South East Coast Ambulance Service NHS
NHS Foundation Trust

Strategic Plan Document for 2013-14

South East Coast Ambulance Service NHS Foundation Trust

Strategic Plan for y/e 31 March 2014 (and 2015, 2016)

This document completed by (and Monitor queries to be directed to):

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Date	**31st May 2013**

The attached Strategic Plan is intended to reflect the Trust's business plan over the next three years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- **The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;**
- **The Strategic Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Strategic Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;**
- **All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission.**

Approved on behalf of the Board of Directors by:

Name	Tony Thorne – Chair

Signature

Approved on behalf of the Board of Directors by:

Name	Paul Sutton - *Chief Executive*

Signature

Approved on behalf of the Board of Directors by:

Name	James Kennedy - *Finance Director*

Signature

Executive Summary

South East Coast Ambulance Service NHS Foundation Trust has a vision “To match and exceed international best practice through embracing innovation and putting the patient at the heart of everything we do.”

The Trust aims to be viewed by its stakeholders as a high-performing, clinically-focussed service. Clinical innovation is coupled with the delivery of consistently high levels of operational and financial performance. The Trust is viewed by its commissioners as being key to reducing the overall cost of emergency and urgent healthcare across the wider system through reducing the number of patients who are treated at hospital when a more suitable pathway exists.

By managing 999 calls, and now 111 calls, the Trust plays a key role in ensuring patients are treated quickly, safely and efficiently. There are three ways in which the Trust can respond to patients. Hear and Treat means the provision of safe and effective advice on the phone without the need to visit the patient. See and Treat means that Ambulance Service clinicians visit the patient in their home and treat them without the need for them to go to hospital. See and Convey means providing safe transport to an acute hospital for treatment. The Trust’s strategy is to improve patient care and reduce pressure on the wider health economy by increasing the number of calls that can be dealt with as Hear and Treat or as See and Treat . The strategy also requires the Trust to be able to convey patients to hospital quickly and safely where this is assessed as being clinically appropriate.

The Annual Plan Review (APR) 2013-14 sets out the key actions for the Trust in continuing to strive towards its vision. These are:

- A renewal of the focus on clinical innovation in Emergency Care;
- Development and implementation of innovative solutions to 999 service delivery to continue to raise the level of Hear and Treat and See and Treat responses; and
- Delivery of an effective service for NHS 111 and Patient Transport Services (PTS).

Renewal of the focus on clinical innovation.

The Trust has been known for leading the way on clinical innovation in care. In this APR the Trust is setting out its plans for leadership both in terms of the measures of performance on Cardiac Arrest, STEMI and Stroke, but also to push the next generation of clinical innovations including patient testing at scene, mechanical assistance to CPR and improvements in clinical supervision.

Performance will be benchmarked against best practice nationally and internationally and a detailed five year roadmap will be developed to deliver this objective.

The Trust will continue to make innovative investments in order to enhance patient care, improve clinical outcomes and achieve efficiencies in operational activity. This includes developing new fleet solutions for paramedics and paramedic practitioners and the potential to use some van conversions in the Emergency Ambulance fleet. Estates investment will focus on the Make Ready concept, and the Trust will continue to invest in equipment to enhance the capability of clinicians in the field.

The Trust will extend the use of Community First Responders (CFRs) and Public Access Defibrillation (PAD) as effective methods of providing fast response to cardiac arrest, thereby enhancing the chances of survival.

Innovative solutions to 999 service delivery.

The plan sets out to increase the proportion of Hear and Treat responses, by continuing to raise the level of clinical support in the 999 call centres and ensuring that there is effective cross over between 111 and 999 call-taking to accord with best practice in the delivery of both services.

The plan sets out to increase the proportion of See and Treat responses by continuing to raise the numbers of paramedics and paramedic practitioners in the workforce, as set out previously in the Trust's Front Loaded Service Model. This will be supported by a learning and development focus on safe reduction of conveyance, and by increasing the clinical support available to staff working in the field from the call centres.

The plan also sets out to improve performance and reduce cost when certain patients require conveyance, by introducing an Intermediate Tier of staffing specialising in transporting patients with less acute clinical needs, as well as achieving more effective use of the high acuity transport of existing ambulances and the Critical Care Paramedics.

The Trust will develop an alternative model of care for rural locations. This involves developing a programme for Community Paramedic schemes.

The plan will continue to reduce costs and raise standards through: the implementation of Make Ready; reduction in support costs; procurement and supply chain savings and reductions in travel and fleet costs. Improvements in the allocation of resources by reviewing staff rota provisions; by reducing the time clinicians spend on non-core activities; and by reducing the hours lost to handover or sickness are also designed to raise the amount of time clinicians can spend working with patients.

Delivery of NHS 111 and PTS

The Trust plans to continue to drive efficiency in the provision of the PTS service in Surrey and in Sussex, while ensuring performance meets the requirements of the contract.

