



South East Coast Ambulance Service **NHS**  
NHS Foundation Trust

# Annual Report and Accounts

1 April 2012 – 31 March 2013





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Ambulance Service  
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## 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 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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# Chairman's *Introduction*

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2012/13 was a challenging year for the Trust. We faced a larger than expected increase in demand and capacity shortfalls in a number of A&E

departments during an extended winter. In addition we expanded our Patient Transport Service and introduced the new 111 health line for the South East Coast region. Our staff performed magnificently in the face of these challenges and this allowed us to maintain good patient care, meet national performance targets for the year as a whole and generate a financial surplus.

Early in the year we reviewed the Trust strategy and agreed that it remained appropriate but that we would put greater emphasis on raising clinical performance, workforce planning and on innovation in the delivery of our service. The latter is particularly important given the tightening financial constraints.

There is good evidence from patient feedback, external audits and 'walking around' that our staff deliver high standards of patient care. Nevertheless, as a result of the Francis report into the failings at Mid Staffordshire NHS Foundation Trust, we are introducing changes to our patient experience reporting. This is to ensure that we have comprehensive information on patient care and experience across all our services and that we address any concerns that arise.

We are also paying greater attention to addressing issues that are important to staff.

There were a number of changes to the membership of the Board of Directors during the year. As indicated in last year's report our Director of Strategy, Planning and Partnerships left the Trust. Her duties are currently divided amongst the other Executive Directors. We were delighted to be able to recruit two high calibre Non Executive Directors in Graham Colbert and Dr. Katrina Herren. Graham has recently retired as Vice President Finance, Astra Zeneca and Katrina is the Medical Director at BUPA Health and Wellbeing UK.

The Council of Governors has continued to exercise its role of holding the Board of Directors to account to good effect. Particular areas of the Trust's activities that the Council has reviewed are regional operational performance, our approach to growing the Community First Responder Network and the implementation of the lessons learnt from the rollout of our Make Ready Centres. The Council also made a significant contribution to the Board's approach to addressing staff issues. The Council provided input into the strategy discussions, the development of the 2013/14 annual plan and the priorities included in the Quality Account.



In the year we introduced the process whereby the Chair of each Board committee reports on the work of their committee to the Council of Governors. Individual Governors also provide feedback on the effectiveness of the committee meetings they have observed.

During 2012/13 we had considerable changes on the Council, a number of governors resigned and some governors whose first term of office came to an end on 28 February 2013 were not re-elected. The detailed changes are set out in the section of this report related to the Council of Governors. My thanks go to those who have left for the excellent contribution they have made. They were part of the formation of the Council and can be proud of what has been achieved during their period of office.

I am pleased to welcome the following to the Council: Lesley Long, Jean Gaston-Parry, Neil Baker, Peter Gwilliam, Priscilla Chandro, Richard Pavey, and Tony Dell as public governors; Toni Schwarz, James Blythe and Chief Superintendent Dave Miller as appointed governors and Warren Falconer as a staff governor.

I look forward to working with them in ensuring the Council continues to fulfil its scrutiny role and supports the development of the Trust.

Looking forward to 2013/14; as part of the implementation of our annual plan we will be ensuring that we maintain a high level of patient care during the difficult winter months, meet agreed PTS quality levels and achieve the required performance for the 111 health line; enabling this service to become a vital part of the region's health system. I am confident we have the leadership and the staff capable to meet the challenges that the next year will bring.



**Tony Thorne**, Chairman

# Chief Executive's *Report*

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As I look back on 2012/13, I am, once again, overwhelmed by just how much we have achieved during the year as a Trust.

Undoubtedly 2012/13 was a challenging year – probably one of the most challenging I can remember – but there were also some real highlights.

The London 2012 Olympics and Paralympics were a fantastic national event, which touched us in the South East in a number of ways. As a Trust, we were extremely proud to see the torch being carried by members of staff and volunteers during the Torch Relay. I was also equally proud to see how well our staff responded to the challenge of providing a high standard of service during the major cycling events that took place in our region, on the road in Surrey and at Brands Hatch. The extensive media coverage not only provided a great showcase for our area, but also highlighted the professionalism and pride of our staff in the care they provide.

It was also an extremely proud moment for the Trust as a whole when long-serving SECAMB paramedic, Dave Fletcher, was presented with one of the first ever Queen's Ambulance Medals by HM The Queen in November 2012. Alongside his unswerving commitment to patient care, the medal also recognised Dave's significant contribution in establishing Protocol C – compression-only CPR – across SECAMB, which has undoubtedly led to many additional lives being saved.

Although not without its challenges, the go-live of the new NHS 111 service in March 2013, which is delivered together with our partner Harmoni, also marked a significant step forwards for us towards our aspiration to be the NHS provider of a seamless urgent and emergency care service. As with any new service, there have been some teething problems, as we and our patients get used to a brand new service that is very different from that provided previously. But as I write, we are already seeing real improvements in the responsiveness of the service and I am confident this will go from strength to strength moving forwards.

During the year, we have had to take account of the changing structure of the NHS around us, in how we are commissioned and how our performance is monitored. We have been working hard to build strong local relationships with the emerging Clinical Commissioning Groups and I feel that during the coming year, as the new structures begin to settle down, this should bring real benefits in terms of being able to work together at a local level, to deliver improvements in patient care and tackle some of the underlying system issues which exist.

A key factor during the year was the ongoing increase in demand, which hit the NHS as a whole.

Not only did we see demand for our own services increase far more than we were anticipating, we also saw the same levels of pressure hitting our partners in the acute Trusts, which had a knock-on effect on our ability to hand over patients at hospital during peak periods. We are continuing to work with our acute colleagues to manage this as best we can but it remains a key challenge moving forwards, not only across our region but across the country as a whole.

We also once again experienced periods of bad weather during the year. In many ways we were better prepared for this than in previous years yet, coupled with on-going increases in demand, the snow again placed us under real pressure. But as always, our staff responded magnificently to this, like all the other challenges we face, going the extra mile to ensure our patients received the best service possible in the circumstances.

We also saw some challenges during the year with the delivery of our two new patient transport services (PTS) contracts across Surrey and Sussex, as well as the news that we had not been successful in our bid to provide patient transport services across Kent. Although we have received highly positive feedback from our patients, we have struggled on occasion to make the system work as efficiently and effectively as it needs to.

But we have worked hard during recent months, together with our PTS staff, to make some significant changes to how we work and I am confident that this is starting to pay real dividends.

Looking ahead, 2013/14 is undoubtedly going to be another challenging year for the NHS as a whole. We are going to have to not only work hard, but also differently, to ensure we can continue to deliver high quality and responsive services to our patients in the light of increasing demand and pressures within the system as a whole. I am also anxious to ensure that during the year, we work hard on improving our clinical performance – learning from best practice elsewhere, through innovation and through working with our staff and learning from their experiences – and remain focussed on what is important.

I firmly believe that SECAmb is a great team and through our staff, we can deliver everything we aspire to.



**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.”*

South East Coast Ambulance Service NHS Foundation Trust (SECAmb) is part of the National Health Service (NHS). It was formed in 2006 following the merger of the three former ambulance trusts in Kent, Surrey and Sussex and became a Foundation Trust on 1 March 2011.

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.

## Our staff deliver our vision (above) through the Trust's values:

- + **Be proud** – taking pride in what we do, doing the best we can, valuing individuals
- + **Show respect** – caring for patients and for each other, being open and honest, listening and accepting differences
- + **Have integrity** – being reliable and trustworthy, being consistent, fair and just, keeping promises and doing what we say we will do

- + **Be innovative** – being open to new ideas, understanding risks and being prepared to take them, developing best practice through research and education
- + **Take responsibility** – understanding our goals and working to achieve them, admitting when something goes wrong and taking action to put it right, taking ownership and being accountable

## As a Trust, we:

- + Receive and respond to 999 calls from members of the public
- + Respond to urgent calls from healthcare professionals e.g. GPs
- + Provide non-emergency patient transport services in Surrey & Sussex
- + Receive and respond to 111 calls from the public

We provide these services across the whole of the South East Coast region (with the exception of patient transport services) – Kent, Surrey, Sussex and parts of North East Hampshire and Berkshire. We work closely with our NHS partners in the region – eight primary care trusts, 12 acute hospital trusts and four mental health and specialist trusts.

### We deliver our services from:

- + Two regional offices at Lewes and Coxheath and the Trust HQ at Banstead. Each of these sites also houses an Emergency Operations Centre (EOC) where 999 calls are received, clinical advice provided and emergency vehicles dispatched if needed
- + Two Contact Centres at Dorking and Ashford where 111 calls are received and responded to
- + Five Make Ready Centres
- + 52 Ambulance Stations
- + 49 Ambulance Community Response Posts
- + Two Hazardous Areas Response centres



### We utilise a fleet of 681 vehicles, including:

- + 251 A&E ambulances
- + 110 response cars
- + 17 4x4 vehicles
- + 186 x PTS 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

During 2012/13 we received £174m of income and incurred expenditure and other costs of £170.9m which resulted in the Trust achieving a surplus of £3.1m. The Trust has delivered a £12.9m capital plan during the year; the areas of significant spend including new vehicles of £8m and medical equipment of £1.4m.

We also achieved savings of £10.5m through our Cost Improvement Programme, allowing us to deliver improved services for lower cost.

### During 2012/13 we:

- + Received more than 761,000 emergency calls of which 37.8% were categorised as the most serious (Red 1 & Red 2 calls)
- + Reached 75.1% of Red 1 & Red 2 patients within eight minutes, achieving the national standard
- + Undertook more than 463,000 Patient Transport Service journeys

# Our people

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SOUTH EAST COAST  
AMBULANCE SERVICE



*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, listen to their views and recognise their achievements each year.*

**SECamb employs 3,535 staff, 88% of whom are in direct contact with patients, either face to face or over the phone. Equally as important are the 418 staff employed in support roles – fleet, HR, finance, infection control, IT, clinical governance – and many others, as it is these staff who support front-line staff in carrying out their roles by ensuring they have the right tools, skills and processes needed.**

### 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.

The Trust Board includes the Chairman, seven Non-Executive Directors, the Chief Executive and five Executive Directors.

The 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.

## Our people

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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 annually. 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.





## 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 and a Member of the Board of the Foundation Trust Network

### 2. Christine Barwell (1 July 2006 to 30 June 2013)

Christine was formerly Chairman of Mid Sussex Primary Care Trust. She 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.

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

**Declared interests** – None

### 3. 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 Chair of the Workforce Development Committee and a member of the Trust Board, the Appointments and Remuneration Committee, the Audit Committee.

**Declared interests** – Director of Komoka Ltd; Director of Human Resource Centre



#### **4. 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.

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

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

**Declared interests** – Director of Sunny Spells Ltd., which provides management consultancy and interim management, including projects within the NHS; Associate of Health Skills Ltd, healthcare consultancy.



#### **5. 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 Chair of the Audit Committee and a member of the Trust Board, the Appointments and Remuneration Committee and the Risk Management and Clinical Governance Committee.

**Declared interests** – Chairman of Trustees, Phyllis Tuckwell Hospice, Farnham

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

**Declared interests** – Member of Surrey Parent Partnership Steering Group

**7. Dr Katrina Herren**  
*(1 September 2012 to 31 August 2015)*

Katrina is Medical Director at BUPA Health and Wellbeing UK. She is a licensed doctor who has more than 10 years' experience operating at board level, in a variety of executive roles, within complex organisations.

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

**Declared interests** – Medical Director, BUPA Health and Wellbeing UK

**8. Graham Colbert**  
*(1 September 2012 to 31 August 2015)*

Graham is Senior Vice President Finance at AstraZeneca and has led a finance function that supports the company in over 60 countries. He has extensive experience in growing businesses in both developed and emerging markets. Graham is a member of the Institute of Chartered Accountants in England and Wales.

Graham is a member of the Trust Board, a member of the Appointments and Remuneration Committee\*, the Finance and Business Development Committee and the Audit Committee.

**Declared interests** – Employee of Astra Zeneca

**9. Dr Isobel Simpson (until 31 July 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 was 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



### **10. 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** – Trustee of Dandelion Time Charity

\* 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.



### **11. James Kennedy – Director of Finance**

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 the Finance and Business Development Committee.

**Declared interests** – none

### **12. 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





**13. Sue Harris – Director of Strategy, Planning & Partnerships (to 31 May 2012)**

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

**Declared interests** – none

**14. 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 role of 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 of 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 Director of the College of Paramedics

**15. 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



## **16. 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** – Chair of St George's Nurses League, Trustee of the League Funds at St George's Charitable Foundation, Chair of the London Leagues' Group (RCN), member of the Review Committee of the American Association of the History of Nursing, Visiting Professor at the University of Surrey, Grant Holder, Burdett Trust for Nursing and applicant to the Heritage Lottery Fund.

The shaded areas in the Board and committee attendance tables below indicate meetings that the relevant member was not eligible to attend.

Member	Attendance at Board Meetings						
	29 May 12	30 July 12	28 Sept 12	26 Oct 12	27 Nov 12	25 Jan 13	26 March 13
Tony Thorne	x	x	x	x	x	x	x
Paul Sutton	x	x	x	x	x	x	x
Christine Barwell	x	x	x	x	x	x	x
Graham Colbert*			x	x	x	x	x
Geraint Davies	x	x	x	x	x	x	x
Sue Harris**	x						
Katrina Herren***			-	x	-	x	x
Tim Howe	x	x	x	x	x	x	x
John Jackson	x	x	x	x	x	x	x
James Kennedy	x	x	x	x	x	x	x
Andy Newton	x	x	x	x	x	x	x
Jane Pateman	x	-	x	x	x	x	x
Nigel Penny	x	x	x	x	x	x	x
Isobel Simpson****	x	-					
Kath Start	x	x	-	x	x	x	x
Trevor Willington	x	x	x	x	x	x	x

\* Non-Executive Director from 1 September 2012

\*\* Director of Strategy, Planning and Partnerships until 10 June 2012

\*\*\* Non-Executive Director from 1 September 2012

\*\*\*\* Non-Executive Director until 31 July 2012

At the end of 2012 the Board made a decision to move from Board Business Meetings to Business Review Meetings to ensure that all decisions made by the Board were taken in public, except in exceptional circumstances where a matter relating to an individual member of staff or an issue that was commercial in confidence was being considered, in which case a Part 2 Board meeting would be held.

Member	Attendance at Board Business/ Review Meetings					
	30 Apr 12	29 Jun 12	5 Sept 12	26 Oct 12	3 Jan 13	28 Feb 13
Tony Thorne	x	x	x	x	x	x
Paul Sutton	x	x	x	x	-	x
Christine Barwell	x	x	x	x	x	x
Graham Colbert*			x	x	x	x
Geraint Davies	x	x	x	x	x	-
Sue Harris**	x					
Katrina Herren***			x	x	x	-
Tim Howe	x	x	x	x	x	x
John Jackson	x	x	x	x	x	x
James Kennedy	x	x	x	x	x	x
Andy Newton	x	x	-	x	x	x
Jane Pateman	x	-	x	x	x	-
Nigel Penny	x	x	x	x	-	x
Isobel Simpson****	x	x				
Kath Start	x	x	x	x	x	x
Trevor Willington	x	x	x	x	x	-

\* Non-Executive Director from 1 September 2012

\*\* Director of Strategy, Planning and Partnerships until 10 June 2012

\*\*\* Non-Executive Director from 1 September 2012

\*\*\*\* Non-Executive Director until 31 July 2012



## 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					
	30 Apr 12	17 May 12	6 June 12	22 Nov 12	27 Nov 12	22 Feb 13
Trevor Willington (Chair)	x	x	x	x	x	x
Tim Howe	x	x	x	x	x	x
Nigel Penny	-	x	x	x	x	x
Isobel Simpson	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 this review the Committee provides assurance to the Chief Executive and to the Board about fulfilment of the responsibilities 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. Two Non-Executive Directors must be present to be quorate.

Member	Meeting Date/Attendance				
	28 May 12	13 June 12	11 Sept 12	22 Dec 12	11 Mar 13
Nigel Penny (Chair)	x	x	x	x	x
Christine Barwell	x	x	x	x	x
Graham Colbert			x	x	x
Tim Howe	x	x	x	x	x
John Jackson	x	-	x	x	x
Isobel Simpson	x	x			
Trevor Willington	x	x	x	x	x

\* Katrina Herren is not currently a member of the Audit Committee.

## 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													
	24 April 12	22 May 12	25 June 12	20 July 12	3 Aug 12	14 Aug 12	21 Sept 12	19 Oct 12	21 Nov 12	21 Dec 12	21 Jan 13	14 Feb 13	21 Feb 13	21 Mar 13
John Jackson (Chair)	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Graham Colbert							x	x	x	x	x	x	x	x
Geraint Davies	x	x	x	x	x	x	x	-	x	x	-	x	x	x
Sue Harris	x	x												
James Kennedy	x	x	x	-	x	x	-	x	-	x	-			
Isobel Simpson	x	-	x	-										
Trevor Willington	x	x	x	x	x	x	x	x	x	x	x	x	-	x

## 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 12	5 July 12	6 Sept 12	6 Nov 12	7 Jan 13	6 Mar 13
Christine Barwell (Chair)	x	x	x	x	x	x
Geraint Davies	x	x	x	x	x	x
Katrina Herren			x	x	x	x
Andy Newton	-	x	-	-	x	-
Jane Pateman	-	x	x	x	-	x
Nigel Penny	x	x	x	x	x	x
Kath Start	x	x	x	-	x	x
Trevor Willington	-	x	x	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 12	20 June 12	26 Aug 12	16 Oct 12	18 Dec 12	18 Feb 13
Tim Howe (Chair)	x	x	x	x	x	x
Christine Barwell	x	x	-	x	x	x
Geraint Davies	x	-	-	-	-	-
John Jackson *	x	-	x	x	-	
Andy Newton	-	-	x	x	x	-
Katrina Herren *						-
Isobel Simpson (prev Chair)	x	x				
Kath Start	x	x	x	x	x	x

\* Katrina Herren replaced John Jackson as a member of the Workforce Development Committee from February 2013.

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## 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) and the 111 Programme Director, 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.

Increases in the remuneration of the Chief Executive and those Executive Directors in post when Foundation Trust status was granted, which had been agreed by the Appointments and Remuneration Committee in 2011 but deferred for implementation, were implemented in April 2013 with effect from 1 January 2013.

To ensure business continuity, where voluntary resignation may occur, the Chief Executive is required to give six months' notice (and other directors are required to give three months' notice) to the Trust.

Objectives for the Chief Executive are determined annually by the Trust 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 and re-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. The level of Non-Executive Director remuneration has not changed during 2012/13.

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

A handwritten signature in blue ink, appearing to read 'Paul Sutton', is positioned above the printed name and date.

**Paul Sutton, Chief Executive**

Date: 29 May 2013

## Remuneration table

Name and Title	Term of office	Year ended 31 March 2013			Year ended 31 March 2012		
		Salary (bands 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)
<b>Chairman</b>							
Mike Harris <i>Chairman</i>	<i>Contract ended 30.09.11</i>	-	-	0	15-20	-	0
Tony Thorne <i>Chairman</i>	<i>Appointed 01.09.11</i>	40-45	-	0	20-25	-	0
<b>Non-Executive Directors</b>							
Christine Barwell <i>Non-Executive Director</i>		10-15	-	0	5-10	-	0
Isobel Simpson <i>Non-Executive Director</i>	<i>Left 31.07.2012</i>	0-5	-	0	5-10	-	0
John Jackson <i>Non-Executive Director</i>		10-15	-	0	5-10	-	0
Nigel Penny <i>Non-Executive Director</i>		15-20	-	0	5-10	-	0
Trevor Willington <i>Non-Executive Director</i>		10-15	-	0	5-10	-	0
Tim Howe <i>Non-Executive Director</i>	<i>Appointed 01.03.11</i>	15-20	-	0	5-10	-	0
Graham Colbert <i>Non-Executive Director</i>	<i>Appointed 03.09.12</i>	5-10	-	0	0	-	0
Katrina Herren <i>Non-Executive Director</i>	<i>Appointed 03.09.12</i>	5-10	-	0	0	-	0
<b>Chief Executive</b>							
Paul Sutton <i>Chief Executive</i>		140-145	5,100	19,400	135-140	5,300	19,400
<b>Executive Directors</b>							
Andy Newton <i>Dir. of Clinical Operations</i>		90-95	3,200	13,300	85-90	3,200	12,400
Colin Perry <i>Interim Dir. of Finance</i>	<i>Contract ended 14.04.11</i>				10-15	1,600*	-
James Kennedy <i>Director of Finance</i>	<i>Appointed 17.10.11</i>	125-130		17,900	55-60	-	8,200
Robert Bell <i>Acting Dir. of Finance</i>	<i>15.04.11 to 16.10.11</i>				45-50	-	11,200
Geraint Davies <i>Dir. of Commercial Services</i>		90-95	4,800	12,600	85-90	4,600	12,600
Kath Start <i>Dir. of Workforce Development</i>		90-95	4,700	12,800	85-90	5,200	12,600
Sue Harris <i>Dir. of Strategy, Planning &amp; Partnerships</i>	<i>Left 31.05.2012</i>	15-20	400	2,500	90-95	4,200	12,600
Jane Pateman <i>Medical Director</i>		95-100	1,800	-	95-100	1,700	-



### Pay Multiple

Band of Highest Paid Director's Total (£000)	140-145	135-140
Median Total Remuneration (£)	30,071	30,335
Remuneration Ratio	4.7	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 2013						
	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 2012	Cash equivalent transfer 31 March 2013	Real increase in cash equivalent transfer value
<b>Chief Executive</b>							
Paul Sutton <i>Chief Executive</i>	0-2.5	5-7.5	35-40	105-110	458	543	61
<b>Executive Directors</b>							
Andy Newton <i>Dir. of Clinical Operations</i>	0-2.5	5-7.5	35-40	115-120	738	840	64
Geraint Davies <i>Dir. of Commercial Services</i>	(0-2.5)	(0-2.5)	25-30	80-85	449	483	10
Kath Start <i>Dir. of Workforce Development</i>	0-2.5	0	5-10	0	55	81	23
Sue Harris <i>Dir. of Strategy, Planning &amp; Partnerships</i>	0-2.5	(0-2.5)	10-15	10-15	128	147	2
James Kennedy <i>Director of Finance</i>	0-2.5	0	0-5	0	9	36	26

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).

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## Directors' Expenses

A total of £41,853 was paid in expenses to members of the Board of Directors during the 2012/13 financial year.

## Off-payroll Engagements

As part of the Review of Tax arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, Foundation Trusts are required to publish information in relation to the number of off-payroll engagements – at a cost of over £58,200 per annum – that were in place on 31 January 2012.

As of this date, the Trust had engaged three individuals from whom assurance has been requested and received that their individual Income Tax and National Insurance Contribution obligations have been met. None of these individuals have been brought onto the Trust's payroll subsequently.

Furthermore, Foundation Trusts are also required to publish all new off-payroll engagements between 23 August 2012 and 31 March 2013 for more than £220 per day and more than six months.

The Trust had engaged one individual between these dates who has now left the Trust.

## Meet the 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 where required. In SECAmb this person acts as a key link between the Chairman and the Council.

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*"The Council of Governors has made excellent progress in working with the Board to ensure that the best possible service is consistently provided to patients. The various Council Committees have been involved in appointing auditors and Non-Executive Directors, and also the Membership Development Committee have done an excellent job in ensuring membership is on the rise. I look forward to working with my colleagues of the Council to ensure that SECAmb is at the forefront of high quality care."*

**Ken Davies, Lead Governor**

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The Trust and the Council have consolidated an effective working relationship in this second year as a Foundation Trust. The Council has undertaken a number of statutory duties, which are outlined here. Elections have also taken place during the year along with changes to Appointed Governor representatives from our stakeholder organisations.

The Council is made up of Public Governors, Staff-Elected Governors, and Appointed Governors from key partner organisations. Public Governors represent six constituencies across the area where SECAmb works (set out in the tables below), and Staff-Elected Governors represent either operational (frontline) or non-operational staff.

The Council has held six formal meetings in public this year. The meetings were held in different parts of the Trust's area to enable members to attend. Council meetings are now held on separate days from Board meetings, however the majority of Governors attend the Board and Board members attend each Council meeting, including the Chief Executive.

The Trust has worked with the Council to update and improve the way Governors interact with the Non-Executive Directors (NEDs) and hold them to account. A rolling schedule of sessions with NEDs and relevant members of the Executive has been set up, to enable Governors and NEDs to interact regarding the operation of and scrutiny performed by the different Committees of the Board.

This arrangement is designed to enable Governors to hear from Board Committee Chairs about the challenges and priorities of each Board Committee, to understand how the Committees provide assurance and guidance to the Trust, and to be aware of current areas of scrutiny and risk.

The Council has a Membership Development Committee and a Governor Development Working Group, and governors also make up the majority of members of a Nominations Committee. Governors have also joined a “task and finish” Audit Working Group. Membership of the committees is outlined in the tables below.

There has been significant turnover in the membership of the Council in 2012/13 as a result of the first set of re-elections and changes to the Appointed Governors. The biographies of the Governors included in the next section relate to those Governors who are members of the Council as at 31 March 2013. Details of all the Governors who have held office during 2012/13 can be found in the tables below.

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

There has been significant turnover in the membership of the Council in 2012/13 as a result of the first set of re-elections and changes to the Appointed Governors. The biographies of the Governors included in the next section relate to those Governors who are members of the Council as at 31 March 2013.

Details of all the Governors who have held office during 2012/13 is outlined in the tables below.

## Meet the Council of Governors

### Staff governors

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*“When SECAmb became a Foundation Trust, we embraced a new way of working that included Governors democratically elected from both the public we serve and our staff. Already those Governors are proving their worth and enhancing SECAmb’s performance and planning. I’m confident this progress will continue and show that Governors and democracy have an important role ensuring public confidence that SECAmb provides top quality care to our patients.”*

**Nigel Sweet – Staff-Elected Governor (Operational)**

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### Non-operational

**Angela Rayner** (Term of office 1 March 2011 to 29 February 2016)

Angela is the Trust’s Inclusion Manager. She’s based at the Trust’s Surrey Headquarters in Banstead. Angela has worked in the NHS since 2002 and at SECAmb since 2008. She works to support staff to promote equality, inclusion and diversity, and address health inequalities. Angela is the Chair of the Membership Development Committee. Membership Development Committee member

**Declared interests** – None

## Staff governors – Operational

**Mark Buckton** (Term of office 1 March 2011 to 28 February 2014)

Mark joined Surrey Ambulance Service eight years ago, starting his career on the Patient Transport Service before becoming a Technician more than five years ago and a Paramedic recently. He is currently on secondment helping manage the Trust's Patient Transport Service in Surrey. His previous career, spanning 17 years, was spent as a Senior Manager within the Financial Services industry.

Nominations Committee member

**Declared interests** – None

**Warren Falconer** (Term of office 1 March 2013 to 29 February 2016)

Warren works on the Trust's Clinical Advice Desk and has been with the Trust for ten years.

**Declared interests** – GMB workplace representative for Brighton

**Nigel Sweet** (Term of office 1 March 2011 to 29 February 2016)

Nigel is an Ambulance Technician working from Shoreham Ambulance Station in Sussex. He had a varied career before joining SECAmb, including setting up a wholefood company and being a District Councillor for Shoreham and Deputy Leader of Adur District Council. He sailed, mainly single-handedly, around Africa and the Mediterranean for a couple of years, and has worked as a political researcher in the House of Commons.

Membership Development Committee member

**Declared interests** – None

## Public governors

### *Brighton*

**Jean Gaston-Parry** (Term of office 21 June 2012 to 20 June 2015)

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

Membership Development Committee member

**Declared interests** – None

### *Medway*

**Richard Pavey** (Term of office 17 January 2013 to 28 February 2014)

Richard worked for London Ambulance Service for ten years, before becoming a health and safety manager for an international engineering firm.

He is Treasurer of the Medway Breathe Easy Group that supports people with chronic lung disease.

**Declared interests** – Treasurer of Medway Breathe Easy part of British Lung Foundation Support Network

### *East Sussex*

**Brian Rockell** (Term of office 1 March 2011 to 28 February 2014)

Brian has represented the public in statutory roles to the Boards of Berkshire Ambulance Service, Sussex Ambulance Service and SECAmb. He chaired the SECAmb Public and Patient Forum and is training to become a Community First Responder.

Nominations Committee member

**Declared interests** – Director of Operations, St John Ambulance

**Peter Gwilliam** (Term of office 1 March 2013 to 29 February 2016)

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

**Declared interests** – None

### *Kent*

**Ken Davies** (Term of office 1 March 2011 to 28 February 2014) and Lead Governor

Ken retired from SECAmb at the end of January 2010 after 37 years of service as an Ambulance Technician. He worked with the Board in his capacity as a Union representative prior to his retirement.

Nominations Committee member

**Declared interests** – None

**Margaret Fenton** (Term of office 1 March 2011 to 28 February 2014)

Maggie nursed at Westminster Hospital, and experienced at first hand the vital role of the ambulance service and its progression to the professional body it is today. She has been a teacher for the past twenty years.

Membership Development Committee member

**Declared interests** – None

**Lesley Long** (Term of office 1 March 2013 to 29 February 2016)

Lesley has lived and worked in Kent for the past twenty years. Prior to retirement last year, Lesley worked in acute hospital clinical practice where the quality of care for patients was her priority. She was a staff governor at the hospital for four years so brings an understanding of the role of a governor.

Membership Development Committee member

**Declared interests** – None

**Margaret Bridges** (Term of office 1 March 2011 to 28 February 2014)

Margaret retired from SECAmb in 2011 where she had worked on staff welfare across the Trust. She brings many years' experience of the NHS and a good knowledge of SECAmb. She is a trained nurse.

Governor Development Working Group member

**Declared interests** – None

## *Surrey*

**Terry Daubney** (Term of office 1 March 2011 to 28 February 2014)

Terry retired from the NHS in October 2008, after completing over 38 years in the Ambulance Service. Terry ran the Trust's Private Ambulance Service prior to retirement.

Governor Development Working Group member

**Declared interests** – None

**Ian Smith** (Term of office 1 March 2011 to 28 February 2014) and Deputy Lead Governor

A Surrey resident for 37 years and, since retiring four years ago, Ian has been deeply involved in SECAMB activities. He chaired the Surrey Patient and Public Involvement Forum. Ian brings financial and governance experience from his previous career.

Governor Development Working Group member

**Declared interests** – None

**Neil Baker** (Term of office 1 March 2013 to 29 February 2016)

Neil is an active Community First Responder in Farnham in his spare time and also works full time as a business executive in an international company. As such he brings financial and operational expertise to the role.

**Declared interests** – St John Ambulance, Community First Responder

**Priscilla Chandro** (Term of office 1 March 2013 to 29 February 2016)

Priscilla has been involved with SECAMB for a number of years, since suffering a heart attack in her thirties. She is a vocal advocate for patients' experiences informing the way health services are developed, and as well as being part of SECAMB's public involvement group is also a champion for the British Heart Foundation. She runs her own karaoke business.

Membership Development Committee member

**Declared interests** –None

## *West Sussex*

**Ted Coleman** (Term of office 1 March 2011 to 29 February 2016)

Ted is a Community First Responder in Billingshurst. He brings financial and statistical expertise through a career in the insurance industry. He is also a qualified Actuary and a magistrate.

Governor Development Working Group member

**Declared interests** – None

**Tony Dell** (Term of office 1 March 2013 to 29 February 2016)

Tony was born in Sussex but has lived and worked outside the county for the last 20 years. He has recently retired from his position as Chair at North East Ambulance Service and brings great understanding of the challenges facing ambulance trusts. He has also worked closely with a Council in this role, and says he greatly valued the advice and support of the Council, so he looks forward to being on the other side of the fence

**Declared interests** – None

### Appointed governors

**Toni Schwarz** (Term of office 17 January 2013 to 29 February 2016)

Toni takes over from Prof Karen Bryan as appointed governor for the University of Surrey. Toni is head of Preparatory Programmes at the University, which runs one of the courses where Paramedics are trained.

**Declared interests** – Trustee of Shooting Star Chase Children's Hospice until February 2013

### Chief Superintendent Dave Miller

(Term of office 28 February 2013 to 29 February 2016)

Chief Superintendent Miller is the Trust's second appointed governor from Surrey Police force. The Trust works closely with colleagues in the other emergency services and this appointment helps reinforce this partnership.

**Declared interests** – None

**Sandra Field** (Term of office 24 May 2011 to 28 February 2014)

Sandra works for the Stroke Association, a charity organisation promoting and lobbying for the best possible outcomes for people who have suffered a stroke.

**Declared interests** – None

**Helen Medlock** (Term of office 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** – Commissioner for 999, NHS 111 and PTS services for Kent and Medway, Surrey and Sussex. Employed by West Kent PCT.

**Michael Hewgill** (Term of office 23 February 2012 to 28 February 2014)

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

**Declared interests** – None

**James Blythe** (Term of office 16 January 2013 to 29 February 2016)

James is the Foundation Trust Programme Director at Brighton and Sussex University Hospitals, the major trauma centre for SECamb in the region.

**Declared interests** – None



**Marian Trendell** (Term of office 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** – County Council appointed governor

A summary of the function and activities of the Committees and Working Groups of the Council is outlined to follow.

### Membership Development Committee (MDC)

The MDC is chaired by a Staff-Elected Governor (Non-Operational), Angela Rayner, and has a membership of four governors at year end (two Staff-Elected and two Public), a reduction in number of two due to elections.

The remit of the Committee is to:

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

The Committee has met five times this year. Key areas of work have included: regular membership monitoring; planning and delivering a Meet Your Governor stall at the Annual Members Meeting, the selection of public and staff members to our Inclusion Hub Advisory Group and staff Foundation Council, and advising on membership recruitment and engagement opportunities.

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*"Since the granting of FT status there has been the formation of several different committees to enhance and facilitate the work of the Governors. The Membership Development Committee is one that seeks to ensure that SECAMB's Public Members really are informed, involved and have a voice. Everything from the Annual Members survey to a Membership badge have been developed! Recently a new focus group (Inclusion Hub Advisory Group) was created by the MDC. This Group was formed from as many diverse Members as possible including the seldom heard ones such as those with learning difficulties, travellers and transgender people. In this way SECAMB can be confident that patient and public perceptions are taken into account in all aspects of their work."*

**Maggie Fenton, Public Governor (Kent)**

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## Nominations Committee (NomCom)

The NomCom is a Committee of the Board but the majority of members of the Committee are Governors. During the majority of this year, membership included two Appointed Governors, one Staff-Elected Governor and four Public Governors.

However due to elections which concluded in late February 2013 the membership is to be reviewed at the Council meeting on 28 March 2013 with new Governors to be elected to the Committee by the Council. The NomCom is chaired by the Chairman of the Trust Board. However, the Senior Independent Director (Tim Howe, Non-Executive Director) chaired NomCom meetings when the Committee is discussing matters relating to the Chairman of the Trust Board.

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

The Committee has met on four occasions this year and has undertaken its statutory duty in recommending NED appointments, as outlined in the section on Statutory Duties.

Attendees	Constituency	11 May 12	19 June 12	6 July 12	12 Sept 12
Tony Thorne	Chairman of the Trust Board	X	X	X	X
Tim Howe	Senior Independent Director	X	X	X	X
Mark Buckton	Staff-Elected Governor (Operational)	-	-	-	X
Ken Davies	Public Governor - Kent, and Lead Governor	X	X	X	X
Marjory Broughton	Public Governor – Surrey	X	X	-	X
Alex Sienkiewicz	Appointed Governor	-	-	X	X
Charlie Doyle	Appointed Governor	-	X	-	-
Alison Arnold	Public Governor – West Sussex	X	-	-	-
Brian Rockell	Public Governor – East Sussex	-	X	X	X

## Audit Working Group (AuWG)

The Audit Working Group was formed in January 2012 as a “task and finish” group, to devise and undertake the tendering process for the appointment of external auditors to the Trust. Membership of the AuWG comprised two Public Governors, one Staff-Elected Governor and one Appointed Governor, who work alongside three Non-Executive Directors, the Finance Director and another senior financial manager.

## Governor Development Working Group (GDWG)

The GDWG has met five times during the year. At year end its membership is four Public Governors. The GDWG 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 GDWG has suggested a number of improvements to the interaction between the Board and the Council, many of which were implemented this year, and the Group continues to regularly advise on the information, interaction and support needs of Governors.

## Statutory Duties

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

### Appointment of two Non-Executive Directors

The Nominations Committee led a process to appoint two new Non-Executive Directors, which culminated in the appointment of Katrina Herren and Graham Colbert in September 2012. An extensive and rigorous process was undertaken, which included conducting candidate searches, long-listing, short-listing, and finally a selection day for the shortlisted candidates. Candidates met with a focus group of Governors, Non-Executives and other staff, and had one to one meetings with the Chair and Chief Executive, before undertaking a final interview with a panel consisting of NomCom members and the Senior Independent Director.

### Appointment of External Auditors

After a competitive and thorough tender process, the Audit Working Group, which included a number of Governors, made a recommendation to the Council to appoint Grant Thornton as external auditors to the Trust beginning with auditing the financial year 2012/13. The Council accepted this recommendation and appointed Grant Thornton.

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## Input to Annual Planning

The Trust has worked with Governors to review its annual plans and also consulted with public and staff FT members to provide constituents' views to the Council. An interactive session with the Executive Team 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 March and provided feedback to the Council about how their input would be addressed.

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*"As a governor, I have been able to witness the high quality care being provided by SECAmb's clinicians in the communities I represent. Their commitment and professionalism is second to none."*

**Brian Rockell, Public Governor (East Sussex)**

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## Other Governor Engagement Activities

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

Governors, working alongside public and staff FT members and other key stakeholders, helped to develop the Trust's Quality Account priorities for quality improvement in 2013-14 (see section xxx on the Quality Account).

Governors have continued to observe our frontline crews in action by spending time on our ambulances and in our Emergency Control Centres, enabling Governors to understand more about the Trust's operation and meet and talk to our staff. Governors also received presentations from our new Hazardous Area Response Team (HART) at Gatwick and learned about how the Team responds in difficult and dangerous environments. Governors attended our Staff Awards ceremonies and also a Survivors Event where members of the public were reunited with SECAmb staff who had helped them.

Along with other stakeholders, including staff and public FT members, Governors attended a two-day workshop to review the Trust's progress towards its five Equality Objectives and develop recommendations for action plans for the coming year. See the section "Our Performance" for more about the Equality Delivery System.

Staff-Elected Governors have also undertaken specific work to understand their constituents' views using a number of methods, including by working as part of the Trust's Foundation Council (see the Membership section page xxx). They have produced their own newsletter, contributed to staff engagement improvements planned by the Trust, and also manage the Trust's staff suggestion scheme.

## Contact Details

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 email [ftmembership@secamb.nhs.uk](mailto: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

## Appointments and Elections

During the year, elections have been held in five of our six public constituencies and in both of our staff constituencies.

Following the resignation of our public Governor for Brighton and Hove in the previous financial year, Jean Gaston-Parry was elected to the position in June 2012 for a three year term.

Alison Arnold, public Governor for West Sussex, resigned for personal reasons in December 2012.

Due to the staggered terms of office of elected Governors at the inauguration of the Council, and Alison Arnold's resignation, six vacancies for public Governors and three for staff Governors became available from 1 March 2013. Consequently, elections were concluded in late February 2013 for public Governors in Kent (one vacancy), Surrey (two vacancies), East Sussex (one vacancy) and West Sussex (two vacancies), and Operational Staff (two vacancies) and Non-Operational Staff (one vacancy). We are pleased that all existing Governors up for re-election chose to stand again.

We would like to thank all those Governors who unfortunately lost their seats in these elections, as well as those who were re-elected and newly elected, for their commitment to and support for the Trust.

The outcomes of these elections are set out in the table below:

Constituency	Governor from 1 March 2013	
East Sussex	Peter Gwilliam	
Kent	Lesley Long	
Surrey	Priscilla Chandro	Neil Baker
West Sussex	Tony Dell	Ted Coleman (re-elected)
Staff-Operational	Nigel Sweet (re-elected)	Warren Falconer
Staff-Non-Operational	Angela Rayner (re-elected)	

Our ranks of our Appointed Governors also underwent some changes during the year. New appointees were nominated by four of our key stakeholder organisations during the year: Surrey Police, Kent County Council, the University of Surrey and Brighton and Sussex University Hospitals. The appointee from Kent County Council resigned due to work pressures in late January 2013 and this remains the only vacancy on the Council at year end.

The table below sets out the terms of office, names and constituency of each Governor who served on the Council during 2012/13. It also shows their attendance at public Council meetings and their Committee and Working Group membership.

Constituency	Name	Appointed	Term of Office	Committee and working group membership	CoG 29 May 12	CoG 30 July 12	CoG 28 Sept 12 and Annual Members Meeting	CoG 28 Nov 12	CoG 29 Jan 13	CoG 28 March 13
Public: Brighton and Hove	Gloria Parks* <sup>1</sup>	01.03.11	3 years	MDC	X					
	Jean Gaston-Parry		3 years	MDC		X	X	X	X	X
Public: East Sussex	Brian Rockell	01.03.11	3 years	NomCom	X	-	X	X	X	X
Public: East Sussex	Terry Steeples* <sup>2</sup>	16.09.11	2 years		X	X	X	X	X	
	Peter Gwilliam	01.03.13	3 years							X
Public: Kent	Robin J Kenworthy	01.03.11	2 years	MDC, GovDevWG	X	X	X	X	X	
	Lesley Long	01.03.13	3 years							X
Public: Kent	Ken Davies	01.03.11	3 years	NomCom	X	X	-	X	X	X
Public: Kent	Maggie Fenton	01.03.11	3 years	MDC	-	X	X	X	-	X
Public: Kent	Margaret Bridges	24.08.11	2 years	GovDevWG	X	X	X	X	X	X
Public: Medway	Colin Hall	01.03.11	3 years	MDC	X	X	X	X		
	Richard Pavey* <sup>3</sup>	17.01.13	3 years						X	X
Public: Surrey	Terry Daubney	01.03.11	3 years	GovDevWG	-	X	-	X	X	-
Public: Surrey	Paul Jordan	01.03.11	2 years	MDC	X	X	X	-	-	
	Priscilla Chandro	01.03.13	3 years							X
Public: Surrey	Ian Smith	01.03.11	3 years	GovDev, AuWG	X	X	X	-	X	X
Public: West Sussex	Ted Coleman* <sup>4</sup>	01.03.13	3 years	AuWG, GovDevWG	X	X	X	X	X	X
Public: West Sussex	Alison Arnold* <sup>5</sup>	01.03.11	3 years	NomCom	-	X	-			
	Anthony Dell	01.03.13	3 years							X

Constituency	Name	Appointed	Term of Office	Committee and working group membership	CoG 29 May 12	CoG 30 July 12	CoG 28 Sept 12 and Annual Members Meeting	CoG 28 Nov 12	CoG 29 Jan 13	CoG 28 March 13
Staff: Non Operational	Angela Rayner* <sup>6</sup>	01.03.13	3 years	MDC (Chair)	-	-	X	X	X	X
Staff: Operational	Mark Buckton	01.03.11	3 years	NomCom	-	X	-	X	X	X
Staff: Operational	John Henderson	01.03.11	2 years	AuWG	X					
	Paul Ellis* <sup>8</sup>	01.07.12	2 years			X	X	-	X	
	Warren Falconer	01.03.13	3 years							X
Appointed: Brighton & Hove University Hospitals NHS Trust	Alex Sienkiewicz* <sup>9</sup>	01.03.11	3 years	NomCom, AuWG	X	X	X	X		
	James Blythe	16.01.13	3 years						X	X
Appointed: Sussex Partnership NHS FT	Marian Trendell	01.03.11	3 years		X	X	X	X	-	-
Appointed: South East Coast Commissioning Group	Helen Medlock	01.03.11	3 years		-	X	-	X	X	-
Appointed: East Kent Hospitals University NHS FT	Mike Hewgill	02.03.12	3 years		-	X	X	-	X	-
Appointed: Surrey Police	Charlie Doyle	16.05.11	3 years	NomCom	-	-	-	-		
	Dave Miller* <sup>10</sup>	28.02.13	3 years							-
Appointed: The Stroke Association	Sandra Field	24.05.11	3 years		-	X	-	X	-	X
Appointed: University of Surrey	Nigel Seaton	01.03.11	3 years							
	Karen Bryan* <sup>11</sup>	18.05.12	3 years		-	X	X	X		
	Toni Schwarz* <sup>12</sup>	17.01.13	3 years						-	X
Appointed: Kent County Council	Paula Parker* <sup>13</sup>	28.06.12	3 years			-	-	-		
	Vacant									

\*1 Gloria Parks resigned 25.03.12

\*2 Terry Steeples took over the remainder of the previous governor's term

\*3 Richard Pavey took over the remainder of Colin Hall's term after Colin resigned 13.01.13

\*4 Ted Coleman was re-elected in March 2013 after serving an initial two year term

\*5 Alison Arnold resigned due to work pressures on 10.12.12

\*6 Angela Rayner was re-elected in March 2013 after serving an initial two year term

\*7 Nigel Sweet was re-elected in March 2013 after serving an initial two year term

\*8 Paul Ellis took over the remainder of Jon Henderson's term after Jon retired from the Trust on 30.06.12

\*9 James Blythe took over from Alex Sienkiewicz after Alex resigned on 29.09.12 due to changing jobs

\*10 Dave Miller took over from Charlie Doyle after Charlie resigned on 07.12.12 due to changing jobs

\*11 Karen Bryan took over from Nigel Seaton after Nigel resigned 31.03.12

\*12 Toni Schwarz took over from Karen Bryan after Karen resigned on 28.11.12 due to leaving the University

\*13 Paula Parker took over from the previous governor who resigned during the previous financial year.

