



Annual Report
& Accounts
2018/19

SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST
ANNUAL REPORT AND ACCOUNTS 2018/19

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the National Health Service Act 2006.

CONTENTS

WELCOME FROM CHAIR, LENA SAMUELS	4
PERFORMANCE REPORT, INC. CHIEF EXECUTIVE'S FOREWORD	
1. OVERVIEW OF PERFORMANCE	7
2. PERFORMANCE ANALYSIS	15
ACCOUNTABILITY REPORT	
3. DIRECTORS' REPORT	34
4. COUNCIL OF GOVERNORS	46
5. MEMBERSHIP & PUBLIC ENGAGEMENT	55
6. STAFF REPORT	60
7. REGULATORY RATING	76
8. ANNUAL GOVERNANCE STATEMENT	77
9. QUALITY REPORT	88
10. REPORT OF THE AUDIT COMMITTEE	177
11. OPERATIONAL AND FINANCIAL REVIEW	179
12. REMUNERATION REPORT	183
ANNUAL ACCOUNTS 2018/19	
• FOREWORD TO THE ACCOUNTS	191
• NOTES TO THE ACCOUNTS	198
• ACCOUNTING OFFICER'S STATEMENT OF RESPONSIBILITIES	244
INDEPENDENT PRACTITIONER'S LIMITED ASSURANCE REPORT TO THE COUNCIL OF GOVERNORS OF SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST ON THE QUALITY REPORT	246
INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST	250
GLOSSARY	263

WELCOME FROM CHAIR, LENA SAMUELS

With the advent of the NHS Long Term Plan and the increased focus on integrating care, South Central Ambulance Service has been at the forefront of shaping how we deliver care that truly meets the needs of patients and citizens. To achieve this, staff at every level of the organisation have played an active part both at regional and community level, working closely with stakeholders and bringing to the fore both our Trust's expertise in working at scale as well the organisation's appetite for applying innovation.

In this regard we are delighted to be supporting IOW NHS Trust in its evolution of the provision of ambulance services on the island. Our teams are working closely with theirs to improve both the capability and framework for the service. We have also established an alliance with London Ambulance Service to explore how we can share best practice, innovate and deliver efficiencies that recognise the need to drive out unwarranted variation. Such a collaborative approach has been an essential hallmark in ensuring that we evolve our own service in a way that is safe, effective and efficient and will continue to be a strength in defining our place in the evolving and exciting integrated care environment.

Our staff, both behind the scenes and at the frontline, have been exemplary in their commitment to delivering the best possible care and I am grateful to them for this. Their passion and energy are both inspiring and uplifting. Our service delivery has also been well supported by community first responders (CFRs) and co-responders. They have played a significant role in ensuring a timely response to non-life-threatening incidents with CFRs also participating in a Falls Pilot to explore alternative models of care. CFRs continue to play a hugely valuable role in fundraising on behalf of the South Central Ambulance Charity and as such continue to be important ambassadors for us. In terms of patient transport services, we have again received excellent support from our dedicated group of volunteer car drivers.

Over the last year we developed our work on cascading and reinforcing the vision and values across the organisation. I would like to thank members of our Council of Governors (CoG) for their support and contributions throughout the year and for also taking part in a specially tailored development programme. In order to remain a well-led organisation, we felt it was important to strengthen and enhance our strategic governance at all levels. We recognise that the leadership agenda is at the heart of creating a culture that is empowering, enabling and transformative and we will continue to develop this agenda further. Specific thanks must go to Barry Lipscomb for serving in the Lead Governor role throughout 2018/19, and I look forward to working with Bob Duggan in that same position over the next 12 months.

Our strategic interface and the neutrality that an ambulance service can bring through working across many counties, contributed to me taking up the position of Independent Chair for the Hampshire and IOW STP. With a commitment of one day per week, I have been able to bring forward the experience of working with many partners across a range of areas and localities in order to evolve collaboration on integrating care. As new models of care evolve, we know that the requirement for the ambulance service to adapt and enhance its service delivery will increase. This is an exciting prospect for us and we welcome the opportunity to evolve our innovation agenda as we continue to seek new and alternative ways of meeting the care needs of patients.

We have also been privileged once again this year to play an active part on the national ambulance service agenda. This saw our Director of Finance working closely with Lord Carter and his team on the improvement agenda of defining the "model ambulance". I was also honoured to be appointed as Chair of the Council of the Association of Ambulance Chief Executives (AACE) and to have chaired AACE's annual conference, the Ambulance Leadership Forum.

The past 12 months has been a year where the health sector has been focused on collaboration and transformation as key levers for delivering better care, greater efficiencies and improved performance. In this regard, under the leadership of Will Hancock as Chief Executive, SCAS has risen both to the challenges and the opportunities that this agenda has brought and delivered a service of which we can be proud. As an organisation we recognise that there is always room for improvement and that we should continue to learn and be energetic in seeking to do better. The coming year will present us with an operating environment of dynamic change as integrated care systems come into being. South Central Ambulance Service is well positioned to respond to and play its part in this new health landscape.



Lena Samuels



PERFORMANCE REPORT

1. OVERVIEW OF PERFORMANCE

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

1.1 CHIEF EXECUTIVE'S FOREWORD

It was a milestone year for our National Health Service with people right across the UK celebrating the 70th birthday of the NHS on 5 July 2018. Our staff and volunteers across the South Central region joined in the celebrations and members of the public took the opportunity to commend our staff on the fantastic jobs they do. For seven decades the NHS has been a mainstay of our society, providing free healthcare to everyone in the UK, no matter who they are or where they are from. The genuine affection and support for the NHS and those who work in it was epitomised for me when members of the public raised £700 for one of our emergency care assistants, Rob Blakley. Rob works from our North Harbour Resource Centre in Portsmouth and whilst on a night shift in May 2018, his bike – and sole means of transport to work and back from his home on the Isle of Wight – was stolen from his base. Within a very short space of time, a crowdfunding site had been created and the public raised £700 to help Rob fund the purchase of a new one.

Once again, the last 12 months have seen our incredibly dedicated, professional and hard-working staff, like Rob, across all our services and corporate operations deliver one of our most successful ever years, despite numerous challenges. Within our 999 service, it has been the first full year we have operated under the Ambulance Response Programme (ARP). This has meant we have begun a transformation programme in our 999 service, not only to change the make-up of our vehicle fleet to meet the ARP operating model, but also to provide a working environment that supports our frontline staff to achieve a healthy work-life balance.

In September, it was heartening to read in Lord Carter's Review into NHS ambulance trusts, that SCAS remains one of the best performing ambulance trusts against national response time targets, is a well-led organisation where operational staff feel engaged and supported, and the Trust delivers an efficient and effective emergency 999 service. Furthermore, a number of recommendations made by Lord Carter had already been implemented, or were already in the process of being implemented, at SCAS, such as our partnerships with London Ambulance Service and the Isle of Wight NHS Trust announced earlier in 2018. In July, our emergency and urgent care, resilience and emergency operations centre hosted an inspection team from the CQC and the following month, we were again visited by the CQC undertaking the Trust's first Well-Led inspection to assess how SCAS is led and governed. The inspection reports following both visits were published by the CQC in November and inspectors rated the Trust as 'Good' across all those services and in the Well-Led domain.

In October 2018, our Integrated Urgent Care / NHS 111 service received a very positive inspection report following a visit from CQC inspectors carried out from 7-9 August. CQC inspectors recognised that significant improvements had been made since the last inspection in 2016, and the service was rated as 'Good' overall but required improvement in the effective domain. We have not only expanded our NHS 111 service into Dorset and Surrey Heath over the last 12 months, but I was delighted that we have also been able to launch a 24-7 mental health service accessible via the 111 number. This service, developed in partnership with Southern Health NHS

Foundation Trust, is available to people in Hampshire and the Isle of Wight, suffering a mental health crisis, or carers of people with mental health problems, as well as local police officers to help them better respond to emergency calls to patients in crisis.

Other developments in our clinical co-ordination centres have included the launch of an Urgent Care Desk and Social Work Line. The Urgent Care Desk is staffed by specialist practitioners between 6am and 2am and the team is able to provide SCAS-wide senior clinical validation and advice to our crews, as well as volunteers and co-responders. The Social Work Line is staffed by a qualified social worker Monday-Friday with access to patient care packages and care plans across Hampshire and is able to support calls from people over 65 who have a social, rather than clinical need. It is heartening that these, and other initiatives, continue to demonstrate how we are developing into a more holistic, healthcare provider offering people a single point of access to exactly the right care and support they need.

It has been another successful year for our Commercial Division, which – despite its own challenging transformation programme – has continued to deliver a high-quality patient transport service and logistics service. Despite the challenges of change, I was very pleased that an innovative pilot scheme undertaken by our PTS team with Wexham Park Hospital, not only demonstrated how we can help improve the flow of patients ready to leave hospital, but has now been rolled out to other hospitals in our region and also generated interest from PTS providers and hospitals in other regions across the country.

I was delighted to be asked to open our very first Community First Responder Conference in April 2018. Nearly 200 of our volunteer CFRs, along with co-responders from the Fire, Police and Military Services, spent the day collaborating, sharing best practice and learning, centred on a theme of improving outcomes. Together with our volunteer car drivers who provide an excellent service to our PTS patients, it demonstrates just how incredibly valuable our volunteers are and the part they continue to play in making us a successful NHS organisation.

This is a very exciting time to be part of the NHS as breakthroughs in medicines and treatments, along with new technologies, are transforming how we can treat, care for and communicate with patients, with colleagues and with our partners across health, social care and other services. The digital transformation has continued apace at SCAS with the launch of a new clinical pathways app for our 999 staff and partners, first response app for our volunteers and becoming the first ambulance trust in the country to provide all its private providers with an electronic patient record system. I am delighted that we are at the forefront of the vision for the National Health Service of the future.

But the heart of the NHS will remain exactly as it did those 70 years ago in the vision of Aneurin Bevan; it's the people in the NHS that make it what it is. That's why it has, and will always remain, my top priority to make our organisation a happy and healthy place to work. Because delivering that objective, will ensure our patients continue to get the very best care and experience whenever and wherever they need us.



Will Hancock, Chief Executive

23 May, 2019

1.2 ABOUT US

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

SCAS was formed on 1 July 2006 following the merger of Hampshire, Oxfordshire, Royal Berkshire and Two Shires Ambulance Services and Will Hancock was appointed as the Trust's first Chief Executive. At that time, the newly formed Trust delivered 999 and non-emergency patient transport services, along with commercial training and logistics, some elements of GP out-of-hours services and the Berkshire Community Equipment Service. South Central Ambulance Service became a Foundation Trust on 1 March 2012 and was the first ambulance trust in England to be rated 'Good' by the Care Quality Commission (September 2016).

SCAS is a monopoly provider of 999 emergency ambulance services within the South Central region (as are all English ambulance trusts in their defined geographical areas); all other services the Trust delivers are tendered for on a competitive basis. With the expansion into Surrey and Sussex, we now serve a population of over seven million people across the six counties. We employ 3,783 staff who, together with over 1,000 volunteers, enable us to operate 24 hours a day, seven days a week.

What we do:

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

Our vision

TOWARDS EXCELLENCE SAVING LIVES AND ENABLING YOU TO GET THE CARE YOU NEED

Our mission

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

Our core values

- ➔ **Teamwork** – delivering high performance through an inclusive and collaborative approach which values diversity
- ➔ **Innovation** – continuous improvement through empowerment of our people
- ➔ **Professionalism** – setting high standards and delivering what we promise
- ➔ **Caring** – for our patients and each other

1.3 OUR STRATEGY

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

- ➔ Care coordination and integrated urgent care
- ➔ Mobile care and emergency responses
- ➔ Expanded patient transport and logistics
- ➔ A partner in local systems

The last five years of modernisation across the NHS and social care have brought some significant changes in the way that our services are organised, accessed and delivered. The NHS has now published the new Long Term Plan which will continue to develop upon the themes and trends whilst also implementing new initiatives. Issues that the Long Term Plan sets out to address include:

- ➔ The provision of care through an increasing number of 'channels', including by telephone, video call and online and a rapid increase in the technology available to support this. Whilst some of these services support 'channel shift' allowing care to be provided in a different way, they are also used to provide additional capacity to cope with rising demand.
- ➔ The rapid consolidation of provider organisations and of commissioners, through mergers and acquisitions and other less formal partnerships, driven by the need to maintain quality whilst containing costs.
- ➔ The development of new organisational forms in the NHS, including the development of accountable care systems bringing together commissioners and providers and new financial models.
- ➔ The need to change the focus of healthcare provision such that it is not immediately assumed that the local hospital will be the best place to see and treat urgent cases

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

- ➔ A continued focus upon meeting performance targets and quality of care, and ensuring that we have plans in place to meet these expectations going forward as they evolve. This should allow us to take a leading role in any future changes which may arise through procurement opportunities, from the recent review of ambulance services and other national changes.
- ➔ The need to plot a careful course through the changing organisational structures. We cover a number of STP footprints, and our role within an ICS is less clear cut than it would be for many organisations. It is vital that we engage with this process and actively build alliances and partnerships, so that we can influence our own future.
- ➔ An ability to anticipate and respond to changing urgent care requirements, by implementing our strategy for the creation of an Integrated Urgent Care Service.

Strategic themes

Care coordination, integrated urgent care and NHS 111
Mobile care and emergency responses
Expanded patient transport and logistics
SCAS as a partner in local care systems

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

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

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

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

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

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

1.4 KEY ISSUES AND RISKS

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

The aims of this strategy are to:

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

In accordance with governance best practice and legislative requirements the Trust formally assesses and records all significant risks in a Corporate Risk Register (operational risks) and in the Board Assurance Framework (strategic risks). Risks are reviewed through the Risk, Assurance and Compliance Committee, the Audit Committee and the Quality and Safety Committee. The Trust's aim is that the carrying out of suitable and sufficient risk assessments should become an integral part of everyday activity, becoming a pre-emptive approach to reducing accidents and adverse incidents rather than being reactive.

The Trust's principal risks have been identified as:

- ➔ Risk of not achieving the NHS England Ambulance Response Programme standards due to changing patterns
- ➔ Risks associated with delays due to queuing at emergency departments, particularly at the Queen Alexandra Hospital in Portsmouth, impacting on patient care and safety
- ➔ Risk of efficiently delivering the non-emergency patient transport service contracts
- ➔ Risk of not achieving the financial targets
- ➔ Risk of non-compliance with the General Data Protection Regulations and ensuring robust digital and data security
- ➔ Risk of ensuring recruitment and retention of key clinical staff in all services
- ➔ Risk of not being at the forefront of changes in the way ICS/ACS will work to manage resources system wide
- ➔ Risk of not maintaining the CQC 'Good' rating

2. PERFORMANCE ANALYSIS

2.1 999 OPERATIONS

As a modern ambulance service, we deliver our services through a combined and integrated approach with our wider health colleagues, as well as responding to emergency 999 and urgent GP calls. The expansion of our non-emergency NHS 111 and patient transport service means that SCAS now provides an integrated urgent care model to clinical assessment, sign-posting and advice.

Our 999 emergency service is delivered in a strategically co-ordinated approach with a local delivery to meet the needs of our patients across the Thames Valley and Hampshire. Through our strategic direction with a local delivery we have seven operational nodes across the Thames Valley and Hampshire areas:

- ➔ Thames Valley
 - North North – Milton Keynes
 - North East – Buckinghamshire
 - North West – Oxfordshire
 - North South – Berkshire
- ➔ Hampshire
 - South North – Basingstoke, Winchester and Eastleigh
 - South East – Portsmouth
 - South West – Southampton

Within Operations we have 23 dedicated 999 resource centres and over 40 standby points where our fleet of 369 specially equipped vehicles operate from, that allows us to meet the needs of our patient demographic. In addition to our stations we have strategically placed standby points in areas of high demand, which allows us to deploy assets to patients in an effective and dynamic way.

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

To meet our demand, we have a diverse clinical and non-clinical workforce that includes emergency care assistants, associate ambulance practitioners, paramedics and specialist practitioners working in various healthcare settings to deliver effective patient care.

Since the implementation of the Ambulance Response Programme (ARP) we as a Trust have continued to make sure that we give the best, high-quality, most appropriate response for each patient first time. These changes are beneficial to our patients as it has allowed us to improve our ability to prioritise the sickest patients; we have also worked with our planning and demand team to map our demand to better allocate resources to times of high demand.

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

- ➔ Multiple vehicle allocation
- ➔ Vehicle diversion/stand downs
- ➔ Long waits for less urgent calls

We are continuing to see those key benefits that we hoped to gain following the implementation of ARP which includes our ability to:

1. Send the most appropriate clinical resource to meet the needs of patients based on the presenting conditions, not simply the nearest, which means patients get to definitive care in a timelier fashion
2. Support more patients through hear and treat, see and treat
3. Ensure a transporting resource is available for patients needing to be taken to a definitive place of care
4. Improve patient experience

These four key areas allow us as a Trust to deliver the following for our patients:

- ➔ The sickest patients receive the fastest response
- ➔ Patients get the response they need first time, and in a timeframe that is appropriate for their condition
- ➔ Waiting times are reduced
- ➔ Patients living in rural areas receive a more equitable response

Performance against national ambulance service response targets 2018/19

Category 1 – Mean	07:01	(Target: 07:00)
Category 1 – 90 th Percentile	12:45	(Target: 15:00)
Category 2 – Mean	16:36	(Target: 18:00)
Category 2 – 90 th Percentile	33:13	(Target: 40:00)
Category 3 – 90 th Percentile	02:02:03	(Target: 02:00:00)
Category 4 – 90 th Percentile	02:54:10	(Target: 03:00:00)

Performance against national ambulance service response targets 2017/18

31 October 2017-31 March 2018		
Category 1 - Mean	07:19	(Target: 07:00)
Category 1 - 90 th Percentile	13:21	(Target: 15:00)
Category 2 - Mean	17:24	(Target: 18:00)
Category 2 - 90 th Percentile	35:05	(Target: 40:00)
1 March-30 October 2017		
Red 1 Performance:	73.9%	(Target: 75.0%)
Red 2 Performance:	70.6%	(Target: 75.0%)
19 minute transportation:	94.2%	(Target: 95.0%)

Cardiac arrest survival to leave hospital rates

Trust	2016-17	Trust	2017-18	Trust	2018-19 YTD*
South Central	10.95%	South Central	14.76%	South Central	15.48%
Isle of Wight	10.81%	Isle of Wight	11.02%	West Midlands	12.23%
Yorkshire	10.07%	West Midlands	10.30%	East of England	10.89%
West Midlands	8.82%	Yorkshire	10.09%	North East	10.73%
East of England	8.45%	North West	8.90%	Isle of Wight	10.47%
North West	8.13%	North East	8.79%	South West	9.46%
London	8.06%	East of England	8.75%	East Midlands	8.70%
South Western	7.80%	London	7.73%	Yorkshire	8.58%
East Midlands	7.44%	South West	7.71%	North West	8.45%
North East	7.12%	East Midlands	7.42%	London	8.27%
South East Coast	6.39%	South East Coast	6.91%	South East Coast	8.25%
England average	8.43%	England average	8.83%	England average	9.93%

Source: NHS England, Ambulance Quality Indicators, Clinical Outcomes, published 9 May 2019
*April-December 2018

As an ambulance service we work in close partnership with both our healthcare providers as well as the other blue light and emergency services in response to a wide range of incidents.

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

The single largest change that the Operations Directorate is working towards in this and the next financial year is the implementation of our Transformation Project. This project is focusing on a high level of staff engagement, so that staff can influence changes affecting their working lives, at a local level. Our aim is to realign the operational work patterns/rosters and fleet ratios having an 85 DCA / 15 RRV % split to achieve the ARP operating model during 2018/19, whilst ensuring (as far as reasonably practicable) the Trust provides a working environment that supports staff's work-life balance.

As part of the project process, we have established a strong project team with representatives from all departments and Staff Side working together in several key workstreams. These include health and wellbeing factors, demand modelling, reviewing the scheduling processes, as well as reviewing the fleet and estates.

In addition, we have completed a number of staff listening events at resource centres and gained invaluable operational staff feedback in areas which staff would like to see practical improvements being made. These include the ways work patterns and roster planning currently works, through to how the allocation of relief/leave could work so that we can support a better work-life balance in the future.

We have also continued to maintain our focus on staff development and improvements within our teams as a more engaged and developed workforce delivers excellence. We have continued

to recruit both clinical and non-clinical staff to include more specialist practitioners (SPs) who will continue to enhance the care of those category three and four patients. This staff group also now undertake rotational working within the wider Health Economy as part of multi-disciplinary teams (MDTs) to include minor injuries units, General Practice and out-of-hours providers.

As a resilient ambulance service we have specialist capability to deliver care in extreme environments, such as collapsed buildings, when called upon to do so. This year our Resilience and Specialist Operations (RSO) Team has supported internal colleagues, as well assisted on a national basis, and been deployed to numerous large scale events.

We have also seen our RSO Team and Hazardous Area Response Team (HART) develop and progress in line with national standards such as the following two areas of legislation/assurance:

➔ **Emergency Preparedness, Resilience and Response (EPRR)** The NHS needs to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an outbreak of an infectious disease or a major transport accident. The Civil Contingencies Act (2004) requires NHS organisations, and providers of NHS-funded care, to show that they can deal with such incidents while maintaining services.

This programme of work is referred to in the health community as emergency preparedness, resilience and response (EPRR) and we as a Trust have worked hard over the past 12 months to make sure that we focus on business continuity planning and adverse weather to name but two key areas. This work has allowed us to maintain our high levels of patient care in the recent snow, where we were able to exercise these plans.

NHS England has published NHS core standards for emergency preparedness, resilience and response arrangements. These are the minimum standards which NHS organisations and providers of NHS funded care must meet. The accountable emergency officer in each organisation is responsible for making sure these standards are met. As part of the national EPRR assurance process for 2018/19, South Central Ambulance Service NHS Foundation Trust has been required to assess itself against these core standards. The outcome of this self-assessment shows that against 49 of the core standards which are applicable to the organisation, the overall rating is:

Substantial

The organisation is 89-99% compliant with the core standards that are expected to achieve.

For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.

➔ **The National Ambulance Resilience Unit (NARU)** works closely with SCAS to help strengthen our specialist capabilities as detailed in the table below.

THE INTEROPERABLE CAPABILITIES

"Interoperable" capabilities can be combined to provide a scalable national response.

- Hazardous material
- MTFA (Marauding Terrorist and Firearms Attack)
- Chemical / biological / radiological
- Nuclear / explosives
- Safe working at height
- Confined space
- Unstable terrain
- Water rescue and flooding
- Support to security operations
- Patient decontamination
- Command & control



<https://i0.wp.com/naru.org.uk/wp-content/uploads/2018/01/CQA-at-a-glance.jpg?ssl=1>

As a provider of the above capabilities we are closely monitored by the NARU Compliance & Quality Assurance (CQA) Team to make sure that our specialist responders are kept safe whilst taking calculated risks to improve the clinical outcomes of patients caught within dangerous environments. We have been busy in the current year to build upon our compliance levels in areas such as the ability to respond to incidents involving terror attacks to make sure that we continually deploy safe systems of work.

This year, as previously, we have seen our demand in terms of 999 calls increase. However, though effective leadership, resource modelling and planning with intelligent deployment we have continued to achieve the vast majority of our national response and clinical targets, and offer a safe and effective service to our patients.

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

➔ **Falls and Frailty Service** – Within Operations we have taken the highly successful model of the Falls and Frailty Service within Berkshire and, through the support of our commissioners, rolled this out in Buckinghamshire and Oxfordshire. These schemes now allow us to deliver a combined assessment to our frail patients by attending with an occupational therapist to allow immediate interventions to reduce risk of further falls.

➔ **Specialist Practitioner Hub** – We have through executive support placed a specialist practitioner within our southern CCC to take the following call types from our clinical and non-clinical workforce:

- Newly Qualified Paramedics (NQP) – This staff group can now call the SP to gain clinical advice and support to assist them in patient treatments and referrals.
- Crew advice – The SP on the desk can offer general advice to all staff around areas such as wound assessments/closure, referral pathways or indeed they can send an SP to the patient to support the crew.

The mobilisation of the SP Hub has delivered several key benefits in terms of enhanced patient safety and outcomes as we now have the designated specialist knowledge in the control centres who target crew support and advice. We have also seen a more engaged specialist workforce as we now can retain staff as we offer a varied work plan that allows this staff group to use their specialist skills to include:

- See, treat and refer using urgent care pathway referrals, e.g. to X-ray, to reduce the need for attendance to the emergency department for a doctor to undertake a referral to the X-ray department.
- Advanced assessment and diagnostics allow the specialist to use their knowledge and clinical abilities to give the patient the right care at the point of contact rather than transporting them to an acute trust.

➔ **Falls and Silent Alarms** – We now send both co-responders (Fire Service) and community first responders who have received additional training, to patients in a place of safety (such as a care home) who have fallen. On arrival they can assess the patient and then report back to the SP Hub and gain clinical approval to mobilise the patient.

➔ **Single Point of Care (SPoC) Testing** – As a new initiative in conjunction with the John Radcliff Hospital (JRH) in Oxford, we now have a dedicated SP on a response car that can undertake point of care diagnostics – including blood gases and lactate C-Reactive Protein (an inflammatory marker) – which allows us to support complex decision making in sepsis/frailty and linking this with referrals/advice to/from the Acute Medical Unit at the JRH.

➔ **Co-Responding** – We have continued to work with our colleagues in the Fire and Police Services to look at how we can continue to use their staff to assist us in patient care. These initiatives include:

- We have worked with our Fire colleagues to assist us with gaining entry to properties; this allows us to have professional support to force entry to allow our staff to gain entry to properties to enable us to treat patients.
- We have worked with Police to allow us to no longer require police attendance at expected deaths within the community which frees up both staff and police time, and also provides better support to relatives.

2.2 INTEGRATED URGENT CARE AND NHS 111 SERVICE

In the last 12 months, SCAS has continued to deliver the NHS 111 service to Hampshire, as well as ongoing developments within the Thames Valley Integrated Urgent Care (IUC) Service. The IUC has matured and will continue to evolve over the next 12-18 months. The IUC celebrated its first anniversary on 5 September 2018 and widespread developments have taken place during this exciting year.

We now have a variety of clinical specialities forming a Clinical Assessment Service (CAS) which includes GPs, mental health practitioners, pharmacists located in the CAS and linking with community pharmacists and palliative care nurses. The enhancement of the CAS will continue to transform over the next 12 months delivering further benefits to the clinical outcomes of our patients. The IUC service continues to enable wider access to healthcare for patients in Berkshire, Buckinghamshire and Oxfordshire. One of the main benefits of an IUC for patients is to provide a healthcare model that delivers a consult and complete approach, thus improving both the patient's experience and their clinical outcome.

Five GPs currently provide input into the IUC service from a hub located in Wokingham, and we continue to utilise their advanced medical skills and experience to provide clinical support to NHS 111 clinicians, as well as enhancing the support specifically to the following patient groups:

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

The GPs have the necessary advanced expertise to ensure that patients who are vulnerable or who have more complex clinical needs are referred to more specialist care pathways across the healthcare economy to receive the care that they need.

The Hampshire NHS 111 service entered into a co-design process with our commissioners and local out-of-hours GP services. This co-design work stream was set up to develop an IUC and is progressing in an extremely collaborative and positive way, with a number of pilot initiatives evolving during the year. We have introduced pharmacists within the out-of-hours services, developed a CAS queue which supports GPs and 111 working on standardised technology which supports the development of a true integrated service.

We have also formed a paediatric working group to scope and develop enhanced paediatric services. This has led to a pilot of a service designed specifically for the assessment and healthcare for children. Due to the work carried out by the paediatric pilot, which goes live in April 2019, specialist paediatric nurses have been employed as part of the clinical work force.

We have also commissioned a specialist mental health service to provide 24/7 mental health access within the CAS. This provides support from subject matter experts in mental health and also provides advice to the Police, frontline ambulance clinicians, 999/111 call handlers and clinicians. Patients are referred to this service for assessment and onward referral if required.

We have continued with a clinical validation process focussing on low acuity ambulance referrals using 111/IUC clinicians. Ambulance response standards are determined by NHS England and Category 3 and 4 responses are defined as urgent and non-urgent, requiring an ambulance response within two and three hours respectively. This initiative is in place across SCAS NHS 111 and IUC service and ensures that patients receive the care they need that is appropriate to their clinical needs. Patients who have been reassessed by a clinician have received better care outcomes and signposting to a more suitable care pathway, such as primary care, other local services and home management.

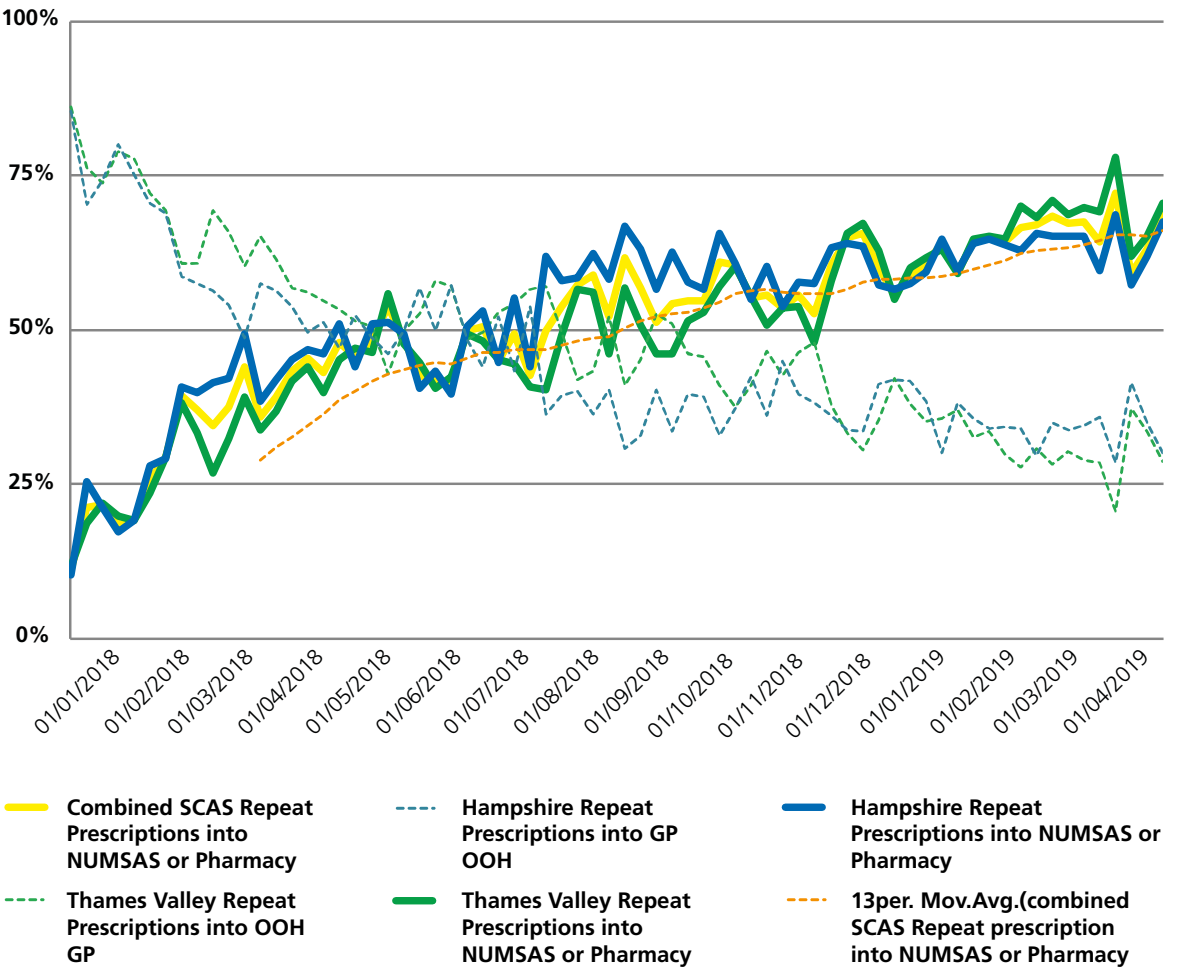
We have also introduced clinical revalidation of emergency department (ED) dispositions for Thames Valley 24/7 using our clinicians, and GPs from one of the out-of-hours services in Hampshire, Monday to Friday 9am-5pm. Again, we are seeing good results with patients being signposted to minor injuries or illness units, primary care or home management.

Within this financial year, 111 Online was nationally rolled out and we introduced the online service across Hampshire and the Thames Valley. This enables patients to self-assess their condition or concern and be signposted to the appropriate service, including the CAS, for a call back from a clinician or a GP for a further consultation. We are currently receiving low numbers via this channel but the 111 Online service is still in its infancy and will be developed over the coming year.

The Hampshire NHS 111 service successfully won the contract for service provision for the Farnham and Surrey Heath area aligning our contract with the Hampshire CCGs, and expanded the Hampshire Dental Service into Dorset covering the Wessex area for Dental patients. These services went live in March 2019.

We have also been signposting patients who require repeat prescriptions or medication advice to local pharmacies across Hampshire and the Thames Valley using the NHS Urgent Medicine Supply Advanced Service (NUMSAS). This is part of a national pilot and we have seen a significant increase in referrals to NUMSAS with over 65% of patients being signposted to local pharmacies, increasing the capacity in the GP out-of-hours services to see other patients who need face to face assessment.

South Central - Repeat Prescription Dispositions - DoS Service Selection Rates



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

Total calls offered	1,273,815	
Total calls answered	1,186,847	
Calls answered within 60 seconds	77.92%	(Target 95%)
Calls abandoned	3.45%	(Target >5%)
Referrals to 999	128,184	
Transfers to clinicians	618,421	

2.3 COMMERCIAL DIVISION

The Commercial Division includes the following services:

- ➔ Patient Transport Services (PTS), which provides non-emergency patient transport over a large and expanding catchment area. We are very proud to hold contracts across:
 - Milton Keynes
 - Thames Valley
 - Oxford Health
 - Surrey
 - Sussex
 - Hampshire
- ➔ Our Logistics Service provides logistics support across Oxfordshire for Oxford University Hospitals NHS Foundation Trust and Oxford Health NHS Foundation Trust.
- ➔ We also manage a call booking service/contact centre for all PTS and logistics contracts, operating 24/7 through telephony and online services.

PTS is by far the largest service provided by the Commercial Division with over 1,000 team members operating 500 vehicles a day, and it accounts for over 95% of the Division's income. It is one of the three core services currently provided by SCAS, alongside 999 and NHS 111. Since PTS provision was de-regulated in 2002, the PTS market share held by ambulance trusts has reduced from 100% of the market to an estimated 50%.

However, SCAS has bucked this trend, and the Trust has successfully retained existing business and won new business through tenders and 'step in' contracts, such as Sussex.

PTS activity for 2018/19 saw us deliver just under one million patient movements covering 34 million miles and our logistics services have moved several million items covering over one million miles. In 2018/19 our Logistics Team introduced a new track and trace parcel service which has been used several thousand times already.

Our contact centres based at Otterbourne, Durrington, Dorking, Eastbourne and Bicester have answered half a million calls and dispatch 500 vehicles daily across all our business areas.

Patient Transport Service (PTS)

Due to the growth of the PTS Division in 2018/19, the Directorate introduced a revised Commercial Business Strategy and also embarked on an ambitious transformation programme.

The strategy outlined the need for a new organisational transformation in order to:

- ➔ Review and improve processes in order to facilitate a lean service, deliver cost efficiencies and performance improvement.
- ➔ Provide improved/structured support to staff in the service following a period of significant growth.

By implementing the strategy it also supports the Commercial Division to achieve its vision of being:

- ➔ The market leading NHS provider for patient transport services, delivering the highest quality of patient care.

Which will in turn help the Trust achieve its mission:

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

The design of the transformation was underpinned by the Trust's core values:

- ➔ Teamwork – delivering high performance through an inclusive and collaborative approach which values diversity
- ➔ Innovation – continuous improvement through empowerment of our people
- ➔ Professionalism – setting high standards and delivering what we promise
- ➔ Caring – for our patients and each other

A significant investment was made by the Trust to support the transformation work which included:

- ➔ An ongoing review of processes
- ➔ Improve career paths
- ➔ Increase opportunities within Commercial services
- ➔ Build stronger links to supporting functions within SCAS

The structural changes not only altered some of the existing roles but added new roles into the structure in order for us to function more efficiently and effectively. The intention was to allow post holders to focus on the key elements of their roles, which in turn enables us to achieve our vision.

The proposed new structure was shared with staff as part of a consultation paper, which was then supported by a series of launch events. A communications plan was introduced ensuring all team members were kept informed of events and changes throughout the transformation consultation process. Additionally, a programme of development and training was designed and is ongoing to support staff working in new positions or in changed roles to help ensure that individuals are clear about their new roles, understand the background and rationale for the changes and are properly equipped to deliver excellent patient care.

The Transformation Programme in addition introduced new roles specifically to support corporate elements of the Commercial Directorate; patient experience, recruitment and ICT managers were embedded in to the Trust's corporate teams and scheduling/fleet teams structured to work alongside the Trust's current teams.

Alongside the structural changes significant work has begun and is ongoing with an 'end to end' review of processes and procedures to ensure these are 'fit for purpose' for the future business, and where possible supported effectively with existing or future technologies. The award of GDE status to the Trust presented an ideal opportunity to accelerate some of the innovation required to further optimise the service and drive greater efficiencies for the future. This work will continue into 2019/20 and we will be continually searching for improvements in the ways we work.

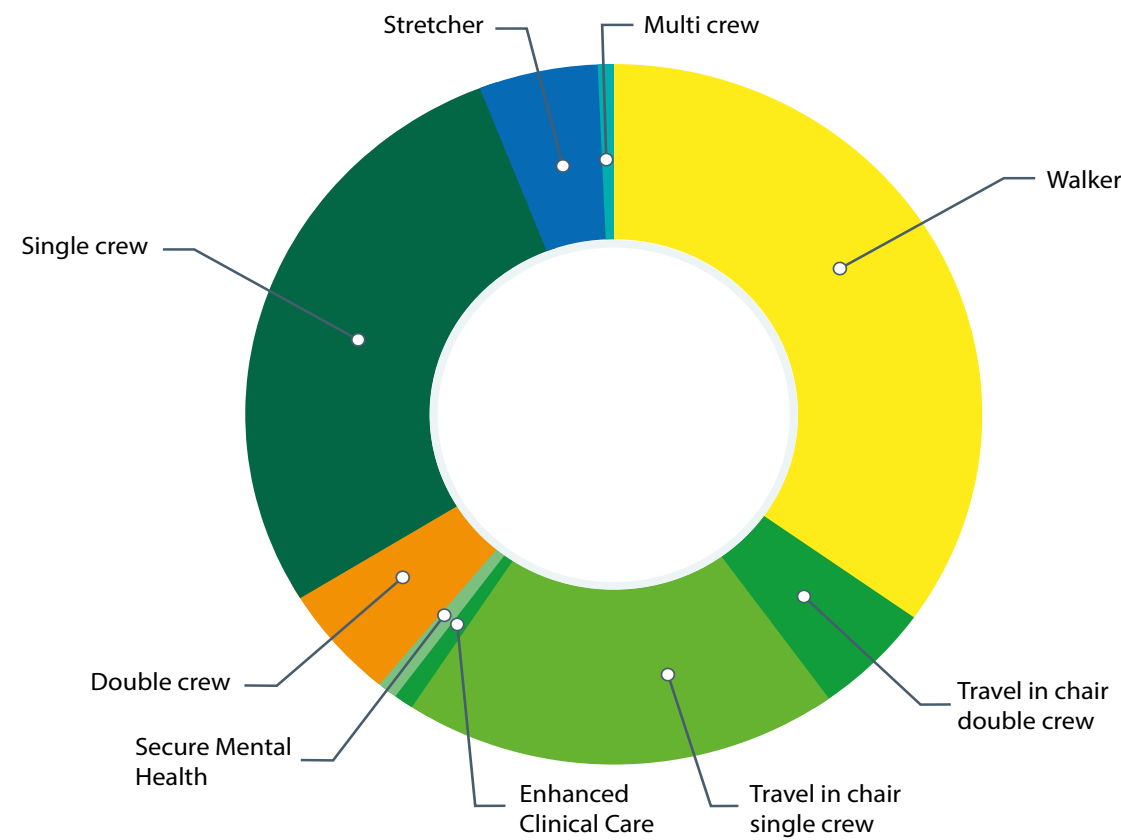
In addition to a significant transformation programme, we continue to work very closely with our volunteers who provide a fantastic service; in the last 12 months our volunteers have conveyed around 8% of our activity. To further support our volunteers, we introduced through our transformation, volunteer leads and volunteer managers to ensure a dedicated focus for the team and to drive further volunteer recruitment. Thank you to all our volunteers for the amazing service you provide.

Case Mix/Innovation

The case mix within PTS continues to be complex for 2018/19, with services ranging from transport for patients who can walk unaided to patients requiring a stretcher, secure mental health transfers or enhanced clinical care. Our ambulance care assistants are trained to manage all types of patients apart from those requiring enhanced clinical care or secure transfer.

Eligibility of patients for NHS funded patient transport services was defined nationally in 2007 but over the course of 2018/19, commissioners across all contracts have reviewed and changed their own requirements placing more stringent checks on walker patients for eligibility. This is due to NHS budgets becoming increasingly constrained.

PTS journeys 2018/19



In July 2018 SCAS, working alongside partners at Wexham Park Hospital, introduced a pilot of a scheduled discharge service. The service provides designated collection times to the hospital to support timely discharges and allows planning for earlier collection of patients, improves use of resource capacity and enhances the internal management of patient flow within the hospital site.

The pilot was proven to be successful in not only increasing the number of journeys conveyed on the discharge resources, but also improving the performance against the KPI and distribution of journeys throughout the day. The use of the schedule service has continued with Wexham and is now also rolled out across Royal Berkshire Hospital, Stoke Mandeville Hospital, John Radcliffe Hospital and very shortly into the new financial year (2019/20) at Frimley Park Hospital. This was a great piece of innovative work by the team who deservedly won the Partners and Stakeholders Award for Innovation at the annual SCAS Ambies Awards.

Contact Centre Performance

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

During the year we have seen mixed performance across some of our individual contracts. We acknowledge that across our contact centres, our call answer performance (percentage of calls answered within 60 seconds) remains below the 95% target. One of the challenges to contact centre (CC) performance has been the number of estimated time of arrival calls (ETAs). Using telephony for ETAs is now an outdated process as the call is only as good as the detail given at the time and does not allow for the ever-changing dynamics of managing the logistics of patient transport. We are currently working with commissioners in the withdrawal of this telephone facility and moving to online ETAs only utilising the digital benefits of a live system that continually updates to take into account logistical issues such as cancellations, patient delays, road works and on the day activity.

Our contact centres are also responsible for the dispatching of crews to our patients on the day; this fundamental part of the PTS business sits at the heart of delivering our operational KPIs. This has been challenging due to the transformation whereby CC team members have moved on to other roles for career progression but leaving a recruitment gap within the dispatch team. A focussed recruitment campaign for the CC continues in to 2019/20.

PTS Quality and Workforce

To maintain SCAS as the provider of choice we constantly strive for high standards and over 2018/19 we successfully met the requirements and were reaccredited with the ISO 9001:2015 Quality Standard.

We also continue to maintain our CQC ratings of:

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

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

We have clinical quality leads within PTS who work with the Trust Medical Director ensuring PTS maintains the clinical standards required. Over 2018/19 we have introduced various quality innovations to improve patient experience such as new procedures around end of life patients and management of wheelchairs.

The Commercial Division manages an Integrated Workforce Plan (IWP) which takes in to account attrition rates and workforce requirement figures. The pipeline for recruitment over 2018/19 has been very good with Facebook campaigns and use of other social media channels.

This IWP continues in to 2019/20 with an enhanced pipeline due to the increased emergency care assistant recruitment which is the next natural step for ambulance care assistant career progression.

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

Logistics

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

Vision

For 2019/20 the Directorate intends to conclude the transformation review based on six sigma methodology, introduce enhanced systems and processes to better understand and respond to patient needs and continue to work with our commissioners and partners in health and social care and beyond to continually improve. Our patient feedback indicates a very high level of satisfaction with the service provided, however, there is always more that can be done. We will continue to work with patients and partners to build on these improvements, particularly supporting discharge planning, greater integration of alternative transport solutions and continuing to improve patient experience.

2.4 COMMUNITY RESILIENCE

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

SCAS has 1,023 active community first responders (CFRs) and co-responders (an increase from 943 last year); they have helped to utilise 593 call signs (response kits), responding within a three-mile radius of their location or deploy themselves to cover an area of SCAS where our clinical coordination centres need them. Together, our CFRs and co-responders from the military, police and fire and rescue services have attended 28,666 emergency 999 incidents for the Trust in 2018/19.

Community first responders	18,197
Fire co-responders	5,650
Military and police co-responders	4,693
Total	28,666

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

We continue to roll out the Level 3 Certificate in Ambulance First Response as well as developing our volunteers across SCAS to respond to non-injury falls and concern for welfare. On average, SCAS receives around 180 calls a day relating to a patient who has fallen – that’s over 65,000 calls a year. The CFRs involved are sent to appropriate calls which have been assessed by paramedics or nurses on the Clinical Support Desk (CSD) or Urgent Care Desk (UCD) within SCAS’ Clinical Coordination Centres and identified as a patient who is non-injured and only has a requirement for moving and handling. They will also be deployed to silent alarm calls from care lines, where we need to respond but not necessarily with an emergency ambulance.

From 1 April 2018 to 31 March 2019, CFRs attended 799 non-injury falls incidents and only 209 of those patients needed to be conveyed to hospital; over the same period CFRs attended 645 concern for welfare incidents and only 109 of those patients needed to be conveyed to hospital. Previously, all the incidents attended would have seen a rapid response vehicle or an ambulance sent to the patient as the first response. We now have 48 CFR vehicles equipped to attend these low acuity calls across SCAS. Elderly and frail patients who may have been at risk of having a long wait for an emergency ambulance response for a non-injury fall, will now be able to be seen more quickly by our volunteer responders and helped off the floor. This is particularly beneficial not just because it ensures more ambulances and rapid response cars are available for patients suffering life-threatening emergencies, but also because it is proven that morbidity increases every hour that a frail and elderly patient is left on the floor without medical intervention.

Our CFRs and our Community Engagement Team continue to focus on growing the number of publicly accessible defibrillators (PADs) installed in the South Central region, as well as providing familiarisation to members of the public in how to perform cardiopulmonary resuscitation (CPR) or chest compressions, and how to use a defibrillator.

At the end of March 2019, there were 1,688 PADs in Berkshire, Buckinghamshire, Hampshire and Oxfordshire, and these had been assigned on 1,202 occasions. We also had 2,253 occasions where CPR was in progress prior to the arrival of an ambulance which is helping to assist in improving Out of Hospital Cardiac Arrest (OHCA).

Once again, SCAS supported World Restart a Heart Day in October 2018, training over 8,000 local students and members of the public in life-saving skills. Restart a Heart Day is an international day designed to train young people how to do CPR and saves more lives in the future with a target of training 200,000 young people this year which was achieved worldwide.

South Central Ambulance Charity

This year our Charity has supported a range of activities across South Central Ambulance Service. As last year our priority has continued to be in supporting the Community First Responder (CFR) Programme working alongside the Community Engagement and Training Team to help fund and support the important work that our volunteers carry out each and every day to support patients in our communities.

The Office of Civil Society awarded us a further grant for Phase 2 of the Q Volunteering project. This has enabled us to roll out training and equipment for the non-injury falls programme across our CFRs. This important funding means that CFRs can deliver shorter waiting times for lower acuity calls, freeing up frontline crews for other more urgent needs.

Support has grown this year from our corporate supporters and we are grateful to Value Retail Management (Bicester Village) Ltd, GE Healthcare, Berkshire Fiesta Centre, Game Retail, Stem Lane Properties, Waitrose, Cala Homes, Hampshire County Council, Groundwork UK, Oscar Pet Foods, Co-op, NHS Shared Business Services, Eaton Ltd, Fujitsu and many others for their support.

In July we celebrated 70 years of the NHS and joined The Association of NHS Charities with their Big 7Tea initiative reflecting on the history of the NHS. Staff in our Northern House and Southern House offices held events raising funds for the Charity in celebration. NHS Shared Business Services in Southampton held a Charity Day, challenging staff to tackle their specially created escape room before being hit by a deadly virus! Along with tombolas and NHS celebration cakes the staff raised over £1,000. It was a fantastic day which also celebrated the huge part the NHS plays in all of our lives.