NHS 111 is a new service and the plan is based not only on working with the Trust's partner, Harmoni (owned by Care UK), to deliver the contract, but also to adapt the service as the Trust gains experience with it. The outcome of the plan will be measured against clinical, performance and financial measures.

Financial Overview

The Trust is aiming to remain financially stable and to deliver a surplus of £3.5M from projected income of £180M. This requires the delivery of £9.7M of Cost Improvements. As with last year the plan focusses on sustainable improvements, which are aligned with the aim of delivering improved quality and service outcomes. The objective is to ensure that financial performance is seen as stable by Monitor and external parties, allowing the Trust the potential to raise capital should it be needed in the future.

Stakeholder Engagement

Stakeholders have been closely involved in the development of this APR. The Trust consulted with staff and public Foundation Trust members on the APR,through the circulation of a plain English version of the draft plan and inviting comments on how far members agreed or disagreed with theTrust's proposed priorities. Members were also asked to note any additional areas that they considered should be prioritised in the coming year.

Responses were overwhelmingly positive, with members also noting some areas for clarification and additional areas for inclusion. The outcomes of this engagement with members were discussed by the Trust's Council of Governors at its formal meeting held in January 2013. Following subsequent consideration by the Trust Board,Governors also received feedback as tot how their views had been taken into account in the further development of the plan at their formal Council meeting in March 2013. The Council of Governors has also confirmed that it considers that the commercial activity to be undertaken by the Trust in 2013/14 will not be detrimental to the Trust's NHS activities.

Strategic Context and Direction

Trust's strategic direction within the Local Health Economy

The local health economy is becoming more complex with the introduction of the Clinical Commissioning Groups (CCGs), NHS England and Local Area Teams.

The Trust is in an unusual position of having dealings with more than 20 Clinical Commissioning Groups as its A&E (Emergency) activity spans Surrey, East and West Sussex, Brighton and Hove, Kent, Medway and parts of Berkshire and Hampshire. The Trust has worked to establish arrangements with all the Commissioning Group Clusters and their respective lead officers and to ensure a lead commissioner arrangement is in place. Arrangements for PTS and NHS 111 are different as contracts have been awarded through open tender.

The Trust takes the challenge of competition seriously and has won competitive tenders for NHS 111, PTS Sussex and PTS Surrey but lost a tender for PTS Kent. The strategy to focus on patient service, clinical excellence and economic efficiency is considered to be the best defence against competition.

Commissioning intentions continue to drive behaviour which will have a significant impact on the overall health economy. This is particularly around an emphasis towards reducing conveyance to A&E resulting in more Hear and Treat and See and Treat activity and use of 'alternative pathways' through the implementation of a Directory of Service. This requires the Trust to accelerate changes to the way it works to deliver the service requirements set by commissioners. In addition commissioners have sought to increase financial certainty on the contract this year by reducing the potential for penalties, and by looking to move risk around variation on activity to the Trust.

<u>Emergency Service (A&E)</u>
The South East Coast (SEC) vision is for financial stability during the transition to CCGs as well as to manage the implications of the introduction of the NHS 111 service into the region. The NHS 111 service changes the priorities for responding to patients and therefore has activity implications for the Emergency Service, A&E departments, Out of Hours Services and Community Health Services.

<u>PTS</u>

The Trust is tracking PTS contracts in other locations and will tender where a commercial bid is considered possible but the plan assumes no further expansion of PTS at this stage.

Threats and opportunities from changes in local commissioning intentions

The Trust has agreed a strategic commissioning plan with the Kent, Surrey and Sussex clusters which supports the developments set out in the APR.

The Trust is leading the development of the Payment by Results (PbR) tariff for the ambulance service in England. A local tariff has been agreed with commissioners which has been used to commission services since 2011/12. In 2013/14, the Trust and commissioners have agreed that due to this being the first year of CCGs and with the introduction of the NHS 111 service in the SEC, a range of activity levels have been incorporated into the contract to ensure stability within the first year of the transition. This guarantees the Trust's income and shares risk with the Commissioners.

The complexity of decentralised commissioning to a CCG level is something that the Trust is aware of and will closely monitor over the coming months, as the Trust currently offers an undifferentiated region wide service against a standard contract.

The development of trauma networks in SEC, which is supported by the Trust, will require SECAmb to develop and implement new trauma pathways increasing job cycle times within the A&E service. In addition to this a number of Acute Trusts are developing clinical strategies to support the development of "hot" sites (with an A&E Department) and "cold" sites (without an A&E Department) which will also result in an increase in job cycle times. Work with commissioners is underway to mitigate the impact of these initiatives.

Emergency Service (A&E)
The provision of emergency assessment and care services by the Trust in a pre-hospital environment in the SEC geographic area is currently not contestable and there is a three year rolling contract which provides security for medium term plans. However, commissioners are considering alternative options for managing unscheduled care and this may result in activity moving away from the A&E contract. The Trust believes that PTS provides a suitable and more cost effective alternative to an ambulance response for some patients and this understanding is part of the commercial reason for bidding for this work.

