and SECAmb.

Brian is a member of the Nominations Committee.

Declared interests – Director of St John Ambulance

Ian Smith (Surrey) and Deputy Lead Governor
[1 March 2011 to February 2014]

Ian was previously Company Secretary for a multi-national minerals and mining company. He previously chaired the Surrey Patient and Public Involvement Forum and has been active in SECAmb as a patient and public representative.

Ian is a member of the Membership Development Committee and the Audit Working Group.

Declared interests - none

Terry Steeples (East Sussex)
[16 September 2011 to 28 February 2013]

Terry is an active member of the community, and is currently Chair of East Sussex Seniors Association.

Terry joined the Council in September 2011, following the resignation of Tony Prince.

Declared interests - none

Vacant (Brighton & Hove)
[26 March 2012 onwards]

Staff Elected Governors

Mark Buckton (Operational Staff)

[1 March 2011 to 28 February 2014]

Mark joined the legacy Surrey Ambulance Service six years ago, starting his career on the Patient Transport Service, before becoming a Technician. He is now a Paramedic based at Epsom Ambulance Station in Surrey.

Mark is a member of the Nominations Committee.

Declared interests - none

Jon Henderson (Operational Staff)

[1 March 2011 to 28 February 2013]

Jon joined the legacy Sussex Ambulance Service in February 2005, working on the Patient Transport Service in Worthing. He qualified as a Technician in August 2006, and since then has been based at Pulborough Ambulance Station.

Jon is a member of the Audit Working Group and has been instrumental in establishing the new staff suggestion scheme.

Declared interests - none

Angela Rayner (Non Operational Staff)

[1 March 2011 to 28 February 2013]

Angela is the Inclusion Manager for the Trust; she has worked in the NHS for 10 years, and at SECAmb for the past three, building links with a diverse range of people, groups, communities and partners.

Angela is the Chair of the Membership Development Committee.

Declared interests - none

Nigel Sweet (Operational Staff)

[1 March 2011 to 28 February 2013]

Nigel is a Technician, based at Shoreham Ambulance Station in Sussex; he has worked for the Trust since October 2007.

Nigel is a member of the Membership Development Committee.

Declared interests - none

Appointed Governors

Alex Sienkiewicz (Brighton & Hove University Hospitals NHS Trust)

[1 March 2011 to 28 February 2014]

Alex is Director of Corporate Affairs at Brighton & Sussex University Hospitals; he has previously worked in senior roles in governance at Monitor and the Charity Commission.

Alex is a member of the Nominations Committee.

Declared interests - none

Helen Belcher (East Kent Hospitals University NHS Foundation Trust)

[1 March 2011 to 15 January 2012]

Helen was General Manager in Accident and Emergency, Acute and Speciality Services at East Kent Hospitals NHS Foundation Trust, and is a qualified nurse.

Helen resigned from the Council of Governors in January 2012.

Helen was a member of the Governor Development Working Group.

Declared interests - none

Mark Dance (Kent County Council)
[1 March 2011 to 05 July 2011]

Mark is a Kent County Councillor, representing Whitstable; he was first elected to the Council in 2007. Mark resigned from the Council in July 2011; the Trust is currently in discussion with Kent County Council to identify a new appointment as a governor.

Mark was a member of the Nominations Committee.

Declared interests - none

Charlie Doyle (Surrey Police)
[16 May 2011 to 28 February 2014]

Charlie is Chief Superintendent of Surrey Police, with Divisional Commander responsibilities for East Surrey; he has worked for Surrey Police since 1988.

Charlie is a member of the Nominations Committee.

Declared interests - none

Sandra Field (The Stroke Association)
[24 May 2011 to 28 February 2014]

Sandra is the Regional Head of Operations for the Stroke Association in the South East Coast region.

Declared interests - none

Michael Hewgill (East Kent Hospitals University NHS Foundation Trust)
[23 February 2012 to 28 February 2014]

Michael is the Programme Office Accountant at East Kent Hospitals University NHS Foundation Trust.

He joined the Council of Governors in February 2012, as a successor to Helen Belcher.

Declared interests - none

Helen Medlock (South East Coast Commission Group)
[1 March 2011 to 28 February 2014]

Helen is Associate Director for Urgent Care and Trauma for NHS Kent & Medway, and is part of the South East Coast Specialist Commissioning Group; she represents the Trust's commissioners on the Council.

Declared interests - none

Nigel Seaton (Surrey University)
[1 March 2011 to 11 March 2012]

Nigel was Senior Deputy Vice-Chancellor at the University of Surrey; the University of Surrey runs a degree in Paramedic Practice that was developed alongside SECAmb.

Nigel resigned from the Council in March 2012; the Trust is currently in discussion with the University of Surrey to identify a new appointment as a governor.

Declared interests - none

Marian Trendell (Sussex Partnership NHS Foundation Trust)

[1 March 2011 to 28 February 2014]

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.

Declared interests – none

Vacant (Kent County Council)

[5 July 2011 onwards]

Vacant (Surrey University)

[11 March 2012 onwards]

Statement from Ken Davies, Lead Governor and Public Governor for Kent

"We have reached the end of our first year as Governors. I feel that the Council has made good progress as a team but there is still a way to go. Both Governors and the Trust have had a lot to learn about working together, but I believe that we have started to make a difference. I am looking forward to 2012/13, which brings both challenges and opportunities for the Trust. I am sure that the Council of Governors will continue to gel and work hard to hold the Board to account on behalf of the public."

Member	2 June 11	28 July 11	28 Sep 11	28 Nov 11	30 Jan 12	28 Mar 12
Mike Harris *	x	-	-			
Tony Thorne**			x	x	x	x
Alison Arnold	-	x	-	x	-	-
Margaret Bridges***			x	x	x	-
Marjory Broughton	-	x	-	x	x	-
Ted Coleman	x	x	x	x	x	x
Terry Daubney	x	x	x	x	x	-
Ken Davies	x	x	-	-	x	x
Maggie Fenton	x	x	x	-	x	x
Colin Hall	x	x	-	-	x	X
Paul Jordan	x	x	x	x	X	x
Robin Kenworthy	x	x	x	x	x	X
Gloria Parks****	x	x	-	x	x	
Tony Prince*****	-	-				
Brian Rockell	-	x	X	x	x	X
Ian Smith	x	x	x	x	x	X
Terry Steeples******			-	x	x	X
Mark Buckton	x	x	-	x	-	X
Jon Henderson	-	x	x	x	x	X
Angela Rayner	x	x	x	x	x	X
Nigel Sweet	x	x	x	x	x	X
Helen Belcher*******	x	x	x	x		
Mark Dance********	-					
Charlie Doyle*********	x	x	x	x	-	-
Sandra Field**********	-	x	x	x	-	
Mike Hewgill**********						X
Helen Medlock	x	x	x	x	x	X
Nigel Seaton**********	-	-	-	x	x	
Alex Sienkewicz	x	x	x	-	x	X
Marian Trendel	x	x	x	x	x	X

*Interim Chairman to 30 September 2011
**Chairman from 1 September 2011
***Joined the Council of Governors on 24 August 2011
****Resigned from the Council of Governors on 25 March 2011
*****Resigned from the Council of Governors on 9 September 2011
******Joined the Council of Governors on 16 September 2011
*******Resigned from the Council of Governors on 15 January 2011
********Resigned from the Council of Governors on 5 July 2011
*********Joined the Council of Governors on 16 May 2011
**********Joined the Council of Governors on 24 May 2011
**********Joined the Council of Governors on 23 February 2012
**********Resigned from the Council of Governors on 11 March 2012

The Trust holds the Council of Governors meetings on the same day as the Board of Directors meetings that are held in public. As such, all Board members who have been in attendance at the public meeting also attend the Council of Governors meetings.

The Trust is pleased to have developed a good working relationship with our Council of Governors throughout the year. 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, and Staff-Elected Governors represent either operational (frontline including EDC staff) or non-operational staff.

The first formal Council meeting was held at the end of March 2011 and we are now a full year into operation as a Foundation Trust with a Council. The Council held six public meetings this year, each in a different part of the Trust's area. The Council meetings are held on the same day as Board meetings to allow Governors to attend the Board and Board members to attend the Council, and encourage interaction over lunch.

In addition, the Trust holds Governor Development Days on a bi-monthly basis, between Council meetings, providing governors with training opportunities. Training offered to date has included: public speaking, understanding FT finances, and Basic Life Support skills. These days also enable Trust staff to brief governors and discuss current issues and challenges in more depth than is possible at Council meetings.

The Council has set up a Membership Development Committee and a Governor Development Working Group, and governors also make up the majority of members of the Nominations Committee. Governors have also joined an Audit Working Group.

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

Membership Development Committee

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

Key areas of work have included: regular membership monitoring; planning and delivering a Meet Your Governor stall at the Annual Members Meeting, shaping a revised Membership Strategy (now called an Inclusion Strategy), devising the annual Members Satisfaction Survey, and advising on membership recruitment and engagement opportunities.

Nominations Committee

As outlined above, the Nominations Committee is a Committee of the Board, but responsible for making recommendations to the Council in relation to appointments of

the Non-Executive Directors; the majority of members of the Committee are Governors. The Committee is chaired by the Chairman of the Trust, and other individuals, such as the Chief Executive and Senior Independent Director, 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.

The remit of the Nominations Committee is to ensure that there is a formal, rigorous and transparent procedure for the appointment of the Chairman and Non-Executive Directors to the Trust Board of Directors in line with the terms of the NHS Foundation Trust's Constitution and the NHS Foundation Trust Code of Governance, to consider whether Non-Executive Directors reaching the end of their tenure in office should be put forward for re-appointment at a general meeting of the Council of Governors and to make recommendations to the Council of Governors in relation to the terms and conditions of appointment of Non-Executive Directors.

The first duty the Committee undertook was to devise the appointment process and ultimately recommend the appointment of a substantive Chairman for the Trust. The Committee has also reviewed the remuneration of the Non-Executive Directors and reviewed the appointment of three Non-Executives. More information about these activities is included in the 'Statutory Duties' section below.

Member	Meeting Date/Attendance							
	13 Apr 11	11 May 11	13 Jun 11	30 Jun 11	23 Sept 11	25 Nov 11	09 Jan 12	29 Feb 12
Alison Arnold	x	x	x	-	-	x	-	-
Marjory Broughton	x	x	x	x	x	x	x	-
Mark Buckton	-	x	x	x	x	x	-	-
Mark Dance*	-	x	-	-				
Ken Davies	x	x	x	x	x	x	x	x
Charlie Doyle**						x	x	x
Brian Rockell	x	x	x	x	x	x	x	x
Alex Sienkiewicz	x	x	x	x	x	x	-	-

*Resigned from the Council of Governors on 5 July 2011

**Joined the Council of Governors on 16 May 2011

Audit Working Group

The Audit Working Group was formed in January 2012 to devise and undertake the tendering process for the appointment of external auditors to the Trust. Membership of the group comprises two Public Governors, one Staff Governor and one Appointed Governor, who work alongside three Non-Executive Directors, the Finance Director and another senior financial manager. It met formally once in 2011/12.

Governor Development Working Group

The group has met four times (three times by telephone conference) during the year. At year end its membership is four Public Governors. There is a vacancy for an Appointed Governor. The group is Chaired by the Membership and Governor Engagement Manager of the Trust, and its remit is to:

- Advise on and develop strategies for ensuring governors have the information and expertise needed to fulfil their role.
- Plan the content of Governor Development sessions.
- Advise on and develop strategies for effective interaction between governors and Trust staff.

The group has devised a programme of development opportunities (including training and learning about the Trust) for Governors over the year, and has suggested a number of improvements to the interaction between the Board and the Council, many of which will be implemented in 2012/13.

Statutory Duties

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

Appointment of the Chairman

The Nominations Committee led a process to appoint a substantive Chairman, which culminated in the appointment of Tony Thorne in July 2011. An extensive and rigorous process was undertaken, which included conducting a candidate search, long-listing, short-listing, and finally a selection day for the four shortlisted candidates. Candidates gave a presentation of their vision for SECAmb to a group of stakeholders, including governors and Foundation Trust members (staff and public), and met with the Executive Team and Non-Executive Team before undertaking a final interview with a panel consisting of Nominations Committee members, the Senior Independent Director and an external Foundation Trust Chairman. In line with the Terms of Reference of the Nominations Committee, external support and guidance was provided by Veredus.

Appointment and remuneration of Non-Executive Directors

The Nominations Committee undertook a process to review the remuneration of the Non-Executive Directors of the Trust and recommended a salary of £13,000 per annum, with an up-lift to £15,500 for the Chair of the Audit Committee and Senior Independent Director due to their additional responsibilities. This recommendation was

approved by the Council of Governors. The Nominations Committee have also reviewed the appointment of three Non-Executive Directors (NEDs) whose terms of office came to end this year. The Council approved the recommendation to reappoint John Jackson on a three-year term, effective from 1 February 2012. In addition, the Council approved the recommendation to reappoint Christine Barwell for a one-year term, to take effect from 1 June 2012. It was agreed that Isobel Simpson would not be reappointed; in 2012/13 the Trust will seek to recruit two new Non-Executive Directors, in line with the Trust's Constitution.

Input to Annual Planning

The Trust has worked with Governors to review its annual plan and has also held two workshops with stakeholders, including public and staff FT members, to consider the plan. An interactive session was held with Governors to review the key areas of the plan, and understand Governors views and priorities for the coming year. The Board considered this input from the Council at its meeting in January and provided feedback to the Council about how their input would be addressed.

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.

Staff-Elected Governors have also undertaken specific work to understand their constituents' views using a number of methods, including by working closely with the Trust's Foundation Council (made up of staff from across the Trust). They have produced their own newsletter, contributed to staff engagement improvements planned by the Trust, and have also started and now manage a successful staff suggestion scheme.

Highlights of other activities undertaken by Governors are set out below.

Input to strategy development and planning

Public and staff governors attended a Fleet Planning Day with Board members, other staff, and stakeholders (including Foundation Trust members) where they received a presentation from the Trust's Head of Fleet about the challenges of ensuring our vehicles match patients' needs into the future. Governors were invited to view various ambulances, cars and other equipment and consider their effectiveness based on a range of criteria.

Governors and members were also heavily involved in revising the Trust's strategy to engage and involve patients, staff and the public (including Foundation Trust members). The development of an Inclusion Strategy which enables us to do this as effectively as possible, and ensures stakeholders' views help the Trust do better for patients and staff, has been greatly influenced by Governors' desire to engage with and learn from Foundation Trust members, whether staff or public. Governors have also been actively involved in developing the Trust's Quality Account

priorities for improvement in 2012/13.

Visits to Trust premises and Observing

Governors have been able to experience life on the frontline of the ambulance service by undertaking observing shifts with ambulance staff. Governors are given health and safety, patient confidentiality and infection control training and have then been able to accompany our frontline staff on a 12 hour shift in their local area. Other Governors have also spent time in our Emergency Dispatch Centres to understand about the work our call takers and dispatchers do. In addition, Governors were invited to visit our new Make Ready Centre at Paddock Wood and were given a guided tour to understand how the Make Ready system works.

Equality Delivery System grading and objective setting

Along with other stakeholders, including staff and public FT members, Governors attended two workshops to review the Trust's evidence of its work on equality and diversity, allocate grades on different areas of work, and formulate objectives for improvement. See the "Our Performance" section for more information on the Equality Delivery System.

Contact details for the Trust's Membership Office are available on the Trust's website. For members who wish to communicate with governors and/or directors, please e-mail: ftmembership@secamb.nhs.uk and your query will be directed accordingly. Alternatively, queries can be addressed in writing to:

Membership and Governor Engagement Manager
South East Coast Ambulance Service NHS Foundation Trust
FREEPOST BR1578
40-42 Friars Walk
Lewes
BN7 2XW

Our people…How we deliver our services

As at 31 March 2012, the breakdown of our staff between clinical and support roles was as follows:

Staff group	Headcount	Whole Time Equivalent (WTE)
A&E	2005	1820.68
Patient Transport Services	307	267.02
Emergency Dispatch Centre	369	308.03
Support staff	454	398.79
TOTAL	3135	2794.52

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 Assistants and Emergency Care Support Workers – drive ambulances under emergency conditions and support the work of qualified ambulance technicians and paramedics. We have 212 Emergency Care Support Workers.

Technicians – 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 the journey to hospital. We have 846 technicians.

During recent years, the role of the ambulance technician has changed significantly, in light of broader and fundamental changes taking place in the pre-hospital environment. As a result, the Trust has opted not to recruit or train new technicians and has concentrated instead on increasing the number of paramedics and specialist paramedics (including Paramedic Practitioners and Critical Care Paramedics), who will be supported by Emergency Care Support Workers.

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 601 paramedics, including those working as clinical managers.

With increased professional entry routes of 70 students per year directly to the universities on the three year programs and the continuation of 48 part time places on the technician to paramedic Foundation Degree program at St Georges, the Trust will have access to a recruitment pool of 70 new and 24 conversion paramedics per year by 2012.

This will back fill the vacancies that are created as a result of Paramedics progressing to Paramedic Practitioner, Critical Care Paramedic and Clinical Team Leader roles.

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 41 staff in these teams.

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. Paramedic Practitioners 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.

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 and ensuring the patient is taken rapidly and safely to a hospital that is able to treat their complex needs. Critical Care Paramedics are able to assess and diagnose illness and injuries and treat patients using more powerful drugs and use equipment on scene that up to now was only used in hospital.

Clinical Team Leaders – are first-line paramedic managers, responsible for managing teams of up to eleven clinical staff.

The number of Critical Care Paramedics and Paramedic Practitioners has increased over the last 12 months with a headcount of 305 staff actively working in these roles (including Clinical Team Leaders) and a further 60 students.

Emergency Dispatch Centre staff – more than 360 staff work in the Trust's three Emergency Dispatch Centres in a variety of roles including Emergency Call Operators, 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.

Patient Transport Services staff – provide a non-emergency service, to take patients to and from NHS facilities for appointments, treatment and hospital admission. They also carry out non-urgent transfers between hospitals and discharge from hospital to home. All Patient Transport Services staff are trained in basic life support should one of their patients need emergency care. During 2011/12 we employed 307 patient transport staff, although this number has increased significantly since then due to SECAmb securing new Patient Transport Services contracts.

Support staff – our front-line staff are supported by over 450 non-clinical staff who work in areas including finance, human resources, service development and corporate affairs, information management and technology, education and training, estate, 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 all our employees work in an environment which respects and includes everyone and is free from discrimination, harassment and unfair treatment.

A key tool in order to help us ensure this is the case is workforce monitoring, whereby we collect relevant information on each member of staff:

Age

There are currently 412 staff aged 55 and above of whom 44% are A&E staff and may choose to retire within the next five years. 27% of the 412 staff within this age group are paramedics and 17% are technicians. The age profile for Critical Care Paramedics and Paramedic Practitioners tends to be younger than for other post-holders within ambulance trusts, with 76% being below the age of 45. The Trust is continuing to attract a younger age range of employees for front line services and it is expected that this trend will continue in the future.

Our age profile as at 31 March 2012 is as below:

Age	Headcount	Per cent %
16 -20	15	0.48
21-30	511	16.30
31-40	1004	32.03
41-50	899	28.68
51-60	564	17.99
61-65	110	3.51
66+	32	1.02
TOTAL	3135	100.00

Gender

Because of the traditional nature of the workforce, women tend to be under-represented in ambulance trusts. Currently, 57% of the workforce is male and 43% is female. SECAmb intends to increase the numbers of women in clinical roles over the next five years to achieve a 50/50 gender split.

The highest ratio of male to female staff is amongst A&E staff 63/37. The highest percentage of women is in the Emergency Dispatch Centres where the ratio is 71/29.

Our gender profile as at 31 March 2012 is as below:

Gender	Headcount	Per cent %
Male	1763	56.24
Female	1372	43.76
Transgender	0	0.00
TOTAL	3135	100.00

Ethnicity

In considering the ethnicity of our workforce, there has been a gradual increase in the number of staff classified as non-white British. In November 2006, the percentage of non-white British staff represented 2.25% of the workforce whereas the current percentage is 5.10%. The actual number of staff from black and minority ethnic groups has more than doubled in the past five years.

For our equality data to be more comprehensive, the Trust recognised that staff needed to be encouraged to complete the equality & diversity monitoring forms. A census was sent to all staff during 2011/12 to enable them to review their personal information held on ESR (Electronic Staff Record). Also included with the information was a monitoring form and a Stonewall booklet titled 'What's it got to do with you'. This booklet explained how the information is used for monitoring, together with the benefits that monitoring brings. Our breakdown by ethnicity as at 31 March 2012 is as below:

Group	Headcount	Per cent %
White British	2792	94.80
White Other	86	2.92
Mixed	30	1.02
Asian or Asian British	14	0.48
Black or Black British	17	0.58
Other	6	0.20
TOTAL	2945	100.00
Unstated	190	

Disability

130 employees have declared that they have a disability. This compares with 54 prior to the census referred to above, although 1,154 (36.81%) have not stated whether or not they have a disability.

	Headcount	Per cent %
Declared	131	4.18
No disability	1850	59.01
Unstated	1154	36.81
TOTAL	3135	100.00

The Trust has a Recruitment and Selection policy that includes a commitment to the

"two ticks" guaranteed interview scheme, where disabled applicants are guaranteed an interview if they meet the minimum requirements for the post. The Trust's recruitment arrangements promote fairness and equality at all stages of the process and staff responsible for the selection of personnel are appropriately trained in recruitment practice and diversity. The policy refers specifically to disability, sex, sexual orientation, age, ethnicity, religious belief and gender reassignment.

During 2011/12, the break-down of applicants to advertised posts was as follows:

Disabled	297
Not disabled	6067
Undisclosed	49

And appointments made were as follows:

Disabled	26
Not disabled	351
Undisclosed	6

Sexual Orientation

Prior to the census 66.5% of employees had not stated their sexual orientation on a monitoring form compared with 26.12% following the census. 8.04% chose not to disclose:

Sexual Preference	Headcount	Per cent %
Bisexual	16	0.51
Gay	37	1.18
Heterosexual	1955	62.36
I do not wish to disclose	252	8.04
Undisclosed	819	26.12
TOTAL	3135	100.00

Religious Belief

This area is still under reported with 40.06% having not stated a belief:

Belief	Headcount	Per cent %
Atheism	404	12.89
Buddhism	17	0.54
Christianity	1222	38.98
Hinduism	1	0.03
Islam	7	0.22
Jainism	0	0.00
Judaism	4	0.13
Sikhism	1	0.03
Other	223	7.11
Undisclosed	1256	40.06
TOTAL	3135	100.00

Our people…protecting our staff

We strive to provide a safe environment for both our staff and the patients we treat. However, with the type of service that we provide our staff may sustain injuries whilst treating or moving patients and on occasion, may potentially suffer aggressive behaviours or even violence from both service users and the public.

The Trust has a strong safety culture 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 meets every three months. It is chaired by an Executive Director and its members include managers and staff representatives.

During 2011/ 2012 we recorded 2,528 adverse incident reports, including:

- 297 incidents related to staff sustaining musculoskeletal injuries
- 121 incidents related to staff being assaulted
- 97 of the incidents were over three days of sickness and were reported to the Health and Safety Executive under the RIDDOR regulations

We encourage staff to report adverse incidents as it assists in giving an accurate appraisal of the hazards which they face; these incidents are regularly analysed and reviewed at the Health and Safety Working Groups and the Risk Management Clinical Governance Committee. Where trends have been identified, measures are implemented to assist in reducing the likelihood of recurrence, thereby making it safer for staff and patients.

During the year…

The workforce review undertaken during 2010/11 had an impact on turnover but the workforce is now re-stabilising with a current turnover rate of 6.45%. Turnover for A&E staff is 3.63%.

As at 31 March 2012, our turn-over was as below:

Staff group	Number of leavers in period (whole time equivalent)	Turnover (%)
A&E	66.00	3.63
Patient Transport Services	19.53	7.32
Emergency Dispatch Centre	25.70	8.51
Support staff	68.75	14.35
TOTAL	179.98	6.45

To date, the Trust has not experienced any problems recruiting staff to operational roles. The development of the critical care paramedic and paramedic practitioner roles offer enhanced career pathways which are likely to continue to make the Trust an employer of choice. This situation is not expected to change over the next five years. If anything, the increased professionalisation of the workforce and the introduction of new roles should continue to ensure that the Trust has enough applicants of the appropriate capacity and capability to maintain and expand the service in accordance with the details of the Workforce Plan.

The non-clinical workforce comprises staff in support departments and includes those non clinical staff in fleet and technical services who provide support to operations. This staff group includes highly skilled staff with professional qualifications. There are a few hard to recruit areas in the IT and telephony area and recruitment of these non-clinical staff will be crucial going forward if we are to realise all the benefits of the new CAD, Pathways system and the Airwave radio communications.

National Industrial Action against pension reform in the Public Sector

Following proposals by the government to make changes to public sector pensions the Trade Union Congress (TUC) conducted national ballots on strike action. A vote in favour saw public sector workers taking co-ordinated strike action on 30 November 2011.

The main unions representing SECAmb staff - Unison, GMB and Unite - all called on their members to take action, although national dispute negotiations were left to individual employers and the respective Union Branches to obtain agreement on maintaining an emergency response. At a national level, assurance had been provided that 75% of planned staff would be available and SECAmb's management team sought and obtained agreement that this would be in place.

A number of staff walked out on the midnight hour including both operational and call centre staff which left less than 75% of staff at work. Over the full 24 hour period there was an average of 68% of staff available against that which was planned. In total 298 staff participated in the period of industrial action.

The Trust had planned to mitigate a loss of normal cover by utilising paramedic managers who were not taking part in the action, along with extending the pre-existing contracts with private ambulance services and voluntary aid society crews. Along with this, additional clinical support was provided to call centre staff to enable the safer management of patients through triage and advice.

However, even with these plans, the Trust identified a number of adverse clinical incidents which were directly attributed to delays in responding and the performance standard for the 24 hour period was 67.6%. A review of the plans and actions was undertaken and learning built into future planning for any subsequent action which may be called.

Our people…engaging with and listening to our staff

Staff survey results 2011/12

The annual national NHS staff survey provides a valuable opportunity for staff to share their views on a number of key issues, including training, communications and personal development.

The results of the 2011/12 survey, undertaken in Autumn 2011were again disappointing.

Although there had been some small improvements, the results overall were poor, indicating that staff perceive that some serious issues remain outstanding for the Trust to address.

	2010/11		2011/12		Trust Improvement or Deterioration
	Trust	National average	Trust	National average	
Response rate	51%	43%	47%	47%	4% deterioration

Top four ranking scores	2010/11		2011/12		Trust Improvement or Deterioration
	Trust	National average	Trust	National average	
Percentage of staff working extra hours	83%	80%	81%	82%	2% improvement
Percentage of staff feeling valued by their work colleagues	69%	70%	67%	66%	2% deterioration
Percentage of staff reporting errors, near misses or incidents witnessed in the last month	86%	89%	91%	90%	5% improvement
Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	20%	19%	19%	20%	1% improvement

Bottom four ranking scores	2010/11		2011/12		Trust Improvement or Deterioration
	Trust	National average	Trust	National average	
Staff intention to leave jobs	2.87	2.51	3.03	2.61	Deterioration
Percentage of staff receiving job-relevant training, learning or development in last 12 months	63%	70%	56%	70%	7% deterioration
Fairness and effectiveness of incident reporting procedures	2.99	3.08	2.97	3.11	Deterioration
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	23%	14%	20%	18%	3% improvement

The Trust Board has made it clear that improving staff satisfaction is a key priority during the coming year and progress in this area is being monitored via the Workforce Development Committee, as well as the Trust Board.

To try to address the issues highlighted, the Executive Directors are working closely with the staff-governors, as well as bringing in external expertise.

Key actions will include:

- Improving current communication mechanisms where possible and introducing new ones where there is an identified need
- Rolling out a management development programme for middle managers to better equip them with proactive engagement skills
- Supporting managers in engaging in local communication by providing them with bespoke toolkits
- Reviewing and rolling out the Trust values, to ensure that they are relevant and meaningful for staff
- Reviewing and improving the appraisal process to ensure its simple and effective for staff and managers

Working together with our staff-side representatives

During 2011/12, with the austere financial climate facing the NHS, the Trust has worked closely with our four recognised unions, (Unison, GMB, UNITE and APAP), to address a number of challenging terms and conditions

issues which needed to be reviewed. These included:

- Unsocial hours enhancements;
- Annual leave;
- Flexible working ; and
- Meal breaks.

There has also been a significant shift in union membership between unions over the past year and this led to two independent membership counts being conducted by ACAS at 31 March and 31 October 2011.

The results of the membership check provided the platform for renegotiation of a new Recognition Agreement which came into effect on 1 September 2011. The new agreement allocated a maximum amount of facilities time per union according to their confirmed membership. Although this is still a generous agreement, it has enabled the Trust to make an efficiency saving in reduced facilities time when compared with the previous agreement and to exercise greater control in the release of union representatives.

All four recognised unions formally signed off this new agreement and approved the new partnership arrangements to include a published behavioural code of conduct and a zero tolerance to any form of bullying and harassment. The purpose of the agreement is to determine trade union recognition and representation within the organisation and establish a framework for consultation and collective bargaining.

The parties have identified common objectives they wish to pursue and achieve.

These are:

- To ensure that employment practices in the Trust are conducted to the highest possible standards
- To enhance effective communication with all staff throughout the Trust
- To achieve greater participation and involvement of all members of staff on the issues to be faced in running and developing the Trust
- To ensure that equal opportunities are offered to staff or prospective staff and that the treatment of staff will be fair and equitable in all matters of dispute
- To engender a culture of staff engagement and involvement as a Foundation Trust and ensure that constructive and harmonious relationships are formed between the elected staff governors and union stewards.

Under the new arrangements, all union meetings are chaired by the Director of Commercial Services and a Strategic Partnership Forum (SPF) is now being held on a quarterly basis, where all policies and procedures subject to consultation with the unions are formally approved. In addition, to enable there to be regular dialogue with staff side representatives on an extensive range of topical issues, all members of the SPF attend Union Liaison Meetings which are held on

a monthly basis between the quarterly SPF and are primarily used as the place where operational and tactical issues are discussed.

In the spirit of openness and transparency, it was agreed that all minutes of the SPF would be published on the Trust's intranet, once approved. It was also agreed that, to enable there to be clearer lines of communication and to ensure that there was consensus on the collective view being expressed on a specific issue, there would be an agreed membership of fourteen individuals at the Strategic Partnership Forum and Union Liaison Meetings, seven from Management and seven from Staff Side. This would ensure all members could state the Trust's agreed definitive position on a given issue and enable greater clarity, avoiding apparent confusion and misunderstandings which had occurred with different views being expressed in the past.

Communicating with our staff

With SECAmb employing more than 3,000 staff working different shift patterns from numerous sites across a large geographical area, communicating effectively with all of our staff can be challenging.

We try to keep staff informed about key issues within the Trust using a number of communication mechanisms:

- A weekly electronic staff bulletin, which contains key performance information, as well as "beeline" messages (where staff pay tribute to their colleagues) and news in brief;
- "Special" bulletins issues on important topics as needed e.g. Olympics;
- Targeted briefings for managers, to enable them to effectively brief their teams;
- A "staff zone" section on the Trust website;
- A programme of "face to face" briefing sessions for operational managers;
- The staff-led Foundation Council – see below.

The Foundation Council was established in June 2009, in order to provide a mechanism to ensure that there is effective communication and consultation with staff on appropriate matters, and to provide a forum for discussion, critical review and analysis. The Foundation Council is comprised of representative members of staff from all levels and areas within the Trust; the four staff-elected governors are all members of the Council.

Recognising that we always need to be looking for new and improved ways of communicating with staff, a number of new initiatives are also being developed currently including:

- Better utilisation of social media – including a Chief Executive's blog, "closed" Facebook pages for particular areas and staff groups and use of twitter;
- A re-vamp of the existing quarterly staff magazine, based on staff feedback, to make it more relevant and useful for staff.

Taking forward staff ideas

A key initiative developed during the year was the new staff suggestion scheme, developed together with the staff governors. This gives all staff an opportunity to suggest any idea that they think could:

- Improve patient care or experience;
- Improve staff working lives;
- Reduce costs or improve efficiency.

Each idea is then submitted to the panel of staff governors for consideration, and where ideas are felt to be useful they are passed to the Trust's senior management group to enable them to be taken forward. The senior managers report back to the Staff-Elected Governors about their progress on implementing the suggestions.

Our people…recognising the achievements of our staff

Every year, SECAmb holds two awards ceremonies where it honours the achievements of its staff, both for long service and outstanding achievements. This March, the ceremony for the East of the region was held at Leeds Castle, with the ceremony for the West held at Felbridge Hotel in East Grinstead.

Although the ceremonies happen annually, each event holds equal weight. As Paul Sutton commented: "Gathering staff together to reflect on their dedication to the service never fails to move me. From risking their own lives for others, to ensuring that the vulnerable are safe long after the ambulance has left the scene, there are some extraordinary people at SECAmb".

Both ceremonies followed the same format, with guests enjoying dinner and receiving a commemorative brochure before the presentations began.

First up on stage were recipients of the Queen's Medal for Long Service and Good Conduct. A total of 26 staff received the award this year, presented by the Deputy Lord Lieutenant of Kent, Richard Oldfield at Leeds Castle, and the Lord Lieutenant of West Sussex, Susan Pyper at Felbridge Hotel.

Next followed the awards for 20, 30 and 40 years' NHS service – overall there were 19, 16 and four recipients respectively. This year there was the special addition of awards to thank volunteer car drivers for their invaluable contribution to SECAmb. Eleven volunteers came to the events, including Denny Nicol who had dedicated over 30 years to the service.

The second half of the evenings focused on the Chief Executive Commendations - 12 members of staff received Commendations for:

- Clinical excellence
- Going "above and beyond the call of duty
- Outstanding Patient Care

- Employee of the Year
- Team of the Year

There were also two Public Commendation Awards - one for four Chichester based police officers, and another to three young boys. Both groups gave substantial support to ambulance crews during difficult incidents.

It is clear that the events play an important role in helping staff morale. Feedback after the ceremonies showed that 92% of staff were happy that they attended.

Outstanding contribution recognised

The outstanding commitment and contribution of SECAmb's HART Training Manager, Simon Morton was recognized during the year, when he was presented with the top prize at the 2011 Ambition Conference in Telford, receiving the national HART Special Achievement Award, based on nominations made by his colleagues.

Our people….developing opportunities

Development of clinical roles

Over the past year, we have continued to develop the Paramedic Practitioner (PP) and Critical Care Paramedic (CCP) programmes, referred to as specialist paramedics.

As at April 2012 we have 180 Paramedic Practitioners (including managers who regularly respond as Paramedic Practitioners) either qualified or in training, and as of July 2012 it is expected that we will have 42 qualified Critical Care Paramedics. We also have seven of our Critical Care Paramedics seconded to the Kent Surrey & Sussex Air Ambulance Trust Helicopter Emergency Medical Service (HEMS), working alongside the HEMS Doctors and Pilots, attending the most serious incidents across the region.

You can read much more about the development of each of the programmes in the Quality Report (in Appendix A) but below is a summary of some of the key points for each role:

Paramedic Practitioners

The last year has seen the numbers of Paramedic Practitioner teams grow and become more embedded into primary care. They are experienced paramedics who have undertaken further higher education to enable them to manage the patients who present to the ambulance service with minor illnesses and injuries, often with highly complex needs. Paramedic Practitioners work closely with the rest of the community-based, multi-disciplinary teams to ensure that these patients are cared for in the community, avoiding unnecessary journeys to A&E.

During the year we have continued to strive to treat as many patients as close to home as possible. Two clinical projects during the year has changed the way Paramedic Practitioners are deployed, to ensure as many patients as possible benefit from their additional skills

We have also developed more 'Patient Group

Direction' (PGD) medicines, including an antibiotic for treating urinary tract infections and a drug to treat patients with long term respiratory problems who suffer an acute episode.

We are undertaking a pilot project in Surrey to provide an emergency visiting service for GPs where patients request a very urgent home visits. In the past, GPs had no choice but to send these patients to A&E by emergency ambulance, but under this new scheme, patients receive a rapid assessment which in many cases removes the need to go to A&E.

Critical Care Paramedics

During the year, we have continued to see the number of Critical Care Paramedics steadily increase and we are on track to have a total of 60 by 2015. This enables us to provide a consistent level of CCP cover for those patients suffering serious injury or illness regardless of where they are within our area.

Next year (2012/13), we will be putting a team of CCPs into our new Make Ready Centre at Paddock Wood in Kent.

Critical Care Paramedics continue to attend an increasing amount of critical incidents contributing as part of the pre-hospital team to improved patient safety and outcomes. As the recently introduced regional Major Trauma system matures, we have the first examples in the country of specialist paramedics working in hospital as part of the A&E team.

Patient Transport Service re-design

At the beginning of 2011/12 with Patient Transport Services contracts across Sussex, Surrey and Kent due to go out to tender, we took the opportunity to review the structure that would support us both in going out to commercial tender and also on an on-going basis should we win the contracts.

The first part of this was to establish a new Commercial Services Directorate, with a particular focus on external contracts. Secondly, we engaged with our staff on a face to face basis to explain what we faced in the year to come and to take account of their views.

The wider team now includes regional based operational managers supporting a network of team leaders responsible for the local teams. The year ahead will be about consolidating and bedding in the new structure to deliver the requirements of the recently won Sussex tender and to bid for and win the tenders for both Surrey and Kent. It is also about continuing the good work started in having a fully engaged staff and more opportunities for face to face meetings will be set up, as well as dealing with morale and sickness issues. It also sets the framework for working with new staff that we take on through TUPE arrangements should we be successful in both those tenders.

You can read more about the development of our Patient Transport Services during the year in the "Our Partners" section.


NHS
ROB

Our patients

This section focuses on the experience of our patients when they use our services and describes the Trust's first ever Survivor's Event, where we re-united patients with the staff involved in their care. It also highlights our plans to further improve patient care and experience through clinical developments.

Our patients….listening to their experience

We are very keen to listen to and learn from patients' experiences of our services, be they good or bad. This year we have seen a significant rise in the number of compliments received for our staff, where patients or their families write, call or email to express their thanks to staff who have helped them.

During 2011/12, we received 1,181 compliments– a 151% increase. This has been facilitated in part by the addition of an electronic form on our website; however there has also been a substantial increase in the number of letters and telephone calls received.

During 2011/12 we handled 688,714 emergency and urgent telephone calls and undertook 401,097 PTS journeys – that's more than one million patient interactions. During that period we received 278 formal complaints, which equates to one complaint for every 3,920 contacts.

Every formal complaint we receive is thoroughly investigated, and in each case the investigating manager tries to speak personally to those concerned, visiting complainants at home in many cases. Following each investigation, we consider whether we feel the complaint was justified, part justified, unjustified or unproven. At the point of writing, investigations for 251 of the 278 complaints for this year had been concluded, with outcomes as follows:

Outcome	Numbers	Percentage of total
Complaint justified	87	31.29%
Justified in part	83	29.86%
Complaint unjustified	65	23.38%
Unproven	16	5.76%
Not yet concluded	27	9.71%
TOTAL	278	100%

Once the enquiries are complete, a full explanation, along with an apology where appropriate, is sent by the Chief Executive to the complainant.

Many of people who contact us with queries, questions or concerns prefer to have them dealt with less formally, and these are handled by our Patient Advice and Liaison Service (PALS) team. PALS provides an opportunity for those who don't necessarily want to make a complaint but have a query, concern or just need information.

Complaints and PALS concerns help us to identify areas where improvements to quality and services can be made and, wherever possible, steps are taken to implement changes as a result. We also ensure that this learning is spread throughout the Trust.

PALS and complaints data are analysed and reports provided to our Trust Board, our commissioners, and our Risk Management

and Clinical Governance Committee (RMCGC) on a regular basis. The bi-monthly board report is available from the Board Papers section on the Trust's public website.

The Trust also has a Professional Standards team, which works closely with the Patient Experience team to ensure that learning outcomes from our investigations are shared across the whole organisation. We place great emphasis on learning from complaints and every effort is made to take all the steps necessary to help prevent similar situations recurring. All recommendations made by investigating managers are recorded on an action plan, which is distributed monthly to senior Trust managers. No action is removed from the plan until it has been completed.

During 2011/12, PALS handled 3,015 enquiries and, as mentioned earlier, 1,181 of which were compliments.

In addition to the information we receive from PALS, complaints and compliments, we also proactively seek patients' opinions and experiences. As one of our Quality Account priorities for 2011/12, we carried out two patient satisfaction surveys. The surveys were aimed at a selection of patients whose call had been resolved with clinical telephone advice or managed without transport to A&E, and the responses from the first, in August, were extremely encouraging. The second survey is still open as we write, and more are planned for next year.

We will also now be carrying out regular patient satisfaction services as a fundamental element of each of our Patient Transport Service contracts, with a view to continually improving the service we provide.

SECAmb has always involved patients and the public in the development of its plans and services, and recognises the importance of listening to their views and preferences as integral to service improvement. This year has been no exception and you can read more about how we are working hard to better involve a whole range of stakeholders in our plans, through the development of our Inclusion Strategy in the "Our Performance" section.

Incident reporting

The Trust complies with the National Patient Safety Agency (NPSA) framework relating to the investigation of serious incidents. A Serious Incident Requiring Investigation (SIRI) is defined as "an incident that occurred in relation to NHS-funded services and care resulting in one of the following:

- Unexpected or avoidable death of one or more patients, staff, visitors or members of the public;
- Serious harm to one or more patients ,staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/ medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm (this includes incidents graded under the NPSA definition of severe harm);
- A scenario that prevents or threatens to

prevent a provider organisation's ability to continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or IT failure;

- Allegations of abuse;
- Adverse media coverage or public concern about the organisation or the wider NHS.

Between 1 April 2011 and 31 March 2012 the Trust reported 40 Serious Incidents Requiring Investigation. The breakdown of these is as follows:

Category	Number
Ambulance (General)	19
Ambulance Accidental Injury	1
Ambulance Delay	8
Confidential Information Leak	4
Drug Incident General	2
Hospital Transfer Issue	3
Other	3
TOTAL	40

These incidents are reported to the Department of Health via the Strategic Executive Information System (STEIS). We conduct thorough investigations to determine the root cause of the incidents, identify learning points and implement actions to prevent a recurrence. The investigations are reviewed by the Primary Care Trust to whom we have to report all learning points and provide copies of the investigation reports. Once they are satisfied with the investigation they will then close the incident.