Paula resigned due to work pressures on 25.01.13

### Governors' Expenses

A total of £3,918 was paid in expenses to members of the Council of Governors during the 2012/13 financial year.

## How we deliver our services

As at 31 March 2013, the breakdown of our staff between clinical and support roles was as follows:

Staff group	Headcount	Whole Time Equivalent (WTE)
A&E	1940	1728
Emergency Operations Centre	376	318
Patient Transport Services	544	462
111	184	105
HART	73	72
Support	418	365
<b>TOTAL</b>	<b>3535</b>	<b>3050</b>

### A&E Workforce

The Trust employs 994 HCPC registered paramedics, including Clinical Managers, Clinical Team Leaders, Critical Care Practitioners and Paramedic Practitioners.

This is complemented by 737 Ambulance Technicians and 209 Emergency Care Support Workers. This gives a total A&E workforce of 1,940.

51% of the A&E workforce are Specialist Practitioners/ Paramedics and 49% are Clinical Support Staff. The aim is to increase the Specialist Practitioners/ Paramedics workforce to 64% and reduce the Clinical Support Staff to 36% by 2016.


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 employ 209 Emergency Care Support Workers.

**Ambulance 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 their journey to hospital. We employ 737 technicians.

During recent years the role of the ambulance technicians has changed significantly, in light of broader and fundamental changes 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 numbers 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 819 paramedics, including those working as clinical managers.

With increased professional entry routes of 80 students per year directly to the universities on the three year programmes and the continuation of 96 part time places on the technician to paramedic Foundation Degree programme at St George's, the Trust will have access to a recruitment pool of 80 new and 48 conversion paramedics per year.

This will backfill the vacancies that are created as a result of Paramedics progressing to Paramedic Practitioner, Critical Care Paramedic and Clinical Team Leaders 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 73 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.

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**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 175 staff actively working in these roles and a further 65 students.

**Emergency Operating Centre Staff** – 376 staff work in the Trust's three Emergency Operations Centres in a variety of roles including Emergency Medical Advisers, Dispatchers, Duty Dispatch Managers and Clinical Desk staff. These staff are responsible for receiving every one of the emergency calls sent to the Trust, providing support and clinical advice to callers as needed and co-ordinating the most appropriate response to send to the patient.

**NHS 111 staff** – almost 300 staff (some of whom are employed by Harmoni, our NHS 111 partner) work in the two Contact Centres at Dorking and Ashford. The majority of these staff are health advisors, who answer the NHS 111 calls and they are supported by nurses, paramedics and GPs who provide clinical advice.

**Patient Transport 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. We employ 544 Patient Transport Services staff.

**Support staff** – our front line staff are supported by 418 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 and 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 525 (15%) staff aged 55 and above of whom 199 (6%) are A&E staff and may choose to retire within the next five years. 117 (3%) of the 199 A&E staff within this age group are paramedics and 82 (2%) are technicians.

The age profile for Critical Care Paramedics and Paramedic Practitioners tends to be younger with 69% being below the age of 45 (this includes students). 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 into the future.

Age	Headcount	Per cent rounded %
16 -20	33	0.9%
21-30	613	17.3%
31-40	1014	28.7%
41-50	1036	29.3%
51-60	658	18.6%
61-65	136	3.9%
66+	45	1.3%
<b>TOTAL</b>	<b>3535</b>	<b>100.0</b>

## Gender

Currently 55% of the workforce is male, which shows the continuing trend towards a more gender balanced workforce. SECAMB's aim is to achieve a 50/50 gender split in clinical roles.

Gender	Headcount	Per cent rounded %
Male	1941	54.9%
Female	1594	45.1%
Transgender	0	0.00%
<b>TOTAL</b>	<b>3535</b>	<b>100.0</b>

The highest percentages of male to female staff are in A&E PTS: 62% to 38%. The highest percentage of female to male is in the EOCs: 67% to 32%. The break-down with support staff is 57% females and 43% males.

## Ethnicity

There has been a gradual increase in the number of staff classified other than 'white British' – the current percentage is 5.9%:

Ethnic Group	Headcount	Per cent rounded %
White British	3050	94.1%
White Other	100	3.1%
Mixed	35	1.0%
Asian or Asian British	19	0.6%
Black or Black British	28	0.9%
Other	9	0.3%
<b>TOTAL</b>	<b>3241</b>	<b>100.0%</b>
<b>Unstated</b>	<b>294</b>	

## Disability

More staff are declaring themselves to have a disability. The current percentage is 4%:

	Headcount	Per cent rounded %
<b>Disabled</b>		
Declared	139	4.0%
No disability	2207	62.4%
Unstated	1189	33.6%
<b>TOTAL</b>	<b>3535</b>	<b>100.00%</b>

The Trust has a recruitment and selection policy that includes a “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 2012/13 the breakdown of applicants to advertised posts was as follows:

Disabled	360
Not disabled	5930
Undisclosed	55

And appointments were made as follows:

Disabled	26
Not disabled	569
Undisclosed	8

## Sexual Orientation

The undisclosed figure has now dropped to 22.7% as against 26.1% in 2011/12:

Sexual Orientation	Headcount	Per cent rounded %
Bisexual	21	0.6%
Gay	45	1.2%
Lesbian	56	1.6%
Heterosexual	2311	65.4%
I do not wish to disclose my sexual orientation	300	8.5%
Undisclosed	802	22.7%
<b>TOTAL</b>	<b>3535</b>	<b>100.00%</b>

## Religion and Belief

This area is still under reported with 37% having not stated a belief:

Religious Belief	Headcount	Per cent rounded %
Atheism	482	13.6%
Buddhism	16	0.4%
Christianity	1435	40.6%
Hinduism	2	0.1%
Islam	11	0.3%
Judaism	7	0.2%
Sikhism	1	0.1%
Other	262	7.4%
Undisclosed	1319	37.3%
<b>TOTAL</b>	<b>3535</b>	<b>100.00%</b>

## 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 2012/13 we recorded 3,234 adverse incident reports, including:

- + 290 incidents related to staff sustaining musculoskeletal injuries
- + 127 incidents related to staff being assaulted
- + 79 of the incidents resulted in over seven 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...

As at 31 March 2013 our turnover was as below:

Staff group	Number of leavers in period (whole time equivalent)	Turnover (%)
A&E	100.11	5.5%
PTS	22.27	6.8%
EOC	45.71	15.3%
Support Staff	75.04	13.8%
<b>TOTAL</b>	<b>243.13</b>	<b>8.3%</b>

Turnover is still comparatively low in front line operational posts. SECAmb remains an employer of choice with the ability to attract high calibre applicants from all over the Country. This has included an intake of around 100 BSc Honours Degree graduate entrants in Paramedic Sciences during the past year.

The increased professionalization of the workforce, to include the critical care paramedic and paramedic practitioner roles, offers enhanced career progression and the ability to develop our workforce with the capability and capacity to achieve the changes required in service delivery, as set out in our workforce plan over the next three years.

## Engaging with and listening to our staff

### Staff Survey results 2012/13

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

For the 2012/13 survey, which was undertaken between October and December 2012, SECAmb opted to survey all staff and the return rate was encouraging, especially compared to the national average for ambulance Trusts:

	2011/12		2012/13		Trust Improvement or Deterioration
	Trust	National average	Trust	National average	
Response rate	47%	47%	49%	39%	2% improvement

Overall, the results were once again quite disappointing.

However, noticeable improvements could be seen in a number of areas, which reflected the impact of action plans put in during the year to address particular issues.

Top four ranking scores	2010/11		2011/12		Trust Improvement or Deterioration
	Trust	National average	Trust	National average	
% of staff agreeing their role makes a difference to patients	88%	89%	90%	87%	2% improvement
% of staff experiencing physical violence from patients, relatives or the public in last 12 months	19%	20%	29%	33%	10% deterioration
% of staff receiving equality & diversity training within last 12 months	29%	37%	63%	45%	34% improvement
% of staff receiving health & safety training within last 12 months	36%	54%	65%	49%	29% improvement
% of staff appraised in last 12 months	66%	67%	80%	74%	14% improvement

Bottom five ranking scores	2010/11		2011/12		Trust Improvement or Deterioration
	Trust	National average	Trust	National average	
% of staff reporting good communication between senior management and staff	8%	12%	12%	16%	4% improvement
% of staff feeling pressure in last three months to attend work when feeling unwell	38%	34%	43%	38%	5% deterioration
% of improvement for effective team working	3.15	3.31	3.18	3.31	Improvement
% of staff experiencing harassment, bullying or abuse from staff in last 12 months	20%	18%	33%	28%	13% deterioration
% of staff believing the Trust provides equal opportunities for career progression or promotion	67%	69%	59%	70%	8% deterioration

Improving the staff survey results and staff satisfaction overall remains a key priority for the Trust Board. Board members recognise that where improvements have been seen in this year's results is as a direct result of specific targeted actions that have been taken. For example, the Trust's Learning & Development and Operational teams have worked closely together to ensure front-line staff can be taken off the road to attend training sessions in a planned way that does not impact on our response to patients.

Regular up-dates have been provided during the year to the Workforce Development Committee and to the Council.

However, moving forwards, it is recognised that a more co-ordinated approach needs to be taken to improving staff satisfaction involving local managers, staff-side representatives and Foundation Council members, amongst others. Work is currently underway to identify the areas for focus during the coming year and actions will be developed, together with staff, to address these.

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## Communicating and engaging with our staff

Communicating effectively with more than 3,500 staff employed by SECAmb is always challenging, especially given the large geographical area the Trust covers and the diverse shift patterns worked by many staff.

Recognising these challenges and the infrequency of opportunities for face to face communication, the Trust uses a range of different mechanisms to try to communicate effectively with staff, including:

- + A weekly electronic staff bulletin, which contains key performance information, as well as "beeline" messages, where staff pay tribute to their colleagues;
- + Targeted briefings for managers on important topics including key messages, to enable them to brief their teams effectively;
- + A dedicated "staff zone" on the Trust's website;
- + A quarterly staff magazine – SECAmb News – which was completely re-vamped during 2012 to include new features and competitions;
- + Use of "Twitter", including the use of a secure "staff only" account;
- + "Face to face" briefings from the Executive team for operational managers – during the year, six sessions were held for Clinical Team Leaders and other managers to come together to discuss topical issues.

However, we recognise that there is a still lot more to be done to improve how we communicate internally.

Plans in place for 2013/14 include increasing the use of social media; including utilising new mechanisms and reviewing our existing mechanisms to ensure they are fit for purpose and effective.

## Working in Partnership with the Unions

The new SECAmb Recognition Agreement which was signed off in September 2011 provided the framework for employee relations in 2012/13. Under this agreement, the Trust originally recognised four unions, (Unison, GMB, UNITE and APAP). Following the Trust's successful tender for the NHS 111 'Single Point of Access' service in June 2012 and the commencement of the NHS 111 contract in March 2013 the Recognition Agreement has been amended to additionally include the Royal College of Nursing (RCN) as a fifth recognised union.

Management and Staff Representatives continue to meet on a monthly basis at the Joint Partnership Forum, our principal consultation and negotiation forum, where consideration is given to issues pertaining to pay and conditions of service, policies and procedures affecting staff employment and operational management.

The Joint Partnership Forum is chaired by the Director of Commercial Services. In the spirit of openness and transparency, all approved minutes of the JPF are published on the Trust's intranet.



2012/13 saw the positive resolution of a number of challenging terms and conditions issues. We worked in partnership to agree new policies and procedures for the management of Unsocial Hours, Meal breaks and Annualised Hours.

The published behavioural code of conduct agreed with the unions has been extended to include appropriate channels of communication for employee relations issues and an agreed protocol for effective utilisation of Trust facilities.

The parties remain focused on common objectives they wish to pursue and achieve. These are:

- + To ensure that employment practices in the Organisation are conducted to the highest possible standards;
- + To enhance effective communication with all Staff throughout the organisation;
- + To achieve greater participation and involvement of all members of staff on the issues to be faced in running and developing the Organisation;
- + 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.

## Recognising the achievements of our staff

Each year, SECAMB holds two awards ceremonies to honour the achievements of staff, volunteers and members of the public. In March of this year, the ceremony for the West of the region was held at Woodlands Park Hotel in Cobham, Surrey and at Oaklands Park Hotel in Maidstone, Kent for the East of the region. Both ceremonies follow the same format, with guests enjoying dinner and receiving a commemorative brochure before the presentations begin.

This year's events also included special presentations to retired staff, who had not had their long service recognised previously.

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### **Chief Executive, Paul Sutton, who presented many of the awards said:**

*"I was delighted to share in the success of every award winner. The dedication and clinical skill demonstrated by those who were presented long service awards and commendations shows the commitment and talent that exists at SECAMB. It was an honour to be joined by past members of the ambulance service. Their combined length of service is truly humbling. It was also fantastic that we recognised the efforts of members of the public. Such actions before the arrival of ambulance service clinicians are absolutely vital."*

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First up on stage at each event were recipients of the Queen's Medal for Long Service and Good Conduct, which is presented to front-line staff who have completed a minimum of 20 years' service. 23 staff received their medals during the two ceremonies, which are presented on behalf of HM The Queen by the local Lord Lieutenant. This year, we were delighted to be joined by Deputy Lord Lieutenants Martin Gerrard in Surrey and Lord Paul Condon in Kent to make the presentations.

Next followed awards for staff who had completed 20, 30 and an incredible 40 years' NHS service. A special mention at the West ceremony went to Equipment Officer Bill Edwards, who joined the then Surrey Ambulance Service in 1971 and had remained on front-line duties until 2006; at the East ceremony Uckfield paramedic Mick Sexton was also recognised for an equally impressive 40 years' service.

Special awards and medals were also presented this year to 27 retired members of staff, who hadn't received recognition for their years of service previously and to long-serving volunteer car drivers, who give up their time to support the Trust's patient transport services.

The second half of each evening focussed on the presentation of Chief Executive Commendation, with awards in the following categories recognising:

- + Clinical Excellence
- + Going "above and beyond the call of duty"
- + Outstanding Patient Care
- + Leadership
- + Employee of the Year
- + Team of the Year
- + Community First Responder of the Year

The Team of the Year Award this year was awarded to the 100 plus staff who were involved in the incident on the A3 close to the Hindhead Tunnel, when a coach careered off the road. The collision sadly claimed the lives of three people, including the driver. With 53 casualties, it was one of the largest emergencies that the Trust has ever dealt with.

Three members of the public also received awards for the help they gave when they came across patients in need, which ultimately helped to save their lives.

## 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 2013 we have 205 Paramedic Practitioners (including ten managers who regularly respond as Paramedic Practitioners) either qualified or in training, and as of July 2013 it is expected that we will have 50 qualified Critical Care Paramedics. We also have eight 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.

The paragraphs below provide 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. 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. 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 by continuously reviewing the deployment of Paramedic Practitioners, to ensure as many patients as possible benefit from their additional skills.

PPs offer a wider range of treatments, including the ability to issue the patient with a course of medicines such as antibiotics, which speeds up the time to treatment. One of the key skills of the PP is their ability to provide a more definitive diagnosis for the patient. Over the last year, SECAmb has been evaluating "near-patient" blood testing devices to help speed up the time to diagnosis and to make the PP more confident in their diagnosis. Once the final evaluation is complete it is hoped to purchase and deploy these devices to all PPs in SECAmb. The evaluation has been very positive with the PPs reporting comments such as below:

5. In the case of WBC analyser, what impact did this have on your decision as whether or not to supply antibiotics under your PODs?

	Very negative impact	Negative impact	No impact	Positive impact	Very positive impact
Impact on prescription				<input checked="" type="checkbox"/>	

Comments:  
Please detail how the analyser result impacted your decision to supply antibiotics under your PODs.

*Positive confirmation of clinical diagnosis*

6. In your opinion, what impact did having the analyser result have on patient satisfaction?

*Patients very impressed w testing & gave positive feedback.*

7. What impact did using the HemoCue WBC analyser and HemoCue Hb analyser have on yourself?

*Added tool in all clinical assessments  
Added confidence in antibiotic administration*

Paramedic practitioners are focussed on providing care closer to home and therefore have a lower conveyance rate to hospital.

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### **Critical Care Paramedics (CCPs)**

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.

During 2012/13, we have put a team of CCPs into our new Make Ready Centre at Paddock Wood in Kent and have continued to recruit CCPs into vacancies across the region. Our intention is to have a team of CCPs in each of our operational areas to ensure that we can provide the highest level of care for patients with the most complex, life threatening conditions.

The CCP scope of practice is also increasing in response to the changing demands of the organisation. This year we have introduced additional pain relieving medicines for use by CCPs and have continued to deploy and further evaluate diagnostic devices. CCPs are already using ultrasound to detect a range of serious conditions such as collapsed lungs in trauma patients.

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.

### **PTS Service Re-design**

PTS staff provide a non-emergency service, to take patients to and from NHS facilities for appointments, treatment and hospital admissions. They also carry out non urgent transfers between hospitals and discharge from hospital to home. All PTS staff are trained in basic life support should one of their patients need emergency care.

During 2011 PTS in Sussex was market tested, the result of which was that SECamb PTS was successful in retaining the contract to provide non-emergency transport to eligible patients across the county of Sussex. We also saw the introduction of the Patient Transport Bureau which is run by the commissioners. This went live on 1 April 2012. Also during 2011/12 PTS in Surrey was market tested and which resulted in SECamb PTS being awarded this contract, with a go live date of 1 October 2012. As a result of further market testing we were not successful in the bid to provide PTS across the county of Kent.

The award of the contracts in Sussex and Surrey has resulted in substantial investment in new fleet along with new technology to allow the road staff to capture patient journey data which includes vehicle tracking.

## Participating in London 2012

The summer of 2012 saw London stage the Olympics and Paralympic Games. This was the single largest event ever staged in this Country and required significant planning and preparation. SECAmb were involved in planning and responding to the event at both a national and local level as well as ensuring that the events being staged within SECAmb's operational response area did not impact on the delivery of our services.

As part of the build-up to the Games opening ceremony the Olympic torch toured the whole of the United Kingdom entering West Sussex on 16 July and remaining within the SECAmb area until the evening of 20 July where, following an evening event in Guildford it was flown to the Tower of London before its final week touring the greater London area. SECAmb were actively involved in the multi-agency planning and delivery of the torch relay including the provision of managers within the co-ordination/communication centres as well as providing medical cover for the route and the evening events put on by the host City or town.

As part of a national agreement for mutual aid SECAmb provided staff to London Ambulance Service (LAS) in support of both the Olympic and Paralympic events taking place across the Capital. All staff selected to provide mutual aid had to receive specific information and training as well as being accredited by the Police and organising committee to ensure they could effectively fulfil their duties.

Five events took place within the Trust's area, the men's and women's road cycling and the men's and women's cycling time trial, which were all staged around Surrey, and the Paralympic cycling which took place over three days at Brands Hatch motor racing circuit in Kent.

To ensure there would be sufficient staffing to not only support the Games themselves but also maintain emergency and routine services an agreement was reached with staff side to reduce the usual numbers of staff allowed annual leave through the period of the games, thereby ensuring sufficient staff were available to meet all the Trusts obligations.

Despite the huge challenges posed in responding to the Games SECAmb, along with all partner agencies can be rightly proud of the response it provided helping make London 2012 one of the most successful Olympic and Paralympic Games ever.

# Our *patients*



*This section focuses on the experience of our patients when they use our services and describes the Trust's Survivor's Event, where we re-unite 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 continued to see a 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 2012/13 SECAmb received 1,318 'compliments', thanking our staff for the treatment and care they provide. This represents a 25% increase over the number received in 2011/12.

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 2012/13 we made over one million (1,075,729) emergency responses and PTS journeys and received 349 formal complaints – this equates to a complaint for every 3,082 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. Once the enquiries are complete, a full explanation, along with an apology where appropriate, is sent by the Chief Executive to the complainant.

On completion of every complaint, we consider whether we feel it was upheld, upheld in part, not upheld or unproven. As this report was compiled, 255 of the 349 complaints for the year 2012/13 had been concluded, with outcomes as follows:

Complaint upheld	86
Upheld in part	85
Complaint not upheld	55
Complaint not upheld	29
<b>TOTAL</b>	<b>255</b>

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 a friendly, listening ear for those who don't necessarily want to make a complaint but have a query, concern or just need information. And if, further to their enquiry, a person does want to make a formal complaint, PALS can support them in doing this, explaining the process and helping to define their expectations and their desired outcome.

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, our Compliance Working Group 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 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, and this is done in a number of ways.

In the first instance this is done directly with the crews through clinical case reviews and reflective practice, peer reviews, and is backed up with internal circulars such as training circulars. The Trust's weekly staff bulletin is also used to highlight learning issues taken directly from complaints and enquiries. The Professional Standards team produces a publication called 'Reflections', which highlights incidents that have occurred, looking specifically at the lessons learnt. This is distributed to all of our operational staff on a quarterly basis and provides valuable information to our crews that they can draw on should they come across a similar situation themselves.

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 of our operational staff attend Key Skills updates every year. We use these days to provide additional training to our staff should our audits of complaints/incidents show that there is a trend in a specific area.

**During 2012/13, PALS handled 3,506 enquiries and, as mentioned earlier, 1,318 of which were 'compliments'. We record all of the compliments we receive, be they letters, cards, emails 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.**



## 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 2012/13 are outlined below.

### **Paramedic Practitioners**

Paramedic Practitioners are 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.

Another development we are aiming to continue into the coming year is the Paramedic Practitioner desk in EOC. This desk is staffed by two PPs 24/7 across our three EOCs, and provides support and supervision for staff who need advice on the best onward care for their patient.

The PP desk takes around 1000 calls per month and arranges around 650 PP referrals. A PP referral is where a PP is dispatched to the patient in order to provide further assessment and treatment. For instance, patients who need wound assessment and closure can be referred to a PP rather than transport them to A&E for treatment.

SECAMB continues to strive to raise and maintain the quality of care for patients, and this must be done within an ever tighter financial envelope. In order to maintain an efficient and effective service, we are reviewing and evaluating ways of ensuring patients get the right care in the right place, and at the right time.

Making sure we deploy paramedics and PPs to the patient as often as possible in order to provide a rapid response and apply good decision making is still a high priority, and we are enhancing this further by developing new ways of providing high quality transport systems to back-up paramedics.

Some patients do not need to be cared for by a paramedic en-route to A&E after they have been assessed by one. The ability to escalate or de-escalate the level of clinical escort to hospital will ensure we have our most skilled clinicians available as often as possible. We are now deploying A&E support crews, staffed by ECSWs and PTS staff, who can focus on high quality care for patients in transit.

Our modern communications infrastructure means that should the patient's condition change; we can provide support and supervision and send additional clinical resources. The protocols which govern the use of A&E support ensure that only stable patients are transported in this way.

## Developing future services

Large scale changes in relation to the wider NHS research agenda are imminent and ambulance services need to be prepared, engaged and responsive to the demands they will encounter in the coming years. Paramedic research has grown rapidly over the last decade in the UK and it is important that ambulance trusts sustain these developments and capitalise on available opportunities to expand the evidence base underpinning paramedic practice and the provision of out-of-hospital unscheduled and urgent healthcare services.

Research is considered as core business for all NHS Trusts no matter what the size and nature of the Trust and SECAMB continues to develop a diverse research portfolio to ensure that its service users receive excellent clinical care grounded in best evidence.

Currently there are many changes and developments nationally in relation to research infrastructure and SECAMB has been involved in the discussions pertaining to the proposed new structures such as the Kent, Surrey and Sussex Academic Health Science Networks which in turn may further influence the parameters of the National Institute for Health Research (NIHR) Clinical Research Networks and the Comprehensive Local Research Networks (CLRN) which are, in any case, currently in consultation with various groups and professional bodies with regard to streamlining their focus and structure.

Even with the current limited resources allocated directly to research within SECAMB, over the past 12 months, we have been an active participant of externally led research as well as developing and undertaking our own research.

A number of clinical studies which are currently in progress are listed here:

- + Evaluation of the ABCD2 score in pre-hospital assessment of patients with suspected Transient Ischaemic Attack (TIA): Pilot study;
- + The contribution of nurses to clinical decision-making in ambulance control settings: scope of practice, education and impact on the service;
- + Efficacy and Safety of pre-hospital vs. in-hospital initiation of Ticagrelor therapy in STEMI Patients planned for percutaneous coronary intervention (involving a majority of ambulance services in the UK in an international study);
- + Mechanical Chest Compression in Patients who are Unlikely to Survive;
- + Decision making and safety in emergency care transitions .

In addition, SECAMB is committed to active engagement of the public in our research developments from inception of a research idea through to dissemination of findings.

Amongst other activities, the Research and Development Sub Group (RDSG) run an annual research event to keep our actual and potential service-users engaged with research developments in the Trust. Last year on 18 June we included a Research Priority Setting Workshop in conjunction with the James Lind Alliance. The James Lind Alliance facilitates Priority Setting Partnerships bringing together patients, carers and clinicians to identify and prioritise topics for healthcare research. The information that we collected at our research event has been analysed and developed into a questionnaire which is being circulated to our service-users across the Trust to establish their views as to what research questions need to be answered in order to continue to improve the wide range of services that the Trust offers.

In conclusion there are several areas for research that SECAMB is exploring for development into research grant applications. These include:

- + Use of oxygen therapy in patients with myocardial infarction;
- + Investigation into feasibility and impact on patient outcome of a variety of near patient testing techniques and adjuncts;
- + Telemedicine;
- + Mental healthcare pathways;
- + Understanding and sustaining professionalism in Paramedic practice;
- + Management of stroke patients;
- + Advanced ECG interpretation;
- + Management of patients with learning disabilities.

## Highlighting lives saved

In September 2012, the Trust held its second Survivors' Event, where eight patients whose lives were saved by the clinical interventions of SECAMB staff were reunited with their lifesavers.

The event, held at Woodlands Park Hotel near Cobham, Surrey recognised the life-saving skills of SECAMB staff, celebrated the lives of everyone SECAMB has helped save and emphasised the importance of early cardiopulmonary resuscitation (CPR).

Along with Chief Executive Paul Sutton and Chairman Tony Thorne, staff were able to hear each patient's amazing recovery first hand as a short film, telling each patient's story, had been made and was shown for the first time at the event. While paying tribute to SECAMB staff and celebrating each patient's recovery, the film also encourages more people to understand the importance of learning CPR and basic life support.

Also attending the event and receiving a small token of the Trust's appreciation for their outstanding contribution to SECAMB were Consultant Cardiologist Professor Douglas Chamberlain, and Paramedic Dave Fletcher.

Douglas Chamberlain's contribution to the development in cardiac care cannot be over-estimated. Among his long list of achievements was a revolutionary move in the early 1970s to train ambulance personnel to become skilled technicians in resuscitation – a move which led to the introduction of the UK's first paramedics.

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Dave was among the first cohort of these new clinicians. He worked closely with Douglas throughout his career to improve out-of-hospital resuscitation survival rates across SECAmb's region of Sussex, Surrey and Kent and from early on in his career acquired a reputation as one of best pre-hospital clinicians. This reputation received royal recognition when Dave became one of just five ambulance personnel across the UK to be put forward to receive a Queen's Ambulance Service Medal in the Queen's Birthday Honours.

He was nominated for his commitment and pioneering work on resuscitation at SECAmb with Professor Chamberlain which led to the introduction of a new resuscitation technique, Protocol C, across the Trust and was duly presented with his medal by HM The Queen at Buckingham Palace in November 2012.

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**Chief Executive, Paul Sutton said:**

*"The Survivor's Event was once again a tremendous opportunity to recognise and pay tribute to our highly-skilled staff and at the same time celebrate the lives which have been saved as a result. The stories told are just a few examples of the many successes which take place across our region every day. SECAmb is just one part of these patients' amazing recoveries but without the calm advice of our staff on the phones in our emergency operations centres, the actions of our clinicians at the scene and indeed the quick-thinking of members of the public to provide vital life-saving CPR in the minutes before our arrival, many lives would not be saved. We want to encourage everyone to take the time to learn how to save a life. I'd also like to pay tribute and personally thank Douglas Chamberlain and Dave Fletcher for the commitment and dedication they have given the ambulance service over so many years."*

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### Our patients... hearing about their care

Starting in early 2012 SECAmb's patient transport service began a new strategic survey program which meant surveying patients quarterly in the Sussex/Surrey region and bi-annually in the Kent region this has allowed the capture of very up to date satisfaction information which leads on to important developments and implementing of patients' suggestions.

Over the year 93-97% of patients in Sussex and Surrey expressed that they were either "very satisfied" or "satisfied" with the service provided. All questions relating to the staff training, attitude and perception of them have been over 96% positive with many of the comments relating to how caring kind and helpful our staff are.

## Providing the right response

During the past 12 months, the Trust has worked hard to ensure that when patients phone 999, they receive the most appropriate response for their needs:

### **Hear & Treat**

For some 999 callers, once their reason for calling has been identified as being minor or self-limiting, care advice can be discussed with the patient by one of our "Hear and Treat" clinicians.

We have teams of Paramedics and Nurses specially trained to provide care and advice to patients over the telephone, and these clinicians are on duty 24/7. Not every 999 caller is suitable for hear and treat, and there is a limit to how many of our 999 calls can be dealt with over the telephone safely. Last year we dealt with 55,310 hear and treat calls, which is a change of 112% on the previous year.

### **See & Treat**

The majority of 999 callers will need a response by a clinician, but this doesn't always mean that a trip to A&E is required. Each year we are asked to take fewer patients to A&E, as this promotes care closer to home and reduces pressure on acute hospitals. Identifying which patients are suitable for treatment at home can be done by all our clinical staff, but these decisions are supported and checked to ensure the patient is safe. SECAMB has over 200 paramedic practitioners; some of which are deployed in our Emergency Operations Centres, and the rest are in

single response vehicles to respond to calls. The PPs in EOC predominantly take calls from crews who wish to discuss referring a patient for on-going care by an operational PP, or to discuss and agree a care plan with the crew. PPs are educated to treat patients with minor injuries and illness, and support crews at the patient's side over the telephone or by attending the patient after the first crew leaves.

Last year, 200,483 of our 999 patients were managed as See and Treat. We were asked by our commissioners to deal with 40% of our patients as See and Treat and the actual percentage was 30%.

### **See & Convey**

For patients who cannot be managed over the telephone, or at home, we convey the patient to hospital. This is known as See and Convey, and doesn't mean that we just provide transport, as the patients who fall into this group are usually those with the most serious conditions. Providing high quality care for patients en-route to hospital has always been the traditional cornerstone of ambulance services, and while we look to other ways of providing care for patients who do not need hospital intervention, we continue to provide a high level of care to patients in the "see and convey" group. Last year, 55% of our 999 callers were taken to hospital as a result of their call to us.

## Providing a joined-up service



During 2012/13, the Trust has continued to develop the use of the Intelligence Based Information System (IBIS) throughout the healthcare community – an innovative software system which better links the ambulance service with other parts of the NHS. IBIS is now used by the following types of provider:

- + Community Trusts (community nursing and therapies)
- + Secondary care (supported reduction in readmission following discharge)
- + Hospices
- + Mental health trusts

We have 487 health professionals with IBIS user accounts, with the majority of them now trained to use the system. Training has been undertaken by a dedicated IBIS trainer, which became a requirement due to the sheer number of requests for user accounts.


There were nearly 800 patients registered on IBIS when this report was prepared, and the organisations using IBIS are pledging to collectively take this number into the several thousand over the coming months.

By registering patients on IBIS, when they call 999, the information available to the clinician at the patients' side can have a huge impact on whether or not it is necessary to take the patient to A&E.

The IBIS patient cohort has made nearly 1400 emergency calls to SECamb, resulting in only around 550 conveyances to A&E. This gives IBIS a conveyance rate 15-20% lower than for non-IBIS patients. This has saved over 200 conveyances to A&E and around 70 admissions.

Another feature of IBIS is the clinical coding of non-conveyed patients. This function collects demographic information, GP practice details and the clinical coding for each non-conveyed patient. This data can be shared with "urgent care clinical dashboards", which exist in some parts of the region and are overseen by the CCGs using strict information governance protocols. The data helps shape future health services and can be used to predict patients at risk of developing long term conditions in the future, based on their use of health services.

We are also starting to use this data to identify our frequent callers. People who call 999 for the same condition regularly are not having their needs met effectively. 999 is often the first choice for unscheduled care needs, and SECamb must ensure that we both support the patients' decision to call us, and ensure that we signpost to the most appropriate service. We are developing specific care planning processes for frequent callers, which we hope to deploy during 2013/14.

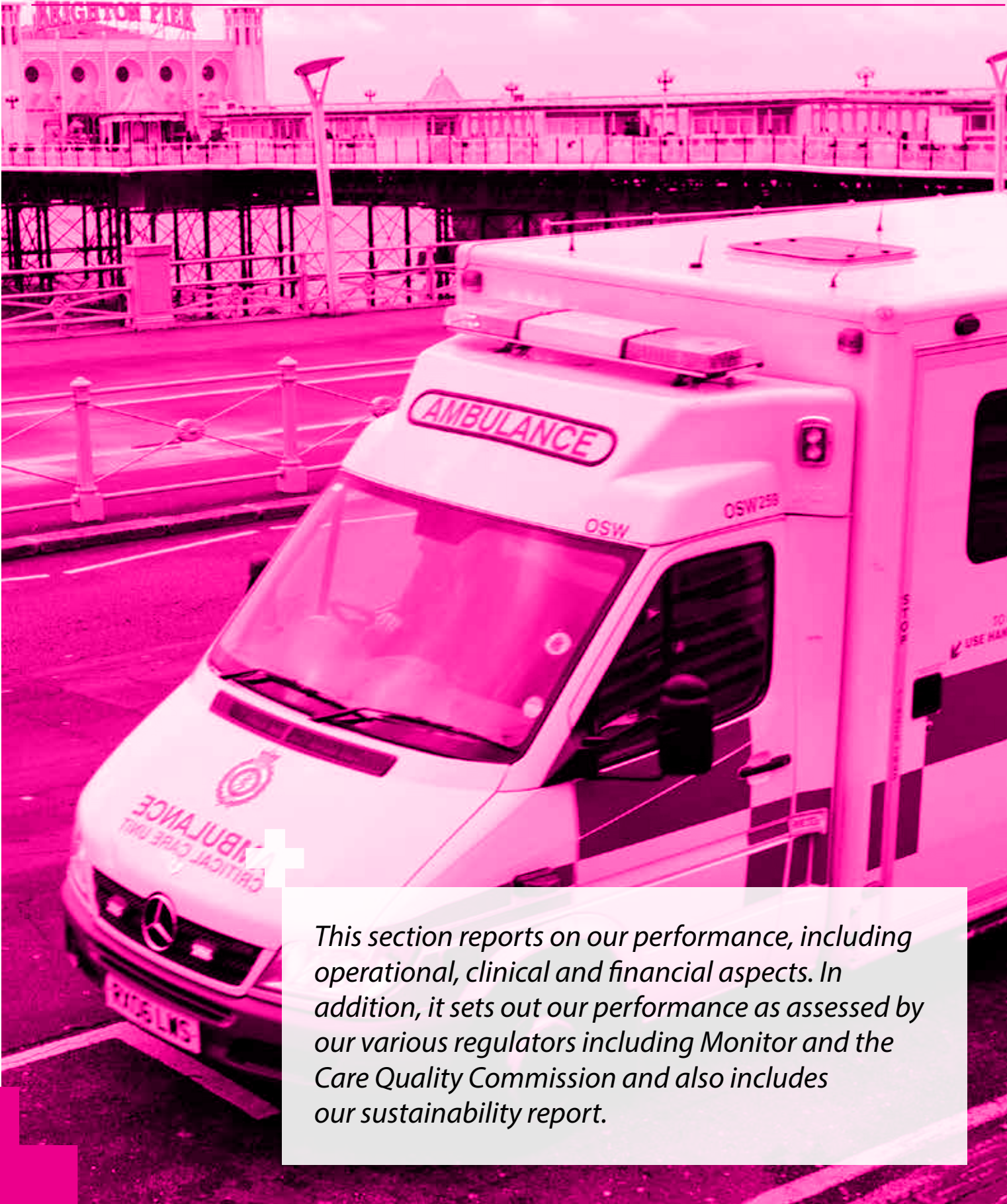


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A sub-set of frequent callers are the “frequent fallers” – patients who fall multiple times. Statistically, patients who suffer repeat falls are at much higher risk of sustaining serious injuries in subsequent falls. Part of the clinical coding function screens each non-conveyed incident for the presence of a fall and notifies the local falls service of the incident using a pro-forma. Even if the patient isn’t hurt, there is almost always a preventable feature with the fall that can be assessed by the expert therapists and nurses in the falls teams. To date, we have sent over 3000 falls notifications to falls services across the region using IBIS.

The two main functions of IBIS are progressing very well. Patients with long term conditions registered with us are attending hospital less, which means more care closer to home which avoids long ambulance journeys. Our non-conveyed patients are also benefitting from SECAMB contributing to urgent care dashboards, as well as being cared for more appropriately should they make repeat calls to us.

# Our *performance*



*This section reports on our performance, including 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.*



## Getting to as many patients as quickly as possible

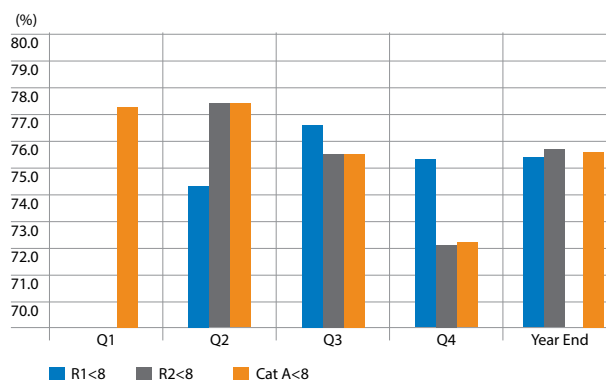
### Response time performance

Ambulance services in England are subject to some of the most demanding response time targets in the world, requiring a response to at least 75% of patients whose life is, or might be, at threat within eight minutes.

The distinction between those patients whose life is at threat versus those whose life might be at threat is one that came to the fore with the introduction of Red 1 and Red 2 performance standards from 1 June 2012. Red 1 patients are the most time critical and cover those patients who are not breathing and don't have a pulse, and other severe conditions. Red 2 patients are serious but less immediately time critical and cover conditions such as stroke and fits. A new clock start time allows call-handlers to get more information about these patients so that they receive the most appropriate response for their specific clinical needs.

Although the new targets were introduced in June 2012, in addition the Trust continued to report and was measured against combined Red 1 and Red 2 performance (Category A) each quarter for the remainder of the year, as the graph shows:

### SECAmb R1, R2 and CatA < 8 min Quarterly Response Performance from Q2 and Year End 2012/13 – National Target 75%



As the graph shows, the Trust achieved its response standards for both categories (Red 1 and Red 2) as well as the combined standard – 75.6% against the target of 75% – at year end.

The Trust fell slightly below the Red 1 target for Quarter 2 (74.3% against the 75% target); this was the first quarter when the new performance standards were measured in full and the low numbers of Red 1 calls can make achieving this target more challenging.

Red 2 performance was also below the required standard during Quarter 4 (72.1% against the 75% target). This was partly due to the winter period being particularly problematic for the whole health system this year, with activity increases as high as 10% over the previous year, which itself was as high as 15% greater than in 2010/11.

### **PTS performance**

Delivery of the PTS service has been challenging since the award of new contracts in Surrey and Sussex. As a result, a significant review of staff rotas across Surrey and Sussex is taking place and a completely new method of planning and dispatching the PTS fleet is being adopted.

### **Additional support when needed – Use of Private Providers**

#### **A&E**

In order to help us provide extra support when needed, the Trust utilises capacity from the Voluntary Aid Societies, including St John Ambulance, as well as private providers to support predicted periods of increased demand and at short notice when activity increases above planned levels. All of these additional providers undergo a rigorous evaluation process including review of CQC registration and clinical competencies before we use them.

Over the course of the year they have made up around 7% of the front-line A&E hours provided by the Trust.

During the key winter months PTS also provided additional support to A&E through PTS staff either being seconded to A&E on a full time basis or working on rest days and at weekends to provide a basic life support tier.

A number of fixed term contract and bank staff were recruited to back fill any vacancies so that the contracted PTS activity was not affected by this action.


2013 will see the development of an Intermediate Tier to work alongside A&E and provide a service to referrals from Health Care Professionals.

### **Improving treatment and outcomes**

The NHS Operating Framework covers a number of measures regarding the quality of ambulance services in England. These include system and clinical indicators.

#### **Clinical Outcome Indicators**

The NHS Operating Framework has seen an increased focus on outcome measures. Clinical Outcome Indicators are data that is collected from the National Ambulance Trusts in England as a component of the National Ambulance Quality Indicators that relate directly to the outcomes of those patients transported by ambulance 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 all Ambulance Trusts every month



Data sampling for these indicators is currently a manual process based on scrutiny by the Clinical Audit Department of the individual patient clinical records. The monthly sample size for each Clinical Outcome Indicator is all cases within the data period. Again, the inclusion and exclusion criteria for each indicator is defined and agreed nationally. Data is obtained with a three month data lag in order for those outcomes to be resolved.

Internally, the Trust reviews performance reports at the Risk Management and Clinical Governance Committee and also with the Lead Commissioners at the scheduled Quality Commissioning meetings.

The nationally agreed 2012/13 Clinical Outcome Indicators were:

- a) **Outcome from cardiac arrest : return of spontaneous circulation (ROSC)** – this indicator measures how many patients who are in cardiac arrest but following resuscitation have a pulse/ heartbeat on arrival at hospital.
- b) **Outcome from acute ST-elevation myocardial infarction (STEMI)** – this indicator measures the outcome of those patients that suffer an out of hospital STEMI (a type of heart attack). Success of the STEMI management is shown by the number of patients that survived against all those patients that suffered a STEMI expressed as a percentage.
- c) **Outcome from cardiac arrest: survival to discharge** – this indicator measures the rate of those who recover from cardiac arrest and are subsequently discharged from hospital.
- d) **Outcome following stroke for ambulance patients** – this indicator measures 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.

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At the time of writing, Clinical Outcome Indicator data has been submitted nationally for the period April 2012 to November 2012. During this period the Trust has seen an improvement in month on month performance for all indicators, except ROSC and Survival to Discharge. However, it is nationally recognised both these indicators have unstable performance from month to month due to relatively low sample figures. The downward turn in ROSC reflected the drop in the national mean for that indicator, however national performance for Survival to Discharge remained stable compared to previous months.