Patient Transport Service
The Trust tendered successfully for both the Sussex PTS contract in 2011/12 and the Surrey contract in 2012/13. The Trust failed to win the contract for the Kent service where SECAmb is the current holder for about 30% of activity across Kent. The on-going challenge to the Trust will be to ensure that services are delivered profitably over the life of the contract and meet patient needs.

NHS 111 service
The SEC NHS 111 service went live in March 2013. Approximately 50% of the service provision, income and risk are shared with our service provision partner, Care UK.

Telehealth and Telecare
The Kent, Surrey and Sussex health economies have begun to focus on investing in Telehealth and Telecare. These services are both aligned with call taking facilities as well as response services. This is an area of potential growth for the Trust, which will be explored over the next two years.

Collaboration, integration and patient choice

The Trust plays a key role in the provision of unscheduled and urgent care acting as both a co-ordinator and key service provider in this area. Unplanned care is typically more expensive to provide than planned care and the impact on the local health economy is very significant. As an ambulance service the Trust is in a unique position in the wider health economy because of the need for close integration with almost all other providers as well as with the commissioners. As such, it is recognised by a range of key stakeholders that the Trust is in a position where its influence on the cost of health provision in the wider health economy is significantly greater than the direct cost of its service provision. This presents a challenge and an important opportunity for the Trust to develop in ways which will significantly enhance local healthcare provision.

The Trust is committed to continuing to implement its Inclusion Strategy regarding public and staff Foundation Trust membership engagement, stakeholder engagement and accord with the provisions of the Equality Act.

Approach taken to quality

Care Quality Commission

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

The CQC inspected 7 outcomes and found the Trust to be fully compliant with 5 of them. Further action is required to ensure full compliance with Outcome 9 – Management of Medicines and Outcome 14 – Supporting Workers. However, the judgement of the inspectors was that the concerns raised in relation to both these outcomes would have only a minor impact on service users.

Action plans developed to ensure full compliance with required outcomes will be monitored by the Trust's Risk Management and Clinical Governance Committee (RMCGC), which reports directly to the Board.

Key quality risks inherent in the plan and how these will be managed

The key quality risk is a failure to achieve the required clinical standards. This is an identified risk on the Trust's corporate risk register and controls in place to mitigate this risk include a robust communications programme to all staff to ensure that they are aware of the required standards, effective clinical audit processes and internal monitoring of performance by the RMCGC, the Quality Commissioning Group and the Board. The risk of failure to record accurate data is also included on the Trust's corporate risk register. This risk is managed through issuing records management guidelines, training on records and security management, defined processes for records storage, analysis and retrieval and approved standards for auditing.

Another significant area of risk relates to failure to forecast and accurately assess the levels of activity. Activity levels increased sharply during 2012/13 creating challenges throughout the health economy. In addition there is evidence that the introduction of NHS 111 has resulted in a significant variation in activity in some parts of the country. To mitigate this risk actions have included the adoption of a risk sharing approach to the A&E contract commissioning and the

development of detailed performance reporting which is reviewed at each fortnightly Trust Executive meeting.

A further risk is that Patient Care Records are paper based and are completed by hand by operational staff. This makes accurate recording and timely management challenging. The Trust is taking part in a project to introduce Electronic Patient Clinical Records to mitigate this risk.

Overview of how the Board derives assurance on the quality of its service and safeguards patient safety (QGF)

The Trust Board meets formally every two months and analyses performance information via a Corporate Dashboard which includes a wide variety of indicators, including a series of clinical outcome indicators which are measured against the Trust's expected levels of performance and the national mean for Ambulance Trusts. General information on new SIRIs, learning points from closed SIRIs, and an analysis of complaints and PALS queries is also provided to each Board meeting.

The Trust's compliance with the Quality Governance Framework has been assessed and is currently being reviewed. The outcome of this review and progress against any further actions that are required will be monitored by the RMCGC and reported to the Board.

Clinical Strategy

The APR has identified the need to undertake a fundamental review of our drive to raise clinical standards through the use of external best practice and innovation. A detailed assessment of the Trust's Clinical Strategy is being led by the Medical Director and the Director of Clinical Operations following which a comprehensive Clinical Strategy for the period 2013/14 – 2017/18 will be published. The new revised strategy will build upon the clinical and quality elements of the Trust's Annual Plan and take account of the Quality Report and Quality Account priorities and the Trust's planned service developments.

IBIS (Intelligence Based Information System)

Part of the clinical strategy is the development of IBIS, which is a system developed by SECAmb with the aim of facilitating appropriate treatment and promoting admission avoidance. IBIS has two main functions:

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

The plan aims to continue to develop and encourage adoption of IBIS by external providers.