The Chiltern American Women's Club (CAWC) once again selected South Central Ambulance Charity as their Charity of the Year, in particular supporting our Buckinghamshire Community First Responders. The now famous CAWC Bazaar raised an incredible, record breaking £21,000 for our Charity and was as colourful, exciting and creative as ever and we are so thrilled to be a part of it.

During the year our CFRs and our Charity attend and support a wide range of community events and this year was no different. A packed summer saw us somewhere different, often in three or four places every weekend. In the autumn as the temperature dropped the Charity was able to provide much needed beanie hats for all our ambulance crews and patient transport staff. We

were also able to provide new signage for our volunteer car drivers using their own vehicles for our patient transport service in the north of our region. Being able to identify vehicles as part of South Central Ambulance Service has provided reassurance and help to our patients using this facility.

We are once again enormously grateful to all our many supporters, friends, donors, patients, families, staff and volunteers who continue to support our events, raise funds and donate and remember their loved ones. All of this plays such an important part in enabling us to continue supporting SCAS.

Thank you.

2.5 SUSTAINABILITY

A new Sustainability Lead has been employed at SCAS and works within the Estates Department. The focus of this role is to develop the network of eco-champions across the Trust, and to further develop the Trust's efforts in this area, in particular, through the Sustainable Development Management Plan (SDMP).

This is a re-focus for SCAS and the new Lead has used the NHS Sustainable Development Unit (SDU) Tool, SDAT (Sustainable Development Assessment Tool), and an SDMP is re-drafted for wide consultation across the Trust.

The UK Government signed the UN Global Development Framework 'Transforming our World: the 2030 Agenda for Sustainable Development' and therefore is committed to delivering against the 17 sustainable development goals and 169 targets which came into force on 1 January 2016. The SDAT methodology has these goals embedded.

By far the largest proportion of carbon footprint for SCAS is from operational vehicles, and recent work by Lord Carter on this area has been partly directed by SCAS. The Trust has joined the Strategic Vehicle Group, which is working together across all UK ambulance trusts to agree a common specification for ambulance vehicles, in part to minimise carbon output. The Trust is investing heavily in new vehicles over the coming months, and after a lengthy national process, will be purchasing vehicles which are van conversions and thus lighter and more efficient than the previous models. All new vehicles will be fitted with telematics to monitor and improve driving habits to reduce fuel consumption.

The 2018/19 carbon emissions from vehicles was 13,297 tonnes and from energy was 2,211 tonnes. Whilst efficiency of building stock remains a key part of carbon reduction, the primary focus is on vehicle usage and procurement.

The new Sustainability Lead is working with senior colleagues through the quarterly sustainability group, to set a number of new, challenging objectives and campaigns for improvement to staff behaviour (e.g. improved rates of recycling) and a focus on the reduction of carbon footprint through energy usage and improved efficiency of vehicles.

ACCOUNTABILITY REPORT



3. DIRECTOR'S REPORT

3.1 EXECUTIVE DIRECTORS 2018/19

Will Hancock
Chief Executive

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

Philip Astle
Chief Operating Officer

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

John Black
Medical Director

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

Professor Helen Young
Director of Patient Care and Service Transformation

I have been an Executive Director of Nursing for over 17 years working at a large number of acute trusts including Oxford University Hospitals NHS Foundation Trust and Kings College Hospital NHS Foundation Trust. Prior to joining SCAS I was on the Board of Birmingham Women's and Children's Hospital NHS Foundation Trust and led some of the national transformation work on maternity and neonatal services. I also spent six years as Executive Clinical Director and Chief Nurse at NHS Direct, shaping and developing the first clinical telephone assessment and virtual patient care services in the country. My role at SCAS is primarily responsible for ensuring the safe provision of high-quality, patient focused care, ensuring ongoing and consistent patient safety and quality standards and adherence to clinical controls and improvement in patient outcomes.

Charles Porter
Director of Finance

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

Melanie Saunders
Director of Human Resources and Organisational Development

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

Mike Murphy
Director of Strategy and Business Development

I have held senior roles within the commercial sector but worked in the NHS for the last 10 years, most recently as an Improvement Director at NHS Improvement, working with two of the most challenged acute trusts in the country. I have also worked for NHS England, where I set up the Urgent and Emergency Care Programme across the south of England and before this I was Executive Director of Strategy at a University Teaching Hospital. My role at SCAS is to ensure that the Trust meets its strategic and operational aims by providing effective strategic leadership, developing and delivering a successful strategic planning process. I also lead the development and delivery of our ambitious commercial strategy, with responsibility for the Patient Transport Service and other 'non-emergency' business opportunities.

3.2 NON-EXECUTIVE DIRECTORS 2018/19

Lena Samuels (Chair)

I started my career as a lecturer in further and higher education, and managed a training centre in London for young people at risk of exclusion. I currently run a company providing communications and training internationally in leadership, human rights and child protection on behalf of organisations such as the British High Commission, the National Crime Agency, CORAM, Bramshill Policing Advisers, UNICEF and UN Women. My healthcare sector experience includes non-executive director roles with University Hospital Southampton NHS Foundation Trust and Isle of Wight NHS Trust, as well as a Lay Advisor with Wessex Deanery. I am a Governor at Solent University and in January 2019 I was appointed as the independent Chair of the Hampshire & Isle of Wight Sustainability and Transformation Partnership.

Sumit Biswas

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

Dr Ilona Blue

I have worked in the Civil Service for 19 years at the Home Office, Department for Work and Pensions, HM Treasury and am currently Group Finance Director at the Department of Transport. Before joining the Civil Service, I undertook public health research. From March 2009 to October 2011, I was a non-executive director of South Central Strategic Health Authority. On 1 April 2019 I was appointed as a Non-Executive Director of the Audit Risk and Assurance Committee of Defence and Support, an arm's length body of the Ministry of Defence.

Les Broude

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

Dr Priya Singh

I began my medical career in general practice, before specialising in legal medicine. I have broad strategic and operational experience in healthcare, legal services, professional indemnity and risk. I am President (Board Chair) of the Society for Assistance to Medical Families, a mutual benevolent fund with charitable status, a Non-Executive Director of Guy's and St Thomas' NHS Foundation Trust, and an Associate with the social enterprise, Working With Cancer.

Mike Hawker

I am a Chartered Accountant and after initially working in finance, moved into general management. I was the managing director of a start-up business, the merchandise director of a major home shopping business, and then the chief executive of several home shopping businesses owned respectively by British, French and German shareholders. I have been involved in new business development and in major change and rationalisation programmes. I am also a Director/Trustee of The Shaw Trust, as well as the Chair of Commercial Activities at Salisbury NHS Foundation Trust, and a member of the Audit Committee of the British Army.

Dr Anne Stebbing

I was appointed Consultant Surgeon in February 1994 at Basingstoke Hospital, now Hampshire Hospitals NHS Foundation Trust, and currently work part-time in my clinical role with a special interest in breast and minor paediatric surgery. For the last 20 years I have held a variety of senior management roles at Hampshire Hospitals NHS FT, including Divisional Medical Director and Director of Governance. For the last five years I have also held the post of Secondary Care Representative for East Berkshire CCGs and I am also a Trustee for St. Michael's Hospice, Basingstoke.

Nigel Chapman

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

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

3.3 BOARD OF DIRECTORS

The Trust's Board of Directors (the "Board") held six Board meetings in public between 1 April 2018 and 31 March 2019. The agendas, papers and minutes of Board meetings are available on the Trust's website.

→ <https://www.scas.nhs.uk/about-scas/our-board/board-meetings/>

Decisions taken by the Board and delegated to management

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

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

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

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

Board of Directors balance

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

The Board started 2018/19 with eight non-executive directors (NEDs), including the Chair, and seven executive directors, including the Chief Executive.

The changes to the composition of the Board during 2018/19 were as follows:

- Priya Singh and Anne Stebbing joined the Board as NEDs on 1 April 2018, replacing Alastair Mitchell-Baker and Professor David Williams as part of the Trust's succession planning arrangements
- Existing NEDs Sumit Biswas and Ilona Blue became Deputy Chair and Senior Independent Director respectively on 1 April 2018
- Mike Murphy replaced James Underhay in the position of Executive Director of Strategy and Business Development in October 2018, following the latter's retirement

This means that the Board also ended 2018/19 with eight non-executive directors (NEDs), including the Chair, and seven executive directors, including the Chief Executive. As a result, and in accordance with the principles of good governance, the Board comprises an excess of independent NEDs over executive directors.

All 15 Board members have voting rights.

Board of Directors performance evaluation and review

The Board reviews its functioning and performance on an ongoing basis throughout the year. In line with the current 'well-led' regulatory guidance, an external and independent review of the Board also takes place every three to five years; the last review took place in 2014, and on current plans the next review will be carried out in 2019. The timing of this reflects changes to the composition of the Board in recent years and the fact that the Trust had a 'well-led' inspection undertaken by the Care Quality Commission in August 2018 (see below).

During 2018/19 there have been a number of reviews with direct implications for the Board, including:

- The Care Quality Commission carried out a 'well-led' inspection of SCAS in August 2018. This, in part, looked at the functioning of the Board and the Trust received an overall rating of 'Good'. The CQC concluded that the Board *"had the skills, knowledge and integrity to run the organisation. There was strong support and constructive challenge among the Trust Board, and leaders were visible and approachable, and they understood the challenges the Trust faced. The Trust had a clear vision and set of values with quality and sustainability as the top priorities."*
- The Trust, as with all other NHS providers, is assessed on an ongoing basis by NHS Improvement as part of its Single Oversight Framework regulatory approach. The reviews consider the following five elements:
 - operational performance
 - financial performance
 - quality of care
 - strategic change
 - leadership and improvement capability

Whilst all five elements have a link to the role of the Board, the 'leadership and improvement capability' element focuses strongly on the effectiveness of the Board.

SCAS has been assessed throughout 2018/19 as being a segment 1 (maximum autonomy) provider, the best possible category.

→ The Council of Governors' Nominations Committee, supported by the Chair, Director of Human Resources and Organisational Development and Company Secretary, continues to review the non-executive director arm of the Board as part of a formal succession planning process. This considered, in particular, the skills and expertise required going forward and resulted in the appointment of Priya Singh and Anne Stebbing as new non-executive directors for the Trust with effect from 1 April 2018. In the same context, it also led to a decision in January 2019 to re-appoint Sumit Biswas and Nigel Chapman for second terms.

In addition, to the processes outlined above, the Board has a systematic approach to assessing its collective performance including through the performance appraisal system. As an example, the 2017/18 appraisals of the Chair and non-executive directors included comprehensive feedback from the Trust's governors through a survey approach, and the same approach will be applied for the 2018/19 appraisals.

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

Governance

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

The Trust was compliant with its Constitution at all times during 2018/19.

The Board is mindful of other opportunities to review its governance arrangements. For example, the Financial Reporting Council published an updated UK Corporate Governance Code which came into effect on 1 January 2019. Although annual reporting compliance with the Code is a listing requirement for companies with a premium listing in equity shares, it was of interest to the Board because it is a benchmark of good corporate governance on which the NHS bases its own corporate governance framework.

We have carried out a self-assessment of our position against the updated Code, and appear to be well-placed in terms of some of the new aspects, including:

- The need for organisations to build trust by fostering strong relationships with their key stakeholders (this is demonstrated by our system/collaborative work)
- The requirement for greater emphasis on Boards to create a culture which aligns the organisation's values with strategy (this is evidenced by our work this year on organisational development and values-based behaviours)
- The increased emphasis that is placed on refreshing Boards and organisations having robust succession planning arrangements in place (the work of our Remuneration and CoG Nominations Committees are key in this respect)

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

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

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

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

Non-Executive Directors

Non-executive directors (NEDs) are members of the Board of Directors. They are not involved in the day to day running of the business, but are instead guardians of the governance process and monitor the executive activity as well as contributing to the development of strategy. They have four specific areas of responsibility – strategy, performance, risk and people – and should provide independent views on resources, appointments and standards of conduct.

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

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

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

During 2018/19 the Trust had eight serving and voting non-executive directors, all of whom are independent:

NED	Date appointed to FT Board	Current term of office	Term
Lena Samuels (Chair)	1 January 2017	31 March 2020	First
Sumit Biswas*	1 July 2016	30 June 2019	First
Ilona Blue	1 March 2012	31 December 2019	Third
Les Broude	1 February 2018	31 January 2021	First
Nigel Chapman	1 March 2016	28 February 2022	Second
Mike Hawker	1 January 2014	31 December 2019	Second
Priya Singh	1 April 2018	31 March 2021	First
Anne Stebbing	1 April 2018	31 March 2021	First

*Sumit Biswas has been re-appointed by the CoG for a second term of office which will run from 1 July 2019 to 30 June 2022.

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

Executive Directors

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

At the end of the 2018/19 financial year there were seven voting executive directors on the Trust Board:

Executive Director	Position
Will Hancock	Chief Executive
Philip Astle	Chief Operating Officer
John Black	Medical Director
Mike Murphy	Director of Strategy and Business Development
Charles Porter	Director of Finance
Professor Helen Young	Director of Patient Care and Service Transformation
Melanie Saunders	Director of Human Resources and Organisational Development

Philip Astle resigned from his position in March 2019 and will leave the Trust in summer 2019.

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

No political donations have been made or received by Board members during 2018/19.

Board committees

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

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

The Audit Committee also seeks assurance that financial reporting and internal control principles are applied. Its members at the end of 2018/19 were Mike Hawker (Chair), Sumit Biswas, Ilona Blue, Les Broude and Priya Singh, and five meetings were held during 2018/19.

The main focus of the Quality and Safety Committee is to enhance Board oversight of quality performance, and probe quality and care issues. Its members at the end of 2018/19 were Anne Stebbing (Chair), Nigel Chapman, Sumit Biswas and Priya Singh, and four meetings were held during 2018/19.

The Remuneration Committee is responsible for ensuring that a policy and process for the appointment, remuneration and terms of service, and performance review and appraisal, of the Chief Executive, executive directors and senior managers are in place. Its members at the end of 2018/19 were Sumit Biswas (Chair), Ilona Blue, Lena Samuels and Anne Stebbing, and seven meetings were held during 2018/19.

The Charitable Funds Committee acts with delegated authority from the Board (the corporate trustee) to ensure that the South Central Ambulance Charity operates with appropriate governance. Its members at the end of 2018/19 were Nigel Chapman (Chair), Lena Samuels, Mike Hawker and Les Broude. Four meetings were held during 2018/19.

Attendance at meetings during 2018/19

The attendance at meetings during 2018/19 of those who have served on the Board, and reflecting their membership of the various committees, is as follows:

Name	Trust Board	Audit Committee	Quality and Safety Committee	Remuneration Committee	Charitable Funds Committee
Total meetings	6	5	4	7	4
NON-EXECUTIVE DIRECTORS					
Lena Samuels	6	N/A	N/A	7	3
Sumit Biswas	6	5	4	7	N/A
Ilona Blue	5	3	N/A	6	N/A
Les Broude	6	4	N/A	N/A	4
Nigel Chapman	6	N/A	3	N/A	4
Mike Hawker	6	5	N/A	N/A	3
Priya Singh	4	4	4	N/A	N/A
Anne Stebbing	6	N/A	3	7	N/A

Name	Trust Board	Audit Committee	Quality and Safety Committee	Remuneration Committee	Charitable Funds Committee
Total meetings	6	5	4	7	4
EXECUTIVE DIRECTORS					
Will Hancock	6	N/A	N/A	6	N/A
Philip Astle	6	N/A	N/A	N/A	N/A
John Black	6	N/A	2	N/A	N/A
Mike Murphy	3/3	N/A	N/A	N/A	1/1
Charles Porter	6	5	N/A	N/A	N/A
Melanie Saunders	5	N/A	N/A	7	N/A
James Underhay	1/1	N/A	N/A	N/A	2/3
Professor Helen Young	6	N/A	4	N/A	N/A

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

4. COUNCIL OF GOVERNORS

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

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

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

SCAS became a Foundation Trust on 1 March 2012; the period 1 April 2018 to 31 March 2019 represented the seventh full year of working for the SCAS CoG.

MEMBERSHIP AND MEETINGS

Membership of the CoG

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

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

The CoG elects a Lead Governor; Barry Lipscomb served in this position throughout 2018/19, and Bob Duggan has been elected to take on the role from 1 April 2019. During 2018/19, the CoG also resolved to introduce a new Deputy Lead Governor position from 1 April 2019; the intention being that this provides some resilience and cover for the Lead Governor if required.

The CoG started the year with 26 governors in place, and therefore no vacancies.

The CoG ended the year with 25 governors in place and therefore one vacancy (Buckinghamshire public constituency).

No governor elections were held during 2018/19, with the next round due to take place in Autumn 2019.

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

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

Formal meetings of the CoG

Four formal meetings of the CoG were held during 2018/19: in April 2018, July 2018, October 2018 and January 2019. All four meetings were held in public, and in accordance with the Trust's Constitution (i.e. fully quorate). Each meeting was chaired by the Trust Chair, and was well attended by Board members, including NEDs.

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

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

The table below reports on the attendance of governors at formal meetings of the CoG, including the four formal meetings held in public.

Other meetings of the CoG

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

Two joint CoG and Board working meetings were held during the year; in June 2018, as part of the CoG Development Programme (see below), and in February 2019, to obtain the views of the governors on the Trust's strategy following the publication of the new NHS Long Term Plan.

DUTIES AND FUNCTIONS

Delivery of specific statutory duties

The governors have a range of specific statutory duties; all of the statutory duties relevant to 2018/19 were satisfactorily discharged.

Duty		Comments
Receive annual accounts, auditor's report and annual report	✓	Received annual accounts and reports at the July 2018 meeting.
Appoint and, if appropriate, remove the external auditor	N/A	The CoG last approved a new external audit appointment in 2017/18 (Grant Thornton). External Audit attended the July 2018 CoG meeting to update governors on their work.
Directors must have regard to governors' views when preparing the forward plan	✓	The CoG and Board hold an annual joint strategy workshop at which the Trust's future plans are discussed. The annual strategy workshop on 6 February 2019 considered the implications for SCAS of the new NHS Long Term Plan.
Appoint and, if appropriate, remove the Chair	N/A	Governors were extensively involved in the appraisal of the Chair.
Appoint and, if appropriate, remove the other non-executive directors (NEDs)	✓	Two NEDs were reappointed in 2018/19 (Sumit Biswas and Nigel Chapman) and governors were extensively involved in the appraisal of the NEDs.
Decide remuneration and terms of conditions for Chair and other NEDs	N/A	No adjustments to Chair and NED remuneration and terms of conditions were made during 2018/19 although a review was carried out.
Approve appointment of Chief Executive	N/A	No new appointment was made in 2018/19.
Approve significant transactions	N/A	No significant transactions required approval in 2018/19.
Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution	N/A	No such applications occurred in 2018/19.
Decide whether the Trust's non-NHS work would significantly interfere with its 'principle purpose'	N/A	This was not required during 2018/19.
Approve amendments to the Constitution	✓	A constitutional amendment was approved during 2018/19 to facilitate the introduction of a new governor position to represent the Trust's community first responders.

Delivery of other duties and functions of the CoG

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

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

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

During 2018/19, most of the Trust's governors attended at least one of the Board meetings in public.

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

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

CoG SUB COMMITTEES

Nominations Committee

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

The Nominations Committee met once during 2018/19 and the attendance of members at this meeting can be seen in the table on page 53.

At this meeting the Nominations Committee:

- ➔ Considered the reappointment of two NEDs for second terms of office – Sumit Biswas and Nigel Chapman. Subsequent recommendations were approved by the full CoG.
- ➔ Considered arrangements for the 2018/19 Chair and NED appraisals, including how to capture the input of governors. Subsequent recommendations were approved by the full CoG.
- ➔ Considered the current remuneration levels for the Chair and NEDs, including with reference to detailed benchmarking information for the NHS Foundation Trust sector. Subsequent recommendations were not approved by the full CoG and the Nominations Committee is undertaking further review.

No new NED recruitment took place during 2018/19 and therefore the Nominations Committee has not conducted any business of this nature.

Membership and Engagement Committee

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

The Membership and Engagement Committee ended the year with seven members, comprising six public governors, and one appointed partner governor. The Membership and Engagement Committee has met on three occasions during 2018/19; meeting attendance levels can be seen in the table on page 53.

During the year, the Membership and Engagement Committee has:

- ➔ Overseen development of Year 2 of the 2017-19 Membership and Public Engagement Strategy
- ➔ Agreed a Foundation Trust Membership Plan for 2018/19, and monitored progress throughout the year
- ➔ Contributed to the development of the Trust’s annual member satisfaction and patient care survey
- ➔ Considered how governors can support the work of the South Central Ambulance Charity (SCAC)

GOVERNOR SUPPORT, TRAINING AND DEVELOPMENT

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

- ➔ Provided a comprehensive and tailored induction programme for all new governors
- ➔ Provided opportunities for governors to develop their understanding of the work of the Trust and its NEDs, including visits to the call centres, crew ride-outs, and attendance at Board committee meetings (a new initiative)
- ➔ Provided access to relevant external training as provided by NHS Improvement and NHS Providers
- ➔ Arranged internal training and briefing sessions from time to time in accordance with governor needs. Each formal CoG meeting is now preceded by a briefing session, which in recent times have included NHS 111/Integrated Urgent Care and finance
- ➔ Issued regular briefings and bulletins on SCAS and the wider NHS

The SCAS CoG Development Programme

The SCAS Governors have participated in an externally facilitated development programme during the course of 2018/19. This acknowledges the status of the CoG as a key part of the Trust’s governance arrangements and has focused on further strengthening the functioning of the CoG and how it works as a team to deliver its statutory duties. The first stage of the development programme has considered conduct and behaviours and, similar to the values-based behaviour frameworks that are in place for Board members and staff, governors have developed a ‘Charter of Behaviours’. This sets our behaviours, aligned to the SCAS values of teamwork, innovation, professionalism and caring, that governors wish to see themselves exhibiting as they carry out their work.

The second stage of the development programme, ongoing at the time of writing, is focusing on role clarity; this aims to ensure that governors have a full and clear understanding of their role and how they can best deliver it – particularly in terms of engaging with members and holding the NEDs to account.

CONCLUSIONS AND PRIORITIES FOR 2019/20

Conclusions

The CoG has overseen some major achievements during 2018/19 and helped contribute to the overall success of the Trust. It has effectively delivered all of the relevant statutory duties for the year, including holding the NEDs to account for the performance of the Trust.

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

Priorities for 2019/20

The CoG has identified the following priorities for 2019/20:

- Reflecting a continually growing membership that now stands at over 17,000 (public and staff), further developing arrangements for engaging with the Trust's membership and ensuring that the interests of members are suitably represented and that their views are brought to the attention of the Trust. In 2019/20, this will include:
 - A focus on engaging more effectively with younger people
 - Ensuring that the Trust's representation and engagement work takes account of the changing NHS landscape
 - Embedding a new Community First Responder Governor role

Underpinned by 1) above:

- Contributing to the development of the Trust's future strategic priorities and forward plans, in a complex and challenging environment and with a strong focus on the newly published NHS Long Term Plan and local systems working together
- Given the challenges faced by the NHS, continuing the strong focus that the governors have in terms of holding the Board to account, via the NEDs, for the performance of the Trust

In delivering 1), 2) and 3) above:

- Continuing to review the effectiveness of the CoG to ensure that the governors are appropriately supported to deliver their roles, that value is added where appropriate, and the functioning of the CoG is delivered in the most cost effective way and aligned with the values of the Trust. This will include implementing the outcomes from the currently ongoing CoG Development Programme.

Attendance at meetings for all governors who served during 2018/19¹

Governor	Constituency	Current term of office	Formal CoG meetings ²	Membership and Engagement Committee	Nominations Committee (exc. teleconferences)	Workshops with Board of Directors ⁴
Paul Ader	Public - Oxfordshire	1/3/17 - 28/2/20	2/4	2/3	N/A	1/2
Andy Bartlett	Public - Hampshire	1/3/18 - 28/2/21	3/4	N/A	N/A	2/2
Sabrina Chetcuti	Partner - CCG	1/7/16 - 30/6/19	³ / ₄	N/A	N/A	1/2
David Chilvers	Partner - CCG	1/7/16 - 30/6/19	2/4	N/A	N/A	1/2
Jeanette Clifford	Partner - Local Authority	1/10/17 - 30/9/20	3/4	N/A	N/A	2/2
Richard Coates	Public - Hampshire	1/3/17 - 28/2/20	3/4	N/A	N/A	1/2
Bob Crocker ³	Public - Buckinghamshire	1/3/18 - 28/2/21	3/3	N/A	N/A	1/1
Emma Crozier	Staff - PTS	1/3/18 - 28/2/21	1/4	N/A	N/A	0/2
Mark Davis	Public - Berkshire	1/3/17 - 28/2/20	3/4	3/3	N/A	1/2
Bernadette Devine	Public - Buckinghamshire	1/3/18 - 28/2/21	1/4	N/A	N/A	2/2
Lynne Dove-Dixon	Staff - Corporate/support	1/3/18 - 28/2/21	3/4	N/A	N/A	1/2
David Drew	Partner - Charity	1/10/17 - 30/9/20	3/4	3/3	N/A	1/2
Bob Duggan	Public - Buckinghamshire	1/3/18 - 28/2/21	3/4	2/3	1/1	2/2
Jim Dunderdale	Staff - Contact centres	1/3/18 - 28/2/21	3/4	N/A	N/A	1/2
Frank Epstein	Public - Berkshire	1/3/17 - 28/2/20	4/4	1/3	N/A	2/2
Colin Godbold	Public - Berkshire	1/3/18 - 28/2/21	3/4	N/A	N/A	2/2
Stephen Haynes	Public - Oxfordshire	1/3/18 - 28/2/21	3/4	N/A	N/A	2/2
Keith House	Partner - Local Authority	1/3/18 - 28/2/21	1/4	N/A	1/1	1/2
Loretta Light	Public - Oxfordshire	1/3/18 - 28/2/21	4/4	N/A	N/A	2/2
Barry Lipscomb	Public - Hampshire/Lead	1/3/17 - 28/2/20	3/4	3/3	1/1	1/2
David Luckett	Public - Hampshire	1/3/17 - 28/2/20	2/4	2/3	N/A	2/2
Charles McGill	Public - Hampshire	1/3/18 - 28/2/21	3/4	N/A	N/A	2/2
Kate Moss	Staff - 999 North	1/3/18 - 28/2/21	1/4	N/A	N/A	0/2
Tony Nicholson	Public - Hampshire	1/3/18 - 28/2/21	4/4	N/A	N/A	1/2
David Palmer	Staff - 999 South	1/3/18 - 28/2/21	4/4	N/A	1/1	1/2

¹This is a full record of the governors who served during 2018/19. Those highlighted in bold were in post at the end of the 2018/19 year (i.e. on 31 March 2019)
²Formal meetings in public held on 16 April 2018, 24 July 2018, 3 October 2018 and 10 January 2019
³Resigned on 11 December 2018 (term of office was until 28 February 2021)
⁴Workshops in private held jointly with the Board of Directors on 5 June 2018 (CoG Development) and 6 February 2019 (Trust Strategy)

5. MEMBERSHIP AND PUBLIC ENGAGEMENT

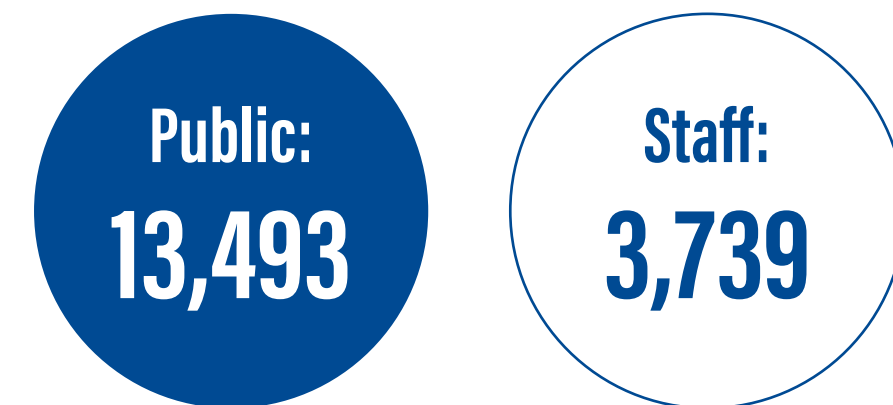
In March 2019, SCAS celebrated its seventh year as a Foundation Trust. The Trust’s membership has grown and developed and continues to be an asset for the organisation in ensuring that the voices of our communities are heard and reflected in how SCAS is run.

The Trust is committed to continue to:

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

SCAS FT members

SCAS has a total membership of 17,232 people as of 31 March 2019, broken down as follows:



Staff constituency

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

Public constituency

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

The public membership breakdown by category on 31 March 2019 is shown below.

	Public
Age	
14-16	24
17-21	198
22-29	1,653
30-39	2,140
40-49	2,441
50-59	2,248
60-74	2,670
75+	1,423
Not stated	696
Gender	
Male	5,497
Female	7,976
Unspecified	20
Ethnicity	
Asian	546
Black	266
Mixed	188
Other	1,958
White	10,535
Acorn Socio-Economic Category	
Affluent Achievers	3,886
Rising Prosperity	1,472
Comfortable Communities	3,579
Financially Stretched	2,757
Urban Adversity	1,510
Not Private Households	243
Not Available	46

Public engagement

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

Throughout the year SCAS representatives attended over 120 events where they met with members of the public and provided information about the Trust’s services and listened to their views.

Events included school and nursery visits, festivals, open days and seven Pride events across the four counties. The Trust also held community engagement roadshows in shopping centres and market squares, recruitment open days at its main sites, charity events, and talks at career job fairs, schools and various organisations.

Furthermore, SCAS undertook regular patient surveys, such as the Annual Members and Patient Survey, together with public consultations at its county forums.

Community Engagement Forums

The involvement of patients, public and stakeholders in the work of the Trust via the Community Engagement Forums (CEFs) has helped SCAS to improve the planning, quality and delivery of services.

In 2018/19 SCAS held its CEFs in the following locations:

- Berkshire – Eton and Bracknell
- Buckinghamshire – Aylesbury and Bletchley
- Hampshire – Alton and Lymington
- Oxfordshire – Didcot and Carterton

The forum minutes are available on the Trust’s website at <http://www.scas.nhs.uk/get-involved/foundation-trust/scas-community-engagement-forums/>

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

In 2018/19 SCAS continued to consult with FT members, members of the public, local organisations and stakeholders in its area.

SCAS 100 Virtual Club

To ensure that people who are unwilling or unable to take part in face-to-face engagement can make their voices heard, SCAS launched the 100 Virtual Club. It aims to appeal to ‘armchair activists’, who are happy to be kept informed or participate in convenience activism such as responding to surveys or consultations issued by the Trust without having to attend meetings and events.

The club has 56 members, who will be involved in providing input into surveys, consultations, ideas on cost savings, working with other organisations, improving our services, and other areas where members can have an influence.

Engagement with young people

The Trust uses various types of engagement activities with young people, traditionally a hard group to engage with.

The SCASYouth website (www.scasyouth.co.uk) was launched in 2018, with the aim of engaging with young people, and providing them with advice and information that is relevant to them. The website was designed following consultation with NHS Youth Groups, Patient Participation Groups and individuals.

In addition, the Trust has:

- ➔ Given talks at colleges, secondary schools and universities
- ➔ Attended college careers fairs
- ➔ Provided CPR demos to secondary schools and colleges as part of Restart a Heart Day, and also as solo initiatives
- ➔ Carried out e-surveys in secondary schools and colleges
- ➔ Invited young FT members and young people to:
 - Join SCAS 100 Virtual Club
 - Take part in educational videos for SCASYouth

Engagement with children

The SCAS mascot, named 999 Ted, plays a leading role attending local events and school visits and has proved a tremendously effective tool for engaging with children.

The Trust is the only ambulance trust in England to have a website dedicated entirely to children's education and engagement (www.scaskids.co.uk). The site was created to provide easy advice and information for children, parents, teachers and group leaders. It was also designed to help young people to stay healthy, safe and know what to do in an emergency. This year the Association of Ambulance Chief Executives and NHS Horizons chose SCASkids for inclusion in their 'Directory of Good Ideas', designed to share best practice across ambulance trusts.

Two of the website's videos, *Dial 999 for emergency* and *What's in an ambulance* have received nearly 578,000 and 2.4m views respectively since their launch in 2016.

In 2018/19 SCAS continued to educate children in schools, scout clubs and various school fairs with live demonstrations and via its SCASkids website, together with the site's 999 Ted activity packs.

Engagement with BME groups

In 2018/19 SCAS continued to engage with existing and new BME stakeholders with the aim of increasing the level of participation and Trust membership within these groups.

The activities included the following:

- ➔ Holding Diabetes Awareness Roadshows at Hindu Temples in Hampshire and Berkshire
- ➔ Holding Health Awareness Roadshows at Mosques in Oxfordshire and Buckinghamshire
- ➔ Attending a Community Iftar at Aylesbury Mosque
- ➔ Attending the Oxford Carnival

Surveys

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

Membership satisfaction and patient care survey

The sixth annual membership survey was undertaken in May 2018 over a five-week period. It was sent via Foundation Times, the Trust's membership newsletter, to all Foundation Trust public members who have supplied the Trust with an email address.

For the fourth year running we invited GP surgeries across our four counties to pass on our request to complete the survey to their Patient Participation Groups (PPGs) so they could tell us about their experience of care they receive from us. For the second year in succession it was emailed to other stakeholders such as Healthwatch groups and councils, and also promoted via social media.

In total we received 348 responses. In 2017 and 2016 we received 543 and 375 respectively. Some highlights from the survey results:

- ➔ 84% of the responders who are members are happy with being kept up to date with what is happening in the Trust through the members' e-newsletter, email, etc.
- ➔ 69% of the responders who are members read Foundation Times, the members' e-newsletter (up 3% and 4% from 2017 and 2016 respectively).
- ➔ 79% of responders who used our 999 service would be extremely likely to recommend the service to friends and family if they needed similar care or treatment

The full survey report can be found on the SCAS website at <http://www.scas.nhs.uk/get-involved/foundation-trust/patient-experience-survey/>

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

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

In 2018/19 SCAS collected 165 responses to this survey.

Contacting a SCAS Governor or Board Director

If a Foundation Trust Member or member of the public wishes to contact one of the governors or directors at SCAS, please contact the Membership Office in the following ways:

By email:	getinvolved@scas.nhs.uk
By telephone:	01869 365126
By post:	FREEPOST Communications – Membership South Central Ambulance Service NHS Foundation Trust Freepost RSJY-USUX-GKBE 7-8 Talisman Business Centre Talisman Road Bicester Oxfordshire OX26 6HR

6. STAFF REPORT

6.1 OUR WORKFORCE

During 2018/19 SCAS employed a total of 785 new employees across the Trust.

The ongoing development of our workforce and the recruitment of additional resources within our 999 frontline services continued to be a key challenge for SCAS during 2018/19. Over the past 12 months, SCAS has welcomed a total of 190 new 999 frontline recruits, whilst 90 staff took up development opportunities to join the frontline. The Trust has continued to recruit paramedics both from abroad and within the UK to meet increasing demand for our emergency services. Attrition amongst 999 frontline services as at 31 March 2019 stands at 12% (14.89% 31 March 2018); the vacancy rate in 999 is currently at 13% (15% 31 March 2018).

CAT	Headcount
999 Frontline	1,785
EOC	284
NHS 111	377
Operational Support Services	156
Patient Transport Services	788
Commercial Logistics	33
Corporate Support Services	360
Grand Total	3,783

The following tables show a breakdown of the Trust’s workforce by age, ethnicity and gender, as well as disability information, for 2017/18 and 2018/19 respectively.

	31 March 2018		31 March 2019	
Ethnic Group	Headcount	%	Headcount	%
A	2,661	80.56%	3,117	82.39%
B-C	220	6.66%	221	5.84%
D-G	37	1.12%	40	1.06%
H-L	37	1.12%	49	1.30%
M-P	26	0.79%	32	0.85%
R-S	9	0.27%	9	0.24%
Z	313	9.48%	315	8.33%
Grand Total	3,303		3,783	

Ethnicity Codes			
A	White - British	J	Asian or Asian British - Pakistani
B	White - Irish	L	Asian or Asian British - Any other Asian background
C	White - Any other White background	M	Black or Black British - Caribbean
D	Mixed - White & Black Caribbean	N	Black or Black British - African
E	Mixed - White & Black African	P	Black Nigerian / Black British
F	Mixed - White & Asian	R	Chinese
G	Mixed - Any other Mixed background	S	Other Specified
H	Asian or Asian British - Indian	Z	Not Stated

	31 March 2018		31 March 2019	
Age Band	Headcount	%	Headcount	%
<20	7	0.21%	49	1.48%
20-30	821	24.86%	932	28.22%
31-40	719	21.77%	836	25.31%
41-50	848	25.67%	949	28.73%
51-60	728	22.04%	806	24.40%
61-70	171	5.18%	199	6.02%
71+	9	0.27%	12	0.36%
Grand Total	3,303		3,783	

	31 March 2018		31 March 2019	
Gender	Headcount	%	Headcount	%
Female	1,742	52.74%	1,868	49.38%
Male	1,561	47.26%	1,915	50.62%
Grand Total	3,303		3,783	

Within the Trust, SCAS defines senior managers as members of the Board. The gender split of the Board of Directors is detailed on page 34-37.

	31 March 2018		31 March 2019	
Disability Flag	Headcount	%	Headcount	%
Yes	145	4.39%	164	4.34%
No	2,526	76.48%	2,950	77.98%
Not declared	433	13.11%	443	11.71%
Unspecified	199	6.02%	226	5.97%
Grand Total	3,303		3,783	

Sickness absence

The overall sickness rate for the Trust for 2018/19 was 6.2% (6.3% in 2017/18) which equated to 13.8 days lost per person (14.7 days lost in 2017/18). Note that the available sickness rate data at the time of publication covers the 12 month period from Jan-Dec 2018 and is therefore compared against the 12 month period of Jan-Dec 2017.

The split between short-term and long-term sickness is approximately 50:50. The highest reason for sickness remains MSK (musculoskeletal) factors followed by illness due to mental health (which includes both work and personal-related mental ill health). Improving attendance at work will remain our focus for the coming year.

6.2 STAFF COSTS

Staff costs

	Group			
			2018/19	2017/18
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	109,419	533	109,952	104,173
Social security costs	10,385	-	10,385	10,047
Apprenticeship levy	523	-	523	499
Employer contributions to NHS pension scheme	13,462	-	13,462	12,988
Temporary staff – agency/contract staff	-	2,766	2,766	2,640
TOTAL GROSS STAFF COSTS	133,789	3,299	137,088	130,347

Included within:

Costs capitalised as part of assets	-	-	-	-
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Average number of employees (WTE basis)

	2018/19	2017/18
	Number	Number
Medical and dental	-	-
Ambulance staff	1,873	1,790
Administration and estates	1,063	1,086
Healthcare assistants and other support staff	546	388
Nursing, midwifery and health visiting staff	86	81
Nursing, midwifery and health visiting learners	-	-
Scientific, therapeutic and technical staff	-	-
Healthcare science staff	-	-
Social care staff	-	-
Other	-	-
Total average numbers	3,568	3,336

Expenditure on consultancy was £262k (2017/18: £223k) which was mainly attributed to Turnaround projects (see Note 5.1 in the Annual Accounts, page 216).

Reporting of compensation schemes

The Group had three compensation packages in 2018/19 totalling £179k (2017/18: nil).

The Group had no other non-compulsory departure costs in 2018/19 (2017/18: nil).

Payments to past senior managers

The Group had no payments to past senior managers in 2018/19 (2017/18: nil).

Payments for loss of office

The Group had no payments for loss of office in 2018/19 (2017/18: nil).

6.3 STAFF POLICIES AND ACTIONS

During the coming year, HR will be aiming to continue to review policies on a rotational basis. As part of reviewing our employment dispute resolution process, we will be taking a proactive approach to developing our Grievance Policy to encourage a new approach for resolving disputes, developing constructive relationships and encouraging positive conversations at work. ACAS' code suggests that employers and employees should always seek to resolve disciplinary and grievance issues in the workplace. Whilst it is vital the Trust has minimum standards, it is acknowledged that for many employees, taking out a grievance is still a daunting and often distressing experience.

We are working on the Trust's Sickness Management Policy to change the emphasis from potential perceived punitive action to focus on managing attendance, which will be a more positive approach and ensure staff are supported during long-term absence. Under Health and Wellbeing, we have developed a process whereby we can, when appropriate, facilitate staff coming back to work on alternative duties which results in staff feeling re-engaged more quickly.

During 2018/19 we have integrated our Trust role-related behaviours into the HR policies and we will continue to build on these as a positive way forward. We will also continue to work closely with the Trust's Freedom to Speak Up Guardian to ensure that staff feel empowered to raise concerns (see page 146 for more detail).

Leadership and Training

SCAS Leader

This year has seen the development of our bespoke six-day leadership programme for all line managers, informed by staff feedback, current research and best practice across the UK. The aim of SCAS Leader is to promote an organisational culture of compassionate, inclusive and collaborative leadership that supports the delivery of high quality, sustainable, values-based care.

Having agreed the business case, the first cohorts started in April 2019 and will be followed by a new group each month for two years. The programme has been developed to be innovative and interactive with each cohort comprising a mix of leadership experience, length of service, area of expertise and banding. Courses are filling up fast and feedback so far has been excellent.

Team development

We have been working with a number of teams across SCAS to focus on areas of development pertinent to them. For example, a 12 month programme is being developed with the senior operational team around becoming a high performing team; values-aligned team charters were developed with two teams around their shared vision and agreed behaviours to support that vision; and several teams have completed MBTI assessments this year to explore how they might work better together.

360 feedback

We have trained more facilitators to debrief the Healthcare Leadership Model 360 so that we have the capacity to offer this to any leader in the organisation at a time that is right for them.

Culture and Leadership Network for Ambulance Services (CALNAS)

SCAS currently holds the Deputy Chair position on the newly established CALNAS. Accountable to the national HRD group and AACE, CALNAS aims to share, promote and lead culture development across the ambulance sector in the UK. The group has been formed to lead on cross-sector developments in this area with direct support from NHSI.

HR training

The HR team deliver a series of nine programmes designed to equip managers and leaders with the skills and knowledge to manage various employee scenarios they may be faced with. These, mostly one-day courses, include absence management, appraisal, change management and disciplinary.

A total of 38 pre-planned training courses were arranged during 2018/19 and an additional 12 programmes, such as Talent Management, were delivered between April and December 2018, with 359 leaders attending the different courses. A similar suite of face-to-face programmes will be delivered throughout 2019/20, along with bespoke courses as requested by local leadership teams. Additionally, we have developed a series of webinars (flexible working, exit interviews, probation training, managing return to work interviews) which can be delivered remotely in order to increase accessibility and operational efficiencies.

Staff Health and Wellbeing

We have a dedicated Health, Wellbeing and Engagement Team who deal with the Health and Wellbeing Agenda, which is a very wide-ranging brief and covers many aspects of staff engagement, support, communication and improving attendance at work. The team currently carries within its portfolio day-to-day management of the Occupational Health and employee assistance contracts, allocation and monitoring of temporary light duties, eye test processing, benefits and discounts, the annual flu campaign and signposting for mental and physical health issues along with the Health and Wellbeing Agenda.

The team deals with health, wellbeing and engagement communications across the Trust and to ensure each campaign is accessible to all our employees; increasingly using internal and external social media to promote its work. The Health and Wellbeing Lead is a member of the National Ambulance Trust Health and Wellbeing Forum, ensuring delivery of contractual requirements, CQUINs, the Health, Safety and Risk Board, and has an active involvement in projects linked to positive staff health and wellbeing, such as the improvement of the response bag.

In the past year the Health Wellbeing and Engagement Team has facilitated many improvements across the Trust. Work has been carried out with our occupational health provider to provide them with what we refer to as SOPs (standard operating procedures); this has been collated into a document that contains information on every role across the Trust. The purpose of this is to ensure they understand the expectations of each staff member, the needs of the Trust when recommending temporary adjustments and phased return to work details, and gain a greater understanding of the challenges our staff and managers face.

The Trust undertook the NHSI 90-day turnaround plan for health and wellbeing within the ambulance sector from the 1 October 2018, in order to analyse the Trust's progress against both others nationally and the required achievements. We completed the Health and Wellbeing Framework document and matched planned improvements to this against those areas that were showing as poor. This was completed at the end of January and feedback has now been received which will be fed into the Health, Wellbeing and Engagement Action Plan for 2019/20. One area identified was that the Trust lacked an in-depth analysis of the data we were producing both internally and externally. A data analyst was appointed to examine our data in depth. Several areas of improvement have been identified from the final report which will also be considered for the Health, Wellbeing and Engagement Action Plan for achievement this year.

Our internal procedure for temporary light duties is now centralised under the Health, Wellbeing and Engagement Team. In the last five months the team has successfully sourced placements for 35 colleagues, thus ensuring that they remain within the workplace whilst not fit enough to carry out their substantive role. The temporary roles offered have been sourced from corporate departments, education, planning and our clinical co-ordination centres. Research has shown that this is not only good for the mental health of the employee, but also promotes a quicker return to work.

In February, to celebrate the national Time to Talk Campaign, we held our first mental health event which was a great success. Staff were asked if they wished to speak and shared various experiences on both a professional and personal level; we had guest speakers from both our Occupational Health and Employee Assistance Programmes. This was followed by a workshop in the afternoon which gave the opportunity to pick up different ideas from the attendees. During February we ran a series of articles in the weekly Trust internal newsletter, Staff Matters, relating to mental health, financial issues and encouraging staff to talk to each other or one of the support services we make available to staff.

The team rolled out our Smoking Cessation Campaign during March, which saw over 20 staff with access to free support across the area of the Trust begin their journey to becoming an ex-smoker. The support offered included group sessions, one-to-one counselling, and access to free NRT products and this support will continue to be available whilst individuals continue their journey to be smoke free. The NHS Trusts that have assisted in this campaign will provide feedback on progress and this will allow us to evaluate the success which will enable us to make improvements for the Trust's own Smoking Cessation Campaign next year.

After feedback from employees during an HWB event within the Trust, it was clear that there was an opportunity to support staff who were nearing retirement. Retirement is a major change in people's lives, particularly after a long career in an organisation such as the ambulance service where a family environment is promoted. We arranged for Affinity to deliver workshops for our staff to assist in how to deal with both the financial and emotional impact of considering retirement. The first workshop provided by Affinity took place in March and workshops will continue to be held across the Trust areas throughout the remainder of 2019/20.

We have secured funding via NHSI for a trial weight loss program; the funds will enable us to support 30 employees in the first steps of their weight loss journey. This will be rolled out during May 2019 where we have requested staff come forward with a short statement as to how the weight loss support will help them and what advantage this will have on their life. We plan to have a prize draw and the first thirty successful employees will be offered a place on a 12-week weight loss program. This program will be anonymously monitored and if successful will be considered for further funding.

Future plans

On 7 May 2019, in partnership with our Occupational Health provider, we will be piloting a “Managers Advice Line” in key areas of the Trust, enabling line managers to be able to call through and speak to an Occupational Health Clinician to ask questions or request additional information, such as:

- ➔ Do I need to refer my team member?
- ➔ Advice on how to make a good referral or what to include in a referral
- ➔ Generic occupational health advice, e.g. in relation to infectious diseases or pregnancy
- ➔ Generic advice for cases where employees have not provided consent to be referred or to release the report
- ➔ Questions around short-term absences

This pilot will be fully monitored and analysed to enable an educated decision to make as to whether or not this will be a benefit Trust-wide.

During 2019/20, the Trust will remain focused on our health and wellbeing agenda in order to assist and encourage an improvement in both the physical and mental health of staff with a view to improving the attendance rates across the areas of the Trust. The Health, Wellbeing and Engagement Team will continue to focus on innovative ideas to improve and maintain supportive ideas for the staff of the Trust.

Health and Safety

SCAS recognises its duty to comply with the Health and Safety at Work Act (HSWA) 1974 and all its subordinate regulations. Therefore, the Trust is committed to ensuring, so far as is reasonably practicable, the health, safety and welfare of all its employees, including those who work on behalf of the Trust.

The Trust has 19 health and safety policies and all of these were current and in date as at 31 March 2019. SCAS has a Joint Health and Safety Inspection Plan and programme whereby all Trust premises are inspected by a member of the Risk Team and a Staff Side representative. Over 2018/19, 69 Trust premises were inspected as part of this programme.

A number of issues were identified, namely the need to carry out task-based risk assessments and Control of Substances Hazardous to Health (COSHH) assessments. The Head of Risk and Security is currently working with Operations to complete their task-based risk assessments and their associated manual handling risk assessments.