Much work has been underway during 2012/13 develop and implement a targeted programme of education and awareness along with defined programmes and systems to ensure staff understand the Clinical Indicator programmes.

In addition, from September 2012 alongside year to date performance, the Trust has been reporting on internally set aspirational measures of improvement for the indicators on the Corporate Dashboard to the Trust Board.

These reflect a 1% increase on Trust clinical performance for the indicators where the Trust performed above the national mean for 2011/12 for:

- a) Cardiac Arrest: Return of Spontaneous Circulation
- b) Cardiac Arrest: Survival to Discharge
- c) STEMI

and a target to meet and exceed by 0.5% on those clinical indicators where the Trust performance fell below the national mean for 2011/12 for:

- a) Cardiac Arrest: Survival to Discharge
- b) Stroke Care

The Trust is currently performing below the year to date national mean on all indicators, with the exception of ROSC which equals it. However, the Trust will work hard during the year to achieve the planned improvements.

During 2013/14 work will continue to deliver a Clinical Outcome Indicator reporting tool to individual staff level to enable greater analysis of the impact of the improvement programme to date and identify target areas for improvement and progress the programme to certificate a number of clinicians in clinical audit.

Figure 3 below tables the performance for the month of November 2012 and year to date performance to this point.

**Figure 3: Clinical Outcome Indicator Data (April 2012 – November 2012)**

Clinical Outcome Indicator			November 12			YTD (April –Nov 12)			
			Nat %	Trust %	Var %	Nat %	Trust %	Var %	
1	Outcome from cardiac arrest	A	Return of spontaneous circulation (ROSC) on arrival at hospital (All)	25.1	26.6	+1.5	25.3	25.1	-0.2
		B	Return of spontaneous circulation (ROSC) on arrival at hospital (Utstein)	44.1	48.4	+4.3	46.9	45.9	-0.1
2	Outcomes from Acute ST-elevation myocardial infarction (STEMI)	A	Proportion receiving thrombolysis within 60 minutes	Not reported					
		B	Proportion receiving primary angioplasty within 150 minutes	88.2	90.5	+2.3	88.1	88.0	-0.1
		C	Outcome from STEMI (Care bundle)	77.8	83.8	+6.0	77.6	77.4	-0.2
3	Outcome from cardiac arrest	A	Survival to discharge (All)	7.0	3.7	-2.3	7.8	6.1	-1.7
		B	Survival to discharge (Utstein)	21.1	22.2	+1.1	21.8	16.7	-5.1
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	63.1	64.1	+1.0	63.6	61.6	-2.0
		B	Proportion of suspected stroke patients assessed face to face who received an appropriate care bundle	96	91.9	-5.1	95.6	90.7	-4.9

1. ROSC is calculated for two patient groups. The overall rate measures the overall effectiveness for managing care of all out of hospital cardiac arrests; the rate for the Utstein comparator group provides more comparable and specific measures of the management of witnessed cardiac arrests only.
2. Survival to Discharge: As with the Return of Spontaneous Circulation (ROSC), survival to discharge following cardiac arrest is reported separately for all patients, and for the subset of patients in the Utstein comparator Group.

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## Clinical Performance Indicators

Clinical Performance Indicators are collected by all ambulance services in England. Each indicator is collected on a rolling Cycle with each indicator being measured twice a year. The indicators are underpinned by a number of metrics which have been refined and revised over successive cycles.

Data is collected by individual Trusts and submitted to the National Ambulance Service Clinical Quality Group. The performance of Trusts is then compared, and the final report for each cycle is then published by the Group and reported to National Ambulance Services Medical Directors Group. Internally, the Trust reviews performance reports at the Risk Management and Clinical Governance Committee and also with the Lead Commissioners at the scheduled Quality Commissioning meetings.

Data sampling for the indicators is a manual process in SECAmb, based on scrutiny by the Clinical Audit Department of individual patient clinical records. The monthly sample size for each indicator is three hundred cases with the inclusion and exclusion criteria for each indicator defined and agreed nationally. Not all participating Trusts have this number of cases for the indicator conditions, and the comparative data is adjusted to accommodate this.

The method for calculating the results from Cycle Seven onwards has been to treat exceptions as positives to the criterion so the denominator remains the same for all criteria in the indicator, and the numerator is the number of positives to the criterion including the number of exceptions.

During 2012/13, two cycles of data for each indicator were collected and submitted, which enabled the measuring and benchmarking of performance against the Clinical Performance Indicators that contributed to the Quality of Care rating and which monitored the management of:

- a) Asthma
- b) Hypoglycaemia

It was agreed by the National Ambulance Services Medical Directors Group to cease data collection during 2012/13 on the Stroke and STEMI Clinical Performance Indicators as these are covered in the Clinical Outcome Indicators.

**Asthma:** The indicator data below in Figure 1 shows SECamb's performance over two cycles of audit against the elements of care delivered for patients suffering from Asthma. Asthma is a chronic disease with a significant impact on the predominantly younger population affecting their quality of life and rapid and appropriate treatment can ensure the patient can safely remain in the community and/or be rapidly transferred to secondary care where appropriate.

**Figure 1: Asthma Data (July 2012 – January 2013)**

	ASTHMA			
	Cycle 9		Cycle 10	
	July 12		June 13	
	SECamb	National Mean	SECamb	National Mean
Respiratory rate recorded	95.2	99.0	98.6	Not yet available
PEFR recorded (before treatment)	69.9	80.6	75.6	Not yet available
SpO2 recorded (before treatment)	98.4	94.7	99.3	Not yet available
Beta-2 agonist given	96.0	97.3	99.3	Not yet available
Oxygen administered	97.6	96.5	98.3	Not yet available
Care bundle	65.9	76.7	73.9	Not yet available

**Hypoglycaemia:** The indicator data shown below in Figure 2 shows SECamb's performance over two 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.

**Figure 2: Hypoglycaemia Data (June 2012 – December 2012)**

	HYPOGLYCAEMIA			
	Cycle 9		Cycle 10	
	July 12		June 13	
	SECamb	National Mean	SECamb	National Mean
Blood glucose before treatment	100.0	99.0	100.0	Not yet available
Blood glucose after treatment	98.5	97.3	93.8	Not yet available
Treatment for hypoglycaemia recorded	99.0	99.1	97.6	Not yet available
Referral to HCP	67.0	61.8	70.16	Not yet available
Care Bundle	98.0	95.8	91.86	Not yet available

As clinical performance improves over successive cycles, a point is reached where clinically relevant improvement is no longer possible. Further, if the focus remains the same, areas of greater potential improvement are at risk of de-emphasis by clinicians, therefore continual refinement of the indicators and development of new ones is essential to ensure the continuous improvement of quality patient care

In addition to the above, during 2012/13 the National Ambulance Service Clinical Quality Group agreed and developed two new Clinical Performance Indicators for piloting:

- a) Management of trauma in patients with below the knee fractures
- b) Febrile convulsion in children

Pilots were conducted in August 2012 and September 2012 respectively by all Trusts. The resultant data samples for these pilot Clinical Performance Indicators have been small and obtained through many different methodologies. Therefore valuable benchmarking internally or externally has not been possible at this stage, although this is being reviewed again at national level by the National Ambulance Service Clinical Quality Group and the National Ambulance Services Medical Directors Group respectively.

## Using our resources effectively

This part of the report is about the Trust's financial performance in the period from 1 April 2012 to 31 March 2013. Our accounts for the period are attached at Appendix B. They are also available for downloading from the Trust's website.

### Income and Expenditure Position

The Trust made a surplus of £3.1m (1.8% of turnover) for the year ended 31 March 2013. The planned surplus for the same period was £3.6M.

Figures are subject to rounding	£M		
	Plan	Actual	Variance
Income	168.5	174.0	5.5
Operating Expenses	153.1	159.0	(5.9)
EBITDA	15.4	15.0	(0.4)
Interest, depreciation, and dividend	11.8	11.9	(0.1)
Retained Surplus/ (Deficit)	3.6	3.1	(0.5)

Overall the Trust performed in line with the expectations in our three year plan. The Trust continued to invest in the key areas of paramedic skills development (FLSM), make ready infrastructure and HART.



## **Income**

Additional income included monies relating to providing the core 999 service which over performed against the commissioned expectations and generated an additional £3.6M of income which was matched by costs. Further funding was received for winter pressures, staff development and as a result of an earlier than planned go live of the NHS 111 service. However the underlying position with income is more challenging.

Looking to the future we continue to be challenged in our core business of providing a 999 service by the tariff deflator (effectively a price reduction) of 4% for the year 2012/13 (1.3% 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' and 'See and Treat' responses which reduces our overall income in future years. As a result we expect reduced income over the next few years.

From 2013/14 our services will be commissioned differently, via Clinical Commissioning Groups (CCGs).

During the year we continued to provide PTS services in Sussex but under a new contract and commenced the service in Surrey. This has been a challenging undertaking as the service has bedded in, particularly in Sussex where the patient activity is via a patient booking service provided externally to the Trust.

In March 2013, we commenced provision of the NHS 111 contract for Surrey, Sussex and Kent with our partners, Harmoni.

The Trust has met the requirement for its income from goods and services for the purpose of the health service to be greater than its income from the provision of goods and services for any other purpose. The income received from the provision of non NHS goods and services has had no impact on the provision of goods and services for the purposes of the health service.

## **Expenses**

Additional operating expenses included investments to ensure operational delivery at the higher activity levels including during over the peak winter months. We also continued with planned staff training, investments to support the delivery and development of NHS 111 and PTS activities and the HART program.

In the future we continue to recognise that we will need to deliver improved efficiencies to counter the price pressure from the Operating Framework deflator and from the Hear and Treat and See and Treat changes as well as to ensure that we have the resource to support key investments in people and infrastructure. We will aim to do this through the cost improvement programme (CiPs) programme which is detailed later in this report.

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Our Capital Spend in the period was £12.9m. We mainly invested in our vehicle fleet for both the 999 service and PTS including medical equipment and improving the resilience of our IT systems. We expect to continue to make significant capital investments in the next four to five years as our estates programme 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 £30.3m. The plan was £22.8m. The principal cause of the difference was the timing of payments as the PCTs ceased on 31 March and closed out their accounts.

#### **Prudential Borrowing Limit**

During the period the Trust was set a Prudential Borrowing Limit of £21.9m. The Trust total borrowing as at 31 March 2013 is £6m.

#### **Working Capital Facility**

During the period the Trust had access to a Working Capital Facility of £13m. 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.

#### **CiP Program**

During the year we delivered CiPs of £10.5m against an expectation from Monitor of £9.3m. This was primarily driven by productivity gains with clinical operations delivered through management of Unit Hour Utilisation (UHU).

For the year 2013/14 we continue to focus on driving improvements in key operational areas including: Hear and Treat; Abstraction; See and Treat; Procurement, continuing focus on improvements in the UHU as well as improving efficiencies within the provision of PTS services.

#### **Financial Risk Ratings (using Monitor's criteria)**

We maintained our risk ratings throughout the quarters.

### **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. We have adopted a risk based approach to focus this training on the areas most at risk. We have ensured that we have a Local Counter Fraud Officer who is active and that all staff are familiar with the procedure for raising concerns in a timely manner. In addition the Trust operates a whistleblowing hotline. We carry out thorough investigations if concerns are raised. Policies with respect to Fraud, Bribery and Gifts have been revised and reissued during the year to ensure that they are clear, easy to understand and appropriate.

### **Audit Performance**

We have an active internal audit program which is overseen through the Audit Committee. The programme 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. During the year the presentation of our Standing Financial Instructions and our Scheme of Delegation has been improved 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 focussed areas including clinical audit, unsocial hours, CiP programme and key financial controls.

### **Accounting Policies**

The accounting policies for the Trust are set out on pages 9 to 17 of the annual accounts.

### **Annual Assurance Statement**

As Accounting Officer for the Trust, the Chief Executive is required to produce a Statement of Internal Control, setting out the systems for managing risk and an assessment of their effectiveness.

The Statement of Internal Control is included in Section 15.

## 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	Invoices paid on time	% of invoices paid within target	Total value paid	Value paid on time	% of invoices by value paid within target
32,064	28,973	90.36%	£55,628,358	£46,422,225	83.45%

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 have 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 2012/13 Better Payment Practice Code percentages are lower than the target of 95% due to issues such as an upgrade of Oracle software during the year resulting in no payments being possible between the end of December 2012 and the middle of January 2013. In addition to 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.

## **Audit Committee**

The existence of an independent Audit Committee is the central means by which the Board of Directors ensures effective control arrangements are in place. In addition, the Audit Committee provides an independent check upon the executive arm of the Board.

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

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

The Audit Committee membership in respect of the period ended March 2013 was:

- + Nigel Penny, Non-Executive Director and Chair of Audit Committee
- + Christine Barwell, Non-Executive Director
- + John Jackson, Non-Executive Director
- + Graham Colbert, Non-Executive Director
- + Trevor Willington, Non-Executive Director
- + Tim Howe, Non-Executive Director
- + The Director of Finance, Director of Commercial Services, Local Counter Fraud Specialist, Internal Audit and External Audit regularly attend the meetings of the Audit Committee.

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

The external auditor for the Trust is Grant Thornton UKLLP. The fees paid to the auditor in respect of the period were £55,440. The fees paid related to audit services, that is statutory audit and services carried out in relation to the statutory audit. There were no other services provided by Grant Thornton in the period.

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## Meeting our regulatory duties

### **CQC Registration and Inspection**

The Trust is registered with the CQC and was subject to a four day unannounced inspection between 4 and 7 February 2013. Inspectors visited regional offices, call centres, make ready centres and A&E Departments at five hospitals. The inspectors also spoke to over fifty members of staff. The report from the inspection states that staff had a positive attitude and that patient care was their primary goal and the focus of the service. Comments from those who used the service were also positive.

They CQC inspected seven outcomes and found the Trust to be fully compliant with five of them. Further action is required by the CQC to ensure full compliance with Outcome 9 – Management of Medicines and Outcome 14 – Supporting Workers. However, the judgement of the inspectors was that the concerns raised in relation to both these outcomes would only have a minor impact on service users.

The actions plans developed to ensure full compliance with Outcomes 9 and 14 will be monitored by the Trust's Risk Management and Clinical Governance Committee, which reports directly to the Board

### **NHS Litigation Authority**

The Trust chose to be re-assessed at Level 1 in November 2012 and scored 50 out of 50 against the NHSLA's requirements.

### **IG Toolkit**

SECAMB published its Information Governance Toolkit V10 submission for 2012/13 and achieved an Overall Assessment of Level 1, Graded Not Satisfactory.

It should be recognised that whilst Levels 2 and 3 were achieved for 34 of the 35 Assessment Areas, a Level 1 was recorded for annual IG Training, where we achieved 80% of staff trained against a target of 95%.

## Monitor Risk Ratings

The tables below summarise the rating performance throughout the year with a comparison against the previous year.

	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

	Annual Plan 2012/13	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.

## Ensuring sustainability and protecting the environment

### Summary of Performance

This year we have worked with the Carbon Trust to establish a robust baseline for our carbon emissions. This process has allowed us to produce a high level Carbon Management Plan endorsed by the Carbon Trust and to set a corporate commitment to achieve a 30% emission reduction target by 2017. This work has been overseen by a Carbon Management Team and a Carbon Management Board and has been fully supported by the Executive Management Team.

Our baseline emissions are accounted for in the following categories;

Category		tCO2 2011
Buildings and Street Lights	ACRP	29
	Administration HQ	1,073
	Large Ambulance Station	212
	Make Ready CR	380
	Make ready Satellite	520
	Small Ambulance Station	1,527
Transport	Fleet	13,415
	Business	1,263
	Outsourced	0
	Commute	0
Further Scope	Refrigerant gas	0
	Waste	110
	Water	47
	Other	0
		<b>18,576</b>

We will build on this baseline work in 2013/14 and place a greater focus on the engagement of our staff in the behaviour changes that we need in order to deliver our carbon reduction targets.

To complement the Carbon Plan we have also drafted a Climate Change Adaptation Action Plan. This is closely aligned with the Government's latest National Assessment Report and updated regional scenario information. Performance management of this plan will be overseen by the Trust's Local Resilience Group.

### Future priorities and targets

We are planning to revise our Board approved Sustainable Development Management Plan (2010) so that it reflects the importance of the delivery of our targets in these areas.

We have an extensive capital build programme underway and a key challenge is to ensure that our new Make Ready Centres, which will replace much of our current estate, are of the lowest carbon specification we can achieve in order to deliver our carbon reduction targets moving in to the future. Linked to this work is a new Headquarters building which, although likely to be a refurbishment of an existing building, should also meet the highest environmental standards and the lowest carbon specification we can guarantee.



The Trust is committed to complying with all environmental legislation and all other relevant regulatory requirements. Ensuring compliance with the law is a responsibility of all staff and must be monitored and reported routinely throughout the organisation. A central register of all applicable legislation has been established so that managers can understand more clearly their responsibilities and direct staff more efficiently within their own specific areas.

We are very conscious of the need to move to more of a fuel mix in our fleet and we are currently analysing low carbon alternatives to diesel fuelled transport which can deliver our services without any compromise to patient care.

Source	Mileage 2011/12	Cost to SECAMB £*
Ambulances	10,446,928	£3,708,659
Single Response Vehicles	3,138,069	£742,675
Patient Transport Services	2,426,068	£689,002
Private Ambulance Service	114,617	£40,688
Specialist vehicles	784,972	£278,665
Fleet non-operational	629,508	£148,983
<b>Total</b>	<b>17,540,162</b>	<b>£6,075,384</b>

\* estimated on £1.42 a litre

Source	Mileage 2011/12	Cost to SECAMB £*
Lease cars	1,232,517	£209,527
Grey fleet	354,823	£150,000
Volunteer Car Service	2,958,000	£1,183,200*
Air travel for business	35,794*	£5,000**
<b>Total</b>	<b>4,581,134</b>	<b>£1,547,727</b>

\*includes contribution to vehicle running costs as well as fuel

\*\*estimated from financial accounts information

<b>Combined Total</b>	<b>22,121,296</b>	<b>£7,623,111*</b>
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\*This figure represents a combination of costs associated with the purchase of diesel fuel, miles travelled by our vehicles and claimed by our staff in the baseline year. These costs are affected by, for example, the purchase of wholesale bunkered fuel which is cheaper than standard pump prices. Other factors include the fact that newer vehicles are more fuel efficient.

### **Building Energy**

We spent £675,413 on electricity, gas and heating oil in 2011/12. We expect to make improvements to our Estates energy management systems through the programme to build Make Ready Centres. We have also submitted a bid to the Department of Health's Energy Efficiency Fund to further support this work.

### **Waste & Water**

Disposing of waste cost SECamb £381,397 in our baseline year. Approximately £132,000 of this was clinical waste. Water charges amounted to £56,000. Both water consumption charges and waste disposal costs are increasing annually so managing our use of them is likely to be a cost effective strategy. We will develop a sustainable waste management policy which will focus on increasing our rate of recycling and reducing our general waste disposal costs by 25%.


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 understand the need to reassure staff that spending money on carbon reduction is in their best interest because it strengthens the resilience of the organisation which in turn safeguards staff jobs. The rationale is clear: if we reduce resource waste, we can save money (and effectively retain more of our budget) which in turn means that we are far more competitive in the marketplace in terms of cost and value as an efficiently-run service. This philosophy ensures that we meet our environmental responsibilities in full.



### **Valuing difference**

During the year 2012/13 we have continued our progress to embed equality, diversity and human rights into core SECamb business activity. We have fully embraced the Equality Delivery System (EDS) to help us demonstrate our commitment to the Public Sector Equality Duty as required by The Equality Act (2010). Our work has focused on engagement with the diverse communities affected by our activities to ensure that policies and services are appropriate and accessible to all and meet the different needs of the communities and people we serve.

In April 2012 the Trust adopted the Equality Delivery System (EDS) which is a framework developed by the NHS. The EDS 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.



It is about making positive differences to healthy living and working lives so that everyone counts. 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.

In tandem with this, the Trust embarked on a review of our governance process and took the opportunity to introduce a new structure aimed at ensuring the principles of equality and fairness are embedded into all we do going forward.

As a result, a new governance process was implemented in April 2011. Since then our Inclusion Working Group, steers and provides assurance for 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 this agenda and it reports to the Risk Management and Clinical Governance Committee. In addition, the Board receives direct reports, twice annually. The Inclusion Working Group is attended by senior managers from different parts of Trust, all with responsibility for assurance within their area of work.

The remit of the group is to ensure equality and diversity work is embedded across the Trust at a senior level and equality policies and principles are translated into action. Membership includes staff side, representatives from our Inclusion Hub Advisory Group and representation from staff equality groups. The group is supported by a full time Inclusion Manager who helps develop policy and provides assistance to service managers and staff equality networks, but the bulk of the equalities agenda is delivered by people who work in the service.

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. This group has overseen the implementation of the Equality Delivery System which was reviewed in February 2013.

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## **Equality Delivery System – 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" which will set up a simple structure to ensure appropriate engagement and involvement with patients, staff and other stakeholders.

### **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:**

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

### **Objective 3:**

The Trust will promote an inclusive culture that works to eradicate bullying and harassment and improves working lives and staff well-being. The Trust will demonstrate its commitment to equal opportunities by developing and publishing a new policy to support this.

### **Objective 4:**

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

## **Key achievements during the year 2012/13 have included;**

- + publishing equality information on our website in November 2012;
- + undertaking a comprehensive Equality Delivery System Review and refining our equality objectives for the coming year;
- + developing action plans to support progress on our equality objectives for the coming year;
- + obtaining Board approval for the new Inclusion Strategy in May 2012;
- + recruiting and launching the Inclusion Hub Advisory Group which is key to implementing the Inclusion Strategy for the Trust;
- + reviewing our Equality Analysis processes;
- + approving a process to develop a Transgender Policy for staff, currently at draft stage and out for consultation;
- + publishing 'Our commitment to Equality, Diversity and Inclusion';
- + developing a minimum set of equality information to strengthen our data collection, monitoring reports and workforce information;
- + continuing the 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;
- + significantly increasing our ranking to number 35 in the Stonewall Work Equality Index, entering the top 100 for the first time;
- + being awarded 'star performer network' as a result of our Stonewall Work Equality Index application;
- + continuing to demonstrate our commitment to eliminating disability discrimination by retaining the 'two tick' accreditation
- + continuing 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, taking work programmes forward with the support of the Ambulance Association Chief Executives group
- + consolidating and renewing robust partnership arrangements with organisations who continue to work with us to ensure some seldom heard communities are not adversely affected by any decisions that may affect them e.g. Gypsy and travellers, Learning Disability, Transgender organisations etc.;
- + establishing a 'Gypsy and Traveller Community Team' who have undertaken enhanced training. This group aims to promote awareness of health inequalities, eliminate discrimination and promote and foster good relations between staff and members of the community.

# Our *partners*



*This section sets out the work undertaken with key stakeholders, including the start-up of the new NHS 111 service, as well as how services are commissioned. It explains our relationship with a diverse range of volunteers who support us in delivering our service.*

## NHS 111

SECamb began to provide the Kent, Medway, Surrey and Sussex (KMSS) NHS 111 service for Kent, Surrey and Sussex on 13 March 2013 in partnership with Harmoni, now part of Care UK. The KMSS NHS 111 service is delivered from two centres based in Dorking, Surrey and Ashford, Kent and provides a service for an anticipated 1.3 million calls per annum.

The implementation of KMSS NHS 111 will need to be carefully monitored to ensure that it meets the required service levels.

The KMSS NHS 111 service provides a service to meet the non-urgent healthcare needs of the population within Kent, Surrey and Sussex and access to the GP Out of Hours call service. It is envisaged that this new service will enable patients to be referred to appropriate services to meet their clinical needs. The impact of the KMSS NHS 111 service will be reviewed with CCGs and provider colleagues during 2013/14.

## 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. SECamb has two HART teams strategically

based at Gatwick in West Sussex and Ashford in Kent. These are supported through a variety of legislative and Government directives.

Before the introduction of HART, ambulance personnel had limited capability to operate within any hazardous area and would not have been able to deliver timely care to patients without the assistance of other agencies, such as the Fire and Rescue Services, who would have had to move casualties to a safe area before any lifesaving treatment could begin. HART operatives receive additional training and can provide specialist clinical care whilst working at height, in confined areas, on water, whilst working within the inner cordon in a chemical or biological environment and during urban search and rescue operations.

HART is both a local and a national resource and should be ready to deploy any-where within the UK to both large scale and major incidents. The SECamb HART staff support the Trust in a number of ways by providing routine operational support and also at major and large scale incidents.

SECamb HART operates a number of specialist vehicles including all terrain, mass casualty and communications vehicles along with fast response vehicles which support operational demand as well as HART specific incidents.

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## Impact of the Planning Framework "Everyone Counts"

The Planning Framework "Everyone Counts" was published by NHS England in December 2012. This document replaces the NHS Operating Framework which was published by the Department of Health in previous years.

The framework sets out the key principles, outcomes and areas of focus for the whole of the NHS and provides the basis for discussions with our commissioners on the following year's contract (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 on the same goals and working towards the same outcomes.

The Planning Framework has a number of impacts on our Accident and Emergency Services. Financial penalties will be introduced from 1 April 2013 for handover delays at Accident and Emergency Departments. All handovers between an ambulance and A&E Department must take place within 15 minutes and crews should be ready to accept new calls within a further 15 minutes. A contractual fine will be levied for all delays over 30 minutes, in both situations, and a further fine for delays over an hour, in both situations. The fines will be levied against the Ambulance Trust or the Acute Trust depending on where the delay occurred.

The Planning Framework also set an efficiency target of 4 per cent for 2013/14. Offset against this was provision for an estimated cost inflation of 2.7%, giving a net reduction in our A&E income of 1.3%. There has been a year on year decrease in the payment received for each unit of activity carried out and this is expected to continue.

## Commissioning

Commissioners are responsible, in conjunction with the Trust, for establishing what level and type of activity needs to be planned to deliver the needs of the local population. During 2012/13 the commissioners were the West Kent PCT representing the eight PCTs that cover Surrey, Sussex, Kent and North Hampshire, where we as an Ambulance Trust provide Accident and Emergency services.

Commissioning responsibilities will transfer from 1 April 2013 to the new CCGs and the Trust will work with them to establish a new commissioning arrangement. 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 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 now and in the future.



It also includes discussion around how much the commissioners are willing to pay for our services and what support for future developments they are willing to give.

For 2012/13 the Trust was commissioned to provide £156m of activity from the Trust.

The A&E contract for 2013/14 was agreed at the end of March 2013. The contract assumes an overall activity growth of 5% in 2013/14. However, the activity planning model within the contract reflects a range of potential activities taking account of the uncertainty around the impact of NHS 111, the total amount of heart and treat activity that is likely and moves by the commissioners to reduce the number of patients transported to A&E departments. The 2013/14 contract also introduces a financial penalty against SECAmb for any breach of the "duty of candour" for failure to declare harm to a patient.

Following a competitive tender process, the Trust is also commissioned to provide Patient Transport services at county level (in Surrey and Sussex) and the NHS 111 service across the whole region, in partnership with Harmoni. The commissioning arrangements for NHS 111 are based on a lead commissioner for the 22 CCGs across Surrey, Sussex, Kent and N Hampshire. This is Swale CCG. There are also lead commissioner arrangements for PTS for Surrey and Sussex and they are the East Surrey and High Weald and Lewes Havens CCGs.

## Community First Responders (CFRs)

We currently have over 500 active Community First Responders spread across 90 schemes across our region. In 2012/13 they responded to in excess of 19,000 calls, attended around 600 cardiac arrests and over 11,000 life threatening calls. During the year we recruited over 200 new Community First Responders.

## Assist, Support, Knowledge (ASK) advisors

Senior colleagues from Voluntary Services and Learning and Development have reviewed, restructured, recruited and trained our internal volunteers, who will provide vital staff welfare and support to our staff and volunteers. ASK advisors will provide a multifunctional role including signposting to key welfare services and as a point of contact for simple to complex welfare needs.

The ASK advisors will work closely with our Chaplains to ensure knowledge and experience is shared and common local issues are highlighted, understood and addressed. We are developing a welfare and pastoral care network to enable our ASK advisors to meet, discuss and share experience and knowledge. The launch of ASK is scheduled for May 2013.

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## Chaplains

The pastoral care provided by our Chaplains has been reviewed and restructured to best match the needs of our staff and volunteers in our changing climate. We have appointed a Senior Chaplain to oversee the day to day “management” of our 30 Chaplains across the South East Coast area. Each operating area has appointed an “Area Lead Chaplain” who oversees local staff contacts, engagement and collates details of local issues.

A system to provide 24/7 Chaplain access has also been implemented, which is managed by our call centres, so an appropriate response from our Chaplains can be provided at significant or difficult incidents attended by our staff or volunteers.

## Public Access Defibrillators (PADs)

Nationally there are huge inroads being made to make placement of defibrillators a statutory requirement. Government, local councils and other bodies are very much aware of the benefits of defibrillator access.

SECamb are well placed to drive this work forward given the external relationships it has with these partners.

We are about to embark on the delivery stage of three main projects to install 4000 defibrillators within the SECamb operating area over the next 18 months.

Projects target high footfall areas such as town centres and leisure facilities as well as rural areas where incidents of cardiac arrest may be low but the local community can be empowered to take ownership of these rare

incidents and provide early intervention, supported by a SECamb professional response.

SECamb have been innovative in working with the private sector and partners from other statutory bodies, to continue to raise the awareness and benefits of PADs.

## Volunteer Drivers

SECamb is fortunate enough to enjoy support from a network of around 223 volunteer car drivers supporting the delivery of PTS. 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 either very early, very late or greater than usual distances to attend their appointments.

During 2012 with the 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. The result of this was a review of the mileage rate that volunteer drivers can claim and this has increased.

## Our Members

SECAmb has a total membership of 9,923 people as of 1 March 2013. We have 6850 public members and 3073 staff members. The public membership target for 2012-13 was 6050 people, which we have exceeded.

### Membership Eligibility

#### Public Constituency

Members of the public aged 16 and over are eligible to become public members of the Trust if they live in the area where SECAmb provides services. 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.

#### Staff Constituency

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

Public constituency	Number of members	Population	Index
<b>Age(years):</b>			
0 - 16	7	52,946	8
17 - 21	196	236,444	51
22+	3,369	3,980,595	52
<b>Ethnicity:</b>			
White	5,433	4,105,882	82
Mixed	48	42,820	69
Asian	164	70,958	144
Black	51	18,853	168
Other	4	30,714	8
<b>Socio-economic groupings:</b>			
ABC1	5,352	1,950,873	171
C2	927	462,210	125
D	107	458,456	14
E	304	466,069	40
<b>Gender analysis:</b>			
Male	2,738	2,066,602	82
Female	3,376	2,202,826	95

Red – Under-represented   Green – Over-represented   Amber – Within correct tolerance

Our efforts to improve membership representation from ethnic minority groups have been successful this year. It is also worth noting that we monitor our representation in terms of disability, sexual orientation, and transgender although this is not required by our regulator. We have improved our representation in each of these three areas during the year.

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

Staff membership	
Non-operational	465
Operational	2608
Total	3073

### Membership Strategy, Engagement and Recruitment

Our membership strategy focuses on meaningful, quality engagement with a representative group of our members and regular, informative educational and health-related communication with all of our members. All members are invited to the Trust's Annual Members Meeting, which is reviewed below in more detail.

The membership strategy is incorporated into the Trust's Inclusion Strategy (see "Our Performance" section), which aims to ensure staff, patients and the public (members and non-members) are involved and engaged appropriately in the Trust.

Governors and members were involved in the developing the Inclusion Strategy, which was approved by the Board in May 2012. The Membership Development Committee of the Council has been part of the steering group for developing the strategy (working alongside staff and public members and other stakeholders) and has oversight of the engagement taking place under the strategy and reports this to the Council. Membership engagement under the Inclusion Strategy is also reported to the Board via the Risk Management and Clinical Governance Committee. Governors are part of and can access the Inclusion Hub Advisory Group, made up of public

Constituency	No.	Percentage of eligible population
Brighton & Hove	364	0.15
East Sussex	1011	0.21
Kent	1985	0.16
Medway	506	0.21
Surrey	1714	0.15
West Sussex	1270	0.17
<b>Total</b>	<b>6850</b>	<b>0.17</b>

members and the Foundation Council, made up of staff members when they wish to discuss issues or hear views.

The Membership Development Committee has discussed and reviewed our strategies for membership recruitment and engagement during the year. Recruitment this year focused on ensuring our volunteers were able to become members, and on improving representation in our Surrey and Kent constituencies, which were under-represented as a proportion of eligible members compared to the other four constituencies. Our public membership now represents 0.17% of the population, and between constituencies' ranges from 0.15% up to 0.21%.

The year has also seen a focus on ensuring we engage with our staff FT members as effectively as our public members. Working with the Staff-Elected Governors, the Trust has revitalised its staff forum, the Foundation Council, which is now managed within the membership and governor engagement team. The Foundation Council consists of a group of staff from across the Trust, and provides our Staff-Elected Governors with a forum in which to share

information about the work of the Council and hear the views of their constituents. This two-way conversation goes some way to enable the Staff-Elected Governors to represent the interests of staff on the Council, and also provides a forum for the Trust to communicate and engage with staff on plans, priorities and issues and for staff members to raise issues with the Trust.

During this year, the Foundation Council has, on behalf of the wider staff membership, advised the Trust on NHS 111 service delivery, proposals to reconfigure our Emergency Operations Centres and Headquarters, development of the IBIS system and the redevelopment of the Trust's values, among other things.

In addition, both public and staff members were involved in commenting on our draft annual plan, and their feedback was reported to the Council of Governors prior to governors' work on the annual plan with members of the Board.

The activities and engagement undertaken with our advisory group of public members are outlined in the Inclusion section.

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## Annual Members Meeting

The Trust held its Annual Members Meeting (AMM) on 28 September 2012 and members of the public and all staff members were invited. We were pleased to welcome around 80 public members and a similar number of staff members, and were able to recruit new members from the stakeholder organisations we also invited. The AMM incorporated a showcase of SECAmb's services and service developments, with stalls at which public members could talk to staff about the way we work and our future plans. The governors had their own stall where they could talk to members, which was well attended. In addition, we invited several community organisations to attend to promote their work and raise awareness among staff and public members, for example about transgender issues and learning disability awareness. The AMM was held on the same day as our public Board and Council meetings and good numbers of staff and public members attended the formal meetings as well as the AMM.

Governors and other SECAmb staff have also participated in a number of recruitment and engagement events in different constituencies throughout the year. Among these were the Egham Royal Show, the Eastbourne 999 Show and the Sheerness Water Safety Day. At events, governors often work alongside our volunteers and frontline staff to promote the Trust and recruit members.

We also attended and recruited at the Surrey Big Health Event for the second year running, which is run for and by people with learning disabilities. We also recruited and taught CPR at the National Ijtema which is held in Surrey and was attended by over 2500 Muslim boys and young men.

Members have been invited to all public Council meetings during the year, through our membership newsletter and meeting 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, spotlight articles on different staff within the ambulance service to help raise awareness of what we do and career opportunities within the Trust. We regularly feature our volunteers and encourage members to get involved in this way. Our Staff-Elected Governors have also sent two newsletters to all staff members about their work and reports from the Foundation Council are regularly included in the Trust's staff bulletin.

## Inclusion

During the last year the Trust has continued to make significant progress on its Inclusion programme. A new Inclusion Strategy has been approved by the Board, following an extensive consultation process. The new strategy draws together the strands of membership and governor engagement, patient and public involvement and equality and diversity into a single strategy based on working effectively with all our stakeholders. We use the term 'inclusion' here to mean "involving and engaging with our stakeholders to help improve access to our services and eliminate discrimination, to better meet the needs of patients and fulfil statutory obligations."

The new strategy will embed accountability for effective and timely involvement and engagement in the Trust's planning, service development and patient experience work. It provides inclusive processes to enable our stakeholders to participate in ways that are right for them, enabling us to act on what we hear and feedback on what has changed as a result. If we are unable to act on what we hear we will tell people why.

Our vision is an inclusive, effective approach to engaging and involving people with an interest in SECamb. We are committed

to eliminate discrimination and reduce inequalities in care. Implementation of the strategy will live up to the NHS value "Nothing about me without me" and live up to our own value of putting the patient at the heart of everything we do. We believe it will fulfil the right to be involved set out in the NHS Constitution and SECamb services will reflect the needs and preferences of patients, their families and carers.

A key aim of 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. This makes it easy for the Trust to benefit from stakeholder engagement, and simplifies the way stakeholders get involved.

As described in the strategy we have established a single, inclusive Inclusion Hub Advisory Group made up of a representative group of stakeholders. The group, launched in September 2012 includes 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).

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The Advisory Group provides advice to 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. Members also work with the Trust, as our 'community of interest' on the Equality Delivery System, participating in equality analysis and monitoring the success of the implementation of our Inclusion Strategy.

Members of the Advisory Group were drawn from a broader 'Inclusion Hub' which comprises staff and public FT members. FT membership is the primary vehicle through which the Trust communicates with and involves and engages stakeholders. However, we recognise that there are groups and communities who will always struggle to be heard. We have put in place partnership arrangements with a number of organisations to eliminate these gaps. They have agreed to work with us to ensure our work reflects the needs of those they represent.

We have partnership arrangements in place with the following organisations:

- + Friends, Families and Travellers – representing the interests of gypsies and travellers
- + The Aldingbourne Trust – representing the interests of people with learning disability
- + 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 transgender people

Working with a diverse membership in the Advisory Hub, provides us with insight at the start of our planning, and throughout development where relevant, which helps us get more things right, first time, more of the time. The Advisory Hub is also able to raise issues with us via its representation on the Trust's Inclusion Working Group of senior managers, so that advice from the Advisory Hub can be incorporated into the Trust's activities effectively.

This new approach enables the Trust to involve and engage in the most appropriate way. For example, simple engagement can take place virtually by email or survey, a single or a series of focus groups and bespoke workshops. Large-scale engagement events are organised as appropriate.



**Key achievements of the Inclusion Hub Advisory Group since its launch in September during the year 2012/13 have included;**

- + developed, approved and published terms of reference;
- + developed the process for and participated in the Equality Delivery System Review 2013
- + presented plans to support progress on equality objectives to the Inclusion Working Group;
- + participated in a planning group to devise a process to develop a Transgender Policy for staff;
- + participated in the Quality Account workshop;
- + provided recommendations regarding the NHS 111 service and agreed a process to undertake a 'mystery shopping' exercise;
- + worked with the Trust to produce a recommended script for recorded messages within the Emergency Operations Centres;
- + attended visits to Emergency Operations Centres to develop knowledge and awareness of SECamb systems and processes;
- + provided feedback and recommendations on the Public Access Defibrillator programme;
- + responded to requests for patient and public representatives to sit on the Trust Research and Development Group and the History Marking Group – representatives identified and their impact monitored;
- + taking part in new vehicle inspections and provided feedback and recommendations on design and experience;
- + participated in a presentation relating to clinical audit and submitted ideas for audit for next year;
- + representatives attended a clinical audit review meeting to assist with prioritising areas for audit for next year;
- + participated in the survey to develop the Trust Annual Plan;

# Our *priorities*

A photograph of two police officers in a vehicle, one driving and one writing in a notebook, with a green tint. The driver is a man in profile, wearing a watch and a uniform with '115' on the sleeve. The passenger is a woman, also in uniform, with 'South Ayrshire' visible on her sleeve. The background shows a building with domes through the window. A white cross symbol is positioned above the text box.

*This section sets out some of the areas that we have identified as key priorities, both within 2012/13 and continuing into the future. Some of these issues pose significant challenges for the Trust and we are developing robust plans to try to address them.*

## Working on what is important

### Tackling sickness

Sickness absence for the period 1 April 2012 to 31 March 2013 was 5.01%. The quarterly breakdown for the period is:

Quarter	
Quarter 1	5.00%
Quarter 2	5.03%
Quarter 3	5.34%
Quarter 4	4.67%
<b>Total Days Lost</b>	<b>52690 WTE days lost</b>
Average working days lost during this period	18.28

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.

Sickness has significantly reduced in the last year due to a focussed approach by managers and the Human Resources team. The Trust continues to recognise the importance of sickness management as a key priority. The sickness reduction action plan is revised annually and the focus continues to be on early intervention and to provide support for staff who are sick. To support this we have a funded Fast Track scheme for the provision of Physiotherapy and Osteopathy treatment, which is available to all staff. This scheme is well utilised by our staff and the aim is to provide prompt support to staff enabling faster recovery.

Recent work with NHS Employers has facilitated a review and revision of the sickness reduction action plan for the forthcoming year which encompasses actions under the 5 High Impact Changes (5 HICs). The 5 HICs were developed by the Department of Health following Dr Boorman's review of the health and wellbeing of NHS staff. The 5 HICs are:

- + Development of local evidence-based improvement plans
- + Strong, visible leadership
- + Improved management capability
- + Access to local, high quality accredited Occupational Health services
- + Encouragement and enablement of staff to take personal responsibility

In 2012 the Trust tendered for Occupational Health services with the contract being awarded to a new provider. The focus for the Trust in the forthcoming year is very much on a pro-active approach to Health and Wellbeing which will include a strong emphasis on taking personal responsibility and re-branding of our Health and Wellbeing initiatives. A Health and Wellbeing spring focus is being launched which will join up a number of Health and Wellbeing developments in the Trust.

Absence management workshops have continued throughout the year so that managers are provided with the tools and support to manage absence within their teams.

## Undertaking staff appraisals

Appraisal completion for the period 1 April 2012 to 31 March 2013 was 67.40%. Staff on zero hours, maternity and career breaks and those who started working for the Trust since April 2012 have not been included in these figures.

Description	Number of Appraisals for 2102/3	Headcount	% Appraisals completed YTD
Ambulance Staff	1323	1818	72.77%
EOC	209	308	67.86%
PTS; ACA & Team Leaders	122	262	46.56%
Support Staff	221	394	56.09%
<b>Total</b>	<b>1875</b>	<b>2782</b>	<b>67.40%</b>

The Trust has continued to focus on the area of appraisals and the number of completed appraisals has increased significantly in the last year from 38% in 2011/12 to 67% 2012/13. Workshops and surgeries on appraisal completion for managers have been provided throughout the year. As part of our Health and Wellbeing strategy we will be revising the appraisal form so that discussions on personal health responsibility are included between the member of staff and their manager.

The Workforce Development Committee monitor and review appraisal completion.

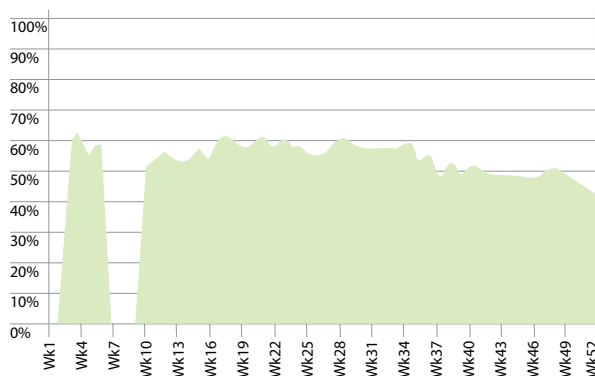
### Hospital Handover

A new policy was developed, agreed and implemented during 2012/13 setting out the expectations and responsibilities when the care for patients is transferred from ambulance crews to hospital staff.

The Hospital Handover policy is based on recognised good practice and contains clearly stated escalation points. Additionally changes have been made to the technology to allow both parties – ambulance crews and hospital staff – to confirm the time at which the patients care was transferred. This ‘double button push’ has helped to improve the quality of the data capture facilitating more meaningful discussions between all parties about what can be done to help improve the patient experience. Weekly league tables are distributed throughout the NHS community across the region and monthly meetings are held to discuss the implications.

A change in practice was made towards the end of the year, prompted by delays across the region, whereby ambulance patients waiting to be handed over to hospital staff are being managed by one ambulance crew instead of individual crews. This allows crews to be freed from waiting and able to respond to further emergency calls.