All Serious Incidents Requiring Investigation are reported to the Risk Management and Clinical Governance Committee, commissioners meetings and the Public Board. These are monitored, in order to identify any trends, however, to date no trends have materialised which would affect the delivery of patient care across the Trust

Our patients. . . .making our services even better

As a clinically-driven organisation we are continually striving to improve the service we provide to patients through clinical innovation and developments. A number of the key areas of development undertaken in 2011/12 are outlined below.

Paramedic Practitioners - Telemedicine

Over the course of the year, we have continued to work with Queen Victoria Hospital on the Telemedicine project; this allows paramedic practitioners to send clinical images of injuries to specialists at the Queen Victoria Hospital who can then provide detailed care, advice or even request that the patient be admitted directly to them, thus avoiding A&E. We have made over 60

referrals using this system this year and we are working on a Phase 2 project to further promote this exciting pathway for patients across our region.

Paramedic Practitioners are also providing more and more clinical support to colleagues for all kinds of incidents, working together to make the care we deliver as safe and effective as possible.

Major Trauma pathway

In 2011/12 there has been much work towards the establishment of Trauma Networks across the SECAmb area. SECAmb is involved in South West London and Surrey Trauma Network, the Sussex Trauma Network and the South East London, Kent and Medway Trauma Network. The networks covering Surrey and Sussex went live on 2 April 2012, with a date yet to be confirmed for the go-live in Kent.

To support the roll-out of the new arrangements for trauma care the Trust has produced an education package for clinical staff which explains the use of the Major Trauma decision tree.

pPCI for ST Elevation Myocardial Infarction (STEMI)

Clinical developments in the care of patients who are having a heart attack means that in preference to thrombolysis, primary angioplasty is being used to unblock the artery carrying blood to the heart, rather than dissolving the clot using drugs. During 2011/12 further pPCI services have been introduced on a 24/7 basis across the South East Coast region. The Trust Board agreed a stance in November 2011 that it would not support any hospitals that did not provide pPCI services on a 24/7 basis, and that alternative arrangements would be made to take patients to a hospital that could provide this. For Stroke and pPCI, SECAmb has engaged fully with the relevant Managed Clinical Networks in all parts of the SECAmb area.

Stroke pathway

Stroke services have undergone a considerable change in the last 12 months. Thrombolysis is now available either in person or by the use of telemedicine across most of the hospitals in Kent. This means that the complex set of diverts and rotas has now been much simplified which not only allows for faster times for patients to receive the appropriate care but also keeps crews in assigned response areas. In Surrey a similar model is in place, with the last hospital going operational on a 24/7 basis in February 2012. Thrombolysis is available across East Sussex, Brighton and parts of West Sussex on a 24/7 basis; assurance has been provided by Western Sussex Hospitals NHS Trust that the service will be expanded to cover the entire area by July 2012. We are currently trying to negotiate a standardised set of thrombolysis criteria across the region.

Pre-Hospital Thrombolysis

Although this has now been withdrawn, as the standard model of care across the region is primary angioplasty, Critical Care Paramedic

crews will maintain a small stock for use in special circumstances under medical guidance. In addition, contingency plans have been made to use thrombolysis during severe weather episodes where the timely transport of patients to a pPCI centre may be prevented; again this would be done under close medical supervision.

Our patients…highlighting lives saved

In September 2011 the Trust held its first ever survivors' event.

Eight patients who would not be alive today if it had not been for the clinical interventions of SECAmb staff attended the event which was held at Leeds Castle near Maidstone in Kent. Joining staff and patients was BBC journalist and BBC's Real Rescue host, Louise Minchin, who along with Chairman, Tony Thorne, and Chief Executive Paul Sutton, had an opportunity to meet and hear the survivors' stories first-hand.

One survivor, Keith Aston, and Joanne Michaelides also shared their inspirational achievements following Keith's dramatic emergency.

Keith from Farnham in Surrey was cycling when he collapsed and suffered a cardiac arrest. A number of people rushed to assist Keith but it was not until Joanne who was passing in her car, stopped to assist that vital CPR started.

A community first responder and SECAmb clinicians arrived on scene shortly afterwards and carried on the treatment started by Joanne. After hospital treatment, Keith has gone on to make a full recovery.

At the event Keith said: "If it wasn't for Joanne, I wouldn't be here today because by the time the ambulance staff arrived it may have been too late. This clearly highlights how important it is that CPR is carried out immediately."

Following this event, Joanne and Keith have kept in touch and, with the support of SECAmb, the two have started a local campaign to see school children in the area taught basic life support.

Chief Executive, Paul Sutton said: "This was a wonderful opportunity to recognise the tremendous efforts of our staff and to celebrate the lives which have been saved as a result.

These are just a few of the many successes which take place across our region every day and are testament to how far the ambulance service has come on in recent years.

What is equally overwhelming is what has also been achieved as a result of these successes such as Keith's story and we would urge people to take up the opportunity to learn basic life support as you never know when you may need it."

Our patients…developing future services

Research and Development (R&D) is important to ensure SECAmb is at the forefront of new and innovative clinical care. To ensure we can participate fully and build on the Trust's reputation as a respected R&D institute, we will be developing the skills and knowledge so that we are able to contribute to developing clinical care and leading in defining best practice.

A number of clinical developments are currently in progress; you can read more about these in the Quality Report but in brief, these include:

- The LUCAS Trial – a trial is underway during 2012/13 to evaluate the use of mechanical chest compressions that may aid the survival of those patients who suffer the most severe cardiac arrests. The equipment being used to support this study is called the Lund University Cardiopulmonary Assist System (LUCAS 2TM).
- i-STAT Blood Gas Analysis – the introduction of the ISTAT blood gas analyser will enable Critical Care Paramedics to undertake blood tests that would normally be undertaken in hospital,
- Research with Heart Attack Patients Project – this has been one of the milestones for SECAmb as it is the first, portfolio adopted clinical trial that SECAmb has undertaken. This study focuses on patients having an ST segment elevation myocardial infarction (STEMI).
- TIA Project - In a joint research project between SECAmb and the University of Surrey, funded by South East Coast Strategic Health Authority, the Trust is undertaking an evaluation study of the ABCD2 score in the pre-hospital assessment of patients with suspected Transient Ischaemic Attack (TIA). This evaluation study is looking at the implementation of the ABCD2 score which has been widely implemented but has not yet been prospectively validated in the context of pre-hospital care. The objective of this study is to externally validate the ABCD2 score as a tool for identifying patients with suspected TIA, assessed by ambulance staff in the pre-hospital setting, who are at high risk of stroke within seven and 90 days.

Our performance

This section reports on our performance, considering operational, clinical and financial aspects. In addition, it sets out our performance, as assessed by our various regulators, including Monitor and the Care Quality Commission, and also includes our sustainability report.

Our performance….getting to as many patients as quickly as possible

Response Time Performance

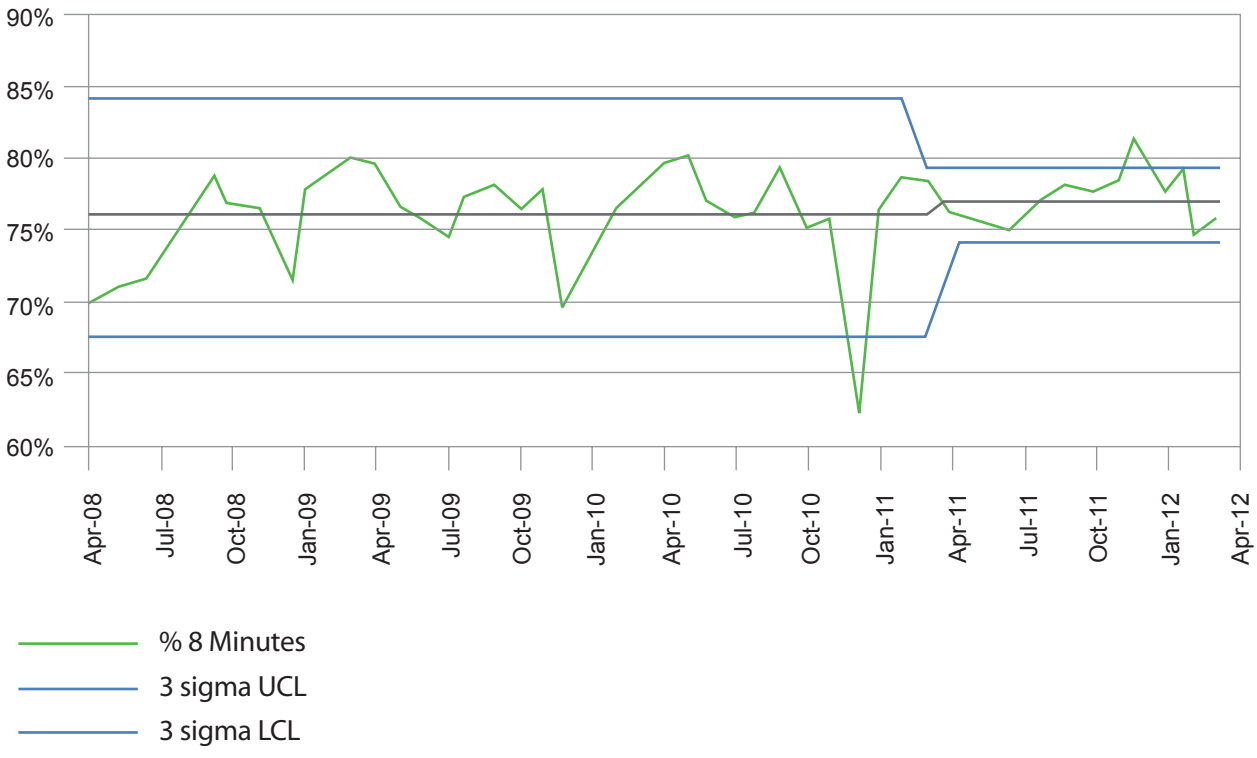
Ambulance services in England are subject to some of the most demanding response time targets in the world, requiring "Category A" life-threating calls to receive a response within eight minutes 75% of the time and within 19 minutes 95% of the time.

Providing quick response times is dependent upon what we do to ensure that there are sufficient staff and vehicles on duty every hour of the day and that the available vehicles are positioned near to the next patient before the 'phone rings.

In the year 2011/12, 77.6% of Category A calls received a response within eight minutes and 98.1% received a response within 19 minutes. This represents the best performance since the Trust was founded in 2007. It also confirms that we are providing some of the quickest response times of any ambulance service in England.

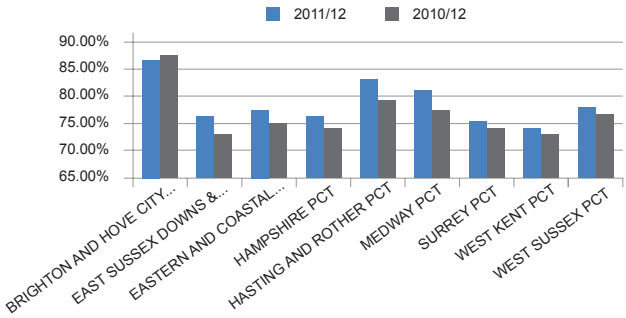
We have stated our commitment to improve our response performance, so we provide reliable response times no matter when or where you need us. The following graph shows that the variation month-on-month, shown by the light blue lines, has reduced significantly following the changes we have made.

Category A Performance by Month



In addition to our own staff, we also received support from community first responders across our region. As well as providing speedy support to patients prior to the arrival of ambulance clinicians, they also contributed approximately 2% to our response time performance. We will be looking to significantly increase this during 2012/13.

We have also worked hard during the year to ensure that, as far as possible, patients in our area receive an equitable and responsive service. Response times have improved in each PCT area across the Trust, with the exception of a slight reduction in Brighton & Hove. This reflects our commitment to ensure that rural and urban areas are served equitably.



Use of private providers

In order to help us provide extra capacity when needed, the Trust utilises capacity from Voluntary Aid Societies and private ambulance providers to support predicted periods of increased demand (e.g. winter planning) and at short notice when activity increases above planned levels. They can also be used to cover where there are staff vacancies that cannot be covered by overtime or bank staff.

All of these providers went through a rigorous evaluation process including review of CQC registration and clinical competencies, led by our clinical team, before we used them.

Over the course of the year they have made up around 6% of the front-line A&E hours provided by the Trust.

PTS

During our busiest period between October and December 2011, we also used basic life support staff and vehicles from our Patient Transport Services team to support the transport of emergency patients when needed and to free up crews to carry out more face to face and urgent work. This meant we needed to use the services of private providers to back-fill gaps in our patient transport services provision.

Moving forwards, we are working on developing a basic life support tier to be implemented during June 2012 and a further tranche of support to be in place before October. Rather than PTS being back filled with private providers we are recruiting additional staff on both a permanent and bank basis to ensure that the patient transport contracts are fully supported in the future without reliance on private providers.

Our performance…improving treatment and outcomes

Clinical Performance Indicators (CPIs) are collected by all ambulance services; four indicators are collected on a rolling cycle with each indicator being measured twice a year, underpinned by a number of metrics.

Data is collected by individual trusts and collected nationally. The performance of trusts is then compared, and the final report for each cycle is then published by the National Ambulance Service Clinical Quality Group. Throughout the year SECAmb submits on-going summary performance reports to the Risk Management and Clinical Governance Committee and the Commissioners.

In 2011/12, two cycles of data were collected and submitted, which enabled the measuring and benchmarking of performance against the four CPIs that contribute to the Quality of Care rating and which monitored the management of:

- Stroke - although Trust performance of 96% against the care bundle was a drop of 1.5% on Cycle 7 it was on a par with the national mean;
- Hypoglycaemia - the Trusts performance for the care bundle is at 100% which remains above the national performance of 95.4%;
- Asthma - overall, the Trusts performance for the asthma care bundle continues to remain above the national mean of 72.4% at 78.7%;
- Acute Myocardial Infarction (STEMI) - overall the Trust continued to maintain performance against the care bundle. National performance was at 78.8%, with the Trust achieving a significant increase from Cycle 7 to 84.3%.

Discussion is currently underway nationally to agree the new conditions that will be reported on by ambulance trusts and the indicators that these will comprise, with the intention to introduce these by December 2012. The first conditions are likely to be management of trauma in patients with below knee fractures and febrile convulsion in children.

Clinical Outcome Indicators (COIs)

The 2011/12 Operating Framework has seen the national performance standards evolve, with an increased focus on outcome measures.

Data relating to patient outcomes is collected from the twelve ambulance trusts in England and aims to measure the overall quality of care to patients and the clinical outcomes of care provided. The data is used by the Department of Health for performance monitoring purposes and is submitted by trusts every month.

By April 2012, data had been submitted for the period April 2011 to November 2011. This summary report focuses on performance for the month of November 2011 (which was the last return at the time of writing), and year to date performance to this point. This indicator information is published internally on the Clinical Quality Indicator Dashboard.

	Clinical Outcome Indicator			November 11			YTD (April –Nov 11)		
				Nat %	Trust %	Var %	Nat %	Trust %	Var %
1	Outcome from cardiac arrest	A	Return of spontaneous circulation (ROSC) on arrival at hospital (All)	21.3	32.3	+11	22.9	27.3	+4.4
		B	Return of spontaneous circulation (ROSC) on arrival at hospital (Utstein)	42.7	59.1	+16	44.1	52.5	+8.4
2	Outcomes from Acute ST-elevation myocardial infarction (STEMI)	A	Proportion receiving thrombolysis within 60 minutes	48.6	100	+51.4	53.6	100	+46.4
		B	Proportion receiving primary angioplasty within 150 minutes	91	94.8	+3.8	89.6	96.2	+6.6
		C	Outcome from STEMI (Care bundle)	75.2	92.0	+17	73.2	78.8	+5.6
3	Outcome from cardiac arrest	A	Survival to discharge – all	5.7	4.9	-0.8	6.7	5.7	-1.0
		B	Survival to discharge - Utstein	20.7	21.4	+0.7	22.2	24.5	+2.3
4	Outcomes from Stroke for Ambulance Patients	A	Proportion of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyper acute stroke unit within 60 minutes	48.6	69.6	+21	53.6	67.6	+14
		B	Proportion of suspected stroke patients assessed face to face who received an appropriate care bundle	95.5	94.0	-1.5	93.3	94.7	+1.4

1. ROSC is calculated for two patient groups: The overall rate measures the overall effectiveness of managing care for all out-of-hospital cardiac arrests; the rate for the Utstein comparator group provides a more comparable and specific measure of the management of witnessed cardiac arrests only.

2. Survival to Discharge: As with the Return of Spontaneous Circulation, survival to discharge following cardiac arrest is reported separately for all patients, and for the subset of patients in the Utstein comparator group

Our performance. . .using our resources effectively

This part of the report is about the Trust's financial performance in the period from 1 April 2011 to 31 March 2012. Our accounts for this period are attached at Appendix B. They are also available for downloading from the Trust website.

Income and Expenditure Position

The Trust made a surplus of £3.5m (2.1% of turnover) for the year ended 31 March 2012. The planned surplus for the same period was £3.2M.

Summary Financial Position year ended 31 March 2012			
Figures are subject to rounding	£M		
	Budget	**Actual**	**Variance**
Income	165.1	170.0	**4.9**
Operating Expenses	148.5	153.4	**4.9**
EBITDA	16.6	16.6	**0.0**
Interest, depreciation, and dividend	13.4	13.1	**(0.3)**
Retained Surplus/ (Deficit)	3.2	3.5	**0.3**

Overall the Trust performed in line with the expectations in our plan and Long Term Financial Model. The Trust continued to invest in the key areas of paramedic skills as well as the development of the Front Loaded Service Model, Make-Ready infrastructure and Hazardous Area Response Team (HART).

Income

Income over budget included monies relating to the funding of HART which came earlier than planned, and revenues from insurance recoveries in Road Traffic Accidents. However the underlying position with income is more challenging. The Trust is no longer funded externally to provide cover for paramedic development via the Non-Medical Education and Training (NMET) budget and has chosen to meet these costs internally as this is a key part of our strategy. The additional funding from HART relates to accelerating the investment in the temporary arrangements for Gatwick and the Channel Tunnel HART coverage.

Looking to the future we have two further areas of challenge in our core business of A&E. The Operating Framework introduced a tariff deflator (effectively a price reduction) of 4% for the year 2012/13 (1.8% after adjusting for inflation) and we expect similar price reductions in future years. Additionally our commissioners are challenging us to raise the level of 'Hear and Treat' response which reduces our overall income in future years. As a result we expect reduced income over the next few years.

We established the necessary steps to build a firm business in Patient Transport this year, securing the contract to continue to provide PTS in Sussex and winning the contract to provide services in Surrey, which takes effect from 1 October 2012. This is a key strategy that has involved us rethinking our product

offering to make it fit for purpose.

We have tendered a bid for the 111 contract for Surrey, Sussex and Kent with our partners, Harmoni. If we were to win this bid, we would expect to see income from April 2013.

Expenses

The expenses over budget included investments to maintain clinical training after a reduction in previous funding, investments to ensure operational delivery over the peak winter months, and investments to support the development of 111 and PTS activities and the spend associated with the HART program.

Going forwards we recognise that we will need to continue to deliver improved efficiencies to counter the price pressure from the Operating Framework deflator and from the Hear and Treat changes as well as to ensure that we have resource to support key investments in people and infrastructure. We will aim to do this through the Cost Improvement Programme which is detailed later in this report.

Our Capital Spend in the period was £11.0m. The original planned capital spend was £8.7m. This plan was then adjusted with the Department of Health providing additional Public Dividend Capital of £2.1m for HART vehicles and £0.2m for Resilience vehicles and equipment. The principal investments were Make Ready, vehicles replacement and HART. We expect to continue to make significant capital investments in the next four to five years as our estates program moves forward, but we are confident that our underlying cash generation will allow us to provide for these investments.

Our cash balance at the year-end was £22.4m. The plan was £17.6m. The principal cause of the difference was the timing of payments in and out relating to the HART investment.

Prudential Borrowing Limit

During the period the Trust was set a Prudential Borrowing Limit of £27.5 million.

Working Capital Facility

During the period the Trust had access to a Working Capital Facility of £13 million. The Trust has not needed to use this facility during the period.

Going Concern

As part of the approval of the annual accounts, the Board of Directors has considered the current and future financial risks facing the Trust. They have concluded that the Trust is clearly a going concern and have authorised the preparation of the accounts on that basis.

Accounting Policies

The accounting policies for the Trust are set out within Appendix B.

Our performance….meeting our regulatory duties

CQC registration & inspection

SECAmb has maintained its registration with the Care Quality Commission (CQC) in accordance with the requirements of the Health and Social Care Act 2008 and are registered to provide:

- Treatment of disease, disorder or injury
- Transport services, triage and medical advice provided remotely
- Diagnostic or screening procedures

On 12 January 2012 SECAmb were subject to an unannounced inspection which was part of the CQC's routine schedule of planned reviews. During their visit, the inspectors visited the administrative offices at Coxheath and the Paddock Wood, Ashford and Thanet Make Ready Centres, as well as the William Harvey Hospital, Ashford and the Queen Elizabeth Queen Mother Hospital, Margate. At these locations the inspectors spoke to our clinical staff, support staff who clean and restock the vehicles and patients to assess our service delivery was of a consistent standard.

Initial feedback identified that information provided at Coxheath supported that given by our clinical staff, that we were compliant in all areas and were safe to continue to provide our services without restriction.

We identified that there were concerns regarding the delivery and recording of training particularly relating to safeguarding and we are looking to introducing new measures to ensure that this was on trajectory for completion.

Overall, the Trust was very pleased with how the CQC visit went. Despite a couple of areas being identified for improvement (see below), the overwhelming feedback was extremely positive.

Areas for improvement

The CQC have however identified that we should make improvements so that we maintain compliance with the essential standards of quality and safety as follows:

Outcome area	Action to be taken
Outcome 07: Safeguarding people who use services from abuse	Arrangements were in place ensure people were safeguarded from abuse and the risk of abuse but not all staff had received the necessary up to date training.
Outcome 14: Supporting staff	People received safe care and treatment from staff that were competent to do their job. There were some gaps in the monitoring of training at trust level and training records did not show that all staff had received the required up to date training to enable the trust to be assured that they had a thorough knowledge of current best practise and understanding of current legislation.

The Trust has developed plans to ensure that we can address these areas to maintain our compliance.

National Health Service Litigation Authority (NHSLA) Risk Pooling Scheme

SECAmb is a member of the NHSLA Risk Pooling Scheme for Trusts which is similar to an insurance scheme and provides cover for claims relating to Clinical Negligence, Employee and Public Liability Claims.

It is essential that we provide safe care to both our patients and our staff and to provide the appropriate framework for a safe environment we are assessed by the NHSLA against the Risk Management Standards. These comprise five standards relating to Governance, Learning from Experience, Competent and Capable Workforce, Safe Environment and Ambulance Services, each standard has ten elements and therefore equates to 50 elements.

We are formally assessed against these standards by the NHSLA auditors and can achieve four levels of proficiency:

- Level 0 – unsuccessful or inappropriate risk management
- Level 1 – The Trust has documented policies and processes for managing risks
- Level 2 – The processes described at Level 1are in use
- Level 3 – The process for managing risk is working across the organisation

All trusts must be assessed commencing at level 1, those unsuccessful are moved to level 0 given advice on where to improve and have to be reassessed within six months.

SECAmb has been assessed by the NHSLA at level 1, this is in common with the majority of other ambulance trusts and it is our intention to progress to level 2. Our next assessment is due at the end of November 2012.

IG Toolkit

The Trust is required to achieve a minimum of level two in each of the 35 criteria in the Information Governance Toolkit, in order to achieve a 'satisfactory' grade. For 2011/2012 the Trust submitted and published a Level 2 attainment; this comprised 23 criteria assessed at Level 2 and 12 at Level 3. Overall, the score achieved by the Trust was 78%, which was classified as a satisfactory grade. Attainment of Level 2 provides assurance that the Trust has systems and processes in place to minimise risks in relation to information governance, and that the Trust is able to fulfill the requirement as set out in the 2012/13 NHS Standard Contract for Acute, Ambulance, Community and Mental Health and Learning Disability Services.

Monitor Risk Ratings

The tables below summarise the rating performance throughout the year and compared to prior year. As we were only authorised as an FT on 1 March 2011, the figures in the first table below are for indicative purposes.

	Annual Plan 2010/11	Q1 2010/11	Q2 2010/11	Q3 2010/11	Q4 2010/11
Financial Risk Rating	4*				4
Governance Risk Rating	Green				Green

*As a first year Foundation Trust the Trust is limited to a Financial Risk Rating of 4

Green: - is defined as no material concerns.

	Annual Plan 2011/12	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q4 2011/12
Financial Risk Rating	4	4	4	4	4
Governance Risk Rating	Green	Green	Green	Green	Green

Green: - is defined as no material concerns.

We maintained our Monitor financial and governance risk ratings throughout the quarters. We paid particular focus to delivery of our Category A 8 minute performance which was highlighted as a specific requirement when we were licenced as a Foundation Trust by Monitor.

Our performance….ensuring sustainability and protecting the environment

The Trust understands that it has a national responsibility to reduce its carbon footprint and also recognizes that this is an enormous challenge. In response to this challenge the Trust has appointed an Environmental Sustainability Manager to lead the Trust in this area.

Managing Sustainability Performance

Work is underway to revise the 2010 Board approved Sustainable Development Management Plan which sets out the corporate framework for carbon reduction based on the national NHS requirement for all Trusts to reduce their carbon footprint by 10% by 2015 on a 2007 baseline. The Trust's Climate Change Adaptation Plan is also being revised in order to ensure alignment with the Government's latest National Assessment Report and updated regional scenario information. Performance management of both of these plans is overseen by the Trust's Local Resilience Group which reports to the RMCGC.

We have an extensive capital build programme underway and a key challenge is to ensure that the new Make Ready Centres are of the lowest carbon specification we can achieve. The two fully operational centres at Paddock Wood and Ashford have been awarded with BREEAM standards Very Good and Excellent respectively.

Addressing climate change

Our carbon footprint is currently under review. We are very conscious of the need to develop better information collection systems for all our impacts so that we can measure, monitor and report on carbon accurately as well as to equate carbon reduction to cost savings.

Adaptation

The Trust is in the process of reviewing its Climate Change Adaptation Plan. The updated plan will ensure alignment with;

- the UK Climate Change Risk Assessment published 26 January 2012
- the National Adaptation Programme (NAP) in particular with the regional and thematic scenarios
- the Heatwave Plan for England

The Plan will also make the case for safeguarding business continuity by developing a fleet of vehicles that do not rely solely on diesel fuel in order to operate, and without operational risk.

Future priorities and targets

We must act to ensure that we are insulated as much as possible from energy and fuel cost volatility. We are also assessing low carbon alternatives to traditionally fuelled vehicle transport which can deliver our services without any compromise to patient care.

We remain very conscious of the need to win staff 'hearts and minds' in relation to this agenda and to ensure that we 'take staff with us' at all times in the progress we make. We recognise that we can't make the resource and carbon savings that we need to without the full support and participation of staff across the organisation. As a start for this engagement process we will publish the revised Sustainable Development Management Plan on the intranet and invite staff to comment and contribute to ensure that they have their say and feel comfortable with its implementation.

We spend £50 million purchasing products and services every year. We estimate that around 50% of our total carbon footprint is a result of the goods and services we purchase. By applying the principles of carbon reduction to our procurement activity purchasing decisions can contribute to the achievement of sustainable development goals such as reduced energy consumption, reduced carbon dioxide emissions, waste minimisation and fair and ethical trade and social justice.

Our performance…valuing differences

The Trust has made considerable investment in understanding the changes that could be made to promote equality and diversity, promoting fairness, respect, dignity and a better experience for those we work with and for. We are a major contributor to the work of 'Pacesetters', a Department of Health programme aimed at reducing health inequalities.

The Trust is focusing on:

- Increasing BME (Black and minority ethnic) representation in the workforce

- Palliative Care with the Sikh community (Kent)
- Stroke Rehabilitation – with BME communities

The year 2011/2012 has seen substantial progress in embedding equality, diversity and human rights into core SECAmb business activity. It has been a year of change and development as we responded to the challenges of the New Equalities Act and the migration from a Single Equalities Scheme to the new NHS Equality Delivery System (EDS).

The General Equality Duty placed on all public bodies was the first phase of legislation from the Equality Act 2010, stating 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"

The Equality Act 2010 expanded the definitions of protected characteristic groups that were protected within the law, pulling together existing legislation to form one, more comprehensive duty. The nine "protected characteristics" are as below:

- Age
- Sexual Orientation
- Religion & Belief
- Race
- Pregnancy & Maternity
- Marriage & Civil Partnership
- Gender Reassignment
- Gender (Sex)
- Disability

In 2011, the next phase of the legislation described the specific duties placed on public bodies. In order to be compliant with the Equality Act 2010, public bodies must deliver the following specific duties:

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

Following a review, a new governance process was implemented in April 2011 which saw the establishment of an Inclusion Working Group set up to steer the Inclusion, Equality and Diversity agenda in relation to both staff and patients. It provides support, advice, assurance and governance to staff who are responsible for Inclusion, Equality and Diversity and has a direct reporting line to the Board through the Workforce Development Committee.

The Inclusion Working Group is committed to promoting, recognising and valuing the diverse nature of our communities, stakeholders and staff, and removing or minimising inequalities of access and discrimination, to enable the Trust to meet the needs of patients. The group has overseen the implementation of the Equality Delivery System,

following the commitment by the Trust Board in August 2011 to implement it with effect from April 2012.

The Equality Delivery System framework is designed to support NHS commissioners and providers to deliver better health care outcomes for patients, communities and better working environments for staff that are personal, fair and diverse. Its purpose is to help us understand how equality can drive improvements to strengthen performance and accountability of services to those using them, bring about work places free from discrimination and help to embed equality into mainstream business.

We have used the Equality Delivery System to help meet our duties and in particular to determine five equality objectives published in April 2012 as required by the Public Sector Equality Duty. These are detailed below:

Overarching objective

The Trust's overarching objective will enable us to achieve the objectives below. To provide the best possible patient care, we know it is essential to understand the needs of the communities we serve and ensure they are involved in developing services that meet those needs. We also know the importance of staff wellbeing, and the value of involving staff in service improvement. We will implement an "Inclusion Strategy" (see below) which will set up a simple structure to ensure appropriate engagement and involvement with patients, staff and other stakeholders informs our work.

Objective 1

Recognising the current changes in our commissioning environment and across the health economy, the Trust will collate and analyse the latest available data about the healthcare needs of our population and priorities in the South East Coast area to ensure that our plans impact positively upon identified health inequalities.

Objective 2

To provide equitable access to care and treatment and to ensure we develop relevant alternative care pathways and tailor existing care, The Trust will establish a minimum set of equality data.

Objective 3

The Trust develops a statement, for and in consultation with our staff, which confirms and clarifies our commitment to equal opportunities, valuing diversity and embracing dignity and respect for all our staff.

Objective 4

The Board has oversight and ownership of the Equality Objectives, and are assured of their own competence in managing equality and diversity across the Trust. Leaders at all levels throughout the Trust play their part in delivering our commitment to equal opportunities, valuing diversity and embracing dignity and respect for all.

Each objective will be supported by a one-year action plan, and the objective and action plan will be reviewed and refreshed annually. We will do this in conjunction with our community of interest, a diverse representation of patients, public, staff, members, governors

and other stakeholders.

Key achievements during the year have included:

- the introduction of a new Equality Impact Analysis processes;
- the strengthening of our engagement processes through the development of a new Inclusion Strategy for the Trust;
- the strengthening of our data collection, monitoring reports and workforce information;
- the continued emphasis we have placed upon Equality and Diversity training for our employees which ensures all new staff joining the organisation receive
- appropriate training and all existing staff routinely receive refresher training;
- the launch and use of a new cultural competency DVD, integrated into our key skills mandatory training cycle;
- implementation of the NHS Equality Delivery System;
- significantly increased our ranking in the Stonewall Work Equality Index
- continued to demonstrate our commitment to retaining the 'two tick' accreditation
- continued to participate in national, regional and local networks to share and develop best practice;
- our Chief Executive, Paul Sutton has continued to Chair the National Ambulance Diversity Forum, which delivered a national conference to support the implementation of the Equality Delivery System;
- developed robust partnership arrangements with organisations who will work with us to ensure some seldom heard communities are not disadvantaged by any decisions that may affect them e.g. Gypsy and travellers, learning disability, transgender organisations etc.

Stonewall DIVERSITY CHAMPION

POSITIVE ABOUT DISABLED PEOPLE

Taking part in the Stonewall annual index provides us with an opportunity to demonstrate our commitment to advancing equality and embedding human rights in SECAmb]

Developing a Inclusion Strategy

As referenced above, during the year we embarked on a significant piece of work to develop a new Inclusion Strategy which efficiently integrates our membership involvement and engagement with our patient and public involvement and equality and diversity engagement work.

As part of this development, we have run a series of workshops and focus group. At these workshops, we asked members (staff and public), governors and other stakeholders (for example members of Local Involvement Networks (LINks) and staff from other NHS Trusts, Local Authorities and the voluntary sector) about their preferences for involvement.

A survey (with responses from more than

600 stakeholders including at least 150 staff, 80 patients, 70 FT members and 60 volunteers) was also undertaken and we held focus groups with people from special interest groups. The resulting strategy incorporates their recommendations about how the Trust should involve and engage.

Our strategy is to embed a simple mechanism in the Trust which enables involvement and engagement with the right people, at the right time, in the right way. We will make it easy for the Trust to benefit from stakeholder engagement, and easy for stakeholders to get involved.

When implemented, the strategy will deliver a single, inclusive Inclusion Hub Advisory Group made up of a representative group of stakeholders. These stakeholders will include patients, staff, governors, Foundation Trust (FT) members, volunteers, people from other NHS organisations and voluntary/community partners, and people with protected characteristics (or their representatives).

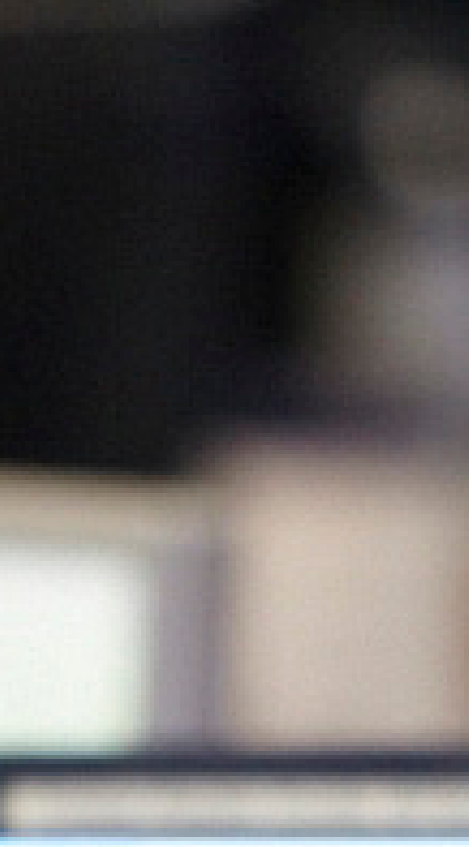
The Advisory Group will advise the Trust on effective engagement and involvement relevant to significant service development planning and implementation, annual planning and other annual engagement such as the Quality Accounts, significant workforce and volunteer developments, and patient experience. The Advisory Group will also work with the Trust to advise on the implementation of the Equality Delivery System and invited to participate in Equality Impact Analyses.

Members of the Advisory Group will be drawn from a broader 'Inclusion Hub' which comprises staff and public FT members but we also recognise that there are groups and communities who will always struggle to be heard. We have put in place partnership arrangements with the following organisations to eliminate these gaps, who have agreed to work with us to ensure our work reflects the needs of those they represent:

- Friends, Families and Travellers – representing the interests of Gypsies and Travellers
- The Aldingbourne Trust – representing the interests of people with learning disabilities
- Surrey Coalition of Disabled People – representing equality of opportunity and independent living for disabled people
- Gender Identity, Research and Education Society – representing the needs of trans people

By working with a diverse membership in the Advisory Hub, we will be provided with insight at the start of our planning, and throughout development where relevant, which will help us get more things right, first time, more of the time. The Hub will also be able to raise issues with us. The proposal links the Advisory Hub closely to the Trust's Inclusion Working Group of senior managers, so that the Hub's advice can be incorporated into Trust activities effectively. A patient and public representative from the Advisory Hub will sit on the Inclusion Working Group.


ULANCE



Our partners

This section sets out the work undertaken with key stakeholders, including the submission of a bid for provision of 111 services, as well as explaining how our services are commissioned. In addition, it covers work that has been undertaken during the year to develop an Inclusion Strategy, to support forthcoming engagement with a broad range of stakeholders. It explains our relationship with a diverse range of volunteers who support us in delivering our service.

Our partners. . . .working together

111

We partnered with Harmoni during the year to develop a service offering for the NHS 111 service in the South East Coast region. Our partnership is based upon sharing the skills that each organisation has in the areas of Emergency and Urgent Care. Our bid focused on providing a service that was safe, clinically sound and local with local clinicians involved in the delivery of the service. At the time of writing we were waiting to hear the outcome of our bid.

Patient Transport Services tendering / contracts

Patient Transport Services contracts have been running in Kent, Surrey and Sussex for a number of years. With a recent change to funding whereby the PTS element has been taken out of the national tariff paid to hospitals and remains with PCTs, the current contracting arrangements do not easily fit into this regime. At the same time, the numerous providers across all counties are working to different specifications, performance targets and are paid at different rates with no real control over the eligibility for access.

A good example of this is within Sussex where SECAmb held 15 different individual patient transport services contracts all with different requirements and at different costs to the trusts we worked for. It was recognised within Sussex that the contracts were all in need of tendering and it was felt that a more patient focussed, efficient and cost effective service could be secured by going out to a single tender for the whole of Sussex.

As part of this process the commissioners (Brighton and Hove PCT on behalf of all the users of PTS within Sussex) have set up a centralised booking service to ensure fairness across Sussex in providing access to the transport and also to act as the performance manager of the new contract and to maximise the efficiencies.

Tender details were published during August 2011 and the Trust had to submit its bid in November. The Tender was subsequently awarded to SECAmb in January 2012 with a go-live date for the new contract of April 2012.

The new contract requires the update of the fleet of vehicles with the procurement of 50 new vehicles underway for delivery during 2012; new information technology to be installed including network interfaces between the new Patient Transport Bureau and our own computer aided despatch system, as well as the introduction of PDA style technology for our crews to access their day's work. Around 40 key performance indicators have been developed covering areas of patient comfort, safety, security and timing of transport which the Trust will be held to account for delivering on.

The Trust was extremely pleased to keep the contract work that we were already undertaking as well as winning in a very competitive market against other national providers of patient transport services. It should be noted

that this has not been the experience in other parts of the country where the incumbent ambulance trust has not always kept their contracts.

The Surrey Tender was put out jointly with Surrey County Council for health and social care transport in a number of lots. The Trust has bid for the healthcare elements only and we were formally informed in May 2012 that our bid was successful. The new contract will commence in October 2012.

Kent are currently at the start of the process of going out to stakeholders to put their tender specification together. Their current timetable is to look to award the contract around October 2012 with a contract go live date of April 2013. This will mean we will be looking to put our submission in around July/August 2012.

Impact of Operating Framework 2012/13

The NHS Operating Framework is a national document that is published during December each year setting out the key principles, outcomes and areas of focus for the whole of the NHS. This provides the basis of discussions with our commissioners on the following year's contracting (for Accident and Emergency Services), identifying key areas that need to be commissioned and supplied. This helps to ensure that all NHS organisations are focussed towards the same overall goals and are working towards the same outcomes.

For us the NHS operating framework published in December 2010 formed the basis of discussions upon which commissioning for 2011/12 was based. This had a number of direct impacts on our services, for example including the commissioning of a second HART (Hazardous Area Response Team) to be based at Gatwick Airport. It also set out a number of financial assumptions as part of the Department of Health's drive to save £20bn pounds by 2015 across the NHS. This included setting us an efficiency target of 4% in year, or around £5.7m pounds and providing for the impact of inflation at 2.5% average or around £3.6m, giving a net reduction in our A&E income of 1.5% or approximately £2.1m pounds. This effectively meant that we were being paid less for each unit of activity that we carried out compared to the previous year.

The operating framework for 2012/13 was published in December 2011, but new to us this year was the introduction of a local NHS South of England operating framework which was published alongside the national document. Both documents identified the main impetus of what the NHS is looking to achieve in 2012/13. The national operating framework remains the over-arching framework, identifying key national goals for the year, for example an increased emphasis on dementia issues; whereas the NHS South of England focussed on regional issues, for example developing the Trauma Networks. The regional operating framework also set some slightly more challenging targets around efficiencies for trusts within its area, including SECAmb. The Department of Health have indicated that the current efficiency program will continue at similar or higher levels for the next few years (the national efficiency target is 4% in 2012/13 but the regional target is 4.3%)

This will continue to mean that the Trust must be very focussed on delivering higher activity levels, at the same or higher levels of clinical excellence within income that is reducing year on year. How we are aiming to meet this challenge is discussed in the section that covers the Trust's Cost Improvement Programme.

Commissioning

Commissioners are responsible in conjunction with the Trust for establishing what level and type of activity needs to be planned for to deliver the needs of the local population. For us, the commissioners are the South East Coast Specialist Commissioning Group and represent the eight PCTs that cover Surrey, Sussex, Kent and North Hampshire that as an Ambulance Trust we provide Accident and Emergency services to. This will include 'blue light' or '999' type responses as well as 'Hear and Treat' triage telephone calls over the phone and other activities. They also commission on behalf of the Department of Health for emergency planning input and HART (Hazardous Area Response Team) capability.

The commissioning process includes a discussion on the level and types of activity that we carry out over the year and forms the basis of how we plan our services; it also includes how we will maintain or improve our quality of care and how we continue to meet the needs of the patients within the area both now and in the future. It also includes discussion around how much the commissioners are willing to pay for the services and what support for future developments they are willing to give

We would say that whilst this is a robust process that gives the most effective, safe and efficient outcome to our patients it also remains a very positive and supportive process as both organisations work for the best outcomes for patients as well as the respective organisations.

For 2011/12 the South East Coast Specialist Commissioning Group commissioned over £145m of activity from the Trust.