The Risk Team will be reviewing all of the previous completed generic COSHH risk assessments and will be working to ensure that each Trust premises has specific COSHH risk assessments. Each of these work projects will be included in the Health and Safety Action Plan for 2019/20.

In 2018/19, the Head of Risk and Security delivered and presented to managers and staff:

- ➔ 10 training courses in how to carry out a task-based risk assessment and a stress risk assessment
- ➔ 12 training courses in how to carry out a display screen equipment risk assessment

The Trust currently has 217 managers and staff trained in how to carry out a task-based risk assessment, and 207 managers and staff trained in how to carry out a stress risk assessment. The Trust also has 140 managers and staff trained to carry out a display screen assessment.

The Trust has an electronic incident reporting system called Datix and all staff are encouraged to report every incident, injury, accident or dangerous occurrence on Datix. In 2018/19 the total number of incidents reported was 6,224 (2017/18: 6,300 incidents). As such, the Trust continues to have a healthy reporting culture with appropriate investigative and remedial action taken to prevent reoccurrence.

Trade Union Facility Time Disclosures

Relevant union officials

What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
61	3772

Percentage of time spent on facility time

How many of your employees who were relevant union officials during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	10
1-50%	48
51%-99%	3
100%	0

Percentage of pay bill spent on facility time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

First Column	Figures
Provide the total cost of facility time	£252,796
Provide the total pay bill	£134,322,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.19%

Paid trade union activities

As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	17.64%
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Countering fraud

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

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

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

6.4 ANNUAL NHS STAFF SURVEY

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

During quarter 3 of 2018/19, all eligible staff were invited to complete the annual NHS Staff Survey. The overall response rate was 63%, with 2,162 staff completing their survey. This was our highest ever response rate, continuing a six-year upward trend.

Key Findings

A total of 90 questions were asked in the survey. Compared to our 2017 results, SCAS is:

- ➔ Significantly better on 15 questions
- ➔ Significantly worse on 9 questions
- ➔ No significant difference on 58 questions

In comparison to other ‘picker’ ambulance trusts, SCAS compares:

- ➔ Significantly better than average on 21 questions
- ➔ Significantly worse than average on none of the 90 questions
- ➔ Scores are average on 69 questions

The 2018 NHS Staff Survey results indicate a continuing improvement on the last two annual survey results, demonstrating that the Trust’s ongoing organisation development agenda is continuing to benefit staff and their working lives. SCAS was the highest ranked ‘picker’ ambulance trust for positive scores in the survey.

Key improvements since 2017

The review or training included a discussion of the values of my organisation, as part of the appraisal process.
In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework review?
The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?
Senior managers here try to involve staff in important decisions.
There are enough staff at this organisation.

The 2018 Survey found that the quality of appraisals, workforce resources available and bullying/ harassment within the workplace had improved since 2017.

Top five results compared to other ambulance trusts

My team often meets to discuss its effectiveness.
My line manager takes a positive interest in my health and wellbeing.
My line manager asks for my opinion before making decisions that affect me.
My line manager values my work.
My line manager gives me clear feedback.

The Staff Survey result showed that the continued investment in our team leaders and the development of a teamworking environment has made a significant impact at the Trust. The Survey showed positive scores in teamworking, leadership and line management.

NHS England Theme Report

The Staff Survey groups the 90 questions into 10 key themes. SCAS performed well compared to the other 10 ambulance trusts, leading the sector in two key themes and being above average in seven. The only area the Trust scored poorly was in staff health and wellbeing, which will be a key focus in 2019/20.

Equality, diversity & inclusion	Above Average
Health & wellbeing	Below Average
Immediate managers	Leading Trust
Morale Quality of appraisals	Above Average
Quality of care Safe environment	Above Average
Bullying & harassment	Above Average
Safe environment - Violence	Above Average
Safe environment – Bullying & Harassment	Average
Safety culture	Leading Trust
Staff engagement	Above Average

Action plans following 2018 results

Managers and HR analyse the results at organisational and departmental levels prior to meeting and engaging with staff to discuss relevant actions emerging from the feedback.

The primary organisational focus in 2019/20 will be on improving our staff’s health and wellbeing which, although much has been achieved, the overall result has decreased both across the NHS as a whole, as well as within SCAS. Whilst the Survey found that the quality of appraisals and bullying/harassment within the workplace have improved since 2017, they are not yet where SCAS would like them to be and, as such, this year’s organisational themes will be:

- ➔ Health and wellbeing
- ➔ Bullying and harassment
- ➔ Quality of appraisals

All departments across SCAS have been asked to work with their staff to develop engagement plans and SMART Staff Survey pledges / objectives which predominantly focus on these themes. Managers have an option to include one or two additional objectives surrounding a local / departmental need if desired. Staff Survey engagement plans will act as a standing agenda item on team meetings across the organisation and regular progress updates will be required which will be monitored and discussed at executive meetings and the Trust’s Health and Wellbeing Forum. Final engagement plans and pledges are to be returned to HR by 31 May 2019.

6.5 DIVERSITY AND INCLUSION

Equality Delivery System 2

The Equality Delivery System (EDS) was designed to be used by all NHS organisations in England, both providers of services and their commissioners. At the heart of the EDS is a set of 18 equality outcomes grouped into four goals. These outcomes focus on the issues providing most concern to patients, carers, communities, NHS staff and Boards. It is against these outcomes that performance is analysed, graded and action determined.

The EDS2 requires NHS organisations to engage with local communities and organisations with an interest in health issues to determine performance through a grading exercise. As part of the EDS process South Central Ambulance Service NHS Foundation Trust identified local stakeholders including patient, staff, communities and partnership groups who were consulted and engaged to review evidence on the four goals and produce a grading of performance.

SCAS is currently at the end of Year 3 of a four-year EDS action plan, with the RAG rating showing 99% achievement.

The CQC rated SCAS well-led as ‘Good’ because:

- ➔ Staff felt respected, supported and valued
- ➔ The Trust’s strategy, vision and values underpinned a culture which was patient centred.
- ➔ Staff felt positive and proud about working for the Trust and their team.
- ➔ Staff felt equality and diversity was promoted in their day-to-day work and when looking at opportunities for career progression.

Gender Pay Gap

Since the Equality Act 2010 (Specific Duties) Regulations 2011 (SDR) came into force on 10 September 2011, there has been a duty for public bodies with 150 or more employees to publish information on the diversity of their workforce. Although the SDR did not require mandatory GPG reporting, the Government Equalities Office (GEO) and the Equality and Human Rights Commission (EHRC) provided guidance that made it clear that employers should consider including GPG information in the data they already publish. It was evident that not all employers did this. To address this disparity, the UK Government has introduced a requirement on all employers, employing over 250 employees, to publish their gender pay gap by 1 April 2018.

As such the data contained covers the period 1 April 2016 to 31 March 2017 and is aligned to these new requirements.

The gender pay gap identifies the difference between men and women’s average earnings and is expressed as a percentage of men’s pay. According to the Office for National Statistics, the current overall UK gender pay gap is 18.1%.

Our data

At the data collection date, 31 March 2017, SCAS employed 3,372 employees on contracted hours (not bank workers). The split between male and female employees was:

Gender	Number	%
Male	1,693	50.21
Female	1,679	49.79

	Male	Female	% Gap
Mean gender pay gap (hourly rate)	£ 12.73	£ 12.08	5.10
Median gender pay gap (hourly rate)	£ 11.09	£ 10.76	2.95
Mean bonus gender pay gap	£ 4,349.54	£ 4,244.22	2.42
Median bonus gender pay gap	£ 4,646.00	£ 4,244.22	8.65
Proportion of males/females receiving performance related pay element	0.28%	0.11%	
Proportion of males/females in pay quartile 1	51.59%	48.41%	
Proportion of males/females in pay quartile 2	47.50%	52.50%	
Proportion of males/females in pay quartile 3	49.67%	50.33%	
Proportion of males/females in pay quartile 4	56.03%	43.97%	

Analysis

While our gender pay gap of 5.1% is significantly below the UK average of 18.1%, we are still committed to do more to close this gap. The first step in rectifying SCAS’ pay gap is to identify the causes and driving factors behind it; this work will continue following a refresh of the data for 2018/19.

When reviewing the 2016/17 data, a key contributor appears to be the National Health Service Standard Terms and Conditions, Agenda for Change (AfC). AfC governs almost all elements of a SCAS employee’s terms of employment, including pay, reward and remuneration. Annex 5 of AfC outlines the payments made to employees of ambulance trusts for working hours that are considered to be unsocial (evenings and weekends); this is paid as a percentage allowance relevant to a member of staff’s basic level of pay.

These payments are received equally and equitably by males and females (78% of males; 80% of females) however with 75% of part-time employees being female, the rate of enhancement is lower for females. This is largely self-determined by employee choice; part-time staff generally choose to work differing work patterns to that of full-time colleagues. Such patterns may include less evenings and weekends, thus reducing the unsocial hours enhancement.

The remaining gender pay gap can be largely attributed to gender balance differences within some areas of the Trust, including some of our more senior roles. The Trust will continue to identify specific areas to improve gender balance following the refresh of data during Q1 2019/20.

7. REGULATORY RATING

Single Oversight Framework

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

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

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

Segmentation

South Central Ambulance NHS Foundation Trust is in segment 1. The Trust continues to be one of the best performing ambulance services achieving a ‘Good’ CQC rating. This segmentation information is the Trust’s position as at 31 March 2019. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

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

Use of Resources Risk Rating Summary	
Capital Service Cover Rating	1
Liquidity Rating	1
I and E Margin Rating	2
I and E Margin distance from financial plan	1
Updated Agency Rating	1
Overall Risk Rating	1

8. ANNUAL GOVERNANCE STATEMENT

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of South Central Ambulance Service NHS Foundation Trust’s policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that South Central Ambulance Service NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of South Central Ambulance Service NHS Foundation Trust (SCAS), to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in SCAS for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

Leadership

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

- ➔ The Director of Patient Care and Service Transformation has day-to-day responsibility for managing the strategic development and implementation of organisational risk management, clinical effectiveness and clinical governance. This includes acting as the designated lead for a range of responsibilities such as health and safety, security management, and infection prevention and control
- ➔ The Medical Director has responsibility for the management and development of clinical standards
- ➔ The Director of Finance has responsibility for financial risk management and, in the role of Senior Information Risk Owner, for risks relating to information
- ➔ The Chief Operating Officer has responsibility for managing the strategic development and implementation of clinical and non-clinical risk management (operational risks) associated with the provision of emergency ambulance services, NHS 111 and fleet management, as well

as being the lead for emergency planning and business continuity activities

- ➔ The Director of Strategy and Business Development has responsibility for managing the risks associated with the provision of non-emergency ambulance services, including patient transport services
- ➔ The Board, with overall responsibility for governance, considers the risks faced by the Trust on a regular basis. For example, it receives the Board Assurance Framework at Board meeting in public
- ➔ The Quality and Safety Committee, with delegated authority from the Board, monitors and reviews the Trust's clinical governance arrangements
- ➔ The Audit Committee, also with delegated authority from the Board, receives the Board Assurance Framework and strategic risk register at every meeting, with the purpose of seeking assurance that effective risk management practice is in place. It also carries out deep-dive reviews into specific individual risks included on the Board Assurance Framework
- ➔ The Executive Team, underpinned by the work of its various sub-committees, receives and reviews updates from all directorates relating to risk management, as well as the Trust's Board Assurance Framework and strategic risk register
- ➔ The Executive Team has also established a Risk, Assurance and Compliance Committee. This committee, comprising the executive directors of the Trust and the Company Secretary, carries out a deep-dive review of the Trust's biggest risks and ensures that appropriate mechanisms are in place to provide assurance over the management of those risks

Training

- ➔ Officers involved in leading the Trust's risk management processes (e.g. Head of Risk and Security Management, Clinical and Non-Clinical Risk Managers) are suitably qualified and experienced governance and risk management professionals. A wide range of training has been delivered to staff to enable them to manage identified clinical and non-clinical risks effectively. This training has been informed by a detailed training needs analysis based on external training requirements outlined by NHS Resolution and the CQC, in addition to training needs identified internally by the Trust. Our corporate induction training programme for new staff covers health and safety, awareness of risk, and incident reporting.
- ➔ The Trust has a very positive culture of incident reporting. The team structure in place enables immediate raising of concerns with on duty team supervisors who are able to directly support the reporting of incidents and the actual investigation, and can apply actions to mitigate. Incidents are monitored and reviewed at different levels of the organisation, including by a Serious Incidents Requiring Investigation Review (SIRI) Group, to ensure trends and patterns are identified and responded to where appropriate.

The risk and control framework

Strategy

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

The key elements of our strategy are to:

- ➔ Integrate risk management into the Trust's culture and everyday management practice by clearly defining the Trust's approach and commitment to risk management, by raising staff awareness, and building knowledge and skills
- ➔ Provide clearly documented responsibilities and structure for managing risk to ensure a coordinated, standard methodology is adopted by every directorate/department
- ➔ Encourage and support incident reporting in a culture to ensure that the Chief Executive and Board are provided with evidence that risks are being appropriately identified, assessed, addressed and monitored
- ➔ Adopt an integrated approach to risk management, whether the risk relates to clinical, organisational, health and safety or financial risk, through the processes and structures detailed in the Trust's Risk Management Strategy
- ➔ Accept that whilst the provision of healthcare is not risk free, the Trust will aim to minimise the adverse effects of any risks through management of risk via the Quality and Safety Committee and Audit Committee both of which are sub committees of the Board

Identification of risk

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

- ➔ The monthly Integrated Performance Report, including SIRIs
- ➔ Review of adverse incidents and accident reports
- ➔ Quarterly reviews of claims and complaints
- ➔ Workforce engagement and leadership walk-rounds
- ➔ Annual fire safety inspections
- ➔ Health and safety risk assessments
- ➔ Review of performance against the NHS Resolution Risk Management Standards
- ➔ Self-assessments against the Care Quality Commission essential standards of quality and safety

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

The Board held a risk workshop during 2018/19, and this looked at the mechanisms for identifying potential future risks (e.g. horizon scanning). It is also due to discuss risk at a Board seminar in early 2019/20 and particularly how the Board Assurance Framework is populated and used.

Appetite for risk

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

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

The Trust has the greatest risk appetite in pursuit of innovation and challenging current working practices to improve patient care, access to services and reputational risk in terms of its willingness to take opportunities where positive gains can be realised, within the constraints of the regulatory environment. The Trust has the lowest level of risk appetite in relation to risks with direct implications for the quality and safety of patient services. The Trust endeavours to mitigate these risks fully; however, it should be noted that there are a number of risks in the current Board Assurance Framework relating to the quality and safety of patient services which are subject of further planned action and mitigation.

Quality governance arrangements

The key elements of our quality governance arrangements are set out in the periodic self-assessments we undertake against the Care Quality Commission's essential standards and well-led assessment framework, and report to the Board. Performance information is key to ensuring delivery of quality, and we have rigorous processes in place to ensure the quality of performance data. These include internal checking mechanisms, internal and external audit reviews, and a comprehensive review of the monthly Integrated Performance Report by the Executive Team prior to being presented to the Board.

Key strategic risks

We have a range of key strategic risks, which we have identified and are proactively managing. The Board considers the Board Assurance Framework (BAF) at every Board meeting in public, and at the final meeting of 2018/19 (in March 2019) the submitted BAF identified the Trust's current biggest strategic risks as follows:

- ➔ The up and coming changes in the way ICS/ACS will work to manage resources including setting a system wide control target. SCAS must work hard to be at the centre of the resource planning and be seen as a relevant and important partner in the system delivery to attract and maintain income for our services

- ➔ The shape and size of the current and future workforce available to the health service and SCAS is a serious concern. The NHS Long Term Plan places great importance on developing the role of paramedics to serve different parts of the health and social care sector. However, we do not currently have sufficient paramedics in the ambulance service sector or being commissioned to train. We also have an ageing existing workforce and this, coupled with the changing life expectations of the up and coming generations, SCAS will need to work to be an employer of choice for many different generations.
- ➔ The constantly growing but changing demand patterns for our services will mean SCAS must work on understanding, predicting, planning and managing the demands of our services. We will need to shape and develop our services to meet the evolving and emerging needs of the populations we serve and the systems we work within.

NHS Foundation Trust licence condition 4 – FT Governance

The Trust undertakes periodic reviews of its position against all of the conditions contained within its provider licence, and reports to the Board accordingly. No risks have been identified in 2018/19, and an annual declaration is reviewed and signed-off by the Board.

In terms of condition 4 – FT governance, the Trust has undertaken a number of steps during 2018/19 to identify any potential risks. These include carrying out a high-level review of the Trust's corporate governance arrangements against the Code of Governance, including a review of the Board's sub-committees and non-executive director responsibilities (a number of changes have been made).

Involvement of public stakeholders

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

Workforce and workforce standards

The Trust has short- and long-term workforce plans in place for all its services, as well as a range of policies and procedures to support staff. The high-level plans include the Annual Operating Plan and the Integrated Workforce Plan, covering all of the Trust's services. The Trust is aware of NHS Improvement's Developing Workforce Safeguards recommendations. Most of these are embedded in current Trust practice, which includes:

Forecasting demand

Overall demand forecasts for our services are based on recent historic trends and adjusted for short-term and longer-term expected changes, including any known external factors. These demand forecasts are then converted into hours required, using a unit hour utilisation linked to performance delivery. The work-effective hours available from Trust staff are calculated for each week of the year utilising the Integrated Workforce Plan and Education Plan alongside budgeted abstraction levels. The gap between work-effective staff hours and the needs of the demand forecast is then quantified, and cover planned from private providers, bank and agency staff.

Developing an integrated workforce plan

The Trust undertakes an integrated approach to workforce planning across all core areas, i.e. 999, NHS 111/IUC and PTS. Our Integrated Workforce Planning (IWP) Group includes stakeholders from Workforce, Recruitment, Education, Operations and Finance. In developing our workforce plan, the IWP Group works together to:

- ➔ Ensure recruitment and education plans are aligned with the strategic direction of SCAS
- ➔ Phase new recruits into the Trust, ensuring all new recruits are adequately supervised
- ➔ Ensure all recruitment streams offer value for money

Monitoring delivery of agreed workforce plans

The Workforce Development Board and Executive Performance Review monitor progress against agreed workforce plans on a monthly basis. Workforce updates (including escalation of identified risks) are provided via the Trust's Quality and Safety Committee (which is a sub-committee of the Board). Progress, issues and risks are also reported through to the Risk, Assurance and Compliance Committee, as part of the Board Assurance Framework. Quality, workforce and financial indicators are reported monthly via the Integrated Performance Report to the Board of Directors.

Compliance with CQC registration requirements

The Foundation Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). The last CQC inspection of SCAS took place in July/August 2018, and the Trust was rated as 'Good' for all areas. Since then the Trust has focused on implementing action plans to address the 'must do' and 'should do' recommendations made by the CQC.

'Managing Conflicts of Interest in the NHS' guidance

The Foundation Trust has published an up-to-date register of interests for decision-making staff within the past 12 months, as required by the 'Managing Conflicts of Interest in the NHS' guidance. The Trust has initially determined decision-making staff to be members of the Board of Directors. A register is maintained on the Trust's public website and some format changes have been made in line with the 'Managing Conflicts of Interest in the NHS' guidance. At each May Board meeting in public, a record of interests, gifts and hospitality is presented.

Compliance with NHS Pension Scheme Regulations

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

Compliance with equality, diversity and human rights legislation

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Reports on the Trust's position in relation to equality and diversity are regularly considered by the Board in public. The Trust recognises that there is further work to undertake in order to ensure that the profile of the workforce from an equality and diversity perspective reflects the population we are serving.

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

SCAS has a Sustainable Development Management Plan which has been refreshed and is ready for consultation. This has been informed by use of the NHS Sustainable Development Unit (SDU) Tool, SDAT (Sustainable Development Assessment Tool). The UK Government signed the UN Global Development Framework *Transforming our World: the 2030 Agenda for Sustainable Development* and therefore is committed to delivering against the 17 Sustainable Development Goals and 169 targets which came into force on 1 January 2016. The SDAT methodology has these goals embedded.

The Climate Change Act (2008) sets a reduction of carbon emissions across the UK by 80% by 2050 (with a 1990 baseline). As the largest public sector emitter of carbon emissions, the health system will contribute to these targets, and the SDMP sets out SCAS' actions and targets towards this end.

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

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

- ➔ The Board has regularly reviewed the economy, efficiency and effectiveness of resources through the regular performance management reports (the Integrated Performance Report, finance reports, and quality and safety reports) considered at each meeting
- ➔ Savings targets are set annually in the form of cost improvement programmes, and the Trust has a very strong track record in terms of delivering annual savings targets. In 2018/19 the Trust exceeded its target of £7.3m. Robust arrangements are in place to ensure that cost improvement programmes in no way compromise the quality of services
- ➔ The Trust's bi-weekly Executive Performance Review meetings are designed to review performance against key financial, operational, clinical and workforce targets as agreed at the start of the year
- ➔ The Trust routinely carries out benchmarking reviews of its performance and efficiency levels with other NHS bodies. Most recently this has included through the Ambulance Response Programme sector performance reports issued by NHS England, the NHS wide corporate benchmarking data produced by NHS Improvement, and the outcomes of the Lord Carter Review. SCAS also benchmarks sickness and recruitment and retention rates
- ➔ The Trust reviewed and updated its Estates Strategy during 2018/19; this aims to ensure that the organisation makes the most efficient and effective utilisation of its available estate
- ➔ The Board receives regular reports on the performance of the estate against a set of key performance indicators. These have been developed to report on criteria such as the physical condition, statutory compliance, functional stability, efficient utilisation and energy performance of the estate
- ➔ The Trust has in place governance and financial policies which include standing financial instructions, standing orders and a scheme of delegation. These policies prescribe the Trust's policy for the effective procurement of goods and services within the Trust
- ➔ An annual programme of internal audits, monitored closely by the Audit Committee, allows further assurance to be given to the Board on the use of its resources

Information governance

There have been no reportable information security breaches during 2018/19.

The Trust carries out an annual assessment of its position against the Data Security and Protection Standards published by the Department of Health and Social Care in January 2018. The most recent review was considered by the Board in April 2019. It was acknowledged that the Trust is compliant with 89 of the 100 mandatory items, and 15 of the 45 non-mandatory items.

An action plan is in place to address the areas where compliance still needs to be achieved. This includes being able to demonstrate that staff are compliant with their data security awareness training.

Annual Quality Report

The Trust's Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on 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.

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

- ➔ The content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2018/19*
- ➔ The content of the Quality Report is not inconsistent with internal and external sources of information
- ➔ The officers accountable for the preparation of the Quality Report have the necessary skills and experience
- ➔ Appropriate processes have been used to develop and quality assure the Quality Report ensuring that it represents a balanced view of performance; this has included scrutiny by the Audit Committee and Quality and Safety Committee
- ➔ The performance information reported in the Quality Report is reliable and accurate
- ➔ There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm they are working effectively in practice
- ➔ The data underpinning the measures of performance reported in the Quality Report are robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Quality and Safety Committee, and the Risk Assurance and Compliance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review during 2018/19 has also been informed by:

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

Taking into account the internal control framework described above, there have been four particular key sources of external assurance for me in 2018/19:

1. There were three separate inspections of SCAS during July and August 2018, undertaken by the CQC as part of their new inspection methodology:
 - an unannounced inspection of 999, the emergency operations centres and the Trust's emergency planning and preparedness, including the Hazardous Area Response Team
 - a comprehensive inspection of NHS 111 focusing on both the Northern House and Southern House clinical co-ordination centres
 - a well-led inspection looking at leadership and governance at Trust Board and Executive Team-level; the overall organisational vision and strategy; organisation-wide governance, management, improvement; and organisational culture and levels of engagement
 - The Trust was rated as 'Good' for all elements inspected, both in terms of the individual domains (safety, caring, effectiveness, responsiveness and well-led) and overall
2. Since May 2017 the regulator, NHS Improvement, has assessed the Trust as being a segment 1 provider under its Single Oversight Framework regulatory assessment. The assessment considers five key themes – quality of care, finance and use of resources, operational performance, strategic change, and leadership and improvement capability – and segment 1 is the best possible category that can be awarded

3. We received an annual Head of Internal Audit Opinion for 2018/19 of "moderate assurance", defined as "generally a sound system of internal control designed to meet the Trust's objectives and that controls are being applied consistently"
4. The Local Counter Fraud Specialist has reported that "during the course of the year, no significant system failures or control weaknesses were identified that impact on the Trust's Annual Governance Statement."

Conclusion

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

No significant internal control issues have been identified in relation to the 2018/19 financial year, applying the examples presented by NHS Improvement in the Annual Reporting Manual.

However, during the course of 2018/19, and with Audit Committee oversight, we have needed to take some action to strengthen controls in relation to rostering recording arrangements in the 999 service, namely the procedures for identifying and calculating staff hours worked balances (the difference between rostered and actual worked hours). Some gaps in control were identified by management, which had led to the inaccurate recording of hours worked balances, with an associated impact on payments made by or owed to staff. In addition to the remedial actions identified by the Executive Team as being required, we commissioned an internal audit review and are now actioning a range of recommendations made by them.



Will Hancock
Chief Executive

23 May 2019

9. QUALITY REPORT



QUALITY REPORT

INCLUDING MANDATORY QUALITY ACCOUNTS

INTRODUCTION

PART 1	STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE
PART 2	PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD
	2.1 LOOKING BACK AT PROGRESS MADE
	2.2 STATEMENT OF ASSURANCE FROM THE BOARD
	2.3 REPORTING AGAINST NHS IMPROVEMENT CORE INDICATORS
PART 3	OTHER INFORMATION AND QUALITY PRIORITIES 2019/20
ANNEX 1:	STATEMENTS FROM COMMISSIONERS, HEALTHWATCH, OVERVIEW AND SCRUTINY COMMITTEES
ANNEX 2:	STATEMENT OF DIRECTORS' RESPONSIBILITIES

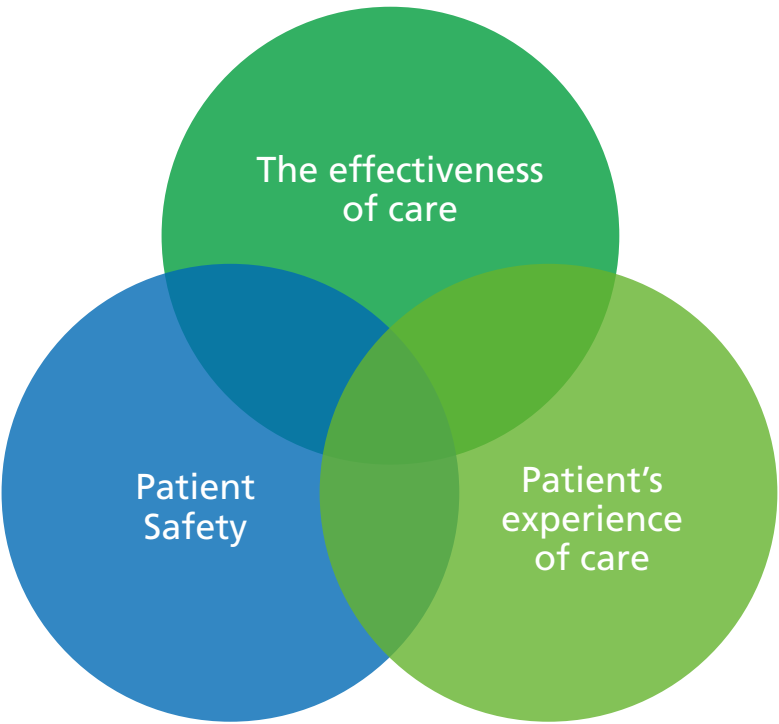
Introduction

What is quality and a quality account?

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

The quality report is comprised of the three core and overlapping themes of quality as seen below.

THE THREE DIMENSIONS OF QUALITY



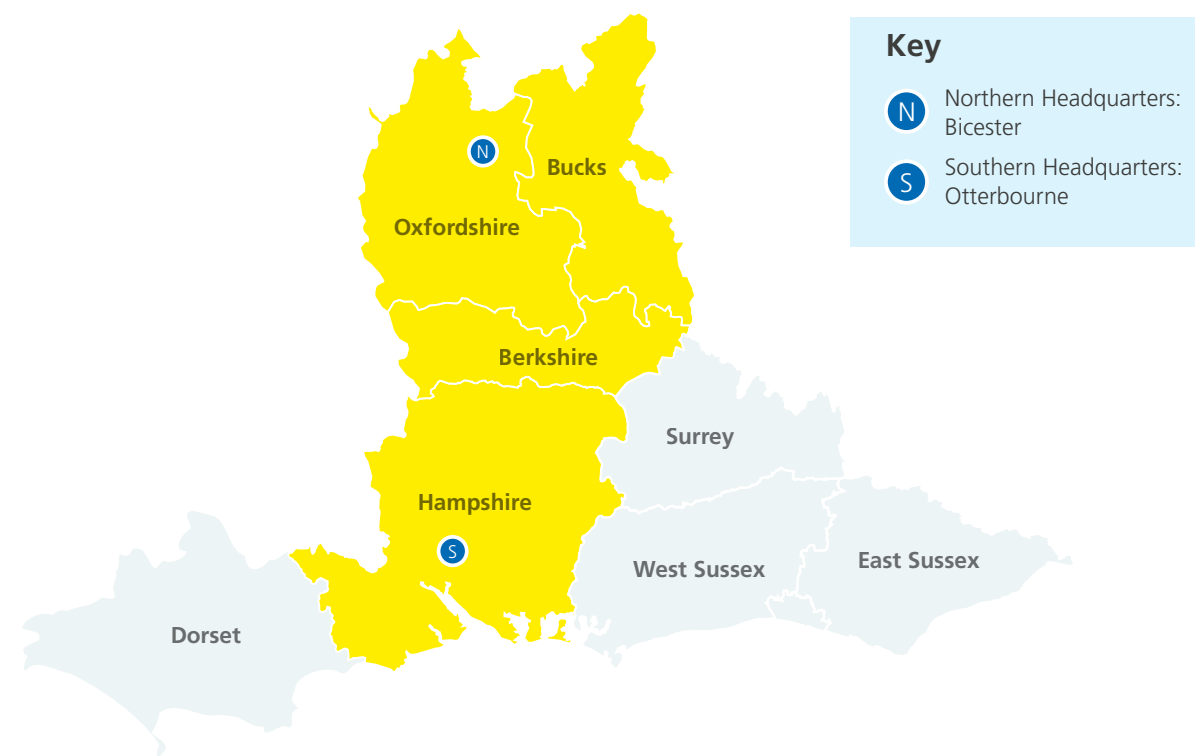
What does SCAS do?

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

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

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

South Central Ambulance Service NHS Foundation Trust covers the counties of Berkshire, Buckinghamshire, Hampshire, Oxfordshire and we are providers of PTS in Sussex and Surrey, as well as a dental service (accessed via NHS 111) in parts of Dorset. This area covers approximately 5,760 square miles and has a residential population of over seven million.



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

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

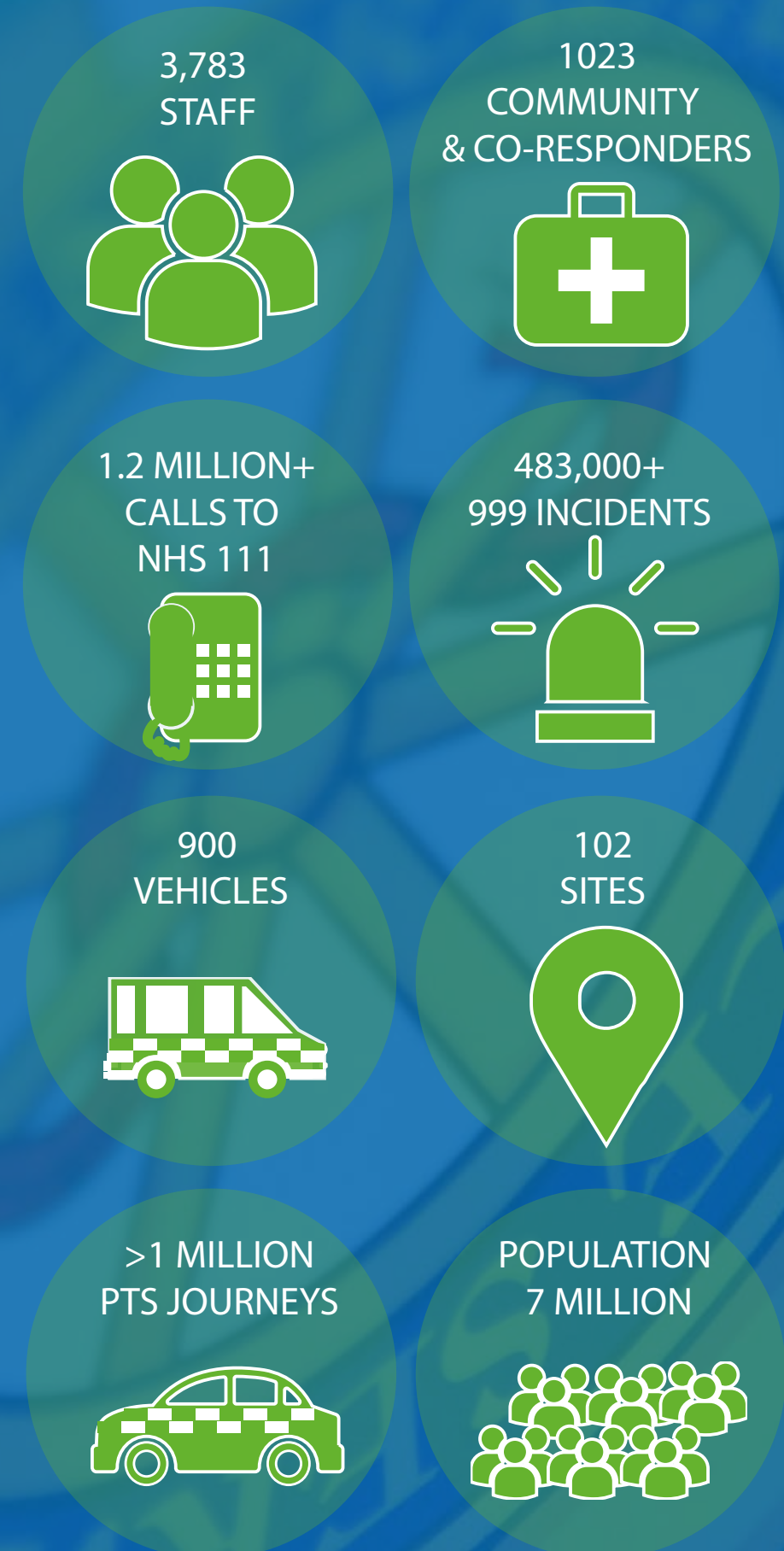
Non-emergency patient transport - Providing routine and non-emergency patient transport services

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

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

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

SCAS IN NUMBERS, 2018/19



PART ONE

STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

I am pleased to introduce our Quality Account for 2018/19 which demonstrates how we have continued to deliver high-quality, cost effective care for patients over the past year. In addition, we set out our key quality improvement priorities for delivery throughout 2019/20.

The Quality Account is designed to summarise our quality performance at South Central Ambulance Service (SCAS) NHS Foundation Trust. It provides assurance to our commissioners and patients that we provide high-quality clinical care, and also identifies areas where we could perform better and what we are doing to improve.

We have a great deal to be proud of. Our staff are hugely committed and skilled and deliver a high-quality service to our local population. We also work nationally with those who require our specialist expertise and to assist us to learn from others. Our Trust has a strong focus on teaching and education and with that comes a willingness to learn and push ourselves to be the very best.

Throughout the report there are examples of high-quality care and our commitment to continuously drive up quality, placing patients at the centre of all that we do.

There are no quieter times of the year in a NHS organisation and I will summarise some of the key events and drivers (both local to SCAS and national) on our quality improvement journey.

Compliance and inspections

SCAS has had three CQC inspections in 2018/19:

- ➔ An unannounced inspection of 999, the emergency operations centres and the Trust's emergency planning and preparedness functions, including the Hazardous Area Response Team
- ➔ A comprehensive inspection of NHS 111 focusing on both the Northern House and Southern House clinical co-ordination centres
- ➔ A well-led inspection looking at leadership and governance at Trust Board and Executive Team level; the overall vision and strategy; organisation-wide governance, management and improvement; and organisational culture and levels of engagement

We were well prepared for all three inspections, and able to showcase our work in a highly professional manner.

I was delighted that we further improved on previous inspections and were rated as 'Good' for all elements inspected, both in terms of the individual domains (safety, caring, effectiveness, responsiveness and well-led) and overall. The reports issued by the CQC confirm that we are making great progress on our journey of continuous improvement, and are now solidly and consistently delivering safe, patient-centred care across all of our services. These reviews are extremely thorough and comprehensive and provide independent assurance to our patients and important triangulation for our own systems of quality monitoring.

NHS Long Term (10 Year) Plan

The NHS Long Term Plan sets out priorities for how public money will be spent over the next ten years, and one of the key pledges outlined for improvement during this time is mental health. I welcome this as we have continued to strengthen our mental health services across the Trust locally this year – with improvements to the service provided by mental health nurses based in our clinical co-ordination centres, close partnership working with statutory mental health service providers, and stronger engagement with the police and service users already in place.

In addition, the Trust provides robust leadership at national level across the wider ambulance service family, and this is expected to increase with the aspirations of the NHS Plan, where it has been acknowledged that ambulance services form a major part of the support people receive in a mental health emergency. This will include the introduction of new mental health transport vehicles, increased use of mental health nurses in ambulance clinical contact centres, and better education for staff who have direct contact with patients. The Trust will continue to be able to influence these national developments based on our own experience locally.

I see the plan as an opportunity to further shape and improve healthcare as a key partner and driver of high-quality, accessible services for patients.

SCAS is well placed to respond to the new plan having, in recent months, developed its first organisational development strategy, updated its estates strategy for the next few years, and achieved Global Digital Exemplar status. We also have a strong focus on productivity and compare favourably on a range of benchmarking indicators across the sector.

We will be reflecting in greater depth on the implications of the NHS Long Term Plan on our own strategy reviews as the year progresses.

Lord Carter Review

On 27 September we welcomed the publication of Lord Carter's report "Operational productivity and performance in English NHS Ambulance Trusts". Work on the report commenced in January 2017 and the publication identifies what the ambulance service as a whole, as well as individual trusts, does well along with recommendations where action and improvements are required.

As well as providing the Trust with evidence of where improvements are needed in comparison to other ambulance services, the report confirms that SCAS is one of the best performing ambulance trusts against national response targets, and also a well-led organisation where operational staff feel engaged and supported, and the Trust delivers an efficient, cost-effective emergency 999 service.

SCAS, alongside our ambulance partners, will be implementing the Carter Review recommendations to improve our services for both staff and patients.

Integrated Care Systems

We continue to be appropriately engaged in all of our local Integrated Care Systems (ICS), with key executive directors, managers and non-executive directors assigned to help shape and inform our contribution. SCAS will work hard to be at the centre of service planning and be seen as a relevant and important partner in the system delivery ensuring high-quality care for all our patients.

European Union exit

Of course (along with the country) we have been planning with partners to look at reducing any risks associated with leaving the European Union (with or without a deal).

At the time of writing this, the NHS is stepping up its preparations for a potential 'No Deal' exit from the European Union, with guidance recently issued by the Department of Health and Social Care. We are following the 'actions for providers' guidance, and our planning and risk assessment processes, led by Professor Helen Young, as Board-level Senior Responsible Officer, are covering the following areas:

- ➔ Supply of medicines, medical devices and clinical consumables
- ➔ Supply of non-clinical consumables, goods and services
- ➔ Workforce research and clinical trials
- ➔ Data sharing, processing and access
- ➔ Civil contingency

As the situation unfolds we will be confident in our preparedness to continue to deliver high-quality services.

Staff survey

I was pleased with participation rates in the 2018 NHS Staff Survey. The feedback is extremely important and drives and will help to shape some of our key workstreams this year in order to improve everyone's working lives, make improvements for the future and tackle the issues that mean the most to our staff in providing good quality care. Despite comparing well with our sector we are concerned at some of the underlying messages we receive from the staff survey, in particular that our staff are under huge pressure and need more support.

A total of 2,162 staff participated, giving us a response rate of 63%; the highest response rate that we have ever had. We improved in a number of areas including training, appraisals and being involved in decision making. Our strengths were identified as health and wellbeing and feeling valued. We will be working on local area actions to address the findings.

Looking forward

This Quality Account for 2018/19 serves as an assessment of how we have improved as an

organisation culturally, building on our solid foundations to further improve the care we provide to patients and make SCAS a better place to work for all of our employees and volunteers. This statement only covers a snapshot of the improvements we are making and the report will highlight initiatives around learning disabilities, more on mental health and equality and diversity as well as operational performance. We recognise there is always work to do to improve and hope these accounts provide a balanced view of success and challenge and provides assurance of our continued commitment to patient safety.

Finally, I would like to say a warm thank you to all the staff that work with me at SCAS delivering consistently high-quality services every single day.

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



Will Hancock
Chief Executive

PART 2

PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

2.1 LOOKING BACK AT PROGRESS MADE

In this section we review progress made since the publication of the 2017/18 Quality Report. Below is a table to show “at a glance” what progress and what we achieved from last year’s priorities.

Priority	Achieved
To implement and assess the effectiveness of the National Early Warning Score (NEWS)2 scoring system for sepsis care (identifying patients with sepsis early)	Achieved
To improve hand hygiene audit compliance (all services)	Partially achieved
To implement the new NICE Mental Capacity Act (MCA) guidance – improving awareness and parity	Achieved
To review and improve call abandonment for PTS (patient transport service), 999 and NHS 111 (two-year priority), 2 nd year	Achieved
To increase clinical assessments in CCCs ensuring consistent methods and application across the services (three-year priority), 2 nd year	Achieved
To improve long waits in the ARP response categories	Partially achieved
To conduct a survey of patients using the 999 service highlighting improvement actions to be taken to improve patients’ experience of the service	Partially achieved
To improve the focus on improving staff health and wellbeing at work in relation to stress	Achieved
To improve end of life care in PTS across all contracts	Achieved

PATIENT SAFETY

1A: TO IMPLEMENT AND ASSESS THE EFFECTIVENESS OF THE NEWS2 SCORING SYSTEM FOR SEPSIS CARE (IDENTIFYING PATIENTS WITH SEPSIS EARLY)

What we said we would do	What we have achieved
Conduct an ePR audit and review of sepsis cases Q1 Introduce the ePR app on sepsis	<p>In Q1, SCAS began comprehensive training on NEWS2, the first ambulance service to do so in the UK, and it also covered during the compulsory update days for all frontline staff. SCAS is further ahead of the national requirement.</p> <p>The key differences between NEWS and NEWS2 are:</p> <ul style="list-style-type: none">➔ NEWS2 has two separate oxygen scores with one for patients within normal parameters and one for patients with chronic hypoxia➔ A ‘new element of confusion’ has been added which gives three points on NEWS2 <p>On review there was little difference between the scores and NEWS2 will mean chronic obstructive pulmonary disease cases won’t be over-triaged and newly confused patients (often a worrying sign of delirium) are recognised more quickly.</p> <p>In 2019, a new national ambulance care quality indicator (ACQI) for patients with a NEWS2 of seven or above for sepsis, will be introduced which includes:</p> <ul style="list-style-type: none">➔ Blue light transfer➔ Pre-alert➔ Administration of oxygen➔ IV fluids

What we said we would do	What we have achieved
Conduct and complete a robust education programme	<p>The total number of staff who have been through face-to-face training is 954 clinical (79%) and 324 non-clinical, i.e. ECAs (77%).</p> <p>For control room staff:</p> <p>All NHS 111 and 999 call takers receive a 'light' version of NEWS2 training, which includes an elearning package on NEWS2.</p> <p>Clinicians working in NHS 111 and the clinical support desk receive a full two-hour training package on NEWS2 and the recognition of the deteriorating patient, delivered by the consultant pre-hospital care practitioner.</p> <p>A NEWS2 score is now automatically calculated on the electronic patient record (ePR) devices used by the frontline crews. At the bottom of each completed set of vital signs a NEWS2 score is displayed. SCAS is the first ambulance service in the UK to use NEWS2; ahead of the national deadline for implementation of March 2019.</p> <p>SCAS now has the ability to record a NEWS2 score at point of booking, i.e. for healthcare professional (HCP) calls. The call takers will be able to record NEWS2 in Adastra (NHS 111) or on iCAD (999). This information can be sent to the crew to provide a baseline prior to their attendance.</p>
<p>Audit the use of NEWS2 and ongoing care (right disposition) from ePR</p> <p>Audit re-attendance in 48 hours</p>	<p>Following an audit of patients recorded with a NEWS2 score we have seen an increase in patients recorded a score of seven or above, indicating good practice.</p>
Did we achieve this priority?	Achieved

1B: TO IMPROVE HAND HYGIENE AUDIT COMPLIANCE (ALL SERVICES)

What we said we would do	What we have achieved
Increase hand hygiene compliance across all services Q2/Q3/Q4 from Q1 baseline	The Q1 baseline established Trust-wide for hand hygiene compliance was 62.5%. At the end of the year, SCAS had improved to 79.9% (however during Q3 we had reached over 85% compliance).
Conduct a hand hygiene campaign in Q1 and Q3	A hand hygiene education tour around SCAS commenced in March 2019. This included a PowerPoint presentation, UV Light hand washing assessment, a multiple choice question paper/quiz and distribution of an education pack to include an Infection Control Hygiene Guide Booklet which is in formal print.
Monitor and report on hand hygiene rates per service	<p>Work has been completed to improve the audit system to make it easier for staff to access and complete audits. This programme of work is being monitored and improvements are expected to continue. Recent improvements include:</p> <ul style="list-style-type: none"> ➔ Introduction of a new tab on eCARS Dashboard to improve visibility for individual staff to be able to view their own compliance and managers to be able to monitor their team's compliance ➔ Regular emails sent to staff reminding them of their non-compliance with enabled links to easily access audits ➔ As operational managers don't see patients but have the potential to have patient contact, it was felt there should be some governance and understanding of individual hygiene practices for these staff. To facilitate this there has been an introduction of discussed/verbal audits rather than an observation in practice audits for this cohort. ➔ Work will continue to support managers with a 'how to' guide ➔ A new link on the SCAS intranet, 'Do It Online' has gone live to obtain easier access to the audit system. <p>Current completion compliance for individual hygiene observation audits</p>

	<p>(which include all items related to hand hygiene):</p> <table><tr><td></td><td>E&UC</td><td>PTS</td></tr><tr><td>May18</td><td>56%</td><td>58%</td></tr><tr><td>Jun 18</td><td>59%</td><td>65%</td></tr><tr><td>Jul 18</td><td>69%</td><td>69%</td></tr><tr><td>Aug 18</td><td>73%</td><td>72%</td></tr><tr><td>Sep 18</td><td>77%</td><td>78%</td></tr><tr><td>Oct 18</td><td>81%</td><td>80%</td></tr><tr><td>Nov 18</td><td>82%</td><td>90%</td></tr><tr><td>Dec 18</td><td>80%</td><td>68%</td></tr><tr><td>Jan 19</td><td>81%</td><td>79%</td></tr><tr><td>Feb 19</td><td>82%</td><td>79%</td></tr><tr><td>Mar 19</td><td>79%</td><td>80%</td></tr></table> <p>(figures are YTD each month)</p> <p>Audit Online has set up automatic email prompts to remind staff of their non-compliance. Reminders were temporarily disabled whilst no-one was in the IPC Lead post; these have now been reinstated.</p> <p>Staff have easy access to Audit Online via the intranet and SCAS apps. They have contact details to the support desk. Further amendments will be made to the layout of audits, including more prompts to support staff to utilise Audit Online.</p>		E&UC	PTS	May18	56%	58%	Jun 18	59%	65%	Jul 18	69%	69%	Aug 18	73%	72%	Sep 18	77%	78%	Oct 18	81%	80%	Nov 18	82%	90%	Dec 18	80%	68%	Jan 19	81%	79%	Feb 19	82%	79%	Mar 19	79%	80%
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Jan 19	81%	79%																																			
Feb 19	82%	79%																																			
Mar 19	79%	80%																																			
Achieve 95% compliance	<p>The overall target trajectory was to reach 95% and we achieved this in PTS but not all areas. It was achieved in all areas of PTS for the discussion audit however not for the observation audits.</p> <p>Areas that have achieved 95%:</p> <ul style="list-style-type: none">➔ PTS, observation audits: Milton Keynes 100%, Surrey 96%, Sussex 97%➔ PTS, discussion audits: Trust-wide 100%➔ Special operations, discussion audits: 100%➔ Special operations, observation audits: 98%➔ E&UC, discussion audits: North East Node 100%, South West Hampshire Node 100%																																				
Did we achieve this priority?	Partially achieved																																				

1C: TO IMPLEMENT THE NEW NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE (NICE) MENTAL CAPACITY ACT (MCA) GUIDANCE – IMPROVING AWARENESS AND PARITY

What we said we would do	What we have achieved
Conduct a staff survey to ascertain knowledge and appropriate use in Q1	<p>The NICE Guideline ‘Decision-making and mental capacity’ was published on 3 October¹. The guideline covers “decision-making in people 16 years and over who may lack capacity now or in the future. It aims to help health and social care practitioners to keep people who lack capacity at the centre of the decision-making process.”</p> <p>SCAS undertook a baseline assessment on release of the NICE guidance to identify areas that needed to be addressed prior to implementation of the guideline. This included a review of the MCA education sessions. These will be amended where necessary to reflect the requirements of the NICE guideline.</p> <p>A random survey of a sample of frontline staff was completed during a two-month period in December 2018 (regarding knowledge and understanding of the Mental Capacity Act 2005). Some of the feedback highlighted that there is uncertainty about the five statutory principle so, in response to this, more in-depth information about these has been included in the education programme planned for next year.</p>
Identify any specific training needs	<p>Training modules were revised to comply with the MCA Competency Framework (2016) and the NICE Guidelines published in 2018. A Train the Trainer event has been delivered to education managers from all staff groups with direct patient contact. An additional Train the Trainer module is planned for PTS education managers to provide a more in-depth session to enhance their ability and confidence in delivering statutory and mandatory MCA sessions in Q4.</p>

¹ <https://www.nice.org.uk/guidance/ng108/resources/decisionmaking-and-mental-capacity-pdf-66141544670917>

Conduct a MCA campaign in Q3 aligned with mental health awareness	Mental health awareness has been highlighted throughout the year in conjunction with the Trust Communications Team and the Health and Wellbeing Board. Short information articles and accounts of personal experience are regularly included in Staff Matters (weekly staff newsletter) and several activities were completed on Time to Talk Day 2018.
Details of the NICE MCA Guidelines will be included in all pertinent education sessions (relevant to role) and used to inform future audits and surveys.	<p>In conjunction with the Skills Network, a free Level 2 certification course, Awareness of Mental Health Problems, has been made available to all staff.</p> <p>Feedback from staff who have completed this course to date has been positive.</p> <p>There have been some significant improvements with our partner agencies, regarding the provision of alternative care pathways for people experiencing a mental health crisis. For example, in Southampton a new Crisis Lounge was opened and is now available 24-7.</p> <p>In other areas, the availability of mental health nurses to respond to mental health calls, and incidents with crews on scene, has increased. This service continues to grow and develop towards being available 24-7.</p>
Did we achieve this priority?	Achieved

CLINICAL EFFECTIVENESS

2A: TO REVIEW AND IMPROVE CALL ABANDONMENT FOR PTS, 999 AND NHS 111 (TWO-YEAR PRIORITY), 2ND YEAR

What we said we would do	What we have achieved																								
Conduct a review of our call announcements on our HCP and patient-facing lines to ensure our online system is promoted – creating a baseline measure of callers that use online services.	A review of our call announcements on the HCP and patient-facing lines has been completed and the online service is promoted on inbound lines for HCPs.																								
We will review our call scripts to ensure that our staff promote pre-planned activity being placed via our online system.	The call handler script has been reviewed and includes promotion of the online service. A memo was recently sent out to the team reminding them of the importance of promoting this service. Once the L&D Lead has been appointed they will be tasked to deliver an overview session on Online and Patient Zone to improve understanding of the service.																								
Review our Patient Zone and release this functionality to the PTS contracts that this is not currently contractually bound to deliver.	Posters advertising Patient Zone have been displayed on all SCAS resources promoting this function to patients.																								
Ensure an abandonment rate of below 1% (999) in line with the national threshold.	<p>In NHS 111, the call abandonment target is <5% and in October 2018 it was 4.06%. May 2018 recorded the best performance which was 1.5%.</p> <p>NHS 111 call abandonment rate</p> <table> <tr><td>Apr 18</td><td>3.1%</td></tr> <tr><td>May 18</td><td>1.5%</td></tr> <tr><td>Jun 18</td><td>1.8%</td></tr> <tr><td>Jul 18</td><td>2.8%</td></tr> <tr><td>Aug 18</td><td>2.2%</td></tr> <tr><td>Sep 18</td><td>3.1%</td></tr> <tr><td>Oct 18</td><td>4.1%</td></tr> <tr><td>Nov 18</td><td>6.2%</td></tr> <tr><td>Dec 18</td><td>6.0%</td></tr> <tr><td>Jan 19</td><td>2.6%</td></tr> <tr><td>Feb 19</td><td>6.4%</td></tr> <tr><td>Mar 19</td><td>1.5%</td></tr> </table> <p>We have achieved a NHS 111 abandonment rate in March below the 5% target.</p>	Apr 18	3.1%	May 18	1.5%	Jun 18	1.8%	Jul 18	2.8%	Aug 18	2.2%	Sep 18	3.1%	Oct 18	4.1%	Nov 18	6.2%	Dec 18	6.0%	Jan 19	2.6%	Feb 19	6.4%	Mar 19	1.5%
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Sep 18	3.1%																								
Oct 18	4.1%																								
Nov 18	6.2%																								
Dec 18	6.0%																								
Jan 19	2.6%																								
Feb 19	6.4%																								
Mar 19	1.5%																								

	999 call abandonment rate		
	Month	Incl. HCP (pre-ARP)*	Excl. HCP (post-ARP)*
	Apr 18	0.24%	0.04%
	May 18	0.52%	0.16%
	Jun 18	0.50%	0.13%
	Jul 18	0.89%	0.31%
	Aug 18	0.59%	0.15%
	Sep 18	0.60%	0.15%
	Oct 18	0.56%	0.13%
	Nov 18	0.36%	0.11%
	Dec 18	0.33%	0.12%
	Jan 19	0.39%	0.11%
	Feb 19	1.29%	0.48%
	Mar 19	0.91%	0.32%
	<p>The rate continues to be below the target of <1% in 999, except for February when we had a spike due to staff turnover. As can be seen in the March data, this has reduced due to staff recruitment and retention activity.</p> <p>In PTS the call abandonment target is <5% against most contracts and this was achieved in nine months out of the last 12; best performance was April 2018. The Sussex PTS area began a call handler rota review in November 2018 to better align staff availability for answering calls in line with demand. See table below.</p> <p>The call abandonment rates continue to be reported monthly in the IPR.</p> <p>Note: this indicator has been locally selected by the Council of Governors to be audited by our external auditors. This is for data accuracy not performance.</p>		
Did we achieve this priority?	Achieved		

*Note: Since the introduction of ARP, the way in which this indicator is reported has changed to call answering times. It now excludes HCP calls. The national guidance is, “the time to answer each call is the time between call connect and call answer”. Hence the data has pre-ARP data and the post-ARP which will be subject to testing be external auditors as a governor-chosen indicator.