## Hospital Handover within 15 minutes 2012/13



In 2013/14 fines are being introduced across England relating to all patients that are not handed over within 60 minutes (applied to the Acute Trust) and all patients where crews are not available after handover within 15 minutes (applied to the Ambulance Trust).

### Improving our fleet

The Trust continues to improve fleet condition and effectiveness through standardisation on as few vehicle platforms as is operationally viable, whilst recognising the need to support the developing clinical specialisms in our work force.

This approach accounts for the needs of patients and staff set against the backdrop of the changing model of care, improved experience, safer environment and enhanced infection control. Standardisation of the fleet also brings other added benefits such as system wide interoperability and better quality back office support.

During the year, the Trust has delivered some significant projects in relation to the fleet replacement programme, including:

- + The procurement of 29 'modular' emergency ambulances, and the development of a critical care paramedic (CCP) vehicle as a pilot;
- + A new 'van conversion' emergency ambulance, likely to deliver significant savings year on year both in capital terms and whole life running costs;
- + The design, build and evaluation of a purpose built paramedic practitioner vehicle – which has been very well received by the staff;
- + Large scale production and delivery of 85 multifunctional PTS vehicles to support the Surrey and Sussex contracts;
- + Design and build of two specialist major incident vehicles.

All schemes have been innovative in their own right, seeing the use of smart/ antibacterial components and in-vehicle technologies such as speed limiters and new construction methods. It is anticipated that this will result in improvements in infection control and a reduced carbon foot print.

In the near future the composition of the fleet is likely to change dramatically, providing for a more specialist and varied service delivery model, 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 impact our fleet has on the environment and the communities we serve whilst ensuring better patient experience and value for money.

**CQUIN**

CQUIN (Commissioning for Quality and Innovation) 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 commissioners 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 2012/13 CQUIN Plan listed four goals (top level detail can be found below):

**Privates – reducing the need**

To reduce the hours bought in from external providers the Trust requires a larger more flexible workforce that can better match patient demand for our services. To achieve this there will be a rigorous recruitment programme alongside adjustments to rotas and contracts so as to match seasonal demand fluctuations with SECAmb staff and vehicles. This will be led by the Operations and Workforce directorates in collaboration with staff side representatives.

Patient Experience	Improve responsiveness to personal needs of patients.
Reduction in emergency and unplanned admissions with long term conditions	Involved the implementation of the case management system (IBIS), actions to support the use of alternative pathways and actions to improve the use of the NHS Pathways triage system and Directory of Services.
Increase skill mix in Workforce	To increase the level of clinical skill in the service. a) Clinicians in Emergency Operations Centre (EOC) b) Increase clinical skill in attending patients to maximise clinical care and use of agreed pathways.
High Impact Innovation	This indicator was to identify, plan and implement a programme to develop the relevant high impact innovations ready for the CQUIN gateway in 2013/14. “Digital by default” which was the most relevant section of this Department of Health document for ambulance services, with the goal being to support the electronic transfer of data to GPs and community based providers to minimise manual data entry and re-triage.

## Maintaining our clinical governance arrangements

### **How the Board considers Clinical Quality and Clinical Governance**

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 Directors, who Chair the Board Committees, are regularly reviewed to ensure their skill set matches the requirements for the committees they are chairing. Executive Directors chair the Working Groups (which report to the Board Committees) to deliver and monitor the work of the Trust to ensure that ownership for clinical quality is achieved. Their skill set is also considered in relation to leading on Trust Service Developments and programmes.

The Board has clearly identified named Executive Leads such as a Caldicott Guardian, SIRO, Accountable Officer (medicines), Patient Champion, DIPC (infection control) and safeguarding as examples.

The Board 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 Risk Management and Clinical Governance Committee (Chaired by a Non-Executive Director) and the Trust Board receives an overview of the position relating to the risks on the Corporate Risk Register at every Board meeting (every two months). Strategic risks are presented to the Board via the Board Assurance Framework. External risks are identified through horizon-scanning, via all Directorates, and reported on the Corporate Risk Register, in addition to internal risks.

The Trust actively seeks external support and engagement on quality initiatives, such as engaging with Commissioners, the Local Improvement Networks (LINKs), NHS South, local Clinical Networks and Groups and with University and Deanery Groups to discuss quality issues around new clinical initiatives.

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The Trust ensures its arrangements to monitor and continuously improve the quality of healthcare provided to patients are undertaken in accordance with the Trust's defined corporate governance arrangements.

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.

The Trust has effective and established processes to define and measure quality throughout the organisation including:

- a) The annual Quality Account which sets out key quality priorities, developed in partnership with our stakeholders, which are linked to the Trust's strategic objectives and service developments
- b) An annual approved Clinical Audit Programme that is reported to the Risk Management and Clinical Governance Committee
- c) An annual CQUIN (Commissioning for Quality and Innovation) programme focused on additional clinical quality targets
- d) The annual Performance Management Matrix which ensures that the objectives from the Trust's Quality Account are monitored and delivered. Following a review of performance management particularly in relation to organisational governance reporting requirements, the Trust is intending to introduce a software solution to speed up reporting and reduce duplication of effort. When implemented it will replace the Performance Management Matrix and will make on-going performance management and reporting within each directorate management more transparent, timely and robust. This process supports embedding the principles of the Quality Governance Framework across the Trust for the period of the plan.
- e) The Corporate Dashboard which includes information on the Trust's performance on national clinical quality standards
- f) The national Clinical Quality Indicators and Clinical Performance Indicators which are used for benchmarking information with other Ambulance Trusts
- g) Patient and public feedback provided via complaints, compliments and PALS enquiries which are reported to both Board Committees and the Trust's Lead Commissioners.



- h) Incident Reports and Serious Incidents Requiring Investigation (SIRIs) which are reported through the Board committee structure
- i) The Corporate Risk Register and Board Assurance Framework – both of which are overseen by the Board and its sub committees
- j) Quality goals which are highlighted to stakeholders through the intranet, internet, staff bulletin and through the local media.
- k) The on-going maintenance of the Trusts Quality Governance Framework by the Executive Team. During 2013/14 this Framework will also be overseen by the Risk Management Clinical Governance Committee.
- l) Team Briefing Folders and Clinical/ Medical Instructions which are provided to clinical staff with regular updates on quality issues.
- m) 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.
- n) The Strategic Quality Commissioning Board which has a quality agenda and considers the Trust's quality goals
- o) A Whistle Blowing policy with details of how to contact are shared with all staff via the weekly bulletin
- p) Engagement in and compliance with External Quality Assessments such as the NHS Litigation Authority (NHSLA) Risk Management Standards for Ambulance Trusts, Information Governance Toolkit and any other assessments.
- q) Quarterly reports to Monitor, including self-certification by the Trust Board relating to Financial Performance, Governance and Quality Governance arrangements
- r) Robust and effective data validation processes which ensure that the quality and integrity of our information is maintained at all levels
- s) Medicines management is a key quality priority for the Trust. The Medical Director is the Executive Lead with responsibility for medicines management and the Director of Commercial Services is the nominated Trusts Controlled Drugs Accountable Officer with responsibility for CD's (as defined by the Health Act) and a Lead Consultant Pharmacist employed on a sessional basis.
- t) The Trust uses its 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.

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### **How staff are involved with Clinical Quality and Clinical Governance**

The Board continues to encourage staff empowerment on quality. The Trust has appointed staff champions to lead on key clinical initiatives. In addition Trust work streams have also facilitated the development of local champions at station level to support work streams such as infection control and medicines management. Plans to develop clinical audit/performance champions are currently in development.

Staff representatives are also assigned to key sub and working groups across the Trust to ensure robust engagement and communication.

SECAMB is committed to meeting the Learning and Development needs of all staff, supported particularly by key skills training (clinical and non-clinical) to underpin the quality in people approach. External courses at 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 all staff. In addition, 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.

During 2012/13, the Trust successfully introduced a new Staff Magazine which includes 'reflections' articles, 'test your knowledge' sections and 'how to' guides for staff. Reflections articles are specifically aimed at improving quality of care 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 actively 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.

### **How our Stakeholders are involved with Clinical Quality and Clinical Governance**

Developed in partnership with our stakeholders the Trust's Quality Report and Quality Account are key enablers to drive the delivery of the identified core quality activities and report on both good performance and quality including areas that require improvement.

The national Clinical Performance Indicator and Clinical Outcome Indicator audit data is benchmarked across the sector and reported nationally.

The Trust Commissions patient and public satisfaction research with results being made available in the Annual Report and on the Trust website. The Board and Executive Team review 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 the Trusts Council 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 information gathered through our PALS processes, serves as an early warning system for SECamb. PALS activity and granulated reports are scrutinised by the Compliance Working Group reporting to the Risk Management and Clinical Governance Committee.

The Trust has in place a revised Corporate Dashboard, which is reviewed by the Board at each Board meeting. 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 Corporate Dashboard is backed up by a pyramid of more granular reports reviewed by Committees, Directorate Heads and Senior Lead Managers in accordance


with the Trusts corporate governance arrangements. 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.

Work is underway to conclude the development of the Trusts new Clinical Strategy for 2013/14 to 2017/18 led by the Medical Director and Director of Clinical Operations. The new revised strategy will build upon the clinical and quality elements of the Trust's Annual Plans and take account of the Quality Report and Quality Account priorities and the Trusts annual planned service developments.

The Trust continues to ensure compliance with nationally defined frameworks for Clinical Pathways and maintains appropriate continued engagement in system wide programmes and developments. Work continues (at different stages) on the development, implementation and monitoring of clinical pathways for pPCI, trauma, stroke and cardiac care, and end of life care. Additional local clinical pathways considered for development include mental health, dementia, sepsis, cancer and respiratory disease although these may be dependent upon the outcomes of the introduction of the NHS Commissioning Board which will see the adoption of Strategic Managed Networks and associated priorities.

# *Our plans*



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

## Changing how we respond to patients

### **FLSM**

The Front Loaded Service Model (FLSM) project was conceived in response to a national directive to explore how ambulance services can deliver more effective and efficient care. The objectives identified in our FLSM project have been evaluated as part of the project management arrangements, and while the overarching intentions have been retained, other additional priorities have been identified leading to a change in how we will strategically realise our aspiration to continue to be a world class service.

Following the Francis Report, it has become clear that we must address the potential for harm coming to our patients. We operate in a challenging environment with demand growing year on year, and we must strive to ensure that we balance quality of care with the quantity of care. We must continue to work to reduce conveyance to A&E in a safe and sustainable way, and we must ensure that we have a workforce that is fit for purpose and intelligently deployed to match the right skills to the right patient.

What has emerged from the original FLSM project is a root and branch review of both the A&E Service Delivery Strategy and the Clinical Strategy. The A&E strategy informs the operational requirements needed to deliver our workforce to the patient's side in the correct proportions, and the Clinical Strategy informs the quality and standards of care, the workforce development requirements and structures, and the future planning needed to maintain those standards.

The term "Front Loaded Service Model" fails to describe adequately our aspirations for the future. While the project is still live/on-going, it has been devolved into individual Directorate portfolios and taking on much more of an iterative service development feel as opposed to a step-wise change in direction.

Over the next few years, we will see changes to our fleet, which will become more focused on the model of care and skills of its user. For example, SECAMB has developed a prototype Paramedic Practitioner vehicle designed specifically to meet the needs of the role.

SECAMB will continue to develop specialist paramedics, and we already have over 200 paramedic practitioners and 50 critical care paramedics. We have recently started a practitioner level programme for our Clinical Supervisors in the Emergency Operations Centre. The challenge of supporting the specialist paramedics with paramedics with higher level skills will be considered in the coming year. With the development of national programmes such as paramedic prescribing, SECAMB must position its workforce in readiness for such opportunities.

Another development which we hope to continue into 2013/14 financial year is the Paramedic Practitioner desk in EOC. This desk is staffed by two PPs 24/7 across our three EOCs, and provides support and supervision for staff who need advice on the best onward care for their patient.

The PP desk takes around 1000 calls per month and arranges around 650 PP referrals. A PP referral is where a PP is dispatched to the patient in order to provide further assessment and treatment. For instance, patients who need wound assessment and closure can be referred to a PP rather than transport them to A&E for treatment.

### **Developing an intermediate tier**

The Trust is planning to improve performance and reduce cost where patients with less acute clinical needs require conveyance, by introducing an Intermediate Tier of staffing who will specialise in transporting these patients. This will ensure patients receive the appropriate treatment through dedicated resources; as well as releasing clinicians, e.g. Critical Care Paramedics, to focus on the most clinically urgent cases. The introduction of an intermediate tier will also make more effective use of the high acuity transport of existing ambulances.



## **Investing in technology**

### **ePCR**

To support our service developments, the Trust is participating in the Southern Region group procurement project led by Connecting for Health, supported by the Department of Health and in conjunction with South Western and South Central Ambulance Services to procure Electronic Patient Care Record technology for front line staff and patients.

The Trust is developing plans to ensure an effective implementation once the procurement determines the preferred solution. This large scale undertaking will benefit greatly from the involvement of our wider health community partners to allow for consistency and continuity of patient care records.

## Improving our estate and vehicles

### **Make Ready Centres**

The roll out of the Make Ready Programme supports the implementation of the high-performance service model within the Trust and delivers improvements in infection control, thereby minimising risk to patients. The Make Ready Centre model ensures that vehicles are cleaned and re-stocked by specially-trained, non-clinical staff, allowing ambulance clinicians to focus on the delivery of high quality patient care.

There is a Board approved phased annual Make Ready Centre implementation plan which will be implemented over the coming three year period. The implementation will take into account the learning from the May 2012 review of the two new Make Ready Centres at Ashford and Paddock Wood that were commissioned in Quarter 3 2011.

The implementation plan recognises that these projects contain inherent risks which are outside our full control; primarily around availability of suitable sites and obtaining planning permission. As a result the Trust will review its capital planning on a very regular basis.

### **New Headquarters and Emergency Operations Centres (EOCs)**

#### **Reconfiguration**

In 2010/11 the Trust completed a Strategic Outline Case for the re-location of the Trust's Headquarters and two regional offices to replace the three existing locations at Banstead, Coxheath and Lewes.

This reconfiguration does not represent a change in service provision as the EOC function is to be re-provided at new locations without significant variation to the current delivery model. The Trust seeks to re-provide, albeit in alternate locations, the same core functions that are delivered from the current EOCs at Banstead, Coxheath and Lewes.

During 2013/14 the Trust will continue its evaluation of the costs and benefits of a re-located Headquarters and Emergency Operations Centres reconfiguration.

# Our *processes*

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*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.*

EMILY



## 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 2012 to 22 March 2013 we received 245 Freedom of Information requests compared to 261 for 2011/2012. This equates to a 6.13% decrease year on year and so far we have responded to 230 (93.88%) within the 20 working day time frame (some of the requests received in March are still in the process of being responded to).

### **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.

### **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 2012.

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.

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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.

### **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.



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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 SECamb news 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 was one data loss which exceeded the level 1 criteria as defined in Gateway letter 13177 during the year.

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### **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 2012. 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.

## 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 2012 and 22 March 2013 the Trust reported 30 Serious Incidents Requiring Investigation. The breakdown of these is as follows:

Ambulance (General)	19
Ambulance Accidental Injury	1
Ambulance Delay	2
Confidential Information Leak	2
Drug Incident General	4
Ambulance Accident – Road Traffic Collision	2
<b>TOTAL</b>	<b>30</b>

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.

The reporting groups will be changed from April 2013 to reflect the reorganisation of the NHS.



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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.

# Annual Governance Statement 2012/13

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## 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 2013 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 harm to its patients, staff, public and other stakeholders, losses and damage to its reputation. 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 ensures that the capacity to deliver key functions and roles in relation to risk assessment and management, health and safety, information governance, financial management and other areas is 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 in the Training Needs Analysis and delivery plan. Lessons learned and guidance on best practice are cascaded to staff through the weekly staff bulletin and the SECamb News magazine.

The Risk Management and Clinical Governance Committee (RMCGC) oversees the management of all areas of risk in the organisation and reports to the Board through the governance structure. The RMCGC is chaired by a Non-Executive Director and is attended regularly by Directors and senior managers. Its membership also includes the Chair of the Audit Committee. 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 Association of 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 have 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 Compliance 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.

During the course of 2012/13 the Trust's LCFS identified through a reactive investigation that a private ambulance provider made an attempt to de-fraud the organisation by submitting false and duplicate invoices. The Trust's systems were sufficiently robust to allow for the interception of these invoices and as such the Trust was not a victim of financial loss in this period.

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However management requested a retrospective investigation to be undertaken by the LCFS which determined that it was likely the Trust had been subjected to a similar fraud with a likely loss of up to £800,000 between July 2008 and January 2009. The size of the fraud cannot be accurately determined as records from the time are inadequate and the prospect of recovery is negligible. Internal Audit tested the current systems for the procuring of private ambulance providers and the processing of payments and determined that the Trust's internal control mechanisms had been strengthened to mitigate against potential future fraud risk and further loss.


### The risk and control framework

The Constitution, Standing Orders, Standing Financial Instructions, Scheme of Delegation 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 with the RMCGC and is reviewed annually. The Risk Management Strategy was most recently reviewed by the Board in July 2012. 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 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 strategy also describes the roles of the committees in managing risks.

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 compliance with the Quality Governance Framework has been reviewed internally and will be monitored by the RMCGC and reported to the Board.

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 RMCGC's Annual Agenda Framework. This ensures the Trust integrates 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 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.

Through the RMC GC the Trust seeks to learn from issues raised and implement good practice at all levels. The Board receives regular reports from the RMC GC, 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 Trust was assessed as compliant with the NHSLA requirements at Level 1 in November 2012.

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 receives 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, has 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 or reduced to a satisfactory level.

The organisation's main risks for 2012/13 were identified as follows:

Risk	Current/ Future	Commentary
Delayed Turnaround – local NHS system preparedness	Current	On-going monitoring of metrics for total time spent at hospital Board to Board meetings with Acute Trusts Whole system monitoring
Potential for adverse patient outcome due to frequency of mapping information on the CAD and inability to add new, individual addresses/locations to the CAD	Current	This risk has been addressed through a successful CAD mapping update in February 2013. Arrangements are being put in place for CAD maps to be regularly updated
Failure to deliver the NHS 111 serviced due to being unable to recruit enough staff	Current	Recruitment is on plan and there has been some over-recruitment to allow for attrition
Business continuity incident	Future	SECAmb resilience group in place with representation from each Directorate. The group reports regularly to the RMCGC and through the RMCGC to the Board
Adverse staff and/or patient outcome due to non-adherence to the Trust's medicine management arrangements	Current	A Medicines Management action plan has been implemented and regular updates are discussed by the RMCGC. New drugs bags have been implemented across the Trust
Non-compliance with Level 2 of the IG Toolkit Assessment	Current	IG training remains below 95%. This is being addressed through a robust action plan.
Failure to deliver the required financial return and quality performance on the PTS contracts	Current	Weekly management meetings are taking place to monitor the effectiveness of actions taken to address these issues. Regular progress reports are subject to scrutiny by both Finance and Business Development Committee and the Board.

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. The Trust has developed an Inclusion Hub Advisory Group (IHAG) drawn from a diverse range of stakeholders within the foundation trust membership and asks for their views about, and involvement in, key service developments and plans. This year, for example, a workshop was held, with wide representation including members of the IHAG, to define the priorities for the coming year's Quality Account. 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 Trust is fully compliant with the registration requirements of the CQC. The Trust had an unannounced visit from the CQC in February 2013. The CQC inspected seven outcomes and found the Trust to be fully compliant with five of them. Further action is required by the CQC to ensure full compliance with Outcome 9 – Management of Medicines and Outcome 14 – Supporting Workers.

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However, the judgement of the inspectors was that the concerns raised in relation to both these outcomes would only have a minor impact on service users. The Trust has submitted action plans to the CQC to address the recommendations made with regard to medicines management and supporting workers.

The Trust's Quality and Risk Profile is routinely monitored by the RMCGC and action taken where necessary.

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 the 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 Corporate Dashboard, which is reviewed at each Board meeting, 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 agreed parameters.

The Trust has a track record of 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 and the contract runs from 1 July to 30 June. All work undertaken within the period from 1 April 2012 to 31 March 2013 has been taken into consideration when forming the Head of Internal Audit Opinion. A three-year strategy covering 2010 to 2013 has been developed and agreed through the Audit Committee and Trust Board.



Detailed internal audit plans are drawn up annually and approved by the Audit Committee taking into account the Trust's objectives, risk profile and after consideration of the Corporate Risk Register and Board Assurance Framework.

As part of the internal audit programme for 2012/2013, 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. A copy of the full Quality Report can be found at Appendix A.

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 detail for each priority within the Quality Account and Quality Report.

The Quality Account and Quality Report has been developed from a range of priorities that were identified as a result of the quality account and quality report stakeholders workshop.

The decision to look at the chosen five

priority areas set out in the Quality Account and Quality Report followed guidance and suggestions from those who attended the stakeholder workshop in February 2013 on quality measures they would like to see included in this year's Quality Account and Quality Report. The workshop included invitations to Governors, IHAG Representatives, LINKs, HOSCs, Foundation Trust Members and Commissioners.

### Monitoring Arrangements

At each meeting of the RMCGC a report on the Quality Account is presented with updates on progress against each of the five quality priorities. Regular progress updates are submitted to Trust Board meetings via the RMCGC summary report.

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

Section 6 of the Quality Account and Quality Report "Review of Quality Performance" lists three indicators under each of 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 have provided 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 (NASCOG). 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 RMCGC every two months via a Complaints and PALS Report. This report is also shared at each 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 Complaints and PALS Report which is provided every two months to the 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.

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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 by the Complaints Manager. 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, clinical audit, and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Finance and Business Development Committee and the Risk Management and Clinical Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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:

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*“Based on the work undertaken in 2012/13, significant assurance can be given that there is a sound system of internal control, designed to meet the organisation’s objectives, and that controls are generally being applied consistently.”*

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

- + Finance and performance reports to each meeting of the Trust Board
- + Corporate dashboard reports to each meeting of the Trust 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 and Governance and an annual self-certification in relation to quality. ;
- + Internal and External audit reports, including the 2012/13 Head of Internal Audit Opinion;
- + 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 were required.
- + On-going compliance with Monitor's Code of Governance for Foundation Trusts.

### **Conclusion**

I am satisfied that we have had a sound system of internal control in operation throughout the financial year and that no significant internal control issues have been identified during the year.



**Paul Sutton**, Chief Executive

Date: 29 May 2013

# Appendix A

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## Quality Account and Quality Report 2012/13

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



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## ii) List of abbreviations/glossary

<b>A&amp;E</b>	Accident and Emergency	<b>PAD</b>	Public Access Defibrillator
<b>CAD</b>	Computer Aided Dispatch System	<b>PALS</b>	Patient Advice and Liaison Service
<b>CCP</b>	Critical Care Paramedic	<b>PCM</b>	Patient Case Manager
<b>CFR</b>	Community First Responder	<b>PCR</b>	Patient Clinical Record
<b>CQC</b>	Care Quality Commission	<b>PCT</b>	Primary Care Trust
<b>CQI</b>	Clinical Quality Indicator	<b>PP</b>	Paramedic Practitioner
<b>CQUIN</b>	Commissioning for Quality and Innovation	<b>pPCI</b>	Primary Percutaneous Coronary Intervention
<b>EOC</b>	Emergency Operations Centre	<b>PSI</b>	Patient Safety Incident
<b>FLSM</b>	Front Loaded Service Model	<b>PTS</b>	Patient Transport Service
<b>HOSC</b>	Health Overview and Scrutiny Committee	<b>R&amp;D</b>	Research and Development
<b>IBIS</b>	Intelligence Based Information System	<b>RMCGC</b>	Risk Management and Clinical Governance Committee
<b>ICAS</b>	Independent Complaints Advocacy Service	<b>SEC</b>	South East Coast
<b>ICL</b>	Infection Control Lead	<b>SECAmb</b>	South East Coast Ambulance Service NHS Foundation Trust
<b>IHAG</b>	Inclusion Hub Advisory Group	<b>SHA</b>	Strategic Health Authority
<b>KPI</b>	Key Performance Indicator	<b>SIRI</b>	Serious Incident Requiring Investigation
<b>LTC</b>	Long Term Condition	<b>STEMI</b>	ST Segment Elevation Myocardial Infarction
<b>MRC</b>	Make Ready Centre	<b>TIA</b>	Transient Ischaemic Attack
<b>MDT</b>	Mobile Data Terminal	<b>UKAS</b>	United Kingdom Accreditation Service
<b>NRLS</b>	National Reporting and Learning System		

### Data sources:

- The data for reports contained within the quality measures A, B, D and E have been gained from the Trust's automated reporting systems – info.secamb, IBIS and 111. Information from these systems is then transformed i.e. charted and narrated to ensure that it is able to be understood by the reader.
- The information contained within elements of quality measure B, and quality measure C, will be gained via a survey, the results of which will be scored on an appropriate software package and calculated for each element within the survey produced.

# Part 1 <sup>(Footnote 1)</sup>

## 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, Sussex and parts of Hampshire. We are one of 11 ambulance trusts in England. We work across a diverse geographical area of 3,600 square miles which includes densely populated urban areas, sparsely populated rural areas and some of the busiest stretches of motorway in the country.

SECAmb's vision and strategy is that "We will match and exceed international excellence through embracing innovation and putting the patient at the heart of everything we do".

To implement our strategy, six objectives have been identified as follows:

- + improve on SECAmb's performance standards and reduce variation;
- + deliver excellence in leadership and development;
- + improve access and outcomes to match international best practice;
- + improve satisfaction and experience for all stakeholders;


- + be an organisation that people seek to join and are proud to be a part of; and
- + convert all available pounds / resources to maximise patient benefit.

SECAmb continues to be 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 an Inclusion Strategy was approved by the Board in May 2012, following an extensive consultation process. This strategy draws together the strands of membership and governor engagement, patient and public involvement and equality and diversity into a single strategy based on working effectively with all our stakeholders. For SECAmb the term '**inclusion**' means "involving and engaging with our stakeholders to help improve access to our services and eliminate discrimination, better meeting the needs of patients and fulfilling statutory obligations."

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

<sup>1</sup>. PART 1 = Statement on quality from the Chief Executive of the NHS Foundation Trust (NHS Foundation Trust Annual Reporting Manual for 2012/13)





The first quality measure was to increase the number of registered Paramedics who attended seriously injured or ill patients. SECAMB provided a registered clinician to 79.84% of patients who required a hospital pre-alert (ASHICE). This is an improvement of 2.29% on 2011/12, with the number of these calls also increasing by 153 cases.

The second quality measure involved the performance of SECAMB's Paramedic Practitioner (PP) teams. It is the Paramedic Practitioner skill set that provides SECAMB with one method of safely reducing patient transports to conventional A&E departments. The average non-conveyance rate for a PP improved during 2012/13 to 49.23% compared with 44.95% in 2011/12. With continued recruitment and development of PPs and the pilot introduction of a PP desk in our emergency operations centres, it has been found that we have been able to increase the number of patients cared for at, or closer to, home which we believe improves patient experience, as the majority of patients prefer to be treated in this way.

The third quality measure was to improve the linking of the electronically scanned paper based patient clinical record to the 999 call/record.

During 2012/13 we achieved an average of 93.19%, which is an improvement of 1.64% on 2011/12. The introduction of an improved collation process has brought some benefits but there still remains room for improvement which we believe will come from an electronic solution, for which a small 'proof of concept' trial took place during 2012/13.

The fourth quality measure looked at how well the infection control process was being maintained within our Make Ready Centres. This measure monitored the deep cleaning of emergency response vehicles across SECAMB and swab testing within the five Make Ready Centres, and this has seen a continued improvement during the year. With regard to deep cleaning, our target was 85% and we achieved 86.9%, with the swab testing target being 95% and actually we achieved 101.52%.

The fifth quality measure surveyed the experience of a sample of patients who dialled 999 with a non-life threatening condition and who did not require conveyance to a conventional A&E department. Views were sought from these patients by carrying out two surveys during 2012/13. The findings from both surveys were shared with our Commissioners and showed an overall satisfaction rate of 93%. Action plans on areas for improvement were also implemented.

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In 2013/14, SECAmb is maintaining the maximum five quality measures which support some of the service development areas of our Annual Plan, demonstrating that we embrace innovation by reporting on the initiatives that can directly affect the strong reputation and positive public image that SECAmb has developed.

Sections 3.1 to 3.5 of this document explain in detail each quality measure by providing a description of the measure, the current status, how we are going to improve the quality and the output measure by the end of the year i.e 31 March 2014.

We have also included updates on other quality initiatives we planned to introduce during 2012/13 and a separate chapter on quality initiatives we proposed to implement during 2013/14 which are in addition to the five quality measures.

Overall it has been a challenging year for SECAmb, but progress has been made on the majority of our quality initiatives (see additional information in sections 4, 6 and 9) and we will continue to work to drive further improvements in 2013/14.

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



**Paul Sutton**, Chief Executive

Date: 29 May 2013

## 2. Introduction to the Quality Account and Quality Report

Welcome to South East Coast Ambulance Service NHS Foundation Trust's (SECAmb) Quality Account and Quality Report for 2012/13. We hope that you find it an interesting and 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?

This document is one method we use to provide more insight into just how effective SECAmb's services are. It also explains how these services are measured and how they will be improved.

In short the Quality Account and Quality Report is aimed at making all NHS trusts 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.

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 believes patient safety should now be added as an explicit requirement (Figure 1).

### High Performance Ambulance System

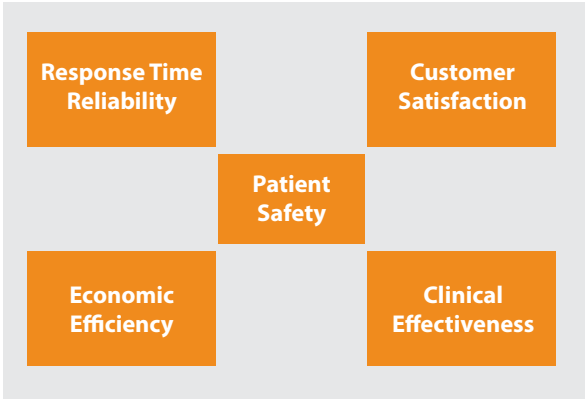


Figure 1: Model of High Performance Ambulance System

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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.

Having recently received the Francis Report<sup>2</sup> (following the review of Mid-Staffordshire NHS Foundation Trust), SECamb had already begun to consider how to identify and implement any potential learning points. We are now undertaking a review of all the recommendations applicable to SECamb and this is being led by Kath Start, Chief Nurse and Director of Workforce and Development, supported by Dr Jane Pateman, Medical Director and myself, Andy Newton, Clinical Director and Consultant Paramedic. As part of this internal review, we are also seeking input from a range of staff and our Council of Governors.



**Professor Andy Newton**, Consultant  
Paramedic & Director of Clinical Operations

Date: 29 May 2013

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<sup>2</sup> Francis, R, QC. 2013. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Executive Summary p. 96. London: The Stationery Office.

# Part 2 <sup>(Footnote 3)</sup>

## 3. How the quality measures were prioritised for the year ahead (2013/14)

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 – our patients deserve nothing less. We aspire to deliver clinical excellence that matches and exceeds international best practice.

In considering which quality measures SECAMB would report, we held an external workshop in February 2013 which was attended by Governors, Inclusion Hub Advisory Group (IHAG) members, patients, LINKs/Healthwatch, Health Overview and Scrutiny Committee members (HOSCs), Foundation Council Members, Commissioners and staff.

During the above workshop participants proposed a wide range of quality measures which they wished to be considered for 2013/14. The proposals were discussed and explored throughout the workshop and the top five were agreed upon by the stakeholders. The stakeholders were aware that they needed to ensure that at least one quality measure was within each quality domain (Clinical Effectiveness, Patient Experience and Patient Safety).

The workshop was very well received and at the end of the day we asked participants to complete an evaluation form of which the summary findings are as follows.

### We asked all participants how useful did they find each element of the day?

	Very useful	Quite useful	Not very useful
What is a Quality Account: what is it for and what should it include?	12	5	0
Trust vision, aims and objectives – Including Performance on 2011/12 Quality Account Measures	14	3	0
Developing new priorities for inclusion in the next Quality Account	15	3	0
Recommending quality priorities for inclusion in the next Quality Account	15	3	0
Thoughts on the format, language, design and accessibility	11	6	1

<sup>3</sup>. PART 2 = Priorities for improvement and statements of assurance from the Board (NHS Foundation Trust Annual Reporting Manual 2012/13)

We also asked what, if any, follow-up activity or support participants would find helpful and the responses included:

- + sight of draft document;
- + pleased to have the opportunity to request support if required;
- + excellent day with good content. Thank you for listening;
- + back next year;
- + look forward to draft document; and
- + none really

The final question was based on did they find the workshop overall worthwhile attending, resulting in the following:

Yes, definitely **16**

Yes, probably **2**

Not really **0**

Not at all **0**

A report was then presented to our Risk Management and Clinical Governance Committee (RMCGC) in March 2013 highlighting the top five quality measures identified from the workshop for inclusion within this document and to be monitored during 2013/14. These quality measures were then approved by SECAMB's Board at the March 2013 Board meeting. (Previous editions of the Quality Account and Quality Report are available at [www.secamb.nhs.uk](http://www.secamb.nhs.uk)).

The quality measures selected for 2013/14 are focused on improving outcomes for our patients; how we are going to do this is described in the detail of each quality measure throughout this document and identifies the responsible designated Board Sponsor and Implementation Lead.

**Quality Measure A – Patient Safety**

“To monitor the effectiveness of SECAMB's Infection Control procedures for emergency response and patient transport vehicles that are deep cleaned and swab tested across SECAMB”

**Quality Measure B – Patient Experience**

“The effectiveness of the 111 service/facility in providing patients with the appropriate service”

**Quality Measure C – Patient Experience**

“To improve the experience of those patients who call SECAMB via 999 and their satisfaction with the service provided”

**Quality Measure D – Clinical Effectiveness**

“To monitor the IBIS system so that those patients with long term conditions (LTC) are able to be provided with the best possible care by attending ambulance crews”

**Quality Measure E – Clinical Effectiveness**

(1) “To improve the number of registered clinicians who attend those patients deemed to have a life-threatening condition at the time the 999 call was raised”.

(2) “To monitor where a Paramedic Practitioner attends a patient through a PP referral where that patient is then subsequently transported to a hospital A&E department”.

Following the external workshop we circulated the draft Quality Account and Quality Report to HOSCs, Healthwatch, Commissioners, workshop attendees, Non-Executive Directors, Governors and IHAG members for comments, providing the required 30 day consultation period.

### **In year monitoring arrangements of our achievements**

The Risk Management and Clinical Governance Committee (RMCGC) will focus in detail on the key areas of quality and receive progress updates on delivery of the quality measures. The Board will receive regular updates via the RMCGC report on achievements against the quality measures.

The Commissioners receive updates on the five quality measures at the joint SECAMB/ Commissioner bi-monthly Quality Focus meetings. As a result, SECAMB already comply with this recommendation of the Francis Report.

### **3.1 Quality Measures to be monitored during 2013/14**

#### **Quality Domain: Patient Safety**

#### **3.1.1 Quality Measure A: To monitor the effectiveness of SECAMB's Infection Control procedures for emergency response and patient transport vehicles that are deep cleaned and swab tested across SECAMB**

#### **Description**

At the current time SECAMB has a total of five Make Ready Centres located at Chertsey, Paddock Wood, Ashford, Thanet and Hastings.

This quality measure will report on the following items, giving comparable data, where possible, from the previous year:

- + deep clean completion (non-make ready and make ready) percentage rate of planned volume for emergency vehicles;
- + swab tested completion (make ready only) percentage rate of planned volume for emergency vehicles;
- + deep clean completion (non-make ready and make ready) percentage rate of planned volume for Patient Transport Service (PTS) vehicles;
- + swab tested completion (make ready only) percentage rate of planned volume for PTS vehicles; and
- + hand hygiene published survey results based on the observed areas:-
  - decontaminated before patient contact;
  - decontaminated before aseptic non-touch procedure;
  - decontaminated after removing gloves following aseptic non-touch procedure;
  - washed hands after patient contact / leaving patient surroundings;
  - used soap and water when and where available; and
  - "bare below the elbow".

## Current status

### + *Deep Clean and Swab Test (A&E)*

- SECAmb's deep clean compliance is reported via a dashboard, which is subsequently reported to the Board. The numbers reflect the deep cleaning of all emergency response vehicles and PTS vehicles across SECAmb. The information reported in this quality measure also includes the figures where the deep cleaned vehicles were not allocated to Make Ready Centres (MRC).
- Outside the MRCs the deep clean programme requires a vehicle be available over a six hour window. Where we do not achieve the 85% target this is principally due to the increase in calls, with the vehicles scheduled for deep cleaning being required to remain operational for emergency response.
- With the introduction of additional MRCs in the future, this will assist in ensuring more vehicles are made available for the deep clean process.
- Deep clean completion (non-make ready and make ready) percentage rate of planned volume for emergency vehicles.
  - In 2012/13, 2626 vehicles were scheduled for the deep clean process, an increase of 84 vehicles (3.3%) on the 2011/12 target.
  - During 2012/13, SECAmb's target was 85%. We exceeded this target with an achievement of 86.3%, which was an improvement of nearly 1.7% on 2011/12.

- Swab tests completed (make ready only) percentage rate of planned volume for emergency vehicles.
  - During 2012/13, in order to meet our target of 95% a total of 125.4 swab tests were required (40.9 more than 2011/12). We planned to undertake 132 swab tests to exceed this target.
  - However, 134 (101.51%) swab tests were completed, exceeding the 95% target by 6.51% and the 2011/12 performance by 3.76%.

### + *Deep Clean and Swab Test (PTS)*

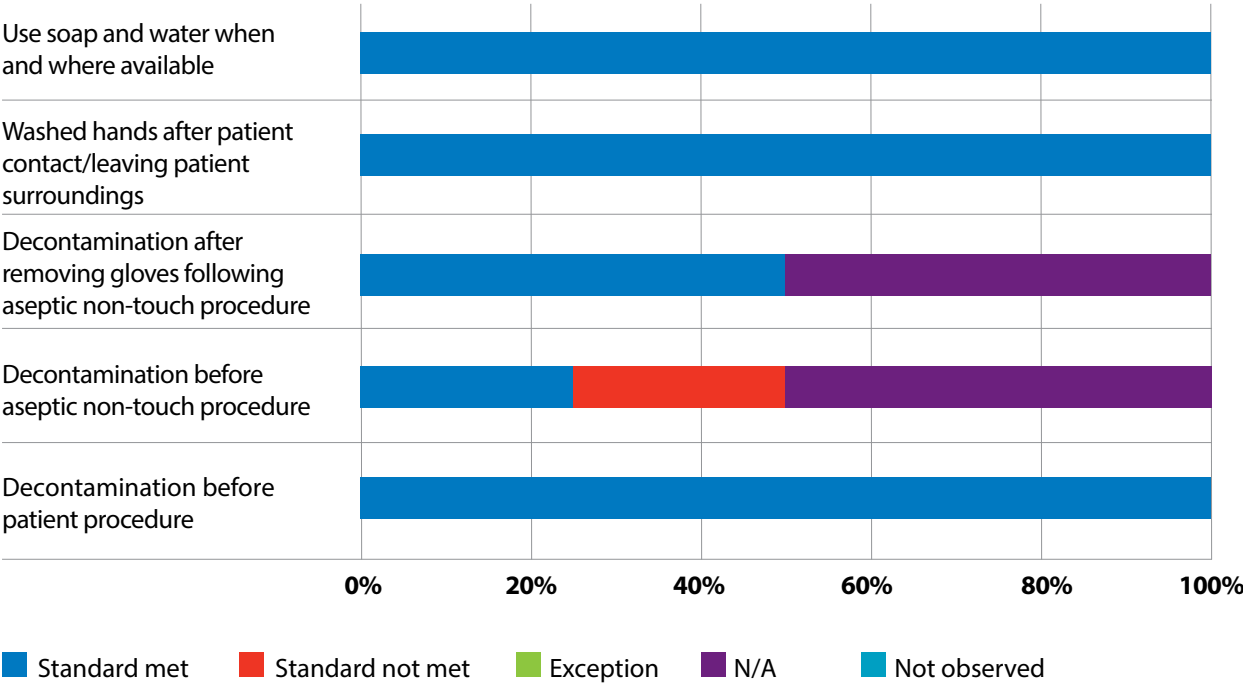
- Deep clean completion (non-make ready and make ready) percentage rate of planned volume for PTS vehicles.
  - In 2012/13, 843 PTS vehicles were scheduled for the deep clean process.
  - During 2012/13, SECAmb's target was 85%. We exceeded this target with an achievement of 89.32%.
- Swab tested completion (make ready only) percentage rate of planned volume for PTS vehicles
  - In 2012/13, 15 PTS vehicles were scheduled for swab testing, an increase of 5 vehicles on 2011/12.
  - During 2012/13, 73.33% of the 15 planned vehicles were swab tested, which is a decrease on the 2011/12 achievement of 100%. This was because of significant disruption as the majority of the fleet was replaced in Q3 and Q4 of 2012/13. The fleet renewal is complete and we expect to return to compliance.



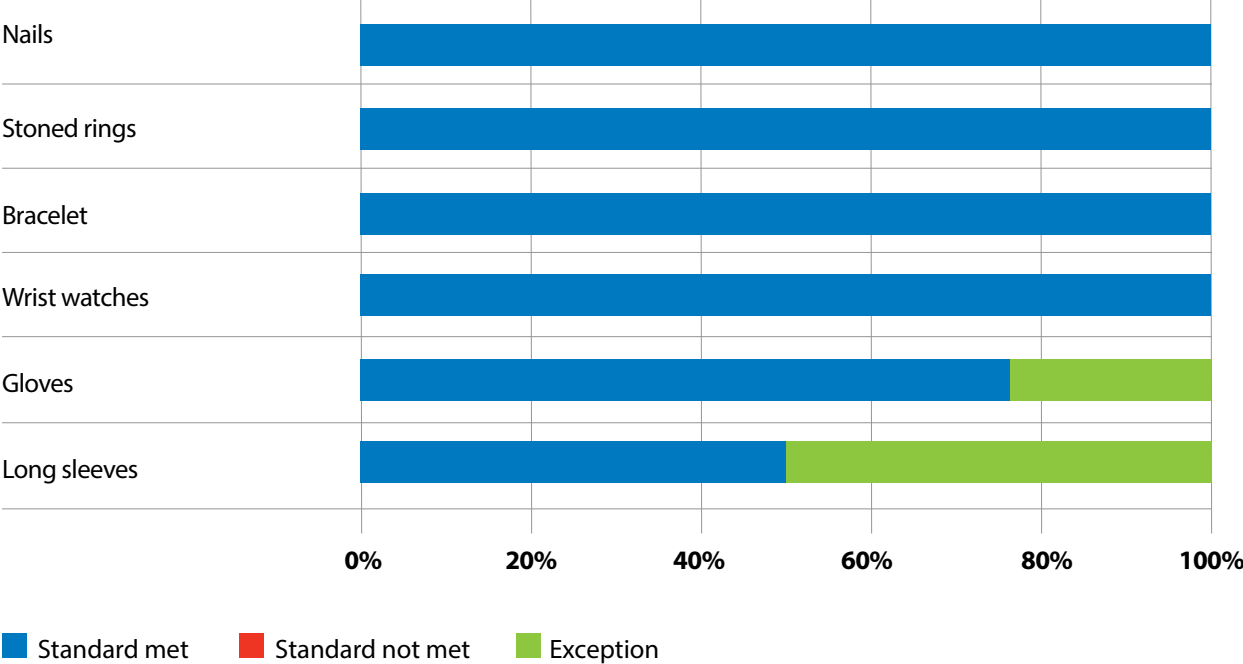
### + **Hand Hygiene**

- An internal audit tool was designed to allow the effectiveness of the hand washing procedures of the crews to be recorded and measured.
- Infection control link staff undertook some local hand hygiene and “bare below the elbow” audits during June 2012, whilst working alongside operational crews, which has enabled them to observe the full range of the audit tool during the crews’ shifts.
- The Infection Control Lead (ICL) carried out random observational hand hygiene audits of SECAMB staff at A&E departments during June and July 2012. Although not all sections of the hand hygiene audit tool could be observed, the summary does provide evidence that SECAMB staff are performing hand hygiene when at hospital.
- The ICL also observed compliance to “bare below the elbow” and when staff had not complied with the procedure he discussed the rationale behind the need for compliance. It was identified that further work is required regarding the removal of wrist watches and the need to remove gloves once the risk of blood/body fluid contamination is unlikely.
- During 2012/13 SECAMB has installed a new range of hand hygiene products across all locations and has encouraged staff to follow the correct hand washing procedures by way of statutory and mandatory annual training updates and the publication of new hand hygiene posters.
- The following tables are a summary of the hand hygiene and “bare below the elbow” audits mentioned above.