We have also just successfully completed the negotiations for 2012/13 with our commissioners and our contract was signed off on 30 March 2012. This includes additional activity, some support for the Olympics, and the full year running costs of the second HART team. Where other organisations have not agreed activity growth we recognise the good work of our commissioners in identifying that activity continues to grow in our field, albeit at a much slower rate than in previous years, and that we both have a plan that we can effectively work towards meeting.

Volunteers

Within SECAmb, we are fortunate to enjoy the support of a wide range of volunteers.

We currently have over 300 active Community First Responders and 90 schemes across our region and during 2011/12 they have had a busy year. They responded to in excess of 18,000 calls, attended around 500 cardiac arrests and over 11,000 life threatening calls. During the year we also recruited over 200 new Community First Responders.

Following criteria from the British Heart

Foundation, we have also taken delivery and placed 244 defibrillators as Public Access Defibrillators during the year, in communities of high footfall, high cardiac arrest activity or areas of deprivation.

Our 38 volunteer chaplains continued to provide support to our staff during the year – both pastoral but also a friendly, supportive and confidential voice. The role of the chaplains is becoming more complicated, as we move towards larger Make Ready Centres but our aim is to improve the chaplaincy service we provide and to ensure this vital role and support is not lost.

This year also saw the formalisation of the relationship between the Trust and the four Retirement Associations, who provide invaluable support to retired members of staff. During the year all four associations have seen an encouraging increase in membership.

SECAmb is fortunate to enjoy support from a network of around 130 volunteer car drivers supporting the delivery of Patient Transport Services. Their support is key in the more rural parts of our region, where it is very difficult to run an effective and efficient service for patients travelling longer distances from more remote areas. Without the support of these volunteers we would be hard pressed to meet the needs of patients who have to travel in either very early, very late or greater than usual distances to make their appointments.

During 2011/12 with ever increasing costs of petrol and diesel our volunteer drivers expressed growing concerns over the impact that this was having on them in being able to support us. Whilst we tried to work with our volunteers we unfortunately did not reach agreement on this issue but have made a commitment to them to reach agreement around reimbursement rates for 2012/13.

Our Members

SECAmb has a total membership of 8,463 people as of 31 March 2012. We have 5,612 public members and 2,851 staff members. The public membership target for 2011/12 was 5,500 people, which we have exceeded.

Our Governors are committed to representing the views of their constituents, and to ensuring the Trust engages with and involves all stakeholders in our work where relevant.

Membership Eligibility

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. The geographical boundaries for public membership follow the boundaries in the map on page 140 (where we work).

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 and advised how they can opt out if they wish.

Membership Strategy, Engagement and Recruitment

This year, a lot of work has gone into revising

our Membership Strategy to focus on meaningful engagement and involvement between members and the Trust and members and Governors. Governors and members have been involved in the revision process and a new strategy, called an 'Inclusion Strategy', is going to the Board and Council for approval in May 2012. The Membership Development Committee has been part of the steering group for revising the strategy. You can read more about the Inclusion Strategy throughout this document.

Members and governors were also consulted about the Trust's development of Make Ready Centres, Annual Plans, the Equality Delivery System, Olympic planning and the Front Loaded Service Model, to provide them with real-life examples of the types of areas where we wish to work more closely with members in the future. This enabled us to get useful feedback in these areas while developing the strategy.

The focus of our work with the membership moving forward will be on embedding involvement and engagement with members across the Trust at the right time, and with the right level of accountability. Staff will be clear about when they should involve stakeholders and how to go about it effectively. Stakeholders will receive feedback on how their input has affected the way the Trust moves forward.

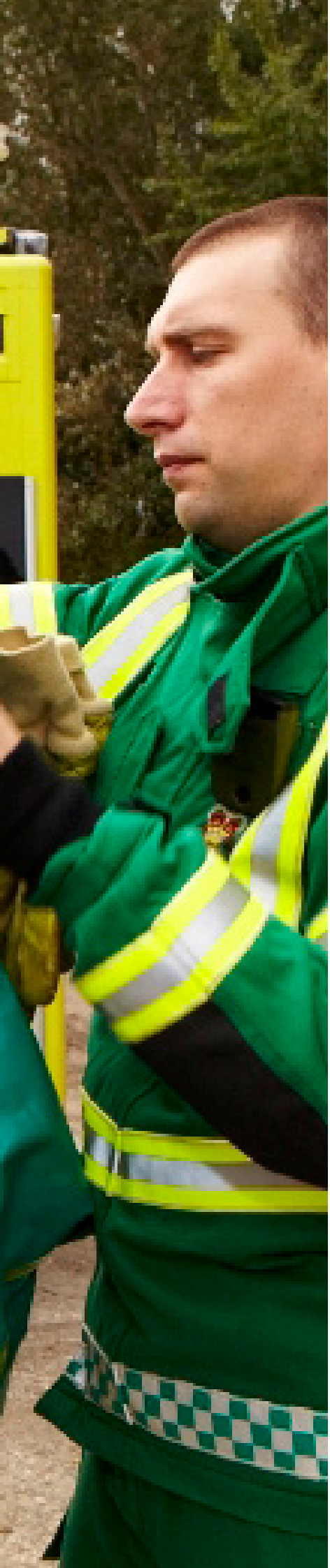
Governors and other SECAmb staff have also participated in a number of recruitment and engagement events throughout the year. Among these were the Kent County Show (where more than 200 new members were recruited in an area where we were previously less well-represented), the Sellindge (also in Kent) Community Fair, and the Woking (West Sussex) Health Event. We also attended and recruited at the Surrey Big Health Event run for and by people with learning disabilities, and the Woking (Surrey) Healthy Hearts event with members of the South Asian community. We also had a stall at Hastings (East Sussex) Older People's Black and Minority Ethnic People's Forum AGM. In addition, we ran ten focus groups with different special interest communities and recruited members at each, as well as engaging with them about developing the Inclusion Strategy. These communities included people with dementia and their carers, people with hearing impairments, young offenders, and patients who regularly use our Patient Transport Service.

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 members this year. The newsletter contains invitations to get involved with the Trust – for example by attending the workshops already mentioned, or our Annual Members Meeting. It also contains 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.

Staff members' engagement happens as part of wider engagement with staff throughout the Trust. Staff-Elected Governors are part of our Foundation Council, which is made up of staff form across the Trust and meets quarterly. This enables Staff-Elected Governors to understand and raise issues of relevance to staff.

The Trust is committed to undertaking an annual members' satisfaction survey, the first of which was sent to all members in March 2012. Results are still being collated however early feedback from 60 members suggests that the majority of members feel their membership gives them the opportunity to be involved with the Trust as they would like (58%) or partially as they would like (33%).


USAR
HART430



Our priorities

This section sets out some of the areas that we have identified as key priorities, both within 2011/12, and continuing into 2012/13 and beyond. Some of these pose significant challenges for the Trust, and we are developing robust plans to deliver these.

Our priorities. . .working on what is important

Tackling sickness

Sickness absence for the period 1 April 2011 to 31 March 2012 was 5.77%. The quarterly breakdown for this period is:

Quarter	Sickness absence %
Quarter 1 (1 April 2011 to 30 June 2011)	5.59%
Quarter 2 (1 July 2011 to 30 September 2011)	5.57%
Quarter 3 (1 October 2011 to 31 December 2011)	6.30%
Quarter 4 (1 January 2012 to 31 March 2012)	5.61%
Total days lost	58,815
Average working days lost during this period	21

The Trust is required by central government to submit sickness absence data in a form that permits aggregation across the NHS. This data is calculated nationally from the Electronic Staff Record data warehouse.

The Trust has recognised that reducing sickness absence levels is a priority for the Trust. So in 2011 a sickness reduction action plan was developed which included revision of the Sickness Absence Management policy with an emphasis on early support and intervention to staff who are sick.

Musculo-skeletal and stress are two of the highest reasons for sickness in the Trust and early medical intervention supports a quicker recovery period. Therefore referral to Occupational Health is immediate for these staff so that we can ensure a pro-active approach such as funding an MRI scan.

We work closely with our Occupational Health provider and have developed very successful absence management case conferences involving the Occupational Health Lead, Human Resources team and line managers. These are held every two weeks and provide the opportunity to ensure the correct support is being provided for each member of staff absent due to sickness.

The Occupational Health service is available to all staff and provides support, guidance and advice to managers and staff. This service is provided by an external provider as is counselling support. The confidential counselling service is available to all staff through self-referral.

A programme of absent management workshops took place in 2011 to equip managers with the tools to manage absence. In addition a comprehensive Absence Management Resource pack has been developed by Human Resources to provide managers with a detailed guide on all aspects of sickness absence management.

The sickness reduction action plan has been revised for 2012/13 and the focus of the plan is on manager responsibilities. Progress against the plan is monitored at the Workforce Development Committee and HR Business meeting.

CQC inspection – training

The CQC made an unannounced visit to SECAmb on 12 January 2012, and looked in particular at outcomes surrounding how we support staff, including the requirement that staff should be properly trained and supervised, and have the chance to develop and improve their skills.

Overall the findings were that we met all the essential standards of quality in this area although there were one or two suggestions on improvements to help us to maintain these standards.

As a result, a plan has been agreed for 2012 which includes:

- Publishing details of the Training Needs Analysis, identifying which subjects each group of staff needs to compete within what time scale
- Developing a prospectus showing all training and development activities available.
- Reviewing and updating the failure to attend procedure, and look at arrangements for notifying line managers of persistent non-attenders
- Introducing a dashboard to be updated on a monthly basis with uptake of training and development activities. This will inform all managers of the uptake in their area.

The Learning and Development team continues to support all staff in providing a range of in-house management, leadership, and personal development programmes in addition to clinical skills training and degree programmes at our partner universities.

Cost Improvement Program (CIP)

During the year we delivered significant Cost Improvements of £11.2m.

We commenced a workforce review in financial year 2010/11 which looked at the structure and staffing in all support functions. This resulted in some difficult decisions to reduce staffing in all of these functions as well as combining several directorates. This delivered a cost improvement of £3.4m in 2011/12.

Our operational efficiencies are delivered through tight management of our Unit Hour Utilisation. This is a productivity measure which is central to our management of front-line operations. The Unit Hour Utilisation is a measure which encompasses improvements in lost unit hours, handover, sickness and abstraction and structural changes to the provision of our services to meet the demands of our public. This delivered a cost improvement of £4.4m.

Efforts to reduce abstraction delivered £0.7m. Abstraction is the cost of non-productive time such as training and sickness. Some abstraction is necessary because we are committed to delivering a highly skilled workforce, but by focussing on the timing and effective management of training and on reducing non-value added abstraction we were able to deliver more front-line unit hours.

We made improvements to cost per unit hour of £0.6m. This included changes to on-call

rota payments and Hear and Treat.

The rest of the cost improvement comes from savings from procurement, infrastructure productivity and facilities.

For the year 2012/13 we have focussed on continuing to drive improvements in key operational areas including Hear and Treat, abstraction, See and Treat, procurement and again through focussing on Unit Hour Utilisation.

Vehicles

The Trust continues to improve fleet condition and effectiveness by standardising on as few vehicle types as is operationally viable, whilst recognising the needs of the patient and staff in the vehicle design. These factors reflect the changing model of care, the developing role of clinicians, improved patient safety through better infection control, the improvements of specialist equipment and environmental issues.

During 2011/12 new vehicles delivered included:

- 19 A&E ambulances
- 16 clinically-capable 4x4s (built to improve resilience during inclement weather)
- Four specialist HART vehicles
- Three specialist Bariatric vehicles (to deal with the unique requirements of larger patients)

In the near future the composition of the fleet is likely to change dramatically providing for more specialist and varied service delivery, supporting primary, urgent and emergency care.

Having vehicles and equipment which support this changing model of care rather than the traditional style of ambulance will also improve the environmental impacts our fleet has on the communities we serve and delivers better value for money.

Olympic planning

The Trust has been planning for the London 2012 Olympic and Paralympic Games since November 2009, working with internal and external stakeholders and partner agencies at both a local and national level.

The Olympic Road Cycling, Time Trial Cycling, Rowing Village, Paralympic Cycling and five days of the Olympic Torch Relay will be taking place within the SECAmb area; in total there will be 14 days of Olympic and Paralympic events taking place within the Trust, in addition to the normal range of public events which take place during the summer. Around 800 athletes and officials will be staying within the SECAmb area during the Games at the Olympic Rowing Village in Egham, Surrey.

A number of staff have the opportunity to take part in events locally and in London, and Jeannette Yeoell, Paramedic Practitioner, and Paul Everest, Clinical Team Leader will be among the 8,000 people to carry the torch in the relay across the UK ahead of the 2012 Olympic Games in July and August.

Over the past year agreement has been reached to support the London aspects of the Games with 28 staff from SECAmb providing medical care at Olympic events within

London. In order to provide this support and manage increased demand within the Trust a 15% leave restriction has been agreed for the three week period of the Olympics.

In the summer of 2011 the Trust contributed to the planning and operation of the London Surrey Cycle Classic, an international cycling event based on the Olympic route. This event was a success from both a clinical and a safety perspective, and the individual and organisational learning from the event is being applied to our planning for the Games in the summer of 2012.

Personal Appraisal and Development Review

Within SECAmb, we recognise that the delivery of high-quality patient care within the NHS critically depends on every member of staff:

- having a clear understanding of their role and the part they play in their team and department
- having an agreed set of priorities and objectives for their work
- possessing and applying the knowledge and skills they need to perform that role effectively and to achieve their objectives

Another key area of focus for the Trust was the area of appraisals. During the year, the Trust delivered appraisals for only 38% of staff (see table below) and recognises that this is below the level expected, as the majority of staff did not receive an appraisal.

Appraisals carried out between 1 April 2011 and 31 March 2012 (staff on career break, maternity leave and long term sick have been removed from the headcount):

Group	Description	Number of Appraisals since 1 April 2011	Headcount	% Appraisals completed
Operations	Ambulance Staff	712	1928	36.93
	Patient Transport Services	123	351	35.04
	Emergency Dispatch Centre	178	295	60.34
Non Operational	Support Staff	146	445	32.81
All Groups		**1159**	**3019**	**38.39**

We have named our appraisal process Personal Appraisal and Development Review (PADR) and on-going support is provided by our Learning and Development department to both managers and staff in the application of the process.

To ensure that we achieve a higher level of completion of appraisals across the Trust in 2012/13, managers have been working hard to improve both the process and the availability of staff to undertake appraisals. This has included reviewing and up-dating the paperwork to make it more user-friendly.

Hospital handover / turnaround

We have reviewed performance in 2011/12 in relation to patient handover, and this has been a close scrutiny item for the Trust Board. Geographically, the South East Coast region is the third worst performing area in the UK in terms of handover delays. This is one of the highest clinical risks for the Trust, due to the potential impact on both patient care and patient experience; this is reflected on both the corporate risk register, where this is the highest-rated overall risk, as well as on the Board Assurance Framework, which reflects the strategic nature of this risk.

In 2011/12 a new reporting system was instigated, based on the electronic capture of handover data. In addition, arrangements were put in place for monthly reporting of handover data to both commissioners and providers. Looking ahead to 2012/13, we are developing a revised handover policy, that will take effect on a South East Coast regional basis. This is based on recognised good practice, and has clearly stated escalation trigger points and compliance targets to achieve for both SECAmb and the respective provider organisations. This revised policy will be implemented from 1 July 2012.

CQUIN

CQUIN is a national framework for locally agreed quality improvement schemes. It makes a proportion of SECAmb's income conditional on the achievement of ambitious quality improvement goals and innovations agreed between commissioner and the Trust, with active clinical engagement. The CQUIN framework is intended to reward excellence, encouraging a culture of continuous quality improvement in all providers.

The SECAmb 2011/12 CQUIN Plan listed three goals, which were:

- Management of Conveyance - the aim was to reduce managed conveyance throughout the year from 64% to 60%, i.e. the number of avoidable patients being admitted to A&E departments
- Develop information and reporting to ensure ability to improve care - the aim was to develop a system where patients who were assessed face to face by our PPs and not conveyed to hospital should have a summary of the care they received sent to their GP. The second part was to devise a system whereby GPs/community providers could advise us of any health information which would assist us in caring for the patient if we received a 999 call with a view to rolling out in 2012/13
- Communications, patient experience and safety - the aim for the year was to carry

out two surveys for patients who were not conveyed to hospital. The survey was also a way of ascertaining the patient's perspective of the appropriateness of the non-conveyance or the alternative responses provided

More information on the actions taken to deliver the CQUIN goals can be found in the Quality Report.

HART

Hazardous Area Response Teams (HART) were established by the Department of Health in 2005 following a central government request to equip ambulance trusts to deliver high quality care to patients within a hazardous environment.

Previously, ambulance personnel had a limited capability to operate within any hazardous area and would have to wait for patients to be moved by other agencies, such as the Fire and Rescue Services, to a safe area before any lifesaving treatment could begin. HART Teams have been placed at locations where the government believe there is a high threat of terrorist activity, or where there is potential for a large scale incident. In the SECAmb area these are the Channel Tunnel and Gatwick Airport. The HART remit is supported by a variety of legislative and Government directives

HART is both a local Trust and a national resource and should be ready to deploy anywhere within the UK to both large scale and major incidents. The SECAmb HART teams support the Trust in a number of ways by providing routine support local to their base and at major and large scale incidents. The Trust currently has one HART team based in Ashford, Kent, and a second based at Gatwick, will go-live in July 2012.

Our priorities. . .maintaining our clinical governance arrangements

How the Trust considers clinical quality and clinical governance

The Trust ensures that its arrangements to monitor and continuously improve the quality of healthcare provided to patients are undertaken in accordance with the Trust's agreed corporate governance arrangements. It has effective, defined and established processes including the on-going maintenance of its Quality Governance Framework by the Executive Team.

The Trust's strategic approach to the management of quality and risk for patients, staff, volunteers, visitors, contractors and other stakeholders affected by its activity is to integrate it with other trust functions through the Risk Management and Clinical Governance Committee's defined annual agenda framework. This ensures that the assets and continuity of trust activities are securely and effectively maintained and develops a culture and mechanism for learning lessons from failure, near misses and successes. It assists in improving compliance with Care Quality Commission (CQC), NHS Litigation Authority (NHSLA) Risk Management Standards for Ambulance Trusts and any other assessments.

The Trust defines and measures its quality through a number of ways including:

- The Quality Account which sets out key quality priorities which are linked to the Trust's strategic objectives and service developments
- The Performance Management Matrix which ensures that the objectives from the Trust's Quality Account are monitored and delivered
- The corporate dashboard which includes information on the Trust's performance on national clinical quality standards
- The national Clinical Quality Indicators and Clinical Performance Indicators which can be used for benchmarking information with other ambulance trusts
- Patient and public feedback provided via complaints, compliments and PALS enquiries which are reported to both Board committees and the Trust's commissioners.
- Incident Reports and Serious Incidents Requiring Investigation which are also reported through the Board committee structure
- Quality goals which are highlighted to stakeholders through the intranet, internet, staff bulletin and through the local media.
- Team Briefing Folders which are provided to clinical staff with regular updates on quality issues.
- The Trust's Organisational Development process which is designed to assist managers throughout the organisation to understand their role and responsibilities in the communication of quality priorities.
- The Strategic Quality Commissioning Board which has a quality agenda and considers the Trust's quality goals
- A Whistle Blowing policy which details of how to contact are shared with all staff via the weekly bulletin
- Clinical and internal audit processes in relation to quality governance which take place at both a local and national level
- Robust and effective data validation processes which ensure that the quality and integrity of our information is maintained at all levels

The Trust uses the internal audit processes to scrutinise and gain assurance on quality issues, as well as considering information from third parties such as regulators and registration bodies.

How the Board considers clinical quality and clinical governance

The Board regularly assesses and understands current and future risks to quality and takes steps to address them. Action points and control measures are identified to reduce and mitigate risk to an acceptable level, or to remove the risk to the organisation. All risks on the corporate risk register are reviewed by the RMCGC and the Trust Board at every public Board meeting (every two months). Strategic risks are also presented to the Board via the Board Assurance Framework. External risks are identified through horizon-scanning, via all directorates, and reported in the risk

register, in addition to internal risks.

The Trust seeks external support and buy-in on quality initiatives, such as engaging with commissioners, the local improvement networks (LINks), and with university and deanery groups to discuss quality issues around new clinical initiatives. Working groups monitor the work of the Trust to ensure that ownership for clinical quality is achieved. The working groups also report into the RMCGC to ensure that governance structures are reviewed at Board level.

The Board takes an active leadership role on quality. Members have relevant skills and expertise that ensures that quality governance is a priority at Board level, and this is given scrutiny by the Non-Executive Directors. Non-Executive Director Chairs (of Committees) are regularly reviewed to ensure their skill set matches the requirements for the committees they are chairing. The skills set of the relevant Executive is considered in relation to leading on Service Developments.

The Board has identified named leads for Caldicott Guardian, SIRO, Patient Champion, medicines management, infection control (DIPC) and safeguarding.

How staff are involved with clinical quality and clinical governance

The Board encourages staff empowerment on quality and the Trust has appointed staff champions to lead on key clinical initiatives. SECAmb is committed to Key Skills training, to underpin the quality in people approach and external courses in universities are promoted to staff, as well as the opportunities of one-off specialist training sessions. This ensures a comprehensive programme of training is available to staff. Continuing Professional Development can be accessed at six partner universities. The Trust's training records evidence involvement in courses both internally and externally to the Trust.

The Trust publishes Reflections - a publication for all staff aimed at improving quality through reflective practice, highlighting incidents where care provided could be improved and ensuring that learning from those incidents is disseminated throughout the Trust, leading to improved practice.

SECAmb has an excellent system for accessing key quality performance information; information about clinical quality, patient data and response times can be attributed to an area, team or individual through this system.

Staff are encouraged to participate in the Trust's annual clinical audit programme, and Trust performance with the national clinical performance indicators, including the clinical outcome indicators, is communicated back to staff regularly through the Trust Bulletin. Staff representatives are also assigned to key sub and working groups across the Trust to ensure robust engagement and communication.

How our stakeholders are involved with clinical quality and clinical governance

The Quality Account is one example of where we report on both good performance and quality including areas that require improvement. The national clinical performance indicator audit data is benchmarked across the sector and reported nationally. Patients and the public are also engaged in the develop-

ment of the Trust's Quality account, via the six LINks within the patch.

The Trust commissions patient and public satisfaction research on a two-yearly basis, with results being made available in the annual report and on the Trust website. The Board reviews feedback from this research as well as any other patient and public involvement sessions on a regular basis. Patients and members of the public are invited to become members of working groups and project teams to ensure on-going patient involvement in service developments. Governors are involved in quality governance through the business development process. As governors are key in patient and public engagement their feedback on quality is also invaluable.

The Trust has in place a corporate dashboard, which is reviewed by the Board on a monthly basis. The corporate dashboard is linked to the Trust's strategic objectives, and includes indicators on safety, clinical effectiveness and patient experience. Tolerances are set for indicators included on the dashboard, and are regularly reviewed. For indicators where tolerances are Amber or Red, an exception report is provided. The metrics contained within the dashboard are reviewed annually to ensure they are fit for purpose.

The Board dashboard is backed up by a pyramid of more granular reports reviewed by sub-committees, divisional leads and individual service lines. Information and reports receive further review and scrutiny at Committee level, with summary reports being provided to the Trust Board, and issues escalated as required.

Senior Trust Managers meet with the lead commissioners at the joint Quality Commissioning meetings to report and review clinical quality performance across multiple work streams.


EMERGENCY
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South East Coast Ambulance Service NHS
MAKE READY

Our plans

This section articulates our key plans for developing our service going forward; these service development enablers and service developments will support the Trust in delivering its vision of matching and exceeding international best practice.

Our plans…changing how we respond to patients

The clinical concept of operation for the UK Ambulance Service continues to evolve at pace with a greater emphasis upon clinical treatment rather than the transport function. This has driven the need to expand the clinical capability of ambulance professionals, leading to a fundamental change in priorities with patient assessment, treatment and, where necessary, appropriate referral, becoming more common, with less demand for transport. These changes are substantial, both operationally and in regard to professional development for paramedics, who have increased responsibility.

The Front Loaded Service Model

The underlying principle of the Front Loaded Service Model is that initial patient assessment is undertaken by an Allied Healthcare Professional, ideally one with advanced qualifications, who is able to determine what the patient needs, and provide treatment or referral to the more appropriate care pathway accordingly.

Through the development of the Front Loaded Service Model, it will be possible to more appropriately match staff skills to vehicle provision to ensure a better utilisation of resources and therefore be more cost efficient. This will enable more intelligent dispatch in the future reducing unnecessary duplicate responses to individual incidents.

During 2011-12 the Front Loaded Service Model has continued to be implemented in line with the five year business case which was approved by the Trust Board in 2010-11.

The project team and governance arrangements are now well established and managing the delivery of the project plan.

Work is progressing well in line with the plan and a number of diverse tasks are underway, this past year has been focussed on the following areas;

Paramedic Practitioner & Critical Care Paramedic Education Programme

The development of 300 Paramedic Practitioners and 60 Critical Care Paramedics by 2015 is a key deliverable to implement the Front Loaded Service Model.

The education programme is on course to achieve these numbers by 2015, with two cohorts per year being recruited to.

There are currently a total of 211 Specialist Paramedics across the Trust, consisting of 169 Paramedic Practitioners and 42 Critical Care Paramedics who are at varying stages of development within the education programme.

Development of the Senior Paramedic Role

Another element of the Front Loaded Service Model is the further development of a clinical career structure at the Trust. A key part of this work is the development and introduction of a Senior Paramedic role.

A Senior Paramedic is a Paramedic with additional specialist clinical skills, who will form the future first line supervisory role within the revised workforce structure.

Work is progressing well on designing a profile of the new role and the team is currently engaged in developing the complex process of 'transition' from the current organisational structure to one that incorporates this new role.

Impact on Vehicles and Equipment

The Front Loaded Service Model will have an impact on both the type and mix of vehicles being used. The project team has established a working group to ensure appropriate governance arrangements exist in the selection and development of any new vehicles and equipment.

A first step in this work has been to establish a 'clinical specification' for the Trusts various operational vehicles, setting out exactly the role and function of each vehicle type. The team are now focussed on more technical areas of vehicle development, beginning the process of designing a vehicle fleet that meets the future requirements of the Front Loaded Service Model.

Our plans... investing in technology

Computer Aided Dispatch

The Trust has deployed a region-wide Computer Aided Dispatch System into its three Emergency Dispatch Centres over the past two years. This is a system on which all details of incoming 999 and health care professional calls are logged and managed. It also records patient activity information allowing monitoring of clinical and response time performance.

As dispatch staff in the three Emergency Dispatch Centres now all work on the same system, they have visibility of all emergency incidents and resources across the Trust. This enables standardisation of working practice across all three sites, leading to consistency of response across the whole Trust.

Work for the coming year includes enhancement to the system resilience infrastructure allowing continuity of service to the public to be maintained.

Patient Transport Services have also benefitted from a new dispatch system. This supports not only regional working to facilitate compliance with new contractual obligations, but also vehicle technology links to track and communicate with staff and an 'e-booking' functionality for health care professionals.

Mobile Data Terminal (MDT) Upgrade

The Mobile Data Terminal is the vehicle based technology link between the Computer Aided Dispatch System in the Emergency Dispatch Centres and the clinical staff who attend to patients. It provides address details and a clinical summary of the incident for the information of the crew. This link also tracks the location of vehicles and alerts the crew radios when new calls are sent. Tracking enables dispatchers to select the most appropriate resource to send when a new emergency call is received. It also assists with staff safety when attending incidents as their location is known should they require assistance. New software is due to be deployed onto the data units

this year to improve the clarity of the display to crews and enable enhanced functionality between this equipment and the Computer Aided Dispatch System.

Telephone System

The Trust implemented a regional telephone system in the Emergency Dispatch Centres during the early part of 2012. This allows emergency calls to be answered by any available call operator across the Trust whereas previously calls would have queued at individual locations in busy periods, while operators may have been available in other Emergency Dispatch Centres. Early indications are that the telephone system has improved call answering times for 999 callers since its introduction.

Deployment of new telephone handsets linked to the regional system for ambulance stations, Make Ready Centres and for office users is due to follow over the next few months, giving a seamless link across all geographic areas of the Trust.

Electronic Patient Care Record (EPCR)

The Trust is participating in a Southern Region group procurement project led by Connecting for Health to explore the benefits of Electronic Patient Care Record technology for front line staff and patients. This is a large scale undertaking that will benefit greatly from the involvement of the wider health community to allow for consistency and continuity of patient care records. This project is in its early stages and not planned to be widely available in the immediate future, although is an aspiration of the Trust to develop as a platform for delivering enhanced patient care and clinical excellence.

Our plans…improving our estate and vehicles

Make Ready

During 2010/11 we commissioned two Make Ready Centres at Paddock Wood and Ashford; both tailored to differing needs. Paddock Wood makes provision for logistic support, stores, fleet, etc. for the east of the Trust, whilst Ashford makes provision for the eastern Hazardous Area Response Team. Both Make Ready Centres meet the required industry standards for best practice in sustainable building design, construction and operation - the first buildings in the Trust so to do.

Each Make Ready Centre is supported by a matrix of Ambulance Community Response Posts, aligned to patient demand that will permit subsequent rationalisation of the old mal-located and costly estate.

The Make Ready programme is a crucial part of the Trust's plan to become a high-performing organisation as well as minimising the risk of cross infection and freeing up clinical staff time. It will take time for these two Make Ready Centres to fully bed in but we can already see evidence of the low numbers of lost unit hours at each that permits an increase in the unit hour utilisation ratio and the subsequent release of efficiencies to be invested in front line services. These efficiency benefits include:

- Increased vehicle availability (through improved servicing and the chance to spot problems early, meaning less breakdowns).
- Improved stock control, as all stores are managed through one central point,

meaning less waste and duplication.

- Increased staff availability, as clinical staff are freed up to concentrate on providing patient care.

Our plans for the future include Make Ready Centres in Brighton, West Sussex and the Guildford area and work is already progressing for all three locations. We are also working on a Make Ready Centre for the Eastbourne area. All future Make Ready Centres will consider the outcome of the Make Ready Review, which was undertaken six months post go-live of Ashford and Paddock Wood.

Part of our programme includes briefings to and visits by Health & Overview Scrutiny Committees and local councils. During the year we have briefed Kent, East Sussex and West Sussex Health Overview and Scrutiny Committee, together with elected representatives from Dover and Tunbridge Wells councils.

Our plans. . .expanding our services

Single Point of Access

SECAmb implemented NHS Pathways, a new triage software, at the beginning of the financial year. Since implementing NHS Pathways we have seen an increase in 'Hear and Treat' rates from 1% to 5%. This means that we are able to manage patient care over the phone on an increasing basis to ensure that patients are not provided with unnecessary services. The use of a Directory of Service (DOS) that is linked with NHS Pathways also means that we are able to refer people to more appropriate services if an ambulance is not required. This means that patients are accessing the right service for them.

We had planned to implement technical links with all Out of Hours (OOH) providers during the year so that we could directly transfer patient consultation reports to other service providers if their service was triaged as being more appropriate than an ambulance. As a result of the NHS 111 tender there were concerns that the technical links may give SECAmb a competitive advantage when bidding for the service. Consequently, the technical links were put on hold. At the end of January we were provided with permission to proceed with technical links with the Medway GP OOH service. We anticipate this concluding during the early part of 2012/13.

Our service development to become a single point of access became a possibility this year as the NHS 111 procurement process began. We submitted our bid in partnership with Harmoni at the end of February 2012 and will hear the outcome of our bid in June 2012.

Geographic expansion

Expanding our current services in respect of Patient Transport Services was identified previously as a key strategic goal for the Trust. The Patient Transport services contracts and tendering is discussed in the 'Our Partners" section.


South East Coast Ambulance Service NHS
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NHS Foundation Trust

Our processes

In this section, we look in detail at the various processes that underpin and support the delivery of our core services, including Freedom of Information requests and how we manage risk within the Trust.

Our processes…underpinning systems

Freedom of Information

The Trust has a full time Freedom of Information Officer who provides expert advice to the Trust and manages all of the requests. During the period from 1 April 2011 to 31 March 2012 we received 261 Freedom Of Information requests compared to 180 for 2010/2011. This equates to a 45% rise year on year and we have responded to 245 (93.87%) within the 20 working day time frame.

Audit Performance

We have an active internal audit program which is overseen through the Audit Committee. The program aims to cover financial and non-financial controls on a risk basis. Much of that work is planned in advance, but we keep some resource to respond to any concerns that might arise during the year. Looking forward we are working to improve the presentation of our Standing Financial Instructions and our Scheme of Delegation to allow all members of the trust to have a much clearer understanding of the limits to the authorities that are delegated to them.

The audit program this year has included work on Fuel, Capital controls, Private Ambulance Provision, PTS and key financial controls.

Counter Fraud and Corruption

We have focussed our efforts on education with respect to the risks and obligations that we face around fraud and bribery and have adopted a risk based approach to focus this training to the areas most at risk. We have ensured that we have a Local Counter Fraud Officer who is active and that all staff know how to get help or to raise concerns in a timely manner and we have a whistleblowing hotline. We carry out thorough investigations if concerns are raised. We are also revising our policies with respect to fraud, bribery and gifts to ensure that they are clear, easy to understand and appropriate.

Accounting Policies

The accounting policies for the Trust are set out on pages 221 to 263 of the annual accounts.

Annual Assurance Statement

As Accounting Officer for the Trust, the Chief Executive is required to produce an Annual Governance Statement, setting out the systems for managing risk and an assessment of their effectiveness. The Annual Governance Statement can be found on page 115.

Better Payments Practice Code

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, whichever is later.

Total invoices paid	31,400
Invoices paid on time	29,134
% of invoices paid within target	92.78%
Total value paid	£55,644,498
Value paid on time	£49,961,800
	89.79%

Our strategy is to support suppliers by paying quickly. We have focussed on process improvements that will have a sustained benefit to all suppliers rather than short-term fixes.

Our initiatives included:

- Actively working with suppliers to take advantage of electronic invoicing to reduce processing time and reduce error rates. Suppliers are starting to take advantage of this.
- Requiring our Invoice Query Manager to pro-actively manage the aged creditors to ensure that issues are resolved at the earliest opportunity. We are focussing on resolving queries on older invoices as these are the ones that are most problematic for suppliers.

The 2011-12 Better Payment Practice Code percentages are lower than the target of 95% due to such issues as supplier disputes, invoices processed but not yet due, system upload errors and timing of NHS payment runs.

Capital Structure

SECAmb's capital structure is similar to all 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 net assets. The Trust has reserves relating to income and expenditure surpluses and revaluations on fixed assets.

Risk Management

The Trust has a Risk Management Strategy that is subject to consultation and is reviewed annually. The strategy has been in place since the formation of SECAmb and was refreshed by the board in July 2011.

We seek to identify, manage and mitigate risks to service users, staff, and other stakeholders. The Trust has adopted a holistic approach to risk management; risk management is viewed as an essential quality system and one that is a fundamental part of an approach to total quality improvements.

The Trust's strategic approach to risk management is to integrate the risk management process with other Trust functions to support clinical excellence, taking account of the requirements of Monitor, the Care Quality Commission and other regulatory bodies. We aim to ensure that we are managing health and safety effectively for patients, staff, volunteers, visitors, contractors and other stakeholders affected by its activity.

Every individual has a responsibility for appropriate risk management and reporting within their area. Where risks are identified and cannot be immediately rectified they are entered onto the Directorate Risk Register and if they have trust-wide implications they are entered onto the Corporate Risk Register. This is formally reviewed by the Risk Management and Clinical Governance Committee on a bi-monthly basis. The Corporate Risk Register is aligned to the Board Assurance Framework, which shows the Trust's strategic risks; this is reviewed on a quarterly basis by the Audit Committee, and considered by the Board twice a year.

The strategy also ensures that the assets and continuity of trust activities are securely and effectively maintained; it sets out a culture and mechanism for learning lessons from failures, near miss and successes.

It assists in improving compliance with Care Quality Commission (CQC), NHS Litigation Authority (NHSLA) Risk Management Standards for Ambulance Trusts and any other assessing

standards. The strategy describes the role of the board and its committees in managing risks. The Audit Committee takes ownership of the Trust's Board Assurance Framework with particular emphasis to address any identified gaps in assurance. It also monitors the action plans arising out of assessments by external agencies and approves the Annual Governance Statement. The Risk Management and Clinical Governance Committee has the responsibility for Trust wide identification, co-ordination and prioritisation of clinical, non-clinical and general risk management issues. These committees ensure that the Board and management of the trust are continually informed of significant risk issues by the provision of consolidated reports.

A description of the principal risks facing the Trust is set out in the Annual Governance Statement.

Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going 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 2012 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Risk Management is a corporate responsibility and, accordingly, the Trust Board has ultimate responsibility for ensuring that effective processes are in place. The Board is committed to the continuous development of a framework to manage risks in a structured and focused way, in order to protect the Trust from losses, damage to its reputation, or harm to its patients, staff, public and other stakeholders. This enables employees to manage and control risks in accordance with agreed procedures. I am accountable for the management of risk within the Trust, and the Director of Commercial Services has been designated as the Director Lead responsible for corporate risk management, however elements of responsibility also lie with employees of the Trust and the structure of the organisation ensures that there is adequate capacity to fulfil these responsibilities.

The Trust Board is aligned to ensure that capacity to deliver key functions and roles in relation to risk assessment and management, health and safety, information governance, financial management and other areas are adequate and effective.

The Trust is committed to supporting its staff in exercising their roles and responsibilities with regard to health and safety and all other forms of risk. This implementation requires varying levels of training across the Trust and is reflected on the Training Needs Analysis and delivery plan. Lessons learned and guidance on best practice are cascaded to staff through the weekly staff newsletter or Reflections magazine. The

Risk Management and Clinical Governance Committee oversees the management of all areas of risk in the organisation and reports to the Board through the governance structure. This is chaired by a Non-Executive Director and is attended regularly by Directors and senior managers. The Trust's Head of Compliance is a Graduate Member of the Institute of Occupational Safety (Grad IOSH) and is supported by a Risk, Health and Safety Manager who is a Chartered Member (CMIOSH). In addition, a number of other managers have risk or health and safety related qualifications relevant to their posts. The Trust is represented on the National Ambulance Quality Governance and Risk Directors Group which feeds in to the Ambulance Chief Executives Group. The Trust participates in local health economy groups to support learning from incidents.

The Director of Commercial Services is the Trust's Senior Information Risk Owner (SIRO). Both he and the Information Governance Lead successfully completed Connecting for Health's (CfH) required e-learning modules. The Trust has a range of Data Protection and Information Security related policies including an Information Risk Management Policy. Information risks and incidents are reported through the same processes as other risks and incidents. Additionally, they are reviewed by the Information Governance Working Group and quarterly reports are provided to the Trust's SIRO. There were no data losses exceeding level 1 as defined in Gateway letter 13177 during the year.

The risk and control framework

The Constitution, Standing Orders and Policies of the Trust, including the Risk Management Strategy and associated procedures, set out the framework and systems for implementation of risk and governance in the Trust. The Risk Management Strategy is subject to consultation and is reviewed annually. The strategy has been in place since the formation of South East Coast Ambulance Service NHS Trust in 2006, and was refreshed by the Foundation Trust Board in July 2011. The Trust has adopted a holistic approach to positively manage all risks to service users, staff (including voluntary staff, ambulance car service drivers, community and co-responders), contractors and other stakeholders. The Trust has adopted a holistic approach to risk management. It aims to reassure its employees, patients, the public and other stakeholders that it makes no segregation between clinical, non-clinical, financial, reputational or other risks. Risk management is viewed as an essential quality system and one that is a fundamental part of an approach to total quality improvements.

The Trust has defined and established processes including the on-going maintenance of its Quality Governance Framework by the Executive Team that further ensure effective arrangements to monitor and continuously improve the quality of healthcare provided to patients in accordance with the Trusts agreed corporate governance arrangements.

The Trust's strategic approach to risk management is to integrate the risk management process with other Trust functions to support clinical excellence through the Risk Management and Clinical Governance Committees defined Annual Agenda Framework. This ensures the Trust is

integrating the management of quality and risk effectively for patients, staff, volunteers, visitors, contractors and other stakeholders affected by its activity. It also ensures that the assets and continuity of Trust activities are securely and effectively maintained and develop a culture and mechanism for learning lessons from failure, near misses and successes. It assists in improving compliance with Care Quality Commission (CQC), NHS Litigation Authority (NHSLA) Risk Management Standards for Ambulance Trusts and any other assessments.

The strategy also describes the roles of the committees in managing risks.

Through the Risk Management and Clinical Governance Committee the Trust seeks to learn from issues raised and implement good practice at all levels. The Board receives regular reports from the Risk Management and Clinical Governance Committee, including trends analysis and benchmarking. Serious Incidents Requiring Investigation are reviewed, investigated fully, analysed and reported back throughout the organisation. The Trust has a fully developed, maintained and comprehensive Risk Register; it is one of the key elements of the Trust's risk management strategy and along with the Board Assurance Framework, is one of the tools that informs future business and strategic planning. This Risk Register is a Trust-wide database recording corporate risks identified from whatever source, the assessed level for current risk, and details of control measures or an action plan to reduce the risk to the lowest practicable level or to a level determined as acceptable by the Board (or its committees).

The Board Assurance Framework links the main elements and aims of the Trust's internal control and governance processes. The Assurance Framework has been reviewed throughout the year by directors and senior managers in the Trust and reported regularly through the Trust's governance structures to the Board. The Audit Committee received the Board Assurance Framework at each of its quarterly meetings in order to review the controls in place for mitigating risks to the strategic objectives of the organisation and identify further sources of assurance. The Board Assurance Framework has identified in detail any gaps in control and gaps in assurance identified by the Trust. The Trust Board, through the Audit Committee, have ensured that actions are in place within the Board Assurance Framework to address these gaps and none have been identified for escalation as significant issues. Where gaps were identified in relation to either control or assurance measures within the Board Assurance Framework, the Trust has taken, and continues to actively take where required, remedial action to address these.

The Trust reviews strategic risks via the Board Assurance Framework at the quarterly Audit Committee meetings, as well as at the Trust Board twice a year. Risks are not removed from the Risk Register or the Board Assurance Framework until all mitigating actions have satisfied the reviewing committee or Board that the risk has been removed, reduced to a satisfactory level or is recognised and been accepted as a continuing risk to the organisation.