	West Hants	Thames Valley	Sussex	Surrey	OHFT	Hants	MK
Apr-18	1.25%	1.47%	1.86%	1.07%	2.36%	1.18%	0.58%
May-18	0.00%	1.92%	2.53%	0.93%	2.50%	1.48%	0.56%
Jun-18	0.00%	1.97%	1.95%	3.72%	0.00%	2.06%	2.17%
Jul-18	0.00%	1.36%	3.77%	2.37%	0.84%	1.20%	1.63%
Aug-18	0.40%	2.04%	2.91%	2.82%	0.00%	1.85%	1.85%
Sep-18	0.00%	6.89%	4.35%	13.10%	0.00%	6.18%	7.07%
Oct-18	0.00%	3.28%	1.64%	4.78%	0.00%	2.69%	2.35%
Nov-18	0.00%	6.49%	2.78%	7.80%	1.42%	6.21%	5.77%
Dec-18	1.00%	4.21%	2.16%	3.40%	0.00%	3.95%	3.82%
Jan-19	2.67%	3.83%	2.67%	3.80%	0.00%	4.16%	3.32%
Feb-19	0.00%	7.96%	4.63%	8.95%	0.00%	7.58%	6.58%
Mar-19	0.00%	9.12%	3.37%	11.49%	0.00%	15.14%	8.25%

2B: TO INCREASE CLINICAL ASSESSMENTS IN CCCs ENSURING CONSISTENT METHODS AND APPLICATIONS ACROSS THE SERVICES (THREE-YEAR PRIORITY) 2ND YEAR

What we said we would do	What we have achieved
Implement the Green project (30 and 60 minute calls) for eight clinical conditions in Year 1 (achieved)	Partial achievement as this is Year 2 of a three-year plan.
Ensure 80% of all eligible calls (green ambulance disposition) are transferred to an enhanced desk for further clinical assessment	<p>The Green Project, now called the Accelerated Clinical Triage (ACT) process, has been implemented and went live in November 2017. The ACT process is still in progress. The benefits of this with the introduction of category 3 and 4 validation is the reduced call taker time and improved patient experience. These calls are given a nature of call in 999 which highlights to the dispatcher to not send a resource until clinical assessment has taken place. The ECT will triage to the end of module 0 in NHS Pathways and the call will then be passed to a clinician for further assessment. As these calls have a low risk of requiring an ambulance response, it is sensible to allow a more detailed triage to take place with a clinician who can then refer into an alternative care facility or provide home care advice. This offers a seamless process for the caller.</p> <p>Category 3 and 4 Clinical Validation Since October 2018, all category 3 and 4 calls reaching an ambulance disposition have automatically been “warm transferred” or put into a clinician queue for validation by a clinician. This was mandated by NHS England to reduce the inappropriate use of ambulances or transfer into the emergency department.</p> <p>The call can be held in a clinician queue for a maximum of 10 minutes for validation. These calls are currently audited (50 per month) and compliance is currently 94%. Audit has demonstrated that there is a 20-30% reduction in ambulance outcomes following effective clinical validation. Demand for clinical validation often exceeds clinician availability in the CCC and therefore some of these calls will be streamed to an IUC Clinician/GP for further validation.</p>

Establish the baseline % of long waits for these Green calls and set an improvement target to commence in Year 2	Long waits are monitored in the North and South at monthly long waits meetings and the process has been signed off with commissioners. These reports are presented to each Patient Safety Group (PSG).
To further model the Green project after implementation and by end of 2017	This is now business as usual; no further symptom groups have been added to the ACT process.
Evaluate the Live Link pilot and analyse the data to demonstrate an improvement in non-conveyance	Collaboration of the CQUIN and GDE project has commenced to ensure evaluation of effectiveness of algorithms in place.
Implement the NHS 111 online symptom checker in Year 1	<p>This is live in Thames Valley for IUC but still to be implemented in Hampshire.</p> <p>This is second year of the priority, therefore work continues.</p>
Did we achieve this priority?	Achieved

2C. TO IMPROVE LONG WAITS IN THE ARP RESPONSE CATEGORIES

What we said we would do	What we have achieved
Ensure the long waits groups utilise an agreed definition of long waits under the ARP categories	<p>The long waits group, which is a sub-group of PSG, includes an agreed definition as part of the terms of reference for the group. This group meets monthly to review long waits and to identify areas requiring further investigation. Terms of reference for this group have been updated to reflect the national changes APR brought to definitions of long waits.</p> <p>To give assurance on category 1 long waits being accurate, further modelling within ARP will be required aligned with fleet changes when they are implemented.</p>
<p>Review monthly long waits ensuring a detailed theme analysis is reported to Patient Safety Group (PSG) and the Quality and Safety (Q&S) Committee</p> <p>Report externally to commissioners with approved actions for improvements</p>	<p>A quarterly report is shared with commissioners in Thames Valley, Southampton, Hampshire and Portsmouth. This report upwardly reports to the Q&S Committee through PSG which includes recommendations and also embeds in the E&UC action plan. This action plan is owned by the SCAS clinical governance leads and heads of operations.</p>

Implement learning and actions from long wait reviews through PSG	<p>Following the multi-disciplinary Long Wait Workshop in 2018, a cross-departmental action plan was developed and circulated. The action plan is presented through the Level 2 process with the senior operations team. The outcomes from the action plan are:</p> <ul style="list-style-type: none">➔ To reduce negative SCAS impact on long waits from SCAS internal practice, policy or procedures➔ To provide assurance that there is no hidden patient harm in those cases defined as long wait <p>A deep dive was commissioned by the Q&S Committee to undertake a review of long waits that are not covered by the regular monthly reviews.</p> <p>The number of patients experiencing a delay has not reduced, however the time those patients have spent waiting has reduced. A multi-departmental action plan is in progress, with the aim of reducing the number of delays.</p> <p>However, analysis of long waits has demonstrated that whilst this can result in a poor patient experience, harm levels are low. A deep dive analysis has also identified that category 1 transport long waits can be incurred when dispatch and transportation decisions are made following a face-to-face assessment, that are appropriate to the patient condition, and suitable from a patient experience perspective.</p> <p>Further analysis demonstrates that the majority of those patients experiencing a delay in response sit within the category 3 and 4 cohorts. These categories are where the urgent and less urgent calls sit, with life-threatening and more urgent emergency calls categorised as category 1 and 2. Therefore it can be seen that those experiencing a delay have more commonly been determined to have a less urgent need.</p>
Did we achieve this priority?	Partially achieved

PATIENT EXPERIENCE

3A: TO CONDUCT A SURVEY OF PATIENTS USING THE 999 SERVICE HIGHLIGHTING IMPROVEMENT ACTIONS TO BE TAKEN TO IMPROVE PATIENTS’ EXPERIENCE OF THE SERVICE

What we said we would do	What we have achieved
Establish baseline in Q1 and set an improvement trajectory to increase respondents	<p>Through the Trust’s website, SCAS invites service users to submit their compliments, complaints and feedback via the Patient Experience Team or via completing our existing online patient feedback survey which is permanently available. Service users are prompted to provide their feedback via a scrolling banner on the front page of the website with a ‘Tell us what you think’ invitation including a link to the patient survey.</p> <p>Respondents are encouraged to tell us about their experience of the 999 service. We ask about how the call was handled, the advice and care given by ambulance staff and we invite respondents to comment on what would have made their experience better.</p> <p>SCAS offers free text boxes for respondents to provide narrative comments which gives us greater insight in to what has gone well and what can be improved.</p>

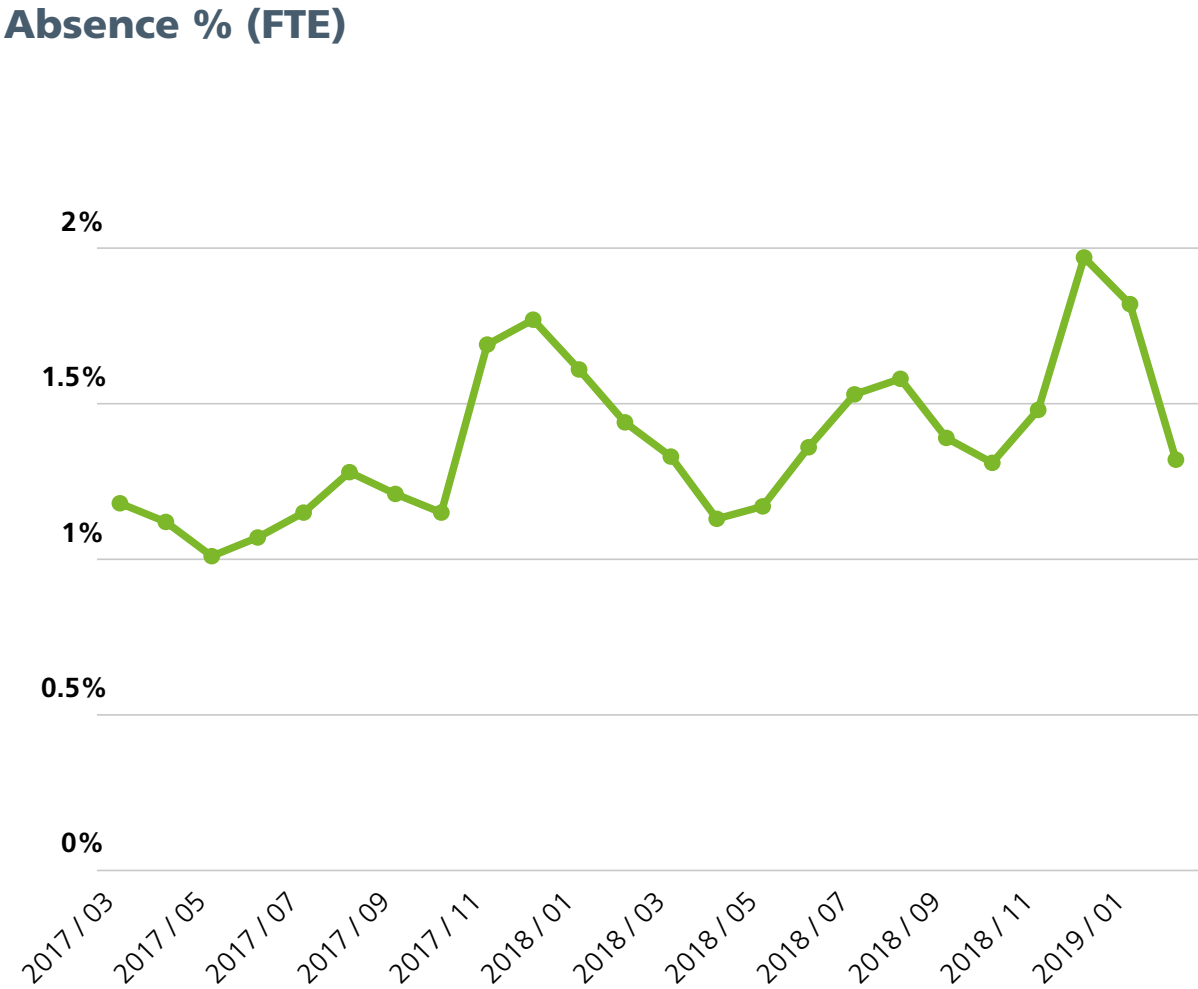
Use the data set to identify actions for learning	<p>During the period 1 April 2018 to 31 March 2019, we received 183 online responses from 999 patients or 999 callers. The responses received were mainly positive and supportive of our staff.</p> <p>We have included the option for responders to indicate if they are a ‘carer’. This is allowing us to extract feedback specifically received from carers to understand their experience of the 999 service.</p> <p>➔ 83% (152) of respondents said they would recommend SCAS to their friends and family.</p> <p>➔ 82% (150) respondents told us they were ‘very satisfied’ with the handling of their call.</p> <p>➔ 80% (146) of respondents rated the advice and care provided as ‘excellent’.</p> <p>We asked our 999 service users “What would have made your experience better?” Many respondents answered ‘nothing’, others told us a faster response time would have been preferred but also acknowledged the service is under pressure.</p> <p>The Trust intended to improve the number of responses received to gain clearer insight of service users’ experience of the 999 service by also issuing postal surveys during Q3 2018/19 to randomly selected callers. These postal surveys have been delayed.</p>
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Conduct thematic analysis with actions for improvement Q4	From the online survey we received 183 responses. We are undertaking thematic analysis with actions for improvement which will be reported to the Trust's Patient Experience Review Group in June 2019 and through external contract meetings.
Report to Patient Experience Group and through external contract meetings	<p>The Patient Experience Team worked with the Specialist Practitioner Manager to devise and introduce a survey seeking feedback face-to-face from 999 See & Treat patients. Specialist practitioners are now using this survey with their patients. Results from the surveys will be included in the thematic analysis.</p> <p>The Trust has also developed a social media post which is run on the Trust's social media pages, along with the introduction of a laminated poster displayed on all 999 frontline vehicles; both of which encourage patients to provide us with their feedback.</p> <p>Work is ongoing with the National Ambulance Services Patient Experience Group to understand the 999 patient surveys issued by other ambulance trusts nationally to benchmark and understand best practice.</p>
Did we achieve this priority?	Partially achieved

3B: TO IMPROVE THE FOCUS ON IMPROVING STAFF HEALTH AND WELLBEING AT WORK IN RELATION TO STRESS

What we said we would do	What we have achieved
Use staff survey action plans to focus on stress reduction per service	Health and Wellbeing Roadshows continue across the Trust, with a plan for 2019 being devised, to ensure the profile of the team and the work they are doing is known Trust-wide.
Agree a reduction trajectory in Q1 for the year	
Report to the Quality & Safety Committee identifying actions for improvement and any new initiatives	<p>Staff survey actions were used locally to focus on wellness at work, welfare, team support and reducing stress through debriefs.</p> <p>The internal sickness audit plan has been approved by our Board and is being rolled out currently. This is as a result of the internal audit that was carried out and recommendations were received. The action plan includes but is not limited to, internal improvements on sickness reporting, policy improvements and improvements to the services provided by occupational health.</p> <p>The graph below demonstrates absence rates that were all below target of 5%.</p> <p>Stress Awareness Day 7 November 2018 was promoted.</p> <p>Since August 2016, the Head of Risk and Security has delivered and presented 36 task-based risk assessment training courses and 34 stress risk assessment training sessions to managers and staff in the following areas:</p> <ul style="list-style-type: none"> ➔ 999 ➔ HART ➔ PTS ➔ Clinical co-ordination centres ➔ NHS 111 ➔ Education and training development ➔ Human resources ➔ Estates ➔ Staff Side representatives ➔ Business intelligence unit

	<p>Sofar, 217 managers and staff have been trained to carry out a task-based risk assessment; and 207 managers and staff have been trained to carry out a stress risk assessment. Other training sessions are planned in April and May 2019. It is intended that all areas will have managers trained in how to carry out a task-based risk assessment and a stress risk assessment.</p> <p>Stress is currently our second most common reason for sickness. We have implemented the following initiatives to help address this issue:</p> <ul style="list-style-type: none"> ➔ Trauma Risk Incident Management (TRiM) ➔ Psych Health specialised counselling ➔ Occupational health ➔ Optum (Livewell) ➔ Access to MIND (Blue Light) <p>Taking our work forward we will include:</p> <ul style="list-style-type: none"> ➔ Mental health first aid training ➔ Stress resilience programme ➔ Health and wellbeing champions, with expertise in mental health resilience
Did we achieve this priority?	Achieved



3C: TO IMPROVE END OF LIFE CARE IN PTS ACROSS ALL CONTRACTS

What we said we would do	What we have achieved
Undertake an analysis of incidents reported on end of life care in PTS Q1	A new PTS Standard Operating Procedure (SOP) entitled 'Expected and Unexpected Death in the Patient Transport Service', has been developed, ratified through Patient Safety Group, and cascaded to a both Operational and Contact Centre PTS staff. This SOP provides guidance to staff on what to do when a patient passes away in their care. It covers multiple scenarios and references both expected and unexpected deaths.
Create an action plan from this analysis to ensure that patients are not being referred to PTS inappropriately encouraging staff to report any issues	
Identify experience and contractual issues that require improvement in Q2	The issue of hospices' reluctance to admit EoL patients who pass away en-route to them has been a focus for SCAS internally and in our work with commissioning to ensure the right outcome at the end of life for patients using the PTS.
Survey staff in Q3 to ascertain staff and patient experiences with improvement actions	
Ensure and report on appropriate use of PTS for transporting patients at the end of their life	An EoL analysis was undertaken early in the year which concluded all reported cases of patients passing away with PTS in the preceding six months, were expected deaths with advanced directives in place, and most were palliative patients. The majority of deaths occurred during the last two months of the year during peak flu season and at a time where general respiratory illnesses are increased. The report noted that PTS staff being required to convey patients to the mortuary was not common, nor was hospice staff refusing to admit deceased patients. It was decided that the situation would be monitored by the clinical governance leads, and the analysis repeated at a later date for assurance.
	The results of a second analysis were presented to the Patient Safety Group (PSG) in July 2018 and they reflected those of the first analysis, but further confirmed that patients were being booked and conveyed by staff when very close to passing away.

	<p>Each PTS contract area has different contract wording surrounding the suitability of EoL conveyance by PTS. Some state that patients must be stable, others state that they must not be expected to pass within 24 hours and some place no restriction at all. This issue was discussed by the PSG with regard to requesting a universal approach across all contracts, and setting a restriction on how close to passing away the patient may be at the time of travel.</p> <p>PSG discussed the challenge of how to assess when a patient may die, but may prevent patients from dying in their preferred place, and potentially divert frontline ambulances from those in need. As such the PSG decided that a restriction would not be requested, and actions arising should be threefold, these are described with progress against them below:</p> <ul style="list-style-type: none">➔ Implement an EoL standard operating procedure (SOP) to advise staff of the correct actions to take for both expected and unexpected deaths within PTS - completed, ratified and cascaded to PTS staff on 17/09/18.➔ Produce a 'Mortuary Directory' to assist staff should the need arise for them to visit a mortuary - this is in production, currently awaiting engagement from approx. 50% of hospitals.➔ Engage with hospices to ensure a unified approach for patients who pass away en-route to them - good engagement received to date, with formal responses from both hospices involved in previous Datix reports.➔ Commissioners have been requested to establish a Task and Finish Group, which can agree a protocol which consults all relevant providers.➔ Staff have been involved in feedback through staff meetings and Datix reporting.
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	<p>In Q1 2018/19 an analysis of EoL issues/incidents/complaints was undertaken to elicit any themes to take the work with SCAS staff awareness and contract review forward. A wildcard search of Datix revealed six EoL incidents in PTS in Q1 and 2 (compared with five for the same period the previous year). In Q3 2018/19 there have been no incidents reported. All PTS staff now report any deaths in their care on Datix for learning/experience purposes. It is too early to say whether awareness of staff and contract discussions have contributed to patients dying in their preferred location or being transported in a timely way, but the analysis will continue.</p> <p>The new SOP resulting from this analysis was released on 17 September 2018 and since that date we have reviewed any further incidents to ascertain any improvements or ongoing issues.</p> <p>Incidents review There were four incidents (showing a small reduction) from October 2018 to March 2019 reporting the deaths of EoL patients whilst in the care of PTS, but no reported issues with these patients being accepted at their destinations, and no mortuary conveyances. Two incidents reported admission refusals by their destination care homes for EoL patients, as they felt the patients were too unwell and needed to be in an acute setting. SCAS continues to review feedback from families and work with partners to ensure the highest level of care and experience for EoL patients.</p>
Did we achieve this priority?	Achieved

2.2 STATEMENT OF ASSURANCE FROM THE BOARD

1. During 2018/19 South Central Ambulance Service NHS Foundation Trust (SCAS) provided and/or sub contracted three relevant health services:

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

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

- ➔ Patient surveys
- ➔ Friends and family
- ➔ Staff surveys
- ➔ Narrative from complaints and feedback and their resolution
- ➔ HCP feedback, themes and actions
- ➔ Patient stories at public Board meetings
- ➔ Root cause analysis of incidents and identified learning
- ➔ Internal audit reports
- ➔ External reviews of quality including the CQC and commissioner visits
- ➔ Leadership walk-rounds and actions
- ➔ Upward reports to Quality & Safety Committee meetings
- ➔ Staff meetings
- ➔ Quality impact assessments of cost savings projects
- ➔ Quality and safety papers to the Board
- ➔ Quality & Safety Committee meeting minutes
- ➔ Patient Experience Review Group meeting minutes
- ➔ Serious Incidents Requiring Investigation meeting minutes
- ➔ Patient Safety Group meeting minutes
- ➔ Clinical Review Group meeting minutes

1.2 The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant health services by SCAS for 2018/19.

2. During 2018/19, eight national clinical audits and nil national confidential enquiries covered relevant health services that SCAS provides.

2.1 During 2018/19, SCAS participated in 100% national clinical audits and 0% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

2.2 The national clinical audits and national confidential enquires that SCAS was eligible to participate in during 2018/19 were as follows:

- ➔ Acute Myocardial Infarction and other Acute Coronary Syndrome (MINAP)
- ➔ Ambulance Clinical Quality Indicator ST Elevation Myocardial Infarction Diagnostic Bundle
- ➔ Ambulance Clinical Quality Indicator Stroke Diagnostic Bundle
- ➔ Ambulance Clinical Quality Indicator Sepsis Diagnostic Bundle
- ➔ Warwick Clinical Trials Unit Out of Hospital Cardiac Arrest Outcomes (OHCAO)
- ➔ Ambulance Clinical Quality Indicator Cardiac Arrest ROSC rates (and separate Utstein ROSC measure)
- ➔ Ambulance Clinical Quality Indicator Cardiac Arrest Survival to Discharge (STD) (and separate Utstein STD measure)
- ➔ Ambulance Clinical Quality Indicator Cardiac Arrest Post ROSC Diagnostic Bundle

2.3 The national clinical audits and national confidential enquires that SCAS participated in during 2018/19 were as follows:

- ➔ Acute Myocardial Infarction and other Acute Coronary Syndrome (MINAP)
- ➔ Ambulance Clinical Quality Indicator ST Elevation Myocardial Infarction Diagnostic Bundle
- ➔ Ambulance Clinical Quality Indicator Stroke Diagnostic Bundle
- ➔ Ambulance Clinical Quality Indicator Sepsis Diagnostic Bundle
- ➔ Warwick Clinical Trials Unit Out of Hospital Cardiac Arrest Outcomes (OHCAO)
- ➔ Ambulance Clinical Quality Indicator Cardiac Arrest ROSC rates (and separate Utstein ROSC measure)
- ➔ Ambulance Clinical Quality Indicator Cardiac Arrest Survival to Discharge (STD) (and separate Utstein STD measure)
- ➔ Ambulance Clinical Quality Indicator Cardiac Arrest Post ROSC Diagnostic Bundle

2.4 The national clinical audits and national confidential enquiries that SCAS participated in, and for which data collection was completed during 2018/19, are listed below alongside the numbers of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National clinical audit	Number of cases	% submitted
Acute Myocardial Infarction and other Acute Coronary Syndrome (MINAP)	412 Apr 18 to Nov 18	100%
Ambulance Clinical Quality Indicator ST Elevation Myocardial Infarction Diagnostic Bundle	551 Apr 18 to Nov 18	100%

Ambulance Clinical Quality Indicator Stroke Diagnostic Bundle	3,976 Apr 18 to Nov 18	100%
Ambulance Clinical Quality Indicator Sepsis Diagnostic Bundle	637 Apr 18 to Nov 18	100%
Warwick Clinical Trials Unit Out of Hospital Cardiac Arrest Outcomes (OHCAO)	2,765 Apr 18 to Nov 18	100%
Ambulance Clinical Quality Indicator Cardiac Arrest ROSC Rates (and separate Utstein ROSC measures)	376 Apr 18 to Nov 18	100%
Ambulance Clinical Quality Indicator Cardiac Arrest Survival to Discharge (STD) Rates (and separate Utstein STD measures)	199 Apr 18 to Nov 18	100%
Ambulance Clinical Quality Indicator Cardiac Arrest Post ROSC Diagnostic Bundle	179 Apr 18 to Nov 18	100%

2.5 and 2.6 The reports of eight national clinical audits were reviewed in 2018/19 and SCAS intends to take the following actions to improve the quality of healthcare provided:

- ➔ Monitor ARP response to Category 1 patients presenting with cardiac arrest, stroke or STEMI
- ➔ Change location of pain scoring element within electronic patient record system to increase recording and monitoring of this by clinicians
- ➔ Launch of ACQI briefing material to ensure clinicians are aware of ACQI diagnostic bundle elements
- ➔ Engage nationally with implementation of new Mental Health and Falls ACQI measures when released
- ➔ Continue monitoring of care provided for patients with sepsis and post cardiac arrest through newly implemented Sepsis and Post-ROSC ACQIs

2.7 and 2.8 The reports of 16 local clinical audits were reviewed in 2018/19 and SCAS intends to take the following actions to improve the quality of healthcare provided:

- ➔ Continue to improve compliance with recording peak flow measures following implementation of a compliance screen to ensure clinicians add the required elements for treating patients with an exacerbation of asthma
- ➔ Continue to ensure clinicians know the required elements for treating a patient suffering a febrile convulsion following implementation of a compliance screen within the electronic patient records system
- ➔ Improve recording of limb immobilisation post fracture following implementation of a compliance screen within the electronic patient records system
- ➔ Continue monthly internal audit of 50 cases for what was the NCPI groupings such as asthma, falls and lower limb fractures

- ➔ Maintain monthly reviews of all private providers including a random audit of patient records
- ➔ Monthly Long Wait Review Group auditing a range of cases per category per nodal area
- ➔ Monitor compliance with clinical validation of decision making of newly qualified paramedics through implementation of changes in the electronic patient record system to enable this data to be recorded
- ➔ Work with commissioners and system partners to increase the care pathway options available for patients at the end of life

3. The number of patients receiving relevant health services provided or sub-contracted by SCAS in 2018/19 that were recruited to participate in research, approved by a research ethics committee was three.

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

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

Research-related activities

Representation on regional and national research committees: Thames Valley & South Midlands Injuries & Emergencies Specialty Group, Wessex Injuries & Emergencies Specialty Group, Wessex Critical Care Specialist Group, National Ambulance Research Steering Group.

Publications

2019

- Brown TP, Booth S, Hawkes CA, Soar J, Mark J, Mapstone J, Fothergill RT, Black S, **Pocock H**, Bichmann A, Gunson I, Perkins GD (2019) Characteristics of neighbourhoods with high incidence of out-of-hospital cardiac arrest and low bystander cardiopulmonary resuscitation rates in England. *European Heart Journal – Quality of Care and Clinical Outcomes*, 5, 51-62.
- **Deakin CD** (2019) Epinephrine in Cardiac Arrest. State of the Future of Resuscitation. JEMS March 2019, p.16.
- Fothergill RT, Emmerson AC, Rajeshwari I, Lazarus J, Whitbread M, Nolan JP, **Deakin CD**, Perkins GD (2019) Repeated adrenaline doses and survival from an out-of-hospital cardiac arrest. *Resuscitation*. In press.
- Harpsø M, Granfeldt A, Løfgren B, **Deakin CD** (2019) Does Hyperoxia in the First 24 Hours Following Major Trauma Affect Outcome? *Open Access Emergency Medicine*. In press.

2018

- Colbeck M, Maria S, **Eaton G**, Campbell C, Batt A, Caffey M (2018) International Examination and Synthesis of the Primary and Secondary Surveys in Paramedicine. *Irish Journal of Paramedicine* 3(2): DOI: <http://dx.doi.org/10.32378/ijp.v3i2.91>.
- **Deakin CD** (2018) The Chain of Survival: Not all links are equal. *Resuscitation*, 126: 80-82.
- **Deakin CD, Anfield S, Hodgetts GA** (2018) Underutilization of public access defibrillation is related to retrieval distance and time-dependent availability. *Heart*. In press. <http://dx.doi.org/10.1136/heartjnl-2018-312998>
- **Deakin CD**, Potter R, Sidebottom D (2018) Can Rescuers Accurately Deliver Subtle Changes to Chest Compression Depth if Recommended by Future Guidelines? **Resuscitation**; 124; 58–62.
- **Eaton G**, Mahtani K, Catterall M (2018) The evolving role of paramedics: NICE problems to have? *Journal of Health Services Research & Policy* 23(3): 193-195.
- **Eaton G**, Renshaw J, Gregory P, Kilner T (2018) Can the British Heart Foundation PocketCPR application improve the performance of chest compressions during bystander resuscitation: A randomised crossover manikin study. *Health Informatics Journal* 24(1):14-23.
- **Eaton G**, Brown S, Raitt J (2018) HEMS dispatch: A Systematic Review. *Trauma* 20(1):3-10.
- Freeman S, **Deakin CD**, Nelson M, Bootland D (2018) Managing Accidental Hypothermia: A UK-wide Survey of Prehospital and Search and Rescue Providers. *Emergency Medicine Journal*, In press.
- Holmberg MJ, Geri G, Wiberg S, Guerguerian A-Marie, Donnino MW, Nolan JP, **Deakin CD**, Andersen LW (2018) Extracorporeal cardiopulmonary resuscitation for cardiac arrest: a systematic review. *Resuscitation*, 131: 91–100. doi: 10.1016/j.resuscitation.2018.07.029. Epub 2018 Jul 29.
- Ji C, Quinn T, Gavalova L, Lall R, Scomparin C, Horton J, **Deakin CD, Pocock H**, Smyth MA, Rees N, Brace-McDonnell SJ, Gates S, Perkins GD (2018) Feasibility of data linkage in the PARAMEDIC trial: a cluster randomised trial of mechanical chest compression in out-of-hospital cardiac arrest. *BMJ Open*. Doi:10.1136/bmjopen-2018-021519.
- Mahtani K, **Eaton G**, Catterall M, Ridley A. (2018) Setting the scene for paramedics in general practice: What can we expect? *Journal of the Royal Society of Medicine* 111(6): 195-198.
- **Mildenhall J** (2019) Protecting the mental health of UK paramedics. *Journal of Paramedic Practice*, 11, 1, 6-7.
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Presentations

2019

- **Ainsworth-Smith M**. Management of Major Trauma. *College of Paramedics CPD event, Isle of Wight, February*.
- **Ainsworth-Smith M**. Sepsis and Recognition of Deterioration: the ambulance service perspective. *NHSI, London, March*.
- **Deakin CD**. Controversies in Resuscitation. The Big Sick 2019. *Zermatt, Switzerland, February*.
- **Deakin CD, Pocock H**. PARAMEDIC-2 results. *SCAS CPD evening. Oxford, March*.
- **Mildenhall J**. Dealing with Distressing Incidents. *SCAS ‘Time to Talk’ Mental Health Awareness Day, February*.
- **Mildenhall J**, Williams R. Psychosocial Consequences of Trauma. *Royal College of Surgeons of Edinburgh Faculty of Pre-hospital Care Trauma Care conference. Stone, Staffordshire, March*.

2018

- **Ainsworth-Smith M**. What we do? The sick patient. *Wessex Patient Safety, June*.
- **Ainsworth-Smith M**. Recognising the sick patient. *Frimley Healthcare, Frimley, Surrey, June*.

- **Ainsworth-Smith M**. The SCAS response to sepsis cases. *AHSN, Wessex, July*.
- **Ainsworth-Smith M**. Focusing on lower grades of emergencies. *NHSI, London, September*.
- **Ainsworth-Smith M**. Sepsis. *AHSN, Thames Valley, October*.
- **Cavalier J**. Frailty: a 999 response: identifying frailty in pre-hospital emergency care. *SCAS Research & You Conference. Newbury, June*.
- **Deakin CD**. PARAMEDIC2 trial update. *Royal College of Emergency Medicine. Clinical Studies Group. London, January*.
- **Deakin CD**. The role of telephone instructions in improving cardiac arrest survival. *NHS Pathways, London, March*.
- **Deakin CD**. Controversies in Advanced Life Support. *Czech Resuscitation Council Annual Congress. Prague, June*.
- **Deakin CD**. Epinephrine. Take Heart America. *First International State of the Future of Resuscitation Conference. Oakland, San Francisco, September*.
- **Deakin CD, Pocock H**. PARAMEDIC-2 results. *SCAS CPD evening. Southampton, November*.
- Colbeck M, Maria S, **Eaton G**, Campbell C, Batt A, Caffey M, Hunter M. International Examination and Synthesis of the Primary and Secondary Surveys in Paramedicine. *Fanshawe College Research and Innovation Day. London, Canada. March*.
- **Eaton G**. What’s that Rash? Exploring Dermatology for Paramedics. *Scottish Paramedic Urgent Care Conference. Stirling, Scotland, November*.
- **Eaton G**. Learning Values in the Paramedic Practicum. *SCAS Research & You Conference. Newbury, June*.
- **Eaton G**. Learning Values in the Paramedic Practicum. *Irish College of Paramedics Research Symposium. Cork, Republic of Ireland, September*.
- **King P, Jadzinski P**. A clinical audit of the electronic data capture of dementia in ambulance service clinical records. *SCAS Research & You Conference. Newbury, June*.
- **Mildenhall J**. Paramedic’s Experiences of Occupational Trauma. *Health Education England. London, August*.
- **Mildenhall J**. The Impact of Psychological Trauma upon Paramedics Mental Health and Wellbeing. *College of Paramedics ‘Mental Health & Wellbeing’ Conference. Milton Keynes, December*.
- **Mildenhall J**. Dealing with Distressing Incidents. *University of West of England, Bristol. June*.
- **Mildenhall J**. Dealing with Distressing Incidents. *SCAS Community First Responder Conference. Newbury, April*.
- **Pocock H**. A clinical audit of the electronic data capture of dementia in ambulance service clinical records. *CRN Wessex Research Nurse & AHP Forum. Wareham, July*.
- **Pocock H**. Exploring factors increasing Paramedics’ likelihood of administering Analgesia in pre-hospital pain: cross sectional study (ExPLAIN). *SCAS Research & You Conference. Newbury, June*.
- **Pocock H**. A clinical audit of the electronic data capture of dementia in ambulance service clinical records. *Alzheimer’s Society Annual Conference. London, May*.
- **Pocock H**. The problem with surveys. *College of Paramedics webinar. July*.
- **Pocock H**. An evaluation of the role of SCAS in the attendance to call-outs and the transport to hospital of older people with dementia. *Celebrating Urgent Care research in Thames Valley, South Midlands and Wessex, October*.

- **Poole K.** Morphine in acute coronary syndrome. *SCAS Research & You Conference. Newbury, June.*
- **Thomson M.** Looking at improving care in older patients with complex needs: a collaboration between SCAS and The Open University. *SCAS Research & You Conference. Newbury, June.*

Poster presentations

- **Eaton G,** (2018) Learning Values in the Paramedic Practicum *College of Paramedics National Research Conference, Belfast, Northern Ireland, December 2018.*

Prizes

Best Presentation: **Pocock H.** A clinical audit of the electronic data capture of dementia in ambulance service clinical records. *CRN Wessex Research Nurse & AHP Forum. Wareham, July 2018.*

4. A proportion of the Trust's income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between SCAS and any person or body the Trust entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

The monetary total for income in 2018/19 conditional on achieving quality improvement and innovation goals was £3,002k and the associate payment in 2017/18 was £2,739k.

4.1 and 4.2 Further details of the agreed goals for 2018/19 and for the following 12-month period are available electronically² and include:

- ➔ Staff flu vaccinations (2019/20)
- ➔ Access to patient information at scene (assurance and demonstration)

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

5.1 The CQC has not taken enforcement action against SCAS during 2018/19.

6. Removed from the legislation by the 2011 amendments.

7. and 7.1 SCAS has participated in special reviews or investigations by the CQC relating to the following areas during 2018/19.

Local System Reviews (LSRs) were carried out following a request from the Secretary of State for Health and Social Care and the Secretary of State for Housing, Communities and Local Government for the CQC to undertake a programme of targeted reviews of local authority areas. The purpose of these reviews was to understand how people move through the health and social care system, with a focus on the interfaces between services. By exploring local area commissioning arrangements and how organisations are working together to meet the needs of people who use services, their families and carers, we can understand people's experience of care

² <https://www.england.nhs.uk/wp-content/uploads/2019/03/CQUIN-Guidance-1920-080319.pdf>

and what improvements can be made.

There was a LSR in Reading 29 October to 2 November 2018 and a LSR progress review in Oxfordshire on 6-7 November 2018.

There were no specific actions for SCAS to take as a result of the reviews but we continue to engage with the local system.

8. and 8.1 SCAS did not submit records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

9. The Trust's Information Governance Assessment Report has now been replaced by the Data Security and Protection Toolkit.

SCAS met 89 of 100 mandatory items and completed 31 of 40 assertions (an assertion contains a group of mandatory items that are not related).

10. and 10.1 The Trust was not subject to the Payment by Results clinical coding audit during 2018/19 by NHS Improvement.