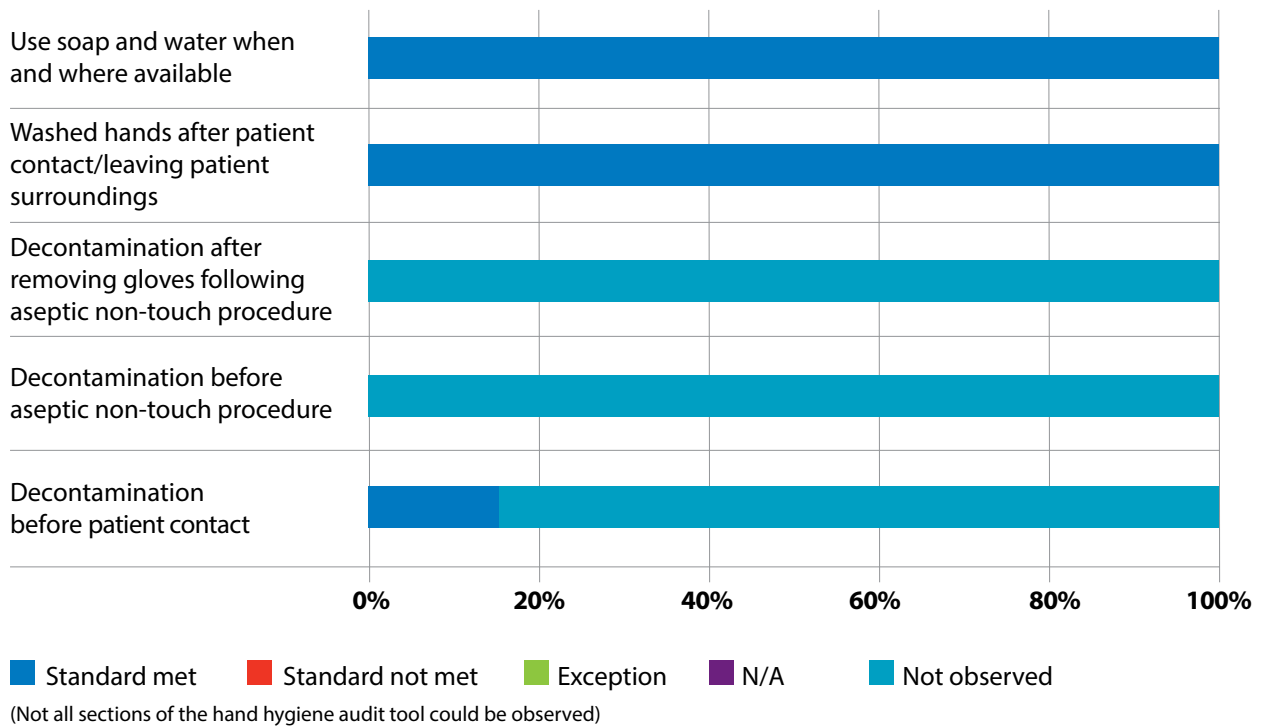
**Link staff hand hygiene audits carried out in June 2012 (8 observations)**



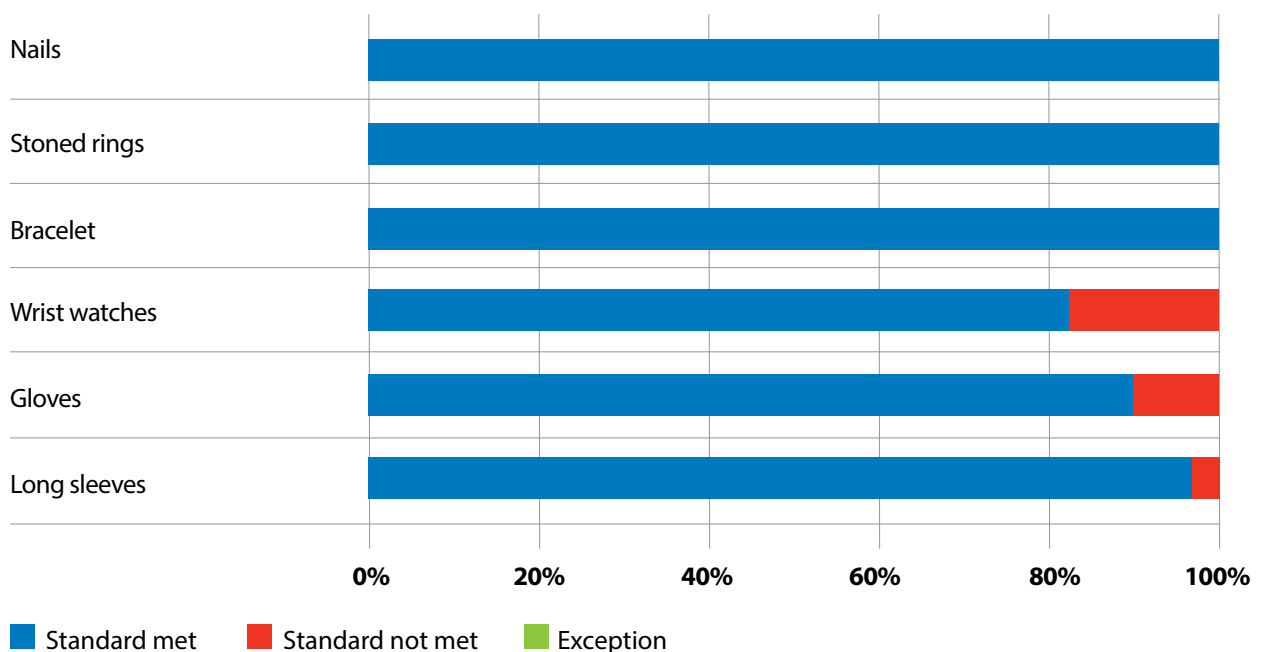
**Link staff hand hygiene audits carried out in June 2012 (8 observations)**



**Hand hygiene audit carried out on 7 June 2012:  
28 observations at the QEQM (Thanet) and William Harvey (Ashford)**



**“Bare Below the Elbow” Audit carried out on the 7th June 2012:  
28 observations at the QEQM (Thanet) and William Harvey (Ashford)**



## How we are going to improve this quality measure during 2013/14

- + ***The Make Ready Centre Initiative (MRC)***  
SECAmb is implementing MRCs, which enable the emergency response vehicles to be 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 MRCs, SECAmb plans to progress the roll-out of more MRCs over the coming years. In addition, during 2013/14 we plan to refurbish the existing MRC at Thanet, with the aim being to have 12 MRCs by the end of 2016.
- + ***Action taken if standards within this quality measure 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 whose processes are accredited by UKAS (United Kingdom Accreditation Service) which provides SECAmb with assurance that the systems standards and methods employed meet 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.

## Output measures for year ending March 2014

- + ***Swab Test and Deep Clean Procedures***  
The output measure for the above procedures will be to ensure that the current target of 85% for the deep clean process and the 95% target for the swab test success rate are maintained/improved with the available resources for both the A&E and PTS fleet.
- + ***Hand Hygiene***  
During 2013 the Infection Control Lead (ICL) has introduced five key performance indicators (KPIs) to ensure SECAmb's effective prevention, monitoring and control of infections are an integral part of the quality, safety and clinical risk management operations of any healthcare service. Hand hygiene forms one of these KPIs and states "The major transmission route for healthcare acquired infections in the health care setting is by direct contact via the hands of health care workers or possibly indirectly via contaminated equipment that is not cleaned between patients". Therefore, there has been renewal in the promotion of hand hygiene as an effective method of preventing transmission of infections.

The three areas of compliance for this KPI are to:

- + continue staff hand hygiene education;
- + collect hand hygiene data compliance (audits); and
- + allocate suitable hand hygiene products in all areas of SECamb.

#### **Name of Board Sponsor**

Dr Jane Pateman, Medical Director

#### **Names of Implementation Leads**

Adrian Hogan, Infection Control Lead

Chris Haines, Head of Logistics

Rory Collinge, Project Manager,  
Commercial Services

### **Quality Domain: Patient Experience**

#### **3.1.2 Quality Measure B: The effectiveness of the 111 service/facility in providing patients with appropriate service**

#### **Description**

NHS 111 is a national telephone service, provided in Kent, Surrey and Sussex by SECamb, working in partnership with Harmoni. This service aims to make it easier for people to access healthcare services when they need medical help fast, but not in a life-threatening situation.

Calls to NHS 111 from landlines and mobile phones within the SECamb area are free of charge and the service is available 24 hours a day, 365 days a year to respond to healthcare needs of the population of SECamb when:

- + they need medical help fast, but it is not a 999 emergency;
- + they do not know who to call for medical assistance or do not have a GP;
- + they think they need to go to A&E or another NHS urgent care service; or
- + they require health information or reassurance about what to do next.

Calls are answered by trained Health Advisors and referred to Clinical Advisors when required. Callers to NHS 111 can be provided with self-care advice, health information or referred to a number of services, including but not limited to, GP practices, walk-in-centres, dentists, opticians, sexual health clinics, mental health services, A&E departments, referral to 999 or the out of hours GP services.

In future should people need to contact the NHS for urgent care there will be three ways to do so:

- + through their GP practice;
- + dialing 111; or
- + dialing 999 for life-threatening emergencies.

People should continue to call 999 for life-threatening emergencies that require an immediate response. However, if a call to NHS 111 is assessed as being a medical emergency, the service can dispatch an ambulance directly and provide first aid advice to the caller until ambulance clinicians arrive, without the need to transfer the call, or for the caller to repeat information.

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The following measures have been selected by participants of our stakeholder workshop that will help provide information on development of the 111 service.

This quality measure will report on the following items, giving comparable data, where possible:

- + total number of calls abandoned;
- + number of calls answered within 60 seconds;
- + provision of interpretation service/ appropriate provision where required within 15 minutes of initial contact;
- + front line staff and advisers to have received training on safeguarding issues for adults and children to an appropriate level;
- + percentage of answered calls transferred to 999;
- + percentage of patients advised to attend Accident and Emergency Department;
- + number of calls warm transferred to NHS 111 service where a clinician is required;
- + number of calls where the time taken for a clinical adviser call back is less than 10 minutes.

+ **Patient Survey**

- In order to ensure continual development of the 111 service in the SECamb area, a process for surveying patient satisfaction has been produced. This will allow for review of services to measure satisfaction of service users.

Feedback will be collected from at least 400 service users per year and will be undertaken quarterly in June, September, December and March with reporting to the Commissioners provided bi-annually by 10 November and 10 May for the preceding two surveys. The survey may be undertaken by post, phone or electronically and should be collected approximately two weeks after the patient or service user has contacted 111.

+ **Feedback**

- Feedback from patients and other non-healthcare professional service users will be collected via the existing PALS, complaints and compliments process.

**Current status**

There are two contact centres providing the 111 service across the SECamb area and these are located in Ashford, Kent and Dorking, Surrey. Between the two centres it is estimated that the call operators will take a total of 1.3 million calls per annum. The call operators employed to deliver the NHS 111 service are trained in the use of NHS Pathways. The contact centres have a mix of Health Advisors, Nurses, Paramedics and GPs.

The NHS 111 service operates differently to 999 call-taking, in that it not only uses NHS Pathways<sup>4</sup> but also other information sources to access health information advice and utilises the Directory of Services (DoS) to manage predetermined care pathways.

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<sup>4</sup> NHS Pathways is an advanced triage system containing hundreds of interlinked clinical questions which are arranged into complex symptom based flows or 'Pathways' and is linked to the Directory of Services, meaning ambulance clinicians are able to link in to a wide range of health and social care services as required. NHS Pathways provides safe and effective clinical decision support to specially trained call handlers and clinicians who provide telephone assessment and advice to the public.

Benchmark data is not yet available, however performance measures are summarised as follows:

KMSS NHS 111 Quality and Performance Indicators		Target
Engaged Calls (NQR8)	Total Number of calls engaged	<0.1%
Answer time (NQR8)	Total Number of Calls Abandoned	<5%
Call waiting time (NQR 8)	Number of calls answered within 60 seconds	>95%
Meeting individual needs (NQR13)	Provision of interpretation service/ appropriate provision where required within 15 minutes of initial contact	100%
Safeguarding (LQR2)	Frontline staff and Advisors training in recognition of safeguarding issues for adults and children to an appropriate level	100%
Transfer to 999 (LQR5)	Percentage of answered calls transferred to 999	<10%
Attend Accident and Emergency Department (LQR6)	Percentage of patients advised to attend Accident and Emergency Department	<5%
Warm Transfers (LQR7)	Warm Transferred to NHS 111 service where Clinician required	98%
Time taken for call back (LQR10)	Time taken for call back <10 minutes	100%

#### How we are going to drive improvements to this quality measures during 2013/14

As we enter 2013/14 financial year, public awareness and understanding of the NHS 111 service through the media and promotion will increase, as will the systems, standards and methods employed within the NHS 111 process. Efficiency will increase as the service providers (SECamb and Harmoni) are able to offer a more comprehensive service to the public who will, in turn, use the service relative to the patient's current condition. Weekly and monthly performance meetings will be used to drive continuous quality improvements.

#### Output measure for year ending March 2014

Provision of an effective single point of contact for access to urgent care across Kent, Medway, Surrey and Sussex. It is anticipated that this will result in an increased use of alternative pathways in preference to 999 and A&E.

#### Name of Board Sponsor

Geraint Davies, Director of Commercial Services

#### Name of Implementation Lead

Anouska Adamson-Parks, 111 Programme Director

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**Quality Domain: Patient Experience**  
**3.1.3 Quality Measure C: To improve the experience of those patients who call SECAmb via 999 and their satisfaction with the service provided**

**Description**

2012/13 saw some changes to the way that SECAmb manages its patients. These changes range from the deployment of Paramedic Practitioners, the introduction of 111 and the creation of the IBIS database system which provides SECAmb with additional information about the patient to pass to the attending clinician.

One of SECAmb's clinical quality indicators (CQIs) is to safely and appropriately increase the number of ambulance calls closed with telephone advice (Hear and Treat) or managed without the need to transport patients to a conventional A&E department. 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 efficiently with those patients who require hospital treatment.

These alternative care pathway options will include treatment by a SECAmb Specialist Paramedic with the appropriate care at or closer to the patient's home.

However, in some cases other healthcare options may be more appropriate. These might include:

- + advice or signposting from a clinical telephone adviser in the Emergency Operations Centre (known as Hear and Treat); or
- + referral – either by the clinical telephone adviser or by the clinician who attends the patient - to another healthcare professional, such as a GP, respiratory nurse, diabetes nurse specialist; referral to a mental health team, social worker, walk-in centre, pharmacy etc.

Overall we are certain that the introduction and development of these systems will lead to more appropriate care for patients (the 'right care, right place, right time' ethos), but we want to ensure that the 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 quality measure in our Quality Account.

**Current status**

Two patient surveys were carried out during 2012/13, surveying those patients whose emergency call had been resolved with clinical telephone advice or managed without transport to A&E. The surveys were undertaken using data from June and November 2012, where both surveys showed an overall satisfaction level of 93%, however action plans from both surveys were implemented for areas requiring improvement.



These surveys were also linked to our 2012/13 CQUIN plan and have an overarching patient experience theme “responsiveness to personal needs of patients”.

### **How we are going to improve this quality measure during 2013/14**

At the Quality Account Workshop held in February 2013, participants confirmed that while they were pleased with the results of our survey of patients who were provided with telephone advice or who we attended but did not convey to hospital, they would like to know how satisfied ALL types of SECamb patients are. Therefore in 2013/14, in addition to surveying patients receiving telephone advice and patients who are not conveyed to hospital, we will also undertake to survey patients who are conveyed to hospital and patients who are conveyed to a facility other than a traditional A&E department.

This survey will provide valuable feedback about the impact of some of our new systems on the experience and expectation of SECamb’s patients and callers. This will help us to determine how these systems can be improved as a result, in order to enhance both the treatment provided and the patient’s overall experience.

### **Output measure for year ending March 2014**

From the 2013/14 survey we will be able to compare the satisfaction levels of ‘Hear and Treat’ and ‘non-conveyed’ patients with those of the previous two years (92% and 93%), aiming to match or surpass these.

The survey of the new cohorts of patients will provide us with a baseline towards the beginning of the year from which to work on improvements as the year progresses.

### **Name of Board Sponsor**

Professor Kath Start, Director of Workforce and Chief Nurse

### **Name of Implementation Lead**

Louise Hutchinson, Patient Experience Lead

## **Quality Domain: Clinical Effectiveness**

### **3.1.4 Quality Measure D: To monitor the IBIS system so that those patients with long-term conditions (LTC) are able to be provided with the best possible care by attending ambulance crews**

#### **Description**

As community care has developed, opportunities to care for patients in or closer to their home environment, instead of in a hospital, have increased. This is particularly true for patients with long-term conditions such as diabetes, heart failure, or respiratory problems. However, if one of these patients calls 999, ambulance clinicians often only see the patient’s immediate condition, without the context of their long-term health details. This limits the scope for the clinician about whether or not the patient needs to go to hospital or could receive care within the community.

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IBIS assists with the above by recording, on a database held by SECAMB, information on patients with long-term conditions. If an ambulance is sent to a patient who is registered on IBIS, the crew will be notified via either the mobile data terminal (MDT) in the vehicle or airwave radio. The attending crew can then telephone the EOC for further details regarding the patient's on-going care needs; in particular what is deemed normal for that patient in context to their disease progression (such as their "oxygen saturation" reading, which can be much lower in patients with certain conditions, but which is an acute sign in the rest of the population). At this point the crew will also be given the contact details of the health care team that has registered the patient on IBIS to discuss the most appropriate option. Should the call be out of hours, the attending crew will be directed to the health care team's preferred service provider.

Without IBIS, patients with long-term conditions are frequently taken to hospital when they could potentially be treated more effectively in or closer to their home environment, thus avoiding unnecessary admissions to A&E departments and improving their experience.

IBIS also records information about patients who are not taken to A&E. In the event of a patient not going to hospital, the crew contact an operator in EOC who enters the patient's details from the attending clinician and the information can then be promptly accessed by both SECAMB as well as primary care providers via urgent care dashboards. This is where GPs see where their patients present in the health economy outside of their surgery e.g. in A&E.

The effectiveness of IBIS in the care and management of patients with LTCs will be monitored using the following items, giving comparable data, where possible, from the previous year:

- + to increase the number of patients who are registered on IBIS and matched to a 999 call;
- + reduce the volume of conveyances for patients registered on IBIS;
- + to increase the number of non-conveyed IBIS patients coded as a percentage of all non-conveyed patients (disregarding exclusions);
- + to increase the number of falls notifications following a non-conveyance; and
- + to increase the number of GP summaries following intervention by a Paramedic Practitioner (PP).

### **Current status**

Of the 47,821 patients eligible for coding 'not conveyed to hospital' between December 2012 to March 2013, SECamb was able to capture details on 17,197 (35.96%).

In total, 1342 patients were matched on the IBIS system between 1 June 2012 and 31 March 2013, of which 42% required transporting to an A&E department. The 42% conveyance rate is lower than the 55.5% Trust managed conveyance rate performance, which excludes those patients where conveyance to A&E has been predetermined by a health care professional. IBIS reporting includes these incidents in order to identify all potentially avoidable conveyances. The output of IBIS is to ensure that those patients with known long term conditions, and which are often transported to A&E, are referred back to their care teams in the community so allowing a more patient focused pathway to affect the decision to convey or not.

The length of time that community clinical teams have been using IBIS varies across the SECamb area and is reflected in the number of active users and the number of patients on IBIS. For the more established community clinical teams (defined here as those whose patients have generated 10 or more emergency call matches) we conveyed 42% of their patients to hospital, whereas the community clinical teams who have been using the system for a shorter period or have less patients (defined as those whose patients have had nine or fewer emergency call matches) we conveyed 36.6% of their patients to hospital.

These are very encouraging figures as the patients being managed are those with long term conditions and as such would have a greater chance of being transported to hospital. The reason for defining the clinical community teams as above allows greater transparency against differing sample sizes. The overall aggregate conveyance rate for the whole IBIS cohort is 42% for the period 1 June 2012 to 31 March 2013.

Between 1 June 2012 and 31 March 2013 Paramedic Practitioners provided assistance to 4981 patients who had their details recorded by the IBIS system, of which 65.74% had a clinical summary of the PP visit sent to their GP.

### **How are we going to improve this quality measure during 2013/14**

By increasing the efficiencies within the IBIS systems and ensuring that IBIS/EOC/Ambulance staff are aware of the appropriate method of recording the non-conveyance, it is expected that the percentage of non-conveyed patients captured by IBIS will increase from 35.96% to 60%.

By increasing the number of patients with long term conditions registered on IBIS, this will support unnecessary admissions to A&E with care being provided in the community.

Following a PP visit a clinical summary will be sent to the patient's GP. We have written to all GP practices in the region to request a secure email address in order to send summaries to. To date, we have over 85% email coverage, and will continue to engage with practices to increase this number further in order to enhance communication between PPs and GPs. During 2013/14 we will provide regular reports to Commissioners, as part of the CQUIN plan, with the aim of increasing the number of email addresses of GP practices registered on IBIS.

**Output measure for year ending March 2014**

It is expected that the percentage of non-conveyed patient details collected by the IBIS system will increase over the coming year to 60% of the total patients held by IBIS.

The aim for the IBIS system is to have several thousand patients registered on the system, to complement the 750 that are already registered. Information about patients on IBIS is supplied by their care team and it is hoped that all eligible partner providers will sign up to use IBIS during 2013/14.

**Name of Board Sponsor**

Professor Andy Newton, Consultant Paramedic & Director of Clinical Operations

**Name of Implementation Lead**

Andy Collen, Clinical Development Manager

**Quality Domain: Clinical Effectiveness**

**3.1.5 Quality Measure E1: To improve the number of registered clinicians who attend those patients deemed to have a life-threatening condition at the time the 999 call was raised**

**3.1.5 1 Quality Measure E2: To monitor where a Paramedic Practitioner attends a patient through a PP referral and where that patient is subsequently transported to a hospital A&E department**

**Description**

In 2012/13 SECAmb responded to 761,416 emergency calls – an increase of 10.5% on 2011/12. Of these, 611,455 calls resulted in an ambulance response, of which 265,988 (43.50%) were categorised to be either Red 1 or Red 2 i.e. life threatening and as such should be attended by a registered clinician (an increase of 0.56% on 2011/12).

During 2012/13, SECAmb introduced a change to the way that the Paramedic Practitioners (PP) were deployed to increase the impact they were able to have on the wider health economy by providing care closer to or at home.

In order to monitor and improve E1 and E2, the following have been chosen by our stakeholders to ensure the most appropriate clinical skills are allocated to these calls.

- + This quality measure will report on the following items, giving comparable data, where possible, from the previous year:
- + to increase the number of Red 1 and Red 2 responses where the patient is attended by a registered clinician. This is to be expressed as a percentage of the total volume of Red 1 and Red 2 responses; and
- + to express as a percentage the total PP referrals of those patients who were then subsequently transported to an A&E department.

### **Current status**

The current percentage of Red 1 and Red 2 responses attended by a registered clinician is 85.50% of a total 265,988 response categorised as life threatening.

During 2012/13, 7077 Paramedic Practitioner (PP) referrals resulted in 10.20% of those patients attended by a PP as a referral being conveyed to an A&E department, compared with 10.42% in 2011/12. However, in 2012/13 twice the number of PP referrals were received compared with that of 2011/12, which in turn means more people were treated at or closer to home. We maintained this percentage with the introduction of the PP desk in EOC, which takes approximately 1000 calls per month from colleagues.

### **How we are going to improve this quality measure during 2013/14**

SECamb has implemented initiatives to ensure that the most appropriately skilled clinician is able to attend and provide care to the population within the health economy. Three of these initiatives are:

#### **+ *Front Loaded Service Model***

Included in SECamb's plans for 2013/14 is the implementation of key service developments which will see an increase in the number of registered clinicians first on scene. 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.

#### **+ *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.

SECAmb plans to ensure that its paramedic workforce who qualified prior to the introduction of higher education awards is given the opportunity to develop to current graduate standards. This additional education centres around enhancing history-taking, physical assessment and clinical decision making. These skills provide paramedics with the ability to differentiate the needs of the patient most effectively and promote/support the correct care pathway; be that A&E or a referral within the community.

**+ Paramedic Education**

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

**Output measure for year ending March 2014**

**Quality Measure E1**

During 2013/14 to ensure that the current level of registered clinicians attending patients with life-threatening conditions is maintained and then increased.

**Quality Measure E2**

During 2013/14 to ensure the consistency of the number of patients attended by PPs via a referral, together with associated A&E conveyance rate, is maintained as at the 2012/13 level.

**Name of Board Sponsor**

Professor Andy Newton, Consultant Paramedic & Director of Clinical Operations

**Names of Implementation Leads**

Sue Skelton, Head of Emergency Operations Centres  
Andy Collen, Clinical Development Manager

## 4. Quality improvements made within SECAMB during 2012/13

### 4.1. IBIS (Intelligence Based Information System)

IBIS is a system SECAMB has developed which has two main functions:

- + the **clinical coding** aspect collects information for non-conveyed patients, which can be shared, collated and analysed, as well as providing the basis for clinical summaries to GPs and for falls referrals. The clinical coding will also provide an early alert for emerging frequent callers; and
- + the **case management** aspect allows patients with long-term conditions to be placed into IBIS and in the event of them calling 999 clinical information can be released to the crew to promote admission avoidance.

These two main functions are becoming embedded as part of operational activity.

Clinical coding of patients who are not conveyed to A&E is recorded on IBIS. There is a plan to increase clinical coding and this will involve enhancements to rota coverage, IBIS system development, first-person system access and improvements to communication systems.

Clinical coding also facilitates falls notifications electronically, and clinical summaries to GP practices by Paramedic Practitioners. Since May 2012, we have sent approximately 3000 falls notifications to falls services across the SECAMB region as we migrate from the fax based system previously used. SECAMB now has secure e-mail addresses for 80% of our GP practices, with over 2000 clinical summaries having been set up until March 2013.

The IBIS case management function allows community teams to register with SECAMB information about their patients with long-term conditions. In the event that the patient calls 999 the information held on IBIS, along with the contact information for their care team, is made available to the attending clinicians. The purpose of IBIS is to safely provide care closer to home for patients who are at risk of calling 999, but for who with the correct levels of information can be referred back to their community team without needing to go to A&E.

The IBIS patient cohort has made 1342 emergency calls to SECAMB between 1 June 2012 and 31 March 2013, resulting in only around 562 conveyances to A&E. This has saved over 200 conveyances to A&E and around 70 admissions.

IBIS has continued to develop during the last year and has been adopted by several providers across the region. This system is now used by the following providers:

- + community trusts (community nursing and therapies);
- + secondary care (supported reduction in readmission following discharge);
- + hospices; and
- + mental health trusts.

As at March 2013, SECamb has 487 health professionals with IBIS user accounts, the majority of whom have now been trained to use the system. Training has been undertaken by a dedicated IBIS trainer, which became a requirement due to the number of requests received from users.

As at March 2013 nearly 800 patients have been registered on IBIS, and the organisations using IBIS are indicating that this number will increase significantly over the coming months.

#### **4.2. Paramedic Practitioners (PPs) in Emergency Operations Centres (EOCs)**

The PP desk in EOCs was introduced during 2012/13 and is currently taking approximately 1000 calls per month and arranges around 650 PP referrals. A PP referral is where a PP is dispatched to the patient in order to provide further assessment and treatment e.g. patients who need wound assessment and closure can be referred to a PP rather than transport them to A&E for treatment.

#### **4.3. iStat Blood Gas Analysis**

The evaluation of the iStat blood gas analyser (known as a near patient testing device) for Critical Care Paramedics (CCPs) and Paramedic Practitioners (PPs) has been on-going throughout 2012/13. The specific outcome of the iStat trial was that this device was unsuitable for pre-hospital use, although the results were extremely useful for a range of patient conditions.

As a result, the engagement with iStat was concluded and the trial machines returned to the supplier. However, SECamb was made aware of a further multi-assay blood testing product "EPOC" which offered better usability in terms of its tolerance to movement and temperature ranges.

A trial was organised and two units successfully deployed to CCP teams in Brighton and Ashford. Positive feedback was received, with the units having a zero failure rate and the testing method easier to use. At the time of the evaluation there were some outstanding matters which required review by the manufacturer concerning intolerance to temperature changes and the sizes of cartridges. However the trial did successfully inform the utility of near patient testing for high acuity patients seen by CCPs, and the subsequent trial of the EPOC system was undertaken. The EPOC project will be continued later in 2013/14 once the CCPs have achieved competencies in arterial sampling which will allow further evaluation using the most appropriate sampling technique.



Therefore, whilst the trial was considered a success, it was concluded without moving to procurement with a view to revisiting in Q3 of 2013/14, by which time the picture will be clearer on the best way to move forward.

It is vital that SECAMB invests in new technology which will provide value for money and enhance patient experience and outcomes. The fact that we did not immediately progress this project is testament to the rigour we apply to the introduction of clinical innovation.

#### 4.4. HemoCue

During 2012/13 we entered into a detailed and comprehensive evaluation of the HemoCue near patient testing system for use by the PPs. We evaluated the White Blood Cell and Haemoglobin analysers; initially to prove the concept of operation. The machines received highly favourable results from the PPs and we are now undertaking a more detailed clinical evaluation to look at specific patient conditions.

#### 4.5. Community First Responders (CFRs)

The Voluntary Services department had planned to recruit and train 120 CFRs during 2012/13 and install a further 100 Public Access Defibrillator (PAD) sites in the SECAMB area.

The CFR target was exceeded by 110 and we installed 91 PADs during 2012/13, just short of our target of 100.

In April 2012 SECAMB rolled out its new Foundation course for CFRs following a review of training received.

At present SECAMB has 750 CFRs across 92 schemes, with 85 team leaders and 13 senior team leaders. Our records show that just over 62% of our CFRs are regularly available to respond, which is an improvement since April 2012 when the figure was 51%.

#### 4.6. Research and Development (R&D)

Large scale changes in relation to the wider NHS research agenda are imminent and ambulance services need to be prepared, engaged and responsive to the demands they will encounter in the coming years. Paramedic research has grown rapidly over the last decade in the UK and it is important that ambulance trusts sustain these developments and capitalise on available opportunities to expand the evidence base underpinning Paramedic practice and the provision of out-of-hospital unscheduled and urgent health care services.

Research is considered as core business for all NHS trusts no matter the size and nature of the trust, and SECAMB continues to develop a diverse research portfolio to ensure that its service users receive excellent clinical care grounded in best evidence.

However, expansion and development of research capacity and capability remains high on the agenda as SECAMB needs to ensure that its staff are *research ready* in order to be responsive to the wider demands on research and innovation within healthcare.

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#### **4.6.1. Mechanical Chest Compression in Patients who are Unlikely to Survive (previously known as the LUCAS Trial)**

This study aims 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<sup>2</sup><sup>TM</sup>) and has been integrated into patient care by the Critical Care Paramedic teams across SECAMB's area.

During 2012/13 this study made steady progress although gaining the appropriate Research Ethics Committee permissions and subsequent acute trusts' R&D governance approvals was a slow process.

Ultimately the following hospitals were approved to participate in the study: William Harvey Hospital, Ashford, Kent; St George's Hospital, London; and St Peter's Hospital, Chertsey, Surrey and the study went live in 2012.

This study has not been without its challenges, as during the course of the study, general clinical developments were introduced within SECAMB enabling Critical Care Paramedics to use mechanical chest compression on any appropriate patient.

Therefore, whilst the clinical practices pertaining to the use of mechanical chest compression are being standardised throughout the Trust, this study has been temporarily suspended to assess what changes in protocol are required in order to apply for various external bodies' governance permissions. Once the relevant amendments have been agreed and the necessary permissions acquired, it is intended to re-commence the study.

#### **4.6.2. Research with Heart Attack Patients Project (Efficacy and safety of pre-hospital vs. in-hospital initiation of Ticagrelor therapy in STEMI Patients planned for percutaneous coronary intervention)**

Research with heart attack patients has been one of the milestones for SECAMB as this is the first portfolio adopted clinical trial that has been undertaken. This study focuses on patients having an ST segment elevation myocardial infarction (STEMI).

SECAMB is one of nine ambulance services in the UK 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). The study is being undertaken in a total of 12 countries.

As identified last year, Paramedics in Hastings had been trained in the study procedures and during the last 12 months Paramedics in Eastbourne and Ashford have also participated in this study.

Since March 2012 the number of patients enrolled in this study within SECAmb are as follows:

**Site reference 2803/Eastbourne = seven patients**

**Site reference 2804/Hastings = six patients**

**Site reference 2810/Ashford = six patients**

The governance procedures for this trial are robust and the sponsors are satisfied with progress and the way in which it is being managed and monitored.

As a first clinical trial for SECAmb this study is a success in terms of research implementation, management and monitoring.

#### **4.6.3. Transient Ischaemic Attack (TIA) Project (Evaluation of the ABCD2 score in pre-hospital assessment of patients with suspected Transient Ischaemic Attack (TIA): Pilot study)**

In a joint research project between SECAmb and the University of Surrey, SECAmb 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 crews in the pre-hospital setting, who are at high risk of stroke within seven and 90 days.

The approvals and permissions processes for this study have required extensive investment of time from SECAmb.

Unfortunately this study has not yet been approved to commence and the approvals process is on-going. However, SECAmb is optimistic that this study will commence before May 2013.

#### **4.7. Patient Transport Services (PTS)**

During 2012/13 four PTS surveys were undertaken in Sussex, two in Kent and one in Surrey, with the questions having been set by our Commissioners. The key findings from these surveys are listed as follows:

- + average overall satisfaction has been at 90%+ for all counties;
- + survey response rates have been around the 40% level which is extremely good;
- + the 'mix' of patients is reflective of the mix of the community in terms of ethnicity, demonstrating that overall access appears to be available to all; and
- + problems with access to make bookings has been the main concern in Surrey and Sussex which we believe is due to the introduction of the Patient Transport Bureau in Sussex and Central Booking Service in Surrey.

The survey questions were not specific enough to obtain real evidence, therefore, we will be working with patient groups and Commissioners to undertake three patient surveys with more focused questions.

#### 4.8. 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 listed four goals (top level details can be found as follows):

- + Patient Experience
  - Improve responsiveness to personal needs of patients.
- + Reduction in emergency and unplanned admissions with long-term conditions
  - Involved the implementation of the case management system (IBIS), actions to support the use of alternative pathways and actions to improve the use of the NHS Pathways triage system and Directory of Services.
- + Increase skill mix in workforce
  - To increase the level of clinical skill in the service.
    - Clinicians in Emergency Operations Centre (EOC).
    - Increase clinical skill in attending patients to maximise clinical care and use of agreed pathways.

#### + High Impact Innovation

- This indicator was to identify, plan and implement a programme to develop the relevant high impact innovations ready for the CQUIN gateway in 2013/14.
- "Digital by default" was the most relevant section of this Department of Health document for ambulance services, with the goal being to support the electronic transfer of data to GPs and community-based providers to minimise manual data entry and re-triage.

Section 5 entitled "CQUIN Framework" provides further detail on 2012/13.

#### 4.9. Clinical Pathways

In 2012/13 the four Clinical Pathways of Percutaneous Coronary Intervention (pPCI), Stroke, Major Trauma and End of Life Care have all been the subject of much work with colleagues in both primary and secondary care.

With the major changes happening in the NHS there has been some movement of networks and systems and to this end pPCI and Stroke pathways will be incorporated into the work of Strategic Clinical Networks.

Trauma and End of Life Care will be managed through operational delivery networks though at this time it is uncertain as to the exact methods of operation until further guidance is issued.

24/7 pPCI has been fully established across the SECAmb area with only one secondary care provider using a dual site rota.

Work is ongoing to further reduce the call to balloon time to 120 minutes. Education sessions have been provided by one pPCI unit which have been very well received by staff and further sessions are planned.

Stroke care is now provided on a 24/7 basis by all of the acute trusts in the SECAmb area with the exception of one site. Out of hours this site is covered by an adjacent acute trust. Some sites use a face to face method of delivering stroke care and some use telemedicine (where the stroke physician is remote to the patient).

End of Life Care work has been progressing with much liaison with hospice and other care providers and commissioners to ensure that patients are given appropriate care and kept in their preferred place of care with support rather than going to an A&E department, which may not be the best place for them.

Awareness of adult 'Do Not Attempt CPR' (DNACPR) documentation has been a regular feature with our staff and there has been much dialogue with police forces and coroners officers about the management of expected death. Paediatric DNACPR has been an issue that is currently being progressed.

Trauma Networks have been operational in Surrey and Sussex for the last 12 months (Kent Network becomes operational in April 2013) and there has been a steady increase in the number of patients who are bypassed directly to a major trauma centre.

SECAmb has introduced various medications to assist in trauma cases, these being Ketamine (used by CCPs only) Paracetamol IV and Tranexamic Acid for Paramedic grade clinicians. SECAmb staff have presented cases of interest to network forums to share learning with multi-disciplinary colleagues. There has also been provision of a Trauma Support Desk staffed by Paramedics from the air ambulance who provide advice and direction for staff in cases of trauma.

#### **4.10. Sustainability and Carbon Reduction**

During 2012/13 SECAmb established an Environmental Legal Compliance Register indicating the status of our legal compliance with the full range of environmental legislation. The Trust conducted an environmental audit of a sample of our buildings in order to test compliance with relevant pollution, waste, water and dangerous substances legislation. This resulted in a series of recommendations supporting improvements to procedures and changes to certain working practices.

Training has been provided to the Estates, HART and Make Ready project management teams in respect of the highest environmentally sustainable and low carbon standards required to ensure that the environment performance of our buildings exceeds that which is achievable by accreditation to BREEAM standards alone.

SECAmb has worked with the Carbon Trust to develop a high level Carbon Management Plan. This has provided a framework within which the Trust has been able to prioritise actions and projects to reduce carbon emissions. A key element of this has been to identify a carbon emissions baseline, with the main components being fleet and estates.

During 2012/13 we have also developed a Climate Change Adaptation Plan in order to ensure that the Trust understands the challenges likely to be faced as a result of the changing climate in the South East Region. This plan will ensure that SECAmb takes the associated climate related actions required to safeguard the delivery of its service in the face of disrupted weather and climate change events in the future.

Complementing the above, work has commenced and is on-going with the Energy Saving Trust on their "Plugged in Fleet Initiative" to identify whether it is possible for SECAmb to integrate electric and hybrid electric vehicles into its fleet to further reduce carbon emissions.

#### 4.11. Fleet Innovations

The Trust delivered some significant projects during 2012/13 in relation to the fleet replacement programme.

These included;

- + the procurement of 29 'modular' emergency ambulances, and the development of a Critical Care Paramedic (CCP) vehicle as a pilot;

- + large scale production and delivery of 85 multifunctional PTS vehicles to support the Surrey and Sussex contracts; and
- + the design build of two specialist major incident vehicles.

All schemes have been innovative in their own right, seeing the use of smart/ antibacterial components in vehicle technologies such as speed limiters and new construction methods. It is anticipated that this will see a reduction in Health Care Associated Infections (HCAIs) and a reduced carbon footprint.

#### 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 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 treat 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 8-minute response and 19-minute response target remain the same. Calls requiring a defibrillator are classed Red 1 and all other life-threatening emergencies as Red 2.

**Category C** – Previous Category C and some Category B calls now become new Category C “green calls” and these will be sub divided into four categories with varying response requirements ranging from an ambulance arriving to telephone advice, 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 who survived against all those patients who suffered a STEMI expressed as a percentage.
  - For the period April to October 2012, SECAmb reports that 89.2% of its patients with this condition received primary angioplasty within 150 minutes of the call for help. The national average was 88.2%.

### ***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 October 2012, SECAmb reports that 24.7% of its patients that had suffered a cardiac arrest had ROSC at arrival at hospital. The national average was 25.6%.

### ***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 October 2012, SECAmb reports that 5.8% of its patients who had suffered a cardiac arrest and arrived at hospital with ROSC, recovered to be discharged from hospital. The national average was 8.3%.

- South East Coast is below the national mean for both Survival to Discharge (All) and Survival to Discharge (Utstein). Survival to Discharge can vary greatly from month to month, largely due to small numbers. SECAmb will, however, be undertaking work to audit the clinical care against defined standards in the pre-hospital setting for patients experiencing cardiac arrest. We will also work with health care partners during 2013/14 to enable more information to be captured in regard to the patient journey post-handover at hospital.

#### ***Outcome following stroke for ambulance patients***

- + This indicator will measure the time it takes from the 999 call to the arrival at a specialist stroke centre of FAST-positive patients, so that they can be rapidly assessed for thrombolysis.
- For the period April to October 2012, SECAmb reports that it transported 62.6% of these patients to a specialist stroke centre within 60 minutes. The national average was 64.9%.

#### ***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 (2012/13) SECAmb was able to provide telephone advice to 9.7% 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 (2012/13) 13% of SECAmb's patients who were given telephone advice re-contacted SECAmb; while 32.8% of the patients treated at scene without the need for transportation to hospital re-contacted 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 2012/13 was 3.5%.

#### ***Time to answer calls***

- + This indicator will measure how quickly all 999 calls we receive are answered.
- SECAmb can report in 2012/13 the average (median) time to answer a call was three seconds.



### Service experience

+ Two patient surveys were carried out 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 were undertaken using data from June and November 2012, where both surveys showed an overall satisfaction level of 93%, however action plans from both surveys were implemented for areas requiring improvement.

### 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 (2012/13) was 77.9%.

### Category A 8-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 Category 'B' performance targets.

## Understanding the changes: at-a-glance guide

Call	999 call received and assessed by Emergency Operations Centre using AMPDS or NHS Pathways					
	Category A (Red)		Category C (Green)			
Assessment	<b>Red 1</b> Life-threatening requiring defib All echo codes	<b>Red 2</b> Immediately life-threatening All other category A	<b>Green 1</b> Serious but non life-threatening Serious clinical needed	<b>Green 2</b> Serious but non life-threatening Less serious clinical needed	<b>Green 3</b> Non life-threatening Non-emergency	<b>Green 4</b> Non life-threatening Non-emergency
Response	Face-to-face ambulance response		Face-to-face ambulance response	Face-to-face ambulance response	Telephone assessment a) Alternative pathway referral b) Upgrade to Red/Green 1/2 c) Advice given and call closed	Telephone assessment a) Alternative pathway referral b) Upgrade to Red/Green 1/2 c) Advice given and call closed
Performance	Within 8 minutes of call received (19 minute transport standard)		Within 20 minutes of call received	Within 30 minutes of call received	Within 20 minutes of call received	Within 60 minutes of call received
	<b>Quality of care given to the patient and the difference that made</b> All patient care given will be now assessed using 11 new Clinical Quality Indicators - including outcome of cardiac arrest, ST elevation myocardial infarction, stroke, service experience and telephone advice given - to measure type, quality and outcome of treatment					

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## 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 for 2012/13 that SECAmb is required to declare.

### Statements of Assurance from the Board

#### *Information on the Review of Services*

During 2012/13 SECAmb provided three and sub-contracted 18 NHS services.

SECAmb has reviewed all the data available to them on the quality of care in all 21 of these relevant health services.

The income generated by the relevant health services reviewed in 2012/13 represents 5.3%<sup>5</sup> of the total income generated from the provision of relevant health services by SECAmb for 2012/13.