Clinical Effectiveness

Clinical Performance Indicators (CPIs) are collected by all ambulance services in England. The indicators are collected on a rolling cycle with each indicator being measured twice a year. These indicators are underpinned by a number of metrics, which have been refined and revised over

successive cycles. Data is collected by individual Trusts and submitted to the National Ambulance Service Clinical Quality Group (NASCQG) and reported to National Ambulance Services Medical Directors Group (NASMED). The performance of Trusts is benchmarked, and the final report for each cycle is then published. The reported CPIs are:

- Hypoglycaemia;
- Asthma;
- Below knee fracture (pilot); and
- Febrile convulsion (pilot).

Clinical Outcomes Indicators (COIs) relate to the outcomes of those patients transported by ambulance and aim to measure the overall quality of care and outcomes. The clinical outcomes data runs with a three month time lag behind the systems indicator data. This time is required to resolve the outcomes of those patients transported by ambulance. This data is submitted monthly to the Department of Health (DH) for performance monitoring purposes. The reported COIs are:

- Outcome from cardiac arrest – return of spontaneous circulation (ROSC);
- Outcome from acute ST-elevation myocardial infarction (STEMI);
- Outcome from stroke for ambulance patients; and
- Outcome from cardiac arrest – survival to discharge.

Patient Experience

The information gathered through our PALS processes serves as an early warning system for SECAmb. PALS activity and granulated reports are scrutinised by the Compliance Working Group (CWG). An analysis of statistics and the monitoring of any trends are discussed and appropriate action plans drafted. This information and any lessons learnt inform service change to improve the patient experience.

The Patient Experience Report is currently being revised to reflect the patient journey through the eyes of the patient, their carers and relatives. This process will use additional information, not just formal or informal complaints (which can only highlight when things go wrong), to ensure a holistic patient journey and experience is captured.

Both the RMCGC and the Compliance Working Group will be apprised of any service change made through learning outcomes from both these reports. The Board and commissioners currently receive the PALS and Complaints Report and will receive the revised Patient Experience Report.

A great deal of emphasis is placed on learning from compliments and complaints and every effort is made to take all the steps necessary to improve the patient experience.

Service Line Management Strategy

The plan is based on a detailed assessment of the activity by Operational Dispatch Area (ODA). This forecast takes account of the historic and current trends externally driving demand as well as our internal objectives with respect to Hear and Treat, See and Treat and conveyance.

This forecast, completed on a despatch area by despatch area basis, is then used to assess the number of resources needed, measured as staff unit hours. This is done by applying the Unit

Hour Utilisation (UHU) which is flexed depending on the historic performance and other factors. Each ODA is the responsibility of a Senior Operations Manager who reports directly to the Executive Director of Clinical Operations.

The Clinical Operations Senior Management team review activity and performance fortnightly and in addition the Finance and Business Development Committee receives a monthly report on the financial performance of each service line within an ODA or contract. Each contract for PTS and NHS 111 is also managed and reported in this way.

The principal change in the delivery of services is the introduction of an Intermediate Tier. The Trust has developed an approach to managing conveyance to hospital which releases clinicians to focus on the most clinically urgent cases and manages transport of less urgent cases through a dedicated resource.

Clinical Workforce Strategy

Workforce planning includes detailed assessments of the key abstractions; leave, learning and development, sickness and light duties, maternity etc. The clinical workforce plan considers the level and skill mix of resources by Operational Despatch Area as well as the specific requirements of training, development, clinical education, and workforce productivity. The plan requires the trust to manage this carefully looking at both skill mix and the source of staff hours (i.e. core hours, overtime, external providers or bank staff).

The workforce plan takes into account the clinical operations staff unit hour demand by despatch area, and the requirements from NHS 111 and PTS. The development of the workforce plan includes significant work on learning and development, including specific training for Paramedics to support their confidence in taking decisions to convey to non-A&E locations safely.

The workforce plan is one of the key pillars of the Trust's financial planning process with all costs of staffing being aligned and reported within the APR.

A number of areas have been highlighted as requiring close scrutiny when measuring and assessing the delivery of the workforce plan during 2013/14 and beyond. Preliminary metrics for measuring success are included where possible:

- A&E provision – Dedicated training to supporting clinically safe discharge.

- NHS 111 impacts – The NHS 111 service is a new service, which is built on estimates of demand. The resourcing within NHS 111 will need to be flexed to meet actual demand as the Trust learns more about the service. In addition NHS 111 is a service which will change the use of other services including 999, A&E and GP out of hours. The field operations plan assumes an increase in the automatic dispatch of 999 vehicles directly from NHS 111 operators. This area will need to be carefully monitored as the NHS 111 service develops.

- Technicians – The Trust currently has approximately 700 technicians, a group of staff who are dedicated and have valuable experience but who do not have the clinical training of a paramedic. The Trust will work to develop a suitable structure for these staff which balances clinical need, training and abstraction costs and the value of their experience.