The organisation's main risks for 2011/12 were identified as follows:

Risk	Current / Future	Commentary
Local NHS system preparedness	Current	The impact of delays in handover and turnaround at hospitals has a significant impact on the Trust's performance. Work is ongoing with individual acute providers to address particular areas of poor performance, and this is reported to the Trust Board. A Key Performance Indicator for capturing handover times has been agreed across the South East Coast region, and is supported by real-time monitoring of hospital turnaround. Performance against handover and turnaround times is reported via the Corporate Dashboard.
Impact of Olympics and other significant events may compromise delivery of core service	Current	A National Pre Planned Mutual Aid Working Group (PPMAWG) established to ensure appropriate planning for all UK ambulance services. Local Olympics and Events Working Group established to ensure appropriate local planning for SECAmb implications. Funding for pre-planned aid has been confirmed. However, there is a significant shortfall in funding for other activity within our geographic area (e.g. road cycling events) for which the Trust is required to provide support. Detailed contingency plans have been established in order to ensure that the Trust can continue to provide continuity of service throughout the Olympic period. The risks to the Trust are managed through the Olympic & Event Working Group.
Achievement of quarterly operational performance standards	Current / Future	The Trust is required to deliver quarterly performance against the national A8 and A19 performance standards. The Trust recognises the importance of a timely response to all patients. Although the trust has always delivered against the performance standards on an annual basis, the Trust had not previously been required to deliver these targets on a quarterly basis, and in particular had not delivered Q3 performance since its formation in 2006; although this was successfully achieved in 2011/12.

Risk	Current / Future	Commentary
Delivery of Service Development Enablers	Current / Future	The Trust's forward plan identifies a series of key Service Developments and Service Development Enablers that support the Trust in delivering its strategy. Failure or delay to delivery of these in line with the planned cost and quality will have a significant impact on the organisation's ability to deliver its stated strategy. All Service Developments are managed as individual programmes of work, with an integrated Service Development Programme Board established to oversee the delivery of all of these. Progress is reviewed regularly, with reports provided to the Trust Board.
Failure to be appointed to deliver the 111 service within the regions	Future	If SECAmb do not win the 111 contract there is a risk that other services will start to dispatch ambulances and that the 999 telephony will reduce. The Trust submitted a bid on 22 February, in partnership with Harmoni; this was approved by the Board on 21 February 2012. The NHS 111 Project Team will continue to monitor progress against the NHS 111 Action Plan. Any risks that are identified through this work are reported through the Service Development Programme Board. A mobilisation project team has been identified to ensure project delivery if we are successful.
Non-delivery of large-scale Cost Improvement Programmes	Future	There is a requirement on all organisations within the NHS to deliver efficiency gains in excess of 4% over the next few years. This is significantly higher than previous levels and therefore there is a risk to the Trust being able to achieve this. The Trust delivered against its CIP plans for 2011/12 and has a challenging target in place for 2012/13. Performance against the CIP target is monitored on a bi-monthly basis by the Finance & Business Development Committee

SECAmb has always involved patients and the public in the development of its plans and services, and recognises the importance of listening to their views and wants as integral to service improvement. We have patient/public representatives on several of our working groups, and patients, members, governors and others are invited to ad hoc workshops in order to elicit their views about and involvement in key service developments and plans. This year, for example, a workshop was held for the public and other stakeholders to help to define the priorities for the coming year's Quality Account, and our foundation trust governors were invited to select which of this year's Quality Account objectives should be put forward for internal and external audit.

The Council of Governors receives the Trust's risk register at the same time as the Board and has the opportunity to scrutinise it and ask questions about risk ratings and mitigation plans. Scrutiny of Board meetings and involvement in planning and reviewing key service developments, such as Make Ready Centres, ensures public representatives are part of the Trust's risk management processes.

Governors are also able to join our frontline crews and observe activity, and staff governors regularly visit different premises to hear any concerns from staff and act on them.

South East Coast Ambulance Service NHS Foundation Trust is responsive to the needs of different groups and individuals; the Trust treats patients as individuals, with respect for their dignity. Equality Impact Analyses (EIAs) are undertaken to assess the likely impact on equality by examining the Trust's functions, policies and strategies, taking into account information gathered, supported by involvement and/or consultation. The policy author is responsible for examining their work to ensure that:

- It does not disadvantage any community or group;
- It will not have a negative impact on anyone's human rights;
- It promotes equality;
- Any issues emerging are considered and included in an action plan; and,
- The promotion of equality is embedded wherever possible.

If the results of the analysis screening leads to a finding of potential adverse impact and/or unlawful discrimination, the policy, function or strategy is revised and any barriers or failings tackled, supported by SMART action plans. Checking for and reporting any potential for adverse impact is a crucial element of the EIA process. Heads of Departments have overall responsibility for ensuring EIAs that fall within their area of work responsibility are undertaken and recorded in line with the approved process.

The foundation 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 foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that th 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 Trust's Performance Management Matrix records the objectives of the Executive Directors on an annual basis. Performance against this is monitored and reported on a bi-monthly basis to the Trust Board. The matrix breaks each objective down into its component parts, enabling assurance to be provided that the Trust is delivering against its key priorities, and enabling each directorate to be challenged and held to account for those areas that they are expected to deliver on.

The Corporate Dashboard, which is reviewed at all public Board meetings, as well as at Board Business meetings, includes a series of metrics that enable the Board to have an overview of performance against key indicators and also serves as a mechanism for performance management. Tolerances are defined against relevant indicators, and exception reports provided when performance deviates from within agreed parameters.

The Trust has a track record for delivery against its cost improvement plan targets, and has agreed future cost improvement plans, which include stretch targets. Each cost improvement plan is supported by an action plan and appropriate metrics. Performance against these plans is monitored by the Finance and Business Development Committee, as well as by the Executive management team. Action plans are adjusted to address any risks to under achievement in a timely manner.

The Trust's internal audit service provider is RSM Tenon. A three-year strategy covering 2010 to 2013 has been developed and agreed through the Audit Committee and Trust Board. Annual detailed plans are drawn up and approved by the Audit Committee at the commencement of each year taking into account the trust objectives, risk profile and after consideration of the corporate risk register and Board Assurance Framework.

As part of the internal audit programme for 2011/2012, economy, efficiency and effectiveness of the use of resources has been considered in a number of individual audits. The key audits have included budgetary control which considered the arrangements in place to manage the budgets within the agreed control total and how these are monitored and variances are reviewed and action plans subsequently put in place to manage the variance. Specific audits were undertaken during the year which considered the arrangements in place to manage resources to achieve value for money and to reduce the risk of fraud or error arising which

may impact on the resources of the Trust. These key audits included a review of private ambulance providers, controls over use of fuel, business continuity planning and key financial controls.

Recommendations from audit reports are monitored by the Audit Committee and other Trust Committees where appropriate. The Audit Committee provides appropriate challenge to management to ensure that recommendations are actioned, so that assurance can be provided to the Trust Board.

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. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

Patient outcomes are the benchmark of quality for any healthcare provider and that is why improving outcomes for patients is at the heart of SECAmb's vision. We aspire to deliver clinical excellence that matches and exceeds international best practice. Therefore in identifying and agreeing the priorities for the Quality Account and Report, we have ensured that all are focused on improving outcomes for our patients; how we are going to do this is described in the detail of each priority throughout this Quality Account and Quality Report.

The Quality Account and Quality Report has been developed throughout the year from a range of priorities that were identified as a result of the quality account and quality report stakeholders workshop and input from the Governors, Board and Executive Team.

The decision to look at the chosen five priority areas followed guidance/ suggestions from those who attended the stakeholder workshop in January 2012 on quality measures they would like to see included in this year's Quality Account/ Report. The workshop included invitations to Governors, PPI Representatives, LINKs, HOSCs, Foundation Trust Members and Commissioners.

Monitoring Arrangements

At each meeting of the Risk Management and Clinical Governance Committee a report on the Quality Account is presented with updates on progress with each of the five priorities. From this meeting regular reports are then submitted at its Public Board meetings on the achievement against the priorities listed above via the Risk Management and Clinical Governance Committee summary report.

Each Priority measure has a designated Board Sponsor and Implementation Lead.

Section 6 of the Quality Account / Report "Review of Quality Performance" lists three indicators under the headings of Patient Safety, Clinical Effectiveness and Patient Experience. Further details can be found below:

1. Patient Safety

a. Serious Incidents Requiring Investigation (SIRIs)

We provide our commissioned Primary Care Trust (PCT) with regular updates on the investigation process.

Within SECAmb we continuously monitor SIRIs, both at a local level and at Board and Committee level. We look for trends within the incidents, ensure root causes are mitigated, improvements are implemented and learning is shared.

b. Medication Errors

The most common medication errors are incorrect drug doses and incorrect drug types. SECAmb monitor both types of incident to ensure that mitigation is enabled before trends begin to develop. We also have a culture of shared learning which allows the learning outcomes of incidents to be highlighted (anonymously) across the Trust.

c. Number of Patient Safety Incidents

Patient Safety Incidents are one of our risk management Key Performance Indicators and as such are reported at each meeting of the Risk Management and Clinical Governance Committee, Central Health & Safety Working Group and Local Health and Safety Sub Groups. Currently there are no clusters, groupings or trends within the sub categories which need incisive action by the Trust.

2. Clinical Effectiveness

Clinical Performance Indicators (CPIs) are collected by all ambulance services in England. Five indicators are collected on a rolling cycle with each indicator being measured twice a year. These indicators are underpinned by a number of metrics, and these have been refined and revised over successive cycles. Data is collected by individual Trusts and submitted to the National Ambulance Service Clinical Quality Group (NASCQG). The performance of Trusts is then compared, and the final report for each cycle is then published by the Group. SECAmb submits summary performance reports to the Risk Management and Clinical Governance Committee and the Commissioners. The three areas reported in the Quality Report are:

a. Stroke
b. Asthma
c. Hypoglycaemia

3. Patient Experience

a. Patient Advice and Liaison Service (PALS)

PALS serves as an early warning system for SECAmb, analysing statistics, discerning and monitoring any trends and reporting this data to the Trust's Risk Management and Clinical Governance Committee (RMCGC) every two months via a Patient Experience Report. This report is also shared at each public Board meeting, and is provided to our commissioners on a quarterly basis.

This information helps us to identify common themes and concerns that patients, their carers and families bring to PALS' attention, thereby providing an opportunity for the Trust to learn from patients' experiences and acting as a catalyst for improvement and change.

b. Compliments

Compliments are recorded on the Trust's Datix database, alongside PALS contacts and formal complaints, ensuring both positive and negative feedback is captured and reported. This data then forms part of the

Patient Experience Report which is provided every two months to the Risk Management and Clinical Governance Committee (RMCGC) and to the Trust Board, and on a quarterly basis to the Trust's Commissioners.

c. Formal Complaints

When we receive a formal complaint we appoint a manager to investigate, who will make arrangements to speak personally to everyone concerned, visiting complainants at home in many cases.

Once an investigation is complete, a full explanation, along with an apology where appropriate, is sent by the Chief Executive to the complainant.

Both complaints and PALS concerns help us to identify areas where improvements to quality and services can be made and, wherever possible, steps are taken to implement changes as a result. We also ensure that this learning is spread throughout the Trust.

We place great emphasis on learning from complaints and every effort is made to take all the steps necessary to help prevent similar situations recurring. All recommendations made by investigating managers are recorded on an action plan, which is distributed monthly to investigating managers, the Professional Standards team, the Patient Experience lead, and various other senior Trust managers. No action is removed from the plan until it has been completed.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed by the work of the internal auditors, other external sources of assurance, and the executive managers within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and other Board Committees.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of Internal Audit's work:

"Based on the work undertaken in 2011/12, significant assurance can be given that there is a sound system of internal control which is designed to meet the organisation's objectives, and that controls are being consistently applied in all the areas reviewed. However, during the course of the year we have undertaken reviews into two separate procurement exercises, which have highlighted weaknesses both within the design of the Standing Financial Instructions and compliance with them. An exercise is underway at the Trust for a complete review of the Standing Financial Instructions and

associated documents. Their re-launch will be accompanied by an exercise to educate staff."

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by work undertaken by the External Auditors, work undertaken by the Internal Auditors and the Trust's registration with the Care Quality Commission, reinforced by the inspection undertaken in January 2012.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by a number of internal mechanisms, including the Trust Board, and the Committees with delegated authority, including the Audit Committee, the Finance and Business Development Committee and the Risk Management and Clinical Governance Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The processes adopted to maintain and review the effectiveness of the system of internal control include:

- Monthly finance and performance reports to the Trust Board;
- Monthly Corporate dashboard reports to the Board, incorporating high-level indicators related to the Trust's strategic objectives;
- Quarterly reports to Monitor, including self-certification by the Trust Board relating to Financial Performance, Governance and Quality Governance arrangements;
- Internal and External audit reports, including the 2011/12 Head of Internal Audit Opinion;
- On-going compliance with the Care Quality Commission's (CQC) essential standards of quality and safety, verified by an inspection undertaken by the CQC in January 2012, in relation to registration with the Care Quality Commission.
- Monthly commissioner performance reviews and quarterly Chief Executive's forums;
- Commissioning meetings and monitoring the delivery of the service level agreements;
- Minutes of Trust Board and Board Committee meetings;
- On-going update and approval of the Assurance Framework at the Audit Committee, to ensure effective controls and assurances are in place to manage the principal risks of the Trust and, where necessary, giving due consideration to appropriateness of risks identified throughout the year;
- Regular review and reports on the position of the Risk Register at both the Risk Management & Clinical Governance Committee, and the Trust Board, ensuring that action is taken to resolve key risks at the appropriate level and assign the necessary resources where required;

- Regular reviews and reports on progress against the organisation's objectives through the Trust's Performance Management Matrix;
- On-going compliance with Monitor's Code of Governance for Foundation Trusts.

The Trust has identified two breaches of Standing Financial Instructions during the year. These have been subject to internal audit review and the due process of report and scrutiny by the Audit Committee. In attempting to uncover the root cause we have concluded that our Scheme of Delegation was written in a way which made it difficult for a trust employee or director to easily understand the limits to their authority. We are working with our internal auditors to develop an amended scheme of delegation which is based around an 'authority matrix' which clearly lays out the level of commitment that can be made on the Trust's behalf by individual directors, the Director of Finance and Chief Executive, Committees of the Board such as the Finance and Business Development Committee and the full Trust Board. Alongside this we are benchmarking our Standing Financial Instructions and Scheme of Delegation against other trusts to ensure that the outcome is best in class.

Conclusion

I am satisfied that we have had a sound system of internal control in operation throughout the financial year and that where issues are identified we take prompt action to close any gaps in control.

Paul Sutton, Chief Executive

Date: 29 May 2012

South East Coast Ambulance Service NHS
NHS Foundation Trust

Appendix A

Quality Account & Quality Report

1 April 2011 – 31 March 2012

(Headings in red relate to additional requirements for the Quality Report)

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List of Abbreviations

Abbreviation	Full Expression
ASHICE	Age, Sex, History, Injuries/Illness, Condition, Estimate Time of Arrival
BASICS	British Association of Immediate Care Scheme
CAD	Computer Aided Dispatch System
CCP	Critical Care Paramedic
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
ECSW	Emergency Care Support Worker
FAST	Face; Arm; Speech; Time to call 999
FLSM	Front Loaded Service Model
PCR	Patient Clinical Record
PGDs	Patient Group Directions
PP	Paramedic Practitioner
R&D	Research and Development
SECAmb	South East Coast Ambulance Service NHS Foundation Trust
SHA	Strategic Health Authority
SIMCAS	Surrey and Sussex Immediate Care Scheme
SIRI	Serious Incident Requiring Investigation

Data source: 'info.secamb' which is SECAmb's internal information system.

PART 1

1. Executive Summary

South East Coast Ambulance Service NHS Foundation Trust (SECAmb) was authorised as a Foundation Trust on 1 March 2011 (one of the first Ambulance Services in the country to gain Foundation Trust status). Prior to authorisation the Trust operated as South East Coast Ambulance Service NHS Trust from 1 July 2006. SECAmb provides ambulance services to over 4.5 million people living in Kent, Surrey and Sussex. We are one of 11 ambulance trusts in England. We work across a diverse geographical area of 3,500 square miles which includes densely populated urban areas, sparsely populated rural areas and some of the busiest stretches of motorway in the country.

SECAmb has always been committed to involving patients and the public in the development of its plans and services, recognising the importance of ensuring that they have the opportunity to influence what services are provided for them and how.

With this in mind the executive team approved a proposal to develop an Inclusion Strategy in October 2011. The aim being to draw together the three strands of i) membership and governor engagement, ii) patient and public involvement and iii) equality and diversity into a single strategy based on working effectively with our stakeholders. It also incorporates staff engagement. From October 2011 to January 2012, SECAmb ran three workshops involving 100 stakeholders, consulted with governors and the Inclusion Working Group of senior managers, undertook a survey (with responses from more than 600 stakeholders including at least 150 staff, 80 patients, 70 Foundation Trust members and 60 volunteers) and held focus groups with people from special interest groups. A draft Inclusion Strategy has been developed with the involvement of all of those stakeholders and was presented to the May Board meeting for approval.

The Quality Account published last year allowed SECAmb to focus on five priorities.

The first priority was to increase the proportion of seriously ill patients that were attended by a registered clinician. This work has continued and good progress made in this area over the last year, with 12% more patients who are seriously / critically ill receiving a response from a registered clinician. In 2012/13 we will continue to improve systems to ensure that the most critically ill or injured patients receive the best care.

The second priority involved the performance of SECAmb's Paramedic Practitioner teams. It is the Paramedic Practitioner skill set that provides SECAmb with one method to reduce patient transports to conventional A&E departments. With a continued increase in the PP scheme and the introduction of the PP desk in the Coxheath emergency dispatch centre, it has been found that there has been an increase in the number of patients that are able to be cared for at or closer to home. The plan is to look to roll this out across more of the SECAmb emergency dispatch centres during 2012/13.

The third priority was to improve the linking of the electronically scanned paper based

patient clinical record to the 999 call/record. The introduction of an improved collation process has bought some benefits but there still remains room for improvement which we believe will come from an electronic solution and as such a small 'proof of concept' trial will go ahead during 2012/13.

The fourth priority looks at how well the infection control process is being maintained with the addition of two Make Ready Centres during 2011/12. This priority will be able to monitor the deep cleaning of emergency response vehicles across SECAmb and swab testing within the five Make Ready Centres.

The fifth priority looks to improve the experience of those patients who call SECAmb and rather than being taken to hospital, are provided with an alternative health care option. Views were sought from some of these patients by carrying out two surveys last year, and the findings were reported to our Commissioners.

In 2012/13, SECAmb is maintaining five priorities. The measures chosen for this year's Quality Account support some of the service development areas of the SECAmb's Annual Plan, demonstrating that SECAmb embraces innovation by reporting on the initiatives that can directly affect the strong reputation and positive public image that SECAmb has developed.

Overall it has been a challenging year for SECAmb, but progress has been made on our chosen indicators; we will continue to work to drive further improvements in 2012/13.
In relation to the Trust's work on CQUIN, in 2011/12 the Trust was successful in achieving just over £1.8m of the £2.1m available for the overall CQUIN funding, which was a substantial achievement for the Trust.

To the best of my knowledge and belief, the information in this account/report is accurate.

Paul Sutton, Chief Executive

Date: 29 May 2012

PART 1

2. Introduction to the Quality Account and Quality Report

Welcome to South East Coast Ambulance Service NHS Foundation Trust (SECAmb) Quality Account and Quality Report for 2011/12. We hope that you find it an interesting and an informative read, providing you with a good understanding of the progress that has been made during the last year by your local ambulance service.

Our patients have a right to expect the ambulance service to deliver a consistently high quality of service, but what does this mean in practice? How can a 'Quality Account and Quality Report' be used to help answer this question and to assure you that SECAmb is working consistently to improve services for our patients? Definitions of quality vary, tending to revolve around concepts (some of which can seem rather vague), such as 'fitness for purpose,' and a reduction in variation with a relationship to effective systems and processes.

In the past, four quality dimensions of High Performance Ambulance Services have been identified as; response time reliability, economic efficiency, customer satisfaction and clinical effectiveness, to which SECAmb believe patient safety should now be added as an explicit requirement (Figure 1).

In recent years the NHS has invested resources to improve patient services through the application of clinical governance, which seeks to embed continuous quality improvement into the culture of the NHS. In practice this means ensuring that all aspects of patient care, such as safety, outcome and experience are understood and systematically refined.

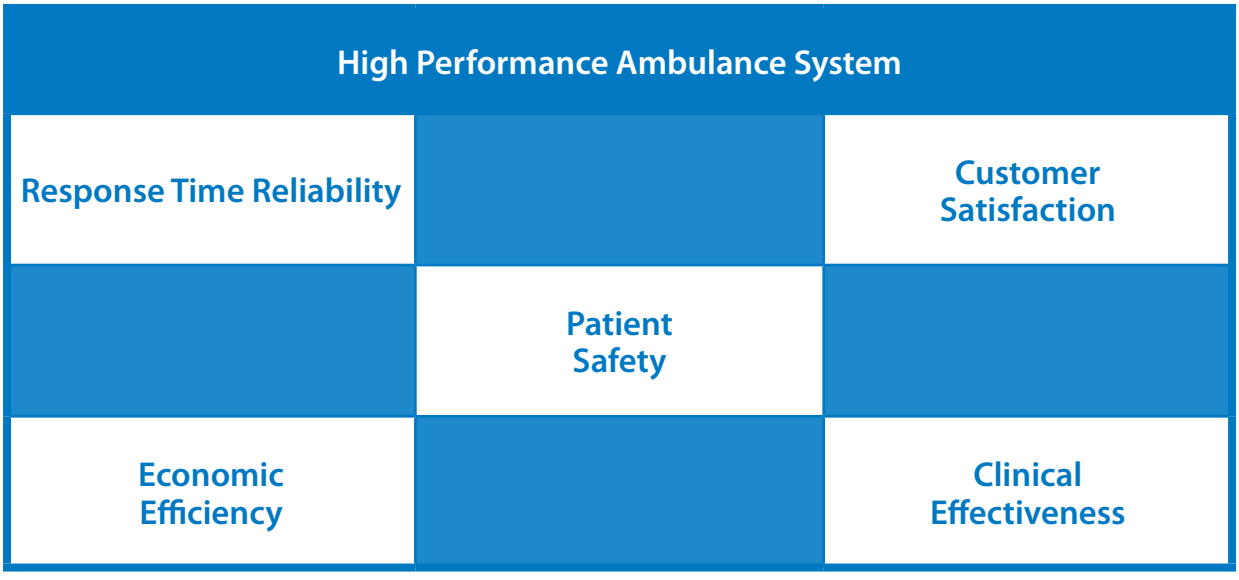


Figure 1: Model of High Performance Ambulance System

The Quality Account and Quality Report is one method SECAmb use to give our service users more insight into just how effective our services are. The document also explains how our services are measured and how they will be improved. In short they are aimed at making all NHS Trust's focus on quality, to show how they ensure 'consistency of purpose', and this responsibility has been made a legal requirement for all Trust Boards and all their members.

Professor Andy Newton, Consultant Paramedic & Director of Clinical Operations

Date: 29 May 2012

PART 2

3. How SECAmb has prioritised quality initiatives for the year ahead

Patient outcomes are the benchmark of quality for any health care provider and that is why improving outcomes for patients is at the heart of SECAmb's vision, because our patients deserve nothing less. We aspire to deliver clinical excellence that matches and exceeds international best practice. Therefore in identifying and agreeing the priorities below, we have ensured that all are focused on improving outcomes for our patients; how we are going to do this is described in the detail of each priority throughout this Quality Account and Quality Report.

Priority 1: To improve the number of registered paramedics who attend seriously injured or ill patients

Priority 2: To increase the number of patients treated at or closer to home by utilising our Paramedic Practitioners, which will result in fewer patients being transported to an A&E department by ambulance

Priority 3: To improve the quality of documentation by linking the computerised information received from the 999 call to the patient care record/form (which is completed at the patient's side)

Priority 4: To monitor the effectiveness of SECAmb's Infection Control procedures for emergency response vehicles that are deep cleaned across SECAmb and swab tested (Make Ready Centres only)

Priority 5: To improve the experience of those patients who call SECAmb and rather than being taken to hospital, are provided with an alternative health care option

In considering which priorities SECAmb would report, we held an external workshop at the end of January 2012 and presented a report to the Board in February with the feedback/suggestions. It was imperative to us that the priorities addressed safety, effectiveness and patient experience.

Monitoring our achievements

The Risk Management and Clinical Governance Committee will focus in detail on the key areas of quality and receive progress updates from relevant working groups that will be responsible for delivering the priorities. The Board will receive regular reports at its Public Board meetings on the achievement against the priorities listed above via the Risk Management and Clinical Governance Committee. Each Priority measure has a designated Board Sponsor and Implementation Lead.

What does being a Foundation Trust Status mean for SECAmb?

At the Quality Account Workshop in January 2012 where the above priorities were discussed, a number of participants asked if we could include information on what it means for SECAmb to be a "Foundation Trust".

We have therefore listed some frequently asked questions and answers below which explain the Foundation Trust status and changes.

What is a foundation trust?

- NHS foundation trusts are a new type of NHS trust. They have been created to devolve decision-making from central government control to local organisations and communities, so they are more

responsive to the needs and wishes of local people.

Will NHS foundation trusts lead to privatisation of the NHS?

- Foundation trusts are not about privatising the NHS but about improving services through increased accountability to local people and patients through devolving government power to them. Foundation trusts are similar to mutual organisations such as co-operative societies and housing associations. Foundation Trusts are also legally prevented from having shareholders and their members can make no profit from them. Foundation trusts still provide free NHS care to patients and work to NHS values.

Will the ambulance service remain a part of the NHS?

- Yes. NHS foundation trusts are established as legally constituted organisations with a duty to provide free NHS services to local communities. We would continue to be subject to the same level of inspection and would still be required to meet national performance standards. We will continue to use the NHS logo and will still receive all of the benefits that come with being part of the NHS.

What difference will this make to the ambulance service?

- Foundation trust status will give us the financial and operating freedoms needed to make improvements to services that our patients need and deserve at a much quicker pace. This will allow us to introduce new technologies and treatments more rapidly.

What difference will this make to patients and the public?

- Public, patients, staff and representatives from partner organisations will have the chance to be more involved in how 999 emergency healthcare services are developed in the future. They will have more of a say than ever before in how their ambulance service is run through becoming a member of the Trust. Members are able to elect or become governors.

Priority 1 – To improve the number of registered paramedics who attend seriously injured or ill patients

Description

During the year (April 2011 to March 2012) SECAmb responded to over 729,987 emergency calls (an increase of 8.5% on the previous year). Of these, just over 418,219 patients were conveyed to hospital, 4.9% of which required the attending clinicians to advise the receiving hospital in advance of the patient's arrival. This kind of pre-alert is known as an "ASHICE". This is an acronym (Table 1) used to pass the important details of a critically ill patient over to the receiving hospital, to ensure that they have all the appropriate equipment, staff assembled and are prepared for the arrival of the patient. It is these patients that can be considered to be in most need of the timeliest expert pre-hospital care and as such they should be cared for, where possible, at minimum by a clinician with the skills of a paramedic, appropriate equipment and staff assembled and prepared.

A	Age	Patients age
S	Sex	Male/Female
H	History	What has happened to cause the injury/illness
I	injuries/ illness	What injury has been sustained or what illness symptoms are there
C	Condition	Observation of patient
E	ETA	Estimated time of arrival

Table 1: Explanation of ASHICE acronym

Current status

All our clinicians, from Emergency Care Support Worker (ECSW) to specialist paramedic, regardless of job role, are trained and supported to provide safe and high quality clinical care.

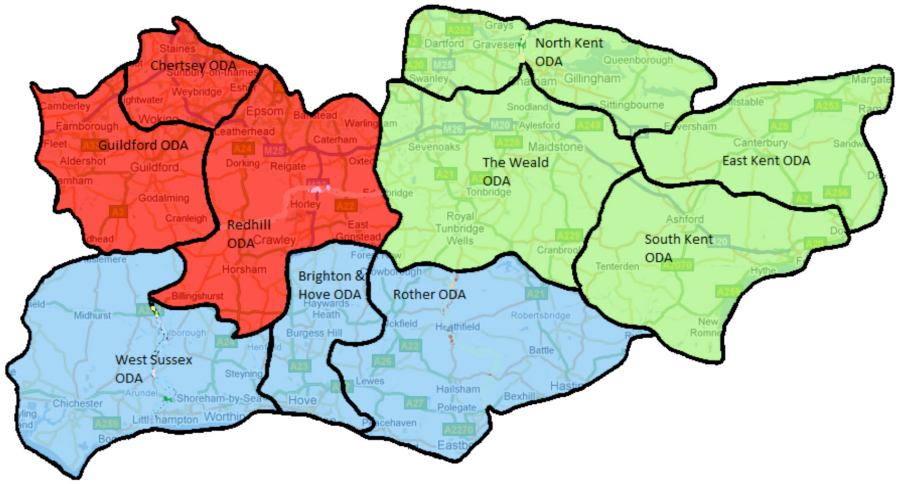


Figure 2: Map showing SECAmb by Operational Dispatch Areas (ODA)

The current status (Table 2) over the page compares data from last year's report (2010/11) as well as data from April 2011 to March 2012:

ODA	April 2010 - March 2011		April 2011 - March 2012		Year on Change	
	Total ASHICE	% Attended by Registered Clinician	Total ASHICE	% Attended by Registered Clinician	Total ASHICE Change 2011 on 2010	% Attended by Registered Clinician Change 2011 on 2010
Brighton & Hove	2233	69.55%	2265	83.11%	32	13.56%
Chertsey	3077	55.31%	2554	72.34%	-523	17.03%
East Kent	880	70.23%	1002	76.44%	122	6.21%
Guildford	3902	62.99%	3175	72.44%	-727	9.45%
North Kent	1437	69.17%	1726	67.57%	289	-1.60%
Redhill	4427	67.00%	3550	78.68%	-877	11.68%
Rother	1496	63.57%	1861	83.00%	365	19.43%
South Kent	620	79.68%	711	80.01%	91	0.33%
The Weald	1100	72.55%	1174	81.21%	74	8.66%
West Sussex	2351	68.78%	2408	84.57%	57	15.79%
Unknown	210	8.10%	102	58.82%	-108	0.5072
SECAmb	21733	65.19%	20528	77.55%	-1205	12.36%

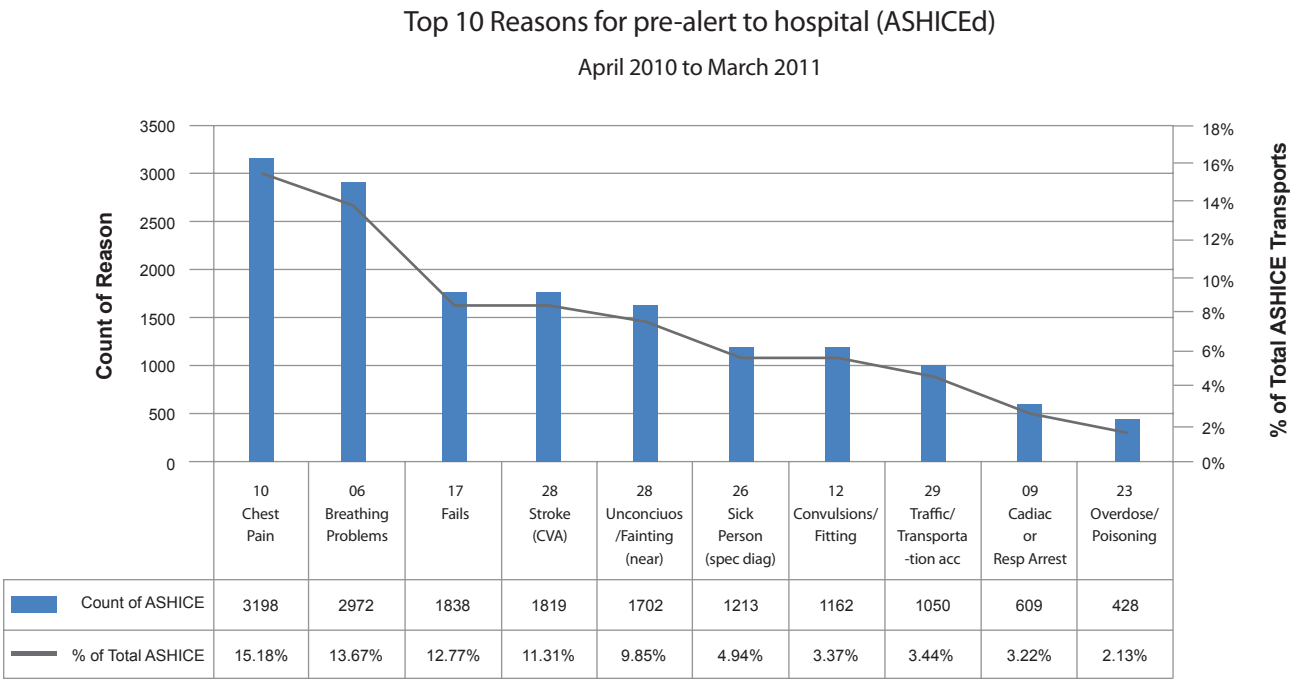
Table 2: % of ASHICE patients attended by a registered clinician by Operational Dispatch Area

Last year (2010/11) we reported that we were able to respond to a seriously/critically ill patient 65.19% of the time with a registered clinician and this year we have been able to improve on this by around 12%, which resulted in 77.55% of SECAmb's seriously/critically ill patients being attended by a registered clinician during 2011/12.

By increasing the number of registered paramedics that attend these patients we will further improve the quality of care and potentially improve patient outcomes towards international standards.

Figure 3 illustrates the top 10 ASHICE as described at the time of the 999 call for the year 2010/11 and 2011/12 respectively, it can be seen from these two charts that the two most frequent ASHICE conveyance reasons are "chest pain" and "breathing problems".

It should be noted the data to produce the charts in figure 3 have different information sources. This is because the introduction of NHS Pathways clinical triage system allows the incident to be described by the injury/illness of the patient rather than the cause as per the previous system used.



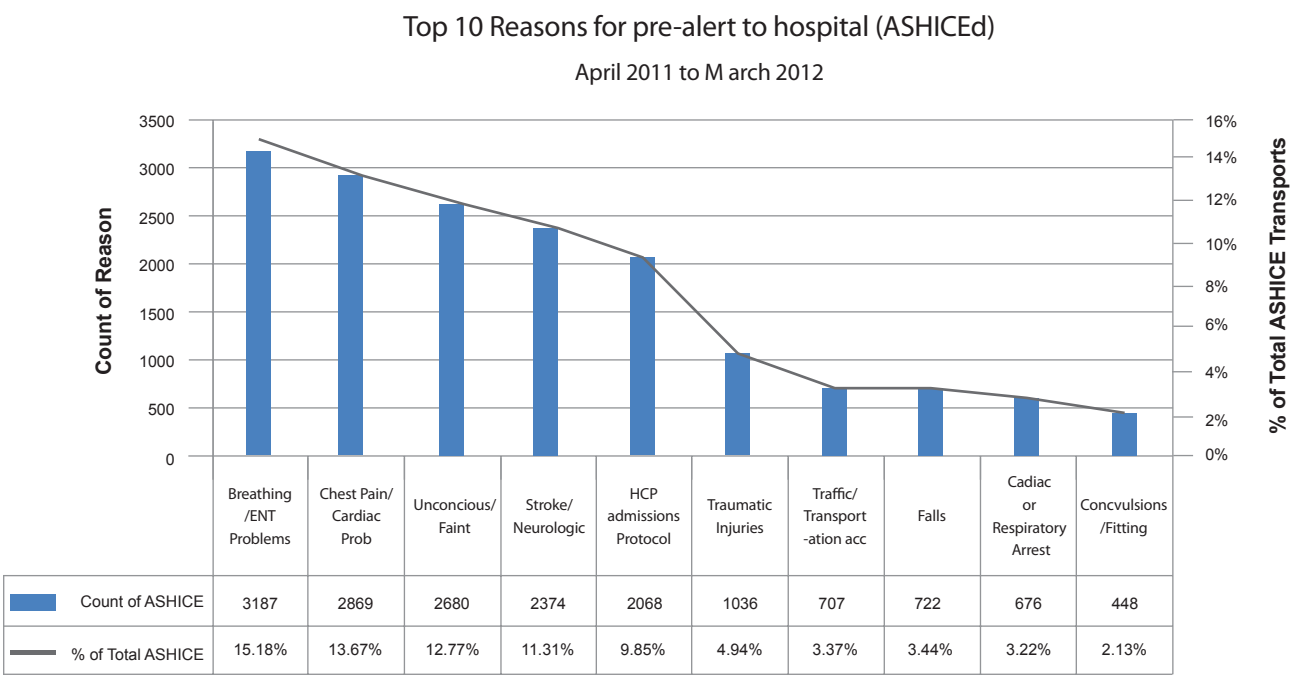


Figure 3: The top ten reasons for pre-alert to hospital

How we are going to improve Priority 1

Getting the right clinician to the right patient is essential to achieving Priority 1. This will mean we need to continue to improve the way we match the clinician to the emergency call. We will also need to be sure we can measure the improvement and so will need to constantly monitor and where possible improve on the data quality work carried out to date.

1. Front Loaded Service Model

Included in SECAmb's plans is the implementation of key service developments over the next three years which will mean that a registered clinician is the first to see the patient 90% of the time in all incidents. This is known as the "Front Loaded Service Model".

It is an ambitious plan that will ensure SECAmb is able to build on the good practice and clinical services already provided, as well as further improve the quality of care that SECAmb's population can expect from its ambulance service.

2. Workforce Development

During the last 30 years or so, the ambulance service has matured to become a highly complex mobile NHS health care provider. There are many areas that will need further development to meet the future challenges and investing in a workforce that is part of a professional body is essential to this challenge. This will mean we can be assured of providing high quality patient care and will be able to advance by developing a 'professional' workforce that is able to meet the challenges of autonomy and accountability in delivering care within their clinical scope of practice.

The development of the workforce will be looked at geographically for SECAmb in line with our CQUIN (Commissioning for Quality and Innovation) Plan for 2012/13.

3. Paramedic education

To enable SECAmb to face the challenges in the future, an education programme has been introduced that will provide undergraduate education. This will mean paramedics are educated to Foundation or Bachelor of Science Degree and all paramedics are registrants on the Health Professions Council.

i. Development of the Paramedic Practitioner and Critical Care Paramedic Programmes

Over the past year, SECAmb have continued to develop the Paramedic Practitioner (PP) and Critical Care Paramedic (CCP) programmes, referred to as specialist paramedics. We now have around 180 PPs, either qualified or in training, and as of July 2012, 42 qualified CCPs. We also have seven of our CCPs seconded to the Kent Surrey & Sussex Air Ambulance Trust Helicopter Emergency Medical Service (HEMS), working alongside the HEMS doctors and pilots attending the most serious incidents across the region. (You can read about each of the programmes developments in more detail below).

ii. Paramedic Practitioners (PPs)

2011/12 has seen the numbers of PP teams grow and become more embedded into primary care. PPs are experienced paramedics who have undertaken further higher education to enable them to manage the patients who present to the ambulance service with minor illnesses and injuries; often with highly complex needs. The PPs work closely with the rest of the community based multi-disciplinary teams to ensure that these patients are cared for in the community, avoiding unnecessary journeys to A&E.

iii. PP Skills Assurance Time (SAT)

The PPs in SECAmb are required to maintain their advanced skills through a system called "skills assurance time". This year we have been working hard to enhance the education that is offered to PPs through SAT. This work has ensured that the skills that are most in demand are refined in order to maximise the effectiveness of PPs and minimise the need for patients to attend A&E with minor illness, minor injuries or exacerbations of long term conditions. From April 2012, the revised Skills Assurance Time plan will go live across SECAmb.

To further enhance the treatment options available to PPs, we have maintained the Patient Group Direction (PGD) medicines introduced last year. The PGDs include painkillers and antibiotics commonly required in primary care, and are already having a big impact.

iv. PP - Telemedicine

Over the course of the year, we have continued to work with Queen Victoria Hospital (QVH) on the Telemedicine project. This project allows PPs to send clinical images of injuries to specialists at QVH, which can then provide detailed care advice or even request that the patient be admitted directly to them, thus avoiding A&E. We have made over 60 referrals to QVH using this system last year and we are working on a phase 2 project to further promote this exciting pathway for patients across our region.

PPs are also providing more and more clinical support to colleagues for all kinds of incidents, working together to make the care we deliver as safe and effective as possible, which gives our patients as much choice as possible about how their care is delivered.

v. Critical Care Paramedics (CCPs) development

We continue to see the number of CCPs steadily increase and with the qualification of the current cohort in July 2012 will have six teams totalling 42 CCPs across the South East region, and are on track to have a total of 60 CCPs by 2015. This enables us to provide a consistent level of CCP cover for those patients suffering serious injury or illness regardless of where they are within SECAmb's boundaries. The teams are located in the following areas:

Current Locations for existing CPP teams		
Ashford	Brighton	Chertsey
Dartford/Medway	Hastings	Worthing

Table 3: Current Locations for our CCP Teams

Some of our CCPs are seconded to work on the Kent, Surrey and Sussex Air Ambulance, and the rest work on ground-based ambulances.

We are working hard to develop enough CCPs to provide coverage for the whole SECAmb area. This year (2012/13), we will be putting a team of CCPs into our new Make Ready Centre at Paddock Wood in Kent.

As the programme continues to mature we have developed close working partnerships with many of the hospitals in the South East Region. We have the first example in the country of CCPs working in hospital as part of the A&E team, helping with the transition of patients from pre-hospital to in-hospital care, providing a crucial link between A&E and ambulance crews.

CCPs have also participated in joint training with Critical Care teams for the transfer of in-

tensive care patients, fostering close working relationships, helping to improve care during these difficult transfers.

We have been continuing to develop "point of care" technology for CCPs to assist with diagnosis and clinical decision making. We are continuing to train CCPs to use ultrasound and are working with the College of Emergency Medicine and several universities to develop a Masters level module in the use of ultrasound. We have also evaluated a blood analyser called "i-stat" which allows CCPs to test blood gases and chemistry.

vi. Critical Care Paramedics (CCPs) Skills Assurance Time (SAT)

CCPs like the PPs have access to Skills Assurance Time. We have been reviewing how we deliver CCP SAT to ensure that the skills available for patient care are honed and that our CCPs are ready for any high-acuity clinical incident.

We have been working with several of our acute hospitals in the region to host CCPs for their SAT within A&E resuscitation rooms, intensive care units and anaesthetic departments.