### Clinical Audits

During 2012/13 four national clinical audits and one national confidential enquiries covered relevant health services that SECAmb provides.

During 2012/13 SECAmb participated in 100% (one hundred per cent) national clinical audits and 100% (one hundred per cent) 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 2012/13 are as follows:

- + Clinical Performance Indicators;
- + Clinical Indicators subset of Ambulance Quality Indicators;
- + Myocardial Infarction National Audit Programme (MINAP);
- + National Research Asthma Deaths (NRAD); and
- + Sentinel Stroke National Audit Programme (SSNAP).

The national clinical audits and national confidential enquiries that SECAmb participated in during 2012/13 are as follows:

- + Clinical Performance Indicators;
- + Clinical Indicators subset of Ambulance Quality Indicators;
- + Myocardial Infarction National Audit Programme (MINAP);
- + National Research Asthma Deaths (NRAD); and
- + Sentinel Stroke National Audit Programme (SSNAP)

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<sup>5</sup> 5.3% represents sub contracted services (relevant health services) as a proportion of total services provided.

The national clinical audits and national confidential enquiries that SECAmb participated in, and for which data collection was completed during 2012/13, 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:

- + 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%); and
- + Sentinel Stroke National Audit Programme (SSNAP) Data collection not yet requested.

The reports of four national clinical audits were reviewed by the provider in 2012/13 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; and
- + delivering the best care to patients suffering a stroke.

The reports of nine local clinical audits were reviewed by the provider in 2012/13 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 relevant health services provided or sub-contracted by SECAmb in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 19.

### **CQUIN Framework**

A proportion of SECAmb income in 2012/13 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 relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2012/13 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](http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275)

**Quality Report:** An additional 2.5% of income in 2012/13 for CQUIN schemes was available which totalled £3,500k. The goals were around Patient Experience (0.20% - £280k); Case Management (0.35% - £490k); Use of Alternative Pathways (0.65% - £910k); Utilising NHS Pathways Triage and Directory of Services (0.50% - £700k); Increased Skill Mix in EOC (0.40% - £560k); Increase Skill Mix at Scene (0.20% - £280k) and High Impact Innovations – Digital by Default (0.20% - £280k).

Due to the complexity of the programme, quarterly targets included a reliance on other parts of the local health economy to deliver elements of the above schemes. Unfortunately, these elements did not all materialise during 2012/13.

2012/13 CQUIN income = £1,295,000. (In 2011/12 the financial payment for CQUIN was £1,847,000).

For 2013/14, SECAmb is working with Commissioners to set achievable CQUIN targets which can deliver benefits to the wider health economy over future years.

### **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 2012/13.

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 2012/13 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 2012/13 was 70% and was graded RED on the IGT grading scheme.

SECAmb was not subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission. (Payment by Results does not currently apply to services provided by Ambulance Trusts).

SECAmb will be taking the following actions to improve data quality:

- + develop improvement plan for IG training 2013-14;
- + implementation of the Southern Region procurement programme for electronic Patient Clinical Record (ePCR);
- + on-going Development and Review of automated data collection systems; and
- + peer Review of Data Submissions to DH, with other Ambulance Services.

## Core Indicators (new requirement for 2012/13)

The following indicators are a new addition to the Quality Account/Report and have been recommended by the National Quality Board for inclusion. The intention is that Trusts will be required to report on:

- + their performance against these indicators;
- + the national average;
- + the highest and lowest NHS Trusts; and
- + a supporting commentary which may explain variation from the national average and any steps taken or planned to improve quality.

Prescribed Information – Reporting Period 1/4/12 – 31/3/13	Formal Statement	Performance Data 1/4/12 – 31/3/13	Related NHS Outcomes Framework Domain
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of Category A telephone calls (Red 1 and Red 2 calls) resulting in an emergency response by the trust at the scene of the emergency within 8 minutes of receipt of that call during the reporting period.	<p>The South East Coast Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons - in line with the guidance issued in the National Operating Framework Technical Guidance 2012/13.</p> <p>The South East Coast Ambulance Service NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by the detailed planning of resources in line with predicted demand.</p>	<p>SECAmb performance = 77.9%</p> <p>The National Average = 75.5%</p> <p>Highest and Lowest = 77.9% and 70.6%</p>	<p>Domain 1: Preventing People from dying prematurely</p> <p>Ambulance Trusts (Ref 14)</p>
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of Category A telephone calls resulting in an ambulance response by the trust at the scene of the emergency within 19 minutes of receipt of that call during the reporting period.	<p>The South East Coast Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons - in line with the guidance issued in the National Operating Framework Technical Guidance 2012/13.</p> <p>The South East Coast Ambulance Service NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by the detailed planning of resources in line with predicted demand.</p>	<p>SECAmb performance = 97.3%</p> <p>The National Average = 96%</p> <p>Highest and Lowest = 98.2% and 91.9%</p>	<p>Domain 1: Preventing People from dying prematurely</p> <p>Ambulance Trusts (Ref 14.1)</p>

Prescribed Information – Reporting Period 1/4/12 – 31/3/13	Formal Statement	Performance Data 1/4/12 – 31/3/13	Related NHS Outcomes Framework Domain
<p>The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients with a pre-existing diagnosis of suspected ST elevation myocardial infarction who received an appropriate care bundle from the trust during the reporting period.</p>	<p>The South East Coast Ambulance Service NHS Foundation Trust considers that this percentage is as described for the following reasons; the lower than anticipated performance is largely due to difficulties associated with robust capture and extraction of data from paper care records, rather than concerns in regard to the actual clinical care delivered to our STEMI patients.</p> <p>The South East Coast Ambulance Service NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, and intends to move to an electronic patient record within 12-18 months, but will in the interim deliver an annual programme of clinical audit education and awareness to clinicians; develop a clinical record quality monitoring tool for Clinical Team Leaders; and share outcome data to progress the quality of services offered within the NHS.</p>	<p>SECAmb performance (Apr-Oct 12) = 76.3%</p> <p>The National Average = 77.7%</p> <p>Highest and Lowest = 93.5% and 67.8%</p>	<p>Domain 1: Preventing People from dying prematurely</p> <p>Domain 3: Helping people to recover from episodes of ill health or following injury</p> <p>Ambulance Trusts (Ref 15)</p>
<p>The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients with suspected stroke assessed face to face who received an appropriate care bundle from the trust during the reporting period.</p>	<p>The South East Coast Ambulance Service NHS Foundation Trust considers that this percentage is as described for the following reasons; the lower than anticipated performance is largely due to difficulties associated with robust capture and extraction of data from paper care records, rather than concerns in regard to the actual clinical care delivered to our stroke patients.</p> <p>The South East Coast Ambulance Service NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, and intends to move to an electronic patient record within 12-18 months, but will in the interim deliver an annual programme of clinical audit education and awareness to clinicians; develop a clinical record quality monitoring tool for Clinical Team Leaders; and share outcome data to progress the quality of services offered within the NHS.</p>	<p>SECAmb performance = 90.2%</p> <p>The National Average = 95.5%</p> <p>Highest and Lowest = 100% and 90.2%</p>	<p>Domain 1: Preventing People from dying prematurely</p> <p>Domain 3: Helping people to recover from episodes of ill health or following injury</p> <p>Ambulance Trusts (Ref 16)</p>

Prescribed Information – Reporting Period 1/4/12 – 31/3/13	Formal Statement	Performance Data 1/4/12 – 31/3/13	Related NHS Outcomes Framework Domain
<p>The data made available to the NHS trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust “responsiveness to the personal needs of its patients” during the reporting period.</p>	<p>The South East Coast Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons – two non-conveyed patient surveys undertaken.</p> <p>The South East Coast Ambulance Service NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by implementation of action plans following each survey.</p>	<p>SECAmb performance = 93% overall satisfaction rate in both surveys</p>	<p>Domain 4: Ensuring that people have a positive experience of care</p> <p>Ambulance Trusts (Ref 20)</p>
<p>The data made available to the NHS trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.</p>	<p>The South East Coast Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons – question included within staff survey.</p> <p>The South East Coast Ambulance Service NHS Foundation Trust intends to take/has taken the following actions to improve this percentage, and so the quality of its services, by: staff survey results shared widely; staff survey summit being planned for June 2013, with summit to review and ‘test’ results for 2012; will agree five priority areas to focus on in 2013; mini action plans to be developed, with lead identified for each; progress to be monitored and reported through appropriate groups.</p>	<p>SECAmb Response Rate = 49% (54% agreed or strongly agreed with being happy to recommend the trust as a provider of care to friends/family)</p> <p>The National Average Response Rate = 42%</p> <p>Highest and Lowest Response Rates = 58% and 32%</p>	<p>Domain 4: Ensuring that people have a positive experience of care</p> <p>All trusts (Ref 21)</p>

Prescribed Information – Reporting Period 1/4/12 – 31/3/13	Formal Statement	Performance Data 1/4/12 – 31/3/13	Related NHS Outcomes Framework Domain
<p>The data made available to the NHS trust or NHS foundation trust by the National Reporting and Learning Service (NRLS) with regard to the number and, where available, rate of patient safety incidents that occurred within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.</p>	<p>The South East Coast Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons:</p> <p>The NRLS have reported that directly comparing the number of reports received from organisations with other ambulance organisations can be misleading as ambulance organisations can vary in size and activity. The NRLS are currently looking into ways to make comparisons across this cluster more effective.</p> <p>It is therefore advised that comparisons drawn within this report should not be used as a basis for assurance.</p> <p>The South East Coast Ambulance Service NHS Foundation Trust intend to take the following actions to improve this number and so the quality of its services, by ensuring that employees are encouraged to report ALL incidents which relate to patient safety which may mean an increase on reported numbers in subsequent reports. This may not mean the Trust is less safe but rather that it is reporting more no harm or low harm incidents. In addition we have identified that Serious Incidents have not previously been included in the NRLS figures and as some of them relate to severe harm or death it is likely that this category will also increase in the next report.</p>	<p>Dataset for reporting period 01/04/12 – 30/09/12 published by NRLS in March 2013.</p> <p>SECAmb total number of incidents occurring = 237</p> <p>Total number of incidents that resulted in severe harm or death = 1</p> <p>Percentage of incidents that resulted in severe harm or death = 0.4%</p> <p>The National Ambulance Cluster Average total number of incidents occurring = 214</p> <p>Highest = 452 Lowest = 63</p> <p>The National Ambulance Cluster average number of incidents that resulted in severe harm or death = 3</p> <p>Highest = 13 Lowest = 0</p> <p>The National Ambulance Cluster average percentage of incidents that resulted in severe harm or death = 2.1%</p> <p>Highest = 7.1% Lowest = 0%</p>	<p>Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm.</p> <p>All Trusts (Ref 25)</p>



# Part 3 <sup>(Footnote 6)</sup>

## 6. Review of Quality Performance

This section provides an overview of the quality of care offered by SECAMB on performance in 2012/13 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 (PCTs), Strategic Health Authorities (SHAs) and other related organisations and stakeholders.

Every SIRI is investigated to identify the root causes, learning outcomes and develop action plans for implementation which will prevent, as far as practicably possible, similar incidents recurring. We provide our commissioned Primary Care Trust (PCT) with regular updates on the investigation process and our findings are presented to them and/or the SHA on completion of the investigation. It is only with the PCT and/or SHA approval of our investigation that a SIRI can be closed. The reporting groups will be changed from April 2013 to reflect the reorganisation of the NHS.

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

The following information has been collated from our SIRI management database and our current incident reporting system (DATIX).

1 April 2012 to 31 March 2013	
Ambulance (General)	19
Ambulance Accident – RTC	2
Ambulance Accidental Injury	1
Ambulance Delay	2
Confidential Information Leak	2
Drug Incident (General)	4
Other	1
<b>Total number of SIRIs investigated</b>	<b>31</b>

Figure 2: Number of Reported SIRIs (April 2012 to March 2013)

1 April 2011 to 31 March 2012	
Ambulance (General)	18
Ambulance Accidental Injury	1
Ambulance Delay	8
Confidential Information Leak	4
Drug Incident (General)	2
Hospital Transfer Issue	3
Other	3
<b>Total number of SIRIs reported</b>	<b>39</b>

Figure 3: Number of Reported SIRIs (April 2011 to March 2012)

<sup>6</sup>. PART 3 = Other information (NHS Foundation Trust Annual Reporting Manual 2012/13)

### 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 contra indications associated with drugs. The administration of drug types is bound by 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 Trust was inspected by the Care Quality Commission (CQC) in February 2013 where they identified that medicines were being administered appropriately by clinical staff, however it was identified that the Trust did not always follow its own policies and procedures regarding the arrangements for obtaining, recording and storage of medicines. As a consequence the CQC assessed that we were unable to satisfy them that we met the standard for the management of medicines and an action plan to address this shortfall will be monitored by the CQC.

Where medication errors do occur the most common circumstances are incorrect drug doses and incorrect drug types. SECAmb monitors both of these 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.

The information in figures 4 and 5 has been collated from SECAmb's Incident Reporting system (DATIX) and is based on clinical patient safety incidents, both actual and near miss.

2012 –2013	Incorrect drug dose administered	Incorrect drug type	Totals per month
April	2	0	<b>2</b>
May	2	1	<b>3</b>
June	2	0	<b>2</b>
July	0	1	<b>1</b>
Aug	0	0	<b>0</b>
Sep	4	0	<b>4</b>
Oct	0	1	<b>1</b>
Nov	1	0	<b>1</b>
Dec	0	1	<b>1</b>
Jan	0	3	<b>3</b>
Feb	0	1	<b>1</b>
Mar	0	0	<b>0</b>
<b>Total</b>	<b>11</b>	<b>8</b>	<b>19</b>

Figure 4: Medication Errors (April 2012 to March 2013)

2011 – 2012	Incorrect drug dose administered	Incorrect drug type	Totals per month
April	1	2	<b>3</b>
May	1	0	<b>1</b>
June	0	0	<b>0</b>
July	0	2	<b>2</b>
Aug	0	2	<b>2</b>
Sep	3	0	<b>3</b>
Oct	0	1	<b>1</b>
Nov	0	1	<b>1</b>
Dec	0	1	<b>1</b>
Jan	0	0	<b>0</b>
Feb	3	1	<b>4</b>
Mar	2	0	<b>2</b>
<b>Total</b>	<b>10</b>	<b>10</b>	<b>20</b>

Figure 5: Medication Errors (April 2011 to March 2012)  
(Updated from previously published figures due to receipt of additional reports)

### 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 local incident reporting system (DATIX). All incident reports and their subsequent investigations are reviewed, where it is identified that an incident could have or did lead to harm for patients receiving NHS funded healthcare the National Reporting and Learning System (NRLS) are informed. The NRLS is provided with the details of the incident, the stage of care and the affect on the patient, such as degree of harm.

The Trust undertakes regular uploads to the NRLS to ensure that information is available in a timely manner however the process of identification and clarification can produce lead in times for upload who could lead to a temporary discrepancy in figures.

SECAMB has a private arm that provides staff and emergency vehicles for events and undertakes the transport of private patients who request transfers from hospitals, nursing homes, private homes and discharges. Patients under the care of SECAMB's private arm are not receiving NHS-funded healthcare and as a result any patient safety incident that occurred during the course of this commercial contract would not be reportable via the NRLS.

Patient safety incidents that occur within the commercial arm of the Trust would however be reported and investigated internally via the Trust incident reporting system (DATIX). Within the financial year 2012/13 there have been no patient safety incidents categorised as occurring within the private arm of SECAMB.

Patient safety incidents are one of our risk management Key Performance Indicators and as such are reported at the Risk Management and Clinical Governance Committee, Central Health and Safety Working Group and Local Health and Safety Sub Groups. Benchmarking of these occurrences is undertaken in association with the National Ambulance Service Quality and Governance and Risk Directors (QGARD).

The information in figures 6 and 7 has been collated from SECAMB's incident reporting system (DATIX) and is based on both actual and near miss incidents.

1 April 2012 to 31 March 2013	
Patient safety incident: Clinical	351
Patient safety incident: Non Clinical	101
<b>Totals:</b>	<b>452<sup>7</sup></b>

Figure 6: Number of Patient Safety Incidents (April 2012 to March 2013)

1 April 2012 to 31 March 2013	
Patient safety incident: Clinical	142
Patient safety incident: Non Clinical	64
<b>Totals:</b>	<b>206</b>

Figure 7: Number of Patient Safety Incidents (April 2011 to March 2012)  
(Updated from previously published figures due to receipt of additional reports)

Following a trial period SECAMB introduced a new system of online incident reporting (DATIX Web) across the Trust in January 2012. The introduction of this electronic system allows Trust staff to describe the occurrence being reported and directly record whether it affected patient safety and the degree of harm (if any) it caused. This new system allows the clinician to decide whether it is a patient safety incident rather than a non clinical administrator in a central team. All these incidents are investigated by nominated managers and reviewed / approved by members of the Compliance department to ensure consistency and accuracy.

The introduction of this system and the associated training, publications and feedback to staff has encouraged the reporting of patient safety incidents. A significant increase in the reporting of no harm / near miss patient safety incidents has been associated with the introduction of this system; this has been encouraged by the Trust as a key feature of a strong incident reporting culture.

See section 7.2 for information regarding the degree of harm suffered as a result of patient safety incidents as reported to the National Reporting and Learning System (NRLS).

<sup>7</sup> See second paragraph in section 6.1.3

## 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 published by the Group.

Data sampling is manual in SECamb, based on scrutiny by the Clinical 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.

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. In 2012/13, two new pilot conditions of febrile convulsion and trauma (below knee fracture) were introduced into the CPIs to replace the conditions of stroke and ST Segment Elevation Myocardial Infarction (STEMI) that are now reported as clinical quality indicators. The first cycles of these pilot conditions have been submitted and work continues at a national level to effectively measure these new indicators.

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 again focussed on in this report.

**6.2.1. 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. Our performance in the first two quarters of 2012/13 for getting FAST (**F**acial weakness, **A**rm weakness, **S**peech problems, **T**est all three) positive patients to treatment centres within 60 minutes of a face to face assessment is shown in figure 8 as follows.

**FAST positive patients at receiving unit <60 mins**

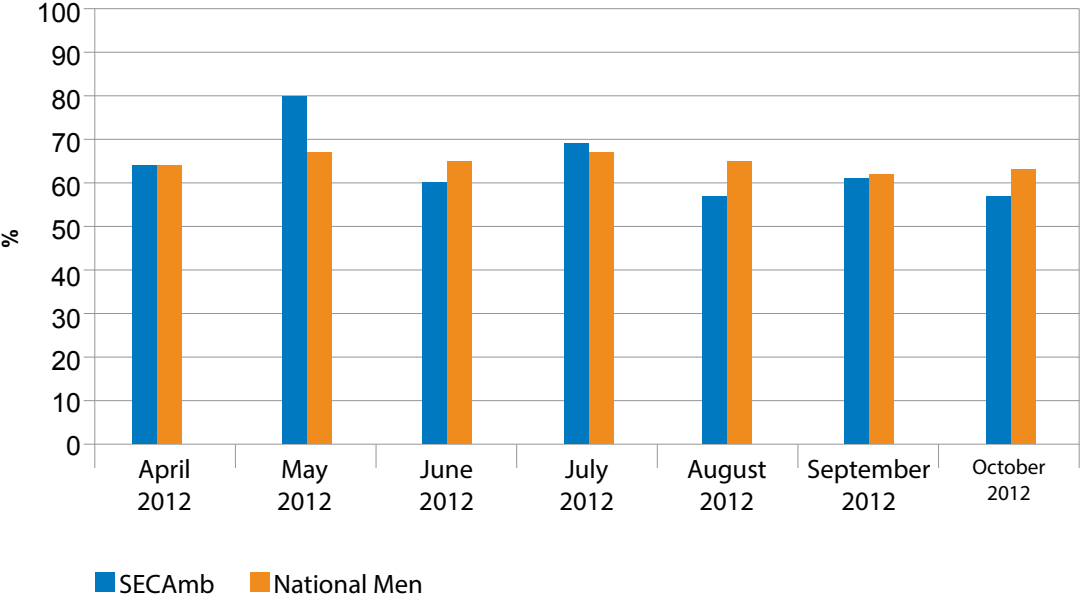


Figure 8: Stroke Care Data (April 2012 - October 2012)

**6.2.2. Asthma:** The indicators in figure 9 show SECAMB's performance for the last two completed 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.

**SECAMB Asthma Performance**

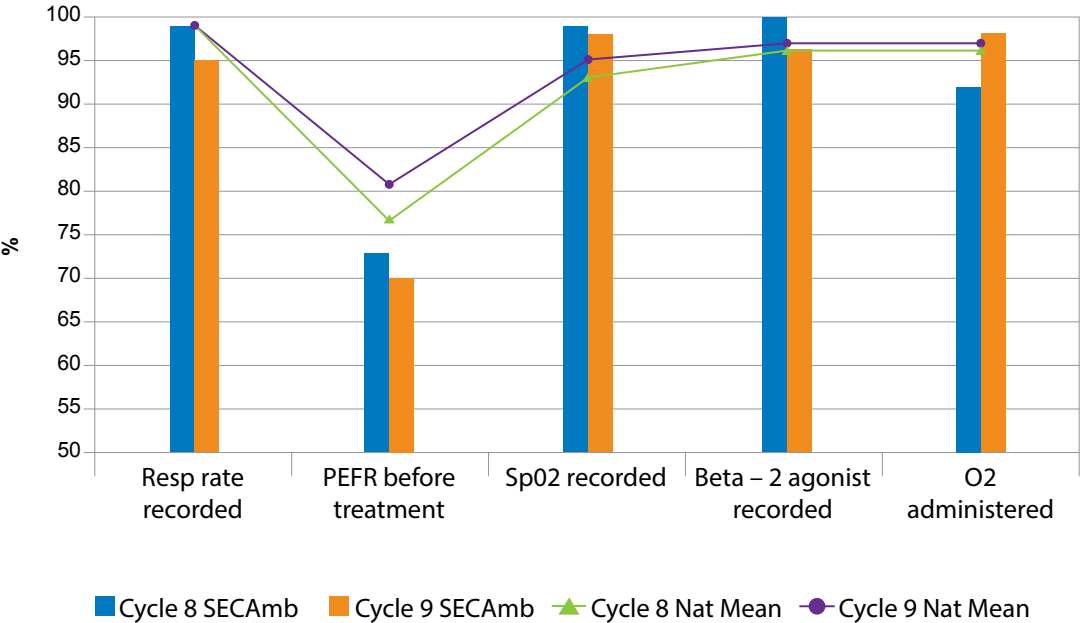


Figure 9: Asthma Data (February 2012 to July 2012)

**6.2.3. Hypoglycaemia:** The indicators in figure 10 show SECamb's performance for the last two completed 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. The indicator of 'direct referral made to an appropriate health professional' has been formally included since cycle 8 (see figure 10 as follows).

**SECamb Hypoglycaemia Performance**

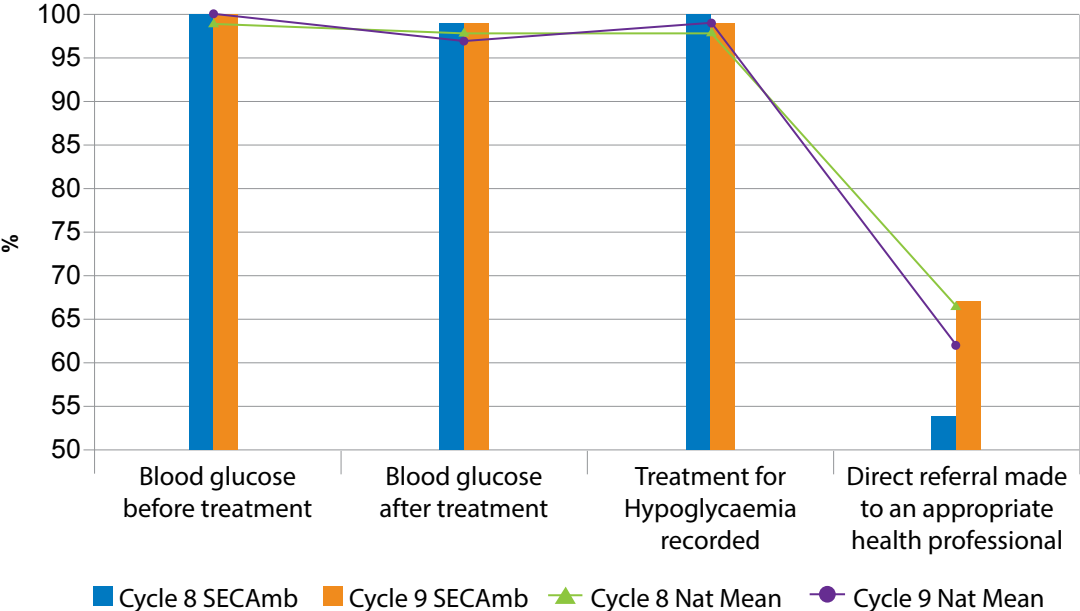


Figure 10: Hypoglycaemia (January 2012 to June 2012)

**6.3. Patient Experience Indicators**

**6.3.1. Patient Advice and Liaison Service (PALS)**

Our PALS team provides help and information for patients, their carers and relatives, other NHS organisations and the general public who have queries or concerns about SECamb's care/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 and direct them to agencies who can provide support 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) and Compliance Working Group (CWG) every two months.



The RMCGC report is also shared at each public Board meeting, and is provided to our Commissioners at their Quality Focus meetings.

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.

SECAMB acknowledges the importance of an effective and efficient PALS service and recognises that PALS enquiries provide useful management information about service quality, reputation and staffing issues from the perspective of patients, their carers and the wider population.

During 2012/13 our PALS team handled 2133 enquiries, broken down as follows:

Enquiry Type	2012/13	2011/12
Administration	3	13
Communication issues	52	20
Information request	685	583
Lost property (Note: PALS no longer handle lost property issues)	113	426
Miscellaneous	100	71
Patient care	328	200
Issues raised by SECAMB staff	1	2
Concern about staff	322	308
Timeliness	217	134
Transport	312	76
<b>Totals:</b>	<b>2133</b>	<b>1835</b>

### 6.3.2. Compliments

People, including our staff, are often surprised to find that SECAMB receives more letters and calls thanking our staff for the wonderful work they do ('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 report provided every two months to the Risk Management and Clinical Governance Committee (RMCGC), the Board and to the Commissioners Quality Focus meeting.

All compliments received are recorded, 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 our Chief Executive.

During 2012/13 SECAMB received 1318 compliments, thanking our staff for the treatment and care they provide. This represents a 25% increase over 2011/12.

Compliments are highly regarded by our staff and an important morale-booster, as well as providing a useful barometer of patient satisfaction.

Compliments	2012/13	2011/12
<b>Totals:</b>	1318	1051

### 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 we provide, as this valuable feedback helps us to learn and continually improve.

During 2012/13 we made over one million emergency responses and PTS journeys and received 349 formal complaints. Although the national target to respond to formal complaints within 25 days no longer exists, SECAmb continues to be committed to responding to as many as possible within this timeframe.

When a formal complaint is received a manager is appointed to investigate, who on most occasions 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 349 complaints for the year 2012/13 had been concluded, with outcomes as follows:

Complaint Outcome	2012/13	2011/12
Complaint justified	97	98
Justified in part	90	93
Complaint unjustified	58	66
Unproven	30	18
<b>Totals:</b>	<b>275</b>	<b>275</b>

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 disseminated 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.

## 7. Assurance on Mandatory Performance Indicators

### 7.1 Response Times

#### 7.1.1 Category A call – emergency response within 8 minutes (17) 75% 1.0 Quarterly

(SECAmb's performance for the year 2012/13 was 77.9% and for the last quarter 72.2%)

- + 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.
- + **Data 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.

#### 7.1.2 Category A call – ambulance vehicle arrives within 19 minutes (17) 95% 1.0 Quarterly

(SECAmb's performance for the year 2012/13 was 97.3 % and for the last quarter 96.5%)

- + 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.

+ **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 Patient safety incidents reported in 2012/13

**7.2.1** The National Reporting and Learning Service (NRLS) was established in 2003. It enables patient safety incident reports to be submitted from NHS organisations to a national database. This data is then analysed to identify hazards, risks and opportunities to improve the safety of patient care.

A patient safety incident is defined by the NRLS as ‘any unintended or unexpected incident(s) that could or did lead to harm for one or more person(s) receiving NHS funded healthcare’.

SECamb has reported 451 patient safety incidents to the NRLS during 2012/13. Each report includes an assessment of the grade of harm suffered as a result of the patient safety incident. 2.2% of SECamb’s patient safety incidents reported to the NRLS record the grade of harm as ‘severe’ or ‘death’.

Following investigation the grade of harm recorded may be adjusted to represent the increased understanding SECamb has gained into the nature of the patient safety incident, where this occurs the incident will be updated to the NRLS.

## 7.2.2 Patient safety incidents reported to the National Reporting and Learning System (NRLS) = 451

### 7.2.2.1 Indicator description

Patient safety incidents reported to the National Reporting and Learning Service (NRLS).

### 7.2.2.2 Indicator construction

The number of incidents as described above.

A patient safety incident (PSI) is defined as 'any unintended or unexpected incident(s) that could or did lead to harm for one or more person(s) receiving NHS funded healthcare'.

### 7.2.2.3 Indicator format

Whole number.

## 7.2.3 Safety incident involving severe harm or death = 2.2%

### 7.2.3.1 Indicator description

Patient safety incidents reported to the National Reporting and Learning Service (NRLS), where degree of harm is recorded as 'severe harm' or 'death', as a percentage of all patient safety incidents reported.

### 7.2.3.2 Indicator construction

**7.2.3.2.1 Numerator:** The number of patient safety incident recorded as causing severe harm / death as described above.

The 'degree of harm' for PSIs is defined as follows:

- **'severe'** – the patient has been permanently harmed as a result of the PSI, and
- **'death'** – the PSI has resulted in the death of the patient

**7.2.3.2.2 Denominator:** The number of patient safety incidents reported to the National Reporting and Learning Service (NRLS).

### 7.2.3.3 Indicator format

Standard percentage.

## 7.3 Audit Findings on Patient Safety Incidents

**7.3.1** The Department of Health issued confirmation of a change to the audit requirements relating to standardising and mandating the local indicator for all Foundation Trusts. In 2011/12 NHS Foundation Trusts were asked to gain assurance – in the form of a private assurance report to the Board – over one local indicator which was selected by the Governors.

**7.3.2** For the reporting period (2012/13) all Foundation Trusts, as a mandatory requirement, gained assurance in the number and where available, rate of patient safety incidents that occurred within SECAMB during 2012/13, and the percentage of such patient safety incidents that resulted in severe harm or death. This is instead, and not in addition to, the locally chosen Governors' indicator. The requirement for a private assurance report to the Board remains.

**7.3.3** An indicator looking at patient harm and patient safety is consistent with the NHS Outcomes Framework 2012/13 and its purpose to "drive quality improvement and outcome measurement throughout the NHS by encouraging a change in culture and behaviour, including a stronger focus on tackling health inequalities".

It is also consistent with Monitor's duty to protect and promote the interest of people who use healthcare services, and it has the benefit that it is applicable to all Foundations Trusts (mental health, ambulance and acute).

**7.3.4** The Auditors commenced an audit in March 2013. The scope of the audit was *"To evaluate the adequacy of risk management and control within the system and the extent to which controls have been applied, with a view to providing an opinion. Control activities are put in place to ensure that risks to the achievement of the organisation's objectives are managed effectively"*.

**7.3.5** Below are 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 area are suitably designed, consistently applied and effective."*

**7.3.6** There are two recommendations of work to be carried out, as follows:

**7.3.6.1** The Trust should submit all types of patient safety incidents to the NRLS in a timely manner in particular the Death & Severe Harm incidents.

**7.3.6.2** The Death & Severe Harm patient safety incidents should be reflected in the Risk Management KPI report presented to the Risk Management and Clinical Governance Committee.

**7.3.7** The above recommendations will be completed by the end of June 2013.

## 8. Statement of Directors' Responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare Quality Accounts for each financial year. 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 is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2012 to June 2013
  - Papers relating to Quality reported to the Board over the period April 2012 to June 2013

- Feedback from the commissioners dated 22 May 2013
- Workshop with the governors took place on 21 February 2013 and subsequent feedback on the draft document was obtained April/May 2013.
- Workshop with LINks/Local Healthwatch organisations took place on 21 February 2013 and subsequent feedback on the draft document was obtained April/May 2013
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated 5 July 2012
- The national patient survey (no routine national annual patient survey is required of ambulance services)
- The 2012 national staff survey – dispatched by 24 September 2012, closed 5 December 2012
- The Head of Internal Audit's annual opinion over the trust's control environment dated 15 May 2013
- CQC quality and risk profiles dated 6 March 2013.

- + 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](http://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](http://www.monitor-nhsft.gov.uk/annualreportingmanual)).

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



**Chairman**  
29 May 2013



**Chief Executive**  
29 May 2013



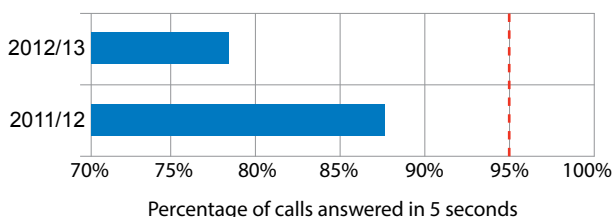
## 9. Overview of the patient journey/ experience during 2012/13

The following section describes SECAmb's performance against selected metrics which have been chosen to measure its performance against.

### 9.1. Taking the 999 Call

During 2012/13 SECAmb answered 78.28% of the 761,416 emergency calls it received in less than five seconds compared with the previous year of 87.61% (688,700 emergency calls), with the national target being 95%.

#### SECAmb Emergency Call Pickup Performance (target 95%)



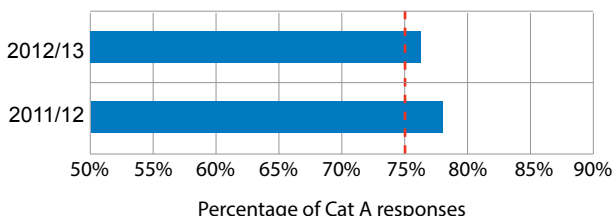
Data Source: info.secamb and KA34

### 9.2. Response Times

#### 9.2.1. Category A 8 Minute Response

For the period 2012/13, SECAmb responded to 265,988 Category A calls of which we were able to provide a response within eight minutes 77.9% of the time against the target of 75%. In comparison during 2011/12 SECAmb responded to 77.6% of Category A responses within eight minutes.

#### SECAmb Cat 'A' 8 minute performance (target 75%)

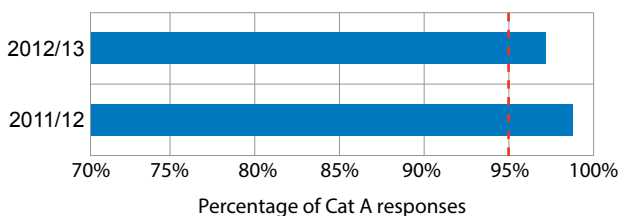


Data Source: KA34

#### 9.2.2. Category A 19 Minute Response

For 2012/13, SECAmb provided a response to Category A 19 minute response calls 97.3% of the time compared to 98.1% for 2011/12 against the national target of 95%.

#### SECAmb Cat 'A' 19 minute performance (target 95%)

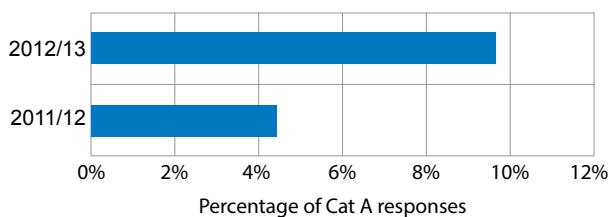


Data Source: KA34

#### 9.2.3. Hear and Treat

During 2012/13 SECAmb provided telephone advice to 9.7% of emergency calls received into our Emergency Operations Centres. This is an increase of 5.5% on 2011/12.

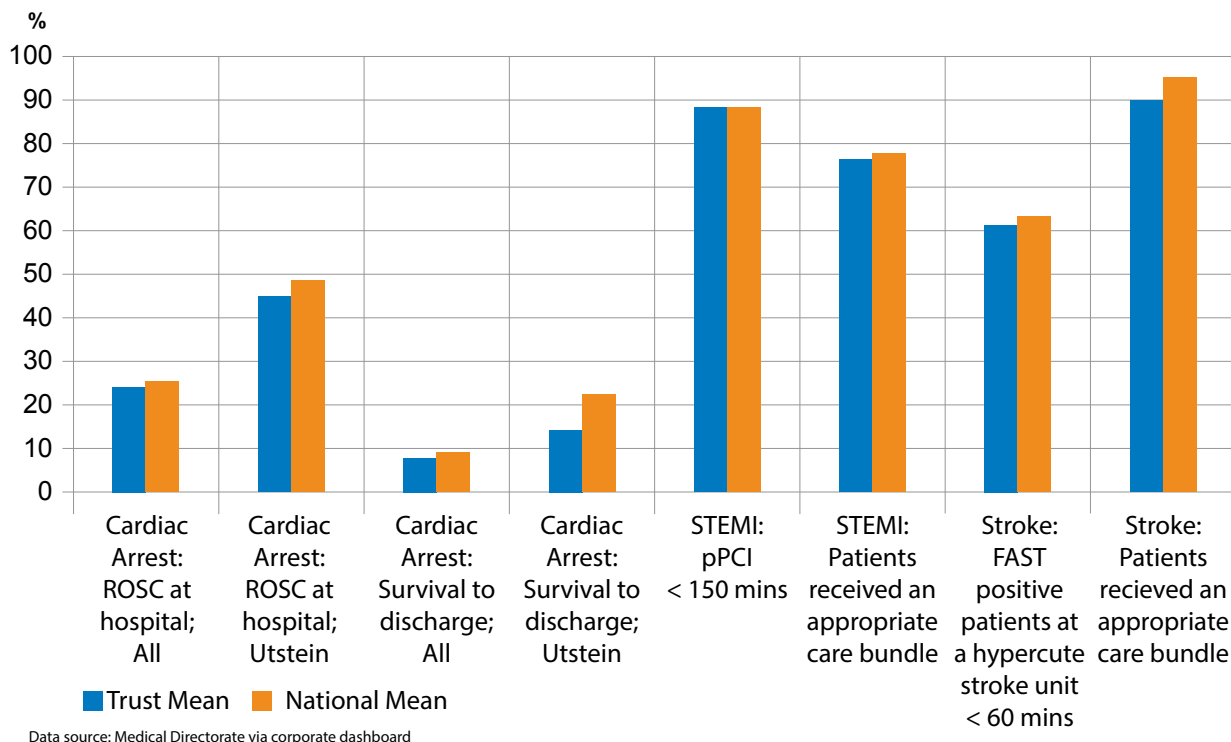
#### SECAmb Hear and Treat



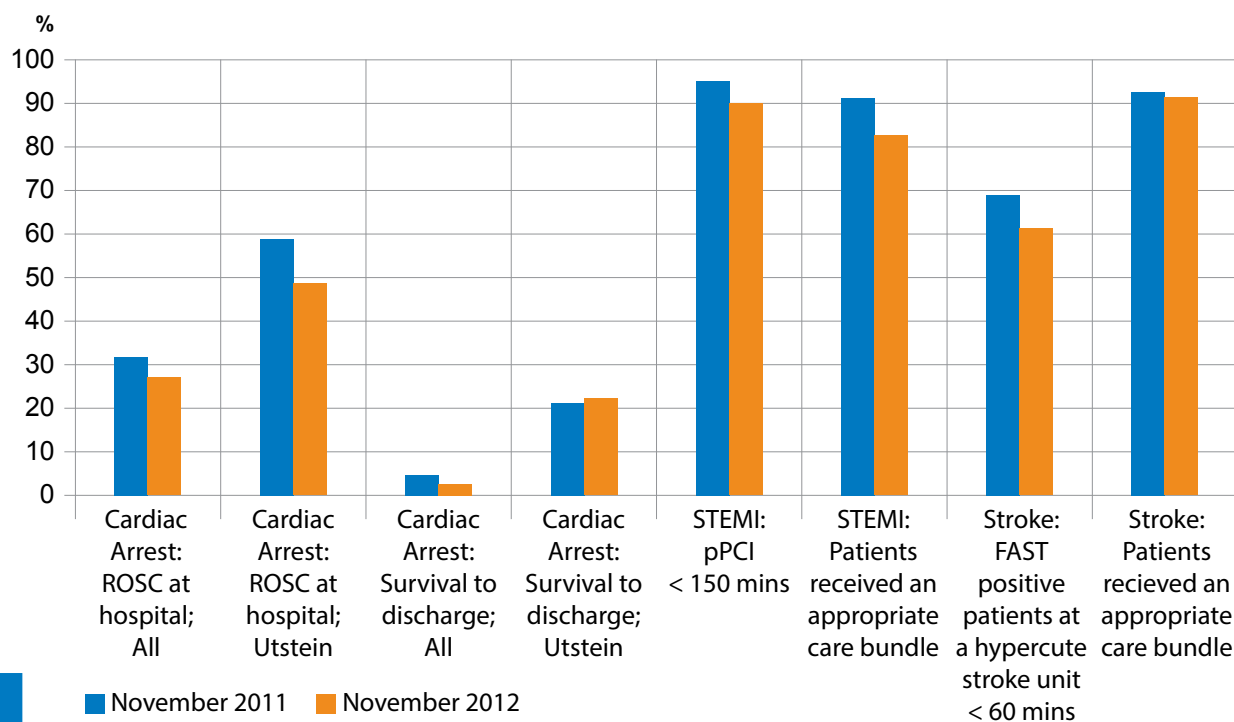
Data Source: Corporate Dashboard

### 9.2.4. Outcome of Care

#### Clinical outcome indicator performance: April-October 2012



#### Trust comparative clinical outcome indicator performance

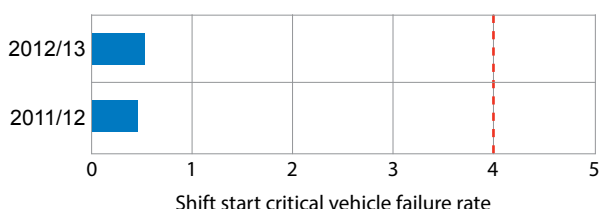


## 9.2.5. Patient Safety

### 9.2.5.1. Make Ready Only A&E Critical Vehicle Failure Rate per 25,000 miles (shift start)

The make ready A&E critical vehicle failure rate at shift start for 2012/13 was 0.46 compared with 0.54 for 2011/12 (shift start).

#### SECamb A&E Critical Vehicle Failure Rate – Shift Start (yearly average | max limit = 4)

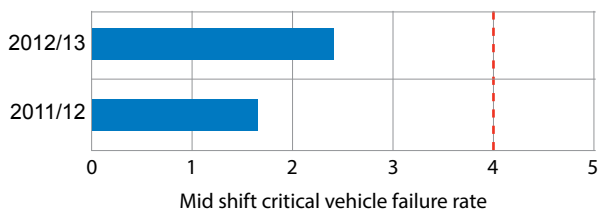


Data source: info.secamb

### 9.2.5.2. Make Ready Only A&E Critical Vehicle Failure Rate per 25,000 miles (mid shift)

The make ready A&E critical vehicle failure rate at shift start for 2012/13 was 2.38 compared with 1.60 for 2011/12.

#### SECamb A&E Critical Vehicle Failure Rate – Mid Shift (yearly average | max limit = 4)

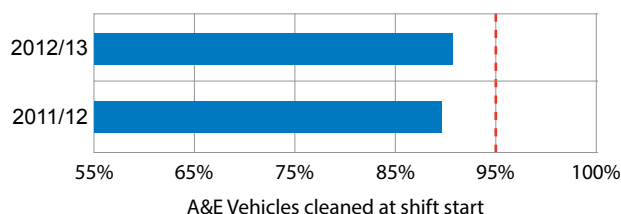


Data source: info.secamb

### 9.2.5.3. Make Ready Only A&E Vehicles Cleaned at Shift Start

During 2012/13 we planned to clean 34,626 vehicles at the start of shift and achieved 31,279 (90.33%) of these. This was a slight improvement on 2011/12 of 22,339 (89.35%) against the target of 95%.