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

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

2.3 REPORTING AGAINST NHS IMPROVEMENT CORE INDICATORS

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

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

Performance against national ambulance service response targets 2018/19

Category 1 2018/19	Category 2 2018/19
07:01 – Mean	16:35 – Mean
12:44 – 90th Percentile	33:15 – 90th Percentile
10:18 – C1T Mean	
Previous years’ data	Previous years’ data (Red 2)
2017/18 – 07:19 (mean) 31 Oct-31 Mar 2017/18 – 13:21 (90th percentile) 2017/18 – 11:45 (C1T mean)	2017/18 – 17:24 (mean) 31 Oct-31 Mar 2017/18 – 35:05 (90th percentile)
2017/18 – 73.9% (Red 1) 1 Apr-30 Oct	2017/18 – 70.6% (Red 2) 1 Apr-30 Oct
2016/17 – 73.3% (Red 1)	2016/17 – 73.1 % (Red 2)
2015/16 – 71.9% (Red 1)	2015/16 – 72.7% (Red 2)
2014/15 – 75.0% (Red 1)	2014/15 – 74.5% (Red 2)

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

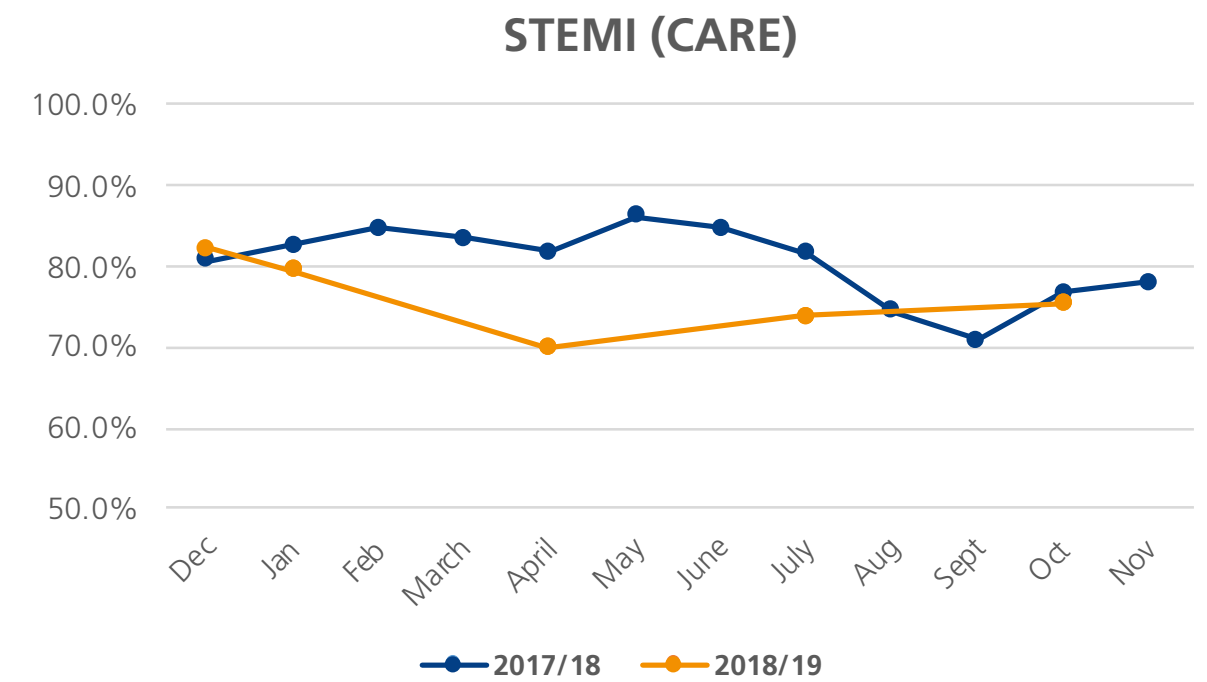
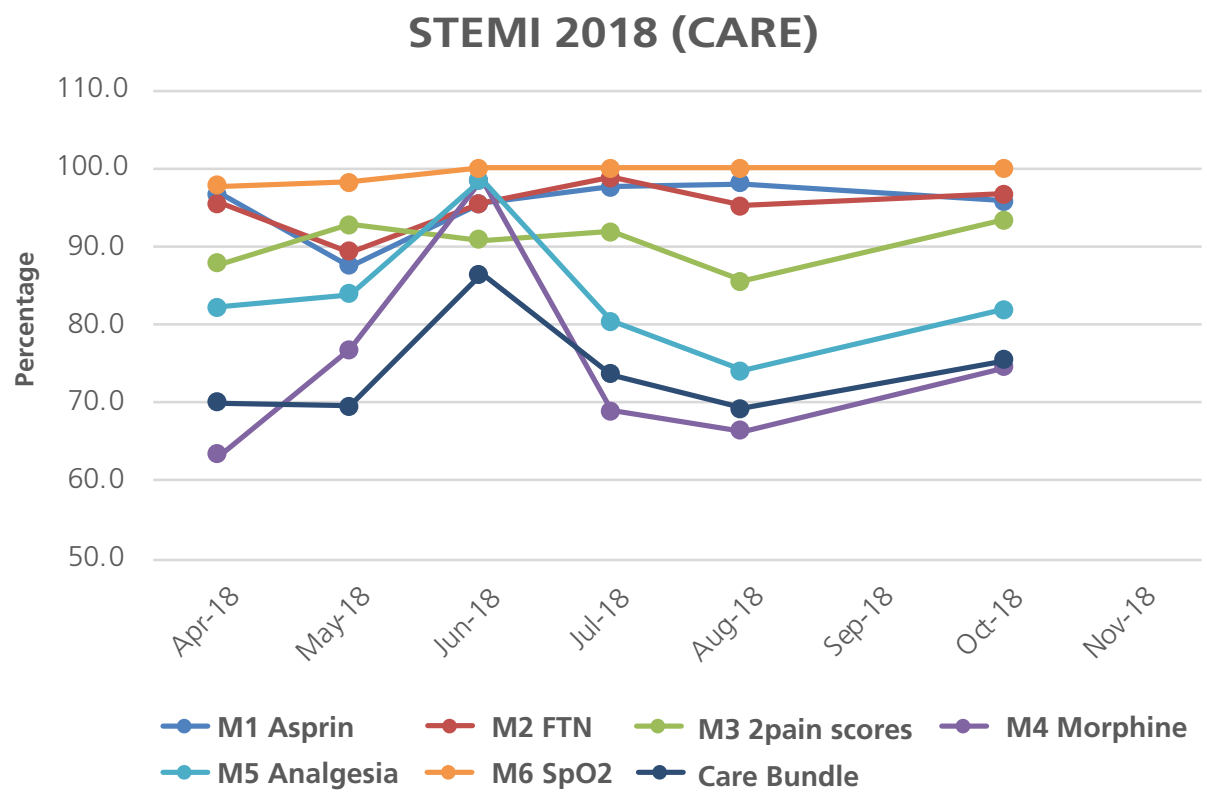
SCAS intends to take the following actions to improve this indicator and so the quality of its services, by continually analysing the ARP data and continuing to model our staff rotas and fleet availability to meet the category requirements. Through the Integrated Performance Report to Trust Board there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

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

Red 19 2018/19	N/A following introduction of ARP from 31 October 2018 in SCAS
Previous years’ data	94.2% - 2017/18 (1 Apr-30 Oct 17) 94.7% - 2016/17 94.4% - 2015/16 95.5% - 2014/15

STEMI Care Bundle Performance

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



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

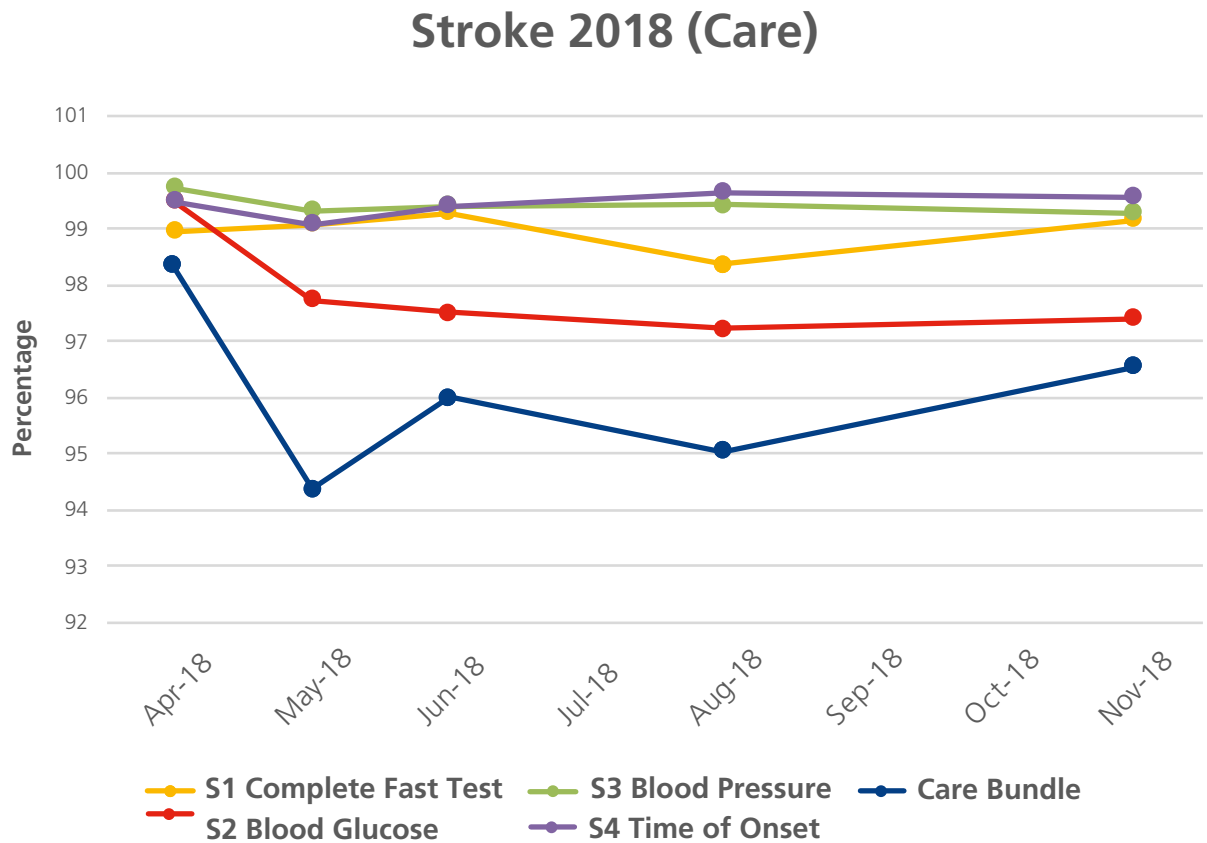
Year	Compliance
2018/19	73.2% YTD
2017/18	78.5%
2016/17	73.8%

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

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

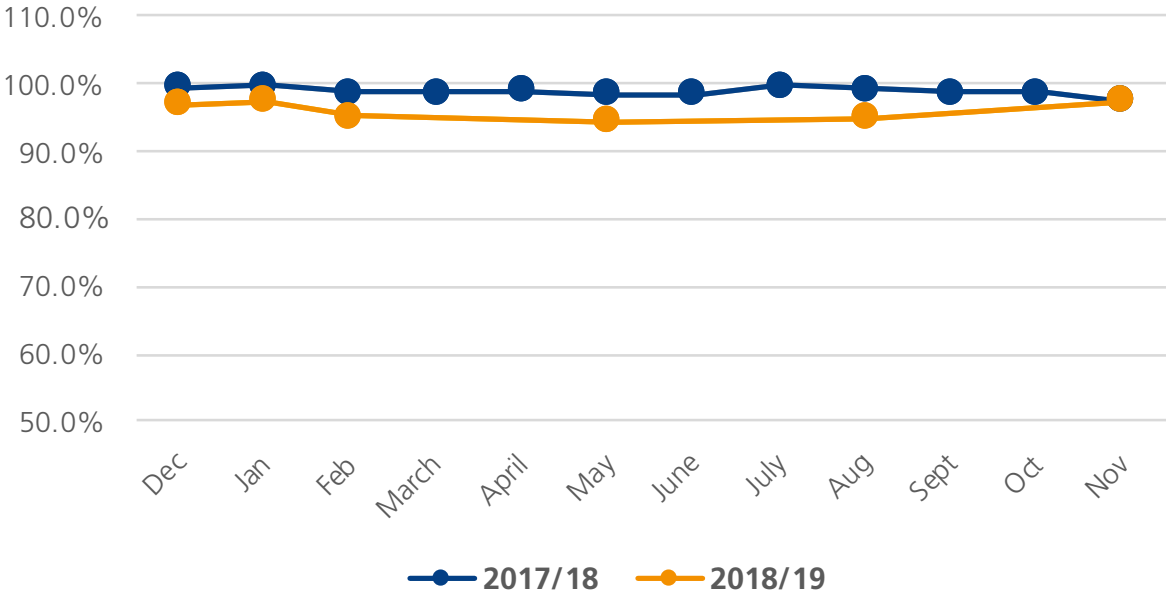
Stroke Care Bundle Performance

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



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

STROKE (CARE)



Year	Compliance
2018/19	95.3% YTD
2017/18	97.9%
2016/17	98.7%

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

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

Ambulance Clinical Quality Indicators YTD April 2018 to February 2019 against national average (YTD)

Clinical Quality Indicator	Lower	Upper	Difference	National Average	South Central	Greater or lower than Average
STEMI - Care	69.30%	92.47%	23.17%	79.03%	71.75%	↓
Stroke - Care	94.72%	100.00%	5.28%	98.44%	94.72%	↓

Ambulance Clinical Quality Indicators YTD April 2017 to March 2018 against national average (YTD)

Clinical Quality Indicator	Lower	Upper	Difference	National Average	South Central	Greater or lower than Average
STEMI - Care	64.57%	90.88%	26.31%	78.62%	79.83%	↑
Stroke - Care	94.53%	99.62%	5.10%	97.45%	98.08%	↑

Ambulance Clinical Quality Indicators YTD April 2016 to November 2016 against national average (YTD)

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

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

		Average (median) for ambulance trusts					
		Your Trust in 2018	Your Trust in 2017	Your Trust in 2016	Your Trust in 2015	Your Trust in 2014	
Q21a	"Care of patients / service users is my organisations top priority"	61.5%	58.2%	56.4%	47.4%	43.4%	
Q21b	"My organisation acts on concerns raised by patients / services users"	70.3%	66.7%	65.9%	59.5%	56.6%	
Q21c	"I would recommend my organisation as a place to work"	54.6%	50.7%	48.4%	37.0%	38.9%	
Q21d	"If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation"	75.9%	74.0%	71.2%	63.3%	63.0%	

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

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

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

	2014/15	2015/16	2016/17	2017/18	2018/19
Number of incidents	570	447	282	129	115
Number and % severe harm / death	52 (9.1%)	21 (4.7%)	13 (4.6%)	1 (0.8%)	3 (2.6%)

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

South Central Ambulance Service NHS Foundation Trust considers that this data is as described for the following reasons: Datix reports; minutes of the Datix Review Group; Board reports and scrutiny of data at the incident reporting group; and NRLS confirmation.

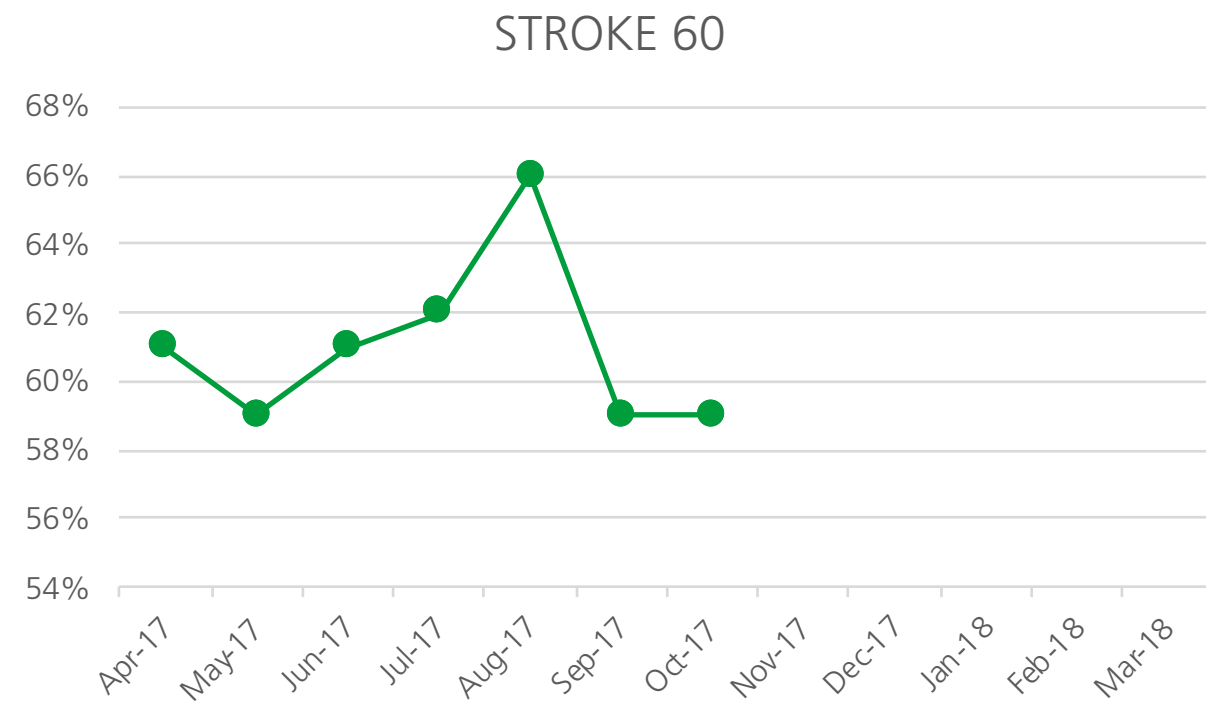
SCAS intends to take the following actions to improve this indicator and so the quality of its services by refresher training for staff on Datix, reviewing numbers, severity and themes of incidents at the Patient Safety Group, Trust Board scrutiny, aggregated learning reports, campaign of awareness around incident reporting, and easy guide reissued to staff on incident reporting.

NHSI issued further detailed guidance for Quality Reports in January 2019. Below is information on those elements now required for ambulance trusts to report on.

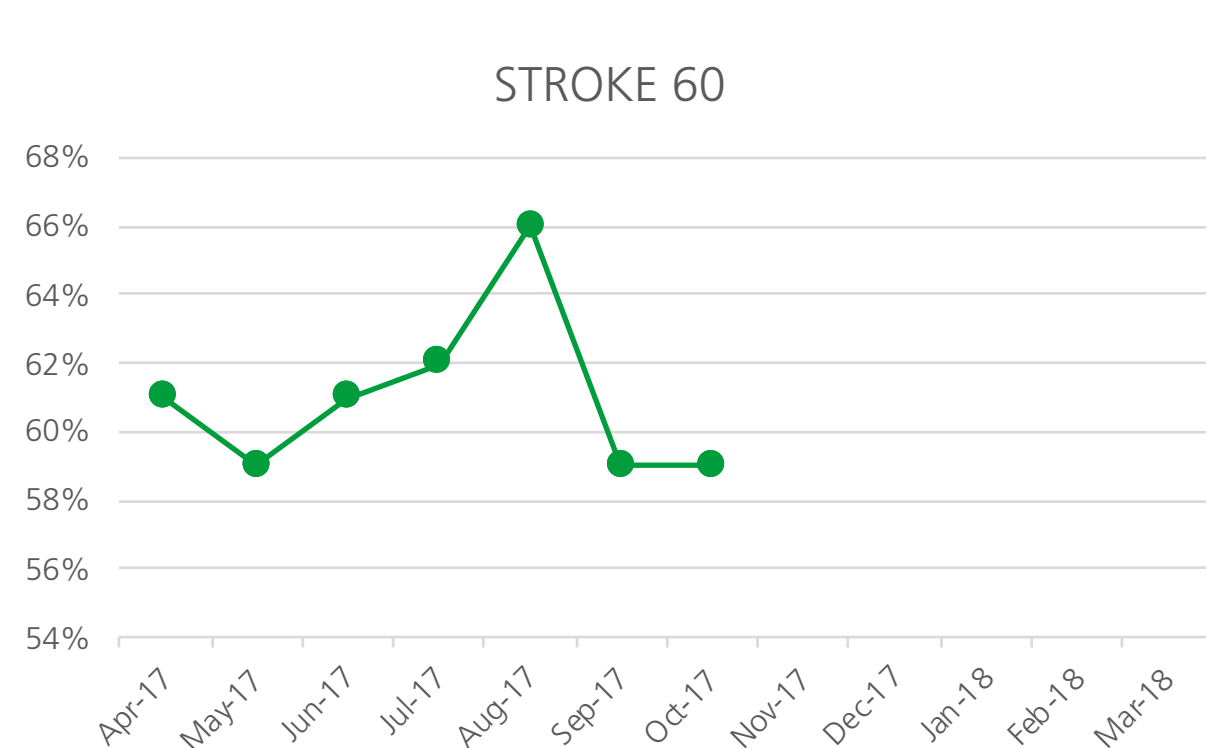
Stroke Performance

The stroke ACQI datasets comprise of timeliness and care elements (diagnostic bundle). Since November 2017 timeliness measures have moved from the old “Stroke 60” (Call to arrival at a Hyper-acute Stroke Unit) to system-based ARP measures related to call to arrival at hospital, arrival at hospital to CT scan and arrival at hospital to thrombolysis. Ambulance services can only directly influence call to door element.

Historical data – Stroke 60, 2017/18



Historical data – Stroke 60, 2016/17



Return of Spontaneous Circulation (ROSC) Performance

The chart on the following page details the current and historic SCAS ROSC rates

PART 3

OTHER INFORMATION AND QUALITY PRIORITIES

2019/20

This section of the Quality Account sets out our quality improvement priorities for 2019/20. The first part though is other quality information that SCAS wants to share and focus on.

In agreeing our priorities, we have engaged with Healthwatch, Overview and Scrutiny Committees and our Council of Governors, all of whom are public-facing bodies.

Regulation and assurance compliance

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

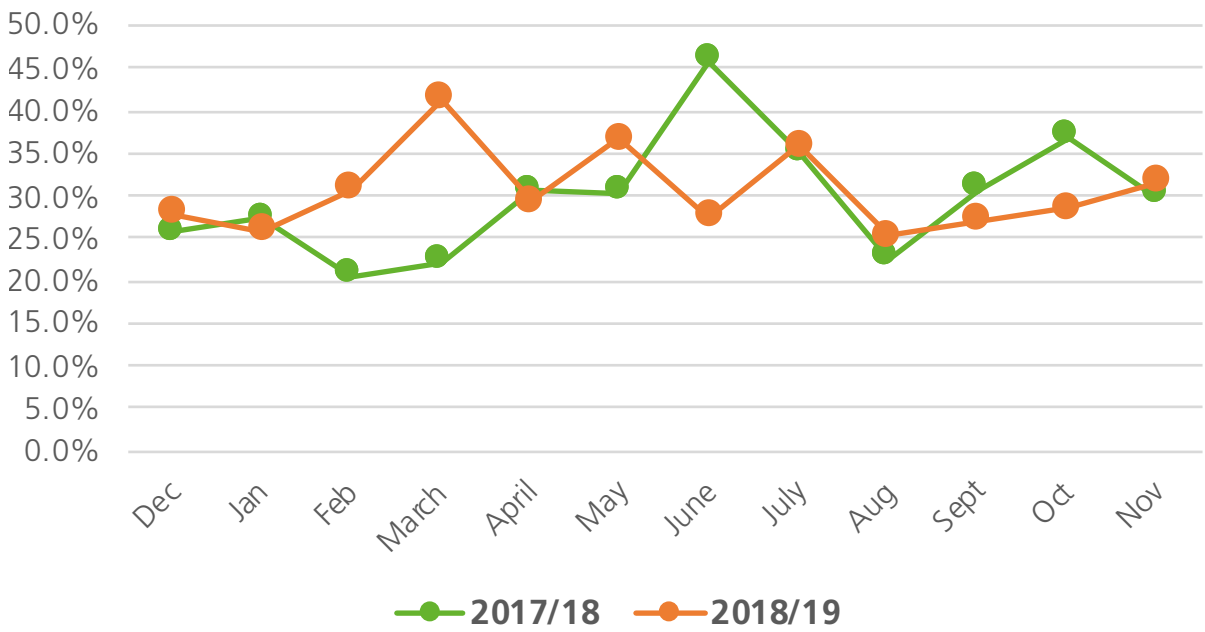
The table below shows the current SCAS rating.

	Safe	Effective	Caring	Responsive	Well-led	Overall
Emergency and Urgent Care	Good ↔ Aug 2018	Good ↑ Aug 2018	Good ↔ Aug 2018	Good ↔ Aug 2018	Good ↑ Aug 2018	Good ↑ Aug 2018
Patient Transport Services	Requires improvement May 2016	Good May 2016	Outstanding May 2016	Good May 2016	Good May 2016	Good May 2016
Emergency Operations Centre	Good ↔ Aug 2018	Good ↔ Aug 2018	Good ↔ Aug 2018	Good ↔ Aug 2018	Good ↔ Aug 2018	Good ↔ Aug 2018
Resilience	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018
Overall	Good ↑ Aug 2018	Good ↑ Aug 2018	Good ↔ Aug 2018	Good ↔ Aug 2018	Good ↑ Aug 2018	Good ↑ Aug 2018

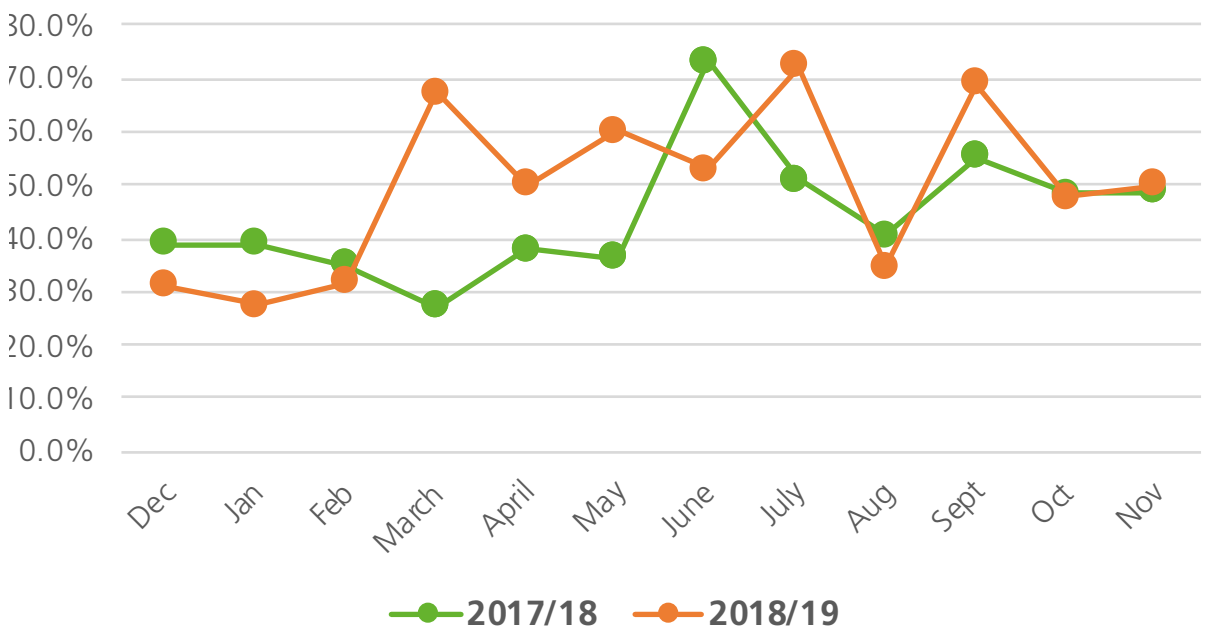
Core service inspection

During July and August 2018, the Trust underwent a comprehensive inspection of the NHS 111 service, core service inspections of emergency and urgent care, resilience, EOC and the Trust well-led review.

ROSC (General)



ROSC (Utstein)



The NHS 111 inspection took place on 7-8 August 2018. The inspection team visited both Northern and Southern House call centres and interviewed a wide range of staff.

The annual core service inspection took place from 23-25 July 2018. Emergency and urgent care, resilience and EOC were the services inspected. No unannounced visits took place in the remaining inspection window.

The Trust well-led inspection took place between 14-16 August 2018. The format was a full programme of interviews with key members of staff.

The Emergency & Urgent Care Division has seen an improvement in two domains with effective and well-led moving from 'Requires improvement' to 'Good'. EOC maintained a rating of 'Good' in all domains.

This is the first inspection where resilience was rated as a service. At the last inspection it was included within the emergency and urgent care division.

NHS 111 showed an improvement in this inspection as 'Effective'; it was rated as 'Requires improvement' in 2016.

The only service not included in this inspection was the patient transport service. The matrix above therefore shows the last ratings from 2016.

Must and should actions

The reports only identified one must action. This relates to ensuring that medicines are kept within the required temperature range.

There were three should actions in the NHS 111 report and fourteen in the core service inspection and well-led review.

Each of the actions will be monitored by the responsible group. The actions have been encompassed in the normal business of the groups. The Assistant Director of Quality will monitor the progress on the actions and will provide progress updates to the Executive Management Group and the Quality and Safety Committee. Progress will also be included in the quality and safety paper to Trust Board.

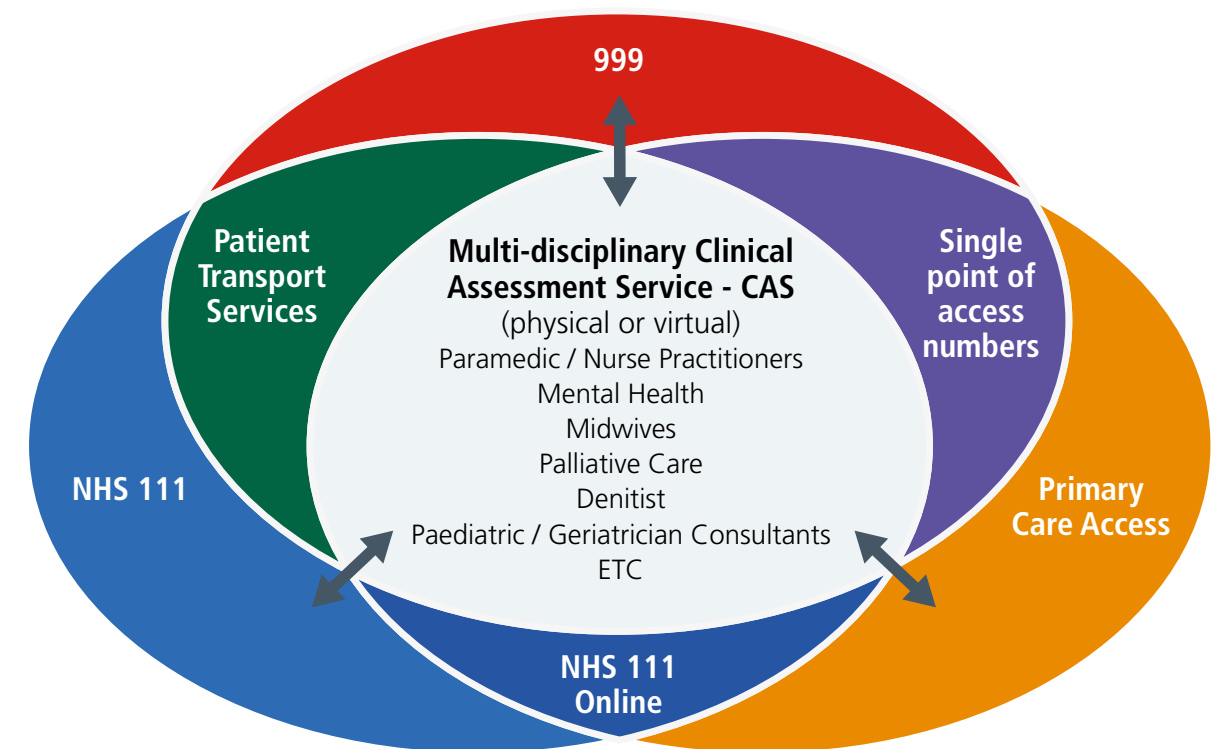
A full report from our last CQC inspection is available at <http://www.cqc.org.uk/provider/RYE>

Integrated Urgent Care (IUC)

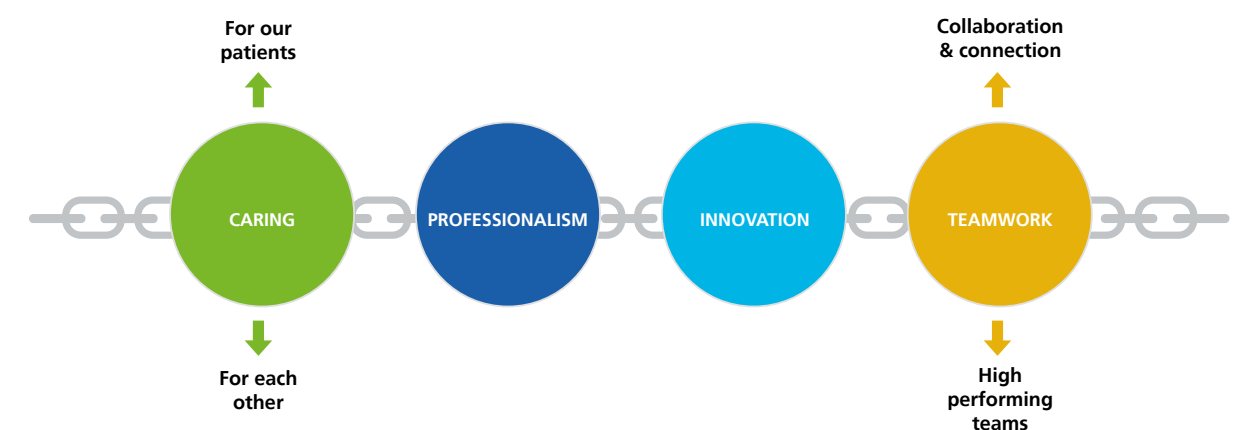
In the last 12 months, SCAS has continued to deliver the NHS 111 service to Hampshire, as well as ongoing developments within the Thames Valley Integrated Urgent Care (IUC) Service. The IUC has matured and will continue to evolve over the next 12-18 months. The IUC celebrated its first anniversary on 5 September 2018 and widespread developments have taken place during this exciting year.

We now have a variety of clinical specialties forming a Clinical Assessment Service (CAS) which includes GPs, mental health practitioners, pharmacists located in the CAS and linking with community pharmacists. The enhancement of the CAS will continue to transform over the next 12 months delivering further benefits to the clinical outcomes of our patients. The IUC Service

continues to enable wider access to healthcare for patients in Berkshire, Buckinghamshire and Oxfordshire. One of the main benefits of an IUC for patients is to provide a healthcare model that delivers a consult and complete approach, thus improving both the patient's experience and their clinical outcome.



HOW WE DELIVER OUR SERVICES



HOW WE WORK WITH EACH OTHER

Sustainability and Transformation Partnerships (STPs) / Integrated Care Systems (ICSs)

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

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

As a result of our PTS contracts, we are also now involved in both Surrey Heartlands and Sussex & East Surrey STPs.

Whilst each STP reflects differing local priorities, they all share common themes around demand management; grouping primary, community and social care partners into hubs; and digital and technological developments.

Mental Health

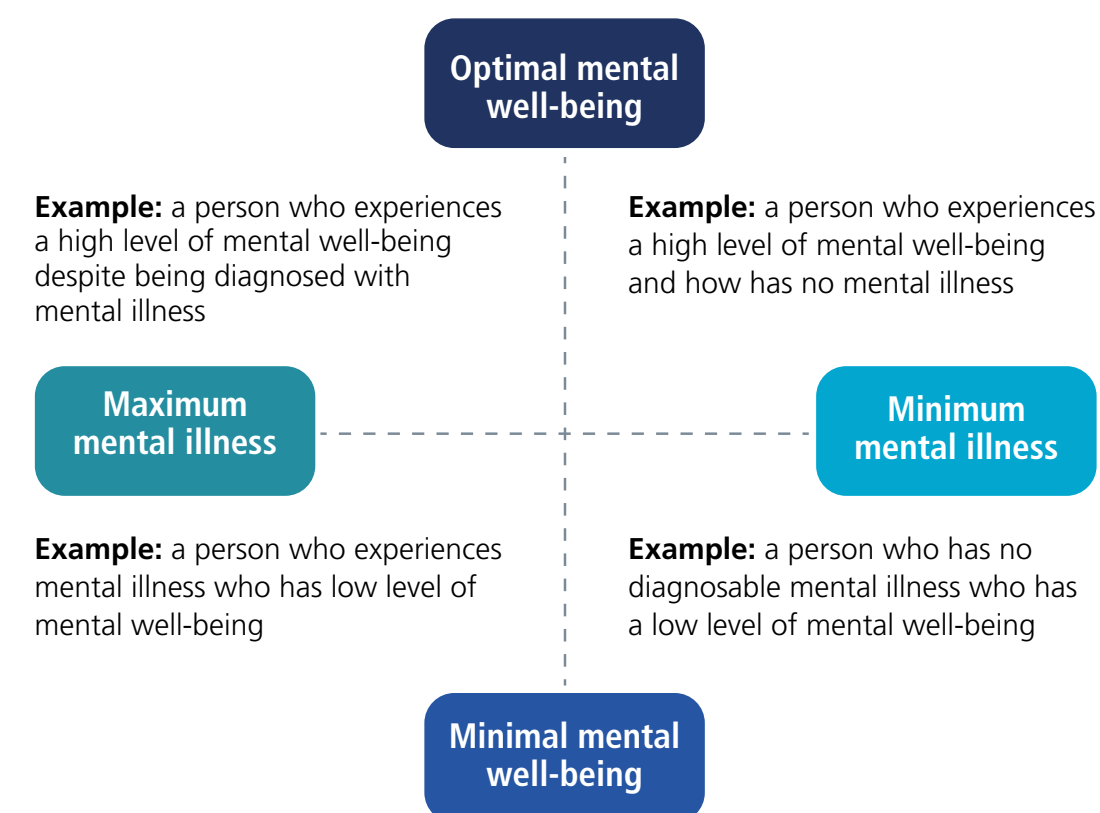
SCAS welcomes the national focus on mental health outlined in the NHS Long Term Plan and this area will remain high on our agenda and in our work streams and service developments this year. Recent strategic documents, such as the Learning Disability Improvement Standards, and improvements in links with key colleagues in acute trusts, the police, local authorities and the voluntary sector (locally, regionally and nationally) are helping to ensure that mental health and learning disability are given due prominence.

Education plays a crucial role in ensuring staff have the knowledge and skills required to help patients with a range of mental health conditions. Completion of an in-depth review of core basic paramedic mental health education has been agreed nationally in partnership with the College of Paramedics. On a regional basis there are a number of opportunities for paramedic and call centre staff to undertake shared learning with police services and other mental health care providers. Education managers have also taken advantage of nationally accredited development opportunities in mental health first aid and suicide prevention. Many call centre staff have completed the full Mental Health First Aid course and found it to be very beneficial in better understanding – and therefore more appropriately responding – to the caller's emotional state.

All mental health education sessions delivered in the Trust include principles of the Mental Health Continuum, as described in the Mental Health First Aid for England programme (see diagram below).

The Mental Health Continuum provides a useful graphic to help staff understand the wide variety of mental health presentations to the ambulance service and NHS 111. It is also useful when considering personal emotional wellbeing.

The Mental Health Continuum



Funding has been secured for a short-term pilot whereby a dedicated vehicle for mental health transport is available. This will significantly enhance our response to patients who have been detained under Section 136 of the Mental Health Act 1983, and also support operational response to other Mental Health Act related incidents. As the Mental Health Lead for The Association of Ambulance Chief Executives (AACE), our Chief Executive Officer chairs a group responsible for national ambulance commissioning. Gaps and inconsistencies in current commissioning have been identified amongst all AACE member NHS ambulance trusts, and it is anticipated that some best practice guidance, prepared by the National Ambulance Mental Health Group in support of AACE, will assist in resolving this matter and improve the quality of care for people detained under the Mental Health Act (1983).

Learning Disability Standards

The Government and NHS England have committed to reducing health inequalities for people with learning disabilities, autism, or both, and have established national programmes to improve treatment and outcomes. The Government's Mandate to the NHS 2018-19 set an objective for the NHS to close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole. It set out nine national recommendations and in June 2018, NHS Improvement launched a set of standards for all NHS Trusts. In response to this, SCAS has implemented a three-year strategy to achieve the NHS Improvement standards which are relevant to the ambulance service:

- ➔ Respecting and protecting rights (Standard 1)
- ➔ Inclusion and engagement (Standard 2)
- ➔ Workforce development (Standard 3)

The strategy will be delivered between April 2019 and March 2022 to ensure that the standards are embedded in core business and provide assurance that patients with a learning disability receive equal – and safe – care from staff, who have the skills to deliver the outcomes that people with a learning disability expect and deserve.

A task and finish group of key senior managers was established, and a gap analysis was completed, to inform the Trust strategy and assist in developing an appropriate education programme. Progress will be reported through the Patient Safety Group.

Equality and Diversity

Equality Delivery System 2

The Equality Delivery System (EDS) was designed to be used by all NHS organisations in England, both providers of services and their commissioners. At the heart of the EDS is a set of 18 equality outcomes grouped into four goals. These outcomes focus on the issues providing most concern to patients, carers, communities, NHS staff and Boards. It is against these outcomes that performance is analysed, graded and action determined.

The EDS2 requires NHS organisations to engage with local communities and organisations with an interest in health issues to determine performance through a grading exercise. As part of the EDS process South Central Ambulance Service NHS Foundation Trust identified local stakeholders including patient, staff, communities and partnership groups who were consulted and engaged to review evidence on the four goals and produce a grading of performance.

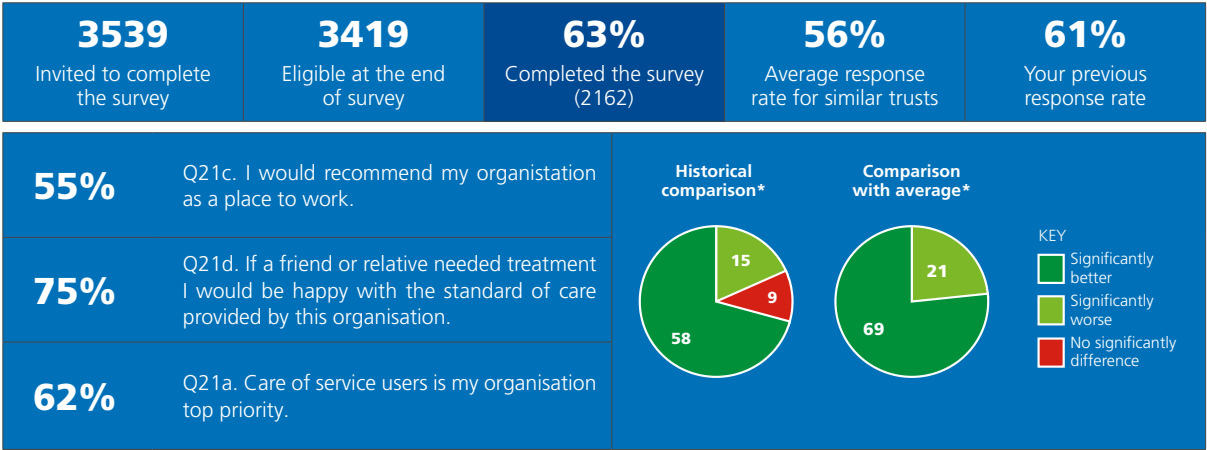
SCAS is currently at the end of Year 3 of a four-year EDS action plan, with the RAG rating showing 99% achievement.

The CQC rated SCAS well-led as ‘Good’ because:

- ➔ Staff felt respected, supported and valued
- ➔ The Trust’s strategy, vision and values underpinned a culture which was patient centred.
- ➔ Staff felt positive and proud about working for the Trust and their team.
- ➔ Staff felt equality and diversity was promoted in their day to day work and when looking at opportunities for career progression.

Staff Survey Results

A total of 2,162 staff participated in the 2018 staff survey, giving us a response rate of 63% and the highest response rate that we have ever had.



Staff feedback from last year’s staff survey has meant that many improvements have been made over the last 12 months, for example the implementation of a new appraisal process.

Of the 90 questions asked, SCAS scored better than other ambulance trusts on 21 questions, similar on 69 questions and significantly worse on none.

Compared to our scores in 2017, SCAS scored better on 15 questions and worse on nine, whilst 58 results were unchanged.

Key improvements since 2017

- 📌 Q19e The review or training included a discussion of the values of my organisation, as part of the appraisal process
- 📌 Q19a In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework review?
- 📌 Q13d The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?
- 📌 Q9c Senior managers here try to involve staff in important decisions
- 📌 Q4g There are enough staff at this organisation

Our core strengths

- ✓ Q4i My team often meets to discuss its effectiveness
- ✓ Q8f My line manager takes a positive interest in my health and wellbeing
- ✓ Q8d My line manager asks for my opinion before making decisions that affect me
- ✓ Q8g My line manager values my work
- ✓ Q8c My line manager gives me clear feedback

Issues to address

- ⊗ Q4g There are enough staff at this organisation
- ⊗ Q16b In the last month have you seen any incidents that could have hurt...service users?
- ⊗ Q6c Relationships at work are strained
- ⊗ Q23b I will probably look for a job at a new organisation in the next 12 months
- ⊗ Q10c On average, how many additional UNPAID hours do you work per week?

Patient and public engagement

The Trust is continually striving to offer the right care, first time for each individual patient and this is also reflected on the high number of compliments which it receives compared to complaints.

It is very important that SCAS continues to be seen and recognised as a trusted organisation among its partners and patients by maintaining a good level of engagement with people from all backgrounds from across its area and ensures that its valuable staff will assist in achieving this.

SCAS has 13,493 Foundation Trust public members and the Trust uses various types of engagement activities to ensure that it meets its duty to involve and consult with its members, patients and the public in the way it develops and designs services. Throughout the year SCAS representatives attend events where they meet with members of the public and provide information about our services and listen to their views. This includes large-scale events such as Pride Days, Emergency Services Days and Recruitment Open Days.

The Trust also holds Community Engagement Forums across its coverage area together with talks at career job fairs, schools and various groups.

Furthermore, SCAS works in partnership with various organisations and undertakes regular patient surveys together with public consultations at its county forums.

In 2018/19 SCAS continued its public engagement and events programme and concentrated on the following themes:

- ➔ **Reducing demand** - Prevention work with council health providers
- ➔ **Young people** - Consultations and videos for and development of the new SCAS Youth website which is dedicated entirely to educating young people on being healthy and safe. The website has also a section on volunteer, membership and job opportunities with the Trust
- ➔ **Working with SCAS 100 Virtual Club** - The Trust is committed to offering members of the public the option to participate in various activities such as consultations, focus groups, etc., by e-communication only if they wish. In 2018/19 some of the Trust's 100 Virtual Club members joined the Trust's Disability Equality Networking Group as permanent members and their role is to ensure that the Trust is as open and supportive as possible and promote equality of opportunities to all.

Freedom to Speak Up

In the introduction of our Freedom to Speak Up policy we state that staff can "... report concerns directly with me as the Chief Executive or any Board member. Concerns may also be raised formally via the nominated Non-Executive Director or our Freedom to Speak Up Guardian" and we use this line in the policy for staff:

"Speak up, we will listen"

To deliver high-quality patient care and protect the interests of patients, staff and the organisation, we encourage a culture of openness and transparency in which members of staff feel comfortable about raising concerns.

By providing transparent and accountable procedures and channels for staff to raise concerns and having a culture of openness where staff can feel confident in raising any concerns they may have, issues can be addressed at the earliest opportunity, in the most appropriate way, so that positive steps can be taken to resolve them.

The Trust values and encourages an open culture as part of its behaviour sets and includes Caring, Teamwork, Professionalism and Innovation in its values. We strive to make decisions in a transparent, inclusive and consultative manner, through a variety of groups and committees, such as our Workforce Development Board, Staff Side Committee, Partnership Forums, Equality and Diversity Steering Board, and project working groups.

SCAS nurtures a healthy culture, based on all staff demonstrating their role-relevant, values-based behaviours within their working lives. All staff are expected to model their behaviours to support SCAS with its strategic aims to become an Employer, Partner and Provider of Choice.

In the event of staff needing to raise concerns we encourage staff to use a variety of methods, both formal and informal, to speak up and raise concerns. These include:

- ➔ Through our established policies and procedures, e.g. grievance, dignity at work
- ➔ Through our incident reporting system
- ➔ Through line managers, human resources team members, either directly or via our Freedom to Speak Up (Whistleblowing) Policy
- ➔ Formally via our nominated non-executive director

Our Freedom to Speak Up Policy also openly recognises that it can at times be daunting to speak up and aims to give staff the assurance that concerns will be listened to and outlines a fair and easy process for staff to raise such matters.

A total of fifteen contacts were made via the Speak Up Guardian route in 2018/19. Of these fifteen; one concern was totally anonymous with insufficient detail, one concern has been raised with the Executive and Non-Executive Leads and is ongoing, and four are ongoing with our Speak Up Guardian's oversight. The remainder being closed with the person speaking up or line manager at level one in line with our procedure and best practice.

To date there are no discernible trends emerging from these cases, but reflections of the process do yield opportunities for organisation learning and improvements such as:

- ➔ A policy review to improve the support for staff who may be suspended as part of an investigation
- ➔ Refining the process and options for our staff wishing to speak up
- ➔ Developing Speak Up guidance for our managers
- ➔ Ensuring the initial contact for staff who wish to speak up is as supportive as possible, including; offers of meeting off site, using guidance which includes welfare and support arrangements for the staff member

Following our most recent CQC inspection in 2018 we were proud to maintain our ‘Good’ rating. With our Freedom to Speak Up Guardian starting in post in winter 2018/19, having undertaken the National Guardians Office Training, we are confident this will further enhance existing practice and channels and continue to encourage our staff to speak up.

Our Speak Up Guardian is linked into; the National Guardian’s Office, the Thames Valley and Wessex Regional Network, the South East Coast Regional Network and the National Ambulance Network. These networks offer a wide range of support and expertise for our Speak Up Guardian and staff.

To provide further assurance our Speak Up Guardian has reviewed key national documentation to identify areas of good practice and areas for continued development for the organisation. This work will not be in isolation as the Speak Up Guardian role weaves through all areas of the organisation at all levels.