4. Understanding the outcome for severely ill/injured patients

During 2011/12 SECAmb has further developed its systems to improve the capture of this information by ensuring that the skill type(s) of clinician(s) deployed are recorded by the computerised aided dispatch system (CAD) so that it can ensure this quality measure can continue to be reported across the whole of SECAmb and accuracy is continually monitored and improved. It is also important that this information is freely available to the managers within SECAmb, so this information will be made available through the web based information reporting portal.

5. Clinical / Audit Outcome Data Sharing

SECAmb is a member of the National Ambulance Service Clinical Quality Group to share data and participates in the Myocardial Ischemia National Audit Project (MINAP) at a national and local level.

During 2012/13 work will progress in respect of the Clinical Performance Indicators to further facilitate the sharing of outcome data to progress the quality of services offered within the NHS service, by participating in "ambulance editing rights pilot" a MINAP project to allow ambulance services to input data about their patients.

SECAmb is also committed to the sharing of and learning from outcome data for Stroke patients and is working with healthcare partners at a local and national level as well as the National Ambulance Service Clinical Quality Group to support the sharing of data with the Sentinel Stroke National Audit Programme (SSNAP).

Name of Board Sponsor
Professor Andy Newton, Director of Clinical Operations

Name of Implementation Lead
Dr Jane Pateman, Medical Director

Priority 2 – To increase the number of patients treated at or closer to home by utilising our Paramedic Practitioners, which will result in fewer patients being transported to an A&E department by ambulance

Description

For some patients this means they will not need to go to hospital and instead will be able to be safely treated at home or closer to home, which is what we are told (and believe) people want and prefer. We are working towards increasing the numbers of patients that are not conveyed to an A&E department (the non-conveyance rate) and the development/provision of alternative health care options (pathways), which mean that the patient may not always be transported to an A&E hospital.

While specialist paramedics known as Paramedic Practitioners (PPs) are first and foremost paramedics, and therefore provide a first line response to 999 calls; they are also trained in advanced clinical assessment, triage and treatment skills either directly or in supporting other SECAmb clinicians.

PPs may 'see and treat' the patient; for example, this is where the patient can be assessed; treatment given and no further follow-up is needed.

The PP may also 'see and treat' the patient but on-going care may be needed in the community. If this is the case a referral will be made to the appropriate alternative health care option, such as a District Nurse/Community Matron; primary care (GP); or a referral service such as a Falls Service.

Working closely and in collaboration with primary/community services is an essential part of the success of the PP role and demonstrates the pivotal function that they can play in supporting the care of patients across the SECAmb population.

In many cases PPs are linked to GP practices and this enables them to build a close working relationship with all members of the practice, from GP to practice nurse or nurse specialists.

Current status

Bases for existing PP teams		
Sittingbourne	Redhill	Brighton
Herne Bay	Crawley	Littlehampton
Thanet	Haywards Heath	Chichester
Folkestone	Haslemere	Hailsham
Maidstone	Chertsey	Bexhill
Sevenoaks	Medway	Ashford
Burgess Hill	Dartford	Newhaven
Pulborough	Leatherhead	

Table 4: Paramedic Practitioner Team bases across the SECAmb area

There are 178 student and trained PPs within 23 teams working across the SECAmb area. The teams are based in the locations listed in Table 4 above.

In addition to the teams shown in Table 4, SECAmb has invested in nine smaller teams that consist of one or two PPs. Table 5 provides the location of these teams:

Bases for the smaller PP teams		
Dorking	Eastbourne	Farnborough
Folkestone	Guildford	Lewes
Sheppey	Thameside	Worthing

Table 5: Smaller Paramedic Practitioner Team bases across the SECAmb area

Data for PP non-conveyance rate, by the hour of the day comparing the periods April 2010 to March 2011 and April 2011 to March 2012 shows that over the last year SECAmb has been able to provide more patients with care at or closer to home than compared with the previous year.

The average PP non-conveyance for the 2011/12 (43.68%) period has improved on the PP non-conveyance of the previous year (2010/11) which was 42.13%. This has been helped by various factors which included the improvements made to the recording and subsequent reporting the activity of the PP skill set and also the introduction of the NHS Pathways time of call triage system.

It is intended to upgrade the PP dashboard throughout the coming year as this will allow the PP data to be consistent with the changes that have taken place within the CAD over the last year.

The difference in conveyance by time of the day is complex. SECAmb's overall activity is higher during the day which will be the same for community services. This may mean access to alternatives to conveyance is harder, could take more time to access or the needs of the patients are different. Certainly if the PP is taking longer to access the available services due to day time demand, then this will decrease the amount of patients the PP can attend and therefore could adversely affect the conveyance rate. Work is constantly on-going so that SECAmb can improve their understanding in this area and put in systems to improve the overall performance of the care systems and hence improve the experience of our patients.

i. Paramedic Practitioner (PP) Pilot in Coxheath Emergency Dispatch Centre EDC)

During the latter part of the 2011/12 year a pilot was introduced looking at the tasking of the Medway PPs. The aim was to appropriately task PPs more effectively by introducing a round the clock PP in the Kent EDC. The PP in the EDC assists in evaluating each incident the EDC receives and assesses the patient's suitability to be attended by a PP. This is where the PP will use their enhanced skill set in an effort to provide more patients with the appropriate care at or closer to home.

ii. Paramedic Practitioner (PP) Satisfaction Cards

The satisfaction cards are left by our PPs where the patient was not transported to hospital. The cards are a method by which SECAmb can establish how the patients that were not transported to hospital felt about the care they received from our clinicians.

Of the 36 replies received, 100% considered the care they received to be very good and 8.33% felt reassured while 91.67% felt very reassured (see figure 4).

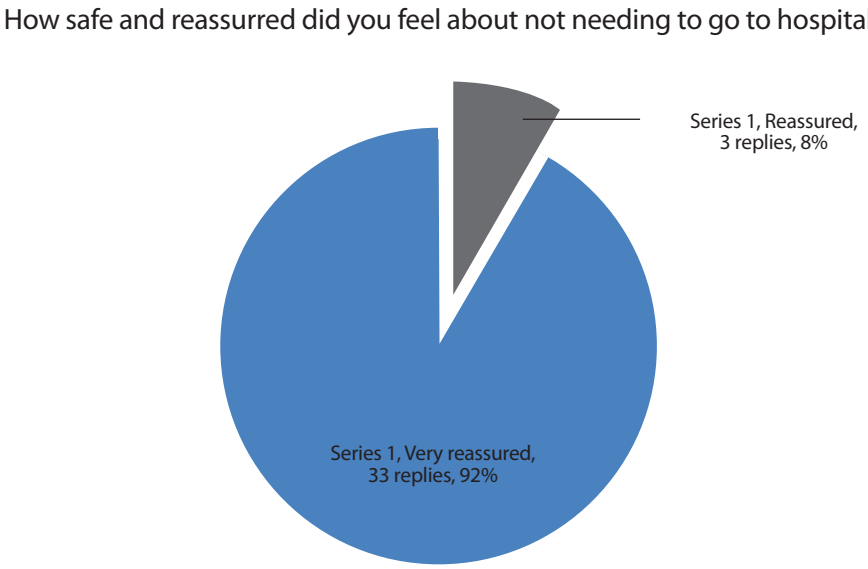


Figure 4: Non conveyance feedback, safety and reassurance

Figure 5 shows the results from the final question on the satisfaction cards which was – whether the care/treatment helped the patient's problem. This category showed that of the 36 replies, 2.78% (1 reply) only somewhat agreed; 8.33% agreed (3 replies) and 88.89% completely agreed (32 replies).

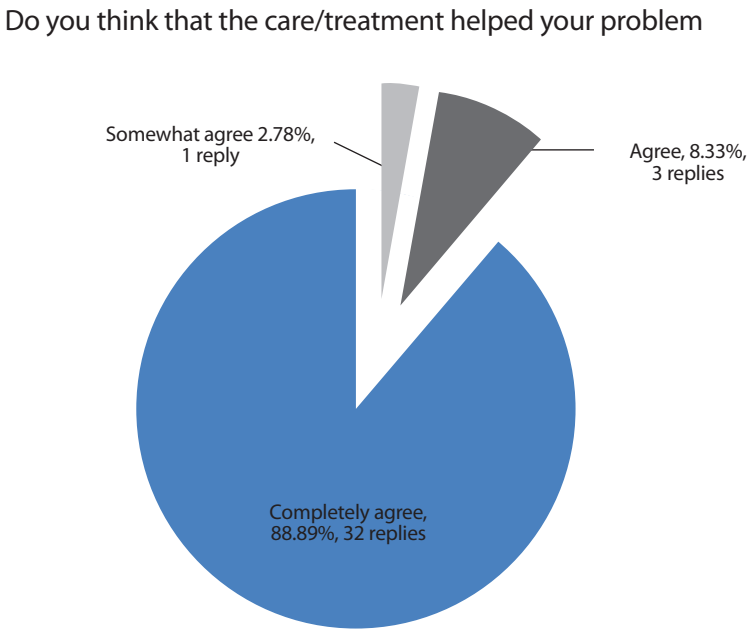


Figure 5: Non conveyance feedback on effectiveness of the care/treatment received

How we are going to improve Priority 2

Improving non-conveyance through the deployment of PPs will mean more patients can be safely treated at, or closer to home. This will further support improvement of the patient experience by providing safe and good quality alternatives to taking people to hospital for the entire 24-hour period. The agreed Commissioning for Quality and Innovation (CQUIN) targets for SECAmb include initiatives for utilising alternative health care options (alternative pathways) that meet the patients need and to report back on the usage of the pathways.

1. Workforce development

i. Paramedic Practitioner (PP) Skills Assurance Time (SAT)

The PPs in SECAmb are required to maintain their advanced skills through a system called "skills assurance time". During 2011/12 we have been working hard to enhance the education that is offered to PPs through SAT and to ensure that the skills that are most in demand are refined in order to maximise the effectiveness of PPs and minimise the need for patients to attend A&E with minor illness, minor injuries or exacerbations of long term conditions. From April 2012 the revised Skills Assurance Time plan will go live across SECAmb.

To further enhance the treatment options available to PPs, we have maintained the Patient Group Direction (PGDs) medicines introduced last year. The PGDs include painkillers and antibiotics commonly required in primary care, and already having a big impact.

SECAmb's learning and development department support the education and development of PPs working within SECAmb in a number of ways:-

- We provide a return to study program that starts to build some of the skills required for autonomous learning. As an extension of this we provide a tangible and accessible level of support, advice and guidance for students during their transition into higher education.
- We drive curriculum review as it relates to the role of the PP ensuring not just that it meets the needs as set out by the SHA to ensure continued funding but to ensure that it equips the individual with the skills to flourish in practice.
- We worked with clinical operations in ensuring the smooth delivery of the placements in General Practice and have developed and are continually refining the assessment tools that PPs use when they go into these placements.
- We have also developed the competency framework for the role and developed a peer led assessment of competence for the role of the PP, the first in the country.

ii. Developing the Paramedic Practitioner (PP) Response

Further to the PP pilot in the Coxheath EDC (as described in Current Status, paragraph i above), it has been found that PPs are able to utilise their enhanced clinical skills by ensuring that where possible and clinically safe to do so they have ensured that more patients have been able to be treated closer to or at home but essentially avoiding an un-necessary transport to hospital.

2. Paramedic Practitioner (PP) Dash board Development

Using the CQUIN funding, SECAmb is further developing the PP dashboard. The dashboard will be used internally, making PP information

available through SECAmb's web based information portal. The portal will allow those with the need to view PP performance against various variables. For example we may wish to compare the PP conveyance rate between teams and by selecting the appropriate criteria, this is possible via the PP dashboard.

3. CQUIN (Commissioning for Quality and Innovation) Indicators

In the 2012/13 CQUIN plan there are indicators relating to increasing the skill mix at scene and to utilising alternative care pathways for patient groups.

4. Hear and Treat

Many patients who call 999 may only require self-care advice and reassurance. As mentioned in paragraph 5 below, during 2011 SECAmb introduced NHS Pathways which enhanced the way patients are triaged and as part of this development a sophisticated Hear & Treat module has been incorporated into the software system. The NHS Pathways system is also linked to an integrated Directory of Services which details the services suitable and available within the location of the caller and enables SECAmb to enhance the treatment provided by the emergency dispatch centres (EDCs) to its patients.

In recent years there has been a strong move towards a paradigm that provides integrated care delivery and commissioning. NHS Pathways provides the most effective patient journey and care delivery system driven by clinical need by providing a common clinical filter that redirects patients, regardless which organisation they call, to the one most appropriate to their clinical need.

5. NHS Pathways

NHS Pathways is a clinical triage system which provides the emergency dispatch centre staff with the ability to link into a wider range of health and social care pathways. This assists the PPs with an even greater ability to provide appropriate care and where possible reduce conveyance rates to conventional A&E sites and allow where clinically safe, to treat patients in their homes or at a treatment centre closer to their home.

NHS Pathways with its extensive store of clinical knowledge can offer pre-arrival advice for out of hospital emergency patients, interim care for those who require a less urgent response, as well as hear and treat advice for those unable to look after themselves clinically.

6. IBIS (Intelligence Based Information System)

Each year, SECAmb is required to meet some additional clinical quality targets through a scheme called CQUIN – Commissioning for Quality and Innovation. During 2011/12, one of the targets in the CQUIN plan was to improve clinical information sharing with other health providers. This has resulted in a system we have called IBIS.

IBIS has three main functions.

- Firstly a database which holds information about patients with long term conditions which is supplied by specialist community teams. This information is passed to our clinicians when one of these patients calls

999 and gives them additional clinical information about the patient to help reduce the need to go to A&E. NHS Brighton & Hove and Sussex Community Trust have been working with us on this part of IBIS and we hope to have 120 patients registered on IBIS over the next few months.

- The second part of IBIS involves the collection of data about patients who are not conveyed to A&E. IBIS provides a system for collecting some key data, such as demographics, GP surgery and reason for calling 999. This data can be used within SECAmb help manage frequent callers and can also be shared with primary care for use in urgent-care dashboards to help GPs see where their patients are accessing services.
- Finally, IBIS allows paramedic practitioners to send clinical summaries of patients they have treated to their GP, in much the same way as out of hours services and A&E departments do. This allows faster communication about the need for follow-up and review.

During 2012/13, the system will be fully rolled out, in all three functions as listed above.

7. Patient satisfaction survey

We propose to link this element into Priority 5 (Patient Experience Survey) for non-conveyed patients which will include two surveys during the year 2012/13.

8. Patient Group Directions and Clinical Practice Guidance

To be able to give drugs to patients safely and within required guidance PPs use what are called 'Patient Group Directions' (PGDs). The PGDs allow PPs to treat conditions such as minor infections and patients with minor injuries (such as sprains and strains).

SECAmb has developed its own set of clinical guidelines for PPs. These guidelines are similar to the national Joint Royal Colleges Ambulance Liaison Committee guidelines used by all paramedics in the delivery of safe effective care. The SECAmb PP "Clinical Management Plans" use national evidence-based best practice guidelines, which continue to be developed in collaboration with our Medical Director and Medical Group, a committee of senior doctors who act as advisors to SECAmb.

9. Develop systems for performance measurement

We will continue to develop as part of SECAmb's performance measures, the ability to measure PP conveyance against non-PP conveyance so that it can be easily identified where changes can be made to improve the patient experience.

Name of Board Sponsor
Dr Jane Pateman, Medical Director

Name of Implementation Lead
Professor Andy Newton, Director of Clinical Operations

Priority 3 – To improve the quality of documentation by linking the computerised information received from the 999 call to the patient care record/form (which is completed at the patients side)

Description

Improving clinical records is a fundamental prerequisite to improving any aspect of clinical care. This is because it is essential to review the evidence of the care given to understand the impact of that care to the patient's outcome. The Patient Clinical Record (PCR) is the document that the clinician completes as a record of the patient assessment and care, and provides essential information about the care SECAmb clinicians give to our population (this form is completed at the patient's side). It is a record we use to pass information on to other health professionals, be that hospital clinicians or those in primary/community care. By monitoring the information contained in this document it tells us about professional practice within SECAmb and is a way of monitoring good practice and also helps us identify issues and risks that may affect delivery of high quality care.

The PCR process provides a range of information (a combined set of data) that supports the reporting of some quality indicators and wider SECAmb performance. Bringing the PCR and the emergency call together in this way means the information is available electronically and can be used to support the integrity of SECAmb's information systems. The journey of the PCR requires close monitoring, so that the maximum number of PCRs are available for scanning and validated against the number of emergency responses. The three factors that link the PCR and CAD record/data are the incident date, incident number and the call sign. If we are not able to match all three then we cannot consider the electronic record valid and not linked and our clinical data is in question.

Current status

It is important that for each patient who is attended by a clinician, a PCR is completed and then forwarded to the scanning/validation and linking process.

Last year we reported based on the number of scanned PCRs we achieved an average of 83% of PCRs successfully linked for the period of April 2010 – March 2011. This figure later rose after publication of the Quality Account to 88% which is due to the data verification process having been completed. For the complete year April 2011 – March 2012 the average has increased to 92%.

The time allowed for this matching process is an average of six weeks and is as follows:

1. This record is currently manually completed by the clinician during their time with the patient.

2. The completed PCRs are collected on a weekly basis from each of the 58 ambulance stations (including the five Make Ready Centres).
3. The PCRs are then passed to the Health Records Team and electronically scanned.
4. Once the form has been scanned it is then manually validated with the data being uploaded onto SECAmb's information system where the scanned PCR data is linked to the emergency dispatch centre system CAD record/data, therefore completing the health record from the initial call through to the documentation.

How we are going to improve Priority 3

In order to ensure that we are giving the highest possible clinical care, we need to ensure that the number of PCRs correspond to the number of responses we make. We will monitor records so that there is a PCR for each patient encounter and that completed PCRs are available in a timely manner.

1. Explore new technologies

We will continue to explore new technologies to see how the compliance can be maintained and subsequently enhanced.

2. Using the PCR Electronic Data

SECAmb is participating in a Southern Region group procurement project to explore the benefits of such technology for front line staff and patients. There is also a small scale 'proof of concept' trial which has commenced recently. This uses an internally developed application on commercially available technology and SECAmb hope to explore other available technological solutions to make the capture of patient information at incidents more accurate and effective. This is all in early stages and not planned to be widely available to crews in the immediate future.

3. Internal Audits

At the Governors Development Day held in January 2012, it was requested that we carry out a one off audit to evaluate the quality of the linkage between the PCR and the CAD data.

This Audit will be carried out in the first quarter (April to June 2012) and the findings will be reported back to the Governors.

A further audit will be carried out in the third quarter of the year to show improvements on outcomes.

Name of Board Sponsor
Dr Jane Pateman, Medical Director

Name of Implementation Lead
James Kennedy, Director of Finance

Priority 4 – To monitor the effectiveness of SECAmb's Infection Control procedures for emergency response vehicles that are deep cleaned across SECAmb and swab tested (Make Ready Centres only)

Description

The cleanliness of SECAmb's emergency response vehicles instils confidence in the public and SECAmb's patients. Last year SECAmb conveyed just over 418,219 patients to hospital (April 2011 to March 2012), therefore to prevent the spread of infection it is crucial that the vehicles are cleaned, not only prior to a shift, but are also deep cleaned on a regular basis.

The deep clean process of emergency vehicles can take two staff up to four hours to complete. On arrival the vehicle is stripped of all its equipment so its floors, ceiling, doors and roof vents can be scrubbed by the staff with a cleaning and disinfectant product. Each item inside the vehicle is dated and quality checked and if necessary replaced before being cleaned with specialist products. Once the clean is complete this is recorded in the vehicle log book.

Swab testing is a Make Ready Centre process by which a measure of cleanliness can be gauged and this works by detecting the levels of adenosine triphosphate (ATP). ATP is a biochemical found in all living organisms and biological residues. If ATP is detected this means the cleaning must be carried out again and the equipment is recalled and the cleaning process is repeated again.

During 2011/12, two additional Make Ready Centres became operational (located at Ashford and Paddock Wood), which makes a total of five centres within the SECAmb region.

Current status

Following the implementation of the two Make Ready Centres at Ashford and Paddock Wood SECAmb is reviewing the Make Ready concept and process to ensure that it is delivering all the benefits that were intended. The review will be considered at the Board Business meeting in April 2012 and then shared more widely. The results will inform whether there needs to be any changes to the plans to roll out the Make Ready Centres initiative across the whole of Sussex, Surrey and Kent by creating 12 centres in total across the SECAmb region by the end of 2016.

1. Deep Clean Process of Emergency Response Vehicles (excluding Single Response Vehicles in non-Make Ready Centre areas)

The Trust's deep clean compliance is reported on a monthly basis via the corporate dashboard, which is reported to the Board. The numbers reflect the deep cleaning of emergency response vehicles (excluding single response vehicles) across the SECAmb region. It is easier to make available the vehicles in the Make Ready Centres for this process. Outside the Make Ready Centres the deep clean programme requires a vehicle is available over a 6 hour window and the drop below the target 85% is principally caused by demand on the service and the vehicles scheduled for deep cleaning being required to respond to emergencies.

Progression of the Make Ready Centres im-

plementation plan will ensure that in future more vehicles are made available for the deep clean process.

2. Swab Testing of Emergency Response Vehicles (Make Ready Centres only)

In 2011/12, 89 swab tests were planned, with a completion rate of 84.5 required to meet the 95% target, thereby providing assurance of cleanliness; in-year, 87 swab tests were completed, which meant the Trust exceeded the target by 2.75%.

How we are going to improve Priority 4

1. The Make Ready Centre Initiative

SECAmb is implementing Make Ready Centres – a scheme in which the emergency response vehicles are regularly deep-cleaned, restocked and checked for mechanical faults in order to significantly minimise the risk of cross-infection and improve patient safety.

Following a successful introduction of the current five Make Ready Centres, SECAmb is not planning to open any additional Make Ready Centres during 2012/13, although following completion of the current review, planning and development is continuing on future sites which will open in subsequent years with the aim being to have a total of 12 Make Ready Centres by the end of 2016.

2. Front Loaded Service Model (FLSM)

As described previously in priority 1, this is where SECAmb is determined to instil confidence within its health economy by aiming to ensure that a registered clinician is first to see the patient 90% of the time within the next three years. The Front Loaded Service Model initiative coupled with improved infection control measures (deep clean and swab testing) will ensure that the patient not only gets the best level of care from SECAmb but receives that care in a clean and hygienic environment.

3. The Annual Plan

SECAmb feels that the linking of the Front Loaded Service Model (already linked to Priority 1) and Priority 4 proves that the Annual Plan is working as it guarantees that the whole of SECAmb is working together to bring patients the best health care SECAmb can offer at the most affordable cost to the public purse.

4. Action taken if standards within this priority reduce

Should a swab test result in failure once the test has been completed then the vehicle is recalled and the piece of equipment that failed the swab test is re-cleaned and retested.

Should the standard begin to fall below the required target of 95% the resulting action plan would include a revision of the deep clean procedure. The swab test samples are tested against the UK national standard in order to be considered a pass. The samples are processed by an external contractor who processes are accredited by UKAS (United Kingdom Accreditation Service) which demonstrates that the systems standards and methods employed are to internationally agreed standards. The contractor is also compliant with the European standard ISO IEC 17025, this standard identifies the high technical competence and management system requirements that guarantee the test results and calibrations are consistently accurate.

Name of Board Sponsor
Dr Jane Pateman, Director of Medical

Name of Implementation Lead
James Kennedy, Director of Finance

Priority 5 – To improve the experience of those patients who call SECAmb and rather than being taken to hospital, are provided with an alternative health care option

Description

Priority 2 in this year's Quality Account is to reduce the number of patients transported to hospital by utilising our specialist paramedics to provide care closer to home or at home. However this is only one of the 'alternative care pathways' that SECAmb can offer to patients. A range of alternative options are available, which may mean that patients are not conveyed to hospital, or which may remove the need for a physical response from the ambulance service, i.e. an ambulance or a car, altogether.

One of SECAmb's Clinical Quality Indicators (CQIs) is to increase the number of ambulance calls closed with telephone advice or managed without transport to A&E. This will lead to an improved experience for more patients – nobody wants to go to hospital unless they have to – as well as a reduction in the number of people attending A&E, freeing up hospitals to deal more quickly with those patients who really do need hospital treatment.

These alternative care pathway options will include treatment by a SECAmb specialist paramedic in the home or close to home, as mentioned in Priority 2. However, in some cases other options (clinical pathways) may be more appropriate. These might include:-

- Advice or signposting from a clinical telephone adviser in the emergency dispatch centre (Hear and Treat) or a
- Referral - either by the clinical telephone adviser or by a clinician who attends the patient - to another health care professional, such as a GP, respiratory nurse, diabetes nurse specialist; referral to a mental health team, social worker, walk-in centre, pharmacy, etc.

We know that this system will lead to more appropriate care for patients (the 'right care, right place, right time', ethos), but we want to ensure that expectations of patients and carers are met and to be able to demonstrate that their experience is improved as a result, thus including this as a priority indicator in our Quality Account.

Current status

As mentioned earlier in this document during spring of 2011 SECAmb introduced a new clinical call triage system called NHS Pathways. This replaced the previous system (AMPDS) and is an advanced clinical triage system that will provide us with the enhanced ability to refer 999 callers to appropriate pathways of care. More detailed information about NHS Pathways is provided in Priority 2 of this document.

To support NHS Pathways, we have introduced a 'directory of services' (DOS) which provides our staff with details of local health care services within the patients area. SECAmb and our primary care trusts (PCTs) have been working together to uploaded local services to the directory, such as out-of-hours services, walk-in centres, minor injury units and mental health crisis teams.

During 2011/12 SECAmb undertook two surveys, using data from August 2011 and February 2012. The August survey yielded a response rate of 29%, with 92% of respondents either satisfied or very satisfied with the service provided by SECAmb.

The results from the February 2012 survey yielded a response rate of 32.4% (an improvement on the August survey, which yielded 29%), with the same percentage (92%) of respondents either satisfied or very satisfied with the service they received from SECAmb.

Although the surveys were anonymous and comments were therefore not attributable to specific incidents, the responses did provide some learning points and an action plan was drawn up from each survey and implemented to address these. Below are some key facts from both of the surveys undertaken:

- The majority of respondents to the surveys perceived that they were calling 999 for a non-life threatening emergency (August – 47% and February 45%), with 13% of respondents from the August survey and 12% from the February survey believing they were calling for a life-threatening emergency.
- We asked if people sought advice before calling 999. The results showed that respondents did seek advice (29% from the August survey and 39% from the February survey) before calling 999. They normally sought advice from GPs, relatives and NHS Direct to name a few alternatives.
- We asked people to let us know about their experience of SECAmb's call taking. A substantial number of respondents did not answer this question in either survey and we think that the likely reason for this is that they were not the caller (they may have been the patient).
- However even including the non-respondents, 85% of respondents from the August survey, and 78.5% from the February survey, agreed or strongly agreed that they were able to answer the questions asked of them by the call takers.
- Of the respondents who spoke to a Clinical Adviser, the August survey showed 58% and 67% from the February survey were either transferred immediately or called back within five minutes. It should also be noted that from the August survey only 3% of respondents had spoken to a Clinical Adviser whereas in the February survey this had increased to 31%. This demonstrates a significant and welcome increase in the use of clinical advisers during triage.
- The majority of respondents (patients and/or carers) agreed with the decision not to be taken to hospital (August survey – 66% and February survey 64.2%). It is also worth noting that from the February survey almost one quarter of respondents did not complete this question, however 80% of these people stated their overall satisfaction as 'very satisfied' or 'satisfied'.

Some items included in our action plans from the surveys were:

- To further improve on documentation left with the patient (when the patient is not conveyed).
- To provide further explanation to callers as to why an ambulance is not being sent.
- To continue working with our healthcare colleagues to improve the range of alternative pathways available to callers dialling 999.
- The above will provide improved informa-

tion for all call takers with regards to out of hours numbers to other healthcare providers.

The results from the two surveys demonstrate the consistence achieved with regards to high levels of satisfaction.

How we are going to improve Priority 5

Ad hoc surveys have been undertaken over the years to determine levels of satisfaction of those patients who are not conveyed to hospital, and feedback has, in the main, been positive. However, with the NHS Pathways clinical triage system and more alternative care pathways being introduced, as well as new clinical quality indicators, it is more important than ever that we determine and benchmark just how good the patient's experience has been, in order to ensure continuous improvement.

1. Patient experience surveys

We therefore plan to undertake two patient surveys during 2012/13, surveying those patients whose emergency call has been resolved with clinical telephone advice or managed without transport to A&E. The surveys will be undertaken using data from June and November 2012, in order to provide an interval for analysis and for some improvements to be implemented as necessary.

The surveys will also be linked to our CQUIN plan for 2012/13 and have an overarching patient experience theme "responsiveness to personal needs of patients".

2. Measuring feedback via complaints and PALS concerns (concerns raised via SECAmb's Patient Experience Team)

In addition to proactive information gathering via the two above mentioned patient surveys, feedback from patients or their carers via complaints and PALS (and PALS may be negative (concerns), positive (compliments) or neutral) will also be analysed and drawn upon to form part of the overall picture of a patient's experience and satisfaction.

The rich information gleaned from these initiatives will provide valuable patient and carer perspectives on experience, expectations, clinical outcomes and satisfaction. It will help us to make improvements and tailor our future service provision, ensuring that our patients receive the service they want and need, and may well lead to some of those patients surveyed becoming involved in the future development of services.

The information gathered via these initiatives will also prove useful for inclusion in the quarterly narrative report required for the 'Patient Experience' Clinical Quality Indicator.

Name of Board Sponsor
Professor Andy Newton, Director of Clinical Operations

Name of Implementation Lead
Kath Start, Director of Workforce and Organisational Development

4. Quality Improvements made within SECAmb during 2011/2012

4.1 Paramedic Practitioner (PPs) Pilot in Emergency Dispatch Centres (EDCs)

During the latter part of the 2011/12 a pilot was introduced looking at the tasking of the Medway PPs. The aim was to appropriately task PPs more effectively by introducing a round the clock PP in the Kent EDC. The PPs in the EDC assists in evaluating each incident the EDC receives and assess the patient's suitability to be attended by a PP. This is where the PP uses their enhanced skill set in an effort to provide more patients with the appropriate care at or closer to home.

4.2 CQUIN (Commissioning for Quality and Innovation) Plan

CQUIN is a national framework for locally agreed quality improvement schemes. It makes a proportion of SECAmb's income conditional on the achievement of ambitious quality improvement goals and innovations agreed between Commissioner and SECAmb, with active clinical engagement. The CQUIN framework is intended to reward excellence, encouraging a culture of continuous quality improvement in all providers.

The SECAmb 2011/12 CQUIN Plan listed three goals, which were:-

- Management of Conveyance
- Develop information and reporting to ensure ability to improve care
- Communications, patient experience and safety

i. Management of Conveyance: the aim was to reduce managed conveyance throughout the year from 64% to 60%, i.e. the number of avoidable patients being admitted to A&E departments.

Actions which have been taken during the year included:-

- In order to monitor the managed conveyance we produced a trajectory per PCT and a SECAmb average. The trajectory demonstrated the plans to achieve 60% performance by 31March 2012 for the whole of SECAmb averaging around 62% throughout the year from the 64% start point. As at 31 March 2012 we had achieved 61.9% (year to date 62.7%).
- Increasing the number of PPs, the introduction of NHS Pathways, alternative care pathways and the directory of services have assisted us with the reduction; however this is an area for further improvement during 2012/13.
- Pocket size information guides were provided to our staff in the form of a pocket book (safe non conveyance guide)
- Snapshot surveys carried out by our staff at A&E departments
- Regular reports were submitted to the Commissioners

ii. Develop information and reporting to ensure ability to improve care: the aim was to develop a system where patients who were assessed face to face by our PPs and not conveyed to hospital should have a summary of the care they received sent to their GP. The second part was to devise a system whereby GPs/Community providers could advise us of any health information which would assist us in caring for the patient if we received a 999

call with a view to rolling out in 2012/13.

Actions which have been taken during 2011/12 included:-

- Worked with GPs/community providers to ascertain the requirements for a system to work.
- The development of the IBIS system (see section 4.3 below for full description of the system).
- Clinical summaries sent to GPs at the end of March 2012.
- Roll out plan for the second part of the system during 2012/13.

iii. Communications, patient experience and safety: the aim for the year was to carry out two surveys for patients who were not conveyed to hospital. The surveys were also a way of ascertaining the patient's perspective of the appropriateness of the non-conveyance or the alternative responses provided.

Actions which have been taken during the year included:-

- Two surveys were carried out using August 2011 and February 2012 data and both surveys showed the same satisfaction rate - 92%. (Further details can be found within Priority 5).
- There were however a few areas for improvement and action plans were implemented and shared with the Commissioners.

4.3 IBIS project

Each year, SECAmb is required to meet some additional clinical quality targets through a scheme called CQUIN (Commissioning for Quality and Innovation). During 2011/12, one of the targets in the CQUIN plan was to improve clinical information sharing with other health providers. This resulted in a system we have called "IBIS".

IBIS has three main functions.

- Firstly a database which holds information about patients with long term conditions which is supplied by specialist community teams. This information is passed to our clinicians when one of these patients calls 999 and gives them additional clinical information about the patient to help reduce the need to go to A&E. NHS Brighton & Hove and Sussex Community Trust have been working with us on this part of IBIS and we hope to have 120 patients registered on IBIS over the next few months.
- The next part of IBIS involves the collection of data about patients who are not conveyed to A&E. IBIS provides a system for collecting some key data, such as demographics, GP surgery and reason for calling 999. This data can be used within SECAmb help manage frequent callers and can also be shared with primary care for use in urgent-care dashboards to help GPs see where their patients are accessing services. This section will be rolled out during 2012/13.
- Finally, IBIS allows paramedic practitioners to send clinical summaries of patients they have treated to their GP, in much the same way as out of hours services and A&E departments do. This allows faster communication about the need for follow-up and review.

4.4 NHS Pathways and Directory of Services

During April and May 2011 SECAmb commissioned the NHS Pathways clinical triage system. NHS Pathways is an advanced clini-

cal triage system that provides us with the enhanced ability to refer 999 callers to appropriate pathways of care. This could be, but is not limited to, an ambulance response, an appointment with a GP, advice to visit the local minor injury unit or walk in centre, or home care.

NHS Pathways sets out to deliver a single clinical assessment tool that provides effective triage over the telephone in any setting taking calls from the public. This could include 999, NHS Direct, GP Out of Hours, NHS 111 and any other Single Point of Access number in place.

This system is better for the patient because it improves the quality of their experience and improves their health outcomes. It is better for the NHS because this will mean a reduction in unnecessary ambulance journeys and a reduction in avoidable admissions to hospital A&E departments.

Supporting NHS Pathways is a robust and accurate directory of service. This has been implemented by SECAmb working with the PCTs and other service providers. Each PCT has identified and uploaded local services to the directory, such as out of hours services, walk-in centres, minor injury units and mental health crisis teams etc. This will ensure every patient accessing urgent and emergency care services are effectively triaged, reducing the need for them to repeat information and helping to make sure that they are directed to the right care at the right time effectively creating a Single Point of Access for Urgent Care. This requires the clinical tools to support those answering the telephone to:

- Seamlessly map an individual patient's specific clinical requirements to the clinical capabilities of all local services.
- Effectively identify emergencies and rapidly dispatch ambulance support without delay.
- Effectively identify the level of urgent care needed and refer at first contact to the most appropriate local provider.
- Identify providers that are open, have capacity and are close to the patient.

In order that the quality of care is maintained SECAmb will ensure that its performance of green calls (non-life threatening – full description can be found at paragraph 4.12) is regularly monitored. This will be required so that for example green responses that then require an ASHICEd conveyance to hospital can be highlighted, examined and addressed.

4.5 Patient Transport Services (PTS)

SECAmb's PTS has undergone a significant change in the last year ahead of bidding for the new Sussex, Surrey and Kent wide PTS tenders when they are/were due out.

Recognising the need to be more pro-active in meeting our patients' needs as well as meeting the demands of our commissioners, PTS undertook a consultation process with its staff to review its management structure. As a result of this it put three regionalised operational managers in post to support the wider team and patient needs.

The Patient Transport Service has also implemented a new Computer Aided Dispatch (CAD) system during 2011/12. This provides a regional facility so that only one CAD is used across Sussex and Kent rather than two separate systems. This means better planning of resources to meet commissioner and patient need.

The service has also implemented e-bookings

across Sussex and Kent. This means that bookings can be entered onto the PTS CAD system on line from any computer terminal across Sussex and Kent.

Looking ahead to 2012/13 Patient Transport Services have won the pan Sussex PTS contract against a number of large multi-national organisations to keep this service in house. This contract started in April 2012. It has also won the pan-Surrey contract which will go live in October 2012 and is looking to win the contract for pan-Kent which would go live April 2013.

With the introduction of these new contracts PTS will be bringing in brand new vehicles with higher levels of safety and comfort for patients as well as further IT systems including live vehicle tracking and monitoring to ensure that patients are transported more efficiently, have less waiting time either to be picked up or collected following appointments.

The new vehicles also mean that there will be improved cleanliness and infection control management and PTS is working with its mental health patients to increase the amount of 'non-logoed' transport carried out.

4.6 Volunteers (including CFRs, Chaplains, Retirement Associations)

We currently have over 300 active Community First Responders and 90 schemes across our region and during 2011/12 they have had a busy year. They responded to in excess of 18,000 calls, attended around 500 cardiac arrests and over 11,000 life threatening calls. During the year we also recruited over 200 new Community First Responders.

Following criteria from the British Heart Foundation, we have also taken delivery and placed 244 defibrillators as Public Access Defibrillators during the year, in communities of high footfall, high cardiac arrest activity or areas of deprivation.

Our 38 volunteer chaplains continued to provide support to our staff during the year – both pastoral but also a friendly, supportive and confidential voice. The role of the chaplains is becoming more complicated, as we move towards larger Make Ready Centres but our aim is to improve the chaplaincy service we provide and to ensure this vital role and support is not lost.

This year also saw the formalisation of the relationship between the Trust and the four Retirement Associations, who provide invaluable support to retired members of staff. During the year all four associations have seen an encouraging increase in membership.

SECAmb is fortunate to enjoy support from a network of around 130 volunteer car drivers supporting the delivery of Patient Transport Services. Their support is key in the more rural parts of our region, where it is very difficult to run an effective and efficient service for patients travelling longer distances from more remote areas. Without the support of these volunteers we would be hard pressed to meet the needs of patients who have to travel in either very early, very late or greater than usual distances to make their appointments.

4.7 Major Trauma pathway

In 2011/12 there has been much work towards the establishment of Trauma Networks across the SECAmb area. SECAmb is involved in the following Trauma Networks:

- South West London and Surrey (already established in 2010)
- - The Bypass pilot that was on and within the M25 has continued and has been

widely regarded as very successful, as of the 2 April 2012 the pilot area has been absorbed into the wider Surrey Bypass system.

- Sussex (operational with bypass from 2 April 2012)
- South East London Kent and Medway (expected to become fully operational autumn 2012)

In Sussex the Major Trauma system went live at 0800 on the 2 April 2012.

Hospitals within the Surrey and Sussex networks have undergone assessment as to their ability to respond to Major Trauma. The following hospitals are recognised as a Major Trauma Centre in their respective networks:

- The Royal Sussex County Hospital, Brighton
- St Georges Hospital, Tooting

Trauma Units

- Frimley Park Hospital
- The Royal Surrey County Hospital, Guildford
- St. Peters Hospital, Chertsey
- St. Richards Hospital, Chichester
- Eastbourne District Hospital, Eastbourne

South East London Kent and Medway have yet to formally designate their Trauma units and the Major Trauma Centre for the Kent area will be Kings College Hospital, Denmark Hill.

SECAmb and the Learning and Development Team have worked closely to produce an education package that was rolled out in late February 2012 to operational staff which explained the concept of the Major Trauma system and the use of the Major Trauma decision tree.

A critical care support desk will be funded from within CQUIN monies and is being run by staff from Kent, Surrey and Sussex Air Ambulance Service (KSSAAS) between 0700 and 2300, outside of these hours there is a senior clinician on call rota. The on-duty Emergency Consultant at the Royal Sussex County Hospital provides further support for the clinician in EDC as required.

KSSAAS and SECAmb are working towards the provision of a 24/7 service on the Clinical Support Desk.

4.8 pPCI for ST Elevation Mycocardial Infarction (STEMI)

Clinical developments in the care of patients who are having a heart attack means that in preference to thrombolysis, primary angioplasty is being used to unblock the artery carrying blood to the heart, rather than dissolving the clot using drugs. This procedure is carried out under local anaesthetic; a small balloon is inserted via an artery in the groin or arm and guided under x-ray to the blockage. Once in place, the balloon is inflated and removed, leaving behind a rigid "stent" which squashes the blockage in the artery allowing blood to flow through. For the treatment to work, it has to be done quickly to minimise the amount of damage to the heart muscle from the lack of oxygen that occurs when blood-flow is blocked.

24/7 pPCI services have been introduced at the following locations, which are accessed by SECAmb:

- Queen Alexandra Hospital, Cosham (from November 2011)
- The Royal Sussex County Hospital, Brighton

- Eastbourne District General Hospital*
- The Conquest Hospital, Hastings*
- Frimley Park Hospital, Frimley
- St Georges Hospital, Tooting
- The William Harvey Hospital, Ashford

In November 2011, SECAmb stopped taking STEMI patients to Worthing for pPCI as the hospital was unable to offer a 24/7 service.

* These hospitals form part of East Sussex Healthcare Trust and share an on-call rota for pPCI out of hours. There is work on-going for this Trust to centralise pPCI services to one site.

For Stroke and pPCI, SECAmb has engaged fully with the relevant Managed Clinical Networks in all parts of the SECAmb area.

4.9 Stroke pathway

Stroke services have undergone a considerable change in the last 12 months. These are described below:

i. Kent: 24/7 Thrombolysis is now available either in person or by the use of telemedicine across most of the hospitals in Kent. This means that the complex set of diverts and rotas has now been much simplified which not only allows for faster times for patients to receive the appropriate care but also keeps crews in assigned response areas.

ii. Surrey: 24/7 Thrombolysis as described above with the last outstanding hospital in Surrey went to 24/7 operations in February 2012.

iii. Sussex: 24/7 Thrombolysis available across East Sussex, Brighton and parts of West Sussex with the exception of St. Richards Hospital which has recently reduced operating hours from an agreed 0730-1730 to 0900-1700 Monday to Friday. All calls out of these hours are currently taken up by Worthing Hospital or Queen Alexandra Hospital in Cosham.