#### SECamb Make Ready A&E Vehicles Cleaned at Shift Start (target 95%)

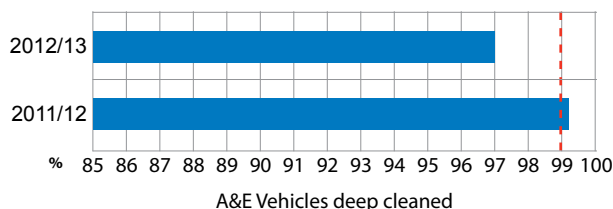


Data source: info.secamb

### 9.2.5.4. Make Ready Only A&E Vehicles Deep Cleaned

During 2012/13, 864 make ready vehicles were planned to be deep cleaned and we achieved 838 (96.99%) of these. Unfortunately this was a slight reduction on 2011/12 when we deep cleaned 660 (99.39%) of vehicles against the target of 99%.

#### SECamb Make Ready Only A&E Vehicles Deep Cleaned (target = 99%)

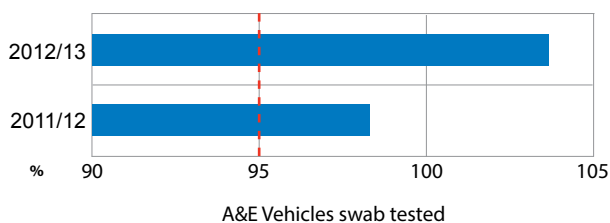


Data source: info.secamb

### 9.2.5.5. Make Ready Only A&E Swab Testing

SECamb planned to swab test 87 Make Ready A&E vehicles during 2012/13. We exceeded this target by three vehicles (103.45%). In 2011/12 we planned to swab test 56 vehicles against a target of 95% and achieved 98.21%.

#### SECamb Make Ready Only A&E Vehicles Swab Tested (target = 95%)

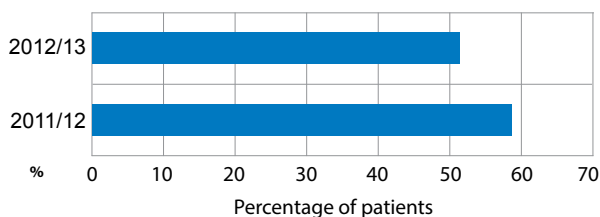


Data source: info.secamb

### 9.2.5.6. Patient Handover at Hospital – 15 Minutes

Where patients were handed over within 15 minutes and times were able to be recorded during 2012/13, 51.20% were handed over to hospital clinicians within the specified timescale compared with 58.40% in 2011/12.

#### SECamb Patient Handover Times (<15mins) (where time was captured)



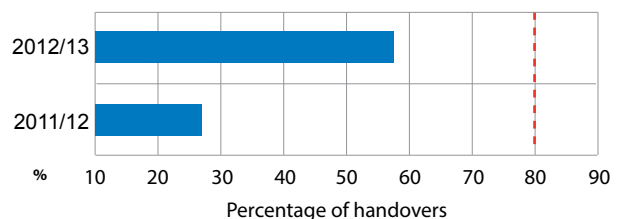
Data source: info.secamb

### 9.2.5.7. Hospital Handover Captured Times

During the year 2012/13 58.00% of hospital handover times were captured against the SECamb target of 80%. In 2011/12 only 26.40% of hospital handover times were captured against the same SECamb target of 80%.

During 2012/13 we experienced some whole system wide challenges on consistently recording patient handover times. This has now been addressed by the implementation of a new NHS Kent, Surrey and Sussex and SECamb Hospital Handover/Turnaround Policy.

#### SECamb Hospital Handover Times Captured (target 80%)



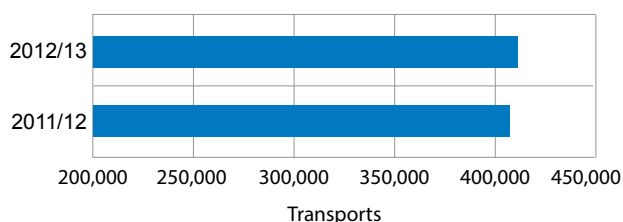
Data source: info.secamb

## 9.2.6. Conveyance to Hospital

### 9.2.6.1. Transports to Hospital

SECAmb transported 410,972 patients to hospital during 2012/13. This is an increase of 1.22% on 2011/12.

#### SECAmb A&E Transport to Hospital

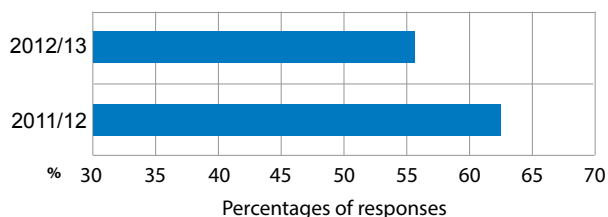


Data source: KA34

### 9.2.6.2. Managed Conveyance Rate\*

Of the patients requiring an emergency response during 2012/13, SECAmb conveyed 55.5%, excluding pre-determined Health Care Professional calls. This is an improvement on 2011/12 when we transported a larger number of patients (62.7%).

#### SECAmb Managed Conveyance to Hospital

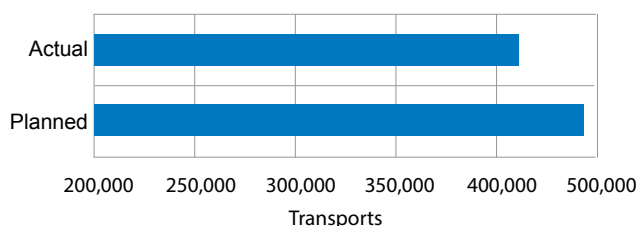


\*includes Hear & Treat and excludes Health Care Professional requests;  
Data source: Corporate Dashboard & Commercial Services Directorate

## 9.2.7. Patient Transport Service (PTS)

PTS transported 463,128 patients to and from appointments for treatment against a forecasted figure of 490,123 patients.

#### SECAmb Patient Transport Service



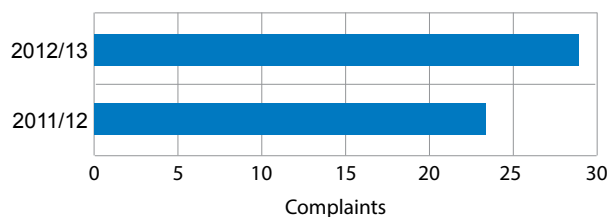
Data source: Corporate dashboard

## 9.2.8. Patient and Public Experience

### 9.2.8.1. Complaints

Complaints (12 month average 2012/13) 29 against the 2011/12 figure of 23.08\*.

#### SECAmb Complaints (monthly average)

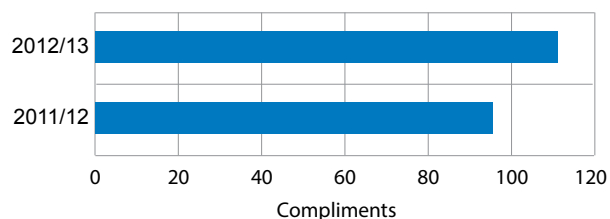


Data source: PALS team, \*2011/12 corporate dashboard

### 9.2.8.2. Compliments

Compliments (12 month average 2012/13)  
110 against the 2011/12 figure of \*93.25.

#### SECamb Compliments (monthly average)

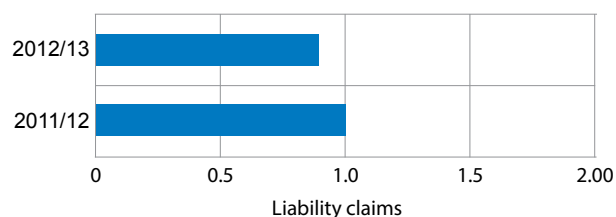


Data source: PALS team, \*2011/12 corporate dashboard

### 9.2.8.4. Liability Claims

The monthly average for clinical negligence and liability claims for 2012/13 was 0.9 compared with 1\* in 2011/12.

#### SECamb Liability Claims (monthly average)

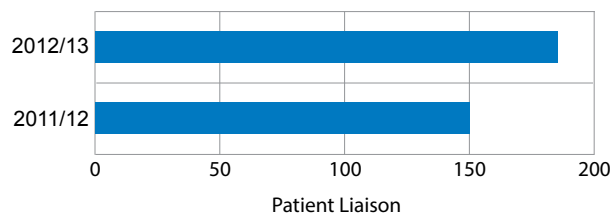


Data source: PALS team, \*2011/12 corporate dashboard

### 9.2.8.3. Patient Advice and Liaison Service (PALS) contacts

The monthly average for patient liaison (PALS) for 2012/13 was 183 compared to 2011/12 of 150.50\*, an increase of 21.59%.

#### SECamb PALS (monthly average)



Data source: PALS team, \*2011/12 corporate dashboard

## 10. Quality improvements to be implemented by SECAmb during 2013/14

### 10.1 IBIS (Intelligence Based Information System)

The functions of IBIS are explained in section 4.1 and during 2013/14 the roll-out of this system will continue.

Our aim is to start using the IBIS data to identify frequent callers. These are people who regularly call 999 with the same condition but who do not have the appropriate care package in place to meet their needs. 999 is often the first choice for unscheduled care needs, and SECAmb must ensure that we both support the patients' decision to call us, and ensure that we signpost them to the most appropriate service. We are therefore developing specific care planning processes for frequent callers, which we aim to implement during 2013/14.

### 10.2 Paramedic Practitioners (PPs) in Emergency Operations Centres (EOCs)

Another development which we plan to continue in 2013/14 is the PP desk in EOCs. This desk is staffed by at least two PPs 24/7, and provides support and supervision for staff who need advice on the best onward care for their patient.

### 10.3 Developing an intermediate tier

The Trust is planning to improve performance and reduce costs where patients with less acute clinical needs require conveyance, by introducing an intermediate tier of staffing who will specialise in transporting these patients. This will ensure patients receive the appropriate treatment through dedicated resources; as well as releasing clinicians, e.g. Critical Care Paramedics, to focus on the most clinically urgent cases. The introduction of an intermediate tier will also make more effective use of the high acuity transport of existing ambulances.

### 10.4 Clinical Pathways

In 2013/14 SECAmb will continue to build on the clinical pathways of Percutaneous Coronary Intervention (pPCI), Stroke, Major Trauma and End of Life Care by engaging with established and newly forming networks, liaising with Commissioners and other service providers in order to promote the best possible care and outcomes for patients.

For pPCI patients we will investigate ways of further reducing the call to balloon time and working with Commissioners, the cardiovascular network and providers to include potential new drug therapies, building on the already established good communications.

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Stroke care will continue to be refined in liaison with the cardiovascular network and SECAmb will maintain support for the concept of 24/7 stroke services available to all communities within the geographical area that it serves.

End of life care will be included within the mandatory training for all operational staff during 2013/14 and a 'train the trainer' package was launched in April 2013 to enhance staff awareness of this crucial area of practice. Further work on Advanced Decision to Refuse Treatment (ADRT) will continue in 2013/14.

SECAmb will continue to work with partners in embedding the concepts of the Trauma Networks. This will include a revision of the Major Trauma Decision Tree in light of experience gained since the three networks have become operational.

SECAmb will also carry out simulation work as a study, in conjunction with the South East London, Kent and Medway Trauma (SELKAM) network, to reduce the time between trauma and the patient arriving at a point of definitive care. It is the intention of the SELKAM network to present the results at a Trauma Conference in the near future.

### **10.5 Community First Responders (CFRs)**

In 2013/14 we plan to establish a further 100 PAD sites and recruit 300 new CFRs.

We will be increasing the number of Senior Community Team Leaders in 2013/14 as the number of responders and schemes continue to grow to ensure each CFR is fully supported.

SECAmb is developing a structure for our Associate Trainers to provide on-going clinical support for the team, with two out of the required three Senior Associate Trainers having been appointed. These trainers will be responsible for delivering to their CFRs a rolling programme of modular lessons, which will replace the current annual recertification and enhance their knowledge base.

### **10.6 Patient Transport Services (PTS)**

SECAmb's PTS will carry out two patient satisfaction surveys during the year.

PTS are also required to report on 40 key performance indicators, which include monitoring the number of delays, waiting times (travelling to or from appointment, or how long after appointment through time to collection), staff training, green measures etc. These will be reported to the Commissioners on a monthly basis.



### **10.7 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 2013/14 CQUIN Plan listed the following indicators:

- + healthcare professional calls;
- + use and access to clinical care registers/plan;
- + pilot for supported conveyance and frequent call management; and
- + reduced handover and turnaround delays.

During 2013/14 we will provide regular monitoring reports to the Lead Commissioners on a quarterly basis.

### **10.8 Professional Standards**

SECAMB has a dedicated Professional Standards team who work with all colleagues in supporting the continuous improvement in the clinical quality of care and patient experience provided.

Another key focus of this team is to cascade learning to staff throughout SECAMB e.g. following investigation of complaints.

### **10.9 Specialist Paramedics (PPs and CCPs)**

SECAMB will continue to develop Specialist Paramedics - Paramedic Practitioners (PPs) and Critical Care Paramedics (CCPs) – of which we already have over 200 PPs and 50 CCPs in place. In addition, we have recently commenced a practitioner level programme for our Clinical Supervisors within the Emergency Operations Centres to increase their knowledge of the scope of practice of these Specialist Paramedics.

### **10.10 Vehicles/Fleet Projects for 2013/14**

In view of the changing model of care, it is important that our vehicles/fleet reflect the needs of the communities we serve, ensuring better patient experience, as well as providing value for money and working towards reducing the impact on the environment.

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The Fleet team are working on the following projects:

- + it is anticipated that 20 new 'modular' ambulances will be delivered to SECamb by the end of September 2013 and will see them operational well in advance of the winter period. The vehicles they replace will be decommissioned from service after March 2014 to allow flexible resourcing throughout the winter period, alleviating some pressure related to vehicle supply;
- + a new 'van conversion' emergency ambulance has been developed on the basis of providing an Intermediate Support Tier vehicle, with further work required to finalise the specification. It is anticipated that nine vehicles will be built by the end of December 2013 and put into service by the end of March 2014;
- + following an evaluation and successful trial of a purpose built, clinically focused, Paramedic Practitioner vehicle in Hastings, we anticipate these vehicles coming into service by March 2014;
- + specification due to be finalised for Black Box technology (driver safety system/ telematics), with implementation expected to commence at the beginning of 2014;
- + following installation of dynamic speed limiters on our new PTS fleet, this will now be rolled out to our A&E fleet (configured specifically to account for blue light use). We anticipate this will see a reduction in fuel use as well as our carbon footprint;

- + the enhanced use of CCTV in conjunction with driver safety systems to protect our staff and wider organisational needs. This will see the installation of cameras mounted to the front and side of the vehicles, and ability for remote access to incident data; and
- + the trial of a tyre pressure monitoring system to improve safety for public, patients and staff, which will have the added benefit of a reduction in fuel use.

#### **10.11 Front Loaded Service Model (FLSM)**

Included in SECamb's plans for 2013/14 is the implementation of key service developments which will see an increase in the number of registered clinicians first on scene. This is known as the "Front Loaded Service Model".

The FLSM project was conceived in response to a national directive to explore how ambulance services can deliver more effective and efficient care. The objectives and delivery arrangements have been evaluated as part of the FLSM project management arrangements, and while the overarching intentions have been retained, other additional priorities have been identified leading to a change in how we will strategically realise our aspiration to continue to be a world class service.

Following the Francis Report, it has become clear that we must address the potential for harm coming to our patients. We operate in a very hostile environment with demand growing year on year, and we must strive to ensure we achieve a balance between quality and quantity of care. We must continue to work to reduce conveyance to A&E in a safe and sustainable way, and we must ensure that we have a workforce that is fit for purpose and intelligently deployed to match the right skills to the right patient.

What has emerged from the original FLSM project is a root and branch review of both the A&E Service Delivery Strategy and the Clinical Strategy. The A&E strategy informs the operational requirements needed to deliver our workforce to the patient's side in the correct proportions, and the Clinical Strategy informs the quality and standards of care, the workforce development requirements and structures, and the future planning needed to maintain those standards.

The term "Front Loaded Service Model" fails to describe adequately our aspirations for the future. Whilst the project is still on-going, it has been devolved into individual directorate portfolios, taking on much more of an iterative service development feel as opposed to a step-wise change in direction.

## 10.12 The Francis Report

The publication of the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry<sup>8</sup>, referred to as the Francis Report, emphasises the need for NHS organisations to always put patients first, and states that 'constant encouragement should be given to patients and other service users, individually and collectively, to share their comments and criticisms with the organisation'.

While SECAmb already seeks the views of patients via a range of surveys, this year we plan to establish a Patient Experience Group, the majority of the membership being SECAmb patients. This group will help us to develop and implement a Patient Experience Strategy that will reflect the Trust's values, vision and objectives and will shape future efforts to obtain patient feedback spanning the whole range of SECAmb services and patients. This will enable us to determine what works well for patients and carers, as well as what doesn't, and to make improvements as a result in order to improve the public's experience of our services.

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### 10.13 Sustainability and Carbon Reduction

In 2013/14 SECAmb aims to deliver a Cost Improvement Plan (CIP) for Travel to reduce staff business mileage by a third, saving approximately £1 million, and supporting our efforts to reduce corporate carbon emissions. Key to the delivery of this CIP will be the investment in updating our video conferencing technology to provide staff with an improved and efficient means of participating in meetings without the need to travel. The business case for this project takes into account savings gained from increased staff productivity by reducing business travel.

Work will continue on diversification of fuel for our fleet in order to strengthen our resilience in the face of fuel price rises and insecurity of supply. An application will be made to the Office for Low Emission Vehicles to seek funding to support provision of a network of electric vehicle fast charging points across our Make Ready Centres in order to support the take up of electrically charged vehicles and hybrids amongst our fleet. If successful, the network could be shared with other emergency service partners such as fire and police to encourage interoperability to promote take up of alternative fuelled vehicles. This work aims to target a reduction in the 3,138,069 miles driven by emergency single response vehicles (baseline 2011/12).

SECAmb will continue to work closely with the Sustrans Charity to develop an Active Travel Plan for the Trust to encourage staff to use more active forms of travel such as walking and cycling, which will save staff money and improve their health and wellbeing. The implementation of our Communications plan to engage our staff in the behavioural change required to reduce carbon emissions and to improve overall environmental/sustainability awareness will complement this work.

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<sup>8</sup> Francis, R, QC. 2013. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Executive Summary p. 96. London: The Stationery Office.

## 11. Formal responses from Healthwatch, HOSCs and Commissioners

### **Who we shared our Quality Account with:**

The Quality Account and Quality Report was shared with our partners during its development (HOSCs included West Sussex County Council, Brighton and Hove City Council, East Sussex County Council, Kent County Council, Surrey County Council and Medway Council. Also, Healthwatch organisations included Kent, Medway, Surrey, East Sussex, Brighton & Hove and West Sussex) and the following formal statements have been received.

### **Statement from Commissioners**

The Trust's draft Quality Accounts and Quality Report document was sent to Clinical Commissioning Groups (CCGs) for consultation and comment. The CCGs have a responsibility to review the Quality Accounts of the Trust each year, using the Department of Health's Quality Accounts checklist tool to ascertain whether all of the required elements are included within the document.

Swale CCG is the lead commissioner for the South East Coast Ambulance NHS Foundation Trust (SECamb) contract and has consulted with its CCG colleagues in relation to this response.

As SECamb is a Foundation Trust (FT), it is bound to create a document that includes not only the Quality Accounts, but an overall Quality Report as well, as prescribed by Monitor. As such, this makes the document more cumbersome and has made it difficult for the CCG to review the Quality Accounts section in isolation.

Our initial observation is that clearly the Trust takes the quality of its services seriously, and has included a significant number of initiatives that will go a long way to further improving the quality of its services throughout 2013/14. The Trust has clearly identified its quality priorities for the coming year, which the CCG endorses, and has set out how it achieved the previous year's priorities. However, it would be useful to clearly summarise the exact improvement targets that it is aspiring to achieve through the quality priorities in a single concise table.

The CCG is required to comment on the accuracy of performance related figures included within the document and the CCG confirms it recognises the figures stated. Where some national figures are still awaited to be inserted into the document, it is recognised that this is due to them not being published yet, and therefore these could not be included within the draft document that was submitted for review.

The overarching indicators for CQUINS have been agreed for 2013/14 between the Trust and its commissioners. The full detail on the key metrics for assessing delivery are being established with commissioners and will be in place by the end of Quarter 1.

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The document states that the Trust is compliant with the majority of CQC standards. This is correct. There are two Essential Standards of Quality and Safety which are non-compliant and require improvement, those being Outcomes 9 and 14. The Trust has developed an Action Plan and this is being monitored by the CQC.

In conclusion, the CCG can see that the Trust puts quality at the forefront of its service provision and that it is central to its operations. The CCG thanks the Trust for the opportunity to comment on this document. The past year has presented many challenges due to the changing NHS infrastructure and the transition which has been required from the old Primary Care Trusts to the new Clinical Commissioning Groups. The CCG looks forward to building stronger relationships with the Trust through closer joint working in the future.

#### **Lead Commissioner Swale CCG**

#### **Health Overview and Scrutiny Committees (HOSCs)**

##### **Comment from East Sussex HOSC**

The Committee welcomes the opportunity to make the following statement in relation to the Trust's Quality Account 2012/13:

##### **Patient and public involvement**

A HOSC representative attended an engagement event held by the Trust to inform the production of this Quality Account. This was an interactive, genuinely consultative event where feedback on potential quality priorities was welcomed.

The quality priorities for 2013/14 reflect the outcomes of that event and can therefore be said to reflect those of public and patient representatives.

The Trust has continued to engage positively with HOSC throughout the year. In particular, Trust representatives made valuable contributions to the Committee's scrutiny of proposed reconfiguration of hospital services in East Sussex. The Trust's well presented evidence helped the Committee to assess the implications of the proposals. The Ambulance Service's ongoing engagement in the implementation of these service changes will be critical.

##### **Quality priorities and local issues**

HOSC welcomes progress made against the priorities which were identified for 2012/13 and, equally, the Trust's acknowledgement that further work is needed in relation to some of these. The Committee also notes that there is room for improvement against some of the core indicators and expects that the Trust's quality ambitions will result in action being taken to ensure continuous improvement.

HOSC recognises that the Trust works within a wider healthcare system and that pressures within the system, which have been particularly acute in the winter of 2012/13, will impact on the ambulance service. There have been reports of delayed ambulance handover and capacity pressures at local A&E departments and HOSC welcomes the Trust's active involvement in addressing such issues, for example by developing a new handover protocol and by expanding 'See and Treat' and 'Hear and Treat' alternatives to hospital attendance.

The five priority areas for 2013/14 are clearly set out. HOSC welcomes the focus on measures to ensure the most appropriate response is deployed to meet patient needs, which will support wider system efforts to reduce unnecessary hospital admissions and ensure specialist care is accessed when it is needed. HOSC also welcomes the focus on NHS 111, which has experienced challenges during its first weeks since launch and will need sustained focus in the coming year to ensure it delivers its intended benefits for patients. HOSC will be monitoring progress in conjunction with other health scrutiny committees in the south east coast area.

**Councillor Rupert Simmons**

Chairman East Sussex Health Overview and Scrutiny Committee

**Comment from Medway HOSC**

On the basis there has been no engagement by SECAMb with the Committee on any specific area in the past year it is not possible for the Committee to provide an evidence based commentary. However, there are some issues mentioned within the report, which I am sure the Committee would like to have further information about.

***These areas are as follows:***

- + In the light of the recent media attention on the roll out of the NHS 111 service, it is mentioned (page 17) that feedback from at least 400 service users will be undertaken quarterly with the first being ready for June - the Committee would appreciate regular updates on service user feedback - perhaps on a quarterly basis commencing in July 2013
- + Reference is made to the IBIS system on page 25 of the report - please could information be provided on the extent to which providers connected with SECAMb across the South East Coast are now adopting the system?
- + Outcome from cardiac arrest – survival to discharge rates for the period April to October 2012 the SECAMb figures appear to be 5.8% with a national average of 8.3% – please can you give further details?

- 
- + Medication errors (page 43) -the Committee would be interested to know how SECAMB is addressing concerns raised by the Care Quality Commission after its inspection in February 2013

**Rosie Gunstone**

Democratic Services Officer on behalf of the Health and Adult Social Care Overview and Scrutiny Committee

**Comment from Surrey County Council HOSC**

The Health Scrutiny Committee is pleased to be offered the opportunity to comment on South East Coast Ambulance NHS Foundation Trust Quality Account for 2012/13. The Trust is thanked for working with the Health Scrutiny Committee over the last year on the key issues of stroke care and ambulance response in rural areas. The Committee endorses the Trust's identified priorities for 2013/14 with the following comments:

- + **Quality Measure A** – Patient Safety  
“To monitor the effectiveness of SECAMB’s Infection Control procedures for emergency response and patient transport vehicles that are deep cleaned and swab tested across SECAMB”

The Trust is commended for its continuing drive to improve the standards of cleanliness and safety.

- + **Quality Measure B** – Patient Experience  
“The effectiveness of the 111 service/ facility in providing patients with the appropriate service”

The Committee is keen to see what the impact of 111 will be and looks forward to working with SECAMB on analysing the data and information. The Trust is also commended on being proactive in seeking early feedback on the efficacy of and satisfaction with the system.

- + **Quality Measure C** – Patient Experience  
“To improve the experience of those patients who call SECAMB via 999 and their satisfaction with the service provided”

The Trust is commended for continuing to improve its patient satisfaction rate and seeking to increase the sources of feedback.

- + **Quality Measure D** – Clinical Effectiveness  
“To monitor the IBIS system so that those patients with long term conditions (LTC) are able to be provided with the best possible care by attending ambulance crews”

The Trust is commended for working with primary care to improve the pathways for patients with Long Term Conditions.

- + **Quality Measure E** – Clinical Effectiveness  
(1) “To improve the number of registered clinicians who attend those patients deemed to have a life-threatening condition at the time the 999 call was raised. (2) To monitor where a Paramedic Practitioner attends a patient through a PP referral where that patient is then subsequently transported to a hospital A&E department”.



The Trust is commended for working to improve the service provided to patients by ensuring the highest level of clinical response.

The Committee looks forward to working with the Trust over the next year to monitor all of the 2013/14 priorities via the new Quality Account Member Reference Groups to be set up in June 2013.

**Leah O'Donovan**

Scrutiny Officer, Adult Social Care Select Committee and Health Scrutiny Committee, Surrey County Council

**Comment from West Sussex County Council Health & Adult Social Care Select Committee (HASC)**

Thank you for offering the Health & Adult Social Care Select Committee (HASC) the opportunity to comment on South East Coast Ambulance Service NHS Foundation Trust's Quality Account for 2012-13. The comments set out below are based on feedback from HASC's liaison members for SECAMB during 2012-13.

HASC welcomes SECAMB's commitment to engagement with patients and the public and the fact that there continues to be constructive liaison arrangements with the HASC. SECAMB has kept HASC updated on key issues of interest, and contributes appropriately to the Committee's work programme. The Ambulance Service is pivotal to the effective and efficient running of the whole health care system in the region, and many of the challenges facing SECAMB are system-wide challenges.

As such, we understand that it can be difficult to isolate SECAMB performance from other elements of the system (e.g. acute care, primary care, community services) – and that SECAMB can play a key role in terms of improving performance (and the quality of patient experience and outcomes) across the NHS. HASC is aware that there has been an apparent rise in emergency admissions across the region, with a consequent pressure on Accident and Emergency Services. There is an urgent need for the whole system to work together to understand and address this, and we plan to review this during the year ahead.

Overall, we wonder how "user friendly" the format of your draft Quality Account is. From a public/patient perspective, it would be useful to be able to see "at a glance" the key performance indicators, your performance against these and how you plan to address any key areas of under-performance. It might also be helpful to provide information on performance for 2012-13 up front, at the start of the document, followed by information on quality measures for the year ahead. We welcome the quality measures you have set for 2013-14, and particularly your focus on patient safety and patient experience.


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Some more specific comments on your draft Quality Account are set out below:

- + **Quality measure B** – effectiveness of the 111 service (pages 16-18): We suggest there should be a measure relating to the percentage of calls that lead to a referral to primary care, community care or other service (e.g. adult social care/voluntary sector). This will help evaluate the overall effectiveness of the new service in terms of increased use of alternative pathways. HASC discussed the new 111 service in November 2012, and raised two key issues for the future delivery of this service: the need to raise public awareness through effective communications; and the need to build effective relationships with health and social care providers. HASC plans to review the implementation of the 111 service later in 2013.
- + **Quality measure D** – IBIS system (pages 21-22): Will other services (e.g. GPs, community services, adult social care) be involved in inputting data into this system? Presumably their involvement will be key to the success of this system, in which case some measure of their involvement may be useful.
- + **Quality improvements made within SECAMB during 2012/13 – Patient Transport Service (p 28-29)**: HASC has heard some specific concerns regarding the Patient Transport Services, particularly relating to the booking system. There is a need to improve the

service to ensure it is meeting patient needs and to rebuild confidence in the service, and we would welcome information in terms of how SECAMB plans to address these. In addition, when HASC reviewed community health services in November 2012, it heard concerns regarding discharge arrangements from hospital (to home and to community setting). In terms of the Patient Transport Service, it will be important for SECAMB to liaise appropriately with acute trusts, Sussex Community NHS Trust and Adult Social Care Services to ensure (where possible) that patients' (and their carers'/families') needs are met - and that discharge after 6pm is avoided.

- + **Category A Calls (page 50-51& 56)**: Whilst much of SECAMB's performance during 2012-13 was good, we are concerned at underperformance for Red 1 (formerly Category A Calls), and particularly the fact that performance seems to be worsening. It would be helpful if the Quality Account could more clearly state how SECAMB is addressing this, and to set out what any key dependencies are for achieving this target.
- + **Patient Handover at Hospital (pages 61-62)**: We understand that there are system-wide challenges in terms of capturing handover times, and welcome the fact that a new regional policy is now live. We will wish to monitor SECAMB performance on this over the year ahead.



Of particular concern to HASC has been Ambulance Service performance in rural areas, and whilst we understand there can be challenges in terms of delivering a timely response in rural areas, it would be helpful if the Quality Account could include data to show performance within the different areas covered by SECAMB (to include rural/urban areas). There may be potential for more joint working between SECAMB and the Fire and Rescue Service (e.g. through co-responder schemes), to help address performance in rural areas, and we would welcome any updates on this.

**Mrs Margaret Whitehead**

Chairman, Health & Adult Social Care Select Committee

**Healthwatch**

**Comment from West Sussex Healthwatch**

Thank you for inviting Healthwatch West Sussex (HWWS) to provide a statement on the 2012/13 Quality Account for South East Coast Ambulance Service NHS Foundation Trust (SECAMB). As you may know, HWWS has recently appointed its Board and is in the process of determining its final representation and liaison arrangements with various strategic forums. Its commentary on Quality Accounts is therefore limited in scope this year.

The West Sussex LINK, the predecessor organisation to HWWS, was pleased to be represented at the Quality Account Workshop on the 21 February 2013.

HWWS is generally satisfied that the Quality Account represents a true reflection of SECAMB's quality of service and is content with the priorities identified.

During 2013/14 HWWS will be monitoring the feedback from the general population in West Sussex on the performance of the 111 service. We sincerely hope that significant inroads will be made into improving the service for West Sussex residents (and those beyond) in the immediate future. In addition the Patient Transport Service is an area where LINK received a large number of complaints during 2012/13 and HWWS will be maintaining an interest in the resolution of transport capacity issues during the course of this year.

In accordance with the Department of Health Guidance on Quality Accounts, we trust you will include these comments verbatim in SECAMB Quality Account 2012/13 and would be grateful for sight of the final submission.

**Frances Russell**

Chair of the Board,  
Healthwatch West Sussex

## 12. Independent Auditor's Report

### Independent Auditors' Limited Assurance Report to the Council of Governors of South East Coast Ambulance Service NHS Foundation Trust on the Quality Report.

We have been engaged by the Council of Governors of South East Coast Ambulance Service NHS Foundation Trust to perform an independent limited assurance engagement in respect of South East Coast Ambulance Service NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (the "Quality Report") and certain performance indicators contained therein.

#### Scope and Subject Matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of those national priority indicators mandated by Monitor:

- + **Category A call** – emergency response within 8 minutes
- + **Category A call** – ambulance vehicle arrives within 19 minutes.

We refer to these national priority indicators collectively as the "indicators".

#### Respective responsibilities of the Directors and Auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- + the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- + the Quality Report is not consistent in all material respects with the sources specified in paragraph 2.1(2) of Monitor's 2012/13 Detailed Guidance for External Assurance on Quality Reports; 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.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- + Board minutes for the period April 2012 to June 2013;
- + Papers relating to quality reported to the Board over the period April 2012 to June 2013;
- + Feedback from the Commissioners dated 22 May 2013;
- + Feedback from local Health-watch organisations dated April / May 2013;

- + The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 5 July 2012;
- + The 2012 national staff survey dated 5 December 2012;
- + Care Quality Commission quality and risk profiles dated 6 March 2013; and
- + The Head of Internal Audit's annual opinion over the trust's control environment dated 15 May 2013.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of South East Coast Ambulance Service NHS Foundation Trust as a body, to assist the Council of Governors in reporting South East Coast Ambulance Service NHS Foundation Trust's quality agenda, performance and activities.

We permit the disclosure of this report within the Trust's Annual Report for the year ended 31 March 2013, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and South East Coast Ambulance Service NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

#### **Assurance work performed**

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- + Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- + Making enquiries of management
- + Limited testing, on a selective basis, of the data used to calculate the indicators back to supporting documentation
- + Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report
- + Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

### **Limitations**

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can 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 scope of our 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 our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- + 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 Monitor's 2012/13 Detailed Guidance for External Assurance on Quality Reports paragraph 2.1(2); 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.



### **Grant Thornton UK LLP**

Grant Thornton House  
Melton Street  
Euston Square  
London  
NW1 2EP

**29 May 2013**

The Quality Account and Quality Report can be accessed on the SECAMB web site or alternatively for copies of the document please e-mail [Qualityaccount@secamb.nhs.uk](mailto:Qualityaccount@secamb.nhs.uk) or write to:

South East Coast Ambulance Service NHS  
Foundation Trust

The Horseshoe  
Banstead  
Surrey  
SM7 2AS



# Appendix B

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Accounts 2012/13





## 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 accruals basis and must give a true and fair view of the state of affairs of South East Coast Ambulance Service NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the 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 2013

**Paul Sutton, Chief Executive**

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## 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 2013

**Paul Sutton, Chief Executive**


## INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS AND BOARD OF DIRECTORS OF SOUTH EAST COAST AMBULANCE SERVICE NHS FOUNDATION TRUST

We have audited the financial statements of South East Coast Ambulance Service NHS Foundation Trust 'the Trust' for the period ended 31 March 2013 which comprise the statement of comprehensive income, the statement of financial position, the statement of cash flow, the statement of changes in taxpayers' equity and the related notes. The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual issued by Monitor, the Independent Regulator of NHS Foundation Trusts.

We 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
- + the table of pension benefits of senior managers and related narrative notes
- + the table of pay multiples and related narrative notes.

This report is made solely to the Council of Governors and Board of Directors of South East Coast Ambulance Service NHS Foundation Trust, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006.



Our audit work has been undertaken so that we might state to the Trust's Governors and Directors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than the Trust as a body and the Trust's Board of Directors as a body, for our audit work, for this report or for the opinions we have formed.

### **Respective responsibilities of the accounting officer and auditor**

As explained more fully in the Chief Executive's Statement, the Chief Executive as Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

The Accounting Officer is responsible for the maintenance and integrity of the corporate and financial information on the Trust's website. Legislation in the United Kingdom governing the preparation and dissemination of the financial statements and other information included in annual reports may differ from legislation in other jurisdictions.

Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts issued by Monitor, and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's (APB'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. In addition, we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements.

If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

## **Opinion on financial statements**

### *In our opinion the financial statements:*

- + give a true and fair view of the state of the financial position of South East Coast Ambulance Service NHS Foundation Trust as at 31st March 2013 and of its income and expenditure for the year then ended; and
- + have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual and the directions under paragraph 25(2) of Schedule 7 of the National Health Service Act 2006.

## **Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts**

### *In our opinion:*

- + the part of the Remuneration Report subject to audit has been properly prepared in accordance with paragraph 25 of Schedule 7 of the National Health Service Act 2006 and the NHS Foundation Trust Annual Reporting Manual 2012-13 issued by Monitor
- + the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

## **Matters on which we are required to report by exception**

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if, in our opinion:

- + the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual or is misleading or inconsistent with information of which we are aware from our audit consistent with the financial statements.
- + we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources
- + the Trust's Quality Report has not been prepared in line with the requirements set out in the NHS Foundation Trust Annual Reporting Manual or is inconsistent with other sources of evidence



## **Certificate**

We certify that we have completed the audit of the financial statements of South East Coast Ambulance Service NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

## **Paul Hughes**

Senior Statutory Auditor  
for and on behalf of Grant Thornton UK LLP

Grant Thornton House  
Melton Street  
Euston Square  
London  
NW1 2EP

29 May 2013

## STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2013

	NOTE	Year ended 31 March 2013	Year ended 31 March 2012
		£000	£000
<b>Revenue</b>			
Revenue from patient care activities	5	<b>172,243</b>	168,171
Other operating revenue	5.1	<b>1,786</b>	1,871
Operating expenses	8	<b>(168,785)</b>	(164,011)
<b>Operating surplus/(deficit)</b>		<b>5,244</b>	6,031
<b>Finance costs:</b>			
Investment revenue	13	<b>171</b>	52
Other gains and losses		<b>0</b>	0
Finance costs	14	<b>(347)</b>	(428)
<b>Surplus/(deficit) for the financial period</b>		<b>5,068</b>	5,655
Public dividend capital dividends payable		<b>(2,013)</b>	(2,169)
<b>Retained surplus/(deficit) for the period</b>		<b>3,055</b>	3,486
<b>Other comprehensive income</b>			
Impairments and reversals		<b>(352)</b>	(578)
Gains on revaluations		<b>0</b>	110
Receipt of donated/government granted assets		<b>0</b>	0
Net gain/(loss) on other reserves (e.g. defined benefit pension scheme)		<b>0</b>	0
Net gains/(losses) on available for sale financial assets		<b>0</b>	0
Reclassification adjustments:		<b>0</b>	0
- Transfers from donated and government grant reserves		<b>0</b>	0
- On disposal of available for sale financial assets		<b>0</b>	0
<b>Total comprehensive income for the period</b>		<b>2,703</b>	3,018

The notes on pages 9 to 43 form part of these accounts.

### Reported NHS financial performance position [Adjusted retained surplus]

<b>Retained surplus for the year</b>	<b>3,055</b>	3,486
IFRIC 12 adjustment	<b>0</b>	0
Impairments	<b>0</b>	0
<b>Reported NHS financial performance position [Adjusted retained surplus]</b>	<b>3,055</b>	3,486

## STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2013

	NOTE	Year ended 31 March 2013	Year ended 31 March 2012
		£000	£000
<b>Non-current assets</b>			
Property, plant and equipment	15	79,544	76,771
Intangible assets	16	454	641
Other financial assets		0	0
Trade and other receivables	20	0	812
<b>Total non-current assets</b>		<b>79,998</b>	78,224
<b>Current assets</b>			
Inventories	19	1,387	949
Trade and other receivables	20	6,768	7,467
Non-current assets held for sale	22	3,333	3,818
Cash and cash equivalents	21	30,317	22,406
<b>Total current assets</b>		<b>41,805</b>	34,640
<b>Total assets</b>		<b>121,803</b>	112,864
<b>Current liabilities</b>			
Trade and other payables	23	(17,802)	(12,127)
Other liabilities	23	(248)	(502)
Borrowings	24	(1,774)	(1,071)
Other financial liabilities		0	0
Provisions	27	(2,435)	(2,603)
<b>Net current assets/(liabilities)</b>		<b>19,546</b>	18,337
<b>Total assets less current liabilities</b>		<b>99,544</b>	96,561
<b>Non-current liabilities</b>			
Borrowings	24	(4,218)	(4,082)
Trade and other payables		0	0
Other financial liabilities		0	0
Provisions	27	(8,535)	(9,391)
Other liabilities		0	0
<b>Total assets employed</b>		<b>86,791</b>	83,088
<b>Financed by taxpayers' equity:</b>			
Public dividend capital		76,024	75,024
Retained earnings		8,327	5,141
Revaluation reserve		2,440	2,923
Other reserves		0	0
<b>Total taxpayers' equity</b>		<b>86,791</b>	83,088

The financial statements on pages 5 to 43 were approved by the Board on 29 May 2013 and signed on its behalf by:

Signed:  (Chief Executive)

Date: 29 May 2013

## STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2013

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Other reserves	Total
	£000	£000	£000	£000	£000
<b>Balance at 1 April 2012</b>	75,024	5,141	2,923	0	83,088
Transfers between reserves	0	131	(131)	0	0
Surplus/(deficit) for the year	0	3,055	0	0	3,055
Impairments	0	0	(352)	0	(352)
Revaluations	0	0	0	0	0
Receipt of donated assets	0	0	0	0	0
Asset disposals	0	0	0	0	0
Share of comprehensive income from associates and joint ventures	0	0	0	0	0
Movements arising from classifying non current assets as Assets Held for Sale	0	0	0	0	0
Fair Value gains/(losses) on Available-for-sale financial investments	0	0	0	0	0
Recycling gains/(losses) on Available-for-sale financial investments	0	0	0	0	0
Other recognised gains and losses	0	0	0	0	0
Actuarial gains/(losses) on defined benefit pension schemes	0	0	0	0	0
Public Dividend Capital received	1,000	0	0	0	1,000
Public Dividend Capital repaid	0	0	0	0	0
Public Dividend Capital written off	0	0	0	0	0
Other reserve movements	0	0	0	0	0
<b>Balance at 31 March 2013</b>	<b>76,024</b>	<b>8,327</b>	<b>2,440</b>	<b>0</b>	<b>86,791</b>



## STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2013

	NOTE	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
<b>Cash flows from operating activities</b>			
Operating surplus/(deficit)		5,244	6,031
Depreciation and amortisation	8	9,631	9,340
Impairments and reversals	17	309	1,397
(Increase)/decrease in inventories	19.1	(438)	(51)
(Increase)/decrease in trade and other receivables		1,422	5,178
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade and other payables		3,071	(2,516)
Increase/(decrease) in other current liabilities	23.1	(254)	(20)
Increase/(decrease) in provisions		(1,154)	1,752
<b>Net cash inflow/(outflow) from operating activities</b>		<b>17,831</b>	<b>21,111</b>
<b>Cash flows from investing activities</b>			
Interest received	13	171	52
(Payments) for property, plant and equipment		(8,378)	(12,091)
Proceeds from disposal of plant, property and equipment		502	175
(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
<b>Net cash inflow/(outflow) from investing activities</b>		<b>(7,705)</b>	<b>(11,864)</b>
<b>Net cash inflow/(outflow) before financing</b>		<b>10,126</b>	<b>9,247</b>
<b>Cash flows from financing activities</b>			
Public dividend capital received		1,000	2,363
Public dividend capital repaid		(2,103)	(2,269)
Interest paid	14	(217)	(280)
Public dividend capital overpaid		190	100
Loans repaid to the DH		0	0
Other loans repaid		0	0
Other capital receipts		0	0
Capital element of finance leases		(1,085)	(1,003)
<b>Net cash inflow/(outflow) from financing</b>		<b>(2,215)</b>	<b>(1,089)</b>
<b>Net increase/(decrease) in cash and cash equivalents</b>		<b>7,911</b>	<b>8,158</b>
<b>Cash and cash equivalents (and bank overdrafts) at the beginning of the financial period</b>		<b>22,406</b>	<b>14,248</b>
Effect of exchange rate changes on the balance of cash held in foreign currencies		0	0
<b>Cash and cash equivalents (and bank overdrafts) at the end of the financial period</b>	21	<b>30,317</b>	<b>22,406</b>

## 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 2012-13 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 2012/13.