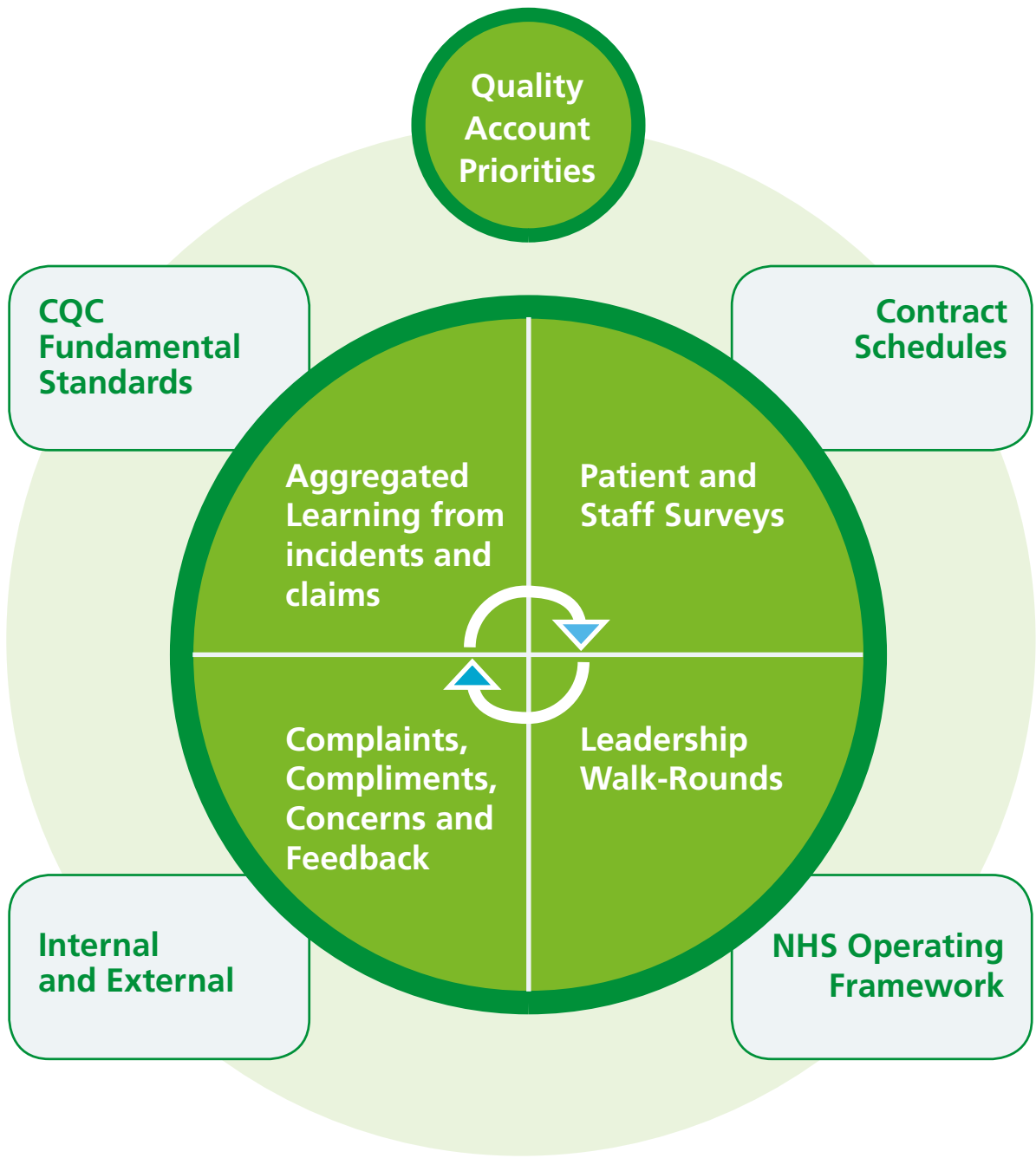
Next steps will involve an internal review to help guide improvements and future direction, and support the framework for the Speak Up Guardian role going forward, which is illustrated below:



Choosing and prioritising quality improvement initiatives

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

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



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

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

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

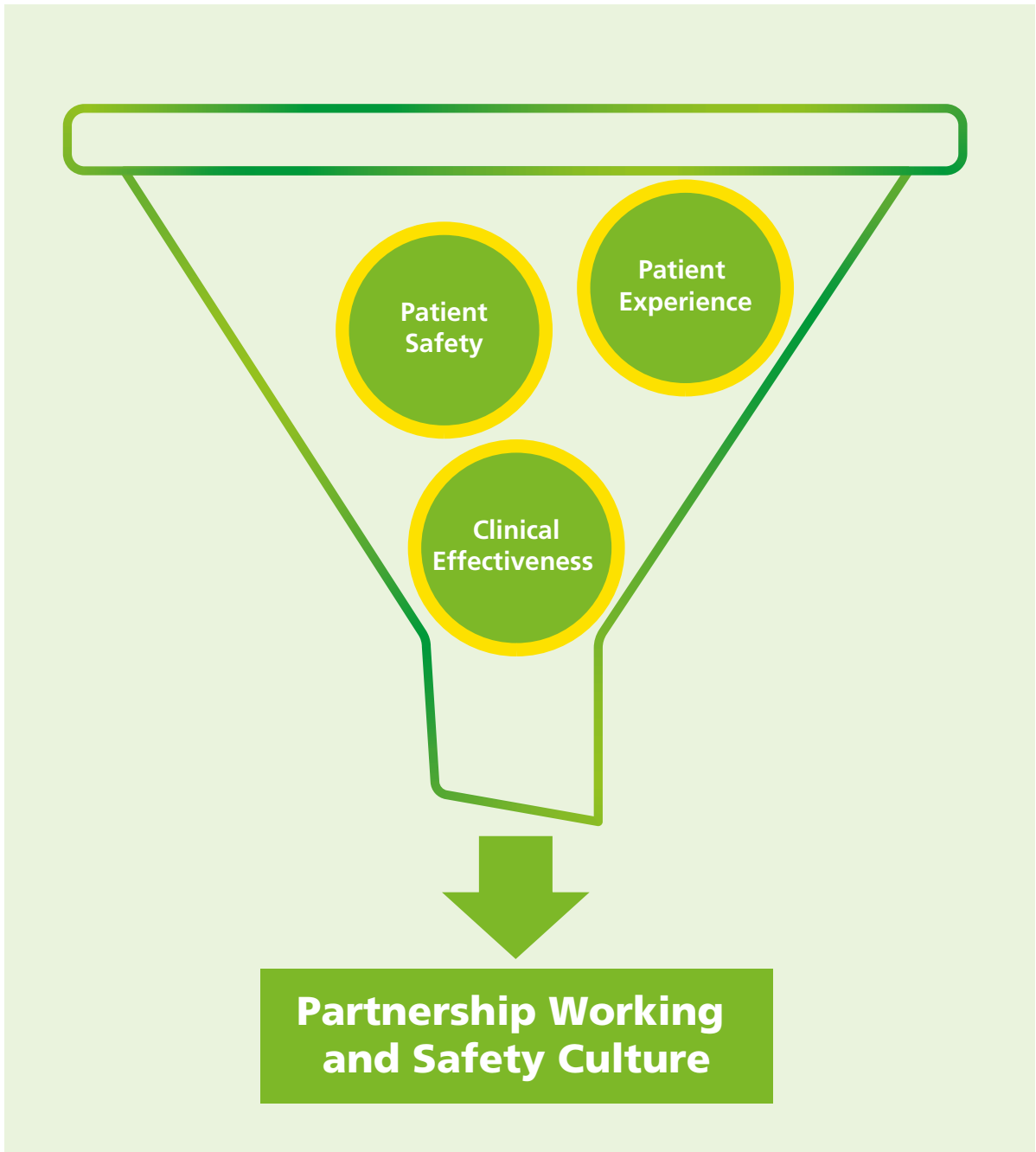
Finally, as a Foundation Trust, we are fortunate to be able to draw on the input of our Council of Governors who provide a picture of the needs of the community which we serve.

Quality Priorities for 2019/20

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

Patient Safety	
1a	To improve safe discharges and transfer home in PTS by increasing the quality of home risk assessments
1b	Further develop medicines governance
1c	Review the mortality and morbidity process to reflect national guidance that demonstrates learning from deaths
Clinical Effectiveness	
2a	Enhance our clinical audit programme to cover a wide range and number of adults
2b	To increase clinical assessments in CCC (clinical co-ordination centres) ensuring consistent methods and application across the services (three-year priority) continues
2c	NHSI mandated indicators: <ul style="list-style-type: none">➔ Category 1 emergency response (mean times)➔ Category 2 emergency response (mean times)➔ To report on heart attack (STEMI) and stroke care bundles (benchmarked nationally)
Patient Experience	
3a	Survey patients who access taxi services via SCAS CCC and implement any recommendations
3b	Evidence of inclusion of children and young persons in service feedback improvements
3c	To embed SCAS behaviours to increase the percentage of our leaders and managers who have been trained and provided with leadership development

Each of our priorities and our proposed initiatives for 2019/20 accounts, are described in detail on the following pages. They will be monitored through the quality improvement plans that are presented to the executive and senior management teams and the Quality and Safety Committee. External audit assurance is provided by our external auditors and through an internal audit programme.



Patient Safety	
1a	To improve safe discharges and transfer home in PTS by increasing the quality of home risk assessments

Why have we chosen this indicator?

In order for crews to have the correct and sufficient equipment when they arrive to transport patients a home assessment form is completed.

There are cases where the journey is aborted or delayed due to the assessment.

As with all processes and documents improvements can be made.

To achieve this we are going to:

- ➔ Reduce the number of aborts per quarter due to incorrect risk assessment
- ➔ Reduce the number of incidents reported each quarter causing a delay in relation to a risk assessment
 - Review the risk assessment form in Q1 and ensure it is standardised
 - Establish numbers of failed discharges due to risk assessment
 - Improve failed discharges due to risk assessments by 10% in Q4
 - Undertake a training needs analysis for team leaders in Q1
 - Implement a risk assessment allocation SOP in Q3
 - Consider options for ensuring crews have access to information contained in risk assessments in Q2/Q3

Board Sponsor

Director of Commercial Services

Implementation Lead

Business managers and hospital liaison officers in PTS

Patient Safety	
1b	Further develop medicines governance

Why have we chosen this indicator?

We have made many improvements to our medicines governance processes in the last year. These have included; improved medicines packing (working with our Make Ready providers), reducing administration errors and reflecting on learning.

Medicines incidents are reported to our Board and remain a high category. The Medicines Review Group actively monitors trends and issues.

This indicator reflects our firm commitment to further improve governance around medicines and in line with our CQC must and should actions.

The CQC inspection gave us clear recommendations to make improvements.

Action the Trust MUST take to improve:

- ➔ The Trust must ensure the temperature of the areas in all buildings where medicines are stored is monitored to ensure medicines are kept within the required range, and action taken if the temperature of any of these areas are outside the recommended range

Action the Trust SHOULD take to improve:

- ➔ The Trust should ensure staff store and dispose of medicines appropriately in line with the Trust's policy
- ➔ The Trust should ensure staff store medical gases safely and in line with the Trust's policy

To achieve this we are going to:

- ➔ Implement the CQC recommendations
- ➔ Create an action log for improving medicines packing
- ➔ Conduct regular leadership walk-rounds to assure on medicines governance
- ➔ Review site specific medical gas storage
- ➔ Ensure temperature monitoring governance arrangements

Board Sponsor

Director of Patient Care and Service Transformation

Implementation Lead

Pharmacy Lead

Patient Safety	
1c	Review the mortality and morbidity process to reflect national guidance that demonstrates learning from deaths

Why have we chosen this indicator?

The publication of the CQC report, *Learning, Candour and accountability: a review of the way NHS Trusts review and investigate the deaths of patients in England*, found that learning from deaths was not given sufficient priority in some organisations and therefore valuable opportunities for improvements were missed. The National Quality Board has since published the first edition of national guidance on learning from deaths. The purpose is to initiate a standardised approach of the review of deaths which will evolve over time.

In line with best practice for other sectors, the Trust is undertaking a review. Information will be included in the public Board paper indicating the categories of patient that will be in scope for review taking a proportionate approach.

To achieve this we are going to:

- ➔ Receive and embed NHS Improvement's guidance for mortality reviews and reporting in ambulance trusts (due June 2019)
- ➔ Highlight best practice from mortality reviews (both internal and external) through contractual and internal reports to the Clinical Review Group
- ➔ Further develop good working relationships with external stakeholders to enable shared learning
- ➔ Scope the technology of an app
- ➔ Approve a policy on learning from deaths by October 2019
- ➔ Ensure the Mortality and Morbidity Review Group meets quarterly to review a sample of screened patients whom SCAS has attended in cardiac arrest
- ➔ Undertake a review of documentation to be used by the Group which will include an audit tool. This sample will be derived from a weekly data set which will be screened for potential issues in care delivered by SCAS

Board Sponsor

Medical Director

Implementation Lead

Consultant Pre-Hospital Care Practitioner, supported by Clinical Governance Leads

Clinical Effectiveness	
2a	Enhance our clinical audit programme to cover a wider range and number of audits

Why have we chosen this indicator?

Clinical audit enables evaluation of the clinical care provided to our service users, in order to identify any changes needed to improve quality of care. Clinical audit also provides assurance that the care delivered was in line with evidence-based guidelines and directives.

As an organisation committed to provide a high standard of safe and effective clinical care, it is vital that clinical audits are undertaken in addition to nationally mandated audits.

To achieve this we are going to:

- ➔ In Q1, develop and approve an annual internal clinical audit plan
- ➔ Report to Clinical Review Group with clear actions for improvement in Q2
- ➔ Twice-yearly report to Quality & Safety Committee with actions taken to improve services
- ➔ Demonstrate improvements as a result of audits

Board Sponsors

Medical Director & Director of Patient Care and Service Transformation

Implementation Lead

Assistant Director of Qualit

Clinical Effectiveness	
2b	To increase clinical assessments in CCC (clinical co-ordination centres) ensuring consistent methods and application across the services (three-year priority) <i>continues</i>

Why have we chosen this indicator?

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

We have implemented NHS 111 online and are working with external providers of online symptom checkers to enable demand to be managed more effectively, giving members of the public the ability to self-assess their symptoms. The online symptom checker went live in July 2018 and was extended in December 2018 to enable patients to directly access out-of-hours.

We have introduced a Live Link pilot in the 999 Call Centre. Patients in high intensity user care homes who dial 999 are assessed by a clinician who can see the patient via Skype for SCAS to manage demand more effectively. This is live with two care homes; one based in the Hampshire area and one in the Thames Valley area.

We have undertaken a demand analysis on low acuity Green calls. We have identified eight low risk conditions that will be identified at the outset of the call and then immediately transferred to a clinician. This aims to continually improve our hear and treat rates and see and treat rates and increase ambulance vehicle availability. This has the real potential to improve patient experience.

Ambulance dispositions from NHS 111 calls that require a Green time (i.e. 30 or 60 minutes) will be re-triaged by a clinician in the call centre to determine the pathway required. This may not mean a frontline ambulance to hospital but a different pathway for the patient such as a pharmacist or walk-in centre.

To achieve this we are going to:

- ➔ Implement the Green project (30 and 60 minute calls) for eight clinical conditions (achieved)
- ➔ Establish the baseline % of long waits for Green calls and set improvement target to commence in Year 2
- ➔ To further model the Green project after implementation and by end of 2017
- ➔ Ensure 80% of all eligible calls (Green ambulance disposition) are transferred to an enhanced clinical advisor desk for further clinical assessment
- ➔ Evaluate Live Link pilot and analyse data to identify improvement in non-conveyance
- ➔ Implement the NHS 111 online symptom checker in Year 1

Board Sponsor
Chief Operating Officer

Implementation Lead
Director of Clinical Coordination Centres and Director of Commercial Services

Clinical Effectiveness

2c	<p>NHS Improvement mandated actions</p> <ul style="list-style-type: none">➔ Category 1 emergency responses (mean times)➔ Category 2 emergency responses (mean times)➔ To report on heart attack (STEMI) and stroke care bundles (benchmarked nationally)➔ Stroke ARP measures
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Why have we chosen this indicator?

See Section 2.3 Reporting against NHS Improvement core indicators (page 130)

To achieve this we are going to:

➔ See Section 2.3 Reporting against NHS Improvement core indicators (page 130)

Board Sponsor
Chief Operating Officer and Director of Patient Care and Service Transformation

Implementation Lead
Director of Operations

Patient Experience	
3a	Survey patients who access taxi services via SCAS call centres and implement any recommendations

Why have we chosen this indicator?

Taxi providers assist SCAS (PTS and 999) in transporting patients with low risk care needs to various appointments and for low acuity transport to hospitals.

As part of our continued commitment to ask patients for feedback on their experience we have chosen this group as one we will focus on.

We need to understand the patient experience of not using a traditional ambulance resource in order to ensure they have a positive and safe experience.

To achieve this we are going to:

- ➔ Conduct a retrospective telephone survey for taxi users, designed by and undertaken by the PTS Patient Experience Manager and Customer Care Managers (agree sample size in Q1)
- ➔ Design question set and conduct survey Q2/Q3
- ➔ Engage with Private Provider Governance Framework Task and Finish Group, and ensure actions arising are implemented
- ➔ Analyse results and design action plan based on responses
- ➔ Disseminate feedback to the taxi companies and also share internally through a variety of communication methods
- ➔ Carry out action plan within agreed timescales

Board Sponsor
Director of Patient Care and Service Transformation

Implementation Lead
Head of Patient Experience

Patient Experience	
3b	Evidence of inclusion of children and young persons in service feedback and improvements

Why have we chosen this indicator?

We often focus on feedback from users of our services being adults. Children access the ambulance service through NHS 111, 999 and PTS for a variety of reasons; some urgent, some emergency and some routine. It is an anxious time for parents, carers and families if a child is ill and SCAS would like to include them in shaping services through their feedback of their experiences.

To achieve this we are going to:

- ➔ In Q1 establish what feedback we have and design a plan for gaining feedback (survey/calls)
- ➔ Utilise the SCAS Youth and Young Person Group to engage with younger users of our services
- ➔ In Q2 send out a questionnaire asking for experience feedback and ascertain improvement focus
- ➔ In Q3/Q4 analyse the results and report to Patient Experience Review Group, demonstrating any changes

Board Sponsor
Director of Strategy and Business Development

Implementation Lead
Head of Communications and Head of Patient Experience

Patient Experience	
3c	To embed SCAS behaviours to increase the percentage of our leaders and managers who have been trained and provided with leadership development

Why have we chosen this indicator?

SCAS has clear behaviours in place that we expect of staff in order to enhance their working life, but also to build skills that ensure we deliver high-quality care consistently through leadership of the teams.

This indicator provides assurance internally, externally and to the public that SCAS invests in staff to deliver our core services.

Embedding SCAS values throughout all services following a leadership development pilot (999) in 2018 has resulted in an improvement in our staff survey results. We will be building on this in 2019/20.

We aim to reduce attrition by ensuring leaders are equipped to do their job and feel valued.

To achieve this we are going to:

- ➔ Launch the SCAS Leadership Programme in Q1
- ➔ Train 150 leaders by the end of March 2020 (out of 365 leaders, this would equate to 41%)
- ➔ Review attrition figures of SCAS leaders in Q1 and compare at the end of Q4 for a reduction

Board Sponsor

Director of Human Resources and Organisational Development

Implementation Lead

Assistant Director of Organisational Development

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

I would like to confirm receipt of the SCAS letter regarding quality accounts. Healthwatch Milton Keynes welcomes the advanced knowledge of the content and priorities within SCAS’ annual quality account. We have no feedback to issue at this stage but like to note that the inclusion of a focus of ensuring young people’s experiences/voices are heard in relation to ambulance services is being considered as a priority area.

We look forward to receiving the quality account in due course.

Maxine Taffetani
Chief Executive Officer
Healthwatch Milton Keynes

These indicators seem to be very appropriate but I did wonder if we could include an indicator on long waits both for PTS and 999 calls as these are the subject of a large number of complaints from our patients.

Loretta Light
Oxfordshire Public Governor, SCAS

The quality accounts and priorities as set out in the draft look very good. I do remember having a presentation recently where an area of improvement was felt to be the transport of patients with mental health problems. I cannot see that this has been included and would be my only comment.

Cllr. Dr. Anne Crampton
SCAS Council of Governors

Thank you for your letter of 24 January 2019 identifying your proposed quality priorities for the 2019/20 Quality Account.

This letter was circulated to the clinical commissioning groups within the SHiP locality and feedback was obtained. Using your template we have included an additional column that captures commissioner comments and proposals.

Priority 1 – Patient Safety

	SCAS Proposal	Commissioner Comments/Proposals
1a	To improve safe discharges and transfer home in PTS by increasing the quality of home risk assessments	During the 2018/19 contractual year, commissioners have been made aware of some poor discharges where patients have had to be returned to the acute setting. It has also been evident that staff have identified safeguarding concerns for vulnerable patients and are therefore supportive of this proposal. However, it would be good to understand how the improvement is to be delivered and can be measured.

1b	Improve and develop medicines management	Commissioners concur with this proposal in view of the challenges that SCAS has highlighted to commissioners. It is positive to note that work already undertaken is having a positive impact on the number of medicines management incidents being reported. It would be good to see the outcomes that SCAS is aspiring too and the components that will be identified to support this work.
1c	Develop a mortality and morbidity review process	Commissioners support the proposal by SCAS and have received reports from their Mortality and Morbidity Review Group that is already in existence. Commissioners look forward to receiving the outcomes that SCAS is anticipating to see and how this will benefit patients and wider learning.

Priority 2 – Clinical Effectiveness

	SCAS Proposal	Commissioner Comments/Proposals
2a	Develop the effectiveness of our clinical audit programme such that it has capacity to go above nationally reported data such as AQIs and covers areas such as policy adherence for the Trust.	Reporting data in line with the Trust's policies, and over and above what is nationally required, is not necessarily a quality improvement. It would be good to understand what outcomes SCAS is hoping to achieve from this quality account proposal.
2b	To increase clinical assessments in CCC (clinical co-ordination centres) ensuring consistent methods and application across the services (three-year priority) this is the third year	Commissioners are supportive of this proposal. As the Integrated Urgent Care patient pathways are developed and rolled out, that require 50% of 111 callers to receive a clinical assessment, commissioners look forward to seeing how SCAS will develop consistent methods of delivery. How will SCAS evidence that the advice given is in line with best practice across both generalist and specialist clinical assessments and how this has impacted patients to improve their outcomes and experience of 'touch points' within the urgent care health system?
2c	NHSI mandated indicators	As SCAS has identified, this is a mandated indicator and is a performance metric not a quality metric. Commissioners therefore suggest that SCAS looks to improve the parity of provision across the various CCGs and how to ensure that those patients who experience a delay are monitored to ensure their safety.

Priority 3 – Patient Experience/Staff Experience

	SCAS Proposal	Commissioner Comments/Proposals
3a	To review patient experience in our taxi services and implement any improvements	It would be good to understand if this proposal is in relation to the small number of patients who are conveyed on behalf of the 999 service or non-emergency patient transport service. How does SCAS propose to differentiate feedback from this specific cohort and what engagement has taken place with the taxi providers to ensure that they will support the feedback from patients? What is the outcome that is aimed for?
3b	Evidence and inclusion of children and young persons in service re-design	Commissioners are supportive of the focus that this longstanding requirement will now receive. It would be good to understand what key aims/outcomes SCAS is aiming for.
3c	To embed SCAS behaviours to increase the percentage of our staff who have been trained and provided with leadership development	To increase the number of staff who have been trained and provided with leadership development is positive. Commissioners would like to understand what outcomes/changes in behaviours SCAS is anticipating will be seen by both staff and patients as a result of this increased number and level of training.

It is vital for commissioners to be able to know if a priority has been delivered and therefore milestones and KPIs linked to each improvement programme must be clearly able to demonstrate this.

I hope that this feedback is useful and we look forward to working with you on your quality priorities during 2019/20.

Suzanne van Hoek
Deputy Director of Quality and Nursing
NHS Fareham & Gosport and South Eastern Hampshire CCGs
Hampshire and Isle of Wight Partnership of Clinical Commissioning Groups

Thank you for sharing your draft priorities with us for review and comment. We are pleased to see a number of priorities that are applicable to PTS and are supportive of these as areas of focus, and therefore will be keen to see how these prioritise progress over the year in relation to our PTS contract.

We would however like you to consider as part of your patient experience priorities one of the areas of concern we have within our area; the low level of responses in relation to patient feedback. We understand that this has been part of priorities in previous years, however we continue to have concerns that the volume of responses that SCAS receives in response to FFT and patient surveys within our area is below the level that we feel is sufficient. Whilst we understand the limitations for the use of traditional FFT and surveys within PTS, we would like SCAS to consider alternative methodologies for seeking and receiving feedback on its services from patients and carers in order to increase the volume of feedback received.

Jane Lovatt, Head of Quality - Community
NHS Guildford and Waverley Clinical Commissioning Group
NHS North West Surrey Clinical Commissioning Group
NHS Surrey Downs Clinical Commissioning Group

Healthwatch Southampton is pleased to be given the opportunity to comment on the Quality Accounts of South Central Ambulance Service NHS Foundation Trust.

Healthwatch Southampton receives very few comments regarding the ambulance service or the NHS 111 service provided by SCAS for Southampton residents. The few comments that are received are mainly positive and response times in the City are generally regarded as acceptable or good. The comments on the NHS 111 service are mostly positive with patients feeling that they have been provided with a professional response to their enquiry. Our comments on the Quality Accounts are therefore limited.

The layout of the Quality Accounts is straightforward, and the key information is accessible to the lay person. It is good to see the priorities for 2018/19 laid out clearly with a summary of the achievements. We are pleased to read that the Trust achieved six of the nine priorities, with partial achievement of the other three. The detail given in the tables is easy to follow.

The priorities selected for 2019/20 are clear and the associated tables provide enough information as to why the priority was chosen and what actions will be taken to achieve them.

Healthwatch Southampton is happy to offer any help required by the Trust in communicating with the public of Southampton and looks forward to hearing the outcomes of their efforts with the listed priorities.

H F Dymond MBE
Chair, Healthwatch Southampton

Thank you for the opportunity to comment on the Trust's quality account for 2018/19. I write as lead commissioner (Fareham and Gosport Clinical Commissioning Group), on behalf of all relevant SHiP commissioners. We note the account covers the Trust's 999 services, non-emergency patient transport service (PTS) and NHS 111 services. This year Surrey Heartlands Clinical Commissioning Groups also requested that they have the opportunity to be included in this response for their PTS service.

Commissioner Introductory Statement

The Trust is commended for its achievement of an overall rating of 'Good', following the Care Quality Commission (CQC) inspection that took place in 2018/19. The CQC inspected the NHS 111 service, emergency and urgent care, resilience and the emergency operations centre (EOC). The non-emergency patient transport service was already rated 'Good' overall during the 2016 CQC inspection and was therefore not revisited during this 2018/19 inspection. Commissioners have welcomed the Trust's engagement in the review and transformation of quality contract monitoring processes and look forward to new ways of working in 2019/20.

We note that 2018/19 was the first full contractual year that SCAS began reporting against the new response times implemented in October 2017, following the national Ambulance Response Programme (ARP). The contractual year was challenging however overall SCAS 999 SHiP performed well. Commissioners would like to thank SCAS for their continued efforts and support to our patients and partners in the SHiP area. SCAS staff have continued to engage effectively

across local systems within the context of significant transformational change, and have been fully engaged in the integrated urgent care (IUC) co-production programme.

Commissioner assessment summary

Commissioners recognise the positive performance of the SCAS 999 service when compared to other national ambulance trusts. We are confident that there are robust mechanisms and governance processes in place within SCAS, to review patients who have experienced delays. The recent review of category 1 delays identified that in many cases either a rapid response vehicle (RRV) or community first responder (CFR) arrived to be with the patient whilst they were waiting. We appreciate the efforts SCAS has made to keep patients safe at times of high demand.

SCAS has continued to experience the holding of ambulances at acute trusts during times of extremely high activity. We are aware that SCAS actively engages in system escalation calls across the various local health economies and ensures that patients waiting at the hospital are kept safe. Patients waiting for an ambulance to arrive are given worsening advice to call back and, additionally, welfare calls take place to ensure the patient's condition has not changed. The Trust's engagement and roll out of the National Early Warning Score 2 (NEWS2) is also improving the identification of patients whose condition is deteriorating.

Performance for the non-emergency patient transport service has not met the contractual requirements of 2018/19 in the SHiP locality. In recognition of many elements outside of the service's control that impact on performance e.g. weather, road accidents and delays by clinics or patients, SHiP commissioners have proposed that SCAS looks to developing statistical process control charts (SPC) to set achievable performance targets. Whilst these changes relate to performance they have a direct link to quality and patient experience. Commissioners recognise that in many instances, by doing the 'right thing' for a patient or prioritising discharges to improve patient flow at the hospital setting, this has a direct impact on achievement of the non-emergency patient transport services key performance indicators and patient experience. SCAS has now developed a standard operating procedure to ensure that the most vulnerable patient journeys are protected from changes that are requested by other health providers to support additional activity that is required on-the-day.

Commissioners share SCAS' ongoing concerns about workforce recruitment and retention. The call centre element of PTS has experienced workforce recruitment and retention challenges throughout the year and commissioners are keen to continue to discuss supportive actions. Challenges with clinical advisor roles within both the 999 and NHS 111 services have been compounded by both local arrangements and NHSE driven developments. Since March 2018 the service has been under pressure to clinically review and re-validate all NHS 111 calls with a category 3 or 4 ambulance disposition following a national mandate; these calls are increasing and the resource for this extra work is expected to be found within the savings the service makes by revalidating. This is yet to be realised and ongoing discussions with commissioners continue.

In the NHS 111 service SCAS has continually underachieved on a number of key performance targets, i.e. call answering and call backs. This impacts on patient experience and staff morale but more importantly has the potential to impact on patient safety and outcomes. The underachievement is compounded by difficulties with recruitment and retention, Commissioners recognise that this is a national problem. SCAS has undertaken a number of initiatives to improve staffing levels and has modified processes to keep the service safe when pressured by low resources.

SCAS has been open and transparent in allowing commissioners to participate in site visits and audits. These have been developed throughout the year and will continue during 2019/20.

Although commissioners are yet to see the staff survey results broken down by the three services that it delivers, and their geographical contract areas, SCAS should be congratulated on their year on year improvement in response rate of 63%; a further increase on last year and the highest return rate of all ambulance trusts. Whilst positive outcomes are clearly noted both internally and when compared to other ambulance trusts, commissioners would encourage SCAS to develop locally sensitive improvement plans.

PART 1 – STATEMENT OF QUALITY FROM THE CHIEF EXECUTIVE

The Chief Executive Officer's quality statement recognises the improvement in their NHS 111 and 999 services that have led to SCAS being rated as 'Good' across the individual domains of safety, caring, effectiveness, responsiveness and well-led, as well as overall.

The statement also recognises the opportunity that the NHS Long Term Plan (published January 2019) provides to mental health patients in particular, and the major impact that ambulance services have to support mental health patients in crisis. It is positive to see that SCAS has developed its first organisational development strategy and that the organisation will continue to reflect on the national plan as 2019/20 progresses.

Finally, it is positive to see the Chief Executive Officer's recognition of not only local work that takes place but the national work in many specialist areas that SCAS is involved in.

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

2.1 Looking back at the progress made

SCAS outlined its priorities for 2018/19 and all SHiP commissioners had the opportunity to review these. New NHSI guidance published in February 2018 indicates that updates on progress should include performance in 2018/19 and, where possible the performance in previous years.

Patient Safety

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

Commissioners acknowledge the work that SCAS has undertaken, ahead of the March 2019 deadline and concur that this priority has been achieved.

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

Commissioners recognise the work that has taken place for this priority and understand that a new lead for infection control has now been recruited. SCAS needs to ensure that all services achieve and maintain compliance levels in 2019/20.

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

Commissioners note that SCAS has identified this priority as having been met but draw attention to the CQC outcomes; 'although staff had training on mental health awareness and related topics, there was notable variation in staff knowledge, ability and confidence when dealing with people in mental health crisis'. As well as delivering the training SCAS needs to ensure that the learning has been embedded

Clinical Effectiveness

2a. To review and improve all abandonment for PTS, 999s and 111s (two-year priority)

Commissioners note that in respect of NHS 111 services, 9 out of 12 months saw an achieved abandonment rate of below the 5% contractual target. For the 999 service 11 out of 12 months achieved performance of below 1% for call abandonment. In respect of the patient transport service there were a number of months and localities where performance was not met. Commissioners argue that this metric has been partially met and believe the quality account would have benefitted from articulating what quality improvement has been noted or changes to practice made.

2b. To increase clinical assessments in clinical coordination centres (CCC) ensuring consistent methods and application across the services (2nd year of three-year priority)

As well as the NHS England (NHSE) mandate that all category 3 and 4 calls from the NHS 111 service should be validated by a clinician before reaching a final disposition, there has been a local Commissioning for Quality and Improvement (CQUIN) programme in place to increase the percentage of validation of category 3 and 4 dispositions by the 999 service. These calls are validated by a clinical advisor (CA), and throughout the contractual year SCAS has been running with high levels of vacancies. The requirement of NHSE may have led to an increase in clinical assessments and the report would have benefited from reflecting the current levels activity against the baseline established. It would have been beneficial to see how this has improved patient outcomes but also how the current vacancies are impacting on staff health and wellbeing.

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

As identified in our response to this quality priority last year, the focus should be on ensuring that patients who are experiencing a long wait are kept safe. Commissioners recognise that SCAS has robust internal processes and governance arrangements for reviewing patients who have experienced a long wait. If a change in focus from performance had been articulated then commissioners would argue that, with ongoing levels of demand, SCAS is doing everything it can to keep patients safe and this quality priority would have been achieved through the processes it has in place.

Patient Experience

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

Commissioners are aware that SCAS has been in ongoing discussions with NHS England regarding the challenges of obtaining meaningful feedback from 999 service users. Whilst these challenges are recognised for patients being conveyed to a different health setting there is an expectation that all patients who are 'seen and treated' should be surveyed. Commissioners acknowledge the work that has been undertaken to invite responses but feel there is still more that can be proactively done to elicit a response from users of 999 services. It is therefore disappointing to note that the postal survey planned for Q3 was delayed.

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

Commissioners recognise that one stress awareness day took place in November 2018 and the initiatives taken to help address this issue. Commissioners note that SCAS reports that stress is currently the second highest category for sickness and the outcomes from the 2018 NHS staff survey support this. SCAS is reporting a higher percentage than the national average but is not the worst performing trust. It is positive to see that further initiatives have been identified for the coming year.

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

It has been positive to see the work that the PTS has undertaken through the year in trying to improve end of life care across their geographical areas and commissioners concur that this quality account priority has been met.

2.2 Statement of Assurances from the Board

Commissioners note the statements of assurance from the Board.

2.3 Reporting against the NHSI core indicators

Commissioners note that for STEMI care although an improvement was noted in 2017/18 performance for this year is below that reported in 2016/17 and continues to be below the national average. Stroke care is reported lower than last year and 2016/17 and is also below the national average. Commissioners look forward to the anticipated increase in performance from the actions identified by SCAS, predominantly through changes in the electronic patient record (e-PR) system.

PART 3 – OTHER INFORMATION AND QUALITY PRIORITIES FOR 2019/20

SCAS outlined its priorities for 2018/19 and all SHiP commissioners had the opportunity to review these. A written response with our comments on those initially identified, together with improvements and suggestions for alternative/additional areas of focus was shared with SCAS for consideration. Details of our response are included under Annex 1 of the SCAS 2018/19 Quality Account.

Commissioners also note the national changes for ambulance quality indicators for the coming financial year, some of which are still in development.

Other quality improvements and initiatives

Commissioners acknowledge the information and updates provided in respect of other activities that have taken place to improve quality. Commissioners also recognise the outcomes from the NHS staff survey and their involvement in national work streams. It is positive to see the improvements SCAS is working towards in respect of Freedom to Speak Up and there is inclusion in the 2019/20 Quality Schedule for SCAS to highlight how it will be improving culture of care within its organisation.

Commissioners look forward to continued positive working relationships with South Central Ambulance NHS Foundation Trust as a valued health care partner who consistently seek ways to improve the outcome and experience of patients in our locality.

Julia Barton

Executive Director of Quality and Nursing

Hampshire and Isle of Wight Partnership Clinical Commissioning Groups

Berkshire West Clinical Commissioning Group (CCG) has reviewed South Central Ambulance Service (SCAS) NHS Foundation Trust's Quality Account and is providing this response on behalf of Berkshire West CCG and associate CCGs across the Thames Valley. The Quality Account 2018/19 provides information for a wide range of quality measures and gives a comprehensive review of quality of care and details upcoming priorities to be undertaken by the Trust during 2019/20. There is evidence that the Trust has relied on internal governance structures to maintain oversight and external assurance mechanisms to triangulate the available data to maintain and improve safety, quality and effectiveness of the patient population.

The CCG is satisfied with the accuracy of the data and information contained in the Account. The CCG supported the nine key priorities in 2018/19, within the domains of patient safety, clinical effectiveness and patient experience identified by the Trust.

Quality Account 2018/19

The Quality Account for 2018/19 clearly identified the successes of South Central Ambulance Service to date and also highlighted the challenges, in addition to areas for continuing focus. The CCG supports openness and transparency and is committed to working with the Trust to achieve further progression and successes in the areas identified within the Quality Account.

Care Quality Commission (CQC) Inspection – July and August 2018

The CCGs were pleased to see the positive findings from the CQC focussed inspection when they undertook the review of 999 and Integrated Urgent Care (IUC) services. We are delighted with the rating of 'Good' with respect to the Well-Led domain, in addition to maintaining an overall rating of 'Good'.

SCAS has shared an action plan which details the supporting governance structures, and assurance mechanisms to address the recommendations from the inspection and support delivery.

Patient Safety Improvement Priorities

Within patient safety, SCAS identified three priorities for 2018/19, all of which ran for a single year and these are discussed below.

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

SCAS has successfully implemented the use of NEWS2 ahead of the national target of March 2019. This enables crews to provide more accurate identification of deteriorating patients and support the new national sepsis indicator for ambulance services which is mandated for reporting during 2019.

1B: To improve hand hygiene audit compliance (all services)

It is positive to note that the priority relating to hand hygiene delivered an improvement in compliance; however, it is disappointing that the target of 95% was not achieved within all areas, or across all services.

1C: To implement the new NICE Mental Capacity Act (MCA) guidance - improving awareness and parity

The approach to drive improvement in general mental health awareness, alongside the implementation of the NICE guidance around the Mental Capacity Act is welcomed by the CCG. It is pleasing to see that 'Train the Trainer' approach has been rolled out across all services, which was as a result of feedback from a survey, that highlighted the need for the training to address the areas that remained uncertain for some staff members.

Clinical Effectiveness Improvement Priorities

Three clinical effectiveness, priorities were defined for 2018/19, one of which ran for a single year. Two are multi-year priorities in their second year, one of which will continue into 2019/20. These priorities are discussed below.

2A: To review and improve call abandonment for PTS, 999 and 111 (two-year priority) 2nd year

The priority relating to a reduction in call abandonment was of focus to ensure that patients receive the best service, and that patients can access urgent and emergency services. It is encouraging to see that abandoned calls are below the required threshold for most months of the year within 999 and IUC, with exception to the winter period. Although this will no longer be a quality priority for 2019/20 and it is to note that, unfortunately, across Thames Valley PTS the abandonment rates have increased over the latter half of the year, the CCG look forward to a positive shift in performance.

2B: To increase clinical assessments in clinical co-ordination centres (CCC) ensuring consistent methods and application across the services (three-year priority) 2nd year

SCAS has completed year two during 2018/19 and we are happy to support this work continuing into the third year for 2019/20 to increase clinical assessments within the clinical coordination centres, this has been adapted by SCAS to incorporate national changes driven by the Ambulance Response Programme and directives within Integrated Urgent Care. The aim to implement clinical validation of emergency department and Category 3 and 4 ambulance dispositions which has initially seen an increase in the number of patients directed to more appropriate services.

2C: To improve long waits in the new ARP response categories

There has been a significant amount of work undertaken by SCAS to develop their long waits process which encompasses patient clinical appropriateness, and prioritisation. The Long Waits Review Group meets on a monthly basis to review a sample of long waits and report into the Patient Safety Group. The themes identified as part of this review are that the highest proportion of patients experiencing a long wait are those who have fallen and not sustained an injury, and that the primary cause of long waits is that demand for 999 services is higher than the number of ambulances available.

Patient Experience Improvement Priorities

SCAS identified three priorities relating to patient experience for 2018/19, all of which ran for a single year and these are discussed below.

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

It is noted that SCAS has experienced challenges when sending out postal surveys to patients who had received care via the 999 service; it is planned that this postal survey will be sent during 2019/20 which will then inform the appropriate action to be undertaken.

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

SCAS has undertaken a campaign to improve staff health and wellbeing, the priority for 2018/19 was a focus on staff stress. The identified measure of success was a reduction in absence and there are clear plans to continue to deliver further support for staff, although this is not a formal quality priority in 2019/20.

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

In 2018/19 SCAS has undertaken a review project with a view to understanding the challenges that patients with an end of life diagnosis have when using the PTS service. This identified opportunities to develop and reinforce processes around when a patient dies while in the care of the PTS service, whether this is expected or unexpected, that help support staff to take the most appropriate action for their patients.

Overall, there have been many positive highlights for the Trust and the CCG has gained assurance via a number of forums and by the undertaking of quality assurance visits, therefore welcome the opportunity to continue to work alongside the Trust within the developing healthcare landscape in order to offer high quality and safe care to our patients.

The CCGs are pleased that the Trust has chosen to continue their focus on priorities within the domains of patient safety, clinical effectiveness and patient experience. It is recognised that a significant amount of combined effort has been undertaken over the past year; however, there is also recognition that continued focus by SCAS is required due to an increasingly challenging and complex environment and the CCG feels the Quality Account has provided a review of previous priorities and has engaged with the CCG and others in defining those key priority areas for improvement.

Simon Hawkins

Quality Improvement Lead, Berkshire West CCG

On behalf of Berkshire West CCG and associate CCGs across the Thames Valley

Thank you for the opportunity to comment on your Quality Account for 2018/19.

Overall the Panel considered that the Account was clearly presented and comprehensive. In particular, the CEO's statement provides a clear overview and highlights the three CQC inspections that have all provided a 'Good' rating.

The previous year's priorities have been classified according to the three recommended issues of Clinical Excellence, Patient Safety and Patient Experience. The priorities appear to be well chosen, and it is noted that they were informed through consultation with Healthwatch and with reference to feedback from scrutiny panels.

The presentation of performance outcomes is clear using a traffic-light approach and there is a commentary against those that are only partially achieved. On the face of it, these appear to be frank and credible.

It is unfortunate that the version submitted to the Panel for comment includes a few places where the latest information has still to be added. Although, in this case it does not detract too much from the overall quality of the report in future years it would be beneficial for the panel to see a finalised version.

The priorities set out in Part 3 for 2019/20 build on those from last year and have also been informed through stakeholder consultation. In the document they are preceded by other quality information which does make this part of the report harder to follow. The panel would recommend in future setting out the new priorities with their rationale before describing the additional information.

The Panel would like to highlight the good focus on mental health support but also that performance for STEMI Care and Stroke Care fell below the national average last year. Something that the Panel sees will continue to be monitored as a priority this year.

Health and Adult Social Care Scrutiny Committee
Milton Keynes Council

ANNEX 2: STATEMENT OF DIRECTORS' RESPONSIBILITIES

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- ➔ The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 and supporting guidance, Detailed Requirements for Quality Reports 2018/19
- ➔ 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 2018 to March 2019
 - Papers relating to quality reported to the Board over the period April 2018 to March 2019
 - Feedback from commissioners dated 01/03/2019 and 08/03/2019
 - Feedback from governors dated 10/01/2019
 - Feedback from local Healthwatch organisations dated 13/02/2019
 - Feedback from Overview and Scrutiny Committee dated 21/05/2019
 - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 25/07/2018, 25/10/2018, 23/01/2019, 25/04/2019
 - The national staff survey 06/03/19
 - The Head of Internal Audit's annual opinion of the Trust's control environment dated 26/04/2018
 - CQC inspection report dated 06/11/2018
- ➔ The Quality Report represents a balanced picture of the NHS Foundation Trust's performance over the period covered
- ➔ The performance information reported in the Quality Report is reliable and accurate
- ➔ There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- ➔ The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- ➔ The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board, 23 May 2019



Will Hancock
Chief Executive



Lena Samuels
Chair

10. REPORT OF THE AUDIT COMMITTEE

The Audit Committee is a statutory committee of the Board comprising non-executive directors of the Trust, all of whom are considered independent. There were five meetings during 2018/19 and all of its members attended each of those meetings. Members of the Audit Committee were Mike Hawker (Chair), Ilona Blue, Sumit Biswas, Les Broude and Priya Singh.

Other managers are regular attendees of the Audit Committee which includes the Director of Finance, Director of Patient Care and Service Transformation and the Company Secretary. Representatives of External Audit, Internal Audit and the Counter Fraud Team are also in regular attendance. Other managers also attend the Audit Committee on an irregular basis.

The Audit Committee's responsibilities include:

- ➔ Review the Trust's draft accounts and make recommendations with regard to their approval to the Board
- ➔ Provide assurance to the Board as to the effectiveness of internal controls and the risk management processes that underpin them
- ➔ Agree the annual plans for external audit, internal audit and counter fraud
- ➔ Make recommendations to the Council of Governors regarding the appointment of the External Auditors
- ➔ In discharging its responsibilities, the Committee reviews and takes account of the Board Assurance Framework, the Trust's Risk Registers and the work of other Board Committees such as the Quality and Safety Committee

EXTERNAL AND INTERNAL AUDIT

The effectiveness of internal and external audit is reviewed on a regular basis by the Audit Committee. The Trust appointed Grant Thornton as its new external auditors, following a competitive tender process, for the 2017/18 financial statements for an initial period of three years with an option to extend for a further two years. Grant Thornton attend every committee reporting on progress and developments that are likely to impact on the final accounts. Grant Thornton will be invited to attend Council of Governor meetings from time to time. Grant Thornton performed some non-audit work (value £17,000) relating to the SCFS audit and some contract assurance work on behalf of the Trust in 2018/19. The value of statutory audit work undertaken was £42,000 (2017/18: £42,000) which is inclusive of the quality report audit fee.

SIGNIFICANT ISSUES

At its meeting on 2 May 2019, the Audit Committee considered matters relating to the 2018/19 accounts which included the following:

Accounting for South Central Fleet Services Ltd

The Audit Committee was requested to note that the Trust Accounts included the results of South Central Fleet Services Ltd which is a wholly owned subsidiary of SCAS. The accounting statements

included the results of the Group which include the Trust and the Company, and the results of the Trust excluding the Company.

Adoption of New Standards

The Audit Committee was asked to note the introduction of two new standards on the accounts and note their impact relating to IFRS 15 (Revenue from contracts with customers) and IFRS 9 (Financial instruments).

Quinquennial Valuation

The Audit Committee was asked to note the process adopted and impact of the results of Trust's owned land and buildings inspection and valuation exercise.

NHSD Activities

Ongoing activities in relation to NHS Direct were discussed by the Committee and the accounting treatment of these activities was discussed by the Committee.

Going Concern

The Committee discussed going concern and agreed that they could recommend to the Board that they could adopt the accounts on the basis that the Trust remained a going concern.

Mike Hawker
Audit Committee Chairman
23 May 2019

11. OPERATIONAL AND FINANCIAL REVIEW

The Group, which includes the results of the Trust and South Central Fleet Services Ltd reported a surplus in 2018/19 of £1.486m.

The Trust undertook a revaluation exercise of its estate in 2018/19 as part of its quinquennial revaluation and the results of this are reflected in the annual accounts. This is in line with the general uplift in land and building values.

The NHS Improvement measure of financial performance and sustainability, using the use of resources metric, was a one for the Trust, which is the highest attainable rating.

Summary of Financial Performance

On Income and Expenditure the Group reported a continuing operations surplus of £1.5m for the year.

Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA) of £10.8m represented 4.8% of turnover which is £2.6m above last year.

Capital expenditure was £9.5m (£10.1m in 2017/18) with ambulances being the largest single item.

The year-end cash balance was £22.6m which was an increase of £4.9m when compared to the previous year. The main increases in cash were due to reductions in capital payments (£3.0m), receipt of public dividend capital (£0.7m) and movements in working capital (£1.0m).

It has been a financially challenging year but we still managed to achieve £8.0 million of cost improvements in 2018/19.

Total revenue income to meet pay and other day-to-day running costs reached £226.0m of which the majority was secured through various service level agreements with clinical care commissioning groups and hospital NHS trusts.

The accounts are stated in accordance with International Financial Reporting Standards. Total fixed assets (land, buildings and capital equipment) of the Trust were valued at £73.5m (£68.7m in 2018).

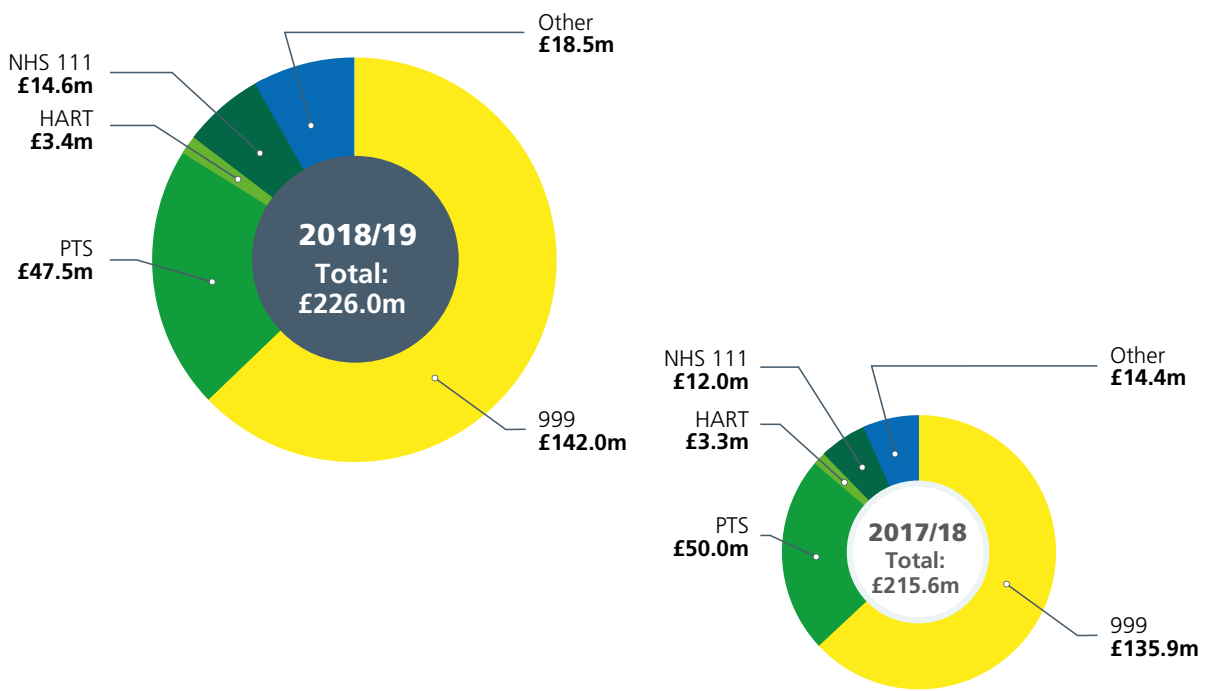
The Trust formed a subsidiary company (South Central Fleet Services Ltd) to provide fleet services which was incorporated in September 2015 and commenced trading on 1 November 2015. The results of the activities of the company are included in the group results with the company recording a surplus of £63k for the year ending 31 March 2019.