Western Sussex Hospitals NHS Trust have given assurance to NHS Sussex that there will be a 24/7 service at St Richards by July 2012.

SECAmb is trying to negotiate one set of thrombolysis criteria.

4.10 Pre-Hospital Thrombolysis

This has been withdrawn, as the standard of care is now primary angioplasty throughout the region. CCP crews will maintain a small stock for use in special circumstances under medical guidance.

Contingency plans have been made to use thrombolysis as a contingency measure during severe weather episodes such as snow which may prevent the timely transport of patients to a pPCI centre, again this would be done under close medical supervision.

SECAmb's Medicines Management Lead has lead on the management of this issue.

4.11 IT Service Developments

i. Computer Aided Dispatch (CAD) – SECAmb has purchased and installed a region wide CAD System into all three EDCs. As they now all work on the same system, this gives visibility of all emergency incidents and resources across the SECAmb region as required and enables standardisation of working practice across all three EDCs.

ii. Mobile Data Terminals (MDT) – SECAmb has installed new terminals in all Emergency Response Vehicles and is planning deployment of a new 'User Interface'. This will improve the clarity of the display to crews in

vehicles and enable enhanced functionality between this equipment and the CAD.

iii. Airwave Radio (ARP) – SECAmb has worked with the Department of Health (DH) and other agencies to deploy the Airwave Radio system. This is now well embedded across SECAmb with on-going work aimed at further improving usability of the system, for example by the addition of telephone functionality (to designated numbers) via the radio handsets to facilitate direct 'clinician to clinician' conversations.

iv. Telephone System – SECAmb has implemented a regional telephone system in the EDCs. This allows emergency calls to be answered by any available call operator across the SECAmb region whereas previously calls would have queued at individual locations in busy period while operators may have been free in other EDCs. Deployment of new telephone handsets linked to the regional system for station and office users is due to follow over the next few months.

v. Electronic Patient Care Record (EPCR) – SECAmb is participating in a Southern Region group procurement project to explore the benefits of such technology for front line staff and patients. There is also a small scale 'proof of concept' trial which has commenced in two areas. This uses an internally developed application on commercially available technology and SECAmb hope to explore other available technological solutions to make the capture of patient information at incidents more accurate and effective. This is all in early stages and not planned to be widely available to crews in the immediate future.

4.12 Clinical Outcome Based Performance Indicators

Prior to 1 April 2011 SECAmb had been preparing for the new series of clinical quality indicators which replaced the Category B 19-minute national performance target. The indicators comprise of two elements, Ambulance System Indicators (AmbSIs) and Ambulance Outcome Indicators (AmbOIs) and were implemented from 1 April 2011. The AmbSIs are reported monthly for the previous month and the AmbOIs are reported monthly but with a three month lag on the month being reported.

In summary, the 11 clinical indicators include survival rates for people who collapse and stop breathing and the recovery rates of patients suffering from heart attacks and strokes (detailed below is a quick reference guide to the new indicators).

The indicators have been introduced by the Department of Health and developed jointly with the National Ambulance Directors of Operations group, the Ambulance Chief Executives group, Ambulance Medical Directors, Commissioners of Ambulance Services and National Clinical Directors for Urgent and Emergency Care.

The introduction of these new indicators will mean that ambulance trusts will not simply be measured on time alone but on how we treated patients and the outcomes of the treatment. These indicators have initially been implemented for benchmarking between trusts to identify outliers and potential good practice relating to outcomes.

What did this change mean to response targets?

Category A – The Category A eight-minute response and 19-minute response target remain the same. Calls requiring a defibrillator are classed a Red 1 and all other life-threatening emergencies as Red 2.

Category B – The Category B 19-minute target no longer exists. The Department of Health

agreed the replacement of this target with a wider set of clinical quality indicators.

Category C – Previous Category C and some Category B calls now become a new Category C "green call" and these will be sub divided into four categories with varying response requirements ranging from an ambulance arriving to advice on the phone, depending on severity of the injuries.

Clinical quality indicators in brief

Outcome from acute ST-elevation myocardial infarction (STEMI)

- This indicator will measure the outcome of those patients that suffer an out of hospital STEMI (a type of heart attack). Success of the STEMI management will be shown by the number of patients that survived against all those patients that suffered a STEMI expressed as a percentage.
- For the period April to November 2011, SECAmb reports that 96.2% of its patients with this condition received primary angioplasty within 150 minutes of the call for help. The national average was 89.6%.

Outcome from cardiac arrest - return of spontaneous circulation

- This indicator will measure how many patients who are in cardiac arrest but following resuscitation have a pulse/ heartbeat on arrival at hospital.
- For the period April to November 2011, SECAmb reports that 27.3% of its patients that that had suffered a cardiac had ROSC at arrival at hospital. The national average was 22.9%.

Outcome from cardiac arrest - survival to discharge

- Following on from the second indicator, this will measure the rate of those who recover from cardiac arrest and are subsequently discharged from hospital.
- For the period April to November 2011, SECAmb reports that 5.7% of its patients that had suffered a cardiac arrest and arrived at hospital with ROSC, recovered to be discharged from hospital. The national average was 6.7%.

Outcome following stroke for ambulance patients

- This indicator will measure the time it takes from the 999 call to the time it takes those FAST positive patients to arrive at a specialist stroke centre so that they can be rapidly assessed for thrombolysis.
- For the period April to November 2011, SECAmb reports that it transported 67.6% of these patients to a specialist stroke centre within 60 minutes. The national average was 53.6%.

Proportion of calls closed with telephone advice or managed without transport to A&E (where clinically appropriate)

- Measure the number of patients effectively managed without the need for an ambulance response or onward transport to hospital.
- Last year (2011/12) SECAmb was able to provide telephone advice to 4.7% of its callers.

Re-contact rate following discharge of care (i.e. closure with telephone advice or following treatment at the scene)

- This indicator will measure how many callers or patients call us back within 24 hours of the initial call being made.
- Last year (2011/12) 10.2% of SECAmb's patients that were given telephone advice re-contacted SECAmb; while 5% of the patients treated at scene without the need for transportation to hospital re-contacted the SECAmb.

Call abandonment rate

- This indicator will ensure that we are not having problems with people phoning 999 and not being able to get through.
- The call abandonment rate for SECAmb during 2011/12 was 1.0%.

Time to answer calls

- This indicator will measure how quickly all 999 calls that we receive get answered.
- SECAmb can report in 2011/12 the average (median) time to answer a call was three seconds.

Service experience

- SECAmb needs to demonstrate how we find out what people think of the service we offer (including the results of focus groups and interviews) and how we are acting on that information to continuously improve patient care.

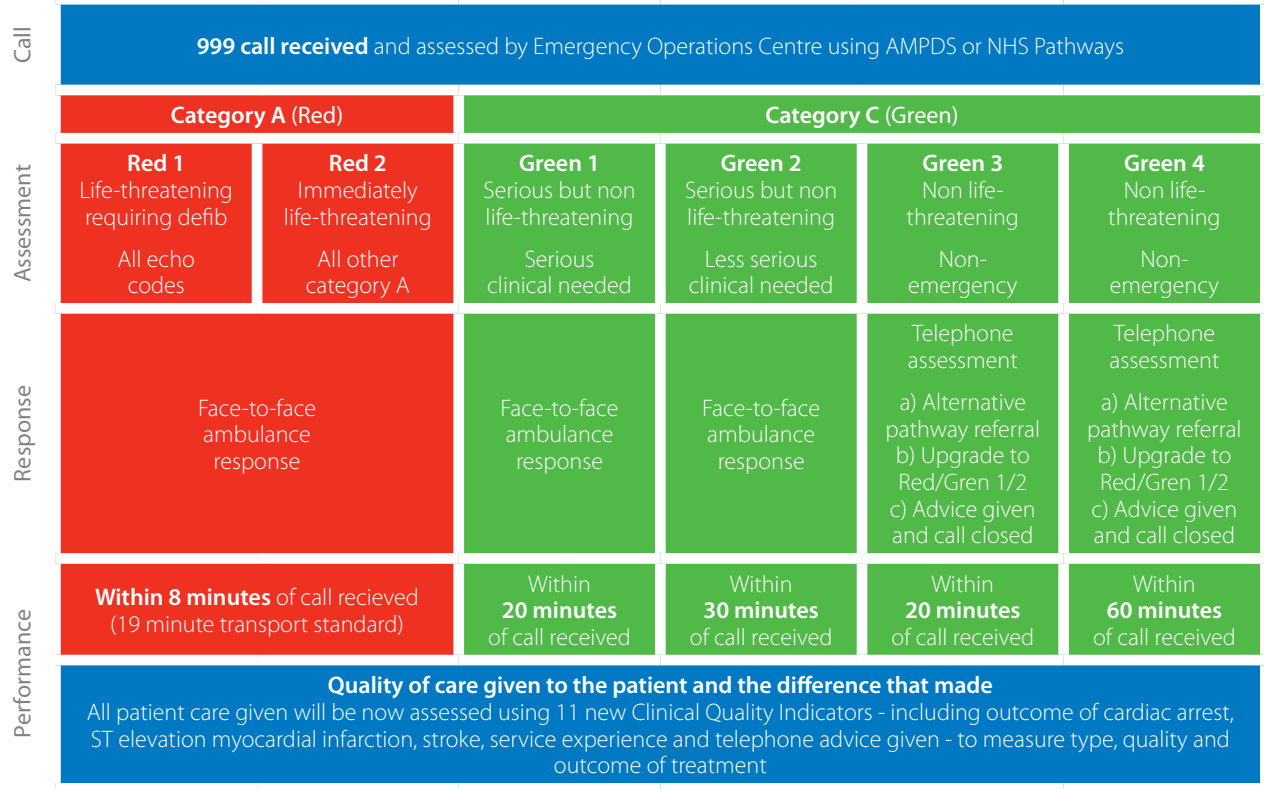
Time to treatment by an ambulance-dispatched health professional

- Time from call categorisation to arrival of health professional for life threatening (category A) calls. The Category 'A' response that SECAmb provided (2011/12) was 77.7%.

Category A eight-minute response time

- The table "Understanding the Changes" provides a guide as to how calls are categorised following the removal of the pre April 2011 Cat 'B' performance targets.

Understanding the changes
at-a-glance guide



5. Statement of Assurance relating to quality of NHS services provided (Red text relates to the Quality Report data requirements)

The information below is as the prescribed schedule as in the Quality Account Regulations (and NHS Foundation Trust Annual Reporting Manual 2011/12 for the Quality Report) that SECAmb is required to declare.

Statements of Assurance from the Board

During 2011/12 SECAmb provided two and sub-contracted 15 NHS services.

SECAmb has reviewed all the data available to them on the quality of care in all 17 of these NHS services.

The income generated by the NHS services reviewed in 2011/12 represent 3.0% (three) per cent of the total income generated from the provision of NHS services by the SECAmb for 2011/12.

Clinical Audits

During 2011/12 five national clinical audits and one national confidential enquiries covered NHS services that SECAmb provides.

During 2011/12 SECAmb participated in 100% (one hundred percent) national clinical audits and 100% (one hundred percent) national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that SECAmb was eligible to participate in during 2011/12 are as follows:

- National non-conveyance audit (NANA)
- Clinical Performance Indicators
- Clinical Indicators subset of Ambulance Quality Indicators
- Myocardial Infarction National Audit Programme (MINAP).
- National Research Asthma Deaths (NRAD)
- Sentinel Stroke National Audit Programme (SSNAP)

The national clinical audits and national confidential enquiries that SECAmb participated in during 2011/12 are as follows:

- National non-conveyance audit (NANA)
- Clinical Performance Indicators
- Clinical Indicators subset of Ambulance Quality Indicators
- Myocardial Infarction National Audit Programme (MINAP).
- National Research Asthma Deaths (NRAD)
- Sentinel Stroke National Audit Programme (SSNAP)

The national clinical audits and national confidential enquiries that SECAmb participated in, and for which data collection was completed during 2011/12, 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.

- National non-conveyance audit (NANA) (100%)
- Clinical Performance Indicators (100%)
- Clinical Indicators subset of Ambulance Quality Indicators (100%)

- Myocardial Infarction National Audit Programme (MINAP) (100%)
- National Research Asthma Deaths (NRAD) (100%)
- Sentinel Stroke National Audit Programme (SSNAP) Registration completed, data collection not yet expected.

The reports of four national clinical audits were reviewed by the provider in 2011/12 and SECAmb intends to take the following actions to improve the quality of healthcare provided:

- Withdrawn pre-hospital thrombolysis except for CCP vehicles and as a contingency in severe weather conditions etc.
- Delivering the best care to patients suffering from an Acute Myocardial Infarction

The reports of seven local clinical audits were reviewed by the provider in 2011/12 and SECAmb intends to take the following actions to improve the quality of healthcare provided:

- Individual action plans have been set against each area for service improvement to advance patient care and improve clinical quality.

Clinical Research

The number of patients receiving NHS services provided or sub-contracted by SECAmb that were recruited during that period to participate in research approved by a research ethics committee was two.

CQUIN Framework

A proportion of SECAmb income in 2011/12 was conditional upon 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 NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2011/12 and for the following 12 month period are available online at: http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275

SECAmb was provided an additional 1.5% of income in 2011/12 for CQUIN schemes which totalled £2,100k. The goals were around Management of Conveyance (0.5% £700k), Develop information reporting to ensure ability to improve care (0.7% - £980k) and Communications, Patient Experience and Safety (0.3% - £420k). Of these 14% (£288k) was returned to commissioners due to non-achievement of quarterly targets.

Care Quality Commission

SECAmb is required to register with the Care Quality Commission and its current registration status is registered without conditions.

The Care Quality Commission has not taken enforcement action against SECAmb during 2011/12.

SECAmb has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

Quality of Data

SECAmb did not submit records during 2011/12 to the Secondary Uses service for inclusion in the Hospital Episode Statistics

which are included in the latest published data.

SECAmb Information Governance Assessment Report overall score for 2011/12 was 78% and was graded GREEN on the IGT trading scheme.

SECAmb was not subject to the Payment by Results clinical coding audit during 2011/2012 by the Audit Commission (Payment by Results does not currently apply to services provided by Ambulance Trusts).

As stated above SECAmb was not subject to Payment by Results during the reporting period although audit of Call Prioritisation (equivalent to Acute Unit Clinical Coding of activity) is undertaken as part of the requirement to maintain licence of the call prioritisation software, it does not form part of the Payment by Result metrics. The metrics for PbR Ambulance contracts are See & Treat, See & Convey and Hear & Treat/Refer, none of these metrics drill down to patient condition necessitating clinical coding level audit.

PART 3

6. Review of Quality Performance

This section provides an overview of the quality of care offered by SECAmb on performance in 2011/12 against indicators selected by the board in consultation with stakeholders, with an explanation of the underlying reason(s) for selection.

6.1 Patient Safety Indicators

6.1.1 Serious Incidents Requiring Investigations (SIRIs)

SECAmb has adopted the National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (SIRIs). This framework was issued by the National Patient Safety Agency, in consultation with the Primary Care Trusts, Strategic Health Authorities and others related organisations and stakeholders.

In essence we investigate every SIRI, identify the root causes and learning outcomes and develop action plans for implementation which will prevent, as far as practicably possible, similar incidents reoccurring, as far as practicably possible. We provide our commissioned Primary Care Trust (PCT) with regular updates on the investigation process. Our findings are presented to them and/or SHA and it is only with their agreement that a SIRI can be closed.

Within SECAmb we continuously monitor SIRIs, both at a local level and at Board and Committee level. We look for trends within the incidents, ensure root causes are mitigated, improvements are implemented and learning is shared.

Currently there are no clusters, groupings or trends which need incisive action by SECAmb.

The information below has been collated from our SIRI management reporting database. We will consider incorporating national benchmarking data when it has matured.

1 April 2011 to 31 March 2012	
Ambulance (General)	19
Ambulance Accidental Injury	1
Ambulance Delay	8
Confidential Information Leak	4
Drug Incident General	2
Hospital Transfer Issue	3
Other	3
Total number of SIRIs reported	**40**

Figure 6: Number of Reported SIRIs - April 2011 to March 2012

1 April 2010 to 31 March 2011	
Ambulance (General)	17
Allegation Against HC Professional (assault)	1
Ambulance Accidental Injury	1
Bogus Health Worker	1
Confidential Information Leak	1
Drug Incident General	1
Total number of SIRIs reported	**22**

Figure 7: Number of Reported SIRIs - April 2010 to March 2011

6.1.2 Medication Errors

Correctly medicating patients is one of the essential elements of ensuring patient safety and wellbeing. The administration of the correct drug type, the correct dosage and the correct method of administration is vital, together with the ability to identify and recognise any contraindications associated with drugs. The administration of drug types is bound to the scope of practice of each operational role. For example, Paramedic Practitioners are able to administer a wider range of drugs than Technicians, because they are more highly qualified and trained.

The most common medication errors are incorrect drug doses and incorrect drug types. SECAmb monitors both types of incident to ensure that mitigation is enabled before trends begin to develop. We also have a culture of shared learning which allows the learning outcomes of incidents to be highlighted (anonymously) across SECAmb.

The information in Figures 8 and 9 has been collated from SECAmb's Incident Reporting database (DATIX) and is based on Clinical patient safety incidents, both actual and near miss.

2011 – 2012	Incorrect drug dose adminis-tered	Incorrect drug type	Totals per month
April	1	2	3
May	1	0	1
June	0	0	0
July	0	2	2
Aug	0	2	2
Sep	2	0	2
Oct	0	0	0
Nov	0	1	1
Dec	0	1	1
Jan	0	0	0
Feb	3	1	4
Mar	2	0	2
Total	**9**	**9**	**18**

Figure 8: 2011 to 2012 Medication Errors

2010 – 2011	Incorrect drug dose adminis-tered	Incorrect drug type	Totals per month
April	0	1	1
May	1	2	3
June	0	1	1
July	0	1	1
Aug	0	0	0
Sep	1	1	2
Oct	1	0	1
Nov	0	0	0
Dec	1	1	2
Jan	0	3	3
Feb	0	1	1
Mar	1	1	2
Total	**5**	**12**	**17**

Figure 9: 2010 to 2011 Medication Errors

6.1.3 Number of Patient Safety Incidents

Patient safety is at the very core of SECAmb's service and we make every effort to ensure and improve safe patient care, and to mitigate risks that may have a detrimental impact on our patients.

Patient safety incidents are recorded on our incident reporting system (DATIX) from which they are uploaded to the National Patient Safety Agency (NPSA) via the National Reporting and Learning System (NRLS). The NPSA is provided with the details of the incident, the stage of care and the affect on the patient, such as degree of harm.

Patient Safety Incidents are one of our risk management Key Performance Indicators and as such are reported at each meeting of the Risk Management and Clinical Governance Committee, Central Health & Safety Working Group and Local Health and Safety Sub Groups. Currently there are no clusters, groupings or trends within the sub categories which need incisive action by the SECAmb region

The information opposite has been collated from our incident reporting system, DATIX.

1 April 2011 to 31 March 2012	
Patient safety incident: Clinical	130
Patient safety incident: Non Clinical	61
Totals:	**191**

Figure 10: Number of Patient Safety Incidents (April 2011 to March 2012)

1 April 2010 to 31 March 2011	
Patient safety incident: Clinical	113
Patient safety incident: Non Clinical	100
Totals:	**213**

Figure 11: Number of Patient Safety Incidents (April 2010-March 2011)

6.2 Clinical Effectiveness Indicators

Clinical Performance Indicators (CPIs) are collected by all ambulance services in England. Four indicators are collected on a rolling cycle with each indicator being measured twice a year. These indicators are underpinned by a number of metrics, and these have been refined and revised over successive cycles. Data is collected by individual Trusts and submitted to the National Ambulance Service Clinical Quality Group (NASCQG). The performance of Trusts is then compared, and the final report for each cycle is then published by the Group.

Data sampling is manual in SECAmb, based on scrutiny by the audit department of individual patient clinical records (PCRs). The monthly sample size is 300 cases, and inclusion/exclusion criteria for each indicator are agreed nationally. Not all Trusts will have this number of cases of the indicator conditions, and the comparative data is adjusted for this.

The method for calculating the results has been changed in 2011/12 from previous years, to reflect the way in which the recently introduced national Clinical Quality Indicators are calculated. Cycles 1 to 6 of the CPIs were calculated by removing exceptions to a criterion from the denominator and numerator. The method from cycle 7 onwards has been to treat exceptions as positives to the criterion so the denominator will remain the same for all criteria in the indicator and the numerator will be the number of positives to the criterion and will include the number of exceptions.

Continual refinement of the indicators is essential to the on-going move to continually improve patient care. As performance improves over successive cycles, a point is reached where clinically relevant improvement is no longer possible, and also if the focus remains the same, areas of greater potential improvement are at risk of de-emphasis by clinicians.

Living with long term conditions is an important part of the South East Coast (SEC) wide health strategy and these are areas where SECAmb can make an impact on the broader health care economy as well as the lives of our patients, and for this reason the conditions of Stroke, Asthma and Hypoglycaemia are focussed on in this report.

6.2.1 Stroke: The indicators in figure 12 show SECAmb's performance over four cycles of audit against the elements of care delivered for patients suffering from Stroke. A common condition affecting predominantly a vulnerable population of patients: rapid recognition and transfer to appropriate care has a higher impact on mortality and morbidity, improving quality of life and reducing cost to the overall health economy. SECAmb has taken a leadership role amongst ambulance services in promoting recognition of stroke amongst our population and primary recognition in treatment by our staff.

	STROKE							
	Cycle 5		Cycle 6		Cycle 7		Cycle 8	
	Jul-10		Jan-11		Jul-11		Dec-11	
	SECAmb	Nat Mean	SECAmb	Nat Mean	SECAmb	Nat Mean	SECAmb	Nat Mean
FAST assessment completed	98%	96%	98%	96%	99%	96%	99%	99%
Blood glucose recorded	97%	91%	97%	91%	98%	96%	96%	97%
Blood pressure recorded	100%	99%	100%	99%	100%	99%	100%	100%

Figure 12: Stroke Data (July 2010 - December 2011)

6.2.2 Asthma: The indicators in figure 13 show SECAmb's performance over four cycles of audit against the elements of care delivered for patients suffering from Asthma. A chronic disease with a significant impact on the predominantly younger population affecting their quality of life; rapid and appropriate treatment can ensure the patient can safely remain in the community and/or be rapidly transferred to secondary care where appropriate.

	ASTHMA							
	Cycle 5		Cycle 6		Cycle 7		Cycle 8	
	Sep-10		Mar-11		Sep-11		Feb-12	
	SECAmb	Nat Mean	SECAmb	Nat Mean	SECAmb	Nat Mean	SECAmb	Nat Mean
Respiratory rate recorded	98%	99%	98%	98%	99%	99%	NK	NK
PEFR recorded (before treatment	55%	50%	59%	56%	82%	79%	NK	NK
SpO2 recorded (before treatment)	98%	91%	99%	94%	97%	93%	NK	NK
Beta-2 agonist given	97%	96%	95%	94%	97%	97%	NK	NK
Oxygen admin	96%	94%	97%	96%	92%	96%	NK	NK

Figure 13: Asthma Data (September 2010 - February 2012)

6.2.3 Hypoglycaemia: The indicators in figure 14 show SECAmb's performance over four cycles of audit against the elements of care delivered for patients suffering from Hypoglycaemia. Speedy treatment of this disease can allow patients to safely remain in a community setting and lead to a reduction in acute complications of hypoglycaemia and better control of diabetes with a reduction in long term morbidity and mortality.

	HYPOGLYCAEMIA							
	Cycle 5		Cycle 6		Cycle 7		Cycle 8	
	Aug-10		Feb-11		Aug-11		Jan-12	
	SECAmb	Nat Mean	SECAmb	Nat Mean	SECAmb	Nat Mean	SECAmb	Nat Mean
Blood glucose before treatment	100%	99%	99%	99%	100%	99%	100%	NK
Blood glucose after treatment	98%	93%	96%	94%	100%	98%	99%	NK
Treatment for hypoglycaemia recorded	97%	95%	95%	98%	100%	98%	100%	NK

Figure 14: Hypoglycaemia (August 2010 - January 2012)

6.3 Patient Experience Indicators

6.3.1 PALS (Patient Advice and Liaison Service)

SECAmb's Patient Advice and Liaison Service, or PALS, provides help and information for patients, their carers and the general public who have queries or concerns about SECAmb and the care and services it provides. PALS also acts as a referral gateway to other local health and voluntary organisations and will signpost people to services appropriate to their needs.

In addition, PALS can assist those who wish to make a formal complaint by explaining SECAmb's complaints process to them and putting them in touch with agencies that can support them through the process, for example the Independent Complaints Advocacy Service (ICAS).

PALS serves as an early warning system for SECAmb, analysing statistics, discerning and monitoring any trends and reporting this data to the Risk Management and Clinical Governance Committee (RMCGC) every two months via a Patient Experience Report. This report is also shared at each public Board meeting, and is provided to our commissioners on a quarterly basis.

This information helps us to identify common themes and concerns that patients, their carers and families bring to PALS' attention, thereby providing an opportunity for SECAmb to learn from patients' experiences and acting as a catalyst for improvement and change. Currently there are no clusters, groupings or trends which require incisive action by SECAmb.

SECAmb acknowledges the importance of an effective and efficient PALS service and recognises that PALS enquiries provide useful management information about service quality, image and staffing issues from the perspective of patients, their carers and the wider population.

During 2011/12 our PALS team handled 1,835 enquiries, broken down into subjects as follows:

	2011/12	2010/11
Administration	13	11
Communication issues	20	17
Information request	583	588
Lost property	426	424
Miscellaneous	71	99
Patient care	200	126
Issues raised by SECAMB staff	2	4
Concern about staff	308	277
Timeliness	134	113
Transport	76	72
Total:	**1835**	**1731**

6.3.2 Compliments

People, including our staff, are often surprised to find that SECAmb receives more letters and calls from people thanking our staff for the wonderful work they do – we call these 'compliments' - than it does complaints.

Compliments are recorded on SECAmb's DATIX database, alongside PALS contacts and formal complaints, ensuring both positive and negative feedback is captured and reported. This data then forms part of the Patient Experience Report which is provided every two months to the Risk Management and Clinical Governance Committee (RMCGC) and to the Board, and on a quarterly basis to SECAmb's Commissioners.

During 2011/12 SECAmb received 1,051 'compliments', thanking our staff for the treatment and care they provide. This represents a 125% increase over 2010/11.

We record all of the compliments we receive, be they letters, cards or phone calls, and members of staff who receive plaudits from patients and the public then receive a letter of thanks from Chief Executive, Paul Sutton.

Compliments are highly regarded by our staff and an important morale-booster, as well as providing a useful barometer of patient satisfaction.

	2011/12	2010/11
Compliments	1051	467

6.3.3 Formal complaints

It is a credit to SECAmb that it receives more letters and calls of thanks than it does formal complaints, however we do encourage people to let us know if they are not satisfied with our service for any reason. We want to know how people feel about the care that we provide, as this valuable feedback helps us to learn and continually improve.

During 2011/12 we made nearly two million (1,919,548) emergency responses and PTS journeys and received 278 formal complaints – this equates to a complaint for every 6,905 journeys; and, although the national target to respond to formal complaints within 25 days was abolished last year, SECAmb is still committed to responding to as many as possible within this timeframe.

When we receive a formal complaint we appoint a manager to investigate, who will make arrangements to speak personally to everyone concerned, visiting complainants at home in many cases. On completion of every complaint, we consider whether we feel it was justified, part justified, unjustified or unproven. As this report was compiled, 275 of the 278 complaints for the year 2011/12 had been concluded, with outcomes as follows:

	2011/12	2010/11
Complaint justified	98	66
Justified in part	93	62
Complaint unjustified	66	73
Unproven	18	16
Total:	**275**	**217**

Once an investigation is complete, a full explanation, along with an apology where appropriate, is sent by the Chief Executive to the complainant.

Both complaints and PALS concerns help us to identify areas where improvements to quality and services can be made and, wherever possible, steps are taken to implement changes as a result. We also ensure that this learning is spread throughout SECAmb.

We place great emphasis on learning from complaints and every effort is made to take all the steps necessary to help prevent similar situations recurring. All recommendations made by investigating managers are recorded on an action plan, which is distributed monthly to investigating managers the Professional Standards team, the Patient Experience lead, and various other senior SECAmb managers. No action is removed from the plan until it has been completed

7. Mandatory Performance Indicators

7.1 Assurance on Mandatory Indicators for Ambulance Services

Category A call – emergency response within 8 minutes (17) 75% 1.0 Quarterly

(SECAmb's performance for the year 2011/12 was 77.7% and for the last quarter 76.8%)

The aim is to improve health outcomes from ensuring a defibrillator and timely response to immediately life-threatening ambulance calls

Category A call – emergency response within 8 minutes

Detailed descriptor

- Improved health outcomes from ensuring a defibrillator and timely response to immediately life-threatening ambulance calls.

Definition:

- **Numerator:** The total number of Category A incidents, which resulted in an emergency response arriving at the scene of the incident within 8 minutes. A response within eight minutes means eight minutes zero seconds or less. (KA34 Line 03 Category A)
- **Denominator:** The total number of Category A incidents, which resulted in an emergency response arriving at the scene. If there have been multiple calls to a single incident, only one incident should be recorded. (KA34 Line 02 Category A)
- **Category A incidents**: presenting conditions, which may be immediately life threatening and should receive an emergency response within 8 minutes irrespective of location in 75% of cases.
- The "clock stops" when the first emergency response vehicle arrives at the scene of the incident. A legitimate clock stop position can include the vehicle arriving at a pre-arrival rendezvous point when one has been determined as appropriate for the safety of ambulance staff in agreement with the emergency dispatch centre.

Category A call – ambulance vehicle arrives within 19 minutes (17) 95% 1.0 Quarterly

(SECAmb's performance for the year 2011/12 was 98.1% and for the last quarter 97.7%)

Patient outcome can be improved by ensuring patients with immediately life-threatening conditions receive a response at scene which is able to transport the patient in a clinically safe manner, if they require such a response

Category A call – ambulance vehicle arrives within 19 minutes

Detailed descriptor

- Patient outcomes can be improved by ensuring patients with immediately life-threatening conditions receive a response at the scene which is able to transport the patient in a clinically safe manner, if they require such a response.

Data definition

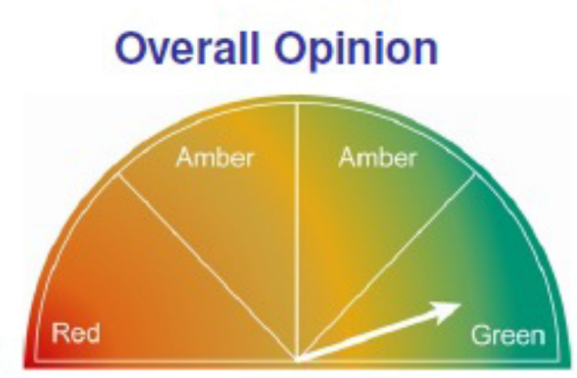
- **Numerator:** The total number of Category A incidents, which resulted in a fully equipped ambulance vehicle (car or ambulance) able to transport the patient in a clinically safe manner arriving at the scene within 19 minutes of the request being made (KA34 Line 06 Category A)
- **Denominator:** The total number of Category A calls resulting in an ambulance able to transport the patient arriving at the scene of the incident (KA34 Line 05 Category A)
- **Category A incidents:** presenting conditions, which may be immediately life threatening and should receive an ambulance response at the scene within 19 minutes irrespective of location in 95% of cases.
- The "clock stops" when the first emergency response vehicle arrives at the scene of the incident. A legitimate clock stop position can include the vehicle arriving at a pre-arrival rendezvous point when one has been determined as appropriate for the safety of ambulance staff in agreement with the emergency dispatch centre.

7.2 Audit Findings on Local Indicator (as selected by our Governors)

One of the requirements for the Quality Report is to seek from our Governors which Priority Measure from within the 2010/11 Quality Account they would like audited within the financial year 2011/12. The selection for this was taken at the Governors Development Day held on the 11th January 2012 and was Priority 2 – "To reduce the number of patients transported to hospital by ambulance by utilising registered paramedic practitioners with specialist skills who can provide care closer to home or at home" (as detailed in the Quality Account/Report 2010/11).

The above choice was passed to our Auditors who undertook the audit in February 2012. The objective of the audit was "To ensure the data reported as part of the SECAmb's Quality Account is accurate, valid, timely and can be verified to evidence".

Below is the overall opinion rating and conclusion from the audit report.



Conclusion

"Taking account of the issues identified, the Board can take substantial assurance that the controls upon which the organisation relies to manage this risk are suitably designed, consistently applied and effective".

There are two recommendations of work to be carried out (see below):-

- Policy and procedures
- Additional information to be included within the procedure documentation on how the evidence is gathered for monitoring the priority measure.
- The data validation processes in place to ensure that accurate information on the quality of services is being reported (internally and externally).
- The Data Validation procedure should be reviewed to ensure current practices are reflected. This should make reference to other Quality Accounts procedure documents. An effective from date should be added and a date set for next review.

The above recommendations will be completed by July/August 2012.

8. Trust Board - Quality Report: Assurance Statement

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor 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 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;
- 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 2011 to May 2012
- Papers relating to Quality reported to the Board over the period April 2011 to May 2012
- Feedback from the commissioners dated 25/05/2012
- Workshop with the governors took place on the 31/1/12 and subsequent feedback on the draft document was obtained in April/May 2012
- Workshop with the LINks took place on 31/1/12 and subsequent feedback on draft document obtained in April/May 2012
- SECAmb's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 (Patient Experience Report), dated July 2011 to our Risk Management and Clinical Governance Committee.
- The national patient survey (no routine national annual patient survey is required of ambulance services)
- The 2011 national staff survey.
- The Head of Internal Audit's annual opinion over the SECAmb's control environment dated 28/05/2012
- CQC quality and risk profiles dated 29/2/2012.
- 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 Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and

prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

The Foundation Trust Board of Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

Tony Thorne, Chairman

Paul Sutton, Chief Executive

Date: 29 May 2012

9. Overview of the patient journey

The following section describes SECAmb's performance against selected metrics which have been chosen to measure its performance against.

Taking the 999 Call
** (95%) 87.64% [-3.56%] of calls answered within 5 seconds
** Average (median) time to answer call 3 seconds
* Average (86%), 87% [n/a] of calls audited (Dec 2011-March 2012)
** 729,987 [+8.5%] calls received
Data Source: * NHS Pathways (Dec 2011 to March 2012). **Corporate Dashboard
[±] change on last year; (nn%) = standard

Response Times
(75%) 77.7% [+1.68%] Category A responses within 8 min standard
(95%) 98.1% [+0.42 %] Category A responses within 19 min standard
Data source: Corporate Dashboard
[±] change on last year; (nn%) = standard

Hear and Treat Triage
Call closed with telephone advice 4.7% (SECAmb wide for the period April 2011 – March 2012)
Data source: Corporate Dashboard

Outcome of Care

Clinical Outcome Indicator		Year to Date (April – Nov) Nat %	SECAmb %	Var %
Outcome from cardiac arrest[1]	Return of spontaneous circulation (ROSC) on arrival at hospital (All)	22.9	27.3	+4.4
	Return of spontaneous circulation (ROSC) on arrival at hospital (Utstein)	44.1	52.5	+8.4
Outcomes from Acute ST-elevation myocardial infarction (STEMI)	Proportion receiving thrombolysis within 60 minutes	53.6	100	+46.4
	Proportion receiving primary angioplasty within 150 minutes	89.6	96.2	+6.6
	Outcome from STEMI (Care bundle)	73.2	78.8	+5.6
Outcome from cardiac arrest[2]	Survival to discharge - all	6.7	5.7	-1
	Survival to discharge - Utstein	22.2	24.5	+2.3
Outcomes from Stroke for Ambulance Patients	Proportion of FAST positive patients potentially eligible for stroke thrombolysis arriving at a hyper- acute stroke unit within 60 minutes	53.6	67.6	+14
	Proportion of suspected stroke patients assessed face to face who received an appropriate care bundle	93.3	94.7	+1.4

Data source: Medical Directorate

[1] ROSC is calculated for two patient groups: The overall rate measures the overall effectiveness of managing care for all out-of-hospital cardiac arrests; the rate for the Utstein comparator group provides a more comparable and specific measure of the management of witnessed cardiac arrests only.
[2] Survival to Discharge: As with the Return of Spontaneous Circulation, survival to discharge following cardiac arrest is reported separately for all patients, and for the subset of patients in the Utstein comparator group

Patient Safety
*Rates of MRSA (Make Ready dependant) (<0) -1 [0]
*Rates of Cdiff (Make Ready dependant) (<100) 9 [0]
*Rates of enterobac (Make Ready dependant) (<100) 68 [59]
*CVFR Shift Start (Make Ready dependant) (<1.5) 0.14 [-0.44]
*CEFR (Make Ready dependant) (>99%) >99% [0%]]
*% turnaround within 30 minutes 58.4% [+2.1%]
*% Patient handover times captured 25.60% [+3.80%]
Data Source: * Make Ready Team ** Corporate dashboard
[±] change on last year

Total Transports to A&E Hospital (2011/12) | 418,219 [+4.54%]
*Overall SECAmb's Managed Conveyance (2011/12) 62.7% [-1.1%]
Category 'A' conveyance (11-12) 73.24% [-4.62%]
Category 'C' conveyance (11-12) 59.53% [-1.16%]
Data source: info.secamb; [±] change on last year
*includes Hear & Treat and excludes Health Care Professional requests; source Corporate dashboard

Patient Transport Service (PTS)
*Actual Patient Journeys 1,319,305
*Target Patient Journeys 1,380,161
Difference -4.41%
** Total PTS journeys by the Volunteer Ambulance Car Service/Drivers 125,380
Data source: *Corporate dashboard ** Patient Transport Service (PTS)

Patient and Public Experience
Complaints (12 month average) 23.08 [+24.22%]
Compliments (12 month average) 93.25 [137.58%]
Liability Claims (clinical negligence + liability) (12 month average) 1
Patient Advice and Liaison (PALS) contacts (12 month average) 150.50 [2.55%]
Data source: Corporate dashboard

Developmental Work on Patient Journey section

As part of the CQUIN (Commissioning for Quality and Innovation) Plan for 2012/13 we will be reporting on alternative care pathways, use of NHS Pathways and the Directory of Services (DoS).

This will enable SECAmb to monitor the availability of the services and pathways available to its health economy but also identify where there is a lack of or no provision as well as those services and care pathways that have the highest demand placed upon them. Once these aspects have been identified SECAmb will be able to work in partnership with the service providers and PCTs to optimise the quality of the services and pathways provided.

10. How the Quality Account and Quality Report was developed

The Board have been appraised and consulted throughout the development of the Quality Account and Quality Report. All the objectives reflect a quality improvements approach and strongly reflect patient and public need alike.

The Quality Account and Quality Report has been developed throughout the year from a range of priorities that were identified as a result of the quality account and quality report stakeholders workshop and input from the Governors, Board and Executive Team.

The decision to look at the chosen five priority areas followed guidance/ suggestions from those who attended the stakeholder workshop in January 2012 on quality measures they would like to see included in this year's Quality Account/ Report. The workshop included invitations to Governors, PPI Representatives, LINKs, HOSCs, Foundation Trust Members and Commissioners.

We asked participants at the end of the workshop to complete an evaluation form and below are the summary of the findings (detailed in Figures 15 to 19).