- Meal breaks – The plan will continue to focus on reducing the number of meal break disturbances.

- CFR's/ PAD sites – The integration of these community resources to provide further support to the front line will ultimately support the new rotas and the reduction of additional hours needed. This will also reduce the use of other external Ambulance service providers.

- Rota realignment – Although rotas are aligned to variations between forecast activity for each day of the week, they are not flexed to allow for monthly or seasonal variations. Alternative methods to improve flexible supply are being reviewed with a trial due to take place from April 2013 in Thanet when it opens as a Make Ready Centre.

- Emergency Operation Centres (EOC) – To meet the changing skill mix during the year and more so for future years the dispatchers will need to work on issues such as multiple dispatch, how to use the intermediate tier and how to maximise the benefit of increased clinical support within the EOC. The increased clinical support includes more Paramedic Practitioners and some GP support within the EOC.

- Make Ready Centres and Ambulance Community Response Posts (ACRPs) – The Make Ready program is much more than a capital investment. It is a concept for an improved way of delivering services. Each Make Ready Centre provides a hub for staff and for vehicles but it is the ACRPs which provide the key response points. The program allows flexibility in meeting demand which improves response and patient care as well as improving the standards of vehicle preparation. As such the introduction of Make Ready requires a significant change program within Clinical Operations to ensure that the provision of clinician hours is aligned to the needs of patients.

- PTS - With respect to PTS the availability of staff must be adjusted to meet the demand profile of the service. This will improve the standard of service and its profitability. This means that there will be consultation with staff about changes to rotas in Surrey and Sussex. There will also be an assessment of the suitability of some staff to support the Intermediate Tier.

- Sickness Absence – Extend best practice established in front line A&E across the Trust.

- Abstraction Management – Manage the release of staff for training and other non-clinical operations requirements at times of lower demand.

The Trust has continued with an integrated approach to leadership development and management skills programmes at all levels of the organisation and across both clinical and support staff.

The Trust continues to recruit a number of graduate paramedics from other parts of the country, and the paramedic role still remains a very popular career choice. A bid is being developed for a research programme to enrol other professions onto the paramedic conversion course.

Clinical Sustainability

The Trust continues to engage with and participate in the National Ambulance Clinical Quality Programme. In 2013/14 work will continue with NASCQG and NASMED to report and benchmark existing and new indicators which embody quality clinical care as part of the broader clinical audit plans. In addition work will continue with local health partner organisations to secure provision of

quality outcome information in line with the Clinical Quality Indicator programme to enable accurate reporting. This will enable the Trust to continue to work to improve performance at organisational and regional levels, to ultimately ensure that there is continued provision of high quality clinical care for patients.

To maintain and enhance the levels of clinical quality over the next three years and in addition to the workforce developments, the Trust has made provision for the following service developments:

Improving IT systems

Effective investment in IT can enable the delivery of effective patient care by maximising the operational performance of the Trust. The plan will focus on continuously improving critical system resilience and availability, the introduction of Interoperability Tool Kit (ITK) capability to support NHS 111 services and the Southern Cluster procurement of Electronic Patient Clinical Records.

The Trust is committed to a significant investment to replace the hardware which supports the core CAD system. This will bring the technology base up to date improving our resilience and performance.

Delivery of the Make Ready Programme

The roll out of the Make Ready Programme supports the implementation of the high-performance service model within the Trust and delivers improvements in infection control, thereby minimising risk to patients. There is a phased annual Make Ready Centre implementation plan which will be implemented over the coming three year period.

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

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

Implementation of the FLSM

The FLSM supports the Trust's aim of ensuring that patients receive high-quality clinical interventions as soon as possible. It is a model of care which supports the most clinically qualified staff to see, assess, decide, treat and ultimately discharge the patient in order to provide clinically appropriate care and to avoid unnecessary conveyance and admission to hospital.

In 2013/14 the Trust plans to:

- Raise the overall percentage of paramedics in the workforce;
- Increase the proportion of paramedic first response
- Further reduce the proportion of patients conveyed to A&E arising from emergency incidents where a response is made
- Refer at least 11% of emergency patients receiving a response to community and primary care services; and
- Provide enhanced care to at least 50% of patients presenting with life threatening injury and illness.

Single Point of Access (SPA)

Implementing a single point of access for patients accessing emergency or urgent healthcare via the telephone will enable the Trust to improve patient satisfaction, as they will receive the most appropriate service according to their need in a seamless way. In 2012/13 the Trust was awarded a contract to deliver the NHS 111 service for the South East for up to five years. It is undertaking this in partnership with Care UK.

Clinical Pathways

The Trust will continue to ensure compliance with nationally defined frameworks for clinical pathways and will maintain appropriate continued engagement in system wide programmes and developments. The Trust Board has committed to supporting service developments that are in line with the Planning Framework for 2013/14, in order to minimise clinical risk to the organisation and patient care.