Analysis of Income

The Trust’s reported income was £226.0 million for the year end 31 March 2019 (2018: £215.6 million). The increase of 4.8% was due to higher base contractual income in Emergency and the NHS 111 services, as well as central funding received for the NHS Agenda for Change pay award.

The Trust’s principal source of income is from local NHS commissioning contracts for the provision of the emergency service. This income totalled £141.6 million (£135.9 million in 2018) which represented 62.7% of the Trust turnover (2018: 63.0%).

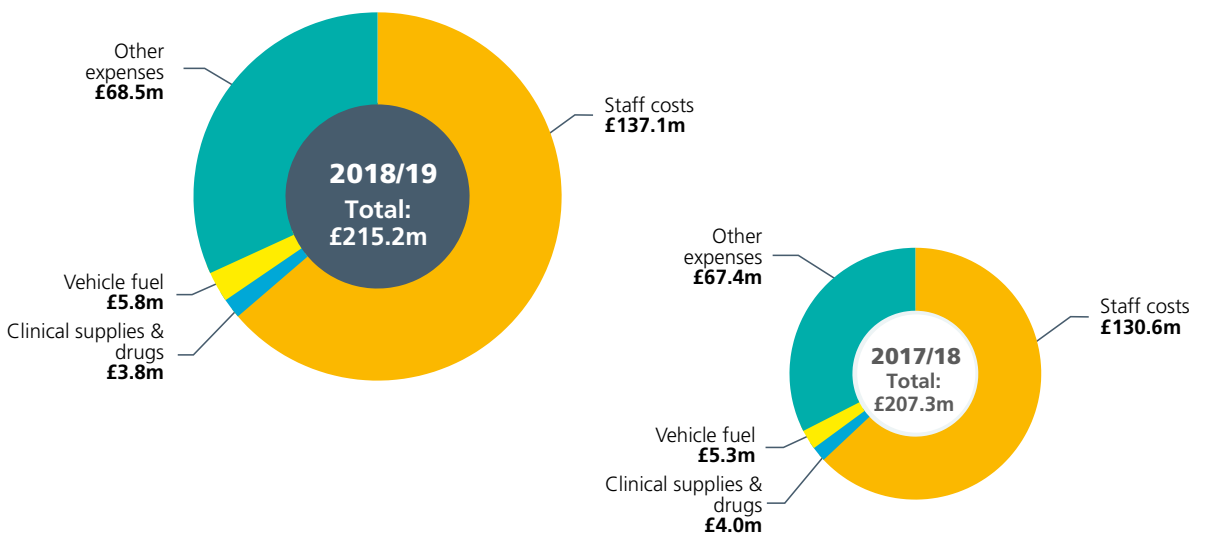
The Trust confirms that the NHS income it receives for the provision of healthcare exceeds its income that it receives for any other purpose in accordance with the requirements of the Health and Social Care Act 2012. The amount of income that the Trust received in this regard for 2018/19 was £212.6m representing 94.1% of total income.



Analysis of operating expenditure

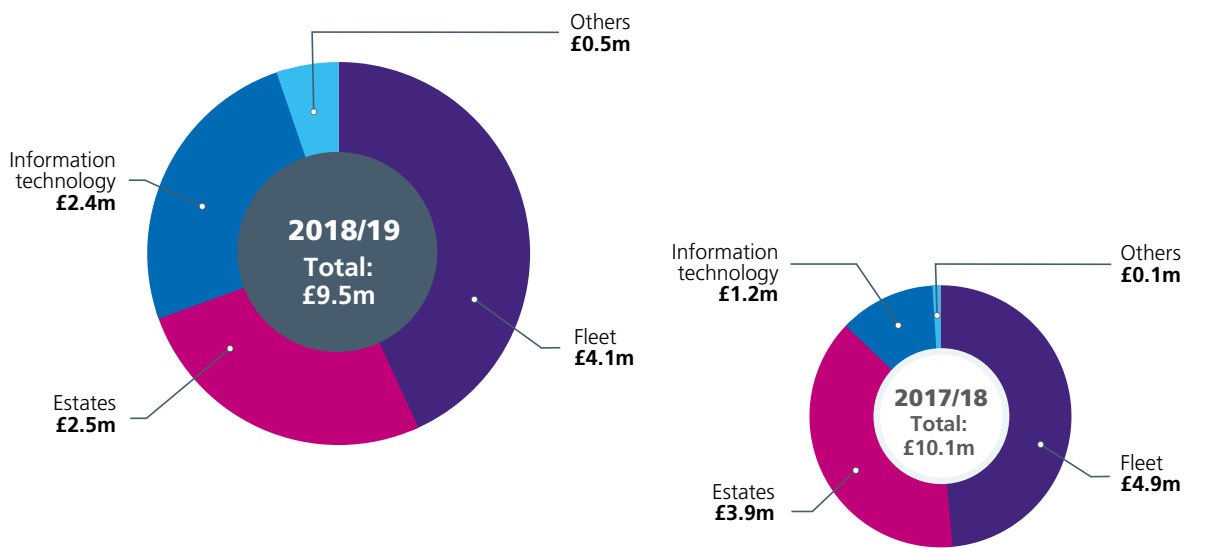
Total operating expenditure for the Group (excluding depreciation, amortisation and impairments) was £215.2 million for the year ended 31 March 2019 (2018: £207.3 million). The increase of 3.8% was mainly due to increased expenditure arising from recruitment of staff in frontline, NHS 111 and PTS services and the NHS Agenda for Change pay increase for staff.

Staff costs represent 63.8% of total operating expenditure (2018: 63.0%).



Capital Investment

Investment in capital resources for 2018/19 was £9.5 million (2018: £10.1 million). This amount includes 999 ambulance replacements and the provision of two facilities (for our PTS in Reading and South Central Fleet Services Ltd in Didcot) and the telephony upgrade.



Internal Audit Function

The Trust’s internal audit function for the past six years has been undertaken by BDO who were appointed for a further three years from 2018/19. BDO work to a pre-agreed internal audit plan which is signed off annually by the Audit Committee. They play an important role in the Trust’s annual governance process providing assurance on the working of the Trust’s internal controls through their Head of Internal Audit Opinion and liaising with other external agencies, including Grant Thornton, the Trust’s appointed external auditor. Internal Audit has a standing invitation to all of the Trust’s Audit Committees.

Going Concern

After making enquiries, the directors have a reasonable expectation that South Central Ambulance NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason they continue to adopt the going concern basis in preparing the accounts.

Disclosure of Information to the Auditors

So far as each of the directors is aware, there is no relevant audit information of which the South Central Ambulance NHS Foundation Trust’s auditor is unaware.

Each director has taken all the steps that they ought to have taken to make themselves of any relevant audit information and to establish that South Central Ambulance NHS Foundation Trust’s auditor is aware of that information.

Cost Allocation and Charging

South Central Ambulance Service NHS Foundation Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector information guidance.

12. REMUNERATION REPORT

ANNUAL STATEMENT FROM CHAIR OF REMUNERATION COMMITTEE

Composition, attendance, establishment and duties

The Remuneration, Nomination and Terms of Service Committee’s self-assessment is that it is performing competently across the range of its duties. The Committee’s Terms of Reference (TOR) were last revised in April 2018 with minor amendments made. From April 2018 – March 2019, seven meetings (including virtual) were held; attendance is shown in the table below. The Committee Chair has been Sumit Biswas, with Ilona Blue, Anne Stebbing and Lena Samuels as members.

Committee work programme 2018/19

- ➔ Director salaries and bonus review
- ➔ IR35/Agency regulations/Off-payroll staff
- ➔ Review of executive and senior team succession plan
- ➔ Review effectiveness of VSM remuneration policy including the reconsideration of inclusion of direct reports to executive directors
- ➔ Equal pay

Governance issues

The Committee’s self-assessment is that it is generally performing competently across all areas. During the year the Committee has been required to spend time reviewing and agreeing the Trust’s position with respect to redundancy business cases, individual employment tribunal and employment-related legal claims, agency ‘spend caps’, IR35 application and off-payroll arrangements.

The Committee has overseen operation of the Trust Remuneration Policy, including appointments of a new executive director and the pay and performance bonuses to executive directors for 2017/18. The Committee has initiated a review of salary levels for executive directors to ensure comparability with the wider market for ambulance and other FTs and adjusted the remuneration package of the Director of Finance and Director of Human Resources and Organisational Development appropriately.

The Committee has ensured compliance with statutory requirements, including the CQC Regulations for ‘Fit and Proper Person’ and the return of staff receiving severance payment to the NHS, and HMRC Regulation relating to off-payroll employment arrangements (including IR35) for senior public sector employees.

Setting performance objectives

The Committee has worked with the Chair and Chief Executive to ensure appropriate oversight, approval and review of the Executive’s annual performance objectives and in particular the quality of these.

Appointments

The Committee appropriately oversees Chief Executive and Executive Director appointments. There was one executive appointment in 2018/19 requiring the Committee’s approval, namely

the Director of Strategy and Business Development. The Committee has approved the approach for recruitment of the Chief Operating Officer which will take place during 2019/20.

Administration

The Committee's self-assessment is that it is performing competently across these areas. It is well supported and advised by the Director of Human Resources and Organisational Development.

Summary of key development issues

The Committee will provide continuous oversight of the quality, relevance and clarity of chief executive, executive director and senior management objective setting and review processes. The Committee will continue to review and refine the Trust Remuneration Policy, including performance bonuses. The Committee will continue to monitor the value of extending its oversight of annual performance objectives and review to the next level of Trust senior management in discussion with the Chief Executive. The Committee will continue to seek assurance of compliance with statutory requirements as it relates to the employment of the Chief Executive, executive directors and senior management. The Committee will continue to maintain an oversight of key recent statutory and NHS Improvement requirements relating to Trust workforce including agency spend caps, IR35 applications and any off-payroll contractor arrangements.

Sumit Biswas
Remuneration Committee Chairman

Approved by:

Will Hancock, Chief Executive 23 May 2019

Remuneration Committee – Attendance List 2018/19

Date	Anne Stebbings	Sumit Biswas	Ilona Blue	Lena Samuels	Melanie Saunders	Will Hancock
26 Apr 18	Yes	Yes	Yes	Yes	Yes	Yes
15 May 18 (EO)	Yes	Yes	Yes	Yes	Yes	No
28 Jun 18	Yes	Yes	Yes	Yes	Yes	Yes
3 Sep 18	Yes	Yes	No	Yes	Yes	Yes
18 Oct 18	Yes	Yes	Yes	Yes	Yes	Yes
31 Jan 19 (EO)	Yes	Yes	Yes	Yes	Yes	Yes
28 Feb 19	Yes	Yes	Yes	Yes	Yes	Yes

DIRECTORS SALARIES AND BENEFITS FOR THE YEAR ENDED 31 MARCH 2019

Name and Title	2018/19				2017/18				Note 1	Note 2	Note 3	Note 4	Note 4	Note 4	Note 4 and 5	Note 8
	Salary (bands of £5,000) £000	Taxable benefits to the nearest £100	Annual performance related bonuses in bands of £5,000	All pension related benefits (bands of £2,500)	Total in bands of £5,000	Salary (bands of £5,000) £000	Taxable benefits to the nearest £100	Annual performance related bonuses in bands of £5,000	All pension related benefits (bands of £2,500)							
Lena Samuels (Chair)	40-45					35-40										
Ilona Blue (Non-Executive Director)	0					0										
Les Broude (Non-Executive Director)	10-15					0-5										
Mike Hawker (Non-Executive Director)	15-20					15-20										
Nigel Chapman (Non-Executive Director)	15-20					10-15										
Sumit Biswas (Non-Executive Director)	10-15					10-15										
Priya Singh (Non-Executive Director)	10-15															
Anne Stebbing (Non-Executive Director)	15-20															
Will Hancock (Chief Executive)	180-185	64	5-10	70-72.5	265-270	175-180	59	5-10	130-132.5			320-325				
Charles Porter (Director of Finance)	125-130		5-10	50-52.5	180-185	115-120		0-5	45-47.5			165-170				
Philip Astle (Chief Operating Officer)	120-125		5-10	30-32.5	155-160	120-125		0-5	30-32.5			150-155				
James Underhay (Director of Strategy and Business Development)	35-40	17	0-5	40-42.5	85-90	120-125	49	0-5	42-45			175-180				
Michael Murphy (Director of Strategy and Business Development)	50-55			NA	50-55											

Melanie Saunders (Director of Human Resources and Organisational Development	110-115	30	0-5	80-82.5	200-205	100-105	26	0-5	77.5-80	185-190	Note 4
John Black (Medical Director)	110-115				110-115	100-105	68			110-115	Note 6
Professor Helen Young (Director of Patient Care and Service Transformation)	120-125			90-95	215-220	65-70			65-70	135-140	Note 7
Mid Point Band of highest paid Director's Total					182.5					177.5	
Median Total Remuneration (£000)					25.2					24.9	
Highest Paid Director as a proportion of the median					7.24					7.13	

Notes

- 1 Les Broude joined the Trust on 1 February 2018
- 2 Priya Singh joined the Trust on 1 April 2019
- 3 Anne Stebbing joined the Trust on 1 April 2019
- 4 William Hancock, Charles Porter, James Underhay, Philip Astle and Melanie Saunders were awarded an annual bonus based on individual performance against objectives, overall contribution to organisational performance, and their leadership
- 5 James Underhay left his executive post on 18 July 2018
- 6 Dr John Black is a recharge from Oxford University Hospitals NHS Foundation Trust
- 7 Professor Helen Young joined the Trust on 1 September 2017. The pension benefit shown is the amount attributable to the Trust
- 8 Michael Murphy joined the Trust on 29 October 2018. Real increase is pension is not shown as data not available from previous employment
- 9 Date of the service contract for all executive directors serving at the end of 2018/19 as follows: Charles Porter 01/02/07, Mike Murphy 29/10/18, Will Hancock 01/07/06, Helen Young 01/07/17, Philip Astle 14/03/16, Melanie Saunders 22/03/16
- 10 All executive directors in post at the end of 2018/19 were contracted to give 6 months notice and all contracts are unexpired

CASH EQUIVALENT TRANSFER VALUE

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

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme.

They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Government Actuary Department (GAD) factors for the calculation of CETVs assume that benefits are indexed in line with CPI which is expected to be lower than RPI which was used previously and hence will tend to produce lower transfer values.

EXPENSES

Details of number and value of expenses claimed by governors and directors are detailed below:

	2018/19			2017/18		
	Total Number in Office	Total Number Receiving Expenses	Aggregate Sum of Expenses paid (£00)	Total Number in Office	Total Number Receiving Expenses	Aggregate Sum of Expenses paid (£00)
Governors	25	12	53	25	18	63
Directors	14	13	179	15	13	133

OFF-PAYROLL ENGAGEMENTS

For all off-payroll engagements as of 31 Mar 2019, for more than £220 per day and that last for longer than six months:

No. of existing engagements as of 31 March 2019	0
Of which:	
Number that have existed for less than one year at the time of reporting	0
Number that have existed for between one and two years at the time of reporting	0
Number that have existed for between two and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £220 per day and that last for longer than six months:

Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	0
Of which:	
Number assessed as within scope of IR35	0
Number assessed as not within scope of IR35	0
Number engaged directly (via PSC contracted to Trust) and are on the Trust’s payroll	0
Number of engagements reassessed for consistency / assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

For any off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019:

Number of off-payroll engagements of Board members, and / or senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed ‘Board members and / or senior officials with significant financial responsibility’ during the financial year. This figure must include both off-payroll and on-payroll engagements	0

ANNUAL ACCOUNTS 2018/19



FOREWORD TO THE ACCOUNTS

South Central Ambulance Service NHS Foundation Trust

These accounts, for the year ended 31 March 2019, have been prepared by South Central Ambulance Service NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

A handwritten signature in black ink, appearing to read 'Will Hancock'.

Will Hancock
Chief Executive

23 May 2019

STATEMENT OF COMPREHENSIVE INCOME

	Note	Group		Trust	
		2018/19 £000	2017/18 £000	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	215,727	207,044	215,727	207,044
Other operating income	4	10,263	8,443	10,215	8,482
Operating expenses	5	(222,927)	(215,015)	(222,938)	(214,730)
Operating surplus/(deficit) from continuing operations		3,063	472	3,004	796
Finance income	10	136	56	136	56
Finance expenses	11	(15)	(87)	(15)	(87)
PDC dividends payable		(1,650)	(1,549)	(1,650)	(1,549)
Net finance costs		(1,529)	(1,580)	(1,529)	(1,580)
Gains/(losses) on disposal of non-current assets	12	(47)	2,288	(51)	2,288
Surplus/(deficit) for the year from continuing operations		1,487	1,180	1,424	1,504
Gain/(loss) from absorption and discontinuance of operations	14	-	131	-	131
Surplus/(deficit) for the year		1,487	1,311	1,424	1,635
Other comprehensive income					
Will not be reclassified to income and expenditure					
Revaluations	16	3,261	-	3,261	-
Total comprehensive income/(expense) for the period		4,748	1,311	4,685	1,635

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2019

	Note	Group		Trust	
		31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Non-current assets					
Intangible assets	15	2,947	3,373	2,947	3,365
Property, plant and equipment	16	70,552	65,322	58,728	57,247
Other investments / financial assets	20	-	-	11,292	7,836
Total non-current assets		73,499	68,695	72,967	68,448
Current assets					
Inventories	18	962	910	626	569
Receivables	19	13,381	15,936	13,328	15,269
Other investments / financial assets	20	-	-	1,497	1,300
Non-current assets for sale and assets in disposal groups	21	-	-	-	-
Cash and cash equivalents	22	22,574	17,632	22,302	17,529
Total current assets		36,917	34,478	37,753	34,667
Current liabilities					
Trade and other payables	23	(19,338)	(17,412)	(19,485)	(17,365)
Borrowings	24	(1,407)	(1,740)	(1,407)	(1,740)
Provisions	25	(6,300)	(4,468)	(6,160)	(4,097)
Total current liabilities		(27,045)	(23,620)	(27,052)	(23,202)
Total assets less current liabilities		83,371	79,553	83,668	79,913
Non-current liabilities					
Trade and other payables	23	(6)	(13)	(6)	(13)
Borrowings	24	-	(1,400)	-	(1,400)
Provisions	25	(5,160)	(5,753)	(5,160)	(5,753)
Total non-current liabilities		(5,166)	(7,166)	(5,166)	(7,166)
Total assets employed		78,205	72,387	78,502	72,747
Financed by					
Public dividend capital		59,284	58,199	59,284	58,199
Revaluation reserve		13,536	10,669	13,536	10,669
Other reserves		(350)	(350)	(350)	(350)
Income and expenditure reserve		5,735	3,869	6,032	4,229
Total taxpayers' equity		78,205	72,387	78,502	72,747

The financial statements on pages 192 to 197 were approved by the Board on 23 May 2019 and signed on its behalf by:



Signed
Will Hancock, Chief Executive
Date: 23 May 2019

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 31 MARCH 2019

Group	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2018 - brought forward	58,199	10,669	(350)	3,869	72,387
Surplus/(deficit) for the year	-	-	-	1,487	1,487
Impact of accounting standards change (IFRS9)	-	-	-	(15)	(15)
Transfer from revaluation reserve to income and expenditure reserve					
for impairments arising from consumption of economic benefits	-	-	-	-	-
Revaluations	-	3,261	-	-	3,261
Transfer to retained earnings on disposal of assets	-	(394)	-	394	-
Public dividend capital received	1,085	-	-	-	1,085
Taxpayers' and others' equity at 31 March 2019	59,284	13,536	(350)	5,735	78,205

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 31 MARCH 2018

Group	Public dividend capital £000	Revaluation reserve £000	Other reserves £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2017 - brought forward	57,874	10,885	(350)	2,342	70,751
Surplus/(deficit) for the year	-	-	-	1,311	1,311
Transfer from revaluation reserve to income and expenditure reserve					
for impairments arising from consumption of economic benefits	-	(216)	-	216	-
Public dividend capital received	325	-	-	-	325
Taxpayers' and others' equity at 31 March 2018	58,199	10,669	(350)	3,869	72,387

See Information on reserves on page 195

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reserve impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Other reserves

Other reserves was a residual balance required in 2006 when the Trust was formed, from ambulance predecessor Trusts, to balance operating net assets with taxpayers' equity.

Income and expenditure

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 31 MARCH 2019

Trust	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 - brought forward	58,199	10,669	(350)	4,229	72,747
Surplus/(deficit) for the year	-	-	-	1,424	1,424
Impact of accounting standards change (IFRS9)	-	-	-	(15)	(15)
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	-
Revaluations	-	3,261	-	-	3,261
Transfer to retained earnings on disposal of assets	-	(394)	-	394	-
Public dividend capital received	1,085	-	-	-	1,085
Public dividend capital written off	-	-	-	-	-
Taxpayers' and others' equity at 31 March 2019	59,284	13,536	(350)	6,032	78,502

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 31 MARCH 2018

Trust	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2017 - brought forward	57,874	10,885	(350)	2,378	70,787
Surplus/(deficit) for the year	-	-	-	1,635	1,635
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	(216)	-	216	-
Public dividend capital received	325	-	-	-	325
Public dividend capital written off	-	-	-	-	-
Taxpayers' and others' equity at 31 March 2018	58,199	10,669	(350)	4,229	72,747

See **Information on reserves** on page 195

STATEMENT OF CASH FLOWS

	Group		Trust	
	2018/19 £000	2017/18 £000	2018/19 £000	2017/18 £000
Cash flows from operating activities				
Operating surplus/(deficit)	3,063	472	3,004	796
Non-cash income and expense:				
Depreciation and amortisation	8,294	7,706	7,102	7,301
Impairment and reversals	(580)	-	(580)	-
(Increase)/decrease in receivables and other assets	(304)	(1,275)	(918)	(787)
(Increase)/decrease in inventories	(52)	28	(57)	21
Increase/(decrease) in payables and other liabilities	1,927	1,716	2,109	2,174
Increase/(decrease) in provisions	1,269	1,274	1,500	903
Net cash generated from/(used in) operating activities	13,617	9,921	12,160	10,408
Cash flows from investing activities				
Interest received	129	52	129	52
Purchase of intangible assets	(689)	(742)	(689)	(733)
Purchase of PPE and investment property	(8,444)	(11,347)	(3,344)	(5,600)
Sales of PPE and investment property	2,608	2,477	2,449	2,477
Net cash flows from/(used in) investing activities	(6,396)	(9,560)	(1,455)	(3,804)
Cash flows from financing activities				
Public dividend capital received	1,085	325	1,085	325
Movement on loans from DHSC	(1,740)	(1,738)	(1,740)	(1,738)
Other interest paid	(45)	(98)	(45)	(98)
PDC dividend (paid)/refunded	(1,579)	(1,621)	(1,579)	(1,621)
Financing cash flows of discontinued operations	-	131	-	131
Cash flows from (used in) other financing activities	-	-	(3,653)	(5,995)
Net cash flows from/(used in) financing activities	(2,279)	(3,001)	(5,932)	(8,996)
Increase/(decrease) in cash and cash equivalents	4,942	(2,640)	4,773	(2,392)
Cash and cash equivalents at 1 April	17,632	20,272	17,529	19,921
Cash and cash equivalents at 31 March	22,574	17,632	22,302	17,529

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES AND OTHER INFORMATION

1.1 BASIS OF PREPARATION

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards, to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust, for the purpose of giving a true and fair view, has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts. Where the statements show Group, this includes the results for both the NHS Foundation Trust and its wholly owned subsidiary, South Central Fleet Services Ltd.

ACCOUNTING CONVENTION

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

GOING CONCERN

These accounts have been prepared on a “going concern” basis. This means that the Trust expects to operate into the future and that the Statement of Financial Position (SOF) reflects the ongoing nature of the Trust’s activities. The Trust Board of Directors has considered and declared that “after making enquiries, the Board of Directors has a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future”. For this reason, they continue to adopt the going concern basis in preparing the accounts.

1.2 CONSOLIDATION

NHS Charitable Fund

South Central Ambulance Service NHS Foundation Trust is the Corporate Trustee to South Central Ambulance Service (SCAS) NHS Charity. South Central Ambulance Service NHS Foundation Trust has considered the materiality of the current annual value of transactions and as a result has not consolidated the charitable fund results into the Trust accounts.

The SCAS Charity had total assets of £618k as at 31 March 2019 (31 March 2018: £729k). During 2018/19 the Charity received income of £373k (2017/18: £558k) and incurred expenditure of £484k (2017/18: £545k). The results for 31 March 2019 are provisional and unaudited at this stage.

Other subsidiaries

On 5 September 2015 the Trust established a wholly owned subsidiary company ‘South Central Fleet Services Ltd’. The accounts show results for the Group and the Trust. The company began trading on 1 November 2015 and provides a range of fleet services to the Trust. The Trust’s investment in the company is £441,310 of share capital.

Subsidiary entities are those over which the Trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year, except where a subsidiary’s financial year end is before 1 January or after 1 July, in which case the actual amounts for each month of the Trust’s financial year are obtained from the subsidiary and consolidated.

Where the subsidiary’s accounting policies are not aligned with those of the Trust (including where they report under UK FRS 102) then amounts are adjusted during consolidation where the differences are material. Inter-entity balances, transactions and gains/losses are eliminated in full on consolidation.

1.3 INCOME

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

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

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners in respect of healthcare services. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. Where income is received for a specific activity, which is to be delivered in a subsequent financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pensions' Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

1.4 EXPENDITURE ON EMPLOYEE BENEFITS

Short-term employee benefits

Salaries, wages and employment-related payments, such as social security costs and the apprenticeship levy, are recognised in the period in which the service is received from employees. The cost of annual leave entitlement, earned but not taken by employees at the end of the period, is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

PENSION COSTS

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. The schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.5 EXPENDITURE ON 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.

1.6 PROPERTY, PLANT AND EQUIPMENT

Recognition

Property, plant and equipment is capitalised where:

- ➔ It is held for use in delivering services or for administrative purposes
- ➔ It is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- ➔ It is expected to be used for more than one financial year and the cost of the item can be measured reliably
- ➔ The item has a cost of at least £5,000, or collectively a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous disposal dates and are under single managerial control
- ➔ Items form part of the initial equipping and setting-up cost of a new building, irrespective of their individual or collective cost

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation. Land and buildings, used for the Trust's services, or for administrative purposes, are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any impairment. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined as follows:

- ➔ Land and non-specialised buildings – market value for existing use
- ➔ Specialised buildings – depreciated replacement cost

An item of property, plant and equipment, which is surplus, with no plan to bring it back into use, is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

The Trust has undertaken a valuation exercise of its owned property (land and buildings) with a valuation date as at 31 March 2019. This was undertaken by an accredited valuer, Bomford Estates Ltd, on a property by property basis.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits, or service potential, deriving from the cost incurred to replace a component of such item, will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised, if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure, that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment, which has been reclassified as 'held for sale', ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits, or of service potential in the asset, are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- ➔ The asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- ➔ The sale must be highly probable, i.e.:
 - Management is committed to a plan to sell the asset
 - An active programme has begun to find a buyer and complete the sale
 - The asset is being actively marketed at a reasonable price
 - The sale is expected to be completed within 12 months of the date of classification as 'held for sale'
 - The actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment, which is to be scrapped or demolished, does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits, embodied in the grant, are to be consumed in a manner specified by the donor; in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Useful economic lives of property, plant and equipment

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

	Min life	Max life
	Years	Years
Land	-	-
Buildings, excluding dwellings	20	70
Dwellings	20	70
Plant & machinery	5	15
Transport equipment	5	10
Information technology	3	5
Furniture & fittings	5	15

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

1.7 INTANGIBLE ASSETS

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust’s business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- ➔ The project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- ➔ The Trust intends to complete the asset and sell or use it
- ➔ The Trust has the ability to sell or use the asset
- ➔ How the intangible asset will generate probable future economic or service delivery benefits, e.g., the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset
- ➔ Adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset
- ➔ The Trust can measure reliably the expenses attributable to the asset during development

Software

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus, with no plan to bring it back into use, is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5. Intangible assets held for sale are measured at the lower of their carrying amount or “fair value less costs to sell”.

Amortisation

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

Useful economic life of intangible assets

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

	Min life	Max life
	Years	Years
Purchased intangible assets – Software	3	5

1.8 REVENUE GOVERNMENT AND OTHER GRANTS

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

1.9 INVENTORIES

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method. This is considered to be a reasonable approximation to fair value due to high turnover of stocks. A review is made where necessary for obsolete, slow moving and defective stocks and written off where considered appropriate.

1.10 FINANCIAL INSTRUMENTS AND FINANCIAL LIABILITIES

Recognition

Financial assets and financial liabilities, which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

De-recognition

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

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

Classification and measurement

Financial assets are categorised as loans and receivables.

Financial liabilities are categorised as other financial liabilities.

Financial assets and financial liabilities at "fair value through income and expenditure"

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the

Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities, carried at amortised cost, is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

1.11 LEASES

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The Trust as lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.12 CASH & CASH EQUIVALENTS

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are instruments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of South Central Ambulance Service NHS Foundation Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.13 PROVISIONS

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 26 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims, are charged to operating expenses when the liability arises.

1.14 CONTINGENCIES

Contingent assets (that is, assets arising from past events, whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 27 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 27, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- ➔ Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control
- ➔ Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability

1.15 PUBLIC DIVIDEND CAPITAL

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require payments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend, thus calculated, is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.16 VALUE ADDED TAX

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged, or input VAT is recoverable, the amounts are stated net of VAT.

1.17 CORPORATION TAX

South Central Ambulance Service NHS Foundation Trust has determined that it has no corporation tax liability as the Trust's profit generated from non-operational income falls below the threshold amount of £50,000.

1.18 FOREIGN EXCHANGE

The functional and presentational currency of the Trust is sterling. A transaction, which is denominated in a foreign currency, is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- ➔ Monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March
- ➔ Non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction
- ➔ Non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise. Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.19 THIRD PARTY ASSETS

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

1.20 LOSSES AND SPECIAL PAYMENTS

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the Health Service or passed by legislation. By their nature, they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register, which reports on an accrual basis, with the exception of provisions for future losses.

1.21 EARLY ADOPTION OF STANDARDS, AMENDMENTS AND INTERPRETATIONS

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

1.22 STANDARDS, AMENDMENTS AND INTERPRETATIONS IN ISSUE BUT NOT YET EFFECTIVE OR ADOPTED

At the date of authorisation of these financial statements, the following Standards and Interpretations, which have not been applied in these financial statements, were in issue but not yet effective. IFRS 9 and IFRS 15 are applicable for financial years commencing after January 2018. None of the remaining IFRS standards listed below are expected to impact on the Trust's financial statements except IFRS 16, applicable date to be determined by the FReM.

- ➔ IFRS 14 Regulatory Deferral Accounts
- ➔ IFRS 16 Leases
- ➔ IFRS 17 Insurance Contracts
- ➔ IFRIC 23 Uncertainty over Income Tax Treatments

1.23 CRITICAL ACCOUNTING ESTIMATES AND JUDGEMENTS

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The following are the critical judgements, apart from those involving estimations (see below), that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Land and buildings have been inspected and revalued by a qualified valuer as part of the Trust’s quinquennial revaluation exercise.

Information provided by NHS Resolution has been used to determine provisions required for potential employer liability claims and disclosure of clinical negligence liability.

The NHS Pensions Agency has provided information with regard to disclosure and calculation of ill health retirement liability.

Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

These valuations are judgemental and future events (such as a change in economic conditions) could cause these valuations to change. Non-current assets relating to land and buildings had a carrying value of £44.9m as at 31 March 2019 (31 March 2018: £40.9m). The Trust undertakes a full valuation exercise every five years.

2. OPERATING SEGMENTS

Each segment is reported separately in the monthly Board report. Emergency Services include the 999 service, NHS 111 call handling, Education and Training and the Hazardous Area Response Team. Non-Emergency Services include non-emergency Patient Transport Services (PTS) and Logistic Services. Direct costs include employee and non-employee costs (staff costs, drugs, medical equipment, vehicle costs, etc.). The Trust only reports contribution before overheads by service line reporting to the Trust Board at public Board meetings.

	Emergency Services	Non-Emergency Services	Total
	2018/19	2018/19	2018/19
	£000	£000	£000
Income	174,611	51,378	225,989
Direct Costs	(134,064)	(47,203)	(181,267)
Contribution Operational Activities	40,547	4,175	44,722
Total Overheads			(33,365)
Depreciation and Amortisation			(8,294)
Total Costs Before Dividends and Interest			(41,659)
Operating Surplus/(Deficit)			3,063
	2017/18	2017/18	2017/18
	£000	£000	£000
Income	163,285	52,202	215,487
Direct Costs	(129,283)	(47,721)	(177,004)
Contribution Operational Activities	34,002	4,481	38,483
Total Overheads			(30,304)
Depreciation and Amortisation			(7,707)
Total Costs Before Dividends and Interest			(38,011)
Operating Surplus/(Deficit)			472

3. OPERATING INCOME FROM PATIENT CARE ACTIVITIES (GROUP)

3.1 INCOME FROM PATIENT CARE ACTIVITIES (BY NATURE)

	2018/19	2017/18
	£000	£000
Ambulance services		
A&E income	162,988	155,049
Patient transport services income	47,535	50,046
Other income	2,101	1,949
AfC pay award central funding	3,103	-
Total income from activities	215,727	207,044

All income from patient care activities derived from the Trust.

3.2 INCOME PATIENT CARE ACTIVITIES (BY SOURCE)

Income from patient care activities received from:	2018/19	2017/18
	£000	£000
NHS England	285	287
Clinical commissioning groups	207,872	200,960
Other NHS providers	3,326	3,136
NHS other	3,425	338
Local authorities	9	28
NHS injury scheme	378	425
Non NHS: other	432	1,870
Total income from activities	215,727	207,044
Of which:		
Related to continuing operations	215,727	207,044

Injury cost recovery income for impairment of receivables of 21.89% of all claims to reflect the percentage probability of not receiving the income. This is in line with the advice issued by the compensation recovery unit for 2018/19 as instructed by the GAM.

4.1 OTHER OPERATING INCOME (GROUP)

	2018/19	2017/18
	£000	£000
Education and training	1,311	1,552
Non-patient care services to other bodies	1,950	1,813
Provider sustainability/sustainability and transformation fund income (PSF/STF)	3,170	3,179
Income in respect of staff costs where accounted on gross basis	1,424	379
Other income*	2,408	1,651
Total other operating income	10,263	8,574
Of which:		
Related to continuing operations	10,263	8,443
Related to discontinued operations	-	131

*Other income includes £236k radio mast income (2017/18: £246k), £335k private event income (2017/18: £318k) and a grant of £800k from Milton Keynes Development Corporation to assist in financing the Milton Keynes Fire and Ambulance Hub, due for completion in 2019/20.

4.2 INCOME FROM ACTIVITIES ARISING FROM COMMISSIONER REQUESTED SERVICES

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2018/19	2017/18
	£000	£000
Income from services designated as commissioner requested services	162,988	155,049
Income from services not designated as commissioner requested services	52,739	51,995
Total other operating income	215,727	207,044

5.1 OPERATING EXPENSES (GROUP)

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	493	255
Purchase of healthcare from non-NHS bodies - Accident & Emergency	15,430	13,141
Purchase of healthcare from non-NHS bodies - Patient Transport	13,457	16,270
Staff and executive director costs	137,088	130,347
Remuneration of non-executive directors	212	260
Supplies and services - clinical (excluding drug costs)	3,524	3,579
Supplies and services - general	1,098	1,195
Drug costs (drugs inventory consumed & purchase of non-inventory drugs)	317	393
Consultancy costs	262	223
Establishment	3,297	3,919
Premises	3,825	3,233
Information technology	4,037	3,735
Transport (including patient travel)	18,337	16,985
Depreciation on property, plant and equipment	7,185	6,643
Amortisation on intangible assets	1,109	1,063
Impairments/(Reversal of impairments)	(580)	-
Increase/(decrease) in provision for impairment of receivables	28	7
Audit fees payable to the external auditor;		
audit services - statutory audit	32	32
other auditor remuneration (external auditor only)	27	15
Internal audit costs	79	70
Clinical negligence	1,526	1,174
Legal fees	91	224
Insurance	1,173	1,089
Education and training	999	1,071
Rentals under operating leases	7,069	6,775
Hospitality	15	18
Other services, e.g. external payroll*	2,508	2,098
Other	289	1,201
Total	222,927	215,015
Of which:		
Related to continuing operations	222,927	215,015

*Other services includes £2,346k from 111 managed service contract (2017/18: £1,933k)

5.2 OTHER AUDITOR REMUNERATION (GROUP)

	2018/19	2017/18
	£000	£000
Other auditor remuneration paid to the external auditor:		
All other assurance services	27	15
Total	27	15

5.3 LIMITATION ON AUDITOR'S LIABILITY (GROUP)

The limitation on auditor's liability for external audit work is £2m (2017/18: £2m)

6. IMPAIRMENT OF ASSETS (GROUP)

There were impairments in 2018/19 of £193k and reversal impairments of £773k which had been previously charged through I&E (2017/18: nil).

7.1 EMPLOYEE BENEFITS (GROUP)

	2018/19	2017/18
	Total	Total
	£000	£000
Salaries and wages	109,952	104,173
Social security costs	10,385	10,047
Apprenticeship levy	523	499
Employer's contributions to NHS pensions	13,462	12,988
Temporary staff (including agency)	2,766	2,640
Total gross staff costs	137,088	130,347
Recoveries in respect of seconded staff	-	-
Total staff costs	137,088	130,347

7.2 RETIREMENTS DUE TO ILL-HEALTH (GROUP)

During 2018/19 there were three early retirements from the Trust agreed on the grounds of ill-health (six in the year ended 31 March 2018). The estimated additional pension liability of these ill-health retirements is £90k (£300k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Further details of directors' remuneration can be found in the Remuneration Report which is included in the Trust Annual Report 2018/19.

In the year ended 31 March 2019, seven directors (2018: six) accrued benefits under a defined pension scheme.

During the year to 31 March 2019, the highest paid director was the Chief Executive who was paid a salary between £180k and £185k and was assessed as in receipt of benefit in kind of £6k.

8. PENSION COSTS

Past and present employees are covered by the provisions of the two NHS Pensions Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on the valuation data as at 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend the contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care has recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgement from the Court of

Appeal in December 2018, the Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

c) National Employment Savings Trust (NEST)

The Pensions Act 2008 introduced new duties on employers in providing access to a workplace pension for all of its employees. The NHS Pension Scheme is not available to all employees and the Trust has provided access to a scheme for these employees which is operated by the National Employment Savings Trust (NEST). NEST is a defined contribution scheme where a minimum contribution is paid by the employer. South Central Ambulance Service NHS Foundation Trust currently contributes 2% of qualifying earnings to the scheme and employees contribute 3% of pensionable pay.

NEST levies a contribution charge of 1.8% and an annual management charge of 0.3% which is paid from the employer contributions. There are no separate employer charges levied by NEST and the Trust is not required to enter into a contract to utilise NEST qualifying pension schemes.

Staff who are recruited by South Central Fleet Services Ltd will be auto-enrolled into the NEST Pension Scheme.

9. OPERATING LEASES (GROUP)

9.1 SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST AS A LESSOR

The Group had no operating lease income in 2018/19 (2017/18: nil).

9.2 SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST AS A LESSEE

This note discloses costs and commitments incurred in operating lease arrangements where South Central Ambulance Service NHS Foundation Trust is the lessee.

	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	7,069	6,775
Less sublease payments received	-	-
Total	7,069	6,775
	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due relating to building leases:		
- not later than one year;	2,373	2,396
- later than one year and not later than five years;	8,507	7,705
- later than five years.	11,420	11,356
Total	22,300	21,457
	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due relating to other leases:		
- not later than one year;	2,407	2,778
- later than one year and not later than five years;	2,949	5,098
- later than five years.	-	-
Total	5,356	7,876

The figures in the table above are identical for both the Group and the Trust.

10. FINANCE INCOME (GROUP)

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

	2018/19 £000	2017/18 £000
Interest on bank accounts	136	56
Total	136	56

11.1 FINANCE EXPENDITURE (GROUP)

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

	2018/19 £000	2017/18 £000
Interest expense:		
Loans from the Department of Health and Social Care	45	78
Total interest expense	45	78
Unwinding of discount on provisions	(30)	9
Total finance costs	15	87

11.2 THE LATE PAYMENT OF COMMERCIAL DEBTS (INTEREST) ACT 1998 / PUBLIC CONTRACT REGULATIONS 2015

No interest payments were made by the Group in the reporting period.

12. OTHER GAINS / (LOSSES) (GROUP)

	2018/19 £000	2017/18 £000
Gains/(losses) on disposal of assets	(47)	2,288
Total gains/(losses) on disposal of assets	(47)	2,288

13. CORPORATION TAX

The Trust has determined that it has no corporation tax liability from its subsidiary, South Central Fleet Services Ltd, in the qualifying period. The Trust does not have any other qualifying income from any of its other activities.

14. DISCONTINUED OPERATIONS (GROUP)

	2018/19 £000	2017/18 £000
Movement in provisions for liabilities on discontinued operations	-	131
Total	-	131

The Trust is the appointed successor body to NHS Direct which ceased providing services on 31 March 2014.

15.1 INTANGIBLE ASSETS 2018/19 - GROUP

	Software	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	8,579	1,307	9,886
Additions	299	390	689
Reclassifications	1,412	(1,412)	-
Disposals / de-recognition	(781)	-	(781)
Valuation / gross cost at 31 March 2019	9,509	285	9,794
Amortisation at 1 April 2018 - brought forward	6,513	-	6,513
Provided during the year	1,109	-	1,109
Disposals / de-recognition	(775)	-	(775)
Amortisation at 31 March 2019	6,847	-	6,847
Net book value at 31 March 2019	2,662	285	2,947
Net book value at 1 April 2018	2,066	1,307	3,373

15.2 INTANGIBLE ASSETS 2017/18 - GROUP

	Software	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	7,686	1,458	9,144
Additions	275	467	742
Reclassifications	618	(618)	-
Disposals / de-recognition	-	-	-
Valuation / gross cost at 31 March 2018	8,579	1,307	9,886
Amortisation at 1 April 2017 - as previously stated	5,450	-	5,450
Provided during the year	1,063	-	1,063
Disposals / de-recognition	-	-	-
Amortisation at 31 March 2018	6,513	-	6,513
Net book value at 31 March 2018	2,066	1,307	3,373
Net book value at 1 April 2017	2,236	1,458	3,694

15.3 INTANGIBLE ASSETS 2018/19 - TRUST

	Software	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	8,447	1,307	9,754
Additions	299	390	689
Reclassifications	1,412	(1,412)	-
Disposals / de-recognition	(781)	-	(781)
Valuation / gross cost at 31 March 2019	9,377	285	9,662
Amortisation at 1 April 2018 - brought forward	6,389	-	6,389
Provided during the year	1,102	-	1,102
Disposals / de-recognition	(776)	-	(776)
Amortisation at 31 March 2019	6,715	-	6,715
Net book value at 31 March 2019	2,662	285	2,947
Net book value at 1 April 2018	2,058	1,307	3,365

15.4 INTANGIBLE ASSETS 2017/18 - TRUST

	Software	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	7,563	1,458	9,021
Additions	266	467	733
Reclassifications	618	(618)	-
Disposals / de-recognition	-	-	-
Valuation / gross cost at 31 March 2018	8,447	1,307	9,754
Amortisation at 1 April 2017 - brought forward	5,344	-	5,344
Provided during the year	1,045	-	1,045
Disposals / de-recognition	-	-	-
Amortisation at 31 March 2018	6,389	-	6,389
Net book value at 31 March 2018	2,058	1,307	3,365
Net book value at 1 April 2017	2,219	1,458	3,677

16.1 PROPERTY, PLANT AND EQUIPMENT 2018/19 - GROUP

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2018 - brought forward	9,139	40,549	1,946	14,378	43,372	8,521	1,437	119,342
Additions	-	1,230	2,497	892	3,870	275	15	8,779
Reclassifications	-	824	(1,433)	5	197	366	41	-
Revaluations	436	421	-	-	-	-	-	857
Reversals of impairments	524	56	-	-	-	-	-	580
Disposals / de-recognition	-	(49)	-	(1,610)	(11,431)	(1,246)	(12)	(14,348)
Valuation/gross cost at 31 March 2019	10,099	43,031	3,010	13,665	36,008	7,916	1,481	115,210
Accumulated depreciation at 1 April 2018 - brought forward	-	8,828	-	9,711	27,550	6,912	1,019	54,020
Provided during the year	-	1,852	-	1,124	3,404	704	101	7,185
Revaluations	-	(2,404)	-	-	-	-	-	(2,404)
Disposals / de-recognition	-	(23)	-	(1,577)	(11,287)	(1,245)	(11)	(14,143)
Accumulated depreciation at 31 March 2019	-	8,253	-	9,258	19,667	6,371	1,109	44,658
Net book value at 31 March 2019	10,099	34,778	3,010	4,407	16,341	1,545	372	70,552
Net book value at 1 April 2018	9,139	31,721	1,946	4,667	15,822	1,609	418	65,322

For land and buildings the Trust uses a qualified professional valuer FRICS independent of the Trust provided by Bomford Estates. They provide on an annual basis indices for use in valuing land and buildings. The Trust undertakes a full valuation exercise every five years. The latest quinquennial exercise was undertaken as at 31 March 2019. The carrying value of land under the cost model is £10.009m, the carrying value of buildings under the cost model is £34.778m.

16.2 PROPERTY, PLANT AND EQUIPMENT 2017/18 - GROUP

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2017 – brought forward	9,139	36,678	3,364	13,769	40,137	7,884	1,436	112,407
Additions	-	2,599	1,864	682	3,784	447	1	9,377
Reclassifications	-	1,302	(3,282)	610	1,180	190	-	-
Disposals / de-recognition	-	(30)	-	(683)	(1,729)	-	-	(2,442)
Valuation/gross cost at 31 March 2018	9,139	40,549	1,946	14,378	43,372	8,521	1,437	119,342
Accumulated depreciation at 1 April 2017 – brought forward	-	7,385	-	9,186	26,321	6,003	924	49,819
Provided during the year	-	1,473	-	1,208	2,958	909	95	6,643
Disposals / de-recognition	-	(30)	-	(683)	(1,729)	-	-	(2,442)
Accumulated depreciation at 31 March 2018	-	8,828	-	9,711	27,550	6,912	1,019	54,020
Net book value at 31 March 2018	9,139	31,721	1,946	4,667	15,822	1,609	418	65,322
Net book value at 1 April 2017	9,139	29,293	3,364	4,583	13,816	1,881	512	62,588

16.3 PROPERTY, PLANT AND EQUIPMENT FINANCING 2018/19 - GROUP

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019								
Owned - purchased	9,111	33,773	3,010	4,407	16,341	1,545	372	68,559
Owned - donated	988	1,005	-	-	-	-	-	1,993
NBV total at 31 March 2019	10,099	34,778	3,010	4,407	16,341	1,545	372	70,552

16.4 PROPERTY, PLANT AND EQUIPMENT FINANCING 2017/18 - GROUP

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	8,235	30,861	1,946	4,667	15,822	1,609	418	63,558
Owned - donated	904	860	-	-	-	-	-	1,764
NBV total at 31 March 2018	9,139	31,721	1,946	4,667	15,822	1,609	418	65,322

16.5 PROPERTY, PLANT AND EQUIPMENT 2018/19 - TRUST

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	9,139	40,549	1,669	13,871	37,639	8,254	1,437	112,558
Adjustments to opening balance*	-	-	-	(244)	(1,729)	-	-	(1,973)
Additions	-	619	2,440	308	55	275	15	3,712
Reclassifications	-	773	(1,185)	5	-	366	41	-
Reversals of impairments	524	56	-	-	-	-	-	580
Revaluations	436	421	-	-	-	-	-	857
Disposals / de-recognition	-	(49)	-	(1,578)	(11,320)	(1,246)	(12)	(14,205)
Valuation/gross cost at 31 March 2019	10,099	42,369	2,924	12,362	24,645	7,649	1,481	101,529
Accumulated depreciation at 1 April 2018 - brought forward	-	8,828	-	9,870	28,682	6,912	1,019	55,311
Adjustments to opening balance*	-	-	-	(244)	(1,729)	-	-	(1,973)
Provided during the year	-	1,830	-	1,035	2,397	637	101	6,000
Revaluations	-	(2,404)	-	-	-	-	-	(2,404)
Disposals / de-recognition	-	(23)	-	(1,570)	(11,284)	(1,245)	(11)	(14,133)
Accumulated depreciation at 31 March 2019	-	8,231	-	9,091	18,066	6,304	1,109	42,801
Net book value at 31 March 2019	10,099	34,138	2,924	3,271	6,579	1,345	372	58,728
Net book value at 1 April 2018	9,139	31,721	1,669	4,001	8,957	1,342	418	57,247

*Adjustment to the gross cost and accumulated depreciation to correct a publishing error in the 2015/16 accounts and the 2017/18 accounts. For land and buildings the Trust uses a qualified professional valuer FRICS independent of the Trust provided by Bomford Estates. They provide an annual basis indices for use in valuing land and buildings. The Trust undertakes a full valuation exercise every five years. The latest quinquennial exercise was undertaken as at 31 March 2019. The carrying value of land under the cost model is £10.009m, the carrying value of buildings under the cost model is £34.138m.