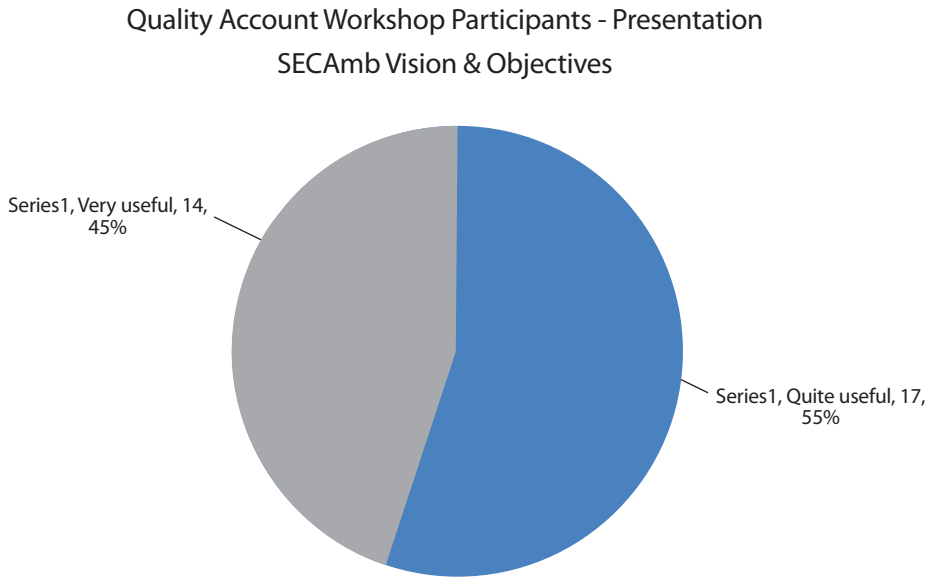


Figure 15: Quality Account Workshop: Vision and Objectives

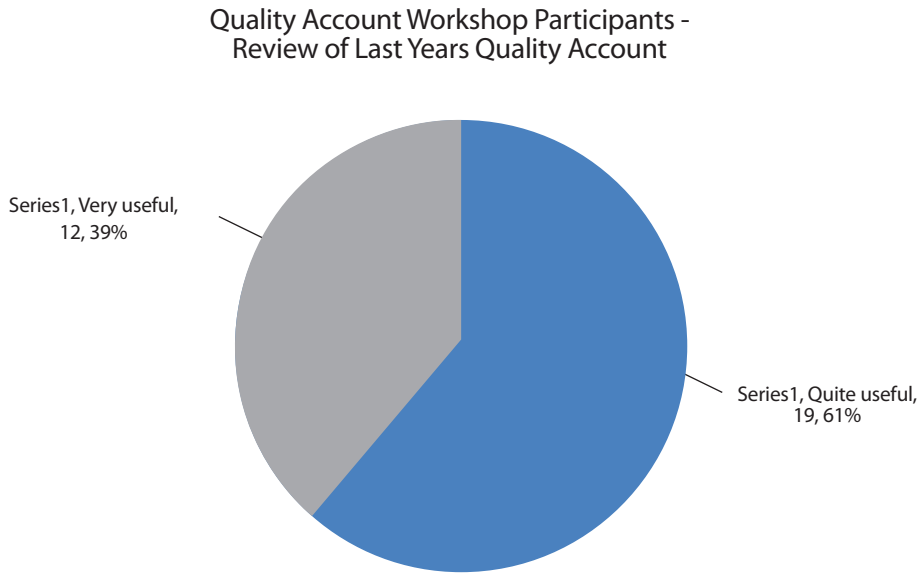


Figure 16: Quality Account Workshop: Review of Last Year

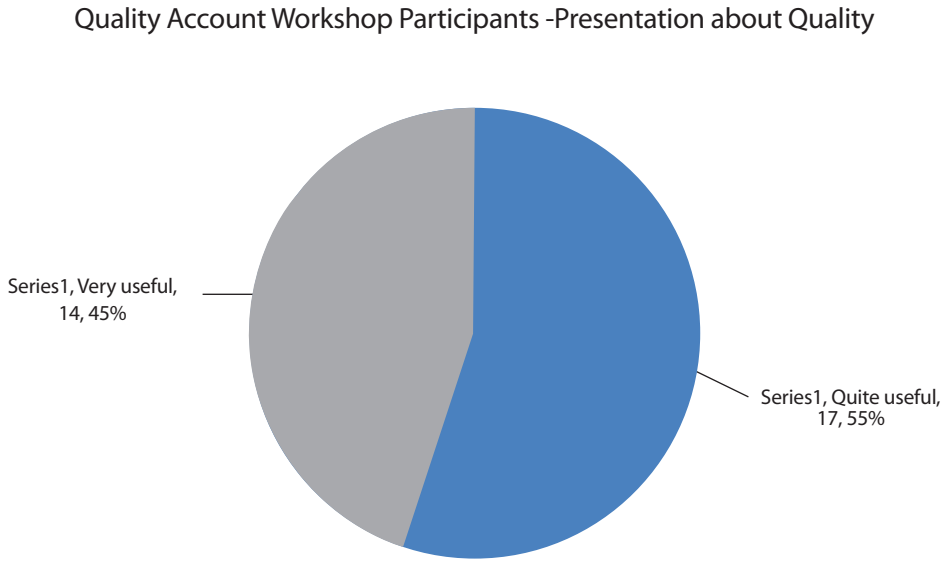


Figure 17: Quality Account Workshop: Feedback on the presentation, language and content of the 2010/11 Quality Account

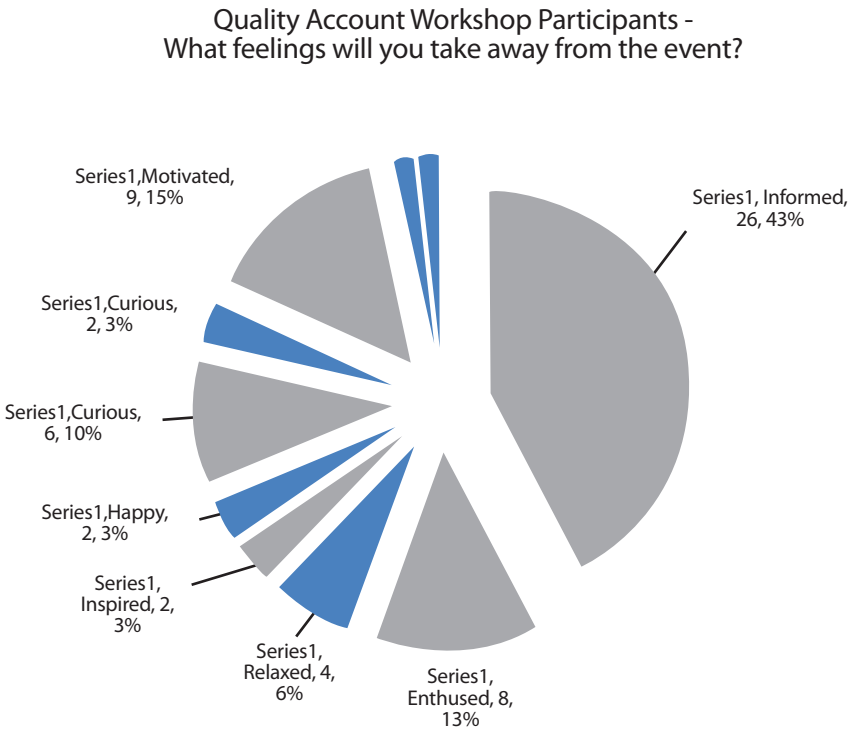


Figure 18: Quality Account Workshop: Feelings taken away from the event?

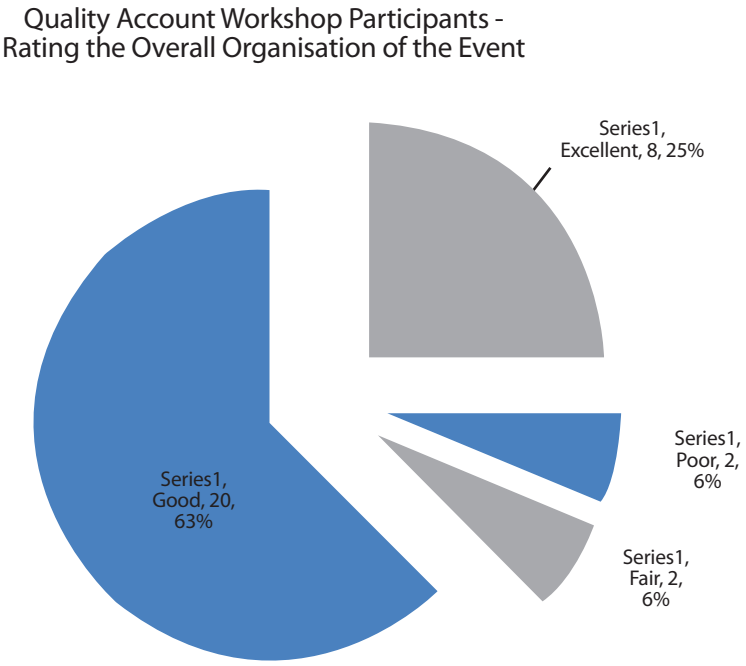


Figure 19: Quality Account Workshop: Rating of overall event

In addition to the workshop we circulated the draft Quality Account and Quality Report to HOSCs, LINks, Governors, SECAmb Non-Executive Directors and Commissioners for comments.

11. Quality Improvements to be implemented by SECAmb during 2012/2013

11.1 CQUIN (Commissioning for Quality and Innovation) Plan

CQUIN is a national framework for locally agreed quality improvement schemes. It makes a proportion of SECAmb's income conditional on the achievement of ambitious quality improvement goals and innovations agreed between Commissioner and SECAmb, with active clinical engagement. The CQUIN framework is intended to reward excellence, encouraging a culture of continuous quality improvement in all providers.

The SECAmb 2012/13 CQUIN Plan lists four goals, which are:-

- Patient Experience
- Reduction in Unplanned admissions as applied in each cluster
- IBIS Case Management System
- Use of alternative Pathways
- Utilising NHS Pathways triage and Directory of Services
- Increase skill mix in Workforce
- Increase skill mix in EDC
- Increased skill mix at scene
- High Impact Innovations – digital by default (Digital by default is the most relevant to ambulance services, and this goal will support the electronic transfer of data to GPs and community based providers to minimise manual data entry and re-triage).

11.2 IBIS project

As referenced in Section 4, we have introduced this system as part of the 2011/12 CQUIN plan, to improve clinical information sharing with other health care providers.

All areas of the system will be rolled out and fully embedded during 2012/13.

11.3 Research and Development (R&D)

R&D is important to ensure SECAmb are at the forefront of new and innovative clinical care. To ensure we can participate fully and build on SECAmb's reputation as a respected R&D institute, we will be developing the skills and knowledge so that we are able to contribute to developing clinical care and leading in defining best practice.

11.4 MeCCPUS (previously known as the LUCAS Trial)

Throughout 2012/13 SECAmb will be working in conjunction with the Royal Sussex County Hospital, Brighton, the William Harvey Hospital, Ashford Kent, St George's Hospital, London, St Peter's Hospital, Chertsey and the University of Hertfordshire to evaluate the use of mechanical chest compressions that may aid the survival of those patients who suffer the most severe cardiac arrests. The equipment being used to support this study is called the Lund University Cardiopulmonary Assist System (LUCAS 2TM) and will be implemented into the patients' care by the Critical Care Paramedic teams across SECAmb's area.

The LUCAS has been devised to compress the chest mechanically at the correct rate

and depth and has been widely used for ambulance transport. It is also the most practical way at present of maintaining chest compressions whilst performing angiography and angioplasty on patients still in cardiac arrest, and is already used in some catheter laboratories (in the UK and elsewhere) for in-patients who are in cardiac arrest resistant to conventional treatment.

11.5 i-STAT Blood Gas Analysis

Another development is the expansion of the range of near patient tests that the CCPs can undertake will increase with the introduction of the i-stat blood gas analyser. This will enable the CCPs to undertake blood tests that would normally be undertaken in hospital, improving the speed that patients can have decisions about appropriate care pathways made, streamlining the flow of the patient through the care system.

11.6 Research with Heart Attack Patients Project

Research with Heart Attack Patients Project has been one of the milestones for SECAmb as this is the first, portfolio adopted clinical trial that SECAmb has undertaken. This study focuses on patients having an ST segment elevation myocardial infarction (STEMI).

SECAmb is one of several ambulances in the UK and abroad participating in a randomised controlled trial to evaluate the efficacy and safety of pre-hospital vs in-hospital initiation of ticagrelor, an oral, fast-acting platelet inhibitor, in patients with ST segment elevation MI (STEMI).

Ticagrelor is already approved by NICE (National Institute for Health and Clinical Excellence) for use in hospital, but there is no data on its use in the ambulance setting.

Paramedics in Hastings have been trained in the study procedures and adopted onto the NIHR (National Institute for Health Research) Portfolio, has MHRA (Medicines and Healthcare products Regulatory Agency), ethics and NHS research and development approval. Currently work is underway to expand the study's recruitment area to include Ashford in Kent.

11.7 Transient Ischaemic Attack (TIA) Project

In a joint research project between SECAmb and the University of Surrey, funded by South East Coast Strategic Health Authority, SECAmb is undertaking an evaluation study of the ABCD2 score in the pre-hospital assessment of patients with suspected Transient Ischaemic Attack (TIA).

Stroke is a major cause of premature death and disability, affecting approximately 110,000 people and their families every year in England, and accounting for 11% of all deaths. Ambulance services have been recognised as an important component of the 'chain of recovery' following stroke with time-dependent treatments such as thrombolytic therapy being shown to improve outcomes.

A further 20,000 people a year suffer a transient ischaemic attack (TIA), considered an important risk of imminent stroke. Diagnosis and risk assessment of TIA are challenging, not least in the pre-hospital setting. Patients who have continuing symptoms on arrival of ambulance staff are considered to be suffering an acute stroke until proven otherwise and standard pathways for rapid referral apply, but ambulance staff experience suggests that a significant proportion of patients in whom

such symptoms have resolved on ambulance arrival decline transport to hospital as they 'feel better'. Moreover, patients who do agree to go to hospital may not be prioritised for rapid specialist assessment and may therefore fail to receive prompt diagnosis, risk stratification and secondary prevention measures, placing them at risk of progression to a stroke. Therefore identifying patients with TIA who are at high risk of stroke is an opportunity to prevent stroke. However, there is as yet no assessment tool for TIA validated for use in the ambulance setting.

This evaluation study is looking at the implementation of the ABCD2 score which has been widely implemented but has not yet been prospectively validated in the context of pre-hospital care. The objective of this study is to externally validate the ABCD2 score as a tool for identifying patients with suspected TIA, assessed by ambulance staff in the pre-hospital setting, who are at high risk of stroke within 7 and 90 days.

The present study is a pilot study. Two cohorts of patients will be recruited (a) patients with suspected TIA attended by study trained ambulance staff in Surrey and (b) patients with suspected TIA from a similar operational area where ambulance staff have not been trained in ABCD2 (Sussex) over a 3 month period.

The primary outcome measures are (a) test performance of the ABCD2 score estimating the sensitivity and specificity, positive predictive value (PPV) and negative predictive value (NPV) of the ABCD2 score for diagnosis of TIA and occurrence of stroke subsequently (at 7 and 90 days) and (b) proportion of patients with true TIA or not (specialist diagnosis) and subsequent stroke or not (at 7 and 90 days).

The secondary outcome measure is the time to specialist assessment in the ABCD2 group compared to controls. The pilot study commenced during 2011 and is scheduled to conclude in March 2013, with on-going progress reports being submitted to the Research and Development Sub Group.

11.8 Community First Responders (CFRs)

We are planning to recruit 120 CFRs this financial year and install a further 100 Public Access Defibrillator sites throughout South East Coast.

We have also recruited 10 Senior Community Team Leaders spread throughout the South East Coast and each of them are the link between the Volunteer Development Coordinators and the Team leaders.

SECAmb is also developing a similar structure for our Associate Trainers who will be providing clinical support for the team.

At present SECAmb have 650 CFRs over 90 schemes, 60 team leaders and 10 Senior Team Leaders and records show that only 50% of our CFRs are active so work is taking place towards addressing this and understanding the reasons behind this low percentage.

11.9 Stakeholder input

We are planning to continue to develop the Quality Account and Quality Report so that it tells the story of the patient journey but want to continue it to be guided by our stakeholders as to what the priorities are for doing this. The priorities chosen start to tell this story as well as those suggested by meeting with SECAmb's public

representatives, but we know that there is more to show and we want to continue our engagement with stakeholders in agreeing these.

11.10 Understanding patient outcomes

For SECAmb to fully understand and develop its clinical care, it is essential to understand the outcomes of the patients it provides care for at a pathway level i.e. the number of patients referred on a pathway and whether the pathway was effective but also so that our clinical teams receive feedback on the cases that they attend.

11.11 Professional Standards

SECAmb has a Professional Standards team who work with all their clinicians to support maintenance of the quality of care given, and professional accountability of all clinical staff. The focus is to constantly strive to improve the clinical quality of care and patient experience that our patients receive.

11.12 Patient Transport Services (PTS) Quality Measures for 2012/13

SECAmb's PTS will carry out two patient satisfaction surveys, so one measure could be to show an improvement between surveys/ maintain a high level of satisfaction amongst users. They already record complaints (running at >0.5%) so could have a measure around this.

Under the new contract there are 40 key performance indicators to monitor including number of delays, waiting time (travelling to or from appointment, or how long after appointment through time to collection), staff training, green measures etc, so the PTS team could also potentially pick some measures from here. These will be reported on monthly from April 2012 to the monthly commissioners meeting.

12. Responses from HOSCs, LINks and Commissioners

Who we shared our Quality Account with:

The Quality Account and Quality Report was shared with partners during its development before it was published and the following formal statements have been received from the above named partners.

Statement from NHS Kent & Medway (Lead Commissioners)

NHS Kent and Medway is the lead commissioning Primary Care Trust (PCT) for South East Coast Ambulance Service NHS Trust and welcomes the publication of this quality account for 2011-12.

The account is clear and well set out and NHS Kent & Medway can verify that the information contained in the Quality Account is accurate and an honest reflection of the strong progress made in many aspects of service improvement. The quality account recognises the challenges faced by SECAMB and reflects plans on how they will be addressed.

SECAMB have been successful in achieving their response times across the Trust and have also made improvements in qualified staff attending serious incidents. This is reflected in the delivery of their workforce plans involving paramedic practitioners and critical care paramedics. However, further assurance is required to address the variation in responses across different geographical areas.

SECAMB continue to achieve well in reaching agreed quality indicators and significantly delivered on their Commissioning for Quality and Innovation incentive scheme.

The PCT wishes to see further assurance of how patient complaints and PALs concerns will inform future patient experience surveys as the detail of current identified themes and trends was not stated in this quality account.

We are assured that SECAMB are procuring a reliable and quality assured product to use in their testing protocol for monitoring the effectiveness of the Trust's infection control procedures for the deep clean process of emergency response vehicles.

NHS Kent & Medway and South East Coast Ambulance Service continue to work very closely to assure the quality of our local health services and ensure the culture of continuous improvement is present in all areas of the Trust.

Sally Allum
Assistant Director – Nursing & Quality (West) and Lead for Clinical Performance

HOSCs

Comment from Surrey Health Overview and Scrutiny Committee

The Health Overview & Scrutiny Committee is pleased to be invited to comment on the Trust's Care Quality Account for 2011/12. At present the Health Overview & Scrutiny Committee does not have a robust process in place for commenting on a trust's Care Quality Accounts; however, this is under review.

The main priority for Health Overview & Scrutiny Members is to seek assurances that any planned changes to the way health services are commissioned and delivered in

the future will not have a detrimental impact on the health of people living in Surrey.

In May, the Committee will look at setting its priorities and work programme for the next year. We look forward to working with the Trust on any areas of scrutiny in which you may be asked to be involved.

Leah O'Donovan, Scrutiny Officer
Adult Social Care Select Committee and Health Overview & Scrutiny Committee
Surrey County Council

Comment from Kent Health Overview and Scrutiny Committee

In recent weeks, the HOSC has received a number of draft Quality Accounts from Trusts providing services in Kent, and may continue to receive more. I would like to take this opportunity to explain to all Trusts the position of the Committee this year.

Given the large number of Trusts which will be looking to the HOSC at Kent County Council for a response, and the standard window of 30 days allowed for responses, the Committee does not intend to submit a statement for inclusion in any Quality Account this year.

Through the regular work programme of HOSC, and the activities of individual Members, we hope that the scrutiny process continues to add value to the development of effective healthcare across Kent and the decision not to submit a comment should not be interpreted as a negative comment in any way.

At part of its ongoing overview function, the Committee would appreciate receiving a copy of your finalised Quality Account for this year and hope to be able to become more fully engaged in next year's process.

Michael Snelling
Chairman, Health Overview and Scrutiny Committee,Kent County Council

Comment from West Sussex County Council

Thank you for offering the Health & Adult Social Care Select Committee (HASC) the opportunity to comment on the 2011-12 Quality Account for South East Coast Ambulance Service (SECAmb) . I apologise for missing your deadline for a response.

Unfortunately, it is difficult for the HASC to comment on Quality Accounts this year. As you may be aware, this is a new Committee, formed by the merger of the former Adults' Services Select Committee and Health Overview and Scrutiny Committee (HOSC). HASC has a new membership, and until last Friday (when I was appointed) did not have a Chairman for the past month. In addition, the former HOSC's liaison arrangements with NHS Trusts will need to be reviewed, given changes to the new Committee's membership, and its wider remit covering both health and adult social care. We will therefore not be providing a comment on the SECAmb Quality Account this year.

However, this is in no way a reflection of the importance of the work of the Ambulance Service, and I would like to reassure you that the Committee will maintain a strong interest SECAmb, and will aim to build on the positive relationships established with you by the HOSC. We will be in touch in the near future to confirm our liaison arrangements for the year ahead.

Mrs Margaret Whitehead
Chairman, Health & Adult Social Care Select

Committee, West Sussex County Council

Statement from East Sussex Health Overview and Scrutiny Committee

East Sussex Health Overview and Scrutiny Committee (HOSC) is made up of elected local councillors from East Sussex County Council and District and Borough Councils in the county, together with representatives from the local voluntary sector. The Committee has reviewed the Trust's Quality Account 2011/12 and makes the following observations:

General observations

HOSC welcomes the themes covered by the Trust's Quality Account. In particular HOSC fully supports the emphasis being given to patient experience alongside clinical quality.

The Committee recognises the efforts made by the Trust to engage stakeholders, including patients and the public, in the development of its priorities particularly through the successful 'Shaping the Future' events. The Trust's recent adoption of an inclusion strategy is also a positive step forward in embedding engagement across its work.

The Trust has engaged positively with HOSC throughout the year and has been responsive to issues raised. This has included an opportunity for HOSC Members to visit the Trust's Sussex Control Room and speak in detail with senior staff about the Trust's plans for the future. This gave the Committee considerable assurance regarding the Trust's aspirations and specific programmes to develop services.

Quality priorities for 2011/12

The five priority areas are clearly set out and explained, with good reasoning for their selection. HOSC welcomes the Trust's acknowledgement that there is further scope for improvement in those areas which are a continuation of priorities from the previous year.

The Committee judges that the selection of priorities for 2011/12 does reflect issues of importance to patients and the public, notably seeking alternatives to hospital admission where appropriate and infection control measures. HOSC also welcomes the Trust's focus on patient outcomes.

Councillor Rupert Simmons, Chairman
Health Overview and Scrutiny Committee

LINks

Statement from West Sussex LINk

The West Sussex LINk was disappointed to note that there were several points at which data were to be inserted after validation; the LINk would have preferred to have been shown a later version of the draft that included these data. The LINk was also disappointed to see that, despite efforts having obviously been made to ensure that the Quality Account was intelligible to the lay reader, there remained instances of jargon. In particular, the LINk was dismayed to see the continued use of the expression 'Front Loaded Model' which is a patently ridiculous term in the ambulance context, and which the LINk had understood would be dropped.

Although representatives of the LINk took part in the discussions around the Draft Inclusion Strategy, they did not attend the

stakeholder workshop in January 2012, which was a matter of regret. But these reservations are relatively minor, and the LINk was generally satisfied that the Quality Account represents a true reflection of SECAmb's quality, and is content with the priorities identified. The LINk has been privileged to have a seat at the table where the South East Coast Specialised Commissioning Group and PCTs hold monthly meetings with SECAmb.

An issue not covered in the Quality Account is that of Category A response times in rural areas. The LINk is fully aware that the distances involved can make meeting the target difficult, and accepts that patients in urban areas of West Sussex are better served; the LINk knows that the overall performance in the county is satisfactory. But the LINk is concerned that, for patients in villages that are on the boundary of more than one Operational Dispatch Area, there have been instances of problems with locating the patient's address, leading to lengthy delays. The LINk knows that GPs and other means of direction finding are not infallible, and hopes that SECAmb will continue to explore ways of overcoming these difficulties.

The LINk is pleased that various initiatives aimed at improving aspects of quality are bearing fruit, and expects that the introduction of IBIS will lead to further improvements. The LINk is still not entirely convinced, however, that Critical Care Practitioners are cost-effective, and awaits proof. On the other hand, the LINk recognises the contribution SECAmb has made to improving Stroke and Trauma pathways, and appreciates the impact these will have on patient outcomes.

The LINk was glad that SECAmb was awarded the pan Sussex Patient Transport Service contract in the face of stiff competition, and is confident that patients' experience of PTS will continue to be consistently good, with even fewer instances of poor experience. The smooth discharge of patients from hospital to home or nursing home in the evening is a potential problem that will require contributions from all concerned, including SECAmb, to solve. SECAmb's active participation in the Sussex Together initiative and in the Managed Clinical Networks shows what can be achieved.

Dr Vicki King, Chair,
West Sussex LINk Stewardship Group

Statement from Kent LINK

The Kent LINk would like to thank South East Coast Ambulance NHS Foundation Trust (SECAmb) for the opportunity to comment on their Quality Account prior to publication. The Kent LINk has used various methods throughout the year to collect patient experience data from users of SECAmb services in order to provide this statement for the Account:

- Kent LINk Governors' Group and Priorities Panel members comments, in line with Department of Health document 'Quality Accounts: a guide for Local Involvement Networks'.
- Kent LINk participants and SECAmb service users, commenting on their experience of using the services, as well as the Trust's performance against last year's priorities and how appropriate they felt this year's priorities are, via an online and paper survey.
- Face to face interviews with patients and visitors within hospitals throughout Kent, who were also asked to comment on the

above areas.

- The LINk has also used intelligence gathered throughout the year through its projects and community engagement events.
- LINk participants with a registered interest in ambulance services were also asked to comment on the presentation and layout of the Account.

1. Is the Quality Account clearly presented for patients and public?

The draft presented to the Kent LINk contained various references to more material yet to be provided, so it is difficult to know what the final presentation will look like. However, what was available is well structured with each priority, its current status and the proposed actions for improvement explained.

The Kent LINk found that there was a large amount of detail contained within the Quality Account, which tended to make each section overly long. This amount of detail, coupled with the length of the document (71 pages in its draft format) could make the document inaccessible to the lay reader. Respondents also noticed that there was a high amount of repetition throughout the document. Whilst the Kent LINk acknowledges that some details relate to more than one priority, a reduction in repetition would perhaps enable the Quality Account to be reduced in size.

Respondents commented that there was a good use of photos and diagrams throughout the Quality Account and that there was also a good use of colour. For the lay reader, the amount of acronyms used throughout the document can be daunting, but the Kent LINk would note that these are clearly referenced and explained.

2. Priorities for 2011 / 2012

Respondents to Kent LINk surveys and those who took part in face to face engagement indicated that the Trust appear to have made good progress with their priorities laid out in last year's Quality Account, and have clearly identified in this year's Quality Account where there are still improvements to be made.

3. Priorities for 2012 / 2013

Respondents were in agreement with the priorities set out within the Quality Account, and the Kent LINk would like to commend the Trust for placing the priorities together at the beginning of the document. Respondents were also positive about the Trust's decision to clearly identify staff members (Board Sponsors and Implementation Leads) responsible for delivery of the priorities laid out with the Quality Account.

4. Safety, Communications and Staff

The Kent LINk has received comments throughout the year rating the services provided by SECAmb as highly efficient, effective and of a high quality. In particular, users of the services have commented on the attitudes of staff members indicating that staff were kind, caring, professional, informative and friendly. Respondents to Kent LINk surveys commented that SECAmb staff often '*went out of their way*' to help, and treated patients with respect whilst maintaining patient privacy and dignity. This is to be commended, and indeed the Quality Account suggested that the Trust receives more compliments than it does complaints.

5. Who has been involved in the preparation of the Quality Account?

SECAmb has clearly demonstrated with their Quality Account that the Trust has engaged with a wide variety of stakeholders, including the public, in the creation of its Quality Account. The LINk was included in this engagement and throughout the year the Trust has shown a great willingness to involve LINk participants in its work.

The LINk would like to take this opportunity to congratulate the Trust on the progress it has made over the past year, and the excellent feedback received by the Kent LINk regarding SECAmb services. Under the Health and Social Care Act 2012, LINk's are to be abolished in March 2012 and a Local Healthwatch will commence operation in Kent in April 2012. Kent LINk would like to recommend that the Local Healthwatch utilizes the LINk's Quality Accounts toolkit when making a statement on next year's SECAmb Quality Account, and would hope that Local Healthwatch and SECAmb can continue the good working relationship that exists between Kent LINk and the Trust.

John Ashelford
Kent LINk Governor and Quality Accounts Project Lead

Statement from Medway LINk

Introduction

The Medway LINk would like to thank South East Coast Ambulance Service NHS Foundation Trust for the opportunity to comment on their Quality Account. This commentary has been compiled using information assembled from numerous responses from:

- Medway LINk participants and service users, commenting on their experience of using the services, as well as the Trust's performance against last year's priorities an online and paper survey carried out between 30 January and 15 March 2012
- Face to face interviews with service users and visitors within the Outpatients areas of Medway Maritime Hospital site, who were also asked to comment on the above key areas.

1. Is the Quality Account clearly presented for patients and public?

As per last year, the document is well structured with each priority, its current status and the proposed actions for improvement explained. Acronyms are clearly referenced and explained.

However, as per our commentary last year, there remains a tendency to include a large amount of detailed explanation that makes the sections overlong and difficult for the lay reader to understand. Last year we commented that '*at over 49 pages in draft format, reading and understanding the whole document is likely to be a daunting prospect for the lay reader*'. This years draft is 71 pages long.

8. Section 6 details a huge rise in the number of 'compliments' received by the Trust, but also apparently significant levels of complaints, which have increased from last year. This carries no explanation of the specifics of the complaints or why they have increased. The document also fails to explain the process by which complaints are investigated and categorised as justified, unjustified, unproved etc. As the Medway LINk stated in last years commentary, *'if (these are) not explained (they) may cause the reader concerns'.*

2. Priorities for 2010 / 11

The overwhelming majority of participants felt that the Trust had met their last year priorities well with respondents reporting that they felt the trust was "improved", noting the need to "be vigilant and continue to strive to improve".

3. Priorities for 2012 /13

When asked what the Trust's priorities for improvement in the coming year should be, there were a few specific suggestions, for example to "review training for ambulance support workers" and "reduce the numbers of patients being taken to hospital by utilising paramedics" both of which are addressed in this years priorities.

However the majority of respondents felt that the trust was doing well and felt that the priority should be to "maintain standards" and "continue to improve on all areas".

4. Safety, Communications and Staff

Respondents were asked to comment on their perceptions of the above three elements

The overwhelming majority reported that they felt very safe, using words such as efficient, professional, first class and superb. Respondents were unanimously positive about experiences and communications with staff and the levels of dignity and respect shown to them. All reported that they were very satisfied across the three questions and commented on the polite, professional and caring attitudes of staff, saying that they felt "put at ease" and reassured". All respondents rated their overall experience as excellent.

5. Who has been involved in the preparation of the Quality Account

In last years commentary, the Medway LINk recommended inclusion of an explanation of 'how service users and the community were engaged and consulted, and how they were involved in SECAmb's decision making about the services it provides'.

This years Quality Accounts includes detailed information on how the account was developed and SECAmb are to be commended for involving a range of key stakeholders

In summary the Medway LINk feel the Trust should be commended on the excellent feedback received regarding patient experience.

For and on behalf of Medway LINk

David J Harris
Chairman, Board of Governors, Medway Link

13. Useful information on regulatory requirements

Care Quality Commission registration

From 1 April 2010 all NHS Trusts were required to be registered with the Care Quality Commission (CQC) in accordance with the requirements of the Health & Social Care Act 2008.

For SECAmb, we received confirmation of registration without conditions in the following areas:

- Treatment of disease, disorder or injury
- Transport services, triage and medical advice provided remotely
- Diagnostic or screening procedures

In January 2012, SECAmb were inspected by the CQC and received glowing feedback from patients following a wide-reaching independent inspection.

The positive feedback from patients formed part of a review of the SECAmb's services to establish whether it meets key government standards of quality and safety. The report highlighted that people who had used the service said that ambulance crews were polite and treated them with respect. One patient surveyed said: "Yes they were respectful, they were calm and reassuring."

Inspectors for the CQC, the independent regulator of all social and health care services in England, spent three days visiting ambulance stations, offices and A&E departments speaking to patients, frontline staff and managers.

The Compliance Review, which was published on Wednesday, 14 March 2012, found that SECAmb was meeting all of the essential standards of quality and safety and made some suggestions for improvement in only two areas.

Chief Executive, Paul Sutton said: "It is always very pleasing to learn that the commitment and dedication that is shown and expressed by our staff when treating patients has been validated in such a positive way through the words and experiences of our patients.

"We are not complacent and of course there are always improvements that can be made. We will be taking swift action to address the concerns which were raised in two areas of this review."

The two areas where the CQC has suggested that improvements should be made are around improving training records to ensure training for all staff is recorded accurately and is up to date, and that all staff regularly receive safe-guarding training.

14. Independent Auditor's Report

Independent Auditor's Report to the Council of Governors of South East Coast Ambulance Service NHS Foundation Trust on the Annual Quality Report

I 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 2012 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Category A call – emergency response within 8 minutes; and
- Category A call – ambulance vehicle arrives within 19 minutes.

I 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 the Independent Regulator of NHS Foundation Trusts ("Monitor").

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me 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*;
- the Quality Report is not consistent in all material respects with the sources specified in the Statement of Directors' Responsibilities in respect of the Quality Report; 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 Guidance for External Assurance on Quality Reports.

I read the Quality Report and consider whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual*, and considered the implications for my report if I became aware of any material omissions.

I read the other information contained in the Quality Report and consider whether it is

materially inconsistent with:

- Board minutes for the period April 2011 to May 2012;
- Papers relating to quality reported to the Board over the period April 2011 to May 2012;
- Feedback from the commissioners dated 25/05/2012;
- Workshop with the governors took place on the 31/1/12 and subsequent feedback on the draft document was obtained in April / May 2012;
- Workshop with the LINKs took place on 31/1/12 and subsequent feedback on draft document obtained in April / May 2012;
- SECAmb's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 (Patient Experience Report), dated July 2011 to the Risk Management and Clinical Governance Committee;
- The national patient survey (no routine national annual patient survey is required of ambulance services);
- The 2011 national staff survey;
- The Head of Internal Audit's annual opinion over SECAmb's control environment dated 28/05/2012;
- CQC quality and risk profiles dated 29/2/2012;
- Any other information included in my review.

I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). My responsibilities do not extend to any other information.

I am in compliance with the applicable independence and competency requirements of the Chartered Institute of Public Finance and Accountancy (CIPFA) Standard of Professional Practice and Ethics. My 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 South East Coast Ambulance Service NHS Foundation Trust's quality agenda, performance and activities. I permit the disclosure of this report within the Annual Report for the year ended 31 March 2012, to enable the Council of Governors to demonstrate that it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, I 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 my work or this report save where terms are expressly agreed and

with my prior consent in writing.

Assurance work performed

I 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'). My limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- 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 less 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 impact 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 thereof, 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.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of my assurance work has not included governance over quality or non-mandated indicators which have been determined locally by South East Coast Ambulance Service NHS Foundation Trust.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that, for the year ended 31 March 2012:

- 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*;
- the Quality Report is not consistent in all material respects with the sources specified in the Statement of Directors' Responsibilities in respect of the Quality Report; and
- the indicators in the Quality Report subject to limited assurance have 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 *Detailed Guidance for External Assurance on Quality Reports*.

Paul Grady

District Auditor / Officer of the Audit Commission

Bridge House
1 Walnut Tree Close
Guildford
GU1 4UA

12 June 2012

For copies of this Quality Account and Quality Report please contact Jo Byers via email Jo.Byers@secamb.nhs.uk or write to:

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South East Coast Ambulance Service NHS
NHS Foundation Trust

Appendix B

Financial Accounts

1 April 2011 – 31 March 2012

Accounts 31 March 2012

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 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 accounting officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

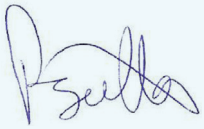
Under the National Health Service Act 2006, Monitor has directed South East Coast Ambulance Service NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts direction. The accounts are prepared on an accrual basis and must give 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 NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, 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 have been followed, and disclose and explain any material departures in the financial statements; 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 to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.



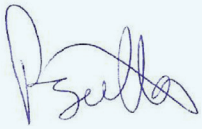
29 May 2012

Paul Sutton, Chief Executive

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.



29 May 2012

Paul Sutton, Chief Executive

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

I have audited the financial statements of South East Coast Ambulance Service NHS Foundation Trust for the period ended 31 March 2012 under the National Health Service Act 2006. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cashflows and all related notes. These financial statements have been prepared under the accounting policies set out in the Statement of Accounting Policies.

I have also audited the information in the Remuneration Report that is subject to audit being:

- the table of salaries and allowances of senior managers [and related narrative notes] on page 240
- the table of pension benefits of senior managers [and related narrative notes] on page 242
- the disclosure of the median remuneration of the reporting entities staff and the ratio between this and the mid-point of the banded remuneration of the highest paid director

This report is made solely to the Council of Governors of South East Coast Ambulance Service NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. My audit work has been undertaken so that I might state to the Council of Governors those matters that I am required to state to it in an auditor's report and for no other purpose.

To the fullest extent permitted by law, I do not accept or assume any responsibility to anyone other than the Foundation Trust as a body, for my audit work, for this report or for the opinions I have formed.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

My responsibility is to audit the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require me to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements.

I read all the information in the annual report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Opinion on financial statements

In my opinion the financial statements:

- give a true and fair view of the state of affairs of South East Coast Ambulance Service NHS Foundation Trust's affairs as at 31 March 2012 and of its income and expenditure for the period then ended; and
- have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and
- the information given in the Annual Report for the financial period for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I report to you, in my opinion the Annual Governance Statement does not reflect compliance with Monitor's requirements. I have nothing to report in this respect.

Delay Certification of completion of the audit

I cannot formally complete the audit and issue an audit certificate until I have completed the work necessary to provide external assurance over the Trust's annual quality report. I am satisfied that this work dose not have a material effect on the financial statements.

Paul Grady

Audit Commission
Bridge House
1 Walnut Tree Close
Guildford
GU1 4UA

30 May 2012

STATEMENT OF COMPREHENSIVE INCOME FOR THE PERIOD ENDED 31 MARCH 2012

	NOTE	Year ended 31 March 2012 £000	One month period ended 31 March 2011 Restated £000
Revenue			
Revenue from patient care activities	5	**168,171**	13,070
Other operating revenue	5.1	**1,871**	1,444
Operating expenses	8	**(164,011)**	(13,923)
Operating surplus/(deficit)		**6,031**	591
Finance costs:			
Investment revenue	13	**52**	6
Other gains and losses		**0**	0
Finance costs	14	**(428)**	(40)
Surplus/(deficit) for the financial period		**5,655**	557
Public dividend capital dividends payable		**(2,169)**	(181)
Retained surplus/(deficit) for the period		**3,486**	376
Other comprehensive income			
Impairments and reversals		**(578)**	0
Gains on revaluations		**110**	0
Receipt of donated/government granted assets		**0**	0
Net gain/(loss) on other reserves (e.g. defined benefit pension scheme)		**0**	0
Net gains/(losses) on available for sale financial assets		**0**	0
Reclassification adjustments:			
- Transfers from donated and government grant reserves		**0**	0
- On disposal of available for sale financial assets		**0**	0
Total comprehensive income for the period		**3,018**	376

The notes on pages 221 to 263 form part of these accounts.

Reported NHS financial performance position [Adjusted retained surplus]

Retained surplus for the year	**3,486**	376
IFRIC 12 adjustment	**0**	0
Impairments	**0**	0
Reported NHS financial performance position [Adjusted retained surplus]	**3,486**	376

The Statement of Comprehensive Income for the one month period ended 31 March 2011 has been restated following a prior year adjustment as a result of the Department of Health accounting policy change regarding donated assets. Further details are given in Note 1.9.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2012

	NOTE	31 March 2012 £000	31 March 2011 Restated £000
Non-current assets			
Property, plant and equipment	15	**76,771**	79,686
Intangible assets	16	**641**	506
Other financial assets		**0**	0
Trade and other receivables	20	**812**	783
Total non-current assets		**78,224**	80,975
Current assets			
Inventories	19	**949**	898
Trade and other receivables	20	**7,467**	12,674
Non-current assets held for sale	22	**3,818**	0
Cash and cash equivalents	21	**22,406**	14,248
Total current assets		**34,640**	27,820
Total assets		**112,864**	108,795
Current liabilities			
Trade and other payables	23	**(12,127)**	(15,737)
Other liabilities	23	**(502)**	(522)
Borrowings	24	**(1,071)**	(1,479)
Other financial liabilities		**0**	0
Provisions	27	**(2,603)**	(5,823)
Net current assets/(liabilities)		**18,337**	4,259
Total assets less current liabilities		**96,561**	85,234
Non-current liabilities			
Borrowings	24	**(4,082)**	(3,243)
Trade and other payables		**0**	0
Other financial liabilities		**0**	0
Provisions	27	**(9,391)**	(4,284)
Other liabilities		**0**	0
Total assets employed		**83,088**	77,707
Financed by taxpayers' equity:			
Public dividend capital		**75,024**	72,661
Retained earnings		**5,141**	1,493
Revaluation reserve		**2,923**	3,553
Donated asset reserve		**0**	0
Other reserves		**0**	0
Total taxpayers' equity		**83,088**	77,707

The Statement of Financial Position as at 31 March 2011 has been restated following a prior year adjustment as a result of the Department of Health accounting policy change regarding donated assets. Further details are given in Note 1.9.

The financial statements on pages 221 to 263 were approved by the Board on 29 May 2012 and signed on its behalf by:

Signed: ..... (Chief Executive) Date: ..29.May.2012.....

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE PERIOD ENDED 31 MARCH 2012

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated asset reserve	Other reserves	Total
	£000	£000	£000	£000	£000	£000
Changes in taxpayers' equity for 2011-12						
Balance at 1 April 2011	**72,661**	**529**	**3,439**	**1,078**	**0**	**77,707**
Restatement - Department of Health accounting policy change	0	964	114	(1,078)	0	0
Restated Balance at 1 April 2011	72,661	1,493	3,553	0	0	77,707
Transfers between reserves	0	162	(162)	0	0	0
Surplus/(deficit) for the year	0	3,486	0	0	0	3,486
Impairments	0	0	(578)	0	0	(578)
Revaluations	0	0	110	0	0	110
Receipt of donated assets	0	0	0	0	0	0
Asset disposals	0	0	0	0	0	0
Share of comprehensive income from associates and joint ventures	0	0	0	0	0	0
Movements arising from classifying non current assets as Assets Held for Sale	0	0	0	0	0	0
Fair Value gains/(losses) on Available-for-sale financial investments	0	0	0	0	0	0
Recycling gains/(losses) on Available-for-sale financial investments	0	0	0	0	0	0
Other recognised gains and losses	0	0	0	0	0	0
Actuarial gains/(losses) on defined benefit pension schemes	0	0	0	0	0	0
Public Dividend Capital received	2,363	0	0	0	0	2,363
Public Dividend Capital repaid	0	0	0	0	0	0
Public Dividend Capital written off	0	0	0	0	0	0
Other reserve movements	0	0	0	0	0	0
Balance at 31 March 2012	**75,024**	**5,141**	**2,923**	**0**	**0**	**83,088**

STATEMENT OF CASH FLOWS FOR THE PERIOD ENDED 31 MARCH 2012

	NOTE	Year ended 31 March 2012 £000	Month ended March 2011 Restated £000
Cash flows from operating activities			
Operating surplus/(deficit)		**6,031**	591
Depreciation and amortisation	8	**9,340**	868
Impairments and reversals	17	**1,397**	0
Transfer from donated asset reserve		**0**	0
(Increase)/decrease in inventories	19.1	**(51)**	(28)
(Increase)/decrease in trade and other receivables	20.1	**5,178**	(4,113)
(Increase)/decrease in other current assets		**0**	0
Increase/(decrease) in trade and other payables	23	**(2,516)**	(2,087)
Increase/(decrease) in other current liabilities	23.1	**(20)**	0
Increase/(decrease) in provisions	27	**1,752**	(794)
Net cash inflow/(outflow) from operating activities		**21,111**	(5,563)
Cash flows from investing activities			
Interest received	13	**52**	6
(Payments) for property, plant and equipment		**(12,091)**	(3,589)
Proceeds from disposal of plant, property and equipment		**175**	5
(Payments) for intangible assets		**0**	0
Proceeds from disposal of intangible assets		**0**	0
(Payments) for investments with DH		**0**	0
(Payments) for other investments		**0**	0
Proceeds from disposal of investments with DH		**0**	0
Proceeds from disposal of other financial assets		**0**	0
Revenue rental income		**0**	0
Net cash inflow/(outflow) from investing activities		**(11,864)**	(3,578)
Net cash inflow/(outflow) before financing		**9,247**	(9,141)
Cash flows from financing activities			
Public dividend capital received		**2,363**	0
Public dividend capital repaid		**(2,269)**	(1,066)
Interest paid	14	**(280)**	0
Public dividend capital overpaid		**100**	0
Loans repaid to the DH		**0**	0
Other loans repaid		**0**	0
Other capital receipts		**0**	0
Capital element of finance leases		**(1,003)**	0
Net cash inflow/(outflow) from financing		**(1,089)**	(1,066)
Net increase/(decrease) in cash and cash equivalents		**8,158**	(10,207)
Cash and cash equivalents (and bank overdrafts) at the beginning of the financial period		**14,248**	24,455
Effect of exchange rate changes on the balance of cash held in foreign currencies		**0**	0
Cash and cash equivalents (and bank overdrafts) at the end of the financial period	21	**22,406**	14,248

NOTES TO THE ACCOUNTS

1. Accounting Policies

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2011/12 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual 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.