Ensuring compliance will require the continued delivery of the rolling annual programme of clinical pathways in accordance with national and local priorities and full engagement at network level. Work continues (at different stages) on the development, implementation and monitoring of clinical pathways for pPCI, trauma, stroke and cardiac care and end of life care.

The publication of the Single Operating Framework for Strategic Clinical Networks is a positive step towards strengthening continuity of care across a wider spectrum of health conditions. This new model set to be in place by April 2013 brings together management support and clinical leadership for mental health, dementia, neurological conditions, maternity and children, cancer and cardiovascular services. These networks will work alongside existing local and Operational Delivery Networks (ODNs) to ensure consistency and promote collaboration.

Productivity and Efficiency

Potential productivity and efficiency gains

The organisation is currently expected to deliver over £6M annually in savings which are passed back to commissioners. This is because the overall NHS funding does not increase in line with an ever increasing demand but includes a contracting mechanism called a deflator. In addition the Trust is seeking to release resources to invest in key initiatives to address patient, operational and clinical needs, resulting in a target of a £9.7M saving in 2013/14.

The key to successful delivery of the Trust's plans is ensuring that the supply of resources available to the Trust is aligned to demand expectations at the correct skill mix in all geographical areas. This not only reduces wastage but also improves efficiency and operational performance.

There is a clear and on-going expectation that Hear and Treat activity, which does not require the dispatch of a resource, and See and Treat, which provides clinical support at scene, will increase. Consequently, additional clinical resources are being moved and recruited into the dispatch centres and there will be increased provision of single response vehicles. This has been included within the financial baseline of the 2013/14 plan and aligned with capital investment in telephony and IT infrastructures.

Hear and Treat and See and Treat represent a productivity benefit for both the Trust and the wider health community. The Trust's investments in the IBIS computer system and in more clinical skills within call centres, as well as the focus on training for paramedics in safe discharge, are all intended to support this outcome.

CIP Governance

The APR identifies opportunities for CIPs totalling £12M in 2013/14. Each opportunity is supported by an action plan and key operational metrics to measure progress. Because the planning process recognises that some of these CIPs may not be delivered either because the actions are delayed or cannot be implemented or because the actions do not result in a measurable improvement, the APR assumes that only £9.7M of these will be delivered.
The CIPs are built into the bottom up planning costs. Where CIPs affect costs directly the cost budgets have been adjusted. Where CIPs affect operational matters either the unit hours or abstraction levels have been adjusted and used to calculate the workforce plan and costs.
The APR process has also reviewed the potential impact of CIPs on clinical performance. This has been done through a risk assessment. The potential impact of CIPs on quality and service will be monitored through the Clinical Quality Working Group.

CIP Profile

The largest element of the Trust's efficiency plan is based on the continued improvement of its UHU, which is a measure of productivity of both staff and resources within frontline A&E services, PTS services and other demand and supply efficiencies. This delivers more activity with the same or less resources, and equates to some 67% of planned efficiencies over the three year planning horizon.

Other elements of front line savings include plans to reduce the cost of each 'unit' of resource by managing overtime, unsocial hours and vehicle costs. There are also a number of productivities and efficiencies around the supply chain built into the plans.

In addition, the Trust aims to secure savings from:

- Reducing hours lost through delayed handovers;
- Reducing hours lost to sickness and reducing the costs of unnecessary transport (linked to carbon reduction);
- Improving supply chain management and procurement;
- Improving the productivity of support services; and
- Increasing the efficiency of the PTS and NHS 111 services.

Plans have been benchmarked against other organisations, prior year performance and are closely matched to the Trust's strategic and operational change programmes. Details of the plans are provided below and the summarised targets are:

2013/14 - £9.7M
2014/15 - £7.5M
2015/16 - £7.0M

CIP enablers

SECAmb's cost and efficiency improvement schemes have been aligned to the overall objectives of the Trust and include consideration of the commissioning expectations and the perceived requirements of the planning framework for the coming years. Generating efficiencies, reducing waste and improving financial performance have developed into core objectives across all areas.

The CIP programme has been developed at a series of events during the last 12 months and reflects a continuous improvement in the understanding of the financial and wider service delivery implications of efficiencies. These workshops have been led by either an Executive Director or the

Chief Executive and have included staff from all directorates including clinical staff, staff side representatives and staff elected Governors.

Stakeholders are now well educated in their understanding of the opportunities these efficiencies can offer and accept that in a national health economy which has a target to deliver £20 billion of efficiency savings, any local service developments and enhancements will need to be funded through improvements to local practice.

Plans are developed with a long term view and are aligned to the expected developments within the local and national health economies. The underpinning metrics ensure that the impact of plans and changes to the operational delivery model are not just considered from a financial perspective but incorporate clinical and patient experience needs as well.