16.6 PROPERTY, PLANT AND EQUIPMENT 2017/18 - TRUST

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2017 - brought forward	9,139	36,678	2,091	13,061	37,639	7,884	1,436	107,928
Additions	-	2,599	1,587	293	-	180	1	4,660
Reclassifications	-	1,302	(2,009)	517	-	190	-	-
Disposals / de-recognition	-	(30)	-	-	-	-	-	(30)
Valuation/gross cost at 31 March 2018	9,139	40,549	1,669	13,871	37,639	8,254	1,437	112,558
Accumulated depreciation at 1 April 2017 - brought forward	-	7,385	-	8,702	26,071	6,003	924	49,085
Impairments	-	1,473	-	1,168	2,611	909	95	6,256
Disposals / de-recognition	-	(30)	-	-	-	-	-	(30)
Accumulated depreciation at 31 March 2018	-	8,828	-	9,870	28,682	6,912	1,019	55,311
Net book value at 31 March 2018	9,139	31,721	1,669	4,001	8,957	1,342	418	57,247
Net book value at 1 April 2017	9,139	29,293	2,091	4,359	11,568	1,881	512	58,843

16.7 PROPERTY, PLANT AND EQUIPMENT FINANCING 2018/19 - TRUST

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2019								
Owned - purchased	9,111	33,133	2,924	3,271	6,579	1,345	372	56,735
Owned - donated	988	1,005	-	-	-	-	-	1,993
NBV total at 31 March 2019	10,099	34,138	2,924	3,271	6,579	1,345	372	58,728

16.8 PROPERTY, PLANT AND EQUIPMENT FINANCING 2017/18 - TRUST

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2018								
Owned - purchased	8,235	30,861	1,669	4,001	8,957	1,342	418	55,483
Owned - donated	904	860	-	-	-	-	-	1,764
NBV total at 31 March 2018	9,139	31,721	1,669	4,001	8,957	1,342	418	57,247

17. INVESTMENTS IN SUBSIDIARIES

South Central Ambulance Service NHS Foundation Trust purchased 441,310 ordinary shares of £1 each in South Central Fleet Services Ltd.

This represents a 100% direct ownership of South Central Fleet Services Ltd which is incorporated in England and Wales. This subsidiary company is included in the consolidation.

18. INVENTORIES

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Consumables	825	771	489	430
Energy	137	139	137	139
Total inventories	962	910	626	569

Inventories recognised in expenses for the year were £0k (2017/18: £28k). Write-down of inventories recognised as expenses for the year were £52k (2017/18: £57k).

19. RECEIVABLES

19.1 TRADE RECEIVABLES AND OTHER RECEIVABLES

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Current				
Contract receivables*	8,437	-	8,425	-
Trade receivables*	-	2,841	-	2,841
Capital receivables (including accrued capital related income)	65	2,511	65	2,511
Accrued income	-	5,267	-	5,267
Capital deposit in advance	270	-	270	-
Allowance for impairment contract receivables / assets*	(377)	-	(377)	-
Provision for impaired receivables*	-	(349)	-	(349)
Prepayments (non-PFI)	3,216	3,204	3,166	3,165
Interest receivable	14	7	14	7
PDC dividend receivable	30	101	30	101
VAT receivable	554	803	575	499
Other receivables	1,172	1,551	1,160	1,227
Total current trade and other receivables	13,381	15,936	13,328	15,269

Of which receivables from NHS and DHSC group bodies:

Current	6,972	7,039	6,972	7,039
Non-current	-	-	-	-

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

The Trust had no non-current trade or other receivables.

The majority of trade receivables are due from clinical commissioning groups, as commissioners for NHS patient care services. As clinical commissioning groups are funded by Government no credit scoring of them is considered necessary.

19.2 ALLOWANCES FOR CREDIT LOSSES – 2018/19

	Group		Trust	
	Contract Receivables and Contract Assets	All Other Receivables	Contract Receivables and Contract Assets	All Other Receivables
	£000	£000	£000	£000
Allowances as at 1 April 2018 – brought forward	-	349	-	349
Impact of implementing IFRS9 (and IFRS 15) on 1 April 2018	349	(349)	349	(349)
Changes in existing				
allowances	40	-	40	-
Utilisation of allowances (write offs)	(12)	-	(12)	-
At 31 March 2019	377	-	377	-

The provision relates to £217k injury cost recovery (2017/18: £229k), £60k trade receivables (2017/18: £41k) and £100k overpaid salaries (2017/18: £79k)

20. OTHER FINANCIAL ASSETS

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Non-current				
Share capital	-	-	441	441
Loans and receivables	-	-	10,851	7,395
Total other non-current assets	-	-	11,292	7,836
Current				
Loans and receivables	-	-	1,497	1,300
Total other current assets	-	-	1,497	1,300

Other financial assets represent six loans made to South Central Fleet Services Ltd to purchase ambulances and one loan for the refurbishment of the Milton Park premises. The Trust has made a total of seven loans of £14,670k which range from 5-10 years, all attracting interest of 3.5%.

21. NON-CURRENT ASSETS HELD FOR SALE AND ASSETS IN DISPOSAL GROUPS

	Group		Trust	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	-	2,700	-	2,700
Assets sold in year	-	(2,700)	-	(2,700)
Impairment of assets held for sale	-	-	-	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>

22.1 CASH AND CASH EQUIVALENT MOVEMENTS

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2018/19	2017/18	2018/19	2017/18
	£000	£000	£000	£000
At 1 April	17,632	20,272	17,529	19,921
Transfers by absorption	-	-	-	-
Net change in year	4,942	(2,640)	4,773	(2,392)
At 31 March	<u>22,574</u>	<u>17,632</u>	<u>22,302</u>	<u>17,529</u>
Broken down into:				
Cash at commercial banks and in hand	272	124	-	21
Cash with the Government Banking Service	22,302	17,508	22,302	17,508
Deposits with the National Loan Fund	-	-	-	-
Other current investments	-	-	-	-
Total cash and cash equivalents as in SoFP	<u>22,574</u>	<u>17,632</u>	<u>22,302</u>	<u>17,529</u>
Bank overdrafts (GBS and commercial banks)	-	-	-	-
Drawdown in committed facility	-	-	-	-
Total cash and cash equivalents as in SoCF	<u>22,574</u>	<u>17,632</u>	<u>22,302</u>	<u>17,529</u>

22.2 THIRD PARTY ASSETS

The Group held no third party assets as at 31 March 2019 (31 March 2018: nil).

23.1 TRADE AND OTHER PAYABLES

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Current				
Trade payables	1,661	1,036	2,506	1,036
Capital payables	926	591	879	511
Accruals	14,044	13,061	13,435	13,133
Social security costs	1,618	1,559	1,598	1,540
Other taxes payable	1,065	1,035	1,041	1,015
Accrued interest on loans*	-	15	-	15
Other payables	24	115	26	115
Total current trade and other payables	<u>19,338</u>	<u>17,412</u>	<u>19,485</u>	<u>17,365</u>
Non-current				
Other payables	6	13	6	13
Total non-current trade and other payables	<u>6</u>	<u>13</u>	<u>6</u>	<u>13</u>
Of which payables from NHS and DHSC group bodies:				
Current	903	993	903	993
Non-current	-	-	-	-

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 24. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Accruals include £1,795k outstanding pension contributions as at 31 March 2019 (31 March 2018: £1,737k).

23.2 EARLY RETIREMENTS IN NHS PAYABLES ABOVE

There were no early retirement payments in the above.

23.3 BETTER PAYMENT PRACTICE CODE

Measure of compliance	March 2019 Number	March 2019 £000	March 2018 Number	March 2018 £000
Non-NHS payables				
Total non-NHS trade invoices paid in the year	40,733	123,512	43,739	123,470
Total non-NHS trade invoices paid within target	37,494	118,669	39,192	117,130
Percentage of non-NHS trade invoices paid within target	92.0%	96.1%	89.6%	94.9%
NHS payables				
Total NHS trade invoices paid in the year	640	4,562	634	3,231
Total NHS trade invoices paid within target	593	4,468	584	3,147
Percentage of NHS trade invoices paid within target	92.7%	97.9%	92.1%	97.4%

The Trust will continue to try to pay invoices from its suppliers promptly and will strive to pay all valid invoices by the due date, or within 30 days of receipt of invoice in accordance with the Better Payment Practice Code.

24.1 BORROWINGS

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
Current				
Loans from DHSC	1,407	1,740	1,407	1,740
Other loans	-	-	-	-
Total current borrowings	1,407	1,740	1,407	1,740
Non-current				
Loans from DHSC	-	1,400	-	1,400
Other loans	-	-	-	-
Total non-current borrowings	-	1,400	-	1,400

The Trust has one capital loan of £7,000k (payable over five years) taken out in 2014/15 at an interest rate of 1.48%.

24.2 RECONCILIATION OF LIABILITIES ARISING FROM FINANCING ACTIVITIES

	Group		Trust	
	DHSC £000	Total £000	DHSC £000	Total £000
Carrying value at 1 April 2018	3,140	3,140	3,140	3,140
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,740)	(1,740)	(1,740)	(1,740)
Financing cash flows - payments of interest	(45)	(45)	(45)	(45)
Non-cash movements:				
Impact of implementing IFRS 9 on 1 April 2018	15	15	15	15
Application of effective interest rate	37	37	37	37
Carrying value as at 31 March 2019	1,407	1,407	1,407	1,407

25.1 PROVISIONS FOR LIABILITIES AND CHARGES ANALYSIS (GROUP)

Group	Pensions - early departure costs £000	Pensions - Injury benefits £000	Legal claims £000	Re-structuring £000	Other * £000	Total £000
At 1 April 2018	3,497	129	288	484	5,823	10,221
Change in the discount rate	(47)	-	-	-	-	(47)
Arising during the year	200	5	-	-	4,209	4,414
Utilised during the year	(191)	(22)	-	(179)	(944)	(1,336)
Reversed unused	(243)	-	(208)	(165)	(1,146)	(1,762)
Unwinding of discount	(30)	-	-	-	-	(30)
At 31 March 2019	3,186	112	80	140	7,942	11,460
Expected timing of cash flows:						
- not later than one year;	219	22	80	140	5,839	6,300
- later than one year and not later than five years;	698	76	-	-	723	1,497
- later than five years.	2,269	14	-	-	1,380	3,663
Total	3,186	112	80	140	7,942	11,460

*Other provisions include £1,918k ongoing costs arising from the management of closure activities including the retention of clinical records, £4,632k staff related costs, £494k property dilapidations, and £898k provision for credit notes.

25.2 PROVISIONS FOR LIABILITIES AND CHARGES ANALYSIS (TRUST)

Trust	Pensions - early depart- ure costs	Pensions - Injury benefits	Legal claims	Re-structuring	Other *	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2018	3,497	129	288	146	5,790	9,850
Change in the discount rate	(47)	-	-	-	-	(47)
Arising during the year	200	5	-	-	4,209	4,414
Utilised during the year	(191)	(22)	-	-	(934)	(1,147)
Reversed unused	(243)	-	(208)	(146)	(1,123)	(1,720)
Unwinding of discount	(30)	-	-	-	-	(30)
At 31 March 2019	3,186	112	80	-	7,942	11,320
Expected timing of cash flows:						
- not later than one year;	219	22	80	-	5,839	6,160
- later than one year and not later than five years;	698	76	-	-	723	1,497
- later than five years.	2,269	14	-	-	1,380	3,663
Total	3,186	112	80	-	7,942	11,320

*Other provisions include £1,918k ongoing costs arising from the management of closure activities including the retention of clinical records, £4,632k staff related costs, £494k property dilapidations, and £898k provision for credit notes.

26. CLINICAL NEGLIGENCE LIABILITIES

At 31 March 2019, £39,089k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of South Central Ambulance Service NHS Foundation Trust (31 March 2018: £39,387k).

27. CONTINGENT ASSETS AND LIABILITIES

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Value of contingent liabilities				
NHS Resolution legal claims	(84)	(70)	(84)	(70)
Other	-	-	-	-
Gross value of contingent liabilities	(84)	(70)	(84)	(70)
Amounts recoverable against liabilities	-	-	-	-
Net value of contingent liabilities	(84)	(70)	(84)	(70)
Net value of contingent assets	-	-	-	-

28. CONTRACTUAL CAPITAL COMMITMENTS

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Property, plant and equipment	462	112	462	112
Intangible assets	333	334	333	334
Total	795	446	795	446

29. FINANCIAL INSTRUMENTS

29.1 FINANCIAL RISK MANAGEMENT

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with clinical commissioning groups and the way those clinical commissioning groups are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust's borrowings are from Government; the borrowings are for 1-10 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2019 are in receivables from customers, as disclosed in the trade and other receivables note. The Trust's procurement process is robust and the Trust restricts prepayments to suppliers. The Trust is not exposed to significant liquidity risks.

29.2 CARRYING VALUES OF FINANCIAL ASSETS

Group	Loans and receivables £000	Available-for- sale £000	Total book value £000
Assets as per SoFP as at 31 March 2019			
Trade and other receivables with NHS and DHSC bodies excluding non-financial assets	6,942	-	6,942
Trade and other receivables with other bodies excluding non-financial assets	2,369	-	2,369
Cash and cash equivalents	22,574	-	22,574
Total at 31 March 2019	31,885	-	31,885

Group	Loans and receivables £000	Available-for- sale £000	Total book value £000
Assets as per SoFP as at 31 March 2018			
Trade and other receivables with NHS and DHSC bodies excluding non-financial assets	6,938	-	6,938
Trade and other receivables with other bodies excluding non-financial assets	4,692	-	4,692
Cash and cash equivalents	17,632	-	17,632
Total at 31 March 2018	29,262	-	29,262

Trust	Loans and receivables £000	Available- for-sale £000	Total book value £000
Assets as per SoFP as at 31 March 2019			
Trade and other receivables with NHS and DHSC bodies excluding non-financial assets	6,942	-	6,942
Trade and other receivables with other bodies excluding non-financial assets	2,169	-	2,169
Other investments	441	-	441
Cash and cash equivalents	22,302	-	22,302
Total at 31 March 2018	31,854	-	31,854

Trust	Loans and receivables £000	Available- for-sale £000	Total book value £000
Assets as per SoFP as at 31 March 2018			
Trade and other receivables with NHS and DHSC bodies excluding non-financial assets	6,938	-	6,938
Trade and other receivables with other bodies excluding non-financial assets	4,506	-	4,506
Other investments	441	-	441
Cash and cash equivalents	17,529	-	17,529
Total at 31 March 2018	29,414	-	29,414

29.3 CARRYING VALUES OF FINANCIAL LIABILITIES

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

Group	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total book value £000
Liabilities as per SoFP as at 31 March 2019			
Borrowings excluding finance lease and PFI liabilities	1,407	-	1,407
Trade and other payables with NHS and DHSC bodies excluding non-financial liabilities	903	-	903
Trade and other payables with other bodies excluding non-financial liabilities	15,563	-	15,563
Provisions under contract	2,411	-	2,411
Total at 31 March 2019	20,284	-	20,284

Group	Other financial liabilities £000	Liabilities at fair value through the I&E £000	Total book value £000
Liabilities as per SoFP as at 31 March 2018			
Borrowings excluding finance lease and PFI liabilities	3,140	-	3,140
Trade and other payables with NHS and DHSC bodies excluding non-financial liabilities	1,072	-	1,072
Trade and other payables with other bodies excluding non-financial liabilities	11,259	-	11,259
Provisions under contract	3,690	-	3,690
Total at 31 March 2018	19,161	-	19,161

Trust	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2019			
Borrowings excluding finance lease and PFI liabilities	1,407	-	1,407
Trade and other payables with NHS and DHSC bodies excluding non-financial liabilities	903	-	903
Trade and other payables with other bodies excluding non-financial liabilities	15,759	-	15,759
Provisions under contract	2,411	-	2,411
Total at 31 March 2019	20,480	-	20,480

Trust	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Borrowings excluding finance lease and PFI liabilities	3,140	-	3,140
Trade and other payables with NHS and DHSC bodies excluding non-financial liabilities	1,071	-	1,071
Trade and other payables with other bodies excluding non-financial liabilities	15,446	-	15,446
Provisions under contract	3,690	-	3,690
Total at 31 March 2018	23,347	-	23,347

29.4 FAIR VALUES OF FINANCIAL ASSETS AND LIABILITIES

The Group held no non-current financial assets as at 31 March 2019 (31 March 2018: nil).

The carrying amount of the following financial assets and liabilities is considered a reasonable approximation of fair value:

- ➔ Cash and cash equivalents
- ➔ Trade and other receivables
- ➔ Trade and other payables

29.5 MATURITY OF FINANCIAL LIABILITIES

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
In one year or less	18,182	15,475	18,378	19,661
In more than one year but not more than two years	259	1,729	259	1,729
In more than two years but not more than five years	387	411	387	411
In more than five years	1,456	1,546	1,456	1,546
Total	20,284	19,161	20,480	23,347

30. LOSSES AND SPECIAL PAYMENTS

	2018/19		2017/18	
Group and Trust	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	-	-
Bad debts and claims abandoned	-	-	-	-
Stores losses and damage to property	2	140	101	283
Total losses	2	140	101	283
Special payments				
Ex-gratia payments	-	-	-	-
Total special payments	-	-	-	-
Total losses and special payments	2	140	101	283

All losses are derived from the Trust.

Note: all losses and special payments are on an accruals basis but exclude provision for future losses.

The 2017/18 figures include uninsured vehicle accident costs of £281k covering 100 cases so the comparative to 2018/19 is one case at £2k.

31. PRIOR PERIOD ADJUSTMENTS

There were no prior period adjustments.

32. EVENTS AFTER THE REPORTING DATE

There were no events after the reporting date.

33. RELATED PARTIES

During the year none of the Board members or members of the key management staff or parties related to them has undertaken any material transactions with South Central Ambulance Service NHS Foundation Trust.

The Department of Health and Social Care is regarded as a related party. During the year South Central Ambulance Service NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

Health Education England	NHS North Hampshire CCG
Oxford University Hospital NHS Foundation Trust	NHS Slough CCG
Buckinghamshire Healthcare NHS Trust	NHS Berkshire West CCG
Isle of Wight NHS Trust	NHS East Berkshire CCG
NHS Oxfordshire CCG	NHS North West Surrey CCG
NHS West Hampshire CCG	NHS North East Hampshire & Farnham CCG
NHS Buckinghamshire CCG	NHS High Weald Lewes Havens CCG
NHS Southampton CCG	NHS Brighton & Hove CCG
NHS Milton Keynes CCG	NHS Hastings & Rother CCG
NHS Fareham & Gosport CCG	NHS Coastal West Sussex CCG
NHS Portsmouth CCG	NHS Crawley CCG
NHS South Eastern Hampshire CCG	NHS Horsham & Mid Sussex CCG
	NHS Eastbourne, Hailsham & Seaford CCG

South Central Ambulance Service NHS Foundation Trust entered into the following transactions during the year with its wholly owned subsidiary, South Central Fleet Services Ltd:

Payments to South Central Fleet Services Ltd £8.126m (2017/18: £6.444m)
Receipts from South Central Fleet Services Ltd £0.393m (2017/18: £0.579m)
Amounts owed to South Central Fleet Services Ltd as at 31 March 2019 £0.383m (2017/18: £0.366m)
Amounts owed from South Central Fleet Services Ltd as at 31 March 2019 £nil (2017/18: £nil)

During the year South Central Ambulance Service NHS Foundation Trust loaned South Central Fleet Services Ltd £5.15m with an interest of 3.5%. At the end of the year South Central Fleet Services Ltd owed South Central Ambulance Services NHS Foundation Trust £12.789m in outstanding loans (2017/18: £9.136m).

During the period South Central Ambulance Service NHS Foundation Trust Charity had total assets of £618k as at 31 March 2019 (2017/18: £729k). During 2018/19 the Charity received income of £373k (2017/18: £558k) and incurred expenditure of £484k (2017/18: £545k). The results for 31 March 2019 are provisional and unaudited at this stage.

34 NEW STANDARDS

34.1 INITIAL APPLICATION OF IFRS 9

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

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

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £15k, and trade payables correspondingly reduced.

The GAM extends the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £349k.

34.2 INITIAL APPLICATION OF IFRS 15

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

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

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

ACCOUNTING OFFICER'S STATEMENT OF RESPONSIBILITIES

Statement of the Chief Executive's responsibilities as the Accounting Officer of South Central Ambulance Service NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS foundation trust.

The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require South Central Ambulance Service NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions.

The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of South Central Ambulance Service NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- ➔ Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- ➔ Make judgements and estimates on a reasonable basis
- ➔ State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ➔ Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- ➔ Confirm that the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy
- ➔ Prepare the financial statements on a going concern basis

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act.

The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.



Signed

Will Hancock, Chief Executive

Date: 23 May 2019

INDEPENDENT PRACTITIONER'S LIMITED ASSURANCE REPORT TO THE COUNCIL OF GOVERNORS OF SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of South Central Ambulance Service NHS Foundation Trust to perform an independent limited assurance engagement in respect of South Central Ambulance Service NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and additional supporting guidance in the 'Detailed requirements for quality reports 2018/19' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- ➔ Category 1 (C1) – Life-threatening calls – the mean average response time across all incidents coded as C1 that received a response on scene; and
- ➔ Category 2 (C2) – Emergency calls – the mean average response time across all incidents coded as C2 that received a response on scene.

We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- ➔ the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance;
- ➔ the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2018/19'; 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 2018/19' and supporting guidance and the six dimensions of data quality set out in the 'Detailed requirements for external assurance for quality reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- ➔ Board minutes for the period 1 April 2018 to the date of the signing of the limited assurance report;
- ➔ papers relating to quality reported to the Board over the period 1 April 2018 to the date of the signing of the limited assurance report;
- ➔ feedback from commissioners dated 01/03/2019 and 08/03/2019;
- ➔ feedback from governors dated 10/01/2019;
- ➔ feedback from local Healthwatch organisations dated 13/02/2019;
- ➔ feedback from the Overview and Scrutiny Committee dated 22/05/2019;
- ➔ the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated 25/07/2018, 25/10/2018, 23/01/2019 and 25/04/2019;
- ➔ the national staff survey dated 06/03/2019;
- ➔ the Head of Internal Audit's annual opinion over the Trust's control environment dated 26/04/2019; and
- ➔ the Care Quality Commission's inspection report dated 06/11/2018

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of South Central Ambulance Service NHS Foundation Trust as a body, to assist the Council of Governors in reporting South Central Ambulance Service NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and South Central Ambulance Service NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- ➔ evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- ➔ making enquiries of management;
- ➔ limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation;
- ➔ comparing the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance to the categories reported in the Quality Report; and
- ➔ reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by South Central Ambulance Service NHS Foundation Trust.

Our audit work on the financial statements of South Central Ambulance Service NHS Foundation Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as South Central Ambulance Service NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to South Central Ambulance Service NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to South Central Ambulance Service NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose.

Our audits of South Central Ambulance Service NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest

extent permitted by law, we do not accept or assume any responsibility to anyone other than South Central Ambulance Service NHS Foundation Trust and South Central Ambulance Service NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- ➔ 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 2018/19' and supporting guidance;
- ➔ the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2018/19'; and
- ➔ the indicators in the Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance.

Grant Thornton UK LLP
Chartered Accountants
30 Finsbury Square
London
EC2A 1AG
24 May 2019

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF SOUTH CENTRAL AMBULANCE SERVICE NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

OPINION

Our opinion on the financial statements is unmodified

We have audited the financial statements of South Central Ambulance Service NHS Foundation Trust (the 'Trust') and its subsidiary (the 'group') for the year ended 31 March 2019 which comprise the Statement of Financial Position, the Statement of Comprehensive Income, the Statement of Changes in Equity (Group), the Statement of Changes in Equity (Trust), the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Accounts Directions issued under the National Health Service Act 2006, the NHS foundation trust annual reporting manual 2018/19 and the Department of Health and Social Care group accounting manual 2018/19.

In our opinion the financial statements:

- ➔ give a true and fair view of the financial position of the group and of the Trust as at 31 March 2019 and of the group's expenditure and income and the Trust's expenditure and income for the year then ended;
- ➔ have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care group accounting manual 2018/19; and
- ➔ have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the group and the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- ➔ the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- ➔ the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the group's or the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Overview of our audit approach

Financial statements audit

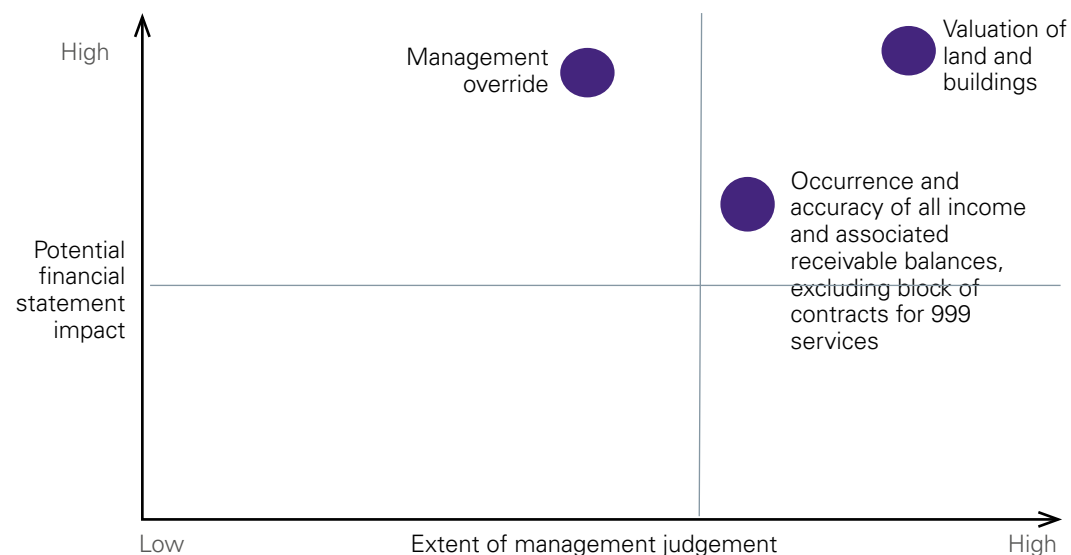
- ➔ Overall materiality: £4,300,000, which represents 1.9% of the group's gross operating costs (consisting of operating expenses and finance expenses);
- ➔ Key audit matters were identified as:
 - Occurrence and accuracy of all income and associated receivable balances, excluding block contracts for 999 services
 - Valuation of land and buildings, in particular revaluations and impairments
- ➔ The group consists of two components – the Trust and its wholly-owned subsidiary company, South Central Fleet Services Ltd
- ➔ Audit testing was performed on classes of transactions, account balances, or disclosures relating to the subsidiary which were material to the group position. There have been no changes in the scope of the group audit from the prior year.
- ➔ 100% of group income, 100% of group expenditure and 90% of group assets and liabilities were subject to testing during the audit.

Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

- ➔ We identified two significant risks in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources relating to sustainable resource deployment (see Report on other legal and regulatory requirements section).

Key audit matters

The graph below depicts the audit risks identified and their relative significance based on the extent of the financial statement impact and the extent of management judgement.



Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current year and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those that had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key Audit Matter – Trust	How the matter was addressed in the audit – Trust
<p>Occurrence and accuracy of income and associated receivable balances other than that from fixed block contract elements of 999 patient care contracts.</p> <p>The group’s significant income streams are operating income from patient care activities and other operating income.</p> <p>Approximately 96% of the Trust income is from patient care activities and contracts with NHS commissioners. These contracts include the rates for and level of patient care activity to be undertaken by the Trust.</p> <p>The Trust recognises income from patient care activity based on the completion of these activities. This includes the block contract, which is agreed in advance at a fixed price, and contract variations.</p>	<p>Our audit work included, but was not restricted to:</p> <ul style="list-style-type: none"> ➔ Evaluating the Trust’s accounting policy for recognition of income for appropriateness and compliance with the Department of Health and Social Care (DHSC) group accounting manual 2018/19; ➔ Updating our understanding of the Trust’s system for accounting for income, and evaluating the design of the associated controls; <p>In respect of patient care income:</p> <ul style="list-style-type: none"> ➔ Using the DHSC mismatch report that details differences in reported income and expenditure and receivables and payables between NHS bodies, investigating unmatched income and receivable balances over £300,000, corroborating the unmatched balances to supporting information;

<p>Patient care activities provided that are additional to those incorporated in these contracts (contract variations) are subject to verification and agreement by commissioners. As such, there is a risk that income is recognised in the financial statements for these additional services that is not subsequently agreed to by the commissioners.</p> <p>The Trust also receive other operating income which is not derived from block contract agreements and represents a material class of transactions in the statement of comprehensive income.</p> <p>Due to the nature of block contracts for 999 calls we have not identified a significant risk of material misstatement of comprehensive income.</p> <p>We therefore identified occurrence and accuracy of all income and associated receivable balances, excluding those related to block contracts for 999 calls as a significant risk, which was one of the most significant assessed risks of material misstatement.</p>	<ul style="list-style-type: none"> ➔ Agreeing, on a sample basis, income from contract variations and year end receivables to signed contract variations, invoices or other supporting evidence such as correspondence from commissioners; ➔ Evaluating the estimates and judgments made by management with regard to corroborating evidence in order to arrive at the total income from contract variations recorded in the financial statements. <p>In respect of other operating income:</p> <ul style="list-style-type: none"> ➔ Agreeing, on a sample basis, income and year end receivables to invoices and cash receipts, or other supporting evidence ➔ Agreeing income from the Provider Sustainability Fund to notifications from NHS Improvement and cash receipts. <p>The Trust’s accounting policy on income recognition is shown in note 1.3 to the financial statements and related disclosures are included in notes 3 and 4.</p> <p>Key observations</p> <p>We obtained sufficient audit evidence to conclude that:</p> <ul style="list-style-type: none"> ➔ The Trust’s accounting policies for income recognition are in accordance with the Department of Health and Social Care group accounting manual 2018/19 and have been properly applied; and ➔ Non-block contract patient care income and other operating income and associated receivable balances are not materially misstated.
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Key Audit Matter – Trust	How the matter was addressed in the audit – Trust
<p>Valuation of land and buildings</p> <p>The Trust revalues its land and buildings on a five-yearly basis, with a full revaluation being performed as at 31 March 2019.</p> <p>This represents a significant estimate by management in the financial statements, which requires the use of an external valuations expert.</p> <p>We therefore identified the valuation of land and buildings as a significant risk, which was one of the most significant assessed risks of material misstatement.</p>	<p>Our audit work included, but was not restricted to:</p> <ul style="list-style-type: none"> ➔ Evaluating management’s processes and assumptions for the calculation of the estimate, the instructions issued to the valuation experts, and the scope of their work; ➔ Evaluating the competence, capabilities and objectivity of the valuation expert; ➔ Writing to the valuer to confirm the basis on which the valuations were carried out; ➔ Challenging the information and assumptions used by the valuer to assess completeness and consistency with our understanding; ➔ Testing, on a sample basis, revaluations made during the year to ensure they were recorded accurately in the Trust’s asset register. <p>The group’s accounting policy on valuation of property, plant and equipment is shown in note 1.6 to the financial statements and related disclosures are included in note 16.</p> <p>Key observations</p> <p>We noted that information relating to the floor areas of the properties subject to revaluation was not provided to the valuer as part of the instructions. Discussion with the valuer revealed that floor areas used in the valuation process had been rolled forward from previous years. We recommended that management instruct the valuer to reassess the floor areas of each property when a full valuation is undertaken, or otherwise that the Trust’s estates team reassess and provide updated floor areas upon instruction.</p> <p>We also identified in review of the accounting treatment for revalued properties that the full extent of the valuation had been recognised against the gross cost of each asset, which is inconsistent with the Group Accounting Manual which requires associated accumulated depreciation to be written out upon revaluation. The impact of this error was £2.4m to the gross cost/valuation of</p>

	<p>buildings with a corresponding error to the accumulated depreciation. There is no impact on the statement of financial position and there is no impact on the carrying value of land assets, which are not subject to depreciation.</p> <p>Subject to the amendment to accounting for gross cost and accumulated depreciation detailed above, we obtained sufficient audit assurance to conclude that:</p> <ul style="list-style-type: none"> ➔ the basis of the valuation of land and buildings was appropriate, and the assumptions and processes used by management in determining the estimate of valuation of property were reasonable; ➔ the valuation of land and buildings disclosed in the financial statements is reasonable.
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Our application of materiality

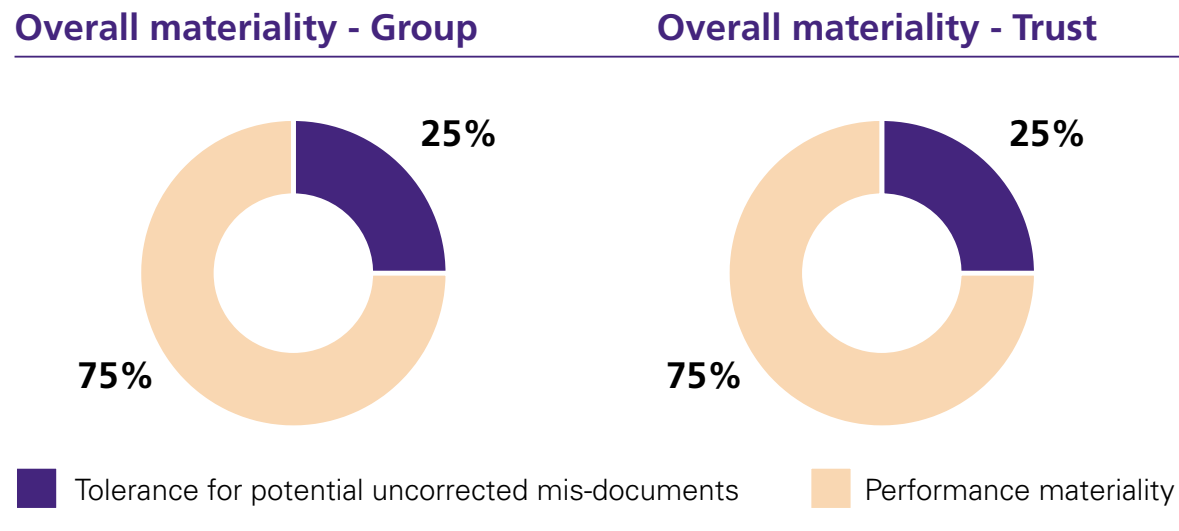
We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

Materiality was determined as follows:

Materiality Measure	Group	Trust
Financial statements as a whole	<p>£4,300,000 which is 1.9% of the group’s gross operating costs. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how the group has expended its revenue and other funding.</p> <p>Materiality for the current year is a slightly lower level of gross operating costs than we determined for the year end 31 March 2018 to reflect the increase in the group’s gross operating costs in 2018/19.</p> <p>We did not identify any significant changes in the group or the environment in which it operates.</p>	<p>£4,294,000 which is 1.9% of the Trust’s gross operating costs. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how the Trust has expended its revenue and other funding.</p> <p>Materiality for the current year is a slightly lower level of gross operating costs than we determined for the year ended 31 March 2018 to reflect the increase in the Trust’s gross operating costs in 2018/19.</p> <p>We did not identify any significant changes in the Trust or the environment in which it operates.</p>

Performance materiality used to drive the extent of our testing	75% of financial statement materiality	75% of financial statement materiality
Communication of misstatements to the Audit Committee	£214,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.	£214,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

The graph below illustrates how performance materiality interacts with our overall materiality and the tolerance for potential uncorrected misstatements.



An overview of the scope of our audit

Our audit approach was a risk-based approach founded on a thorough understanding of the group’s business, its environment and risk profile, and in particular included:

- ➔ Evaluation by the group audit team of identified components to assess the significance of that component and to determine the planned audit response based on a measure of materiality. For example, significance as a percentage of the group’s gross costs based on qualitative factors, such as specific use or concerns over specific components;
- ➔ The group audit was undertaken entirely at the premises of the Trust. Audit testing was performed on classes of transactions, account balances, or disclosures relating to the subsidiary which were material to the group position to the group financial statements;
- ➔ We completed a full scope statutory audit of the Trust, including completing audit procedures on 100% of total revenues, 100% of operating costs and 90% of assets and liabilities;
- ➔ The audit fieldwork was concluded in three phases. A planning visit was undertaken during November 2018 which included an evaluation of the group’s internal controls environment including its IT systems and controls; an interim audit visit was undertaken during February 2019 which included testing of transactions recorded in the first nine months of the year; the final audit fieldwork visit occurred during May 2019 and comprised completion of testing of transactions recorded in the final three months of the year and testing of year-end balances and disclosures;
- ➔ There were no changes in the scope of the current year audit from the scope of the prior year.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor’s report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

In this context, we also have nothing to report in regard to our responsibility to specifically address the following items in the other information, and to report as uncorrected material misstatements of the other information where we conclude that those items meet the following conditions:

- ➔ Fair, balanced and understandable set out on page 37, in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance – the statement given by the directors that they consider the Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the group and Trust’s performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit; or
- ➔ Audit Committee reporting set out on pages 177 to 178, in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance – the section describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice), we are required to consider whether the Annual Governance Statement does not meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2018/19. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Our opinion on other matters required by the Code of Audit Practice is unmodified

In our opinion:

- ➔ The parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2018/19 and the requirements of the National Health Service Act 2006; and
- ➔ Based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust’s arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice we are required to report to you if:

- ➔ We issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- ➔ We refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure that was unlawful, or is about to take, or has begun a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Chief Executive’s responsibilities as the Accounting Officer set out on pages 244 to 245, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2018/19, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the group’s and the Trust’s ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust and the group without the transfer of the Trust’s services to another public sector entity.

The Audit Committee is Those Charged with Governance. Those changed with governance are responsible for overseeing the Trust’s financial reporting process.

Auditor’s responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor’s report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council’s website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor’s report.

REPORT ON OTHER LEGAL AND REGULATORY REQUIREMENTS – CONCLUSION ON THE TRUST’S ARRANGEMENTS FOR SECURING ECONOMY, EFFICIENCY AND EFFECTIVENESS IN ITS USE OF RESOURCES

Matter on which we are required to report by exception - Trust’s arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if, in our opinion we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

We have nothing to report in respect of the above matter.

Significant risks

Under the Code of Audit Practice, we are required to report on how our work addressed the significant risks we identified in forming our conclusion on the adequacy of the Trust’s arrangements for securing economy, efficiency and effectiveness in its use of resources. Significant risks are those risks that in our view had the potential to cause us to reach an inappropriate conclusion on the audited body’s arrangements. The table below sets out the significant risks we have identified. These significant risks were addressed in the context of our conclusion on the Trust’s arrangements as a whole, and in forming our conclusion thereon, and we do not provide a separate opinion on these risks.

Significant risks	How the matter was addressed in the audit
<p>Financial outturn and sustainability</p> <p>Before the start of each financial year the Trust agrees a control total set by NHS Improvement (NHSI) which determines the target financial performance for the financial year. Achievement of the control total also ensures the Trust receives additional Provider Sustainability Funding (PSF).</p> <p>In 2018/19 the Trust was set its most challenging control total yet, with a £2.3 million deficit budget before allocation of £1.5 million funding from Provider Sustainability Funding (PSF), contingent on the Trust meeting the required performance targets.</p> <p>Challenges in achieving the performance targets include improving 111 sickness and attrition rates. The Trust has developed a financial improvement plan to address the challenges.</p> <p>We identified a significant risk in respect of the Trust's arrangements for continuing to meet its financial performance targets through sustainable mechanisms given its operating environment.</p>	<p>Our audit work included, but was not restricted to:</p> <ul style="list-style-type: none"> ➔ Evaluating the Trust's performance against its control total and the critical factors in working towards this target and achieving Provider Sustainability Fund monies, including whether these were specific in-year circumstances or events, or will recur in future years <p>Key findings</p> <ul style="list-style-type: none"> ➔ The Trust reported a surplus outturn position of £1.4 million in 2018/19, which was achieved through exceeding its target deficit budget, receipt of PSF income in line with the plan and subsequently receiving additional bonus and incentive PSF funding of £1.7 million of which it was notified in April 2019. ➔ The Trust received a one-off grant in the year of £0.8 million but the impact of this on the financial outturn was more than offset by two unbudgeted employment-related provisions which were required, having a combined impact of £4.2 million. ➔ The Trust has set and submitted a forward plan for 2019/20 which includes a breakeven revenue position.
<p>Cost improvement programmes</p> <p>In the ongoing context of rising patient demand, stringent contract negotiation with commissioners, and cost pressures, notwithstanding the Trust's success over recent years of achieving the majority of its savings targets, going forward more challenging savings will need to be made.</p> <p>We identified a significant risk around the Trust's ability to set Cost Improvement Programmes (CIPs) which have a sustainable impact on its medium-term financial performance, accurately monitoring and reporting on its delivery against these CIPs.</p>	<p>Our audit work included, but was not restricted to assessing:</p> <ul style="list-style-type: none"> ➔ The Trust's future cost improvement programmes (CIPs) for achievability and level of sustained impact on service delivery ➔ The Trust's arrangements for identifying, setting, monitoring and reporting savings and understanding reasons for non-delivery ➔ How well the Trust delivered against original 2018/19 CIPs to gauge the effectiveness of the arrangements for identifying and delivering feasible schemes; and

	<p>➔ The impact of these schemes on the achievement of the Trust's performance targets.</p> <p>Key findings</p> <ul style="list-style-type: none"> ➔ The Trust achieved £7.8 million savings through its CIPs in 2018/19, against an initial plan of £7.2 million. The overachievement is largely attributable to overperformance in 999 services. The Trust achieved 97% of its original plan. ➔ The Trust has set a 2019/20 CIP target of £7.5 million within its forward financial plan. This represents 3.2% of expenditure before efficiencies. The majority of CIPs outlined in the plan build on those which the Trust has already been successful in achieving in 2018/19 and in previous years.
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Responsibilities of the Accounting Officer

The Accounting Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

REPORT ON OTHER LEGAL AND REGULATORY REQUIREMENTS – CERTIFICATE

We certify that we have completed the audit of the financial statements of South Central Ambulance Service NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust’s Council of Governors those matters we are required to state to them in an auditor’s report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust’s Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Paul Grady

Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

London

24 May 2019

GLOSSARY

A&E	Accident & Emergency
AACE	Association of Ambulance Chief Executives
ACAS	Advisory, Conciliation & Arbitration Service
Acorn	Consumer classification that segments the UK population by analysing demographic data, social factors, population and consumer behaviour
ACQI	Ambulance Care Quality Indicator
ACS	Accountable Care System
ACT	Accelerated Clinical Triage
Adastra	Electronic patient management software
AfC	Agenda for Change
AQI	Ambulance Quality Indicator
ARP	Ambulance Response Programme
BAF	Board Assurance Framework
BBC	British Broadcasting Corporation
BME	Black and Minority Ethnic
CA	Clinical Advisor
CAD	Computer Aided Despatch
CALNAS	Culture and Leadership Network for Ambulance Services
CAS	Clinical Assessment Service
CC	Contact Centre
CCC	Clinical Coordination Centre
CCG	Clinical Commissioning Group
CEF	Community Engagement Forum
CEO	Chief Executive Officer
CETV	Cash Equivalent Transfer Value
CFR	Community First Responder
CIP	Cost Improvement Programme
CoG	Council of Governors
COSHH	Control of Substances Hazardous to Health
CPD	Continuing Professional Development
CPI	Consumer Prices Index
CPR	Cardiopulmonary Resuscitation
CQA	Compliance & Quality Assurance
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CSD	Clinical Support Desk
DCA	Dual Crewed Ambulance

DHSC	Department of Health and Social Care
DoS	Directory of Services
E&UC	Emergency & Urgent Care
EBITDA	Earnings Before Interest, Tax, Depreciation and Amortisation
ECA	Emergency Care Assistant
ECT	Emergency Call Taker
ED	Emergency Department
EDC	Equality and Disability Council
EDS	Equality Delivery System
EHRC	Equality & Human Rights Commission
EPRR	Emergency Preparedness, Resilience and Response
EOC	Emergency Operations Centre
EoL	End of Life
ePR	Electronic Patient Record
ETA	Estimated Time of Arrival
FFT	Friends and Family Test
FReM	Financial Reporting Manual
FRICS	Fellow Royal Institution of Chartered Surveyors
FT	Foundation Trust
FTE	Full-Time Equivalent
GAD	Government Actuary Department
GAM	Group Accounting Manual
GBS	Government Banking Services
GDE	Global Digital Exemplar
GEO	Government Equalities Office
GP	General Practitioner
GPG	Gender Pay Gap
HART	Hazardous Area Response Team
HCP	Healthcare Professional
HIOWAA	Hampshire and Isle of Wight Air Ambulance
HM	Her Majesty's
HMRC	Her Majesty's Revenue and Customs
HOSC	Health Overview and Scrutiny Committee
HR	Human Resources
HWB	Health and Wellbeing
IAS	International Accounting Standard
iCAD	Intergraph Computer Aided Dispatch
ICS	Integrated Care System
IFRS	International Financial Reporting Standards

ISO	International Organisation for Standardisation
IOW	Isle of Wight
IPR	Integrated Performance Report
IUC	Integrated Urgent Care
IWP	Integrated Workforce Plan
JESIP	Joint Emergency Services Interoperability Programme
JRH	John Radcliffe Hospital
KPI	Key Performance Indicator
L&D	Learning & Development
LSR	Local System Review
MBTI	Myers-Briggs Type Indicator
MBE	Member of The British Empire
MCA	Mental Capacity Act
MDT	Multi-Disciplinary Team
MINAP	Myocardial Ischaemia National Audit Project
MSK	Musculoskeletal
MTFA	Marauding Terrorist Firearms Attack
NARU	National Ambulance Response Unit
NED	Non Executive Director
NEST	National Employment Savings Trust
NEWS	National Early Warning Score
NHS	National Health Service
NHSE	NHS England
NHSI	NHS Improvement
NICE	National Institute of Clinical Excellence
NLF	National Loans Fund
NQP	Newly Qualified Paramedic
NUMSAS	NHS Urgent Medicine Supply Advanced Service
OHCA	Out of Hospital Cardiac Arrest
OHCAO	Out of Hospital Cardiac Arrest Outcomes
OHFT	Oxford Hospitals NHS Foundation Trust
ONS	Office for National Statistics
PAD	Publically Accessible Defibrillator
PDC	Public Dividend Capital
PFI	Private Finance Initiative
PPE	Property, Plant and Equipment
PPG	Patient Participation Group
PSF	Provider Sustainability Funding
PSG	Patient Safety Group

PTS	Patient Transport Service
Q1/Q2	Quarter 1 / 2
Q3/Q4	Quarter 3 / 4
Q&S	Quality & Safety
RAG	Red Amber Green
ROSC	Return of Spontaneous Circulation
RPI	Retail Prices Index
RRV	Rapid Response Vehicle
RSO	Resilience and Specialist Operations
SCAC	South Central Ambulance Charity
SCAS	South Central Ambulance Service NHS Foundation Trust
SCFS	South Central Fleet Services Ltd
SDAT	Sustainable Development Assessment Tool
SDMP	Sustainable Development Management Plan
SHiP	Southampton, Hampshire, Isle of Wight and Portsmouth
SIRI	Serious Incident Requiring Investigation
SMART	Specific, Measurable, Achievable, Relevant and Time-Based
SoFP	Statement of Financial Position
SOP	Standard Operating Procedure
SP	Specialist Practitioner
SPoC	Single Point of Care
STD	Survival To Discharge
STEMI	ST Elevation Myocardial Infarction (Heart Attack)
STP	Sustainability & Transformation Partnership
TOR	Terms of Reference
TRiM	Trauma Risk Management
TVAA	Thames Valley Air Ambulance
UCD	Urgent Care Desk
UK	United Kingdom
UN	United Nations
UNICEF	United Nations Children’s Fund
UV	Ultra Violet
VAT	Value Added Tax
VSM	Very Senior Manager
WTE	Whole Time Equivalent
YTD	Year To Date



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