#### 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 2012/13.

#### 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 Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at [www.nhsbsa.nhs.uk/pensions](http://www.nhsbsa.nhs.uk/pensions). The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

##### ***a) Accounting valuation***

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2013, is based on the valuation data as at 31 March 2012, updated to 31 March 2013 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have been used.

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

### ***b) Full actuarial (funding) valuation***

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

### ***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. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

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 employer.

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 had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- + items form part of the initial equipping and setting-up cost of a new building, 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 31 March 2010.

For 2013 the Trust has applied an indexation factor to reflect the current market and has used the Investment Property Databank (IPD) sector capital value industrial index for all buildings with the exception of the Ashford and Paddock Wood Make Ready Centres which are both new-builds. For Land the Industrial development land index was used.

### **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 attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.

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 Foundation Trust 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 method.

### **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 rates for general provisions, except for early retirement and injury benefit provisions which both use the HM Treasury's post employment benefit discount rate of 2.35% (2011-12: 2.8%) 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 is 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 6 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 liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above.

### ***De-recognition***

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

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

### ***Classification and measurement***

Financial assets and financial liabilities are initially recognised at fair value, net of transaction costs.

Financial assets are classified as loans and receivables. Financial liabilities are classified as other financial liabilities. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

### ***Loans and receivables***

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Trust's loans and receivables comprise: cash and cash equivalents, NHS 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.

#### **1.2.4 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.

#### **1.25 Joint operations – Accounting for the NHS 111 service**

The NHS 111 service is a national telephone service whose aim is to make it easier for the public to access healthcare services when urgent medical help is required but not in life-threatening, emergency situations.

As of March 2013, the Trust provides the 111 service in Kent, Surrey and Sussex working in partnership with an independent provider of urgent care services in England, Harmoni MS Limited.

The Trust holds the head contract to provide the service but the contractual arrangement between the Trust and Harmoni is such that the service is subject to joint control and that strategic, financial and operating decisions relating to the service require the unanimous consent of both parties.

Both the Trust and Harmoni uses its own property, plant and equipment and carries its own inventories. Both parties also incur their own expenses and liabilities and raise their own finance which represents their own obligations. In addition Harmoni provide the Trust with a Managed IT service via Amicus both of whom are part of the Care UK Group.

The activities of the service are undertaken by the Trust's employees alongside the Trust's similar activities of patient services. Each party independently accounts for the assets it controls and the liabilities and expenses that it incurs. The accounting entries are included in each party's financial statements. No separate joint entity exists.

Therefore under International Accounting Standard (IAS) 31, the contractual arrangement for the NHS 111 service is a joint venture.

IAS 31 recognises three forms of Joint Venture, namely Jointly Controlled Operations, Jointly Controlled Assets and Jointly Controlled Entity. The Trust's arrangement falls under Jointly Controlled Operations as no separate entity exists and both parties are responsible and account for their own assets.

## 2. Pooled budget

The Trust has no pooled budget arrangements.

## 3. Operating segments

The segments identified and reported are Patient Services and Commercial Activities. Commercial Activities are external training, private ambulance services and third party fleet maintenance that are offered by the Trust. All other activities are reported under Patient Services (including Primary Care Trust revenue).

	Patient Services		Commercial Activities		Total	
	2012-13	2011-12	2012-13	2011-12	2012-13	2011-12
	£000	£000	£000	£000	£000	£000
Income	<b>173,456</b>	169,467	<b>573</b>	575	<b>174,029</b>	170,042
Surplus/(deficit) before interest	<b>5,361</b>	6,126	<b>(117)</b>	(95)	<b>5,244</b>	6,031

## 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.

	2012-13	2011-12
	£000	£000
Income	<b>573</b>	575
Full cost	<b>690</b>	670
Deficit	<b>(117)</b>	(95)

## 5. Revenue from patient care activities

	2012-13 £000	2011-12 £000
Strategic Health Authorities	0	0
NHS Trusts	606	7,349
Primary Care Trusts	168,571	156,735
Foundation Trusts	459	1,092
Local Authorities	40	0
Department of Health	1,963	1,474
NHS other	0	0
<b>Non-NHS:</b>		
Private patients	19	18
Overseas patients (non-reciprocal)	0	0
Injury costs recovery	871	765
Other	(286)	738
	<b>172,243</b>	168,171

## 5.1 Other operating revenue

	2012-13 £000	2011-12 £000
Education, training and research	798	917
Charitable and other contributions to expenditure	0	35
Transfers from donated asset reserve	0	0
Non-patient care services to other bodies	43	203
Income generation	573	575
Rental revenue from finance leases	0	0
Rental revenue from operating leases	0	0
Other revenue	157	17
Income in respect of staff costs where accounted on gross basis	215	124
	<b>1,786</b>	1,871



## 6. Revenue by classification

	2012-13 £000	2011-12 £000
A & E income	147,850	145,857*
Other NHS clinical income	13,304	10,459
Private patient income	19	18
Other non-protected clinical income	11,070	11,837*
Other operating income	1,786	1,871
	<b>174,029</b>	170,042

Of total revenue from patient care activities, £147,850k is mandatory and £24,393k is non-mandatory.

\* Prior Year A&E income restated to exclude Hazardous Area Response Team (HART) income which is now shown in Other non-protected clinical income.

## 6.1 Private patient income

With effect from 1 October 2012 the Health and Social Care Act 2012 repealed the statutory limitation on private patient income. Therefore this disclosure is no longer required.

## 7. Revenue

Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.

## 8. Operating expenses

	2012-13 £000	2011-12 £000
Services from other NHS Trusts	0	0
Services from other NHS bodies	0	2,729
Purchase of healthcare from non NHS bodies	8,296	2,758
Executive Directors	760	877
Employee Expenses - Non-executive Directors	137	104
Employee Expenses - Staff	112,812	109,677
Drug costs	937	1,157
Supplies and services - clinical (excluding drug costs)	3,723	3,327
Supplies and services - general	2,221	1,952
Establishment	4,444	4,155
Research and development	3	16
Transport	14,901	12,917
Premises	8,632	8,123
Increase in bad debt provision	0	0
Increase in other provisions	(770)	2,856
Depreciation on property, plant and equipment	9,444	9,152
Amortisation on intangible assets	187	188
Impairments of property, plant and equipment	309	(50)
<b>Audit fees :</b>		
Audit services - statutory audit	58	65
Audit services - regulatory reporting	0	0
Other auditors remuneration	1	16
Further assurance services	0	0
Other services	0	0
Clinical negligence	523	455
Loss on disposal of investments	0	0
Loss on disposal of intangible fixed assets	0	12
Loss on disposal of land and buildings	0	0
Loss on disposal of other property, plant and equipment	0	0
Loss on disposal of assets held for sale	0	0
Impairments of assets held for sale	0	1,447
Legal fees	451	380
Consultancy costs	559	527
Training, courses and conferences	930	701
Patient travel	3	5
Car parking & security	1	0
Redundancy	198	343
Losses, ex gratia & special payments	25	122
Other	0	0
<b>TOTAL</b>	<b>168,785</b>	<b>164,011</b>

## 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 or escalation clauses and there are no specific restrictions imposed by the lease arrangements.

#### Payments recognised as an expense

	2012-13 £000	2011-12 £000
Minimum lease payments	3,691	2,306
Contingent rents	0	0
Sub-lease payments	0	0
Less sublease payments received	0	0
	<b>3,691</b>	2,306

#### Total future minimum lease payments

	2012-13 £000	2011-12 £000
<b>Payable:</b>		
Not later than one year	1,752	1,697
Between one and five years	2,524	2,949
After five years	2,500	2,881
<b>Total</b>	<b>6,776</b>	7,527

Total future sublease payments expected to be received: £nil

## 10. Employee costs and numbers

### 10.1 Employee costs

	2012-13			2011-12		
	Total	Permanently employed	Other	Total	Permanently employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	<b>93,674</b>	<b>89,923</b>	<b>3,751</b>	91,071	90,397	674
Social security costs	<b>7,202</b>	<b>7,202</b>	<b>0</b>	6,998	6,998	0
Employer contributions to NHS pension scheme	<b>10,952</b>	<b>10,952</b>	<b>0</b>	10,636	10,636	0
Pension cost - other contributions	<b>0</b>	<b>0</b>	<b>0</b>	0	0	0
Other post employment benefits	<b>0</b>	<b>0</b>	<b>0</b>	0	0	0
Other employment benefits	<b>0</b>	<b>0</b>	<b>0</b>	0	0	0
Termination benefits	<b>196</b>	<b>196</b>	<b>0</b>	343	343	0
Agency staff	<b>1,746</b>	<b>0</b>	<b>1,746</b>	1,849	0	1,849
<b>Employee benefits expense</b>	<b>113,770</b>	<b>108,273</b>	<b>5,497</b>	110,897	108,374	2,523

## 10.2 Average number of people employed

	2012-13			March 2011-12		
	Total	Permanently employed	Other	Total	Permanently employed	Other
	Number	Number	Number	Number	Number	Number
Ambulance staff	<b>1,985</b>	<b>1,927</b>	<b>58</b>	1,978	1,959	19
Administration and estates	<b>775</b>	<b>714</b>	<b>61</b>	697	689	8
Healthcare assistants and other support staff	<b>336</b>	<b>307</b>	<b>29</b>	281	278	3
Bank and agency staff	<b>54</b>	<b>0</b>	<b>54</b>	62	0	62
Other	<b>0</b>	<b>0</b>	<b>0</b>	7	7	0
<b>Total</b>	<b>3,150</b>	<b>2,948</b>	<b>202</b>	<b>3,025</b>	<b>2,933</b>	<b>92</b>
<b>Of the above:</b>						
Number of whole time equivalent staff engaged on capital projects	<b>6</b>			<b>2</b>		

## 10.3 Staff sickness absence

	2012-13 Number	2011-12 Number
Total days lost	<b>33,433</b>	36,156
Total staff years	<b>2,824</b>	2,785
Average working days lost	<b>11.8</b>	13.0
Total staff employed in period (headcount)	<b>3,265</b>	3,102

Data provided by Department of Health for 12 months period January to December 2012.

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#### **10.4 Retirements due to ill-health**

During 2012 -13 there were 14 (2011-12, 7) early retirements from the NHS Foundation Trust agreed on the grounds of ill-health at an additional cost of £1,001,118 (2011-12, £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 2012-13 was £142,500 (2011-12: £137,500). This was 4.7 times (2011-12: 4.5 times) the median remuneration of the workforce, which was £30,071 (2011-12: £30,335)

In 2012-13, no employees received remuneration in excess of the highest paid director. Remuneration ranged from £12,500 to £132,500.

## 10.6 Staff Exit Packages during 2012-13

There were 6 exit packages paid in 2012-13 (2011-12:12) at a total cost of £198k (2011-12 : £343k)

Exit package cost band (including any special payment element)	2012-2013			2011-2012		
	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
Less than £10,000	2	0	2	2	2	4
£10,001-£25,000	2	0	2	2	1	3
£25,001-£50,000	0	0	0	2	0	2
£50,001-£100,000	2	0	2	3	0	3
£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
<b>Total number of exit packages by type</b>	<b>6</b>	<b>0</b>	<b>6</b>	<b>9</b>	<b>3</b>	<b>12</b>
<b>Total resource cost (£000s)</b>	<b>198</b>	<b>0</b>	<b>198</b>	<b>325</b>	<b>18</b>	<b>343</b>

## 11. Salary and Pension Entitlements of Senior Managers

### 11.1 Remuneration

Name and Title	Term of office	Year ended 31 March 2013			Year ended 31 March 2012		
		Salary (bands of £5,000) £'000	Benefits in kind (rounded to the nearest £100)	Employer Pension Contribution (rounded to the nearest £100)	Salary (band of £5,000) £'000	Benefits in kind (rounded to the nearest £100)	Employer Pension Contribution (rounded to the nearest £100)
<b>Chairman</b>							
Mike Harris <i>Chairman</i>	<i>Contract ended 30.09.11</i>	-	-	0	15-20	-	0
Tony Thorne <i>Chairman</i>	<i>Appointed 01.09.11</i>	40-45	-	0	20-25	-	0
<b>Non-Executive Directors</b>							
Christine Barwell <i>Non-Executive Director</i>		10-15	-	0	5-10	-	0
Isobel Simpson <i>Non-Executive Director</i>	<i>Left 31.07.2012</i>	0-5	-	0	5-10	-	0
John Jackson <i>Non-Executive Director</i>		10-15	-	0	5-10	-	0
Nigel Penny <i>Non-Executive Director</i>		15-20	-	0	5-10	-	0
Trevor Willington <i>Non-Executive Director</i>		10-15	-	0	5-10	-	0
Tim Howe <i>Non-Executive Director</i>	<i>Appointed 01.03.11</i>	15-20	-	0	5-10	-	0
Graham Colbert <i>Non-Executive Director</i>	<i>Appointed 03.09.12</i>	5-10	-	0	0	-	0
Katrina Herren <i>Non-Executive Director</i>	<i>Appointed 03.09.12</i>	5-10	-	0	0	-	0
<b>Chief Executive</b>							
Paul Sutton <i>Chief Executive</i>		140-145	5,100	19,400	135-140	5,300	19,400
<b>Executive Directors</b>							
Andy Newton <i>Dir. of Clinical Operations</i>		90-95	3,200	13,300	85-90	3,200	12,400
Colin Perry <i>Interim Dir. of Finance</i>	<i>Contract ended 14.04.11</i>				10-15	1,600*	-
James Kennedy <i>Director of Finance</i>	<i>Appointed 17.10.11</i>	125-130		17,900	55-60	-	8,200
Robert Bell <i>Acting Dir. of Finance</i>	<i>15.04.11 to 16.10.11</i>				45-50	-	11,200
Geraint Davies <i>Dir. of Commercial Services</i>		90-95	4,800	12,600	85-90	4,600	12,600
Kath Start <i>Dir. of Workforce Development</i>		90-95	4,700	12,800	85-90	5,200	12,600
Sue Harris <i>Dir. of Strategy, Planning &amp; Partnerships</i>	<i>Left 31.05.2012</i>	15-20	400	2,500	90-95	4,200	12,600
Jane Pateman <i>Medical Director</i>		95-100	1,800	-	95-100	1,700	-



<b>Pay Multiple</b>	<b>Year ended 31 March 2013</b>	<b>Year ended 31 March 2012</b>
Band of Highest Paid Director's Total (£000)	140-145	135-140
Median Total Remuneration (£)	30,071	30,335
Remuneration Ratio	4.7	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.

## 11.2 Pension Entitlements

Name and Title	Year ended 31 March 2013						
	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 2012	Cash equivalent Transfer 31 March 2013	Real increase in cash equivalent transfer value
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
<b>Chief Executive</b>							
Paul Sutton <i>Chief Executive</i>	0-2.5	5-7.5	35-40	105-110	458	543	61
<b>Executive Directors</b>							
Andy Newton <i>Director of Clinical Operations</i>	0-2.5	5-7.5	35-40	115-120	738	840	64
Geraint Davies <i>Director of Commercial Services</i>	(0-2.5)	(0-2.5)	25-30	80-85	449	483	10
Kath Start <i>Director of Workforce Development</i>	0-2.5	0	5-10	0	55	81	23
Sue Harris <i>Director of Strategy, Planning and Partnerships</i>	0-2.5	(0-2.5)	10-15	10-15	128	147	2
James Kennedy <i>Director of Finance</i>	0-2.5	0	0-5	0	9	36	26

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).

## 12. Better Payment Practice Code

### 12.1 Better Payment Practice Code – measure of compliance

	2012-13		2011-12	
	Number	£000	Number	£000
Total Non-NHS trade invoices paid in the period	<b>30,985</b>	<b>53,448</b>	30,749	50,780
Total Non-NHS trade invoices paid within target	<b>28,211</b>	<b>45,148</b>	28,635	45,551
Percentage of Non-NHS trade invoices paid within target	<b>91%</b>	<b>84%</b>	93%	90%
Total NHS trade invoices paid in the period	<b>1,079</b>	<b>2,181</b>	651	4,864
Total NHS trade invoices paid within target	<b>762</b>	<b>1,274</b>	499	4,411
Percentage of NHS trade invoices paid within target	<b>71%</b>	<b>58%</b>	77%	91%

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 2012-13 Better Payment Practice Code percentages are lower than the target of 95% in part due to the upgrade of Oracle software during the year resulting in no payments being possible between the end of December 2012 and the middle of January 2013. In addition, supplier disputes, invoices processed but not yet due, system upload errors and timing of NHS payment runs were also reasons for the Better Payment Practice Code percentages being lower than target.

## 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 (2011-12: £nil)

### 13. Investment revenue

	2012-13 £000	2011-12 £000
Interest revenue:		
Bank accounts	171	52
<b>Total</b>	<b>171</b>	<b>52</b>

### 14. Finance costs

	2012-13 £000	2011-12 £000
Interest on obligations under finance leases	217	280
Unwinding of discount	130	135
Other	0	13
<b>Total interest expense</b>	<b>347</b>	<b>428</b>

## 15. Property, plant and equipment

	Land	Buildings excluding dwellings	Assets under construct	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
2012-13	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2012	18,117	28,130	1,216	13,467	46,238	6,197	439	113,804
Transfers by absorption	0	0	0	0	0	0	0	0
Additions purchased	0	9	10,813	0	0	2,073	0	12,895
Additions donated	0	0	0	0	0	0	0	0
Impairments	0	(352)	0	0	0	0	0	(352)
Reversal of Impairments	0	0	0	0	0	0	0	0
Reclassifications	0	(162)	(395)	0	557	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	(1,500)	(1,751)	(95)	(11)	(3,357)
<b>At 31 March 2013</b>	<b>18,117</b>	<b>27,625</b>	<b>11,634</b>	<b>11,967</b>	<b>45,044</b>	<b>8,175</b>	<b>428</b>	<b>122,990</b>
Depreciation at 1 April 2012	0	570	0	7,972	24,366	3,686	439	37,033
Provided during the year	0	1,245	0	1,580	5,712	907	0	9,444
Impairments	0	309	0	0	0	0	0	309
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	(1,500)	(1,734)	(95)	(11)	(3,340)
<b>Depreciation at 31 March 2013</b>	<b>0</b>	<b>2,124</b>	<b>0</b>	<b>8,052</b>	<b>28,344</b>	<b>4,498</b>	<b>428</b>	<b>43,446</b>
<b>Net book value</b>								
Purchased	18,117	24,140	11,634	3,915	14,135	1,764	0	73,705
Donated	0	0	0	0	0	0	0	0
Finance leased	0	1361	0	0	2,565	1,913	0	5,839
<b>Total at 31 March 2013</b>	<b>18,117</b>	<b>25,501</b>	<b>11,634</b>	<b>3,915</b>	<b>16,700</b>	<b>3,677</b>	<b>0</b>	<b>79,544</b>
<b>Asset financing</b>								
Owned	18,117	24,140	11,634	3,915	14,135	1764	0	73,705
Finance leased	0	1,361	0	0	2,565	1913	0	5,839
<b>Total 31 March 2013</b>	<b>18,117</b>	<b>25,501</b>	<b>11,634</b>	<b>3,915</b>	<b>16,700</b>	<b>3677</b>	<b>0</b>	<b>79,544</b>
<b>Asset financing</b>								
Protected Assets	15,904	13,605	0	0	0	0	0	29,509
Unprotected Assets	2,213	11,896	11,634	3,915	16,700	3,677	0	50,035
<b>Total 31 March 2013</b>	<b>18,117</b>	<b>25,501</b>	<b>11,634</b>	<b>3,915</b>	<b>16,700</b>	<b>3,677</b>	<b>0</b>	<b>79,544</b>

2011-12	Land	Buildings excluding dwellings	Assets under construct	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	11,470*	14,575	40,684	8,920	439	117,836
Transfers by absorption	0	0	0	0	0	0	0	0
Additions purchased	0	1,563	10,867	0	0	0	0	12,430
Additions donated	0	0	0	0	0	0	0	0
Impairments	11	39	0	0	0	0	0	50
Reversal of Impairments	0	0	0	0	0	0	0	0
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)
<b>At 31 March 2012</b>	<b>18,117</b>	<b>28,130</b>	<b>1,216</b>	<b>13,467</b>	<b>46,238</b>	<b>6,197</b>	<b>439</b>	<b>113,804</b>
Depreciation at 1 April 2011	0	89	0*	10,243	20,910	6,469	439	38,150
Provided during the year	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)
<b>Depreciation at 31 March 2012</b>	<b>0</b>	<b>570</b>	<b>0</b>	<b>7,972</b>	<b>24,366</b>	<b>3,686</b>	<b>439</b>	<b>37,033</b>
<b>Net book value</b>								
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
<b>Total at 31 March 2012</b>	<b>18,117</b>	<b>27,560</b>	<b>1,216</b>	<b>5,495</b>	<b>21,872</b>	<b>2,511</b>	<b>0</b>	<b>76,771</b>
<b>Asset financing</b>								
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
<b>Total 31 March 2012</b>	<b>18,117</b>	<b>27,560</b>	<b>1,216</b>	<b>5,495</b>	<b>21,872</b>	<b>2,511</b>	<b>0</b>	<b>76,771</b>
<b>Asset financing</b>								
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
<b>Total 31 March 2012</b>	<b>18,117</b>	<b>27,560</b>	<b>1,216</b>	<b>5,495</b>	<b>21,872</b>	<b>2,511</b>	<b>0</b>	<b>76,771</b>

\* Impairment of Assets under construction £186k transferred from Depreciation at 1 April 2011 to Cost or valuation at 1 April 2011

## 15. Property, plant and equipment (cont.)

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 2013, to reflect the current market and has used the Investment Property Databank (IPD) sector capital value industrial index for all buildings with the exception of the Ashford and Paddock Wood Make Ready Centres which are both new-builds. For Land the Industrial development land index was used.

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 historical 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

	Computer software – purchased	Computer software – internally generated	Licences and trademarks	Patents	Development expenditure (internally generated)	Total
2012-13	£000	£000	£000	£000	£000	£000
Gross cost at 1 April 2012	1,065	0	0	0	0	1,065
Additions purchased	0	0	0	0	0	0
Additions donated	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Revaluation / indexation	0	0	0	0	0	0
Transferred to disposal group as asset held for sale	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversals of impairments	0	0	0	0	0	0
Disposals	(18)	0	0	0	0	(18)
<b>Gross cost at 31 March 2013</b>	<b>1,047</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,047</b>
Amortisation at 1 April 2012	424	0	0	0	0	424
Reclassifications	0	0	0	0	0	0
Reclassifications as held for sale	0	0	0	0	0	0
Disposals	(18)	0	0	0	0	(18)
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	187	0	0	0	0	187
<b>Amortisation at 31 March 2013</b>	<b>593</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>593</b>
<b>Net book value</b>						
Purchased	454	0	0	0	0	454
Donated	0	0	0	0	0	0
Government granted	0	0	0	0	0	0
<b>Total at 31 March 2013</b>	<b>454</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>454</b>

## 16. Intangible assets (cont.)

	Computer software -purchased	Computer software -internally generated	Licences and trademarks	Patents	Development expenditure (internally generated)	Total
2011-12	£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 donated	0	0	0	0	0	0
Reclassifications	337	0	0	0	0	337
Reclassified as held for sale	0	0	0	0	0	0
Revaluation / indexation	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversals of impairments	0	0	0	0	0	0
Disposals	(828)	0	0	0	0	(828)
<b>Gross cost at 31 March 2012</b>	<b>1,065</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>1,065</b>
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	(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
<b>Amortisation at 31 March 2012</b>	<b>424</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>424</b>
Net book value						
Purchased	641	0	0	0	0	641
Donated	0	0	0	0	0	0
Leased	0	0	0	0	0	0
<b>Total at 31 March 2012</b>	<b>641</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>641</b>

### 16.1 Amortisation rate of intangible assets

Software – 5 years



## 17.1 Analysis of impairments and reversals recognised in 2012-13

	31 March 2013 Total £000	31 March 2012 Total £000
<b>Property, Plant and Equipment impairments and reversals taken to SoCI</b>		
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
<b>Total charged to Departmental Expenditure Limit</b>	<b>0</b>	<b>0</b>
Unforeseen obsolescence	0	0
Loss as a result of catastrophe	0	0
Other	0	0
Changes in market price	309	(50)
<b>Total charged to Annually Managed Expenditure</b>	<b>309</b>	<b>(50)</b>
<b>Property, Plant and Equipment impairments and reversals charged to the revaluation reserve</b>		
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	352	0
<b>Total impairments for PPE charged to reserves</b>	<b>352</b>	<b>0</b>
<b>Total Impairments of Property, Plant and Equipment</b>	<b>661</b>	<b>(50)</b>
<b>Intangible assets impairments and reversals charged to SoCI</b>		
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
<b>Total charged to Departmental Expenditure Limit</b>	<b>0</b>	<b>0</b>
Unforeseen obsolescence	0	0
Loss as a result of catastrophe	0	0
Other	0	0
Changes in market price	0	0
<b>Total charged to Annually Managed Expenditure</b>	<b>0</b>	<b>0</b>
<b>Intangible Assets impairments and reversals charged to the Revaluation Reserve</b>		
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
<b>Total impairments for Intangible Assets charged to Reserves</b>	<b>0</b>	<b>0</b>
<b>Total Impairments of Intangibles</b>	<b>0</b>	<b>0</b>
<b>Financial Assets charged to SoCI</b>		
Loss or damage resulting from normal operations	0	0
<b>Total charged to Departmental Expenditure Limit</b>	<b>0</b>	<b>0</b>
Loss as a result of catastrophe	0	0
Other	0	0
<b>Total charged to Annually Managed Expenditure</b>	<b>0</b>	<b>0</b>
<b>Financial Assets impairments and reversals charged to the Revaluation Reserve</b>		
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
<b>Total Impairments of Financial Assets</b>	<b>0</b>	<b>0</b>

## 17.1 Analysis of impairments and reversals recognised in 2012-13 (cont.)

	31 March 2013 Total £000	31 March 2012 Total £000
<b>Non-current assets held for sale - impairments and reversals charged to SoCI.</b>		
Loss or damage resulting from normal operations	0	0
Abandonment of assets in the course of construction	0	0
<b>Total charged to Departmental Expenditure Limit</b>	<b>0</b>	<b>0</b>
<b>Unforeseen obsolescence</b>		
Loss as a result of catastrophe	0	0
Other	0	0
Changes in market price	0	1,447
<b>Total charged to Annually Managed Expenditure</b>	<b>0</b>	<b>1,447</b>
<b>Non-current assets held for sale - impairments and reversals charged to the revaluation reserve.</b>		
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	578
<b>Total impairments for non-current assets held for sale charged to Reserves</b>	<b>0</b>	<b>578</b>
<b>Total impairments of non-current assets held for sale</b>	<b>0</b>	<b>2,025</b>
<b>Investment Property impairments charged to SoCI</b>		
Loss as a result of catastrophe	0	0
Other	0	0
Changes in market price	0	0
<b>Total charged to Annually Managed Expenditure</b>	<b>0</b>	<b>0</b>
<b>Total Investment Property impairments charged to SoCI</b>	<b>0</b>	<b>0</b>
<b>Total Impairments charged to Revaluation Reserve</b>	<b>352</b>	<b>578</b>
<b>Total Impairments charged to SoCI - DEL</b>	<b>0</b>	<b>0</b>
<b>Total Impairments charged to SoCI - AME</b>	<b>309</b>	<b>1,397</b>
<b>Overall Total Impairments</b>	<b>661</b>	<b>1,975</b>
<b>Of which:</b>		
Impairment on revaluation to "modern equivalent asset" basis	0	0
Donated and Gov Granted Assets, included above		
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
<b>Total Donated Asset Impairments</b>	<b>0</b>	<b>0</b>
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
<b>Total Gov Granted asset Impairments.</b>	<b>0</b>	<b>0</b>
<b>TOTAL DONATED/GOVERNMENT GRANTED ASSET IMPAIRMENTS</b>	<b>0</b>	<b>0</b>

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## **17.2 Property, Plant and Equipment**

The PPE impairment of £309k (2011-12: £(50)k) results from the current year indexation of Land and Buildings with the debit charged to the SoCI.

## **17.3 Non-current assets held for sale**

As a result of the Trust's programme of transferring Operations to Make Ready Centres, during 2011-12 the Board approved the disposal of eight ambulance stations relating to the Make Ready Centres at Ashford and Paddock Wood.

Fair value market valuations were received from local estate agents, costs to sell deducted and the results compared with the net book value of the assets.

This has identified an impairment loss of £nil (2011-12:£ 2,025k) of which £nil (2011-12: £1,447k) has been recognised in Surplus/(Deficit) for the financial period in the Statement of Comprehensive Income and £nil (2011-12:£ 578k) 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:

	<b>31 March 2013</b>	31 March 2012
	<b>£000</b>	£000
Property, plant and equipment	<b>1,167</b>	269
<b>Total</b>	<b>1,167</b>	269

## 19. Inventories

### 19.1 Inventories

	<b>31 March 2013</b>	31 March 2012
	<b>£000</b>	£000
Drugs	<b>6</b>	4
Consumables	<b>1,153</b>	747
Fuel	<b>228</b>	198
<b>Total</b>	<b>1,387</b>	949

### 19.2 Inventories recognised in expenses

	<b>31 March 2013</b>	31 March 2012
	<b>£000</b>	£000
Inventories recognised as an expense in the period	<b>438</b>	51
Write-down of inventories	<b>0</b>	0
Reversal of write-downs that reduced the expense	<b>0</b>	0
<b>Total inventories recognised in the period</b>	<b>438</b>	51

## 20. Trade and other receivables

### 20.1 Trade and other receivables

	<b>Current</b> <b>31 March</b> <b>2013</b> <b>£000</b>	<b>Non-current</b> <b>31 March</b> <b>2013</b> <b>£000</b>	Current 31 March 2012 £000	Non-current 31 March 2012 £000
NHS receivables	879	0	1,003	812
Other receivables with related parties	0	0	24	0
Provision for impaired receivables	0	0	0	0
Prepayments	3,053	0	4,335	0
Accrued income	956	0	914	0
Other receivables	1,880	0	1,191	0
<b>Total</b>	<b>6,768</b>	<b>0</b>	<b>7,467</b>	<b>812</b>

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

	<b>31 March</b> <b>2013</b> <b>£000</b>	31 March 2012 £000
By up to three months	150	363
By three to six months	118	136
By more than six months	96	74
<b>Total</b>	<b>364</b>	<b>573</b>

## 21. Cash and cash equivalents

	<b>31 March</b> <b>2013</b> <b>£000</b>	31 March 2012 £000
Opening Balance	22,406	14,248
Net change in year	7,911	8,158
Closing Balance	30,317	22,406
<b>Made up of</b>		
Cash with Government banking services	30,286	22,374
Commercial banks and cash in hand	31	32
Cash and cash equivalents as in statement of financial position	30,317	22,406
Cash and cash equivalents as in statement of cash flows	30,317	22,406

## 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 2012	1,578	2,240	0	0	0	3,818
Plus assets classified as held for sale in the year	0	0	0	0	0	0
Less assets sold in the year	(194)	(291)	0	0	0	(485)
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
<b>Balance at 31 March 2013</b>	<b>1,384</b>	<b>1,949</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>3,333</b>
Balance at 1 April 2011	0	0	0	0	0	0
Plus assets classified as held for sale in the year	2,415	3,428	0	0	0	5,843
Less assets sold in the year	0	0	0	0	0	0
Less impairments of assets held for sale	(837)	(1,188)	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	1,578	2,240	0	0	0	3,818

Non-current assets held for sale have been split between Land and Buildings for both 2012-13 and 2011-12. The total value of both Land and Buildings were shown under Buildings in the 2011-12 financial statements.

## 22.2 Non-current assets held for sale

As a result of the Trust's programme of transferring Operations to Make Ready Centres, during 2011-12 the Board 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.

Two ambulance stations, namely Crowborough and Tonbridge, have been sold in the year resulting in a reduction in the Non-current assets held for sale of £485k (2011-12: £nil)

The expected disposal date of the remaining ambulance stations is prior to 31st March 2014.

## 23. Trade and other payables

	<b>Current 31 March 2013 £000</b>	<b>Non-current 31 March 2013 £000</b>	<b>Current 31 March 2012 £000</b>	<b>Non-current 31 March 2012 £000</b>
Receipts in advance	0	0	0	0
NHS payables	153	0	154	0
Amounts due to other related parties	0	0	491	0
Trade payables - capital	2,905	0	461	0
Other trade payables	1,307	0	281	0
Taxes payable	3,888	0	3,707	0
Other payables	0	0	0	0
Accruals	9,549	0	7,033	0
PDC payable	0	0	0	0
<b>Total</b>	<b>17,802</b>	<b>0</b>	<b>12,127</b>	<b>0</b>

### 23.1. Other liabilities

	<b>Current 31 March 2013 £000</b>	<b>Non-current 31 March 2013 £000</b>	<b>Current 31 March 2012 £000</b>	<b>Non-current 31 March 2012 £000</b>
Deferred grants income	0	0	0	0
Other deferred income	248	0	502	0
Deferred PFI credits	0	0	0	0
Lease incentives	0	0	0	0
Net Pension Scheme Liability	0	0	0	0
	<b>248</b>	<b>0</b>	502	0

### 24. Borrowings

	<b>Current 31 March 2013 £000</b>	<b>Non-current 31 March 2013 £000</b>	<b>Current 31 March 2012 £000</b>	<b>Non-current 31 March 2012 £000</b>
Obligations under finance leases	1,774	4,218	1,071	4,082
<b>Total</b>	<b>1,774</b>	<b>4,218</b>	1,071	4,082



## 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 and the NHS 111 Managed IT Service on a 3 years 3 months commercial lease arrangement.

### Amounts payable under finance leases:

	<b>Minimum lease payments</b>	<b>Present value of minimum lease payments</b>	Minimum lease payments	Present value of minimum lease payments
	<b>31 March 2013 £000</b>	<b>31 March 2013 £000</b>	31 March 2012 £000	31 March 2012 £000
Within one year	<b>1,941</b>	<b>1,774</b>	1,303	1,071*
Between one and five years	<b>3,083</b>	<b>3,065</b>	2,801	2,703*
After five years	<b>2,115</b>	<b>1,153</b>	2,100	1,379
Less future finance charges	<b>(1,147)</b>	<b>0</b>	(1,051)	0
<b>Value of minimum lease payments</b>	<b>5,992</b>	<b>5,992</b>	5,153	5,153
Included in:				
Current borrowings		<b>1,774</b>		1,071
Non-current borrowings		<b>4,218</b>		4,082
		<b>5,992</b>		5,153

Future sublease payments expected to be received total £nil.

Contingent rents recognised as an expense £nil.

\* Prior year Present value of minimum lease payments within one year and Between one and five years have been restated. Total value remains the same

## 26. Prudential borrowing limit

	<b>31 March 2013 £000</b>	<b>31 March 2012 £000</b>
Total long term borrowing limit set by Monitor	<b>21,900</b>	27,500
Working capital facility agreed by Monitor	<b>13,000</b>	13,000
<b>Total long term borrowing limit</b>	<b>34,900</b>	40,500
<b>Long term borrowing at start of period for new FTs</b>		
Borrowing at 1 April	<b>5,153</b>	4,722
Net actual borrowing/(repayment) in year - long term	<b>839</b>	431
Long term borrowing at 31 March	<b>5,992</b>	5,153

	<b>Actual Ratios 2013</b>	<b>Approved PBL ratios</b>	<b>Actual Ratios 2012</b>	<b>Approved PBL ratios</b>
Minimum Dividend Cover	<b>7x</b>	<b>&gt;1x</b>	7x	>1x
Minimum Interest Cover	<b>69x</b>	<b>&gt;3x</b>	52x	>3x
Minimum Debt Service Cover	<b>7x</b>	<b>&gt;2x</b>	6x	>2x
Maximum Debt Service to revenue	<b>1.28%</b>	<b>&lt;2.5%</b>	1.45%	<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 ratio 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
- + 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

	<b>Current 31 March 2013 £000</b>	<b>Non-current 31 March 2013 £000</b>	Current 31 March 2012 £000	Non-current 31 March 2012 £000
Pensions relating to other staff	<b>356</b>	<b>4,127</b>	342	3,955
Other legal claims	<b>1,281</b>	<b>0</b>	1,342	0
Other	<b>798</b>	<b>4,408</b>	919	5,436
<b>Total</b>	<b>2,435</b>	<b>8,535</b>	2,603	9,391

	<b>Pensions relating to other staff £000</b>	<b>Legal claims £000</b>	<b>Agenda for Change £000</b>	<b>Other £000</b>	<b>Total £000</b>
At 1 April 2012	<b>4,297</b>	<b>1,342</b>	<b>0</b>	<b>6,355</b>	<b>11,994</b>
Arising during the year	<b>417</b>	<b>0</b>	<b>0</b>	<b>26</b>	<b>443</b>
Utilised during the year	<b>(351)</b>	<b>(61)</b>	<b>0</b>	<b>(1,185)</b>	<b>(1,597)</b>
Unwinding of discount	<b>120</b>	<b>0</b>	<b>0</b>	<b>10</b>	<b>130</b>
At 31 March 2013	<b>4,483</b>	<b>1,281</b>	<b>0</b>	<b>5,206</b>	<b>10,970</b>

### Expected timing of cash flows:

Within one year	<b>356</b>	<b>1,281</b>	<b>0</b>	<b>798</b>	<b>2,435</b>
Between one and five years	<b>1,655</b>	<b>0</b>	<b>0</b>	<b>4,086</b>	<b>5,741</b>
After five years	<b>2,472</b>	<b>0</b>	<b>0</b>	<b>322</b>	<b>2,794</b>

Other provisions include dilapidations of leasehold premises, holiday pay and pre-1985 banked leave.

The pension provision of £4,483k represents the organisation's pension liability for pre-1995 reorganisations (31 March 2012: £4,297k).

Legal claims are the member provision for personal injury claims being handled by the NHS Litigation Authority.

A further £6,991k is included in the provisions of the NHS Litigation Authority at 31 March 2013 (not in these accounts) in respect of clinical negligence liabilities of the NHS Trust (2011-12: £8,353k).

## 28. Contingencies

### 28.1 Contingent liabilities

	<b>2012-13</b>	2011-12
	<b>£000</b>	£000
Legal claims	<b>502</b>	596
Potential redundancy costs	<b>0</b>	110
Total	<b>502</b>	706

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:

	<b>Payments to Related Party</b>	<b>Receipts from Related Party</b>	<b>Amounts owed to Related Party</b>	<b>Amounts due from Related Party</b>
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
Ashford & St Peter's Hospitals NHS Foundation Trust	49	81	2	70
Berkshire East PCT		82		77
Berkshire West PCT		7		7
Brighton and Hove City Teaching PCT		8,464		198
Brighton & Sussex University Hospitals NHS Trust	140	2	9	1
Dartford & Gravesham NHS Trust	14		7	
Department of Health *		1,983	120	80
East of England Ambulance Service NHS Trust	69			
East Kent Hospitals University NHS Foundation Trust	1		4	6
East Sussex Downs & Weald PCT		278		277
East Sussex Healthcare NHS Trust	54		35	41
Eastern & Coastal Kent Community Health NHS Trust				106
Eastern & Coastal Kent PCT	1	586		
Epsom & St Helier University Hospitals NHS Trust	25	3	2	
Frimley Park Hospital NHS Foundation Trust	52		10	
Hampshire PCT		322	15	327
Hounslow PCT		46		49
Isle of Wight NHS Trust			3	
Kent & Medway NHS & Social Care Partnership		106	2	43
Kent Community Health NHS Trust		6		
Kings College Hospital NHS Foundation Trust	1			
London Ambulance Service NHS Trust	4	131		
London SHA	5			15
Maidstone and Tunbridge Wells NHS Trust	60	203	30	31
Medway NHS Foundation Trust	216	16		4
Medway PCT		670		30
NHS Litigation Authority	540			
North East Ambulance Service NHS Foundation Trust	1			
Oxford Health NHS Foundation Trust	9			
Portsmouth Hospitals NHS Trust		69	62	
Queen Victoria Hospital NHS Foundation Trust	2	234		230
Royal Surrey County Hospital NHS Foundation Trust		130		134

	<b>Payments to Related Party</b>	<b>Receipts from Related Party</b>	<b>Amounts owed to Related Party</b>	<b>Amounts due from Related Party</b>
	<b>£000</b>	<b>£000</b>	<b>£000</b>	<b>£000</b>
Skipton Fund		27		
South Central Ambulance Service NHS Foundation Trust		14		3
South East Coast Strategic Health Authority	3	798		5
South West Ambulance Service NHS Foundation Trust	20		3	
South West Strategic Health Authority				10
St Georges Healthcare NHS Trust		42		8
Surrey and Sussex Healthcare NHS Trust	25	45	3	
Surrey PCT		2,838		116
Sussex Community NHS Trust	6		2	5
Sussex Partnership NHS Foundation Trust			24	
University Hospitals of Bristol NHS Foundation Trust				12
West Kent PCT		155,278	20	
West Midlands Ambulance Service NHS Foundation Trust	43			
West Suffolk Hospital NHS Foundation Trust	11			
Western Sussex Hospitals NHS Trust	174		29	
Yorkshire and the Humber Strategic Health Authority	2			

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 £8k (2012: £14k) 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 2013				31 March 2012			
	Current receivable	Non-current receivable	Current payable	Non-current payable	Current receivable	Non-current receivable	Current payable	Non-current payable
	£000	£000	£000	£000	£000	£000	£000	£000
Balances with other central government bodies	642	0	3,888	0	1	0	3,707	0
Balances with local authorities	5	0	0	0	23	0	510	0
Balances with NHS trusts and foundation trusts	588	0	227	0	626	812	266	0
Balances with other NHS bodies *	1,487	0	155	0	1,399	0	43	0
Balances with public corporations and trading funds	0	0	0	0	0	0	0	0
<b>Intra government balances</b>	<b>2,722</b>	<b>0</b>	<b>4,270</b>	<b>0</b>	<b>2,049</b>	<b>812</b>	<b>4,526</b>	<b>0</b>
<b>Balances with bodies external to government</b>	<b>4,046</b>	<b>0</b>	<b>13,532</b>	<b>0</b>	<b>5,418</b>	<b>0</b>	<b>7,601</b>	<b>0</b>
<b>At 31 March</b>	<b>6,768</b>	<b>0</b>	<b>17,802</b>	<b>0</b>	<b>7,467</b>	<b>812</b>	<b>12,127</b>	<b>0</b>

\* Intra Government balances restated for 2011/12 as Balances with other NHS bodies omitted

### **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 service provider relationship that the Trust has with Primary Care Trusts and the way those Primary Care Trusts are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust's financial assets and liabilities are generated by day-to-day operational activities rather than by the change in the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal 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 commercial rate. The Trust aims to ensure that it has low exposure to interest rate fluctuations by fixing rates for the life of the borrowing where possible. The Trust has low exposure to interest rate risk and currently has 54 front line vehicles on a 5 year fixed rate finance lease. Similarly the Trust has the building element of the Paddock Wood Make Ready Centre on a fixed rate 30 year finance lease and a 3 years 3 months zero rate finance lease for the NHS 111 Managed IT Service.

#### ***Credit risk***

As the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2013 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 2013	31 March 2012
	£000	£000
Receivables	3,074	4,044
Cash at bank and in hand	30,317	22,406
<b>Total at 31 March 2013</b>	<b>33,391</b>	26,450

### 31.2 Financial liabilities

	Other financial	Other financial
	liabilities	liabilities
	£000	£000
Payables	13,914	8,420
Finance lease obligations	5,992	5,153
Provisions under contract	6,487	7,697
<b>Total at 31 March 2013</b>	<b>26,393</b>	21,270

### 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 1,546 cases of losses and special payments (2011 - 12 : 1,667 cases) totalling £698k (2011-12 : £1,390k) reported during 2012-13. The amounts are reported on an accruals basis.

### 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 trading allowance 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 CO2 emissions

### 36. Events after the reporting period

There are no post balance sheet events.







## For more information

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