Each scheme has a lead Director and a lead responsible manager and is supported by an action plan and an underlying metric to assess on-going performance. Delivery against these plans is reviewed regularly by the executive and at the Financial and Business Development Committee (FBDC).

The Trust works to an internal stretch target to mitigate under achievement of certain schemes and holds a financial reserve which, if required, supports the underlying position and delivery of these schemes. Each plan is underpinned by an operational metric which identifies the risks associated with the scheme at inception and during the reporting period. Through the monitoring process the Trust will identify new schemes during the year and whilst there is no assumption around these in the plans, they provide further mitigations to slippage of existing schemes.

Lead managers are nominated from areas of the organisation where the direct impact from a CIP scheme is the greatest, and as such certain schemes are owned by clinicians and front line staff. Furthermore, each relevant scheme is underpinned by an operational metric which profiles the performance against the Trust's core targets of performance, efficiency and patient satisfaction and these form part of the regular monitoring. The RMCGC is charged with ensuring clinical quality standards are monitored and maintained.

The CIP plans are signed off by the Trust Board and progress has been shared at various Board meetings as the plans have developed.

Quality Impact of CIPs

The FBDC and RMCGC were presented with the detailed CIPS plans for 2013/14 including details of the clinical quality indicators to be reviewed throughout the year to ensure patient care is not detrimentally impacted. It is recognised that CIPs require change and that change can pose a risk to performance. The assessment has considered those CIPs which pose a potential risk to quality. The Clinical Quality Working Group, which reports to the Board through the RMCGC, will be the vehicle to raise concerns about any adverse quality impact from CIPs in the first instance. The Trust will then assess the validity of the concern and, where appropriate to do so, take remedial action.

Financial and Investment Strategy

Current financial position

The Trust continues to maintain the financial stability required to deliver its strategic plans. 2012/13 delivered A&E activity growth of 6.4% when compared to activity in 2011/12. This is on top of growth of 6.8% in the previous year. The Trust was paid at PbR tariffs for See and Convey,

See and Treat and Hear and Treat. This delivered an underlying EBITDA and Profit in line with expectations.

The 2012/13 financial risk rating was a level 4 in line with the forecast outcome. The key factors underpinning the three year plan 2013/14 to 2015/16 are set out below.

Income

88% of the Trust's income comes from the contract to deliver A&E services and is negotiated under the terms laid out by the Planning Framework for 2013/14. Agreement with commissioners about the impact of the increase in activity, the requirement to meet a 4% productivity improvement target, and agreement about CQUINs have been key in the 2013/14 contract negotiations.

For the planning period, the tariff rate includes the requirements of the NHS South of England Operating Framework to deliver a 1.3% overall tariff reduction in 2013/14. This is made up of a 4% 'deflator' representing the required productivity savings offset by a 2.7% inflationary increase in costs.

The biggest uncertainty facing both commissioners and SECAmb in 2013/14 is the impact of the NHS 111 service. The national data from the pilot services varies greatly, although where the Ambulance Trust also provides the NHS 111 service there are more synergies available. This uncertainty has been factored into the 2013/14 contract, with a financial and clinical capacity review clause included should 999 activity reach a level which is considered to be clinically unsafe.

In considering this, activity growth for A&E has been agreed with commissioners at 5% in 2013/14 and then 5% per annum growth thereafter. The previous year's outturn has been consolidated at 100% into the 2013/14 contract.

In addition the 2013/14 plan includes the full year impact of the service for Surrey PTS, the loss of the Kent PTS service from July 2013 and additional expenditure and revenues from the NHS 111 service.

Pay costs

Pay inflation is assumed to be 1% in 2013/14 and 2% thereafter. The plan also accounts for spine point increments.

Non Pay costs

Non pay expenditure continues to include the service development enabler costs which support the Trust's on-going development and delivery of high performance, including the costs of leasing significant capital assets under the Make Ready banner and the costs of renewing frontline ambulances and response cars in order to provide a modern fleet. Non pay inflation has been assumed at 2% unless the market pressures are different. Known differences include fuel and fleet costs.

Cash

The Trust anticipates that its cash balances will be £27.5M (equivalent to over 8 weeks turnover) by the end of 2014/15.

The Trust does not plan to make use of loans or a working capital facility during this period.

Capital

The Trust has a five year capital programme which reflects plans for vehicle procurement, IM&T, clinical equipment and the estates programme. The total capital financing required to implement the plans is £50.9M during the three year period 2013/14 – 2015/16.

The primary source of capital funding is internally generated cash through increased surpluses from operations. Additionally, capital receipts will be received on the sale of assets. The Trust recognises that there is considerable uncertainty caused by the timing of some major investments and is prepared to seek short and medium term external funding should forecasting show that it may be necessary.

Other changes from prior year

The Trust successfully tendered for and was awarded three to five year contracts to provide Patient Transport Services for Sussex in 2011/12 and for Surrey in 2012/13.