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.

Accounting Standards issued but not yet adopted: IFRS 7 "Financial Instruments: Disclosure - amendments" has an effective date of 2012/13; IFRS 10 "Consolidated Financial Statements"; IFRS 11 "Joint arrangements" ; IFRS 12 "Disclosure of Interests in other Entities"; IFRS 13 "Fair Value Measurement" all have an effective date of 2013/14. IAS 1 "Presentation of financial statements, on other comprehensive income"; IAS 27 " Separate Financial Statements"; IAS 28 "Associates and joint ventures" all have an effective date of 2013/14. The Treasury Financial Reporting Manual does not require these standards to be applied in 2011-12.

1.1 Critical judgements in applying accounting policies

The Trust's significant accounting policies are outlined in Note 1 to the accounts. None of these significant accounting policies require management to make difficult, subjective or complex judgements or estimates.

1.2 Key sources of estimation uncertainty

There are no sources of estimation uncertainty which may cause a material adjustment in 2011/12.

1.3 Income recognition

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 Foundation Trust is contracts with commissioners in respect of healthcare services.

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

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.4 Expenditure on Employee Benefits Short term employee benefits

Salaries, wages and employment-related payments 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.

1.5 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. It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers 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 retirement is due to ill-health. The full amount of the liability for the additional costs is charged to operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. It continues to operate on a sound financial basis.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had, up to April 2008, paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

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

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the Statement of Comprehensive Income at the time the Trust commits itself to the retirement, regardless of the method of payment.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

1.6 Expenditure on Other Goods and Services

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

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- 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 have 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, ward 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.

Valuation

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 fair 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 non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

Professional valuations are carried out by a Chartered Surveyor. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual in so far as these terms are consistent with the agreed requirements of the Department of Health, the last asset values were recorded at 31st March 2010. Since the valuation date a further impairment review was performed at the 28th February 2011, whereby relevant indices were applied to the land and building valuations

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying

amount of the asset when it is probable that additional future economic benefits or service potential, deriving from the cost incurred to replace a component of such item, will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is 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'.

1.8 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; where the cost of the asset can be measured reliably, and where the cost 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 atttributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsquently 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.

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

1.9 Donated Assets

Donated non-current assets 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.

1.10 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 FT Annual Reporting Manual impairments that are due to a loss 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 loss 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.

1.11 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 plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their "fair value less costs to sell", 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.

1.12 Leases
Finance leases

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

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. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on 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.

1.13 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.

1.14 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 rate of 2.2% in real terms, except for early retirement and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.9% (2010/11: 2.9%) 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.

1.15 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA 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 NHSLA on behalf of the Trust is disclosed at Note 27 Provisions.

1.16 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.

1.17 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 but are disclosed in Note 28.1 Contingent liabilities unless the possibility of a payment is remote.

1.18 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.

1.19 Corporation tax

The Trust has determined that it has no Corporation Tax liability as its commercial activities provides less than £50k profit.

1.20 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.

1.21 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.

1.22 Financial assets and financial liabilities
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 which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liablities 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 debtors, accrued income and other debtors. After initial recognition, 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. Fair value is determined by reference to quoted market prices where possible.

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, 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.

1.23 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 Financial Instruments.

PDC represents taxpayers' equity in the Trust. At any time the Secretary of State can issue new PDC to and require repayment of PDC from the Trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as PDC dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for donated assets, cash balances with the Government Banking Service and any

PDC dividend balance payable or receivable. The dividend payable is based on the actual average relevant net assets for the year rather than forecast amounts. 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.

1.24 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 32) is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

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 and private ambulance services that are offered by the Trust. All other actives are reported under Patient Services (including Primary Care Trust revenue).

	Patient Services		Commercial Activities		Total	
	2011-12	March 2011 Restated	2011-12	March 2011	2011-12	March 2011 Restated
	£000	£000	£000	£000	£000	£000
Income	169,467	14,461	575	53	170,042	14,514
Surplus/(deficit) before interest	**6,126**	599	**(95)**	(8)	**6,031**	591

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 whose full cost exceeded £1m or was otherwise material.

	2011-12	March 2011 Restated
	£000	£000
Income	575	53
Full cost	670	61
Deficit	(95)	(8)

5. Revenue from patient care activities

	2011-12	March 2011 Restated
	£000	£000
Strategic Health Authorities	0	0
NHS Trusts	7,349	683
Primary Care Trusts	156,735	12,251
Foundation Trusts	1,092	38
Local Authorities	0	0
Department of Health	1,474	0
NHS other	0	0
Non-NHS:		
Private patients	18	39
Overseas patients (non-reciprocal)	0	0
Injury costs recovery	765	54
Other	738	5
	168,171	**13,070**

5.1 Other operating revenue

	2011-12	March 2011 Restated
	£000	£000
Patient transport services	0	0
Education, training and research	917	510
Charitable and other contributions to expenditure	35	0
Transfers from donated asset reserve	0	0
Non-patient care services to other bodies	203	701
Income generation	575	53
Rental revenue from finance leases	0	0
Rental revenue from operating leases	0	0
Other revenue	17	0
Income in respect of staff costs where accounted on gross basis	124	180
	1,871	**1,444**

6. Revenue by classification

	2011-12 £000	March 2011 Restated £000
A & E income	154,862	11,690
Other NHS clinical income	10,459	850
Private patient income	18	42
Other non-protected clinical income	2,832	488
Other operating income	1,871	1,444
	170,042	**14,514**

Of total revenue from patient care activities, £145,857k is mandatory and £22,314k is non-mandatory.

Block Contract Income for March 2011 Restated (£7,444k) has been included in A&E income.

6.1 Private patient income

	2011-12 £000	Base Year 2007-08 £000
Private patient income	18	132
Total patient related income	168,171	132,574
Proportion (as a percentage)	**0.01%**	**0.1%**

Section 44 of the 2006 Act requires that the proportion of private patient income to the total patient related income of NHS foundation trusts should not exceed its proportion whilst the body was an NHS trust in 2002/03 or the base year.

7. Revenue

Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.

8. Operating expenses

	2011-12 £000	March 2011 £000
Services from other NHS bodies	2,729	0
Purchase of healthcare from non NHS bodies	2,758	0
Executive Directors	877	62
Employee Expenses - Non-executive Directors	104	7
Employee Expenses - Staff	109,677	9,106
Drug costs	1,157	41
Supplies and services - clinical (excluding drug costs)	3,327	375
Supplies and services - general	1,847	95
Establishment	4,155	316
Research and development	16	19
Transport	12,917	1,459
Premises	8,123	1,002
Increase in bad debt provision	0	0
Increase in other provisions	2,856	0
Depreciation on property, plant and equipment	9,152	861
Amortisation on intangible assets	188	7
Impairments of property, plant and equipment	(50)	0
Audit services- statutory audit	65	49
Audit services -regulatory reporting	8	8
Other auditors remuneration	0	0
Further assurance services	0	0
Other services	113	8
Clinical negligence	455	37
Loss on disposal of intangible fixed assets	12	0
Loss on disposal of other property, plant and equipment	0	28
Impairments of assets held for sale	1,447	0
Legal fees	380	66
Consultancy costs	527	288
Training, courses and conferences	701	75
Patient travel	5	0
Car parking & Security	0	0
Redundancy	343	14
Early retirements	0	0
Publishing	0	0
Losses, ex gratia & special payments	122	0
Other	0	0
TOTAL	**164,011**	**13,923**

9. Operating leases

9.1 As lessee

Operating leases relate to the leasing of land and buildings, vehicles and other immaterial operating items. There are no contingent rents, terms of renewal of purchase options and escalation clauses and there are no specific restrictions imposed by the lease arrangements.

Payments recognised as an expense

	2011-12 £000	March 2011 £000
Minimum lease payments	2,306	202
Contingent rents	0	0
Sub-lease payments	0	0
	2,306	**202**

Total future minimum lease payments

	2010-11 Total £000	March 2011 Total £000
Payable:		
Not later than one year	1,697	2,528
Between one and five years	2,949	5,399
After 5 years	2,881	2,368
Total	**7,527**	**10,295**

Total future sublease payments expected to be received: £nil

10. Employee costs and numbers

10.1 Employee costs

	2011-12			March 2011		
	Total	Permanently employed	Other	Total	Permanently employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	91,071	90,397	674	7,492	7,460	32
Social security costs	6,998	6,998	0	569	569	0
Employer contributions to NHS pension scheme	10,636	10,636	0	900	900	0
Pension cost - other contributions	0	0	0	0	0	0
Other post employment benefits	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0
Termination benefits	343	343	0	14	14	0
Agency staff	1,849	0	1,849	207	0	207
Employee benefits expense	**110,897**	**108,374**	**2,523**	**9,182**	**8,943**	**239**

10.2 Average number of people employed

	2011-12			March 2011		
	Total	Permanently employed	Other	Total	Permanently employed	Other
	Number	Number	Number	Number	Number	Number
Ambulance staff	1,978	1,959	19	1,991	1,991	0
Administration and estates	697	689	8	732	732	0
Healthcare assistants and other support staff	281	278	3	270	270	0
Bank and agency staff	62	0	62	12	0	12
Other	7	7	0	0	0	0
Total	**3,025**	**2,933**	**92**	**3,005**	**2,993**	**12**
Of the above:						
Number of whole time equivalent staff engaged on capital projects	**2**			**1**		

10.3 Staff sickness absence

	2011-12 Number	2010-11 Number
Total days lost	36,156	38,027
Total staff years	2,785	2,855
Average working days lost	13	13
Total staff employed in period (headcount)	**3,102**	**3,202**

Data provided by Department of Health for 12 months period January to December 2011.

10.4 Retirements due to ill-health

During 2011 -12 there were 7 early retirements from the NHS Foundation Trust agreed on the grounds of ill-health at an additional cost of £814,142 to the NHS Pension Scheme

10.5 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 the Trust in the financial year 2011-12 was £137,500. This was 4.5 times the median remuneration of the workforce, which was £30,335

In 2011-12, no employees received remuneration in excess of the highest-paid director. Remuneration ranged from £12,500 to £117,000.

10.6 Staff Exit Packages during 2011-12

There were 12 exit packages paid in 2011-12 (March 2011 : 1) at a total cost of £343k (March 2011 : £14k)

Exit package cost band (including any special payment element)	2011-2012 Number of compulsory redundancies	2011-2012 Number of other departures agreed	2011-2012 Total number of exit packages by cost band	March 2011 Number of compulsory redundancies	March 2011 Number of other departures agreed	March 2011 Total number of exit packages by cost band
	Number	**Number**	**Number**	Number	Number	Number
Less than £10,000	2	2	4	0	0	0
£10,001-£25,000	2	1	3	0	1	1
£25,001-£50,000	2	0	2	0	0	0
£50,001-£100,000	3	0	3	0	0	0
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type	**9**	**3**	**12**	0	1	1
Total resource cost (£000s)	**325**	**18**	**343**	0	14	14

11. Salary and Pension Entitlements of Senior Managers

11.1 Remuneration

			Year ended 31 March 2012			Month ended 31 March 2011		
Name	Title	Term of Office	Salary (bands of £5,000) £'000	Benefits in Kind Rounded to the nearest £100	Employer Pension Contribution Rounded to the nearest £100	Salary (bands of £5,000) £'000	Benefits in Kind Rounded to the nearest £100	Employer Pension Contribution Rounded to the nearest £100
Chairman								
Mike Harris	Chairman	*(Contract ended 30/09/11)*	15-20	-	0	0-5	-	0
Tony Thorne	Chairman	*(Appointed 01/09/11)*	20-25	-	0	-	-	0
Non Executive Directors								
Christine Barwell	Non-Executive Director		5-10	-	0	0-5	-	0
Isobel Simpson	Non-Executive Director		5-10	-	0	0-5	-	0
John Jackson	Non-Executive Director		5-10	-	0	0-5	-	0
Nigel Penny	Non-Executive Director		5-10	-	0	0-5	-	0
Trevor Willington	Non-Executive Director		5-10	-	0	0-5	-	0
Tim Howe	Non-Executive Director	*(Appointed 01/03/11)*	5-10	-	0	0-5	-	0
Chief Executive								
Paul Sutton	Chief Executive		135-140	5,300	19,400	10-15	400	1,600
Executive Directors								
Andy Newton	Director of Clinical Operations		85-90	3,200	12,400	5-10	100	1,000
Colin Perry	Interim Director of Finance	*(Contract ended 14/04/11)*	10-15	1600*	-	30-35	1,800*	-
James Kennedy	Director of Finance	*(Appointed 17/10/2011)*	55-60	-	8,200	-	-	-
Robert Bell	Acting Director of Finance	*(15/04/11 to 16/10/11)*	80-85	-	11,200	-	-	-
Geraint Davies	Director of Commercial Services		85-90	4,600	12,600	5-10	400	1,000
Kath Start	Director of Workforce Development		85-90	5,200	12,600	5-10	500	1,000
Sue Harris	Director of Strategy, Planning and Partnerships		90-95	4,200	12,600	5-10	300	1,100
Jane Pateman	Medical Director		95-100	1,700	-	5-10	200	-

Pay Multiple

Band of Highest Paid Director's Total (£000)	135-140
Median Total Remuneration (£)	30,335
Remuneration Ratio	4.5

Benefits in Kind

* These figures relate to the provision of accommodation and subsistence to named individual.

All other 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.

11.2 Pension Entitlements

Year ended 31 March 2012

Names	Titles	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 2011	Cash equivalent Transfer 31 March 2012	Real increase in cash equivalent transfer value
Chief Executive		**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Paul Sutton	Chief Executive	0-2.5	5-7.5	30-35	95-100	376	458	71
Executive Directors								
Andy Newton	Director of Clinical Operations	0-2.5	0-2.5	35-40	105-110	685	738	32
Geraint Davies	Director of Commercial Services	0-2.5	0-2.5	25-30	75-80	377	449	61
Kath Start	Director of Workforce Development	0-2.5	0-2.5	0-5	0	30	55	24
Sue Harris	Director of Strategy, Planning and Partnerships	2.5-5.0	(10-12.5)	10-15	10-15	109	128	16
Robert Bell	Acting Director of Finance	5-7.5	17.5-20.0	5-10	15-20	0	105	105*
James Kennedy	Director of Finance	0-2.5	0-2.5	0-5	0	0	9	9

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 takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from other pensions).

* Please note that the Real increase in cash equivalent transfer value for Robert Bell refers to his cumulative NHS service and not only for 2011-12.

12. Better Payment Practice Code

12.1 Better Payment Practice Code - measure of compliance

	2011-12		March 2011	
	Number	£000	Number	£000
Total Non-NHS trade invoices paid in the period	**30,749**	**50,780**	3,086	7,571
Total Non NHS trade invoices paid within target	**28,635**	**45,551**	2,946	7,162
Percentage of Non-NHS trade invoices paid within target	**93%**	**90%**	**95%**	**95%**
Total NHS trade invoices paid in the period	**651**	**4,864**	61	3,110
Total NHS trade invoices paid within target	**499**	**4,411**	52	3,101
Percentage of NHS trade invoices paid within target	**77%**	**91%**	**85%**	**100%**

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 2011-12 Better Payment Practice Code percentages are lower than the target of 95% due to supplier disputes, invoices processed but not yet due, system upload errors and timing of NHS payment runs.

12.2 The Late Payment of Commercial Debts (Interest) Act 1998

There were no payments made as a result of late payment of Commercial Debts (March 2011: £nil)

13. Investment revenue

	2011-12	March 2011
	£000	£000
Interest revenue:		
Bank accounts	**52**	**6**
Total	**52**	**6**

14. Finance costs

	2011-12	March 2011
	£000	£000
Interest on obligations under finance leases	**280**	26
Unwinding of discount	**135**	14
Other	**13**	0
Total interest expense	**428**	40

15. Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Assets under construct and poa	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2011	19,525	22,223	11,656	14,575	40,684	8,920	439	118,022
Additions purchased	0	1,563	10,867	0	0	0	0	12,430
Additions donated	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reversal of Impairments	11	39	0	0	0	0	0	50
Reclassifications	931	8,425	(21,121)	2,551	8,036	841	0	(337)
Revaluations	65	45	0	0	0	0	0	110
Transferred to disposal group as asset held for sale	(2,415)	(4,165)	0	0	0	0	0	(6,580)
Disposals	0	0	0	(3,659)	(2,482)	(3,564)	0	(9,705)
At 31 March 2012	**18,117**	**28,130**	**1,402**	**13,467**	**46,238**	**6,197**	**439**	**113,990**
Depreciation at 1 April 2011	0	89	186	10,243	20,910	6,469	439	38,336
Provided during the month	0	1,218	0	1,388	5,779	767	0	9,152
Impairments	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	(737)	0	0	0	0	0	(737)
Disposals	0	0	0	(3,659)	(2,323)	(3,550)	0	(9,532)
Depreciation at 31 March 2012	**0**	**570**	**186**	**7,972**	**24,366**	**3,686**	**439**	**37,219**
Net book value								
Purchased	18,117	26,151	1,216	5,495	18,133	2,511	0	71,623
Donated *	0	0	0	0	0	0	0	0
Finance leased	0	1,409	0	0	3,739	0	0	5,148
Total at 31 March 2012	**18,117**	**27,560**	**1,216**	**5,495**	**21,872**	**2,511**	**0**	**76,771**
Asset financing								
Owned	18,117	26,151	1,216	5,495	18,133	2,511	0	71,623
Finance leased	0	1,409	0	0	3,739	0	0	5,148
Total 31 March 2012	**18,117**	**27,560**	**1,216**	**5,495**	**21,872**	**2,511**	**0**	**76,771**
Asset financing								
Protected Assets	15,904	14,914	0	0	0	0	0	30,818
Unprotected Assets	2,213	12,646	1,216	5,495	21,872	2,511	0	45,953
Total 31 March 2012	**18,117**	**27,560**	**1,216**	**5,495**	**21,872**	**2,511**	**0**	**76,771**

* Following the alignment project these assets have been reclassified as owned and include Hove and Thanet ambulance stations.

15. Property, plant and equipment continued

March 2011	Land	Buildings excluding dwellings	Assets under construct and poa	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 March 2011	19,525	22,223	7,333	14,575	41,594	8,920	439	114,609
Additions purchased	0	0	4,323	0	0	0	0	4,323
Additions donated	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0
Revaluations	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	0	0	0	(910)	0	0	(910)
At 31 March 2011	**19,525**	**22,223**	**11,656**	**14,575**	**40,684**	**8,920**	**439**	**118,022**
Depreciation at 1 March 2011	0	0	186	10,153	21,166	6,408	439	38,352
Provided during the month	0	89	0	90	621	61	0	861
Impairments	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	0	0	0	(877)	0	0	(877)
Depreciation at 31 March 2011	**0**	**89**	**186**	**10,243**	**20,910**	**6,469**	**439**	**38,336**
Net book value								
Purchased	19,525	22,134	11,470	4,332	14,952	2,451	0	74,864
Donated *	0	0	0	0	0	0	0	0
Finance leased	0	0	0	0	4,822	0	0	4,822
Total at 31 March 2011	**19,525**	**22,134**	**11,470**	**4,332**	**19,774**	**2,451**	**0**	**79,686**
Asset financing								
Owned	19,525	22,134	11,470	4,332	14,952	2,451	0	74,864
Finance leased	0	0	0	0	4,822	0	0	4,822
Total 31 March 2011	**19,525**	**22,134**	**11,470**	**4,332**	**19,774**	**2,451**	**0**	**79,686**
Asset financing								
Protected Assets	15,833	14,453	0	0	0	0	0	30,286
Unprotected Assets	3,692	7,681	11,470	4,332	19,774	2,451	0	49,400
Total 31 March 2011	**19,525**	**22,134**	**11,470**	**4,332**	**19,774**	**2,451**	**0**	**79,686**

* Following the alignment project these assets have been reclassified as owned and include Hove and Thanet ambulance stations.

15. Property, plant and equipment continued

There were no assets donated in the year.

All land and buildings were valued by the Valuation Office Agency (VOA) as at 31 March 2010 to reflect their Modern Equivalent Value (MEV). The Trust has applied an indexation factor in 2012, to reflect the current market and has used the IPD sector capital value industrial index.

All other assets are capitalised at historic cost depreciated over the remaining useful lives on a straight line basis.

The Trust has determined that the open market value of assets is not materially different from their carrying values.

The Trust uses depreciated historial cost as a fair value proxy in respect of assets with short useful lives and low values, namely plant and machinery, transport equipment, IT and furniture & fittings.

The economic lives of fixed assets range from:

	Min Life Years	Max Life Years
Buildings excluding dwellings	30	50
Plant & Machinery	5	5
Transport Equipment	5	12
Information Technology	5	5
Furniture & Fittings	10	10

16. Intangible assets

2011-12	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 2011	1,556	0	0	0	0	1,556
Additions purchased	0	0	0	0	0	0
Additions internally generated	0	0	0	0	0	0
Additions donated	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0
Reclassifications	337	0	0	0	0	337
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	(828)	0	0	0	0	(828)
Revaluation / indexation	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversals of impairments	0	0	0	0	0	0
Gross cost at 31 March 2012	1,065	0	0	0	0	1,065
Amortisation at 1 April 2011	1,050	0	0	0	0	1,050
Reclassifications	0	0	0	0	0	0
Reclassifications as held for sale	0	0	0	0	0	0
Disposals other than by sale	(814)	0	0	0	0	(814)
Revaluation	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Charged during the year	188	0	0	0	0	188
Amortisation at 31 March 2012	424	0	0	0	0	424
Net book value						
Purchased	641	0	0	0	0	641
Donated	0	0	0	0	0	0
Government granted	0	0	0	0	0	0
Total at 31 March 2012	641	0	0	0	0	641

16. Intangible assets (cont.)

March 2011	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 March 2011	1,556	0	0	0	0	1,556
Additions - purchased	0	0	0	0	0	0
Additons - donated	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Revaluations	0	0	0	0	0	0
Transferred to disposal group as asset held for sale	0	0	0	0	0	0
Disposals	0	0	0	0	0	0
Gross cost at 31 March 2011	**1,556**	**0**	**0**	**0**	**0**	**1,556**
Amortisation at 1st March 2011	1,043	0	0	0	0	1,043
Provided during the month	7	0	0	0	0	7
Impairments	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Revaluation surpluses	0	0	0	0	0	0
Transferred to disposal group as asset held for sale	0	0	0	0	0	0
Disposals	0	0	0	0	0	0
Amortisation at 31 March 2011	**1,050**	**0**	**0**	**0**	**0**	**1,050**
Net book value						
Purchased	506	0	0	0	0	506
Leased	0	0	0	0	0	0
Donated	0	0	0	0	0	0
Total at 31 March 2012	**506**	**0**	**0**	**0**	**0**	**506**

16.1 Amortisation rate of intangible assets

Software	5 years

17 Analysis of impairments and reversals recognised in 2011-12

17.1 Analysis of impairments and reversals recognised in 2011-12

	31 March 2012 Total £000	31 March 2011 Total £000
Property, Plant and Equipment impairments and reversals taken to SoCI		
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
Total charged to Departmental Expenditure Limit	0	0
Unforeseen obsolescence	0	0
Loss as a result of catastrophe	0	0
Other	0	0
Changes in market price	(50)	0
Total charged to Annually Managed Expenditure	(50)	0
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	0
Total impairments for PPE charged to reserves	0	0
Total Impairments of Property, Plant and Equipment	(50)	0
Intangible assets impairments and reversals charged to SoCI		
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
Total charged to Departmental Expenditure Limit	0	0
Unforeseen obsolescence	0	0
Loss as a result of catastrophe	0	0
Other	0	0
Changes in market price	0	0
Total charged to Annually Managed Expenditure	0	0
Intangible Assets 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	0
Total impairments for Intangible Assets charged to Reserves	0	0
Total Impairments of Intangibles	0	0
Financial Assets charged to SoCI		
Loss or damage resulting from normal operations	0	0
Total charged to Departmental Expenditure Limit	0	0

17.1 Analysis of impairments and reversals recognised in 2011-12 (cont.)

	31 March 2012 Total £000	31 March 2011 Total £000
Loss as a result of catastrophe	0	0
Other	0	0
Total charged to Annually Managed Expenditure	0	0
Financial Assets impairments and reversals charged to the Revaluation Reserve		
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	0	0
Non-current assets held for sale - impairments and reversals charged to SoCI.		
Loss or damage resulting from normal operations	0	0
Abandonment of assets in the course of construction	0	0
Total charged to Departmental Expenditure Limit	0	0
Unforeseen obsolescence	0	0
Loss as a result of catastrophe	0	0
Other	0	0
Changes in market price	1,447	0
Total charged to Annually Managed Expenditure	1,447	0
Non-current assets held for sale - 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	578	0
Total impairments for non-current assets held for sale charged to Reserves	578	0
Total impairments of non-current assets held for sale	2,025	0
Investment Property impairments charged to SoCI		
Loss as a result of catastrophe	0	0
Other	0	0
Changes in market price	0	0
Total charged to Annually Managed Expenditure	0	0
Total Investment Property impairments charged to SoCI	0	0

Total Impairments charged to Revaluation Reserve	578	0
Total Impairments charged to SoCI - DEL	0	0
Total Impairments charged to SoCI - AME	1,397	0
Overall Total Impairments	1,975	0
Of which:		
Impairment on revaluation to "modern equivalent asset" basis	0	0
Donated and Gov Granted Assets, included above	0	0
Donated Asset Impairments: amount charged to SOCI - DEL	0	0
Donated Asset Impairments: amount charged to SOCI - AME	0	0
Donated Asset Impairments: amount charged to revaluation reserve	0	0
Total Donated Asset Impairments	0	0
Government Granted Asset Impairments: amount charged to SoCI - DEL	0	0
Government Granted Asset Impairments: amount charged to SoCI - AME	0	0
Government Granted Asset Impairments: amount charged to revaluation reserve	0	0
Total Gov Granted asset Impairments.	0	0
TOTAL DONATED/GOVERNMENT GRANTED ASSET IMPAIRMENTS	0	0

17.2 Property, Plant and Equipment

The PPE reversal of an impairment of £50k (2010-11: £nil) results from the current year indexation of Land and Buildings with the credit taken to the SoCI to offset impairment losses from prior years for the same assets

17.3 Non-current assets held for sale

As a result of the Trust's programme of transferring Operations to Make Ready Centres, in November 2011 the Board approved the disposal of eight ambulance stations relating to the Make Ready Centres at Ashford and Paddock Wood.

Fair value market valuations have been received from local estate agents, costs to sell have been deducted and the results compared with the net book value of the assets.

This has identified an impairment loss of £2,025k (2010/11:£ nil) of which £1,447k (2010/11: £nil) has been recognised in Surplus/(deficit) for the financial period in the Statement of Comprehensive Income and £578k (2010/11:£ nil) in the Revaluation Reserve in Taxpayers' Equity.

The impaired assets relate to the Patient Services Operating segment

Please also see Note 22.2 Non-current assets held for sale for details of the ambulance stations.

18. Commitments

18.1 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2012	31 March 2011
	£000	£000
Property, plant and equipment	**269**	0
Total	**269**	0

19. Inventories

19.1 Inventories

	31 March 2012	31 March 2011
	£000	£000
Drugs	**4**	11
Consumables	**747**	705
Energy	**198**	182
Total	**949**	898

19.2 Inventories recognised in expenses

	31 March 2012	31 March 2011
	£000	£000
Inventories recognised as an expense in the period	**51**	28
Write-down of inventories	**0**	0
Reversal of write-downs that reduced the expense	**0**	0
Total inventories recognised in the period	**51**	28

20. Trade and other receivables

20.1 Trade and other receivables

	Current 31 March 2012 £000	**Non-current 31 March 2012 £000**	Current 31 March 2011 £000	Non-current 31 March 2011 £000
NHS Receivables	**1,003**	**812**	2,271	783
Other receivables with related parties	**24**	**0**	261	0
Provision for impaired receivables	**0**	**0**	0	0
Prepayments	**4,335**	**0**	6,757	0
Accrued income	**914**	**0**	1,167	0
Other receivables	**1,191**	**0**	2,218	0
Total	**7,467**	**812**	12,674	783

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

20.2 Receivables past their due date but not impaired

	31 March 2012 £000	31 March 2011 £000
By up to three months	**363**	516
By three to six months	**136**	125
By more than six months	**74**	34
Total	**573**	675

21. Cash and cash equivalents

	31 March 2012 £000	31 March 2011 £000
Opening Balance	**14,248**	24,455
Net change in year	**8,158**	(10,207)
Closing Balance	**22,406**	14,248
Made up of		
Cash with Government banking services	**22,374**	14,212
Commercial banks and cash in hand	**32**	36
Cash and cash equivalents as in statement of financial position	**22,406**	14,248
Cash and cash equivalents as in statement of cash flows	**22,406**	14,248

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 2011	**0**	**0**	**0**	**0**	**0**	**0**
Plus assets classified as held for sale in the year	**0**	**5,843**	**0**	**0**	**0**	**5,843**
Less assets sold in the year	**0**	**0**	**0**	**0**	**0**	**0**
Less impairments of assets held for sale	**0**	**(2,025)**	**0**	**0**	**0**	**(2,025)**
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 2012	**0**	**3,818**	**0**	**0**	**0**	**3,818**
Balance at 1 March 2011	0	0	0	0	0	0
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	0	0	0
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 2011	0	0	0	0	0	0

22.2 Non-current assets held for sale

As a result of the Trust's programme of transferring Operations to Make Ready Centres, the Board has approved the marketing of eight ambulance stations for sale relating to the Make Ready Centres at Ashford and Paddock Wood.

The eight ambulance stations are Cranbrook, Crowborough, Dover, Folkestone, Lydd, Maidstone, Sevenoaks and Tonbridge.

The expected disposal date is prior to 31st March 2013.

23. Trade and other payables

	Current 31 March 2012 £000	Non-current 31 March 2012 £000	Current 31 March 2011 £000	Non-current 31 March 2011 £000
Receipts in advance	**0**	**0**	0	0
NHS payables	**154**	**0**	44	0
Amounts due to other related parties	**491**	**0**	14	0
Trade payables - capital	**461**	**0**	1,555	0
Other trade payables	**281**	**0**	1,048	0
Taxes payable	**3,707**	**0**	62	0
Other payables	**0**	**0**	0	0
Accruals	**7,033**	**0**	13,014	0
PDC payable	**0**	**0**	0	0
Total	**12,127**	**0**	15,737	0

23.1. Other liabilities

	Current 31 March 2012 £000	Non-current 31 March 2012 £000	Current 31 March 2011 £000	Non-current 31 March 2011 £000
Deferred grants income	**0**	**0**	0	0
Other deferred income	**502**	**0**	522	0
Deferred PFI credits	**0**	**0**	0	0
Lease incentives	**0**	**0**	0	0
Net Pension Scheme Liability	**0**	**0**	0	0
	502	**0**	**522**	**0**

24. Borrowings

	Current 31 March 2012 £000	Non-current 31 March 2012 £000	Current 31 March 2011 £000	Non-current 31 March 2011 £000
Obligations under finance leases	**1,071**	**4,082**	1,479	3,243
Total	**1,071**	**4,082**	1,479	3,243

25. Finance lease obligations

The Trust leases 54 A&E ambulances 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	**Present value of minimum lease payments**	Minimum lease payments	Present value of minimum lease payments
	31 March 2012	**31 March 2012**	31 March 2011	31 March 2011
	£000	**£000**	£000	£000
Within one year	**1,303**	**1,479**	**1,479**	1,479
Between one and five years	**2,801**	**2,295**	**3,243**	3,243
After five years	**2,100**	**1,379**	**0**	0
Less future finance charges	**(1,051)**	**0**	**0**	0
Value of minimum lease payments	**5,153**	**5,153**	**4,722**	4,722
Included in:				
Current borrowings		**1,071**		1,479
Non-current borrowings		**4,082**		3,243
		5,153		4,722

Future sublease payments expected to be received total £nil.

Contingent rents recognised as an expense £nil.

26. Prudential borrowing limit

	31 March 2012	March 2011
	£000	£000
Total long term borrowing limit set by Monitor	27,500	25,600
Working capital facility agreed by Monitor	13,000	13,000
Total long term borrowing limit	40,500	38,600
Long term borrowing at start of period for new FTs	0	4,800
Borrowing at 1 April	4,722	0
Net actual borrowing/(repayment) in year - long term	431	(78)
Long term borrowing at 31 March	5,153	4,722

	Actual Ratios	Approved PBL ratios	Actual Ratios	Approved PBL ratios
	2012	2012	2011	2011
Minimum Dividend Cover	7x	>1x	8x	>1x
Minimum Interest Cover	52x	>3x	56x	>3x
Minimum Debt Service Cover	6x	>2x	7x	>2x
Maximum Debt Service to revenue	1.45%	<2.5%	1.43%	<2.5%

The Trust is required to comply and remain within a Prudential Borrowing Limit (PBL). This is made up of two elements:

• the maximum cumulative amount of long term borrowing, this is set by reference to the four ration tests set out in Monitor's Prudential Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit; and Borrowing Code. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit and;

• the amount of any working capital facility approved by Monitor.

Further information on the Trust's Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

27. Provisions

	Current 31 March 2012 £000	Non-current 31 March 2012 £000	Current 31 March 2011 £000	Non-current 31 March 2011 £000
Pensions relating to other staff	**342**	**3,955**	329	3,914
Other legal claims	**1,342**	**0**	845	0
Agenda for Change	**0**	**0**	611	0
Other	**919**	**5,436**	4,038	370
Total	**2,603**	**9,391**	5,823	4,284

	Pensions relating to other staff £000	Legal claims £000	Agenda for Change £000	Other £000	Total £000
At 1 April 2011	**4,243**	**845**	**611**	**4,408**	**10,107**
Arising during the year	**0**	**497**	**0**	**3,193**	**3,690**
Utilised during the year	**(69)**	**0**	**(611)**	**(1,258)**	**(1,938)**
Unwinding of discount	**123**	**0**	**0**	**12**	**135**
At 31 March 2012	**4,297**	**1,342**	**0**	**6,355**	**11,994**
Expected timing of cash flows:					
Within one year	**342**	**1,342**	**0**	**919**	**2,603**
Between one and five years	**1,567**	**0**	**0**	**5,155**	**6,722**
After five years	**2,388**	**0**	**0**	**281**	**2,669**

Other provisions include dilapidations of leasehold premises, holiday pay and pre-1985 banked leave.

The pension provision of £4,297k represents the organisation's pension liability for pre-1995 reorganisations (31 March 2011: £4,243k).

Legal claims are the member provision for personal injury claims being handled by the NHS Litigation Authority.

A further £8,353k is included in the provisions of the NHS Litigation Authority at 31 March 2012 (not in these accounts) in respect of clinical negligence liabilities of the NHS Trust (31 March 2011: £4,267k).

28. Contingencies

28.1 Contingent liabilities

	2011-12	March 2011
	£000	£000
Legal claims	**596**	391
Potential redundancy costs	**110**	0
Total	**706**	391

The contingent liability for legal claims is based on information from the NHS Litigation Authority and relates to other legal claims shown in Note 27. The NHS Litigation Authority 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.

28.2 Contingent assets

The Trust has no contingent assets

29. 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 South East Coast Ambulance Service NHS Foundation Trust with the exception of the Medical Director who had a material transaction with Brighton & Sussex University Hospitals NHS Trust with whom the Trust also has a material transaction, see note below and Note 11.1.

The Department of Health is regarded as a related party. During the year South East Coast Ambulance Service Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are:

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Ashford & St Peter's Hospitals NHS Foundation Trust	18	26	1	6
Brighton and Hove City Teaching PCT	0	86	0	241
Brighton & Sussex University Hospitals NHS Trust	129	3,835	19	14
Dartford & Gravesham NHS Trust	9	0	6	0
Department of Health *	2,729	1,474	14	522
East of England Ambulance Service NHS Trust	30	0	0	0
East Kent Hospitals University NHS Foundation Trust	12	7	4	7
East Sussex Downs & Weald PCT	0	74	0	8
East Sussex Healthcare NHS Trust	54	1,407	12	314
Eastern & Coastal Kent Community Health NHS Trust	0	1	0	1
Eastern & Coastal Kent PCT	0	1,387	0	276
Epsom & St Helier University Hospitals NHS Trust	18	3	1	0
Frimley Park Hospital NHS Foundation Trust	33	0	7	0
Great Western Ambulance Service NHS Trust	0	2	0	2
Hastings & Rother PCT	0	151	0	1
Kent & Medway NHS & Social Care Partnership	5	150	1	0
Kent Community Health NHS Trust	0	1	0	1
London Ambulance Service NHS Trust	23	0	19	0
London SHA	0	0	12	0
Maidstone and Tunbridge Wells NHS Trust	38	172	12	14
Medway NHS Foundation Trust	271	19	39	12
Medway PCT	0	818	13	0
NHS Litigation Authority	455	0	1	0
North East Ambulance Service NHS Trust	0	0	1	0
Portsmouth Hospitals NHS Trust	0	342	69	0
Queen Victoria Hospital NHS Foundation Trust	2	481	0	35
Royal Surrey County Hospital NHS Trust	0	210	1	83
South Central Ambulance Service NHS Trust	0	9	0	0
South East Coast Strategic Health Authority	3	917	0	13

St Georges Healthcare NHS Trust	0	34	0	5
Surrey and Sussex Healthcare NHS Trust	19	0	14	0
Surrey PCT	52	3	3	0
Sussex Community NHS Trust	5	317	6	7
Sussex Partnership NHS Foundation Trust	1	373	0	30
University Hospital Birmingham NHS Foundation trust	0	2	0	2
Wandsworth Teaching PCT	0	0	0	1
West Kent PCT	0	153,511	0	76
West Midlands Ambulance Service NHS Trust	1	0	0	16
West Suffolk Hospital NHS Trust	6	0	0	0
West Sussex PCT	0	705	0	973
Western Sussex Hospitals NHS Trust	155	1,092	54	78
Yorkshire and the Humber Strategic Health Authority	4	0	0	0

In addition, the Trust has had a number of transactions with other Government Departments and other central and local Government bodies.

The Trust has also received revenue payments from the South East Coast Ambulance Charitable Fund, the Trustee for which is the South East Coast Ambulance Service NHS Foundation Trust. The Trust has charged the Charity £14k (2011: £8k) for administration and associated costs for the financial year 2011/12.

* The Department of Health excludes Public Dividend Capital repaid.

30. Intra Government Balances

	31 March 2012				31 March 2011			
	Current receivable £000	**Non-current receivable £000**	**Current payable £000**	**Non-current payable £000**	Current receivable £000	Non-current receivable £000	Current payable £000	Non-current payable £000
Balances with other central government bodies	**1**	**0**	**3,755**	**0**	702	0	11	0
Balances with local authorities	**23**	**0**	**510**	**0**	130	0	30	0
Balances with NHS trusts and foundation trusts	**1,925**	**812**	**309**	**0**	2,547	1,242	27	0
Balances with public corporations and trading funds	**0**	**0**	**0**	**0**	0	0	0	0
Intra government balances	**1,949**	**812**	**4,574**	**0**	3,249	1,242	38	0
Balances with bodies external to government	**4,227**	**0**	**7,348**	**0**	4,411	0	18,010	0
At 31 March	**6,176**	**812**	**11,922**	**0**	7,790	1,242	18,078	0

31. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with Primary Care Trusts and the way those Primary Care Trusts are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low 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 commerical 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 54 front line vehicles on a 5 year fixed rate finance lease. Similarily the Trust has the building element of the Paddock Wood Make Ready Centre on a fixed rate 30 year finance lease.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2012 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with Primary Care Trusts, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its Prudential Borrowing Limit. The Trust is not, therefore, exposed to significant liquidity risks.

31.1 Financial assets

	Loans and receivables	
	31 March 2012	31 March 2011
	£000	£000
Receivables	4,044	6,190
Cash at bank and in hand	22,406	14,248
Total at 31 March 2012	26,450	20,438

31.2 Financial liabilities

	Other financial liabilites	Other financial liabilites
	£000	£000
Payables	8,420	15,675
Finance lease obligations	5,153	4,722
Provsions under contract	7,697	5,864
Total at 31 March 2012	21,270	26,261

31.3 Fair Values

There is no difference between the carrying amount and the fair values of financial instruments.

31.4 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.

32. Losses and special payments

There were 1,667 cases of losses and special payments (March 2011 : 93 cases) totalling £1,390k (March 2011 : £93k) reported during 2011/12. The amounts are reported on an accruals basis but exclude provisions for future losses.

33. Auditor liability limitation agreement

The Trust's contract with its auditors, as set out in the engagement letter, provides for no limitation of the auditor's liability.

34. EU greenhouse gas emissions trading allowance scheme

The EU greenhouse gas emissions allowance trading scheme does not apply to the Trust as the Trust is below the threshold.

35. Carbon reduction commitment energy efficiency (CRC) scheme

The Trust is not a member of the CRC scheme as it is below the threshold of C02 emissions

36. Events after the reporting period

There are no post balance sheet events.

For more information

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