The Sussex contract commenced on 1 April 2012 and the Surrey contract began in October 2012. The Trust was not successful in retendering for the PTS service in Kent and will withdraw from this contract on the 1st July 2013.

The NHS 111 service provision went live in mid-March 2013 and is estimated to generate £4M of additional income and £0.2M of profit per annum.

Future years' outlook

The Trust's operating income is expected to grow by 5% in the period through to 2015/16, primarily as a result of:

- A&E contract growth of 5% in year and 5% per annum thereafter;
- a deflator of 1.3% in year and 2% per annum thereafter; and
- a change in the activity mix and hence the tariff earned towards more Hear and Treat rather than See and Convey.

EBITDA as a percentage of operating income is forecast at 9.4% in 2013/14 and at end the planning period.

The Trust will deliver a surplus every year and plans to have generated a surplus of £4.2M by 2014/15.

The capital programme from 2013/14 – 2015/16 will amount to £50.9M, of which £22.8M is capital to implement the Make Ready and HART Programme over the plan period.

Key financial priorities and investments and how these link to the Trust's strategy

The key to successful delivery of the Trust's financial plans continues to be ensuring that the supply of resources available to the Trust is aligned to demand expectations at the correct skill mix in all geographical areas. This will not only reduce wastage but will also improve efficiency and operational performance.

The Trust has been working with the commissioners to develop further appropriate responses and pathways for patient care, and the Trust is continuously improving the skill mix of staff and its own estate, transport and IT infrastructure to support these aims.

There is a clear and on-going expectation that Hear and Treat activity, which does not require the dispatch of a resource will continue to be a key service that the Trust provides. Additional clinical

resources will continue to be added into the dispatch centres and this has been included within the financial baseline of the 2013/14 plan.

Increases in See and Treat activity require the Trust to focus on the development of staff to deliver high level clinical care without the need to convey the patient to hospital. Therefore different equipment and consumables are required to effectively meet patient demand. These requirements are included within the financial and workforce plans and monitored via working groups, Board Committees and the Board.

Combined with this the Trust will continue to develop an Intermediate Tier, which will transport non urgent patients who have been assessed via See and Treat or other clinicians to the relevant place.

In the longer term the delivery of Make Ready Centres, ACRPs, IT developments and fleet changes all align to the Trust's strategy as laid out in the APR.

Key risks to achieving financial strategy and mitigations

Activity levels not in-line with the contract expectations
The mitigating actions in response to this risk are as follows:

The Trust has agreed performance penalties at a Trust wide rather than CCG level. A specific plan with appropriate resources budgeted to deliver performance on a quarterly basis is in place.

The Trust has agreed expected activity with commissioners and will monitor activity levels throughout the year on a monthly basis. The agreement with the commissioners has the Trust taking the financial risk on 2.5% activity growth above the contract. The Trust has considered this risk, which represents a net adverse impact of up to £1.7m, and has assessed that it could accommodate this level of risk without affecting the fundamental financial stability of the Trust.

The Trust has renewed its focus on the type and level of demand for services, aligning the demand with the supply of an appropriate resource mix, and is focused on continually improving the speed at which it can change its supply of resources to react to changes in demand.

One of the most significant problems faced by the Trust is the delayed handover of patients at hospital A&E departments. This has been acknowledged by the commissioners and a new handover policy has been agreed which seeks to penalise the acute hospitals where the problem occurs as a result of an inability by the hospital to receive patients.

Reserves will be used where appropriate to support activity changes in the short term.

CQUIN funding targets are inappropriately set
The total value of this funding is £3.7M for 2013/14.

The mitigating actions in response to this risk are as follows:

The CQUIN program is agreed each year with specified milestones. These are built into the Trust's internal performance reviews and have key milestones, actions and a named executive lead. Costs only arise to deliver specific plans, and are generally lower than the income received. In 2013/14, the Trust and commissioners have agreed to work together to ensure that the enablers to deliver improved performance in the wider health economy are embedded so that that these improvements can be delivered in future years.

NHS 111 service activity changes and maintenance of the planned cost base
The mitigating action in response to this risk is as follows:

The A&E contract has been commissioned in such a way as to share the potential risk of NHS 111 either significantly changing the demand or changing the mix of the demand between the Trust and commissioners.

The NHS 111 contract is written so as to always provide the Trust with between 90% and 110% of total planned income.

Monthly reporting on financial performance will be undertaken via internal review mechanisms including reports to the FBDC, and corrective measures will be implemented immediately.

PTS activity levels not being achieved.
This could equate to an adverse impact of £0.5 million during 2013/14. If cost controls within PTS are not maintained the service may be provided at a financial loss.

In mitigation the Trust is working to reshape the delivery of PTS activity to better align it to patient and commissioner need. This should allow the Trust to be better placed to adapt to future changes in activity. The Trust has also restructured its services to deliver these contracts on a more cost effective and commercial basis. Additional “new” activity is available on the geographic borders of these contracts.